MODERN CAPACITIES OF DIAGNOSTICS AND SURGERY TREATMENT OF THE RECURRENT GASTRIC CANCER

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Abstract. Gastric cancer is one of the most widespread oncology diseases of the world. The aim of this research is to analyze direct and end results of medicated treatment of gastric recurrent cancer with use of Oncomarker CA 72-4. 129 surgically operated patients were investigated after having recidive gastric cancer. They had hospital care at the Department of abdominal oncology of the National Scientific Oncology Centre of the Ministry of Healthcare of the Republic of Uzbekistan during period of 2000-2013. Out of that amount of patients 18 (13,9%) had recidive after having proximal subtotal partial gastrectomy, 89(69%) – distal subtotal partial gastrectomy, 22(17,1%) – full gastrectomy. Out of 89 most of patients 66(74,1%) had preceded operation of Bilrot-I of distal subtotal partial gastrectomy and rest of them 23(25,9%) – Bilrot-II. According to sexual characters males were 93(72,1%), females – 36(27,9%). Age criteria were torn between 24 and 79 years. All patients were operated due to gastric cancer without covering of the principals of oncologic radicalism. Out of 129 patients 104(80,6% ) patients had the first surgical interferences at the different general surgery clinics and only 25 (19,4%) operations were made at the oncologic clinics. 13(10,1%) patients had anatomic structure of well-differentiated adenocarcinoma, 19(14,7%) – minor-differentiated, 68 (52,7%) – law-differentiated, 29 (22,5%) – colloid and poorly-differentiated carcinoma. Dynamic overview with use of Oncomarker CA-72-4 helps to detect recurring at yearly stages of its developing more than 5 months before its clinic manifestation. Evidently that detecting of recidive at yearly stage and its well-timed occasional radical fast treatment gives better direct as well as forthcoming results of surgery treatment of the patients with recidue gastric cancer. The most effective method of treatment resectable recidive stump cancer is surgical interferences which include standard and combined extirpation of gastric remnant. This brings to rise rates of 1-year survival up to 73,2%, 2-years survival up to 41,1% and 3-years and more than it up to 19,6% in such cases survival after nonradical operations of 3-6 months comes to 64,3%.

Keywords: Recidive Gastric cancer, adenocarcinoma, Oncomarker CA-72-4, gastrectomy, survival, standard and combined extirpation of gastric remnant.

Objective

Gastric cancer is one of the most widespread oncology diseases of the world. It occupies leading positions in the structure of death rate (803 thousand of death cases annually). The most incidence of this disease has been disclosed in Japan 80-85 people among 100000 populations and in South Korea 66.5-72.5 among men and 19.5-30.4 among women. But the same rates in USA are less in 10 times (Chernousov, Khorobrykh and Rogal, 2014; Vashakmadze and Pikin, 2000; Jemal et al., 2008; Lee et al., 2007). Presently there is only one definitive therapy of the gastric cancer carriers that is interventional. It depends out of localization and stage of the cancer process the surgical interferences might be as advanced as combined and also be attended by lymph node dissection in any case (Tarasov et al., 2001; Schepotin and Evans, 2000).

One of the main reasons of the poor results of the medicated treatment of the patients is recurrent gastric cancer. According to literature data the incidences after the first medicated interferences is 38% which is the main reason of the death cases of the patients even after the potential definitive medicated interferences. One of the main reasons of the failure cases of medicated as well as combined methods of the treatments is loco-regional recidive and metastasis of far located organs which are mostly visible in the first two years after the radical operation. Clinical laboratory recurrent gastric cancer is mostly detected when it is came out at bigger range, extend to the next organs and became inoperable. The reason of it the mostly is the late medical resource utilization as a result of which the operations are made on the edge of operability.
It should be mentioned that it is specific for the stomach that the synchronic mono-organ damage is accrued in view of multicentre growth of tumor (A.S. Mamontov, S.L. Shlyakov, 1996). According to Willis theory “about tumor field” the multiple tumor rudiments may became a new source of tumor growth in stomach. (Vashakmadze, Alyoshkina and Chaika, 2001).

Recidive stump cancer and oesophageal and gastrointestinal anastomosis accrued with 16-20% of the patients including 11-13% of patients with only distribution recidive. (Skoropad et al., 2005; Maehara et al., 2000; Yoo et al., 2000). Usually it is not enough to have segregated medicated treatment for such patients that is why it is necessary to have aggressive combined therapy to exclude the next recidive of the tumor.

The aim of this research is to analyze direct and end results of medicated treatment of gastric recurrent cancer with use of Oncomarker CA 72-4.

Materials and Methods

129 surgically operated patients were investigated after having recidive gastric cancer. They had hospital care at the Department of abdominal oncology of the National Scientific Oncology Centre of the Ministry of Healthcare of the Republic of Uzbekistan during period of 2000-2013. Out of that amount of patients 18(13,9%) had recidive after having proximal subtotal partial gastrectomy, 89 (69%) – distal subtotal partial gastrectomy, 22 (17,1%) – full gastrectomy. Out of 89 most of patients 66 (74,1%) had preceded operation of Bilrot-I of distal subtotal partial gastrectomy and rest of them 23 (25.9%) – Bilrot-II. According to sexual characters males were 93 (72,1%), females – 36 (27,9%). Age criteria were torn between 24 and 79 years. All patients were operated due to gastric cancer without covering of the principals of oncologic radicalism. Out of 129 patients 104 (80,6%) patients had the first surgical interferences at the different general surgery clinics and only 25 (19,4%) operations were made at the oncologic clinics. 13 (10,1%) patients had anatomic structure of well-differentiated adenocarcinoma, 19 (14,7%) – minor-differentiated, 68 (52,7%) – law-differentiated, 29 (22,5%) – colloid and poorly-differentiated carcinoma.

Clinical signs of recidive stump cancer had no difference between primary gastric cancers. So 81(62,8%) of patients had clinical sins of the stegnosis, 54 (41,9%) patients had cases of dysphagia, 16 (12,4%) – bleeding out of recurrent tumor. Diagnostic of the recidive has been made through medical visualization methods like (X-Ray, Ultrasound diagnostics, computer tomography, gastrofibroscopy) determination of the level of oncomarker CA3724 even during occasional surgical interferences.

Determination of recidives of gastric cancer still recalls certain difficulties. This is due to that recidive appears in the setting of “disease of operated stomach”. Recidive problems can be explained by that it is difficult to detect now by Ultrasound and Computer Tomography investigations. In accordance with it certain importance in clinic receives investigation of levels of associated tumor antigens as indicators of reinitiation of tumor growth particularly CA-72-4. Its rate of rise was associated with the stage of disease and prevalence rate of process. After surgical interferences level of CA 72-4 back to its normal level (average 3-4 weeks). This marker has slightly more highest sensitivity to next recidive disease comparably with REA and CA 19-9. Average rate of concentration of CA-72-4 of patients made among investigated group was 6,9 U/ml. (according to clinical investigated laboratory “Electroset”). In accordance with this to determine the dynamic of the process all patients had investigations every 1,3,6,9 months. While dynamic visualization it was determined that appreciable rise of CA-72-4 level in blood had been accrued from 13,82 till 116,9 U/ml. We couldn’t detect process of recidive with a help of visualization methods like (x-Ray, Ultrasound dianostics, computer tomography, gastrofibroscopy). These patients in average rate of 4-6 months after having immunochemiluminstic and clinical laboratory investigations were determined by the recidive of gastric cancer.

Discussion and Results

Out of 129 patients with recidive gastric cancer 98(75,9%) patients had occasional surgical operations. As a total surgical interferences 7(7,1%) patients had extirpation of gastric remnant, 4(4,1%) had surgical removal of gastric remnant. Out of that amount of patients 45(46,0%) patients had combined surgical interferences due to extension of tumor to neighbouring structures, and 42(42,8%) patients’ operations were limited by overlapping of gastroenterostomy and explorative laparotomy. Reason for implementing of nonradical surgical interferences to these patients were total damage by tumor of the gastric remnant with stegnosis of gastrointestinal anastomosis. Operable patients among all admitted patients were 75,9%, rest 31(24,1%) patients were nonoperable due to checked process they had. Reasons of that were cartesianosis with 9(29%) patients, metastasis damage of liver and far located lymph glands with 6(19,4%); loco-regional
spreading of tumor with implication of pancreatic glands, left lobe of liver, extraperitoneal and extraperitoneal of lymph glands 16(51.6%) patients.

In our research work resectability composed 43.4%. According to different authors (Blokhin et al., 1987; Skoropad and Berdov, 2005; Morgoshiya and Gulyayev, 2003), rate of resectability counterchanges in slight wide ranges from 40 to 83%. After distal subtotal gastric resection by Bilrot-I radical surgical interference were incurred 17 (25.7%) patients, by resection of Bilrot-II 15 (65.2%) patients. The most highest resectability was after preceding gastric resection by Bilrot-II (65.2%), much more lower after gastric resection by Bilrot-I (25.7%) due to extending of tumor to head of pancreas and elements of clamp of liver. Dependence of type of reconstruction after extirpation of gastric remnant in all cases ezoafoganoanasmosis by Ru or by Gilyarovich was formed. Operations had combined character with 56 (57.2%) patients. The most frequently splenectomy has been implemented to 22(39.2%) patients; resection of loop of intestine – 17(30.4%); liver – 8(14.3%); transverse colon – 11(19.6%); pancreatic glands – 9(16.1%) patients.

In postoperative period 2 patients have die which composed 2.1%. Causes of death were thromboembolism of pulmonary artery and acute coronary insuffiency.

Median of survival of radical operated patients were 25.6 months. Total 1-year survival was 73.2%, 2-years – 41.1% and 3-years and more than it was 19.6%. Out of 42 patients with nonradical surgery 64.3% of patients have die during 3-6 month after operation is done.

Conclusions
Dynamic overview with use of Oncomarker CA-72-4 helps to detect recurring at yearly stages of its developing more than 5 months before its clinic manifestation. Evidently that detecting of recidive at yearly stage and its well-timed occasional radical fast treatment gives better direct as well as forthcoming results of surgery treatment of the patients with recidive gastric cancer. The most effective method of treatment resectable recidive stump cancer is surgical interferences which include standard and combined extirpation of gastric remnant. This brings to rise rates of 1-year survival up to 73.2%, 2-years survival upto 41.1% and 3-years and more than it upto 19.6% in such cases survival after nonradical operations of 3-6 months comes to 64.3%.

References