02, to 12). For the entire cohort the median number of lymph nodes per specimen was 16+/-11. The mean follow-up time was 60 months. The length of hospital stay was 14 days (range 5 to 100) with an inhospital mortality rate of 1.3%. The overall-five years survival was 80% (74% and 82% in patients submitted to D1 and D2 lymphadenectomy, respectively; p = ns. Fig.2 (a-b).

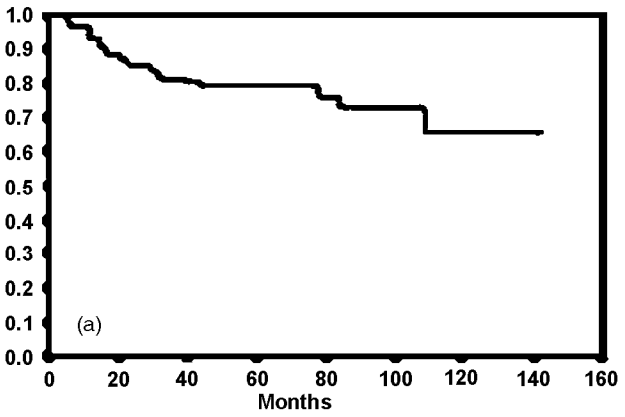

Fig. 2a.

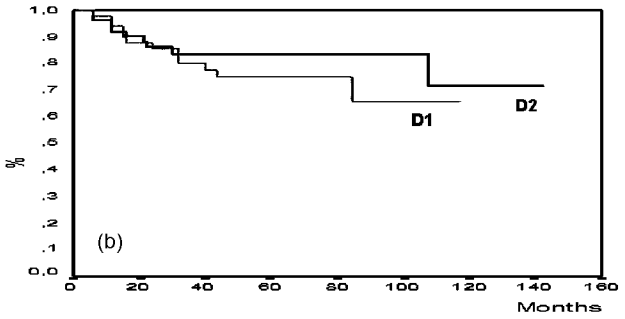

Fig. 2b.

In order to comparing survival, the follow factors were analysed for prognosis: extent of lymphadenectomy (D1 vs D2), patient age, tumor stage, tumor size. In the multivariate analysis only the tumor stage was predictor of outcome (Fig3).

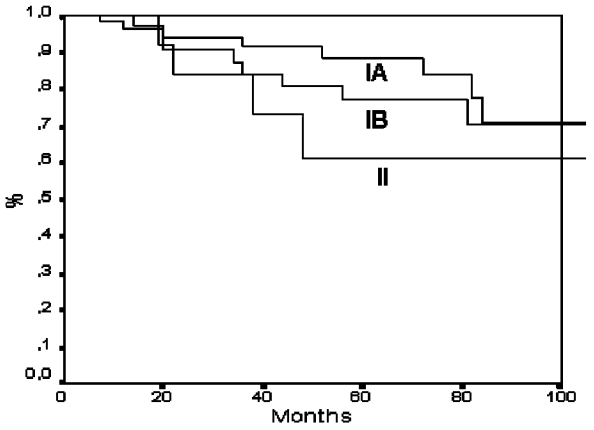

Fig. 3.

Conclusions: The high long-term survival rates reported by experienced centers after systematic, standardized extensive D2 and D3 gastrectomies are encouraging. In our center, D2 gastrectomy is become rourine. However, in the multivariate analysis the extent of lymphadenectomy does not influence survival of patients submitted to gastric resection for node negative gastric cancer. In these patients, only T stage is closely related to the clinical outcome.

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Chemotherapy in advanced gastric cancer: a systematic review and meta-analysis

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Background: Systemic chemotherapy is the major treatment option for the majority of gastric cancer patients. Uncertainty remains regarding the choice of the regimen.
Materials and methods: Our objectives were to assess the effect of
1. Chemotherapy versus best supportive care (BSC)
2. Combination versus single agent chemotherapy
3. The following different combination chemotherapy regimens:
   a. 5-FU/cisplatin combinations with versus without anthracyclines
   b. 5-FU/anthracycline combinations with versus without anthracyclines

on overall survival and toxicity.
Search strategy: We searched: Cochrane Central Register of Controlled Trials, MEDLINE, EMBASE, proceedings from DDW, ECCO, ESMO, ASCO until February 2005.
Selection criteria: Randomised controlled trials on systemic intravenous chemotherapy versus BSC, combination versus single agent chemotherapy and different combination chemotherapies as above in advanced gastric cancer.
Results: 24 randomised trials with a total number of 3304 patients are included in this meta-analysis. Analysis of 1. Chemotherapy versus BSC consistently demonstrated a significant benefit in terms of overall survival in favour of the group receiving chemotherapy (HR 0.39, 95%CI 0.28–0.52). Analysis of 2. Combination versus single-agent chemotherapy provides evidence for a survival benefit in favour of combination chemotherapy (HR 0.83, 95%CI 0.74–0.93), which is achieved at the price of increased toxicity. When comparing 3a.) 5-FU/cisplatin-containing combination therapy regimens with anthracyclines versus those without anthracyclines (comparison 4 including 501 patients: HR 0.77, 95%CI 0.62–0.95) and 3b.) 5-FU/anthracycline-containing combinations with cisplatin versus those without cisplatin (HR 0.83, 95%CI 0.76–0.91), both demonstrate a significant survival benefit for regimens including 5-FU, anthracyclines and cisplatin. Among these three-drug-regimens, the rate of treatment related deaths was higher when 5-FU was administered as bolus compared to infusional 5-FU (3.3 versus 0.6%).
Conclusions: Chemotherapy significantly improves survival in comparison to best supportive care. In addition, combination chemotherapy improves survival compared to single-agent 5-FU, but the effect size is much smaller. Among the combination chemotherapy regimens studied, best survival results are achieved with three-drug regimens containing 5-FU, anthracyclines and cisplatin. Among these, ECF (epirubicin, cisplatin, 5-FU) is tolerated best.

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Lymph node ratio as prognostic factor in digestive tumours

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Background: The current TNM classification in digestive cancers uses different rules for the pathologic staging of regional lymph node involvement. For stomach, staging is based on the number of involved nodes, with N1 defined as 1 to 6 regional nodes involved, N2 as 7 to 15, N3 as 16 or more involved. For colon and rectum, N1 means 1 to 3 involved nodes, and N2, four or more. For anal canal, the staging is based on the anatomical location of the involved lymph nodes. For esophagus and other sites, N1 indicates involvement without any subdivision. The different rules can be confusing. It might be asked if a more unified approach can be considered. There is a growing literature suggesting that the lymph node ratio (LNR), defined as the proportion of nodes found involved among excised nodes, might give more accurate prognostic information. The present study investigates whether or not the LNR can be used to consistently define prognostic subgroups.
Material and methods: Data was abstracted from the Surveillance, Epidemiology, and End Results public use database 2004. Selection was histology confirmed primary invasive carcinoma diagnosed between 1988 and 1997, surgically resected. Retroperitoneum, peritoneum and unspecified organs were excluded. Three groups were defined based on