Gastric Cancer

Cancer Centre of Southeastern Ontario
Standard Management Guidelines

Intended for use by Clinicians and Health Care Providers involved in the Management or Referral of adult patients with Gastric Cancer

Section	Activity	Activity Description	Details	Reference(s)
AA	Cancer Centre Referrals		• All patients who are not candidates for definitive Endoscopic Mucosal Resection (EMR)	
A	Diagnosis		• Localized disease – endoscopic biopsy or EMRMetastatic disease – endoscopic biopsy or biopsy of metastatic tumor focus if accessible	
B	History and Physical exam		• Family history of HNPCC, BRCA2, DHGC	
C	Investigations	Based on disease presentation	• Blood work: CBC, liver and renal function tests • H. Pylori testing • Upper endoscopy with biopsy • Endoscopic ultrasound for select patients (suspected to have more advanced disease ≥ T3 and/or node positive disease) • CT chest/abdomen/pelvis • Renal perfusion scan for radiation patients • Bone scan • PET • Laparoscopy ± peritoneal washings for specific indications (large tumors, node positive, suspicious for metastatic disease on imaging)	

D	Pathology of Diagnostic Specimen	Synoptic Report	KGH pathology review of cases with outside pathology as requested Biopsy specimen: • Surgical report to include: o Tumor type (histology), grade, depth of invasion HER2 testing initiated by pathologist for primary gastric or GE junction adenocarcinoma Resection specimen: • Synoptic report includes: • Location of primary tumor, tumor type (histology), grade, depth of invasion, presence of lymphovascular invasion and/or perineural invasion, number of lymph nodes, lymph node involvement, assessment of resection margins, assessment of treatment effect	
E	Post-Investigation Management	Definitive Curative Intent treatment	T1 N0 – Surgery alone (selected T1a patients may be candidates for endoscopic mucosal resection) (referral to GI) T2-4 and/or LN+, resectable and operable: Options: • Surgery alone for pT2N0 patients with R0 resection • Surgery → adjuvant chemo (5FU) → chemo 5FU/RT →chemo (5FU)	[1] [2] [3] CCO Guidelines

			• Pre-op chemotherapy (ECF) →surgery→ post-op chemotherapy (ECF) (MAGIC regimen) Surgery to consist of: Laparoscopic or open D1 or D2 gastrectomy (subtotal or total gastrectomy depending on location of the tumor) Proximal gastrectomy in select Siewert type 3 tumors. Esophagogastrectomy for select proximal tumours with proximal submucosal spread GE junction: options include neoadjuvant chemoRT as per Esophageal/GE junction guidelines for advanced tumors	**Neoadjuvant or Adjuvant Therapy for Resectable Gastric Cancer**
F	Post-Investigation Management	Advanced Disease	Unresectable and/or inoperable disease: Options: Palliative chemo alone Palliative radiation Palliative surgery (i.e. Bypass) Stent Best supportive care ***For GEJ cancers, see esophageal cancer guidelines	

Metastatic disease:

Options:

Palliative chemo

HER2 +

- HCX
- HCCarboX

HER2 –

- ECF/ECX
- CF/X
- FOLFIRI

Palliative radiation

Palliative surgery

Best supportive care

G	Post-Investigation Management	Locally recurrent disease	Dependent on initial management (subtotal vs. total gastrectomy) and timing of recurrence For localized disease Options: Surgery External beam radiation Chemotherapy	
H	Follow up with no evidence of disease	Follow up after curative treatment with no evidence of disease	• Clinic visit for Hx/PE q3-6 months for 3 years, then q6 months until 5 years • CT and/or other investigations as clinically indicated • Upper endoscopy annually and/or as required symptomatically	
I	Controversies		• Role of adjuvant chemotherapy without radiation following surgical resection • Laparoscopic staging • Surgeon and centre volumes	[4]
J	Clinical Trials		Active Clinical Trials:	[5] Clinical Trials

References

1. Macdonald JS, Smalley SR, Benedetti J, et al. Chemoradiotherapy after surgery compared with surgery alone for adenocarcinoma of the stomach or gastroesophageal junction. N Engl JMed 2001;345:725-30. back
2. Cunningham D, Allum WH, Stenning SP, et al. Perioperative chemotherapy versus surgery alone for resectable gastroesophageal cancer. N Engl J Med 2006;355:11-20 back
3. CCO guidelines: Neoadjuvant or Adjuvant Therapy for Resectable Gastric Cancer
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4. The GASTRIC (Global Advanced/Adjuvant Stomach Tumor Research International Collaboration) Group. Benefit of adjuvant chemotherapy for resectable gastric cancer: a meta-analysis. JAMA. 2010;303(17):1729-1737. back
5. **Cancer Centre of Southeastern Ontario.** Oncology Clinical Trials. *Cancer Centre of Southeastern Ontario at the Kingston General Hospital.* [Online] http://krcc-2/DotNetNuke/DesktopDefault.aspx?alias=krcc-2/dotnetnuke/clinicaltrials

Revisions

- 2014/02/17: Put information in coloured template for DSG Chairs Council Meeting
- 2016/05/17 Reduction in regimens for Advanced Disease – Reorganized by HER2 status. Links to clinical trials added.