

Dear Sir

Thank you for mail. I had made corrections according to the reviewer's comments.

Reviewer1

1 The important finding is that patients aged > 80 years have more complications and a worse overall survival probably due to co-morbidity and postoperative complications. This is a retrospective analysis. a. How were patients selected for surgery? Maybe only the best patients underwent surgery? This is an important selection bias that limits definitive conclusions.

The patients selections were not specific when we performed the gastrectomy more than 80 years old ,best patients were not chosen. The indications for gastrectomy to all gastric cancer patients were ASA score less than 3 and informed consent was fully obtained.

We added following comments in Patients and Methods.

“All patients were ASA (American Society of Anesthesiologists) risk less than three and there was no selection bias in each groups”.

2 To make a conclusion from this is to compare patients aged >80 years with patients of the same age-group but did not undergo surgery; what is overall and cancer-specific survival in this group? Do the authors have data on this? This needs better discussion.

This manuscript was evaluated only gastrectomy patients, not evaluated non-gastrectomy patients using propensity score.

We have no data available concerned to gastric cancer patients over 80 years old who were not received gastrectomy. Therefore, we could not discuss the patients over 80 years old who were not received gastrectomy.

3 The authors state that lymph node metastasis is related to OS. Is that also true for the elderly group? A substantial number of this group did not undergo lymph node dissection. Is this because these patient had a non-curative resection (also n=18). If this is so, the conclusion that a better lymph node dissection is necessary in this patient group is potentially nod valid. Please comment.

The lymph nodes dissections were performed in 96 patients(D1,2 dissection) in elderly group, only 18 patients were non-curative resection who were not received lymph nodes dissection(palliative surgery). Therefore, we could evaluated the relationship between lymph nodes metastasis and prognosis as fully number of patients.

In Cox multivariate analysis as the gastric cancer patients in elderly, we thought D2 lymph nodes dissection increased the survival in these patients.

4 The main conclusions in the Core tip/abstract and discussion is that a better lymph node dissection is necessary and that careful FU is necessary. I do not agree with this. I think the important conclusion is that postoperative complications are higher, mortality is higher (although still acceptable). But we have to see this in light of doing nothing in these patients. Adding such data would increase the scientific value of this manuscript.

In univariate analysis in elderly group (Table 3), postoperative complications were not associated with overall survival ,although hospital death and postoperative respiratory complications were more common in elderly.

But we believed that postoperative complications after gastrectomy were very important factors in elderly.

Therefore, we added following comments in conclusions of ABSTRACT and Core/Tip.

“When the gastrectomy was performed in gastric cancer patients, we should recognized high mortality and comorbidities in that of elderly”.

Additionally,

In results in Page9~10 “In multivariate analysis”was changed to following comment.

“In multivariate analysis, we found that extent of lymph node dissection was independent prognostic factors in elderly patients with gastric cancer. Also, postoperative complications, especially respiratory complication and hospital death were more common in elderly group.”

In discussion on Page 10 added following comment.

“However, postoperative complications lead to hospital death should be noted.”

#Reviewer2

- 1. RESULTS; Page 6, Line 18: Patient’s characteristics are shown in Table 1,2→ Flow chart of group distribution in the registry is to be added, and Table1,2 should be the patient and surgical characteristics which contain both of “observational dataset” and “matched dataset” by a propensity score, with standard difference.**

It is difficult to describe the patients characteristics after IPTW, because it cannot analyzed

the recent software, Stata or R.

Please note the differences between propensity score matching and IPTW.

2. RESULTS; Page 6, Line 21: optimal cut-off age for gastrectomy in terms of OS was 79.2 years old (AUC=0.642, TP=0.536, FP=0.248).→ Please present these data in a Figure.

We added the ROC curve in Fig.4. AUC,TP,FP were changed because of our mistake.

3. RESULTS; Page 7,8, Table3,4→Univariate and multivariate data should present “unweighted” and “weighted data”, with “crude” and “adjusted” 95% CI and hazard ratio.

We analyzed the data, again.

Data were similar between unweighted and weighted data in elderly group.

Therefore, we only showed the data after iptw. Cox model was changed because of inappropriate factors included.

4. RESULTS; Page 7-8, and Figure1-2 →I wonder the unit of horizontal axis of “times after surgery” in Figure 1A,1B,2A,2B would be “years”, not “months”.

I had made corrections.

Finally, I hope the revised manuscript is acceptable for publication in “World Journal of Gastrointestinal Oncology”

Sincerely yours,

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