LETTER TO THE EDITOR

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

TO THE EDITORS:

In response to Dr. Deng's and Dr. Liang's comments to our article, our study focused on comparing staging systems based on absolute positive lymph node number versus lymph node ratio (i.e., ratio of positive nodes to examined nodes) in all patients who underwent surgical resection with curative intention for gastric cancer our institution over a 10-year period. We would disagree that "positive microscopic margin, lymphovascular invasion, and venous invasion ... should be considered as noncurative resection." These are certainly negative prognostic factors, but some patients with 1 or more of these negative prognostic factors were in fact cured of disease.

The comment regarding patients with ≥ 15 nodes examined having worse overall prognostic factors than patients with < 15 nodes examined is correct. However, the subsequent comment that "obviously the patients with no fewer than 15 dissected nodes ... [had] markedly dismal survival ... compared with those patients with fewer than 15 lymph dissected nodes" is incorrect. In fact, the overall survival curves for these 2 groups are not statistically

different. This point was emphasized in our Discussion and suggests a possible survival benefit to dissecting more lymph nodes. However, one must be wary in drawing this type of conclusion based on a retrospective study.

In response to the comment regarding the Nr0 category, the rationale for designating the Nr0 category is explained in the Methods. Patients with no positive lymph nodes and < 15 nodes examined had an overall survival similar to that of patients with a node ratio between 0.01 and 0.3 and ≥ 15 nodes examined. Patients with no positive lymph nodes and ≥ 15 nodes had significantly better survival than all other groups.

The letter's authors suggest that we "analyze the difference in 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." Patients with < 15 nodes are compared with patients with ≥ 15 nodes in terms of surgical treatment (Table 2), pathological characteristics (Table 3), pathological staging (Table 4), and survival (Tables 5 and 6; Fig. 1 and 2). We are unclear as to what further analysis is requested.

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