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Treatment of stomach cancer - still surgical dilemma?

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Surgical therapy in gastric cancer is the only hope for cure for more than 120 years, from the first gastric resection in 1881 by Billroth in Vienna, but proper surgical management still remains controversial. The role of other forms of therapy (neo-adjuvant, adjuvant chemotherapy or irradiation) remain to be proved, as none of the large randomized trials showed promising results. (Price-2000, Hallisey-1994, Lorimier-1998, Minsky-1996). Survival rates were greatly different between Japanese and other world centers, including ours (see elsewhere in this issue), and the 5-year-overall survival makes over 50% in Japan versus 10% in Europe. The most likely reasons are: more than 50% of Japanese cases belong to early cancers, but in Europe less than 20% of cases belong to this category, and according to our experiences (see elsewhere in this issue) less than 4%. Japanese patients are 5-10 years younger, and mortality rate of gastric resection in Japan are between 0-2% versus 10-15% in Europe (Humphreys-1995). In our experience, severely malnourished patients that lost more than 35-40 kilos of body weight in the last six months before the operation, present special survival problems. Many trials addressed this problem, of seemingly racial differences, even employing Japanese instructors and introducing the same surgical techniques (Bonenkamp-1995, Hundahl-1996), but for early gastric cancers differences still existed with 96% of 5-year survival in Japan, versus less than 70% in European centers.

In evaluating the results of radical surgery in early gastric cancers better staging is necessary, as Japanese D-2 dissections are often actually only D-1, 5 resection (Wanebo-1993, Volpe-1995, Gudurić-1998), so the usage of new TNM classification (1997) that involves counting of positive lymph nodes in continuity, instead of distance from the lesions (3 cm diameter cut-off point) as in Japanese and old TNM classification (1990), can partially solve this problem.

Some other questions of learning curve in these radical dissections, as well as the number of operated cases/ per center/ per year deserve special consideration. According to Parikh (1996) 15-24 months and 15-25 cases are necessary to learn the proper technique of D-2 dissection, and some large Japanese centers performed up to 226 curative gastric resections/per year, versus 11-35 in the rest of the world (Hundahl-1996). In this respect, the most interesting data came from Taiwan with a decline of mortality from 5.5 to 1.5%, after the first 200 operated cases. (Wu-1995). We have some similar experiences with historical comparison of two treatment protocols (Gudurić-1997).

Finally, an important question has to be raised: in a situation where majority of cases presented with advanced stage of disease, radical surgery is of questionable value for a better survival. If radical surgery had to be restricted only to the early stages, then, just a few cases would be seen by the individual surgeon; personal expertise could not be gained, unless all early gastric cancers were referred to the surgeons working in specialized centers, where they could get proper treatment. But then, loss of expertise in gastric surgery by general surgeon, lack of teaching of junior stuff and the question who will be dealing with the emergency gastric problems, will inevitably result, if this policy is to be accepted.

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