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Neuroendocrine Differentiation of the Carcinoids Distinguished by the Tumor Necrosis

Ambrosini Guido*

Department of Oncology, University of Naples, Italy

INTRODUCTION

Typical carcinoid tumors, atypical carcinoid tumors, large cell neuroendocrine carcinoma and small cell carcinoma. Neuroendocrine tumors of the lung account for approximately 20% of all primary lung cancers. Among them, small cell carcinoma is the most common. Reliable histologic diagnosis and clinical and pathological staging systems are essential for an appropriate medical approach, as clinical behaviour, treatment, and prognosis vary. Although complete surgical resection is the most effective treatment for early-stage bronchial carcinoid and large cell neuroendocrine carcinoma, chemotherapy remains the main treatment for small cell carcinoma.

DESCRIPTION

All carcinoids are malignant tumors that can metastasize. The majority of patients with pulmonary carcinoids have excellent survival rates, even if they have lymph node involvement. Large cell neuroendocrine carcinoma and small cell carcinoma occur rapidly and are common at diagnosis. Your overall prognosis is poor. Increasing knowledge about the biology of pulmonary neuroendocrine tumors and their genetic features means that carcinoid tumors appear to have a distinct etiology and etiology from large cell neuroendocrine and small cell carcinomas. Typical carcinoid tumors associated with more benign behaviors should be classified as low-grade neuroendocrine tumors/cancers, and atypical carcinoid tumors as moderate-grade tumors/cancers. Large cell neuroendocrine carcinoma and small cell carcinoma should be grouped under the term high-grade neuroendocrine tumor/cancer.

They are a heterogeneous group with some similarities to carcinoids, small cell carcinomas, and large cell or adenocarcinoma. Evidence of at least one of the above neuroendocrine characteristics is considered necessary for this diagnosis. Small cell carcinomas are also a heterogeneous group of tumors, characterized primarily by their fine-grained chromatin pattern. It has a much poorer prognosis but is more likely to respond to chemotherapy and radiation therapy. Many small cell carcinomas share carcinoid or atypical carcinoid neuroendocrine differentiation, but some do not, and demonstration of these features is not a requirement for inclusion in the sub-group. Morphological evidence of neuroendocrine differentiation may be more difficult in small cell carcinomas, which more frequently produce clinically relevant levels of ectopic neuropeptides. Although the term neuroendocrine lung cancer encompasses several different entities and conveys no histogenetic or prognostic implications per se, detection of neuroendocrine differentiation in lung tumors has implications for other cytological and histological studies. It is an important step when combined with the detection of identifiable features.

CONCLUSION

Lung neuroendocrine tumors typical carcinoids and atypical carcinoids-have unique molecular alterations that are distinct from neuroendocrine carcinomas of the lung and non-small cell lung cancers. Here, we review the role of molecular profiling in the prognosis and treatment of lung neuroendocrine tumors. There have been no recently identified molecular prognostic factors for lung neuroendocrine tumors and none that have been routinely used to guide management of patients with lung neuroendocrine tumors. Previous findings suggest that patients with loss of chromosome may have a worse prognosis along with upregulation of anti-apoptotic pathways. Major mutations in lung neuroendocrine tumors occur in genes that regulate chromatin remodelling and histone modifications, and potential targeted therapies are emerging in clinical. Lung nets show recurrent changes in genes that regulate the epigenome. Future targeted therapies that interfere with epigenetic signalling pathways may hold promise.

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Corresponding author Ambrosini Guido, Department of Oncology, University of Naples, Italy, E-mail: guido.ambrosini@uninp.it

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