INTRODUCTION
Gastrointestinal tract neuroendocrine tumors (NET) are relatively rare neoplasms, diverted from the diffuse endocrine system (DES) and classified as apudoma (APUD). These neoplasms include pancreatic endocrine tumors and carcinoid tumors of the digestive tract.

Although malign, the digestive NET have slow growth, but also metastatic potential. They represent a heterogeneous group of tumors, rare (approximately 1% of all malign tumors), with a rate of incidence of 2-3/100,000 inhabitants/year (1, 2). The digestive NET are classified depending on the location and dimension of the primary tumor, the tumor grading, the markers of cell proliferation, the local and vascular invasiveness and the production of active biological substances [3, 4].

The main types of digestive NET are:

• Endocrine tumors well differentiated characterized by a low malign index, which are aggressive especially due to metastases presence
• Endocrine carcinoma poorly differentiated with a high grade of malignity and a bad prognosis
• Endocrine and exocrine mixed tumors

Gastro-entero-pancreatic endocrine tumors can generate specific symptoms due to hormonal hypersecretion. The diagnosis is based on the clinical arguments, the dosage of hormone, the imagistic methods of primary tumor and metastases detection as well as on the scintigraphic methods. The golden standard is the histological diagnosis which has to be obtain as many times as possible. The curative treatment is, obviously, the major objective, but such a treatment is rarely possible, because of the discovery in a late stage, 40%-70% of the patients already have liver metastases at the diagnosis time [5, 6]. The surgical treatment is the only curative one. Often, the patients come to the hospital as an emergency (occlusion, appendicular syndrome), and the histopathology detects a neuroendocrine tumor, in such cases a radical intervention, within oncological limits is to be considered, for a loco-regional assessment.

Chemotherapy brings benefits especially in poorly differentiated forms, using schemes that associate etoposide and cisplatin [5].

Chemoembolization is used in unresectable NET for tumor mass reduction, with a symptomatic and survival improvement. The clinical cours of these patients is sometime unpredictable, there are some factors that influence their clinical evolution [14,15]:

Factors associated with poor prognosis

<table>
<thead>
<tr>
<th>Liver metastases</th>
<th>Extent of liver metastases</th>
<th>Lymph nodes metastases</th>
<th>Bone metastases</th>
<th>Development of ectopic Cushing’ syndrome</th>
<th>Rapid tumor growth (in liver)</th>
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Factors associated with aggressive clinical course and development of liver metastases

<table>
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<tr>
<th>Tumor size over 3 cm</th>
<th>Female gender</th>
<th>Absence of MEN1 syndrome</th>
<th>Increases serum gastrine level</th>
<th>Primary localization in pancreas</th>
<th>Results of flow citometry (high S phase)</th>
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In Romania, about 1.3 million people suffer from a rare disease in their lifetime. Although a low prevalence in the population, rare diseases can be considered a public health priority, as their consequences are numerous and occur on many dimensions (diseases generating death, invalidity, high economic and social costs, etc).

Gastric neuroendocrine tumors (NET), mainly through their metastatic potential, is a type of tumors with unfavorable evolution. Because of their potential to increase their size and volum, the therapeutic approach of these forms is complex, phased and multi-disciplinary. The case we presented strengthens the necessity for using a multisectoral approach in case management of rare diseases, as neuroendocrine tumor is.

The late presentation of the patient, with a tumor having significant dimensions, as well as the absence of other evocative symptoms of an secreting tumors derived from the diffuse endocrine system, requires an inter-disciplinary approach to solving the case with preoperative chemical embolization extremely useful for reducing tumor volume.

Detection, diagnosis, treatment, monitoring and subsequent supervision of the case must be achieved through collaboration and active participation of a multidisciplinary medical team.

Keywords: Giant neuroendocrin tumor, therapeutic management, mutidisciplinary approach, case study.

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We are presenting a gastric NET case, operated in our clinic.

Clinical case – Giant gastric neurenoedocrine tumor, operated in the 1st Surgery Clinic from Tg. Mureș

The case of a 46 years old patient, without other notable co-morbidities, was submitted to our service for diffuse abdominal pain and increase in volume of the abdomen.

The initial evaluation included the complete medical history and the physical examination by body systems. From the medical history we noted that the disease started in a insidious way, by graduated increase of the abdomen volume, followed by the appearance of a diffuse abdominal pain, unsystematized, unconditioned by food intake effort, position or by well established timing.

General clinical exam on admission revealed: moderate general condition, normal weight patient, hemodynamic and respiratory stable, apyretic, pale-sallow teguments and mucosa, evoking neoplastic impregnation.

Local exam: mobile abdomen, moving with breathing, relaxed, asymmetrically increased in volume at epigastric and left hypochondrium level, painful on superficial and profound palpation on epigastric and left hypochondrium level, where is noted the presence of a tumor about 9 cm in diameter, mobile against the profound levels, imprecisely delimited, painful on palpation; intestinal transit is present; good digestive tolerance.

Laboratory investigations were within normal limits.

CT scan reveals a space replacing process, localized in the left hypochondrium, native and post contrast inhomogeneous, with a polilobate contour and the dimensions of 109/130/189 mm.

At 48 hours preoperative, after an interdisciplinary review af the case with the oncologist and the interventional radiologist, has been established the opportunity of a chemoembolization of the left gastric artery with 400 mg of 5 FU, using a femoral
Figure 3. Final aspect postembolization

Figure 4. The aspect of the surgical resection piece

approach with the complete obstruction of the left gastric artery using Tachocomb pellets, arteriographically objectified, for the purpose of tumor mass reduction and to facilitate the surgery (Figure 1,2,3).

Surgery is required practicing a left subcostal incision which reveals a giant gastric tumor which penetrates the pancreas, transverse mesocolon and the celiac trunk. The liver and the other abdominal organs presented normal macroscopic aspect. Total gastrectomy with terminal-lateral esophago-jejunoo anastomosis on omega loop with Braun fistula has been performed (Figure 4).

There were no special anesthetic problems registered, during the entire surgical intervention the patient was stable regarding the blood pressure.

Postoperative evolution was favorable, with resumption of the transit on the third day postoperative, enteral nutrition started on day 7 and the patient was discharged after 12 days from the surgical intervention.

The postoperative result of the histopathological examination from the resection piece showed a gastric neuroendocrine carcinoma with a high grade of malignity which infiltrates the entire gastric wall, with the serosal invasion and tear and produces metastasis in 1 of 11 lymph nodes of the greater curvature and in 1 of 6 lymph nodes of the lesser curvature.

After the definitive histopathological result the patient was send to oncology for chemotherapy.

At present time, after 2 months from surgery, the patient presents a good general condition and will undergo control endoscopy and computer tomography (Figure 5, 6, 7 8, 9).

DISCUSSIONS
The presented case was a rare pathology. It is a neoplastic disease having a starting point the cells of diffuse endocrine system (DES).

Neuroendocrine tumors can be sporadic or in multiple endocrine neoplasia syndromes (MEN I); the risk of a person with a 1st degree relative suffering from a neuroendocrine tumor is 4 times greater than general population.; a recent populational study showed that about 20% of those with NET will develop another neoplasm, more frequent a digestive one.
metabolite is 5HIAA), histamine (its urinary metabolite is methylimidazole acetic acid), tachykinins, P substance, A neurokinin or K polypeptide, which are responsible for the flush and can be an early indicator of the carcinoid syndrome.

Carcinoid syndrome usually appears late in the disease evolution, accompanied by the liver metastases, as a result of hormonal hyper secretion and is classically described as the association of flush and diarrhea. Less frequent, the patients can present a pelagroid syndrome, wheezing or palpitations (the cardiac and pulmonary disease usually appears after years of carcinoid syndrome evolution) [3, 7, 8].

Carcinoid crises characterized by an intense flush, bronchospasm, tachycardia and blood pressure instability, is usually caused by the anesthetic drugs, intraoperative mobilization of the tumor or by other invasive procedures such as radiofrequency ablation or chemoembolization.

Pancreatic NET secrets one or more hormones, either those normally secreted by the endocrine pancreatic cells (insulin, glucagon, somatostatin), or the non-pancreatic hormones such as adrenocorticotropic hormone [9]. The most frequent pancreatic NET is represented by insulinoma. As a result of the insulin hypersecretion the patients presents hypoglycemic symptomatic episodes with dizziness, confusion, sight disorders and even coma. The insulin and the C peptide determination confirm the diagnosis. The glucagonoma is a glucagonoma secreting tumor with two main clinical manifestations: the presence of a migratory necrosant rash and of the diabetes mellitus (by glycogenolysis and hepatic gluconeogenesis hyper stimulation, in other words hyperglycemia), with an usually increased insulin level (the ketoacidosis occurrence is rare in these patients). The diagnosis is based on the glucagon determination, whose level is

Carcinoid tumors can be localized anywhere at the digestive tract level, but more frequent they are found near ileocaecal valve.

They can be asymptomatic or they can generate obstructive symptoms. The clinical symptoms are the expression of the hormonal hyper secretion. The substances released by a carcinoid tumor include: serotonin (its urinary

Figure 5. Gastric wall with gastric mucosa and underlying with tumoral formation (neuroendocrine carcinoma)

Figure 6. Tumoral cells present cytoplasmic positivity on Chromogranin immunomarking
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increased, and by demonstration using imagistic methods of a pancreatic tumor [7, 10].

Somatostatinoma is usually confused with pancreatic adenocarcinoma. Clinically the patients present an obstructive jaundice, the tumors having large dimensions. The somatostatinoma is associated with diabetes mellitus, diarrhea, steatorrhea and lithiasis caused by the biliary stasis.

Gastrinoma (Zollinger-Ellison syndrome) produces multiple and recurrent ulcers, with frequent postbulbar localization, recurrent after surgery. The gastrinoma is associated with diarrhea and steatorrhea due to pancreatic enzymes inactivation by acid excess, and with esophagitis. The diagnosis is based on gastrine determination.

VIPoma is a rare tumor that produces watery and profuse diarrhea and pronounced hypokalemia caused by hyper secretion of the vasoactive intestinal peptide (VIP). The diagnosis is made by determining the VIP and highlighting the tumor through imaging (hypervascular tumor) [5, 11].

At a patient with clinical suspicion of NET, according to the current recommendations, one must first determine chromogranine A and 5HIAA and as a second line of tests, depending on the clinical suspicion: serum gastrine, insulin and C peptide, glucagon, VIP, somatostatin.

Also, chromogranin A levels are increased in carcinoid tumors and can be used for disease progression [12, 13].

For tumor detection it is necessary a multimodal approach that includes: CT scan, MRI, endoscopy, echoendoscopy, somatostain receptors scintigraphy (the most sensitive method for metastases detection and tracking necrotic NET).

The prognosis of these tumors differs, the literature agrees that prognosis concerning the localization is the best for carcinoid tumors of the appendix, following in a decreasing order: rectum, intestine and stomach.

The case we presented had an immediate favorable evolution, but requires further clinical and biological evaluation.

CONCLUSIONS
The particularity is represented in this case by the late presentation of the patient, with a tumor having significant dimensions, as well as the absence of other evocative
symptoms of an secreting tumors derive d from the diffuse endocrine system. Also the particularity of this case is represented by the necessity of an interdisciplinary approach of the tumor with preoperative chemoembolization extremely useful for the reduction of the tumoral volume. Another particularity was represented also by the surprising histopathological result. The case we presented strengthens the necessity for using a multisectoral approach in case management of rare diseases, as neuroendocrin tumor is. Detection, diagnosis, treatment, monitoring and subsequent supervision of the case must be achieved through collaboration and active participation of a multidisciplinary medical team.

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NEWS FROM THE LATIN ASSOCIATION FOR THE ANALYSIS OF HEALTHCARE SYSTEMS

The Latin Association for the Analysis of Healthcare Systems (ALASS) was created in January 1989, with the aim of contributing to issues in the healthcare systems within the Latin countries healthcare systems, through the sharing of experience and the acquisition of new skills among healthcare professionals (doctors, managers, health economists etc.) and researchers from different countries with a common characteristic, i.e. the Latin culture. This common culture is seen in the perception of the quality of life, the behaviour towards the prevention of diseases and the utilisation of the healthcare services, despite concomitant national, regional and local peculiarities. ALASS has about 300 individual members (majority of whom are from Europe) and 30 institutional members from 25 countries in different continents. Last year, ALASS organized, for the first time, a congress in Latin America (Mexico) with professionals from European, Northern and Southern American joining the local participants. “2010 was a year of new hopes for us”, the Mexico congress was an important step to get “closer to our vision which is to effectively be a Latin organization”, said Prof Anamaria Malik (Brasilia), president of the association at the press conference organized in that occasion. Romania has always been represented in ALASS, and organized an ALASS congress in Bucharest in 2004. The institutional members from the National School of Public Health and Health Services Management and the Romanian Association of Public Health and Healthcare Management. Several Romanian individual members are regular participants in the ALASS scientific events dedicated to various themes of interest in the field of public health and healthcare management.

Useful information on the advantage of becoming an ALASS member and on how to do it can be found on the website of the association (www.alass.org). Visiting the website regularly, detailed information can be found about the main scientific manifestations of the association, e.g.: the annual congress (CALASS) which lasts for three days the one day workshops organized each trimester and the summer school in management of health services (UDEASS), consisting of five courses lasting one week each. CALASS 2011 will focus on the governance in healthcare organizations and will be held in Lausanne (Switzerland) lasting from the 1st-3rd of September. The first two workshops in 2011 will be held in Italy: one focusing on the networks in healthcare and will be held in Ancona, on the 27th of May, and the other focus ing the assessment of doctors’ services and will be held in Milan, on the 17th of June. The annual congress could be attended by any professionals who are interested. The number of participants for the workshops is limited (maximum 25-30). UDEASS 2011 will be hosted by the University of Luxembourg, from the 18th to the 22nd July. The proposed courses are: healthcare technologies assessment, tsocial marketing, human resource management, clinical pathways and qualitative research in healthcare. The courses will be taught in French (except the last one which will be in Spanish and could be attended by maximum 20 participants per course (www.udeass.lu).

Any professionals who share the ALASS mission and vision, and believe that the scientific events of the association could help them to cope with their day-to-day challenges in their professional activity, are warmly invited to contact us (email: alass@alass.org).