Has the issue of the "point of no return" in gastric carcinogenesis already been resolved?

To the Editor:

We have read the article focusing on the timing of *Helicobacter pylori* eradication on the risk of development of metachronous gastric cancer (MGC) after treatment of early gastric cancer (EGC) by Kim et al.[1] The authors showed that the timing of *H pylori* eradication within 1 year after treatment was better to reduce the risk of development of MGC than the late timing based on a large-scale national insurance database. They described that this finding was supported by a randomized controlled study by Choi et al[2] showing that *H pylori* eradication after endoscopic resection (ER) of EGC improved atrophy and intestinal metaplasia during the 3-year follow-up. Consequently, they concluded that the "point of no return" may no longer be an issue.

Recently, Kato et al[3] extended the follow-up period of a previous study and showed that *H pylori* eradication after ER of EGC had a preventive effect on the development of MGC in patients with mild to moderate atrophic gastritis, but this was not observed in severe atrophy.[4] They compared patients with *H pylori* eradication within 1 year after ER to those without or with failed eradication. This finding can mean that atrophic severity can have interaction effects, a predictive factor of MGC, but not confounding factors as a prognostic value. Therefore, it is suggested that the "point of no return" may not be resolved in patients with severe gastric atrophy. A recent meta-analysis revealed that a preventive effect was more significant in patients with extended follow-up (≥5 years) (OR, 0.32; 95% CI, 0.24-0.43) than in those with short follow-up (<5 years) (OR, 0.55; 95% CI, 0.41-0.72).[5] Therefore, we may need more additional observation times in patients with severe gastric atrophy to conclude whether the issue of the "point of no return" is resolved.

DISCLOSURE

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Response:

We wish to thank Dr Nishida and his colleagues[1] for their interest in our article.[2] In the past, the benefit of *Helicobacter pylori* eradication was less evident if intestinal metaplasia occurred.[3] This "point of no return" concept raised questions about the preventative effect of *H pylori* eradication therapy against metachronous gastric cancer in patients who underwent endoscopic resection for gastric cancer because they usually present with advanced precancerous lesions, including metaplasia, on histologic evaluation.[4,5] However, the point-of-no-return concept has been challenged by recent studies showing the beneficial effect of *H pylori* eradication for the prevention of metachronous gastric cancer.[5-7] The severity of atrophic gastritis and intestinal metaplasia improved and the risk of metachronous gastric cancer decreased after *H pylori* eradication in patients with early gastric cancer.[5]

Nevertheless, we agree with the opinions of Nishida et al[1] that we need more observations of patients with severe atrophic gastritis. As they mentioned, Kato et al[8,9] successfully identified the preventative effect of *H pylori* eradication against metachronous gastric cancer in patients with mild-to-moderate atrophic gastritis by extending the observation period in their cohort. Although early atrophic gastritis and intestinal metaplasia are precancerous lesions that may be controllable by *H pylori* eradication, advanced grades of atrophic gastritis and intestinal metaplasia may be a concern. Our study also demonstrated that *H pylori* eradication does not completely eliminate the risk of metachronous lesions.[2] The risk of metachronous lesions increases when *H pylori* is eradicated late. These findings imply that the preventative effect of *H pylori* eradication may decrease if atrophic gastritis and intestinal

metaplasia progress. We hope that more studies will be conducted with sufficient observation periods so that we may reach a definitive conclusion regarding this issue.

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The diagnostic value of EUS-guided fine-needle aspiration/biopsy for solid pancreatic lesions: contrast-enhanced versus conventional EUS

To the Editor:

We read with great interest the article by Cho et al,[1] which compared the diagnostic sensitivity for pathologic diagnosis of solid pancreatic lesions (SPLs) between a contrast-enhanced harmonic EUS(CEH-EUS) group and a conventional EUS group. The authors recommended that CEH-EUS-guided fine-needle aspiration/biopsy (FNA/B) might be considered for small, indeterminate SPLs, consistent with the previous study.[2]

Patients were randomly assigned to the CEH-EUS group (n = 120) and the conventional EUS group (n = 120). Actually, the randomized controlled design was the strength of this study. However, we believe that a crossover design might be a better choice.[3] In the CEH-EUS group, CEH-EUS–guided FNA/B was performed, followed by conventional EUS-guided FNA/B. In the conventional EUS group, conventional EUS was used first. This design method can not only balance the basic characteristics of patients and lesions but also enlarge the sample size in each group to 240 patients.

In addition, when the diagnostic values of the 2 groups were evaluated, the criterion standard was mainly based on the results of FNA/B instead of the surgical results. False positive or negative results might occur during FNA/B. We were puzzled that the authors used the results of EUS-FNA/B to evaluate the diagnostic value of EUS-guided FNA/B and each pass. In our opinion, the diagnostic value used in this article should be converted to the adequacy of the tissue sample.

Finally, the authors concluded that larger needle diameters might predict a higher diagnostic value. However, they put 19-gauge and 22-gauge needles into the same group to make a comparison with a 25-gauge needle. Although no significant differences in needle type and size between the 2 groups were noted, fewer FNB needles and more 25-gauge needles used in the conventional group underestimated the diagnostic value of conventional EUS.

In conclusion, it is an excellent study, providing us with a better understanding of CEH-EUS-guided FNA/B.

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