UK and Ireland Neuroendocrine Tumour Society

UKINETS bitesize guidance Management of patients with Gastric Neuroendocrine Neoplasm

	Type I (70%)	Type II (10%)	Type III (20%)
Clinical Features	• asymptomatic • small • multiple • found in fundus and body • mostly grade 1 • malignant behaviour/ metastasis rare • caused by achlorhydric hypergastrinaemia associated with pernicious anaemia and chronic atrophic gastritis	• rare • often small and multiple • grade 1 or 2 • caused by hypergastrinaemia due to a gastrinoma (ZES) often as part of MEN-1 • peptic ulcers • +/-diarrhoea	• single, • often > 2 cms, • may be ulcerated • usually grade 3 but some may be lower grade • not associated with hypergastrinaemia • malignant behaviour/ metastatic disease common
Diagnosis	• vitamin B12 (usually low) • Hb and iron studies (IDA common) • anti-parietal cell antibodies (usually positive) • fasting serum gastrin off PPI therapy (high) • +/- gastric pH measurement during endoscopic assessment (pH>4)	• vitamin B12 (usually normal) • Hb and iron studies (IDA common) • anti-parietal cell antibodies (negative) • fasting serum gastrin off PPI therapy (high) : substitute H2RA for 7 days, or do not stop PPI if felt high risk of peptic ulceration • +/- gastric pH measurement during endoscopic assessment (pH<2)	• biopsy • full staging with CT (+/- somatostatin receptor scintigraphy) • FDG-PET
Management	• biopsy several of largest polyps and background stomach • consider removal of polyps > 10 mm in size (ESD or EMR), consider EUS and CT assessment prior to removal • surveillance OGD and screening for adenocarcinoma – biopsy background mucosa for dysplasia - every 1-2 years • Preferably stop PPIs– will further increase gastrin and little rationale for ongoing treatment	• PPI +/- somatostatin analogues • identify and remove gastrinoma where possible • manage gastric polyps> 1cm as per type 1 GNENs	• operable disease: surgical resection following principles of managing adenocarcinoma • lower grade tumours with no loco-regional spread (EUS): endoscopic removal by ESD (possibly EMR) may be considered • systemic therapies are required for inoperable disease, choice is dictated by grade e.g. platinum-based chemo for G3, SSRA +/- PRRT

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For more information, please visit our website: www.ukinets.org

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References

1. ENETs consensus management of patients with gastroduodenal neoplasms. Delle Fave et al. Neuroendocrinology 2012;95:74-87

2. The investigation and management of gastric neuroendocrine tumours. Basuroy R et al. AP&T 2014;39(10)1071-84

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