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ABSTRACT BOOK

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Abstract Book

1 Management of Patients with Esophageal Cancer

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Keywords: esophageal cancer, squamous, adenocarcinoma, treatment

Introduction
Esophageal cancer is one of the most common cancers and leading cause of cancer-related mortality worldwide because of its poor survival prognosis. The predominant histological types of esophageal cancer are adenocarcinoma and squamous cell carcinoma. Currently treatment options include surgery, chemotherapy, and radiotherapy. Early detection and treatment of esophageal cancer are crucial to improving one's survival. The aim of this study was to observe the presentation, stage distribution, and treatment of patients with esophageal cancer in our department.
Methods
We evaluated 50 patients with esophageal cancer admitted in Fundeni Clinical Institute in Gastroenterology II Department during January 2014 – October 2018.
Results
The mean age of patients was 62.76 years. 74% of the patients were male and 26% of the patients were females, corresponding to a ratio of approximately 3:1 male to female ratio (2.84:1 to be exact). The most common symptom among patients was dysphagia (78%) followed by the weight loss (52%); loss of appetite was as much as common as odynophagia (22%) and heartburn was the rarest symptom (12%). The majority of the patients (62%) had the tumor in the lower third of the esophagus. The predominant type of esophageal cancer was the squamous cell histology type (68%) followed by adenocarcinoma with a 32%.
In the affected people, the smoking criteria was present among 56% of the patients. The proportion of squamous cell type was more common (68%) for the smoking patients than adenocarcinoma type (32%). Barrett's esophagus occurred in 4 patients, or 25% of those with adenocarcinoma.
The majority of the patients (54%) were Stage III at diagnosis, and only 22% were Stage I and received surgery treatment. Of all patients with different stages of squamous cell type, 41% received radiation therapy plus chemotherapy as treatment methods and 41% palliative treatment, meaning only 18% underwent surgery initially, being diagnosed in an early stage. For patients with adenocarcinoma, palliative treatment was most frequent (38%) and there was no difference between neoadjuvant chemoradiation and primary resection (31%, 31%).
Conclusions
Esophageal cancer has high probability to occur to people which are heading towards the third age and shows an increasing occurrence of squamous cell type, especially in the lower third of the esophagus. Smoking was not a direct cause of the diagnostic. Esophageal cancer has many treatment options (surgical and non-surgical treatments) and it's likely to be diagnosed in Stage II or III which implies that multidisciplinary team approach is necessary.

Unpredictable Site of Metastasis of an Esophageal Cancer

2

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Keywords: squamous-cell carcinoma esophageal cancer; chemotherapy ; gastric metastasis

Oesophageal cancer is the 19th most common cancer in the European Union (EU), with ~ 45 900 new cases diagnosed in 2012. Variation between countries is high and may reflect different prevalence of risk factors, use of screening and diagnostic methods. Oesophageal cancer has two main subtypes—oesophageal squamous-cell carcinoma (SCC) and oesophageal adenocarcinoma (AC). Although SCC is responsible for ~ 90% of cases of oesophageal cancer worldwide, mortality rates associated with AC are rising and have surpassed those of SCC in several regions in the EU .
We present the case of a 48-year-old female, smoker with a SCC located in the thoracic esophagus, G2/G3, who initialy underwent subtotal esophagectomy with intrathoracic esogastroanastomosis. She refused any therapy after surgery. After 5 months, CT scan showed mediastinal lymph nodes and pleural metastases. She received 6 cycles of palliative chemotherapy with CDDP/ capecitabine, well tolerated. The best response was stable disease. One year later, she was diagnosed with a gastric tumor. Initial biopsy showed normal cells. The repeated endoscopy with biopsy raised the suspicion of gastric MALT lymphoma. The third endoscopy with biopsy revealed the same SCC as in the esophagus.
The ECOG performance status(ECOG PS) was 0, the only symptom being dysphagia to solids. She received two cycles of chemotherapy with docetaxel. At the third cycle she had an ECOG PS 3-4 with complete dysphagia and we continued with best supportive care.

3 Carcinod tumor of the cecum- Clinical case

Autor: Goia Irina MD
Medisprof Cancer Center , Cluj Napoca 2018

Background
Carcinoid tumours are most commonly found in the gastrointestinal tract. Up to 34.5 to 48% of all colorectal carcinoids occur in the cecum and ascending colon. They can appear at all ages, with the highest incidence being at 50 years of age. The incidence rates of cecal NETs are similar between male and female. Carcinoid tumors of the cecum arise from the amine precursor uptake and decarboxylation (APUD) cells of the intestine. They are capable of secreting many different cytokines and hormones, which may or may not be biologically active. The most commonly employed markers are urinary 5-hydroxyindole acetic acid (5-HIAA), although the specificity of this marker is only about 88% and Chromogranin A .
Case report
A 68-year-old woman 7 years ago had appendicitis like symptoms (diarrhea, abdominal bloating, sudden pain in right iliac fossa). Abdominal ultrasound revealed a parenchymatous tumor mass in the right iliac fossa arising probably from the colon.
Colonoscopy revealed a 4cm vegetative and stenotic tumor mass of the cecum and iliocecal valve. During open surgery right hemicolectomy was practiced. The histopathological result was carcinoid tumor of the cecum.
Firts recidive was in december 2013 in liver. She starts Sandostatin until June 2017 when the hepatic lesions progresed and starts Lanreotide until progression in octomber 2017 when starts Capecitabine .
Conclusion
Carcinoid tumour presents considerable problems of diagnosis because symptoms are nespecific. Carcinoid tumors arising from the small intestine, cecum and appendix are more commonly associated with carcinoid syndrome, related to the secretion of serotonin, hitamine or tachykininsinto the systemic circulation causing episodic flushing and diarrehea.
Carcinoid tumors are relatively slow growing, and, even in the presence of metastatic disease, patients can survive for several years with current treatment strategies.

4 Ileal Carcinoid Tumor Presented as Recurrent Obscure Digestive Bleeding

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Small-intestine Neuroendocrine Tumors, originally described as "carcinoid" tumors, are rare, but serious clinical condition which sometimes can be difficult to diagnose. That's because clinical symptoms in affected patients range from non-specific symptoms (abdominal pain, weight loss, fatigue), carcinoid syndrome (flushing and diarrhea, wheezing), tumor-mass-related symptoms (palpable abdominal mass), overt or occult digestive bleeding, small bowel ischemia or metastatic disease (jaundice, hepatomegaly).

This case report describes a 72 years-old woman who was referred to the Departament of Gastroenterology for evaluation of severe iron deficiency anemia, with extreme fatigue, weakness, shortness of breath and headaches. No abdominal mass was found, no history of rectal bleeding or melena and no anticoagulant medication, with normal liver and spleen and normal stools at rectal examination. After a complete evaluation by standard endoscopic techniques (upper and lower endoscopy) and other imaging investigation (chest X ray, abdominal US, CT scan) all results were normal. It was decided to follow-up the patient and extensive endoscopic evaluations of gastro-intestinal tract were performed: 4 EGD (2 with jejunal biopsies), 2 ileo-colonoscopies, 1 negative small bowel capsule endoscopies, CT enterography and no lesions was found. After 5 years, a dual camera colon capsule endoscopy (small-bowel protocol) was performed and an ileal ulcerated polypoid tumor was found. The patient underwent surgery and histopathological and immunohistochemical examination revealed well-differentiated ileal neuroendocrine tumor with tumor cells positive for chromogranin.

This case shows that the diagnosis of small-intestine neuroendocrine tumor is a medical challenge, even if all investigations were apparently normal at first side. Sometimes, it's necessary to be calm and follow-up the patient because, finally, the benefits outweigh the costs.

5 Rectal cancer case presentation with cardiac toxicities after fluoropyrimidine treatment

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Introduction
Neoadjuvant radiotherapy with concurrent 5-fluorouracil-based chemotherapy is currently considered the standard of care for locally advanced rectal cancer.
Pathologically complete response is a desirable outcome and has been associated with increased disease-free survival.
Irinotecan has an established role in the treatment of metastatic rectal cancer. In-vitro and in-vivo data have shown promising radiosensitization properties.
Case presentation
A 40 years old adult male presented with symptoms of hematochezia and persistent abdominal pain for 6 months. He has no chronic disease or familial history of malignancy.
Clinical findings
We performed a clinical examination, colonoscopy with biopsies, MRI of pelvis, thorax and abdominal CT scan and a PET/CT scan which showed an inferior (at 3-4 cm of anal margin, with invasion of anal canal) rectal G1 adenocarcinoma, cT3N1M0.
He starts neoadjuvant chemotherapy with CapOx and after the 1st cycle he develops cardiac toxicities (chest pain). After that, he perform 2 cycles of Oxaliplatin monotherapy with partial response, on thorax, abdominal and pelvic CT scan.
Than he started the concurrent radiochemotherapy and we choose weekly Irinotecan as a chemotherapy agent in dose of 65 mg/mp. Radiotherapy dose was 50.4 Gy in 28 fractions, with 1.8 Gy/fraction. The treatment was well tolerated, with G2 digestive toxicities (diarrhea).
Following treatment, a colonoscopy (no biopsies was performed) and a MRI did not show any residual tumor (complete response). The patient underwent surgery (abdominoperineal resection) at 6 weeks after radiochemotherapy with pathologic finds: rectal G2 adenocarcinoma pT3N1(2N+/16N)L1V0R0.
After surgery the patient underwent adjuvant chemotherapy with Oxaliplatin monotherapy.
Conclusions
Irinotecan is a good alternative for fluoropyrimidine chemotherapy in patients with cardiac pathology. Not all of the patients are candidates for neoadjuvant setting. Maybe post radiochemotherapy PET/CT could give more information about the locoregional status. Fluoropyrimidine plus radiotherapy remain the standard for locally advanced rectal cancer.

6 Clinic and Treatment Features at Patients with Gastric Cancer: A Single Center Retrospective Study

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Introduction
Gastric cancer is one of the most common cancers worldwide, almost half of the patients diagnosed annually being expected to die. Most patients with gastric cancer that are symptomatic already have advanced incurable disease at the time of presentation. At diagnosis almost 50% of the patients have disease that extends beyond locoregional limits and only half of the patients that apparently have locoregional tumor can undergo a potentially curative resection. Surgically curable early gastric cancers are usually asymptomatic.
Methods
We evaluated 49 patients with gastric cancer admitted in Fundeni Clinical Institute in the Gastroenterology II Department during October 2017 – October 2018. Out of these patients, 24 were known with the disease prior this admission and 25 were diagnosed during this period of time and were enrolled in this study.
There are two major classification systems in use for gastric cancer: the Japanese classification – based on anatomic location, particularly of the lymph node stations, and the AJCC and UICC classification – based on tumor, node and metastasis (TNM).
Results
The mean age of the evaluated patients was 64 years, with the age at diagnosis of 63 years. The majority of the patients (65.30%) were men. 59.18% of the patients were without any digestive tract antecedents.
Each patient underwent an upper endoscopy – more sensitive and specific for diagnosing a variety of gastric, esophageal and duodenal lesions than alternative diagnostic strategies, biopsies being performed each time. Gastric adenocarcinoma was the most frequent histopathologic diagnosis (92%, n=23) the other patients being diagnosed with non-Hodgkin lymphoma and one neuroendocrine tumor. Out of the patients with gastric adenocarcinoma 34.78% had poorly differentiated adenocarcinoma (G3), but unfortunately for the majority of them (43.47%) the data was not available.
The treatment was chosen considering the staging of the disease (TNM classification) and the ECOG performance status. 48% (n=12) of the patients underwent surgery, 32% necessitating adjuvant

chemotherapy. Only 2 patients were diagnosed with early gastric cancer (T1N0M0), being cured with surgery alone. 24% of patients received only palliative chemotherapy. Considering the staging of the disease and the performance status, for 8 patients the treatment of choice was best supportive care.

Conclusions

Gastric cancer is one of the most deadly cancers worldwide. Most of the patients with early gastric cancer are asymptomatic, the detection rate being very low without active screening.

Keywords: gastric cancer, Fundeni, chemotherapy, early gastric cancer, surgery, endoscopy

Metastasized gastric carcinoma

7 *Iuliu Ionas Onesti County Hospital*

I am tired. At the oncology office in the Onesti County Hospital 385 new cases have been taken in. 53 forms of cancer - colon, pulmonary, breast but also very rare cases as parathyroid cancer and adrenal cancer. If 20 years ago things were easier, now they are more complicated. In 1998 any breast cancer patient had surgery, followed chemotherapy, irradiated and received Tamoxifen treatment, any pulmonary cancer was following treatment with Cisplatin and Etopozid and any colon cancer was doing 5 FU with Calcium Folinate.

Now we determine if it is luminal or basal, HER 2 or not, adenocarcinoma or squamous, EGFR, ALK, PDL1, RAS, BRAF, etc.

All these things almost on our own, needing to treat a lot of patients with a lot of different types of cancer, with many, different, medications! Tailored treatment!

Over them, a patient like P.S. with a Metastasized gastric carcinoma scheduled for treatment with Oxals, Fadr and Capecitabine. After this I realized that it was Her 2 positive and added Herceptin and finally I established that the laterocervical and supraclavicular adenopathy is not Wircow-Troisier but metastasized pharynx carcinoma. The treatment plan has changed to 5FU with Cisplatin and Herceptin. Would it have been useful to add Cetuximab?

After 3 treatment cycles the patient felt better, gained weight, liver tests have improved. The patient was scheduled for a CT.

To be continued...

8 From Neuroendocrine Cells Hyperplasia to Neuroendocrine Neoplasms in Inflammatory Bowel Disease

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Introduction

Increased densities of hyperplastic neuroendocrine (NE) cells in colonic mucosa of inflammatory bowel disease (IBD) colitis has been described. There are multiple case reports and case series available of the association –neuroendocrine tumor- IBD.

The aim of our study is to determine de morphological alterations on NE cells in colonic mucosa of patients with IBD in our Department and the association with neuroendocrine neoplasms.

Methods

A full colonoscopy with multiple biopsies has been performed in 11 patients with colonic IBD and 11 controls. Chromogranin A (CgA) and synaptophysin antibodies (Syn) have been used for the identification of NE cells.

Results

In IBD group NE cells had a patchy and superficial distribution, organized in groups or nodules of 3 to 6 hyperplastic cells/crypt with a mean density of 3.16 CgA positive and 2.54 Syn positive NE cells/ crypt in IBD group compared to 1.7 CgA positive and 1.28 Syn positive NE cells/crypt in non-IBD controls; P=0,0001, P=0,002.

When compared to IBD duration, NE cells densities decreased with IBD evolution so that in patients with IBD duration between 1 and 5 years mean NE cells densities were 3,4 NE cells/crypt (CgA)and 2.8 NE cells/crypt (Syn) compared to 2,76 NE cells/crypt and 1,72 NE cells/crypt respectively in patients with disease evolution longer than 5 years; P=0,19, P=0,14.

There are no significant differences between NE cells distributions in active versus inactive disease with a mean density of 2,3NE cells/ crypt (CgA) and 3 NE cells/crypt(Syn) in active IBD colitis and 3 NE cells/crypt (CgA) and 3.5 NE cells/crypt (Syn) in inactive colitis; P= 0,1 and 0,2 respectively.

No dysplasia of NE cells has been described and we found no neuoendocrine tumors in our patients.

Conclusion

Further studies are needed to assess the sequence hyperplasia-dysplasia- neoplasia of NE cells in IBD patients

Keywords: neuroendocrine cells hyperplasia, neoroendocrine neoplasms, inflammatory bowel disease

9 Early gastric cancer – something new?

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Introduction

Early gastric cancer is defined since 1971: carcinoma limited to the mucosa and/or submucosa regardless of the lymph node status. Globally, mucosal tumors have a 6% risk of lymph node metastases vs 28% in case of submucosal tumors. The size of the lesion more than 2 cm and the depressed lesions on upper digestive endoscopy are the most important factors for the existance of lymph node metastases.

Report

We present the case of a 77 year-old male who was referred to our clinic for: fatigue, epigastric pain, loss of appetite, nausea occasionally. His associated diseases were mild hypertension, mixed dyslipidemia. Clinical evaluation revealed no significant modifications. Bioumoral analysis revealed only minor anemia (hemoglobin 12 g/dl) and a minor dyslipidemia. Upper digestive endoscopy was performed: concave ulcer base of the angular incisure, the ulcer depth was greater than the thickness of adjacent mucosal surface, approximate 3 cm in diameter. Histopathology: ulcerated and moderate differentiated adenocarcinoma, no H. pylori infection. EUS confirmed a hypoechoic tumor invading the submucosa (sm2); no lymphatic involvement was present. According to the international recommendations, we performed subtotal gastrectomy with regional lymphatics and along celiac axis. So, final diagnosis was: pT1b pN0 M0: We recomended further, according to the stage I gastric cancer: upper digestive endoscopy in one year, CT scan of the chest, abdomen and pelvis in one year and screening for nutritional deficiencies (vitamin B12 and iron).

Conclusion

Still a strong recommendation for surgery and not for endoscopic therapy in case of large ulcerated early gastric cancer.

10 Survival in patients with diagnosed pancreatic adenocarcinoma

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Introduction
Pancreatic cancer is difficult to diagnose in its early stages, therefore the survival rate at the time of diagnosis is notoriously low. However, chemotherapy is cited to have impact on the survival of the patients.
Methods
We designed a retrospective study to include all patients who were diagnosed with pancreatic cancer in the last 15 months, who were diagnosed by EUS/FNA.
Results
Out of the 27 patients included in this study, 67% had a tumor of the pancreatic body, 26% had a tumor in the head of the pancreas and 7% had a tumor of the tail. According to the literature, only a third of the pancreatic neoplasm occur in the tail and body, whereas in our study, three quarters of the tumors had this localization.
In a group of 12 deceased patients, the mean survival was 4.4 months, with a minimum of 1 month and a maximum of 7 months, a value which is consistent with the existing data. Out of these patients, 5 received chemotherapy, and their mean survival was 4.8 months which is far less than the mean survival with chemotherapy cited in the literature of 23 months.
Even though all of the patients had a normal BMI at the time of the diagnosis, 42.9% were malnourished and 65.2% had weight loss as presenting symptom.
66.6% of the patients had metastatic disease at the time of the diagnosis, with no difference in the precentage of metastases in the deceased group, compared to the survival group.
CA19-9 was elevated in 48% of the cases and 60% of the patients were smokers.
Conclusions
Undergoing chemotherapy did not improve survival rate in our group of patients. Other markers besides BMI should be used in assessing nutritional status. Presence of metastatic disease at the time of diagnosis did not alter the mean survival.
Keywords: pancreatic cancer, adenocarcinoma, survival, chemotherapy, nutritional status

11 Multidisciplinary Treatment in a Rectal Cancer with Synchronous Liver Metastases

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A 40-years old female without significant medical history (only intestinal transit disorders with predominant constipation) was diagnosed in December 2018 with obstructing rectal adenocarcinoma with unresectable synchronous liver metastases (LM1), after having a colonoscopy which revealed an obstructing tumor at 6-10 cm from the anal orifice (lower medium rectum) that couldn't be passed through by the colonoscope. The initial pathological exam identified a well-differentiated adenocarcinoma. We performed a chest, abdomen and pelvic CT scan which highlighted multiple bilobate LM1(3-30 mm diameter) that occupied 50% of liver parenchyma.

The patient underwent surgery on 08/12/2018 – low anterior rectal resection with end-to-end mechanic colorectal anastomosis. The pathological exam revealed a well-differentiated tubulo-papillary adenocarcinoma pT3pN1c, with microsatellite stability, Ki67 68%, all-Ras wild type and BRAF V600 negative.

In between January and May 2017, the patient was administrated mFOLFOX6 and from April 2017 Cetuximab was also associated. From May 2018 we continued with 5FU+LV iv 48h q14d plus Cetuximab weekly until October 2017. The CT scan from September 2017 showed a partial response and the multidisciplinary team considered the LM1 resectable. Therefore, in December 2017 the patient underwent the hepatic surgery – segmentectomy of the 3rd segment, atypical hepatectomy for segment 4A and 8, segment 7, segment 5, two metastasectomies segment 7 and anterograde cholecystectomy.

The surgery was complicated with transudative right pleural effusion, small pericardial effusion and vegetation on mitral valve: infectious endocarditis with negative blood cultures - treated with antibiotics with complete remission in February 2018.

From February 2018 the patient restarted 5FU+LV iv 48h q14d plus Cetuximab weekly for four months, with complete response. The abdominal MRI from September 2018 revealed a progressive liver disease associated with elevation of the tumor markers. The PET-CT from September 2018 highlighted multiple, unresectable liver metastasis. The proposal of MTD team was systemic therapy with mFOLFIRI and bevacizumab.

12 Hepatic Carcinosarcoma: Case Report

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Primary hepatic carcinosarcoma is defined as a malignant tumor containing an intimate mixture of carcinomatous (either hepatocellular or cholangiocellular) and sarcomatous elements. The occurrence of HCS is very rare with only 31 cases having been reported in the literature. Reports on risk factors, epidemiology, and pathogenesis of the tumor as well as the experience in its treatment are limited. Median survival rate does not exceed 9 months.

Here, we report the case of a 76-year-old female who developed a liver mass on a cirrhotic liver due to chronic hepatitis C. She presented into our clinic after 6 months of the initial finding without major symptoms or signs of tumour burden. Blood panel revealed no signs of decompensated cirrhosis. A marked elevation in alpha-fetoprotein level (>1210 ng/ml, normal range<8ng/ml) was noted. The contrast enhanced abdominal CT scan revealed a 5.6/7 centimeters hepatic lesion with typical features of HCC. She underwent resection of liver segments II and III under a pre-operative diagnosis of hepatocellular carcinoma. The diagnosis of HCS was made by the histopathological examination; a panel of immunohistochemical markers helped establishing the complete diagnosis. Because of the multiple cardiac comorbidities, chemotherapy could not be started. Four months after surgery the patient presented bulky tumor recurrence at the level of the hepatectomy, and lung metastases. The oncological evaluation recommended best supportive care.

13 Gastric Neuroendocrine Carcinoma

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BACKGROUND
Gastric neuroendocrine carcinoma is a rare tumor, comprising < 1% of stomach cancers. Neuroendocrine carcinoma is a tumor with rapid growth, high grade malignancy and poor prognosis.
CASE REPORT
A 60-year-old man was referred to the Digestive Oncology Department of Fundeni Clinical Institute, Bucharest, with diarrhea, flushes and a large ulcerated mass in the upper stomach. Histopathological and immunohistochemical diagnosis was obtained through gastric biopsy: neuroendocrine carcinoma with small cells with a Ki67 proliferation index of 90%. Contrast-enhanced computed tomography (CT) revealed cardia tumor, infiltrating subdiaphragmatic oesophagus and lesser curvature, with intraabdominal adenopathies and multiple liver metastases.
In March 2014, palliative chemotherapy with Etoposide/Cisplatin was started. In August 2014, Sandostatin LAR 30mg/28d was added. He achieved partial remission, with a decrease in size of liver metastases and of the primary tumor.
After a year, in March 2015, patient had progressive disease. He received mFOLFOX6 as second line of therapy but with early progressive disease at follow-up. Etoposide/Cisplatin was rechallenged and the patient developed grade 3 neutropenia.
Next eight months we treated patient only with somatostatin analogue. His performance status has gradually worsened over time.
DISCUSSIONS
Even though neuroendocrine carcinoma doesn't have indication for treatment with somatostatin analogs (SSA), our patient received the treatment with octreotide, for the carcinoid syndrome. Somatostatin analog led to symptom control and probably had antiproliferative properties that increased patient's survival.
Keywords: gastric neuroendocrine carcinoma, carcinoid syndrome, somatostatine analogues

14 Metastatic neuroendocrine rectal tumor – case report

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BACKGROUND
Neuroendocrine tumors of the digestive tract are rare neoplasms, with rectal tumors being 5%-14% of all neuroendocrine tumors. Prognosis in metastatic disease is poor with scarce data regarding specific treatment. Herein we describe a case of rectal neuroendocrine metastatic tumor in a patient with total thyroidectomy for papillary carcinoma and active acromegaly.
CASE REPORT
A 63-year-old male with a personal history of thyroid papillary carcinoma (15 years ago), was admitted in the Fundeni Clinical Institute for rectal bleeding constantly present for 3 weeks and constipation for 4 months. Clinically, the patient had an enlarged jaw, macroglosia and hepatomegaly. Rectoscopy demonstrated a rectal multilobulated mass, 35 mm in diameter, located 5 cm from the anus. CT scan showed an invasive loco-regional rectal mass with multiple liver metastases, ascitis and right pleural effusion. The histopathology evaluation identified a neuroendocrine tumor NET-G2. Also, a diagnosis of active acromegaly (high IGF-I) with secondary type II diabetes was made.
The patient underwent rectal resection with definitive colostomy prior to initiation of palliative chemotherapy (Oxaliplatine/Capecitabine) and Octreotid LAR 20 mg/28d was added. Three months later, in the absence of response to the first-line chemotherapy and presence of anemia 8 g/dl, a switch to Cisplatine/Etoposide was decided, but after the first cycle, the patient presented marked agitation and confusion. The cerebral CT scans revealed multiple non-specific frontal lesions. Patient died 2 weeks later, 8 months after initial diagnosis.
DISCUSSIONS
This is a case describing the sequence of two endocrine tumors: thyroid papillary carcinoma and neuroendocrine rectal tumor, and the association with other endocrine pathologies: active acromegaly and diabetes mellitus type II. While the first tumor was cured, a rapid, multi-metastatic progression of the second neoplasia was observed.

15 Metastatic Gastric Neuroendocrine Tumor with Transition from G2 NET to Small Cell NEC

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BACKGROUND
Gastric neuroendocrine neoplasms (NEN) represent rare entities, the gastric localisation representing 6.9% of all digestive NENs. They are being increasingly recognised due to the expanding indications and disponibility of the upper gastrointestinal endoscopy, as well as to the higher awareness of the practitioners.
CASE REPORT
This is a case report of a 37 years old female patient who was admitted to the Digestive Oncology Department of Fundeni Clinical Institute, Bucharest, in February 2014. She was diagnosed with a bulky gastric neuroendocrine tumor (G2), initially non metastatic, and underwent curative intent surgery.
Two months after surgery, 2 hepatic lesions were identified on the surveillance CT scan. She received palliative chemotherapy with Capecitabine/Temozolamide, achieving complete remission after 6 months of treatment.
In June 2015, after 6 months of complete remission, the patient stopped chemotherapy and underwent only close surveillance.
Three years later, in April 2018, she developed 2 new hepatic lesions, along with a left ovarian tumor. She underwent another surgical procedure (left adnexectomy and hepatic nodule biopsy). The histological report shows that both lesions were metastases of Small Cell NEC.
In September 2018, the patient restarts chemotherapy following the same protocol (Capecitabine/Temozolamide).
DISCUSSIONS
This is a rare case of a metastatic gastric NET G2, with a long term disease free survival (3.5 years) following surgery and Capecitabine/Temozolamide chemotherapy, with transition from NET G2 to Small Cell NEC over time.
Keywords: gastric NET, neuroendocrine tumor, Capecitabine/Temozolamide, gastric NEC, neuroendocrine carcinoma, chemotherapy, transition, liver metastases