Modern Approach to Colorectal Liver Metastases

Diego T. Enjuto¹,²*, Norberto Herrera¹, Antonio Ramos¹, Patricia Diaz¹, Carmen Jiménez- Ceinos², Marta Pérez-Gonzálezt, Juan Bernar de Oriol¹ and Javier Fernández-Merino¹

¹ Hospital Universitario Severo Ochoa. Avda. de Orellana s/n. 28911, Leganés, Madrid, Spain
² Hospital Universitario del Hernares. Avda. de Marie Curie 2. 28822, Coslada, Madrid, Spain

Abstract

Colorectal cancer is the third leading cause of death worldwide. Approximately 15–20% of the patients present synchronous Colorectal Liver Metastases (CRLM) and 60% will develop them metachronally. Surgical treatment is the only therapy that gives these patients the option of long-term survival. In the 1980s surgical treatment offered a 5-year survival rate of approximately 20% for patients undergoing liver resection. Recent studies show 5-year overall survival rates ranging between 42 and 58% [2,3].

Introduction

Colorectal cancer is the third most common malignancy in the United States with 132,700 new cases in 2015. In Europe 241,621 new cases were diagnosed in 2012 and 113,168 cancer related deaths occurred. Approximately 15-20% of the patients present with synchronous Colorectal Liver Metastases (CRLM) and 60% will develop them metachronally [1]. Surgical treatment is the only therapy that gives these patients the option of long-term survival. Outcomes have improved in the last three decades due to better surgical technique and more effective systemic chemotherapy. In the 1980s surgical treatment offered a 5-year survival rate of approximately 20% for patients undergoing liver resection. Recent studies show 5-year overall survival rates ranging between 42 and 58% [2,3].

Keywords: Colorectal liver metastases; Irresectable metastases; Synchronous metastases

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*Corresponding author: Diego T. Enjuto, Hospital Universitario Severo Ochoa. Avda. de Orellana s/n, 28911, Leganés, Madrid, Spain. E-mail: dtenjuto@gmail.com
Chemotherapy regimens are also influenced by the tumor biology, RAS mutations are a well-known predictive factor for resistance to anti-EGFR monoclonal antibodies such as cetuximab and panitumomab. In the presence of such mutations we would substitute the anti-EGFR for an anti-angiogenic factor such as bevacizumab. Chemotherapy can be used as neoadjuvant therapy, adjuvant therapy or both.

Regimes are based on fluoropyrimidines and the most frequently used are FOLFIRI (flurouracil, irinotecan, leucovorin), FOLFOX (flurouracil, irinotecan and oxaliplatin) or Cape-ox (capecitabin and oxaliplatin).

It seems logical to treat unresectable CRLM with neoadjuvant chemotherapy in order to make them resectable and downstage patients’ status. It has still not been clarified whether neoadjuvant chemotherapy regimens should also be used in resectable CRLM. According to EORTC 40,983, a phase III trial published in 2013 all patients should be treated with perioperative chemotherapy independtly of their resectable status [5]. Although it has not been established as the gold standard it is already included as an alternative to initial resection in the NCCN guidelines. A possible benefit could be testing the sensitivity of the tumor to chemotherapy enabling the choice of the best postoperative treatment. Prospective studies should determine the risks and benefits of preoperative chemotherapy in resectable liver metastases.

Potential disadvantages of preoperative chemotherapy like liver damage or complete radiological response to the treatment without pathological confirmation should be considered in these patients.

There is more consensus when we are using chemotherapy following surgery. Adjuvant chemotherapy has showed better overall survival and progression free survival in patients treated surgically for CRLM.

As mentioned above, surgical approach to CRLM has changed dramatically in the last years. There are no contraindications nowadays in relation to the number of metastases or the size of them. Synchronic liver and lung metastases are neither a contraindication of resection independently of their resectable status [5]. Although it has not been established as the gold standard it is already included as an alternative to initial resection in the NCCN guidelines. A possible benefit could be testing the sensitivity of the tumor to chemotherapy enabling the choice of the best postoperative treatment. Prospective studies should determine the risks and benefits of preoperative chemotherapy in resectable liver metastases.

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The liver-first approach also known as the reverse approach is based on the idea that treating the metastases first instead of the primary avoids the risk of progression of the metastatic disease. Initial data showed that up to 80 % could undergo complete resection treatment if performing a reverse approach [6]. Survival rates are similar in both approaches if the treatment is totally completed.

New strategies have recently been defined for previously considered irresectable liver metastases. In 1980s Makuch introduced the concept of Portal Vein Embolization (PVE) of the right portal branch to allow the left lobe to hypertrophy before surgery. It was performed mostly to enable removal of large tumors located in the right hemiliver. In 2000 the Paul Bousse Hospital team published the results for two-stage hepatectomy. The first surgery intention is to remove the highest possible number of tumors while the second resects the remaining after a period of liver regeneration. This procedure was modified a few years later associating right portal vein ligation and wedge resection of the left lobe tumors in the first surgery followed by right extended hepatectomy in the second. Portal vein ligation allows shorter periods of time to allow liver hypertrophy than PVE. This solved the problem of drawback patients between both procedures that could initially be of more than two months and after portal vein ligation was reduced to about four weeks. In 2011 a novel approach was reported and in 2012 this technique was labeled as Associating Liver Partition and Portal vein Ligation for Staged hepatectomy (ALPPS). It is also a two-stage surgical technique. In the first procedure a right portal ligation associated to an in situ split of the liver and wedge resection of left tumor charge is performed. The second step consists of resection of the diseased right hemiliver. Initial reports of rapid increase of volume between both surgeries were promising. Schnitzbauer et al. reported a 74 % volume increase in 9 days. On the other hand, morbidity and mortality (3 patients out of 25) rates were significant [7]. In order to improve the outcomes and search for a better selection criterion an international registry and modified approaches to the ALPPS procedure such as partial ALPPS (50-80 % of liver partition) were developed. In 2014 the international ALPPS registry including 202 patients revealed an in-hospital mortality rate of 9 % [8].

**Conclusion**

All these developments are widening surgical indications in CRLM. Surgical and systemic treatment as well as a better understanding of molecular alterations have changed the approach of liver metastases. The development of predictive
scores has helped us make a better patient selection. It is thanks to these efforts that the outcomes are improving daily and more and more patients can benefit from this year’s experience with CRLM.

Declaration

All the mentioned authors in the cover letter declare:

• That have contributed in the design of the article
• Having revised and edited the paper
• Provide consent to the final version of the manuscript to be published

References


