Biological Behavior of Perihepatic Lymph Node Metastasis and Its Impact on Prognosis Following Liver Resection for Colorectal Metastases

To the Editors:

Bennett et al. have done a commendable job in analyzing the impact of perihepatic lymph node metastases following partial hepatectomy for colorectal metastases.¹ The conclusion that involvement of perihepatic lymph nodes would adversely affect outcome is not surprising. What is remarkable is that, despite their involvement, the 3-year overall survival was 76% for the immunohistochemistry (IHC)-positive group and 25% for the hematoxylin and eosin (H&E)-positive group. This is a fairly good result and it opens the discussion about the biological behavior of the perihepatic lymph node metastasis in the presence of liver metastasis.

Metastases from colorectal cancers are amenable to curative resection; this has been shown quite convincingly for liver metastases^{2,3} and also for selected patients with lung metastases.⁴ Involvement of other extrahepatic sites is generally considered incurable. The involvement of perihepatic lymph nodes in the presence of liver metastasis is a unique circumstance.

Whether the perihepatic lymph nodal involvement represents metastasis from the liver metastasis or is a manifestation of metastasis from the colorectal primary itself is a matter of debate. This distinction is important because these two mechanisms represent two different biological behaviors of this disease. If the perihepatic nodes are metastatic from colorectal primary itself, there are at least two detectable sites of distant metastases and the probability of having micrometastasis at other sites would be quite high; thus the disease is more likely to be disseminated. On the other hand, if these lymph nodes are metastatic from the

liver metastasis, it would be somewhat similar to a regional disease of liver if the colorectal primary has been controlled. This gives an opportunity to treat both the metastases (liver and perihepatic lymph nodes) with curative intent. Hence, the prognosis in such a situation would be better than if these nodes were metastatic from the colorectal primary itself. This view is in variance to that of Bennett et al., who state that “tumor deposits in these lymph nodes likely represent spread from metastases within the liver itself rather than from the primary tumor, and this might explain the dismal survival in these patients.”¹

Durgatosh Pandey, M.Ch,
Department of Surgical Oncology,
Institute of Medical Sciences,
Banaras Hindu University
Varanasi, India
e-mail: durgatosh@gmail.com

REFERENCES

1. Bennett JJ, Schmidt CR, Klimstra DS, et al. Perihepatic lymph node micrometastases impact outcome after partial hepatectomy for colorectal metastases. *Ann Surg Oncol* 2008; 15:1130–6.
2. Kato T, Yasui K, Hirai T, et al. Therapeutic results for hepatic metastasis of colorectal cancer with special reference to effectiveness of hepatectomy: analysis of prognostic factors for 763 cases recorded at 18 institutions. *Dis Colon Rectum* 2003; 46:S22–31.
3. Fong Y. Surgical therapy of hepatic colorectal metastasis. *CA Cancer J Clin* 1999; 49:231–55.
4. Yedibela S, Klein P, Feuchter K, et al. Surgical management of pulmonary metastases from colorectal cancer in 153 patients. *Ann Surg Oncol* 2006; 13:1538–44.

Published online April 19, 2008.
DOI: 10.1245/s10434-008-9919-9