

Editorial

Peritoneal Carcinomatosis or Liver Metastases from Colorectal Cancer: Similar Standards for a Curative Surgery?

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In this issue of the *Annals of Surgical Oncology*, Shen et al.¹ report their results using cytoreductive surgery and intraperitoneal hyperthermic chemotherapy (IPCH) with mitomycin C in 77 patients with colorectal peritoneal carcinomatosis treated between December 1991 and April 2002. Their most important message is that this procedure, albeit aggressive, time-consuming, and costly, results in the cure of peritoneal carcinomatosis in some patients. The 5-year survival rate was 17% for the entire series, but 34% when complete resection of macroscopic disease was realized (48% of their patients). This rate, however, was 0% after incomplete resection and the mortality rate of the procedure was high (12%).

These results represent another important stone in the foundations to cure peritoneal carcinomatosis (PC), and are close to those reported by similar series using the same approach.^{2–5} As reported in other series, the completeness of macroscopic disease excision is the main prognostic factor.^{1–5} Thus, it is clear that this new procedure should be performed in the future only with a curative intent, when an R0–1 status can be obtained with surgery. For this reason, it is feasible only in selected patients.

When complete resection is accomplished, one third of patients experience long-term survival.^{1–4} When considering colorectal metastatic disease at large, these results are surprisingly similar to those obtained after hepatectomy for liver metastases.^{6–8} Hepatectomy for colorectal liver metastases is also strictly contraindicated if surgery is incomplete and so is palliative.^{6–8} Similar rules, there-

fore, apply to the treatment of colorectal liver metastases or peritoneal carcinomatosis and the same results are obtained after R0 resections of both diseases.

Concerning hepatectomy for liver metastases, no randomized study has ever been done to demonstrate the survival benefit of surgery over systemic chemotherapy alone in similar patients. Despite that, curative hepatectomy is currently the gold standard for resectable colorectal liver metastases, and a randomized study aimed at demonstrating its superiority over systemic chemotherapy alone would be unethical today. In the same way, an increasing number of studies concerning cytoreductive surgery plus IPCH act to reach the same conclusion, and even more since the Amsterdam group clearly demonstrated the superiority of surgery plus IPCH over classic systemic chemotherapy in 104 randomized patients.⁴

In the study of Shen et al.,¹ as in the Amsterdam group's study, the design of IPCH was established before December 1991 and is currently not optimal. This can and must be improved, mainly by using new molecules inside the peritoneal cavity, such as oxaliplatin,⁹ irinotecan, or both.¹⁰ The results with oxaliplatin are promising, with a 2-year survival rate of 74%.¹¹

In 2004, increasing evidence leads to the consideration of two new statements. First, peritoneal carcinomatosis is finally considered as a regional tumorous disease in the same way as liver metastases. Second, for some types of advanced tumors, the combination of surgery, treating the macroscopic component, with an efficient chemotherapy, treating the microscopic one, greatly increases the chance of cure for many patients who were doomed with the traditional treatment. This is true for liver metastases as well as for peritoneal carcinomatosis, because both diseases now respond to the same treatment approach and result in similar survival rates.

We must thank Shen et al.¹ for giving us supplementary data that act toward these new perspectives.

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