Roma 07/11/2021

Dear Editorial Office Director,

Thank you for the opportunity to respond to your e-mailed message.

My collaborators and I are pleased that our manuscript, entitled "MORTALITY AND MORBIDITY AFTER SURGERY FOR GASTRIC CANCER. A RETROSPECTIVE COHORT STUDY.", has met the requirements for publication in the World Journal of Gastroenterology (Manuscript NO: 72100).

We have read the comments of the two referees with interest.

The manuscript has been reviewed considering the comments in your letter.

In addition, the technical corrections requested have been carried out.

We have responded point by point to the suggestions of reviewers and this is shown below. Where we feel a change would improve the manuscript, this has been done and the change is highlighted in the text.

Reviewer #1:
Scientific Quality: Grade B (Very good)
Language Quality: Grade A (Priority publishing)
Conclusion: Accept (General priority)

Specific Comments to Authors: Personally, I do not recommend prophylactic cholecystectomy during cancer surgery due to its increased operative time and it's non-functional for the patient. Other than that, the article is good and practical. Good work.

My co-workers and I thank Reviewer 1 for the compliments on our work.
In relation to cholecystectomy, we believe that the removal of the gallbladder at the same time as the gastrectomy facilitates the execution of the hepatic pedicle lymphadenectomy and avoids the onset of biliary complications in the long term, especially in patients in the initial stage of the disease undergoing extensive lymphadenectomy.
An atony of the gallbladder is commonly observed, with progressive dilation of the gallbladder, after total or subtotal operations, especially in the case of exclusion of the duodenal transit.
We usually reconstruct digestive continuity with a Roux-en-Y gastrojejunostomy or a Roux Y-loop esophagojejunostomy.
In our experience, the association of cholecystectomy did not lead to biliary complications in the postoperative period in our patients undergoing total or subtotal gastric demolition with lymphadenectomy.
The procedure did not cause biliary complications. This aspect is controversial in the literature.
We believe that in patients with a radical resection, when a D2 lymphadenectomy is performed and the duodenum is excluded in the intestinal reconstruction, cholecystectomy, considered by some to be a non-essential measure, is necessary to avoid gallstone formation and its complications.
In this setting, we believe that prophylactic cholecystectomy is necessary for patients with a good cancer prognosis. Studies on the subject conclude that prophylactic cholecystectomy does not have a significant impact on the natural course of the disease.

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Reviewer #2:
Scientific Quality: Grade A (Excellent)
Language Quality: Grade A (Priority publishing)
Conclusion: Accept (High priority)

Specific Comments to Authors: The authors evaluated the impact of stage on morbidity and mortality of gastric cancer patients and concluded that mortality and morbidity rate were higher in N+ and advanced gastric cancer patients and the removal of more than 35 lymph nodes does not lead to an increase in mortality. This study could provide some useful suggestions for future clinical practice. As known to us, D2 lymphadenectomy is recommended in most East Asian countries such as China, Southern Korean and Japan, in your opinion, should D2 lymphadenectomy be routinely performed among gastric cancer patients and does the range of lymphadenectomy actually affect survival of gastric cancer patients? And as a suggestion, it is best to evaluate the impacts of the range of lymphadenectomy on survival of gastric cancer patients.

My co-workers and I thank Reviewer 2 for the compliments on our work.
We believe, in fact, that the favorable prognostic role of extensive lymphadenectomy is widely documented in the literature by many clinical trials on a very large number of cases. Conversely, smaller findings are reported regarding complications and mortality secondary to the execution of extensive lymphadenectomy.
My co-workers and I wanted to report early results in our patient population. We observed postoperative hemoperitoneum and pancreatic fistulas, especially in patients with removal of more than 35 lymph nodes.
My collaborators and I believe that lymphadenectomy, even more than the extent of gastric demolition, is the element with the most important prognostic significance in patients with stomach cancer.
We believe that the extent of lymphadenectomy is the only factor that can be influenced by the surgeon.
The total number of lymph nodes resected, or the total number of positive to negative ratio of lymph nodes have all been found to be predictors of survival in gastric cancer patients. For potentially resectable gastric cancer, a linear trend toward superior survival was found for higher lymph node removal up to 35-40 lymph nodes, based on the analysis of the SEER database from 1973 to 1999. Adjuvant therapy is used in advanced gastric cancer to improve the survival and may be useful in high-risk patients treated with limited lymph node dissection. Moreover, lymph node dissection remains crucial to make every effort to improve the prognosis in those patients unsuitable for any adjuvant treatment. In a study Biffi et al showed that extended lymph node resection offers survival benefit even in the subgroup of patients with early-stage disease. Evaluation of distant disease-free survival risk by number of harvested lymph nodes showed that the risk of recurrence is inversely proportional to the number of dissected lymph nodes. The results did not change when pT1 and pT2-3 cancers were analyzed separately, suggesting the need to remove at least 15 nodes even in patients with early-stage disease.

Science editor:

This retrospective study analyzed the factors that influence mortality and morbidity in 186 cases with gastric cancer who have undergone RO resection and D2 lymphadenectomy. The Results demonstrate that mortality was related to a Kattan's score and the presence of advanced gastric cancer. On the other hand, the incidence of morbidity was higher in cases with more than 35 harvested lymph nodes and was not related to mortality. The content of the study contains important information about gastric cancer surgery. However, The Core type is too long. Instead, please write a summary of no more than 100 words. The purpose of the study should be clearly stated in the introduction

section, not as a subheading in the material methods section. Please revise the manuscript according to the comments of the referees.

Language Quality: Grade A (Priority publishing)

Scientific Quality: Grade B (Very good)

The core tip has been modified according to the Editor's suggestions. The purpose of the study have been included in the paragraph "Introduction". The manuscript was revised in accordance with the suggestions made by the reviewers. The text was revised and corrected by a native English speaker (Dr. Neill James Adams).

Company editor-in-chief:

I have reviewed the Peer-Review Report, the full text of the manuscript, and the relevant ethics documents, all of which have met the basic publishing requirements of the World Journal of Gastroenterology, and the manuscript is conditionally accepted. I have sent the manuscript to the author(s) for its revision according to the Peer-Review Report, Editorial Office's comments and the Criteria for Manuscript Revision by Authors. Please authors are required to provide standard three-line tables, that is, only the top line, bottom line, and column line are displayed, while other table lines are hidden. The contents of each cell in the table should conform to the editing specifications, and the lines of each row or column of the table should be aligned. Do not use carriage returns or spaces to replace lines or vertical lines and do not segment cell content.

The tables have been modified in accordance with the recommendations of the Editor in Chief.

Thank You very much for your interest, we look forward to your reply.

Sincerely,

Giuseppe Brisinda