Are all centers able to offer an adequate carcinological treatment for gastric carcinoma?

**Keywords:** Gastric carcinoma, multidisciplinary management, supportive care.

**Abbreviations:** FLOT, 5 fluoro-uracil, leucovorin, oxaliplatin, docetaxel; ECF, epirubicin, cisplatin, 5 fluoro-uracil; ECX, epirubicin, cisplatin, capecitabine; PF, cisplatin, 5 fluoro-uracil

**Opinion article**

Gastric carcinoma (GC) is the fourth most common malignancy worldwide and remains the second cause of death of all malignancies. Gastric cancer results from a combination of environmental factors along with specific genetic alterations. Multimodal approach from the diagnosis until the treatment (chemotherapy, radiotherapy and surgery) is necessary for an optimal outcome along with the implementation of novel promising agents.

Dysphagia, hematemesis, pain, anorexia, and dyspepsia are among the most common presenting symptoms of gastric cancer. Thus, the patients are initially referred to the gastroenterologist for further evaluation. The diagnosis of GC is made via upper gastro-intestinal endoscopy and biopsies. The pathologist must evaluate the specimen with microscopic morphologic and immune-histochemical studies. As all the cancers are now re-classified in different molecular genomic sub-types, as described in the cancer genome atlas (TCGA), the pathologic reports are becoming more challenging. However, outside a clinical trial, the recommendations are to test for human epidermal growth factor receptor 2 (Her-2) and program death ligand 1 (PD1) expressions.1-3

Once the diagnosis is made, the next step is to do an optimal staging work up to differentiate between a localized v/s a metastatic disease. Knowing that gastric carcinoma metastasizes most commonly to regional lymph nodes, peritoneum and liver, it is mandatory to exclude non-operable and non-resectable cases. An incomplete surgery is more deleterious than leaving the non-resectable tumor while offering a non-surgical systemic strategy. The surgeons must have good skills in undergoing radical carcinologic surgeries in experienced centers: surgical techniques, negative margins, adequate lymph nodes dissection (N2 level) and management of the perioperative period which is crucial in determining post-operative complications, disease recurrence as well as overall survival. The surgical treatment is mutilating by itself, and the patients require a good post-surgical care: reanimation, nutritional support, rehabilitation, physical and psychosocial therapies. Unfortunately, 40% of the patients become frail, and won’t be able to continue the post-operative chemotherapy. In this perspective, the supportive care team acts to help them overcoming the morbidities and toxicities of the surgery to let them achieve the pre-planned treatment.4-5 On the other side, many centers in the US adopt the perioperative chemo-radiation therapy and other centers in Asia use the modality of adjuvant chemotherapy treatment. Regardless of the therapeutic strategy, a multidisciplinary team discussion and decision are mandatory all over the treatment and disease courses.6-11

In the metastatic settings or when the patients are not candidates for surgery, the goal of the treatment will consist of a palliative chemotherapy and a preservation of the quality of life: psycho-social care, pain management, nutritional support, management of tumor related bleeding or stenosis. So, these patients must be addressed to the palliative/supportive care team as early as possible, because the early referral is correlated with a better outcome.

To conclude, gastric cancer remains a challenging disease with high potential of developing micro-metastases and generalized disease. Despite all the progresses, the 5-year survival doesn’t exceed 20-25%.
An adequately performed, radical gastrectomy is the cornerstone of the treatment. Knowing the patients' comorbidities, the treatment related toxicities and the risks associated with the surgery, GC must be referred to experienced centers (Figure 1). The management of these tumors requires many surgical, medical and supportive skills, and so, is any center allowed to treat gastric cancer?

**Figure 1** Multimodal multidisciplinary team management required in every tumor and specifically in gastric cancer for a better outcome and improved survival.

**Acknowledgements**
None.

**Conflict of interest**
All authors declare no conflicts of interest.

**References**

**Citation:** Sadek M, Jounblat Y, El Hachem G. Are all centers able to offer an adequate carcinological treatment for gastric carcinoma? Int Clin Pathol J. 2018;6(4):167–168. DOI: 10.15406/icpjl.2018.06.00180