

March 4<sup>th</sup> , 2014

Dear Editor,

Please find enclosed the edited manuscript in Word format (file name: 7836-edited.docx).

**Title:** Laparoscopic gastric surgery for cancer: Where do we stand?

**Author:** Pantelis Antonakis, Hutan Ashrafian, Alberto Martinez-Isla

**Name of Journal:** *World Journal of Gastroenterology*

**ESPS Manuscript NO: 7836**

The manuscript has been improved according to the suggestions of reviewers:

1 Format has been updated

2 Revision has been made according to the suggestions of the reviewers as follows

Reviewer 00055311

Comment1: "However, there are some redundancies in the section for early (stage) gastric cancer regarding the differences between East and West, which might be shortened a little bit. Especially regarding the background that one of the author's central arguments is the approximation regarding surgical treatment of gastric cancer between East and West."

Reply 1

The section on early stage gastric cancer differences between the east and west has been significantly shortened in accordance with the reviewer's suggestions ( manuscript pages 4-6)

Comment 2: "One aspect in training should be mentioned in my opinion as many technical aspects of dissection and resection of the proximal stomach as well as technical aspects of esophagojejunal or proximal gastrojejunal anastomoses have been developed and practiced by bariatric surgeons since decades laparoscopically. Laparoscopic gastric cancer surgeons may profit from these experiences in their clinical training by an internship in a bariatric/metabolic surgical unit."

Reply 2: The underlying idea of this comment is fully incorporated in the revised manuscript p19-20 in the following text "For Western health systems an important available educational pathway is the experience that can be gained in the context of a fellowship in a bariatric surgical unit. Bariatric surgery with all the surgical manoeuvres and anastomoses performed in the oesophagogastric junction area is probably the second best stepping stone for a future laparoscopic gastric cancer surgeon."

Reviewer 00040587

Comment 1: "The paragraph "Laparoscopic distal gastrectomy" is a bit long, especially regarding the short and long term outcomes. It would be better maybe to shorten a bit and insert one or two tables, at least, to fix better the current literature."

Reply 1: The section referred in this comment has been formally revised and shortened (manuscript pages 7-16). Furthermore, Table 1 was added for manuscript succinctness.

Comment 2: "Since authors also described the technique, I guess inserting the most common trocar layout could be a good idea. "

Reply 2: In order to communicate the most common trocar layout, we have added a new Figure 1 to depict this.

Comment 3: "In order to get a more clear schematic work, I suggest to insert a subparagraph of short and long term outcomes also for lap total gastrectomy."

Reply 3: The short and long term results were given a heading in p18 of the revised manuscript and also a subparagraph was inserted as suggested starting from "Dulucq et al [64] in 2005 and Husher al [65] in 2007 from Europe published 8 and 11 laparoscopic total gastrectomies respectively, showing the feasibility of the operation in the Western setting. Median operative time was approximately..." and finishing at "... On the other hand Eastern surgeons continued publishing their results, thus allowing the comparison between laparoscopic and open gastrectomy by means of several large sized recent contemporary meta-analyses [69-71]."

Comment 4: "In the paragraph about robotic assisted lap gastrectomy, the authors state that "the smaller view of the operating field is one of the main drawbacks of the rob technique". Actually, I think that a great knowledge of anatomy and of the area where you are working is mandatory to be able to perform a surgery in a smaller area. This might be a limitation just before the surgeon has not overcome the learning curve. After this step, working in a narrow operating field helps to focus on the target area without any additional retraction. The rob technique is really helpful in case of narrow areas since it can provide an optimal view and the technical advantages of the instrumentation let to do a very precise surgery. For instance, in case of gastric surgery, the surgical steps all around the oesophagus-gastric junction in case of lymphadenectomy or when an anastomosis has to be performed during a total gastrectomy are much more easy to carry out by rob approach."

Reply 4: The comment regarding the smaller operating field being a disadvantage only at the beginning of the robotic experience was incorporated in p21 of the revised manuscript as follows "Robotic assistance is one of the latest adjuncts to laparoscopic gastrectomy. The high cost and the increased operating times are the main drawbacks of the technique. Another potential disadvantage is the smaller view of the operating field, at least at the beginning of the robotic experience"

The comment on the advantages of the focused operating field was also incorporated in p21 of the revised manuscript as follows "The aforementioned advantages are theoretically well suited for the special needs of the minimally invasive (MI) surgery for gastric cancer. Visualisation of a small and focused operating field, combined with enhanced dexterity and movement precision are of utmost importance in the dissection around vessels during lymphadenectomy, especially near the pancreas and the spleen, and definitely during the construction of the OJ anastomosis, in case of total gastrectomy."

3 References and typesetting were corrected

Thank you again for publishing our manuscript in the *World Journal of Gastroenterology*.

Sincerely yours,



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