Palliation for “advanced” gastric cancer

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Dear Editor,

I read the article by Maturu et al with great interest [1]. The authors retrieved the medical records of 98 patients with “advanced” gastric carcinoma who underwent laparotomy over a period of 2 years (March 2003 to February 2005). Survival data was available for 42 of the 98 patients. Fifteen out of these 98 patients could be followed up at the time of the study. These 15 patients underwent either gastric “resection” (n=10) or gastric “bypass” (n=5). The aim of the study was to ascertain whether surgery (resection versus bypass versus neither) had palliated the symptoms in patients with “advanced” gastric carcinoma.

I would like the authors and the editors of the Indian Journal of Surgery to clarify certain issues regarding the article.

Firstly, the authors do not state their definition of “advanced” gastric carcinoma. On careful scrutiny of the data presented in Table 1, we find 32 out of the 98 patients underwent gastric resection. Only 21 patients out of the 32 however, had either serosal spread (n=10), adhesion to pancreas (n=2) or other organs (n=5), omental deposits (n=1) or free fluid (n=3). This implies that 11 or more patients who underwent gastric resection may not have had features of “advanced” gastric carcinoma. Unfortunately, the pathologic staging for gastric cancer (as proposed by the American

Joint Committee on Cancer), was not ascertained in any of the patients in this study.

The authors state elsewhere that “in patients undergoing gastric bypass or exploratory laparotomy alone, the tumor progress to a *stage* beyond which surgical resection is possible” (pg 241). The authors also state that “the lower survival time of the resection group in our study (as compared to other studies) could be because of the *more advanced stage* of the disease with which our patients presented” (pg 241). Was the clinical or pathological lymph node status ascertained in any of these patients? This could have affected the survival analysis in these patients. Moreover, there is no information on adjuvant therapy received by these patients, which also could have influenced survival.

Secondly, the authors state that 78 out of the 98 patients had antral carcinoma (pg 239). Why were patients (n=20) with body, cardia or diffuse cancers included in the study, when the aim of the study was to define the “role of bypass” (gastro-jejunostomy)?

Thirdly, the authors state that pain and bleeding were the most common symptoms in the 15 patients who could be followed up (Table 3). How “bypass” alone palliated the symptoms of pain and bleeding in at least 3 of these patients is not elaborated by the authors.

Fourthly, among these 15 patients the authors state that they found “no significant *difference* in patient satisfaction with palliation of symptoms” between the resection and bypass groups (pg 239). The authors therefore conclude that palliation of symptoms is “equally *good*” in resection and bypass groups (pg 241). However, there is no mention of pain scores or number of episodes of vomiting or weight measurements before or after surgery. There is no objective or subjective evidence of the magnitude of symptomatic improvement in either of the groups. Hence the statistical result of an insignificant P value between

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the groups could indicate equally *poor* results in both the groups as well.

Fifthly, the authors have **no** follow up data on the palliation afforded to the patients who underwent a laparotomy without resection or bypass (Table 3). It is a well known fact that once a patient undergoes laparotomy for gastric carcinoma and the tumor cannot be resected, a surgical bypass is done to palliate symptoms of distal obstruction (if present). The question that should be asked is **not if** bypass can palliate. We know the answer is yes, when performed for symptomatic distal obstruction. Rather studies should be undertaken to ascertain the indications for performing surgical procedures versus endoscopic duodenal stenting [2] or the use of adjuvant therapy [3, 4] for palliating symptoms in patients with stage IV gastric cancer. Improving the quality of life with minimal surgical intervention should be the goal of our endeavors in these patients.

Sixthly, the authors state that the mean survival of “advanced” gastric carcinoma is ten months as per their study and 12–18 months as per other studies (pg 241). If the survival of “advanced” gastric carcinoma is so short, why did the authors send post cards to recall patients more than 2 years after their first patient was operated? If they had included patients operated within a year of their study, their follow up rate could have improved.

Seventhly, the authors do not state their reasons for not performing a palliative resection in patients where it could have been possible to increase survival (as they themselves state). One gets a confusing picture from Table 1 which shows that, 6% and 15% of patients (n=32) underwent resection in spite of adherence to the pancreas or other adjacent organ(s) respectively; whereas 59% and 79% of patients respectively (n=44) underwent bypass because of the same reasons. Palliative resections are not necessarily R0 resections. The authors need to clarify their stand of not attempting a resection in some patients while resecting tumors in other similar patients.

Lastly, there are numerous glaring copy-editing and typographic errors. The corresponding author has been erroneously labeled as a Professor of Surgery when in fact he was a medical student when the present study was conducted [5]. The principal investigators of this study viz. the senior authors on the other hand have been erroneously labeled as assistant professors [6]. The source of funding for the study has not been mentioned either.

In conclusion, I would like to suggest that IJS should make the process of peer-review and copy-editing more stringent. The drawbacks of a study and the key educational points should be clearly mentioned at the end of the article. A well written article is one which gives a clear message to the reader and is not a mere repetition of known facts.

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RETRACTION NOTICE

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The above article has been published twice by an oversight, once in December 2007 and again in December 2008. We have received a letter to editor on the version published in 2007. We are retracting the 2008 version (10.1007/s12262-008-0089-6) as this is a duplicate publication.

The publishers would like to apologise for this error.