

Supplementary Information

Supplementary Material S1 Survey questionnaire

Intermediate hepatocellular carcinoma (iHCC) in Asia

***=answer required**

Safety and adverse event reporting

Please be advised that, according to pharmacovigilance regulations, we are required to declare to the sponsor of this study any adverse event or special situation (eg off-label use, overdose, quality issues, etc), even if it has already been reported to the sponsor or the relevant health authorities. In the event that a pharmacovigilance observation is mentioned in your responses to this survey, Amiculum will contact you directly to seek your agreement to provide your contact details to the study sponsor. Amiculum will only contact you directly regarding your participation in this survey and any pharmacovigilance observations.

Please indicate your agreement below.*

- ☐ Yes, I agree to be contacted directly by Amiculum in the event of my disclosing a pharmacovigilance observation in my responses to this survey
- ☐ No, I refuse permission for Amiculum to contact me directly in the event of my disclosing a pharmacovigilance observation in my responses to this survey
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SECTION 1: DEMOGRAPHICS

1) In which market do you primarily practise?*

- ☐ Korea
- ☐ Malaysia
- ☐ Philippines
- ☐ Singapore
- ☐ Taiwan
- ☐ Thailand
- ☐ Vietnam
- ☐ Other (please specify): _____ *

2) Please indicate your medical specialty*

☐ Medical oncologist

☐ Interventional radiologist

☐ Gastroenterologist/hepatologist

☐ Surgeon

☐ Other (please specify): _____ *

3) In which healthcare setting do you practise?*

☐ Public only

☐ Private only

☐ Both public and private

4) Which of the following most accurately describes your primary institution?*

☐ National or regional cancer centre

☐ Large or mid-sized regional hospital

☐ Rural or local hospital

☐ Private clinic/practice

☐ Other (please specify): _____ *

5) Indicate your number of years of experience in diagnosing and treating HCC*

6) On average, how many patients with HCC do you assess annually?*

7) Approximately what percentage of your patients have HCC?*

8) What is your current role/professional rank at your primary institution?

*If applicable, you may select more than one option**

☐ Junior doctor/resident

☐ Consultant

☐ Fellow

☐ Assistant/Associate Professor

☐ Professor

☐ Leadership position at an institution (eg Head of Department, Programme Director, institutional committee leadership)

☐ Leadership position in a medical society (eg President, Vice President, Executive Committee Member)

☐ Other (please specify): _____ *

SECTION 2: SURVEILLANCE AND DIAGNOSIS OF HCC

9) Which of the following are the most predominant risk factors for HCC in your country? Please select the three most common risk factors*

☐ Chronic hepatitis C virus (HCV) infection

☐ Fatty-liver-induced/non-alcoholic steatohepatitis (NASH)

☐ Alcohol-related cirrhosis

☐ Chronic hepatitis B virus (HBV) infection

☐ Liver cirrhosis

☐ Other (please specify): _____ *

10) National screening*

Is there a national screening programme for HCC in your country?*

☐ Yes

☐ No

Is the screening programme reimbursable to the patient?*

☐ Yes, fully

☐ Yes, partially

☐ No

Is the screening programme restricted to certain subgroups?*

☐ Yes

☐ No

If yes, which criteria are necessary for screening? *Please select all that apply**

☐ HCV/HBV positivity

☐ Cirrhosis

☐ Family history

☐ Age (please specify in years): _____ *

☐ Other (please specify): _____ *

11) How often does the national screening take place?*

☐ Every 6 months

☐ Yearly

☐ Every 2 years

☐ Other (please specify): _____ *

12) Which of the following tumour markers are tested for as part of the national screening programme? *If applicable, you may select more than one option**

☐ DCP/PIVKA-II

☐ AFP-L3

☐ AFP

☐ Other (please specify): _____ *

☐ None; tumour markers are not tested as part of the national screening programme

13) Which of the following imaging methods are used as part of the national screening programme? *Please select all that apply**

☐ Ultrasound

☐ Computed tomography (CT)

☐ Magnetic resonance imaging (MRI)

☐ Other (please specify): _____ *

☐ None; imaging methods are not used as part of the national screening programme

14) What proportion of your patients diagnosed with HCC are referred by the national screening programme?*

15) Considering patients not identified through any national screening programme, which healthcare professional (HCP) is usually the first to suspect HCC?*

☐ General practitioner/primary healthcare provider

☐ Medical oncologist

☐ Gastroenterologist/hepatologist

☐ Radiologist

☐ Surgeon

☐ Other (please specify): _____ *

16) Which HCP usually diagnoses HCC?*

☐ General practitioner/primary healthcare provider (PCP)

☐ Medical oncologist

☐ Gastroenterologist/hepatologist

☐ Radiologist

☐ Surgeon

☐ Other (please specify): _____ *

17) In your country, where does HCC diagnosis usually take place?*

☐ Large national hospital

☐ Mid-sized hospital

☐ Rural hospital

☐ Private practice clinic

☐ Other (please specify): _____ *

18) Which of the following methods are used to diagnose HCC in your country?

*Please select all that apply**

- ☐ Ultrasound
- ☐ Multiphasic CT
- ☐ Multiphasic MRI
- ☐ Liver biopsy
- ☐ Other (please specify): _____ *

19) Please estimate the proportion of your patients with HCC who are diagnosed at the following stages. The sum of the answers must be equal 100%. Please enter 0% for stages at which no patients are usually diagnosed*

Early HCC (BCLC-0 or -A): _____

Intermediate HCC (BCLC-B): _____

Advanced HCC (BCLC-C): _____

End-stage HCC (BCLC-D): _____

20) Which factors are most important for improving the rate of early diagnosis of HCC in your country? Please select the three most important factors*

- ☐ Patient education and/or awareness
 - ☐ General practitioner/PCP education
 - ☐ Specialist education
 - ☐ Availability of a national screening programme
 - ☐ Availability of specific imaging technologies
 - ☐ Delays in laboratory or imaging results
 - ☐ Reimbursement of diagnostic methods
 - ☐ Other (please specify): _____ *
-

SECTION 3: TREATMENT DECISION MAKING IN HCC

21) In your institution, who is the primary treatment decision maker for patients with early HCC (BCLC-0 or -A)?*

- ☐ Medical oncologist
- ☐ Gastroenterologist/hepatologist
- ☐ Surgeon
- ☐ Interventional radiologist

22) In your institution, who is the primary treatment decision maker for patients with intermediate HCC (BCLC-B)?*

- ☐ Medical oncologist
- ☐ Gastroenterologist/hepatologist
- ☐ Surgeon
- ☐ Interventional radiologist

23) In your institution, who is the primary treatment decision maker for patients with advanced HCC (BCLC-C)?*

- ☐ Medical oncologist
- ☐ Gastroenterologist/hepatologist
- ☐ Surgeon
- ☐ Interventional radiologist

24) In your institution, who is the primary treatment decision maker for patients with end-stage HCC (BCLC-D)?*

- ☐ Medical oncologist
 - ☐ Gastroenterologist/hepatologist
 - ☐ Surgeon
 - ☐ Interventional radiologist
-

SECTION 3: TREATMENT DECISION MAKING IN HCC

How heavily involved in treatment decision making for patients with early HCC (BCLC-0 or -A) are the following HCPs at your institution?*

	Heavily involved	Moderately involved	Limited or no involvement	Specialist unavailable
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25) How heavily involved in treatment decision making for patients with intermediate HCC (BCLC-B) are the following HCPs at your institution?*

	Heavily involved in decision making	Moderately involved in decision making	Limited or no involvement in decision making	Specialist unavailable
Medical oncologist	()	()	()	()
Gastroenterologist/hepatologist	()	()	()	()
Surgeon	()	()	()	()
Interventional radiologist	()	()	()	()

**In your opinion, why do medical oncologists have limited or no involvement in treatment decision making for patients with iHCC (BCLC-B) in your institution?
Select the most important factor***

- () Institutional protocols/institution-specific practices
- () Resourcing issues
- () Limited familiarity/experience with locoregional therapies
- () Limited familiarity/experience with systemic therapies
- () Other (please specify): _____

*

In your opinion, why do gastroenterologists/hepatologists have limited or no involvement in treatment decision making for patients with iHCC (BCLC-B) in your institution? *Select the most important factor**

- ☐ Institutional protocols/institution-specific practices
- ☐ Resourcing issues
- ☐ Limited familiarity/experience with locoregional therapies
- ☐ Limited familiarity/experience with systemic therapies
- ☐ Other (please specify): _____ *

In your opinion, why do surgeons have limited or no involvement in treatment decision making for patients with iHCC (BCLC-B) in your institution? *Select the most important factor**

- ☐ Institutional protocols/institution-specific practices
- ☐ Resourcing issues
- ☐ Limited familiarity/experience with locoregional therapies
- ☐ Limited familiarity/experience with systemic therapies
- ☐ Other (please specify): _____ *

In your opinion, why do interventional radiologists have limited or no involvement in treatment decision making for patients with iHCC (BCLC-B) in your institution? *Select the most important factor**

- ☐ Institutional protocols/institution-specific practices
- ☐ Resourcing issues
- ☐ Limited familiarity/experience with locoregional therapies
- ☐ Limited familiarity/experience with systemic therapies
- ☐ Other (please specify): _____ *

How heavily involved in treatment decision making for patients with advanced HCC (BCLC-C) are the following HCPs at your institution?*

	Heavily involved	Moderately involved	Limited or no involvement	Specialist unavailable
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How heavily involved in treatment decision making for patients with end-stage HCC (BCLC-D) are the following HCPs at your institution?*

	Heavily involved	Moderately involved	Limited or no involvement	Specialist unavailable
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SECTION 3: TREATMENT DECISION MAKING IN HCC

26) Which treatment guidelines do you follow for the treatment of intermediate-stage HCC? *Select all that apply**

☐ AASLD

☐ ASCO

☐ EASL

☐ ESMO

☐ NCCN

☐ APPLE

☐ Local guidelines

☐ Not sure

☐ Other (please specify): _____ *

☐ None; I do not follow any guidelines for the treatment of iHCC

27) Which treatments are currently available for intermediate-stage HCC in your country? *Please indicate all treatments that are available to your patients, regardless of reimbursement status**

	Available	Not available	I don't know
C-TACE	()	()	()
DEB-TACE	()	()	()
TARE	()	()	()
Other radiotherapy	()	()	()

Ablation	☐	☐	☐
Resection	☐	☐	☐
Systemic therapies alone	☐	☐	☐
Systemic therapy in combination/sequence with locoregional therapy	☐	☐	☐

Which other radiotherapies are available?*

Which systemic therapies are available alone?*

Which systemic therapies are available in combination with locoregional therapy?*

C-TACE*

- ☐ Reimbursable
- ☐ Not reimbursable
- ☐ I don't know

DEB-TACE*

- ☐ Reimbursable
- ☐ Not reimbursable
- ☐ I don't know

TARE*

- ☐ Reimbursable
- ☐ Not reimbursable
- ☐ I don't know

Other radiotherapy*

- ☐ Reimbursable
- ☐ Not reimbursable
- ☐ I don't know

Ablation*

- ☐ Reimbursable
- ☐ Not reimbursable
- ☐ I don't know

Resection*

- ☐ Reimbursable
- ☐ Not reimbursable
- ☐ I don't know

Systemic therapies alone*

- ☐ Reimbursable
- ☐ Not reimbursable
- ☐ I don't know

Systemic therapies in combination/sequence with locoregional therapy*

- ☐ Reimbursable
- ☐ Not reimbursable
- ☐ I don't know

**28) Among patients with intermediate-stage HCC, which characteristics do you consider most important for determining TACE unsuitability in clinical practice?
Please select the three most important factors***

- ☐ 'Up to seven' criteria out nodules
- ☐ Child–Pugh B
- ☐ Albumin-bilirubin grade ≥ 2
- ☐ Previous TACE refractoriness/failure
- ☐ Lack of clear boundaries within tumour(s)
- ☐ Presence of confluent multinodular tumours
- ☐ Presence of massive tumour(s)
- ☐ Poorly differentiated HCC
- ☐ Other (please specify): _____ *

29) Indicate your PRIMARY TREATMENT GOAL in the different treatment settings below*

	First-line setting	Second-line setting
Intermediate: BCLC-B1 Meets extended liver transplant criteria of institution (CPS 5–7, ECOG PS 0; 'up to seven' in)	_____ _____	_____ _____
Intermediate: BCLC-B2 Well-defined nodules, preserved portal flow, selective access (CPS 5–7, ECOG PS 0; 'up to seven' out)	_____ _____	_____ _____
Intermediate: BCLC-B3 Diffuse, infiltrative, extensive bilobar liver involvement (CPS 7, ECOG PS 0; 'up to seven' out)	_____ _____	_____ _____

Advanced: BCLC-C Portal invasion and/or extrahepatic spread, preserved liver function (ECOG PS 1–2)		
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Comments:

30) Indicate your PREFERRED TREATMENT CHOICE in the different treatment settings below. *Where necessary, please specify your treatment choice in the comments box**

	First-line setting	Second-line setting
Intermediate: BCLC-B1 Meets extended liver transplant criteria of institution (CPS 5–7, ECOG PS 0; ‘up to seven’ in)		
Intermediate: BCLC-B2 Well-defined nodules, preserved portal flow, selective access (CPS 5–7, ECOG PS 0; ‘up to seven’ out)		
Intermediate: BCLC-B3 Diffuse, infiltrative, extensive bilobar liver involvement (CPS 7, ECOG PS 0; ‘up to seven’ out)		
Advanced: BCLC-C Portal invasion and/or extrahepatic spread, preserved liver function (ECOG PS 1–2)		

Comments:

31) Indicate the most important factor affecting your treatment decision in the different treatment settings below*

	First-line setting	Second-line setting
Intermediate: BCLC-B1 Meets extended liver transplant criteria of institution (CPS 5–7, ECOG PS 0; ‘up to seven’ in)		
Intermediate: BCLC-B2 Well-defined nodules, preserved portal flow, selective access (CPS 5–7, ECOG PS 0; ‘up to seven’ out)		
Intermediate: BCLC-B3 Diffuse, infiltrative, extensive bilobar liver involvement (CPS 7, ECOG PS 0; ‘up to seven’ out)		
Advanced: BCLC-C Portal invasion and/or extrahepatic spread, preserved liver function (ECOG PS 1–2)		

Comments:

3C. THE ROLE OF SYSTEMIC THERAPIES IN iHCC

32) Are you licensed to prescribe systemic therapies for the treatment of HCC in your country?*

☐ Yes

☐ No

3C. THE ROLE OF SYSTEMIC THERAPIES IN iHCC

33) Which factors would most influence your decision to add systemic therapy to locoregional therapy (either in combination or in sequence) in the treatment of iHCC? Please select the three most important factors*

☐ Size, location or number of target lesions

☐ Patient performance score

☐ Patient liver function

☐ Tumour differentiation

☐ Tumour vascularization

☐ Possible side effects of the systemic therapy

☐ My own familiarity with the systemic therapy

☐ Cost or reimbursement status of the systemic therapy

☐ National or international guideline recommendation

☐ More evidence for combination therapies used in iHCC

☐ Patient preference

☐ Input from or consultation with colleagues

☐ Other (please specify): _____ *

34) Which factors would most influence your decision to use systemic therapy instead of locoregional therapy in the treatment of iHCC? Please select the three most important factors*

☐ Size, location or number of target lesions

☐ Tumour differentiation

☐ Tumour vascularization

☐ Patient performance score

☐ Patient liver function

☐ Possible side effects of the systemic therapy

- ☐ My own familiarity with the systemic therapy
- ☐ Cost or reimbursement status of the systemic therapy
- ☐ National or international guideline recommendation
- ☐ More evidence for systemic therapies without locoregional therapy in iHCC
- ☐ Patient preference
- ☐ Input from or consultation with colleagues
- ☐ Other (please specify): _____ *

35) How familiar are you with the evidence for the addition of the following therapies to TACE in iHCC?*

	Not familiar at all	Vaguely familiar	Familiar	Very familiar
Lenvatinib	()	()	()	()
Sorafenib	()	()	()	()
Pembrolizumab + lenvatinib	()	()	()	()
Atezolizumab + bevacizumab	()	()	()	()
Durvalumab + bevacizumab	()	()	()	()
Durvalumab + tremelimumab	()	()	()	()

36) Please indicate systemic therapies you have experience of using in combination/sequence with locoregional therapy to treat iHCC. Please select all that apply*

- ☐ Lenvatinib
- ☐ Sorafenib
- ☐ Pembrolizumab + lenvatinib
- ☐ Atezolizumab + bevacizumab

- ☐ Durvalumab + bevacizumab
- ☐ Durvalumab + tremelimumab
- ☐ Other (please specify): _____ *
- ☐ None of the above
-

3C. THE ROLE OF SYSTEMIC THERAPIES IN iHCC

37) In which setting have you used the above systemic therapies? Please select all that apply* (*Options show only for systemic therapies participants have indicated using Q36*)

	In a clinical trial	In clinical practice	Not used
Without locoregional therapy	☐	☐	☐
In combination/sequence with a locoregional therapy	☐	☐	☐

38) Which locoregional therapy have you used the above systemic therapies with? Select all that apply* (*Options show only for systemic therapies participants have indicated using in combination/sequence with LRT in Q37*)

- ☐ C-TACE
- ☐ DEB-TACE
- ☐ TARE
- ☐ Other radiotherapy
- ☐ Ablation

39) In your practice, when is the systemic therapy given in relation to TACE?* (*Options show only for systemic therapies participants have indicated using in combination with C-TACE or DEB-TACE in Q38*)

- ☐ Pre-TACE
- ☐ Peri-TACE
- ☐ Post-TACE
- ☐ Other (please specify): _____ *

3C. THE ROLE OF SYSTEMIC THERAPIES IN iHCC

40) If all TACE + IO ± TKI combinations were approved and reimbursable in your country, in which of the following patients with iHCC would you be most likely to use combination/sequential therapy in the first-line setting? *Select all that apply**

☐ **Intermediate: BCLC-B1**

Meets extended liver transplant criteria of institution
(CPS 5–7, ECOG PS 0; ‘up to seven’ in)

☐ **Intermediate: BCLC-B2**

Well-defined nodules, preserved portal flow, selective access
(CPS 5–7, ECOG PS 0; ‘up to seven’ out)

☐ **Intermediate: BCLC-B3**

Diffuse, infiltrative, extensive bilobar liver involvement
(CPS 7, ECOG PS 0; ‘up to seven’ out)

☐ **Advanced: BCLC-C**

Portal invasion and/or extrahepatic spread, preserved liver function (ECOG PS 1–2)

☐ **None of the above**

3C. THE ROLE OF SYSTEMIC THERAPIES IN iHCC

Which systemic therapy would you be most likely to combine/sequence with TACE? *Please assume that all therapies are available and reimbursable in your country**

☐ Lenvatinib

☐ Sorafenib

☐ Pembrolizumab + lenvatinib

☐ Atezolizumab + bevacizumab

☐ Durvalumab + bevacizumab

☐ Durvalumab + tremelimumab

☐ Unsure/it depends (please comment): _____ *

☐ Other (please specify): _____ *

Which of the following factors plays the largest role in your treatment choice? *Select the most important factor**

☐ Patient-related characteristics

☐ My own familiarity with one or both of the systemic treatments

☐ Familiarity of others within my institution with one or both of the systemic treatments

- ☐ Adverse event profile of the agent
 - ☐ Efficacy data surrounding the systemic treatment
 - ☐ Other (please specify): _____ *
-

3C. THE ROLE OF SYSTEMIC THERAPIES IN THE CURRENT AND FUTURE iHCC LANDSCAPE

41) If all TACE + IO ± TKI combinations were approved and reimbursable in your country, in which of the following patients with iHCC would you be most likely to use combination/sequential therapy in the second-line setting? *Select all that apply**

☐ **Intermediate: BCLC-B1**

Meets extended liver transplant criteria of institution
(CPS 5–7, ECOG PS 0; ‘up to seven’ in)

☐ **Intermediate: BCLC-B2**

Well-defined nodules, preserved portal flow, selective access
(CPS 5–7, ECOG PS 0; ‘up to seven’ out)

☐ **Intermediate: BCLC-B3**

Diffuse, infiltrative, extensive bilobar liver involvement
(CPS 7, ECOG PS 0; ‘up to seven’ out)

☐ **Advanced: BCLC-C**

Portal invasion and/or extrahepatic spread, preserved liver function (ECOG PS 1–2)

☐ **None of the above**

3C. THE ROLE OF SYSTEMIC THERAPIES IN THE CURRENT AND FUTURE iHCC LANDSCAPE

Which systemic therapy would you be most likely to combine/sequence with TACE?
*Please assume that all therapies are available and reimbursable in your country**

- ☐ Lenvatinib
- ☐ Sorafenib
- ☐ Pembrolizumab + lenvatinib
- ☐ Atezolizumab + bevacizumab
- ☐ Durvalumab + bevacizumab
- ☐ Durvalumab + tremelimumab
- ☐ Unsure/it depends (please comment): _____ *
- ☐ Other (please specify): _____ *

Which of the following factors plays the largest role in your treatment choice? *Select the most important factor**

- ☐ Patient-related characteristics
- ☐ My own familiarity with one or both of the systemic treatments
- ☐ Familiarity of others within my institution with one or both of the systemic treatments
- ☐ Adverse event profile of the agent
- ☐ Efficacy data surrounding the systemic treatment
- ☐ Other (please specify): _____ *

3C. THE ROLE OF SYSTEMIC THERAPIES IN THE CURRENT AND FUTURE iHCC LANDSCAPE

42) If TACE + IO $\pm$ TKI was approved and reimbursable in your country, indicate which three factors would most influence your decision to choose the following regimens:*

	1.	2.	3.
TACE + IO/IO	_____	_____	_____
TACE + IO/TKI	_____	_____	_____
TACE + IO/VEGF	_____	_____	_____

Comments:

43) If TACE + IO $\pm$ TKI was approved but not reimbursable in your country, which of the following would represent the greatest barriers to clinical adoption? *Select the three greatest barriers**

- ☐ Lack of familiarity among physicians with using TACE in combination with IO/TKI
- ☐ Lack of national guideline recommendation

- ☐ Lack of international guideline recommendation
 - ☐ Cost of the approved treatments
 - ☐ Reimbursement status of the approved treatments
 - ☐ Concerns over adverse events
 - ☐ Lack of suitable patients in the real world
 - ☐ Other (please specify): _____ *
-

SECTION 4: THE ROLE OF THE MDT IN THE MANAGEMENT OF iHCC

44) Do you have access to an MDT for the management of iHCC in:*

	Yes	No
Your institution?	()	()
Your country (eg in collaboration with other institutions in your country)?	()	()

45) Considering your MDT for the management of iHCC, which specialties participate in the MDT board? *Please select all that apply**

- ☐ Medical oncologist
- ☐ Interventional radiologist
- ☐ Gastroenterologist/hepatologist
- ☐ Surgeon
- ☐ Nurse
- ☐ Project coordinator/administrative assistant
- ☐ Patient liaison/educator
- ☐ Other (please specify): _____ *

46) Considering the management of iHCC, how often does the MDT board meet?*

- ☐ Once a week (or more often)
- ☐ Once every 2 weeks
- ☐ Monthly
- ☐ On an *ad hoc* or as-needed basis
- ☐ Other (please specify): _____ *

47) Considering the management of iHCC, when does the MDT usually discuss each patient case? *Select all that apply**

- ☐ At diagnosis
- ☐ Before first-line treatment
- ☐ During first-line treatment
- ☐ On progression or before second/later-line treatment
- ☐ During second/later-line treatment
- ☐ Other (please specify): _____ *

48) Considering the management of iHCC, please indicate the extent to which you agree with the following statements:*

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
Members of the MDT share equal responsibility for making treatment decisions	☐	☐	☐	☐	☐
Members of the MDT share equal responsibility for implementing treatment decisions	☐	☐	☐	☐	☐

49) How satisfied are you with the current MDT care arrangement for patients with iHCC?*

- ☐ Very unsatisfied
- ☐ Unsatisfied
- ☐ Neutral
- ☐ Satisfied
- ☐ Very satisfied

50) Please indicate the top three barriers to MDT care for patients with iHCC*

- ☐ Lack of specialists within my centre/country to create an MDT
- ☐ Time constraints
- ☐ Budget constraints
- ☐ Lack of support from the administration
- ☐ Lack of familiarity of MDT members with the cases being discussed
- ☐ Differences of opinion between members of an existing MDT
- ☐ Suboptimal coordination between members of an existing MDT
- ☐ Suboptimal leadership within an existing MDT
- ☐ Lack of responsibility/accountability within an existing MDT
- ☐ Suboptimal referral network between specialties
- ☐ Suboptimal referral network between private practice and public hospitals
- ☐ Other (please specify): _____ *

51) In your opinion, would it be possible to establish an online multi-institutional MDT that connects rural hospitals with urban cancer centres in your country?*

- ☐ Yes
- ☐ No
- ☐ Unsure

52) In your opinion, which steps are most important in implementing a multi-institutional online MDT? Please select the three most important steps*

- ☐ Identifying experts to lead the MDT
- ☐ Identifying treaters in rural areas who may be interested in participating in the MDT
- ☐ Setting up related IT infrastructure
- ☐ Securing funding
- ☐ Applying to relevant authorities for permission
- ☐ Other (please specify): _____ *

53) In your opinion, which of the following factors represent the greatest barriers to establishing a multi-institutional online MDT? Please select the three greatest barriers*

- ☐ Lack of experts in my country to lead the MDT
- ☐ Lack of interest from local/rural hospitals
- ☐ Time constraints
- ☐ Budget constraints
- ☐ Lack of support from hospital-level administration
- ☐ Lack of IT infrastructure
- ☐ Government or health board policy
- ☐ Other (please specify): _____ *

54) For iHCC cases not managed in an MDT setting, please indicate the extent to which you agree with the following statements:*

	Strongly disagree	Disagree	Neutral	Agree	Strongly Agree
I regularly refer patients with iHCC to other specialties	()	()	()	()	()
When I refer a patient with iHCC to another specialty, I am not involved in their care for the duration of treatment	()	()	()	()	()

When I refer a patient with iHCC to another specialty, the new physician is solely responsible for follow-up	()	()	()	()	()
When I refer a patient with iHCC to another specialty, I expect the patient to be referred back to me at some point	()	()	()	()	()

SECTION 5: IMPROVING OUTCOMES FOR PATIENTS WITH iHCC

55) In your opinion, which of the following is most important in improving outcomes for patients with iHCC? *Select the three most important factors**

- ☐ Improved screening programme in my country
- ☐ Improved patient disease awareness
- ☐ Improved PCP disease awareness
- ☐ Faster referral pathways
- ☐ Improved access to MDT care
- ☐ Availability of systemic therapies with/without TACE
- ☐ Training for specialists on the use of locoregional therapies
- ☐ Training for specialists on the use of systemic therapies
- ☐ Other (please specify): _____ *

Please review your responses

Thank you!

Supplementary Table 1 Preferred first-line treatment choices by Barcelona Clinic Liver Cancer substage and country

	Korea (n=10)	Malaysia (n=10)	Philippines (n=10)	Singapore (n=10)	Taiwan (n=10)	Thailand (n=10)	Vietnam (n=10)
BCLC-B1, n (%)							
C-TACE	3 (30.0)	4 (40.0)	3 (30.0)	2 (20.0)	6 (60.0)	6 (60.0)	3 (30.0)
DEB-TACE	–	–	3 (30.0)	1 (10.0)	–	–	1 (10.0)
TARE	5 (50.0)	1 (10.0)	–	1 (10.0)	1 (10.0)	–	1 (10.0)
Ablation	–	–	–	–	–	–	2 (20.0)
Resection	2 (20.0)	4 (40.0)	3 (30.0)	3 (30.0)	3 (30.0)	3 (30.0)	2 (20.0)
Systemic therapy alone	–	–	–	1 (10.0)	–	–	–
Systemic therapy in combination/sequence with LRT	–	1 (10.0)	1 (10.0)	2 (20.0)	–	–	1 (10.0)
BCLC-B2, n (%)							
C-TACE	5 (50.0)	6 (60.0)	2 (20.0)	3 (30.0)	5 (50.0)	4 (40.0)	2 (20.0)
DEB-TACE	–	–	–	–	3 (30.0)	2 (20.0)	4 (40.0)
TARE	5 (50.0)	–	1 (10.0)	3 (30.0)	1 (10.0)	–	–
Ablation	–	–	–	–	–	–	–
Resection	–	2 (20.0)	1 (10.0)	–	–	–	–
Systemic therapy alone	–	1 (10.0)	2 (20.0)	1 (10.0)	–	–	–

Systemic therapy in combination/sequence with LRT	-	1 (10.0)	4 (40.0)	3 (30.0)	1 (10.0)	3 (30.0)	4 (40.0)
BCLC-B3, n (%)							
C-TACE	1 (10.0)	1 (10.0)	-	-	1 (10.0)	1 (10.0)	-
DEB-TACE	-	-	1 (10.0)	-	2 (20.0)	1 (10.0)	1 (10.0)
TARE	2 (20.0)	1 (10.0)	-	-	1 (10.0)	-	-
Ablation	-	-	-	-	-	-	-
Resection	-	-	-	-	-	-	-
Systemic therapy alone	6 (60.0)	6 (60.0)	9 (90.0)	8 (80.0)	1 (10.0)	6 (60.0)	3 (30.0)
Systemic therapy in combination/sequence with LRT	1 (10.0)	2 (20.0)	-	1 (10.0)	5 (50.0)	2 (20.0)	6 (60.0)

BCLC: Barcelona Clinic Liver Cancer; C-TACE: Conventional transarterial chemoembolization; DEB-TACE: Drug-eluting beads transarterial chemoembolization; LRT: Locoregional therapy; TARE: Transarterial radioembolization.