



# Actualités ESTOMAC

Lorient

C. Mongin

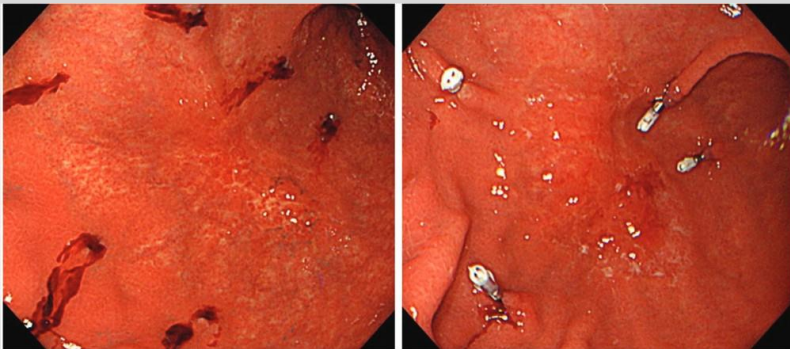


# Améliorer la qualité d'exérèse chirurgicale

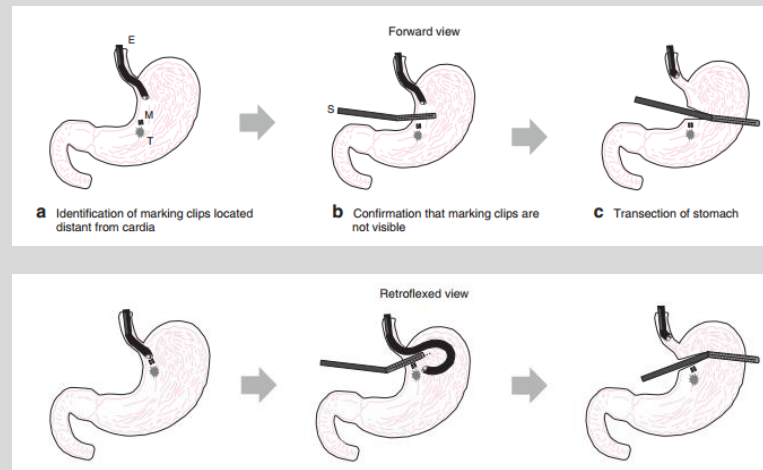
[Br J Surg.](#) 2017 Sep 11. doi: 10.1002/bjs.10618. [Epub ahead of print]

## Use of endoscopy to determine the resection margin during laparoscopic gastrectomy for cancer.

[Kawakatsu S](#)<sup>1,2</sup>, [Ohashi M](#)<sup>1</sup>, [Hiki N](#)<sup>1</sup>, [Nunobe S](#)<sup>1</sup>, [Nagino M](#)<sup>2</sup>, [Sano T](#)<sup>1</sup>.



99% marges négatives



[J Gastric Cancer.](#) 2017 Sep;17(3):220-227. doi: 10.5230/jgc.2017.17.e25. Epub 2017 Aug 25.

## A Promising Method for Tumor Localization during Total Laparoscopic Distal Gastrectomy: Preoperative Endoscopic Clipping based on Negative Biopsy and Selective Intraoperative Radiography Findings.

[Chung JW](#)<sup>1</sup>, [Seo KW](#)<sup>1</sup>, [Jung K](#)<sup>2</sup>, [Park MI](#)<sup>2</sup>, [Kim SE](#)<sup>2</sup>, [Park SJ](#)<sup>2</sup>, [Lee SH](#)<sup>1</sup>, [Shin YM](#)<sup>1</sup>.

# Gastrectomie par voie coelioscopique ?

[Ann Surg.](#) 2012 Mar;255(3):446-56. doi: 10.1097/SLA.0b013e31824682f4.

**Laparoscopic versus open distal gastrectomy for gastric cancer: a meta-analysis of randomized controlled trials and high-quality nonrandomized studies.**

[J Am Coll Surg.](#) 2010 Nov;211(5):677-86. doi: 10.1016/j.jamcollsurg.2010.07.013.

**Laparoscopic surgery for gastric cancer: a collective review with meta-analysis of randomized trials.**

[Kodera Y](#)<sup>1</sup>, [Fujiwara M](#), [Ohashi N](#), [Nakayama G](#), [Koike M](#), [Morita S](#), [Nakao A](#).

[Ann Surg.](#) 2012 Jul;256(1):39-52. doi: 10.1097/SLA.0b013e3182583e2e.

**Laparoscopy-assisted versus open distal gastrectomy for early gastric cancer: evidence from randomized and nonrandomized clinical trials.**

[Zeng YK](#)<sup>1</sup>, [Yang ZL](#), [Peng JS](#), [Lin HS](#), [Cai L](#).



Résultats oncologiques similaires  
Bénéfice sur la récupération post-opératoire

# Gastrectomie par voie coelioscopique ?

[Ann Surg](#). 2016 Jan;263(1):28-35. doi: 10.1097/SLA.0000000000001346.

## **Decreased Morbidity of Laparoscopic Distal Gastrectomy Compared With Open Distal Gastrectomy for Stage I Gastric Cancer: Short-term Outcomes From a Multicenter Randomized Controlled Trial (KLASS-01).**

[Kim W<sup>1</sup>](#), [Kim HH](#), [Han SU](#), [Kim MC](#), [Hyung WJ](#), [Ryu SW](#), [Cho GS](#), [Kim CY](#), [Yang HK](#), [Park DJ](#), [Song KY](#), [Lee SI](#), [Ryu SY](#), [Lee JH](#), [Lee HJ](#); [Korean Laparo-endoscopic Gastrointestinal Surgery Study \(KLASS\) Group](#).

1416 patients randomisées

Taux complications globales (coelio 13.0% vs open 19.9%, P = 0.001)

Taux complications abdominales (coelio 3.1% vs open 7.7%, P < 0.001).

[BMC Cancer](#). 2015 May 5;15:355. doi: 10.1186/s12885-015-1365-z.

## **Efficacy of laparoscopic subtotal gastrectomy with D2 lymphadenectomy for locally advanced gastric cancer: the protocol of the KLASS-02 multicenter randomized controlled clinical trial.**

[Hur H<sup>1</sup>](#), [Lee HY<sup>2</sup>](#), [Lee HJ<sup>3</sup>](#), [Kim MC<sup>4</sup>](#), [Hyung WJ<sup>5</sup>](#), [Park YK<sup>6</sup>](#), [Kim W<sup>7</sup>](#), [Han SU<sup>8</sup>](#).

[Surg Endosc](#). 2017 Jul 19. doi: 10.1007/s00464-017-5730-7. [Epub ahead of print]

## **Long- and short-term outcomes of laparoscopic gastrectomy versus open gastrectomy in patients with clinically and pathological locally advanced gastric cancer: a propensity-score matching analysis.**

[Inokuchi M<sup>1</sup>](#), [Nakagawa M<sup>2</sup>](#), [Tanioka T<sup>2</sup>](#), [Okuno K<sup>2</sup>](#), [Gokita K<sup>2</sup>](#), [Kojima K<sup>3</sup>](#).



Biais technique  
Trop précoce pour recommandations ?

# Jéjunostomie

J Gastrointest Surg. 2017 Feb;21(2):259-265. doi: 10.1007/s11605-016-3297-6. Epub 2016 Oct 26.

## **Complications of Feeding Jejunostomy Tubes in Patients with Gastroesophageal Cancer.**

Choi AH<sup>1</sup>, O'Leary MP<sup>1</sup>, Merchant SJ<sup>2</sup>, Sun V<sup>3</sup>, Chao J<sup>4</sup>, Raz DJ<sup>1</sup>, Kim JY<sup>1</sup>, Kim J<sup>5</sup>.

World J Gastrointest Surg. 2017 Feb 27;9(2):53-60. doi: 10.4240/wjgs.v9.i2.53.

## **Critical analysis of feeding jejunostomy following resection of upper gastrointestinal malignancies.**

J Surg Oncol. 2015 Aug;112(2):195-202. doi: 10.1002/jso.23983. Epub 2015 Aug 4.

## **An assessment of feeding jejunostomy tube placement at the time of resection for gastric adenocarcinoma: A seven-institution analysis of 837 patients from the U.S. gastric cancer collaborative.**

Dann GC<sup>1</sup>, Squires MH 3rd<sup>1</sup>, Postlewait LM<sup>1</sup>, Kooby DA<sup>1</sup>, Poultides GA<sup>2</sup>, Weber SM<sup>3</sup>, Bloomston M<sup>4</sup>, Fields RC<sup>5</sup>, Pawlik TM<sup>6</sup>, Votanopoulos KI<sup>7</sup>, Schmidt CR<sup>4</sup>, Ejaz A<sup>6</sup>, Acher AW<sup>3</sup>, Worhunsky DJ<sup>2</sup>, Saunders N<sup>4</sup>, Levine EA<sup>7</sup>, Jin LX<sup>5</sup>, Cho CS<sup>3</sup>, Winslow ER<sup>3</sup>, Russell MC<sup>1</sup>, Cardona K<sup>1</sup>, Staley CA<sup>1</sup>, Maithe SK<sup>1</sup>.

Complications infectieuses (36% vs. 19%; P < 0.001)



Complications propres  
Non systématique : malades sélectionnés



# Ganglion sentinelle

[World J Surg](#). 2017 Sep 18. doi: 10.1007/s00268-017-4226-x. [Epub ahead of print]

## **Sentinel Node Navigation Surgery for Early Gastric Cancer: Analysis of Factors Which Affect Direction of Lymphatic Drainage.**

[Shida A](#)<sup>1</sup>, [Mitsumori N](#)<sup>2</sup>, [Fujioka S](#)<sup>2</sup>, [Takano Y](#)<sup>2</sup>, [Fujiisaki M](#)<sup>2</sup>, [Hashizume R](#)<sup>2</sup>, [Takahashi N](#)<sup>2</sup>, [Ishibashi Y](#)<sup>2</sup>, [Yanaga K](#)<sup>2</sup>.

[Ann Med Surg \(Lond\)](#). 2017 Jun 27;20:61-65. doi: 10.1016/j.amsu.2017.06.019. eCollection 2017 Aug.

## **New method of indocyanine green fluorescence sentinel node mapping for early gastric cancer.**

[Ohdaira H](#)<sup>1</sup>, [Yoshida M](#)<sup>1</sup>, [Okada S](#)<sup>2</sup>, [Tsutsui N](#)<sup>1</sup>, [Kitajima M](#)<sup>1</sup>, [Suzuki Y](#)<sup>1</sup>.

[World J Surg Oncol](#). 2017 May 16;15(1):103. doi: 10.1186/s12957-017-1159-7.

## **Feasibility and diagnostic performance of dual-tracer-guided sentinel lymph node biopsy in cT1-2N0M0 gastric cancer: a systematic review and meta-analysis of diagnostic studies.**

[Huang L](#)<sup>1</sup>, [Wei T](#)<sup>1</sup>, [Chen J](#)<sup>2</sup>, [Zhou D](#)<sup>3</sup>.

[Transl Gastroenterol Hepatol](#). 2017 May 9;2:42. doi: 10.21037/tgh.2017.05.02. eCollection 2017.

## **Laparoscopic sentinel node navigation surgery for early gastric cancer.**

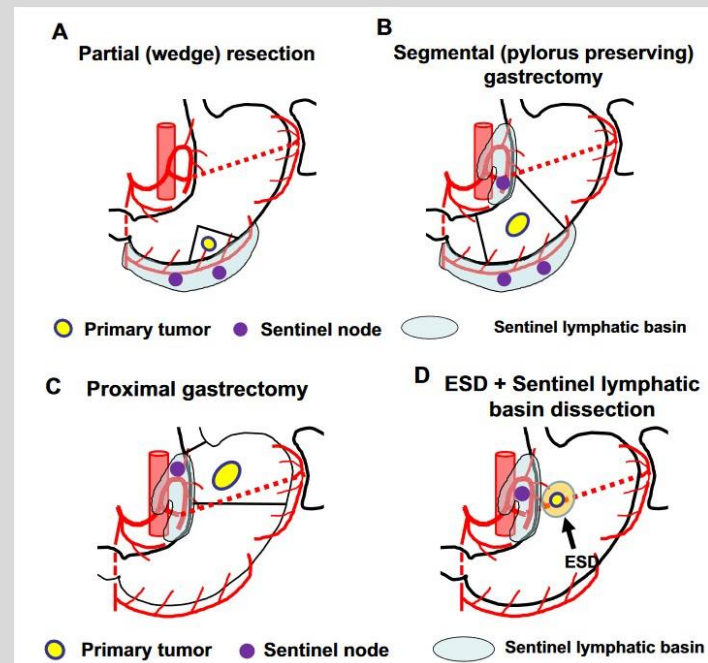
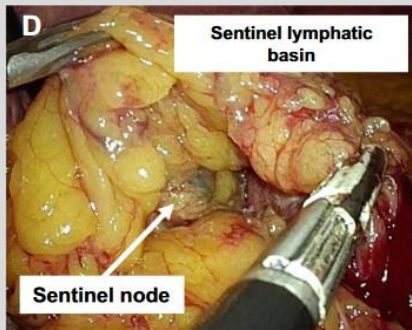
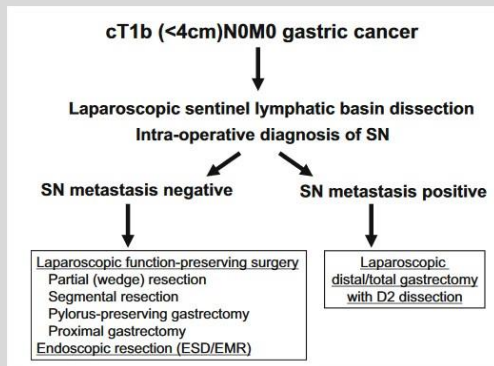
[Kinami S](#)<sup>1</sup>, [Kosaka T](#)<sup>1</sup>.

# Ganglion sentinelle : Préservation

*Gastric Cancer*. 2017 Mar;20(Suppl 1):53-59. doi: 10.1007/s10120-016-0649-6. Epub 2016 Oct 6.

## Function-preserving gastrectomy based on the sentinel node concept in early gastric cancer.

Takeuchi H<sup>1</sup>, Goto O<sup>2</sup>, Yahagi N<sup>2</sup>, Kitagawa Y<sup>3</sup>.

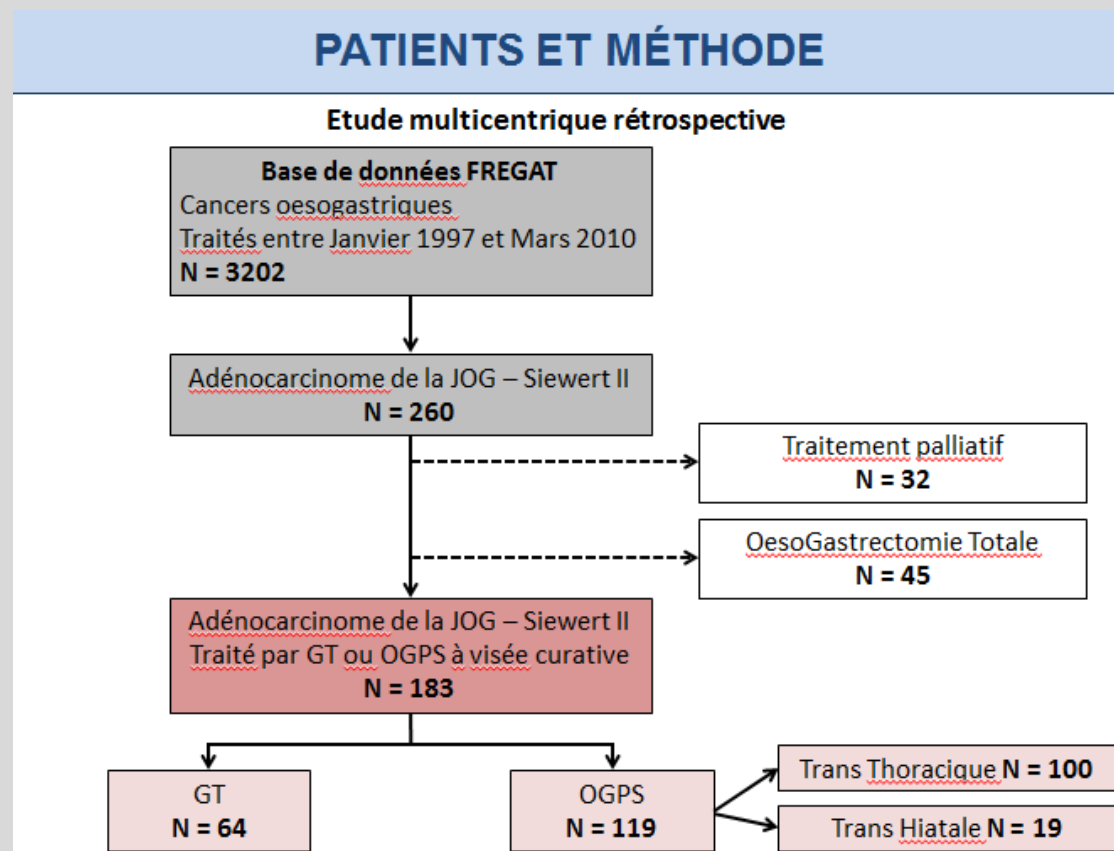


## Communication Orale AFC

### Adénocarcinomes de la jonction oeso-gastrique Siewert II : gastrectomie totale ou oesogastrectomie polaire supérieure ?

T. Voron, C. Gronnier, A. Pasquer, J. Théreaux, J. Gagnière, G. Lebreton, B. Meunier, D. Collet, C. Mariette, F. Paye. Fregat Working Group-French-Afc

## PATIENTS ET MÉTHODE





Adénocarcinomes de la jonction oeso-gastrique Siewert II : gastrectomie totale ou oesogastrectomie polaire supérieure ?

**Le type de résection chirurgicale effectuée (GT vs OGPS) est un facteur pronostique indépendant de survie globale et sans récurrence**

- Survie globale à 5 ans : 49% vs 31%
- Survie Sans Récurrence à 5 ans : 47% vs 30%

**Morbi-mortalité péri-opératoire comparable**

**Qualité d'exérèse, la GT :**

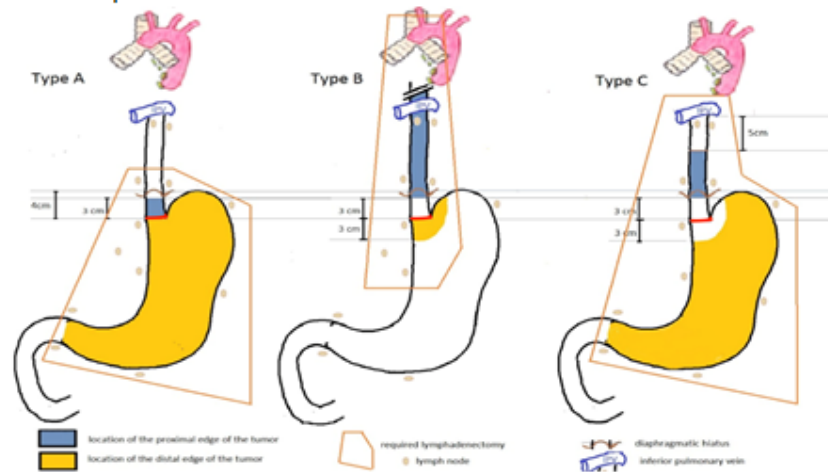
- Analyse de plus de ganglions: 23,5 vs 19,5 (p=0,009)
- Risque de résection R1: 12,5% vs 5,9% (p=0,115)

Adénocarcinomes de la jonction oeso-gastrique Siewert II : gastrectomie totale ou oesogastrectomie polaire supérieure ?

## CLASSIFICATION FREGAT

**Classification pragmatique, reposant sur 2 principes:**

- Résection R0
- Curage ganglionnaire optimal



Type	<u>Limite sup. tumeur - ligne Z</u>	OU	<u>Limite sup. tumeur - hiatus</u>	ET	<u>Limite inf. tumeur - ligne Z</u>	<u>Résection chirurgicale</u>
A	≤ 3cm		≥ 1cm			GT
B	> 3cm		< 1 cm		≤ 3cm	OGPS
C	>3cm				> 3cm	OGT



Si GT permet a priori d'obtenir R0, elle doit être préférée à l'OGPS : Siewert II