Neoadjuvant chemotherapy

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Most operable patients should have neoadjuvant chemother - apy as there is level 1 evidence of improved survival. Since the early 2000s a platinum-based triplet regime containing epirubicin (e.g. epirubicin, cisplatin and 5-fluorouracil [5-FU]; ECF) has been the standard of care. Recently epirubicin has - been re placed by docetaxel after publication of the FLOT4 trial; this was a direct comparison of ECF with FLOT (fluoro - uracil, leucovorin, oxaliplatin, docetaxel) chemotherapy that showed a significant survival advantage for FLOT (50 months versus 35 months). Unfortunately , only a minority of patients y . receive a clinically meaningful survival adv antage and mecha - nisms to predict response are urgently required to prevent the ine ff ective and harmful treatment of the majority . Evidence for the use of perioperative (before and after surgery) chemo - therapy is less r obust, as in all major trials (MRC-MAGIC and FLOT4) fewer than 50% of patients received the postopera - tive component.

(b) 4 10 17 11 6 14 15 (a) the anterior view of the stomach; (b) the

This is best performed through a long upper midline incision. The stomach is removed en bloc, including the tissues of the entire greater omentum and lesser omentum (Figure 67.30 commencing the operation, the transverse colon is completely separated from the greater omentum. The dissection may then be commenced proximally or, more usually , distally . The subpyloric nodes are dissected, and the first part of the duode num is divided, usually with a surgical stapler. The hepatic nodes are dissected to clear the hepatic artery; this dissection also includes the suprapyloric nodes. The right gastric artery is divided at its origin from the hepatic artery . The lymph node dissection is contin ued to the origin of the left gastric artery , which is divided at its origin. Dissection is continued along the splenic artery , removing all nodes on the superior aspect of the pancreas and accessible nodes in the splenic hilum. Separation of the stomach from the spleen, if it is not going to be removed, allows access to the nodal tissues around the upper stomach and GOJ. The oesophagus can then be divided at an appropriate point using a combination of stay sutures and a soft non-crushing clamp, usually of the right-ang led vari ety . It is important that the resection margins are well clear of the tumour (>5 /uni00A0 cm). Frozen section should be performed if involvement of either proximal or distal resection margin is in doubt. Gastrointestinal continuity is reconstituted by means of a Roux loop. The alimentary limb of the Roux loop should be at least 50 /uni00A0 cm long to avoid bile reflux oesophagitis. The simplest means of e ff ecting the oesophagojejunostomy is to place a purse-string suture in the cut end of the oesophagus and, using a circular stapler introduced through the blind end of the Roux loop, staple the end of the oesophagus onto the side of the Roux loop. The blind open end of the Roux loop may then be closed either with sutures or with a linear stapler. Recent evidence supports long-term intestinal and nutritional benefits of construction of a jejunal pouch. The anastomosis can also be fashioned end to end. The Roux loop may be placed in either an antecolic or retrocolic position. The end to-side jejunojejunostomy is undertaken at a convenient point (Figure 67.31). The di ff erentiation between a D1 and a D2 operation depends upon the tiers of nodes removed. Di

ff erent tiers need to be remo ved depending on the positions of primary tumour (Table 67.7). In general, a D1 r esection involves the removal of the perigastric nodes and a D2 resection involves the clearance of the major arterial trunks. In practice the majority of special ist centres will perform a radical total gastrectomy , conserving the spleen and pancreas, with D2 lymphadenectomy sparing station 10 lymph nodes.

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