Webinar 2 – Questions and Answer Summary

1,"In general, is the behaviour of pNETs in Von Hippel Lindau disease more or less aggressive than sporadic or MEN-related tumours"

A: There is a general belief that panNET with a genetic background are less aggressive rather than sporadic ones. However, in the context of genetic background panNET are usually recognized when small in size, thus justifying the feeling of a more indolent course.

2,"Good evening, Prof Falconi, thank you for the presentation. What are resection margins accepted today for PaNEN?"

A: In case of an enucleation, margins are considered as R1. R1 resection are associated with a worse PFS, but does not influence OS.

3, Christos Dervenis We heard that Benign and malignant PanNETs have different genomic profiling can we use this for our decision making for surgery instead of size which is sometimes a "dangerous" indicator?

A: There are some ongoing researches on this point on cytological samples. Our group is working on, along with JH, on this issue for research purposes. However, we are still far from using genomic profiling in the clinical setting.

4,"Can you please comment on the differences between DOTATOC, DOTANOC and DOTATATE for PET imaging",

A: live answered

5,Christos Dervenis I fully agree with Massimo that we should always balance oncological risks against surgical risks. Based on this should we act differently whit the tumor location Body vs. head in small tumors?

A: live answered

6,Thank you for the answer. Do you consider an extempo pathology analysis during the surgery for R0 ? or this does not make sense ? also fluorescence imaging preop does it has any beneficial role ?

A: live answered

7,"Thank you both for great talks. In cases of metastatic NET, especially to the liver, opinion varies on the relationship between disease burden and response to PRRT. In your opinion, is it necessary to debulk large liver metastases in order for PRRT to be more effective, or is response/ success independent of disease burden?"

A: live answered

8,"Marcello Di Martino, Madrid, Spain. For Prof. Falconi: what's your treatment strategy por NE Cancer (poorly differentiated). Would you consider upfront surgery?",

A: live answered

Webinar 2 – Questions and Answer Summary

9,What is the role for ablative therapies for PNENs.

A: live answered

10,"Dr Falconi - how would you manage a patient with MEN 1 with 3 tumours in pancreas in head, body and tail on Ga DOTATATE scan, 2 of them being > 2 cm in size with one positive lymph node in periportal area."

A: live answered

11,"Measurements of the same tumour on CT, MRI and EUS often differ by several mm. Which one determines whether to operate or not, Massimo"

A: We usually take the decision based on the largest measurement, as for Ki67 proliferative index: the highest one determines the grading.

12,"how would you approach a patient. with MEN 1 Syndrome with ,two NON FUNCTIONING PNet 1. lesion one in head measuring 8x6mm 2. lesion two in tail pancreas ms. 8x9 mm histopathology EUS guided biopsy of pancreatic head lesion suggestive of a G1 disease",

A: live answered

13,"To Prof. Falconi: in case of multiple liver mets, do you perform multiple biopsies to assess different G to guide the optimal treatment?"

A: It would be great and right to do it, but, practically, it is almost impossible. What we try to do is to target the biopsy to the lesion with highest SUV at 18F-FDG PET, if available, or to that lesion which radiological appearance looks like less vascularized. In any case if the liver tumoral burden is high we always perform a double tracer PET-CT, to properly assess the aggressiveness.

14,"Thank you for the two great talks. i have two questions for prof Fanconi, what kind of EUS guided biopsies are you using (size of FNB) and is there any role for FNA with cell block techniques?

A: Incredibly, in our center, the referral pathologist prefers to have, from pancreatic primary, cytology instead of biopsy, since the cells amount is larger rather than biopsy, he says. Experiences are quite heterogenous in current the Literature. For liver mets, always biopsy.

The second question is regarding criteria for liver mets resection do you use? number or size of mets?"

A: We usually adopt the Frilling's criteria described in Br J Surg Br J Surg. 2009 Feb;96(2):175-84. Grading, however, should represents the more important driver for the decision, beyond any technical feasibility issue. Never G3 upfront.

15,"Great talks. Thank you. Rashid Nashidengo, HPB surgeon in Windhoek, Namibia. In debulking liver mets, would one aim for R0 or R1. Is R2 acceptable? Any survival benefit between R0, R1 or R2?"

Webinar 2 – Questions and Answer Summary

A: All published surgical series are, unfortunately, retrospective, and then, by definition, deeply biased. There are many articles published at this regard and, keeping well in mind the previous limitation, almost all favor the resection. One example is in Partelli, et al Neuroendocrinology 2015;102(1-2):68-76. A R2 resection, in my personal opinion, is acceptable for low grading tumors and in the contest of a comprehensive strategy discussed at MDT.