Letter to the Editor

Is D2 laparoscopic gastrectomy essential for elderly patients with advanced gastric cancer?

Qingbo Feng, Tao Zhang, Ming Xie

Department of General Surgery, Affiliated Hospital of Zunyi Medical University, Affiliated Digestive Hospital of Zunyi Medical University, Zunyi, China

Correspondence to: Ming Xie. Department of General Surgery, Affiliated Hospital of Zunyi Medical University, Affiliated Digestive Hospital of Zunyi Medical University, 149 Dalian Road, Zunyi 563000, China. Email: 2581303091@qq.com.

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We read with great interest the recent published study written by Sakaguchi and colleagues entitled "*Is D2 laparoscopic gastrectomy essential for elderly patients with advanced gastric cancer? A propensity score matched analysis*" (1), published in *Journal of Gastrointestinal Oncology*. The standard D2 gastrectomy has increasingly been adopted for elderly patients with gastric cancer (GC). However, the necessity of the standard D2 gastrectomy remains controversial, especially in older patients with advanced GC. With a total of 119 patients that underwent laparoscopic surgery with or without standard D2 gastrectomy. The authors have shown that D2 laparoscopic gastrectomy (D2 LG) is not recommended as a routine operation for elderly patients with GC. Although some limitations discussed by the authors, there still are some defects we are concerned.

To begin with, regarding inclusion criteria, the eligible patients were diagnosed with clinical T1N+ or clinical T2-4 and age ≥75 years. Nevertheless, for patients with clinically staged T1N+ or T2-T4a, the standard treatment is gastrectomy with adequate lymphadenectomy and perform perioperative chemotherapy routinely to provide a lower recurrence rate and longer survival (2). In this study, only 7 patients and 5 patients received adjuvant chemotherapy in the D2 LG and non-D2 LG groups, respectively. Thus, no adjuvant chemotherapy GC patients need to be elaborated. What's more, to avoid the impact of advanced age on survival, we recommend lowering the age to 70 years.

Second, after careful reading, we found that there is an obvious typographic error in *Tab. 3*. *Tab. 3* was listed to show the postoperative outcomes of the matched sample of patients undergoing D2 LG or non-D2 LG. The investigators claimed that recurrence was found in 5 patients during follow-up in the non-D2 LG group in the results section. While the number of recurrence patients in non-D2 LG group is 6 in *Tab. 3*.

Third, the optimal extent of lymphadenectomy and the lymph node harvest number plays a vital role in the surgical strategy of GC. As the author thinks, the extent of dissection remains controversial for GC patients. There are obvious contradictions between the eastern and western studies on the question of whether to choose supporting D2 lymphadenectomy (3-7). In an analysis of more than 25,000 GC patients based on international datasets from the US and Korea, 29 lymph node harvest number were associated with an optimum survival benefit (8). In this study, no significant difference in the lymph node harvest number (D2 *vs.* non-D2: 44 *vs.* 38, P=0.1332). That may be the reason for no significant differences in the OS and RFS between the D2 and non-D2 groups.

Finally, according to the data in the article, no difference in the overall complication rate between the D2 LG and non-D2 LG groups. What's more, the sample size (only 26 in each group) is very small, the conclusion that D2 LG could not recommended as a routine operation for elderly patients with GC is rough. We thank all authors for their excellent contributions to assess the efficiency of D2 LG for elderly patients with advanced GC. We believe that further more well-designed studies with a large sample size are

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needed to further validate these findings.

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Ethical Statement: The authors are accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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