Prognostic value of plasma fibrinogen in hepatocellular carcinoma: a meta-analysis

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Background: Elevated plasma fibrinogen levels have been associated with tumor progression in several malignancies. Our study aims to characterize the clinical significance of elevated plasma fibrinogen levels in patients with hepatocellular carcinoma (HCC).

Materials and methods: Relevant published articles were systematically searched in electronic databases including PubMed, Embase, and Web of Science. The pooled differences in plasma fibrinogen levels among HCC, cirrhotic, and control groups were expressed as weighted mean differences (WMDs) and their corresponding 95% CIs. The associations between elevated fibrinogen and overall survival (OS) and disease-free survival (DFS)/recurrence-free survival (RFS) were expressed as HRs and their 95% CIs, whereas the associations between elevated fibrinogen and various types of clinical characteristic of patients with HCC were expressed as ORs and their corresponding 95% CIs.

Results: Results showed that the plasma fibrinogen levels in patients with HCC were not significantly different than that in healthy controls (WMD = 0.50, 95% CI = [–0.82, 1.82], P = 0.457) or patients with cirrhosis (WMD = –0.62, 95% CI = [–1.56, 0.33], P = 0.200). However, our results showed that compared to those with normal levels, patients with HCC and elevated plasma fibrinogen levels showed poorer OS (HR = 2.08, 95% CI = [1.67, 2.59], P < 0.0001) and DFS/RFS (HR = 1.90, 95% CI = [1.52, 2.37], P < 0.0001). Results of trial sequential analysis of the OS indicated that currently available studies were sufficient to validate the negative prognostic value of elevated plasma fibrinogen in patients with HCC. Clinicopathological analyses showed that high plasma fibrinogen levels were associated with tumor progression as indicated by advanced tumor stage, larger tumor size, increased tumor number, and the presence of vascular invasion.

Conclusion: Elevated plasma fibrinogen levels are associated with poor prognosis and advanced tumor progression. Plasma fibrinogen may serve as a negative prognostic biomarker in patients with HCC.

Keywords: hepatocellular carcinoma, fibrinogen, prognosis, tumor progression, meta-analysis

Introduction

Hepatocellular carcinoma (HCC) is a primary malignancy of the liver and is now the second leading cause of cancer deaths worldwide, following lung cancer. The global incidence of HCC is still on the rise with the highest prevalence in East Asia, where the mortality rate is 33.5 per 100,000 people. The majority of HCC cases occur with underlying chronic hepatitis B or C viral infection and cirrhosis. The other main risk factors for HCC are alcohol intoxication and aflatoxin. Current treatment modalities include radical therapies (eg, surgical resection, liver transplantation, radiofrequency ablation) and adjuvant therapies (eg, transarterial chemoembolization [TACE], systemic...
chemotherapy, sorafenib). Although these methods have significantly improved the long-term survival of patients with HCC, the overall prognosis is largely limited by the extent of liver dysfunction. Although various tumor staging systems are available to predict prognosis, they too have major limitations. For instance, the Milan criteria are solely based on the preoperative imaging without consideration of molecular signatures and biopsy has the risk of introducing tumor cell seeding. Therefore, it would be useful to identify effective preoperative prognostic biomarkers that may facilitate outcome prediction and indicate the requirement for aggressive therapy in high-risk patients with HCC.

To date, the most common serum biomarker used by clinicians to diagnose HCC is alpha-fetoprotein (AFP). However, the reliability of AFP is questionable due to its lack of sensitivity and specificity. In addition, AFP marker is less valuable in the early stages of HCC when the tumor size is less than 3 cm. Therefore, new and more effective prognostic serum biomarkers are needed to improve clinical outcomes.

Fibrinogen is a 340-kDa soluble plasma glycoprotein synthesized in the liver by hepatocytes. It is an important coagulation factor. In the coagulation cascade, fibrinogen is enzymatically converted to fibrin by activated thrombin and subsequently forms a clot. In situations such as tissue injury, enzymatically converted to fibrin by activated thrombin and coagulation factor. In the coagulation cascade, fibrinogen is synthesized in the liver by hepatocytes. It is an important serum biomarkers are needed to improve clinical outcomes.

HCC, the overall prognosis is largely limited by the extent of liver dysfunction. Although various tumor staging systems are available to predict prognosis, they too have major limitations. For instance, the Milan criteria are solely based on the preoperative imaging without consideration of molecular signatures and biopsy has the risk of introducing tumor cell seeding. Therefore, it would be useful to identify effective preoperative prognostic biomarkers that may facilitate outcome prediction and indicate the requirement for aggressive therapy in high-risk patients with HCC.

Materials and methods
This meta-analysis was conducted in accordance with the PRISMA guidelines. The studies included in this meta-analysis are previously published, and therefore, ethical approval and informed consent are not required.

Literature search strategy
Relevant published literatures were systematically searched in electronic databases including PubMed, Embase, and Web of Science. The last update was September 2017. The keywords used included “Fibrinogen”, “liver neoplasm”, and “hepatocellular carcinoma”. Specifically, the keywords used in PubMed were (Fibrinogen) AND (neoplasm, liver [MeSH Terms] OR hepatocellular carcinoma). In Embase, the keywords used were Quick search: Fibrinogen AND (liver neoplasm OR hepatocellular carcinoma). In Web of Science, the keywords used were Fibrinogen AND (liver neoplasm OR hepatocellular carcinoma) [Topic]. There were no restrictions to the search process in terms of language, date, research design, or publication status.

Study selection criteria
Studies were included when they met the following inclusion criteria:

1. diagnosis of HCC was proven by pathological methods;
2. pretreatment plasma fibrinogen was measured in all participants;
3. mean and SD of pretreatment plasma fibrinogen levels were reported in patients with HCC, cirrhosis, and/or healthy controls;
4. complete clinicopathological characteristics were evaluated prior to treatment; and
5. outcomes included overall survival (OS), disease-free survival (DFS), and/or recurrence-free survival (RFS).

Studies were excluded when they met the following exclusion criteria:

1. experiments were performed in vitro or in vivo;
2. study designs were case reports and reviews;
3. fibrinogen peptide chains, mRNA or protein expression, or fibrinogen degradation products were measured;
Outcomes of interest
The primary outcomes of interest were OS, DFS, and RFS. Another outcome of interest was the association between fibrinogen levels and clinicopathological parameters. Other outcomes of interest were pretreatment plasma fibrinogen levels of HCC, cirrhotic, and/or healthy subjects.

Data extraction and quality assessment
Two independent researchers performed literature selection, evaluation, and extraction. Data on the following characteristics were retrieved: first author; year of publication; country in which the study was conducted; number of HCC, cirrhotic, and control subjects enrolled; age; sex; pretreatment plasma fibrinogen level measurements and methods; plasma fibrinogen cutoff values; methods used to determine cutoff values; treatments received; and follow-up period. Discrepancies were resolved by discussion to consensus. If both univariate and multivariate outcomes were provided in an article, we chose the latter. Efforts were made to contact the corresponding authors for any information not reported in the article.

The Newcastle–Ottawa Scale (NOS) was used to assess the quality of the studies included. NOS employs a “star” rating system that evaluates eight items, which are categorized into three domains: selection (four items: maximum one star each), comparability (one item: maximum two stars), and outcome (three items: maximum one star each). The NOS assessment, which ranges from 0 (worst) to 9 (best) stars, provides a semiquantitative appraisal for the overall quality of each study. Studies with scores of 6 or higher were regarded as high quality.

Statistical analyses
All statistical analyses were performed using Stata 13.1 (StataCorp LP, College Station, TX, USA). The pooled differences in plasma fibrinogen levels among HCC, cirrhotic, and control groups were expressed as weighted mean differences (WMDs) and their corresponding 95% CIs. The associations between elevated fibrinogen and OS or DFS/RFS were expressed as the HRs and their corresponding 95% CIs, and the associations between elevated fibrinogen and various types of clinical characteristics of patients with HCC were expressed as ORs and their corresponding 95% CIs. Heterogeneity among studies was assessed using Cochran’s Q test and Higgins’ F statistic. If no significant heterogeneity was indicated among studies (P > 0.1, F < 50%), a fixed effect model was applied for analysis. Otherwise, the random effect model was adopted. Sensitivity analysis was performed using sequential omission of individual studies to evaluate the influence of an individual study on the overall pooled estimates. If the pooled estimates were affected after removal, it indicated that the results were inconsistent. Egger’s linear regression tests were used to assess for publication bias, and any indication of publication bias was further tested with trim and fill analysis. P < 0.05 indicated significant bias.

Trial sequential analysis (TSA) was conducted to minimize type I error, evaluate required information size, and assess whether current available studies were sufficient for a firm conclusion. The required information size refers to the required number of participants to produce statistically significant result in meta-analysis. The diversity-adjusted required information size of 784 patients was calculated on the basis of type I error of 5%, type II error of 20%, the control event proportion of 40%, and a relative risk reduction of 20% in outcomes. When the cumulative Z-curve crossed the trial sequential monitoring boundary for benefit, harm or futility, or the required information size, this result suggests conclusive evidence within this meta-analysis. Otherwise, more clinical studies are warranted to reach a consistent conclusion.

Results
Study selection process
Figure 1 depicts the fully detailed process of article search and selection. The electronic database searches yielded a total of 1,128 potential articles (PubMed = 410, Embase = 565, and Web of Science = 153). The titles and abstracts were screened, and 1,094 articles were excluded because they covered irrelevant research topics (n = 1,019), lacked full text (n = 20), or were duplicates (n = 55). Thirty-four full-text articles were retrieved for detailed evaluation. Eighteen articles were eliminated due to the following reasons: in vivo/in vitro study (n = 2); case report (n = 2); study that measured fibrinogen peptide chains, mRNA or protein expression, or fibrinogen degradation product (n = 12); cases that included other primary liver tumor besides HCC (n = 1); and data not presented as mean ± SD (n = 1). A total of 16 articles were included in this study: eight articles measured and compared the plasma fibrinogen levels among HCC, cirrhotic, and healthy subjects, and eight articles studied the clinicopathological and prognostic value of plasma fibrinogen in HCC.
Study characteristics and quality assessment

Eight studies that reported OS, DFS, or RFS were included in the meta-analysis to assess the prognostic value of plasma fibrinogen in patients with HCC. The main characteristics of the included studies are presented in Table 1. All studies were conducted in Asia, involving a total of 1,961 patients with HCC. Pretreatment plasma fibrinogen levels were measured using Clauss assay or serum biochemistry method. The cutoff values for plasma fibrinogen level were determined by different methods, including receiver operating characteristics (ROC), clinical reference range, or median. The cutoff values divided patients with HCC into an elevated plasma fibrinogen group and a normal plasma fibrinogen group. All patients with HCC also received either curative treatment or palliative treatment. In addition, eight studies were included to examine the pretreatment plasma fibrinogen levels in HCC, cirrhotic, and/or healthy subjects. Six studies presented plasma fibrinogen levels in patients with HCC and healthy controls, three studies presented data for patients with cirrhosis and controls, and six studies presented data for patients with HCC and patients with cirrhosis. The details of the studies are provided in Table 2.

We also used the NOS to evaluate the quality of the eight studies that reported OS, DFS, and RFS. All of the studies...
## Table 1 Study characteristics of the included studies for prognostic analysis

<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Country</th>
<th>No. of HCC patients</th>
<th>Age (range in years)</th>
<th>Sex (M/F)</th>
<th>Cutoff value</th>
<th>Cutoff level method</th>
<th>Cutoff (range)</th>
<th>Fibrinogen measurement</th>
<th>Treatment received</th>
<th>Follow-up (range in months)</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wang et al[2]</td>
<td>2016</td>
<td>China</td>
<td>41</td>
<td>Mean = 49 ± 10.7 (27–72)</td>
<td>38/3</td>
<td>2.675 g/L</td>
<td>ROC</td>
<td>Mean = 2.68 ± 1 g/L (0.84–5.06 g/L)</td>
<td>Clauss method</td>
<td>Liver transplantation</td>
<td>Mean = 43 months; &gt;5 years</td>
<td>OS, DFS 1, 3, 5 years</td>
</tr>
<tr>
<td>Fu et al[3]</td>
<td>2017</td>
<td>China</td>
<td>130</td>
<td>Median = 49.5 (13–72)</td>
<td>121/9</td>
<td>2.345 g/L</td>
<td>ROC</td>
<td>– –</td>
<td>Liver transplantation</td>
<td>&gt;5 years</td>
<td>OS, DFS 1, 3, 5 years</td>
<td></td>
</tr>
<tr>
<td>Ruan et al[5]</td>
<td>2016</td>
<td>China</td>
<td>352</td>
<td>Mean = 50.6 ± 11.7</td>
<td>315/37</td>
<td>3.43 g/L</td>
<td>ROC</td>
<td>Mean = 3.4 ± 2.0 g/L</td>
<td>Serum biochemistry</td>
<td>Curative resection</td>
<td>Median = 42 months</td>
<td>OS 3.5 years</td>
</tr>
<tr>
<td>Kinoshita et al[9]</td>
<td>2013</td>
<td>Japan</td>
<td>113</td>
<td>Median = 72 (45–87)</td>
<td>76/37</td>
<td>3.15 mg/dL</td>
<td>ROC</td>
<td>Median = 279 mg/dL (91–720 mg/dL)</td>
<td>Clauss method</td>
<td>Curative treatment (surgical resection, RFA/PEI) or palliative treatment (TACE, TAI, systemic chemotherapy, sorafenib, BSC)</td>
<td>Median = 18 months (1–88)</td>
<td>OS 1, 3, 5 years</td>
</tr>
<tr>
<td>Liu et al[24]</td>
<td>2017</td>
<td>China</td>
<td>192</td>
<td>Mean = 46 ± 7.8</td>
<td>164/28</td>
<td>4 g/L</td>
<td>Clinical reference range</td>
<td>– –</td>
<td>Operation</td>
<td>3 years</td>
<td>OS, RFS 3 years</td>
<td></td>
</tr>
<tr>
<td>Wang et al[34]</td>
<td>2017</td>
<td>China</td>
<td>539</td>
<td>Mean = 53 (19–88)</td>
<td>480/59</td>
<td>2.83 g/L</td>
<td>Median</td>
<td>Median = 2.83 g/L</td>
<td>Serum biochemistry</td>
<td>All patients received treatment</td>
<td>5 years</td>
<td>OS, DFS 5 years</td>
</tr>
<tr>
<td>Zhang and Long[19]</td>
<td>2017</td>
<td>China</td>
<td>308</td>
<td>Mean = 51.2 ± 12.9</td>
<td>220/88</td>
<td>4.0 g/L</td>
<td>Clinical reference range</td>
<td>Mean = 3.4 ± 0.9</td>
<td>Clauss method</td>
<td>RFA, resection, TACE, sorafenib, or others</td>
<td>&gt;5 years</td>
<td>OS, DFS 5 years</td>
</tr>
<tr>
<td>Li et al[26]</td>
<td>2015</td>
<td>China</td>
<td>286</td>
<td>Mean = 47.6 ± 11.6 (12–73)</td>
<td>261/25</td>
<td>3.24 g/L</td>
<td>ROC</td>
<td>Median = 2.98 g/L</td>
<td>– –</td>
<td>Liver resection (n = 184) or transplantation (n = 102)</td>
<td>Median = 23 months (1–132)</td>
<td>RFS 1, 3 years</td>
</tr>
</tbody>
</table>

**Abbreviations:** BSC, best supportive care; DFS, disease-free survival; HCC, hepatocellular carcinoma; OS, overall survival; PEI, percutaneous ethanol injection; RFA, radiofrequency ablation; RFS, recurrence-free survival; ROC, receiver operating characteristics; TACE, transcatheter arterial chemoembolization; TAI, transcatheter arterial infusion.
We examined the plasma fibrinogen levels in HCC, cirrhotic, and healthy subjects. A random effect model showed no significant difference in the plasma fibrinogen levels among patients with HCC and healthy controls (WMD = 0.34, 95% CI = [-0.34, 0.97], P = 0.26; Figure 2A). However, compared to healthy individuals, patients with cirrhosis had significantly lower plasma fibrinogen levels (WMD = -0.45, 95% CI = [-0.65, -0.25], P = 0.03; Figure 2B). The plasma fibrinogen levels were not significantly different between patients with HCC and patients with cirrhosis (WMD = -0.26, 95% CI = [-0.43, -0.09], P = 0.21; Figure 2C).

**Table 2 Baseline plasma fibrinogen levels of HCC, cirrhotic, and healthy subjects**

<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Country</th>
<th>No. of controls</th>
<th>No. of HCC subjects</th>
<th>No. of cirrhotic subjects</th>
<th>Plasma fibrinogen level (g/L)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zhu et al22</td>
<td>2009</td>
<td>China</td>
<td>30</td>
<td>114</td>
<td>–</td>
<td>2.90 ± 0.46</td>
</tr>
<tr>
<td>Alkim et al39</td>
<td>2012</td>
<td>Turkey</td>
<td>10</td>
<td>11</td>
<td>13</td>
<td>2.6 ± 0.4</td>
</tr>
<tr>
<td>Hessien et al25</td>
<td>2015</td>
<td>Egypt</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>2.74 ± 0.44</td>
</tr>
<tr>
<td>Doğan et al21</td>
<td>1997</td>
<td>Turkey</td>
<td>–</td>
<td>20</td>
<td>44</td>
<td>–</td>
</tr>
<tr>
<td>Basili et al23</td>
<td>1997</td>
<td>Italy</td>
<td>–</td>
<td>18</td>
<td>18</td>
<td>–</td>
</tr>
<tr>
<td>Casaril et al30</td>
<td>1989</td>
<td>Italy</td>
<td>–</td>
<td>49</td>
<td>11</td>
<td>–</td>
</tr>
<tr>
<td>Al Ghumlas et al30</td>
<td>2005</td>
<td>South Africa</td>
<td>40</td>
<td>13</td>
<td>67</td>
<td>3.07 ± 1.17</td>
</tr>
<tr>
<td>van der Walt et al28</td>
<td>1977</td>
<td>South Africa</td>
<td>19</td>
<td>19</td>
<td>–</td>
<td>3.15 ± 0.76</td>
</tr>
</tbody>
</table>

**Note:** Data are presented as mean ± SD.

**Abbreviation:** HCC, hepatocellular carcinoma.

Correlation between elevated plasma fibrinogen and DFS/RFS

Meta-analysis of the 5 DFS-/RFS-related studies showed low heterogeneity among studies (I² = 20.8%, P = 0.139). A fixed effect model showed that patients with HCC and high pretreatment plasma fibrinogen levels had significantly poorer outcomes compared to those with normal fibrinogen levels (HR = 2.08, 95% CI = [1.67, 2.59], P < 0.0001; Figure 3A). Sensitivity analysis showed that the pooled result was relatively stable (Figure 3B). Egger’s test (P = 0.008) showed the presence of publication bias. Further, trim and fill analysis showed that after adjusting for three studies, the recalculated pooled HR for OS was 1.85 (95% CI = [1.52, 2.37]; Figure 3C), which was not significantly changed from the initial estimate (HR = 1.90, 95% CI = [1.67, 2.59]). Our data suggest that the presence of publication bias has no significant effect on the overall finding.

We also performed TSA meta-analysis on the OS results. Although the number of participants had not reached the required information size, our TSA showed that the cumulative Z-curve crossed the trial sequential monitoring boundary for harm, confirming the poorer survival rate among patients with HCC and high levels of plasma fibrinogen. Our results suggest that currently available studies are sufficient to conclude the negative prognostic value of elevated plasma fibrinogen in patients with HCC (Figure 4).
### Table 3 Quality assessment of the included studies for prognostic evaluation

<table>
<thead>
<tr>
<th>Selection</th>
<th>Representativeness of the exposed cohort</th>
<th>Selection of the nonexposed cohort</th>
<th>Ascertainment of exposure</th>
<th>Demonstration that outcome of interest was not present at start of study</th>
<th>Comparability</th>
<th>Exposure Assessment of outcome</th>
<th>Was follow-up long enough for outcomes to occur</th>
<th>Adequacy of follow-up of cohorts</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wang et al (2016)</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>**</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>8</td>
</tr>
<tr>
<td>Fu et al (2017)</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>**</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>8</td>
</tr>
<tr>
<td>Ruan et al (2016)</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>**</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>8</td>
</tr>
<tr>
<td>Kinoshita et al (2013)</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>**</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>8</td>
</tr>
<tr>
<td>Liu et al (2017)</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>**</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>9</td>
</tr>
<tr>
<td>Wang et al (2017)</td>
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<td>**</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>9</td>
</tr>
<tr>
<td>Zhang and Friedman (2012)</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>**</td>
<td>*</td>
<td>*</td>
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<td>9</td>
</tr>
<tr>
<td>Li et al (2015)</td>
<td>*</td>
<td>*</td>
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<td>**</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>9</td>
</tr>
</tbody>
</table>

**Notes:** The Newcastle–Ottawa Scale (NOS) was used to assess the quality of the studies included. NOS employs a “star” rating system that evaluates eight items, which are categorized into three domains: selection (four items: maximum one star each), comparability (one item: maximum two stars), and outcome (three items: maximum one star each). The NOS assessment, which ranges from 0 (worst) to 9 (best) stars, provides a semiquantitative appraisal for the overall quality of each study. Studies with scores of 6 or higher were regarded as high quality.

### Discussion

In this meta-analysis, we identified eight studies, with a total number of 1,961 patients with HCC, demonstrated that those patients with cirrhosis had significantly lower plasma fibrinogen levels in HCC cases and significantly elevated when compared with that in healthy subjects (WMD $=-0.44$, 95% CI $=-0.62$ to $-0.26$). Fibrinogen is a product of hepatocytes. Therefore, patients with cirrhosis and compensated liver function may generally have less plasma fibrinogen levels than healthy controls. Higher plasma fibrinogen was also marginally associated with increased serum AFP level (OR $=1.37$, 95% CI $=[1.17, 1.60])$ and vascular invasion (OR $=1.99$, 95% CI $=[1.95, 2.03]$). Patients with cirrhosis had significantly lower plasma fibrinogen levels than those with moderate or advanced cirrhosis (Child B/C) compared with Child A (Child A vs Child B/C OR $=1.53$, 95% CI $=[1.10, 2.33]$, P $=0.04$). Patients with cirrhosis and elevated fibrinogen levels are more likely to experience poorer OS (HR $=2.08$, 95% CI $=[1.67, 2.59]$, P $<0.0001$) and recurrence (HR $=2.90$, 95% CI $=[1.56, 0.33]$, P $=0.200$). Therefore, plasma fibrinogen level is not usable as a diagnostic marker for HCC detection.

On the other hand, our prognostic value analyses, which included eight studies, with a total number of 1,961 patients with HCC, demonstrated that those patients that examined the pretreatment plasma fibrinogen levels and the clinical features of HCC are depicted in Figure 6 and summarized in Table 4.

### Clinopathological parameters of HCC and clinicopathological parameters of HCC

Association between plasma fibrinogen and clinicopathological parameters of HCC. Clinopathological analyses showed that elevated plasma fibrinogen levels were significantly associated with advanced tumor stage (stage III–IV vs stage I–II, OR $=2.37$, 95% CI $=[1.93, 2.94]$, P $<0.0001$), larger tumor size ($>5$ vs $\leq 5$ cm, OR $=1.04$, 95% CI $=[1.22, 1.45]$, P $<0.0001$), increased tumor number (multiple vs single, OR $=1.54$, 95% CI $=[1.17, 2.05]$, P $=0.002$), and vascular invasion (OR $=3.81$, 95% CI $=[2.25, 6.49]$, P $<0.0001$). However, our prognostic value analyses did not show a significant association with age, sex, hepatitis B surface antigen (HBSAg), and alcohol use. The correlations between plasma fibrinogen and clinicopathological parameters of HCC are depicted in Figure 6 and summarized in Table 4.
Figure 2 Forest plot for plasma fibrinogen levels in (A) patients with HCC compared to that in healthy controls, (B) cirrhotic patients compared to healthy controls, and (C) patients with HCC compared to patients with cirrhosis.

**Abbreviations:** HCC, hepatocellular carcinoma; WMD, weighted mean difference.
**A** Overall survival

<table>
<thead>
<tr>
<th>Study</th>
<th>HR (95% CI)</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wang et al 2016</td>
<td>5.00 (1.27, 12.08)</td>
<td>3.82</td>
</tr>
<tr>
<td>Fu et al 2017</td>
<td>3.00 (1.00, 4.07)</td>
<td>9.82</td>
</tr>
<tr>
<td>Ruan et al 2016</td>
<td>2.00 (1.00, 3.09)</td>
<td>15.28</td>
</tr>
<tr>
<td>Liu et al 2017</td>
<td>4.00 (1.23, 11.81)</td>
<td>3.79</td>
</tr>
<tr>
<td>Wang et al 2017</td>
<td>2.16 (1.43, 3.26)</td>
<td>28.35</td>
</tr>
<tr>
<td>Zhang et al 2017</td>
<td>1.61 (1.20, 2.43)</td>
<td>38.95</td>
</tr>
<tr>
<td>Overall (<em>I^2=25.7%, P=0.242</em>)</td>
<td>2.08 (1.67, 2.59)</td>
<td>100.00</td>
</tr>
</tbody>
</table>

**B** Sensitivity analysis

Meta-analysis estimates, given named study is omitted

**C** Trim and fill analysis

Figure 3 Association of elevated plasma fibrinogen level with overall survival in patients with hepatocellular carcinoma.

Notes: (A) Forest plot of HRs for overall survival. (B) Sensitivity analysis of overall survival. (C) Trim and fill analysis for the overall survival. The squares represent the adjusted studies.
The prognostic value of elevated plasma fibrinogen levels in patients with HCC. Our clinicopathological analyses also indicated that patients with HCC and elevated plasma fibrinogen levels are likely to be associated with a higher pathological stage including advanced tumor stage, larger tumor size, increased tumor number, and the presence of vascular invasion, implicating that plasma fibrinogen level is closely related to tumor progression.

In addition to our analysis, recent studies also indicated a positive correlation between elevated plasma fibrinogen levels and poorer prognosis in other solid tumors including esophageal carcinoma,37–39 small cell lung carcinoma,40 non-small cell lung carcinoma,41 upper urinary tract urothelial carcinoma,42,43 epithelial ovarian cancer,44 colorectal cancer,45 renal cell carcinoma,46,47 and gastric cancer.48,49 There are several theories that may explain this association: 1) tumor progression is usually coupled with elevated inflammatory responses and leukocyte infiltration into tumor stroma. Infilt rated leukocytes may convert fibrinogen into fibrin matrix, which encapsulates the tumor cells and promotes tumor angiogenesis;20 2) fibrinogen may serve as an extracellular matrix protein that regulates the growth of cancer cells by binding to growth factors (eg, vascular endothelial growth factor, fibroblast growth factor-2, platelet-derived growth factor) and promote cellular adhesion, proliferation, and metastasis; and51–53 3) fibrinogen promotes the adhesion of tumor cells to platelets, which leads to platelet aggregation and thrombin formation around tumor cells. The tumor-associated platelets and thrombin protect tumor cells against the attack of natural killer cells.54 Moreover, in vitro studies also suggested that high levels of fibrinogen induced epithelial–mesenchymal transition, which is a hallmark for cancer invasion and metastasis.14

As a plasma biomarker, fibrinogen has its advantages: blood sampling is a minimally invasive method that patients tolerate well, and it allows replicated sampling for long-term surveillance. Plasma fibrinogen levels can be determined easily by using routine coagulation parameters tested in the laboratory, which is rapid and cost-effective compared to other measurements, such as serum AFP level. Similar to serum AFP level, which has been identified as a significant prognostic marker in HCC, fibrinogen may also achieve similar accuracy for predicting clinical outcomes. In fact, Fu et al55 found that subgroups with negative AFP levels or
less aggressive clinicopathology but with elevated plasma fibrinogen levels still demonstrated poorer survival outcomes, suggesting that plasma fibrinogen could be a better prognostic biomarker compared to AFP, although further studies are warranted.

Most importantly, the examination of pretreatment plasma fibrinogen levels may help clinicians identify and provide more aggressive treatments to the appropriate group of patients to improve clinical outcomes. By comparing the normal- and high-fibrinogen groups, Zhang and Long19 found that patients with HCC and elevated plasma fibrinogen levels had poorer responses to TACE, a recommended adjuvant therapy for intermediate and advanced HCC. The poor response to TACE treatment in high-fibrinogen groups requires further examination due to its small sample size, and it is not one of our primary outcomes due to the limited number of studies available.

Aside from the limited studies available, there are several other limitations in our analyses. The association between the elevated plasma fibrinogen levels and poor survival outcomes could potentially be overestimated because all included studies are published studies. Positive results are always favored for publication when compared to negative results; thus exaggerating the effect of the group tested. There are variations in the plasma fibrinogen measurement methods, the cutoff values, tumor stages, and treatments received among all included studies; however, analysis suggested little heterogeneity among studies. Moreover, all patients included in the

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**Figure 5** Association of elevated plasma fibrinogen level in patients with hepatocellular carcinoma and disease-free/recurrence-free survival.

**Notes:** (A) Forest plot of HR for disease-free/recurrence-free survival. (B) Sensitivity analysis of disease-free/recurrence-free survival.
Heterogeneity: $\chi^2=105.84$, $df=27$, $I^2=74\%$; Test for overall effect: $Z=9.12$, $P<0.00001$.

**Tumor number (multiple versus single)**

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Experimental Events</th>
<th>Control Events</th>
<th>Total Events</th>
<th>Total Weight</th>
<th>M–H, fixed, 95% CI</th>
<th>Odds ratio M–H, fixed, 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liu 2017</td>
<td>62</td>
<td>45</td>
<td>107</td>
<td>36</td>
<td>3.83</td>
<td>3.83 (2.01, 7.31)</td>
</tr>
<tr>
<td>Wang 2016</td>
<td>123</td>
<td>120</td>
<td>243</td>
<td>84</td>
<td>3.83</td>
<td>3.83 (1.40, 10.08)</td>
</tr>
<tr>
<td>Subtotal (95% CI)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total events</td>
<td>189</td>
<td>194</td>
<td>383</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Heterogeneity: $\chi^2=10.01$, $df=1$, $I^2=90\%$; Test for overall effect: $Z=3.03$, $P=0.002$.

**Vascular invasion (with invasion versus without invasion)**

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Experimental Events</th>
<th>Control Events</th>
<th>Total Events</th>
<th>Total Weight</th>
<th>M–H, fixed, 95% CI</th>
<th>Odds ratio M–H, fixed, 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wang 2016</td>
<td>6</td>
<td>27</td>
<td>33</td>
<td>45</td>
<td>3.60</td>
<td>3.60 (0.63, 20.53)</td>
</tr>
<tr>
<td>Wang 2017</td>
<td>38</td>
<td>46</td>
<td>84</td>
<td>84</td>
<td>3.81</td>
<td>3.81 (2.25, 6.44)</td>
</tr>
<tr>
<td>Subtotal (95% CI)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total events</td>
<td>44</td>
<td>63</td>
<td>107</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Heterogeneity: $\chi^2=10.04$, $df=1$, $P=0.001$; Test for overall effect: $Z=3.03$, $P=0.002$.

**AFP (400ng/mL or <400ng/mL)**

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Experimental Events</th>
<th>Control Events</th>
<th>Total Events</th>
<th>Total Weight</th>
<th>M–H, fixed, 95% CI</th>
<th>Odds ratio M–H, fixed, 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fu 2017</td>
<td>48</td>
<td>48</td>
<td>96</td>
<td>36</td>
<td>2.85</td>
<td>2.85 (1.36, 5.97)</td>
</tr>
<tr>
<td>Wang 2016</td>
<td>18</td>
<td>32</td>
<td>50</td>
<td>18</td>
<td>1.91</td>
<td>1.91 (1.07, 3.40)</td>
</tr>
<tr>
<td>Subtotal (95% CI)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total events</td>
<td>66</td>
<td>66</td>
<td>132</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Heterogeneity: $\chi^2=10.04$, $df=1$, $P=0.002$; Test for overall effect: $Z=2.01$, $P=0.04$.

**HBsAg (positive versus negative)**

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Experimental Events</th>
<th>Control Events</th>
<th>Total Events</th>
<th>Total Weight</th>
<th>M–H, fixed, 95% CI</th>
<th>Odds ratio M–H, fixed, 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fu 2017</td>
<td>58</td>
<td>58</td>
<td>116</td>
<td>36</td>
<td>3.94</td>
<td>3.94 (2.31, 6.76)</td>
</tr>
<tr>
<td>Liu 2017</td>
<td>175</td>
<td>175</td>
<td>350</td>
<td>111</td>
<td>2.57</td>
<td>2.57 (1.74, 3.83)</td>
</tr>
<tr>
<td>Subtotal (95% CI)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total events</td>
<td>233</td>
<td>233</td>
<td>466</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Heterogeneity: $\chi^2=10.04$, $df=1$, $P=0.002$; Test for overall effect: $Z=2.01$, $P=0.04$.

**Alcohol use (with versus without alcohol use)**

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Experimental Events</th>
<th>Control Events</th>
<th>Total Events</th>
<th>Total Weight</th>
<th>M–H, fixed, 95% CI</th>
<th>Odds ratio M–H, fixed, 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liu 2017</td>
<td>15</td>
<td>15</td>
<td>30</td>
<td>15</td>
<td>1.22</td>
<td>1.22 (1.00, 1.48)</td>
</tr>
<tr>
<td>Wang 2017</td>
<td>162</td>
<td>162</td>
<td>324</td>
<td>104</td>
<td>1.97</td>
<td>1.97 (1.60, 2.45)</td>
</tr>
<tr>
<td>Subtotal (95% CI)</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total events</td>
<td>177</td>
<td>177</td>
<td>354</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Heterogeneity: $\chi^2=10.04$, $df=1$, $P=0.002$; Test for overall effect: $Z=2.01$, $P=0.04$.

**Age (>50 vs ≤50 years)**

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Experimental Events</th>
<th>Control Events</th>
<th>Total Events</th>
<th>Total Weight</th>
<th>M–H, fixed, 95% CI</th>
<th>Odds ratio M–H, fixed, 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fu 2017</td>
<td>53</td>
<td>53</td>
<td>106</td>
<td>36</td>
<td>3.83</td>
<td>3.83 (1.34, 10.36)</td>
</tr>
<tr>
<td>Liu 2017</td>
<td>191</td>
<td>191</td>
<td>382</td>
<td>111</td>
<td>4.11</td>
<td>4.11 (2.46, 6.87)</td>
</tr>
<tr>
<td>Subtotal (95% CI)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Total events</td>
<td>244</td>
<td>244</td>
<td>488</td>
<td></td>
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</tr>
</tbody>
</table>

Heterogeneity: $\chi^2=10.04$, $df=1$, $P=0.002$; Test for overall effect: $Z=2.01$, $P=0.04$.

**Heterogeneity:** $\chi^2=105.84$, $df=27$, $I^2=74\%$; Test for overall effect: $Z=9.12$, $P<0.00001$; Test for subgroup differences: $\chi^2=58.07$, $df=10$, $P=0.00001$; $I^2=82.9\%$.

Figure 6 Association between elevated plasma fibrinogen levels and clinicopathological parameters including age (>50 vs ≤50 years), sex (male vs female), tumor stage (III–IV vs I–II), tumor size (≥5 cm vs <5 cm), tumor number (multiple vs single; >3 vs ≤3), vascular invasion (with vs without invasion), Child–Pugh stage (A vs B/C), serum AFP level (≥400 vs <400 ng/mL), HBsAg (positive vs negative), and alcohol use (with vs without alcohol use).

**Abbreviations:** AFP, alpha-fetoprotein; HBsAg, hepatitis B surface antigen.
Variables & No. of study & OR (95% CI) & P-value & Heterogeneity & P (%) & P-value  
Age (>50 vs ≤50 years) & 2 & 0.70 (0.43, 1.11) & 0.13 & 2 & 0.31  
Sex (male vs female) & 4 & 1.19 (0.84, 1.67) & 0.32 & 74 & 0.010  
Tumor stage (III–IV vs I–II) & 3 & 2.37 (1.83, 3.07) & <0.0001 & 69 & 0.04  
Tumor size (≥5 vs <5 cm) & 3 & 3.04 (2.22, 4.15) & <0.0001 & 53 & 0.12  
Tumor number (multiple vs single) & 3 & 1.54 (1.17, 2.05) & 0.002 & 50 & 0.13  
Tumor number (>3 vs ≤3) & 2 & 1.99 (1.02, 3.87) & 0.04 & 0 & 0.59  
Vascular invasion (with invasion vs without invasion) & 2 & 3.81 (2.25, 6.44) & <0.0001 & 0 & 0.95  
Child-Pugh (stage A vs B/C) & 2 & 1.53 (1.01, 2.33) & 0.04 & 90 & 0.002  
AFP (≥400 vs <400 ng/mL) & 3 & 1.37 (1.00, 1.86) & 0.05 & 65 & 0.06  
HBsAg (positive vs negative) & 2 & 1.30 (0.56, 3.03) & 0.54 & 0 & 0.78  
Alcohol use (with vs without alcohol use) & 2 & 1.07 (0.79, 1.45) & 0.68 & 76 & 0.04  

**Abbreviations:** AFP, alpha-fetoprotein; HBsAg, hepatitis B surface antigen.

**Table 4 Overall analysis of the association between elevated plasma fibrinogen levels and clinical features of patients with hepatocellular carcinoma**

prognostic evaluation were Asians, which may not reflect as general phenomena in other ethnic populations. All of these factors could have influenced the outcome of our evaluation.

**Conclusion**

From our analyses of eight high-quality studies, we conclude that patients with HCC and elevated plasma fibrinogen levels have poor survival outcomes. High plasma fibrinogen levels are associated with heavier tumor burden and advanced tumor progression. Therefore, plasma fibrinogen level may serve as a prognostic biomarker in HCC.

**Acknowledgments**

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**Author contributions**

GH, HJ, ZJ, and XZ conceived and designed the study. GH, HJ, and YL searched the database and checked them according to the eligible criteria and exclusion criteria. YW and WC analyzed the data. BS and YL designed the methodology. ZJ and XZ supervised the planning and execution of the research activity. GH and HJ wrote the paper. All authors contributed toward data analysis, drafting and critically revising the paper and agree to be accountable for all aspects of the work. All authors read and approved the final manuscript.

**Disclosure**

The authors report no conflicts of interest in this work.

**References**


