Surgery in GEP tumors

- Therapeutic strategies are defined according to **histopathological staging**
- **Curative resection** is possible in the minority of GEP tumors
- **Palliative resection** of hepatic metastases in combination with complete removal of the primary+ln may increase survival
- **Palliative surgery** of the primary has not shown prolonged survival

Histology of forgut NEC (lig. Treitz)

- Well differentiated tumour — Ki67 < 2%
- Well differentiated carcinoma — Ki67 2-10%
- Low differentiated carcinoma — Ki67 > 30%

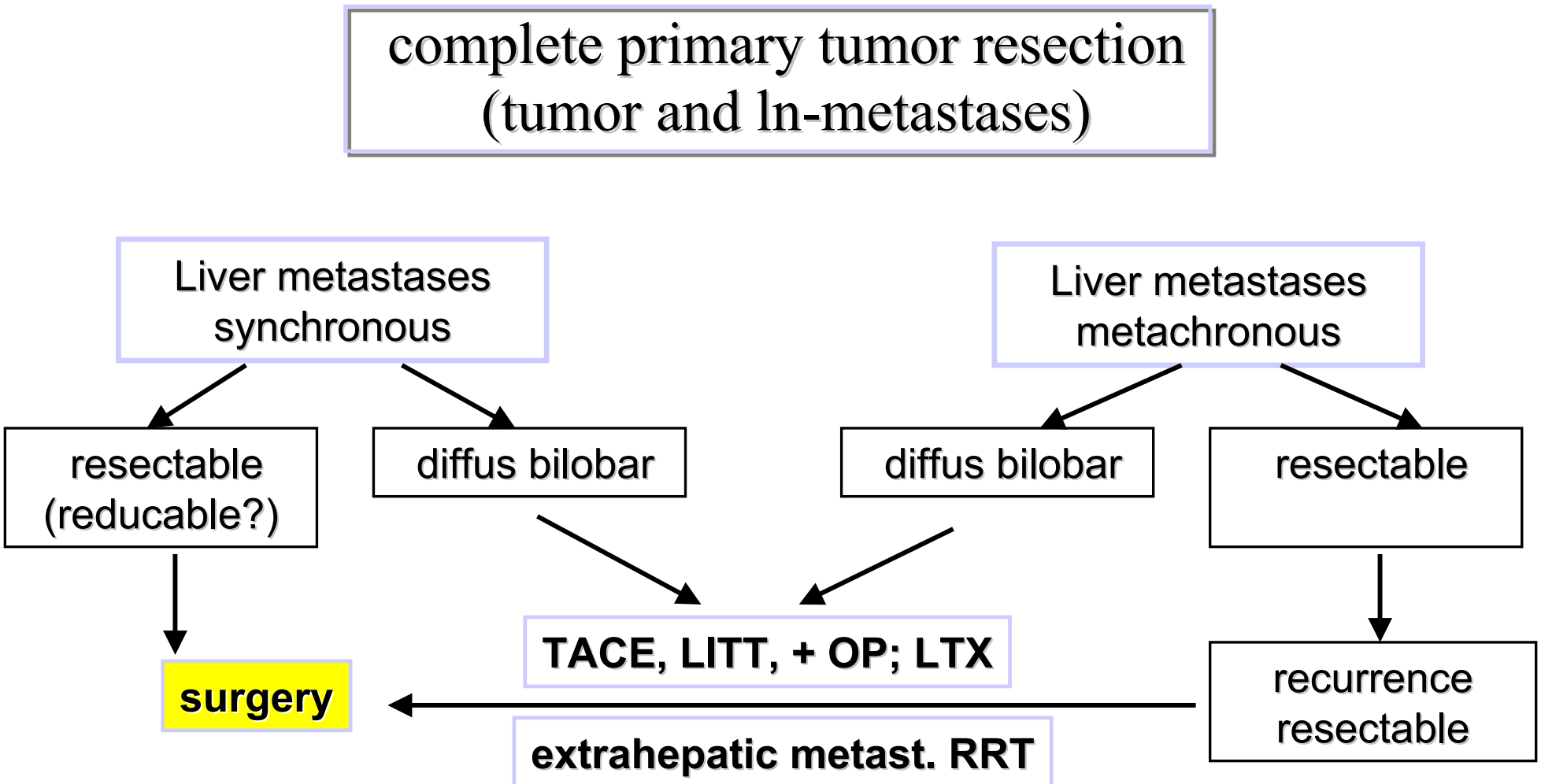
- Definition of malignancy — vascular invasion
  metastases,
- Chromogranin A positive
- Hormones, Neurotransmitter variable

Capella C, Virchows Arch 1995, Caplin ME Lancet 1998

Algorithm for NEC of GEP (well differentiated NEC) (ENETS, Frascati 2005)

Therapeutic Strategy: well diff.NEC (>2cm, Ki67 2-10%, 2-10 mitosis)	**Exception**
Curative tumor resection Palliative tumor res. (>90%) Reduction of liver disease Debulking (symptom pos.)	gastric ECL 1-2 gastrinoma / MEN-1 appendiceal NEC
TACE; TAE; RFA 5-FU + Doxorubicine; STZ; Somatostatin; a-interferon	dediff. NEC: cisplatin+etoposide

NEUROENDOKRINE CARCINOMA (NEC) OF GASTRO-ENTERO-PANCREATIC SYSTEM (GEP)



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Palliative surgery in GEP tumors

- **41** patients with liver metastases

- 16/26 curative intent → 13/16 R0
  - med. survival 70 months

- 15/41 without hepatic resection
  - med. survival 47 months

Jaeck D et al. World J Surg 2001;25:689

Cytoreductive Therapy

- **Aims at reduction of tumor mass**
  - to improve the response to systemic chemo-tx
  - to reduce symptoms of progressive metastatic disease confined to the liver
  - in patients unresponsive to systemic chemo-tx
- **Trials**
  - *combine results on functioning and non-functioning neuroendocrine tumors of the pancreas and midgut*