



## Diagnostic difficulty in subepithelial gastric tumors, and the efficacy of laparoscopy-assisted distal gastrectomy in gastric cancer

Dear Editor,

A letter to the editor entitled "Laparoscopic Resection of Signet Ring Cell Gastric Cancer Resembling Infiltrating Subepithelial Tumor" was published in the Turkish Journal of Gastroenterology (1). First of all, we would like to thank the authors for their presentation. The standard surgical treatment for cT1cN+ and the potentially curable T2-T4 gastric cancer is a gastrectomy, in addition to a D2 lymphadenectomy. In appropriate cases, an endoscopic mucosal resection (EMR), endoscopic submucosal dissection (ESD), D1, D1 plus alpha (D1+ n.7), and D1 plus beta (D1+ n. 7, 8a, 9) lymphadenectomy may also be performed. In the present report, the patient underwent only two preoperative endoscopic biopsies. To achieve a definitive histopathological diagnosis, and thus make a better surgical plan, an endoscopic ultrasonography (EUS)-assisted deep biopsy could have been carried out, and an evaluation of the depth of the wall invasion of the tumor and the lymph node involvement could have also been provided. The authors, however, reported that the only surgical intervention was a laparoscopic subtotal gastrectomy. On a numerical basis, despite the sufficient number of lymph nodes, the level of lymphadenectomy was not stated. Moreover, it would be better if the pathological TNM stage was stated together with the tumor depth (T).

Another significant point is the use of laparoscopy-assisted distal gastrectomy (LADG) in gastric cancer surgery since 1994, which has witnessed increasing use particularly in cT1N0 (Stage IA), cT1N1 (Stage IB) and cT2N0 (Stage IB) patients (2); furthermore, its safety and feasibility in cases of advanced gastric cancer also seem promising (3). That said, some studies have reported a high risk of morbidity, including anastomosis leaks, stenosis and pancreatic fistulas for LADG, when compared to the open distal gastrectomy method (ODG) (4). Regarding

the safety of LADG, the Japan Clinical Oncology Group (JCOG) Gastric Cancer Surgical Study Group carried out a Phase II study (JCOG0703) of Stage I gastric cancers that confirmed the safety of LADG (2). However, it was reported that the full effectiveness of LADG would remain as an investigational treatment until the evaluation of a Phase III study. Subsequently, a Phase III study in the clinically Stage IA/IB gastric cancers (JCOG0912) was initiated by the JCOG Gastric Cancer Surgical Study Group (5).

In conclusion, it is not always possible to reach a definitive histopathological diagnosis in cases of subepithelial gastric tumors. To avoid an insufficient or unnecessary lymphadenectomy, endoscopic or EUS-assisted multiple biopsies should be carried out. That said, for a full comparison of LADG and ODG in gastric cancer surgery, the results of the Phase III studies are awaited, and so we suggest that the researcher should be more cautious when recommending LADG for curative surgical treatment of gastric cancer, and especially in cases where a preoperative histopathological diagnosis is absent.

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## Author's Reply

To the Editor,

We thank the authors for their interest in our article. We appreciate the comments on this case. Making a diagnosis of gastric infiltrating tumors is challenging, and is often delayed due to false negative endoscopic and histological tests. The diagnostic yield of endoscopy with biopsy is 35%, endoscopic ultrasound (EUS) with fine needle aspiration (FNA) 84%, abdominal computed tomography (CT) 74% (1). As it was mentioned in our article, CT showed diffuse and irregular thickening of the stomach. It is known that EUS is a helpful diagnostic test but in patients with irregular thickening of the stomach in CT screening EUS-assisted FNA does not change the operative strategy. In our patient, histopathology revealed tumor size was 3.5x2.3x2.0 mm and tumor invasion was limited to the serosa.

Laparoscopic surgery has become widely applied in the field of general surgery including gastric cancer. Several randomized trials and numerous retrospective studies have evaluated the advantages and limitations of the laparoscopic approach. The emerging paradigm of minimally invasive surgery promises clinically relevant benefits to the surgical patient including better pulmonary function, less blood loss, decreased postoperative pain, and earlier discharge from the hospital compared with the traditional open approach (2). An important previous finding is that laparoscopic gastrectomy showed similar results to open gastrectomy with regard to quality of oncological resection, whereas patient recovery was faster and admission duration shorter. Recently, Kim et al. has shown that the long-term-5-year oncologic outcomes of laparoscopic gastrectomy for patients with gastric cancer were comparable to those of open gastrectomy (3).

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