Surgical Treatment of Liver Metastases of Gynecological Cancer: Local Treatment of a Systemic Disease

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Even today, oncological surgery implies the resection of all malignant tissue. Incomplete resection, of local or distant disease, is not used and may be harmful for the patient [1]. Because of this assertion and due to the mortality associated with hepatectomy, 50 years ago the presence of liver metastases was a palliative situation [2]. During this era, with great daring some surgeons proposed to operate on colorectal liver metastases. The metastatic dissemination of malignant cells into the liver only via the portal vein justified this aggressive attitude [3]. Hence, patients with extra-hepatic metastases of colorectal cancer, even when resectable, were not considered suitable for surgery. Now, with the exception of involved celiac lymph nodes, there is no contraindication to resection of all colorectal metastases if they are all macroscopically resectable [4]. Even peritoneal carcinomatosis is not a contraindication to resection of colorectal liver metastases anymore, with a 3-year overall survival of more than 40% [5]. Evolution of these therapeutic attitudes was due to the major improvements of medical oncology, radiology and surgery [6]. Oncosurgical strategies in metastatic disease are now always the result of a debate that implies all these specialties. Thanks to this association, surgery of liver metastases is now poten-

tially feasible even in patients with systemic disease. It is the
treatment of these patients of this series (62%). In this group, resection of liver deposits clearly improved the outcome with a 5-year overall survival of 50% compared to a median of survival of 7.4 months without resection. The small number of patients treated for liver metastases of ovarian (n = 8) or uterine cancer (n = 8) makes it difficult to interpret the results that showed no clear advantage of liver surgery compared to exploratory laparotomy. It is a pity that the results have not been stratified according to the primary tumors.

The major interest of this paper is to describe the results of a series of patients recently treated for liver metastases of breast cancer and within a relatively short period (2000–2007). In fact, several series of this pathology are now available but all of these have covered long periods of inclusion. For instance, the two largest series include 69 and 108 patients, but the patients included were operated on between 1988 and 1999 [8] and 1984 and 2004, respectively [9].

Even though the present series of patients is small, it demonstrates of the end of a dogma. Surgical therapy now plays an important role in the treatment of cancer patients with apparent systemic disease spread, as in metastatic breast cancer. Approximately 50% of breast cancer patients develop metastases [10] and this series confirms that patients with liver metastases from breast cancer will probably more often be offered surgery. The benefit of neoadjuvant chemotherapy has been demonstrated only recently in patients operated for resectable colorectal liver metastases [11], soon the benefit of adjuvant surgery in patients treated by chemotherapy for metastases of breast cancer will become apparent.
References


