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Summary

Surgery and local therapies for metastases in advanced colorectal cancer: Do they offer real benefit or promise more than they deliver?

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Two speakers debate the role of liver and metastatic resection in colorectal cancer, with both concluding that multidisciplinary assessment and combined systemic plus local treatment strategies improve outcomes when surgery is feasible.

KEY POINTS

- The first speaker reported that in the Cairo 5 trial (300 patients, median 12 liver metastases per group), patients amenable to resection or destruction had substantially longer survival than those not amenable, and recommended reassessment every 2 months during systemic therapy.
- The Coalition trial found that for liver lesions in the middle of the liver, less than 3 cm, and fewer than 3 lesions, destruction is equivalent to resection according to the speaker.
- The second speaker noted that in Cairo 5, intensified induction chemotherapy (triple chemotherapy in right-sided or RAS-mutated tumors, anti-EGFR in left-sided RAS/BRAF wild-type tumors) improved objective response rates from 33% to 54% and 53% to 80% respectively, driven by partial responses.
- In the Prodige 7 trial for peritoneal metastases, cytoreductive surgery alone achieved a median overall survival of 3.5 years after induction chemotherapy, and adding HIPEC did not improve outcomes, the speaker stated.
- The Orchestra trial in multi-organ metastatic colorectal cancer showed no survival benefit for tumor debulking plus chemotherapy (median OS 30 months) versus chemotherapy alone (27 months), leading the speaker to recommend chemotherapy alone in this setting.
- Both speakers emphasized that decisions require expert multidisciplinary teams including hepatobiliary surgeons, molecular pathology at initial discussion, and that surgery or local therapies should be offered at centers with daily expertise if unavailable locally.

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