***Case report***

**A Case Report on Neuroendocrine Tumour of Liver**

**ABSTRACT**

Neuroendocrine Tumours (NETs) represent a diverse array of aberrant cellular growths, often characterized by their unique hormonal secretion patterns and varied clinical presentations. These Tumours, arising from cells responsive to neurological signals, exhibit a spectrum of behavior ranging from benign to malignant. While neuroendocrine neoplasms (NENs) share common morphological features, their biological characteristics are notably heterogeneous, contributing to challenges in accurate diagnosis and treatment planning. A significant subset of NETs originates in the gastrointestinal tract, although they can manifest in various organs including the lungs, pancreas, and thyroid. Liver metastases, often multifocal, pose diagnostic dilemmas resembling other hepatic pathologies.

**Keywords:** Tumours, Neuroendocrine Tumours (NETs), Benign, Malignant, Liver Metastases, Prevalence, Incidence.

**INTRODUCTION**

Clusters of aberrant cells that resemble lumps or growths are called Tumours. Any of the trillions of cells that make up our bodies can be the starting point for them. Depending on whether a Tumour is precancerous, benign, or malignant, it will develop and act differently [1]. Neuroendocrine Tumours (NETs) are Tumours made of cells that react to a signal from the neurological system by releasing hormones into the circulation. Hormone production may be increased in neuroendocrine Tumours compared to normal, leading to a variety of symptoms. These growths could be malignant or benign [2]. Neuroendocrine neoplasms (NENs) are a diverse group of Tumours with unique morphological and biological characteristics [3]. Due to its non-specific clinical appearance and highly diverse radiologic characteristics, it is often misdiagnosed as another hepatic Tumour. Furthermore, the most effective therapeutic approach for raising survival rates is still surgical excision with well-defined margins [4]. NETs, a subset of extremely rare cancers account for 0.46% of gastrointestinal and bronchopulmonary malignancies [5]. Metastases from NENs primarily damage the liver [6]. Liver metastases caused by neuroendocrine disorders are often numerous and vary in size. Although miliary seeding across the liver is rare, both liver lobes are typically afflicted [7]. As hepatocytes may metabolize neuroactive amines and peptide hormones and lessen their effects, most cancers really originate in the portal venous drainage. Hepatic venous drainage, however, provides unchanged Tumour products with direct access to the systemic circulation once secondary hepatic illness manifests [3]. Merely 0.5% of all cancers are neuroendocrine Tumours. The prevalence is roughly 2/100,000, and because of the appendiceal position, there is a female preponderance under 50 years of age. The lung (22-27%) and gastrointestinal system (62–67%) are the two main primary locations.12–22% of cases involve a presentation with metastatic illness [8]. Over a 15-year period, there has been a noticeable increase in the frequency of NETs, accompanied by a drop in the proportion of cases with metastatic presentation. This suggests that the notable increase in incidence may be explained by increased detection [5].

**CASE REPORT**

A 52-year-old female, Mrs. X presented with the chief complaints of lower limb swelling for 1 month, she had no history of abdominal pain /fever/loss of appetite/loss of weight. She has a known case of type 2 diabetes mellitus and hypertension for 10 years and a heterogenous lesion of the liver. She had a past medication history of T. Glirum ½ tablet 1-0-1, T.Telma 1tablet 0-0-1, T. Ironforte and T. Prenerve 75mg 0-1-0. On general examination, her temperature was found to be 98.4℉, BP was 130/90mmHg, pulse rate was 86 beats per minute, and respiratory rate was 20 breaths/min. She had no history of allergies. Alpha Fetoprotein:2.55IU/mL. USG whole abdomen report showed a multifocal lesion seen in the liver, the largest in the right lobe of the liver- a complete cystic lesion measuring 16x15x18 cm. Vascularity seen within the solid components to meet out metastasis and bulky uterus with heterogeneous myometrial junction with adenomyosis of uterus and a heterogenous lesion measuring 3.6x3.5 seen in the right lateral wall. Abdomen Triple Phase Report showed gross hepatomegaly, large mass lesions in segments 4a, 4b, and 8, and multiple liver lesions in the wall of the liver segments. F/S/O Multifocal hepatocellular carcinoma, multiple lymph nodes at portal hepatitis, hepatoduodenal ligaments, along left gastric vessel, common hepatic artery and upper retroperitoneum, no ascites, no peritoneal deposit, no omental thickness; bilateral grade I hydronephrosis, bulky uterus with adenomyosis.

Histopathology Report showed liver space-occupying lesion, core needle biopsy: well-differentiated hepatocellular carcinoma, well-defined neuroendocrine Tumour, identified through immunohistochemistry (IHC). PET CT whole body screen report showed a large non-FDG heterogeneously enhancing centrally necrotic mass lesion involving segments ivA, ivB, v, and viii of the liver, 13.8x12.7x19.1 cm suggestive of HCC. Suggested HPE & IHC correlation. The right and left branches of the portal vein are splayed around the lesion. No filling defect was noted in the mass portal vein and the branches. The middle hepatic vein appears exerted by the main lesion; right hepatic vein appears displaced posteriorly. the lesion is seen to compress the intrahepatic IVC. Inferiorly the mass is seen to displace the gall bladder. There is compression of the right and left hepatic duct, causing mild bilateral CHBRD. Mechanically the lesion is abutting the D1& D2 segment of the duodenum and displacing it to the left. Multiple non-FDG avid gastrohepatic periportal and peripancreatic lymph nodes are noted, the largest measuring 23x14 mm- likely metastasis. Low-grade FDG avid sub cranial lymph node is noted- likely inflammatory. No other abnormal hypermetabolic lesion was seen.

Based on subjective and objective evidence, the patient was diagnosed with Neuroendocrine Tumour of the Liver with Multifocal Hepatocellular Carcinoma and was planned for the TACE procedure along with nuclear medicine. The treatment chart includes T, Telma-AM HS, T. Ironfast-2 OD, T. Prenerve OD, T. Methylprednisolone 4mg OD, and T. Montek FX HS. No Drug interactions were found.

**DISCUSSION**

Neuroendocrine Tumours originate in neuroendocrine cells, which produce hormones in response to electrical signals from nerves. Neuroendocrine cancer that originates in the liver is exceptionally rare. It tends to progress slowly and is often not diagnosed until it reaches an advanced stage [9]. Neuroendocrine Tumours are cancers that can develop wherever endocrine cells are present. They are distributed throughout the body, but the most common sites for Tumours to develop from them are the lungs, small intestines, and pancreas. The symptoms of neuroendocrine Tumours can be categorized into hormonal and mechanical symptoms. Hormonal symptoms include severe diarrhoea, severe gastric ulcers, or uncontrolled blood sugar that responds poorly to treatment. The hormones produced can vary depending on the location in the body where the Tumour originates. On the other hand, mechanical symptoms are related to the physical impact of the tumour on the body, such as a small bowel obstruction or localized pain due to pressure on a specific structure.[10] Functioning neuroendocrine Tumours are known for releasing biologically active polypeptides or amines, leading to specific clinical symptoms. Therefore, it is essential to identify the hormone or amine that is being overproduced. Currently, four non-invasive imaging studies are used to detect and assess the spread of neuroendocrine liver metastases. The hyper vascular nature of neuroendocrine metastases may cause them to appear isodense with the normal liver tissue during computerized tomography (CT) scans when a contrast infusion is used. Magnetic resonance imaging (MRI) with appropriate pulse sequences is equally effective as CT in detecting liver metastases in patients with neuroendocrine Tumours. Somatostatin receptor scintigraphy (SRS) is useful for locating primary neuroendocrine Tumours, especially those originating in the foregut, and for detecting metastatic disease, particularly outside the liver. Selective hepatic arteriography can detect liver metastases with a sensitivity of 65% and is capable of visualizing lesions smaller than 5 mm in diameter. However, due to its invasive nature, it has been largely replaced by the less invasive modalities mentioned above [11].

Around 12% to 27% of all patients with NETs are diagnosed with distant metastasis, with the liver being the most common site for NET metastasis regardless of the primary site. The percentages of patients with pancreatic, cecal, colonic, and small bowel NETs presenting with distant disease are 64%, 44%, 32%, and 30% respectively. Metastatic disease has a negative impact on survival, with patients presenting with distant metastases having a 4-fold increased risk of death compared to those with localized disease [12].Options for treatment include ablation, hepatic arterial embolization, liver transplantation, and surgical resection. Surgical resection is usually the only curative treatment for NELM. However, other interventions are important for managing the symptoms caused by Tumour-secreted hormones, reducing the size of the Tumour, and potentially improving the selection of patients for surgery [13].

**CONCLUSION**

In conclusion, neuroendocrine Tumours (NETs) present a complex and challenging clinical scenario, with origins in neuroendocrine cells found throughout the body, particularly in the gastrointestinal tract and lungs. While primary neuroendocrine cancer in the liver is rare, its optimal management remains elusive due to limited understanding and late-stage diagnosis. Symptoms of NETs encompass hormonal and mechanical manifestations, reflecting the diverse array of hormones produced and the physical impact of Tumour growth. Accurate diagnosis is crucial, often relying on non-invasive imaging modalities such as CT, MRI, somatostatin receptor scintigraphy (SRS), and selective hepatic arteriography. The incidence of NETs has risen substantially over the years, attributed partly to improved diagnostic techniques.

Treatment options, including surgical resection, ablation, and liver transplantation, aim not only to eradicate Tumours but also to alleviate symptoms and improve patient selection for curative procedures.

**DECLARATION OF CONFLICT OF INTEREST**

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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