Sesiones HBP-CHUVI

SESIÓN 7 :

Metástasis hepáticas de origen colo-rectal. Abordaje multidisciplinar

CIRUGÍA
HBP VIGO

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FEA. Unidad HBP. Servicio Cirugía General. CHUVI

INTRODUCCIÓN: Abordaje Multidisciplinar

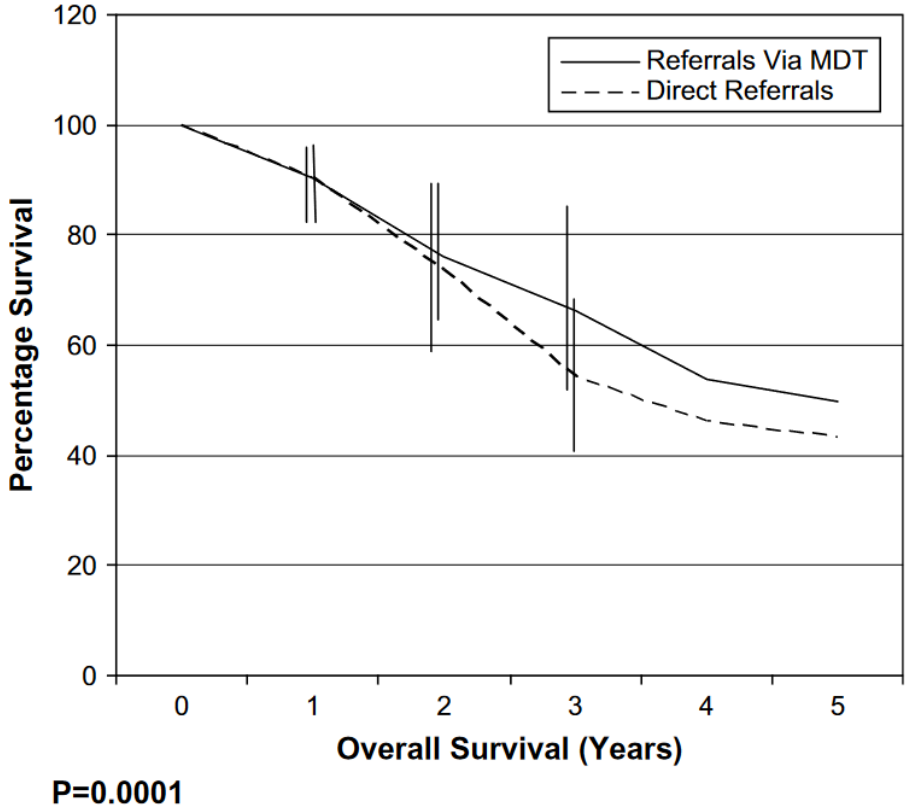


Figure 1. Overall mortality with 95% confidence intervals. $P = 0.0001$.

Table 6
Multivariate predictors of overall survival using Cox regression method

Referrals via hepatobiliary MDT	*P* value
Post-hepatic resection systemic recurrence	0.004
Septicaemia	0.003
Pre-operative chemotherapy	0.01
Macroscopic diaphragmatic invasion	0.04
Referrals from all other hospitals	
Severe complications	0.001
Days in hospital >10	0.01
Pre-operative chemotherapy	0.049
Referrals via hepatobiliary MDT versus referrals from all other hospitals	0.0001

J.T. Lordan, N.D. Karanjia, N. Quiney, W.J. Fawcett, T.R. Worthington. A 10-year study of outcome following hepatic resection for colorectal liver metastases – The effect of evaluation in a multidisciplinary team setting. EJSO 35 (2009) 302-306*

INTRODUCCIÓN: Incidencia

- Indicencia CCR **Galicia**: **100/100.000 hab/año**
- 50-60% pacientes con CCR (25% Sincrónicas)
- Resecables 10-20%

- **<u>Área Sanitaria de Vigo</u>**: 450 casos /año -> 110 Mtx sincrónicas
- 28 resecables al diagnóstico
- 15 resecables tras QT

INTRODUCCIÓN: Resección

La **resección** es el tratamiento de **elección** (*NCCN. Colon Cancer Versión 3.2022 - January 25,2023*

La cura es posible

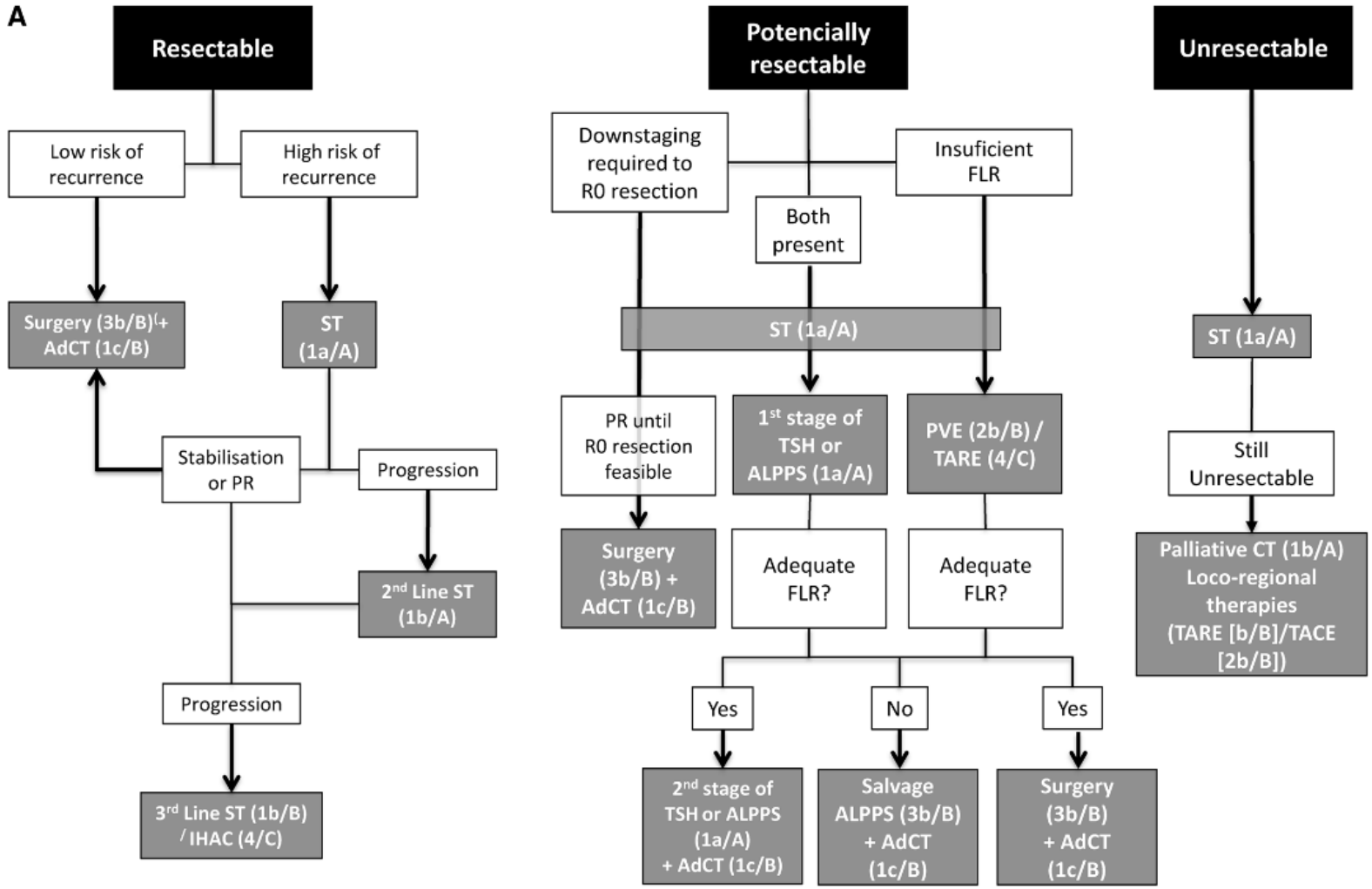
Supervivencias libres de enfermedad a los 5 años de hasta el **38% a los 5 años**.

Casos seleccionados de metástasis únicas, **supervivencias a los 5 años del 71 %.**

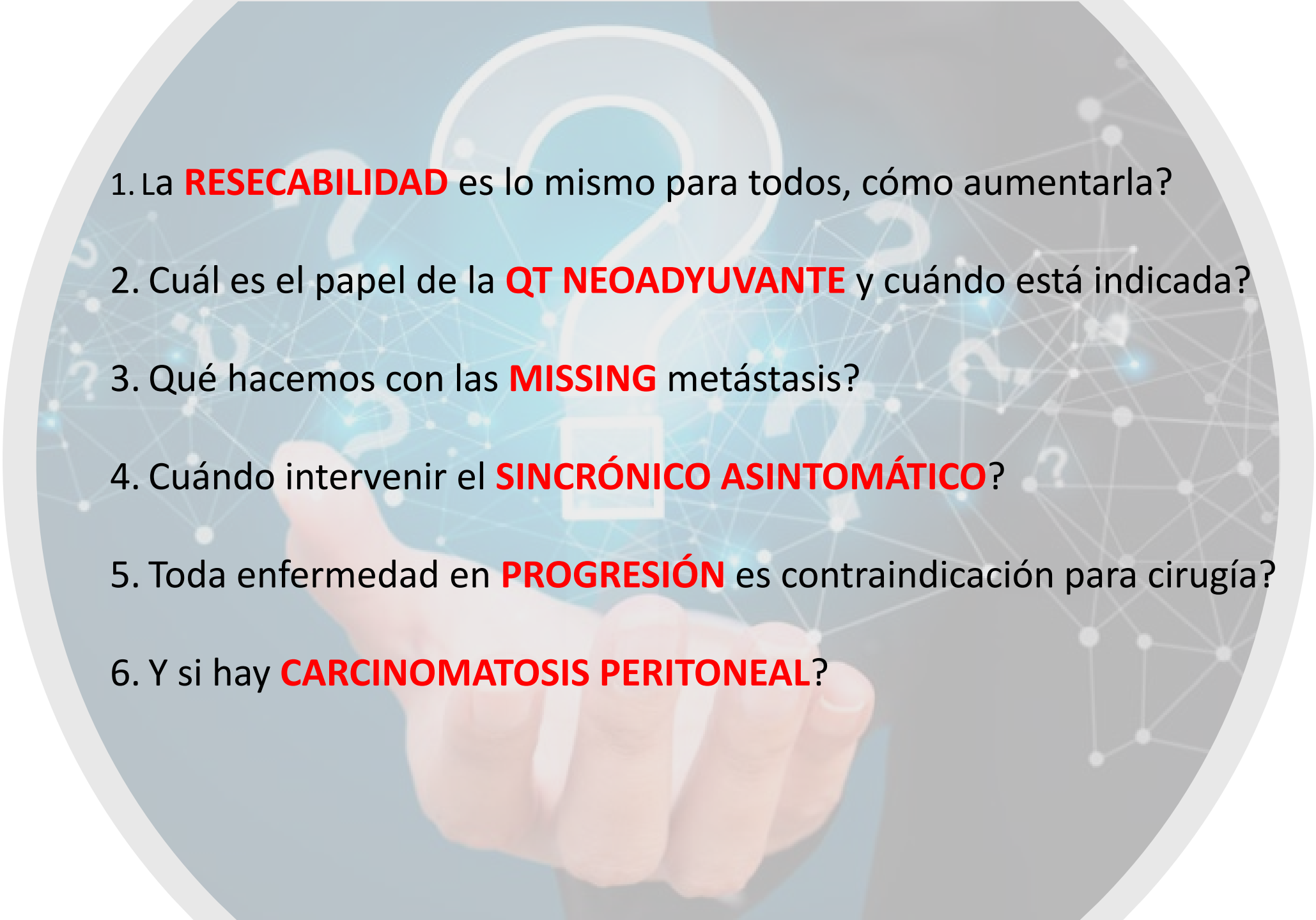
Gena P. Kanas et al. Survival after liver resection in metastatic colorectal cancer: review and meta-analysis of prognostic factors. Clinical Epidemiology 2012:4

CONSENSO SEOM, AEC, SEOR, SERVEI Y SEMNIM

(*R. Vera et al.. Clinical and Transational ONcology (2020) 22:647-662*)




PREGUNTAS



1. La **RESECABILIDAD** es lo mismo para todos, cómo aumentarla?
2. Cuál es el papel de la **QT NEOADYUVANTE** y cuándo está indicada?
3. Qué hacemos con las **MISSING** metástasis?
4. Cuándo intervenir el **SINCRÓNICO ASINTOMÁTICO**?
5. Toda enfermedad en **PROGRESIÓN** es contraindicación para cirugía?
6. Y si hay **CARCINOMATOSIS PERITONEAL**?

RESECABILIDAD: Es lo mismo para todos?

DEFINICIÓN DE RESECABILIDAD -> **Remanente hepático funcional** adecuado (20-30% hígado sano / 40% Hepatopatía o post-QT/ total body weith ratio >0,5%) Para **obtener R0**

(*Jean-Nicolas Vauthey et al. HPB 2010, 12, 289-299*)

RESECABLES(20-10%)

POTENCIALMENTE RESECABLES:

R0 posible + FLR insuficiente

R0 comprometido (tamaño mtx)

IRRESECABLES

80-90%

RESECABILIDAD: Es lo mismo para todos?

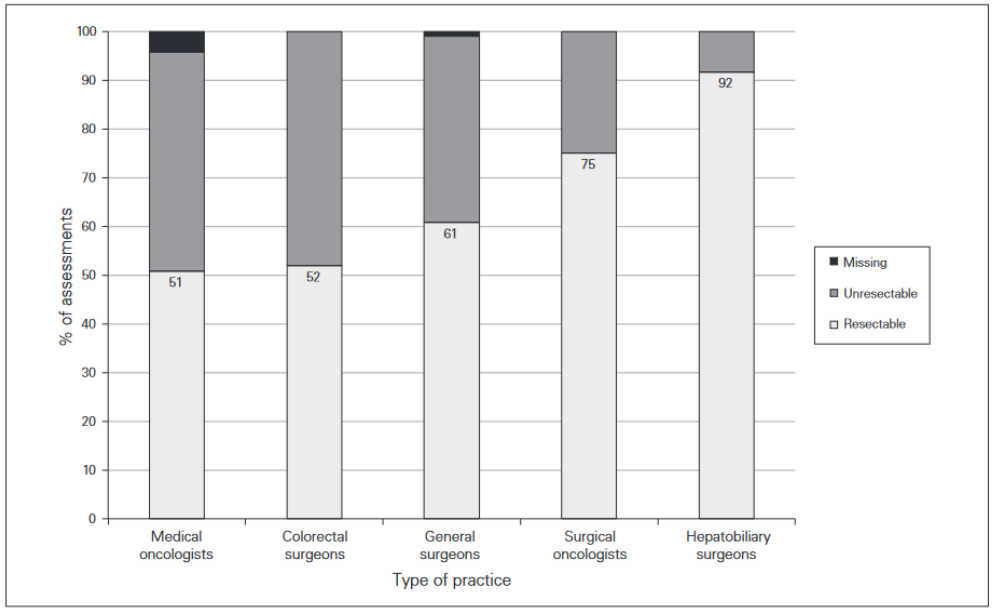


Fig. 1. Proportion of assessments in which colorectal liver metastases were considered resectable according to respondents' type of practice ($p < 0.001$).

Jean-Michel Aubin et al. Can J Surg 61,4. August 2018

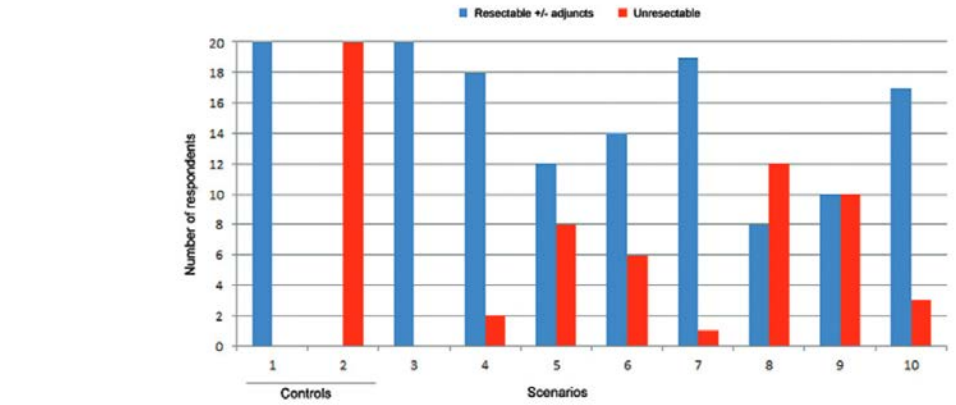


Figure 2 Agreement on resectability per scenario

Walled M. Mohammad et al. HPB 2012, 14, 291-297

RESECABILIDAD: Cómo podemos aumentarla?

- **QT CONVERSIÓN**:

Tasas de resección R0 hasta el **57%**

(*Karen Bolhuis et al. European Journal of Cancer 141 (2020) 225-238*)

RESECABILIDAD: Cómo podemos aumentarla?

- **QT CONVERSIÓN**:

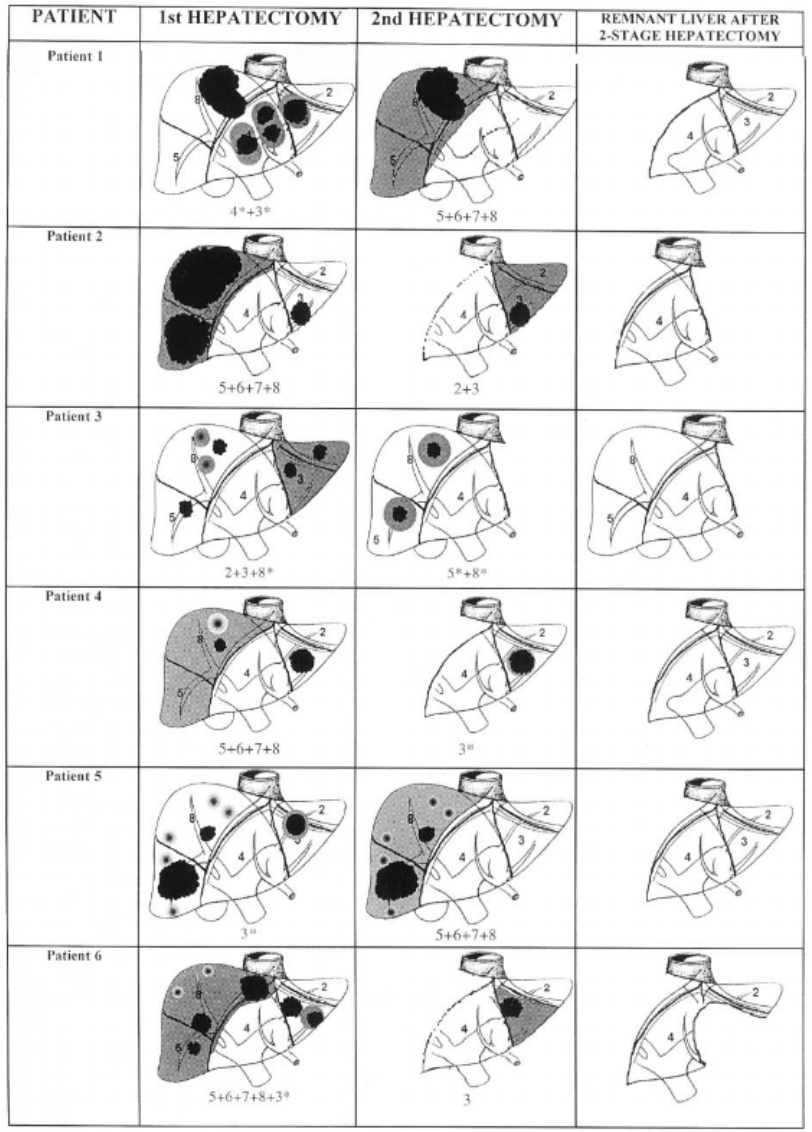
Tasas de resección R0 hasta el **57%**

(*Karen Bolhuis et al. European Journal of Cancer 141 (2020) 225-238*)

Heterogeneidad
Definición de resecabilidad!!!!!!

Cómo LA CIRUGÍA HA COLABORADO CON EL AUMENTO DE RESECABILIDAD

A



R. Adam et alAnn Surg 2000 Dc, 232(6):777-85

HEPATECTOMÍA EN DOS TIEMPOS

Bilobares >3 cm
> 3 metástasis en FLR insuficiente

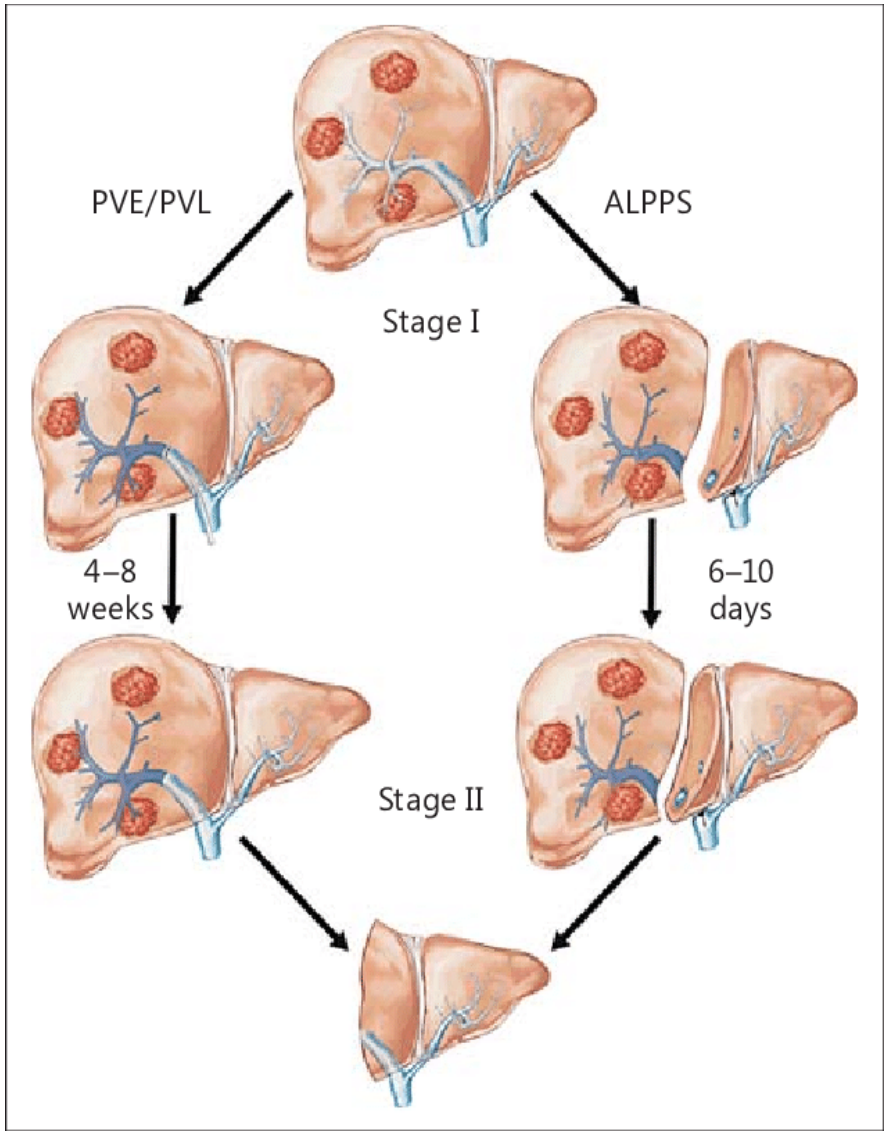
1	Resección Mtx futuro remanente Embolización portal -> Hipertrofia
2	Resección hígado embolizado

"DROP OUT"
- Progresión
- FLR insuficiente

35%

Guido Torzilli et al. Liver Cancer 2017; 6:80-89

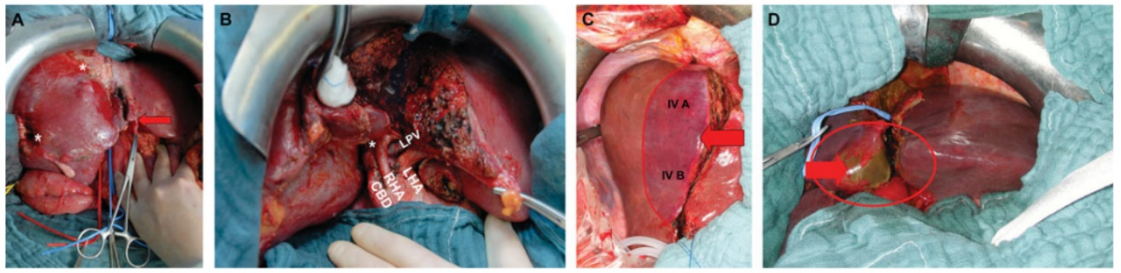
Cómo LA CIRUGÍA HA COLABORADO CON EL AUMENTO DE RESECABILIDAD



ALPPS

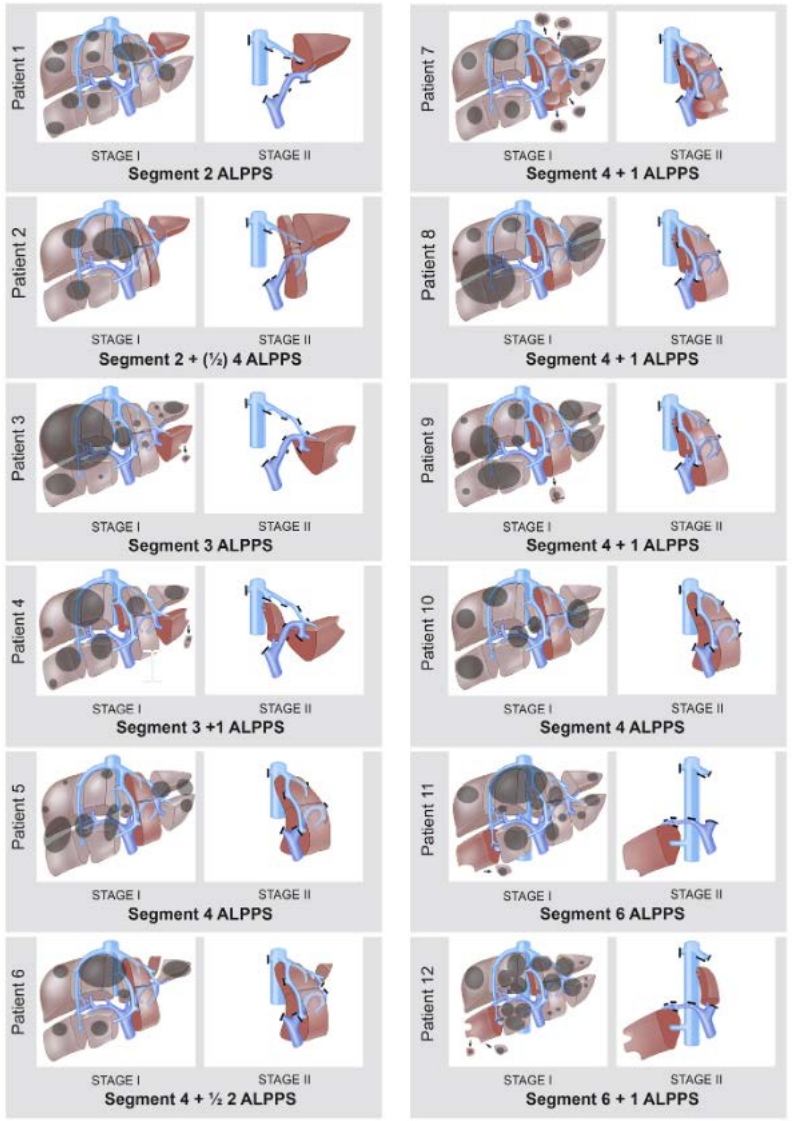
Hipertrofias > 100% en 9 días

1	Resección Mtx futuro remanente Ligadura portal + Transección hepática
2	Se completa resección



Schnitzbauer et al Ann Surg 2012. 255:3

Cómo LA CIRUGÍA HA COLABORADO CON EL AUMENTO DE RESECABILIDAD



(*Erik Schadde et al. 2015; 157:676-89*)

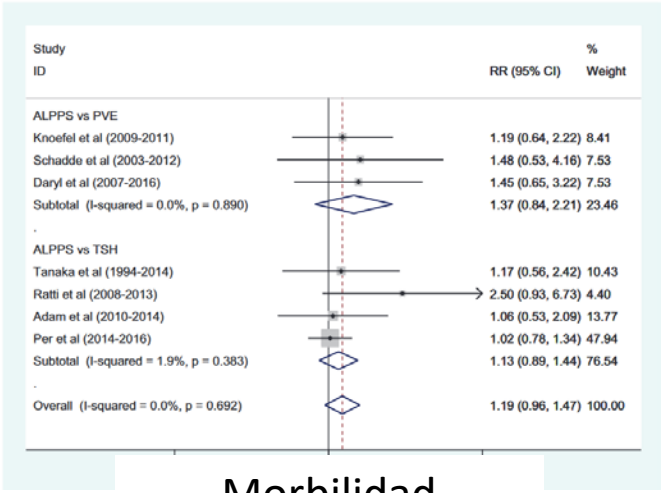
ALPPS

Metaanálisis

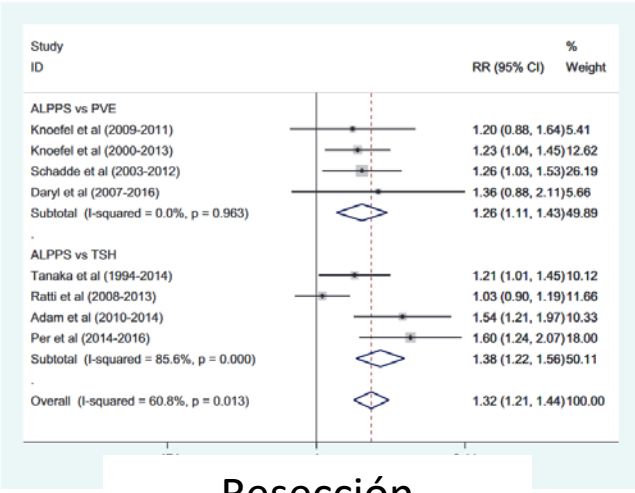
Morbilidad 71,4%
Mortalidad 15%

> Tasa de resección
> Hipertrofia

Yanmo Liu et al. Medicine (2019) 98:15

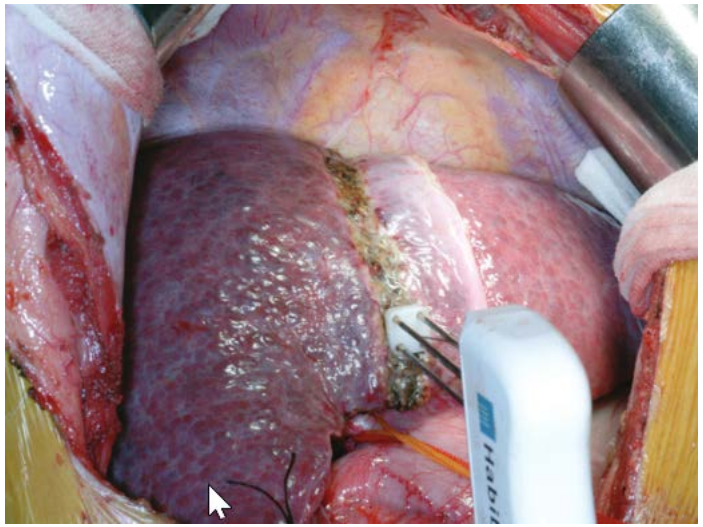


Morbilidad

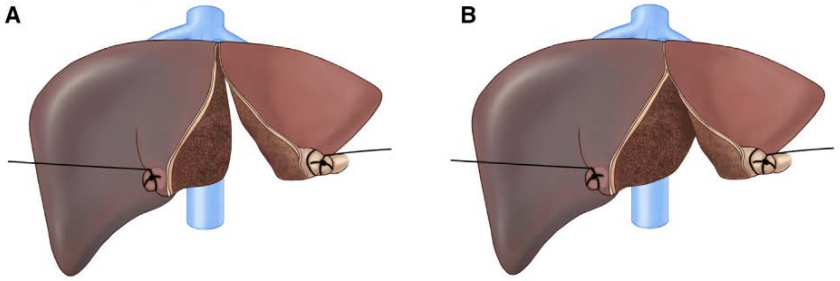


Resección

Cómo LA CIRUGÍA HA COLABORADO CON EL AUMENTO DE RESECABILIDAD



(Qiang Wang et al. Int J Hypertermia,2017. 33:7)



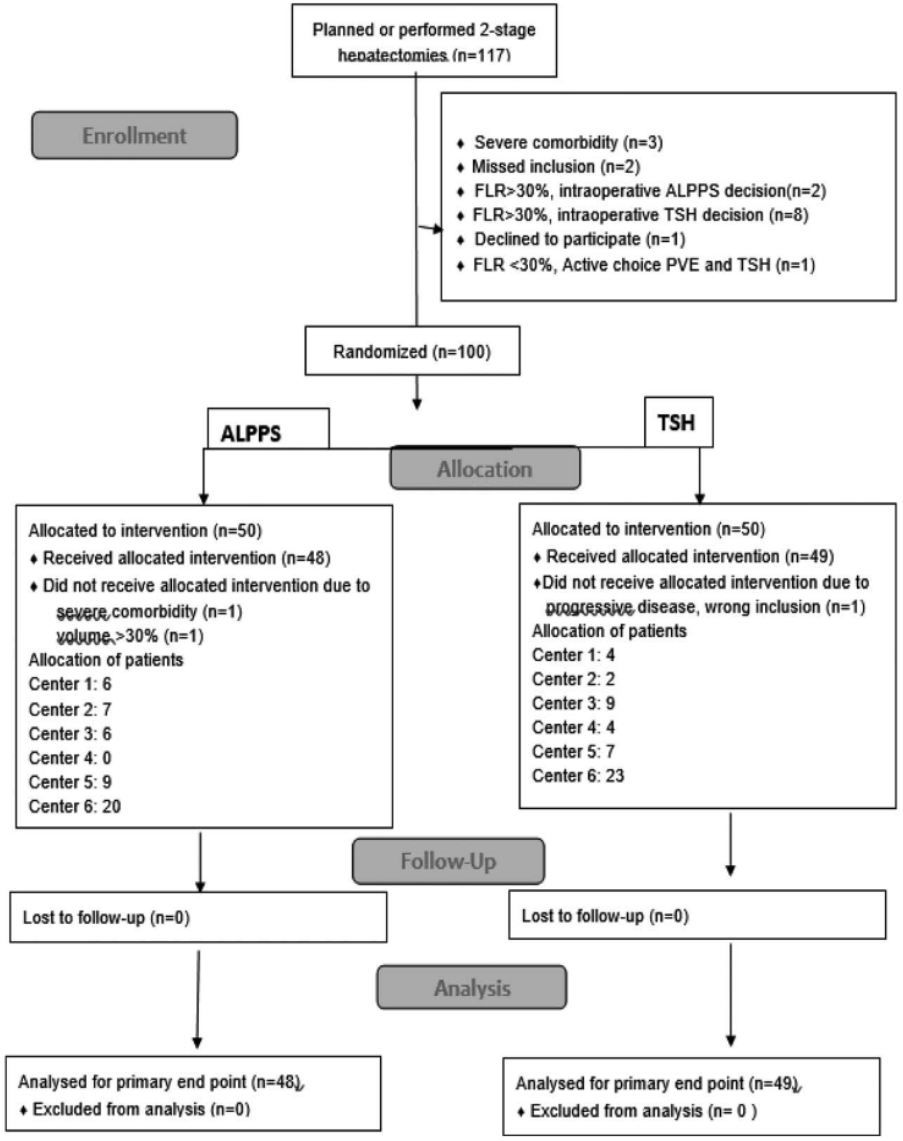
(*Xukin Wu et al. BMC Gastroenterology (2019) 19:170*)

ALPPS

- **Partición parcial**
- **ALPPS-Torniquete**
- **RALPPS**: Partición parcial con RF
- **ALPPS Híbrido** (Partición hepática sin manipular hilio)
- **ALPSS salvador** (Porta embolizada + partición)
- Mejor selección Pacientes

Morbilidad

Cómo LA CIRUGÍA HA COLABORADO CON EL AUMENTO DE RESECABILIDAD



ALPPS - RCT

RESULTADOS	ALPPS	H. EN DOS TIEMPOS	P
Finalización	**92%**	**57%**	**<0,0001**
Morbilidad (≥ 3)	43%	43%	0,99
Mortalidad	8,3%	6,1%	0,68
R0	77%	57%	0,11

Per Sandström et al. (LIGRO Trial) Ann Sug 2018. 267:5

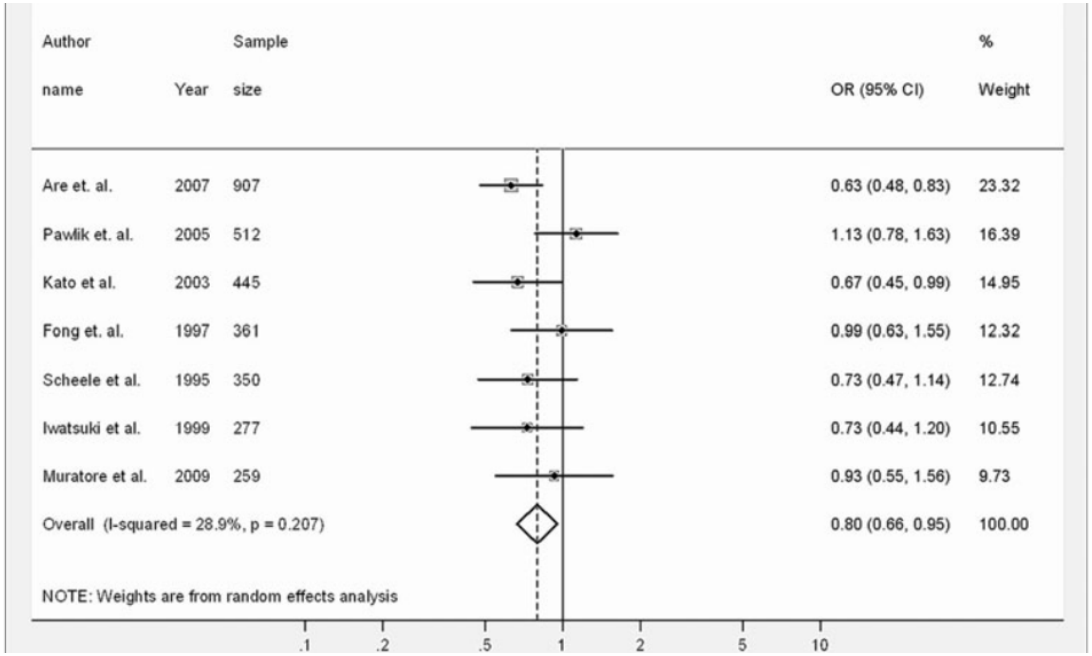

R0

METAANÁLISIS

Supervivencia 5 a

46% vs 38% (p=0,009)

RO (>/< 1 cm)

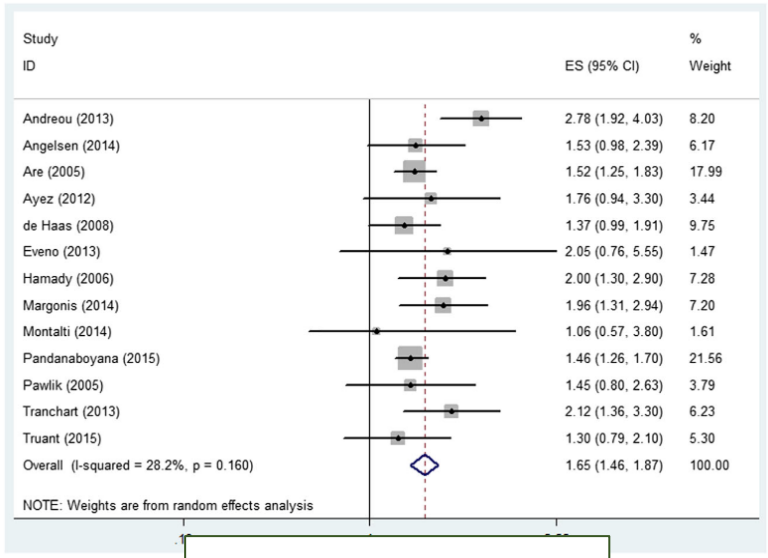


(*Mashaal Dhir et al 254 (2). Aug 2011*)

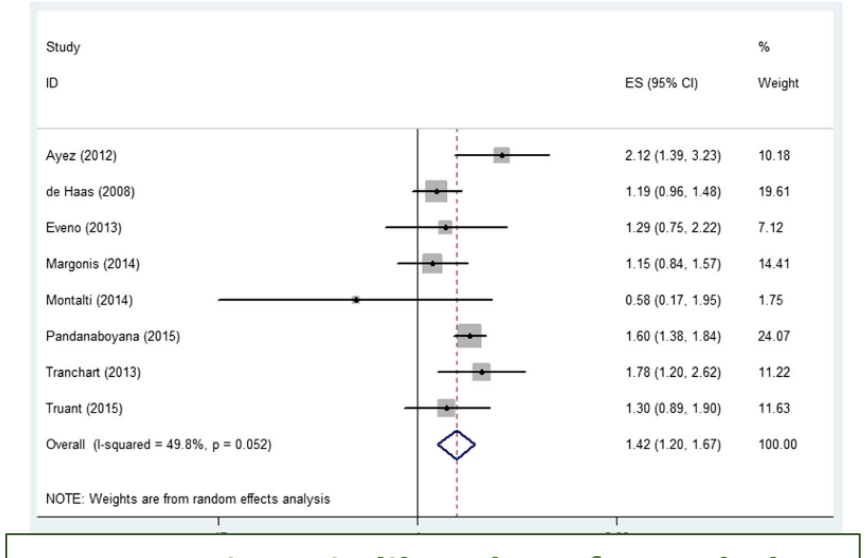
Metaanálisis

RO vs R1 (<1 mm)

Supervivencia



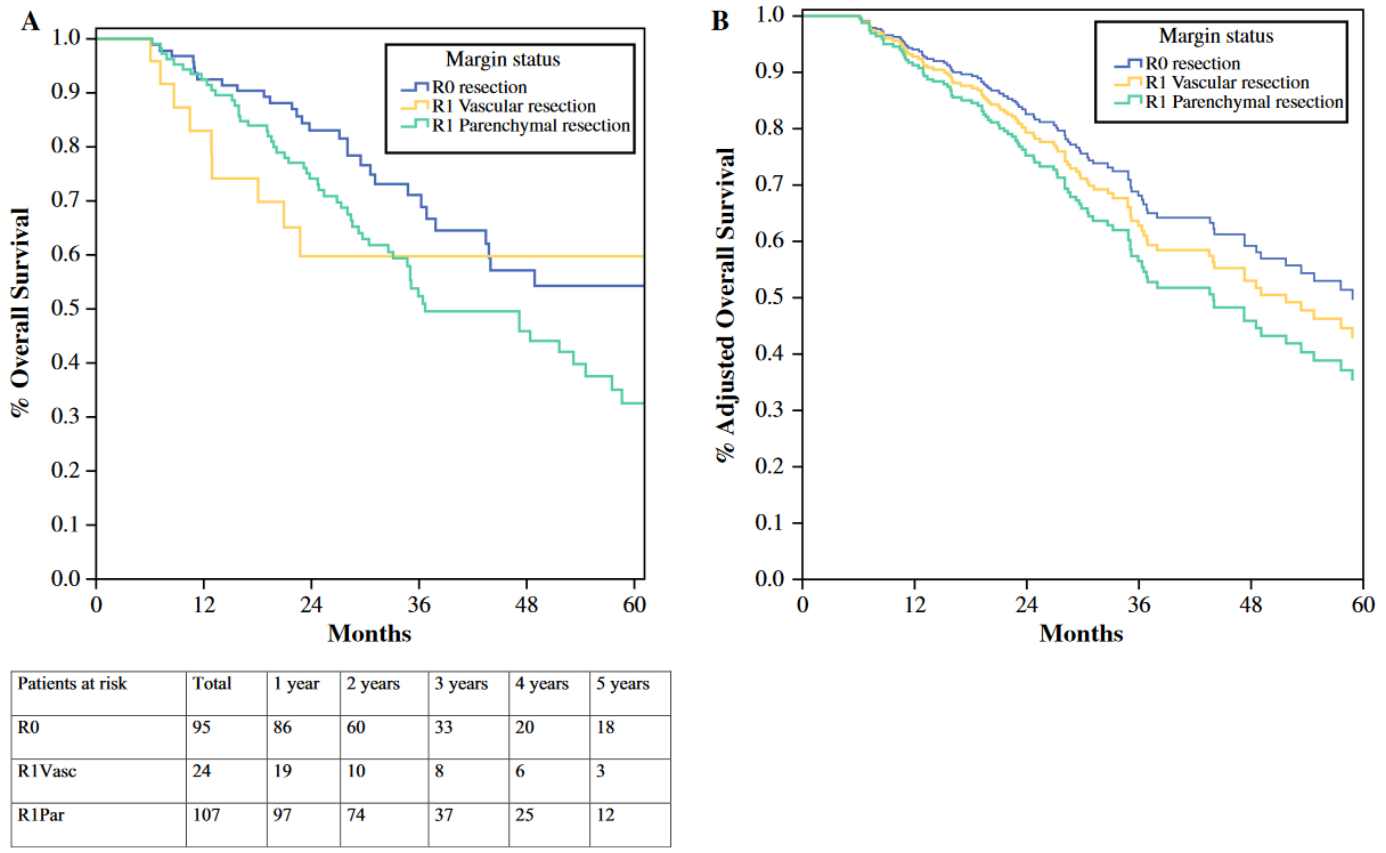
Supervivencia 5 a



Supervivencia libre de enfermedad

(*Wei Liu et al. Ing J Colorectal Dis (2015) 30:1365-73*)

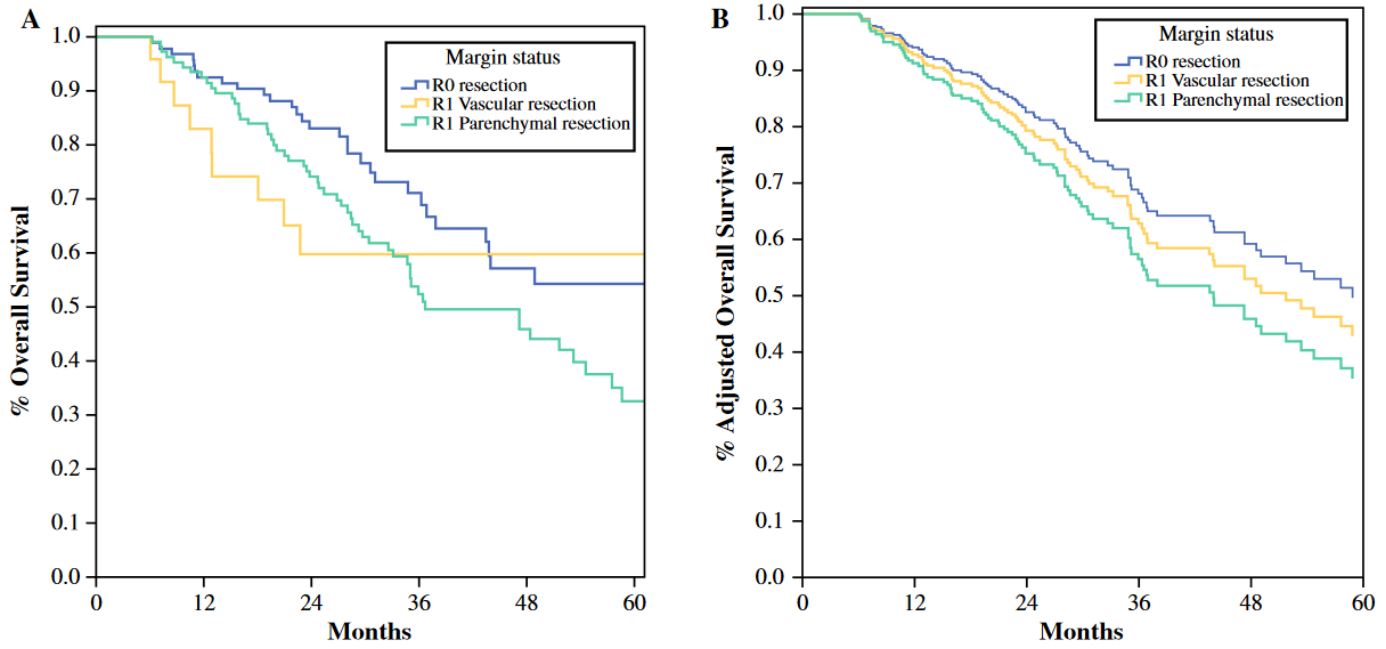
Son todos los R1 iguales?



Patients at risk	Total	1 year	2 years	3 years	4 years	5 years
R0	95	86	60	33	20	18
R1Vasc	24	19	10	8	6	3
R1Par	107	97	74	37	25	12

FIG. 2 OS curves after LR according to the margin status. **a** OS curves by Kaplan–Meier analysis (univariate analysis R0 vs. R1Par, $p = 0.023$, and R0 vs. R1Vasc, $p =$ n.s.). **b** OS curves for all values of R status (R0, R1Par, and R1Vasc) plotted at mean of the covariates in the Cox model (multivariate analysis R0 vs. R1Par, $p = 0.034$, and R0 vs. R1Vasc, $p =$ n.s.)

Son todos los R1 iguales?



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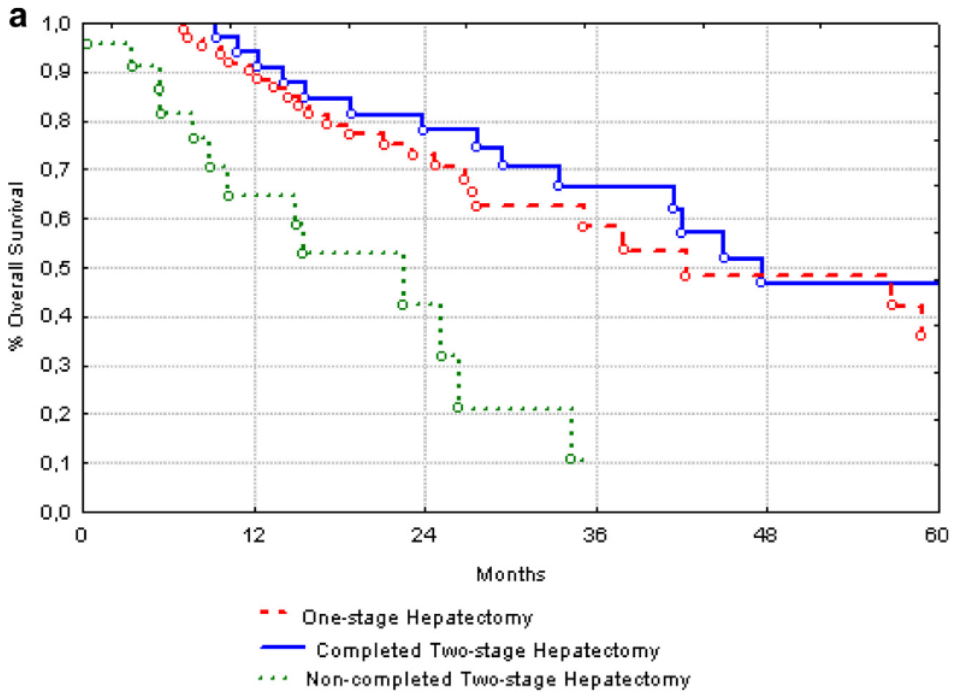
R1 VASCULAR = R0

R1 PARENQUIMATOSO≠ R0

(*Luca Vigano et al. Ann Surg Oncol (2016) 23:1352-1360*)

Cómo LA CIRUGÍA HA COLABORADO CON EL AUMENTO DE RESECABILIDAD



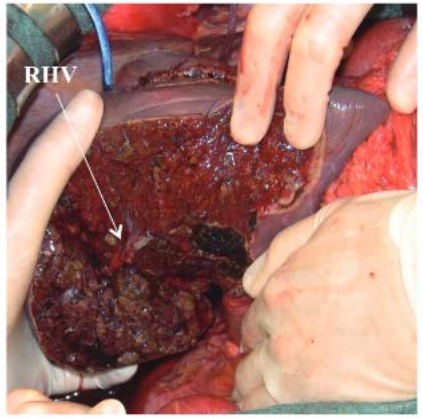
Patients at risk	Total	1 year	2 years	3 years	4 years	5 years
OSH	63	54	33	13	9	5
Completed TSH	39	31	24	15	9	6
Non-completed TSH	24	11	4	-	-	-

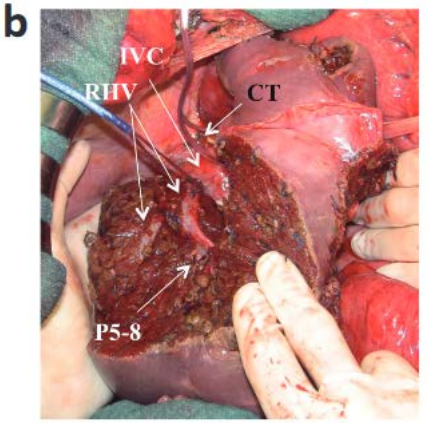
(L. Viganò et alEJSO 42 (2019) 1385-1393)

Cirugía ahorradora de parénquima

RESULTADOS	CAP	C. EN 2 TIEMPOS	P
Morbilidad (≥3)	14%	36%	0,04
Tasa R0	17%	11%	

(*Guido Torzilli et al. 2017; 6:80-89*)





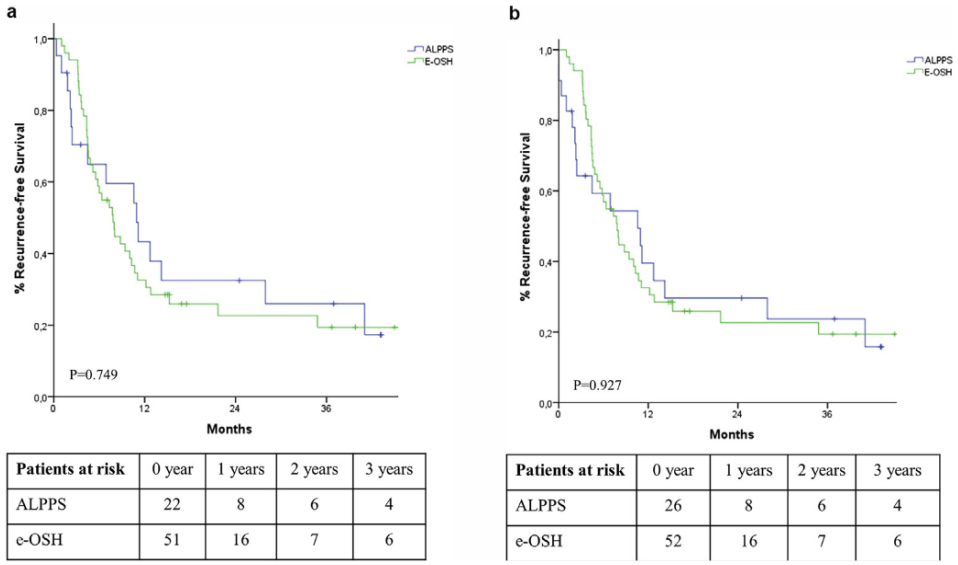
Cómo LA CIRUGÍA HA COLABORADO CON EL AUMENTO DE RESECABILIDAD

Table 2 Postoperative details between matched-in groups

	ALPPS (26 pts)	e-OSH (52 pts)	*p* value
	n (%)	*n* (%)	
Patient characteristics			
Mortality	2 (7.7)	1 (1.9)	0.256
Overall morbidity	18 (69.2)	24 (46.2)	0.054
Severe morbidity (grade 3–4)	7 (26.9)	4 (7.7)	0.036
PHLF	10 (38.5)	9 (17.3)	0.040
ISGLS Grade B/C	2 (7.7)	1 (1.9)	0.256
Bilirubin peak >7 mg/dL	5 (19.2)	3 (5.8)	0.109
"50-50" criteria	3 (11.5)	1 (1.9)	0.105
Blood transfusions	13 (50.0)	12 (23.1)	0.016
Hospital stay, median (IQR), days	21 (15–30)	8 (8–14)	<0.001
Resection margins			
R0 resection	21 (80.8)	11 (21.2)	<0.001
R1	3 (11.5)	39 (75.0)	<0.001
R2 (drop-out)	2 (7.7)	–	0.108

ALPPS = Associating Liver Partition and Portal vein Ligation; PSH = parenchyma-sparing hepatectomy; PHLF = post-hepatectomy liver failure; ISGLS = international study group of liver surgery.

Cirugía ahorradora de parénquima



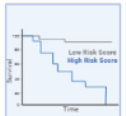
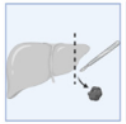
Patients at risk	0 year	1 years	2 years	3 years
ALPPS	22	8	6	4
e-OSH	51	16	7	6

Patients at risk	0 year	1 years	2 years	3 years
ALPPS	26	8	6	4
e-OSH	52	16	7	6

Figure 3 Disease-free survival for the whole series (a) and by intention-to-treat (b)

(*Guido Torzilli et al. HPB 2019, 21, 1411-1418*)

Cómo LA CIRUGÍA HA COLABORADO CON EL AUMENTO DE RESECABILIDAD

	Available evidence	Open Issues
 **Post-transplant survival**	Disease free-survival after LT seems to be comparable to progression-free survival after chemotherapy, however LT seems to offer better long-term survival to patients with unresectable CRLM than any available chemotherapeutic regimen.	• No randomized controlled trial on chemotherapy versus transplantation • No data on quality of life after LT versus "chronic" chemotherapy
 **Prognostic factors**	Some selection criteria for LT are now considered well-established. LT should be avoided in patients with • Progressive disease • Extrahepatic dissemination • BRAF mutation	Many potential prognostic factors and selection criteria have been identified through retrospective analyses, however those results may change with the emergence of prospective evidence and larger datasets.
 **Transplant vs resection**	Retrospective studies have identified LT as superior to LR in case of high tumor burdens requiring portal vein embolization.	Some patients with tumors that are technically resectable may benefit from LT. No comparison has been made between parenchymal-sparing resection and LT. The definition of resectability is not univocal.
 **Endpoints**	Recurrence-free survival may not be an appropriate endpoint. Recurrence is common after LT, however overall survival may be excellent also after recurrence.	Establishing appropriate trial endpoints is going to be crucial if CRLM become an established indication for LT. Overall survival and transplant benefit may be candidate endpoints.
 **Ethical considerations**	The current number of patients eligible to LT for CRLM is low and unlikely to have a substantial impact on a waiting list. Patients who have been on systemic chemotherapy for 1-2 years are likely to be stable enough to wait 3-4 months for LT without progressing and dropping out of the wailist. For now, prioritization should be tailored on the local situation.	• The number of eligible patients would dramatically increase if resectable patients were included • Whether LDLT is an acceptable option for this indication remains to be established • The RAPID procedure may be an option, however the risk of tumor diffusion between the two steps needs to be investigated
 **Medical management**	Patients should remain on maintenance chemotherapy while on the waiting list. Most trials involved an immunosuppressive switch to mTOR.	There is limited evidence of the effect of different immunosuppressive regimens on post-LT outcomes.
 **Treatment of recurrent disease**	Post-recurrence survival can be good in case of curative-intent treatment. Post-LT recurrences should be managed aggressively.	Treatment of post-LT recurrence should follow oncological principles.

(Marianna Maspero et al. Cancers 2023. 15, 345)

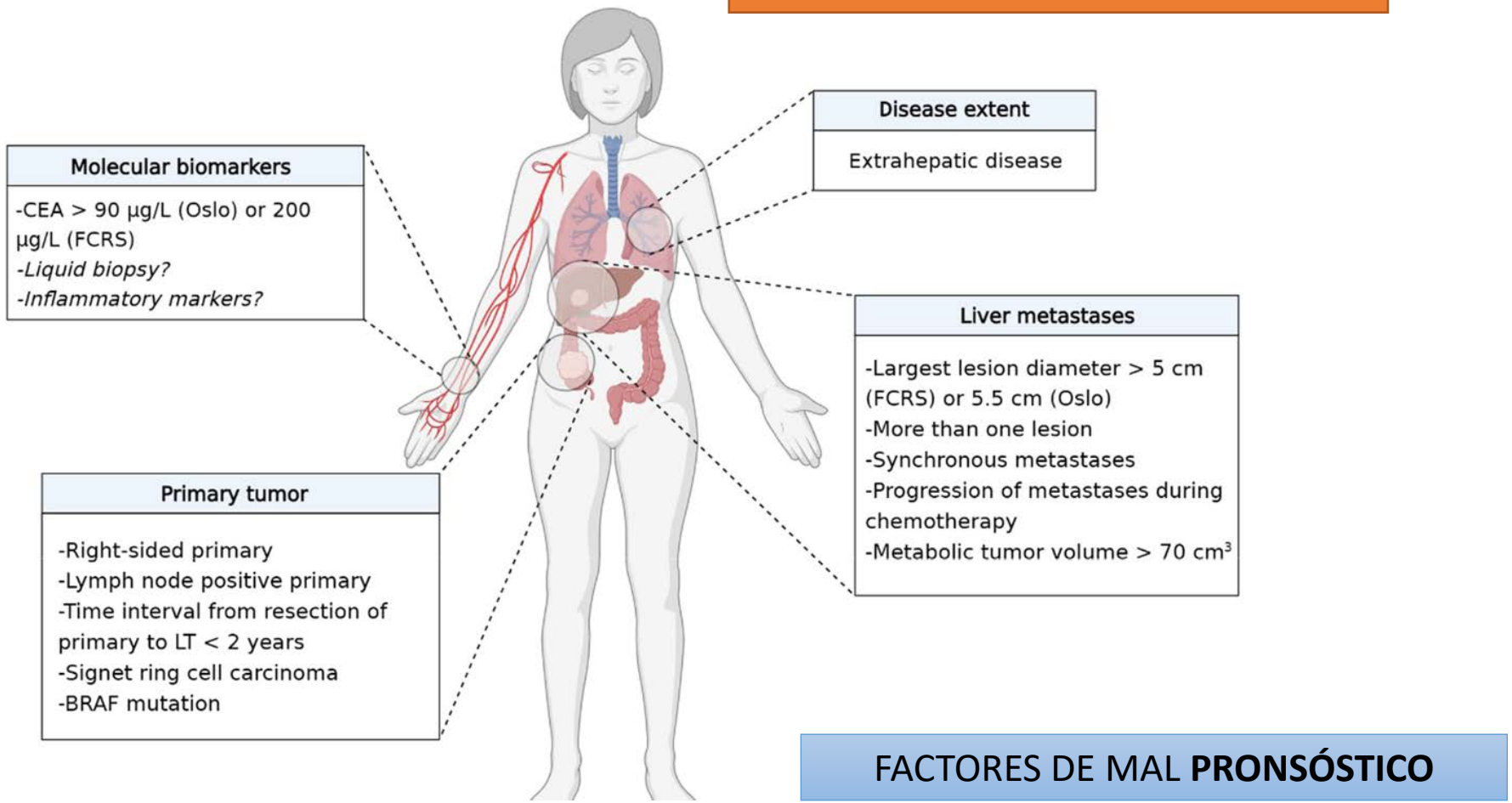
TRASPLANTE

Supervivencias

85% a los 5 años

Cómo LA CIRUGÍA HA COLABORADO CON EL AUMENTO DE RESECABILIDAD

TRASPLANTE



FACTORES DE MAL **PRONSÓSTICO**

(Marianna Maspero et al. Cancers 2023. 15, 345)

Cómo LA CIRUGÍA HA COLABORADO CON EL AUMENTO DE RESECABILIDAD

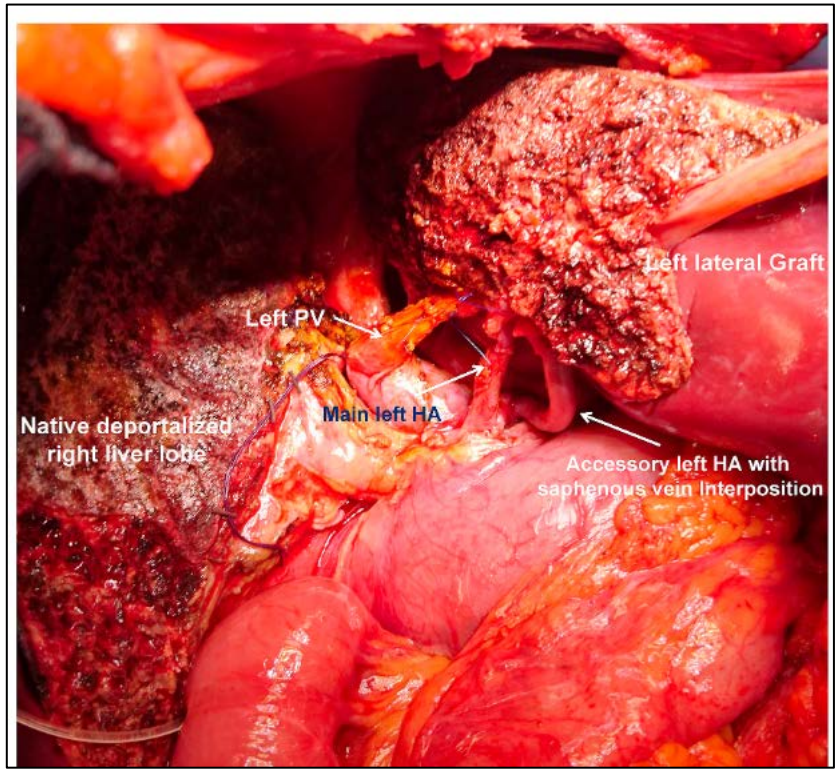
TRASPLANTE

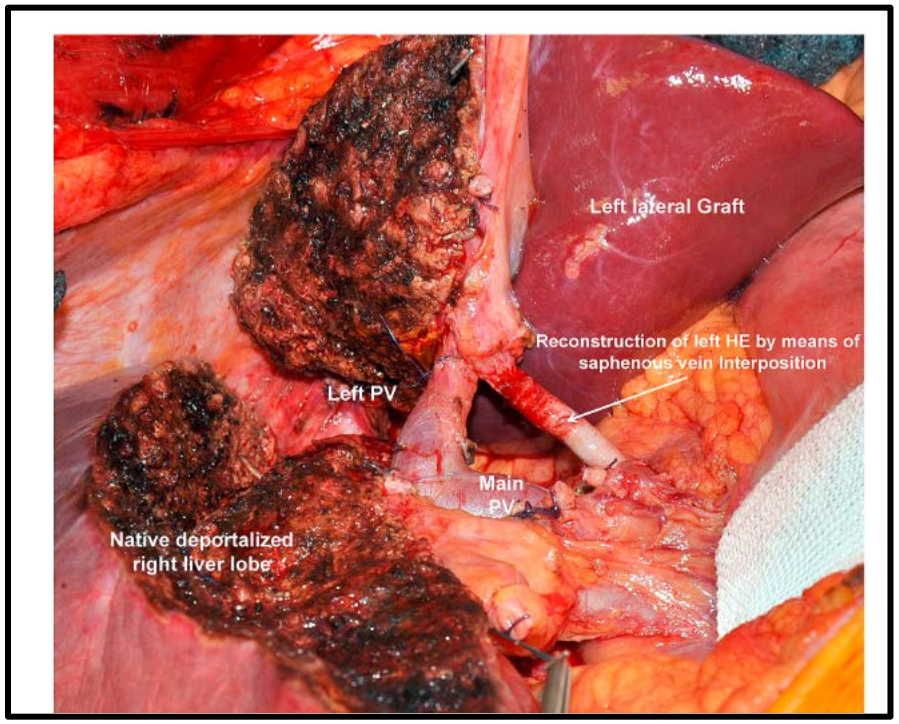
Clinical Trial Identifier Acronym	Timeline	Country	Interventions	Inclusion & Exclusion Criteria	Expected Enrollment
NCT05398380	2022–2026	Spain	LT	- Unresectable CRLM - No extrahepatic disease - Primary pT3N1 max - At least 2 months of CT, max 2 lines - At least 1 year from primary tumor resection to LT - -BRAF wild type - Liver mets < 5.5 cm at latest imaging - CEA < 80 ng/mL - ≥3 months tumor control after CT (SD or PR on RECIST)	35

(Marianna Maspero et al. Cancers 2023. 15, 345)

Cómo LA CIRUGÍA HA COLABORADO CON EL AUMENTO DE RESECABILIDAD

RAPID





(*Nadalin S et al. RAPID procedure for colorectal cancer liver metastasis. Int J Surg. 2020*)

Es la **RESECCIÓN** LA ÚNICA **POSIBILIDAD?**

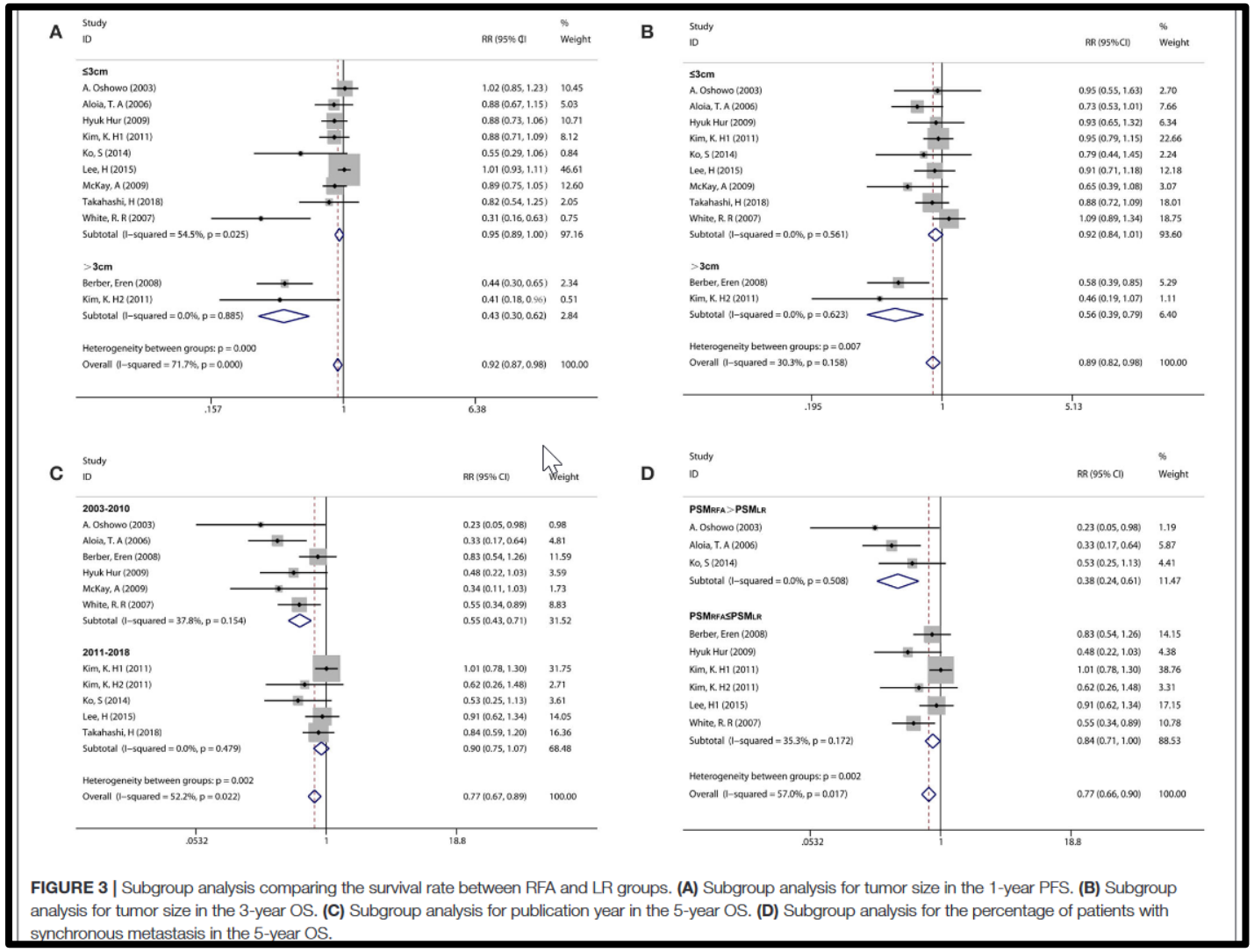


FIGURE 3 | Subgroup analysis comparing the survival rate between RFA and LR groups. **(A)** Subgroup analysis for tumor size in the 1-year PFS. **(B)** Subgroup analysis for tumor size in the 3-year OS. **(C)** Subgroup analysis for publication year in the 5-year OS. **(D)** Subgroup analysis for the percentage of patients with synchronous metastasis in the 5-year OS.

(Wu Hao et alFrontiers in Oncology. Nov 2020 (10))

RADIOFRECUENCIA

Resultados equivalentes en casos en los de

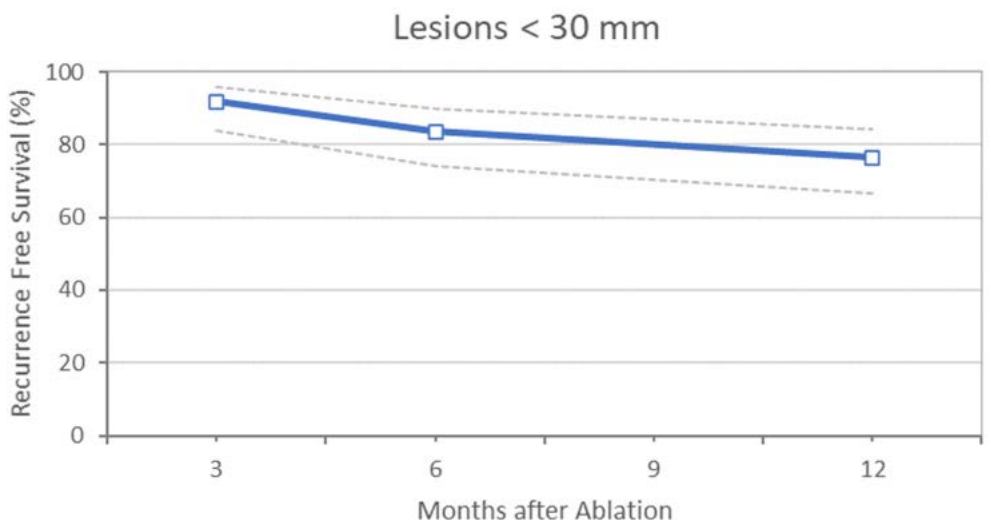
única metástasis ≤3 cm

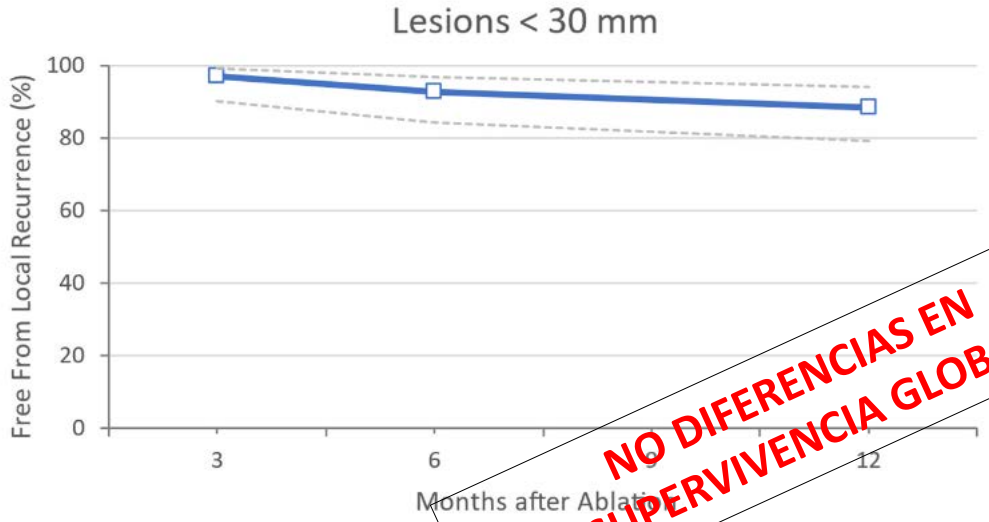
Es la **RESECCIÓN** LA ÚNICA **POSIBILIDAD?**

MICROONDAS

Supervivencia libe de Enfermedad 1,3 y 5 años del 65,1%, 44,6% y **34,3%**

SUPERVIVENCIAS a 1,3 y 5 años del 86,7%, 59,6% y **44,8%.** *(Antonio Mimmo et al. Cancers 2022, 14)*





NO DIFERENCIAS EN SUPERVIVENCIA GLOBAL

(Gang Yang et al. International Journal of Surgery 77 (2020)85-93)

1. La **RESECABILIDAD** es lo mismo para todos, cómo aumentarla?

2. Cuál es el papel de la **QT NEOADYUVANTE** y cuándo está indicada?

3. Qué hacemos con las **MISSING** metástasis?

4. Cuándo intervenir el **SINCRÓNICO ASINTOMÁTICO**?

5. Toda enfermedad en **PROGRESIÓN** es contraindicación para cirugía?

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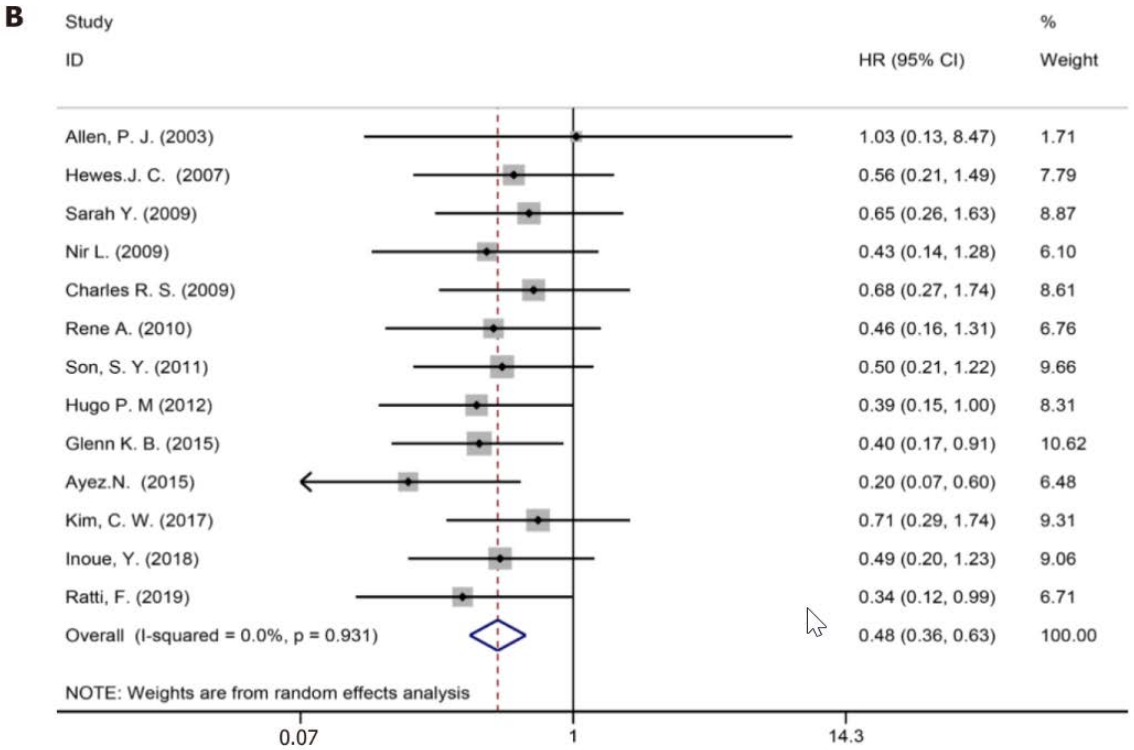
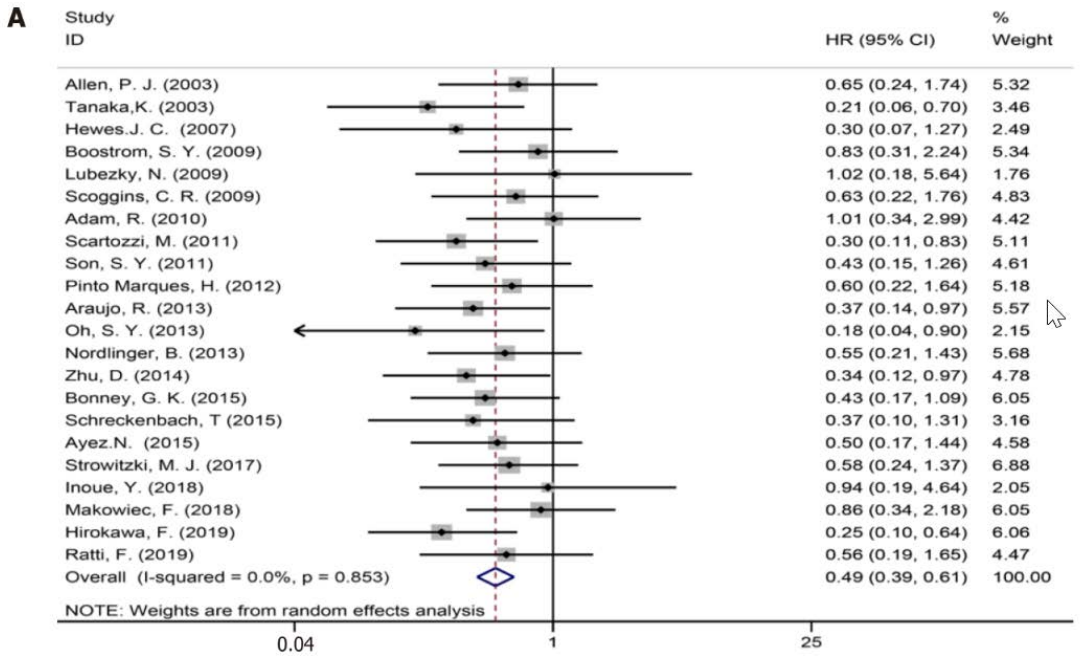
Neoadyuvancia



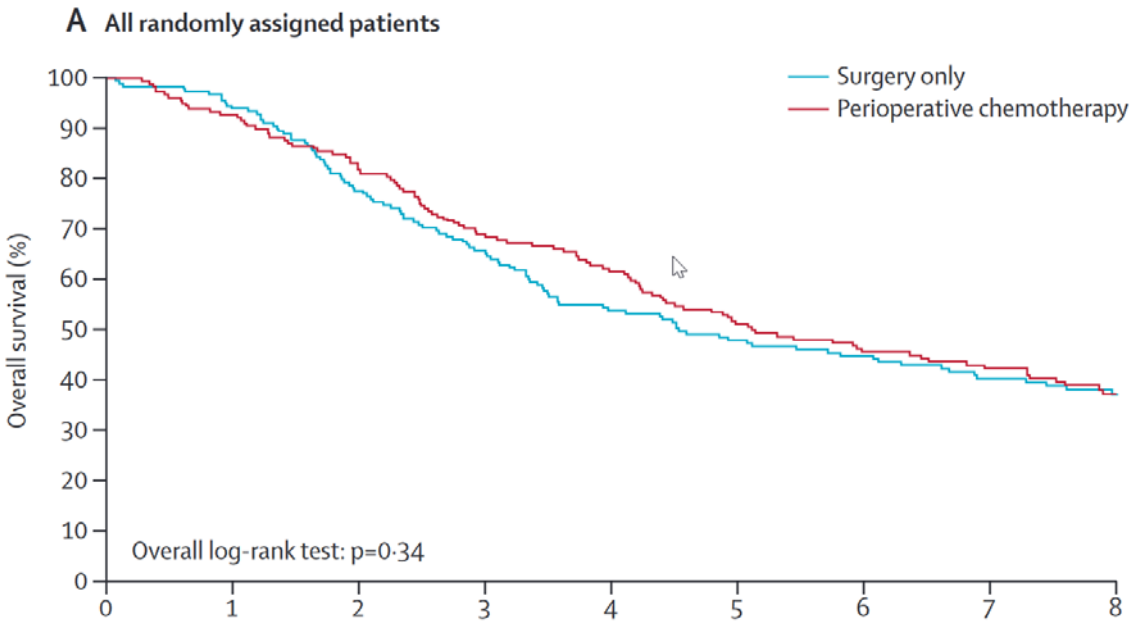


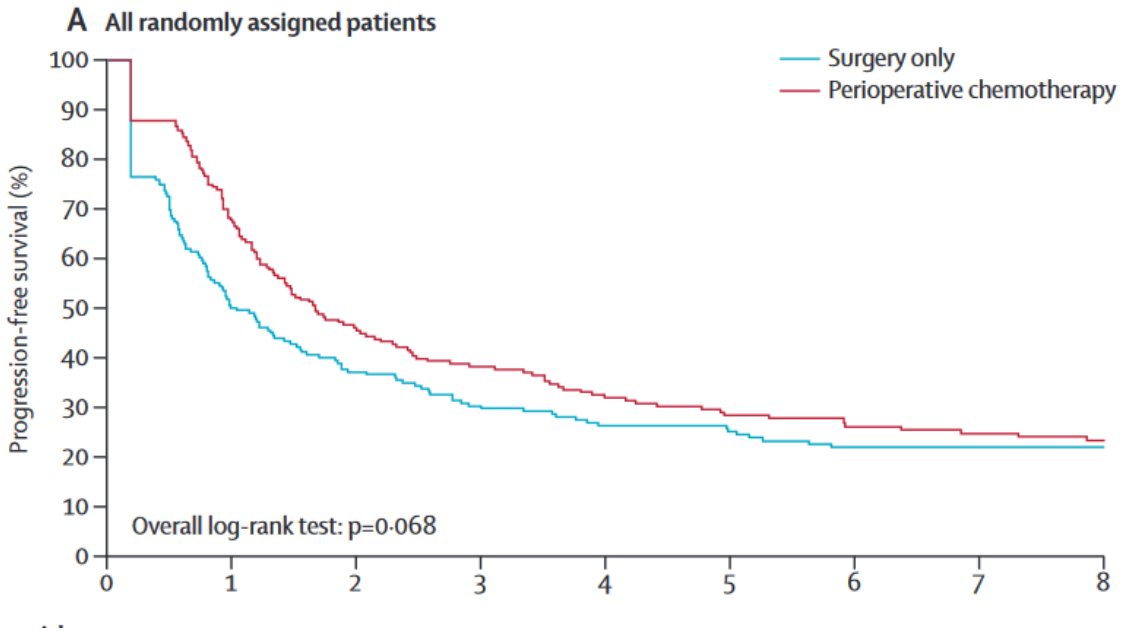
Supervivencia global y libre de enfermedad

(Yue Zhang et al. WJCC. Aug 6, 2021. 6:22)

Neoadyuvancia

RCT





(Bernard Nordlinger et al.Lancet Oncol. 2013 Nov; 14(12):1208-15)

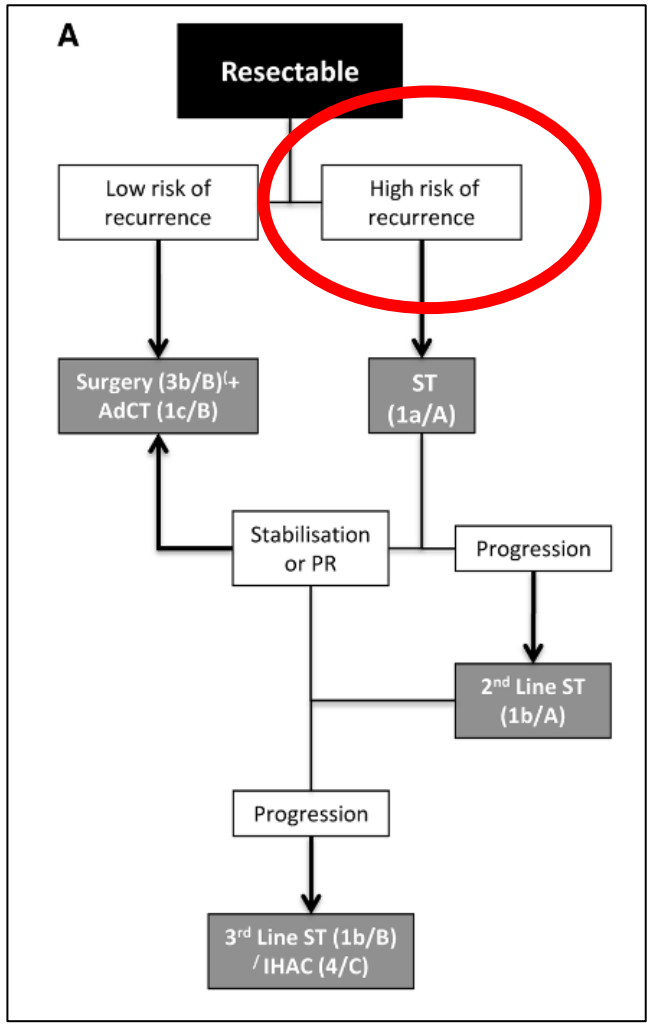
Neoadyuvancia, en QUÉ casos?

GAME SCORE

Variable	Puntos
KRAS mutado *	1
CEA≥ 20 ng/mL	1
Afectación ganglionar	1
TBS**: 3-8	1
TBS**>8	2
Enfermedad Extrahepática	2

* Mutaciones KRAS exón 2 codones 12 y 13 y exón 3 codón 61

**TBS²=(diámetro máximo lesión hepática)²+ (nº metástasis hepáticas)²



Grupos de Riesgo	Puntos
Bajo	0-1
Medio	2-3
Alto	≥4

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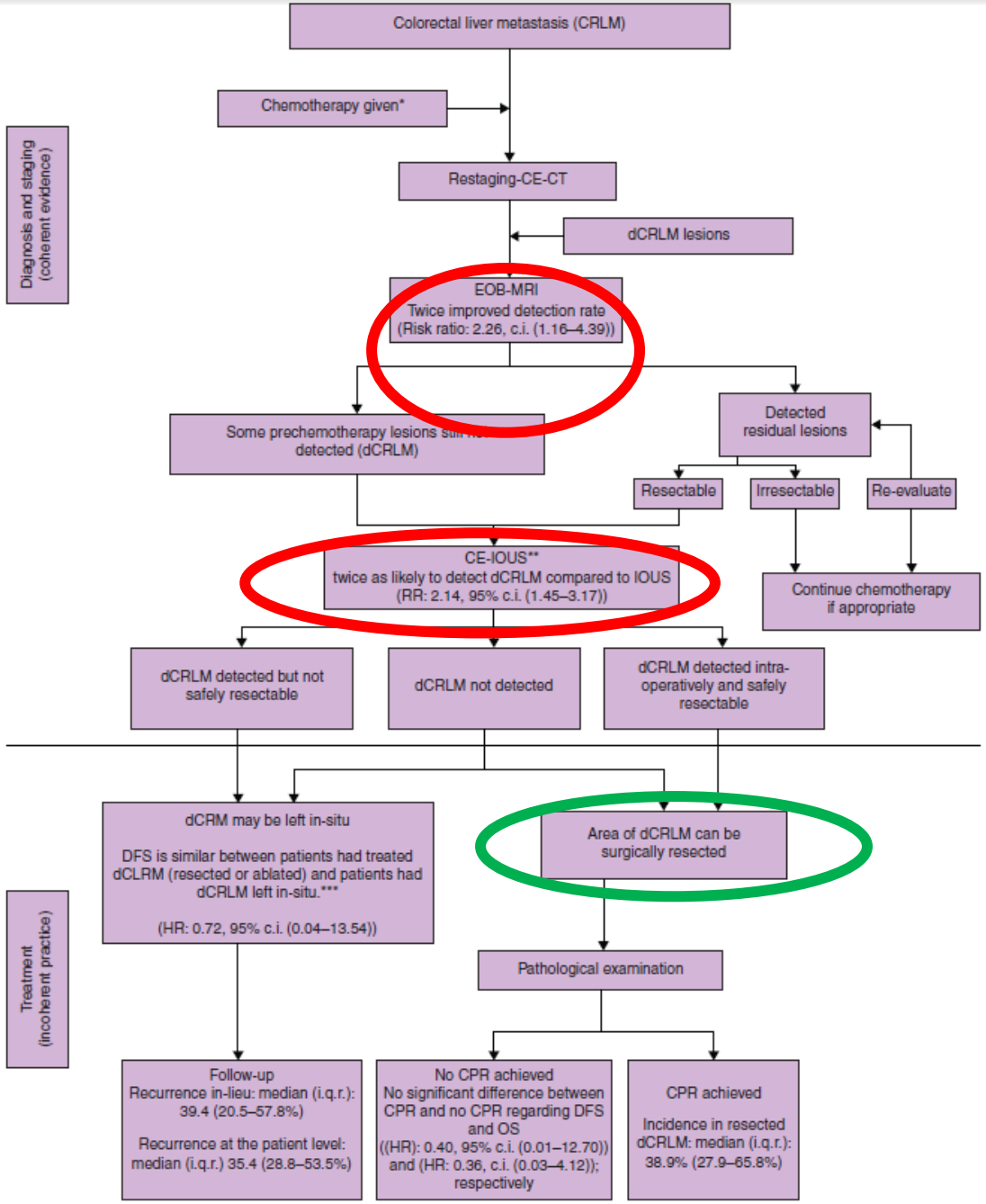
Qué hacemos con las MISSING MTX?



Ahmed Nassar et al. BJS Open, 2022

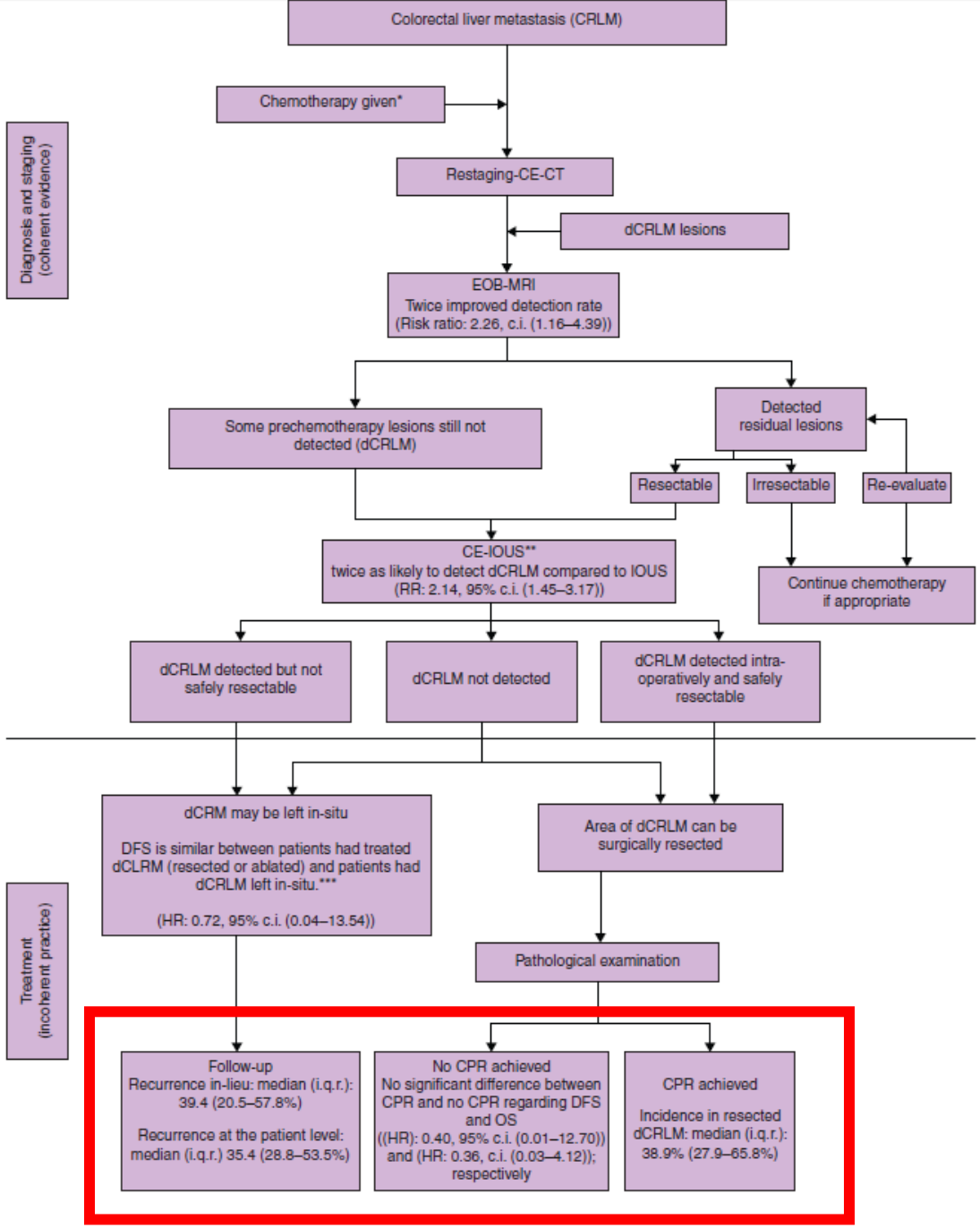
MISSING MTX

Respuesta patológica COMPLETA

97,8%

NO DIFERENCIAS SLE Y SG: Respuesta completa / no

NO DIFERENCIAS SLE: Tratadas /seguidas



Ahmed Nassar et al. BJS Open, 2022

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Cuándo intervenir **sincrónico** **ASINTOMÁTICO**?

Table 3 Pooled results of the comparison of all outcomes between the two groups

Outcomes	Number of studies	Number of patients		WMD/SMD/OR/HR	95% CI	Heterogeneity	*P* value
		Simultaneous resection	Staged resection				
Complications							
Total complications	17	1342	1891	OR = 0.88	0.66–1.19	$I^2 = 61.3\%, P < 0.001$	$P = 0.409$
Gastrointestinal complications	16	1358	1627	OR = 1.19	0.89–1.59	$I^2 = 21.6\%, P = 0.208$	$P = 0.241$
Hepatic complications	17	1398	1806	OR = 1.04	0.83–1.31	$I^2 = 0.0\%, P = 0.529$	$P = 0.734$
Perioperative characteristics							
Perioperative mortality	10	730	1470	OR = 1.79	0.88–3.64	$I^2 = 8.5\%, P = 0.364$	$P = 0.108$
Intraoperative blood loss	9	599	950	SMD = −0.39	−0.60 to −0.18	$I^2 = 69.1\%, P = 0.001$	$P < 0.001$
Total hospital stay	13	648	946	WMD = −5.43	−7.29 to −3.58	$I^2 = 76.9\%, P < 0.001$	$P < 0.001$
Long-term prognosis							
5-year DFS	4	208	150	HR = 1.26	0.96–1.66	$I^2 = 18.1\%, P = 0.300$	$P = 0.098$
5-year OS	10	1017	1337	HR = 1.13	0.95–1.34	$I^2 = 34.6\%, P = 0.131$	$P = 0.164$

- No diferencias: complicaciones, mortalidad perioperatoria y SG a 5 años.
- < Estancia resección simultánea.

(*Shi-hao Wang et al. European Journal of Medial Research (2022)27:297*)

RCT. *METASYNC Study group. Ann Surg 2021 Jan. 1;273(1):49-56*

- No diferencias complicaciones postoperatorias.
- > SLE a 2 a en resección simultánea.

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Progresión, es el **FIN**?

- Series en las que La progresión durante la **QT no influyó en la supervivencia** a largo plazo (*Neuman et al , Gallager et al*)
- La **progresión en el remanente tras embolización** portal no impide el segundo tiempo.(*Jouffret et al*)
- Existe posibilidad de **resección tras 2ª línea** (*Bouquet e al, Adam et al.*)

World Journal of Gastrointestinal Surgery

Submit a Manuscript: https://www.f6publishing.com World J Gastrointest Surg 2022 September 27; 14(9): 877-886

DOI: 10.4240/wjgs.v14.i9.877 ISSN 1948-9366 (online)

MINIREVIEWS

Oncologic aspects of the decision-making process for surgical approach for colorectal liver metastases progressing during chemotherapy

Raphael L C Araujo, Camila G C Y Carvalho, Carlos T Maeda, Jean Michel Milani, Diogo G Bugano, Pedro Henrique Z de Moraes, Marcelo M Linhares

Abstract

Colorectal cancer represents the third most diagnosed malignancy in the world. The liver is the main site of metastatic disease, affected in 30% of patients with newly diagnosed disease. Complete resection is considered the only potentially curative treatment for colorectal liver metastasis (CRLM), with a 5-year survival rate ranging from 35% to 58%. However, up to 80% of patients have initially unresectable disease, due to extrahepatic disease or bilobar multiple liver nodules. The availability of increasingly effective systemic chemotherapy has contributed to converting patients with initially unresectable liver metastases to resectable disease, improving long-term outcomes, and accessing tumor biology. In recent years, response to preoperative systemic chemotherapy before liver resection has been established as a major prognostic factor. Some studies have demonstrated that patients with regression of hepatic metastases while on chemotherapy have improved outcomes when compared to patients with stabilization or progression of the disease. Even if disease progression during chemotherapy represents an independent negative prognostic factor, some patients may still benefit from surgery, given the role of this modality as the main treatment with curative intent for patients with CRLM. In selected cases, based on size, the number of lesions, and tumor markers, surgery may be offered despite the less favorable prognosis and as an option for non-chemo responders.

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Carcinomatosis peritoneal, es el **FIN**?

Langenbecks Arch Surg. 2019 Jun;404(4):477-488. doi: 10.1007/s00423-019-01787-w. Epub 2019 Apr 25.

Synchronous liver metastases and peritoneal carcinomatosis from colorectal cancer: different strategies for curative treatment?

Amandine Pinto [1] [2], Christian Hobeika [2], Antoine Philis [1], Sylvain Kirzin [1], Nicolas Carrère [1], Laurent Ghouti [3]

Background: Management of patients with resectable hepatic metastases (HMs) and colorectal peritoneal carcinomatosis (CRPC) is not currently standardised.

Objective: The aims of this study were to evaluate the safety of cytoreductive surgery with hyperthermic intraperitoneal chemotherapy (CRS/HIPEC) and hepatic surgery for patients with CRPC with synchronous hepatic metastases (HM), and its impact on survival rates.

Methods: A retrospective analysis was performed, including patients undergoing CRS/HIPEC for CRPC from 2007 to September 2016 in two groups, with (HM+) and without (HM-) synchronous hepatic metastases. Patients with extra-abdominal metastases were excluded. The hepatic strategy was described. Morbimortality and survival were compared between the two groups.

Results: One hundred nine patients underwent CRS/HIPEC for CRPC with or without hepatic surgery with curative intent: 33 patients with (HM+) and 76 patients without (HM-) synchronous HM. The median follow-up was 30 months. All patients with HM (HM+) received neoadjuvant chemotherapy vs. 88.1% in the HM- group (p = 0.04) associated with monoclonal antibody in 66.6% of cases in the HM+ group vs. 57% in the HM- group (p = 0.01). In the HM+ group, two steps were implemented to treat peritoneal and hepatic metastases in 15 patients (45%). In this group, planned hepatic resection in two procedures was performed for eight patients, all presenting bilobar HM. Postoperative morbidity did not differ between the two groups. No deaths occurred. Median overall survival (OS) and recurrence-free survival (RFS) were 31 and 65 months (p = 0.188), versus 21 and 24 months (p = 0.119), respectively, in the HM+ versus HM- groups. In multivariate analysis, the peritoneal cancer index (PCI) was the only significant prognostic factor whereas synchronous HM was not a significant prognostic factor.

Conclusion: Curative surgical treatment for CRPC with synchronous HM seems to be feasible and safe, and could facilitate long survival rates, compared to patients without HM. The hepatic strategy is not standardised. However, a "two-step" surgical strategy could be proposed in order to reduce postoperative morbidity rates.


CONCLUSIONES

1. **RESECABILIDAD** : Es necesario evaluar la resecabilidad en comité multidisciplinar, teniendo en cuenta **TODAS** las posibilidades técnicas (ablación y resección), adaptando su indicación a cada paciente.

2. **La QT NEOADYUVANTE** puede mejorar los resultados oncológicos en pacientes de **alto riesgo** (GAME score)

3. Las **MISSING** pueden considerarse un factor de **buen pronostico**. Se recomienda resección siempre que sea factible. La prueba de elección para definirlas como tal es la **RM con Primovist.**

4. Cuándo intervenir el **SINCRÓNICO ASINTOMÁTICO**? En general deben evitarse la realización simultanea de hepatectomía mayor con resección del primario, así como combinar resección hepática con resección rectal.

5. La **PROGRESIÓN** y la **CARCINOMATOSIS PERITONEAL** contraindican la cirugía de las metástasis hepáticas? Pese al bajo nivel de evidencia, hay experiencias donde se demuestra que es posible y seguro.

CIRUGÍA HBP VIGO
Servicio de Cirugía General
HOSPITAL ÁLVARO CUNQUEIRO
18 y 19 de mayo 2023

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GRACIAS

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