National Comprehensive Cancer Network®

NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®)

Biliary Tract Cancers

Version 2.2025 — July 2, 2025

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NCCN recognizes the importance of clinical trials and encourages participation when applicable and available. Trials should be designed to maximize inclusiveness and broad representative enrollment.

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ф Diagnostic/Interventional radiology
¤ Gastroenterology
‡ Hematology/Hematology oncology
Þ Internal medicine
† Medical oncology
≠ Pathology
¥ Patient advocacy
§ Radiotherapy/Radiation oncology
¶ Surgery/Surgical oncology
ξ Transplantation
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Find an NCCN Member Institution: https://www.nccn.org/home/member-institutions.

NCCN Categories of Evidence and Consensus: All recommendations are category 2A unless otherwise indicated.

See NCCN Categories of Evidence and Consensus.

NCCN Categories of Preference: All recommendations are considered appropriate.

See NCCN Categories of Preference.

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Updates in Version 2.2025 of the NCCN Guidelines for Biliary Tract Cancers from Version 1.2025 include:

MS-1
• The discussion was updated to reflect the changes in the algorithm.

Updates in Version 1.2025 of the NCCN Guidelines for Biliary Tract Cancers from Version 6.2024 include:

General
• Fatty liver disease was changed to metabolic dysfunction-associated steatotic liver disease (MASLD) throughout.
GALL-1
• Primary Treatment
  ▸ Bottom pathway, options: Best supportive care moved to separate node. (Also for GALL-2 through GALL-5 and EXTRA-1)
• Bottom pathway, last column revised: *Assess for response and Reconsider resection or locoregional therapy or Subsequent-line systemic therapy if* progression on or after systemic therapy. (Also for GALL-2 through GALL-5 and EXTRA-1)
GALL-6
• Bottom pathway, column 2 revised: ~~Resected~~ Gross residual disease (R2). (Also for INTRA-2 and EXTRA-2)
GALL-A (1 of 2)
• Incidental Finding of Suspicious Mass During Surgery
  ▸ Last bullet added: Minimally invasive approaches by experienced surgeons have been proven to be safe and effective for well-selected cases. (Also for General Principles on INTRA-A)
GALL-A (2 of 2)
• Mass on Imaging: Patients Presenting with Gallbladder Mass/Disease Suspicious for Gallbladder Cancer
  ▸ Bullet 1 revised: Staging should be carried out with multiphasic cross-sectional imaging of the *liver with* chest, abdomen, and pelvis *CT*.

Intrahepatic Cholangiocarcinoma
INTRA-1
• Workup
  ▸ Bullet 1 added: Multidisciplinary evaluation.
  ▸ Bullet 3 revised: Multiphasic abdomen/pelvis CT/MRI with IV contrast *(preferred) or contrast-enhanced US.*
• Primary Treatment
  ▸ Middle pathway: Last bullet added: Consider referral to transplant center.
  ▸ Middle and bottom pathways, added "Options" before 1st bullet.
• Middle and bottom pathways, last column: Last bullet added: Consider evaluation for liver transplantation.
• Footnote d revised: ASCO guidelines for management of viral hepatitis B virus in patients with cancer/receiving chemotherapy: ~~https://www.asco.org/sites/new-www.asco.org/files/content-files/advocacy-and-policy/documents/2020-HBV-PCO-Algorithm.pdf~~ *Hwang JP, et al. J Clin Oncol 2020;38:3698-3715.*
• Footnote q revised: *Hepatic* ~~intra-~~arterial *infusion* chemotherapy (with or without systemic chemotherapy) may be used in a clinical trial or at experienced centers in carefully selected cases.
• Footnote s added: Patients who meet the following criteria will be eligible for transplant exception points: biopsy-proven iCCA or mixed HCC-iCCA, presence of cirrhosis, unresectable, received locoregional or systemic therapy, and 6 months from time of diagnosis or last treatment with no new lesions or extrahepatic disease.
• Footnote removed: Consult with multidisciplinary team.

Continued

Updates in Version 1.2025 of the NCCN Guidelines for Biliary Tract Cancers from Version 6.2024 include:

INTRA-B (1 of 2)
- Paragraph 3 revised: ~~Those identified as~~ *Patients with* HCC-CCA that ~~are~~ *is* limited ~~to Milan criteria~~ in size *based on center-specific criteria used* should be considered for evaluation in a transplant center~~, but may need a research protocol or live donor approach to do so~~.

INTRA-D
- Ablation, bullet 3 revised: Options for ablation include ~~cryoablation,~~ radiofrequency ablation, microwave ablation, and irreversible electroporation.
- Arterially directed therapies, last bullet added: Hepatic arterial infusion chemotherapy (with or without systemic chemotherapy) may be used in a clinical trial or at experienced centers in carefully selected cases.

Extrahepatic Cholangiocarcinoma

EXTRA-1
- Column 2
  - Bullet 1 added: Multidisciplinary evaluation.
  - Bullet 5 added: Biliary protocol imaging.
  - Last bullet revised: Consider serum IgG4 to rule out *IgG4-related sclerosing cholangitis* ~~autoimmune cholangitis.~~
- Column 4, resectable pathway, bullet removed: Multidisciplinary review.
- Footnote b added: Imaging evaluation for suspected extrahepatic CCA is ideally performed prior to biliary decompression to facilitate accurate local staging for surgical candidacy.
- Footnote g revised: Before biopsy, evaluate if patient is a resection or transplant candidate. If patient is a potential transplant candidate, consider referral to transplant center before biopsy. *Importantly, transperitoneal and surgical biopsy may be contraindicated in transplant candidates.* Unresectable perihilar or hilar CCAs that measure ≤3 cm in radial diameter, with the absence of intrahepatic or extrahepatic metastases and without nodal disease, as well as those with primary sclerosing cholangitis, may be considered for liver transplantation at a transplant center that has an UNOS-approved protocol for transplantation of CCA.

Biliary Tract Cancers

BIL-A
- Gallbladder Cancer, bullet 2 revised: If gallbladder cancer is suspected preoperatively, ~~multidetector~~ multiphase CT of the abdomen (and pelvis) or contrast-enhanced MRI with magnetic resonance cholangiopancreatography (MRCP) of the abdomen (and pelvis) and chest CT with or without contrast should be performed. MRI is preferred for evaluating masses within the gallbladder and demonstrating bile duct involvement.
- Biliary Drainage, bullets added:
  - Multidisciplinary discussion of drainage is recommended, especially in patients with potentially resectable disease.
  - Route (percutaneous vs. endoscopic) should be considered based on local expertise after multidisciplinary review.
  - All segments that are opacified should be drained, with the aim to drain >50% of the viable liver volume, including the future liver remnant. Atrophic liver segments, in general, should not be drained.

BIL-B (6 of 8)
- HER2/ERBB2 Overexpression/Amplification/Activating Mutations
  - Bullet 1 revised: Testing Modalities and Considerations: HER2 *overexpression*/amplification...

Continued

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Updates in Version 1.2025 of the NCCN Guidelines for Biliary Tract Cancers from Version 6.2024 include:

BIL-C (1 of 5)
- References were moved from footnotes to references pages. (Also for BIL-C 3)
- Footnote b revised: The decision to use neoadjuvant therapy needs to be individualized and in close consultation with surgical oncologist and multidisciplinary team. A period of 2 to 6 months with reassessment every 2 to 3 months is reasonable. There are limited clinical trial data to define a standard regimen or definitive benefit. Clinical trial participation is encouraged. ~~The listed regimens are extrapolated from the metastatic setting.~~
- Footnote e added: If a patient is ineligible for cisplatin, carboplatin may be used. (Also for BIL-C 2)

BIL-C (3 of 5)
- Subsequent-Line Therapy for Biliary Tract Cancers if Disease Progression
  - For CCA with *FGFR2* fusions or rearrangements: Erdafitinib was added as a category 2A recommendation.
  - For HER-2-positive tumors
    - Sub-bullet 2 revised: Trastuzumab + pertuzumab *(IHC3+/ISH+/NGS amplification).*
    - Sub-bullet 3 revised: Tucatinib + trastuzumab *(IHC3+/ISH+/NGS amplification).*
- Footnote k added: An FDA-approved biosimilar is an appropriate substitute for any recommended systemic biologic therapy in the NCCN Guidelines.
- Footnote m added: Repotrectinib is an option if there was progression on a prior therapy, which may include prior NTRK inhibitors. Entrectinib and larotrectinib should not be used if there was progression on prior NTRK inhibitors.
- Footnote p added: Futibatinib and pemigatinib are preferred over erdafitinib.
- Footnote q added: The data available for this agent are from a smaller trial.
- Footnote removed: An FDA-approved biosimilar is an appropriate substitute for trastuzumab.

BIL-C (4 of 5)
- Reference 4 added: Williams KJ, Picus J, Trinkhaus K, et al. Gemcitabine with carboplatin for advanced biliary tract cancers: a phase II single institution study. HPB (Oxford) 2010;12:418-426.
- Reference 21 revised: ~~Schenker M, Burotto M, Richardet M, et al. CheckMate 848: A randomized, open-label, phase 2 study of nivolumab in combination with ipilimumab or nivolumab monotherapy in patients with advanced or metastatic solid tumors of high tumor mutational burden [abstract]. Cancer Res 2022;82:Abstract CT022.~~ *Schenker M, Burotto M, Richardet M, et al. Randomized, open-label, phase 2 study of nivolumab plus ipilimumab or nivolumab monotherapy in patients with advanced or metastatic solid tumors of high tumor mutational burden. J Immunother Cancer 2024;12:e008872.*

BIL-C (5 of 5)
- Reference 30 added: Pant S, Schuler M, Iyer G, et al. Erdafitinib in patients with advanced solid tumours with FGFR alterations (RAGNAR): an international, single-arm, phase 2 study. Lancet Oncol 2023;24:925-935.

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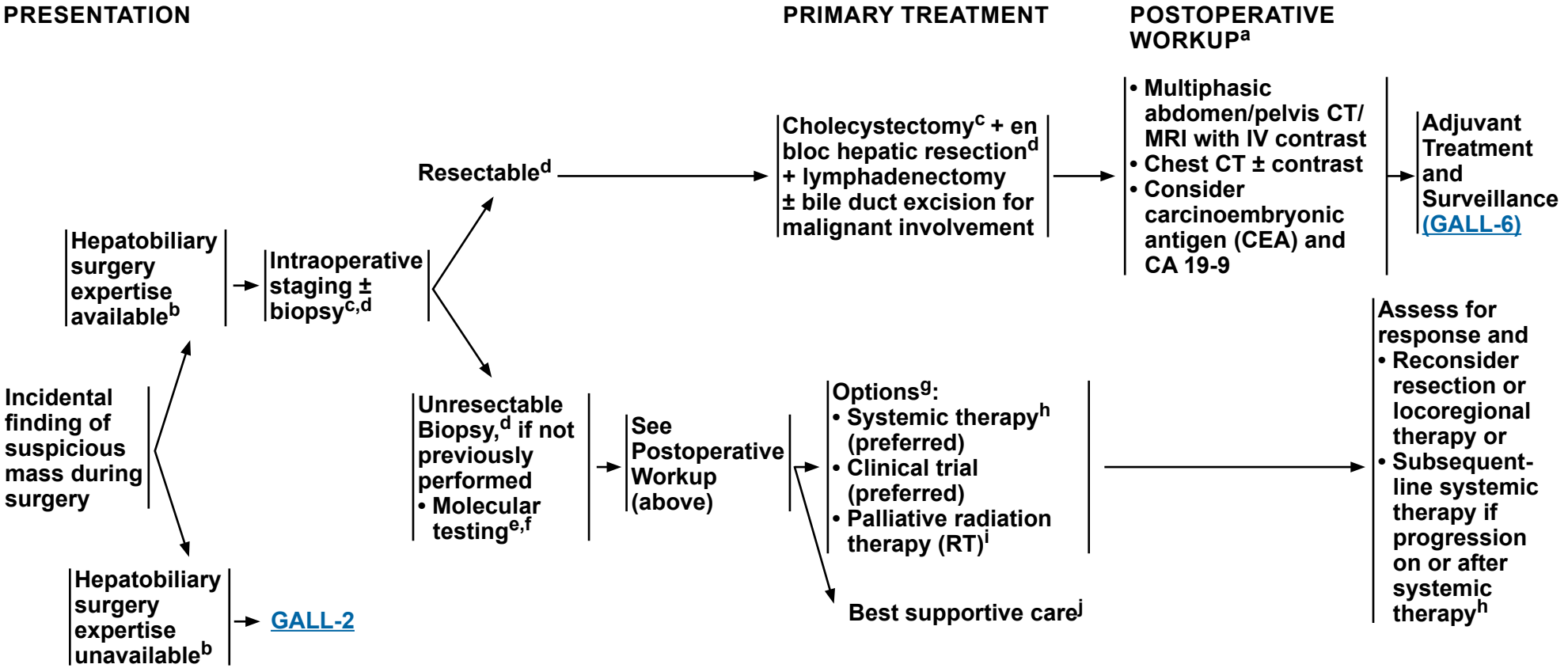

[a] Principles of Imaging (BIL-A).
[b] If expertise unavailable or resectability unclear, visually inspect the abdomen, document all findings, and refer to surgeon with hepatobiliary expertise and/or proceed with staging.
[c] Principles of Surgery (GALL-A).
[d] Principles of Pathology (GALL-B).
[e] For patients with mismatch repair deficient (dMMR)/microsatellite instability-high (MSI-H) tumors or a family history suggestive of *BRCA1/2* mutations, consider germline testing and/or referral to a genetic counselor.
[f] Principles of Molecular Testing (BIL-B).
[g] Order does not indicate preference. The choice of treatment modality may depend on extent/location of disease and institutional capabilities.
[h] Principles of Systemic Therapy (BIL-C).
[i] Principles of Radiation Therapy (BIL-D).
[j] See NCCN Guidelines for Palliative Care.

Other Clinical Presentations
GALL-3, GALL-4, and GALL-5

Note: All recommendations are category 2A unless otherwise indicated.

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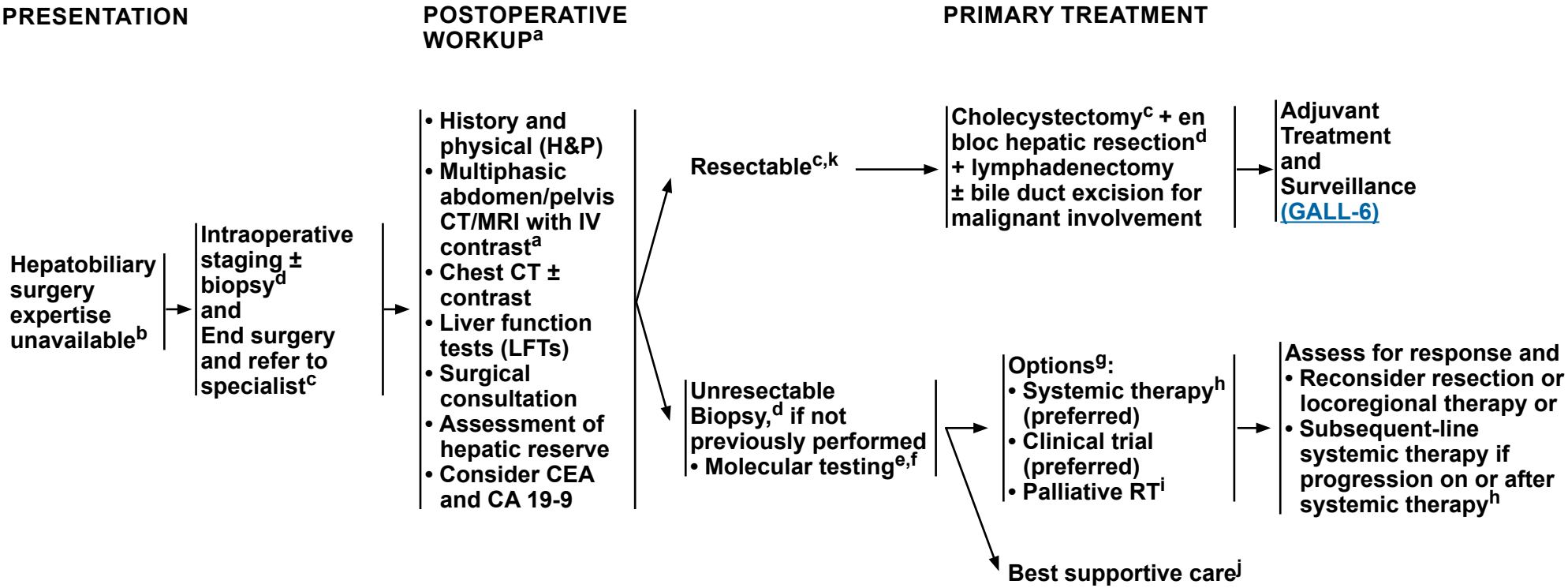

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[d] Principles of Pathology (GALL-B).
[e] For patients with dMMR/MSI-H tumors or a family history suggestive of *BRCA1/2* mutations, consider germline testing and/or referral to a genetic counselor.
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[g] Order does not indicate preference. The choice of treatment modality may depend on extent/location of disease and institutional capabilities.
[h] Principles of Systemic Therapy (BIL-C).
[i] Principles of Radiation Therapy (BIL-D).
[j] See NCCN Guidelines for Palliative Care.
[k] For locoregionally advanced disease, consider neoadjuvant systemic therapy to rule out rapid progression and avoid futile surgery. There are limited clinical trial data to define a standard regimen or definitive benefit. See Principles of Systemic Therapy (BIL-C).

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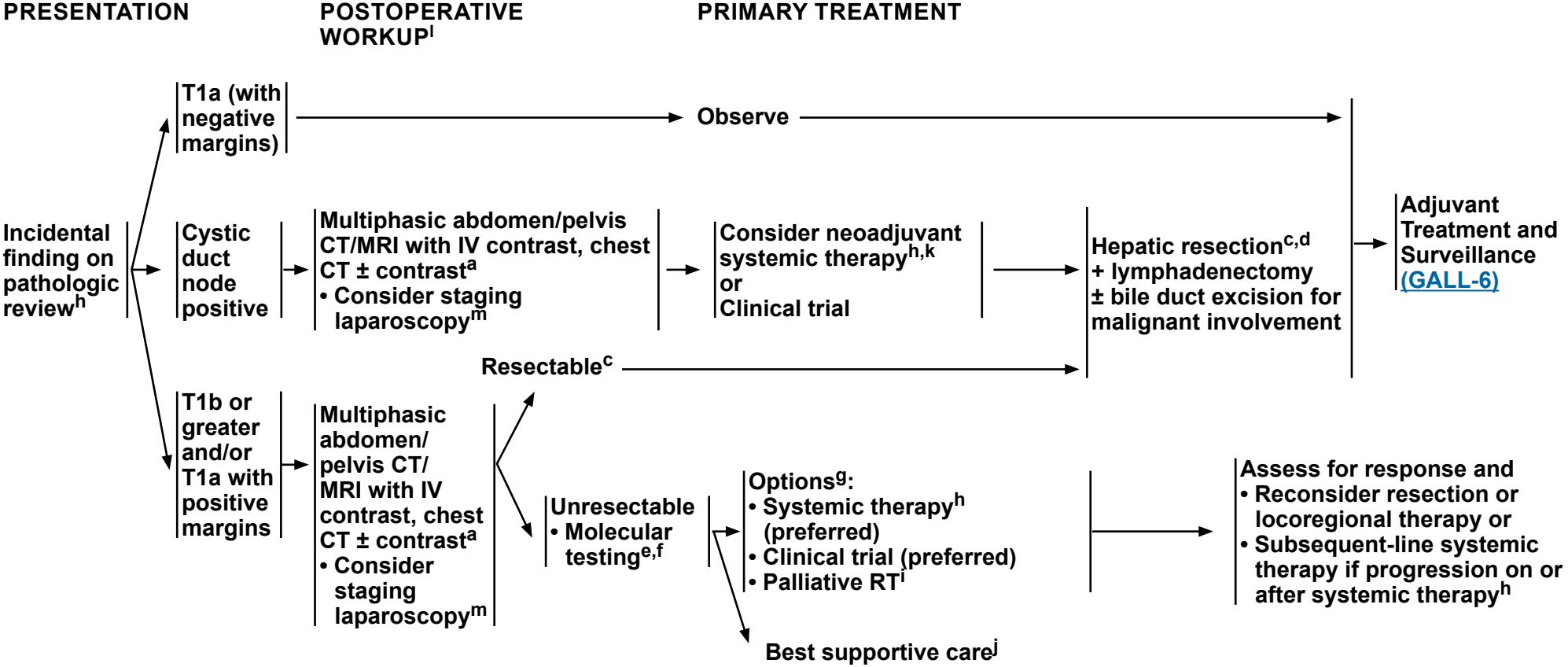

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[i] Principles of Radiation Therapy (BIL-D).
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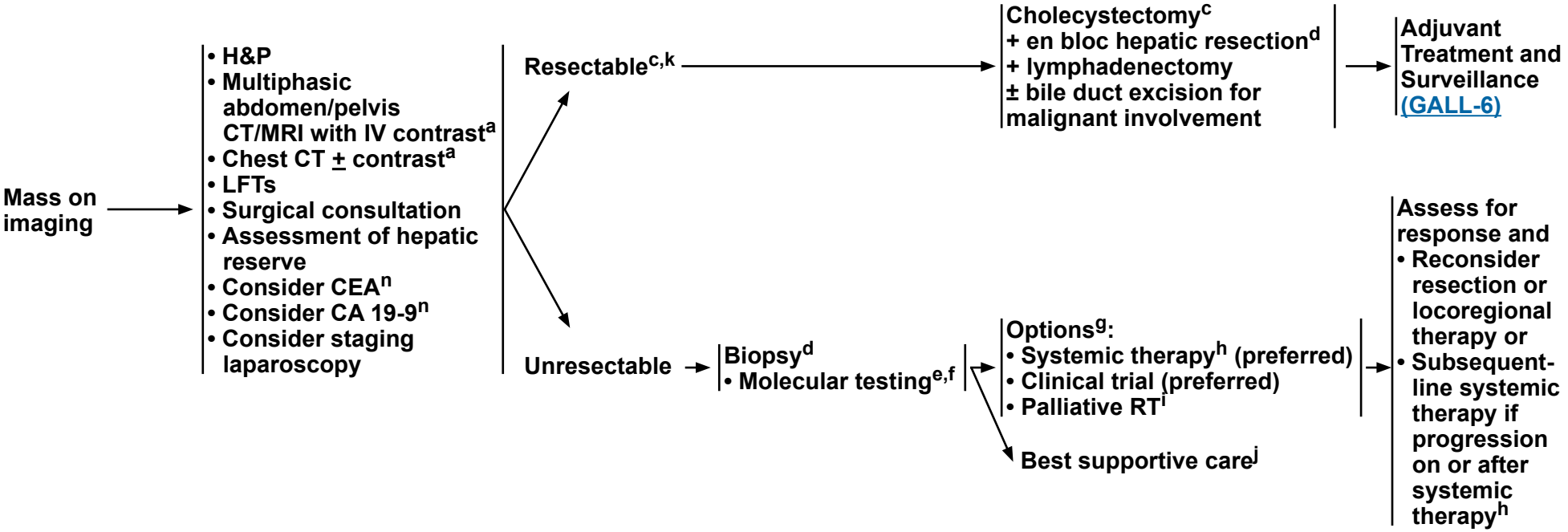
[k] For locoregionally advanced disease, consider neoadjuvant systemic therapy to rule out rapid progression and avoid futile surgery. There are limited clinical trial data to define a standard regimen or definitive benefit. See Principles of Systemic Therapy (BIL-C).
[l] Consider multidisciplinary review.
[m] Butte JM, et al. HPB (Oxford) 2011;13:463-472.

Other Clinical Presentations
GALL-4
and GALL-5

Note: All recommendations are category 2A unless otherwise indicated.

PRESENTATION AND WORKUP

PRIMARY TREATMENT



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[h] Principles of Systemic Therapy (BIL-C).
[i] Principles of Radiation Therapy (BIL-D).
[j] See NCCN Guidelines for Palliative Care.
[k] For locoregionally advanced disease, consider neoadjuvant systemic therapy to rule out rapid progression and avoid futile surgery. There are limited clinical trial data to define a standard regimen or definitive benefit. See Principles of Systemic Therapy (BIL-C).
[n] CEA and CA 19-9 are baseline tests and should not be done to confirm diagnosis.

Other Clinical Presentations
GALL-1, GALL-3, and GALL-5

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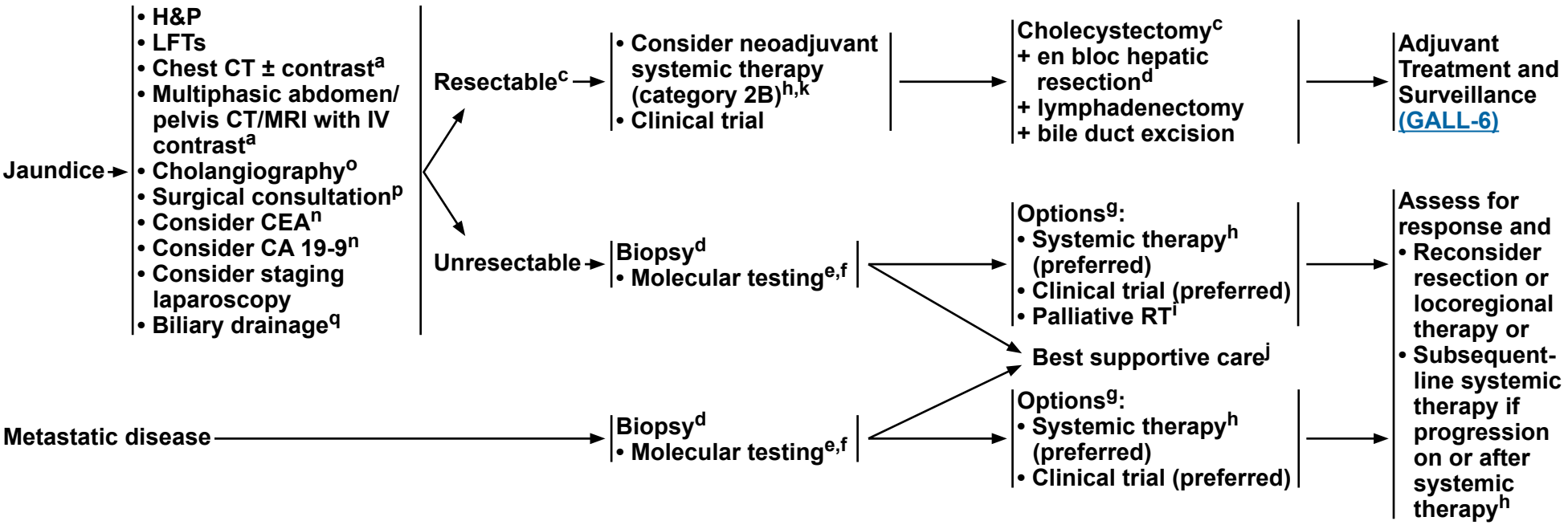
PRESENTATION AND WORKUP

PRIMARY TREATMENT



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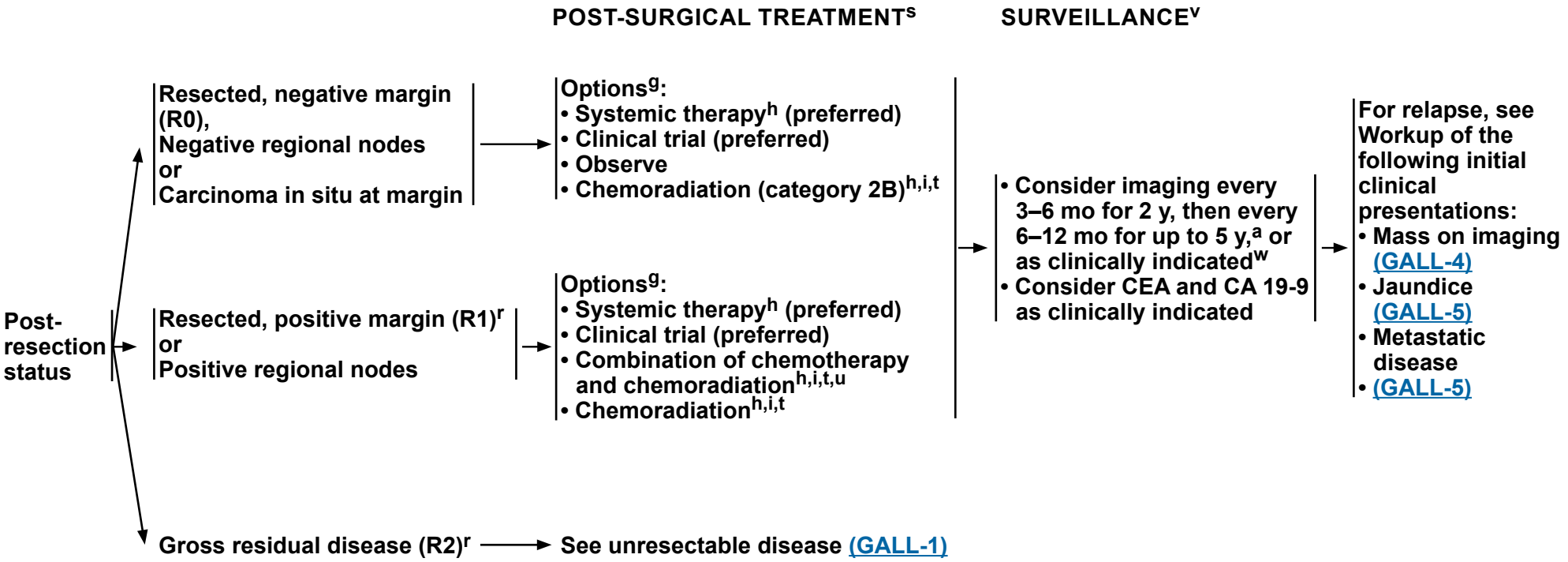
[i] Principles of Radiation Therapy (BIL-D).
[j] See NCCN Guidelines for Palliative Care.
[k] For locoregionally advanced disease, consider neoadjuvant systemic therapy to rule out rapid progression and avoid futile surgery. There are limited clinical trial data to define a standard regimen or definitive benefit. See Principles of Systemic Therapy (BIL-C).
[n] CEA and CA 19-9 are baseline tests and should not be done to confirm diagnosis.
[o] Magnetic resonance cholangiopancreatography (MRCP) is preferred. Endoscopic retrograde cholangiopancreatography/percutaneous transhepatic cholangiography (ERCP/PTC) are used more for therapeutic intervention.
[p] Consult with a multidisciplinary team.
[q] Consider biliary drainage for patients with jaundice prior to resection and systemic therapy. Consider baseline CA 19-9 after biliary decompression.

Other Clinical Presentations GALL-3 and GALL-4

Note: All recommendations are category 2A unless otherwise indicated.



[a] Principles of Imaging (BIL-A).
[g] Order does not indicate preference. The choice of treatment modality may depend on extent/location of disease and institutional capabilities.
[h] Principles of Systemic Therapy (BIL-C).
[i] Principles of Radiation Therapy (BIL-D).
[r] Management of disease in patients with R1 or R2 resections should be evaluated by a multidisciplinary team.
[s] Adjuvant chemotherapy or chemoradiation has been associated with survival benefit in patients with biliary tract cancer (BTC), especially in patients with lymph node-positive disease (Horgan AM, et al. J Clin Oncol 2012;30:1934-1940).
[t] There are limited clinical trial data to define a standard regimen or definitive benefit. Clinical trial participation is encouraged. (Macdonald OK, et al. Surg Oncol Clin N Am 2002;11:941-954).
[u] For a list of gemcitabine-based regimens and fluoropyrimidine-based regimens to be used before or after chemoradiation, see Adjuvant Chemotherapy (BIL-C, 1 of 5).
[v] There are no data to support a specific surveillance schedule or tests for monitoring. Physicians should discuss appropriate follow-up schedules/imaging with patients.
[w] Based on surveillance schedule used in the phase III BILCAP trial. Primrose JN, et al. Lancet Oncol 2019;20:663-673.

Note: All recommendations are category 2A unless otherwise indicated.

PRINCIPLES OF SURGERY

Incidental Finding of Suspicious Mass During Surgery:

- **If expertise is unavailable, document all relevant findings and refer the patient to a center with available expertise. If there is a suspicious mass, a biopsy is not necessary as this can result in peritoneal dissemination.**
- **If expertise is available and there is convincing clinical evidence of cancer, a definitive resection[a] can be performed as written below. If the diagnosis is not clear, frozen section biopsies can be considered in selected cases before proceeding with definitive resection. If malignancy is suspected or confirmed after cholecystectomy has been initiated and expertise is available, then definitive resection should be undertaken.**
- **If malignancy is suspected before cholecystectomy has begun and there is a question of resectability (ie, locally advanced, possible metastatic disease, other), then definitive resection can be postponed, regardless of available expertise, until complete staging and evaluation has been performed. Document all findings and consider biopsy[a] if chemotherapy is anticipated.**
- **The principles of resection are the same as below consisting of radical cholecystectomy including segments IV B and V and lymphadenectomy and extended hepatic or biliary resection as necessary to obtain a negative margin.**
- **Consider neoadjuvant systemic therapy for locoregionally advanced disease to rule out rapid progression and avoid futile surgery (biopsy required).**
- **Minimally invasive approaches by experienced surgeons have been proven to be safe and effective for well-selected cases.**

Incidental Finding on Pathologic Review:

- **Consider pathologic re-review by a hepatobiliary pathology expert[a] and/or speak to surgeon to check for completeness of cholecystectomy, signs of disseminated disease, location of tumor, and any other pertinent information. Review the pathology report for T stage, cystic duct margin status, and other margins.**
- **Diagnostic laparoscopy can be performed but is of relatively low yield. Higher yields may be seen in patients with T3 or higher tumors, poorly differentiated tumors, or with a margin-positive cholecystectomy. Diagnostic laparoscopy should also be considered in patients with any suspicion of metastatic disease on imaging that is not amenable to percutaneous biopsy.[1]**
- **Repeat cross-sectional imaging of the chest, abdomen, and pelvis should be performed prior to definitive resection.**
- **Initial exploration should rule out distant lymph node metastases in the celiac axis or aorto-caval groove as these contraindicate further resection.**
- **Hepatic resection[a] should be performed to obtain clear margins, which usually consists of segments IV B and V. Extended resections beyond segments IV B and V may be needed in some patients to obtain negative margins.**
- **Lymphadenectomy should be performed to clear all lymph nodes in the porta hepatis.**
- **Resection of the bile duct may be needed to obtain negative margins. Routine resection of the bile duct for lymphadenectomy has been shown to increase morbidity without convincing evidence for improved survival.[2,3]**
- **Port site resection has not been shown to be effective, as the presence of a port site implant is a surrogate marker of underlying disseminated disease and has not been shown to improve outcomes.[4]**
- **Consider neoadjuvant systemic therapy for locoregionally advanced disease to rule out rapid progression and avoid futile surgery.**

Footnote

[a] Principles of Pathology (GALL-B).

References

[1] Butte JM, Gonen M, Allen PJ, et al. The role of laparoscopic staging in patients with incidental gallbladder cancer. HPB (Oxford) 2011;13:463-472.
[2] Fuks D, Regimbeau JM, Le Treut YP, et al. Incidental gallbladder cancer by the AFC-GBC-2009 Study Group. World J Surg 2011;35:1887-1897.
[3] D'Angelica M, Dalal KM, Dematteo RP, et al. Analysis of extent of resection for adenocarcinoma of gallbladder. Ann Surg Oncol 2009;16:806-816.
[4] Maker AV, Butte JM, Oxenberg J, et al. Is port site resection necessary in the surgical management of gallbladder cancer. Ann Surg Oncol 2012;19:409-417.

Note: All recommendations are category 2A unless otherwise indicated.

PRINCIPLES OF SURGERY

Mass on Imaging: Patients Presenting with Gallbladder Mass/Disease Suspicious for Gallbladder Cancer

- **Staging should be carried out with multiphasic cross-sectional imaging of the liver with chest, abdomen, and pelvis CT.**
- **If there is a suspicious mass, a biopsy is not necessary and a definitive resection[a] should be carried out.**
- **Diagnostic laparoscopy is recommended prior to definitive resection.**
- **In selected cases where the diagnosis is not clear it may be reasonable to perform a cholecystectomy (including intraoperative frozen section) followed by the definitive resection during the same setting if pathology confirms cancer.**
- **The resection is carried out as per the principles described above.**
- **Consider neoadjuvant systemic therapy for locoregionally advanced disease to rule out rapid progression and avoid futile surgery (biopsy required).**

Gallbladder Cancer and Jaundice

- **The presence of jaundice in gallbladder cancer usually portends a poor prognosis.[5-7]**
- **Although a relative contraindication, in select patients curative intent resection[a] can be attempted for resectable disease in centers with available expertise.**
- **Consider neoadjuvant systemic therapy for locoregionally advanced disease to rule out rapid progression and avoid futile surgery.**

Footnote

[a] Principles of Pathology (GALL-B).

References

5 Hawkins WG, DeMatteo RP, Jarnagin WR, et al. Jaundice predicts advanced disease and early mortality in patients with gallbladder cancer. Ann Surg Oncol 2004;11:310-315.

6 Regimbeau JM, Fuks D, Bachellier P, et al. Prognostic value of jaundice in patients with gallbladder cancer by the AFC -GBC-2009 study group. Eur J Surg Oncol 2011;37:505-512.

7 Nishio H, Ebata T, Yokoyama Y, et al. Gallbladder cancer involving the extrahepatic bile duct is worthy of resection. Ann Surg 2011;253:953-960.

Note: All recommendations are category 2A unless otherwise indicated.

PRINCIPLES OF PATHOLOGY
GALLBLADDER CANCER APPROPRIATE FOR RESECTION

Staging for Diagnosis and Prognosis of Primary Gallbladder Cancer

Pathologic Staging

The following parameters should be reported for cancer with histopathologic type:

- **Reported parameters**
  - **Carcinoma in situ/high-grade dysplasia**
  - **Tumor depth of invasion into or through (T stage)**
    - ◊ **Lamina propria**
    - ◊ **Muscular layer**
    - ◊ **Perimuscular connective tissue on the peritoneal side and/or on the hepatic side**
    - ◊ **Serosa (visceral peritoneum)**
    - ◊ **Main portal vein or hepatic artery**
    - ◊ **Liver**
    - ◊ **Adjacent organ or structure, such as the stomach, duodenum, colon, pancreas, omentum, or extrahepatic bile ducts**
  - **Number of regional lymph nodes (N stage)**
  - **Distant organ (M stage)**
  - **Adequate sample**[1]
    - ◊ **Identify individual blocks containing malignant tissue and non-malignant tissue ideal for further testing**

If Adequate Sample Available

- **Histopathologic types of gallbladder carcinoma**[a,b]

- **Background liver disease and staging of fibrosis**
  - **Indicate the presence or absence of chronic liver disease (viral hepatitis, metabolic dysfunction-associated steatotic liver disease [MASLD], metabolic disorder, etc) either from the clinical history or histopathologic changes.**
  - **Report the degree of fibrosis and the presence or absence of cirrhosis.**

Footnotes

[a] Well-differentiated neuroendocrine tumor is not staged as a gallbladder carcinoma.

[b] For rare histologies with distinct systemic therapy options (such as pure neuroendocrine tumors or sarcomas), recommend treatment according to the relevant NCCN guideline for those tumor histologic types.

Reference

[1] College of American Pathologists. Protocol for the examination of specimens from patients with carcinoma of the gallbladder. 2021. Accessed January 2, 2024.

Note: All recommendations are category 2A unless otherwise indicated.

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NCCN Guidelines Version 2.2025
Intrahepatic Cholangiocarcinoma

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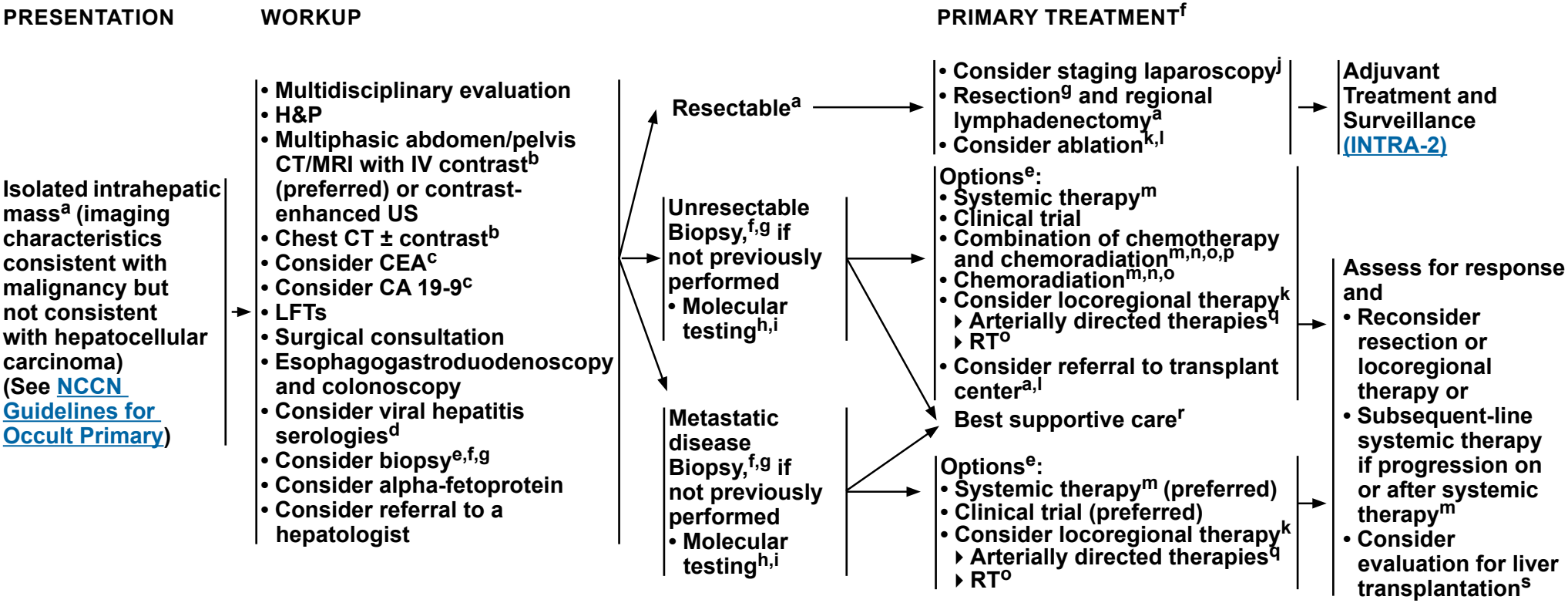

[a] Principles of Surgery (INTRA-A).
[b] Principles of Imaging (BIL-A).
[c] CEA and CA 19-9 are baseline tests and should not be done to confirm diagnosis.
[d] ASCO guidelines for management of viral hepatitis B virus in patients with cancer/receiving chemotherapy: Hwang JP, et al. J Clin Oncol 2020;38:3698-3715.
[e] Order does not indicate preference. The choice of treatment modality may depend on extent/location of disease and institutional capabilities.
[f] Principles of Mixed HCC-CCA (INTRA-B).
[g] Principles of Pathology (INTRA-C).
[h] For patients with dMMR/MSI-H tumors or a family history suggestive of *BRCA1/2* mutations, consider germline testing and/or referral to a genetic counselor.
[i] Principles of Molecular Testing (BIL-B).
[j] Laparoscopy may be done in conjunction with surgery if no distant metastases are found.
[k] Principles of Principles of Arterial/Locoregional Therapy for Intrahepatic Cholangiocarcinoma (INTRA-D).
[l] For small single tumors <3 cm.
[m] Principles of Systemic Therapy (BIL-C).
[n] There are limited clinical trial data to define a standard regimen or definitive benefit. Participation in clinical trials is encouraged (Macdonald OK, et al. Surg Oncol Clin N Am 2002;11:941-954).
[o] Principles of Radiation Therapy (BIL-D).
[p] For a list of gemcitabine-based regimens and fluoropyrimidine-based regimens to be used before or after chemoradiation, see Adjuvant Chemotherapy (BIL-C, 1 of 5).
[q] Hepatic arterial infusion chemotherapy (with or without systemic chemotherapy) may be used in a clinical trial or at experienced centers in carefully selected cases.
[r] See NCCN Guidelines for Palliative Care.
[s] Patients who meet the following criteria will be eligible for transplant exception points: biopsy-proven iCCA or mixed HCC-iCCA, presence of cirrhosis, unresectable, received locoregional or systemic therapy, and 6 months from time of diagnosis or last treatment with no new lesions or extrahepatic disease.

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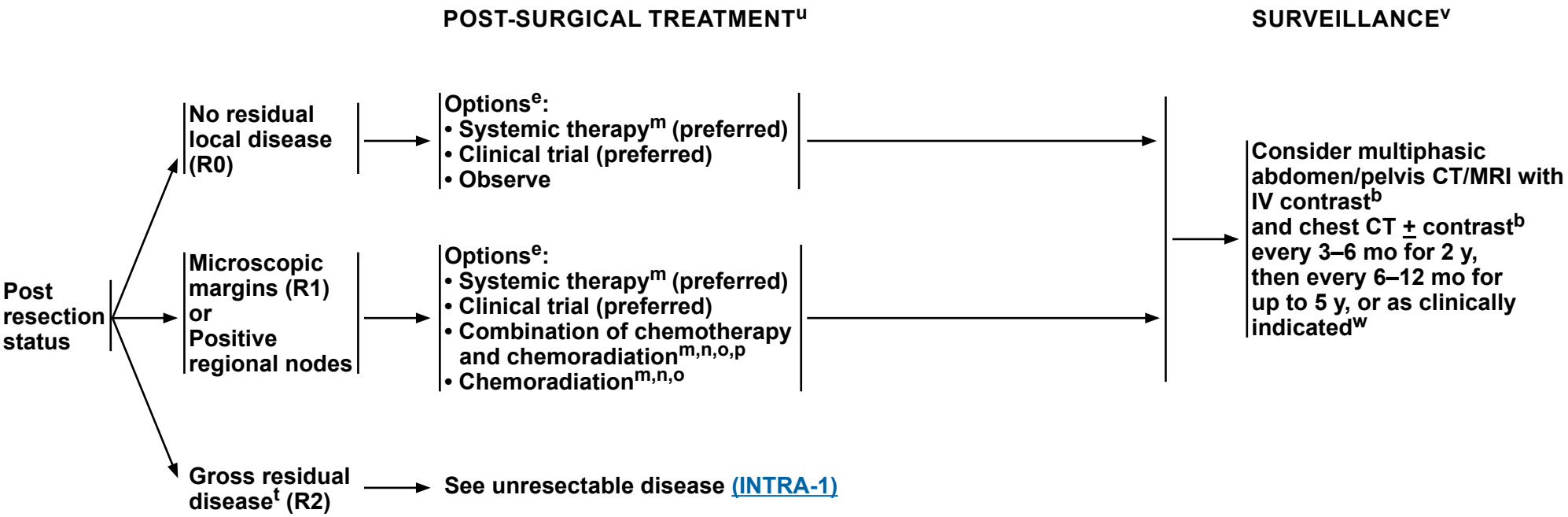

[b] Principles of Imaging (BIL-A).
[e] Order does not indicate preference. The choice of treatment modality may depend on extent/location of disease and institutional capabilities.
[m] Principles of Systemic Therapy (BIL-C).
[n] There are limited clinical trial data to define a standard regimen or definitive benefit. Clinical trial participation is encouraged (Macdonald OK, et al. Surg Oncol Clin N Am 2002;11:941-954).
[o] Principles of Radiation Therapy (BIL-D).
[p] For a list of gemcitabine-based regimens and fluoropyrimidine-based regimens to be used before or after chemoradiation, see Adjuvant Chemotherapy (BIL-C, 1 of 5).
[t] Consult with multidisciplinary team.
[u] Adjuvant chemotherapy or chemoradiation has been associated with survival benefit in patients with BTC, especially in patients with lymph node-positive disease (Horgan AM, et al. J Clin Oncol 2012;30:1934-1940).
[v] There are no data to support a specific surveillance schedule or tests for monitoring. Physicians should discuss appropriate follow-up schedules/imaging with patients.
[w] Based on surveillance schedule used in the phase III BILCAP trial. Primrose JN, et al. Lancet Oncol 2019;20:663-673.

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PRINCIPLES OF SURGERY[1,2]

General Principles

- **A preoperative biopsy is not always necessary before proceeding with a definitive, potentially curative resection. A suspicious mass on imaging in the proper clinical setting should be treated as malignant.**
- **Diagnostic laparoscopy to rule out unresectable disseminated disease should be considered.**
- **Initial exploration should assess for multifocal hepatic disease, lymph node metastases, and distant metastases. Lymph node metastases beyond the porta hepatis and distant metastatic disease contraindicate resection.**
- **Hepatic resection with negative margins is the goal of surgical therapy. While major resections are often necessary, wedge resections and segmental resections are all appropriate given that a negative margin can be achieved.**
- **A regional lymphadenectomy of the porta hepatis is carried out.**
- **Multifocal liver disease is generally representative of metastatic disease and is a contraindication to resection. In highly selected cases with limited multifocal disease resection can be considered.**
- **Gross lymph node metastases to the porta hepatis portend a poor prognosis and resection should only be considered in highly selected cases.**
- **Minimally invasive approaches by experienced surgeons have been proven to be safe and effective for well-selected cases.**

[1] Endo I, Gonen M, Yopp A. Intrahepatic cholangiocarcinoma: Rising frequency, improved survival and determinants of outcome after resection. Ann Surg 2008;248:84-96.
[2] de Jong MC, Nathan H, Sotiropoulos GC. Intrahepatic cholangiocarcinoma: an international multi-institutional analysis of prognostic factors and lymph node assessment. J Clin Oncol 2011;29:3140-3145.

Note: All recommendations are category 2A unless otherwise indicated.

PRINCIPLES OF MIXED HCC-CCA

An estimated 1% to 10% of patients with primary liver tumors are found to have a combination of both hepatocellular carcinoma (HCC) and cholangiocarcinoma (CCA) histologies on pathologic review.[1-4] In some cases, tumors may contain separate foci of both HCC and CCA histology in discrete areas of a tumor, while in other cases a tumor may be biphenotypic with expression of immunohistochemical markers associated independently with HCC and CCA but co-expressed on the same cells. Next-generation sequencing of mixed HCC-CCA suggests a higher prevalence of genomic aberrations more commonly associated with HCC than CCA (such as presence of *TP53* and *TERT* promoter mutations), particularly in patients with underlying hepatitis C virus infection, but interpretation of these results is limited by small sample sizes.[3,5]

Liver resection is considered the standard treatment for resectable mixed HCC-CCA.[6] Though prospective data are lacking, liver-directed local therapies may be appropriate for patients with a limited extent of unresectable hepatic disease, similar to management algorithms for HCC and intrahepatic CCA (See NCCN Guidelines for Hepatocellular Carcinoma and INTRA-1).

Patients with HCC-CCA that is limited in size based on center-specific criteria used should be considered for evaluation in a transplant center.

In patients with metastatic or locally-advanced recurrence after a prior resection or local therapies for mixed HCC-CCA, a repeat biopsy[a] should be considered to ascertain the dominant histology at recurrence. If the biopsy at recurrence suggests an isolated recurrence of either the HCC or CCA component, the Panel would consider a systemic therapy option appropriate for that histologic component.

Tumor molecular profiling should be considered in all patients with advanced stages of mixed HCC-CCA tumors to identify potential targetable aberrations, which may be associated with CCA (BIL-B, BIL-C).

For patients with histologic evidence of mixed HCC-CCA at advanced stages requiring systemic therapy, there are limited prospective data to guide the choice of regimen. A retrospective series of 101 patients with mixed HCC-CCA treated with systemic therapy demonstrated similar overall response rates for patients treated with chemotherapy versus non-chemotherapy-based systemic therapies; there was a trend towards longer median overall survival in patients treated with chemotherapy (15.5 vs. 5.3 months; *P* = .052).[7] Based upon these data as well as the potential for activity of component parts in both histologies, a regimen of gemcitabine plus cisplatin chemotherapy combined with either durvalumab or pembrolizumab immunotherapy is an appropriate choice for first-line therapy, noting that these combinations include agents with anti-tumor activity in both CCA[8-10] and HCC histologies.[11-14] At progression, molecularly-targeted therapies should be considered if the tumor harbors a targetable aberration. In the absence of a targetable aberration, regimens with demonstrated activity in both HCC and CCA are reasonable options, including the combination of nivolumab plus ipilimumab[15,16] or regorafenib.[17,18] A repeat biopsy at tumor progression may be warranted to reassess dominant histology of a progressing lesion, especially if there are discordant areas of response and progression and if the patient remains a candidate for further systemic therapy.

[a] Principles of Pathology (INTRA-C).

References on INTRA-B 2 of 2

Note: All recommendations are category 2A unless otherwise indicated.

PRINCIPLES OF MIXED HCC-CCA
REFERENCES

[1] Childs A, Zakeri N, Ma YT, et al. Biopsy for advanced hepatocellular carcinoma: Results of a multicentre UK audit. Br J Cancer 2021;125:1350-1355.
[2] Teufel A, Rodriguez I, Winzler C, et al. Clinical characterization of HCC/CCA mixed cancers in a population-based cohort. J Gastrointestin Liver Dis 2023;32:190-196.
[3] Raevskaya O, Appelman H, Razumilava N. A contemporary approach to diagnosis and treatment of combined hepatocellular-cholangiocarcinoma. Curr Hepatol Rep 2020;19:478-485.
[4] Tang Y, Wang L, Teng F, et al. The clinical characteristics and prognostic factors of combined hepatocellular carcinoma and cholangiocarcinoma, hepatocellular carcinoma and intrahepatic cholangiocarcinoma after surgical resection: A propensity score matching analysis. Int J Med Sci 2021;18:187-198.
[5] Joseph NM, Tsokos CG, Umetsu SE, et al. Genomic profiling of combined hepatocellular-cholangiocarcinoma reveals similar genetics to hepatocellular carcinoma. J Pathol 2019;248:164-178.
[6] Claasen MPAW, Ivanics T, Beumer BR, et al. An international multicentre evaluation of treatment strategies for combined hepatocellular-cholangiocarcinoma. JHEP Rep 2023;5:100745.
[7] Pomej K, Balcar L, Shmanko K, et al. Clinical characteristics and outcome of patients with combined hepatocellular-cholangiocarcinoma-a European multicenter cohort. ESMO Open 2023;8:100783.
[8] Kelley RK, Ueno M, Yoo C, et al. Pembrolizumab in combination with gemcitabine and cisplatin compared with gemcitabine and cisplatin alone for patients with advanced biliary tract cancer (KEYNOTE-966): a randomised, double-blind, placebo-controlled, phase 3 trial. Lancet 2023;401:1853-1865
[9] Oh DY, He AR, Qin S, et al. Durvalumab plus gemcitabine and cisplatin in advanced biliary tract cancer. NEJM Evid 2022;1:EVIDoa2200015.
[10] Valle J, Wasan H, Palmer DH, et al. Cisplatin plus gemcitabine versus gemcitabine for biliary tract cancer. N Engl J Med 2010;362:1273-1281.
[11] Abou-Alfa GK, Lau G, Kudo M, et al. Tremelimumab plus durvalumab in unresectable hepatocellular carcinoma. NEJM Evid 2022;1:EVIDoa2100070.
[12] Finn RS, Ryoo BY, Merle P, et al. Pembrolizumab as second-line therapy in patients with advanced hepatocellular carcinoma in KEYNOTE-240: A randomized, double-blind, phase III trial. J Clin Oncol 2020;38:193-202.
[13] Qin S, Chen Z, Fang W, et al. Pembrolizumab versus placebo as second-line therapy in patients from Asia with advanced hepatocellular carcinoma: A randomized, double-blind, phase III trial. J Clin Oncol 2023;41:1434-1443.
[14] Zhu AX, Finn RS, Edeline J, et al. Pembrolizumab in patients with advanced hepatocellular carcinoma previously treated with sorafenib (KEYNOTE-224): A non-randomised, open-label phase 2 trial. Lancet Oncol 2018;19:940-952.
[15] Yau T, Kang YK, Kim TY, et al. Efficacy and safety of nivolumab plus ipilimumab in patients with advanced hepatocellular carcinoma previously treated with sorafenib: The checkmate 040 randomized clinical trial. JAMA Oncol 2020;6:e204564.
[16] Klein O, Kee D, Nagrial A, et al. Evaluation of combination nivolumab and ipilimumab immunotherapy in patients with advanced biliary tract cancers: Subgroup analysis of a phase 2 nonrandomized clinical trial. JAMA Oncol 2020;6:1405-1409.
[17] Bruix J, Qin S, Merle P, et al. Regorafenib for patients with hepatocellular carcinoma who progressed on sorafenib treatment (RESORCE): A randomised, double-blind, placebo-controlled, phase 3 trial. Lancet 2017;389:56-66.
[18] Sun W, Patel A, Normolle D, et al. A phase 2 trial of regorafenib as a single agent in patients with chemotherapy-refractory, advanced, and metastatic biliary tract adenocarcinoma. Cancer 2019;125:902-909.

Note: All recommendations are category 2A unless otherwise indicated.

PRINCIPLES OF PATHOLOGY

Intrahepatic Cholangiocarcinoma Appropriate for Biopsy

Histologic confirmation of primary hepatic malignancy with cholangiocyte differentiation

- **Establish cholangiocyte differentiation by histology and if appropriate supported by immunohistochemical and albumin in-situ hybridization studies. There is overlap in the immunohistochemistry (IHC) profiles of these malignancies.**
- **Report the presence of small vessel invasion, undifferentiated/poor differentiation, and associated component of hepatocyte differentiation (possible combined hepatocellular cholangiocarcinoma).**

Intrahepatic Cholangiocarcinoma Undergoing Resection

Staging for diagnosis and prognosis of intrahepatic cholangiocarcinoma
These features support but do not definitively lead to a clinical diagnosis.
The following parameters should be reported for cancer with cholangiocyte differentiation[a]:

- **Reported parameters**
  - **Carcinoma in situ/high-grade dysplasia**
  - **Number and size of tumor(s) (T stage)**
  - **Number of regional lymph nodes[b] evaluated and infiltrated with malignancy (N stage)**
  - **Metastatic disease (M stage)**
  - **Histologic differentiation**
  - **Vascular invasion**
  - **Perineural invasion**
  - **Resection margin status**
  - **Cancer perforation of visceral peritoneum or direct invasion into adjacent extrahepatic structures.**
  - **If adequate sampling: Identify individual blocks containing malignant tissue and non-malignant tissue ideal for further testing.**

If adequate sample available

- **Histopathologic types of primary carcinomas of the intrahepatic bile ducts[c,d]**

- **Evaluation of Nontumor Liver Parenchyma**
  - **Indicate the presence or absence of chronic liver disease (viral hepatitis, MASLD, metabolic disorder, etc) either from the clinical history or histopathologic changes.**
  - **Report the degree of fibrosis and the presence or absence of cirrhosis.**

[a] Perihilar bile duct cancer, gallbladder and HCC have separate staging.
[b] Regional lymph nodes include those associated with the hilar hepatic artery, portal vein and cystic duct, inferior phrenic, gastrohepatic, periduodenal, and peripancreatic regions.
[c] Mass-forming type of bile duct cancer is a multinodular distinct mass of cholangiocytes forming malignant glands in a sclerotic stroma and well demarcated boarders. Periductal growth type is characterized by poorly defined borders and a linear growth pattern likely along a intermediate or larger native bile duct.
[d] For rare histologies with distinct systemic therapy options (such as pure neuroendocrine tumors or sarcomas), recommend treatment according to the relevant NCCN guideline for those tumor histologic types.

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PRINCIPLES OF ARTERIAL/LOCOREGIONAL THERAPY FOR INTRAHEPATIC CHOLANGIOCARCINOMA

Patients with intrahepatic CCA should be evaluated for potentially curative therapies (resection and for small lesions, ablation). Locoregional treatment may be considered in patients who are not candidates for surgical curative therapies or to downstage for other treatments.[1] Locoregional therapies are broadly categorized into ablation, arterially directed therapies, and RT.

Ablation

- **All tumors should be amenable to complete ablation so that the tumor and a margin of normal tissue up to 1 cm can be treated.**
- **For small single tumors <3 cm, whether recurrent or primary, thermal ablation is a reasonable alternative to surgical resection, particularly in patients with high-risk disease.[2-4]**
- **Options for ablation include radiofrequency ablation, microwave ablation, and irreversible electroporation.**

Arterially directed therapies

- **Hepatic tumors may be amenable to arterially directed therapies provided the supply to tumor may be isolated without excessive non-target treatment.**
- **Select patients with limited extrahepatic disease (hilar lymph node ≤3 cm or ≤5 lung nodules each ≤1 cm) may be considered for arterially directed therapy in combination with systemic therapy.**
- **Arterially directed therapies include transarterial embolization, transarterial chemoembolization (TACE), TACE with drug-eluting beads, and Y90.[5,6]**
- **Arterially directed therapies may be used alone or followed by systemic chemotherapy with the intention to prolong survival or downstage to curative resection.[7,8]**
- **When treating with Y90, personalized dosimetry/radiation segmentectomy to achieve >205 Gy to tumor may improve outcome.[9]**
- **Y90 is relatively contraindicated in patients with bilirubin >3 mg/dL. With well-selected patients, grade 3–4 hepatic toxicity occurs in <10% of patients, although this may be significantly higher in patients with cirrhosis.**
- **Hepatic arterial infusion chemotherapy (with or without systemic chemotherapy) may be used in a clinical trial or at experienced centers in carefully selected cases.**

[1] Bridgewater J, Galle PR, Khan SA, et al. Guidelines for the diagnosis and management of intrahepatic cholangiocarcinoma. J Hepatol 2014;60:1268-1289.
[2] Kim GH, Kim PH, Kim JH, et al. Thermal ablation in the treatment of intrahepatic cholangiocarcinoma: A systematic review and meta-analysis. Eur Radiol 2022;32:1205-1215.
[3] Edeline J, Lamarca A, McNamara MG, et al. Locoregional therapies in patients with intrahepatic cholangiocarcinoma: A systematic review and pooled analysis. Cancer Treat Rev 2021;99:102258.
[4] Han K, Ko HK, Kim KW, et al. Radiofrequency ablation in the treatment of unresectable intrahepatic cholangiocarcinoma: Systematic review and meta-analysis. J Vasc Interv Radiol 2015;26:943-948.
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[6] Schartz DA, Porter M, Schartz E, et al. Transarterial yttrium-90 radioembolization for unresectable intrahepatic cholangiocarcinoma: A systematic review and meta-analysis. J Vasc Interv Radiol 2022;33:679-686.
[7] Edeline J, Tochefeu Y, Guiu B, et al. Radioembolization plus chemotherapy for first-line treatment of locally advanced intrahepatic cholangiocarcinoma. JAMA Oncol 2020;6:51-59.
[8] Ahmed O, Yu Q, Patel M, et al. Yttrium-90 radioembolization and concomitant systemic gemcitabine, cisplatin, and capecitabine as the first-line therapy for locally advanced intrahepatic cholangiocarcinoma. J Vasc Interv Radiol 2023;34:702-709.
[9] Paz-Fumagalli R, Core J, Padula C, et al. Safety and initial efficacy of ablative radioembolization for the treatment of unresectable intrahepatic cholangiocarcinoma. Oncotarget 2021;12:2075-2088.

Note: All recommendations are category 2A unless otherwise indicated.

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Extrahepatic Cholangiocarcinoma

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PRESENTATION AND WORKUP

- Pain
- Jaundice
- Abnormal LFTs
- Obstruction or abnormality on imaging

→

- Multidisciplinary evaluation
- H&P
- Multiphasic abdomen/pelvis CT/MRI (assess for vascular invasion) with IV contrast[a,b]
- Chest CT ± contrast[a,b]
- Biliary protocol imaging[a,b]
- Cholangiography[c]
- Consider CEA[d]
- Consider CA 19-9[d]
- LFTs
- Consider endoscopic ultrasound (EUS) after surgical consultation
- Consider serum IgG4 to rule out IgG4-related sclerosing cholangitis[e]

PRIMARY TREATMENT

Resectable[f] →
- Surgical exploration[h]
- Consider laparoscopic staging
- Consider preoperative biliary drainage[a]

→ **Resectable[f]** → **Resection[f,j]** → **Adjuvant Treatment and Surveillance (EXTRA-2)**

→ **Unresectable, see below**

Unresectable[g] →
- Biliary drainage,[a,i] if indicated
- Biopsy[g,j] (only after determining transplant status)
  - Molecular testing[k,l]
- Consider referral to transplant center

→ **Options[m]:**
- Systemic therapy[n]
- Clinical trial
- Combination of chemotherapy and chemoradiation[n,o,p,q]
- Chemoradiation[n,o,q]
- Palliative RT[q]

→ **Best supportive care[r]**

Metastatic disease →
- Biliary drainage,[a,i] if indicated
- Biopsy[j]
  - Molecular testing[k,l]

→ **Options[m]:**
- Systemic therapy[n]
- Clinical trial

→ **Assess for response and**
- Reconsider resection or locoregional therapy or
- Subsequent-line systemic therapy if progression on or after systemic therapy[n]

[a] Principles of Imaging (BIL-A).
[b] Imaging evaluation for suspected extrahepatic CCA is ideally performed prior to biliary decompression to facilitate accurate local staging for surgical candidacy.
[c] MRCP is preferred. ERCP/PTC are used more for therapeutic intervention.
[d] CEA and CA 19-9 are baseline tests and should not be done to confirm diagnosis.
[e] Patients with IgG-4–related cholangiopathy should be referred to an expert center.
[f] Principles of Surgery (EXTRA-A).
[g] Before biopsy, evaluate if patient is a resection or transplant candidate. If patient is a potential transplant candidate, consider referral to transplant center before biopsy. Importantly, transperitoneal and surgical biopsy may be contraindicated in transplant candidates. Unresectable perihilar or hilar CCAs that measure ≤3 cm in radial diameter, with the absence of intrahepatic or extrahepatic metastases and without nodal disease, as well as those with primary sclerosing cholangitis, may be considered for liver transplantation at a transplant center that has an UNOS-approved protocol for transplantation of CCA.
[h] Surgery may be performed when index of suspicion is high; biopsy is not required.
[i] Consider biliary drainage for patients with jaundice prior to instituting systemic therapy. Consider baseline CA 19-9 after biliary decompression.
[j] Principles of Pathology (EXTRA-B).
[k] For patients with dMMR/MSI-H tumors or a family history suggestive of *BRCA1/2* mutations, consider germline testing and/or referral to a genetic counselor.
[l] Principles of Molecular Testing (BIL-B).
[m] Order does not indicate preference. The choice of treatment modality may depend on extent/location of disease and institutional capabilities.
[n] Principles of Systemic Therapy (BIL-C).
[o] There are limited clinical trial data to define a standard regimen or definitive benefit. Clinical trial participation is encouraged (Macdonald OK, et al. Surg Oncol Clin N Am 2002;11:941-954).
[p] For a list of gemcitabine-based regimens and fluoropyrimidine-based regimens to be used before or after chemoradiation, see Adjuvant Chemotherapy (BIL-C, 1 of 5).
[q] Principles of Radiation Therapy (BIL-D).
[r] See NCCN Guidelines for Palliative Care.

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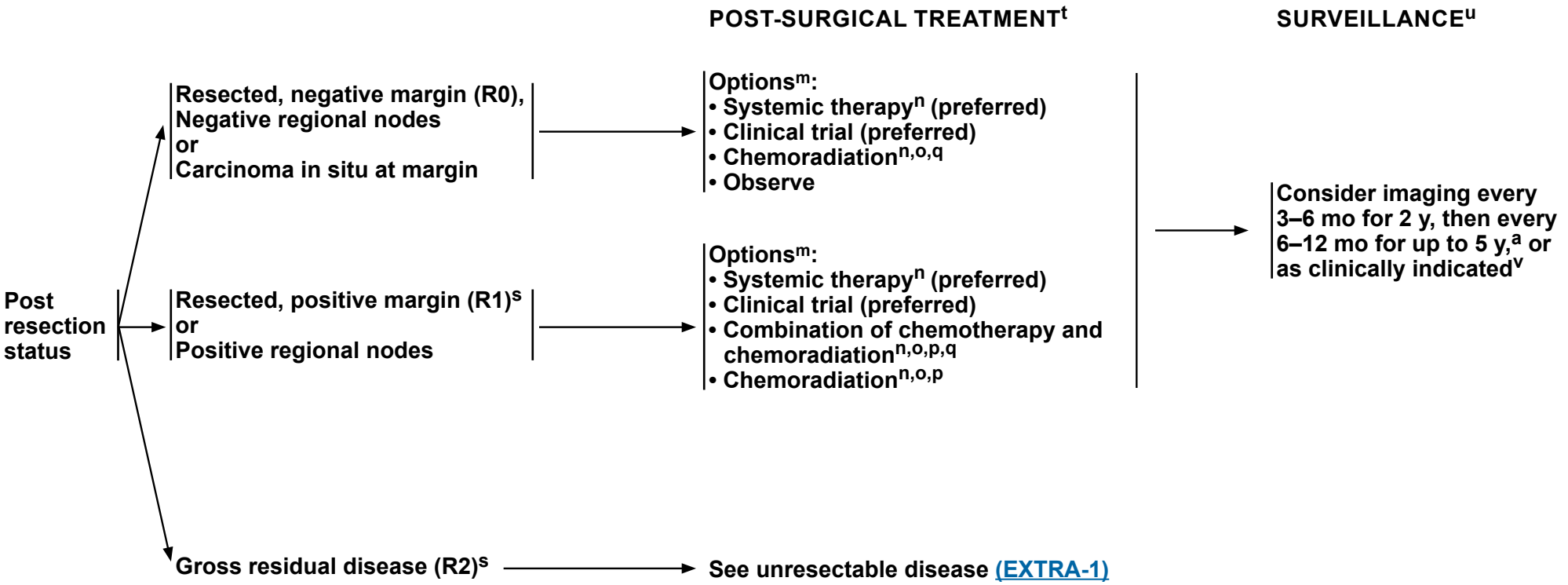

[a] Principles of Imaging (BIL-A).
[m] Order does not indicate preference. The choice of treatment modality may depend on extent/location of disease and institutional capabilities.
[n] Principles of Systemic Therapy (BIL-C).
[o] There are limited clinical trial data to define a standard regimen or definitive benefit. Clinical trial participation is encouraged (Macdonald OK, et al. Surg Oncol Clin N Am 2002;11:941-954).
[p] For a list of gemcitabine-based regimens and fluoropyrimidine-based regimens to be used before or after chemoradiation, see Adjuvant Chemotherapy (BIL-C, 1 of 5).
[q] Principles of Radiation Therapy (BIL-D).
[s] Management of disease in patients with R1 or R2 resections should be evaluated by a multidisciplinary team.
[t] Adjuvant chemotherapy or chemoradiation has been associated with survival benefit in patients with BTC, especially in patients with lymph node-positive disease (Horgan AM, et al. J Clin Oncol 2012;30:1934-1940).
[u] There are no data to support a specific surveillance schedule or tests for monitoring. Physicians should discuss appropriate follow-up schedules/imaging with patients.
[v] Based on surveillance schedule used in the phase III BILCAP trial. Primrose JN, et al. Lancet Oncol 2019;20:663-673.

Note: All recommendations are category 2A unless otherwise indicated.

PRINCIPLES OF SURGERY

General Principles

- **The basic principle is a complete resection with negative margins and regional lymphadenectomy. This generally requires a pancreaticoduodenectomy for distal bile duct tumors and a major hepatic resection for hilar tumors. Rarely, a mid bile duct tumor can be resected with a bile duct resection and regional lymphadenectomy.**
- **A preoperative biopsy is not always necessary before proceeding with a definitive, potentially curative resection. A suspicious mass on imaging in the proper clinical setting should be treated as malignant.**
- **Diagnostic laparoscopy should be considered.**
- **Occasionally a bile duct tumor will involve the biliary tree over a long distance such that a hepatic resection and pancreaticoduodenectomy will be necessary. These are relatively morbid procedures and should only be carried out in very healthy patients without significant comorbidity. Nonetheless, these can be potentially curative procedures and should be considered in the proper clinical setting. Combined liver and pancreatic resections performed to clear distant nodal disease are not recommended.**

Hilar Cholangiocarcinoma

- **Detailed descriptions of imaging assessment of resectability are beyond the scope of this outline. The basic principle is that the tumor will need to be resected along with the involved biliary tree and the involved hemi-liver with a reasonable chance of a margin-negative resection. The contralateral liver requires intact arterial and portal inflow as well as biliary drainage.[1-3]**
- **Detailed descriptions of preoperative surgical planning are beyond the scope of this outline but require an assessment of the future liver remnant (FLR). This requires an assessment of biliary drainage and volumetrics of the FLR. While not necessary in all cases, the use of preoperative biliary drainage of the FLR and contralateral portal vein embolization should be considered in cases of a small FLR.[4,5]**
- **Initial exploration rules out distant metastatic disease to the liver, peritoneum, or distant lymph nodes beyond the porta hepatis as these findings contraindicate resection. Further exploration must confirm local resectability.**
- **Since hilar tumors, by definition, abut or invade the central portion of the liver they require major hepatic resections on the involved side to encompass the biliary confluence and generally require a caudate resection.**
- **Resection and reconstruction of the portal vein and/or hepatic artery may be necessary for complete resection and require expertise in these procedures.**
- **Biliary reconstruction is generally through a Roux-en-Y hepaticojejunostomy.**
- **A regional lymphadenectomy of the porta hepatis is carried out.**
- **Frozen section assessment of proximal and distal bile duct margins is recommended if further resection can be carried out.**

Distal Cholangiocarcinoma

- **Initial assessment is needed to rule out distant metastatic disease and local resectability.**
- **The operation generally requires a pancreaticoduodenectomy with typical reconstruction.**

[1] Nishio H, Nagino M, Nimura Y. Surgical management of hilar cholangiocarcinoma: the Nagoya experience. HPB (Oxford) 2005;7:259-262.
[2] Matsuo K, Rocha FG, Ito K, et al. The Blumgart preoperative staging system for hilar cholangiocarcinoma: analysis of resectability and outcomes in 380 patients. J Am Coll Surg 2012;215:343-355.
[3] Jarnagin WR, Fong Y, DeMatteo RP, et al. Staging, resectability, and outcome in 225 patients with hilar cholangiocarcinoma. Ann Surg 2001;234:507-517.
[4] Nimura Y. Preoperative biliary drainage before resection for cholangiocarcinoma. HPB (Oxford) 2008;10:130-133.
[5] Kennedy TJ, Yopp A, Qin Y, et al. Role of preoperative biliary drainage of live remnant prior to extended liver resection for hilar cholangiocarcinoma. HPB (Oxford) 2009;11:445-451.

Note: All recommendations are category 2A unless otherwise indicated.

PRINCIPLES OF PATHOLOGY

Extrahepatic Cholangiocarcinoma Appropriate for Biopsy

Histologic confirmation of primary hepatic malignancy with cholangiocyte differentiation

- **Establish cholangiocyte differentiation by histology and if appropriate supported by immunohistochemical and albumin in-situ hybridization studies.**
- **Report the presence of small vessel invasion and undifferentiated/poor differentiation.**

Extrahepatic Cholangiocarcinoma Undergoing Resection

Staging for diagnosis and prognosis of primary hepatic malignancy

Pathologic staging

The following parameters should be reported for cancer with histopathologic type: perihilar, Klatskin type, and distal bile duct cancers have separate staging parameters. Perihilar tumors are defined by a tumor arising in the main lobar ducts in the extrahepatic biliary system proximal to the cystic duct. Extrahepatic bile duct cancers are defined as tumors arising in the extrahepatic biliary tree between the confluence of the cystic duct and common hepatic duct and the Ampulla of Vater. Tumors of the Ampulla of Vater (hepatopancreatic ampulla) are staged separately.

- **Reported Parameters**
  - **Perihilar bile duct**
    - ◊ **Carcinoma in situ/high-grade dysplasia**
    - ◊ **Tumor extent (T stage)**
      - – **Confined to the bile duct**
      - – **Tumor depth of invasion into or through**
        - ▪ **Bile duct muscle layer or fibrous tissue**
        - ▪ **Bile duct wall**
        - ▪ **Surrounding adipose tissue**
        - ▪ **Adjacent hepatic parenchyma**
        - ▪ **Uni- or bilateral branches of the portal vein or hepatic artery**
        - ▪ **Main portal vein**
        - ▪ **Second-order biliary radicals with contralateral portal vein or hepatic artery involvement**
  - **Extrahepatic bile duct**
    - ◊ **Carcinoma in situ/high-grade dysplasia**
    - ◊ **Depth of tumor invasion into the bile duct wall less than 5 mm 5–12 mm greater than 12 mm**
    - ◊ **Tumor involves the celiac axis, superior mesenteric artery, and/or common hepatic artery**
  - **Number of regional lymph nodes (N stage)**
  - **Distal organ metastasis (M stage)**
  - **If adequate sampling: Identify individual blocks containing malignant tissue and non-malignant tissue ideal for further testing.**

If adequate sample available

- **Histopathologic types of extrahepatic cholangiocarcinoma[a,b]**

- **Background liver disease**
  - **Indicate the presence or absence of chronic liver disease (viral hepatitis, MASLD, metabolic disorder, etc) either from the clinical history or histopathologic changes.**
  - **Report the degree of fibrosis and the presence or absence of cirrhosis.**

[a] Well-differentiated neuroendocrine tumor is not staged as a extrahepatic biliary carcinoma.
[b] For rare histologies with distinct systemic therapy options (such as pure neuroendocrine tumors or sarcomas), recommend treatment according to the relevant NCCN Guideline for those tumor histologic types.

Note: All recommendations are category 2A unless otherwise indicated.

PRINCIPLES OF IMAGING[1-4]

General Principles

- **CT of the chest with or without contrast and multiphasic contrast-enhanced CT or MRI of the abdomen and pelvis are recommended for follow-up imaging.**
- **PET/CT has limited sensitivity but high specificity and may be considered when there is an equivocal finding or on a case-by-case basis.[5] The routine use of PET/CT in the preoperative setting has not been established in prospective trials.**

Gallbladder Cancer

- **Detection of early-stage gallbladder cancer remains difficult, and is commonly discovered incidentally at surgery or pathologic examination of the gallbladder.**
- **If gallbladder cancer is suspected preoperatively, multiphase CT of the abdomen (and pelvis) or contrast-enhanced MRI with magnetic resonance cholangiopancreatography (MRCP) of the abdomen (and pelvis) and chest CT with or without contrast should be performed. MRI is preferred for evaluating masses within the gallbladder and demonstrating bile duct involvement.**
- **Because lymphatic spread is common, careful attention should be made to evaluate nodal disease, specifically the porta hepatis and left gastric and aorto-caval basins.**

Intrahepatic[6] and Extrahepatic Cholangiocarcinoma

- **Surgical management is based on the location and extent of the tumor.**
- **Preoperative imaging for accurate staging of extrahepatic CCA should be done with multidetector multiphasic abdomen/pelvis CT or MRI. Contrast-enhanced MRI with MRCP is preferred for evaluating the extent of biliary tract involvement. Imaging with multiphasic CT or MRI with thin cuts, or multiphase CT or MRI of the liver and biliary tree should specifically address the anatomy of the biliary tree, hepatic arteries, and portal veins and their relationship to the tumor.[7]**
- **Chest CT with or without contrast is recommended for staging.**
- **When biliary duct involvement is suspected, it is very important to obtain high-quality biliary protocol imaging (preferably CT) to evaluate the extent of tumor prior to stenting. Reactive changes from stenting could potentially compromise the ability to delineate the complete extent of biliary tract involvement.**
- **EUS or ERCP may be helpful in the setting of bile duct dilation if no mass is seen on CT or MRI. EUS or ERCP can also be used to establish tissue diagnosis and provide access to relieve biliary obstruction.**
- **CT of the chest with or without contrast and CT or MRI of the abdomen and pelvis with contrast may be used for follow-up.**
- **Delayed phase imaging is preferred when the diagnosis of intrahepatic CCA is suspected or confirmed.**

Biliary Drainage

- **Multidisciplinary discussion of drainage is recommended, especially in patients with potentially resectable disease.**
- **Route (percutaneous vs. endoscopic) should be considered based on local expertise after multidisciplinary review.**
- **All segments that are opacified should be drained, with the aim to drain >50% of the viable liver volume, including the future liver remnant. Atrophic liver segments, in general, should not be drained.**

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Note: All recommendations are category 2A unless otherwise indicated.

PRINCIPLES OF MOLECULAR TESTING

- **Biliary tract cancers (BTCs) are known to harbor clinically relevant molecular alterations that are differentially expressed in gallbladder cancers, and intrahepatic and extrahepatic (perihilar and distal) CCAs. Specifically, genotyping of the tumor tissue has identified translocations in *FGFR2* and *NTRK*, mutations in the *IDH1* and *BRAF* genes, and microsatellite instability (MSI) along with other rare molecular alterations for which specific treatments are now available.[1-22]**

- **Additionally, while most biliary tract carcinomas are considered sporadic, up to 10%–15% of BTCs may be associated with an inherited cancer predisposition syndrome.[23,24] Recent studies have evaluated germline mutation testing in large cohorts of unselected patients with biliary tract carcinoma and discovered high to moderate penetrance deleterious germline mutations in roughly 9% to 11% of BTCs, including intrahepatic/extrahepatic CCAs and gallbladder carcinomas.[23,25] The highest prevalence was found for *BRCA2* mutation followed by *BRCA1* and to a lesser extent *MLH1*, *MSH2*, *PALB2*, *RAD51D*, *BAP1,* and *ATM* mutations.[23,25,26] These findings are consistent with earlier literature suggesting an increased risk of BTC in patients with *BRCA* mutations and Lynch syndrome.[27,28]**

Recommendations

- **Molecular profiling in BTCs: Comprehensive molecular profiling is recommended for patients with unresectable or metastatic BTC who are candidates for systemic therapy (see Table 1 and Table 2). A comprehensive panel including the targets listed in Table 1 may optimize the chance of identifying a targetable aberration. If tissue is too scant or not available, consider repeat biopsy depending on tumor accessibility, safety, and clinical context. A cell-free DNA (cfDNA) test may also be considered for identifying gene mutations. This technique may not reliably identify gene fusions or rearrangements depending on the panel used and the specific partner gene.**

- **Germline testing in hepatobiliary cancers: Evidence remains insufficient for definitive recommendations regarding specific criteria to guide genetic risk assessment in hepatobiliary cancers or for universal germline testing in these tumors. In BTCs, genetic counseling referral and potential germline testing should be considered in patients with any of the following characteristics: young age at diagnosis; a strong personal or family history of cancer; no known risk factors for liver disease; or presence of mutations identified during tumor testing that are suspected to be possible germline alterations. For patients who harbor a known germline mutation associated with a cancer predisposing syndrome (ie, Lynch syndrome or hereditary breast and ovarian cancer syndrome), there is currently insufficient evidence to support screening for biliary tract malignancies. Further recommendations and a detailed discussion of genetic counseling and testing can be found in the NCCN Guidelines for Genetic/Familial High-Risk Assessment: Breast, Ovarian, Pancreatic, and Prostate and NCCN Guidelines for Genetic/Familial High-Risk Assessment: Colorectal, Endometrial, and Gastric.**

References on BIL-B 7 of 8

Note: All recommendations are category 2A unless otherwise indicated.

PRINCIPLES OF MOLECULAR TESTING

Table 1: Recommendations for Molecular Testing in Unresectable or Metastatic Biliary Tract Cancers[a-d]

Recommended Molecular Testing	Anatomic Subsite		
	Gallbladder	Intrahepatic CCA	Extrahepatic CCA
***NTRK* gene fusion**	X	X	X
MSI-H/dMMR	X	X	X
TMB-H	X	X	X
***BRAF* V600E mutation**	X	X	X
***FGFR2* fusion or rearrangement**	–	X	X
***IDH1* mutation**	–	X	X
HER2 *(ERBB2)* overexpression and/or amplification	X	X	X
***RET* gene fusion**	X	X	X
***KRAS* G12C mutation**	X	X	X

MSI-H: microsatellite instability-high
dMMR: mismatch repair deficient
TMB-H: tumor mutational burden-high

[a] Consider repeat biopsy or performing cfDNA analysis if initial biopsy sample yields insufficient tumor content, depending on clinical context.
[b] If unsure about the primary anatomic site within the biliary tree, comprehensive testing is recommended, including consideration of *FGFR2* fusion or rearrangement testing and *IDH1* mutation testing in gallbladder cancer or in large tumors of uncertain anatomic origin within the biliary tree.
[c] Testing for *FGFR2* fusions or rearrangements and *IDH1* mutations should be considered in patients with unresectable or metastatic gallbladder cancer.
[d] Genetic counseling referral and germline testing should be considered in patients with any of the following characteristics: young age at diagnosis; a strong personal or family history of cancer; no known risk factors for liver disease; or presence of mutations identified during tumor testing that are suspected to be possible germline alterations.

Note: All recommendations are category 2A unless otherwise indicated.

PRINCIPLES OF MOLECULAR TESTING

Table 2: Incidence of Therapeutic Targets in Advanced Biliary Tract Cancers

Aberration	Approximate Incidence[e]
***NTRK* fusion**	**<1%**
MSI-H/dMMR	**1%–3%**
TMB-H	**<5%**
***BRAF* V600E mutation**	**1%–5%**
***FGFR2* fusion or rearrangement**	**9%–15% of intrahepatic CCAs and rare in other subsites**
***IDH1* mutation**	**10%–20% of intrahepatic CCAs and rare in other subsites**
HER2 (*ERBB2*) overexpression and/or amplification	**5%–20% of CCAs, 15%–30% of gallbladder cancer**
***RET* fusion**	**<1%**
***KRAS* G12C mutation**	**1%**

[e] The rarity of individual subgroups limits precise incidence and frequency estimates. Incidence estimates refer to BTCs across anatomic subsites, unless otherwise stated.

Note: All recommendations are category 2A unless otherwise indicated.

PRINCIPLES OF MOLECULAR TESTING

NTRK Fusions

- **Testing Modalities and Considerations: Multi-gene next-generation sequencing (NGS) testing, preferably with a transcriptome-based approach, is the preferred assay given the rarity of *NTRK* fusions in BTCs.**

- **Recommendation: Testing for *NTRK* fusions is recommended for patients with unresectable or metastatic gallbladder cancer, intrahepatic CCA, or extrahepatic CCA. These assessments are feasible in the context of multi-target assessment in NGS gene panels currently in clinical use and *NTRK* fusion-positive CCA have demonstrated responses in clinical trials.**

Immunotherapy Biomarkers (MSI-H/dMMR/TMB-H, PD-L1)

- **Testing Modalities and Considerations: There are three possible tests to evaluate mismatch repair (MMR) protein deficiency or microsatellite status. First, immunohistochemical staining for the *MLH1*, *MSH2*, *MSH6*, and *PMS2* gene products establishes protein retention or loss. If all 4 proteins are retained, it is unlikely the sample will display high rates of DNA mutations in microsatellite regions. Loss of two of the four proteins (typical in MLH1/PMS2 and MSH2/MSH6 pairs) correlates with MSI or MSI-H. Second, NGS determines if there are inactivating mutations in the MMR genes: *MLH1*, *MSH2*, *MSH6*, and *PMS2*. Mutations associated with nonfunctional MMR proteins correlate with MSI-H status. Last, microsatellite repeats of tumor DNA are examined by polymerase chain reaction (PCR). Abnormal microsatellites in two or more regions demonstrates MSI-H status. Tumor mutational burden (TMB) can be tested with a clinically validated NGS panel but has inherent platform variation.**

- **Recommendation: Testing for MSI or MMR deficiency is recommended in patients with unresectable or metastatic gallbladder cancer, intrahepatic CCA, or extrahepatic CCA.**

- **Testing for TMB is recommended for patients with unresectable or metastatic gallbladder cancer, intrahepatic CCA, or extrahepatic CCA based upon clinical benefit observed across advanced solid tumors.**

- **Further recommendations for MSI/MMR testing can be found in the NCCN Guidelines for Colon Cancer.**

Note: All recommendations are category 2A unless otherwise indicated.

PRINCIPLES OF MOLECULAR TESTING

BRAF V600E Mutations

- **Testing Modalities and cfDNA Considerations: NGS or PCR testing of tumor tissue; NGS of cfDNA can also detect tumor *BRAF* mutations.**
- **Recommendation: Testing for *BRAF* V600E mutations is recommended for patients with unresectable or metastatic gallbladder cancer, intrahepatic CCA, or extrahepatic CCA.**

FGFR2 Fusions/Other *FGFR* Pathway Aberrations

- **Testing Modalities and Considerations: Both NGS assays, which include the *FGFR2* gene including its intronic regions, and break apart fluorescence in situ hybridization (FISH) assays, can be used to identify patients with *FGFR2* fusions/rearrangements in tumor tissue samples.[1,29] Some fusion breakpoints may be detectable using cfDNA assays but sensitivity is lower than for tumor tissue testing.[30]**
- **Recommendation: Testing for *FGFR2* fusions or rearrangements is recommended for patients with unresectable or metastatic intrahepatic or extrahepatic CCA and should be considered for patients with unresectable or metastatic gallbladder cancer.**

IDH1 Mutations

- **Testing Modalities and Considerations: *IDH1* mutations in intrahepatic CCA occur most commonly at codon 132 (R132X).[9,31] Testing can be performed by tumor NGS using a multi-gene panel or by hotspot mutation testing. cfDNA testing can also detect hotspot mutations in *IDH1*.**
- **Recommendation: Testing for *IDH1* mutations is recommended for patients with unresectable or metastatic intrahepatic CCA or extrahepatic CCA and should be considered for patients with unresectable or metastatic gallbladder cancer.**

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Note: All recommendations are category 2A unless otherwise indicated.

PRINCIPLES OF MOLECULAR TESTING

HER2/*ERBB2* Overexpression/Amplification/Activating Mutations

- **Testing Modalities and Considerations: HER2 overexpression/amplification can be detected by IHC, FISH, or NGS techniques. NGS testing offers the ability to assess numerous molecular alterations simultaneously and has the added benefit of detecting HER2 activating mutations. NGS can be considered upfront when limited diagnostic tissue is available, though other methodologies such as IHC/FISH remain the most commonly utilized. However, the predominant limitation of HER2 or *ERBB2* testing in hepatobiliary tumors is the lack of specific guideline cutoff points or standardized algorithms to define HER2 positivity by protein expression or *ERBB2* amplification in hepatobiliary malignancies. Various cutoff values including those described for breast and gastroesophageal junction neoplasms have been used in prior and ongoing clinical trials, making direct comparisons between studies difficult. Other challenges to be considered include the significant heterogeneity that can be seen with protein overexpression in BTCs, which may affect positivity rates when IHC is performed in biopsy specimens.[32] Lastly, while most alterations are identified through overexpression or amplification, activating missense mutations have also been shown to represent a significant subset of HER2-altered tumors, which will be missed with standard IHC and FISH techniques.[13,33]**

- **Recommendation: Testing for HER2 (*ERBB2*) overexpression/amplification is recommended for patients with unresectable or metastatic gallbladder cancer, intrahepatic CCA, or extrahepatic CCA.**

Other Biomarkers (RET/ROS1, KRAS G12C/Other KRAS, Other Tumor-Agnostic Markers)

- **In addition to the genomic aberrations reviewed above, NGS testing may uncover other potentially actionable molecular alterations that could determine eligibility for ongoing clinical trials in patients with advanced BTCs. While there is insufficient evidence to recommend universal assessment, alterations for which targeted therapies exist and have been FDA-approved in other tumor types, including *KRAS* G12C mutation,[34-36] *MET* amplification,[37-39] and *ALK*,[40] *RET*,[19] or *ROS1* fusions,[41] among others,[42] have been described with variable but overall rare frequency in biliary tract carcinomas and hepatocellular carcinoma.[43] However, limited data currently exist regarding the efficacy of targeted therapy in these situations, due to their rarity.**

- **Recommendation: Testing for *RET* fusions is recommended for patients with unresectable or metastatic gallbladder cancer, intrahepatic CCA, or extrahepatic CCA. A comprehensive NGS panel may identify additional alterations for which targeted therapies exist and have FDA-approved treatments in other tumor types.**

- **Recommendation: Testing for *KRAS* G12C mutations is recommended for patients with unresectable or metastatic gallbladder cancer, intrahepatic CCA, or extrahepatic CCA.**

References on BIL-B 7 of 8

Note: All recommendations are category 2A unless otherwise indicated.

PRINCIPLES OF MOLECULAR TESTING
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Note: All recommendations are category 2A unless otherwise indicated.

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Note: All recommendations are category 2A unless otherwise indicated.

PRINCIPLES OF SYSTEMIC THERAPY[a]

Neoadjuvant Therapy[b] (for gallbladder cancer only)

Preferred Regimens	Other Recommended Regimens	Useful in Certain Circumstances
• None	• See Principles of Systemic Therapy, Primary Treatment for Unresectable and Metastatic Disease (BIL-C 2 of 5)	• None

Adjuvant Therapy[c,1]

Preferred Regimens	Other Recommended Regimens	Useful in Certain Circumstances

• Capecitabine (category 1)[d,2]	• Gemcitabine + capecitabine[3]
	• Gemcitabine + cisplatin[e,4]
	• Single agents:
	  ▸ 5-fluorouracil
	  ▸ Gemcitabine
		• None

Agents Used with Concurrent Radiation

- 5-fluorouracil
- Capecitabine

[a] Order does not indicate preference.
[b] The decision to use neoadjuvant therapy needs to be individualized and in close consultation with surgical oncologist and multidisciplinary team. A period of 2 to 6 months with reassessment every 2 to 3 months is reasonable. There are limited clinical trial data to define a standard regimen or definitive benefit. Clinical trial participation is encouraged.
[c] Adjuvant therapy up to 6 months. Adjuvant chemotherapy or chemoradiation has been associated with survival benefit in patients with BTC, especially in patients with lymph node-positive disease.
[d] The phase III BILCAP study shows improved overall survival for adjuvant capecitabine in the per-protocol analysis, and the overall survival did not reach statistical significance in the intent-to-treat analysis.
[e] If a patient is ineligible for cisplatin, carboplatin may be used.

Note: All recommendations are category 2A unless otherwise indicated.

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Continued

PRINCIPLES OF SYSTEMIC THERAPY[a]

Primary Treatment for Unresectable and Metastatic Disease

Preferred Regimens

- **Durvalumab + gemcitabine + cisplatin (category 1)[e-h,4,5]**
- **Pembrolizumab + gemcitabine + cisplatin (category 1)[e,g,h,4,6]**

Other Recommended Regimens

- **Gemcitabine + cisplatin (category 1)[e,4,7]**
- **Capecitabine + oxaliplatin**
- **FOLFOX**
- **Gemcitabine + albumin-bound paclitaxel**
- **Gemcitabine + capecitabine**
- **Gemcitabine + oxaliplatin**
- **Single agents:**
  - **5-fluorouracil**
  - **Capecitabine**
  - **Gemcitabine**

Useful in Certain Circumstances

- **Targeted therapy (BIL-C 3 of 5)**

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

Preferred Regimens

- **FOLFOX[8]**

Other Recommended Regimens

- **FOLFIRI[9]**
- **Liposomal irinotecan + fluorouracil + leucovorin (category 2B)[10]**
- **Regorafenib (category 2B)[11]**
- **See also: Preferred and Other Recommended Regimens for Unresectable and Metastatic Disease above**

Useful in Certain Circumstances

- **Targeted therapy (BIL-C 3 of 5)**
- **Nivolumab (category 2B)[g,h,j,12]**

[a] Order does not indicate preference.
[e] If a patient is ineligible for cisplatin, carboplatin may be used.
[f] This regimen is also a recommended treatment option for patients who developed recurrent disease >6 months after surgery with curative intent and >6 months after completion of adjuvant therapy.
[g] See NCCN Guidelines for Management of Immunotherapy-Related Toxicities.
[h] For patients who have not been previously treated with a checkpoint inhibitor when used as subsequent-line therapy because there is a lack of data for use of immunotherapy in patients who have previously been treated with a checkpoint inhibitor.
[i] Treatment selection depends on clinical factors including previous treatment regimen/agent, somatic molecular testing results, and extent of liver dysfunction.
[j] Nivolumab and hyaluronidase-nvhy subcutaneous injection may be substituted for IV nivolumab. Nivolumab and hyaluronidase-nvhy has different dosing and administration instructions compared to IV nivolumab.

Note: All recommendations are category 2A unless otherwise indicated.

References on BIL-C 4 of 5
Continued

PRINCIPLES OF SYSTEMIC THERAPY[a,k]
TARGETED THERAPY

Primary Treatment for Unresectable and Metastatic Disease

Useful in Certain Circumstances

- For *NTRK* gene fusion-positive tumors:
  - Entrectinib[13,14]
  - Larotrectinib[15]
  - Repotrectinib[16]
- For MSI-H/dMMR tumors:
  - Pembrolizumab[g,l,17-20]
- For TMB-H tumors:
  - Nivolumab + ipilimumab (category 2B)[g,21]
- For *RET* gene fusion-positive tumors:
  - Pralsetinib (category 2B)[22]
  - Selpercatinib (category 2B)[23]

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

Useful in Certain Circumstances

- For *NTRK* gene fusion-positive tumors[m]:
  - Entrectinib[13,14]
  - Larotrectinib[15]
  - Repotrectinib[16]
- For MSI-H/dMMR tumors:
  - Pembrolizumab[g,h,l,17-20]
  - Dostarlimab-gxly (category 2B)[g,h,n,24]
- For TMB-H tumors:
  - Nivolumab + ipilimumab[g,h,o,21]
  - Pembrolizumab[g,h,l,17,25]
- For *BRAF* V600E-mutated tumors
  - Dabrafenib + trametinib[26,27]
- For CCA with *FGFR2* fusions or rearrangements[p]:
  - Futibatinib[28]
  - Pemigatinib[29]
  - Erdafitinib[q,30]
- For CCA with *IDH1* mutations
  - Ivosidenib (category 1)[31,32]
- For HER2-positive tumors:
  - Fam-trastuzumab deruxtecan-nxki (IHC3+)[33]
  - Trastuzumab + pertuzumab (IHC3+/ISH+/NGS amplification)[34]
  - Tucatinib + trastuzumab (IHC3+/ISH+/NGS amplification)[35]
  - Zanidatamab-hrii (IHC3+)[36]
- For *RET* gene fusion-positive tumors:
  - Selpercatinib[23]
  - Pralsetinib (category 2B)[22]
- For *KRAS* G12C mutation-positive tumors:
  - Adagrasib[37]

[a] Order does not indicate preference.
[g] See NCCN Guidelines for Management of Immunotherapy-Related Toxicities.
[h] For patients who have not been previously treated with a checkpoint inhibitor when used as subsequent-line therapy because there is a lack of data for use of immunotherapy in patients who have previously been treated with a checkpoint inhibitor.
[i] Treatment selection depends on clinical factors including previous treatment regimen/agent, somatic molecular testing results, and extent of liver dysfunction.
[k] An FDA-approved biosimilar is an appropriate substitute for any recommended systemic biologic therapy in the NCCN Guidelines.
[l] There are limited clinical trial data to support pembrolizumab in this setting.
[m] Repotrectinib is an option if there was progression on a prior therapy, which may include prior NTRK inhibitors. Entrectinib and larotrectinib should not be used if there was progression on prior NTRK inhibitors.
[n] Dostarlimab-gxly is a recommended treatment option for patients with MSI-H/dMMR recurrent or advanced tumors that have progressed on or following prior treatment and who have no satisfactory alternative treatment options.
[o] For patients with disease refractory to standard therapies or who have no standard treatment options available.
[p] Futibatinib and pemigatinib are preferred over erdafitinib.
[q] The data available for this agent are from a smaller trial.

References on BIL-C 4 of 5

Note: All recommendations are category 2A unless otherwise indicated.

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Note: All recommendations are category 2A unless otherwise indicated.

Continued

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Note: All recommendations are category 2A unless otherwise indicated.

PRINCIPLES OF RADIATION THERAPY

General Principles

- **All tumors irrespective of the location may be amenable to RT (three-dimensional conformal RT [3D-CRT], intensity-modulated RT [IMRT]). Image-guided RT (IGRT) is strongly recommended when using RT, IMRT, and stereotactic body RT (SBRT) to improve treatment accuracy and reduce treatment-related toxicity.**
- **RT dosing is based on the ability to meet normal organ constraints and underlying liver function[1]**

- **Unresectable tumors**
  - **SBRT: Doses ranging between 40–60 Gy (in 3–5 fractions; BED10 > 100 Gy) is preferred if dose constraints can be met.[1,2]**
  - **Hypofractionation: Doses ranging between 58–67.5 Gy (in 15 fractions; median EQD_2 80.5 Gy) using photons[3] or protons[4] are recommended at centers with experience.**
  - **If unable to do SBRT/hypofractionation: Conventional fractionation (doses ranging from 60 Gy/30 fractions to 77 Gy/35 fractions)[5,6] or chemoradiation[a] up to 60 Gy/30 fractions[3] is recommended.**

- **Postoperative**
  - **Postoperative RT using conventional 3D-CRT or IMRT is an option for resected extrahepatic CCA and gallbladder cancer.[7,8] Target volumes should cover the draining regional lymph nodes: porta hepatis, celiac, superior mesenteric, gastrohepatic, and para-aortic to 45 Gy at 1.8 Gy/fraction and 50–60 Gy in 1.8–2 Gy/fraction to the tumor bed depending on margin positivity.**

- **Palliative RT is appropriate for symptom control of primary tumor and metastatic lesions, such as bone or brain.**

Footnote

[a] Principles of Systemic Therapy (BIL-C).

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Note: All recommendations are category 2A unless otherwise indicated.

American Joint Committee on Cancer (AJCC)
TNM Staging for Gallbladder Carcinoma (8th ed., 2017)

Table 3. **Definitions for T, N, M**

T	**Primary Tumor**
TX	Primary tumor cannot be assessed
T0	No evidence of primary tumor
Tis	Carcinoma in *situ*
T1	Tumor invades lamina propria or muscular layer
T1a	Tumor invades lamina propria
T1b	Tumor invades muscle layer
T2	Tumor invades the perimuscular connective tissue on the peritoneal side, without involvement of the serosa (visceral peritoneum) Or tumor invades the perimuscular connective tissue on the hepatic side, with no extension into the liver
T2a	Tumor invades the perimuscular connective tissue on the peritoneal side, without involvement of the serosa (visceral peritoneum)
T2b	Tumor invades the perimuscular connective tissue on the hepatic side, with no extension into the liver
T3	Tumor perforates the serosa (visceral peritoneum) and/or directly invades the liver and/or one other adjacent organ or structure, such as the stomach, duodenum, colon, pancreas, omentum, or extrahepatic bile ducts
T4	Tumor invades main portal vein or hepatic artery or invades two or more extrahepatic organs or structures

N	**Regional Lymph Nodes**
NX	Regional lymph nodes cannot be assessed
N0	No regional lymph node metastasis
N1	Metastases to one to three regional lymph nodes
N2	Metastases to four or more regional lymph nodes

M	**Distant Metastasis**
M0	No distant metastasis
M1	Distant metastasis

Table 4. **AJCC Prognostic Groups**

	T	N	M
Stage 0	Tis	N0	M0
Stage I	T1	N0	M0
Stage IIA	T2a	N0	M0
Stage IIB	T2b	N0	M0
Stage IIIA	T3	N0	M0
Stage IIIB	T1-3	N1	M0
Stage IVA	T4	N0-1	M0
Stage IVB	Any T	N2	M0
	Any T	Any N	M1

Histologic Grade (G)

GX	Grade cannot be assessed
G1	Well differentiated
G2	Moderately differentiated
G3	Poorly differentiated

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Continued

American Joint Committee on Cancer (AJCC)
TNM Staging for Intrahepatic Bile Duct Tumors (8th ed., 2017)

Table 5. **Definitions for T, N, M**

T		Primary Tumor
TX		Primary tumor cannot be assessed
T0		No evidence of primary tumor
Tis		Carcinoma *in situ* (intraductal tumor)
T1		Solitary tumor without vascular invasion, ≤5 cm or >5 cm
	T1a	Solitary tumor ≤5 cm without vascular invasion
	T1b	Solitary tumor >5 cm without vascular invasion
T2		Solitary tumor with intrahepatic vascular invasion or multiple tumors, with or without vascular invasion
T3		Tumor perforating the visceral peritoneum
T4		Tumor involving local extrahepatic structures by direct invasion

N	Regional Lymph Nodes
NX	Regional lymph nodes cannot be assessed
N0	No regional lymph node metastasis
N1	Regional lymph node metastasis present

M	Distant Metastasis
M0	No distant metastasis
M1	Distant metastasis present

Table 6. **AJCC Prognostic Groups**

	T	N	M
Stage 0	Tis	N0	M0
Stage IA	T1a	N0	M0
Stage IB	T1b	N0	M0
Stage II	T2	N0	M0
Stage IIIA	T3	N0	M0
Stage IIIB	T4	N0	M0
	Any T	N1	M0
Stage IV	Any T	Any N	M1

Histologic Grade (G)

GX	Grade cannot be assessed
G1	Well differentiated
G2	Moderately differentiated
G3	Poorly differentiated

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Continued

American Joint Committee on Cancer (AJCC)
TNM Staging for Perihilar Bile Duct Tumors (8th ed., 2017)

Table 7. **Definitions for T, N, M**

T	**Primary Tumor**
TX	Primary tumor cannot be assessed
T0	No evidence of primary tumor
Tis	Carcinoma *in situ*/high-grade dysplasia
T1	Tumor confined to the bile duct, with extension up to the muscle layer or fibrous tissue
T2	Tumor invades beyond the wall of the bile duct to surrounding adipose tissue, or tumor invades adjacent hepatic parenchyma
T2a	Tumor invades beyond the wall of the bile duct to surrounding adipose tissue
T2b	Tumor invades adjacent hepatic parenchyma
T3	Tumor invades unilateral branches of the portal vein or hepatic artery
T4	Tumor invades main portal vein or its branches bilaterally, or the common hepatic artery; or unilateral second-order biliary radicals bilaterally with contralateral portal vein or hepatic artery involvement

N	**Regional Lymph Nodes**
NX	Regional lymph nodes cannot be assessed
N0	No regional lymph node metastasis
N1	One to three positive lymph nodes typically involving the hilar, cystic duct, common bile duct, hepatic artery, posterior pancreatoduodenal, and portal vein lymph nodes
N2	Four or more positive lymph nodes from the sites described for N1

M	**Distant Metastasis**
M0	No distant metastasis
M1	Distant metastasis

Table 8. **AJCC Prognostic Groups**

	T	**N**	**M**
Stage 0	Tis	N0	M0
Stage I	T1	N0	M0
Stage II	T2a-b	N0	M0
Stage IIIA	T3	N0	M0
Stage IIIB	T4	N0	M0
Stage IIIC	Any T	N1	M0
Stage IVA	Any T	N2	M0
Stage IVB	Any T	Any N	M1

Histologic Grade (G)

GX	Grade cannot be assessed
G1	Well differentiated
G2	Moderately differentiated
G3	Poorly differentiated

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Continued

American Joint Committee on Cancer (AJCC)
TNM Staging for Distal Bile Ducts Tumors (8th ed., 2017)

Table 9. **Definitions for T, N, M**

T	Primary Tumor
TX	Primary tumor cannot be assessed
Tis	Carcinoma in situ/high-grade dysplasia
T1	Tumor invades the bile duct wall with a depth less than 5 mm
T2	Tumor invades the bile duct wall with a depth of 5–12 mm
T3	Tumor invades the bile duct wall with a depth greater than 12 mm
T4	Tumor involves the celiac axis, superior mesenteric artery, and/or common hepatic artery

N	Regional Lymph Nodes
NX	Regional lymph nodes cannot be assessed
N0	No regional lymph node metastasis
N1	Metastasis in one to three regional lymph nodes
N2	Metastasis in four or more regional lymph nodes

M	Distant Metastasis
M0	No distant metastasis
M1	Distant metastasis

Table 10. **AJCC Prognostic Groups**

	T	N	M
Stage 0	Tis	N0	M0
Stage I	T1	N0	M0
Stage IIA	T1	N1	M0
	T2	N0	M0
Stage IIB	T2	N1	M0
	T3	N0	M0
	T3	N1	M0
Stage IIIA	T1	N2	M0
	T2	N2	M0
	T3	N2	M0
Stage IIIB	T4	N0	M0
	T4	N1	M0
	T4	N2	M0
Stage IV	Any T	Any N	M1

Histologic Grade (G)

GX	Grade cannot be assessed
G1	Well differentiated
G2	Moderately differentiated
G3	Poorly differentiated

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ABBREVIATIONS

3D-CRT	three-dimensional conformal radiation therapy
BED	biologically effective dose
BTC	biliary tract cancer
CCA	cholangiocarcinoma
CEA	carcinoembryonic antigen
cfDNA	cell-free DNA
dMMR	mismatch repair deficient
ERCP	endoscopic retrograde cholangiopancreatography
EUS	endoscopic ultrasound
FISH	fluorescence in situ hybridization
FLR	future liver remnant
H&P	history and physical
HCC	hepatocellular carcinoma
iCCA	intrahepatic cholangiocarcinoma
IGRT	image-guided radiation therapy
IHC	immunohistochemistry
IMRT	intensity-modulated radiation therapy
LFT	liver function test
MASLD	metabolic dysfunction-associated steatotic liver disease
MMR	mismatch repair
MRCP	magnetic resonance cholangiopancreatography
MSI	microsatellite instability
MSI-H	microsatellite instability-high
NGS	next-generation sequencing
PCR	polymerase chain reaction
PTC	percutaneous transhepatic cholangiography
SBRT	stereotactic body radiation therapy
TACE	transarterial chemoembolization
TMB	tumor mutational burden
TMB-H	tumor mutational burden-high
UNOS	United Network for Organ Sharing

NCCN Categories of Evidence and Consensus	
Category 1	Based upon high-level evidence (≥1 randomized phase 3 trials or high-quality, robust meta-analyses), there is uniform NCCN consensus (≥85% support of the Panel) that the intervention is appropriate.
Category 2A	Based upon lower-level evidence, there is uniform NCCN consensus (≥85% support of the Panel) that the intervention is appropriate.
Category 2B	Based upon lower-level evidence, there is NCCN consensus (≥50%, but <85% support of the Panel) that the intervention is appropriate.
Category 3	Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate.

All recommendations are category 2A unless otherwise indicated.

NCCN Categories of Preference	
Preferred intervention	Interventions that are based on superior efficacy, safety, and evidence; and, when appropriate, affordability.
Other recommended intervention	Other interventions that may be somewhat less efficacious, more toxic, or based on less mature data; or significantly less affordable for similar outcomes.
Useful in certain circumstances	Other interventions that may be used for selected patient populations (defined with recommendation).

All recommendations are considered appropriate.

National Comprehensive Cancer Network®

NCCN Guidelines Version 2.2025
Biliary Tract Cancers

Discussion

This discussion corresponds to the NCCN Guidelines for Biliary Tract Cancers. Last updated: July 2, 2025.

Table of Contents

Overview

Gallbladder cancer and bile duct cancer (intrahepatic and extrahepatic cholangiocarcinoma [CCA]) are highly lethal cancers and are collectively known as biliary tract cancers (BTCs). In 2025, it is estimated that 42,240 people in the United States will be diagnosed with liver cancer including intrahepatic bile duct cancer and an additional 12,610 people will be diagnosed with gallbladder cancer or other BTC.[1] Approximately 30,090 deaths from liver or intrahepatic bile duct cancer and 4400 deaths due to gallbladder cancer or other BTC are anticipated.

The NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Biliary Tract Cancers are the work of the members of the NCCN Biliary Tract Cancers Guidelines Panel. The types of BTCs covered in these guidelines include: gallbladder cancer, and intrahepatic and extrahepatic CCA. By definition, the NCCN Guidelines cannot incorporate all possible clinical variations and are not intended to replace good clinical judgment or individualization of treatments. Although not explicitly stated at every decision point of the guidelines, participation in prospective clinical trials is encouraged for the treatment of BTCs.

Guidelines Update Methodology

The complete details of the Development and Update of the NCCN Guidelines are available at www.NCCN.org.

Literature Search Criteria

Prior to the update of this version of the NCCN Guidelines® for Biliary Tract Cancers, an electronic search of the PubMed database was performed to obtain key literature in BTCs published since the previous Guidelines update, using the search terms: biliary tract cancer OR gallbladder cancer OR cholangiocarcinoma. The PubMed database was chosen because it remains the most widely used resource for medical literature and indexes only peer-reviewed biomedical literature.

The search results were narrowed by selecting studies in humans published in English. Results were confined to the following article types: Clinical Trial, Phase II; Clinical Trial, Phase III; Clinical Trial, Phase IV; Guideline; Practice Guideline; Randomized Controlled Trial; Meta-Analysis; Systematic Reviews; and Validation Studies. The data from key PubMed articles and articles from additional sources deemed as relevant to these Guidelines as discussed by the Panel have been included in this version of the Discussion section. Recommendations for which high-level evidence is lacking are based on the Panel's review of lower-level evidence and expert opinion.

Sensitive/Inclusive Language Usage

NCCN Guidelines strive to use language that advances the goals of equity, inclusion, and representation.[2] NCCN Guidelines endeavor to use language that is person-first; not stigmatizing; anti-racist, anti-classist, anti-misogynist, anti-ageist, anti-ableist, and anti-weight-biased; and inclusive of individuals of all sexual orientations and gender identities. NCCN Guidelines incorporate non-gendered language, instead focusing on organ-specific recommendations. This language is both more accurate and more inclusive and can help fully address the needs of individuals of all sexual orientations and gender identities. NCCN Guidelines will continue to use the terms *men*, *women*, *female*, and *male* when citing statistics, recommendations, or data from organizations or sources that do not use inclusive terms. Most studies do not report how sex and gender data are collected and use these terms interchangeably or inconsistently. If sources do not differentiate gender from sex assigned at birth or organs present, the information is presumed to predominantly represent cisgender individuals. NCCN encourages researchers to collect

more specific data in future studies and organizations to use more inclusive and accurate language in their future analyses.

Gallbladder Cancer

Gallbladder cancer is the most common anatomic subtype of BTC. The vast majority of gallbladder cancers are adenocarcinomas.[3] Incidence steadily increases with age, females are more likely to be diagnosed with gallbladder cancer than males, and incidence and mortality rates in the United States are highest among individuals of American Indian, Alaska Native, and Asian/Pacific Islander descent.[4,5] However, from 1973 to 2015, the incidence of gallbladder cancer has decreased in both males and females, white individuals, and individuals of American Indian/Alaskan Native and Asian/Pacific Islander descent but there was a small trend for an increase in Black individuals.[5] Globally, there are pockets of increased incidence in Korea; Japan; some areas of Eastern Europe and South America, especially Bolivia, Chile, and Spain; and in females in India, Pakistan, and Ecuador.[6-8] Gallbladder cancer is characterized by local and vascular invasion, regional lymph node metastasis, and distant metastases.

Risk Factors

Cholelithiasis with the presence of chronic inflammation is the most prevalent risk factor for gallbladder cancer, and the risk increases with stone size.[9,10] Calcification of the gallbladder wall (porcelain gallbladder), a result of chronic inflammation of the gallbladder, has also been regarded as a risk factor for gallbladder cancer, with historical estimates of cancer in up to 22% of gallbladders with calcification.[9] Subsequent reports, however, suggest that the risk of developing gallbladder cancer in patients with gallbladder calcification is lower than anticipated, with gallbladder cancer being present in 7% to 15% of these patients.[11-13] Other risk factors include anomalous pancreaticobiliary duct junction, gallbladder polyps (>1 cm), chronic typhoid infection, primary sclerosing cholangitis, and inflammatory bowel disease.[10,14-16] Adenomyomatosis of the gallbladder is also a potential, albeit somewhat controversial, risk factor. Prophylactic cholecystectomy is probably beneficial for patients who are at high risk of developing gallbladder cancer (eg, porcelain gallbladder, polyps >1 cm).[9] The Society of Radiologists in Ultrasound has proposed 3 risk categories for gallbladder polyps: extremely low risk, low risk, and indeterminate risk; and recommend a surgical consult for extremely low risk and low risk polyps ≥1.5 cm and for indeterminate risk polyps ≥0.7 cm.[17] Patients with a history of chronic cholecystitis or pancreaticobiliary maljunction have a greater prevalence of gallbladder cancers that are microsatellite instability-high (MSI-H).[18]

Staging and Prognosis

In the AJCC staging system, gallbladder cancer is classified into four stages based on the depth of invasion into the gallbladder wall and the extent of spread to surrounding organs and lymph nodes. In the revised 8th edition of the AJCC staging system, T2 gallbladder carcinoma was divided into two groups: tumors on the peritoneal side (T2a) and tumors on the hepatic side (T2b).[19] This revision is supported by two retrospective studies showing that gallbladder tumors located on the hepatic side is associated with worse prognosis, compared to tumors located on the peritoneal side.[20,21] However, it is important to note that it can be difficult to determine the location of the tumor, and gallbladder cancer can spread beyond the visible tumor, contributing to difficulty in predicting tumor location. Regional lymph node involvement is now staged according to number of positive nodes, as opposed to staging based on anatomic location of involved lymph nodes.

Tumor stage is the strongest prognostic factor for patients with gallbladder cancer.[22,23] Results from a retrospective analysis of 435 patients treated at a single center showed a median overall survival (OS) of 10.3 months for the entire cohort of patients.[23] The median survival was 12.9 and 5.8 months for those presenting with stage IA–III and stage IV disease,

respectively. It is important to note, however, that this retrospective analysis did not control well for treatment-related variables.[24] See the *Principles of Pathology* in the algorithm for recommendations pertaining to primary gallbladder cancer appropriate for resection.

Diagnosis

Gallbladder cancer is commonly diagnosed at an advanced stage because it is often asymptomatic in its early stages and has an aggressive nature that can spread rapidly. Another factor contributing to late diagnosis of gallbladder cancer is a clinical presentation that mimics that of biliary colic or chronic cholecystitis. Hence, it is common for a diagnosis of gallbladder cancer to be an incidental finding at cholecystectomy for presumed benign gallbladder disease or, more frequently, on pathologic review following cholecystectomy for symptomatic cholelithiasis. In a retrospective review of 435 patients diagnosed and treated with curative resection at a single center from 1995 to 2005, 123 patients (47%) were diagnosed with gallbladder cancer as an incidental finding after cholecystectomy.[23] Other possible clinical presentations of gallbladder cancer include a suspicious mass detected on ultrasound (US) or biliary tract obstruction with jaundice or chronic right upper quadrant abdominal pain. The presence of jaundice in patients with gallbladder cancer is associated with a poor prognosis; patients with jaundice are more likely to have advanced-stage disease (96% vs. 60%; $P < .001$) and significantly lower disease-specific survival (6 vs.16 months; $P < .0001$) than those without jaundice.[25] In a sample of 82 patients with gallbladder cancer who presented with jaundice, the resectability rate was low (7%), with even fewer having negative surgical margins (5%) and no disease-free survivors at 2 years.[25] In another study, 30% of patients with gallbladder cancer presenting with jaundice underwent resection with curative intent, compared to 75% of those without jaundice.[26] Jaundice also negatively impacted perioperative morbidity (69% vs. 38% in those without jaundice) and OS post-resection (median of 14 vs. 32 months in those without jaundice).

Workup

The initial workup of patients presenting with a gallbladder mass or disease suspicious for gallbladder cancer should include liver function tests and an assessment of hepatic reserve. High-quality multiphasic contrast-enhanced cross-sectional imaging (CT and/or MRI) of the chest, abdomen, and pelvis is recommended to evaluate tumor penetration through the wall of the gallbladder and the presence of nodal and distant metastases, and to detect the extent of direct tumor invasion of other organs/biliary system or major vascular invasion.[27] CT is more useful than US for the detection of lymph node involvement, adjacent organ invasion, and distant metastasis; MRI may be useful for distinguishing benign conditions from gallbladder cancer.[3] However, both techniques were unreliable in the detection of lymph node metastases that were smaller than 10 mm.[28] Although the role of PET scan has not been established in the evaluation of patients with gallbladder cancer, emerging evidence from retrospective studies indicates that it may be useful for the detection of radiologically occult regional lymph node and distant metastatic disease in patients with otherwise potentially resectable disease.[29-32] However, false positives related to an inflamed gallbladder are problematic.

For patients presenting with jaundice, additional workup should include cholangiography to evaluate for hepatic and biliary invasion of tumor. Noninvasive magnetic resonance cholangiography (MRCP) is preferred over endoscopic retrograde cholangiopancreatography (ERCP) or percutaneous transhepatic cholangiography (PTC), unless a therapeutic intervention is planned.[27]

Carcinoembryonic antigen (CEA) and CA 19-9 testing could be considered as part of initial workup (in conjunction with imaging studies). Elevated serum CEA levels or CA 19-9 levels could be suggestive of gallbladder cancer.[33] While CA 19-9 tends to have higher specificity (92.7% vs. 79.2% for CEA), its sensitivity tends to be lower (50% vs. 79.4% for CEA).

However, these markers are not specific for gallbladder cancer and CA 19-9 could also be elevated in patients with other cancers or jaundice from other causes. Therefore, the Panel recommends carrying out these tests as part of a baseline assessment, and not for diagnostic purposes.

Surgical Management

The surgical approach for the treatment of all patients with resectable gallbladder cancer is the same, with the exception that in patients with an incidental finding of gallbladder cancer on pathologic review, the gallbladder has been removed. Complete resection with negative margins remains the only potentially curative treatment for patients with gallbladder cancer.[34] The optimal resection consists of cholecystectomy with a limited hepatic resection (typically segments IVB and V) and portal lymphadenectomy to encompass the tumor with negative margins.[35] Lymphadenectomy should include lymph nodes in the porta hepatis, gastrohepatic ligament, and retroduodenal regions without routine resection of the bile duct. Extended hepatic resections (beyond segments IV B and V) and resection of the bile duct may be necessary in some patients to obtain negative margins, depending on the stage and location of the tumor, depth of tumor invasion, proximity to adjacent organs, and expertise of the surgeon.

A simple cholecystectomy is an adequate treatment for patients with T1a tumors, with the long-term survival rate approaching 100%.[36] Cholecystectomy combined with hepatic resection and lymphadenectomy is associated with an improved survival for patients with T2 or higher tumors. There is some controversy regarding the benefit of radical resection over simple cholecystectomy for patients with T1b tumors, and there is some risk of finding residual nodal or hepatic disease when re-resecting these patients.[37-42] Some studies have demonstrated an associated improvement in cancer-specific survival for patients with T1b and T2 tumors and no improvement in survival for patients with T3 tumors.[38-40] Other reports suggest that survival benefit associated with extended resection and lymphadenectomy is seen only in patients with T2 tumors and some T3 tumors with localized hepatic invasion and limited regional node involvement.[41,42] One meta-analysis noted that regional lymphadenectomy was associated with prolonged survival in patients with T1b, T2, and T3 tumors.[43] Vega et al[44] reported a recurrence-free survival (RFS) rate of 47% at 5 years in patients with gallbladder cancer that was T1b or greater following oncologic extended resection. T3 and T4 disease were identified as independent risk factors for recurrence at 24 months post extended resection.

Empiric major hepatic resection and bile duct resection have been shown to increase morbidity without any demonstrable difference in survival.[35,45] Bile duct resection was also not associated with a higher lymph node yield or improvements in survival.[46] A retrospective analysis of prospective data collected on 104 patients undergoing surgery for gallbladder cancer from 1990 to 2002 showed that in a multivariate analysis, higher T and N stage, poor differentiation, and common bile duct involvement were independent predictors of poor disease-specific survival.[45] Major hepatectomy and common bile duct excision significantly increased overall perioperative morbidity (53%) and were not independently associated with long-term survival. Fuks et al from the AFS-GBC-2009 study group also reported that bile duct resection resulted in a postoperative morbidity rate of 60% in patients with an incidental finding of gallbladder cancer.[35] However, for these patients, it has been suggested that common duct resection should be performed at the time of re-resection for those with positive cystic duct margins due to the presence of residual disease.[47] However, occasionally the cystic duct stump can be re-resected to a negative margin.

With these data in mind, the guidelines recommend that extended hepatic resections (beyond segments IV B and V) should be performed only when necessary to obtain negative margins (R0 resection) in well-selected

clinical situations as discussed above.[38,40-42] Bile duct excision should only be performed in the presence of adherent nodal disease and/or locally invasive disease or to obtain a negative cystic duct margin if necessary.[45]

Among patients with an incidental finding of gallbladder cancer, there is some evidence that a delayed resection due to referral to a tertiary cancer center or a radical resection following an initial noncurative procedure is not associated with a survival deficit compared with immediate resection.[48,49] However, these comparisons are difficult to interpret due to selection bias. Nevertheless, in all patients with convincing clinical evidence of gallbladder cancer, the guidelines recommend that surgery should be performed by an experienced surgeon who is prepared to do a definitive resection of the tumor. If malignancy is suspected or confirmed after cholecystectomy has been initiated and expertise is available, then definitive resection should be undertaken. If expertise is unavailable, patients should be referred to a center with available expertise. If the diagnosis is not clear, frozen section biopsies can be considered in selected cases before proceeding with definitive resection. The Panel is also of the opinion that surgery should not be performed in situations where the extent and resectability of the disease has not been established with good quality imaging. If malignancy is suspected before cholecystectomy has begun and there is a question of resectability (ie, locally advanced disease, possible metastatic disease, other), then definitive resection can be postponed regardless of available expertise, until complete staging and evaluation has been performed. All findings should be documented, and biopsy considered if chemotherapy is anticipated. Consultation with a pathologist with expertise in the hepatobiliary region should be considered, and careful review of the pathology report for T stage, cystic duct margin status, and other margins following surgery is crucial. If an imaging study shows a suspicious gallbladder mass, then the patient should be referred to an experienced center where they may be considered for upfront definitive resection.

Management of Resectable Disease

All patients should undergo cross-sectional imaging (CT and/or MRI) of the chest, abdomen, and pelvis prior to surgery to evaluate local extent of disease and the presence of distant metastases. Staging laparoscopy has been shown to identify radiographically occult disseminated disease in patients with primary gallbladder cancer.[50] In a prospective study that evaluated the role of staging laparoscopy in 409 patients diagnosed with primary gallbladder cancer, Agarwal et al reported a significantly higher yield in locally advanced tumors compared with early-stage tumors (25.2% vs. 10.7%; $P = .02$); the accuracy for detecting unresectable disease and a detectable lesion in locally advanced tumors (56.0% and 94.1%, respectively) was similar to that in early-stage tumors (54.6% and 100%, respectively).[50] In this study, the use of staging laparoscopy obviated the need for laparotomy in 55.9% of patients with unresectable disease. Staging laparoscopy, however, is of relatively low yield in patients with incidental finding of gallbladder cancer, since disseminated disease is relatively uncommon, and the patients have already had an assessment of their peritoneal cavity at the time of cholecystectomy.[51] Higher yields may be obtained in patients who are at higher risk for disseminated metastases (those with poorly differentiated, T3 or higher tumors or margin-positive tumors at cholecystectomy).[51]

In patients with a suspicious gallbladder mass discovered during surgery, a definitive resection with cholecystectomy and en bloc hepatic resection and lymphadenectomy is recommended when hepatobiliary surgery expertise is available. In cases where a suspicious gallbladder mass is discovered during surgery, but hepatobiliary surgery expertise is unavailable or resectability is unclear, the abdomen should be visually inspected, and all findings should be documented. Intraoperative staging, with or without biopsy, is recommended. The surgery should be ended and the patient should be referred to a specialist. Additional postoperative workup is recommended. Contraindications for resection include tumors with distant

lymph node metastases beyond the porta hepatis (most commonly the celiac axis or aortocaval groove [retropancreatic]) or distant metastatic disease (ie, most commonly liver and peritoneal cavity). Additionally, some tumors are unresectable based on local invasion of the porta hepatis and its vascular and biliary structures.

Among patients with an incidental finding of gallbladder cancer on pathologic review, those with T1a lesions may be observed if the tumor margins are negative since these tumors have not penetrated the muscle layer and long-term survival approaches 100% with simple cholecystectomy.[36] In a sample of 122 patients with gallbladder cancer diagnosed incidentally, identified in a prospectively maintained database, liver involvement at re-resection (after cholecystectomy) was associated with decreased RFS and disease-specific survival for patients with T2 tumors (median RFS was 12 months vs. not reached for patients without liver involvement, $P = .004$; median was 25 months vs. not reached for patients without liver involvement, $P = .003$) but not in patients with T1b tumors.[24]

As mentioned above, hepatic resection and lymphadenectomy with or without bile duct excision (for malignant involvement) is recommended for patients with T1b or greater lesions and/or with T1a lesions with positive margins.[38,40,41] Re-resection to achieve negative margins is recommended for these patients with incidental gallbladder cancer since a significant percentage of these patients have been found to harbor residual disease within the liver and common bile duct.[23,47] Furthermore, although randomized trials are lacking, re-resection is generally associated with improved OS compared to cholecystectomy alone. Port site disease is associated with disseminated peritoneal metastases, and prophylactic port site resection is not associated with improved survival or disease recurrence in patients with incidental findings of gallbladder cancer and, thus, should not be considered during definitive resection.[52,53]

For patients with a suspicious mass detected on imaging, the guidelines recommend cholecystectomy plus en bloc hepatic resection, and lymphadenectomy, with or without bile duct excision (for malignant involvement). A biopsy is not necessary in most cases and a diagnostic laparoscopy is recommended prior to definitive resection.[50] Jaundice in patients with gallbladder cancer is considered a relative contraindication to surgery, and outcomes are generally poor in these patients; only a rare group of patients with localized node-negative disease potentially benefit from complete resection.[25,54-56] In patients with jaundice, if gallbladder cancer is suspected, surgery should only be performed if a complete resection is feasible. These patients should be carefully evaluated prior to surgery and referral to an experienced center should be considered. The guidelines recommend consideration of preoperative biliary drainage for patients with jaundice. However, caution should be exercised in patients with biliary obstruction as drainage is not always feasible and can be dangerous. Decisions regarding biliary drainage should be made by an experienced multidisciplinary team.

Although there are limited clinical trial data to define a standard regimen or definitive benefit, the Panel recommends consideration of a course of neoadjuvant systemic therapy for patients with jaundice. Gallbladder cancer that is locally advanced or has lymph node involvement is associated with a poor prognosis, but neoadjuvant systemic therapy may allow the oncologist to evaluate the biology of the tumor and identify patients who are most likely to benefit from surgical intervention. A systematic review of eight studies found that approximately one third of the 474 patients achieved an R0 resection with the use of neoadjuvant chemotherapy or chemoradiotherapy.[57] In a retrospective analysis of 74 patients with locally advanced or lymph node-positive disease who received systemic therapy, 30% of patients underwent resection.[58] Out of the 22 patients who underwent resection, 45% underwent definitive resection, with OS being significantly greater for patients who underwent

definitive resection compared to those who did not (51 vs. 11 months, respectively; *P* = .003). Another study reported a response rate of 52.5% and a clinical benefit rate of 70% in 160 patients with gallbladder cancer treated with neoadjuvant chemotherapy. 41.2% of patients underwent resection with curative intent.[59] These patients had an associated prolonged OS (49 vs. 7 months; *P* = .0001) and event-free survival (25 vs. 5 months; *P* = .0001) compared to those who did not undergo resection. A phase III randomized study is underway to compare neoadjuvant chemotherapy versus neoadjuvant chemoradiation in patients with locally advanced gallbladder cancer (NCT02867865).[60]

In patients for whom there is evidence of locoregionally advanced disease (ie, nodal disease or evidence of other high-risk disease), neoadjuvant systemic therapy should be considered to rule out rapid progression and avoid futile surgery. The decision to use neoadjuvant therapy needs to be individualized and in close consultation with a surgical oncologist and a multidisciplinary team. A period of 2 to 6 months with reassessment every 2 to 3 months is reasonable. Neoadjuvant treatment options are included as other recommended regimens and are the same as those recommended for the primary treatment for unresectable and metastatic disease (see the *Principles of Systemic Therapy*). The Panel currently does not recommend neoadjuvant chemoradiation for these patients, although a prospective study including 28 patients with locally advanced gallbladder cancer showed that an R0 resection was achieved in 14 patients, with good local control (93%) and 5-year survival (47%), following treatment with gemcitabine with concurrent radiation therapy (RT).[61]

A combination of chemotherapy (gemcitabine-based or fluoropyrimidine-based) and chemoradiation may be options for adjuvant treatment. See the section on *Adjuvant Chemotherapy* and *Chemoradiation for Biliary Tract Cancers*.

Management of Unresectable or Metastatic Disease

Preoperative evaluation and a biopsy to confirm the diagnosis is recommended for patients with unresectable (includes tumors with distant lymph node metastases in the celiac axis or aortocaval groove) or metastatic disease (includes distant metastases, nodal metastases beyond the porta hepatis, and extensive involvement of the porta hepatis causing jaundice or vascular encasement). Molecular testing is recommended. Primary options for these patients include: 1) systemic therapy (preferred); 2) clinical trial (preferred); or 3) best supportive care. In addition, palliative RT is included as an option for patients with unresectable disease. See sections on *Chemotherapy* and *Chemoradiation and Radiation Therapy* for *Treatment for Advanced Biliary Tract Cancers*. Following primary treatment, except for those receiving best supportive care, the disease should be assessed for response. Resection or locoregional therapy should be reconsidered. Subsequent-line systemic therapy is an option if there is progression on or after systemic therapy.

In patients with unresectable or metastatic gallbladder cancer and jaundice, biliary drainage is an appropriate palliative procedure and should be considered before instituting resection and systemic therapy if technically feasible.[54] However, caution should be exercised in patients with biliary obstruction as drainage is not always feasible and can be dangerous due to extensive segmental biliary isolation. Decisions regarding biliary drainage should be made by a multidisciplinary team and carefully planned. Biliary drainage followed by chemotherapy can result in improved quality of life. CA 19-9 testing can be considered after biliary decompression.

Surveillance

There are no data to support a specific surveillance schedule or tests following resection of gallbladder cancer; determination of appropriate follow-up schedule/imaging should include a careful patient/physician discussion. Follow-up of patients undergoing an extended cholecystectomy

for gallbladder cancer should include consideration of imaging studies every 3 to 6 months for 2 years, then every 6 to 12 months for up to 5 years, or as clinically indicated. Assessment of CEA and CA 19-9 may also be considered as clinically indicated. Re-evaluation according to the initial workup should be considered in the event of disease relapse or progression. In a study of 217 patients who underwent surgery with curative intent, 35.0% had a recurrence at the last follow-up, with a median time to recurrence of 9.5 months.[62] The authors note that recurrence occurred within a 2-year time-frame post-surgery in most patients.

Cholangiocarcinomas

Cholangiocarcinomas encompass tumors originating in the epithelium of the biliary tree. More than 90% of CCAs are adenocarcinomas and are broadly divided into three histologic types based on their growth patterns: mass-forming, periductal-infiltrating, and intraductal-growing.[63] CCAs are diagnosed throughout the biliary tree and are typically classified as either intrahepatic or extrahepatic CCA. Extrahepatic CCAs are more common than intrahepatic CCAs.[64] Analyses of SEER data from 2001 to 2017 showed that incidence of intrahepatic CCA increased dramatically (148.8%), while incidence of extrahepatic CCA increased at a slower rate (7.5%).[65] The increase in incidence of intrahepatic CCA may have been due to an improvement in the ability to accurately diagnose intrahepatic CCA, such as with imaging, molecular diagnostics, and pathology.[66] These cancers might have previously been diagnosed as cancers of unknown primary, for which incidence decreased from 1973 to 2012 (annual percentage change, -1.87%).[66] Five-year OS rates for CCA improved from 1973 to 2008, likely due to improvements in treatment for this disease.[67]

Intrahepatic CCAs are located within the hepatic parenchyma and have also been called “peripheral CCAs” (Figure 1). Extrahepatic CCAs occur anywhere within the extrahepatic bile duct—from the junction of the right and left hepatic ducts to the common bile duct, including the intrapancreatic portion (Figure 1)—and are further classified into hilar or distal tumors. Hilar or perihilar CCAs (also called Klatskin tumors) occur at or near the junction of the right and left hepatic ducts including the common hepatic duct; distal CCAs are extrahepatic lesions arising in the extrahepatic bile ducts above the ampulla of Vater and below the junction of the common hepatic duct and cystic duct.[64] Perihilar CCAs are the most common type of extrahepatic CCAs.

The NCCN Guidelines discuss the clinical management of intrahepatic and extrahepatic CCAs including hilar and distal subtypes. Tumors of the ampulla of Vater are not included in the NCCN Guidelines for Biliary Tract Cancers.

Risk Factors

No predisposing factors are identified in most patients diagnosed with CCA,[68] although there is evidence that particular risk factors may be associated with the disease in some patients. These risk factors, like those for gallbladder cancer, are associated with the presence of chronic inflammation. Primary sclerosing cholangitis, chronic calculi of the bile duct (hepatolithiasis), choledochal cysts, and liver fluke infections are well-established risk factors for CCA. Unlike gallbladder cancer, however, cholelithiasis is not thought to be linked with CCA.[69] Inflammatory bowel disease may also be a risk factor for CCA, although this association may be confounded by primary sclerosing cholangitis.[70] Other risk factors specific to intrahepatic CCA, which tends to be similar to hepatocellular carcinoma (HCC), have been found to include hepatitis B virus (HBV) infection, cirrhosis, diabetes, obesity, alcohol, and tobacco.[71] A systematic review and meta-analysis reported that the strongest risk factors for both intrahepatic and extrahepatic CCA included biliary cysts and stones, cirrhosis, HBV, and hepatitis C virus.[72] This may be responsible for the increased incidence of intrahepatic CCA observed at some centers, although future studies are needed to further explore this putative

association.[73] A systematic review including seven case-control studies (9102 patients and 129,111 controls) showed that metabolic dysfunction-associated steatotic liver disease is associated with increased incidence of both intrahepatic (pooled adjusted OR, 2.09; 95% CI, 1.49–2.91) and extrahepatic CCA (pooled adjusted OR, 2.05; 95% CI, 1.59–2.64).[74]

Staging and Prognosis

Intrahepatic Cholangiocarcinoma

In the 6th edition of the AJCC staging system, intrahepatic CCA was staged identically to HCC. However, this staging system did not include predictive clinicopathologic features (multiple hepatic tumors, regional nodal involvement, and large tumor size) that are specific to intrahepatic CCA.[75] In some reports, tumor size had no effect on survival in patients undergoing complete resection.[76,77] In a SEER database analysis of 598 patients with intrahepatic CCA who had undergone surgery, Nathan et al reported that multiple lesions and vascular invasion predicted adverse prognosis following resection; lymph node status was of prognostic significance among patients without distant metastases.[76] In this study, tumor size had no independent effect on survival. These findings were confirmed in a subsequent multi-institutional international study of 449 patients undergoing surgery for intrahepatic CCA.[77] The 5-year survival rate was higher for patients who lacked all three risk factors (multiple tumors, vascular invasion, and N1 disease) than for those with ≥1 risk factors (38.3%, 27.3%, and 18.1%, respectively) and, more importantly, tumor number and vascular invasion were of prognostic significance only in patients with N0 disease. Although tumor size was associated with survival in the univariate analysis, it was not of prognostic significance in a multivariate analysis.

In the revised 7th edition of the AJCC staging system, intrahepatic CCA had a new staging classification that was independent of the staging classification used for HCC.[78] This classification focused on multiple tumors, vascular invasion, and lymph node metastasis. Farges et al from the AFC-IHCC study group validated this staging classification in 163 patients with resectable intrahepatic CCA.[79] The revised classification was useful in predicting survival according to the TNM staging. With a median follow-up of 34 months, the median survival was not reached for patients with stage I disease, was 53 months for those with stage II disease (P = .01), and was 16 months for those with stage III disease (P < .0001).

In the revised 8th edition of the AJCC staging system, T1 disease (ie, solitary tumor without vascular invasion) should now be staged according to tumor size (ie, T1a refers to a tumor that is ≤5 cm, while T1b refers to a tumor that is >5 cm).[19] T2 disease, on the other hand, is no longer divided into T2a (solitary tumor with vascular invasion) and T2b (multiple tumors with or without vascular invasion) disease. See the *Principles of Pathology* in the algorithm for recommendations pertaining to intrahepatic CCA appropriate for biopsy and for patients undergoing resection.

Extrahepatic Cholangiocarcinoma

The 7th edition of the AJCC staging system included a separate TNM classification for hilar and distal extrahepatic CCA, based on the extent of liver involvement and distant metastatic disease.[78] In the revised 8th edition of the AJCC staging system, regional lymph node involvement is now staged according to number of positive nodes.[19] Depth of tumor invasion is an independent predictor of outcome in patients with distal as well as hilar CCAs.[80,81] In the revised 8th edition of the AJCC staging system for cancer of the distal bile duct, depth of tumor invasion has been added to the categorization of T1, T2, and T3 tumors.[19]

The modified Bismuth-Corlette staging system[82] and the Blumgart staging system[83] are used for the classification of hilar CCAs. The modified Bismuth-Corlette staging system classifies hilar CCAs into four types based on the extent of biliary involvement. However, this does not include other clinicopathologic features such as vascular encasement, lymph node

involvement, distant metastases, and liver atrophy. In addition, both the AJCC and the Bismuth-Corlette staging systems are not useful for predicting resectability or survival. The Blumgart staging system is a useful preoperative staging system that predicts resectability, likelihood of metastatic disease, and survival.[83,84] In this staging system, hilar CCAs are classified into three stages (T1–T3) based on the location and extent of bile duct involvement, the presence or absence of portal venous invasion, and hepatic lobar atrophy.[83] Negative histologic margins, concomitant partial hepatectomy, and well-differentiated tumor histology were associated with improved outcome after resection; increasing T stage significantly correlated with reduced R0 resection rate, distant metastatic disease, and lower median survival.[84] See the *Principles of Pathology* in the algorithm for recommendations pertaining to extrahepatic CCA appropriate for biopsy and for patients undergoing resection.

Diagnosis

Early-stage CCA may only manifest as mild changes in serum liver function tests (particularly alkaline phosphatase). Patients with intrahepatic CCA, due to their often late presentation, are more likely to present with nonspecific symptoms such as fever, weight loss, and/or abdominal pain; symptoms of biliary obstruction are uncommon because these tumors do not necessarily involve the common hepatic/bile duct. Intrahepatic CCA may be detected incidentally as an isolated intrahepatic mass on imaging.[85] In contrast, patients with extrahepatic CCA are likely to present with jaundice followed by evidence of a biliary obstruction or abnormality on subsequent imaging.

Workup

The initial workup should include liver function tests. CEA and CA 19-9 testing can be considered for baseline assessment, although these markers are not specific for CCA; they are also associated with other malignancies and benign conditions.[86] CA 19-9 may be falsely elevated due to jaundice.[87] Viral hepatitis serologies should be considered for intrahepatic CCA. If viral hepatitis is diagnosed, it needs to be monitored and managed following ASCO's guidelines.[88] Since the diagnosis of HCC versus intrahepatic CCA can be difficult, alpha-fetoprotein (AFP) testing may also be considered, especially in patients with chronic liver disease. Further, there are a number of mixed HCC/intrahepatic CCA cases in which AFP may be elevated. Liver Imaging Reporting and Data System provides some guidance in distinguishing between HCC and intrahepatic CCA lesions.[89]

Early surgical consultation (prior to drainage in patients with jaundice) with a multidisciplinary team is recommended as part of the initial workup for assessment of resectability in intrahepatic and extrahepatic CCAs. The Panel emphasizes that a multidisciplinary review of imaging studies involving experienced radiologists and surgeons is necessary to stage the disease and determine potential treatment options (ie, resection or other approach). Providers should only proceed with biopsy once transplant (for patients with extrahepatic CCA) or resectability status has been determined. For patients with hilar CCA who may be candidates for transplant, transperitoneal biopsy is contraindicated and will likely preclude transplantation based on current protocols.[90] For patients undergoing resection, biopsy is usually not necessary. However, it should be noted that approximately 5% to 10% of these cases will turn out to be benign.[91]

Tissue diagnosis from the most accessible site is necessary to document the disease, obtain genomics information, and start treatment. Multiphasic abdomen and pelvis CT/MRI IV contrast to assess the involvement of the liver, major vessels, nearby lymph nodes, and distant sites is also recommended when extrahepatic CCA is suspected.[92,93] There are no pathognomonic CT/MRI features associated with intrahepatic CCA, but CT/MRI can indicate the involvement of major vessels and the presence of vascular anomalies and satellite lesions.[92,94,95] Therefore, multiphasic

CT/MRI with IV contrast is used to help determine tumor resectability by characterizing the primary tumor, its relationship to nearby major vessels and the biliary tree, the presence of satellite lesions and distant metastases in the liver, and lymph node involvement.[85,92] Multiphasic abdomen/pelvis CT/MRI with IV contrast is preferred for intrahepatic CCA; however, contrast-enhanced US is also an option. In addition, chest CT (with or without contrast) should be performed, and staging laparoscopy may be considered in conjunction with surgery if no distant metastasis is found. The American College of Radiology has published recommendations for liver MRI.[96] Imaging evaluation for suspected extrahepatic CCA is ideally performed prior to biliary decompression to facilitate accurate local staging for surgical candidacy.

Endoscopic US may be useful for distal common bile duct cancers for defining a mass or abnormal thickening, which can direct biopsies. For hilar CCA, endoscopic US should only be done after surgical consultation to prevent jeopardizing a patient's candidacy for transplantation. Esophagogastroduodenoscopy and colonoscopy are recommended as part of initial workup for patients with intrahepatic CCA since a mass diagnosed as adenocarcinoma can be metastatic disease. Pathologic workup can be suggestive of CCA but is not definitive. IgG4-associated cholangitis, which presents with biliary strictures and obstructive jaundice, may mimic extrahepatic CCA.[97,98] Therefore, serum IgG4 should be considered to rule out autoimmune cholangitis in patients for whom a diagnosis of extrahepatic CCA is not clear, in order to avoid an unnecessary surgical resection.[99,100] Patients with IgG4-related cholangiopathy should be referred to an expert center.

Contrast-enhanced MRCP and/or CT as a diagnostic modality is recommended over direct cholangiography for the diagnosis of bile duct cancers.[101,102] MRCP has been shown to have a higher sensitivity, specificity, and diagnostic accuracy compared to ERCP in the diagnosis and pre-treatment staging of hilar CCAs.[103] Data also support the use of MRCP and CT as the preferred method of cholangiography for the assessment of bile duct tumors.[104] Direct cholangiography should only be performed when necessary as a diagnostic procedure in patients with unresectable disease or in patients in whom a therapeutic intervention is necessary. ERCP/PTC is not recommended for the diagnosis of extrahepatic CCA, since this is associated with complications and contamination of the biliary tree. For distal bile duct tumors in which a diagnosis is needed or where palliation is indicated, an ERCP allows for complete imaging of the bile duct and stenting of the obstruction. In addition, brush cytology of the bile duct can be obtained for pathologic evaluation. Since many of the patients with extrahepatic CCA present with jaundice, workup should include noninvasive cholangiography with cross-sectional imaging to evaluate local tumor extent.[92] Although the role of PET imaging has not been established in the evaluation of patients with CCA, emerging evidence indicates that it may be useful for the detection of regional lymph node metastases and distant metastatic disease in patients with otherwise potentially resectable disease.[29-31,105,106]

Management of Intrahepatic Cholangiocarcinoma

Patients with intrahepatic CCA should be evaluated for potentially curative therapies (resection; and for small lesions, ablation). However, most patients are not candidates for surgery due to the presence of advanced disease at diagnosis. The optimal surgical margin associated with improved survival and reduced risk of recurrence in patients undergoing surgery remains uncertain, with some reports documenting R0 resection as a significant predictor of survival and recurrence,[107-112] while others suggest that margin status is not a significant predictor of outcome.[113,114] Ribero et al from the Italian Intrahepatic Cholangiocarcinoma Study Group reported that margin-negative resection was associated with significantly higher survival rates (the estimated 5-year survival rates were 39.8% vs. 4.7% for patients with a positive margin) and significantly lower recurrence rates

(53.9% vs. 73.6% for those with a positive margin); however, in patients resected with negative margins, the margin width had no long-term impact on survival (P = .61) or recurrence (P > .05) following resection.[112] Farges et al from the AFC-IHCC-2009 study group reported that although R1 resection was the strongest independent predictor of poor outcome in pN0 patients undergoing surgery, its prognostic impact on survival was very low in patients with pN+ intrahepatic CCA (median survival was 18 months and 13 months, respectively, after R0 and R1 resections; P = .10).[114] In this study, a margin width >5 mm was an independent predictor of survival among patients with pN0 intrahepatic CCA with R0 resections, which is in contrast to the findings reported by Ribero et al.[112] A retrospective analysis of 535 patients with intrahepatic CCA who underwent resection showed that other factors associated with worse survival post-resection include multifocal disease (hazard ratio [HR], 1.49; 95% CI, 1.19–1.86; P = .01), lymph node metastasis (HR, 2.21; 95% CI, 1.67–2.93; P < .01), and vascular invasion (HR, 1.39; 95% CI, 1.10–1.75; P = .006).[115]

Available evidence (although not conclusive) supports the recommendation that hepatic resection with negative margins should be the goal of surgical therapy for patients with potentially resectable disease.[94] Extensive hepatic resections are often necessary to achieve clear margins since the majority of tumors present as large masses.[112]

Initial surgical exploration should include assessment of multifocal liver disease, lymph node metastases, and distant metastases.[116] Multifocal liver disease, distant (beyond the porta hepatis) nodal metastases, and distant metastases contraindicate surgery as these generally indicate advanced incurable disease. In highly selected situations, resection can be considered. A preoperative biopsy is not always necessary prior to definitive and potentially curative resection. Although limited multifocal liver tumors (including satellite lesions) and gross lymph node metastases to the porta hepatis are considered relative contraindications to surgery, surgical approaches can be considered in selected patients. Minimally invasive approaches by experienced surgeons have been proven to be safe and effective for well-selected cases.[117,118] Patient selection for surgery is facilitated by careful preoperative staging, which may include laparoscopy to identify patients with unresectable or disseminated metastatic disease.[119,120] Staging laparoscopy has been shown to identify peritoneal metastases and liver metastases with a respective yield of 36% and 67% accuracy in patients with potentially resectable intrahepatic CCA and should be considered.[119] A portal lymphadenectomy helps provide accurate staging information.[121] Lymph node metastasis is an important prognostic indicator of survival.[77,112] Therefore, resection and regional lymphadenectomy of the porta hepatis are recommended. It is important to note, however, that there are no data to support a therapeutic benefit of routine lymph node dissection in patients undergoing surgery.[122-125] Ablation may be considered in the rare patients with small single tumors <3 cm.

One study determined that neoadjuvant chemotherapy was associated with higher OS (HR, 0.16; P = .01) but did not impact RFS (HR, 0.54; P = .27) in patients undergoing hepatic resection.[126] Another study found no difference in survival both in an unadjusted analysis (P = .51) and in a propensity score-matched analysis (HR, 0.78; P = .16).[127] However, the data suggest that patients with stage II–III intrahepatic CCA may have a survival benefit from neoadjuvant therapy (unadjusted analysis, P = .10; propensity-score matched analysis HR, .58; P = .02). The optimal adjuvant treatment strategy for patients with resected intrahepatic CCA has not been determined and there are limited clinical trial data to support a standard regimen for adjuvant treatment. Lymphovascular and perineural invasion, lymph node metastasis, and tumor size ≥5 cm have been reported as independent predictors of recurrence and reduced OS following resection.[128,129] Since recurrence following resection is common, these tumor-specific risk factors could be considered as criteria for selection of

patients for adjuvant treatment in clinical trials. See *Adjuvant Chemotherapy and Chemoradiation for Biliary Tract Cancers* in this Discussion.

There are clinical trials investigating whether liver transplantation would be beneficial for patients with intrahepatic CCA (NCT04195503). Very highly selected candidates may meet the criteria for referral. However, these trials are only available at a small subset of centers. The results of a retrospective study showed that patients with very early intrahepatic CCA, defined as single tumors ≤2 cm, had a 5-year cumulative risk of recurrence of 18%, compared to 61% in patients with advanced intrahepatic CCA, defined as a single tumor >2 cm or with the presence of multifocal disease.[130] The 5-year actuarial survival rates were 65% in the former group compared to 45% in the advanced intrahepatic CCA cohort. In another study, researchers found that patients with intrahepatic CCA who underwent liver transplantation had an improved prognosis compared to those who underwent resection in unmatched (HR, 0.65; $P = .002$) and matched (HR, 0.62; $P = .009$) cohorts.[131] In a prospective case-series, out of 6 patients who underwent transplantation for intrahepatic CCA, 50% had RFS at 5 years.[132] OS was 83.3% at 5 years.

Primary treatment options for patients with unresectable or metastatic disease include: systemic therapy; clinical trial; or consideration of locoregional therapy (arterially directed therapies or RT); or best supportive care. In addition, the combination of chemotherapy and chemoradiation, chemoradiation alone, and consideration of referral to a transplant center are included as options for patients with unresectable disease. Systemic therapy or enrollment in a clinical trial are preferred options for patients with metastatic intrahepatic CCA. See sections on *Chemotherapy* and *Chemoradiation and Radiation Therapy* for *Treatment for Advanced Biliary Tract Cancers* in this Discussion. Following primary treatment, except for those receiving best supportive care, the disease should be assessed for response. Resection or locoregional therapy should be reconsidered. Subsequent-line systemic therapy is an option if there is progression on or after systemic therapy. Evaluation for liver transplantation should also be considered as patients who meet the following criteria will be eligible for transplant exception points: biopsy-proven intrahepatic CCA or mixed HCC-intrahepatic CCA, presence of cirrhosis, unresectable, received locoregional or systemic therapy, and 6 months from time of diagnosis or last treatment with no new lesions or extrahepatic disease.[133]

Locoregional Therapy

Locoregional therapy may be considered in patients who are not candidates for surgical curative therapies or to downstage for other treatments.[134] Locoregional therapies such as radiofrequency ablation,[135,136] transarterial chemoembolization (TACE),[137-139] TACE with drug-eluting beads (DEB-TACE), or TACE drug-eluting microspheres,[138,140,141] and radioembolization (TARE) with Y90 microspheres[139,142-147] have been shown to be safe and effective in a small retrospective series of patients with unresectable intrahepatic CCAs. For recurrent or primary small single tumors <3 cm, thermal ablation is a reasonable alternative to surgical resection, particularly in patients with high-risk disease.[148-150] Ablation options include radiofrequency ablation, microwave ablation, and irreversible electroporation. Hepatic tumors may be amenable to arterially directed therapies provided the supply to the tumor may be isolated without excessive non-target treatment. Arterially directed therapies may be considered for select patients with limited extrahepatic disease (hilar lymph node ≤3 cm or ≤ 5 lung nodules ≤1 cm each). These therapies may be used alone or followed by systemic chemotherapy with the intention to prolong survival or downstage to curative resection.[151,152]

The results of two independent prospective studies showed that the efficacy of TACE with irinotecan DEB was similar to that of gemcitabine and oxaliplatin (GEMOX), but was superior to that of TACE with mitomycin

in terms of progression-free survival (PFS) and OS for patients with unresectable intrahepatic CCA.[138] In a systematic review of 12 studies with 298 patients, the effects of radioembolization with Y90 microspheres in unresectable intrahepatic CCA were assessed.[153] The overall weighted median survival for this treatment was 15.5 months, partial tumor response was seen for 28% of patients, and stable disease (SD) was seen for 54% of patients. Another systematic review and meta-analysis of 21 studies with 921 patients reported an overall disease control rate of 82.3% in patients with unresectable intrahepatic CCA treated with radioembolization with Y90.[154] The median OS and PFS were 12.7 months and 7.8 months, respectively. Other smaller series have also reported favorable response rates and survival benefit for patients with unresectable intrahepatic CCA treated with TARE with Y90 microspheres.[142,145,147] Due to the rarity of this disease, none of these locoregional approaches has been evaluated in randomized controlled trials (RCTs). Personalized dosimetry/radiation segmentectomy to achieve delivery of >205 Gy to the tumor may improve outcomes in patients treated with Y90.[155] Y90 is relatively contraindicated in patients with bilirubin >3 mg/dL. In well-selected patients, grade 3–4 hepatic toxicity occurs in <10% of patients, although this may be significantly higher in patients with cirrhosis.[156] In the phase II MISPHEC trial, investigators determined that the combination of radioembolization with Y90 microspheres with chemotherapy (cisplatin and gemcitabine) as a first-line treatment option in 41 patients with unresectable intrahepatic CCA resulted in a 39% response rate, by RECIST criteria.[151] The median PFS and OS were 14 months and 22 months, respectively. Additionally, 22% of patients were downstaged to surgery.

Consideration of RT is a locoregional treatment option for unresectable intrahepatic CCA.[157] A single-institution study including 79 patients with unresectable intrahepatic CCA showed that higher doses of RT (3D conformal RT [3D-CRT] with photons or protons) were associated with better 3-year OS (73% vs. 38%, respectively; $P = .017$) and 3-year local control (78% vs. 45%, respectively; $P = .04$), compared with lower doses of RT.[158] A study using data from the National Cancer database determined that patients treated with ablative RT had improved survival outcomes (23.7 vs. 12.8 months; $P < .001$) compared to those treated with conventional RT (23.7 vs. 12.8 months).[159] Stereotactic body RT (SBRT) may also be used for patients with unresectable intrahepatic CCA.[160] A non-randomized multi-institutional trial including 39 patients with unresectable intrahepatic CCA showed that hypofractionated proton therapy resulted in a 2-year OS rate of 46.5% (median OS, 22.5 months) and a 2-year PFS rate of 25.7%.[161] Another multi-institutional trial reported a local control rate of 90.9% and an OS rate of 81.8% at 1 year for patients with intrahepatic CCA treated with hypofractionated proton beam therapy.[162]

RT dosing depends on the ability to meet normal organ constraints and underlying liver function.[163] All tumors irrespective of the tumor location may be amenable to RT using 3D-CRT and intensity-modulated RT.[164,165] The Panel strongly recommends image-guided RT when using RT, intensity-modulated radiation therapy (IMRT), and SBRT to improve treatment accuracy and reduce treatment-related toxicity. Dosing schedules may depend on margin positivity and may include up to 45 Gy at 1.8 Gy/fraction or 50 to 60 Gy at 1.8 to 2.0 Gy/fraction (to allow for an integrated boost) to the tumor bed.[166,167] RT dosing[163] is dependent on the ability to meet normal organ constraints and underlying liver function. If SBRT or hypofractionation are not options, conventional fractionation with doses ranging from 60 Gy per 30 fractions to 77 Gy per 35 fractions[168,169] or chemoradiation up to 60 Gy per 30 fractions is recommended.[158] The preferred dosing schedule for SBRT for unresectable disease is 40 to 60 Gy, typically done in 3 to 5 fractions, if dose constraints can be met.[163,170]

Data from prospective studies support the use of hepatic arterial infusion (HAI) chemotherapy in patients with advanced, liver-confined, and unresectable intrahepatic CCA.[171-175] In a phase II trial of HAI of floxuridine

in combination with gemcitabine and oxaliplatin in 38 patients with unresectable intrahepatic CCA, 58% of patients had an objective radiographic response and 84% of patients had disease control.[176] The median OS and median PFS were 25.5 months and 11.8 months respectively. A prospective single arm phase II trial investigated the use of gemcitabine and cisplatin along with HAI of floxuridine in 50 patients with advanced intrahepatic CCA confined to the liver.[177] At a median follow-up of 26.4 months, the median OS was 22.1 months, the median PFS was 10 months. The 1-year and 2-year OS rates were 80% and 28.6%, respectively. In a meta-analysis including 20 studies (*N* = 657), HAI was compared to TACE, DEB-TACE, and TARE with Y90 microspheres.[178] OS and tumor response were greatest for HAI, with a median tumor response rate of 57%, although grade III/IV toxicity was also highest, relative to the other arterially directed therapies. A retrospective analysis of 525 patients with intrahepatic CCA showed that patients who received a combined regimen of HAI and another chemotherapy agent (gemcitabine, irinotecan, or 5-FU) had greater OS, relative to patients receiving chemotherapy without HAI (30.8 vs. 18.4 months; *P* < .001).[179] In a retrospective analysis comparing HAI chemotherapy with modified FOLFOX (mFOLFOX; fluorouracil, leucovorin, and oxaliplatin) to first-line systemic therapy in patients with unresectable intrahepatic CCA, the median OS and PFS did not differ.[180] However, the authors note that intrahepatic PFS was improved in those receiving HAI chemotherapy (*P* = .035). Subgroup analysis revealed that HAI chemotherapy was more beneficial for patients with single tumors in terms of OS (*P* = .047) and PFS (*P* = .009).

Based on the available evidence as discussed above, the Panel has included locoregional therapy as a treatment option that may be considered for patients with unresectable disease or metastatic cancer without extrahepatic disease. HAI chemotherapy, with or without systemic chemotherapy, may be used in the context of a clinical trial or at experienced centers in carefully selected cases for patients with advanced disease confined to the liver.

Management of Mixed HCC-CCA

An estimated 1% to 10% of patients with primary liver tumors are found to have a combination of both HCC and CCA histologies on pathologic review.[181-184] Tumor molecular profiling should be considered in all patients with advanced stages of disease to identify potential targeted aberrations, which may be associated with CCA.[185] Liver resection is considered the standard treatment for resectable disease. Though prospective data are lacking, liver-directed local therapies may be appropriate for patients with a limited extent of unresectable hepatic disease. Patients with HCC-CCA that is limited in size based on center-specific criteria used should be considered for evaluation in a transplant center. In patients with metastatic or locally-advanced recurrence after a prior resection or local therapies, a repeat biopsy should be considered to ascertain the dominant histology at recurrence. If biopsy results at recurrence suggests an isolated recurrence of either the HCC or CCA component, the Panel considers a systemic therapy option appropriate for that histologic component. There are limited prospective data to guide treatment decisions for advanced disease.

A retrospective study of patients with mixed HCC-CCA treated with palliative systemic therapy demonstrated similar overall response rates (ORRs) with chemotherapy versus non-chemotherapy-based systemic therapies.[186] There was a trend towards longer median OS in patients treated with chemotherapy (15.5 vs. 5.3 months; *P* = .052). Based upon this study and the potential for activity of component parts in both histologies, gemcitabine plus cisplatin combined with either durvalumab or pembrolizumab is an appropriate choice for first-line therapy. The Panel notes that these combinations include agents with anti-tumor activity in both CCA[187-189] and HCC histologies.[190-193] Upon disease progression, molecularly-targeted therapies should be considered if the tumor harbors a

targetable aberration. In the absence of a targetable aberration, regimens with demonstrated activity in both HCC and CCA are reasonable options, including nivolumab plus ipilimumab[194,195] or regorafenib.[196,197]

Management of Extrahepatic Cholangiocarcinoma

Complete resection with negative margins is the only potentially curative treatment for patients with resectable disease. The reported 5-year survival rates following complete resection are in the range of 20% to 42% and 16% to 52%, respectively, for patients with hilar and distal CCAs.[198,199]

Surgical margin status and lymph node metastases are independent predictors of survival following resection.[111,200,201] Regional lymphadenectomy of the porta hepatis (hilar CCA) or in the area of the head of the pancreas (distal CCA) are considered standard parts of curative resections.[202,203] Since these surgical procedures are associated with postoperative morbidity, they should be carried out in patients who are medically fit for a major operation. Surgery is contraindicated in patients with distant metastatic disease to the liver, peritoneum, or distant lymph nodes beyond the porta hepatis (or head of the pancreas for distal tumors).

The type of surgical procedure for a resectable tumor is based on its anatomic location in the biliary tract. Resection of the involved biliary tract and en bloc liver resection (typically a major hepatectomy involving the right or left liver with the caudate lobe) is recommended for hilar tumors. Bile duct excision with frozen section assessment of proximal and distal bile duct margins. Pancreaticoduodenectomy can be attempted for mid bile duct tumors not involving the liver or pancreas. However, mid bile duct tumors that can be completely resected with an isolated bile duct resection are uncommon. A combined pancreaticoduodenectomy and hepatic resection is required, in rare instances, for a bile duct tumor with extensive biliary tract involvement. This operation, however, is associated with high morbidity and should only be considered in well-selected cases.[204,205]

Combined hepatic and pancreatic resections to clear distant nodal disease (as opposed to biliary extent) are not recommended, as these are highly morbid procedures with no obvious associated survival advantage. The guidelines recommend consideration of biliary drainage prior to definitive resection for patients with jaundice prior to instituting systemic therapy. However, caution should be exercised in patients with hilar biliary obstruction as drainage is not always simple and can be associated with significant morbidity.[206] Decisions about whether preoperative biliary drainage is appropriate (and the type of drainage) should be made by a multidisciplinary team at an experienced high-volume center.

In patients with hilar CCA, extended hepatic resection (to encompass the biliary confluence) (usually with caudate lobectomy) is recommended, since hilar tumors, by definition, abut or invade the central portion of the liver. The recommendation for extended liver resection is supported by retrospective analyses showing a higher rate of R0 resection, prolonged survival, and decreased hepatic recurrence associated with extended hepatic resections as compared to bile duct resections.[207-211] Resection and reconstruction of the portal vein and/or hepatic artery may be necessary for complete resection, especially in patients with more advanced disease. This approach requires substantial experience and appropriate surgical support for such technical operations.[212,213] For adjuvant treatment of resected hilar CCA, see the section on *Adjuvant Chemotherapy and Chemoradiation for Biliary Tract Cancers*.

Patient selection for surgery is facilitated by careful preoperative staging, surgical exploration, biopsy, and consideration of diagnostic laparoscopy to identify patients with unresectable or distant metastatic disease. A preoperative biopsy is not necessary if the index of suspicion is high. Laparoscopy can identify the majority of patients with occult metastatic hilar CCA, albeit with a lower yield. A review including six studies of staging laparoscopy in patients with hilar CCA showed a yield of 14% to 45% and

an accuracy of 32% to 71%.[214] The decreasing yield of staging laparoscopy over time may be due to improvements in imaging techniques.[215]

While not routinely used in all patients undergoing resection, the consensus of the Panel is that in patients with hilar CCA, preoperative treatments including biliary drainage targeted to the future liver remnant (FLR) (using ERCP or PTC)[216-219] and contralateral portal vein embolization[220,221] should be considered for patients with low FLR volumes. Patients with unresectable or metastatic disease should be considered for biliary drainage using either surgical bypass (although rarely used) or ERCP or PTC, most often involving biliary stent placement.[222-225]

In patients with unresectable or metastatic disease, biopsy is recommended to confirm the diagnosis prior to the initiation of further treatment. For patients with unresectable disease, biopsy is recommended only after determining transplant status as transperitoneal and surgical biopsy may be contraindicated in transplant candidates. Molecular testing is recommended to potentially guide targeted treatment. Primary treatment options for these patients include: systemic therapy, clinical trial, or best supportive care. In addition, combination of chemotherapy and chemoradiation, chemoradiation, and palliative RT are also included as options for patients with unresectable disease. Data to support particular chemoradiation and chemotherapy regimens are limited. See sections on *Chemotherapy* and *Chemoradiation and Radiation Therapy* for *Treatment of Advanced Biliary Tract Cancers*. Following primary treatment, except for those receiving best supportive care, the disease should be assessed for response. Resection or locoregional therapy should be reconsidered. Subsequent-line systemic therapy is an option if there is progression on or after systemic therapy.

Liver transplantation is a potentially curative option for selected patients with lymph node-negative, non-disseminated, locally advanced hilar CCAs.[226-229] There is retrospective evidence suggesting that neoadjuvant chemoradiation followed by liver transplantation is effective for selected patients with hilar CCA; particularly in patients with primary sclerosing cholangitis.[230-232] Results from two studies suggest that the combination of liver transplantation and neoadjuvant and/or adjuvant chemoradiation is associated with higher RFS than a potentially curative resection.[233,234] However, in one of these studies, there were substantial differences in the characteristics of patients in the two treatment groups.[233] It is important to note that many of these reports include patients with primary sclerosing cholangitis, and some have not had a definitive histologic cancer diagnosis. Liver transplantation should be considered only for highly selected patients (ie, tumor ≤3 cm in radial diameter, no intrahepatic or extrahepatic metastases, no nodal disease) with either unresectable disease with otherwise normal biliary and hepatic function or underlying chronic liver disease precluding surgery. The Panel encourages continuation of clinical research in this area, and referral of patients with unresectable disease to a transplant center with a United Network for Organ Sharing-approved protocol for transplant of CCA should be considered.

Photodynamic therapy (PDT) is an ablative therapy that involves intravenous injection of a photosensitizing drug followed by selective irradiation with light of a specific wavelength to initiate localized drug activation, and has been used for palliation in patients with extrahepatic CCA. The combination of PDT with biliary stenting was reported to be associated with prolonged OS in patients with unresectable CCA in two small RCTs.[235,236]

Surveillance

There are no data to support a specific surveillance schedule or tests in patients undergoing resection of CCA; determination of appropriate follow-up schedule/imaging should include a careful patient/physician discussion. It is recommended that follow-up of patients undergoing resection of CCA should include consideration of imaging studies every 3

to 6 months for 2 years, then every 6 to 12 months for up to 5 years, or as clinically indicated. Re-evaluation according to the initial workup should be considered in the event of disease progression. One study reported a cumulative recurrence rate of 44%, 65%, and 70% at 1, 3, and 5 years, respectively, post resection for patients with intrahepatic CCA.[237] Another study reported that among patients with intrahepatic CCA with disease recurrence, almost all instances of recurrence were observed within 5 years; the highest risk was within 2 years of resection.[238] In a sample of 80 patients with extrahepatic CCA who underwent resection, 48.8% died of disease by 28 months, while 11.3% died of other causes.[83]

Adjuvant Chemotherapy and Chemoradiation for Biliary Tract Cancers

Recurrence following surgery is a primary limitation for cure in patients with BTCs and provides an important justification for the use of adjuvant therapy, which is recommended for up to 6 months. The role of adjuvant chemotherapy or chemoradiation therapy in patients with resected BTCs is poorly defined, with a lack of data from multiple phase III randomized controlled trials.[166,239] Due to the low incidence of BTCs, the efficacy and safety of adjuvant chemotherapy or chemoradiation therapy in these patients have been primarily evaluated in retrospective studies that have included only a small number of patients. Further, these studies often combined patients with gallbladder and bile duct cancers (with a few exceptions), which may be problematic since the biology of these tumors is completely different. Despite the challenges associated with the accrual of large numbers of patients with BTC for randomized phase III trials, it is widely recognized that efforts should be made to conduct such studies in which the individual disease entities are evaluated separately.

Data supporting adjuvant chemotherapy in patients with resected BTC have come from two randomized phase III trials. In the phase III BILCAP study, 447 patients with R0/R1 resected CCA or gallbladder cancer were randomized to receive either adjuvant capecitabine or observation.[240] RFS was significantly greater for patients in the capecitabine arm in both the intent-to-treat analysis (24.4 vs. 17.5 months; HR, 0.75; 95% CI, 0.58–0.98; P = .033) and in the per-protocol analysis (N = 430; HR, 0.70; 95% CI, 0.54–0.92; P = .009). The primary endpoint of median OS was 51.1 months for the capecitabine arm and 36.4 months for the observation arm. This difference was statistically significant in the per-protocol analysis (HR, 0.75; 95% CI, 0.58–0.97; P = .028) but not in the primary intent-to-treat analysis. Data from a long-term analysis in the intent-to-treat population determined a median OS of 49.6 months for the capecitabine arm and 36.1 months for the observation arm (adjusted HR, 0.84; 95% CI, 0.67–1.06).[241] A hazard ratio of 0.74 (95% CI, 0.59–0.94) was reported in the protocol-specified sensitivity analysis. In the STAMP randomized study from South Korea, adjuvant gemcitabine and capecitabine did not improve disease-free survival at 2 years and median OS, when compared to capecitabine, in patients with lymph node-positive extrahepatic CCA following resection.[242]

In a phase III randomized trial reported in 2002, 508 patients with resected pancreaticobiliary cancer (139 patients had CCA and 140 patients had gallbladder cancer) were randomly assigned to adjuvant chemotherapy with fluorouracil and mitomycin C or to a control arm.[243] Results from unplanned subgroup analyses showed a significantly better 5-year disease-free survival for patients with gallbladder cancer treated with chemotherapy (20.3% compared to 11.6% in the control group; P = .021), although no significant differences between the two treatment arms were observed for all patients with biliary tract cancers. Results from this trial suggested that patients with gallbladder cancer undergoing resection may derive survival benefit with adjuvant chemotherapy but the gallbladder cohort on the BILCAP trial did not see a similar benefit on exploratory analysis.[241,243]

A randomized phase III trial from Japan investigated whether S-1, an oral fluoropyrimidine derivative given as adjuvant therapy, benefited patients with BTCs who underwent R0/R1 resection.[244] Compared to patients treated with surgery alone, patients treated with adjuvant S-1 had a significantly improved 3-year OS (adjusted HR, 0.69; 95% CI, 0.51–0.94; *P* = .008). However, the 3-year RFS rate was not significantly higher (HR, 0.80; 95% CI, 0.61–1.04; *P* = .088). Furthermore, S-1 is not available in the United States.

Negative results were reported from gemcitabine-based regimens in two randomized phase III trials. In the phase III PRODIGE 12-ACCORD 18 trial, 196 patients with R0/R1 resected BTC were randomized to receive GEMOX or surveillance alone.[245] No statistically significant differences were found between the study arms for RFS and OS. In another phase III trial from Japan, adjuvant gemcitabine monotherapy (compared to observation) in 226 patients with resected extrahepatic CCA reported no difference in survival.[246]

Retrospective studies that have combined patients with gallbladder cancer and CCAs provide conflicting evidence regarding the role of adjuvant therapy.[247-249] It should be noted that the majority of recurrences after resection of gallbladder cancer involve distant sites, supporting the idea of developing effective adjuvant systemic therapies.[247]

In a systematic review and meta-analysis of 6712 patients with BTCs, Horgan et al reported an associated improvement in OS (although nonsignificant) with adjuvant therapy compared with surgery alone, with no difference between patients with gallbladder cancer and bile duct cancers.[250] Chemotherapy or chemoradiation therapy was associated with statistically greater benefit than RT alone, with the greatest benefit observed in patients with lymph node-positive disease and macroscopic residual disease (R1 resection). Another systematic review and meta-analysis of 42,917 patients found a significantly higher OS with adjuvant therapy after surgery compared with surgery alone.[251] Ren et al reported a higher 5-year OS with adjuvant RT compared to surgery only in patients with gallbladder cancer or extrahepatic CCA in a meta-analysis of 21 clinical trials.[252]

In studies that included only patients with gallbladder cancer, a meta-analysis of 10 retrospective studies with 3191 patients showed that adjuvant chemotherapy was associated with improved OS, compared to resection alone (HR, 0.42; 95% CI, 0.22–0.80).[253] Subgroup analyses showed that the patients who are most likely to benefit from adjuvant therapy include those with a positive margin, nodal disease, or at least stage II disease. Retrospective studies have concluded that adjuvant chemotherapy or chemoradiation following R0 resection might improve OS in selected patients with T2 or T3 tumors and lymph node-positive gallbladder cancer.[254-257]

Retrospective studies that included only patients with resected extrahepatic CCA suggest that adjuvant chemoradiation may improve local control and survival, although distant metastases was the most common pattern of recurrence.[258-261] Other studies have suggested that adjuvant chemoradiation may have a significant survival benefit only in a subgroup of patients with T3 or T4 tumors or those with a high risk of locoregional recurrence (R1 resection or positive lymph nodes).[260,262,263]

Most of the collective experience of chemoradiation in BTCs involves concurrent chemoradiation and fluorouracil. The phase II SWOG S0809 trial, which enrolled patients with extrahepatic CCA or gallbladder cancer (*N* = 79), provided prospective data on adjuvant chemotherapy/chemoradiation (ie, capecitabine/gemcitabine followed by concurrent capecitabine and RT).[164] Two-year OS was 65%, and median survival was 35 months. A majority of patients enrolled in the trial (86%) completed therapy, and the regimen was generally tolerable. The results from a large national database also support the use of adjuvant

chemoradiation (HR, 0.86; *P* = .004) over adjuvant chemotherapy only.[264] Confirmatory phase III trial data are needed. Concurrent chemoradiation with capecitabine has been used in other studies.[260,265] Concurrent chemoradiation with gemcitabine is not recommended due to the limited experience and toxicity associated with this treatment.[266]

Among patients with cancer of the gallbladder or extrahepatic bile duct, those who have undergone an R0 resection and who have negative regional nodes or those with carcinoma in situ at margin may be followed with systemic therapy (preferred), clinical trial (preferred), observation alone, or chemoradiation (category 2B for patients with gallbladder cancer). Patients with intrahepatic CCA who have undergone an R0 resection may be followed with systemic therapy (preferred), clinical trial (preferred), or observation.

Patients with gallbladder cancer or extrahepatic CCA with resected, positive margins (R1) or gross residual disease (R2) or those with intrahepatic CCA with gross residual disease (R2) after resection should be evaluated by a multidisciplinary team to review the available treatment options on a case-by-case basis. Evaluation and treatment of gross residual disease (R2) should be consistent with evaluation and treatment for unresectable disease. For patients with R1 margins or positive regional nodes, the optimal treatment strategy has not been established but options are systemic therapy (preferred), clinical trial (preferred), combination of chemotherapy and chemoradiation, or chemoradiation.

There are limited data to support a specific chemoradiation regimen or definitive benefit. If RT is used, then RT using 3D conformal RT and intensity-modulated RT are options.[164,165] Dosing schedules may depend on margin positivity and may include up to 45 Gy at 1.8 Gy/fraction or 50 to 60 Gy at 1.8 to 2.0 Gy/fraction (to allow for an integrated boost) to the tumor bed.[166,167] RT dosing[163] is dependent on the ability to meet normal organ constraints and underlying liver function. If SBRT or hypofractionation are not options, conventional fractionation with doses ranging from 60 Gy per 30 fractions to 77 Gy per 35 fractions[168,169] or chemoradiation up to 60 Gy per 30 fractions is recommended.[158] The preferred dosing schedule for SBRT for unresectable disease is 40 to 60 Gy, typically done in 3 to 5 fractions, if dose constraints can be met.[163,170]

Recommended adjuvant chemotherapy regimens include capecitabine monotherapy (category 1); gemcitabine monotherapy or combined with cisplatin or capecitabine; and 5-fluououracil monotherapy. Capecitabine monotherapy is preferred while all other options are included as other recommended regimens. If a patient is ineligible for cisplatin, carboplatin may be used.[267] Besides capecitabine monotherapy, whose use in this setting is supported by the pre-specified secondary endpoint of the phase III BILCAP study,[240] data to support particular chemotherapy regimens for adjuvant treatment of resected BTC are limited and are based on the extrapolation of data from studies of patients with advanced disease. Additionally, some of the recommendations are based on practice patterns at NCCN Member Institutions and retrospective studies from single-center experiences. The recommendations in the NCCN Guidelines on the use of adjuvant chemotherapy are not specific to the particular type of BTC, due to the limited data and the heterogeneity of patient populations included in many of the published studies.

Treatment for Advanced Biliary Tract Cancers

The prognosis of patients with advanced BTCs is poor and the median survival for those undergoing supportive care alone is short.[268] Treatment options for advanced BTCs may include systemic therapy, enrollment in a clinical trial, combination of chemotherapy and chemoradiation, chemoradiation, palliative RT, consideration of locoregional therapy (arterially directed therapies or RT), consideration of referral to a transplant center, and best supportive care, depending on the disease stage and specific disease subtype. Following primary treatment, except for those

receiving best supportive care, the disease should be assessed for response. Resection or locoregional therapy should be reconsidered. Subsequent-line systemic therapy is an option if there is progression on or after systemic therapy. Selection of subsequent-line systemic therapy for progressive disease depends on clinical factors including previous treatment regimen/agent, somatic molecular testing results, and extent of liver dysfunction. A U.S. Food and Drug Administration (FDA)-approved biosimilar is an appropriate substitute for any recommended systemic biologic therapy in the NCCN Guidelines.

Immunotherapy Plus Chemotherapy

The phase III TOPAZ-1 trial, which randomized 685 patients with unresectable or metastatic BTC with no prior systemic treatment 1:1, demonstrated that treatment with durvalumab in combination with gemcitabine plus cisplatin significantly improved the primary endpoint of OS (HR, 0.80; 95% CI, 0.66–0.97; *P* = .021) along with the secondary endpoint of PFS (HR, 0.75; 95% CI, 0.63–0.89; *P* = .001) compared to placebo in combination with gemcitabine plus cisplatin.[188] The overall response rate (ORR) was 26.7% and 18.7%, respectively. Following an updated analysis, the authors report an updated median OS of 12.9 months for patients treated with durvalumab in combination with gemcitabine and cisplatin, compared to 11.3 months for those treated with placebo in combination with gemcitabine and cisplatin (HR, 0.76; 95% CI, 0.64–0.91).[269] Decreased neutrophil count (treatment group, 21%; control group, 25%), anemia (19% in both groups), and neutropenia (treatment group, 19%; control group, 20%) were the most frequent grade 3 or 4 treatment-related adverse events.

The phase III randomized KEYNOTE-966 trial investigated the combination of pembrolizumab with gemcitabine and cisplatin compared to the combination of placebo with gemcitabine and cisplatin in 1069 patients with unresectable, locally advanced, or metastatic BTC with no prior treatment.[187] In the intention-to-treat population, there was a significant improvement in the primary endpoint of OS, with a median OS of 12.7 months in the treatment group and a median OS of 10.9 months in the control group (HR, 0.83; 95% CI, 0.72–0.95; *P* = .0034). At the first interim analysis, treatment with pembrolizumab/gemcitabine/cisplatin did not result in a statistically significant benefit in PFS (HR, 0.86; 95% CI, 0.75–1.00; *P* = .023). Similar results were obtained in the final analysis for PFS. Both groups had an ORR of 29% at the first interim analysis. 70% of patients treated with pembrolizumab in combination with gemcitabine and cisplatin experienced a grade 3 or 4 treatment-related adverse event compared to 69% of patients treated with placebo in combination with gemcitabine and cisplatin.

Based on these data, the Panel has included combination therapy with durvalumab plus gemcitabine plus cisplatin, as well as combination therapy with pembrolizumab plus gemcitabine plus cisplatin, as category 1 preferred recommendations for the first-line systemic treatment of unresectable or metastatic BTCs. Durvalumab in combination with gemcitabine and cisplatin is also a recommended treatment option for patients who developed recurrent disease >6 months after surgery with curative intent and >6 months after completion of adjuvant therapy. These combinations are also recommended as subsequent-line systemic therapy options (other recommended regimens) for progressive disease in patients who have not been previously treated with a checkpoint inhibitor. If a patient is ineligible for cisplatin, carboplatin may be used.[267]

Chemotherapy Alone

The survival benefit of chemotherapy (fluorouracil, leucovorin, and etoposide) over best supportive care for patients with advanced BTCs was initially suggested in a phase III trial of 90 patients with advanced pancreatic and BTCs, 37 of whom had advanced BTCs.[270] In a single-center randomized study of 81 patients with unresectable gallbladder

cancer, Sharma et al reported that modified GEMOX improved PFS and OS compared to best supportive care or fluorouracil.[271] Median OS was 4.5, 4.6, and 9.5 months, respectively, for the best supportive care, fluorouracil, and modified GEMOX arms (P = .039). The corresponding PFS was 2.8, 3.5, and 8.5 months (P < .001).

Several phase II studies have also demonstrated the efficacy of chemotherapy for the treatment of patients with advanced BTCs.[272,273] The results of a pooled analysis of 104 trials that have included 2810 patients with advanced BTCs showed that response rates and tumor control were higher for the subgroup of patients receiving a combination of gemcitabine and platinum-based agents.[274] In a retrospective study of 304 patients with unresectable BTCs who were treated with gemcitabine alone, a cisplatin-based regimen, or a fluoropyrimidine-based regimen, patients receiving gemcitabine were shown to have a lower risk of death.[275] Most importantly, the support for the use of gemcitabine-based or fluoropyrimidine-based chemotherapy for patients with advanced BTCs comes from four randomized studies.[189,276-278] A phase II study comparing modified FOLFIRINOX (mFOLFIRINOX; fluorouracil, leucovorin, irinotecan and oxaliplatin) to gemcitabine plus cisplatin in patients with locally advanced or metastatic BTCs did not achieve its primary endpoint of PFS at 6 months in the modified intention-to-treat population.[279]

The randomized, controlled, phase III ABC-02 study, which enrolled 410 patients with locally advanced or metastatic CCA, gallbladder cancer, or ampullary cancer, demonstrated that the combination of gemcitabine and cisplatin improved OS and PFS by 30% over gemcitabine alone.[189] Median OS was 11.7 months and 8.1 months (HR, 0.64; 95% CI, 0.52–0.80; P < .001), and median PFS was 8.0 months versus 5.0 months (HR, 0.63; 95% CI, 0.51–0.77; P < .001), both in favor of the combination arm. Although the rate of neutropenia was higher in the group receiving gemcitabine and cisplatin, there was no significant difference in the rate of neutropenia-associated infections between the two arms. Okusaka et al also reported similar findings in a phase II randomized study of 84 patients with advanced BTCs.[278] If a patient is ineligible for cisplatin, carboplatin may be used. A phase II study with 48 patients with advanced BTCs revealed that 31.1% of evaluable patients treated with gemcitabine plus carboplatin had an overall response, with a median OS and PFS of 10.6 and 7.8 months, respectively.[267]

Results from the randomized phase III ABC-06 study showed that compared to active symptom control alone, active symptom control combined with FOLFOX in patients previously treated with combined cisplatin and gemcitabine improved the primary endpoint of median OS (6.2 vs. 5.3 months; adjusted HR, 0.69; P = .031).[280] FOLFOX is a preferred subsequent-line systemic therapy option for unresectable or metastatic progressive disease. Second-line treatment with fluorouracil and irinotecan (FOLFIRI) also provided some benefits to patients (median PFS, 1.7 months [95% CI, 0.66–2.67 months]; median OS, 5 months [95% CI, 2.77–7.20 months]).[281] A retrospective analysis of patients with advanced BTCs treated with FOLFIRI also demonstrated some efficacy (median OS, 6.6 months [95% CI, 4.7–8.4 months]; median PFS, 2.4 months [95% CI, 1.7–3.1 months]).[282] Patients treated with concurrent bevacizumab or EGFR-targeted therapy had a median PFS of 2.7 months. A randomized phase II trial comparing mFOLFOX (leucovorin, fluorouracil, and oxaliplatin) with mFOLFIRI in patients with locally advanced or metastatic BTCs previously treated with gemcitabine and cisplatin reported similar efficacy between the two regimens.[283] The median OS and PFS were 6.3 months (95% CI, 4.4–8.2 months) and 2.8 months (95% CI, 2.3–3.3 months), respectively, in the mFOLFOX group and 5.7 months (95% CI, 4.7%–6.7%; P =.677) and 2.1 months (95% CI, 1.1–3.1 months; P = .974) in the mFOLFIRI group, respectively. An ORR of 5.9% and 4.0% (P = .663) was achieved in the mFOLFOX and mFOLFIRI groups, respectively, and the disease control rate was 66.7% and 64.0% (P = .778), respectively. FOLFIRI is a

subsequent-line systemic therapy option (other recommended regimen) for unresectable or metastatic progressive disease.

The phase IIb NIFTY trial from South Korea showed that treatment with liposomal irinotecan with fluorouracil and leucovorin in patients with confirmed metastatic BTC with disease progression on gemcitabine and cisplatin significantly improved median PFS (7.1 months; 95% CI, 3.6–8.8 months) compared to treatment with fluorouracil and leucovorin (1.4 months; 95% CI, 1.2–1.5 months; HR, 0.56; 95% CI, 0.39–0.81; *P* = .0019) on a blinded independent central review.[284] In an updated analysis, the median PFS, as assessed by a different blinded independent central review, was 4.2 months for patients treated with the former compared to 1.7 months (HR, 0.61; *P* = .004) for patients treated with fluorouracil and leucovorin.[285] Unfortunately, a similar randomized phase II AIO NALIRICC trial from Europe showed no difference in median overall survival with 6.9 months (95% CI, 5.3–10.6 months) in the liposomal irinotecan plus fluorouracil and leucovorin arm and 8.2 months (5.4–11.9 months) in the fluorouracil plus leucovorin arm (HR, 1.08; 95% CI, 0.68–1.72; *P* = .74].[286] There was also no difference in the primary endpoint of PFS (HR, 0.87; 95% CI, 0.56–1.35; *P* = .52). Liposomal irinotecan plus fluorouracil plus leucovorin is a category 2B subsequent-line systemic therapy option (other recommended regimen) for unresectable or metastatic progressive disease.

Examples of other gemcitabine-based or fluoropyrimidine (fluorouracil or capecitabine)-based regimens with demonstrated activity in phase II trials include: gemcitabine and cisplatin or oxaliplatin[287-295]; gemcitabine and fluoropyrimidine[296-300]; gemcitabine and albumin-bound paclitaxel (for CCA)[301]; gemcitabine and cetuximab[302]; and fluoropyrimidine and oxaliplatin or cisplatin.[303-306] A phase III study showed that the combination of capecitabine and oxaliplatin was noninferior to the GEMOX combination in terms of the 6-month PFS.[307] Triple-drug chemotherapy regimens have also been shown to be effective in patients with advanced BTCs, albeit in a very small number of patients.[308-310] The phase III trial that evaluated fluorouracil, leucovorin, and etoposide versus fluorouracil, cisplatin, and epirubicin did not show one regimen to be significantly superior with respect to OS (12 vs. 9 months, respectively) in patients with advanced BTCs, although the trial was underpowered to detect such a difference.[308] In a phase II trial, the combination of panitumumab, a monoclonal anti-EGFR antibody, with gemcitabine and irinotecan showed encouraging efficacy with good tolerability in patients with advanced CCA, with a 5-month PFS rate of 69%.[311] The median PFS and OS were 9.7 months and 12.9 months, respectively.

The effects of other gemcitabine combination therapies have been examined in phase II trials. In a randomized phase II study of 51 patients, Kornek et al established the efficacy and tolerance of mitomycin in combination with gemcitabine or capecitabine in previously untreated patients with advanced BTCs.[276] Mitomycin and capecitabine were associated with superior complete response (CR) rate (31% vs. 20%), median PFS (5.3 vs. 4.2 months), and OS (9.25 vs. 6.7 months). The results of the 40955 EORTC trial showed that cisplatin and fluorouracil was more active than high-dose fluorouracil in terms of ORRs (19% and 7.1%, respectively) and OS (8 and 5 months, respectively), but the PFS was similar in both treatment arms (3.3 months).[277] In a randomized phase II trial, the combination of gemcitabine and sorafenib was compared to gemcitabine with a placebo in 102 patients with unresectable or metastatic BTC.[312] There were no significant between-group differences for OS and PFS rates, but patients who developed liver metastases following resection survived longer if they received sorafenib, relative to patients who received the placebo (*P* = .019). Data from the randomized phase II NIFE trial showed that in the intention-to-treat population, 51% of patients receiving nanoliposomal irinotecan in combination with fluorouracil and leucovorin achieved PFS at 4 months compared to 59.5% in the gemcitabine and

cisplatin arm.[313] The OS and PFS data suggest that the combination regimen may be particularly beneficial for extrahepatic CCA; however gemcitabine plus cisplatin may be more beneficial for intrahepatic CCA. Additional data from phase III trials are needed.

A phase II trial in India randomized patients with advanced BTC with SD after 6 months of gemcitabine-based chemotherapy to either active surveillance or switch maintenance.[314] The latter consisted of bevacizumab every 21 days and erlotinib once a day. The results showed that switch maintenance improved PFS (median PFS of 3.1 months for the active surveillance group vs. 5.3 months for the switch maintenance group; HR, 0.51; *P* = .0013).

Based on the experiences from phase II or phase III studies, the following gemcitabine-based and fluoropyrimidine-based combination chemotherapy regimens are included as other recommended options for the treatment of patients with advanced BTCs: gemcitabine with cisplatin (category 1 in the first-line setting), capecitabine with oxaliplatin; FOLFOX (preferred regimen in the subsequent-line setting); gemcitabine combined with albumin-bound paclitaxel; gemcitabine with capecitabine or oxaliplatin; and single-agent fluorouracil, capecitabine, and gemcitabine. If a patient is ineligible for cisplatin, carboplatin may be used.[267] The combination of gemcitabine and fluorouracil is not included due to the increased toxicity and decreased efficacy observed with this regimen[296] when compared with results of studies of the gemcitabine and capecitabine regimen in the setting of advanced BTC.

Chemoradiation and Radiation Therapy

Chemoradiation in the setting of advanced BTCs can provide control of symptoms due to local tumor effects and may prolong OS. However, there are limited clinical trial data to define a standard regimen or definitive benefit. In a retrospective analysis of 37 patients treated with chemoradiation for unresectable extrahepatic CCA, the actuarial OS rates at 1 and 2 years were 59% and 22%, respectively, although effective local control was observed in the majority of patients during this time period (actuarial local control rates of 90% and 71% at 1 and 2 years, respectively).[315] The most extensively investigated chemotherapeutic agent for use in concurrent chemoradiation in the treatment of BTCs has been fluorouracil,[316,317] although capecitabine has been substituted for fluorouracil in some studies.[265] The Panel recommends that concurrent chemoradiation (RT guided by imaging) should be limited to either 5-fluorouracil or capecitabine, and that such treatment should be restricted to patients without evidence of metastatic disease. Concurrent chemoradiation with gemcitabine is not recommended due to the limited experience and toxicity associated with this treatment.

Evidence supports the consideration of RT for treatment of unresectable and metastatic intrahepatic CCA,[158,160,161,318] but there is little evidence to support this treatment option for gallbladder cancer and extrahepatic CCA without concurrent chemotherapy and in patients with unresected disease.[319,320]

Targeted Therapy

BTCs are known to harbor clinically relevant molecular alterations that are differentially expressed in gallbladder cancer and intrahepatic and extrahepatic CCAs. The rarity of individual subgroups limits precise incidence and frequency estimates. Given emerging evidence regarding actionable targets for treating BTCs, comprehensive molecular profiling is recommended for patients with unresectable or metastatic BTC who are candidates for systemic therapy (see *Principles of Molecular Testing* in the algorithm for additional information regarding testing modalities and considerations).[321] While most BTCs are considered sporadic, up to 10% to 15% of BTCs may be associated with an inherited cancer predisposition syndrome.[322,323] As evidence remains insufficient for definitive

recommendations regarding specific criteria to guide genetic risk assessment in hepatobiliary cancers or for universal germline testing, genetic counselling referral and potential germline testing should be considered in patients with BTCs with any of the following: young age at diagnosis; a strong personal or family history of cancer; no known risk factors for liver disease; or the presence of mutations identified during tumor testing that are suspected to be possible germline alterations. For patients who harbor a known germline mutation associated with a cancer predisposing syndrome (ie, Lynch syndrome or hereditary breast and ovarian cancer syndrome), there is currently insufficient evidence to support screening for biliary tract malignancies.

NTRK Fusions

NTRK is a membrane-bound receptor that autophosphorylates and activates downstream pathways that drive oncogenesis. *NTRK1/NTRK2/NTRK3* fusions are estimated to occur at <1% prevalence in BTCs.[324,325] Three NTRK inhibitors have been approved by the FDA for a tumor agnostic indication in *NTRK* fusion-positive solid tumors: larotrectinib[326] in 2018, entrectinib[327] in 2019, and repotrectinib[328] in 2024. Studies with entrectinib and larotrectinib have demonstrated response rates in the 57% to 75% range in pre-treated *NTRK* fusion-positive tumors.[325-327] These studies included small numbers of patients with CCA and demonstrated evidence of clinical benefit. Abstract data for repotrectinib showed a confirmed ORR of 50% in patients with tyrosine kinase inhibitor-pretreated *NTRK* fusion-positive solid tumors.[328] Entrectinib, larotrectinib, and repotrectinib are useful in certain circumstances first-line or subsequent-line (for progressive disease) systemic therapy options for unresectable or metastatic *NTRK* gene fusion-positive tumors. In the subsequent-line setting, repotrectinib is an option if there was progression on a prior therapy, which may include prior NTRK inhibitors; entrectinib and larotrectinib should not be used if there was progression on prior NTRK inhibitors.

Testing for *NTRK* fusions is recommended for patients with unresectable or metastatic gallbladder cancer, intrahepatic CCA, or extrahepatic CCA. These assessments are feasible in the context of multi-target assessment in next-generation sequencing (NGS) gene panels currently in clinical use and *NTRK* fusion-positive CCAs have demonstrated responses in clinical trials.

Immunotherapy Biomarkers (MSI-H/dMMR/TMB-H/PD-L1)

Mismatch repair (MMR) deficiency results from somatic alterations in *MLH1, MSH2, MSH6,* and *PMS2,* which are genes encoding proteins that regulate DNA repair. MMR deficiency results in a unique genetic signature characterized by high rates of mutations, particularly in repetitive DNA sequences called microsatellites that occur throughout the genome. This signature is referred to as MSI or MSI-H. MSI-H or mismatch repair deficient (dMMR) status is rare in BTCs and has an approximate incidence of 1% to 3%.[329-331]

Tumor mutational burden (TMB) is defined as the total number of somatic mutations per coding area of a tumor's genome. Higher rates of tumor mutation may result in increased production of immunogenic mutant proteins or neoantigens.[331-336] The incidence of TMB-high (TMB-H) has been shown to be <5% across studies.[321,337]

The programmed cell death ligand 1 (PD-L1) system functions to inhibit T cell functions. PD-L1 protein expression on malignant or inflammatory associated tumor cells generally indicates active tumor immunity suppressed by the programmed cell death protein 1 (PD-1)/PD-L1 system. In BTCs, PD-L1 high status ranges from around 45% to 65% for combined tumor plus immune cell PD-L1 expression ≥1%, and 10% to 70% for tumor cell PD-L1 expression ≥1%.[331,333]

MSI-H or MMR deficiency are predictive of substantially higher rates of durable, objective response to immune checkpoint inhibition in patients across a range of solid tumor types in studies that have included patients with BTCs.[329,333,338,339] In the KEYNOTE-158 trial, 233 patients with MSI-H or dMMR non-colorectal solid tumor types after failure of standard therapy, including 22 patients with CCA, demonstrated an ORR of 34.3% (95% CI, 28.3%–40.8%) with median PFS of 4.1 months (95% CI, 2.4–4.9 months) and median OS of 23.5 months (95% CI, 13.5 months–not reached).[338] Grade 3–5 treatment-related adverse events were observed in 14.6% of patients. Analyses of a CCA subgroup (*N* = 22) revealed an ORR of 40.9% (95% CI, 20.7%–63.6%) with a median PFS and OS of 4.2 months (95% CI, 2.1 months–not reached) and 24.3 months (95% CI, 6.5 months–not reached), respectively. The results from an updated analysis showed that out of 351 patients with advanced MSI-H/dMMR noncolorectal solid tumors who received prior treatment, 30.8% (95% CI, 25.8%–36.2% achieved an overall response.[339] The median PFS, median OS, and median duration of response (DOR) were 3.5 months (95% CI, 2.3–4.2 months), 20.1 months (95% CI, 14.1–27.1 months), and 47.5 months (95% CI, 2.1+ to 51.1+ months), respectively. Twelve percent of patients experienced a grade 3–5 treatment-related adverse event. In the CCA/biliary tract subgroup, the ORR was the same as previously reported. The median PFS was 4.2 months (95% CI, 2.1–24.9 months) and the median OS was 19.4 months (95% CI, 6.5 months–not reached). These findings contributed to the FDA approval of pembrolizumab for patients with unresectable or metastatic MSI-H or dMMR solid tumors, as determined by an FDA-approved test, which have progressed following prior treatment and who have no satisfactory alternative treatment options, agnostic to tumor histology.

In the KEYNOTE-158 trial, 102 of 805 evaluable patients were found to have tumors with TMB-H status, defined as ≥10 mutations/megabase of DNA based upon the platform used; objective radiographic responses occurred in 29% of patients (95% CI, 21%–39%) by comparison with only 6% of patients (95% CI, 5%–8%) in the non-TMB-H group.[332] These findings led to a histology-agnostic FDA approval of pembrolizumab for patients with TMB-H advanced solid tumors that have progressed following prior treatment and who have no satisfactory alternative treatment options. Though none of the 63 BTC patients in the KEYNOTE-158 TMB cohort were found to harbor TMB-H tumors, other studies have shown that approximately 4% of advanced BTCs have TMB-H tumors, supporting testing for TMB in this population.[331,334]

Pembrolizumab is a useful in certain circumstances first-line or subsequent-line (for progressive disease and with no prior treatment with a checkpoint inhibitor) systemic therapy option for unresectable or metastatic MSI-H, dMMR, or TMB-H (for subsequent-line therapy only) BTCs, though the Panel cautions that data to support this recommendation are limited, particularly in the first-line setting.[340]

Dostarlimab-gxly, another anti-PD-1 antibody, was assessed in the open-label phase I GARNET study with 2 cohorts.[341] One cohort had patients with advanced or recurrent MSI-H/dMMR endometrial cancer and another had patients with advanced or recurrent MSI-H/dMMR or POLE-mutated non-endometrial solid tumors. The ORR for the cohort with non-endometrial cancer was 43.1% (95% CI, 36.2%–50.2%). The median DOR and median OS were not reached at the time of follow up and the median PFS was 7.1 months. The most frequent grade 3 or higher treatment-emergent adverse events were anemia (2.5%), increased lipase (1.3%), and increased alanine aminotransferase (1.9%). Dostarlimab-gxly is a category 2B useful in certain circumstances subsequent-line systemic therapy option for patients with MSI-H/dMMR recurrent or advanced tumors that have progressed on or following prior treatment, who have no satisfactory alternative treatment options, and who have not been previously treated with a checkpoint inhibitor.

The phase II CheckMate 848 trial randomized patients with unresectable or metastatic TMB-H solid tumors with no prior immunotherapy and who had disease refractory to standard local therapies 2:1 to receive the combination of nivolumab and ipilimumab or nivolumab monotherapy.[342] TMB status was assessed using tumor tissue (tTMB) or circulating tumor DNA in the blood (bTMB). The data revealed an ORR of 38.6% (95% CI, 28.4%–49.6%) (vs. 29.8% for nivolumab [95% CI, 17.3%–44.9%]), a median OS of 15.0 months (95% CI, 10.2–29.8 months) (vs. 14.6 months for nivolumab [95% CI, 7.7–20.7 months]), and a median PFS of 5.7 months (95% CI, 3.2–11.6 months) (vs. 2.8 months for nivolumab [95% CI, 2.7–5.7 months]) in patients with tTMB-H tumors treated with nivolumab plus ipilimumab. In patients with bTMB-H tumors treated with nivolumab plus ipilimumab, the ORR, median OS, and median PFS were 22.5% (95% CI, 13.9%–33.2%) (vs. 15.6% for nivolumab [95% CI, 6.5%–29.5%]), 8.1 months (95% CI, 5.8–10.5 months) (vs. 11.2 months for nivolumab [95% CI, 5.3–19.0 months]), and 2.8 months (95% CI, 2.3–3.0 months) (vs. 2.8 months for nivolumab [95% CI, 2.6–3.3 months]), respectively. Treatment-related adverse events occurred in 28.7% of patients with tTMB-H tumors (vs. 8.0% for nivolumab) and in 37.3% of patients with bTMB-H tumors (vs. 2.1% for nivolumab) treated with the combination therapy. Nivolumab plus ipilimumab is a useful in certain circumstances first-line (category 2B) or subsequent-line (for progressive disease and with no prior treatment with a checkpoint inhibitor) systemic therapy option for patients with unresectable or metastatic TMB-H tumors. In the subsequent-line setting, the recommendation is for patients with disease refractory to standard therapies or who have no standard treatment options available.

Testing for MSI or MMR deficiency is recommended in patients with unresectable or metastatic gallbladder cancer, intrahepatic CCA, or extrahepatic CCA. Further recommendations for MSI/MMR testing can be found in the NCCN Guidelines for Colon Cancer (available at www.NCCN.org). Testing for TMB is recommended for patients with unresectable or metastatic gallbladder cancer, intrahepatic CCA, or extrahepatic CCA based upon clinical benefit observed across advanced solid tumors.

In advanced BTCs, tumor or tumor plus immune cell PD-L1 expression has shown trends towards higher rates of objective radiographic response in single-arm phase 2 studies of pembrolizumab or nivolumab as monotherapy.[333,343] However, ORR rates are low overall and data from these small, uncontrolled studies are insufficient to warrant a recommendation for testing. PD-L1 testing is not used as PD-L1 negative disease can still respond to anti-PD-1/PD-L1 drugs, albeit at a lower rate than PD-L1 positive disease.[344]

In a phase II trial with 46 evaluable patients with advanced BTCs, an ORR of 22% and a disease control rate of 59% were obtained, upon investigator assessment, with the use of nivolumab, another anti-PD1 drug.[343] With blinded independent central review, the ORR was 11% and the disease control rate was 50%. In the intention-to-treat cohort, the median PFS and median OS were 3.7 months (95% CI, 2.3–5.7 months) and 14.2 months (95% CI, 6.0 months–not reached), respectively. Nivolumab is a category 2B useful in certain circumstances subsequent-line systemic therapy option for patients with unresectable or metastatic progressive disease who have not been previously treated with a checkpoint inhibitor. Nivolumab and hyaluronidase-nvhy subcutaneous injection may be substituted for intravenous nivolumab. Nivolumab and hyaluronidase-nvhy has different dosing and administration instructions compared to intravenous nivolumab.

BRAF V600E Mutations

Mutation in the *BRAF* gene may lead to constitutive activation of the MAPK pathway. The most common *BRAF* mutation is type 1 alteration, which results in a single amino acid substitution of valine at residue 600 typically with glutamic acid (V600E). *BRAF* mutations have been reported in around 1% to 5% of BTCs.[325,345-348] The phase II, open-label, single-arm,

multicenter, Rare Oncology Agnostic Research (ROAR) basket trial enrolled 43 patients with *BRAF* V600E-mutated BTC, who had previously received systemic therapy.[345] The primary endpoint of an ORR was achieved by 22 patients (ORR, 51%; 95% CI, 36%–67%). Median PFS and OS were 9 months (95% CI, 5–10 months) and 14 months (95% CI, 10–33 months), respectively. Results from the Subprotocol H trial, which enrolled patients with solid tumors (except for melanoma, thyroid, colorectal cancer, and later non-small cell lung cancer) with a BRAF *V600E* mutation, revealed an ORR of 38% (90% CI, 22.9%–54.9%; $P < .0001$) and a PFS of 11.4 months (90% CI, 8.4–16.3 months) in 29 patients.[349] Dabrafenib plus trametinib received accelerated FDA approval for *BRAF* V600E advanced solid tumors. The oral combination of dabrafenib and trametinib is a useful in certain circumstances subsequent-line systemic therapy option for unresectable or metastatic progressive *BRAF* V600E-mutated tumors.

Testing for *BRAF* V600E mutations is recommended for patients with unresectable or metastatic gallbladder cancer, intrahepatic CCA, or extrahepatic CCA.

FGFR2 Fusions/Other FGFR Pathway Aberrations

FGFR2 is a member of the *FGFR* family of receptor tyrosine kinases that activate a variety of downstream signaling cascades leading to cell proliferation and tumorigenesis. *FGFR2* fusions or rearrangements occur at ~9% to 15% prevalence in intrahepatic CCAs and are rare in other subsites.[337,350,351] Pan-FGFR inhibitors have received accelerated approval from the FDA for the treatment of pre-treated, locally advanced or metastatic *FGFR2*-fusion/rearranged CCA. Results from the phase II FOENIX-CA2 trial demonstrated an ORR of 42% (95% CI, 32%–52%) with futibatinib in patients with previously unresectable or metastatic intrahepatic CCA with *FGFR2* fusions/rearrangements.[352] The median OS, median PFS, median DOR, and disease control rate were 21.7 months (95% CI, 14.5 months–not reached), 9.0 months (95% CI, 6.9–13.1 months), 9.7 months (95% CI, 7.6–17.0 months), and 83% (95% CI, 74%–89%), respectively. Studies are ongoing to determine the activity of individual FGFR inhibitors for specific *FGFR* kinase domain activating mutations or other *FGFR* aberrations. Pemigatinib FDA approval in 2020 was based on the FIGHT-202 study, an open-label study including 108 patients with advanced, pre-treated *FGFR2*-fusion-positive or *FGFR2*-rearranged CCA.[353,354] The ORR was 37.0% (95% CI, 27.9%–46.9%), with a median PFS of 7.0 months (95% CI, 6.1–10.5 months), a median OS of 17.5 months (95% CI, 14.4–22.9 months), and median DOR of 9.1 months (95% CI, 6.0–14.5 months).[354]

The phase II RAGNAR study investigated the efficacy of erdafitinib, a selective pan-FGFR tyrosine kinase inhibitor, in patients with advanced or metastatic tumors of any histology (except urothelial cancer) with *FGFR*1-4 alterations and disease progression on a prior systemic therapy and with no alternative standard therapies.[355] An objective response was achieved in 30% (95% CI, 24%–36%) of patients. The median DOR, median OS, and median PFS were 6.9 months (95% CI, 4.4–7.1 months), 10.7 months (95% CI, 8.7–12.1 months), and 4.2 months (95% CI, 4.1–5.5 months), respectively. Fourteen percent of patients had CCA. For this subset of patients, the ORR was 52% (95% CI, 33%–70%). The median DOR, median OS, and median PFS were 5.5 months (95% CI, 2.9–not evaluable), 14.7 months (95% CI, 12.1–24.3 months), and 8.3 months (95% CI, 6.4–9.7 months), respectively. In addition, interim results from the phase II FIDES-01 study were reported in a published abstract.[356] Treatment with derazantinib, an FGFR 1-3 inhibitor, resulted in an ORR of 8.7%, as determined by the investigator, a median PFS of 7.3 months (95% CI, 3.5–16.7 months), and a disease control rate of 73.9% (95% CI, 51.6%–89.8%) in patients with advanced intrahepatic CCA with *FGFR2* mutations or amplifications who received prior chemotherapy treatment.

Futibatinib, pemigatinib, and erdafitinib are useful in certain circumstances subsequent-line systemic therapy options for unresectable or metastatic progressive CCA with *FGFR2* fusions or rearrangements. Futibatinib and pemigatinib are preferred over erdafitinib.

Testing for *FGFR2* fusions or rearrangements is recommended for patients with unresectable or metastatic intrahepatic or extrahepatic CCA and should be considered for patients with unresectable or metastatic gallbladder cancer.

IDH1 Mutations

The isocitrate dehydrogenase-1 (IDH-1) enzyme catalyzes the conversion of alpha-ketoglutarate to D-2-hydroxyglutarate (2-HG), an aberrant metabolite that impacts chromatin regulation and cellular differentiation. Activating mutations in the *IDH1* gene lead to high levels of 2-HG accumulation and impairment of normal differentiation, accumulation of hepatic progenitor cells, and malignant transformation to intrahepatic CCA.[357] *IDH1* mutations have been reported in approximately 10% to 20% of intrahepatic CCAs and are rare in other subsites.[350,358,359] In a randomized phase III study with 185 patients with *IDH1*-mutated CCA that progressed on standard chemotherapy, ivosidenib resulted in prolongation of PFS over placebo, with a median PFS of 2.7 versus 1.4 months (HR, 0.37; $P < .0001$).[360] Patients with ivosidenib had significantly less decline in physical functioning scores than those treated with placebo. In the intention-to-treat population, the median OS for the ivosidenib and placebo arms were 10.3 months (95% CI, 7.8–12.4 months; HR, 0.79 [95% CI, 0.56–1.12]; $P = .09$) and 7.5 months (95% CI, 4.8–11.1 months), respectively.[361] After taking into account 43 patients who crossed from the placebo arm to the ivosidenib arm, the median OS for the placebo arm was 5.1 months (95% CI, 3.8–7.6 months; HR, .49 [95% CI, 0.34–0.70]; $P < .001$). Ascites was the most frequently reported grade 3 or higher treatment-emergent adverse event in both groups. Ivosidenib has been approved by the FDA for previously treated, locally advanced or metastatic CCA harboring *IDH1* mutations. Ivosidenib is a category 1 useful in certain circumstances subsequent-line systemic therapy option for unresectable or metastatic progressive CCA with *IDH1* mutations. Clinical trials of next-generation IDH1 inhibitors are ongoing.

Testing for *IDH1* mutations is recommended for patients with unresectable or metastatic intrahepatic CCA or extrahepatic CCA and should be considered for patients with unresectable or metastatic gallbladder cancer.

HER2/ERBB2 Overexpression/Amplification/Activating Mutations

HER2 (*ERBB2*) is a member of the *ErbB/EGFR* family of receptor tyrosine kinases that functions as both a homodimer and heterodimer with other family members to activate a variety of downstream signaling cascades leading to cell proliferation and tumorigenesis. HER2 overexpression or pathway activation is present in around 5% to 20% of CCAs, and 15% to 30% of gallbladder cancer.[351,359,362-368] Early clinical trials of HER2-targeted therapy in BTCs failed to show efficacy[369,370] but these studies were unselected for HER2 overexpression/amplification or mutation.

Several studies have reported promising results of HER2-targeted therapy in BTCs.[371-373] In the phase II DESTINY-PanTumor02 trial, treatment with trastuzumab deruxtecan, a HER2 targeted antibody-drug conjugate, in 267 patients with locally advanced or metastatic HER2 overexpressing tumors after prior systemic treatment or without alternative treatments, resulted in improved outcomes.[374] With an ORR of 61.3% (95% CI, 49.4%–72.4%), median OS, median PFS, and median DOR of 21.1 months (95% CI, 15.3–29.6 months), 11.9 months (95% CI, 8.2–13.0 months), and 22.1 months (95% CI, 9.6 months–not reached), respectively, clinical benefit was more pronounced in patients with HER2 IHC3+ expression. Of 16 patients with BTCs with HER IHC3+ expression, the investigator-assessed ORR, median OS, and median PFS were 56.3%, 12.4 months, and 7.4 months,

respectively. The results of the phase II HERB trial from Japan showed that out of 22 evaluable patients with HER2-positive BTCs refractory or intolerant to a gemcitabine-based regimen, 36.4% (95% CI, 19.6%–56.1%) achieved a significantly improved confirmed ORR (*P* = .01) following treatment with trastuzumab deruxtecan.[375] The median OS, PFS, and disease control rate were 7.1 months (95% CI, 4.7%–14.6%), 5.1 months (95% CI, 3.0%–7.3%), and 81.8% (95% CI, 59.7%–94.8%), respectively. Encouraging data were also reported in patients with HER2-low disease (ORR, 12.5%; median OS, 8.9 months; median PFS, 3.5 months; disease control rate, 75.0%).

Javle et al[376] retrospectively reported 8 patients with advanced gallbladder carcinoma harboring HER2 overexpression or amplification treated with trastuzumab (alone or in combination with pertuzumab or chemotherapy); all patients experienced disease stability (3), partial response (PR) (4), or CR (1). The MyPathway study included 39 patients with HER2 amplified and/or overexpressed previously treated, metastatic BTCs.[377] Patients received pertuzumab plus trastuzumab, and 9 patients achieved a PR (ORR, 23%; 95% CI, 11%–39%) with an additional 11 patients showing SD for >4 months. In the TAPUR study, out of 28 evaluable patients with advanced BTC with an *ERBB2/3* alteration treated with pertuzumab plus trastuzumab, 32% (95% CI, 16%–52%) had an objective response.[378] The disease control rate was 40% (90% CI, 27%–100%). Additionally, a prospective pilot study of a trastuzumab biosimilar (trastuzumab-pkrb) in combination with chemotherapy (gemcitabine plus cisplatin) included 4 patients with BTC and identified a PR in 2 patients and SD in 2 patients.[379]

In the phase II SGNTUC-019 study, 46.7% (90% CI, 30.8%–63.0%) of patients with HER2-positive metastatic BTCs treated with tucatinib and trastuzumab as subsequent therapy achieved the primary endpoint (confirmed ORR).[380] The disease control rate was 76.7% (90% CI, 60.6%–88.5%), with a median DOR and PFS of 6.0 months (90% CI, 5.5–6.9 months) and 5.5 months (90% CI, 3.9–8.1 months), respectively.

The phase IIb HERIZON-BTC-01 trial investigated the efficacy of zanidatamab, a HER2-targeted bispecific antibody, in patients with *HER2*-amplified unresectable, locally advanced, or metastatic BTC whose disease progressed following prior treatment with a gemcitabine-based therapy.[381] Patient were assigned to 2 cohorts: cohort 1 (IHC2+ or IHC3+) and cohort 2(IHC0 or IHC1+). In cohort 1, 41.3% (95% CI. 30.4%–52.8%) of patients achieved the primary endpoint of confirmed ORR, as assessed by independent central review. The disease control rate was 68.8% (95% CI, 57.4%–78.7%), and the median DOR and median PFS were 12.9 months (95% CI, 6.0 months–not estimable) and 5.5 months (3.7–7.2 months), respectively. A subgroup analysis of cohort 1 showed responses in all 3 subtypes examined (gallbladder cancer ORR, 46.3%; intrahepatic CCA ORR, 30.4%; extrahepatic CCA, 43.8%). Additionally, the response was more pronounced in patients with IHC3+ tumors (51.6%) compared to those with IHC2+ tumors (5.6%).

Of 25 patients with BTCs in the SUMMIT trial, a phase II basket trial including patients with tumors with HER2 mutations treated with neratinib, 16% had a confirmed objective response.[382] First-line treatment of patients with HER2-positive BTC (96% of whom had gallbladder cancer and 78% of whom had ≥2 metastatic sites) with gemcitabine and cisplatin plus trastuzumab yielded a median PFS of 7 months (95% CI, 6.2–7.8 months) and a PFS rate of 75.6% (95% CI, 66.6%–84.6%) at 6 months.[383]

Fam-trastuzumab deruxtecan-nxki (for IHC3+ tumors), trastuzumab plus pertuzumab (for IHC3+/ISH+/NGS amplification tumors), tucatinib plus trastuzumab (for IHC3+/ISH+/NGS amplification tumors), and zanidatamab-hrii (for IHC3+ tumors) are useful in certain circumstances subsequent-line systemic therapy options for unresectable or metastatic progressive HER2-positive tumors.

Testing for HER2 (*ERBB2*) overexpression/amplification is recommended for patients with unresectable or metastatic gallbladder cancer, intrahepatic CCA, or extrahepatic CCA.

Other Biomarkers (RET/ROS1, KRAS G12C/Other KRAS, Other Tumor-Agnostic Markers)

In addition to the genomic alterations described in the previous sections, NGS testing may uncover other potentially actionable molecular alterations that could help determine eligibility for ongoing clinical trials in patients with advanced BTCs. While there is insufficient evidence to recommend universal assessment, alterations for which targeted therapies exist and have been FDA-approved in other tumor types, including *KRAS* G12C mutation,[384-386] *MET* amplification,[387-389] *ALK*,[390] *RET*,[391] or *ROS1* fusions,[392] among others,[393] have been described with variable but overall rare frequency in biliary tract carcinomas and HCC.[394] *RET* fusions have been reported to occur in approximately <1% of patients with BTCs, while *KRAS* G12C mutations have been reported in about 1% of patients.[395,396] Limited data currently exist regarding the efficacy of targeted therapy in these situations, due to their rarity.

In the phase I/II ARROW study, pralsetinib, a selective RET inhibitor, demonstrated an ORR of 57% (95% CI, 35%–77%) in patients with *RET* fusion-positive tumors other than non-small cell lung cancer and thyroid cancer and who received prior treatment or were ineligible for standard therapies.[391] The median OS, median PFS, and median DOR were 14 months, 7 months, and 12 months, respectively. A response was observed in two out of three patients who had CCA. However, *RET* mutations in CCA are rare.[397] Pralsetinib is a category 2B useful in certain circumstances first-line or subsequent-line (for progressive disease) systemic therapy option for unresectable or metastatic *RET* gene fusion-positive tumors.

Selpercatinib, a selective RET kinase inhibitor, was investigated in the phase 1/2 LIBRETTO-001 clinical trial in patients with *RET* fusion-positive tumors.[398] Of 41 patients evaluable for efficacy and with tumors other than lung or thyroid, the ORR, as assessed by an independent review committee, was 43.9% (95% CI, 28.5%–60.3%). An objective response was obtained in the one patient who had CCA. Selpercatinib is a useful in certain circumstances first-line (category 2B) or subsequent-line (for progressive disease) systemic therapy option for unresectable or metastatic *RET* gene fusion-positive tumors.

Testing for *RET* fusions is recommended for patients with unresectable or metastatic gallbladder cancer, intrahepatic CCA, or extrahepatic CCA. A comprehensive NGS panel may identify additional alterations for which targeted therapies exist and have FDA-approved treatments in other tumor types.

The phase II KRYSTAL-1 trial investigated adagrasib, a KRAS inhibitor, in patients with unresectable or solid tumors with a *KRAS* G12C mutation.[386] 35.1% (95% CI, 22.9%–48.9%) of patients had an objective response, with a median DOR of 5.3 months, a median OS of 14.0 months, and a median PFS of 7.4 months. In patients with BTCs, the ORR was 41.7% (50.0% of 8 patients with CCA, 33.3% of 3 patients with ampullary cancer, and 0% of 1 patient with gallbladder cancer), with a median OS of 15.1 months and a median PFS of 6.9 months. Adagrasib is a useful in certain circumstances subsequent-line systemic therapy option for unresectable or metastatic progressive *KRAS* G12C mutation-positive tumors.

Testing for *KRAS* G12C mutations is recommended for patients with unresectable or metastatic gallbladder cancer, intrahepatic CCA, or extrahepatic CCA.

Other Targeted Therapies

In a phase II trial, regorafenib was found to have a disease control rate of 56% and could thus be useful in patients with disease refractory to chemotherapy.[197] Another phase II trial reported an ORR of 9.1% and a

disease control rate of 64%.[399] In the phase II REACHIN trial, patients with BTCs were randomized to receive best supportive care along with either regorafenib or placebo.[400] The median PFS for patients in the regorafenib arm was 3.0 months compared to 1.5 months for those in the placebo arm. The median OS was 5.3 months for the regorafenib group compared to 5.1 months for the placebo group. Regorafenib is a category 2B subsequent-line systemic therapy option (other recommended regimen) for unresectable or metastatic progressive disease.

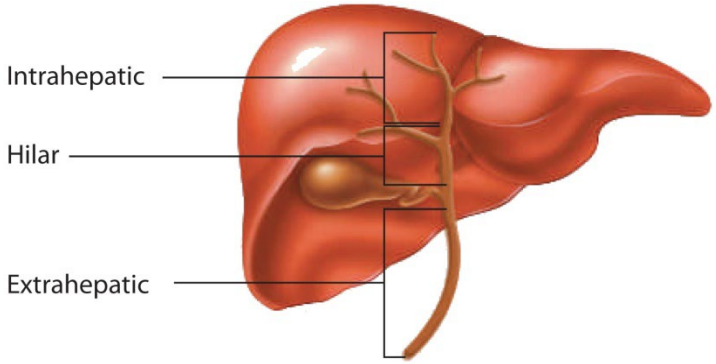
Summary

BTCs are associated with a poor prognosis and patients with BTCs commonly present with advanced disease. In the past few years, several advances have been made in the therapeutic approaches. Complete resection of the tumor in well-selected patients is currently the best available potentially curative treatment. Ablation is potentially curative for small intrahepatic CCAs. Consideration of locoregional therapy is included as an option for patients with unresectable or metastatic intrahepatic CCA. The combination of chemotherapy and chemoradiation, chemoradiation alone, and consideration of referral to a transplant center are options for unresectable intrahepatic or extrahepatic CCA. Palliative RT may be used in patients with unresectable gallbladder cancer or extrahepatic CCA. Systemic therapy is also an option for patients with unresectable or metastatic BTCs.

The combination of durvalumab/gemcitabine/cisplatin, pembrolizumab/gemcitabine/cisplatin, as well as the combination of gemcitabine/cisplatin, are included as category 1 first-line systemic therapy recommendations for patients with unresectable or metastatic BTCs. Drugs such as entrectinib, larotrectinib, repotrectinib, pembrolizumab, dostarlimab-gxly, nivolumab plus ipilimumab, dabrafenib plus trametinib, futibatinib, pemigatinib, erdafitinib, ivosidenib, fam-trastuzumab deruxtecan-nxki, trastuzumab plus pertuzumab, tucatinib plus trastuzumab, zanidatamab-hrii, pralsetinib, selpercatinib, and adagrasib, may benefit certain patients with advanced disease harboring specific genomic mutations.

A multidisciplinary team consultation is recommended for the assessment of resectability for patients with gallbladder cancer presenting with jaundice and for intrahepatic and extrahepatic CCAs. Careful patient selection for treatment and patient engagement are essential. Patient participation in prospective clinical trials is encouraged for the treatment of patients with all stages of disease.

Figure 1: Classification of Cholangiocarcinoma



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