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 of 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 potentially feasible even in patients with systemic disease. It is the improvement of chemotherapy and targeted treatments that allows to treat patients in this situation. The role of chemotherapy is to select patients with resectable macroscopic liver metastases and to possibly treat microscopic systemic malignant cell dissemination. The difficult work of the radiologist is to detect the (sometimes microscopic) residual tumors, so the surgeon can assess whether surgery is feasible and thus avoid a laparoscopy or worse, an explorative laparotomy.

The interesting paper of Kollmar et al. [7] in the last issue of ONKOLOGIE very well summarizes the development of liver surgery in patients with liver metastases from gynecological cancer. In this work, they report on 43 patients that have been operated on for liver metastases of gynecological cancers between 2000 and 2007. More than 80% of these patients re-

ceived chemotherapy before and after laparotomy, which allowed a curative liver resection in 30 patients. Except for 3 patients, all had metachronous disease with a mean delay of more than 6 years after resection of the primary tumor. There was no postoperative mortality after hepatectomy and only 4 patients had positive margins.

Liver metastases of breast cancer represented the major subset of the 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 explorative 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 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.

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