at the NCCH, I reviewed the radiology and witnessed the mind that, apart from the proportion of early stage disease, gastric treatment of all stages of gastric cancer. There is no doubt in my between the UK and Japan are only slight. In my two-month stay tumours is certainly increasing in the UK but the differences recent MRC randomised controlled trial, 56% of patients underwent a total gastrectomy (2). The incidence of proximal gastric cancer patients treated by the gastric surgery division in conjunction with greater population awareness has lead to the Japanese gastric surgical practice I can address these two hypotheses in randomised trials. I have recently had the opportunity to visit the National Cancer Center Hospital (NCCH) where I co-operate in clinical trials (4). Study number JCOG 9501 is one of five current studies in gastric cancer, four of which are run by JCOG. This study is designed to compare the standard D2 dissection with a D4 dissection in patients with advanced gastric cancer. The hypothesis is that patients with a locally advanced tumour, i.e. at least involvement of the subserosal layer but without evidence of distant or peritoneal disease, will benefit from an extended lymphadenectomy. The eligibility criteria are strict, to ensure that only the correct sub-groups are included and the patients are randomised during the operation. Recruitment started 18 months ago and 155 patients have been recruited to date with a total of 404 needed to complete the study. Study number JCOG 9502 is a randomised trial in patients with tumours of the cardia encroaching on the oesophagus. Patients are randomised to either an abdominal approach or to a thoraco-abdominal approach, which may allow a more radical lymphadenectomy at the expense of a higher operative mortality. Two randomised studies of adjuvant chemotherapy are currently recruiting; one in patients with positive peritoneal cytology (JCOG 9701) and a second in patients with pT2 disease and lymph node metastases (NSAS-GC). A randomised study of adjuvant chemotherapy in tumours without serosal involvement (JCOG 9206–1) has recently finished recruiting and a study of adjuvant chemotherapy in locally advanced tumours (JCOG 9206–2) is due to complete recruitment in March 1998.

It appears that Japanese surgeons are willing to test their hypotheses in randomised clinical trials and that Japanese patients will consent to such trials when appropriately counselled. Perhaps of more importance is that, unlike British surgeons, the leading Japanese surgeons will not adopt new surgical practice as routine

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The Pre-conceived British Beliefs of Gastric Cancer in Japan Need to be Changed

To the Editor:
British surgeons have long been criticised for their poor quality research and reliance on historical reviews of their own personal series. A brief read of any surgical journal over the last five years will seldom reveal a randomised surgical trial, a point noted by Richard Horton (Editor of The Lancet) when he described British surgical research as comic opera (1).

When British surgeons compare their own results for gastric cancer surgery with those of Japanese surgeons, two excuses are offered: firstly gastric cancer in Japan is a different disease than in the West and secondly Japanese surgeons refuse to test their hypotheses in randomised trials. I have recently had the opportunity to visit the National Cancer Center Hospital (NCCH) in Tokyo and feel that after such a thorough introduction to Japanese gastric surgical practice I can address these two misconceptions.

The gastric surgery division of the NCCH, in conjunction with the endoscopy division, will treat approximately 430 gastric cancer cases per year. Approximately 60% of these will be early gastric cancer (limited to the mucosa and submucosa only) whereas the proportion of early cases in the UK is nearer to 20% (2). The incidence of gastric cancer in Japan however, is approximately five times that in the UK. The Japanese government established a screening programme 30 years ago and this, in conjunction with greater population awareness has lead to the greater proportion of early disease being treated. In 1996, 40% of gastric cancer patients treated by the gastric surgery division underwent either total or proximal gastrectomy, while in the recent MRC randomised controlled trial, 56% of patients underwent a total gastrectomy (2). The incidence of proximal tumours is certainly increasing in the UK but the differences between the UK and Japan are only slight. In my two-month stay at the NCCH, I reviewed the radiology and witnessed the treatment of all stages of gastric cancer. There is no doubt in my mind that, apart from the proportion of early stage disease, gastric cancer in Japan appears both macroscopically and microscopically to be exactly the same as gastric cancer in the UK.

The standard gastrectomy in Japan is a D2 resection and this is performed with almost no mortality and minimal morbidity. It is true that Japanese surgeons are not prepared to test their standard resection against the British D1 resection. The surgical mortality rates at the NCCH are under 1%, when this is compared to the 6.5% mortality rate in the D1 resection group in the MRC trial and the fact that the NCCH can achieve an overall five-year survival rate of 71.8% (all stages), who can blame them (2,3).

Japanese surgeons, like surgeons all over the world, are constantly looking at methods of improving their survival rates and so the D4 resection was devised. A D4 dissection can now be performed with no increased mortality over a D2 dissection, with only a slightly longer post-operative stay and a slightly higher morbidity. The safety and tolerability of the treatment has therefore, been established. It is at this point that the British surgical community would expect their Japanese colleagues to amass a large personal series and present and publish their data recommending this procedure as the cure for gastric cancer. This approach may have been true in the past but it is no longer the case.

The Japanese Clinical Oncology Group (JCOG) consists of major oncology centres (both public and private) around Japan who co-operate in clinical trials (4). Study number JCOG 9501 is one of five current studies in gastric cancer, four of which are run by JCOG. This study is designed to compare the standard D2 dissection with a D4 dissection in patients with advanced gastric cancer. The hypothesis is that patients with a locally advanced tumour, i.e. at least involvement of the subserosal layer but without evidence of distant or peritoneal disease, will benefit from an extended lymphadenectomy. The eligibility criteria are strict, to ensure that only the correct sub-groups are included and the patients are randomised during the operation. Recruitment started 18 months ago and 155 patients have been recruited to date with a total of 404 needed to complete the study.

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It appears that Japanese surgeons are willing to test their hypotheses in randomised clinical trials and that Japanese patients will consent to such trials when appropriately counselled. Perhaps of more importance is that, unlike British surgeons, the leading Japanese surgeons will not adopt new surgical practice as routine
until it has been tested to their own satisfaction in a randomised controlled trial.

This only leaves one question unanswered. Why are the Japanese results for gastric cancer surgery, stage for stage, so superior to those in the UK? I believe that the reasons are now clearer. The higher operative mortality amongst UK patients is partly related to the slightly older patient group and to the higher incidence of ischaemic heart disease and chronic pulmonary disease seen within the UK population. The most important factors however, which lead to both a lower operative mortality and improved survival, in stage matched patients, were neatly summarised by R Welbourn (1997) when he wrote that Japanese surgeons achieve gentleness, haemostasis, minimal trauma and meticulous accuracy (5). We can now add that as well as being master craftsmen, the leading Japanese surgeons base their surgical judgement on sound science.

I would like to thank the Foundation for Promotion of Cancer Research and the British Council of Japan for their generous support and the surgeons of the gastric division of the NCCH for allowing me to witness at first hand how cancer surgery can and should be practised. This experience should allow me to change my personal practice and perhaps help to change some of the misconceptions amongst British surgeons.

References


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