Exhibit 99.1

Delcath

Corporate Presentation

(NASDAQ: DCTH)

December 2021

Forward-looking Statements

The Private Securities Litigation Reform Act of 1995 provides a safe harbor for forward-looking statements made by the Company or on its behalf. This presentation contains forward-looking statements, which are subject to certain risks and uncertainties that can cause actual results to differ materially from those described. Factors that may cause such differences include, but are not limited to, uncertainties relating to: the timing and results of the Company's clinical trials, including without limitation the mOM and ICC clinical trial programs, as well as the receipt of additional data and the performance of additional analyses with respect to the mOM clinical trial, our determination whether to continue the ICC clinical trial program or to focus on other alternative indications, and timely monitoring and treatment of patients in the global Phase 3 mOM clinical trial and the impact of the COVID-19 pandemic on the completion of our clinical trials; the impact of the presentations at major medical conferences and future clinical results consistent with the data presented; approval of Individual Funding Requests for reimbursement of the CHEMOSAT procedure; the impact, if any, of ZE reimbursement on potential CHEMOSAT product use and sales in Germany; clinical adoption, use and resulting sales, if any, for the CHEMOSAT system to deliver and filter melphalan in Europe including the key markets of Germany and the UK; the Company's ability to successfully commercialize the HEPZATO KIT/CHEMOSAT system and the potential of the HEPZATO KIT/CHEMOSAT system as a treatment for patients with primary and metastatic disease in the liver; our ability to obtain reimbursement for the CHEMOSAT system in various markets; approval of the current or future HEPZATO KIT/CHEMOSAT system for delivery and filtration of melphalan or other chemotherapeutic agents for various indications in the U.S. and/or in foreign markets; actions by the FDA or foreign regulatory agencies; the Company's ability to successfully enter into strategic partnership and distribution arrangements in foreign markets and the timing and revenue, if any, of the same; uncertainties relating to the timing and results of research and development projects; and uncertainties regarding the Company's ability to obtain financial and other resources for any research, development, clinical trials and commercialization activities. These factors, and others, are discussed from time to time in our filings with the Securities and Exchange Commission. You should not place undue reliance on these forward-looking statements, which speak only as of the date they are made. We undertake no obligation to publicly update or revise these forward-looking statements to reflect events or circumstances after the date they are made.

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Executive Summary

Delcath aims to be the leader in targeted, safe and highly-effective minimally-invasive treatments for patients with cancers of the liver.

UNMET NEED LIVER CANCER

Incidence US/EU
- >200K primary and metastatic liver tumors per year[2-14,29]

Current local/regional treatments
- Cannot treat the whole liver
- Targeted to visible and accessible tumors
- Limited in their ability to retreat

PERCUTANEOUS HEPATIC PERFUSION (PHP)

PHP drug-device platform
- Delivers high dose chemotherapy to the entire liver
- Limits systemic exposure
- Minimally invasive, repeatable and well-tolerated

US: HEPZATO KIT
EU: CHEMOSAT

COMPANY & CLINICAL PROGRAM

FOCUS pivotal trial
- Metastatic Ocular Melanoma (mOM)
- Primary endpoint met*
- NDA submission mid '22

Real World Evidence
- **>1k** commercial treatments in EU
- Multiple single center publications

ANTICIPATED FDA APPROVAL: Q4 2022

LARGE MARKET OPPORTUNITY

Near-term (mOM)
- >$300M TAM in US and EU
- No effective standard of care

Longer Term (CRC, ICC, Pancreatic, etc.)
- >>$1B TAM
- Investigator interest in more than 10 other tumor types

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Metastatic Ocular Melanoma (mOM)[2,3], Cholangiocarcinoma (ICC)[4,5], Liver-dominant Breast Cancer (mBC)[8-11], Metastatic Neuroendocrine Tumors (mNET)[6,7], Metastatic Pancreatic Cancer (mPC)[8,16], Metastatic Colorectal Cancer (mCRC)[12,13], Hepatocellular carcinoma (HCC)[29]

Liver-Dominant Cancers

High incidence with poor prognosis

Up to **80%**

Many patients with liver metastases are not amenable to surgical resection largely due to extensive tumor burden[1]

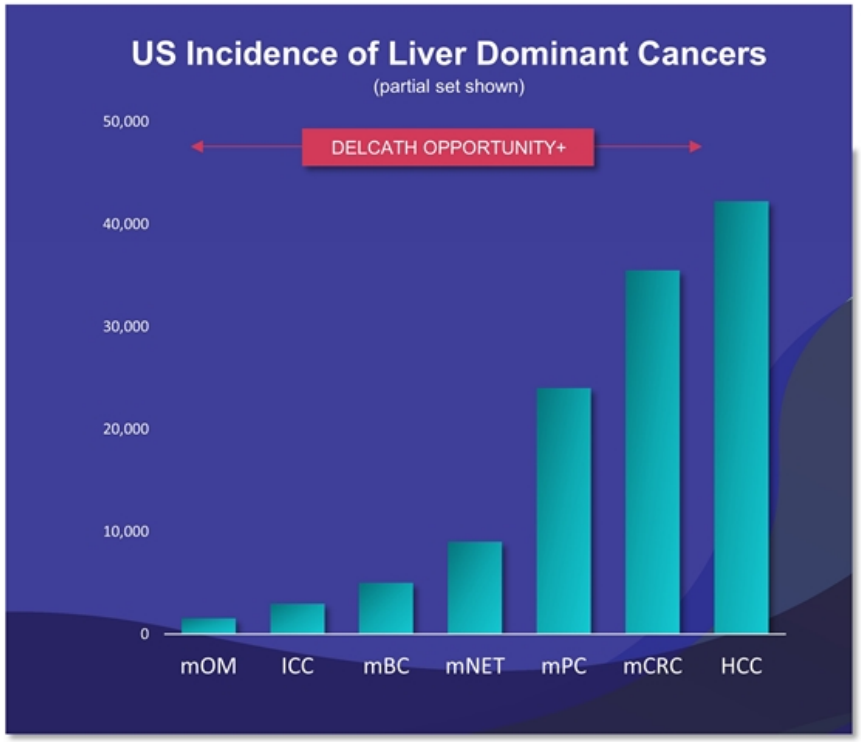
Liver: Common Site of Metastases

Limited Effective Systemic Treatments

- Systemic therapies - low efficacy
- Immuno-oncology agents - become less effective in the presence of metastases

Limited Overall Survival – Unresectable Liver Cancer

- Often the life-limiting organ



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Metastatic Ocular Melanoma (mOM)[2,3], Cholangiocarcinoma (ICC)[4,5], Liver-dominant Breast Cancer (mBC)[8-11], Metastatic Neuroendocrine Tumors (mNET)[6,7], Metastatic Pancreatic Cancer (mPC)[8,16], Metastatic Colorectal Cancer (mCRC)[12,13], Hepatocellular carcinoma (HCC)[29]

Limitations of Current Liver-Directed Therapies

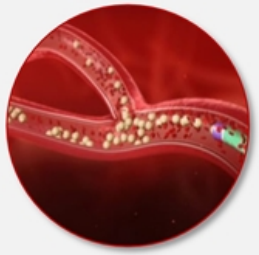
Majority of Treatment

Trans Arterial Chemo Embolization (TACE)

- Beads obstruct blood flow to tumor and elute chemo
- **50-60k treatments per year** in US (and growing)

Y90

- Radioactive beads delivered into the tumor
- **10-15k treatments per year** in US (and growing)



- ⊗ Effective, but tumors recur & retreatment limited due to damaged vasculature
- ⊗ Diffuse disease: cannot be treated with a tumor-by-tumor modality
- ⊗ Many tumors are not imageable – micro-metastases are common

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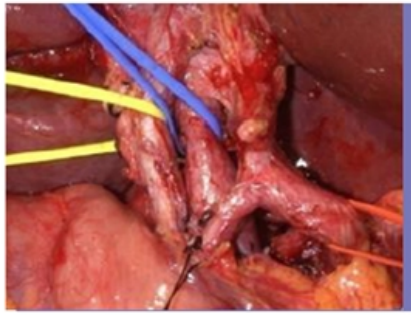
Isolated Hepatic Perfusion (IHP)

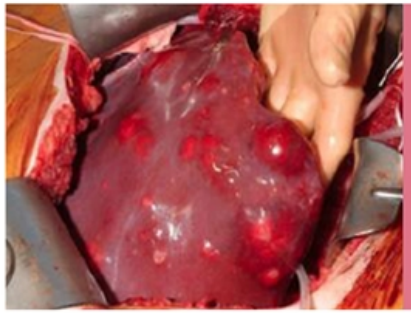
The pathway to developing Percutaneous Hepatic Perfusion

Benefits



- Temporarily isolates liver blood supply
- Delivers substantially higher concentrations of chemotherapy (Melphalan) with limited toxicity

Limitations



- High treatment related mortality (>5%)
- Not repeatable and few patients are eligible

HISTORY OF IHP[1]

1961 — Dr. Robert Ausman publishes 1st description of IHP technique

1975 — Stehlin demonstrates effects of Melphalan in regional perfusion

1984 — Isolated liver perfusion in advanced metastases of colorectal cancers studied.

1990s — Phase I-II study of Isolated Hepatic Perfusion using Melphalan for patients with metastatic Ocular Melanoma.

1998 — National Cancer Institute conducts trial establishing IHP, using melphalan as a viable treatment option.

2000s — IHP documented efficacy across multiple tumor types including mOM, CRC, and NET

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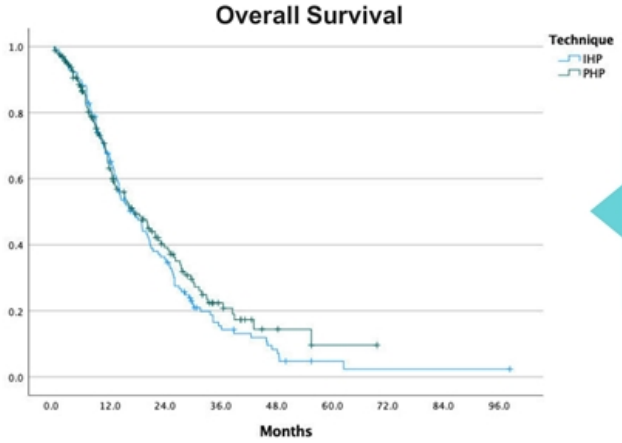
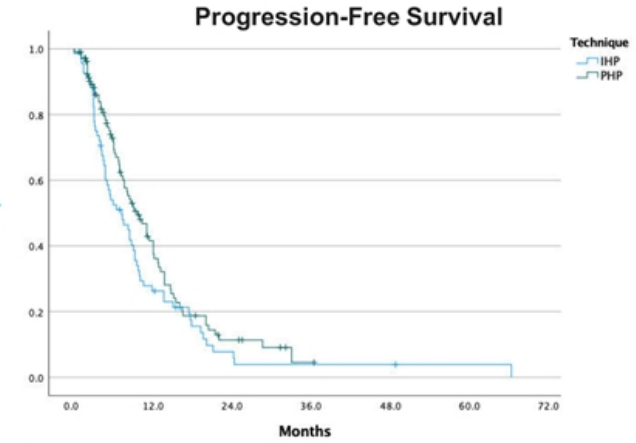
PHP Advances IHP Clinical Benefits



Comparable OS & PFS Between Techniques[30]

cancers



Meta-Analysis of Isolated Hepatic Perfusion and Percutaneous Hepatic Perfusion as a Treatment for Uveal Melanoma Liver Metastases

> "There was no difference in overall survival (OS) or progression-free survival (PFS) between IHP and PHP for patients with uveal melanoma liver metastases, but patients have **significantly less** of a **risk for complications and mortality following PHP**."

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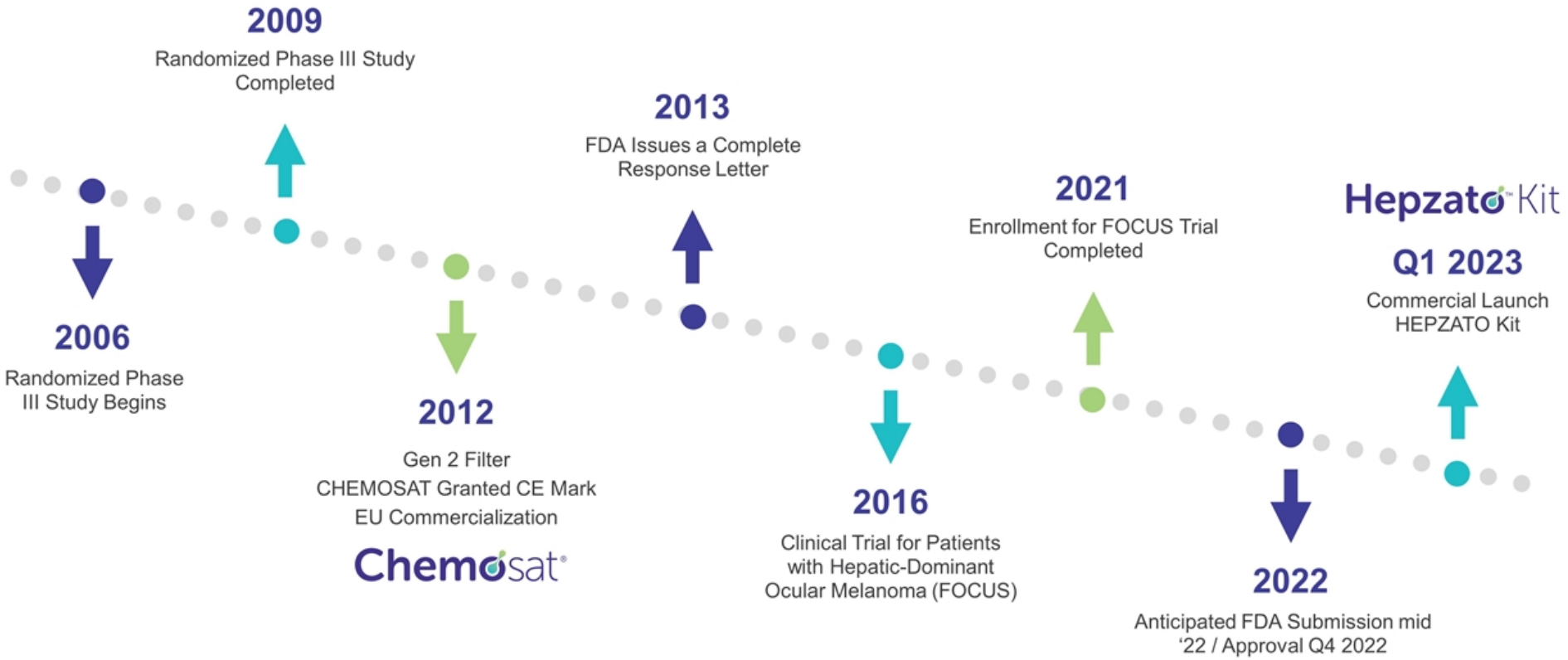
History of HEPZATO Kit Development

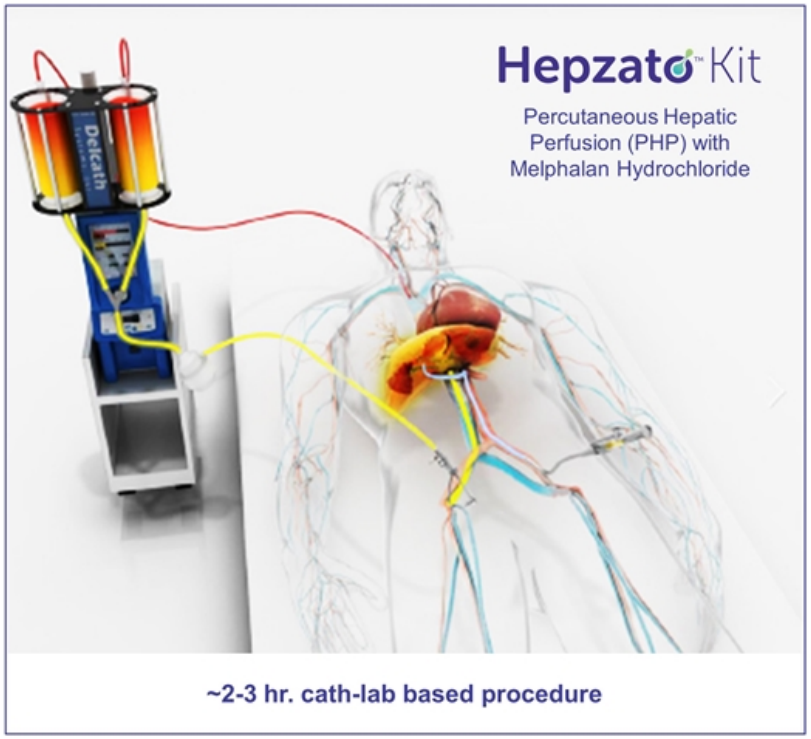


HEPZATO™ Kit: Percutaneous Hepatic Perfusion (PHP)

Repeatable, safe & effective liver-focused disease control

Next-Generation, Minimally-Invasive Liver-Directed Treatment

The only minimally invasive cancer treatment that isolates the liver from systemic circulation, allowing for repeated delivery of high-dose chemo to the entire liver while limiting systemic side effects.



~2-3 hr. cath-lab based procedure

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Three Steps. Targeted Treatment.

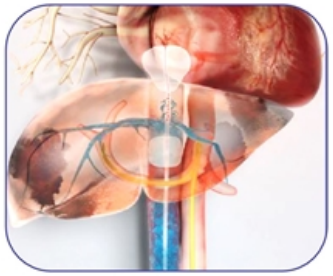
Hepzato™ Kit

Novel, whole-organ treatment that provides targeted, high-dose liver chemo while minimizing systemic exposure.

1

ISOLATION

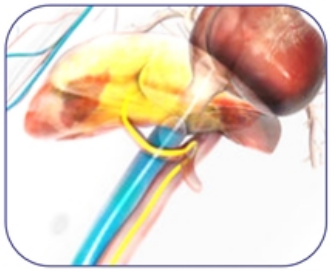
Hepatic venous flow is isolated, enabling 12x increased dose



2

SATURATION

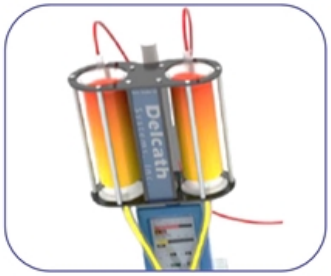
Melphalan (chemo) treats micro and macro lesions simultaneously



3

FILTRATION

Proprietary filters remove greater than 85% of chemo from the body[1]*



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*In vitro model - Data on file

1. de Leede E., et al. Cardiovascular Intervent Radiol. 2017 Aug;40(8):1196-1205.

mOM: Beachhead Market Opportunity

No FDA-approved treatment, no current standard of care

Unmet Need

- ~6,000 cases of ocular melanoma per year in the US/EU[13,17]
- 50% metastasize, 90% to the liver[3,14]
- Median survival up to 12 months.[15]

Low Risk Opportunity

- FOCUS pivotal trial has met primary endpoints to support approval in mOM[19]
- Significantly improved safety profile over Gen 1 filter technology
- Real world safety and efficacy demonstrated in EU

High Barrier to Entry

- EXCLUSIVE: Granted orphan indication status allows for extended exclusivity
- HEPZATO is a combination drug device regulated by CDER – no ANDA pathway
- Melphalan granted orphan indication

Favorable Commercial Economics

- Payer/hospital financial stakeholder interviews suggest expected pricing is on par with immuno-oncological agents ~$250k annually
- 20 US treatment centers = ~80% patients

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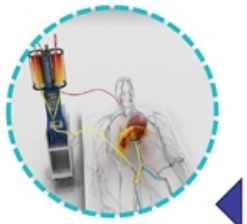
Competitive Landscape for mOM

HEPZATO™ is the only highly-effective, targeted mOM treatment that enables repeat treatments while optimizing QoL



	Minimally Invasive – Liver Directed			Infusion – Systemic	
	HEPZATO™	TACE[23]	Y90/SIRT[21]	Mono/Combo IO[24]	Tebentafusp[22*]
High Efficacy ORR %	31.4%	<21%	<17%	5.5%	Up to 9%[25]
OS at 12 months (% surviving)	75%**	-	-	-	73%***
Repeatable (>3x)	✓	X / ✓	X	✓	✓
Preserves QoL	✓	✓	✓	X	✓
FDA Approved for mOM	Q4 2022	X	X	Melanoma	Pending
Applicable to most mOM patients	✓	✓	✓	✓	X

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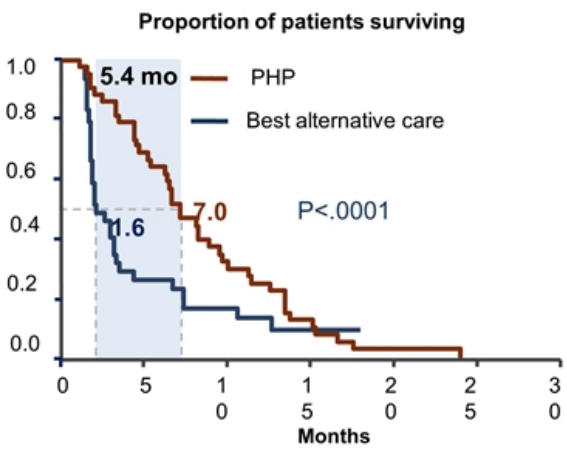
*HLA A+ patient indication only **mITT, BAC OS 47%, HR 0.37 , 95% CI 0.17, 0.79, p-value 0.01
***Control OS 59%, HR 0.51, 95% CI 0.37, 0.71, p-value <0.001

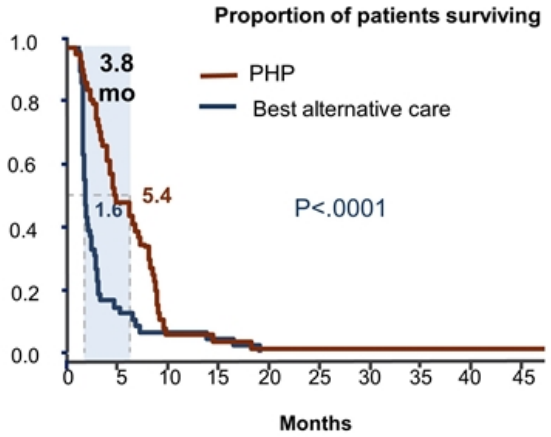
First Phase 3 RCT Results*

Hepatic Progression Free Survival (IRC Assessment)



Hazard Ratio (95% CI) = 0.39

Overall Progression Free Survival (INV Assessment)



Hazard Ratio (95% CI) = 0.42

Response Rates (ITT population)

Cohort	PHP (N=44)	BAC (N=49)	P-Value
hOR	36.4%	2.0%	<0.001
ORR	27.3%	4.1%	=0.003

Crossover design confounded overall survival analysis – most subjects in BAC arm [57.1%] crossed over to PHP arm

*Mix of mOM and metastatic melanoma with >90% patients diagnosed with mOM - NDA 201848 Clinical Study Report dated 15 August 2012.

Safety Issues and Resulting Improvements

Safety Issue

Hematological toxicities led to 3 patient deaths

Adverse Event G3/4	Gen 1 Hughes 2016[20]	
	%	n
Anemia	62.9%	44
Neutropenia	85.7%	60
Thrombocytopenia	80.0%	56

Improvement

Gen 2 Filter introduced in 2013

Adverse Event G3/4	Gen 2 Karydis 2018[15]		% Improvement Gen 1 → 2
	%	n	
Anemia	29.4%	15	**53% ↓**
Neutropenia	31.3%	16	**64% ↓**
Thrombocytopenia	31.3%	16	**61% ↓**

Inappropriate patient selection and procedural issues led to 1 patient death and other AE's

- ~90% liver involvement causing tumor lysis syndrome

- Protocol amendments were put in place for patient selection
- Training improved

FDA required these issues be addressed prior to the start of the FOCUS trial

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FOCUS Trial

2nd Registration Clinical Trial for Patients with mOM

FOCUS

OVERVIEW:

- Multinational, multicenter, single-arm trial
- Endpoints:
  - Primary: Objective Response Rate compared to historic control
  - Secondary: Duration of response, disease control rate, overall survival, progression free survival, safety, PK, QoL
- 102 subjects enrolled, 91 completed treatments at 30 centers in the US and EU
- HEPZATO Tx every 6-8 weeks up to a maximum of 6 cycles

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FOCUS Trial Analysis: Prespecified Endpoint Met

Intent to Treat:

Primary Effectiveness Endpoint[19]	PHP (N=91 treated + 11 untreated)	95% CI*
Objective Response Rate	**31.4%**	**[22.55-41.31]**

*A meta-analysis of checkpoint inhibitors (476 patients,16 publications) calculated a 95% Confidence Interval for ORR of 3.6% - 8.3%"

Lower bound 22.55% far exceeds 8.3% upper bound prespecified threshold.

PRELIMINARY DATA - SUBJECT TO CHANGE

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Hematological Toxicities - Comparison with Previous Trials

Grade 3 or higher Adverse Events	Focus Trial (n=91)	Hughes 2016 (n=70)
Anemia	27 (29.7%)	44 (62.9%)
Thrombocytopenia	24 (26.4%)	56 (80.0%)
Neutropenia	18 (19.8%)	60 (85.7%)

Hematological AE's consistent with European experience

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FOCUS Trial – Safety Comparison with Previous Trials

Category	FOCUS Trial (N=91)	Pooled Analysis of Prior Studies (N=121)
Patients who Withdrew due to an AE or SAE	20 (22%)	46 (38%)
Patients who Required a Dose Reduction	12 (13.2%)	27 (22.3%)
Average Number of Cycles	4.1	2.8

Improvement in tolerability led to a larger number of treatments

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Recent Initial Approvals Using ORR in Single-Arm Oncology Trials

Danyelza (naxitamab-gqgk)	Gavreto (pralsetinib)	Monjuvi (tafasitamab-cxix)	Tazverik (tazemetostat)	Zepzelca (lurbinectedin)	Tabrecta (capmatinib)	Trodelvy (sacituzumab)	Pemazyre (pemigatinib)	Koselugo (selumetinib)
Single trial n=50								
Accelerated	**Accelerated**	**Accelerated**	**Accelerated**	**Accelerated**	**Accelerated**	**Accelerated**	**Accelerated**	**Accelerated**
Relapsed or refractory neuroblastoma in bone or marrow post response or stable disease to prior therapy	Metastatic *RET* fusion-positive NSCLC	Relapsed or refractory diffuse large B-cell lymphoma	Relapsed or refractory follicular lymphoma positive for EXH2 mutation	Metastatic SMLC with progression on or after platinum chemotherapy	Metastatic NSCLC with mutation MET exon 14 skipping	Metastatic triple-negative breast cancer after at least 2 prior metastatic disease therapies	Previously treated metastatic cholangiocarcinoma with FGFR2 fusion	Neurofibromatosis Type 1 with inoperable plexiform neurofibromas

Ayvakit (avapritinib)	Enhertu (famtrastuzmab deruxtecan)	Padcev (enfortumab vedotin)	Brukinsa (zanubrutinib)	Rozlytrek (entrectinib)	Xpovio (selinexor)	Balversa (erdafinitib)	Vitrakvi (larotrectinib)	Libtayo (cemiplimab-rwlc)
Single trial N=43				Pooled subgroup analysis n=51 | 3 single arm trials				Pooled subgroup analysis n=72 | 2 single arm trials
Standard	**Accelerated**	**Accelerated**	**Accelerated**	**Standard**	**Accelerated**	**Accelerated**	**Accelerated**	**Standard**
Unresectable or metastatic gastrointestinal stromal tumor with PDGFRA exon 18 mutation	Unresectable or metastatic HER2+ breast with two or more prior anti HER2 regimens in metastatic setting	Metastatic urothelial cancer with previously received PD-1 or PD-L1 and platinum chemotherapy	Mantle cell lymphoma with at least one prior therapy	Metastatic NSCLC that is *ROSI+*	Relapsed or refractory multiple myeloma with at least 4 prior therapies	Metastatic unrothial carcinoma with susceptible FGFR 3(2) alterations	Solid tumors with neurotrophic receptor tyrosine kinase fusion	Metastatic squamous cell carcinoma

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Supportive Evidence: Comparison Versus BAC

Best Alternative Care (BAC) Arm	Enrolled N=42	Treated N=32
Dacarbazine	1	0
Ipilimumab	7	1
Pembrolizumab	8	6
Transarterial Chemoembolization (TACE)	26	25

Amended Study

- FOCUS was initially a RCT against Best Alternative Care (BAC)
- Due to enrollment challenges as a result of known limited efficacy of BAC control arm and availability of treatment with PHP (CHEMOSAT), FDA agreed to amend it to single-arm, non-RCT

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FOCUS Trial – Exploratory Analyses vs BAC

Statistically Significant ORR and DCR Advantage vs. BAC

Intent to Treat:

Efficacy Endpoint	PHP (N=102)	BAC (N=42)	P-Value*
Objective Response Rate - Primary	32 (31.4%)	4 (9.5%)	0.0059
95% CI	[22.55 - 41.31]	[2.66 - 22.62]	
Disease Control Rate	67 (65.7%)	12 (28.6%)	<0.0001
95% CI	[55.63 - 74.81]	[15.72 - 44.58]	

Modified Intent to Treat**:

Efficacy Endpoint	PHP (N=91)	BAC (N=32)	P-Value*
Objective Response Rate	32 (35.2%)	4 (12.5%)	0.0154
95% CI	[25.44 – 45.88]	[3.51 – 28.99]	
Disease Control Rate	67 (73.6%)	12 (37.5%)	0.0002
95% CI	[63.35 - 82.31]	[21.10 - 56.31]	

*Chi-square
** mITT Population – any patient who received at least one study treatment

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FOCUS Trial – Exploratory Analyses vs BAC

ORR Advantage Coupled With Meaningful Duration of Response

	mITT Population	
	PHP (N=91)	BAC (N=32)
Duration of Response (DOR, median)	14.00 mos.	NC
95% CI	[8.54 - NC]	[6.93 - NC]
Patients with Confirmed CR or PR	32	4
Patients with Subsequent PD	14 (43.7%)	1 (25.0%)
Censored	18 (56.3%)	3 (75.0%)

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FOCUS Trial - Exploratory Analyses vs BAC

PHP Progression-Free Survival ~3X that of BAC[19]

Secondary Endpoint		PHP (N=91)*	BAC (N=32)*	P-Value*
Median Progression-Free Survival		9.03 mos.	3.12 mos.	0.0007
	95% CI	[6.34 - 11.56]	[2.89 - 5.65]	
PFS Status	Events	64 (70.3%)	25 (78.1%)	
	Censored	27 (29.7%)	7 (21.9%)	
Hazard Ratio Estimate		0.39		0.0002
	95% CI	[0.237 - 0.643]		

* Treated patients only, per the protocol untreated patients were not followed

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Focus Trial Results – 12 Month Survival*

Intent to Treat:

Secondary Endpoint	PHP (N=102)	BAC (N=42)
% Surviving at 12 months	68%	36%
Hazard Ratio**	0.42	
95% CI	0.20 - 0.88	
p-value	0.0215	

Modified Intent to Treat***:

Secondary Endpoint	PHP (N=91)	BAC (N=32)
% Surviving at 12 months	75%	47%
Hazard Ratio*	0.37	
95% CI	0.17, 0.79	
p-value	0.010	

* Post Hoc analysis
** Log Rank Test
*** mITT Population – any patient who received at least one study treatment

Focus Trial Results – Overall Survival

Data still maturing
PHP enrollment ended in May 2020, BAC in 2018
OS will be analyzed 24 months post last patient last treatment

Intent to Treat:

Secondary Endpoint		PHP (N=102)*	BAC (N=42)*	P-Value*
Overall Survival (OS, Median)		19.25 mos.	14.06 mos.	0.2021
	95% CI	[16.30 – 24.35]	[9.99 – 19.78]	
OS Status	Events	66 (64.7%)	23 (54.8%)	
	Censored	36 (35.3%)	19 (45.2%)	
Hazard Ratio Estimate		0.739		0.2308
	95% CI	[0.451 – 1.212]		

Modified Intent to Treat**:

Secondary Endpoint		PHP (N=91)*	BAC (N=32)*	P-Value*
Overall Survival (OS, Median)		20.53 mos.	14.06 mos.	0.1626
	95% CI	[16.59 – 24.53]	[9.99 – 19.78]	
OS Status	Events	64 (70.3%)	23 (71.9%)	
	Censored	27 (29.7%)	9 (28.1%)	
Hazard Ratio Estimate		0.708		0.1725
	95% CI	[0.431 – 1.163]		

*Chi-square
** mITT Population – any patient who received at least one study treatment

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mOM Beachhead Market Strategy

BEACHHEAD MARKET | mOM

LIVER DISEASE

SIGNIFICANT REVENUE OPPORTUNITY:

- Oncologists* believe ~80% of mOM patients would be HEPZATO candidates - ~800 patients
- Considered a significant advancement over other therapies
- Payer & hospital finance stakeholders suggest pricing expectations in the range of IO agents - ~$256k per yr.
- May be positioned as a first-line treatment due to limited efficacy of available therapies.

US TAM

>$200M

per year

*Source: Boston Health Associates primary research n=13 physicians

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Experienced Interventional Oncology Leadership

- Kevin Muir-VP Commercial
  - Formerly Head of Sales for US Therasphere Y90 (BTG/Boston Scientific)
  - Led sales revenue growth from $60M to $220M
  - Built sales team to focus on all members of the MDT
- Michael Ujhelyi - US Medical Director
  - Formerly Head of Medical Affairs US Therasphere (BTG/Boston Scientific)
  - Built Medical Science Liaison Team
  - Responsible for Clinical Trial recruitment and IISs and IITs

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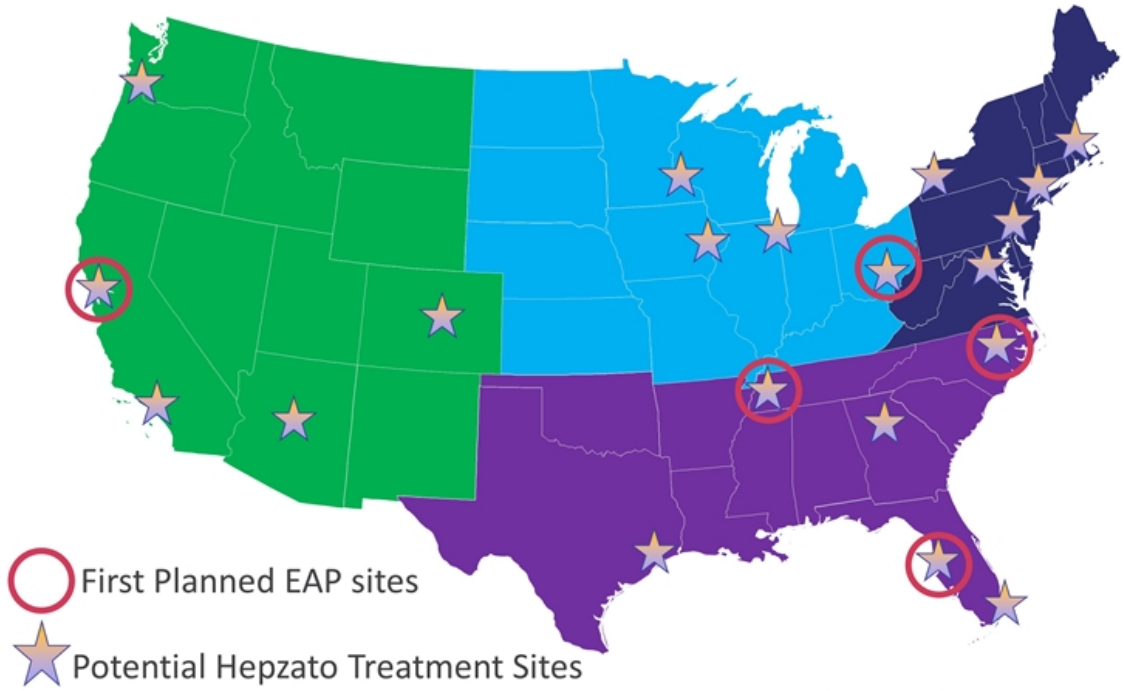
Specialized, Targeted Sales Team Will Leverage Expanded Access Protocol (EAP) and Longitudinal Data

EAP (FDA Approved)
- Provide immediate access to patients
- First Commercial Sites
- Train new medical teams to use Hepzato after launch

Regional Based Sales Team
- Experienced, Oncology focused
- Upon launch, placed in key geographies
- Supplement with Clinical Support Specialist

Leverage Longitudinal Data
- Partnered with data provider to access patient level longitudinal data with 3-week refresh
- Accurately map and quantify surveillance, referral and treatment patterns at the patient and MD level



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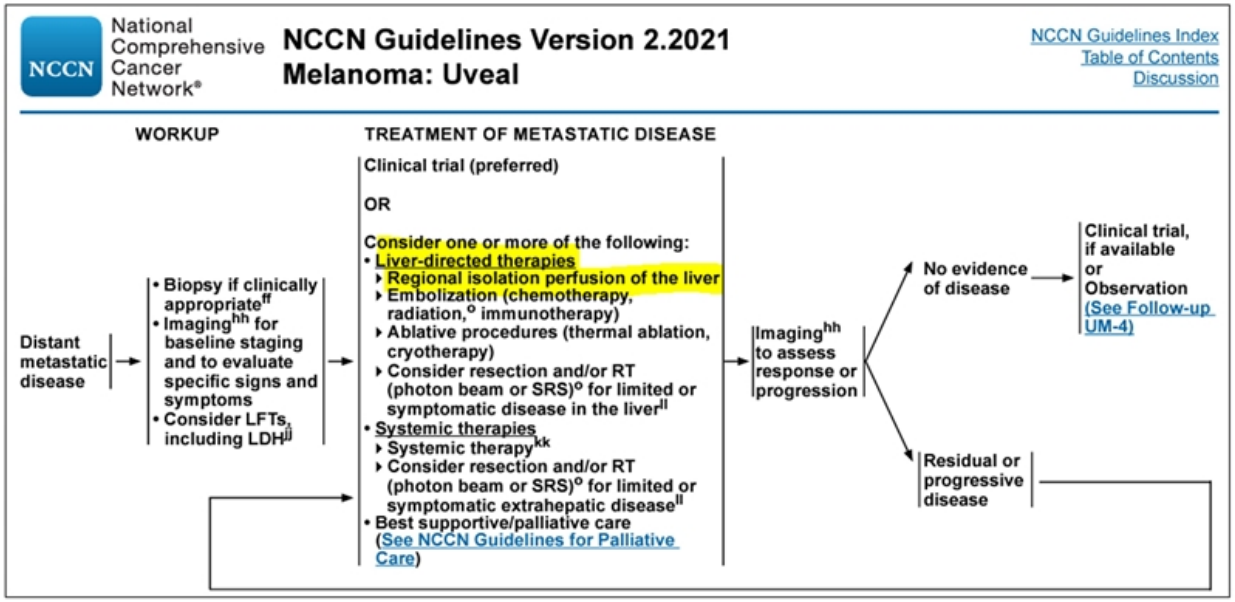
PHP Is Likely Part of Current NCCN Guidelines for mOM

"Regional Isolation Perfusion of the Liver"

PHP- Percutaneous Hepatic Perfusion



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Reimbursement

HEPZATO will be billed as a drug with a J-Code

- Medicare Patients
  - Majority of patients will be outpatient (2 midnight rule) with the drug directly covered by Medicare
  - For patients which become inpatient patients split billing (inpatient / outpatient) allows the drug to still be directly billed (e.g., not paid under a DRG)
- Private Payer Patients
  - Private Payers for rare disease generally follow Medicare guidelines and we expect these patients to be treated as outpatients
  - Prior-Authorization of patients might be needed, we are planning to contract out a hub service
  - Centers of Excellence (PPS exempt and NCI designated Cancer Centers) have the leverage to negotiate favorable rates and reimbursement terms (our target sites are all either PPS exempt or NCI Cancer Centers)

EU – Broad Reimbursement Pending Focus Trial Data, But Strong Interest Across Multiple Indications

- CE Marked - available in ~23 centers in 4 countries
- Currently distributed by MEDAC Pharma
- MEDAC has been notified of our intent to terminate – discussions ongoing

- NICE (UK) upgraded status from "Research" to "Special Status"
- German reimbursement based on annual hospital special request ("ZE" process)

- Strong interest to fuel additional indications driven by HCP's

- 1,343 commercial Chemosat kits shipped to the EU
- Queensbury facility has been inspected 21 times by the Notified Bodies LRQA and BSI, Health Authorities FDA and ANVISA

CHEMOSAT Used In 13 Tumor Types

~70%: Metastatic Ocular Melanoma (mOM)

Other Types Treated:

- Intrahepatic Cholangiocarcinoma (ICC)
- Hepatocellular Carcinoma (HCC)
- Metastatic Colorectal Cancer (mCRC)
- Metastatic Breast (mBreast)
- Pancreatic
- Metastatic Neuroendocrine Tumors (mNET)
- Metastatic Cutaneous Melanoma (mCM)

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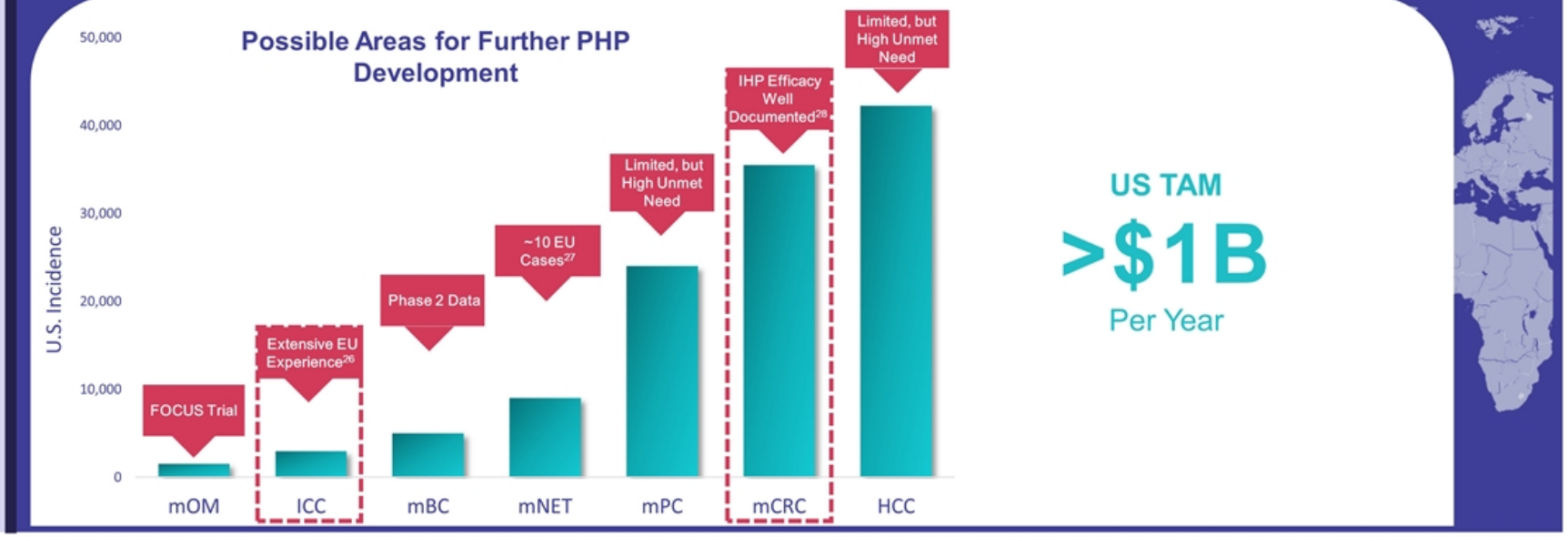
Market Expansion: Liver Disease

BEACHHEAD MARKET | mOM

LIVER DISEASE



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Metastatic Ocular Melanoma (mOM)[2,3], Cholangiocarcinoma (ICC)[4,5], Liver-dominant Breast Cancer (mBC)[8-11], Metastatic Neuroendocrine Tumors (mNET)[6,7], Metastatic Pancreatic Cancer (mPC)[8,16], Metastatic Colorectal Cancer (mCRC)[12,13], Hepatocellular carcinoma (HCC)[29]

Clinical Rationale for Broad Development Effort

"Broad-spectrum" alkylating agent given at 12X normal systemic doses

- Promising ORR and DCR signals seen across multiple tumor types in Europe and in earlier studies with IHP

Liver mets are often life limiting and reduce I/O efficacy

- When the liver is the life limiting organ, systemic chemotherapy can be paused and HEPZATO added to prolong survival
- Early data supports that combination with I/O agents is safe

PHP treats the entire liver and is not dependent on tumor location

- For patients at high risk of liver mets based on tumor characteristics or ctDNA, adjuvant therapy is logical

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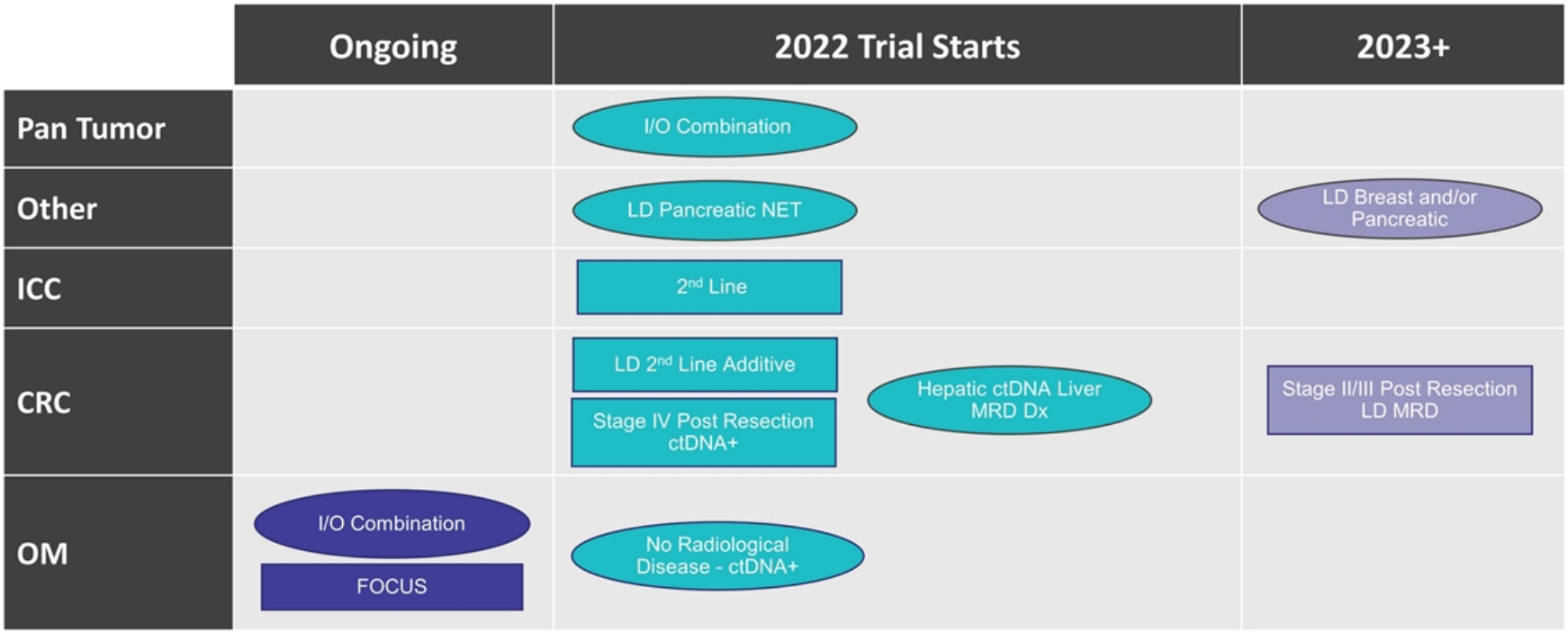
Near Term HEPZATO Development Plan



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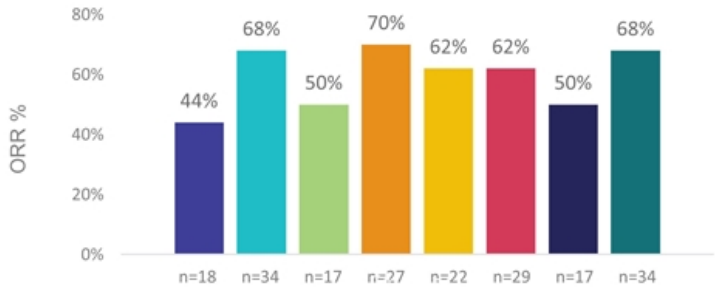
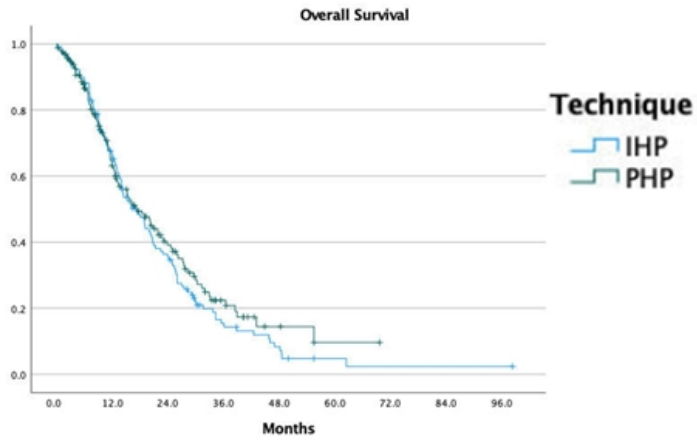
Liver Dominant CRC IHP Results Provide Strong Rationale for CRC PHP Trials

mOM Results Similar Between IHP and PHP

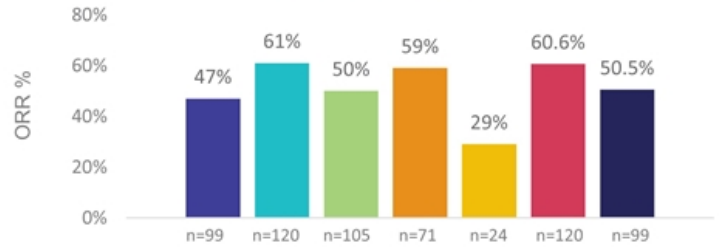
IHP/mOM ORR[31-38]



mOM Overall Survival



IHP/CRC ORR[43-49]



Pending Future Investigation

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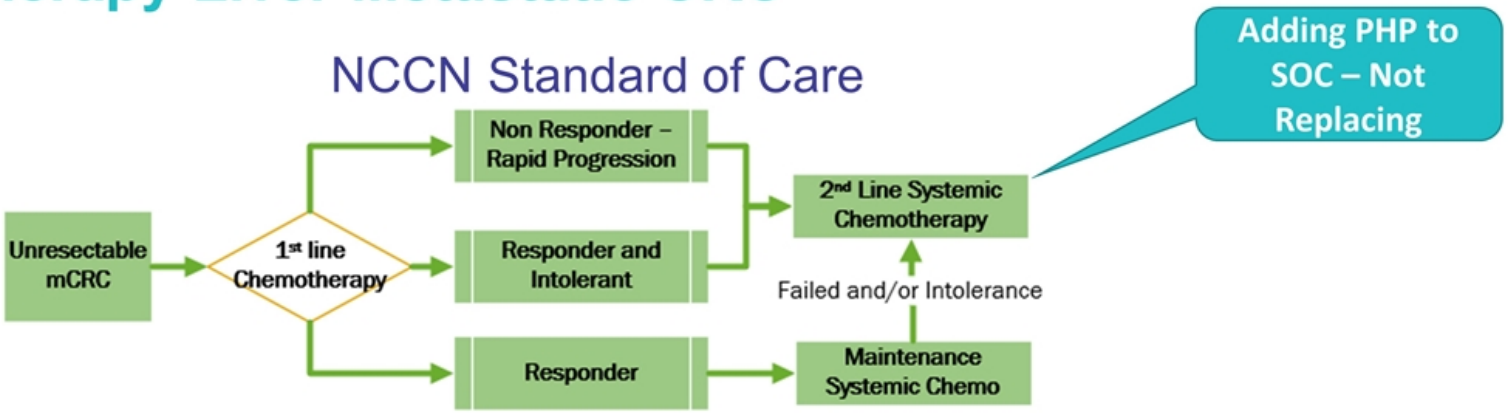
31. Vogl et al (2017). 32. Olofsson et al (2014). 33. Varghese et al (2010). 34. Rizell et al (2008). 35. Alexander et al (2000). 36. Alexander et al (2003). 37. Varghese et al (2010). 38. Olofsson et al (2014). 39. Artzner et al. Cancer Imaging 2019. 40. Bruning et al. Radiology Research and Practice 2020. 41. Karydis et al. Journal of Surgical Oncology 2017. 42. Meijer Annal of Surgical Oncology 2020. 43. van Iersel et al (2010). 44. Alexander et al (2009). 45. van Iersen et al (2008). 46. Rothbarth et al (2003). 47. Vahrmeijer et al (2000). 48. Alexander et al (2009). 49. Van Iersel et al (2010).

2nd Line Therapy Liver Metastatic CRC

NCCN Standard of Care



Population Base

US Incidence = 160K new CRC Cases	TAM
50% diagnosed metastatic	80K
50% Liver only metastases	40K
65-75% are unresectable	26-30K
85% fail 1st line therapy by 24-36 months	**22-25K**

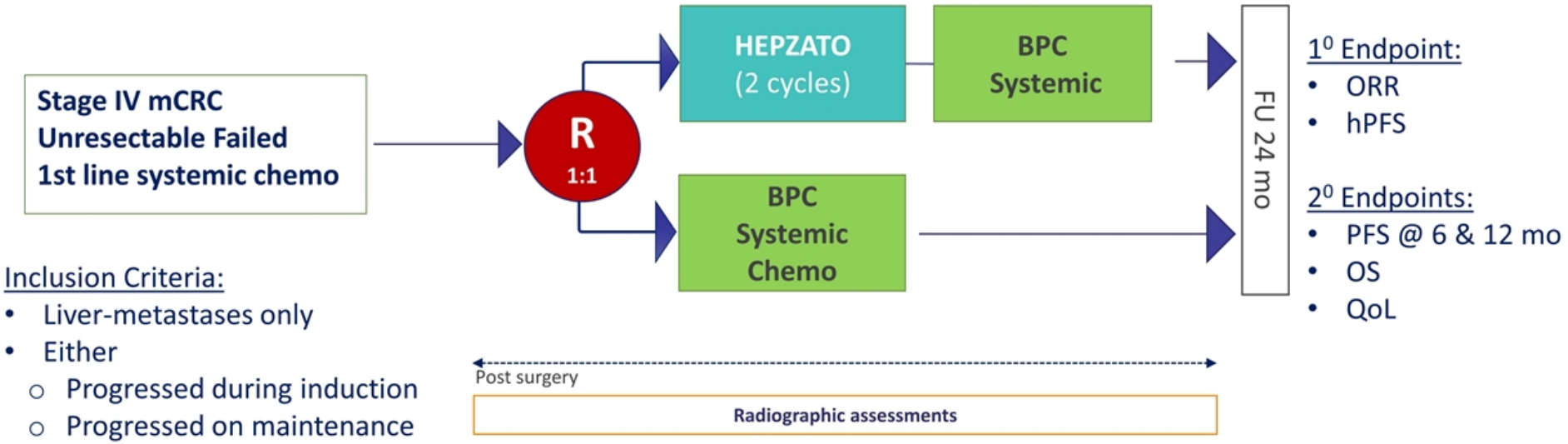
Current Treatment Options

- Therapy Goal = Disease control
- 1st line systemic chemotherapy - 85-90% will have disease progression within 3 yrs

National Cancer Institute. Cancer Stat Facts: Colon and Rectum Cancer. https://seer.cancer.gov/statfacts/html/colorect.html
Bulut G etal PLoS ONE 16(11): e0259622. https://doi.org/10.1371/journal.pone.0259622.

Hepzato in Stage IV Unresectable mCRC

Hepzato + Best Physician Choice vs Best Physician Choice



Inclusion Criteria:

- Liver-metastases only
- Either
  - Progressed during induction
  - Progressed on maintenance
  - Intolerant
- ECOG 1/2

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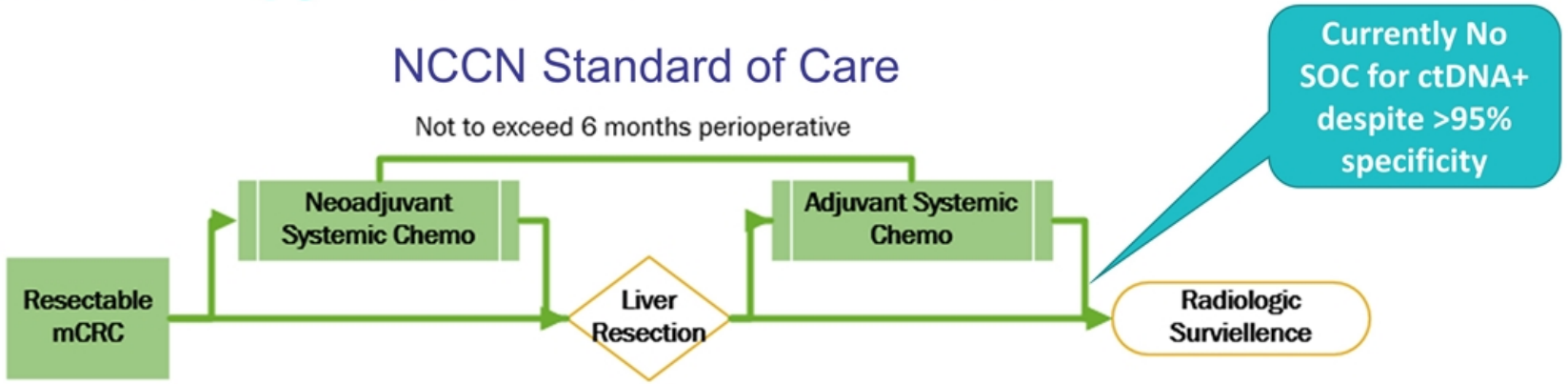
Adjuvant Therapy : CRC Post Liver Resection



Population Base

US Incidence = 160k new CRC Cases	TAM
50% diagnosed metastatic	80K
50% Liver only metastases	40K
25-35% are resectable; initial or converted to resectable	10-14K
70% ctDNA positive (based on recurrence)	**7-10K**

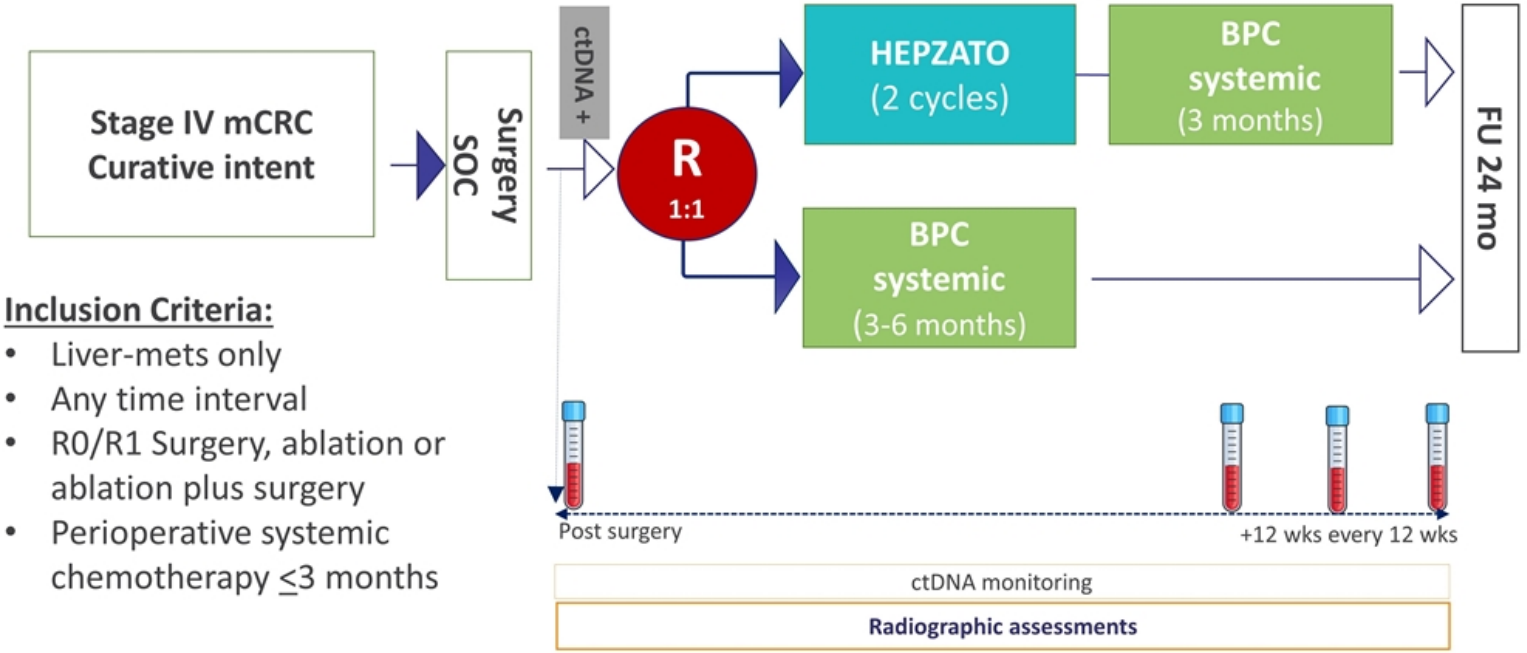
Siegel et al CA CANCER J CLIN 2020;70:145–164
National Cancer Institute. Cancer Stat Facts: Colon and Rectum Cancer. https://seer.cancer.gov/statfacts/html/colorect.html.
Holch et al Visc Med 2017;33:70–75 DOI: 10.1159/000454687

Current Treatment Options

- Therapy Goal = Prevent recurrence
  - ➢50-70% recurrence rate within 24 months
  - ➢ 70% recur in the liver
- Current adjuvant treatment is +/- chemo up to 6 months perioperative treatment duration

HEPZATO in Post-resection Stage IV ctDNA Positive Patients

Hepzato + Best Physician Choice vs Best Physician Choice



Inclusion Criteria:

- Liver-mets only
- Any time interval
- R0/R1 Surgery, ablation or ablation plus surgery
- Perioperative systemic chemotherapy ≤3 months

1⁰ Endpoint:

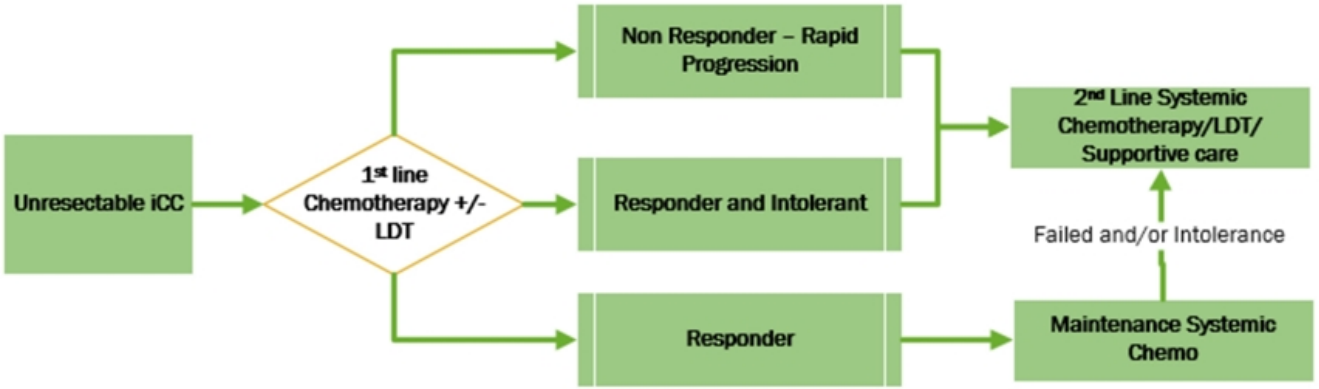
- DFS

2⁰ Endpoints:

- PFS by ctDNA status
- OS
- Toxicity / SAE
- QoL

Standard of Care & Epidemiology for iCC

NCCN Standard of Care



Population Base

US Incidence = 3.5k new iCC Cases	TAM
90-95% Unresectable or resection with recurrence	3.2-3.3K

Current Treatment Options

- Therapy Goal = Disease control
- 80% respond to 1st line therapy
- 75% will have disease progression by 1 year

Gupta et al HepatoBiliary Surg Nutr 2017;6(2):101-104

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Advanced ICC – 2nd Line

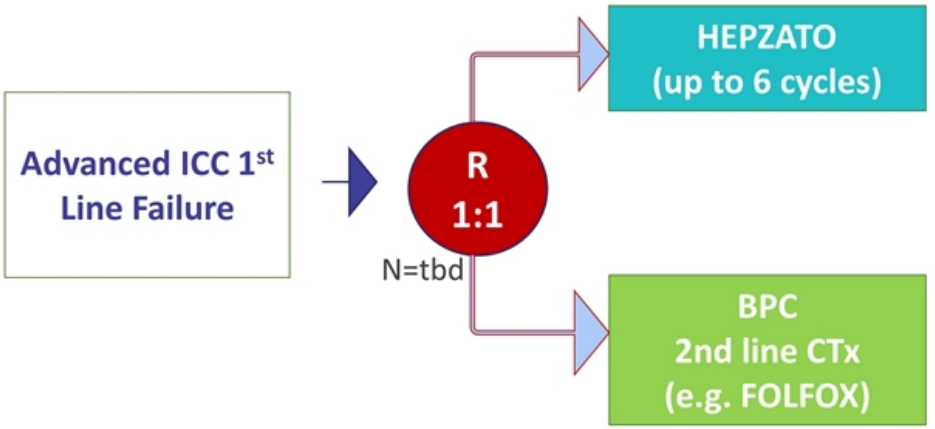
CHEMOSAT in ICC - European Experience[31,32,32]

N	ORR	DCR	CR
20	30%	75%	3

Hepzato 2nd Line vs Best Physician's Choice

Inclusion criteria

- Liver dominant disease
- 1 prior line of CTx (e.g. gemcitabine or 5FU-containing based regimen)
- Adequate liver function
- ECOG 0-1



1⁰ Endpoint:
PFS@ 6 mo and 12 mo

2⁰ Endpoints:

- OS
- ORR
- QoL
- Safety

Critical IITs

Hepatic ctDNA Validation

- The liver clears 70% - 80% of ctDNA
- Systemic ctDNA levels should be higher than hepatic vein levels unless there is residual disease in the liver
- The study will collect samples from CRC patients with confirmed liver and non liver mets
- Validation will enable a study targeting stage II/III CRC patients with hepatic MRD - metachronous liver metastases occur 50% in patients post primary resection[34],
- Hepatic MRD in CRC up to 40K patient TAM

Treating ctDNA+ OM

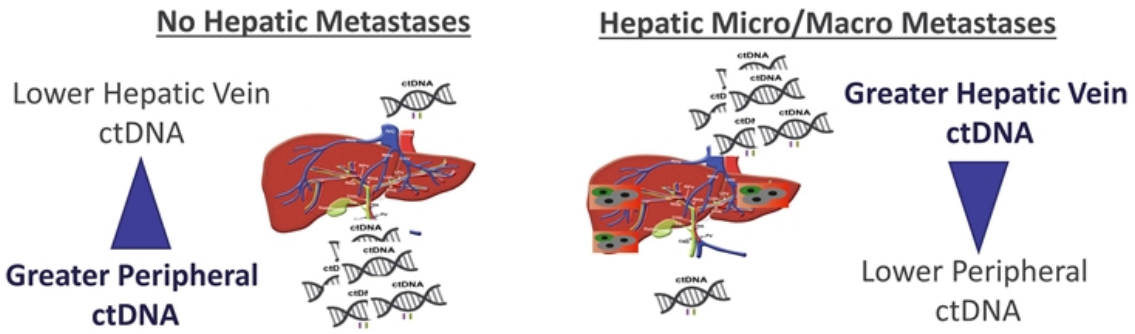
- ~90% of mOM patients present with liver mets
- ctDNA has high specificity for disease recurrence
- ctDNA is likely detectable well prior to radiological evidence enabling earlier treatment

I/O Combination

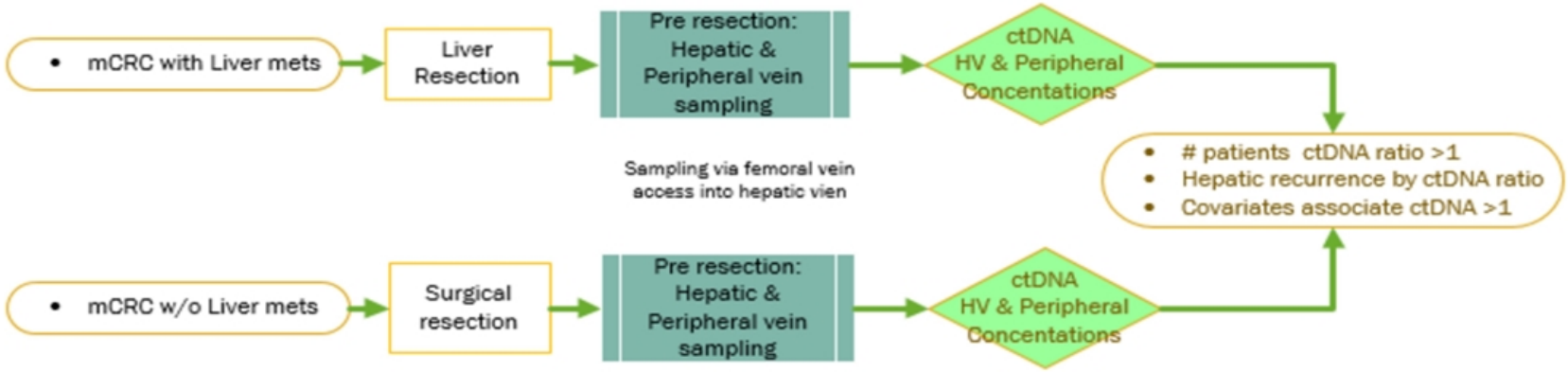
- I/0 agents lose efficacy when liver mets are present due to the immunomodulating role of the liver
- The study will be a basket trial for any patients on I/O therapy with liver mets
- Goal will be to make HEPZATO SOC for any patient with liver mets on I/O therapy

Detecting Liver Minimal Residual Disease

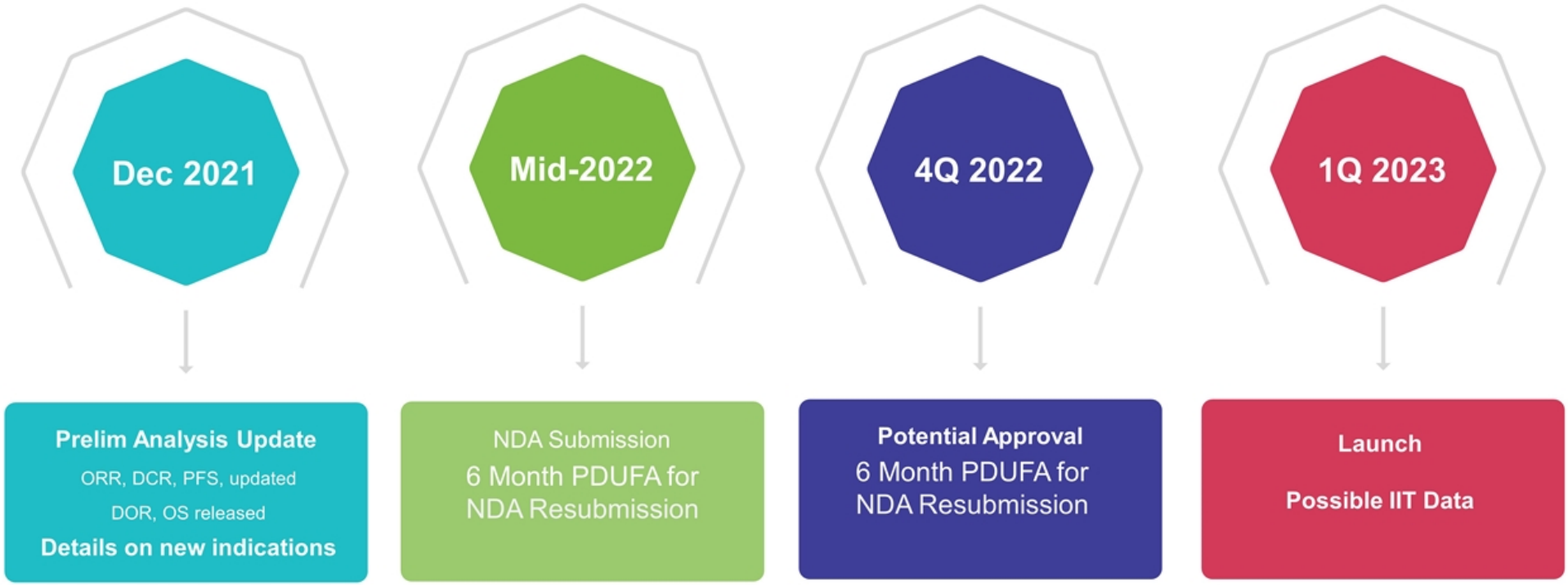
Enabling Technology = ctDNA



~20-30K/year Stage II & III patients recur with liver metastases



FOCUS Study – Upcoming News Flow



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Capital Structure and Share Information - September 30, 2021

Share Listing - Current	DCTH (NASDAQ)
Shares Outstanding[1]	8.81M
Cash and Cash Equivalents[2]	$29.0M
Warrants Outstanding[3]	3.61M
Stock Options Granted	1.70M
2020 Cash Burn (YTD)[4]	$16.2M
Debt[5]	$17.0M
52 week Low – High[6]	$8.28 - $25.18
30d Average Daily Volume[7]	27,533

[1] As of September 30, 2021; includes 7.3M of Common plus 1.2M, Preferred E & E-1 & 0.3M Pre-funded Warrants as converted
[2] As of September 30, 2021; (10-Q filing on November 9, 2021) Includes $4.2M of restricted cash
[3] As of September 30, 2021; Warrants at a $10 exercise price
[4] YTD Net cash used in operating activities through Q3, 2021
[5] Includes $5.0M of notes convertible at $11.98 per common share equivalent
[6] Used NASDAQ price information starting on September 30, 2020 - September 30, 2021
[7] 30-day average calculated between August 19, 2021 - September 30, 2021

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Multi-Disciplinary, Experienced Leadership Team

GERARD MICHEL
Chief Executive Officer

- 30+ yrs. pharma/medtech experience
- C-suite roles at Vericel Corp, Biodel, & NPS
- M.S. Microbiology, B.S. Biology & Geology from the Univ. of Rochester School of Medicine
- M.B.A. Simon School of Business & Leadership

JOHN PURPURA
Chief Operating Officer

- Past VP and Exec Director roles of Reg. Affairs for Bracco Diagnostics
- Held senior roles Sanofi-Aventis, Bolar Pharma, Luitpold Pharma & Eon Labs
- M.S. Mgmnt. & Policy and B.S. Chemistry and Biology at the State University of NY at Stony Brook

JOHNNY JOHN, MD
SVP Clinical Development & Medical Affairs

- 15+ yrs. experience in oncology drug development and clinical trials
- 11 years of personal clinical practice
- Received M.D. from Mangalore University, India; post-grad training at the University of IL

KEVIN MUIR
VP, Commercial Operations

- 20+ yrs. of medtech/bioTx sales & marketing experience.
- Held senior leadership roles at BTG, ClearFlow, Aragon Surgical, Kensey Nash Corporation, and Kyphon.
- Field Artillery officer in the U.S. Army
- B.S. in Management Systems Engineering at the U.S. Military Academy at West Point

BOARD OF DIRECTORS

Dr. Roger G. Stoll, Ph.D.	Chairman
John R. Sylvester	Director
Elizabeth Czerepak	Director
Steven Salamon	Director
Dr. Gil Aharon, Ph.D.	Director
Gerard Michel	CEO

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Delcath: A Unique Opportunity

- Novel platform in interventional oncology
- Multiple near-term catalysts (Final data and NDA filing, new indications)
- Safety and efficacy supported by multiple trials and commercial usage
- Initial orphan indication allows for targeted marketing effort and rapid uptake
- Platform has potential utility in multiple indications

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THANK YOU

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References

1. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4107710/
2. Cancer.net Editorial Board (2020) Eye Cancer - Statistics. In: Cancer.Net. https://www.cancer.net/cancer-types/eye-cancer/statistics. Accessed 22 Jun 2020
3. Ocular Melanoma Foundation. Treatment of Metastatic Disease. In: OMF – Metastatic Treatment. http://www.ocularmelanoma.org/metstreatment.htm. Accessed 22 Jun 2020
4. Patel N, Benipal B. Incidence of Cholangiocarcinoma in the USA from 2001 to 2015: A US Cancer Statistics Analysis of 50 States. Cureus. 2019;11(1):e3962. Published 2019 Jan 25.
5. United States Census Bureau. (2019) Monthly Population Estimates for the United States: April 1, 2010 to December 1, 2020 (NA-EST2019-01).
6. Cancer.net Editorial Board. (2020) Neuroendocrine Tumors - Statistics. In: Cancer.Net. https://www.cancer.net/cancer-types/neuroendocrine-tumors/statistics. Accessed 22 Jun 2020
7. Saeed A, Buell JF, Kandil E. Surgical treatment of liver metastases in patients with neuroendocrine tumors. Ann Transl Med. 2013;1(1):6. doi:10.3978/j.issn.2305-5839.2013.01.08
8. Surveillance, Epidemiology, and End Results (SEER) Program Populations (1969-2018) (www.seer.cancer.gov/popdata), National Cancer Institute, DCCPS, Surveillance Research Program, released December 2019.
9. Adam R, Aloia T, Krissat J, Bralet MP, Paule B, Giacchetti S, Delvart V, Azoulay D, Bismuth H, Castaing D. Is liver resection justified for patients with hepatic metastases from breast cancer? Ann Surg. 2006 Dec;244(6):897-907; discussion 907-8. doi: 10.1097/01.sla.0000246847.02058.1b. PMID: 17122615; PMCID: PMC1856635.
10. Insa A, Lluch A, Prosper F, Marugan I, Martinez-Agullo A, Garcia-Conde J. Prognostic factors predicting survival from first recurrence in patients with metastatic breast cancer: analysis of 439 patients. Breast Cancer Res Treat. 1999 Jul;56(1):67-78. doi: 10.1023/a:1006285726561. PMID: 10517344.
11. Clark GM, Sledge GW Jr, Osborne CK, McGuire WL. Survival from first recurrence: relative importance of prognostic factors in 1,015 breast cancer patients. J Clin Oncol. 1987 Jan;5(1):55-61. doi: 10.1200/JCO.1987.5.1.55. PMID: 3806159.
12. Cancer.net Editorial Board. (2020) Colorectal Cancer - Statistics. In: Cancer.Net. https://www.cancer.net/cancer-types/colorectal-cancer/statistics. Accessed 22 Jun 2020
13. Ismaili N. Treatment of colorectal liver metastases. World J Surg Oncol. 2011;9:154. Published 2011 Nov 24. doi:10.1186/1477-7819-9-154
14. Lane AM, Kim IK, Gragoudas ES. Survival Rates in Patients After Treatment for Metastasis From Uveal Melanoma. JAMA Ophthalmol. 2018 Sep 1;136(9):981- 986
15. Karydis I, Gangi A, Wheater MJ, et al. Percutaneous hepatic perfusion with Melphalan in uveal melanoma: A safe and effective treatment modality in an orphan disease. J Surg Oncol. 2018;117(6):1170-1178. doi:10.1002/jso.24956

References

16. Oweira H, Petrausch U, Helbling D, Schmidt J, Mannhart M, Mehrabi A, Schöb O, Giryes A, Decker M, Abdel-Rahman O. Prognostic value of site-specific metastases in pancreatic adenocarcinoma: A Surveillance Epidemiology and End Results database analysis. World J Gastroenterol. 2017 Mar 14;23(10):1872-1880. doi: 10.3748/wjg.v23.i10.1872. PMID: 28348494; PMCID: PMC5352929.
17. Xu L, T, Funchain P, F, Bena J, F, Li M, Tarhini A, Berber E, Singh A, D: Uveal Melanoma Metastatic to the Liver: Treatment Trends and Outcomes. Ocul Oncol Pathol 2019;5:323-332. doi: 10.1159/000495113
18. Data on file: presented at American Society of Clinical Oncology – June 4, 2021.
19. Preliminary analysis of FOCUS trial released 3/31/21
20. Hughes S., et al. Ann Surg Oncol. 2016 Apr;23(4):1309-19. doi: 10.1245/s10434-015-4968-3.8-3
21. Tulokas S, Mäenpää H, et al. Selective internal radiation therapy (SIRT) as treatment for hepatic metastases of uveal melanoma: a Finnish nation-wide retrospective
22. Sacco J, et al. Annals of Oncology (Dec 2020) 31 (suppl_7): S1441-S1451. 10.1016/annonc/annonc392
23. Shibayama Y, Namikawa K, Sone M, et al. Efficacy and toxicity of transarterial chemoembolization therapy using cisplatin and gelatin sponge in patients with liver metastases from uveal melanoma in an Asian population. Int J Clin Oncol. 2017 Jun;22(3):577-584. doi: 10.1007/s10147-017-1095-0. Epub 2017 Jan 31. PMID: 28144882.
24. Meta-analysis: Data on file
25. Piperno - Neumann, et. al. AACR Annual Meeting 2021
26. Ferrucci, P.Fet al. A New Option for the Treatment of Intrahepatic Cholangiocarcinoma: Percutaneous Hepatic Perfusion with CHEMOSAT Delivery System. Cells 2021, 10, 70. https://doi.org/10.3390/cells10010070
27. Vogel, A., Gupta, S., Zeile, M. et al. Chemosaturation Percutaneous Hepatic Perfusion: A Systematic Review. Adv Ther 33, 2122–2138 (2016). https://doi.org/10.1007/s12325-016-0424-4
28. Reddy SK, Kesmodel SB, Alexander HR. Isolated hepatic perfusion for patients with liver metastases. Therapeutic Advances in Medical Oncology. July 2014:180-194. doi:10.1177/1758834014529175
29. https://www.cancer.org/cancer/liver-cancer/about/what-is-key-statistics.html
30. Bethlehem M., et al. Cancers 2021, 13(18), 4726; https://doi.org/10.3390/cancers13184726
31. Marquardt, S., Kirstein, M.M., Brüning, R. et al. Percutaneous hepatic perfusion (chemosaturation) with melphalan in patients with intrahepatic cholangiocarcinoma: European multicentre study on safety, short-term effects and survival. Eur Radiol 29, 1882–1892 (2019). https://doi.org/10.1007/s00330-018-5729-
32. Vogl TJ, Zangos S, Scholtz JE etal. Chemosaturation with Percutaneous Hepatic Perfusions of Melphalan for Hepatic Metastases: Experience from Two European Centers. Fortschr Röntgenstr 2014; 186: 937–944
33. Personal communication, data on file, **Pier Francesco Ferrucci**, Tumor Biotherapy Unit, Department of Experimental Oncology, European Institute of Oncology, IRCCS, 20141 Milan, Italy
34. Zeng, X.; Ward, S.E.; Zhou, J.; Cheng, A.S.L. Liver Immune Microenvironment and Metastasis from Colorectal Cancer-Pathogenesis and Therapeutic Perspectives. Cancers 2021, 13, 2418. https://doi.org/10.3390/cancers13102418