Supplementary

Table S1 Consensus on statements in third Delphi survey

No.	Statement	Strength of recommendation (n=76); No. (%)					
		Recommend			Do not recommend		
		Strong	Weak	GPS	Strong	Weak	GPS
1	It is recommended to use the MVI pathological grading criteria as outlined in the "Guidelines for Pathological Diagnosis of Primary Liver Cancer": M0: No MVI found; M1: ≤5 MVI and occurring in the peri-tumoral liver tissue area (≤1 cm); M2: >5 MVI or MVI occurring in the distant peri-tumoral liver tissue area (>1 cm)	76 (100)	0	0			
2	It is recommended to use the "7-point method" for sampling liver cancer specimens (Evidence level: B; Recommendation level: Strong), and IDS may be used where feasible	76 (100)	0	0			
3	It is recommended that hepatocellular carcinoma patients undergo preoperative MVI prediction, and using the EHBH nomogram for predicting MVI is highly recommended	61 (80.2)	5 (6.6)	10 (13.2)			
4	For patients with resectable HCC, surgical resection is recommended as the first choice; for patients with a diameter ≤3 cm who are predicted to be at low risk for MVI, either surgery or PRFA/PMCT can be chosen	70 (92.1)	4 (5.3)	2 (2.6)			
5	It is not currently recommended to use TACE or radiotherapy alone as neoadjuvant therapy for HCC patients who are predicted to be at high risk for MVI				0	71 (93.4)	5(6.6)
	to reduce postoperative recurrence rates, it is encouraged to conduct clinical trials of neoadjuvant therapy in these patients.	0	0	76 (100)			
6	It is recommended to perform anatomic liver resection or ensure a margin distance ≥1 cm for HCC patients predicted to be at high risk for MVI	76 (100)	0	0			
	if anatomic liver resection is not possible or a margin distance ≥1 cm cannot be ensured, intraoperative radiotherapy may be used in equipped centers	0	66 (86.8)	10 (13.2)			
7	Postoperative antiviral therapy is recommended for hepatitis B-related HCC patients	76 (100)	0	0			
	and for patients diagnosed with MVI postoperatively, at least one of the following adjuvant treatments are recommended: T+A	76 (100)	0	0			
	Sintilimab	76 (100)	0	0			
	TACE	76 (100)	0	0			
	radiotherapy	76 (100)	0	0			
	HAIC	76 (100)	0	0			
	lenvatinib or sorafenib	0	62 (81.6)	14 (18.4)			
8	It is recommended to decide on the prevention and treatment plan for MVI-positive HCC recurrence after MDT discussion: if there are ≤3 recurrences and the maximum diameter is ≤3 cm, PRFA/PMCT is preferred; if the recurrence focus is solitary, there is no portal vein main trunk cancer thrombus, and TTR ≥1 year, surgical resection may be considered; for unresectable recurrence foci or early recurrence (TTR ≤1 year) and PMCT/PRFA cannot be performed, TACE is recommended	0	66 (86.8)	10 (13.2)			

https://dx.doi.org/10.21037/hbsn-24-359