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Commentary

Centralized multidisciplinary team assessment of metastasis resectability in patients with metastatic colorectal cancer: A fundamental necessity

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In patients with colorectal cancer (CRC), visceral metastases are observed in 40%–60% of cases and 25% of them are synchronous. Despite the progress achieved with chemotherapy and targeted therapies, surgical resection or destruction of lesions by focal treatment can lead to complete remission and sometimes cure and therefore these should always be debated and discussed in a multidisciplinary tumour board (MDT) as treatment options. An ideal MDT for CRC should include access to both a colorectal surgeon (preferably with expertise in peritoneal approaches) and a hepatobiliary surgeon, and/or a thoracic surgeon as necessary, with the obligatory inclusion of a pathologist and a diagnostic radiologist, as well as radiation and medical oncologists [1]. An interventional radiologist may also be included if appropriate, given that the role of ablative treatments is gaining increasing importance. The CRC experts' discussion evaluates the benefit–risk balance of local treatments. For hepatic or pulmonary metastases, the benefit/risk criteria of surgery are, no contraindications to surgery and anaesthesia (performance status <2, no severe comorbidity), the R0 resection feasibility of all metastases, prediction of >25% to 40% of "non-tumoral" residual liver, and the absence of progression under neoadjuvant chemotherapy if administered [1]. The European Society of Medical Oncology (ESMO) guidelines recommended that patients should be treated in either specialist cancers or, alternatively, if this is not possible, as part of a network of individuals dedicated to the management of CRC with an established referral route between their centre and a specialist cancer centre (virtual MDTs) [1]. Although several retrospective population based studies underlined the importance of MDT meetings for face-to-face discussions amongst the experts involved with the patient management and for improved metastatic CRC resectability assessment, limited prospective data are evaluable on this topic [2,3].

In this issue of the *The Lancet Regional Health Europe*, Österlund et al., present the results of a prospective repeated centralized MDT

resectability assessment on line in real-world Finnish population with metastatic CRC [4]. The local oncologists organized the systemic therapy and oversaw repeated referrals to organ-specific CRC MDTs at Helsinki University Hospital tertiary referral center and resections performed at high-volume centres. This is a well-conducted study with reliable prospective clinical database on resections of CRC metastases, owing to high coverage of the Finnish population. This report is of the utmost importance for the gastrointestinal oncologists and surgeons community. Despite the prospective nature of the study, it was not population-based and may be prone to selection bias. The resectability and resection rates of 40% and 36%, respectively, are impressive. The study population most likely included patients with questionable resectability. In Finland, like in all over Europe and across the world, most of metastasis resection or ablations are performed in expert centres and not in lower-volume hospitals. The RAXO study highlights the interest to present all metastatic CRC patient in MDTs, at the beginning of their treatment, but also imperatively after neoadjuvant treatment, with the opportunity to have access in high-volumes centres for resection/destruction. It is also important for patients with initially unresectable metastases, where conversion of resectability is sometimes feasible [4].

Many questions remain. Considerable inconsistencies exist amongst expert surgeons when choosing a therapeutic strategy for resection of CRC metastases [5,6]. This may confuse both patients and referring physicians and points out the need for an international high-level consensual statement and widely accepted guidelines [7]. While adjuvant chemotherapy improves OS for stage III CRC [8], peri-operative chemotherapy significantly increases disease-free survival (DFS), but not OS, for resectable metastatic CRC [9]. Improvements in both DFS and OS rates after CRC metastases resection are awaited. For the small proportion (5%) of microsatellite-instability-high CRC patients, immune-checkpoint inhibitors revolutionized the therapeutic management and survival of this population. Moreover, immune-checkpoint inhibitors may change the rules concerning surgery in this rare group of patients with CRC metastases, stressing the importance of MDTs with specialists with the expertise in new therapeutic options [10].

To conclude, the RAXO trial is an example of how to organize the management of patients with CRC metastases. Repeated MDT assessments including virtual MDTs for CRC metastases, adapted to the size and the specific constraints of each country, with the possibility to refer patients to high-volume centres for surgical resection of metastatic disease, must be organised.

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Declaration of Competing Interest

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