The NCCN Guidelines® for Gastric Cancer includes cancer in the proximal 5cm of the stomach.

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The 2.2012 version of the Gastric Cancers Guidelines represents the addition of the updated Discussion text (MS-1).

**GAST-1**
- Workup:
  - “EMR may contribute to accurate staging of early stage cancers” was added as a recommendation.
  - “Smoking cessation advice, counseling, and pharmacotherapy” was added as a recommendation.
  - 9th bullet: “Biopsy confirmation of suspected metastatic disease” changed to “Biopsy of metastatic disease as clinically indicated”.
  - 10th bullet: HER2-neu testing if metastatic disease is documented/suspected changed to “HER2-neu testing if metastatic is documented/suspected”. A similar change was made on page.

**GAST-3**--Patients Have Not Received Preoperative Chemotherapy or Chemoradiation
- R0 resection; T3, T4, Any N or Any T, N+: The following recommendation was added for postoperative treatment: “Capecitabine + oxaliplatin for patients who have undergone primary D2 lymph node dissection”. A corresponding footnote to the randomized phase 3 CLASSIC trial reference (Bang Y-J, Kim Y-W, Yang H-K, et al. Adjuvant capicitabine and oxaliplatin for gastric cancer after D2 gastrectomy (CLASSIC): a phase 3 open-label, randomised controlled trial. The Lancet 2012;379:315-321) was also added.

**GAST-4**--Patients Received Preoperative Chemotherapy or Chemoradiation
- R0 resection; T2, N0: “5-FU ± leucovorin or capecitabine, then fluoropyrimidine-based chemoradiation, then 5-FU ± leucovorin or capecitabine for selected patients,” was removed as an option for postoperative treatment.
  - R0 resection; T3, T4 Any N or Any T, N+: “5-FU ± leucovorin or capecitabine, then fluoropyrimidine-based chemoradiation, then 5-FU ± leucovorin or capecitabine,” was removed as an option for postoperative treatment.

**GAST-5**
- Post Treatment Assessment: “Pelvic CT as clinically indicated” was added.
- Outcome:
  - The top pathway was changed to “Resectable and medically operable”.
  - The bottom pathway was change to “Unresectable or Medically inoperable and/or Metastatic disease”.

**GAST-6**
- 4th bullet: Clarified as “Monitor for nutritional deficiency (eg, B₁₂ and iron) in surgically resected...”
- After the “Karnofsky performance score ≥ 60 % or...” pathway, the following recommendation was added, “Confirm HER2-neu testing has been done if metastatic adenocarcinoma is suspected”.

**GAST-A**: Principles of Endoscopic Staging and Therapy
- Diagnosis; 4th bullet: After the second sentence, a new sentence was added that states, “EMR can be therapeutic/diagnostic”.

**GAST-B 3 of 4**: Principles of Pathologic Review and HER2-neu Testing
- The first paragraph was revised as follows: “For patients with inoperable locally advanced, recurrent, or metastatic adenocarcinoma of the stomach or esophagogastric junction for whom trastuzumab therapy is being considered, assessment for tumor HER2-neu overexpression using immunohistochemistry (IHC) and fluorescence in situ hybridization (FISH) or other in situ hybridization methods is recommended.”
- Table 3: In the” 2+” overexpression row, the last column was revised as follows: “Equivocal (FISH is recommended)”.
- Footnote “#” was revised as follows, “The NCCN Guidelines panel recommends that cases showing less than 3+ overexpression of HER2-neu by immunohistochemistry should be additionally examined by FISH or other in situ hybridization methods. Cases with 3+ overexpression by IHC or FISH positive (HER2:CEP17 ≥ 2) are considered positive.”
GAST-D: Principles of Surgery
• Staging
  ▶ First bullet: CT scan clarified as “chest, abdomen, and pelvic”.
  ▶ Third bullet: Revised as follows, “Positive peritoneal cytology (performed in the absence of visible peritoneal implants), is associated with poor prognosis and is defined as M1 disease.” Previously this stated, “...should be considered as M1 disease”.
• Resectable tumors: Two new bullets were added regarding the definition of D1 and D2 lymph node dissections.
• Palliative Procedures
  ▶ This section was previously called, “Unresectable tumors (palliative procedures)
  ▶ First bullet was revised as follows, “Gastric resections should be reserved for the palliation of symptoms (eg, obstruction or uncontrollable bleeding) in patients with incurable disease.”

GAST-E: Principles of Systemic Therapy
• 1 of 13: The third bullet was clarified as, “The use of three-drug cytotoxic regimens for advanced...”
• 2 of 13:
  ▶ Postoperative Chemoradiation (including EG junction): The regimen “5-FU (bolus) and leucovorin (category 1)” was removed.
• 3 of 13:
  ▶ First line therapy: The statement, “Two-drug regimens or single agent preferred. Three-drug regimens should be reserved for medically fit patients...” changed to “Two-drug regimens are preferred. Three-drug cytotoxic regimens should be reserved...”
  ▶ Alternative regimens to be considered: Cetuximab was removed as an option. The corresponding dose recommendations on page 10 of 13 were also removed.
• 6 of 13: For Postoperative Chemoradiation, the dosing recommendations for “5-FU (bolus) and leucovorin” were removed.
• 9 of 13: Under Definitive Chemotherapy for Metastatic or Locally Advanced Cancer; First line therapy: A new dose for Trastuzumab (with chemotherapy) was added as follows, “Trastuzumab 6 mg/kg IV loading dose on Day 1 of cycle 1, then 4 mg/kg IV every 14 days”. The same dose was also added for Second-line therapy 9 of 13.

GAST-G: Principles of Best Supportive Care
• Obstruction; Venting gastrostomy
  ▶ After “Ventic gastrostomy”, the following phrase was added “if endoscopic lumen enhancement is not undertaken or is unsuccessful”.
  ▶ First arrow was revised as follows, “Percutaneous endoscopic or interventional radiology gastrostomy tube placement can be placed for gastric decompression if tumor location permits.”
  ▶ Second arrow was revised as follows, “Ascites, if present, should be drained prior to venting gastrostomy tube placement to reduce the risk of infectious complications.”
WORKUP

• H&P
• Upper GI endoscopy and biopsy
• Chest/abdominal CT with oral and IV contrast
• Pelvic CT as clinically indicated
• PET evaluation preferred if no evidence of M1 disease (PET/CT preferred over PET scan)
• CBC and chemistry profile
• Endoscopic ultrasound (EUS) if no evidence of M1 disease, with FNA as indicated (preferred).
• Endoscopic mucosal resection (EMR) may contribute to accurate staging of early stage cancers
• Biopsy of metastatic disease as clinically indicated
• HER2-neu testing if metastatic adenocarcinoma is documented/suspected
• Smoking cessation advice, counseling and pharmacotherapy

CLINICAL STAGE

Tis or T1a\textsuperscript{d}

Medically fit

Medically unfit

Locoregional (M0)

Medically fit,\textsuperscript{e} potentially resectable

Medically fit,\textsuperscript{e} unresectable

Medically unfit

Stage IV (M1)

Consider laparoscopy (category 2B)

Palliative Therapy (see GAST-6)

ADDITIONAL EVALUATION

Multidisciplinary review preferred\textsuperscript{g} (See GAST-2)

\textsuperscript{a}See Principles of Endoscopic Surgery and Therapy (GAST-A).

\textsuperscript{b}May not be appropriate for T1 patients.

\textsuperscript{c}See Principles of Pathologic Review and HER2-neu Testing (GAST-B).

\textsuperscript{d}Tis or T1a: Defined as carcinoma in situ (Tis) or invasion of mucosa without submucosal invasion (T1a).

\textsuperscript{e}Medically able to tolerate major abdominal surgery.

\textsuperscript{f}Laparoscopy is performed to evaluate for peritoneal spread when considering chemoradiation or surgery. Laparoscopy is not indicated if a palliative resection is planned.

\textsuperscript{g}See Principles of Multidisciplinary Team Approach (GAST-C).

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.
**NCCN Guidelines Version 2.2012**

**Gastric Cancer**

**FINAL STAGE**

- **Medically unfit**
  - Tis or T1ad
  - M0
  - T2 or higher, Any N
  - M1

- **Medically fit, potentially resectable**
  - Tis or T1ad
  - T1b
  - M0
  - T2 or higher, Any N
  - M1

- **Medically fit, unresectable**
  - Tis or T1ad
  - M0
  - T2 or higher, Any N
  - M1

- **Medically unfit**
  - M0
  - M1

---

**PRIMARY TREATMENT**

**Endoscopic mucosal resection (EMR)**

- Medically fit, potentially resectable:
  - Tis or T1ad
  - Surgery

- Medically fit, unresectable:
  - Tis or T1ad
  - Surgery

- Medically unfit:
  - M0
  - M1

---

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**NCCN Guidelines Version 2.2012**

**Gastric Cancer**

**SURGICAL OUTCOMES/CLINICAL PATHOLOGIC FINDINGS**

(Patients Have Not Received Preoperative Chemotherapy or Chemoradiation)

- **Tis or T1, N0**
  - Observe

- **T2, N0**
  - Observe or
  - 5-FU ± leucovorin or capecitabine, then fluoropyrimidine-based chemoradiation, then 5-FU ± leucovorin or capecitabine for selected patients

- **T3, T4, Any N or Any T, N+**
  - 5-FU ± leucovorin or capecitabine, then fluoropyrimidine-based chemoradiation, then 5-FU ± leucovorin or capecitabine (category 1) or
  - Capecitabine + oxaliplatin for patients who have undergone primary D2 lymph node dissection
  - Observe or 5-FU ± leucovorin or capecitabine, then fluoropyrimidine-based chemoradiation, then 5-FU ± leucovorin or capecitabine

**POSTOPERATIVE TREATMENT**

- **R0 resection**
  - Chemoradiation (fluoropyrimidine-based)

- **R1 resection**
  - Chemoradiation (fluoropyrimidine-based) or Chemotherapy or Best supportive care

- **R2 resection**
  - Chemoradiation (fluoropyrimidine-based) or Chemotherapy or Best supportive care

**Follow-up**

(see GAST-6)

**Palliative Therapy**

(see GAST-6)

---

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**References:**

- High risk features include poorly differentiated or higher grade cancer, lymphovascular invasion, neural invasion, or < 50 years of age.

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**Key Points:**

- **R0** = No cancer at resection margins, **R1** = Microscopic residual cancer, **R2** = Macroscopic residual cancer or M1B.
- **M1B** = Bone involvement.
- **See Principles of Surgery (GAST-D).**
- **See Principles of Systemic Therapy (GAST-E).**
- **See Principles of Radiation Therapy (GAST-F).**
- **See Principles of Best Supportive Care (GAST-G).**
### Surgically Resected Gastric Cancer

#### Tumor Classification

- **T2, N0**
  - **R0 resection**
    - Observe or
    - ECF or its modifications \(^k\) if received preoperatively (category 1)

- **T3, T4 Any N or Any T, N+**
  - **R0 resection**
    - ECF or its modifications \(^k\) if received preoperatively (category 1)
  - **R1 resection**
    - Chemoradiation \(^k, l, s\) (fluoropyrimidine-based)
  - **R2 resection**
    - Chemoradiation \(^k, l, s\) (fluoropyrimidine-based) or
    - Chemotherapy \(^k\) or
    - Best supportive care \(^s\)

- **M1**
  - Palliative Therapy \((see GAST-6)\)

\(^k\) See Principles of Systemic Therapy (GAST-E).
\(^l\) See Principles of Radiation Therapy (GAST-F).
\(^m\) R0 = No cancer at resection margins, R1 = Microscopic residual cancer, R2 = Macroscopic residual cancer or M1B.
\(^q\) See Principles of Best Supportive Care (GAST-G).
\(^r\) See Staging (ST-1).
\(^s\) Postoperative chemoradiation only if not received preoperatively.

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**GAST-5**

**POST TREATMENT ASSESSMENT**

- Restaging (preferred):
  - Chest/abdominal CT with oral and IV contrast
  - CBC and chemistry profile
  - PET/CT or PET scan (optional)
  - Pelvic CT as clinically indicated

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**OUTCOME**

- Resectable and medically operable

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**ADJUNCTIVE TREATMENT**

- Surgery (preferred), if appropriate or follow-up (see GAST-6)

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**Medically fit, unresectable or medically unfit patients following primary treatment**

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**Unresectable or medically inoperable and/or metastatic disease**

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**Palliative Therapy (see GAST-6)**

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*See Principles of Surgery (GAST-D).*

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**FOLLOW-UP**

- H&P: every 3-6 mo for 1-2 y, every 6-12 mo for 3-5 y, then annually
- CBC and chemistry profile as indicated
- Radiologic imaging or endoscopy, as clinically indicated
- Monitor for nutritional deficiency (eg, B₁₂ and iron) in surgically resected patients and treat as indicated.
- Confirm that HER2-neu testing has been done if metastatic adenocarcinoma was present at diagnosis

**PERFORMANCE STATUS**

- Karnofsky performance score ≥ 60 %
- ECOG performance score ≤ 2

**PALLIATIVE THERAPY**

- Confirm HER2-neu testing has been done if metastatic adenocarcinoma is suspected
- Best supportive care

**Recurrence**

- Karnofsky performance score < 60 %
- ECOG performance score ≥ 3

- Chemotherapy
- Clinical trial
- Best supportive care

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<sup>c</sup> See Principles of Pathologic Review and HER2-neu Testing (GAST-B).

<sup>k</sup> See Principles of Systemic Therapy (GAST-E).

<sup>q</sup> See Principles of Best Supportive Care (GAST-G).

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PRINCIPLES OF ENDOSCOPIC STAGING AND THERAPY

Endoscopy has become an important tool in the diagnosis, staging, treatment and palliation of patients with gastric cancer. Although some endoscopy procedures can be performed without anesthesia, most are performed with conscious sedation administered by the endoscopist or assisting nurse or deeper anesthesia (monitored anesthesia care) provided by the endoscopist and nurse, a nurse anesthetist, or an anesthesiologist. Some patients who are at risk of aspiration during endoscopy may require general anesthesia.

DIAGNOSIS

• Diagnostic and surveillance endoscopies are performed with the goal of determining the presence and location of neoplastic disease and to biopsy any suspicious lesion. Thus, an adequate endoscopic exam addresses both of these components. The location of the tumor in the stomach (cardia, fundus, body, antrum, and pylorus) and relative to the esophagogastric junction (EGJ) for proximal tumors should be carefully recorded to assist with treatment planning and follow up examinations.
• Multiple (8-10) biopsies using standard size endoscopy forceps should be performed to provide adequate sized material for histologic interpretation, especially in the setting of an ulcerated lesion. Larger forceps may improve the yield.
• Endoscopic mucosal resection (EMR) can be therapeutic/diagnostic. EMR of focal nodules ≤ 1.5 cm can be performed in the setting of early stage disease to provide accurate T-staging, with the potential of being therapeutic. En-bloc excision by endoscopic submucosal dissection (ESD) has been shown to be more effective than EMR in curing early gastric cancer, but requires greater skills and instrumentation to perform and has a significant risk of complications including perforation.
• Cytologic brushings or washings are rarely adequate in the initial diagnosis, but can be useful in confirming the presence of cancer when biopsies are not diagnostic.
PRINCIPLES OF ENDOSCOPIC STAGING AND THERAPY

STAGING

- Endoscopic ultrasound (EUS) performed prior to any treatment is important in the initial clinical staging of gastric cancer.\(^4\) Careful attention to ultrasound images, provides evidence of depth of tumor invasion (T-stage), presence of abnormal or enlarged lymph nodes likely to harbor cancer (N-assessment), and occasionally signs of distant spread, such as lesions in surrounding organs (M-stage) or the presence of ascites.\(^5\) This is especially important in patients who are being considered for EMR.\(^6\)

- Hypoechoic (dark) expansion of the gastric wall layers identifies the location of tumor, with gradual loss of the layered pattern of the normal stomach wall corresponding with greater depths of tumor penetration, correlating with higher T-stages. A dark expansion of layers 1-3 correspond with infiltration of the superficial and deep mucosa plus the submucosal, T1 disease. A dark expansion of layers 1-4, correlates with penetration into the muscularis propria, T2 disease, and expansion beyond the muscularis propria resulting in an irregular outer border correlates with invasion of the subserosa, T3 disease. Loss of the bright line recognized as the serosa is now staged as T4a, and extension of the mass into surrounding organs such as the liver, pancreas, spleen is staged T4b disease.

- Perigastric lymph nodes are readily seen by EUS, and the identification of enlarged, hypoechoic (dark), homogeneous, well circumscribed, rounded structures around the stomach correlates with the presence of malignant or inflammatory lymph nodes. The accuracy of this diagnosis is significantly increased with the combination of features, but also may be confirmed with the use of fine needle aspiration (FNA) biopsy for cytology assessment.\(^7\) FNA of suspicious lymph nodes should be performed if it can be achieved without traversing an area of primary tumor or major blood vessels, and if it will impact on treatment decisions.

TREATMENT

- EUS exams performed after chemotherapy or radiation therapy have a reduced ability to accurately determine the post-treatment stage of disease.\(^8\) Similarly, biopsies performed after chemotherapy or radiation therapy may not accurately diagnose the presence of residual disease but still provide useful information.\(^9\)

- Endoscopic tumor ablation can be performed for the short-term control of bleeding. Endoscopic insertion of expandable metal stents is effective in long-term relief of tumor obstruction at the EGJ or the gastric outlet, though surgical gastrojejunostomy may be more efficacious for those with longer-term survival (see Principles of Best Supportive Care [GAST-G]).\(^10,11\)

- Long-term palliation of anorexia, dysphagia or malnutrition may be achieved with endoscopic or radiographic assisted placement of feeding gastrostomy (PEG) in carefully selected cases where the distal stomach is uninvolved by tumor, or the placement of a feeding jejunostomy (PEJ).\(^12\)

POST-TREATMENT SURVEILLANCE

- Endoscopic surveillance following definitive treatment of gastric cancer requires careful attention to detail for mucosal surface changes, and multiple (4-6) biopsies of any visualized abnormalities. Strictures should be biopsied to rule-out neoplastic cause. EUS performed in conjunction with endoscopy exams has a high sensitivity for recurrent disease.\(^13\) EUS-guided FNA should be performed if suspicious lymph nodes or areas of wall thickening are seen.

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PRINCIPLES OF ENDOSCOPIC STAGING AND THERAPY

(REFERENCES)

**PRINCIPLES OF PATHOLOGIC REVIEW AND HER2-NEU TESTING**

### Pathologic Review

**TABLE 1**

<table>
<thead>
<tr>
<th>Specimen Type</th>
<th>Analysis/Interpretation/Reporting&lt;sup&gt;a&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endoscopic mucosal resection</td>
<td>Include in pathology report:</td>
</tr>
<tr>
<td></td>
<td>• Invasion, if present</td>
</tr>
<tr>
<td></td>
<td>• Histologic type&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>• Grade</td>
</tr>
<tr>
<td></td>
<td>• Depth of tumor invasion</td>
</tr>
<tr>
<td></td>
<td>• Vascular invasion</td>
</tr>
<tr>
<td></td>
<td>• Status of mucosal and deep margins</td>
</tr>
<tr>
<td>Gastrectomy, without prior chemoradiation</td>
<td>For pathology report, include all elements as for endoscopic mucosal resection plus</td>
</tr>
<tr>
<td></td>
<td>• Location of tumor midpoint in relationship to EGJ&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>• Whether tumor crosses EGJ</td>
</tr>
<tr>
<td></td>
<td>• LN status and number of lymph nodes recovered</td>
</tr>
<tr>
<td>Gastrectomy, with prior chemoradiation</td>
<td>Tumor site should be thoroughly sampled for specimens s/p neoadjuvant therapy</td>
</tr>
<tr>
<td></td>
<td>without grossly obvious residual tumor</td>
</tr>
<tr>
<td></td>
<td>For pathology report, include all elements as for resection without prior chemoradiation plus assessment of treatment effect</td>
</tr>
</tbody>
</table>

<sup>a</sup>Use of a standardized minimum data set such as the College of American Pathologists Cancer Protocols (available at [http://www.cap.org](http://www.cap.org)) for reporting pathologic findings is recommended.

<sup>b</sup>Subclassification of gastric adenocarcinomas as intestinal or diffuse type may have implications for therapy, as intestinal type cancers may be more likely to overexpress HER2-neu.<sup>1</sup>

<sup>c</sup>Tumors arising in the proximal stomach and crossing the EGJ are classified for purposes of staging as esophageal carcinomas.<sup>2</sup>

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Assessment of treatment response
Response of the primary tumor to previous chemotherapy or radiation therapy should be reported. Although grading systems for tumor response in gastric cancer have not been uniformly adopted, in general, three-category systems provide good reproducibility among pathologists. The following system developed for rectal carcinoma is reported to provide good interobserver agreement, but other systems may also be used. Sizable pools of acellular mucin may be present after chemoradiation but should not be interpreted as representing residual tumor.

**TABLE 2**

<table>
<thead>
<tr>
<th>Tumor Regression Grade</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 (Complete response)</td>
<td>No cancer cells</td>
</tr>
<tr>
<td>1 (Moderate response)</td>
<td>Single cells or small groups of cancer cells</td>
</tr>
<tr>
<td>2 (Minimal response)</td>
<td>Residual cancer outgrown by fibrosis</td>
</tr>
<tr>
<td>3 (Poor response)</td>
<td>Minimum or no treatment effect; extensive residual cancer cells</td>
</tr>
</tbody>
</table>

Number of lymph nodes retrieved
- While there is no universally accepted minimum number of lymph nodes necessary for accurate staging of gastric cancer, retrieval of at least 15 lymph nodes is recommended to avoid stage migration.\(^4\,^5\)

Assessment of Overexpression of HER2-neu in Gastric Cancer

For patients with inoperable locally advanced, recurrent, or metastatic adenocarcinoma of the stomach or esophagogastric junction for whom trastuzumab therapy is being considered, assessment for tumor HER2-neu overexpression using immunohistochemistry (IHC) and fluorescence in situ hybridization (FISH) or other in situ hybridization method is recommended. The following criteria used in the ToGA trial are recommended:

### TABLE 3: Immunohistochemical Criteria for Scoring HER2-neu Expression in Gastric and Esophagogastric Carcinoma*

<table>
<thead>
<tr>
<th>Surgical Specimen Expression Pattern, Immunohistochemistry</th>
<th>Biopsy Specimen Expression Pattern, Immunohistochemistry</th>
<th>HER2-neu Overexpression Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0  No reactivity or membranous reactivity in &lt; 10% of cancer cells</td>
<td>No reactivity or no membranous reactivity in any cancer cell</td>
<td>Negative</td>
</tr>
<tr>
<td>1+  Faint or barely perceptible membranous reactivity in ≥ 10% of cancer cells; cells are reactive only in part of their membrane</td>
<td>Cancer cell cluster with a faint or barely perceptible membranous reactivity irrespective of percentage of cancer cells positive</td>
<td>Negative</td>
</tr>
<tr>
<td>2+  Weak to moderate complete, basolateral or lateral membranous reactivity in ≥ 10% of cancer cells</td>
<td>Cancer cell cluster with a weak to moderate complete, basolateral, or lateral membranous reactivity irrespective of percentage of cancer cells positive</td>
<td>Equivocal</td>
</tr>
<tr>
<td>3+  Strong complete, basolateral or lateral membranous reactivity in ≥ 10% of cancer cells</td>
<td>Cluster of five or more cancer cells with a strong complete, basolateral, or lateral membranous reactivity irrespective of percentage of cancer cells positive</td>
<td>Positive</td>
</tr>
</tbody>
</table>

*The NCCN Guidelines panel recommends that cases showing less than 3+ overexpression of HER2-neu by immunohistochemistry should be additionally examined by FISH or other in situ hybridization methods. Cases with 3+ overexpression by IHC or FISH positive (HER2:CEP17 ratio ≥ 2) are considered positive.


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PRINCIPLES OF PATHOLOGIC REVIEW AND HER2-NEU TESTING


PRINCIPLES OF MULTIDISCIPLINARY TEAM APPROACH FOR ESOPHAGO Gastric Cancers

Category 1 evidence supports the notion that the combined modality therapy is effective for patients with localized esophagogastric cancer. The NCCN panel believes in an infrastructure that encourages multidisciplinary treatment decision-making by members of all disciplines taking care of this group of patients.

The combined modality therapy for patients with localized esophagogastric cancer may be optimally delivered when the following elements are in place:

- The involved institution and individuals from relevant disciplines are committed to jointly reviewing the detailed data on patients on a regular basis. Frequent meetings (either once a week or once every two weeks) are encouraged.

- Optimally at each meeting, all relevant disciplines should be encouraged to participate and these may include: surgical oncology, medical oncology, gastroenterology, radiation oncology, radiology, and pathology. In addition, the presence of nutritional services, social workers, nursing, palliative care specialists, and other supporting disciplines are also desirable.

- All long-term therapeutic strategies are best developed after adequate staging procedures are completed, but ideally prior to any therapy that is rendered.

- Joint review of the actual medical data is more effective than reading reports for making sound therapy decisions.

- A brief documentation of the consensus recommendation(s) by the multidisciplinary team for an individual patient may prove useful.

- The recommendations made by the multidisciplinary team may be considered advisory to the primary group of treating physicians of the particular patient.

- Re-presentation of select patient outcomes after therapy is rendered may be an effective educational method for the entire multidisciplinary team.

- A periodic formal review of relevant literature during the course of the multidisciplinary meeting is highly encouraged.


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PRINCIPLES OF SURGERY

Staging

- Determine extent of disease with CT scan (chest, abdomen, and pelvic) ± EUS
- Laparoscopy may be useful in select patients in detecting radiographically occult metastatic disease
- Positive peritoneal cytology (performed in the absence of visible peritoneal implants), associated with poor prognosis and is defined as M1 disease. Patients with advanced tumors, clinical T3 or N+ disease should be considered for laparoscopic staging with peritoneal washings.

Criteria of unresectability for cure

- Locoregionally advanced
  - Level 3 or 4 lymph node highly suspicious on imaging or confirmed by biopsy
  - Invasion or encasement of major vascular structures
  - Distant metastasis or peritoneal seeding (including positive peritoneal cytology)

Resectable tumors

- Tis or T1<sup>3</sup> tumors limited to mucosa (T1a) may be candidates for endoscopic mucosal resection (in experienced centers)<sup>4</sup>
- T1b-T3<sup>5</sup>: Adequate gastric resection to achieve negative microscopic margins (typically ≥ 4 cm from gross tumor).
  - Distal gastrectomy
  - Subtotal gastrectomy
  - Total gastrectomy
- T4 tumors require en bloc resection of involved structures

Resectable tumors—continued

- Gastric resection should include the regional lymphatics—peri gastric lymph nodes (D1) and those along the named vessels of the celiac axis (D2), with a goal of examining at least 15 or greater lymph nodes<sup>6,7,8</sup>
  - Definition of D1 and D2 lymph node dissections
    - D1 dissection entails gastrectomy and the resection of both the greater and lesser omenta (which would include the lymph nodes along right and left cardiac, along lesser and greater curvature, suprapyloric along the right gastric artery, and infrapyloric area);
    - D2 dissection is a D1 plus the anterior leaf of the transverse mesocolon and all the nodes along the left gastric artery, common hepatic artery, celiac artery, splenic hilum and splenic artery.
- Routine or prophylactic splenectomy is not required.<sup>9</sup> Splenectomy is acceptable when the spleen or the hilum is involved.
- Consider placing feeding jejunostomy tube in select patients (especially if postoperative chemoradiation appears a likely recommendation)

Palliative procedures

- Gastric resections should be reserved for the palliation of symptoms (eg, obstruction or uncontrollable bleeding) in patients with incurable disease.
  - Lymph node dissection not required
  - Gastric bypass with gastrojejunostomy to the proximal stomach instead of self-expanding metal stenting in symptomatic patients if they are fit for surgery and have a reasonable prognosis due to the lower rate of recurrent symptoms<sup>10</sup>
  - Venting gastrostomy and/or jejunostomy tube may be considered

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.
PRINCIPLES OF SURGERY

PRINCIPLES OF SYSTEMIC THERAPY

- Chemotherapy regimens recommended for advanced esophageal and esophagogastric junction (EGJ) adenocarcinoma, squamous cell carcinoma of the esophagus, and gastric adenocarcinoma may be used interchangeably (except as indicated).
- Regimens should be chosen in the context of performance status, medical comorbidities, toxicity profile, and HER2-neu expression (for adenocarcinoma only).
- The use of three cytotoxic drug regimens for advanced disease should be reserved for patients who are medically fit, with a good performance status (ECOG performance status of 0 or 1), and with access to frequent toxicity assessment.
- Modifications of category 1 regimens or use of category 2A or 2B regimens may be preferred (as indicated), with evidence supporting more favorable toxicity profile without a compromise of efficacy.
- Doses and schedules for any regimen that is not derived from category 1 evidence is a suggestion, and subject to appropriate modifications depending on the circumstances.
- Alternate combinations and schedules of cytotoxics based on the availability of the agents, practice preferences, and contraindications are permitted.
- Infusional 5-FU and capecitabine may be used interchangeably (except as indicated). Infusion is the preferred route compared with bolus 5-FU.\(^1\)
- Cisplatin and oxaliplatin may be used interchangeably depending on toxicity profile.
- For localized EGJ adenocarcinoma, preoperative chemoradiation is the preferred approach.
- For localized stomach cancer, perioperative chemotherapy\(^2\) or postoperative chemotherapy plus chemoradiation\(^3\) is the preferred approach.
- Upon completion of chemotherapy, patients should be assessed for response and monitored for any long-term complications.
- Please refer to the Principles of Radiation Therapy for the radiation therapy administration details. (GAST-F)

The selection, dosing, and administration of anticancer agents and the management of associated toxicities are complex. Modifications of drug dose and schedule and initiation of supportive care interventions are often necessary because of expected toxicities and because of individual patient variability, prior treatment, nutritional status, and comorbidity. The optimal delivery of anticancer agents therefore requires a health care delivery team experienced in the use of anticancer agents and the management of associated toxicities in patients with cancer.
PRINCIPLES OF SYSTEMIC THERAPY

Preoperative Chemoradiation (EG junction and gastric cardia):
- Paclitaxel and carboplatin (category 1)\(^4,5\)
- Cisplatin and fluoropyrimidine (5-FU or capecitabine) (category 1)\(^6-8\)
- Oxaliplatin and fluoropyrimidine (5-FU\(^\dagger\) or capecitabine)\(^9-11\)
- Paclitaxel and cisplatin\(^12\)
- Carboplatin and 5-FU (category 2B)\(^13\)
- Irinotecan and cisplatin (category 2B)\(^14\)
- Docetaxel or paclitaxel and fluoropyrimidine (5-FU or capecitabine) (category 2B)\(^15-18\)
- Oxaliplatin, docetaxel, and capecitabine (category 2B)\(^18\)

Perioperative Chemotherapy (including EG junction)
(3 cycles preoperative and 3 cycles postoperative):
- ECF (epirubicin, cisplatin and 5-FU) (category 1)\(^2\)
- ECF modifications (category 1)\(^19\)
  - Epirubicin, oxaliplatin and 5-FU
  - Epirubicin, cisplatin and capecitabine
  - Epirubicin, oxaliplatin and capecitabine

Sequential Chemotherapy and Chemoradiation
- Irinotecan and cisplatin\(^20-22\)
- Paclitaxel and cisplatin\(^20\)
- Docetaxel and cisplatin\(^23\)
- 5-fluorouracil and cisplatin; 5-fluorouracil and paclitaxel\(^15\)

Postoperative Chemoradiation (including EG junction):
- LV5FU2 before and after infusion 5-FU or capecitabine with radiation(preferred)\(^24-26\)

\(^\dagger\)Leucovorin is indicated with certain 5-FU-based regimens. For important information regarding the leucovorin shortage, please see (Discussion).

The selection, dosing, and administration of anticancer agents and the management of associated toxicities are complex. Modifications of drug dose and schedule and initiation of supportive care interventions are often necessary because of expected toxicities and because of individual patient variability, prior treatment, nutritional status, and comorbidity. The optimal delivery of anticancer agents therefore requires a health care delivery team experienced in the use of anticancer agents and the management of associated toxicities in patients with cancer.

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.
Definitive Chemotherapy for Metastatic or Locally Advanced Cancer [where chemoradiation is not indicated]

First-Line Therapy
Two-drug regimens are preferred. Three-drug cytotoxic regimens should be reserved for medically fit patients with good PS and access to frequent toxicity evaluation.

- Trastuzumab with chemotherapy for HER2-neu overexpressing adenocarcinoma (category 1 for combination with cisplatin and fluoropyrimidine; category 2B for combination with other chemotherapy agents; not recommended for use with anthracyclines)\(^\text{28}\)

[See Principles of Pathologic Review and HER2-neu Testing (GAST-B)]

- DCF (docetaxel, cisplatin and 5-FU)\(^\dagger\) (category 1)\(^\text{29}\)
- DCF modifications (preferred over DCF) (category 2A; category 2B for docetaxel, carboplatin, and 5-FU)\(^\text{30-34}\)
  - Docetaxel, oxaliplatin and 5-FU\(^\dagger\)
  - Docetaxel, carboplatin and 5-FU
- ECF (category 1)\(^\text{35,36}\)
- ECF modifications (category 1)\(^\text{36}\)
  - Epirubicin, oxaliplatin and 5-FU
  - Epirubicin, cisplatin and capecitabine
  - Epirubicin, oxaliplatin and capecitabine
- Fluoropyrimidine (5-FU\(^\dagger\) or capecitabine) and cisplatin (category 1)\(^\text{28,37-40}\)
- Fluoropyrimidine (5-FU\(^\dagger\) or capecitabine) and oxaliplatin\(^\text{38,41}\)
- Fluoropyrimidine (5-FU\(^\dagger\)) and irinotecan\(^\text{39,42-44}\)
- Paclitaxel with cisplatin or carboplatin\(^\text{45-47}\)
- Docetaxel with cisplatin\(^\text{34,48,49}\)
- Docetaxel and irinotecan (category 2B)\(^\text{50}\)
- Fluoropyrimidine (5-FU\(^\dagger\) or capecitabine)\(^\text{39,51,51}\)
- Docetaxel or paclitaxel\(^\text{53-55}\)

\(^\dagger\)Leucovorin is indicated with certain 5-FU-based regimens. For important information regarding the leucovorin shortage, please see (Discussion).

Second-Line Therapy
Dependent on prior therapy and performance status (PS):

- Trastuzumab with chemotherapy for HER2-neu overexpressing adenocarcinoma if not used in first line therapy (category 2A for combination with cisplatin and fluoropyrimidine; category 2B for combination with other chemotherapy agents; not recommended for use with anthracyclines)\(^\text{28}\) [See Principles of Pathologic Review and HER2-neu Testing (GAST-B)]
- Irinotecan and cisplatin\(^\text{41,56}\)
- Irinotecan and fluoropyrimidine (5-FU\(^\dagger\) or capecitabine) (category 2B)\(^\text{57,58}\)
- Irinotecan and docetaxel (category 2B)\(^\text{50}\)
- Irinotecan and mitomycin (category 2B)\(^\text{59,60}\)
- Docetaxel or paclitaxel (category 2B)\(^\text{53-54}\)
- Irinotecan (category 2B)\(^\text{61,62}\)

Alternative regimens to be considered (these may be combined with other agents when appropriate) (category 2B):

- Gemcitabine, 5-FU and leucovorin\(^\text{64}\)
- Pegylated liposomal doxorubicin, cisplatin and 5-FU\(^\text{65}\)
- Mitomycin and irinotecan\(^\text{66}\)
- Mitomycin, cisplatin, and 5-FU\(^\text{35}\)
- Mitomycin and 5-FU\(^\dagger\)\(^\text{67}\)
- Etoposide\(^\text{68,69}\)
- Erlotinib\(^\text{70,71}\)

The selection, dosing, and administration of anticancer agents and the management of associated toxicities are complex. Modifications of drug dose and schedule and initiation of supportive care interventions are often necessary because of expected toxicities and because of individual patient variability, prior treatment, nutritional status, and comorbidity. The optimal delivery of anticancer agents therefore requires a health care delivery team experienced in the use of anticancer agents and the management of associated toxicities in patients with cancer.
### PREOPERATIVE CHEMORADIATION (EG JUNCTION AND GASTRIC CARDIA)

<table>
<thead>
<tr>
<th>Regimen</th>
<th>Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paclitaxel and carboplatin</td>
<td>Paclitaxel 50 mg/m² IV on Day 1</td>
</tr>
<tr>
<td></td>
<td>Carboplatin AUC 2 IV on Day 1</td>
</tr>
<tr>
<td></td>
<td>Weekly for 5 weeks</td>
</tr>
<tr>
<td>Cisplatin and fluoropyrimidine</td>
<td>Cisplatin 75-100 mg/m² IV on Days 1 and 29</td>
</tr>
<tr>
<td></td>
<td>5-FU 750-1000 mg/m² IV continuous infusion</td>
</tr>
<tr>
<td></td>
<td>over 24 hours daily on Days 1-4 and 29-32</td>
</tr>
<tr>
<td></td>
<td>35-day cycle</td>
</tr>
<tr>
<td>Cisplatin 30 mg/m² IV on Day 1</td>
<td>Cisplatin 30 mg/m² IV daily on Days 1-5</td>
</tr>
<tr>
<td></td>
<td>Capecitabine 800 mg/m² PO BID on Days 1-5</td>
</tr>
<tr>
<td></td>
<td>Weekly for 5 weeks</td>
</tr>
<tr>
<td>Cisplatin 15 mg/m² IV daily on Days 1-5</td>
<td>Cisplatin 15 mg/m² IV daily on Days 1-5</td>
</tr>
<tr>
<td></td>
<td>5-FU 800 mg/m² IV continuous infusion</td>
</tr>
<tr>
<td></td>
<td>over 24 hours daily on Days 1-5</td>
</tr>
<tr>
<td></td>
<td>Cycled every 21 days for 2 cycles</td>
</tr>
<tr>
<td>Oxaliplatin and fluoropyrimidine</td>
<td>Oxaliplatin 45 mg/m² IV on Day 1 weekly for 5 weeks</td>
</tr>
<tr>
<td></td>
<td>5-FU 225 mg/m² IV continuous infusion</td>
</tr>
<tr>
<td></td>
<td>over 24 hours daily on Days 1-33</td>
</tr>
<tr>
<td>Oxaliplatin 85 mg/m² IV on Days 1, 15,</td>
<td>Oxaliplatin 85 mg/m² IV on Days 1, 15, and 29</td>
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<tr>
<td>and 29</td>
<td>5-FU 180 mg/m² IV daily on Days 1-33</td>
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<tr>
<td></td>
<td>Oxaliplatin 85 mg/m² IV on Days 1, 15, and 29</td>
</tr>
<tr>
<td></td>
<td>Capecitabine 625 mg/m² PO BID</td>
</tr>
<tr>
<td></td>
<td>on Days 1-5 for 5 weeks</td>
</tr>
<tr>
<td>Taxane and cisplatin</td>
<td>Paclitaxel 60 mg/m² IV on Days 1, 8, 15, and 22</td>
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<tr>
<td></td>
<td>Cisplatin 75 mg/m² IV on Day 1</td>
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<td></td>
<td>Given for 1 cycle</td>
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<tr>
<td>Carboplatin and 5-FU</td>
<td>Carboplatin AUC 6 IV on Days 1 and 22</td>
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<tr>
<td></td>
<td>5-FU 200 mg/m² IV daily on Days 1-42</td>
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<tr>
<td>Irinotecan and cisplatin</td>
<td>Irinotecan 65 mg/m² IV on Days 1, 8, 22, and 29</td>
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<td></td>
<td>Cisplatin 30 mg/m² IV on Days 1, 8, 22, and 29</td>
</tr>
<tr>
<td>Taxane and fluoropyrimidine</td>
<td>Paclitaxel 45-50 mg/m² IV on Day 1</td>
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<tr>
<td></td>
<td>Capecitabine 625-825 mg/m² PO BID</td>
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<tr>
<td>Docetaxel 20 mg/m² IV on Day 1</td>
<td>5-FU 200-300 mg/m² IV daily on Days 1-5</td>
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<tr>
<td></td>
<td>Weekly for 5 weeks</td>
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<tr>
<td>Docetaxel 20 mg/m2 IV on Day 1</td>
<td>Docetaxel 20 mg/m2 IV on Day 1</td>
</tr>
<tr>
<td></td>
<td>Capecitabine 625-825 mg/m² PO BID</td>
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<tr>
<td></td>
<td>Weekly for 5 weeks</td>
</tr>
<tr>
<td>Docetaxel 20 mg/m² IV on Day 1</td>
<td>Docetaxel 20 mg/m² IV on Day 1</td>
</tr>
<tr>
<td></td>
<td>Capecitabine 625-825 mg/m² PO BID</td>
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<tr>
<td></td>
<td>Weekly for 5 weeks</td>
</tr>
<tr>
<td>Oxaliplatin, docetaxel, and capecitabine</td>
<td>Oxaliplatin 40 mg/m² IV on Days 1, 8, 15, 22, and 29</td>
</tr>
<tr>
<td></td>
<td>Docetaxel 20 mg/m² IV on Days 1, 8, 15, 22, and 29</td>
</tr>
<tr>
<td></td>
<td>Capecitabine 1000 mg/m² PO BID</td>
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<tr>
<td></td>
<td>Given for 1 cycle</td>
</tr>
</tbody>
</table>

The selection, dosing, and administration of anticancer agents and the management of associated toxicities are complex. Modifications of drug dose and schedule and initiation of supportive care interventions are often necessary because of expected toxicities and because of individual patient variability, prior treatment, nutritional status, and comorbidity. The optimal delivery of anticancer agents therefore requires a healthcare delivery team experienced in the use of anticancer agents and the management of associated toxicities in patients with cancer.
PERIOPERATIVE CHEMOTHERAPY (INCLUDING EG JUNCTION)

ECF (epirubicin, cisplatin, and 5-FU)
Epirubicin 50 mg/m² IV on Day 1
Cisplatin 60 mg/m² IV on Day 1
5-FU 200 mg/m² IV continuous infusion over 24 hours daily on Days 1-21
Cycled every 21 days for 3 cycles preoperatively
and 3 cycles postoperatively

ECF modifications
Epirubicin 50 mg/m² IV on Day 1
Oxaliplatin 130 mg/m² IV on Day 1
5-FU 200 mg/m² IV continuous infusion over 24 hours daily on Days 1-21
Cycled every 21 days for 3 cycles preoperatively
and 3 cycles postoperatively

Epirubicin 50 mg/m² IV on Day 1
Cisplatin 60 mg/m² IV on Day 1
Capecitabine 625 mg/m² PO BID on Days 1-21
Cycled every 21 days for 3 cycles preoperatively
and 3 cycles postoperatively

Epirubicin 50 mg/m² IV on Day 1
Cisplatin 60 mg/m² IV on Day 1
Capecitabine 625 mg/m² PO BID on Days 1-21
Cycled every 21 days for 3 cycles preoperatively
and 3 cycles postoperatively

SEQUENTIAL CHEMOTHERAPY AND CHEMORADIATION

Paclitaxel 50 mg/m² IV on Day 1
Cisplatin 30 mg/m² IV on Day 1
Weekly with radiation for 5 weeks preoperatively, then
Paclitaxel 175 mg/m² IV on Day 1
Cisplatin 75 mg/m² IV on Day 1
Cycled every 21 days for 3 cycles postoperatively

Preoperative docetaxel 75 mg/m² IV on Day 1
Cisplatin 75 mg/m² IV on Day 1
Cycled every 21 days for 2 cycles
Followed by
Docetaxel 20 mg/m² IV on Days 1, 8, 15, 22, and 29
Cisplatin 25mg/m² IV on Day 1, 8, 15,22, and 29
Given for 1 cycle with radiation

Cisplatin 30 mg/m² IV on Days 1, 8, 22, 29
Irinotecan 50 mg/m² IV on Days 1, 8, 22, 29
With radiation preoperative, then
Cisplatin 30 mg/m² IV on Days 1 and 8
Irinotecan 65 mg/m² IV on Days 1 and 8
Cycled every 21 days for 3 cycles postoperative

Preoperative cisplatin 30 mg/m² IV on Days 1 and 8
Irinotecan 65 mg/m² IV on Days 1 and 8
Cycled every 21 days for 2 cycles
Followed by
Cisplatin 30 mg/m² IV
Irinotecan 65 mg/m² IV
Given with radiation Days 1, 8, 15 and 22 or Days 1, 8, 22, and 29

Preoperative cisplatin 20 mg/m² IV on Days 1-5
5-FU 200 mg/m² IV continuous infusion over 24 hours daily on Days 1-21
Cycled every 28 days for 2 cycles
Followed by
Paclitaxel 45 mg/m² IV on Day 1
5-FU 300 mg/m² IV continuous infusion over 24 hours daily on Days 1-5
Weekly for 5 weeks with radiation

The selection, dosing, and administration of anticancer agents and the management of associated toxicities are complex. Modifications of drug dose and schedule and initiation of supportive care interventions are often necessary because of expected toxicities and because of individual patient variability, prior treatment, nutritional status, and comorbidity. The optimal delivery of anticancer agents therefore requires a health care delivery team experienced in the use of anticancer agents and the management of associated toxicities in patients with cancer.

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Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.
POSTOPERATIVE CHEMORADIATION (INCLUDING EG JUNCTION)

LV5FU2 before and after infusional 5-FU or capecitabine (preferred)
1 cycle before and 2 cycles after radiation
Leucovorin 400 mg/m² IV on Days 1 and 15 or Days 1, 2, 15, and 16
5-FU 400 mg/m² IVP on Days 1 and 15 or Days 1, 2, 15, and 16
5-FU 1200 mg/m² IV continuous infusion
over 24 hours daily on Days 1, 2, 15, and 16
Cycled every 28 days

With radiation
5-FU 200-250 mg/m² IV continuous infusion
over 24 hours daily on Days 1-5 or 1-7
Weekly for 5 weeks

With radiation
Capecitabine 625-825 mg/m² PO BID on Days 1-5 or 1-7
Weekly for 5 weeks

POSTOPERATIVE CHEMOTHERAPY

Capecitabine and oxaliplatin
Capecitabine 1000 mg/m² PO BID on Days 1 – 14
Oxaliplatin 130 mg/m² IV on Day 1
Cycled every 21 days for 8 cycles

The selection, dosing, and administration of anticancer agents and the management of associated toxicities are complex. Modifications of drug dose and schedule and initiation of supportive care interventions are often necessary because of expected toxicities and because of individual patient variability, prior treatment, nutritional status, and comorbidity. The optimal delivery of anticancer agents therefore requires a health care delivery team experienced in the use of anticancer agents and the management of associated toxicities in patients with cancer.

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**NCCN Guidelines Version 2.2012**

**Gastric Cancer**

**PRINCIPLES OF SYSTEMIC THERAPY--REGIMENS AND DOSING SCHEDULES**

**DEFINITIVE CHEMOTHERAPY FOR METASTATIC OR LOCALLY ADVANCED CANCER (WHERE CHEMORADIATION IS NOT INDICATED)**

**FIRST-LINE THERAPY**

**Trastuzumab (with chemotherapy)**

- **DCF (docetaxel, cisplatin, and 5-FU)**
  - DCF modifications---continued
    - **Docetaxel 50 mg/m² IV on Day 1**
    - **Oxaliplatin 85 mg/m² IV on Day 1**
    - **5-FU 1200 mg/m² IV continuous infusion**
    - over 24 hours daily on Days 1 and 2
    - Cycled every 14 days
  - **Docetaxel 60 mg/m² IV on Day 1**
    - **Cisplatin 60 mg/m² IV on Day 1**
    - **5-FU 750 mg/m² IV continuous infusion**
    - over 24 hours daily on Days 1-4
    - Cycled every 21 days
  - **Docetaxel 75-85 mg/m² IV on Day 1**
    - **Cisplatin 75 mg/m² IV on Day 1**
    - **5-FU 300 mg/m² IV continuous infusion**
    - over 24 hours daily on Days 1-14
    - Cycled every 21 days
  - **Docetaxel 75 mg/m² IV on Day 1**
    - **Carboplatin AUC 6 IV on Day 2**
    - **5-FU 1200 mg/m² IV continuous infusion**
    - over 24 hours daily on Days 1-3
    - Cycled every 21 days
  - **ECF**
    - **Epirubicin 50 mg/m² IV on Day 1**
    - **Cisplatin 60 mg/m² IV on Day 1**
    - **5-FU 200 mg/m² IV continuous infusion**
    - over 24 hours daily on Days 1-21
    - Cycled every 21 days
  - **Epirubicin 50 mg/m² IV on Day 1**
    - **Cisplatin 130 mg/m² IV on Day 1**
    - **5-FU 200 mg/m² IV continuous infusion**
    - over 24 hours daily on Days 1-21
    - Cycled every 21 days

- **DCF modifications**
  - **Docetaxel 40 mg/m² IV on Day 1**
    - **Leucovorin 400 mg/m² IV on Day 1**
    - **5-FU 400 mg/m² IV on Day 1**
    - **5-FU 1000 mg/m² IV continuous infusion**
    - over 24 hours daily on Days 1-5
    - Cycled every 28 days
  - **Docetaxel 50 mg/m² IV on Day 1**
    - **Oxaliplatin 85 mg/m² IV on Day 1**
    - **Leucovorin 200 mg/m² IV on Day 1**
    - **5-FU 2600 mg/m² IV continuous infusion**
    - over 24 hours daily on Day 1
    - Cycled every 14 days

**DEFINITIVE CHEMOTHERAPY FOR LOCALLY ADVANCED CANCER (WHERE CHEMORADIATION IS INDICATED)**

**CHEMORADIATION REGIMENS**

**First-Line Chemotherapy**

- **ECF**
  - **Epirubicin 50 mg/m² IV on Day 1**
  - **Cisplatin 130 mg/m² IV on Day 1**
  - **5-FU 200 mg/m² IV continuous infusion**
  - over 24 hours daily on Days 1-21
  - Cycled every 21 days

**Second-Line Chemotherapy**

- **ECF**
  - **Epirubicin 50 mg/m² IV on Day 1**
  - **Cisplatin 130 mg/m² IV on Day 1**
  - **5-FU 200 mg/m² IV continuous infusion**
  - over 24 hours daily on Days 1-21
  - Cycled every 21 days

**Third-Line Chemotherapy**

- **ECF**
  - **Epirubicin 50 mg/m² IV on Day 1**
  - **Cisplatin 130 mg/m² IV on Day 1**
  - **5-FU 200 mg/m² IV continuous infusion**
  - over 24 hours daily on Days 1-21
  - Cycled every 21 days

**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.
GAST-E

PRINCIPLES OF SYSTEMIC THERAPY--REGIMENS AND DOSING SCHEDULES

DEFINITIVE CHEMOTHERAPY FOR METASTATIC OR LOCALLY ADVANCED CANCER (WHERE CHEMORADIATION IS NOT INDICATED)

FIRST-LINE THERAPY---continued

Fluoropyrimidine and oxaliplatin

Oxaliplatin 85 mg/m² IV on Day 1
Leucovorin 400 mg/m² IV on Day 1
5-FU 400 mg/m² IV on Day 1
5-FU 1200 mg/m² IV continuous infusion over 24 hours daily on Days 1 and 2
Cycled every 14 days

Oxaliplatin 85 mg/m² IV on Day 1
Leucovorin 200 mg/m² IV on Day 1
5-FU 2600 mg/m² IV continuous infusion over 24 hours on Day 1
Cycled every 14 days

5-FU and irinotecan

Irinotecan 80 mg/m² IV on Day 1
Leucovorin 500 mg/m² IV on Day 1
5-FU 2000 mg/m² IV continuous infusion over 24 hours on Day 1
Weekly for 6 weeks followed by 1 week off treatment

Irinotecan 180 mg/m² IV on Day 1
Leucovorin 400 mg/m² IV on Day 1
5-FU 400 mg/m² IV on Day 1
5-FU 1200 mg/m² IV continuous infusion over 24 hours daily on Days 1 and 2
Cycled every 14 days

Irinotecan 80 mg/m² IV on Day 1
Leucovorin 500 mg/m² IV combined with
5-FU 2000 mg/m² IV continuous infusion over 24 hours on Day 1
Weekly for 6 weeks followed by 2 weeks off treatment

Paclitaxel with cisplatin or carboplatin

Paclitaxel 135 mg/m² IV on Day 1
Cisplatin 75 mg/m² IV on Day 2
Cycled every 21 days

Paclitaxel 90 mg/m² IV on Day 1
Cisplatin 50 mg/m² IV on Day 1
Cycled every 14 days

Paclitaxel 200 mg/m² IV on Day 1
Carboplatin AUC 6 IV on Day 1
Cycled every 21 days

Docetaxel and cisplatin

Docetaxel 70-85 mg/m² IV on Day 1
Cisplatin 70-75 mg/m² IV on Day 1
Cycled every 21 days

Docetaxel and irinotecan

Docetaxel 35 mg/m² IV on Days 1 and 8
Irinotecan 50 mg/m² IV on Days 1 and 8
Cycled every 21 days

Fluoropyrimidine

Leucovorin 400 mg/m² IV on Day 1
5-FU 400 mg/m² IV on Day 1
5-FU 1200 mg/m² IV continuous infusion over 24 hours daily on Days 1 and 2
Cycled every 14 days

5-FU 800 mg/m² IV continuous infusion over 24 hours daily on Days 1-5
Cycled every 28 days

Capecitabine 1000 mg/m² PO BID on Days 1-14
Cycled every 21 days

Docetaxel 75-100 mg/m² IV on Day 1
Cycled every 21 days

Paclitaxel 135-175 mg/m² IV on Day 1
Cycled every 21 days

Paclitaxel 80 mg/m² IV on Day 1 weekly
Cycled every 28 days

The selection, dosing, and administration of anticancer agents and the management of associated toxicities are complex. Modifications of drug dose and schedule and initiation of supportive care interventions are often necessary because of expected toxicities and because of individual patient variability, prior treatment, nutritional status, and comorbidity. The optimal delivery of anticancer agents therefore requires a health care delivery team experienced in the use of anticancer agents and the management of associated toxicities in patients with cancer.

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.
**GAST-E**

Gastric Cancer

### PRINCIPLES OF SYSTEMIC THERAPY--REGIMENS AND DOSING SCHEDULES

**DEFINITIVE CHEMOTHERAPY FOR METASTATIC OR LOCALLY ADVANCED CANCER (WHERE CHEMORADIATION IS NOT INDICATED)**

#### SECOND-LINE THERAPY

<table>
<thead>
<tr>
<th>Drug Combination</th>
<th>Dosage Details</th>
</tr>
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<tbody>
<tr>
<td><strong>Trastuzumab (with chemotherapy)</strong></td>
<td>Trastuzumab 8 mg/kg IV loading dose on Day 1 of Cycle 1, then Trastuzumab 6 mg/kg IV every 21 days or Trastuzumab 6 mg/kg IV loading dose on Day 1 of cycle 1, then 4 mg/kg IV every 14 days</td>
</tr>
<tr>
<td><strong>Irinotecan and cisplatin</strong></td>
<td>Irinotecan 65 mg/m² IV on Days 1 and 8 Cisplatin 25-30 mg/m² IV on Days 1 and 8 Cycled every 21 days</td>
</tr>
<tr>
<td><strong>Irinotecan and fluoropyrimidine</strong></td>
<td>Irinotecan 250 mg/m² IV on Day 1 Capecitabine 1000 mg/m² PO BID on Days 1-14 Cycled every 21 days</td>
</tr>
<tr>
<td><strong>Irinotecan 180 mg/m² IV on Day 1</strong></td>
<td>Leucovorin 400 mg/m² IV on Day 1 5-FU 400 mg/m² IVP on Day 1 5-FU 1200 mg/m² IV continuous infusion over 24 hours daily on Days 1 and 2 Cycled every 14 days</td>
</tr>
<tr>
<td><strong>Irinotecan and docetaxel</strong></td>
<td>Docetaxel 35 mg/m² IV on Days 1 and 8 Irinotecan 50 mg/m² IV on Days 1 and 8 Cycled every 21 days</td>
</tr>
</tbody>
</table>

The selection, dosing, and administration of anticancer agents and the management of associated toxicities are complex. Modifications of drug dose and schedule and initiation of supportive care interventions are often necessary because of expected toxicities and because of individual patient variability, prior treatment, nutritional status, and comorbidity. The optimal delivery of anticancer agents therefore requires a health care delivery team experienced in the use of anticancer agents and the management of associated toxicities in patients with cancer.

**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.

**Continue**
**NCCN Guidelines Version 2.2012**  
**Gastric Cancer**

**PRINCIPLES OF SYSTEMIC THERAPY--REGIMENS AND DOSING SCHEDULES**

**DEFINITIVE CHEMOTHERAPY FOR METASTATIC OR LOCALLY ADVANCED CANCER (WHERE CHEMORADIATION IS NOT INDICATED)**

**ALTERNATIVE REGIMENS FOR CONSIDERATION**

**Gemcitabine, 5-FU, and leucovorin**
- Gemcitabine 1000 mg/m² IV on Days 1, 8, and 15
- Leucovorin 20 mg/m² IV on Days 1, 8, and 15
- 5-FU 500 mg/m² IV on Days 1, 8, and 15
- Cycled every 28 days

**Pegylated liposomal doxorubicin, cisplatin, and 5-FU**
- Pegylated liposomal doxorubicin 20 mg/m² IV on Day 1
- Cisplatin 50 mg/m² IV on Day 1
- 5-FU 400 mg/m² IVP on Day 1
- 5-FU 600 mg/m² IV continuous infusion over 24 hours daily on Days 1 and 2
- Cycled every 14 days

**Mitomycin and irinotecan**
- Mitomycin 10 mg/m² IV on Days 1 and 22
- Leucovorin 500 mg/m² IV on Day 1
- 5-FU 2600 mg/m² IV continuous infusion over 24 hours on Day 1
- Weekly for 6 weeks followed by 2 weeks off treatment

**Mitomycin, leucovorin, and 5-FU**
- Mitomycin 10 mg/m² IV on Days 1 and 22
- Leucovorin 500 mg/m² IV on Day 1
- 5-FU 2600 mg/m² IV continuous infusion over 24 hours on Day 1
- Weekly for 6 weeks followed by 2 weeks off treatment

**Etoposide**
- Etoposide 90-120 mg/m² IV on Days 1-3
- Cycled every 28 days

**Erlotinib**
- Erlotinib 150 mg PO daily

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The selection, dosing, and administration of anticancer agents and the management of associated toxicities are complex. Modifications of drug dose and schedule and initiation of supportive care interventions are often necessary because of expected toxicities and because of individual patient variability, prior treatment, nutritional status, and comorbidity. The optimal delivery of anticancer agents therefore requires a health care delivery team experienced in the use of anticancer agents and the management of associated toxicities in patients with cancer.

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30 Shah MA, Shibata S, Stoller RG, et al. Random assignment multicenter phase II study of modified docetaxel, cisplatin, fluorouracil (mDCF) versus DCF with growth factor support (GCSF) in metastatic gastroesophageal adenocarcinoma (GE). J Clin Oncol (Meeting Abstracts) 2010;28:4014-
PRINCIPLES OF RADIATION THERAPY

General Radiation Information

- Prior to simulation, pertinent radiographs, procedure notes and pathology reports should be reviewed by a multidisciplinary team including surgical, radiation, medical oncologists, gastroenterologists, radiologists and pathologists. This will allow an informed determination of treatment volume and field borders prior to simulation.

Simulation and Treatment Planning

- Use of CT simulation and 3D treatment planning is strongly encouraged.
- The patient should be instructed to avoid intake of a heavy meal for 3 hours before simulation and treatment. When clinically appropriate, use of IV and/or oral contrast for CT simulation may be used to aid in target localization.
- Use of an immobilization device is strongly recommended for reproducibility of daily set-up.
- All patients should be simulated and treated in the supine position.
- Although AP/PA fields can be weighted anteriorly to keep the spinal cord dose at acceptable levels using only parallel-opposed techniques, a 4-field technique (AP/PA and opposed laterals), if feasible, can spare spinal cord with improved dose homogeneity. Patients with a stomach that is sufficiently anterior to allow treatment via laterals to the target volume and draining lymph nodes with 1.5-2 cm margin while sparing spinal cord may have more liberal use of lateral beams with multiple-field techniques. The uncertainties arising from variations in stomach filling and respiratory motion should also be taken into consideration.
- With the wide availability of 3D treatment-planning systems, it may be possible to target more accurately the high-risk volume and to use unconventional field arrangements to produce superior dose distributions. To accomplish this without marginal misses, it will be necessary to both carefully define and encompass the various target volumes because the use of oblique or non-coplanar beams could exclude target volumes that would be included in AP/PA fields or multiple-field techniques.

Simulation and Treatment Planning—continued

- Intensity modulated radiation therapy (IMRT) may be appropriate in selected cases to reduce dose to normal structures such as heart, lungs, kidneys and liver. As discussed above, target volumes need to be carefully defined and encompassed while designing IMRT plans. Uncertainties from variations in stomach filling and respiratory motion need to be taken into account. For structures such as the lungs, attention should be given to the volume receiving low to moderate doses, as well as the volume receiving high doses.

Target Volume (General Guidelines)

- Preoperative\(^1\)
  - Pre-treatment diagnostic studies (EUS, UGI, EGD, and CT scans) should be used to identify the tumor and pertinent nodal groups.\(^2,3\)
    - The relative risk of nodal metastases at a specific nodal location is dependent on both the site of origin of the primary tumor and other factors including width and depth of invasion of the gastric wall.
- Postoperative\(^4\)
  - Pre-treatment diagnostic studies (EUS, UGI, EGD, and CT scans) and clip placement should be used to identify the tumor/gastric bed, the anastomosis or stumps, and pertinent nodal groups.\(^2,3\)
    - Treatment of the remaining stomach should depend on a balance of the likely normal tissue morbidity and the perceived risk of local relapse in the residual stomach. The relative risk of nodal metastases at a specific nodal location is dependent on both the site of origin of the primary tumor and other factors including width and depth of invasion of the gastric wall.\(^5\)

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### PRINCIPLES OF RADIATION THERAPY

#### Proximal one-third/Cardia/Esophagogastric Junction Primaries
- **Preoperative and Postoperative**
  - With proximal gastric lesions or lesions at the EG junction, a 3- to 5-cm margin of distal esophagus, medial left hemidiaphragm and adjacent pancreatic body should be included. Nodal areas at risk include: adjacent paraesophageal, perigastric, suprapancreatic, and celiac lymph nodes.

#### Middle one-third/Body Primaries
- **Preoperative and Postoperative**
  - Body of pancreas should be included. Nodal areas at risk include: perigastric, suprapancreatic, celiac, splenic hilar, porta hepatic, and pancreaticoduodenal lymph nodes.

#### Distal one-third/Antrum/Pylorus Primaries
- **Preoperative**
  - Head of pancreas, 1st and 2nd part of duodenum should be included if the gross lesion extended to the gastroduodenal junction. Nodal areas at risk include: perigastric, suprapancreatic, celiac, porta hepatic, and pancreaticoduodenal lymph nodes.
- **Postoperative**
  - Head of pancreas, a 3- to 5-cm margin of duodenal stump should be included if the gross lesion extended to the gastroduodenal junction. Nodal areas at risk include: perigastric, suprapancreatic, celiac, porta hepatic, and pancreaticoduodenal lymph nodes.

#### Blocking
- Custom blocking is necessary to reduce unnecessary dose to normal structures including liver (60% of liver < 30 Gy), kidneys (at least 2/3 of one kidney < 20 Gy), spinal cord (< 45 Gy), heart (1/3 of heart < 50 Gy, effort should be made to keep the left ventricle doses to a minimum) and lungs.\(^a\)

#### Dose
- 45-50.4 Gy (1.8 Gy/day)

#### Supportive Therapy
- Treatment interruptions or dose reductions for manageable acute toxicities should be avoided. Careful patient monitoring and aggressive supportive care are preferable to treatment breaks.
- During radiation treatment course, patients should be seen for status check at least once a week with notation of vital signs, weight and blood counts.
- Antiemetics should be given on a prophylactic basis, and antacid and anti diarrheal medications may be prescribed when needed.
- If estimated caloric intake is < 1500 kcal/day, oral and/or enteral nutrition should be considered. When indicated, feeding jejunostomies (J-tube) or nasogastric feeding tubes may be placed to ensure adequate caloric intake. During surgery, a J-tube may be placed for postoperative nutritional support.
- \(B_{12}\) iron, and calcium level should be closely monitored, especially for postoperative patients. Monthly \(B_{12}\) shots may be needed because of loss of intrinsic factor. Iron absorption is reduced without gastric acid. Oral supplementation, given with acid such as orange juice, can often maintain adequate levels. Calcium supplementation should also be encouraged.
- Adequate enteral and/or IV hydration is necessary throughout chemoradiation and early recovery.

\(a\) Lung Dose Volume Histogram (DVH) parameters as predictors of pulmonary complications in gastric/esophagogastric junction cancer patients treated with concurrent chemoradiotherapy should be strongly considered, though consensus on optimal criteria has not yet emerged. Every effort should be made to keep the lung volume and doses to a minimum. Treating physicians should be aware that the DVH reduction algorithm is hardly the only risk factor for pulmonary complications. DVH parameters as predictors of pulmonary complications in gastric/esophagogastric junction cancer patients are an area of active development among the NCCN institutions and others.

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PRINCIPLES OF RADIATION THERAPY

PRINCIPLES OF BEST SUPPORTIVE CARE

The goal of best supportive care is to prevent and relieve suffering and to support the best possible quality of life for patients and their families, regardless of the stage of the disease or the need for other therapies. For gastric cancer, interventions undertaken to relieve major symptoms may result in prolongation of life. This appears to be particularly true when a multimodality interdisciplinary approach is pursued, and therefore, a multimodality interdisciplinary approach to palliative care of the gastric cancer patient is encouraged.

**Bleeding**
- Bleeding is common in patients with gastric cancer and may directly arise from the tumor, or as a consequence of therapy. Patients with acute severe bleeding (hematemesis or melena) should undergo prompt endoscopic assessment.\(^1\)
  - Endoscopic hemostatic interventions appropriate to the findings should be carried out
  - Interventional radiology angiographic embolization techniques may be useful in those situations where endoscopy is not helpful
  - External beam radiation therapy\(^2\)
- Chronic blood loss from gastric cancer
  - External beam radiation therapy\(^2\)

**Obstruction**
- Endoscopic relief of obstruction
  - Balloon dilation
  - Placement of enteral stent for relief of outlet obstruction,\(^3\) or esophageal stent for EGJ/cardia obstruction
    (see NCCN Guidelines for Esophageal and Esophagogastric Junction Cancers)
- Surgery
  - Gastrojejunal bypass\(^3\)
  - Gastrectomy in select patients\(^4\)
- Establish enteral access for purposes of hydration and nutrition if endoscopic lumen enhancement is not undertaken or is unsuccessful
  - Feeding percutaneous endoscopic gastrostomy for patients with EGJ/cardia obstruction if tumor location permits
  - Endoscopic or surgical placement of jejunal feeding tube for patients with mid and distal gastric obstruction
- Venting gastrostomy (if endoscopic lumen enhancement is not undertaken or is unsuccessful)
  - Percutaneous endoscopic or interventional radiology gastrostomy tube placement can be placed for gastric decompression if tumor location permits
  - Ascites, if present, should be drained prior to venting gastrostomy tube placement to reduce the risk of infectious complications.
- External beam radiation therapy
- Chemotherapy\(^a\)

\(^a\)See Principles of Systemic Therapy (GAST-E)
PRINCIPLES OF BEST SUPPORTIVE CARE

Pain
- External beam radiation therapy
- Chemotherapy
- If patient is experiencing tumor related pain, then the pain should be assessed and treated in accordance with the NCCN Guidelines for Adult Cancer Pain.
- Severe uncontrolled pain following gastric stent placement should be treated with endoscopic removal of the stent once uncontrollable nature of pain is established.

Nausea/Vomiting
- If patient is experiencing nausea and vomiting, then the patient should be treated in accordance with the NCCN Guidelines for Antiemesis.
- Nausea and vomiting may be associated with luminal obstruction, so endoscopic or fluoroscopic evaluation should be performed to determine if luminal enhancement is indicated.

*aSee Principles of Systemic Therapy (GAST-E)*
PRINCIPLES OF BEST SUPPORTIVE CARE

(References)

4. Lim S, Muhs BE, Marcus SG, Newman E, Berman RS, Hiotis SP. Results following resection for stage IV gastric cancer; are better outcomes observed in selected patient subgroups? J Surg Oncol. 2007;95(2):118-122.
### Table 1

**American Joint Committee on Cancer (AJCC)**

**TNM Staging Classification for Carcinoma of the Stomach**

*(7th ed., 2010)*

<table>
<thead>
<tr>
<th>Primary Tumor (T)</th>
<th>Distant Metastasis (M)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TX Primary tumor cannot be assessed</td>
<td>M0 No distant metastasis</td>
</tr>
<tr>
<td>T0 No evidence of primary tumor</td>
<td>M1 Distant metastasis</td>
</tr>
<tr>
<td>Tis Carcinoma in situ: intraepithelial tumor without invasion of the lamina propria</td>
<td><strong>Histologic Grade (G)</strong></td>
</tr>
<tr>
<td>T1 Tumor invades lamina propria, muscularis mucosae or submucosa</td>
<td>GX Grade cannot be assessed</td>
</tr>
<tr>
<td>T1a Tumor invades lamina propria or muscularis mucosae</td>
<td>G1 Well differentiated</td>
</tr>
<tr>
<td>T1b Tumor invades submucosa</td>
<td>G2 Moderately differentiated</td>
</tr>
<tr>
<td>T2 Tumor invades muscularis propria*</td>
<td>G3 Poorly differentiated</td>
</tr>
<tr>
<td>T3 Tumor penetrates subserosal connective tissue without invasion of visceral peritoneum or adjacent structures**,***</td>
<td>G4 Undifferentiated</td>
</tr>
<tr>
<td>T4 Tumor invades serosa (visceral peritoneum) or adjacent structures**,**</td>
<td></td>
</tr>
<tr>
<td>T4a Tumor invades serosa (visceral peritoneum)</td>
<td></td>
</tr>
<tr>
<td>T4b Tumor invades adjacent structures</td>
<td></td>
</tr>
</tbody>
</table>

**Regional Lymph Nodes (N)**

| NX Regional lymph node(s) cannot be assessed | **The adjacent structures of the stomach include the spleen, transverse colon, liver, diaphragm, pancreas, abdominal wall, adrenal gland, kidney, small intestine, and retroperitoneum.** |
| N0 No regional lymph node metastasis§ | |
| N1 Metastasis in 1 - 2 regional lymph nodes | **Intramural extension to the duodenum or esophagus is classified by the depth of the greatest invasion in any of these sites, including the stomach.** |
| N2 Metastasis in 3 - 6 regional lymph nodes | §A designation of pN0 should be used if all examined lymph nodes are negative, regardless of the total number removed and examined. |
| N3 Metastasis in seven or more regional lymph nodes | |
| N3a Metastasis in 7 - 15 regional lymph nodes | |
| N3b Metastasis in 16 or more regional lymph nodes | |

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*Note: A tumor may penetrate the muscularis propria with extension into the gastrocolic or gastrohepatic ligaments, or into the greater or lesser omentum, without perforation of the visceral peritoneum covering these structures. In this case, the tumor is classified T3. If there is perforation of the visceral peritoneum covering the gastric ligaments or the omentum, the tumor should be classified T4.*

**The adjacent structures of the stomach include the spleen, transverse colon, liver, diaphragm, pancreas, abdominal wall, adrenal gland, kidney, small intestine, and retroperitoneum.**

**Intramural extension to the duodenum or esophagus is classified by the depth of the greatest invasion in any of these sites, including the stomach.**

§A designation of pN0 should be used if all examined lymph nodes are negative, regardless of the total number removed and examined.
Table 1 - Continued
American Joint Committee on Cancer (AJCC)
TNM Staging Classification for Carcinoma of the Stomach
(7th ed., 2010)

Anatomic Stage/Prognostic Groups

<table>
<thead>
<tr>
<th>Stage</th>
<th>T</th>
<th>N</th>
<th>M</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 0</td>
<td>Tis</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>Stage I A</td>
<td>T1</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>Stage IB</td>
<td>T2</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td></td>
<td>T1</td>
<td>N1</td>
<td>M0</td>
</tr>
<tr>
<td>Stage IIA</td>
<td>T3</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td></td>
<td>T2</td>
<td>N1</td>
<td>M0</td>
</tr>
<tr>
<td></td>
<td>T1</td>
<td>N2</td>
<td>M0</td>
</tr>
<tr>
<td>Stage IIB</td>
<td>T4a</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td></td>
<td>T3</td>
<td>N1</td>
<td>M0</td>
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<tr>
<td></td>
<td>T2</td>
<td>N2</td>
<td>M0</td>
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<tr>
<td></td>
<td>T1</td>
<td>N3</td>
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</tr>
<tr>
<td>Stage IIIA</td>
<td>T4a</td>
<td>N1</td>
<td>M0</td>
</tr>
<tr>
<td></td>
<td>T3</td>
<td>N2</td>
<td>M0</td>
</tr>
<tr>
<td></td>
<td>T2</td>
<td>N3</td>
<td>M0</td>
</tr>
<tr>
<td>Stage IIIB</td>
<td>T4b</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td></td>
<td>T4b</td>
<td>N1</td>
<td>M0</td>
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<tr>
<td></td>
<td>T4a</td>
<td>N2</td>
<td>M0</td>
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<td></td>
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<tr>
<td>Stage IIIC</td>
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<td>N3</td>
<td>M0</td>
</tr>
<tr>
<td>Stage IV</td>
<td>Any T</td>
<td>Any N</td>
<td>M1</td>
</tr>
</tbody>
</table>
Discussion

NCCN Categories of Evidence and Consensus

Category 1: The recommendation is based on high-level evidence (e.g. randomized controlled trials) and there is uniform NCCN consensus.

Category 2A: The recommendation is based on lower-level evidence and there is uniform NCCN consensus.

Category 2B: The recommendation is based on lower-level evidence and there is nonuniform NCCN consensus (but no major disagreement).

Category 3: The recommendation is based on any level of evidence but reflects major disagreement.

All recommendations are category 2A unless otherwise noted.

Overview

Upper gastrointestinal (GI) tract cancers originating in the esophagus, esophagogastric junction (EGJ), and stomach, constitute a major health problem around the world. An estimated 38,780 new cases of and 25,610 deaths from upper GI tract cancers will occur in the United States in 2012. A dramatic shift in the location of upper GI tract tumors has occurred in the United States. Changes in histology and location of upper GI tract tumors have also been observed in some parts of Europe. In Western countries, the most common sites of gastric cancer are the proximal lesser curvature, in the cardia, and the EGJ. It is possible that in the coming decades these changing trends will also occur in South America and Asia.

Epidemiology

Gastric cancer is rampant in many countries around the world. In Japan, it remains the most common type of cancer among men. More new cases of gastric cancer are diagnosed in China each year than any other country. The incidence of gastric cancer, however, has been declining globally since World War II and it is one of the least common cancers in North America. By some estimates, it is the fourth most common cancer worldwide. In 2012, an estimated 21,320 new cases will be diagnosed and 10,540 cases will eventually die of their disease in United States. In developed countries, the incidence of gastric cancer originating from the cardia follows the distribution of esophageal cancer. Non-cardia gastric adenocarcinoma shows marked geographic variation with countries such as Japan, Korea, China, Taiwan, Costa Rica, Peru, Brazil, Chile and the former Soviet Union show a high incidence of the cancer. In contrast to the incidence trends in the West, non-proximal tumors continue to predominate in Japan and other parts of the world. The etiology of this shift remains elusive and may be multifactorial.

Gastric cancer is often diagnosed at an advanced stage. In Japan (and in a limited fashion in Korea) where screening is performed widely, early detection is often possible. In other parts of the world, it continues to pose a major challenge for healthcare professionals. Environmental risk factors include Helicobacter pylori (H. pylori) infection, smoking, high salt intake, and other dietary factors. In a recent meta-analysis, there was no appreciable association between moderate alcohol drinking and gastric cancer risk, however, there was a positive association with heavy alcohol drinking, particularly for non-cardia gastric cancers. Patients with a family history of non-hereditary gastric cancer have a higher risk of developing gastric cancer. In a limited number of patients (1% to 3%), its diagnosis is associated with
inherited syndromes. E-cadherin mutations occur in approximately 25% of families with an autosomal dominant of a hereditary form of diffuse gastric cancer. Genetic counseling is recommended and a consideration should be given to prophylactic gastrectomy in young, asymptomatic carriers of germ-line truncating \textit{CDH1} mutations who belong to families with highly penetrant hereditary diffuse gastric cancer.\textsuperscript{13}

### Staging

Two major classifications are currently used. The Japanese classification is more elaborate and is based on anatomic involvement, particularly the lymph node stations.\textsuperscript{14} The other staging system developed jointly by the American Joint Committee on Cancer (AJCC) and the International Union against Cancer (UICC), is the system used in countries in the Western Hemisphere (Table 1).\textsuperscript{15} A minimum of 15 examined lymph nodes is recommended for adequate staging. The 7th Edition of AJCC staging does not include proximal 5 cm of the stomach and this has created debates, confusion and disagreements. In addition, the new classification suffers from a number of other drawbacks, in that it is based on primary surgery and is not reliable when considering clinical baseline staging or after preoperative therapy.

Clinical baseline stage provides useful information for the development of an initial treatment strategy. Approximately 50% of patients will present with advanced disease at diagnosis and have a poor outcome. Other measures of poor outcome include poor performance status, presence of metastases, and alkaline phosphatase level of 100 U/L or more.\textsuperscript{16} In patients with localized resectable disease, outcome depends on the surgical stage of the disease. Nearly 70-80% of patients have involvement of the regional lymph nodes. The number of positive lymph nodes has a profound influence on survival.\textsuperscript{17}

### Preoperative Staging

Clinical staging has greatly improved with the availability of diagnostic modalities such as endoscopic ultrasound (EUS), computed tomography (CT), combined positron emission tomography (PET) and CT (PET/CT), magnetic resonance imaging (MRI) and laparoscopic staging.\textsuperscript{18-20}

CT scan is routinely used for preoperative staging. It has an overall accuracy of 43% to 82% for T staging. PET/CT has a low detection rate because of the low tracer accumulation in diffuse and mucinous tumor types which are frequent in gastric cancer.\textsuperscript{21} It has a significantly lower sensitivity compared to CT in the detection of local lymph node involvement (56% vs.78%), although it has an improved specificity (92% vs. 62%).\textsuperscript{22} Combined PET/CT imaging, on the other hand, has several potential advantages over PET scan alone.\textsuperscript{23} PET/CT has a significantly higher accuracy in preoperative staging (68%) than PET (47%) or CT (53%) alone. Recent reports have confirmed that PET alone is not an adequate diagnostic procedure in the detection and preoperative staging of gastric cancer but it could be helpful when used in conjunction with CT.\textsuperscript{24,25}

EUS is indicated for assessing the depth of tumor invasion.\textsuperscript{26} The accuracy of EUS for T-staging ranges from 65% to 92% and 50% to 95% for N staging and is operator dependent. Distant lymph node evaluation by EUS is suboptimal given the limited depth and visualization of the transducer.\textsuperscript{27}

Laparoscopic staging can detect occult metastases. In a study conducted by Memorial Sloan Kettering Cancer Center, 657 patients with potentially resectable gastric adenocarcinoma underwent laparoscopic staging over a period of 10 years.\textsuperscript{28} Distant metastatic disease (M1) was detected in 31% of the patients. Limitations of
laparoscopic staging include two-dimensional evaluation and limited use in the identification of hepatic metastases and perigastric lymph nodes.

Indications for the use of laparoscopic staging differ among various NCCN member institutions. In some, laparoscopic staging is reserved for medically fit patients with potentially resectable disease, specifically when consideration is made for chemoradiotherapy or surgery. In medically unfit patients, laparoscopy may still be considered especially if there is consideration for adding radiation to chemotherapy. The guidelines have included laparoscopic staging with a category 2B recommendation.

Cytogenetic analysis of peritoneal fluid can help improve staging through identification of occult carcinomatosis. Positive peritoneal cytology is associated with poor prognosis in patients with gastric cancer. A positive peritoneal cytology is an independent predictor for identifying patients who are at higher risk for recurrence following curative resection. Laparoscopic lavage cytology is also very useful to identify the subset of patients with M1 disease who are unlikely to benefit from resection alone. Recent report suggests that clearing of cytology-positive disease by chemotherapy is associated with a statistically significant improvement in disease-specific-survival but cures are rare. Therefore, positive peritoneal cytology in the absence of visible peritoneal implants should be considered M1 disease. The panel recommends that patients with advanced tumors, T3 or N1 disease should be considered for laparoscopic staging with peritoneal washings for cytology.

Principles of Pathology

Biopsy

A specific diagnosis of gastric adenocarcinoma should be established for staging and treatment purposes. In the revised AJCC staging system, tumors arising in the proximal stomach and crossing the EGJ are classified as esophageal carcinomas. In addition to the histologic type, the pathology report (regardless of the specimen type) should include specifics about tumor invasion and pathologic grade (required for stage grouping). In addition to the above mentioned elements, the pathology report of the EMR and surgical resection specimens should also include assessment of lymphovascular invasion, depth of tumor invasion and the status of mucosal and deep margins. The pathology report of the surgical resection specimen should also document the location of the tumor midpoint in relationship to the EGJ, lymph node status and the number of lymph nodes recovered. In the case of gastrectomy with prior chemoradiation and without grossly obvious residual tumor, the tumor site should be thoroughly sampled to detect microscopic residual disease.

While there is no universally accepted minimum number of lymph nodes necessary for accurate staging of gastric cancer, retrieval of at least 15 lymph nodes is recommended to stage nodal status more accurately. Data from a SEER database show that the number of lymph nodes examined correlated with overall survival after gastrectomy. A trend for superior survival based on more lymph nodes examined was confirmed across all stage subgroups.

Assessment of Treatment Response

The type of pathological response and histologic tumor regression after neoadjuvant therapy has been shown to be a predictor of survival in patients with gastric adenocarcinoma. Lowy et al reported that clinical
response to neoadjuvant chemotherapy was the only important predictor of overall survival in patients who underwent curative resection for gastric cancer. In another study, Becker et al demonstrated that histopathologic grading of tumor regression correlated with survival in patients treated with neoadjuvant chemotherapy. Median survival was significantly better for patients with less than 10% of residual tumor compared to those patients with 10-50% or greater than 50% of residual tumor. In a recent report, Mansour et al reported that the 3-year disease-specific survival was significantly higher for patients with more than 50% pathologic response to neoadjuvant chemotherapy compared to those with less than 50% (69% and 44% respectively). Tumor size, perineural or lymphovascular invasion and the nodal status have been shown to be stronger predictors of survival.

Although grading systems for tumor response in patients with gastric cancer have not been uniformly adopted, in general, 3-tiered classification system provides good reproducibility among pathologists. The grading system developed by Ryan et al for rectal carcinoma is reported to provide good interobserver agreement, but other systems may also be used. Sizable pools of acellular mucin may be present after chemoradiation but should not be interpreted as representing residual tumor. See “Principles of Pathologic Review and HER2-neu Testing-Assessment of Treatment Response-Table 2” in the guidelines.

Assessment of HER2-neu Overexpression

Human epidermal growth factor receptor 2 gene (HER2 also known as HER2-neu) is a member of the human epidermal growth factor receptor (EGFR) family and is implicated in the development of various solid tumour types. HER2-neu overexpression in EGJ cancers varies widely (2-45%). HER2-neu-positivity has been reported to be higher in EGJ cancers (24-25%) than in gastric cancers (9.5-12%). HER2-neu overexpression is more common in the intestinal subtype of gastric cancer. In the Trastuzumab for Gastric Cancer (ToGA) trial, which evaluated the addition of trastuzumab to chemotherapy in HER2-neu-positive advanced gastric cancer, HER2-neu-positivity rates were 33%, 21%, 32% and 6% respectively in patients with EGJ adenocarcinoma, gastric adenocarcinoma, intestinal and diffuse or mixed type cancer. Therefore, subclassification of gastric adenocarcinomas as intestinal or diffuse type may have implications for therapy. Some studies have suggested that HER2-neu-positivity is associated with poor outcomes, whereas in a recent study that evaluated HER2-neu expression in a large cohort of patients with gastric cancer other there was no relationship between HER2-neu expression and patient survival. Further studies are needed to assess the impact of HER2-neu expression and prognosis.

For patients with unresectable locally advanced, recurrent, or metastatic gastric adenocarcinoma assessment for HER2-neu overexpression should be performed using immunohistochemistry (IHC) and/or fluorescence in situ hybridization (FISH), following the 4-tier scoring system developed by Hoffman et al, which was also used in the ToGA trial (Table 1). In a subsequent validation study, this scoring system was also found to be reproducible between different pathologists. Surgical and biopsy specimens with intense immunoreactivity in less than 10% of cancer cells (IHC score = 0) and those with faint or barely perceptible membranous reactivity in 10% or more of cancer cells (IHC score = 1) are considered negative for HER2-neu overexpression. Specimens with strong complete, basolateral or lateral membranous reactivity in 10% or more of cancer cells (IHC score = 3) in resection specimens, or in a cluster of 5 or more tumor cells in biopsy specimens, are considered positive for
HER2-neu overexpression. In cases showing weak to moderate complete, basolateral or lateral membranous reactivity in more than 10% of cancer cells (IHC score = 2), the HER2-neu overexpression is considered equivocal. The panel recommends that cases showing less than 3+ overexpression of HER2-neu by IHC should be additionally confirmed by FISH or other in situ hybridization methods.

To summarize, it is better to request IHC first; if the IHC score is 3+ then there is no need to request FISH; however, if the IHC score is 2+, FISH should be requested and if there is evidence of HER2-neu amplification by FISH, trastuzumab can be recommended. Trastuzumab is not recommended if IHC score is 0 or 1+.

Surgery
Surgery is the primary treatment for early stage gastric cancer. Complete resection with adequate margins (4 cm or greater) is widely considered as a standard goal, whereas the type of resection (subtotal versus total gastrectomy) along with extent of lymphadenectomy remains a subject of controversy.

Principles of Surgery
The primary goal of surgery is to accomplish a complete resection with negative margins (R0 resection). Only 50% of patients will end up with an R0 resection of their primary. R1 indicates microscopic residual disease (positive margins); and R2 indicates gross (macroscopic) residual disease in the absence of distant metastasis.

Subtotal gastrectomy is the preferred approach for distal gastric cancers. This procedure has a similar surgical outcome compared to total gastrectomy although with significantly fewer complications. Proximal gastrectomy and total gastrectomy are both indicated for proximal gastric cancers and are typically associated with postoperative nutritional impairment.

Clinical staging using CT scan with or without EUS should be performed before surgery to assess the extent of the disease. Proximal and distal margins of 4 cm or greater from the gross tumor are preferred. The guidelines recommend distal, subtotal or total gastrectomy for T1b-T3 tumors. T4 tumors require en bloc resection of involved structures. Routine or prophylactic splenectomy should be avoided if possible. In a randomized clinical study, postoperative mortality and morbidity rates were slightly higher in patients who underwent total gastrectomy combined with splenectomy, and marginally better survival, but there were no statistically significant differences between the groups. The results of this study do not support the use of prophylactic splenectomy to remove macroscopically negative lymph nodes near the spleen in patients undergoing total gastrectomy for proximal gastric cancer. Placement of a jejunostomy feeding tube may be considered for selected patients who will be receiving postoperative chemoradiation.

Carcinomas are considered unresectable if there is evidence of peritoneal involvement, distant metastases, or locally advanced disease such as (invasion or encasement of major blood vessels. Limited gastric resection, even with positive margins is acceptable for unresectable tumors for symptomatic palliation of bleeding. Gastric resections should be reserved for the palliation of symptoms (obstruction or uncontrollable bleeding) in patients with incurable disease. Lymph node dissection is not required. Gastric bypass with gastrojejunostomy to the proximal stomach instead of self-expanding metal stent placement is preferred in symptomatic patients, if they are fit for surgery and have a reasonable prognosis due to lower rate of
recurrent symptoms. Placement of venting gastrotomy and/or a feeding jejunostomy tube may be considered.

Lymph Node Dissection
Gastric resection should include lymph node dissection (or lymphadenectomy) which involves the removal of regional lymph nodes. A recent retrospective analysis has shown that more extensive lymph node dissection and analysis influences survival in patients with advanced gastric cancer. This analysis included 1,377 patients diagnosed with advanced gastric cancer in the Surveillance Epidemiology and End Results (SEER) database. Patients who had more than 15 N2 nodes and more than 20 N3 nodes examined had the best long-term survival outcomes. However, the extent of lymph node dissection remains controversial. The Japanese Research Society for the Study of Gastric Cancer has established guidelines for pathologic examination and evaluation of lymph node stations that surround the stomach. The perigastric lymph node stations along the lesser curvature (stations 1, 3, and 5) and greater curvature (stations 2, 4, and 6) of the stomach are grouped together as N1. The nodes along the left gastric artery (station 7), common hepatic artery (station 8), celiac artery (station 9), and splenic artery (stations 10 and 11) are grouped together as N2. More distant nodes, including para-aortic (N3 and N4), are regarded as distant metastases.

Lymph node dissection may be classified as D0, D1 or D2 depending on the extent of lymph nodes removed at the time of gastrectomy. D0 refers to incomplete resection of N1 lymph nodes. D1 involves gastrectomy and the removal of the involved proximal or distal part of the stomach or the entire stomach (distal or total resection), including the greater and lesser omental lymph nodes (which would include the lymph nodes along the right and left cardiac, along lesser and greater curvature, suprapyloric along the right gastric artery and infra pyloric area). D2 involves D1 plus the removal of the anterior leaf of the transverse mesocolon and all the nodes along the corresponding arteries (left gastric artery, common hepatic artery, celiac artery, splenic hilum and splenic artery). A splenectomy (to remove stations 10 and 11) is required for a D2 lymph node dissection for proximal gastric tumors. The technical aspects of performing a D2 lymph node dissection require a significant degree of training and expertise.

Gastrectomy with D2 lymph node dissection is the standard treatment for curable gastric cancer in eastern Asia. In a randomized controlled trial (JCOG9501), Japanese investigators comparing D2 lymph node dissection alone with D2 lymphadenectomy with para-aortic nodal dissection (PAND) in patients undergoing gastrectomy for curable (T2b, T3 or T4) gastric cancer reported a postoperative mortality rate of 0.8% in each arm. The final results of this study showed that D2 lymphadenectomy with PAND does not improve survival rate in curable gastric cancer, compared to D2 lymphadenectomy alone. The 5-year overall survival rates were 70.3% and 69.2% respectively. There were also no significant differences in the relapse-free survival rates between the two groups. In a post hoc subgroup analysis, among patients with pathologically negative nodes, the survival rates were better for patients who underwent D2 lymphadenectomy plus PAND than those who were assigned to D2 lymphadenectomy alone, whereas in patients with metastatic nodes, the survival rates were worse for those assigned to D2 lymphadenectomy plus PAND. However, the investigators of this study caution that these results from post hoc analysis could be false positive due to multiple testing and the survival benefit of D2 lymphadenectomy plus PAND in node-negative patients need to be clarified in further studies. The investigators concluded that D2
lymphadenectomy plus PAND should not be used to treat patients with curable gastric cancer (T2b, T3 or T4).

Japanese investigators have often emphasized the value of extensive lymph node dissection (D2). However, Western investigators have not found a survival advantage for extensive lymph node dissection compared with a D1 lymph node dissection.58-61

In the Dutch Gastric Cancer Group Trial, 711 patients who underwent surgical resection with curative intent were randomized to undergo either a D1 or D2 lymphadenectomy.60 Both the postoperative morbidity (25% vs. 43%, P < .001) and mortality (4% vs. 10%, P = .004) were higher for patients who underwent D2 lymph node dissection, with no difference in overall survival (30% vs. 35%, P = .53) between the two groups. In a subset analysis, patients with N2 cancer undergoing a D2 lymphadenectomy showed a trend towards improved survival. Unfortunately, N2 cancer can only be detected after microscopic examination of the surgical specimen. After a median follow-up of 15 years, D2 lymphadenectomy was associated with lower local (12% vs. 22%) regional recurrence (13% vs. 19%) and gastric-cancer-related death rates (37% vs. 48%) than D1 lymphadenectomy. However, the D2 lymphadenectomy was also associated with significantly higher postoperative mortality, morbidity, and reoperation rates.62

The British Cooperative trial conducted by the Medical Research Council also failed to demonstrate a survival benefit for D2 over D1 lymphadenectomy.59 The 5-year overall survival rates were 35% and 33% respectively, for D1 and D2 lymph node dissections. In addition, the D2 lymph node dissection was associated with increased postoperative morbidity and mortality. Both these trials found that splenectomy and pancreatectomy performed along with the D2 lymph node dissection significantly increased the mortality and morbidity.

Despite these results, interest in extensive lymph node dissections (D2 and greater) has not waned.63 Investigators have argued that if the complication rate after a D2 lymph node dissection could be decreased then there may be a benefit in selected patients. A surgical option that may decrease morbidity and mortality is a modified D2 lymph node dissection without pancreatectomy and splenectomy.64-67

The phase II study conducted by the Italian Gastric Cancer Study Group (IGCSG) reported a survival benefit for pancreas-preserving D2 lymphadenectomy when performed in experienced cancer centers.68, 69 The 5-year overall survival rate among all eligible patients was 55%. The overall 5-year morbidity rate was 20.9% and a postoperative in-hospital mortality rate was 3.1% for D2 lymph node dissection without pancreatectomy.68 These rates are comparable to the rates for D1 lymph node dissections in the Dutch and United Kingdom trial. The inclusion of pancreatectomy and splenectomy in D2 lymph node dissection resulted in increased morbidity and mortality.

Other reports from Western countries have also shown better outcomes for D2 lymphadenectomy when performed according to the recommendations of Japanese Research Society of Gastric cancer. In an Austrian study, 5-year and 10-year overall survival rates were 45.7% and 34.3% respectively.70 For patients who underwent curative surgery, 5-year and 10-year survival rates were 57.7% and 44.3% respectively, which are comparable to those reported in Japanese trials. Postoperative mortality rates for R0, R1/R2 and palliative resections were 4.9%, 9% and 13.4% respectively. However, cross-trial comparisons result in weak evidence and conclusions.

Sierra and colleagues from a single institution in Spain reported longer 5-year survival rates in the D2 group (50.6%) than the D1 group (41.4%).71 No significant differences were seen in morbidity (48.2% and
53.5% respectively for D1 and D2). Operative mortality rate was 2.3% for D1 and 0% for D2 lymph node dissection. Pancreatectomy, hepatic wedge resection or partial colectomy was performed only for macroscopic invasion.

In a recent analysis involving patients from the Intergroup 0116 adjuvant chemoradiation trial, Enzinger and colleagues assessed the impact of hospital volume on the outcome of patients who underwent lymphadenectomy.\(^2\) Patients were stratified into two groups: those who underwent D0 lymph node dissection (54%) and those who underwent D1 or D2 resection (46%). For patients who underwent D0 lymph node dissection, high-volume centers did not have any effect on overall or disease-free survival. However, there was a trend toward improved overall survival among patients who underwent D1 or D2 lymph node dissection at moderate to high volume cancer centers. In a recent meta-analysis that compared D1 vs. D2 lymph node dissections, among patients who underwent D2 lymph node dissections, there was a trend toward improved survival for patients who did not undergo resection of the spleen or pancreas, as well as for patients with T3 or T4 cancers.\(^3\)

In the West, D2 lymph node dissection is considered a recommended but not required operation. Modified D2 lymph node dissection (without pancreatectomy and splenectomy) is associated with low mortality and reasonable survival times when performed in institutions that have sufficient experience with the operation and postoperative management.\(^4\)

The panel recommends that gastric cancer surgery should be performed by experienced surgeons in high volume centers and should include removal of perigastric lymph nodes (D1) and those along the named vessels of the celiac axis (D2), with a goal of examining 15 or more lymph nodes.\(^5,6\)

**Endoscopic Therapies**

Endoscopic mucosal resection (EMR) and endoscopic submucosal dissection (ESD) have been used as alternative to surgery for the treatment of patients with early stage gastric cancer. The applicability of these techniques in the United States is limited because of the low incidence of early gastric cancer.

EMR represents a major advance in minimally invasive approaches in the GI tract.\(^7\) Most of the experience with EMR for early gastric cancer has been gained by countries with a high incidence of gastric cancer and an active screening program.\(^8\) En-bloc excision by ESD has been shown to be more effective than EMR in curing early gastric cancer.\(^9\) In a multicenter retrospective study of endoscopic resection in patients with early gastric cancer, the 3-year cumulative residual-free or recurrence-free rate in the ESD group (97.6%) was significantly higher than that in the EMR group (98% and 93% respectively).\(^10\) The complete resection rates were significantly better for ESD for lesions more than 5 mm in diameter whereas the rates were not different between EMR and ESD for lesions less than 5 mm in diameter regardless of location.\(^11-13\) ESD requires greater skills and instrumentation to perform and is also associated with higher rates of bleeding and perforation complications.

No randomized studies have compared EMR with other surgical techniques for GI tract cancers. Nevertheless, EMR continues to evolve as a promising technology in the diagnosis and treatment of early gastric cancers. Since long-term follow-up and survival data are lacking, the routine use of endoscopic techniques is not recommended.
outside a clinical trial and should be limited to medical centers with extensive experience.

**Principles of Endoscopy**

Endoscopy has become an important tool in the diagnosis, staging, treatment and palliation of patients with gastric cancer. Most endoscopy procedures are performed with the aid of conscious sedation or monitored anesthesia provided by the endoscopist, nurse, a nurse anesthetist, or an anesthesiologist. Some patients who are at risk of aspiration during endoscopy may require general anesthesia.

**Diagnosis**

Diagnostic endoscopies are performed to determine the presence and location of a gastric cancer and to biopsy any suspicious lesions. Multiple biopsies (8-10), using standard size endoscopy forceps should be performed to provide sufficient material for histologic interpretation, especially in the setting of an ulcerated lesion. Larger forceps may improve the yield. Cytologic brushings or washings are rarely adequate in the initial diagnosis, but can be useful in confirming persistent disease following treatment.

For proximal tumors, the location of tumor in the stomach (cardia, fundus, body, antrum, and pylorus) relative to the EGJ should be carefully recorded to assist with treatment planning and follow-up. EMR of focal nodules (1.5 cm or smaller) can be performed in the setting of early stage disease to provide accurate staging of the tumor, with the potential of being therapeutic.

**Staging**

EUS provides accurate initial clinical staging of locoregional gastric cancer. EUS performed prior to any treatment provides evidence of depth of tumor invasion (T), presence of abnormal or enlarged lymph nodes likely to harbor cancer (N), and occasionally signs of distant spread, such as lesions in surrounding organs (M) or the presence of ascites. This is especially important in patients who are being considered for endoscopic resection.

Perigastric lymph nodes are readily identified by EUS, and the identification of enlarged, hypoechoic (dark), homogeneous, well circumscribed, rounded structures in these areas indicates the presence of malignant or inflammatory lymph nodes. The accuracy of this diagnosis is significantly increased with the combination of features, but also confirmed with the use of fine needle aspiration (FNA) biopsy for cytology assessment. FNA of suspicious lymph nodes should be performed without traversing an area of primary tumor or major blood vessels. The combined use of EUS and FNA is an accurate method for diagnosis of gastric submucosal tumor and for differentiating potentially malignant lesions.

**Treatment**

Proper patient selection is essential when employing endoscopic or limited wedge gastric resections. The probability of lymph node metastasis in early gastric cancer is influenced by the tumor characteristics and increases with increasing tumor size, submucosal invasion, poorly differentiated tumors, and lymphatic and vascular invasion. Indications for definitive EMR for gastric cancer include carcinoma in situ (Tis), well or moderately differentiated lesions confined to mucosa (T1a) without evidence of ulceration, lymph node metastases or lymphovascular invasion.

Endoscopic tumor ablation can be performed for the short-term control of bleeding. Endoscopic insertion of expandable metal stents is effective in long-term relief of tumor obstruction at the EGJ or the
gastric outlet, though surgical gastrojejunostomy may be more efficacious for those with longer-term survival.93, 94

Long-term palliation of anorexia, dysphagia or malnutrition may be achieved with endoscopic or radiographic assisted placement of feeding gastrostomy (PEG) in carefully selected cases where the distal stomach is uninvolved by tumor, or the placement of a feeding jejunostomy (PEJ).95

**Post-treatment Surveillance**

EUS performed after chemotherapy or RT has a reduced ability to accurately determine the post-treatment stage of disease.96 Similarly, biopsies performed after chemotherapy or RT may not accurately diagnose the presence of residual disease.97

Endoscopic surveillance following definitive treatment of gastric cancer requires careful attention to detail for mucosal surface changes, and multiple biopsies of any visualized abnormalities. Strictures should be biopsied to rule out neoplastic cause. EUS performed in conjunction with endoscopy exams has a high sensitivity for recurrent disease.98 EUS-guided FNA should be performed if suspicious lymph nodes or areas of wall thickening are seen.

**Laparoscopic Resection**

Laparoscopic resection is an emerging surgical approach which offers important advantages (less blood loss, reduced postoperative pain, accelerated recovery, early return to normal bowel function and reduced hospital stay) when compared with open surgical procedures for patients with gastric cancer.99 A prospective randomized study conducted by Hulscher and colleagues compared early and 5-year clinical outcomes of laparoscopic and open subtotal gastrectomy in 59 patients with distal gastric cancer.100 Operative mortality rates (3.3% vs. 6.7% respectively), 5-year overall (58.9% vs. 55.7% respectively) and disease-free survival rates (57.3% vs. 54.8% respectively) were better for the laparoscopic group, though not significant. However, the role of this approach in the treatment of gastric cancer requires further investigation in larger randomized clinical trials.

**Radiation Therapy**

Radiation therapy (RT) has been assessed in randomized trials in both the preoperative and postoperative setting in patients with resectable gastric cancer. Smalley and colleagues have reviewed clinical and anatomic issues related RT and offer detailed recommendations for the application of RT for the management of patients with resected gastric cancer.101 Two randomized trials have compared surgery alone to surgery plus RT in patients with gastric cancer. In the first trial conducted by the British Cancer Stomach Group, 432 patients were randomized to undergo surgery alone or surgery followed by RT or chemotherapy.102 At 5-year follow-up, no survival benefit was seen for patients receiving postoperative RT or chemotherapy compared with those who underwent surgery alone. But there was a significant reduction in locoregional recurrence with the addition of RT to surgery (27% with surgery vs. 10% for surgery plus RT and 19% for surgery plus chemotherapy). In the second trial Zhang and colleagues randomized 370 patients to preoperative RT or surgery alone. There was a significant improvement in survival with preoperative RT (30% vs. 20%, \( P = .0094 \)).103 Resection rates were also higher in the preoperative RT arm (89.5%) compared to surgery alone (79%), suggesting that preoperative RT improves local control and survival.

The results from a recent systematic review and meta-analysis showed a statistically significant 5-year survival benefit with the addition of RT in
patients with resectable gastric cancer. However, randomized trials are needed to confirm these results in patients from the Western Hemisphere.

External-beam RT (45-50.4 Gy) as a single modality has minimal value in patients with locally unresectable gastric cancer and does not improve survival. However, when used concurrently with 5-fluorouracil, external-beam RT improves survival. Moertel and colleagues assessed 5-fluorouracil plus RT compared with RT alone in the treatment of locally unresectable gastric cancer. Patients receiving combined modality treatment had a significantly better median survival (13 vs. 6 months) and 5-year overall survival (12% vs. none). In another study by the Gastrointestinal Tumor Study Group (GITSG), 90 patients with locally advanced gastric cancer were randomized to receive either combination chemotherapy with 5-fluorouracil and methyl-CCNU (lomustine) or split-course RT with a concurrent intravenous bolus of 5-fluorouracil followed by maintenance 5-fluorouracil and methyl-CCNU. In the first 12 months mortality was higher in the combined modality group. At 3 years the survival curve reached a plateau in the combined modality arm, but tumor-related deaths continued to occur in the chemotherapy alone arm, suggesting that a small fraction of patients can be cured with combined modality treatment. In most of the randomized trials, combined modality treatment showed advantage over RT alone in relatively few patients with unresectable cancer, as reviewed by Hazard and colleagues.

Intensity modulated radiation therapy (IMRT) has great potential to reduce radiation-related toxicity by delivering large doses of radiation to target tissues. The use of this technique in gastric cancer remains investigational and the impact of new conformal radiotherapy technologies needs to be assessed in randomized clinical trials.

Principles of Radiation Therapy

RT (preoperative, postoperative or palliative) can be an integral part of treatment for gastric cancer. All patients should be simulated and treated in the supine position. The panel encourages the use of CT simulation and 3D treatment planning. Intravenous and/or oral contrast may be used when appropriate for CT simulation to aid target localization. Use of an immobilization device is strongly recommended for reproducibility.

The panel recommends involvement of a multidisciplinary team, which should include medical, radiation and surgical oncologists, radiologists, gastroenterologists and pathologists to determine optimal diagnostic, staging and treatment modalities. Pretreatment diagnostic studies such as EUS, upper GI endoscopy and CT scans should be used to identify tumor and pertinent nodal groups. The relative risk of nodal metastases at a specific location is dependent on the location of the primary tumor and the extent of invasion of the gastric wall. It may be possible to accurately target high-risk areas and to produce superior dose distributions with the use of 3D treatment planning systems and unconventional field arrangements. To accomplish this, it is necessary to carefully define and encompass various target volumes.

The panel recommends a dose range of 45-50.4 Gy delivered in fractions of 1.8 Gy per day. Every effort should be made to reduce unnecessary radiation doses to vital organs such as liver, kidneys, spinal cord, heart (especially the left ventricle) and lungs. Lung dose volume histogram (DVH) parameters should be considered as predictors of pulmonary complications in patients with gastric and EGI cancers treated with concurrent chemoradiation, though optimal criteria have not yet emerged. Optimal criteria for DVH parameters are being actively developed in NCCN member institutions.
Custom blocking is necessary to limit the volume of normal organs receiving high RT doses (less than 30 Gy to 60% of liver), kidneys (less than 20 Gy to at least 60% of one kidney), spinal cord (less than 45 Gy), heart (less than 50 Gy to 30% of heart and effort should be made to keep the left ventricle doses to a minimum) and lungs (20 Gy or more to 20% and 10 Gy or more to 40%) to reduce incidence of postoperative pulmonary complications. These guidelines may be exceeded as needed to achieve other important planning goals, and as further information becomes available. IMRT may be appropriate in selected cases to reduce dose to normal structures such as heart and lungs. In designing IMRT plans, for structures such as the lungs, attention should be given to the volume receiving low to moderate doses, as well as the volume receiving high doses.

Close patient monitoring and aggressive supportive care are essential during radiation treatment. Management of acute toxicities is necessary to avoid treatment interruptions or dose reductions. Antiemetics should be given for prophylaxis when appropriate. Antacid and antidiarrheal medications may be prescribed when needed. If the caloric intake is inadequate, enteral and/or parenteral nutrition should be considered. Oral and/or intravenous hydration is often necessary throughout chemoradiation and early recovery. Feeding jejunostomies may be placed if clinically indicated. It is essential to monitor levels of B12, iron and calcium in postoperative patients. Oral supplementation is recommended to maintain adequate levels.

Combined Modality Treatment: Concurrent Chemotherapy and Radiation Therapy

Preoperative Chemoradiation Therapy

In a pilot study, Lowy and colleagues assessed the feasibility of preoperative chemoradiation (45 Gy of external beam RT with concurrent continuous infusion of 5-fluorouracil) followed by surgery and IORT (10 Gy) in the treatment of patients with potentially resectable gastric cancer. Significant pathologic responses were seen in 63% of patients and complete pathologic response was seen in 11% of patients who received preoperative chemoradiation. Eighty three percent of patients who received chemoradiation therapy underwent D2 lymphadenectomy. In a prospective, randomized trial, preoperative chemoradiation with fluorouracil and cisplatin followed by surgery was superior to surgery alone in patients with resectable adenocarcinoma of the esophagus (74 patients) and gastric cardia (39 patients); the median survival was 16 months and 11 months respectively, for patients assigned to multimodal therapy and surgery alone (p = 0.01).

Preoperative Sequential Chemotherapy and Chemoradiation Therapy

Recent studies have also shown that sequential preoperative induction chemotherapy followed by chemoradiation yields a substantial pathologic response that results in durable survival time.

In the RTOG 9904 study, preoperative induction chemotherapy with fluorouracil and cisplatin followed by concurrent chemoradiation with infusional fluorouracil and paclitaxel resulted in a pathologic complete response rate of 26% of patients with localized gastric adenocarcinoma. D2 lymphadenectomy and R0 resection were achieved in 50% and 77% of patients respectively.

In a phase II study, preoperative chemotherapy with irinotecan and cisplatin followed by concurrent chemoradiation with the same regimen resulted in moderate response rates in patients with resectable locally advanced gastric and EGJ adenocarcinoma. R0 resection was
achieved in 65% of patients. Median survival and the actuarial 2-year survival rate were 14.5 months and 35% respectively.115

In a recent phase III study, Stahl et al. compared preoperative chemotherapy (cisplatin, fluorouracil and leucovorin) with chemoradiation therapy using the same regimen in 119 patients with locally advanced adenocarcinoma of the EGJ.114 Patients with locally advanced adenocarcinoma of the lower esophagus or EGJ were randomized between two treatment groups: chemotherapy followed by surgery (arm A) or chemotherapy followed by chemoradiation followed by surgery (arm B). Patients in arm B had a significantly higher probability of achieving pathologic complete response (15.6% vs. 2.0%) or tumor-free lymph nodes (64% vs. 38%) at resection. Preoperative chemoradiation improved 3-year survival rate from 28% to 47%

Although the study was closed prematurely due to low accrual and statistical significance was not achieved, there was a trend towards survival advantage for preoperative chemoradiotherapy compared with preoperative chemotherapy for patients with EGJ adenocarcinoma.

The value of preoperative chemoradiation therapy for patients with resectable gastric cancer remains uncertain and is the subject of an ongoing international prospective phase III randomized trial.116

Postoperative Chemoradiation Therapy

Limited reports from randomized trials of postoperative RT with or without chemotherapy after a complete resection with negative margins did not reveal a clear survival advantage.117, 118

The landmark Intergroup trial SWOG 9008/INT-0116 investigated the effect of surgery plus postoperative chemoradiation on the survival of patients with resectable adenocarcinoma of the stomach or EGJ.119 In this trial 556 patients with resectable adenocarcinoma of the stomach or EGJ (stage IB-IV, M0 according to 1988 AJCC staging criteria) were randomly assigned to surgery alone (n=275) or surgery plus postoperative chemoradiation [n=281; 5-fluorouracil and leucovorin before and after concurrent chemoradiation with 5-fluorouracil and leucovorin, delivered in five monthly cycles of bolus chemotherapy (5-fluorouracil and leucovorin) with RT (45 Gy) concurrent with cycles 2 and 3]. Patients were at high risk for relapse; more than two thirds of them had T3 or T4 tumors and 85% of patients had node positive disease. Resection of all detectable disease was required for participation in the trial. Postoperative chemoradiation was offered for all patients with tumors T1 or higher, with or without lymph node metastases. Postoperative chemoradiation therapy significantly improved overall survival and RFS for all patients at high risk for recurrence of adenocarcinoma of the stomach or EGJ. Median overall survival in the surgery only group was 27 months, as compared with 36 months in the chemoradiation group. The hazard ratio for death was 1.35. The chemoradiation group had better 3-year overall (50% vs. 41%) and relapse-free survival rates (48% vs.31%) than the surgery only group. There was also a significant decrease in local failure as the first site of failure (19% vs. 29%) in the chemoradiation group.

With more than 10 years of median follow-up, survival remains improved in patients with stage IB-IV (M0) gastric cancer or EGJ adenocarcinoma treated with postoperative chemoradiation. No increases in late toxic effects were noted.120 D2 lymph node dissection was not recommended and patients were not excluded on the basis of the extent of lymphadenectomy. Only 10% of patients had the D2 lymph node dissection. D1 lymph node dissection was performed in 36% of the patients and 54% underwent D0 lymph node dissection. It should be noted that surgery was not part of this protocol and patients...
were eligible for the study only after recovery from surgery. Nevertheless, the results of this study have established postoperative chemoradiation therapy as a standard of care in patients with resected gastric cancer who have not received preoperative therapy.

In a recent retrospective analysis that compared the outcome of patients treated with surgery alone and patients treated with postoperative fluoropyrimidine-based chemoradiation in several Dutch phase I/II studies, postoperative chemoradiation was associated with significantly lower recurrence rates after D1 lymph node dissection (2% for those who underwent D1 lymph node dissection followed by postoperative chemoradiation compared to 8% for patients who underwent D1 lymph node dissection alone; \( \text{p} = 0.001 \)) whereas there was no significant difference in recurrence rates between the two groups following D2 lymph node dissection.\(^{121}\)

The recently completed phase III trial (ARTIST trial; \( n = 458 \)) which compared postoperative chemoradiation (capecitabine and cisplatin plus RT) with postoperative chemotherapy with the same regimen after curative D2 lymph node dissection of gastric cancer also showed that postoperative chemoradiation did not significantly improve disease-free survival for this group of patients.\(^{122}\) Patients with T2a, N0 tumors, microscopically positive resection margin, involvement of M1 lymph node or distant metastases and those who had undergone gastrectomy with D1 lymph node dissection were excluded from this study. At a median follow-up of 53 months, the estimated 3-year disease-free survival rates were 78% and 74% respectively for postoperative chemoradiation and chemotherapy (\( \text{p} = 0.0862 \)). However, in the subgroup analysis of patients with positive pathologic lymph nodes, postoperative chemoradiation was associated with a statistically significant prolongation of 3-year disease-free survival compared to chemotherapy alone (77.5% and 72%, respectively; \( \text{p} = 0.0365 \)).\(^{122}\)

Alternative postoperative chemoradiation regimens with newer agents and RT techniques have been evaluated in non-randomized studies. Leong et al reported that postoperative chemotherapy with epirubicin, cisplatin, and 5-FU (ECF) before and after concurrent chemoradiation with infusional fluorouracil was safe and effective in patients with completely resected gastric adenocarcinoma.\(^{123}\) At a median follow-up of 36 months, the estimated 3-year overall survival rate was 62%. In a pilot study, postoperative adjuvant chemoradiation regimen of fluorouracil and cisplatin before and after capecitabine and concurrent RT was well tolerated in patients with completely resected stage III-IV, M0 gastric cancer.\(^{124}\) The 3-year disease free and overall survival rates were 82.7% and 83.4%, respectively. However, in the randomized Intergroup trial (CALGB 80101), postoperative chemoradiation with ECF before and after 5-FU and RT did not improve survival compared to the INT0116 regimen in patients who have undergone curative resection for gastric or EGJ adenocarcinoma.\(^{125}\)

**Chemotherapy**

**Postoperative Chemotherapy**

Postoperative chemotherapy following complete resection has not been associated with a significant survival benefit in patients with gastric cancer.\(^{126-131}\) In the randomized trial conducted by Japan Clinical Oncology Group (JCOG 8801) curative surgery alone was associated with very good survival rates in patients with T1 cancer.\(^{126}\) However, two recent large Asian randomized phase III studies (ACTS GC trial and CLASSIC trial) have documented survival benefit for postoperative chemotherapy after curative D2 lymph node dissection in patients with gastric cancer.\(^{132, \ 133}\)
ACTS GC trial in Japan evaluated the efficacy of postoperative chemotherapy with a novel oral fluoropyrimidine S-1 [combination of tegafur (prodrug of 5-fluorouracil; 5-chloro-2,4-dihydropyridine) and oxonic acid] in patients with stage II (excluding T1) or stage III gastric cancer who underwent R0 gastric resection with D2 lymph node dissection. In this study, 1,059 patients were randomized to surgery alone or surgery followed by postoperative chemotherapy with S-1.132 The 3-year overall survival rate was 80.1% and 70.1% respectively, for S-1 group and surgery alone. Hazard ratio for death in the S-1 group was 0.68. The 5-year follow-up data also confirmed these findings.134 This is the first time postoperative chemotherapy has been shown to be beneficial after D2 resection in the Japanese patient population.

The CLASSIC trial (conducted in South Korea, China and Taiwan) evaluated postoperative chemotherapy with capecitabine and oxaliplatin after curative D2 gastrectomy in patients with stage II-IIIB gastric cancer; at least 15 lymph nodes were removed to ensure adequate disease classification.133 In this study, 1035 patients were randomized to surgery alone or surgery followed by postoperative chemotherapy.133 The planned interim analysis of this trial (after a median follow-up of 34.2 months) showed that postoperative chemotherapy with capecitabine and oxaliplatin significantly improved disease-free survival compared to surgery alone for all disease stages (II, IIIA and IIIB). The 3-year disease-free survival rates were 74% and 59% respectively (p < 0.0001). The lack of difference in overall survival is most likely due to inadequate length of follow-up but the overall survival is expected to become significant.

The results of these studies support the use of postoperative chemotherapy after curative surgery with D2 lymph node dissection in patients with resectable gastric cancer. However, it should be noted that the benefit of this approach following a D1 or D0 lymph node dissection has not been documented in randomized clinical trials. Postoperative chemotherapy trials in the West have consistently lacked efficacy for survival. Thus postoperative chemoradiation remains an effective treatment of choice for this group of patients.119,121 S-1 remains an investigational agent in North America.

**Perioperative Chemotherapy**

The British Medical Research Council performed the first well-powered phase III trial (MAGIC trial) for perioperative chemotherapy.135 In this trial, 503 patients were randomized to receive either perioperative chemotherapy [preoperative and postoperative chemotherapy with ECF] and surgery or surgery alone. In each group, 74% of patients had stomach cancer, 14% had lower esophageal cancer and 11% had cancer of EGJ. The perioperative chemotherapy group had a greater proportion of pathologic T1 and T2 tumors (51.7%) than the surgery group (36.8%). Five-year survival rates were 36% among those who received perioperative chemotherapy and 23% in the surgery group. Perioperative chemotherapy with the ECF regimen significantly improved progression-free and overall survival in patients with operable gastric and lower esophageal adenocarcinomas. The results of this study have established perioperative chemotherapy as another added option to the standard of care for patients with resectable gastric cancer.

**Chemotherapy for Advanced or Metastatic Disease**

Chemotherapy can provide palliation, improved survival and quality of life compared to best supportive care in patients with advanced and metastatic disease.136,137 Chemotherapy regimens including older agents (mitomycin, 5-fluorouracil, cisplatin, and etoposide) as well as newer agents (irinotecan, oral etoposide, paclitaxel, docetaxel and
pegylated doxorubicin\textsuperscript{141-154} have demonstrated activity in patients with advanced gastric cancer.

In the early 1980s, FAM (5-fluorouracil, doxorubicin, and mitomycin) was considered the gold standard for patients with advanced gastric cancer.\textsuperscript{155} The pivotal study performed by the North Central Cancer Treatment Group (NCCTG) comparing FAM to 5-fluorouracil alone and 5-fluorouracil plus doxorubicin showed no significant survival difference between all 3 arms.\textsuperscript{156} Higher response rates were observed in patients who received combination chemotherapy versus 5-fluorouracil alone. Several randomized studies have compared various fluorouracil-based combination regimens [FAM vs. FAMTX (5-fluorouracil, adriamycin, and methotrexate),\textsuperscript{157} FAMTX vs. ECF (epirubicin, cisplatin, and 5-fluorouracil),\textsuperscript{158} FAMTX vs. ELF (etoposide, leucovorin, and 5-fluorouracil) vs. 5-fluorouracil plus cisplatin,\textsuperscript{159} and ECF vs. MCF (mitomycin, cisplatin, 5-fluorouracil)\textsuperscript{160}] ECF demonstrated improvements in median survival and quality of life when compared to FAMTX or MCF regimens.

The combination of fluorouracil, leucovorin and oxaliplatin has been evaluated as an alternative to cisplatin and fluorouracil in patients with advanced or metastatic gastric cancer.\textsuperscript{161, 162} Recently, a phase III trial conducted by the German Study Group showed that the combination of fluorouracil, leucovorin and oxaliplatin (FLO) had a trend toward improved median progression-free survival compared to fluorouracil, leucovorin and cisplatin (FLP) (5.8 vs. 3.9 months).\textsuperscript{163} However, there were no significant differences in median overall survival (10.7 vs. 8.8 months, respectively) between the two groups. FLO was associated with significantly less toxicity than FLP. In patients older than 65 years, FLO resulted in significantly superior response rates (41.3\% vs.16.7\%), time to treatment failure (5.4 vs. 2.3 months), progression-free survival (6.0 vs. 3.1 months), and an improved overall survival (13.9 vs. 7.2 months) compared with FLP.

The combination of docetaxel, cisplatin and 5-fluorouracil was evaluated in a randomized multinational phase III study (V325). In this trial, 445 untreated patients with advanced gastric cancer were randomized to receive either docetaxel, cisplatin and 5-fluorouracil (DCF) every 3 weeks or cisplatin and fluorouracil (CF).\textsuperscript{164} Majority of patients had advanced gastric cancer and 19-25\% of patients had EGJ cancer. At a median follow-up of 13.6 months, time to progression was significantly longer with DCF compared with CF (5.6 vs. 3.7 months; p < 0.001). The median overall survival was significantly longer for DCF compared with CF (9.2 months vs. 8.6 months; p = 0.02), at a median follow-up of 23.4 months; the overall confirmed response rate was also significantly higher with DCF than CF (37\% and 25\%, respectively; p = 0.01).\textsuperscript{164} In 2006, based on the results of this study, FDA (Food and Drug Administration) approved DCF regimen for the treatment of patients with advanced gastric cancer, including EGJ cancers, in patients who have not received prior chemotherapy.

In a subsequent randomized phase II trial of the Swiss Group for Clinical Cancer Research, a trend towards better overall response rate was observed in patients with advanced gastric cancer treated with DCF compared to those who received ECF or docetaxel plus cisplatin.\textsuperscript{165} However, DCF was associated with increased myelosuppression and infectious complications.

Various modifications of DCF regimen with an intent to improve tolerability are being evaluated in clinical trials for patients with advanced gastric cancer.\textsuperscript{166-169} In a recent randomized phase II trial, treatment with docetaxel, oxaliplatin and 5-fluorouracil had a better safety profile and was also associated with improved TTP, RR and
median overall survival (7.7 months, 47% and 15 months respectively) compared to docetaxel and oxaliplatin (4.5 months, 23% and 9 months respectively) and docetaxel, oxaliplatin and capecitabine (5.6 months, 26% and 11 months respectively) in patients with advanced gastric cancer.\textsuperscript{168}

Capecitabine is an orally administered fluoropyrimidine which is converted to 5-fluorouracil intracellularly. Several studies have evaluated capecitabine, as a single agent or in combination regimens, in patients with advanced gastric and EGJ cancers.\textsuperscript{170-173} Two phase III trials (REAL-2 and ML 17032) have compared the efficacy and safety of capecitabine-based combinations and fluorouracil-based combinations in patients with advanced gastric cancer.\textsuperscript{174, 175}

The REAL-2 (with 30% of patients having an esophageal cancer) trial was a randomized multicenter phase III study comparing capecitabine with fluorouracil and oxaliplatin with cisplatin in 1003 patients with advanced esophagogastric cancer.\textsuperscript{174} Patients with histologically confirmed adenocarcinoma, squamous or undifferentiated cancer of the esophagus, EGJ or stomach were randomized to receive one of the four epirubicin-based regimens [ECF, epirubicin, oxaliplatin, 5-fluorouracil (EOF), epirubicin, cisplatin and capecitabine (ECX) and epirubicin, oxaliplatin and capecitabine (EOX)]. Median follow-up was 17.1 months. Results from this study suggest that capecitabine and oxaliplatin are as effective as fluorouracil and cisplatin respectively, in patients with previously untreated esophagogastric cancer. As compared with cisplatin, oxaliplatin was associated with lower incidences of grade 3 or 4 neutropenia, alopecia, renal toxicity, and thromboembolism but with slightly higher incidences of grade 3 or 4 diarrhea and neuropathy. The toxic effects from 5-fluorouracil and capecitabine were not different.

ML 17032, another phase III randomized trial, evaluated the combination of capecitabine and cisplatin (XP) versus the combination of 5-fluorouracil and cisplatin (FP) as first-line treatment in patients with previously untreated advanced gastric cancer.\textsuperscript{175} Overall response rate (41% vs. 29%) and overall survival (10.5 months vs. 9.3 months) were superior for patients who received XP regimen. No difference in median progression-free survival was seen for both regimens (5.6 months for XP and 5.0 months for FP). The results of this study suggest that capecitabine is as effective as 5-fluorouracil in the treatment of patients with advanced gastroesophageal cancers.

A meta-analysis of the REAL-2 and ML17032 trials suggested that overall survival was superior in the 654 patients treated with capecitabine-based combinations compared with the 664 patients treated with 5-fluorouracil-based combinations although no significant difference in progression-free survival between treatment groups was seen.\textsuperscript{176}

Irinotecan as a single agent or in combination has been explored extensively in single arm and randomized clinical trials.\textsuperscript{177-191} The results of a randomized phase III study comparing irinotecan in combination with 5-fluorouracil and folinic acid to cisplatin combined with infusional 5-fluorouracil in patients with advanced adenocarcinoma of the stomach or EGJ showed non-inferiority for progression-free survival but not for overall survival and improved tolerance of the irinotecan containing regimen, thus it can be an alternative when platinum-based therapy cannot be delivered.\textsuperscript{186} In another randomized multicenter phase II study, Moheler et al. compared capecitabine combined with irinotecan or cisplatin in metastatic adenocarcinoma of the stomach or EGJ.\textsuperscript{190} There were no significant differences in overall response rates (37.7% and 42.0% respectively), and median progression-free survival (4.2 months and 4.8 months respectively),
although there was a trend towards better median overall survival in the irinotecan arm (10.2 vs. 7.9 months). The results of this study need to be validated further in larger studies.

Irinotecan has also been evaluated in second-line setting.\(^{172, 192-194}\) Second-line chemotherapy with irinotecan, fluorouracil and leucovorin (FOLFIRI) was active and well tolerated in patients with metastatic gastric cancer not previously treated with fluoropyrimidines.\(^{193}\)

Irinotecan (studied in combination with other cytotoxic agents in phase II and phase III trials) has not produced a category 1 evidence for prolongation of survival in patients with advanced gastric cancer; therefore, its use is preferred in the second line or third line setting.

Another novel oral fluoropyrimidine S-1 has shown promise in advanced gastric cancer, both as a single agent and in combination with cisplatin in early phase studies.\(^{195-197}\) In a randomized phase III trial (SPIRITS trial), 298 patients with advanced gastric cancer were randomized to S-1 plus cisplatin and S-1 alone. Median overall survival (13 vs. 11 months respectively) and progression-free survival (6.0 vs. 4 months respectively) were significantly longer for the combination of S-1 and cisplatin compared with S-1 alone.\(^{198}\) The combination of S-1 and cisplatin in patients with untreated advanced gastric and EGJ adenocarcinoma was shown to be safe and active in a multicenter phase II trial conducted in the United States.\(^{199, 200}\) In the phase III randomized trial [First Line Advanced Gastric Cancer Study (FLAGS)], 1053 patients with advanced gastric or EGJ adenocarcinoma were randomized to either cisplatin and S-1 (CS) with cisplatin or 5-fluorouracil (CF). CS and CF resulted in similar median overall survival (8.6 months and 7.9 months respectively; \(p = 0.20\)), but cisplatin and S-1 was associated with a significantly improved safety profile.\(^{201}\) In a subset analysis, CS produced statistically superior overall survival for patients with diffuse type histology. Additional studies are needed to confirm the activity of S-1 in the US and western hemisphere. S-1 remains an investigational agent in North America.

**Targeted Therapies**

The overexpression of epidermal growth factor receptor (EGFR), vascular endothelial growth factor receptor (VEGFR) and \(\text{HER2-neu}\) has been associated with poor prognosis in patients with gastric and esophageal cancers.\(^{39, 202}\) In clinical trials, trastuzumab (anti-HER2 antibody), bevacizumab (an anti-VEGFR antibody) and cetuximab (anti-EGFR antibody) have been evaluated in combination with chemotherapy in the treatment of patients with advanced gastric and EGJ adenocarcinoma.

The ToGA study is the first randomized, prospective, multicenter, phase III trial to evaluate the efficacy and safety of trastuzumab in patients with HER2-neu-positive gastric and EGJ adenocarcinoma in combination with cisplatin and a fluoropyrimidine.\(^{44}\) The results of this study confirmed that trastuzumab plus standard chemotherapy is superior to chemotherapy alone in patients with HER2-neu-positive advanced gastric cancer. Five hundred and ninety four patients with HER2-neu-positive gastric and EGJ adenocarcinoma (locally advanced, recurrent, or metastatic) were randomized to receive trastuzumab plus chemotherapy (5-fluorouracil or capecitabine and cisplatin) or chemotherapy alone. Median follow-up was 19 in the trastuzumab plus chemotherapy group and 17 months in the chemotherapy alone group. There was a significant improvement in the median overall survival with the addition of trastuzumab to chemotherapy compared to chemotherapy alone (13.5 vs. 11 months, respectively). Safety profiles were similar with no unexpected adverse events in the trastuzumab group. There was also no difference in symptomatic congestive heart failure between the treatment arms. This study establishes trastuzumab
in combination with chemotherapy as a new standard of care for the treatment of patients with HER2-neu-expressing advanced gastric and EGJ adenocarcinoma.

The safety and efficacy of bevacizumab, erlotinib, sorafenib, and cetuximab has been evaluated in multiple phase II studies. Ongoing phase III trials are underway to confirm the efficacy and safety of the above mentioned agents in combination with standard chemotherapy in patients with advanced gastric and EGJ adenocarcinoma.

**Treatment Guidelines**

The management of gastric cancer requires the expertise of several disciplines and these may include surgical oncology, medical oncology, gastroenterology, radiation oncology, radiology, and pathology. In addition, the presence of nutritional services, social workers, nursing, palliative care specialists, and other supporting disciplines are also desirable. Hence, the panel believes in an infrastructure that encourages multidisciplinary treatment decision-making by members of any discipline taking care of patients with esophageal gastric cancer. Optimally at each meeting, the panel encourages all relevant disciplines to participate. The recommendations made by the multidisciplinary team may be considered advisory to the primary group of treating physicians of the particular patient. See the section on Principles of Multidisciplinary Team Approach for Gastroesophageal Cancers in the guidelines.

**Workup**

In patients with gastric cancer, symptoms can include anemia, early satiety, weight loss, nausea/vomiting, and/or bleeding. Newly diagnosed patients should undergo a complete history, physical examination, and endoscopy with biopsy of the entire upper GI tract. A complete blood count (CBC), chemistry profile and CT scan (with oral and IV contrast) of the chest and abdomen should also be performed. Pelvic CT should be obtained as clinically indicated. At this point, if metastatic cancer is not evident, EUS with fine needle aspiration is recommended if indicated. EMR may contribute to accurate staging of early stage cancers. PET/CT scans are useful for predicting response to preoperative chemotherapy as well as in the evaluation of recurrent gastric cancer. They may also be useful in demonstrating occult metastatic disease, although there may be false positive results. Therefore, histologic confirmation of occult PET-avid metastasis is recommended. Additional studies are needed to assess the efficacy of combined PET/CT scan in gastric cancer. PET evaluation is preferred if there is no evidence of metastatic disease (PET/CT is preferred over PET scan). HER2-neu testing is recommended if metastatic disease is documented or suspected. See the section on “Principles of Pathology”, for assessment of HER2-neu overexpression.

Initial workup enables patients to be classified into three groups with the following characteristics:

- Localized (Tis or T1a) cancer
- Locoregional cancer (stages I-III or M0)
- Metastatic cancer (stage IV or M1)

Patients with apparent locoregional cancer are further classified into the following groups:

- Medically fit patients (who are able to tolerate major abdominal surgery) with potentially resectable disease
- Medically fit patients with unresectable disease
- Medically unfit patients
Primary Treatment

Medically Fit Patients

EMR or surgery is the primary treatment option for patients with Tis or T1a tumors whereas surgery is the primary treatment option for patients with potentially resectable locoregional cancer (T1b, T2 or higher, any N tumors). Based on the results of the MAGIC trial, the guidelines have included perioperative chemotherapy with ECF regimen or its modifications with a category 1 recommendation for patients with resectable T2 or higher, any N tumors. This strategy is feasible in the institutions where a multidisciplinary approach is already in place for the treatment of patients with localized gastric cancer. The efficacy of preoperative induction chemotherapy followed by chemoradiation has been demonstrated only in non-randomized studies. Although preoperative chemoradiation was associated with a survival advantage in two prospective randomized studies, both of these studies were limited by small sample size. Since the efficacy of preoperative chemoradiation has not been proven in large prospective randomized trials, the panel has included preoperative chemoradiation (fluoropyrimidine- or taxane-based) as an alternate option with a category 2B recommendation for patients with resectable T2 or higher, any N tumors. See “Principles of Systemic Therapy” section of the guidelines for list of specific regimens.

Concurrent fluoropyrimidine- or taxane-based chemoradiation or chemotherapy is recommended (category 1) for patients with unresectable locoregional cancer.

All patients diagnosed with metastatic disease after laparoscopic staging should be treated with palliative therapy (chemotherapy, best supportive care or clinical trial). Chemotherapy with any one of the regimens used for patients with metastatic or locally advanced cancer may be offered to this group of patients depending on their performance status.

Medically Unfit Patients

EMR is the preferred option for patients with Tis or T1a tumors whereas concurrent fluoropyrimidine- or taxane-based chemoradiation (category 1) is recommended for patients with T1b, T2 or higher, any N tumors.

All patients diagnosed with metastatic disease after laparoscopic staging should be treated with palliative therapy as described above for medically fit patients.

Posttreatment Assessment and Adjunctive Treatment

Medically fit patients with unresectable disease as well as medically unfit patients should undergo restaging [including CBC and chemistry profile, CT scan (with oral and IV contrast) of the chest and abdomen (pelvic CT as clinically indicated) and PET/CT or PET scan] after completion of primary treatment. If the cancer has become resectable and medically operable, surgery is the preferred treatment. Alternatively, these patients can also be observed. If the disease remains unresectable and there is evidence of distant metastatic disease, patients may be offered palliative therapy (chemotherapy, best supportive care or clinical trial) depending on their performance status.

Postoperative Treatment

Postoperative treatment is based on the surgical margins and nodal status. The benefits of postoperative chemoradiation have been demonstrated in randomized studies only in patients who have not received preoperative therapy.
For Patients Who Have Not Received Preoperative Therapy

No further treatment is necessary for patients with Tis, T1, N0 tumors, if there is no residual disease at surgical margins (R0 resection). Based on the results of the Intergroup trial (INT-0116), the panel has included postoperative chemoradiation [5-FU (± leucovorin) or capecitabine before and after fluoropyrimidine-based chemoradiation] for all patients with T3, T4, or any N tumors and for selected patients with T2, N0 tumors with high risk features (poorly differentiated or higher grade cancer, lymphovascular invasion, neural invasion, or age younger than 50 years), if there is no residual disease at surgical margins (R0 resection). Alternatively, patients with T2, N0 tumors can be observed. Based on the interim results of the CLASSIC trial, the panel has included postoperative chemotherapy with capecitabine and oxaliplatin as an option for patients with T3, T4, any N tumors following R0 resection and D2 lymph node dissection. Postoperative chemotherapy is not recommended for patients who undergo less than D2 lymph node dissection.

Patients with microscopic (R1 resection) or macroscopic residual disease with no distant disease (R2 resection) should be treated with fluoropyrimidine-based chemoradiation. Palliative chemotherapy or best supportive care, based on the performance status, is an alternative option for patients with macroscopic residual disease.

For Patients Who Have Received Preoperative Therapy

Postoperative chemotherapy (category 1) with ECF or its modifications is recommended, if given preoperatively for all patients with T2 or higher any N tumors. Alternatively patients with T2, N0 tumors can be observed. The value of postoperative chemoradiation in patients who have received preoperative therapy is currently being evaluated in a phase III trial (CRITICS study).

In the absence of metastases (M1), patients with microscopic (R1 resection) or macroscopic residual disease (R2 resection) should be treated with fluoropyrimidine-based chemoradiation, if not received preoperatively. Palliative chemotherapy or best supportive care, based on the performance status, may be offered for patients with macroscopic residual disease.

Follow-up and Surveillance

All patients should be followed up systematically. Follow-up should include a complete history and physical examination every 3-6 months for 1-2 years, every 6-12 months for 3-5 years and annually thereafter. CBC, chemistry profile, imaging studies or endoscopy should be done if clinically indicated. Patients who have undergone surgical resection should be monitored and treated as indicated for vitamin B12 and iron deficiency.

Metastatic or Recurrent Disease

In a randomized comparison between chemotherapy and best supportive care vs. best supportive care alone for advanced gastric cancer, overall survival (8 months vs. 5 months, though not statistically significant) and time to progression (5 months vs. 2 months) were longer in patients receiving chemotherapy. More patients in the chemotherapy group (45%) had an improved or prolonged high quality of life for a minimum of 4 months compared to those who received only best supportive care (20%). A recent meta-analysis of randomized trials that compared chemotherapy and supportive care in patients with advanced gastric cancer also showed that chemotherapy increased the one year survival rate and improved the quality of life. The results of two small phase III randomized studies have demonstrated the survival benefit of second line chemotherapy compared to best supportive care in patients with metastatic or...
In a randomized phase III study of the Arbeitsgemeinschaft Internistische Onkologie (AIO), second-line chemotherapy with irinotecan significantly prolonged overall survival compared to best supportive care in patients with metastatic or locally advanced gastric or EGJ adenocarcinoma (n = 40). The study was closed prematurely due to poor accrual. Median survival was 4 months in the irinotecan arm compared to 2.4 months in the best supportive care only arm. In another larger randomized trial (n = 193), second-line chemotherapy with irinotecan or docetaxel significantly improved overall survival (5.1 months vs. 3.8 months) compared to best supportive in patients with advanced gastric cancer. However, both studies have limitations and larger studies are now underway.

Best supportive care is always indicated for patients with advanced gastric cancer. The decision to offer best supportive care alone or with chemotherapy is dependent on the patient’s performance status. Several scales are available to measure performance status in patients with cancer. Karnofsky scale of Performance Status (KPS) and Eastern Cooperative Group Performance Status (ECOG PS) are the two commonly used scales. KPS is an ordered scale with 11 levels (0 to 100) and the general functioning and survival of a patient is assessed based on their health status (activity, work and self-care). Low Karnofsky scores are associated with poor survival and serious illnesses. ECOG PS is a 5-point scale (0-4) based on the level of symptom interference with normal activity. Patients with higher levels are considered to have poor performance status.

Palliative treatment options include chemotherapy, or clinical trial or best supportive care. Patients with a Karnofsky performance score of 60 or less or an ECOG performance score of 2 or less may be offered best supportive care with or without chemotherapy, or a clinical trial.

For metastatic gastric cancer, there have been a number of phase III trials that assessed combinations such as ECF, DCF, and FOLFIRI. The guidelines provide recommendations with category 1 evidence and some modifications. The basic two classes of drugs include a fluoropyrimidine and a platinum compound. Based on the patient’s performance status and organ function, a third agent (a triplet cytotoxic regimen) may be added. Some of the regimens listed in the guidelines are based on institutional preferences that have support only from phase II studies. The survival benefit of second line chemotherapy compared to best supportive care has been demonstrated in recent phase III randomized studies in small cohort of patients with metastatic or advanced gastric cancer. The panel consensus was that there is no category 1 evidence to support any specific regimen(s) as second-line or third-line therapy for patients with advanced or metastatic gastric cancer. The use of trastuzumab in combination with an anthracycline is not recommended. Leucovorin can be used with certain infusional 5-fluorouracil-based regimens. The following regimens are listed in the guidelines for patients with metastatic or locally advanced cancer (See “Principles of Systemic Therapy” section of the guidelines for list of specific regimens):

**First-line therapy**

- DCF or its modifications (category 1 for docetaxel, cisplatin and fluorouracil; category 2B for docetaxel, carboplatin or oxaliplatin and fluorouracil; category 2A for all other combinations)
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- ECF or its modifications (category 1)
- Fluoropyrimidine-based or taxane-based regimens, single agent or combination therapy (category 1 for combination of fluoropyrimidine and cisplatin; category 2A for all other regimens)
- Trastuzumab with active chemotherapy (category 1 for combination with cisplatin and fluoropyrimidine; category 2B for combination with other chemotherapy agents) for patients who are HER2-neu-positive, as determined by a standardized method.

Second-line Therapy
- Trastuzumab with active chemotherapy (category 1 for combination with cisplatin and fluoropyrimidine; category 2B for combination with other chemotherapy agents) for patients who are HER2-neu-positive, if not used as first-line therapy
- Docetaxel or paclitaxel (category 2B)
- Irinotecan-based single agent or combination therapy (category 2B)

Leucovorin Shortage
There is currently a shortage of leucovorin in the United States. There are no specific data to guide management under these circumstances, and all proposed strategies are empiric. The panel recommends several possible options to help alleviate the problems associated with this shortage. One is the use of levo-leucovorin, which is commonly used in Europe. Levo-leucovorin dose of 200 mg/m\(^2\) is equivalent to 400 mg/m\(^2\) of standard leucovorin. Another option is to use lower doses of leucovorin for all doses in all patients, since lower doses are likely to be as efficacious as higher doses, based on several studies in patients with colorectal cancer.\(^{227-229}\) Finally, if none of the above options are available, treatment without leucovorin would be reasonable. For patients who tolerate this without grade II or higher toxicity, a modest increase in fluorouracil dose (in the range of 10%) may be considered.

Best Supportive Care
The goal of best supportive care is to prevent, reduce, and relieve suffering, and improve the quality of life for patients and their caregivers, regardless of disease stage. In patients with unresectable or locally advanced cancer, palliative interventions undertaken to relieve major advanced symptoms may result in prolongation of life.

Bleeding
Bleeding is common in patients with gastric cancer and may be secondary to tumor or tumor related phenomenon, or as a consequence of therapy. A multidisciplinary approach is required for the proper diagnosis and management of gastrointestinal bleeding in patients with cancer.\(^{230}\) Patients with acute severe bleeding (hematemesis or melena) should undergo prompt endoscopic assessment. Angiographic embolization techniques may be useful in those situations where endoscopy is not helpful. External beam RT and/or endoscopic treatment may be indicated in patients experiencing bleeding.\(^{231}\)

Obstruction
Surgery (gastrojejunostomy or gastrectomy in selected patients), venting gastrostomy, external beam RT, chemotherapy and endoscopic palliative procedures such as balloon dilation, placement of enteral stent for relief of gastric outlet obstruction or esophageal stent for EGJ/cardia obstruction are used to alleviate symptoms of obstruction. The optimal palliative treatment for patients with malignant gastric outlet obstruction needs to be determined in large randomized clinical trials. Treatment options for the management of obstruction should be individualized. A multimodality interdisciplinary approach is strongly encouraged.
Endoscopic placement of self-expanding metal stents (SEMS) is a safe and effective minimally invasive palliative treatment for patients with luminal obstruction due to advanced gastric cancer.\textsuperscript{232-234} In a systematic review, patients treated with endoscopic placement of stents were more likely to tolerate oral intake and they also had shorter hospital stay than patients treated with gastrojejunostomy.\textsuperscript{235} The results of a systematic review suggest that stent placement may be associated with more favorable results in patients with a relatively short life expectancy, whereas gastrojejunostomy is preferable in patients with a more prolonged prognosis.\textsuperscript{53} A recent randomized trial also reported similar findings.\textsuperscript{236} However, these results need to be confirmed in larger cohort of patients. Percutaneous decompressive gastrostomy either by endoscopic or radiologic gastrostomy have also been beneficial for patients with gastric outlet obstruction.\textsuperscript{237, 238}

If endoscopic lumen restoration is not undertaken or successful, percutaneous endoscopic or interventional radiology gastrostomy tube placement for gastric decompression may be performed, if tumor location permits. Ascites, if present, should be drained prior to venting gastrostomy tube placement to reduce the risk of infectious complications.\textsuperscript{239, 240} Endoscopic or surgical placement of jejunal feeding tube may be necessary to provide adequate hydration and nutritional support for patients with mild and distal gastric obstruction. Nutritional counseling may also be valuable.

**Pain**

Pain control may be achieved with the use of RT and pain medications. If the patient is experiencing tumor related pain, then pain should be assessed and treated according to the NCCN Guidelines for Adult Cancer Pain. Severe uncontrolled pain following gastric stent placement should be treated emergently with endoscopic removal of the stent once uncontrollable nature of pain is established.

**Nausea and Vomiting**

Patients experiencing nausea and vomiting should be treated according to the NCCN Guidelines for Antiemesis. Nausea and vomiting may be associated with luminal obstruction, so endoscopic or fluoroscopic evaluation should be performed to determine if luminal enhancement is indicated.

**Summary**

Gastric cancer is rampant in several countries around the world. Its incidence in the Western Hemisphere has been on the decline for more than 40 years. In the past 15 years, the incidence of proximal gastric cancer has increased in Western countries compared to non-proximal gastric cancer, which is more prevalent in Japan and other parts of the world. Diffuse histology is also more common now than intestinal type of histology. H. pylori infection, smoking, and high salt intake are the risk factors for gastric cancer. Few gastric cancers are associated with inherited gastric cancer predisposition syndromes.

Several advances have been made in treatment approaches, imaging techniques and staging procedures. Multidisciplinary team management is essential for treating patients with gastric cancer. Patients with locoregional disease should be referred to high volume centers.

EMR is an appropriate primary treatment options for patients with Tis or T1a tumors whereas surgery is the primary treatment option for medically fit patients with resectable T1b, T2 or higher, any N tumors. Subtotal gastrectomy is preferred for distal gastric cancers whereas proximal or total gastrectomy is recommended for proximal tumors. However, in the West, surgery alone is an insufficient therapy for most patients. Based on the results of the MAGIC trial, perioperative chemotherapy with the ECF regimen or its modifications is
recommended (category 1) following R0 resection for patients with more advanced disease (T2 or higher, any N). Preoperative chemoradiation may also be considered for these patients (category 2B). For patients who have not received preoperative therapy, based on the results of the INT-0116 trial, postoperative chemoradiation is recommended for selected patients with no residual disease at surgical margins and no evidence of metastases after gastrectomy. Based on the interim results of the CLASSIC trial, the panel has included postoperative chemotherapy with capecitabine and oxaliplatin as an option following R0 resection and D2 lymph node dissection in patients with T3, T4, any N tumors.

Fluoropyrimidine-based postoperative chemoradiation is recommended for all patients with residual disease at surgical margins. Patients with unresectable and/or distant metastatic disease may be offered palliative therapy (chemotherapy, best supportive care or clinical trial).

Targeted therapies in combination with chemotherapy have produced encouraging results in the treatment of patients with advanced gastric, esophageal and EGJ cancers. Based on the results of the ToGA trial, trastuzumab plus chemotherapy is included as an option for patients with HER2-neu-positive advanced or metastatic gastric cancer or EGJ adenocarcinoma. HER2-neu testing is recommended if metastatic disease is documented or suspected. The efficacy VEGFR and EGFR inhibitors in combination with chemotherapy in patients with advanced gastric and EGJ cancers are being evaluated in ongoing randomized phase III trials.

Best supportive care is an integral part of treatment, especially in patients with metastatic and advanced gastric cancer. Patients with good performance status can be treated with chemotherapy or best supportive care, whereas best supportive care alone is the appropriate treatment for patients with poor performance status.

Assessment of severity of the disease and related symptoms is essential to initiate appropriate palliative interventions that will prevent and relieve suffering and improve quality of life for patients and their caregivers. Treatment options used for palliation of symptoms in patients with advanced gastric cancer include endoscopic placement of SEMS, surgery, chemotherapy or RT.

The NCCN Guidelines for Gastric Cancer provide an evidence and consensus based systematic approach to the management of patients with gastric cancer in the United States. Novel therapeutic modalities, such as targeted therapies, vaccines and gene therapy are being studied in clinical trials. The panel encourages patients with gastric cancer to participate in well designed clinical trials to enable further advances.
**Table 1. Guidelines for Assessment of HER2-neu Overexpression**

<table>
<thead>
<tr>
<th>Surgical Specimen</th>
<th>Biopsy Specimen</th>
<th>Score/ HER2-neu overexpression</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reactivity or membranous reactivity in &lt;10% of cancer cells</td>
<td>No reactivity or no membranous reactivity in any cancer cells</td>
<td>0/Negative</td>
</tr>
<tr>
<td>Faint or barely perceptible membranous reactivity in ≥10% of cancer cells; cells are reactive only in part of their membrane</td>
<td>Cancer cell cluster with a faint or barely perceptible membranous reactivity irrespective of percentage of cancer cells positive</td>
<td>1+/Negative</td>
</tr>
<tr>
<td>Weak to moderate complete, basolateral or lateral membranous reactivity in &gt;10% of cancer cells</td>
<td>Cancer cell cluster with a weak to moderate complete, basolateral, or lateral membranous reactivity irrespective of percentage of cancer cells positive</td>
<td>2+/Equivocal</td>
</tr>
<tr>
<td>Strong complete, basolateral or lateral membranous reactivity in ≥10% of cancer cells</td>
<td>Cluster of five or more cancer cells with a strong complete, basolateral, or lateral membranous reactivity irrespective of the percentage of cancer cells positive</td>
<td>3+/Positive</td>
</tr>
</tbody>
</table>


2. The NCCN Guidelines panel recommends that cases showing HER2-neu overexpression less than 3+ by immunohistochemistry should be additionally examined by FISH or other in situ hybridization methods. Cases with 3+ HER2-neu overexpression by IHC or FISH positive (HER2:CEP17 ratio ≥ 2) are considered positive.
References


61. McCulloch P, Nita ME, Kazi H, Gama-Rodrigues J. Extended versus limited lymph nodes dissection technique for adenocarcinoma of


Gastric Cancer


144. Einzig AI, Lipsitz S, Wiernik PH, Benson AB, 3rd. Phase II trial of taxol in patients with adenocarcinoma of the upper gastrointestinal tract...


