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Multidisciplinary Clinic for Gastrointestinal Neuroendocrine Tumors: Impact on Diagnosis and Management

Jordan Kaplan[1], Grace Suh[1], Harrison Winters[1], Jin He[2], Norman Nicholson[2], Ozlem Kulak[3], Lilja Solnes[4], Fabian Johnston[2], Jonathan Greer[2], Ron Banerjee[5], Stanley Chen Cardenas[5], Marco Dal Molin[2], Kelvin Hong[6], Christos Georgiades[6], Robert Liddell[6], Chris Shubert[2], Richard Burkhart[2], Kelly Lafaro[2], William Burns[2], Amol Narang[7], Meisam Hoseinyazdi[4], Dan Laheru[1], Katie Bever[1], Lindsay Dyson[1], Ana De Jesus-Acosta[1]

[1]Johns Hopkins School of Medicine; Department of Oncology, Sidney Kimmel Comprehensive Cancer Center, Johns Hopkins School of Medicine, Baltimore, MD; [2]Department of Surgical Oncology, Johns Hopkins University School of Medicine, Baltimore, MD; [3]Department of Pathology, Johns Hopkins University School of Medicine, Baltimore, MD; [4]Department of Nuclear Medicine, Johns Hopkins University School of Medicine, Baltimore, MD; [5]Department of Endocrinology, Johns Hopkins University School of Medicine, Baltimore, MD; [6]Department of Interventional Radiology, Johns Hopkins University School of Medicine, Baltimore, MD; [7]Department of Radiation Oncology, Johns Hopkins University School of Medicine, Baltimore, MD

BACKGROUND

Gastrointestinal neuroendocrine tumors (GI-NETs) are heterogeneous neoplasms requiring coordinated multidisciplinary expertise. While multidisciplinary clinics (MDCs) improve outcomes across cancer types, data specific to GI-NET MDCs remain limited. We evaluated the impact of a dedicated GI-NET MDC on diagnosis and management.

METHODS

Retrospective analysis of new patients evaluated at our GI-NET MDC (February 2020–May 2026). The MDC integrated medical oncology, surgery, interventional radiology, pathology, endocrinology, and nuclear medicine. Outcomes included changes in diagnosis, staging, and management; additional testing; same-day multidisciplinary access; and plan adherence within 6 months.

RESULTS

237 patients were evaluated (54.4% female; 71.7% White, 13.5% Black, 4.2% Asian, 3.4% Hispanic/Latino). Referral sources were external (54.9%) and internal (45.1%). Visit types: newly diagnosed first opinion 103 (43.5%), newly diagnosed second opinion 76 (32.1%), and second opinion 58 (24.5%). Patients were seen by ≥2 specialties same day in 147 (62.0%).

Variable	N (%)
Pancreas (including small PNET)	116 (48.9%)

Small bowel	59 (24.9%)
Appendix	19 (8.0%)
Gastric/Duodenum	20 (8.4%)
Other/Unknown/Ruled out	23 (9.7%)
Stage I / II / III / IV	68 (29.1%) / 28 (12.0%) / 52 (22.2%) / 86 (36.8%)
Grade 1 / 2 / 3 / Unknown	91 (38.9%) / 72 (30.8%) / 33 (14.1%) / 38 (16.2%)
Functional tumor	36 (15.2%)
MEN1 syndrome	12 (5.1%)
Mortality	26 (11.0%)

Diagnostic changes occurred in 10 patients (4.2%), including reclassification to paraganglioma (n=2), NET ruled out (n=2), primary site changed (n=2), and histology reclassified (n=4). Staging was revised in 11 (4.6%), with upstaging in 7 and downstaging in 2. Additional testing was ordered prior to MDC in 101 (42.6%) and recommended after MDC in 47 (19.8%). Management was changed in 55 (23.2%), including recommendations to start systemic therapy (n=16), surgery (n=15), different systemic therapy (n=9), IR procedures (n=8), different surgery (n=4), and changed sequencing (n=2). The MDC was the first to establish a treatment plan in 124 (52.3%). Deviation from MDC recommendations occurred in 17 (7.2%).

CONCLUSIONS

A dedicated GI-NET MDC led to diagnostic changes in 4.2%, staging revisions in 4.6%, and management changes in 23.2% of patients. The MDC established the initial treatment plan for over half the cohort, with 92.8% plan adherence. These findings support the clinical value of multidisciplinary evaluation for GI-NETs.

ABSTRACT ID #36632