IMAGING GUIDELINES FOR MEDICAL NECESSITY

Eviti Imaging: Gastric Cancer

Version: 1.0

Effective Date: 1/1/2026

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Please note the following:

For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Please refer to the CMS website at http://www.cms.gov for additional information.

For Medicaid members/enrollees, circumstances when state Medicaid coverage provisions conflict with the coverage provisions within this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Gastric Cancer Imaging

Discussion

This imaging guideline provides a standardized framework for the use of diagnostic and surveillance imaging in the management of common adult malignancies, specifically gastric cancer. The goal is to ensure timely, evidence-based imaging that supports accurate staging, treatment planning, response assessment, and post-treatment surveillance.

Guiding Principles

- Follow evidence-based practices from major guidelines (e.g., NCCN, ESMO, ACR Appropriateness Criteria)
- Ensure imaging aligns with the clinical context and stage of disease
- Minimization of unnecessary radiation exposure
- Promote timely and cost-effective imaging utilization
- Incorporate multidisciplinary collaboration in imaging decisions

Imaging Guidelines

This guideline applies to the following patients:

1. At least 18 years of age with confirmed or suspected diagnoses of gastric cancer; AND
2. All phases of oncologic care, including one of the following:
   a) Initial staging
   b) Treatment response evaluation
   c) Post-treatment surveillance
   d) Detection of recurrence or progression; AND
3. All imaging modalities used in oncology care, including but not limited to the following:
   a) Computed tomography (CT) (neck, chest, abdomen, pelvis, neck, or site-specific)
   b) Magnetic resonance imaging (MRI) (including site-specific protocols such as pelvis MRI, brain MRI, liver MRI)
   c) Fluorodeoxyglucose positron emission tomography/CT (FDG-PET/CT)
   d) PET/MRI
   e) Somatostatin receptor PET/CT (SSTR-PET/CT)
   f) Nuclear medicine (e.g., bone scan, PSMA PET)
   g) Single photon emission computed tomography/CT (SPECT/CT) (e.g., octreotide SPECT/CT for neuroendocrine tumors)

Notes:

1. The concurrent utilization of multiple advanced imaging modalities—such as PET/CT and MRI—is not routinely warranted and should be considered only when each modality is expected to provide distinct and clinically relevant information that will directly impact patient management. The selection of the most appropriate imaging study should be individualized, taking into account tumor type, clinical presentation, prior imaging, and other patient-specific factors. Imaging requests will be evaluated on a case-by-case basis to ensure clinical necessity, appropriateness, and the potential to influence therapeutic decision-making.

2. When PET imaging is clinically indicated, the appropriate radiotracer should be selected based on tumor type and clinical scenario.

Esophageal Cancer Imaging

Information summarizing key points related to cancer type and imaging goes here. Imaging in gastric cancer plays a pivotal role in the diagnosis, staging, treatment planning, and detection of recurrence. Cross-sectional imaging helps define local extent of disease, assess nodal involvement, and evaluate for distant metastases (especially peritoneal and hepatic). Accurate staging is essential to determine resectability and guide multidisciplinary management. Post-treatment surveillance imaging supports early detection of recurrence and treatment-related complications while minimizing unnecessary radiation exposure.
These recommendations are consistent with NCCN Gastric Cancer Guidelines (v2025) and may also be applied to gastroesophageal junction (GEJ) adenocarcinomas when appropriate.

Esophageal Cancer Recommendations			
Clinical Scenario	**Recommended Modality**	**Frequency/Timing**	**Purpose/Notes**
Initial Diagnosis/Staging	CT chest/abdomen/pelvis	Once at diagnosis	Baseline staging to assess primary tumor, nodes, and metastatic disease (liver, lung, peritoneum)
	Endoscopic ultrasound (EUS)	Once, when endoscopic visualization feasible	Provides locoregional (T and N) staging, particularly for potentially resectable or early lesions
	PET/CT, when clinically indicated due to inconclusive or inadequate findings on conventional imaging	Optional, once at initial staging	Consider if metastatic disease not clearly evident on CT or if non-FDG-avid histology excluded May be helpful with locally advanced disease to rule out metastases Not indicated for T1
Treatment Monitoring (Curative)	PET/CT	5-8 weeks after completion of pre-op therapy and within 3–6 months post-surgery	Restage to assess response and continued resectability

	CT chest/abdomen/pelvis		May omit CT scans if PET is done
Treatment Monitoring (Metastatic)	CT chest/abdomen/pelvis PET/CT, when clinically indicated due to inconclusive or inadequate findings on conventional imaging	Every 3 months	NCCN does not specify imaging intervals
Surveillance (Stages II/III)	CT chest/abdomen/pelvis	Every 6 months for first 2 years, then annually up to 5 years	Frequency individualized by stage, symptoms, and risk of recurrence Surveillance imaging based on symptoms for stage I PET scan is generally not indicated for surveillance
Suspected Recurrence or Progression	CT chest/abdomen/pelvis	As clinically indicated	Evaluate for recurrence or progression of disease
	PET/CT, when clinically indicated due to inconclusive or inadequate findings on conventional imaging	As indicated	Use if standard imaging equivocal or if considering change in management
	MRI abdomen (liver protocol)	As indicated	Evaluate indeterminate hepatic lesions or peritoneal disease not well characterized on CT

Notes:

1. PET/CT not routinely required for all cases; utility highest in FDG-avid adenocarcinomas.
2. MRI may substitute for CT in patients with contrast allergy or renal impairment.
3. Surveillance imaging should be guided by clinical symptoms and treatment intent; avoid overlapping modalities.
4. Applicable to both gastric and GE junction adenocarcinomas unless otherwise specified.[1]

Revision and Review History

No.	Description	Date
1	Original Effective Date:	1/1/2026
2	Policy Annual Review Dates:	
3	Department Owner:	Medical Affairs
4	NH Advisory Committee Approval Dates:	
5	Revision Changes:	

References

[1] National Comprehensive Cancer Network Guidelines: Gastric Cancer. https://www.nccn.org/professionals/physician_gls/pdf/gastric.pdf. Accessed December 16, 2025.