Le lesioni neoplastiche iniziali dello stomaco

H. Pernthaler

Merano
Istopathologia

- Adenocarcinoma
- GIST
- Carcinoide
Adenocarcinoma

• nessun RCT Gastrectomia vs EMR – ESR
• outcome simile
• costi ca
  2000€ EMR
  vs ca
  4000€ gastrectomia
• Gastrointest Endosc. 2011;73(5):942. Choi KS et al
early gastric cancer, gastrectomia

- 98% 5 year survival rate (304 paz. no cancer related mortality)
  

- 3% delayed gastric emting/leaks/abscesses
Postoperative Outcomes and Complications After Laparoscopy-assisted Pylorus-preserving Gastrectomy for Early Gastric Cancer

Jiang, Xiaohua MD, PhD*,†; Hiki, Naoki MD, PhD*; Nunobe, Souya MD, PhD*; Fukunaga, Tetsu MD, PhD*; Kumagai, Koshi MD*; Nohara, Kyoko MD*; Sano, Takeshi MD, PhD; Yamaguchi, Toshiharu MD, PhD*

January 2005 to December 2009, 307 patients

gastric stasis, 19 patients (6.2%). Body mass index (BMI) and surgical experience of LAPPG were identified as significant risk factors of postoperative complications.
FIGURE 1

Postoperative Outcomes and Complications After Laparoscopy-assisted Pylorus-preserving Gastrectomy for Early Gastric Cancer.
Jiang, Xiaohua; MD, PhD; Hiki, Naoki; MD, PhD; Nunobe, Souya; MD, PhD; Fukunaga, Tetsu; MD, PhD; Kumagai, Koshi; Nohara, Kyoko; Sano, Takeshi; MD, PhD; Yamaguchi, Toshiharu; MD, PhD
DOI: 10.1097/SLA.0b013e3182117b24

FIGURE 1. Length of hospital stay related to the grades of postoperative complications. Error bars represent the standard deviation of the mean.
Lymph nodes from stations 1 (right cardia), 3 (lesser curvature), 4sb (left gastroepiploic artery), 4d (right gastroepiploic artery), and 6 (infrapyloric) were excised; this was defined as D1 lymphadenectomy. D1 + [alpha] lymphadenectomy also involved station 7 (left gastric artery), whereas D1 + [beta] involved stations 7, 8a (anterosuperior group of common hepatic artery), and 9 (celiac artery), and D1 + [beta] + 11p involved stations 7, 8a, 9, and 11p (proximal splenic artery). The lymph nodes at station 5 (suprapyloric) were routinely left intact. Infrapyloric vessels were routinely preserved to maintain sufficient blood supply to the pyloric cuff, and the root of the right gastric artery was preserved and transected just distally to the first branch. The hepatic and pyloric branches of the vagus nerves were routinely preserved, and the celiac branch of the vagus nerve was preserved if possible.
### TABLE 2. Comparison of Patients Characteristics

<table>
<thead>
<tr>
<th>Variables</th>
<th>LADG Group (n = 82)</th>
<th>ODG Group (n = 82)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td>0.425</td>
</tr>
<tr>
<td>Male</td>
<td>47</td>
<td>52</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>35</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Mean age (range), (yr)</td>
<td>56.7 (35–80)</td>
<td>54.5 (28–78)</td>
<td>0.155</td>
</tr>
<tr>
<td>Mean body weight ± SD (kg)</td>
<td>64.6 ± 10.2</td>
<td>64.6 ± 11.2</td>
<td>0.996</td>
</tr>
<tr>
<td>Mean height ± SD (cm)</td>
<td>162.5 ± 8.5</td>
<td>165.0 ± 8.8</td>
<td>0.996</td>
</tr>
<tr>
<td>Mean BMI ± SD (kg/m²)</td>
<td>24.4 ± 2.9</td>
<td>24.3 ± 3.0</td>
<td>0.903</td>
</tr>
<tr>
<td>Mean AC ± SD (cm)</td>
<td>83.8 ± 8.4</td>
<td>83.9 ± 8.8</td>
<td>0.896</td>
</tr>
<tr>
<td>Pathologic stage</td>
<td></td>
<td></td>
<td>0.967</td>
</tr>
<tr>
<td>IA/IB</td>
<td>69/11</td>
<td>69/9</td>
<td></td>
</tr>
<tr>
<td>II/IIIIB</td>
<td>2/0</td>
<td>3/1</td>
<td></td>
</tr>
</tbody>
</table>

BMI indicates body mass index; AC, abdominal circumference.
Improved Quality of Life Outcomes After Laparoscopy-Assisted Distal Gastrectomy for Early Gastric Cancer: Results of a Prospective Randomized Clinical Trial

Kim, Young-Woo MD, PhD*†; Baik, Yong Hae MD, PhD†**; Yun, Young Ho MD, PhD‡; Nam, Byung Ho PhD§; Kim, Dae Hyun MD, PhD¶; Choi, Il Ju MD, PhD*†; Bae, Jae-Moon MD, PhD*†‡

Conclusions: Comparison of LADG to ODG in patients with early gastric cancer resulted in improved QOL outcomes
FIGURE 2. Mean change (+/-SD) of QOL by ST-22 from baseline (actual score - baseline score) according to treatment group (y-axis) at assessments 7, 30 and 90 days after surgery (x-axis). Deterioration is indicated by positive values, and improvement is indicated by negative values (* means <0.05, + means <0.01, ++ means <0.0001).
GIST guidelines (NCCN, ESMO)

- resezione completa (R0)
- risparmio della parte non interessata
- escissione completa della parete
- non dissezione linfonodale
- biopsia in caso di possibile cambiamento di strategia
Consensus meeting for the management of gastrointestinal stromal tumors

Report of the GIST Consensus Conference of 20–21 March 2004, under the auspices of ESMO


*Correspondence to: Dr J.-Y. Blay, Unité INSERM 590, Centre Léon Bérard, 69008 Lyon and Hospital Edouard Herriot, Place d’Arsonval, 69003 Lyon, France. Tel: +33 4 78 78 51 99; Fax: +33 4 78 78 27 14; Email: blay@lyon.fnaces & cend; Email: Blay.Jean.Yves@hle.ulyon.fr.
GIST, indicazione per chirurgia laparoscopica

- NCCN tumori < 2 cm
- diametro 2-5 cm R0 resezione senza lesione di capsula; l’indice mitotico è correlato con recidiva
  Nakamori, 2008 Am J Surg in press
- Hand assisted per tumori > 5 cm
<table>
<thead>
<tr>
<th>Patient/Tumor Characteristics</th>
<th>No Recurrence (n = 46)</th>
<th>Recurrence (n = 4)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (yr)</td>
<td>61</td>
<td>60</td>
<td>NS</td>
</tr>
<tr>
<td>Tumor size (cm)</td>
<td>4.2</td>
<td>7.0</td>
<td>0.02</td>
</tr>
<tr>
<td>MI</td>
<td>3.4</td>
<td>22.5</td>
<td>0.003</td>
</tr>
<tr>
<td>CD117+ [n (%)]</td>
<td>35 (77%)</td>
<td>4 (100%)</td>
<td>NS</td>
</tr>
<tr>
<td>CD34+ [n (%)]</td>
<td>36 (78%)</td>
<td>4 (100%)</td>
<td>NS</td>
</tr>
<tr>
<td>Ulceration [n (%)]</td>
<td>7 (16%)</td>
<td>4 (100%)</td>
<td>0.0001</td>
</tr>
<tr>
<td>Necrosis [n (%)]</td>
<td>7 (16%)</td>
<td>4 (100%)</td>
<td>0.0001</td>
</tr>
</tbody>
</table>

NS indicates not significant; MI, mitotic index (number of mitosis per 50 high power fields).
carcinoid

• Type 1, associato a gastrite atrofica
• Type 2, associato a gastrinoma duodenale o gastrico controlli, chirurgia non indicata
• Type 3, carcinoide sporadico, tumore agressivo con 65% probabilità di metastasi
conclusione

- La classificazione precisa delle lesioni iniziali dello stomaco è fondamentale per poter indicare la terapia più opportuna.
- L’asportazione adeguata delle lesioni è fondamentale per poter garantire la prognosi favorevole con chirurgia radicale.
- Le metodiche chiurgiche meno invasive offrono ai pazienti una qualità di vita migliore confrontate con quelle convenzionali.