Letter to the editor

Locoregional control remains a critical issue in gastric cancer

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To the Editor:

We read with interest the recent article by Hundahl et al. entitled “Improved regional control and survival with ‘low Maruyama Index’ surgery in gastric cancer: autopsy findings from the Dutch D1-D2 trial” [1], which further clarifies and supports the use of adjuvant therapy. We were struck by the similarity between the 21% rate of locoregional failure (LRF) in the Maruyama Index (MI) ≥ 5 patients (reported in this article) to that of 23% reported in 1982 by Gunderson and Sosin [2]. Despite the 25-year gap between the publication of these two articles, and the geographic and cultural differences between patients operated on in Holland and Minnesota (USA), respectively, these results suggest that, with standard surgery alone, LRF continues to be important. Persistently significant LRF, despite more aggressive nodal dissection, is not unexpected if we consider the patterns of LRF. Failure is observed in the gastric bed in 21%–54%, regional nodes in 40%–50%, and in the anastomosis or stump in about 25% [3]. The frequency of such locoregional failure was not substantially altered by more extensive nodal dissection in the University of Minnesota reoperative series.

Debate continues regarding the potential for survival benefit with more extensive surgery [4] despite the results of the Dutch trial [5]. Meanwhile, throughout North America and much of Europe, D2 and more extensive nodal dissections remain the exception; the majority of patients are treated in the community, often by general surgeons. For example, in Toronto, Canada, 82 patients treated with post-operative adjuvant therapy for gastric cancer were operated on at 16 different hospitals, with only 6% receiving D2+ nodal dissections [6]. Analysis of the surgery in the Intergroup 0116 study of adjuvant chemoradiotherapy showed that 88% of cases were MI > 5 [7].

The survival and locoregional control benefits of adjuvant treatment have been demonstrated in phase III randomized trials [8, 9], yet the incorporation of adjuvant concurrent chemoradiation in clinical practice has been incomplete [10]. The observation by Hundahl et al. that isolated LRF continues to be more frequent than distant failure (21% vs. 13%) in this group again provides a rationale for adjuvant concurrent chemoradiation, ideally with the use of systemic therapy which is effective for micrometastatic disease. Unless or until unequivocal evidence from randomized trials is available to effect a dramatic change in practice throughout the surgical community, strategies to improve combined modality adjuvant therapy continue to be the best option available for the majority of resectable gastric cancer patients.

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