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Loco-regional therapies competing with radiofrequency ablation in potential indications for hepatocellular carcinoma: A network meta-analysis

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Editorial

Chemoembolization combined with radiofrequency ablation is the best option for the local treatment of early hepatocellular carcinoma?

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Loco-regional therapies competing with RFA in potential indications for HCC: a network meta-analysis

Setting & Methods

To compare the efficacies of **non-surgical treatments** for **early HCC** (≤5 cm)

19 randomized-controlled trials comprising **2,793** patients involving **11** different therapies

Network meta-analysis
Primary outcome: OS

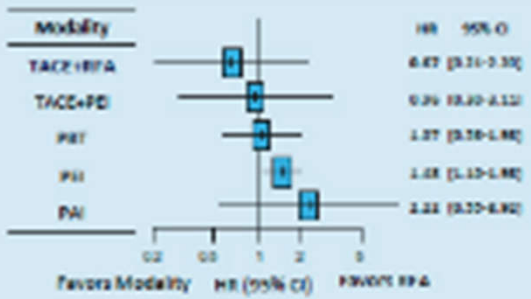
OS and overall PFS

TACE + RFA ranked 1st

✓ The only regimen significantly superior OS to RFA
HR (95% CI) **0.52** (0.33-0.82)

✓ TACE + RFA was ranked as best treatment for overall PFS.

HCC ≤3 cm



✓ **No** significant OS or overall PFS **differences** found between TACE+RFA and RFA alone in treating **HCC ≤3 cm**

Study Highlights

- In a network meta-analysis of 19 randomized trials exploring 11 loco-regional therapies, only the combination of TACE and RFA showed a significant improvement in the overall survival of patients with HCC measuring ≤5 cm, compared to RFA alone (HR, 0.52; 95% CI, 0.33–0.82). This combination treatment also ranked first based on P-score (0.964).
- An analysis of overall progression-free survival involving eight treatments in ten trials revealed that the HR for the combination therapy was significantly better than that for RFA alone (HR, 0.58; 95% CI, 0.38–0.89), again having the highest P-score (0.999).
- No modalities outperformed RFA alone in terms of local progression-free survival rates.

NEWS | 11 October 2023

Monkey survives for two years after gene-edited pig-kidney transplant

Survival time is one of the longest for any interspecies transplant — and moves pig organs closer to human use.

A pig (*Sus domesticus*) kidney is prepared for transplant into a human recipient who had been declared legally dead. Credit: Shelby Lum/AP via Alamy

REVIEW

TH
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ME

Should Antihypertensive Medications Be Routinely Administered in the Nighttime Instead of Daytime?

Hardik Patel, DO,[a] Felix Berglund, MD,[a] Luke Laffin, MD,[b] Nicholas Ruthmann, MD, MPH[b]

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Family Heart, Vascular and Thoracic Institute, Cleveland Clinic, Ohio.

ABSTRACT

The optimal timing for administering antihypertensive medications remains a topic of debate. This review examines the effectiveness of nighttime vs daytime administration of antihypertensive medications in controlling blood pressure (BP). The MAPEC and Hygia trials suggest that nighttime dosing achieves better BP control and significantly lowers cardiovascular events. However, concerns about methodology and generalizability have been raised. In contrast, the HARMONY and TIME trials found no significant difference in BP control nor cardiovascular outcomes between daytime and nighttime dosing. Current research suggests that the timing of antihypertensive medication administration may not be a crucial factor. Therefore, the decision about the timing of antihypertensive medications administration should be individualized, taking into account patient preference and clinical context, in order to promote consistent compliance.
 • The American Journal of Medicine (2023) 136:975–978

diurnal BP variation where BP tends to be higher during the day and lowest at night, support the argument for taking antihypertensive medications at nighttime to better control BP during the morning surge. Studies, including the Hygia Trial, provide data supporting this claim; however, the limitations of these studies make the findings far from definitive. However, data from both the HARMONY and the TIME Trials indicate that the timing of antihypertensive medication administration, whether in the morning or evening, does not have a significant impact on 24-hour BP nor the occurrence of adverse CVD events such as heart attack, stroke, or all-cause death. Overall, it is our recommendation that time of day is not of the essence when administering blood pressure medication. Rather, patients should consistently take their medications at a time most convenient for them.

Linked to: A. B. Wulff et al. J Intern Med 2023; https://doi.org/10.1111/joim.13694 doi: 10.1111/joim.13656

Elevated low-density lipoprotein cholesterol: An inverse marker of morbidity and mortality in patients with myocardial infarction

Jessica Schubert[1], Bertil Lindahl[1,2], Håkan Melhus[1], Henrik Renlund[2], Margrét Leosdottir[3,4], Ali Yari[5], Peter Ueda[6], Tomas Jernberg[5] & Emil Hagström[1,2]

From the [1]Department of Medical Sciences, Uppsala University, Uppsala, Sweden; [2]Uppsala Clinical Research Center, Uppsala, Sweden; [3]Department of Cardiology, Skåne University Hospital, Malmö, Sweden; [4]Department of Clinical Sciences, Faculty of Medicine, Lund University, Malmö, Sweden; [5]Department of Clinical Sciences, Karolinska Institutet, Danderyd Hospital, Stockholm, Sweden; and [6]Department of Medicine, Clinical Epidemiology Division, Karolinska Institutet, Solna, Stockholm, Sweden

Abstract. Schubert J, Lindahl B, Melhus H, Renlund H, Leosdottir M, Yari A, et al. Elevated low-density lipoprotein cholesterol: An inverse marker of morbidity and mortality in patients with myocardial infarction. *J Intern Med.* 2023;**294**:616–627.

Background. The incidence of atherosclerotic cardiovascular disease increases with levels of low-density lipoprotein cholesterol (LDL-C). Yet, a paradox may exist where lower LDL-C levels at myocardial infarction (MI) are associated with poorer prognoses.

Objective. To assess the association between LDL-C levels at MI with risk factor burden and cause-specific outcomes.

Methods. Statin-naive patients hospitalized for a first MI and registered in SWEDEHEART were included. Data were linked to Swedish registers. Primary outcomes were all-cause mortality and nonfatal MI. Associations between LDL-C and outcomes were assessed using adjusted proportional (interquartile range 2.4–3.6). Patient age and comorbidities increased as LDL-C decreased. During a median follow-up of 4.5 years, 10,236 patients died, and 4973 had nonfatal MI. Patients with the highest LDL-C had a lower risk of mortality (hazard ratio [HR] 0.75; 95% confidence interval [CI] 0.71–0.80). The risk of hospitalization for pneumonia, hip fracture, chronic obstructive pulmonary disease, and new cancer diagnosis was lower with higher LDL-C (HR range, 0.40–0.81). Patients with the highest LDL-C had a greater risk of recurrent MI (HR 1.16; 95% CI 1.07–1.26).

Conclusions. Patients with the highest LDL-C levels at MI had the lowest incidence of mortality and morbidity. This seems to reflect lower age at MI, less underlying morbidities, paired with the modifiability of LDL-C. However, supporting the causal association between LDL-C and ischemic heart disease, elevated LDL-C was simultaneously associated with an increased risk of nonfatal MI.

Conclusion

Patients with a first MI despite low LDL-C levels have increased risk of mortality and outcomes associated with ageing, compared with patients with higher LDL-C. Conversely, higher LDL-C was associated with an increased incidence of recurrent nonfatal MI. Further, a greater reduction in LDL-C after MI was associated with reduced mortality, even in those with the lowest LDL-C at the time of MI. These results indicate that there is no real paradox, rather that LDL-C is a marker of overall frailty reflecting morbidity and biological ageing and that patients who suffer an MI, despite low LDL-C, have other strong drivers of atherosclerotic CVD. This emphasizes the importance of continuing lipid-lowering treatment in patients with MI, regardless of the level of LDL-C at the time of that MI. This is of special significance when untreated LDL-C is low at the time of MI, as this might

INVITED EDITORIAL

AP&T Alimentary Pharmacology & Therapeutics WILEY

Editorial: Time to consider early treatment for chronic hepatitis B in both children and adults

Alimentary Pharmacology & Therapeutics / Volume 58, Issue 9 / p. 866-873

ORIGINAL ARTICLE

Age at treatment initiation predicts response in children with chronic hepatitis B

Xiaoli Wu, Zhenzhen Yao, Xin Lai, Yingping Gu, Songxu Peng

First published: 17 August 2023
https://doi.org/10.1111/apt.17667
Citations: 2

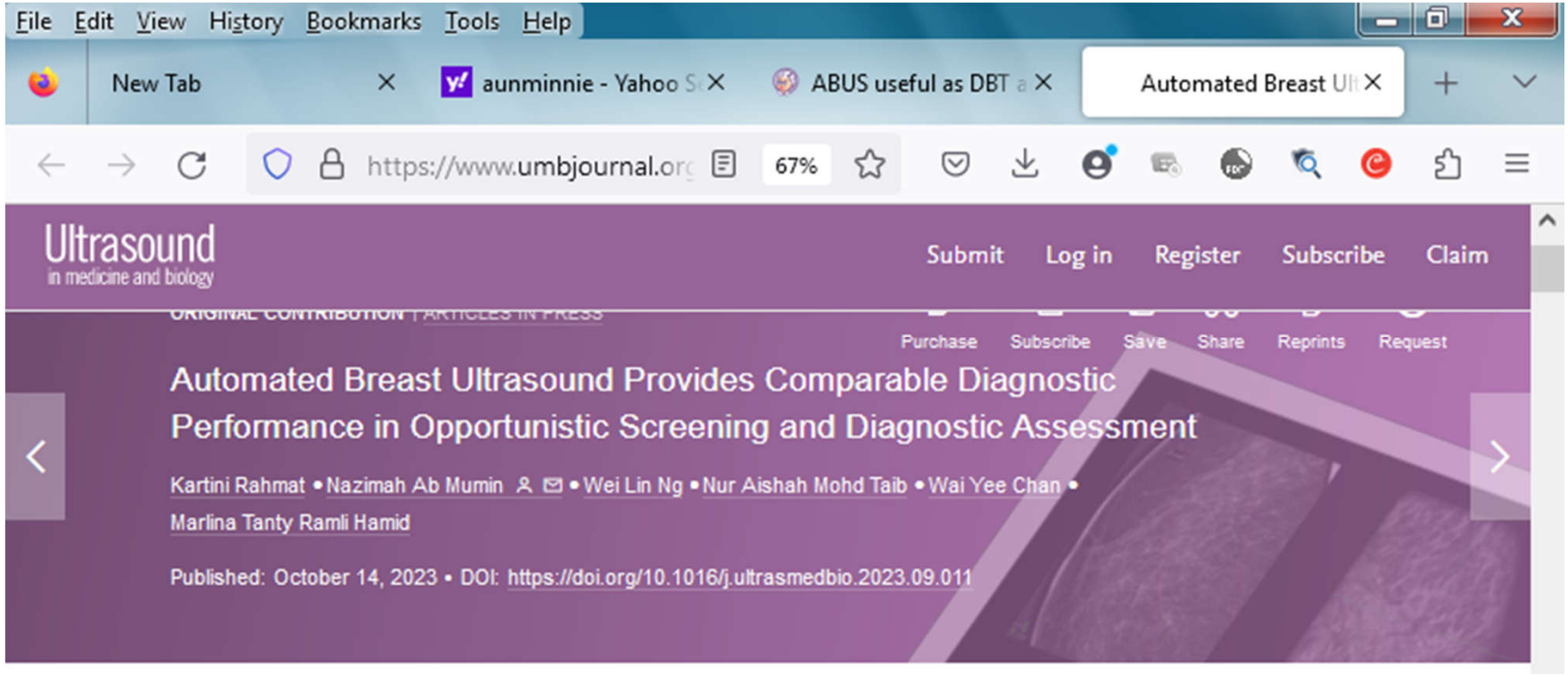
The Handling Editor for this article was Professor Grace Wong, and it was accepted for publication after full peer-review.

Results

Of the 306 subjects, 200 (65.4%) were male. Median (IQR) duration of follow-up was 26 (17, 42) months. There were 139 (45.4%), 79 (25.8%) and 88 (28.6%) of participants in the 1–3 years, 4–6 years and 7–17 years groups, respectively. After adjusting for other covariates, age at treatment initiation was negatively associated with the occurrence of HBsAg loss (1–3 years: HR = 5.07, 95% CI = 2.91–8.82; 4–6 years: HR = 2.42, 95% CI = 1.31–4.46) and HBeAg clearance (1–3 years: HR = 1.73, 95% CI = 1.18–2.53). In addition, we observed linear dose–responses relationships between age at treatment initiation and the probability of HBsAg loss and HBeAg clearance.

Conclusions

In children with CHB receiving antiviral treatment, HBsAg loss and HBeAg clearance were frequently observed. Age at treatment initiation can predict treatment response, including HBsAg loss and HBeAg clearance.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Kartini Rahmat • Nazimah Ab Mumin • Wei Lin Ng • Nur Aishah Mohd Taib • Wai Yee Chan • Marlina Tanty Ramli Hamid
Published: October 14, 2023 • DOI: https://doi.org/10.1016/j.ultrasmedbio.2023.09.011

sample) were calculated.

Results

A total of 1089 ABUS examinations were performed (age range: 29–85 y, mean: 51.9 y). Among these were 909 screening (83.5%) and 180 diagnostic (16.5%) examinations. A total of 579 biopsies were performed on 407 patients, with a biopsy rate of 53.2%. There were 100 (9.2%) malignant lesions, 30 (5.2%) atypical/B3 lesions and 414 (71.5%) benign cases. In 9 cases (0.08%), ABUS alone detected malignancies, and in 19 cases (1.7%), DBT alone detected malignancies. The PPV3 in the screening group was 14.6%.

Conclusion

ABUS is useful as an adjunct to DBT in the opportunistic screening and diagnostic setting.

THE END