PE 290

International Surgical Week
The World's Congress of Surgery
isw2024.org
Kuala Lumpur, Malaysia
25-29 August 2024

GASTRIC MALIGNANCY: FROM DIAGNOSE TO SURGERY - OUR CASUISTIC

[1]Predrag Pocevski, [2,3]Božidar Pocevski

[1]Surgical Department, Health Center Vranje, Vranje, Serbia
[2]First Surgical Clinic, Clinical Center of Serbia, Belgrade, Serbia
[3]Medical School Belgrade, Belgrade, Serbia

Introduction

Gastric cancer (GC) is the **5th most common malignancy worldwide**, with 5.7% of all diagnosed cancers.

From all gastric malignant tumors most common are adenocarcinoma (90%).

Other 10% represents primary gastric lymphoma, gastrointestinal stromal tumor, carcinoid tumor and others.

Main treatment option is **surgery intervention** because radiation therapy and cytostatic therapy didn't lead to visible results. GC is big problem in world because of high mortality rate which has been decreasing in recent years.

An important prerequisite for successful treatment is **early diagnostic and operative procedures**.

Materials and methods

On our 10-year material at Surgery Department, Health Center Vranje, it was diagnosed 87 cancer malignancies: 20% with **physical examination**, 30% with **roetgenoscopy**, and 50% with **biopsy gastroscopy**. CT and ultrasonography were used to identify intramural processes and to provide insight into the possible extent of metastases.

Absolut indication for a patient who is losing weight, has indeterminate problems in the epigastrium, nausea and possible bleeding is gastroscopy with biopsy, as well as for those with classical clinical triad (nausea, loss of appetite, weight loss).

Conclusion

Even though today are more patients which goes to operation in early stage, it is **still bigger number of those who come with advanced stage of cancer**, with widespread metastases, obstructions, ascites etc. **We insist** on **early depistage for patients with gastric problems** and **emphasize operative treatment radical measures such as subtotal and total gastrectomy**.

Results

Of 87 patients with diagnosed GC (49 males, 38 females), 47 patients (54.02%) were in advanced stadium. Lab tests had no practical value in early detection. We had to settle for one of the palliative methods at 30 patients: gastro-entero anastomosis on 10 patients, explorative laparotomy with biopsy on 7, suture of perforating cancer on 5, explorative laparotomy without biopsy on 5, and jejunostomy on 3 patients. Palliative methods mortality rate in first year was 70%. Operative methods were done: 9 patients - *total gastrectomy*; 26 patients - *subtotal gastrectomy*. In total gastrectomy it was done mostly **Roux-en-Y reconstruction**, with remote jejunal anastomosis of at least 40 cm from ezofagojejunal anastomosis. Of 22 subtotal resections, 8 were done with **splenectomy and omentectomy in block**, and digestive continuity was restored with **Billroth II with Braun**. Remaining 22 patient treated conventionally or refused operation.

Discussion

Our aim is to present diagnose protocol, treatment modalities regarding tumor localization, size, and type and survival rates.

Gastric cancer remains far from eradicated despite declining global and national trends.

Treatment tipically involves surgery, chemotherapy, and sometimes radiation therapy, depending on the stage and extent of the cancer.

Gastric cancer is still major problem in Serbia, but it is mainly curable if it is detected in early stage. In the underdeveloped areas - south Serbian parts, specifically Vranje, people are still shy away from doctors so there are many cases of abdominal pathology in late stage, when it is difficult to achieve something with therapy.

The literature today still poses numerous conflicting trials and clinical recommendations, so it is on surgeons to decide personally which procedure to do.

1. Hu B, El Hajj N, Sittler S, LammertN, Barnes R, Meloni-Ehrig A. Gastric cancer: Classification, histology and application of molecular pathology. J Gastrointest Oncol 2012;3(3):251-261. doi: 10.3978/j.issn.2078-6891.2012.021
2. Guggenheim D.E, and Shah M.A. Gastric cancer epidemiology and risk factors. J. Surg. Oncol. 2013, 107: 230-236. doi: 10.1002/jso.23262
3. Smyth, E. C., Nilsson, M., Grabsch, H. I., van Grieken, N. C., & Lordick, F. Gastric cancer. Lancet 2020, 396(10251), 635–648. doi: 10.1016/S0140-6736(20)31288-5
4. Ryun Park S. Management of gastric cancer: East vs west. Current Problems in Cancer 2015; 39: 315-41. doi: 10.1016/j.currproblcancer.2015.10.005
5. Japanese Gastric Cancer Association (2011). Japanese classification of gastric carcinoma: 3rd English edition. Gastric cancer: official journal of the International Gastric Cancer Association and the Japanese Gastric Cancer Association, 14 (2), 101–112. doi: 10.1007/s10120-011-0041-5
6. Wyman, A., Karatsis, P., & Rogers, K. (1994). Surgery for gastric cancer. Digestive diseases (Basel, Switzerland), 12 (2), 117–126. https://doi.org/10.1159/000171444
7. Cui LH, Son SY, Shin HJ, et al. Billroth II with Braun Enteroenterostomy Is a Good Alternative Reconstruction to Rouxen-Y Gastrojejunostomy in Laparoscopic Distal Gastrectomy. Gastroenterol Res Pract. 2017; 2017: 1803851. doi: 10.1155/2017/1803851