



Stomach Cancer 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.

- [Stomach Cancer Stages](#)
- [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 [Tests for Stomach Cancer](#).

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](#)

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Last Medical Review: December 1, 2017 Last Revised: December 14, 2017

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Signs and Symptoms of Stomach Cancer

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
- Blood in the stool
- 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](#)

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Tests for Stomach Cancer

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 medical 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 **esophagogastroduodenoscopy** 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 with 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 probably need someone to take you home.

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. Doctors can 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).

More testing may be done if a sample contains certain types of cancer cells. For instance, the tumor may be tested to see if it has too much of a growth-promoting protein called HER2. Tumors with increased levels of HER2 are called **HER2-positive**.

Stomach cancers that are HER2-positive can be treated with drugs that target the HER2 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 protein are applied to the sample, which causes 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* 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.

It's also possible that the tumor may be tested to see if it has a certain amount of an immune checkpoint protein called *PD-L1*. If it does, the tumor may be treated with an immune checkpoint inhibitor such as pembrolizumab (Keytruda[®]). This type of treatment may be given if other treatments have stopped working. To learn more about this type of immunotherapy, see [Immune Checkpoint Inhibitors to Treat Cancer](#).

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 if 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 can 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

A CT scan uses x-rays to make detailed, cross-sectional images of your body. Unlike a regular x-ray, a CT scan creates detailed images of the soft tissues in the body.

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 if [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

Like CT scans, MRI scans show detailed images of soft tissues in the body. But MRI scans use radio waves and strong magnets instead of x-rays.

Positron emission tomography (PET) scan

For a PET scan, you are injected with a slightly radioactive form of sugar, which collects mainly in cancer cells. A special camera is then used to create a picture of areas of radioactivity in the body. The picture is not detailed like a CT or MRI scan, but a PET scan can look for possible areas of cancer spread in all areas of the body at once.

Some newer machines can do both a PET and CT scan at the same time (PET/CT scan). This lets the doctor see areas that “light up” on the PET scan in more detail.

PET is sometimes useful if your doctor thinks the cancer might have spread but doesn't know where. The picture is not 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.

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 make detailed pictures of the inside of the body, they can miss some tumors, especially very small tumors. Doctors might do a laparoscopy

before any other [surgery](#) to help confirm the 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) this is called **peritoneal washing**. The fluid 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 can't be seen by 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](#)

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Last Medical Review: December 1, 2017 Last Revised: December 14, 2017

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Stomach Cancer Stages

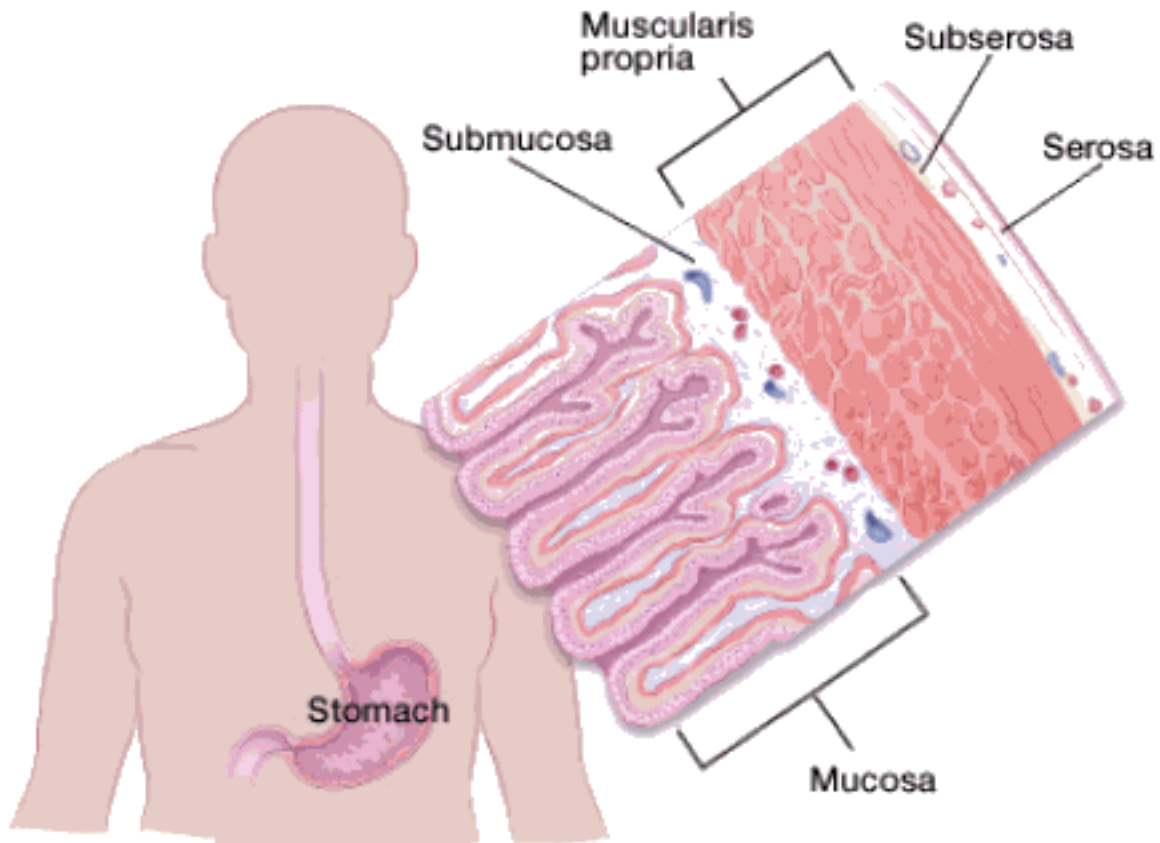
After someone is [diagnosed with stomach cancer](#), doctors will try to figure out if it has spread, and if so, how far. This process is called **staging**. The stage of a cancer describes the extent of the cancer in the body. It helps determine how serious the cancer is and how best to [treat](#) it. Doctors also use a cancer's stage when talking about survival statistics.

The earliest stage stomach cancers are called stage 0 (carcinoma in situ), and then range from stages I (1) through IV (4). As a rule, the lower the number, the less the cancer has spread. A higher number, such as stage IV, means cancer has spread more. Although each person's cancer experience is unique, cancers with similar stages tend to have a similar outlook and are often treated in much the same way.

How is the stage determined?

The staging system most often used for stomach cancer is the American Joint Committee on Cancer (AJCC) **TNM** system, which is based on 3 key pieces of information:

- The extent (size) of the **tumor (T)**: How far has the cancer grown into the 5 layers of the stomach wall? Has the cancer reached nearby structures or organs?



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.

- The spread to nearby lymph nodes (**N**): Has the cancer spread to nearby lymph nodes?
- The spread (**metastasis**) to distant sites (**M**): Has the cancer spread to distant lymph nodes or distant organs such as the liver or lungs?

The system described below is the most recent AJCC system, effective January 2018. 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](#)).

Numbers or letters after T, N, and M provide more details about each of these factors. Higher numbers mean the cancer is more advanced. Once a person's T, N, and M categories have been determined, this information is combined in a process called **stage grouping** to assign an overall stage. For more information see [Cancer Staging](#).

The staging system in the table below is the **pathologic stage** (also called the surgical stage). It is determined by examining tissue removed during an operation.

Sometimes, if surgery is not possible right away or at all, the cancer will be given a **clinical stage** instead. This is based on the results of a physical exam, biopsy, and imaging tests, not on what is found at surgery. The clinical stage will be used to help plan treatment. Sometimes, though, the cancer has spread further than the clinical stage estimates, and may not predict the patient's outlook as accurately as a pathologic stage.

Other staging systems have been created if your cancer has been clinically staged or if you have had surgery or neoadjuvant therapy. It is best to talk to your doctor about your specific stage for those situations.

Cancer staging can be complex, so ask your doctor to explain it to you in a way you understand.

AJCC Stage	Stage grouping	Stage description*
0	Tis N0 M0	There is high grade dysplasia (very abnormal looking cells) in the stomach lining OR there are cancer cells 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 (Tis). This stage is also known as carcinoma in situ (Tis). It has not spread to nearby lymph nodes (N0) or distant sites (M0).
IA	T1 N0 M0	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 (T1). It has not spread to nearby lymph nodes (N0) or to distant sites (M0).
IB	T1 N1 M0	The cancer 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 (T1) AND it has spread to 1 to 2 nearby lymph nodes (N1). It has not spread to distant sites (M0).
	OR	

	T2 N0 M0	The cancer is growing into the muscularis propria layer (T2). It has not spread to nearby lymph nodes (N0) or to distant sites (M0).
IIA	T1 N2 M0	The cancer 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 (T1) AND 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 is growing into the muscularis propria layer (T2) AND it has spread to 1 to 2 nearby lymph nodes (N1) but not to distant sites (M0).
	OR	
	T3 N0 M0	The cancer is growing into the subserosa layer (T3). It has not spread to nearby lymph nodes (N0) or to distant sites (M0).
IIB	T1 N3a M0	The cancer 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 (T1) AND it has spread to 7 to 15 nearby lymph nodes (N3a). It has not spread to distant sites (M0).
	OR	
	T2 N2 M0	The cancer is growing into the muscularis propria layer (T2) AND it has spread to 3 to 6 nearby lymph nodes (N2). It has not spread to distant sites (M0).
	T3 N1 M0	The cancer is growing into the subserosa layer (T3) AND AND it has spread to 1 to 2 nearby lymph nodes (N1) but not to distant sites (M0).
	T4a N0 M0	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 (T4a). It has not spread to nearby lymph nodes (N0) or to distant sites (M0).
IIIA	T2 N3a M0	The cancer is growing into the muscularis propria layer (T2) AND it has spread to 7 to 15 nearby lymph nodes (N3a). It has not spread to distant sites (M0).
	OR	
	T3 N2 M0	The cancer is growing into the subserosa layer (T3) AND it has spread to 3 to 6 nearby lymph nodes (N2). It has not spread to distant sites (M0).
	OR	
	T4a	The cancer has grown through the stomach wall into the serosa,

	N1 M0	but it has not grown into any of the nearby organs or structures (T4a). It has spread to 1 to 2 nearby lymph nodes (N1) but not to distant sites (M0).
	OR	
	T4a N2 M0	The cancer has grown through the stomach wall into the serosa, but it has not grown into any of the nearby organs or structures (T4a). It has spread to 3 to 6 nearby lymph nodes (N1) but not to distant sites (M0).
	OR	
	T4b N0 M0	The cancer has grown through the stomach wall and into nearby organs or structures (T4b). It has not spread to nearby lymph nodes (N0) or to distant sites (M0).
IIIB	T1 N3b M0	The cancer 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 (T1) AND it has spread to 16 or more nearby lymph nodes (N3b). It has not spread to distant sites (M0).
	OR	
	T2 N3b M0	The cancer is growing into the muscularis propria layer (T2) AND it has spread to 16 or more nearby lymph nodes (N3b). It has not spread to distant sites (M0).
	OR	
	T3 N3a M0	The cancer is growing into the subserosa layer (T3) AND it has spread to 7 to 15 nearby lymph nodes (N3a). It has not spread to distant sites (M0).
	OR	
	T4a N3a M0	The cancer has grown through the stomach wall into the serosa, but it has not grown into any of the nearby organs or structures (T4a) AND it has spread to 7 to 15 nearby lymph nodes (N3a). It has not spread to distant sites (M0).
	OR	
	T4b N1 M0	The cancer has grown through the stomach wall and into nearby organs or structures (T4b). It has spread to 1 to 2 nearby lymph nodes (N1) but not to distant sites (M0).
OR		
	T4b N2 M0	The cancer has grown through the stomach wall and into nearby organs or structures (T4b). It has spread to 3 to 6 nearby lymph nodes (N1) but not to distant sites (M0).
IIIC	T3 N3b	The cancer is growing into the subserosa layer (T3) AND it has spread to 16 or more nearby lymph nodes (N3b).

	M0	It has not spread to distant sites (M0).
	OR	
	T4a N3b M0	The cancer has grown through the stomach wall into the serosa, but it has not grown into any of the nearby organs or structures (T4a) AND it has spread to 16 or more nearby lymph nodes (N3b). It has not spread to distant sites (M0).
	OR	
	T4b N3a M0	The cancer has grown through the stomach wall and into nearby organs or structures (T4b) AND it has spread to 7 to 15 nearby lymph nodes (N3a). It has not spread to distant sites (M0).
	OR	
	T4b N3b M0	The cancer has grown through the stomach wall and into nearby organs or structures (T4b) AND it has spread to 16 or more nearby lymph nodes (N3b). It has not spread to distant sites (M0).
IV	Any T Any N M1	The cancer can grow into any layers (Any T) and might or might not have spread to nearby lymph nodes (Any N). It has spread to distant organs such as the liver, lungs, brain, or the peritoneum (the lining of the space around the digestive organs) (M1).

* The T categories are described in the table above, except for: **TX**: Main tumor cannot be assessed due to lack of information. **T0**: No evidence of a primary tumor. The N categories are described in the table above, except for: **NX**: Regional lymph nodes cannot be assessed due to lack of information.

- [References](#)

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Last Medical Review: December 18, 2017 Last Revised: December 18, 2017

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Stomach Cancer Survival Rates

Survival rates tell you what portion of people with the same type and stage of cancer are still alive a certain length of time (usually 5 years) after they were diagnosed. These numbers can't tell you how long you will live, but they might help give you a better understanding about how likely it is that your treatment will be successful.

What is a 5-year survival rate?

Statistics on the outlook for people with a certain type and stage of cancer are often given as 5-year survival rates, but many people live longer – often much longer – than 5 years. **The 5-year survival rate is the percentage of people who live at least 5 years after being diagnosed with cancer.** For example, a 5-year survival rate of 90% means that an estimated 90 out of 100 people who have that cancer are still alive 5 years after being diagnosed.

Relative survival rates are a more accurate way to estimate the effect of cancer on survival. These rates compare people with stomach cancer to people in the overall population. For example, if the 5-year relative survival rate for a specific type and stage of cancer is 90%, it means that people who have that cancer are, on average, about 90% as likely as people who don't have that cancer to live for at least 5 years after being diagnosed.

But remember, the 5-year relative survival rates are estimates – your outlook can vary based on a number of factors specific to you.

Cancer survival rates don't tell the whole story

Survival rates are often based on previous outcomes of large numbers of people who had the disease, but they can't predict what will happen in any particular person's case. There are a number of limitations to remember:

- The numbers below are among the most current available. But to get 5-year survival rates, doctors have to look at people who were treated at least 5 years ago. As treatments are improving over time, people who are now being diagnosed with stomach cancer may have a better outlook than these statistics show.
- These statistics are based on the stage of the cancer when it was first diagnosed. They do not apply to cancers that come back later or spread, for example.

- Besides the cancer stage, many other factors can affect a person's outlook, such as age and overall health, and how well the cancer responds to treatment.

Your doctor can tell you how these numbers may apply to you, as he or she is familiar with your situation.

Stomach cancer survival rates, by stage

These survival rates come from the National Cancer Database (NCDB) and were published in 2017 in the 8th edition of the AJCC Staging Manual. They are based on people diagnosed with stomach cancer *and* treated with surgery between 2004 and 2008. 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 5-year survival rates by stage for stomach cancer treated with surgery are as follows:

Stage	5 year observed survival
Stage IA	94%
Stage IB	88%
Stage IIA	82%
Stage IIB	68%
Stage IIIA	54%
Stage IIIB	36%
Stage IIIC	18%

The overall 5-year *relative* survival rate of all people with stomach cancer in the United States is about 31%. 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](#)

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Last Medical Review: December 18, 2017 Last Revised: December 18, 2017

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Questions to Ask Your Doctor about Stomach Cancer

When you're told you have stomach cancer

- 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?
- Based on what you've learned about my cancer, what is my prognosis (outlook)?

When deciding on a treatment plan

- 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?
- Should I get a second opinion? How do I do that? Can you recommend someone?
- 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?

During treatment

- How will we know if the treatment is working?
- Is there anything I can do to help manage side effects?
- What symptoms or side effects should I tell you about right away?
- How can I reach you on nights, holidays, or weekends?
- Do I need to change what I eat during treatment?
- Are there any limits on what I can do?
- Should I exercise? What should I do, and how often?
- Can you suggest a mental health professional I can see if I start to feel overwhelmed, depressed, or distressed?
- What type of [follow-up](#) will I need after treatment?

After treatment

- Are there any limits on what I can do?
- What symptoms should I watch for?
- What kind of exercise should I do now?
- What type of follow-up will I need after treatment?
- How often will I need to have follow-up exams and tests?
- How will we know if the cancer has come back? What should I watch for?
- What will my options be if the cancer comes back?
- 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.

Keep in mind that doctors aren't the only ones who can give you information. Other health care professionals, such as nurses and social workers, can answer some of your questions. To find more about speaking with your health care team, see [Talking With Your Doctor](#).

- [References](#)

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

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