ITGGC 2022

University of Health Sciences Turkey, İzmir Faculty of Medicine Scientific Meetings-27











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Ege University, Ataturk Cultural Center - IZMIR

ABSTRACT BOOK





> 14-16 October 2022

ÍTGCC 2022



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Gastroe Surgery Society

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INVITATION

Dear Colleagues,

Gastric cancer continues to be an important public health problem in the world and in our country. Although there are many different treatment approaches such as adjuvant and neoadjuvant chemotherapy, radiotherapy, and targeted therapies, surgical treatment is the most important cornerstone. On the other hand, it is an indispensible need to clarify the treatment of gastric cancer cases after being discussed in multidisciplinary oncology councils.

We are organizing the 1st International Turkish Gastric Cancer Congress in Izmir to provide an innovative and comprehensive overview of the latest developments in the treatment of gastric cancer, which concerns such a wide and diverse group of physicians. This time, we aim to take the Gastric Cancer Symposiums which we have organized in previous years to higher scientific level and to create a unique platform for all of us.

At the congress that we are planning to hold on October 14-16, 2022, many speakers who are interested in the treatment of gastric cancer in our country, as well as scientists who are authors in their field and well-known all over the world, will share their knowledge and experiences with us. Mitsuru SASAKO from Japan will also contribute to us scientifically, as in previous years.

The 1st International Turkish Gastric Cancer Congress will be held with the cooperation of University of Health Sciences Turkey, İzmir Faculty of Medicine which was established in 2020 and Ege University Faculty of Medicine. Turkish Surgical Society, Surgical Oncology Association, Gastroenterology Surgery Association and Aegean Region Surgery Association will also support our congress.

As we are coming to the end of the Covid-19 pandemic, we are very happy to invite you to İzmir, the pearl of the Aegean, with the excitement of meeting face to face again.

Prof. Dr. Enver İLHAN Congress Co-Chair Dean of University of Health Sciences Turkey, İzmir Faculty of Medicine Department of General Surgery Prof. Dr. Sinan ERSİN Congress Co-Chair Ege University Faculty of Medicine Department of General Surgery





COMMITTEES

Ege University, Ataturk Cultural Center - IZMIR

Honorary Presidents of the Congress

Hikmet AKGÜL Musa AKOĞLU Salim DEMİRCİ Adem GÜLER Özdemir YARARBAŞ

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Scientific Committee

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Presenter Students

Aylin Akın Simay Güney Doğa Eylül Erbey Zeynep Yavuz İrem Çoban Nuran Çoban Elif Sude Keskin Ece Töre Yaren Yılmaz Melsa Seçkin

* The Scientific Committee is listed alphabetically according to the surname.





SCIENTIFIC PROGRAM

October 14, 2022 Friday

13:00-13:50 Session 1: Genetic and Pathological Features in Gastric Cancer Moderators: Dr. Hikmet Akgül, Dr. Taha Reşid Özdemir

13:00-13:20 Immunology and Genetics of Gastric Cancer, *Dr. Füsun Özmen* 13:20-13:40 Pathological and Molecular Classifications, *Dr. Murat Sezak* 13:40-13:50 Discussion

13:50-15:00 Session 2: Diagnosis and Clinical Staging in Gastric Cancer (PANEL) Moderators: Dr. Musa Akoğlu, Dr. Serhat Bor

Public Health, **Dr. Mustafa Necmi İlhan** Gastroenterology, **Dr. Fatih Tekin** Radiology, **Dr. Hilal Şahin** Nuclear Medicine, **Dr. Ülkem Yararbaş** General Surgery, **Dr. Cüneyt Kayaalp** 14:50-15:00 Q&A

15:00-15:20 Coffee Break

15:20-16:40 Session 3: Patient Management in Early Gastric Cancer (PANEL) Moderators: Dr. Koray Atila, Dr. Işıl Somalı

General Surgery, **Dr. Serhan Derici** Medical Oncology, **Dr. Tuğba Ünek** Radiation Oncology, **Dr. Mihriban Erdoğan** 16:30-16:40 Discussion

16:40-18:00 Session 4: Oral Presentations-1 Moderators: Dr. Fikret Ezberci, Dr. Osman Yüksel

October 15, 2022 Saturday

07:30-08:45 Session 5: Oral Presentations-2 Moderators: Dr. Hasan Kaplan, Dr. Ali Güner

09:00-09:30 Opening Session

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09:30-10:40 Session 6: Epidemiology, Etiology, Screening and Early Diagnosis Moderators: Dr. Sultan Eser, Dr. Fatma Tatar

09:30-09:50 Gastric Cancer in the World and in Turkey, *Dr. Sultan Eser* 09:50-10:10 Prevention of Gastric Cancer, *Dr. Jin Young Park (France)* 10:10-10:30 Screening and Early Diagnosis in Gastric Cancer, *Dr. Partha Basu (France)* 10:30-10:40 Discussion

10:40-10:50 Coffee Break

10:50-12:15 Session 7: Gastric Cancer in Japan - Immunotherapy in Gastric Cancer Moderator: *Dr. Salim Demirci*

10:50-11:40 History of Gastric Cancer Treatment in Japan for 50 years : Global Review, Clinical Trials and Future Perspective, *Dr. Mitsuru Sasako (Japan)*11:40-12:00 Immunotherapy in Gastric Cancer, *Dr. Kohei Shitara (Japan)*12:00-12:15 Discussion
12:15-12:30 The Art of Scientific Communication - How to Present, *Dr. Vinay K. Kapoor (India)*

12:30-13:15 Lunch Break

12:30-13:00 Breakout Session Moderators: Dr. Kemal Erdinç Kamer, Dr. Bahri Çakabay

Pressurized Intraperitoneal Aerosol Chemotherapy (PIPAC), Dr. Taylan Özgür Sezer

13:15-14:10 Session 8: Neoadjuvant Therapy Moderators: Dr. Serdar Özkök, Dr. Mustafa Değirmenci

13:15-13:30 Current Approaches in Neoadjuvant Therapy, *Dr. Mutlu Doğan*13:30-13:45 Radiotherapy to Whom? How?, *Dr. Fatma Sert*13:45-14:00 Regression Assessment After Neoadjuvant Therapy, *Dr. Başak Doğanavşargil*14:00-14:10 Discussion

14:10-15:40 Session 9: Surgical Techniques in Gastric Cancers (with Videos) Moderators: Dr. Özdemir Yararbaş, Dr. Osman Yüksel

14:10-14:30 Gastrectomy: to Whom? How? (Subtotal, Total, Proximal, Pylorus Preserving Protector), **Dr. Orçun** Yalav 14:30-14:50 D2 Lymph Node Dissection: to Whom? How?, **Dr. Ali Güner** 14:50-15:10 Combined Resections (Splenectomy, Distal Esophagus, Distal Pancreas Resection, Omentectomy?), **Dr. Osman Yüksel** 15:10-15:20 Discussion

15:20-15:40 Poster Presentations Moderator: Dr. Orhan Üreyen





15:40-15:50 Coffee Break

15:50-17:00 Session 10: Study Results of Gastric Cancer Moderators: Dr. Sinan Ersin, Dr. Adam Uslu

15:50-16:05 GASTROS Study: A Core Out Come Set for Surgical Trials in Gastric Cancer, **Dr. Bilal Alkhaffaf (England)** 16:05-16:10 Discussion 16:10-16:50 Superextented Lymphadenectomy in Gastric Cancer Surgery, Italy Results, **Dr. Franco Roviello (Italy)** 16:50-17:00 Discussion

17:00-17:45 Session 11: Gastroesophageal Junction Tumors Moderator: *Dr. Bülent Karabulut*

17:00-17:30 Treatment Strategies of Esophagogastric Junction Tumors, *Dr. Maria Bencivenga (Italy)* 17:30-17:45 Discussion

October 16, 2022 Sunday

08:00-09:00 Session 12: Let's Discuss with the Cases Moderators: Dr. Evren Durak, Dr. Orçun Yalav

Case-1 (Gastric Cancer), *Dr. Abdullah Şenlikçi* Case-2 (EGJ Tumor), *Dr. Orhan Üreyen*

Panelists

Dr. Nidal Iflazoğlu Dr. Zehra Hilal Adıbelli Dr. Ömer Burçak Binicier Dr. Nuriye Yıldırım Özdemir Dr. Mihriban Erdoğan Dr. Murat Sezak

09:00-10:10 Session 13: How I do it? Moderators: Dr. Enver İlhan, Dr. Birol Bostancı, Dr. Hasan Bektaş

09:00-09:15 Open Surgery, **Dr. Ali Alemdar** 09:15-09:30 Laparoscopic Surgery, **Dr. Ayşe Gizem Ünal** 09:30-09:45 Robotic Surgery, **Dr. Erol Pişkin** 09:45-10:10 Discussion TGCGZ





10:10-11:30 Session 14: Anastomosis Techniques and Complications and Learning Curve Moderators: *Dr. Mehmet Yıldırım, Dr. Haldun Kar*

10:10-10:30 Anastomosis Techniques, *Dr. Yavuz Albayrak*10:30-10:50 Pre-Operative Complications and Management, *Dr. Özgür Fırat*10:50-11:10 Post-Operative (Early and Late) Complications and Management, *Dr. Erman Aytaç*11:10-11:20 Learning Curve in Gastric Cancer, *Dr. M. Akif Üstüner*11:20-11:30 Discussion

11:30-11:40 Coffee Break

11:40-12:50 Session 15: Management of Patients with Metastatic Gastric Cancer Moderators: Dr. Ömer Faruk Özkan, Dr. Aziz Karaoğlu

11:40-12:00 Systemic Treatment Approach, *Dr. Burçak Karaca* 12:00-12:20 Conversion Surgery, *Dr. Bahri Çakabay* 12:20-12:40 Cytoreductive Therapy, *Dr. Kürşat Karadayı* 12:40-12:50 Discussion

12:50-13:40 Lunch Break

13:40-14:30 Session 16: Approach to Neuroendocrine and Gastrointestinal Stromal Tumors of the Stomach (PANEL) Moderators: *Dr. Asuman Argon, Dr. Erkan Oymacı*

Medical Oncology, **Dr. Özgür Tanrıverdi** General Surgery, **Dr. Ebru Esen** Gastroenterology, **Dr. Gözde Derviş Hakim** Radiology, **Dr. Mahmut Öksüzler** Pathology, **Dr. Dudu Solakoğlu Kahraman** 14:20-14:30 Discussion

14:30-15:55 Session 17: Nutritional Status and Patient Management in the Terminal Period Moderators: Dr. Fevzi Cengiz, Dr. Ahmet Deniz Uçar

14:30-14:45 Nutrition and Eras Protocol in Patient with Gastric Cancer, *Dr. Halil Özgüç* 14:45-15:00 Palliative Radiotherapy: to Whom? How? When?, *Dr. Berna Yıldırım* 15:00-15:15 Palliative Surgery, *Dr. Abdullah Böyük* 15:15-15:30 Patient Care in the Terminal Period, *Dr. Aslı Bayındır* 15:30-15:45 Management of Chemotherapy Side Effects, *Dr. Özlem Özdemir* 15:45-15:55 Discussion

15:55-17:00 Session 18: Oral Presentations-3 Moderators: Dr. Savaş Yakan, Dr. Bülent Çalık

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17:00-17:35 Session 19: Organ Transplantation Panel Moderators: Dr. Erdinç Kamer, Dr. Cengiz Aydın

16:25-16:40 Organ Transplantation from Cadaver, Problems and Solution Suggestions, *Dr. Adam Uslu* 16:40-16:55 Immunosuppression Treatment Management in Kidney Transplantation and Innovations in Treatment, *Dr. Erhan Tatar* 16:55-17:00 Discussion

17:35-17:50 Session 20: Rational Drug Use Moderator: *Dr. Cengiz Ceylan*

Rational Drug Use, Dr. Özden Yıldırım Akan

17:50-18:30 Closing Session





ORAL ABSTRACT SESSIONS

14 October 2022, Friday I. Oral Abstract Session 16:40-18:00 (UTC +3) Moderators: *Dr. Fikret Ezberci, Dr. Osman Yüksel*

OP1- SURGICAL AND PATHOLOGICAL OUTCOMES IN PATIENTS WITH A CDH-1 MUTATION UNDERGOING TOTAL GASTRECTOMY: A SYSTEMATIC REVIEW - <u>Atousa KHIABANY</u>, Sivesh KAMARAJAH, Meisien LIEW, Ewen GRIFFITHS

OP2- RISK COFACTORS FOR GASTRIC CANCER IN PATIENTS WITH LYNCH SYNDROME - José Pedro VİEİRA DE SOUSA, Ana OLIVEIRA, Miguel ALMEIDA, Fabiana SOUSA, Manuela BAPTISTA, José BARBOSA, Elisabete BARBOSA

OP3- OUR LAPAROSCOPIC GASTRIC CANCER EXPERIENCE IN TURKEY PERIPHERAL HOSPITAL - <u>*Ertugrul Gazi*</u> <u>*ALKURT*</u>

OP4- OUR EXPERIENCES AND RESULTS OF STOMACH CANCER SURGERY AT THE NEWLY ESTABLISHED 3rd STAGE BURSA STATE HOSPITAL - <u>Direnc YIGIT</u>

OP5- CLINICOPATHOLOGICAL FEATURES AND SURGICAL RESULTS IN PATIENTS WITH STOMACH CANCER APPLIED TO ROBOTIC SURGERY - *Sercan YUKSEL, Ismail CALIKOGLU, Yasin NALBANTLAR, <u>Hasan BEKTAS</u>*

OP6- WITH THE EXPANDATION OF ENDOSCOPY AND IMAGING METHODS INCREASED DETECTION RATE OF GIST AND MANAGEMENT - *Adil KOYUNCU, Serife Seniha FINCANOGLU*

OP7- EVALUATION OF FACTORS RELATED TO CLAVIEN - DINDO 3 AND ABOVE COMPLICATIONS IN PATIENTS UNDERGOING GASTRECTOMY DUE TO GASTRIC CANCER - **Orcun YALAV**, Ugur TOPAL, Ismail Cem ERAY, Cem Kaan PARSAK

OP8- OUR EXAMINATION RESULTS WITH UPPER GASTROINTESTINAL SYSTEM ENDOSCOPY OF THE STOMACH AND DUODENUM - <u>Habip SARI</u>, Serdar GUMUS

OP9- INCREASED AVERAGE THROMBOCYTE VOLUME, AN INFLAMMATORY HEMATOLOGICAL MARKER CAN IT PREDICT LYMPH NODE METASTASIS IN STOMACH CANCER? - <u>Kaan HUSEMOGLU</u>, Adil KOYUNCU

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15 October 2022, Saturday II. Oral Abstract Session 07:30-08:45 (UTC +3) Moderators: *Dr. Hasan Kaplan, Dr. Ali Güner*

OP10- TECHNICAL DETAILS AND SHORT-TERM OUTCOMES OF BILLROTH-I GASTRODUODENOSTOMY: WESTERN EXPERIENCE - *Mehmet ULUSAHIN, Arif Burak CEKIC, Murat Emre REIS, Kayahan EYUBOGLU, Adnan GUNDOGDU, Mehmet Arif USTA, <u>Ali GUNER</u>*

OP11- OUR ERAS RESULTS IN STOMACH CANCER SURGERY IN SURGICAL ONCOLOGY CLINIC - <u>Pirilti OZCAN</u>, Murat KALIN, Ozgul DUZGUN, Omer Faruk OZKAN

OP12- OUR INITIAL EXPERIENCE IN ONCOLOGIC LAPAROSCOPIC GASTRIC SURGERY - *Mehmet Akif USTUNER, Dogukan DURAK, Oguzhan Fatih AY*

OP13- BRAIN METASTASIS FROM GASTRIC ADENOCARCINOMA: A LARGE COMPREHENSIVE POPULATION-BASED COHORT STUDY ON RISK FACTORS AND PROGNOSIS - *Lei HUANG*

OP14- CHARACTERISTICS AND IN-HOSPITAL OUTCOMES OF GASTRIC CANCER PATIENTS WHO ARE ≥65 YEARS IN A TOP-RANKED HOSPITAL IN CHINA, 2016-2020 - *Lei HUANG*

OP15- OUR FIRST PIPAC EXPERIENCE IN AZERBAIJAN USING STANDARDIZED TECHNIQUE WITH THE TOPOL® NEBULIZER DEVICE - *Emin BAYRAMOV*

OP16- PROGNOSTIC SIGNIFICANCE OF METASTATIC LYMPH NODE RATIO IN GASTRIC CANCER: A SINGLE-CENTER ANALYSIS - *Muhammer ERGENC, <u>Ece Elif HEKIMOGLU</u>, Tevfik Kıvılcım UPRAK*

OP17- RESEARCH PROTOCOL: COMPARISON OF PERIOPERATIVE CHEMOTHERAPY AND SURGERY WITH ADJUVANT THERAPY FOR LOCALLY ADVANCED GASTRIC CANCER - *Roman IZRAILOV*, *Danila* <u>MATVECHUK</u>, Nikolay SEMENOV, Oleg VASNEV

OP18- THE EFFECT OF NEOADJUVANT TREATMENT ON SURVIVAL OF STGAE II-III GASTRIC CANCER, <u>Mehmet</u> <u>Güray DUMAN</u>, Ali ALEMDAR, Cemal ULUSOY

OP19- CLINICOPATHOLOGIC DIFFERENCES BETWEEN EARLY-ONSET GASTRIC CANCER AND LATE ONSET GASTRIC CANCER - <u>Habip SARI</u>, Sami BENLI

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16 October 2022, Sunday III. Oral Abstract Session 15:55-17:00 (UTC +3) Moderators: Dr. Savaş Yakan, Dr. Bülent Çalık

OP20- FACTORS AFFECTING ANASTOMOTIC LEAKAGE AND LEAKAGE MANAGEMENT IN GASTRIC CANCER - <u>Tolga</u> <u>GIRGIN</u>, Can UC, Busra KUCUKATES, Tugce TURK, Tufan GUMUS, Taylan Ozgur SEZER, Ozgur FIRAT, Sinan ERSIN

OP21- EFFECT OF NEOADJUVAN TREATMENT TO SURGERY ON PATHOLOGICAL RESPONSE IN GASTRIC CANCER: PRELIMINARY STUDY - Enver ILHAN, Orhan UREYEN, Asuman ARGON, Ozlem OZDEMIR, Emrehan INCI, <u>Abidin</u> <u>Gazi ALAGOZ</u>

OP22- DEMOGRAPHIC AND CLINICOPATHOLOGICAL EVALUATION OF OUR PATIENTS WITH GASTRIC TUMOR IN THE COVID-19 PANDEMIC AND NON-PANDEMIC PERIOD: A RETROSPECTIVE STUDY - <u>Omer CAGLIYAN</u>, Ahmet Mucteba OZTURK, Sedat TAN, Yasemin SAHIN, Erkan OYMACI, Ahmet Deniz UCAR, Mehmet YILDIRIM

OP23- PROGNOSTIC FACTORS IN STOMACH GASTROINTESTINAL SYSTEM STROMAL TUMORS - Can UC, Tufan GUMUS, <u>Busra KUCUKATES</u>, Tolga GIRGIN, Taylan Ozgur SEZER, Ozgur FIRAT, Sinan ERSIN

OP24- CLINICOPATHOLOGICAL CHARACTERISTICS OF YOUNG ADULT (<40 YEARS OLD) GASTRIC CANCER PATIENTS - Gokalp OKUT, <u>Mehmet Alperen UGUR</u>, Murat KARATAS, Erkan OYMACI, Orhan UREYEN, Mehmet YILDIRIM, Savas YAKAN, Enver ILHAN

OP25- CLINICOPATHOLOGICAL FEATURES, PROGNOSIS AND SURVIVAL OUTCOMES OF STOMACH CANCER IN YOUNG PATIENTS - <u>Emran Kuzey AVCI</u>, Murat GUNER, Cengiz AYDIN

OP26- OVERALL SURVIVAL ANALYSIS OF OUR PATIENTS WITH GASTRIC CANCER WHO HAVE NEOADJUVANT CHEMOTHERAPY, <u>Seval AKAY</u>, Mustafa DEĞİRMENCİ, Hamza Ekmel NAZLI, Özlem ÖZDEMİR , Cengiz YILMAZ, Orhan ÜREYEN, Enver İLHAN

OP27- H.PYLORI AS A PREDICTIVE FACTOR FOR GASTRIC MALIGNENCIES: SPECTRUM OF SLEEVE GASTRECTOMY SPECIMENS - <u>Ahmet CEKIC</u>, Ahmet Mucteba OZTURK, Erkan OYMACI, Funda TASLI, Mehmet YILDIRIM

OP28- METASTATIC LYMPH NODE RATIO AS A PROGNOSTIC FACTOR IN GASTRIC ADENOCARCINOMA - *Tufan GUMUS, Can UC,* <u>*Recep TEMEL*</u>, *Taylan Ozgur SEZER, Ozgur FIRAT, Sinan ERSIN*

OP29- THE OUTCOMES OF GASTRIC CANCER SURGERY IN ELDERLY PATIENTS - Osman BOZBIYIK, <u>Can UC</u>, Sinan ERSIN

OP30- ANALYSIS OF GASTRIC ADENOCARCINOMA WITH NEUROENDOCRINE DIFFERANTIATION IN PATIENTS WHO UNDERWENT GASTRIC CANCER SURGERY - <u>Murat GUNER</u>, Cengiz AYDIN

OP31- HYDRO BT IN DIAGNOSIS AND FOLLOW-UP OF STOMACH CANCER - Recep Yilmaz BAYRAKTARLI

OP32- SHOULD DIAGNOSTIC LAPAROSCOPY BE PERFORMED PRIOR TO OPERATION IN GASTRIC CANCER? - <u>Berkay DEMIRORS</u>, Mehmet Akif ÜSTÜNER, Doğukan DURAK, Yurdakul Deniz FIRAT

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POSTER ABSTRACTS LIST

PP1 - A RARE LOCATION OF METASTASIS OF RENAL CELL CARCINOMA: A CASE REPORT OF STOMACH METASTASIS, <u>Mert ADALI,</u> Doğukan DURAK, Mehmet Akif ÜSTÜNER, İsmayil YILMAZ

PP2 - RADİKAL GASTREKTOMİ SONRASI NADİR GÖRÜLEN BİR GEÇ DÖNEM KOMPLİKASYON: RETROGRAD JEJUNO-JEJUNAL İNVAJİNASYON, *Taha Anıl KODALAK, Hakan KÜÇÜKASLAN, Bilal ALKAŞ, Adnan GÜNDOĞDU, <u>Ali GÜNER</u>*

PP3 - A CASE OF THE SYNCHRONOUS GASTRIC AND COLON CANCER: PATIENT-BASED THERAPY, <u>Yiğit Kaan ŞEN</u>, Ahmet Mücteba ÖZTÜRK, Özlem ÖZDEMİR , Ahmetcan YAŞAR , Mehmet YILDIRIM

PP4 - MULTIDISCIPLINARY MANAGEMENT OF ESOPHAGOJEJUNOSTOMY RECONSTRUCTION LEAK IN A GASTRIC CANCER PATIENT, *Bülent ÇALIK, Ahmet ÇEKİÇ, Ahmet Mücteba ÖZTÜRK, Erkan OYMACI, Mehmet YILDIRIM*

PP5 - MINEN - NEUROENDOCRINE AND NON-NEUROENDOCRINE TUMOR COMPONENTS IN A GASTRIC NEOPLASM: MIXED NEUROENDOCRINE -NON-NEUROENDOCRINE NEOPLASIA, <u>Ömer CAĞLIYAN</u>, Hale KIZANOĞLU, Yiğit Kaan ŞEN, Yaşar Çağlar BEKKİ, Mehmet YILDIRIM

PP6 - INCIDENTAL GASTRIC GLOMUS TUMOUR – A CASE REPORT, <u>Daniela MARTINS</u>, Francisca FREITAS, Pedro COSTA, Ana MONTEIRO, Herculano MOREIRA, João PINTO-DE-SOUSA

ITGCC 2

October







SPEECH SUMMARIES

ÍTGCC 202

14-16 October 2022





A CORE OUTCOME SET FOR SURGICAL TRIALS IN GASTRIC CANCER (GASTROS STUDY): INTERNATIONAL PATIENT AND HEALTHCARE PROFESSIONAL CONSENSUS

Dr. Bilal Alkhaffaf

Background

Surgery is the primary treatment that can offer potential cure for gastric cancer, but is associated with significant risks. Identifying optimal surgical approaches should be based on comparing outcomes from well-designed trials. Currently, trials report different outcomes, making synthesis of evidence difficult. To address this, the aim of this study was to develop a core outcome set (COS)—a standardized group of outcomes important to key international stakeholders—that should be reported by future trials in this field.

Methods

Stage 1 of the study involved identifying potentially important outcomes from previous trials and a series of patient interviews. Stage 2 involved patients and healthcare professionals prioritizing outcomes using a multilanguage international Delphi survey that informed an international consensus meeting at which the COS was finalized.

Results

Some 498 outcomes were identified from previously reported trials and patient interviews, and rationalized into 56 items presented in the Delphi survey. A total of 952 patients, surgeons, and nurses enrolled in round 1 of the survey, and 662 (70 per cent) completed round 2. Following the consensus meeting, eight outcomes were included in the COS: disease-free survival, disease-specific survival, surgery-related death, recurrence, completeness of tumour removal, overall quality of life, nutritional effects, and 'serious' adverse events.

Conclusion

A COS for surgical trials in gastric cancer has been developed with international patients and healthcare professionals. This is a minimum set of outcomes that is recommended to be used in all future trials in this field to improve trial design and synthesis of evidence.



MANAGEMENT OF CHEMOTHERAPY SIDE EFFECTS

Dr. Özlem Özdemir

Department of Medical Oncology, Izmir Bozyaka Education and Research Hospital, The University of Health Sciences, Izmir

Traditional cytotoxic chemotherapy and the newer targeted systemic anticancer therapies and Immunotherapies are part of a number of treatment modalities used to manage patients with malignant disease. Patients who are receiving chemotherapy/ systemic therapies will have been given specific verbal and written information regarding the side effects associated with their individual treatment regimen. The side effects of systemic chemotherapy used to treat cancer are often severe. For decades, oncologists have focused on treating the tumor, which may result in damage to the tumor-bearing host and its immune system. The most common chemotherapy-induced side effects are neutropenia, stomatitis, mucositis, diarrhea, and emesis. The efficacy of tumor therapy can be improved by good prophylaxis and standardized management of side effects.

ALOPECIA

Temporary alopecia is a frequently encountered side effect associated with chemotherapy and a number of chemotherapeutic agents can cause alopecia including cyclophosphamide, Ifosfamide, doxorubicin (adriamycin), epirubicin, taxanes (paclitaxel and docetaxel), and etoposide. The incidence of alopecia increases when these drugs are used in higher doses or in combination with other chemotherapeutic drugs. Scalp cooling may be offered to oncology patients depending on the drugs used and patient preference. It is noted that scalp cooling should not routinely be offered to patients where there is a likelihood of metastatic disease in the cranium.

DIARRHOEA

Several chemotherapy agents may be associated with diarrhoea, including 5- fluorouracil (5FU), methotrexate, oral capecitabine and irinotecan* (* See page 6). Diarrhoea can lead to dehydration, metabolic disturbances, infection and malnutrition and can be life threatening. The relative risk of diarrhoea relates to the chemotherapy agent/s being administered, dose, and tumour site and regime e.g. concurrent radiotherapy

All patients who are receiving agents that may result in diarrhoea are provided with home care instructions including • Maintaining fluid intake - 2 litres of fluid per day. • Maintaining a healthy, low residue diet. If a patient presents with symptoms consistent with neutropenic sepsis they should be treated as a medical emergency.

FATIGUE

Cancer-related fatigue can affect over three quarters of patients undergoing chemotherapy. All patients who are receiving chemotherapy are provided with home care information including: • Gentle exercise • Energy conservation techniques • Adequate nutritional intake

HHHHA



MOUTH PROBLEMS (Mucositis / Stomatitis)

GASTRIC CANCER

The mouth and digestive tract are lined by mucous membranes containing rapidly dividing cells that are more sensitive to the effects of chemotherapy. A patient may therefore present, during or after chemotherapy or radiotherapy with mouth problems. All patients who are receiving chemotherapy are provided with home care information including: • Maintenance of good oral hygiene rinsing the mouth frequently and effective brushing of the teeth with a soft brush 2–3 times daily. • Altered taste – sharp, highly flavoured foods or foods of varying temperatures can occasionally reduce this problem. • Dry mouth - avoid foods that are very hot, cold, spicy or acidic although some people gain relief from sucking fresh or tinned pineapple chunks in their own juice.

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In the 1990's nausea and or vomiting was often cited by patients as the most distressing side effect of chemotherapy but this has improved with the advent of 5- HT3 antagonists (in combination with corticosteroids) and NK-1 receptor antagonists. All patients who are receiving potentially emetogenic chemotherapy regimes are given intravenous antiemetic prior to the administration of their chemotherapy and supplied with a discharge script containing oral antiemetic. The key to successfully managing this problem lies in accurately assessing the patients nausea and vomiting, being aware of symptoms that could suggest an alternative cause for the patient's nausea and vomiting and modify their treatment accordingly.

BONE MARROW SUPPRESSION

Neutropenia is defined by the neutrophil count, not the total white cell count. Platelet count can also drop, though thrombocytopenia is less common than neutropenia. The levels at which treatments are delayed may vary from regimen to regimen and even from prescriber to prescriber. Example of commonly used blood count limits Platelets 100 x 109 cells/L White Cell Count 3 x 109 cells/L Absolute Neutrophil Count* 1.5 x 109 cells/L.

PERIPHERAL NEUROPATHY

Occasionally some chemotherapy agents, such as taxanes (paclitaxel and docetaxel), platinum agents (carboplatin, cisplatin or oxaliplatin), and vinca alkaloids (vincristine, vinblastine and vinorelbine) can cause peripheral neuropathy. Treatment of chemotherapy-induced peripheral neuropathy includes Pain management (opioids, tricyclic antidepressants, anticonvulsants, serotonin-norepinephrine reuptake inhibitors, nonsteroid anti-inflammatory agents),Antioxidants (alphalipoic acid, glutathione, vitamin E) ,Substances influencing ion channels (calcium/magnesium supplementation, pregabaline, carbamazepine) ,Neuroprotectors (ginkgo biloba, glutamine)

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GASTRIC CANCER

PALMAR-PLANTAR ERYTHRODYSAETHESIA (PPE) /HAND-FOOT SYNDROME

Hand-foot syndrome (also called palmar-plantar erythrodysesthesia) is a side effect of some chemotherapy drugs that can cause redness, swelling and blistering on the palms of the hands and soles of the feet.PPE is usually associated with patients who are receiving fluorouracil (5FU), oral capecitabine, liposomal doxorubicin (caelyx / myocet) and tyrosine kinase inhibitors (TKI) such as Sunitinib, Pazopanib and Axitinib. Effective measures exist for prevention and treatment of HFS including systemic and topical treatments, dose reductions, and switching to other drugs in the same class that have lower rates of HFS. These approaches allow patients to continue cancer treatment while reducing negative impacts on QoL.

FERTILITY / FAMILY PLANNING

Some chemotherapy agents, such as ifosfamide, high dose cyclophosphamide, doxorubicin (adriamycin), epirubicin and etoposide can cause temporary or permanent infertility.All patients who are receiving agents that can reduce fertility are assessed by their oncologist and appropriate interventions or strategies instigated e.g. sperm storage, ovarian preservation.

Conclusions

Chemotherapy is associated with numerous severe side effects, which include immediate signs of toxicity and late signs of chronic toxicity. Their intensity can be mild (grade 1), moderate (grade 2), severe (grade 3), or life-threatening or disabling (grade 4), according to the WHO classification. Immediate effects can be observed on skin and hair, bone marrow and blood, the gastrointestinal tract and the kidneys. All organs of the body can be affected, including essential organs, such as the heart, lungs and brain. Grade 3 and 4 neurotoxicity can induce somnolence, paresthesia, paralysis, ataxia, spasms and coma. In addition, the chronic effects of chemotherapy include drug resistance, carcinogenicity and infertility.

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RATIONAL DRUG USE

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In today's world, one of the most important parts in the provision of health services is the use of drugs. The definition of Rational Drug Use (RDU) was first made by the World Health Organization in 1985. Rational drug use should be able to provide the appropriate drug at the lowest price and easily, in the appropriate time and dose, according to the clinical findings and individual characteristics of the patients. Worldwide, approximately 50% of the drugs are prescribed, sold or dispensed incorrectly, while approximately 50% of the patients do not use drugs correctly. In addition, approximately one-third of the world's population unfortunately lacks access to essential medicines (1). The main examples of irrational drug use are; drug use when not needed, wrong drug and treatment selection, use of drugs with dubious effects, failure to provide safe and effective drugs that are accessible, use of the right drug in the wrong dose, duration and form (2). The World Countries with irrational drug use face with; "ineffective and unreliable treatments; recurrence or prolongation of the diseases, increase in side effects of the drugs, development of resistance to antibiotics, decrease in drug stocks, drug addiction, increase in economic costs.

The difficulties amog to RDU are; the lack of objective information, the inadequacy or defiency of continuity in pharmacology education, the inadequacy of regulations on drug use, the presence of many drugs in the market, the existence of profit motives from selling medicines and the community belief that there is a drug fore cure every disease (3).

Necessary steps to improve RDU are; making the correct diagnosis according to the patient's symptoms, determining the underlying cause, determining the purpose of the treatment clearly. The appropriate drug should be choosed for the patient; factors such as drug efficacy, safety, drug interactions, age of the patient, side effects of existing comorbidities, and cost are must be evaluated. Prescription of the drug sholud be written (the physician prescribes the drug chosen in accordance with the prescription) and the patient sholuld be informed about in which way, in which dose and for how long the drug will be used. The doctor should provide adequate information, explaining the possible side effects of the drug and possible drug-drug/drug-food interactions and if there are situations that require discontinuation of the drug, and following up the treatment (while passive follow-up is done by the patient, active follow-up is done by the physician and the patient is called for control) (4).

The first studies of the World Health Organization on RDU started in 1977 and its recommendations are being updated. These recommendations are; Establishing an institution to control drug use policies, creating lists of commonly used drugs in each country, creating guidelines, adding courses on this subject to medical education, giving importance to in-service training, educating the public on drug use, preventing incentives from the pharmaceutical industry and controlling drug expenditures.

As a result, we encounter similar problems in RDU in our country as in the whole world. Continuity of education and raising awareness of the society are the most basic requirements in AİK. In addition to training, the establishment of the necessary control mechanisms is also one of the important principles.

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ORAL ABSTRACTS

TGCC 202

14-16 October 2022





OP1- SURGICAL AND PATHOLOGICAL OUTCOMES IN PATIENTS WITH A CDH-1 MUTATION

UNDERGOING TOTAL GASTRECTOMY: A SYSTEMATIC REVIEW

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Objectives

Patients with CDH1 (E-cadherin) gene mutations have a 60-80% increased lifetime risk of hereditary diffuse gastric cancer (HDGC). Prophylactic total gastrectomy reduces long-term risk of gastric cancer, however the associated morbidity and mortality remains unclear. This systematic review aims to characterise postoperative surgical outcomes in patients undergoing total gastrectomy.

Materials-Methods

A systematic literature search was conducted for studies reporting endoscopic surveillance, surgical and pathological outcomes for patients with a CDH1 mutation undergoing a total gastrectomy.

Results

A total of 1013 patients were assessed across 33 studies, with 93% harbouring a CDH1 mutation (n=941). Seven hundred and seventy-three CDH1+ patients had 791 endoscopy results reported across 26 studies, with 70% revealing no evidence of cancer (n=564). Outcomes following endoscopy were reported for 678 CDH1+ patients. Of the 494 patients with negative endoscopy, only 11% did not have evidence of cancer post-operatively. Histology revealed cancer in 57% of patients (n=284) and 31% chose to defer surgery or were lost to follow up (n=157). A total of 658 total gastrectomies were reported across 33 studies. Pathology outcomes were reported for 540 patients across 27 studies, of which 84% had pT1 disease (n=454). Surgical complications were reported for 405 patients across 20 studies. Four studies reported zero complications. A total of 189 complications were reported, with the most common presentations being anastomotic strictures (22%), anastomotic leaks (12%), wound infections (11%) and pulmonary complications (10%). Post-operative mortality was reported for 344 patients undergoing surgery across 17 studies. One mortality was reported post-operatively at <30 days.

Conclusion

Prophylactic total gastrectomy is recommended for managing gastric cancer risk in CDH1+ patients. Currently, reliable endoscopic surveillance is lacking. Patients choosing to undergo surgery should be provided with adequate counselling, with careful consideration of the associated morbidity.

Keywords: Gastric cancer, Total gastrectomy, CDH1

TGGGZ





OP2- RISK COFACTORS FOR GASTRIC CANCER IN PATIENTS WITH LYNCH SYNDROME

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Objectives

Lynch Syndrome (LS) is the most common cause of hereditary colorectal carcinoma but is also associated with other tumors, like gastric cancer (GC) (6-13% in patients with LS). This study aimed to assess risk cofactors for the development of GC in LS.

Materials-Methods

We included patients with LS followed in our institution. The characteristics of the population were collected, and statistical analysis was performed using SPSS, version 28.

Result

Out of the 229 patients with LS, 11 (4; 7) developed GC (4.8 %). Of these, five were index cases, nine met Amsterdam criteria, five had a personal history of other LS-related tumors (colorectal, urothelium, and sebaceous adenoma), six had GC as the first manifestation of LS, and six had a family history of GC. Regarding mutations, five had a mutation in MLH1, four in MSH2, one in MSH6, and one in PMS2. Histologically, six of the GC were intestinal-type adenocarcinomas, three were diffuse-type, and one was GC with lymphoid stroma. Chronic atrophic gastritis with intestinal metaplasia was diagnosed in eight patients. The median age at diagnosis was 53 years, and the median survival time was 17 years. All patients underwent resection of the lesion, eight underwent total gastrectomy, and three underwent distal subtotal gastrectomy. At the time of surgery, the mean BMI was 23.82, four were overweight, and none were obese.

Conclusions

This study suggests that LS is associated with a higher risk of GC and that atrophic gastritis is an important risk cofactor. Endoscopic surveillance of LS patients should be based on the estimated risk determined by the presence of cofactors, particularly atrophic gastritis.

Keywords: gastric cancer, lynch syndrome, atrophic gastritis, risk cofactors

TGGGGZ





OP3- OUR LAPAROSCOPIC GASTRIC CANCER EXPERIENCE IN TURKEY PERIPHERAL HOSPITAL

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Objective

We performed laparoscopic gastric cancer surgery in 55 patients in total.Demographic characteristics of the patients, indications for surgery, complications, duration of operation and hospital stay were recorded.

Materials-Methods

Laparoscopic gastrectomies performed between September 2020 and June 2022 were divided into two groups as total and distal, and were examined in terms of technique, pathological outcome and early postoperative complications.

Results

55 patients, 36 men and 19 women, were included in the study. The mean age was 53.4 and the mean BMI was 27.3. Surgery was considered first in 50 patients, and neoadjuvant treatment protocol was applied to only five patients. Total gastrectomy was the preferred surgical method in 26 patients and distal gastrectomy in 12 patients. Standard D2 lymphatic dissection was performed in all patients according to tumor location and 29 lymph nodes were dissected in the total gastrectomy group, with a mean of 31.2 in the distal gastrectomy group. The mean oral onset time was 5.4 days in the Total gastrectomy group and 2.5 days in the distal gastrectomy group. Duodenal stump leakage was detected in 4 patients, esophagojejunostomy leak was detected in 2 patients, and bleeding at the drain site was observed in 1 patient.

Conclusion

There are many studies showing the adequacy of laparoscopic gastrectomy and lymphatic dissection. However, we think that as experience and experience increase in these surgeries, which have a long learning process and high technical difficulties, the operation time will be shortened and the complication rate will decrease.

Keywords in English: gastric, cancer, laparoscopy

TGCGZ





OP4- OUR EXPERIENCES AND RESULTS OF STOMACH CANCER SURGERY AT THE NEWLY ESTABLISHED 3rd STAGE BURSA STATE HOSPITAL

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Objectives

We aimed to determine the surgical procedures performed for gastric cancer since the opening of our hospital, and to question whether adequate lymphadenectomy was performed, and how patient management could be done better according to the metastatic lymph node removed.

Materials-Methods

A total of 153 total and subtotal gastrectomy surgeries performed in our hospital between September 2019 and July 2022 were analyzed through the hospital software with the permission of the hospital manager. Patients were grouped as total-subtotal, laparoscopic-open. The number of lymph nodes removed and the metastatic lymph node status were determined in the postoperative pathology results of the patients. Patients receiving neoadjuvant therapy were excluded from the evaluation.

Results

Of the 153 identified patients, 12 were performed for benign reasons (emergency cases and elective benign cases), 3 for lymphoma-related hemorrhage, and 138 patients for adenocarcinoma. Twenty-seven of these were excluded from evaluation because they received neoadjuvant therapy. It was seen that 65 of 111 patients underwent total gastrectomy and 46 of them underwent subtotal gastrectomy. Of the patients who underwent total gastrectomy, 28 had laparoscopic surgery and 37 had open surgery. The mean number of lymph nodes dissected was 28 in laparoscopy and 31 in open surgery. The number of patients with positive metastatic lymph nodes was 8 in laparoscopy and 14 in open surgery. Of the patients who underwent subtotal gastrectomy, 19 underwent laparoscopic surgery and 26 underwent open surgery. The mean number of lymph nodes dissected was 23 in laparoscopy and 14 in open surgery. The mean number of lymph nodes dissected was 26 underwent open surgery. The mean number of lymph nodes dissected was 26 underwent open surgery. The mean number of lymph nodes dissected was 26 underwent open surgery. The mean number of lymph nodes dissected was 26 underwent open surgery. The mean number of lymph nodes dissected was 28 in laparoscopy and 14 in open surgery. The mean number of lymph nodes dissected was 23 in laparoscopy and 25 in open surgery. The number of patients with positive metastatic lymph nodes was 9 in laparoscopy and 12 in open surgery.

Conclusions

In our evaluation made according to the postoperative pathology results, it was observed that adequate lymph node dissection could be performed in both open surgery and laparoscopic surgery in patients who underwent total and subtotal gastrectomy. However, considering the metastatic lymph nodes status, we determined that our preoperative patient management strategies should be developed, since neoadjuvant treatment is recommended primarily for these patients according to the NCCN guideline.

Keywords

mide kanseri cerrahisi, lenfadenektomi, laparoskopik mide cerrahisi, total-subtotal gastrektomi, metastatik lenf nodu





OP5 – CLINICOPATHOLOGICAL FEATURES AND SURGICAL RESULTS IN PATIENTS WITH STOMACH CANCER APPLIED TO ROBOTIC SURGERY

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ROBOTİK CERRAHİ UYGULANAN MİDE KANSERLİ HASTALARDA KLİNİKOPATOLOJİK ÖZELLİKLER VE CERRAHİ SONUÇLAR

Amaç

Mide kanserinin tedavisinde altın standart cerrahi rezeksiyondur. Robotik cerrahi mide kanserli hastalarda son yıllarda artarak uygulanmaktadır. Çalışmamızda mide kanserinde robotik cerrahinin etkinliğini değerlendirmeyi amaçladık.

Gereç-Yöntem

2021-2022 yıllarında genel cerrahi kliniğinde mide kanseri nedeniyle robotik cerrahi uygulanan 27 hasta çalışmaya dahil edildi. Hastaların demografik ve klinik özellikleri, intraoperatif ve postoperatif sonuçları, tümöre ait özellikleri, erken dönem morbidite ve mortalite sonuçları incelendi.

Bulgular

27 (K/E: 8/19) hastanın yaş ortalaması 63.2 (42-83) idi. 19 (%70) hasta neoadjuvan tedavi almıştı. Ameliyat süresi ortalama 258 (110-380) dakika idi. 10 (%37) hasta subtotal, 17 (%63) hastaya total gastrektomi uygulandı. 4 (%14) hastada açık cerrahiye geçildi. Hiçbir hastada intraoperatif komplikasyon yaşanmadı. Bir (%3) hastaya ameliyat sonrası üçüncü gününde gastroentorostomi anastomozunda obstrüksiyon nedeniyle tekrar anastomoz yapıldı. Tümörün yerleşimi 10 (%37.1) hastada antrum, 8 (%29.6) hastada kardia, 9 (%33.3) korpus yerleşimli idi. Tümör histolojisi tüm hastalarda adenokarsinom idi. Tümörün en geniş çaı ortalama 5 (0.7-9) santimetre idi. 2 (%7) hastada proksimal, 1 (%3) hastada distal cerrahi sınır pozitif idi. Çıkarılan lenf nodu sayısı ortalama 30.2 (11-50) idi. Ameliyat sonrası ortalama yatış süresi 5.7 (3-12) gün idi. 30 günlük erken mortalite sayısı sıfırdı. 90 günlük hastaneye tekrar başvuru sayısı 3 (%11) idi.

Sonuç

Mide kanserli hastalarda robotik cerrahi başarılı klinikopatolojik sonuçları, kısa hastane yatışı süresi, düşük morbidite ve mortalite oranları nedeniyle etkin bir şekilde uygulanabilir.

Keywords: MİDE KANSERİ, GASTREKTOMİ, ROBOTİK CERRAHİ

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OP6- WITH THE EXPANDATION OF ENDOSCOPY AND IMAGING METHODS INCREASED DETECTION RATE OF GIST AND MANAGEMENT

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ENDOSKOPİNİN VE GÖRÜNTÜLEME YÖNTEMLERİNİN YAYGINLAŞMASI İLE TESPİT ORANI ARTAN MİDE GİST VE YÖNETİMİ

Amaç

Gastrointestinal stromal tümörler (GIST),çok nadir görülen gastrointestinal kanalın malign subepitelyal mezenkimal lezyonları olup %60'ına midede rastlanmaktadır.Son yıllarda endoskopinin yaygınlaşması,radyolojik görüntüleme yöntemlerindeki gelişme ve görüntüleme sayılarındaki artışla birlikte GIST yönetimi değişmeye başlamıştır.Endoskopi ve endoskopik ultrasonografinin (EUS) yaygın olarak uygulanmasıyla birlikte, erken bir aşamada (nispeten küçük çaplı ve metastazsız) giderek daha fazla gastrik GIST tespit edilmesi,tam rezeksiyon şansı vermekle beraber özellikle küçük çaptaki lezyonların yönetimini değiştirmeye başlamış ve cerrahların cerrahi tedavi kararını almasını zorlaştırmıştır. Hızlı yaşanan bu gelişmeler henüz cerrahlar tarafından aynı hızla uygulamaya geçirilememektedir.Çalışmada preoperatif görüntülemelerdeki ve endoskopik bulgulardaki tümör boyutu ile histopatolojik değerlendirme sonucu raporlanan risk sınıflandırması karşılaştırılarak cerahlardaki farkındalığın arttırılması amaçlanmıştır.

Gereç ve Yöntem

2013-2022 tarihleri arasında kliniğimizde mide GIST tanısı alan ve cerrahi tedavileri tamamlanan 19 hasta değerlendirilmiştir.Patoloji piyeslerinin histopatolojik incelemesinde tümör çapı ve mitoz oranı belirlenerek tümörler düşük, orta, yüksek ve çok yüksek riskli olarak 4 gruba ayrılmıştır. Gruplar hastaların preoperatif bilgisayarlı tomografi (BT) görüntülerindeki tümör boyutları ve endoskopik bulguları ile karşılaştırılmıştır.

Bulgular

Yaş ortalaması 58,36 yıl olan 19 hastanın 12'si erkek,7'si kadındı.Hastaların %36,82'si başka nedenlerle tetkik edilirken insidental olarak tanı almıştı. Yüksek risk grubunda olan 8 hastanın (%42.1) tümörü diğer risk gruplarındaki hastalarla karşılaştırıldığında BT'de tanımlanan çap ve metastaz görülme durumu ile istatistiksel anlamlı fark saptanmıştır.Hastaların 11'ine açık, 8'ine laparoskopik cerrahi uygulanmıştır. Takiplerinde metastaz saptanan hastaların tamamı yüksek risk grubunda olup 1 hastada imatinib tedavisine direnç saptanmıştır. Bir hastada nüks saptanmış olup medikal tedaviye yanıt vermesi nedeniyle non-operatif takip kararı alınmıştır.

Sonuç

Elde ettiğimiz sonuçların ışığında endoskopik bant ligasyonu (EBL),endoskopik submukozal diseksiyon (ESD), endoskopik submukozal ekskavasyon (ESE),endoskopik full-thickness rezeksiyon (EFTR) ve submukozal tünelleme ile endoskopik rezeksiyon (STER) gibi endoskopik rezeksiyonların yapılabildiği günümüzde bu teknikler küçük tümör çaplarında cerrahiye alternatiftir. Gastrointestinal stromal tümörlerde prognoz tümör çapı ve mitotik aktiviteye bağlıdır. Tümörün tanısı, tedaviye yanıtın değerlendirilmesi, nüks ve metastaz açısından takiplerde BT ve endoskopi önemli yer tutmaktadır.

Keywords: Gastrointestinal stromal tümör (GIST), Bilgisayarlı tomografi (BT), cerrahi tedavi





OP7- EVALUATION OF FACTORS RELATED TO CLAVIEN - DINDO 3 AND ABOVE COMPLICATIONS IN PATIENTS UNDERGOING GASTRECTOMY DUE TO GASTRIC CANCER

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Objective

Clavien-Dindo classification for postoperative complications has been established as a standard system and has been applied in many surgical fields. In our study, we aimed to evaluate the complications after total gastrectomy by Clavien-Dindo classification and to determine the related risk factors.

Material-Method

Patients who underwent total gastrectomy due to gastric cancer between 2015-2019 were included in the study. Patients were divided into two groups according to postoperative complication classification Clavien Dindo, those with 3 or higher were Group 1 and the others were Group 2. Demographic and clinical features, laboratory parameters, tumor characteristics, postoperative results and mean survival were compared in the groups. Risk factors for Clavien Dindo 3 and above were analyzed by univariate analysis and multivariate logistic regression analysis.

Results

A total of 104 patients participated in our study. Group 1 consisted of 25 and Group 2 consisted of 79 patients. Male sex was high in both groups (52% vs 67.1%, p: 0.130). BMI (26 vs 23, p:0.023), albumin (3.24 vs 3.51, p:0,040), postoperative mortality (%28 vs % 2.5, p:0.001), postoperative duration of hospitalization (17.60 vs 9.25 days, p:0.000) were different between the groups, but total survival (month) was not statistically significantly different (19.60 vs 18.53, p:0.377). In multivariate analysis, tumor Stage 3C (OR =0.177, 95% CI = (0.067-0.468), p: 0.000), operation duration \geq 240 min (OR =2.105, 95% CI = (1.080-4.100, p:0.029) and application of neoadjuvant treatment (HR =3.026, 95% CI = (1.682-5.446), p:0.000) were indepent risk factors.

Conclusion

In conclusion, obesity, hypoalbuminemia, anemia, tumor stage, duration of operation, and taking neoadjuvant therapy were closely related to postoperative complications. Although the development of postoperative complication increased the length of hospitalization and postoperative mortality, it did not decrease survival in the long term. Knowing the factors associated with postoperative complications will guide us in preventing complications.

Keywords: Gastric Cancer, Total Gastrectomy, Clavien Dindo classification, Postoperative Complications





OP8 - OUR EXAMINATION RESULTS WITH UPPER GASTROINTESTINAL SYSTEM ENDOSCOPY OF THE STOMACH AND DUODENUM

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Objectives

The main symptoms of the upper gastrointestinal system (GIS); dyspepsia, epigastric burning and pain, dysphagia, nausea and vomiting. In this study, we aimed to examine the pathological conditions detected in the stomach and duodenum during endoscopy.

Materials-Methods

The records in the Endoscopy unit and Pathology department of the patients who applied to the Surgical Oncology (CO) and Gastroenterological Surgery (GEC) polyclinics, who underwent upper GIS (Gastro Intestinal System) endoscopy between August 2021 and August 2022, were reviewed retrospectively (Table 1). Demographic, clinical and histopathological characteristics of the patients were evaluated (Table 2).

Results

Polyps were detected in 40 (4.02%) of 993 (542 (54.5%) female, 451 (54.5%) male) patients. female(60%) and their mean age was 57. The most common complaint of dyspepsia (87.5%) was in patients with polypoid lesions. A single polyp was detected in 30 (75%) of 40 patients, and multiple polyps in 10 (25%) patients. The most common type of polyp was hyperplastic polyp in 30 (75%) of the patients. While polypoid lesions were most common in the antrum (15 patients, 37.5%), they were least observed in the bulb (3 patients, 7.5%). In 10%), bleeding in the form of leakage was stopped with sclerotherapy. Thirty-nine (97.5%) of the polyps that underwent excision or biopsy were sessile. In 25 (62.5%) of the patients with polyps, Helicobacter pylori was positive. High-grade dysplasia was detected in 1 patient. Malignancy was detected in 10 (1%) patients. While the malignancy rate in the patients who applied to the GEC outpatient clinic was 0.58%, it was 3.54% in the patients who applied to the CO outpatient clinic.The mean general age was 51 (youngest 17, oldest 72). The most common localization site was the antrum in 7 patients (70%). Perioperative chemotherapy was given to 5 patients. 1 patient It was considered unresectable. Gastrectomy and D2 lymph node dissection were performed in 9 patients.

Conclusions

Upper GIS Endoscopy should be performed in patients with dyspeptic complaints, especially those over the age of fifty. Early stage gastric cancer catching rates are still low in our country. Upper GIS Endoscopy application is safe and complication rate is very low.

Keywords: early gastric cancer, gastric polyp, endoscopy





14-16 October 2022 TGGGZ

Ege University, Ataturk Cultural Center - IZMIR

OP9- INCREASED AVERAGE THROMBOCYTE VOLUME, AN INFLAMMATORY HEMATOLOGICAL MARKER CAN IT PREDICT LYMPH NODE METASTASIS IN STOMACH CANCER?

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Background

In this study, we aimed to investigate the relationship between the ratio of positive lymph nodes to total lymph node in surgical pathology and mean platelet volume in patients who underwent surgery for gastric cancer retrospectively. In addition, the reliability of mean platelet volume (MPV) as an easily accessible hematological biomarker was evaluated.

Materials and methods

141 patients who underwent surgery for gastric cancer between 2017 and 2022 were included in the study. Age, gender, total number of lymph nodes removed and positive lymph node count in the surgical pathology, tumor size, ratio of positive lymph node count to total lymph node count, mean platelet volume and platelet count in preoperative hemogram parameters of the cases were evaluated retrospectively.

Results

104(74%) of the cases were male and the mean age was 63.9(28-87) years. in 141 cases; mean number of lymph nodes removed was 26.35(±13.97), mean number of positive lymph nodes was 6.09(0-39) and mean tumor size was 5.17±2.83 cm (0-16). A statistically significant positive correlation was found between the tumor size of the cases and the number of positive lymph nodes (p<0.001). A statistically significant positive correlation was found between the ratio of the number of positive lymph nodes to the total number of lymph nodes and the mean platelet volume (p<0.001)

Conclusion

Systemic inflammatory response accompanies in patients with malignant tumors. Inflammatory cytokines (eg, interleukin-1, IL-6, tumor necrosis factor- α (TNF- α)) cause macrophage maturation and proliferation. In addition, these cytokines can cause platelet activation and release of larger platelets. Therefore, it causes an increase in MPV. Activated platelets synthesize proangiogenic cytokines. This envelops tumor cells, protecting them from the host's immune response and causing tumor growth, angiogenesis, and metastasis. This may indicate that high MPV levels may be associated with poor prognosis. The positive correlation between the positive/total lymph node ratio and MPV in our study also supports this hypothesis. MPV level can be used as a reliable and inexpensive biomarker in terms of prognosis and treatment modalities in patients with gastric cancer. Higher quality studies are needed for more reliable results.

Keywords: MPV, Gastrik Kanser, Mide Kanseri, Prognoz, Belirteç





14-16 October 2022 TGGG

Ege University, Ataturk Cultural Center - IZMIR

OP10- TECHNICAL DETAILS AND SHORT-TERM OUTCOMES OF BILLROTH-I GASTRODUODENOSTOMY: WESTERN EXPERIENCE

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Objectives

Due to its technical simplicity, providing a single anastomosis, maintaining physiological intestinal continuity, and endoscopic access to the duodenum when necessary, Billroth-I gastroduodenostomy is a frequently used anastomosis technique in eastern countries after distal gastrectomy. However, while Billroth-II and Roux-N-Y gastrojejunostomy are frequently used techniques in western countries, Billroth-I anastomosis is rarely used. In this presentation, we aimed to present the technical details and short-term clinico-pathological outcomes of patients who underwent circular-stapled Billroth-I gastroduodenostomy anastomosis.

Materials-Methods

Between May-2015 and March-2020, 121 patients underwent distal gastrectomy due to gastric tumor. Patients in whom intestinal continuity was achieved with Billroth-I anastomosis were reviewed from the prospectively obtained database. Technical details of the operation, clinicopathological characteristics of patients, operative data, and postoperative outcomes including complications were reviewed.

Results

Eighteen patients underwent Billroth-I anastomosis. Median age of patients was 62.5 (IQR, 46.75 to 74), and male/female ratio was 12/6. The indication of gastric resection was gastric cancer in 16 patients, GIST in 1 patients, and gastric metastasis of colon cancer in 1 patients. All patients except one underwent elective surgery. There were no margin positivity. Among 14 patients who underwent curative gastric cancer surgery with D2 lymphadenectomy, median number of removed lymph nodes was 41 (IQR, 32.25 to 55), and median operation time was 85 (IQR, 61.25 to 90) minutes. Median hospital stay was 7 days (IQR, 6 to 7.75) in all patients and 6 days (IQR, 6 to 7) in curative patients.

Conclusion

Billroth-I gastroduodenostomy is a simple, oncologically safe, and physiological procedure that can be performed in patients with suitable tumor location.

Keywords: Billroth-I, Gastrectomy, Gastroduodenostomy, Gastric cancer





OP11- OUR ERAS RESULTS IN STOMACH CANCER SURGERY IN SURGICAL ONCOLOGY CLINIC

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CERRAHİ ONKOLOJİ KLİNİĞİNDE MİDE KANSERİ CERRAHİSİNDEKİ ERAS SONUÇLARIMIZ

Amaç

Cerrahi sonrası gelişmiş iyileşme (ERAS), perioperatif yönetimi optimize eden ve rehabilitasyonu hızlandıran multidisipliner bir yaklaşım bütünüdür. Biz bu çalışmamızda mide kanseri nedeniyle opere edilen ve ERAS uygulanan ve uygulanmayan olgularımızın sonuçlarını ve ERAS protokollerin komplikasyon oranını arttırmadan başarı ile yapılabileceğini sunmayı amaçladık.

Gereç-Yöntem

Mayıs 2017–2022, arasında ERAS uygulanmayan (konvansiyonel)70 ve ERAS uygulanan (ERAS) 104 olgunun dataları retrospektif olarak analiz edildi.Tüm olgular total gastrektomi D2 LND yapılmış olgulardı. Acil evre 4,subtotal ve wedge rezeksiyon yapılan olgular çalışmaya dahil edilmedi.Olguların demografik verileri,operasyon ve mobilizasyon ,oral sıvı ve katı gıda alım zamanı,gaz ve gaita çıkışı,analjezik gereksinimi,komplikasyonlar,taburculuk zamanı ,yeniden başvuru ve mortalite oranları değerlendirildi.

Bulgular

Konvansiyonel grupta ortalama yaş 55(36-70) ,40(%57) i erkek,30(%43)ı kadın idi. ERAS grubunda ortalama yaş 57(33-77) 62(%59,6) si erkek,42(%40,4) sı kadın idi .Ortalama ameliyat süresi konvansiyonel ve ERAS grubunda sırasıyla 205.6 (\pm 80.6) ve 207.4(\pm 55.8) dakika olarak saptandı .ERAS grubunda aynı gün1.1(1-1) oral alım teşvik edilmişken konvansiyonel grupta 3.gün 3(3-5) oral alım başlandı.Semi fluid diet ERAS grubunda 2. günde konvansiyonel grupta ise 5.günde ,soft bland diet ise ERAS grubunda 4. günde konvansiyonel grupta ise 6.günde başlandığı saptandı.Gaz çıkışı sırasıyla ERAS ve konvansiyonel grupta 2.8 (1-5) ve 3.5 (1–5, p = 0.008) oldu. Taburculuk süresi konvansiyonel grupta 7(7-22) iken ERAS grubunda 5,5(5-14) gün idi.İlk 15 gün yeniden hastaneye yatış konvansiyonel grupta 1(%3,3) ERAS grubunda 4(%3,8) olguda görüldü.Bu olgular uzamış ileus nedeniyle interne edildi.İlk 30 günde konvansiyonel grupta hiçbir mortalite görülmezken ERAS grubunda 1(%0,9) olgu özefagojejunostomi kaçağı nedeniyle ex oldu.

Sonuç

ERAS protokollerinin konvansiyonel ERAS uygulanmayan gruba göre daha az cerrahi strese daha erken beslenmeye ve komplikasyon oranının arttırmadan daha erken taburculuk süresine neden olduğunu saptadık. Bununla birlikte yeniden yatış oranının ERAS grubunda daha yüksek olduğu görüldü. Gastrik kanser cerrahisinde ERAS protokollerini daha kesin olarak değerlendirmek için uzun süreli takipli çok merkezli prospektif randomize kontrollü çalışmalara ihtiyaç vardır.

Keywords: gastrik kanser, ERAS, fast track

HHH Z





OP12- OUR INITIAL EXPERIENCE IN ONCOLOGIC LAPAROSCOPIC GASTRIC SURGERY

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Objectives

Today, minimally invasive surgery is increasingly performed even for complex oncological procedures.

In the literature, Minimally Invasive Oncologic Gastric Surgery has been associated with reduced blood loss, shorter hospital stay, reduced complication rates, and better oncologic outcomes.

Materials and Methods

The data of 9 gastric cancer patients who were scheduled for curative laparoscopic gastrectomy in our clinic between *January* **2021** and *August 2022* were evaluated. 6 out of **9** cases were completed laparoscopically. 5 cases were performed as laparoscopic total gastrectomy and 1 case as laparoscopic subtotal gastrectomy.

The reason for the transition to open surgery was impaired venous return in 2 cases and invasion of the diaphragmatic mass in the cardia in one case.

Result

Mean operation time was **04:53** hours, mean blood loss was **288** cc. All patients underwent R0 resection. The mean number of lymph nodes removed was **16**, and the mean number of metastatic lymph nodes was **2**. Atelectasis and globe were observed in 2 patients with a complication rate of 22%. The mean hospital stay was 7.7 days.

Conclusion

Even in low-volume centers, the initial treatment plan for gastric cancer patients can be based on minimally invasive surgery.

Keywords: laparoscopic gastrectomy, minimally invasive, gastric cancer

TGEGZ





OP13- BRAIN METASTASIS FROM GASTRIC ADENOCARCINOMA: A LARGE COMPREHENSIVE POPULATION-BASED COHORT STUDY ON RISK FACTORS AND PROGNOSIS

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Aims

To explore factors associated with brain metastasis in gastric adenocarcinoma (GaC), and investigate the time-dependent cumulative mortalities and prognostic factors in GaC patients with brain metastasis at the population level.

Methods

Data on patients with GaC diagnosed in 2010 through 2016 were retrieved from a large population-based database. Factors associated with brain metastasis were explored using the multivariable-adjusted logistic regression model. Time-dependent cancer-specific mortalities in GaC patients with brain metastasis were then calculated using the cumulative incidence function, and mortalities compared across subgroups using Gray's test. Factors associated with mortality were further assessed using the multivariable-adjusted Fine-Gray sub-distribution hazard model.

Results

Together 28,736 eligible patients were enrolled, who included 231 (1%) cases with brain metastasis and 10,801 (38%) with other metastasis, encompassing 39,168 person-years of follow-up. Brain metastasis was more frequently detected in younger patients (overall cancers), in cases with gastric cardia cancers, in people with signet-ring cell carcinoma (overall cancers), and in those with positive lymph nodes (overall cancers); it was less commonly observed in black patients. Brain metastasis was associated with more frequent bone and lung metastases. The median survival of patients with brain metastasis was 3 months; the 6-month and 1-year cancer-specific cumulative mortalities were 57% and 71%, respectively. Among patients with GaC and brain metastasis, patients with cardia cancers (radiotherapy), people undergoing resection, and those receiving chemotherapy had lower mortality hazards, while younger patients (chemotherapy or radiotherapy) and people with positive lymph nodes (radiotherapy) had higher mortality risks.

Conclusion

In patients with GaC brain metastasis was associated with various clinicopathologic factors including age, ethnicity, tumor location, histology, lymph node involvement, and metastasis to other sites. Patients with brain metastasis had poor prognosis which was associated with age, tumor location, lymph node involvement, and treatment. Our findings provide important hints for tailed patient management and for further mechanistic investigations.

Keywords: Gastric adenocarcinoma, brain metastasis, cumulative incidence function, Fine-Gray sub-distribution hazard regression, competing risk analysis





OP14- CHARACTERISTICS AND IN-HOSPITAL OUTCOMES OF GASTRIC CANCER PATIENTS

<u>Lei HUANG</u>

WHO ARE ≥65 YEARS IN A TOP-RANKED HOSPITAL IN CHINA, 2016-2020

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Aims

Older patients with gastric cancer (GC) are generally frailer with more often comorbidities. This study aimed to describe the characteristics and the in-hospital outcomes, both overall and stratified by sex and resection, and to explore factors associated with duration and fee of first hospitalization, in older GC patients who were admitted to a top-ranked hospital in China.

Methods

Data on hospitalized GC patients ≥65 years were retrieved from the electronic medical records of Ruijin Hospital, Shanghai Jiao Tong University School of Medicine in Shanghai, China, and were structured into analyzable format with the assistance of BaseBit.AI using Embedding and Natural Language Processing. Baseline patient and tumor characteristics, medical and medication histories, changes of weight and food intake, diet, risk assessments, self-care ability, duration and fee of hospitalization, and in-hospital mortality were described for overall patients and compared between males and females and between unresected and resected cases. Factors associated with duration and fee of first hospitalization were respectively explored using multivariable-adjusted logistic regression. Associations between duration and fee of first hospitalization were further evaluated in overall and stratified cases.

Results

3238 eligible patients with male proportion of 74% and median age of 70 years were analyzed. 58% of the patients underwent resection in our hospital and 23% had a history of major abdominal surgery. Most of the patients did not reside in Shanghai. Hypertension (42%) and diabetes (15%) were the most common comorbidities, and antihypertensive (39%) and hypoglycemic (13%) drugs were the most frequently used medications. The median duration and fee of first hospitalization were 13 days and 40,000 RMB, respectively. 16 (<1%) and 32 (1%) deaths occurred during first and any hospitalization, respectively. Compared to male patients, female cases more often resided in Shanghai, had more often signet ring cell carcinoma, had more often reduced food intake, had more often resection in our hospital and history of major abdominal surgery. Compared to unresected cases, resected patients were less often diagnosed in 2020, more often encoded through emergency pathway, had higher body mass index and Barthel index for self-care ability, had less often reduced food intake, weight loss, and risk of malnutrition, had more often common diet, longer hospital stay, higher fee. Multivariable analysis showed that: Longer first hospital stay was associated with earlier year of diagnosis, older ages, emergency admission, signet ring cell carcinoma, resection, history of anticoagulant intake, larger body mass index, non-common diet, and non-low-salt and non-diabetes diets; higher fee of first hospitalization was associated with later year of diagnosis, male sex, older ages, emergency admission, signet ring cell carcinoma and resection. For first hospitalization, fee was significantly correlated with duration, both overall (r=0.811) and in stratified analyses.

Conclusion

While with frequent and complex conditions, older GC patients had good in-hospital outcomes in our hospital. Various differences existed between male and female patients and between unresected and resected cases, and various factors were associated with duration and fee of first hospitalization, highlighting the need of individualized and stratified care.

Keywords: Gastric adenocarcinoma, geriatric oncology, in-hospital outcomes, characteristics, large comprehensive institution-based study





OP15- OUR FIRST PIPAC EXPERIENCE IN AZERBAIJAN USING STANDARDIZED TECHNIQUE WITH THE TOPOL® NEBULIZER DEVICE

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BACKGROUND

Pressurized intraperitoneal aerosol chemotherapy (PIPAC) is a novel method to deliver chemotherapy directly into the peritoneal surface. It can be argued that PIPAC can be a compatible subside to control peritoneal carcinomatosis.

The chemotherapeutic agent is instilled into the peritoneal cavity using laparoscopic capnoperitoneum. This is a more efficient method compared to peritoneal lavage. Thus, we present our first experience with PIPAC in Azerbaijan, according to the standard technique with the Topol® nebulizer device.

CASE REPORT

A 66-year-old man with gastric adenocarcinoma, multiple liver metastasis, and peritoneal carcinomatosis was given systemic treatment with the FOLFOX-HERCEPTIN and FOLFIRI-HERCEPTIN protocols periodically within the span of 2 years. After a radiological response to the systemic treatment and achievement to progress free survival, we discussed the patient with the multidisciplinary team and decided to perform peritonectomy, total gastrectomy and PIPAC procedure. We performed total gastrectomy, splenectomy, and strippage of diaphragmatic peritoneum. After closuring the laparotomy incision, two laparoscopic trocars were placed on both sides of the abdomen, through one of them a laparoscopic telescope was inserted, through the other port tube of the nebulizer was inserted and PIPAC procedure was performed. The procedure was completed successfully. Final pathology report revealed gastric adenocarcinoma, total lymph nodes 28, metastatic lymph nodes 16, pT4bN3bM1. The patient was discharged on postop 7 day later, with minor complications like fever and nausea.

CONCLUSION

Metastatic gastric cancer is an imperative problem and alternative methods for its treatment are being researched. PIPAC shows promising results, however to ensure successful outcomes randomized controlled trials are needed.

Keywords: PIPAC, gastric cancer, carcinomatosis

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OP16- PROGNOSTIC SIGNIFICANCE OF METASTATIC LYMPH NODE RATIO IN GASTRIC CANCER: A SINGLE-CENTER ANALYSIS

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Objectives

Tumor node metastasis (TNM) staging is the central staging system for gastric cancer, but it provides an inaccurate prognostic assessment in patients with inadequate lymphadenectomy. However, the lymph node ratio (LNR) can be used regardless of the type of lymphadenectomy and is considered an important prognostic factor and an appropriate staging method for patients with positive lymph nodes. This study aimed to evaluate the relationship between LNR and survival in patients who underwent curative gastric cancer surgery.

Materials-Methods

All patients who underwent radical gastric surgery at Marmara University Hospital between January 2014 and December 2021 were retrospectively evaluated. Clinicopathological features of tumors, TNM stage, and survival rates were analyzed. LNR was used to compare overall survival within each interval and between bordering subgroups with similar survival outcomes. The LNR system was classified: LNR0=0; $0.01 < LNR1 \le 0.1$; $0.1 < LNR2 \le 0.25$ and LNR3 > 0.25. Tumor characteristics and overall survival of the patients were compared between LNR groups.

Results

After exclusion, 413 patients were analyzed. The mean age was 62±14 years, and the female to male ratio was 129/284. According to the LNR classification, no difference was found between groups in terms of age and gender. However, TNM stage 3 disease was statistically significantly higher in LNR3 patients. In terms of tumor characteristics (lymphatic, vascular, and perineural invasion), the LNR3 group had significantly poorer prognostic factors. Cox regression analysis indicated that age, TNM stage, and LNR significantly affected overall survival. When stage 1, 2, and 3 patients were examined separately, LNR was again shown to affect overall survival in regression analysis.

Conclusions

Our study showed that a high LNR was significantly associated with poor overall survival in patients who underwent curative gastrectomy, regardless of the number of LNs examined. LNR can be used as an independent prognostic predictor in gastric cancer patients.

Keywords: Gastric cancer, Gastrectomy, Lymph node ratio, Survival, Prognosis, Metastatic lymph node ratio

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Ege University, Ataturk Cultural Center - IZMIR

OP17- RESEARCH PROTOCOL: COMPARISON OF PERIOPERATIVE CHEMOTHERAPY AND SURGERY WITH ADJUVANT THERAPY FOR LOCALLY ADVANCED GASTRIC CANCER

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Introduction

Different countries prefer particular types of multimodal treatment for locally advanced gastric cancer. Two general approaches - perioperative chemotherapy FLOT 4+4 combined with surgical treatment and "surgery first" with adjuvant chemotherapy XELOX 8 had been widely applied for the last decades. There are no randomized prospective clinical trials, comparing both approaches.

Objectives

To compare immediate and long-term outcomes of perioperative (Arm 1) and adjuvant (Arm 2) chemotherapy combined withsurgery in patients with stage cll-III gastric cancer.

Materials-Methods

The trial was designed to detect an absolute increase in 3-year OS of 10% in the perioperative-chemotherapy group, with a two-sided alpha level of 5% and a statistical power of 80%, that requires the enrollment of 582 patients. The volume and approach of surgical procedure (distal or total gastrectomy with D2 lymphadenectomy) was determined after multimodal examination (CT, EUS, Endoscopy, Staging laparoscopy). Patients from Arm 1 receive 4 courses of FLOT before surgery and 4 courses after it. Patients from Arm 2 receive surgery and adjuvant chemotherapy XELOX 8. Follow-up will be performed after 3, 6, 9, 12, 18, 24, 36, 48, and 60 months.

Results

Since December 2019, we have already enrolled 42 and 35 patients to the Arm 1 and 2, respectively. We didn't get any statistically significant difference in immediate outcomes between groups. At the moment, we have only 1-year and 2-year OS that doesn't differ in the groups.

Conclusion

Both approaches show moderate adverse events and complications rate and no significant difference in OS. Further research and data collection is needed to find out the benefits of compared treatment strategies.

Keywords: locally advanced gastric cancer, perioperative chemotherapy, adjuvant chemotherapy





OP18- THE EFFECT OF NEOADJUVANT TREATMENT ON SURVIVAL OF STGAE II-III GASTRIC CANCER

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Objectives

Despite the use of curative resection with D2 lymphatic dissection following with or without the addition of adjuvant treatment, advanced gastric cancer survival is poor. Neoadjuvant therapy is a different treatment modality. This study aims to provide the potential effect of the neoadjuvant treatment on the survival of different tumor locations of advanced gastric cancer.

Material and Methods

Medical data of Stage II-III gastric cancer patients who underwent curative resection with D2 lymphadenectomy was analyzed retrospectively. Tumor localization and neoadjuvant treatment status were compared. Patients were divided into two groups; Group 1 with neoadjuvant treatment conduction and Group 2 without neoadjuvant treatment conduction. According to tumor localization, patients were divided into four groups, upper third (cardia and gastric fundus), middle third (gastric corpus), lower third (antrum), and extensive. Overall survival comparison was compared between groups.

Results

In this study, 94 patients (23 female, 71 male) were included. In 39 of them, the tumor was localized in the upper third, 32 in the middle third, 22 in the lower third, and four patients with extensive gastric tumor. According to age and gender, there was no statistically significant difference. Tumor localization had no statistically significant effect on the overall survival between groups (P=0.334). Neoadjuvant treatment was conducted in 61 patients. Neoadjuvant treatment (mean 18.9 months) did not improve overall survival when compared to the non-neoadjuvant group (mean 14.9 months) (P=0.06).

Conclusion

Advanced gastric cancer retains its high mortality despite the different use of the proposed neoadjuvant treatment. Surgery is still playing the main role in the treatment initiation of advanced gastric cancer.

Keywords: gastric cancer, neoadjuvant treatment, survival

GBBBA





OP19- CLINICOPATHOLOGIC DIFFERENCES BETWEEN EARLY-ONSET GASTRIC CANCER AND LATE ONSET GASTRIC CANCER

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Objective

While the incidence of gastric cancer has decreased in the last 10 years, the incidence of early-onset gastric cancer (EOGC), like other gastrointestinal malignancies, has increased. The aim of this study is to compare the similarities and differences of early-onset gastric cancers with average-onset gastric cancers in line with demographic and clinicopathological findings.

Materials-methods

In this retrospective study, the data of 174 patients who were operated for gastric cancer in a tertiary healthcare institution between January 2017 and June 2022 were examined. The patients were divided into two groups as the early-onset gastric cancer group and the control group. The early-onset group was accepted as the age of endoscopy screening (45 years). In addition to demographic data such as age and gender, tumor location, depth of invasion, lymph node status, distant metastasis status, histopathological type of tumor, degree of differentiation, preoperative tumor marker status, and operative findings were recorded.

Results

Twenty-four (13.79%) patients included in the study were in the early-onset group (aged \leq 45 years), 150 (86.21%) patients (aged > 45 years) were in the late-onset group. There was no difference between the groups in terms of operation time, number of lymph nodes dissected, preoperative tumor markers and gender. However, there is a difference in terms of T and N stage of the tumor, poor differentiation degree (75.0 vs. 45.3%), distal location (70.83% vs. 48.0%) and signet ring pathology (20.83% vs. 8.66%).

Conclusion

The incidence of early-onset gastric cancer is increasing, and clinicopathologically advanced stage, higher grade, diffuse type and signet ring cell histology have worse prognostic features. Complate elucidation of the genomic formation of the disease will be effective in terms of new treatment modalities and improving the prognosis of the disease.

Keywords: Clinicopathologic characteristics, early-onset gastric cancer, Gastric cancer, prognostic.

TGBBZ





OP20- FACTORS AFFECTING ANASTOMOTIC LEAKAGE AND LEAKAGE MANAGEMENT IN GASTRIC CANCER

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Objective

In our study, we aimed to investigate the factors that can predict anastomotic leakage.

Materials-Methods

Patients who were operated for gastric cancer in our clinic between 2015-2022 were evaluated retrospectively. Demographic data, comorbidities, ASA score, preoperative biochemical data, neoadjuvant therapy, tumor localization, operation type, postoperative pathology results were evaluated retrospectively.

Results

A total of 261 patients were included in the study. Of the patients, 89 (34.1%) were female and 172 (65.9%) were male. The mean age is 64.52±11.29 (min-max:26-93). Complications developed in 27 (10.3%) of the patients included in the study. Of these, 12 (4.59%) surgical site infections, 6 (2.29%) pneumonia, 1 (0.38%) ischemic stroke and 8 (3.1%) patients developed anastomotic leakage. Total gastrectomy was performed in 6 of these 8 patients, proximal gastrectomy in 1, and distal gastrectomy in 1 (p:0.045). Age, gender, ASA score, comorbidities and tumor localization were not statistically significant in terms of anastomotic leakage. While 7 patients did not receive neoadjuvant treatment, 1 patient received neoadjuvant treatment. There was no significant difference between the two groups in preoperatively measured CRP, albumin, thrombocyte, leukocyte, lymphocyte and neutrophil counts. However, the mean neutrophil/lymphocyte ratio was found to be 1.94±2.15 in the non-leakage group, while it was 0.95±0.56 in the leaky group (p:0.017). Similarly, while the platelet/lymphocyte ratio was 153.76±98.02 in the group without leakage, it was found as 225.40±329.78 in the group with leakage (p:0.013).

Endoscopic stenting was performed in 6 of 8 patients who developed anastomotic leakage, endoscopic clipping was performed in 1 patient, and primary repair + drainage was performed in 1 patient on the 2nd postoperative day. Percutaneous drainage was required in 2 of the patients who underwent endoscopic intervention. Leakage occurred in an average of 6.75 (min-max:2-15) days. Seven of the patients with anastomotic leakage died in a mean postoperative 16.57 days (min-max: 7-33). 1 patient was discharged on the 53rd postoperative day.

Conclusion

Neutrophil/lymphocyte and platelet/lymphocyte ratios can be used to predict anastomotic leakage.

Keywords: gastric cancer, anastomotic leakage, risk factors

TGGG





OP21- EFFECT OF NEOADJUVAN TREATMENT TO SURGERY ON PATHOLOGICAL RESPONSE IN GASTRIC CANCER: PRELIMINARY STUDY

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MİDE KANSERİNDE NEOADJUVAN TEDAVİDEN CERRAHİYE KADAR GEÇEN SÜRENİN PATOLOJİK YANITA ETKİSİ: ÖN ÇALIŞMA

Amaç

Bu çalışmada, NAKT'den cerrahiye kadar olan bekleme süresinin ve ek klinikopatolojik özelliklerin patolojik yanıta etkisinin araştırılması amaçlanmıştır.

Gereç-Yöntem

Çalışmamıza 2019-2022 yılları arasında NAKT sonrası opere olan 24 olgu dahil edildi. Olgulara ait tüm patolojik preparatlar yeniden değerlendirilerek, regresyon için Modifiye Ryan regresyon skorlaması yapıldı. Demografik (yaş, cinsiyet), klinik (alınan neoadjuvan tedavi, ecog performansı, preoperatif hemoglobin ve albümin değeri, vücut kitle indeksi (BMİ), tedavi sayısı, cerrahiye kadar geçen süre, operasyon tipi) ve patolojik (regresyon derecesi, tümör evresi, perinöral ve lenfovasküler invazyon durumu, HER2 ekspresyonu) özellikler her hasta için ayrı ayrı not edildi. Tüm veriler SPSS 25.0 programında cox regresyon, pearson ki kare testleri ve Kaplan Meier sağkalım testi ile analiz edildi.

Bulgular

Tümör regresyon düzeyi ile kategorik değişkenlerin karşılaştırılmasında cinsiyet, ecog performansı, aldığı tedavi rejimi, HER2 durumu, perinöral ve lenfovasküler invazyon ilişkisi saptanmaz iken (p>0,05) yüksek tümör histolojik derecesinin tedaviye iyi yanıtla ile ilişkili olduğu saptandı (p=0,008). Skala değişkenler ile tümör regresyon düzeyleri karşılaştırıldığında yaş, preoperatif hemoglobin değeri, albümin değeri, BMİ ve tedavi sayısı ile ilişkisi yoktu (p>0,05).

Genel sağkalım %79, ortalama yaşam süresi 34,6±3,06 ay idi. Korelasyon analizinde NAKT sonrası bekleme süresi ile yaşam süresi arasında ilişki görülmedi (p=0,493). Bekleme süresini 5 hafta'dan uzun ve 5 haftaya eşit veya kısa olarak iki gruba ayırdığımızda tümör regresyon düzeyleri farklılık göstermedi (p>0,05). Cinsiyet, operasyon tipi, tümör T evresi, N evresi, BMİ, histolojik derece ve yanıt derecesi sağkalım ile ilişkili bulunmadı (p>0,05). Olgulardan dördünde(%17) R0 rezeksiyon sağlanamadı ve cerrahi sınır pozitif olguların yaşam süreleri R0 rezeksiyona göre daha düşüktü (P=0,001).

Sonuç

Çalışmamız NAKT sonrası bekleme süresinin hem tümör regresyon derecesine hem de sağkalıma etkisi görülmedi. Mide kanserinde tümörsüz cerrahi rezeksiyon ve D2 lenfadenektomi temel ve vazgeçilmez hedef olmalıdır. Mide kanserinde NAKT uygulaması standardizasyon çalışmalarının, uzun izlem süresine sahip daha geniş serilerde yapılmasına ihtiyaç devam etmektedir. Bu açıdan çalışmamız literatüre ışık tutabilecek öncü çalışmalardandır.

Keywords: Mide kanseri, zaman, cerrahi, neoadjuvan kemoterapi



Congress

GASTRIC CANCER

OP22- DEMOGRAPHIC AND CLINICOPATHOLOGICAL EVALUATION OF OUR PATIENTS WITH GASTRIC TUMOR IN THE COVID-19 PANDEMIC AND NON-PANDEMIC PERIOD: A RETROSPECTIVE STUDY

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Introduction

It is unclear whether the Covid 19 pandemic is causing difficulties in diagnosis and treatment in gastric cancer patients. Despite advanced diagnostic methods ,patients are detected at an advanced stage. In this study, we aimed to evaluate the demographic and clinicopathological features of patients with gastric cancer in the Covid-19 pandemic and non-pandemic period.

Methods

This retrospective study consisted of 73 patients with gastric cancer who were hospitalized between January 2016 and July 2022. The number, demographic and clinicopathological characteristics , stages, types of surgery and postoperative complications were compared during the Covid19 pandemic and the non-pandemic period.

Results

Seventy -three cases of gastric cancer were identified in 29(40%) women and in 44(60%)men,with an avarage of 62(aged 34-85). All patients had been diagnosed by CT, MRI and endoscopic biopsy.The localisation of tumors were found 10(13%), 35(45%) and 33(42%) in the proximal, corpus and distal stomach, respectively. Fifty-seven patients was found resectable and 8 of them received neoadjuvant chemotherapy.The patients underwent total gastrectomy + D2 lymph node dissection, subtotal gastrectomy, distal gastrectomy, wedge resection and proximal gastrectomy in 26 (35%), 21 (28%), 4(5%), 3 (4%) and 1 (2%)patients.Two patients underwent only exploratrive laparotomy.Three metastasized

patients had to undergo emergency laparotomy as a result of upper gastrointestinal bleeding. Patients were classified by TNM staging according to 8th edition of the AJCC guidelines as Stage I;7((12%) ,Stage II; 4 (7%), Stage III: 46 (79%) and Stage IV: 16 (21%).While a significant decrease was observed during the pandemic year (2020) in patients, the total number of patients diagnosed with gastric cancer is 5(6%) patients. In this group, 2 and 3 patients was found on Stage II and Stage III disease. Histopathologically, adenocarcinoma, gastrointestinal stromal tumor, neuroendocrine tumors and other types was found in 68%, 4%, 4% and 24% of patients. Avarage count of lymph node was found 17(1-92) and median positivity rate was 9(0-51).While the postoperative morbidity was found in 3 patients (Anastomotic leakage , pneumothorax, acute kidney failure), mortality rate was found 9%. Hospital lenght of stay time was found 10.2 days(5-49 days).

Conclusion

A decrease in gastric cancer surgeries suggested that there was a significant patients' based negative impact on the admission and diagnostic period of the patients with gastric cancer. However, there was no decrease in the number of endoscopic and imaging tests in our institution, and the lack of early diagnosis of the disease was not different from the general incidence rate.

Keywords: gastric cancer, adenocarcinoma, gist, net, covid19



Congress

FRNATIONAL

KSH

OP23- PROGNOSTIC FACTORS IN STOMACH GASTROINTESTINAL SYSTEM STROMAL TUMORS

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Objective

GISTs are the most common tumors in the stomach in the gastrointestinal tract and their 5-year survival is between 20-44%. Tumor-related factors are mainly effective in prognosis. In our study, we aimed to evaluate the prognostic factors in gastric GISTs.

Materials-Methods

Patients who were operated for gastric GIST between 2017-2021 were evaluated retrospectively. Demographic data, symptoms, preoperative imaging methods, pathology data, postoperative complications, follow-up time, survival and disease-free survival data of the patients were evaluated.

Results

33 patients were included in the study. Of the patients included in the study, 23(69.7%) were female, 10(30.3%) were male, mean age was 59.42±11.47(min-max:31-86). According to pathology results, 1 was very low risk(3.0%), 11 low risk(33.3%), 6 intermediate risk(18.2%), 15 high risk(45.5%) was found. The mean pathological tumor size was 7.71±6.73cm, the mean number of mitoses in 50 high-magnification fields was 2.55±1.58, and the Ki-67 score was 9.88±7.53. 10 patients(30.3%) received adjuvant imatinib treatment. During a mean follow-up period of 3.09±1.16 years, 7 patients(21.2%) developed local recurrence and the same 7 patients developed distant metastasis(21.2%). During the follow-up period, death developed in 11 (33.3%) patients. The mean disease-free survival was 3.03±1.31 years, and the mean overall-survival was 3.15±1.20 years. When the risk factors associated with mortality are evaluated, the tumor size is 10.20cm on average(p: 0.034), high-risk tumor according to Fletcher risk class(p: 0.013), mean Ki-67 score is 12.3(p: 0.014), 50 large Mean mitosis of 3.45 in the magnification area(p:0.017), positive surgical margin(p:0.040), positive CD117 and CD34(p:0.018, p:0.044) were found to be associated. When the risk factors associated with metastasis are evaluated, the tumor size is 11.8cm on average(p: 0.048), the mean Ki-67 score is 12.7(p: 0.018), the mean 3.8 mitoses in 50 high-power fields (p: 0.011), Having a high-risk tumor according to Fletcher risk class (p:0.010) was found to be significant. CD117 and CD34 positivity were not found significant.

Conclusion

Tumor size, grade, Ki-67 score, mitosis in 50 magnification fields were found to be effective factors in terms of both mortality and metastasis development.

Keywords: gist, prognosis, gastrointestinal system stromal tumor





OP24- CLINICOPATHOLOGICAL CHARACTERISTICS OF YOUNG ADULT (<40 YEARS OLD) GASTRIC CANCER PATIENTS

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GENÇ ERİŞKİN (<40 YAŞ) MİDE KANSERİ HASTALARININ KLİNİKOPATOLOJİK ÖZELLİKLERİ

AMAÇ

Mide kanseri genellikle yaşa bağlı bir hastalıktır ve çoğunlukla yaşamın altıncı dekatından sonra teşhis edilir. Bu çalışmanın amacı genç hastalarda (≤40) mide kanserinin klinikopatolojik özelliklerini ve prognozunu araştırmaktır.

GEREÇ-YÖNTEM

Kliniğimizde 2008-2022 yılları arasında histolojik olarak primer mide karsinomu tanısı alan ve gastrektomi uygulanan hastaların verileri retrospektif olarak incelendi. Veri ve takipte eksiği olmayan 38 hasta çalışmaya dahil edildi. Daha sonra demografik ve klinikopatolojik özellikler incelendi.

BULGULAR

Hastaların 24'ü (%63) erkek, ortalama yaşları 36.4±4.67 yıl idi. En sık semptom kilo kaybı ve karın ağrısıydı. Tümör sıklıkla distal 1/3 yerleşimliydi (%58). Dört hasta metastatik olmasına rağmen tümöre bağlı komplikasyonlar nedeniyle cerrahi uygulandı (Takipler sırasında dört hastada da mortalite gelişti, ortalama survi 12,6 aydı). Postoperatif ilk 28 gün Dindo Clavien Sınıf 3 komplikasyon

Histopatolojk olarak 15 (%39) hastada tümör kötü differansiye natürdeydi. Kötü differansiye tümörü olan hastalarda mortalite oranı %46,6 iken iyi differansiye olanlarda bu oran %34,7 idi. Oransal olarak farklılık olmasına rağmen istatistiksel olarak anlamlı farklılık saptanmadı (p=0,514). Bu durumu çalışma grubundaki hasta sayısının az olması ile ilişkili olduğunu düşünüyoruz.

19 hasta intestinal tipteydi (Lauren Sınıflaması). Lauren sınıflamasına göre dağılım ile mortalite arasında istatistiksel olarak ilişki görülmedi (p=0,723). Helicobacter pylori pozitifliği %66 oranındaydı. Hp pozitifliği ile diffüz tip (Lauren Sınıflaması) ve kötü differansiye tip arasında anlamlı ilişki görüldü (sırasıyla p=0,10 ve 0,14).

Hastaların preoperatif dönemdeki ortalama "prognostik nutrisyonel indeks (PNI) skoru" 42.19 ± 7.20 idi (mortalite görülenlerde $38,73\pm5,86$, görülmeyenlerde $45,30\pm7,17$). PNI skoru düşük (<43) olan hastalarda mortalite anlamlı olarak yüksekti (p=0.009). Preoperatif tümör markerları ile evre ve mortalite arasında anlamlı ilişki görülmemiştir (Ca 19-9: p=0.281 ve p=0,752; CEA: p=0.626 ve p=0.703). Takipler sırasında 15 (%39) hastada mortalite görüldü. Mortalite ile cinsiyet (p=0.18), tumör lokalizasyonu(p=0.56), histolojik tip (p=0.15) arasında ilişki saptanmamıştır. İleri evre (≥3) mortaliteyi arttıran nedenlerdendir (p=0.005).

SONUÇ

Genç hasta grubunda mide kanseri literatürdeki genel popülasyon verilerine kıyasla undifferansiye histolojik pattern daha sık görülür. Daha yüksek lenf nodu metastazı oranı ve ileri evre ile başvurulmaktadır. Genç hasta grubunda kadın popülasyon dominansı bilinse de hasta grubumuzda bunun tersi görülmüştür. Solid organ metastazı olan hastalarda tümör ilişkili komplikasyonlara bağlı geçirilen cerrahinin (palyatif rezeksiyonların) surviye katkısı yoktur.

Keywords: mide kanseri, genç, kanser, mide





OP25- CLINICOPATHOLOGICAL FEATURES, PROGNOSIS AND SURVIVAL OUTCOMES OF STOMACH CANCER IN YOUNG PATIENTS

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GENÇ HASTALARDA MİDE KANSERİNİN KLİNİKOPATOLOJİK ÖZELLİKLERİ, PROGNOZU VE SAĞKALIM SONUÇLARI

Amaç

Genç mide kanserli hastaların genel popülasyona göre daha kötü prognoza sahip olup olmadığı halen tartışılmaktadır. Bu çalışmanın amacı, genç mide kanserli hastaların klinikopatolojik özelliklerini incelemek, prognoza etki eden faktörleri araştırmak ve sağkalım sonuçları ile değerlendirmekdir.

Materyal-Metot

2006-2018 yılları arasında İzmir Tepecik Eğitim ve Araştırma Hastanesinde mide kanseri nedeniyle küratif rezeksiyon yapılmış 45 yaş ve altı hastalar demografik verileri klinikopatolojik özellikleri ve sağkalım verileri ile retrospektif olarak incelendi. Kırkbeş yaş ve altı operable mide kanserili hastalar çalışmaya dahil edildi. Toplam 394 hasta dosyası incelendi ve 36 hasta çalışmaya dahil edildi.

Bulgular

Hastaların 26 (%72,2)'sı erkek, 10 (%27,8)tanesi kadın idi. Hastaların 22 (%61,1)'sine total gastrektomi +D2 lenf nodu disseksiyonu , 14 (%39,9) 'üne subtotal gastrektomi + D2 lenf nodu disseksiyonu uygulandı. Tümör lokalizasyonuna göre değerlendirildiğinde 15 'i mide antrumda , 9'u mide korpusda , 7 'si küçük kurvaturda, 5 'i kardiyoözafagial bileşkede yer almaktaydı. Histopatolojik özelliklerine göre değerlendirildiğinde 18(%50)'i taşlı yüzük hücreli alt tipine sahip idi. Hastaların 23'ü kötü diferansiye , 6 tanesi orta diferansiye ve 7 tanesi iyi differansiye adenokanser olarak değerlendirildi. Hastaların 5(%13,9)'inde cerrahi sınır pozitifliği olduğu gözlendi. 5 yıllık genel sağkalım %39,8 bulundu. Çalışmamızda histopatolojik alt tipin ve diferansiyasyon düzeyinin sağkalıma etki etmediği gözlendi. Erkek cinsiyetin kadın cinsiyete göre sağkalımın daha iyi olduğu bulundu (%46,2'ye karşı %20). Evrelere göre en kötü sağkalım evre 2b, 3a ve 3c'de olduğu gözlendi (sırasıyla %30, %25 ve %25).

Sonuç

Literatür ile değerlendirildiğinde çalışmamızda genç mide kanserli hastaların sağkalımı genel popülasyona benzer sonuçlar göstermektedir. Mide kanserinin genç hastalarda da görülebileceği de akılda tutulmalıdır. Genç hastalarında yaşlı hastalara göre benzer sağkalım göstermesi, yaşın prognostik bir faktör olmadığına işaret etmektedir. Genç hastalarda tümör davranışını daha iyi anlamak ve tedavi seçeneklerini geliştirebilmek için daha geniş popülasyonlu çalışmalara ihtiyaç vardır.

Keywords: Mide kanseri, Genç yaş, Sağkalım







OP26- OVERALL SURVIVAL ANALYSIS OF OUR PATIENTS WITH GASTRIC CANCER WHO HAVE NEOADJUVANT CHEMOTHERAPY

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NEOADJUVAN KEMOTERAPİ ALAN MİDE KANSERLİ HASTALARIMIZIN SAĞ KALIM SONUÇLARI

Amaç

Mide kanseri, dünyada en sık görülen kanserler arasında 4. ve kanserden ölümler arasında 2. Sıradadır. Küratif cerrahi ve yeterli lenf nodu diseksiyonuna rağmen ileri evre mide kanserinin sağ kalım oranları düşüktür. Sağ kalımı (OS) iyileştirmek için çeşitli tedavi ve yöntem arayışları devam etmektedir, ne var ki sonuçlar halen yüz güldürücü değildir. Neoadjuvan kemoterapi (NAKT) ile rezeke edilemeyen tümörü rezektabl hale getirmek, patolojik tam yanıt oranlarını ve sağ kalımı arttırmak, tümör ilişkili semptomları azaltma, tümöre downstaging ve postoperatif dönemde ameliyat ilişkili semptomlara bağlı azalan kemoterapi toleransını iyileştirmeyi hedefler. Tek başına cerrahiye karşı NAKT alan mide kanserli hastalarda 5 yıllık sağ kalımda %12'lik bir avantaj sağlamıştır (sırasıyla %30'a karşı %42).Mide kanseri sağ kalımı halen düşük bir kanserdir. Sağ kalıma etki eden faktörlerin araştırılması sağ kalımı iyileştirme çabalarına ışık tutacaktır.

Yöntem

2012-2022 arasında Tepecik ve Bozyaka Eğitim Araştırma Hastaneleri Onkoloji kliniğinde NAKT alan mide kanserli hastalar hastane kayıt sistemi üzerinden tarandı. Yaş, cinsiyet, histolojik tip, neaodjuvan rejim, diseksiyon denişliği, adjuvan kemoterapi (KT) ve radyoterapi (RT) almalarına göre sınıflandırıldı. Gastrointestinal stromal tümör (GIST) ve nöroendokrin tümör (NET) tanıları olan 2 hasta çalışma dışı bırakıldı. Verilerin sağ kalım analizi SPSS.21 programında Kaplan-Meier testi kullanılarak yapıldı.

TGEGZ



Sonuç

En az evre 1b olan mide kanserli 37 hastanın 28'i erkek 9'u kadındı (yaklaşık oran E:K=3:1). Sağ kalım analizinde cinsiyet farkı izlenmedi (p=0,3). Yaş ortalaması hem kadın hem de erkeklerde 59 yıldı. 12 hasta >65 yaş gruptayken 25 hasta 65 yaşından gençti. Mide tümörlerinin 13'ü kardiya, 16'sı korpus ve 8'i antrum yerleşimliydi. Kardiya tümörü proksimal; korpus ve antrum tümörleri distal mide tümörü olarak ayrıca gruplandırıldı. 37 hastanın 22'sinde radyolojik olarak lenf nodu izlenirken 15'inde izlenmemişti. NAKT alan hastaların 23'ünde FLOT,13'ünde FOLFOX, birinde FOLFIRI verilmişti. FLOT alan 23 hastadan 17'si yaşıyorken (sağ kalım %74) FOLFOX alan 13 hastadan 8'i yaşıyordu (sağ kalım %61). FOLFIRI alan bir hasta tanıdan 6 ay sonra kaybedildi. FLOT tedavisi neoadjuvan dönemde istatistiksel anlamlı olarak sağ kalım üzerinde daha faydalı idi.

Operasyon histolojisine göre değerlendirildiğinde 5'i taşlı yüzük morfolojisinde olmak üzere 36'sı adenokarsinom yapısındaydı. Bir hasta skuamoz hücreli karsinom tanısı almıştı. Skuamoz hücreli karsinom tanısı alan bu hasta tanıdan 6 ay sonrasında adjuvan tedavi alamadan kaybedildi. Taşlı yüzük ve skuamoz komponente sahip hastaların sağ kalımları istatistiksel anlamlı olarak düşük bulundu (p=0.001). Adjuvan RT almanın sağ kalım üzerine faydası görülmedi.

Tartışma

Elimizdeki verilerle rezektable mide kanserinin neoadjuvan tedavisinde en iyi tedavi rejimi FLOT olarak izlenmiştir. Prognozun esas belirleyicisi TNM ve histolojik tip olmakla birlikte OS katkısı sağlayacak en iyi tedaviyi vermek sonuçlarımızı iyileştirecektir. OS düşük bir kanser grubu olan mide kanserinde NAKT vermek operasyon morbiditesini azalttığı gibi KT toleransını da arttırmaktadır. Kendi içinde değerlendirdiğimizde FLOT rejimi ile daha iyi sonuçlar alınmıştı.

Keywords: mide kanseri, sağ kalım, neoadjuvan kemoterapi

TGCCZU





OP27- H.PYLORI AS A PREDICTIVE FACTOR FOR GASTRIC MALIGNENCIES: SPECTRUM OF SLEEVE GASTRECTOMY SPECIMENS

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Introduction

Obesity rates are increasing worldwide. Accordingly, there is also an increase in laparoscopic sleeve gastrectomy operations performed for obesity. H.pylori infection is a strong risk factor for certain types of gastric cancer, as well as causing various gastric pathologies such as gastritis and peptic ulcer.

Objective

Our aim is to reveal the histopathological changes in the gastric specimen of patients who underwent sleeve gastrectomy for obesity and to examine the relationship between H.pylori and these changes.

Materials-Methods

A retrospective study was designed with the histopathologic findings from pathology specimens of 456 patients who experienced LSG between April 2014 and Dec 2021. Our institution's database is used to access the necessary data for our study.

Results

Overall, the mean age was 44 years, with 367 females and 89 males. Chronic gastritis, chronic active gastritis, intestinal metaplasia, atrophic gastritis, neuroendocrine hyperplasia (NEH) were found in 301, 66, 13, 11, 6 patients, respectively. Gastrointestinal stromal tumor(GIST) was detected in 4 patients. H.pylori was detected in 97(21.3%) of the specimens. Gastric pathology data which obtained by preoperative endoscopy were found to be H.pylori positive in 199(66.3%) of 300 patients. Preoperative H.pylori positivity was observed in 67.06% of the patients with gastritis in the operation samples.

Discussion

We found that only 89(19.5%) patients had normal gastric mucosa and the rest had pathological changes. Microscopic examination of the piece is important in countries where H.pylori infection is common. We see that the H.pylori positivity rate, which was 66.3% preoperatively, decreased to 21.3% in patients who were operated after medical treatment. Despite this success in eradicating H.pylori, the cases, which could not be eradicated, needs to be followed closely. In addition, the detected GIST and NEH findings are at a substantial level.

Conclusion

Pathological examination should be done routinely after LSG operation. H. pylori is an important risk factor for gastritis, ulcer and gastric malignancy. Therefore, when the prevalence of H.pylori in our country is considered, close clinical follow-up of the patients is required in terms of H.pylori positivity both preoperatively and postoperatively.

Keywords: sleeve gastrectomy, helicobacter pylori, bariatric surgery, obesity







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Objective

Gastric cancer is one of the common common causes of cancer-related death. The long term prognosis is poor even after radical resection and requires different treatment approaches. Determining prognostic factors is essential for planning the treatment. The aim of our study is to evaluate the difference in survival according to stages and metastatic lymph node ratio.

Materials-Methods

Patients who were operated for gastric cancer between 2015 and 2022 were analyzed retrospectively. Patients with non adenocancer, who received neoadjuvant therapy, who have perioperative metastasis, dissected lymph nodes which less than 16 lymph nodes were excluded. Patients were grouped according to their stage and metastatic lymph node ratio.

Results

129 patients were included in the study. 83 (64.34%) were male and 46 (35.66%) were female. Total gastrectomy was performed in 88 (68.2%) patients, distal gastrectomy in 14 (10.90%) patients and proximal gastrectomy in 27 (20.90%) patients. When the pathology results were examined, the mean number of lymph nodes removed was 27.55 (\pm 10.69). The mean survival was calculated as 65.5 months for stage 1, 67.3 months for stage 2, and 40.5 months for stage 3 (p: 0.008). The mean survival of the group with a metastatic lymph node ratio of 0-25% was 68.1 months; 39.9 months for 26% – 50%; 39.6 months for 51 – 75%; It was found to be 17.0 months for 76 – 100% (p<0.001). All patients in stage 1 and 2 have a 0 - 25% lymph node metastasis rate. When stage 3 is evaluated in itself; The mean survival rate was 61.7 months in the group with a metastatic lymph node rate of 0-25%, and 39.9 months in the group with 26-50%; In the 51-75% group, the mean survival was 39.6 months; In the 76-100% group, the mean survival was found to be 17.1 months (p: 0.016). The mean survival was calculated as 59.2 months for stage 3a, 37.6 months for stage 3b, and 33.0 months for stage 3c (p: 0.028).

Conclusion

It has been shown that the lower the metastatic lymph node rate, the longer the survival.

Keywords: gastric cancer, metastatic lymph node ratio, prognosis

THE BE





OP29- THE OUTCOMES OF GASTRIC CANCER SURGERY IN ELDERLY PATIENTS

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Objectives

Gastric cancer has become more common in elderly patients as the population has aged. Surgery is still the primary treatment option for gastric cancer. The aim of this study was to evaluate the treatment patterns and outcomes of elderly patients who underwent gastric cancer surgery.

Materials-Methods

This was a single-center retrospective study. Patients aged 80 years and older who underwent surgery for gastric adenocarcinoma between January 2015 and June 2022 were retrospectively analyzed. Demographic, clinical, and histopathological parameters and postoperative outcomes were evaluated.

Results

During the study period, 261 gastric cancer surgeries were performed in our clinic. Twenty-three patients aged 80 years and older were included in the study. The mean age was 81.95 ± 3.11 (Range 80.96) years. 8 were female and 15 were male. 5 patients were ASA I, 11 patients were ASA II, and 7 patients were ASA III. Neoadjuvant therapy was applied to 3 patients. Total gastrectomy was performed in 11 patients, distal gastrectomy in 5 patients, and proximal gastrectomy in 7 patients. The mean number of lymph nodes removed was 19.87 ± 12.61 , and the number of metastatic lymph nodes was 9.22 ± 9.82 . Insufficient (less than 16) lymph nodes were excised in nine patients. The hospital stay was 9.34 ± 3.45 days. Type B anastomotic leakage was developed in 1 patient and treated successfully with endoscopic stenting. One patient died as a result of sudden cardiac arrest on the 4th postoperative day.

Conclusions

Octagenerians are a special group of patients and the treatment plan should be individualized. Whenever possible, curative surgery should be performed on all patients.

Keywords: Elderly patients, Gastric cancer, Octagenerians

IGGG





OP30- ANALYSIS OF GASTRIC ADENOCARCINOMA WITH NEUROENDOCRINE DIFFERANTIATION IN PATIENTS WHO UNDERWENT GASTRIC CANCER SURGERY

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Background

Gastric cancer is the 5th most common in the world. It is a type of cancer and 3 th in deaths caused by cancer.By the developing technology; endoscopic resections have an important role in the diagnosis and treatment of early gastric cancer. In advanced gastric cancer, surgical treatment is still the preferred treatment method.One of the factors determining the prognosis of the disease is tumor histopathology.In this paper, we aim to evaluate analysis of gastric adenocarcinoma with neuroendocrine differantiation in patients who underwent gastric cancer surgery

Materials and Methods

Ten gastric cancer patients who were operated between 2014 and 2018 and evaluated as adenecarcinoma with neuroendocrine differentiation as a result of pathology were retrospectively examined. Demographic findings, type of operation, TNM stage , tumor localization, tumor size, histopathological findings and overall survival of the patients were examined.

Results

When the patients were examined according to gender, 2 patients were female and 8 patients were male. The mean age of the patients was 65.1 (40-83). Total gastrectomy + D2 lymph node dissection was performed in nine patients and subtotal gastrectomy + D2 lymph node dissection was performed in 1 patient. according to TNM 8 th edition, 4 patients were evaluated as Stage 1B, 4 patients as Stage 3A, and 2 patients as Stage 3C. The mean tumor size was 6.5 cm (3-12). All patients underwent surgery after neoadjuvant chemotherapy. The mean survival time of the patients was 30.2 months (12-60 months).

Conclusion

With current treatment approaches, a significant increase in survival times of 5 years is achieved in patients with gastric cancer, but despite the fact that the patients we studied were treated appropriately with the literature, only 1 patient is still alive. We believe that the presence of neuroendocrine differentiation in patients with gastric cancer will be considered a poor prognostic finding, and it may be necessary to add additional treatment methods to standard treatment regimens.

Keywords: Gastric cancer, Neuroendocrine, adenocarcinoma

THE BE





OP31- HYDRO BT IN DIAGNOSIS AND FOLLOW-UP OF STOMACH CANCER

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MİDE KANSERİ TEŞHİS VE TAKİBİNDE HİDRO BT

Amaç

Mide kanseri, ölüme sebep olan malign kanserlerin önde gelenlerindendir.

Bilgisayarlı Tomografi (BT), mide kanserlerinin değerlendirilmesinde, gastroskopiye ek bilgiler vererek hastalığın evrelenmesinde ve operasyon öncesi cerrahın kararında oldukça etkili olmaktadır.

Standart batın BT çekimlerinde midenin değerlendirilmesinde iyotlu oral kontrast maddeler kullanılır. İyotlu oral kontrast maddeler mide duvarı ile lümenin ayrımına engel olduğundan iyotlu maddeler yerine sadece su ile midenin distandü edilmesi ile elde edilen BT ye hidro BT denilir.

Mide kanserlerinde hidro BT nin standart oral kontrastlı BT'ye göre daha etkin olduğunu kendi rutin uygulamalarımızda gördüğümüz için bu çalışma ile mide kanserleri ile ilgilenen meslektaşlarımıza da sunmayı amaçladık.

Gereç-Yöntem

alışmamızda; radyoloji kliniğine neoadjuvan kemoterapi öncesi ve sonrası gastrik kanser görüntülenmesi için son altı ayda gönderilen hastalardan 18 tanesinin hidro BT leri karşılaştırmalı olarak değerlendirildi.

İncelemeye aldığımız hastaların yaklaşık 8 saat aç olması istendi. İncelemeden önce 1500cc içme suyu içirildi ve yine çekime başlamadan önce masada bir miktar daha içirilerek yeterli distandü sağlanmaya çalışıldı. İncelemeye başlanmadan önce bir adet intravenöz hiyosin-N-butilbromür yapıldı. Sonra intravenöz yoldan 3-4ml/sn hızla 100-150ml iyotlu kontrast verilerek tek fazda görüntüler alındı. Çekim sonrası görüntüler, radyoloji iş istasyonlarındaki yüksek rezolüsyonlu monitorlarda çok yönlü planlar yapılarak (aksiyel, sagittal ve koronal) (multiplaner rekonstrüksiyon, MPR) değerlendirildi. Hidro BT uygulama yöntemleri içerisinde olan, arteriyel faz için 40-45 saniyede ve venöz faz için 60-70 saniyede alınan görüntülerle elde edilen bifazik dinamik görüntüleme incelemelerimizde kullanılmamıştır. Bu tür iki fazlı ya da üç fazlı dinamik kontrastlı BT görüntülemesinde tümörün normal mide duvarından ayırımını kolaylaştırır ancak verilen radyasyon dozu da artar. Ancak tümörün sadece mide duvarında olabileceği düşünülen ve ayırım için zorlanılan erken dönem hastaları gibi seçili hastalarda kullanılması tavsiye edilebilir.

Bulgular

Hastanemizde gastrointestinal cerrahinin kontrolünde yapılan hasta değerlendirme konseylerinde tartışılan 18 mide kanseri vakasının radyolojik görüntülemesi hidro BT ile yapılarak evrelemesi yapılarak neoadjuvan tedavi almaları kararlaştırıldı. Görüntüleme sonrası bu 18 hastanın 6 tanesi T1, 3 tanesi T2, 8 tanesi T3 ve 1 tanesi T4 tümör olarak değerlendirildi ve neoadjuvan tedavi sonrası görüntülemeleri tekrar hidro BT ile yapılarak tedavi etkinliği, tümör volümünün tedaviye cevabı ve lenf nodlarının durumu tekrar değerlendirilerek tedavi seçenekleri sunuldu.

Sonuç

Mide kanserlerinde Hidro BT, tümörün mide duvarındaki yayılımını, çevre doku ve organlara yayılım düzeyini, lenf bezleri varlığını doğru olarak ortaya koyabilen önemli bir görüntüleme ve evreleme aracıdır.

Doğru bir görüntüleme ve evreleme sonrası tedavi seçeneklerinin de doğruluğunun artacağı kesindir.

Keywords: gastric cancer, hidro BT, tomografi, staging







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OBJECTIVE

Diagnostic laparoscopy has been incorporated into the diagnostic strategy in gastric cancer for years. The main purpose of laparoscopy is to detect occult peritoneal dissemination, aiming for more accurate M1 staging (distant metastases) than diagnosis by imaging. It allows easy biopsy. Unnecessary laparotomy is avoided, and the morbidity of the procedure is minimal.

MATERIAL & METHOD

Ten patients who had DL between May 2022 to August 2022 were prospectively reviewed. Age, gender, preoperative staging (8th edition), Borman classification, operative data and postoperative pathology data of the patients were recorded.

RESULTS

The group was consisted of 6 male and 4 female patients and the average age was 62 (42-74). The mean tumor size was 6.8cm (2-20). Five patients were Borman type 3, while 2 patients were Borman type 4. Clinically 4 patients were classified as stage 2B and 3 patients as stage 3A (8th edition).

CONCLUSION

A current literature review suggests that staging laparoscopy is very important for determining the correct therapeutic strategy for the treatment of advanced gastric cancer. Peritoneal metastasis which was not detected by preoperative imaging methods was observed in 3 (33%) of the first 10 patients (up staging). Long-term results of our prospective trial will enable us to understand the importance of staging laparoscopy much better.

Keywords: Diagnostic Laparoscopy, Gastric Cancer, Neoadjuvant Chemotherapy

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POSTER ABSTRACTS

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ÍTGCC 202

14-16 October 2022







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RENAL HÜCRELİ KARSİNOMUN NADİR BİR METASTAZ YERİ: MİDE METASTAZI OLGU SUNUMU

AMAC

Renal hücreli karsinom (RCC), tüm primer renal neoplazmların %80-85'ini oluşturur. En yaygın metastaz bölgeleri akciğerler, kemikler, karaciğer ve beyindir. RCC'den mide metastazları son derece nadirdir. Genel olarak, metastatik RCC'de sonuç kötüdür ve 5 yıllık sağkalım oranları %5-30'dur. Çoğu RCC gastrik metastazı mide gövdesi ve fundusta bulunur. Tek tümörler çoklu tümörlere göre daha sık görülür ve prognozu daha iyidir. Hastanemizde Laparoskopik Total Gastrektomi + D2 Lenf Nodu Diseksiyonu sonrası ameliyat patolojisi RCC metastazı olarak değerlendirilen hastayı RCC öykülü hastalarda göz önünde bulundurulması gereken nadir bir durum olması sebebiyle literatüre katkı sağlayacağına inandığımız için sunmak istedik.

GEREÇ-YÖNTEM

Anemi etiyolojisi araştırılmak üzere tetkik edilen, RCC nedeniyle operasyon öyküsü bulunan hastanın peroperatif ve postoperatif tetkikleri ve bulguları değerlendirildi.

BULGULAR

Vaka sunumu: 73 yaşında bilinen HT, DM, koroner ater hastalığı olan 1 yıl önce sağ böbrekte Clear Cell RCC nedeniyle parsiyel nefrektomi yapılan erkek hastada, anemi etyolojisi arastırılması sebebiyle endoskopi planlandı. Vitalleri stabil, batın muayenesi doğaldı. Hgb: 8,9 diğer tetkikleri normaldi. Yapılan Gastroskopide; mide korpusta yaklaşık 2-3 cm çaplı hipervasküler, polipoid, dibine adrenalin enjeksiyonuyla submukozadan ayrılmayan malign karakterli kitle izlendi. Biyopsi alındı. Biyopsi sonucu Karsinoma İnfiltrasyonu olarak geldi. Hastaya Laporoskopik total gastrektomi + D2 LN diseksiyonu yapıldı. Operasyon sonrası patolojisinde RCC metastazı olarak değerlendirildi.

SONUC

Gastrointestinal semptomlarla başvuran RCC öyküsü olan herhangi bir hastada nadir de olsa mideye metastatik RCC'den şüphelenilmelidir. Tedavi seçenekleri arasında kanama için embolizasyon, epinefrin enjeksiyonu ve endoskopik rezeksiyon veya cerrahi yer alır. Cerrahi rezeksiyon, soliter gastrik metastaz için en iyi terapötik seçenek olmaya devam etmektedir ve uygun hastalarda anlamlı sağkalım uzaması ile sonuçlanmaktadır.

Keywords: Renal hücreli karsinom, Gastrik metastaz, Anemi





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PP2 - RADİKAL GASTREKTOMİ SONRASI NADİR GÖRÜLEN BİR GEÇ DÖNEM KOMPLİKASYON: RETROGRAD JEJUNO-JEJUNAL İNVAJİNASYON

Taha Anıl KODALAK, Hakan KÜÇÜKASLAN, Bilal ALKAŞ, Adnan GÜNDOĞDU, <u>Ali GÜNER</u> Karadeniz Technical University Faculty of Medicine, Department of General Surgery, Trabzon

İnvajinasyon proksimaldeki barsak segmentinin distal segment içerisine girmesi ile karakterize bir klinik tablodur. Erişkin grupta önde gelen nedenler arasında meckel divertikülü, malignite, geçirilmiş cerrahi bulunmaktadır. Bu sunumda dört yıl önce Siewert tip III özofagogastrik bileşke tümörü nedeniyle genişletilmiş total gastrekomi, D2 lenf nodu diseksiyonu ve Rouxen-Y özofagojejunostomi yapılan hastada jejuno-jejunostomi anastomozun hemen distalinde gelişen retrograd jejuno-jejunal invajinasyon vakasının sunulması amaçlanmıştır.

Olgu sunumu

Kanlı kusma nedeniyle acil servise başvuran 61 yaşındaki erkek hasta gastrointestinal sistem kanaması ön tanısı ile tarafımıza konsulte edildi. Özgeçmişinde dört yıl önce (Mayıs 2018) Siewert tip III özofagogastrik bileşke tümörü nedeniyle genişletilmiş total gastrektomi ameliyatı öyküsü mevcuttu (pT3N2M0, 6/46 LN, margin (-)). Üç kür adjuvan XELOX alan hastada radyoterapi öyküsü yoktu.

Kan basıncı 116/92 mmHg, nabzı 58 atım/dk ve hastaneye başvuru hemoglobini 12,3 g/dL olan hastanın fizik muayenesinde rektal tuşede normal gaita bulaşı olup karın muayenesi doğal idi. Yapılan endoskopide kanama odağı görülmedi. Özofagojejunal ve jejuno-jejunal anastomozda patoloji saptanmadı, barsak lümeni içerisinde iskemiye bağlı olduğu düşünülen nekrotik sıvı görüldü (Resim-1a,b). Tüm abdomen bilgisayarlı tomografisinde sol üst kadranda mezenterde girdap işareti ve komşuluğunda iç içe geçmiş ince barsak saptanması üzerine invajinasyon öntanısı ile cerrahi tedavi kararı alındı (Resim-2a,b). Ameliyatta jejuno-jejunal anastomozun 20 cm distalinde invajine olmuş barsak segmentleri saptandı (Resim-3a). İnvajine segment açıldığında yaklaşık 30 cm'lik barsak segmentinin distalden proksimale invajine olduğu ve tamamının nekroze olduğu görüldü (Resim-3b). Nekroze barsak segmenti rezeke edilip yan-yan jejuno-jejunostomi uygulandı. Patolojik incelemede malignite lehine bulguya rastlanmayıp iskemik değişiklikler izlendi. Postoperatif ek problem gelişmeyen hasta 7.günde taburcu edildi.

Tartışma ve Sonuç

Literatürde gastrektomi sonrası anastomozla ilgili komplikasyonlar arasında darlık, tıkanıklık, afferent ve efferent loop sendromlarının yanı sıra invajinasyon da bildirilmiştir. İnvajinasyon olguları çoğunlukla gastrojejunal anastomozda (jejunogastrik invajinasyon) olup mide cerrahisi sonrası jejuno-jejunal anastomozda retrograd invajinasyon bildirilen olgular nadirdir. İnvajinasyon olguları atipik klinik bulgularıyla başvurduğundan gastrektomi öyküsü olan hastaların acile başvurularında akılda bulundurulmalıdır.

Keywords: İnvajinasyon, Total gastrektomi, Roux-en-Y anastomoz, Retrograd invajinasyon







PP3 - A CASE OF THE SYNCHRONOUS GASTRIC AND COLON CANCER PATIENT-BASED THERAPY

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Introduction

Synchronous gastric and colon cancer rarely seen and its prevalence is 2-10%. Synchronous cancer is defined as two cancer identified simultaneously. Surgical decisions and adjuvant treatments to improve survival and prognosis must be planned according to features of the patients. In hereby, the importance of patient-based treatment in a patient with synchronous cancer is emphasized.

Case

A 73-year-old female was admitted to our hospital with complaints of abdominal pain and loss of appetite. Medical history has included ischemic heart disease/myocardial infarction and cardiac stent. Laboratory findings showed iron deficiency anemia.Upper GIT endoscopy showed tumoral lesions in the distal stomach histologically diagnosed as adenocarcinoma. The patient referred to our center for advanced evaluation and treatment. An abdominal CT scan showed a gastric tumoral mass and also a second tumor in the transverse colon.



At laparatomy, multiple tumoral lesions were identified on the distal antrum wall. A Subtotal gastrectomy+ D2 Lymphadenectomy+ Billroth II gastrojejunostomy+ Braun Anastamosis were performed. Additionally, a tumoral mass, extending from the serosa at the transverse colon, was found. A segmenter colectomy and end -to-end anastomosis was performed. Histopathologic examination of the gastric specimen disclosed T1 and T4a lesion and 0/14 lymph nodes metastasis. The gastric tumor was reported as Stage IIB according to 8th AJCC TNM staging system. The specimen of the colon was reported as stage IIA disease. The patient was discharged uneventhfully on the eighth postoperative day. The patient was consulted to oncologist . The patient was given antimetabolite monoterapy due to her older age, and myocardial comorbidities. She treated with adjuvant capecitabine 2500 mg/m2/day for 14 days then 7 days rest in 8 cycle. In the 60th months of therapy, no relapse or metastatic disease were not demonstrated clinic and radiologically. Result

Synchronous gastric and colon cancer patients' primer treatment options should be surgical resection. Adjuvant oncological treatment regimens must be determined according to patients' general health status, age and tumors' biological specialities.

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Introduction

Esophagojejunal anastomosis leakage(EJAL) is one of the most serious complication in surgery for gastric cancer. This is a case of a patient who underwent total gastrectomy and Roux-en-Y esophagojejunostomy anastomosis (EJA) for gastric cancer, and who subsequently developed EJAL, and successfully treated with endoscopic and surgical intervention. Case

Case

In the endoscopy of a 58 year old female patient, adenocarcinoma was detected taken from an ulcerovegetant mass detected in the antrum. Total gastrectomy, Roux-en-Y EJA and D2 lymphadenectomy were performed in the patient. The patient had progressive dyspnea after oral feeding on the 5th day, and had a daily seropurulent drainage of 100 cc from the abdominal drain. Blood analysis revealed leukocytosis and elevated CRP. Oral intake was stopped and antibiotic therapy was started. Bilateral pleural effusion and a 3 cm diameter collection in the operation site were observed in the CT scan(Picture 1- black arrow). Pleuracan was applied for pleural effusion. On the 14th postoperative day, surgical intervention decision was made. The abscess was drained. EJAL was detected through a 15mm opening in the anastomosis. A 10 cm covered self-expandable nitinol stent (CSENS) was placed with endoscopy(Picture 2- red arrow). Control endoscopy showed the opening in the anastomosis was not closed, and 18 cm CSENS was applied and a nasojejunal feeding tube was placed.

In the follow-up, patient's drain content turned into serous. Leukocytosis and CRP values are regressed. Oral intake was started and tolerated by patient. The patient was discharged 12 days after the second stenting procedure. Poorly cohesive gastric carcinoma was found in the pathology. Surgical margins were intact. Of the 61 lymph nodes dissected, 15 were metastatic. There was no significant finding of recurrence or metastasis in the PET-CT of the patient. The patient is in the postoperative 9th month and the follow-up continues in clinic.

Conclusion

EJAL can be seen in up to 14% of patients who have undergone total gastrectomy for gastric cancer. Mortality rates are up to 50%. Various imaging methods can be used in the diagnosis and the suspicion of leakage is important. There is no standard treatment for EJAL. Conservative treatment, drainage, endoscopic clip placement or stent placement and surgical treatment are the most commonly used treatment methods.

Picture 1



Picture 2



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PP5 - MINEN- NEUROENDOCRINE AND NON-NEUROENDOCRINE TUMOR COMPONENTS IN A GASTRIC NEOPLASM: MIXED NEUROENDOCRINE -NON-NEUROENDOCRINE NEOPLASIA

<u>Ömer ÇAĞLIYAN¹</u>, Hale KIZANOĞLU², Yiğit Kaan ŞEN¹, Yaşar Çağlar BEKKİ¹, Mehmet YILDIRIM University of Health Sciences Turkey, İzmir Bozyaka Education&Research Hospital Department of ¹General Surgery and ²Medical Pathology

Introduction

Gastric neuroendocrine -neuroendocrine neoplasms (MiNEN)are infrequently seen in surgery practice. MiNEN are heterogeneous subgroup of a neuroendocrine and adenocarcinoma components.WHO was defined each component must be present at least 30%.Here we report a gastric MiNEN case to identify the characteristics of the tumor. Case

A 54-year-old woman presented with complaints of indigestion and increased bloating after eating. There was no relevant past history. A CT was detected wall thickness in the greater curvature of the stomach. An endoscopic examination confimed ulcerovegetan soid mass located on the corpus of the stomach . The gastric biopsy was reported as adenocarcinoma. Laparotomy revealed a gastric mass without serosal invasion. Laparoscopic total gastrectomy + D2 lymph node dissection + Roux-en Y esophagojejunostomy was performed. Histologically ,the tumor was of two components. Although one component had a signet ring type adenocarcinoma (Pic 1HEX10),the other had a neuroendocrine tumor with G2 component.Immunohistochemical studies showed cytokeratin (+)(Pic 2), synaptophysin (-) .In a section ,neuroendocrine tumors-G2 (pic 3 HEx10) was found invading the muscularis mucosa and synaptophysin (Pic 4)and chromogranin (+) . No metastasis was detected in 30 lymph nodes. Histopathologic examiantion of the tumor showed MiNEN.









Picture3&4

Conclusion

It is known that cases with MiNEN have an aggressive course. Since there are tumors with different components, if the neuroendocrine component is well differentiated, adenocarcinoma can determine the prognosis, The selection of adjuvant treatment regimens according to the differentiation of subtypes contributes to the prognosis.

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Image: Weight of the second

14-10 Octobe 2022 **ITGCC 2**

PP6 - INCIDENTAL GASTRIC GLOMUS TUMOUR – A CASE REPORT

Daniela MARTINS, Francisca FREITAS, Pedro COSTA, Ana MONTEIRO, Herculano MOREIRA, João PINTO-DE-SOUSA CHTMAD, Vila Real, Portugal

Glomus tumours are benign rare tumours most commonly found on subungual regions of digits. Even rarely, these tumours could be found on stomach which corresponds to less than 1% of cases.

We present a case of an 81 years-old female, with past medical history of breast cancer and urolithiasis. Her only symptom was frequent belching. She had no other symptoms, namely bloating, nausea, vomiting nor dysphagia. A routine CT scan revealed a nodular lesion of 25mm, appearing to be dependent on the stomach wall, in the lesser curvature. She went through an upper endoscopy, which revealed a gastric body submucosal bulging. Then, the patient went through an echoendoscopy, with biopsies, which raised the suspicion of a neoplasm with neuroendocrine differentiation, that could be a GIST or breast cancer metastasis.

In view of the suspicion of malignant neoplasm (primitive/secondary) the multidisciplinary oncologic group meeting decided for surgery approach. The patient went through atypical laparoscopic gastrectomy. The post operative period was uneventful, and patient was discharged at post-operative day 4.

The anatomopathological examination revealed a glomus tumour of the gastric wall with free margins. This type of tumour is most frequently benign but rare cases of malignity have been described. They are often asymptomatic but can cause gastrointestinal bleeding and perforation. Surgery, preferably minimally invasive, is the treatment of choice, with complete resection and free margin, without lymphadenectomy required.

Keywords: Glomus Tumour, Gastric, Laparoscopy, Minimally invasive





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OP6 - WITH THE EXPANDATION OF ENDOSCOPY AND IMAGING METHODS INCREASED DETECTION RATE OF GASTROINTESTINAL STROMAL TUMORS AND MANAGEMENT

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INTRODUCTION

Gastrointestinal stromal tumors (GIST) are malignant subepithelial mesenchymal lesions of the gastrointestinal tract which is very rare. Lesions are originating from Cajal's interstitial cells or related stem cells, they are predominantly c-Kit (CD117) positive and have the PDGFRA mutation. GIST, which can be seen anywhere in the gastrointestinal tract, is seen in the stomach at a rate of 60% and in the small intestines at a rate of 20%¹. It can rarely be seen in non-GIS regions (e.g. omentum, retroperitoneum, mesentery). The average age of occurrence is 55-60 years. There is no significant difference in terms of gender. Although the clinical presentation can be very different, the symptoms are not specific. They are most commonly encountered with gastrointestinal bleeding. It may also cause nonspecific clinical symptoms such as dysphagia, abdominal pain, nausea or signs of intestinal obstruction. Asymptomatic patients may be diagnosed incidentally in examinations performed for other reasons. With the widespread use of endoscopy in recent years, the development of radiological imaging methods and the increase in the number of imaging, the number of patients diagnosed with GIST has increased compared to previous years and patient management has begun to change. With the widespread use of endoscopy, detection of more gastric GISTs in the early stage gave the chance for complete resection². Started to change the management of especially small lesions and made it difficult for surgeons to decide on surgical treatment. These rapid developments are not yet implemented by surgeons at the same speed. In this study, it was aimed to discuss the changing treatment modalities and increase the awareness of surgeons.

MATERIALS AND METHODS

19 patients who were diagnosed with gastric GIST in our clinic between 2013-2022 and whose surgical treatments were completed were evaluated. Groups were compared with patient's tumor sizes and endoscopic findings on preoperative computed tomography (CT) images³. Of 19 patients with a mean age of 58.36 years, 12 (63.15%) were male and 7 (36.84%) were female. 7 (36.82%) of the patients were diagnosed incidentally while being examined for other reasons. When the tumors of 8 (42.1%) patients in the high-risk group were compared with the patients in other risk groups, a statistically significant difference was found with the diameter defined on CT and the presence of metastasis. Open surgery was performed in 9 patients and laparoscopic surgery was performed in 10 patients (<u>Table 1</u>). Endoscopic treatment methods were not used in any of the patients. All of the patients with metastases in their follow-up were in the high-risk group and resistance to imatinib treatment was found in 1 patient. In a patient in the high-risk group, recurrence was detected in the postoperative 4th year and responded to medical treatment, but surgical treatment was decided because complete regression could not be achieved.





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PARAMETER	RESULT	
GENDER	Female	7 (%36.84)
	Male	12 (%63.15)
TUMOR SITE	Cardia	4 (%21.05)
	Fundus	1 (%5.26)
	Corpus	13 (%68.42)
	Antrum	1 (%5.26)
HISTOLOGYCAL TYPE	Spindle	13 (%68.42)
	Mixt	4 (%21.05)
	Epitheloid	2 (%10.52)
RISK CLASSIFICATION	Very low	2 (%10.52)
	Low	6 (%31.57)
	Intermediate	3 (%15.78)
	High	8 (%42.10)
IMMUNOHISTOCHEMICAL TESTS	CD117	18 (%94.73)
	CD34	18 (%94.73)
	DESMİN	2 (%10.52)
	SMA	3 (%15.78)
	DOG1	13 (%68.42)

TABLE-1 Demographic and pathological characteristics of patient with GIST



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RESULTS

With the development and easier access of imaging methods, the rate of patients diagnosed with small scale, in the early stage and in the metastasis-free period has started to increase. Since endoscopic interventions can be used safely in these patients, it is recommended to evaluate this aspect before the decision of surgical treatment. Prognosis in gastrointestinal stromal tumors depends on tumor size and mitotic activity³. CT and endoscopy have an important place in the diagnosis of the tumor, evaluation of the response to treatment, recurrence and metastasis.

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OP8 - OUR EXAMINATION RESULTS WITH UPPER GASTROINTESTINAL SYSTEM ENDOSCOPY OF THE STOMACH AND DUODENUM

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Introduction

Esophageo-gastro-duodenoscopy (EGD) is an important procedure used for detection and diagnosis of esophago-gastric lesions. Kussmaulin 1868 firstly arranged a straight, rigid gastroscope, and introduced it into the stomach of a sword swallower . With the introduction of the electric light, semiflexible instruments and fibreoptic, endoscopy became a key tool in the management of adult patients with GI problems(1).

Upper GI (UGI) endoscopy is commonly performed and carries a low risk of adverse events. Large series reportadverse event rates of 1 in 200 to 1 in 10,000 and mortalityrates ranging from none to 1 in 2000 (2).

Major adverse events related to diagnostic UGI endoscopy are rare and include : Cardiopulmonaryadverse events, İnfection, Perforation, and Bleeding(3).

Cardiopulmonary adverse events related to sedationand analgesia account for as much as 60% of UGIendoscopy adverse events. The rate of cardiopulmonaryadverse events in large, national studies is between 1in 170 and 1 in 10,000. Reported adverse events rangefrom minor incidents, such as changes in oxygen saturationor heart rate, to significant adverse eventssuch asaspirationpneumonia, respiratoryarrest, myocardialinfarction, stroke, and shock(4).

Infection :can result from either the procedure itself or failure tofollow guidelines for the reprocessing and use of endoscopicdevicesandaccessories. Transientbacteremiaas a result of diagnostic UGI endoscopy has been reported at rates as high as 8%, but the frequency of infectious endocarditis and other clinical sequelae is extremelylow. Current guidelines do not recommend antibiotic prophylaxis withdiagnostic UGI endoscopy solely to prevent infectious endocarditis(5).

Perforation : Perforationrates of 1 in 2500 to 1 in 11,000.Factors predisposing toperforation include the presence of anterior cervical osteophytes,Zenker'sdiverticulum, esophagealstricture, malignancies of the UGI tract, and duodenal diverticula. Perforation of the esophagus is associated with amortality rate between 2% and 36%. Earlyidentificationand expeditious management of a perforation havebeen shown to decrease associated morbidity andmortality(6).

Materials and methods

In our study, we aimed to documentto the demographic characteristics of the patients and macroscopic and microscopic diagnosis of Upper Gastrointestinal Endoscopic (UGE) examination.

Within Hatay Training and Research Hospital: Between August 2021 and August 2022: 993 endoscopic procedures were performed by the Surgical Oncology (CO) and Gastroenterological Surgery (GEC) clinics(Table1). The records in the endoscopy unit and pathology department were reviewed retrospectively.





	Endosco py	Endoscopic biopsy	Polypectomy	Malignancy	Sclerotherapy (1/10000 Adrenaline injection)
GEC	852	787(92,3%)	35(4,1%)	5(0,58%)	90(10,5%)
СО	141	112 (79,4%)	5(3,5%)	5 (3,5%)	10(7%)
Total number	993	899 (90,5%)	40(%4)	10(%1)	100(%10)

Table1: Number of polypectomy, sclerotherapy and malignancy in endoscopies performed in GEC and CO polyclinics.

Results

Polyps were detected in 40 (4.02%) of 993 (542 (54.5%) female, 451 (54.5%) male), female(60%) and their mean age was 57 (Table2). The most common symptom in patients with polypoid lesions wasdyspepsia.(87.5%) A single polyp was detected in 30 (75%) of 40 patients, and multiple polyps in 10 (25%) patients. The most common type of polyp was hyperplastic polypin 30 (75%) of the patients. While polypoid lesions were most common in the antrum (15 patients, 37.5%), they were least observed in the bulbus (3 patients, 7.5%). Bleeding in the form of leakage was stopped with sclerotherapy(1/10000 Adrenaline injectionin) 100 (10%) patients after polypectomy. The most common accompanying endoscopic pathology was chronic active gastritis (72.5%). Thirty-nine (97.5%) of the polyps that underwent excision or biopsy were sessile Helicobacter pylori was positive in 25 (62.5%) of the patients with polyps. High-grade dysplasia was detected in 1 patient. Subtotal gastrectomy was performed at the request of the patient. Thepathology result was reported as low grade dysplasia. Malignancy was detected in 10 (1%) patients. While the malignancy rate in the patients who applied to the GEC outpatient clinic was 0.58%, it was 3.54% in the patients who applied to the CO outpatient clinic. The mean overall age was 51 (youngest 17, oldest 72). The most common localization was the antrum in 7 patients (70%). Perioperative chemotherapy was given to 5 patients. 1 patient was considered unresectable. Gastrectomy and D2 lymph node dissection were performed in 9 patients. In addition, 2%) patients had lithobezoar, Gastric diverticulum in 2 (0.2%) patients, Duodenal diverticulum was detected in 4 (0.4%) patients.

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Characteristics	Number of polyps (%)
Localization	
Antrum	15(%37,5)
Corpus	7(%17,5)
Fundus	4(%10)
Cardia	11(%27,5)
Bulbus	3(%7,5)
Number	
Single	30(%75)
More than one	10(%25)
Shape	
Sessile polyp	39(%97,5)
Peduncle polyp	1(%2,5)
Dimension	
0-1 cm	39(%97,5)
1-2 cm	1(%2,5)
Clinic	2
Dyspepsia	35(%87,5)
Gor	30(%75)
Pain	14(%35)
Anemia	12(%30)
Weight loss	5(%12,5)

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Characteristics	Number of polyps (%)	
Endoscopic finding		
Gastritis	40(100%)	
Esophagitis	15(37,5)	
Gastric ulcer	7(%17,5)	
Hiatal hernia	8(%20)	
Pathological features		
Chronic inflammation	40(%100)	
Chronic gastritis	11(%27,5)	
Chronic active gastritis	29(%72,5)	
Neutrophil activity	31(%77,5)	
Glandular atrophy	2(%5)	
Intestinal metaplasia	4(%10)	
H.pylori	25(%62,5)	
Subtype,other	•	
Hyperplastic	30(%75)	
Fundic gland	4(%10)	
Adenomatous	1(%2,5)	
Foveolar hyperplasia	3(%7,5)	
Vascular ectasia	1(%2,5)	
Nodular duodenitis	1(%2,5)	and the

Table 2: Clinical symptoms, endoscopic findings and clinical and pathological features of the detected lesions ,upper gastrointestinal endoscopy.



Premalignant lesions of gastric cancer encompass a variety of conditions such as chronicgastritis, intestinal metaplasia(IM)and dysplasia, in which elevated risk of developing gastric cancer have been documented. Gastric polyps are histologically classified as hyperplastic, adenomatous or inflammatory polyps. The incidence of gastric polyps detected(4%)with endoscopic procedures has been reported to range from 2 to 6% is similarin ourstudy (13). The majority of gastric polyps are hyperplastic(75%)or fundic glandpolyps(10%). The presence of H pylori infection(63%) is closely related to chronic gastritis which significantly increases the risk of developing peptic ulcer, gastric adenocarcinoma andgastric mucosa-associatedlymphoid tissue lymphoma is similar to literature(8). In cases with hyperplastic polyps, the incidence of HP infection and concomitant chronic atrophic gastritis and intestinal metaplasia is higher. Inourstudy 66% of hyperplastic polypshaveHP infection,83% of hyperplastic polypshavechronic gastritis, 17% of hyperplastic polypshaveand intestinal metaplasia similartoliterature. Faveolar hyperplasia (7.5%) is the third most common and can be regarded as a precursor of hyperplastic polyps .

Conclusion

Gastric adenomatous polyps have potential for malignancy. Endoscopy is recommended 1 year after adenomatous polyp resection. It was reported that about 11% of such polyps developed into carcinoma in situ within 4 years of followup (10). After excision, the recurrence rate is 16% (11).

Pedunculated lesions smaller than 2 cm in diameter are not usually malignant. Roughly 10% of the benign adenomatous polyps may show malignant transformation therefore endoscopic monitoring of patients is recommended after these polyps have been removed by polypectomy(14)

Endoscopy should be performed in patients with dyspeptic complaints, especially those over the age of fifty. Endoscopy application is safe and complication rate is very low. Biopsies should be taken from at least two topographic sites (antrum and corpus). Higher malignity rates are detected in endoscopies performed surgical oncology polyclinic patients. *H.pylori* eradication is recommended.

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OP9- INCREASED AVERAGE THROMBOCYTE VOLUME, AN INFLAMMATORY HEMATOLOGICAL MARKER CAN IT PREDICT LYMPH NODE METASTASIS IN STOMACH CANCER?

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Introduction

Stomach cancer is a common type of cancer in the world. The 5-year survival of gastric cancer cases remains at the level of 30% despite improved treatments. Various markers can be used to predict the prognosis in patients with gastric cancer and to tailor treatment modalities according to the patient.

Tumor cells; express tissue factors and secrete cytokines. It causes the activation of platelets by participating in the prothrombotic microenvironment. Activated platelets play an important role in the thrombotic cascade.

Malignant tumors can be defined as persistent wounds and continuous inflammation associated with them. Platelets are cells that play an important role in hemostasis and also play a role in inflammation. Platelets have both pro-cancerous and anticancerous effects in their interaction with cancer cells. Cancer cells help tumor growth by activating platelets, causing angiogenesis and neovascularization. (Dahlen et al., 2021; Palacios-Acedo et al., 2019)

MPV is the mean circulating platelet volume in femtoliters. Cytokines and growth factors affect megakaryocytopoiesis. This causes larger platelets to enter the blood. Therefore, the MPV will be high.(Panova-Noeva et al., 2016)

At the same time, MPV is an easily accessible hematological marker.

In the study of Kılınçalp et al., it was found that MPV was higher in the preoperative period in patients with gastric cancer and showed a significant decrease after the operation. It has been shown that the prognosis is good in patients with low MPV levels and it has an impact on survival.(Kılınçalp et al., 2014)

This retrospective study, it was aimed to investigate the relationship between the ratio of positive lymph nodes in piece pathology to total lymph nodes and the mean platelet volume (MPV) in patients who underwent surgery for gastric cancer in our clinic.

Materials and Methods

A total of 141 patients who underwent surgery for gastric cancer in our clinic between 2017 and 2022 were included in the study.

Age, gender, the total number of lymph nodes removed and positive lymph node count in the surgical pathology, tumor size, the ratio of positive lymph node count to total lymph node count, mean platelet volume and platelet count in preoperative hemogram parameters of the cases were evaluated retrospectively.

SPSS 15.0 for Windows program was used for statistical analysis. Descriptive statistics; numbers and percentages for categorical variables, mean, standard deviation, minimum and maximum for numerical variables were given. The relationships between numerical variables were analyzed by Spearman Correlation Analysis since the parametric test condition was not met. The relationship was given by Linear Regression Analysis. The statistical alpha significance level was accepted as p<0.05.



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Results

104(74%) of the cases were male and the mean age was 63.9(28-87) years. In 141 cases, the mean number of lymph nodes removed was 26.35(±13.97), the mean number of positive lymph nodes was 6.09(0-39), mean turnor size was 5.17±2.83 cm (0-16).

A statistically significant positive correlation was found between the cases' tumor size and lymph node ratio (p<0.001). A statistically significant positive correlation was found between lymph node ratio and mean platelet volume (MPV) (p<0.001)

Discussion

Malignant tumors are accompanied by a systemic inflammatory response. Inflammatory cytokines (eg: interleukin-1, IL-6, tumor necrosis factor- α (TNF- α)) cause macrophage maturation and proliferation. In addition, these cytokines can cause platelet activation and the release of larger platelets. Therefore, it causes an increase in MPV.(Chen et al., 2020; Li et al., 2014; Shen et al., 2016)

Activated platelets synthesize proangiogenic cytokines. This envelops tumor cells, protecting them from the host's immune response and causing tumor growth, angiogenesis, and metastasis. This may indicate that high MPV levels may be associated with poor prognosis as they increase the likelihood of lymphatic metastases.

The positive correlation between the positive/total lymph node ratio and MPV in our study also supports this hypothesis.

MPV level can be used as a reliable, inexpensive, and easily accessible biomarker in terms of treatment modalities in predicting lymph node metastasis and prognosis in patients with gastric cancer.

More high-quality studies are needed for more reliable results.

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Mean platelet volume provides beneficial diagnostic and prognostic information for patients with resectable gastric cancer. Oncology Letters, 12(4), 2501-2506. https://doi.org/10.3892/ol.2016.4913





OP12- OUR INITIAL EXPERIENCE IN ONCOLOGIC LAPAROSCOPIC GASTRIC SURGERY

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I. Introduction

Gastric cancer continues to be the third biggest cause of cancer-related deaths globally, with almost 1 million new cases reported each year.¹ Globally, the incidence of stomach cancer varies greatly, with developing nations accounting for more than 70% of all new cases. Endoscopic screening has resulted in earlier detection, with around 50% of patients being detected with early stomach malignancies, attributed to the rising prevalence and improved awareness of gastric cancer in nations like Japan and Korea.²

Turkey has a lower incidence of curative surgery than the rest of the globe because the majority of patients with stomach cancer are found to have the disease at an advanced stage and procedures are more palliative than originally anticipated (63.3%).³

In the past ten years, more and more work has gone into producing level I data to support the idea that minimally invasive gastrectomy offers patients a less traumatic, quicker recovery from surgery while being oncologically equal to open gastrectomy.

A rising body of evidence from both the East and the West indicates that, for carefully chosen patient populations, minimally invasive surgery may be the best option for the surgical treatment of stomach cancer.²

II. Method

Patients who underwent laparoscopic gastric cancer surgery between January 2021 and September 2022 were reviewed in retrospect.



Figure 1 The location of trocars and the surgeons. (A) The general location; (B) the location during dissection of the splenic hilar ly nodes (LNs).
Figure 1: Huh, Y. J., & Lee, J. H. (2017). The Advances of

Laparoscopic Gastrectomy for Gastric Cancer⁵

Patient selection and workup: The treatment plan of each patient is managed by the General Surgery-Oncology-Radiology-Pathology council.Preoperative preparation: All patient were given low molecule weightheparin , we provide compression stockings and respiratory exercise tool.

Surgical Technique: The patient was lying supine in the reverse Trendelenburg position during the procedure (Figure 1). Two 5-mm ports were positioned in the right lateral position, one in the left upper quadrant, one in the left midabdomen, and one 12-mm port was positioned in the left midabdomen after accessing the abdominal cavity by a supraumbilically positioned 10-mm trocar.



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After gaining access to the abdomen, a thorough examination was performed to look for signs of metastasis. The larger omentum was moved, and the gastrocolic ligament was divided. The left gastroepiploic artery was divided at its origin, and short gastric vessels were divided at the splenic hilum as the dissection was carried out along the larger curvature of the stomach up to the level of the left crus. The first part of the duodenum was mobilized after the right gastroepiploic arteries were cut at their point of origin. The stomach was moved to the left upper side after the duodenum was transectioned using an endoscopic linear stapler, and the lymphadenectomy procedure was started³. The removal of lymph nodes (8 - 12 - 7 -9 - 11) is included in the D2 Dissection procedure.

In the continuation, if the esophagus is divided using an orvil, the esophagus is divided using a surgical stapler. If a side-toside esophagojejunostomy is performed, the esophagus and jejunum are opened without the esophagus being divided during the anastomosis procedure. The esophagus is separated after anastomosis, and the proximal resection is conducted (Figure 2-3).



Figure 2- side to side esophagojejunostomy



Figure 3- completion of proksimal resection

III. Results

Four of the fourteen patients scheduled for laparoscopic gastric surgery converted open surgery (2 venous return problems, 1 spleen invasion, 1 technical reason). Our conversion rate to open surgery was 28%.

Table 1 details the patient's stage and surgical procedure for the laparoscopic gastric surgery.



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-The average number of Harvested Lymph nodes was 16.3. The longest follow up was 16 months.

-Patients who received adjuvant therapy were 4 patients. No recurrences were seen.

-Tables 3 and 4 explain the characteristics, technical information, and prognosis of 8 patients who underwent laparoscopic surgery for advanced gastric cancer.

7 male				
* puterst • 1 female				
• 63,8 ± 11,7 y				
• 21.7 ± 2.1				
• 2 ASA II, 6 ASA III				
1 distal laparoscopic gastrectomy				
• 7 total laparoscopic gastrectomy				
• 1 patient - T3N1				

Table 3: Patients charecteristics and types of operation



Table 4: The details of operations and patient prognosis

IV. Discussion

Whichever the technical procedure, the objectives of surgery for gastric cancer include obtaining a full (R0) resection with negative microscopic margins, conducting a sufficient lymph node dissection, lowering the risk (morbidity) to the patient, and enhancing long-term quality of life.²

Table 5 provides a detailed summary of the review published by Kinoshita for early gastric cancer surgery in 2020. As a result, we may conclude that in terms of operation duration, estimated blood loss, and morbidity, we lag behind the literature.⁶



Table 5: Kinoshita T. (2020). Minimally invasive approaches for early gastric cancer in East Asia:

In 2016, according to the Korean Laparoscopic Study Group (KLASS), the average number of lymph nodes retrieved in the LADG :40. Because our average number of lymph nodes retrieved is

16, we are aware that we must improve in order to attain the number stated in the literature at this time. Kelly and colleagues emphasize that patients undergoing laparoscopic procedures were more likely to receive adjuvant therapy (82% vs 51%).² We may say that our adjuvant therapy rate is comparable to the literature.

With all these The Japanese Gastric Cancer Association is recommended that at least 16 lymph nodes be pathologically examined for optimal assignment of an accurate nodal (N) stage.²

We may claim that we lag behind in terms of morbidity and opening rates, which have been highlighted in prior assessments of the literatüre (Table 6).



V. Conclusion

Our study contains weaknesses since it is retrospective. A longer follow-up period for our patients is essential for diseasefree survival and oncological outcomes.

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When we compare our results to the literature, we can see which areas require improvement, particularly the excised lymph node and predicted blood loss.

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OP18- THE EFFECT OF NEOADJUVANT TREATMENT ON SURVIVAL OF STGAE II-III GASTRIC CANCER

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Objectives

Despite the use of curative resection with D2 lymphatic dissection following with or without the addition of adjuvant treatment, advanced gastric cancer survival is poor^{1,2}. Neoadjuvant therapy is a different treatment modality. However, it isn't easy to assess the relative contribution of the pre- versus postoperative component concerning survival benefit for both the MAGIC and ACCORD-07 trials³. With the development of more effective regimens, pre-operative chemotherapy was considered to downstage the tumor and improve resectability and survival.

This study aims to provide the potential effect of the neoadjuvant treatment on the survival of varying tumor locations of advanced gastric cancer.

Material and Methods

Medical data of Stage II-III gastric cancer patients who underwent curative resection with D2 lymphadenectomy was analyzed retrospectively. Tumor localization and neoadjuvant treatment status were compared. Patients were divided into two groups; Group 1 with neoadjuvant treatment conduction and Group 2 without neoadjuvant treatment conduction. Patients in the neoadjuvant group received FLOT (SFU, docetaxel, oxaliplatin, leucovorin) treatment for four cycles. According to tumor localization, patients were divided into four groups, upper third (cardia and gastric fundus), middle third (gastric corpus), lower third (antrum), and extensive. Overall survival comparison was compared between groups.

Results

In this study, 94 patients (23 female, 71 male) were included. In 39 of them, the tumor was localized in the upper third, 32 in the middle third, 22 in the lower third, and four patients with extensive gastric tumors. According to age and gender, there was no statistically significant difference. Tumor localization had no statistically significant effect on the overall survival between groups (P=0.334). Neoadjuvant treatment was conducted in 61 patients. Neoadjuvant therapy (mean 18.9 months) did not improve overall survival when compared to the non-neoadjuvant group (mean 14.9 months) (P=0.06).

Discussion

In our study, we couldn't show the beneficial effect of neoadjuvant chemotherapy over the surgery-alone group. Also, in the EORTC study, neoadjuvant treatment did not gain statistical significance compared to the surgery group³. Neoadjuvant chemotherapy aims to downstage tumor and increase the rate of resectability⁴. Pathologic regression as a prognostic factor in gastric and gastroesophageal junction tumors is a question⁵. There has been general debate about considering tumor regression as a parameter for predicting survival⁶⁻⁹. Our study didn't detect any benefit of neoadjuvant chemotherapy in terms of tumor downstage and, thus, survival. Studies designed in prospective nature with a large number of patients may be more informative about the survival benefit of neoadjuvant chemotherapy.



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Conclusion

Advanced gastric cancer retains its high mortality despite the different use of the proposed neoadjuvant treatment. Surgery is still playing the main role in the treatment initiation of advanced gastric cancer.

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OP19- CLINICOPATHOLOGIC DIFFERENCES BETWEEN EARLY-ONSET GAS LATE ONSET GASTRIC CANCER

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Introduction

Globally stomach cancer is a significant public health problem. In 2020, the number of new cases of stomach cancer has exceeded 1 million and the annual number of deaths has been reported as 769.000 (1). These numbers making it the fifth most common cancer and fourth most common cause of cancer-related death (1).

Cancers usually affect the aged 50 years and older and are caused by multifactorial reasons. However, evidence indicate that recent years, breast, colorectal, pancreas and gastric cancers rising in adults <50 years of age (2, 3, 4, 5). Early-onset Gastric Cancer (EOGC) constitutes 10-30 % of gastric cancers of all ages (6). The aim of this study is to evaluate the similarities and differences of early-onset gastric cancers with late-onset gastric cancers in terms of demographic and clinicopathological features.

Materials and methods

The data of 174 patients who were evaluated retrospectively were analyzed. Who were operated for gastric cancer in a tertiary healthcare institution between January 2017 and June 2022 were examined. Patients were divided into two groups as the early-onset gastric cancer group and the late onset group.

Definition of Patients Age Group

Gastric cancer incidence rate in countries such as Japan and Korea since it is more frequent, 40 years of age is taken as a screening age (7). However, since the incidence in Western countries is relatively less, the screening age was determined as 45 years according to The American Cancer Society's Newest Guidelines (8). In our study, we identified the age limit as 45 years of age by taking the base of Amercan Cancer Society's Newest Guidelines.

Among the inclusion criteria; There are surgical treatment (including open and laparoscopic surgery), pathologically confirmed primary gastric cancer and complete available medical records.

Within the exlusion criteria; There are the presence of other malignant tumors, operated under emergency conditions, lymph node dissection of less than 15 lymph nodes, the presence of tumors of nonepithelial origin in the stomach and recurrent gastric cancers.

Data Collection

The patients' age and gender, tumor location, depth of invasion, lymph node status, distant metastasis status, histopathological type of tumor, degree of differentiation, preoperative tumor marker status and operative findings were recorded. Statistical analysis

Pearson's chi-square test was used to compare categorical variables in independent groups. Logistic regression analysis was performed using the backward method with the variables whose relationship with the age group was evaluated, with P < 0.100. The statistical significance value of this study was accepted as P < 0.05. The research data were evaluated through the SPSS 25.0 statistical package program.

Results

A total of 174 primary gastric adenocarcinomas were surgically resected during the years 2017 through 2022. When the patient's age was considered at the time of diagnosis, 24 (13.79 %) of the patients were in the age group of 45 and under, While 150 (86.21 %) patients were in the group above 45 years of age. There was no statistically significant difference between the two groups in terms of gender, operation time, total number of lymph nodes dissected, and preoperative tumor





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markers. However, statistical differences were found in terms of T and N stage, degree of differentiation, tumor location and signet ring cell pathological variant. These findings are shown in Table 1 in detail.

Characteristics		AGE 45 AND UNDER (N:24,%)	>45 YEARS (N:150, %)	P - Value
Gender	Male	13	81	0.534
	Female	11	69	
Operation time (minutes)		162 ± 21	154±17	0.672
Location	Proksimal	7 (29.17 %)	72 (48.0%)	<0.001
	Distal	17 (70.83 %)	78 (52.0%)	
T stage	T1	2 (12.5%)	28 (18.6 %)	0.002
	T2	4 (20.83 %)	42 (28.0 %)	
	тз	7 (29.17 %)	46 (30.7 %)	
	T4	9 (37.5 %)	34 (22.7 %)	
N stage	NO	6 (25.0 %)	36 (24.0 %)	0.021
	N1	4 (16.6 %)	49 (32.6 %)	
	N2	6 (25.0 %)	34 (22.7 %)	
	N3	8 (33.4 %)	31 (20.7 %)	
Distant metastasis	M0	3 (12.5 %)	23 (15.3 %)	0.713
	M1	21 (87.5 %)	127 (84.7 %)	
Dissected lymph nodes	27 ± 8	31±6	0.784	
CEA	>5 ng/ml	9 (37.5 %)	43 (28.6 %)	0.984
	≤5 ng/ml	15 (62.5 %)	107 (71.4%)	
CA-19.9	>30 U/ml	16 (66.7 %)	38 (25.3 %)	0.623
	≤30 U/ml	8 (33.3%)	112 (74.7%)	
Histological type	Adenocarcinoma	16 (66.7 %)	126 (84.0%)	<0.001
5	Mucinous adenocarcinoma	2 (8.3%)	10 (6.7%)	JAR.
	Signet ring cell carcinoma	5 (20.84%)	11 (7.3%)	And a
	Others	1 (4.16%)	3 (2.0 %)	822 0
Degree of differentiation	Well differentiated	3 (12.5 %)	26 (17.3%)	<0.001
	Moderately differentiated	4 (16.6%)	51 (34.0%)	

Table 1: Comparison of the clinicopathological data of the patients



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Discussion

The results of our study showed that; EOGC differs in terms of poor prognostic factors (T, N stage, poorly differentiation, signet ring cell pathological type). Considering the tumor location, the tumor localization was predominantly distal in the EOGC group in our study.

Takatsu et al. reported that young patients had a predominance of gastric body cancer and a significantly higher proportion than controls (9). However, other studies claimed that EOGC occurred mainly in the lower third of the stomach (10). The proportion of patients with poorly differentiated adenocarcinoma was significantly higher in the EOGC group (70.9% vs. 48.7%). There was a higher proportion of patients with signet ring cell carcinoma (20.84% vs. 7,3%) in the EOGC group. This proportion was generally consistent with the findings of Bergquist et al (11). However, the results of Rona et al. showed a much higher proportion of young GC patients with signet ring cell carcinoma, reaching nearly 90% (12).

Our study has several limitations. The first of these is the single-center retrospective analysis design of the study. Another limitation is the small number of patients included in the study. One of the important limitation is that our cohort did not include data of genetic information. Finally, inadequate follow-up time and therefore not performing a survival analysis are among the limitations.

Conclusion

The incidence of early-onset gastric cancer is increasing. Clinicopathologically advanced stage, higher grade, diffuse type and signet ring cell histology have worse prognostic features. Complate elucidation of the genomic formation of the disease will be effective in terms of new treatment modalities and improving the prognosis of the disease.

Declaration of conflicting interests

The authors declared no conflicts of interest with respect to the authorship and/or publication of this article.

Funding statement

The authors received no financial support for the research and/or authorship of this article.

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OP20- FACTORS AFFECTING ANASTOMOTIC LEAKAGE AND LEAKAGE MANAGEMENT IN GASTRIC CANCER

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BACKGROUND

Anastomotic leakage is a life-threatening complication that is significantly associated with postoperative mortality in patients operated for gastric cancer (4). The incidence of leakage has been reported between 0% and 17% in the literature (1,2,3). Between 20 and 75% of post-gastrectomy mortality (depending on the type of gastrectomy performed) (10-13) is thought to be due to anastomotic leakage. Mortality in anastomotic leakage has been reported as 26% (16). Except for mortality; prolonged hospital stay and increased financial burden cause motility and nutritional disorders and worsening of quality of life (4,14,15).

In the last 20 years, there has been a paradigm shift towards more conservative and endoscopic methods of anastomotic leakage. Early detection of leakage and early intervention; It reduces mortality and morbidity with treatment options such as endoscopic stent-clip, percutaneous drainage or surgery. For this reason, we aimed to investigate the factors affecting anastomotic leakage and the factors that can predict leakage.

METHOD

Patients who were operated for gastric cancer in the general surgery clinic of Ege University Hospital between 2015 and 2022 were evaluated. Gastric resection followed by D2 lymph node dissection was added to all patients participating in the study. Demographic data of the patients, comorbidities, ASA score, preoperative biochemical data, neoadjuvant chemotherapy information, tumor localization, operation type, postoperative pathology results were retrospectively documented in an excel table.

Statistical analysis of the data was performed using the SPSS 24 (SPSS Inc., Chicago, IL, USA) package program. The normal distribution of the data was evaluated with the Shapiro Wilk test.

Descriptive statistics were presented as numbers (n) and percentages (%) for categorical variables, and mean and standard deviation for numerical variables. Chi-square test was used for categorical variables, Independet t-test and One Way Anova test were used for quantitative variables in pairwise and multiple comparisons. Pearson correlation analysis was used in multiple correlation analysis. Roc analysis was used to determine the factors affecting mortality. To determine the statistical significance level, p<0.05 was considered significant at the 95% confidence interval.

RESULTS

A total of 261 patients were included in the study. Of the patients, 89 (34.1%) were female and 172 (65.9%) were male. The mean age is 64.52±11.29 (min-max:26-93). There was proximal gastric cancer in 59 patients (22.6%), corpus localized in 100 patients (38.3%), and distal gastric cancer in 102 patients. While 43 patients (16.5%) received neoadjuvant chemotherapy; 218 patients (83.5%) did not receive it. Total gastrectomy + roux-en-y esophagojejunostomy was performed in 150 patients (57.5%), distal gastrectomy roux-en-y gastroenterostomy was performed in 61 patients (23.4%), and proximal gastrectomy + esophagogastrostomy was performed in 50 patients (19.2%).

When the specimens from the operation were examined, the mean tumor diameter was 4.89 cm (±2.73). The mean number of lymph nodes dissected was 21.65 (±12.21), and the mean number of metastatic lymph nodes removed was 6.31 (±8.55).



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Postoperative complications developed in 27 (10.3%) of the patients included in the study. Of these, 12 (4.59%) surgical site infections, 6 (2.29%) pneumonia, 1 (0.38%) ischemic stroke, and 8 (3.1%) patients developed anastomotic leakage. Of these 8 patients, 6 had Total Gastrectomy + Roux-En-Y Esophagojejunostomy, 1 had Proximal Gastrectomy + Esophagogastrostomy, 1 had Distal Gastrectomy + Roux-En-Y Reconstruction (p:0.045). Of 8 patients who developed anastomotic leakage; Endoscopic stenting was performed in 6 patients, endoscopic clipping in 1 patient, and surgical treatment (primary repair + drainage) in 1 patient. Surgery was decided in one patient who underwent surgical treatment, after anastomotic leakage developed on the 2nd postoperative day. Percutaneous drainage was required in 2 of the patients who underwent endoscopic intervention. After the operation, the average anastomotic leakage is 6.75. (min-max:2-15) days.

According to tumor biology; Lymphovascular invasion (p=0.021) and venous invasion (p=0.048) were significantly higher in patients who developed anastomotic leakage. Although perineural invasion was proportionally higher in the group with leakage, it was not statistically significant (p=0.051).

Age, gender, ASA score, comorbidities and tumor localization were not statistically significant in terms of anastomotic leakage. There was no significant difference between the two groups in preoperatively measured CRP, albumin, thrombocyte, leukocyte, lymphocyte and neutrophil counts. However, the mean neutrophil/lymphocyte ratio was found to be 1.94±2.15 in the non-leakage group, while it was 0.95±0.56 in the leaky group (p:0.017). Similarly, while the platelet/lymphocyte ratio was 153.76±98.02 in the group without leakage, it was found as 225.40±329.78 in the group with leakage (p:0.013).

Endoscopic stenting was performed in 6 of 8 patients who developed anastomotic leakage, endoscopic clipping was performed in 1 patient, and primary repair + drainage was performed in 1 patient on the 2nd postoperative day. Percutaneous drainage was required in 2 of the patients who underwent endoscopic intervention. Leakage occurred in an average of 6.75 (min-max:2-15) days. 3 of the patients with anastomotic leak average postoperative 11.3. day (min-max: 3 - 23) died. 1 patient died due to ischemic SVO, 1 patient had aspiration pneumonia, and 1 patient died due to malignant arrhythmia.

DISCUSSION - CONCLUSION

In our study, we found the rate of anastomotic leakage to be 3.06%. Leakage rate was 2% in esophagogastric anastomosis, 1.63% in gastroenterostomy anastomosis, and 4% in esophagojejunostomy anastomosis. These data were compatible with the literature. Again in our study, the mortality of anastomotic leakage was found to be 37.5%.

In the literature, it has been reported that the risk of anastomotic leakage increases in cases of increasing age, male gender, comorbidities (HT, cardiovascular disease, pulmonary disease, etc.) and high ASA score (17). We could not find statistically significant results in this respect in our study. We think that this is due to the low number of patients with leakage and the inhomogeneous distribution of these data.

As tumor biology; Presence of lymphovascular or venous invasion increases the risk of leakage.

In our study, we found that neutrophil/lymphocyte and thrombocyte/lymphocyte ratios could be used to predict anastomotic leakage. We think that this is significant in terms of systemic inflammatory response.

Surgical treatment in the approach to anastomotic leakage; We suggest that it should be performed in cases of multi-organ failure sepsis, diffuse peritonitis symptoms, radiological or endoscopic failed drainage, jejunal stump necrosis, and surgical treatment should be performed in early anastomotic leakage (within postoperative <72 hours) as it is usually caused by a technical error. According to the defect size and tissue condition in the anastomosis; Defects larger than 2 cm or one-third of the anastomotic circumference are generally not suitable for endoscopic treatment. For this, surgical treatment should be performed.

The choice of surgical treatment or conservative/endoscopic treatment should be decided on a case-by-case basis. Anastomotic leakage still continues to be a difficult and complicated condition to manage with high mortality, requiring long hospital stay.

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OP26- OVERALL SURVIVAL ANALYSIS OF OUR PATIENTS WITH GASTRIC CANCER WHO HAVE NEOADJUVANT CHEMOTHERAPY

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Aim

Gastric cancer (GC) ranks 4th among the most common cancers and 2nd among cancer deaths worldwide. Despite curative surgery and adequate lymph node dissection, survival rates of advanced gastric cancer are low. Various treatments and methods are being sought to improve survival, but the results are still not encouraging. Neoadjuvant chemotherapy (NACT) aims to increase pathologic complete response rates beyond making unresectable tumors resectable.

With NAKT;

Survival advantage ?

reduction of tumor related symptoms

the possibility of downstaging the tumor

aims to destroy microscopic tumor cells

Surgery in a narrower field will also have fewer comorbidities.

As a result, NACT aims to improve chemotherapy tolerance in the postoperative period due to decreased surgery-related symptoms.

In this group of patients with such low survival, NACT has been a promising new treatment option.

Patients with gastric cancer who received NACT versus surgery alone had a 12% advantage in 5-year survival (30% versus 42%, respectively).

Methods

Patients who received neoadjuvant treatment for gastric cancer at Izmir Tepecik Training and Research Hospital and Izmir Bozyaka Training and Research Hospital between 2012 and 2022 were evaluated. Data were obtained by file search in the hospital registration system. Patients with ECOG performance score between 0-2 and histologically diagnosed gastric cancer stage 1b and above were included in the study. Patients with distant organ metastases, cardiac or renal failure, and prior chemotherapy or radiotherapy were excluded. Two patients with gastrointestinal stromal tumor (GIST) and neuroendocrine



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tumor (NET) were excluded. Patients are gropued into gender, age at diagnosis, overall survival, histological diagno regimen and number of courses, dissection width (D2 or D3), adjuvant chemotherapy or adjuvant radiothera

py or not

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D1 dissection of perigastric LNs (LN along the right and left cardia and the lesser and greater curvature, and supra- and infrapyloric LN); D2 dissection includes LNs in the root of the celiac axis (LN in the splenic hilus in addition to LNs in the left gastric, common hepatic, celiac and splenic arteries), hepatoduodenal, periduodenal and mesenteric root. In D3 dissection, the LN is removed in an extended area extending to the paraaortic LNs. Approval was obtained from the local ethics committee for the two-centered study. SPSS 21.0 program was used for statistical evaluation. Survival curves were calculated using Log-Rank analysis with the Kaplan-Meier method. P value less than 0.01 was considered statistically significant.

Results

Of 37 patients, 28 were male and 9 were female (approximate ratio M:F=3:1). There was no gender difference in survival analysis (p=0.3). The mean age was 59 years in both men and women. 12 patients were in the geriatric group aged 65 years and older, while 25 patients were younger than 65 years. Thirteen of the gastric tumors were located in the cardia, 16 in the corpus and 8 in the antrum. Cardia tumors were grouped as proximal and corpus and antrum tumors as distal gastric tumors. Of the 37 patients, 22 had radiologic evidence of lymph nodes and 15 did not. Patients whome receive NACT ; FLOT for 23 patients, FOLFOX for 13 patients, one of them was given FOLFIRI. 17 of 23 patients who received FLOT were alive (survival 74%). (Figure-1) Of the 13 patients who received FOLFOX, 8 were alive (survival 61%). One patient receiving FOLFIRI died 6 months after diagnosis. (Figure-2)





Figure-2: Overall survival for patients according to NACT

According to the histology of the operation;

- 36 patients had adenocarcinoma structure, 5 of which had stony ring morphology.
- One patient was diagnosed as squamous cell carcinoma.
- This patient with squamous cell carcinoma died 6 months after diagnosis without receiving adjuvant treatment.
- The survival of patients with stony ring and squamous components was statistically significantly lower (p=0.001).

12 patients received adjuvant RT. Receiving adjuvant RT had no survival benefit (p=0.624). Of the 34 patients who received adjuvant CT, 24 were alive (survival 70%). Of the 3 patients who did not receive adjuvant CT, 1 had just started adjuvant treatment and the other two had died. Although the difference was not statistically significant, the survival of those who did not receive adjuvant CT was lower (p=0.028).



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Despite curative resection, patients with gastric cancer have a poor prognosis. Despite curative surgery and good chemotherapy tolerance, patients die due to distant metastases or recurrences. Microscopic incomplete resections are blamed as the underlying cause of this situation. At this point, NACT has been a hope to improve survival.

Although the efficacy of NACT has not yet been proven to improve survival, good results have been reported with various CT regimens. A meta-analysis comparing different treatment modalities found no significant differences between treatment regimens and no increase in mortality or complication rates in the postoperative period.

- FAMTX (methotrexate, 5FU, leukoverin),
- DCF (docetaxel, cisplatin, 5FU),
- ECF(epirubicin, cisplatin, 5FU),
- Regimens such as TCF (docetaxel, cisplatin, 5FU) were compared.

Even in R0 resected patients, recurrence and mortality rates are high and 5-year survival is around 10-30%. D2 dissection is the standard approach for gastric cancer surgery in eastern countries. With our data, FLOT is the best treatment regimen for neoadjuvant treatment of resectable gastric cancer.

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OP27- HELICOBACTER PYLORI AS A PREDICTIVE FACTOR FOR GASTRIC MALIGNENCIES: SPECTRUM OF SLEEVE GASTRECTOMY SPECIMENS

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Introduction

Obesity rates are increasing worldwide. In our country, the prevalence of obesity in adults, which was 18.8% in the 1990s, almost doubled in 2010 and reached 36% (1). Recent studies show that our country is the most obese society in Europe (2). Accordingly, there is also an increase in laparoscopic sleeve gastrectomy operations performed for obesity. *Helicobacter pylori* infection is a strong risk factor for certain types of gastric cancer, as well as causing various gastric pathologies such as gastritis and peptic ulcer (3). For these reasons, eradication of *H.pylori* is important for human health and eradication treatment is recommended for patients who are found to be positive for *H.pylori* (3,4).

Our aim is to reveal the histopathological changes in the gastric specimen of patients who underwent sleeve gastrectomy for obesity and to examine the relationship between *H.pylori* and these changes.

Materials and Methods

A retrospective study was designed with the histopathologic findings from pathology specimens of 456 patients who experienced LSG between April 2014 and Dec 2021. Our institution's database is used to access the necessary data for our study. SPSS v26.0 program is used for statistical analysis. For analysis among the groups, x², Anova, Post-hoc tests are used and Fisher's exact test is used in cases where the number was less than 5. p<0.05 is considered statistically significant.

Results

456 patients who underwent LSG were analyzed. Demographic data, pathology data, *H.pylori* data in the specimen and *H.pylori* data in the preoperative endoscopic biopsy of the patients were compared. Overall, 367(80,5%) of the patients were females and 89 (19,5%) were males. The mean age was 44 (range 22 to 72) years. Chronic gastritis, chronic active gastritis,



intestinal metaplasia, atrophic gastritis, neuroendocrine hyperplasia (NEH) were found in 301, 66, 13, 11, 6 patients, respectively. Gastrointestinal stromal tumor (GIST) was detected in 4 patients. All the GISTs were pathologically low risked and the tumor size were below 2 cm. In 1 patient Neuroendocrine Tumor (NET) was detected.

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H.pylori was detected in 97 (21.3%) of the specimens. There was no significant relationship between *H.pylori* and age (p=0,923) or gender (p=0,464). Normal gastric histology was not observed in the patients with *H.pylori* positive in the specimen. Chronic gastritis was observed in 52 (53.6%) and chronic active gastritis was observed in 45 (46.3%) among *H.pylori* positive patients. Gastritis was found in all patients with positive H.pylori in the specimen, and this was statistically significant as expected (Graph-1). All of the patients were evaluated with upper gastrointestinal endoscopy before the operation. Preoperative gastric pathology data were found to be *H.pylori* positive in 199(66.3%) of 300 patients whose endoscopy data could be accessed. All

patients with preoperative *H.pylori* positivity received triple eradication therapy (proton pump inhibitor, amoxicillin and clarithromycin) for 2 weeks. Among patients whose preoperative endoscopic biopsy was positive for *H.pylori* normal gastric histology was observed in 24 patients (12,0%), chronic gastritis in 139 (69,8%) patients, and chronic active gastritis in 36 (18,1%) patients in the operation specimens. In cases with *H.pylori* positivity in gastric pathology obtained by preoperative endoscopy, gastritis finding in the specimen was significantly higher (Graph-2). Preoperative and postoperative *H.pylori* data, intestinal metaplasia, atrophic gastritis, NEH, GIST and NET data were analyzed. Significant relationship between *H.pylori* and intestinal metaplasia, atrophic gastritis, GIST and NET.

Discussion

We found that only 89(19.5%) patients had normal gastric mucosa and the rest had pathological changes. H. pylori is seen at varying rates in various countries around the world. Our country is one of the countries where *H.pylori* is common (>70%). According to 2015 data in our country, more than 60,000,000 people are thought to be infected with *H.pylori* (3). We saw that the *H.pylori* positivity rate, which was 66.3% preoperatively, decreased to 21.3% in patients who were operated after medical treatment. Similar findings were found in the literature in patients who underwent LSG for obesity (5–8).

The preoperative *H.pylori* positivity rate of the patients with gastritis finding in the specimen was 70.28% (n=300). The postoperative *H.pylori* positivity rate of the patients with gastritis finding in the specimen was 26.43% (n=456). These data show that even if H. pylori is eradicated, gastritis findings in the specimen persist, at least for a while. Despite this decrease in *H.pylori*, the cases, which could not be eradicated, needs to be followed closely.

There were studies advocating that macroscopic examination of LSG specimens might be cost-effective, especially in countries where *H.pylori* and gastric cancer are seen with a low incidence (9,10). However, there are studies showing the importance of routine microscopic examination in studies conducted in countries with a high prevalence of *H.pylori*, such as our country (6,11–13). Microscopic examination of the piece is important in countries where *H.pylori* infection is common. In addition, the detected GIST and NEH findings are at a substantial level.

Conclusion

Pathological examination should be done routinely after LSG operation. H. pylori is an important risk factor for gastritis, ulcer and gastric malignancy. Therefore, when the prevalence of *H.pylori* in our country is considered, close clinical follow-up of the patients is required in terms of *H.pylori* positivity both preoperatively and postoperatively.



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OP28- METASTATIC LYMPH NODE RATIO AS A PROGNOSTIC FACTOR IN GASTRIC **ADENOCARCINOMA**

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BACKGROUND

Gastric cancer is the 5th most common cancer in worldwide and between cancer related death in 3rd place (1). The long term prognosis is poor even after radical resection and requires different treatment approaches. Determining prognostic factors is essential for planning the treatment. Staging of the tumour determine the main treatment pathway. The most important part of the staging is determined by the collected lymph node. Minimum 16 lymp node harvesting requires in recent guidelines (2). In some cases harvesting the lmyph node is insufficent and its creates a problem in staging. Therefore we need to another value for the treatment algorithm. Metastatic lymph node ratio can be a helpful in that kind of situations. The aim of our study is to evaulate the difference in survival according to stages and metastatic lymph node ratio.

MATERIAL & METHOD

Patients who were operated for gastric cancer in the general surgery clinic of Ege University Hospital between 2015 and 2022 were evaluated. Gastric resection followed by D2 lymph node dissection was added to all patients participating in the study. Patients who; diagnosed non-adenocarcinoma in pathology slides, took neoadjuvan treatment, diagnosed metastatic diseases with CT, MRI, PET-CT scan or perioperatively, underwent emergency operations, dissected less than 16 lymph node were excluded from the study. Demographic datas of the patient, operation type, pathology results, local recurrence, distant organ metastasis, exitus, pTNM stages, metastatic lymph node ratio and survival time were retrospectively decumented. Patients were grouped according to their stage and metastatic lymph node ratio.

Statistical analysis of the data was performed using the SPSS 25 (SPSS Inc., Chicago, IL, USA) package program. The normal distribution of the data was evaluated with the Shapiro Wilk test. Descriptive statistics were presented as numbers (n) and percentages (%) for categorical variables, and mean and standard deviation for numerical variables. Chi-square test was used for categorical variables, Independet t-test and One Way Anova test were used for quantitative variables in pairwise and multiple comparisons (If the data is not normally distrubuted MWU and Kruskall Wallis were used for calculation). Pearson correlation analysis was used in multiple correlation analysis. Roc analysis was used to determine the factors affecting mortality. Kaplan Mieger and Cox Regressin survival models used in survival analysis. To determine the statistical significance level, p<0.05 was considered significant at the 95% confidence interval.

RESULTS

129 patients were included in the study. 83 (64.34%) were male and 46 (35.66%) were female. Total gastrectomy was performed in 88 (68.2%) patients, distal gastrectomy in 14 (10.90%) patients and proximal gastrectomy in



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27 (20.90%) patients. When the pathology results were examined; the mean number of lymph nodes removed was 27.55 (± 10.69), mean number of metastatic lymph nodes removed was 9,29 (± 10,34).

The mean follow up time was 29.24 months (± 21,82). In that period; local recurrence seen in 1 patient (%1,1), distant organ metastasis seen in 24 patients (%18,6), exitus seen in 72 (%55,8) patients.

The mean survival was calculated as 59,1 months for stage 1, 32,95 months for stage 2, and 28,13 months for stage 3 (p: 0.018). The mean survival of the group with a metastatic lymph node ratio of 0-25% was 59,38 months; 37,98 months for 26% - 50%; 34,32 months for 51 - 75%; 16,93 moths for 76-100% (p<0,001).

All patients in stage 1 and 2 have a 0 - 25% lymph node metastasis rate. When stage 3 is evaluated in itself; The mean survival rate was 61.7 months in the group with a metastatic lymph node rate of 0-25%, and 39.9 months in the group with 26-50%; In the 51-75% group, the mean survival was 39.6 months; In the 76-100% group, the mean survival was found to be 17.1 months (p= 0.001).

It was found that; there was a relations between metastatic lymph node ratio and the survival (p<0,001 in ROC analysis). Cut-off value was found as a %25,4 which is calculated by using Youden Index. According to this cut-off value, patients devided into two groups as a; low-metastatic lymph node ratio (L-MLNR) and high-metastatic lymph node ratio groups (H-MLNR). In H-MLNR group mean survival was calculated as 33,05 months and in L-MLNR group mean survival was calculated as 67,36 months (p<0,001).

DISCUSSION – CONCLUSION

We determined that mean survival was decreased when the both TNM stages and metastatic lymph node ratio were increased. The overall 5-year survival in patients undergoing a potentially curative resection is between 24-57%. Although the rate of resection has increased in recent years, it is known in the literature that survival does not increase at the same rate (3).

In the treatment of gastric cancer, lymph node dissection reduces local recurrences and provides a more accurate staging opportunity. Determining the stage of the patient is an important step in the planning of the individual treatment modality. It can be used to predict metastatic lymph node rate, survival and recurrence, and to determine the treatment protocol (4).

At least 16 lymph nodes must be removed for TNM staging; but this is not always possible. In this case, the metastatic lymph node ratio can be used as a marker (4).

Wang et al. Were compared metastatic lymph node ratio with TNM staging on survival and prognosis. They evaluated the tumor size / metastatic lymph node ratio in pathology preparations and found that survival rates for stages 3A, 3B and 3C were higher in the 'low T-MLN' group.

Jing-Yu et al. were compared metastatic lymph node ratio and TNM staging in terms of survival and prognosis. They found significantly difference between metastatic lymph node ratio and survival. They also found that local recurrence is related with the metastatic lymph node ratio. (5)



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In our study we also found that when the metastatic lymph node ratio was increased, mean survival was decreased even between in the stage 3. Therefore we can say that metastatic lymph node ratio can be used to predict the mean survival in same stages.

Yeon et al. were found the cut-off value for the metastatic lymph node ratio as %10 and %60. They devided the patients into 3 groups according to that ratios. They said that metastatic lymph node ratio is a alternative marker in determining the survival for treatment algorithm against TNM stage, especially in elderly and patients who underwent insufficent resected lymph nodes (6).

Gülmez et al. were found the cut-off value for the metastatic lymph node ratio as %25, %50, %75. They devided the patients into 4 groups according to that ratios. They found that metastatic lymph node ratio is superior to N staging for overall survival and disease-free survival (7). In our study, we found that mean survival extremely decreased when the metastatic lymph node ratio is under the cut-off level which is %25,4.

In conclusion, it has been shown that not only the stage but also the resected metastatic lymph node / total resected lymph node ratio can make a difference in mean survival. In gastric cancer surgery, as many lymph nodes as possible should be resected to determine the best treatment options for the patient. Other parameters affecting the prognosis must also be considered.

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OP29- THE OUTCOMES OF GASTRIC CANCER SURGERY IN ELDERLY PATIEN

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Introduction

Gastric cancer is the fifth most common cancer in the World and is the third most common cause of cancer-related death. The incidence of gastric cancer has been increasing in octogenarians. Elderly patients need an individualized treatment modality. The modality should be decided by a multidisciplinary approach. Outcomes of surgery in elderly patients are limited in the literature. The primary aim of this study is to evaluate the perioperative outcomes of gastric cancer surgery in octogenarians.

Materials – Method

This was a single-center retrospective study. Patients aged 80 years and older who underwent surgery for gastric adenocarcinoma between January 2015 and June 2022 in Ege University Hospital General Surgery Department were retrospectively analyzed. Demographic, clinical, and histopathological parameters and postoperative outcomes were evaluated.

Results

During the study period, 261 gastric cancer surgeries were performed in our clinic. Twenty-three patients aged 80 years and older were included in the study. The mean age was 81.95 ± 3.11 (Range 80.96) years. 8 were female and 15 were male. 5 patients were ASA I, 11 patients were ASA II, and 7 patients were ASA III. Neoadjuvant therapy was applied to 3 patients. Total gastrectomy was performed in 11 patients, distal gastrectomy in 5 patients, and proximal gastrectomy in 7 patients. The mean number of lymph nodes removed was 19.87 ± 12.61 , and the number of metastatic lymph nodes was 9.22 ± 9.82 . Insufficient (less than 16) lymph nodes were excised in nine patients. The mean hospital stay was 9.34 ± 3.45 days. Anastomotic leakage had been developed in 1 patient and had treated with endoscopic stenting however uncontrolled sepsis occured and the patient was dead on the postoperative 23rd day. One patient died as a result of sudden cardiac arrest on the 3rd postoperative day. One patient had pneumonia treated with antibiotics successfully and outpatient on the postoperative 15th day.

Discussion

Advanced age and high ASA score are associated with mortality and morbidity. Perioperative mortality rates have been reported as 0-10% in the literature. In our study, perioperative mortality was found to be 8.6%.

Fujiwara et al; compared the age group 80 years and older with those under 79 years of age; mortality 4.3% vs 0.9% and respiratory complications 6% vs 2.1% were significant.

Konishi et al; He presented 0 mortality and 30% morbidity in a series of 134 cases in the 85-year-old and older patient group, and suggested that curative surgery should be performed together with D2 lymphadenectomy, even in the elderly patient group.

Schendel et al; It presented 10% mortality in a series of 130 cases aged 57 years and over; however, they showed that diseasefree survival was longer with surgery alone.

Fujisaki et al; He advocated that laparoscopic gastrectomy can also be applied in patients aged 75 years and older.



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Conclusion

Elderly patients are a special group of patients. The treatment plan should be tailored to the individual. If possible, curative surgery should be applied to all medically fit patients.

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OP30- ANALYSIS OF GASTRIC ADENOCARCINOMA WITH NEUROENDOCRINE DIFFERANTIATION IN PATIENTS WHO UNDERWENT GASTRIC CANCER SURGERY

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Gastric cancer is the 6th most common cancer type in the world and 4th in cancer-related deaths. Endoscopic resections have an important role in the treatment of early gastric cancer. Surgery is still the preferred treatment method in advanced gastric cancer. One of the most important parameters determining the prognosis in patients with gastric cancer is tumor histopathology. In this study, we aim to investigate neuroendocrine differentiation in gastic cancer patients.

Materials and Methods

Between 2014 and 2018, 10 gastric cancer patients with neuroendocrin differantiation who underwent radical resection were retrospectively analyzed. Demographic findings, operation type, TNM stage, tumor localization, tumor size, neoadjuvant treatment, histopathological findings and survival of patients were examined.

Results

Ten gastric cancer patients (8 male and 2 female) had neuroendocrin differantiation. The mean age was 65.1 years (range: 40–83 years). According to the AJCC 8th edition of TNM staging system for gastric cancer; 4 patients had stage 1B, 4 patients had stage 3A, and 2 patients had stage 3C gastric cancer. All patients received neoadjuvant chemotherapy. Total gastrectomy + D2 lymph node dissection was performed in 9 patients and subtotal gastrectomy + D2 lymph node dissection was performed in 1 patient. The mean tumor size was 6.5 cm (3-12). Demographic characteristics of patients are shown in Table 1 and the histopathological findings of the patients are shown in Table 2. The median survival time of the patients was 30.2 months (12-60 months). Only 1 patient is still alive and 9 patients died during the follow-up period.

Discussion

Neuroendocrine cells are secrete peptides and hormones according to the organ in which they are located. They differ from epithelial cells and they can be found along the gastrointestinal tract (1). And olso neuroendocrine cells are secrete chromogranin A and synaptophysin, which are markers of neuroendocrine cell differentiation (2). In our study 8 Patients had Chromogranin A positive and 9 patients had synaptophysin positive. The classification of neuroendocrine tumors has changed over the years. As it is classified as well-poor differential, it is also classified according to whether it shows function or not. Ki 67 index and number of mitosis plays an important role in determining the degree of neuroendocrine tumor. The prognosis changes due to the stage of the tumor, surgical margin status , WHO degree , histological differentiation level and the origin of tumor (3). Gastric neuroendocrine tumors are mainly divided into 3 groups; Type 1 gastric neuroendocrine constitutes about 10% of tumors. mostly, autoimmunity and atrophic gastritis are blamed. There are some studies that show that the prognosis is better than that of other neuroendocrine tumors (4). Type 2 gastric neuroendocrine tumors are associated with Zollinger-Ellison syndrome , some of which may also be associated with MEN 1. Type 2 gastric nets account for 5% or less of all gastric neuroendocrine tumors. They have a good prognosis, similar to type 1 (5) . Adenocarcinoma is the most common pathological type of stomach cancers. Neuroendocrine differentiated adenocarcinoma, mixed

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adenouroendocrine carcinoma and neuroendocrine carcinoma are more rarely seen (6). If neuroendocrine cells make up less than 30% of all cancer tissue, it is classified as a neuroendocrine differentiated (GCNED) gastric carcinoma If the proportion of each cell type exceeds 30%, it will be classified as mixed adenoneuroendocrine (MANEC; WHO 2017 version, renamed mixed neuroendocrine-neuroendocrine neoplasms, MiNENs) (7). In our study 10 gastric cancer patients had neuroendocrin differentiation . The differentiation degree of tumor was changes 5% to 10% . Jiang and colleagues analyzed the survival outcome of 86 patients and found that GC with neuroendocrin differentiation more than 20% had a worse prognosis (8).

In a study conducted by Yi Zou and colleagues with 945 patients, it was similarly reported that the worse the degree of differentiation, the worse the prognosis (10). There are very few studies on this topic in the literature. Gastric neuroendocrine carcinomas (NECs) and mixed adenouroendocrine carcinomas (MANECS) are aggressive tumors, but the prognosis is uncertain in patients with <30% of the tumor containing neuroendocrine components . According to the AJCC 8th edition of TNM staging system for gastric cancer; 4 patients had stage 1B, 4 patients had stage 3A, and 2 patients had stage 3C gastric cancer. The median survival time of the patients was 30.2 months (12-60 months). Only 1 patient is still alive and 9 patients died during the follow-up period. Only 1 patient in stage 1B group is still alive, and we think that the patients in this group should be evaluated in more detail. Because our survival expectation was higher in this patient group.

Conclusion

With current treatment approaches, a significant increase in the survival time of 5 years is achieved in patients with gastric cancer, but despite the fact that the patients we studied were treated appropriately with the literature, only 1 patient is still alive. We believe that the presence of neuroendocrine differentiation in patients with gastric cancer will be considered a poor prognostic finding, and it may be necessary to add additional treatment methods to standard treatment regimens.

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Tables

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Table 1 Demographic characteristics of patients

Table 2 Histopatological findings of patients

Table 1 Demographic characteristics of patients

Patients	n=10
Age, mean±SS	65,1(40-83)
Gender	
Male	8
Female	2
Tumor localization	
Corpus	5
Cardia	3
Fundus	2
Differantiation Grade	
Well differantiated (n/%)	2 (%20)
Moderately differentiated (n/%)	5 (%50)
Poorly differentiated (n/%)	3 (%30)
Type of surgery	
Total gastrectomy	9
Subtotal gastrectomy	1
Tumor size (cm)	6,5 cm (3-12)
TNM Stage	
Stage 1B	4
Stage 3A	4
Stage 3C	2

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Histopatologia of tumor	Patients (n/%)
Chromogranin A + (n/%)	8 (%80)
Synaptophysin + (n/%)	9 (%90)
Differantiation	
Well differantiated (n/%)	2 (%20)
Moderately differentiated (n/%)	5 (%50)
Poorly differentiated (n/%)	3 (%30)





OP31- HYDRO BT IN DIAGNOSIS AND FOLLOW-UP OF STOMACH CANCER

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INTRODUCTION

Gastric cancer is one of the leading malignant cancers that cause death. Computed Tomography (CT) is very effective in detecting gastric cancers, in addition to gastroscopy, in the staging of the disease and in the decision of the surgeon before the operation by providing information about the extent of gastric wall invasion and lymph node involvement (1,2).

In standard CT scans, iodinated oral contrast agents are used in the detection of the stomach, and these iodinated oral contrast agents prevent the separation of the gastric wall and the lumen.

Hydro CT is the imaging of the stomach with CT by distending the stomach by using only water instead of iodinated oral contrast agents (Figure 1).

Hydro CT in gastric tumors; It is a valuable staging tool that can accurately reveal the spread of the tumor in the organ wall, the extent of the tumor in the surrounding tissues and organs, and the relationship between the lymph nodes.

Since we have seen in our routine applications that hydro CT is more effective than standard oral contrast CT in gastric cancers, we aimed to present this application method to our colleagues who are interested in gastric cancers.



Figure 1: Hydro CT image. Incisura angularis thickening of the stomach wall (red arrows) and multiple lymph nodes in the hepatogastric area (white arrows)

MATERIAL – METHOD

In our study; Pre- and post-treatment hydro CTs of 18 patients who were prediagnosed with gastric cancer at gastroscopy and were scheduled for neoadjuvant chemotherapy were evaluated comparatively.

The patients we examined were asked to fast for approximately 6-8 hours. Before the examination, the patients were made to drink 1000cc of drinking water, and again, just before starting the shooting, another glass of water was given on the shooting table to ensure sufficient distention in the stomach.

Before starting the detection, an intravenous line was opened and an ampoule of i.v. scopolamine butylbromide was administered. Then, images were taken in a single phase by injecting 100-150 ml of iodinated contrast intravenously at a rate of 3-4 ml/sec with an automatic pump. (Figure 2)

Post-extraction images were evaluated by acquiring multiplaner reconstruction (MPR; axial, sagittal and coronal) on highresolution monitors in radiology workstations (Figure 3).

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Figure 2: Examination method

Image: Optimized in the string for about 6-8 hours

Figure 2: Examination method

Image: Optimized in the string for about 6-8 hours

Image: Optimized in the string for about 6-8 hours

1-Before the examination starts, the patient is quickly given 1000cc of water to drink.

2-Before the examination, an intravenous line is opened and 1 amp of scopolamine butylbromide (Buscopan®) is administered i.v. makes.

3- When it is taken to the table, a glass of water is drunk and the shooting begins.

4- I.V. Shooting is done by giving iodinated contrast. (3-4ml/min. 100-150ml.)

For a successfully hydro CT scan, the stomach wall folds should be distended to the extent of indistinguishability. In case of insufficient lumen filling, the stomach wall is observed as thicker than normal and wrong incorrect evaluation can be made and therefore, the result can lead to incorrect evaluation.

In dynamic imaging, which is one of the hydro CT application methods; biphasic or triphasic imaging can be performed (3).In biphasic dynamic imaging; the stomach is evaluated with images taken in 40-45 seconds for the arterial phase and 60-70 seconds for the venous phase. In triphasic imaging, late imaging is also performed.

Such biphasic or triphase dynamic contrast CT imaging facilitates the differentiation of the tumor from the normal gastric wall, but it also increases the radiation dose delivered. However, it can be recommended to be used in selected patients such as early stage patients who are thought to have the tumor only in the stomach wall and have difficulty in distinguishing. (4)

In dynamic imaging, gastric wall layers are displayed as 3 layers.

- 1- The innermost and contrasting layer: MUCOSA
- 2- 2-3mm thick hypodense layer in the middle: SUBMUCOSA
- 3- The outermost and slightly contrasting layer: MUSCULARIS AND SEROSA

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Figure 3: 74-year-old female patient. Early gastric ca -MPR: multiplanar reconstruction (A) axial (B) coronal (C) sagittal. Tumor invasion depth: submucosa



Figure 4: Hyd"ro BT; Abdominal CT without contrast (A) Hydro CT -one day later- (B)





Figure 5: Abdominal CT with oral and iv contrast (A) and Hydro CT (B) with gastric wall sufficiently distended with water

RESULTS

In our study, we obtained images of 18 gastric cancer patients discussed in the patient councils of our hospital GIS surgery. Four of the patients were female and 14 were male. The mean age was 61.

When the stages of these 18 patients were examined; 3 patients as T1, 5 patients as T2, 6 patients as T3, and 4 patients were evaluated as T4 tumors.

After neoadjuvant therapy (NACT), the effectiveness of the treatment was examined by re-imaging with hydro CT, and evaluating the tumor volume and response of lymph nodes to the treatment

The patients were operated on, and these findings were confirmed pathologically. The re-evaluation after the control hydroCT showed that there were 12 patients who were regressed, 2 patients who were stable, and 4 patients who had progressed. (Picture 6-9)

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Figure 6: Hydro CT examination of 55y female patient before (A and C) and 2 months after neoadjuvant therapy (B and D). Optimal viewing. Polypoid mass protruding from the stomach wall in the minor curvature of the stomach (red arrow) and multiple conglomerated lymph nodes in the hepatogastric area (blue arrow), no response to treatment and progressive

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Figure 7: 43-year-old male patient, vegetative mass in the lesser curvature of the stomach in the inferior of the cardia (red arrow), adeno ca, progression after Hydro CT, neoadjuvant chemotherapy multiple conglomerated lymph nodes in the hepatogastric area (blue arrow)

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Picture 8: 52 yrs. Male patient, hydro CT, mass surrounding the cardia in coronal sections (red arrow) (A), partially regressing after neoadjuvant chemotherapy (B). Metastasis of lymph nodes and dirty fatty planes in the hepatogastric area (blue arrow)





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Figure 9: 59y male patient, hydro CT, axial sections, tumoral mass in the preploric region sections (red arrow). Before (A), after (B) neoadjuvant therapy, regressed

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CONCLUSION

Hydro CT in gastric cancers is an important imaging and staging tool that can accurately reveal the extent of the tumor in the stomach wall, the extent of its spread to the surrounding tissues and organs, and the presence of lymph nodes.

It is known that the accuracy of treatment options will increase after an accurate imaging and staging.

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OP32- SHOULD DIAGNOSTIC LAPAROSCOPY BE PERFORMED PRIOR TO OPERATION IN GASTRIC CANCER?

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According to the World Health Organization GLOBOCAN databases, gastric cancer is the fourth most common cancer in developed countries and, at the same time, the second most common cancer among less developed countries. Despite the varied numbers of patients with malignancy among countries, males are affected significantly more than females. (1)

Surgical management plays a crucial role on treatment. However, there is still a lack of standards and insufficient evidence for minimal invasive approaches to gastric cancer. ($\underline{2}$)

Our study is based on the evaluation of gastric cancers with laparoscopic approaches. We have described five advantages of this procedure, which are: 1. Detecting occult peritoneal dissemination; 2. Accurate information about distant metastasis; 3. Easy biopsy; 4. Avoiding unnecessary laparatomies; 5. Lower morbidity rates.

In this prospective single-center study includes ten patients who had DL between May 2022 to August 2022. The participants were classified according to age, gender, malignancy size, Borrmann's classification, operation data, and post-operative pathological data. The group consisted of six males and four females. The youngest patient was 42 years old and the oldest one was 74 years old. The average age was 62.8 years. Secondly, the smallest tumor size was 2 cm, and the largest tumor size was 20 cm. The mean tumor size was 6.8 cm. Five patients were Borrmann's type 3, while two patients were type 4. Lastly, clinically, four patients were classified as stage 2B and three patients as stage 3A (according to the American Joint Committee on Cancer).

As a conclusion, a current literature review suggests that staging laparoscopy is very important for determining the correct therapeutic strategy for the treatment of advanced gastric cancer. (2) Peritoneal metastasis which was not detected by preoperative imaging methods was observed in 3 (33%) of the first 10 patients (up staging). Long-term results of our prospective trial will enable us to understand the importance of staging laparoscopy much better.

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