

Treatment of colon cancer with multiple liver metastases

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ABSTRACT

Treatment of patients with colorectal cancer and synchronous liver metastases is challenging. We present the case of a 34-year-old woman who had about 50 liver metastases from an adenocarcinoma of the sigmoid colon. Neoadjuvant chemotherapy led to a remarkable response of the hepatic metastases. The patient was subjected to sigmoidectomy with primary anastomosis and synchronous treatment of all liver metastases. The number of liver lesions should not in itself present a contraindication to resection. This is the first report of successful concomitant surgical treatment of sigmoid adenocarcinoma and multimetastatic liver disease.

KEYWORDS Colon cancer; liver metastasis; resection; synchronous

Treatment of patients suffering from colorectal cancer with synchronous liver metastases is challenging. Improvement in chemotherapeutic agents and surgical techniques has prolonged the life expectancy of some of these patients.¹ We report herein a 34-year-old woman who underwent a successful colectomy with concomitant extensive metastasectomy.

CASE DESCRIPTION

A 34-year-old woman had liver metastases from a moderately differentiated adenocarcinoma of the sigmoid colon. Cross-sectional imaging revealed about 50 liver metastases with no other metastatic deposits. The patient was fully active, with a Karnofsky Performance Scale Index of 90%. After 12 cycles of neoadjuvant chemotherapy, a noticeable response of the hepatic metastases was apparent, with 28 metastases remaining detectable. The initial chemotherapeutic regimen was FOLFIRINOX (leucovorin, fluorouracil, irinotecan, and oxaliplatin) in combination with bevacizumab. The regimen had to be switched to FOLFIRI/bevacizumab after two cycles of treatment due to oxaliplatin-associated emesis. The patient was subjected to sigmoidectomy with primary anastomosis and synchronous treatment (resection or radiofrequency ablation) of all metastatic lesions in the

liver. An en block atypical hepatectomy of segment VI and half of segment V (encompassing 10 liver metastases) and five wedge resections in segments III, IV, and VII were performed. Thirteen further detectable lesions (located in segments I, III, IV, V, VII, and VIII) had been treated with ultrasound-guided radiofrequency ablation. The postoperative course was uneventful. The patient received adjuvant chemotherapy and remains in good general condition without radiological evidence of tumor recurrence 10 months postoperatively.

DISCUSSION

The present case underlines that synchronous resection of a primary neoplasm and liver metastases seems to be the ideal procedure when feasible. Previous reports had set the limit of “resectable” liver disease as up to three lesions. The main argument was that the presence of multiple (≥ 4) macroscopically detectable liver metastases indicates aggressive tumor behavior.² More recent studies, based on encouraging outcomes, support the view that the number of liver lesions should not present a contraindication to resection in itself. The factors that are crucial are the initial liver function, the remnant liver volume, the performance status of the patient, and the possibility to achieve an R0

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resection or even complete tumor destruction of every detectable liver lesion.³ Current guidelines support that, in cases of a synchronous approach, the ideal combination is to perform a major intervention at one organ (colon/rectum or liver) with a minor one to the other (liver or colon/rectum).⁴ In fact, the limit and extent of liver intervention remain unknown.

Our patient had an ideal performance status and showed an excellent response to neoadjuvant chemotherapy. To the best of our knowledge, this is the first report of successful surgical treatment of sigmoid adenocarcinoma and such a multimetastatic (28 lesions) liver disease.

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Avocations



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