Royal Berkshire
NHS Foundation Trust

Gastric (stomach) cancer

Information for patients

This booklet is for patients who have been diagnosed with gastric (stomach) cancer and will explain your treatment options.

For anyone, receiving news of the diagnosis of cancer comes as a shock. This leaflet is written for you to explain the clinical problem of gastric (stomach) cancer to you and how you may be investigated and treated. If anything in this leaflet is not clear, do not be afraid to ask any of the Upper Gastrointestinal (UGI) Specialist team caring for you.

What is cancer?

A cancer arises when the cells that line the upper intestine multiply beyond the normal control mechanisms of the body. In the stomach this process may lead to a number of different symptoms. It may cause a blockage of the exit of the stomach, resulting in vomiting. There may be a notable loss of appetite or weight, or symptoms of indigestion. Sometimes a cancerous growth can bleed; this may result in you becoming short of blood (anaemic), or you may vomit blood.

In general, the main treatment of gastric cancer is by surgery. This is usually a major operation.

What function does the stomach perform?

The stomach is a part of the intestine that acts like a large bag to hold food and slowly let it pass through into the intestines so it can be digested.

What investigations will I need?

Any cancerous growth, whatever organ it starts in, may spread to other organs such as the liver or lungs. This is called "secondary spread". Surgery is not usually recommended if secondary spread has occurred and some other form of treatment is offered. In order to minimise the possibility of undergoing unnecessary surgery in these circumstances, you will undergo several investigations to find out if this spread has happened. These ‘tests’ are called "staging" investigations. They are not individually 100% accurate, but when all are completed, the accuracy of diagnosing the presence of secondary spread is around 90%.

Not everyone will have all of the staging investigations. Some patients will decide they do not wish to undergo surgery, whilst others may have other medical problems such as heart or lung disease which would make surgery and anaesthesia too risky to contemplate. If secondary spread is picked up on the first staging investigation, you will not be asked to undergo further staging tests: a variety of non-surgical methods of treatment will then be discussed with you.

- **Gastroscopy (Endoscopy)** – In this investigation under sedation or local anaesthetic (throat spray), the doctor will look down your oesophagus, into your stomach and perhaps take a small piece (biopsy) to send to the laboratory. This may have been performed before your admission to the Royal Berkshire Hospital.
- **Endoscopic ultrasound (EUS)** – This test is carried out in a similar way to the endoscopy. A scope with an ultrasound probe on the end is used to estimate the depth of your tumour through the oesophageal wall, using sound waves. It is also used to assess the spread of tumour into local nodes and nearby structures. You may find you have a sore throat after the procedure. It takes about half an hour.
- **CT scan** – This is a series of special x-rays which view the body in thin slices. It involves you lying on a table, which slowly passes through a circular machine (like going through the hole of a mint!). The test takes a few minutes to set up and then the scan lasts about 2-5 minutes.

- **PET scan** – This scan is similar to a CT scan. You will be given an injection of special glucose which passes in to rapidly dividing cells (tumour cells). When the scan is taken any areas of disease spread and the primary cancer will show up on the scan pictures. This test is performed in Oxford. You will be contacted directly by them with the appointment and more details will be given at this time.
- **Cardiopulmonary exercise (Cpex) test** – This test is a basic fitness assessment. You will be asked to cycle on a type of exercise bicycle whilst machines monitor your heart and breathing.The results of the test give the anaesthetist an accurate assessment of how well your heart and lungs work allowing them to predict more accurately the risk of surgery.
- **Barium swallow** – This is a series of x-rays taken when you swallow some fluid, which will show up on the x-ray film. This allows us to see the part of the oesophagus or stomach which has become involved in the disease. **This test also allows us to see if your stomach is emptying correctly.** Some patients find the fluid they are given to drink unpleasant but the amount drunk is small. This test takes about half an hour.
- **Ultrasound scan** – This test is completely painless. A listening probe and gel is applied to your abdomen (tummy) so the liver can be seen clearly. Pregnant women have a similar test (scan) to look at the unborn baby. The reason for this test is to show if the disease (cancer) has spread to the liver. The scan takes about 20 minutes.
- **Laparoscopy** – A look inside the abdomen (tummy) by putting a small camera through one or two holes about ½ inch long. The space around the liver and stomach can be seen. This test is performed under general anaesthetic and shows if the disease (cancer) has spread. This takes about half an hour to perform and you would usually be able to go home on the same day.

What happens next?

Once all your staging investigations are completed, we will discuss them at our "multi-disciplinary team meeting". This is where all the specialist consultants who may be involved with your overall care meet up. Decisions about the treatment that you will be advised to have are made jointly at this meeting. Surgery for gastric cancer is carried out at Churchill Hospital in Oxford so your details will also be discussed at their MDT. If part of your treatment involves surgery the Oxford team will invite you to a clinic appointment with them in Oxford to discuss surgery in more detail.

If all the staging investigations are normal and you wish to have surgical treatment, we may advise you to meet with an oncologist (a specialist in the treatment of cancers using chemotherapy or radiotherapy) prior to having an operation. This is because such treatment may be recommended both before and after an operation and some further tests may be needed to prepare for this. The pros and cons of this treatment will be discussed with you, since not all patients are suitable for post-operative chemotherapy or radiotherapy.

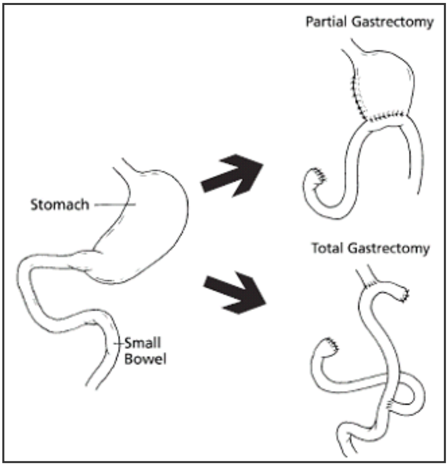
The whole process from diagnosis through staging to the start of treatment may take several weeks. Although this can seem a long time, it is vital for your treatment that proper staging and specialist discussion is undertaken to prevent unnecessary surgery.

Pre-operative chemotherapy

This treatment is given before the operation over a period of 4 - 9 weeks. You will be given two or three courses of strong drugs, either by intravenous injection (directly into the blood) or in tablets for you to take. These may make you feel unwell with nausea (sickness), vomiting and tiredness. The nausea and vomiting will be controlled with strong anti-sickness drugs. Your ability to fight infection may reduce but this returns to normal after the treatment. Occasionally, some people have some hair loss – but if this occurs, a wig can be provided. This treatment is being offered to patients following research, which shows some cancers get smaller after the drugs. In order to have this you must be fit and able to cope with the side effects. More details will be given when you see the specialist chemotherapy doctor (oncologist) at his/her outpatient clinic.

After the surgery the doctors may suggest a further course of chemotherapy. The pros and cons will be discussed with you, as not all patients are suitable for post-operative chemotherapy or radiotherapy (X-ray treatment).

What does the operation involve?



The aim of surgery is to remove the cancerous growth and any tissue next to it that may also involve the cancer, such as local lymph glands. There are a number of ways this can be done and your surgeon will discuss the best approach for you.

In the operation, part or all of the stomach has to be removed, and a loop of the small intestine brought up to be joined to the part of the stomach that remains, or to the lower most part of the gullet (oesophagus). The operation is performed through an incision in the abdominal wall. Sometimes the chest wall also has to be opened.

Some surgeons are now able to use keyhole surgery to perform all or part of the operation, but this is very much dependent on the size and area of the cancer, and the personal preference of your surgeon.

Immediately after the operation you will be cared for on the surgical ward, although some patients (particularly those with heart or lung problems) may require a stay on the intensive care or high dependency unit prior to returning to the ward.

What happens in the early post-operative days?

The first few days after the operation may be spent in the intensive care unit (usually 1-2 nights) and then you will be transferred to a ward. Whilst in these areas you are carefully monitored by the nurses who are always close at hand.

During this time you will have a number of drains/tubes. The first you become aware of is the one that does your breathing for you; it goes through the mouth down the back of the throat into the lungs. When you are warm and stable, this tube is removed to be replaced with an oxygen mask over your nose and mouth to aid your breathing.

Other tubes stay in for up to seven days.

These are:

- **Nasogastric tube** – This goes through the nose into the stomach to keep it empty.
- **Central venous line** – This is a drip into the side of your neck so we can give you fluids because you can’t eat or drink for four or five days. We can also give drugs that you may need through this line.
- **Jejunostomy tube** – A curled tube on the tummy, which goes into the small intestine. We give you a liquid feed through here.
- **Catheter** – This drains the urine so we can know accurately how much you are making. This helps us to decide the amount of fluid to give.
- **Epidural** – This is a very thin plastic tube put into the area around the spine. Drugs are given down this to reduce your pain. It normally stays in place for five days. The anaesthetist will give you more details about this.

At the Churchill Hospital, Oxford there is a Pain Control Team who visit to make sure pain is under control at all times – there is no reason to have pain.

Most of these tubes and drains stay in place for five to seven days. At this time some patients have a barium swallow to check everything is all right. If it is, then you are allowed to drink freely. It is at this stage that these tubes are removed.

During your stay you will receive physiotherapy and dietary advice.

Cancer is a big disease to come to terms with. We can provide specialist advice and the hospital can arrange for someone to talk to you confidentially about how you are feeling. This support can be arranged when you go home as well if you wish.

Are there any risks?

Patients and their relatives are understandably very anxious about the risks of surgery. With today's modern anaesthesia and monitoring, it is extremely unlikely that you will come to harm during your operation.

Some patients have other problems (angina, diabetes, chronic bronchitis, asthma, emphysema or hypertension – high blood pressure). Unfortunately, a combination of these factors is sometimes too much for the body to bear. Occasionally, we run into complications (problems) and sadly there are times when a patient dies.

In order to put this into perspective, in the United Kingdom this operation has a mortality rate of about 10%. These figures may well frighten you but they have to be set against the fact that if nothing is done for your disease then you will probably come to a situation where you are unable to swallow even your own saliva. We feel that the risks are fairly low and we do all in our power to minimise these.

We realise that the information in this booklet may be a little alarming. On the back are numbers to contact if you need further questions answered. When patients have had their first meeting and have read this booklet, we arrange a second meeting with the surgeon to go over any worries.

After the operation there are some short term and longer term problems you may experience

These are:

1. The majority of patients notice a temporary disturbance of their taste. In particular, tea may taste extremely unpleasant. This usually returns to normal after 6 weeks.
2. You are unlikely to be able to eat three large meals a day and you will have to change your diet to take small meals often with snacks in between.
3. Something that may be affected is the feeling of hunger. Within about 5 –7 days of surgery, most patients are eating again. Usually soft food to start with, gradually building up to normal food. It is important to remember as time progresses and your sense of taste returns to normal, you will start to enjoy food again.

This booklet will have hopefully provided some useful information to help with your recovery. If anything is not clear or you still have questions, it may help to write them down and discuss them with the nurses or ourselves at clinic or when you next visit the hospital.

Please write down any questions that you may have below or overleaf.

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Notes and questions:

If English is not the best language for you, may we suggest you talk to Macmillan Cancer Support on 0808 808 00 00 for information in the following languages: Arabic, Bengali, Cantonese, French, Greek, Gujarati, Hindi, Polish, Punjabi, Urdu and Vietnamese.

Interpreters are also available on request.

Support group

Macmillan Cancer Support Tel: 0808 808 00 00
www.macmillan.org.uk

Macmillan Cancer Information Centre Tel: 0118 322 8700
Email: macmillan.information@royalberkshire.nhs.uk

Contact us

Upper GI Specialist Nurse Tel: 0118 322 7748

To find out more about our Trust visit www.royalberkshire.nhs.uk

Please ask if you need this information in another language or format.

Written by Ruth Moxon, RBFT BCC.
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