Neuroendocrine Tumors (NET) and Nuclear Medicine

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EDITORIAL

Neuroendocrine tumors, most commonly shortened in NET, are rare diseases: every year are diagnosed less than 5 new cases per 100 thousand people¹.

The term NET groups together different types of cancer that develop in various regions of the human body. They are born, in fact, by cells with characteristics partly similar to nerve cells ("neuro") partly similar to the endocrine ones, scattered almost everywhere in the human organism. So, some NET develop in endocrine glands (such as adrenals, pituitary gland and pancreas), while others affect other organs, such as bowel and lungs. The most frequent forms are born in the digestive tract that is the so-called GEP (gastro-entero-pancreatic)². In the majority of cases, these tumors evolve slowly, but a minority of NET is very aggressive, as in the case of pheochromocytoma, paraganglioma or medullary thyroid cancer³.

A neuroendocrine tumor is often discovered accidentally, during the execution of diagnostic tests performed for other reasons. Other times it is suspected from symptoms; blood tests can in these cases reveal increased levels of hormones (such as just insulin, gastrin, etc.) or other substances produced by the tumor, particularly chromogranin A (a protein generally produced by endocrine tumors)⁴.

In order to confirm the suspected diagnosis, identify the exact location of the tumor and its overall dimensions, check if it is already widespread to other organs and if it is surgically removable, it is essential to use imaging techniques⁵,⁶.

Computed tomography (CT) is established as the primary modality, although subsequent technologies such as RMI are currently competing with the CT in the recognition of these diseases. Endoscopic ultrasound has an important role in the preoperative assessment of the pancreas where a small functioning tumor or the possibility of multiple tumors is suspected⁷.

As it is well known, these techniques show mostly the morphological aspect of the lesions, while the best technical research of these tumors is to study their functional behavior.

Functional imaging modalities – such as somatostatin receptor scintigraphy (SRS)⁸ – have great impact on patient management by providing tools for diagnosing, better staging of the disease, visualization of occult tumor, and evaluation of eligibility for somatostatin analogue treatment⁹. In fact, various tumors, classically specified as either neuroendocrine or non-neuroendocrine, contain high numbers of somatostatin receptors, which enable in vivo localization of the primary tumor and its metastases by scintigraphy with the radiolabelled somatostatin analogue octreotide. In many instances a positive scintigram predicts a favorable response to treatment with octreotide⁹. It is now well known that octreotide or other somatostatin analogues labeled with an appropriate radionuclide such as beta-emitters Yttrium-90 or Lutetium-177 are used in cancer therapy¹⁰,¹¹.

The cited SRS by means of 111-Indium labeled octreotide is in fact capable of magnify the 5 receptor subtypes of somatostatin present on the cell surface of these tumors, allowing to identify also small neoplastic agglomerates, whose definition is often difficult by conventional imaging techniques¹². This method also allows a prognostic evaluation in relation to receptor density in vivo¹³, also enabling to consider the analogues also for the therapy of these tumors in the case of positive results¹⁴ and finally, thanks to its particular sensitivity (58-100%) is able to modify the therapeutic approach in over 50% of cases¹⁵.

Recently, spatial resolution has come to represent the main limiting factor in the use of 111-Indium labeled octreotide in the diagnostic
The approach in neuroendocrine tumors. In this scenario the receptor PET with 68Ga-DOTA-octreotide is playing an increasingly important role\(^9\). Currently, 68Ga-DOTA-peptides mostly used are 68Ga-DOTA-TOC, 68Ga-DOTA-NOC and 68Ga-DOTA-TEC\(^10\). The rationale for their use as in the case of indium-labeled octreotide is due to the ability of the NET to over-express the somatostatin receptors on the cell membranes. In literature\(^19\), PET with 68Ga-DOTA-peptides is reported as a reference method for the diagnosis and staging of neuroendocrine tumours, with sensitivity and specificity respectively of 97% and 96%, well above that of CT and Octreoscan. PET with 68Ga-DOTA-peptides provides additional information compared to other radiological surveys in 21.4% of cases and leads to a change in therapeutic management in 51% of patients. 18F-DiOxyPhenylAlanine (DOPA) is an amino acid precursor of dopamine, which being a precursor of catecholamines can also be used in the study of neuroendocrine tumors. The rationale for use in the imaging of the NET is based on the ability of these tumors to accumulate and decarboxylate the amine precursors, including the dioxophenylalanine through the amino acid enzyme decarboxylase which has significantly increased levels in neuroendocrine tumors. The main use of this method is in the NET with high release of catecholamines such as Pheochromocytoma and Paraganglioma, where the methodology achieves the best sensitivity and specificity (90% and 100% respectively). The indication of 18F-DOPA for the study of both adrenal and extra-adrenal Pheochromocytoma is reported in both the presentation of the disease and the suspicion of recurrence (sensitivity 91%, specificity 95%). In addition, PET with 18F-DOPA is a highly sensitive method of identifying paragangliomas in the head-to-neck district, even those with small dimensions, due to its high target/background ratio. Furthermore generator-derived radionuclides for PET/CT imaging are promising for optimizing targeted radiotherapy by an individual patient-based approach, applying pre-therapeutic evaluation, as well as dosimetric calculations, and for measuring treatment response after radionuclide therapy\(^20\). In this way molecular targeting vectors could be used for both diagnoses (molecular imaging) and therapy (molecular targeted treatment), which is reflected in the acronym THERANOSTICS\(^21\).

The combination of structural images (CT or MRI) with functional SPECT or PET images of the same sections of the body can provide complementary anatomical and physiological information that is of great importance to diagnosis and treatment\(^22\). From the clinical point of view the application of such an imaging system is particularly used for those performances which involve a radio pharmaceutical distribution hard to be attributed to a specific anatomical region. The data obtained from the CT component also make it possible to obtain attenuation-corrected scintigraphic data, thus improving on the quality of the SPECT or PET image alone\(^23\).

In conclusion, the management of neuroendocrine tumors requires a fairly accurate diagnostic phase in which nuclear medicine plays a predominant role. Somatostatin analogues for SPECT (111In-Octreoscan and the more recent 99mTc-EDDA/HYNIC-TOC)\(^24\) or PET (68Ga-DOTA-peptides) offer better staging of the disease, visualization of occult tumour, and evaluation of eligibility for somatostatin analogue treatment.

The subsequent therapy is based on the surgical approach for the more localized and affordable forms. In presence of metastases and/or generalized forms, can be used medical treatments based on chemotherapeutics, but generally the standard of care for metastatic NETs is somatostatin analog therapy with octreotide (available in both short- and long-acting formulations) or a depot formulation of lanreotide\(^25\). But nuclear medicine, as reported, is becoming essential for radioreceptor therapy with somatostatin analogues labeled with beta emitters. The basic principle is to replace the gamma-emitting radionuclide that marks the diagnostic radiopharmaceutical with a beta emitters radionuclides. At the present time, the most commonly used somatostatin analogues are radiopharmaceuticals 90Y-DOTA-TOC and 177Lu-DOTA-TATE. All these compounds with peptides have as a critical organ the kidney for glomerular filtration and their tubular resorption, therefore the exposure threshold of this organ should not exceed the share of 25 Gy. Appropriate pre-therapy dosing estimates are therefore necessary, which in the case of Radiopharmaceutical 90Y-DOTATOC (which does not emit \(\gamma\)-rays) are based on a diagnostic examination with Octrescan, whereas in the case of 177Lu-DOTA-TATE are based on the scintigraphic detection of the \(\gamma\) emission of the therapeutic radiopharmaceutical itself. Therapy with radiolabelled somatostatin analogues with 90y-DOTA-TOC or 177Lu-DOTA-TATE is
significantly effective in NET with response rates up to 30%. In particular a study with 
[177Lu-DOTA-TATE] (Lu-PRRT) showed this to be a viable option of targeted therapy in the pancreatic neuroendocrine tumors G1-G2 (PNET) with positive results also in terms of survival with passage from 40 to 72 months of survival from diagnosis, compared to a similar control group.

It is effective therapy in over 80% of cases. Overall it is well tolerated, with mild and reversible bone marrow and renal toxicity, in particular fractioning the total dose of radiopharmaceutical\(^2\). Another very recent study showed that peptide receptor radionuclide therapy is a valuable treatment option in patients with advanced NETs, especially in small bowel\(^3\).

Alpha emitters have significantly more potent effects and various advantages compared to beta emitters\(^4\). Although a limited number of studies have been performed with alpha emitters, only a few have targeted NETs. But there is a rationale for alpha emitters, existing clinical use of alpha emitters (Bi-213, Ac-225, Pb-212, At-211, Ra-223) in various clinical applications (non-NET), and review existing literature on the preclinical and clinical use of alpha emitters in NETs\(^5\).

**REFERENCES**


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