



Comment on “Clinical features and course of brain metastases in colorectal cancer: an experience from a single institution”

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Re: Damiens K, Ayoub JP, Lemieux B, *et al.* Clinical features and course of brain metastases in colorectal cancer: an experience from a single institution. *Curr Oncol* 2012;19:254–8.

We read with interest the article by Damiens *et al.* focusing on the clinical features and course of brain metastases in colorectal cancer. We have some comments to make to emphasize their findings.

We strongly agree with Damiens *et al.* that, with improvements in the management of colorectal tumours, the incidence of metastases at previously uncommon sites such as brain is expected to rise. The situation is similar to that previously described with HER2-overexpressing metastatic breast cancer patients receiving trastuzumab and chemotherapy as treatment^{1,2}, where taking into consideration the presence of brain metastases in symptomatic patients is now standard procedure.

In our experience, the percentage of patients with long-lasting metastatic colorectal disease bearing brain metastases has dramatically increased in the recent years, especially last 2 years. This is, in our opinion, certainly a result of the benefit received in terms of survival by patients who had a chance to receive modern monoclonal-antibody-based chemotherapy (bevacizumab, cetuximab, panitumumab). Long survival with active metastatic disease means that there is a possibility for metastatic cells hiding in the brain-sanctuary to grow and become clinically evident. At our institution, we recently lost, within the last month, 3 of our longest-surviving metastatic colorectal patients (8, 7, and 6 years respectively) because of the sudden onset of brain metastases that became clinically evident and led to rapid death in these patients (4, 2, and 1 month). Radiation therapy was administered to only 2 patients, and no treatment was applied in 1 patient because of a rapidly

deteriorating clinical condition. Because there is evidence that an improvement in survival in this setting can be obtained with surgery followed by radiation therapy³ (as also underlined by Damiens *et al.*), we are considering including brain imaging in the restaging of all our long-surviving metastatic colorectal cancer patients. In doing so, we aim to detect brain metastases as soon as possible, so as to be able to treat those metastases with a bimodality approach when possible, and to offer our patients longer and better survival.

As Damiens *et al.* describe in their paper, treating patients later, only when the brain metastases become clinically evident, leads to dismal survival, despite any treatment.

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CONFLICT OF INTEREST DISCLOSURES

The authors declare that no financial conflict of interests exists.

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