New trends in management of gastric carcinoma

Mohamed Gamal Dawoud

Gastric cancer is a biologically aggressive disease. Untill 1988, adenocarcinoma of the stomach was the leading cause of cancer death worldwide. There has always been several premalignant conditions and risk factors incriminated in the pathogenesis and development of gastric carcinoma, However a debate still exists concerning each and every risk factor and whether it’s role in gastric cancer is a pure co-existence or an actual precancerous triggering factor. Approximately 95% of all malignant gastric neoplasms are adenocarcinomas, and the term gastric cancer usually refers to adenocarcinoma of the stomach which represents two distinct types of cancer localised and diffuse types with different pathogenesis, epidemiology and prognosis. Patients with gastric cancer often present with a clinical picture that fails to trigger the proper diagnostic impression in the physician’s mind so the investigation of patients without symptoms with predisposing conditions is valuable.The established methods of investigation of the uppergastrointestinal tract are roentgenography and endoscopy.Endoscopy allows direct visualization and biopsy from the lesion and with the recent technique of using carbon inkinjection marking for determination of resection line on the gastric wall in stomach and also the use of strip biopsytechnique especially for early gastric cancer. Other investigational tools include ultrasound, magnetic resonance imaging, computed tomography, endoscopic ultrasonography which is the most accurate diagnostic method at present especially in detection of submucosal invasion of early gastric carcinomas, also laparoscopy which permits direct inspection and biopsy taking for histo pathological examination, and the more recently combined laparoscopy and ultrasonography which can be done under local anaesthesia on an out patient basis, this technique may replace other preoperative radiological investigations, among recent investigations used nowadays tumor markers and oncogens, also the use of flow cytometry in prediction of tumor invasion and early metastases, also the use of endoscopic color doppler ultrasonography (ECD-US) in -the evaluation of the flow dynamics of submucosal tumors and for diagnostic work up. The role of radical surgery in the treatment of this disease has not been clearly defined, the only curative treatment for carcinoma of the stomach is resection which is most successful in early stages of carcinoma of the stomach, a more extensive lymphadenectomy had improved the five year survival rate. In patients who have undergone resection with curative intent, radiation therapy, external beam or intraoperative radiotherapy, has been used to reduce the high incidence of local and regional failure. Palliative resection of an incurable carcinoma of the stomach has been shown to be more worthwhile than a bypass procedure. A new

endoscopic technique has recently been developed which allows resection of polypoid and depressed lesion of the gastric mucosa. A newer palliative procedure such a laser resection of inoperable gastric lesions at the oesophagogastric junction or pylorus may be beneficial allevating obstruction. Intraperitoneal chemotherapy for gastric cancer is valuable in view of the failure pattern of the disease, regimens involving biochemical modulation of 5-F such as FAMTX regimen are one major focus of investigation. Immunochemotherapy, hormone therapy and a new concept of multimodality treatment called immunochemo surgery is going to play an important role in the future.