LIVER METASTASES IN COLORECTAL CANCER. REPLY TO FIGUERAS ET AL

We sincerely appreciate the comments made by Figueras et al. We all agree that surgical resection in isolated colorectal (CCR) liver metastases is the unique choice to cure such patients, with a 5 year survival between 25%-40%. However we emphasize in the review that we should separate patients with poor prognosis from others with good prognosis¹. The value of neoadjuvant chemotherapy in poor prognosis patients has been only evaluated in retrospective series². In these series, poor prognostic isolated liver metastases were considered unresectable because of large or multinodular disease, which is not currently considered as an unresectable disease. In all these retrospective series, including the report from Figueras et al³, two major biases the careful selection of patients (less than 30%) with poor prognosis features (>3 liver metastases) considered for resection in retrospective surgical series^{4,5}. In the report of Figueras et al, only 16% (40/250) of patient with poor prognosis features were considered for resection. Scheele⁶ described 638 patients with CCR liver metastases and of those, 59% of patients that were considered for resection had more than 3 nodules. Curative resection was done in 44% (121/278) of patients with 3 or less nodules, 17% (12/69) with 4-7 nodules and less than 1% (1/294) on patients with eight or more nodules. The second bias regards to the assumption that, only those patients with sensitive disease (or at least stable disease) after neoadjuvant treatment are considered for resection (53 of 151 patients in the Bismuth report). This strategy seems a logical approach, but survival on patients with progressive disease after neoadjuvant chemotherapy should also be analyzed. These two biases could influence positively on survival (40%-50% at 5 years in the reports of Figueras and Bismuth).

Regarding adjuvant chemotherapy, three prospective randomized trials have been published. There we-

re two positive^{7,8} and one negative⁹, but all have used intra-arterial chemotherapy combined or not with systemic chemotherapy. In the adjuvant setting, in good prognostic patients, only prospective trials comparing surgical resection alone versus resection plus adjuvant chemotherapy will be able to highlight the impact of systemic chemotherapy. To answer some of these questions, the TTD group is starting a in good prognostic isolated CCR liver metastases (less than 4 nodules and disease free interval more than 6 months) comparing surgical resection alone versus surgical resection plus adjuvant irinotecan and continuous infusion 5-fluorouracil.

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