Meta-Analysis of the Risk of Gastric Stump Cancer: Detection of High Risk Patient Subsets for Stomach Cancer after Remote Partial Gastrectomy for Benign Conditions


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ABSTRACT

Controversy about gastric cancer risk after partial gastrectomy exists, especially in the United States. Therefore, we performed a meta-analysis to determine overall relative risk and weighted mean relative risk for subsets of postgastrectomy patients, define possible high risk patients suitable for surveillance, and assess for publication bias which would overestimate risk.

If 2 studies were excluded because of heterogeneity, overall relative risk (RR) for gastric stump cancer in 22 studies analyzed was 1.66 (95% confidence limits (CL), 1.54–1.79). With these 2 studies included, the RR summarized with a random effects model to account for study heterogeneity was 1.46 (95% CL, 1.18–1.82). No obvious evidence of publication bias was detected. Patients 15 years or more postoperative had a weighted mean RR of 1.48 (95% CL, 1.31–1.67) and patients 5–14 years postoperative had a RR of 0.91 (95% CL, 0.71–1.17) (P = 0.026). Patients operated upon for gastric ulcer had a weighted mean RR of 2.12 (95% CL, 1.73–2.59) and patients with duodenal ulcers had a RR of 0.84 (95% CL, 0.66–1.05) (P = 0.001). The weighted mean RR for females was 1.79 (95% CL, 1.39–2.29) and for males 1.43 (95% CL, 1.27–1.61) (P = 0.074). For Billroth II gastrectomy the weighted mean RR was 1.60 (95% CL, 1.15–2.18) and for Billroth I gastrectomy 1.20 (95% CL, 1.01–1.42) (P = 0.220).

Although differences in risk between subsets of postgastrectomy patients seem to exist, recommendations concerning endoscopic surveillance await further studies of cost-benefit analysis.

INTRODUCTION

The preponderance of medical literature indicates an increased risk of gastric cancer after peptic ulcer surgery, and in Western Europe the operated stomach is considered a premalignant condition (1). However, controversy concerning cancer risk after partial gastrectomy still remains, especially in the United States where literature reports are less convincing (2, 3).

If gastric stump cancer is assumed to be a real phenomenon, the overall risk of cancer appears too low to justify large scale screening programs (4, 5). Although the prognosis of advanced gastric stump cancer is poor, survival improves dramatically if gastric stump cancer is assumed to be a real phenomenon. Only studies in the English or German language with high appraisals were analyzed. The collected studies are listed in Table I (2, 3, 7, 11, 16–39). Several of these reports have been reviewed elsewhere (40).

Three literature reports were excluded because the relative risk could not be estimated from the data presented (17, 23, 29); one study (30) had too small a sample size (13) and two studies (33, 37) did not fulfill the assumption of sample homogeneity (P < 0.01). This assumption states that all studies under investigation are measuring the same risk estimate so that differences between estimates are due to random error (13). Homogeneity was tested by comparing the relative risk of each study with the summary relative risk from all other studies by x2 (13). Of the remaining 22 reports, 4 were case-control studies and 18 were longitudinal cohort studies. In the 22 studies used, 827 cases of gastric stump cancer occurred. When 95% CL were unavailable in the original study, the RR could not be estimated from the data presented (17, 23, 29); one study (30) had too small a sample size (13) and two studies (33, 37) did not fulfill the assumption of sample homogeneity (P < 0.01). This assumption states that all studies under investigation are measuring the same risk estimate so that differences between estimates are due to random error (13). Homogeneity was tested by comparing the relative risk of each study with the summary relative risk from all other studies by x2 (13). Of the remaining 22 reports, 4 were case-control studies and 18 were longitudinal cohort studies. In the 22 studies used, 827 cases of gastric stump cancer occurred. When 95% CL were unavailable in the original publications, this statistic was calculated from the estimated risks using a method by Woolfe (41) for odds ratios from unmatched case-control studies and a technique by Ederer and Mantel (42) for the cohort studies. Risk estimates were transformed logarithmically for approximation to a normal distribution. Thus, independent of the study type, the standard error of the logarithm of the RR could be used to measure statistical uncertainty (13, 43). This was accomplished by logarithmic transformation of these three quantities and then calculation of the average distance between logarithm RR and upper and lower limits and division by 1.96 (43). Results were depicted in a funnel display plotting logarithm of RR against a measure of precision (standard error of logarithm of RR) (13, 14, 43).

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G. J. A. O. is a recipient of a gastrointestinal-pathology fellowship at The Johns Hopkins Hospital by the Netherlands Organization for Scientific Research and by the Netherlands Digestive Diseases Foundation. To whom requests for reprints should be addressed, at Carnegie, Room 214, The Johns Hopkins Hospital, 600 N. Wolfe Street, Baltimore, MD 21205.
The present meta-analysis makes important observations in the understanding of gastric stump cancer. Many investigators have reported a trend toward increased risk with longer latency after surgery (11, 18, 24, 31, 34, 36, 38, 39). Interestingly, the first 15 years postoperative interval (1, 11, 39) has been reported to have a decreased incidence of gastric stump cancer. Therefore, the pooled data from 4 studies (11, 34, 38, 39) were used for comparison of the pooled data for males and females (11, 16, 24, 31, 34, 36, 39).

The weighted mean relative risk for stump cancer of subsets of postgastrectomy patients (13) was noted for patients operated on for duodenal ulcers (RR, 0.84; 95% CL, 0.66–1.05) compared with gastric ulcers (RR, 2.12; CL 95%, 1.73–2.59) (P = 0.001) and for patients with 5–14 years of postoperative follow-up (RR, 0.91; 95% CL, 0.71–1.17) compared to patients with ≥15 years of follow-up (RR, 1.48; CL 95%, 1.31–1.67) (P = 0.023).

Differences in sex or procedure type were not statistically significant. The RR for males was 1.43 (95% CL, 1.27–1.62) and for females 1.79 (95% CL, 1.39–2.29). The weighted mean relative risk for Billroth II gastrectomy was 1.60 (95% CL, 1.15–2.18) and for Billroth I gastrectomy 1.20 (95% CL, 1.01–1.42). Table 2 summarizes the results of the pooled data for patient subgroups.

DISCUSSION

Although meta-analysis is a useful statistical tool to answer clinical inquiries by pooling literature data, some differences among individual studies which contribute to the observed results will remain unquantified (13). Despite these limitations, the present meta-analysis makes important observations in the understanding of gastric stump cancer. This study confirms an increased relative risk of gastric stump cancer in patients with partial gastrectomy. No obvious evidence of overestimation of cancer risk by publication bias was detected. If publication bias did exist, a gap in the lower left side of the funnel display due to a lack of studies published with negative results would be expected (43).

The risk of cancer in the gastric remnant occurs after a long latency. The relative risk of stump cancer after a postoperative interval of ≥15 years was significantly higher than the first 14 years postoperatively. Many investigators have reported a trend toward increased risk with longer latency after surgery (11, 18, 21, 34, 36, 39). Moreover, a long cancer-free interval corre-

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### Table 1 Twenty-eight literature reports on the risk of gastric cancer after remote peptic ulcer surgery

<table>
<thead>
<tr>
<th>Author (Ref.)</th>
<th>Estimated relative risk</th>
<th>95% CL</th>
<th>Average follow-up (yr)</th>
</tr>
</thead>
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<tr>
<td>Viste et al. (36)</td>
<td>2.1</td>
<td>1.7–2.6</td>
<td>28.4</td>
</tr>
<tr>
<td>Lundegardh et al. (39)</td>
<td>1.0</td>
<td>0.8–1.2</td>
<td>25–33</td>
</tr>
<tr>
<td>Krause (24)</td>
<td>2.2</td>
<td>1.4–3.3</td>
<td>24.3</td>
</tr>
<tr>
<td>Loscos et al. (35)</td>
<td>2.2</td>
<td>1.8–2.7</td>
<td>23.8</td>
</tr>
<tr>
<td>Clark et al.* (30)</td>
<td>4.4</td>
<td>0.0–10.0</td>
<td>22–27</td>
</tr>
<tr>
<td>Offerhaus et al. (11)</td>
<td>1.8</td>
<td>0.8–2.1</td>
<td>&gt;20.0</td>
</tr>
<tr>
<td>Tokudome et al.* (33)</td>
<td>0.2</td>
<td>0.1–0.4</td>
<td>&lt;20.0</td>
</tr>
<tr>
<td>McLean and Ross (2)</td>
<td>0.8</td>
<td>0.3–1.5</td>
<td>18.9</td>
</tr>
<tr>
<td>Fischer et al. (31)</td>
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<td>0.7–2.1</td>
<td>18.0</td>
</tr>
<tr>
<td>Schaefer et al. (11)</td>
<td>0.8</td>
<td>0.1–2.8</td>
<td>&lt;18.0</td>
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<tr>
<td>Hirohata (27)</td>
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<td>0.5–3.0</td>
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<td>Amberson et al. (38)</td>
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<td>17.0</td>
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<tr>
<td>Asano et al.* (37)</td>
<td>0.3</td>
<td>0.2–0.5</td>
<td>13.1</td>
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<tr>
<td>Kuhlmann and Rokitsky (22)</td>
<td>1.9</td>
<td>1.3–2.6</td>
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<tr>
<td>Helsing and Hillestad (16)</td>
<td>2.1</td>
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<td>Grieser and Schmidt (25)</td>
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<td>1.3–2.0</td>
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<td>Domellöf and Janunger (7)</td>
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<td>0.8–2.3</td>
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<td>Peitsch and Becker (28)</td>
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<td>Watt et al. (32)</td>
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<td>Caygill et al. (34)</td>
<td>1.8</td>
<td>1.3–2.2</td>
<td>?</td>
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<tr>
<td>Denck and Salzer* (23)</td>
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<td>Welvaart and Warnsinn* (29)</td>
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<td>Vitek et al.* (17)</td>
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<td>Stalsberg and Taksdal (18)</td>
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<td>1.8–5.3</td>
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<td>Kivilaakso et al. (19)</td>
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<td>?</td>
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<tr>
<td>Papachristou et al. (20)</td>
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<td>1.5–6.2</td>
<td>?</td>
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<tr>
<td>Sandell et al. (21)</td>
<td>0.3–1.6</td>
<td>?</td>
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* 95% Confidence limits (when confidence limits were lacking in the original publication they were calculated, see text: Refs. 41 and 42). * Excluded from meta-analysis; see text.

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**Fig. 1.** Funnel plot of RR of gastric stump cancer (on logarithmic scale) according to standard error of logarithm (ln) of RR for studies with a mean follow-up of ≥20 years (Θ), of 20 years (Ο), and follow-up not specified or case-control study (x), calculated on 22 studies summarized in Table 1. ---, weighted relative risk of pooled data.
cancer is >4-fold higher than the general population in patients who underwent surgery for gastric ulcer seem at higher risk for stump cancer. This relationship may be explained by gastric mucosal atrophy which already exists in gastric ulcer patients at the time of the initial operation in contrast to the duodenal ulcer patients (45).

Although not statistically significant, a higher relative risk of stump cancer was observed in females than in males and after Billroth II than Billroth I gastrectomy. The risk of other surgical procedures could not be assessed, but vagotomies and gastroenterostomies for peptic ulcer have had increased risk of stomach cancer (18, 32, 34, 36). In animal experiments, the frequency of gastric cancer varied with surgical procedure and increased with each additional 5-year period of follow-up (7, 11, 18, 21, 34, 36, 38, 39). In several reports, the risk of stump cancer is >4-fold higher than the general population in patients ≥25 years postoperatively (11, 18, 21, 34, 36, 38, 39). In reports of follow up with a mean follow-up of >20 years (10). As noted by others (1, 11, 39), the long cancer-free latency explains discrepancies between studies; almost all studies with a mean follow-up of ≥20 years reported an increased risk of gastric stump cancer (Fig. 1, Table 1).

The mechanism thought to underlie the increased risk of stomach cancer is production of N-nitroso carcinogens in the gastric remnant. These compounds are generated from nitrate and nitrite by gastric bacteria which have overgrown from postoperative hypochlorhydria. In addition, gastric reflux of bile with increased level of bile acids may play a role (40). The bile with increased level of bile acids may play a role (40). The increasing risk of gastric stump cancer with duration of postoperative period suggests a dose-response relationship and supports this mechanism of carcinogenesis.

Also, an association between initial surgical indication and subsequent risk of stomach cancer was detected. Patients who underwent surgery for gastric ulcer seem at higher risk for stump cancer. This relationship may be explained by gastric mucosal atrophy which already exists in gastric ulcer patients at the time of the initial operation in contrast to the duodenal ulcer patients (45).

At first glance, the overall risk of gastric stump cancer, being slightly higher than the general population, seems unimpressive. However, closer examination reveals that postgastrectomy patients had no increased relative risk of gastric cancer during the first 15 years after surgery. Yet, the risk seems to increase steadily with each additional 5-year period of follow-up (7, 11, 18, 19, 21, 34, 36, 38, 39). In several reports, the risk of stump cancer is ≥25 years postoperatively (11, 18, 21, 34, 36, 38, 39). In reports of follow up with a mean follow-up of >20 years (10). As noted by others (1, 11, 39), the long cancer-free latency explains discrepancies between studies; almost all studies with a mean follow-up of ≥20 years reported an increased risk of gastric stump cancer (Fig. 1, Table 1).

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In conclusion, this meta-analysis reveals differences in relative risk between subsets of postgastrectomy patients. The postoperative interval appears to be a significant risk factor. Also, the type of ulcer which prompted surgery may be important. Screening studies of postgastrectomy patients utilizing endoscopic biopsy of the gastric stump have been effective in detecting early gastric cancer (7–10, 47, 48), a lesion considered curable by surgical resection (49). Although large-scale screening programs of all postgastrectomy patients seem unjustified (4, 5), surveillance of high risk patient subsets may constitute an appropriate medical care strategy. Recommendations concerning this approach await cost-benefit analysis.

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