Survivorship – Gastric Cancer

ELIGIBILITY

Gastric cancer 5 years post-treatment and NED

CONCURRENT COMPONENTS OF VISIT

SURVEILLANCE

Annually:
- History and physical examination
- Screen for low bone density
  - Vitamin D-25OH annually
  - Baseline bone mineral density (BMD) for patients who are post-menopausal **or** age > 50 years **or** at initial survivorship visit. Then repeat BMD every 5 years[1] if normal.
- Labs[2]: CBC with differential, iron level, electrolytes, micronutrients[3], and vitamin B12[4]

Suspected new primary or relapsed disease?

Yes → Return to primary treating physician
- **Primary Oncologist** to discuss Goal Concordant Care (GCC) with patient, or if clinically indicated, with Patient Representative[5]

No → Continue survivorship monitoring

MONITORING FOR LATE EFFECTS

- Fatigue
- Weight loss
- Neuropathy
- Acid reflux
- Diarrhea

RISK REDUCTION/ EARLY DETECTION

Patient education, counseling, and screening:
- Lifestyle risk assessment[6]
- Cancer screening[7]
- Screening for Hepatitis B and C as clinically indicated (see Hepatitis B Virus (HBV) Screening and Management and Hepatitis C Virus (HCV) Screening algorithms)
- Consider cardiovascular screening[8]
- Vaccinations[9] as appropriate
  - HPV vaccination as clinically indicated (see HPV Vaccination algorithm)

PSYCHOSOCIAL FUNCTIONING

Assess for:
- Distress management (see Distress Screening and Psychosocial Management algorithm)
- Depression
- Financial stressors
- Social support

→ Refer or consult as indicated

NED = no evidence of disease

[1] If abnormal, consider repeating BMD within 1-3 years
[2] Labs may be monitored by primary care provider (PCP)
[3] Micronutrients may include the following: zinc, copper, selenium, thiamine (B1), vitamin B6, vitamin A, vitamin E, vitamin K or prothrombin time, ferritin, transferrin, transferrin saturation, folate, methylmalonic acid, parathyroid hormone
[4] Vitamin B12 monitoring is at least every 6 months (if not on parenteral B12 supplement)
[5] GCC should be initiated by the **Primary Oncologist**. If Primary Oncologist is unavailable, Primary Team/Attending Physician to initiate GCC discussion and notify Primary Oncologist. Patients, or if clinically indicated, the Patient Representative should be informed of therapeutic and/or palliative options. GCC discussion should be consistent, timely, and re-evaluated as clinically indicated. The Advance Care Planning (ACP) note should be used to document GCC discussion. Refer to GCC home page (for internal use only).
[6] See Physical Activity, Nutrition, Obesity Screening and Management and Tobacco Cessation Treatment algorithms; ongoing reassessment of lifestyle risks should be a part of routine clinical practice
[7] Includes breast, cervical, colorectal, liver, lung, pancreatic, prostate, and skin cancer screening
[8] See Survivorship - Adult Cardiovascular Screening algorithm
[9] Based on American Society of Clinical Oncology (ASCO) guidelines

Department of Clinical Effectiveness V2
Approved by The Executive Committee of the Medical Staff on 10/15/2024

SUGGESTED READINGS

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MD Anderson Institutional Policy #CLN1202 - Advance Care Planning Policy
Advance Care Planning (ACP) Conversation Workflow (ATT1925)

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DEVELOPMENT CREDITS

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