Gastric Cancer

Disclaimer: *This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson's specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient's care. This algorithm should not be used to treat pregnant women.*

Note: Consider Clinical Trials as treatment options for eligible patients. Consider referral to a Comprehensive Cancer Center.

INITIAL EVALUATION

- Multidisciplinary evaluation
- Nutrition consult as clinically indicated
- History and physical
- CBC with differential and chemistry profile
- CT chest, abdomen and pelvis with oral and IV contrast
- Esophagogastroduodenoscopy (EGD) and biopsy
- PET/CT scan (if clinically indicated)
- Endoscopic ultrasound (optional)
- H. pylori test, treat if positive
- Microsatellite (MS) status
- *HER2-neu* evaluation by immunohistochemistry (IHC)[1] and *PD-L1* in patients with advanced, metastatic cancer (not localized cancer)
- Additional biomarkers as clinically indicated[1]
- Lifestyle risk assessment[2]

CLINICAL STAGE

ADDITIONAL EVALUATION

POST LAPAROSCOPY STAGING

PRIMARY TREATMENT

cTis or cT1a → Medically fit[3]?

- Yes → • Endoscopic resection (ER) **or** • Surgery
- No → ER

M0

Medically fit[3] and potentially resectable (consider laparoscopy staging) → cT1b, M0, cT2 or greater **or** N+, but M0 →

- Surgery **or**
- Preoperative chemotherapy **or**
- Chemoradiation (45 Gy)
- Discuss Goal Concordant Care (GCC) with patient[6] or if clinically indicated, with Surrogate-Decision Maker (SDM)

Medically fit[3] and unresectable[4,5] (consider laparoscopy staging) → M0 →

- Discuss GCC with patient[6] or if clinically indicated, with SDM
- Chemoradiation (45 Gy) **or**
- Chemotherapy

Medically unfit → M0 →

- Discuss GCC with patient[6] or if clinically indicated, with SDM
- Radiation therapy (45 Gy) **or**
- Supportive care including Nutrition Services as clinically indicated

Stage IV (M1) → KPS score ≥ 60% **or** ECOG performance score ≤ 2?

- Yes →
  - Discuss GCC with patient[6] or if clinically indicated, with SDM
  - Chemotherapy **or**
  - Clinical trial **or**
  - Supportive care including Nutrition Services as clinically indicated
- No →
  - Discuss GCC with patient[6] or if clinically indicated, with SDM
  - Consult to Palliative/Supportive Care as clinically indicated

Post-Primary Treatment Assessment

- CT chest, abdomen and pelvis with oral and IV contrast (if clinically indicated)
- PET/CT scan (if clinically indicated)
- CBC with differential and chemistry profile
- See Page 2 for post-surgical response evaluation

KPS = Karnofsky Performance Status
ECOG = Eastern Cooperative Oncology Group

[1] Consider HER2-neu evaluation initially by IHC and if IHC score 2+, follow-up with FISH test. See Biomarkers - MD Anderson Approved algorithm.
[2] See Physical Activity, Nutrition, and Tobacco Cessation algorithms; ongoing reassessment of lifestyle risks should be a part of routine clinical practice
[3] Medically fit implies low risk (< 5% chance of mortality) for major surgery
[4] M0 unresectable refers to an unresectable T4 primary
[5] Medically fit patients with positive cytology in the peritoneal fluid (but no macroscopic cancer) may be re-assessed for surgery after prolonged systemic therapy and chemoradiation
[6] GCC should be initiated by the Primary Oncologist. If Primary Oncologist is unavailable, Primary Team Attending Physician to initiate GCC discussion and notify Primary Oncologist. Patients or if clinically indicated the SDM should be informed of therapeutic and/or palliative options. GCC discussion should be consistent, timely, and re-evaluated as clinically indicated. The Advance Care Planning (ACP) note should be used to document GCC discussion. Refer to the GCC home page (for internal use only).

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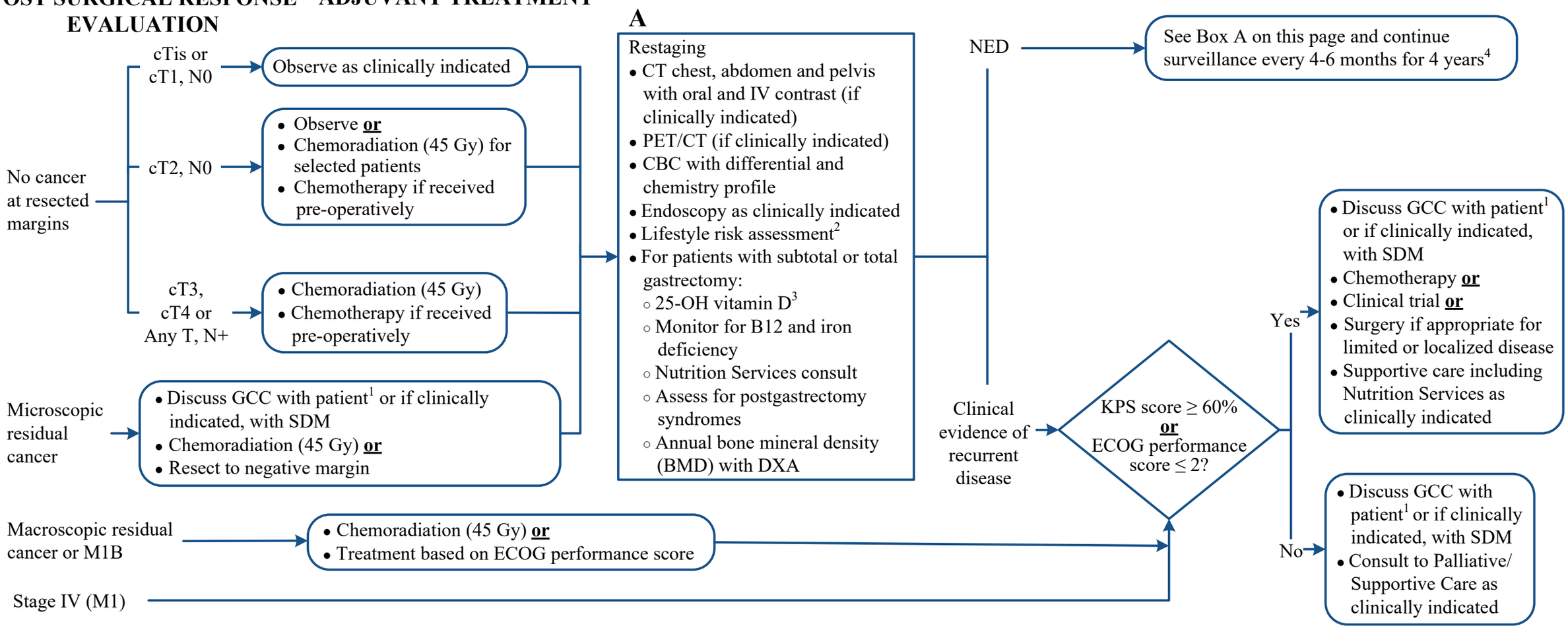
Gastric Cancer

Note: Consider Clinical Trials as treatment options for eligible patients. Consider referral to a Comprehensive Cancer Center.

POST SURGICAL RESPONSE EVALUATION

ADJUVANT TREATMENT



ECF = epirubicin, cisplatin and fluorouracil
DXA = Dual-energy X-ray Absorptiometry

[1] GCC should be initiated by the Primary Oncologist. If Primary Oncologist is unavailable, Primary Team Attending Physician to initiate GCC discussion and notify Primary Oncologist. Patients or if clinically indicated the SDM should be informed of therapeutic and/or palliative options. GCC discussion should be consistent, timely, and re-evaluated as clinically indicated. The Advance Care Planning (ACP) note should be used to document GCC discussion. Refer to the GCC home page (for internal use only).

[2] See Physical Activity, Nutrition, and Tobacco Cessation algorithms; ongoing reassessment of lifestyle risks should be a part of routine clinical practice

[3] 25-hydroxyvitamin D, also known as 25-hydroxycholecalciferol, calcidiol or abbreviated as 25-OH Vitamin D, the main vitamin D metabolite circulating in plasma

[4] For patients who are 4 years post-treatment and no evidence of disease (NED), refer to Survivorship – Gastric Cancer algorithm.

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SUGGESTED READINGS

PRINCIPLES OF MULTIDISCIPLINARY TEAM APPROACH FOR GASTROESOPHAGEAL CANCERS

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PRINCIPLES OF SYSTEMIC THERAPY FOR GASTRIC OR GASTROESOPHAGEAL JUNCTION ADENOCARCINOMA

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Al-Batran, S. E., Homann, N., Pauligk, C., Goetze, T. O., Meiler, J., Kasper, S., … FLOT4-AIO Investigators. (2019). Perioperative chemotherapy with fluorouracil plus leucovorin, oxaliplatin, and docetaxel versus fluorouracil or capecitabine plus cisplatin and epirubicin for locally advanced, resectable gastric or gastro-oesophageal junction adenocarcinoma (FLOT4): a randomised, phase 2/3 trial. *The Lancet, 393*(10184), 1948-1957.

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SUGGESTED READINGS - continued

PRINCIPLES OF SYSTEMIC THERAPY FOR GASTRIC OR GASTROESOPHAGEAL JUNCTION ADENOCARCINOMA – continued

Dank, M., Zaluski, J., Barone, C., Valvere, V., Yalcin, S., Peschel, C., … Bugat, R. (2008). Randomized phase III study comparing irinotecan combined with 5-fluorouracil and folinic acid to cisplatin combined with 5-fluorouracil in chemotherapy naive patients with advanced adenocarcinoma of the stomach or esophagogastric junction. *Annals of Oncology, 19*(8), 1450-1457. doi: 10.1093/annonc/mdn166

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OTHER SUPPORTIVE READINGS

MD Anderson Institutional Policy #CLN1202 - Advance Care Planning Policy
Advance Care Planning (ACP) Conversation Workflow (ATT1925)

Peterson, L. A., Zeng, X., Caufield-Noll, C. P., Schweitzer, M. A., Magnuson, T. H., & Steele, K. E. (2016). Vitamin D status and supplementation before and after bariatric surgery: a comprehensive literature review. *Surgery for Obesity and Related Diseases*, *12*(3), 693-702. doi:10.1016/j.soard.2016.01.001

DEVELOPMENT CREDITS

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