Professor Sung Hoon Noh: treatment for advanced gastric cancer

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Prof. Sung Hoon Noh (*Figure 1*) is Director of the Yonsei Cancer Centre, Yonsei University Health System, Yonsei University College of Medicine in Seoul, South Korea. Prof. Noh has served as President of the Korean Gastric Cancer Association and the International Gastric Cancer Association, as well as Chairman of the Board of the Korean Cancer Association and the Board of the Korean Surgical Society. As an outstanding surgeon who specializes in gastric cancer surgery, Prof. Noh has received numerous awards, including the Cancer Academic Award by the Korean Gastric Cancer Association, the Yuhan Academic Award by the Seoul Medical Association and so on.

Translational Gastrointestinal Cancer (*TGC*) editor met Prof. Noh in the 10th Chinese Gastric Cancer Congress (CGCC), where he gave an excellent speech on "Standard Treatment for Advanced Gastric Cancer". We are honored to have an interview with Prof. Noh to share his opinion on the treatment of advanced gastric cancer.

Figure 1 Professor Sung Hoon Noh, Yonsei University College of Medicine, Korea.

TGC: I know that you had a speech on "Standard Treatment for Advanced Gastric Cancer" in this meeting. Could you make a brief introduction of your idea on the standard treatment of advanced gastric cancer for our readers who could not be on site?

Prof. Noh: The current main strategy against gastric cancer is centered around radical gastrectomy with D2 lymph node dissection, adjuvant and peri-operative multimodal therapies such as chemotherapy and radiation therapy. Through decades of debate and evolution, the extent of surgical resection is decided into D2 level and it was revealed that additional chemotherapy and/or radiation therapy provide survival benefit to the patients with advanced gastric cancer. Thus, now multidisciplinary treatment is a standard treatment for advanced gastric cancer.

TGC: Over the decades, many clinical trials have tried to prove the value of adjunct chemotherapy after surgery for gastric cancer. What is your opinion on this therapy? And is it suitable for the patients with advanced gastric cancer?

Prof. Noh: As you said, many trials failed to show the benefit of additional chemotherapy after surgery for advanced gastric cancer, so only surgery is considered as standard treatment for gastric cancer before 21th century. The reason of the failures was thought that we did not find adequate population and regimen for adjuvant chemotherapy. However, RCTs from West such as Intergroup0116 trial and MAGIC trial showed the benefit of adjuvant chemo-radiation therapy and peri-operative chemotherapy followed by gastrectomy with limited lymph node dissection. Also, ACTS-GC from Japan, and the most recent CLASSIC trial from Korea, China, and Taiwan showed adjuvant chemotherapy improve patients' survival

even after radical D2 surgery. Now I can say, we don't need to have doubt whether adjuvant chemotherapy after surgery is needed or not for advanced gastric cancer.

TGC: Laparoscopic gastrectomy (LG) has been adapted to treat the patients with advanced gastric cancer, but there are some concerns on its safety. Comparing to the open gastrectomy, what are the advantages and disadvantages of LG for patients with advanced gastric cancer?

Prof. Noh: As all of the surgeons know, the advantages of laparoscopic surgery are known to be cosmetic benefit due to smaller incision size, less pain and shorter hospital stay, and may improve quality of life compared to open surgery in most of surgical fields. In case of gastric cancer surgery, especially for advanced gastric cancer, we need to think about the role of it very conservative way. Cancer surgery is totally different to that of benign surgery. For cancer surgery, we need to keep the oncologic principles such as no touch technique, en-block resection, and resect with adequate safety margin from cancer cell. Nowadays, a few very experienced and handful laparoscopic surgeons might be able to do LG with very similar quality compared to that of open surgery. However, standard radical D2 surgery is not well standardized yet in the world even the field of open surgery. Also, it is still difficult to perform LG for serosa positive cases, because it sometimes requires combined resection of other organs and bursectomy. Minimally invasive surgery should not be misinterpreted as minimal extent of surgery in cancer surgery.

TGC: What are the updates on surgical management of advanced gastric cancer?

Prof. Noh: The extent of lymph node dissection for advanced gastric cancer is decided as D2 level after long time of debate. This issue is quite old, but very important in gastric cancer surgery. Also organ preserving surgery such as pancreas and spleen preserving total gastrectomy with adequate lymph node dissection (of course it mean D2 surgery) need to be adapted in practice. Performing bursectomy may improve the patients' survival in case of serosa positive gastric cancer especially when the tumor is located in posterior wall. The role of cytoreductive surgery, conversion surgery, which means surgery after palliative chemotherapy, and massive peritoneal lavage after gastrectomy for serosa positive gastric cancer with hope that it can decrease free cancer cells in peritoneum, consequently decrease peritoneal recurrence are going to be evaluated by various investigators.

TGC: In your opinion, what are the challenges of the treatment of advanced gastric cancer?

Prof. Noh: Thanks to extraordinary efforts by a lot of investigators from the world over the last couple of decades, the prognosis of gastric cancer has been improved. However, we still have a long way we have to go. In other types of cancers such as breast cancer, lung cancer, and colon cancer which are common malignancies in West, state-of-the-art bio-technologies are actively adapted, and the efforts to realize precision medicine are accelerated. Also, immunotherapy is raised as the next generation of anti-cancer strategies followed by surgery, chemotherapy, and radiation therapy. So integrating and adopting those new disciplines into the treatment of advanced gastric cancer is urgent issue to us who take care of gastric cancer patients.

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Footnote

Conflicts of Interest: The author has no conflicts of interest to declare.

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