Comment on "Dealing with the gray zones in the management of gastric cancer: The consensus statement of the İstanbul Group"

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Dear Editor,

I read the article titled "Dealing with the gray zones in the management of gastric cancer: The consensus statement of the İstanbul Group" published in the Turkish Journal of Gastroenterology (1). We are grateful to the authors for their relevant effort in this area.

In statement 17, it has been mentioned that "a total gastrectomy should be the procedure of choice in patients with signet ring cell and poorly cohesive gastric carcinoma regardless of the tumor location, but distal gastrectomy can be performed for early stage tumors." However, in the explanation of this statement, it is difficult to see a reliable explanation for this recommendation that is given with Level A recommendation. In the reference list, #61 and #62 references are in accordance with the lack of survival benefit of total gastrectomy for distal gastric cancers (1).

Considering the extent of gastrectomy in signet ring cell gastric cancer, Arer et al. (2) reported that "subtotal gastrectomy can be performed safely for patients with gastric signet ring cell carcinoma and is equal to total gastrectomy with respect to prognosis and complication rates." In a meta-analysis, total gastrectomy for distal gastric cancers has not been shown to be superior to distal gastrectomy with respect to overall survival (3). It has been also reported that distal gastrectomy is superior to total gastrectomy even for middle-third gastric cancer (4). Although there was no subgroup analysis based on tumor histology for the studies (3, 4), recommendation of total gastrectomy for signet ring cell and poorly cohesive gastric carcinoma regardless of the tumor location needs to be supported by published, high grade evidence.

On the basis of Japanese guidelines, a tumor-free resection margin of 2 cm for T1, 3 cm for T2 of higher, and 5 cm for diffuse tumors seems to be easy for their applicability for all gastric cancers (5).

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Re: Comment on "Dealing with the gray zones in the management of gastric cancer: The consensus statement of the İstanbul Group"

Author's Response

Dear Editor,

We received the letter regarding the extend of gastrectomy for patients with signet ring cell (SRC) and poorly cohesive gastric carcinoma. We do appreciate the authors of the letter for giving us the opportunity to re-clarify the complex part of gastric cancer treatment. We would like to start with the methods of the consensus. The recommendations relayed on the voting of the experts on the discussed topics. If all the participants accepted a statement, this mean it had a full support (Level A recommendation). If more than 80% of the participants agreed with a statement, this meant it had a strong support (Level B recommendation). If more than 50% and less than 80% agreed with a statement, then this meant it had a moderate support (Level C recommendation). Therefore, this should not be considered as the level of evidence which is related to particular topic. Some of the recommendations have no level A evidence in the literature to support its conclusion (1).

As mentioned in the consensus, it is well know that a subtotal/total gastrectomy with D2 lymphadenectomy is the standard surgical approach for gastric adenocarcinoma in general. However, SRC has special place for its treatment due to its aggressive biology. The data are scarce about the impact of tumor histology on postoperative outcomes of gastric cancer. The series (2) that you cited with 13% (n=7/53) rate of positive surgical margin also supports our reason to offer a total gastrectomy for patients with SRC, especially for advanced stages. Exclusion of patients with R1-R2 resections in the article would definitely fluctuate the real-world outcomes by creating selection bias regardless of type of resection. It has been demonstrated that risk of positive surgical margin is higher in patients undergoing surgery for gastric SRC compared to the patients with non- SRC histology (3). An algorithm had already been proposed to increase resected specimen quality in gastric SRC prior to our consensus (3). Primary laparoscopy to eliminate diffuse peritoneal dissemination, total gastrectomy with frozen margins section and re-resection if necessary, an intensive postoperative follow-up after curative surgery, an attentive research of the family history, stratification in future chemotherapy to determine chemosensitivity to enhance survival and determine suitable therapeutic strategy had been described as the cardinal steps of treatment for gastric SRC (3). We recommend a total gastrectomy in patients with locally advanced gastric SRC due its diffusely spread pattern and related difficulties for estimating proximal and distal border invasion. A distal subtotal gastrectomy should be reserved for early stage distally located gastric SRC in a very selective manner.

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