

EDITORIAL

AHPBA/SSO/SSAT sponsored consensus conference on the multidisciplinary treatment of colorectal cancer metastases

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On 18 January 2012, the Americas Hepato-Pancreato-Biliary Association (AHPBA) convened a Consensus Conference on the multidisciplinary treatment of colorectal cancer liver metastases (CRLM). The event followed the format of previous consensus conferences, and as in previous years was cosponsored by the Society of Surgical Oncology, the Society for Surgery of the Alimentary Tract and the University of Texas MD Anderson Cancer Center. The goals of this conference included the assembly of international experts on the diagnosis and treatment of CRLM, presentations and discussions on evolving standards for the multidisciplinary approach to CRLM, and initiation and facilitation of a consensus-finding process regarding novel aspects within the field. The meeting took place over 1 day and consisted of three sessions that focused on the topics of selection for hepatic resection, locoregional surgical and interventional therapies, and systemic cytotoxic and biological therapies.

This issue of HPB contains three manuscripts, each representing the content of one session, including summaries of subtopics as well as a listing of the resulting consensus statements.¹⁻³ The process and organization of this event was kept quite similar to earlier consensus conferences on hepatic colorectal cancer metastases,⁴ resectable and borderline resectable pancreatic cancer⁵ and hepatocellular cancer.⁶ After preparatory steps among experts within the specialty and in consultation with the co-sponsoring societies, a programme with relevant innovative topics on CRLM was compiled, and a group of thought leaders was identified and invited to serve as presenters or panelists during the conference.

Each presenter was requested to summarize relevant data on a specific subtopic, and to propose statements that could serve as a basis for a subsequent consensus. A panel of experts was invited to

comment on the presentation topic and the proposed statements, and the conference audience was encouraged to participate in this discussion. After the symposium, three manuscripts were written by the presenters and these have been reviewed by the session panelists whose accompanying commentaries are also included in this issue.

A previous consensus conference held in 2006 had addressed the topic of CRLM, and provided statements regarding the selection of patients for resection, methods of improving resectability, and the selection of systemic chemotherapy and regional treatments.⁴ Why, then, should there be another consensus conference on CRLM after an interval of just 6 years? What may seem to be an event at risk of premature repetition is actually a reflection of the significant and rapid advances that have been made in the multidisciplinary approach to CRLM during this short time span.

Improved accuracy of pre-operative imaging has guided local and regional therapies to greater anatomic precision and better patient selection. High-quality imaging at baseline appears to be crucial for developing a successful multidisciplinary plan. We have learned that traditional means of radiographical response assessment to induction therapy carry limitations, and that novel response parameters are better predictors of systemic therapy efficacy and tumour biology. Questions on what can be resected and what should be resected have been better defined, especially in the light of effective systemic therapy leading to disappearing metastases. The experience with extensive non-anatomic resections or staged approaches for bilateral CRLM has grown significantly, as has the spectrum of options in the approach to patients with primary colon or rectal cancers and synchronous CRLM. An entire spectrum of therapeutic options for local ablative and regional therapies has emerged, and requires a balanced approach that provides the individual patient with those options that can ascertain a best possible result. Finally, systemic treatment options are rapidly expanding with cytotoxic and/or biological therapeutics providing significant gains, both for an adjuvant indication as well as for definitive therapy of ultimately

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unresectable disease. Importantly, the increased use of chemotherapy as a pre-operative treatment has led to advances in the understanding of chemotherapy-associated liver injury mechanisms, thereby setting new standards for type and duration of such approaches.

A 'consensus' in this arena of interactions between multiple specialties cannot be expected to be truly complete or to remain permanent. The interested reader will undoubtedly recognize that the current statements only represent a contemporary snapshot of specific aspects within a rapidly developing field, and that they are intended to complement evolving evidence-based practice standards. Their desired purpose is primarily to enhance the multidisciplinary awareness, commitment and directives of physicians involved in the care of CRLM patients. We are encouraged by the developments within the field, and hope that the inclusion of these novel contributions to the consensus guidelines contributes to the process of achieving a balanced multidisciplinary therapy strategy for every patient with CRLM and thus of enhancing the quality of care. We thank those who actively contributed to the consensus-finding effort to create such a possibility.

Conflicts of interest

None declared.

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