

T3 Cancer of the Stomach

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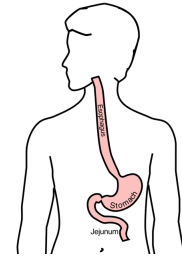
Anatomy

Food moves from the throat

→ esophagus

→ stomach

→ small bowel (jejunum)



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Cancer Staging

Staging refers to the tests to determine

- How large is the tumor?
- Has there been spread to lymph nodes?
- Has it spread to other parts of the body?

Treatment options depend upon the cancer stage

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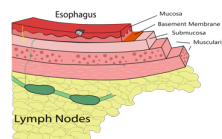
Cancer Staging

- **T** = Tumor - Depth of growth into the wall
- **N** = Nodes - Spread to the lymph nodes
- **M** = Metastasis - Spread to liver, lungs, or bone

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Early Stage Cancers

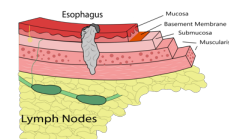
Cancers start on the very inside layer called the mucosa



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Locally-advanced Cancers

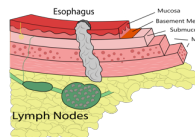
Over time, cancers can grow into the muscular wall



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Lymph Nodes

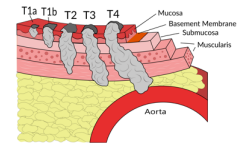
In some cases, cancer cells can break off from the main tumor and spread to lymph nodes



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T Stage

Cancers are categorized based upon the thickness of the tumor, known as the T stage

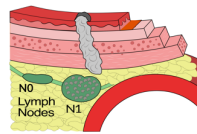


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N Stage

Cancers are categorized by whether there is spread to the nodes.

- **N0** cancers have not spread to the nodes
- **N1** cancers have spread to the nodes.

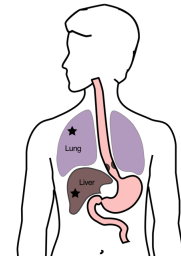


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M Stage

Some cancers spread to other parts of the body

- **M0** cancers have not spread to other parts of the body
- **M1** cancers have spread to lungs, liver, or bone

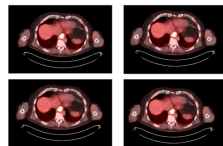


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PET scan

PET scan is similar to CT scan

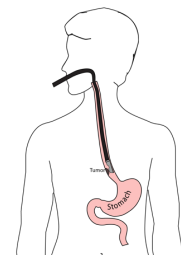
- Tracer shows 'hot spots'
 - Cancer
 - Inflammation or infection
 - Normal organs (heart)



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Endoscopic Ultrasound

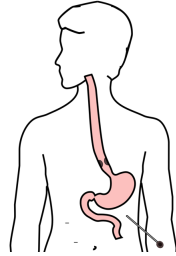
- Similar to upper endoscopy (EGD)
- Ultrasound in scope
- Evaluates T stage



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Laparoscopy

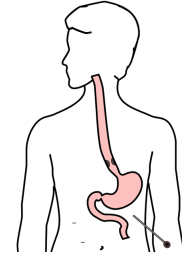
- Some stomach cancers can spread inside the abdomen
- Areas of spread can be very small (grain of rice)
- Laparoscopy can detect spread inside the abdomen



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Laparoscopy

- General anesthetic
- Several 1/4" incisions 1/4"
- Telescope examines the abdomen
- Biopsies can be performed.



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Treatment Plan

Superficial (T1) ⇒ Endoscopic Therapy

Localized (T1b/T2) ⇒ Surgery

Locally-advanced (T3/N1) ⇒ Chemo → Surgery → Chemo

Metastatic (M1) ⇒ Chemotherapy

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Locally-advanced Adenocarcinoma

"Sandwich" chemotherapy before + after surgery:

Chemo (8 wks) → Surgery → Chemo (8 wks)

Two different drug combinations:

- FLOT (more effective)
- FOLFOX (better tolerated)

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"Sandwich" Chemotherapy Drugs

FLOT

- 5-FU
- Leucovorin
- Oxaliplatin
- Taxotere

FOLFOX

- 5-FU
- Leucovorin
- Oxaliplatin

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Tumor Biomarkers

Pathology tests show whether other drugs may be helpful:

- HER-2 → Herceptin can be helpful
- PD-L1 → Immunotherapy can be helpful
- MMR → Immunotherapy can be helpful

Biomarkers reported in a separate pathology report

Your medical oncologist will review these with you

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Chemotherapy Administration

- Most chemotherapy is administered by vein.
Several options exist to administer chemotherapy:
- Intravenous catheter in peripheral veins
 - Peripheral Intravenous Central Catheter (PICC)
 - Central Venous port

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Intravenous Catheter in Peripheral Vein ("IV")

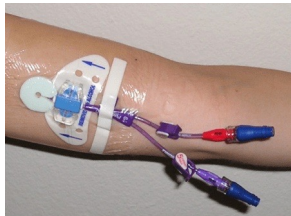
- IV catheter placed in vein of hand or arm
- Allows administration of chemo and fluids
- Placed for each dose
- Removed that day
- Not suitable for FLOT chemo



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PICC Lines

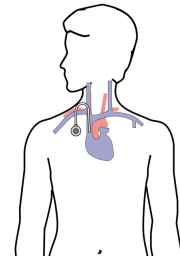
- Placed in Radiology
- Stay in place during all of treatment
- Needs to be kept clean and dry
- Suitable for FLOT chemotherapy



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Central Venous Port

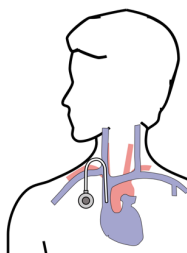
- Implantable device makes chemo easier
- May shower in 24 hrs
- No special care at home
- OK for FLOT chemo
- Allows for blood draws



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Central Venous Port

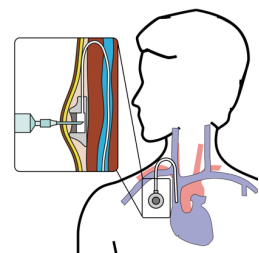
- Implanted under the skin
- Neck incision (1/4")
- Incision below the collarbone
- Sutures dissolve
- "Superglue" on incisions



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Central Venous Port

When it is time for chemotherapy, a needle is inserted through the skin into the port



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Restaging

CT or PET scan performed after preoperative therapy

- Surgery performed after restaging
- Timing depends upon recovery from therapy

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Primary Care Practitioner (PCP)

Critical to coordinate care between specialists.

We will update your PCP after each visit

PCP Referral Line (844) 235-6998

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My Atrium Patient Portal

- Critical to good communication with your care team
- Available for desktop or laptop or phone
- Sign up at my.atriumhealth.org

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Exercise

- Reduces risk of complications from treatment
- Goal is 30min/day of vigorous exercise 6 days/week
 - Working hard enough that you can't converse
 - Start slowly and build up
 - Every day counts! (Aim for daily activity)

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Smoking Cessation

- Smoking makes cancer treatment more difficult
 - Increases risk of complications after surgery
- Options for help with smoking cessation:
 - NC Quit Line 1-800-QUIT-NOW (1-800-784-8669)
 - American Lung Assn
www.freedomfromsmoking.org
 - Smoking Cessation Counseling (Metro Charlotte)

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Protein Needs

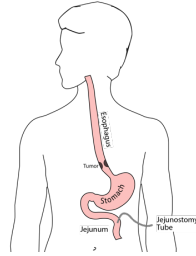
- Men: Average 75 grams/day
 - Women: Average 60 grams/day
- Protein Shakes provide protein with minimal sugar



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Jejunostomy Tube

- Nutrition to bypasses the esophagus and stomach
- Placed in small intestine
- Pump administers feedings slowly
- Feeding usually done at night



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Jejunostomy Typical Regimen

- Jejunostomy tube feeds for 16 hours (6pm-10am)
 - Men: 75mL/hour x 16 hours = 5 cartons
 - Women: 60mL/hour x 16 hours = 4 cartons
 - Water 240ml (8oz) via syringe 4x/day
- Hospital nurses will teach use of the feeding tube

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Jejunostomy Feeds with Diabetes

Jejunostomy feedings elevate blood sugars

- Insulin may be required along with feeds
- Typical Pattern for tube feeds
- Feeds run via pump from 6pm to 10am
 - Insulin at 6pm (70/30 insulin)
 - Insulin at Midnight (70/30 insulin)
 - No insulin if tube feedings are not run

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Jejunostomy Video

A video is available to help become familiar with the feeding jejunostomy



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Stomach Cancer Surgery Goals

Staging refers to the tests to determine

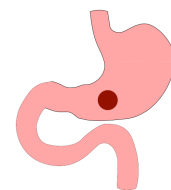
- Remove the tumor
- Remove lymph nodes (depends upon tumor type)
- Preserve stomach function
- Reconstruct GI tract

Treatment options depend upon the cancer stage

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Distal Cancers

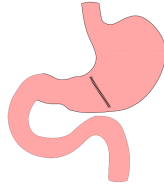
Distal cancers are those in the lower part of the stomach



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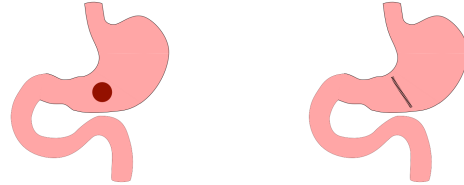
Partial Gastrectomy

- Removes the tumor
- Does not remove lymph nodes
- Best suited for:
 - Small adenocarcinoma
 - GI Stromal Tumors



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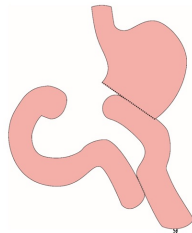
Partial Gastrectomy



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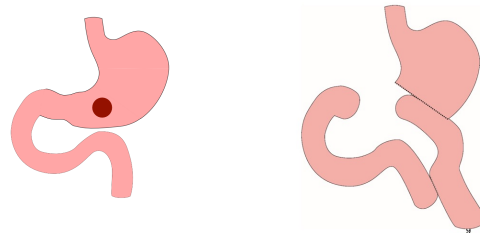
Distal Gastrectomy

- Removes bottom half of the stomach
- Does not remove all lymph nodes



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Distal Gastrectomy



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Body Cancers

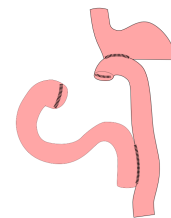
Body is the mid-portion of the stomach



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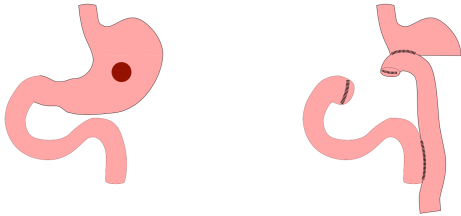
Subtotal Gastrectomy

- Removes bottom 2/3 of stomach
- Removes nearby lymph nodes
- Reconstruction with



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Subtotal Gastrectomy



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Proximal Tumors

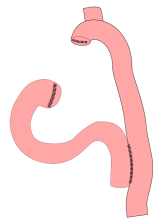
- Located near the top of the stomach
- Challenging area for surgery



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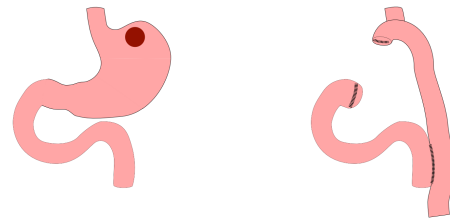
Total Gastrectomy

- Removes all of the stomach
- Reconstruction with small intestine
- Needed for those with CDH1 mutations



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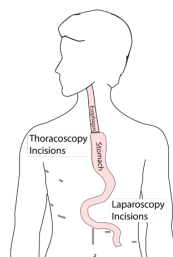
Total Gastrectomy



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Esophagogastrectomy

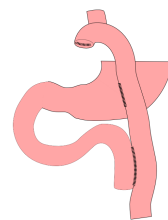
- Removes top part of stomach
- Remove bottom half of esophagus
- Surgery in both abdomen and chest



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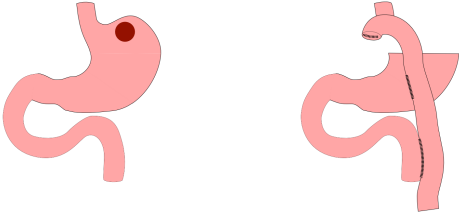
Dual Tract Gastrectomy

- Alternative surgical approach for small tumors near the top of the stomach
- Preserves the bottom of the stomach as a reservoir



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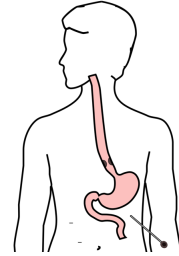
Dual Tract Gastrectomy



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Laparoscopy

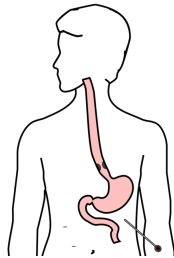
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Laparoscopy

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- Telescope examines the abdomen
- Biopsies can be performed.



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Risks of Surgery

- Leak where bowel is joined together (anastomosis)
- Bleeding requiring reoperation
- Delayed stomach function
- Infection in the abdomen

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