for treatment in multimodality programs with the ultimate aim to cure. To achieve this goal, meticulous preoperative assessment of tumor burden is important in patients with colorectal cancer liver metastasis (CRCLM). Preoperative imaging is essential for the evaluation of tumor burden, number of segments involved, tumor location, vascular anatomy, and estimation of the future liver remnant. In addition to the planning for surgery, imaging plays an important role in determining treatment strategies and monitoring response.

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How to optimize perioperative chemotherapy

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Patients with resectable liver metastases who are have a high chance of relapse as only about 30% -40% of patients are enjoying long-term cure. Perioperative chemotherapy has therefore been utilised in order to improve the results. The EORTC EPOCH study used six cycles of FOLFOX preoperatively followed by operation and postoperatively another six cycles of FOLFOX. The progression-free survival was significantly prolonged as compared to patients receiving immediate surgery. The New-EPOCH study intensified the FOLFOX regimen adding cetuximab in patients with KRAS wild-type disease. Surprisingly patients receiving cetuximab had an inferior outcome as compared to patients receiving FOLFOX alone. The patient charac-teristics differed between EPOCH and New-EPOCH and may explain these surprising results. Also, in all of these studies the effect on long-term survival, which may need a ten-year follow-up, is unclear at the moment. Neoadjuvant chemotherapy in resectable liver metastases may be a disadvantage as invisible metastases may disappear even at the time of surgery and may not be resected, thus the place of early relapse of remaining microscopic deposits.

In patients with unresectable liver-limited disease the adjuvant chemotherapy in combination with an EGFR inhibitor in patients with KRAS wild-type disease increases the chance of resectability and significantly prolongs long-term survival according to a prospectively randomised trial giving important evidence for this kind of approach. Liver resection, although it may not be curative, does significantly prolong overall survival as compared to no resection (27 vs 54 months median). The higher the response rates, the more likely R0 resection may be achieved. Patients must be seen by a multidisciplinary team consisting of an experienced liver surgeon and a medical oncologist in order to achieve the best results.

CRC surgeons' view for synchronous CRLM?

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Liver surgeons' view for synchronous CRLM

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