Pedunculated gastric neuroendocrine tumor: a case report

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Introduction

Neuroendocrine tumors (NETs) are neoplasms that develop from neuroendocrine cells of diffuse neuroendocrine systems. Gastric NETs are rare lesions, representing approximately 7% of all NETs and less than 1% of all stomach neoplasms [1]. According to the histologic classification of tumors developed by the World Health Organization in 2010, NETs are classified into 3 types based on the rate of mitosis and Ki-67 labeling index; the NET G1 type is synonymously referred to as carcinoid. Gastric NETs are usually discovered as submucosal tumors during upper gastrointestinal endoscopic examination. This study reports a rare case of pedunculated gastric NET. The lesion was found as a result of gastroendoscopy. The gastric lesion was a pedunculated polyp with a reddish head. We performed endoscopic submucosal dissection and an en-bloc resection of the gastric lesion. The resected specimen was evaluated histopathologically and diagnosed as a carcinoid (NET G1).

Case Report

An 87-year-old man was hospitalized because of abdominal pain. He had a history of hypertension and was taking medication to lower blood pressure (enalapril maleate 2.5 mg/day, amlodipine besilate 5 mg/day). We performed gastroendoscopy to search for disease of the gastrointestinal tract and found a polypoid lesion in the stomach.
mogranin A and synaptophysin (Fig. 4). Although pseudopyloric glands were not observed, endocrine cell micronests (ECMs) were observed. The Ki-67 positive index was less than 2%. Thus, the lesion was finally diagnosed pathologically as an NET G1, pM-pSM, ly0(D2–40), v0(EM), pHM0, pVM0 (Fig. 4). Computed tomography showed no evidence of pituitary tumor or pancreatic tumor. The serum gastrin level evaluated 9 months after the patient stopped taking a proton pump inhibitor was elevated at 552 pg/ml (normal range: 42–200 pg/ml). We biopsied the mucosa of the gastric antrum, and found no evidence of over-expression of G cells pathologically. Chronic gastritis was widely seen endoscopically, and the Helicobacter pylori antibody titer was markedly increased at 24.3 U/mL (normal range: < 10 U/mL). The serum level of vitamin B12 was 879 pg/mL (normal range: 233–914 pg/mL), and serotonin was 154.5 ng/ml (normal range: 81–262 ng/ml). The results for anti-parietal cell antibody and anti-intrinsic factor were negative.
After extended consultation with the patient and his family, who preferred to avoid surgical treatment, we decided on a strategy of close monitoring without additional surgical treatment. We checked the condition of the patient periodically, and computed tomography and gastroendoscopy showed no evidence of local or other metastatic recurrences. One year after the ESD was performed, the patient was in good condition without carcinoid tumor recurrence.

Discussion

Gastric NETs are classified into 3 subtypes: Type I lesions arising in patients with chronic atrophic gastritis, including autoimmune gastritis and H. pylori-associated atrophic gastritis; Type II lesions associated with gastrin-producing neoplasms in patients with multiple endocrine neoplasia or Zollinger–Ellison syndrome; and Type III gastric lesions, which are sporadic carcinoids without specific background factors [7]. In this case, the disease was negative for both anti-parietal cell antibody and anti-intrinsic factor. However, the gastric mucosa was highly atrophic, with H. pylori infection, elevated gastrin, and the presence of ECMs. Hence, we diagnosed the lesion as a type I gastric carcinoid.

The aim in treating gastric NET should always be to maintain good quality of life for as long as possible [4]. Carcinoids generally have an excellent prognosis, especially type I gastric carcinoid tumors, which have low malignant potential and low frequency of metastasis [4,7,8]. Patients managed by lesion resection and endoscopic follow-up have a 100% survival rate when the lesions are confined to the submucosa and there are no metastases during observation [8]. In many cases surveillance only is appropriate, although limited surgery with endoscopic polypectomy and/or antrectomy may be preferable [4].

In the current case, the patient had hoped for endoscopic treatment of his gastric lesion. ESD is reportedly more feasible than endoscopic mucosal resection for removal of type I gastric carcinoid [7]. Complete histologic resection was performed by ESD in the current case, and no complications such as bleeding or gastric perforation occurred during or after endoscopic treatment. If polypectomy had been performed for this lesion, the cut edge of the tumor would have been positive for neoplasia, because the carcinoid tumor had invaded to the level of the submucosal layer in the stalk of the polyp.

Pedunculated carcinoid tumor is very rare, and there are only a few previously reported cases [9,10]. However, the previous reports did not contain detailed endoscopic findings or images of pedunculated carcinoid tumor. In this report, we describe detailed endoscopic findings of pedunculated carcinoid tumor with endoscopic images (Fig. 1, Fig. 2). As this was our first case of pedunculated gastric carcinoid tumor, we did not initially consider the lesion a carcinoid tumor. This case shows that it is difficult to immediately diagnose a NET based on endoscopic findings. Based on the endoscopic findings in the current case, we initially believed that the lesion was potentially a hyperplastic polyp or neoplastic lesion with strong inflammatory changes on its surface. Fisher reported that a pedunculated gastric carcinoid develops because peristalsis causes formation of a pedicle and a pedunculated polyp [9]. Peristalsis could misalign the carcinoid tumor and the gastric muscle layer, and cause the tumor to extend to the submucosal layer toward the inner cavity. Because gastric carcinoids are slowly progressive tumors, they change shape slowly over time from a semi-pedunculated to a peduncu-
lated polyp. In the current case, because the patient had never had an endoscopic examination, the gastric carcinoid grew slowly and gradually formed into a pedunculated polyp. Furthermore, the tumor mass was located in the stalk, which was recognizable as a bulging area of the tumor stalk (Fig. 1, Fig. 2), and served as a prop by forming a solid part of the stalk.

Because our institute (Kakunodate Municipal Hospital) did not have an ultrasonographic endoscope, we were not able to perform endoscopic ultrasonography (EUS) of the lesion, which might have provided more detailed information regarding the submucosal layer. In cases of pedunculated gastric lesion where the lesion originates from the submucosal layer or the lesion may potentially have invaded the submucosal layer, EUS provides valuable information that helps in selecting the treatment strategy.

Competing interests: None

Acknowledgements

The authors wish to thank Yasuhumi Omori, MD, PhD, and Aki Nishijima-Matsunobu, MD, PhD, from Akita University Graduate School of Medicine, Department of Molecular and Tumor Pathology, for evaluating the histopathologic findings of our case.

References