locoregional recurrence for antral cancer for both intestinal and diffuse types of carcinomas, according to Lauren classification. Because total gastrectomy has an increased morbidity, subtotal gastrectomy is the treatment of choice for antral cancer. The spleen and pancreas should be preserved. Whether a D2 lymphadenectomy should be performed in addition to subtotal gastrectomy is still open for debate; however, the current data indicate that it should be performed only in experienced centers with low morbidity and mortality rates.

References

1. Robertson CS, Chung SCS, Woods SDS, et al. A prospective randomized trial comparing R_1 subtotal gastrectomy with R_3 total gastrectomy for antral cancer. Ann Surg 1994; 220:176–182.
2. Roukos D, Schmidt-Mathiesen A, Encke A. Adenocarcinoma of the gastric antrum: does D2 total gastrectomy with splenectomy improve prognosis compared to D1 subtotal gastrectomy? A long-term survival analysis with emphasis on Lauren classification. Surg Oncol 1996; 5 (in press).
3. Boettcher K, Siewert JR, Roder JD, et al. fuer die Deutsche Magencarcinom-Studiengruppe (GGCS '92). Risiko der chirurgischen Therapie des Magencarcinoms in Deutschland. Chirurg 1994; 65: 298–306.
4. Dent DM, Madden MV, Price SR. Randomised comparison of R_1- and R_2-gastrectomy for gastric carcinoma. Br J Surg 1988; 75:110–112.
5. Bonenkamp JJ, Songun I, Hermans J, et al. Randomised comparison of morbidity after D1 and D2 dissection for gastric cancer in 996 Dutch patients. Lancet 1995; 345:745–748.
6. Marujama K, Okabayashi K, Kinoshita T. Progress in gastric cancer surgery in Japan and its limits of radicality. World j Surg 1987; 11:418–425.
7. Smith JW, Shiu MH, Kelsey L, Brennan MF. Morbidity of radical lymphadenectomy in the curative resection of gastric carcinoma. Arch Surg 1991; 126:1469–1473.
8. Siewert JR, Boettcher K, Roder JD, et al. Prognostic relevance of systematic lymph node dissection in gastric carcinoma. Br J Surg 1993; 80:1015–1018.
9. Roukos D, Hottenrott C, Lorenz M, Koutsogiorgas-Couchell S. A critical evaluation of effectivity of extended lymphadenectomy in patients with carcinoma of the stomach. J Cancer Res Clin Oncol 1990; 116:307–313.
10. Roukos D, Baltogiannis G, Cassioumis D. Prognostic relevance of systematic lymph node dissection in gastric carcinoma. Br J Surg 1995; 82:1287–1289 (letter).
11. Siewert JR. Lymphadenectomy for gastric cancer (invited commentary). World J Surg 1995; 19:553.
12. Roder JD, Boettcher K, Siewert JR, et al. Prognostic factors in gastric carcinoma: results of the German Gastric Carcinoma Study 1992. Cancer 1993; 72:2089–2097.
13. Okajima K, Isozaki H. Splenectomy for treatment of gastric cancer: Japanese experience. World J Surg; 1995; 19:537–540.

DIMITRIOS ROUKOS, M.D.
GEORGIOS MARCOUIZOS, M.D.
CHARALAMPOS BATSIS, M.D.
AGGELOS KAPPAS, M.D.
Ioannina, Greece
ALBRECHT ENCKE, M.D.
Frankfurt, Germany

November 14, 1995

Dear Editor:

We thank Dr. Roukos and associates for their comments.

In our patients randomized to R_1 subtotal gastrectomy, no recurrence developed in the gastric remnant. The high morbidity rate in the R_3 group is largely related to abscess formation around the pancreatic stump. The long-term survival in the R_3 group is significantly worse than that in the R_1 group. We agree that subtotal gastrectomy with preservation of the spleen and pancreas should be the recommended operation for antral cancer. Like Roukos et al., we believe that the additional morbidity of the more radical operation is related to resection of the spleen rather than the lymph node dissection per se. A subtotal gastrectomy with a D_2 lymph node clearance currently is the operation of choice for antral cancer in our department.

S. C. S. CHUNG, M.D.
A. K. C. LI, M.D.
Shatin, Hong Kong

July 24, 1995

Dear Editor:

There were several pleas for a phase III trial within the manuscript and the discussion regarding preoperative chemoradiotherapy for rectal cancer.[1] Unfortunately, no one mentioned the fact that there are now two such trials active. Both the Intergroup (Eastern Cooperative Oncology Group [ECOG], Radiation Therapy Oncology Group [RTOG], Southwest Oncology Group [SWOG], Cancer and Leukemia Group B [CALGB], and North Central Cancer Treatment Group [NCCTG]) and the National Surgical Adjuvant Breast Project (NSABP) have initiated trials that (if accrual targets are met) will answer the question of the relative value of preoperative chemoradiotheroapy sequencing in patients with T3 rectal cancers. Because surgeons usually are the first treatment consultants, the fates of these trials with respect to patient accrual are largely in their hands.

Reference

1. Chari RS, Tyler DS, Anscher MS, et al. Preoperative radiation and chemotherapy in the treatment of adenocarcinoma of the rectum. Ann Surg 1995; 221:778–787.

JOHN P. HOFFMAN, M.D.
Philadelphia, Pennsylvania

Nov. 28, 1995

Dear Editor:

We would like to thank Dr. Hoffman for his letter regarding our article. In our manuscript,[1] the impact of preoperative chemotherapy and radiation on the histopathology of a subgroup