

Systemic Therapy for Advanced Hepatocellular Carcinoma ASCO Guideline Update

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Background & Methodology

Introduction

- There were approximately 725,000 new cases and 664,000 deaths worldwide due to hepatocellular carcinoma (HCC) in 2020.
- In recent years, several newer systemic therapy options have shown efficacy in the first and second-line settings for advanced HCC, including evidence of the effectiveness of combination therapy.¹⁻³
- This guideline provides an update to the 2020 recommendations, including updated evidence profiles for treatments included in the previous version of the guideline, and newer data from randomized trials of other agents alone or in combination.
- Data on combination therapy in the adjuvant setting is outside the scope of this guideline update.



ASCO Guideline Development Methodology

- The ASCO Evidence Based Medicine Committee (EBMC) guideline process includes:
 - a systematic literature review by ASCO guidelines staff
 - an expert panel provides critical review and evidence interpretation to inform guideline recommendations
 - final guideline approval by ASCO EBMC
- The full ASCO Guideline methodology manual can be found at: <u>www.asco.org/guideline-methodology</u>

Clinical Questions

This clinical practice guideline addresses the following clinical questions:

- 1. What are the preferred treatment options for first-line systemic therapy for patients with advanced hepatocellular carcinoma?
- 2. What are the preferred treatment options for second- or later-line therapy for patients with advanced hepatocellular carcinoma?

Target Population and Audience

Target Population

• Patients with advanced hepatocellular carcinoma.

Target Audience

 Clinicians who are involved in the care and treatment of patients with advanced hepatocellular carcinoma, including medical oncologists, hepatologists, gastroenterologists, surgeons, interventional radiologists, radiation oncologists, radiologists, pathologists, and palliative care specialists.

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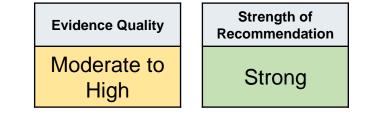




First-Line Therapy

Recommendation 1.1

 Atezolizumab + bevacizumab (atezo+bev) or durvalumab + tremelimumab (durva+treme) may be offered as first-line treatment for patients with Child-Pugh class A, and ECOG PS 0-1 advanced HCC.





Qualifying statements for Recommendation 1.1:

- For patients receiving atezo+bev, screening for and management of esophageal varices when present are recommended prior to initiation of therapy and according to institutional guidelines.
- The choice between treatment options in Recommendation 1.1 should be made through a discussion involving the physician and patient (and caregiver, where applicable), and should include factors such as medical history, toxicities associated with treatment, cost, goals of treatment, patient preference, and expected treatment benefit.
- When choosing between the two combination therapy options, consider risk of bleeding and thrombosis with the VEGF inhibitor bevacizumab.
- Patients with active or previously documented autoimmune disease should consider the risk of immunerelated adverse effects associated with atezo and durva+treme.

Recommendation 1.2

 Where there are contraindications to atezo+bev or durva+treme, sorafenib, lenvatinib, or durvalumab may be offered as first-line treatment for patients with Child-Pugh class A, and ECOG PS 0-1 advanced HCC.

Qualifying statements for Recommendation 1.2:

• The choice between treatment options should take into account the factors listed in the second qualifying statement to Recommendation 1.1.

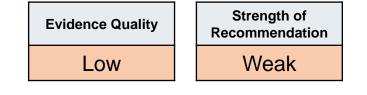
Evidence Quality	Strength of Recommendation
Moderate	Strong



Second-Line Therapy

Recommendation 2.1

 Following first-line treatment with atezo+bev, second-line therapy with a tyrosine kinase inhibitor (TKI) (i.e., sorafenib, lenvatinib, or cabozantinib), or ramucirumab (AFP ≥400 ng/mL) are recommended.





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Qualifying statements for Recommendation 2.1:

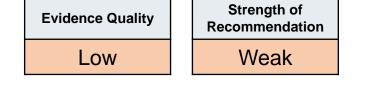
- The Expert Panel also agreed that nivolumab + ipilimumab (nivo+ipi) is an option that may be considered following first-line treatment with atezo+bev, although the evidence for nivo+ipi is limited to data from case series.⁴⁻⁶
- While there is currently no published evidence to support a recommendation for durva+treme, the Expert Panel agreed that this option may be considered following first-line treatment with atezo+bev.

Recommendation 2.2

• Following first-line treatment with durva+treme, second-line therapy with a TKI is recommended.

Qualifying statement for Recommendation 2.2:

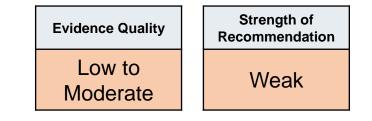
 The Expert Panel also agreed that atezo+bev may be considered following durva+treme for patients who do not have contraindications to the former combination, although there is no data available to select patients for this combination therapy vs. second-line therapy with a TKI.





Recommendation 2.3

Following first-line treatment with sorafenib or lenvatinib, second-line therapy with another TKI (cabozantinib or regorafenib), ramucirumab (AFP ≥400 ng/mL), nivo+ipi, or durvalumab may be recommended for appropriate candidates. Atezo+bev or durva+treme may be considered for patients who may not have had access to these therapies in the first-line setting, and do not have contraindications to these combinations. Considerations regarding choice of therapy are included in the Clinical Interpretation in the full guideline.





Qualifying statement for Recommendation 2.3:

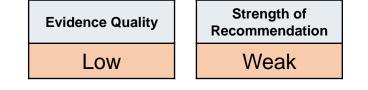
 In addition, pembrolizumab or nivolumab are reasonable options that may be considered for appropriate candidates following first-line therapy with sorafenib or lenvatinib.



Third-Line Therapy

Recommendation 3.1

 Third-line therapy may be considered in Child-Pugh A patients with good performance status, using one of the agents listed previously that has a non-identical mechanism of action with previously received therapy.

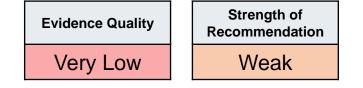




Child-Pugh Class B

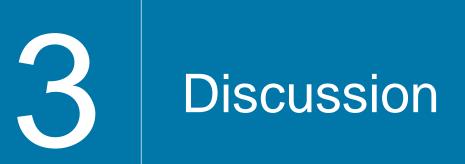
Recommendation 4.1

 The Expert Panel agrees on a cautious approach to systemic therapy in advanced HCC patients who are Child-Pugh class B with good PS, considering underlying liver function, bleeding risk, presence of portal hypertension, extent of extrahepatic spread, tumor burden, and major vascular invasion. Limited data suggest that regimens typically used for Child-Pugh A can be beneficial in untreated patients with Child-Pugh B cirrhosis. Given the modest expectations for clinical benefit from systemic therapy in this population, the Expert Panel emphasizes shared decision-making with patients.









Future Directions

- There is currently no head-to-head data to assist with discrimination between some of the recommended treatment options
 - For example, in Recommendation 1.1 two first-line options combination therapy options are recommended because of their respective demonstrated benefit compared to sorafenib alone.
- Biomarkers that could assist with treatment decision-making would be helpful in this context, and real-world and post-hoc analyses have provided some information on genetic subtyping and biomarkers to guide the selection of patients for treatment.
- Another gap is the topic of sequencing of therapy in later lines; the Expert Panel awaits future studies on this topic, while acknowledging that they are likely to be retrospective.



Health Disparities

- Although ASCO guidelines represent expert recommendations on the best practices in disease management to provide the highest level of cancer care, it is important to note that many patients have limited access to medical care.
- Up to 5.3 million people—two percent of the U.S. population—are living with chronic HBV or HCV. Half of those with chronic HBV infection are Asian and Pacific Islander Americans.
- HBV is the most common serious infection of the liver and can lead to premature death from liver cancer or liver failure.
- For patients with HCC, studies have shown disparities in access to care, including liver transplantation, by race and/or ethnicity.⁷⁻¹⁰
- HCC was also detected at a more advanced stage in an African American study population, compared to other racial and ethnic groups.¹¹

Health Disparities

- Detection at an earlier stage could help to reduce ethnic and racial disparities in outcomes.¹²
- Awareness of low rates of treatment with systematic therapy and/or disparities in access to care and clinical trials, and outcomes should be considered in the context of this clinical practice guideline, and health care providers should strive to deliver the highest level of cancer care to more vulnerable populations.
- It is equally important to redefine the context of HCC disparity research to include the assessment of the impact of socioeconomic factors, and social policies on outcomes, in order to inform strategies to minimize cancer treatment and outcome disparities.
- Finally, social and health policies must emphasize prevention of known risk factors for HCC and a campaign for early detection methods should be promoted within racial and ethnic groups.

Additional Resources

- More information, including a supplement and clinical tools and resources, is available at <u>www.asco.org/gastrointestinal-cancerguidelines</u>
- Patient information is available at <u>www.cancer.net</u>

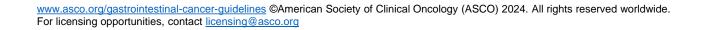
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Abbreviations

- AFP, alpha-fetoprotein
- ASCO, American Society of Clinical Oncology
- atezo+bev, atezolizumab + bevacizumab
- durva+treme, durvalumab + tremelimumab
- EBMC, Evidence Based Medicine
 Committee
- ECOG, Eastern Cooperative Oncology Group
- HBV, Hepatitis B virus

- HCC, hepatocellular carcinoma
- HCV, Hepatitis C virus
- nivo+ipi, nivolumab + ipilimumab
- PGIN, Practice Guidelines Implementation Network
- PS, performance status
- TKI, tyrosine kinase inhibitor
- VEGF, vascular endothelial growth factor



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