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EDITORIAL

- 2365 Immunotherapy for gastric cancer and liver metastasis: Is it time to bid farewell
Dehal A
- 2369 Role of endoscopic ultrasound-guided biliary drainage for palliation of malignant biliary obstruction
Singh S, Chandan S, Facciorusso A
- 2374 Consideration on immunotherapy of liver metastases of malignant tumors
Jiang C, Zhang ZH, Li JX
- 2382 Beyond total mesorectal excision: The emerging role of minimally invasive surgery for locally advanced rectal cancer
Perini D, Cammelli F, Scheiterle M, Martellucci J, Di Bella A, Bergamini C, Prosperi P, Giordano A
- 2386 Clinical application value of long non-coding RNAs signatures of genomic instability in predicting prognosis of hepatocellular carcinoma
Xing XW, Huang X, Li WP, Wang MK, Yang JS
- 2393 Treatment strategy and therapy based on immune response in patients with gastric cancers
Jacenic D, Fichna J

FRONTIER

- 2396 Problems with repairing gut sphincters malfunctions
Bortolotti M

REVIEW

- 2409 Advancements in nutritional diagnosis and support strategies during the perioperative period for patients with liver cancer
Li XQ, Liang Y, Huang CF, Li SN, Cheng L, You C, Liu YX, Wang T

ORIGINAL ARTICLE**Case Control Study**

- 2426 Surgical resection and neoadjuvant therapy in patients with gastric cancer and ovarian metastasis: A real-world study
Yan HP, Lu HR, Zhang YX, Yang L, Chen ZL
- 2436 Alteration of ascending colon mucosal microbiota in patients after cholecystectomy
Fan MY, Jiang QL, Cui MY, Zhao MQ, Wang JJ, Lu YY

Retrospective Cohort Study

- 2451** Survival prognostic analysis of laparoscopic D2 radical resection for locally advanced gastric cancer: A multicenter cohort study
Sun XM, Liu K, Wu W, Meng C
- 2461** Benefits of jejunostomy feeding in patients who underwent gastrectomy for cancer treatment
Jaquet R, Rivkine E, De Souza N, Roudié J
- 2474** Application of ¹⁸F-fluorodeoxyglucose positron emission tomography/computed tomography imaging in recurrent anastomotic tumors after surgery in digestive tract tumors
Ge DF, Ren H, Yang ZC, Zhao SX, Cheng ZT, Wu DD, Zhang B
- 2484** Impact of minimally invasive surgery on immune function and stress response in gastric cancer patients
Zhu RH, Li PC, Zhang J, Song HH
- 2494** Assessment of perianal fistulizing Crohn's disease activity with endoanal ultrasound: A retrospective cohort study
Hong N, Liu WY, Zhang JL, Qian K, Liu J, Ye XJ, Zeng FY, Yu Y, Zhang KG
- 2503** Lymph node dissection does not affect the survival of patients with tumor node metastasis stages I and II colorectal cancer
He F, Qu SP, Yuan Y, Qian K

Retrospective Study

- 2511** Energy spectrum computed tomography multi-parameter imaging in preoperative assessment of vascular and neuroinvasive status in gastric cancer
Wang J, Liang JC, Lin FT, Ma J
- 2521** Clinical significance of peripheral blood immune cells in patients with gastric cancer after surgery
Wang QW, Zhu JW, Gong LZ
- 2528** Lone-Star retractor perineal exposure method for laparoscopic abdominal perineal resection of rectal cancer
Ma J, Tang DB, Tang YQ, Wang DT, Jiang P, Zhang YM
- 2538** Indication of conservative treatment by antibiotics for uncomplicated and complicated acute appendicitis
Hosokawa Y, Moritani M, Makuuchi Y, Nagakawa Y
- 2546** Preoperative prediction of hepatocellular carcinoma microvascular invasion based on magnetic resonance imaging feature extraction artificial neural network
Xu JY, Yang YF, Huang ZY, Qian XY, Meng FH
- 2555** Transmembrane serine protease 4 expression in the prognosis of radical resection for biliary tract cancer
Shibata Y, Sudo T, Tazuma S, Tanimine N, Onoe T, Shimizu Y, Yamaguchi A, Kuraoka K, Takahashi S, Tashiro H

- 2565** Systemic immune-inflammation index combined with pediatric appendicitis score in assessing the severity and prognosis for paediatric appendicitis
Guo LM, Jiang ZH, Liu HZ
- 2574** Establishment of predictive models and determinants of preoperative gastric retention in endoscopic retrograde cholangiopancreatography
Jia Y, Wu HJ, Li T, Liu JB, Fang L, Liu ZM
- 2583** Prediction model establishment and validation for enteral nutrition aspiration during hospitalization in patients with acute pancreatitis
Hou P, Wu HJ, Li T, Liu JB, Zhao QQ, Zhao HJ, Liu ZM
- 2592** New anti-mesenteric delta-shaped stapled anastomosis: Technical report with short-term postoperative outcomes in patients with Crohn's disease
Lee JL, Yoon YS, Lee HG, Kim YI, Kim MH, Kim CW, Park IJ, Lim SB, Yu CS
- 2602** Construction of a predictive model for gastric cancer neuroaggression and clinical validation analysis: A single-center retrospective study
Lan YY, Han J, Liu YY, Lan L
- 2612** Efficiency and safety of laparoscopic left hemihepatectomy: A study of intrathecal *vs* extrathecal Glissonian pedicle techniques
Kang LM, Xu L, Zhang FW, Yu FK, Lang L
- 2620** Predictive utility of the Rockall scoring system in patients suffering from acute nonvariceal upper gastrointestinal hemorrhage
Han DP, Gou CQ, Ren XM
- Observational Study**
- 2630** Nomogram predicting the prognosis of primary liver cancer after radiofrequency ablation combined with transcatheter arterial chemoembolization
Shen HH, Hong YR, Xu W, Chen L, Chen JM, Yang ZG, Chen CH
- 2640** Relationship between postoperative rehabilitation style, gastrointestinal function, and inflammatory factor levels in children with intussusception
Wei XY, Huo HC, Li X, Sun SL, Zhang J
- Prospective Study**
- 2649** Innovative integration of lung ultrasound and wearable monitoring for predicting pulmonary complications in colorectal surgery: A prospective study
Lin C, Wang PP, Wang ZY, Lan GR, Xu KW, Yu CH, Wu B
- Randomized Controlled Trial**
- 2662** Effects of fluid therapy combined with a preoperative glucose load regimen on postoperative recovery in patients with rectal cancer
Xia LC, Zhang K, Wang CW

Randomized Clinical Trial

- 2671 Application value of dexmedetomidine in anesthesia for elderly patients undergoing radical colon cancer surgery
Bu HM, Zhao M, Ma HM, Tian XP

Basic Study

- 2679 Effect of growth hormone on colonic anastomosis after intraperitoneal administration of 5-fluorouracil, bleomycin and cisplatin: An experimental study
Lambrou I, Mantzoros I, Ioannidis O, Tatsis D, Anestiadou E, Bisbinas V, Pramateftakis MG, Kotidis E, Driagka B, Kerasidou O, Symeonidis S, Bitsianis S, Sifaki F, Angelopoulos K, Demetriades H, Angelopoulos S

SYSTEMATIC REVIEWS

- 2689 Management of distal cholangiocarcinoma with arterial involvement: Systematic review and case series on the role of neoadjuvant therapy
Hall LA, Loader D, Gouveia S, Burak M, Halle-Smith J, Labib P, Alarabiyat M, Marudanayagam R, Dasari BV, Roberts KJ, Raza SS, Papamichail M, Bartlett DC, Sutcliffe RP, Chatzizacharias NA

SCIENTOMETRICS

- 2702 Global research landscape of Peutz-Jeghers syndrome and successful endoscopic management of intestinal intussusception in patients with recurrent laparotomies
Sun Q, Wang XY, Guo GJ, Wang L, Meng LM, Guo YF, Sun T, Ning SB

CASE REPORT

- 2719 Ultrasound-guided peripheral nerve blocks for anterior cutaneous nerve entrapment syndrome after robot-assisted gastrectomy: A case report
Saito Y, Takeuchi H, Tokumine J, Sawada R, Watanabe K, Yorozu T
- 2724 Primary coexisting adenocarcinoma of the colon and neuroendocrine tumor of the duodenum: A case report and review of the literature
Fei S, Wu WD, Zhang HS, Liu SJ, Li D, Jin B
- 2735 Anorectal hemangioma, a rare cause of lower gastrointestinal bleeding, treated with selective embolization: A case report
Pospisilova B, Frydrych J, Krajina A, Örhalmi J, Kajzrlíkova IM, Vitek P

LETTER TO THE EDITOR

- 2742 Hepatic recompensation according to the Baveno VII criteria *via* a transjugular intrahepatic portosystemic shunt: Is this true?
Zhang JS
- 2745 Machine learning in predicting postoperative complications in Crohn's disease
Zhang LF, Chen LX, Yang WJ, Hu B

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WJGS mainly publishes articles reporting research results and findings obtained in the field of gastrointestinal surgery and covering a wide range of topics including biliary tract surgical procedures, biliopancreatic diversion, colectomy, esophagectomy, esophagostomy, pancreas transplantation, and pancreatectomy, *etc.*

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Immunotherapy for gastric cancer and liver metastasis: Is it time to bid farewell

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Abstract

Patients with metastatic gastric cancer have a grim prognosis. Palliative chemotherapy offers a limited survival improvement, but recent advancements in immunotherapy have sparked hope. However, the effectiveness of immunotherapy in patients with liver metastases remains debated. This article reviews a recent study by Liu *et al* and evaluates conflicting evidence on the impact of liver metastases on response to immunotherapy in metastatic gastric cancer. While some studies suggest no significant difference in treatment response based on liver involvement, others report varied response rates. The present study, a retrospective analysis of 48 patients by Liu *et al*, examines this issue and concludes that immunotherapy is less effective in patients with liver metastases. Despite methodological limitations and a small sample size, the study contributes to the ongoing discourse. The nuanced response to immunotherapy in certain patients underscores the importance of understanding the tumor microenvironment, immune cell infiltration, and the expression of immune checkpoints. Rather than dismissing immunotherapy for patients with gastric cancer and liver metastases, a shift towards personalized treatment strategies and a more profound understanding of tumor-specific biomarkers is essential. By unraveling the molecular intricacies of individual cases, clinicians may tailor more effective and customized treatments, offering a glimmer of hope for this challenging patient group.

Key Words: Immunotherapy; Gastric cancer; Liver metastasis; Efficacy; Prognosis

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Core Tip: The prognosis of patients with gastric cancer and liver metastasis is abysmal. Palliative chemotherapy is associated with a limited survival benefit yet is very toxic. Immunotherapy is considered an emerging promising therapy with some remarkable results. There has been a growing body of literature from animal and human studies that question the efficacy of immunotherapy in these patients. In this article, we discuss this issue and provide a balanced appraisal of the literature.

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INTRODUCTION

The median survival of patients with metastatic gastric cancer is only 3 to 5 months without treatment. Palliative chemotherapy may prolong survival to approximately 9-11 months in patients with Her2-negative disease[1]. Recently, immunotherapy has emerged as a promising therapy after a remarkable response in various malignancies. Results from several randomized trials, including the Checkmate-649[2] trial and the KEYNOTE-158[3] trial, which showed improved survival compared to chemotherapy, led to the approval of drugs such as Nivolumab and Pembrolizumab, respectively.

Current recommendations for the management of patients with HER2-negative metastatic gastric cancer include Fluoropyrimidine, oxaliplatin, or Cisplatin, with or without nivolumab or pembrolizumab as first-line therapy, followed by Ramucirumab and paclitaxel, Docetaxel, Paclitaxel, Irinotecan, Fluorouracil, or irinotecan as a second line therapy[4]. However, several pre-clinical[5] and clinical studies[6-8] have suggested reduced efficacy of immunotherapy in patients with liver metastases in melanoma and non-small cell lung cancer. Scientific observation from animal studies nicely described the mechanisms for this phenomenon. Liver metastases induce a systemic loss of antigen-specific T cells, siphon activated CD8+ T cells from the systemic circulation, reduce peripheral T cell numbers, and diminish tumoral T cell diversity and function. Liver metastases alter the hepatic immune microenvironment by inducing activated T cell apoptosis *via* the Fas-FasL pathway. Consequently, liver metastases create a systemic immune desert[5].

CURRENT EVIDENCE

In gastric cancer, previous studies evaluating the efficacy of immunotherapy in the setting of liver metastases have shown conflicting results. In a subgroup analysis with a 2-year follow-up from the CheckMate-649, the presence of liver metastases did not impact the rate of response in patients with metastatic gastric cancer treated with immunotherapy[9]. Similarly, findings from the ATTRACTION-2 trial and the ATTRACTION-4 trial demonstrated that the survival benefit of Nivolumab did exist regardless of the status of the liver metastases[10,11]. Contrarily, in the REGONIVO trial, patients with liver metastases had a response rate of approximately 42%, whereas patients without liver involvement had a response rate of 80%[12]. Retrospective studies examining the role of immunotherapy in patients with gastric cancer and liver metastases have yielded mixed results as well. Some studies demonstrated that liver metastasis was associated with a decreased response rate and rapid disease progression, compared to other metastases[13,14], whereas other studies showed no such impact[15].

In the study by Liu *et al*[16] published in this issue of the *World Journal of Gastrointestinal Surgery*, the authors challenged the efficacy of immunotherapy in this group of patients. This study is a small ($n = 48$) retrospective evaluation of patients with HER2-negative metastatic gastric cancer treated with immunotherapy at a Chinese hospital. The methodology is a simple comparison of two groups of patients (metastatic gastric cancer with or without liver metastasis) across the study outcomes: Objective response rate, disease control rate, progression-free survival (PFS), and overall survival. Although clinical differences were noted between the two groups in all measured outcomes favoring the group without liver metastasis, apart from the PFS, none of the other outcomes showed statistical significance. The study concluded that immunotherapy is less effective in patients with liver metastases than those without.

I commend the authors for their efforts to expand our understanding of the role of immunotherapy for this disease and improve patient selection for this costly and potentially risky treatment. Several issues are worth discussing. Paclitaxel is not a first-line chemotherapy for patients with metastatic gastric cancer. Tirellizumab, an investigational, humanized PD-1 inhibitor, has demonstrated preliminary antitumor activity in hepatocellular carcinoma. It is unclear how this agent was selected as part of the combination regimen as it has not been approved for treating metastatic gastric cancer patients. The study's retrospective design, with its inherited selection bias, especially given the significant difference in baseline performance status and, finally, the small sample size, are additional issues that should be considered when evaluating the study.

While some studies suggest a limited efficacy of immunotherapy in patients with gastric cancer and liver metastases, a broader examination of the literature revealed diverse findings. Other studies counter this notion, demonstrating that the mere presence of liver metastases does not definitively predict poor response to immunotherapy; instead, it underscores the importance of delving into the underlying tumor biology as variation in molecular characteristics and genetic makeup may play a pivotal role in determining the responsiveness of these patients.

CONCLUSION

Throughout history, surgeons have always understood with much clarity that the biology of the tumor dictates prognosis. No better than the late Dr. Blake Clady's famous quotation, "Biology is King," who eloquently illustrated this understanding. However, as another surgical giant, the late Dean Lutin, once said, "We are only at the foothills of understanding cancer, and the biological mountain still lies in the clouds ahead," we are yet to fully understand the biology of tumors. The diverse response to immunotherapy in patients with gastric cancer and liver metastases may be attributed to several underlying tumor biological characteristics such as a tumor microenvironment, immune cell infiltration, and expression of immune checkpoint. Tumors with high levels of immune cell infiltration and increased expression of PD L1 may exhibit an enhanced response to immunotherapy[17].

Additionally, genomic instability, tumor mutational burden, and specific molecular subtypes of gastric cancer can influence treatment outcomes[18-20]. Even more interesting is the revolutionary cutting-edge single-cell omics and spatial transcriptomics technologies, which enabled the exploration of cellular heterogeneity and molecular landscapes of gastric cancer at the single-cell level and revolutionized our understanding of cellular function and tissue organization. These technologies have a promising potential for even more personalized treatment for patients with gastric cancer[21-23]. Therefore, it is not time yet to bid farewell to immunotherapy in this unfortunate group of patients whose prognosis is otherwise dismal. Instead, we need to shift focus toward comprehensive tumor profiling to identify these biomarkers and understand the molecular intricacies of individual cases to tailor more personalized and effective treatment strategies.

FOOTNOTES

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