THE CANADIAN ASSOCIATION OF GENERAL PRACTITIONERS IN ONCOLOGY
CAGPO
L'ASSOCIATION CANADIENNE DES MÉDECINS OMNIPRATICIENS EN ONCOLOGIE
ACMOO

GASTRIC CANCER CASE

Case #1

Gastric Cancer Case

A 63-year-old male presents with a 2 month history of anorexia and a 5 kilogram weight loss. His past medical history is significant for a 40-pack-year smoking history. He consumes 10-15 alcoholic beverages weekly. Five years ago he was diagnosed with H. Pylori on biopsy at the time of endoscopy to investigate a history of worsening GERD.

His physical examination is unremarkable. CBC, electrolytes, and chemistry are normal. His liver function tests have been mildly elevated for years secondary to his alcohol consumption. Chest x-ray and abdominal ultrasound are normal. He is referred to a gastroenterologist for further investigation. At the time of endoscopy an abnormality is seen in the upper stomach. Biopsy confirms adenocarcinoma, grade 2.

1. How would you proceed with further investigations at this time? Would a PET scan be required? If so, in what scenario?

2. What are the more common risk factors for gastric cancer?

3. What historical changes have been noticed in the type and location of gastric cancers?

4. What factors influence prognosis?

A CT scan of the chest, abdomen and pelvis confirm a lesion in the upper stomach measuring 5cm. Lymph nodes along the lesser curvature of the stomach appear enlarged on imaging. There is no evidence of metastases to lung, liver, pancreas or adrenals. CBC and chemistry (renal and liver function are normal).

5. Under what scenario would you recommend neoadjuvant combined modality therapy? (review how it is delivered)

He is referred for surgical opinion. His ECOG is 1. He is deemed to be a reasonable surgical risk.

6. What surgical options should be considered for this patient? Does this patient require a staging laparotomy?

7. What are the pros and cons of these options?

8. What would this patient's prognosis be regarding survival following surgical resection?

9. How does one address his nutritional needs given the need for surgical intervention?

This patient proceeds to a total gastrectomy with lymphadenectomy. Pathology reveals a grade 3 signet ring cell adenocarcinoma of the gastroesophageal junction measuring 4 cm in size. There is invasion of the muscularis propria. Of the regional lymph nodes, fifteen perigastric lymph nodes are resected, 8 have metastases. There are no distant nodal metastases.

9. What stage of disease does this patient have?

10. What further treatment options (regarding radiation and chemotherapy) should be discussed with this patient? Should his pathology be tested for Her2Neu? How would that affect any treatment recommendations?

11. What toxicities are commonly expected?

12. How beneficial is additional treatment with respect to improving his disease-free and overall survival?

Post-gastectomy and lymphadenectomy, he undergoes combined modality therapy. He tolerates this reasonably well. Throughout the course of treatment your nutritionist follows him very closely to ensure adequate intake of fluids and nutrition.

13. Following completion of his adjuvant therapy, how frequently should this patient be followed in clinic?

14. Does he require any routine investigations such as lab tests and imaging?

15. When should he undergo repeat endoscopy?

Nine months following completion of treatment he presents with a cough. Chest x-ray confirms a left-sided effusion. On questioning he admits to some progressive dysphagia for liquids and solids. Repeat CT scan of the chest and abdomen confirm metastatic disease to lung, liver and intra-abdominal nodes.

16. Does he require an endoscopy? If so, why?

17. Assuming his performance status is acceptable, is he a candidate for further chemotherapy? If so, what would you offer him, and how effective would it be?

18. What other non-systemic treatment options should you consider?

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