A 56-year old male was referred to our gastroenterology clinic for further evaluation of gastric subepithelial tumor. The patient was in good health, and his medical and family history was unremarkable. The patient’s laboratory data showed no abnormalities (CEA 0.85 ng/mL, CA19-9 21.9 U/mL, Gastrin 210.8 pg/mL, CA72-4 3.4 U/mL, vitamin B12 1172.1 pg/mL). Abdominal CT showed a 1.2 cm-sized, well-defined, oval shaped, enhancing nodular lesion in the greater curvature side of the stomach body (Fig. 1). Esophagogastroduodenoscopy (EGD) revealed 1 cm sized sessile polyp on the greater curvature side of stomach. I performed snare polypectomy (Fig. 2). It was immunoreactive with chromogranin, synaptophysin, and CD56. The Ki-67 was positive in less than 2% of nuclei (2010 WHO classification, grade 1). Further laparoscopic wedge resection was performed (Fig. 3). There was no residual tumor cell. Abdominal CT was performed 4 month later. There was no evidence of local recurrence or distant metastasis.
CASE 2

A 75-year old male was referred to our gastroenterology clinic for further evaluation of ulceroinfiltrative mass in the cardia of stomach. He had a COPD, diabetes mellitus and hypertension. His family history is unremarkable. His vital signs were stable and abdomen was soft and flat. The patient’s laboratory data showed no abnormalities (CEA 2.25 ng/mL, CA19-9 41.52 U/mL, CA72-4 1.90 U/mL, vitamin B12 675 pg/mL).

EGD revealed well demarcated ulcerative mass with neighboring mucosal elevation in the gastric cardia region (Fig. 1). Abdominal CT showed a 3-4 cm-sized irregular wall thickening and infiltration with regional LN metastasis in the gastric cardia region and a 1.5 cm-sized rim enhancing nodules were noted in segment 6 and 8 of the liver (Fig. 2). PET/CT showed hot uptake at the cardia of the stomach, regional lymph node, and the liver (Fig. 3). Pathology of endoscopic biopsy was immunoreactive with chromogranin, synaptophysin and CK7. The Ki-67 was positive in 70% of nuclei (2010 WHO classification, grade 3) (Fig. 4).

He was treated with four cycles of etoposide and cisplatin chemotherapy. Follow-up PET/CT scan still showed hot uptake at the cardia of the stomach, regional lymph node, and the liver.
Gastric neuroendocrine tumors (NETs) can be classified into well to poorly-differentiated gastric NETs. The management of gastric NET is determined by subtype, and by whether the disease is localized or metastatic. Type 1 gastric NET showed benign and indolent clinical behaviors. Tumor sized less than 1cm and confined to the mucosa/submucosa can be treated with endoscopic submucosal dissection. Local resection (e.g., wedge resection) should be considered in the case of which is involved beyond submucosa, or have positive resection margin. After local resection, annual or biannual endoscopic surveillance may be appropriate. In the advanced case, presence of systemic symptom should be considered. Patient with symptom due to hormonal hypersecretion often benefit from somatostatin analogue treatment. Type 3 gastric NET revealed similar biologic behavior with gastric adenocarcinoma and required radical oncological management. Treatment of the advanced and inoperable case can be treated with systemic chemotherapy such as streptozotocin-based regimens, cisplatin plus etoposide, or newer molecular targeted therapies like sunitinib or everolimus. Loco-regional therapies including trans-arterial hepatic chemoembolization or radiofrequency ablation may be used to treat well-differentiated hepatic predominant disease. Peptide receptor-targeted radiotherapy may be useful in the case of octreotide-positive tumors.

**REFERENCES**