

# Laparoscopic D2 dissection for gastric cancer

Qinshu Shao, Xiaojun Yu, Jin Yang

Department of Gastrointestinal Surgery, Zhejiang Provincial People's Hospital, China

Corresponding to: Qinshu Shao. Department of Gastrointestinal Surgery, Zhejiang Provincial People's Hospital, China. Email: Shaoqs1955@163.com.



Submitted May 08, 2013. Accepted for publication May 28, 2013.

doi: 10.3978/j.issn.2224-4778.2013.05.24

Scan to your mobile device or view this article at: <http://www.amepc.org/tgc/article/view/2077/2862>

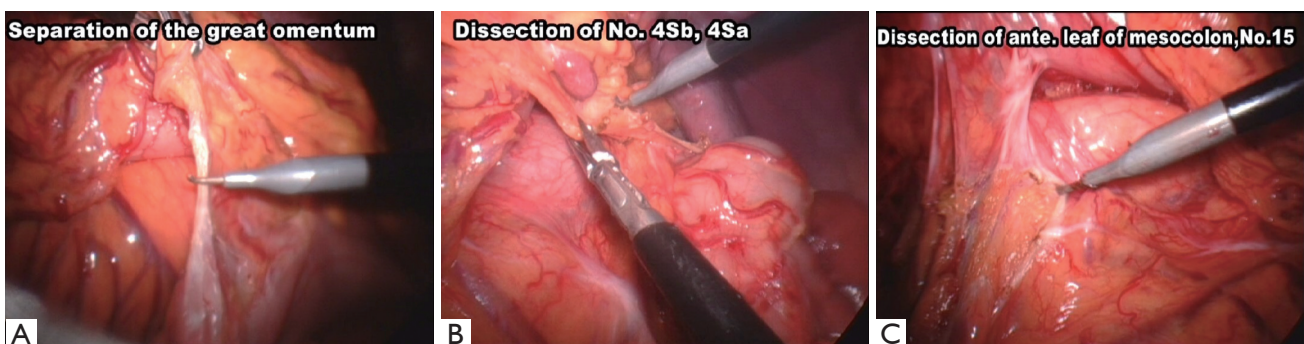
Since laparoscopy-assisted gastrectomy (LAG) was initially reported in 1994, laparoscopic gastrectomy has been widely accepted especially in patients with early-stage gastric cancer. However, LAG for the treatment of advanced gastric cancer (AGC) has remained controversial, mainly due to its technical difficulties in systematic lymph node dissection and doubts about the effectiveness of lymphadenectomy compared to conventional open gastrectomy. Now we share a case of laparoscopic D2 dissection for gastric cancer to confirm the feasibility and efficacy of laparoscopy-assisted gastrectomy (LAG) for advanced gastric cancer (AGC) without serosal exposure, which can achieve the same radicalness as open gastrectomy by the experienced surgeon. (Video 1, Figures 1-8)



Video 1 Laparoscopic D2 dissection for gastric cancer

## Acknowledgements

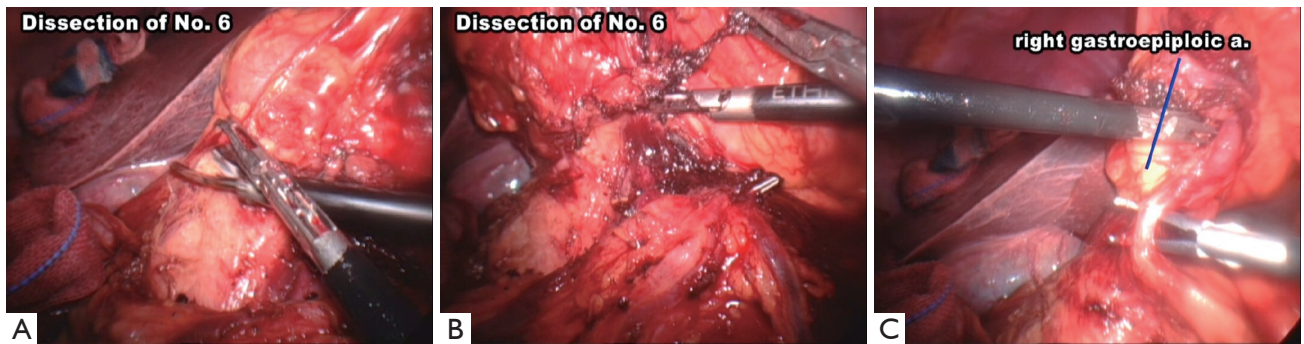
*Disclosure:* The authors declare no conflict of interest.



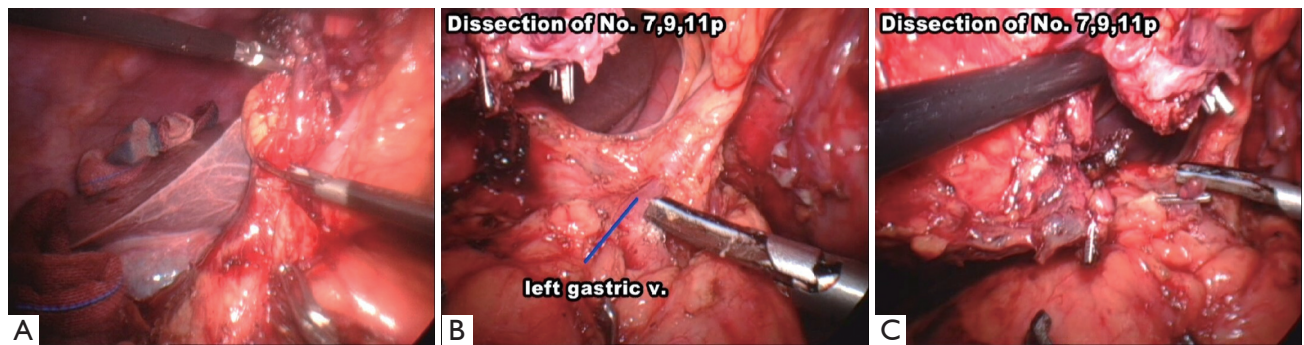
**Figure 1** A. The greater omentum was first dissected, using the ultrasonicactivated scissors, along the border of the transverse colon; B. The gastrosplenic ligament was divided and No. 4Sb, and 4Sa were dissected; C. The superior leaf of the mesocolon and the anterior leaf of the pancreas rightward the pylorus was resected



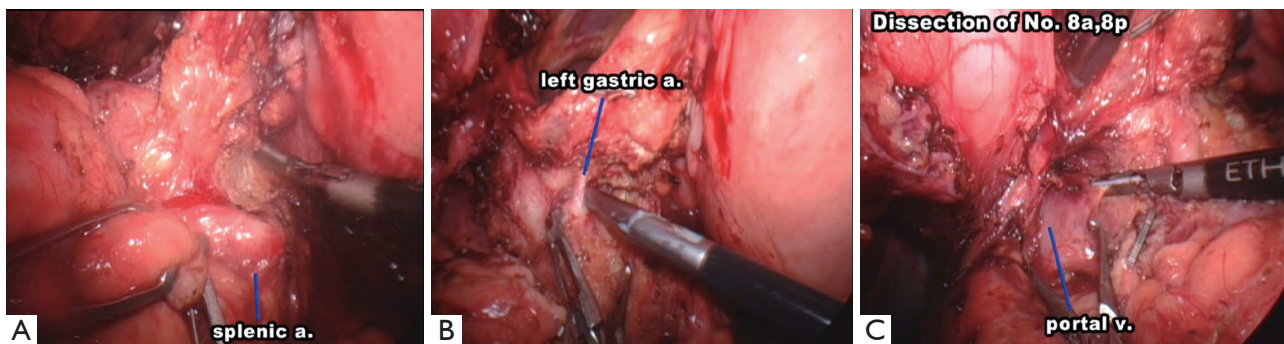
**Figure 2** A. The No.14v lymph nodes were dissected; B. The superior mesenteric vein was exposed; C. The right gastroepiploic vessel was exposed and clamped at its origin



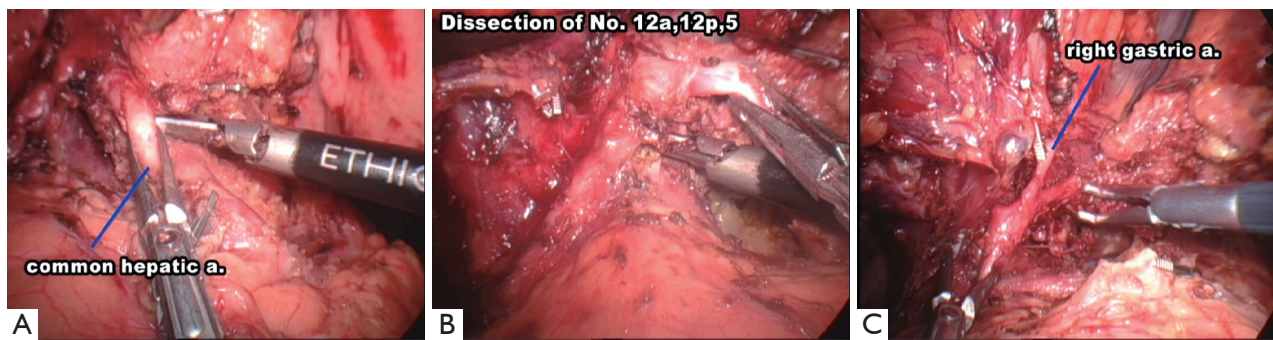
**Figure 3** A. No.6 lymph nodes were dissected; B. No.6 lymph nodes were removed; C. The right gastroepiploic artery was dissected



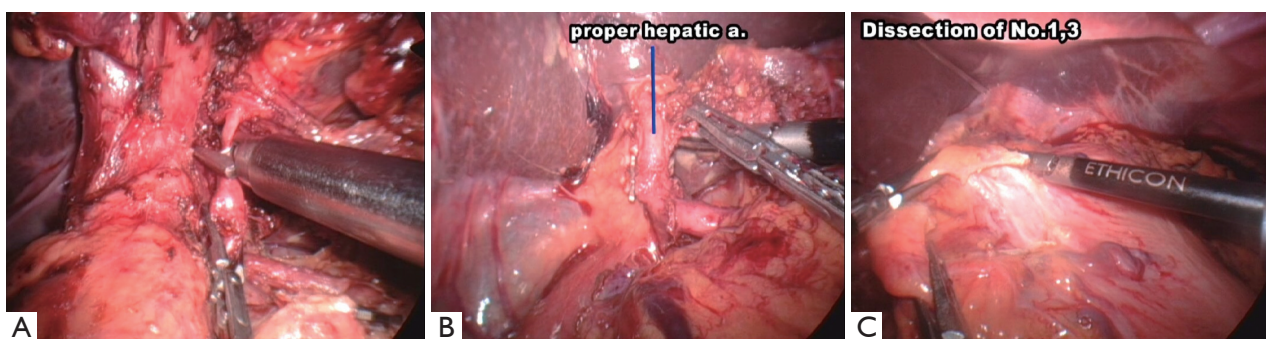
**Figure 4** A. The right gastroepiploic artery was clamped at its origin; B. No 7, 9, 11p lymph nodes were dissected; C. The left gastric vein was clamped at its origin



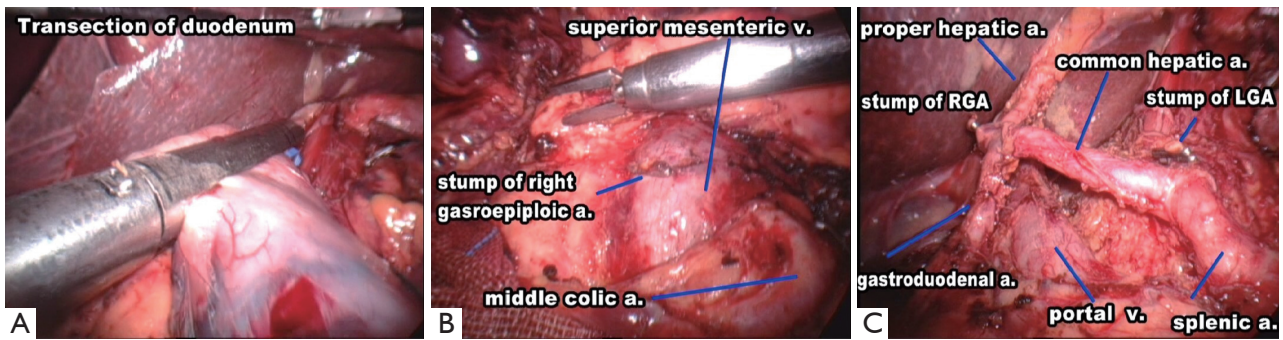
**Figure 5** A. The gastrosplenic ligament was divided and resected along the edge of spleen; B. The left gastric artery was divided and cut from the celiac trunk; C. No. 8a, 8p was dissected



**Figure 6** A. The common hepatic artery was skeletonized along the gastroduodenal artery; B. No. 12a, 12p, 5 lymph nodes were dissected; C. The right gastric artery was divided



**Figure 7** A. The right gastric artery was cut at its origin; B. The proper hepatic artery was skeletonized and No. 12a lymph nodes were dissected; C. The lesser omentum could be resected with dissection of No. 1 and 3 lymph nodes



**Figure 8** A. Transection of duodenum; B. View of skeletonized vascular (superior mesenteric vein, stump of right gastroepiploic artery, middle colic artery); C. View of skeletonized vascular (proper hepatic artery, stump of RGA, common hepatic artery, stump of LGA, gastroduodenal artery, portal vein, splenic artery)

**Cite this article as:** Shao Q, Yu X, Yang J. Laparoscopic D2 dissection for gastric cancer. *Transl Gastrointest Cancer* 2013;2(S1):69-72. doi: 10.3978/j.issn.2224-4778.2013.05.24