



Wednesday, 23 June 2021

Dear President of the European Commission, Ursula Von der Leyen,

Dear Members of the European Parliament,

Dear President of the European Council, Charles Michel,

Open Letter: 10 Asks to Improve Liver Cancer Care in Europe

EASL is writing you this Open Letter representing the scientific liver health community in Europe and with the endorsement of relevant scientific societies, patient advocacy organisations, and public health associations engaged in the improvement of care for patients with liver cancer.

Cancer that has originated in the liver, generally named liver cancer, is the sixth-most common cancer and the third-most frequent cause of cancer-related death globally.ⁱ Hepatocellular carcinoma (HCC) represents about 90% of liver cancers and is consequently a major global health problem. The incidence of HCC increases progressively with advancing age in all populations, reaching a peak at 70 years.^{ii,iii,iv}

There are many risk factors for developing liver cancer, and chronic liver diseases caused by viral hepatitis, alcohol, or fatty liver disease (NAFLD/NASH) are the most important.^v That treatment of these chronic liver diseases to avoid disease progression to precancerous states like cirrhosis significantly reduces the risk of liver cancer has been convincingly demonstrated.^{vi,vii,viii} Therefore, improved and equal access to state-of-the-art management of these diseases is a core element in the fight against liver cancer.

In 2020, in Europe, the average age-standardised annual incidence rate of liver cancer was 5.2 per 100,000 persons. Put differently: ≈87,000 Europeans were diagnosed with liver cancer in 2020, and ≈78,000 have already died from the disease.ⁱ Patients are diagnosed late, with 51% in an advanced cancer stage already at the time of diagnosis.^{v, ix} Such patients have less than a year to live.^x In total, there was a 70% increase of liver cancer-related mortality in the EU, from 1990 to 2019.^{xi, xii}

In the USA, the rate of deaths from liver cancer increased by 40% from 1990 to 2004, whereas the overall rate of cancer deaths declined by 18%.^{xiii} Projections for the USA

estimate that, in 2030, liver cancer will be the third-leading cause of cancer-related deaths, surpassing breast, colorectal, and prostate cancers.^{xiv, xv}

Although liver cancer remains one of the few cancers with increasing incidence and mortality, the public awareness of liver cancer appears to be much lower than for other cancers. As a consequence, patients who have liver cancer and patients who are at increased risk for liver cancer often face stigma in their social lives, and also in the medical care setting.

Treatment options for liver cancer have improved significantly over recent years, which makes early diagnosis the most critical point. Therefore, case-finding strategies need to be implemented broadly, at least in at-risk patients, as strongly recommended by clinical guidelines.^{xvi, xvii}

Last but not least, we must directly tackle the key environmental factors that cause liver diseases and liver cancer. In addition, successful hepatitis B vaccination programmes need to be continued and expanded, as the core element of primary liver cancer prevention, as it has the potential to prevent roughly twice as many cancer cases as the human papillomavirus (HPV) vaccination does.^{xviii}

In this context, we are addressing the following **10 Asks to Improve Liver Cancer Care in Europe**:

1. The EU and Member States should ensure adequate awareness, prevention, and management standards for liver cancer, across all regions and countries. Pivotal elements on this path include education and awareness-raising, especially among healthcare professionals, patients and families, risk groups, policymakers, and the general public.
2. The EU and Member States should ensure improved access to better disease management for patients with liver cancer, across all Member States of the EU. An essential first step towards equally high standards of care across Europe is the implementation of structured patient pathways comprising diagnostics, treatment, and follow up in a cross-sectoral way (hospital, outpatient, and home care).
3. The structured patient pathways (see point 2, above) need to be based on the most up-to-date and comprehensive scientific evidence. Therefore, the EU and Member States should encourage enhanced inter-disciplinary cooperation among hepatology, oncology, and other relevant disciplines.
4. The EU and Member States should also encourage all relevant experts and their accompanied societies and organisations to develop clinical guidelines collaboratively, addressing the management of liver cancer (treatment and prevention) on the basis of the most comprehensive scientific evidence available.
5. Patients and their families should have unrestricted access to information, medical treatment, and measures to improve their quality of life, regardless of their life situation and ethnic origin. The EU and Member States should reduce existing inequalities and ensure that all patients with liver cancer can benefit from the same high standards of care.

6. Some liver diseases, e.g., viral hepatitis B and C, alcohol-related and non-alcoholic fatty liver disease, are associated with a high risk of liver cancer. Early detection would be critical for these patients. Therefore, the EU and Member States should add liver cancer to their screening scheme list, at least for patients with underlying risk factors. In addition, existing programmes providing the opportunity of early case-finding of liver diseases should be leveraged where possible. (For example, salivary screening for hepatitis C using point-of-care testing, which would match with the World Health Organization's hepatitis C programme's aim of fighting HCC.)

7. Liver cancer occurs in response to environmental risks and as a consequence of an underlying liver disease. Therefore, the EU and Member States should implement preventive measures. Such measures include: evidence-based strategies to combat alcohol and obesity, hepatitis B vaccination, risk education, and consumer-product labelling of alcohol as a carcinogen.

8. The high standard of care in the EU is based on high-level science and research. In order to maintain these standards and furthermore to drive improvements, it is essential to collect data collaboratively across all Member States. The EU and Member States should support the setting up of specific patient registries for liver cancer. The collection of this data would facilitate surveillance, research, and the overall management of patients with liver cancer.


9. In addition, basic research continues to be a critical element for improving patient outcomes in liver cancer. There is still further knowledge needed about aetiology, rare liver cancer entities, markers, and diagnostics which might facilitate early detection, even in primary care. The EU and Member States should support such research projects and cross-country collaboration, by setting up EU-wide platforms with the aim of sharing data and closing the gap between medical knowledge and clinical practice.

10. Europe's Beating Cancer Plan is the ideal platform for implementing all the actions claimed above. For the immediate benefit of all patients, we ask the European Commission to urgently call all relevant scientific societies, experts, and patient groups to get actively involved in the above-listed 9 asks.

Together with all signatories, EASL will fully contribute our expertise, knowledge, and capacity to implement these 10 Asks to Improve Liver Cancer Care in Europe. We pledge our cooperation with EU institutions and within the existing EU health programmes, such as the EU Beating Cancer Plan and the EU4Health programme.

Sincerely,

Prof. Thomas Berg, EASL Secretary General Elect, Head of the Division of Hepatology, Department of Medicine II, Leipzig University Medical Center, Germany



Prof. Maria Buti, EASL EU Policy Councillor, Professor of Medicine and Chief of Internal Medicine and Hepatology at the Hospital General Universitari Valle Hebron, Barcelona, Spain



Prof. Francesco Negro, EASL Governing Board Member, Full Professor at the Divisions of Gastroenterology and Hepatology and of Clinical Pathology, University Hospital of Geneva, Switzerland



Marko Korenjak, President, European Liver Patients' Association (ELPA)



Prof. Peter R. Galle, Liver Cancer Expert, the University Medical Center Mainz, Germany, former President of The German Association for the Study of Liver Diseases



Prof. Peter Jepsen, Clinical Professor of Hepato-epidemiologist & Liver Cancer Expert, Aarhus University Hospital, Department of Hepatology and Gastroenterology, Denmark



Prof. Peter Jepsen, Hepato-epidemiologist & Liver Cancer Expert

Prof. Massimo Colombo, Viral Hepatitis, Liver Transplantation and Liver Cancer Expert, Chair of EASL International Liver Foundation (EILF), MD, Professor of Medicine, Head of Translational Liver Research, IRCCS, Humanitas, Milan, Italy

Mosnier

Prof. Nathalie Carrie, Liver Cancer Expert, Service d'Hépatologie, Hôpital Avicenne, Bobigny, Université de Sorbonne Paris Nord, France



Prof. Jerzy Jaroszewicz, Liver Transplant, Viral Hepatitis, Cirrhosis Expert, Vice-President of the Polish Association for the Study of the Liver (PASL), Department of Infectious Diseases and Hepatology, Medical University of Silesia, Poland

Jerzy Jaroszewicz



The European Association for the Study of the Liver aims to be the Home of Hepatology so that all who are involved with treating liver disease can realise their full potential to cure and prevent it. The purpose of the association is to promote communication between European workers interested in the liver and its disorders. In particular, the association strives to:

- promote research concerning the liver*
- promote education of physicians, scientists, and public awareness of liver diseases and their management*
- act as an advisor to European and national health authorities concerning liver diseases, provision of clinical services and the need for research funding*
- foster European multicentre controlled trials*
- facilitate scientific exchange*
- facilitate the participation of Young Investigators at its meetings*

-
- ⁱ Sung H et al. Global Cancer Statistics 2020: GLOBOCAN Estimates of Incidence and Mortality Worldwide for 36 Cancers in 185 Countries *Ca Cancer J Clin* 2021;71:209
- ⁱⁱ El-Serag HB. Epidemiology of viral hepatitis and hepatocellular carcinoma *Gastroenterology* 2012 May;142(6):1264-1273.e1. doi: 10.1053/j.gastro.2011.12.061
- ⁱⁱⁱ Dasgupta P, Henshaw C, Youlden DR, Clark PJ, Aitken JF, Baade PD. Global Trends in Incidence Rates of Primary Adult Liver Cancers: A Systematic Review and Meta-Analysis. *Frontiers in Oncology* 2020;10. <https://doi.org/10.3389/fonc.2020.00171>.
- ^{iv} Pimpin L, Cortez-Pinto H, Negro F, Corbould E, Lazarus J v., Webber L, et al. Burden of liver disease in Europe: Epidemiology and analysis of risk factors to identify prevention policies. *Journal of Hepatology* 2018;69:718–35. <https://doi.org/10.1016/j.jhep.2018.05.011>
- ^v Dimitroulis D, Damaskos C, Valsami S, Davakis S, Garmpis N, Spartalis E, et al. From diagnosis to treatment of hepatocellular carcinoma: An epidemic problem for both developed and developing world. *World Journal of Gastroenterology* 2017;23:5282–94. <https://doi.org/10.3748/wjg.v23.i29.5282>.
- ^{vi} Nahon P et al. Eradication of Hepatitis C Virus Infection in Patients With Cirrhosis Reduces Risk of Liver and Non-Liver Complications *Gastroenterology* 2017;152:142
- ^{vii} Alavi M et al. Declining hepatitis C virus-related liver disease burden in the direct-acting antiviral therapy era in New South Wales, Australia *J Hepatol* 2019;71:281
- ^{viii} Kim D et al. Gastroenterology 2020 showing HCV and HCC declining whereas HCC related to NALFD AFLD increases
- ^{ix} Park JW, Chen M, Colombo M, Roberts LR, Schwartz M, Chen PJ, et al. Global patterns of hepatocellular carcinoma management from diagnosis to death: The BRIDGE Study. *Liver International* 2015;35:2155–66. <https://doi.org/10.1111/liv.12818>.
- ^x Forner A, Reig M, Bruix J. Hepatocellular Carcinoma. *Lancet* 2018; 391:1301-1314
- ^{xi} Group GBoDS. Global burden of 369 diseases and injuries in 204 countries and territories, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019 1990-2019 *Lancet* 2020;396:1204;
- ^{xii} Group GBoDS. Global Burden of Disease Results Tool; <http://ghdx.healthdata.org/gbd-results-tool>
- ^{xiii} Jemal A, Siegel R, Xu J, Ward E. Cancer statistics, 2010. *CA Cancer J Clin* 2010;60:277–300.
- ^{xiv} Welzel TM, Graubard BI, Quraishi S, Zeuzem S, Davila JA, El-Serag HB, et al. Population-attributable fractions of risk factors for hepatocellular carcinoma in the United States. *Am J Gastroenterol* 2013;108:1314–1321.
- ^{xv} El-Serag HB, Kanwal F. Epidemiology of hepatocellular carcinoma in the United States: Where are we? Where do we go? *Hepatology* 2014; 108: 1314-1321
- ^{xvi} Galle PR et al. EASL Clinical Practice Guidelines: Management of hepatocellular carcinoma *Journal of Hepatology* 2018 vol. 69 j 182–236
- ^{xvii} Vogel A et al. Hepatocellular Carcinoma: ESMO Clinical Practice Guideline. *Annals of Oncology* 2018; 29 (Suppl 4):iv238-iv255
- ^{xviii} GLOBAL Progress Report 2021 on HIV, viral hepatitis and sexually transmitted diseases, WHO; May 2021