



# Primary Tumor Resection in Asymptomatic Colorectal Cancer Patients With Unresectable Metastases: Can It Improve Survival?

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## See Articles on Page 94-100

Colorectal cancer (CRC) is one of the most frequent cancer types and a common cause of cancer-related death. Various strategies have now been developed for the treatment of CRC, such as surgery, chemotherapy, radiotherapy, targeted, and immunotherapy. Despite advances in treatment, relapse occurs in ~30% of stages I to III and 65% of stage IV CRC patients [1]. In addition, approximately 20% of CRC patients are diagnosed with stage IV at the time of initial diagnosis [2]. According to the current treatment guidelines, surgical resection combined with chemotherapy is the treatment of choice for patients with resectable metastases, whereas chemotherapy is the treatment of choice for patients with unresectable metastases [3]. However, primary tumor resection (PTR) or palliative surgery are required for symptomatic relief and further medical treatment in patients with unresectable metastases who present with symptoms related to their primary tumors, such as intestinal obstruction, significant bleeding, fistulas, or perforation.

The role of PTR remains controversial in asymptomatic CRC patients with unresectable metastases. Traditionally, PTR in asymptomatic patients with unresectable metastases has been performed for the goal of avoiding late complications in selective patients, although there was little evidence to support this approach. Recently, there were many studies to evaluate the effectiveness of PTR on survival in asymptomatic patients with unresectable metastases [4-

9]. These studies reported that PTR could provide significant survival benefits. In addition, a recent meta-analysis, which included 21 retrospective studies with a total of 44,226 patients, revealed that the mortality rate was lower with PTR than with chemotherapy alone [4]. However, their results were not free from selection bias because of a significant imbalance in the distribution of confounders, and most studies were single-center studies.

Currently, several randomized controlled trials (RCTs) are ongoing to address this issue [10-13]. However, it does not seem easy to draw conclusions early. As the authors mentioned, all RCTs carry numerous intrinsic difficulties caused by strict eligibility criteria, patient preferences, and clinician bias lead to poor acceptance of the randomized assignment and difficulties in patient accrual.

The authors have suggested that asymptomatic CRC patients with unresectable metastases could gain a survival benefit from upfront PTR [14]. In this study, the median survival of the PTR group was 18 months and that of the non-PTR group was 15 months, and it was statistically insignificant ( $P=0.152$ ). However, in the multivariate weighted Cox regression, the results indicated that the PTR showed a significantly decreased risk of cancer-related death (hazard ratio, 0.61; 95% confidence interval, 0.40–0.94). Although this study may also have a potential for selection bias because of the retrospective study nature, it is meaningful that the authors try to evaluate the effectiveness of PTR using the ‘inverse probability of treatment weighting’ method, which is a recently emerging statistical tool to minimize selection bias by adjusting the baseline confounders. Ongoing RCTs and further large-scale prospective studies will be helpful in verifying the results.

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## CONFLICT OF INTEREST

No potential conflicts of interest relevant to this article were reported.

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