Ca. stomach

Neoplasia of stomach

1. Benign : adenoma & polyp
2. Malignant : from epithelial cell (adenocarcinoma) , fromconnective tissue (GIST)*gastro intestinal stromal tumor ..

GISTether low grade (benign) or high gradė (malignant)

Solid tumor more common in male than female & increase with age

10/100000 in united state

15/100000 in in UK

40/100000 in in west Uribe

70/100000 in japan

▶ Predisposing factor

△More common causes;

1. Developed country: *GERD *proximal than distal part ofstomach
2. Developing country: *H .pylori common *ca. in distal part ofstomach

—Other causes;

- Change in PH of stomach such as antiacid Therapy
- Atrophic gastritis (hypochlorhydria)
- Pernicious anemia
- Operation of peptic ulcer or DU
- Gastric polyp & adenoma
- alcohol intake
- smoking
- loss of antioxidants in diet

*Ca. in stomach depend on environmental effect than genetic

◊Pathology

- Male > female
- Solid tumor
- Increase with age
- Microscopic:

Gastric ca ether proliferative or infiltrative or ulcrrative

Two type: intestinal type presented as mass
diffused type whole wall of stomach affected

(EGC) Japanese use OGD to detect ca. at early stage

Early Gastric: Early stage ca. :when carcinoma affect mucosa or submucosa withor without lymph node involvement , if we deal with this bysurgery 10 years survive 90% without recurrent & symptomfree

(LGC) Late stage ca. :carcinoma going beyond submucosa

∞-Staging:

TNM

T TUMOR SIZE

T0 ----- no

T1------lamina propria (mucosa and submucosa)

T2------muscularis

T3-------serosa

T4-------beyond serosa to adjacent structure

N lymph node

N0 no regional L.N.

N1 1-6 regional L.N.

N2 7-15 REGIONAL l.n.

N3 >15 regional L.N.

M METASTASIS

M0 NO METASTASIS

M1 POSITIVE (LLBB)

▶ How gastric carcinoma metastasis??

- localy to (esophagus,pancrase,colon,)
- LN metastasis ether by permission or by emobilism (virchow's Ca) To Rt left clavicul
- Blood borne metastasis(2L,2b);

Lungs,liver,bone & brain..

- transplacental metastasis to ovary and form (Krukenbergtumor)from pancrase,colon & gastric cancers.

▶ **How the patient presented to you?? (clinical pictures)**

Depend on site of tumor

1. Distal part of stomach : pyloric obstruction
2. Proximal part of stomach : dysphagia & regurgitation
3. Tumor in body of stomach (vague feature) Three A
   Anemia, asthenia, anorexia, malaise, loss of wt.
   Metastatic: to lt. supraclavicular L.N. (virchow's L.N.) trouserL.N. & thromboembolic phenomena (DVT + ca. stomach =trouseous)
4. Transpertonial spread to umbilicus (sister joseph nodule) inlate stage ca. stomach
5. Pt. might present with ascites

△-investigation:

- OGD =biopsy
- Ba. Meal
- Abd. U/S (FOR LIVER metastasis , para aortic L.N. metastasis,mass in stomach)
- CT or MRI for staging
  To do TNM & post-operative

⌂-Treatment:

Assessment by investigation there are two type

1. Resectable : surgery + adjuvant therapy(chemotherapy & DXT)
   Surgery depend on site of tumor
   - Distal part by distal radical gastrectomy + billroth II (lesser,greater curvature , 1st duodenal part & gastro jejunostomy)
     Proximal part by radical proximal gastrectomy (removeproximal of 70% stomach greater & lesser curvature,lower part of esophagus &spleen).
   - Body of stomach by radical total gastrectomy + rox-en-y Esophago- jejunostomy.

- Non resectable : beyond reactive by gastrojejunostomy.
  Proximal part by using feeding tube + chemo and radiotherapy.