Sir,

I read with great interest the article by Rath et al.[1] They report good results in 40 patients with liver metastasis at 2-year follow-up. However, several questions remain unanswered. Surgical resection of primary and metastatic hepatic tumors remains the gold standard of therapy. The small tumor size (median tumor size = 1.5 cm) reported in the study, and the fact that 34 (85%) patients had a solitary liver lesion raises the question: why were these patients not offered surgery? I am sure the authors had a valid reason to consider radiofrequency ablation (RFA) as the therapeutic modality, but nowhere in their report do they mention the reason why surgery was not offered. One would also be curious to know the site and status of primary disease in all 40 patients, also not reported, since it is of paramount importance in selection of the treatment modality.

RFA should not be considered as an alternative to surgical resection, which has a well-documented record of safety and clinical efficacy.[2] The absolute contraindications to resection of disease metastatic to the liver are inability to resect the tumor completely, the presence of metastatic disease involving hepatic or celiac nodes, or unresectable extrahepatic disease. The relative contraindications to resection are finding multiple nodules (more than 4) or a tumor size that would require an extended resection.[3] Although there is clarity regarding absolute unresectability, there is variation among individual liver surgeons regarding borderline cases, as illustrated in the study by Alberts et al.[4] Although the results reported by the authors are comparable to the landmark study by Curley et al.[5] more information about the site and status of primary malignancy, and the reason for not offering surgery as the primary modality for management of these liver secondaries would have added a greater value to an otherwise well conceived and written article.

REFERENCES