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Gastric Carcinoma

1. GROSS DESCRIPTION

Specimen

— gastric cancer can present with anaemia, weight loss or dyspeptic symptoms. Investigation is by endoscopy with biopsy. Staging for local and distant disease includes ELUS (endoluminal ultrasound: tumour depth and nodal spread), CT scan chest, abdomen and pelvis, PET scan and peritoneal laparoscopy with cytological washings and biopsy. Non-regional disease is an indicator for palliative treatment including chemotherapy, and surgery if there is anatomical dysfunction, e.g. extensive ulceration and bleeding or gastric outlet obstruction. Curative intent surgery can be localized [e.g. endoscopic mucosal resection (EMR)] or radical, the extent of the latter depending on the patient's age, fitness, tumour type, stage and location.
— cytological brushing, washing or aspirate/biopsy/ partial (proximal or distal) or total gastrectomy/oesophagogastrectomy/lymphadenectomy ± omentectomy.
— length (cm) along greater curvature.
— length (cm) of oesophagus and duodenum.

Tumour

Site

— distal oesophagus/cardia/fundus/corpus/antrum/pylorus/duodenum.
— lesser curve/greater curve.
— anterior/posterior.

Antrum (50%) and lesser curve (15%) are traditionally the most frequent sites. However, the incidence of distal gastric carcinoma is decreasing while that of the proximal stomach and cardia is markedly increasing. This is in part due to eradication of Helicobacter pylori infection and loss of its acid suppression effect and more reflux changes. It presents at a more advanced stage than equivalent-size distal lesions with a worse prognosis and similarities in behaviour to distal oesophageal adenocarcinoma. Adenocarcinomas involving the oesophagogastric junction are TNM staged as either oesophageal (Siewert I: distal oesophagus coming

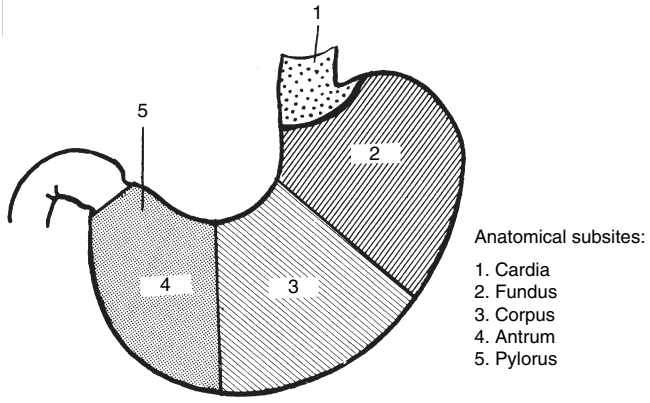

FIGURE 2.1. Stomach.

down) or gastric (Siewert II: junctional, Siewert III: gastric cardia going up).

— multifocal 6%: in particular early gastric cancer and lymphoma.

Size

— length × width × depth (cm) or maximum dimension (cm).

Appearance

— polypoid/plaque/ulcerated/infiltrative/mucoid/linitis plastica/scirrhous/fleshy.

Advanced (muscle invasive) gastric cancer is classified macroscopically according to Borrmann type as:

I polypoid
II fungating
III ulcerated
IV infiltrative.

Types I, II/III and IV tend to correspond to tubulo/papillary, intestinal and signet ring cell (linitis plastica) adenocarcinoma, respectively, although there is overlap between the categories. Polypoid/ulcerated tumours are regarded as being of better prognosis than infiltrative cancers.

Edge

— circumscribed/irregular.

2. HISTOLOGICAL TYPE

An amalgam of the WHO and Lauren* classifications is used