ABSTRACT
THESIS
Epidemiology, FACTORS
RISK, DIAGNOSIS AND TREATMENT ISSUES
In gastric cancer

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INTRODUCTION

Etiology of gastric cancer is unknown. Presence age usually occurs between 40 and 60 years, but there were also cases in a younger age (20 years) and even in children. These latter forms are characterized by rapidly evolving and extreme malignity.

For reasons still unclear, the mortality rate has decreased markedly in the last 60 years. Epidemiological studies have suggested that the risk for gastric cancer is higher in classes with lower socioeconomic level, more immigrants coming from countries with high incidence of gastric cancer, established in countries with low incidence seem to keep increasing susceptibility to gastric cancer, while their offspring is equal to the incidence of new country. These observations suggest that exposure to some environmental factors, which probably begins during early life is correlated with development of gastric cancer, the most likely etiological factors involved is the food.

GENERAL PART

Gastric cancer is one of the most common sites of visceral malignancies. Is found mainly in males, which represents one third of all neoplasms and ranks first in frequency, while the female ranks second after uterine cancer.

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To introduce a comprehensive solution was required documentation with recent data from literature played briefly in the paper overall.

In the second part of the thesis, I worked on personal research and study material consisting of 258 cases of gastric cancer. On these issues we sought to highlight the historical data of possible risk factors for these cancers and to determine their epidemiological profile.

We also pursued aspects of signs and subjective and objective, and examinations and laboratory tests in order to identify a possible clinical picture, pathognomonic for gastric cancer.

Since proximal gastric tumors are more advanced at presentation and worse prognosis than distal cancers, we studied separately two categories of patients.
PARTY SPECIAL
MATERIAL AND METHOD

Material sought was represented by patients hospitalized between 2000-2009, in General Surgery Clinic Emergency Hospital Craiova No.1 clinical diagnosis of gastric cancer.

From clinical observation sheets on specified time we selected a series of clinical data: reasons for hospitalization, medical history, personal history and heredocolaterale clinical examination general clinical examination locally, the results of laboratory tests and protocols operators.

I consulted and included in the analysis results of the laboratory for evaluation of biological status preoperatively. Study of Barite transit images allowed me suspicion of gross morphological characters investigated tumors: infiltrative form with appropriate thickening macroscopic plants and ulcerative form. Diagnostic accuracy afforded by such an inquiry is over 75%. Endoscopic investigation in cases where it was made with high accuracy allowed determination of lesion topography and reveal associated injuries, some of the canals being and etiopathogenic relationship with tumors investigated.

Endoscopic investigation was complemented with tomography, namely the lack of information about the extent of invasion into the structures and the adjacent gastric wall was substituted by CT scan carried out whenever possible. So CT has allowed the process to establish limits tumor, its degree of extension, the possible nature of benign or malignant tumors investigated by way of contrast to capture the substance and the presence of any metastases.

I also studied and data register operator for all patients and performed surgery. We watched and data macroscopioce aspects of tumors and their possible invasion or metastasis. Thus, we recorded data on the dimensions removed tumor formation and its relationship with adjacent anatomical structures, its form, presence or absence of tumor capsule, signs of tumor invasion, tumor consistency and appearance of the surface section.

RESULTS

The results obtained from research material represented by patients diagnosed with gastric cancer and hospitalized in the Surgery Clinic Emergency Hospital Craiova a period of ten years were eloquent.

Correlation of clinical data along with laboratory diagnostic imaging allowed the development of malignant gastric tumor suspected 284 cases and then confirmation of 258 cases of gastric cancer.

Therefore, according to the data rate of malignant tumors is significantly higher than benign 8,16:1 their relationship to the detriment of being benign.

After clinical and imaging data correlate with those obtained by histopathological examination of surgical excision of parts we could determine precisely the type and subtype injuries allegedly from stomach cancer.

Thus, clinical diagnosis supplemented by imaging, laboratory and histology had a maximum accuracy in the precise diagnosis of gastric cancer.

After the WHO histopathological classification of tumors of the gastrointestinal tract 258 253 cases were adenocarcinomas, 4 squamous cell carcinoma cases and
one small cell carcinoma.

In our study we included 253 cases who were diagnosed with adenocarcinoma. Depending on the topographical location of the largest percentage of the pole is held gastric adenocarcinomas with a lower percentage of 71.94% compared to the upper gastric pole which totaled a rate of 28.06%.

In 30 years the majority of gastric adenocarcinomas in the U.S. belong to the distal stomach with a continuous downward trend until the 80's. Since 1976, according to data from The surveillance, epidemiology and end results was a greater number of patients with gastric adenocarcinoma of the upper pole while gastric adenocarcinomas of the lower pole remained unchanged in number. From here you can suggest that adenocarcinomas of the upper gastric pole may have a common pathogenesis but with some nuances to gastric adenocarcinomas of the lower pole.

There are relatively recent reports showing an incidence of adenocarcinomas of the upper gastric pole especially in males in northern Europe, North America, China, United Kingdom. Unlike gastric cancer pole below the upper gastric pole is encountered in a population with high socioeconomic level. (Hund SA et al., 2000)

The distribution of 253 cases of adenocarcinoma according to age and disease, taking into account the location process showed that gastric adenocarcinoma of the upper gastric pole occurs ten years earlier It is known that gastric malignancies are multifactorial diseases determinism; marcantele geographical variations, trends change over time and the effect of migration on the incidence of gastric cancer suggests that environmental factors and life plays an important role in the etiology of this disease. (Nomura A, 1996)

Helicobacter pylori infection, gram-negative bacillus is the most common chronic bacterial infection worldwide (Marshall and Warren -1984). Countries with the highest rate of gastric cancer have a high prevalence of atypical and Helicobacter pylori infection and reduce the incidence of these infections recorded in developed countries has reduced the incidence of parallel and gastric cancer (Parsonnet -1995). For example, in U.S., H. pylori infection is less than 20% at 20 years and increase to 50% at 50 years (Dooley - 1989), while in Japan within 20 years is below 20% but more than 40 years the incidence increased to 80% (Asaka - 1992). The prevalence of this infection is closely linked to socioeconomic factors such as reduced medical addressability, low education, poor living conditions especially during childhood. (Goodman and Correa -2000; Kurosava M and collaborators in 2000). The association between chronic infection with Helicobacter pylori and gastric cancer is well known. Helicobacter pylori infection is associated with an increased risk of severe atrophic gastritis and distal gastric cancer (Huang et al. - 2003 and Parsonnet and colab.-1997). Thus, the meta prospective cohort studies, Helicabacter pylori infection was associated with risk of developing cancers noncardiale, but not the cardiale (Helicobacter and Cancer Collaborative Group - 2001). Other studies have demonstrated a rather close association between H pylori infection and development of adenocarcinomas cardiale (Chow WH, 1998, Hansen and colab.-1999). There is evidence that consumption of salted food-nitroso compounds and derivatives, and reduced consumption of fresh fruits and vegetables increases the risk of cancer gatric.

Gastritis caused by H pylori bacteria nitrosated facilitate growth, which catalyzes the production of compounds nitrozoaminici (Sânduleanu and colab.-2001). In animal models demonstrated that salt intake can cause gastritis and potentiates the gastric carcinogens (Takahashi M-1985 colab.). Numerous case-control studies have shown
that increased consumption of salt and foods preserved by salting is associated with an increased risk of gastric cancer (Hirohata Kano S and T -1996, Kim HJ et al. - 2002. Lee HS et al. - World Cancer Research Fund 2003 - 1997). The prospective study showed a significant and dose-dependent relationship between smoking and gastric cancer, smoking is more profound effect for distal cancers (Gonzalez et al., 2003, Koizumi Y et al., 2004).

Obesity is the main risk for cardial adenocarcinoma (Chow WH et al., 1998). Obesity may promote gastroesophageal reflux disease which predisposes to Barrett's esophagus, a precursor to esophageal adenocarcinoma and squamous metaplasia of the gastroesophageal junction. (Ishaq S. Jankowski JA, 2001). A study showed that Swedish developer obezii 2.3 times more frequently than the rest of the population.cardial adenocarcinoma (Lagergren J. et al., 1999).

Other risk factors for gastric cancer are family history of gastric cancer - extremely important factor, blood group A (previous surgery for benign diseases).

Of clinical data obtained from history and analysis in the chart below shows that the most common symptom of patients with gastric adenocarcinoma accused was abdominal pain felt in most cases, it is with weight loss and the The third place is anorexia.

I recorded the location of injuries reported greater frequency of dysphagia 14.62% in gastric adenocarcinomas of the upper pole, while the distal location of the most frequently recorded symptom was weight loss 32%, followed by pain by 30.83% and anorexia with 24.11%. Gastric carcinomas of higher specific pole was a presentation to the doctor every 6 to 12 months shorter as 9.88% of adenocarcinomas had a presentation to the doctor every 2-6 months between 14.62% and between 6 - 12 months. Also, patients who presented within six months with adenocarcinoma of upper gastric pole were 2.78 times more than those with gastric adenocarcinoma of the lower pole.

Data from literature indicates that it is completely non-specific clinical symptoms and is only suggestive manner of presentation, development of train general association with digestive symptoms or occurrence of complications suggestive of cancer (T. Ciurea et al., 2003, Angelescu N., 2003).

In terms of establishing diagnostic possibilities can be considered as the disease progresses in two stages: asymptomatic stage (absolute latency) and symptomatic stage.

Asymptomatic stage can last between 6-12 months, and after some authors even longer. Diagnosis at this stage arises by chance, when medical investigations systematic detection of cancer in situ, pathological, not to exceed mucosa muscle.

Symptomatic stage is characterized by the appearance of symptoms varied, with some nuances, however, particular in relation to established process, with the effect that the fornixului solitary. During clinical appearance of the first accused in the so-called relative latency phase, patients have discrete dyspeptic disorders, abdominal discomfort after meals, the fullness or mild epigastric discomfort, early satiety by, belching, nausea, heartburn, all making Savitski syndrome. Although uncharacteristic, these symptoms become significant through their persistence and slow, gradual progress, especially in people with risk factors or precancerous lesions.

Predisfagică stage is characterized by symptoms varied in discrete oesophageal embarrassment or retroxifoidiană during swallowing, with petulance, appearing and disappearing suddenly, representing expression also shows esofagocardial spasm. Sometimes, after meal fullness occurs, the pressure in the upper epigastric and
retrosternal, accompanied by painful heartburn or belching. Sialoreea fetiditatea smell and must be warning signs.

Phase dysphagia is often a late stage in the upper pole gastric cancer. Diagnostic value of dysphagia vary based report process. Thus, dysphagia may be the cancer cases or cardiale juxtacardiale a good sign, by setting up more quickly than in other sites of cancer tuberozitar. Tuberozitar cancer that start at some distance from the cardia has predisfagică development period much longer, the events are usually dyspeptic or general type, with cardial cancer, found mainly dysphagia events. Cardiei invasion triggered by mechanical dysphagia and lumen narrowing dysphagia must be distinguished from reflex spasm expression of a cardial. Dysphagia reflex is paradoxical and capricious unlike mechanical toughness and translated by progressive worsening.

Dysphagia is the main symptom in almost half the cases investigated, it translates into food intake blocking sensation, dysphagia is initially daily and passenger in nature, easily disappear leading to a false peace of the patient. Sometimes it manifests itself as a violent pain, burning or sustainable. During clinically manifest upper gastric cancer pole has some peculiarities in relation to the location process: adenocarcinoma with cardială location at the junction has developed symptoms that installs quickly, compared with cardiei functional disorder.

The main symptoms in this location are in order: dysphagia and pain, dysphagia can be capricious and transient, occurring at intervals after ingestion of liquids or paradoxical as the expression esofagocardial reflex spasm induced by disease, process. Dysphagia reflex can be brutal and to not give the spasmolytic medication, dysphagia reflect subsequent mechanical barrier became permanent. According to some authors warning signs that could lead quickly to targeted investigations in order of frequency are: progressive dysphagia, epigastric pain, dysphagia brutal, dyspeptic disorders, melaena, haematemesis, progressive asthenia, vomiting, anorexia and weight loss. However, they noted that since their appearance diagnostic alarm to last at least six months. Epigastric pain is located, is postprandial and takes various aspects: the sense of touch to pain, pain is increasing steadily and no fixed timetable.

CONCLUSIONS.

Following this study, we found that:

1. Gastric tumor diseases are dominated by malignant pathology, malignant tumors being 8.16 times larger than benign.
2. Malignant lesions at this level are particularly dominant in the distal zone 46.97% 34.43% 18.62% in average and third in the upper pole.
3. In terms of gender distribution of men are affected more than twice; Urban population is also less affected compared to the rural also increased incidence
in those who consume alcohol and smoke.

4. Patients who developed a distal location had a peak incidence in the decade 61-70 years while in patients with proximal location within the maximum was 10 years earlier.

5. Physical examination revealed that patients with proximal location of the dominant symptom was pain followed by dysphagia, and distal location dominated weight loss followed by pain and anorexia.

6. Imaging examinations revealed the prevalence of radiological issues incomplete picture of the location of proximal and segmental stiffness for the distal location, also dominated in both sites endoscopic vegetant diffuse infiltrative forms.

7. Histopathologic most frequent form was the gut after Laurens classification, and in terms of degree of differentiation was found predominance of well differentiated form.

8. Direct invasion of gastric wall structure, vascular and limfoganglionară was greater in proximal to the distal location.

9. Postoperative staging showed that both locales are found in advanced stages as

10. The objective was a curative treatment in cases with localized disease and palliation in patients with advanced disease.