ABSTRACTS SELECTED FOR POSTER PRESENTATIONS

Discussion: In the current WHO classification of gastric tumors, only carcinoids and small cell carcinomas are included in the neuroendocrine (NE) tumor category. However, a new pathologic entity has recently been described by Jiang et al. High-grade gastric NE carcinomas of non-small cell type have been tentatively named large cell neuroendocrine carcinomas (LCNEC). Morphologically, these tumors differ from both carcinoids and small cell carcinomas, and are confirmed immunohistochemically using NE markers, chromogranin-A and synaptophysin. Gastric LCNEC is currently defined if > 50% of tumor cells demonstrate positivity for chromogranin-A and/or synaptophysin.

LCNECs account for < 1.5% of all gastric cancers. LCNECs, which had been previously diagnosed as adenocarcinomas (ACs) are highly malignant and portend a significantly worse prognosis than ACs. Reported 5-year survival rates for LCNECs and ACs have are 31.1% and 69.3%, respectively. At the time of presentation, 70-75% of LCNECs have lymph node metastases and 5-10% also have metastases to liver. Clinical management of gastric LCNECs has not been clearly defined given the rarity of the malignancy and limited experience in its management. An overall regression rate of 67% was achieved in a small series of poorly differentiated gastroenteropancreatic NE carcinomas treated with cisplatin and etoposide.

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Zollinger-Ellison Syndrome with Subsequent Association of Insulinoma

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Case: A 64-year-old-woman was admitted to our hospital in 2000 for evaluation of epigastric pain, chronic diarrhea, and 15-lb weight loss. Past medical and family histories were unrevealing for any endocrine tumors. Esophagogastroduodenoscopy showed diffuse severe duodenitis and an atypical post-bulbar ulcer. Her serum gastrin level was elevated (193). ERCP showed a possible mass in the head of the pancreas compressing the main pancreatic duct. Subsequent octreotide scan confirmed a pancreatic head mass, and she underwent a Whipple procedure in 2000. The mass proved to be a 2.8 cm gastrinoma with focal venous and perineural invasion. Immunohistochemically, tumor cells were diffusely positive for gastrin, and focally positive for chromogranin A, synaptophysin and insulin. Tumor cells were negative for glucagon, VIP, somatostatin, or calcitonin. The patient received no adjuvant chemotherapy or radiotherapy. She was well until 2002, when she again developed peptic symptoms and recurrent bleeding gastric ulcers. Octreotide scan was negative. In 2003, she had an emergent laparotomy because of a perforated marginal ulcer and underwent revision of Roux-en-Y gastrojejunostomy and vagotomy. A few months later she again presented with abdominal pain and had elevated liver enzymes. Repeat octreotide scan showed positive hepatic uptake suggestive of metastatic neuroendocrine to liver. The patient was treated with depot-octreotide and proton pump inhibitors (PPI) but ultimately underwent chemo-embolization in early 2004 for progressive disease. She was stable until 2007 when she developed diaphoresis and syncopal episodes associated with hypoglycemia. Extensive cardiovascular, neurologic, and endocrine evaluations revealed elevated insulin, proinsulin and C-peptide levels consistent with a functioning insulinoma. She was treated with depot-octreotide and diazoxide with poor control of hypoglycemic episodes. She underwent hepatic embolization with complete resolution of symptoms. Subsequently, she has been devoid of hypoglycemic symptoms and requires no medications other than PPI.