

Gastric Carcinoma: Early Detection and Prognosis

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Gastric carcinoma is relatively common in Jamaica and indeed the Caribbean. Plummer *et al* found an increase in gastric cancers in the 50–59-year age group in a retrospective review of gastrectomies and gastric biopsies in Jamaica (1). Patients are invariably diagnosed when the cancer is at an advanced stage and hence in general, carries a poor prognosis. The time of diagnosis is the most critical factor determining prognosis. In this issue Rende Guo *et al* examines the use of tumour proteins – P53 and vascular endothelial growth factor (VEGF) – in predicting prognosis. The authors suggest that P53 and VEGF may play an important role in controlling angiogenesis and that VEGF expression is associated closely with tumour recurrence (2). This information would be of value in tumour management. Patients with early gastric carcinoma have non-specific symptoms – namely epigastric pain, burning, nausea, vomiting and loss of appetite. However, these early symptoms are almost identical to benign gastric pathologies related to hydrochloric acid production. As such, patients are often self-treated and/or medically directed with therapies aimed at acid reduction, often with positive results. This may reassure not only the patient but also the physician that the initial diagnosis is correct. Prior therapies may be repeated if symptoms recur and by the time diagnosis is made, the cancer may be at an advanced stage. How then can we break this pattern? Despite its increasing incidence, there is no screening programme for gastric carcinoma in the

Caribbean unlike other countries with very high incidence such as Japan and Chile. There should be a high index of suspicion of gastric carcinoma in older patients, those with a positive family history of gastric cancer, patients with *H pylori* infection, “acid problems” with weight loss and other constitutional symptoms, steadily progressive symptoms and symptoms unresponsive to therapy. Physical examination in early gastric cancers is almost always normal. Once there is a suspicion of cancer, patients ideally should have upper gastrointestinal endoscopy which is highly sensitive and specific for gastric carcinomas and which allows tissue diagnosis and anatomic localization of the tumour. The use of endoscopic ultrasound has been shown to be useful in determining appropriate therapy for patients with gastric cancers (3).

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