

Reviewer 1 Dear prof. thank you for your valuable comments

1. The text is too crude to follow.It includes too many grammatical errors..
Manuscript is revised
2. **Which setting it has been done; hospital or clinic. Academic or private?**
This study was done in gastroenterology surgical and transplantation center, Mansoura University, Egypt. Which is a tertiary referral center not only from Egypt but for African and middle east countries (hospital, Academic)
3. **Also please detail how the changes impacted on your outcomes?**
Our center is a referral tertiary center, most of our patients comes with a relatively advanced tumor stage. **Only 10(13%)** patients had a T1 tumor stage. Intra-operatively there was much LN involvement. So our policy is to remove of all suspected LN involved with the disease. This does not add morbidity for such patients with T1 tumor. The extent of resection also goes to more radical resection with removal of adjacent near organs if it was infiltrated (tail of the pancreas, left liver lobe,transverse colon). Both strategies improve our results as it shown in the text.
4. **Why not compare the study findings with some relevant studies which have similar objectives as yours**

We compare our results with some similar published series on prognostic factors after resection for gastric carcinoma. And this added to the table .

Auther, Yr	Period	Number	Gender	Age	Location	No. excised NL	LN ratio	T stage	Histologic type	N stage	Curative resection
Adachi, 1997 (47)	1977-1987	479	NS	NS	P<0.01	P<0.01	NR	P<0.01	P<0.01	P<0.01	NR
Bando, 2002 (27)	1974-1995	650	NR	NR	NR	P<0.001	P<0.001	P<0.001	NS	NR	NR
Yokota, 2004 (48)	1985-1995	926	NS 0.347	NS 0.099	P<0.0001	NR	NR	P<0.0001	P<0.0001	P<0.0001	NR
Angelov, 2014 (49)	2005-2013	101	NS 0.587	NS 0.670	NS 0.540	NR	NR	NR	NR 0.169	P=0.003	P<0.001
Basaran, 2015 (50)	2006-2014	228	NS	0.000	P<0.001	NR	NR	NS 0.137	P<0.015	P<0.002	P=0.000
Present study	2009-2013	80	NS 0.830	NS 0.259	NS 0.315	P<0.001	p<0.001	P=0.001	P=0.001	NR	P<0.001

5. We remove the last figure (effect of recurrence)

Reviewer 2

1,Abstract:Conclusion: Surgery remains... The study methods does not address whether surgery is a mainstay or not.

Our study is based on patients underwent surgery only. During the study period, the median survival for patients who did not undergo surgery and only had palliative management was 6 months .

This issue is added to the patients and methods

2,Abstract: Conclusion: Extended LN.... this term does not appear anywhere in the abstract, which will lead to confusion when reading only the abstract. The authors stated that this approach did not increase morbidity yet nor the methods nor the results section addresses this problem

Dear prof your comment is very helpful

We mean that extended LN : when 15 LN or more were removed (removal of all draining LN as we can, this policy was attended in our center as a part of a radical surgery that we aim to reach) and this was mentioned in the last sentence in the patients and methods

As regard the difference in morbidity, we review our data base between patients with 15 or more LN removed (15 patients) and patients with less than 15 LN removed (65 patients), and we found that there was no statistical significance between both groups ($p=0.34$) .

this item is added to the result section.

3,Introduction:Line 4; common health problems in Egypt. It is advisable to cite for this information particularly that in a recent study gastric cancer was not among the common cancer in Egyptian population. (Journal of Cancer EpidemiologyVolume 2014 (2014), Article ID 437971, 18 pageshttp://dx.doi.org/10.1155/2014/437971)

Our center is a referral tertiary center in upper Egypt and Nile delta, gastric carcinoma comes after liver, pancreatic and colorectal carcinoma. From the published article: **Journal of Cancer EpidemiologyVolume 2014 (2014)**: gastric carcinoma account for 1.2% of all cancers after liver 33% (due to presence of hepatitis C viral infection), bladder 10.7% (due to presence of bilharzias, lung 5%, prostate 4.2%, colon 2.6% and pancreatic 2.4%. so after exclusion of liver and bladder cancer (due to presence of a predisposing factors) it comes fifth in frequency and this why it is becoming a common health problem in Egypt.

4,Introduction: Paragraph 2; Therefore, surgeon is the most...We think that authors should express their opinions using merely academic terms.

Therefore, the surgeon experience toward more radical resection with LN removal is the most important non-TMN prognostic factors in gastric cancer

5,Introduction paragraph 3:However, prognosis...It is an important notice, however it does not serve the introduction to the hypothesis neither to the methods, so it might be of use into the discussion if deemed explanatory to the high mortality rate.

We want to explain that, the difference in prognosis and survival may varies between patients with the same tumor stage, so there might be another factors may determine the survival and recurrence for each patient. In our study we search many possible factors that may affect survival.

6,Methods:Paragraph 3; line: 6: A roux-en-Y... please rephrase this to describe what was actually done. Use past tense, and there is no place for recommendation any more since all interventions where done.

Old one : A roux-en-Y reconstruction was strongly recommended for patients left with a small gastric pouch (< 20% of the stomach), although a loop gastrojejunostomy is acceptable for patients with large pouches.

A roux-en-Y reconstruction was done for 18 patients who left with small gastric pouches (< 20% of the stomach), while 32 patients had a loop gastrojejunostomy as they had a large remnant gastric pouches.

7,Line 9; included instead of includes (generally methods are in the past tense)

This was corrected

8,Line 9: if there suspected LN... Would the authors please recheck the grammar in this sentence.

For TG, the resection included removal of the spleen if there was a suspected LN involvement at splenic hilum

9,Methods: In all patients, extended lymphadenectomy...Could the authors explain why extended lymphadenectomy was routinely implemented in their study. How this affected the morbidity of patients with T1 tumors. Did the authors ran endoscopic ultrasound evaluation prior to surgery?

Our center is a referral tertiary center, most of our patients comes with a relatively advanced tumor stage. **Only 10(13%)** patients had a T1 tumor stage. Intra-operatively there was much LN involvement. So our policy is to remove of all suspected LN involved with the disease. This does not add morbidity for such patients with T1 tumor. We did not use endoscopic ultrasound in our center. (this part is added to patients and methods)

Late diagnosis of our patients might be related to that, patients thought upper abdominal pain was just a dyspepsia and take long time before they thought a medical advice so Upper endoscopy was done late in our population.

10,Results:Paragraph 1, line 4: were males and were females

This was corrected

11,Results: Why table1 is in capital?Possible risk factors IN instead of OF

This was corrected

12,Locations (single) .. was the most common location.

This was corrected

13,Results:Operative data: The radicality of the operation... It is uncommon practice to extend the primary resection to hepatic lobe and colon. These cases are liable to peritoneal recurrence if it was not primarily involved. It is striking though that there are no data related to the preoperative staging procedure neither on the adjuvant or neoadjuvant therapy. Likewise, the incidence of postoperative complications, including the leak has been linked to the immunonutrition in those patients in the perioperative phase, the phase on which no information were given.

The radicality of the operation necessitates extension of the resection to the tail of the pancreas and to the spleen in 5 patients, to the colon in 2 patients and to the left liver lobe in one patient.

In those patients, there were no peritoneal dissemination, the tumor just infiltrate these adjacent stricture which could be removed safely together with the primary tumor as one piece (for fear of tumor dissemination during dissection and excision).

All patients did not receive a preoperative adjuvant or neoadjuvant therapy. I will add this sentence to the manuscript (methods)

Three patients (4%) had anastomotic leakage and were managed conservatively (2 patients after TG and 1 patient after STG). **the leakage after gastrectomy may be attributed to many factors like: Obesity, old age, malnutrition, surgeons related factors such as technique of reconstruction, congestion of the loop of small intestine (short mesentry) during the reconstruction procedure. In our study 3 patients had leakage that stopped spontaneously after conservative treatment.**

14,Results:There is no operative mortality.... Since the nuer of cases in limited similarly, it might be reasonable to present a flow chart linking the tumor location to the procedure and its extend to the complications.

Methods : STG was performed for tumors located in the lower and middle third of the stomach when a 3-6 cm tumor proximal free safety margin can be achieved. All the other patients underwent TG. Total gastrectomy was performed in 30 patients (38%) and subtotal gastrectomy in 50 patients (62%).

As regard to tumor location: STG was done for patients if the tumor located in the antrum, pyloric canal and body with a satisfactory safety margin at least 3-6 cm proximally. TG for tumors located in the fundus or gastric body with a small proximal safety margin. This is our policy, and here we don't compare between TG and STG. the complication in the current study occurred in a relatively small number : internal hemorrhage 1 patients, splenic bed collection 2 patients, pleural effusion 2 patients and wound infection in 2 patients

15,Results:The median survival was (69.96 months)...From where in figure 1 could the (not completed)