metastatic disease. All tumours were pMMR/MSS, 2 (7%) of tumours had a KRAS mutation, 2 (7%) had a BRAF mutation and 25 (86%) were RAS/BRAF wild type. At liver transplantation patients received a median of 22 chemotherapy cycles (IQR 16−28) in up to two lines of chemotherapy. During first-line chemotherapy, 18 (62%) had received doublet chemotherapy and 11 (38%) had received triplet regimens; 27 (93%) of 29 had targeted therapy. Serious adverse events occurred in 18 (62%) of 29 patients who underwent liver transplantation. Three patients had an acute rejection, no patient was retransplanted, one patient died from intraoperative haemorrhage. Median follow-up was 20.5 months (IQR 7.0−35.3). 11 (38%) of transplanted patients had a recurrence, in 8 (73%) the site was pulmonary, in 3 (27%) it was peritoneal. The median time to recurrence was 6.3 months (IQR 5.3−6.7). 2-year progression-free survival (PFS) was 35.7% (95% CI 12.8–64.9) among 14 patients eligible for analysis; 1-year PFS was 47.6% (95% CI 25.7–70.2) among 21 patients. 2-year overall survival (OS) was 53.3% (95% CI 43.3–74.1) among 15 patients eligible for analysis; 1-year OS was 68.2% (95% CI 45.6–85.8) among 22 patients. The two BRAF-mutated patients in this cohort have follow-ups of 36 and 110 months, respectively, and are alive without relapse.

Conclusions: LTx for uCLM is feasible in Belgian practice, with encouraging short-term outcomes despite heterogeneous selection criteria and relatively short follow-up. However the recurrence rate was high despite the limited timeframe, though notably, no hepatic recurrences were observed. Our results suggest BRAF status alone (among other mutations) should not exclude patients from LTx; disease control and behaviour might be more relevant. These retrospective findings should be interpreted cautiously but support further uptake of LTx in clinical practice, while emphasizing the importance of a standardized national protocol to optimize patient selection and improve long-term outcomes.

-O02-

BELGIAN PROTOCOL FOR INDICATION AND SELECTION OF PATIENTS WITH UNRESECTABLE COLORECTAL CANCER LIVER METASTASES ELIGIBLE FOR LIVER TRANSPLANTATION. G. Rasschaert (1), M. Vandermeulen (2), M. Van den Eynde (3), H. Eker (4), T. Vandamme (5), B. Bracke (6), V. Xavier (7), J. Verbeek (8), H. Van Vlierberghe (7), H. Topal (9), V. Labille (10), D. Monbaliu (11), B. Op de Beeck (12), T. Gustot (13), M. Sainz Barriga (11), F. Sclafani (14), V. Vandecaveye (15), T. Vanwolleghem (16), C. Amicone (10), V. Lucidi (17), C. Verslype (18), T. Chapelle (6), K. Geboes (19), G. Dahlqvist (20), J. Pirenne (11), O. Detry (2), L. Coubeau (21) / [1] University Hospitals Gasthuisberg, Leuven and KU Leuven, Leuven, Belgium, Gastrointestinal Oncology Department, University Hospitals Leuven, Leuven, Belgium, [2] CHU de Liège, Liège, Belgium, Abdominal and Transplant Surgery Department, University Hospital Liège, Liège, Belgium, [3] UCLouvain, Cliniques universitaires Saint-Luc, Belgium, Oncology Department, Cliniques Universitaires Saint-Luc, Bruxelles, Belgium, [4] University Hospital Ghent (UZ Gent), Gent, Belgium, General and Hepatopancreatobiliary Surgery Department, University Hospital Gent, Gent, Belgium, [5] UZA, Universitair Ziekenhuis Antwerpen, Edegem, Belgium, Oncology Department, University Hospital Antwerpen, Antwerpen, Belgium, [6] UZA, Universitair Ziekenhuis Antwerpen, Edegem, Belgium, Hepatopancreatobiliary and Transplant Surgery Department, University Hospital Antwerpen, Antwerpen, Belgium, [7] University Hospital Ghent (UZ Gent), Gent, Belgium, Gastroenterology Department, Hepatology Division, University Hospital Gent, Gent, Belgium, [8] University Hospitals Gasthuisberg, Leuven and KU Leuven, Leuven, Belgium, Gastroenterology and Hepatology Department, University Hospitals Leuven, Leuven, Belgium, [9] University Hospitals Gasthuisberg, Leuven and KU Leuven, Leuven, Belgium, Abdominal Surgery Department, University Hospitals Leuven, Leuven, Belgium, [10] CHU de Liège, Liège, Belgium, Gastroenterology Department, University Hospital Liège, Liège, Belgium, [11] University Hospitals Gasthuisberg, Leuven and KU Leuven, Leuven, Belgium, Abdominal Transplant Surgery Department, University Hospitals Leuven, Leuven, Belgium, [12] UZA, Universitair Ziekenhuis Antwerpen, Edegem, Belgium, Radiology Department, University Hospital Antwerpen, Antwerpen, Belgium, [13] Hôpital Universitaire de Bruxelles (HUB), Université Libre de Bruxelles (ULB), Brussels, Belgium, Gastroenterology and Hepatology Department, Hôpital Universitaire de Bruxelles, Bruxelles, Belgium, [14] Hôpital Universitaire de Bruxelles (HUB), Université Libre de Bruxelles (ULB), Brussels, Belgium, Gastrointestinal Oncology Department, Hôpital Universitaire de Bruxelles, Bruxelles, Belgium, [15] University Hospitals Gasthuisberg, Leuven and KU Leuven, Leuven, Belgium, Radiology Department, University Hospitals Leuven, Leuven, Belgium, [16] UZA, Universitair Ziekenhuis Antwerpen, Edegem, Belgium, Gastroenterology and Hepatology Department, University Hospital Antwerpen, Antwerpen, Belgium, [17] Hôpital Universitaire de Bruxelles (HUB), Université Libre de Bruxelles (ULB), Brussels,

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Introduction: Colorectal cancer (CRC) is common in Western countries, about 50% of patients develop liver metastases (CLM). While local CLM therapies can achieve 5-year survival up to 60%, most patients eventually become unresectable (uCLM) and have poor outcomes with systemic treatment alone. Prospective studies, including SECA I and II and the TransMet trial, showed that in carefully selected patients, liver transplantation (LTx) can achieve survival outcomes comparable to standard LTx indications.
Aim: The aim of this work was to develop a harmonized national consensus protocol for the indication and selection of uCLM patients eligible for LTx.
Methods: Under the coordination of the Belgian Liver & Intestine Advisory Committee (Be-LIAC), all six Belgian transplant centres delegated a transplant surgeon, an oncologist and an hepatologist to a working group that performed a literature review and drafted preliminary criteria. Three successive national meetings and a structured voting refined these criteria in the current protocol.
Results: Consensus was reached on inclusion and exclusion criteria for LTx in uCLM. Two key conditions are liver-only disease and technically uCLM. Strict requirements include a six months disease stability or response on systemic therapy and an obligatory eight-week treatment holiday. Absolute CEA levels and specific somatic mutations are not excluded. An independent central auditing committee was established.
Conclusions: A harmonized national protocol for LTx inuCLM has been established, ensuring consistent patient selection across all Belgian centres. Stricter criteria and an independent auditing committee aim to optimize outcomes while maintaining ethical allocation of donor organs.

-O03-

TARGETING THE LIVER: INSIGHTS FROM A TERTIARY CENTRE ON POST-OPERATIVE HEPATIC ARTERIAL OXALIPLATIN FOR METASTATIC COLORECTAL CANCER. K. Sarti (1), M. Gelli (2), P. Beunon (3), B. Bonnet (3), L. Tselikas (3), G. Camilleri (4), E. Fernandez-de-Sevilla (2), C. Smolenschi (4), M. Valéry (4), A. Fuerea (4), D. Malka (5), T. Pudlarz (4), A. Tarabay (4), A. Hollebecque (4), M. Ducreux (4), V. Boige (4), A. Boileve (4) / [1] CHU-UCL-Namur site Godinne, Yvoir, Belgium, Gastroenterology, [2] Institut Gustave Roussy, Villejuif, France, Surgery, [3] Institut Gustave Roussy, Villejuif, France, interventional radiology, [4] Institut Gustave Roussy, Villejuif, France, medical oncology, [5] Institut Mutualiste Montsouris Paris, Paris, France, medical oncology.

Introduction: As the liver is the most common site of metastasis in colorectal cancer (CRC), and metastatic recurrence frequently occurs after resection of colorectal liver metastases (CRLM), hepatic arterial infusion chemotherapy (HAIC) has emerged as a promising treatment approach.
Aim: To investigate the feasibility, safety, and efficacy of postoperative HAIC with oxaliplatin following curative-intent resection of CRLM.
Methods: A retrospective analysis was conducted on all patients with resected CRLM who received postoperative HAIC with oxaliplatin between 2008 and 2022 at a tertiary cancer centre. The primary study endpoint were disease-free-survival (DFS) and overall survival (OS).
Results: Overall, 119 patients (median age, 56 years; synchronous metastatic disease, 82%) received postoperative HAIC with oxaliplatin after complete resection of their CRLM (median number of metastases resected, 7). They received a median number of 6 HAIC cycles (range, 1–12), mostly combined with intravenous chemotherapy with 5-fluorouracil/leucovorin (n=118, 99%) and irinotecan (n=41, 34%). The median DFS was 10.2 months (95%CI, 9–12.4; 12 month DFS rate, 42%). The median OS reached 55.5 months (95% CI, 50.0–86.6; 5-year OS rate, 46%). Grade 3–4 toxicities occurred in 45% of patients (neutropenia, 38%; peripheral neuropathy, 9%); 54% of patients experienced pain (mostly mild to moderate) during oxaliplatin infusion. HAI catheter-related complications included extrahepatic perfusion (30%) and catheter occlusion (11%).