



National Comprehensive
Cancer Network®

NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®)

Gastric Cancer

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NCCN Guidelines Panel Disclosures

Continue

▣ Gastroenterology	≠ Pathology
Δ Genetics	§ Radiotherapy/Radiation oncology
‡ Hematology/Hematology oncology	¶ Surgery/Surgical oncology
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[NCCN Gastric Cancer Guidelines Panel Members](#) [Summary of the Guidelines Updates](#)

[Workup and Additional Evaluation \(GAST-1\)](#)

[Conclusions of Multidisciplinary Review, Primary Treatment \(GAST-2\)](#)

[Response Assessment, Additional Management \(GAST-3\)](#)

[Surgical Outcomes/Clinical Pathologic Findings for Patients Who Have Not Received Preoperative Therapy \(GAST-4\)](#)

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[Principles of Endoscopic Staging and Therapy \(GAST-A\)](#)

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[Principles of Surgery \(GAST-C\)](#)

[Principles of Genetic Risk Assessment for Gastric Cancer \(GAST-D\)](#)

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[Principles of Systemic Therapy \(GAST-F\)](#)

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[Principles of Surveillance \(GAST-H\)](#)

[Principles of Survivorship \(GAST-I\)](#)

[Principles of Palliative Care/Best Supportive Care \(GAST-J\)](#)

[Staging \(ST-1\)](#)

Clinical Trials: NCCN believes that the best management for any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

To find clinical trials online at NCCN Member Institutions, [click here: nccn.org/clinical_trials/member_institutions.aspx](#).

NCCN Categories of Evidence and Consensus: All recommendations are category 2A unless otherwise indicated.

See [NCCN Categories of Evidence and Consensus](#).

NCCN Categories of Preference: All recommendations are considered appropriate.

See [NCCN Categories of Preference](#).

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Updates in Version 1.2020 of the NCCN Guidelines for Gastric Cancer from Version 4.2019 include:

GAST-1

- **Workup;**
 - ▶ **Seventh bullet revised:** Endoscopic resection (ER) is essential for the accurate staging of early-stage cancers (T1a or T1b). *Early-stage cancers can best be diagnosed by ER.*
 - ▶ **Ninth bullet revised:** ~~MSI-H/dMMR~~ **MSI by PCR/MMR by IHC testing** if metastatic disease is documented/suspected.

GAST-3

- **Primary Treatment for Medically Fit Patients; Response Assessment:** *FDG-PET/CT scan as clinically indicated was added.*

GAST-9

- **Unresectable locally advanced, Locally recurrent or metastatic disease; Good performance status:** Revised, Perform HER2, PD-L1, ~~MSI/MMR~~ **MSI by PCR/MMR by IHC testing** (if not done previously) if metastatic adenocarcinoma is documented or suspected.

GAST-B Principles of Pathologic Review and Biomarker Testing

3 of 6

- **Assessment of Overexpression or Amplification of HER2 in Gastric Cancer**
 - ▶ **Recommendation revised:** "... fluorescence in situ hybridization (FISH) or other in situ hybridization (ISH) methods is recommended. *Next-generation sequencing (NGS) offers the opportunity to assess numerous mutations simultaneously, along with other molecular events such as amplification, deletions, tumor mutation burden, and microsatellite instability status. When limited diagnostic tissue is available for testing and the patient is unable to undergo additional procedures, NGS can be considered instead of sequential testing for single biomarkers. It should be noted that NGS has several inherent limitations and thus whenever possible, the use of gold-standard assays (IHC/ISH) should be performed.*"

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- **Microsatellite Instability (MSI) or Mismatch Repair (MMR) Testing:**
 - ▶ **Bullet revised:** ~~MMR or Testing for MSI by polymerase chain reaction (PCR) or MMR by IHC testing~~ should be considered on locally advanced, recurrent, or metastatic gastric cancer in patients who are candidates for treatment with PD-1 inhibitors. The testing is performed on formalin-fixed paraffin-embedded (FFPE) tissue and results are interpreted as MSI-high (MSI-H) or mismatch protein-repair-deficient (dMMR) in accordance with [CAP DNA Mismatch Repair Biomarker Reporting Guidelines](#). MMR or MSI testing should be performed only in CLIA-approved laboratories. *Patients with MSI-H or dMMR tumors should be referred to a genetics counselor for further assessment.*
 - ▶ **New sub-bullets added for MMR interpretation and MSI interpretation.**
- **PD-L1 Testing:** First bullet revised, "...gastric adenocarcinoma. A minimum of 100 tumor cells must be present in the PD-L1-stained slide for the specimen to be considered adequate for PD-L1 evaluation..."
- **Footnote h revised:** ~~IHC for MMR and PCR for MSI are different assays measuring the same biological effect. PCR for MSI and IHC for MMR proteins measures different biological effects caused by dMMR function.~~

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- **Next-Generation Sequencing:** Bullet revised, "...Pembrolizumab is based on testing for MSI by PCR/MMR by IHC and or PD-L1 expression by CPS...."
- A new section was added for liquid biopsy.
- Footnote "i" is new: [See Guidelines for Management of Immunotherapy-Related Toxicities](#).

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- References were updated.

Continued

UPDATES

**GAST-C Principles of Surgery**

- **Siewert classification:** The term "center" was clarified as "*epicenter*".
- **Resectable tumors, Bullets and sub-bullets revised:**
 - ▶ **T1b–T3:** Adequate gastric resection to achieve negative microscopic margins (~~typically ≥4 cm from gross tumor~~).
 - ▶ ~~"...at least 15 16 or greater lymph nodes."~~
 - ▶ **D2 dissection** is a D1 plus 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. Splenectomy is acceptable when the spleen or the hilum is involved~~ *Routine splenectomy is not indicated unless the spleen is involved or extensive hilar adenopathy is noted.*

GAST-F: Principles of Systemic Therapy**1 of 13**

- **Third bullet:** Clarified as, Trastuzumab should be added to *first-line* chemotherapy for HER2 overexpressing metastatic adenocarcinoma.

2 of 13

- **Postoperative Chemotherapy**
 - ▶ The NCCN Categories of Preference have been applied to the suggested regimens.
 - ◇ Capecitabine and oxaliplatin listed as a *preferred* regimen
 - ◇ *Fluorouracil and oxaliplatin* was added as a postoperative chemotherapy option and is listed as *preferred*.
- **Chemoradiation for Unresectable Disease**
 - ▶ The NCCN Categories of Preference have been applied to the suggested regimens.
 - ▶ Corresponding dosing for all regimens was added ([8 of 13](#))

Systemic Therapy for Unresectable Locally Advanced, Recurrent or Metastatic Disease**3 of 13**

- **First-Line Therapy:** New bullet added, *Oxaliplatin is generally preferred over cisplatin due to lower toxicity.*

4 of 13

- **Second-Line or Subsequent Therapy**
 - ▶ *Fluorouracil and irinotecan + ramucirumab* was added as an option under "Useful in Certain Circumstances." Dosing for this regimen was added to page [11 of 13](#).
 - ▶ New footnote g added: [See NCCN Guidelines for Management of Immunotherapy-Related Toxicities.](#) (Also for [11 of 13](#))

- ▶ Footnote h revised: "Pembrolizumab is FDA-approved for the third-line treatment of patients with ..."

Principles of Systemic Therapy-Regimens and Dosing Schedules**5 of 13**

- Footnote c was added to additional pages: Leucovorin is indicated with certain fluorouracil-based regimens. Depending on availability, these regimens may be used with or without leucovorin. For important information regarding the leucovorin shortage, please see the [Discussion](#). (Also for [6 of 13](#), [7 of 13](#), [9 of 13](#), [10 of 13](#), [11 of 13](#))

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- **Postoperative Chemoradiation** (for patients who have undergone primary D2 lymph node dissection)
 - ▶ The "fluorouracil (bolus) and leucovorin" dosing schedule was removed.
 - ▶ The explanatory text was revised: "The Panel Acknowledges That The Intergroup 0116 Trial Formed The Basis For Postoperative Adjuvant Chemoradiation Strategy. However, The Panel Does Not Recommend The Above Specified Doses Or And Schedule Of Cytotoxic Agents Because Specified In This Trial Due To Concerns Regarding Toxicity. The Panel Recommends One Of The Following Modifications Instead..."
 - ▶ **Fluorouracil:** The "With radiation" dosing was revised:
 - ◇ Fluorouracil 200–250 mg/m² IV continuous infusion over 24 hours daily on Days 1–5 ~~or 1–7~~ Weekly for 5 weeks
 - ◇ **Capecitabine:** The "With radiation" dosing was revised: Capecitabine 625–825 mg/m² PO BID on Days 1–5 ~~or 1–7~~ Weekly for 5 weeks
- **Postoperative Chemotherapy**
 - ▶ Dosing was added for fluoropyrimidine and oxaliplatin.

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- ▶ **First-Line Therapy; Preferred regimens:** For "fluoropyrimidine and oxaliplatin" a new low dose capecitabine and oxaliplatin regimen was added:
 - ▶ *Capecitabine 625 mg/m² PO BID on Days 1–14*
 - ▶ *Oxaliplatin 85 mg/m² IV on Day 1*
 - ▶ *Cycled every 21 days*

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- The reference pages were updated to reflect the changes in the algorithm.

Continued**UPDATES**



GAST-G Principles of Radiation Therapy

4 of 5

- Supportive Therapy; Last bullet revised: Adequate enteral and/or IV hydration ~~may be~~ *is* necessary during chemoradiation and early recovery.

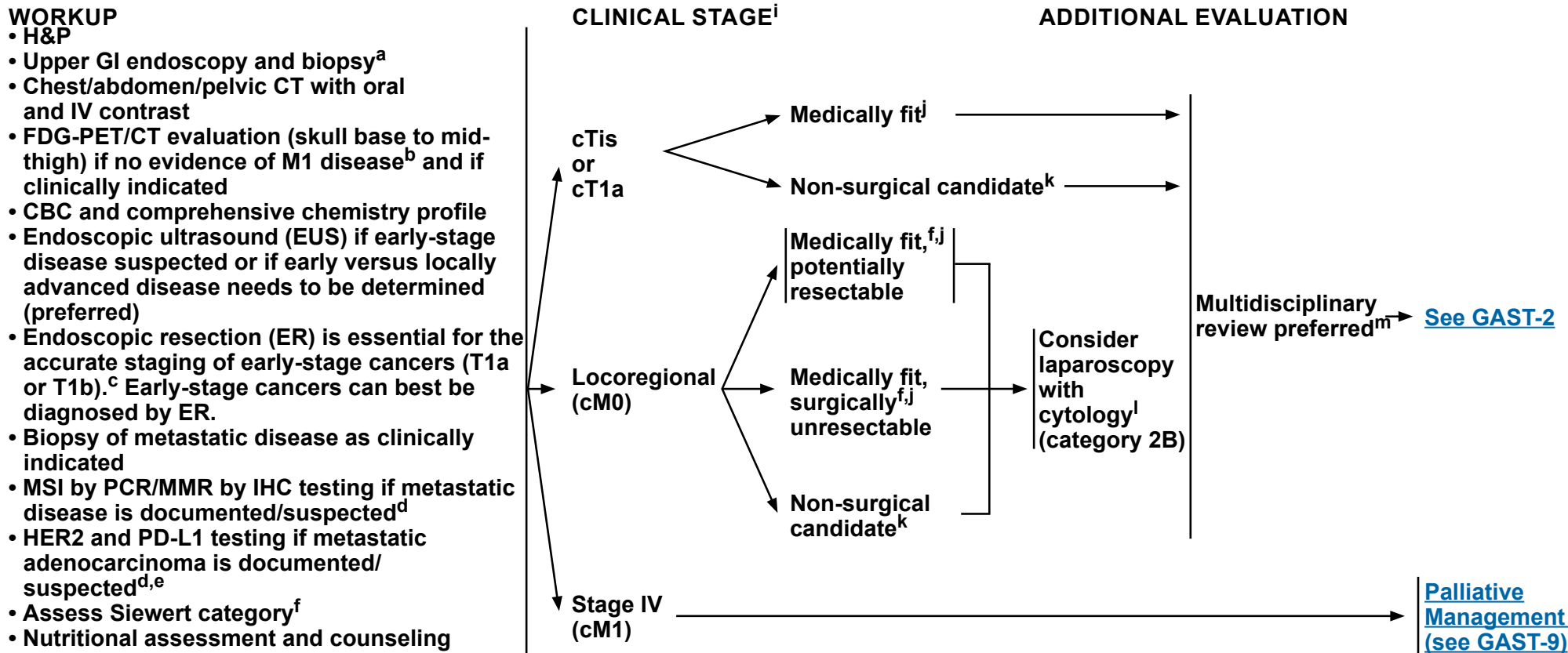
GAST-I Principles of Survivorship

3 of 3

- Counseling Regarding Health Behavior: Last bullet revised, Additional preventive health *measures* and immunizations should be performed as indicated under the care of or in conjunction with a PCP.
- Survivorship Care Planning and Coordination of Care
 - ▶ Link added: [See NCCN Guidelines for Prevention and Treatment of Cancer-Related Infections](#)
 - ▶ Fourth bullet and corresponding sub-bullets about survivorship care plans was replaced with the following
 - ◇ **Planning for ongoing survivorship care**
 - Information on treatment received including all surgeries, radiation therapy, and systemic therapies
 - Information regarding follow-up care, surveillance, and screening recommendations
 - Information on post-treatment needs, including information regarding acute, late and long-term treatment-related effects and health risks when possible ([See NCCN Guidelines for Treatment of Cancer by Site](#))
 - Delineation regarding roles of oncologists, primary care physicians (PCPs), and subspecialty care physicians in long-term care and the timing of transfer of care if appropriate
 - Healthy behavior recommendations ([See NCCN Guidelines for Survivorship \[see HL-1\]](#))
 - Periodic assessment of ongoing needs and identification of appropriate resources

GAST-J Principles of Palliative Care/Best Supportive Care

- Footnote b is new: For patients who have immune-mediated toxicity, [See NCCN Guidelines for Management of Immunotherapy-Related Toxicities](#).



^aSee Principles of Endoscopic Staging and Therapy (GAST-A).

^bMay not be appropriate for T1.

^cER may also be therapeutic for early-stage disease/lesions.

^dSee Principles of Pathologic Review and Biomarker Testing (GAST-B).

^eTumor Epstein-Barr virus status is emerging as a potential biomarker for personalized treatment strategies for gastric cancer, but is not currently recommended for clinical care.

^fSee Principles of Surgery (GAST-C).

^gSee NCCN Guidelines for Smoking Cessation.

^hSee Principles of Genetic Risk Assessment for Gastric Cancer (GAST-D). Also see [NCCN Guidelines for Colorectal Cancer Screening](#) and [NCCN Guidelines for Genetic/Familial High-Risk Assessment: Breast and Ovarian](#).

ⁱSee Staging (ST-1) for tumor classification.

^jMedically able to tolerate major surgery.

^kMedically unable to tolerate major surgery or medically fit patients who decline surgery.

^lLaparoscopy with cytology is performed to evaluate for peritoneal spread when considering chemoradiation or surgery. Laparoscopy with cytology is not indicated if a palliative resection is planned. Laparoscopy with cytology is indicated for clinical stage T1b or higher.

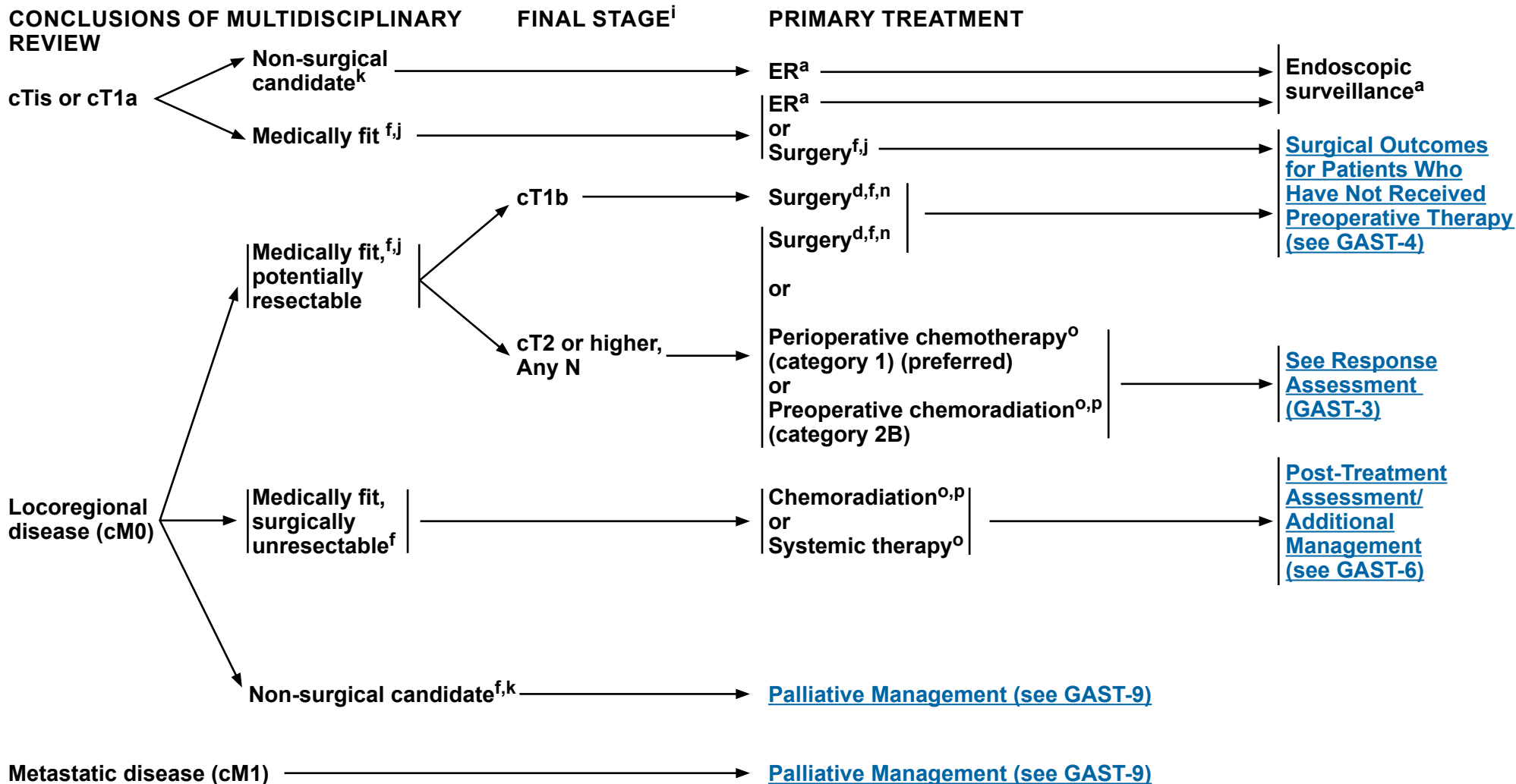
^mSee Principles of Multidisciplinary Team Approach (GAST-E).

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Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.



NCCN Guidelines Version 1.2020 Gastric Cancer



^aSee Principles of Endoscopic Staging and Therapy (GAST-A).

^dSee Principles of Pathologic Review and Biomarker Testing (GAST-B).

^fSee Principles of Surgery (GAST-C).

ⁱSee Staging (ST-1) for tumor classification.

^jMedically able to tolerate major surgery.

^kMedically unable to tolerate major surgery or medically fit patients who decline surgery.

ⁿSurgery as primary therapy is appropriate for ≥T1b cancer or actively bleeding cancer, or when postoperative therapy is preferred.

^oSee Principles of Systemic Therapy (GAST-F).

^pSee Principles of Radiation Therapy (GAST-G).

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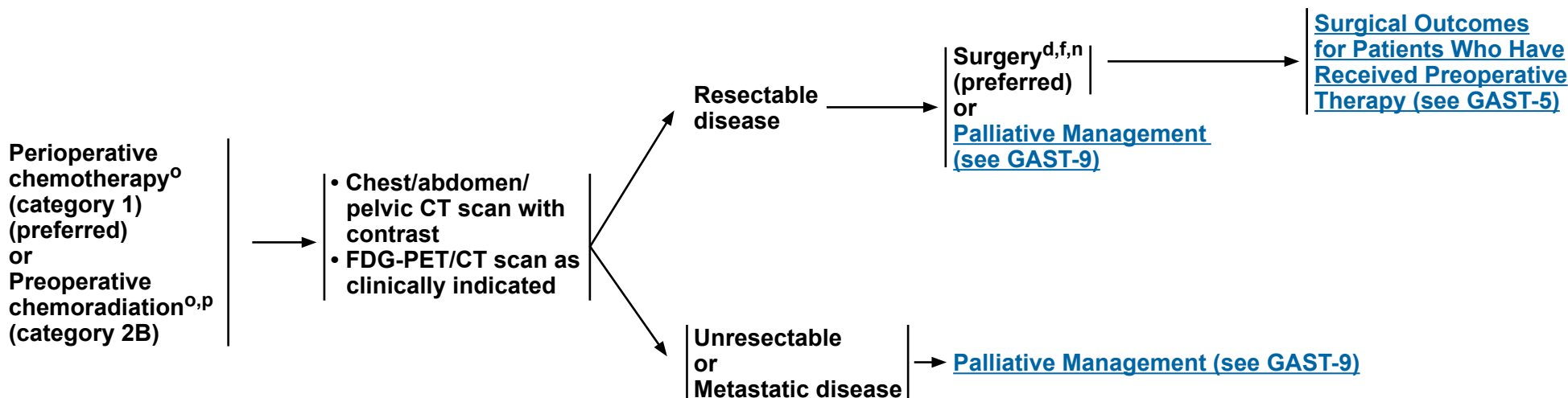


PRIMARY TREATMENT FOR MEDICALLY FIT PATIENTS

RESPONSE ASSESSMENT

OUTCOME

ADDITIONAL MANAGEMENT



^dSee Principles of Pathologic Review and Biomarker Testing (GAST-B).

^fSee Principles of Surgery (GAST-C).

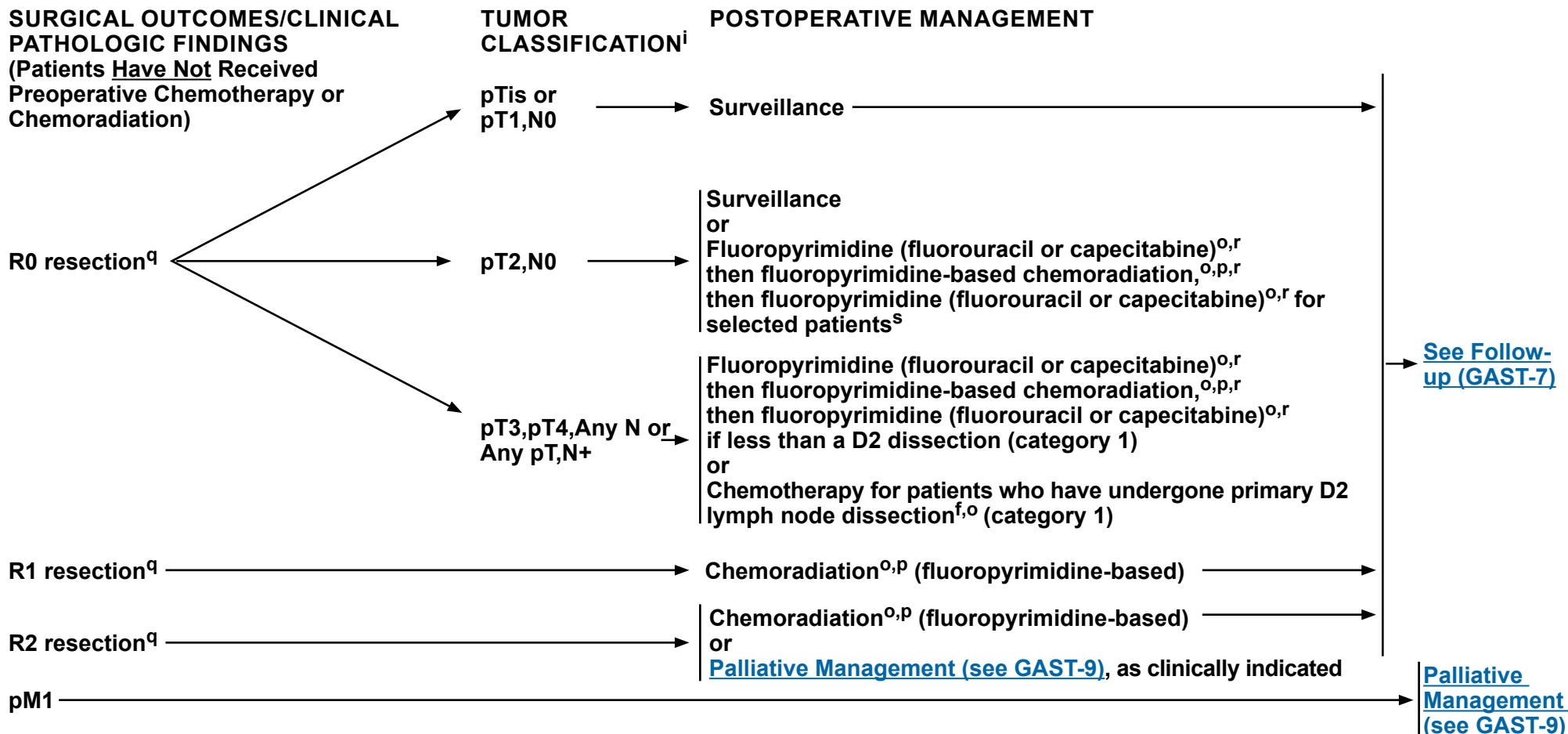
ⁿSurgery as primary therapy is appropriate for $\geq T1b$ cancer or actively bleeding cancer, or when postoperative therapy is preferred.

^oSee Principles of Systemic Therapy (GAST-F).

^pSee Principles of Radiation Therapy (GAST-G).

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^fSee Principles of Surgery (GAST-C).

ⁱSee Staging (ST-1) for tumor classification.

^oSee Principles of Systemic Therapy (GAST-F).

^pSee Principles of Radiation Therapy (GAST-G).

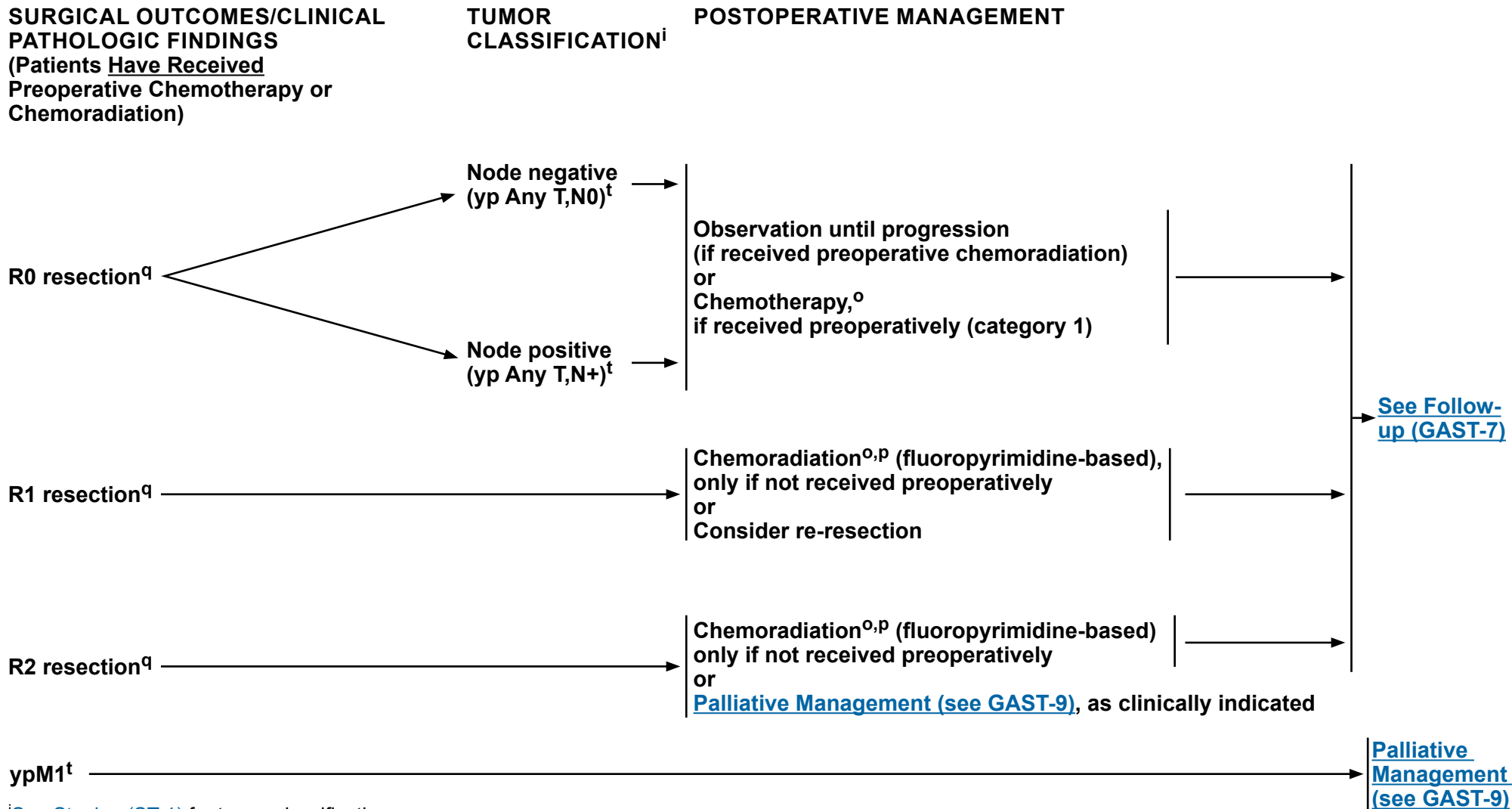
^qR0 = No cancer at resection margins, R1 = Microscopic residual cancer, R2 = Macroscopic residual cancer or M1.

^rSmalley SR, Benedetti JK, Haller DG, et al. Updated analysis of SWOG-directed intergroup study 0116: a phase III trial of adjuvant radiochemotherapy versus observation after curative gastric cancer resection. J Clin Oncol 2012;30:2327-2333. See Principles of Systemic Therapy (GAST-F).

^sHigh-risk features include poorly differentiated or higher grade cancer, lymphovascular invasion, neural invasion, or <50 years of age or patients who did not undergo D2 lymph node dissection.

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ⁱSee [Staging \(ST-1\)](#) for tumor classification.

^oSee [Principles of Systemic Therapy \(GAST-F\)](#).

^pSee [Principles of Radiation Therapy \(GAST-G\)](#).

^qR0 = No cancer at resection margins, R1 = Microscopic residual cancer, R2 = Macroscopic residual cancer or M1.

^tThe yp prefix is used to indicate cases in which staging is performed following preoperative therapy.

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POST-TREATMENT ASSESSMENT

OUTCOME

ADDITIONAL MANAGEMENT

Unresectable disease or Non-surgical candidate^k following primary treatment

Restaging:
 • Chest/abdomen/pelvic CT with oral and IV contrast
 • CBC and comprehensive chemistry profile
 • FDG-PET/CT scan as clinically indicated^u

Resectable and medically operable →

Surgery (preferred),^{d,f} if appropriate or [See Follow-up \(GAST-7\)](#)

Unresectable or Medically inoperable and/or Metastatic disease

[Palliative Management \(see GAST-9\)](#)

^dSee [Principles of Pathologic Review and Biomarker Testing \(GAST-B\)](#).

^fSee [Principles of Surgery \(GAST-C\)](#).

^kMedically unable to tolerate major surgery or medically fit patients who decline surgery.

^uIn cases of renal insufficiency or allergy to CT contrast.

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FOLLOW-UP/SURVEILLANCE^w

Tis
(successfully
treated by
ER)^v

- H&P every 3–6 mo for 1–2 y, every 6–12 mo for 3–5 y, and annually thereafter
- CBC and chemistry profile as clinically indicated
- Upper GI endoscopy (EGD) every 6 mo for 1 y, then annually for 3 y
- Routine imaging (CT chest/abdomen/pelvis with oral and IV contrast) as clinically indicated based on symptoms and concern for recurrence

p stage I
(T1a,T1b,
N0–1 treated
by surgical
resection or
T1a treated
by ER)^v

- H&P every 3–6 mo for 1–2 y, every 6–12 mo for 3–5 y, and annually thereafter
- CBC and chemistry profile as clinically indicated
- For patients treated by ER, EGD every 6 mo for 1 y, then annually for up to 5 years
 - ▶ Thereafter, as needed based on symptoms and/or radiographic findings
- For patients treated by surgical resection, EGD as clinically indicated
- CT chest/abdomen/pelvis with oral and IV contrast as clinically indicated^x
- Monitor for nutritional deficiency (eg, B₁₂ and iron) in surgically resected patients (especially after total gastrectomy) and treat as indicated

p stage II/III or
yp stage I–III
(treated with
neoadjuvant
± adjuvant
therapy)^v

- H&P every 3–6 mo for 1–2 y, every 6–12 mo for 3–5 y, and annually thereafter
- CBC and chemistry profile as clinically indicated
- For patients who had partial or subtotal gastrectomy, EGD as clinically indicated
- CT chest/abdomen/pelvis with oral and IV contrast (preferred) every 6–12 months for first 2 years, then annually up to 5 years^x and/or can consider FDG-PET/CT as clinically indicated
- Monitor for nutritional deficiency (eg, B₁₂ and iron) in surgically resected patients (especially after total gastrectomy) and treat as indicated

Recurrence
(See GAST-8)
or
Survivorship^y

^vFor patients undergoing total gastrectomy for curative intent, surveillance should follow these recommendations except for endoscopy. Endoscopy has no role in routine surveillance for total gastrectomy unless patients are symptomatic.

^wSee [Principles of Surveillance \(GAST-H\)](#).

^xAfter 5 years, additional follow-up may be considered based on risk factors and comorbidities.

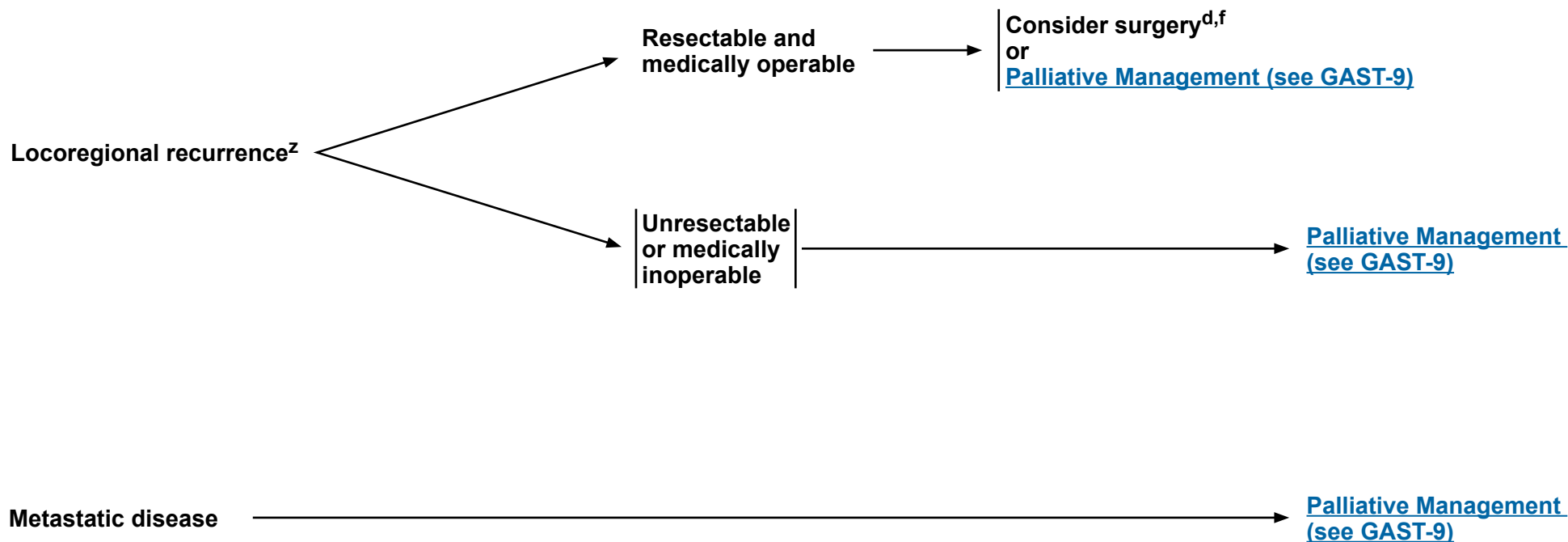
^ySee [Principles of Survivorship \(GAST-I\)](#).

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RECURRENCE



^dSee [Principles of Pathologic Review and Biomarker Testing \(GAST-B\)](#).

^fSee [Principles of Surgery \(GAST-C\)](#).

^zReview if surgery is appropriate for patients with isolated local recurrences. Surgery should be considered as an option for locoregional recurrence in medically fit patients.

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PERFORMANCE STATUS

PALLIATIVE MANAGEMENT

Unresectable locally advanced, Locally recurrent or metastatic disease

Karnofsky performance score $\geq 60\%$
or
ECOG performance score ≤ 2

Perform HER2, PD-L1, MSI by PCR/MMR by IHC testing (if not done previously) if metastatic adenocarcinoma is documented or suspected^d

Chemoradiation (only if locally unresectable and not previously received)^{o,p}
or
Systemic therapy^o
or
Best supportive care^{aa}

Karnofsky performance score $< 60\%$
or
ECOG performance score ≥ 3

Best supportive care^{aa}

^dSee Principles of Pathologic Review and Biomarker Testing (GAST-B).

^oSee Principles of Systemic Therapy (GAST-F).

^pSee Principles of Radiation Therapy (GAST-G).

^{aa}See Principles of Palliative Care/Best Supportive Care (GAST-J).

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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 for 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 (6–8) biopsies using standard size endoscopy forceps should be performed to provide adequately sized material for histologic interpretation, especially in the setting of an ulcerated lesion.^{1,2} Larger forceps may improve the yield.
- Endoscopic mucosal resection (EMR) or endoscopic submucosal dissection (ESD) can be performed in the evaluation of small lesions. EMR or ESD of focal nodules ≤ 2 cm can be safely performed to provide a larger specimen that can be better assessed by the pathologist, providing greater information on degree of differentiation, the presence of lymphovascular invasion (LVI), and the depth of infiltration, thereby providing accurate T-staging.³ Such excisional biopsies have the potential of being therapeutic.⁴
- 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.

Staging

- EUS performed prior to any treatment is important in the initial clinical staging of gastric cancer.⁵ Careful attention to ultrasound images provides evidence of depth of tumor invasion (T-category), 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-category) or the presence of ascites.⁶ This is especially important in patients who are being considered for endoscopic resection (EMR or ESD).⁷
- 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-categories. A dark expansion of layers 1–3 corresponds with infiltration of the superficial and deep mucosa plus the submucosa, 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 that correlates with invasion of the subserosa, T3 disease. Loss of the bright line recognized as the serosa is now staged as pT4a, and extension of the mass into surrounding organs such as the liver, pancreas, and spleen is staged as pT4b 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.⁸ 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 treatment decisions. Furthermore, an attempt should be made to identify the presence of ascites and FNA should be considered to rule out peritoneal spread of disease.

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[Continued](#)
[References](#)

GAST-A
1 OF 3

**PRINCIPLES OF ENDOSCOPIC STAGING AND THERAPY****Treatment**

- EMR or ESD of early-stage gastric cancer can be considered adequate therapy when the lesion is ≤ 2 cm in diameter, is shown on histopathology to be well or moderately well differentiated, does not penetrate beyond the superficial submucosa, does not exhibit LVI, and has clear lateral and deep margins. En-bloc excision of small gastric lesions by ESD has been shown to be more effective than EMR in curing *small* early-stage gastric cancer, but requires greater skills and instrumentation to perform and has a significant risk of complications including perforation.⁹
- Japanese Gastric Cancer guidelines recommend that EMR or ESD should be considered for early-stage gastric cancer lesions ≤ 2 cm in diameter without associated ulcer formation.³
- EMR or ESD of gastric cancers that are poorly differentiated, harbor evidence of LVI, invade into the deep submucosa, or have positive lateral or deep margins or lymph node metastases, should be considered to be incomplete. Additional therapy by gastrectomy with lymphadenectomy should be considered.¹⁰
- EUS performed after chemotherapy or radiation therapy has a reduced ability to accurately determine the post-treatment stage of disease.¹¹ Similarly, biopsies performed after chemotherapy or radiation therapy may not accurately diagnose the presence of residual disease but still provide useful information.¹²
- 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 Palliative Care/Best Supportive Care \[GAST-J\]](#)).^{13,14}
- Long-term palliation of anorexia, dysphagia, or malnutrition may be achieved with endoscopic- or radiographic-assisted placement of a feeding gastrostomy tube in carefully selected cases where the distal stomach is uninvolved by tumor, or the placement of a feeding jejunostomy tube (J-tube).¹⁵

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 detecting recurrent disease.¹⁶ EUS-guided FNA should be performed if suspicious lymph nodes or areas of wall thickening are seen.

Note: All recommendations are category 2A unless otherwise indicated.

Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

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**PRINCIPLES OF PATHOLOGIC REVIEW AND BIOMARKER TESTING****Pathologic Review****Table 1**

Specimen Type	Analysis/Interpretation/Reporting^a
Biopsy	Include in pathology report: <ul style="list-style-type: none"> • Invasion, if present • Histologic type^b • Grade
Endoscopic mucosal resection	Include in pathology report: <ul style="list-style-type: none"> • Invasion, if present • Histologic type^b • Grade • Depth of tumor invasion • Vascular/lymphatic invasion • Status of mucosal and deep margins
Gastrectomy, without prior chemoradiation	For pathology report, include all elements as for endoscopic mucosal resection plus <ul style="list-style-type: none"> • Location of tumor midpoint in relationship to EGJ^c • Whether tumor crosses EGJ • Lymph node status and number of lymph nodes recovered
Gastrectomy, with prior chemoradiation	Tumor site should be thoroughly sampled for specimens s/p neoadjuvant therapy without grossly obvious residual tumor For pathology report, include all elements as for resection without prior chemoradiation plus assessment of treatment effect

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

^bSubclassification of gastric adenocarcinomas as intestinal or diffuse type may have implications for therapy, as intestinal type cancers may be more likely to overexpress HER2.¹

^cMidpoint of tumors arising in the proximal 2 cm of the stomach and crossing the EGJ are classified for purposes of staging as esophageal carcinomas, while those with the epicenter located greater than 2 cm into the proximal stomach are staged as gastric carcinomas.²

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GAST-B
1 OF 6

**PRINCIPLES OF PATHOLOGIC REVIEW AND BIOMARKER TESTING****Assessment of Treatment Response**

Response of the primary tumor and lymph node metastases to previous chemotherapy and/or radiation therapy should be reported. Although scoring systems for tumor response in gastric cancer have not been uniformly adopted, in general, 3-category systems provide good reproducibility among pathologists. The following system developed for rectal cancer 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.³

Table 2^d

Tumor Regression Score	Description
0 (Complete response)	No viable cancer cells, including lymph nodes
1 (Near complete response)	Single cells or rare small groups of cancer cells
2 (Partial response)	Residual cancer cells with evident tumor regression but more than single cells or rare small groups of cancer cells
3 (Poor or no response)	Extensive residual cancer with no evident tumor regression

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}

^dReproduced and adapted with permission from Shi C, Berlin J, Branton PA, et al. Protocol for the examination of specimens from patients with carcinoma of the stomach. In: Cancer Protocol Templates. Northfield, IL: College of American Pathologists; 2017. (available at <http://www.cap.org>).

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GAST-B
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**PRINCIPLES OF PATHOLOGIC REVIEW AND BIOMARKER TESTING****Assessment of Overexpression or Amplification of HER2 in Gastric Cancer**

For patients with inoperable locally advanced, recurrent, or metastatic adenocarcinoma of the stomach for whom trastuzumab^e therapy is being considered, assessment for tumor HER2 overexpression using immunohistochemistry (IHC) and fluorescence in situ hybridization (FISH) or other in situ hybridization (ISH) method is recommended.⁶ Next-generation sequencing (NGS) offers the opportunity to assess numerous mutations simultaneously, along with other molecular events such as amplification, deletions, tumor mutation burden, and microsatellite instability status. When limited diagnostic tissue is available for testing and the patient is unable to undergo additional procedures, NGS can be considered instead of sequential testing for single biomarkers. It should be noted that NGS has several inherent limitations and thus whenever possible, the use of gold-standard assays (IHC/ISH) should be performed.

Table 3: Immunohistochemical Criteria for Scoring HER2 Expression in Gastric Cancer^{f,g}

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

^eAn FDA-approved biosimilar is an appropriate substitute for trastuzumab.

^fThe NCCN Guidelines Panel recommends that HER2 IHC be ordered/performed first, followed by ISH methods in cases showing 2+ (equivocal) expression by IHC.

Positive (3+) or negative (0 or 1+) HER2 IHC results do not require further ISH testing. Cases with HER2:CEP17 ratio ≥2 or an average HER2 copy number ≥6.0 signals/cell are considered positive by ISH/FISH.

^gReprinted and adapted from Bartley AN, Washington MK, Colasacco C, et al. HER2 testing and clinical decision making in gastroesophageal adenocarcinoma: guideline from the College of American Pathologists, American Society of Clinical Pathology, and American Society of Clinical Oncology. J Clin Oncol 2017;35:446-464 with permission from the American Society of Clinical Oncology.

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GAST-B
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**PRINCIPLES OF PATHOLOGIC REVIEW AND BIOMARKER TESTING****Microsatellite Instability (MSI) or Mismatch Repair (MMR) Testing^h**

• Testing for MSI by polymerase chain reaction (PCR) or MMR by IHC should be considered on locally advanced, recurrent, or metastatic gastric cancer in patients who are candidates for treatment with PD-1 inhibitors.⁷ The testing is performed on formalin-fixed, paraffin-embedded (FFPE) tissue and results are interpreted as MSI-high (MSI-H) or mismatch repair-deficient (dMMR) in accordance with [CAP DNA Mismatch Repair Biomarker Reporting Guidelines](#).⁸ MMR or MSI testing should be performed only in CLIA-approved laboratories. Patients with MSI-H or dMMR tumors should be referred to a genetics counselor for further assessment.

▶ MMR Interpretation

- ◊ No loss of nuclear expression of MMR proteins: No evidence of deficient mismatch repair (low probability of MSI-H)
- ◊ Loss of nuclear expression of one or more MMR proteins: deficient mismatch repair

▶ MSI Interpretation

- ◊ MSI-Stable (MSS)
- ◊ MSI-Low (MSI-L)
 - 1%–29% of the markers exhibit instability
 - 1 of the 5 National Cancer Institute (NCI) or mononucleotide markers exhibits instability
- ◊ MSI-High (MSI-H)
 - ≥30% of the markers exhibit instability
 - 2 or more of the 5 NCI or mononucleotide markers exhibit instability

PD-L1 Testing

- PD-L1 testing may be considered on locally advanced, recurrent, or metastatic gastric carcinomas in patients who are candidates for treatment with PD-1 inhibitors. An FDA-approved companion diagnostic test for use on FFPE tissue is available as an aid in identifying patients for treatment with PD-1 inhibitors. PD-L1 testing should be performed only in CLIA-approved laboratories.
- Assessment of PD-L1 Protein Expression in Gastric Cancers
 - ▶ This is a qualitative immunohistochemical assay using anti-PD-L1 antibodies for the detection of PD-L1 protein in FFPE tissues from gastric adenocarcinoma. A minimum of 100 tumor cells must be present in the PD-L1-stained slide for the specimen to be considered adequate for PD-L1 evaluation. A specimen is considered to have PD-L1 expression if the Combined Positive Score (CPS) ≥1. CPS is the number of PD-L1 staining cells (ie, tumor cells, lymphocytes, macrophages) divided by the total number of viable tumor cells, multiplied by 100.

^hPCR for MSI and IHC for MMR proteins measures different biological effects caused by dMMR function.

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References



PRINCIPLES OF PATHOLOGIC REVIEW AND BIOMARKER TESTING REFERENCES

Next-Generation Sequencing (NGS):

- At present, three targeted therapeutic agents, trastuzumab,^e ramucirumab, and pembrolizumabⁱ have been approved by the FDA for use in gastric cancer. Trastuzumab is based on testing for HER2 positivity. Pembrolizumab is based on testing for MSI by PCR/MMR by IHC or PD-L1 expression by CPS. The FDA granted approval for the use of select TRK inhibitors for *NTRK* gene fusion-positive solid tumors. When limited tissue is available for testing, sequential testing of single biomarkers or use of limited molecular diagnostic panels may quickly exhaust the sample. In these scenarios, comprehensive genomic profiling via a validated NGS assay performed in a CLIA-approved laboratory may be used for the identification of HER2 amplification, MSI, and *NTRK* gene fusions. It should be noted that NGS has several inherent limitations and thus whenever possible, the use of gold-standard assays (IHC/FISH/targeted PCR) should be performed.

Liquid Biopsy^{9,10}

- The genomic alterations of solid cancers may be identified by evaluating circulating tumor DNA (ctDNA) in the blood, hence a form of “liquid biopsy.” Liquid biopsy is being used more frequently in patients with advanced disease who are unable to have a clinical biopsy for disease surveillance and management. The detection of mutations/alterations in DNA shed from gastric carcinomas can identify targetable alterations or the evolution of clones with altered treatment response profiles. Therefore, for patients who are unable to undergo a traditional biopsy, testing using a validated NGS-based comprehensive genomic profiling assay performed in a CLIA-approved laboratory may be considered. A negative result should be interpreted with caution, as this does not exclude the presence of tumor mutations or amplifications.

^eAn FDA-approved biosimilar is an appropriate substitute for trastuzumab.

ⁱ[See Guidelines for Management of Immunotherapy-Related Toxicities.](#)

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**PRINCIPLES OF SURGERY****N Category Determination**

- Determine extent of disease by CT scan (chest, abdomen, and pelvic) ± EUS (if no metastatic disease seen on CT).
- In patients being considered for surgical resection without preoperative therapy, laparoscopy¹ may be useful in detecting radiographically occult metastatic disease in patients with cT3 and/or cN+ disease seen on preoperative imaging. If laparoscopy with cytology is performed as a separate procedure, peritoneal washings should be performed as well.
- In patients receiving preoperative therapy, a baseline laparoscopy along with peritoneal washings should be considered.
- Positive peritoneal cytology (performed in the absence of visible peritoneal implants) is associated with poor prognosis and is defined as pM1 disease.²

Siewert Classification

- Siewert tumor type should be assessed in all patients with adenocarcinomas involving the EGJ.^{3,4}
 - ▶ Siewert Type I: adenocarcinoma of the lower esophagus (often associated with Barrett esophagus) with the epicenter located within 1 cm to 5 cm above the anatomic EGJ.
 - ▶ Siewert Type II: true carcinoma of the cardia at the EGJ, with the tumor epicenter within 1 cm above and 2 cm below the EGJ.
 - ▶ Siewert Type III: subcardial carcinoma with the tumor epicenter between 2 cm and 5 cm below the EGJ, which infiltrates the EGJ and lower esophagus from below.
- The treatment of Siewert types I and II is as described in the [NCCN Guidelines for Esophageal and EGJ Cancers](#).
- Siewert type III lesions are considered gastric cancers, and thus should be treated as described in the NCCN Guidelines for Gastric Cancer. In some cases additional esophageal resection may be needed in order to obtain adequate margins.^{3,5,6}

Criteria of Unresectability for Cure

- Locoregionally advanced
 - ▶ Disease infiltration of the root of the mesentery or para-aortic lymph node highly suspicious on imaging or confirmed by biopsy
 - ▶ Invasion or encasement of major vascular structures (excluding the splenic vessels)
- Distant metastasis or peritoneal seeding (including positive peritoneal cytology)

Resectable Tumors

- Tis or T1⁷ tumors limited to mucosa (T1a) may be candidates for EMR (in experienced centers).⁸
- T1b–T3⁹: Adequate gastric resection to achieve negative microscopic margins.
 - ▶ Distal gastrectomy
 - ▶ Subtotal gastrectomy
 - ▶ Total gastrectomy
- T4 tumors require en bloc resection of involved structures.
- Gastric resection should include the regional lymphatics—perigastric lymph nodes (D1) and those along the named vessels of the celiac axis (D2), with a goal of examining at least 16 or greater lymph nodes.¹⁰⁻¹²
 - ▶ 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, lesser and greater curvature, suprapyloric along the right gastric artery, and infrapyloric area);
 - ◊ D2 dissection is a D1 plus all the nodes along the left gastric artery, common hepatic artery, celiac artery, and splenic artery.
- Routine splenectomy is not indicated unless the spleen is involved or extensive hilar adenopathy is noted.¹³
- Consider placing feeding 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 is not required.
- In patients fit for surgery and who have a reasonable prognosis, gastrojejunostomy (open or laparoscopic) is preferable to endoluminal stenting in patients with gastric outlet obstruction.¹⁴
- Venting gastrostomy and/or feeding tube may be considered.

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PRINCIPLES OF GENETIC RISK ASSESSMENT FOR GASTRIC CANCER

Criteria for Further Risk Evaluation for High-Risk Syndromes:¹⁻⁶

• Referral to a cancer genetics professional is recommended for an individual with one or more of the following:

- ▶ An individual affected with gastric cancer before age 40
- ▶ An individual affected with gastric cancer before age 50 who had one first- or second-degree relative affected with gastric cancer
- ▶ An individual affected with gastric cancer at any age who has 2 or more first- or second-degree relatives affected with gastric cancer
- ▶ An individual affected with gastric cancer and breast cancer with one diagnosis before age 50
- ▶ An individual affected with gastric cancer at any age and a family history of breast cancer in a first- or second-degree relative diagnosed before age 50
- ▶ An individual affected with gastric cancer at any age and a family history of juvenile polyps or gastrointestinal polyposis
- ▶ An individual affected with gastric cancer at any age and a family history of cancers associated with Lynch syndrome (colorectal, endometrial, small bowel, or urinary tract cancer)

OR a family history of:

- ▶ Known mutation in a gastric cancer susceptibility gene in a close relative
- ▶ Gastric cancer in one first- or second-degree relative who was diagnosed before age 40,
- ▶ Gastric cancer in 2 first- or second-degree relatives with one diagnosis before age 50,
- ▶ Gastric cancer in 3 first- or second-degree relatives independent of age, or
- ▶ Gastric cancer and breast cancer in one patient with one diagnosis before age 50, juvenile polyps, or gastrointestinal polyposis in a close relative

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PRINCIPLES OF GENETIC RISK ASSESSMENT FOR GASTRIC CANCER

Risk Assessment/Genetic Counseling¹⁻⁶

- While most gastric cancers are considered sporadic, it is estimated that 5% to 10% have a familial component and 3% to 5% are associated with an inherited cancer predisposition syndrome. Genetic counseling/patient education is highly recommended when genetic testing is offered and after results are disclosed. A genetic counselor, medical geneticist, oncologist, gastroenterologist, surgeon, oncology nurse, or other health professional with expertise and experience in cancer genetics should be involved early in counseling patients who potentially meet criteria for an inherited syndrome. Risk assessment and genetic counseling should include:
 - ▶ Detailed family history
 - ▶ Detailed medical and surgical history
 - ▶ Directed examination for related manifestations
 - ▶ Psychosocial assessment and support
 - ▶ Risk counseling
 - ▶ Education support
 - ▶ Discussion of genetic testing
 - ▶ Informed consent
- The most efficient strategy to identify a causative gene mutation in a family is to test a close relative with cancer. If the relative is either unwilling or unavailable for testing, then consider testing of an unaffected relative. A detailed discussion of genetic counseling and testing can be found in the [NCCN Guidelines for Genetic/Familial High-Risk Assessment: Colorectal](#) and [NCCN Guidelines for Genetic/Familial High-Risk Assessment: Breast, Ovarian, and Pancreatic](#).
- A close relative is defined as a first-, second-, or third-degree relative. First-degree relatives include parents, siblings, and offspring. Second-degree relatives include grandparents, aunts, and uncles. Third-degree relatives include cousins and great grandparents.

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**PRINCIPLES OF GENETIC RISK ASSESSMENT FOR GASTRIC CANCER****Hereditary Cancer Predisposition Syndromes Associated with an Increased Risk for Gastric Cancers****• Hereditary Diffuse Gastric Cancer**

- ▶ This is an autosomal dominant syndrome characterized by the development of diffuse (signet ring cell) gastric cancers at a young age.^{7,8} Truncating mutations in *CDH1*, the gene encoding the cell adhesion molecular E-cadherin, are found in 30% to 50% of cases.⁹ The lifetime risk for gastric cancer by age 80 is estimated to be at 67% for men and 83% for women.¹⁰ Average age at diagnosis of gastric cancer is 37 years. Women with *CDH1* mutations are at higher risk of developing lobular carcinoma of the breast. Such patients should be referred to a center with a multidisciplinary team focusing on this condition. The team should include a surgeon specializing in upper gastrointestinal (UGI) cancer surgery, a gastroenterologist, a clinical genetics expert, a nutritionist, and a counselor or psychiatrist.
- ▶ Genetic testing for *CDH1* mutations should be considered when any of the following criteria are met:^a
 - ◊ Two gastric cancer cases in a family, one confirmed diffuse gastric cancer (DGC) diagnosed before age 50 years
OR
 - ◊ Three confirmed cases of DGC in first- or second-degree relatives independent of age
OR
 - ◊ DGC diagnosed before age 40 years without a family history
OR
 - ◊ Personal or family history of DGC and lobular breast cancer, one diagnosed before age 50 years

• Lynch Syndrome

- ▶ Individuals with Lynch syndrome (LS) have a 1% to 13% risk of developing gastric cancer and the risk is higher in Asian compared to Western kindreds. Gastric cancer is the second most common extracolonic cancer in these patients, after endometrial cancer. Individuals with LS are also at increased risk for other cancers: [See NCCN Guidelines for Genetic/Familial High-Risk Assessment: Colorectal](#).

• Juvenile Polyposis Syndrome

- ▶ Individuals with Juvenile polyposis syndrome (JPS) have a lifetime risk of 21% for developing gastric cancer when involvement of the UGI tract is present, which is primarily seen in *SMAD4* mutation carriers. Individuals with JPS are also at increased risk for other cancers: [See NCCN Guidelines for Genetic/Familial High-Risk Assessment: Colorectal](#).

• Peutz-Jeghers Syndrome

- ▶ Individuals with Peutz-Jeghers syndrome (PJS) have a 29% risk of developing gastric cancer. Individuals with PJS are also at increased risk for other cancers: [See NCCN Guidelines for Genetic/Familial High-Risk Assessment: Colorectal](#).

• Familial Adenomatous Polyposis

- ▶ Individuals with familial adenomatous polyposis (FAP), in addition to attenuated FAP (AFAP), have a 1% to 2% lifetime risk for gastric cancer. Individuals with FAP/AFAP are also at increased risk for other cancers: [See NCCN Guidelines for Genetic/Familial High-Risk Assessment: Colorectal](#).

^aAdapted and reproduced with permission from Fitzgerald RC, Hardwick R, Huntsman D, et al. Hereditary diffuse gastric cancer: updated consensus guidelines for clinical management and directions for future research. *J Med Genet* 2010;47:436-444.

Note: All recommendations are category 2A unless otherwise indicated.

Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

[Continued](#)
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GAST-D
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**PRINCIPLES OF GENETIC RISK ASSESSMENT FOR GASTRIC CANCER****Screening Recommendations**

Insufficient evidence exists for screening for hereditary cancer syndromes associated with gastric cancer risk, but the following guidelines have been proposed. Each of these cancer syndromes is associated with significant risks for other cancers, some of which are addressed in other NCCN Guidelines.

<u>Syndrome</u>	<u>Gene(s)</u>	<u>Inheritance Pattern</u>	<u>Gastric Screening Recommendations</u>
Hereditary diffuse gastric cancer ¹⁻⁴	<i>CDH1</i>	Autosomal dominant	<ul style="list-style-type: none"> • Prophylactic total gastrectomy is recommended between ages 18 and 40 for CDH1 mutation carriers. A baseline endoscopy is indicated prior to prophylactic total gastrectomy. Intraoperative frozen sections should be performed to verify that the proximal margin contains esophageal squamous mucosa and the distal margin contains duodenal mucosa, to ensure complete removal of gastric tissue. A D2 lymph node dissection is not necessary for prophylactic total gastrectomy. • Prophylactic gastrectomy prior to 18 years of age is not recommended, but may be considered for certain patients, especially those with family members diagnosed with gastric cancer before 25 years of age. • CDH1 mutation carriers, who elect not to undergo prophylactic gastrectomy, should be offered screening every 6–12 months by upper endoscopy with multiple random biopsies. Women with CDH1 mutations are at increased risk for breast cancer and should be followed using high-risk guidelines as outlined in the NCCN Guidelines for Genetic/Familial High-Risk Assessment: Breast, Ovarian, and Pancreatic.
Lynch syndrome (LS)	<i>EPCAM, MLH1, MSH2, MSH6, PMS2</i>	Autosomal dominant	Selected individuals or families or those of Asian descent may consider EGD with extended duodenoscopy (to distal duodenum or into the jejunum). See NCCN Guidelines for Genetic/Familial High-Risk Assessment: Colorectal for additional screening recommendations.

Note: All recommendations are category 2A unless otherwise indicated.

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[Continued](#)
[References](#)**GAST-D**
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**PRINCIPLES OF GENETIC RISK ASSESSMENT FOR GASTRIC CANCER****Screening Recommendations (continued)**

Syndrome	Gene(s)	Inheritance Pattern	Gastric Screening Recommendations
Juvenile polyposis syndrome (JPS)	<i>SMAD4</i> , <i>BMPR1A</i>	Autosomal dominant	Consider EGD starting around age 15 years and repeat annually if polyps are found and every 2–3 years if no polyps are found. See NCCN Guidelines for Genetic/Familial High-Risk Assessment: Colorectal for additional screening recommendations.
Peutz-Jeghers syndrome (PJS)	<i>STK11</i>	Autosomal dominant	Consider EGD starting in late teens and repeating every 2–3 years. See NCCN Guidelines for Genetic/Familial High-Risk Assessment: Colorectal for additional screening recommendations.
Familial adenomatous polyposis (FAP)/ Attenuated FAP (AFAP)	<i>APC</i>	Autosomal dominant	<ul style="list-style-type: none"> • There is no clear evidence to support screening for gastric cancer in FAP/AFAP. However, given the increased risk for duodenal cancer in FAP/AFAP, the stomach should be examined at the same time of duodenoscopy. • Non-fundic gland polyps in the stomach should be managed endoscopically if possible. Patients with polyps that cannot be removed endoscopically, but with high-grade dysplasia or invasive cancer detected on biopsy, should be referred for gastrectomy. • A baseline EGD with side-viewing endoscope is recommended at age 25–30 years and repeated based on duodenal polyp status (See NCCN Guidelines for Genetic/Familial High-Risk Assessment: Colorectal for duodenoscopic findings and interval of duodenoscopy). See NCCN Guidelines for Genetic/Familial High-Risk Assessment: Colorectal for additional screening recommendations.

Note: All recommendations are category 2A unless otherwise indicated.

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[Continued](#)

**PRINCIPLES OF GENETIC RISK ASSESSMENT FOR GASTRIC CANCER**

Other hereditary cancer predisposition syndromes listed below may also be associated with an increased risk of developing gastric cancer. However, insufficient evidence exists for gastric cancer screening in these syndromes.

Syndrome	Gene(s)	Inheritance Pattern
Ataxia- telangiectasia	<i>ATM</i>	Autosomal recessive
Bloom syndrome	<i>BLM/RECQL3</i>	Autosomal recessive
Hereditary breast and ovarian cancer syndrome	<i>BRCA1, BRCA2</i>	Autosomal dominant
Li-Fraumeni syndrome	<i>TP53</i>	Autosomal dominant
Xeroderma pigmentosum	7 different genes	Autosomal recessive
Cowden syndrome	<i>PTEN</i>	Autosomal dominant

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References



PRINCIPLES OF GENETIC RISK ASSESSMENT FOR GASTRIC CANCER

References

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- ⁸Dixon M, Seevaratnam R, Wirtzfeld D, et al. A RAND/UCLA appropriateness study of the management of familial gastric cancer. *Ann Surg Oncol* 2013;20:533-541.
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PRINCIPLES OF MULTIDISCIPLINARY TEAM APPROACH FOR ESOPHAGOGASTRIC CANCERS

Category 1 evidence supports the notion that the combined modality therapy is effective for patients with localized esophagogastric cancer.^{1,2,3} 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.**

¹Cunningham D, Allum WH, Stenning SP, et al. Perioperative chemotherapy versus surgery alone for resectable gastroesophageal cancer. *N Engl J Med* 2006;355(1):11-20.

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³Macdonald JS, Smalley SR, Benedetti J, et al. Chemoradiotherapy after surgery compared with surgery alone for adenocarcinoma of the stomach or gastroesophageal junction. *N Engl J Med* 2001;345(10):725-730.

Note: All recommendations are category 2A unless otherwise indicated.

Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

**PRINCIPLES OF SYSTEMIC THERAPY**

- Systemic therapy regimens recommended for advanced esophageal and 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 (PS), medical comorbidities, and toxicity profile.
- Trastuzumab^a should be added to first-line chemotherapy for HER2 overexpressing metastatic adenocarcinoma.
- Two-drug cytotoxic regimens are preferred for patients with advanced disease because of lower toxicity. Three-drug cytotoxic regimens should be reserved for medically fit patients with good PS and access to frequent toxicity evaluation.
- Modifications of category 1 regimen or use of category 2A or 2B regimens may be preferred (as indicated), with evidence supporting a more favorable toxicity profile without compromising efficacy.¹
- Doses and schedules for any regimen that is not derived from category 1 evidence are a suggestion, and are 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.
- Perioperative chemotherapy^{2,3} or postoperative chemotherapy plus chemoradiation⁴ is the preferred approach for localized gastric cancer.
- Postoperative chemotherapy is recommended following primary D2 lymph node dissection.^{5,6} ([See Principles of Surgery \[GAST-C\]](#))
- In the adjuvant setting, upon completion of chemotherapy or chemoradiation, patients should be monitored for any long-term therapy-related complications.

Footnotes

^aAn FDA-approved biosimilar is an appropriate substitute for trastuzumab.

References

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- ⁵Noh SH, Park SR, Yang HK, et al. Adjuvant capecitabine plus oxaliplatin for gastric cancer after D2 gastrectomy (CLASSIC): 5-year follow-up of an open-label, randomised phase 3 trial. *Lancet Oncol* 2014; 15:1389-1396.
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Note: All recommendations are category 2A unless otherwise indicated.

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GAST-F
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**PRINCIPLES OF SYSTEMIC THERAPY****Perioperative Chemotherapy****Preferred Regimens**

- Fluoropyrimidine and oxaliplatin^{b,c}
- Fluorouracil,^c leucovorin, oxaliplatin, and docetaxel (FLOT)^d (category 1)¹

Other Recommended Regimens

- Fluorouracil and cisplatin (category 1)²

Preoperative Chemoradiation(Infusional fluorouracil^c can be replaced with capecitabine)**Preferred Regimens**

- Fluorouracil^c and oxaliplatin (category 1)^{3,4}
- Fluorouracil and cisplatin (category 1)^{5,6}
- Fluoropyrimidine (fluorouracil or capecitabine) and paclitaxel (category 2B)⁷

Other Recommended Regimens

- Paclitaxel and carboplatin (category 2B)⁸

Postoperative Chemoradiation(For patients who received less than a D2 lymph node dissection ([See Principles of Surgery \[GAST-C\]](#)))

- Fluoropyrimidine (infusional fluorouracil^c or capecitabine) before and after fluoropyrimidine-based chemoradiation⁹

Postoperative Chemotherapy(for patients who have undergone primary D2 lymph node dissection ([See Principles of Surgery \[GAST-C\]](#)))**Preferred Regimens**

- Capecitabine and oxaliplatin^e (category 1)¹⁰
- Fluorouracil^c and oxaliplatin^e

Chemoradiation for Unresectable Disease(Infusional fluorouracil^c can be replaced with capecitabine)**Preferred Regimens**

- Fluorouracil^c and oxaliplatin^{3,4}
- Fluorouracil and cisplatin^{5,6}

Other Recommended Regimens

- Fluoropyrimidine (fluorouracil or capecitabine) and paclitaxel (category 2B)⁷

^bThe use of this regimen and dosing schedules is based on extrapolations from published literature and clinical practice.^cLeucovorin is indicated with certain fluorouracil-based regimens. Depending on availability, these regimens may be used with or without leucovorin. For important information regarding the leucovorin shortage, please see [Discussion](#).^dDue to toxicity, three-drug regimens are recommended only in select patients who are medically fit.^eCisplatin may not be used interchangeably with oxaliplatin in this setting.

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 patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.[Continued
References](#)**GAST-F
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**PRINCIPLES OF SYSTEMIC THERAPY****Systemic Therapy for Unresectable Locally Advanced, Recurrent or Metastatic Disease (where local therapy is not indicated)**

- Trastuzumab^a should be added to first-line chemotherapy for HER2 overexpressing metastatic adenocarcinoma ([See Principles of Pathologic Review and Biomarker Testing \[GAST-B\]](#))
 - ▶ Combination with fluoropyrimidine and platinum (category 1 in combination with cisplatin;¹¹ category 2A in combination with other platinum agents)
 - ▶ Trastuzumab is not recommended for use with anthracyclines

First-Line Therapy

- Two-drug cytotoxic regimens are preferred because of lower toxicity.
- Three-drug cytotoxic regimens should be reserved for medically fit patients with good PS and access to frequent toxicity evaluation.
- Oxaliplatin is generally preferred over cisplatin due to lower toxicity.

Preferred Regimens

- Fluoropyrimidine (fluorouracil^c or capecitabine) and oxaliplatin¹²⁻¹⁴
- Fluoropyrimidine (fluorouracil^c or capecitabine) and cisplatin^{12, 15-17}

Other Recommended Regimens

- Fluorouracil^{c,f} and irinotecan¹⁸
- Paclitaxel with cisplatin or carboplatin¹⁹⁻²¹
- Docetaxel with cisplatin^{22,23}
- Fluoropyrimidine^{16,24,25} (fluorouracil^c or capecitabine)
- Docetaxel^{26,27}
- Paclitaxel^{28,29}
- DCF modifications
 - ▶ Docetaxel, cisplatin, and fluorouracil^{c,30}
 - ▶ Docetaxel, oxaliplatin, and fluorouracil³¹
 - ▶ Docetaxel, carboplatin, and fluorouracil (category 2B)³²
- ECF (epirubicin, cisplatin, and fluorouracil) (category 2B)³³
- ECF modifications (category 2B)^{34,35}
 - ▶ Epirubicin, oxaliplatin, and fluorouracil
 - ▶ Epirubicin, cisplatin, and capecitabine
 - ▶ Epirubicin, oxaliplatin, and capecitabine

^aAn FDA-approved biosimilar is an appropriate substitute for trastuzumab.^cLeucovorin is indicated with certain fluorouracil-based regimens. Depending on availability, these regimens may be used with or without leucovorin. For important information regarding the leucovorin shortage, please see [Discussion](#).^fCapecitabine may not be used interchangeably with fluorouracil in regimens containing irinotecan.**Note: All recommendations are category 2A unless otherwise indicated.****Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.****Continued
References****GAST-F
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**PRINCIPLES OF SYSTEMIC THERAPY****Systemic Therapy for Unresectable Locally Advanced, Recurrent or Metastatic Disease (where local therapy is not indicated)****Second-Line or Subsequent Therapy**

- Dependent on prior therapy and PS

Preferred Regimens

- Ramucirumab and paclitaxel (category 1)³⁶
- Docetaxel (category 1)^{26,27}
- Paclitaxel (category 1)^{28,29,37}
- Irinotecan (category 1)³⁷⁻⁴⁰
- Trifluridine and tipiracil (category 1)⁴¹
 - ▶ For third-line or subsequent therapy
- Fluorouracil^{c,f} and irinotecan^{38,42,43}
- Pembrolizumab^g
 - ▶ For second-line or subsequent therapy for MSI-H or dMMR tumors^{44,45}
 - ▶ For third-line or subsequent therapy for gastric adenocarcinoma with PD-L1 expression levels by CPS of ≥ 1 ^{h,46}

Other Recommended Regimens

- Ramucirumab (category 1)⁴⁷
- Irinotecan and cisplatin^{13,48}
- Entrectinib or larotrectinib for *NTRK* gene fusion-positive tumors^{49,50}
- Docetaxel and irinotecan (category 2B)⁵¹

Useful in Certain Circumstances

- Fluorouracil and irinotecan + ramucirumab (category 2B)^{c,f,52}

^cLeucovorin is indicated with certain fluorouracil-based regimens. Depending on availability, these regimens may be used with or without leucovorin. For important information regarding the leucovorin shortage, please see [Discussion](#).

^fCapecitabine may not be used interchangeably with fluorouracil in regimens containing irinotecan.

^gSee [NCCN Guidelines for Management of Immunotherapy-Related Toxicities](#).

^hPembrolizumab is FDA-approved for patients with gastric tumors with PD-L1 expression levels by CPS of ≥ 1 as determined by an FDA-approved companion diagnostic test. For more information on PD-L1 testing, [See Principles of Pathology and Biomarker Testing \(GAST-B\)](#).

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**PRINCIPLES OF SYSTEMIC THERAPY—REGIMENS AND DOSING SCHEDULESⁱ****PERIOPERATIVE CHEMOTHERAPY****PREFERRED REGIMENS****Fluoropyrimidine and oxaliplatin^c****(3 cycles preoperative and 3 cycles postoperative)****Oxaliplatin 85 mg/m² IV on Day 1****Leucovorin 400 mg/m² IV on Day 1****Fluorouracil 400 mg/m² IV Push on Day 1****Fluorouracil 1200 mg/m² IV continuous infusion****over 24 hours daily on Days 1 and 2****Cycled every 14 days¹³****Oxaliplatin 85 mg/m² IV on Day 1****Leucovorin 200 mg/m² IV on Day 1****Fluorouracil 2600 mg/m² IV continuous infusion****over 24 hours on Day 1****Cycled every 14 days¹²****Capecitabine 1000 mg/m² PO BID on Days 1–14****Oxaliplatin 130 mg/m² IV on Day 1****Cycled every 21 days¹⁴****Fluorouracil, leucovorin, oxaliplatin, and docetaxel (FLOT)^c****(4 cycles preoperative and 4 cycles postoperative)****Fluorouracil 2600 mg/m² IV continuous infusion****over 24 hours on Day 1****Leucovorin 200 mg/m² IV on Day 1****Oxaliplatin 85 mg/m² IV on Day 1****Docetaxel 50 mg/m² IV on Day 1****Cycled every 14 days¹****OTHER RECOMMENDED REGIMENS****Fluorouracil and cisplatin****(4 cycles preoperative and 4 cycles postoperative)****Fluorouracil 2000 mg/m² IV continuous infusion****over 48 hours on Days 1–2****Cisplatin 50 mg/m² IV on Day 1****Cycled every 14 days**

^cLeucovorin is indicated with certain fluorouracil-based regimens. Depending on availability, these regimens may be used with or without leucovorin. For important information regarding the leucovorin shortage, please see [Discussion](#).

ⁱSystemic therapy regimen and dosing schedules are based on extrapolations from published literature and clinical practice.

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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**PRINCIPLES OF SYSTEMIC THERAPY—REGIMENS AND DOSING SCHEDULESⁱ****PREOPERATIVE CHEMORADIATION****PREFERRED REGIMENS****Fluorouracil and oxaliplatin^c**

Oxaliplatin 85 mg/m² IV on Day 1
 Leucovorin 400 mg/m² on Day 1
 Fluorouracil 400 mg/m² IV Push on Day 1
 Fluorouracil 800 mg/m² IV continuous infusion
 over 24 hours daily on Days 1 and 2
 Cycled every 14 days for 3 cycles with radiation ^{j,3}

Capecitabine and oxaliplatin

Oxaliplatin 85 mg/m² IV on Days 1, 15, and 29
 for 3 doses
 Capecitabine 625 mg/m² PO BID
 on Days 1–5 for 5 weeks⁵³

Fluorouracil and cisplatin

Cisplatin 75–100 mg/m² IV on Days 1 and 29
 Fluorouracil 750–1000 mg/m² IV continuous infusion
 over 24 hours daily on Days 1–4 and 29–32
 35-day cycle⁵

Cisplatin 15 mg/m² IV daily on Days 1–5
 Fluorouracil 800 mg/m² IV continuous infusion
 over 24 hours daily on Days 1–5
 Cycled every 21 days for 2 cycles⁶

PREFERRED REGIMENS—CONTINUED**Capecitabine and cisplatin**

Cisplatin 30 mg/m² IV on Day 1
 Capecitabine 800 mg/m² PO BID on Days 1–5
 Weekly for 5 weeks⁵⁴

Paclitaxel and fluoropyrimidine

Paclitaxel 45–50 mg/m² IV on Day 1 weekly
 Fluorouracil 300 mg/m² IV continuous infusion
 daily on Days 1–5
 Weekly for 5 weeks⁷

Paclitaxel 45–50 mg/m² IV on Day 1
 Capecitabine 625–825 mg/m² PO BID on Days 1–5
 Weekly for 5 weeks⁷

OTHER RECOMMENDED REGIMENS

Paclitaxel and carboplatin
 Paclitaxel 50 mg/m² IV on Day 1
 Carboplatin AUC 2 IV on Day 1
 Weekly for 5 weeks⁸

^cLeucovorin is indicated with certain fluorouracil-based regimens. Depending on availability, these regimens may be used with or without leucovorin. For important information regarding the leucovorin shortage, please see [Discussion](#).

ⁱSystemic therapy regimen and dosing schedules are based on extrapolations from published literature and clinical practice.

^jThis regimen can be individualized and/or attenuated on a patient basis.

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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**PRINCIPLES OF SYSTEMIC THERAPY—REGIMENS AND DOSING SCHEDULESⁱ****POSTOPERATIVE CHEMORADIATION****(for patients who received less than a D2 lymph node dissection)**

THE PANEL ACKNOWLEDGES THAT THE INTERGROUP 0116 TRIAL^{9,54} FORMED THE BASIS FOR POSTOPERATIVE ADJUVANT CHEMORADIATION STRATEGY. HOWEVER, THE PANEL DOES NOT RECOMMEND THE DOSES AND SCHEDULE OF CYTOTOXIC AGENTS SPECIFIED IN THIS TRIAL DUE TO CONCERNS REGARDING TOXICITY. THE PANEL RECOMMENDS ONE OF THE FOLLOWING MODIFICATIONS INSTEAD:

Fluorouracil^c

2 cycles before and 4 cycles after chemoradiation
Leucovorin 400 mg/m² IV on Day 1
Fluorouracil 400 mg/m² IV Push on Day 1
Fluorouracil 1200 mg/m² IV continuous infusion over 24 hours daily on Days 1 and 2
Cycled every 14 days

With radiation

Fluorouracil 200–250 mg/m² IV continuous infusion over 24 hours daily on Days 1–5
Weekly for 5 weeks⁵⁶

Capecitabine

1 cycle before and 2 cycles after chemoradiation
Capecitabine 750–1000 mg/m² PO BID on Days 1–14
Cycled every 21 days⁵⁷

With radiation

Capecitabine 625–825 mg/m² PO BID on Days 1–5
Weekly for 5 weeks⁵⁸

^cLeucovorin is indicated with certain fluorouracil-based regimens. Depending on availability, these regimens may be used with or without leucovorin. For important information regarding the leucovorin shortage, please see [Discussion](#).

ⁱSystemic therapy regimen and dosing schedules are based on extrapolations from published literature and clinical practice.

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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POSTOPERATIVE CHEMOTHERAPY**(for patients who have undergone primary D2 lymph node dissection)****PREFERRED****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 cycles¹⁰

Fluoropyrimidine and oxaliplatin^c

Oxaliplatin 85 mg/m² IV on Day 1
Leucovorin 400 mg/m² IV on Day 1
Fluorouracil 400 mg/m² IV Push on Day 1
Fluorouracil 1200 mg/m² IV continuous infusion over 24 hours daily on Days 1 and 2
Cycled every 14 days¹³

Oxaliplatin 85 mg/m² IV on Day 1
Leucovorin 200 mg/m² IV on Day 1
Fluorouracil 2600 mg/m² IV continuous infusion over 24 hours on Day 1
Cycled every 14 days¹²

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**PRINCIPLES OF SYSTEMIC THERAPY—REGIMENS AND DOSING SCHEDULESⁱ****CHEMORADIATION FOR UNRESECTABLE DISEASE** (Infusional fluorouracil^c can be replaced with capecitabine)**PREFERRED REGIMENS****Fluorouracil and oxaliplatin^c****Oxaliplatin 85 mg/m² IV****on Days 1, 15, and 29 for 3 doses****Fluorouracil 180 mg/m² IV daily on Days 1–33⁴****Oxaliplatin 85 mg/m² IV on Day 1****Leucovorin 400 mg/m² IV on Day 1****Fluorouracil 400 mg/m² IV Push on Day 1****Fluorouracil 800 mg/m² IV continuous infusion****over 24 hours daily on Days 1 and 2****Cycled every 14 days for 3 cycles with radiation****followed by 3 cycles without radiation³****Capecitabine and oxaliplatin****Oxaliplatin 85 mg/m² IV on Days 1, 15, and 29 for 3 doses****Capecitabine 625 mg/m² PO BID****on Days 1–5 weekly for 5 weeks⁵³****Fluorouracil and cisplatin****Cisplatin 75–100 mg/m² IV on Day 1****Fluorouracil 750–1000 mg/m² IV continuous infusion****over 24 hours daily on Days 1–4****Cycled every 28 days for 2 cycles with radiation****followed by 2 cycles without radiation⁵⁹****Capecitabine and cisplatin****Cisplatin 30 mg/m² IV on Day 1****Capecitabine 800 mg/m² PO BID on Days 1–5****Weekly for 5 weeks⁵⁴**ⁱSystemic therapy regimen and dosing schedules are based on extrapolations from published literature and clinical practice.

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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**PRINCIPLES OF SYSTEMIC THERAPY—REGIMENS AND DOSING SCHEDULESⁱ****SYSTEMIC THERAPY FOR METASTATIC OR LOCALLY ADVANCED CANCER (WHERE LOCAL THERAPY IS NOT INDICATED)****FIRST-LINE THERAPY****Trastuzumab^a (with chemotherapy)****Trastuzumab 8 mg/kg IV loading dose on Day 1 of cycle 1, then****Trastuzumab 6 mg/kg IV every 21 days¹¹****or**
Trastuzumab 6 mg/kg IV loading dose on Day 1 of cycle 1, then 4 mg/kg IV every 14 days**PREFERRED REGIMENS****Fluoropyrimidine and oxaliplatin^c****Oxaliplatin 85 mg/m² IV on Day 1****Leucovorin 400 mg/m² IV on Day 1****Fluorouracil 400 mg/m² IV Push on Day 1****Fluorouracil 1200 mg/m² IV continuous infusion over 24 hours daily on Days 1 and 2****Cycled every 14 days¹³****Oxaliplatin 85 mg/m² IV on Day 1****Leucovorin 200 mg/m² IV on Day 1****Fluorouracil 2600 mg/m² IV continuous infusion over 24 hours on Day 1****Cycled every 14 days¹²****Capecitabine 1000 mg/m² PO BID on Days 1–14****Oxaliplatin 130 mg/m² IV on Day 1****Cycled every 21 days¹⁴****Capecitabine 625 mg/m² PO BID on Days 1–14****Oxaliplatin 85 mg/m² IV on Day 1****Cycled every 21 days⁶⁰**^aAn FDA-approved biosimilar is an appropriate substitute for trastuzumab.^cLeucovorin is indicated with certain fluorouracil-based regimens. Depending on availability, these regimens may be used with or without leucovorin. For important information regarding the leucovorin shortage, please see [Discussion](#).ⁱSystemic therapy regimen and dosing schedules are based on extrapolations from published literature and clinical practice.**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 patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.****PREFERRED REGIMENS—continued****Fluoropyrimidine and cisplatin^c****Cisplatin 75–100 mg/m² IV on Day 1****Fluorouracil 750–1000 mg/m² IV continuous infusion over 24 hours daily on Days 1–4****Cycled every 28 days¹⁵****Cisplatin 50 mg/m² IV daily on Day 1****Leucovorin 200 mg/m² IV on Day 1****Fluorouracil 2000 mg/m² IV continuous infusion over 24 hours daily on Day 1****Cycled every 14 days^{12,16}****Cisplatin 80 mg/m² IV daily on Day 1****Capecitabine 1000 mg/m² PO BID on Days 1–14****Cycled every 21 days¹⁷****OTHER RECOMMENDED REGIMENS****Fluorouracil and irinotecan^c****Irinotecan 180 mg/m² IV on Day 1****Leucovorin 400 mg/m² IV on Day 1****Fluorouracil 400 mg/m² IV Push on Day 1****Fluorouracil 1200 mg/m² IV continuous infusion over 24 hours daily on Days 1 and 2****Cycled every 14 days¹⁸****Irinotecan 80 mg/m² IV on Day 1****Leucovorin 500 mg/m² IV on Day 1****Fluorouracil 2000 mg/m² IV continuous infusion over 24 hours on Day 1****Weekly for 6 weeks followed by 2 weeks off treatment⁶¹****Paclitaxel with cisplatin or carboplatin****Paclitaxel 135–200 mg/m² IV on Day 1****Cisplatin 75 mg/m² IV on Day 2****Cycled every 21 days¹⁹****Paclitaxel 90 mg/m² IV on Day 1****Cisplatin 50 mg/m² IV on Day 1****Cycled every 14 days²⁰****Paclitaxel 200 mg/m² IV on Day 1****Carboplatin AUC 5 IV on Day 1****Cycled every 21 days²¹**

**PRINCIPLES OF SYSTEMIC THERAPY—REGIMENS AND DOSING SCHEDULESⁱ**
SYSTEMIC THERAPY FOR METASTATIC OR LOCALLY ADVANCED CANCER (WHERE LOCAL THERAPY IS NOT INDICATED)**FIRST-LINE THERAPY—continued****OTHER RECOMMENDED REGIMENS—continued****Docetaxel and cisplatin**Docetaxel 70–85 mg/m² IV on Day 1Cisplatin 70–75 mg/m² IV on Day 1Cycled every 21 days^{22,23}**Fluoropyrimidine^c**Leucovorin 400 mg/m² IV on Day 1Fluorouracil 400 mg/m² IV Push on Day 1Fluorouracil 1200 mg/m² IV continuous infusion

over 24 hours daily on Days 1 and 2

Cycled every 14 days¹⁶Fluorouracil 800 mg/m² IV continuous infusion

over 24 hours daily on Days 1–5

Cycled every 28 days²⁴Capecitabine 1000–1250 mg/m²

PO BID on Days 1–14

Cycled every 21 days²⁵**Taxane**Docetaxel 75–100 mg/m² IV on Day 1Cycled every 21 days^{26,27}Paclitaxel 135–250 mg/m² IV on Day 1Cycled every 21 days²⁸Paclitaxel 80 mg/m² IV weeklyCycled every 28 days²⁹**OTHER RECOMMENDED REGIMENS—continued****DCF modifications^c**Docetaxel 40 mg/m² IV on Day 1Leucovorin 400 mg/m² IV on Day 1Fluorouracil 400 mg/m² IV on Day 1Fluorouracil 1000 mg/m² IV continuous infusion

over 24 hours daily on Days 1 and 2

Cisplatin 40 mg/m² IV on Day 3Cycled every 14 days³⁰Docetaxel 50 mg/m² IV on Day 1Oxaliplatin 85 mg/m² IV on Day 1Fluorouracil 1200 mg/m² IV continuous infusion

over 24 hours daily on Days 1 and 2

Cycled every 14 days³¹Docetaxel 75 mg/m² IV on Day 1

Carboplatin AUC 6 IV on Day 2

Fluorouracil 1200 mg/m² IV continuous infusion

over 24 hours daily on Days 1–3

Cycled every 21 days³²**OTHER RECOMMENDED REGIMENS—continued****ECF**Epirubicin 50 mg/m² IV on Day 1Cisplatin 60 mg/m² IV on Day 1Fluorouracil 200 mg/m² IV continuous infusion

over 24 hours daily on Days 1–21

Cycled every 21 days³³**ECF modifications**Epirubicin 50 mg/m² IV on Day 1Oxaliplatin 130 mg/m² IV on Day 1Fluorouracil 200 mg/m² IV continuous infusion

over 24 hours daily on Days 1–21

Cycled every 21 days^{34,35}Epirubicin 50 mg/m² IV on Day 1Cisplatin 60 mg/m² IV on Day 1Capecitabine 625 mg/m² PO BID on Days 1–21Cycled every 21 days^{34,35}Epirubicin 50 mg/m² IV on Day 1Oxaliplatin 130 mg/m² IV on Day 1Capecitabine 625 mg/m² PO BID on Days 1–21Cycled every 21 days^{34,35}

^cLeucovorin is indicated with certain fluorouracil-based regimens. Depending on availability, these regimens may be used with or without leucovorin. For important information regarding the leucovorin shortage, please see [Discussion](#).

ⁱSystemic therapy regimen and dosing schedules are based on extrapolations from published literature and clinical practice.

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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**PRINCIPLES OF SYSTEMIC THERAPY—REGIMENS AND DOSING SCHEDULESⁱ****SYSTEMIC THERAPY FOR METASTATIC OR LOCALLY ADVANCED CANCER (WHERE LOCAL THERAPY IS NOT INDICATED)****SECOND-LINE AND SUBSEQUENT THERAPY****PREFERRED REGIMENS****Ramucirumab and paclitaxel**

Ramucirumab 8 mg/kg IV on Days 1 and 15
Paclitaxel 80 mg/m² on Days 1, 8, and 15
Cycled every 28 days³⁶

Taxane

Docetaxel 75–100 mg/m² IV on Day 1
Cycled every 21 days^{26,27}

Paclitaxel 135–250 mg/m² IV on Day 1
Cycled every 21 days²⁸

Paclitaxel 80 mg/m² IV on Day 1 weekly
Cycled every 28 days²⁹

Paclitaxel 80 mg/m² IV on Days 1, 8, and 15
Cycled every 28 days³⁷

Irinotecan

Irinotecan 250–350 mg/m² IV on Day 1
Cycled every 21 days⁴⁰

Irinotecan 150–180 mg/m² IV on Day 1
Cycled every 14 days^{37,38}

Irinotecan 125 mg/m² IV on Days 1 and 8
Cycled every 21 days⁴⁰

PREFERRED REGIMENS—continued**Trifluridine and tipiracil**

Trifluridine and tipiracil 35 mg/m² up to a maximum dose of 80 mg per dose (based on the trifluridine component) PO twice daily on Days 1–5 and 8–12
Repeat every 28 days⁴¹

Fluorouracil and irinotecan^c

Irinotecan 180 mg/m² IV on Day 1
Leucovorin 400 mg/m² IV on Day 1
Fluorouracil 400 mg/m² IV Push on Day 1
Fluorouracil 1200 mg/m² IV continuous infusion over 24 hours daily on Days 1 and 2
Cycled every 14 days³⁸

Pembrolizumab^g

(For second-line or subsequent therapy for MSI-H/dMMR tumors or third-line or subsequent therapy for gastric adenocarcinoma with PD-L1 expression levels by CPS of ≥1)
Pembrolizumab 200 mg IV on Day 1
Cycled every 21 days⁴⁶

OTHER RECOMMENDED REGIMENS**Ramucirumab**

Ramucirumab 8 mg/kg IV on Day 1
Cycled every 14 days⁴⁷

Irinotecan and cisplatin

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^{13,48}

Entrectinib or Larotrectinib

(For NTRK gene fusion-positive tumors)
Entrectinib 600mg PO once daily⁴⁹
or
Larotrectinib 100mg PO twice daily⁵⁰

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 days⁵¹

USEFUL IN CERTAIN CIRCUMSTANCES**Fluorouracil and irinotecan + ramucirumab^c**

Ramucirumab 8 mg/kg IV on Day 1
Irinotecan 180 mg/m² IV on Day 1
Leucovorin 400 mg/m² IV on Day 1
Fluorouracil 400 mg/m² IV push on Day 1
Fluorouracil 1,200 mg/m² IV continuous infusion over 24 hours daily on Days 1 and 2
Cycled every 14 days⁶²

^cLeucovorin is indicated with certain fluorouracil-based regimens. Depending on availability, these regimens may be used with or without leucovorin. For important information regarding the leucovorin shortage, please see [Discussion](#).

^gSee [NCCN Guidelines for Management of Immunotherapy-Related Toxicities](#).

ⁱSystemic therapy regimen and dosing schedules are based on extrapolations from published literature and clinical practice.

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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PRINCIPLES OF RADIATION THERAPY

General Guidelines

- Treatment recommendations should be made after joint consultation and/or discussion by a multidisciplinary team including surgical oncologists, radiation oncologists, medical oncologists, radiologists, gastroenterologists, and pathologists.
- CT scans, EUS, endoscopy reports, and FDG-PET or FDG-PET/CT scans, when available, should be reviewed by the multidisciplinary team. This will allow an informed determination of treatment volume and field borders prior to simulation.
- All available information from pretreatment diagnostic studies should be used to determine the target volume.
- In general, Siewert I and II tumors should be managed with radiation therapy guidelines applicable to esophageal and EGJ cancers. Depending on the clinical situation, Siewert III tumors may be more appropriately managed with radiation therapy guidelines applicable to either esophageal and EGJ or gastric cancers. These recommendations may be modified depending on the location of the bulk of the tumor.
- Image guidance may be used appropriately to enhance clinical targeting.

Simulation and Treatment Planning

- CT simulation and conformal treatment planning should be used. Intensity-modulated radiation therapy (IMRT) may be used in clinical settings where reduction in dose to organs at risk (eg, heart, lungs, liver, kidneys, small bowel) is required, which cannot be achieved by 3-D techniques.
- The patient should be instructed to avoid intake of a heavy meal for 3 hours before simulation and treatment. When clinically appropriate, 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 setup.
- It is optimal to treat patients in the supine position as the setup is generally more stable and reproducible.
- 4D-CT planning or other motion management may be appropriately utilized in select circumstances where organ motion with respiration may be significant.
- Target volumes need to be carefully defined and encompassed while designing IMRT plans. Uncertainties from variations in stomach filling and respiratory motion should be taken into account.

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[Continued](#)

GAST-G
1 OF 5



PRINCIPLES OF RADIATION THERAPY

Target Volume (General Guidelines)

• Preoperative¹

- ▶ Pretreatment diagnostic studies (EUS, EGD, FDG-PET, 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. Coverage of nodal areas may be modified based on clinical circumstances and the risks of toxicity.

• Postoperative⁴

- ▶ Pretreatment diagnostic studies (EUS, EGD, FDG-PET, 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
- ▶ Coverage of nodal areas may be modified based on clinical circumstances and the risks of toxicity.

Proximal One-Third/Fundus/Cardia/Esophagogastric Junction Primaries

- With proximal gastric lesions or lesions at the EGJ, a 3- to 5-cm margin of distal esophagus and nodal areas at risk should be included. Nodal areas at risk include: perigastric, celiac, left gastric artery, splenic artery, splenic hilar, hepatic artery, and porta hepatic lymph nodes.

Middle One-Third/Body Primaries

- Nodal areas at risk include: perigastric, celiac, left gastric artery, splenic artery, splenic hilar, hepatic artery, porta hepatic, suprapyloric, subpyloric, and pancreaticoduodenal lymph nodes.

Distal One-Third/Antrum/Pylorus Primaries

- A 3- to 5-cm margin of duodenum or duodenal stump should be included if the gross lesion extended to the gastroduodenal junction. Nodal areas at risk include: perigastric, left gastric artery, celiac, hepatic artery, porta hepatic, suprapyloric, subpyloric, and pancreaticoduodenal lymph nodes.

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**PRINCIPLES OF RADIATION THERAPY****Normal Tissue Tolerance Dose-Limits**

- Treatment planning is essential to reduce unnecessary dose to organs at risk.
- It is recognized that these dose guidelines may be appropriately exceeded based on clinical circumstances.

<u>Lungs</u>^a	<u>Heart</u>
<ul style="list-style-type: none"> • $V_{20\text{Gy}} \leq 30\%$ • Mean ≤ 20 Gy 	<ul style="list-style-type: none"> • $V_{30\text{Gy}} \leq 30\%$ (closer to 20% preferred) • Mean < 30 Gy
<u>Spinal Cord</u>	<u>Left Kidney, Right Kidney</u>
<ul style="list-style-type: none"> • Max ≤ 45 Gy 	(evaluate each one separately): <ul style="list-style-type: none"> • $V_{20\text{Gy}} \leq 33\%$ • Mean < 18 Gy
<u>Bowel</u>	<u>Liver</u>
<ul style="list-style-type: none"> • $V_{45\text{Gy}} < 195$ cc 	<ul style="list-style-type: none"> • $V_{30\text{Gy}} \leq 33\%$ • Mean < 25 Gy

RT Dosing

- 45–50.4 Gy (1.8 Gy/day)
 - Higher doses may be used for positive surgical margins in selected cases as a boost to that area.

^aLung 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 Member Institutions and others.

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References



PRINCIPLES OF RADIATION THERAPY

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 interruptions.
- During a radiation treatment course, patients should be seen for a 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 antidiarrheal 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-tubes) or nasogastric feeding tubes may be placed to ensure adequate caloric intake. During surgery, a J-tube may be placed for postoperative nutritional support.
- Adequate enteral and/or IV hydration is necessary during chemoradiation and recovery.

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PRINCIPLES OF RADIATION THERAPY REFERENCES

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PRINCIPLES OF SURVEILLANCE

- Surveillance strategies after curative intent resection (R0) for gastric cancer remain controversial, with sparse prospective data to construct evidence-based algorithms that balance benefits and risks (including cost) within this cohort.
- The guidance provided on [GAST-7](#) for stage-specific surveillance is based on the currently available retrospectively analyzed literature¹⁻¹⁰ and expert consensus.
- While the majority of gastric cancer relapses occur within 2 years (70%–80%) and almost all recurrences by 5 years (~90%) after completion of local therapy, it is important to note that occasionally potentially actionable relapses have been recognized more than 5 years after curative intent therapy. Therefore, after 5 years additional follow-up may be considered based on risk factors and comorbidities.
- Differences in follow-up for early-stage gastric cancer reflect a heterogeneous potential for relapse and overall survival.¹⁻¹⁰ Whereas R0-resected Tis disease has a prognosis that approximates a non-cancer cohort, T1aN0 and T1b disease do not have such a favorable prognosis. Thus, recommendations vary according to the depth of invasion and treatment modality.

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PRINCIPLES OF SURVEILLANCE REFERENCES

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PRINCIPLES OF SURVIVORSHIP

Surveillance: ([See GAST-7](#))

- Surveillance should be performed in conjunction with good routine medical care, including routine health maintenance, preventive care, and cancer screening.
- Routine gastric cancer-specific surveillance (ie, radiologic imaging, endoscopic evaluation, tumor markers) is not recommended beyond 5 years.

Management of Long-Term Sequelae of Disease or Treatment: (For common survivorship issues, see [NCCN Guidelines for Survivorship](#))

• General issues in gastric cancer survivors:

▶ Weight loss:

- ◊ Monitor weight regularly after gastrectomy to ensure stability
- ◊ Encourage more frequent feeding and avoiding fluid intake with meals
- ◊ Consider referral to dietician or nutrition services for individualized counseling
- ◊ Assess for and address contributing medical and/or psychosocial factors

▶ Diarrhea: Consider anti-diarrheal agents, bulk-forming agents, and diet manipulation

▶ Chemotherapy-induced neuropathy:

- ◊ Consider duloxetine for painful neuropathy only (not effective for numbness or tingling)
- ◊ See [NCCN Guidelines for Survivorship \(SPAIN-3\)](#) and [NCCN Guidelines for Adult Cancer Pain \(PAIN-3 through PAIN-5 and PAIN-H\)](#)

▶ Fatigue:

- ◊ Encourage physical activity and energy conservation measures as tolerated
- ◊ Assess and address contributing medical and/or psychosocial factors
- ◊ See [NCCN Guidelines for Survivorship \(SFAT-1\)](#) and [NCCN Guidelines for Cancer-Related Fatigue](#)

▶ Bone health:

- ◊ Screen for and manage low bone density at regular intervals as per established national guidelines
- ◊ Consider vitamin D testing and replacement as clinically indicated

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**PRINCIPLES OF SURVIVORSHIP****Management of Long-Term Sequelae of Disease or Treatment** (For common survivorship issues, see [NCCN Guidelines for Survivorship](#))• **Issues in subtotal gastrectomy survivors:**▶ **Indigestion:**

- ◊ Avoid foods that increase acid production (ie, citrus juices, tomato sauces, spicy foods) or lower gastroesophageal sphincter tone (ie, caffeine, peppermint, chocolate).

- ◊ Consider proton pump inhibitor

▶ **Vitamin B₁₂ deficiency: (distal gastrectomy only)**

- ◊ Monitor CBC and B₁₂ levels every 3 months for up to 3 years, then every 6 months up to 5 years, then annually

- ◊ Supplement B₁₂ as clinically indicated

▶ **Iron deficiency: (distal gastrectomy only)**

- ◊ Monitor CBC and iron levels at least annually

- ◊ Supplementation with iron as clinically indicated

• **Issues in total gastrectomy survivors:**▶ **Postprandial fullness or eating dysfunction:**

- ◊ Encourage small portions and more frequent eating

- ◊ Avoid fluid intake with meals

▶ **Dumping syndrome:**◊ **Early:**

- Occurs within 30 minutes of meal

- Associated with palpitations, diarrhea, nausea, and cramps

◊ **Late:**

- Occurs within 2–3 hours of a meal

- Associated with dizziness, hunger, cold sweats, faintness

- ◊ Encourage frequent meals scheduled throughout day

- ◊ Consume a diet high in protein and fiber, and low in simple carbohydrates or concentrated sweets

- ◊ Avoid fluid consumption with meals

▶ **Vitamin B₁₂ deficiency:**

- ◊ Monitor CBC and B₁₂ levels every 3 months for up to 3 years, then every 6 months for up to 5 years, then annually

- ◊ Supplement B₁₂ as clinically indicated

▶ **Iron deficiency:**

- ◊ Monitor CBC and iron levels at least annually

- ◊ Supplement iron as clinically indicated; avoid sustained-release or enteric-coated formulations if possible

▶ **Small intestine bacterial overgrowth (blind loop)**

- ◊ Consider treatment with antibiotics

- (rifaximin 550 mg TID x 7–10 days preferred)

- ◊ Consume a diet high in protein and low in carbohydrates

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[Continued](#)

**PRINCIPLES OF SURVIVORSHIP****Counseling Regarding Health Behaviors (See [NCCN Guidelines for Survivorship \[HL-1\]](#))**

- Maintain a healthy body weight throughout life
- Adopt a physically active lifestyle and avoid inactivity. Goal: at least 30 minutes of moderate-intensity activity most days of the week. Modify physical activity recommendations based on treatment sequelae (ie, neuropathy).
- Consume a healthy diet with emphasis on plant sources, with modifications as needed based on treatment sequelae (ie, dumping syndrome, bowel dysfunction).
- Limit alcohol consumption.
- Recommend smoking cessation as appropriate. [See NCCN Guidelines for Smoking Cessation.](#)
- Additional preventive health measures and immunizations should be performed as indicated under the care of or in conjunction with a primary care physician.

Cancer Screening Recommendations (for average-risk survivors)

- Breast Cancer: [See NCCN Guidelines for Breast Cancer Screening and Diagnosis](#)
- Colorectal Cancer: [See NCCN Guidelines for Colorectal Cancer Screening](#)
- Prostate Cancer: [See NCCN Guidelines for Prostate Cancer Early Detection](#)
- Lung Cancer: [See NCCN Guidelines for Lung Cancer Screening](#)

Survivorship Care Planning and Coordination of Care:

- [See NCCN Guidelines for Survivorship \(SURV-1 through SURV-B\)](#)
- [See NCCN Guidelines for Prevention and Treatment of Cancer-Related Infections](#)
- Encourage maintenance of a therapeutic relationship with a PCP throughout life. The oncologist and PCP should have defined roles in survivorship care, with roles communicated to patient.
- Planning for ongoing survivorship care^a
 - Information on treatment received including all surgeries, radiation therapy, and systemic therapies
 - Information regarding follow-up care, surveillance, and screening recommendations
 - Information on post-treatment needs, including information regarding acute, late and long-term treatment-related effects and health risks when possible ([See NCCN Disease-Specific Guidelines](#))
 - Delineation regarding roles of oncologists, primary care physicians (PCPs), and subspecialty care physicians in long-term care and the timing of transfer of care if appropriate
 - Healthy behavior recommendations ([See NCCN Guidelines for Survivorship \[HL-1\]](#))
 - [Periodic assessment of ongoing needs and identification of appropriate resources](#)

^aFrom Commission on Cancer. Optimal Resources for Cancer Care (2020 Standards): https://www.facs.org/-/media/files/quality-programs/cancer/coc/optimal_resources_for_cancer_care_2020_standards.ashx and [NCCN Guidelines for Survivorship](#).

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**PRINCIPLES OF PALLIATIVE CARE/BEST SUPPORTIVE CARE^a**

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.^b

Bleeding

- **Acute 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 Treatment**
 - ◇ **The efficacy of endoscopic therapy for bleeding in patients with gastric cancer is not well studied.² The limited data suggest that while endoscopic therapies may initially be effective, the rate of recurrent bleeding is very high.³**
 - ◇ **Widely available treatment options include injection therapy, mechanical therapy (eg, endoscopic clips), ablative therapy (eg, argon plasma coagulation), or a combination of methods.**
 - ▶ **Interventional Radiology**
 - ◇ **Angiographic embolization techniques may be useful in those situations where endoscopy is not helpful or bleeding occurs.**
 - ▶ **External beam radiation therapy (EBRT) has been shown to effectively manage acute and chronic gastrointestinal bleeding in multiple small series.^{4,5}**
- **Chronic blood loss from gastric cancer**
 - ▶ **Although proton pump inhibitors can be prescribed to reduce bleeding risk from gastric cancer, there are no definite data supporting its use at this time.**
 - ▶ **EBRT may be used for chronic blood loss due to gastric cancer.^{4,5}**

^a[See NCCN Guidelines for Palliative Care.](#)

^bFor patients who have immune-mediated toxicity, [See NCCN Guidelines for Management of Immunotherapy-Related Toxicities.](#)

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[Continued](#)
[References](#)

GAST-J
1 OF 3

**PRINCIPLES OF PALLIATIVE CARE/BEST SUPPORTIVE CARE^a****Obstruction**

The primary goals of palliation for patients with malignant gastric obstruction are to reduce nausea and vomiting and, when possible, allow resumption of an oral diet.

• Alleviate or bypass obstruction**▶ Endoscopy**

- ◊ Placement of enteral stent for relief of outlet obstruction,⁶ or esophageal stent for EGJ/gastric cardia obstruction (see [NCCN Guidelines for Esophageal and Esophagogastric Junction Cancers](#))

▶ Surgery

- ◊ Gastrojejunostomy⁶
- ◊ Gastrectomy in select patients⁷

▶ EBRT**▶ Chemotherapy^b****• When obstruction cannot be alleviated or bypassed, the primary goal is to reduce the symptoms of obstruction via venting gastrostomy (if endoscopic lumen enhancement is not undertaken or is unsuccessful).⁸**

- ▶ Percutaneous, endoscopic, surgical, 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.

• In patients who cannot take an oral diet, feeding gastrostomy tubes for patients with EGJ/gastric cardia obstruction or jejunal feeding tubes for patients with mid and distal gastric obstruction can be placed if tumor location permits.**Pain****• EBRT****• Chemotherapy^c****• 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](#).****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 obstruction is present.**^aSee [NCCN Guidelines for Palliative Care](#).^cSee [Principles of Systemic Therapy \(GAST-F\)](#).

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**American Joint Committee on Cancer (AJCC)**
TNM Staging Classification for Carcinoma of the Stomach (8th ed., 2017)**Table 1. Definitions for T, N, M**

T	Primary Tumor	N	Regional Lymph Nodes
TX	Primary tumor cannot be assessed	NX	Regional lymph node(s) cannot be assessed
T0	No evidence of primary tumor	N0	No regional lymph node metastasis
Tis	Carcinoma <i>in situ</i> : intraepithelial tumor without invasion of the lamina propria, high-grade dysplasia	N1	Metastasis in one or two regional lymph nodes
T1	Tumor invades the lamina propria, muscularis mucosae, or submucosa	N2	Metastasis in three to six regional lymph nodes
T1a	Tumor invades the lamina propria or muscularis mucosae	N3	Metastasis in seven or more regional lymph nodes
T1b	Tumor invades the submucosa	N3a	Metastasis in seven to 15 regional lymph nodes
T2	Tumor invades the muscularis propria*	N3b	Metastasis in 16 or more regional lymph nodes
T3	Tumor penetrates the subserosal connective tissue without invasion of the visceral peritoneum or adjacent structures**,***	M	Distant Metastasis
T4	Tumor invades the serosa (visceral peritoneum) or adjacent structures**,***	M0	No distant metastasis
T4a	Tumor invades the serosa (visceral peritoneum)	M1	Distant metastasis
T4b	Tumor invades adjacent structures/organs	G	Histologic Grade

*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 as T3. If there is perforation of the visceral peritoneum covering the gastric ligaments or the omentum, the tumor should be classified as 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 not considered invasion of an adjacent structure, but is classified using the depth of the greatest invasion in any of these sites.

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American Joint Committee on Cancer (AJCC)
TNM Staging Classification for Carcinoma of the Stomach (8th ed., 2017)

Table 2. AJCC Prognostic Stage Groups
Clinical Staging (cTNM)

	cT	cN	M
Stage 0	Tis	N0	M0
Stage I	T1	N0	M0
	T2	N0	M0
Stage IIA	T1	N1, N2, N3	M0
	T2	N1, N2, N3	M0
Stage IIB	T3	N0	M0
	T4a	N0	M0
Stage III	T3	N1, N2, N3	M0
	T4a	N1, N2, N3	M0
Stage IVA	T4b	Any N	M0
Stage IVB	Any T	Any N	M1

Pathological Staging (pTNM)

	pT	pN	M
Stage 0	Tis	N0	M0
Stage IA	T1	N0	M0
Stage IB	T1	N1	M0
	T2	N0	M0
Stage IIA	T1	N2	M0
	T2	N1	M0
	T3	N0	M0
Stage IIB	T1	N3a	M0
	T2	N2	M0
	T3	N1	M0
	T4a	N0	M0
Stage IIIA	T2	N3a	M0
	T3	N2	M0
	T4a	N1 or N2	M0
	T4b	N0	M0
Stage IIIB	T1	N3b	M0
	T2	N3b	M0
	T3	N3a	M0
	T4a	N3a	M0
	T4b	N1 or N2	M0
Stage IIIC	T3	N3b	M0
	T4a	N3b	M0
	T4b	N3a or N3b	M0
Stage IV	Any T	Any N	M1

Post-Neoadjuvant Therapy (ypTNM)

	ypT	ypN	M
Stage I	T1	N0	M0
	T2	N0	M0
	T1	N1	M0
Stage II	T3	N0	M0
	T2	N1	M0
	T1	N2	M0
	T4a	N0	M0
	T3	N1	M0
	T2	N2	M0
	T1	N3	M0
Stage III	T4a	N1	M0
	T3	N2	M0
	T2	N3	M0
	T4b	N0	M0
	T4b	N1	M0
	T4a	N2	M0
	T3	N3	M0
	T4b	N2	M0
	T4b	N3	M0
	T4a	N3	M0
Stage IV	Any T	Any N	M1

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**NCCN Categories of Evidence and Consensus**

Category 1	Based upon high-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
Category 2A	Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
Category 2B	Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate.
Category 3	Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate.

All recommendations are category 2A unless otherwise indicated.

NCCN Categories of Preference

Preferred intervention	Interventions that are based on superior efficacy, safety, and evidence; and, when appropriate, affordability.
Other recommended intervention	Other interventions that may be somewhat less efficacious, more toxic, or based on less mature data; or significantly less affordable for similar outcomes.
Useful in certain circumstances	Other interventions that may be used for selected patient populations (defined with recommendation).

All recommendations are considered appropriate.



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Overview

The incidence and mortality of gastric cancer have decreased substantially in the United States and much of the developed world over the past several decades.¹⁻⁴ However, upper gastrointestinal (GI) tract cancers originating in the stomach, esophagus, or esophagogastric junction (EGJ) still constitute a major global health problem, especially in low and middle income countries.⁵ The global incidence of gastric cancer shows wide geographic variation, with a 15- to 20-fold difference between high- and low-incidence regions.¹ The highest gastric cancer incidence rates occur in East Asia, South and Central America, and Eastern Europe.⁵ Rates are particularly high in Japan and Korea, where gastric cancer is the most commonly diagnosed cancer in men, and in China, where gastric cancer is a leading cause of cancer-related mortality.^{5,6} Globally, there was an estimated 1.03 million cases resulting in over 780,000 deaths in 2018, making gastric cancer the 5th most frequently diagnosed cancer and the 3rd leading cause of cancer-related deaths in the world.^{7,8} In contrast, gastric cancer is one of the least commonly diagnosed cancers in Western Europe, Australia, and North America. In 2019, an estimated 27,510 people will be diagnosed and 11,140 people will die of this disease in the United States, making gastric cancer the 15th most commonly diagnosed cancer and the 15th leading cause of cancer-related death in America.^{9,10}

Over 95% of gastric cancers are adenocarcinomas, which are typically classified based on anatomic location (cardia/proximal or non-cardia/distal) and histologic type (diffuse or intestinal).³ The diffuse type, which is characterized by undifferentiated tumor cells arranged in a scattered formation in fibrous stroma, is more prevalent in low-risk areas and is mostly associated with heritable genetic abnormalities.^{3,6,11-13} The intestinal type, which is characterized by well-differentiated tumor cells arranged in a tubular or glandular formation, occurs more frequently in high-risk areas and accounts for most of the geographic variation seen with this disease. Intestinal type gastric cancer is often related to

environmental factors such as *Helicobacter pylori* (*H. pylori*) infection, smoking, high salt intake, and other dietary factors.^{3,6,11-13} However, the role of alcohol as a risk factor for gastric cancer is controversial. While the results of several meta-analyses have shown no appreciable association between light or moderate alcohol consumption and gastric cancer risk, they did show a positive association between heavy alcohol use and gastric cancer, particularly non-cardia gastric cancer.¹⁴⁻¹⁶

A dramatic shift in the type and location of upper GI tract tumors has occurred in North America and Europe.^{2,17,18} There has been a marked decline in intestinal type gastric cancers of the distal stomach in Western countries over the past several decades, mainly due to higher standards of hygiene, improved food conservation, improved diet, and *H. pylori* eradication.^{1-4,13} However, incidence rates of diffuse type gastric cancer of the proximal stomach are rising.¹⁻³ The etiology of this increase mainly remains elusive and may be multifactorial. In contrast to the incidence trends in the West, tumors of the distal stomach continue to predominate in developing countries.² Despite overall declining rates, gastric cancer is difficult to cure in Western countries because it 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, resulting in improved prognosis.¹ In other parts of the world, survival rates from gastric cancer remain poor as early detection continues to pose a major challenge for health care professionals.

Literature Search Criteria and Guidelines Update Methodology

Prior to the update of this version of the NCCN Guidelines for Gastric Cancer, an electronic search of the PubMed database was performed to obtain key literature published since the last Guidelines update, using the following search terms: gastric cancer, gastric adenocarcinoma, and stomach cancer. The PubMed database was chosen as it remains the



most widely used resource for medical literature and indexes peer reviewed biomedical literature.¹⁹

The search results were narrowed by selecting studies in humans published in English. Results were confined to the following article types: Clinical Trial, Phase II; Clinical Trial, Phase III; Clinical Trial, Phase IV; Guideline; Randomized Controlled Trial; Meta-Analysis; Systematic Reviews; and Validation Studies.

The data from key PubMed articles selected by the panel for review during the Guidelines update meeting as well as articles from additional sources deemed as relevant to these Guidelines and discussed by the panel have been included in this version of the Discussion section (eg, e-publications ahead of print, meeting abstracts). Recommendations for which high-level evidence is lacking are based on the panel's review of lower level evidence and expert opinion.

The complete details of the Development and Update of the NCCN Guidelines are available at www.NCCN.org.

Hereditary Cancer Predisposition Syndromes Associated with an Increased Risk for Gastric Cancer

It is estimated that 3% to 5% of gastric cancers are associated with inherited cancer predisposition syndromes. Referral to a cancer genetics professional is recommended for individuals with a known high-risk syndrome associated with gastric cancer. See *Principles of Genetic Risk Assessment for Gastric Cancer* in the algorithm for criteria that warrant further risk evaluation for high-risk syndromes.

Hereditary Diffuse Gastric Cancer

Hereditary diffuse gastric cancer (HDGC) is an autosomal dominant syndrome characterized by the development of gastric cancers, predominantly the diffuse type, at a young age.^{20,21} Germline truncating

mutations in the tumor suppressor gene *CDH1* (encoding the cell-to-cell adhesion protein E-cadherin) are found in 30% to 50% of families with HDGC.^{22,23} The average age at diagnosis of gastric cancer is 37 years, and the lifetime risk for the development of gastric cancer by the age of 80 years is estimated at 67% for men and 83% for women.²⁴

Prophylactic total gastrectomy (without a D2 lymph node dissection) is recommended between ages 18 and 40 years for carriers of germline truncating *CDH1* mutations.^{25,26} Prophylactic gastrectomy prior to 18 years of age is not recommended but may be considered for certain patients, especially those with family members diagnosed with gastric cancer before age 25. A baseline endoscopy is indicated prior to prophylactic total gastrectomy. Screening by upper endoscopy with multiple random biopsies every 6 to 12 months should be offered to *CDH1* mutation carriers who elect not to undergo prophylactic total gastrectomy. However, available evidence suggests that endoscopy may not adequately detect the precursor lesions in diffuse gastric cancer.²⁷⁻²⁹ Additionally, women with *CDH1* mutations are at an increased risk for developing breast cancer³⁰ and should be followed similarly to *BRCA1/BRCA2* mutation carriers as outlined in the [NCCN Guidelines for Genetic/Familial High-Risk Assessment: Breast and Ovarian](#).

More than 40% of patients with HDGC do not carry *CDH1* mutations, suggesting the existence of additional susceptibility genes.³¹ Known breast cancer predisposition gene *PALB2*, which encodes for an adaptor protein necessary for *BRCA2* function, has recently been shown to confer susceptibility to familial gastric cancer.^{32,33} In a large genomic study of cancer predisposition variants, five different germline loss-of-function mutations in *PALB2* were identified in gastric adenocarcinoma patients.³³ *PALB2* was also identified as being significantly enriched for loss-of-function variants in a whole-exome sequencing study of families with HDGC not associated with a *CDH1* mutation.³² Furthermore, *PALB2* loss-of-function variants were found to be substantially more common in



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families with HDGC than in the general population.³² These findings suggest a putative role for *PALB2* in HDGC; however, more sufficient evidence is required to justify routine genetic testing of *PALB2* in families with HDGC without *CDH1* mutations.

Lynch Syndrome

Lynch syndrome (also referred to as hereditary non-polyposis colorectal cancer) is an autosomal dominant syndrome characterized by the early onset of colorectal, endometrial, and gastric cancers.³⁴ Lynch syndrome arises from germline mutations in any of the 4 DNA mismatch repair genes (*MLH1*, *MSH2*, *MSH6*, and *PMS2*).³⁵ Deletions of the epithelial cell adhesion molecule (*EPCAM*) gene have also been implicated in Lynch syndrome.³⁶ Gastric cancer is the second most common extracolonic cancer (after endometrial cancer) in patients with Lynch syndrome. These patients have a 1% to 13% risk of developing gastric cancer, predominantly the intestinal type, which occurs at an earlier age than the general population.³⁷⁻⁴⁰ This risk is higher among Asians than Westerners.

Esophagogastroduodenoscopy (EGD) with extended duodenoscopy (to the distal duodenum or into the jejunum) may be considered as a screening strategy in select individuals or those of Asian descent.³⁴ See the [NCCN Guidelines for Genetic/Familial High-Risk Assessment: Colorectal](#) for additional screening recommendations.

Juvenile Polyposis Syndrome

Juvenile polyposis syndrome (JPS) is a rare autosomal dominant syndrome characterized by the presence of multiple juvenile polyps along the GI tract and is associated with an increased risk of developing GI cancers.⁴¹ JPS arises from a germline mutation in the *SMAD4* or *BMPR1A* genes.³⁴ The lifetime risk of developing GI cancers in patients with JPS varies from 9% to 50% with the type of mutation.⁴² The lifetime risk of developing gastric cancer in individuals with JPS is 21% when the upper

GI tract is involved, which is mainly seen in *SMAD4* mutation carriers.⁴² Screening with EGD may be considered, beginning in the mid-teens and repeated annually if polyps are found or every 2 to 3 years if no polyps are found.³⁴ See the [NCCN Guidelines for Genetic/Familial High-Risk Assessment: Colorectal](#) for additional screening recommendations.

Peutz Jeghers Syndrome

Peutz Jeghers syndrome (PJS) is an autosomal dominant syndrome caused by germline mutations in the *STK11* tumor suppressor gene,^{43,44} which occurs in 30% to 80% of patients.⁴⁵ PJS is characterized by mucocutaneous pigmentation and GI polyposis and is associated with an elevated risk of developing GI cancers.⁴⁶⁻⁵⁰ Individuals with PJS have a 29% lifetime risk of developing gastric cancer and are also at an increased risk for other cancers.^{34,46} Screening with EGD may be considered, beginning in the late teens and repeated every 2 to 3 years based on gastric polyp burden.³⁴ See the [NCCN Guidelines for Genetic/Familial High-Risk Assessment: Colorectal](#) for additional screening recommendations.

Familial Adenomatous Polyposis

Familial adenomatous polyposis (FAP) is an inherited autosomal dominant colorectal cancer syndrome resulting from germline mutations in the adenomatous polyposis coli (*APC*) gene on chromosome 5q21.^{51,52} FAP is characterized by adenomatous colorectal polyps that progress to colorectal cancer at 35 to 40 years of age. Upper GI polyps in the stomach, duodenum, and periampullary region are the most common extracolonic manifestations of FAP.⁵³ The majority (~90%) of gastric polyps are nonadenomatous benign fundic gland polyps, developing in approximately 50% of patients with FAP. Gastric adenomatous polyps, which can lead to gastric cancer, represent 10% of the gastric polyps

diagnosed in these patients.⁵³ Individuals with FAP have a 1% to 2% lifetime risk of developing gastric cancer.

There is no clear evidence to support specific screening recommendations for gastric cancer in patients with FAP. However, given the increased risk of duodenal cancer, the stomach should be examined at the same time of duodenoscopy. Non-fundic gland polyps in the stomach should be managed endoscopically, if possible.⁵⁴ Patients with polyps that cannot be removed endoscopically (as in the case of invasive cancers) should be referred for gastrectomy.⁵⁴ A baseline EGD with side-viewing endoscope is recommended at age 25 to 30 years and repeated based on duodenal polyp burden. See the [NCCN Guidelines for Genetic/Familial High-Risk Assessment: Colorectal](#) for additional screening recommendations.

Less Common Hereditary Cancer Predisposition Syndromes

In addition to the more common syndromes discussed above, there are a number of hereditary cancer predisposition syndromes that are less commonly associated with a risk of developing gastric cancer. Ataxia-telangiectasia,⁵⁵ Bloom syndrome,⁵⁶ hereditary breast and ovarian cancer syndrome,^{55,57} Li-Fraumeni syndrome,^{55,57} Xeroderma pigmentosum,⁵⁵ and Cowden syndrome⁵⁷ have all been reported to increase the risk of gastric cancer. However, evidence for gastric cancer screening in these patients is insufficient and therefore not recommended at this time.

Staging

The tumor (T), node (N), and metastasis (M) staging system used by the American Joint Committee on Cancer (AJCC) is the internationally accepted standard for cancer staging and is a major factor influencing prognosis and treatment decisions. Staging recommendations for gastric cancer presented in the 8th edition of the AJCC Cancer Staging Manual include clinical staging (cTNM; newly diagnosed, not yet treated patients), pathologic staging (pTNM; patients undergoing resection without prior

treatment), and postneoadjuvant staging (ypTNM; patients receiving preoperative therapy).⁵⁸ The 8th edition also introduced modifications regarding tumors located at the EGJ and within the gastric cardia. Using this system, tumors involving the EGJ with an epicenter located >2 cm into the proximal stomach are now staged as gastric carcinomas. Tumors involving the EGJ with an epicenter ≤2 cm into the proximal stomach will still be staged as esophageal carcinomas. Cancers located within the gastric cardia that do not involve the EGJ are staged as gastric carcinomas.

The 8th edition of the AJCC Cancer Staging Manual provides additional resources for gastric cancer not available in the 7th edition, including the addition of new c and yp stage groupings, to fulfill unmet needs in staging patients under different circumstances. Due to the lack of an official clinical stage classification in the past, treating physicians have typically used the pathologic stage to clinically stage patients. Furthermore, due to the lack of yp stage groupings, pathologic staging has also been applied to patients who had received preoperative therapy. The use of pathology assessments to establish c and yp stage has not been validated and may not be appropriate. Therefore, new c and yp stage groupings and prognostic information were added to the 8th edition to overcome these issues. New clinical stage groupings and prognostic information are based on datasets from the National Cancer Database (NCDB), representing patients treated surgically or nonsurgically in the United States, and the Shizuoka Cancer Center dataset, representing patients treated surgically in Japan, for a total of 4,091 patients. These clinical stage groupings are different from groupings used for pathologic or postneoadjuvant staging. Newly provided prognostic information for yp staging is presented using only the four broad stage categories (stage I–IV) due to the limited number of patients (n = 700) available for analysis. The addition of this new ypTNM stage grouping system fulfills an unmet need in the clinics since many gastric cancer patients are now treated with preoperative therapy.

Furthermore, the stage groupings and prognostic information for p staging presented in the 8th edition are now based on data from >25,000 gastric cancer patients from the International Gastric Cancer Association (IGCA) database who have had surgery with adequate lymph node removal. Patients treated with preoperative therapy were not included in the analysis. Pathologic stage groupings were refined based on 5-year survival data. Although most (84.8%) of the eligible cases from the IGCA database came from Japan and Korea, the predictive ability and accuracy of parameters used in the 8th edition for p staging of gastric cancer have been validated for U.S. populations.^{59,60} However, limitations of this dataset still remain, including a lack of uniformity in initial clinical stage assessments, the lack of a uniform surgical approach, and the use of p assessments of yp categories.⁵⁸

Baseline clinical stage provides useful information for the development of an initial treatment strategy. The availability of diagnostic modalities such as endoscopic ultrasound (EUS), CT, 18-fluorodeoxyglucose (FDG)-PET/CT, and laparoscopy has greatly improved baseline clinical staging of gastric cancer.⁶¹⁻⁶³ EUS is indicated for assessing the depth of tumor invasion (T staging).⁶⁴ However, the diagnostic accuracy of EUS is operator dependent, ranging from 57% to 88% for T staging and 30% to 90% for nodal (N) staging.⁶⁵ In a large multi-institutional study that evaluated the use and accuracy of EUS in patients undergoing curative intent resection for gastric adenocarcinoma, the overall accuracy of EUS was 46.2% for T staging and 66.7% for N staging.⁶⁶ Distant lymph node evaluation by EUS is also suboptimal given the limited depth and visualization of the transducer.⁶⁷ EUS may be useful for differentiating T3 and T4 tumors, but it should be used in combination with other staging modalities.^{65,66} EUS is also useful to identify T1 tumors for potential endoscopic approaches. Therefore, EUS should be used if early-stage disease is suspected or if early versus locally advanced disease needs to be determined.

CT scan is routinely used for preoperative staging and has an overall accuracy of 43% to 82% for T staging. In contrast, FDG-PET has a lower accuracy rate because of low FDG uptake in diffuse and mucinous tumor types, which are common in gastric cancer.^{68,69} FDG-PET also has significantly lower sensitivity compared to CT in the detection of local lymph node involvement (56% vs. 78%), although FDG-PET has improved specificity (92% vs. 62%).⁷⁰ Thus, combined FDG-PET/CT imaging offers several potential advantages over FDG-PET or CT scans alone.⁷¹ FDG-PET/CT has a significantly higher accuracy rate in preoperative staging (68%) than FDG-PET (47%) or CT (53%) alone. Additionally, reports have confirmed that FDG-PET alone is not an adequate diagnostic procedure in the detection and preoperative staging of gastric cancer, but can be helpful when used in conjunction with CT.^{72,73}

Laparoscopic staging can be used to detect occult metastases. In a study conducted at Memorial Sloan Kettering Cancer Center, 657 patients with potentially resectable gastric adenocarcinoma underwent laparoscopic staging over a period of 10 years.⁷⁴ Distant metastatic disease (M1) was detected in 31% of patients. However, limitations of laparoscopic staging include two-dimensional evaluation and limited use in the identification of hepatic metastases and perigastric lymph nodes. Cytology testing of peritoneal fluid can help improve laparoscopic staging through identification of occult carcinomatosis.⁶¹ Positive peritoneal cytology is associated with a poor prognosis in patients with gastric cancer and is an independent predictor for recurrence following curative resection.⁷⁵⁻⁷⁷ Clearing of cytology-positive disease by chemotherapy is associated with a statistically significant improvement in disease-specific survival, but cures are rare and the role of surgery is uncertain.⁷⁶ Therefore, positive peritoneal cytology even in the absence of visible peritoneal implants should be considered as M1 disease, and surgery as initial treatment is not recommended. In patients being considered for surgical resection without preoperative therapy, laparoscopy may be useful for the detection



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of radiographically occult metastatic disease in patients with T3 and/or N+ tumors identified on preoperative imaging. In patients receiving preoperative therapy, laparoscopy along with cytology of peritoneal washings is recommended.⁷⁴ Laparoscopic staging with peritoneal washings for cytology is indicated for clinical stages \geq T1b (category 2B). The panel recommends laparoscopy to evaluate for peritoneal spread when chemoradiation or surgery is considered. However, laparoscopy is not indicated if a palliative resection is planned.

In North America and Western Europe, where screening programs for early detection of gastric cancer are not in use or practical because of low incidence, diagnosis is often made late in the disease course. Approximately 50% of patients present with advanced disease at diagnosis and will likely have a poor outcome. Other measures of poor outcome include poor performance status, presence of metastases, and an alkaline phosphatase level \geq 100 U/L.⁷⁸ Additionally, nearly 80% of patients have involvement of the regional lymph nodes and the number of positive lymph nodes has a profound influence on survival.⁷⁹ In patients with localized resectable disease, outcome depends on the surgical stage of the disease.

Pathologic Review and Biomarker Testing

Pathologic review and biomarker testing play important roles in the diagnosis, classification, and molecular characterization of gastric cancer. Classification based on histologic subtype and molecular features helps improve early diagnosis and has implications for therapy. An accumulation of genetic aberrations occurs during gastric carcinogenesis, including overexpression of growth factors and/or receptors, alterations in DNA damage response, and loss of genomic stability. Characterization of these pathways has enabled the application of molecular pathology to aid in the diagnosis, classification, and treatment of gastric cancer.¹³ The implementation of molecular testing,

especially analysis of human epidermal growth factor receptor 2 (HER2) status, has had a significant impact on clinical practice and patient care.

Principles of Pathologic Review

A specific diagnosis of gastric adenocarcinoma should be established for staging and treatment purposes. Subclassification of gastric adenocarcinoma as intestinal or diffuse type may have implications for therapy since intestinal type tumors are more likely to be HER2 positive (see below). In addition to the histologic type, the pathology report (regardless of the specimen type) should include specifics about tumor invasion and pathologic grade, which are required for staging. The pathology report of endoscopic mucosal resection (EMR) specimens should include an assessment of lymphovascular invasion (LVI), depth of tumor invasion, and the status of mucosal and deep margins. Pathology reports of gastrectomy specimens without prior chemoradiation should also document the location of the tumor midpoint in relationship to the EGJ, whether the tumor crosses the EGJ, the 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. The pathology report should include all of the above elements plus an assessment of treatment effect.

While there is no universally accepted minimum number of lymph nodes necessary for accurate staging of gastric cancer, retrieval of \geq 15 lymph nodes is recommended to stage nodal status more accurately.^{80,81} Analysis of data from the SEER database and NCDB showed a trend for improved overall survival (OS) with a higher number of lymph nodes examined after gastrectomy.⁸¹⁻⁸³ The trend for superior survival based on more lymph nodes examined was confirmed across all stage subgroups.

Assessment of Treatment Response

Response of the primary tumor and involved lymph nodes to previous chemotherapy and/or RT should be reported. Pathologic response and histologic tumor regression after neoadjuvant therapy have been shown to be predictors of survival in patients with gastric adenocarcinoma. Lowy et al reported that response to neoadjuvant chemotherapy was the only independent predictor of OS in patients who underwent curative resection for gastric cancer.⁸⁴ Additionally, Mansour et al reported that the 3-year disease-specific survival rate was significantly higher for patients with >50% pathologic response to neoadjuvant chemotherapy compared to those with <50% pathologic response (69% and 44%, respectively).⁸⁵ In another study, Becker et al demonstrated that histopathologic grading of tumor regression was correlated with survival in patients treated with neoadjuvant chemotherapy.⁸⁶ Conversely, Smyth et al reported that lymph node metastasis, not pathologic response to therapy, was the only independent predictor of survival in patients who received neoadjuvant chemotherapy as part of the MAGIC trial.⁸⁷

Tumor response scoring systems for gastric cancer have not been uniformly adopted. The panel recommends using the modified scheme developed by Ryan et al^{88,89} because it generally provides good reproducibility among pathologists, but other systems may also be used. The following scheme is suggested: 0 (complete response; no viable cancer cells, including lymph nodes); 1 (near complete response; single cells or rare small groups of cancer cells); 2 (partial response; residual cancer cells with evident tumor regression, but more than single cells or rare small groups of cancer cells); and 3 (poor or no response; extensive residual cancer with no evident tumor regression). Because of the impact of residual nodal metastases on survival, it is recommended that lymph nodes be included in the regression score. Sizable pools of acellular mucin may be present after chemoradiation, but should not be interpreted as representing residual tumor.

Principles of Biomarker Testing

Presently, molecular testing for HER2 status, microsatellite instability status, and programmed death ligand 1 (PD-L1) expression are implicated in the clinical management of metastatic gastric cancer.

Although an enhanced understanding of the genomics/epigenomics of gastric cancer is needed, there are insufficient data to support the use of next generation-sequencing (NGS) at the time of initial diagnosis for clinical decision making. However, NGS profiling can be used for the identification of treatment and/or clinical trial enrollment. NGS may be useful in patients with advanced cancer in later stages of therapy rather than in the early phases of disease. The role of liquid biopsy for genomic profiling of gastric cancer remains unclear at the present time and is a subject of ongoing investigation.

Assessment of HER2 Positivity

Overexpression or amplification of the HER2 gene or protein has been implicated in the development of gastric adenocarcinoma.⁹⁰ However, unlike in breast cancer, the prognostic significance of HER2 status in gastric cancer is unclear. Some studies suggest that HER2 positivity is associated with poor prognosis⁹¹⁻⁹⁶ while others have shown that it is not an independent prognostic factor of patient outcome, except in a very small subgroup of patients with intestinal histology.⁹⁷⁻⁹⁹ While further studies are needed to assess the prognostic significance of HER2 status in gastric cancer, the addition of HER2 monoclonal antibodies to chemotherapy regimens is a promising treatment option for patients with HER2-positive metastatic disease.

The reported rates of HER2 positivity in patients with gastric cancer range from 12% to 23%.^{92,93,98-101} HER2 positivity also varies with the histologic subtype (intestinal > diffuse) and tumor grade (moderately differentiated > poorly differentiated).^{93,98-100} HER2 positivity is reported in ≤20% of Western patients with metastatic gastric cancer with significantly higher

rates seen in patients with intestinal histology (33% vs. 8% for diffuse/mixed histology; $P = .001$).⁹⁸ In the U.S. population, the reported HER2 positivity rate in gastric cancer is 12% and is more often identified in the intestinal subtype rather than the diffuse subtype (19% and 6%, respectively).⁹⁹ In the ToGA trial that evaluated the addition of trastuzumab to chemotherapy in patients with HER2-positive advanced gastric or EGJ cancers, HER2 positivity rates were 32.2%, 21.4%, 31.8%, and 6.1%, respectively, in patients with EGJ adenocarcinoma, gastric adenocarcinoma, intestinal gastric adenocarcinoma, and diffuse gastric adenocarcinoma.^{102,103} Therefore, subclassification of gastric adenocarcinomas as intestinal or diffuse type may have implications for therapy.

HER2 testing is recommended for all gastric adenocarcinoma patients at the time of diagnosis if metastatic disease is documented or suspected. In concordance with HER2 testing guidelines from the College of American Pathologists (CAP), the American Society for Clinical Pathology (ASCP), and the American Society for Clinical Oncology (ASCO),¹⁰⁴ the NCCN Guidelines recommend using immunohistochemistry (IHC) and, if needed, in situ hybridization (ISH) techniques to assess HER2 status in gastric cancer. IHC evaluates the membranous immunostaining of tumor cells, including the intensity and extent of staining and the percentage of immunoreactive tumor cells, with scores ranging from 0 (negative) to 3+ (positive). In 2008, Hofmann et al refined this 4-tiered scoring system to assess HER2 status in gastric cancer by using a cut-off of $\geq 10\%$ immunoreactive tumor cells for resection specimens.^{103,105} In a subsequent validation study ($n = 447$ prospective diagnostic gastric cancer specimens), this scoring system was found to be reproducible between different pathologists.¹⁰⁶ This modified HER2 scoring system is therefore recommended by the panel. A score of 0 (membranous reactivity in $< 10\%$ of cancer cells) or 1+ (faint membranous reactivity in $\geq 10\%$ of cancer cells) is considered to be

HER2-negative. A score of 2+ (weak to moderate membranous reactivity in $\geq 10\%$ of cancer cells) is considered equivocal and should be additionally examined by fluorescence in situ hybridization (FISH) or other ISH methods. FISH/ISH results are expressed as the ratio between the number of copies of the *HER2* gene and the number of chromosome 17 centromeres (CEP17) within the nucleus counted in at least 20 cancer cells (*HER2*:CEP17). Alternatively, FISH/ISH results may be given as the average *HER2* copy number per cell. Cases that have an IHC score of 3+ (strong membranous reactivity in $\geq 10\%$ of cancer cells) or an IHC score of 2+ and are FISH/ISH positive (*HER2*:CEP17 ratio ≥ 2 or average *HER2* copy number ≥ 6 signals/cell) are considered HER2-positive. Positive (3+) or negative (0 or 1+) HER2 IHC results do not require further ISH testing. See *Principles of Pathologic Review and Biomarker Testing: Assessment of Overexpression or Amplification of HER2 in Gastric Cancer* - Table 3 in the algorithm for more information.

Assessment of Microsatellite Instability and PD-L1 Expression

In its first-ever site-agnostic approval, the U.S. Food and Drug Administration (FDA) approved pembrolizumab for the treatment of unresectable or metastatic microsatellite instability-high (MSI-H) or deficient mismatch repair (dMMR) solid tumors in the second-line or subsequent setting.¹⁰⁷ Therefore, MSI-H/dMMR status should be assessed in all gastric adenocarcinoma patients if metastatic disease is documented or suspected. MMR status is assessed by IHC staining to measure expression levels of proteins involved in DNA mismatch repair (ie, MLH1, MSH2, MSH6, PMS2).¹⁰⁸ MSI is assessed by polymerase chain reaction (PCR) to measure gene expression levels of microsatellite markers (ie, *BAT25*, *BAT26*, *MONO27*, *NR21*, *NR24*).¹⁰⁹ It should be noted that IHC for MMR and PCR for MSI are different assays measuring the same biological effect. Testing is performed on formalin-fixed, paraffin-embedded (FFPE) tissue and results are interpreted as MSI-H or dMMR in accordance with [CAP DNA Mismatch Repair Biomarker Reporting Guidelines](#).¹¹⁰

In addition, pembrolizumab has been granted accelerated FDA approval as a third- or subsequent-line treatment option for patients with recurrent locally advanced or metastatic gastric adenocarcinoma whose tumors express PD-L1 with a combined positive score (CPS) ≥ 1 as determined by an FDA-approved companion diagnostic test.¹¹¹ This is a qualitative IHC assay using anti-PD-L1 antibodies for the detection of PD-L1 protein levels in FFPE tumor tissue. CPS is defined as the number of PD-L1 staining cells (ie, tumor cells, lymphocytes, macrophages) divided by the total number of viable tumor cells evaluated, multiplied by 100.¹¹¹ PD-L1 testing is recommended for all patients with gastric adenocarcinoma if metastatic disease is documented or suspected.

Emerging Biomarker: Tumor Epstein-Barr Virus

Tumor Epstein-Barr virus (EBV) status is emerging as a potential biomarker for personalized treatment strategies in gastric cancer. An estimated 8% to 10% of gastric cancers are associated with EBV infection, making EBV-positive gastric cancer the largest group of EBV-associated malignancies.^{112,113} EBV-positive tumors occur preferentially in the proximal stomach and are associated with diffuse-type histology. Although the prognostic value of EBV status on the survival of gastric cancer patients remains a subject of debate, several studies suggest that patients with EBV-positive gastric cancer have better OS rates compared to other genotypes.¹¹⁴⁻¹¹⁸ Additional studies have shown that expression of PD-L1 is elevated in EBV-positive gastric cancers and is associated with decreased OS rates.¹¹⁹⁻¹²¹ Furthermore, Derks et al reported that an interferon- γ -driven gene signature was enriched in EBV-positive gastric cancers, suggesting increased sensitivity to PD-1/PD-L1 immunotherapies.¹²⁰ Therefore, PD-1/PD-L1 immunotherapies may be a viable option to treat EBV-positive gastric cancer patients; however, more data are needed to substantiate this claim. Due to the lack of prospective trials and limited understanding of the exact association between EBV and

gastric cancer, testing for EBV status is not currently recommended for routine clinical care.

Surgery

Surgery is the primary treatment option for patients with localized gastric cancer. Complete resection with negative margins is widely considered as a standard goal, whereas the type of resection (subtotal vs. total gastrectomy) and the extent of lymph node dissection remain subjects of controversy.

Principles of Surgery

Clinical staging using chest/abdominal/pelvic CT scan, with or without EUS (if no metastatic disease is seen on CT), should be performed before surgery to assess the extent of the disease and degree of nodal involvement. The primary goal of surgery is to accomplish a complete resection with negative margins (R0 resection); however, only 50% of patients will have an R0 resection of their primary tumor.^{122,123} An R1 resection indicates microscopic residual disease and an R2 resection indicates macroscopic residual disease in the absence of distant metastasis.¹²⁴ Adequate gastric resection to achieve negative microscopic margins (generally ≥ 4 cm from the gross tumor) is preferred for resectable T1b to T3 tumors, while T4 tumors require en-bloc resection of involved structures.¹²⁵ Patients with Tis or T1a tumors may be considered for EMR in experienced centers.

Subtotal gastrectomy is the preferred surgical approach for distal gastric cancers. This procedure has a similar surgical outcome compared to total gastrectomy, although with significantly fewer complications.¹²⁶ Proximal gastrectomy and total gastrectomy are both indicated for proximal gastric cancers and are typically associated with postoperative nutritional impairment. Placement of a jejunostomy feeding tube may be considered

for select patients, especially those who will be receiving postoperative chemoradiation.

Routine or prophylactic splenectomy should be avoided. In a randomized clinical study, postoperative mortality and morbidity rates were significantly higher in patients who underwent total gastrectomy combined with splenectomy compared to those who underwent total gastrectomy alone.¹²⁷ A recently published meta-analysis of randomized controlled trials also concluded that splenectomy should not be recommended for proximal gastric cancer since it increases operative morbidity without improving OS when compared to spleen-preserving procedures.¹²⁸ The results of these studies do not support the use of prophylactic splenectomy or removal of macroscopically negative lymph nodes near the spleen in patients undergoing total gastrectomy for proximal gastric cancer.

In patients with incurable disease, gastric resections should be reserved for the palliation of symptoms (eg, obstruction or uncontrollable bleeding) and should not include lymph node dissection.^{129,130} Gastric bypass with gastrojejunostomy (open or laparoscopic) is preferable to endoluminal stenting in patients with gastric outlet obstruction, if they are fit for surgery and have a reasonable prognosis, due to lower rates of recurrent symptoms.^{131,132} Placement of venting gastrostomy and/or a feeding jejunostomy tube may be also considered.

Gastric adenocarcinomas are considered unresectable if there is evidence of peritoneal involvement (including positive peritoneal cytology), distant metastases, or locally advanced disease (N3 or N4 lymph node involvement or invasion/encasement of major vascular structures, excluding the splenic vessels). Limited gastric resection, even with positive margins, is acceptable for patients with unresectable tumors for the palliation of symptomatic bleeding.

Lymph Node Dissection

Gastric resection should include the removal of regional lymph nodes (lymphadenectomy). Retrospective analyses have shown that the dissection of ≥ 15 lymph nodes positively influences survival in patients with advanced gastric cancer.^{133,134} In a SEER database analysis that included 1377 patients with advanced gastric cancer, patients who had ≥ 15 nodes examined had the best long-term survival outcomes.¹³³ However, the extent of lymph node dissection remains controversial. Lymph node dissection may be classified as D0, D1, or D2 depending on the extent of lymph node removal at the time of gastrectomy. D0 dissection refers to an incomplete resection of lymph nodes along the lesser and greater curvature of the stomach. D1 dissection involves the removal of the greater and lesser omenta (which includes the right and left cardiac lymph nodes along lesser and greater curvature and the suprapyloric lymph nodes along the right gastric artery and infra-pyloric area). D2 involves D1 dissection plus the removal of all the lymph nodes along the left gastric artery, common hepatic artery, celiac artery, splenic hilum, and splenic artery. The technical aspects of performing a D2 lymph node dissection require a significant degree of training and expertise. Therefore, D2 dissections should be performed in centers experienced with this technique.

Gastrectomy with D2 lymph node dissection is the standard treatment for curable gastric cancer in East Asia. In Western countries, extended dissection of distant lymph nodes contributes to accurate staging of the disease; however, its contribution to the prolongation of survival is unclear.^{82,133,135} Initial results from two large randomized trials performed in Western countries failed to demonstrate a significant survival benefit for D2 over D1 lymph node dissection.^{136,137} 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 lymph node dissection.¹³⁶ The postoperative morbidity (25% vs. 43%, $P < .001$) and

mortality (4% vs. 10%, $P = .004$) rates were higher for patients who underwent D2 lymph node dissection, with no difference in OS (30% vs. 35%, $P = .53$) between the two groups. After a median follow-up of 15 years, D2 lymph node dissection was associated with lower local recurrence (12% vs. 22%), regional recurrence (13% vs. 19%), and gastric cancer-related deaths (37% vs. 48%) than D1 lymph node dissection, but OS rates were similar between the two groups (21% and 29%, respectively, $P = .34$).¹³⁸ The British Cooperative trial conducted by the Medical Research Council also failed to demonstrate a survival benefit for D2 over D1 lymph node dissection (5-year OS rates of 35% and 33%, respectively).¹³⁷ Therefore, D2 lymph node dissection is considered a recommended but not required procedure in the West. However, there is uniform consensus that the removal of an adequate number of lymph nodes (≥ 15) is beneficial for staging purposes.

In contrast, other reports from Western countries have suggested that D2 lymph node dissection is associated with lower postoperative complications and a trend toward improved OS when performed in high-volume centers that have sufficient experience with the operation and postoperative management.¹³⁹⁻¹⁴¹ In an analysis involving patients from the Intergroup 0116 trial, Enzinger et al assessed the impact of hospital volume on the outcomes of patients who underwent lymph node dissection (54% underwent D0 lymph node dissection and 46% underwent D1 or D2 lymph node dissection).¹³⁹ High-volume centers did not have any effect on OS or disease-free survival (DFS) for patients who underwent D0 lymph node dissection. However, there was a trend toward improved OS among patients who underwent D1 or D2 lymph node dissection at moderate- to high-volume cancer centers. In a randomized phase II trial of D1 versus D2 lymph node dissection conducted by the Italian Gastric Cancer Study Group involving 267 patients (133 patients allocated to D1 lymph node dissection and 134 patients allocated to D2 lymph node dissection), the 30-day postoperative morbidity and mortality rates were not significantly

different between the two groups.^{140,141} After a median follow-up of 8.8 years, the 5-year OS rates were 66.5% and 64.2% after D1 and D2 lymph node dissections, respectively, although this difference was not significant ($P = .695$).¹⁴¹

Investigators have long argued that D2 lymph node dissection may be beneficial in select patients, if the complication rate is decreased. Although pancreatectomy and splenectomy have been widely performed with D2 lymph node dissections in Japan, both of these procedures have been shown to increase postoperative mortality and morbidity.^{136,137,142,143} In a prospective, randomized, phase II study conducted by the Italian Gastric Cancer Study Group, pancreas-preserving D2 lymph node dissection was associated with a survival benefit and lower complication rate in advanced gastric cancer patients.^{142,143} Pancreatectomy was performed only when T4 tumor involvement was suspected. Postoperative complications were higher after D2 gastrectomy (16.3% vs. 10.5% after D1), but the difference was not significant ($P = .29$). Postoperative mortality rates were 0% and 1.3%, respectively, in the D1 and D2 groups. The overall 5-year morbidity rate was 20.9% and the postoperative in-hospital mortality rate was 3.1% for D2 lymph node dissection without pancreatectomy.¹⁴³ These rates are comparable with the rates for D1 lymph node dissections in the Dutch and United Kingdom trials.^{136,137} Meta-analyses have confirmed that among patients who underwent D2 lymph node dissections, there was a trend toward improved survival and lower gastric cancer-related mortality in patients who did not undergo resection of the spleen or pancreas.¹⁴⁴⁻¹⁴⁶

For patients with localized resectable gastric cancer, the NCCN Guidelines recommend gastrectomy with a D1 or a modified D2 lymph node dissection, with a goal of examining ≥ 15 lymph nodes.^{133,138,142,143} The guidelines emphasize that D2 lymph node dissections should be performed by experienced surgeons in high-volume centers. Routine or prophylactic pancreatectomy is not recommended with D2 lymph node

dissection,^{127,147} and splenectomy is acceptable only when the spleen or hilum is involved.

Laparoscopic Resection

Laparoscopic resection is an emerging surgical approach that offers several potential advantages (less blood loss, reduced postoperative pain, accelerated recovery, early return to normal bowel function, and reduced hospital stay) when compared to open surgical procedures for gastric cancer.¹⁴⁸⁻¹⁵⁰ Therefore, the safety and efficacy of laparoscopic resection versus standard open resection has been evaluated in several recent studies. In a multicenter phase III clinical trial (CLASS-01), 1056 patients with locally advanced gastric cancer were randomized (1:1) to receive laparoscopic or open distal gastrectomy, both with D2 lymph node dissection.¹⁵¹ After 3 years, the DFS rate was 76.5% in the laparoscopic group and 77.8% in the open group (hazard ratio [HR] for recurrence = 1.069). The 3-year OS rates were similar between the two groups (83.1% in the laparoscopic group and 85.2% in the open group; HR = 1.162). Therefore, the long-term oncologic outcomes of laparoscopic distal gastrectomy were non-inferior to those of the conventional open surgery for patients with advanced gastric cancer. In a recently published propensity score-matched analysis of 692 patients who underwent total gastrectomy for gastric cancer, patients who received laparoscopic resection had less blood loss, shorter mean operation time, and a higher number of retrieved lymph nodes compared to patients who received an open procedure.¹⁵² The 3-year cumulative survival rates after a median follow-up of 45 months were similar between the two groups. Results of a recent meta-analysis involving 9337 advanced gastric cancer patients (5000 received laparoscopic gastrectomy and 4337 received open gastrectomy) showed that the laparoscopic procedure resulted in less intraoperative blood loss and faster recovery times.¹⁵³ However, there was no difference in operative time, number of harvested lymph nodes, postoperative mortality, or 5-year OS. Although these results suggest that

laparoscopic resection may be a feasible surgical strategy, the role of this approach in the treatment of gastric cancer requires further investigation.

Endoscopic Therapies

Endoscopy has become an important tool in the diagnosis, staging, treatment, and palliation of patients with gastric cancer. EMR and endoscopic submucosal dissection (ESD) have been used as alternatives to surgery for the treatment of patients with early-stage gastric cancer in Asia. However, the applicability of these techniques in the United States is limited because of the low incidence of early-stage disease.

Principles of Endoscopy

Most endoscopy procedures are performed with the aid of conscious sedation or monitored anesthesia provided by the endoscopist, nurse, nurse anesthetist, or anesthesiologist. Some patients who are at risk for aspiration during endoscopy may require general anesthesia. Endoscopic procedures are best performed in centers with experienced physicians.

Diagnosis

Diagnostic endoscopies are performed to determine the presence and location of gastric neoplasia and to biopsy suspicious lesions. The location of the tumor in the stomach (cardia, fundus, body, antrum, or pylorus) and relative to the EGJ should be carefully recorded to assist with treatment planning. Multiple biopsies (6–8), using standard-size endoscopy forceps, should be performed to provide sufficient material for histologic interpretation.^{154,155} Use of larger forceps may improve this yield.

EMR or ESD of focal nodules (≤ 2 cm) can be safely performed in the setting of early-stage disease to provide greater information on the degree of differentiation, the presence of LVI, and the depth of invasion, with the added potential of being therapeutic.^{156,157} 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.

Staging

EUS provides accurate initial clinical staging of locoregional gastric cancer. EUS performed prior to any treatment provides evidence of the depth of tumor invasion (T), presence of abnormal or enlarged lymph nodes likely to harbor cancer (N), and signs of metastasis, such as lesions in surrounding organs (M).^{158,159} Accurate clinical staging is especially important in patients who are being considered for endoscopic resection (ER).¹⁶⁰

Hypoechoic (dark) expansion of the gastric wall layers identifies the location of the tumor, with gradual loss of the layered pattern of the normal stomach wall corresponding with greater depths of tumor infiltration and thus higher T-categories. Perigastric lymph nodes are readily seen by EUS, and the identification of enlarged, hypoechoic, homogeneous, well-circumscribed, rounded structures around the stomach indicates the presence of malignant or inflammatory lymph nodes. The accuracy of this diagnosis is significantly increased with the combination of features, but can also be confirmed with the use of fine-needle aspiration (FNA) biopsy for cytology assessment.¹⁶¹ FNA of suspicious lymph nodes should be performed, without traversing an area of primary tumor or major blood vessels, if it will impact treatment decisions. FNA should also be considered to rule out peritoneal spread of disease.

Treatment

EMR represents a major advance in minimally invasive approaches for the management of patients with early-stage gastric cancer.¹⁶² Most of the experience with EMR for early-stage disease has been gained by countries with a high incidence of gastric cancer and an active screening program.¹⁶³⁻¹⁶⁷ In a study of 124 patients with early-stage mucosal gastric

cancers, Uedo et al reported 5- and 10-year survival rates of 84% and 64%, respectively, for patients receiving EMR.¹⁶⁴ In another retrospective study of 215 patients with intramucosal gastric cancer, EMR resulted in significantly shorter hospital stays, but was comparable to surgery in terms of risk of death and recurrence.¹⁶⁷ The proper selection of patients is essential to improve the clinical outcomes of EMR; endoscopic gross type (depressed lesion), the degree of differentiation, and the depth of invasion were identified as independent predictors of higher complete resection rates.¹⁶⁵

ESD has also been reported to be a safe and effective procedure for patients with early-stage gastric cancer when performed by experienced endoscopists.¹⁶⁸⁻¹⁷⁵ En-bloc excision of small gastric lesions by ESD has been shown to be more effective than EMR in several studies.¹⁷⁶⁻¹⁸³ In a multicenter retrospective study of ER in patients with early-stage gastric cancer, the 3-year recurrence-free rate in the ESD group was significantly higher than that in the EMR group (98% vs. 93%, respectively).¹⁷⁶ The complete resection rates for ESD were significantly better for lesions >5 cm in diameter, whereas the rates were not different between EMR and ESD for lesions <5 cm in diameter regardless of location.¹⁷⁷⁻¹⁷⁹ ESD requires a higher level of skill to perform and is also associated with higher rates of bleeding and perforation complications.¹⁸¹⁻¹⁸⁴ As these technologies continue to evolve as promising options for the diagnosis and treatment of early-stage gastric cancers, the NCCN Panel recommends that ER (EMR or ESD) be performed in high-volume medical centers with extensive experience in these techniques.

Early-stage gastric cancer that is ≤ 2 cm in diameter, well to moderately differentiated, does not invade the deep submucosa, does not exhibit LVI or lymph node metastases, and has clear lateral and deep margins can be effectively treated with EMR or ESD.^{157,183,185} EMR or ESD of poorly differentiated gastric cancers with evidence of LVI, lymph node metastases, invasion into the deep submucosa, and positive lateral or

deep margins should be considered incomplete and additional therapy (gastrectomy with lymph node dissection) should be considered.¹⁸⁶

Endoscopic therapies also play a role in palliative care. Endoscopic tumor ablation can be performed for the short-term control of gastric cancer-associated bleeding. Endoscopic insertion of self-expanding metal stents (SEMS) is effective for the long-term relief of tumor obstruction at the EGJ or gastric outlet, though surgical gastrojejunostomy may be more efficacious for those with longer-term predicted survival.^{187,188} Long-term palliation of anorexia, dysphagia, or malnutrition may be achieved with endoscopic- or radiographic-assisted placement of a feeding gastrostomy tube in carefully selected cases where the distal stomach is uninvolved by tumor, or the placement of a feeding jejunostomy tube.¹⁸⁹

Surveillance

Endoscopic surveillance following definitive treatment of gastric cancer requires careful attention to detail for mucosal surface changes. Multiple (4–6) biopsies of any visualized abnormalities should be performed. Additionally, strictures should also be biopsied to rule out neoplastic cause. EUS performed in conjunction with endoscopy exams has a high sensitivity for detecting recurrent disease.¹⁹⁰ EUS-guided FNA should be performed if suspicious lymph nodes or areas of wall thickening are observed. It should be noted that EUS performed after chemotherapy or radiation therapy (RT) has a reduced ability to accurately determine the post-treatment stage of disease.¹⁹¹ Similarly, biopsies performed after chemotherapy or RT may not accurately diagnose the presence of residual disease.¹⁹²

Radiation Therapy

RT has been assessed in randomized trials in both the preoperative and postoperative settings in patients with resectable gastric cancer. Smalley et al have reviewed clinical and anatomic issues related to RT and offer

detailed recommendations for the application of RT to the management of patients with gastric cancer.¹⁹³

RT as a single modality has minimal value in patients with unresectable gastric cancer.¹⁹⁴ However, early studies showed that RT improved survival when used concurrently with chemotherapy. Moertel et al assessed fluorouracil plus RT compared with RT alone in the treatment of locally advanced unresectable gastric cancer.¹⁹⁵ Patients receiving combined modality treatment had significantly better median survival (13 months vs. 6 months) and 5-year OS (12% vs. 0%) rates compared to those receiving RT alone. In another study by the Gastrointestinal Tumor Study Group, 90 patients with locally advanced gastric cancer were randomized to receive either combination chemotherapy with fluorouracil and lomustine or split-course RT with concurrent bolus fluorouracil followed by maintenance with fluorouracil and lomustine.¹⁹⁶ At 3 years, the survival curve reached a plateau in the combined modality arm while tumor-related deaths continued to occur in the chemotherapy-alone arm, suggesting that a small fraction of patients can be cured with combined modality therapy.

Randomized clinical trials have also been conducted to compare surgery alone to surgery plus RT in patients with resectable gastric cancer. In a trial conducted by the British Stomach Cancer Group, 432 patients were randomized to undergo surgery alone or surgery followed by either RT or chemotherapy.¹⁹⁷ At the 5-year follow-up, no survival benefit was seen for patients receiving postoperative RT or chemotherapy compared with those who underwent surgery alone. However, 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 another trial, which randomized 370 patients to preoperative RT or surgery alone, there was a significant improvement in survival with preoperative RT (30% vs. 20%, $P = .0094$).¹⁹⁸ Resection rates were also higher with preoperative RT (89.5%) compared to surgery

alone (79%), suggesting that preoperative RT improves local control. The results from a systematic review and meta-analysis also showed a significant 5-year survival benefit with the addition of RT to surgery in patients with resectable gastric cancer.¹⁹⁹

Intensity-modulated RT (IMRT) has the potential to reduce radiation-related toxicity by delivering large doses of RT to target tissues while sparing adjacent organs. Several retrospective studies have demonstrated the feasibility of IMRT in the treatment of localized and advanced gastric cancer.²⁰⁰⁻²⁰⁴ Therefore, IMRT may be used in clinical settings where reduction in RT dose to organs at risk (eg, heart, lungs, liver, kidneys, small bowel) is required and cannot be achieved by 3-D techniques.

Principles of Radiation Therapy

General Guidelines

RT treatment recommendations should be made after joint consultation and/or discussion by a multidisciplinary team, which should include medical oncologists, radiation oncologists, surgical oncologists, radiologists, gastroenterologists, and pathologists. Imaging studies and endoscopy reports should be reviewed by this multidisciplinary team to ensure an informed determination of treatment volume and field borders prior to simulation. All available information from pretreatment diagnostic studies should be used to determine the target volume. Image guidance may be used appropriately to enhance clinical targeting. In general, Siewert Type I and II tumors should be managed with RT guidelines applicable to esophageal and EGJ cancers (see the [NCCN Guidelines for Esophageal and EGJ Cancers](#)). Depending on the clinical situation, Siewert Type III tumors may be appropriately managed with RT guidelines applicable to either esophageal and EGJ cancers or gastric cancer. These recommendations may be modified depending on the location of the bulk of the tumor.

A dose range of 45 to 50.4 Gy delivered in fractions of 1.8 Gy per day is recommended by the panel. Higher doses may be used as a boost for positive surgical margins in select patients.

Simulation and Treatment Planning

CT simulation and conformal treatment planning should be used. IV and/or oral contrast may be used for CT simulation to aid in target localization when clinically appropriate. It is optimal to treat patients in the supine position as this setup is generally more stable and reproducible. The use of an immobilization device is strongly recommended for reproducibility. Motion management techniques, such as 4D-CT planning, may be appropriately utilized in select circumstances where organ motion with respiration may be significant.

IMRT may be used in clinical settings where dose reduction to organs at risk is required and cannot be achieved by 3D techniques.²⁰⁰⁻²⁰⁴ Target volumes need to be carefully defined and encompassed when designing IMRT plans. Uncertainties from variations in stomach filling and respiratory motion should be taken into account. In designing IMRT for organs at risk, attention should be given to the volume receiving low to moderate doses, as well as the volume receiving high doses.

Target Volume

In the preoperative setting, pretreatment diagnostic studies such as EUS, EGD, FDG-PET, and CT scans should be used to identify the primary tumor and pertinent nodal groups.^{193,205} In the postoperative setting, clip placement should be performed in addition to pretreatment diagnostic studies to identify the tumor/gastric bed, the anastomosis or stumps, and pertinent nodal groups.^{193,206} Treatment of the remaining stomach should depend on a balance of the normal tissue morbidity and the risk of local recurrence in the residual stomach.

The relative risk of nodal metastases at a specific location is dependent on the site of the primary tumor and other factors including the depth of invasion into the gastric wall. Nodal areas at risk include the perigastric, celiac, left gastric artery, splenic artery, splenic hilar, hepatic artery, porta hepatic, suprapyloric, subpyloric, and pancreaticoduodenal lymph nodes. Coverage of nodal areas may be modified based on clinical circumstances and the risks of toxicity. See *Principles of Radiation Therapy- Target Volume* in the algorithm for more information.

Normal Tissue Tolerance and Dose Limits

Treatment planning is essential to reduce unnecessary RT doses to organs at risk (liver, kidneys, small bowel, spinal cord, heart, and lungs) and to limit the volume of organs at risk receiving high RT doses. Particular effort should be made to keep RT doses to the left ventricle of the heart to a minimum. Additionally, use of lung dose-volume histogram (DVH) parameters as predictors of pulmonary complications in patients treated with concurrent chemoradiation should be strongly considered, though consensus on optimal criteria has not yet emerged. Optimal criteria for DVH parameters are actively being developed at NCCN Member Institutions. Although every effort should be made to minimize RT doses to organs at risk, it is recognized that these dose guidelines may be appropriately exceeded based on clinical circumstances.

Supportive Care

Careful monitoring and management of acute toxicities with aggressive supportive care is essential to avoid treatment interruptions or dose reductions. During an RT treatment course, patients' vital signs, weight, and blood counts should be measured at least once per week. Prophylactic antiemetics should be given when appropriate. Additionally, antacid and antidiarrheal medications may be prescribed when needed. If the estimated caloric intake is inadequate (<1500 kcal/d), oral and/or

enteral nutrition should be considered. Feeding jejunostomies or nasogastric feeding tubes may be placed to ensure adequate caloric intake. Adequate enteral and/or IV hydration may also be necessary throughout chemoradiation and early recovery.

Combined Modality Therapy

Combined modality therapy has been shown to significantly increase survival in gastric cancer patients with locoregional disease.²⁰⁷⁻²⁰⁹ Perioperative chemotherapy is the preferred approach for localized resectable disease.^{208,210-213} Postoperative chemoradiation is preferred for patients who received less than a D2 lymph node dissection.^{206,214,215} Other treatment options include preoperative chemoradiation^{205,216,217} or postoperative chemotherapy for patients who have undergone primary D2 lymph node dissection.²¹⁸⁻²²⁰ Chemoradiation alone should be reserved for patients with unresectable disease or those who decline surgery.

Perioperative Chemotherapy

The survival benefit of perioperative chemotherapy in gastric cancer was first demonstrated in the landmark phase III MAGIC trial.²¹³ This study, which compared perioperative chemotherapy with epirubicin, cisplatin, and fluorouracil (ECF) to surgery alone, established that perioperative chemotherapy improves progression-free survival (PFS) and OS in patients with non-metastatic stage II and higher gastric or EGJ adenocarcinoma. In the randomized controlled phase II/III FLOT4 trial, Al-Batran et al compared perioperative chemotherapy with fluorouracil, leucovorin, oxaliplatin, and docetaxel (FLOT) to the standard ECF regimen in patients with resectable non-metastatic gastric or EGJ adenocarcinoma (\geq T2 and/or N+).^{210,221} In the phase II part of the study, 265 patients were randomized to receive either 3 preoperative and postoperative cycles of ECF (n = 137) or 4 preoperative and postoperative cycles of FLOT (n =

128). Results showed that FLOT was associated with significantly higher proportions of patients achieving pCR than was ECF (16%; 95% CI, 10–23 vs. 6%; 95% CI, 3–11; $P = .02$).²²¹ Additionally, FLOT was associated with a reduction in the percentage of patients experiencing at least one grade 3–4 adverse event, including neutropenia, leucopenia, nausea, infection, fatigue, and vomiting (40% of patients in the ECF group vs. 25% of patients in the FLOT group). In the phase III part of the trial, 716 patients were randomized to receive FLOT ($n = 356$) or ECF ($n = 360$).²¹⁰ Results showed that median OS was increased in the FLOT group compared with the ECF group (50 months vs. 35 months; HR = 0.77; 95% CI, 0.63 to 0.94). The percentage of patients with serious chemotherapy-related adverse events was the same in the two groups (27% in the ECF group vs. 27% in the FLOT group). Therefore, ECF should no longer be recommended in this setting. However, because of considerable toxicity associated with the FLOT regimen, the panel recommends its use in select patients with good performance status. The preferred perioperative regimen for most patients who have good to moderate performance status is FOLFOX (fluorouracil and oxaliplatin).

In the FNCLCC ACCORD 07 trial ($n = 224$ patients; 25% had gastric adenocarcinoma), Ychou et al reported that perioperative chemotherapy with fluorouracil and cisplatin significantly increased the curative resection rate, DFS, and OS in patients with resectable cancer.²¹¹ At a median follow-up of 5.7 years, the 5-year OS rate was 38% for patients in the perioperative chemotherapy group and 24% for patients in the surgery alone group ($P = .02$). The corresponding 5-year DFS rates were 34% and 19%, respectively. Although this trial was prematurely terminated due to low accrual, the panel feels that perioperative fluorouracil and cisplatin is a viable treatment option for patients with locally advanced resectable gastric cancer.

The phase III randomized CRITICS trial, which compared perioperative chemotherapy with preoperative chemotherapy followed by postoperative

chemoradiation in 788 patients with resectable gastric adenocarcinoma, found that postoperative chemoradiation did not improve OS compared with postoperative chemotherapy.²¹² Patients were randomized to receive either 3 preoperative and 3 postoperative cycles of modified ECF regimens (chemotherapy group; $n = 393$) or capecitabine and cisplatin with concurrent RT (chemoradiation group; $n = 395$). At a median follow-up of 61.4 months, median OS was 43 months (95% CI, 31–57) in the chemotherapy group and 37 months (95% CI, 30–48) in the chemoradiation group (HR = 1.01; 95% CI, 0.84–1.22; $P = .90$). Therefore, adding RT to postoperative chemotherapy confers no survival benefit following adequate preoperative chemotherapy and surgery. Since there was poor postoperative patient compliance in both treatment groups, optimization of preoperative treatment strategies is integral. An ongoing phase II trial (CRITICS II), which will compare three preoperative strategies (chemotherapy, concurrent chemoradiation, and sequential chemotherapy and chemoradiation), is actively recruiting participants with resectable gastric cancer (Clinical Trial ID: [NCT02931890](https://clinicaltrials.gov/ct2/show/study/NCT02931890)).²²²

Preoperative Chemoradiation Therapy

Several small, single-arm studies have demonstrated the ability of preoperative chemoradiation to produce a pathologic response in resectable gastric cancer.^{223–226} However, the value of preoperative chemoradiation in treating resectable gastric cancer remains uncertain since phase III randomized controlled trials demonstrating a survival benefit in gastric cancer are lacking. Therefore, the regimens listed in the NCCN Guidelines for preoperative chemoradiation are largely derived from phase II/III trials involving patients with cancers of the esophagus and/or EGJ.^{205,216,227–230}

A small trial of 38 patients with stage II–IV esophageal carcinoma showed that FOLFOX combined with RT is safe and well-tolerated in the preoperative setting, with 38% of patients achieving pCR.²²⁹ The CALGB



9781 prospective trial that randomized patients (n = 56) with stage I–III esophageal cancers to receive preoperative chemoradiation or surgery alone found a survival benefit for preoperative chemoradiation with fluorouracil and cisplatin.²²⁸ After a median follow-up of 6 years, median OS was 4.5 years versus 1.8 years in favor of preoperative chemoradiation. Patients receiving preoperative chemoradiation also had a significantly better 5-year OS rate (39% vs. 16%). In a randomized phase III trial (PRODIGE5/ACCORD17), 267 patients with unresectable esophageal cancer or those medically unfit for surgery were randomized to receive chemoradiation with either FOLFOX or fluorouracil and cisplatin.²²⁷ The median PFS was 9.7 months in the FOLFOX group compared to 9.4 months in the fluorouracil and cisplatin group ($P = .64$). Although FOLFOX was not associated with a PFS benefit compared to fluorouracil and cisplatin, the investigators suggest that FOLFOX might be a more convenient option for patients who may not be candidates for surgery. Therefore, FOLFOX and fluorouracil plus cisplatin are both category 1 preferred recommendations for preoperative chemoradiation, although FOLFOX is associated with less treatment-related adverse events.

Results from the multicenter phase III randomized CROSS trial showed that preoperative chemoradiation with paclitaxel and carboplatin significantly improved OS and DFS compared to surgery alone in patients with resectable (T2-3,N0-1,M0) esophageal or EGJ cancers (n = 368).²¹⁶ Median survival time was 49 months in the preoperative chemoradiation arm compared to 24 months in the surgery alone arm. The R0 resection rate was also higher in the preoperative chemoradiation arm compared to the surgery alone arm (92% vs. 69%, respectively). The 1-, 2-, 3-, and 5-year survival rates were 82%, 67%, 58%, and 47%, respectively, in the preoperative chemoradiation arm compared to 70%, 50%, 44%, and 34%, respectively, in the surgery alone arm. A study reporting the long-term results of the CROSS trial verified that median OS was significantly

improved in the preoperative chemoradiation group after a median follow-up time of 84.1 months.²¹⁷ Since patients with gastric cancer were excluded from this trial, paclitaxel and carboplatin is a category 2B recommendation in this setting.

Preoperative Sequential Chemotherapy and Chemoradiation Therapy

Several studies have shown that preoperative sequential chemotherapy followed by chemoradiation and surgery yields a pathologic response in patients with resectable gastric cancer.^{205,224-226,231} In the phase II RTOG 9904 trial, preoperative chemotherapy with fluorouracil and cisplatin followed by concurrent chemoradiation with infusional fluorouracil and paclitaxel resulted in a pCR rate of 26% in patients with localized gastric adenocarcinoma. D2 lymph node dissections and R0 resections were achieved in 50% and 77% of patients, respectively.²⁰⁵ In another 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.²²⁶ R0 resection was achieved in 65% of patients and the median OS and actuarial 2-year survival rates were 14.5 months and 35%, respectively.²²⁶ Therefore, induction chemotherapy prior to preoperative chemoradiation therapy is feasible and may be appropriate for select patients. However, this approach needs to further evaluated in phase III randomized clinical trials.

Postoperative Chemoradiation Therapy

The landmark Intergroup-0116 (INT-0116) trial investigated the effectiveness of surgery followed by postoperative chemotherapy plus chemoradiation on the survival of patients with resectable gastric or EGJ adenocarcinoma.^{206,214} In this trial, 556 patients (stage IB to IV, M0) were randomized to receive surgery followed by postoperative chemotherapy

plus chemoradiation (n = 281; bolus fluorouracil and leucovorin before and after concurrent chemoradiation with the same regimen) or surgery alone (n = 275).²⁰⁶ The majority of patients had T3 or T4 tumors (69%) and node-positive disease (85%). After a median follow-up of 5 years, median OS in the surgery-only group was 27 months compared to 36 months in the postoperative chemotherapy plus chemoradiation group ($P = .005$). The postoperative chemotherapy plus chemoradiation group also had better 3-year OS (50% vs. 41%) and recurrence-free survival (RFS) rates (48% vs. 31%) than the surgery-only group. There was also a significant decrease in local failure as the first site of failure in the chemoradiation group (19% vs. 29%). After a median follow-up of >10 years, survival remained improved in patients treated with postoperative chemoradiation.²¹⁴

The results of the INT-0116 trial established the efficacy of postoperative chemoradiation in patients with completely resected gastric or EGJ adenocarcinoma who have not received preoperative therapy. However, the dosing schedule of chemotherapy agents used in this trial was associated with high rates of grade 3–4 hematologic and GI toxicities (54% and 33%, respectively). Among the 281 patients assigned to the chemoradiation group, 17% discontinued treatment and 3 patients died as a result of chemoradiation-related toxicities, including pulmonary fibrosis, cardiac event, and myelosuppression. Therefore, the doses and schedule of chemotherapy agents used in the INT-0116 trial are no longer recommended due to concerns regarding toxicity. See *Principles of Systemic Therapy—Regimens and Dosing Schedules* in the algorithm for recommended modifications to this regimen.

The degree of lymph node dissection during gastrectomy may influence the efficacy of postoperative chemoradiation. A retrospective analysis that compared the outcomes of patients treated with surgery alone to patients treated with postoperative fluoropyrimidine-based chemoradiation reported that 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; $P = .001$). However, there was no significant difference in recurrence rates between the two groups following D2 lymph node dissection.²¹⁵ The results of the phase III ARTIST trial also showed that postoperative chemoradiation did not significantly reduce recurrence after D2 lymph node dissection in patients with curatively resected gastric cancer compared to postoperative chemotherapy^{219,232} Therefore, postoperative chemoradiation is recommended for patients who received less than a D2 lymph node dissection while patients who received a D2 lymph node dissection should be treated with postoperative chemotherapy. Interestingly, in a subgroup analysis of patients with positive lymph nodes, postoperative chemoradiation was associated with a significant prolongation of 3-year DFS compared to postoperative chemotherapy (77.5% vs. 72%; $P = .0365$).²³² Since these results suggest a significant DFS benefit for postoperative chemoradiation in subsets of patients, the ARTIST II trial evaluating postoperative chemotherapy and chemoradiation in patients with node-positive, D2-resected gastric cancer is currently recruiting patients (Clinical Trial ID: [NCT01761461](https://clinicaltrials.gov/ct2/show/study/NCT01761461)).

Postoperative Chemotherapy

The phase III CLASSIC trial (conducted in South Korea, China, and Taiwan) evaluated postoperative chemotherapy with capecitabine and oxaliplatin after curative gastrectomy with D2 lymph node dissection in 1035 patients with stage II or IIIB gastric cancer.^{218,220} In this study, patients were randomized to receive either surgery alone (n = 515) or surgery followed by postoperative chemotherapy (n = 520). After a median follow-up of 34.2 months, postoperative chemotherapy with capecitabine and oxaliplatin significantly improved 3-year DFS (74%) compared to surgery alone (59%) for all disease stages ($P < .0001$).²²⁰ After a median follow-up of 62.4 months, the estimated 5-year DFS rate was 68% for the

postoperative chemotherapy group compared to 53% for the surgery alone group; the corresponding estimated 5-year OS rates were 78% and 69%, respectively.²¹⁸ These results support the use of postoperative chemotherapy after D2 lymph node dissection in patients with advanced 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. Thus, postoperative chemoradiation remains the treatment of choice for this patient population.^{206,214,215}

Chemoradiation for Unresectable Disease

Chemoradiation alone may be offered to medically fit patients with unresectable disease. Since there are limited data in gastric cancer, the panel recommends extrapolation of fluorouracil-based chemoradiation regimens with proven efficacy in esophageal carcinoma (See *Preoperative Chemoradiation Therapy* above). Recommended regimens in this setting include FOLFOX, fluorouracil and cisplatin, and fluoropyrimidine (fluorouracil or capecitabine) and paclitaxel (category 2B). Chemoradiation with either FOLFOX or fluorouracil and cisplatin were shown to be effective in a randomized phase III trial of patients with unresectable esophageal cancer.²²⁷ A trial of patients with stage II–IV esophageal carcinoma confirmed the safety and efficacy of FOLFOX combined with RT with or without surgery.²²⁹ In the FFCD 9102 trial, survival was similar for patients with esophageal cancer receiving fluorouracil and cisplatin-based chemoradiation with or without surgery.²³⁰ Additionally, patients may receive a fluoropyrimidine combined with paclitaxel, which has proven efficacy in yielding a pathologic response in resectable gastric cancer.²⁰⁵ Following primary treatment, patients should be re-staged to determine whether surgery is an option. Surgery is preferred for patients with resectable disease after chemoradiation while those found to still have unresectable disease should receive palliative management.

Systemic Therapy for Locally Advanced or Metastatic Disease

First-Line Therapy

Systemic therapy can provide palliation of symptoms, improved survival, and enhanced quality of life in patients with locally advanced or metastatic gastric cancer.²³³⁻²³⁶ First-line systemic therapy regimens with two cytotoxic drugs are preferred for patients with advanced disease because of their lower toxicity. Three-drug cytotoxic regimens should be reserved for medically fit patients with good performance status and access to frequent toxicity evaluation. Based on the results of the ToGA trial, the guidelines recommend the addition of trastuzumab to first-line chemotherapy (category 1 for combination with cisplatin and fluoropyrimidine; category 2B for combination with other chemotherapy agents) for patients with HER2-positive metastatic gastric adenocarcinoma.¹⁰³ The use of trastuzumab in combination with anthracyclines is not recommended. See *Targeted Therapies* below for more information on trastuzumab.

The preferred regimens for first-line systemic therapy include a fluoropyrimidine (fluorouracil or capecitabine) combined with either oxaliplatin²³⁷⁻²³⁹ or cisplatin.^{237,240-242} A phase III trial conducted by the German Study Group compared treatment with fluorouracil and cisplatin to FOLFOX in patients (n = 220) with previously untreated advanced adenocarcinoma of the stomach or EGJ.²³⁷ Results showed that FOLFOX (referred to as FLO) was associated with significantly less toxicity and showed a trend towards improved median PFS (5.8 vs. 3.9 months; $P = .77$) compared to fluorouracil and cisplatin (FLP).²³⁷ However, there was no significant difference in median OS (10.7 vs. 8.8 months, respectively) between the two groups. Interestingly, FOLFOX resulted in significantly superior response rates (41.3% vs. 16.7%; $P = .12$), time to treatment failure (5.4 vs. 2.3 months; $P < .001$), PFS (6.0 vs. 3.1 months; $P = .029$),



and improved OS (13.9 vs. 7.2 months) compared with FLP in patients >65 years (n = 94). Therefore, FOLFOX offers reduced toxicity and similar efficacy compared to fluorouracil plus cisplatin and may also be associated with improved efficacy in older adult patients. The safety and efficacy of FOLFOX has also been demonstrated in other studies.^{238,243,244}

Regimens combining a platinum agent with capecitabine have also been evaluated in several studies for patients with advanced gastric cancer.^{242,245,246} A phase III randomized trial (ML 17032) that evaluated the efficacy of combined capecitabine and cisplatin (XP) compared to fluorouracil and cisplatin (FP) found that XP was noninferior to FP as first-line therapy in patients with advanced gastric cancer.²⁴² Additionally, two phase II trials concluded that capecitabine in combination with oxaliplatin is active and well-tolerated as first-line therapy for advanced gastric cancer.^{245,246} Furthermore, results of a meta-analysis suggest that OS was superior in advanced gastroesophageal cancer patients treated with capecitabine-based combinations compared to patients treated with fluorouracil-based combinations, although no significant difference in PFS between treatment groups was seen.²⁴⁷ These results suggest that capecitabine can be considered an effective alternative to fluorouracil in first-line treatment of patients with advanced gastroesophageal cancers.

DCF has also demonstrated activity in patients with locally advanced or metastatic gastric cancer.^{248,249} An international phase III study (V325) that randomized 445 patients with untreated advanced gastric or EGJ cancer to receive either DCF or cisplatin and fluorouracil (CF) found that the addition of docetaxel to CF significantly improved time to progression, OS, and overall response rate (ORR).²⁴⁸ However, DCF was associated with increased toxicities including myelosuppression and infectious complications. Various modifications of the DCF regimen have demonstrated improved safety in clinical trials of patients with advanced gastric cancer compared to the DCF regimen evaluated in the V325 study.²⁵⁰⁻²⁵⁵ In a randomized phase II study, a dose-modified DCF regimen

was less toxic than standard DCF and was also associated with improved efficacy in previously untreated patients with metastatic gastric or EGJ adenocarcinoma.²⁵⁵ Dose-modified DCF was also associated with improved median OS (18.8 months vs. 12.6 months; $P = .007$). In another randomized phase II trial that evaluated docetaxel plus oxaliplatin with or without infusional fluorouracil or capecitabine in patients with metastatic or locally recurrent gastric or EGJ adenocarcinoma, docetaxel, oxaliplatin, and fluorouracil had a better safety profile and were associated with higher response rates and longer median PFS and OS (47%, 7.7 months and 14.6 months, respectively) compared to docetaxel and oxaliplatin (23%, 4.5 months and 9 months, respectively) or docetaxel, oxaliplatin, and capecitabine (26%, 5.6 months and 11.3 months, respectively).²⁵⁴ Additionally, the frequency of grade 3–4 toxicities was lower among patients treated with docetaxel, oxaliplatin, and fluorouracil (25%) compared to those treated with docetaxel and oxaliplatin (37%) or docetaxel, oxaliplatin, and capecitabine (38%). Therefore, due to concerns regarding toxicity, dose-modified DCF or other DCF modifications should be used as alternative options to the standard DCF regimen for first-line therapy.^{251,254,255}

First-line treatment with irinotecan-based regimens has been explored extensively in clinical trials involving patients with advanced or metastatic gastroesophageal cancers.^{241,256-267} The results of a randomized phase III study comparing irinotecan and fluorouracil (FOLFIRI) to cisplatin and fluorouracil in patients with advanced gastric or EGJ adenocarcinoma (n = 337) showed that FOLFIRI was non-inferior to CF in terms of PFS (PFS at 6 and 9 months were 38% and 20%, respectively, for FOLFIRI compared to 31% and 12%, respectively, for CF) but not in terms of OS (9 months vs. 8.7 months) or time to progression (5 months vs. 4.2 months).²⁶² FOLFIRI was also associated with a more favorable toxicity profile. A more recent phase III trial (French Intergroup Study) compared FOLFIRI with ECF as first-line treatment in patients (n = 416) with advanced or

metastatic gastric or EGJ adenocarcinoma.²⁶⁷ After a median follow-up of 31 months, median time to treatment failure was significantly longer with FOLFIRI than with ECF (5.1 months vs. 4.2 months; $P = .008$).²⁶⁷ However, there were no significant differences in median PFS (5.3 months vs. 5.8 months; $P = .96$), median OS (9.5 months vs. 9.7 months; $P = .95$), or response rate (39.2% vs. 37.8%). Importantly, FOLFIRI was less toxic and better tolerated than ECF. Therefore, the NCCN Panel feels that FOLFIRI is an acceptable option for first-line therapy in patients with advanced or metastatic gastric cancer. Other recommended regimens for first-line therapy include paclitaxel with either cisplatin or carboplatin,²⁶⁸⁻²⁷⁰ docetaxel with cisplatin,^{271,272} or single-agent fluoropyrimidine (fluorouracil or capecitabine),^{241,273,274} docetaxel,^{234,275} or paclitaxel.^{276,277} Combined docetaxel, carboplatin, and fluorouracil²⁵¹ as well as ECF²⁷⁸ and ECF modifications^{279,280} are category 2B recommendations in this setting.

Second-Line and Subsequent Therapy

The selection of regimens for second-line or subsequent therapy is dependent upon prior therapy and performance status. Based on the available data and FDA approvals, the guidelines have included the targeted therapy ramucirumab as a single agent (category 1) or in combination with paclitaxel (category 1; preferred) as treatment options for second-line or subsequent therapy.^{281,282} Additionally, pembrolizumab has been included as a second-line or subsequent therapy option for MSI-H/dMMR tumors (preferred)^{108,283} and as a third-line or subsequent therapy option for gastric adenocarcinoma with PD-L1 expression levels by CPS of ≥ 1 .²⁸⁴ See *Targeted Therapies* below for more information on ramucirumab and pembrolizumab.

Category 1 preferred options for second-line or subsequent therapy include single-agent docetaxel,^{234,275} paclitaxel,^{276,277,285} and irinotecan.^{235,285-287} In a randomized phase III trial (COUGAR-02) single-agent docetaxel was shown to significantly increase 12-month OS

compared to active symptom control alone (5.2 months vs. 3.6 months, respectively; HR = 0.67; $P = .01$).²³⁴ Additionally, patients receiving docetaxel reported less pain, nausea, vomiting, dysphagia, and constipation. A randomized phase III trial comparing second-line therapy with paclitaxel to irinotecan in patients with advanced gastric cancer found similar OS between the two groups (9.5 months in the paclitaxel group vs. 8.4 months in the irinotecan group; HR = 1.13; $P = .38$).²⁸⁵ Therefore, single-agent docetaxel, paclitaxel, and irinotecan are all recommended as preferred second-line treatment options for advanced gastric cancer.

Second-line therapy with FOLFIRI has also been shown to be active and well-tolerated in patients with metastatic gastric cancer.^{258,287-290} A phase II trial investigating the efficacy and toxicity of FOLFIRI in patients ($n = 40$) with recurrent or metastatic gastric cancer reported an ORR of 29% and median OS of 6.4 months.²⁹⁰ Another phase II trial reported similar results with an ORR of 20% and OS of 6.7 months in advanced gastric cancer patients ($n = 59$) treated with FOLFIRI in the second-line setting.²⁸⁷ Additionally, FOLFIRI was shown to be an effective and safe treatment option in a cohort of patients with metastatic gastric or EGJ cancers refractory to docetaxel-based chemotherapy.²⁸⁸ In this study, the ORR was 22.8% and median PFS and OS were 3.8 and 6.2 months, respectively. The most common grade 3–4 toxicities were neutropenia (28.5%) and diarrhea (14.5%). Therefore, FOLFIRI is considered as a preferred treatment option that can be safely used in the second-line setting if it was not previously used in first-line therapy. Other recommended combined regimens for second-line therapy include irinotecan and cisplatin^{238,291} and irinotecan and docetaxel (category 2B).²⁹²

A recently published phase III trial (TAGS) has demonstrated activity for the combined regimen of trifluridine and tipiracil in metastatic gastric and EGJ adenocarcinoma in the third-line setting.²⁹³ The trifluridine and tipiracil regimen, which was approved by the FDA in 2019 for previously treated recurrent or metastatic gastric and EGJ adenocarcinoma,²⁹⁴ was initially

investigated in a phase II trial in Japan that reported a median OS of 8.7 months and a disease control rate of 65.5%.²⁹⁵ In the global phase III TAGS trial, 507 patients with heavily pretreated metastatic gastric or EGJ cancer were randomized 2:1 to receive trifluridine and tipiracil plus best supportive care (n = 337) or placebo plus best supportive care (n = 170).²⁹³ This study reported a significant improvement in median OS by 2.1 months (5.7 vs. 3.6 months) with the trifluridine and tipiracil regimen compared to placebo (HR = 0.69; 95% CI, 0.56–0.85; *P* = .0003). PFS was statistically significantly longer in the trifluridine and tipiracil group (2.0 vs. 1.7 months; HR = 0.57; 95% CI, 0.47–0.70; *P* < .0001). The most frequently reported grade 3–4 toxicities associated with the trifluridine and tipiracil regimen were neutropenia (38%), leukopenia (21%), anemia (19%), and lymphocytopenia (19%), which was consistent with other studies involving these agents. Trifluridine and tipiracil is recommended as a preferred category 1 treatment option for patients with recurrent or metastatic gastric cancer in the third-line or subsequent setting following prior fluoropyrimidine-, platinum-, taxane-, or irinotecan-based chemotherapy and anti-HER2 therapy (if HER2-positive). However, trifluridine and tipiracil did not result in any partial or complete responses and produced substantial grade 3–4 toxicities. Therefore, this treatment should be considered for a very select population of patients with low-volume gastric cancer who have minimal or no symptoms and the ability to swallow pills. Other recommended regimens for third-line or subsequent therapy include regimens recommended for second-line therapy that were not previously used and pembrolizumab for PD-L1–positive adenocarcinoma.

Targeted Therapies

At present, three targeted therapeutic agents, trastuzumab, ramucirumab, and pembrolizumab, have been approved by the FDA for use in gastric cancer.^{107,111,296-298} Treatment with trastuzumab is based on testing for

HER2 status.¹⁰³ Treatment with pembrolizumab is based on testing for microsatellite instability and PD-L1 expression.^{108,283,284,299} Investigational agents targeting epidermal growth factor receptor (EGFR) or poly (ADP-ribose) polymerase (PARP) have also shown encouraging results in patients with advanced or metastatic gastric cancer.^{238,300-303} However, further investigation of these agents is required before they can be recommended for clinical care.

Trastuzumab

The ToGA trial was the first randomized, prospective, multicenter, phase III trial that evaluated the efficacy and safety of trastuzumab in patients with HER2-positive advanced gastric or EGJ adenocarcinoma.¹⁰³ In this trial, 594 patients with HER2-positive, locally advanced, recurrent, or metastatic gastric or EGJ adenocarcinoma were randomized to receive trastuzumab plus chemotherapy (cisplatin plus fluorouracil or capecitabine) or chemotherapy alone.¹⁰³ The majority of patients had gastric cancer (80% in the trastuzumab group and 83% in the chemotherapy group). Median follow-up was 19 months and 17 months, respectively, in the two groups. Results showed significant improvement in median OS with the addition of trastuzumab to chemotherapy in HER2-positive patients (13.8 vs. 11 months, respectively; *P* = .046). This study established trastuzumab in combination with cisplatin and a fluoropyrimidine as the standard treatment for patients with HER2-positive metastatic gastroesophageal adenocarcinoma. The addition of trastuzumab was particularly beneficial in patients with a tumor score of IHC 3+ or IHC 2+ and FISH positivity for HER2. In a post-hoc subgroup analysis, the addition of trastuzumab to chemotherapy further improved OS in patients whose tumors were IHC 2+ and FISH positive or IHC 3+ (n = 446; 16 months vs. 11.8 months; HR = .65) compared to those with tumors that were IHC 0 or 1+ and FISH positive (n = 131; 10 months vs. 8.7 months; HR = 1.07).



In a retrospective study of 34 patients with metastatic gastric or EGJ adenocarcinoma, the combination of trastuzumab with a modified FOLFOX regimen (mFOLFOX6) improved tolerability compared with the cisplatin plus fluorouracil regimen in previously untreated patients with HER2-positive tumors.³⁰⁴ The ORR with this regimen was 41% and median PFS and OS were 9.0 months and 17.3 months, respectively. The most frequent grade 3–4 toxicities were neutropenia (8.8%) and neuropathy (17.6%). These results suggest that the combination of mFOLFOX6 and trastuzumab is an effective regimen with an acceptable safety profile and warrants further study in patients with HER2-positive gastroesophageal cancers.

Ramucirumab

Ramucirumab, a VEGFR-2 antibody, has shown favorable results in patients with previously treated advanced or metastatic gastroesophageal cancers in two phase III clinical trials.^{281,282} An international randomized multicenter phase III trial (REGARD) demonstrated a survival benefit for ramucirumab in patients with advanced gastric or EGJ adenocarcinoma progressing after first-line chemotherapy.²⁸¹ In this study, 355 patients were randomized to receive ramucirumab (n = 238; 178 had gastric cancer and 60 had EGJ adenocarcinoma) or placebo (n = 117; 87 had gastric cancer and 30 had EGJ adenocarcinoma). Median OS was 5.2 months in patients treated with ramucirumab compared to 3.8 months for those in the placebo group ($P = .047$). Ramucirumab was associated with higher rates of hypertension than placebo (16% vs. 8%), whereas rates of other adverse events were similar.

A more recent international phase III randomized trial (RAINBOW) evaluated paclitaxel with or without ramucirumab in patients (n = 665) with metastatic gastric or EGJ adenocarcinoma progressing on first-line chemotherapy.²⁸² Patients randomized to receive ramucirumab plus paclitaxel (n = 330) had significantly longer median OS (9.63 months)

compared to patients receiving paclitaxel alone (n = 335; 7.36 months; $P < .0001$). The median PFS was 4.4 months and 2.86 months, respectively, for the two treatment groups. Additionally, the ORR was 28% for ramucirumab plus paclitaxel compared to 6% for paclitaxel alone ($P = .0001$). However, neutropenia and hypertension were more common with ramucirumab plus paclitaxel. Based on the results of these two studies, ramucirumab, as a single agent or in combination with paclitaxel, was approved by the FDA for the treatment of patients with advanced gastric or EGJ adenocarcinoma refractory to or progressive following first-line therapy with platinum- or fluoropyrimidine-based chemotherapy. Interestingly, an exposure-response analysis of these two trials revealed that ramucirumab was a significant predictor of OS and PFS in both trials.³⁰⁵ Higher ramucirumab exposure was associated with longer OS and PFS, but also with higher rates of grade ≥ 3 hypertension, leukopenia, and neutropenia. This exploratory exposure-response analyses suggest a positive relationship between ramucirumab exposure and efficacy with manageable toxicities.

An international randomized phase III trial (RAINFALL) has recently completed investigation of ramucirumab in combination with a fluoropyrimidine and cisplatin in the first-line treatment of gastroesophageal adenocarcinoma.³⁰⁶ This trial randomized 645 patients to receive capecitabine and cisplatin in combination with ramucirumab (n = 326) or placebo (n = 319). Preliminary results showed that median PFS was significantly longer in patients treated with ramucirumab versus placebo (5.7 vs. 5.4 months, respectively; $P = .011$; HR, 0.75; 95% CI, 0.61–0.94). However, no improvement in median OS was observed with the addition of ramucirumab (11.2 vs. 10.7 months; $P = .68$; HR, 0.96; 95% CI, 0.80–1.16). The ORR was 41.1% (95% CI, 35.8–46.4) in the ramucirumab arm compared to 36.4% (95% CI, 31.1–41.6) in the placebo arm. The most common grade ≥ 3 adverse events in the ramucirumab arm were neutropenia, anemia, and hypertension. These early results suggest



that the addition of ramucirumab may not reduce the risk of disease progression or death in treatment-naïve patients with metastatic gastroesophageal adenocarcinoma. Therefore, the addition of ramucirumab to first-line fluoropyrimidine and cisplatin chemotherapy is not recommended at this time. However, more data are needed to ascertain whether the addition of ramucirumab to other first-line chemotherapy regimens can improve OS in these patients.

Pembrolizumab

Pembrolizumab is a PD-1 antibody that was granted accelerated approval by the FDA in 2017 for the treatment of patients with unresectable or metastatic MSI-H or dMMR solid tumors that have progressed following prior treatment and who have no satisfactory alternative treatment options.¹⁰⁷ This first-ever tissue- and site-agnostic approval was based on data from 149 patients with MSI-H/dMMR cancers (90 patients had colorectal cancer) enrolled across 5 multicenter single-arm clinical trials. The ORR was 39.6% (95% CI, 31.7–47.9) and responses lasted ≥ 6 months for 78% of those who responded to pembrolizumab. There were 11 complete responses and 48 partial responses to pembrolizumab, and the ORR was similar irrespective of whether patients were diagnosed with colorectal cancer (36%) or a different cancer type (46% across the 14 other cancer types).

One of the trials included in the FDA approval was KEYNOTE-016, a multicenter phase II trial that evaluated the activity of pembrolizumab in 41 patients with metastatic treatment-refractory dMMR colorectal cancers, MMR-proficient colorectal cancers, or dMMR non-colorectal cancers who had received at least two previous lines of chemotherapy.^{108,283} In this study, the immune-related ORR for patients with dMMR non-colorectal cancers ($n = 9$) was 71% with an immune-related PFS rate of 67% at 20 weeks.²⁸³ Median PFS was 5.4 months and OS was not reached. Adverse events of clinical interest included rash or pruritus (24%), thyroid

dysfunction (10%), and asymptomatic pancreatitis (15%), which were similar to those reported in other trials involving pembrolizumab. In a recently reported expansion of this study, data from 86 patients with dMMR tumors representing 12 different cancer types, including gastroesophageal cancers, achieved an ORR of 53% with 21% of patients achieving a complete response to pembrolizumab.¹⁰⁸ While median PFS and OS have not yet been reached, estimates of these outcomes at 1 and 2 years are 64% and 53% for PFS and 76% and 64% for OS, respectively. The KEYNOTE-016 trial is still recruiting patients at several institutions (Clinical Trial ID: [NCT01876511](https://clinicaltrials.gov/ct2/show/study/NCT01876511)).

Another 2017 FDA approval for pembrolizumab was for the treatment of patients with recurrent, locally advanced, or metastatic PD-L1–positive gastric or EGJ adenocarcinoma who had progressed following two or more prior lines of therapy, including fluoropyrimidine- and platinum-containing chemotherapy and, if appropriate, HER2-targeted therapy.¹¹¹ This approval was based on the results of two KEYNOTE studies (KEYNOTE-012 and KEYNOTE-059). KEYNOTE-012 was a multicenter phase Ib study that evaluated the safety and activity of pembrolizumab in patients with PD-L1–positive recurrent or metastatic gastric or EGJ adenocarcinoma.³⁰⁷ The ORR was 22% and 13% of patients had grade 3–4 treatment-related adverse events including fatigue, pemphigoid, hypothyroidism, peripheral sensory neuropathy, and pneumonitis. The results of this trial justified the study of pembrolizumab monotherapy in cohort 1 of the phase II KEYNOTE-059 trial, which included 259 patients with gastric or EGJ adenocarcinoma who had progressed on two or more prior lines of therapy.²⁸⁴ Of those with PD-L1–positive tumors (57.1%; $n = 143$), the ORR was 15.5% (95% CI, 10.1–22.4), with 2% (95% CI, 0.4–5.8) of patients achieving a complete response. The median duration of response was 16.3 months. Investigations involving cohorts 2 and 3 of the KEYNOTE-059 trial, which examine the efficacy of first-line pembrolizumab as a single agent or in combination with chemotherapy,



are ongoing (Clinical Trial ID: [NCT02335411](#)).³⁰⁸⁻³¹⁰ Preliminary results suggest that pembrolizumab as a single agent or in combination with cisplatin and fluorouracil demonstrates promising antitumor activity and acceptable toxicity as first-line therapy for PD-L1–positive advanced gastric and EGJ cancers.

One of the most recent KEYNOTE trials (KEYNOTE-061) compared monotherapy with pembrolizumab to paclitaxel in patients with advanced pre-treated gastric or EGJ cancers.³¹¹ In this multicenter international phase III trial, 395 patients who had a PD-L1 CPS ≥ 1 were randomized to receive either pembrolizumab (n = 196) or standard-dose paclitaxel (n = 199). Median OS was 9.1 months (95% CI, 6.2–10.7) with pembrolizumab and 8.3 months (95% CI, 7.6–9.0) with paclitaxel (HR = 0.82, 95% CI, 0.66–1.03; *P* = .0421). Median PFS was 1.5 months (95% CI, 1.4–2.0) and 4.1 months (95% CI, 3.1–4.2), respectively (HR = 1.27; 95% CI, 1.03–1.57). Grade 3–5 treatment-related adverse events occurred in 14% of the patients treated with pembrolizumab compared to 35% of the patients treated with paclitaxel. Therefore, while pembrolizumab did not significantly improve OS compared with paclitaxel as second-line therapy for advanced gastric or EGJ cancer, pembrolizumab had a better safety profile and was better tolerated by patients.

Based on the KEYNOTE trials, pembrolizumab shows manageable toxicity and promising antitumor activity in patients with heavily pretreated PD-L1–positive or MSI-H/dMMR advanced gastroesophageal adenocarcinoma. Additional trials of pembrolizumab in gastric and EGJ cancers are ongoing. Please visit <https://keynoteclinicaltrials.com> for more information regarding ongoing KEYNOTE clinical trials of pembrolizumab in patients with gastric and EGJ cancers.

Other Immunotherapies

Preliminary studies have demonstrated the activity of the immune checkpoint inhibitors nivolumab (a PD-1 antibody) and ipilimumab (a CTLA-4 antibody) for the treatment of advanced, recurrent, or metastatic gastric and EGJ cancers.³¹²⁻³¹⁴ While these data are encouraging, the panel considers these studies too preliminary for inclusion in the guidelines and will reevaluate once more mature data become available.

CheckMate-032 is a phase I/II study evaluating the safety and activity of nivolumab alone or in combination with ipilimumab for advanced or metastatic gastric, esophageal, and EGJ cancers.³¹² Patients, irrespective of PD-L1 status, were randomized to receive nivolumab 3 mg/kg (N3, n = 59), nivolumab 1 mg/kg + ipilimumab 3 mg/kg (N1 + I3, n = 49), or nivolumab 3 mg/kg + ipilimumab 1 mg/kg (N3 + I1, n = 52). The ORR in each treatment group was 12%, 24%, and 8% for N3, N1+I3, and N3+I1, respectively. Among PD-L1–positive patients, the ORR was 19%, 40%, and 23%, respectively, in each treatment group. One-year PFS rates were 8%, 17%, and 10%, and one-year OS rates were 39%, 35%, and 24%, respectively. Grade 3–4 treatment-related adverse events occurred in 17%, 47%, and 27% of patients treated with N3, N1+I3, and N3+I1. Although nivolumab and nivolumab plus ipilimumab demonstrated clinically meaningful activity in patients with advanced gastroesophageal cancer, this will need to be confirmed in larger phase III trials. The phase III trial CheckMate-649, which is comparing first-line nivolumab + ipilimumab, nivolumab + chemotherapy, and chemotherapy alone in patients with advanced gastric and EGJ cancers, is currently recruiting patients (Clinical Trial ID: [NCT02872116](#)).³¹⁵ However, because of the high rate of grade 4 and 5 toxicities, enrollment for the nivolumab + ipilimumab arm of the study has been terminated. It is important to note that although encouraging in combination with nivolumab, ipilimumab monotherapy has not shown any benefit in the treatment of gastric or EGJ cancers. A phase II trial comparing ipilimumab to best supportive care for

treatment of advanced gastric or EGJ cancers following first-line chemotherapy showed no significant improvement in OS or PFS for patients treated with ipilimumab.³¹³

A recently published randomized phase III trial (ATTRACTION-2) investigating the safety and efficacy of nivolumab in Asian patients (n = 493) with heavily pretreated advanced gastric or EGJ cancer reported significantly improved OS with nivolumab compared to placebo (5.26 months vs. 4.14 months; HR = 0.63; $P < .0001$).³¹⁴ The 12-month OS rate was 26.2% in the nivolumab group (n = 330) compared to 10.9% in the placebo group (n = 163). OS in the nivolumab group was also higher than the placebo group at 18 months, indicating a persistent survival advantage with nivolumab over time. Grade 3–4 treatment-related adverse events, including fatigue and decreased appetite, were reported in 10% of patients receiving nivolumab and 4% of patients receiving placebo. The outcomes of this trial led the Japanese Ministry of Health, Labour and Welfare to approve nivolumab for the treatment of unresectable advanced or recurrent gastric cancer that has progressed after chemotherapy.³¹⁶ However, due to differences in gastric cancer gene expression patterns, these results may not be applicable to non-Asian populations.^{314,317,318} A retrospective analysis that evaluated the gene expression profiles of more than 1000 gastric adenocarcinomas from Asian and non-Asian patients found that immune and inflammation signatures were differentially expressed between the two cohorts, suggesting that Asian and non-Asian patients may respond differently to immunotherapy drugs.³¹⁷ Therefore, a confirmatory randomized controlled trial investigating nivolumab for advanced gastric or EGJ cancers in non-Asian populations is needed.

The PD-L1 antibody avelumab has also been investigated in the third-line or first-line maintenance settings for advanced or metastatic gastric and EGJ cancers.^{319,320} The randomized phase III JAVELIN Gastric 300 trial, which compared avelumab to physician's choice of chemotherapy in

patients (n = 371) with advanced gastric or EGJ cancer, showed that treatment with single-agent avelumab in the third-line setting did not improve OS or PFS compared to chemotherapy.³¹⁹ However, avelumab showed a more favorable safety profile, with only 9.2% of patients experiencing grade ≥ 3 treatment-related adverse events compared with 31.6% in the chemotherapy arm. The phase III JAVELIN Gastric 100 trial, which will compare first-line maintenance therapy with avelumab to continuation of chemotherapy in patients with advanced or metastatic gastric or EGJ cancer, is ongoing (Clinical Trial ID: [NCT02625610](https://clinicaltrials.gov/ct2/show/study/NCT02625610)).³²⁰

Treatment Guidelines

The management of patients with gastric cancer requires the expertise of several disciplines, including surgical oncology, medical oncology, radiation oncology, gastroenterology, radiology, and pathology. In addition, the presence of nutritional services, social workers, nurses, palliative care specialists, and other supporting disciplines are also desirable.¹³⁰ Hence, the panel believes in an infrastructure that encourages multidisciplinary treatment decision-making by members of all disciplines taking care of patients with gastric cancer. The recommendations made by the multidisciplinary team may be considered advisory to the primary group of treating physicians. See *Principles of Multidisciplinary Team Approach for Esophagogastric Cancers* in the algorithm for more information.

Workup

Newly diagnosed patients should receive a complete history and physical examination, complete blood count (CBC), comprehensive chemistry profile, and upper GI endoscopy with biopsy of the primary tumor. CT scan (with oral and IV contrast) of the chest, abdomen, and pelvis should also be performed. FDG-PET/CT evaluation from skull base to mid-thigh is recommended, if clinically indicated and if metastatic disease is not evident. EUS should be performed if early-stage disease is suspected or if

early-stage versus locally advanced disease needs to be determined (preferred). ER is also recommended since it is essential for the accurate staging of early-stage cancers (T1a or T1b). HER2, MSI-H/dMMR, and PD-L1 testing is recommended at the time of diagnosis if metastatic disease is documented or suspected. Assessment of Siewert tumor type should also be included as part of the initial workup in all patients with EGJ adenocarcinoma.^{321,322} The guidelines also recommend screening for family history of gastric cancers. Referral to a cancer genetics professional is recommended for those with a family history or a known high-risk syndrome associated with gastric cancer. See *Principles of Genetic Risk Assessment for Gastric Cancer* in the algorithm for more information.

Initial workup enables patients to be classified into three clinical stage groups:

- Localized cancer (stages cTis or cT1a)
- Locoregional cancer (stages cT1b–cT4a; cM0)
- Metastatic cancer (stage cT4b; cM1)

Additional Evaluation

Additional evaluations are warranted to assess a patient's medical condition, his/her ability to tolerate major surgery, and the feasibility of resection. These evaluations may include pulmonary function studies, cardiac testing, and nutritional assessment. Laparoscopy with cytology may be performed to evaluate for peritoneal spread when considering chemoradiation and/or surgery for patients with unresectable locoregional disease, but is not indicated if palliative resection is planned. Laparoscopy with cytology is indicated for stage cT1b or higher (category 2B).

Additional evaluation enables patients with locoregional cancer to be further classified into the following groups:

- Medically fit patients with potentially resectable disease

- Medically fit patients with unresectable disease
- Non-surgical candidates (medically unable to tolerate major surgery or medically fit patients who decline surgery)

Primary Treatment

Medically Fit Patients

ER or surgery are the primary treatment options for patients with localized (cTis or cT1a) tumors. Surgery is also the primary treatment option for patients with potentially resectable locoregional tumors (cT1b or higher, any N). However, since surgery alone is insufficient for most patients with cT2 or higher tumors, perioperative chemotherapy (category 1; preferred) or preoperative chemoradiation (category 2B) are recommended.^{205,210,211,231} Chemoradiation or systemic therapy are the recommended treatment options for medically fit patients whose locoregional cancer is found to be surgically unresectable after laparoscopic staging.^{195,323}

Non-surgical Candidates

ER is recommended for non-surgical candidates with cTis or cT1a tumors. Non-surgical candidates with locoregional disease should receive palliative management. All patients diagnosed with metastatic disease are considered non-surgical candidates and should be treated with palliative management/best supportive care. See the *Principles of Palliative Care/Best Supportive Care* in the algorithm for more information.

Response Assessment and Additional Management

Additional management options are based on the assessment of response to primary treatment. Therefore, chest/abdominal/pelvic CT scan with contrast should be performed in medically fit patients after the completion of preoperative therapy (chemotherapy or chemoradiation) and before



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surgical intervention. Patients found to have resectable disease on imaging should proceed with surgery while those found to have unresectable or metastatic disease after primary treatment should receive palliative management.

Non-surgical candidates should also be restaged using chest/abdominal/pelvic CT scan with oral and IV contrast following primary treatment. FDG-PET/CT scan can be performed as clinically indicated in cases of renal insufficiency or allergy to CT contrast. A CBC and comprehensive chemistry profile are also recommended. Surgery is preferred, if appropriate, for patients found to have resectable, medically operable disease at restaging. Patients with unresectable, medically inoperable, or metastatic disease at restaging should receive palliative management.

Postoperative Management

Postoperative management is based on pathologic tumor stage, nodal status, surgical margins, the extent of lymph node dissection, and previous treatment.

Patients Who Have Not Received Preoperative Chemotherapy or Chemoradiation

The benefit of postoperative chemoradiation for patients who have not received preoperative therapy has been established in randomized trials.^{206,214,219} Therefore, postoperative chemoradiation is recommended for all patients following an R1 or R2 resection. Palliative management, as clinically indicated, is an alternative option for patients following an R2 resection. Postoperative chemoradiation is also recommended following an R0 resection for select patients with pT2, N0 tumors and high-risk features (eg, poorly differentiated or higher grade cancer, LVI, neural invasion, age <50 years, and not undergoing D2 lymph node dissection)³²⁴ and for patients with pT3-pT4, any N or any pT, N+ tumors who received

less than a D2 dissection (category 1). Patients with pT3-pT4, any N or any pT, N+ tumors who have undergone primary D2 lymph node dissection should receive postoperative chemotherapy (category 1).^{218,220} Given the relatively good prognosis combined with the lack of evidence from randomized clinical trials showing any survival benefit for postoperative chemoradiation for patients with pTis or pT1, N0 tumors following R0 resection, the panel recommends surveillance for this group of patients.

Patients Who Have Received Preoperative Chemotherapy or Chemoradiation

Patients who have received preoperative chemoradiation should be observed until disease progression following R0 resection, regardless of tumor stage or nodal status. However, patients who have received preoperative chemotherapy should receive postoperative chemotherapy following R0 resection (category 1). In the absence of distant metastases, chemoradiation is recommended for patients following R1 or R2 resection, only if it was not received preoperatively. Although this approach has not been evaluated in prospective studies, the panel feels this is a reasonable treatment option given the significantly worse prognosis associated with margin-positive resections, especially in patients who have not received preoperative therapy. Re-resection, if feasible, can also be considered following R1 resection. Palliative management should be offered to all patients with metastatic disease and may also be offered to patients with R2 resection, as clinically indicated.

Follow-up/Surveillance

All patients should be followed systematically. However, surveillance strategies after curative intent (R0) resection for gastric cancer remain controversial with sparse prospective data to construct evidence-based



recommendations that balance the benefits and risks, including costs, within this cohort. The surveillance strategies provided in this guideline are based on the currently available retrospectively analyzed literature³²⁵⁻³³⁴ and expert consensus. While studies have shown that most gastric cancer recurrences occur within the first 2 years after the completion of local therapy (70%–80%) and almost all recurrences occur by 5 years (~90%),^{325,327,332} a study of 1573 patients who underwent curative intent therapy showed that 7.6% of recurrences occurred >5 years after treatment.³²⁸ Therefore, additional follow-up after 5 years may be considered based on risk factors and comorbidities. Differences in follow-up for early-stage gastric cancer reflect a heterogeneous potential for relapse and OS.³²⁵⁻³³⁴ For example, whereas R0 resected Tis disease has a prognosis that approximates a non-cancer cohort, T1a, N0 and T1b disease do not perform as well. Thus, surveillance recommendations vary according to the depth of invasion and treatment modality received by the patient.

In general, surveillance for all patients should include a complete history and physical examination every 3 to 6 months for the first 2 years, every 6 to 12 months for years 3 to 5, and then annually thereafter. CBC and chemistry profile should be obtained as clinically indicated. Patients with early-stage (Tis or T1a) tumors treated by ER should be surveilled with EGD every 6 months for the first year, and then annually for either 3 years (Tis) or 5 years (T1a). EGD surveillance beyond 5 years for patients with T1a tumors should be based on symptoms and/or radiographic findings. Patients with stage I disease (T1a or T1b) treated with surgery should receive EGD as clinically indicated. EGD should also be performed as clinically indicated in patients who had partial or subtotal gastrectomy. Patients with Tis or stage I disease may receive CT scan of the chest, abdomen, and pelvis with contrast as clinically indicated based on symptoms and concern for recurrence. Patients with stage II or III disease should receive chest/abdominal/pelvic CT scan with oral and IV contrast

(preferred) every 6 to 12 months for the first 2 years, then annually for up to 5 years. FDG-PET/CT can also be considered as clinically indicated. Surveillance for patients undergoing curative intent total gastrectomy should follow these recommendations, except for endoscopy. Endoscopy has no role in the routine surveillance of these patients and should only be used if patients are symptomatic. Surgically resected patients with stage I–III disease should also be monitored for nutritional deficiencies (eg, B₁₂ and iron), especially after total gastrectomy, and treated as indicated.

Unresectable Locally Advanced, Recurrent, or Metastatic Disease

When locoregional recurrence develops after prior therapy, the clinician should determine whether surgery is an appropriate option. Surgery should be considered in medically fit patients with isolated resectable recurrences. Palliative management, which includes chemoradiation (only if locally unresectable and not previously received), systemic therapy, and/or best supportive care, is recommended for patients with unresectable or metastatic recurrence. If not done previously, HER2, MSI-H/dMMR, and PD-L1 testing should be performed in patients with suspected metastatic adenocarcinoma.

Palliative management and best supportive care are always indicated for patients with unresectable, locally advanced, recurrent, or metastatic disease. The decision to offer palliative/best supportive care alone or with systemic therapy is dependent upon the patient's performance status. The [Eastern Cooperative Oncology Group Performance Status Scale](#) (ECOG PS) and the [Karnofsky Performance Status Scale](#) (KPS) are commonly used to assess the performance status of patients with cancer.³³⁵⁻³³⁷ ECOG PS is a 5-point scale (0–4) based on the level of symptom interference with normal activity. Patients with higher ECOG PS scores are considered to have worse performance status. KPS is an ordered scale with 11 levels (0%–100%) in which patients are classified based on their degree of functional impairment (activity, work, and self-care). Lower

KPS scores are associated with worse survival for most serious illnesses. Patients with a KPS score <60% or an ECOG PS score ≥ 3 should be offered palliative/best supportive care only. Systemic therapy or chemoradiation (only if locally unresectable and not previously received) can be offered in addition to palliative/best supportive care for patients with better performance status (KPS score of $\geq 60\%$ or ECOG PS score ≤ 2).

The survival benefit of systemic therapy compared to palliative/best supportive care alone for patients with advanced gastric cancer has been demonstrated in several randomized trials.²³³⁻²³⁶ In an early comparison between chemotherapy and best supportive care versus best supportive care alone, OS (8 months vs. 5 months) and time to progression (5 months vs. 2 months) were longer in patients receiving chemotherapy in addition to best supportive care for advanced gastric cancer.²³³ More patients in the chemotherapy group (45%) had an improved or prolonged quality of life for a minimum of 4 months compared to those who received best supportive care alone (20%). In a more recent randomized phase III study, the addition of second-line chemotherapy with irinotecan significantly prolonged OS compared to best supportive care alone in patients with metastatic or locally advanced gastric or EGJ adenocarcinoma (n = 40).²³⁵ Median survival was 4 months in the irinotecan and best supportive care group compared to 2.4 months in the best supportive care alone group. However, the study was closed prematurely due to poor accrual. In a larger randomized trial (n = 193), second-line chemotherapy with irinotecan (or docetaxel) was also found to significantly improve OS (5.1 months vs. 3.8 months) compared to best supportive care alone in patients with advanced gastric cancer.²³⁶ In another phase III randomized trial, the addition of docetaxel to best supportive care was associated with a survival benefit for patients with advanced adenocarcinoma of the esophagus (n = 33), EGJ (n = 59), or stomach (n = 76) that had progressed on or within 6 months of treatment

with platinum and fluoropyrimidine-based combination chemotherapy.²³⁴ After a median follow-up of 12 months, the median OS was 5.2 months for patients in the docetaxel and best supportive care group compared to 3.6 months for those in the best supportive care alone group ($P = .01$). Therefore, the addition of systemic therapy to best supportive care can improve the quality of life and may prolong survival in patients with advanced gastric cancer.

See *Principles of Systemic Therapy* in the algorithm for a full list of specific regimens for unresectable, locally advanced, recurrent, or metastatic disease. Some of the chemotherapy regimens and dosing schedules included in the guidelines are based on extrapolations from published literature and clinical practice.

Leucovorin Shortage

Leucovorin is used with certain fluorouracil-based regimens. However, there is currently a shortage of leucovorin in the United States.³³⁸ There are no specific data to guide management under these circumstances, and all proposed strategies are empiric. One is the use of levoleucovorin, which is commonly used in Europe. A levoleucovorin dose of 200 mg/m² is equivalent to 400 mg/m² of standard leucovorin. Another option is to use lower doses of leucovorin in all patients, since lower doses are likely to be as efficacious as higher doses, based on several studies in patients with colorectal cancer.³³⁹⁻³⁴¹ However, the panel recommends use of these regimens without leucovorin in situations where leucovorin is not available.

Palliative/Best Supportive Care

The goals of palliative/best supportive care are to prevent, reduce, and relieve suffering and improve the quality of life for patients and their caregivers, regardless of the stage of the disease or the need for other therapies. In patients with advanced or metastatic gastric cancer, palliative/best supportive care provides symptom relief, improvement in

overall quality of life, and may result in prolongation of life. This is especially true when a multimodality interdisciplinary approach is pursued. Therefore, a multimodality interdisciplinary approach to palliative/best supportive care of gastric cancer patients is encouraged.

Bleeding

Acute bleeding is common in patients with gastric cancer and may be tumor-related or a consequence of therapy. Patients with acute severe bleeding (hematemesis or melena) should undergo prompt endoscopic assessment.³⁴² The efficacy of endoscopic treatment for bleeding in patients with gastric cancer is not well-studied, but limited available data suggest that while endoscopic therapies may be effective as initial treatment, the rate of recurrent bleeding is very high.^{343,344} Widely available options for endoscopic therapies include injection therapy, mechanical therapy (eg, endoscopic clip placement), ablative therapy (eg, argon plasma coagulation), or a combination of modalities.³⁴³ Interventional radiology with angiographic embolization techniques may be useful in situations where endoscopy is not helpful. Additionally, external beam RT (EBRT) has been shown to effectively manage acute and chronic GI bleeding.^{345,346} Proton pump inhibitors can also be prescribed to reduce the risk of bleeding from gastric cancer; however, there are no definitive data supporting their use at this time.

Obstruction

The primary goals of palliation for patients with malignant gastric obstruction are to reduce nausea and vomiting and, when possible, allow resumption of an oral diet. Management of malignant gastric obstruction should be individualized and treatment options should be selected as clinically appropriate. Treatment options used to alleviate or bypass obstruction include surgery (gastrojejunostomy¹³¹ or gastrectomy in select patients¹²⁹), EBRT, chemotherapy, and endoscopic placement of enteral

stent for relief of gastric outlet obstruction¹³¹ or esophageal stent for EGJ/cardia obstruction. Endoscopic placement of SEMS is a safe and effective minimally invasive palliative treatment for patients with luminal obstruction due to advanced gastric cancer.³⁴⁷⁻³⁵⁰ In a systematic review, patients treated with endoscopic placement of SEMS were more likely to tolerate oral intake and had shorter hospital stays than patients treated with gastrojejunostomy.³⁵¹ The results of another systematic review suggest that SEMS 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.¹³¹ A randomized trial also reported similar findings.³⁵² However, these results need to be confirmed in larger randomized trials.

When obstruction cannot be alleviated or bypassed, the primary goal is to reduce the symptoms of obstruction via venting gastrostomy.³⁵³ Percutaneous, endoscopic, surgical, or interventional radiology gastrostomy tube placement may be performed for gastric decompression, if tumor location permits. Percutaneous decompressive gastrostomy has been associated with palliative benefit for patients with gastric outlet obstruction.^{354,355} Ascites, if present, should be drained prior to venting gastrostomy tube placement to reduce the risk of infectious complications.^{356,357} Feeding gastrostomy tubes for patients with EGJ/gastric cardia obstruction or jejunal feeding tubes for patients with mid and distal gastric obstruction may be necessary to provide adequate hydration and nutritional support for patients who cannot tolerate an oral diet. Nutritional counseling may also be valuable.

Pain

Pain control may be achieved with the use of EBRT or chemotherapy. 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 with immediate endoscopic removal of the stent.

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 obstruction is present.

Survivorship

In addition to survivorship care relevant to all cancer survivors (see [NCCN Guidelines for Survivorship](#)), gastric cancer survivors have special long-term care needs due to the nature of their illness and treatments. Therefore, screening and management of long-term sequelae are important for all gastric cancer survivors. However, due to a lack of large randomized trials, the survivorship management recommendations provided by the panel are based on smaller studies and clinical experience. Survivorship care planning should include appropriate timing of transfer of care to a primary care physician and maintenance of a therapeutic relationship with the primary care physician throughout life. The oncology team and primary care physician should have clearly delineated roles in survivorship care, with these roles communicated to the patient. In general, routine gastric cancer-specific surveillance is not recommended for more than 5 years following the end of treatment.

In general, gastric cancer survivors should be counseled to maintain a healthy body weight, adopt a physically active lifestyle, consume a healthy diet with an emphasis on plant-based sources, and limit alcohol intake. Smoking cessation should also be encouraged, as appropriate. Common issues facing gastric cancer survivors include weight loss, diarrhea, chemotherapy-induced neuropathy, and fatigue. Weight loss and fatigue can be effectively managed by monitoring patients' weight regularly,

encouraging more frequent consumption of smaller meals without fluid intake, and encouraging physical activity and energy conservation measures. Anti-diarrheal medications, bulk-forming agents, or diet manipulation can be considered to treat diarrhea. Duloxetine can be considered to treat painful chemotherapy-induced neuropathy, but is ineffective for numbness or tingling. Osteopenia/osteoporosis is another common long-term sequelae in gastric cancer survivors, caused by deficiencies in vitamin D, calcium, phosphorus, and other vitamins and minerals. Supplementation with vitamin D, and treatment with other therapies, has been shown to improve bone health in these patients.^{358,359} Therefore, bone density should be screened at regular intervals and low bone density should be managed as per established national guidelines.³⁶⁰ In addition to the issues discussed above, gastric cancer survivors who underwent gastrectomy face other long-term health issues including indigestion and nutritional deficiencies. Patients experiencing indigestion should be counseled to avoid foods that increase acid production (eg, citrus, tomato sauce, spicy foods) or lower gastroesophageal sphincter tone (eg, caffeine, peppermint, chocolate). Use of a proton pump inhibitor can also be considered. Gastrectomy survivors also have unique nutritional needs due to frequent vitamin and mineral deficiencies and other GI dysfunctions.³⁶¹ Studies have shown that long-term anemia, iron deficiency, and vitamin B₁₂ deficiency are common in patients treated with gastrectomy for gastric cancer.^{362,363} Supplementation of vitamin B₁₂³⁶⁴ and iron³⁶⁵ is safe and effective for reversing these deficiencies. If needed, referral to a dietician or nutritional services for individualized counseling can be considered.

Survivors who underwent total gastrectomy are at particular risk for long-term health issues, as they have been shown to have greater restrictions and a significantly worse quality of life compared to those who received partial gastrectomy.³⁶⁶⁻³⁶⁸ A prospective study of 254 patients who were followed for 5 years following gastrectomy (partial or total) as treatment for

gastric cancer found that symptoms including diarrhea, dysphagia, reflux, eating restrictions, physical functioning, cognitive functioning, and fatigue negatively impacted the patients' long-term quality of life.³⁶⁹ Dumping syndrome, which results from rapid emptying of the stomach into the small bowel, is another concern for total gastrectomy survivors. Patients suffering from early dumping syndrome (within 30 minutes of eating a meal) may experience palpitations, diarrhea, nausea and cramps while those with late dumping syndrome (within 2–3 hours of eating a meal) may experience dizziness, hunger, cold sweats, and faintness. A large study of 1153 total gastrectomy survivors reported that 67.6% and 38.4% of patients experienced early and late dumping, respectively.³⁷⁰ To help manage the symptoms of dumping syndrome, the panel recommends making dietary changes including frequent eating throughout the day, avoiding fluid intake with meals, and consuming a diet high in protein and fiber and low in simple carbohydrates and sugars.

Summary

Gastric cancer is rampant in many parts of the world and is often diagnosed at advanced stages in Western countries. Risk factors for gastric cancer include *H. pylori* infection, smoking, and high salt intake; few gastric cancers are associated with inherited gastric cancer predisposition syndromes. Referral to a cancer genetics professional is recommended for an individual with a genetic predisposition. The NCCN Panel strongly recommends multidisciplinary team management as essential for the management of patients with gastric cancer. Best supportive care is an integral part of treatment, especially in patients with locally advanced or metastatic disease.

Endoscopic resection (EMR or ESD) is the primary treatment option for patients with early-stage (Tis or T1a) tumors. Surgery with lymph node dissection is the primary treatment option for medically fit patients with resectable T1b or higher, any N tumors. Perioperative chemotherapy is

preferred (category 1) for patients with resectable T2 or higher, any N tumors. Preoperative chemoradiation may also be considered for these patients (category 2B). Postoperative chemoradiation is recommended for patients with T3–T4, any N tumors and node-positive T1–T2 tumors who had received less than a D2 lymph node dissection. Selected patients with T2, N0 tumors and high-risk features can also be considered for postoperative chemoradiation. Postoperative chemotherapy should be reserved for patients with T3–T4, any N and node-positive T1–T2 tumors who had received D2 lymph node dissection. Postoperative chemoradiation is recommended for all patients with residual disease at surgical margins. Patients with unresectable and/or distant metastatic disease may be offered best supportive care and palliative management with or without systemic therapy, depending on performance status.

Targeted therapies have produced encouraging results in the treatment of patients with advanced gastric cancer. Trastuzumab plus chemotherapy is recommended as first-line therapy for patients with HER2-positive metastatic gastric cancer. Ramucirumab, as a single agent or in combination with paclitaxel, and pembrolizumab (for MSI-H/dMMR tumors) are included as options for second-line or subsequent therapy for patients with metastatic gastric cancer. Pembrolizumab is also included as a third-line or subsequent therapy option for PD-L1-positive gastric adenocarcinoma.

The NCCN Guidelines for Gastric Cancer provide an evidence- and consensus-based treatment approach for the management of patients with gastric cancer. The panel encourages patients with gastric cancer to participate in well-designed clinical trials investigating novel therapeutic strategies to enable further advances.



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Discussion
update in
progress