Evaluating the Effectiveness of Yttrium-90 Glass Microspheres in the Treatment of Hepatocellular Carcinoma, Intrahepatic Cholangiocarcinoma, and Metastatic Colorectal Cancer in Practice: Protocol for the Prospective PROACTIF Phase IV Registry Study in France

Etienne Garin, Jean-Baptiste Pinaquy, Clement Bailly, Christian Sengel, Denis Mariano-Goulart, Julien Edeline, Jean-Frederic Blanc, Antoine Bouvier, Jeremie Tordo, Agnes Rode, et al.

Title: Evaluating the Effectiveness of TheraSphere Yttrium-90 Glass Microspheres in the Treatment of Hepatocellular Carcinoma, Intrahepatic Cholangiocarcinoma, and Metastatic Colorectal Cancer in Practice: Protocol for the PROACTIF Phase IV Study

Running Title: Yttrium-90 Glass Microspheres in Current Clinical Use

Authors: Etienne Garin, MD, PhD[1]; Jean-Baptiste Pinaquy, MD[2]; Clement Bailly, MD, PhD[3]; Christian Sengel, MD[4]; Denis Mariano-Goulart, MD, PhD[5]; Julien Edeline, MD[6]; Jean-Frederic Blanc, MD[7]; Antoine Bouvier, MD[8]; Jeremie Tordo, MD[9]; Agnes Rode, MD[10]; Stéphanie Becker, MD, PhD[11]; David Sefrioui, MD, PhD[12]; Thierry de Baere, MD[13], PhD; Claude Somma, MD[14]; Charles Mastier, MD[15]; Jean Goupil, MD[16]; Patrick Chevallier, MD[17]; Helene Regnault, MD[18]; Eric Vibert MD, PhD[19]; Sylvain Manfredi, MD, PhD[20]; Eric Vicaut MD, PhD[21]; Binal Patel[22]; Eveline Boucher, MD, PhD[23]; Boris Guiu, MD, PhD[24], On behalf of PROACTIF registry group*

1. Nuclear Medicine Unit, Centre Eugene Marquis, Rennes, France
2. Nuclear Medicine Service, CHU Bordeaux, Bordeaux, France
3. Nuclear Medicine unit, University Hospital, Nantes, France
4. Radiology and Medical Imaging, CHU Hospital Michallon, Grenoble, France
5. Nuclear Medicine, CHU Hospital Bordeaux, France
6. Medical Oncology, Centre Eugène Marquis, Rennes, France
7. Hepatology, Gastroenterology, and Digestive Oncology, CHU Bordeaux, Bordeaux, France
8. Department of Radiology, University Hospital, Angers, France
9. Department of Nuclear Medicine, CHU Lyon Sud, Lyon, France
10. Department of Medical Imaging, CHU Lyon, Lyon, France
11. Departments of Medical Imaging and Nuclear Medicine, Centre Henri Bequerel, Rouen, France
12. Department of Hepatogastroenterology, Rouen University Hospital, France
13. Department of Interventional Radiology Gustave Roussy Cancer Center, Villejuif, France
14. Department of Nuclear Medicine, CHU La Timone, Marseille, France
15. Department of Radiology, CRLCC Centre Léon Bérard, Lyon, France
16. Department of Radiology and Medical Imaging, CHU Nimes, France
17. Department of Radiology, CHU Nice, Nice, France
18. Department of Hepatology, Henri Mondor Hospital, Creteil, France
19. Department of Hepatology and Surgery, Paul Brousse Hospital, Villejuif, France
20. Department of Digestive Oncology, University Hospital, Dijon, France
21. Clinical Trial Unit, AP-HP Groupe hospitalier Lariboisière - Fernand-Widal, Paris, France
22. Biostatistics, Boston Scientific Corporation, Marlborough, MA, USA
23. Interventional Oncology, Boston Scientific Corporation, Marlborough, MA, USA
24. Department of Radiology, St-Eloi University Hospital, Montpellier, France

*All members of PROACTIF Registry Group listed in Supplementary Material A

Corresponding Author: Boris Guiu, MD, PhD
Department of Radiology

St. Eloi University Hospital – Montpellier School of Medicine
80 avenue Augustin Fliche
34295 MONTPELLIER – FRANCE
Tel: +33 4 67 33 75 46
Fax: +33 4 67 33 75 49
Email: b-guiu@chu-montpellier.fr

Word Count (excluding abstract): 3198
Abstract Word Count: 248
Tables: 2
Figures: 2
Supplementary Material: 3 appendices

Trial registration: ClinicalTrials.gov Identifier: NCT04069468

Acknowledgements: The authors wish to acknowledge Carole Allimant, MD, for performing blinded centralized dosimetric assessments, and Alexandra Greenberg-Worisek, PhD, MPH (Boston Scientific Corporation) for medical writing assistance.

COMPLIANCE WITH ETHICAL STANDARDS

1. **Funding:** The PROACTIF Registry study is funded by Biocompatibles/Boston Scientific Corporation. The funding body provided support in the analysis of data and in providing medical writing support for the manuscript.

2. **Conflict of Interest:** E.G.: Received fees and a grant from BTG Ltd./Boston Scientific Corporation.

   J.P.: Nothing to disclose.

   C.B.: Nothing to disclose.

   C.S.: Nothing to disclose.

   D.M-G.: Nothing to disclose.

   J.E.: Received fees and support for research from Boston Scientific; consultant for Roche, AstraZeneca, MSD, BMS, Eisai, Bayer, and Ipsen.

   J-F.B: Consultant for Bayer, Astra-Zeneca, IPSEN, ESAI, Roche, and BMS.

   A.B.: Nothing to disclose.

   J.T.: Nothing to disclose.

   A.R: Nothing to disclose.

S.B.: Nothing to disclose.

D.S.: Nothing to disclose.

T. de B.: Consultant for Boston Scientific Corporation, Guerbet, GE-Healthcare, HD Technologies, Terumo, Astra-Zeneca, and Eisai; speaker for Boston Scientific Corporation, Guerbet, GE-Healthcare, HD Technologies, and Terumo.

C. S-D: Nothing to disclose.

C.M.: Nothing to disclose.

J.G.: Nothing to disclose.

P.C.: Nothing to disclose.

H.R.: Consultant for Boston Scientific Corporation.

E.V.: Received fees for methodological consulting from Biocompatibles UK Ltd.

S.M.: Nothing to disclose.

E.V.: Receives fees from Bayer, BMS, Johnson & Johnson, and Boston Scientific Corporation; serves as consultant for Nanobiotix; academic collaboration with EchoSens, Fluoptics, and IntraSence.

B.P.: Employee of Biocompatibles/Boston Scientific Corporation.

E.B.: Employee of Biocompatibles/Boston Scientific Corporation.

B.G.: Consultant for Boston Scientific, Quantum Surgical, Terumo. Received research grant from Roche, Guerbet.

3. **Ethical Approval:** All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

   This study was classified in France as Recherche Impliquant la Personne Humaine de Catégorie 3 (RIHP 3) by the Agence Nationale de Sécurité du Médicament et des Produits de Santé (ANSM) due to its observational, non-interventional design. The protocol was approved by a randomly assigned to one of the 39 Independent Ethics Committees in France prior to the study's initiation (assigned to French Ethics Committee « Ile de France VII ») ; assignments are made by the French National Commission for Research Involving Human Persons (CNRIPH).

4. **Informed Consent:** Patients will receive a Patient Information Sheet (PIS), which they will be able to review prior to treatment and about which patients will be given the opportunity to ask questions of the investigator or delegate. As detailed by the General Data Protection Regulation (GDPR) and requested by the ethics committee, this PIS will inform the patient

about the purpose and aim of the registry and how their personal medical data will be used. After reviewing this sheet, clinicians will document whether the patient expresses verbal non-opposition to data collection in the patient's record ("non-opposition to data collection").

5. **Consent for publication:** Consent for publication was obtained for every individual person's data included in the study.

120

Title: Evaluating the Effectiveness of Yttrium-90 Glass Microspheres in the Treatment of Hepatocellular Carcinoma, Intrahepatic Cholangiocarcinoma, and Metastatic Colorectal Cancer in Practice: Protocol for the PROACTIF Phase IV Study

Running Title: Yttrium-90 Glass Microspheres in Current Clinical Use

ABSTRACT

Primary Objective: Recently, selective internal radiation therapy (SIRT) using yttrium-90 (Y90) glass microspheres (TheraSphere™) was approved for reimbursement by health authorities in France. The PROACTIF study aims to gather data on effectiveness, patient quality of life (QoL), and safety with use of Y90 glass microspheres in real-world clinical settings in France.

Inclusion Criteria: Patient with a diagnosis of hepatocellular carcinoma (HCC), intrahepatic cholangiocarcinoma (iCC), and/or metastatic colorectal cancer (mCRC) who was treated with a dose of Y90 glass microspheres that has been reimbursed in France and who do not oppose use of their personal medical data.

Exclusion Criteria: If data collection is opposed, treatment is reimbursed but not administered, or treatment is administered but not reimbursed.

Outcome Measures: Primary outcome measures include overall survival from time of Y90 glass microsphere treatment and quality of life, as assessed using the Functional Assessment of Cancer Therapy- Hepatobiliary questionnaire.

Estimated Number of Patients to Be Included: This is an open study and there is no set number of patients; 115 have already been enrolled.

Planned Subgroup Analyses: Analyses will be stratified by disease state (HCC, iCC, or mCRC). Subgroups to be analyzed include age group, unilobar/bilobar disease at baseline, Eastern Cooperative Oncology Group (ECOG) status at baseline, liver tumor burden at baseline, target lesion size, and standard versus multi-compartment personalized dosimetry treatment.

Planned Recruitment and Observation Period: Recruitment includes patients who are prescribed and treated with a commercial vial of Y90 glass microspheres between 01 January 2019 and 31 December 2024.

Key Words: selective internal radiation therapy; hepatocellular carcinoma; intrahepatic cholangiocarcinoma; liver metastatic colorectal cancer; yttrium-90

INTRODUCTION

Current treatment paradigms for patients with unresectable hepatocellular carcinoma (HCC), intrahepatic cholangiocarcinoma (iCC), and metastatic colorectal cancer (mCRC) often include local treatments, locoregional therapies (mainly intra-arterial), or systemic agents. Systemic therapies used in the treatment of HCC may include sorafenib, regorafenib, lenvatinib, and emerging combinations of these and other systemic drugs such as the recent atezolizumab + bevacizumab combination. Locoregional therapies aside of intraarterial treatments, often used include various forms of ablation.[10-13] Treatment options and sequencing vary significantly for liver tumors based upon whether they are of primary or metastatic origin, as detailed in the National Comprehensive Cancer Network (NCCN) guidelines.[2; 3] Depending on an individual patient's disease characteristics (i.e., disease stage, performance status, liver function), these treatments may sometimes be able to serve as a bridge to transplantation or resection.[4; 13; 14; 28]

Selective internal radiation therapy (SIRT) is a locoregional treatment option that is used for patients with primary or secondary liver tumors. SIRT involves the administration of radioactive microspheres into the tumor through the tumor vasculature to deliver targeted radiation therapy directly to malignant tissue. Benefits of SIRT for patients include reduced toxicities and preservation of quality of life (QoL) as compared to other treatments for patients with nonresectable disease. [9; 35; 39] SIRT is not currently part of the Barcelona Clinic Liver Cancer (BCLC) treatment algorithm for HCC, as positive randomized phase III trials are needed to support its integration. However, there is a large body of literature documenting the safety and efficacy of radioactive microspheres when used in the standard of care clinical practice.[1; 26; 37-39] Specifically, there is over 20 years' worth of data supporting the use of TheraSphere™ Yttrium-90 (Y90) glass microspheres in the treatment of HCC for early to advanced disease, including the recent LEGACY study, which served as the basis

for approval in the United States, and the recent positive guidance from the United Kingdom's National Institute for Health and Care Excellence.[6; 21-23; 26; 27; 29; 31; 34; 36] Additionally, there is a growing body of evidence demonstrating the utility of Y-90 glass microspheres in the treatment of liver metastases, including the recently published EPOCH clinical trial, which combined systemic therapy with SIRT in patients with liver-dominant mCRC.[7; 19; 24; 25; 32; 33]

In early 2019, a "positive recommendation" was issued in France for reimbursement of Y90 glass microspheres for HCC for a trial period of five years (through 2024); in early 2020, this recommendation for reimbursable use was expanded to include iCC and mCRC to the liver for an additional four-year trial period (through 2024). These decisions were issued by the Haute Autorité de Santé – Commission Nationale d'évaluations des dispositifs médicaux et des Technologies de Santé (HAS-CNEDiMTS). A post-market clinical follow-up study was requested by the French health authorities to support the continuation of the reimbursement after the initial 5-year period.

To that end, a registry was developed and is being maintained to monitor effectiveness of treatment (A **Pro**spective, Post-**A**pproval, Multiple Centre, Open-Label, Non-Interventional, Registry Study to Evaluate Effe**c**tiveness of **T**heraSphere in Cl**i**nical Practice in **F**rance, or PROACTIF). PROACTIF includes approximately 30 sites across France. The aggregation of high-quality data from multiple sites across multiple malignancies presents a unique opportunity to study Y90 glass microspheres in clinical practice and could support inclusion of SIRT into BCLC treatment algorithm and into European and US guidelines for HCC and iCC. The primary objective of PROACTIF is to gather data on effectiveness, patient quality of life (QoL), and safety with use of Y90 glass microspheres in real-world clinical settings in France. In this manuscript, we detail the research protocol of the PROACTIF study.

STUDY DESIGN

PROACTIF is a prospective registry of the clinical use of Glass Y90 microsphere for the treatment of liver malignancies in France. This study was classified in France as *Recherche Impliquant la Personne Humaine de Catégorie 3* (RIHP 3) by the Agence Nationale de Sécurité du Médicament et des Produits de Santé (ANSM), this is an observational, non-interventional study. The protocol was was assigned by the French National Commission for Research Involving Human Persons (CNRIPH) for review to an Independent Ethics Committee prior to the study's initiation (French Ethics Committee « Ile de France VII ») and approved by this committee. The study is registered at ClinicalTrials.gov (NCT04069468).

Inclusion/Exclusion Criteria

Inclusion Criteria: The registry includes patients with a diagnosis of HCC, mCRC, or iCC for whom a commercial dose of Y90 glass microspheres has been/will be administered between 01 January 2019 and 31 December 2024, and who do not oppose use of their personal medical data (verbal consent). All data generated during patient visits conducted as part of local standard medical practices will be included in the registry (Figure 1). Participating sites and investigators are listed in Supplementary Material 1. Eligibility and conditions for reimbursement for patients with HCC, iCC, and mCRC are detailed in Table 1.

Exclusion Criteria: If the patient is reimbursed, treatment is administered, and data collection is opposed, only information about the patient's eligibility will be documented. Similarly, if Y90 glass microsphere treatment is ordered but not administered, only patient eligibility and end-of-study data are collected (**Figure 2**).

Procedure

All treatment planning and procedures will be performed according to each site's institutional procedures and in accordance with the Instructions for Use (IFU) included with Y90 glass microspheres. The investigator should document the expected treatment outcome (i.e. partial/complete response, disease control, improvement of disease symptoms, improvement of portal vein thrombosis (PVT), and downstaging to resection). Baseline data on disease presentation will be collected, including type of tumoral portal thrombus, location of the portal vein thrombosis, and whether the thrombus is present in the hepatic vein. Pre-treatment procedures will include administration of technetium macroaggregated albumin (^{99m}Tc-MAA) and imaging (^{99m}Tc-MAA single-photon emission computed tomography [SPECT] or SPECT/computed tomography [CT]) to ensure the absence of extrahepatic deposition of Y90 glass microspheres, coiling of aberrant arteries (if appropriate), and evaluation of lung shunting. ^{99m}Tc-MAA SPECT or SPECT/CT should be used also to determine appropriate dosimetry to the tumor and liver normal tissue. Laboratory tests will be conducted as part of routine institutional practice for each malignancy, and should include alanine aminotransferase (ALT), aspartate aminotransferase (AST), international normalized ratio (INR), albumin, bilirubin, creatinine, and tumor markers (alpha-fetoprotein [AFP], carbohydrate antigen 19-9 [CA 19-9], carcinoembryonic antigen [CEA]). QoL data will be collected at baseline, prior to, and after treatment. Pre- and post-treatment imaging assessments will be conducted as part of routine institutional practice for each malignancy; this should include pre-treatment imaging (CT or magnetic resonance imaging [MRI]) with appropriate description of tumor number, location, and target and non-target evaluation according to Response Evaluation Criteria in Solid Tumors 1.1 (RECIST 1.1) and modified Response Evaluation Criteria in Solid Tumors (mRECIST).

Data on dosimetry will be collected as part of the registry database for all patients. Multi-compartment personalized dosimetry (MCD) will be performed whenever possible for HCC and iCC and will rely on dosimetry software (e.g., Simplicit^{90}Y^{TM} [Mirada Medical]) to calculate tumor and non-tumor absorbed doses. For centers that do not have access to dosimetry software, such software (Simplicit^{90}Y^{TM}) will be provided free of charge by the study sponsors for the duration of the study, along with appropriate training. In addition, dosimetry guidance for threshold tumor absorbed dose and perfused liver, all normal liver absorbed dose are providing in the protocol based on data on dose/response and outcome and dose/toxicity known threshold [8; 15-18]

Initial local reads of imaging and dosimetry will be completed by the site radiophysicist and nuclear medicine physician. A central read of dosimetry by an experienced central reviewer is planned for patients with HCC and iCC; therefore, pre-treatment CT or MRI, ^{99m}Tc-MAA SPECT or SPECT/CT and post-Y90 glass microsphere administration imaging (Y-90 PET) will be uploaded to a central imaging data base. The reviewer is unblinded, and will receive information regarding previous treatment, treated lesion location, activity administered, and location of the administration; the reviewer will not have access to the patient's record itself or information beyond what has been listed. Central reads will be completed only for HCC and iCC due to the recommendation for personalized dosimetry in these patients; as single-compartment dosimetry is recommended for mCRC, central reads will not be completed for these patients.

Y90 glass microsphere infusion can either be selective (tumor feeding artery, liver segment, or specific liver sector) or non-selective (whole liver, left or right liver). Depending on the mapped vasculature of the patient and the biological distribution of the target tumor, treatment may be done in one or in a series of infusions. If multiple treatments are needed, the first session will typically focus on the area of the liver with the greatest tumor burden. After completion of the first treatment,

a second ^{99m}Tc-MAA SPECT or SPECT/CT could be performed to confirm or update treatment plans if the second treatment will be greater than one month after the initial mapping; the aim of this is to ensure that the lung shunt evaluation and dosimetry evaluation are still accurate. Second treatments will typically take place 30-45 days after the initial treatment.

Follow-Up Protocol

Post-Y90 glass microsphere treatment will be conducted per site standards; treatment follow-up data will be gathered at the routine follow-up visit for each patient along with QoL data (Figure 1). Follow-up visits will be conducted every 2-4 months post-Y90 glass microsphere treatment until 12 months post-treatment; after 12 months, follow-up visits will be performed per local practice standards. Laboratory tests should include ALT, AST, INR, albumin, bilirubin, creatinine, and tumor markers (AFP, CA 19-9, CEA). Imaging follow-up should include CT or MRI with the local qualitative evaluation of target lesion and overall response, method of imaging, and evaluation results, which should be documented using RECIST 1.1 and mRECIST. Additionally, investigators should document if the expected treatment goal was reached. Additionally, treatment data involving systemic therapy is collected throughout the study period, including type of treatment, duration of treatment, and indication for treatment. After the first 12 months of follow-up after the final Y90 glass microsphere administration, only QoL and survival status will be collected at each follow-up visit. If follow-up treatment is conducted outside of the treatment center, efforts will be made to gather these data from the patient's home institution. Data collection will be stopped if the patient withdraws their non-opposition to data collection status, starts another anti-cancer treatment, receives best supportive care, or follow-up is no longer possible.

If the patient withdraws from the data collection, the date and reason for withdrawal will be documented. Patient survival status (alive or dead) and subsequent anti-cancer treatment received (type and start/stop dates) will be documented at interim analysis points and at study end date; these data will be entered by study sites. If the patient is lost to follow-up, the principal investigator at the site will attempt to re-contact the patient at least twice before the patient is deemed lost to follow-up, in this situation survival status will be collected at the study closure date by contacted the patient GP or the civil status registry.

Outcome Measures

Primary outcomes are defined as follows:

1) Overall Survival: defined as time from start of Y90 glass microsphere treatment until date of death from any cause or study end date.
2) Quality-of-Life assessment: determined by the administration of the FACT-Hep Questionnaire before and after treatment.[5]

Secondary outcomes are defined as follows:

1) Serious Adverse Events (SAEs) of any cause graded using the National Cancer Institute Common Terminology Criteria for Adverse Events, version 5.0 (NCI-CTCAE v 5.0).[20]
2) Grade 3 or Higher Adverse Events (AEs) related or possibly related to the device or the device administration procedure that occur up to 90 days after treatment or the first follow-up visit (if after 90 days post-treatment), graded using NCI-CTCAE v. 5.0.

3) Re-Hospitalizations: number and duration of re-hospitalizations related to Y90 glass microsphere treatment up to 30 days after the first administration of Y90 glass microsphere treatment.
4) Treatment Expectation: based upon the description of the treatment expectation (e.g. survival, disease control) before Y90 glass microsphere treatment, and number of patients achieving their treatment expectations.
5) Qualitative Tumor Response Assessment: will be conducted for both the index lesion and overall response. Defined as the number of patients having achieved a complete response (CR), partial response (PR), stable disease (SD), or progressive disease (PD) using either RECIST 1.1 or mRECIST.
6) Target tumor marker response, defined as a ≥ 50% decrease in:
    a. AFP levels for patients with a baseline AFP level ≥ 200ng/mL;
    b. CA 19-9 levels for patients with a baseline CA 19-9 level greater than or equal to twice the upper limit of normal; and/or
    c. CEA levels for patients with a baseline CEA level greater than or equal to twice the upper limit of normal.
7) Post-Y90 glass microsphere anti-cancer treatment; includes both the number of patients receiving such treatment and type of treatment.
8) Post-Y90 glass microsphere best supportive care, if no follow-up is no longer possible or if follow-up was interrupted by investigator decision.
9) Vascular access: description of vascular access (radial or femoral) used to administer Y90 glass microspheres.

Additionally, specific outcomes related to dosimetry will be collected; these are detailed in Supplementary Material 2.

Planned Subgroup Analyses

All analyses will be performed according to the disease indication (HCC, iCC, and mCRC). The "treated population" for analysis will include all patients within each disease type who were prescribed, received, and reimbursed for Y90 glass microsphere treatment, and who have not opposed collection of their data as part of this study. The "dosimetry population" for analysis will include all patients for whom dosimetry data are available within each disease type. All analyses will be performed on the "treated population" for each disease, save for the dosimetry analyses. Additional analyses may be performed on several subgroups of interest. For each of the three disease types, the following subgroup analyses may be conducted:

- Age group (≥18 to <65 years, ≥65 to <75 years, ≥75 years)
- Unilobar or bilobar disease at baseline
- Eastern Cooperative Oncology Group (ECOG) status (0, >0) at baseline
- Albumin/bilirubin (ALBI) score (1 or 2, 3) at baseline
- Liver tumor burden at baseline (<25%, ≥25%)
- Target lesion size (≤ 5cm vs >5cm, ≤7cm vs >7cm, ≤ 10cm vs >10cm)
- Selective versus non-selective (lobar or whole liver) administration
- Standard versus multi compartment personalized dosimetry treatment

Additional analyses for each disease type are summarized in Table 2.

Statistical Methods to Be Applied

Effectiveness Analyses: All effectiveness analyses will utilize the treated population. Kaplan-Meier analysis will be used for OS, and median OS will be computed along with a 95% confidence interval (CI). Kaplan-Meier will also be used for time to deterioration of QoL. To assess the impact of subgroup factors detailed earlier, univariate and multivariate Cox Proportional Hazards analyses will be performed. The number of patients achieving their treatment expectations will be summarized. Similarly, tumor marker response and qualitative tumor response will also be reported. Univariate and multivariate logistic regression analyses of binary effectiveness points (i.e., achievement of treatment expectation, tumor marker response, and qualitative tumor response) will also be performed to assess the impact of the afore mentioned subgroup factors.

Safety Analyses: Incidence of AEs (Grade 3 or higher) and SAEs will be calculated according to the Medical Dictionary for Regulatory Activities.[30] Descriptive summaries of laboratory results will be presented by study visit; these will include changes from baseline. Number of re-hospitalizations due to Y90 glass microsphere treatment as well as length of re-hospitalizations will be summarized

Treatment Targeting and Dosimetry Analyses: All dosimetry analyses will utilize the dosimetry population. For the treatment targeting description, the following will be cross-tabulated and summarized as numbers and percentages for local assessments (all indications) and central assessments (HCC and iCC):

- Location of tumor(s) at baseline and locations of lesions targeted by ^{99m}Tc-MAA using ^{99m}Tc-MAA SPECT or SPECT/CT;

- Location of tumor(s) at baseline and location of lesions targeted by Y-90 using Y-90 PET/CT, Y-90 PET/MRI, or Y-90 SPECT/CT;
- Location of tumor(s) targeted by ^{99m}Tc-MAA based on ^{99m}Tc-MAA (SPECT or SPECT/CT) and location of tumor targeted by Y-90 using post-treatment PET/CT, PET/MRI, or SPECT/CT; and
- PVT at baseline and PVT targeted by ^{99m}Tc-MAA (using ^{99m}Tc-MAA SPECT or SPECT/CT) and Y-90 (using Y-90 PET/CT, PET/MRI, or SPECT/CT), when applicable.

For dosimetry-specific outcomes, the following the following will be cross-tabulated and summarized for local assessments (all indications) and central assessments (HCC and iCC):

- Pre-treatment and post treatment volume and absorbed dose determined for total perfused tumor, index lesion, perfused normal tissue and whole liver normal tissue using 99mTc-MAA (SPECT or SPECT/CT) and Y-90 (PET/CT or PET/MRI), when applicable.

- DVH for total perfused tumor, index lesion and whole normal liver tissue, using 99mTc-MAA (SPECT or SPECT/CT) and Y-90 (PET/CT or PET/MRI), when applicable.

Additional details regarding planned regression analyses of dosimetry data can be found in Supplementary Material 3.

Quality of Life Analyses: QoL scores will be calculated for each domain and each item at each time point; differences from baseline will be summarized. A “deterioration in QoL” is defined as a 7-point decrease in the total score or death, whichever comes first. The time to deterioration in QoL will be calculated as the interval between the date of first Y90 glass microsphere treatment and deterioration in QoL. If a patient is lost to follow-up the patient will be considered to be a “death” in the time-to-deterioration analysis. The Kaplan-Meier method will be used.

Interim and Final Analyses: Planned interim analyses will be conducted 1, 2, and 4 years into the overall study. Final analyses will be performed after the 5 years of enrollment and one additional year of follow-up is completed; the registry will close one year after the final patient receives Y90 glass microsphere treatment so as to ensure follow-up data for that individual, therefore in 2025. The first interim analysis will only include patients with HCC, as the registry was begun prior to the addition of the iCC and mCRC indications.

DISCUSSION

The PROACTIF study was designed to collect real-world data of the use of Y90 glass microspheres in the treatment of primary and secondary liver tumors in France. An extrinsic goal of the study is to provide these data in response to a request from HAS-CNEDMiTS, which requested such follow-up after its 5-year approval for reimbursement; we believe this will help to ensure patients in France continue to have access to this treatment.

More broadly, however, the study will provide data on patient outcomes in the context of real-world cancer care for HCC, iCC, and mCRC, particularly in conjunction with other concurrent treatment options, These data will include variables that will be critical in informing treatment decision-making in the future, including the diversity of patient selection, disease presentation, treatment procedures, treatment effectiveness (including, but not restricted to, survival), safety, QoL, and dosimetry. Additionally, the hope is to help equip hospitals in France to expand the use of multicompartment/personalized dosimetry, which has been shown to yield better outcomes in select HCC patients. Finally, we believe that the results from this registry could support the inclusion of SIRT with Y90 glass microspheres in the BCLC treatment algorithm for HCC, as well as in the European and US guidelines for the treatment of mCRC and iCC.

ABBREVIATIONS

Abbreviation	Definition
HCC	Hepatocellular carcinoma
iCC	Intrahepatic cholangiocarcinoma
mCRC	Metastatic colorectal cancer
SIRT	Selective internal radiation therapy
BCLC	Barcelona Clinic Liver Cancer
Y90	Yttrium-90
PROACTIF	A Prospective, Post Approval, Multiple Centre, Open-Label, Non- Interventional, Registry Study to Evaluate Effectiveness of TheraSphere in Clinical Practice in France
QoL	Quality of life
RIHP3	Recherche Impliquant la Personne Humaine de Catégorie 3
FACT-Hep	Functional Assessment of Cancer Therapy – Hepatobiliary Cancer
Bq	Becquerel
EDC	Electronic data capture
PIS	Patient information sheet
GDPR	General Data Protection Regulation
eCRF	Electronic case report form
PVT	Portal vein thrombosis
^{99m}Tc-MAA	Technetium albumin aggregated
SPECT	Single-photon emission computed tomography
CT	Computed tomography
IFU	Instructions for use
ALT	Alanine aminotransferase
AST	Aspartate aminotransferase
INR	International normalized ratio
AFP	Alpha-fetoprotein
CA19-9	Carbohydrate antigen 19-9
CEA	Carcinoembryonic antigen
MRI	Magnetic resonance imaging
RECIST 1.1	Response Evaluation Criteria in Solid Tumors
mRECIST	Modified Response Evaluation Criteria in Solid Tumors
MCD	Multicompartment dosimetry
PET	Positron emission tomography
OS	Overall survival
SAEs	Serious adverse events
AEs	Adverse events
NCI-CTCAE	National Cancer Institute Common Terminology Criteria for Adverse Events
CR	Complete response
PR	Partial response
SD	Stable disease
PD	Progressive disease
DVH	Dose Volume Histogram
ECOG	Eastern Cooperative Oncology Group
ALBI	Albumin-bilirubin
CI	Confidence interval
FOLFOX	Folinic acid, Fluorouracil, and Oxaliplatin

REFERENCES

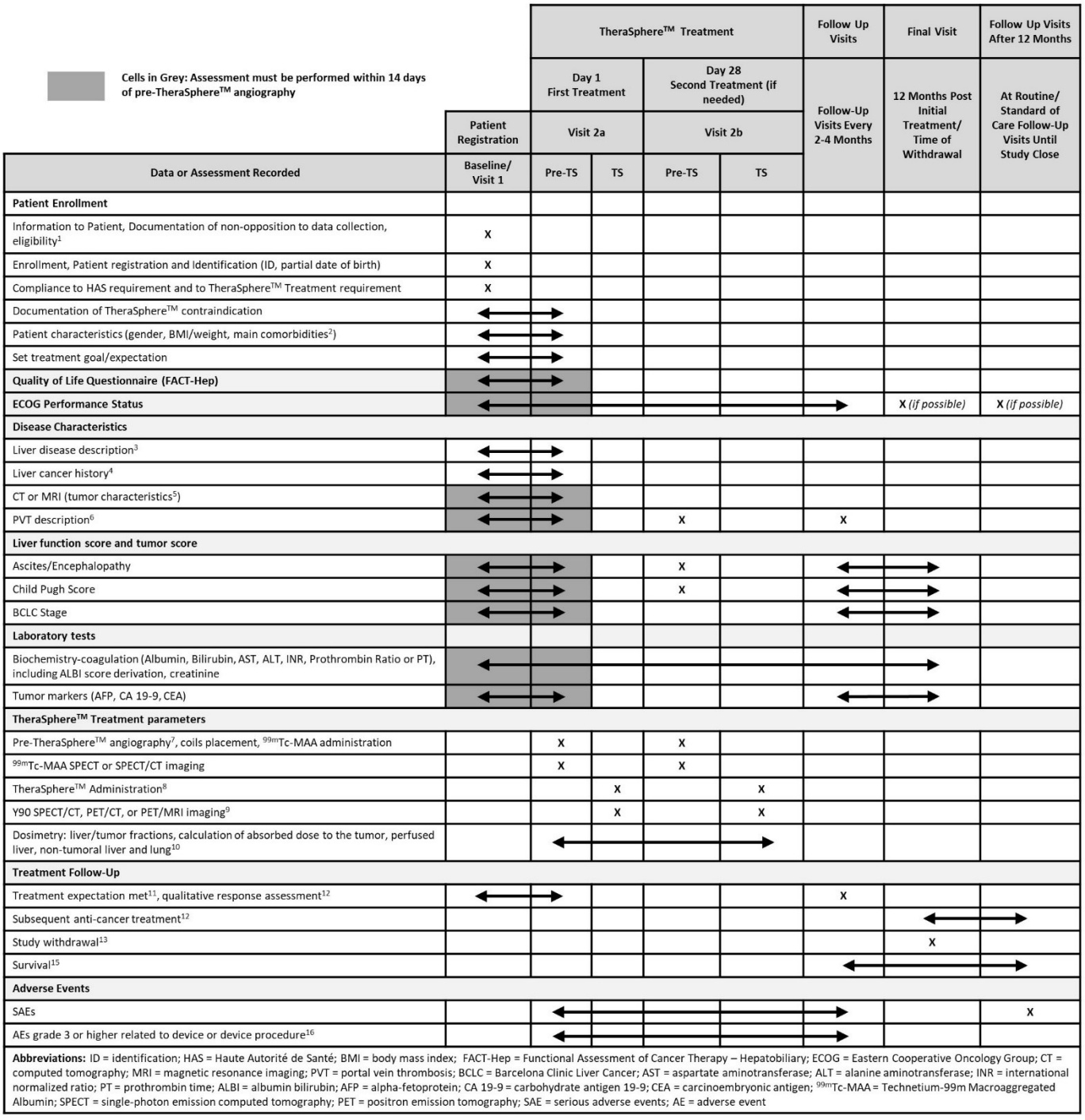
1. Abbott AM, Kim R, Hoffe SE, et al. (2015) Outcomes of Therasphere radioembolization for colorectal metastases. Clinical colorectal cancer, 14(3):146-153
2. Benson AB, D'Angelica MI, Abbott DE, et al. (2021) Hepatobiliary Cancers, Version 2.2021, NCCN Clinical Practice Guidelines in Oncology. J Natl Compr Canc Netw, 19(5):541-565
3. Benson AB, Venook AP, Al-Hawary MM, et al. (2021) Colon Cancer, Version 2.2021, NCCN Clinical Practice Guidelines in Oncology. J Natl Compr Canc Netw, 19(3):329-359
4. Bruix J, Reig M, Sherman M (2016) Evidence-Based Diagnosis, Staging, and Treatment of Patients With Hepatocellular Carcinoma. Gastroenterology, 150(4):835-853
5. Cella D, Butt Z, Kindler HL, et al. (2013) Validity of the FACT Hepatobiliary (FACT-Hep) questionnaire for assessing disease-related symptoms and health-related quality of life in patients with metastatic pancreatic cancer. Qual Life Res, 22(5):1105-1112
6. Chauhan N, Bukovcan J, Boucher E, et al. (2018) Intra-arterial TheraSphere yttrium-90 glass microspheres in the treatment of patients with unresectable hepatocellular carcinoma: Protocol for the STOP-HCC phase 3 randomized controlled trial. JMIR research protocols, 7(8):e11234
7. Chauhan N, Mulcahy MF, Salem R, et al. (2019) TheraSphere Yttrium-90 Glass Microspheres Combined With Chemotherapy Versus Chemotherapy Alone in Second-Line Treatment of Patients With Metastatic Colorectal Carcinoma of the Liver: Protocol for the EPOCH Phase 3 Randomized Clinical Trial. JMIR Res Protoc, 8(1):e11545
8. Chiesa C, Mira M, Bhoori S, et al. (2020) Radioembolization of hepatocarcinoma with (90)Y glass microspheres: treatment optimization using the dose-toxicity relationship. Eur J Nucl Med Mol Imaging, 47(13):3018-3032
9. Chow PKH, Gandhi M, Tan SB, et al. (2018) SIRveNIB: Selective Internal Radiation Therapy Versus Sorafenib in Asia-Pacific Patients With Hepatocellular Carcinoma. Journal of clinical oncology : official journal of the American Society of Clinical Oncology, 36(19):1913-1921
10. European Association For The Study Of The L, European Organisation For R, Treatment Of C (2012) EASL-EORTC clinical practice guidelines: management of hepatocellular carcinoma. J Hepatol, 56(4):908-943
11. European Association for the Study of the Liver. Electronic address eee (2019) Corrigendum to "EASL Clinical Practice Guidelines: Management of hepatocellular carcinoma" [J Hepatol 69 (2018) 182-236]. J Hepatol, 70(4):817-817
12. European Association for the Study of the Liver. Electronic address eee, European Association for the Study of the L (2018) EASL Clinical Practice Guidelines: Management of hepatocellular carcinoma. J Hepatol, 69(1):182-236
13. Forner A, Reig M, Bruix J (2018) Hepatocellular carcinoma. Lancet, 391(10127):1301-1314
14. Gabr A, Kulik L, Mouli S, et al. (2020) Liver Transplantation Following Yttrium-90 Radioembolization: 15-year Experience in 207-Patient Cohort. Hepatology (Baltimore, Md.)
15. Garin E, Palard X, Rolland Y (2020) Personalised Dosimetry in Radioembolisation for HCC: Impact on Clinical Outcome and on Trial Design. Cancers (Basel), 12(6)
16. Garin E, Rolland Y, Edeline J (2019) (90)Y-Loaded Microsphere SIRT of HCC Patients With Portal Vein Thrombosis: High Clinical Impact of 99mTc-MAA SPECT/CT-Based Dosimetry. Semin Nucl Med, 49(3):218-226
17. Garin E, Tselikas L, Guiu B, et al. (2021) Personalised versus standard dosimetry approach of selective internal radiation therapy in patients with locally advanced hepatocellular carcinoma (DOSISPHERE-01): a randomised, multicentre, open-label phase 2 trial. Lancet Gastroenterol Hepatol, 6(1):17-29

18. Gulec SA, Mesoloras G, Stabin M (2006) Dosimetric techniques in 90Y-microsphere therapy of liver cancer: The MIRD equations for dose calculations. Journal of nuclear medicine : official publication, Society of Nuclear Medicine, 47(7):1209-1211
19. Hickey R, Lewandowski RJ, Prudhomme T, et al. (2016) 90Y Radioembolization of Colorectal Hepatic Metastases Using Glass Microspheres: Safety and Survival Outcomes from a 531-Patient Multicenter Study. Journal of nuclear medicine : official publication, Society of Nuclear Medicine, 57(5):665-671
20. Institute NC (2018) Common Terminology Criteria for Adverse Events (CTCAE) version 5. US Department of Health and Human Services, Bethesda, MD,
21. Kappadath SC, Mikell J, Balagopal A, Baladandayuthapani V, Kaseb A, Mahvash A (2018) Hepatocellular Carcinoma Tumor Dose Response After (90)Y-radioembolization With Glass Microspheres Using (90)Y-SPECT/CT-Based Voxel Dosimetry. Int J Radiat Oncol Biol Phys, 102(2):451-461
22. Kokabi N, Camacho JC, Xing M, et al. (2015) Open-label prospective study of the safety and efficacy of glass-based yttrium 90 radioembolization for infiltrative hepatocellular carcinoma with portal vein thrombosis. Cancer, 121(13):2164-2174
23. Kulik LM, Atassi B, van Holsbeeck L, et al. (2006) Yttrium-90 microspheres (TheraSphere) treatment of unresectable hepatocellular carcinoma: downstaging to resection, RFA and bridge to transplantation. J Surg Oncol, 94(7):572-586
24. Kurilova I, Beets-Tan RGH, Flynn J, et al. (2019) Factors Affecting Oncologic Outcomes of 90Y Radioembolization of Heavily Pre-Treated Patients With Colon Cancer Liver Metastases. Clin Colorectal Cancer, 18(1):8-18
25. Kurilova I, Bendet A, Fung EK, et al. (2021) Radiation segmentectomy of hepatic metastases with Y-90 glass microspheres. Abdom Radiol (NY), 46(7):3428-3436
26. Lance C, McLennan G, Obuchowski N, et al. (2011) Comparative analysis of the safety and efficacy of transcatheter arterial chemoembolization and yttrium-90 radioembolization in patients with unresectable hepatocellular carcinoma. J Vasc Interv Radiol, 22(12):1697-1705
27. Lewandowski RJ, Gabr A, Abouchaleh N, et al. (2018) Radiation Segmentectomy: Potential Curative Therapy for Early Hepatocellular Carcinoma. Radiology, 287(3):1050-1058
28. Lewandowski RJ, Kulik LM, Riaz A, et al. (2009) A comparative analysis of transarterial downstaging for hepatocellular carcinoma: chemoembolization versus radioembolization. Am J Transplant, 9(8):1920-1928
29. Lewandowski RJ, Salem R (2006) Yttrium-90 radioembolization of hepatocellular carcinoma and metastatic disease to the liver. Semin Intervent Radiol, 23(1):64-72
30. Manfredi S, Lepage C, Hatem C, Coatmeur O, Faivre J, Bouvier AM (2006) Epidemiology and management of liver metastases from colorectal cancer. Annals of surgery, 244(2):254-259
31. Moreno-Luna LE, Yang JD, Sanchez W, et al. (2013) Efficacy and safety of transarterial radioembolization versus chemoembolization in patients with hepatocellular carcinoma. Cardiovasc Intervent Radiol, 36(3):714-723
32. Mulcahy MF, Mahvash A, Pracht M, et al. (2021) Radioembolization With Chemotherapy for Colorectal Liver Metastases: A Randomized, Open-Label, International, Multicenter, Phase III Trial. Journal of clinical oncology : official journal of the American Society of Clinical Oncology:Jco2101839
33. Padia SA, Johnson GE, Agopian VG, et al. (2021) Yttrium-90 radiation segmentectomy for hepatic metastases: A multi-institutional study of safety and efficacy. J Surg Oncol, 123(1):172-178
34. Salem R, Gabr A, Riaz A, et al. (2018) Institutional decision to adopt Y90 as primary treatment for hepatocellular carcinoma informed by a 1,000-patient 15-year experience. Hepatology (Baltimore, Md.), 68(4):1429-1440

35. Salem R, Gilbertsen M, Butt Z, et al. (2013) Increased quality of life among hepatocellular carcinoma patients treated with radioembolization, compared with chemoembolization. Clin Gastroenterol Hepatol, 11(10):1358-1365.e1351
36. Salem R, Johnson GE, Kim E, et al. (2021) Yttrium-90 Radioembolization for the Treatment of Solitary, Unresectable HCC: The LEGACY Study. Hepatology (Baltimore, Md.)
37. Salem R, Lewandowski RJ, Kulik L, et al. (2011) Radioembolization results in longer time-to-progression and reduced toxicity compared with chemoembolization in patients with hepatocellular carcinoma. Gastroenterology, 140(2):497-507.e492
38. Venerito M, Pech M, Canbay A, et al. (2020) NEMESIS: Non-inferiority, Individual Patient Meta-analysis of Selective Internal Radiation Therapy with Yttrium-90 Resin Microspheres versus Sorafenib in Advanced Hepatocellular Carcinoma. Journal of nuclear medicine : official publication, Society of Nuclear Medicine
39. Vilgrain V, Pereira H, Assenat E, et al. (2017) Efficacy and safety of selective internal radiotherapy with yttrium-90 resin microspheres compared with sorafenib in locally advanced and inoperable hepatocellular carcinoma (SARAH): an open-label randomised controlled phase 3 trial. The Lancet. Oncology, 18(12):1624-1636

Figures.

Figure 1. SPIRIT flow diagram for the PROACTIF study.

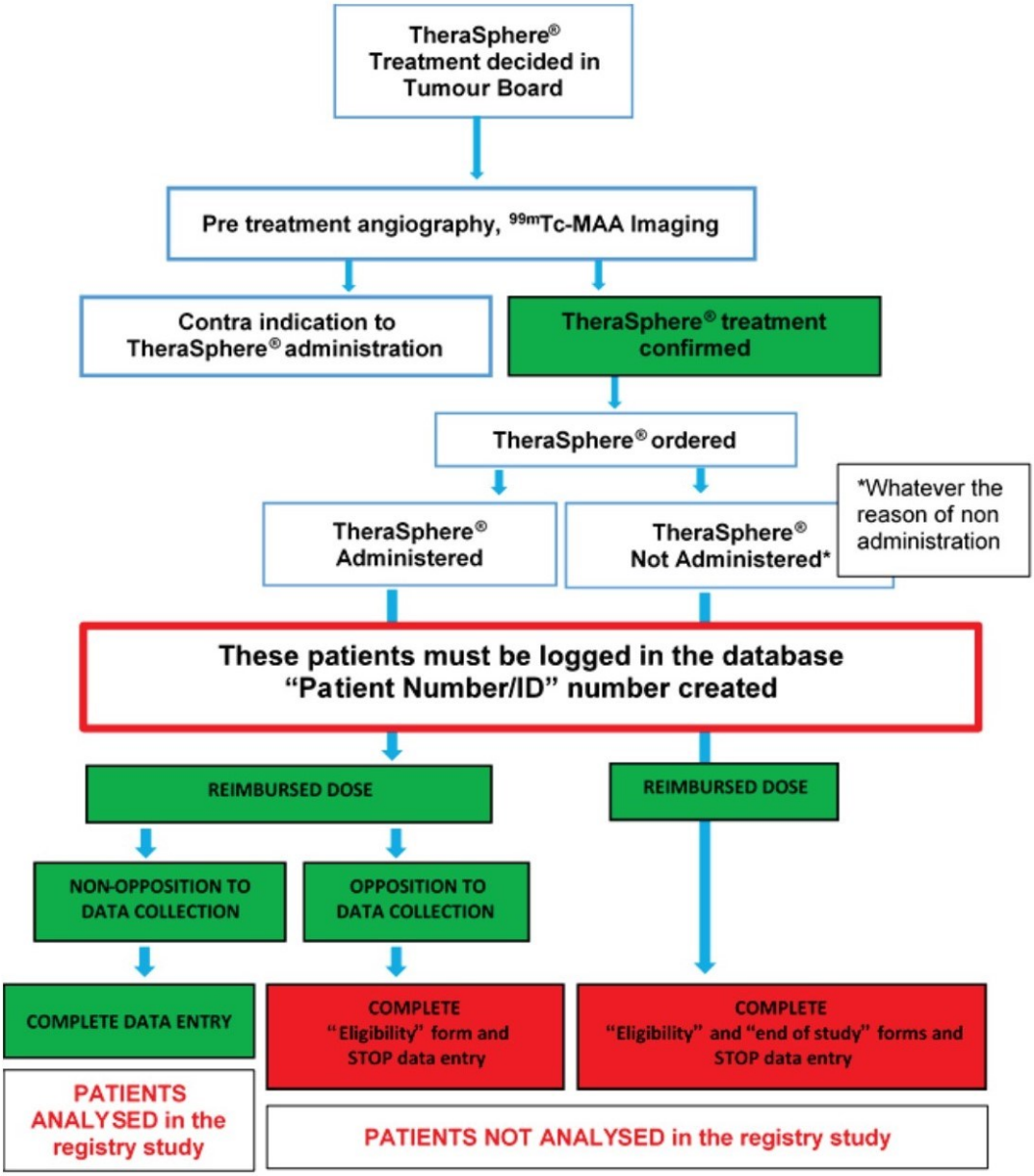


Cells in Grey: Assessment must be performed within 14 days of pre-TheraSphere™ angiography

	TheraSphere™ Treatment					Follow Up Visits	Final Visit	Follow Up Visits After 12 Months
		Day 1 First Treatment		Day 28 Second Treatment (if needed)		Follow-Up Visits Every 2-4 Months	12 Months Post Initial Treatment/ Time of Withdrawal	At Routine/ Standard of Care Follow-Up Visits Until Study Close
	Patient Registration	Visit 2a		Visit 2b				
Data or Assessment Recorded	**Baseline/ Visit 1**	**Pre-TS**	**TS**	**Pre-TS**	**TS**			
Patient Enrollment								
Information to Patient, Documentation of non-opposition to data collection, eligibility[1]	X							
Enrollment, Patient registration and Identification (ID, partial date of birth)	X							
Compliance to HAS requirement and to TheraSphere™ Treatment requirement	X							
Documentation of TheraSphere™ contraindication	←	→						
Patient characteristics (gender, BMI/weight, main comorbidities[2])	←	→						
Set treatment goal/expectation	←	→						
Quality of Life Questionnaire (FACT-Hep)	←	→						
ECOG Performance Status	←					→	X *(if possible)*	X *(if possible)*
Disease Characteristics								
Liver disease description[3]	←	→						
Liver cancer history[4]	←	→						
CT or MRI (tumor characteristics[5])	←	→						
PVT description[6]	←	→		X		X		
Liver function score and tumor score								
Ascites/Encephalopathy	←	→		X		←	→	
Child Pugh Score	←	→		X		←	→	
BCLC Stage	←	→				←	→	
Laboratory tests								
Biochemistry-coagulation (Albumin, Bilirubin, AST, ALT, INR, Prothrombin Ratio or PT), including ALBI score derivation, creatinine	←						→	
Tumor markers (AFP, CA 19-9, CEA)	←	→				←	→	
TheraSphere™ Treatment parameters								
Pre-TheraSphere™ angiography[7], coils placement, ^{99m}Tc-MAA administration		X		X				
^{99m}Tc-MAA SPECT or SPECT/CT imaging		X		X				
TheraSphere™ Administration[8]			X		X			
Y90 SPECT/CT, PET/CT, or PET/MRI imaging[9]			X		X			
Dosimetry: liver/tumor fractions, calculation of absorbed dose to the tumor, perfused liver, non-tumoral liver and lung[10]		←			→			
Treatment Follow-Up								
Treatment expectation met[11], qualitative response assessment[12]	←	→				X		
Subsequent anti-cancer treatment[12]							←	→
Study withdrawal[13]							X	
Survival[15]						←		→
Adverse Events								
SAEs		←			→	→		X
AEs grade 3 or higher related to device or device procedure[16]		←			→	→		

Abbreviations: ID = identification; HAS = Haute Autorité de Santé; BMI = body mass index; FACT-Hep = Functional Assessment of Cancer Therapy – Hepatobiliary; ECOG = Eastern Cooperative Oncology Group; CT = computed tomography; MRI = magnetic resonance imaging; PVT = portal vein thrombosis; BCLC = Barcelona Clinic Liver Cancer; AST = aspartate aminotransferase; ALT = alanine aminotransferase; INR = international normalized ratio; PT = prothrombin time; ALBI = albumin bilirubin; AFP = alpha-fetoprotein; CA 19-9 = carbohydrate antigen 19-9; CEA = carcinoembryonic antigen; ^{99m}Tc-MAA = Technetium-99m Macroaggregated Albumin; SPECT = single-photon emission computed tomography; PET = positron emission tomography; SAE = serious adverse events; AE = adverse event

538 **Figure 2.** TheraSphere Registry recruitment process.



539

Table 1. Inclusion and exclusion criteria for the PROACTIF Registry for patients with hepatocellular carcinoma, intrahepatic cholangiocarcinoma, and metastatic colorectal cancer.

	Hepatocellular Carcinoma	**Intrahepatic Cholangiocarcinoma**	**Metastatic Colorectal Cancer**
Inclusion Criteria (conditions for reimbursement)	1. Confirmed HCC, by histology or America Association for the Study of Liver Diseases (AASLD) or EASL imaging criteria 2. Patient scheduled to receive TherasSphere treatment per Multi-disciplinary Tumour Board (MTB) decision 3. Treatment given as a palliative intent (patient not eligible* for resection or ablation) 4. Patient who is BCLC B or BCLC C or with PVT** 5. Patient who is not eligible* for, or has failed sorafenib treatment 6. Patient with good general status (ECOG score 0 or 1) 7. Patient with preserved liver function*** (Child Pugh A-B)	1. Confirmed iCC 2. Patient scheduled to receive TherasSphere treatment per MTB decision 3. First line palliative treatment for iCC 4. Patient unresectable at diagnosis or in a recurrence after resection 5. With or without association with chemotherapy 6. Preserved general health condition (ECOG ≤ 1) when treated with TheraSphere with concomitant chemotherapy 7. Preserved general health condition (ECOG score ≤ 2) when treated with TheraSphere alone 8. Absence of extrahepatic disease 9. Hepatic tumour load <50% 10. Patient with preserved liver function (Child-Pugh score A or B in case of cirrhosis)	1. Confirmed mCRC 2. Patient scheduled to receive TherasSphere treatment per MTB decision 3. Preserved general health condition (ECOG score ≤ 2). 4. Hepatic tumour load (<25%) 5. Absence of extrahepatic disease (except in situ primary colorectal cancer) 6. Refractory or intolerant to all approved intra venous and oral therapies for colorectal cancer. Progression under chemotherapy should be documented
Exclusion Criteria	1. Have refused data collection; and/or 2. Will not receive reimbursement for their TheraSphere treatment.		

* Treatment not recommended by the MTB or contra indicated or has failed or was not tolerated

** Portal vein invasion by tumor

***Preserved liver function: includes patients with different degrees of liver functional reserve (non-treated liver) that has to be carefully evaluated. Compensated liver disease (without ascites) is required to obtain optimal outcome. (Forner et al. 2018; EASL Guidelines 2018)

548 **Table 2.** Subgroup analyses for each malignancy type in the PROACTIF registry study.

Hepatocellular Carcinoma	Intrahepatic Cholangiocarcinoma	Metastatic Colorectal Cancer
• Etiology of underlying disease • Child Pugh score (A or B) at baseline for cirrhotic patients • Cirrhosis versus no cirrhosis • Prior TACE treatment (Yes, No) • PVT classification (PVT 1, PVT 2, PVT 3, PVT 4) at baseline • BCLC stage (B, C) at baseline • Prior systemic treatment, including sorafenib (Yes, No) • AFP (<200 ng/ml, ≥200 ng/mL, <400ng/mL, ≥400 ng/mL) at baseline • Threshold absorbed doses to the tumour ≥ 205, < 205 Gy and ≥250, <250 Gy (by local and central assessment)	• Prior resection (Yes, No) • CA 19-9 (<2xULN, ≥ 2xULN) at baseline • Cirrhosis versus no cirrhosis • Concomitant chemotherapy versus non concomitant chemotherapy • Threshold absorbed doses to the tumour < 205 Gy, 205-250 Gy, >250 Gy (by local and central assessment)	• CEA (<2xULN, ≥ 2xULN) at baseline • Previous line of systemic chemotherapy (≤ 2, >2) • Prior local or/and locoregional treatment (Yes, No) • Concomitant chemotherapy versus non concomitant chemotherapy • Threshold absorbed doses to the tumour <100 and ≥ 100 Gy (by local assessment)

549

Supplemental Material 1: PROACTIF Registry Group Principal Investigators

Boris Guiu, MD, PhD (CHRU St-Eloi, Montpellier, FR);
Gilles Grimon, MD (Hôpital, Bicêtre, FR);
Agnès Rode, MD (Centre hospitalier de la Croix Rousse, Lyon, FR);
Andrea Skanjeti, MD, PhD (Centre Hospitalier Lyon Sud, Lyon, FR);
Annie Sibert, MD (Hôpital, Beaujon, FR);
Antoine Bouvier, MD (CHU, Angers, FR);
Charles Mastier, MD (CRLCC Centre Léon Bérard, Lyon, FR);
Christian Sengel, MD (CHU Hôpital Michallon, Grenoble, FR);
Clément Bailly, MD, PhD (CHU Site Hotel Dieu, Nantes, FR);
David Sefrioui, MD, PhD (CHU, Rouen, FR);
Elodie Chevalier, MD (CHU Brabois Adultes);
Eric Vibert, MD, PhD (Hopital Paul Brousse, Villejuif, FR);
Etienne Garin, MD, PhD (CRLCC Eugène Marquis, Rennes, FR);
Inna Dygai-Cochet, MD (Centre George-François Leclerc, Dijon, FR);
Iulian Enescu, MD (Nouvel Hopital Civil, Strasbourg, FR);
Jean Goupil, MD (CHU, Nimes, FR);
Jean-Baptiste Peron, MD (CHU Purpan, Toulouse, FR);
Jean-Baptiste Pinaquy, MD (CHU Hôpital Haut Levesque, Bordeaux, FR);
Jean-Pierre Tasu, MD (CHU La Miletrie, Poitiers, FR);
Julia Chalaye, MD (Hôpital Henri Mondor, Créteil, FR);
Michel Greget, MD (CHU Hôpital Hautepierre, Strasbourg, FR);
Patrick Chevalier, MD (CHU, Nice, FR);
Paul Calame, MD (Centre Hospitalier Régional Universitaire, Besançon, FR);
Pierre-Jean Valette, MD (Centre hospitalier Edouard Herriot, Lyon, FR);
Stéphanie Becker, MD (Centre Henri Becquerel, Rouen, FR);
Sylvain Manfredi, MD, PhD (CHU Dijon Bourgogne – Hôpital François Mitterand, Dijon, FR);
Thierry Yzet, MD (CHU, Amiens, FR);
Claude Somma-Delpero, MD (CHU La Timone, Marseille, FR);
Thierry de Baere, MD, PhD (Institut Gustave Roussy, Villejuif, FR);
Isabelle Brenot Rossi, MD (Institut Paoli Calmettes, Marseilles, FR);
Vittorio Catena, MD (Institut Bergonié , Bordeaux, FR);
Stéphane Renaud, MD (Centre Hospitalier de Perpignan, Perpignan, FR);
Géraldine Baudson-Sergent, MD (CHRU, Lille, FR).

Supplemental Material 2: Planned Dosimetry Outcome Measures

Evaluation of treatment targeting and dosimetry outcomes are defined as follows:

1) Concordance between location of tumor(s) at baseline (CT or MRI) and locations of lesions targeted by ^{99m}Tc-MAA using ^{99m}Tc-MAA SPECT or SPECT/CT.
2) Concordance between location of tumor(s) at baseline (CT or MRI) and location of lesions targeted by Y-90 using PET/CT, Y-90 PET/CT or PET/MRI, or Y-90 SPECT/CT.
3) Concordance between location of tumor(s) based on ^{99m}Tc-MAA (SPECT or SPECT/CT) and location of tumor targeted by Y-90 using post-treatment Y-90 PET/CT, PET/MRI, or SPECT/CT.
4) Concordance between PVT at baseline and PVT targeted by ^{99m}Tc-MAA (SPECT or SPECT/CT) and Y-90 (PET/CT, PET/MRI, or SPECT/CT).
5) Associations between pre-treatment tumor and normal tissue liver-absorbed doses with qualitative tumor response (CR, PR), OS, and safety, respectively.
6) Association between post treatment tumor and normal tissue liver-absorbed doses with qualitative tumor response (CR, PR), OS, and safety, respectively.
7) Association between pre and post treatment tumor and normal tissue liver-absorbed doses determined with qualitative tumor response (CR, PR), OS, and safety, respectively.
8) Pre-treatment and post treatment absorbed dose determined for total perfused tumor, index lesion, perfused normal tissue and whole liver normal tissue.
9) Pre-treatment and post treatment Dose Volume Histogram (DVH): as determined for total perfused tumor, index lesion, and whole normal liver tissue.

Supplemental Material 3: Planned Advanced Dosimetry Analyses

All regression analyses will be conducted with both pre-procedural dosimetry and post-treatment dosimetry data. Cox regression analyses will be performed to determine the impact of tumor-absorbed dose on OS for patients with HCC and iCC. For patients with mCRC, a similar Cox regression analysis will be performed to evaluate the impact of absorbed dose to perfused liver on OS. Logistic regression analysis of qualitative tumor/index lesion response will be performed to assess the impact of the tumor/index lesion absorbed doses. In mCRC patients, a similar logistic regression analysis will be conducted to assess the impact of the absorbed dose to tumor and perfused liver on response; it is expected that most of these patients will be treated using standard dosimetry. In patients with HCC and iCC, logistic regression analyses of SAEs will be performed to evaluate association with non-tumoral liver absorbed doses in patients with HCC and iCC; a parallel analysis will be conducted for patients with mCRC to evaluate the impact of absorbed dose to normal liver tissue on SAEs. The relationship between absorbed doses will be assessed separately for non-tumoral liver-absorbed doses and tumor-absorbed doses using Bland-Altman analysis. A similar analysis will be performed for patients with mCRC to determine the relationship between absorbed dose to perfused liver volume and absorbed dose to normal tissue liver. In patients with HCC and iCC, linear regression of absorbed dose from pre-procedural dosimetry and post-treatment dosimetry data will be performed and Pearson's correlation coefficient will be calculated. In patients with mCRC, a linear regression will also be performed for absorbed dose to perfused liver volume and absorbed dose to normal tissue.