Current Trends in the Treatment of Gastric Cancer in Japan

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There are changing trends of gastric cancer in Japan, such as increase of early and minute gastric cancer, increase of localized type and cardiac cancer. The incidence of early gastric cancer has greatly increased in our country. The standard treatment of gastric cancer has become more complicated. What is the concept of standard treatment of gastric cancer? The Japanese Gastric Cancer Association published the guidelines for the treatment of gastric cancer at this spring.

At first, I will focus on the indication of endoscopic mucosal resection (EMR). What are standard criteria for curative EMR for early gastric cancer? There are some issues concerning mucosal gastric cancer which might be indicated: lymph node metastasis is found in 2 to 3%, multifocal mucosal cancer is found in 8 to 15%, and occurring of secondary cancer after 10 year might be found in nearly 10% of cases. So, in applying EMR for early gastric cancer, we have to pay more attention to these issues. Furthermore, the indications of EMR or limited operation are determined by a gross diagnosis of the mucosal cancer by preoperative or intra-operative assessment. But, we should always keep in mind that nearly 20% of the clinical mucosal cancers were found to be deeper than mucosal cancers by histopathology.

Recently, less invasive surgery has greatly advanced and become familiar in Japan. How should we deal with less invasive surgery for early gastric cancer? In the new guidelines, 2 types of limited operations were proposed: A and B type. Limited operation A means D1+alpha. Alpha means the dissection of No. 7 station, left gastric artery. If the tumor is located in the lower third of the stomach, No. 8a (common hepatic artery) should be dissected. As another issue, we have to consider the clinical significance of micrometastasis in the treatment of gastric cancer. Surprisingly, we found micrometastasis in 11% of the cases with submucosal cancer, which were diagnosed as having negative node by HE stain. Concerning micrometastasis, however, there is a lot of confusions and no consensus about clinical significance. As another topic, nowadays, sentinel node navigation surgery has become a current trend in oncological surgery, as you know. Is SNNS for early gastric cancer applicable? My answer is probably, yes. However, we have to resolve the technical problems and establish a standard procedure.

What is the optimal extent of lymphadenectomy for advanced gastric cancer? As for advanced gastric cancer, a gastrectomy more than 2/3 plus D2 lymphadenectomy has been well accepted as a standard

operation. Every Japanese surgeon agrees to it. Japanese general rules have clearly a defined standard operation for advanced gastric cancer. That is, when the tumor is located in the middle third with lower extension, antrectomy is recommended. When the tumor extends into the upper portion, total gastrectomy should be indicated.

As the last topic, I will focus on the clinical significance of extended lymphadenectomy including paraaortic dissection.

In summary, I would like to emphasize the selection of operation methods according to: 1) spread of the tumor, 2) activity and background of each patient, 3) biological behavior of the tumor. As a result, we have to establish true standard treatment and order-made treatment.