


# “Locally Treatable” to Replace “Resectable”: Highlights from the European Multi-societal Consensus on Synchronous Colorectal Cancer with Liver Metastases

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The recent release of the multi-societal multidisciplinary consensus on synchronous colorectal cancer and liver metastases has brought a refreshing perspective to the table [1, 2]. In the realm of colorectal cancer liver metastases, words have the power to shape our perception and approach to treatment. The European-African Hepato-Pancreato-Biliary Association (E-AHPBA), European Society of Surgical Oncology (ESSO), European Society of Coloproctology (ESCP), European Society of Gastrointestinal and Abdominal Radiology (ESGAR) and Cardiovascular and Interventional Radiological Society of Europe (CIRSE) partnership emphasizes the crucial role of interventional oncology and especially ablation, leading to a shift from the term “resectable disease” to the more encompassing and empowering label of “locally treatable disease” [1, 2].

The consensus project aimed to create a practical framework for the management of patients with synchronous colorectal cancer and liver metastases. The group produced statements focusing on terminology, diagnosis, and management. The statements were refined through an online Delphi process, and those with 70% agreement or

higher were reviewed at a final in-person meeting in the city of Zaragoza, Spain, in December of 2022.

The group established that *synchronous* liver metastases refer to those detected at the time of presentation of the primary tumour. “Early metachronous metastases” apply to those found within 12 months of diagnosis of the primary tumour and “late metachronous metastases” are those detected after 12 months. *Disappearing metastases* are lesions that no longer appear on post-treatment imaging at the prerequisite of having acquired a contrast-enhanced magnetic resonance imaging (ceMRI).

Consensus guidance was provided on the composition of multidisciplinary tumour boards: the consensus recommends the addition of interventional radiology to the core specialties: abdominal radiology (with an expertise in gastrointestinal imaging), hepatobiliary (liver) surgery, colorectal surgery, gastrointestinal oncology, histopathology, cancer nurse specialist and board coordinator (case manager), though realizing that the composition represents a compromise between an ideal arrangement and a pragmatic acknowledgement that logistics and workforce issues often restrict the ability of all specialties to be present. Integration of interventional radiology into tumour boards discussing patients with liver metastases makes sense from a practical perspective—if these meetings are solely surgeon-led then it is hard to adequate weight to the full range of modern non-surgical interventions.

Regarding workup, a contrast-enhanced computed tomography (CT) of the chest and abdomen and hepatobiliary ceMRI scan of the liver should be undertaken at the time of presentation (and prior to any chemotherapy). Pathology confirmation, preferably including tumour mutation status for RAS, BRAF and HER2 amplifications and mismatch repair status (MMR), should be available

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from the primary tumour, but not ordinarily from liver metastases. The tumour marker carcino-embryonic antigen (CEA) should be measured at baseline presentation for disease monitoring. The consensus acknowledges the value of 18-fluorodeoxyglucose positron emission tomography (18-FDG-PET) in decision-making in patients with stage IV colorectal cancer but does not recommend that this test be routinely used. The presence or absence of extrahepatic metastases should be specified together with site. In relation to thoracic metastases, number, laterality and definite or “indeterminate” should be noted. In relation to liver metastases, the size, number and distribution within Couinaud segments should be specified.

Regarding treatment, the consensus recommends that when upfront synchronous partial hepatectomy is to be undertaken together with colectomy, the hepatectomy component should be minor and recommends systemic chemotherapy first in patients with a performance status which precludes surgery (but not systemic chemotherapy), in those with extrahepatic disease at presentation (M1b status) and in patients with peritoneal metastases at presentation (M1c status). The consensus supports the “*bowel-first*” approach in the settings of symptomatic or locally advanced primary tumours. The consensus supports the “*liver-first*” approach for borderline locally treatable metastatic disease after systemic chemotherapy and for patients with rectal tumours, preferably in the window between completion of chemo(radio)therapy and evaluation of local treatment response. Resection of an asymptomatic colorectal tumour is not recommended in the presence of liver metastases that cannot be eradicated.

As we have seen positive results from the non-randomized MAVERRIC trial and eagerly await the results of the randomized controlled COLLISION and NEW-COMET trials, the management of patients with colorectal liver metastases is expected to evolve substantially. The demonstration of non-inferiority in survival between ablation and resection is likely to require modification of long-held paradigms and lead to the adoption of the term “locally treatable” instead of the uni-dimensional term “resectable”. In turn, this addresses the increasing plurality of treatment options. In order for patients to receive the best possible care perhaps the most important “take home” message from this multi-societal collaborative is the need for different specialties to work together and emphasize the

aim to complement rather than clash as ablation and resection most often work synergistically [3–5].

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**Informed consent** Not applicable.

**Consent for publication** Consent for publication was obtained for every individual person’s data included in the study.

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