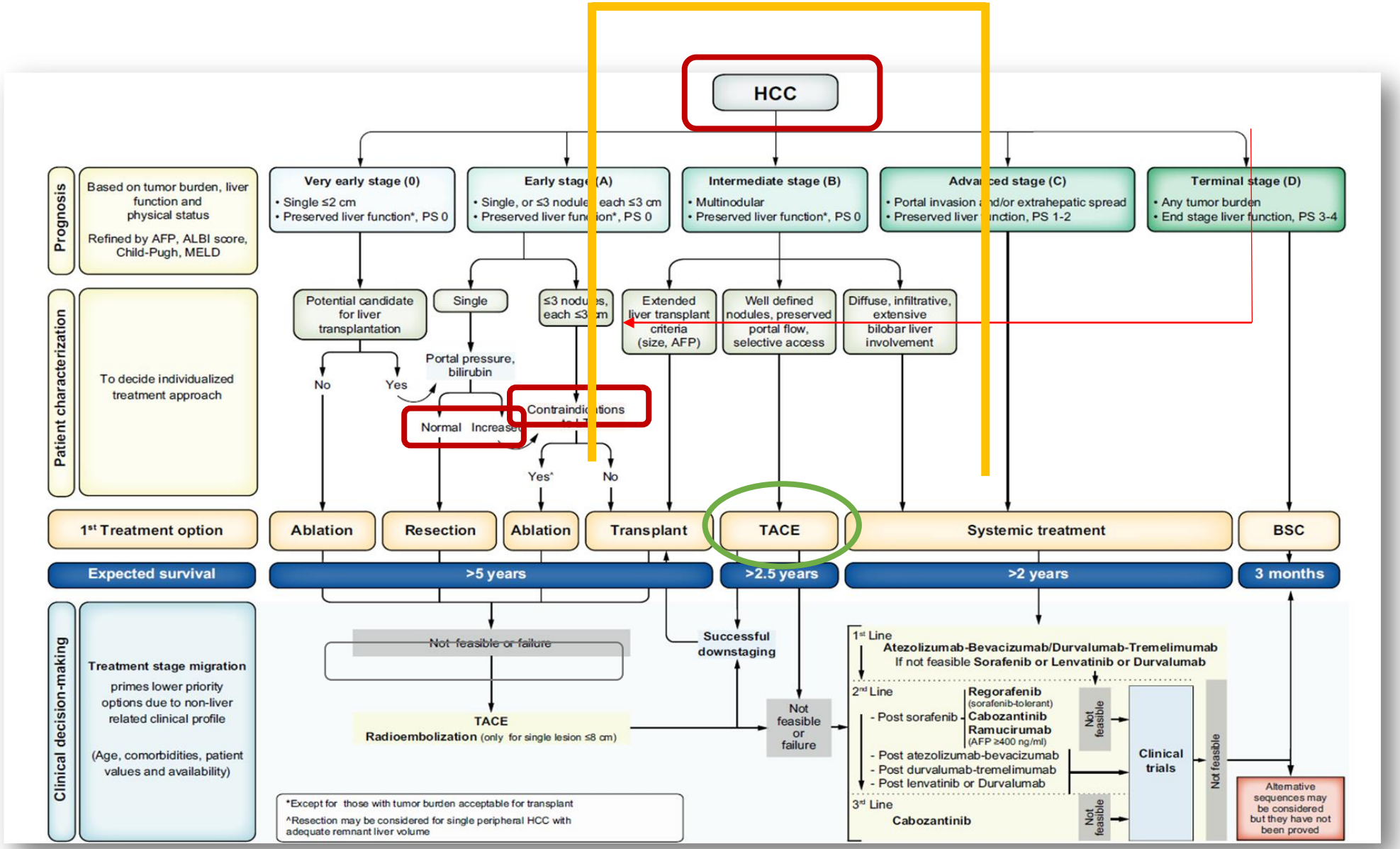
UNIVERSITÀ DEGLI STUDI DI PADOVA

Tavola Rotonda: GOM E PDTA DELL'HCC NELLE RETI ONCOLOGICHE REGIONALI E GESTIONE DEL PAZIENTE CON HCC NEL TRIVENETO: ESPERIENZE A CONFRONTO

Dalle linee guida alla multidisciplinarietà, l'esigenza dei GOM

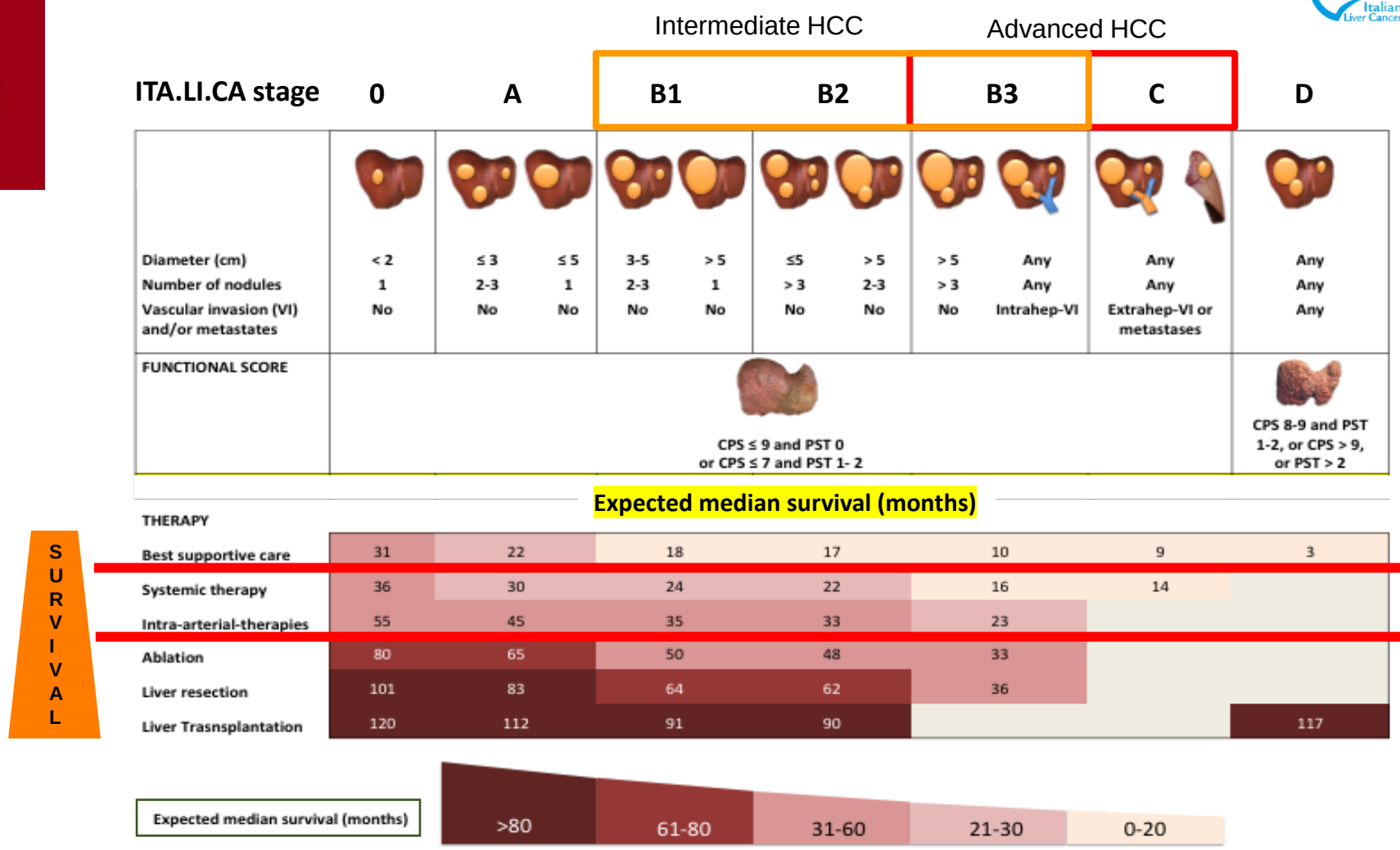
F. Farinati

The 2022 updated BCLC therapeutic algorythm



Reig M et al. J Hepatol 2022;76: 681-93

ITA.LI.CA staging system and therapeutic hierachy



Therapeutic hierachy

Vitale A et al. Hepatology 2020; 72: 2206-2218

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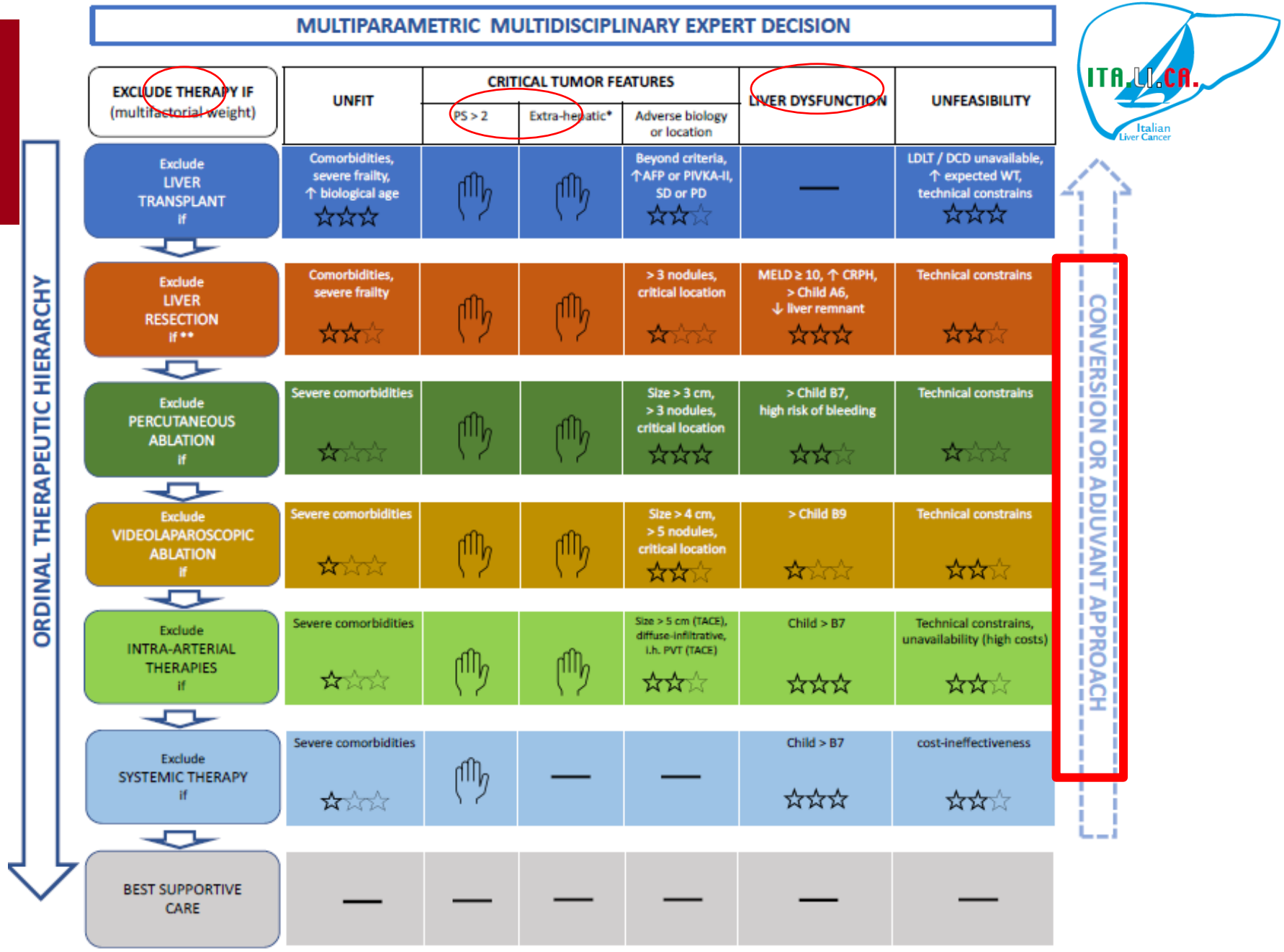
ITA.LI.CA. Italian Liver Cancer

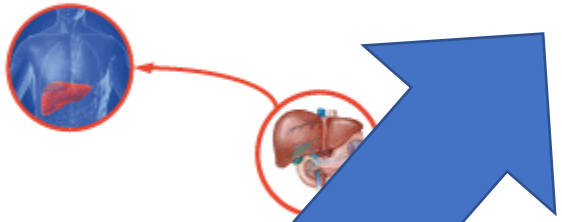
Stars indicate the importance
☆
☆☆
☆☆☆

Vitale A et al.
Lancet Oncol
2023



17 Ottobre 2016 - PADOVA

Rete Oncologica Veneta
Ricerca, innovazione, assistenza



Proposta di PDTA della Rete Onc ica Veneta per i pazienti affetti da Patologia On gica Epatobiliare

Old
Outdated
Limited relevance

Università degli Studi di Padova

From uni to multi-disciplinary

National, retrospective cohort study of all patients diagnosed with HCC from January 1, 2008 through December 31, 2010 (n 3988) and followed through December 31 2014 who received care through the Veterans Administration (128 centers).

.Multivariable Analysis of Time-varying HCC Therapy, Patient, Facility, and Provider Factors on All-Cause Mortality

Variable	Model 1[a] HR	Model 1[a] 95% CI	Model 1[a] *P* value	Model 2[b] HR	Model 2[b] 95% CI	Model 2[b] *P* value value
Active HCC therapy[c]			<.001			<.001
No therapy	1.00	REF		1.00	REF	
Liver transplantation	0.18	0.13–0.25		0.22	0.16–0.31	
Resection	0.31	0.13–0.25		0.38	0.28–0.52	
Ablative therapy	0.50	0.42–0.60		0.63	0.52–0.76	
Transarterial therapy	0.72	0.65–0.80		0.83	0.74–0.92	
Sorafenib	1.70	1.54–1.86		1.99	1.80–2.20	
Provider factors						
Specialist seen within 30 days of diagnosis[d]						
Hepatology				0.70	0.63–0.78	<.001
Medical oncology				0.82	0.74–0.91	<.001
Surgery				0.79	0.71–0.89	<.001
Gastroenterology				1.02	0.93–1.13	.673
Palliative care				2.10	1.87–2.36	<.001
No specialist				0.89	0.65–1.21	.447
Evaluation by ≥1 specialist				1.09	0.96–1.23	.187
Multidisciplinary tumor board				0.83	0.77–0.90	<.001
Presenting BCLC Stage			<.001			<.001
0	1.00	REF		1.00	REF	
A	1.13	0.94–1.35		1.13	0.94–1.36	
B	1.71	1.43–2.05		1.63	1.36–1.96	
C	2.92	2.41–3.54		2.50	2.05–3.05	
D	2.88	2.36–3.51		2.40	1.96–2.93	

Serper M, et al. Gastroenterology 2017; 152: 1954-1964

Journal of Multidisciplinary Healthcare

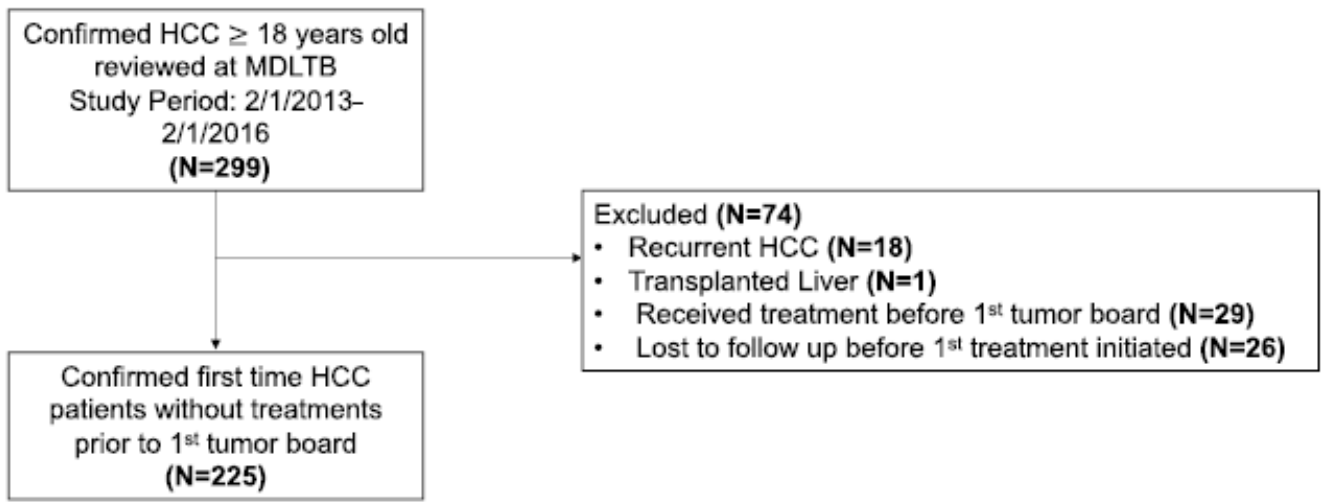
Dovepress
open access to scientific and medical research

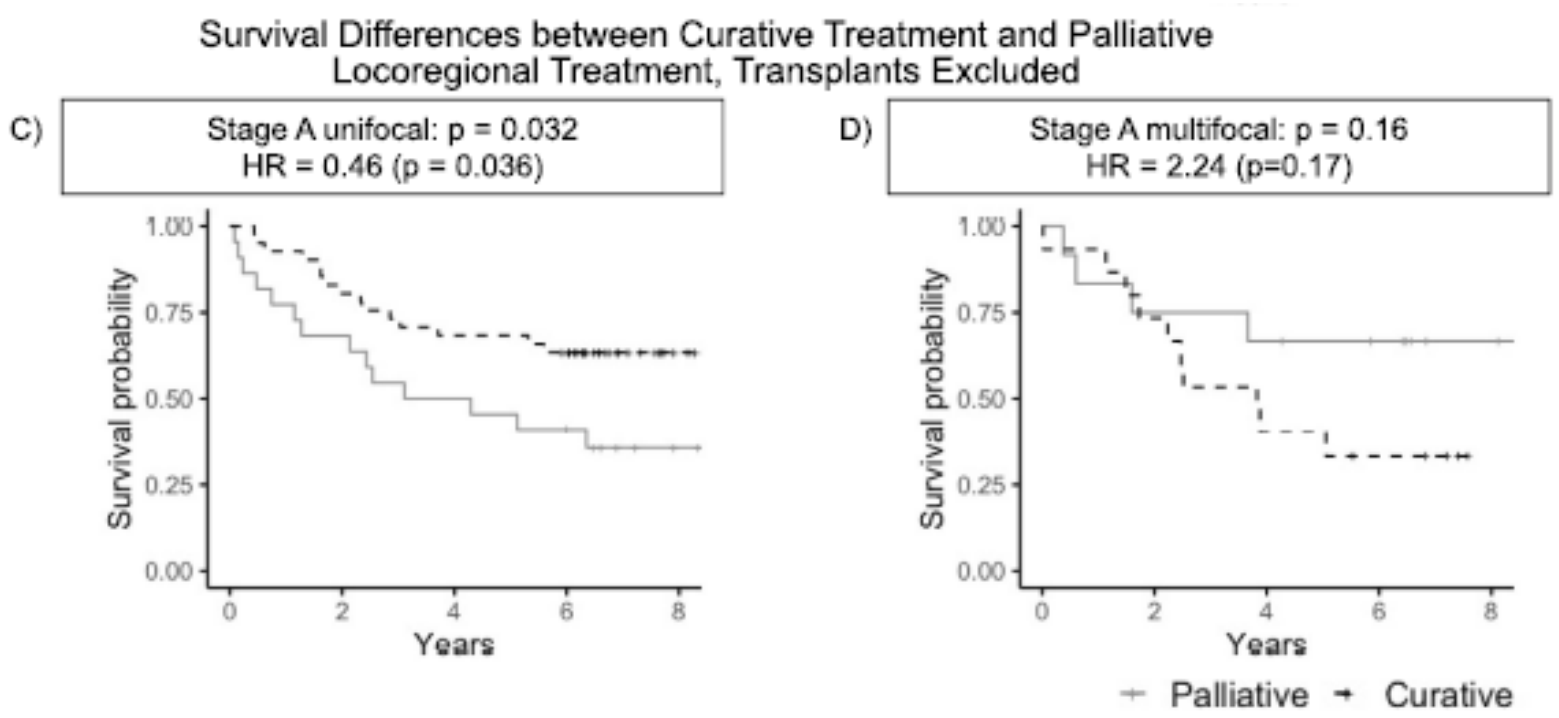
Open Access Full Text Article

ORIGINAL RESEARCH

Adherence to Tumor Board Recommendations in the Treatment of Patients with Hepatocellular Carcinoma

Yueming Cao[1], Catherine Mezzacappa[1,2], Ariel Jaffe[1,2], Mario Strazzabosco[1,2], Tamar H Taddei[1,2]





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Treatment adherent to MDLTB recommendations occurred in 85.3% of patients (n=192).

Conclusion: Most forms of non-adherence to MDLTB recommendations were unavoidable; however, treatment discordance in the management of patients with BCLC Stage A unifocal disease may present an opportunity for clinically significant quality improvement.

frontiers | Frontiers in Oncology

TYPE Original Research
PUBLISHED 21 December 2023
DOI 10.3389/fonc.2023.1251571

OPEN ACCESS

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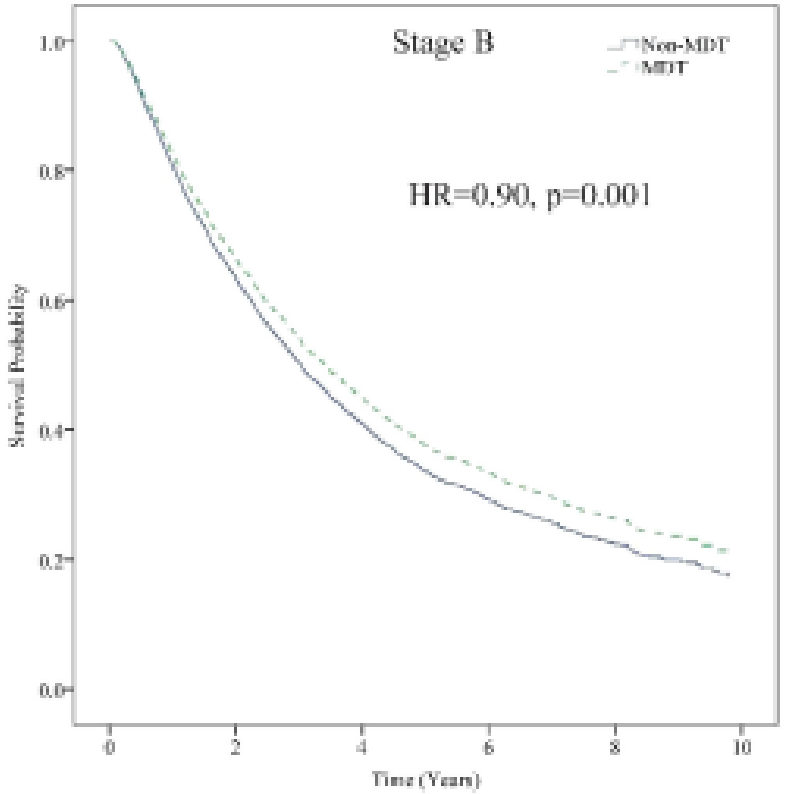
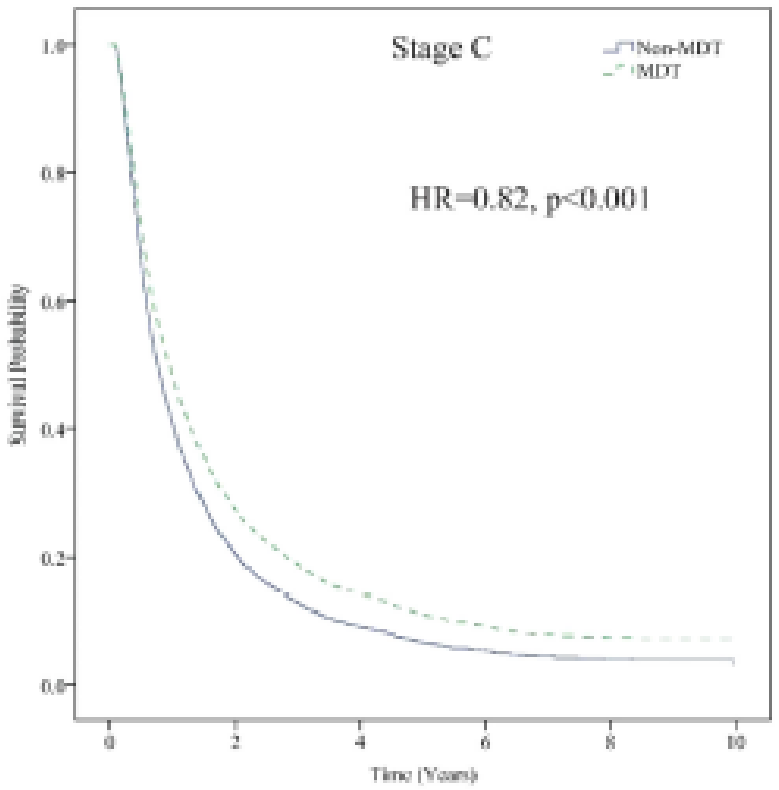
Effect of multidisciplinary team care on patient survival in chronic hepatitis B or C hepatocellular carcinoma





Multidisciplinary Management of Hepatocellular Carcinoma Improves Access to Therapy and Patient Survival

Parul D. Agarwal, MD, Paulina Phillips, MD,* Luke Hillman, MD,† Michael R. Lucey, MD,* Fred Lee, MD,‡ Josh D. Mezrich, MD,§ and Adnan Said, MD**

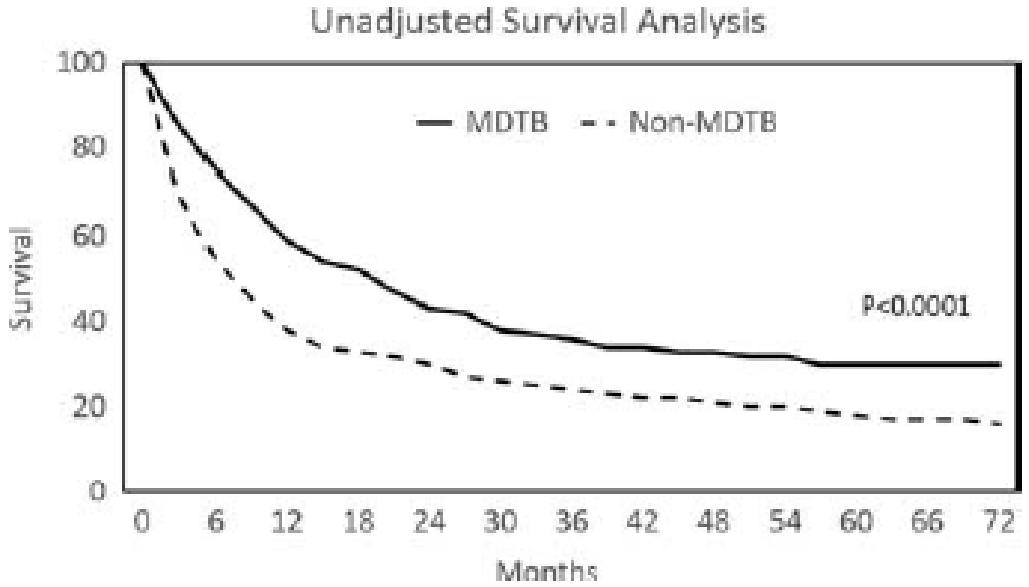
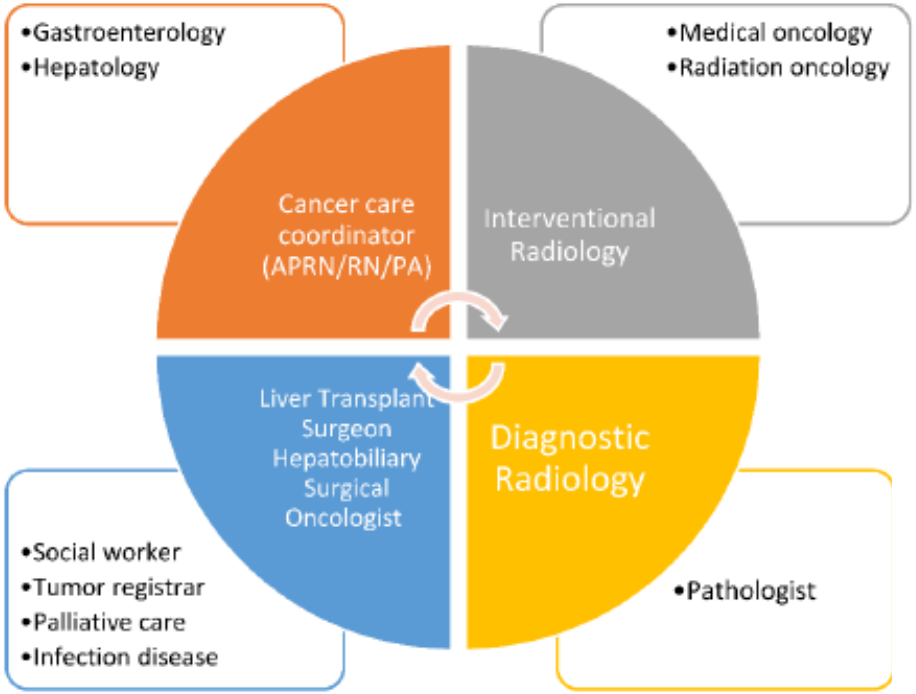


FIGURE 1. Kaplan-Meier survival analysis (unadjusted) of MDTB and non-MDTB cohorts. MDTB indicates multidisciplinary tumor board.

TABLE 5. Multivariate Survival Analysis of HCC T1 or T2 Stage (From Presentation)

Variables*	Hazard Ratio for Mortality	95% CI	*P*
Sex	1.17	0.693-1.976	0.558
Age	1.0	0.989-1.012	0.201
Presence of cirrhosis	2.156	0.727-6.396	0.166
MELD score at presentation	1.024	0.963-1.088	0.452
AFP at presentation	1.000	1.000-1.000	0.002
HCC specific treatment	0.247	0.098-0.627	0.003
Tumor board	0.58	0.367-0.918	0.02
Ablation	1.44	0.743-2.791	0.28
Resection	0.52	0.229-1.184	0.119
Liver transplantation	0.095	0.047-0.193	0.0001



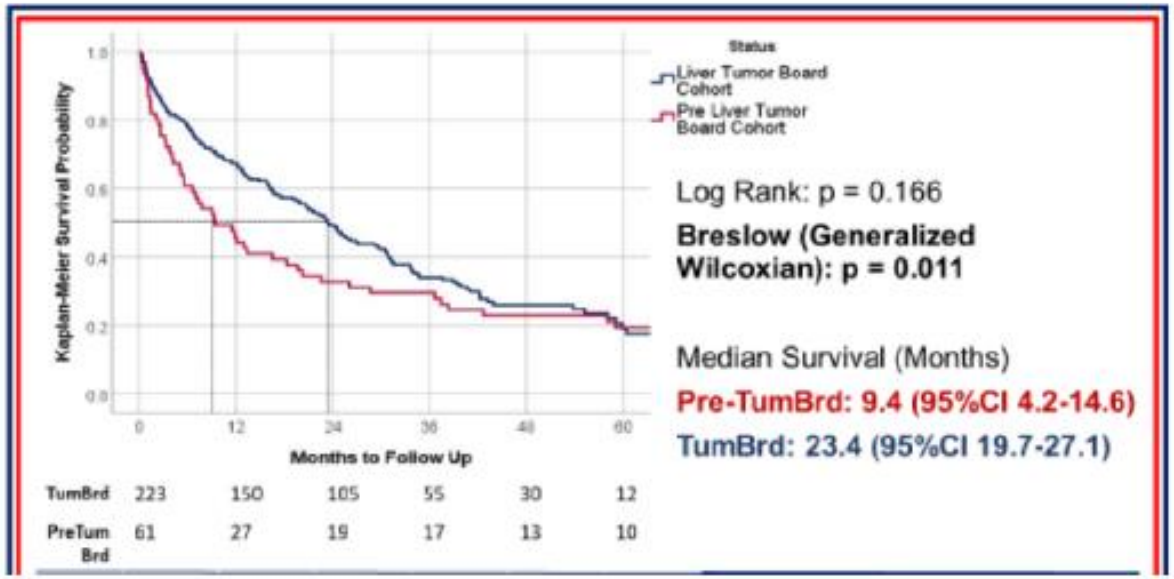


Figure 4. Median survival of patients with liver cancer in VISN 2 before and after implementation of MDTB.

frontiers | Frontiers in Surgery

TYPE Original Research
PUBLISHED 06 January 2023
DOI 10.3389/fsurg.2022.1045003

OPEN ACCESS

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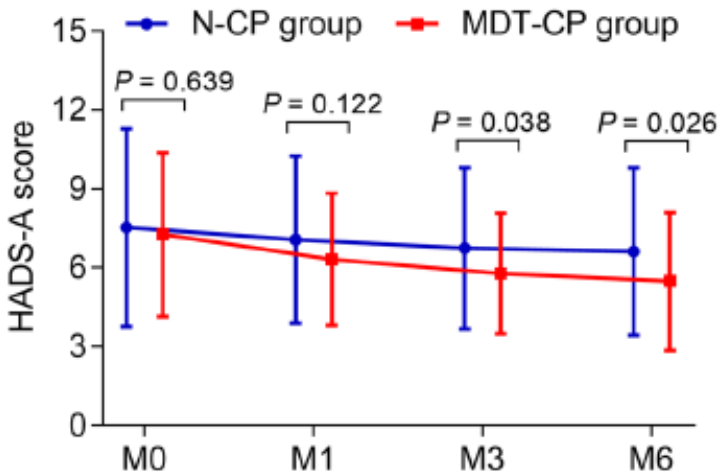
Jingjing Wang

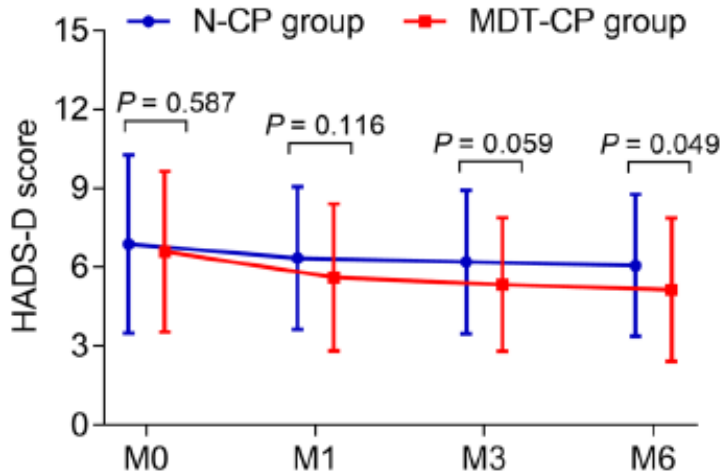
Effect of multi-disciplinary team care program on quality of life, anxiety, and depression in hepatocellular carcinoma patients after surgery: A randomized, controlled study

A



HADS-A score	M0	M1	M3	M6
N-CP group	7.5±3.8	7.1±3.2	6.7±3.1	6.6±3.2
MDT-CP group	7.3±3.1	6.3±2.5	5.8±2.3	5.5±2.6

B



HADS-D score	M0	M1	M3	M6
N-CP group	6.9±3.4	6.3±2.7	6.2±2.7	6.1±2.7
MDT-CP group	6.6±3.0	5.6±2.8	5.3±2.5	5.1±2.7

Published in final edited form as:
Gastroenterology. 2017 June ; 152(8): 1954–1964. doi:10.1053/j.gastro.2017.02.040.

Association of Provider Specialty and Multidisciplinary Care With Hepatocellular Carcinoma Treatment and Mortality

Marina Serper[1,2,*], **Tamar H. Taddei**[3,*], **Rajni Mehta**[3], **Kathryn D'Addeo**[3], **Feng Dai**[3], **Ayse Aytaman**[4], **Michelle Baytarian**[5], **Rena Fox**[6], **Kristel Hunt**[7], **David S. Goldberg**[2], **Adriana Valderrama**[8], and **David E. Kaplan**[1,2] **for the VOCAL Study Group**

Specialist seen within 30 days of diagnosis[d]			
Hepatology	0.70	0.63–0.78	<.001
Medical oncology	0.82	0.74–0.91	<.001
Surgery	0.79	0.71–0.89	<.001
Gastroenterology	1.02	0.93–1.13	.673
Palliative care	2.10	1.87–2.36	<.001
No specialist	0.89	0.65–1.21	.447
Evaluation by ≥1 specialist	1.09	0.96–1.23	.187
Multidisciplinary tumor board	0.83	0.77–0.90	<.001

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Digestive and Liver Disease xxx (xxxx) xxx
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journal homepage: www.elsevier.com/locate/dld

Guidelines

Multidisciplinary treatment of hepatocellular carcinoma in 2023: Italian practice Treatment Guidelines of the Italian Association for the Study of the Liver (AISF), Italian Association of Medical Oncology (AIOM), Italian Association of Hepato-Bilio-Pancreatic Surgery (AICEP), Italian Association of Hospital Gastroenterologists (AIGO), Italian Association of Radiology and Clinical Oncology (AIRO), Italian Society of Pathological Anatomy and Diagnostic Cytology (SIAPeC-IAP), Italian Society of Surgery (SIC), Italian Society of Gastroenterology (SIGE), Italian Society of Medical and Interventional Radiology (SIRM), Italian Organ Transplant Society (SITO), and Association of Patients with Hepatitis and Liver Disease (EpaC) – Part II – Non-surgical treatments

Giuseppe Cabibbo[a,*], Bruno Daniele[b], Mauro Borzio[c], Andrea Casadei-Gardini[d], Umberto Cillo[e], Agostino Colli[f], Massimiliano Conforti[g], Vincenzo Dadduzio[h], Francesco Dionisi[i], Fabio Farinati[j,k], Ivan Gardini[g], Edoardo Giovanni Giannini[l], Rita Golfieri[m,n], Maria Guido[o], Andrea Mega[p], Michela Cinquini[q], Fabio Piscaglia[r,s], Lorenza Rimassa[t,u], Laura Romanini[v], Anna Pecorelli[w], Rodolfo Sacco[x], Marta Scorsetti[y,z], Luca Viganò[aa,ab], Alessandro Vitale[e], Franco Trevisani[s,ac,**]

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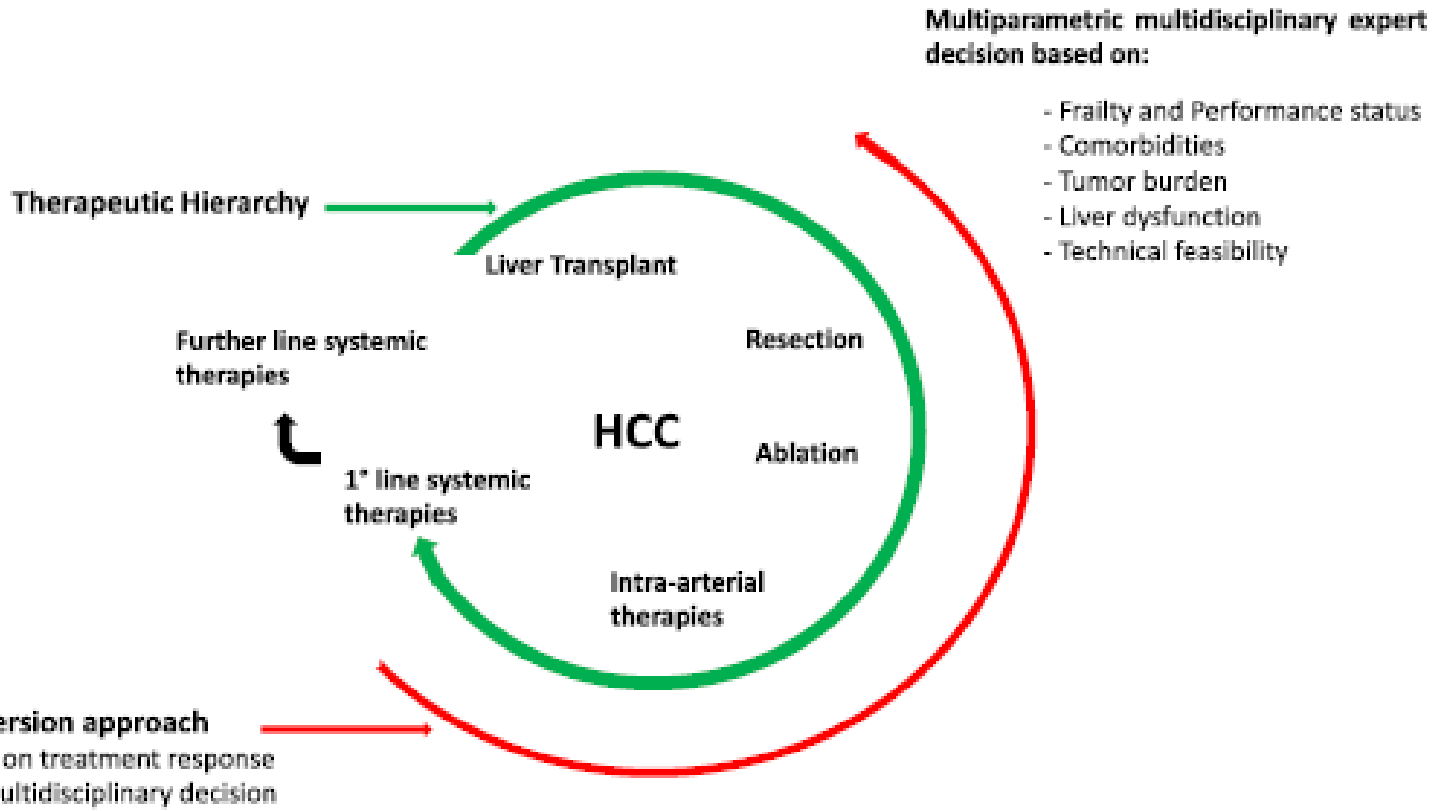

cancers

MDPI

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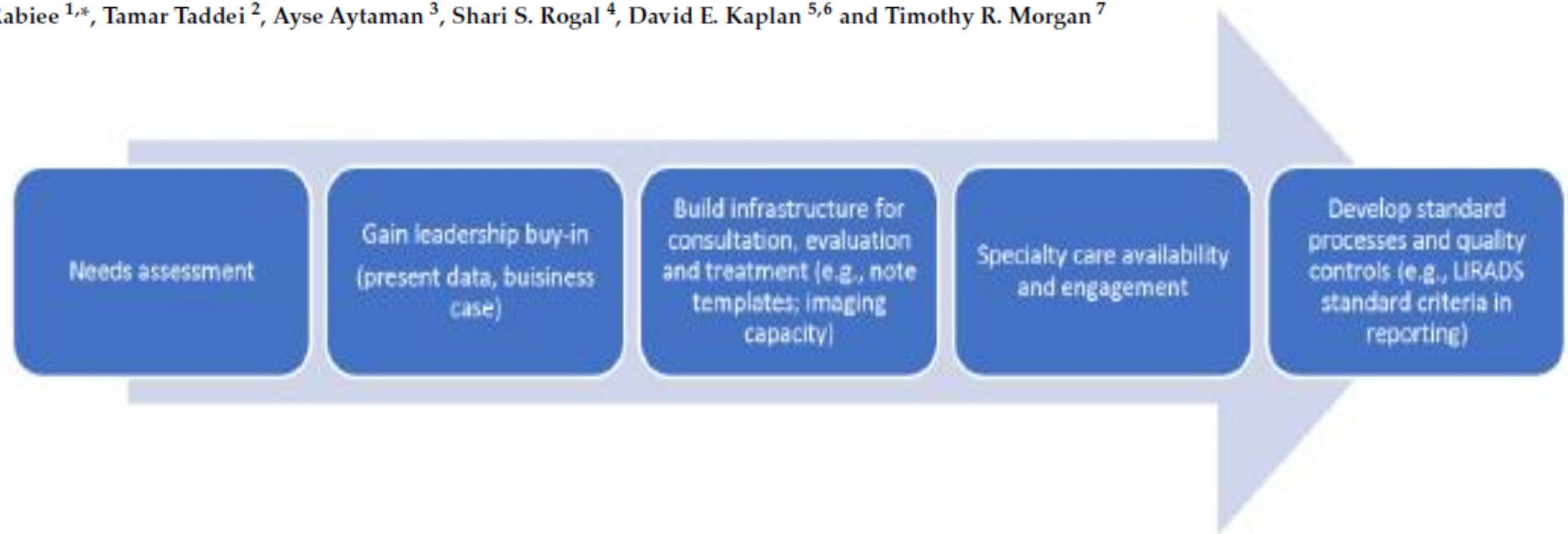
Perspective

Development and Implementation of Multidisciplinary Liver Tumor Boards in the Veterans Affairs Health Care System: A 10-Year Experience

Atoosa Rabiee [1,*], Tamar Taddei [2], Ayse Aytaman [3], Shari S. Rogal [4], David E. Kaplan [5,6] and Timothy R. Morgan [7]



Journal of Gastrointestinal Cancer
https://doi.org/10.1007/s12029-022-00844-w

ORIGINAL RESEARCH

Using Telemedicine to Facilitate Patient Communication and Treatment Decision-Making Following Multidisciplinary Tumor Board Review for Patients with Hepatocellular Carcinoma

Debra T. Chol[1,2] · Yvonne H. Sada[1,2,3] · Shubhada Sansgiry[1,2,5] · David E. Kaplan[6,7] · Tamar H. Taddel[8,9] · Jason K. Aguilar[1,2] · Michael Strayhorn[1,2] · Ruben Hernaez[1,4] · Jessica A. Davila[1,2]

Accepted: 18 June 2022

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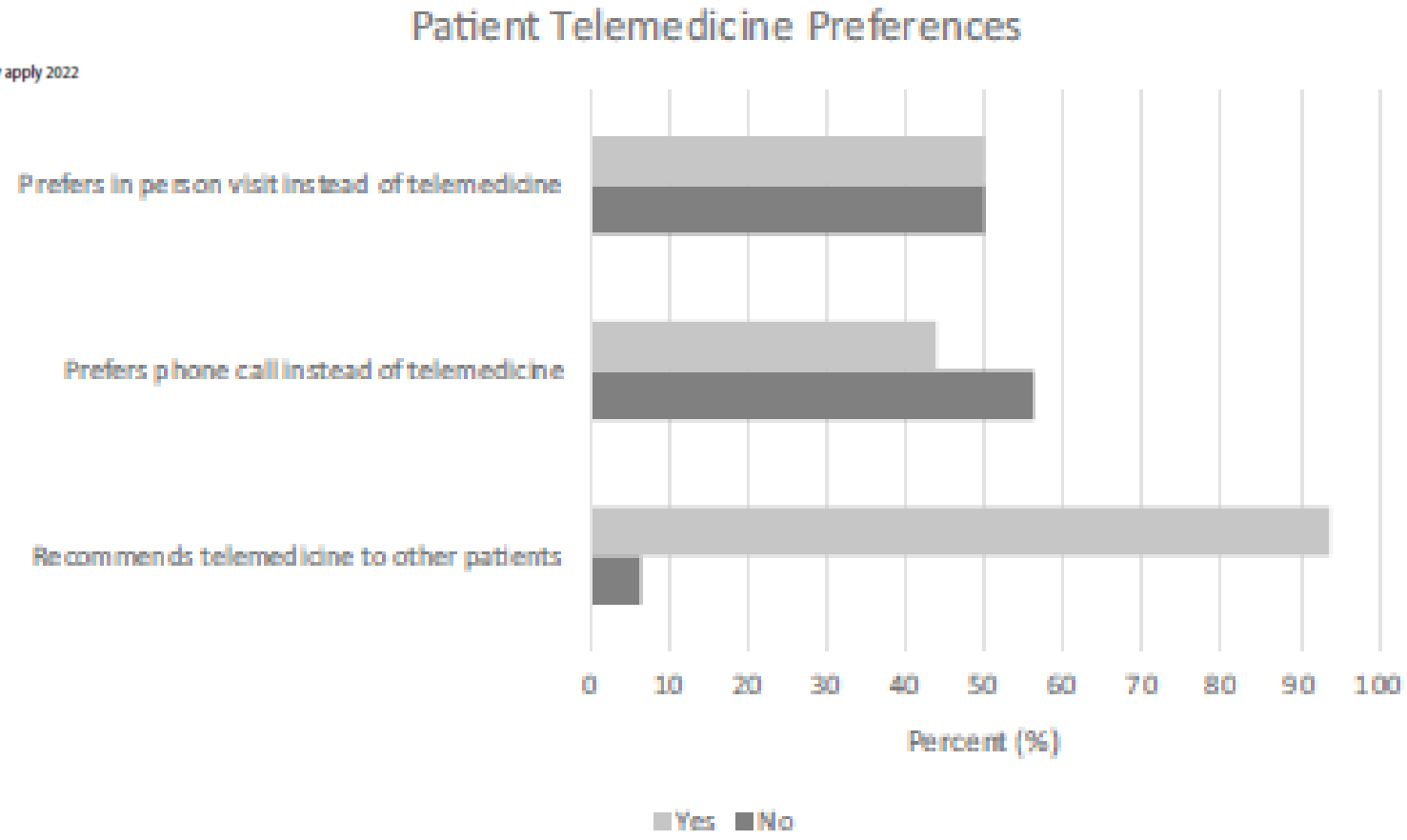


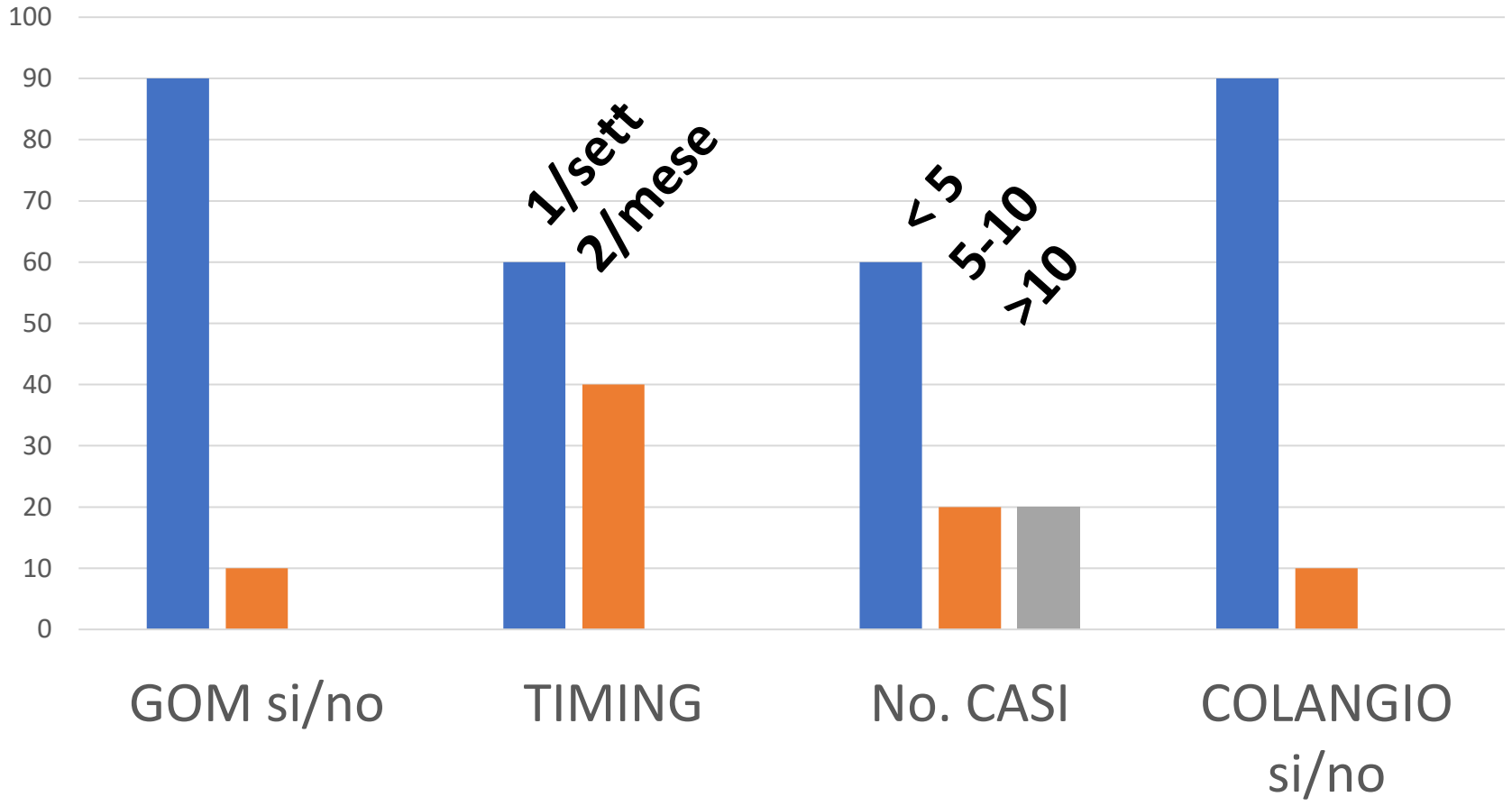
Domain	Theme	Illustrative quote
Patients' confidence in MTB	1. Patients said they felt comfortable and confident and hopeful with the treatment plan when their case was discussed by a group of physicians	1. "It made me comfortable that they came up with three choices and that it was discussed by more than one doctor."
	2. Patients said they felt they were receiving better care because of a multidisciplinary viewpoint when their case was discussed by a group of physicians	2. "I feel that a group of doctors is the way to go because they bring everything to the table, they can see what is the best for the Veteran to get back to health, and they can discuss my how my other problems may affect which treatment plan."
Patient understanding of MTB recommendations	1. Patients felt MTB recommendations were very clear	1. "They told me what to expect, what was going to happen, how the procedure was going to work, how the radiation was going to get administered and how it was going to affect the tumor."
	2. Patients found MTB recommendations helpful	2. "The information they gave me was about the treatment and about having cancer of the liver, and I found it useful."
	3. Patients liked that they were able to ask a lot of questions about the different treatment options following MTB recommendations	3. "If the doctors have the possibility of different options, they should explain to you all the different options…"
	4. Patients wanted to be included in the treatment decision-making process	4. "I definitely felt I was part of the decision-making process for my treatment. If I had any questions or concerns, I would address it prior to the treatment."
Communication of MTB recommendations to patient	1. There is variation in the method of communication of MTB recommendations	1. "During the course of my treatments they have delivered the results in different various ways by either telling me verbally, in written form, or a phone call. They have also shown me images on the computer."
	2. Patients expressed they would have liked to receive MTB recommendations in person and face-to-face	2. "I think MTB recommendations should at least have a face-to-face consultation."
	3. Patients reported mixed feelings about using the patient portal to communicate MTB recommendations	3. "I don't think MTB recommendations should be on my [patient portal]; they should be kept in person with the doctor."
Patient concerns about receiving healthcare	1. Patients emphasized concerns about adverse side effects from treatment recommended by MTB	1. "I was concerned about how sick the procedure would make me…"
	2. Patients reported spending a significant time on transportation for in-person visits	2. "I live in Port Arthur and now I've been to Houston about 10 times, hey, I would just rather [have] that information, instead of go all the way back to my doctor."
	3. Patients expressed concerns about wait-times for scheduling an in person appointment	3. "Every time I made an appointment to see somebody it was like a two month wait."

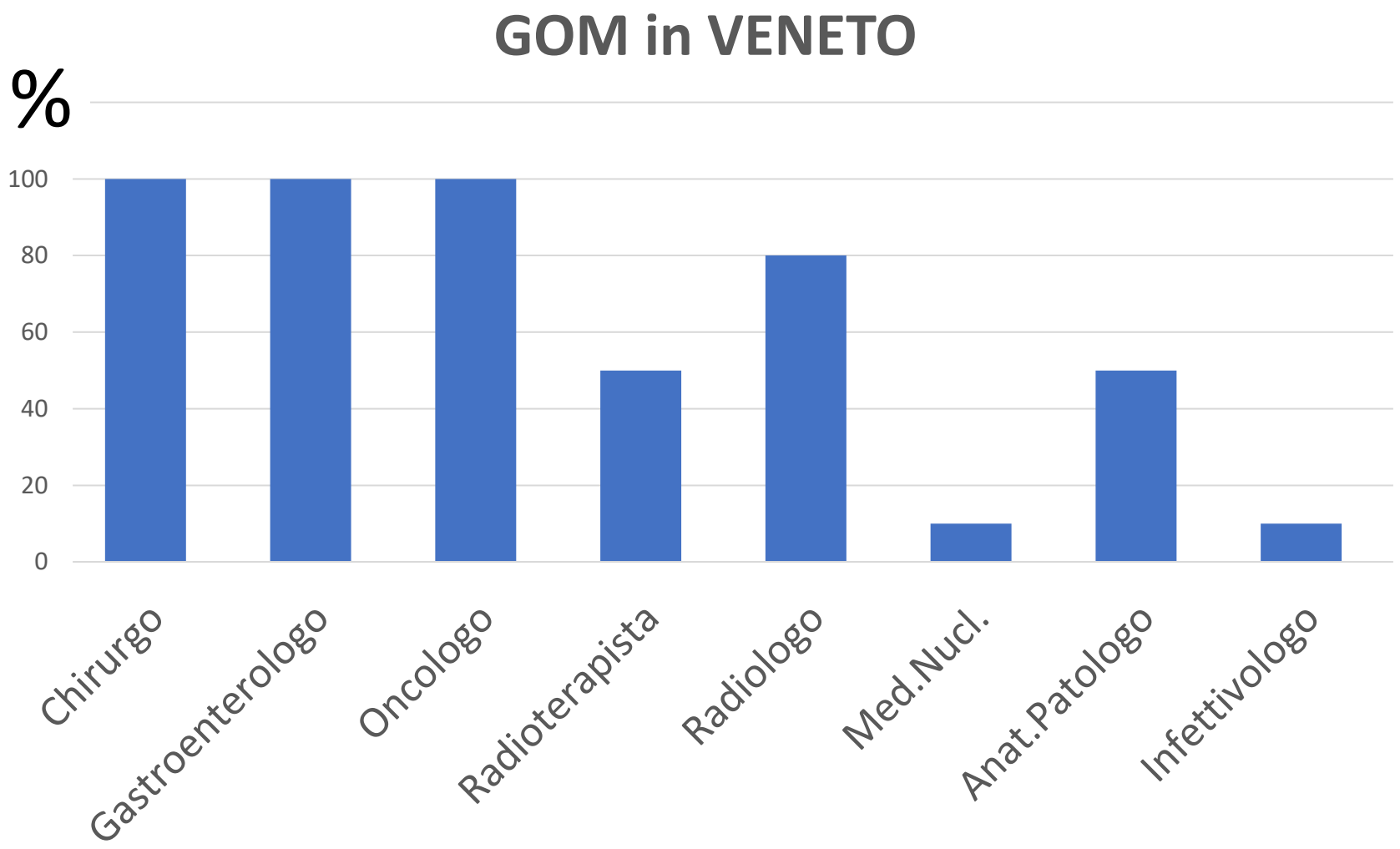
MTB multidisciplinary tumor board

Agenda

1. *All cases of HCC should be discuss?*
2. *By whom? Who is mandatory, who is not*
3. *What is the medical-legal impact of the indications*
4. *Is teleconsulting a viable option?*

GOM HCC in VENETO




GOM in VENETO
%
100
80
60
40
20
0
Chirurgo
Gastroenterologo
Oncologo
Radioterapista
Radiologo
Med.Nucl.
Anat.Patologo
Infettivologo

UNIVERSITÀ DEGLI STUDI DI PADOVA

Tavola Rotonda: GOM E PDTA DEL COLANGIOCARCINOMA NELLE RETI ONCOLOGICHE REGIONALI E GESTIONE DEL PAZIENTE NEL TRIVENETO: ESPERIENZE A CONFRONTO

Dalle linee guida alla multidisciplinarietà, l'esigenza dei GOM

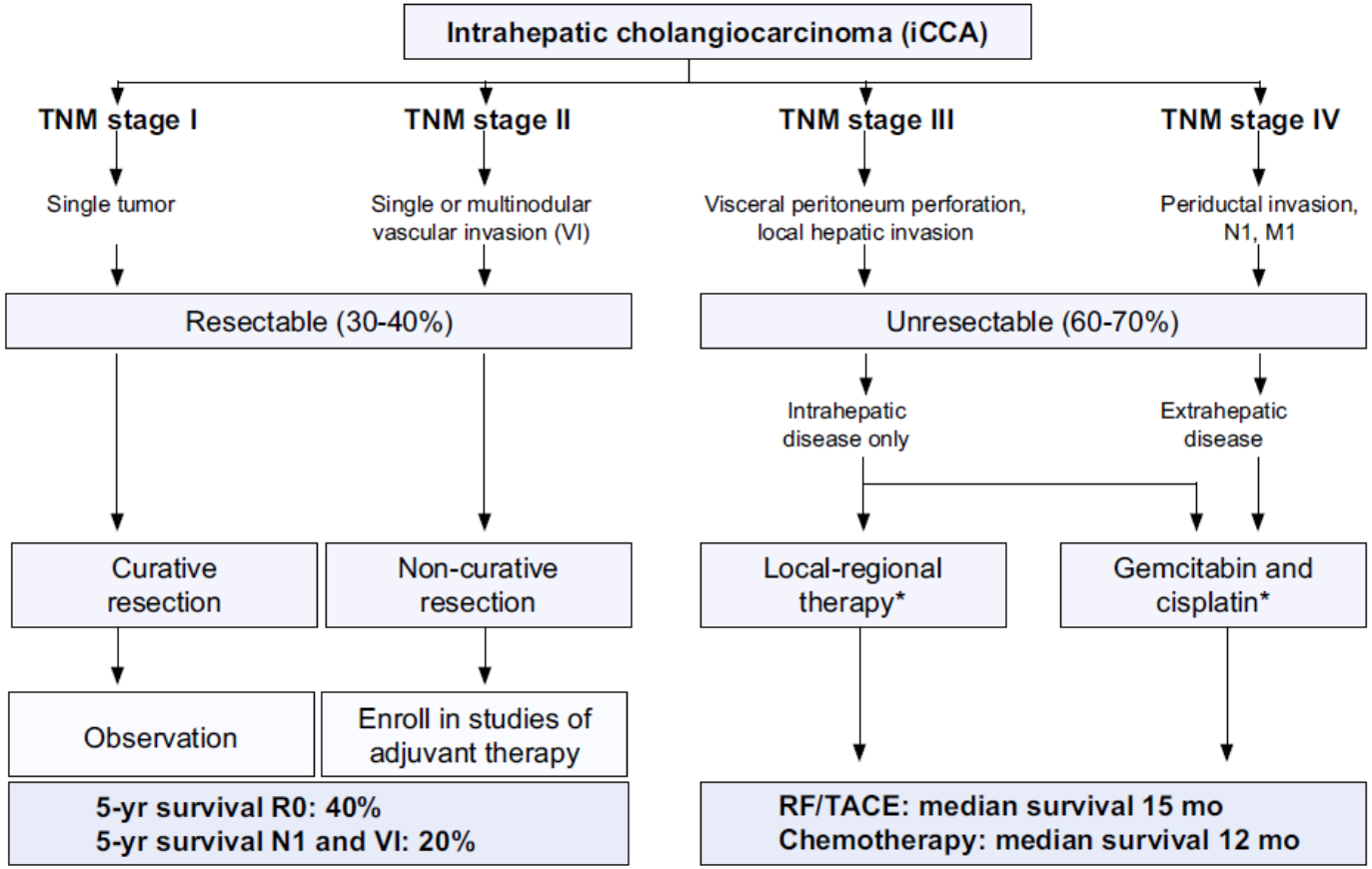
F. Farinati

EASL EUROPEAN ASSOCIATION FOR THE STUDY OF THE LIVER | JOURNAL OF HEPATOLOGY

Guidelines for the diagnosis and management of intrahepatic cholangiocarcinoma

John Bridgewater[1], Peter R. Galle[2], Shahid A. Khan[3], Josep M. Llovet[4,5], Joong-Won Park[6], Tushar Patel[7], Timothy M. Pawlik[8], Gregory J. Gores[9,*]

Guidelines



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Biliary Tract Cancers, Version 2.2023

Featured Updates to the NCCN Guidelines

PRINCIPLES OF SYSTEMIC THERAPY

Primary Treatment for Unresectable and Metastatic Disease

Preferred Regimens	Other Recommended Regimens	Useful in Certain Circumstances
• Durvalumab + gemcitabine + cisplatin (category 1)[d,e,f,4]	• Gemcitabine + cisplatin (category 1)[5] • FOLFOX • Capecitabine + oxaliplatin • Gemcitabine + albumin-bound paclitaxel • Gemcitabine + capecitabine • Gemcitabine + oxaliplatin • Gemcitabine + cisplatin + albumin-bound paclitaxel (category 2B)[1] • Single agents: ▸ 5-fluorouracil ▸ Capecitabine ▸ Gemcitabine	• Targeted therapy (BILC 3 of 5)

Subsequent-Line Therapy for Biliary Tract Cancers if Disease Progression[g]

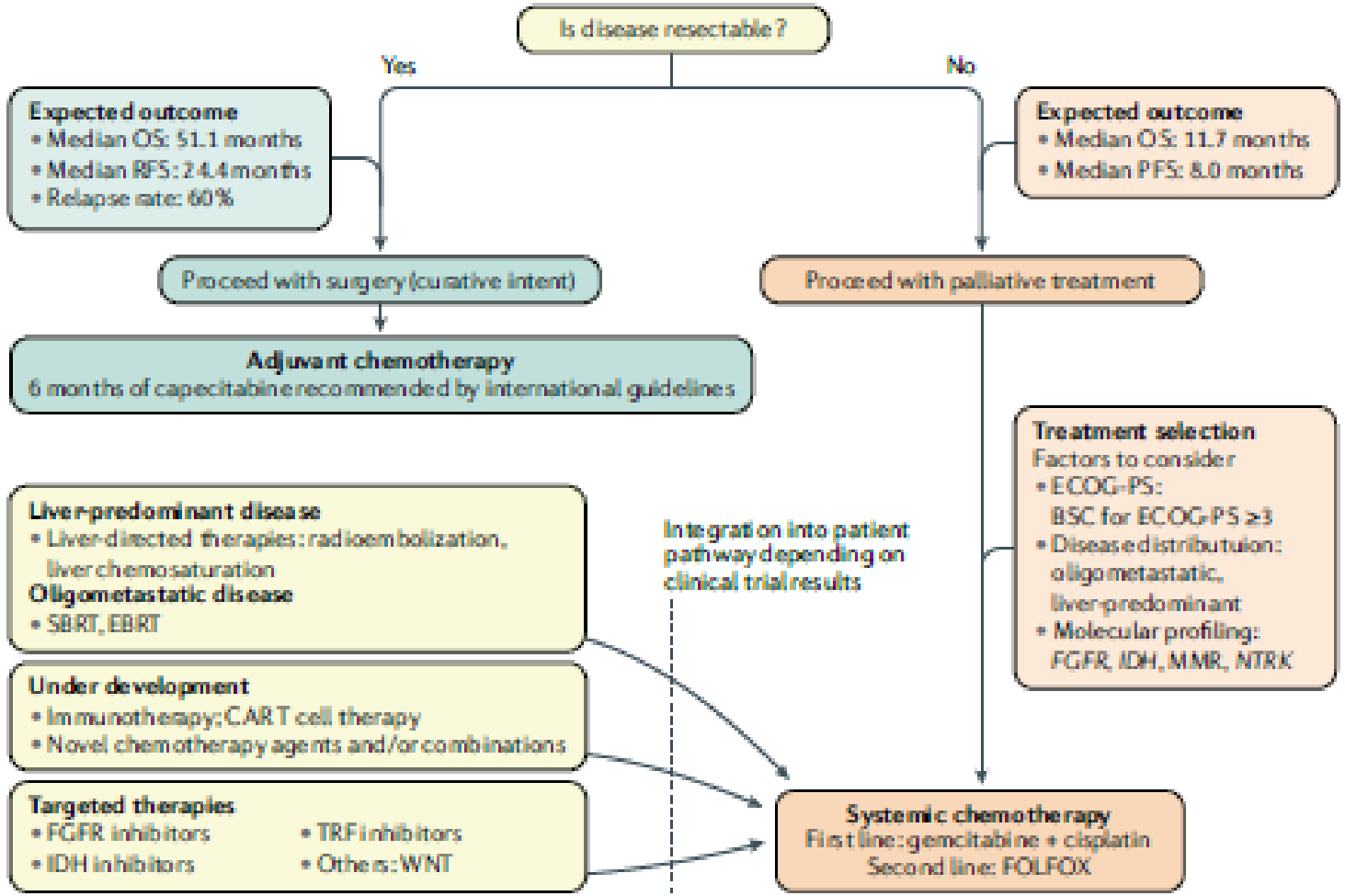
Preferred Regimens	Other Recommended Regimens	Useful in Certain Circumstances
• FOLFOX[6]	• FOLFIRI (category 2B)[7] • Regorafenib (category 2B)[8] • Liposomal irinotecan + fluorouracil + leucovorin (category 2B)[9] • See also: Preferred and Other Recommended Regimens for Unresectable and Metastatic Disease above	• Targeted therapy (BILC 3 of 5) • Nivolumab (category 2B)[e,f,10] • Lenvatinib + pembrolizumab (category 2B)[e,f,11]

CONSENSUS
STATEMENT

OPEN

Check for updates

Cholangiocarcinoma 2020: the next horizon in mechanisms and management



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Category	Priority	Timescale	Cost–benefit ratio	Initiative
Basic or translational research				
Expertise	Dedicated centres with multidisciplinary expertise are urgently required	Long-term	Proper translation of basic investigation to clinical practice and amelioration of CCA management will be boosted	NA
Expertise	Dedicated special topic conferences bringing together basic and clinical researchers, industry and also stakeholders and governmental counterparts must be implemented	Short-term	This constitutes a great opportunity to share fundamental research findings, develop multi-team international collaborations and also engage political institutions to speed up the translation of research into clinics	ENS-CCA has established a biannual meeting; CCF and AMMF have annual meetings; EASL has an annual meeting on liver cancer

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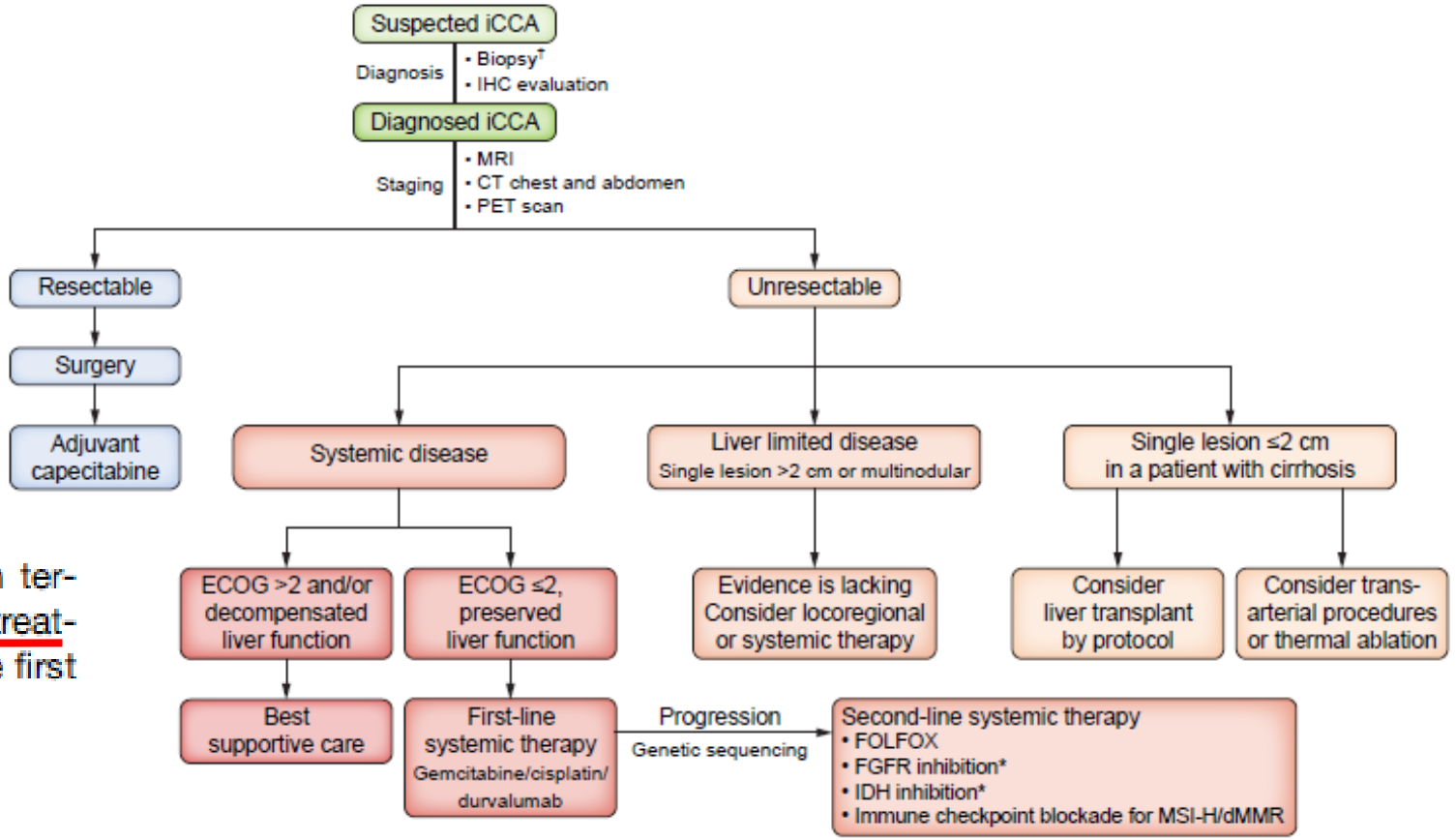
is endorsed by the European Network for the Study of Cholangiocarcinoma (ENS-CCA), we provide a comprehensive and critical overview of current knowledge

Clinical Practice Guidelines

JOURNAL OF HEPATOLOGY

EASL-ILCA Clinical Practice Guidelines on the management of intrahepatic cholangiocarcinoma☆

European Association for the Study of the Liver*



resection occur in a minority of patients and therefore, in tertiary centres, a multidisciplinary discussion on the best treatment option is the norm for most patients with iCCA. The first

British Society of Gastroenterology guidelines for the diagnosis and management of cholangiocarcinoma

Simon M Rushbrook,[1] Timothy James Kendall ,[2,3] Yoh Zen,[4] Raneem Albazaz,[5] Prakash Manoharan,[6] Stephen P Pereira,[7] Richard Sturgess,[8] Brian R Davidson,[9] Hassan Z Malik,[10] Derek Manas,[11] Nigel Heaton,[12] K Raj Prasad,[13] John Bridgewater,[14] Juan W Valle,[15] Rebecca Goody,[16] Maria Hawkins,[17] Wendy Prentice,[18] Helen Morement,[19] Martine Walmsley,[20] Shahid A Khan [21,22]

Recommendation 1: All patients with CCA discussed at multidisciplinary team (MDT) meetings should be classified as best as possible into either intrahepatic, perihilar or distal CCA. This should be clearly recorded in the MDT outcome discussion.

Strength of recommendation: STRONG

Quality of evidence: MODERATE

ESMO GOOD SCIENCE BETTER MEDICINE BEST PRACTICE

ESMO OPEN | CANCER HORIZONS

ORIGINAL RESEARCH

Setup of multidisciplinary team discussions for patients with cholangiocarcinoma: current practice and recommendations from the European Network for the Study of Cholangiocarcinoma (ENS-CCA)

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MDT setup

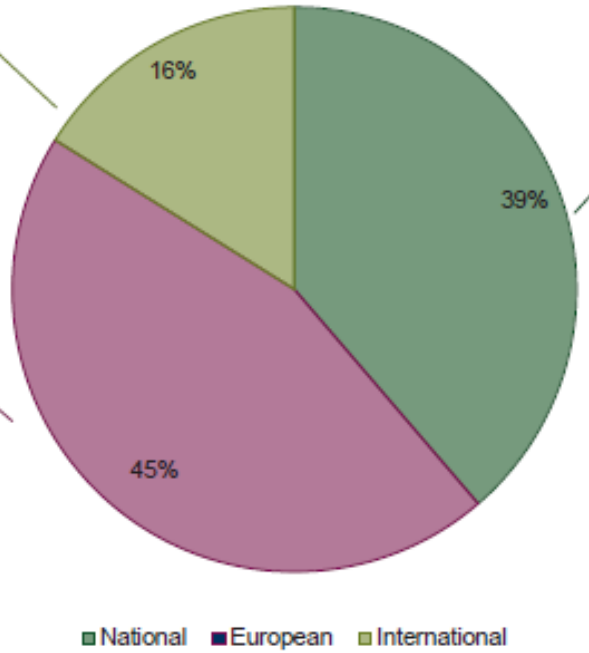
	Current		Ideal		
	N	%	*N*	%	WA
MDT coordinator					
Yes	22	84.62	Mandatory (11); important (12)	Mandatory (42.31); important (46.15)	3.31/4
No	4	15.38	Not important (3); unnecessary (0)	Not important (11.54); unnecessary (0)	
Preliminary information					
Yes	24	92.31	Mandatory (15); important (10)	Mandatory (57.69); important (38.46)	3.54/4
No	2	7.69	Not important (1); unnecessary (0)	Not important (3.85); unnecessary (0)	
Frequency					
Weekly	17	65.38	20	76.92	n/a
Two-weekly	4	15.38	5	19.23	
Monthly	2	7.69	0	0	
Other[a]					
Criteria for patient referral					
All new patients and discussion of every new treatment	12	46.15	17	73.08	n/a
[illegible]	10	38.46	7	26.92	
All new patients only, with no discussion after first treatment decision is made	2	7.69	0	0	
Discussion of selected scenarios only	2	7.69	0	0	
Number of CCAs discussed per week					
Number of total CCAs discussed per week, mean (range)	3.27 (1-10)		n/a	n/a	n/a
[illegible]	1.72 (0.5-4+)		n/a	n/a	n/a
Cancer type discussed in MDT					
Only CCA	0	0	n/a	n/a	n/a
Liver cancer	17	65.38	n/a	n/a	
Other GI cancer	4	30.76	n/a	n/a	
Other GI and not cancers also	1	3.85	n/a	n/a	

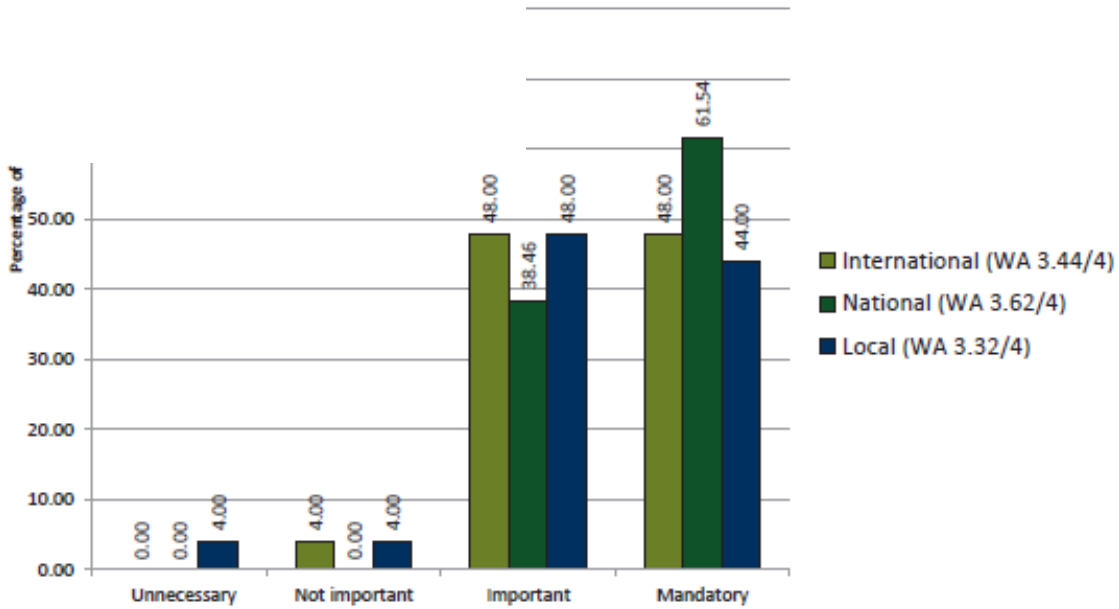
A

International guidelines:
NCCN
ASCO
ILCA

European guidelines
EASL
ESMO

National guidelines:
DGVS
AIOM
AISF
TNCD





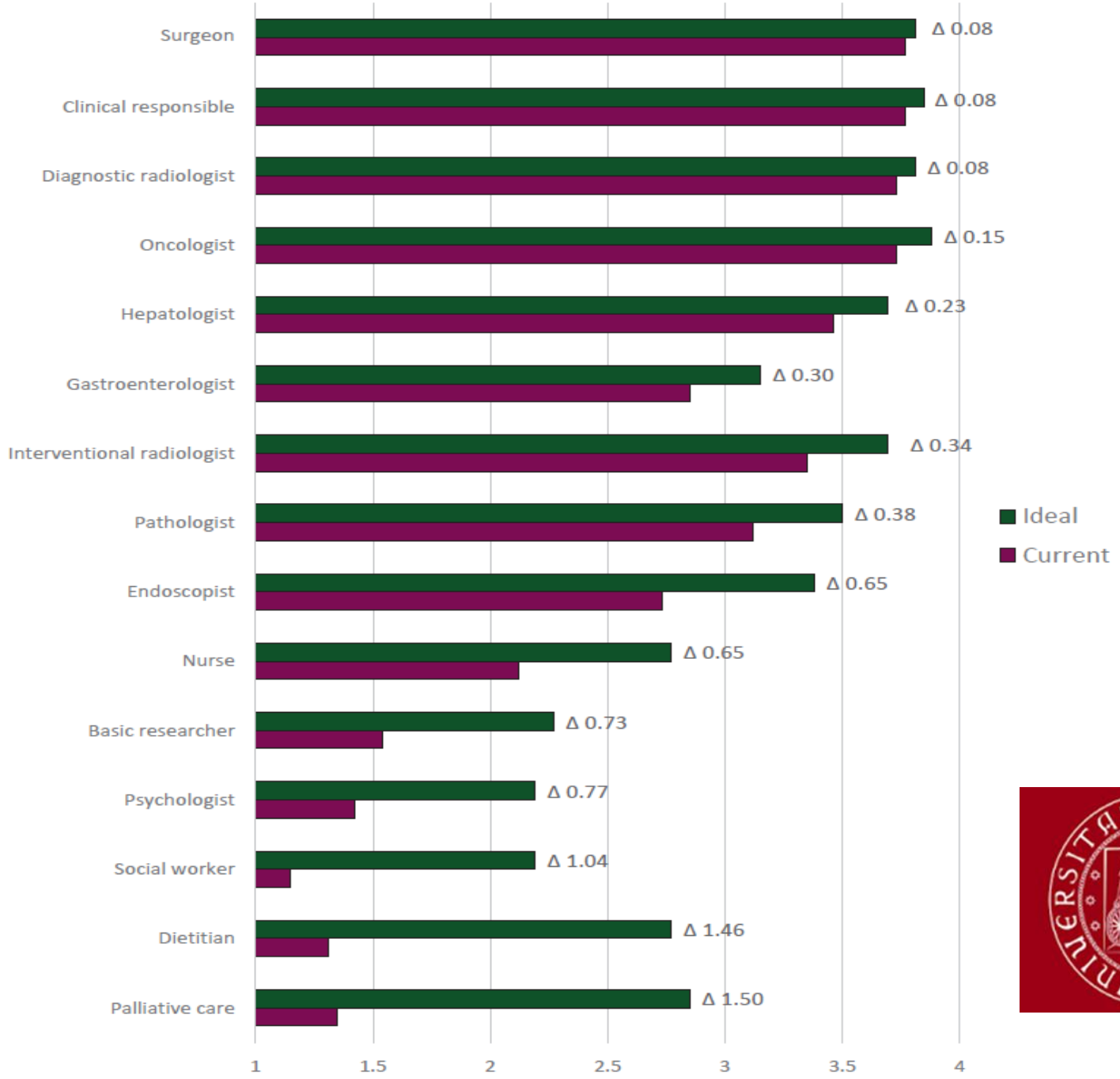


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Table 2. ENS-CCA recommendations for CCA MDT

	Recommendations
MDT coordinator	Presence of MDT coordinator should be mandatory for a well-functioning MDT
Frequency	The MDT should meet weekly. In escenarios of worsening obstructive jaundice or hospitalization in need of urgent review and discussion, an *Ad hoc* same-day multidisciplinary discussion should be considered for staging, determining resectability and the corresponding segments that require urgent drainage.
Referral	Patients should be referred online to the MDT discussion via standard platform or email
Patient information	Information should be provided before the discussion in order to allow radiologists to prepare properly the case and the images
Discussion criteria	Each new patient and each new treatment should be discussed
Type of MDT	Patients with CCA should be discussed in MDTs dedicated to liver cancers only. Whenever possible, centralisation of care/MDTs within a region is recomended to secure adequate experienced decision making.
Guidelines	Guidelines should be used for diagnosis and treatment decision making. Our preference is to use national guidelines, more aware of locally accessible treatment options
Mandatory aspects to be discussed	Collective discussion of diagnostic decision and treatment, patients' preferences and supportive care needs should be mandatory
Mandatory specialists	Presence of the oncologist, clinician responsible for the patient's care, surgeon, diagnostic and interventional radiologist, hepatologist, pathologist, endoscopist and gastroenterologist should be mandatory in a well-functioning MDT
Desirable specialists	Presence of palliative, nurse and dietitian, basic researcher, psychologist and social worker should be recommended

25 European countries

59- questions online survey on ***pCCA Preoperative Management***

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61 Centers, highly experienced in HPB surgery

6333 pCCA cases

Centers' caseload

≥ 5 pCCA cases /years — ***43*** centers

< 5 pCCA cases /years — ***18*** centers

Preoperative Institutional Protocol

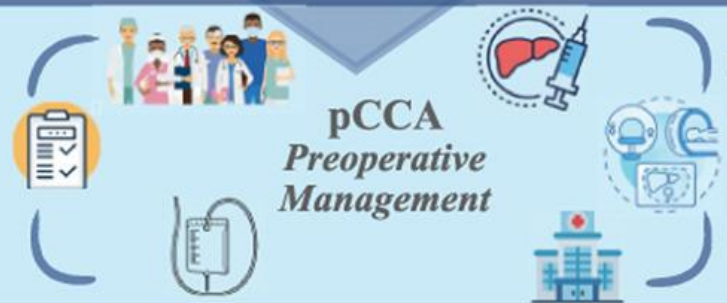
Presence — ***45*** centers

Absence — ***16*** centers

Multidisciplinary pCCA case discussion

Application of an established preoperative management protocol

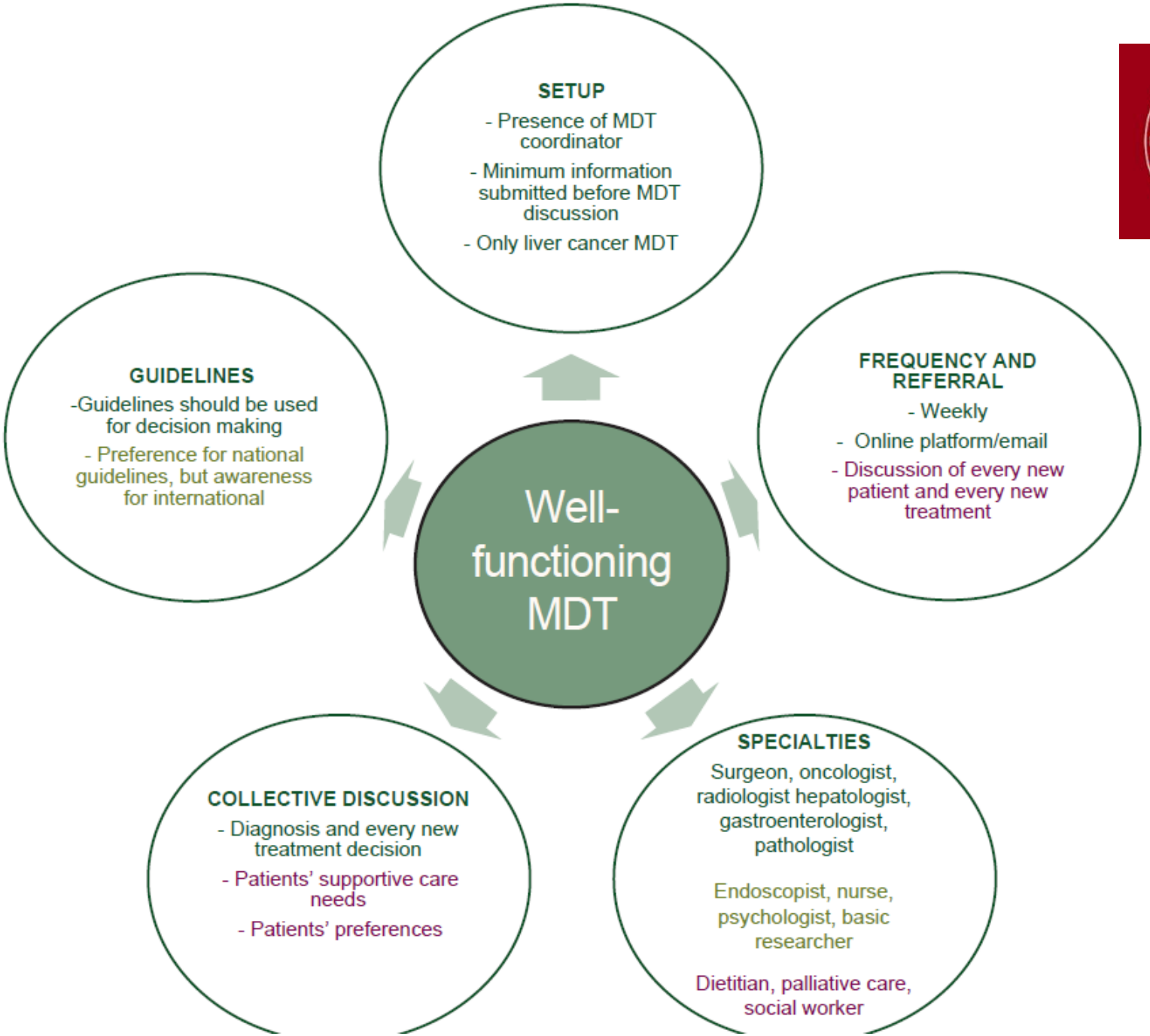
PTBD procedure of choice for biliary drainage



PVE technique of choice for liver hypertrophy

Liver function evaluation mainstay of preoperative work

Management within tertiary referral centers



Agenda

1. *The cases of CholangioCarcinoma should be discuss?*
2. *By whom? Who is mandatory, who is not*
3. *What is the medical-legal impact of the indications*
4. *Is teleconsulting a viable option?*