

FACTSHEET: GLOBAL

BOWEL CANCER THAT HAS SPREAD TO THE LIVER

Bowel cancer is one of the most common cancers in the world

- Bowel cancer is the third most common cancer with 1,360,602 new cases a year;¹
- Every hour 155 people are diagnosed with bowel cancer;¹
- Of those affected, 45% are women and 55% are men.¹

Bowel cancer commonly spreads to the liver

- Around a quarter of people that are first diagnosed with bowel cancer will already have secondary cancer that has spread to the liver;^{2,3}
- A further 25–35% of patients will go on to develop secondary liver cancer after their diagnosis with bowel cancer;²
- The outlook for patients with bowel cancer that has spread to the liver is very poor, particularly for certain groups of patients, such as those with primary colon cancer that starts from the right side of the bowel;⁴
- The majority of people with bowel cancer that has spread to the liver (66–90%) will die from liver failure caused by liver tumours;^{3,5–7}
- Estimates suggest that this could equate to as many as 457,966 deaths a year worldwide – that's 1,255 lives per day.^{1,3,5–7}

Only one in five patients will have liver tumours that can be removed by surgery

- Surgical removal (also known as resection) of the liver tumours currently provides the only realistic possibility of providing a cure for patients with tumours that have spread from the bowel. However, approximately 20–30% of patients will have liver tumours that can be removed in this way;^{8,9}
- Of those patients that can be treated using resection, 15–67% (median 30%) have been reported to be alive after five years, compared to 0–6% for patients who do not undergo surgery;⁹
- In some cases the use of chemotherapy, biological drugs and/or Selective Internal Radiation Therapy (SIRT) can reduce the size of non-resectable liver tumours to make them resectable;
- A recent analysis by liver surgeons of radiological images from the SIRFLOX study concluded that a significantly greater percentage of patients treated first-line with SIR-Spheres® Y-90 microspheres were eligible to potentially curative liver surgery compared to those treated with chemotherapy alone.¹⁰

SIR-Spheres Y-90 resin microspheres can extend life and may lead to potentially curative surgery in patients

- SIRT using SIR-Spheres Y-90 resin microspheres is currently mainly given to patients that are unresponsive to chemotherapy. In this setting, the therapy has been shown to extend life, and in some cases shrink liver tumours so much that they can be surgically removed in patients with inoperable liver cancer, particular liver cancer that has spread from the bowel;^{11–14}
- It is also possible to treat other cancers that have spread to the liver from other parts of the body, for example liver cancer that has spread to the liver from the breast, lung or eye;
- The 2016 European Society for Medical Oncology (ESMO) guidelines for physicians recommend the use of SIR-Spheres Y-90 resin microspheres to treat liver tumours that have spread from the bowel and failed to respond to chemotherapy;¹⁵
- SIR-Spheres Y-90 resin microspheres are approved in Australia, the European Union (CE Mark) and several other countries for the treatment of patients with non-operable liver tumours;
- SIR-Spheres Y-90 resin microspheres are recommended for use by FDA for the treatment of inoperable tumours from primary colorectal cancer that have spread to the liver.

For more information please visit: www.sirtex.com

1. Globocan 2012 Estimated cancer mortality, incidence and prevalence worldwide, Available at <http://globocan.iarc.fr/Default.aspx>. Last accessed February 2017.
2. Van Cutsem E *et al.* *Eur J Cancer* 2006; **42**: 2212–21.
3. McMillan DC, McArdle CS. *Surg Oncol* 2007; **16**: 3–5.
4. Petrelli F *et al.* *JAMA Oncol* 2017; **2**: 211–9.
5. Sharma R *et al.* *J Clin Oncol* 2007; **25**: 1099–106.
6. Van den Eynde M, Hendlisz A. *Rev Recent Clin Trials* 2009; **4**: 56–62.
7. Kennedy A *et al.* *Int J Radiat Oncol Biol Phys* 2006; **65**: 412–25.
8. Kopetz S *et al.* *J Clin Oncol* 2009; **27**: 3677–83.
9. Simmonds PC *et al.* *Br J Cancer* 2006; **94**: 982–99.
10. Garlipp B *et al.* *E-AHPBA* 2017; Abs. FP 15.08.
11. Seidensticker R *et al.* *Cardiovasc Intervent Radiol* 2012; **35**: 1066–73.
12. Bester L *et al.* *J Vasc Intervent Radiol* 2012; **23**: 96–105.
13. Van den Eynde M *et al.* *Clin Nucl Med* 2008; **33**: 697–9.
14. Whitney R *et al.* *J Surg Res* 2011; **166**: 236–40.
15. Van Cutsem E *et al.* *Ann Oncol* 2016; **27**: 1386–422.