

# Cryotherapy for the treatment of liver metastases

HealthTech guidance

Published: 15 December 2010

[www.nice.org.uk/guidance/htg241](https://www.nice.org.uk/guidance/htg241)

## Your responsibility

This guidance represents the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, healthcare professionals are expected to take this guidance fully into account, and specifically any special arrangements relating to the introduction of new interventional procedures. The guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

All problems (adverse events) related to a medicine or medical device used for treatment or in a procedure should be reported to the Medicines and Healthcare products Regulatory Agency using the [Yellow Card Scheme](#).

Commissioners and/or providers have a responsibility to implement the guidance, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties. Providers should ensure that governance structures are in place to review, authorise and monitor the introduction of new devices and procedures.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should [assess and reduce the environmental impact of implementing NICE recommendations](#) wherever possible.

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This guidance replaces IPG369.

# 1 Recommendations

- 1.1 Current evidence on the safety of cryotherapy for the treatment of liver metastases appears adequate in the context of treating patients whose condition has such a poor prognosis, but the evidence on efficacy is inadequate in quality. Therefore, cryotherapy for the treatment of liver metastases should only be used with special arrangements for clinical governance, consent and audit or research.
- 1.2 Clinicians wishing to undertake cryotherapy for the treatment of liver metastases should take the following actions.
  - Inform the clinical governance leads in their Trusts.
  - Ensure that patients and their carers understand that other ablative treatments are available and provide them with clear written information. In addition, the use of [NICE's information for the public](#) is recommended.
  - Audit and review clinical outcomes of all patients having cryotherapy for liver metastases (see [section 3.1](#)).
- 1.3 Patient selection and treatment should be carried out by a hepatobiliary multidisciplinary team with expertise in the use of ablative techniques.

## 2 The procedure

### 2.1 Indications and current treatments

- 2.1.1 Liver metastases are commonly caused by colorectal cancer or other primary malignancies, such as lung and gastric cancer.
- 2.1.2 For a minority of patients, surgical resection of liver metastases with curative intent may be possible. For most patients however, treatment is palliative, and options include systemic chemotherapy, external beam radiotherapy, other thermal ablation techniques, and selective internal radiation therapy. Multiple treatment modalities may be used for individual patients.

### 2.2 Outline of the procedure

- 2.2.1 Thermal ablation procedures including cryotherapy may be used as the primary treatment for liver metastases in patients who are not considered suitable for surgery, or to treat post-resection recurrence. They may also be used as an adjunct to hepatic resection. Cryotherapy can be delivered as part of an open resection procedure (requiring general anaesthesia and intraoperative ultrasound), or percutaneously (under local or general anaesthesia, with ultrasound, CT or MRI guidance).
- 2.2.2 Cryotherapy probes (single or multiple, depending on the size of the tumour) deliver coolant at subzero temperatures directly to the tumour in freeze-thaw cycles with the aim of destroying tumour cells.
- 2.2.3 The maximum recommended hepatic tumour size for cryotherapy is 4 cm. Cryotherapy for larger tumours requires multiple probes and is associated with increased morbidity.
- 2.2.4 Various devices can be used for this procedure.

## 2.3 Efficacy

Sections 2.3 and 2.4 describe efficacy and safety outcomes from the published literature that the Committee considered as part of the evidence about this procedure. For more detailed information on the evidence, see the [overview](#).

- 2.3.1 A randomised controlled trial (RCT) of 123 patients treated by cryotherapy and chemotherapy or by surgical resection and chemotherapy reported disease-free survival in 14% (9 out of 63) and 5% (3 out of 60) of patients respectively at 10-year follow-up (significance not stated).
- 2.3.2 A non-randomised controlled trial of 415 patients treated by surgical resection and cryotherapy (for remnant lesions) or resection alone reported median survival of 29 and 34 months respectively ( $p=0.206$ ).
- 2.3.3 A case series of 326 patients reported median overall survival of 29 months after cryotherapy of colorectal liver metastases, with tumour recurrence in 42% (136 out of 326) of patients at a median of 32 months. In a subset of 280 patients who had CT imaging at baseline and during follow-up, complete response was reported in 15% (41 out of 280), partial response in 41% (115 out of 280), stable disease in 24% (68 out of 280), and progressive disease in 20% (56 out of 280; follow-up not stated).
- 2.3.4 The Specialist Advisers listed key efficacy outcomes as tumour destruction with small margins of additional tissue destruction, and survival.

## 2.4 Safety

- 2.4.1 A non-randomised controlled study of 223 patients reported no significant difference in perioperative mortality between the cryotherapy group (2% [1 out of 55]) and the surgical resection group (5% [8 out of 168];  $p=0.30$ ). However, overall perioperative morbidity was significantly lower in the cryotherapy group (11% [6 out of 55]) than in the resection group (26% [44 out of 168];  $p=0.01$ ).
- 2.4.2 A case series of 326 patients reported mortality in 2% (7 out of 326) of patients (follow-up period and details of causes were not reported, but 1 patient died from

'cryoshock' syndrome and 1 from liver failure).

- 2.4.3 A case report described death of a patient from hepatic failure related to portal vein thrombosis and intra-hepatic MRSA sepsis, 2 months after a second cryotherapy course via an open approach.
- 2.4.4 Infections directly related to cryotherapy were reported after 8% (12 out of 158) of procedures in the case series of 150 patients (most occurred within 3 weeks of treatment). Fever over 38°C was reported in 33% (108 out of 326) of patients in the case series of 326 patients (timing of events not stated).
- 2.4.5 Haemorrhage was reported in 4% (2 out of 55) and 1% (2 out of 168) of patients treated with cryotherapy and surgical resection respectively in the non-randomised controlled trial of 223 patients (timing of event not stated).
- 2.4.6 The Specialist Advisers listed anecdotal adverse events as damage to bile ducts and structures outside the liver. The Specialist Advisers also cited reports of major haemorrhage, the rare but fatal complication of cryoshock syndrome, and a high local recurrence rate; they stated that cryotherapy is therefore no longer widely used.

## 2.5 Other comments

- 2.5.1 The Committee noted possible differences in the safety of this procedure when used intraoperatively, compared with the percutaneous approach that uses narrower probes. Evidence on the percutaneous approach is limited in quantity.

## 3 Further information

- 3.1 This guidance requires that clinicians undertaking the procedure make special arrangements for audit. NICE has identified relevant audit criteria and has developed an [audit tool](#) (which is for use at local discretion).



# Update information

## Minor changes since publication

**January 2026:** Interventional procedures guidance 369 has been migrated to HealthTech guidance 241. The recommendations and accompanying content remain unchanged.

ISBN: 978-1-4731-8257-8

# Endorsing organisation

This guidance has been endorsed by [Healthcare Improvement Scotland](#).