Professor Hyung-Ho Kim: Korean experience in lymphadenectomy for early gastric cancer

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Prof. Hyung-Ho Kim (*Figure 1*), Chairman & Professor of Department of Surgery, Seoul National University Bundang Hospital, is an outstanding laparoscopic surgeon. His main interest is minimal invasive surgery especially in laparoscopic surgery, and lymph node metastasis in early gastric cancer. Prof. Kim reported the very first case of laparoscopic surgery in early gastric cancer in Korea. He is the principal investigator of the first multicenter study (KLASS-01 study) in the world to evaluate the feasibility of laparoscopic surgery in early gastric cancer.

This interview was conducted on the 2015 CGCC (Chinese Gastric Cancer Congress), in which he shared his surgical experience and opinion. Prof. Kim also had an amazing live-demo surgery during this CGCC, together with Prof. Jiafu Ji from Peking University Cancer Hospital & Institute, China and Prof. Takeshi Sano from Cancer Institute Hospital, Japan.

TGC: You are talking about the "Korean Experience in lymphadenectomy for early gastric cancer". So could you kindly summarize the main points of Korean experience?

Prof. Kim: As you know, Korea is the one of endemic area of gastric cancer. Fortunately, more than 60% of gastric cancer of Korea is early gastric cancer because we have mass screening system provided by National Insurance System. The 5-year overall survival rate of early gastric cancer is very favorable which is over 90% and the common causes of death of these patients (early gastric cancer patient) were not related to cancer recurrence or metastasis, but related to other diseases. So we actively have adopted limited resection with D1 + lymphadenectomy or function-preserving surgeries by laparoscopic way in which included sentinel node navigation surgery, pylorus preserving gastrectomy, proximal gastrectomy, and so on.

TGC: According to your operation experience, what do you think is the most difficult thing in such kind of surgery?

Prof. Kim: The most important thing to perform such kind of surgery is team building that we should understand well about the procedures and harmonize for patients' safety. However, the most difficult thing is to make standardization and evidence. Surgery itself is not too much difficult to experienced team. But making evidence needs clinical trial. It is very difficult. Before clinical trial you have to make protocol and agreement of all delegates and it takes a very long time, sometimes will over 10 years.

TGC: From your perspective, what are the differences of gastric cancer research in Western countries and Asian countries?

Prof. Kim: In basic research there is no difference between two continents. But in clinical research, the Asian countries focus more on surgery's role, on the other hand western countries are more interested in chemotherapy. I think collaboration of these two is very important to make synergistic effect.

TGC: As we know, you are the principal investigator of the first multicenter study (KLASS-01 study) in the world to evaluate the feasibility of laparoscopic surgery in early gastric cancer. Would you like to share with us about this?

Prof. Kim: Last 10 years we have been conducting KLASS 01 trial. Through this trial we already reported the milestone papers regarding laparoscopic gastrectomy for gastric cancer. We are very proud of that. And we will report the final result of KLASS 01 study in the coming October. Now we are very closing to the final goal; whether

Figure 1 Professor Kim (middle) and his team in the 2015 CGCC.

laparoscopic gastrectomy is standard procedure for clinical stage I gastric cancer or not.

TGC: We know that you are focusing on minimally invasive surgery represented by laparoscopic surgery, and lymph node metastasis in early gastric cancer. Today, robotic surgery or 3D surgery is becoming very hot. What's your opinion on these new techniques?

Prof. Kim: Recent evidence regarding robotic gastric surgery through meta-analysis is that robotic gastrectomy shows less blood loss, same complication rate but needs more operation time, costs high. So at this moment there is no advantage of robotic gastrectomy over laparoscopic gastrectomy. And it seems that to figure out the advantage of robotic surgery is failed. Personally I think robotic surgery is less effective than 3D laparoscopic surgery in terms of technical aspect and cost issues because even single port or reduced gastrectomy is feasible and safe laparoscopically but it is impossible through robotic system. But current robotic system is not a permanent platform, which has potentially to be sophisticated and continuously developed. So most surgeons, especially young surgeons should open their mind to adopt this technology and push the engineer and company to develop a better system. But I think my career as a surgeon is enough to be a laparoscopic surgeon, not robotic surgeon.

TGC: Thank you very much!

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Footnote

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