Editors-in-Chief

World Journal of Gastroenterology

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Utrecht, 29 January 2016

Dear Ze-Mao Gong,

Enclosed please find our revised manuscript (ID 23789) entitled “Worldwide practice in gastric cancer surgery” considered for publication in the World Journal of Gastroenterology. We have addressed the reviewer’s points on page 2-5 of this letter.

All authors approved this revised manuscript and this submission. We appreciate your time and look forward to your response.

Also on behalf of the co-authors, yours sincerely,

Prof. Dr. R. van Hillegersberg

Reviewer 1

This is an interesting paper describing the current trend of surgical treatment of gastric cancer. The authors performed an international cross-sectional survey and concluded that surgical preferences for gastric cancer surgery vary between surgeons worldwide. The results are informative, but a few minor points should be revised. 1) Page 9. The authors mentioned that no studies compared D2 to D3 dissection. However, JCOG9501 trial revealed that D2 plus para-aortic nodal dissection does not improve the survival rate as compared with D2 alone in curable gastric cancer. The authors should cite this large RCT and discuss about that [Sasako et al. D2 lymphadenectomy alone or with para-aortic nodal dissection for gastric cancer. N Engl J Med 2008 359, 453]. 2) Questions dealing with the preferred method for reconstruction after distal gastrectomy (B-I, B-II, or R-Y) are not included in the survey? The reviewer is very interested in this matter. 3) Page 5, line 12; "an university" is to be corrected to "a university"

Response

1. We thank the reviewer for this comment and agree this study should be mentioned. We have cited the trial and changed the previous statement in the manuscript to: "*Some surgeons in Asia also perform a D3 dissection, since a Taiwanese trial showed an improved survival compared to D1 dissection* [32]*. However, a D3 dissection did not improve survival compared to a D2 dissection in a Japanese trial (Sasoko et al.)"*.
2. Indeed, the reconstruction after distal gastrectomy was not included in this survey. We agree with the reviewer that this is an interesting matter and will include this question in the next survey, which we wish to perform in the coming years to evaluate the changes in surgical preferences over time.
3. We thank the reviewer for this comment and have adjusted this in the manuscript.

Reviewer 2

This study aims to depict the current practice in gastric cancer surgery worldwide. The study design was a cross-sectional survey covering the questions from the anastomoses,extent of dissection， (Neo)adjuvant therapy to pen versus minimally invasive gastrectomy and etc. Overall, the manuscript is thorough, straightforward and well-organized, however, we have one concern which is why the practice in china has not been included. As we know, China has a very high incidence in gastric cancer and a huge gastric cacner population

Response

We thank the reviewer for his positive comments. Surgical practice of gastric cancer surgery in China has been included in this study and presented within the results of the Asian responders (fig. 1). A total of 29 responders (13%) originated from China.

Reviewer 4

1,This manuscript was described an international survey on gastric cancer surgery among the gastrointestinal surgeons in the world. But the only 227/615(37%) were evaluated. The mainly responders originated from Asia(54%), other countries were evaluated small number of responders. Therefore, it is difficult for evaluated among the three or four areas in the world wide. If the authors evaluated the gastric surgery in the world, it should be focused for high incidence area of gastric cancer. The areas of south Africa should be excludes in this study because of a small number of responders, see Table1 and 2. 2,Additionally, the classification of gastric cancer staging, D number with the area of lymph nodes dissection are different from Japanese and TNM classification. Please clarify these different point. Therefore, demographic data 13-16 were evaluated again, and mentioned the differences of lymph nodes dissection in Japan and other countries if the Japanese data were included in this manuscript. 3,Definition of early gastric cancer was T1N0M0 or T1N1M0 by Japanese classification, see Page17. Please reconfirmed this definition. 4,Discussion was too long, pleased reduced, and discussion was should be mentioned of only results in this study. This discussion was review of gastric cancer survey in the world. Please correct.

Response

1. We agree with the reviewer that the majority of responders originated from Asia. However, we did not include areas of South Africa in our results; we believe the reviewer means South America. South America is one of the regions with the highest incidence of gastric cancer in the world (**Ferlay J** et al. Cancer incidence and mortality worldwide: sources, methods and major patterns in GLOBOCAN 2012. *Int J Cancer* 2015; **136**: E359-86 [PMID: 25220842 DOI:10.1002/ijc.29210]). As the reviewer mentions, it is important that countries with a high incidence of gastric cancer are represented in this study and therefore we would not prefer to exclude the results from South America even though the number of respondents (*n*=27, 12%) is relatively small. In general we think that it is methodologically not correct to exclude any respondents, as this would introduce bias in the results.

2. We thank the reviewer for his comments. For the lymph node dissection we adhere to the Japanese classification. This has been clarified in the methods section of the manuscript.
3. We agree with the reviewer that the definition of early gastric cancer includes T1N0M0 and T1N1M0 tumors according to the Japanese classification and have clarified this in the methods section of the manuscript.
4. The discussion has been shortened according to your suggestion