Letter to the Editor

Comment on "Risk Factors for Esophagojejunal Anastomotic Leakage after Total Gastrectomy"

To the Editor:

I read with interest the article "Risk Factors for Esophagojejunal Anastomotic Leakage in Gastric Cancer Patients after Total Gastrectomy" by Maejima et al.[1] The authors conducted a retrospective study to identify risk factors for esophago-jejunal anastomotic leakage (EJAL) in 309 patients who underwent total gastrectomy and Roux-en-Y esophago-jejunal anastomosis for gastric cancer. The study found that 23 patients (7.4%) experienced EJAL. Univariate analysis indicated that age, gender, diabetes mellitus, esophageal invasion, and blood loss were associated with EJAL. In multivariate analysis, age ≥ 68 years (odds ratio [OR]: 4.98, 95% confidence interval [CI]: 1.65-15.05), male gender (OR: 8.64, 95% CI: 1.07-70.05), presence of diabetes mellitus (OR: 5.18, 95% CI: 1.77-15.13), and blood loss ≥ 1,100 g (OR: 3.96, 95% CI: 1.46-10.74) were identified as independent risk factors.

Bracale et al.[2] conducted a systematic review of 16 studies (42,489 cases in total) to identify risk factors for EJAL after total gastrectomy for gastric cancer. Multivariate analysis identified age, BMI, respiratory dysfunction, prognostic nutritional index (PNI), alcohol consumption, diabetes, chronic renal failure, and mixed histology as independent risk factors. For instance, patients with a BMI>25 exhibited a substantially elevated risk of EJAL (OR: 12.127, 95% CI: 2.652-72.933). Similarly, patients with a PNI<55 demonstrated a significant association with EJAL (OR: 0.208, 95% CI: 0.044). These findings suggest that BMI and PNI may serve as useful preoperative variables for predicting postoperative complications, including EJAL. Liu et al.[3] conducted a retrospective analysis of 609 patients who underwent total gastrectomy for gastric cancer and Siewert type II/III esophagogastric junction cancer. The incidence of EJAL was found to be 48 cases (7.9%). Multivariate analysis identified two or more comorbidities (OR: 3.464, 95% CI: 1.178-10.189) and operative time exceeding 260 minutes (OR: 2.657, 95% CI: 1.242-5.685) as independent risk factors for EJAL. These findings highlight the importance of careful perioperative management, especially in patients with multiple comorbidities, and emphasize the need to minimize operative time when possible.

The studies by Maejima et al.[1], Bracale et al.[2], and Liu et al.[3] suggest common trends in the risk factors associated with EJAL, reinforcing the understanding that EJAL is a multifactorial complication involving patient-related factors, comorbidities, nutritional status, and intraoperative variables. Looking ahead, the development of risk prediction models based on preoperative factors, along with the integration of intraoperative and postoperative variables into a stepwise risk assessment approach, may improve early detection and enhance perioperative management. Moreover, further studies are warranted to clarify the relationship between minimally invasive techniques—such as laparoscopic and robot-assisted surgery—and the risk of EJAL. Establishing prospective data registries for the systematic collection and analysis of perioperative variables will also be important for future research. Lastly, I would like to express my sincere respect to the authors for their valuable contribution and hope that their findings will help improve the safety of gastric cancer surgery.

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Conflict of Interest: The author declares no conflict of interest.

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