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Summary

Panel discussion: Pancreatic and small bowel neuroendocrine tumours

Postgraduate Teaching Programme Barcelona 2026 | Presentation

Small Intestine & Nutrition | Pancreas | Digestive Oncology

October 17, 2026

Panel discussion on neuroendocrine tumours emphasized individualized treatment decisions through dedicated multidisciplinary team meetings, balancing surgical intervention against patient fitness and disease burden.

KEY POINTS

- All neuroendocrine tumour cases should be discussed in dedicated MDT meetings, described as 100% necessary and in some countries a regulatory requirement for rare tumours
- The panel stressed that all NETs are malignant even if slow-growing, and pancreatic NETs below 1.5 cm are currently followed closely rather than immediately resected, though one centimetre tumours commonly grow to two centimetres within a couple of years
- For a 72-year-old with ischaemic heart disease and metastatic pancreatic NET, the speaker would avoid Whipple's procedure due to 5-10% morbidity and persistence of liver disease, favouring somatostatin analogues to reduce tumour burden first
- Gallium PET was discussed as a diagnostic tool that can guide surveillance decisions without biopsy, as used in the ASPEN study, though FDG PET was recommended as complementary imaging
- Biopsy-resection correlation for grading is not perfect due to tumour heterogeneity and variable Ki-67 expression in different compartments, with EUS-FNA reliability questioned in discussion
- The speaker described embolization as very good therapy with very good results when only liver metastases are present, but noted that performing Whipple's may preclude certain liver-directed therapies

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