



III INTERNATIONAL TURKISH GASTRIC CANCER CONGRESS

Supporting Associations



Gastroenteroloji
Cerrahisi
Derneği



ABSTRACT BOOK

ITGCC 2026

President: Prof. Enver İLHAN

Supported by



TÜBİTAK

"Challenges and Discussions"

15-17
October
2026

egekongre
Turizm & Organizasyon

Radisson Blu Hotels, Çeşme - İzmir, TÜRKİYE

www.gastriccancercongressizmir.com.tr

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WELCOME

Dear Colleagues,

It is our great pleasure and privilege, on behalf of the National Gastric Cancer Society, to invite you to participate in the III. International Turkish Gastric Cancer Congress (ITGCC 2026), to be held at the Radisson Blu Hotel in Izmir, Turkey, on 15 – 17 October 2026. The present congress is being organized by the National Gastric

Cancer Association in collaboration with the Izmir Faculty of Medicine, University of Health Sciences Turkey. Also, is being supported scientifically by the International Gastric Cancer Association, the Turkish Surgery Association, the Turkish Medical Oncology Association and the Gastroenterology Surgery Society.

Gastric cancer remains one of the most challenging malignancies worldwide, requiring true multidisciplinary collaboration and constant innovation in diagnosis and treatment. Remarkable progress in molecular oncology, immunotherapy, precision medicine and minimally invasive surgery over the past decade has reshaped the entire therapeutic landscape. The ITGCC 2026 congress aims to serve as an international platform to discuss these advances, share collective experience and set new directions for the future management of gastric cancer, by bringing together young, enthusiastic physicians and their more experienced, pioneering counterparts.

With the theme 'Challenges and Discussions', the congress will feature an inspiring scientific programme designed to stimulate dialogue between experts from the East and West. The sessions will include:

- Keynote lectures by distinguished international leaders;
- Multidisciplinary panel discussions on evolving treatment paradigms;
- Video sessions and surgical innovation workshops;
- Translational research and clinical trial updates;
- Poster and oral presentations highlighting original scientific contributions, especially from young investigators.

The congress will bring together surgeons, medical and radiation oncologists, gastroenterologists, pathologists, radiologists and basic scientists to promote collaboration and knowledge exchange across specialties.

We sincerely hope that you will join us in Izmir to contribute to ongoing progress in gastric cancer research and patient care. Your participation will strengthen our shared mission to improve outcomes and quality of life for patients around the world.

With warm regards,

Prof. Enver İLHAN

President, ITGCC 2026

On behalf of the Organizing Committee

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SCIENTIFIC PROGRAMME

15 October 2026

COURSE HALL I

12:00 – 17:00 **Laparoscopic suturing and intracorporeal knot-tying workshop**

Managers: **Gökalp OKUT, Mehmet TORUN, Murat GÜNER**

12:00 – 12:15 **Introduction & key principles**

12:00 – 12:05 Ergonomics and instrument handling

12:05 – 12:10 Needle positioning

12:10 – 12:15 Common technical errors

12:15 – 12:30 **Faculty live demonstration**

12:15 – 12:18 Needle loading

12:18 – 12:21 Needle driving

12:21 – 12:25 Intracorporeal knot tying

12:25 – 12:30 Running suture

12:30 – 13:15 **Module 1 | Needle handling and precision suturing**

12:30 – 12:45 Needle loading

12:45 – 13:00 Needle transfer

13:00 – 13:15 Target penetration exercises

13:15 – 14:00 **Module 2 | Intracorporeal knot-tying**

13:15 – 13:30 C-loop technique

13:30 – 13:45 Reverse C-loop technique

13:45 – 14:00 Secure knot formation

14:00 – 14:15 **Break**

14:15 – 15:00 **Module 3 | Interrupted and continuous suturing**

14:15 – 14:30 Interrupted sutures

14:30 – 14:45 Running sutures

14:45 – 15:00 Defect closure exercises

15:00 – 16:15 **Module 4 | Simulated gastrointestinal anastomosis**

15:00 – 15:25 Enterotomy closure

15:25 – 15:50 Gastrotomy closure

15:50 – 16:15 Anastomotic corner sutures

Gökalp OKUT

Mehmet TORUN

Murat GÜNER

Gökalp OKUT

Mehmet TORUN

Murat GÜNER

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16:15 – 16:50 Module 5 | Advanced challenges & error correction

- 16:15 – 16:22 Difficult angles
- 16:22 – 16:30 Restricted working space
- 16:30 – 16:40 Suture management
- 16:40 – 16:50 Faculty tips and tricks

Mehmet TORUN
Murat GÜNER
Gökalep OKUT
Mehmet TORUN

16:50 – 17:00 Wrap-up & closing remarks

- 16:50 – 16:55 Faculty feedback
- 16:55 – 17:00 Course evaluation

Murat GÜNER
Mehmet TORUN
Gökalep OKUT

COURSE HALL II

13:00 – 17:05 Robotic surgery for gastric cancer: Current evidence, standardization and advanced techniques

Manager: Erman AYTAÇ

13:00 – 13:05 Welcome & course introduction

Chairs: Enver İLHAN, Erman AYTAÇ

13:05 – 14:05 Session I | Current evidence, patient selection and operative preparation

Chairs: Ali KOCATAŞ, Hüseyin ÇİYİLTEPE, Mehmet TORUN

- 13:05 – 13:20 Current evidence in robotic gastric cancer surgery
- 13:20 – 13:35 Patient selection throughout the learning curve and establishing a robotic gastric cancer program
- 13:35 – 13:50 Operating room organization, equipment and patient setup
- 13:50 – 14:05 Surgical anatomy and anatomical landmarks for robotic gastric cancer surgery

Mihai EFTIME

Octavian POPESCU
Mehmet C. KIZILKAYA

Yılmaz ÖZDEMİR

14:05 – 14:20 Break

14:20 – 15:30 Session II | Standardized robotic resections, advanced techniques and interactive case discussions

Chairs: Vasile BINTINTAN, Fatih ALTINTOPRAK

- 14:20 – 14:30 Step-by-step standardized robotic gastric resection
- 14:30 – 14:45 D2 lymphadenectomy: technical pearls for safe and reproducible dissection
- 14:45 – 15:00 Esophagojejunostomy and gastrojejunostomy: technical options and decision making
- 15:00 – 15:15 Double-tract, roux-en-y, braun and omega reconstruction
- 15:15 – 15:30 Managing challenging situations in robotic gastric cancer surgery

Erman AYTAÇ

Fatih ALTINTOPRAK

Erman AYTAÇ
Sercan YÜKSEL
Erman AYTAÇ

15:30 – 17:00 Interactive course | Expert-led hands-on dry lab: robotic suturing and reconstruction techniques

Chairs: Turgut DÖNMEZ, Ahmet SÜREK, Mert TANAL

17:00 – 17:05 Wrap-up, take-home messages & closing remarks

Erman AYTAÇ

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16 October 2026
Hall C

07:30 – 08:30 Session 1 | Simultaneous round table panels 1

Round Table Panel 1: T4a Gastric cancer – Where should we draw the line?

Chair: **Maria BENCIVENGA**

Panelists: **Mehmet Onur GÜL, Yiğit DÜZKÖYLÜ, Deniz TİKİCİ, Serhan DERİCİ, Halil YILDIZ, M. Kaan DEMİRCİOĞLU**

Round Table Panel 2: Response to neoadjuvant therapy – Surgery or surveillance?

Chair: **Stefan MÖNIG**

Panelists: **Orhan ÜREYEN, Ömer ÖZDUMAN, Girayhan ÇELİK, Ömer ÇAĞLIYAN**

Round Table Panel 3: Elderly and frail patients – How aggressive should surgery be?

Chair: **Paulo KASSAB**

Panelists: **Mehmet Akif ÜSTÜNER, Tolga ÖLMEZ, Ahmet Orhan SUNAR, Hüseyin ESİN, Tuba GÖÇMEN**

Round Table Panel 4: MDT Decisions vs intraoperative reality

Chair: **Antonio C. WESTON**

Panelists: **İskan ÇALLI, Güray DUMAN, Mert GEDİK**

Round Table Panel 6: Unexpected T4b invasion – Salvage strategies

Chair: **Paolo MORGAGNI**

Panelists: **Serkan ADEMOĞLU, Melih Can GÜL, Abidin Gazi ALAGÖZ, Emrah DADALI, Emrehan İNCİ**

Round Table Panel 7: Imaging–Pathology discordance – Who is right?

Chairs: **Hilal ŞAHİN, Dudu SOLAKOĞLU KAHRAMAN**

Panelists: **Cem OFLUOĞLU, Sercan YÜKSEL, Mert ERCAN**

Round Table Panel 8: Lymph node retrieval – Is the pathologist sufficient, or is surgical support needed?

Chair: **Paulo Matos DA COSTA**

Panelists: **M. Taha DEMİRPOLAT, Arif ATAY, Sami AÇAR, Merve YUMAK, Ata Mert ATEŞÇİ**

Round Table Panel 9: CY1 disease – Induction therapy or upfront surgery?

Chair: **Paul SCHNEIDER**

Panelists: **Hüseyin ÇİYİLTEPE, Bahar CANBAY, Metin BOZKAYA, Atakan KILINÇ**

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Round Table Panel 10: Borderline resectable gastric cancer – Who truly benefits?

Chair: **Masanori TERASHIMA**

Panelists: **Azmi LALE, Erman YEKENKURUL, Emrah CENGİZ**

Round Table Panel 22(Addition): CY1 disease – Induction therapy or upfront surgery?

Chair: **Filippo PIETRANTONIO (Online)**

Panelists: **Özlem KUTLU, Seval AKAY, Damla GÜNENÇ EŞİM**

16 October 2026

Hall A

08:40 – 09:40 **Session 2 | Preoperative assessment – Gray zones**

Chairs: **Osman YÜKSEL, Erman AYTAÇ, Turgut DÖNMEZ**

08:40 – 08:55 CT / PET / DWI-MRI: When is imaging insufficient?

08:55 – 09:10 Staging laparoscopy: Who really needs it?

09:10 – 09:25 Peritoneal cytology: Prognostic marker or therapeutic decision-maker?

09:25 – 09:40 Discussion

Hilal ŞAHİN

Antonio C. WESTON

Masanori TERASHIMA

09:40 – 10:40 **Session 3 | Early-Stage gastric cancer – Management and decision-making**

Chairs: **Koray ATİLA, Ali GÜNER, Elçin AYDIN**

09:40 – 09:55 Diagnosis and staging: endoscopic findings, biopsy, and radiologic assessment

09:55 – 10:10 Surgical treatment options: Minimally invasive surgery vs endoscopic resection – where is the limit?

(ESD indications and management after non-curative resection)

10:10 – 10:25 Risk of lymph node metastasis: Implications for diagnosis and treatment strategy

10:25 – 10:40 Discussion

Gözde DERVİŞ HAKİM

Takeshi SANO

Paulo Matos DA COSTA

10:40 – 11:00 **Coffee break**

11:00 – 12:00 **Session 4 | Gastrectomy and D2 lymphadenectomy – Technical challenges**

Chairs: **Mehmet MİHMANLI, Fikret EZBERCİ, Akın Fırat KOCAAY**

11:00 – 11:15 Surgery of "Difficult Stations": 8p, 13, 16a1/b2, 14v, 10, 110–112 (Which approach is safer? When is each technique advantageous?)

11:15 – 11:30 Subtotal, total, and proximal gastrectomy: Technical challenges in surgical decision - making (Patient selection and proximal/distal margin issues)

11:30 – 11:45 PIPAC: Experimental or evolving standard?

11:45 – 12:00 Discussion

Takeshi SANO

Yiğit DÜZKÖYLÜ

Orhan SUNAR

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12:00 – 12:30

**Satellite session: CPS $\geq$ 5 in 1L Gastric cancer:
Driving outcomes with OPDIVO® + Chemo**

Timuçin ÇİL

12:30 – 13:30

Lunch

13:30 – 14:30

Session 5 | Anastomosis and reconstruction – The most challenging decisions

Chairs: **Salim DEMİRCİ, Recep ÇETİN, Erman AYTAÇ**

13:30 – 13:45

Esophagojejunostomy (EJ): Circular vs linear stapling vs
hand-sewn techniques

**Carlos Garcia CARRASCO
(Online)**

13:45 – 14:00

Leak prevention strategies

Felix BERLTH

14:00 – 14:15

Double-tract reconstruction (DTR) vs Roux-en-Y vs interposition

Mehmet TORUN

14:15 – 14:30

Discussion

14:30 – 15:30

Session 6 | Minimally invasive and robotic surgery – Is it truly superior?

Chairs: **Cüneyt KAYAALP, Osman YÜKSEL, Ahmet SÜREK**

14:30 – 14:45

Laparoscopic vs robotic surgery: Patient selection

Danielle MARRELLI

14:45 – 15:00

Robotic D2 Lymphadenectomy: Real advantage or illusion?

Paulo KASSAB

15:00 – 15:15

ICG-Guided surgery: Standard or overestimated?

Maria BENCIVENGA

15:15 – 15:30

Discussion

15:30 – 15:50

Coffee break

15:50 – 16:50

Session 7 | T4b Tumors and complex surgery – Where are the limits?

Chairs: **Ahmet Serdar KARACA, Fatih Mehmet AVŞAR**

15:50 – 16:05

Multivisceral Resection: How aggressive should we be?

Paulo KASSAB

16:05 – 16:20

Initially cT4b gastric cancer: Should surgery be based on initial extent
or post-treatment findings?

Çetin KOTAN

16:20 – 16:35

Major vascular and retroperitoneal invasion: Is surgery still an option?

Vasile BINTINTAN

16:35 – 16:50

Discussion

16:50 – 17:50

Session 8 | Precision perioperative treatment strategies in resectable gastric cancer

Chairs: **Şuayib YALÇIN, Mahmut İLHAN, Giovanni DE MANZONI**

16:50 – 17:05

Perioperative systemic treatment intensification and total
neoadjuvant strategies in resectable gastric cancer

Özgür TANRIVERDİ

17:05 – 17:20

MSI, CPS and ctDNA guided perioperative treatment selection
in resectable gastric cancer

Ömer DİZDAR

17:20 – 17:35

HER2- and CLDN18.2-directed perioperative strategies:
patient selection and ongoing clinical trials

**Filippo PIETRANTONIO
(Online)**

17:35 – 17:50

Discussion

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17:50 – 18:35

Session 9 | Recent studies session

Chairs: **Maria BENCIVENGA**, Özlem ÖZDEMİR, Hüseyin ÇİYİLTEPE

17:50 – 18:05

IGCA International registry for metastatic gastric cancer.

18:05 – 18:30

Turkish national consensus study (CONTRA-GAST Study)

18:30 – 18:35

National Gastric Cancer Academia

Erica SECCHETTIN

Leyla ÖZER, Gökalep OKUT

Mehmet TORUN

19:00 – 19:30

OPENING CEREMONY

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Hall B

07:40 – 08:40

Session 10 | Oral presentation session

Chairs: Halil TAŞKAYNATAN, Ali Kemal KAYAPINAR

08:40 – 09:40

Session 11 | Debate session 1

Chairs: Mehmet YILDIRIM, Serhan DERİCİ

08:40 – 09:10

Proximal margin in EGJ tumors: 3 cm vs 5 cm

08:40 – 08:50

3 cm

08:50 – 09:00

5 cm

09:00 – 09:10

Discussion

09:10 – 09:40

PCI Threshold for CRS/HIPEC candidates: ≤6 vs 7–12

Chairs: Yavuz ERYAVUZ, M. Reşit SÖNMEZ, Arif ATAY

09:10 – 09:20

PCI Score 7–12

09:20 – 09:30

PCI Score ≤ 6

09:30 – 09:40

Discussion

Ulaş ADAY

Sercan YÜKSEL

Abdullah ŞENLİKÇİ

Mehmet TORUN

09:40 – 10:00

Coffee break

10:00 – 11:00

Session 12 | Worst-case scenario panels 1

Chairs: Aziz SÜMER, Mustafa Taner BOSTANCI, Adil KOYUNCU

10:00 – 10:30

High-risk patient: 82 years old, cT4a, N+, sarcopenic, frail, unable to tolerate FLOT

10:00 – 10:10

Proceed with surgery – potential for cure

10:10 – 10:20

Do not operate – Harm outweighs benefit

10:20 – 10:30

Discussion

Serkan ADEMOĞLU

Tolga ÖLMEZ

10:30 – 11:00

R0 Gastrectomy with D2 lymphadenectomy, followed by peritoneal recurrence at postoperative month 3

Chairs: Musa AKOĞLU

10:30 – 10:40

The surgery was appropriate – The biology was aggressive

10:40 – 10:50

The wrong patient was selected from the outset

10:50 – 11:00

Discussion

Melih Can GÜL

Yılmaz ÖZDEMİR

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11:00 - 12:00

Session 13 | Worst-case scenario panels 2

11:00 - 11:30

MSI-H Resectable gastric cancer: surgery first or immunotherapy first?

Chairs: **Metin ERCAN, Mutlu DOĞAN, Turgut ANUK**

11:00 - 11:10

Upfront surgery remains standard,

11:10 - 11:20

Neoadjuvant immunotherapy should be preferred in MSI-H disease

11:20 - 11:30

Discussion

Cem OFLUOĞLU

Deniz Can GÜVEN

11:30 - 12:00

Post-ESD case: SM2 invasion with LVI (+), patient fit

Chairs: **Ali UZUNKÖY, Tahsin DALGIÇ, Fevzi CENGİZ**

11:30 - 11:40

Completion gastrectomy is mandatory

11:40 - 11:50

Close Surveillance May Be Considered

11:50 - 12:00

Discussion

Azmi LALE

Salim İlksen BAŞÇEKEN

12:00 - 13:30

Lunch

13:30 - 14:00

Session 14 | Debate Session 2

Clinical stage II gastric cancer – Upfront D2 surgery for selected patients or perioperative therapy for all?

Chairs: **Fatih ALTINTOPRAK, Orhan ÜREYEN, Ebubekir GÜNDEŞ**

13:30 - 13:40

Upfront D2 surgery for selected patients

13:40 - 13:50

Perioperative therapy for all

13:50 - 14:00

Discussion

İskan ÇALLI

Arda Şakir YILMAZ

14:00 - 15:00

Session 15 | Nutritional management in challenging clinical scenarios in gastric cancer

Chairs: **Savaş YAKAN, Kemal Erдің KAMER**

14:00 - 14:15

Nutrition during neoadjuvant therapy in obstructive gastric cancer: what is the optimal approach?

14:15 - 14:30

Nutrition after upper GI anastomotic leak: How should the strategy be determined?

14:30 - 14:45

Post-gastrectomy nutrition: Early rehabilitation or controlled approach?

14:45 - 15:00

Discussion

Abidin Gazi ALAGÖZ

Örgün GÜNEŞ

Ozan B. NAMDAROĞLU

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16:50 – 17:50 **Session 16 | Debate Session 3**

16:50 – 17:20 **Management of CY1 Disease: Upfront systemic therapy vs conversion surgery after cytology conversion**

Chairs: **Masanori TERASHIMA**, Ali KOCATAŞ, Sami AÇAR

16:50 – 17:00 Upfront Systemic Therapy

Erman AKKUŞ

17:00 – 17:10 Conversion surgery if cytology turns negative

Paolo MORGAGNI

17:10 – 17:20 Discussion

17:20 – 17:50 **Re-Staging laparoscopy – Who should undergo it? Only patients with initial CY1/P1 disease vs all patients receiving neoadjuvant therapy (cT4 / Diffuse Type / Bulky N+)**

Chairs: **Yasuhiro KODERA**, Nuri OKKABAZ, Enver REYHAN

17:20 – 17:30 Only patients with initial CY1/P1 disease,

Mert TANAL

17:30 – 17:40 All patients receiving neoadjuvant therapy (cT4 / Diffuse Type / Bulky N+)

Murat GÜNER

17:40 – 17:50 Discussion

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Hall C

07:00 – 08:00 **Session 17 | Simultaneous round table panels 2**

Round Table Panel 11: Anastomotic leakage – Prevention or damage control?

Chair: **Felix BERLTH**

Panelists: Yiğit DÜZKÖYLÜ, İkbâl OVALI ERDOĞDU, Mehmet Şah BENK, M. Kaan DEMİRCİOĞLU

Round Table Panel 12: Oligometastatic disease – True biology or stage migration artifact?

Chair: **Giovanni DE MANZONI**

Panelists: Özlem ÖZDEMİR, Nidal İFLAZOĞLU, Gökâl OKUT, Mehmet Can AYDIN, Mehmet Fatih ERMAN

Round Table Panel 13: Conversion surgery – True success or selection bias?

Chair: **Yasuhiro KODERA**

Panelists: Murat GÜNER, Mehmet Alperen UĞUR, Halil TÜRKAN, Demet ALAY

Round Table Panel 14: Obesity and gastric cancer?

Chair: **Antonio C. WESTON**, Aziz SÜMER,

Panelists: Orhan ÜREYEN, Melih Can GÜL, Ferhat ÇAY, Arda Şakir YILMAZ, Halil TAKCI, Şebnem ÇİMEN

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Round Table Panel 15: Standardization in gastric cancer surgery – Is it achievable?

Chair: **Danielle MARRELLI**

Panelists: **Zeynep TAŞKIN, Mehmet Alperen AVCI, Furkan TAŞ, Yiğit Kaan ŞEN**

Round Table Panel 16: High-risk patients – When should we avoid surgery?

Chair: **Octavian POPESCU**

Panelists: **Ayşe Gizem ÜNAL, Örgün GÜNEŞ, Necati Osman OKUMUŞ, Fadime KUTLUK**

Round Table Panel 17: Complication-related mortality – Can it be predicted?

Chair: **Takeshi SANO**

Panelists: **Murat KARATAŞ, Ulaş ADAY, Deniz TİKİCİ, Ozan B. NAMDAROĞLU, Cemre DİNÇSOY**

Round Table Panel 18: National Gastric Cancer Registry – Mandatory or voluntary?

Chair: **Paolo MORGAGNI**

Panelists: **Mehmet Onur GÜL, Yılmaz ÖZDEMİR, Mehmet TORUN, Gözde ERTUNÇ, Hasan Çağrı YILDIRIM, Riyad EZDEŞİR**

Round Table Panel 19: CY1 disease – Induction therapy or upfront surgery?

Chair: **Filippo PIETRANTONIO (ONLINE)**

Panelists: **Özlem Zeliha SERT, Özlem KUTLU, Merve YUMAK, Kübra CANASLAN**

Round Table Panel 20: Early recurrence after curative surgery – What went wrong?

Chair: **Enver İLHAN**

Panelists: **Hilmi BOZKURT, Abdullah ŞENLİKÇİ, Kadir ÇORBACI, Mücahit ÜNAL, Mehmet Emin GÖNÜLLÜ, Gürkan GÜNERİ**

Round Table Panel 21: Obesity and gastric cancer-2

Chair: **Vasile BINTINTAN**

Panelists: **Çağrı BÜYÜKKASAP, Muzaffer Önder ÖNER, İbrahim SAYAR, Mert GEDİK, Mert Yiğit AKDOĞAN, Eyüp GEMİCİ**

Round Table Panel 5: R0 at all costs? Ethical and oncologic limits

Chair: **Suzanne S. GISBERTZ**

Panelists: **Salim İlksen BAŞÇEKEN, Mert TANAL, Ömer KUBAT, Anıl ORHAN, Emrehan İNCİ**

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Hall A

08:00 – 09:00 Session 18 | Complications – “Hard sessions”

Chairs: **Paulo KASSAB**, Erdal Birol BOSTANCI

- 08:00 – 08:15 Surgery for recurrence: When is it justified?
08:15 – 08:30 Duodenal stump leak: Who is at risk? Management strategies
08:30 – 08:45 Esophagojejunostomy (EJ) Leak: Stent vs VAC vs surgical intervention
08:45 – 09:00 Discussion

Octavian POPESCU
Mehmet Akif ÜSTÜNER
Paul SCHNEIDER

09:00 – 09:30 Session 19 | Debate Session 4

Chairs: **Hasan KAPLAN**, Evren DİLEKTAŞLI

Siewert II EGJ Adenocarcinoma – Transthoracic esophagectomy or Transhiatal/Abdominal gastrectomy?

- 09:00 – 09:10 Transthoracic esophagectomy,
09:10 – 09:20 Transhiatal/Abdominal gastrectomy?
09:20 – 09:30 Discussion

Stefan MÖNIG
Vasile BINTINTAN

09:40 – 10:40 Session 20 | Risk stratification and recurrence prediction after curative treatment in gastric cancer

Chairs: **Tuğba YAVUZŞEN**, **Suzanne S. GISBERTZ**

- 09:40 – 09:55 Pathological response after neoadjuvant therapy: prognostic biomarker or guide for postoperative treatment adaptation?
09:55 – 10:10 Positive peritoneal cytology and occult peritoneal disease biology after curative treatment
10:10 – 10:25 Circulating tumor DNA (ctDNA) and minimal residual disease after curative treatment: toward biomarker-driven adjuvant strategies
10:25 – 10:40 Discussion

Faysal DANE
Mehmet Ali ŞENDUR
Okta Halit AKTEPE

10:40 – 11:00 Coffee break

11:00 – 12:00 Session 21 | Oligometastatic disease – Who should undergo surgery?

Chairs: **Stefan MÖNIG**, **Paolo MORGAGNI**, Enver İLHAN

- 11:00 – 11:15 Defining “True” oligometastatic disease: Diagnosis and management
11:15 – 11:30 Conversion surgery: Who and when?
11:30 – 11:45 Lymph node-only metastasis (Para-aortic disease)
11:45 – 12:00 Discussion

Giovanni DE MANZONI
Yasuhiro KODERA
Daniele MARRELLI

12:00 – 12:30 GENERAL ASSEMBLY

12:30 – 13:30 Lunch

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13:30 – 14:30

Session 22 | Peritoneal disease – The most controversial field

Chairs: **Mustafa DUMAN, Lütfi DOĞAN, Burhan Hakan KANAT**

13:30 – 13:45

Omentectomy debate: Total or partial – when is it necessary?
(Current oncologic evidence and the pathophysiology of omental metastasis)

13:45 – 14:00

HIPEC: Evidence vs hype

14:00 – 14:15

Systemic + Intraperitoneal therapy: combination strategies

14:15 – 14:30

Discussion

Suzanne S. GISBERTZ

Özlem Zeliha SERT

Mehmet TORUN

14:30 – 15:30

Session 23 | Recurrence – Where are the failures?

Chairs: **Abdulkadir BEDİRLİ, Osman YÜKSEL**

14:30 – 14:45

Local vs systemic recurrence

14:45 – 15:00

Chylous leak: Current management approaches,

15:00 – 15:15

Modern systemic therapies in recurrent disease

15:15 – 15:30

Discussion

M. Taha DEMİRPOLAT

Ali ALEMDAR

Hasan Çağrı YILDIRIM

15:30 – 15:50

Coffee break

15:50 – 16:50

Session 24 | Biomarker-driven systemic treatment strategies in metastatic gastric cancer

Chairs: **Ömer Faruk ÖZKAN, Berk ÖZYILMAZ, Mehtat ÜNLÜ**

15:50 – 16:05

First-Line immunotherapy strategies in metastatic gastric cancer:

CPS-guided treatment selection and emerging predictive biomarkers

16:05 – 16:20

HER2-Positive metastatic gastric cancer: Treatment sequencing in the
Trastuzumab-Deruxtecan era

16:20 – 16:35

CLDN18.2, FGFR2b and next-generation antibody-drug conjugates in
metastatic gastric cancer

16:35 – 16:50

Discussion

İlkay Tuğba ÜNEK
Tarkan YETİŞYİĞİT
(ONLINE)

Sezer SAĞLAM

16:50 – 17:30

Session 25 | Oral presentation awards and closing session

Chair: **Enver İLHAN**

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07:40 – 08:40 **Session 26 | Oral presentation session**

Chairs: Erkan OYMACI, Seval AKAY

08:40 – 09:45 **Session 27 | The future – Where is surgery heading?**

Chairs: Ertuğrul Gazi ALKURT, Mustafa Taner BOSTANCI

08:40 – 08:55 Artificial intelligence and decision support systems: will the role of the surgeon diminish?

08:55 – 09:10 Video-based surgical quality assessment

09:10 – 09:25 ERAS: Does it truly make a difference?

09:25 – 09:35 The use of AI in the academic studies

09:35 – 09:45 Discussion

Emir G. KAHRAMAN

Gözde ERTUNÇ

Ayşe Gizem ÜNAL

Mert ERCAN

09:45 – 10:40 **Session 33 (Additional session) | Oral presentation session**

Chairs: Gökalep OKUT, Çağrı BÜYÜKKASAP, Eyüp GEMİCİ

10:40 – 11:00 **Coffee Break**

11:00 – 12:00 **Session 28 | Selected oral presentations**

Chairs: Kutay SAĞLAM, Özlem Zeliha SERT

11:00 – 11:10 **Selected oral presentation:** Pathological T stage and omental tumor involvement in gastric adenocarcinoma: A retrospective cohort study

Abidin Gazi ALAGÖZ

11:10 – 11:20 **Selected oral presentation:** Comparison of radiologist, surgeon, and multidisciplinary assessments in clinical staging of gastric cancer and factors associated with misstaging

Beyza İzem ERDEM

11:20 – 11:30 **Selected oral presentation:** Textbook outcome in patients with curative resection with D2 dissection for locally advanced gastric adenocarcinoma

Mehmet Güray DUMAN

11:30 – 11:40 **Selected oral presentation:** From operative narrative to structured surgical data in primary gastric malignancy: A multi-axial content analysis of 249 operative notes

Mert ERCAN

11:40 – 11:50 **Selected oral presentation:** Comparison of immunonutrition and standard nutritional support before gastrectomy after neoadjuvant FLOT

Muhammed K.YILDIRAK

11:50 – 12:00 **Selected oral presentation:** Is double-tract reconstruction inferior to Roux-en-Y reconstruction in proximal gastric cancer surgery? A retrospective analysis of functional and nutritional outcomes

Ömer KUBAT

12:00 – 13:00 **Lunch**

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13:00 – 14:00 Session 29 | Gastric precancerous lesions – Surgical boundaries and decision-making

Chairs: Ümit Haluk İLİKLERDEN, Bahar CANBAY

- 13:00 – 13:10 Helicobacter pylori eradication & cancer prevention: Too late or still effective?
- 13:10 – 13:20 Gastric polyps: When does endoscopic management become insufficient?
- 13:20 – 13:30 Gastric Dysplasia: Is ESD enough, or when should we proceed to surgery?
- 13:30 – 13:40 Intestinal metaplasia: Surveillance or surgical intervention?
- 13:40 – 13:50 Atrophic gastritis: Who needs surveillance? Who are we missing?
- 13:50 – 14:00 Discussion

Anıl ORHAN

Kadir ÇORBACI

İkbal OVALI ERDOĞDU
M. Kaan DEMİRCİOĞLU
Muzaffer Önder ÖNER

14:00 – 15:00 Session 30 | Early complications of gastric cancer surgery

Chairs: Mert TANAL, Girayhan ÇELİK

- 14:00 – 14:10 Intraoperative and early postoperative bleeding
- 14:10 – 14:20 Perioperative organ injuries in gastrectomy
- 14:20 – 14:30 Leak testing during gastrectomy: Which method works, if any?
- 14:30 – 14:40 Internal herniation after laparoscopic gastrectomy: Prevention, early diagnosis, or surgical failure?
- 14:40 – 14:50 Intestinal obstruction due to peritonitis carcinomatosa
- 14:50 – 15:00 Discussion

Canberk TOY
Ömer ÖZDUMAN
Merve YUMAK

Mehmet Şah BENK
Halil TÜRKAN

15:00 – 15:50 Session 31 | Non-Adenocarcinoma gastric tumors – Surgical strategy and limits

Chairs: Hilmi BOZKURT, Mehmet Alperen AVCI

- 15:00 – 15:10 GIST: When does surgery become too aggressive?
- 15:10 – 15:20 Gastric lymphoma: Is there still a role for surgery in the modern era?
- 15:20 – 15:30 Gastric NETs: Local resection, formal gastrectomy, or observation?
- 15:30 – 15:40 Rare gastric tumors (e.g., leiomyosarcoma, schwannoma): Do we treat them like GIST?
- 15:40 – 15:50 Discussion

Erman YEKENKURUL
Deniz TİKİCİ
Ömer KUBAT

Emrah DADALI

15:50 – 16:00 Session 32 | Rational use of drugs

Chair: Mehmet YILDIRIM

- 15:50 – 16:00 Rational use of drugs

Berk ÖZYILMAZ

16:00 – 16:50 Session 34 (Additional Session) | Oral presentation session

Chairs: Mehmet YILDIRIM, Orhan ÜREYEN, Murat GÜNER

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Gastroenteroloji
Cerrahisi
Derneği



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1172 - Endoscopic Management of Anastomotic Leak Following Oesophagogastric Cancer Resection: A Systematic Review

*James BUTTERWORTH¹, William BUTTERWORTH², Gökalp OKUT³, Neyar RIZKALLAH¹,
James CATTON¹, Simon PARSONS¹, Fady YANNI¹, Vohra RAVI¹*

¹Nottingham University Hospital

²Birmingham University Hospital

³ University Of Health Sciences Turkey, Izmir Faculty of Medicine, Izmir City Hospital, Department of Gastroenterological Surgery, Izmir, Türkiye

Aim: Anastomotic leak is a serious complication following oesophagogastric resectional surgery and is associated with substantial morbidity and mortality. Endoscopic techniques — including self-expanding metallic stents (SEMS), endoscopic vacuum/negative-pressure therapy (EVT/ENPT), over-the-scope clips, and fibrin sealant — have increasingly replaced surgical re-intervention as first-line management across both operation types, however there is no consensus on the optimal approach. This systematic review aimed to synthesise the evidence on endoscopic management of anastomotic leak following oesophagectomy or total/subtotal gastrectomy for oesophagogastric cancer, evaluating technique-specific success rates, complications, and mortality.

Method: A systematic electronic search was conducted of PubMed, Embase, and Cochrane CENTRAL from inception to August 2026 using MeSH and free-text terms combining concepts of oesophagectomy/total gastrectomy/subtotal gastrectomy/oesophagojejunostomy/oesophagogastric anastomosis, anastomotic leak, and endoscopic management (full search strategy available on request/in supplementary material). Studies were eligible if they reported endoscopic management of anastomotic leak following oesophagectomy or total gastrectomy for oesophagogastric cancer in adult patients, including case series, retrospective/prospective cohort studies, and comparative studies; studies reporting exclusively on benign (non-oncological) leaks, bariatric surgery, non-endoscopic management or case-reports were excluded.

Findings: Of an initial 1314 studies identified, 304 were screened and 11 studies met inclusion criteria together comprising approximately 417 patients. Endoscopic techniques reported included self-expanding metal stents (SEMS; six studies, approximately 168 patients), endoscopic vacuum/negative-pressure therapy (EVT/ENPT; seven studies, approximately 100 patients), and fibrin glue/endoclips (one study, n=12). Reported clinical success (leak healing) rates ranged from 74–93% for EVT and 78–92% for SEMS across individual series. The only head-to-head comparative study (Berith et al., 2018, n=111) reported numerically higher healing with EVT than SEMS (85.7% vs 72.4%) but no significant

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difference in complications or other outcomes. Leak-related mortality, where reported, ranged from 0–16% across series.

Conclusion: Current evidence demonstrates endoscopic techniques — principally SEMS and EVT/ENPT — are safe and achieve broadly comparable clinical success (70–90%) in the management of anastomotic leak following oesophagectomy or total/subtotal gastrectomy for oesophagogastric cancer, with EVT possibly associated with modestly higher healing in the single head-to-head comparative study identified, though without a corresponding significant difference in complications. Prospective, comparative studies are needed to establish an optimal, technique-specific management algorithm for this population.

Keywords: Endoscopic management, anastomotic leak, oesophagogastric cancer resection, oesophagectomy, gastrectomy

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1230 - Comparison of Clinicopathological Features with Microsatellite Instability in Patients with Gastric Cancer

Ezgi ALTINTAŞ¹, Simge BARAN², Ahmet Can YAŞAR³, Asuman ARGON⁴, Mehmet YILDIRIM⁵

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² University of Health Sciences Turkey, İzmir City Hospital, Department of Medical Pathology, İzmir, Türkiye

³ Erzurum Horasan State Hospital

⁴ University of Health Sciences Turkey, İzmir Faculty of Medicine, İzmir City Hospital, Department of Medical Pathology, İzmir, Türkiye

⁵ University of Health Sciences Turkey, İzmir Faculty of Medicine, İzmir City Hospital, Department of General Surgery, İzmir, Türkiye

Aim: Replication errors and defects in DNA repair mechanisms play an important role in the carcinogenesis of gastric cancer. Microsatellite instability (MSI), which has been well established in colorectal cancers, is known to be closely associated with the development of multiple cancers. However, the impact of MSI on gastric cancer development has not yet been fully elucidated.

This study was designed to investigate the relationship between microsatellite instability and clinicopathological features in patients with gastric cancer.

Method: This retrospective study included patients diagnosed and treated for gastric cancer between October 26, 2023, and April 20, 2026. A total of 37 patients were evaluated. Three patients who underwent surgery for gastrointestinal stromal tumors (GISTs) were excluded from the study. Age, sex, tumor location, TNM stage, total number of lymph nodes, number of metastatic lymph nodes, and MSI status were evaluated.

Findings: The mean age of the patients was 65.3 years. The female-to-male ratio was 7/27. Regarding tumor location, tumors were located in the cardia in 4 patients, corpus in 20 patients, and antrum in 10 patients. According to TNM staging, 5 patients had stage I disease, 5 had stage II disease, 20 had stage III disease, and 4 had stage IV disease. 9 patients received neoadjuvant therapy.

Total gastrectomy was performed in 18 patients and subtotal gastrectomy in 12 patients. Witzel jejunostomy was performed in 4 patients because their tumors were considered inoperable. The mean number of dissected lymph nodes was 26.2, and the mean number of metastatic lymph nodes was 7.3. 12 patients were lymph node-negative, whereas 22

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patients were lymph node-positive. A cutoff value of $\geq 10\%$ was used to define CerbB2 positivity, and 5 patients were positive. Following the evaluation of MSH and MLH1-6 expression, MSI was identified in 17.6% of the tumors. Among patients with MSI, 83.4% were lymph node-positive. And MSS group has %60 lymph node-positive. No significant association was observed between MSI and lymph node positivity($p=0.613$)

The mortality rate in the study population was 32%, and MSI was detected in 36.3% of patients who died. No significant association was observed between mortality and MSI group ($p=0.659$). No statistically significant association was observed between MSI status and sex, tumor location, neoadjuvant treatment or type of surgery. Only significant association with MSI status is age. MSI-H group 8.6 years older than those MSS ($p=0,025$).

Conclusion: The 17.6% prevalence of microsatellite instability observed among patients with gastric cancer, together with its close association with a high rate of lymph node positivity, supports the importance of incorporating MSI testing into routine pathological evaluation of gastric cancer.

Keywords: MSI, Gastric cancer, Lymph nodes, Demographic features

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1231 - Gastric Cancer Managed in a CRS-HIPEC Program: A Single-Center Experience

*Muhammed İkbâl AKIN¹, Ömer Faruk KANDAZ¹, Canberk TOY¹, Emir Mehmet YÜNLÜEL¹,
Ayşegül Bahar ÖZOCAK¹, Nurdan BEZİR¹, Ahmet Orhan SUNAR¹,
Mehmet Ömer ÖZDUMAN¹, Aziz Serkan SENER¹, Selçuk GÜLMEZ¹, Mustafa DUMAN¹,
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Aim: Randomized trials showed no overall survival benefit of cytoreductive surgery (CRS) with hyperthermic intraperitoneal chemotherapy (HIPEC) in gastric cancer. We evaluated survival, morbidity and recurrence patterns in our CRS-HIPEC program.

Method: Retrospective single-center cohort of 41 patients who underwent 42 CRS-HIPEC procedures (one repeat) between January 2018 and September 2026. Endpoints were overall survival (OS), disease-free survival (DFS; recurrence at any site or death) and peritoneal recurrence-free survival (PRFS; peritoneal recurrence or death). Survival from CRS-HIPEC was analyzed with Kaplan–Meier and log-rank methods; peritoneal recurrence was also estimated as cumulative incidence, with death as a competing event. One patient with persistent disease was excluded from DFS, PRFS and recurrence analyses. Adjuvant chemotherapy was analyzed in 37 disease-free patients, from surgery and from a 3-month landmark. Completeness-of-cytoreduction scores were not recorded.

Findings: Median age was 55 years; 39 patients (95%) received neoadjuvant chemotherapy and 22 of 37 with known histology (59%) had signet-ring cell or poorly cohesive carcinoma. Median peritoneal cancer index (PCI) was 1 (interquartile range 0–3; range 0–23). HIPEC was prophylactic in 17 patients (all PCI 0) and therapeutic in 24 (median PCI 2.5). Forty of 42 procedures were cisplatin-based. Major complications (Clavien–Dindo ≥IIIa) followed 8 procedures (19%); 30-day mortality was 1/42 (2.4%) and 90-day mortality 3/39 (7.7%). All three deaths within 3 months followed an infectious complication (3/10 vs 0/28 patients; Fisher p=0.014, post hoc). Median OS was 19 months (95% confidence interval [CI] 14–26), DFS 12 and PRFS 14 months; 3-year OS was 27%. Twenty-five of 40 disease-free patients recurred, at a median of 12 months; the peritoneum was involved in 18. The 2-year cumulative incidence of peritoneal recurrence was 54% (extraperitoneal-only 17%), similar after prophylactic and therapeutic HIPEC (53% vs 56%). Patients without adjuvant chemotherapy had shorter OS from surgery (7 vs 22 months, p=0.043), but 3 of 8 died within 3 months; from the landmark the difference was not significant (hazard ratio 1.49, 95% CI

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0.56–3.99). Only 2 of 19 patients with 5-year potential follow-up remained alive and disease-free beyond 5 years; none who recurred reached 5 years.

Conclusion: In this series, recurrence after CRS-HIPEC was frequent, early and mainly peritoneal, even at PCI 0 and after prophylactic HIPEC. All early deaths followed infectious complications. The apparent benefit of adjuvant chemotherapy was not robust to a landmark analysis, consistent with immortal-time bias. Long-term disease-free survival was rare.

Keywords: Gastric cancer, cytoreductive surgery, hyperthermic intraperitoneal chemotherapy, HIPEC, peritoneal metastasis, survival outcomes

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1312 - Impact of Stent Timing on Clinical Outcomes of Esophagojejunal Anastomotic Leakage after Total Gastrectomy for Gastric Cancer

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¹Ordu Şehir Hastanesi

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Aim: Endoscopic stent therapy is an established treatment for esophagojejunal anastomotic leakage after total gastrectomy; however, the effect of the diagnosis-to-stent interval on clinical outcomes remains poorly defined. This study aimed to evaluate its association with the clinical success of stent therapy and with subsequent clinical outcomes.

Method: Between January 2021 and April 2026, 239 patients who underwent total gastrectomy for gastric cancer at the Division of Surgical Oncology, Ankara University Faculty of Medicine, were retrospectively screened. Twenty-nine patients who developed esophagojejunal anastomotic leakage and were treated with endoscopic stent placement were included. Demographic, perioperative, leak-related, stent-related, and clinical outcome data were reviewed. The interval between leak diagnosis and stent placement was evaluated in relation to clinical success and other outcomes using comparative analyses, logistic regression, and ROC analysis. The optimal cut-off was determined by the Youden index.

Findings: A total of 29 patients who underwent endoscopic stent placement for esophagojejunal anastomotic leakage were included in the study. Clinical success of stent therapy was achieved in 21 patients (72.4%). The diagnosis-to-stent interval was significantly shorter in the successful treatment group than in the unsuccessful group [median 3.0 (IQR 2.0–4.0) days vs. 6.5 (5.0–8.0) days; $p < 0.001$]. No significant differences were observed between the successful and unsuccessful groups in leak defect diameter, postoperative day of leak diagnosis, presence of sepsis/peritonitis at diagnosis, stent type, or stent fixation. When the diagnosis-to-stent interval was analyzed as a continuous variable, each additional day of delay in stent placement was associated with a significant decrease in the probability of clinical success (OR 0.24; 95% CI 0.08–0.73; $p=0.012$). On ROC analysis, the diagnosis-to-stent interval showed good discriminative ability in predicting clinical success (AUC=0.964). The Youden index identified 4 days as the optimal cutoff for discriminating clinical success. The clinical success rate was 100% in patients who underwent stent placement within the first 4 days, compared with 20.0% in those who underwent stent placement after 4 days ($p < 0.001$). Stent-related complication rates were

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15.8% and 80.0%, respectively ($p=0.001$), and re-laparotomy rates were 0% and 30.0%, respectively ($p=0.033$).

Figure 1: Receiver operating characteristic analysis of diagnosis-to-stent interval for clinical success

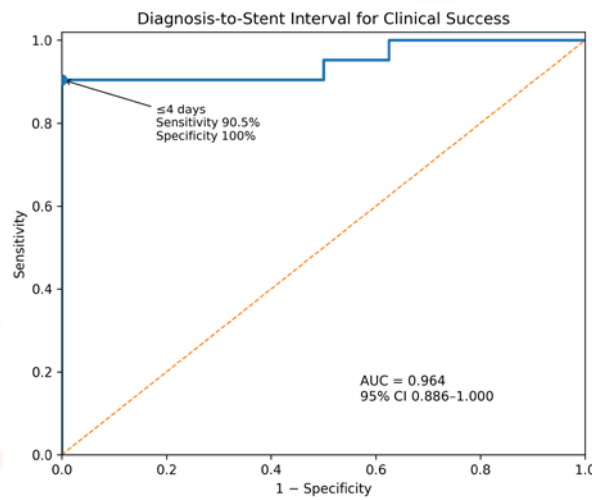


Table 1: Characteristics according to clinical success of stent treatment

Characteristic	Clinical success (n=21)	Clinical failure (n=8)	p value
Age, years	60 (55–67)	55.5 (50.8–61)	0.241
Male sex	16 (76.2%)	5 (62.5%)	0.646
BMI, kg/m ²	27.9 (26.2–30.5)	24.8 (23.8–28.0)	0.157
ASA ≥III	6 (28.6%)	2 (25.0%)	1.000
Leak diagnosis, POD	6 (5–8)	5 (4–8.2)	0.471
Leak defect size, mm	15 (10–15)	11 (10–15)	0.362

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Sepsis/peritonitis	6 (28.6%)	3 (37.5%)	0.675
Intra-abdominal abscess	7(33.3%)	3 (37.5%)	0.827
Percutaneous drainage	6(28,5 %)	2 (25%)	0.733
Stent placement, POD	9 (8-10)	12 (11.5-14.2)	0.013
Diagnosis-to-stent interval, days	3.0 (2.0-4.0)	6.5 (5.0-8.0)	<0.001
Fully covered SEMS	14 (66.7%)	6 (75.0%)	1.000
Stent fixation	14 (66.7%)	7 (87.5%)	0.381

Conclusion: A shorter diagnosis-to-stent interval, particularly within 4 days of leak diagnosis, was associated with higher clinical success, fewer stent-related complications, and lower re-laparotomy rates in patients with esophagojejunal anastomotic leakage. These findings suggest that minimizing delay in stent placement may improve outcomes. Given the retrospective, single-center design and limited sample size, these findings should be validated in larger prospective multicenter studies.

Keywords: Stomach neoplasms, anastomotic leak, self expandable metallic stents, gastrectomy

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1492 - Preoperative Albumin Level and Inflammatory-Nutritional Biomarkers as Predictors of Postoperative Complications in Curative Gastrectomy for Gastric Cancer: A Single-Center Cohort Study

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Aim: Preoperative inflammatory and nutritional biomarkers have emerged as cost-effective tools for risk stratification in gastric cancer surgery. The lymphocyte-albumin-neutrophil ratio (LANR) is a recently introduced composite index, yet its clinical utility in predicting surgical outcomes in gastric cancer remains unvalidated. This study aimed to evaluate the association of preoperative LANR, neutrophil-to-lymphocyte ratio (NLR), platelet-to-lymphocyte ratio (PLR), C-reactive protein-to-albumin ratio (CAR), and serum albumin level with postoperative complications, and — as an exploratory secondary objective — with NAC response, in patients undergoing curative gastrectomy.

Method: A retrospective cohort study was conducted on 67 consecutive gastric cancer patients who underwent curative gastrectomy between January 2023 and December 2025 at a tertiary referral center. Preoperative inflammatory indices (NLR, PLR, LANR, CAR) were calculated from routine blood tests. The primary outcome was the occurrence of postoperative complications (Clavien-Dindo grade $\geq$ II). In the NAC subgroup (n=35), RECIST response was used as the secondary outcome. Receiver operating characteristic (ROC) analysis was performed to determine optimal cut-off values.

Findings: Postoperative complications occurred in 15 patients (22.4%), with anastomotic leak being the most common specific complication (n=6, 9.0%). Preoperative albumin was the only significant predictor of postoperative complications (median 36.6 vs. 41.5 g/L; p=0.023; AUC=0.695; OR=8.22, 95%CI 2.09–32.39; p=0.003 at cut-off $\leq$ 36.60 g/L). NLR, PLR, LANR (corrected formula: lymphocyte $\times$ albumin / neutrophil), and CAR did not significantly predict postoperative complications or anastomotic leak. In the NAC subgroup (n=27 with evaluable RECIST data), the corrected LANR showed a non-significant trend toward higher values in good compared to poor responders (median 19.84 vs. 13.73; p=0.095; AUC=0.704). These results are considered exploratory given the small sample size and the post-NAC timing of blood sampling.

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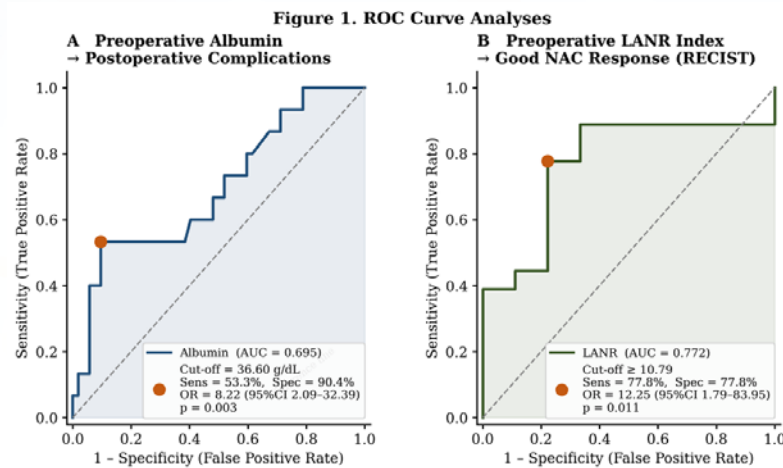
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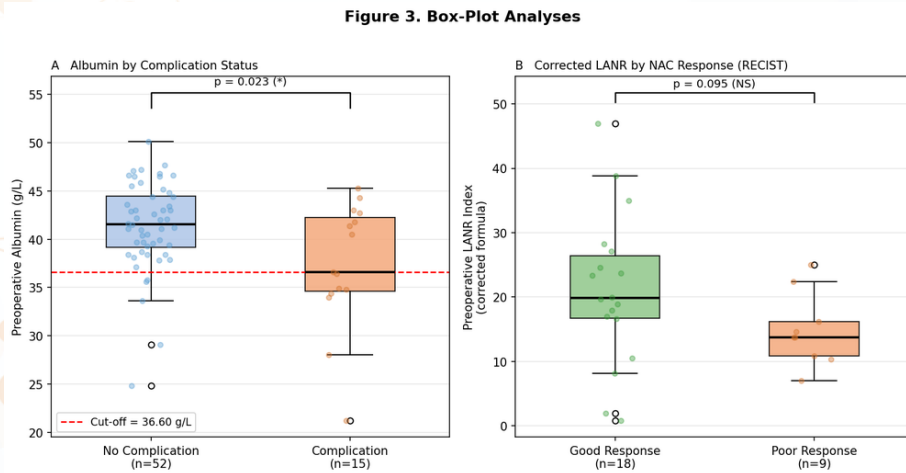
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Preoperative albumin-complications and preoperative LANR index-NAC response ROC curve



Preoperative albumin-complications and preoperative LANR Index-NAC response box-plot analyses



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Biomarker-Complications Table

Biomarker / Outcome	No Complication (n=42) Median [IQR]	Complication (n=25) Median [IQR]	p
Albumin (g/L)	41.55 [39.15–44.50]	36.60 [34.60–42.25]	0.023*
NLR	2.27 [1.66–3.08]	2.41 [1.72–3.22]	0.697
LANR	18.76 [13.73–23.47]	18.94 [13.23–25.20]	0.886
CAR	0.06 [0.03–0.18]	0.06 [0.03–0.13]	0.937
Hospital LOS (days)	11.00 [9.00–14.25]	29.00 [19.50–44.00]	<0.001
Anastomotic Leak Subanalysis	No Leak (n=61)	Leak (n=6)	
Albumin (g/L)	41.60 [38.70–44.40]	35.65 [34.23–36.55]	0.006*
LANR	18.23 [13.72–23.35]	25.80 [15.92–36.18]	0.497

Comparison of preoperative biomarkers by complication status. All values are median [IQR]. *p < 0.05; **p < 0.01. Mann-Whitney U test throughout. LANR = (Lymphocyte × Albumin) / Neutrophil; CAR = CRP/Albumin; NLR = Neutrophil/Lymphocyte; LOS = length of stay; IQR = interquartile range.

Conclusion: Preoperative serum albumin is a significant predictor of postoperative complications in gastric cancer surgery, with hypoalbuminemia (≤ 36.60 g/L) associated with an 8-fold increase in complication risk. The corrected LANR index showed a non-significant trend toward higher values in NAC responders, warranting prospective evaluation. These findings support routine preoperative albumin assessment for surgical risk stratification in gastric cancer patients.

Keywords: Gastric cancer, gastrectomy, albumin, postoperative complications, neoadjuvant chemotherapy

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1794 - Pathological Tumor Size and Adverse Histopathological Features in Gastric Cancer: Does Neoadjuvant Chemotherapy Matter?

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Aim: Pathological tumor size is routinely reported after gastrectomy, yet its relationship with adverse histopathological features remains incompletely defined in gastric cancer. This study aimed to evaluate the association between pathological tumor size and pathological T stage (pT), pathological N stage (pN), lymphovascular invasion (LVI), perineural invasion (PNI), and lymph node ratio (LNR), and to determine whether these associations differ according to neoadjuvant chemotherapy (NACT) status.

Method: A retrospective analysis was conducted on 56 patients who underwent curative-intent gastrectomy for gastric adenocarcinoma. Pathological tumor size, pT stage, pN stage, LVI, PNI, and LNR were recorded from final pathology reports. Patients were evaluated as an overall cohort and according to NACT status (NACT, n=20; upfront surgery, n=36). Associations between tumor size and pT stage, pN stage, and LNR were assessed using Spearman correlation analysis. Differences in tumor size according to LVI and PNI status were analyzed using the Mann-Whitney U test. Statistical significance was defined as $p < 0.05$.

Findings: In the overall cohort, pathological tumor size was positively correlated with pT stage ($p=0.399$, $p=0.002$) and was significantly greater in patients with LVI ($p=0.003$) and PNI ($p=0.029$). No significant association was observed with pN stage ($p=0.150$) or LNR ($p=0.232$). Among patients who received NACT, residual pathological tumor size demonstrated a strong correlation with pT stage ($p=0.628$, $p=0.003$) and significant correlations with pN stage ($p=0.467$, $p=0.038$) and LNR ($p=0.457$, $p=0.043$). Larger residual tumors were also significantly associated with LVI ($p=0.008$) and PNI ($p=0.008$). In contrast, among patients undergoing upfront surgery, pathological tumor size showed no significant association with pT stage, pN stage, LNR, LVI, or PNI (all $p > 0.05$).

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Conclusion: Pathological tumor size was associated with several adverse histopathological features in gastric cancer, including advanced local invasion, lymphovascular invasion, and perineural invasion. Notably, these associations were most pronounced among patients who received neoadjuvant chemotherapy, in whom tumor size also correlated with nodal disease burden and lymph node ratio. These findings suggest that the relationship between pathological tumor size and tumor aggressiveness may differ according to neoadjuvant treatment status and warrants further investigation in larger cohorts.

Keywords: Gastric cancer, pathological tumor size, neoadjuvant chemotherapy

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2250 - Nutritional Reserve and the Complication Cascade after Gastrectomy: A Single-centre Retrospective Cohort Study

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¹Başakşehir Çam ve Sakura City Hospital

Aim: Composite haematological indices such as HALP and CIPI are increasingly reported as predictors of morbidity after gastrectomy, but whether they outperform their constituent analytes is rarely tested. Since complications seldom occur in isolation, we also asked whether such markers indicate who develops a complication or who fails to contain one.

Method: We analysed 199 consecutive gastrectomy patients with complete preoperative laboratory data and complications graded by Clavien-Dindo. Eight markers were compared: albumin, CEA, NLR, PLR, SII, PNI, HALP and CIPI. Prediction was split into two stages: whether any complication occurred, and — among those who developed one — whether it escalated to ≥ 4 concurrent complications. Cut-offs came from the Youden index; incremental value from nested likelihood-ratio tests and cross-validation.

Findings: Leak occurred in 20 patients (10.1%), major morbidity in 33 (16.6%), death in 5 (2.5%); no deaths occurred with ≤ 2 complications ($n=170$). Albumin discriminated poorly for occurrence of any complication (AUC 0.618) but strongly for escalation (0.912), ranking above every composite for leak (0.906 vs PNI 0.880, HALP 0.827, CIPI 0.820). Cut-offs were albumin ≤ 32 g/L (leak 54.5% vs 1.2%; sensitivity 90%, specificity 92%), HALP ≤ 2.35 (24.1% vs 0.8%) and CIPI ≥ 17 (30.8% vs 2.7%). Adding HALP to albumin did not improve prediction of major morbidity ($\chi^2=0.04$, $p=0.84$), whereas CIPI did ($\chi^2=7.25$, $p=0.007$) — CIPI equals CEA $\times$ NLR, a tumour-burden axis. Cross-validated discrimination was highest for albumin plus CIPI (0.924 vs 0.899). Albumin predicted leak (OR 0.70 per g/L, $p < 0.0001$) and death overall (OR 0.78, $p=0.010$) but not death once leak had occurred (OR 1.06, $p=0.69$). Tumour stage predicted nothing.

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Analysis of preoperative albumin, PNI, HALP and CIPI in relation to postoperative complications, mortality and risk stratification

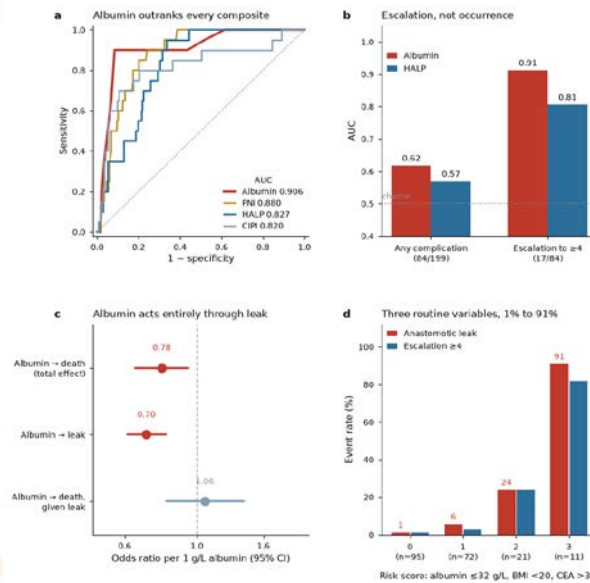


Figure 1: (a) Receiver-operating characteristic curves for the four best-performing markers in predicting anastomotic leak (20 events among 199 patients); legend gives the area under each curve. (b) Discrimination of albumin and HALP at two prediction stages — whether any complication occurred, and, among the 84 patients who developed one, whether it escalated to four or more concurrent complications. Both markers are near chance for occurrence and strong for escalation. (c) Odds ratios per 1 g/L albumin from three sequential logistic models; the association with death disappears once leak has occurred, indicating that albumin acts on mortality entirely through leak. Points are odds ratios, lines 95% confidence intervals. (d) Anastomotic leak and escalation rates by the three-point score (one point each for albumin ≤ 32 g/L, body mass index < 20 kg/m² and CEA > 3.9 ng/mL); patient numbers per score are given on the axis.

Conclusion: Albumin alone matched or exceeded every composite index. HALP added nothing beyond it; CIPI did, because it encodes tumour burden rather than nutrition. Markers indicated not who developed a complication but who failed to contain one — supporting graded postoperative vigilance.

Keywords: Gastric cancer, gastrectomy, anastomotic leak, HALP score, serum albumin

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2391 - Surgical Treatment of Adrenal Metastases from Gastric Cancer: A Systematic Review

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Aim: Adrenal metastases from gastric cancer are rare, and the survival benefit of adrenalectomy remains uncertain. This systematic review aimed to evaluate the clinical characteristics and surgical and oncological outcomes of patients who underwent adrenalectomy for adrenal metastases from gastric cancer.

Method: Electronic databases were systematically searched, and the reference lists of eligible studies were screened. Case reports and case series describing patients who underwent adrenalectomy for adrenal metastases from gastric cancer were included. Data were extracted on demographics, characteristics of the primary tumor and adrenal metastasis, synchronous or metachronous presentation, presence of extra-adrenal disease, treatments, recurrence, follow-up, and survival. Overall survival (OS), disease-free survival (DFS), and recurrence-free survival (RFS) were estimated using the Kaplan–Meier method. Outcomes were compared between synchronous and metachronous metastases and between isolated and non-isolated adrenal metastases.

Findings: Thirty-five patients reported in 34 publications were included. Among the 24 patients evaluable for DFS/RFS, the 1- and 3-year DFS/RFS rates were both 59.6%. No significant differences were observed between synchronous and metachronous metastases in OS ($p=0.532$) or DFS/RFS ($p=0.527$). The 1-year DFS/RFS rate was 71.6% in patients with isolated adrenal disease and 37.5% in those with non-isolated disease ($p=0.111$). OS was numerically better in the isolated adrenal metastasis group than in the non-isolated group, although the difference did not reach statistical significance (1-year OS, 100% vs 73%; $p=0.053$).

Conclusion: Long-term survival after adrenalectomy is achievable in selected patients with gastric cancer, particularly those with isolated adrenal metastasis, irrespective of synchronous or metachronous presentation. Adrenalectomy should not be recommended routinely; however, it may be considered in fit patients with oligometastatic disease in whom

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all disease can be completely resected (R0) and who show no progression during systemic therapy.

Keywords: Gastric cancer, adrenal metastasis, adrenalectomy, metastasectomy, oligometastatic disease, systematic review.

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2420 - Time-Related Trends In The Lauren Classification Of Gastric Adenocarcinoma: A Single-Center Retrospective Study

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Aim: Gastric cancer is the fifth most common cause of mortality of cancer worldwide. Lauren classification is widely used system for gastric adenocarcinomas according to their histopathological features. In this study, we investigated recent temporal changes of gastric adenocarcinoma in Türkiye.

Method: This retrospective study was designed using demographic and clinicopathological data from institutional records of patients who underwent gastric resection for gastric adenocarcinoma at a single center between 2015 and 2026. Tumor location was categorized as cardia, fundus, corpus, antrum and linitis for the tumor covering all the stomach. Histopathological subtype was classified as diffuse, intestinal, and mixed types according to the Lauren classification. Patients with unclassified histology and missing classification data (n=102) were excluded from the analysis. To assess temporal variation, patients were divided into two study periods (2015–2020 and 2021–2026).

Findings: A total of 347 patients who underwent gastric resection were included in the study. Tumor localization demonstrated a temporal change between the two study periods ($p=0.003$). The most prominent finding was an increase in the proportion of cardia tumors, from 23.8% in 2015–2020 to 39.8% in 2021–2026. The proportion of corpus tumors decreased from 38.1% to 25.1%. Regarding tumor localization, the proportion of antral tumors decreased modestly from 36.7% in 2015–2020 to 33.5% in 2021–2026, although this temporal change was not statistically significant ($p=0.609$). After excluding unclassified tumors, 239 patients were included in the histopathological subtype analysis. Diffuse-type tumors decreased from 46.3% in 2015–2020 to 34.4% in 2021–2026, whereas intestinal-type tumors increased from 50.0% to 60.7%. The overall three-category Lauren distribution did not reach statistical significance ($p=0.132$). Similar results reported, when mixed-type tumors were excluded and diffuse and intestinal types were compared directly ($p=0.068$). Moreover, year-based trend analysis demonstrated an annual increase in intestinal-type tumors ($p=0.035$) and a corresponding annual decrease in diffuse-type tumors ($p=0.035$). For cardia tumors, the annual trend had a meaningful difference, with an approximately 15.6% increase in the odds of cardia localization per year ($p < 0.001$).

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Conclusion: These findings suggest a temporal shift in the anatomical location and Lauren classification of gastric adenocarcinoma.

Keywords: Gastric adenocarcinoma, lauren classification, anatomical subsite, trends over time

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2564 - Clinical Impact of Genetic Testing in Gastric Tumors; The Selective Effect of Variants and Family History

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Aim: To evaluate the contribution of comprehensive hereditary cancer panels performed in patients followed for gastric tumors to treatment decisions and family screening in general surgical practice.

Method: 61 Gastric tumor cases in whom a germline hereditary cancer panel was studied were retrospectively reviewed (37 operated at our center, 14 operated at an outside center, 10 non-operative). Variants were grouped as pathogenic/likely pathogenic (P/LP; Class 1–2) and variant of uncertain clinical significance (VUS; Class 3); descriptive statistics were used.

Findings: The median age was 55.5 (30.9–80.1), there were 31 male/30 female patients, and the median follow-up was 51 months. Of the 37 cases operated at our center, 18 had undergone subtotal/distal and 15 total or near-total gastrectomy; an additional primary tumor had been detected in 18 cases (29.5%). A total of 110 variants were found on the genetic tests performed; at least one variant was detected in 48 cases (78.7%). Eighty percent of the variants (88/110) were VUS, and 47.5% of the cases (29/61) had a report containing VUS only. A pathogenic variant was found in 9 cases (14.8%), and a likely pathogenic variant in 10 cases. P/LP variants were predominantly in the DNA damage response/homologous recombination pathway (12 cases; ATM, BRCA cases; ATM2, NBN, CHEK2, RAD51D, MRE11, RINT1, POLE); MMR/Lynch (MLH1, MSH2, MSH6, PMS2) was detected in 3 cases, MUTYH in 2 cases, CDH1 in 1 case, and MEN1 in 1 case. The CDH1 carrier was a non-operative case whose father and two siblings had been lost to gastric cancer. Two of the CTNNA1 variants were at the VUS level. Family history was selective: a P/LP variant was detected in 50% (10/20) of those with gastric cancer in the family and in 22% (9/41) of those without, and 18/19 (94.7%) of the P/LP carriers had a history of cancer in family members.

Conclusion: Comprehensive panels reveal carriership in approximately one third of the cases. The great majority of the results are VUS, which are taken into follow-up in the medical genetics outpatient clinic but do not change management in surgical practice. A CDH1 finding, which may directly affect the extent of resection, is rare. Genetic tests are important for systemic treatment planning, metachronous tumor screening, and the evaluation of family members. It is particularly important that the tests not be omitted in

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individuals in whom the family history is prominent. VUS, on the other hand, should not be disregarded in patient follow-up. They cannot be the main basis of the surgical decision; however, their follow-up through periodic reclassification in the light of the recurring literature, familial segregation studies, and prioritization according to phenotype is extremely important.

Keywords: Gastric cancer, germline panel, pathogenic variant, variant of uncertain clinical significance (VUS), surgical management

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2821 - Gastric Splenosis and Gastric Accessory/Ectopic Spleen: A Systematic Review of 74 Cases

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Aim: Gastric splenosis and accessory or ectopic spleen involving the stomach are rare lesions that generally require no treatment. Because they may mimic gastric subepithelial lesions, particularly gastrointestinal stromal tumors (GISTs), they can lead to unnecessary invasive procedures. This systematic review aimed to characterize the distinguishing diagnostic features of gastric splenosis and gastric accessory/ectopic spleen and to summarize the clinical experience reported in 74 published cases.

Method: PubMed/MEDLINE, Google Scholar, Web of Science, and Scopus were searched. Studies reporting clinical, imaging, treatment, or outcome data on splenosis, accessory spleen, splenule, or ectopic splenic tissue located in or adjacent to the stomach were included.

Findings: Seventy-four patients from 72 reports were analyzed. Forty-nine patients had splenosis, representing acquired ectopic splenic tissue, whereas 25 had an accessory spleen, splenule, or ectopic spleen. The median age was 49 years (range, 1.5–77 years), and the median lesion diameter was 2.7 cm (range, 0.9–12.7 cm). Ninety percent of the lesions were located in the proximal stomach, and 82% were initially diagnosed as GISTs or other gastric subepithelial neoplasms. A history of splenectomy or splenic trauma was present in 86% of patients. Endoscopic ultrasound-guided biopsy yielded diagnostic tissue in 10 of 15 patients (66%). Nuclear imaging was used in only nine patients and correctly identified ectopic splenic tissue in all cases. Overall, 79% of patients underwent unnecessary invasive procedures, including surgical or endoscopic resection, because of alternative presumptive diagnoses. No deaths occurred among patients receiving invasive treatment; however, four complications (9.5%) were reported. Bleeding was the most common presentation among symptomatic patients and occurred in 16 cases. Bleeding lesions were larger than asymptomatic lesions (median, 6.0 vs 2.7 cm; $p=0.03$), and the bleeding rate among lesions larger than 4 cm was 37.5%.

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Conclusion: Gastric ectopic splenic tissue should be considered in the differential diagnosis of GIST-like subepithelial lesions, particularly those located in the fundus or proximal stomach. A history of splenectomy or splenic trauma should heighten diagnostic suspicion. Splenic tissue-specific nuclear imaging and endoscopic ultrasound-guided biopsy may help reduce unnecessary invasive interventions.

Keywords: Splenosis, accessory spleen, ectopic spleen, gastric subepithelial lesion, gastrointestinal bleeding

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2943 - Pathological T Stage And Omental Tumor Involvement in Gastric Adenocarcinoma: A Retrospective Cohort Study

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Aim: To investigate the association between pathological T stage and omental/perigastric tumor involvement in patients undergoing surgical resection for gastric adenocarcinoma and to determine whether advanced pathological T stage is associated with a higher frequency of such involvement.

Method: This retrospective study included patients who underwent surgical resection for gastric adenocarcinoma. Omental/perigastric involvement was defined as a composite pathological endpoint comprising discrete tumor deposits or satellite foci in perigastric fat, tumor involvement of the omentum, metastatic lymph nodes within omental tissue, or tumor involvement of an omental surgical margin. Direct contiguous extension of the primary tumor into perigastric fat alone was not considered positive. Among 233 patients with confirmed gastric adenocarcinoma, 227 had evaluable pathological T stages between T1 and T4b. Stage-specific involvement rates were compared using the Fisher-Freeman-Halton test, followed by Holm-adjusted pairwise comparisons. A sensitivity analysis excluding anatomically uncertain cases was also performed

Findings: Omental/perigastric involvement was identified in 48 of 227 evaluable patients (21.1%). The involvement rate was 0/28 (0%) in T1, 0/30 (0%) in T2, 6/52 (11.5%) in T3, 39/103 (37.9%) in T4a, and 3/14 (21.4%) in T4b tumors. Pathological T stage was significantly associated with omental/perigastric involvement ($p < 0.001$). T4a tumors had a significantly higher involvement rate than T3 tumors (37.9% vs. 11.5%; Holm-adjusted $p=0.0032$). When T4a and T4b were combined, T4 disease was associated with higher odds of involvement compared with T3 disease (odds ratio [OR] 4.29, 95% confidence interval [CI] 1.69–10.89; $p=0.0009$). In an exploratory multivariable analysis adjusted for age, sex, and pathological staging prefix (p vs. yp), T4 stage remained independently associated with involvement

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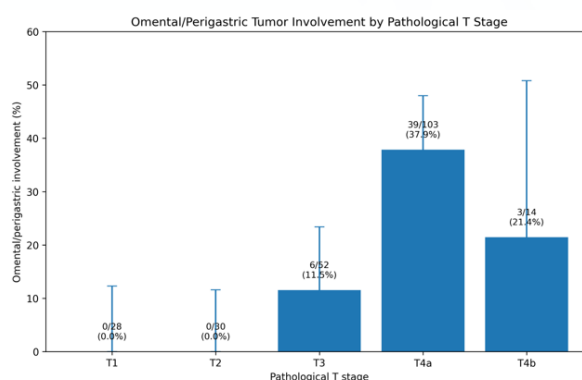


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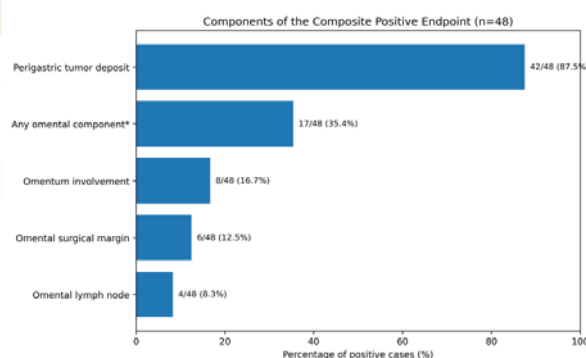
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(adjusted OR 4.68, 95% CI 1.77–12.35; $p=0.0018$). Excluding four anatomically uncertain cases did not materially alter the association ($p < 0.001$).

Omental tumor involvement by pathological T stage



Components of the composites positive endpoint



Conclusion: Omental/perigastric tumor involvement was significantly associated with advanced pathological T stage in gastric adenocarcinoma and was most frequently observed in T4a tumors. These findings suggest that greater local tumor depth may serve as a marker of increased likelihood of omental/perigastric tumor involvement. The persistence of the association after sensitivity and adjusted analyses further supports the consistency of this finding.

Keywords: Gastric cancer, omental metastasis, T stage

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2944 - The Effect of Neoadjuvant Chemotherapy on Postoperative Outcomes and Survival in Gastric Cancer Patients

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Aim: Neoadjuvant chemotherapy has emerged as a promising strategy to improve outcomes. The aim of this study is to investigate the effects of neoadjuvant chemotherapy on postoperative outcomes, morbidity, and long-term survival in patients undergoing curative-intent treatment for gastric cancer.

Method: This study is a retrospective cohort study evaluating patients who underwent curative-intent gastrectomy at the Karadeniz Technical University, between May 2015 and October 2025. Patients were divided into two groups: those who received neoadjuvant chemotherapy prior to surgery (NAC group) and those who underwent upfront surgery (Surgery group). The primary endpoint was major postoperative complications, while the secondary endpoints were oncological resection margins, overall survival, and recurrence-free survival. Clinical, pathological, and follow-up data of the patients were obtained from the Upper GI Department database and the hospital medical record system. Logistic regression models were used to analyze postoperative complications and determine risk factors. For survival analyses, the Kaplan-Meier method was used to generate survival curves, and differences between groups were compared using the log-rank test. Besides, Cox regression analyses was used to identify prognostic factors related to survival outcomes.

Findings: Following several exclusion criteria were applied, a total of 236 patients were included in the study; 83 patients (35.2%) received NAC. No statistically significant difference was observed in patients receiving NAC compared to the surgery group in terms of major postoperative complications, need for reoperation, length of hospital stay, and mortality. In the analysis of oncological outcomes, NAC was found to have no independent association with overall survival (HR=1.03, [0.65–1.65], p=0.892). On the other hand, when patients who underwent curative resection were evaluated, recurrence-free survival was lower in the NAC group (HR=2.32, [1.33–4.05], p=0.003). This is likely due to the selection bias inherent in the retrospective nature of the study and the fact that the NAC patient group had a more advanced clinical stage and a higher tumor burden at the time of diagnosis.

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Conclusion: The presented study demonstrated that with appropriate patient selection, gastrectomy following neoadjuvant chemotherapy can be performed without increasing major postoperative complications and without compromising surgical safety. There was no statistically significant effect on overall survival. The observed disadvantage regarding recurrence-free survival is likely associated with selection bias.

Keywords: Neoadjuvant treatment, complication, overall survival, disease-free survival, gastric cancer

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3271 - Patients' Experiences, Perceptions and Acceptability of Prehabilitation Before Upper Gastrointestinal Cancer Surgery: 'My Part in the Fight'

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Aim: Prehabilitation has become an increasingly important component of perioperative care for patients undergoing surgery for upper gastrointestinal (UGI) cancers. Current programmes commonly incorporate exercise, nutritional optimisation and psychological support, with growing evidence suggesting reduced incidence post-operative pneumonia, reduced hospital length of stay and reduced rate of readmission. Relevant reviews predominantly focus on quantitative outcomes such as postoperative complications, length of stay, functional capacity and quality of life. However, retrospective studies demonstrate the majority of patients (up to 82%) decline, drop out of, or miss elements of prehabilitation due to fatigue, clerical issues, or lack of support. Understanding how patients perceive, engage with and make sense of prehabilitation is essential to understand this gap. We aim to examine published factors influencing engagement with prehabilitation, thereby informing the design of more patient-centred services.

Method: A systematic electronic search of qualitative and mixed-methods studies included MEDLINE, Embase, CINAHL, PsycINFO. Eligible studies included adults undergoing prehabilitation before curative surgery for oesophageal, gastro-oesophageal junction or gastric cancer and reporting qualitative data on patients' experiences, perceptions or acceptability of prehabilitation. Studies reporting only quantitative patient-reported outcomes or satisfaction measures were excluded. Methodological quality was assessed using the Critical Appraisal Skills Programme (CASP) qualitative checklist. Data were synthesised using Thomas and Harden's thematic synthesis to generate descriptive and analytical themes.

Findings: Six studies met the inclusion criteria, comprising two qualitative studies and four mixed-methods studies involving patients undergoing prehabilitation before upper gastrointestinal cancer surgery. Thematic synthesis identified five overarching themes: Reclaiming control following cancer diagnosis, where participation represented an active response to uncertainty; motivation through perceived surgical readiness, with patients viewing prehabilitation as an opportunity to optimise recovery; relationships as enablers of engagement, highlighting the importance of clinician encouragement, family support and

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personalised supervision; treatment burden as a barrier, including chemotherapy-related fatigue, logistical challenges and competing demands; and the need for flexible, individualised programmes, with patients favouring tailored interventions that accommodated changing physical and psychological needs. These themes informed a preliminary conceptual framework describing patient engagement with prehabilitation as a dynamic process influenced by perceived agency, support and treatment burden.

Conclusion: Existing qualitative evidence suggests that engagement with prehabilitation is shaped not only by programme content but also by patients' perceived agency, treatment burden and social support. The proposed conceptual framework provides a patient-centred perspective that may help to inform design and implementation of future upper gastrointestinal prehabilitation services.

Keywords: Patient perspective, upper gastrointestinal cancer, prehabilitation, oesophagectomy, gastrectomy

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4235 - The Rapid Rise of PD-L1 Testing in Gastric Cancer: A 5-Year Trend Analysis of 521 Consecutive Gastrectomies

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Aim: Current guidelines recommend mismatch-repair or microsatellite instability (MMR/MSI), HER2, and PD-L1 testing in gastric cancer. While numerous studies report biomarker positivity rates, the actual testing rate (the denominator) in real-world surgical cohorts is rarely reported. We investigated the frequency and predictors of biomarker testing in a complete consecutive surgical series and estimated the number of missed immunotherapy candidates.

Method: We retrospectively reviewed the full pathology reports of 521 consecutive gastrectomies performed at a single tertiary center between November 2020 and June 2026. No patients were excluded, ensuring a complete denominator. For each specimen, the performance and results of MMR/MSI, HER2, and PD-L1 testing were recorded. Temporal uptake was analyzed using the Cochran-Armitage trend test, and predictors of testing were evaluated using multivariable logistic regression adjusted for calendar year.

Findings: Testing rates were 54.3% (n=283) for HER2, 49.1% (n=256) for MMR/MSI, and 15.9% (n=83) for PD-L1. All three markers were assessed in 12.3% (n=64) of patients, while 34.2% (n=178) underwent no testing at all. From 2021 to 2026, MMR/MSI uptake increased from 3.4% to 64.0%, and PD-L1 increased from 8.6% to 40.0% (both $P < 0.001$); HER2 testing remained stable at approximately 50% ($P = 0.31$). In the adjusted model, calendar year was the sole significant predictor of testing (MMR/MSI adjusted OR 1.86 per year, 95% CI 1.51–2.27; PD-L1 aOR 1.47, 95% CI 1.16–1.86). Age, histological subtype, pT category, and neoadjuvant chemotherapy were not predictive. Among tested patients, 18.8% (48/256) were MSI-H and 34.6% (28/81) had a PD-L1 Combined Positive Score (CPS) ≥ 5 . Extrapolating these rates suggests that approximately 50 MSI-H and 151 PD-L1-high tumors potentially went unidentified in the untested cohort. A CPS ≥ 5 was significantly associated with MSI-H status (81.2% in MSI-H vs. 21.6% in MSS; OR 15.8, $P < 0.001$).

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Table 1: Temporal trends in biomarker testing uptake (2021 vs. 2026)

Biomarker	2021 Testing Rate	2026 Testing Rate	Trend Significance (P-value)	Adjusted Odds Ratio (Per Year)*
PD-L1	8.6%	40.0%	P < 0.001	1.47 (95% CI: 1.16–1.86)
MMR/MSI	3.4%	64.0%	P < 0.001	1.86 (95% CI: 1.51–2.27)
HER2	~50.0%	~50.0%	P = 0.31	Not Significant

Adjusted for calendar year. Age, histological subtype, pT category, and neoadjuvant chemotherapy were not predictive of testing.

Conclusion: One-third of gastrectomy patients received no predictive biomarker testing. Testing was driven primarily by the year of surgery rather than tumor or patient characteristics. While HER2 and MMR/MSI have historically been more established in routine practice, the significant recent rise in PD-L1 testing likely reflects the expanding clinical literature, the increased availability of commercial pathology kits, and improved access to immunotherapies such as pembrolizumab and durvalumab in recent years. Given the strong clustering of PD-L1 positivity in MMR-deficient tumors, prioritizing MMR testing remains a pragmatic first step in resource-limited settings.

Keywords: Gastric cancer, microsatellite instability, PD-L1, biomarker testing, monoclonal antibody

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4237 - Is Double-Tract Reconstruction Inferior to Roux-en-Y Reconstruction in Proximal Gastric Cancer Surgery? A Retrospective Analysis of Functional and Nutritional Outcomes

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Aim: The optimal reconstruction method following resection for proximal gastric cancer remains controversial. This study aimed to compare the clinical, endoscopic, metabolic/nutritional, and survival outcomes of total gastrectomy with Roux-en-Y esophagojejunostomy (TG+RnY) and proximal gastrectomy with double-tract reconstruction (PG+DTR).

Method: Patients who underwent surgery for distal esophageal or upper-third gastric cancer between January 2015 and November 2022 were retrospectively reviewed. Patients with at least 2 years of follow-up who underwent either TG+RnY or PG+DTR were included. Patients with distant metastases, palliative surgery, early recurrence, death within 2 postoperative years, or incomplete data were excluded. Endoscopic findings according to the Los Angeles classification, laboratory-based nutritional and metabolic parameters at postoperative years 1 and 2, and survival outcomes were evaluated. Survival was analyzed using the Kaplan–Meier method and compared with the log-rank test.

Findings: A total of 97 patients were included in the analysis (TG+RnY, n=46; PG+DTR, n=51). The mean age was 57.39±12.49 years, and 70.1% of the patients were male. Postoperative endoscopy demonstrated a higher rate of normal findings in the DTR group (92.2% vs 63.0%), whereas esophagitis was more frequent in the RnY group (7.8% vs 37.0%; P < 0.001). Kaplan–Meier analysis showed no statistically significant difference in overall survival (OS) between the groups (P=0.054), and no significant difference was observed in progression-free survival (PFS) (P=0.21). At postoperative year 2, phosphorus (P=0.005) and vitamin D levels (P=0.01) were higher, whereas lactate dehydrogenase levels were lower (P=0.02) in the DTR group. Analysis of changes between postoperative years 1 and 2 [Δ (year 2–year 1)] showed greater increases in albumin (P=0.005), calcium (P=0.04), and vitamin D (P=0.001) in the DTR group.

Conclusion: Compared with TG+RnY, PG+DTR was associated with fewer abnormal endoscopic findings and more favorable recovery in selected nutritional and metabolic parameters, without a statistically significant difference in survival outcomes. These

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findings suggest that PG+DTR is not inferior to TG+RnY, at least with respect to survival and major clinical outcomes. However, given the imbalance in tumor location between the groups, these results should be interpreted cautiously and validated in prospective studies or analyses with appropriate adjustment for baseline differences.

Keywords: Cardia tumors, double-tract reconstruction, proximal gastric cancer, nutritional outcomes

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4473 - "Can Surgery be Avoided in Gastric MiNEN? A Case Managed with Endoscopic Resection and Close Surveillance"

Mehmet Ömer ÖZDUMAN¹

¹Kartal Koşuyolu Yüksek İhtisas Eğitim ve Araştırma Hastanesi

Aim: Can Surgery Be Avoided in Gastric MiNEN? A Case Managed with Endoscopic Resection and Close SurveillanceIntroductionGastric mixed neuroendocrine–non-neuroendocrine neoplasms (G-MiNENs) are rare, heterogeneous tumors containing neuroendocrine and non-neuroendocrine components and account for less than 1% of gastric malignancies . Evidence regarding optimal treatment is limited, and surgical resection remains the predominant approach for localized disease . Evidence for endoscopic treatment followed by non-operative surveillance is scarce. We present a G-MiNEN managed by endoscopic resection and close surveillance.

Method: This case report was prepared based on the retrospective review of the patient's clinical, endoscopic, histopathological, and radiological records. Diagnostic findings, endoscopic treatment, histopathological characteristics, and follow-up outcomes were evaluated. The patient was managed through a multidisciplinary decision-making process, and follow-up was performed using serial endoscopic and radiological assessments.

Findings: Case PresentationA 52-year-old woman was referred after endoscopy revealed multiple lesions extending from the proximal stomach to the distal corpus. Initial biopsies showed grade 2 neuroendocrine tumor (NET). 68Ga-DOTATATE PET/CT demonstrated intense uptake in two gastric lesions (SUVmax 30.77). Endoscopy at our center revealed multiple corpus polypoid lesions, the largest approximately 3 cm. The dominant mid-corpus lesion was removed en bloc by endoscopic submucosal dissection (ESD).Histopathology demonstrated G-MiNEN comprising a grade 1 well-differentiated NET (2.3 cm) and a well-differentiated adenocarcinoma component (1 cm; approximately 15%). Both components invaded the submucosa (4 mm and 2 mm, respectively). Ki-67 was 2%, with 0–1 mitoses/10 HPF. No lymphovascular or perineural invasion was detected. Adenocarcinoma margins were negative; the NET extended to the lateral margin and was within 1 mm of the deep margin. CT and 18F-FDG PET/CT showed no nodal or distant metastases. Surgery and surveillance were discussed, and close non-operative follow-up was selected.At 3 months, two approximately 1-cm corpus nodules were removed by snare polypectomy. Pathology showed grade 2 NETs measuring 0.9 and 1.0 cm (Ki-67 10% and 5.6%), without lymphovascular or perineural invasion. Biopsies from the previous ESD scar showed no

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residual/recurrent MiNEN or adenocarcinoma. The patient remains under close endoscopic and radiological surveillance without surgery

Gastric lesion



Gastric lesion treated by esd

Gastric lesion



After esd

Conclusion: Endoscopic management followed by non-operative surveillance may be feasible in highly selected G-MiNEN patients. However, surgery remains the predominant treatment for localized disease, and long-term surveillance is essential before the oncological safety of an organ-preserving strategy can be established

Keywords: Gastric MiNEN, neuroendocrine tumor, endoscopic submucosal dissection

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4474 - Is Young-Onset Gastric Adenocarcinoma More Aggressive? A Clinicopathological and Histological Comparison

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Aim: Young-onset gastric adenocarcinoma has been reported to exhibit more aggressive tumor biology and to present at a more advanced stage. This study compared the clinicopathological features of patients aged ≤ 50 and > 50 years who underwent gastrectomy, focusing on stage, nodal burden, metastatic spread, and histological phenotype.

Method: This single-center retrospective cohort included 235 patients (≤ 50 years, $n=22$; > 50 years, $n=213$). Non-adenocarcinoma gastric malignancies, non-gastric primary tumors, and Siewert type I gastroesophageal junction adenocarcinomas were excluded. Groups were compared for pathological/post-neoadjuvant pathological (p/yp) T and N stages, lymph node ratio (LNR), lymphovascular invasion (LVI), perineural invasion (PNI), metastatic (M1) disease, peritoneal/omental dissemination or positive peritoneal cytology, and histological characteristics. Fisher's exact, Fisher-Freeman-Halton exact, and Mann-Whitney U tests were used. Available-case analysis was used for missing histological data. Exploratory logistic regression models were adjusted for sex and neoadjuvant treatment.

Findings: The ≤ 50 -year group did not have higher rates of p/ypT3-4 disease (59.1% vs 73.2%; $p=0.211$), M1 disease (13.6% vs 10.9%; $p=0.721$), or peritoneal/omental dissemination or positive cytology (9.1% vs 9.6%; $p=1.000$). N3 disease, LVI, PNI, and median LNR were also similar (all $p \geq 0.351$). Nodal positivity was numerically higher in younger patients (81.8% vs 63.7%; $p=0.103$). Poorly cohesive morphology (84.2%, 16/19 vs 56.1%, 83/148; $p=0.024$) and a signet-ring cell component (77.8%, 14/18 vs 45.2%, 61/135; $p=0.012$) were more frequent in younger patients. Lauren subtype distribution also differed ($p=0.014$). After adjustment, age ≤ 50 years was independently associated with poorly cohesive morphology (adjusted odds ratio [aOR] 3.99, 95% confidence interval [CI] 1.10-14.41; $p=0.035$) and a signet-ring

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cell component (aOR 4.07, 95% CI 1.24-13.32; p=0.020). The association with nodal positivity did not reach statistical significance (aOR 2.84, 95% CI 0.92-8.83; p=0.071).

Clinicopathological comparison of the gastric adenocarcinomas in younger and older patients

Table 1. Clinicopathological comparison of gastric adenocarcinomas in younger and older patients

Variable	≤50 years	>50 years	p
Number of patients	22	213	
Neoadjuvant therapy	14/22 (63.6%)	109/213 (51.2%)	0.370
p/ypT3-4	13/22 (59.1%)	156/213 (73.2%)	0.211
N+	18/22 (81.8%)	135/212 (63.7%)	0.103
N3	9/22 (40.9%)	72/212 (34.0%)	0.638
LNR, median	0.131	0.091	0.351
LVI+	11/21 (52.4%)	115/189 (60.8%)	0.487
PNI+	9/20 (45.0%)	106/189 (56.1%)	0.356
M1	3/22 (13.6%)	22/201 (10.9%)	0.721
Peritoneum/omentum/CY1	2/22 (9.1%)	19/198 (9.6%)	1.000

LNR: lymph node ratio; LVI: lymphovascular invasion; PNI: perineural invasion; CY1: positive peritoneal cytology.

Histological phenotype comparison

Table 2. Histological phenotype comparison

Histological feature	≤50 years	>50 years	p	Adjusted OR (95% CI)
Poorly cohesive	16/19 (84.2%)	83/148 (56.1%)	0.024	3.99 (1.10-14.41)
Signet-ring component	14/18 (77.8%)	61/135 (45.2%)	0.012	4.07 (1.24-13.32)
Lauren diffuse	10/16 (62.5%)	62/141 (44.0%)	0.014*	—
Lauren intestinal	1/16 (6.3%)	56/141 (39.7%)	0.014*	—
Lauren mixed	5/16 (31.3%)	23/141 (16.3%)	0.014*	—

*Fisher-Freeman-Halton exact test was used for the Lauren distribution.

Conclusion: In this surgical cohort, young-onset gastric adenocarcinoma was not associated with more advanced locoregional or metastatic stage. However, the higher prevalence of poorly cohesive and signet-ring cell morphologies suggests a distinct histopathological phenotype despite the absence of stage differences. The observed

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tendency toward higher nodal positivity in younger patients requires confirmation in larger cohorts.

Keywords: Histological type, gastric cancer, agresivity, lenf node ratio, poorly cohesive

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4600 - Association of the Pre-Treatment SII-PNI Score With Pathologic Response after Neoadjuvant FLOT in Gastric Cancer: A Single-Center Retrospective Study

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Aim: Systemic inflammation and nutritional status may influence response to neoadjuvant treatment in gastric cancer. The systemic immune-inflammation index (SII) and prognostic nutritional index (PNI) are simple markers derived from routine blood tests. We aimed to evaluate the association of pre-treatment SII, PNI, and their combined score with pathologic response after neoadjuvant fluorouracil, leucovorin, oxaliplatin, and docetaxel (FLOT).

Method: In this single-center retrospective study, 73 patients with locally advanced gastric adenocarcinoma received neoadjuvant FLOT followed by surgery. Pathologic response was classified by Mandard tumor regression grade (TRG): TRG 1–3 as response and TRG 4–5 as poor response. Published Ding et al. cutoffs defined adverse factors as SII ≥ 568.5 and PNI ≤ 52.7 , generating scores 0–2. Continuous variables were compared with independent-samples t or Mann–Whitney U tests; SII-PNI correlation used Spearman analysis. Score categories and TRG were assessed by chi-square and logistic regression. Because scores 1 and 2 had similar poor-response rates, a post-hoc binary analysis compared score 0 versus scores 1–2. The primary multivariable model adjusted for age, clinical T stage, and nodal status; a sensitivity model adjusted for clinical T stage, nodal status, and signet-ring cell component. Cohort-derived receiver operating characteristic (ROC) analyses were exploratory.

Findings: Among 73 patients, 41 (56.2%) had TRG 1–3 and 32 (43.8%) had TRG 4–5. Patients with poor response had lower PNI and higher SII and SII and PNI were moderately inversely correlated (Spearman $\rho = -0.525$, $p < 0.001$). Poor-response rates were 16.7%, 52.4%, and 52.9% for SII-PNI scores 0, 1, and 2, respectively ($p = 0.028$; Figure 1). Because scores 1 and 2 showed nearly identical poor-response rates, a binary analysis compared score 0 with scores 1–2. After adjustment for age, clinical T stage, and clinical nodal status, having at least one adverse SII-PNI factor remained associated with poor response [adjusted odds ratio (aOR) 5.70, 95% confidence interval (CI) 1.32–24.57; $p = 0.019$]. In a histology-adjusted sensitivity model including clinical T stage, clinical nodal status, and signet-ring cell component, the association remained significant (aOR 7.03, 95% CI 1.59–30.97; $p = 0.010$),

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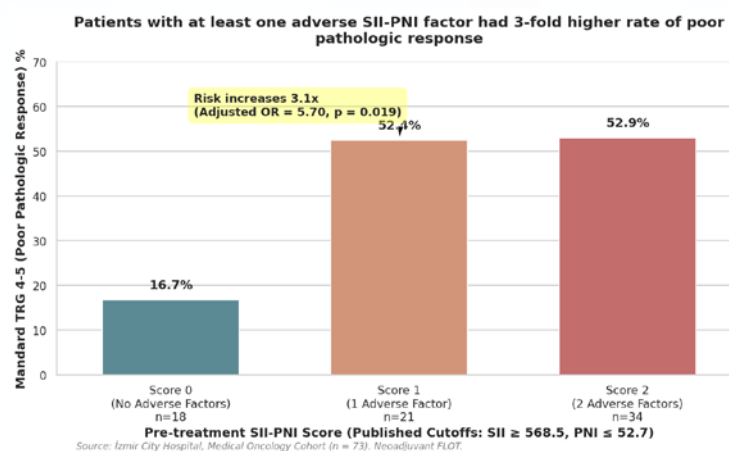


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while signet-ring cell component was also independently associated with poor response (aOR 3.12, 95% CI 1.04–9.40; $p=0.043$). Exploratory ROC findings are shown in Table 1.

Figure 1: Poor pathologic response according to the pre-treatment SII-PNI score.



Multivariable logistic regression models for poor pathologic response

Predictor	Clinical adjustment model aOR (95% CI)	p	Histology-adjusted sensitivity model aOR (95% CI)	p
≥ 1 adverse SII-PNI factor vs 0	5.70 (1.32–24.57)	0.019	7.03 (1.59–30.97)	0.010
Age, per year	1.01 (0.96–1.06)	0.766	—	—
cT3–4 vs cT1–2	4.52 (0.85–23.96)	0.076	4.01 (0.73–22.14)	0.112
cN-positive vs cN0	0.48 (0.13–1.76)	0.267	0.48 (0.13–1.84)	0.285
Signet-ring cell component, present vs absent	—	—	3.12 (1.04–9.40)	0.043

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Conclusion: Pre-treatment SII-PNI score was associated with pathologic response after neoadjuvant FLOT. The association remained significant across two clinically motivated adjusted models. This inexpensive score may provide a simple pre-treatment risk-stratification signal, but validation in larger FLOT-treated cohorts is required.

Keywords: Gastric cancer, neoadjuvant FLOT, systemic immune-inflammation index, prognostic nutritional index, pathologic response.

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5226 - Predictors of Overall and Cancer-Specific Survival in Primary Gastric Diffuse Large B-Cell Lymphoma: A Population-Based Cohort Study

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Aim: Primary gastric diffuse large B-cell lymphoma (DLBCL) is an uncommon extranodal lymphoma with heterogeneous clinical outcomes. This study aimed to identify demographic, socioeconomic, clinical and treatment-related factors associated with overall survival (OS) and cancer-specific survival (CSS).

Method: Patients diagnosed with primary gastric DLBCL between 2010 and 2021 were identified from the Surveillance, Epidemiology, and End Results (SEER) database. Demographic characteristics, Ann Arbor stage, household income, chemotherapy, radiotherapy and surgery were examined. Survival was estimated using the Kaplan-Meier method and predictors of OS and CSS were evaluated using Cox proportional hazards regression models.

Findings: The cohort included 2,099 patients; 58.6% were male, 49.0% were aged 60–79 years, 42.6% had Ann Arbor stage I disease and chemotherapy was documented in 77.1%. In univariate analyses, chemotherapy was associated with improved OS (hazard ratio [HR], 0.24; $P < 0.001$) and CSS (HR, 0.22; $P < 0.001$). Radiotherapy was also associated with improved OS (HR, 0.57; $P < 0.001$) and CSS (HR, 0.45; $P < 0.001$). Age ≥ 80 years was strongly associated with worse adjusted OS, with an adjusted hazard ratio (aHR) of 4.82 at 12 months and 8.70 at 120 months (both $P < 0.001$). Stage II (aHR, 1.43; $P < 0.001$), stage III (aHR, 1.48; $P = 0.005$) and stage IV disease during the first 12 months (aHR, 2.15; $P < 0.001$) were associated with worse OS. Male sex, single or divorced marital status, Non-Hispanic Black race and lower income were also associated with worse OS. For CSS, stage IV disease was associated with higher lymphoma-specific mortality (aHR, 2.55; $P < 0.001$). Among patients aged ≥ 80 years, the aHR was 4.43 at 12 months and 8.36 at 120 months (both $P < 0.001$). Non-Hispanic Black race and single or divorced marital status were also associated with higher lymphoma-specific mortality.

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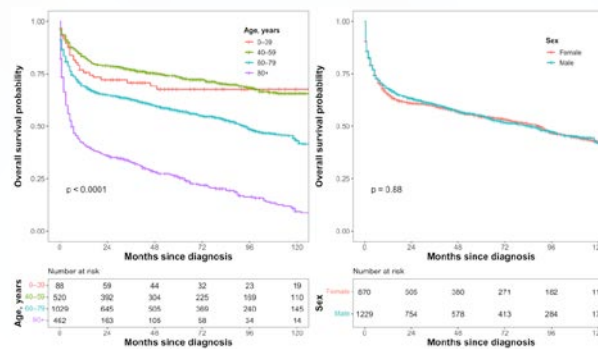
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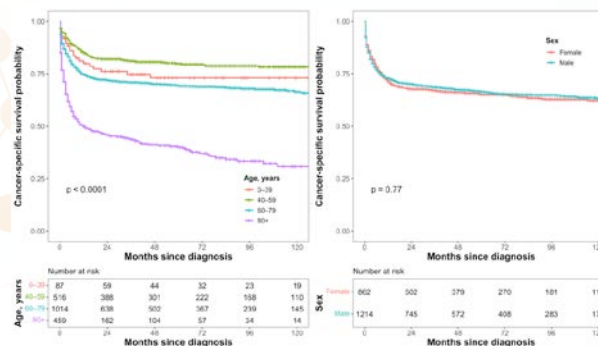
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Figure 1



Kaplan–Meier curves for overall survival according to age group and sex. Overall survival differed significantly by age ($P < 0.0001$) but not by sex ($P = 0.88$).

Figure 2



Kaplan–Meier curves for cancer-specific survival according to age group and sex. Cancer-specific survival differed significantly by age ($P < 0.0001$) but not by sex ($P = 0.77$).

Conclusion: Advanced age and disease stage were the strongest predictors of mortality in primary gastric DLBCL. Patients aged ≥ 80 years had substantially worse OS and CSS, while the adverse effect of stage IV disease was greatest during the first year after diagnosis. Non-Hispanic Black race and unmarried status were independently associated with poorer outcomes. Chemotherapy and radiotherapy were associated with improved survival in univariate analyses; however, these associations should not be interpreted as causal.

Keywords: Primary gastric lymphoma, diffuse large B-cell lymphoma, overall survival, cancer-specific survival

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5246 - Textbook Outcome in Patients with Curative Resection with D2 Dissection for Locally Advanced Gastric Adenocarcinoma

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Aim: This study aimed to evaluate a composite measure of multiple outcome parameters, defined as Textbook Outcome (TO), representing clinically surgical quality metrics in patients with locally advanced gastric cancer who underwent curative gastric resection with D2 lymph node dissection.

Method: Between January 2014 and December 2024, the medical records of patients with locally advanced gastric adenocarcinoma who underwent curative resection with D2 lymph node dissection were retrospectively reviewed. Patient and treatment characteristics were analyzed in relation to TO achievement. Patients were divided into two groups: those who achieved TO and those who did not (no-TO). TO was defined as comprised 9 items: no postoperative mortality, no intraoperative complication, R0 resection, lymphadenectomy more than 25 lymph node, no severe postoperative complication Clavian-Dindo (CD) grade III or higher, no 30 day intervention, no unplanned intensive care unit admission, no prolonged hospital stay, (defined as more than 21 days after surgery), no readmission after discharge. Overall survival (OS) was analyzed using the Kaplan-Meier method, and Cox regression was performed for both univariate and multivariate analyses to identify factors influencing OS.

Findings: This study included a total of 314 patients. The patients had a mean age of 63 years (range 53-70), with 213 males and 101 females. TO was achieved in 225 patients (71.65%), whereas 89 patients (28.34%) were no-TO. Among the outcome parameters, failure to achieve TO was most commonly due to dissecting at least 25 lymph nodes (87.3%), followed by no intraoperative complication (93%) and no severe complication (93%). In the multivariate analysis, total postoperative complication [(odds ratio (OR)=0.127(0.063-0.256)] was identified as independent risk factors for failure to achieve TO. The 5 year OS was 61.80% in the TO and 49.90% in the no-TO group. TO group had a significantly higher survival rate (p=0.015).

Patients' demographic and clinical features with or without textbook outcome.

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		Textbook outcome(TO) (n=225)	No-Textbook outcome(no- TO) (n=89)	All (n=314)	p value
Age(years)		61(53-69)	65(56-71)	63(53-70)	0,098
Sex n(%)	Male	150 (70)	63 (30)	213(67,8)	0,481
	Female	75 (74)	26 (26)	101(32,2)	
BMI ^a (kg/m ²) n(min-max)		26(24-28)	25(24-28)	26(24-28)	0,825
Comorbidity count, n(%)	No	133 (78)	37 (22)	170(54,1)	0,014
	I	58 (62)	36 (38)	94(29,9)	
	≥ II	34 (68)	16 (32)	50(15,9)	
T Stage ^b n(%)	T0	5 (71)	2 (29)	7(2,2)	0,925
	T1	38 (68)	18 (32)	56(17,8)	
	T2	40 (74)	14 (26)	54(17,2)	
	T3	96 (73)	35 (27)	131(41,7)	
	T4	46 (70)	20 (30)	66(21)	
N Stage n(%)	N0	81 (74)	28 (26)	109(34,7)	0,898
	N1	40 (70)	17 (30)	57(18,2)	
	N2	46 (71)	19 (29)	65(20,7)	
	N3	58 (70)	25 (30)	83(26,4)	
Preoperative chemotherapy n(%)	Yes	137 (75)	47 (26)	184(58,6)	0,19
	No	88 (68)	42 (32)	130(41,4)	
Tumor localisation n(%)	EGJ	131 (70)	56 (30)	187(59,6)	0,444
	GC	94 (74)	33 (26)	127(40,4)	
Type of gastrectomy n(%)	Total	136 (71)	56 (29)	192(61,1)	0,685
	Subtotal	89 (73)	33 (27)	122(38,9)	
Multiorgan resection n(%)	Yes	31 (62)	19 (38)	50(15,9)	0,098
Operation time (minutes) n(min-max)		240(190-250)	240(200-260)	240(190-260)	0,81
Length of hospital stay (days) n(min-max)		7(7-8)	7(7-11)	7(7-9)	0,003
^a BMI: Body mass index, Data presented as median (1 st -3 rd quartiles) or n (%). ^b pathological stage was based on the eighth edition of the AJCC Cancer Staging Manual by the American Joint Committee on Cancer.					

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Conclusion: TO is a valuable surgical quality metric that can be used to evaluate surgical outcomes and identify patients at risk of fail to achieve TO. Achievement of TO was associated with both favorable short-term and long-term outcomes in gastric cancer patients who underwent D2 gastric resection.

Keywords: Gastric cancer, textbook outcome, surgical quality, curative D2 gastric resection

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5303 - Preoperative HALP Score as an Independent Predictor of Lymph Node Metastasis in Gastric Cancer

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Aim: The hemoglobin, albumin, lymphocyte, and platelet (HALP) score is an immuno-nutritional biomarker associated with prognosis in various malignancies. This study aims to evaluate the predictive value of the preoperative HALP score for histopathological tumor staging and postoperative outcomes in patients undergoing elective surgery for gastric cancer.

Method: This retrospective cohort study included 93 patients who underwent elective total or subtotal gastrectomy for gastric adenocarcinoma. The HALP score was calculated using preoperative laboratory values. The optimal cut-off value for predicting advanced lymph node metastasis (pN1-N3) was determined using Receiver Operating Characteristic (ROC) curve analysis. Patients were stratified into low and high HALP score groups based on this cut-off. Relationships between the HALP score and clinicopathological factors were evaluated using Chi-square tests. A multivariate logistic regression model was constructed to identify independent predictors of lymph node metastasis.

Findings: The mean age of the patients was 66.2 ± 11.0 years, and 65.6% were male. The median HALP score was 26.27. ROC curve analysis identified an optimal HALP cut-off value of 28.93 for predicting lymph node metastasis (Area Under the Curve = 0.680, $p=0.006$). Lymph node metastasis was detected in 83.6% of patients in the low HALP group (≤ 28.93), compared to 52.6% in the high HALP group (> 28.93) ($p=0.002$). In the multivariate logistic regression analysis—adjusted for age, sex, body mass index, and tumor size—a low preoperative HALP score (≤ 28.93) was identified as a strong independent predictor of lymph node metastasis (Odds Ratio = 8.24, 95% Confidence Interval: 2.04-33.31, $p=0.003$). Tumor size was also identified as an independent predictor ($p=0.003$). No statistically significant relationships were found between the HALP score and advanced T stage ($p=0.452$) or major postoperative complications ($p=1.000$).

Conclusion: The preoperative HALP score is an easily accessible, cost-effective, and powerful immuno-nutritional biomarker. A low HALP score (≤ 28.93) serves as an independent predictor of lymph node metastasis in patients with gastric cancer, providing valuable preoperative insight for tailoring personalized surgical and multidisciplinary treatment strategies.

Keywords: HALP score, lymph node metastasis, gastric cancer

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5308 - Risk of Gastric Cancer After Liver Transplantation: A Meta-analysis

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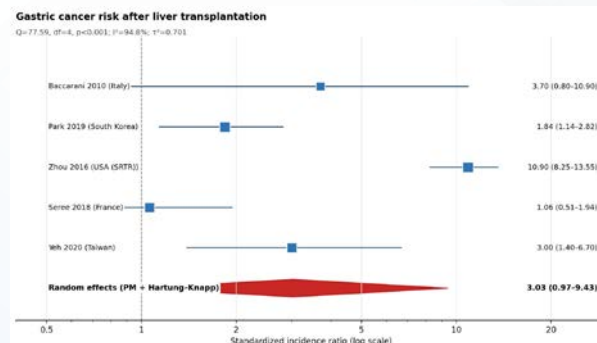
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Aim: Although the overall risk of malignancy is increased after solid organ transplantation, estimates of gastric cancer risk among liver transplant recipients vary across countries and registry systems. This study aimed to compare the risk of gastric cancer after liver transplantation with that in the general population.

Method: Studies in a database of de novo malignancies after solid organ transplantation were reviewed. Cohort studies reporting standardized incidence ratios (SIRs) with 95% confidence intervals (CIs) for gastric cancer among liver transplant recipients were included. For overlapping cohorts derived from the same center or national registry, only the most appropriate and comprehensive study was retained. SIRs were pooled on the natural logarithmic scale.

Findings: Five independent cohorts were included in the meta-analysis, comprising 105 reported cases of gastric cancer. Study-specific SIRs ranged from 1.06 to 10.90. The pooled SIR under a random-effects model was 3.03 (95% CI, 0.97–9.43). Substantial between-study heterogeneity was present ($Q=77.59$; degrees of freedom=4; $p < 0.001$; $I^2=94.8\%$; $\tau^2=0.701$). After exclusion of the study based on the US Scientific Registry of Transplant Recipients, which reported the highest risk estimate, the pooled SIR decreased to 1.92 (95% CI, 0.86–4.31), and heterogeneity decreased to 42.5%.

Gastric cancer risk after liver transplantation



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Conclusion: The available evidence suggests a signal toward an approximately two- to threefold increase in gastric cancer incidence after liver transplantation. However, the magnitude of this association cannot be estimated precisely because of marked heterogeneity and the strong influence of a large US registry study; moreover, the pooled estimates did not reach statistical significance. Endoscopic surveillance may nevertheless warrant consideration, particularly for liver transplant recipients living in populations with a high background incidence of gastric cancer or those with individual risk factors.

Keywords: Liver transplantation, gastric cancer, de novo malignancy, standardized incidence ratio, meta-analysis

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5628 - From Peripheral Blood to Pathological Risk: Predicting Nodal Metastasis and Lymphovascular Invasion in Gastric Cancer

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Aim: Pathological lymph node metastasis and lymphovascular invasion (LVI) are important indicators of tumor aggressiveness and prognosis in gastric cancer. However, these features are usually confirmed after surgical resection. This study aimed to evaluate whether routinely available preoperative peripheral blood parameters could predict pathological lymph node positivity and LVI in patients undergoing surgery for gastric cancer.

Method: This retrospective study included 109 patients who underwent surgery for gastric cancer. Demographic data, operative characteristics, pathological findings, and preoperative laboratory parameters were analyzed. The evaluated variables included age, sex, hemoglobin, hematocrit, platelet count, neutrophil count, lymphocyte count, monocyte count, and serum albumin. Patients were compared according to LVI, pathological lymph node status, and the coexistence of lymph node positivity with LVI. Diagnostic performance was assessed using receiver operating characteristic (ROC) curve analysis, and independent predictors were identified using stepwise logistic regression analysis. Statistical significance was accepted as $p < 0.05$.

Findings: The mean age was 60.29 ± 10.46 years, and 72.5% of patients were male. Total gastrectomy was performed in 61.5% and subtotal gastrectomy in 38.5%. Lymphovascular invasion (LVI) was detected in 72.5% of patients, and the coexistence of lymph node positivity and LVI was observed in 64.2%. Patients with combined positivity were significantly older than the remaining patients (62.30 ± 9.72 vs. 56.69 ± 10.90 years; $p=0.007$) and had significantly lower hemoglobin levels (10.99 ± 1.87 vs. 12.08 ± 2.15 g/dL; $p=0.007$), hematocrit levels (33.90 ± 5.58 vs. 37.42 ± 5.94 ; $p=0.003$), lymphocyte counts ($1.82 \pm 0.59 \times 10^9/L$ vs. $2.12 \pm 0.68 \times 10^9/L$; $p=0.017$), and serum albumin levels (3.77 ± 0.52 vs. 4.08 ± 0.37 g/dL; $p=0.001$). Serum albumin showed the highest individual diagnostic performance, with an area under the curve (AUC) of 0.690 at a cut-off value of ≤ 4.1 g/dL. In stepwise logistic regression analysis, age ≥ 57 years, lymphocyte count $\leq 1.94 \times 10^9/L$, and serum albumin ≤ 4.1 g/dL were independent predictors of combined lymph node positivity and LVI. The final model showed an AUC of 0.769, sensitivity of 85.7%, specificity of 59.0%, and accuracy of 76.1%.

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Distribution of demographic characteristics and laboratory parameters in patients with LVI (+) and pN (+)

Table 1. Distribution of demographic characteristics and laboratory parameters in patients with LVI (+) and pN (+)

a. Comparison according to lymphovascular invasion (LVI)

Variables	LVI (-) (n=30)	LVI (+) (n=79)	p value
Age	57.57±10.98	61.33±10.14	0.094 ^a
Sex (male, %)	18(60)	61(77.2)	0.072 ^b
HB	11.96±2.09	11.16±1.98	0.063 ^a
HCT	37.21±5.72	34.38±5.86	0.026 ^a
PLT 10 ³ /mL	290.41±72.15	284.22±78.71	0.708 ^a
NEU 10 ⁹ /mL	4.60±1.41	4.46±1.37	0.623 ^a
LYM 10 ⁹ /mL	2.21±0.72	1.82±0.57	0.004 ^a
MONO 10 ⁹ /mL	0.70±0.26	0.62±0.20	0.080 ^a
ALB (g/dL)	4.07±0.35	3.81±0.52	0.013 ^a

b. Comparison according to pathological lymph node status (pN)

Variables	pN (-) (n=32)	pN (+) (n=77)	p value
Age	55.66±10.16	62.22±10.03	0.002 ^a
Sex (male, %)	21(65.6)	58(75.3)	0.302 ^b
HB	12.15±2.19	11.06±1.88	0.010 ^a
HCT	37.65±6.16	34.12±5.56	0.004 ^a
PLT 10 ³ /mL	284.22±73.01	286.63±78.61	0.882 ^a
NEU 10 ⁹ /mL	4.62±1.68	4.45±1.24	0.565 ^a
LYM 10 ⁹ /mL	2.12±0.73	1.85±0.58	0.039 ^a
MONO 10 ⁹ /mL	0.70±0.25	0.62±0.20	0.056 ^a
ALB (g/dL)	4.12±0.36	3.78±0.51	0.001 ^a

c. Comparison according to combined LVI and pN positivity

Variables	LVI/pN (-)/(+) (n=39)	LVI+pN (+) (n=70)	p value
Age	56.69±10.90	62.30±9.72	0.007 ^a

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Sex (male, %)	25(64.1)	54(77.1)	0.144 ^b
HB	12.08±2.15	10.99±1.87	0.007 ^a
HCT	37.42±5.94	33.90±5.58	0.003 ^a
PLT 10 ³ /mL	289.21±78.96	284.09±75.89	0.740 ^a
NEU 10 ⁹ /mL	4.52±1.55	4.48±1.28	0.886 ^a
LYM 10 ⁹ /mL	2.12±0.68	1.82±0.59	0.017 ^a
MONO 10 ⁹ /mL	0.69±0.25	0.61±0.20	0.064 ^a
ALB (g/dL)	4.08±0.37	3.77±0.52	0.001 ^a

a: Independent samples t-test, b: Pearson chi-square test, Mean±standard deviation

Conclusion: Preoperative peripheral blood parameters may help predict pathological aggressiveness in gastric cancer. Older age, lymphopenia, and hypoalbuminemia were independently associated with combined lymph node positivity and LVI. A simple model based on age, lymphocyte count, and albumin may contribute to preoperative risk stratification in surgically treated gastric cancer patients.

Keywords: Gastric cancer, hypoalbuminemia, lymph node metastasis, lymphopenia, lymphovascular invasion

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6974 - From Operative Narrative to Structured Surgical Data in Primary Gastric Malignancy: A Multi-Axial Content Analysis of 249 Operative Notes

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Aim: Structured and semantically explicit representations of surgical procedures are increasingly important for video-based phase recognition, Surgical Data Science, and Surgiomics. However, evidence on whether routine operative narratives for primary gastric malignancy preserve information at the workflow, anatomical, action, and oncologic levels remains limited. We aimed to characterise their documentation preparedness by evaluating published gastrectomy phases and steps, vascular anatomy–action relations, instrument–verb–target events, and prespecified oncologic synoptic fields.

Method: We conducted a retrospective, single-centre content analysis at İzmir City Hospital. Using national procedure codes, 331 consecutive gastric-resection records were screened; 82 were excluded because of inadequate or inappropriate documentation (n=8), non-gastric primary malignancy (n=32), benign or metabolic indication (n=32), or non-gastric procedure (n=10). Primary oesophageal malignancies were excluded, whereas Siewert type III tumours were considered gastric. The remaining 249 de-identified free-text notes were mapped using rule-based whole-word matching across four axes: published gastrectomy workflow frameworks; named vessels and vessel-directed actions; sentence-level instrument–verb–target components; and oncologic synoptic, anastomotic, and narrative-quality fields. Documentation was evaluated as recorded content, not as confirmation of operative performance. Automated extraction was not externally validated.

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Case selection, demographic profile, and narrative characteristics of the analysed operative notes

Characteristic	Value
Case selection	
Records screened using national procedure codes, n	331
Excluded: inadequate or inappropriate record, n	8
Excluded: non-gastric primary malignancy, n	32
Excluded: benign or metabolic indication, n	32
Excluded: non-gastric procedure, n	10
Operative notes analysed, n	249
Demographic characteristics	
Male/female, n (%)	177 (71.1)/72 (28.9)
Age, years, median (IQR)	65 (56–73)
Age, years, range	19–91
Narrative characteristics	
Note length, characters, median (range)	2,254 (634–5,549)
Sentences per note, median	36
Words per note, mean	307
Sentences analysed, total	9,439

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Values are presented as n, n (%), median (interquartile range), median (range), or mean, as indicated. Narrative characteristics were calculated from the 249 operative notes included in the final analysis. IQR, interquartile range.

Findings: Patients had a median age of 65 years (IQR 56–73); 177/249 (71.1%) were male. Notes contained 9,439 sentences. Mean nine-phase coverage was 7.29/9 (81.0%), yet all phases appeared in only 3/249 notes (1.2%); coverage across two additional frameworks was 78.8% and 80.2%, with complete coverage in 0% and 4.0%, respectively. Explicit numbered step lists appeared in 42 notes (16.9%); operative duration was recorded in 10 (4.0%), and phase- or step-level timing in none. At least one named vessel appeared in 236 notes (94.8%) and a vessel–action relation in 162 (65.1%), whereas a ligation level bound to a named vessel appeared in 13 (5.2%). Complete instrument–verb–target triplets occurred in 535/9,439 sentences (5.7%), although 214 notes (85.9%) contained at least one. Tumour location was documented in 88.8%, margin status in 33.3%, and distant-metastasis assessment in 7.2%. Ten notes (4.0%) were byte-identical to another patient's note.

Figure 1: Documented operative content and nine-phase workflow coverage in 249 gastric cancer operative notes

A Documented operative content and technical elements		B Coverage of the nine-phase gastrectomy workflow			
Element	n (%)	Phase	n (%)		
Procedure-related content					
Total gastrectomy	219 (88.0)	P1 Preparation (ports, retraction, adhesiolysis)	246 (98.8)		
D2 lymphadenectomy	176 (70.7)	P2 Left greater curvature / left omental dissection	217 (87.1)		
Subtotal gastrectomy	74 (29.7)	P3 Right greater curvature / right omental dissection	160 (64.3)		
Omentectomy	36 (14.5)	P4 Duodenal transection ¹	46 (18.5)		
Cholecystectomy	36 (14.5)	P5 Suprapancreatic lymphadenectomy	215 (86.3)		
Laparoscopic access	29 (11.6)	P6 Lesser curvature lymphadenectomy	206 (82.7)		
Splenectomy	27 (10.8)	P7 Gastric transection / resection	238 (95.6)		
Pancrectomy	13 (5.2)	P8 Reconstruction	238 (95.6)		
		P9 Post-reconstruction (lavage, drain, closure)	249 (100.0)		
Technical documentation elements					
Drain type specified	205 (82.3)	Mean coverage per note	7.29/9 (81.0)		
Suture material specified	197 (79.1)	All nine phases documented	3 (1.2); 95% CI 0.4–3.5		
Lesion size in centimetres	195 (78.3)	Explicit numbered step list	42 (16.9)		
Lymph node count	173 (69.5)	JGIC nodal station number specified	45 (18.5)		
Linear stapler (GIA)	163 (65.5)	Total operative duration recorded in the note ²	10 (4.0)		
Stapler cartridge diameter	154 (61.8)	Phase- or step-level duration recorded in the note ²	0 (0)		
Circular stapler (EEA)	143 (57.4)	Convergence across three independently derived frameworks			
Stapler cartridge colour	59 (23.7)	Framework	Units	Mean coverage	Complete
Vagal preservation statement	57 (22.9)	Nine-phase gastrectomy workflow	9 phases	81.0%	3/249 (1.2%)
Trocar count	8 (3.2)	Robotic distal gastrectomy step scheme	9 applicable steps	78.8%	0/249 (0%)
		Laparoscopic surgical anatomy: gastric-applicable	10 phases	80.2%	10/249 (4.0%)

Categories are not mutually exclusive. Documentation of an element was not interpreted as confirmation that it was performed.

¹ Duodenal transection is not performed in every gastrectomy; the lowest level of documentation was documented as 29.7% of notes, so this value reflects applicability rather than documentation failure.

² Operative duration is recorded in the hospital information system; this study examined the operative note entry and the institutional record was not consulted, so these values indicate absence within the note, not absence of the information.

Categories are not mutually exclusive. Documentation of an element was not interpreted as confirmation that it was performed.

¹ Duodenal transection is not performed in every gastrectomy; subtotal gastrectomy was documented in 29.7% of notes, so the low value reflects applicability rather than documentation failure.
² Operative duration is recorded in the hospital information system; this study examined the operative note only and the institutional record was not consulted, so these values indicate absence within the note, not absence of the information.

Panel A: operative content and technical detail documented in 249 free-text gastric cancer operative notes. Panel B: the same notes mapped onto a published nine-phase gastrectomy workflow. Phases are individually well documented, but only 1.2% of notes (95% CI 0.4–3.5) contain all nine, and three independently derived frameworks converge near 80% coverage - a ceiling of the narrative form rather than of any single framework (Yoshida 2024; Komatsu 2024; Strong & Yura 2025; Lavanchy 2023). Nodal stations follow

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the JCGC; stapler cartridge parameters follow the surgomics framework (Wagner et al.). Accuracies reported in those video-based sources are not comparable with textual coverage.

Figure 2: Bound surgical events and oncologic synoptic coverage in 249 gastric cancer operative notes

C	From named entities to bound surgical events			D	Oncologic synoptic coverage and narrative quality		
C1 - Vascular binding ladder						D1 - Twelve prespecified oncologic synoptic fields	
Level	n (%)	95% CI		Field	n (%)		
At least one named vessel	236 (94.8)	91.3-96.9		Specimen organ	249 (100.0)		
At least one vessel bound to an action in the same sentence	162 (65.1)	59.0-70.7		Procedure performed	225 (90.4)		
Level of ligation stated anywhere in the note	59 (23.7)	18.8-29.4		Tumour location	221 (88.8)		
Level of ligation bound to a named vessel in the same sentence	13 (5.2)	3.1-8.7		Lymphadenectomy extent	193 (77.5)		
				Specimen handling / orientation	167 (67.1)		
				Margin status	83 (33.3)		
				Peritoneal spread	44 (17.7)		
				Adjacent organ invasion	40 (16.1)		
				Frozen section	32 (12.8)		
				Distant metastasis assessment	18 (7.2)	9.5-14.6 (6.1-11.3)	
				Sexual involvement	10 (4.0)		
				Nodal staging finding	0 (0)		
C2 - Documentation by vessel						D2 - Anatomical descriptors	
Vessel	Named, n (%)	Action-bound, n (%)		Descriptor	n (%)		
Left gastric artery	203 (81.5)	93 (37.3)		Reconstruction topology	215 (86.3)		
Right gastroepiploic vessels	151 (60.6)	45 (18.1)		Anastomotic configuration	119 (47.8)		
Coeliac trunk	113 (45.4)	31 (12.4)		Leak / integrity test	26 (10.4)		
Splenic artery	96 (38.6)	21 (8.4)		Fluorescence-based perfusion assessment ¹	0 (0)		
Left gastroepiploic vessels	88 (35.3)	56 (22.5)					
Right gastric artery	84 (33.7)	46 (18.5)					
Common hepatic artery	83 (33.3)	2 (0.8)					
Left gastric (coronary) vein	39 (15.7)	30 (12.0)					
Portal / splenic vein / SMV	14 (5.6)	5 (2.0)					
Short gastric vessels	9 (3.6)	5 (2.0)					
Gastroduodenal artery	5 (2.0)	4 (1.6)					
Hesse's gastroduodenal trunk ²	0 (0)	0 (0)					
C3 - Instrument-verb-target events						D3 - Narrative structure, events and reuse	
Level	n (%)	95% CI		Measure	n (%)		
Sentences containing an anatomical target (N = 9,439)	4,763 (50.5)	—		Ordinal connective present	247 (99.2)		
Sentences containing a verb	3,756 (39.8)	—		Explicit numbered step list	42 (16.9)		
Sentences containing an instrument	1,242 (13.2)	—		Any free-text intraoperative event wording	83 (33.3)		
Sentences with at least two components	3,080 (32.6)	—		Graded intraoperative adverse-event classification	0 (0)		
Sentences with a complete triplet	135 (5.7)	5.2-6.2		Any time expression in the note ³	40 (16.1)		
Notes with at least one complete triplet	214 (85.5)	81.1-89.7		Clock timestamp in the note ⁴	0 (0)		
Median complete triplets per note	2	—		Byte-identical to another patient's note	10 (4.0)		
						Footnote 1: gastroduodenal trunk = not routinely described in the operative notes Footnote 2: gastroduodenal trunk = 'broaden first and second' statements of operative interest rather than an assessment, and was not correlated to any documented fluorescence-based or intraoperative perfusion assessment Footnote 3: time expression is recorded in the hospital information systems this study examined the operative note only so these values reflect absence within the note	

Panel C separates whether an entity is named from whether it is bound to an action within one sentence - the minimum extractable event unit (CholecT50/Rendezvous action triplet; surgomics, Wagner et al.). A vessel is named in 94.8% of notes (95% CI 91.3-96.9), action-bound in 65.1% (59.0-70.7), and carries a ligation level attributable to that vessel in 5.2% (3.1-8.7); the common hepatic artery is named in a third of notes but action-bound in only 2.4% of those, functioning as a landmark. At sentence level 5.7% (5.2-6.2) bind instrument, verb and target; 85.9% (81.1-89.7) of notes contain at least one. Panel D reports twelve prespecified oncologic synoptic fields individually, without a composite, since any composite depends on field selection. Graded adverse-event classification refers to ClassIntra; byte-identical reuse follows the copy-forward literature (Tsimiklis 2024).

Conclusion: Routine operative notes preserved substantial macro-level workflow and named anatomy but progressively lost resolution at the levels of complete phase sequences, anatomy-action binding, sentence-level surgical events, and auditable oncologic detail. These findings identify documentation priorities rather than deficiencies in operative performance. Multicentre replication and disease-specific consensus are needed to define applicability-aware, synoptic, semantically explicit, and ontology-aligned

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reporting fields that complement narrative documentation and support future Surgical Data Science.

Keywords: Gastric cancer, gastrectomy, operative notes, synoptic operative reporting, surgical workflow analysis

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7058 - Robotic vs Laparoscopic Distal Gastrectomy BI in Gastric Cancer Patients with Obesity: Short-term Outcomes

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Jun Ho LEE², Jae Moon BAE²*

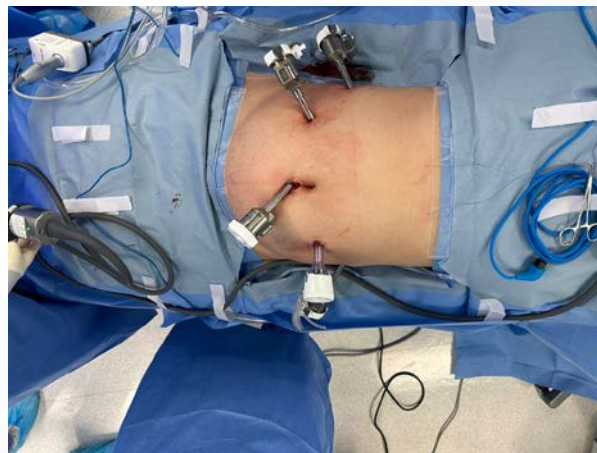
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Aim: Surgical management in patients with obesity and gastric cancer is inherently challenging due to increased technical difficulty and postoperative morbidity. While laparoscopic distal gastrectomy with Billroth I reconstruction (LDG-BI) is widely adopted, the role of robotic distal gastrectomy with Billroth I reconstruction (RDG-BI) in this population remains less well defined. This study compared short-term surgical outcomes between RDG-BI and LDG-BI in patients with obesity and gastric cancer, and presented an operative video.

Method: This retrospective cohort study included patients with histologically confirmed gastric cancer and BMI ≥ 25 kg/m² who underwent RDG-BI or LDG-BI at a single high-volume center between 2015 and 2023. Perioperative outcomes and clinically significant 30-day postoperative complications were compared between groups. Multivariable logistic regression was used to identify factors associated with postoperative complications.

Port placement



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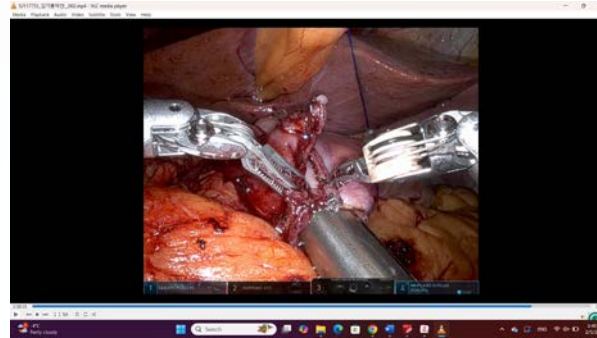
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Billroth I robotic



Findings: A total of 391 patients were included (RDG-BI: 156, LDG-BI: 235). Operative time was longer in the RDG-BI group than in the LDG-BI group (151.3 vs. 138.1 minutes, $p < 0.001$), whereas estimated intraoperative blood loss did not differ significantly. BMI showed a weak but significant positive correlation with operative time in both groups (LDG-BI: $r = 0.214$, $p < 0.001$; RDG-BI: $r = 0.216$, $p = 0.007$). The number of retrieved lymph nodes was higher with RDG-BI (36 vs. 34, $p = 0.041$). All postoperative complication rates were comparable between the RDG-BI and LDG-BI groups (5.8% vs. 4.3%, $p = 0.632$), with no significant difference in clinically significant complications (Clavien-Dindo grade $\geq III$; 1.3% vs. 2.1%, $p = 0.707$). All anastomotic leaks occurred in the LDG-BI group, although this difference was not statistically significant. In multivariable analysis, higher BMI and advanced pathological stage, but not surgical approach, were independently associated with postoperative complications.

Conclusion: RDG-BI demonstrated comparable rates of clinically significant postoperative complications to LDG-BI in patients with obesity and gastric cancer. The directional trend towards fewer anastomotic leaks in the robotic group warrants further investigation in prospective studies. Although RDG-BI was associated with longer operative time, the relationship between BMI and operative duration was similar in both surgical approaches. These findings suggest that RDG-BI is a safe and feasible alternative to LDG-BI in this population, while potential differences in specific complications, such as anastomotic leakage, require validation in larger studies.

Keywords: Gastric cancer, robotic assisted distal gastrectomy with billroth I reconstruction, short-term postoperative outcomes, gastric cancer patient with obesity

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7123 - The Value of Preoperative 18F-FDG PET/CT and Endoscopy in Predicting Surgical Margin Distance in Gastric Cancer Surgery: Correlation with Histopathological Results

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Aim: Achieving microscopically negative surgical margins (R0) is the prognostic cornerstone of curative gastric cancer surgery. The decision between organ-preserving subtotal gastrectomy and total gastrectomy requires balancing postoperative quality of life with absolute oncological safety. Although 18F-Fluorodeoxyglucose (18F-FDG) Positron Emission Tomography/Computed Tomography (PET/CT) is widely utilized in preoperative staging, false-positive or false-negative findings frequently complicate margin determination. While endoscopy effectively maps mucosal involvement, it remains limited in identifying deeper intramural spread. This study evaluates the diagnostic accuracy of preoperative PET/CT and endoscopy in predicting surgical margin distances by correlating them with gold-standard histopathology. Furthermore, we investigate the critical role of Lauren histological subtypes in predicting insidious submucosal extension and the risk of resection margin positivity (R1).

Method: We retrospectively analyzed 22 consecutive gastric adenocarcinoma patients (18 males, 4 females; mean age 62.4) undergoing laparoscopic total or subtotal gastrectomy at Antalya and Samsun City Hospitals (2024-2026). Preoperative endoscopy and PET/CT findings were systematically compared with postoperative histopathological surgical margin distances (mm) and Lauren subtypes (intestinal, diffuse, mixed).

Findings: Twelve patients underwent total and 10 underwent subtotal gastrectomy. Histologically, 10 were intestinal, 9 diffuse (signet ring cell), and 3 mixed type. PET/CT maximum standardized uptake value (SUVmax) was significantly lower in diffuse types (5.45 ± 1.06) compared to intestinal (7.43 ± 4.19) and mixed (11.99 ± 3.50) tumors. PET/CT primary tumor sensitivity was 90.9%, with false negativity in two early-stage (pT1/pT2) intestinal cases. The series' only R1 proximal margin occurred in an endoscopically antrum-located diffuse tumor with a low SUVmax (4.9), where PET/CT significantly underestimated longitudinal submucosal extension. Conversely, hypermetabolic lymph nodes (SUVmax 22.4) at the esophagogastric junction caused false positivity; however, subtotal resection successfully achieved a 95mm clear (R0) margin.

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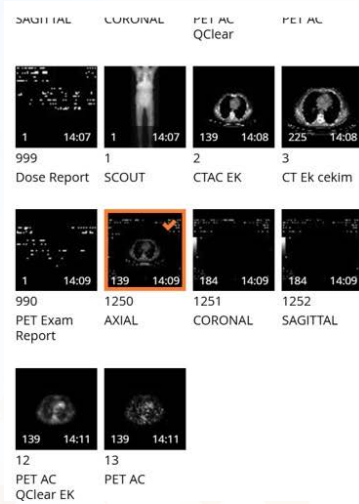
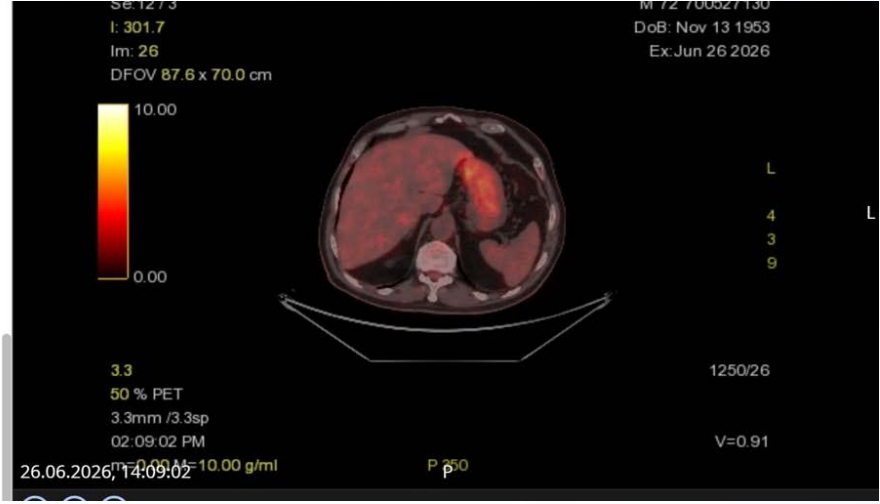
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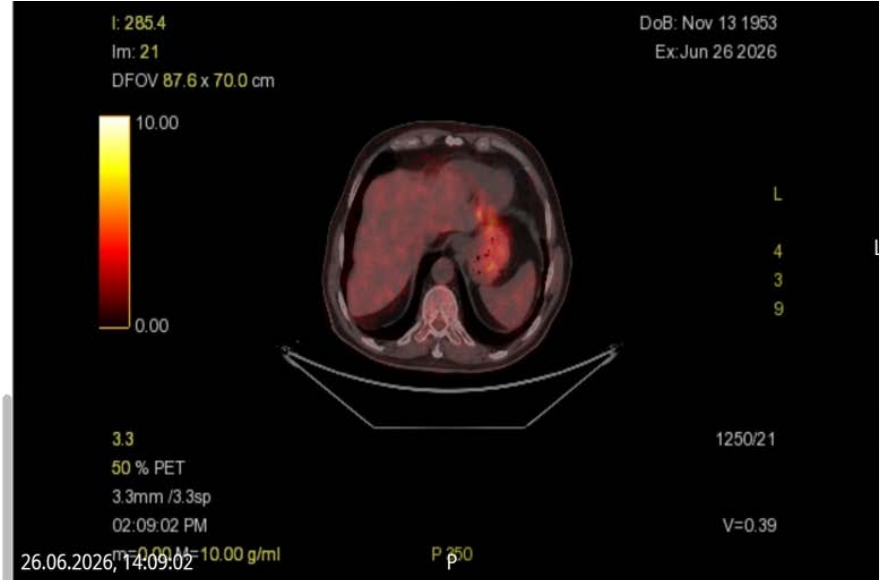
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Preop PET/CT



PET/CT shows an example of transmural spread.

preoperative image 2



PET/CT shows an example of transmural spread.

Conclusion: While 18F-FDG PET/CT accurately maps anatomical boundaries in intestinal and mixed-type gastric tumors, its inherently low glycolytic activity in diffuse types dangerously masks longitudinal spread. Consequently, metabolic avidity should be

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interpreted as a surrogate marker of tumor biology, not just a staging tool. In diffuse-type cancers, relying solely on PET/CT for subtotal resection decisions carries a high R1 risk; therefore, routine intraoperative frozen section examinations or upfront total gastrectomy should be prioritized to guarantee oncological radicality. Conversely, PET/CT false positivities in proximal lymph nodes must be rigorously verified to avoid unnecessary, function-limiting total gastrectomies. Integrating endoscopic ultrasonography (EUS) into the preoperative evaluation of infiltrative tumors with low PET/CT uptake provides superior transmural mapping, optimizing personalized clinical decision-making

Keywords: Gastric cancer, PET/CT, surgical margins, lauren classification, endoscopy

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7250 - Comparison of Immunonutrition and Standard Nutritional Support Before Gastrectomy after Neoadjuvant Flot

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Aim: The purpose of this study was to compare the effects of preoperative immunonutrition and standard oral nutritional support on nutritional parameters and early postoperative morbidity in patients undergoing gastrectomy after neoadjuvant FLOT chemotherapy for gastric adenocarcinoma.

Method: This retrospective study included 76 patients with resectable cT2–T4N0 or node-positive gastric adenocarcinoma who completed four cycles of preoperative FLOT chemotherapy and underwent total or subtotal gastrectomy 4–6 weeks after the last chemotherapy cycle. Twenty-nine patients received preoperative immunonutrition for 7 days, whereas 47 received standard oral nutritional support for 14 days. Demographic characteristics, body mass index (BMI), serum albumin, hemoglobin, type of gastrectomy, operative time, estimated blood loss, and postoperative complications were evaluated. Complications were graded according to the Clavien–Dindo classification.

Findings: Age, sex, preoperative hemoglobin, type of gastrectomy, operative time, and estimated blood loss were comparable between groups. After FLOT, BMI and serum albumin were significantly lower in the immunonutrition group than in the standard nutrition group (BMI: 22.6 vs 24.6 kg/m², $P < .001$; albumin: 2.80 vs 3.21 g/dL, $P < .001$). Serum albumin increased significantly during nutritional support in both groups, while the magnitude of increase did not differ significantly between groups. Overall postoperative morbidity was similar between the immunonutrition and standard nutrition groups (34.5% vs 36.2%, $P = 1.000$). No significant differences were observed in pneumonia, pleural effusion requiring drainage, esophagojejunostomy leakage, early postoperative ileus, or surgical-site infection. Clavien–Dindo grade $\geq$ II morbidity (13.8% vs 14.9%) and grade $\geq$ III morbidity (10.3% vs 12.8%) were also comparable. No patient required reoperation, and no postoperative mortality occurred.

Conclusion: Although patients in the immunonutrition group had poorer baseline nutritional status, postoperative morbidity and major complication rates were comparable with those observed in the standard nutrition group. This finding may suggest that preoperative immunonutrition could help offset the adverse impact of poorer nutritional status and may contribute to more favorable postoperative outcomes than standard nutritional support alone. Further standardized, prospective randomized studies are

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warranted to better define the potential clinical benefits of preoperative immunonutrition in this patient population.

Keywords: Gastric cancer, immunonutrition, FLOT, gastrectomy, postoperative morbidity

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7643 - Percutaneous Transhepatic Laser Lithotripsy for Common Bile Duct Stones after Failed ERCP in Patients with Previous Gastrectomy: A Two-Case Report

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Aim: Altered gastrointestinal anatomy after gastrectomy may make conventional endoscopic retrograde cholangiopancreatography (ERCP) difficult or unsuccessful. This report presents two patients with previous gastrectomy in whom common bile duct stones could not be removed by ERCP and were subsequently treated with percutaneous transhepatic laser lithotripsy using a urological system.

Method: Two patients with previous gastrectomy and common bile duct stones that could not be removed by conventional ERCP were retrospectively evaluated. One had undergone subtotal and the other total gastrectomy. In both, stones were fragmented via a percutaneous transhepatic approach using a urological laser lithotripsy system, followed by interventional radiology-guided clearance of residual fragments. Clinical, laboratory, procedural, and hospitalization data were assessed.



Lithotripsy



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Findings: The first patient was an 84-year-old man with a history of subtotal gastrectomy. Ultrasonography demonstrated a 14-mm common bile duct containing a 15-mm stone. Following unsuccessful ERCP, percutaneous transhepatic laser lithotripsy was performed. Stone fragments were advanced into the duodenum, and residual debris was cleared using a Fogarty thrombectomy catheter. Completion cholangiography showed no residual stones and free passage into the duodenum. ALP decreased from 181 to 109 U/L, GGT from 60 to 34 U/L, leukocyte count from 15.3 to $7.6 \times 10^3/\mu\text{L}$, and CRP from 147.5 to 29.2 mg/L. No procedure-related complications occurred, and the patient was discharged after 13 days. The second patient was a 75-year-old man with a history of total gastrectomy. Computed tomography revealed a 13-mm common bile duct stone. Following unsuccessful ERCP, percutaneous transhepatic laser lithotripsy was performed using the same urological lithotripsy system. Residual distal common bile duct fragments were advanced into the duodenum using a balloon, followed by balloon ductoplasty. An internal-external biliary drainage catheter was left in place. After treatment, total bilirubin decreased from 2.5 to 1.0 mg/dL, direct bilirubin from 2.2 to 0.7 mg/dL, ALP from 255 to 101 U/L, GGT from 168 to 22 U/L, ALT from 118 to 62 U/L, AST from 263 to 66 U/L, and CRP from 113 to 4.9 mg/L. No procedure-related complications occurred, and the patient was discharged after 8 days.

Conclusion: In patients with altered anatomy after gastrectomy, conventional ERCP may be unsuccessful. In these two cases, 13–15 mm common bile duct stones were successfully treated with percutaneous transhepatic laser lithotripsy and interventional radiology-guided fragment clearance. This minimally invasive approach may be an effective alternative to surgery in selected patients.

Keywords: Gastrectomy, common bile duct stone, ERCP, extracorporeal shock wave lithotripsy, altered gastrointestinal anatomy

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7792 – From Macroscopy To Metastasis: Prediction of the Relationship between the Borrmann Score and Metastasis

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Aim: Gastric cancers are the 5th most common type of cancer in the world and the 3rd most common type of cancer among cancer-related deaths (1). Due to its high incidence and high mortality rate, many opinions have been reported from the past to the present regarding the planning and application of its treatment, and treatment methods have diversified with the development of technology and the increase in humanity's knowledge about cancer treatment (2-5). In order to obtain optimum benefit from treatment, general oncological principles recommend that treatment be personalized according to certain characteristics.

For diagnosis and preoperative evaluation, endoscopic examination is performed on every patient today. Tumor types are widely expressed with the Borrmann classification, which is used to express the obtained data in a universal way (6). With the development of molecular tests, the view of cancer pathogenesis has become more detailed, and the relationships between the morphological features of gastric cancers and certain genetic features have been proven by genetic analyses performed. In polypoid and ulcerative masses (Borrmann 1-2), MSI-H is generally observed as positive (7), whereas in masses with a more infiltrative pattern (Borrmann 3-4), MSS and Chromosomal instability (CIN) have been observed as positive (8).

The aim of our study is to reveal the relationship between the biological behavior, metastasis and stage of the disease, based on the relationship between some genetic and biological characteristics of gastric cancers and their macroscopic appearance. In this way, it is aimed to both provide verification of the radiological examinations to be used for staging and to ensure that some genetic characteristics are investigated in terms of suspicious masses, thereby preventing the application of expensive genetic tests to every patient.

Method: Study was designed retrospectively, and archive screening was performed after obtaining appropriate ethics committee approval. In the study, the sample size was calculated using the G-Power V3.1.9.7 program with 80% power and a 95% confidence interval, and the study was

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initiated with a minimum sample size of 130 patients, and the sample was prepared by accessing 141 patient files through the archive screening performed. The inclusion criteria for the study were "being over 18 years of age, having access to the diagnostic endoscopy report, having access to the operation pathology report, and in patients receiving neoadjuvant treatment, having access to the CT or EUS report proving the extent of spread before neoadjuvant treatment," while "being under 18 years of age, gastric malignancies other than gastric carcinoma (lymphoma, GIST, neuroendocrine tumor), those without a diagnostic endoscopy report, those without radiological examination for staging purposes (CT or PET-CT, EUS), and patients whose gastric malignancy originated from histological types other than gastric carcinoma" were excluded from the study. Normal distribution was checked with the Shapiro-Wilk test. The obtained data were grouped and analyzed with SPSS v27. The Pearson Chi-Square test was used in the analysis.

Findings: 141 cases included in the study, 68% were observed to be male and 32% female. The mean age was observed to be 63.5 and the median age 64. When the groups were formed, 7 patients (5%) were categorized in the Borrmann I group, 58 patients (41.1%) in the Borrmann II group, 72 patients (51.1%) in the Borrmann III group, and 4 patients (2.8%) in the Borrmann IV group. While the rate of T3–T4 tumors was 32.8% in Borrmann II, it reached 66.7% in Borrmann III and 100% in Borrmann IV. The overall difference between the Borrmann groups was significant, and ordinal analysis also showed that an increase in Borrmann grade was associated with more advanced T categories. A statistically significant relationship was observed between the Borrmann classification and T score with the Pearson Chi-Square analysis ($p=0.013$).

The N2–N3 rate was observed as 28.6% in Borrmann I, 37.9% in II, 48.6% in III, and 50.0% in IV. No significant statistical relationship was observed between the Borrmann classification and N score ($p=0.876$). The M1 rate increased regularly, being 14.3% in Borrmann I, 17.2% in II, 33.3% in III, and 50.0% in IV. This monotonic increase was found to be significant in the ordinal trend analysis ($p=0.019$; Spearman $p=0.203$, $p=0.016$) and retained its significance after Holm correction for the three trend tests (adjusted $p=0.038$). When the relationship between the Borrmann classification and M score was examined, although no significant statistical finding was observed ($p=0.103$), in the linear trend tests performed, it was observed that as the Borrmann class increased, the tendency for metastasis to occur increased ($p=0.019$). (Table 1)

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Borrmann	N0	N1	N2	N3	Total
I	3 (42,9%)	2 (28,6%)	2 (28,6%)	0 (0,0%)	7
II	18 (31,0%)	18 (31,0%)	17 (29,3%)	5 (8,6%)	58
III	16 (22,2%)	21 (29,2%)	25 (34,7%)	10 (13,9%)	72
IV	1 (25,0%)	1 (25,0%)	2 (50,0%)	0 (0,0%)	4

Borrmann	M0	M1	Total
I	6 (85,7%)	1 (14,3%)	7
II	48 (82,8%)	10 (17,2%)	58
III	48 (66,7%)	24 (33,3%)	72
IV	2 (50,0%)	2 (50,0%)	4

Table 1: Borrmann- N and M score relationship

Discussion: In this study, the relationship between the Borrmann classification, which describes the macroscopic morphology of gastric cancer, and the fundamental components of the TNM system—local tumor invasion (T), regional lymph node involvement (N), and distant metastasis (M)—was investigated. Before the evaluation of the study, the results of our study should be assessed within the framework of some important limitations. Although the total sample consisted of 141 patients, the Borrmann groups were markedly unbalanced; there were 7 patients in the Borrmann I group and only 4 patients in the Borrmann IV group. This situation causes the percentages, especially in the extreme categories, to carry wide sampling uncertainty and reduces the power of the tests. The main finding of the study is that a statistically significant relationship was found between the Borrmann classification and the T category, and that as the Borrmann grade increased, the frequency of more advanced T categories increased. In contrast, the overall distribution of the N category did not show a significant difference between the Borrmann groups. In terms of distant metastasis, although the comparison did not reach statistical significance, a significant linear increase in the M1 rate was observed as one progressed from Borrmann I to IV. When these findings are evaluated together, it is thought that a more infiltrative macroscopic morphology is primarily associated with more advanced local invasion, that the relationship in terms of nodal spread is more heterogeneous, and that in terms of distant metastasis, a trend parallel to increasing Borrmann grade may exist.

The strongest relationship in our study was detected between the Borrmann classification and the T category. Therefore, it is biologically expected that macroscopically more infiltrative phenotypes would show deeper mural invasion. In the study conducted by Díaz del Arco et al. in a Western population, the infiltrative growth pattern rose from 45% in Borrmann I tumors to 90.9% in Borrmann IV, and the relationship between the Borrmann classification and the infiltrative growth pattern was found to be significant ($p=0.004$). In the same study, the fact that Borrmann III–IV tumors were associated with more infiltrative biological features such as signet-ring cells,

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high histological grade, and the diffuse Laurén phenotype suggests that Borrmann morphology may reflect not only the superficial macroscopic appearance but also, in part, the underlying tumor biology. However, Díaz del Arco et al. did not demonstrate a significant relationship between Borrmann type and T stage, lymph node involvement, or TNM stage. The authors attributed this difference in part to their study being conducted in a Western population, to the evaluation of only cases that underwent curative R0 resection, and to a smaller sample size compared with Asian series. In this respect, our study is noteworthy in that it shows that the histopathological relationship between infiltrative morphology and invasion may also be directly reflected in the T category(9).

Our findings show a more pronounced parallelism with the results obtained from large Asian cohorts. In the study by Li et al., in which 3,966 cases of advanced gastric cancer were evaluated, the T4 rates in the Borrmann I-II, III, and IV groups were reported as 7.5%, 12.0%, and 21.7%, respectively, and a significant difference was detected between the groups in terms of invasion depth. In the same study, it was stated that serosal invasion was more common in Borrmann III and especially Borrmann IV tumors. Therefore, both the results in the large Asian series and the ordinal relationship in our present study support the existence of a connection between the macroscopic infiltrative phenotype and local tumor progression(5). This relationship is also observed in the more recent study by Wei et al. In the main cohort consisting of a total of 1,824 patients, the T4 rate rose from only 4.6% in Borrmann II to 18.1% in Borrmann III and 41.0% in Borrmann IV. Likewise, advanced pTNM stages were seen more frequently in more infiltrative Borrmann phenotypes. These results are in the same direction as the marked increase in the T3-T4 rate from Borrmann II toward III and IV in our study (10).

In our study, a statistically significant overall relationship between the Borrmann classification and the N category could not be demonstrated. The ordinal trend also did not reach the threshold of significance ($p=0.095$). However, the distribution does not show a completely random pattern. Therefore, although there is a numerical increase in the rate of advanced nodal stages in more advanced Borrmann categories, the present sample did not provide sufficient evidence for this trend to be statistically confirmed. At this point, it is seen that the literature is also not entirely homogeneous. In the Western cohort of 260 cases by Díaz del Arco et al., similar to our results, no significant relationship could be demonstrated between the Borrmann classification and lymph node involvement. Interestingly, in the same study, although infiltrative growth increased markedly as the Borrmann type advanced, this difference was not reflected in the nodal stage(9).

In contrast, a pronounced Borrmann-N relationship was reported in the much larger series of Li et al. The N0 rate fell from 36.1% in the Borrmann I-II group to 27.8% in Borrmann III and 14.9% in Borrmann IV, while the N3 rate rose to 9.1%, 16.0%, and 33.8%, respectively. More importantly, in the multivariable logistic regression analysis, Borrmann type remained independently associated with nodal involvement even after accounting for invasion depth and other variables; the reported

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effect estimate was 1.245 (95% CI 1.060–1.461; $p=0.008$) for Borrmann III and 2.180 (95% CI 1.636–2.905; $p<0.001$) for Borrmann IV(5). Similarly, in the 2026 study by Wei et al., the proportion of node-positive patients was reported as 41.1% in Borrmann II, 73.2% in Borrmann III, and 75.9% in Borrmann IV(10).

In our study, the comparison of the M0/M1 distribution among the Borrmann groups did not reach statistical significance. When the findings in the literature are separated according to the anatomical route of distant metastasis, this result becomes more meaningful. Li et al. reported that peritoneal dissemination was more common in Borrmann III–IV tumors, whereas no significant difference was found between the Borrmann groups in terms of hepatic metastasis(5). The large cohort of Wei et al. demonstrates this distinction more clearly. The peritoneal metastasis rate rose from 2.0% in Borrmann II to 10.8% in III and 32.2% in IV. In contrast, the hepatic metastasis rates were 0.9%, 2.4%, and 2.6%, respectively, and did not show a significant difference (10).

Conclusion: Our study suggests that the Borrmann classification may be a macroscopic indicator of tumor spread in gastric cancer. An increase in Borrmann grade was found to be significantly and consistently associated with more advanced T categories, whereas an independent distributional relationship with the N category could not be demonstrated. In terms of distant metastasis, although the overall Borrmann–M comparison was not significant, the rise in the M1 rate from 14.3% to 50% from Borrmann I to IV and the significance of the ordinal trend test point to a relationship worth investigating between infiltrative macroscopic phenotype and metastatic potential. When the increased nodal and especially peritoneal spread reported in large Asian cohorts and the infiltrative histopathological phenotype demonstrated in Western cohorts are evaluated together, it appears more appropriate to consider the Borrmann classification not as an alternative to anatomical TNM staging, but rather as a marker that may provide complementary macroscopic information regarding the invasive and metastatic behavior of the tumor.

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7821 - Comparison of Radiologist, Surgeon, and Multidisciplinary Assessments in Clinical Staging of Gastric Cancer and Factors Associated with Misstaging

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Aim: Computed tomography (CT) is routinely used for preoperative staging of gastric cancer but has recognized limitations. Incorporating clinical and endoscopic findings may improve staging performance. This study aimed to compare the diagnostic performance of radiologist, surgeon, and multidisciplinary team (MDT) assessments in preoperative staging.

Method: This retrospective observational study included patients who underwent curative-intent surgery for gastric adenocarcinoma between 2015-2025 at Karadeniz Technical University. Patients who received neoadjuvant therapy were excluded. Preoperative clinical staging was performed using three different assessment approaches. The radiologist evaluated the CT images with knowledge only of the diagnosis of gastric cancer. The surgeon evaluated the CT images together with the available preoperative clinical and endoscopic data. Finally, the surgeon and radiologist jointly performed the MDT assessment. Clinical T stage was categorized into three groups (T1/T2-3/T4), while N stage was classified as N- or N+. Diagnostic performance was assessed. Risk factors associated with misstaging were evaluated using regression analysis.

Findings: A total of 177 patients were included in the study. Of the patients, 40 (22.6%) were pT1, 99 (55.9%) were pT2-3, and 38 (21.5%) were pT4. A total of 112 patients (63.3%) were N+. Clinical T-staging accuracy was 58.8%, 57.1%, and 59.3% for the radiologist, surgeon, and MDT, respectively (p=0.861). The highest agreement was observed with MDT (kappa=0.47). For the detection of T1 disease, the highest sensitivity was observed with the radiologist (62.5%), while the highest specificity was observed with the surgeon and MDT (97.1%). Similarly, for the detection of T4 disease, the highest sensitivity was observed with the surgeon and MDT (47.4%), while the highest specificity was observed with the radiologist (86.3%). In the evaluation of nodal metastasis, the highest sensitivity was observed with the surgeon and MDT (97.3% and 90.2%), while the highest specificity was observed with the radiologist (80.0%). N-staging accuracy differed significantly among the evaluators overall

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(Cochran Q, $p=0.017$); however, no statistically significant difference was found in adjusted pairwise comparisons. Histological differentiation, Borrmann classification, and endoscopic gross appearance were identified as risk factors associated with misstaging.

Conclusion: In gastric cancer, agreement between preoperative T staging and pathological staging was moderate, with no significant difference in overall accuracy among radiologist, surgeon, and MDT assessments. In nodal evaluation, the radiologist demonstrated higher specificity, whereas the surgeon and MDT achieved substantially higher sensitivity. These distinct but complementary diagnostic performance profiles suggest that integrating radiological assessment with clinical and endoscopic data may improve the preoperative staging of gastric cancer.

Keywords: Gastric cancer, computed tomography, clinical staging, multidisciplinary team, endoscopy

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7937 - Histologic Spectrum of Surgically Resected Gastric Neuroendocrine Neoplasms and Aggressive Pathologic Features of Minen: A Single-Center Experience

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Aim: Gastric neuroendocrine neoplasms (NENs) are a heterogeneous group ranging from well-differentiated neuroendocrine tumors (NETs) to poorly differentiated neuroendocrine carcinomas (NECs) and mixed neuroendocrine-non-neuroendocrine neoplasms (MiNENs). This study aimed to describe the histologic spectrum of surgically resected gastric NENs and compare the aggressive pathologic features of MiNENs with those of NETs.

Method: In this single-center retrospective study, 19 surgically resected gastric cases were identified among 33 gastrointestinal NENs recorded between 2010 and 2025. Diagnoses were verified from final pathology reports, and previous MANEC terminology was standardized as MiNEN. Two pure NECs and three spatially separate synchronous adenocarcinoma+NET cases were described but excluded from the main comparison. Analysis included 9 NETs and 5 MiNENs. Continuous variables are presented as median [interquartile range] and categorical variables as n/N. Mann-Whitney U and Fisher's exact tests were used; $p < 0.05$ was considered significant.

Findings: The median age of the 19 patients was 65 [59-73.5] years, and 63.2% (12/19) were male. Histology comprised 9 NETs, 5 MiNENs, 2 NECs, and 3 spatially separate synchronous adenocarcinoma+NETs. NET grades were G1 in 2, G2 in 5, and G3 in 2 cases. Age (63 vs 70 years; $p=0.640$) and tumor size (2.75 vs 3.1 cm; $p=0.419$) were similar between NET and MiNEN groups. Ki-67 was higher in MiNENs (60% [60-70] vs 4% [4-7]; $p=0.007$). Lymphovascular invasion (5/5 vs 2/8; $p=0.021$), necrosis (5/5 vs 0/8; $p < 0.001$), metastatic lymph node count (5 [3-8] vs 0 [0-1.25]; $p=0.013$), and lymph node ratio (0.148 [0.120-0.533] vs 0 [0-0.098]; $p=0.035$) were also higher in MiNENs. Lymph node metastasis was present in all MiNENs and in 3/8 evaluable NETs ($p=0.075$). Perineural invasion (4/5 vs 4/8; $p=0.565$) and the number of examined lymph nodes ($p=0.418$) did not differ.

Conclusion: Despite comparable tumor size, MiNENs showed greater proliferative activity, lymphovascular invasion, necrosis, and nodal tumor burden. Although lymph node metastasis occurred in every MiNEN, the difference did not reach significance, likely because of the small cohort. The pattern is consistent with larger gastric NEN series.

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reporting higher Ki-67 and lymph node ratios in aggressive histologies. MiNEN histology is associated with a more aggressive pathologic phenotype than gastric NET. Detailed reporting of both components, consideration of nodal burden, and multidisciplinary evaluation are warranted. Multicenter studies incorporating survival outcomes are needed to validate these findings.

Comparison of selected clinicopathologic features between NET and MiNEN groups

Variable	NET (n=9)	MiNEN (n=5)	p
Age, years	63	70	0.640
Tumor size, cm	2.75	3.1	0.419
Ki-67, %	4 [4-7]	60 [60-70]	0.007
Lymph node metastasis	3/8 (37.5%)	5/5 (100%)	0.075
Metastatic lymph node count	0 [0-1.25]	5 [3-8]	0.013
Lymph node ratio	0 [0-0.098]	0.148 [0.120-0.533]	0.035
Lymphovascular invasion	2/8 (25%)	5/5 (100%)	0.021
Perineural invasion	4/8 (50%)	4/5 (80%)	0.565
Necrosis	0/8 (0%)	5/5 (100%)	<0.001

Data are presented as median [interquartile range] or n/N (%). Denominators vary because of missing pathology variables. Mann-Whitney U and Fisher's exact tests were used for continuous and categorical variables, respectively. Bold/green p values indicate statistical significance.

Keywords: Gastric neuroendocrine neoplasm, MiNEN, Ki-67, lymph node metastasis, lymphovascular invasion

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8009 - The Importance of Gag Reflex and Anxiety in Determining the Need for Sedation in Patients Undergoing Upper Gastrointestinal System Endoscopy. A Prospective Clinical Study.

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Aim: Esophagogastroduodenoscopy (EGD) is one of the most widely used and most reliable diagnostic methods in the diagnosis of esophagus, stomach and proximal duodenal diseases. Today, EGD is performed with sedoanalgesia and/or topical local anesthesia applied to the oropharyngeal area. The preferred anesthesia method varies according to the traditional habits of the clinic, the preference of the patient or the presence of an anesthesiologist. Defining an excessive gag reflex and determining factors for tolerating the procedure without sedation would be guiding in patient selection. In this study, we evaluated the role of gag reflex and anxiety score in predicting the need for sedoanalgesia during EGD.

Method: This prospective study performed between July-2019 and January-2020 and 150 consecutive patients were included. The demographic data, gag reflex score, vital signs and anxiety states before the procedure noted. All EGD procedures were started without sedation and the procedure was continued by administering sedative medication according to the patient's tolerance status.

Findings: Patients were divided into two groups according to tolerance. While 55 of the patients (36.7%) (group 2) could not tolerate topical anesthesia, 95 patients (63.3%) (group 1) showed tolerance and the procedure was successfully completed without sedation. Younger age was found to be significant in terms of procedural tolerance. Patients with gag reflexes score 3 and 4 had significantly lower procedural tolerance than patients with gag reflexes score 1 and 2. Also, anxiety score was significantly higher in the group 2.

Conclusion: Our study shows that evaluation of the gag reflex, measurement of heart rate, and assessment of the patient's anxiety level before diagnostic EGD procedures can help create to estimate the patient's toleration to EGD procedures with topical anesthesia. Preventing unnecessary sedative application to patients who may tolerate EGD procedures with topical anesthetics may reduce complications that may develop due to sedatives, prevent unnecessary health expenditures, return the patient's to

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daily life much more quickly, and increase the number of procedures that can be performed daily.

Keywords: Endoscopy, gag reflexes, sedation

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8374 - Diagnostic Value of Peritoneal Lavage Cytology in Gastric Cancer: A 10-Year Single-Center Experience

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Aim: Peritoneal spread in gastric cancer is known to be important in terms of disease stage, treatment approach, and prognosis. In patients without macroscopic peritoneal metastasis, peritoneal lavage cytology may contribute to the detection of microscopic peritoneal spread. In this study, we aimed to evaluate the contribution of peritoneal lavage cytology in patients undergoing surgery for gastric cancer.

Method: In this retrospective study, 362 patients who underwent surgery for gastric cancer between 2015 and 2026 were evaluated. Peritoneal lavage cytology was performed in 250 (69.1%) patients. Peritoneal cytology results were compared with intraoperative findings of macroscopic peritoneal metastasis. The aim of the study was to determine the proportion of patients who had positive peritoneal cytology without macroscopic peritoneal metastasis among all operated patients and to evaluate the contribution of peritoneal lavage cytology.

Findings: A total of 362 patients who underwent surgery for gastric cancer over the last 10 years were retrospectively evaluated. Peritoneal lavage cytology was performed in 250 (69.1%) patients. Positive peritoneal cytology was detected in 21 (8.4%) of these 250 patients. Among these patients, 15 had simultaneous macroscopic peritoneal metastasis, whereas no macroscopic peritoneal metastasis was observed in 6 patients. The 6 patients who had positive peritoneal cytology despite the absence of macroscopic peritoneal metastasis accounted for 1.6% of all 362 operated patients.

Conclusion: In our 10-year single-center experience, positive peritoneal cytology without macroscopic peritoneal metastasis was detected in 1.6% of patients who underwent surgery for gastric cancer.

Keywords: Gastric cancer, cytological examination, peritoneal washing cytology, malign cell

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8703 - Frequency, Localization, and Demographic Distribution of Premalignant and Malignant Lesions in Endoscopic Biopsies of the Upper Gastrointestinal System: A Retrospective Analysis of 3,809 Cases from a Single Center

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Aim: To determine the frequency, anatomical distribution and age–sex associations of premalignant and malignant lesions in upper gastrointestinal (GI) endoscopic biopsies. Although gastric precursor lesions are well characterised within dedicated surveillance cohorts, their distribution relative to established malignancy across an unselected, real-world biopsy population — and the extent to which the two share the same anatomical territory — remains poorly defined.

Method: 3,809 consecutive upper GI endoscopic biopsies reported at a single centre between Jan 2024 and Jul 2026 were reviewed retrospectively. Biopsies were assigned to six groups: malignant, neoplasm of malignant potential, premalignant lesion, premalignant background (intestinal metaplasia and/or atrophy), suspicious–inadequate specimen, and benign. Chi-square and Mann-Whitney U tests were used, with $p < 0.05$ considered significant.

Findings: There were 2,216 women (58.2%) and 1,593 men (41.8%); mean age was 55.2 ± 15.0 years (18–92). Malignancy was identified in 47 cases (1.2%): 38 adenocarcinomas (8 with a signet-ring cell component), 4 unclassified malignant tumours, 2 intramucosal carcinomas, and one each of neuroendocrine carcinoma, lymphoma and squamous cell carcinoma. Neoplasms of malignant potential occurred in 17 (0.4%); 14 neuroendocrine tumours, 2 GISTs, premalignant lesions in 38 (1.0%); 16 low-grade dysplasia, 13 Barrett oesophagus, 7 adenomas, 2 high-grade dysplasia and a premalignant background in 414 (10.9%). Malignant cases were older than the cohort overall (70.9 ± 10.5 years; $p < 0.001$): the malignancy rate was 0% below 40 years, 1.4% at 60–69, 3.3% at 70–79 and 7.6% above 80 ($p < 0.001$). Malignancy was 2.2 times more frequent in men (1.82% vs 0.81%; RR 2.24, 95% CI 1.25–4.02; $p=0.009$), as was premalignant background (13.7% vs 8.8%; $p < 0.001$); conversely, 12 of 14 neuroendocrine tumours occurred in women. Malignant lesions clustered in the corpus–fundus ($n=12$) and oesophagus–cardia–oesophagogastric junction

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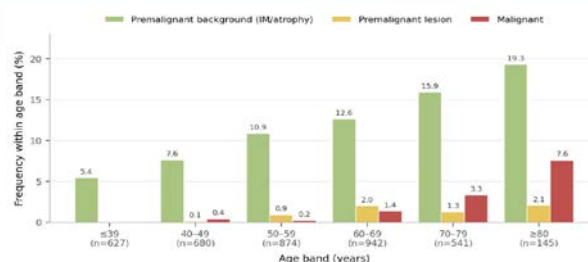


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(n=13), whereas 46% of the premalignant background (192/414) was antral and 39% of premalignant lesions (15/38) oesophageal.

Figure-1



Frequency of premalignant background, premalignant lesions and malignancy within each age band (%).

Table-1

Category	n (%)	Age (years) mean ± SD	Male / Female	Commonest site (n)
Malignant	47 (1.2)	70.9 ± 10.5	29 / 18	Corpus-fundus (12); oesophagus-cardia- OGJ (13)
Neoplasm of malignant potential	17 (0.4)	63.8 ± 11.4	5 / 12	Corpus (10)
Premalignant lesion	38 (1.0)	66.3 ± 9.1	19 / 19	Oesophagus (15); antrum (9)
Premalignant background	414 (10.9)	60.2 ± 13.6	218 / 196	Antrum-pylorus (192)
Suspicious / inadequate	15 (0.4)	63.5 ± 17.0	10 / 5	—
Benign, non-neoplastic	3,278 (86.1)	54.1 ± 15.0	1,312 / 1,966	—
TOTAL	3,809 (100)	55.2 ± 15.0	1,593 / 2,216	—

Case numbers, age and sex distribution and commonest anatomical site by category (n=3,809).

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Conclusion: Malignancy was present in 1.2% and clinically relevant premalignant or neoplastic change in 13.5% of upper GI biopsies. Risk rose steeply with age and was more than doubled in men. The discordance between an antrum-predominant premalignant background and proximally located malignancy suggests that proximal sampling should not be neglected in surveillance protocols; the absence of malignancy below 40 years supports age as a strong determinant of biopsy indication.

Keywords: Upper gastrointestinal endoscopy, gastric biopsy, intestinal metaplasia, dysplasia, adenocarcinoma

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8712 - Histopathological Predictors of Lymph Node Metastasis in Gastric Adenocarcinoma

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Aim: Lymph node metastasis is a key feature in staging and determining the prognosis of gastric adenocarcinomas. In addition to the presence of lymph node metastasis, the pN stage, reflecting the extent of metastatic lymph nodes, can provide important information about the biological behavior of the tumor. This study aimed to evaluate the relationship between the presence of lymph node metastasis and pN stage with histopathological features in gastric adenocarcinomas.

Method: The study included 100 cases of gastric adenocarcinoma that underwent surgical resection without neoadjuvant therapy between 2023 and 2026. Cases were evaluated in terms of histological type, tumor differentiation level, tumor localization, pT stage, tumor budding, lymphocytic response, lymphovascular invasion (LVI), perineural invasion (PNI), surgical margin status, and surrounding mucosal characteristics. The relationships between the presence of lymph node metastasis and histopathological features were statistically analyzed using Pearson chi-square test or Fisher's exact test. pN stage was classified as pN0, pN1, pN2 and pN3. The statistical significance level was $p < 0.05$.

Findings: Lymph node metastasis was detected in 67 out of 100 cases (67.0%). 33 cases (33.0%) were pN0, 10 (10.0%) were pN1, 16 (16.0%) were pN2, and 41 (41.0%) were pN3. The presence of lymph node metastasis was associated with diffuse and mixed histological type ($p=0.024$), poor differentiation ($p=0.013$), advanced pT stage ($p < 0.001$), prominent tumor budding ($p=0.007$), LVI ($p < 0.001$), and PNI ($p < 0.001$). Of the cases with significant tumor budding, 68.8% were in stage pN3, compared to 15.2% in cases without tumor budding ($p < 0.001$). In the presence of LVI, 56.7% of cases were pN3, while only 9.1% of cases without LVI ($p < 0.001$). Similarly, 65.6% of PNI-positive cases were in stage pN3, while only 2.6% of PNI-negative cases ($p < 0.001$). 61.3% of T4 tumors were in stage pN3,

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while no pN3 stage was detected in T1 tumors ($p < 0.001$). N3 stage was more common in mixed type (66.7%), followed by diffuse type (47.4%)($p=0.035$).

Conclusion: Lymph node metastasis in gastric adenocarcinomas is significantly associated with histopathological features reflecting the aggressive biological behavior of the tumor, such as advanced T stage, increased tumor budding, LVI, PNI, histological type, and differentiation. Furthermore, the correlation of many of these features with an increase in pN stage suggests that the histopathological aggressiveness of the tumor is related not only to the presence of lymph node metastasis but also to the extent of nodal disease. Further studies in larger series are needed to support the relationship between histopathological features indicative of aggressiveness in gastric adenocarcinomas and nodal metastatic behavior

Keywords: Gastric adenocarcinoma, lymphovascular invasion, lymph node metastasis, metastatic nodal burden, tumor budding

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8763 - Histopathological Features Associated with Tumor Regression and Residual Lymph Node Disease in Gastric Cancers Treated with Neoadjuvant Therapy

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Aim: Neoadjuvant therapy has become the standard practice in locally advanced gastric cancers. Post-treatment primary tumor regression and residual disease in lymph nodes are important for prognostic evaluation. However, current regression grading systems only evaluate the primary tumor. This study aimed to investigate the histopathological features associated with poor tumor regression and residual metastasis in lymph nodes in gastric cancers resected after neoadjuvant therapy.

Method: A total of 111 gastric carcinoma cases undergoing gastrectomy after neoadjuvant therapy were retrospectively evaluated. Tumor localization, histological morphology, signet-ring-cell component, residual tumor diameter, pathological T stage(ytT), lymphovascular invasion(LVI), perineural invasion(PNI), surgical margin and lymph node metastasis were recorded. Primary tumor regression was assessed using the Ryan tumor regression score. Residual lymph node disease was defined as metastatic lymph nodes after neoadjuvant treatment(ytN+). Statistically, pearson chi-square, Fisher exact, and Fisher-Freeman-Halton tests were used. Odds ratios (OR) and 95% confidence intervals (CI) were calculated for two-category variables. $p < 0.05$ was considered statistically significant.

Findings: Tumor regression was Ryan 0-1 in 16 cases (14.4%) and Ryan 2-3 in 95 (85.6%). Poor tumor regression was significantly associated with signet-ring-cell component ($p=0.011$), residual tumor diameter > 4 cm ($p=0.033$), ytT3-4 stage ($p < 0.001$), LVI($p=0.003$),

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PNI ($p < 0.001$), and lymph node metastasis ($p=0.010$). Residual lymph node metastasis was detected in 73 cases (65.8%). ypN positivity was significantly associated with signet-ring-cell component (OR=7.41; 95% CI: 2.39–23.02; $p < 0.001$), ypT3-4 stage (OR=7.22; 95% CI: 3.00–17.41; $p < 0.001$), LVI (OR=11.93; 95% CI: 4.15–34.28; $p < 0.001$), and PNI (OR=10.01; 95% CI: 3.50–28.64; $p < 0.001$). Residual nodal metastasis was present in 90.4% of cases with LVI and 89.8% with PNI. Notably, 6 of 16 cases (37.5%) had primary tumor regression had residual lymph node metastasis.

Conclusion: The tumor with a poor response to neoadjuvant therapy and residual lymph node metastasis after neoadjuvant therapy are associated with LVI, PNI, advanced ypT stage, and signet-ring-cell components. Importantly, residual nodal metastasis persisted in over one-third of cases despite tumor with a good response to neoadjuvant therapy. This finding highlights a limitation of current regression systems focusing solely on the primary tumor and supports further investigation of scoring approaches incorporating nodal disease after neoadjuvant therapy.

Keywords: Gastric cancer, lymph node metastasis, neoadjuvant therapy, signet-ring cell, tumor regression

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8991 - Should Routine Biopsy Be Performed for Perforated Gastric Ulcers Because of Suspected Malignancy? A Systematic Review

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Aim: Perforated gastric ulcer is a life-threatening surgical emergency in which treatment delay is poorly tolerated. Intraoperative biopsy of the ulcer margin has traditionally been performed to exclude malignancy. This systematic review aimed to evaluate the need for intraoperative biopsy in perforated gastric ulcers by examining contemporary rates of biopsy-proven malignancy and the potential effect of biopsy on postoperative complications.

Method: The review was conducted in accordance with the PRISMA guidelines and registered with INPLASY (INPLASY202650135). Studies reporting adults who underwent surgery for a perforated gastric ulcer were eligible. The primary outcome was detection of malignancy. Malignancy proportions were pooled using a random-effects model after Freeman–Tukey double-arcsine transformation, and statistical heterogeneity was quantified using the I^2 statistic.

Findings: Twelve studies comprising 1,122 patients were included. Of these, 953 patients (64% men; mean age, 52 years) underwent intraoperative ulcer biopsy. Twenty-seven patients had biopsy-proven malignancy on intraoperative histopathological examination. One additional patient had a false-negative intraoperative biopsy, with malignancy subsequently confirmed by postoperative endoscopy; accordingly, the primary biopsy-proven outcome was based on 27 events. Among patients without a previous diagnosis of gastric cancer, the pooled random-effects proportion of biopsy-proven malignancy was 3.1% (95% CI, 1.4%–5.7%). Between-study heterogeneity was substantial ($I^2=72\%$; Cochran $Q=39.8$; degrees of freedom=11; $p < 0.001$). Biopsy was omitted in 169 patients. Only one study compared complications between patients who did and did not undergo biopsy. In that retrospective single-center study, both overall complications (46.4% vs 11.8%; $p=0.007$) and Clavien–Dindo grade III or higher complications (34.5% vs 5.9%; $p=0.017$) were more frequent after biopsy. Because this finding arose from a single comparison and may have been confounded by ulcer complexity, it should be regarded as hypothesis-generating rather than evidence of a causal effect.

Conclusion: The available evidence does not support routine intraoperative biopsy of all perforated gastric ulcers. Nevertheless, because the evidence is almost entirely

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retrospective and the included studies did not stratify lesions by size or macroscopic appearance, selective biopsy or intraoperative frozen-section examination may remain appropriate for large, chronic, mass-like, or otherwise suspicious ulcers, particularly in older patients.

Keywords: Gastric cancer, peptic ulcer perforation, stomach cancer, gastric ulcer

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9007 - Association of Artificial Intelligence-Assisted Tumor–Stroma Ratio Assessment with Tumor Biology in Gastric Intestinal-Type Adenocarcinomas

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Aim: With advances in cancer biology, the tumor microenvironment, particularly the stromal component, has gained increasing recognition for its role in tumor behavior. Manual assessment of the tumor-stroma ratio (TSR) is subject to interobserver variability. This study aimed to investigate the association between AI-assisted image analysis-based TSR assessment and prognostically relevant histopathological features in gastric intestinal-type adenocarcinomas.

Method: A total of 57 patients diagnosed with gastric intestinal-type adenocarcinoma who underwent surgical resection between 2023 and 2026 were included in the study. The proportions of tumor and stromal areas were assessed using artificial intelligence-assisted image analysis. TSR values were dichotomized into low- and high-TSR groups according to the median value. The groups were compared with respect to tumor localization, differentiation, pT stage, tumor budding, lymphocytic response, lymphovascular invasion (LVI), perineural invasion (PNI), and lymph node metastasis (LNM). Categorical variables were analyzed using the chi-square or Fisher's exact test, while continuous variables were assessed using the Mann-Whitney U test.

Findings: The mean age of the patients was 69.5±10.8 years, and 70.2% were male. The median TSR was 0.78; 28 patients (49.1%) were classified into the low-TSR group and 29 (50.9%) into the high-TSR group. Antral localization was significantly more frequent in the high-TSR group (p=0.025). Prominent tumor budding was observed in 9 patients (32.1%) in the low-TSR group, whereas it was not identified in any patient in the high-TSR group, representing a statistically significant association (p=0.003). Similarly, a prominent lymphocytic response was observed in 35.7% of patients in the low-TSR group compared with 55.2% in the high-TSR group, and this association was also statistically significant (p=0.009). No significant associations were identified between TSR and tumor differentiation, pT stage, LVI, PNI, or LNM.

Conclusion: Our findings demonstrate that TSR assessed using artificial intelligence-assisted image analysis is associated with histomorphological features reflecting tumor

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behavior, particularly tumor budding and lymphocytic response, in gastric intestinal-type adenocarcinomas. The more prominent lymphocytic response observed in tumors with a high TSR may indicate a close interaction between the tumor stroma and the immune microenvironment. AI-assisted tumor–stroma assessment represents a promising approach for enabling a more objective and standardized evaluation of the tumor microenvironment in gastric adenocarcinomas.

Keywords: Artificial intelligence, gastric adenocarcinoma, intestinal type, tumor microenvironment, tumor–stroma ratio tumor microenvironment

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9672 - Retrospective Evaluation of the Relationship Between Body Composition Analysis, Tumor Stage Survival, and Postoperative Morbidity in Patients with Gastric Adenocarcinoma Receiving Neoadjuvant Chemotherapy and Curative Gastrectomy

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Aim: This study retrospectively evaluated the relationship between computed tomography-based body composition analysis at the L3 level and tumor stage, overall survival, and postoperative morbidity in patients with gastric adenocarcinoma receiving neoadjuvant chemotherapy (NAC) and curative gastrectomy.

Method: Skeletal muscle, subcutaneous fat, and visceral fat areas/indices were measured on pre- and post-NAC computed tomography images in 110 patients. Survival was analyzed using Kaplan-Meier and Cox regression; complication associations were analyzed using logistic regression.

Findings: Overall and major (Clavien-Dindo $\geq$ IIIa) complication rates were 30.0% and 11.8%, respectively; median overall survival was 54 months (5-year survival: 42.9%). Static sarcopenia, defined using literature-based cutoffs (Martin, Fearon, Prado), was not significantly associated with survival (all $p > 0.30$). In contrast, dynamic skeletal muscle loss during NAC (Δ SMI%, Δ SMA%) independently predicted poor survival regardless of stage, age, sex, and grade (adjusted HR: 0.94 and 0.95; $p=0.003$ and 0.004), and was confirmed in male, ≥ 65 -year, and high-grade subgroups. The sarcopenic visceral obesity phenotype (low muscle mass plus high visceral fat, $n=26$) was not significantly associated with major complications (adjusted OR: 2.37; $p=0.237$). Skeletal muscle decreased significantly during NAC, while subcutaneous and visceral fat were preserved.

Conclusion: Unlike static measurements, dynamic skeletal muscle loss during treatment is a clinically valuable indicator that complements staging in predicting prognosis in gastric cancer; literature-based static sarcopenia definitions and composite phenotypes such as sarcopenic visceral obesity did not independently predict survival or morbidity in this cohort.

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Keywords: Gastric adenocarcinoma, body composition, neoadjuvant chemotherapy, gastric cancer, sarcopenia and tumor cachexia

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5551 - Hereditary Diffuse Gastric Cancer (HDGC): Incidence, Surveillance Strategies and Prophylactic Gastrectomy Recommendations Based on International Guidelines

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Aim: Hereditary diffuse gastric cancer(HDGC) is a rare autosomal dominant cancer predisposition syndrome characterized by an increased risk of diffuse gastric cancer(DGC), typically with signet ring cell carcinoma(SRCC) histology. Germline pathogenic variants in CDH1 are the principal genetic cause, while CTNNA1 variants account for a smaller proportion of families. This review aimed to summarize current evidence on gastric cancer risk in HDGC and to compare international guideline recommendations regarding genetic assessment, endoscopic surveillance, and risk-reducing total gastrectomy(RRTG).

Method: IGCLC 2020, NCCN v1.2025, ESMO, and relevant British and Japanese guidelines were reviewed, focusing on genetic assessment, endoscopic surveillance, and indications and timing of RRTG.

Findings: Gastric cancer risk among CDH1 pathogenic variant carriers varies with ascertainment and family history. Earlier selected family-based studies estimated lifetime DGC risks of approximately 70% in men and 56% in women. More recent data indicate lower risks of advanced gastric cancer, approximately 10% in men and 7% in women by age 80, with higher risk in those with a stronger family history. Guidelines emphasize surveillance at expert centers using high-quality endoscopy, careful mucosal inspection, and targeted biopsies. Random-biopsy strategies differ: IGCLC protocols incorporate systematic sampling, whereas NCCNv1.2025 focuses on identifying individuals at risk of > pT1a SRCC and does not require random biopsies in every carrier. Surveillance is limited by the multifocal, microscopic, and frequently occult nature of early SRCC. Intramucosal pT1a SRCC foci are common and may be indolent; a systematic review identified gastric cancer in 85.4% of RRTG specimens from CDH1 pathogenic variant carriers, highlighting limitations of endoscopic detection. RRTG provides the greatest reduction in advanced gastric cancer risk for appropriately selected CDH1 pathogenic variant carriers. IGCLC and ESMO recommend consideration of surgery in early adulthood, generally at 20–30 years, whereas NCCNv1.2025 adopts a more individualized approach integrating endoscopic findings, clinical factors, and patient preferences. For CTNNA1 pathogenic variant carriers, whose penetrance is less well defined, IGCLC recommends annual expert-center endoscopic

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surveillance, with gastrectomy considered according to biopsy findings and DGC family history. Decisions should balance cancer risk reduction against the lifelong nutritional and quality-of-life consequences of gastrectomy.

Figure 1: Comparison of international recommendations for HDGC management

IGCC 2020	SURVEILLANCE APPROACH	RRTG APPROACH / TIMING	KEY POINTS
IGCC 2020	<ul style="list-style-type: none"> Annual endoscopic surveillance in individuals who defer gastrectomy High-definition white-light endoscopy in expert centers Targeted biopsies of suspicious lesions plus systematic random biopsies 	<ul style="list-style-type: none"> Risk-reducing total gastrectomy is generally recommended for appropriate CDH1 pathogenic variant carriers, regardless of endoscopic findings Earlier gastrectomy may be considered in selected circumstances 	<ul style="list-style-type: none"> 20-30 systematic random biopsies recommended RRTG is the preferred risk management strategy for CDH1 pathogenic variant carriers Surveillance does not eliminate gastric cancer risk
NCCN v1.2025	SURVEILLANCE APPROACH	RRTG APPROACH / TIMING	KEY POINTS
NCCN	<ul style="list-style-type: none"> Surveillance is an alternative to RRTG for individuals who decline or postpone surgery Focus is on detection of clinically significant disease (cT1a) Annual endoscopy in expert centers if surveillance is chosen 	<ul style="list-style-type: none"> RRTG is recommended for carriers with pT1a or higher signet ring cell carcinoma (SRCC) on biopsy RRTG is recommended for those with endoscopic findings concerning for advanced disease For others, shared decision-making is advised between RRTG and endoscopic surveillance Timing of RRTG should be individualized according to age, family history and patient preferences 	<ul style="list-style-type: none"> Goal is to identify individuals at risk for pT1a invasive signet ring cell carcinoma rather than detect oligo/mucosal intramucosal pT1a foci Microscopic pT1a SRCC foci are common, but their risk of progression to pT1a disease remains uncertain Random biopsies may be used at clinician discretion Surveillance does not eliminate gastric cancer risk
ESMO	SURVEILLANCE APPROACH	RRTG APPROACH / TIMING	KEY POINTS
ESMO	<ul style="list-style-type: none"> Annual endoscopic surveillance in expert centers if surgery is deferred High-definition white-light endoscopy in expert centers Targeted biopsies of suspicious lesions plus systematic random biopsies 	<ul style="list-style-type: none"> Risk-reducing total gastrectomy is recommended between 20 and 30 years of age for CDH1 pathogenic variant carriers Decision-making should be individualized considering operative risk and the long-term consequences of gastrectomy 	<ul style="list-style-type: none"> Endorse IGCC approach with systematic biopsies and early RRTG Surveillance aims to detect clinically significant cT1a disease Surveillance does not eliminate gastric cancer risk
CTNNA1	<p>Pathogenic variants in CTNNA1 are identified in approximately 1-2% of HDGC families. Annual endoscopic surveillance in expert centers is recommended. RRTG may be considered based on biopsy findings, family history, and patient preferences through shared decision-making.</p>		

Conclusion: Risk-reducing total gastrectomy remains the most definitive strategy for reducing gastric cancer risk in CDH1-associated HDGC. Endoscopic surveillance is an alternative for selected individuals who defer or decline surgery but has important limitations in excluding clinically significant disease. Contemporary management should integrate genotype, family history, endoscopic findings, operative risk, and patient preferences through multidisciplinary counseling and shared decision-making.

Keywords: CDH1, endoscopic surveillance, hereditary diffuse gastric cancer, risk-reducing total gastrectomy, signet ring cell carcinoma

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9998 - Nonoperative Management of Anastomosis Leakage after Postoperative Bleeding in Remnant Gastric Cancer

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Aim: Anastomosis leakage is a rare complication in gastric surgery. When it occurs after relaparotomy for postoperative bleeding is more unusual and complicated problem. Aim of this presentation that it can be solved with percutaneous bilier drainage catheter without any other interventions.

Method: 66 years old female patient who had distal gastrectomy underwent total gastrectomy for remnant gastric cancer. There was no surgical problems until the postoperative 4th day and then massive vascular bleeding happened suddenly. Emergency relaparotomy performed and vasculer religation right gastric artery was done succesfully. After the relaparotomy bile leakage was seen also the patient needed dialysis and vasopressor agents for hemodynamic stability. With resuscitation and other intensive care supports, the patient turned the situation around. By the way bilier leakage was going on approximately 500 ml for free drainage catheter per day. Origin of the leakage was dedected on jejunojejunostomy anastomosis by cholangiography. After that nasojejunal tube inserted to distal of the anastomosis for enteral nutrition and internal-external biliary drainage catheter insterted to the intestin for running away of bile from the defect area.

Findings: In the following days, drainage from the free catherher was decreased gradually and completely came to an end nearly two weeks after the bilier catheterizaiton. Then methylen blue test was negative and computerized tomography confirmed that leakage was ended. Also the patient's clinical status and labaroty parameters got recovered. The patient's oral intake was gradually resumed. Despite contiuned oral intake, there was no bilier drainage anymore. So biliary drainage catheter was removed in postoperative 3rd week and finally the patient was discharged after the free drainage catheter was removed in postoperative 4th week. There was no surgical problems or need for interventions arose during the post-discharge follow up.

Conclusion: Anastomosis leakage, which presents as a rare complication following unexpected bleeding in an atypical case, ceases to be a major problem when managed carefully through a multidisciplinary approach and it can be completely resolved using non-surgical interventions.

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7509 - Endoscopic-Laparoscopic Hybrid Approach to a Gastric Polyp

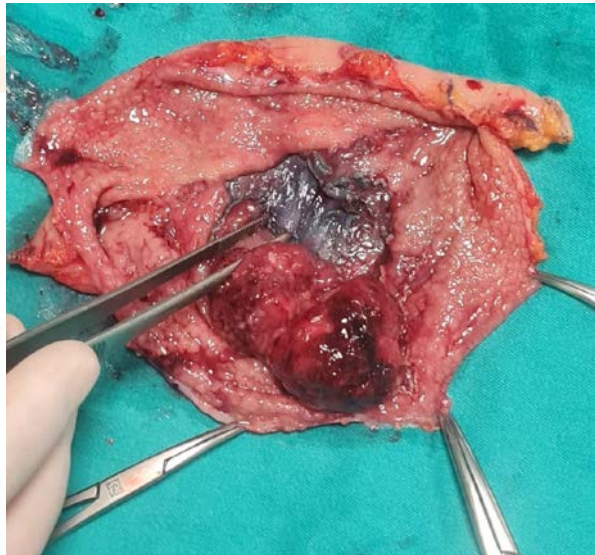
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Aim: We aim to present a case of a large gastric polyp with malignant potential, initially managed with endoscopic submucosal dissection(ESD) and subsequently completed via laparoscopic resection

Method: A 78-year-old male patient presenting with gastric pain was referred for ESD after an external endoscopy and biopsy of a polypoid lesion revealed a tubulovillous adenoma. ESD was scheduled under general anesthesia in the operating theater, anticipating a possible need for surgical resection. Due to the lesion's size and malignant potential identified intraoperatively during ESD, the procedure was converted to a laparoscopic wedge resection.

Macroscopic appearance



Intraoperative macroscopic appearance of the opened resection specimen in the operating room.

Findings: The pathology report following laparoscopic wedge resection revealed an intestinal-type, well-differentiated T1b adenocarcinoma with a tumour size of 5.5 cm and a

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submucosal invasion depth of 1.2 mm (> 500 microns). Neither lymphovascular nor perineural invasion was observed, and the surgical margins were negative. Due to a 9 mm suspicious lymph node detected on PET-CT, lymph node surgery was recommended by the multidisciplinary oncology board. However, the patient requested medical therapy and non-surgical follow-up. At the 15-month follow-up after medical oncological treatment, no uptake was observed on PET-CT, and the control endoscopy was normal. The patient continues to be followed up healthily.

Pathology Report

Yapılan Özel İşlemler

*IHK: Pankreatikatin ile yaygın pozitif boyanma görüldü. MLH-1, PMS-2, MSH-2 ve MSH-6 ile intakt nükleer ekspresyon izlenmiştir. Sinaptofizin ve kromogranin ile boyanma izlenmedi (Negatif). CerbB2 ile boyanma saptanmadı (Skor 0: Negatif). PDL-1 (SP263): Pozitif (>5%).
*ISH: EBER ile boyanma saptanmadı (Negatif).

PATOLOJİK TANI

Mide, Rezeksiyon:
-Adenokarsinom, iyi diferansiye
-Tümör boyutu: 5.5 cm
-Lauren: İntestinal tip
-Tümör lamina propria, muskularis mukoza ve submukozaya invaze olup muskularis propriaya invazyon izlenmedi.
-Submukozal invazyon derinliği: 1.2 mm (>500 mikron)
-Lenfovasküler invazyon saptanmadı.
-Perinöral invazyon saptanmadı.
-Cerrahi sınırlar: Tümör saptanmadı.
-Ülser: Mevcut
-Patojik evre: pT1b

Detailed pathology report

Conclusion: When ESD is planned for large gastric tumours, it is appropriate to perform the procedure under operating theatre conditions with laparoscopy preparation in anticipation of a potential need for resection. In the management of patients whose gastric polyp is reported as a T1b adenocarcinoma, the decision for medical follow-up or surgery must be made through a multidisciplinary approach

Keywords: Gastric polyp, ESD, hybrid management, T1b adenocarcinoma

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8094 - Cerebral Air Embolism Following Endoscopic Balloon Dilatation of an Esophagojejunal Anastomotic Stricture after Total Gastrectomy: A Case Report

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Aim: Cerebral air embolism is a rare but potentially life-threatening complication of upper gastrointestinal endoscopy. We report a case following endoscopic balloon dilatation of an esophagojejunal anastomotic stricture after total gastrectomy, highlighting the importance of considering this diagnosis when a patient fails to regain consciousness after the procedure.

Method: The patient's clinical course, endoscopic and radiological findings, treatment, and follow-up records were retrospectively reviewed.

Findings: A 51-year-old male underwent radical total gastrectomy with hyperthermic intraperitoneal chemotherapy in November 2022 for advanced gastric cancer after receiving neoadjuvant chemotherapy. The postoperative course was complicated by an anastomotic leak requiring covered stent placement. After healing, a severe fibrotic anastomotic stricture developed a few months later. In February 2024, an 18–20-millimeter multistage balloon was inflated to 19 millimeters under direct endoscopic visualization. Air was used for insufflation. Biopsies obtained before dilatation revealed necrosis, ulceration, granulation tissue, and fibrosis, with scattered malignant epithelial cells in one biopsy, suggesting local recurrence. After dilatation, no evidence of perforation was observed endoscopically or on thoracic computed tomography. Following propofol sedation, the patient failed to regain consciousness. His Glasgow Coma Scale score fell to 5, requiring intubation. Cranial computed tomography showed multiple intracranial air foci confined to the right cerebral hemisphere, consistent with cerebral air embolism. Hyperbaric oxygen therapy was unavailable; therefore, one hundred percent oxygen was administered. Despite a decrease in intracranial air, progressive cerebral edema and midline shift required emergency decompressive craniectomy. The patient remained in intensive care with persistent aphasia and left hemiplegia and died after 89 days.

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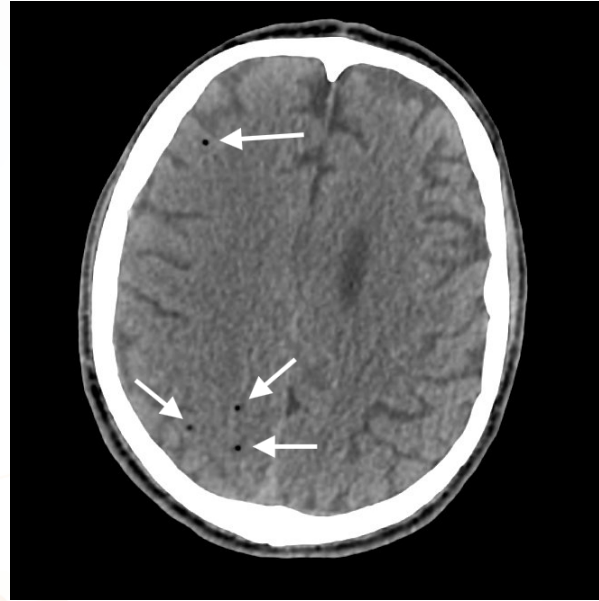
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Cranial Computed Tomography Showing Cerebral Air Embolism



Axial non-contrast cranial computed tomography showing multiple intracranial air foci in the right cerebral hemisphere (arrows)

Conclusion: Cerebral air embolism should be considered when a patient fails to regain consciousness or develops acute neurological signs after therapeutic upper gastrointestinal endoscopy. The absence of overt gastrointestinal perforation does not exclude the diagnosis. Early neuroimaging, airway and oxygenation support, and prompt neurological and hyperbaric medicine consultation are essential to minimize irreversible neurological injury.

Keywords: Air embolism, balloon dilatation, anastomotic stricture, total gastrectomy, upper gastrointestinal endoscopy



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