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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Gastric Cancer Screening & Surveillance Strategies

Dr. Buch:
The U.S. has no current guidelines for gastric cancer screening. Yet we know there are significant risk factors. This is your ReachMD *GI Insights* host, Dr. Peter Buch. Joining us to better understand the progression to gastric cancer is Dr. Joo Ha Hwang. Dr. Hwang is Professor of Medicine at the Stanford University Medical Center. He specializes in the early detection of gastrointestinal malignancies. Welcome to the program, Dr. Hwang.

Dr. Hwang:
Thank you so much for having me.

Dr. Buch:
To start us off, why don't we have guidelines for gastric cancer screening in the United States?

Dr. Hwang:
So that's a great question. We really should have gastric cancer screening guidelines. But I think the reason that we don't have them right now is that the perception in the United States is that gastric cancer is a rare cancer. But the truth of the matter is, it is not as rare as we think. So I'm hoping to change that perception. There's a lot of us who are working on, educating the general community, including gastroenterologists, that gastric cancer is not rare, especially in certain populations, and we can do something about it.

Dr. Buch:
Can you help us understand the difference among chronic gastritis, atrophic gastritis, and intestinal metaplasia?

Dr. Hwang:
Yeah, so we know that for a large percentage of gastric cancer, it takes this progression what's well known as the Correa cascade developed by Paul Correa at Vanderbilt. And basically, it's this progression from chronic gastritis, to atrophic gastritis, and intestinal metaplasia, which then goes on to dysplasia and cancer. And in most cases, chronic gastritis initially develops due to product H. pylori infection. And we could actually stop the progression or the risk of progression by treating H. pylori at a certain stage. But we believe that once it's gone on to atrophic gastritis and then intestinal metaplasia that it becomes, for the most part, irreversible depending on the extent of the disease. So it's essentially a progression from chronic gastritis to atrophic gastritis. Atrophic gastritis is then the milieu in which intestinal metaplasia can then develop. And then with ongoing inflammation, the intestinal metaplasia can go on to dysplasia and cancer.

Dr. Buch:
There would also be a subset of those patients with this cascade who do not have helicobacter. Can you tell us a little bit about those?

Dr. Hwang:
Yeah, intestinal metaplasia can develop due to any type of chronic inflammation that impacts the gastric lining. So you can have autoimmune atrophic gastritis that also goes on to develop intestinal metaplasia. So basically, chronic gastritis, atrophic gastritis, and intestinal metaplasia just require some form of chronic inflammation to affect the stomach. And again, worldwide the most common cause is chronic H. pylori infection, but obviously, autoimmune atrophic gastritis is another one, and other types of chronic inflammation of the stomach.

Dr. Buch:
Thank you. What subsets of patients with gastric intestinal metaplasia are at highest risk of progression?

Dr. Hwang:
Yeah, that's an area that's being investigated right now. Because we know like Barrett's, and I think that there is an excellent analogy between Barrett's esophagus and gastric intestinal metaplasia of the stomach. They're both intestinal metaplasia, and they're both thought to be part of the progression on to cancer. We don't necessarily know all the risk factors of people who develop intestinal metaplasia of the stomach that go on to cancer, so just as we don't know for those who have Barrett's esophagus, we do know that extent of disease. So the more of the stomach that's involved with intestinal metaplasia is one of the risk factors. Also, we know that there's a type called incomplete-type intestinal metaplasia that also increases your risk for going on to gastric cancer. But there's other forms, and we're looking at biomarkers and other things that we can evaluate within the milieu of the intestinal metaplasia that determine which patients are at higher risk that might want to undergo closer surveillance.

Dr. Buch:
So without guidelines, what do you suggest as an interval for serial endoscopies in gastric intestinal metaplasia?

Dr. Hwang:
Yeah, that's the challenging question. And I think that most of us do feel that patients with intestinal metaplasia, especially from areas that have a high prevalence of gastric cancer, warrant surveillance. It really depends, again, on the extent, so if you have a white male with just a focus of intestinal metaplasia in the antrum, they're probably at very low risk for going on. And the AGA guidelines actually suggests that patient not be surveilled. But if you have another patient who perhaps is from East Asia and has extensive intestinal metaplasia and might have incomplete type pathology, that patient probably warrants more intense surveillance. And also somewhere between every one to three years, really depending on the extent of the intestinal metaplasia and other risk factors that that patient might have. But we don't have good guidelines. The Europeans have recently reported guidelines or suggested guidelines for most patients who have intestinal metaplasia to undergo surveillance every three years. The Asians, so Japan and Korea, survey their patients on an every-two-year basis. And certainly, if patients have more advanced type of, for example low-grade dysplasia, those patients should probably have surveillance on an annual basis.

Dr. Buch:
For those just tuning in, this is Dr. Peter Buch, and today discussing screening and surveillance for gastric cancer is Dr. Joo Ha Hwang.

Dr. Hwang, how close are we to developing an algorithm to identify high-risk subpopulations who might benefit from screening programs?

Dr. Hwang:
I would say we have the algorithms. We've written many papers and other groups have also written many papers. The Europeans have an algorithm as well. So I think that we have the algorithms. The question is, how soon are we in terms of a broad adoption of these algorithms? And I think what we really need to do is to get societies such as the American College of Gastroenterology, the AGA, the ASGE, to put forth societal guidelines. The ASG actually does have guidelines in terms of identifying and screening and surveying high-risk populations, but they're buried in a very obscure SOP document. But the ASG actually does recommend screening patients who are recent immigrants from high-risk or high-incidence countries. So we have the algorithms, it's just a matter of educating the broader population that these groups exist and that we need to start surveying.

The other real problem actually is insurance companies. So a lot of the patients that are at high risk are recent immigrants, and a lot of them own small businesses in order to survive and they have high deductible insurances. And so I recently had a patient who has gastric intestinal metaplasia and needed an endoscopy, and they were charged $4,000. And they have a high deductible insurance. And so we need to make it more accessible also for these patients to have endoscopy.

Dr. Buch:
Before we conclude, are there any other thoughts you would like to share with our audience?

Dr. Hwang:
Well, what I would say is the perception that gastric cancer is a rare cancer in the U.S. should be debunked. Gastric cancer is not rare. Gastric cancer is more prevalent than esophageal cancer. And we have clear guidelines for screening and surveillance of Barrett's esophagus. And so I would say that there's probably about 10,000 more cases of gastric cancer annually in the U.S. than esophageal cancer. And if you look at our five-year survival for gastric cancer and compared to the rest of the world, we were a very poor performer. If you look at Asia, Korea, and Japan have an overall survival of about 60 to 70% five-year survival, whereas the U.S. has an overall five-year survival of 30%. And basically, that's because we're not detecting gastric cancer early. And gastric cancer is a cancer that we can detect early and, if detected early, we can treat endoscopically and cure. So I would like to conclude by saying that gastric cancer is not rare in certain populations and we know who those high-risk populations are. And we need to start screening, and if we identify intestinal metaplasia or other high-risk factors, we should survey these patients, and we can make a difference in the outcomes of gastric cancer.

Dr. Buch:
This has been an extremely informative session on risk factor screening and surveillance for gastric cancer in the United States. I wanted to thank Dr. Hwang for sharing your insights.

Dr. Hwang:
Thank you very much for having me. I enjoyed this talk and anything that we can do to spread the word that gastric cancer can be tackled and we can make an impact.

Dr. Buch:
For ReachMD *GI Insights*, this is Dr. Peter Buch. To access this episode, as well as others from the series, visit ReachMD.com/GIInsights, where you can Be Part of the Knowledge. Thanks for listening, and see you next time.