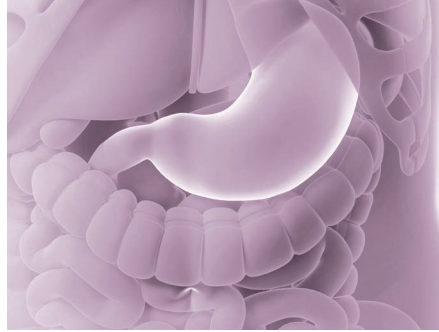


Gastric Cancer Surgery



An individualized and tailored approach
by a multidisciplinary gastric cancer team

About the Gastric Surgery Program

The *Center for Global Excellence in Gastric Cancer Care at NewYork-Presbyterian Hospital/Columbia University Medical Center* is dedicated to the cure and care of our patients with gastric cancer.

We offer three approaches to gastric cancer operations – open, laparoscopic, and robotic. There are benefits to each of the approaches which your surgeon will discuss with you. Regardless of the method of operation, the goals of your surgery are to provide you the best cancer operation and to ensure long-term survival and maintaining a good quality of life.

Gastric Surgery & Reconstruction

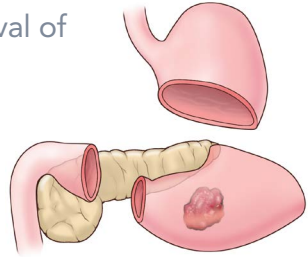
Surgery is the mainstay of curative treatment for gastric adenocarcinoma. The role of surgery in the treatment of gastric cancer depends primarily on the stage of the cancer and your health. Whether you will need surgery alone, or in combination with chemotherapy and/or radiation will be determined during a discussion with your surgeon.

Once surgery becomes part of your treatment plan, you may be receiving one of the following types gastric cancer operations. Your surgeon will determine which of these options applies to you.

Gastric cancer, or stomach cancer, occurs when abnormal cells start to grow uncontrollably within the walls of your stomach. There are different types of gastric cancer but focus of this brochure is adenocarcinoma, a condition that effects approximately 95% of the patients we treat.

Location and aggressiveness of the tumor determine the amount of stomach that needs to be removed. A *subtotal distal gastrectomy* and *total gastrectomy* are the two most common types of resection.

Subtotal Distal Gastrectomy is the removal of the bottom two-thirds of the stomach. It is performed for tumors located in the mid-to-bottom part of your stomach.



Subtotal Distal Gastrectomy

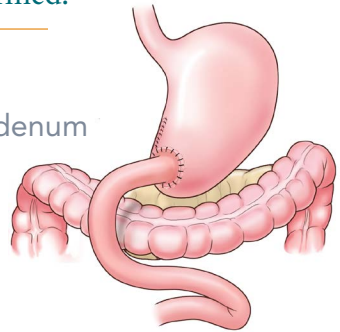


Total Gastrectomy

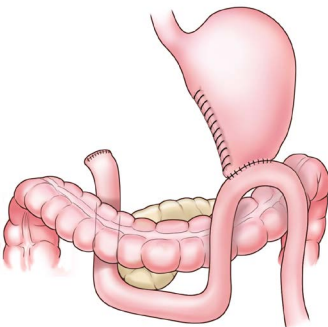
Total Gastrectomy is the removal of the entire stomach and is indicated for tumors in the upper third of the stomach.

The three most common types of reconstructions are *Gastroduodenostomy*, *Gastrojejunostomy* and *Roux-en-Y*. Typically an individual's health status and surgical preference determines which reconstruction is performed.

Gastroduodenostomy refers to the connection of the stomach to the duodenum (the first portion of small bowel).



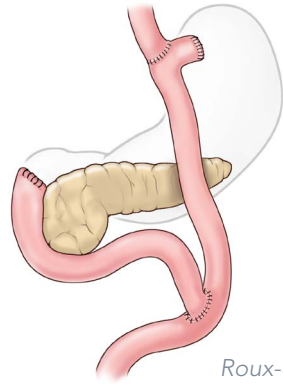
Gastroduodenostomy



Gastrojejunostomy

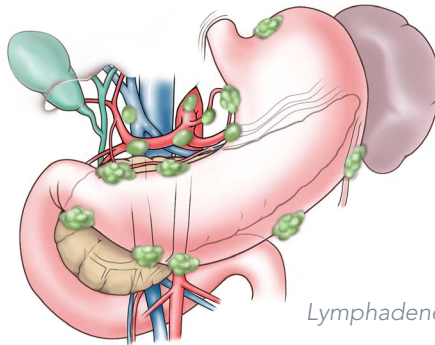
Gastrojejunostomy refers to the connection of the stomach to the jejunum (the second section of the small intestine).

Roux-en-Y refers to the reconstruction of both the jejunum and duodenum in the shape of the letter Y to create two passages: one for food from the stomach and one for digestive enzymes from the gallbladder and pancreas.



Roux-en-Y

Lymphadenectomy is the removal of the lymph nodes that drain the stomach tumor which has the potential to harbor cancer cells. The depth of the tumor determines the extent of the retrieval of the lymph nodes that drain the stomach. The type of lymphadenectomy is very important to your prognosis.



Lymphadenectomy

D1 is the removal of the soft tissue containing lymph nodes around the stomach. This is indicated in very early stages.

D1 plus is an additional limited retrieval of lymph nodes around select arteries that supply the stomach. This is indicated in early stage cancer limited to the first two layers of the stomach.

D2 is a more extensive lymph node dissection to remove the second tier (N2) lymph node, performed for select patients with more locally advanced disease.

After Surgery

Lifestyle changes:

Sometimes there are early post-operative issues, the most common after gastric surgery is a wound infection. These are typically treated while you are still in the hospital, but may require visiting nurse care once you are discharged home.

In addition to wound infection, you may experience intra-abdominal fluid collections and leakages or bile-reflux where bile comes back into the remnant stomach or esophagus. Dumping syndrome may occur as well. This is the rapid transit of food from the remnant stomach into the small bowel causing dizziness, flushing, nausea, vomiting, cramps, and diarrhea. If any of these do occur, we will help you manage these problems.

Dietary changes after surgery are highly individualized. Some may only need to adjust their diet for the first few weeks post-operatively, while others may require life-long changes. The most important points to know are that weight loss is normal after surgery and small, calorie-dense meals eaten multiple times a day is the best way to receive the proper nutrients and minimize further weight loss.

In terms of food choices, the physiological effects of surgery vary widely. In general, it is recommended to avoid sugar and high fiber foods for at least the first two weeks following surgery. Some may have difficulty tolerating dairy products, while others will have no trouble. For this reason, it is suggested that you maintain a food diary for several weeks to help you tailor your diet to your specific needs.

For more information on diet choices, please see the resources listed on the back of this pamphlet, or consult your healthcare team.

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To learn more about the Gastric Cancer Center, please visit us on the internet at: www.columbiasurgery.org/gastric

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