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Research Article

**HEPATIC MALIGNANCIES AT TERTIARY CARE HOSPITAL**

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**Abstract:**

**Objective:** To determine the frequency of hepatic malignancies at tertiary care hospital.

**Patients and Methods:** This cross sectional clinical study comprises fifty cases of hepatic tumours. Patients for this study were selected from tertiary care hospital. The inclusion criteria were the patient presenting with hepatic mass firm to hard in consistency and the patients who are diagnosed as hepatic tumours by any of investigative methods (alpha fetoprotein, ultrasound, CT and MRI scan). The detailed history was obtained from the patient as per the pretested structural proforma. Thorough clinical examination was done on each patient and was then subjected to investigations. All patients included in this study underwent treatment either conservatively or surgically as referred to relevant surgeon for intervention. The frequency / percentages (%) and means  $\pm$ SD computed for study variables.

**Results:** During six months study period total fifty patients of hepatic mass were explored. the frequency for male and female population was 40 (80%) and 10 (20%) with mean  $\pm$  sd for age of male and female individuals was 58.81 $\pm$ 9.91 and 55.83 $\pm$ 7.75 respectively. The male population was predominant as male 40 (80%) and female 10 (20%) while the type of hepatoma identified as benign 20 (40%), malignant 06 (12%), focal nodular hyperplasia 07 (14%), malignant 12 (24%), HCC 01 (2.0%), secondaries 01 (2.0%).

**Conclusion:** The hepatic malignancies are more prevalent at tertiary care hospital of developing country.

**Keywords:** Hepatoma, Liver, Cancer and Malignancy.

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**INTRODUCTION:**

Primary and secondary liver tumours account for the fourth most common cause of dying from most cancers worldwide, therefore it is very essential that therapeutic possibilities are consistently developed [1]. Besides the regular modalities of surgery and chemotherapy a range of new methods emerge, however these new procedures in liver tumour therapy have to be seriously investigated and evaluated in context of current hooked up modalities [2]. Tumours of the liver can also be benign or malignant and the latter may be principal or secondary. Benign liver tumours are common and are commonly asymptomatic. Although most need no treatment, it is important to be able to differentiate them from malignant lesions [3]. Haemangiomas are the commonest benign strong tumours of the liver, with an incidence in the established population. Those over 10 cms in diameter now and again produce non unique signs of belly discomfort and fullness and rarely fever, thrombocytopenia and hypofibrinogenaemia due to thrombosis in cavernous cavities [4]. Malignant transformation and spontaneous rupture are rare. Contrast better computed tomography is commonly adequate to diagnose most haemangiomas, and in equivocal instances magnetic resonance imaging or technetium-99 labelled purple blood mobile scintigraphy will confirm the diagnosis [5]. Angiography and biopsy are seldom required. Resection is indicated only for giant symptomatic tumours. Liver mobilephone adenoma grew to become greater normal with the sizable use of oral contraceptives but the decreased estrogen content of current contraceptives has made it less common. Most sufferers existing with pain due to speedy tumour growth, intratumour haemorrhage, or the sensation of a mass [6]. The chance of rupture is 10% and malignant transformation is discovered in 10% of resected specimens [7]. Patient ought to have liver resection to forestall these events. Focal nodular hyperplasia is now not related to use of oral contraceptives, is commonly asymptomatic, and is no longer premalignant [8]. Mass lesions normally include a central stellate scar on computed tomography and magnetic resonance imaging [9]. It does now not require remedy unless symptomatic. Hepatocellular carcinoma is exclusive in United Kingdom and bills for only 2% of all cancers. In sufferers with cirrhosis, the diagnosis need to be suspected when there is deterioration in liver function, an acute complication (ascites, encephalopathy, variceal bleed, jaundice), or development of higher belly ache and fever [10].

Ultrasonography will identify most tumours, and the presence of a discrete mass within a cirrhotic liver, collectively with an alpha fetoprotein concentration above 500 ng/ml is diagnostic. Biopsy is unnecessary and have to be averted to reduce the risk of tumour seeding. Surgical resection is the only remedy that can offer cure [11]. However, owing to nearby spread of tumour and severity of pre-existing cirrhosis, such remedy is feasible in much less than 20% of patients. Average operative mortality is 12% in cirrhotic patients, and five year survival is round 15%. Patients with cirrhosis and small (<5 cm) tumours must have liver transplantation. Injection of alcohol or radiofrequency ablation can improve survival in patients with small tumours who are unsuitable for transplantation. For large tumours, transarterial embolisation with lipiodol and cytotoxic capsules (cisplatin or doxorubicin) may also induce tumour necrosis in some patients.

**PATIENTS AND METHODS:**

This cross sectional clinical study comprises fifty cases of hepatic tumours. Patients for this study were selected from tertiary care hospital. The inclusion criteria were the patient presenting with hepatic mass firm to hard in consistency and the patients who are diagnosed as hepatic tumours by any of investigative methods (alpha fetoprotein, ultrasound, CT and MRI scan) while the exclusion criteria were the patients presenting with generalised hepatomegaly, patients diagnosed with hepatic cysts and the patients diagnosed with hepatic abscesses. The detailed history was obtained from the patient as per the pretested structural proforma. Thorough clinical examination was done on each patient and was then subjected to investigations. All patients included in this study underwent treatment either conservatively or surgically as referred to relevant surgeon for intervention. On discharge, the patients were advised to come for follow up after every 3 months at the hospital while the data was collected on pre-designed proforma and analyzed in SPSS to manipulate the qualitative and quantitative variables for frequencies and percentages.

**RESULTS:**

During six months study period total fifty patients of hepatic mass were explored. The frequency for male and female population was 40 (80%) and 10 (20%) with mean  $\pm$  SD for age of male and female individuals was  $58.81 \pm 9.91$  and  $55.83 \pm 7.75$  respectively. The demographical and clinical profile of study population is presented in Table 1.

**TABLE 1: THE DEMOGRAPHICAL AND CLINICAL PROFILE OF STUDY POPULATION**

| Parameter                       | Frequency (N=50) | Percentage (%) |
|---------------------------------|------------------|----------------|
| <b>AGE (yrs)</b>                |                  |                |
| 20-29                           | 02               | 4.0            |
| 30-39                           | 12               | 24             |
| 40-49                           | 16               | 32             |
| 50+                             | 20               | 40             |
|                                 |                  |                |
| <b>GENDER</b>                   |                  |                |
| Male                            | 40               | 80             |
| Female                          | 10               | 20             |
|                                 |                  |                |
| <b>TYPE OF LIVER MALIGNANCY</b> |                  |                |
| Benign                          | 20               | 40             |
| Malignant                       | 06               | 12             |
| Focal nodular hyperplasia       |                  |                |
|                                 | 07               | 14             |
| <b>MALIGNANT</b>                | 12               | 24             |
| HCC                             | 01               | 2.0            |
| Secondaries                     | 01               | 2.0            |

**DISCUSSION:**

The rising rate of HCC in Western nations seems to correspond with the expanding commonness of hepatitis C infection (HCV) [12]. As of now, the frequency of HCC keeps on rising and the multiyear survival rate stays low [13]. Hepatitis B and C are autonomous hazard factors for the advancement of cirrhosis [14]. Liquor utilization remains an essential extra hazard factor in the United States as liquor misuse is multiple times higher than hepatitis C [15]. Analysis is affirmed without pathologic affirmation. Screening incorporates both radiologic tests, for example, ultrasound, mechanized tomography, and attractive reverberation imaging, and serological markers, for example,  $\alpha$ -fetoprotein at half year interims. Numerous treatment modalities exist; be that as it may, just orthotopic liver transplantation (OLT) or careful resection is remedial. In a study conducted by Edoute Y et al, majority of patients were males and in the present study also majority of patients presenting are males (80%) [16]. In the study conducted by Edoute Y, et al females were diagnosed as benign hepatic tumors [16]. In a similar study

conducted by Osamah H [17] the incidence of benign hepatic tumours was 51% and malignant hepatic tumour was 49%. In a similar study conducted by Osamah H [17], the mode of presentation of malignant disease was pain abdomen 69%, weight loss 83%, jaundice 19% and hepatomegaly 65%.

**CONCLUSION:**

HCC is a malignant growth that happens in the setting of incessant liver ailment and cirrhosis that habitually displays in cutting edge arranges and has turned into a noteworthy weight all around, adding to significant morbidity and mortality.

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