

UGI cancer Diagnosis and management

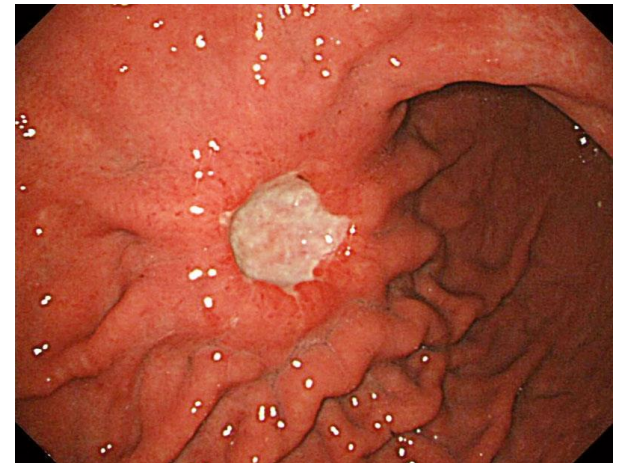
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UGI cancer

Red flag symptoms

- Progressive dysphagia
- Odynophagia
- Non intentional weight loss
- Early satiety/ Vomiting
- Hoarseness
- Retrosternal pain
- Haematemesis/malaena
- Abdominal mass /enlarged LN



NICE Guidelines-Stomach cancer

Urgent direct access (within 2 weeks) :

- upper abdominal mass consistent with stomach cancer **or**
- dysphagia **or**
- aged 55 and over with weight loss **and** any of the following:
upper abdominal pain, reflux or dyspepsia.

Non-urgent direct access

- haematemesis
- people aged 55 or over with:
 - treatment-resistant dyspepsia **or**
 - upper abdominal pain with low haemoglobin levels **or**
 - raised platelet count with any of the following:
Nausea, vomiting, wt. loss, reflux,
dyspepsia ,upper abdo pain **or**
 - nausea or vomiting with any of the following:
weight loss, reflux, dyspepsia or upper abdominal pain.



NICE Guidelines-Oesophageal cancer

Urgent direct access (within 2 weeks)

- with dysphagia **or**
- aged 55 and over with weight loss **and** any of the following:
upper abdominal pain, reflux, or dyspepsia.

Non-urgent direct access

- haematemesis.
- people aged 55 or over with:
 - treatment-resistant dyspepsia **or**
 - upper abdominal pain with low haemoglobin levels **or**
 - raised platelet count with any of the following:
Nausea, vomiting, wt loss, reflux,
dyspepsia, upper abdo pain, **or**
 - nausea or vomiting with any of the following:
weight loss, reflux, or dyspepsia



A 57 year old man presents with reflux and heartburn. He has no weight loss or dysphagia . He is treated with a PPI and represents 2 months later with persisting symptoms and now weight loss of 3kg.

What would you do next ?

- A. Refer for urgent direct access OGD (within 2 weeks)
- B. Refer for non urgent direct access OGD
- C. Give a further course of PPI
- D. Treat empirically for Helicobacter Pylori
- E. Reassure , no indication to refer for OGD



Case report

Gastric cancer



Surgical OPD 1st visit-March

- 28 yr old gentleman
- Symptoms: ~3 month hx of GORD- some response to PPI.
 - ~3 week hx of post prandial fullness
 - ~3 week hx of weight loss (3kg)
 - ~1 week hx nausea/vomiting (A/E admission)



A 28 year old gentleman presents with heartburn and reflux. He is given a PPI and has some symptom resolution. He represents with vomiting and decreased appetite. As a result he has lost weight. He mentions that there were streaks of blood in vomitus.

What would you do next ?

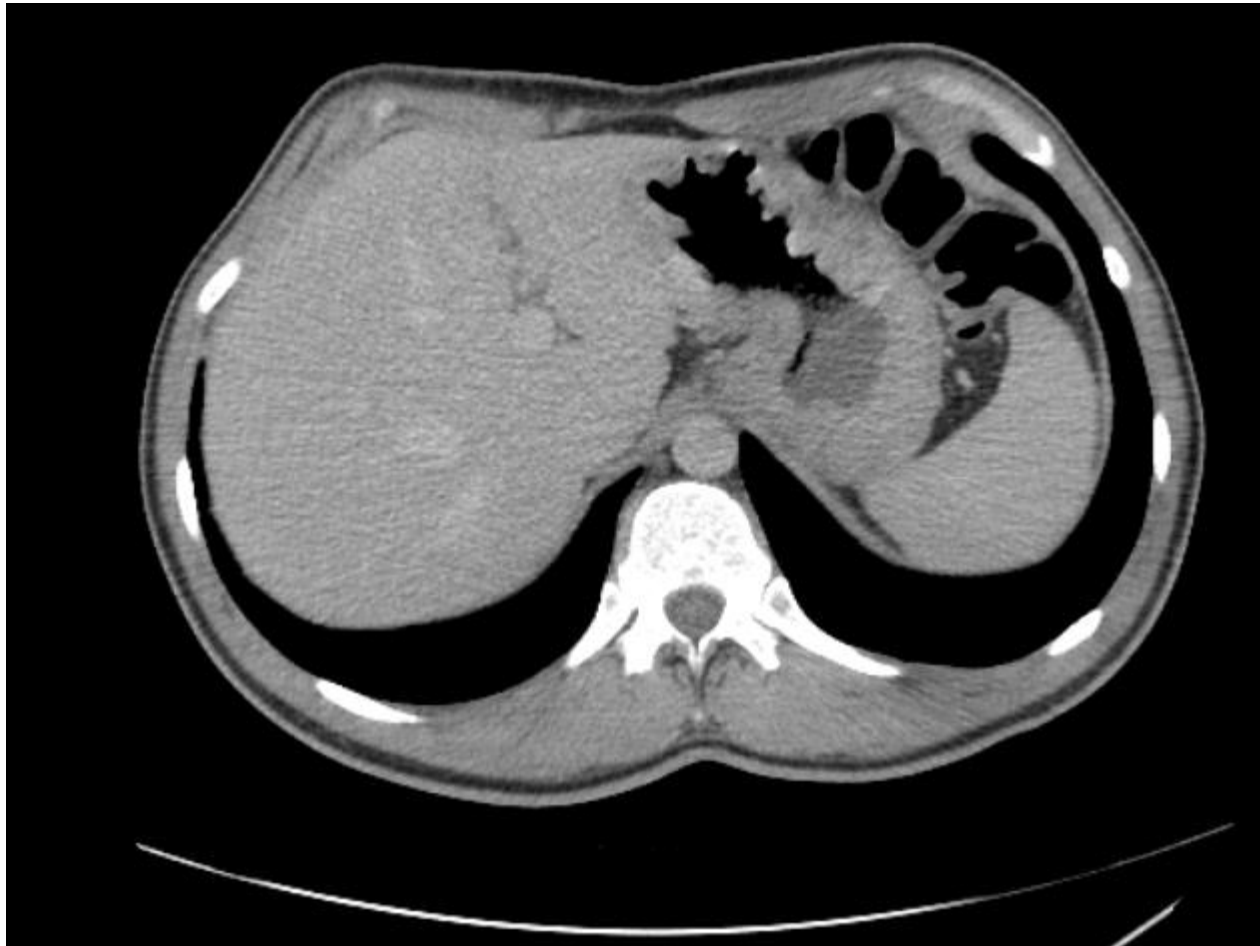
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Investigations

- OGD: food residue oesophagus and stomach.
- Reflux oesophagitis.
- Gastric fold thickening prepyloric area. Difficult to get through into duodenum.
- Histology: **poorly diff signet ring cell adenocarcinoma**
- CT TAP: Concentric thickening of gastric antrum
T₃N₀M_x





Surgical OPD 1st visit-March

- Discussion with pt. and relatives regarding diagnosis
- MDT outcome-Staging laparoscopy & OGD. Peri-op chemotherapy.
- Procedure explained & risks involved
- CNS –HNA, information given, contact details, pre op assessment (bloods showed K 2.6)
- Physio –shuttle walk assessment -660m, advice about exercise and smoking given
- Dietitian –Not tolerating solid food (vomiting) liquidised diet, supplements –Fortisip, calogen



Oncology OPD

- Discussed diagnosis
- Seen by dietician weight loss by now concerning ++
- Discussed genetics referral
- Discussed counselling
- Discussed support
- Discussed need for peri-operative chemotherapy
- Discussed side effects of chemotherapy
- Discussed prognosis



What is prognosis for localised OG cancer after treatment ?

- A. 5 yr survival 70-80%
- B. 5 yr survival 60-70 %
- C. 5 yr survival <50%
- D. 5 yr survival <40%
- E. 5 yr survival <30%

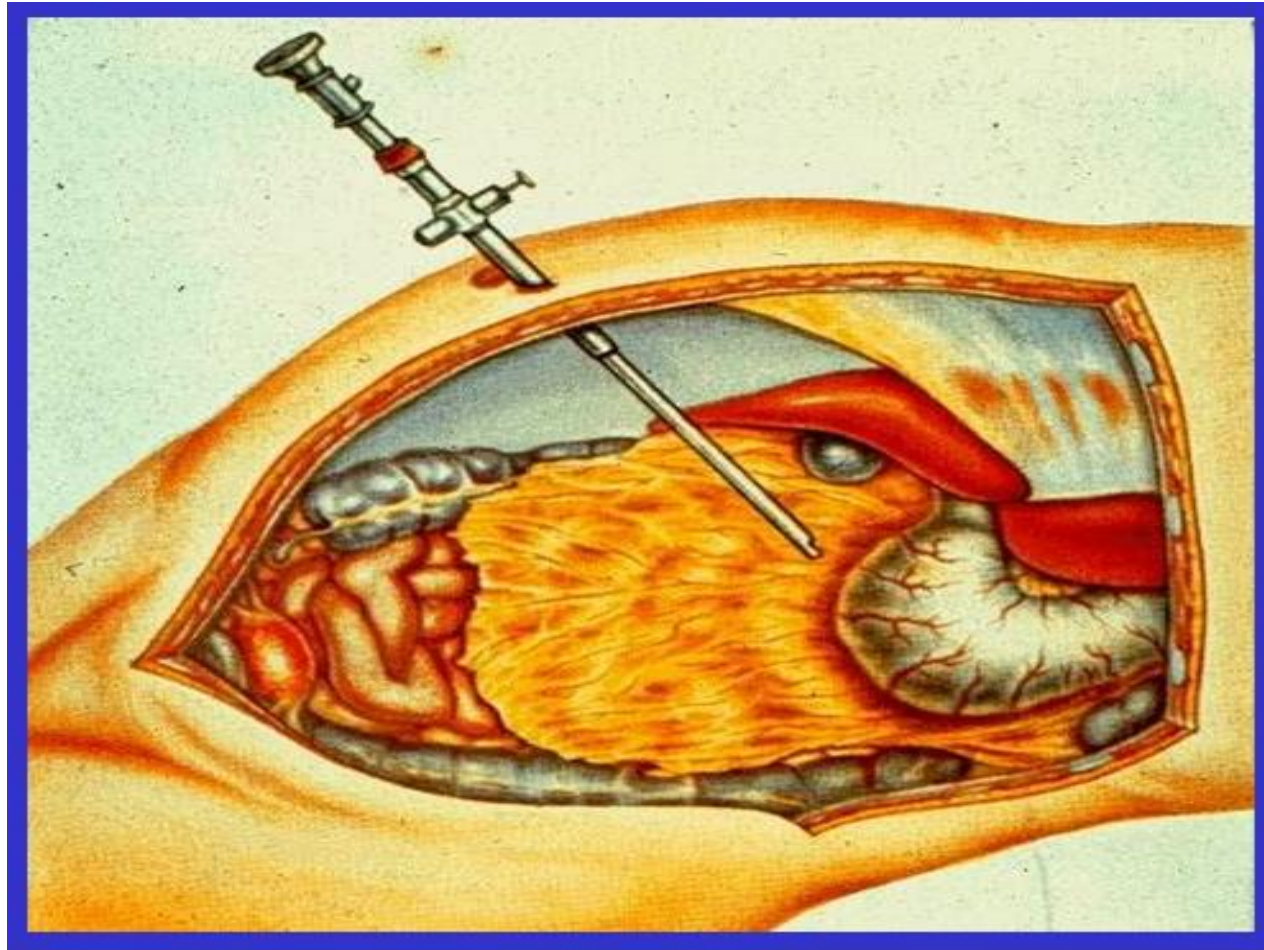


Answer

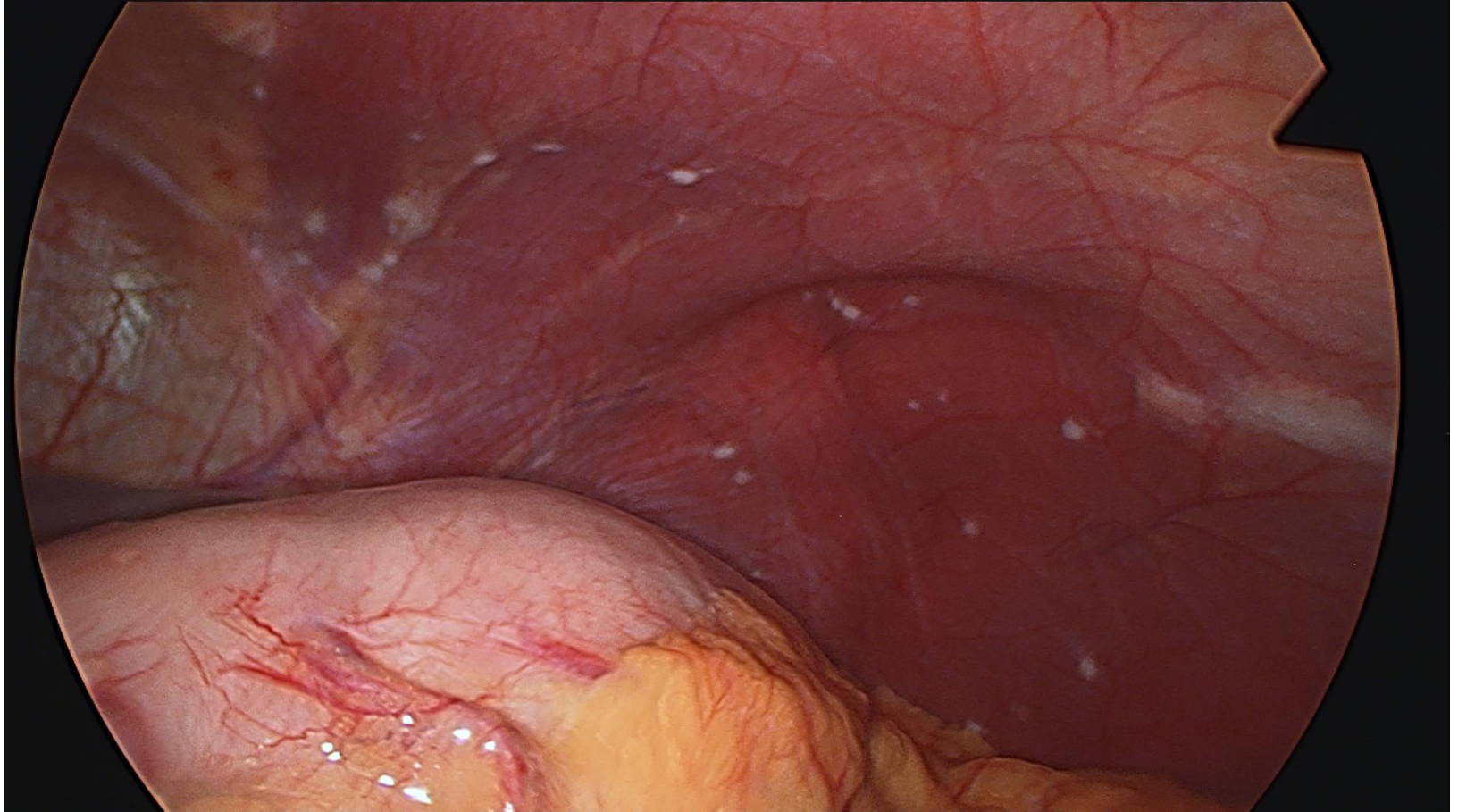
– <40% 5 yr survival



Staging laparoscopy



Carcinomatosis Peritonei

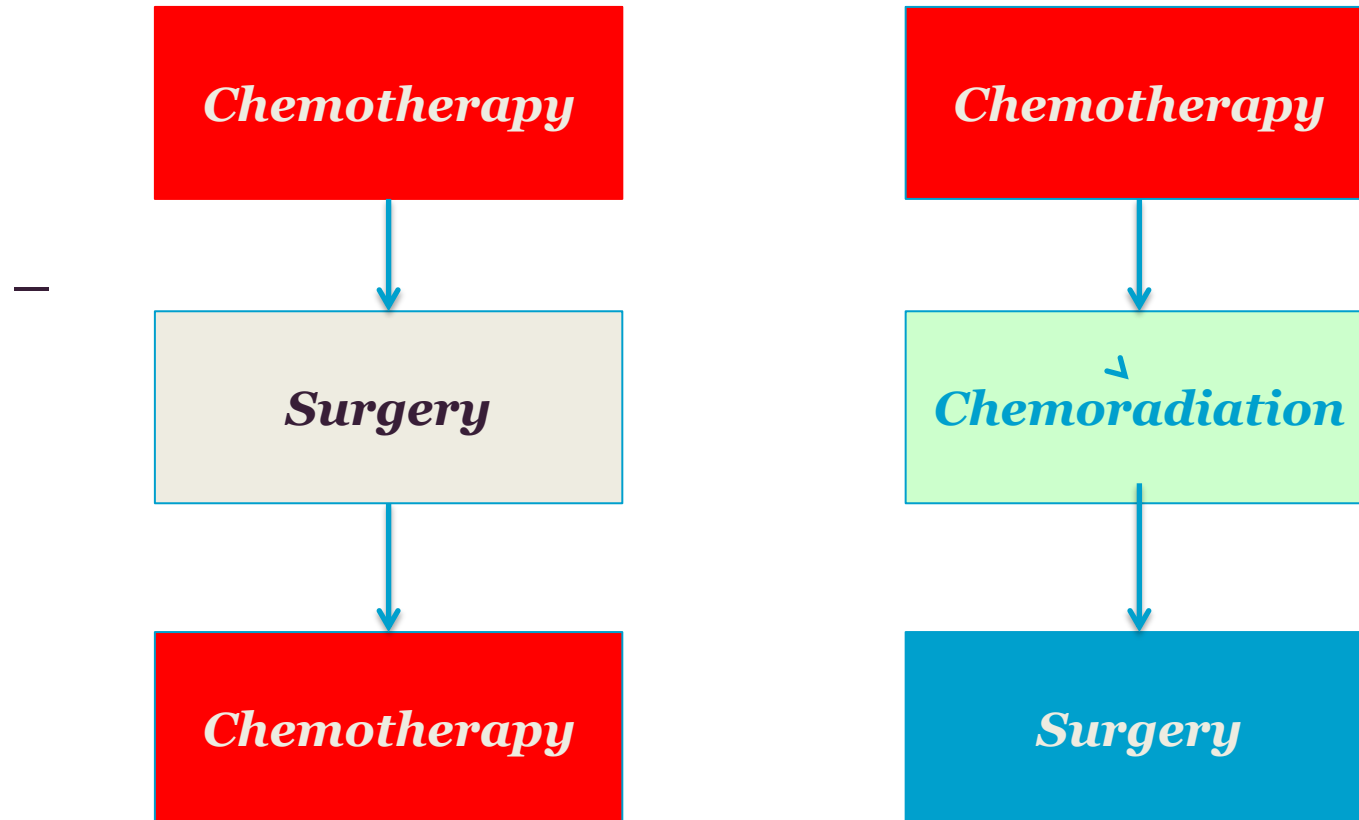


Staging laparoscopy and OGD-March

- Laparoscopy – Normal serosal appearance of stomach
 - Felt thickened at antrum
 - Nodule on falciform ligament biopsied
 - No other peritoneal lesions
- OGD – Diffusely thickened gastric mucosa from cardia to antrum. Fluid in stomach despite pylorus open.
- Would be suitable for total gastrectomy
- Histopathology – fatty tissue only
- Referred back to oncology for chemotherapy



Strategy for Localised Oesophageal/Gastric adenocarcinoma



Urgent surgical review-May

- Pt received 1st cycle neoadjuvant chemotherapy
- Persistent nausea, vomiting , unable to keep anything down. Continued weight loss.
- Admitted to hospital. Rehydrated. PICC line/ TPN.
- Ryles NG tube drained 500mls
- Laparoscopy and OGD performed. At OGD Fluid stasis (500mls) in stomach . Stomach rigid c/w linitis plastica. Pylorus open
- Laparoscopy no peritoneal disease , Feeding jejunostomy tube inserted into proximal jejunum.



Chemotherapy induced Emesis

Table 2. Treatment Guidelines for CINV

Emetic Risk	Treatment Regimen
High ^a	Day 1: NK ₁ antagonist + 5HT ₃ antagonist + dexamethasone Days 2-3: NK ₁ antagonist (if using aprepitant) + dexamethasone Day 4: dexamethasone
Moderate ^a	Day 1: 5HT ₃ antagonist (palonosetron preferred) + dexamethasone ± NK ₁ antagonist Days 2-4: 5HT ₃ antagonist (if did not use palonosetron), or dexamethasone or aprepitant + dexamethasone ± 5HT ₃ antagonist. If aprepitant used on day 1, days 2-3 aprepitant ± dexamethasone on days 2-4 ± lorazepam
Mild ^a	Metoclopramide, dexamethasone, or prochlorperazine ± lorazepam
Minimal	No routine prophylaxis

^a Lorazepam ± H₂ blocker or PPI on day 1.

CINV: chemotherapy-induced nausea and vomiting; 5HT₃: serotonin subtype 3; H₂: histamine 2; NK₁: neurokinin 1; PPI: proton pump inhibitor.

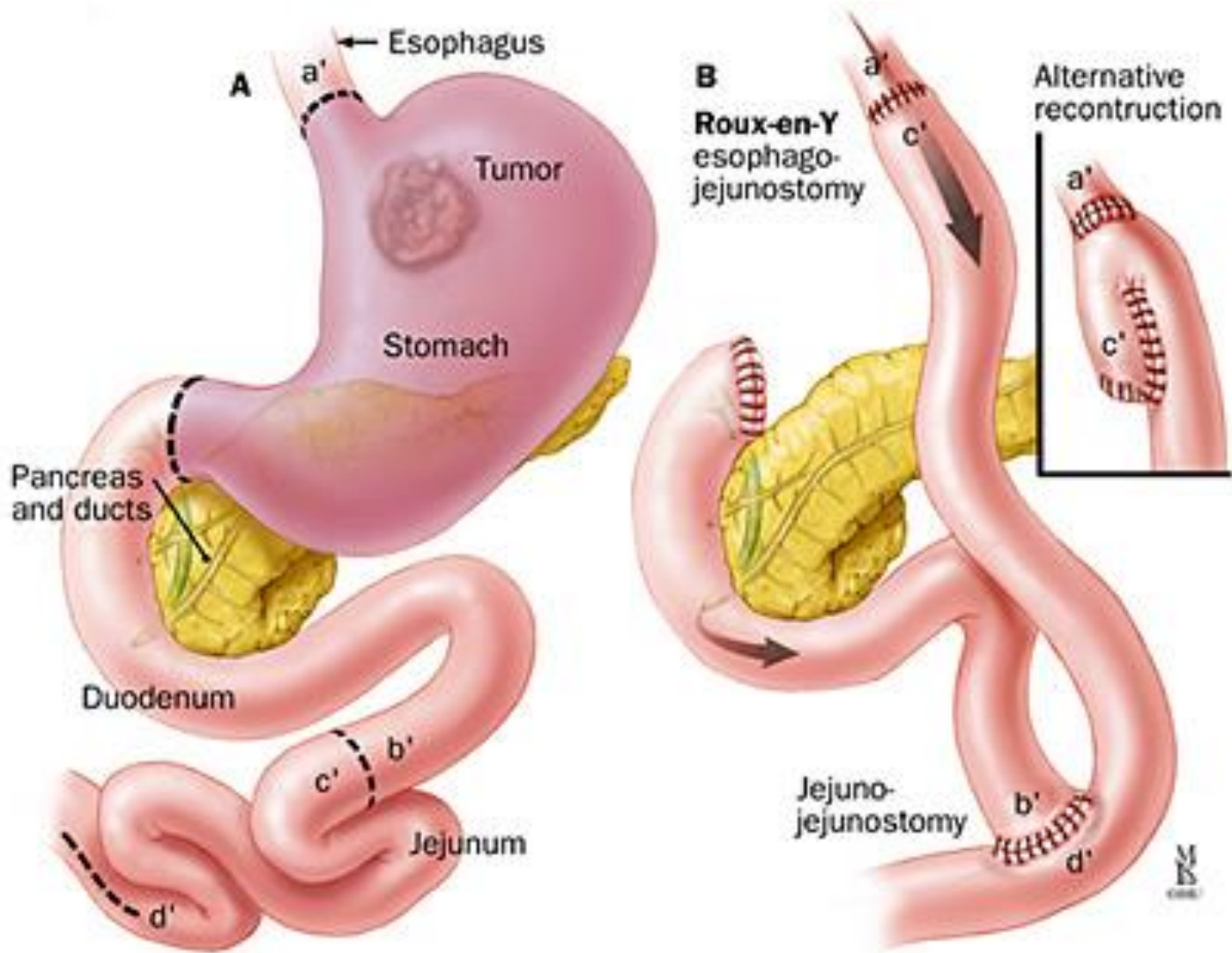
Source: References 1, 3.



Surgical OPD-2nd visit. July

- Pt had completed neoadjuvant chemotherapy
- Restaging CT –stable disease
- Discussion regarding operation, sequelae & risks involved. Explained wait of 4-6 weeks prior to surgery
- Pre operative assessment (low K, continued vomiting, metabolic alkalosis, syringe driver metoclopramide, Feeding jej)
- CNS –information sheet , pre op work up.
- Physio –shuttle walk test 670m, advice re exercise
- Dietitian – feeding jejunostomy regime . Discussed feeding post gastrectomy





Surgery-Total gastrectomy, August

- Midline laparotomy
- Findings –prominent tumour distal stomach.
Desmoplastic reaction duodenal bulb/ portal triad
- Omentectomy , total gastrectomy, D2 lymphadenectomy, removal of feeding jejunostomy, Roux en Y jejunal anastomosis.
- Post op CCU. Renal review –K+ losing enteropathy
- Uneventful post op recovery. On ERP
- Discharged home day 9 post op .
- Tinzaparin x 28 days post op



Surgical OPD 3rd visit August

- Pt. reviewed –wounds , weight, eating habits, pain, bowel movements, medications.
- Histopathological results
 - Poorly differentiated diffuse adenocarcinoma TRG4. pT4a, N2 (6/29 LN pos) . Margins clear.
- Explained pathway-post op CT scan , oncology review
- CNS review-support
- Dietitian review: feeding assessment, VitB12



Surgical OPD-4th visit Dec

- Completed chemotherapy
- Pt reviewed –weight, eating habits, bowel movements, wounds , LN
- (functional outcome/ recurrence)
- Bloods –FBC, LFTs, U&E, CEA/CA19.9. Imaging
- Vit B12
- Genetics appt
- CNS review
- Dietitian review
- F/U 3mnthly 1st yr, 6mnthly 2nd yr, discharge



A 60 year old woman attends for first appointment at your practice . She has moved from abroad and you are waiting for her detailed medical history . She states she had her stomach removed for a cancerous growth 3 years ago and was given ‘the all-clear’. She is complaining of tiredness

What should you do?

- A. Refer urgently to UGI surgeons
- B. Check FBC
- C. Check FBC, Ferritin, Vit. B12
- D. Book CT scan for follow up imaging



What percentage of gastric cancers are inherited ?

- A. 30%
- B. 20%
- C. 10%
- D. 5%
- E. 3%- correct answer



Which are associated with gastric cancer ?
(You can choose more than 1)

- A. BRCA 2 mutation
- B. BRCA 1 mutation
- C. E cadherin
- D. HNPCC
- E. FAP



Answer:

- All of them could be associated apart from B.



Advanced disease-treatment

- Palliative chemotherapy
- HER 2 testing

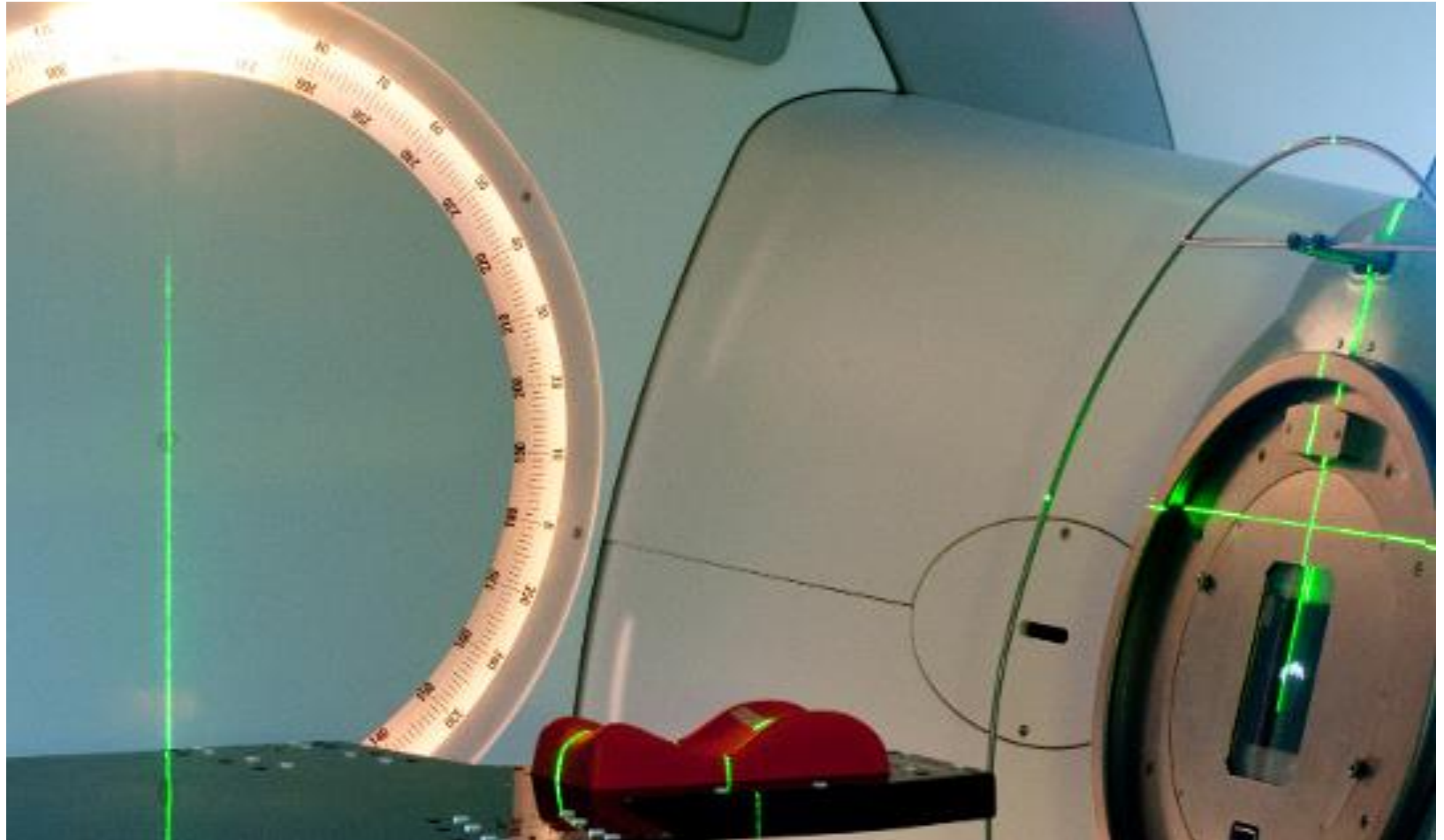
- Palliative stenting

- Palliative radiotherapy

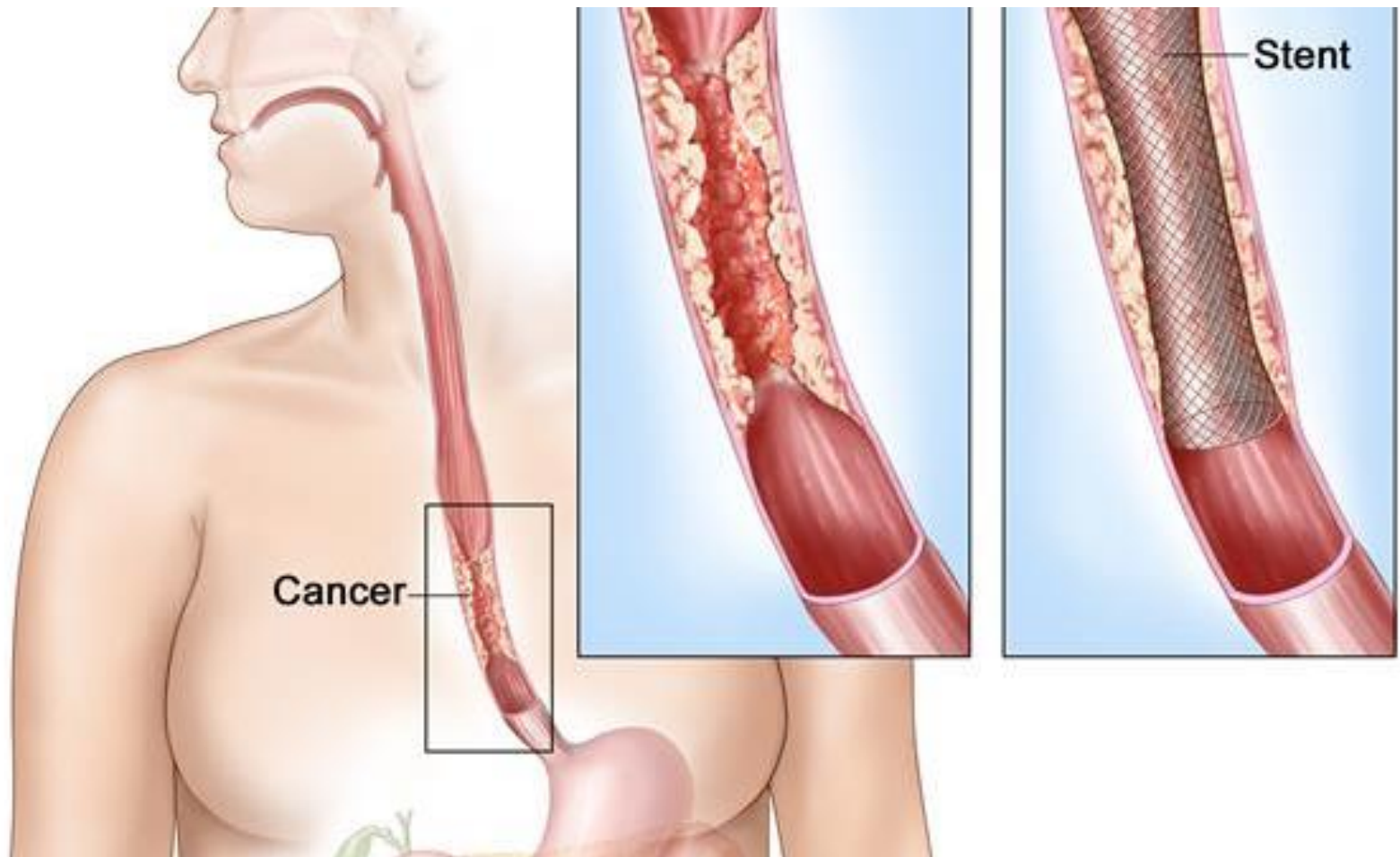
- Nutrition and feeding vital in care



Radiotherapy



Nutrition



Summary

Upper GI cancer

- Difficult to diagnose early
- Nutrition problems can add to complexity of management
- Treatment may involve chemotherapy, chemoradiation and/or major surgery
- Treatments may result in poor GI function which can be very symptomatic
- Recurrence is always a concern

