STOMACH CANCER

Symptoms :Dyspepsia Pain, Bleeding, Vomiting, Lumps, Unexplained weight loss, Anaemia
Upper GI Endoscopy with multiple biopsies(6-8)
Pathology : Adenocarcinoma.

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CECT scan thorax, abdomen and pelvis
Multidisciplinary Tumour board
Pre-anesthetic evaluation
Nutritional support-Oral or tube feeding
Staging Laparoscopy if CT s/o no mets if Periop chemo is planned
Endoscopic ultrasonography

Early, Localized
(T1-2, N0)

Loco-regionally advanced
T3-4, N+ve

Metastatic Disease[a]
Any T, any N, M1
Or T4 stuck tumours
Poor PS/ ASA 4
Consider Her 2 testing

Unfit for surgery or refusing surgery

Surgery

Perioperative Chemo

Surgery
D2 gastrectomy

Palliative
CT±Radiotherapy

Palliative treatment
Endoscopic Stenting if needed, [GEJ and Pylorus]
Pain management
Nutritional support
Chemotherapy
First line
DCF/ EOX/ FLOT/ DOX/ FOLFOX/ CAPOX/ Irinotecan
Her2 neu positive – Add Trastuzumab
Second line
DCF/ EOX/ FLOT/ DOX/ FOLFOX/ CAPOX/ Irinotecan
Ramicurimab (O)
Third line
Test PDL1
Immunotherapy(O)

If pathologicallyT1-2, N0: No adjuvant treatment
D2 Dissection (More than15 nodes)
If T3+or N+:
Adjuvant chemotherapy CAPOX/ Cape cis/ FOLFOX for 6 months
D1 dissection or margins positive
Adjuvant Chemo radiotherapy
1 cycle EOX/CAPOX/FOLFOX, CT/RT with Capecitabine 850mg/m2 bd 5 weeks+ RT 45Gy over 25 fractions, followed by 2 cycles of EOX/ FOLFOX
R2 resection
Palliative chemotherapy

Perioperative chemo therapy

T4 lesions preferred

FLOT X 4 cycles -Sx- 4 cycles adj

EOX x 3 cycles – Sx -3 cycles adj.

FOLFOX/ CAPOX x 3 months – Sx -3 months adj.

Role of PET Scan: PET scan should NOT be performed in gastric cancer.

Early supportive care team and nutrition evaluation is encouraged in all cases

Testing for CDH1 mutation is essential in:

Patient with diffuse gastric cancer under the age of 40.
Families with two gastric cancers, one confirmed to be diffuse irrespective of age.
Personal or family history (first or second degree relative) of diffuse gastric cancer and lobular breast cancer, one diagnosed under the age of 50.
Family members with CDH1 mutation need counselling and treatment at a tertiary centre.

Gastric cancer screening is essential in patients with high risk ie Lynch syndrome, familial adnenomatous polyposis, gastric adenomas, gastric metaplasia and pernicious anaemia. The ideal interval for upper GI endoscopy is every 3 years.

Early gastric cancer optimally need narrow band imaging endoscopy to determine extent. Endoscopic mucosal resection is ideally indicated for < 2cm non ulcerated lesions with no nodes on EUS . EMR and follow up should be performed at tertiary care centres.Follow up 6 monthly for first year than annually for 5 years then as clinically indicated.

EUS is desirable in patients with resectable disease to determine precise T and N stage for choice of NACT vs upfront surgery.

Post operative surveillance: It is essential to follow up patients post gastrectomy to ensure good nutrition and supplement iron, vitamin b12, vit D and calcium.
Radiological and endoscopic surveillance in asymptomatic patients post radical surgery is optional.