

Role of Surgery in Gastric Adeno Carcinoma

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"Team Work"

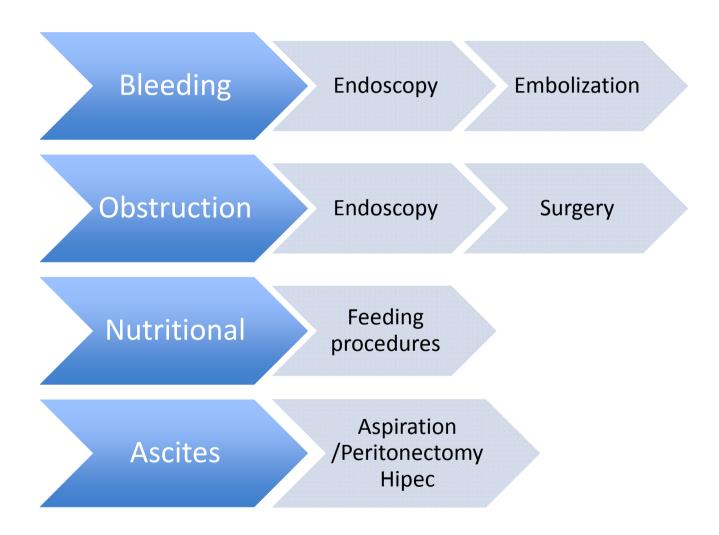


Surgery of Ca Stomach

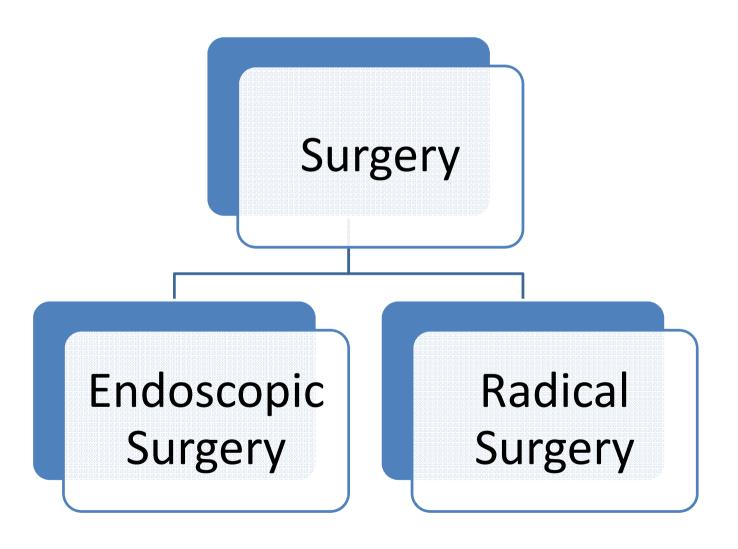
- Essential in Cure
- Role in Palliation



Palliation



Surgery for Cure



Surgery for Cure

No Metastatic Disease

No Locally Inoperable disease

- No Level N3 (hepatoduodenal and root of mesentery)
- No N4 (para-aortic) lymph node
- No Invasion or encasement of major vascular structures

Medically Fit Patient

Procedures

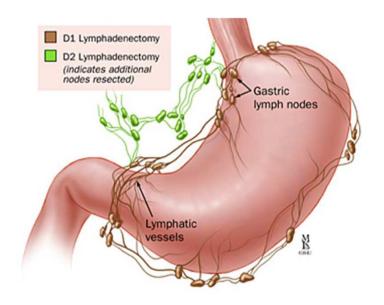
T stage	Procedure
Tis, T1a	Endoscopic Surgery
T2b,T3	D2 Gastrectomy
T4	+Adjacent Organ Resection

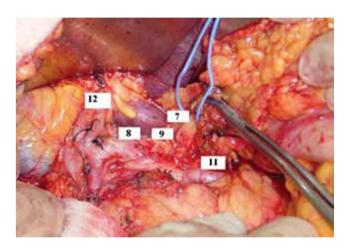
Radical Surgery

- Depends on
- Stage
- Location
- Previous Medical /Surgical History

Radical Surgery

Gold Standard "D2 Gastrectomy"





Approaches

- Minimally Invasive
- Open

Laparoscopy in Carcinoma Stomach

- Diagnosis
- Staging
- Treatment

Staging work up

- Upper GI endoscopy and biopsy
- Chest/abdomen/pelvic CT
- HER2-neu testing if metastatic

National Cancer Network®

Comprehensive

NCCN Guidelines Version 1.2014 Gastric Cancer

Gastric Cancer Table of Contents NCCN Guidelines Index Discussion

Multidisciplinary → (See GAST-2) review preferred^k Management (see GAST-7) Palliative (category 2B) ADDITIONAL EVALUATION laparoscopy Consider Medically unfit Medically unfit Medically fit, Medically fit, unresectable Medically fit resectable potentially Locoregional (M0) CLINICAL STAGE^h Stage IV Tis or MI) Nutritional assessment and counseling PET-CT evaluation if no evidence of M1 Smoking cessation advice, counseling may contribute to accurate staging of Endoscopic mucosal resection (EMR) Endoscopic ultrasound (EUS) if no Chest/abdomen/pelvic CT with oral disease^b and if clinically indicated evidence of M1 disease (preferred) · Upper GI endoscopy and biopsya adenocarcinoma is documented/ Biopsy of metastatic disease as HER2-neu testing if metastatic CBC and chemistry profile Assess Siewert categorye Screen for family history9 and pharmacotherapy early stage cancers^c clinically indicated and IV contrast suspectedd NORKUP

aSee Principles of Endoscopic Staging and Therapy (GAST-A). ^bMay not be appropriate for T1 patients. €EMR may also be therapeutic for early stage disease/lesions.

^dSee Principles of Pathologic Review and HER2-neu Testing (GAST-B)

Smoking cessation guidelines are available from the Public Health Service "See Principles of Surgery (GAST-C).

at: http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/update/treating_tobacco_use08.pdf

3See Principles of Genetic Risk Assessment for Gastric Cancers (GAST-D). Also see

Medically able to tolerate major abdominal surgery. Laparoscopy is performed to evaluate for peritoneal spread when considering chemoradiation or surgery. Laparoscopy is not indicated if a palliative resection is

planned. Laparoscopy is indicated for clinical stage T1b or higher. See Principles of Multidisciplinary Team Approach (GAST-E).

Note: All recommendations are category 2A unless otherwise indicated.

Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.

OG Junction Cancers

Siewert Type I	adenocarcinoma of the lower esophagus (often associated with Barrett's esophagus) with the center located within 1 cm to 5 cm above the anatomic EGJ
Siewert Type II	true carcinoma of the cardia at the EGJ, with the tumor center within 1 cm above and 2 cm below the EGJ.
Siewert Type III	: subcardial carcinoma with the tumor center between 2 and 5 cm below EGJ, which infiltrates the EGJ and lower esophagus from below.

Postoperative Morbidity

- Bleeding
- Leak
- Sepsis
- Wound infection
- Chest infection

Morbidity

- Delays adjuvant
- Adjuvant precipitates the event