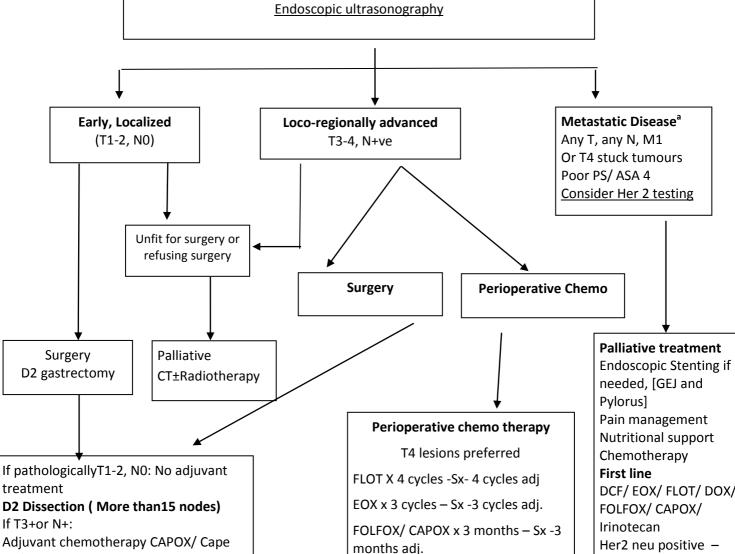
STOMACH CANCER

Symptoms: Dyspepsia Pain, Bleeding, Vomiting, Lumps, Unexplained weight loss, Anaemia

Upper GI Endoscopy with multiple biopsies(6-8) Pathology: Adenocarcinoma.

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



treatment

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

DCF/ EOX/ FLOT/ DOX/ Her2 neu positive -

Second line

Add Trastuzumab

DCF/ EOX/ FLOT/ DOX/ FOLFOX/ CAPOX/ Irinotecan Ramicurimab (O)

Third line

Test PDL1 *Immunotherapy(0)* 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.

<u>EUS is desirable in patients with resectable disease</u> 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.