



SDI Review Form 1.6

Journal Name:	<u>Journal of Cancer and Tumor International</u>
Manuscript Number:	Ms_JCTI_35246
Title of the Manuscript:	Histopathological analysis for omental deposits in patients with gastric malignancies following gastrectomy
Type of the Article	Original Research Article

General guideline for Peer Review process:

This journal's peer review policy states that **NO** manuscript should be rejected only on the basis of '**lack of Novelty**', provided the manuscript is scientifically robust and technically sound.

To know the complete guideline for Peer Review process, reviewers are requested to visit this link:

(<http://www.sciencedomain.org/page.php?id=sdi-general-editorial-policy#Peer-Review-Guideline>)



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PART 1: Review Comments

	Reviewer's comment	Author's comment (if agreed with reviewer, correct the manuscript and highlight that part in the manuscript. It is mandatory that authors should write his/her feedback here)
Compulsory REVISION comments	MAJOR REVISION SHOULD BE DONE (AS INDICATED IN THE NOTES IN THE TEXT). ENGLISH REVISION SHOULD BE DONE. It is unclear why the authors considered patients with adenocarcinoma, lymphoma, Kaposi ect in the analysis of the greater omentum. Data about positive cytology in the peritoneal washing is not considered. The milky spots and the role of greater omentum is very important and not so clear in gastric cancer, however in the discussion and in the aim of the study the topic is not clearly discussed. Is important to know in other countries like south Africa what is the epidemiology of this tumor, however all these aims should be better clarify. Moreover is important specify the role of hipec in these patients, if you use this technique in our center.	Thank you very much for reviewing our manuscript. We sincerely appreciate the inputs. English revision: We accept the criticism and have revised the English language. See changes shaded yellow. Why Kaposi, lymphoma and GISTs were included: As it is indicated in the methodology the study was based on an audit of histopathological records of patients who were diagnosed with gastric malignancies. Diagnosis of gastric malignancy would have been made following upper gastrointestinal endoscopy or biopsy taken during an emergency procedure for either perforated or bleeding gastric ulcer. In certain cases confirmation follows gastrectomy e.g. GIST, Lymphoma or Kaposi. Yes, the primary treatment would not be gastrectomy for lymphoma and Kaposi; if the diagnosis is known preoperatively. The primary aim was to establish if pathologists evaluate the greater omentum if it is submitted following gastrectomy for malignancy.



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		All these tumours including GIST (although rare) may spread to lymph nodes and greater omentum. 3. Regarding data on peritoneal cytology: As it has already been alluded to previously the main purpose was to determine how thorough pathologists are during evaluation of the greater omentum. However in our practice if pre-operative imaging (CT scan and EUS) does not show irresectable disease curative gastrectomy is preceded by staging laparoscopy with lavage cytology. We appreciate the suggestion but did consider to include mining for peritoneal cytology results in the current study. 4. The milky spots and the role of greater omentum is very important and not so clear in gastric cancer, however in the discussion and in the aim of the study the topic is not clearly discussed: We avoided an extensive coverage of ontogeny, anatomy, physiology, pathogenesis of tumour seeding and implantation; and clinical relevance as the manuscript would have been long and resemble a review article. 5. Is important to know in other countries like South Africa what is the epidemiology of this tumor, however all
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		these aims should be better clarify: The study was primarily focused on determining the quality of pathology reports regarding the greater omentum. Although we do keep very good cancer statistics, adenocarcinoma of the stomach is around 8-10 most common cancer in South Africa and the 5th most common cause of cancer death. 6. Moreover is important specify the role of hipec in these patients, if you use this technique in our centre: We are aware of hyperthermic intraperitoneal chemotherapy (HIPEC) but it has not been used in any of our patients and perhaps at any centre in South Africa. Three years ago we sponsored one of our surgeons to visit a centre Belgium which does cytoreductive surgery and HIPEC, but we haven't as yet started the program.
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<u>Minor</u> REVISION comments		
<u>Optional/General</u> comments		Perhaps the following background may be of assistance to the reviewer: 1. The study was motivated by the established cut of definition of D1 versus D2 gastrectomy which uses a cut-off of 16 lymph nodes. 2. The greater omentum is almost always resected during gastrectomy for cancer, and often ends up being the largest piece of tissue. 3. We erroneously thought there were lymphatics and therefore lymph nodes in the greater omentum; which if included in the count would easily reach the magic 16. 4. Practically, however it has been rare to reach the count following majority of gastrectomies. 5. The average number of lymph nodes in each station according to the Japanese Classification is known but up to recently there is nothing reported regarding the greater omentum. 6. We initiated a study for a Master degree with Department of Anatomy which was aborted because they reported that it was very difficult to look for "normal" lymph nodes in the greater omentum. 7. It then motivated the current study. 8. Additionally, popularization of omentum preserving gastrectomy (high recurrence when it is preserved versus high morbidity if it is resected).