LETTER TO THE EDITOR

Does Metastatic Lymph Node Ratio Really Suit for Prognostic Prediction of the D1 Lymphadenectomy?

TO THE EDITORS:

Recently, Maduekwe et al. reported the results of their retrospective clinical study of the best prognostic prediction of metastatic lymph node ratio in gastric cancer patients who underwent the D1 lymphadenectomy.¹

Although the results are the novel and original in the reports from the United States, we think there are some detailed matters should be further discussed in that study. First, the enrolled patients in that study included cases with positive resection margin, lymphovascular invasion, and venous invasion, which should be considered as noncurative resection and potentially distant metastasis for patients according to the AJCC/UICC or JGCA. Therefore, the 5-year survival rate must be influenced inevitably.

Furthermore, patients with no fewer than 15 dissected nodes had significantly higher T stage, N stage, Nr stage, and TNM stage than those with fewer than 15 dissected nodes. Obviously, most of the patients with no fewer than 15 dissected nodes were in the advanced stage of disease, which must incur the markedly dismal survival result in these patients, compared with those patients with fewer than 15 dissected nodes. Besides, the tumor size that is reported as an important prognostic independent factor of gastric cancer after curative resection in many articles of patients with no fewer than 15 dissected nodes was much bigger than that of patients with fewer than 15 dissected nodes.^{2,3} Therefore, we think the conclusion of that study of “Based on the factors which were significantly different between patients with <15 and $\geq$ 15 nodes examined, the patients with $\geq$ 15 nodes were generally a poorer prognosis group” is not very accurate.

Last, we could not understand why the author designed the Nr0 as the patients with no regional lymph node metastases who also had $\geq$ 15 lymph nodes examined,

while the patients with no regional lymph node metastases who had <15 lymph nodes examined were included in the Nr1 group. Actually, all enrolled patients underwent the D1 lymphadenectomy that could not provide the extragastric lymph node metastatic information in spite of the number of dissected nodes. The stage migration of lymph node metastasis is inevitable for all patients, even in patients with no fewer than 15 dissected nodes who presented without positive nodes. In our previous study, we demonstrated that patients with no fewer than 15 dissected nodes who presented with positive nodes had significantly higher 5-year survival rate than those with fewer than 15 dissected nodes who presented with positive nodes using the case-control method analysis.⁴ So we suggest that author may analyze the difference of survival rates between the patients with no fewer than 15 dissected nodes and the patients with fewer than 15 dissected nodes with detailed stratified analysis.

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