

Conference Abstracts

The Deleterious Effect of Treatment Inaccessibility in Hepatocellular Carcinoma: A Discussion of Care Disparity

Aryan Dowlatshahi, MD¹, Ali Totonchian, MD^{2a}, Devkarn Sandhu, MD^{3b}, Kaushik Kondubhatla, MD^{2c}

¹ University of Texas MD Anderson Cancer Center, ² University of New Mexico School of Medicine, ³ University of the Incarnate Word Laredo Medical Center Internal Medicine Residency Program

Corresponding author

^a Ali Totonchian, MD, University of New Mexico School of Medicine, Email: atotonch@gmail.com

^b Devkarn Sandhu, MD, University of the Incarnate Word Laredo Medical Center Internal Medicine Residency Program, Email: dsandhu@uiwt.edu

^c Kaushik Kondubhatla, MD, University of New Mexico School of Medicine, Email: kaushik.kon23@gmail.com

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Background

Hepatocellular carcinoma (HCC) is known as the most severe sequelae of chronic liver disease, as well as the most frequent primary liver cancer, and is the third leading cause of cancer-related deaths. Curative treatment options consist of surgical resection or transplantation; however, most patients are only candidates for palliative treatments, of which only chemoembolization has proven to be effective. In HCC, almost all of the tumor burden is confined to the liver, with locoregional liver-directed therapies (LDT) providing an opportunity to control intrahepatic disease with minimal systemic side effects. LDT should be considered in patients with unresectable disease. Resection is not an option in about 90% of patients due to factors such as lesion location, significant portal hypertension, impaired liver function, or concurrent medical conditions. Currently, ablative treatments represent the first line of treatment for early-stage unresectable HCC and serve as effective bridging therapies prior to liver transplantation.

Case Discussion

Our patient was a 57-year-old female with a history of decompensated liver cirrhosis who

presented to the ER with hematemesis. In the ER, she was found to have symptomatic anemia secondary to bleeding esophageal varices. CT revealed a 1.6 x 1.8 hypodense mass in the liver and large esophageal varices. Gastroenterology was consulted and banded 3 bleeding varices and additionally drained 4L of yellow ascites fluid. Further workup revealed an elevated AFP value of 28.73. MRI Abdomen with and without contrast showed a 6.7cm enhancing mass in segment 8 of the liver with a 2.4 cm enhancing mass in segment 6 of the liver, consistent with HCC. Oncology was consulted, and the patient was referred for outpatient ablation/transcatheter arterial chemoembolization at a local hospital; IR was unavailable at that time. She returned three months later with recurrent ascites and received therapeutic paracentesis, though was transferred to the ICU due to hypotension and altered mental state. Labs revealed a hemoglobin of 4.5 and a lactic acid of 14.8, with CT confirming the presence of hemoperitoneum in the context of a necrotic liver lesion. Patient was volume resuscitated with pRBCs, with improvement in blood pressure and lactic acidosis. Given the patient's severe coagulopathy and risk in the context of her advanced decompensated liver

cirrhosis, general surgery would not operate on the hemoperitoneum, and the patient was additionally denied transfer to a higher level of care. She would, unfortunately, succumb to the disease shortly after transferring to inpatient hospice.

Conclusion

Multiple variables were pertinent to this patient's lack of access to life-prolonging treatment, including significant socioeconomic barriers as

she was undocumented and uninsured. As such, she was unable to follow-up in San Antonio for LDT. HCC remains the most devastating consequence of chronic liver disease but given the efficacy of LDT, there have been significant improvements in survival. In areas with underserved populations, unavailability of subspecialties remains a glaring barrier to patient health along with the ongoing socioeconomic barriers, as seen in this patient's case.