# DAnderson Gastric Cancer

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Disclaimer: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson's specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient's care. This algorithm should not be used to treat pregnant women.

**Note:** Consider Clinical Trials as treatment options for eligible patients. Consider referral to a Comprehensive Cancer Center. INITIAL CLINICAL **ADDITIONAL** POST LAPAROSCOPY **PRIMARY EVALUATION STAGE EVALUATION STAGING TREATMENT** • Multidisciplinary evaluation Endoscopic mucosal resection (EMR) or Yes • History and physical Surgery cTis or • CBC with differential and Medically fit<sup>3</sup>? cT1a chemistry profile **EMR** No • CT chest, abdomen and pelvis with oral and IV contrast cT1b, M0, Medically fit<sup>3</sup> and • Surgery or • Pelvic ultrasound if clinically • Restaging (preferred) cT2 or greater potentially resectable • Preoperative chemotherapy or indicated in female patients Chest imaging <u>or</u> (consider laparoscopy staging) Chemoradiation • Esophagogastroduodenoscopy • CT abdomen/pelvis N+, but M0 (EGD) and biopsy with intravenous and • Radiation therapy (45-50.4 Gy) • PET/CT or PET scan (optional) Medically fit<sup>3</sup> and oral contrast plus concurrent 5-fluorouracil • Endoscopic ultrasound (optional) unresectable<sup>4,5</sup> • Pelvic imaging (as radiosensitizer) or M0• H. pylori test, treat if positive (females) (consider laparoscopy staging) Chemotherapy • Microsatellite instability (MSI) • CBC with differential for all patients and chemistry • Radiation therapy (45-50.4 Gy) • *HER2-neu* evaluation by profile plus concurrent 5-fluroruracil • PET/CT or PET scan immunohistochemistry Medically unfit M0(as radiosensitizer) or (IHC)<sup>1</sup> and *PD-L1* in patients (optional) Best supportive care • See Page 2 for postwith advanced, metastatic cancer (not localized cancer) surgical response • Chemotherapy or clinical trial or • Additional biomarkers as evaluation Best supportive care clinically indicated<sup>1</sup> KPS score  $\geq 60\%$  or Stage IV (M1) ECOG performance score  $\leq 2$ ? • Lifestyle risk assessment<sup>2</sup> Best supportive care KPS = Karnofsky Performance Status

ECOG = Eastern Cooperative Oncology Group

<sup>1</sup>Consider HER2-neu evaluation initially by IHC and if IHC score 2+, follow-up with FISH test. See MD Anderson Approved Biomarker algorithm

<sup>&</sup>lt;sup>2</sup> See Physical Activity, Nutrition, and Tobacco Cessation algorithms; ongoing reassessment of lifestyle risks should be a part of routine clinical practice

<sup>&</sup>lt;sup>3</sup> Medically fit implies low risk (< 5% chance of mortality) for major surgery

<sup>&</sup>lt;sup>4</sup>M0 Unresectable refers to an unresectable T4 primary

<sup>&</sup>lt;sup>5</sup> Medically fit patients with positive cytology in the peritoneal fluid (but no macroscopic cancer) may be re-assessed for surgery after prolonged systemic therapy and chemoradiation

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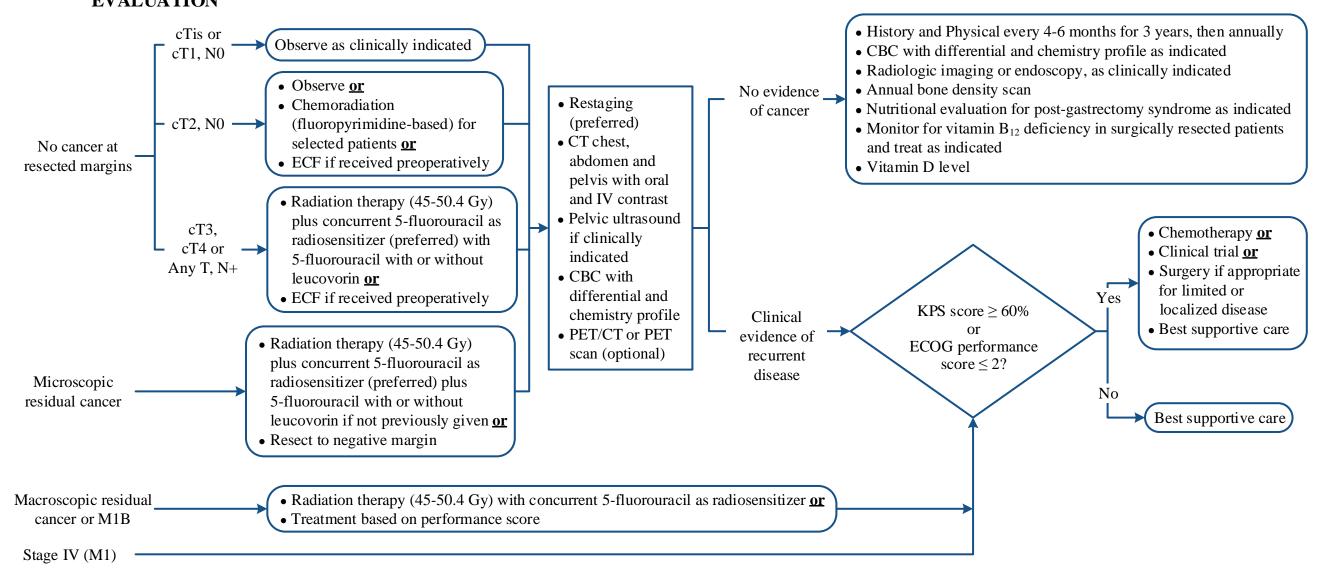
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# POST SURGICAL RESPONSE EVALUATION

#### ADJUVANT TREATMENT



ECF = epirubicin, cisplatin and 5-fluorouracil

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#### SUGGESTED READINGS

#### PRINCIPLES OF MULTIDISCIPLINARY TEAM APPROACH FOR GASTROESOPHAGEAL CANCERS

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#### **SUGGESTED READINGS - continued**

#### PRINCIPLES OF SYSTEMIC THERAPY FOR GASTRIC OR GASTROESOPHAGEAL JUNCTION ADENOCARCINOMA - CONTINUED

- Cunningham, D., Starling, N., Rao, S., Iveson, T., Nicolson, M., Coxon, F., ... Norman, A. R. (2008). Upper Gastrointestinal Clinical Studies Group of the National Cancer Research Institute of the United Kingdom capecitabine and oxaliplatin for advanced esophagogastric cancer. *The New England Journal of Medicine*, 358(1), 36-46. doi:10.1056/NEJMoa073149
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#### OTHER SUPPORTIVE READINGS

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#### **DEVELOPMENT CREDITS**

This practice algorithm is based on majority expert opinion of the Gastrointestinal Center Faculty at the University of Texas MD Anderson Cancer Center. It was developed using a multidisciplinary approach that included input from the following:

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