

Mayo Clinic Q & A - Dr. Lionel Kankeu Fonkoua "Stomach Canc...

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SPEAKERS

Dr. Lionel Kankeu Fonkoua, Dr. Halena Gazelka, Narrator

N Narrator 00:01

Coming up on Mayo Clinic Q&A, we'll take a look at stomach cancer. While not as well known as other types of cancers, such as breast or colon, stomach cancer is still an abnormal growth of cells only this time it begins in the stomach. In fact, it can affect any part of the stomach, the disease tends to develop slowly, often over years. And symptoms can be subtle.

D Dr. Lionel Kankeu Fonkoua 00:24

The signs can be vague and nonspecific. They range from abdominal pain or weight loss, or nausea, vomiting, heartburn that doesn't go away. And then in some of the most advanced cases, we can see bleeding. So really, if there's something that's alarming and doesn't go away, you know, bring it up to the attention of your primary care provider.

D Dr. Halena Gazelka 00:43

Welcome, everyone to Mayo Clinic Q&A. I'm Dr. Halena Gazelka. Stomach cancer, also known as gastric cancer, can affect any part of the stomach. In most of the world, gastric cancers are more common in the main part of the stomach. But in the United States, gastric cancers tend to form where the esophagus meets the stomach. Where the cancer occurs is one factor that doctors consider when determining treatment options. Treatment usually includes surgery to remove the stomach cancer, but it can involve other treatments as well. November is Stomach Cancer Awareness Month. Can you believe it? Here to discuss this with us today is Mayo Clinic oncologist, Dr. Lionel Kankeu Fonkoua. Thanks for being here today, Lionel.

D Dr. Lionel Kankeu Fonkoua 01:29

Thank you so much for having me.

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Dr. Halena Gazelka 01:31

Well, I always like to say that I love to learn something new. And I didn't know there was a stomach cancer awareness month. So, I'm glad that we're talking about this today.

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Dr. Lionel Kankeu Fonkouda 01:40

Absolutely.

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Dr. Halena Gazelka 01:42

Before we get started talking Lionel, we haven't had you on the podcast before. So, could you tell us a little bit about yourself? And what made you decide to go into medicine and into oncology?

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Dr. Lionel Kankeu Fonkouda 01:53

Yeah, absolutely. So, my last name actually stems from Cameroon, Central Africa, that's where I was originally from, born and raised there. I came to the states probably about 16 years ago to further my education. But also, I would say that the sad loss to stomach cancer, actually of my grandmother to stomach cancer, really was an event that really impacted and influenced my career trajectory and my goals for my life. So, I think as I was, you know, as a teenager, I was really distraught with, you know, her lack of response to multiple therapies. And I wish I had the medical expertise to really help her more than I could at the time, and that loss was painful. But you know, it's part of a really powerful force that has helped direct me and guide really my career goals. My training, you know, always my medical training I meant, I always found myself drawn towards cancer patients, you know, and I think I was intrigued by the science and the research element. But, you know, I think the patient's interactions were very unique, you know, whether you're navigating challenging goals of care discussions or rejoicing with them, you know, when they're doing well, or even holding their hands at the end of life, you know, those interactions were really unique, and I found it incredibly fulfilling and rewarding to walk that journey with my patients. So, it's been a true privilege. You know, I've kind of built the foundation so far over the past 15-16 years for a career in oncology, and I'm really glad I chose that career path.

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Dr. Halena Gazelka 03:31

Thank you so much for sharing with us Lionel. I'm very sorry about the loss of your grandmother, but I am delighted to hear that the silver lining is that you ended up in oncology doing what you do today to help patients.

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Dr. Lionel Kankeu Fonkouda 03:44

Absolutely.

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Dr. Halena Gazelka 03:45

Can you tell us what causes stomach cancer? And why does it occur in different parts of the stomach?

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Dr. Lionel Kankeu Fonkoua 03:51

Yeah, so that's a great question and a common question, you know. So, stomach cancer is really a heterogeneous group of cancers, you know, multiple subtypes, that can be classified in different ways based on the anatomic location, you know, the histology, how the cancer cells look under the microscope, or even more recently, you know, the molecular characteristics of the tumor. But to keep things simple, I think I would try to say, I would say that there are two main types of stomach cancer, cardia stomach cancer and non-cardia. And cardia is because that's the top part of the stomach that's near the junction with the esophagus, that's the food pipe. So, where the stomach joins the esophagus, the top part of the stomach is called cardia, obviously because of proximity to the heart, and that type of cancer is actually the type that's more common in the U.S. as you mentioned in your introduction, predominantly because of some of the risk factors associated with it, you know, reflux, chronic acid reflux, something called Barrett's esophagus, which is a precancerous lesion, and you know, that type of cancer, actually, the incidence has been rapidly, dramatically rising in the U.S., as opposed to the other type, which is the non-cardia, which is what you find in the stomach proper. And that could be because that's most commonly seen in other parts of the world, predominantly in Asia, you know, Africa, and that's predominately caused by carcinogens that the stomach is exposed to, predominantly in food. So, commonly, you know, preservatives, you know, food preservatives, such as salt, you know, smoking, smoked foods, tobacco also has been associated with it. And in some parts of the world, an infection with a bacteria called *H. pylori* has also been proven to cause a chronic inflammation that eventually leads to development of a cancer. So, that's last but not least, you know, that type of cancer can also be associated with, you know, inherited mutations and as part of familial syndromes. So, that's in a nutshell, you know, to keep things simple the types and the different risk factors that you can see with each type.

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Dr. Halena Gazelka 06:08

How interesting. So, who is at risk of developing stomach cancer?

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Dr. Lionel Kankeu Fonkoua 06:13

Yeah, so as I alluded previously, you know, the top part of cardia tumors, stomach cancers, one common risk is Barrett's esophagus. And that's, you know, a precancerous type of lesion that's caused by, you know, repeated exposure of stomach acid, you know, refluxing back towards the esophagus, and over time that tissue, you know, changes and transforms into, you know, from the normal epithelium. And, you know, we can, the typical risk factors associated with that type of precancerous lesion is actually reflux disease, obviously, men more than women. We see that more commonly with men than women. Age, so people over the age of 55 are more prone to develop that. And interestingly, obesity carries a three to four-fold risk. Yeah, and smoking as well. So, those are two very important risk factors for Barrett's esophagus. Now for the other types, you know, tobacco, you know, like I mentioned salty foods, smoked foods, *H. pylori* infection. And then, last but not least, a family history, you know, especially some of these familial syndromes that we see with inherited genetic mutations.

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Dr. Halena Gazelka 07:36

I know smoking seems to be on the list for every bad disease that happens.

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Dr. Lionel Kankeu Fonkoua 07:41

That's correct. Yeah. So, you know, I always tell my patients, you know, if you are still smoking try to quit, you know.

And so, yeah, it's a common risk factor.

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Dr. Halena Gazelka 07:52

What are the signs and symptoms? So, how would someone know if they might have a stomach cancer?

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Dr. Lionel Kankeu Fonkoua 07:57

Yeah, that's a good question. So, unfortunately, the science can be vague and nonspecific, you know. We could see them not specifically with just stomach cancer, but they range from abdominal pain, you know, weight loss, you know, nausea, vomiting, heartburn that doesn't go away. You know, that feeling of early satiety of fullness, sometimes. And then in some of the most advanced cases we can see bleeding, so it can be anemia. A lot of patients present with anemia in the setting of bleeding. And that type of bleeding is a little different, you know, it's kind of what we call melena. Melena, or dark, tarry stools, as opposed to bright red blood, it usually indicates that the bleeding is coming from higher up in the GI tract. So that's, you know, in a nutshell, some of the symptoms, you know, that we can dip that will typically prompt an evaluation, as you can see, not necessarily specific. So, really if there's something that's alarming and doesn't go away, you know, bring it up to the attention of your primary care provider.

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Dr. Halena Gazelka 08:56

And then what is likely to be ordered to help with diagnosis?

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Dr. Lionel Kankeu Fonkoua 09:00

Yeah, good question. So, really the workup or evaluation for this patient can be pretty extensive. So, the symptoms will prompt an initial evaluation with what we call an endoscopy. That's typically where we start, you know, if there is a concern for something arising the esophagus or the stomach, we start with an upper endoscopy, which is kind of a camera with a probe that goes in and examines that area. And usually they will find, you know, what looks like a cancerous, suspicious cancerous lesion that will be biopsied. And we take that back to the pathologist who would review those cells under the microscope and kind of confirm that there's an abnormal growth in the stomach. And once that's established, really the next step is determining, you know, the extent of the stage of the disease. And that triggers another battery of tests, which I'm going to try to quickly go over because I think it's important for patients to know, you know, have an idea of what to expect because a lot of time this process can take a few days up to a week, and the patient is really stressed and overwhelmed. So, after the endoscopy, the next step is usually a CAT scan of the chest, the abdomen and pelvis, to try to determine, you know, if the cancer that started presumably in the stomach has started to spread elsewhere, you know, some common places of spread, you know, include the belly cavity, we call the peritoneum, the liver, the lungs, the bone, and lymph nodes, distant lymph nodes. And even if on that CAT scan there is no clear evidence of spread, usually the next step is a PET scan, which is a different type of scan that looks at not just the size or the structure of your organs, but you know, the metabolic activity, the activity of the cancer, you know, how it is metabolizing, how quickly it is metabolizing sugar, for example. And we look at that because some of these tumors can be missed on the CAT scan but picked up with a PET scan. And so, that's another layer of evaluation. And then, if both the PET scan and the CAT scan, you know, come back suggestive of what we call metastatic or spread of stage-four disease, another test that we do is an endoscopic ultrasound. So, very similar to the initial endoscopy. But this time, you know, we really look at the depth of invasion of the cancer through the stomach wall. And we also evaluate and sample the surrounding lymph nodes to see if the cancer has not only invaded through the wall, but maybe spread already to some of the lymph nodes. And usually, this test will help us tease out is this is a stage one, you know, localized, or a stage-two or three, which is more locally advanced. And

lastly, one more procedure. Again, like I said, it's a long, it's a battery of tests. But one last procedure that we can do is something called a diagnostic laparoscopy. And this is because sometimes even when the CT scan and the PET scan do not suggest evidence of spread, if the endoscopic ultrasound shows that we're dealing with what might be a locally advanced stage, the most common site of spread is the peritoneum, which is that cavity that lines and covers the abdominal organs. Because of the proximity to the stomach, it's a very early, it's a common site of spread. So, that procedure, typically done by a surgeon, they will go in make an incision, it's a minimally invasive procedure, and they, you know, examine or do an exploration of the belly cavity. And also, if they don't see any suspicious lesion, sometimes even do washing, so they will spread fluid or salt water in the peritoneum, do washings that we can go back and look at, look for cells that could be cancerous in that fluid. So again, this is a thorough evaluation to really make sure that we stage the patients appropriately because the staging forms the treatment and how we treat these patients.

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Dr. Halena Gazelka 13:04

Tell us a little bit about the treatment. I mentioned surgery in the intro but what are some of the other treatments and some of the more innovative treatments?

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Dr. Lionel Kankeu Fonkouda 13:12

Yeah. So surgery, you know, obviously, it's the cornerstone for early-stage disease or non-metastatic disease, but to be honest, the treatment depends on the stage and the location of the cancer meaning whether it was a cardia, you know, stomach cancer or noncardiac stomach cancer. But, in general stage 1 typically will recommend surgery alone. Most of the stage 1 are very early stages, we could just do surgery alone. For stage 2 or stage 3, we know based on the data that, you know, surgery typically alone would not you know, cut it. You know, we need more in the form of chemotherapy and/or radiation to try to eradicate any micro-metastatic disease that we may have missed with surgery alone. And usually requires what we call a multidisciplinary evaluation with, you know, the surgeons, the medical oncologist, a radiation oncologist to really put our minds together and say, What can we do to best help this patient and improve the chances of cure? So, surgery, typically in the form of a partial or total gastrectomy is, you know, really with the goal of taking out as much of the cancer as possible. And then for the cardiac tumors. So, those are the ones higher up and close to the gastroesophageal junction, you know, usually combined chemo, we usually give chemotherapy with radiation. So concurrently, before surgery, that's the typical approach for the cardia or G junction gastroesophageal junction tumors. However, for the non-cardiac tumors, usually it's chemotherapy before and after surgery, almost in a sandwich approach. And that's why it's very important to really know where did the cancer from, what location, and the stage because all of that guides what we do. Finally, for stage 4, or metastatic disease, meaning the cancer has spread distantly, really we don't use surgery, because, you know, it hasn't proven to be effective and will not address all the areas where the cancer is involved. And this is where we use a combination again, of chemotherapy, immunotherapy, targeted therapy, to try to, you know, see how we can best help the patients. So, that's kind of a big, big, big picture, you know, of how we approach these patients.

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Dr. Halena Gazelka 15:39

Lionel, tell us about survival rates for stomach cancer?

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Dr. Lionel Kankeu Fonkouda 15:43

Yeah, so survival rates again, you know, if you take all comers, you know, the five-year overall survival, you know, which is how many of the percentage of patients will be alive five years after treatment for stomach cancer is about

30-32%. But again, if you break it down by stage, you know, for early stage localized is about 70%. You know, if you look at the locally advanced stage, about 32%, and then for distant metastatic disease is about, you know, 6%. But, you know, and I'm just saying that because we are on a podcast. But typically, in my clinic I try to not talk about, you know, the survivor rates, and because those are just estimates based on, you know, previous outcomes, they're outdated. You know, a lot of them actually, at least the ones that I just showed you, you know, they're at least five years old. Not really reflective of the most recent treatments, you know, that we have, and if you look at your stomach cancer over the last year, there's been an emergence of new therapies that have, you know, been FDA approved, and that are not reflected in these survival estimates. Yeah, so immunotherapy, for example, like I mentioned, so far the longest chemotherapy has been traditionally used for 40 plus years. And that's pretty much just a therapy that kills rapidly dividing cells. And you know, as most people know, more recently, probably 10 years ago, you know, we had the first targeted therapy approved. So, that's a type of therapy that targets a specific mutation or a specific protein that tends to be overexpressed in the cancer. And that was the common drug called Herceptin, or trastuzumab for the HER2+, you know, stomach cancer, or usually a lot of them are in the cardia, actually the GE junction. So, that was the first target therapy approved. But now over the past three years, and to be honest, more recently, over the last year, we've had immunotherapy that, you know, that we've incorporated into the treatment armamentarium for stomach cancer, both in the most advanced stage, and also more recently, for some of the early-stage after surgery, you know, we are starting to use immunotherapy. And that type of therapy is actually a type of therapy to put it simply that boosts the immune system to go after the cancer, you know. The cancer cells are very smart and find ways to evade or put brakes on the immune system. And so, this type of therapy is kind of designed to release those, break and unleash the immune system to go after the cancer. And when that's effective, really, it can be, we've seen some dramatic and durable responses in some of these patients. And that's why I said those survival rate estimates may not really be accurate.

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Dr. Halena Gazelka 16:53

What kind of therapy?

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Dr. Lionel Kankeu Fonkoua 17:03

That's sort of like teaching your own immune system, your own body, to go kill your cancer. Exactly, exactly. And that's part of the reason why when it works, you know, we've seen some dramatic, durable responses because the immune system is active. Obviously, you know, now the future is looking at combining this form of therapy with, you know, chemotherapy and targeted therapy. And I think, you know, that's reflected in the most recent approvals of the regimen in this disease.

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Dr. Halena Gazelka 19:06

Fascinating.

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Dr. Lionel Kankeu Fonkoua 19:07

Yeah.

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Dr. Halena Gazelka 19:07

Lionel, what can individuals do to decrease their risk of stomach cancer?

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Dr. Lionel Kankeu Fonkoua 19:13

Yeah, so stomach cancer, unfortunately, you know, we don't have an approved screening test like, you know, colon cancer, colonoscopy for colon cancer, or mammograms, for breast cancer, but, you know, I hope we get there one day, but as of today, we don't have one. And so, the best way to prevent is look at, you know, identify the populations that are the greatest risk to begin with. So, you know, like I mentioned, some of the familiar syndromes, with inherited predisposition genes, and some of them can be eligible for risk reducing, you know, what we call prophylactic surgeries, for example. If we know there's a high risk that they will get, you know, stomach cancer. That's one way of preventing. The other ways, you know, looking at the different risk factors. You know, stop smoking, you know, for example, lifestyle dietary changes, obesity like I said can increase the risk of Barrett's esophagus by three to four-fold. Same thing with smoking. H. pylori, you know, not really a problem here in the states but outside of the states H. pylori is a class one carcinogen. So, adequate treatment of H. pylori infection can reduce the risk and prevent, you know, the inflammation that eventually turns into a cancer later down the road. And, you know, last but not least, in patients with Barrett's esophagus, for example, you know, if it's picked up early, usually they want to go surveillance through endoscopy and sometimes ablations, you know, depending on the setting. So, really they work with the GI doctors pretty closely to make sure that we prevent those lesions, those precancerous lesions from developing into cancer.

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Dr. Halena Gazelka 20:59

I know, I remember a couple of decades ago we were treating many, many ulcer patients, or suspected ulcer patients for H. pylori with antibiotics. And that's where I'm most familiar, and I'm sure many of our listeners have heard of that as well.

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Dr. Lionel Kankeu Fonkoua 21:15

Yeah, absolutely. And like I said, in this part of the world, it may not be as common nowadays, but you know, outside in Southeast Asia, Africa, H. Pylori, like I said, it's a class one carcinogen, and it really deserves aggressive treatment. I totally agree.

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Dr. Halena Gazelka 21:32

Well, this has been really interesting. Any last words you want to share with our listeners today?

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Dr. Lionel Kankeu Fonkoua 21:37

No, I would just say, you know, I've been on the other end, on the other side of this battle with stomach cancer as a family member, as a caregiver. So, I know how overwhelming and how stressful this can be. But, you know, hopefully, this this podcast kind of helps patients understand the process, because that alone could be overwhelming. And that, you know, there's an army of cancer providers and researchers and investigators that are working at this, you know, every day to hopefully improve outcomes.

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Dr. Halena Gazelka 22:09

Well, we are so glad that you are working on this every day.

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Dr. Lionel Kankeu Fonkoua 22:12

I'm glad I chose this path. And really, I think it's a true privilege.

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Dr. Halena Gazelka 22:17

Thank you for being here today.

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Dr. Lionel Kankeu Fonkoua 22:18

My pleasure. Thank you.

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Dr. Halena Gazelka 22:20

Our thanks to Dr. Lionel Kankeu Fonkoua, medical oncologist at Mayo Clinic for being with us today to discuss stomach cancer. Remember that November is Stomach Cancer Awareness Month. I hope that you learned something today. I know that I did. We wish you a wonderful day.

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Narrator 22:38

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