

To the Editors:

Resection of colorectal liver metastases: single unit experience in Sri Lanka

The liver is the commonest site of metastases from colorectal cancer (CRC), with 50% of patients being affected either synchronously or metachronously [1]. Surgical resection offers excellent results (up to 65% five year survival), although it is feasible in only 20% of patients with CRC metastases [2, 3]. This is the first published series of patients from Sri Lanka following hepatic resection for colorectal liver metastases.

The data base in the unit was used for data retrieval. After assessing fitness for major surgery, operability of the lesions was assessed with triphasic computerized tomography. All patients had pre-operative chemotherapy. The preferred incision for exposure was a right sided "J" incision with extension to the left when necessary. Most patients had intermittent inflow vascular control (Pringle's manoeuvre) during hepatic transection, while a few had selective inflow and outflow control. Parenchymal transection was done with Kelly clamp-crush technique. Bleeding was controlled with diathermy coagulation, polypropylene sutures and titanium clips. Complications were recorded and patients were followed up at regular intervals.

Out of a total of 50 hepatectomies performed from January 2002 to January 2009, 17 patients underwent hepatic resection for colorectal liver metastases. Forty one percent (7/17) were males. The median age was 55 years (range 39-69). Only 1/17 of the resections was done synchronously (at the same time as the bowel resection). The median time from initial surgery to hepatic resection was 2 years (range 4 to 36 months). All except two patients were in American Society of Anesthesiologists (ASA) grade I. Seven were major resections (3 or more segments resected). The mean operating time was 4 (SD 1.25) hours. The median blood loss was 700ml (range 100-1500 ml). The only significant morbidity was a bile collection in one patient, which was aspirated under ultrasound guidance. There were no 30 day mortalities. All except one had R₀ tumour clearance (microscopically clear margins). Patients were followed up for a median period of 18 months (range 3 to 72 months). Of those who came for regular follow up, one developed recurrent liver metastases and underwent re-resection. The longest survivor died after 6 years from myocardial infarction.

Hepatic resection has been proven to be the most effective method of treating patients with CRC liver

metastases. However, the limited facilities for evaluation of these patients, lack of sophisticated transection equipment, and limited expertise would have prevented this modality being used to its maximum potential in this country. As described above, with the use of simple techniques such as inflow control with Pringle's manoeuvre, and transection with Kelly clamp-crush technique, we were able to successfully perform surgery in all our patients with minimum morbidity and no mortality. Having clear microscopic resection margins in all but one patient is an indication of possible satisfactory outcome with regards to the surgical technique. Although the numbers are small to comment on survival, these results auger well for a better outlook for patients with resectable colorectal liver metastases in this country.

Over 7 years we had only 17 patients with resectable colorectal liver metastases. This is a low number considering the CRC incidence of 3.29/100,000 in our country and the reported incidence of developing liver metastases and operability rates in the literature [4]. Our unit had over 200 patients who were operated and followed up for colorectal cancer during this period. The reasons for the low number resected could be either a lack of awareness among clinicians on the possibility of safe hepatic resection (hence non-referral), late presentation of patients due to poor follow-up or a lower incidence of CRC liver metastases in our patients.

References

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