UCCH Pathway

UCCH Guideline
Gastric Cancer

Version May/2020

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Ein Kompetenznetzwerk des UKE

Guideline Gastric Cancer

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according to TNM classification 8th edition

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Revised	Jun/2012, Jun/2014, Mar/2017, Mar/2019, May/2020
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Staging gastric adenocarcinoma (TNM v8)

Clinical Stage			
Stage I	T1, T2,	N0	M0
Stage IIA	T1, T2,	N1, N2, N3	M0
Stage IIB	T3, T4a	N0	M0
Stage III	T3, T4a	N1, N2, N3	M0
Stage IV	T4b	Any N	M0
Stage IV	Any T	Any N	M1

Pathological Stage			
Stage 0	Tis	N0	M0
Stage IA	T1	N0	M0
Stage IB	T1	N1	M0
	T2	N0	M0
Stage IIA	T1	N2	M0
	T2	N1	M0
	T3	N0	M0
Stage IIB	T1	N3a	M0
	T2	N2	M0
	T3	N1	M0
	T4a	N0	M0

Legend of Colours

= Therapeutic procedure

= Clinical or diagnostical condition

= Diagnostic procedure

= Clinical trial

= Supportive measure

= Referral

= Tumorboard (including post tumorboard interaction with patient that follows the principles of shared decision-making)

Pathway: Gastric Cancer

Work up

Gastric Cancer Baseline:

- Physical examination
- Laboratory
- CT-chest / Abdomen
- Upper GI endoscopy (in case of external endoscopy and non M+ a re-endoscopy is indicated)
- EUS
- Biopsy and histology (HER2/neu and MSI/dMMR for all, PD-L1 (CPS) for M+, EBV optional
- Optional diagnostic laparoscopy[1], PET
- **Supportive:**
  - Offer contact to self help group
  - Offer psychooncological support

TB

Consider

- Resectability
- Comorbidity
- Clinical trial

T1/T2 N0[2] → Pathway page 2

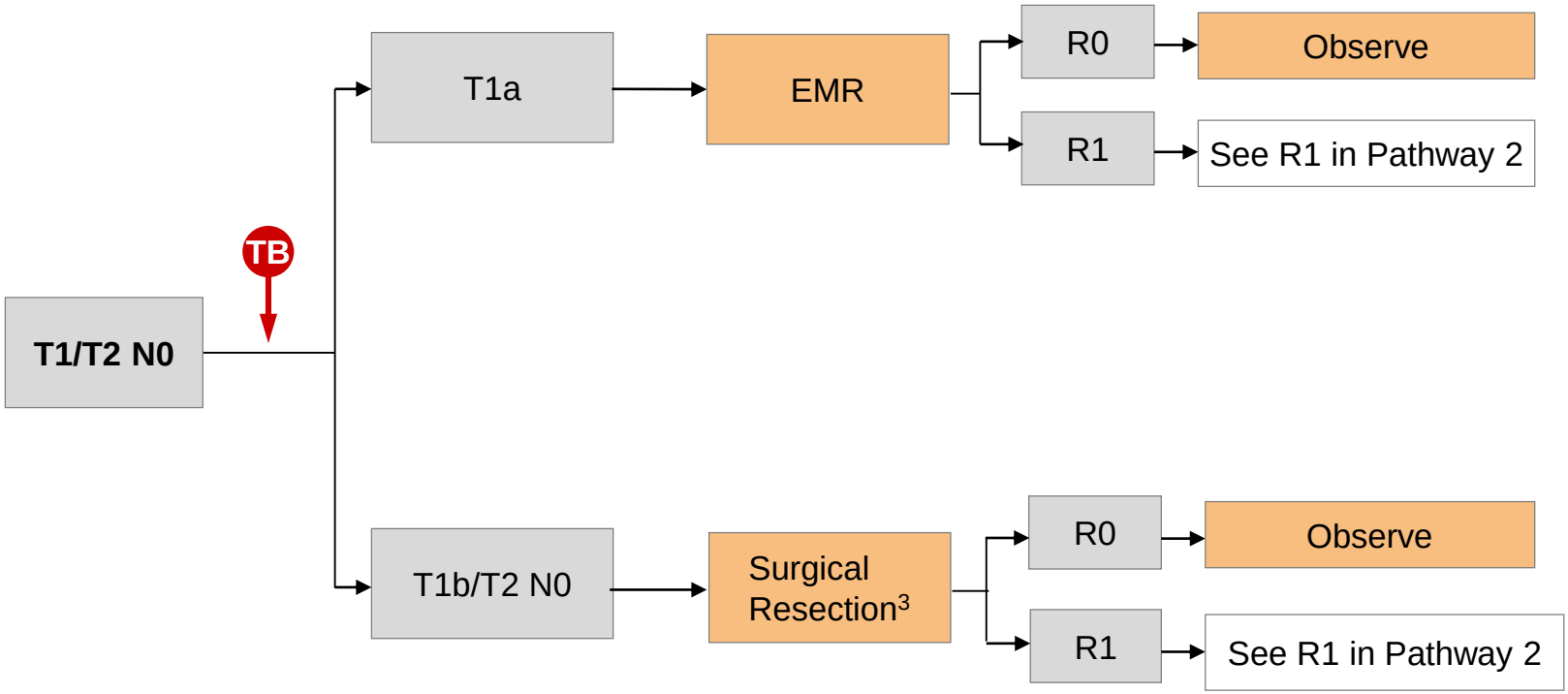
T3/T4 or N+[2] → Pathway page 3

Metastatic disease → Pathway page 5

[1] Diagnostic laparoscopy in case of ascites or large T3 or T4 tumor

[2] T stage: T3 visible on CT scan, independent of EUS staging. T2 not visible on CT scan, T2 in EUS.
N stage: N+ determined by CT scan lymph node >1cm (long axis).

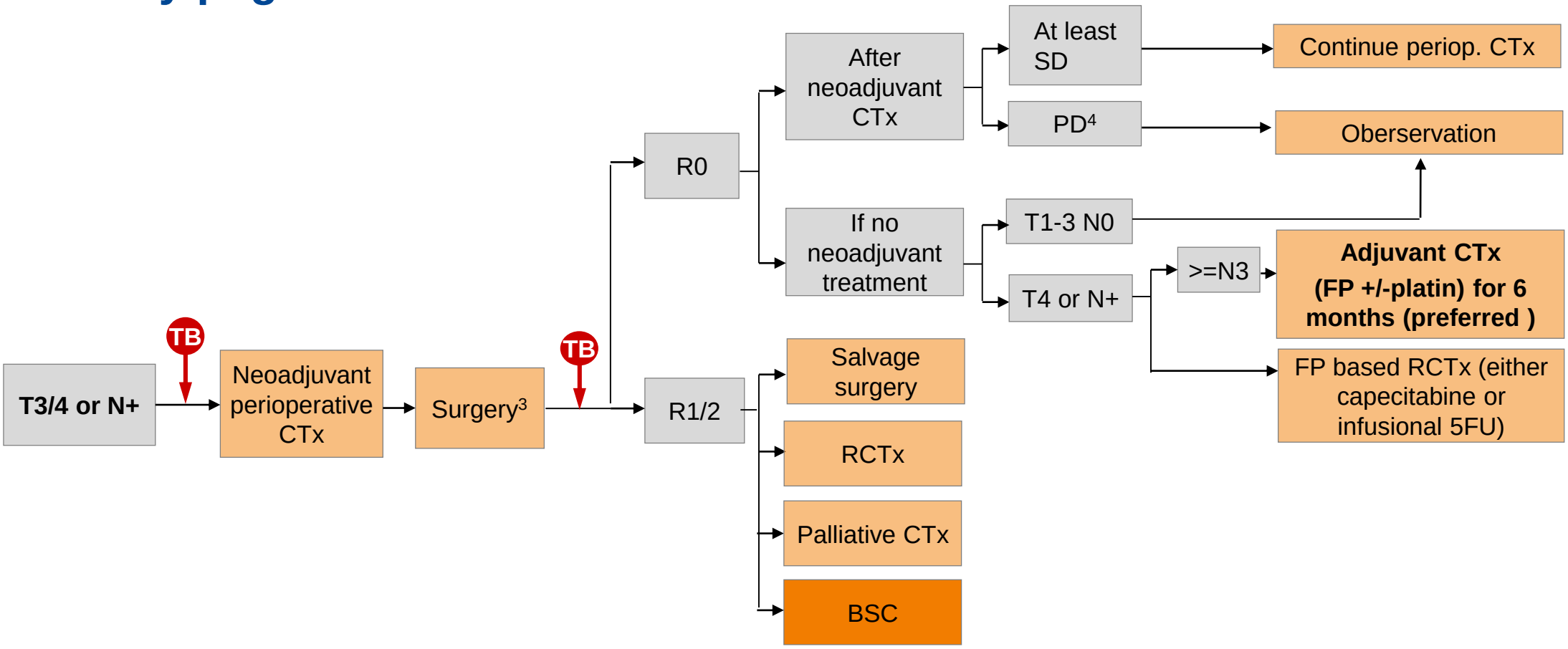
Pathway page 2: T1/T2 N0



EMR Endoscopic mucosal resection

[3] See pathway page 4

Pathway page 3: T3/T4 or N+

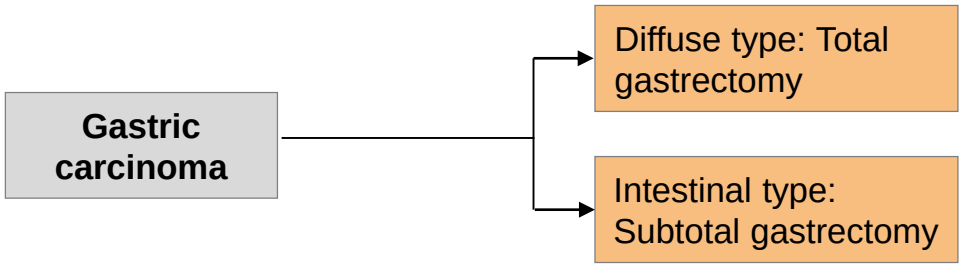


BSC Best Supportive Care, CTx Chemotherapy, RCTx Radiochemotherapy, PD Progressive disease, SD Stable disease

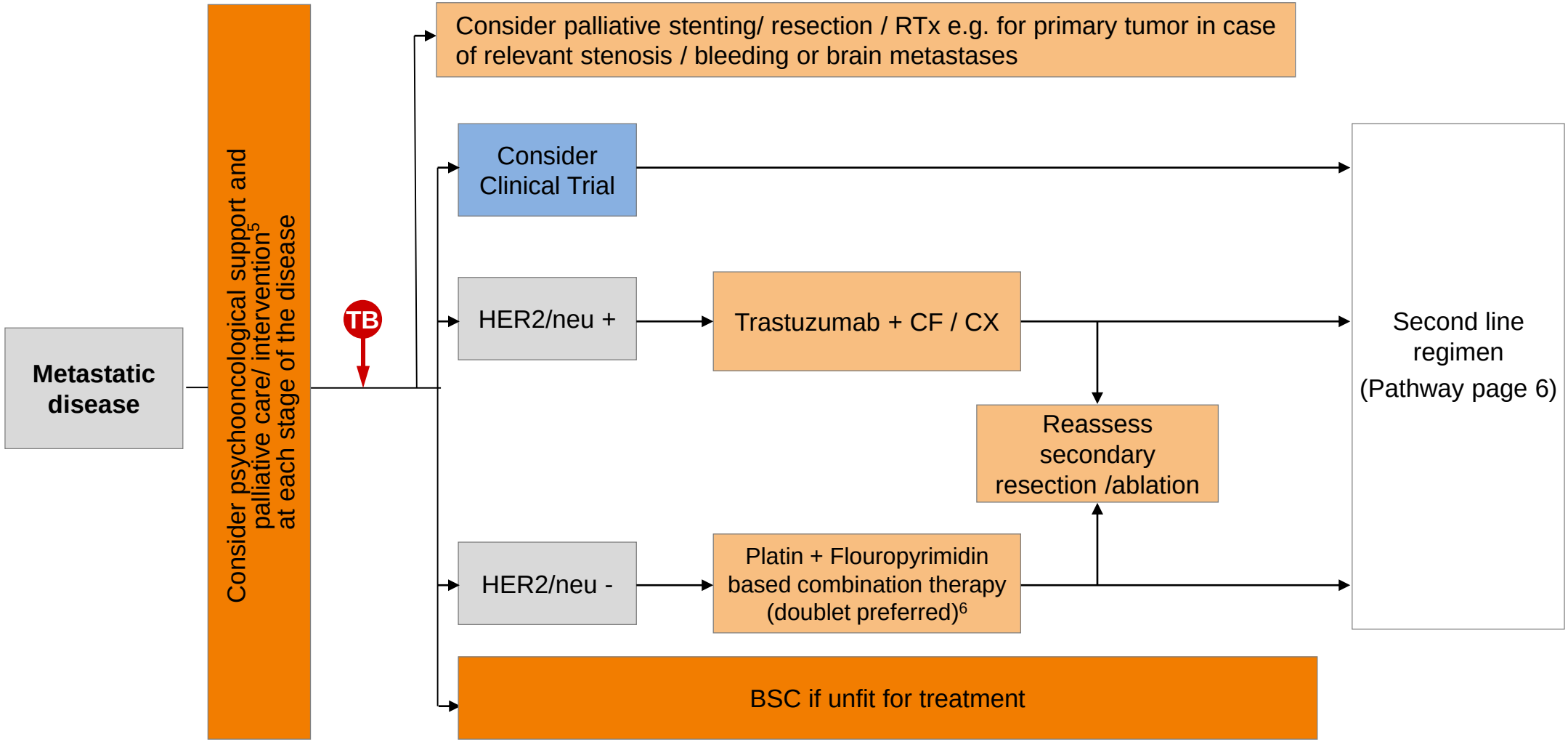
[3] See pathway page 4

[4] PD: according to RECIST or endoscopically and no pathohistological response

Pathway page 4: Surgical resection for pathway 1 + 2 according to histological subtype



Pathway page 5: Metastatic disease, first line treatment

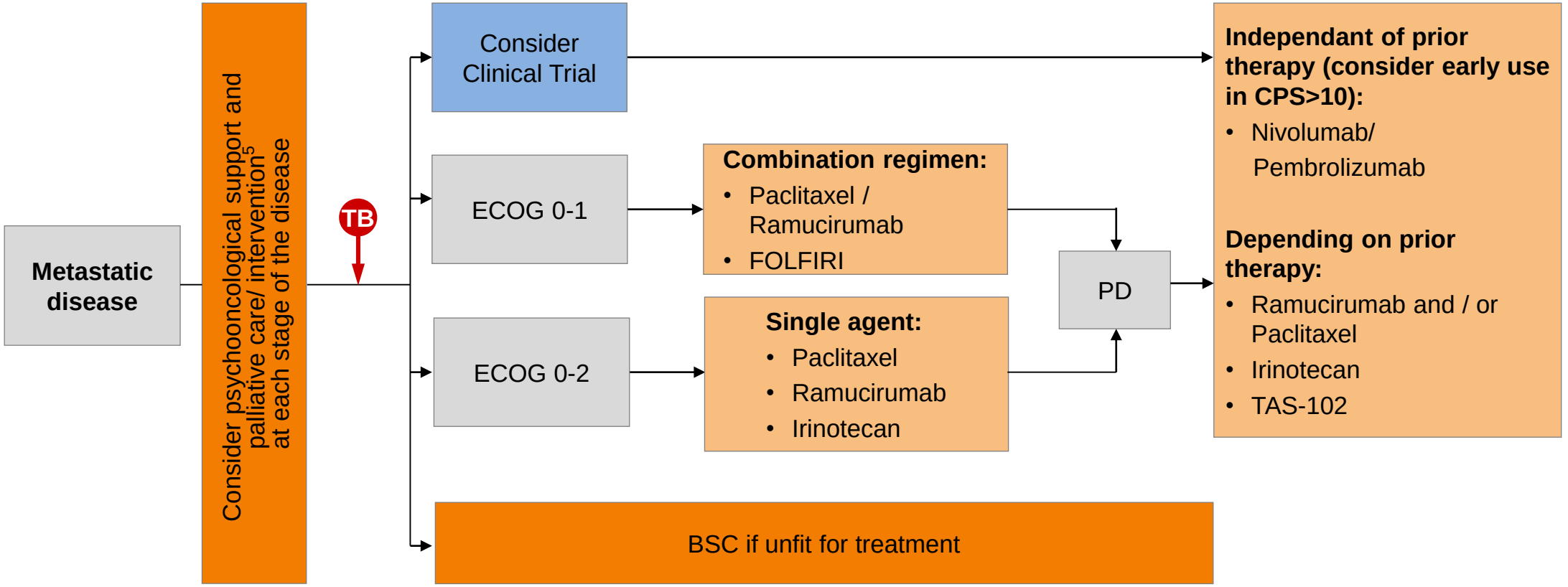


BSC Best Supportive Care, RTx Radiotherapy, RCTx Radiochemotherapy with carboplatin/paclitaxel

[5] See palliative care screening tool on page 8

[6] triplet only in case of planned secondary resection or urgent need for response

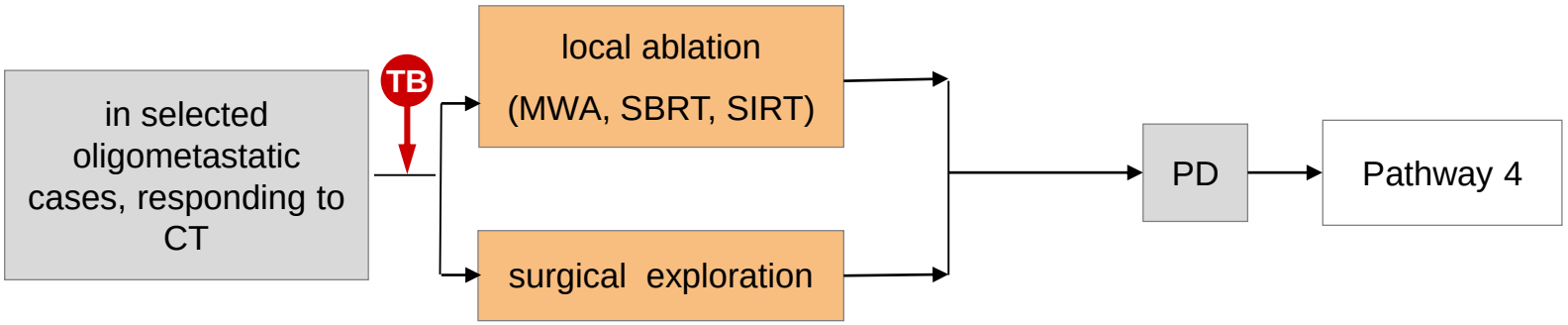
Pathway page 6: Metastatic disease, second + thirdline treatment



BSC Best Supportive Care, PD Progressive disease

[5] See palliative care screening tool on page 8

Pathway page 7: Oligometastatic disease



PD Progressive disease, SBRT Stereotactic body radiotherapy, SIRT selective internal radiotherapy, MWA microwave ablation

Page 8: Follow up

- There is no evidence that regular follow up after initial therapy influence outcome.
- After endoscopic resection (EMR) endoscopic follow up should be every 3 months in the first year, every 6 months in the second and afterwards yearly.
- General follow up should concentrate on symptoms, nutrition and psychosocial problems. Laboratory evaluations should include transferrin saturation and vitamin B12.
- First two years 3 monthly followed by 6 monthly for 3 years visits with clinical examination + alternating abdominal-ultrasound and CT scan and yearly endoscopy is recommended according to UCCH standards.

Page 9: Palliative care screening tool

Screening items			Points
1.		• Presence of metastatic or locally advanced cancer	**2**
2.		• ECOG score (functional status score, performance status)	**0-4**
3.		• Presence of one or more serious complications of advanced cancer usually associated with a prognosis of < 12 months (e.g. brain metastases, hypercalcemia, delirium, spinal cord compression, cachexia)	**1**
4.		• Presence of one or more serious comorbid diseases also associated with poor prognosis (e.g. moderate-severe COPD or CHF, dementia, AIDS, end stage renal failure end stage liver cirrhosis)	**1**
5.		• Presence of palliative care problems	**1**
	a.	• Symptoms uncontrolled by standard approaches	**1**
	b.	• Moderate to severe distress in patient or family, related to cancer diagnosis or therapy (personal targets and expectations, educational and informational requirements, cultural factors)	**1**
	c.	• Patient/family requests palliative care consult	**1**
	d.	• Team needs assistance with complex decision making or determing goals of care (benefit/side effects of treatment)	**1**
	e.	• Instable or deficient network especially for emergency situation or 24-h care	**1**

A total of > 5 points signalizes need for supportive palliative care

According to Glare et al. (2011); NCCN Clinical Practice guidelines in Oncology 2015