Clinicopathologic Characteristics and Multidisciplinary Treatment of Neuroendocrine Carcinoma of Gallbladder: Report of Three Cases with an Update

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Abstract

Primary neuroendocrine carcinoma of gallbladder (GB-NEC) is extremely rare and the clinical presentations of most patients are nonspecific. Pathological examination and immunohistochemical staining are required for the diagnosis of GB-NEC. It has a poor prognosis and often escapes detection until advanced stage. Because of rarity of GB-NEC, there is limited evidence about its clinicopathologic characteristics, treatment and prognosis. Here we reported three cases of incidental metastatic GB-NEC. Multidisciplinary treatments were adopted and they present good response and had long survival. We aimed to provide a comprehensive literature review on GB-NEC and compare it with carcinoma of gallbladder and neuroendocrine neoplasms of other origins.

Keywords: Gallbladder; Neuroendocrine carcinoma; Neuroendocrine tumors; Chemotherapy; Multidisciplinary treatment

Introduction

Neuroendocrine neoplasm (NEN) is a heterogeneous group of tumors originating from neuroendocrine cells located throughout the body, most commonly in the lung and gastrointestinal tract [1]. Data from the surveillance, epidemiology, and end results (SEER) database indicates the incidence of NENs is about 2.5–5/100,000 people [2]. NENs occur in the gallbladder are rare and only account for only 0.5% of all NETs and 2% of all gallbladder tumors [3]. Because of aggressive biological behavior and lack of specific symptoms, patients are often diagnosed at advanced stage when radical surgery is not available. Three cases we reported all underwent a multidisciplinary therapy and showed good responses.

Case Report

Case 1

A 66-year-old male complained of back pain for 1 week. Physical examination was negative. A thick-walled gallbladder with liver invasion was visualized by computed tomography (Figure 1). ECT indicated multiple bone metastases. 99mTc-somatostatin receptor scintigraphy (SRS) was positive throughout the body. Diagnostic liver biopsy was thereafter performed. Immunohistochemistry revealed strong expression of CgA, Syn, CK and CD56. Ki-67 index was 30%. Blood level of CgA was within normal limits. Considering the tumor is unresectable at this stage, chemotherapy, transarterial chemoembolization (TACE), radiotherapy of gallbladder region, somatostatin treatments were adopted based on multidisciplinary team (MDT) discussion. The chemotherapy regimen consisted of cisplatin 100 mg/m² given intravenously on days 1–3 and etoposide 75 mg/m² intravenously on days 1-3, repeated every 3 weeks. The abdominal lesions were partial response (PR) after 7 cycles of this regimen (Figure 2). The patient remained stable for 15 months after the initial chemotherapy until CT scan revealed opisthion metastasis. He underwent only one cycle of IP regimen because of intolerance of nausea and vomit caused by chemotherapy. Instead, radiotherapy of opisthion was applied to alleviate pain related to the metastasis. Abdominal CT scan revealed liver metastasis in the fifth segment (Figure 2) 10 month later. The patient underwent TACE and the liver metastasis was diminished. The patient developed rapid deterioration and jaundice 4 months after TACE. The patient died due to liver failure with overall survival (OS) of 36 month.

Case 2

A 56-year-old male complained of back pain and jaundice for 1 month. An enlarged left supraclavicular lymph node with a diameter of 2 cm was found by physical examination. Abdominal CT scan revealed a polyloid intra-luminal lesion within the gallbladder with local infiltration to the adjacent live and lymph node enlargement around the hepatic hilum and retroperitoneum (Figure 3). 99mTc-SRS depicted positive of left cervical region. Blood hormone test showed her serum CgA was 125.3 ng/ml (normal range 17–34 ng/ml). Percutaneous transhepatic cholangial drainage (PTCD) and diagnostic biopsy of left suprACLavicular lymph nodes were thereafter performed (Figure 4). Immunohistochemistry was positive for CgA, Syn, CD56 and CK7. The Ki-67 index was over 80%. In January 2014, the patient underwent TACE as treatment for his liver metastases. After that, chemotherapy, radiotherapy of gallbladder region and left suprACLavicular lymph nodes were adopted. The chemotherapy regimen consisted of cisplatin 40 mg/
and irinotecan 130 mg/m² intravenously on day 1, repeated every 2 weeks. The abdominal lesions were PR after 8 cycles of this regimen. After radiotherapy of gallbladder, his abdominal lesions remained stable while left supraclavicular lymph nodes increased. Thereafter he underwent 3 more cycles of IP regimen, but the lymph nodes did not shrink, rendering him to turn to radiotherapy. As of February 2015, he was alive, with stable disease and no progression or improvement in the metastatic lesions.

**Case 3**

A 50-year-old female presented to our hospital with a history of multiple liver masses found by ultrasound occasionally for 2 weeks. No history of jaundice, abdominal pain, or other systemic symptoms was present. Physical examination was negative. The patient underwent abdomen CT scan, which revealed several hepatic lesions and a mass in the fundus of the gallbladder lumen (Figure 5). 99mTc-SRS showed positive in...
the bilateral thyroid (Figure 6). While the thyroid ultrasound confirmed multiple benign hyperplastic nodules. Diagnostic biopsy of liver was performed (Figure 7). Immunohistochemistry revealed strong positivity for CgA, Syn, CD56, CK7, and CK19. The Ki-67 index was 80%. Serum CgA was 283.7 ng/ml. The patient underwent 6 cycles of chemotherapy and TACE 3 times from July 2014. The regimen consisted of cisplatin 50 mg/m^2 and irinotecan 150 mg/m^2 intravenously on day 1, repeated every 2 wk. The CT scan performed after the third cycle revealed stable disease (SD), which was confirmed after three more cycles of chemotherapy. No recurrence or metastasis was found using CT scan until February 2015.

**Discussion**

**Symptoms**

The clinical presentations of most patients are nonspecific, such as upper abdominal pain, body weight loss and jaundice, with only 1% in all cases presenting hormone-related syndromes [3]. As with other gallbladder carcinomas, NEC can readily invade the adjacent live parenchyma and later cause biliary obstruction, making it challenging to detect at early stage. GB-NEC patients are often diagnosed at advanced stage with local invasion or distal metastases, and accordingly

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**Figure 4:** Pathological examination, H&E 200X; A: Case 1: A monotonous proliferation of small round cells with hyperchromatic nuclei and scanty cytoplasm; B: Case 2: Diffuse small round cells with scanty cytoplasm and round nucleus, Abundant necrosis and innumerable mitotic figures were seen; C: Case 3: Predominantly large sized, round-to-oval nuclei, proliferating in a solid and focal nesting pattern.

**Figure 5:** A: Case 1: 99mTc-SRS showed positive throughout the body; B: Case 2: 99mTc-SRS presented positive in the left cervical region; C: Case 3: 99mTc-SRS revealed positive in bilateral thyroid.

**Figure 6:** A: Case 1: OS 36months, PFS1 16 months, PFS2 10 months; B: Case 2: PFS 7months; C: Case 3: PFS>9 months.
have a poor prognosis. All of the three patients had no hormone-related symptoms, presenting back pain, supraclavicular lymph node enlargement, obstructive jaundice or even asymptomatic.

Biochemical markers

Serum CgA is currently the most useful general biomarker for the assessment of GB-NEC. Levels of circulating CgA are increased in 60% to 80% of patients with GEP-NETs [4]. An Italian multicenter observational study [5] demonstrated that higher CgA levels associated with metastatic disease, and that lower CgA levels in patients with extensive metastatic spread than in those with liver metastases only. In our study, the serum CgA of patient with multiple metastases was negative while other patients with only liver metastasis presented high CgA levels.

Diagnostic imaging modalities

Radiological findings of GB-NEC have been described as focal...
of each subtype need to be more clearly defined for selection of therapy and prognosis improvement.

The 2010 WHO classification of GEP-NET implied that G3 neoplasms with Ki-67 index>20% were NECs, while several studies demonstrated that this subgroup of NENs was heterogeneous and contained both morphologically well and poorly differentiated tumors with different clinical expressions, prognosis, and sensitivity to treatment. The NORDIC study found that patients with Ki-67<55% had a lower response rate (15% vs.42%, P<0.001), but better survival than patients with Ki-67>55% (14 vs.10mo, P<0.001) [12]. The data indicated that Ki-67 index should be considered for chemotherapy treatment.

**Somatostatin analogues**

Somatostatin analogues are commonly used to treat symptoms associated with hormone hypersecretion in NETs; however, data on their antitumor effects is limited. Recently, studies found that somatostatin analogues can inhibit tumor cell growth directly by modulating the signal transduction of proliferation and apoptosis [18]. The PROMID study used octreotide LAR at a dose of 30 mg intramuscularly every month until tumor progression and found that the median time to progression was 13.6 months compared with 5.9 months (P<0.001) [19]. The 2013 ASCO reported CLARINET study included 204 patients with advanced, well-differentiated or moderately differentiated, nonfunctioning GEP-NETs of grade 1 or 2 (Ki-67<10%). Lanreotide, as compared with placebo, was associated with significantly prolonged PFS (median>27 mo vs. median of 18.0 mo, P<0.001) [20]. In our study, for three poor-differentiated GB-NEC patients, chemotherapy was the dominant treatment. Case 1 (Ki-67 30%) received octreotide LAR after 7 cycles of EP regimen and no evidence of recurrence and metastasis was found for 10 months. For GB-NEC (WHO G3) patients with low Ki-67 index, somatostatin analogues may not only be considered as symptomatic treatment but also as antitumor agents.

**Radiotherapy**

Radiotherapy (RT) has not historically played a major role in the treatment of NENs. However, from the treatment of SCLCs, radiotherapy should be considered to control local recurrence or metastasis. GB-NEC mostly locates at hepatic hilar region, resulting in obstruction of biliary tracts. RT could be an optional treatment modality for achieving local control in patients with advanced GB-NECs. In our study, RT of gallbladder or abdominal cavity was adopted in 2 cases and yielded excellent local control.

**Radiofrequency ablation**

GB-NECs frequently metastasize to regional lymph nodes, the bones, and the liver. In addition, hepatic metastases not only lead to incapacitating symptoms but also decrease long-term survival. Surgery is the mainstay for curative intent, but in most of GB-NEC patients with hepatic metastases, when surgery cannot be employed, intervention therapy is adopted. TACE for neuroendocrine hepatic metastases have been shown to be an extremely effective treatment of symptoms related to the metastases and survival benefit [21]. As for 3 cases with liver metastasis, TACE was adopted and resulted in liver lesions decreased and symptoms relieved.

**Conclusion**

GB-NEC is a rare subtype of gallbladder tumor with aggressive biological behavior and poor prognosis. Most of the cases are non-hormone producing and often asymptomatic, leading it challenging.
to diagnose in early stage. Pathological diagnosis and identification of clinical stage are of vital importance. Platinum-based chemotherapy and somatostatin analogues are reference treatments for unresectable or metastatic GB-NECs. Meanwhile, Ki-67 index, biological characteristics, metastasis and complications should be considered. Radiotherapy and interventional therapy are promising to control local recurrence or metastasis. In conclusion, a multidisciplinary approach including chemotherapy, radiotherapy, biological targeted therapy and interventional therapy is the primary treatment for GB-NEC. The standardization of treatment still requires further investigations.

References

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