

July, 2020

World Journal of Gastrointestinal Surgery

Manuscript No: 57133

We would like to thank you for reviewing our manuscript, "Resection of the distal gastric tube with preservation of RGEA and RGA for gastric tube cancer: A case report.". We appreciate the opportunity to revise the manuscript according to the recommendations of the reviewers. Please find below our responses to those comments, together with any corrections. We have reorganized the manuscript after due consideration of the recommendations; all changes to the text written in red. Please contact me if you have any questions.

Sincerely,

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Reviewers' comments:

Reviewer #1:

#1. For stage T1b cancer, the standard treatment should include D2 lymphadenectomy rather than local excision, because of the difficulties identifying lymph node status pre-operatively.

Thank you for raising this important issue.

In general, total resection of the gastric tube with LN dissection is considered the standard radical treatment with D2 lymph adenectomy for gastric tube cancer for which ESD is not indicated. However, surgical removal of the reconstructed gastric tube is invasive and carries a relatively high risk of postoperative mortality (23.8%-33%). Furthermore, this procedure is complicated when the reconstruction route selected at the original esophagectomy was via the posterior mediastinum, because the gastric tube is surrounded by vital organs, including the heart, lungs, and aorta.

In this case, considering the patients risk (82 years old, chronic kidney dysfunction, middle aortic stenosis, surgery after esophagectomy), gastrectomy with D2 resection is not acceptable. The estimated lymph node metastasis rate is 10% in cT1b cases. In other words, 90% of cases are negative for lymph node metastasis, which means that there is a 90% chance that local excision can be a curative treatment. Therefore, we think that gastrectomy with lymph node

dissection with a mortality rate of near 30% (previously reported) should not be done for high-risk patients.

#2. There might exist residual tumor when the RGEA and RGA were preserved. Besides, the preservation of vessels might account for relatively long operation time.

Thank you for your important comment.

RGEA and RGA is main trunk to supply blood to gastric tube because LGA, LGEA and SGA was already cut at former operation to reconstruct using gastric tube. Thus, if we ligate the RGEA and RGA for lymph node dissection, we may have to perform complete resection of gastric tube due to ischemia of gastric tube. As noted in #1, such procedure is not acceptable for high-risk patients. Therefore, it is necessary to preserve the RGEA and RGA to keep blood supply.

#3. In INTRODUCTION part, the author noted that " Recent advances in the diagnosis and treatment of esophageal cancer have improved prognosis after esophagectomy but have also led to an increasing occurrence of gastric tube cancer", could you further demonstrate the association of improved prognosis of esophageal cancer and increased occurrence of GTC. The same situation also existed in DISCUSSION part "Due to recent advances in the diagnosis and treatment of esophageal cancer, surgical outcomes have improved and the prevalence of GTC after esophagectomy has increased to 2.1-3.5%".

Thank you for your important comment.

In the past, when esophageal cancer patients seldom survived for a long time, the occurrence of GTC was considered to be infrequent. If the prognosis is extended, the number of examinations that undergoes an endoscope will increase, and thus the frequency of detection will inevitably increase. In fact, the mean intervals from the original esophageal cancer to GTC was reported 60.9 (4-236) months, which is a relative long period. In addition, there have been many reports in which the occurrence of cancer in the remnant stomach after gastrectomy was considered to be the result of some mucosal injury induced by various factors including reflux of duodenal contents, H pylori infection, blood flow disturbance, and lost innervation caused by the previous gastrectomy. In other words, the longer a remnant stomach is exposed to them, the greater the incidence of gastric tube cancer.

#4. The language still needs some polishing.

Thank you for your advice.

We asked again for check by Native speaker.

#5. A systemic review of all eligible literatures regarding the clinical characteristics and treatment of GTC would be more tempting.

Thank you for your comments.

We reviewed the literature of gastric tube cancer and added information to our report in discussion (Line 22, p9- line 5, p10)

Reviewer #2:

#1. This article described the resection of the distal gastric tube with preservation of RGEA and RGA for gastric tube cancer. GTC that had invaded the duodenum has a certain probability of lymph node metastasis, especially in No.5 and No.6. Preservation of RGEA and RGA may affect the completeness of lymph node dissection. Such a surgical method also increases the operation time. Preservation of the gastric stump also increases the possibility of gastric stump cancer. However, for an 82-year-old patient, with hypertension and chronic renal disease, such a surgical approach maybe reasonable. Please provide images of enhanced CT scans.

Thank you for your comments.

Since this patient had chronic renal dysfunction, contrast-enhanced CT examination was not performed and only plain CT was performed. Images of plain CT have been added to the report.