Early Detection, Diagnosis, and Staging

Detection and Diagnosis

Catching cancer early often allows for more treatment options. Some early cancers may have signs and symptoms that can be noticed, but that is not always the case.

- Can Stomach Cancer Be Found Early?
- Signs and Symptoms of Stomach Cancer
- How Is Stomach Cancer Diagnosed?

Stages and Outlook (Prognosis)

After a cancer diagnosis, staging provides important information about the extent of cancer in the body and anticipated response to treatment.

- How Is Stomach Cancer Staged?
- Survival Rates for Stomach Cancer, by Stage

Questions to Ask About Stomach Cancer

Get some questions you can ask your cancer care team to help you better understand your cancer diagnosis and treatment options.

- What Should You Ask Your Doctor About Stomach Cancer?

Can Stomach Cancer Be Found Early?

Screening is testing for a disease, such as cancer, in people without symptoms. In countries such as Japan, where stomach cancer is very common, mass screening of the population has helped find many cases at an early, curable stage. This may have reduced the number of people who die of this disease, but this has not been proven.
Studies in the United States have not found that routine screening in people at average risk for stomach cancer is useful, because this disease is not that common. On the other hand, people with certain stomach cancer risk factors may benefit from screening. If you have any questions about your stomach cancer risk or about the benefits of screening, please ask your doctor.

Some of the tests that could be used for screening, such as upper endoscopy, are described in How Is Stomach Cancer Diagnosed?

Because routine screening for stomach cancer is not done in the United States, most people with this disease are not diagnosed until they have certain signs and symptoms that point to the need for medical tests.

- **References**
  See all references for Stomach Cancer

Last Medical Review: May 20, 2014 Last Revised: February 10, 2016

American Cancer Society medical information is copyrighted material. For reprint requests, please contact permissionrequest@cancer.org.

**Signs and Symptoms of Stomach Cancer**

Unfortunately, early-stage stomach cancer rarely causes symptoms. This is one of the reasons stomach cancer is so hard to detect early. The signs and symptoms of stomach cancer can include:

- Poor appetite
- Weight loss (without trying)
- Abdominal (belly) pain
- Vague discomfort in the abdomen, usually above the navel
- A sense of fullness in the upper abdomen after eating a small meal
- Heartburn or indigestion
- Nausea
- Vomiting, with or without blood
- Swelling or fluid build-up in the abdomen
- Low red blood cell count (anemia)

Most of these symptoms are more likely to be caused by things other than cancer, such as a stomach virus or an ulcer. They may also occur with other types of cancer. But people who have any of these problems, especially if they don’t go away or get worse, should check with their doctor so the cause can be found and treated.

Since symptoms of stomach cancer often do not appear until the disease is advanced, only about 1 in 5 stomach cancers in the United States is found at an early stage, before it has spread to other areas of the body.

- References
See all references for Stomach Cancer

How Is Stomach Cancer Diagnosed?

Stomach cancers are usually found when a person goes to the doctor because of signs or symptoms they are having. The doctor will take a history and examine the patient. If stomach cancer is suspected, tests will be needed to confirm the diagnosis.

Medical history and physical exam

When taking your medical history, the doctor will ask you questions about your symptoms (eating problems, pain, bloating, etc.) and possible risk factors to see if they might suggest stomach cancer or another cause. The physical exam gives your doctor information about your general health, possible signs of stomach cancer, and other health problems. In particular, the doctor will feel your abdomen for any abnormal changes.

If your doctor thinks you might have stomach cancer or another type of stomach problem, he or she will refer you to a gastroenterologist, a doctor who specializes in diseases of the digestive tract, who will examine you and do further testing.
**Upper endoscopy**

Upper endoscopy (also called *esophagastroduodenoscopy* or *EGD*) is the main test used to find stomach cancer. It may be used when someone has certain risk factors or when signs and symptoms suggest this disease may be present.

During this test, the doctor passes an endoscope, which is a thin, flexible, lighted tube with a small video camera on the end, down your throat. This lets the doctor see the lining of your esophagus, stomach, and first part of the small intestine. If abnormal areas are seen, biopsies (tissue samples) can be taken using instruments passed through the endoscope. The tissue samples are sent to a lab, where they are looked at under a microscope to see if cancer is present.

When seen through an endoscope, stomach cancer can look like an ulcer, a mushroom-shaped or protruding mass, or diffuse, flat, thickened areas of mucosa known as *linitis plastica*. Unfortunately, the stomach cancers in hereditary diffuse gastric cancer syndrome often cannot be seen during endoscopy.

Endoscopy can also be used as part of a special imaging test known as *endoscopic ultrasound*, which is described below.

This test is usually done after you are given medication to make you sleepy (sedation). If sedation is used, you will need someone to take you home (not just a cab).

**Endoscopic ultrasound**

Ultrasound uses sound waves to produce images of organs such as the stomach. During a standard ultrasound, a wand-shaped probe called a transducer is placed on the skin. It gives off sound waves and detects the echoes as they bounce off internal organs. The pattern of echoes is processed by a computer to produce a black and white image on a screen.

In endoscopic ultrasound (EUS), a small transducer is placed on the tip of an endoscope. While you are sedated, the endoscope is passed down the throat and into the stomach. This lets the transducer rest directly on the wall of the stomach where the cancer is. It lets the doctor look at the layers of the stomach wall, as well as the nearby lymph nodes and other structures just outside the stomach. The picture quality is better than a standard ultrasound because of the shorter distance the sound waves have to travel.

EUS is most useful in seeing how far a cancer may have spread into the wall of the
stomach, to nearby tissues, and to nearby lymph nodes. It can also be used to help guide a needle into a suspicious area to get a tissue sample (EUS-guided needle biopsy).

**Biopsy**

Your doctor may suspect cancer if an abnormal-looking area is seen on endoscopy or an imaging test, but the only way to tell for sure if it is really cancer is by doing a biopsy. During a biopsy, the doctor removes a sample of the abnormal area.

Biopsies to check for stomach cancer are most often obtained during upper endoscopy. If the doctor sees any abnormal areas in the stomach lining during the endoscopy, instruments can be passed down the endoscope to biopsy them.

Some stomach cancers are deep within the stomach wall, which can make them hard to biopsy with standard endoscopy. If the doctor suspects cancer might be deeper in the stomach wall, endoscopic ultrasound can be used to guide a thin, hollow needle into the wall of the stomach to get a biopsy sample.

Biopsies may also be taken from areas of possible cancer spread, such as nearby lymph nodes or suspicious areas in other parts of the body.

**Testing biopsy samples**

Biopsy samples are sent to a lab to be looked at under a microscope. The samples are checked to see if they contain cancer, and if they do, what kind it is (for example, adenocarcinoma, carcinoid, gastrointestinal stromal tumor, or lymphoma).

If a sample contains adenocarcinoma cells, it may be tested to see if it has too much of a growth-promoting protein called HER2/neu (often just shortened to HER2). The HER2/neu gene instructs the cells to make this protein. Tumors with increased levels of HER2/neu are called HER2-positive.

Stomach cancers that are HER2-positive can be treated with drugs that target the HER2/neu protein, such as trastuzumab (Herceptin®). See [Targeted Therapies for Stomach Cancer](#) for more information.

The biopsy sample may be tested in 2 different ways:

- Immunohistochemistry (IHC): In this test, special antibodies that stick to the
HER2/neu protein are applied to the sample, which cause cells to change color if many copies are present. This color change can be seen under a microscope. The test results are reported as 0, 1+, 2+, or 3+.

- Fluorescent in situ hybridization (FISH): This test uses fluorescent pieces of DNA that specifically stick to copies of the HER2/neu gene in cells, which can then be counted under a special microscope.

Often the IHC test is used first.

- If the results are 0 or 1+, the cancer is HER2-negative. People with HER2-negative tumors are not treated with drugs (like trastuzumab) that target HER2.
- If the test comes back 3+, the cancer is HER2-positive. Patients with HER2-positive tumors may be treated with drugs like trastuzumab.
- When the result is 2+, the HER2 status of the tumor is not clear. This often leads to testing the tumor with FISH.

See Testing Biopsy and Cytology Specimens for Cancer to learn more about different types of biopsies and tests, how the tissue is used in the lab to diagnose cancer, and what the results will tell you.

**Imaging tests**

Imaging tests use x-rays, magnetic fields, sound waves, or radioactive substances to create pictures of the inside of your body. Imaging tests may be done for a number of reasons, including:

- To help find out whether a suspicious area might be cancerous
- To learn how far cancer may have spread
- To help determine if treatment has been effective

**Upper gastrointestinal (GI) series**

This is an x-ray test to look at the inner lining of the esophagus, stomach, and first part of the small intestine. This test is used less often than endoscopy to look for stomach cancer or other stomach problems, as it may miss some abnormal areas and does not allow the doctor to take biopsy samples. But it is less invasive than endoscopy, and it might be useful in some situations.

For this test, the patient drinks a white chalky solution containing a substance called barium. The barium coats the lining of the esophagus, stomach, and small intestine.
Several x-ray pictures are then taken. Because x-rays can’t pass through the coating of barium, this will outline any abnormalities of the lining of these organs.

A double-contrast technique may be used to look for early stomach cancer. With this technique, after the barium solution is swallowed, a thin tube is passed into the stomach and air is pumped in. This makes the barium coating very thin, so even small abnormalities will show up.

**Computed tomography (CT or CAT) scan**

The CT scan is an x-ray test that produces detailed cross-sectional images of your body. Instead of taking one picture, like a standard x-ray, a CT scanner takes many pictures as it rotates around you. A computer then combines these pictures into images of slices of the part of your body being studied.

Before the test, you may be asked to drink 1 or 2 pints of a contrast solution and/or receive an intravenous (IV) line through which a contrast dye is injected. This helps better outline structures in your body.

The IV contrast can cause some flushing (redness and warm feeling). Some people are allergic and get hives, or rarely have more serious reactions like trouble breathing and low blood pressure. Be sure to tell the doctor if you have any allergies or have ever had a reaction to any contrast material used for x-rays.

A CT scanner has been described as a large donut, with a narrow table that slides in and out of the middle opening. You will need to lie still on the table while the scan is being done. CT scans take longer than regular x-rays, and you might feel a bit confined by the ring while the pictures are being taken.

CT scans show the stomach fairly clearly and often can confirm the location of the cancer. CT scans can also show the organs near the stomach, such as the liver, as well as lymph nodes and distant organs where cancer might have spread. The CT scan can help determine the extent (stage) of the cancer and whether surgery may be a good treatment option.

**CT-guided needle biopsy:** CT scans can also be used to guide a biopsy needle into a suspected area of cancer spread. The patient remains on the CT scanning table while a doctor moves a biopsy needle through the skin toward the mass. CT scans are repeated until the needle is within the mass. A fine-needle biopsy sample (tiny fragment of tissue) or a core-needle biopsy sample (a thin cylinder of tissue) is then removed and looked at under a microscope.
Magnetic resonance imaging (MRI) scan

MRI scans use radio waves and strong magnets instead of x-rays. The energy from the radio waves is absorbed by the body and then released in a pattern formed by the type of body tissue and by certain diseases. A computer translates the pattern into a very detailed image of parts of the body. A contrast material might be injected just as with CT scans, but this is used less often.

Most doctors prefer to use CT scans to look at the stomach. But an MRI may sometimes provide more information. MRIs are often used to look at the brain and spinal cord.

MRI scans take longer than CT scans, often up to an hour. You may have to lie inside a narrow tube, which is confining and can upset people with a fear of enclosed spaces. Special, open MRI machines can help with this if needed, although the images may not be as sharp in some cases. The MRI machine makes loud buzzing noises that you may find disturbing. Some places provide headphones to block this noise out.

Positron emission tomography (PET) scan

In this test, radioactive substance (usually a type of sugar related to glucose, known as FDG) is injected into a vein. (The amount of radioactivity used is very low and will pass out of the body over the next day or so.) Because cancer cells are growing faster than normal cells, they use sugar much faster, so they take up the radioactive material. After about an hour, you are moved onto a table in the PET scanner. You lie on the table for about 30 minutes while a special camera creates a picture of areas of radioactivity in the body.

PET is sometimes useful if your doctor thinks the cancer might have spread but doesn’t know where. The picture is not finely detailed like a CT or MRI scan, but it provides helpful information about the whole body. Although PET scans can be useful for finding areas of cancer spread, they aren’t always helpful in certain kinds of stomach cancer because these types don’t take up glucose very much.

Some machines can do both a PET and CT scan at the same time (PET/CT scan). This lets the doctor compare areas of higher radioactivity on the PET with the more detailed appearance of that area on the CT. PET/CT may be more helpful than PET alone for stomach cancer. This can help show if the cancer has spread beyond the stomach to other parts of the body, in which case surgery might not be a good treatment.

Chest x-ray
This test can help find out if the cancer has spread to the lungs. It might also determine if there are any serious lung or heart diseases present. This test is not needed if a CT scan of the chest has been done.

You can read more about imaging tests in *Imaging (Radiology) Tests for Cancer*.

**Other tests**

**Laparoscopy**

If this procedure is done, it is usually only after stomach cancer has already been found. Although CT or MRI scans can create detailed pictures of the inside of the body, they can miss some tumors, especially if they are very small. Doctors might do a laparoscopy before any other surgery to help confirm a stomach cancer is still only in the stomach and can be removed completely with surgery. It may also be done before chemotherapy and/or radiation if these are planned before surgery.

This procedure is done in an operating room with the patient under general anesthesia (in a deep sleep). A laparoscope (a thin, flexible tube) is inserted through a small surgical opening in the patient’s side. The laparoscope has a small video camera on its end, which sends pictures of the inside of the abdomen to a TV screen. Doctors can look closely at the surfaces of the organs and nearby lymph nodes, or even take small samples of tissue. If it doesn’t look like the cancer has spread, sometimes the doctor will “wash” the abdomen with saline (salt water). The fluid (called peritoneal washings) is then removed and checked to see if it contains cancer cells. If it does, the cancer has spread, even if the spread couldn’t be seen.

Sometimes laparoscopy is combined with ultrasound to give a better picture of the cancer.

**Lab tests**

When looking for signs of stomach cancer, a doctor may order a blood test called a *complete blood count (CBC)* to look for anemia (which could be caused by the cancer bleeding into the stomach). A fecal occult blood test may be done to look for blood in stool (feces) that isn’t visible to the naked eye.

The doctor might recommend other tests if cancer is found, especially if you are going to have surgery. For instance, blood tests will be done to make sure your liver and kidney functions are normal and that your blood clots normally. If surgery is planned or
you are going to get medicines that can affect the heart, you may also have an
electrocardiogram (EKG) and echocardiogram (an ultrasound of the heart) to make sure
your heart is functioning well.

- References

See all references for Stomach Cancer

How Is Stomach Cancer Staged?

The stage of a cancer is a description of how far the cancer has spread. The stomach
cancer’s stage is an important factor in choosing treatment options and predicting a
patient’s outlook (prognosis).

There are actually 2 types of stages for stomach cancer.

The clinical stage of the cancer is the doctor’s best estimate of the extent of the
cancer, based on the results of physical exams, endoscopy, biopsies, and any imaging
tests (such as CT scans) that have been done. These exams and tests are described in
How Is Stomach Cancer Diagnosed?

If surgery is done, the pathologic stage can be determined using the same test results
used for the clinical stage, plus what is found from tissues removed during surgery.

The clinical stage is used to help plan treatment. Sometimes, though, the cancer has
spread further than the clinical stage estimates. Because the pathologic stage is based
on what was found at surgery, it can more accurately predict the patient’s outlook. The
staging described here is the pathologic stage.

A staging system is a way for members of the cancer care team to describe the extent
of a cancer’s spread. The system most often used to stage stomach cancer in the
United States is the American Joint Commission on Cancer (AJCC) TNM system. The
TNM system for staging contains 3 key pieces of information:
• **T** describes the extent of the primary tumor (how far it has grown into the wall of the stomach and into nearby organs).

• **N** describes the spread to nearby (regional) lymph nodes.

• **M** indicates whether the cancer has metastasized (spread) to distant parts of the body. The most common sites of distant spread of stomach cancer are the liver, the peritoneum (the lining of the space around the digestive organs), and distant lymph nodes. Less common sites of spread include the lungs and brain.

Numbers or letters appear after **T**, **N**, and **M** to provide more details about each of these factors:

• The numbers 0 through 4 indicate increasing severity.

• The letter X means “cannot be assessed” because the information is not available.

• The letters “is” refer to carcinoma in situ, which means the tumor is only in the top layer of mucosa cells and has not yet invaded deeper layers of tissue.

This system is for staging all stomach cancers except those starting in either the gastroesophageal junction (where the stomach and the esophagus meet) or in the cardia (the first part of the stomach) and growing into the gastroesophageal junction. Those cancers are staged (and often treated) like cancers of the esophagus. (See [Esophagus Cancer](#))

**T categories of stomach cancer**

Nearly all stomach cancers start in the innermost layer of the stomach wall (the mucosa). The **T** category describes how far through the stomach’s 5 layers the cancer has invaded.
The innermost layer is the **mucosa**. The mucosa has 3 parts: epithelial cells, which lie on top of a layer of connective tissue (the **lamina propria**), which is on top of a thin layer of muscle (the **muscularis mucosa**).

- Under the mucosa is a supporting layer called the **submucosa**.
- Below this is the **muscularis propria**, a thick layer of muscle that moves and mixes the stomach contents.
- The next 2 layers, the **subserosa** and the outermost **serosa**, act as wrapping layers for the stomach.

**TX:** The main (primary) tumor cannot be assessed.

**T0:** No signs of a main tumor can be found.

**Tis:** Cancer cells are only in the top layer of cells of the mucosa (innermost layer of the stomach) and have not grown into deeper layers of tissue such as the lamina propria or muscularis mucosa. This stage is also known as **carcinoma in situ**.
**T1:** The tumor has grown from the top layer of cells of the mucosa into the next layers below such as the lamina propria, the muscularis mucosa, or submucosa.

- **T1a:** The tumor is growing into the lamina propria or muscularis mucosa.
- **T1b:** The tumor has grown through the lamina propria and muscularis mucosa and into the submucosa.

**T2:** The tumor is growing into the muscularis propria layer.

**T3:** The tumor is growing into the subserosa layer.

**T4:** The tumor has grown into the serosa and may be growing into a nearby organ (spleen, intestines, pancreas, kidney, etc.) or other structures such as major blood vessels.

- **T4a:** The tumor has grown through the stomach wall into the serosa, but the cancer hasn’t grown into any of the nearby organs or structures.
- **T4b:** The tumor has grown through the stomach wall and into nearby organs or structures.

**N categories of stomach cancer**

**NX:** Nearby (regional) lymph nodes cannot be assessed.

**N0:** No spread to nearby lymph nodes.

**N1:** The cancer has spread to 1 to 2 nearby lymph nodes.

**N2:** The cancer has spread to 3 to 6 nearby lymph nodes.

**N3:** The cancer has spread 7 or more nearby lymph nodes.

- **N3a:** The cancer has spread to 7 to 15 nearby lymph nodes.
- **N3b:** The cancer has spread to 16 or more nearby lymph nodes.

**M categories of stomach cancer**

**M0:** No distant metastasis (the cancer has not spread to distant organs or sites, such as the liver, lungs, or brain).
**M1**: Distant metastasis (the cancer has spread to organs or lymph nodes far away from the stomach).

**TNM stage grouping**

Once the T, N, and M categories have been determined, this information is combined and expressed as a stage, using the number 0 (zero) and the Roman numerals I through IV. This is known as *stage grouping*. Some stages are split into substages, indicated by letters.

**Stage 0: Tis, N0, M0**

This is stomach cancer in its earliest stage. It has not grown beyond the inner layer of cells that line the stomach (Tis). The cancer has not spread to any lymph nodes (N0) or anywhere else (M0). This stage is also known as *carcinoma in situ*.

**Stage IA: T1, N0, M0**

The cancer has grown beneath the top layer of cells in the mucosa into tissue below, such as the connective tissue (lamina propria), the thin muscle layer (muscularis mucosa), or the submucosa (T1). The cancer has not spread to any lymph nodes (N0) or anywhere else (M0).

**Stage IB: Any of the following:**

**T1, N1, M0**: The cancer has grown into the layer of connective tissue (lamina propria), and may have grown into the thin layer of muscle beneath it (muscularis mucosa) or deeper into the submucosa (T1). Cancer has also spread to 1 or 2 lymph nodes near the stomach (N1), but not to any distant tissues or organs (M0).

**OR**

**T2, N0, M0**: The cancer has grown into the main muscle layer of the stomach wall, called the *muscularis propria* (T2). It has not spread to nearby lymph nodes (N0) or to any distant tissues or organs (M0).

**Stage IIA: Any of the following:**

**T1, N2, M0**: The cancer has grown beneath the top layer of cells of the mucosa into the
layer of connective tissue (lamina propria), thin muscle layer (muscularis mucosa), or the submucosa (T1). It has spread to 3 to 6 nearby lymph nodes (N2). It has not spread to distant sites (M0).

OR

**T2, N1, M0:** The cancer has grown into the main muscle layer of the stomach called the muscularis propria (T2). It has spread to 1 or 2 nearby lymph nodes (N1), but has not spread to distant sites (M0).

OR

**T3, N0, M0:** The cancer has grown through the main muscle layer into the subserosa, but has not grown through all the layers to the outside the stomach (T3). It has not spread to any nearby lymph nodes (N0) or to distant tissues or organs (M0).

**Stage IIB: Any of the following:**

**T1, N3, M0:** The cancer has grown beneath the top layer of cells of the mucosa into the layer of connective tissue (lamina propria), the thin muscle layer, or the submucosa (T1). It has spread to 7 or more nearby lymph nodes (N3). It has not spread to distant tissues or organs (M0).

OR

**T2, N2, M0:** The cancer has grown into the main muscle layer, called the muscularis propria (T2). It has spread to 3 to 6 nearby lymph nodes (N2), but it has not spread to distant tissues or organs (M0).

OR

**T3, N1, M0:** The cancer has grown into the subserosa layer, but not through all the layers to the outside of the stomach (T3). It has spread to 1 or 2 nearby lymph nodes (N1), but has not spread to distant tissues or organs (M0).

OR

**T4a, N0, M0:** The cancer has grown completely through all the layers of stomach wall into the outer covering of the stomach (the serosa), but it has not grown into nearby organs or tissues, such as the spleen, intestines, kidneys, or pancreas (T4a). It has not spread to any nearby lymph nodes (N0) or distant sites (M0).
Stage IIIA: Any of the following:

T2, N3, M0: The cancer has grown into the main muscle layer, called the *muscularis propria* (T2). It has spread to 7 or more nearby lymph nodes (N3), but has not spread to distant tissues or organs (M0).

OR

T3, N2, M0: The cancer has grown into the subserosa layer, but not through all the layers to the outside of the stomach (T3). It has spread to 3 to 6 nearby lymph nodes (N2), but it has not spread to distant tissues or organs (M0).

OR

T4a, N1, M0: The cancer has grown completely through all the layers of the stomach wall into the outer covering of the stomach (the serosa), but it has not grown into nearby organs or tissues (T4a). It has spread to 1 or 2 nearby lymph nodes (N1), but it has not spread to distant sites (M0).

Stage IIIB: Any of the following:

T3, N3, M0: The cancer has grown into the subserosa layer, but not through all the layers to the outside of the stomach (T3). It has spread to 7 or more nearby lymph nodes (N2), but it has not spread to distant sites (M0).

OR

T4a, N2, M0: The cancer has grown completely through all the layers of the stomach wall into the serosa (the outer covering of the stomach), but it has not grown into nearby organs or tissues (T4a). It has spread to 3 to 6 nearby lymph nodes (N2), but it has not spread to distant sites (M0).

OR

T4b, N0 or N1, M0: The cancer has grown through the stomach wall and into nearby organs or structures such as the spleen, intestines, liver, pancreas, or major blood vessels (T4b). It may also have spread to up to 2 nearby lymph nodes (N0 or N1). It has not spread to distant sites (M0).

Stage IIIC: Any of the following:
**T4a, N3, M0:** The cancer has grown completely through all the layers of the stomach wall into the serosa, but it has not grown into nearby organs or tissues (T4a). It has spread to 7 or more nearby lymph nodes (N3), but it has not spread to distant sites (M0).

**OR**

**T4b, N2 or N3, M0:** The cancer has grown through the stomach wall and into nearby organs or structures such as the spleen, intestines, liver, pancreas, or major blood vessels (T4b). It has spread to 3 or more nearby lymph nodes (N2 or N3). It has not spread to distant sites (M0).

**Stage IV: Any T, any N, M1**

The cancer has spread to distant organs such as the liver, lungs, brain, or bones (M1).

If you have any questions about the stage of your disease, ask your doctor to explain this to you. The stage of a stomach cancer is an important factor, but it is not the only factor in considering treatment options and in predicting outlook for survival.

**Resectable vs. unresectable cancer**

The AJCC staging system provides a detailed summary of how far a stomach cancer has spread. But for treatment purposes, doctors are often more concerned about whether the tumor can be removed (resected) with surgery.

- **Resectable cancers** are those the doctor believes can be completely removed during surgery.
- **Unresectable cancers** can’t be removed completely. This might be because the tumor has grown too far into nearby organs or lymph nodes, it has grown too close to major blood vessels, it has spread to distant parts of the body, or the person is not healthy enough for surgery.

There is no distinct dividing line between resectable and unresectable in terms of the TNM stage of the cancer, but earlier stage cancers are more likely to be resectable.

- **References**

 *See all references for Stomach Cancer*

Last Medical Review: May 20, 2014 Last Revised: February 10, 2016
Survival Rates for Stomach Cancer, by Stage

Survival rates are often used by doctors as a standard way of discussing a person’s prognosis (outlook). Some people with cancer may want to know the survival statistics for people in similar situations, while others may not find the numbers helpful, or may even not want to know them. If you do not want to read about the survival statistics for stomach cancer, stop reading here and skip to the next section.

The 5-year survival rate refers to the percentage of patients who live at least 5 years after their cancer is diagnosed. Of course, many of these people live much longer than 5 years (and many are cured).

To get 5-year survival rates, doctors have to look at people who were treated at least 5 years ago. Improvements in treatment since then may result in a better outlook for people now being diagnosed with stomach cancer.

Survival rates are often based on previous outcomes of large numbers of people who had the disease, but they cannot predict what will happen in any particular person’s case. Many other factors may affect a person’s outlook, such as their general health, the location of the cancer in the stomach, the treatment received, and how well the cancer responds to treatment. Your doctor can tell you how these survival rates may apply to you.

The survival rates that follow come from the National Cancer Institute’s SEER database and were published in 2010 in the 7th edition of the AJCC Staging Manual. They are based on people diagnosed with stomach cancer and treated with surgery between 1991 and 2000. Survival rates for patients not treated with surgery are likely to be lower. It is also important to note that these are observed survival rates. People with cancer can die of other things, and these rates do not take that into account.

The rates below are based on the stage of the cancer at the time of diagnosis. When looking at survival rates, it’s important to understand that the stage of a cancer does not change over time, even if the cancer progresses. A cancer that comes back or spreads is still referred to by the stage it was given when it was first found and diagnosed, but
more information is added to explain the current extent of the cancer.

The 5-year survival rates by stage for stomach cancer treated with surgery are as follows:

<table>
<thead>
<tr>
<th>Stage</th>
<th>5-year observed survival</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage IA</td>
<td>71%</td>
</tr>
<tr>
<td>Stage IB</td>
<td>57%</td>
</tr>
<tr>
<td>Stage IIA</td>
<td>46%</td>
</tr>
<tr>
<td>Stage IIB</td>
<td>33%</td>
</tr>
<tr>
<td>Stage IIIA</td>
<td>20%</td>
</tr>
<tr>
<td>Stage IIIB</td>
<td>14%</td>
</tr>
<tr>
<td>Stage IIIC</td>
<td>9%</td>
</tr>
<tr>
<td>Stage IV</td>
<td>4%</td>
</tr>
</tbody>
</table>

The overall 5-year relative survival rate of all people with stomach cancer in the United States is about 29%. The 5-year relative survival rate compares the observed survival of people with stomach cancer to that expected for people without stomach cancer. Since some people may die from other causes, this is a better way to see the impact of cancer on survival.

This survival rate has improved gradually over the last 30 years. One reason the overall survival rate is poor in the United States is that most stomach cancers are diagnosed at an advanced rather than an early stage. The stage of the cancer has a major effect on a patient’s prognosis (outlook for survival).

- **References**
  See all references for Stomach Cancer

Last Medical Review: May 20, 2014 Last Revised: February 10, 2016

American Cancer Society medical information is copyrighted material. For reprint requests, please contact permissionrequest@cancer.org.

What Should You Ask Your Doctor
About Stomach Cancer?

As you cope with cancer and cancer treatment, we encourage you to talk openly with your doctor, nurse, and cancer care team. You should feel free to ask any question that's on your mind, no matter how small it might seem. Here are some questions you might want to ask. Be sure to add your own questions as you think of them. Nurses, social workers, and other members of the treatment team should also be able to answer many of your questions.

- What kind of stomach cancer do I have?
- Where is the cancer in my stomach?
- What is the stage of my cancer, and what does that mean in my case?
- Are there other tests that need to be done before we can decide on treatment?
- Will I need to see other doctors?
- How much experience do you have treating this type of cancer?
- What treatment choices do I have?
- What do you recommend and why?
- What is the goal of treatment (to cure the cancer, slow its growth, ease symptoms, etc.)?
- Are there any clinical trials I should think about now?
- How quickly do we need to decide on treatment?
- What should I do to be ready for treatment?
- How long will treatment last? What will it involve? Where will it be done?
- What risks or side effects are there to the treatments you suggest? How long are they likely to last?
- How will treatment affect my daily life? Will it affect the way I eat?
- Based on what you’ve learned about my cancer, what is my prognosis (outlook)?
- What type of follow-up will I need after treatment?
- What would my options be if the treatment doesn’t work or if the cancer recurs?
- Where can I find more information and support?

Along with these sample questions, be sure to write down some of your own. For instance, you might want more information about recovery times, or you might want to ask about getting a second opinion.

- References

See all references for Stomach Cancer

Last Medical Review: May 20, 2014 Last Revised: February 10, 2016