Gastric Cancer

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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)
- Microsatellite (MS) status
- HER2-neu evaluation by immunohistochemistry (IHC)
- PD-L1 in patients with advanced, metastatic cancer
- Additional biomarkers as clinically indicated
- Lifestyle risk assessment

CLINICAL STAGE

- cTis or cT1a
- Medically fit and potentially resectable (consider laparoscopy staging)
- cT1b, M0, cT2 or greater or N+, but M0
- Medically fit and unresectable (consider laparoscopy staging)
- Medically unfit

ADDITIONAL EVALUATION

- M0
- Stage IV (M1)
- KPS score ≥ 60% or ECOG performance score ≤ 2?

PRIMARY TREATMENT

- ER
- Endoscopic resection (ER) or
- Surgery or
- Preoperative chemotherapy or
- Chemoradiation (45 Gy)
- Discuss Goal Concordant Care (GCC) with patient or if clinically indicated, with Surrogate-Decision Maker (SDM)

POST LAPAROSCOPY STAGING

- M0
- M0
- Discuss GCC with patient or if clinically indicated, with SDM
- Chemoradiation (45 Gy) or
- Chemotherapy

ADDITIONAL TREATMENT

- Supportive care including Nutrition Services as clinically indicated
- Discuss GCC with patient or if clinically indicated, with SDM
- Consult to Palliative/Supportive Care as clinically indicated

Stage IV (M1)

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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Department of Clinical Effectiveness V7
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**POST SURGICAL RESPONSE**

**ADJUVANT TREATMENT**

**EVALUATION**

- cTis or cT1, N0
  - Restaging
    - CT chest, abdomen and pelvis with oral and IV contrast (if clinically indicated)
    - PET/CT (if clinically indicated)
    - CBC with differential and chemistry profile
    - Endoscopy as clinically indicated
    - Lifestyle risk assessment
    - For patients with subtotal or total gastrectomy:
      - 25-OH vitamin D
      - Monitor for B12 and iron deficiency
      - Nutrition Services consult
      - Assess for postgastrectomy syndromes
      - Annual bone mineral density (BMD) with DXA
  - Observe as clinically indicated
    - Observe or Chemoradiation (45 Gy) for selected patients
    - Chemotherapy if received pre-operatively
- cT2, N0
  - Chemoradiation (45 Gy)
  - Chemotherapy if received pre-operatively
  - Discuss GCC with patient or if clinically indicated, with SDM
- cT3, cT4 or Any T, N+
  - Chemoradiation (45 Gy)
  - Chemotherapy if received pre-operatively
  - Discuss GCC with patient or if clinically indicated, with SDM
  - Chemoradiation or Resect to negative margin
- Microscopic residual cancer
  - Discuss GCC with patient or if clinically indicated, with SDM
  - Chemoradiation (45 Gy) or Resect to negative margin
- Macroscopic residual cancer or M1B
  - Chemoradiation (45 Gy) or Treatment based on ECOG performance score
  - Clinical evidence of recurrent disease
  - KPS score ≥ 60%
  - ECOG performance score ≤ 2?
- Stage IV (M1)
  - Chemoradiation (45 Gy) or Treatment based on ECOG performance score
  - Clinical evidence of recurrent disease
  - KPS score ≥ 60%
  - ECOG performance score ≤ 2?

**A**

- NED
  - See Box A on this page and continue surveillance every 4-6 months for 4 years
  - Yes
  - Clinical evidence of recurrent disease
  - KPS score or ECOG performance score ≤ 2?
  - Discuss GCC with patient or if clinically indicated, with SDM
  - Chemotherapy or Clinical trial or Surgery if appropriate for limited or localized disease
  - Supportive care including Nutrition Services as clinically indicated
  - No
  - Discuss GCC with patient or if clinically indicated, with SDM
  - Consult to Palliative/Supportive Care as clinically indicated

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

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**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.
SUGGESTED READINGS

PRINCIPLES OF MULTIDISCIPLINARY TEAM APPROACH FOR GASTROESOPHAGEAL CANCERS


PRINCIPLES OF GASTRIC CANCER SURGERY


PRINCIPLES OF SYSTEMIC THERAPY FOR GASTRIC OR GASTROESOPHAGEAL JUNCTION ADENOCARCINOMA


SUGGESTED READINGS - continued

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


OTHER SUPPORTIVE READINGS

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

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DEVELOPMENT CREDITS

This practice algorithm is based on majority expert opinion of the Gastrointestinal Center Faculty at the University of Texas MD Anderson Cancer Center. It was developed using a multidisciplinary approach that included input from the following:

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