Subject: [CARCINOID] another research reference - part 1 (part 2 sent earlier)
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this was listed in an oncology review – (splitting into two parts to send)

TAKE-HOME MESSAGE

This cohort study evaluated outcomes in 363 asymptomatic patients with stage IV small intestinal neuroendocrine tumors and distant metastases.

No difference was found in overall survival between the 161 patients who underwent prophylactic surgery within 6 months of the diagnosis and the 202 patients who were treated nonsurgically or with delayed surgery (median, 7.9 vs 7.6 years, respectively). Nor was there a difference in cancer-specific survival (median, 7.7 vs 7.6 years, respectively).
Written by
[http://www.practiceupdate.com/author/thorvardur-halfdanarson/2844 | Thorvardur R. Halfdanarson, MD

The role of primary tumor resection in patients with small bowel neuroendocrine tumors (SB NETs) metastatic to the liver and other organs is controversial. Most practitioners agree that patients with symptomatic primary tumors should undergo resection, even in the presence of distant unresectable metastases. It is therefore very important to carefully inquire about symptoms, especially symptoms of intermittent partial small bowel obstruction. The role of resection of asymptomatic primary tumors in patients with distant metastases is much less clear.

A recent cohort study from the Uppsala University in Sweden attempted to determine the association of locoregional surgery with outcomes in patients with asymptomatic SB NETs and distant metastases. 1 A total of 161 patients with metastatic SB NETs without abdominal symptoms who had prophylactic upfront surgery within 6 months from diagnosis combined with oncologic treatment were compared with 202 similar patients who did not undergo resection of the primary tumor. The measured outcomes included overall survival, length of hospital stay, postoperative morbidity and mortality, and reoperation rates. Prophylactic upfront primary tumor resection conferred no survival advantage in asymptomatic patients with metastatic SB NETs. Delayed surgery as needed was comparable in all examined outcomes and was associated with fewer reoperations for intestinal obstruction. In other words, resection of primary SB NETs was not beneficial in this asymptomatic patient population.

A careful history-taking will reveal symptoms from the small bowel primary in up to half of patients, and the most common symptoms are abdominal pain, nausea and vomiting, and weight loss. 2 These symptomatic patients will benefit from resection of the primary tumor. Some patients will retrospectively appreciate that there were symptoms from the primary tumor, but only after the resection has taken place. 3

Multiple retrospective studies have suggested improved survival in patients whose primary tumors were resected, but many of these studies suffer from potential biases, especially selection bias where more fit patients with less extensive disease were more likely to undergo resection. 4,5 A recent study suggested that resection of symptomatic primary SB NETs could improve survival. 6 In this study, the authors attempted to adjust for other prognostic factors including high tumor load. The question still remains, is the observed survival in resected patients a real phenomenon or the result of a bias wherein patients who would otherwise have done better were preferentially selected for an operation?

Guidelines on the surgical management of SB NETs have been published by the North American

and European Neuroendocrine Tumor Societies (NANETS and ENETS). 7,8 The NANETS guidelines recommend considering resection when feasible to relieve symptoms and avoid future symptoms and for potential survival advantage, but also state that survival of asymptomatic patients receiving systemic therapy is long and that the risks of resection need to be weighed against the benefits. 8 ENETS recommends resection for symptomatic patients but does not specifically address asymptomatic patients other than to state that there may be a role for resection to prevent later complications.

The study by Daskalakis does not support resection of asymptomatic primary tumors and suggests that a conservative approach delaying the primary tumor resection until symptoms arise is a safe approach, and the findings should be incorporated in future guidelines. 1 A prospective, randomized trial is needed to adequately address this important question, something that is already underway for patients with metastatic colorectal cancer, where this question frequently arises. Until then, the decision of primary tumor resection in asymptomatic patients should ideally be made after a multidisciplinary evaluation of the patient.