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PG 1.04 SPEAKER ABSTRACT

How to select the appropriate surgical approach in rectal cancer

T. Holm. *Karolinska Universitetsssjukhuset, Stockholm, Sweden*

Abstract not available.

Thursday, 22 March, 10:30−12:00

Session II. Individualising Therapy in Colorectal Cancer

PG 2.01 SPEAKER ABSTRACT

Differentiating colon cancer by clinical criteria

E. Van Cutsem. *Katholieke Universiteit Leuven, Leuven, Belgium*

Abstract not available.

PG 2.02 SPEAKER ABSTRACT

Colorectal cancer with synchronous liver metastases

T. Ruers. *Surgical Oncology, The Netherlands Cancer Institute, Amsterdam, Netherlands*

This lecture will concentrate the on treatment strategy in patients that present with stage IV primary colorectal cancer In patients with asymptomatic stage IV colon cancer and irresectable metastatic disease the most optimal treatment strategy remains controversial. Resection of the primary tumor may lead to high morbidity rates in malnourished patients, while on the other hand conservative or systemic treatment without resection of the primary tumor may still harbor the risk of bowel obstruction or tumor bleeding. Meta-analysis of mainly retrospective studies indicates, however, that conservative treatment and start of palliative chemotherapy may be save and leads to clinical symptoms of bowel obstruction in only a small minority of patients (14%). On the other hand several studies mention that colon resection may lead to surgical mortality in up to 5−10% of the patients. The results from a recent meta-analysis suggest that for patients with stage IV incurable colon cancer, resection of the asymptomatic primary tumor provides only minimal palliative benefit, can give rise to major morbidity and mortality, and may potentially delay the administration of systemic chemotherapy. Providing asymptomatic disease, initial resection seems not absolutely indicated and may mainly be reserved for the small proportion of patients who may develop complications due to the presence of primary tumor. On the other hand, when initial chemotherapy is started and incurable stage IV disease is converted into potentially curative disease, resection of both the primary tumor and its metastases should certainly be considered. Another debate concentrates on the treatment policy in patients with rectal cancer and operable colorectal liver metastases. The original treatment order in these patients consist of initial rectal resection followed by liver resection. Several group, however, make a clear statement for the reverse sequence of treatment and opt for a liver first approach. Recently, also another approach was advocated in which the conventional 6 week chemoradiation course was replaced by a one week (5×5 Gy) radiotherapy course followed by 6 weeks chemotherapy for optimal chemotherapy treatment of metastatic disease. Subsequently, initial rectal or initial liver resection was planned. The different treatment options for patients with synchronous colorectal liver metastases will be extensively discussed.