

Re-do surgery

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Close follow-up identifies recurrent isolated liver metastases and if CT and PET exclude additional disease repeat resection is appropriate when possible. The operative approach must take into account the consequences of previous surgery and hypertrophy following a major resection. Left lobe resections may produce a more inferiorly based and medially shifted portal triad, making the origin of the right hepatic pedicle deeper and more medial than expected, and a right hepatectomy will often rotate the hilum more anteriorly . Non-colorectal, non-neuroendocrine metastases Although metastases from non-CRCs do not spread via the portal circulation and are rarely confined to the liver, with the low mortality associated with liver resection palliative or potentially curative surgery for metastases from renal, breast, gastric and lung metastases together with deposits from melanoma, sarcoma and a range of rarer tumours is reported. Management of metastatic gastrointestinal stromal cell tumours Gastrointestinal stromal tumours (GISTs) are non-epithelial tumours originating in interstitial Cajal cells of the autonomic nervous system, which metastasise in 20–25% of patients. Management has changed with the effective chemotherapy The primary bowel tumour should be removed if possible and the liver assessed to identify potentially resectable disease. If metastases respond to postoperative imatinib, surveillance is recommended; however, when metastases escape imatinib control debulking has no role and surgical resection is performed only if extirpation of all disease is possible.

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