Consensus Statements

PREVENTION, SCREENING AND SURVEILLANCE OF GASTRIC CANCER
(C. Wong, S. Ahmed)

1) Should gastric cancer screening be performed in any population group?
   • Gastric cancer screening is not recommended for the general population.
   • Gastric cancer screening can be considered on a case-by-case basis in high-risk patients.
   • The optimal screening method and frequency is currently not known.
   • In patients with CDH1 mutation, screening gastroscopy is ineffective. Prophylactic gastrectomy is recommended.

2) What is the optimal surveillance strategy for patients with gastric cancer following curative resection?
   • Currently, the best strategy for the follow-up of patients who have undergone surgical treatment with curative intent for gastric cancer is not known.
   • Patient education and self-referral for abnormal symptoms are important.
   • Periodic assessments are useful to address treatment-related complications, nutritional deficiencies including vitamin B12 and iron, and psychosocial issues.
   • Currently, there are no data to support that early detection of an asymptomatic recurrence by tumor markers or radiologic imaging improves quality of life or prolongs survival, and routine imaging studies and bloodwork in asymptomatic patients are not recommended.
   • In patients with a subtotal gastrectomy, eradication of Helicobacter pylori is recommended.

ISSUES IN THE SURGICAL MANAGEMENT OF GASTRIC CANCER
(Y. McConnell, E. Woo)

3) What is the optimal surgical treatment?
   • The choice of surgery depends upon the location of the tumor, the clinical stage, and the histologic type.
   • The oncologic procedure should achieve clear margins with removal of the tumor. An extensive lymphadenectomy with at least fifteen lymph nodes as offered by surgeons that have an expertise in gastric cancer should be performed.
   • Intra-operative frozen section assessment of margins is highly recommended.
   • Optimal surgical management can be guided by a diagnostic laparoscopy, particularly in patients at high risk of peritoneal disease.
4) Should gastrectomy be limited to high volume centres?

- There is an association between higher volume and improved outcomes. However, the definition of a high volume centre is controversial.
- Surgeries should be performed in centres with adequate resources and supports, and by surgeons with training and expertise in oncologic gastric surgery.
- Centres performing gastric cancer surgery should actively participate actively in provincial programs to monitor quality.

**NEOADJUVANT AND ADJUVANT THERAPY FOR EARLY STAGE GASTRIC CANCER**

(M. Ferguson, P. Tang)

5) What is the preferable adjuvant/neoadjuvant therapy for patients with operable gastric cancer?

- It is not possible to define a preferable adjuvant/neoadjuvant therapy for patients with operable gastric cancer. The choice is defined by patient preference, patient characteristics, and surgical techniques. Evidence-based options include peri-operative and post-operative therapy. In patients unable to receive post-operative radiation, adjuvant fluoropyrimidine-based chemotherapy may be considered.

**SYSTEMIC THERAPY OPTIONS FOR ADVANCED DISEASE**

(H. Lim)

6) What is the role of anti-VEGF or immune therapy in metastatic gastric cancer?

- Bevacizumab has no demonstrated benefit over chemotherapy alone in the first-line therapy for metastatic gastric cancer.
- Ramucirumab monotherapy or Ramucirumab with Paclitaxel have level 1 evidence for a benefit as second-line therapy.
- Currently, immune therapy is considered investigational.

7) What is the optimal sequence of chemotherapy for metastatic gastric cancer?

- For patients appropriate for systemic therapy, the choice and sequence of chemotherapy is determined by patient’s performance status, comorbidities, previous therapies, response and duration of response to prior therapies, and patient preferences.
  - Enrollment in clinical trials should be considered, where possible.
  - In *HER2* positive disease, first-line treatment would be offered with fluoropyrimidine-Cisplatin with Trastuzumab.
  - For disease without *HER2* over-expression, there is evidence of use fluoropyrimidine-Platinum combinations or fluoropyrimidine-Irinotecan combinations in first-line setting.
  - Acceptable second-line therapies include fluoropyrimidine-Platinum, fluoropyrimidine-Irinotecan, Irinotecan monotherapy, Docetaxel, Paclitaxel monotherapy, Ramucirumab-Paclitaxel, or Ramucirumab monotherapy.