



Optimising Management of Lung Carcinoids: Early vs. Advanced Disease – A Case-Based Multidisciplinary Discussion

Wednesday, 29 April 2026, 18:00 – 19:10 CEST

Disclosure Statement

Anna Koumarianou (moderator) reports the following potential conflicts of interest:

- Receipt of grants/research supports: SERVIER
- Receipt of honoraria or consultation fees: ASTRA ZENECA
- Participation in a company sponsored speaker's bureau: IPSEN.

The Aim and Concept

- ✓ **Mission:** Bridging the gap between cutting-edge research and clinical practice.
- ✓ **Accessibility:** Free and open to all healthcare professionals.
- ✓ **On-Demand:** All webinars are recorded and hosted on the ENETS website (webinar archive).
- ✓ **Eligibility:** Content is tailored for HCPs qualified to prescribe medicine.

CME Accreditation by UEMS-EACCME®



- ✓ **Accreditation:** 1.0 European CME Credit (ECMEC®) via UEMS-EACCME®.
- ✓ **Requirements:** Attend the live session and complete the feedback form.
- ✓ **Privacy:** All responses are strictly anonymous.
- ✓ **Certificates:** Email the ENETS Office at office@enets.org.

Live poll question: Getting to know the audience

In which medical discipline are you trained or currently working?

Tonight's moderator



Anna KOUMARIANOU

National and Kapodistrian
University of Athens, Greece
Oncology

Tonight's faculty



Luca BERTOLACCINI

European Institute of Oncology IRCCS,
University of Milan, Italy
Thoracic Surgery



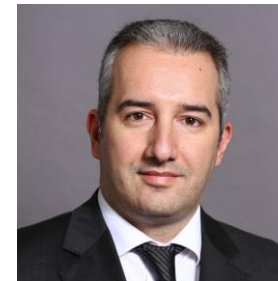
Jules DERKS

Erasmus University Medical Center,
Rotterdam, the Netherlands
Pulmonology



Christophe DEROOSE

University Hospitals Leuven, Belgium
Nuclear Medicine



Dimitrios FILIPPIADIS

National and Kapodistrian
University of Athens, Greece
Interventional radiology

NEW ENETS Guidance paper on Lung and Thymic Carcinoids (April 2026)

This 2026 ENETS guidance paper, developed by a multidisciplinary expert group, provides evidence-based, practical recommendations for the diagnosis and management of lung and thymic carcinoids to improve patient outcomes.

Link to *Journal of Neuroendocrinology*:

<https://onlinelibrary.wiley.com/doi/10.1111/jne.70174>

ENETS members may access this and other ENETS guidance papers via the MyENETS account: <https://my.enets.org/>.

Tonight's agenda

- | | |
|---------------|--|
| 18:00 – 18:05 | Opening comments
<i>Anna KOUMARIANOU, GRE</i> |
| 18:05 – 18:15 | Case presentation 1: Early-stage
<i>Luca BERTOLACCINI, ITA</i> |
| 18:15 – 18:30 | Multidisciplinary panel discussion
<i>Luca BERTOLACCINI, ITA</i>
<i>Jules DERKS, NED</i>
<i>Anna KOUMARIANOU, GRE</i>
<i>Christophe DEROOSE, BEL</i>
<i>Dimitrios FILIPPIADIS, GRE</i> |
| 18:30 – 18:45 | Case presentation 2: Advanced / metastatic case
<i>Jules DERKS, NED</i> |
| 18:45 – 19:00 | Multidisciplinary panel discussion |
| 19:00 – 19:10 | Closing comments
<i>Anna KOUMARIANOU, GRE</i> |

Case Presentation 1: Early-Stage

Luca Bertolaccini, MD PhD FCCP

1. Department of Oncology and Hemato-Oncology, University of Milan, Milan, Italy
2. Department of Thoracic Surgery, IEO, European Institute of Oncology IRCCS, Milan, Italy
luca.bertolaccini@unimi.it

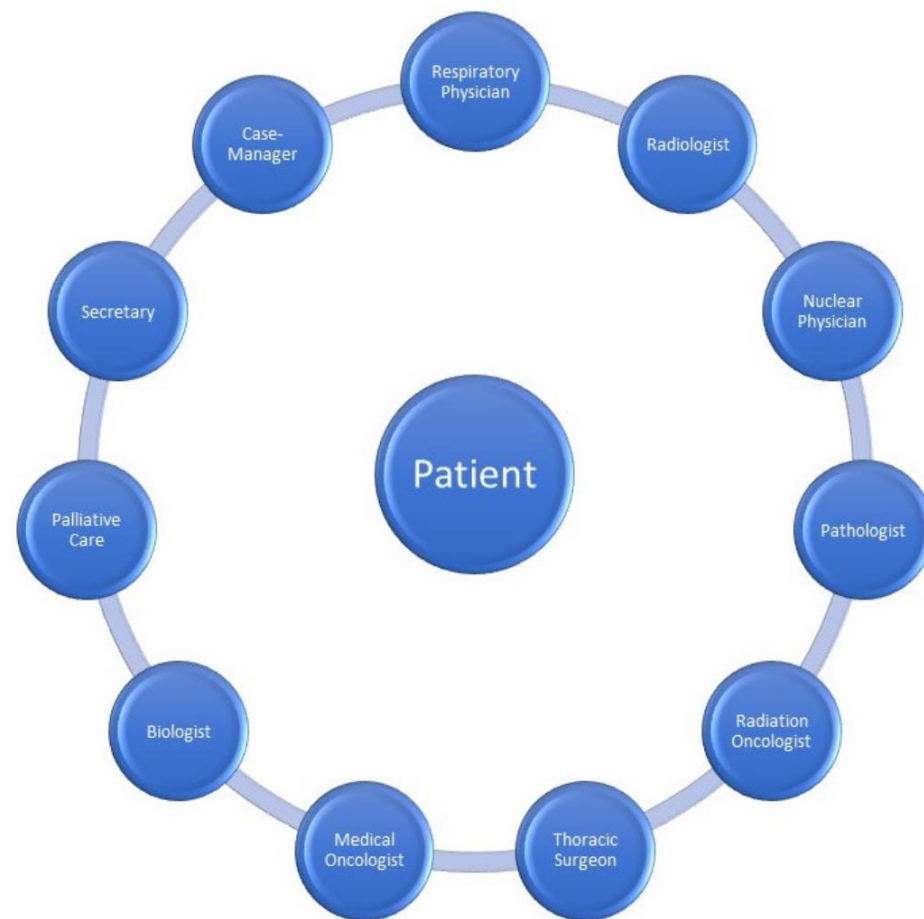


DISCLOSURE SLIDE

I have no conflicts/disclosures to declare

The Interdisciplinary Management of Lung Cancer in the European Community

Luca Bertolaccini ^{1,*},[†] , Shehab Mohamed ^{1,†}, Claudia Bardoni ¹, Giorgio Lo Iacono ¹ , Antonio Mazzella ¹,
Juliana Guarize ² and Lorenzo Spaggiari ^{1,3}



J. Clin. Med. **2022**, *11*, 4326. <https://doi.org/10.3390/jcm11154326>

The role of multimodal treatment in patients with advanced lung neuroendocrine tumors

Nicola Fazio^{1*}, Antonio Ungaro¹, Francesca Spada^{1*}, Chiara Alessandra Cella¹, Eleonora Pisa^{2*}, Massimo Barberis^{2*}, Chiara Grana^{3*}, Dario Zerini^{4*}, Emilio Bertani^{5*}, Dario Ribero^{5*}, Luigi Funicelli^{6*}, Guido Bonomo^{7*}, Davide Ravizza^{8*}, Juliana Guarize⁹, Filippo De Marinis¹⁰, Francesco Petrella⁹, Ester Del Signore¹⁰, Giuseppe Pelosi^{11,12}, Lorenzo Spaggiari⁹

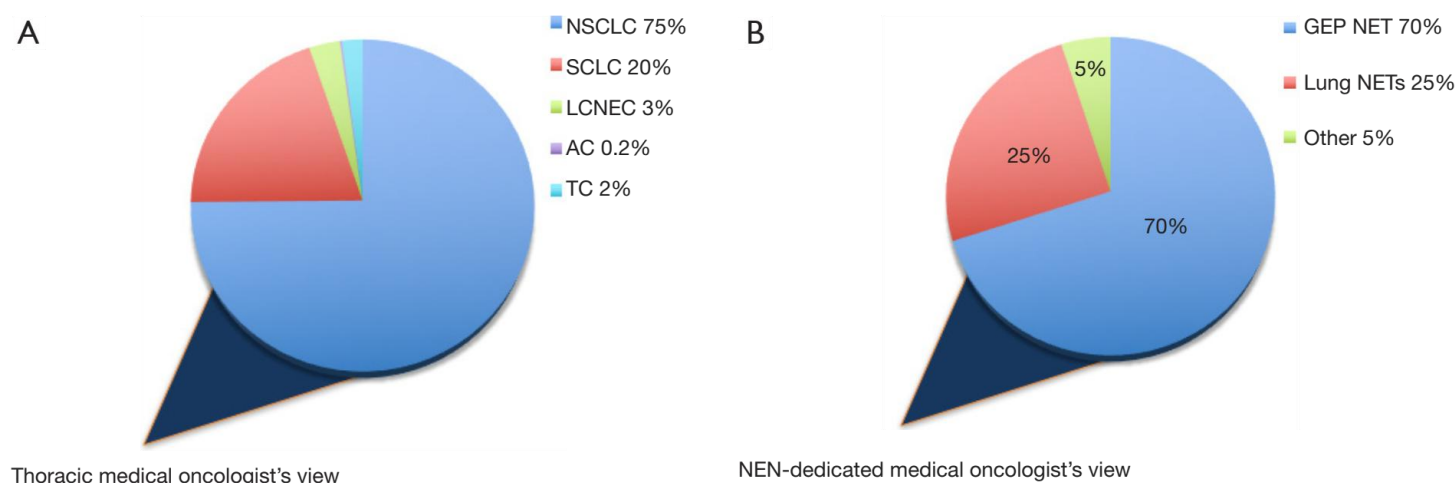


Figure 1 Lung NETs in the medical oncologist's view. (A) Frequency of lung NETs (also named as carcinoids) in thoracic medical oncologist's clinical practice; (B) frequency of lung NETs in the NEN-dedicated medical oncologist's clinical practice. NEN, neuroendocrine neoplasm; NETs, neuroendocrine tumors; NSCLC, non-small cell lung cancer; SCLC, small cell lung cancer; LCNEC, large cell neuroendocrine carcinoma; AC, atypical carcinoid; TC, typical carcinoid; GEP, gastroenteropancreatic.

lung NEN-dedicated multidisciplinary tumor board should include NEN-dedicated medical oncologists, thoracic medical oncologist, thoracic surgeons, pathologists, interventional radiologists, endocrinologists, radiotherapists, interventional pneumologists, nuclear physician.

J Thorac Dis 2017;9(Suppl 15):S1501-S1510

Summary of Published Guidelines (2012 – 2024)

Guideline	Year	Lung resection	Lymph Node
ESMO	2012	• Lobectomy or sleeve resection (III, A) • Pneumonectomy in selected cases	Systematic dissection
ENETS	2015	• Lobectomy or sleeve resection (V, A) • Parenchymal-sparing surgery over pneumonectomy (V, C) • In limited pulmonary function, segmentectomy than wedge	Systematic dissection (V, D)
NANETS	2020	Lobectomy or sleeve resection (III, A)	Sampling
CommNETs & NANETS	2020	• Lobectomy or sleeve resection (III, B) • Sublobar resection in peripheral <2 cm (III, B)	Systematic dissection (III, B)
NCCN	2021	Lobectomy or another anatomical resection	• Sampling • Systematic dissection

Appraisal of Guidelines for Research and Evaluation



Viewing My Co-ordinated Group Appraisal

Status of your Co-ordinated Group Appraisal

Name of the guideline

Pulmonary neuroendocrine (carcinoid) tumors: European Neuroendocrine Tumor Society expert consensus and recommendations for best practice for typical and atypical pulmonary carcinoids

Group name

NET Lung

Due date

Sunday 22nd September 2024

Guideline URL

<https://www.ncbi.nlm.nih.gov/pubmed/25646366>

Work on this Appraisal

[Edit the details](#) [Edit the cover sheet](#) [View the data](#) [Mark as complete](#) [Delete](#)

Raising the bar: evaluating quality and consistency in clinical guidelines for surgical management of pulmonary carcinoid

Luca Bertolaccinia, Claudia Bardonia*, Giovanni Caffarenaa*, Matteo Chiaria*, Cristina Diotti*, Antonio Mazzella*, Lavinia Benini^b, Francesca Spada^b, Giovanni Corso^{c,d}, Eleonora Pisa^e, Monica Casiraghi^{a,d}, Nicola Fazio^{b,†} and Lorenzo Spaggiari^{a,d,†}

Table 3 AGREE II scores by domain

Domain	Mean	SD	95% CI	Median	Minimum	Maximum
Scope and Purpose	47	10	0.26	50	33	56
Stakeholder Involvement	63	17	0.44	59	47	87
Rigor of Development	61	9	0.22	65	48	66
Clarity of Presentation	63	4	0.10	63	60	67
Applicability	60	4	0.11	59	55	65
Editorial Independence	45	13	0.33	48	30	57

Data are presented as percentages.
AGREE, Appraisal of Guidelines for Research and Evaluation; CI, confidence interval.

score. The methodological quality of guidelines on the surgical management of PC varies significantly. The findings underscore the need for future guidelines to prioritize practical implementation in clinical and surgical practice, ensuring that recommendations reflect best practices and effectively meet surgeons' needs. Based on our AGREE II appraisal, the ENETS and ESMO guidelines might be recommended as a model for developing future recommendations and guidelines. *European Journal of*

DOI: 10.1097/CEJ.0000000000000949

Anna Koumarianou¹ | Pier Luigi Filosso² | Lisa Bodei³ | Justo P. Castano⁴ |
Lynnette Fernandez-Cuesta⁵ | Christophe M. Deroose⁶ | Matthieu Foll⁵ |
Clarisse Dromain⁷ | Nicholas Simon Reed⁸ | Martyn Caplin⁹ |
Jaume Capdevila¹⁰ | Jenny Falkerby¹¹ | Antongiulio Faggiano¹² |
Andrea Frilling¹³ | Enrique Grande¹⁴ | Rodney J. Hicks¹⁵ | Atsuko Kasajima¹⁶ |
Beata Kos-Kudla¹⁷ | B. A. Krishna¹⁸ | Eric Lim¹⁹ | Anja Rinke²⁰ |
Simron Singh²¹ | Chrissie Thirlwell²² | Marco Volante²³ | Thomas Walter²⁴

- ✓ Surgical approach remains *uncertain*
 - Centrally located typical carcinoids
 - Lobectomy or sleeve resection
 - Small peripheral lesions
 - Segmentectomy (typical or atypical?)
 - Locally advanced carcinoid tumours
 - *To be determined*



J Neuroendocrinol. 2024;36:e13412.

Eric Baudin¹ | Alice Durand²  | Wieneke Buikhuisen³ | Jaume Capdevila⁴ |
Martyn Caplin⁵ | Christophe M. Deroose^{6,7} | Clarisse Dromain⁸  |
Antongiulio Faggiano⁹ | Pier Luigi Filosso¹⁰ | Gregory Kaltsas¹¹ |
Marco Volante¹² | Thomas Walter² | Rocio Garcia-Carbonero¹³



Anatomical surgical resection with
standardised routine lymph node
dissection

Alternative approaches in limited lung
functional reserve or comorbidities
Pneumonectomy avoided as much as possible



Lung-sparing segmentectomy or non-anatomical wedge resection also
considered to confirm and definitively classify carcinoid according to
WHO criteria

J Neuroendocrinol. 2026;38:e70174.
<https://doi.org/10.1111/jne.70174>

Case Presentation

Female, 18 years old

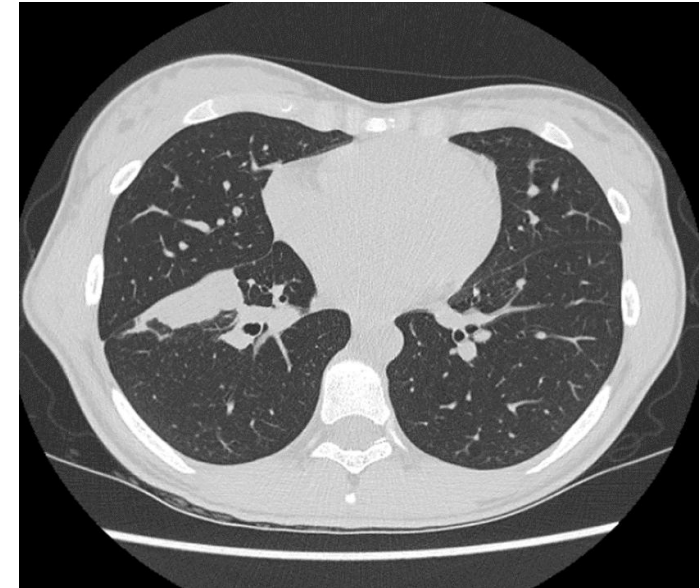
Comorbidities: none

Allergies: none

Family history: none

Physiological history: non-smoker

- ✓ Initial symptoms
 - 08/2023. Fever and dyspnoea treated with antibiotic therapy
 - 12/2023. Persistent dyspnoea → chest CT shows lesion in right lower lobe



Pulmonologist – Jules Derks

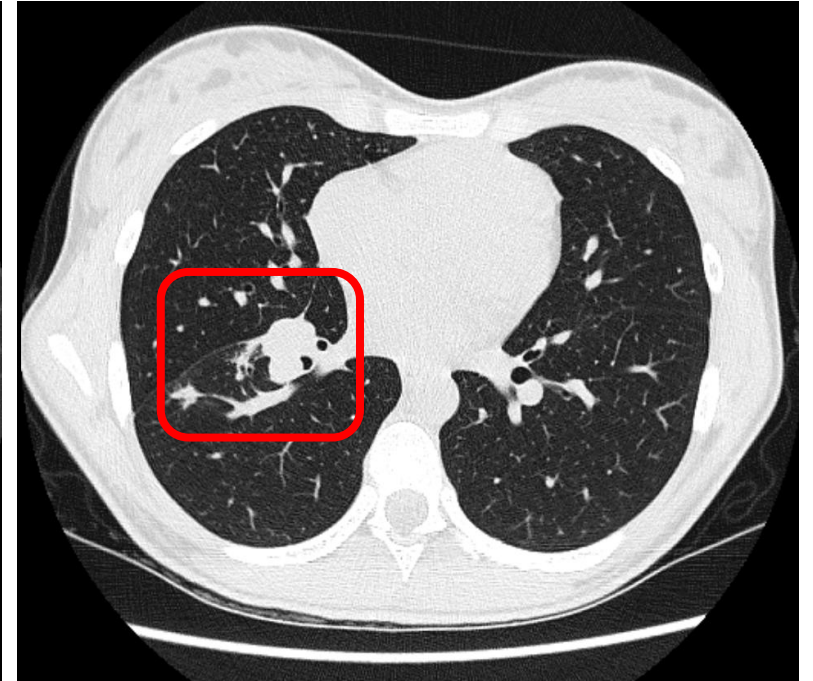
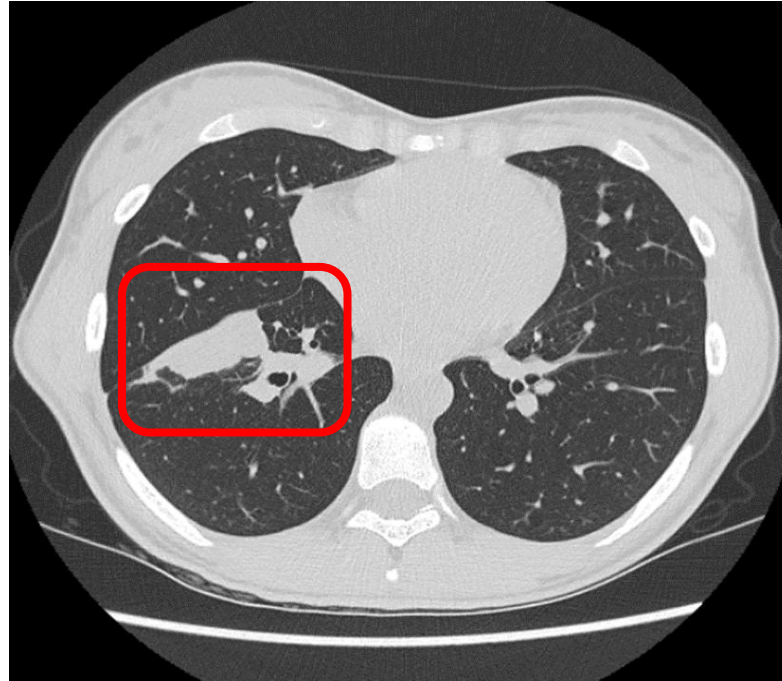
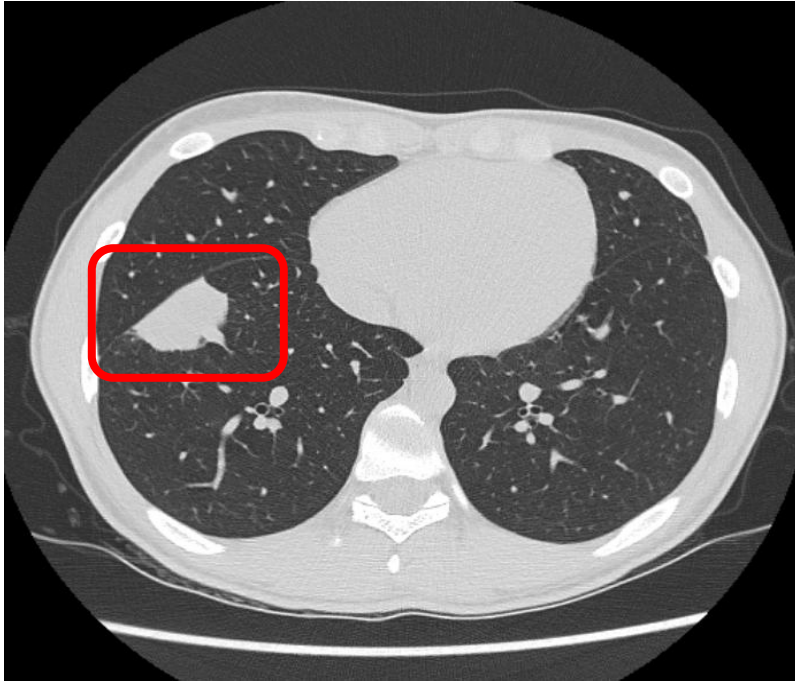
In a young, non-smoking patient with a suspected carcinoid tumor, what is your preferred diagnostic pathway?

How do you balance the role of bronchoscopy with EBUS versus upfront surgical resection?

How relevant is preoperative histological confirmation in this setting?

Case Presentation

- ✓ 03/2024. Right thoracotomic lower lobectomy + hilar-mediastinal lymphadenectomy
- ✓ Histology
 - Atypical carcinoid, Ki-67 15%, tumor involvement in station 10R and 7.
 - pT2aN2M0 → Stage IIIA, R0



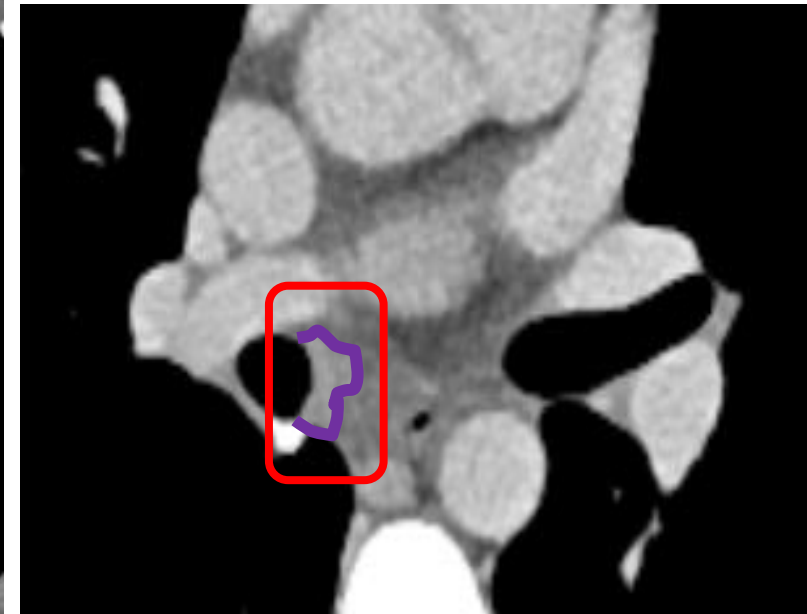
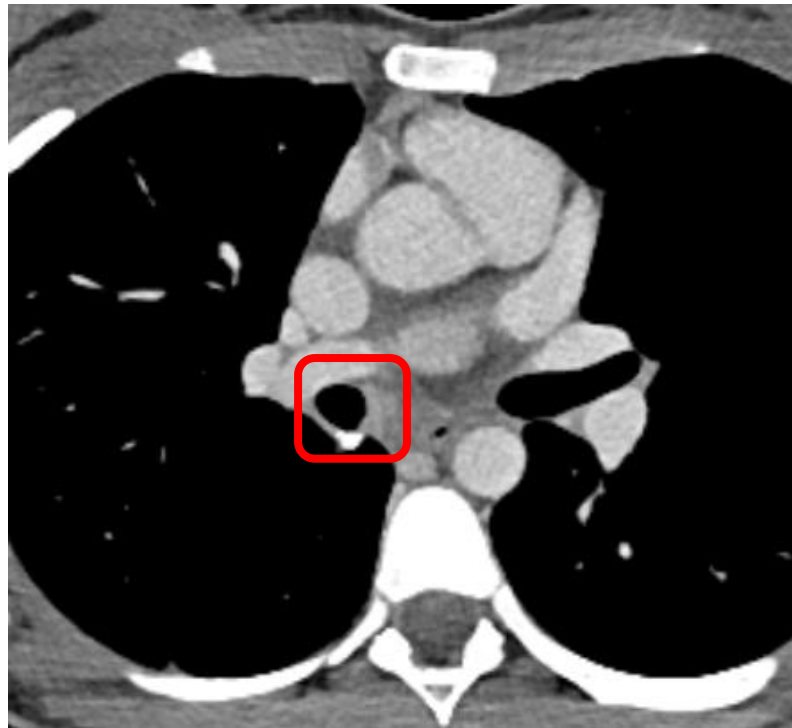
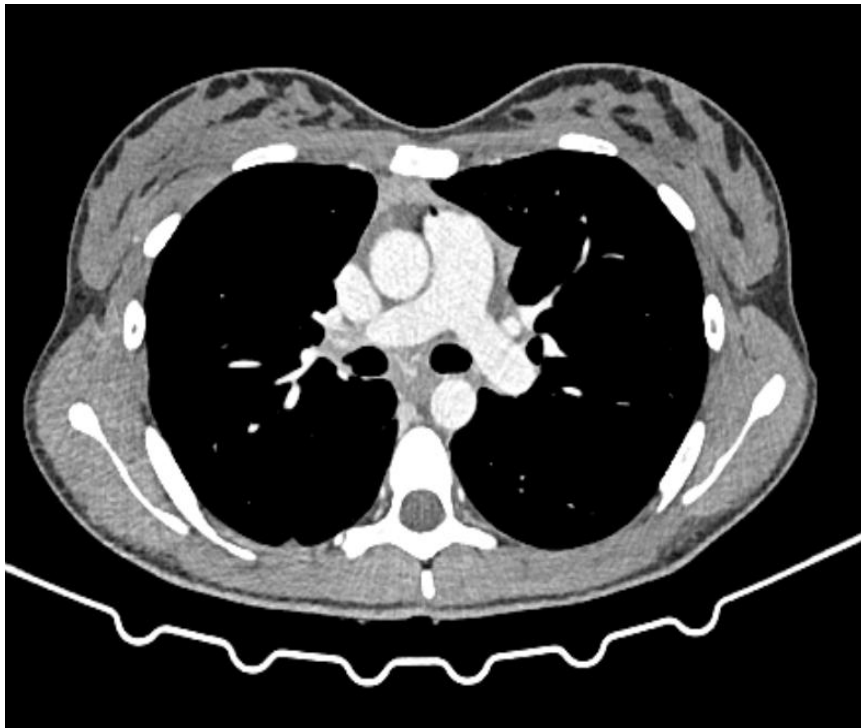
Oncologist – Anna Koumarianou

In a pT2aN2 atypical carcinoid with R0 resection and Ki-67 around 15%, how do you approach the indication for adjuvant therapy?

Is there any role for chemotherapy, somatostatin analogues, or should surveillance remain the standard in the absence of robust evidence?

Case Presentation

- ✓ 07/2024. Contrast-enhanced chest CT scan
 - 9 × 5 mm tissue adherent to medial wall of intermediate bronchus



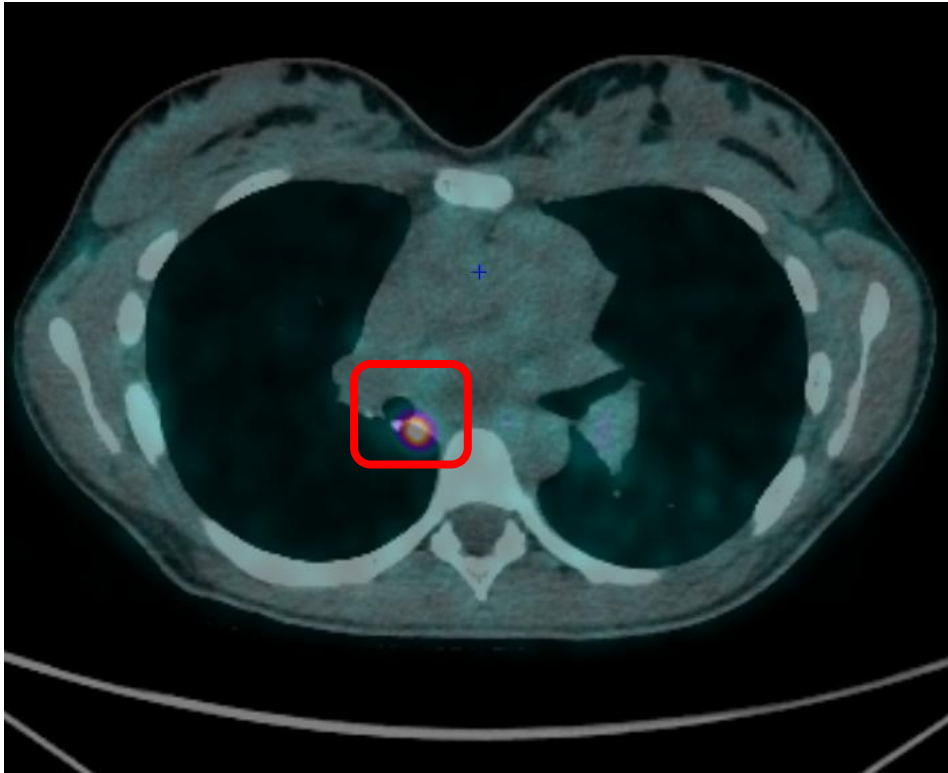
Live poll question for the Audience

- ✓ Which management would you choose?
 - Surgical radicalization after pulmonary function testing
 - Completion of diagnostic work-up with FDG PET and Gallium PET
 - Genetic counseling
 - Adjuvant chemotherapy with Capecitabine + Temozolomide for 6 months

Case Presentation

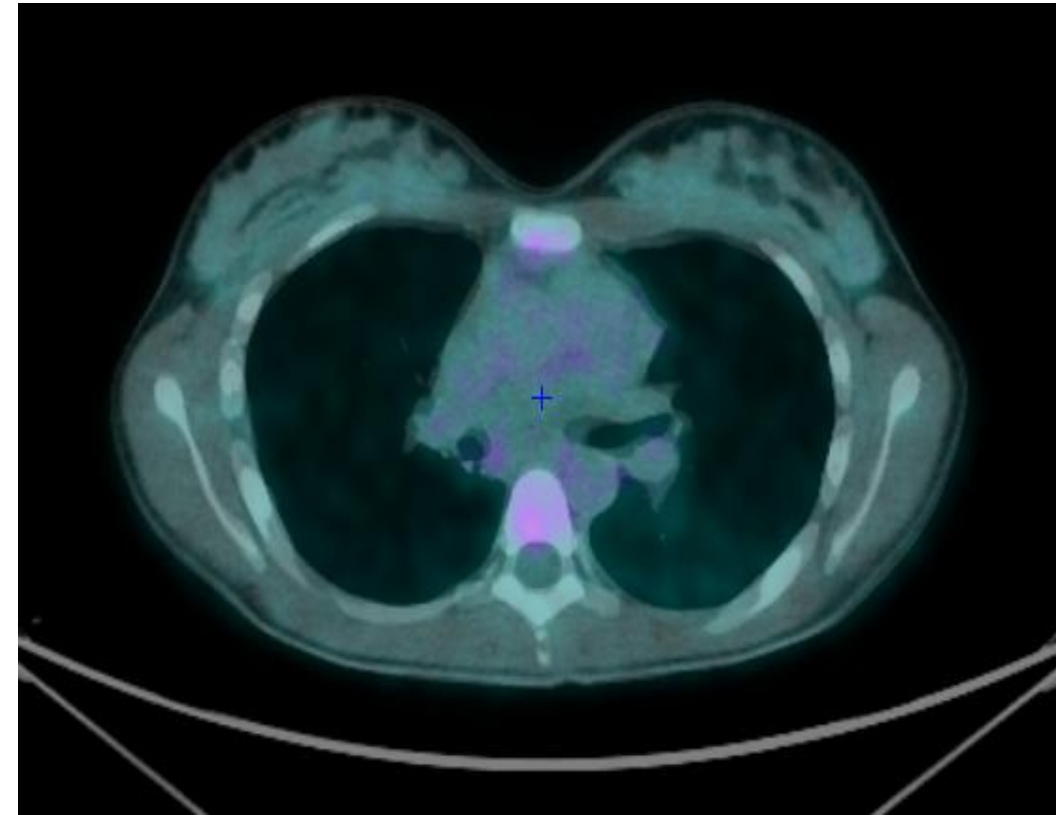
✓ Gallium PET

- High somatostatin receptor density in right hilar pulmonary lymph nodes



✓ FDG PET

- Negative for areas of high glucose metabolism



Nuclear Medicine Physician – Christophe Deroose

Could you comment on the complementary role of FDG PET and Ga-68 PET in this context?

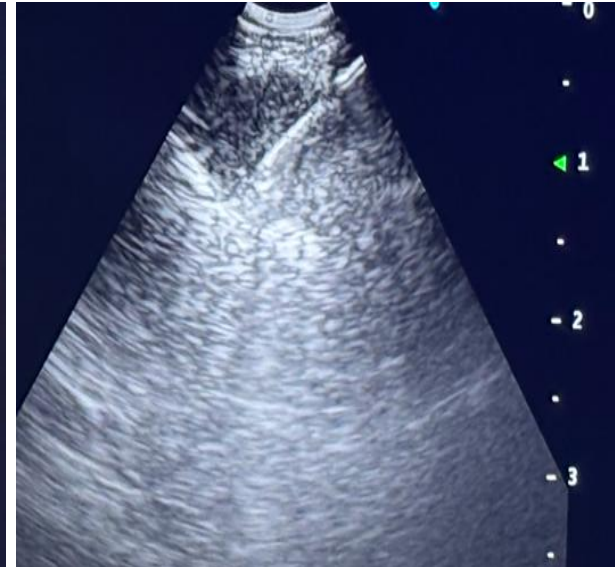
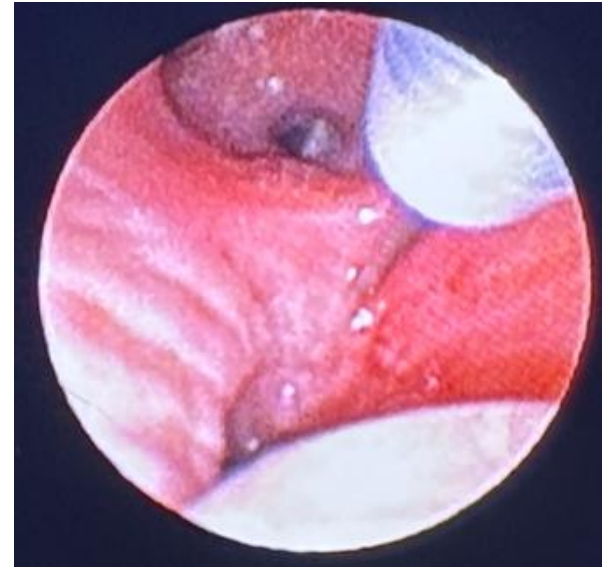
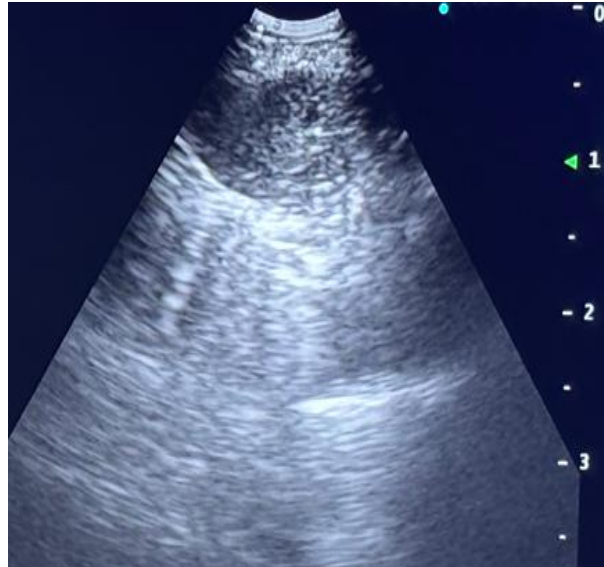
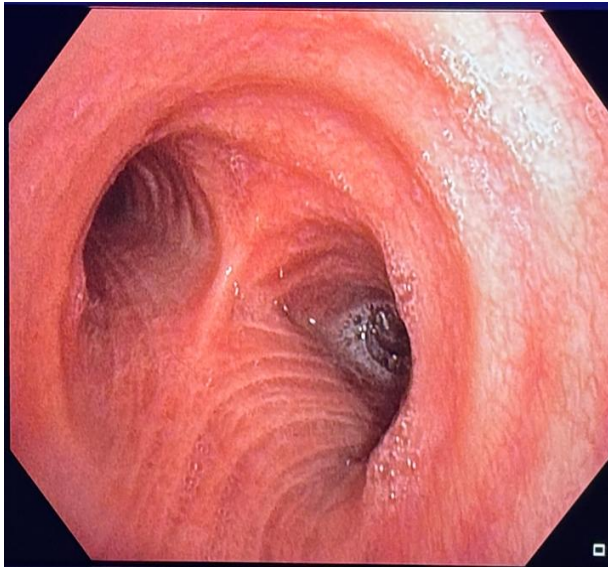
How do you interpret discordant findings, such as FDG negativity with positive somatostatin receptor imaging?

How does this influence staging and treatment planning?

Case Presentation

✓ 08/2024. EBUS bronchoscopy

- US transbronchial needle performed at station 7 and small peribronchial thickening adjacent to surgical clip of bronchial stump
- Cytological examination: negative for malignant tumor cells in lymph node aspirate and in peribronchial thickening (compatible with scar tissue)



Interventional Radiologist – Dimitrios Filippiadis

In the presence of discordant imaging and negative EBUS cytology, what is your threshold for pursuing further tissue confirmation?

Additionally, in case of oligometastatic or bone disease, what is the potential role of ablative techniques (e.g., RFA) in disease control?

Case Presentation

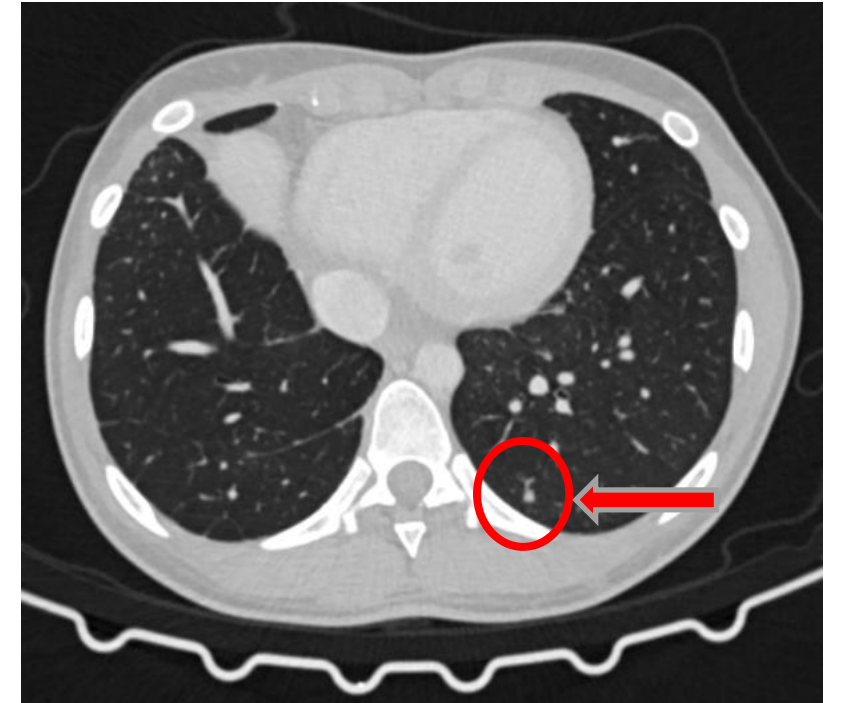
- ✓ 12/2024 contrast-enhanced chest CT
 - Slight increase in size of pseudonodular tissue adherent to medial wall of intermediate bronchus (13×8 mm)
 - 4 mm nodule in peripheral location of left upper lobe



07/2024



12/2024



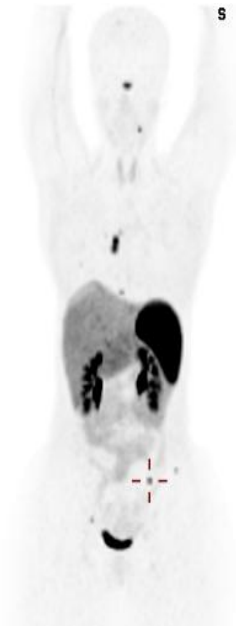
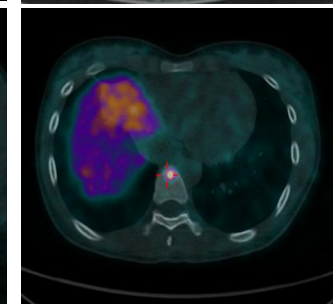
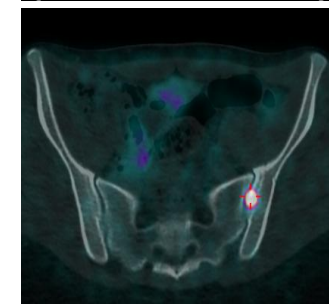
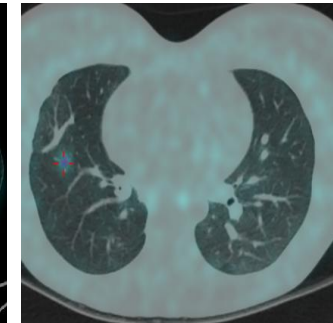
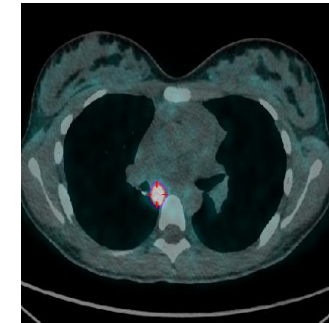
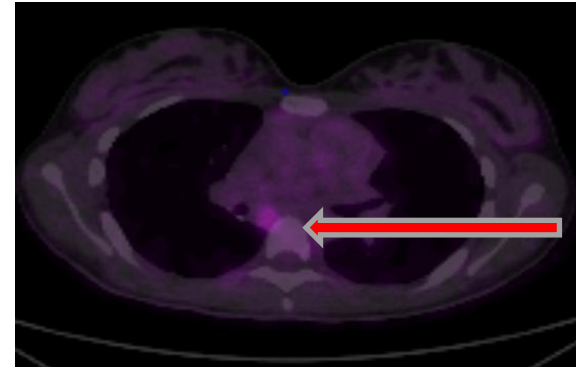
Case Presentation

✓ FDG PET

- Uptake (SUVmax 7.1) of right hilar pulmonary tissue
- No uptake of left lower micronodule

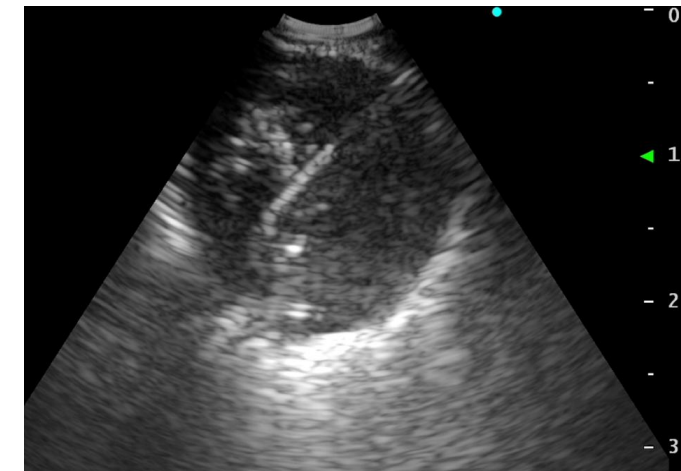
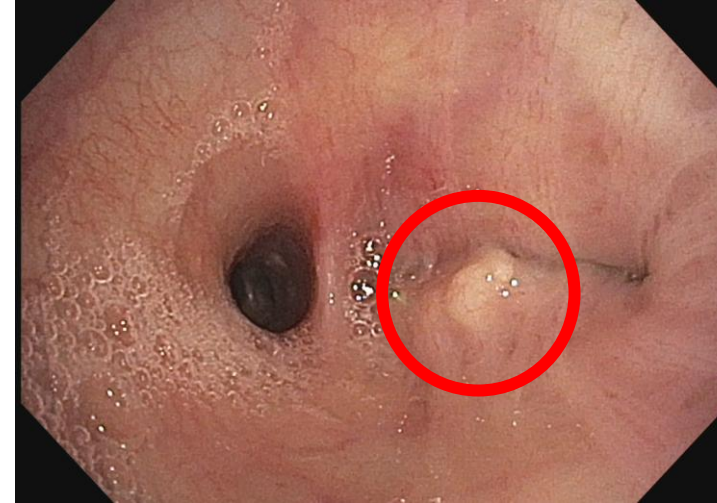
✓ Gallium PET

- Pathological uptake of subcarinal tissue extending to right peribronchial region
- Focal uptake in pseudonodular lesion of right lower lobe
- Pathological uptake in skull, left pedicle of C3, D9, L5, left iliac wing, and left sacroiliac synchondrosis



Case Presentation

- ✓ 01/2025. EBUS bronchoscopy
 - Small (3 mm) hypervascularized endobronchial lesion suspicious for recurrence at mid-third of suture line
 - Cytological examination
 - Right peribronchial: epithelial malignant cells consistent with well-differentiated neuroendocrine tumor, with rare foci of necrosis, <1 mitosis, Ki-67 13%
 - No malignant cells in station 7



Live poll question for the Audience

- ✓ Which treatment would you recommend?
 - Surgery
 - Somatostatin analogues
 - Radiotherapy for bone and pulmonary lesions
 - Radioligand therapy
 - mTOR inhibitor

Thoracic Surgeon – Luca Bertolaccini

Given current guidelines and the evolving evidence base, how do you define the role of surgery in this scenario, particularly in the setting of locoregional recurrence with synchronous distant disease?

Where do you see the main grey areas in decision-making?

What are the key research priorities to better guide surgical indications?

Conclusions



Extent and location of pulmonary carcinoids should drive surgical strategy within a multidisciplinary framework



Anatomical resection with systematic lymph node dissection remains standard of care



Parenchyma-sparing approaches appropriate in selected patients



Accurate lymph node staging mandatory



Management dynamic and longitudinal, integrating imaging, endoscopy, and pathology to guide decisions over time





Ille terrarum mihi praeter omnis angulus ridet
Horatius, Carmina (2, 6)

Case presentation 2: Advanced / metastatic lung carcinoid

Presenter: Jules Derks

Pulmonologist
ENETS center Erasmus MC, the Netherlands

DISCLOSURE SLIDE

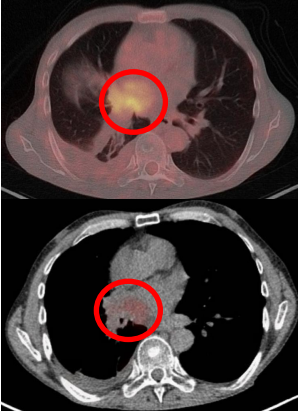
Personal financial interests

Honoraria: Daichi (ENDEAVOUR training program)

Advisory board: IPSEN

The Case

cT4N2aM1a
TC (Ki-67 10%)



2020

Symptoms:

- Male, 60y age
- ECOG 0, no pain

Staging:

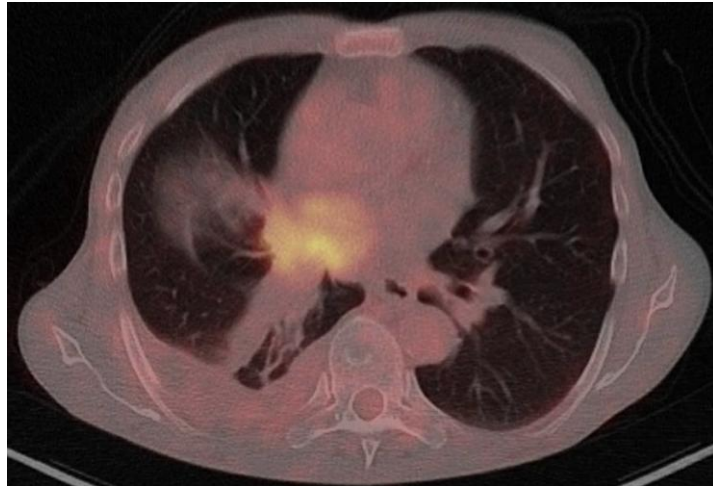
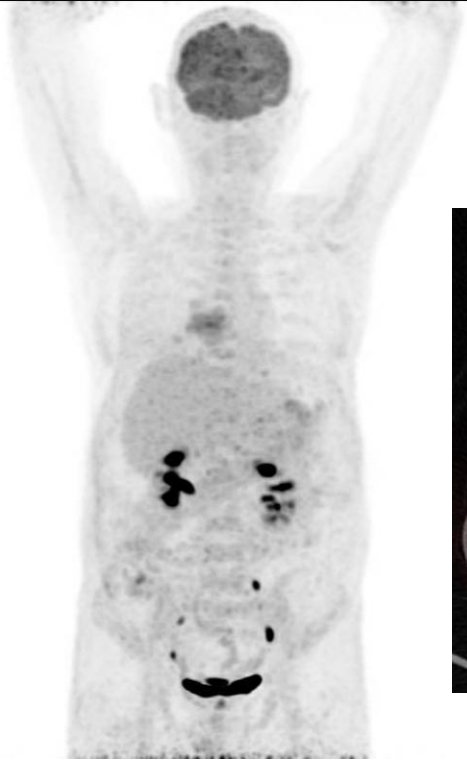
- Stage IVa disease, cT4 (mediastinal invasion) N2a (N7) M1a (pleural fluid)
- Biopsy typical carcinoid

Assessment of hormonal activity:

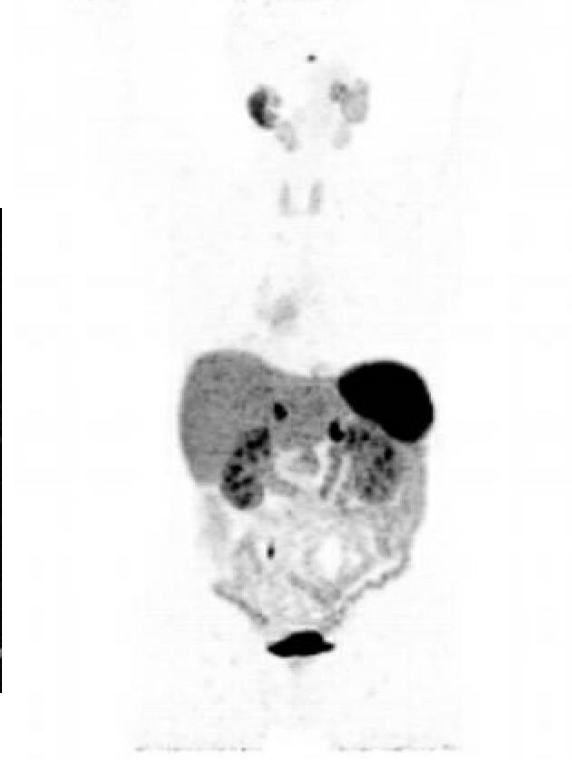
- No carcinoid syndrome related complaints
- 5-HIAA normal (blood)
- No Cushing syndrome related complaints

Nuclear imaging performed: FDG & 68GA-DOTATATE PET

FDG-PET



68GA-DOTATATE PET



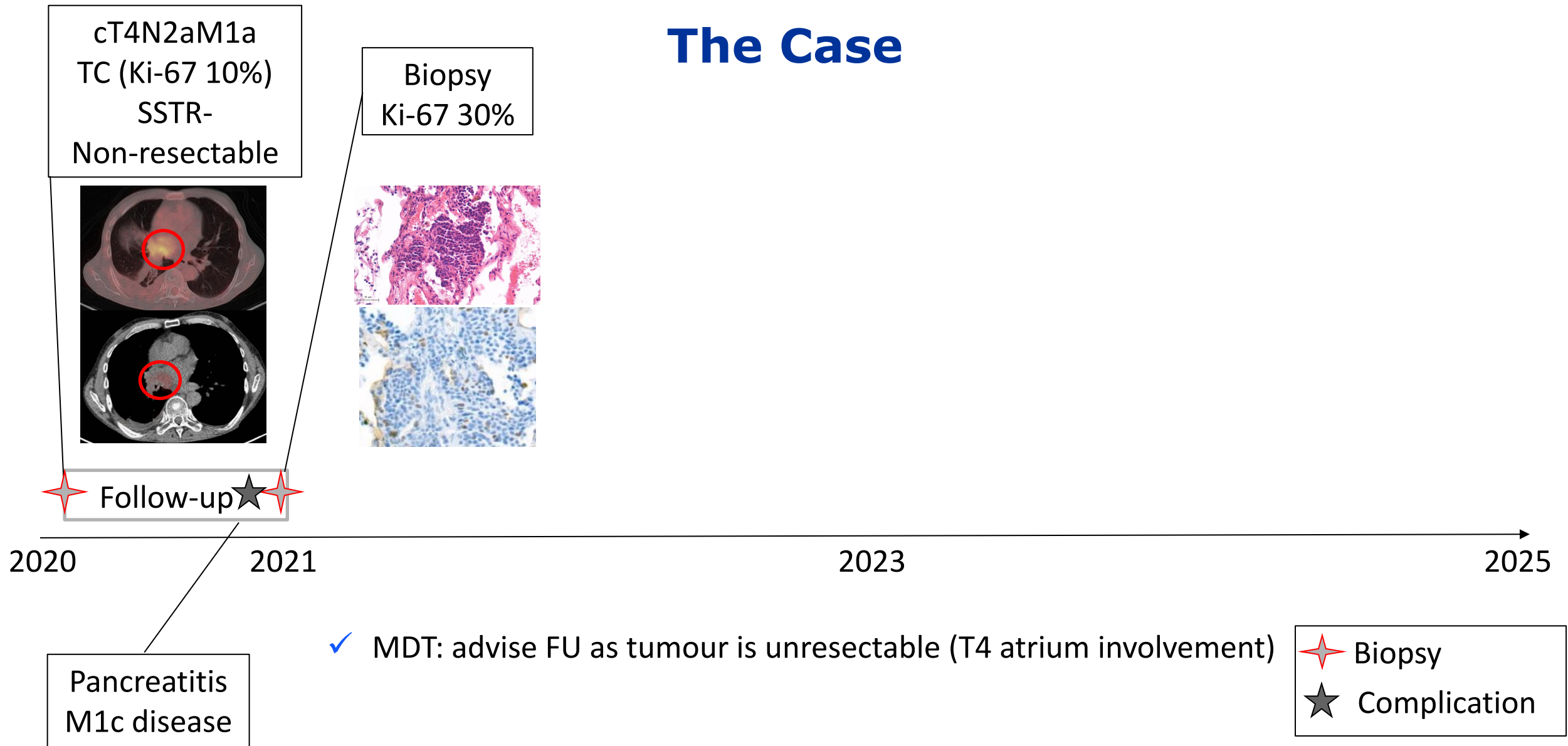
Question for the Nuclear physicist – Christophe Deroose

- ✓ **Should a clinician always make a SSTR-PET in (metastatic) lung carcinoid?**
 - ✓ What would you advise if the tumour is strongly FDG+ at baseline?
- ✓ **Could we provide PRRT here?**
 - ✓ What are the most important considerations for PRRT in metastatic lung carcinoid?

Question for the Surgeon – Luca Bertolaccini

- ✓ **Would you consider a resection in metastatic lung carcinoid?**
 - ✓ What if the patient did not have pleural fluid but a single metastatic lesion (e.g. oligometastatic disease stage M1b).
 - ✓ Would surgery of the primary tumour lesion be appropriate?
- ✓ **What if there were complaints of obstructive pneumonia?**

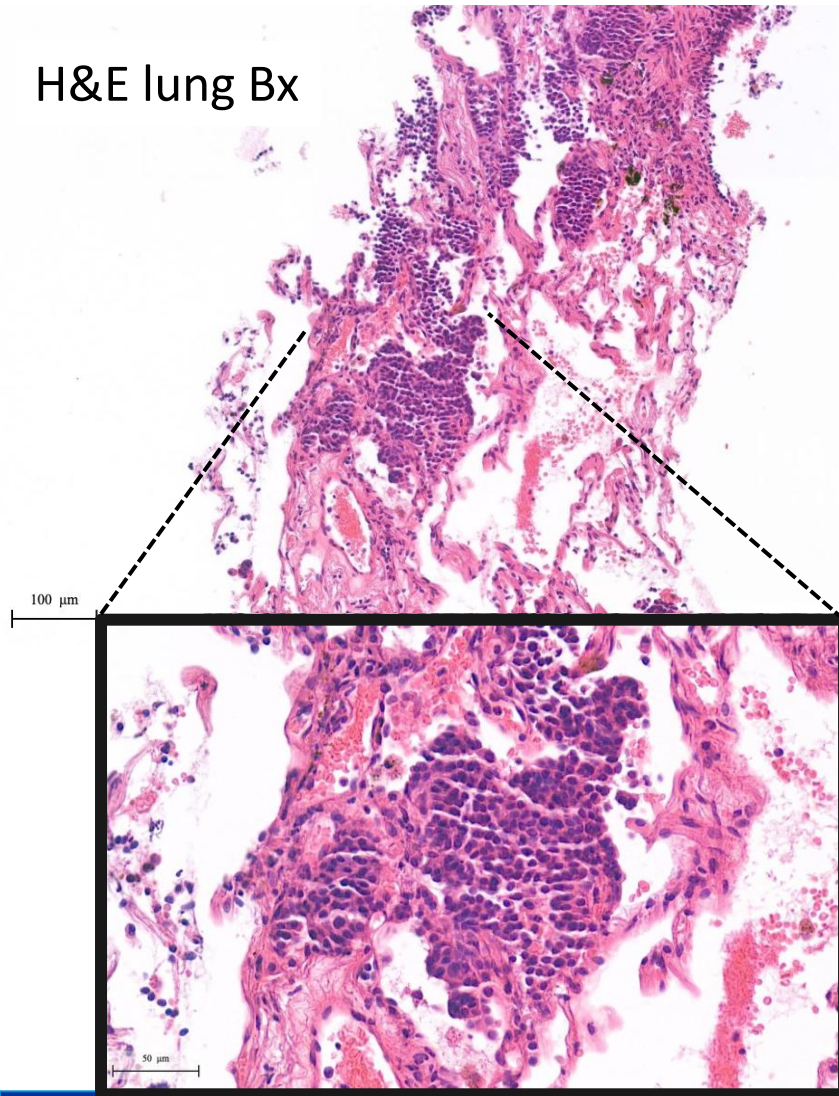
The Case



Pathological evaluation of the case: Typical carcinoid (WHO)

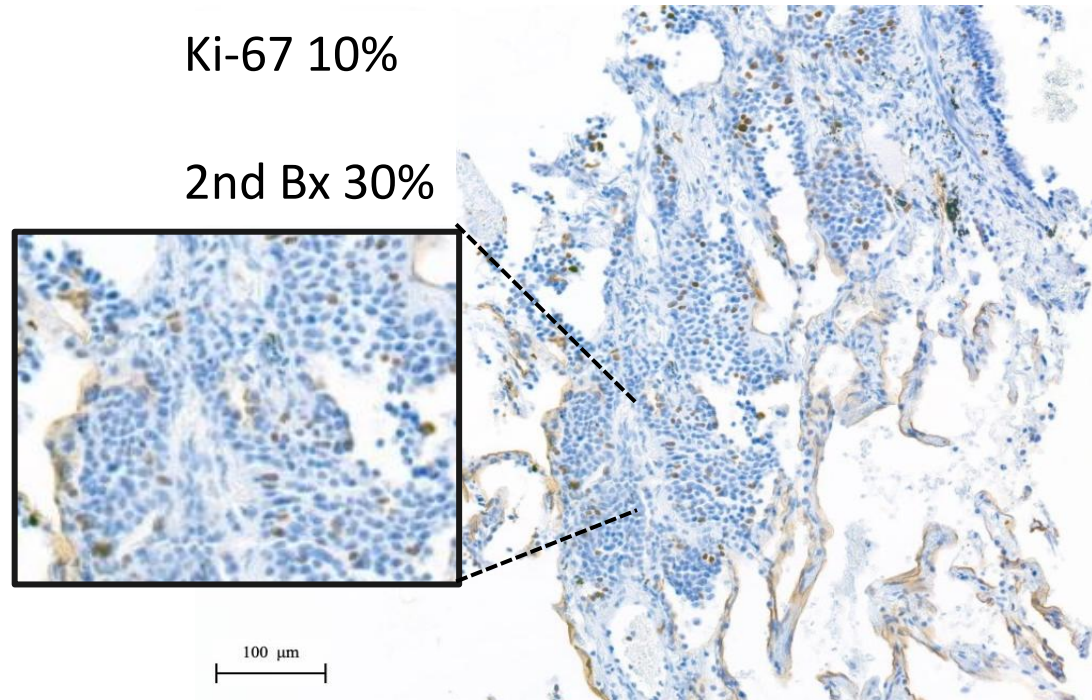
Elevated Ki-67 (10-30%)

H&E lung Bx

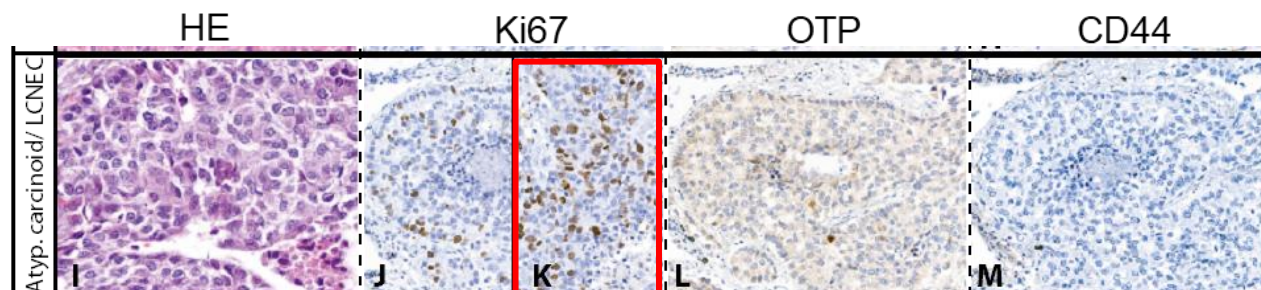


Ki-67 10%

2nd Bx 30%

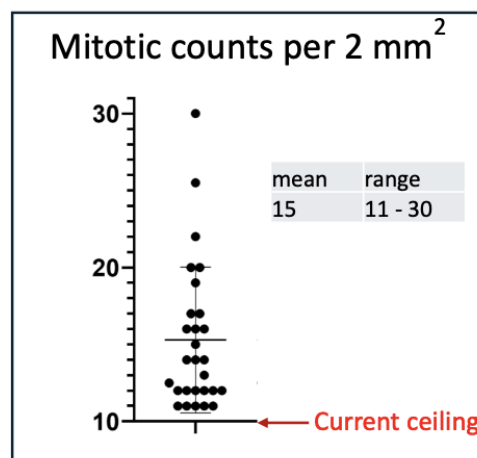


Pathological evaluation of the case: G3-NET?

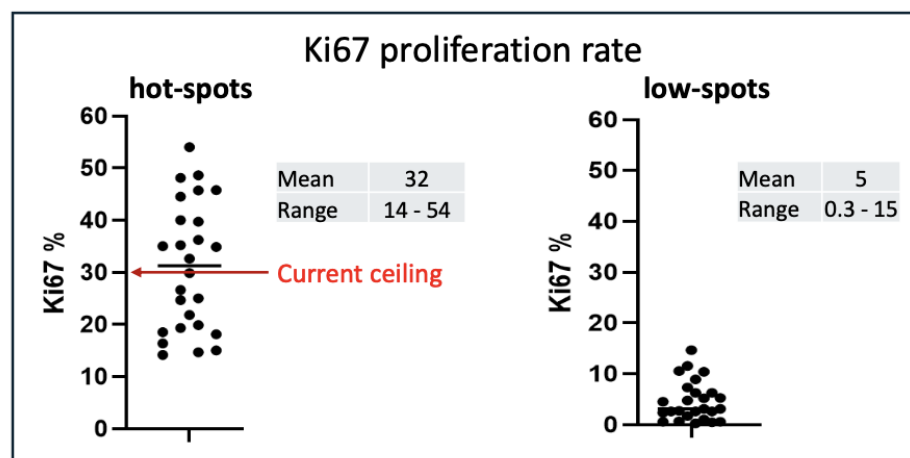


Rb / TP53 wildtype

Proliferation rates for the whole cohort (n=28).

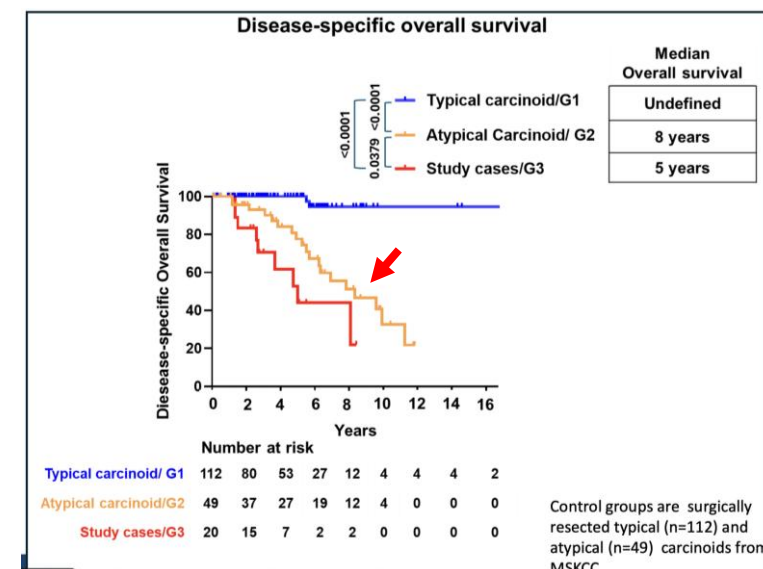


exceeds WHO ceiling rate in carcinoids (10 per 2 mm²)
but below typical rates in NEC of 70-80 per 2 mm²



exceeds typical rate in carcinoids
but below typical rates in NEC of 50-100%

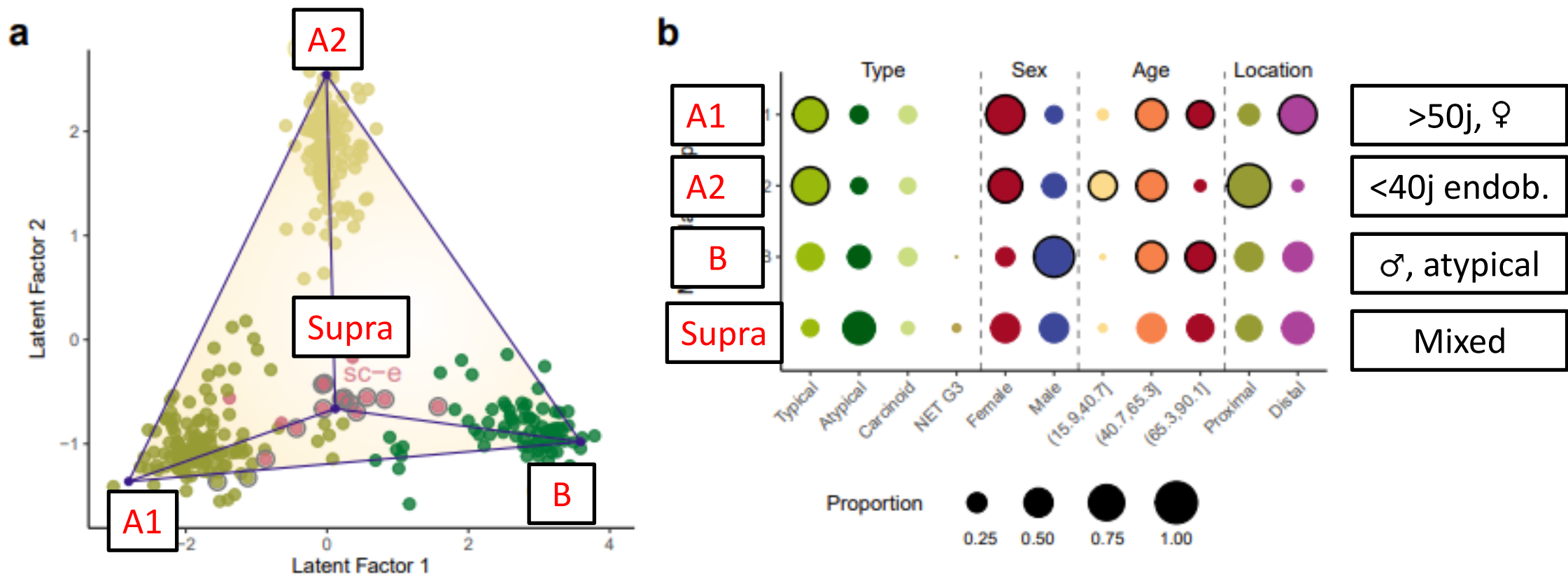
Mitotic counts and Ki67 is higher than usually seen in atypical carcinoids, but lower and more heterogeneous than in small cell or large cell neuroendocrine carcinomas.



Control groups are surgically resected typical (n=112) and atypical (n=49) carcinoids from MSKCC

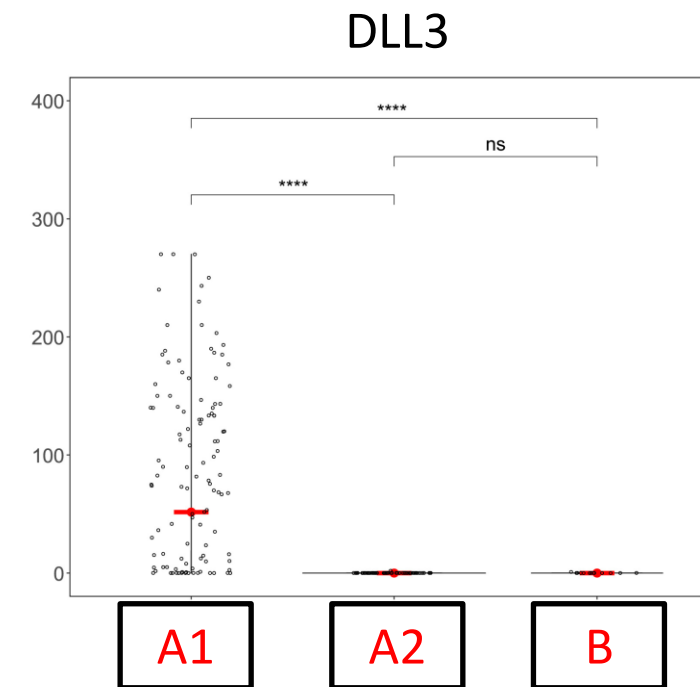
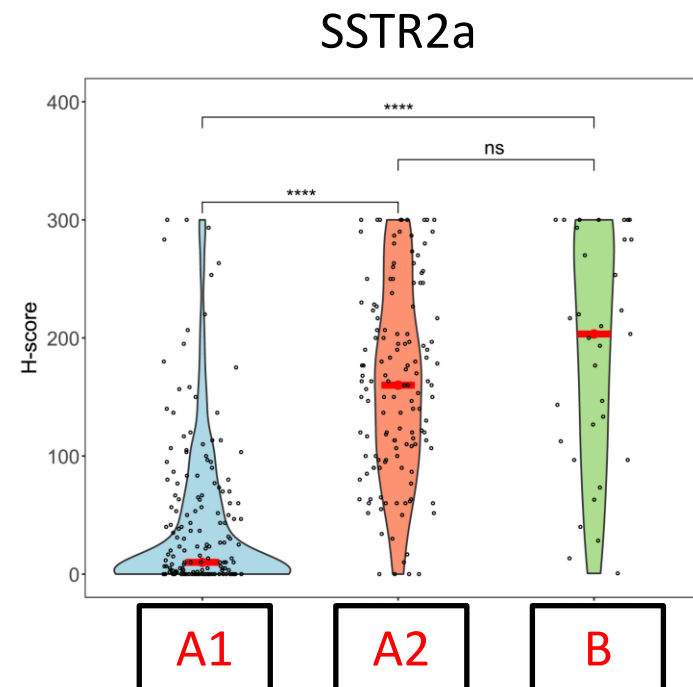
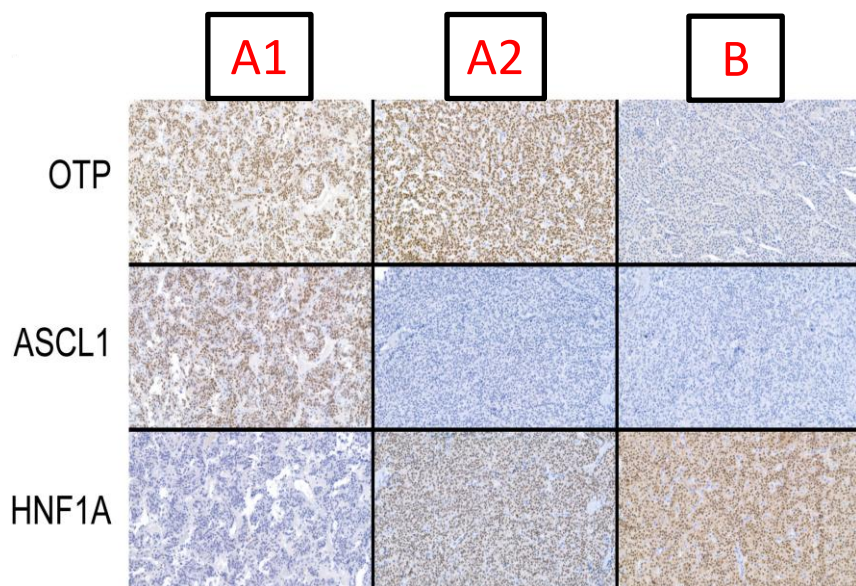
OA13.04 Rekhtman et al. 2025 WCLC conference

Pathological evaluation of the case: New molecular insights



Sexton-Oates *et al*, medRxiv 2025

Pathological evaluation of the case: New molecular insights

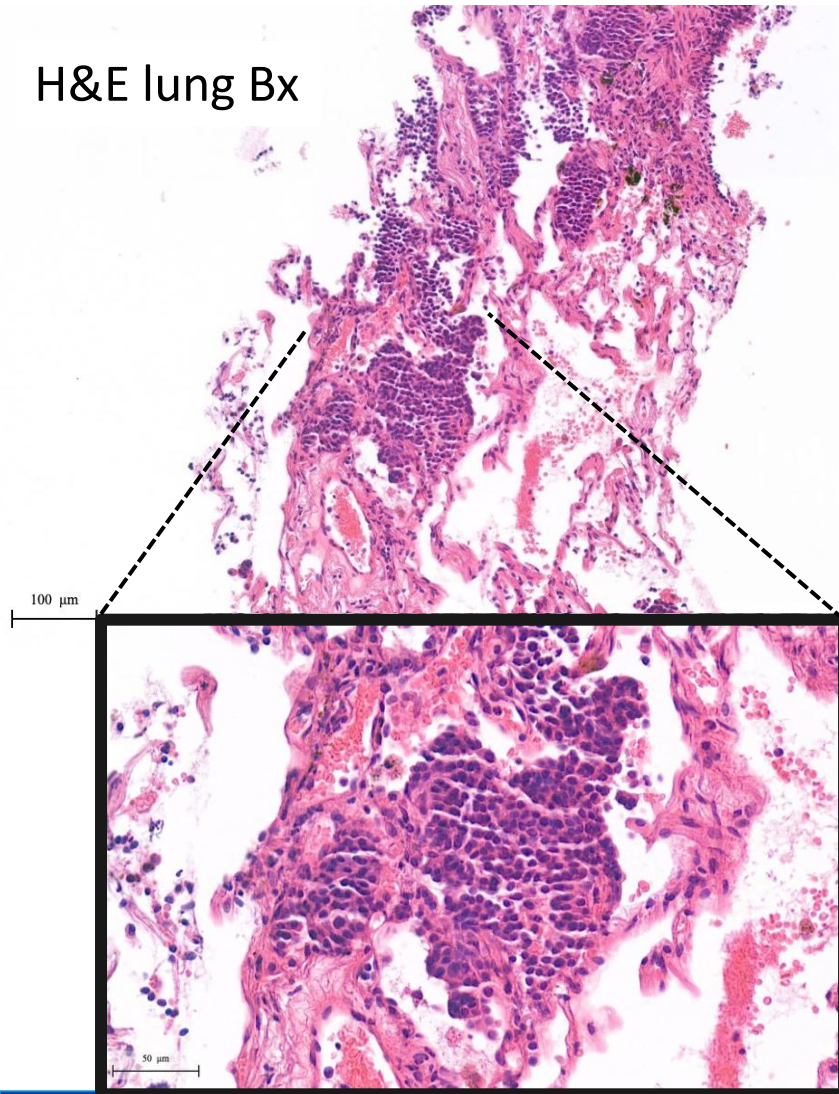


Leunissen et al. JTO 2025
Sexton-Oates et al, medRxiv 2025

Pathological evaluation of the case: Typical carcinoid (WHO)

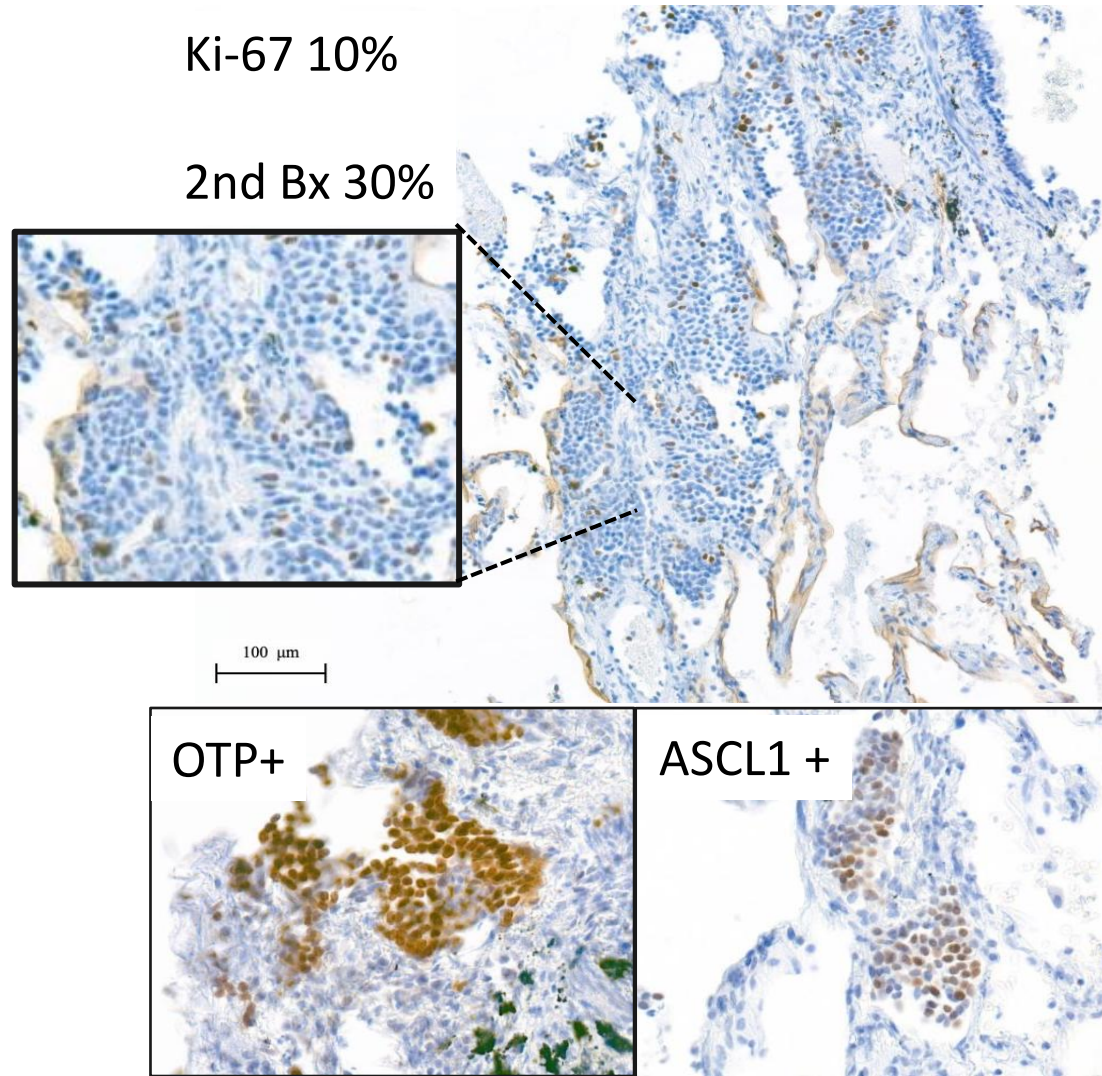
Elevated Ki-67 (10-30%) / SSTR2a- / TTF1+

H&E lung Bx



Ki-67 10%

2nd Bx 30%



Other IHC

TTF1+

CD56/ChrA/Syn+

pRb+ / TP53 WT

SSTR2a-

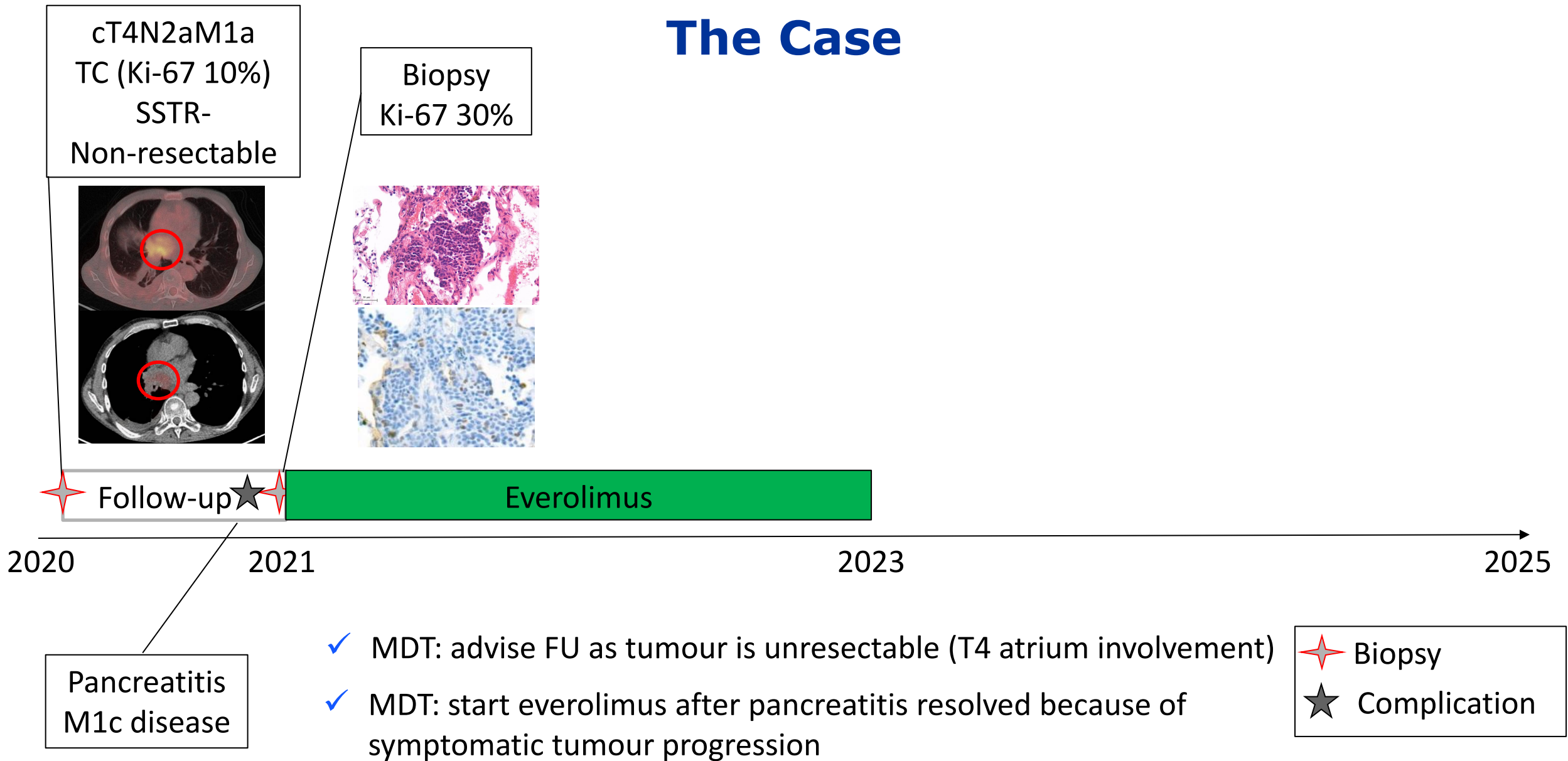
NGS: NA

Live poll question for the Audience:

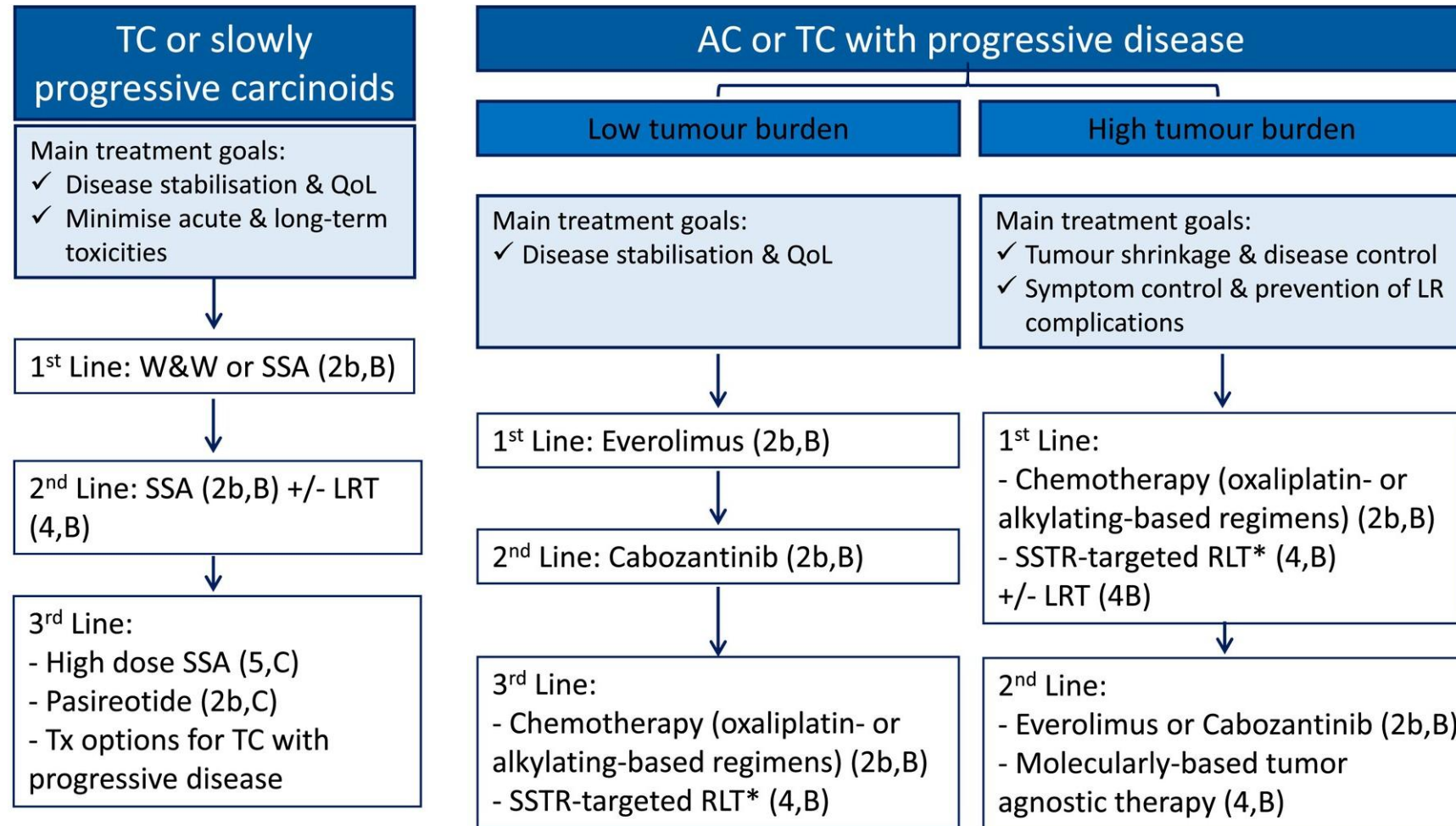
What would be your advice?

- SSA
- Everolimus
- Cabozantinib
- PRRT
- Chemotherapy treatment (e.g. capecitabine-temozolomide)

The Case



ENETS guideline 2026



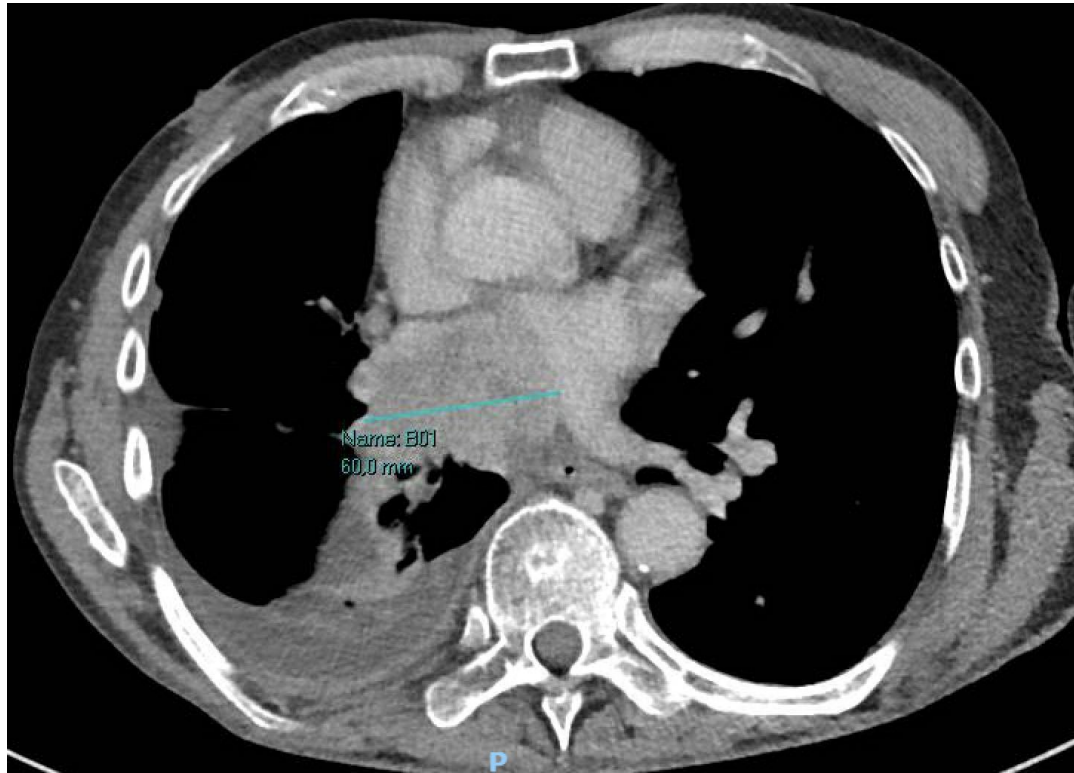
Baudin et al. Journal of
Neuroendocrinology 2026

Question for the oncologist – Anna Koumarianou

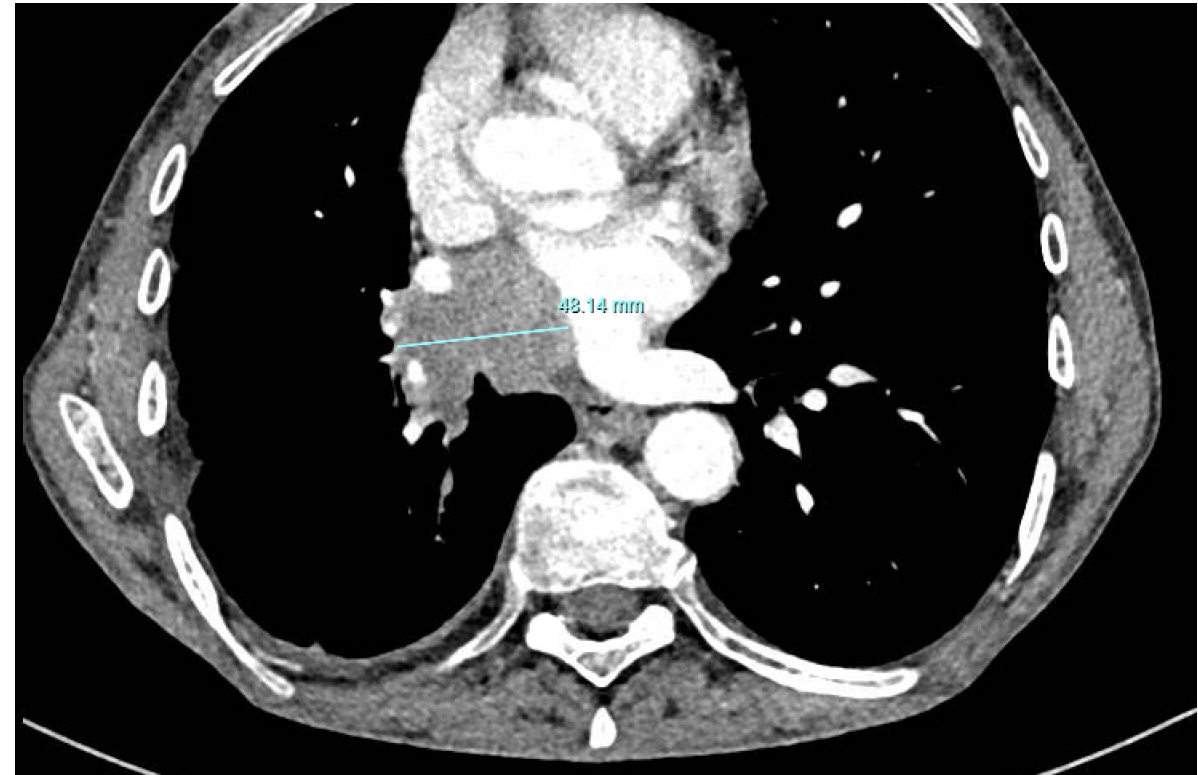
- ✓ **How to start everolimus?**
 - ✓ What are the expected toxicities and pro-active management?

The Case: Response to everolimus

Baseline

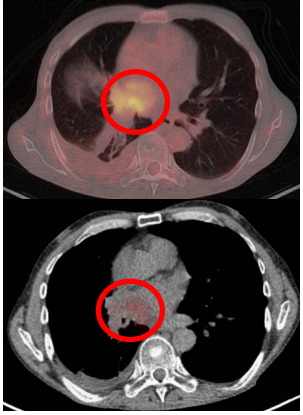


Response 8 weeks (Recist SD)

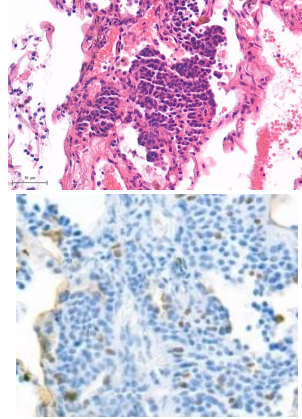


The Case

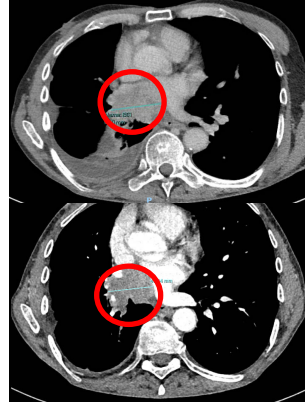
cT4N2aM0
TC (Ki-67 10%)
SSTR-
Non-resectable



Biopsy
Ki-67 30%



Response
RECIST SD



Follow-up

Everolimus

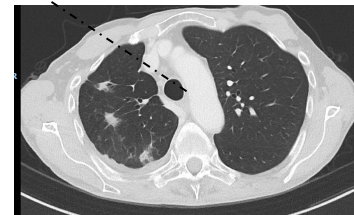
2020

2021

2023

2025

Pancreatitis
M1c disease

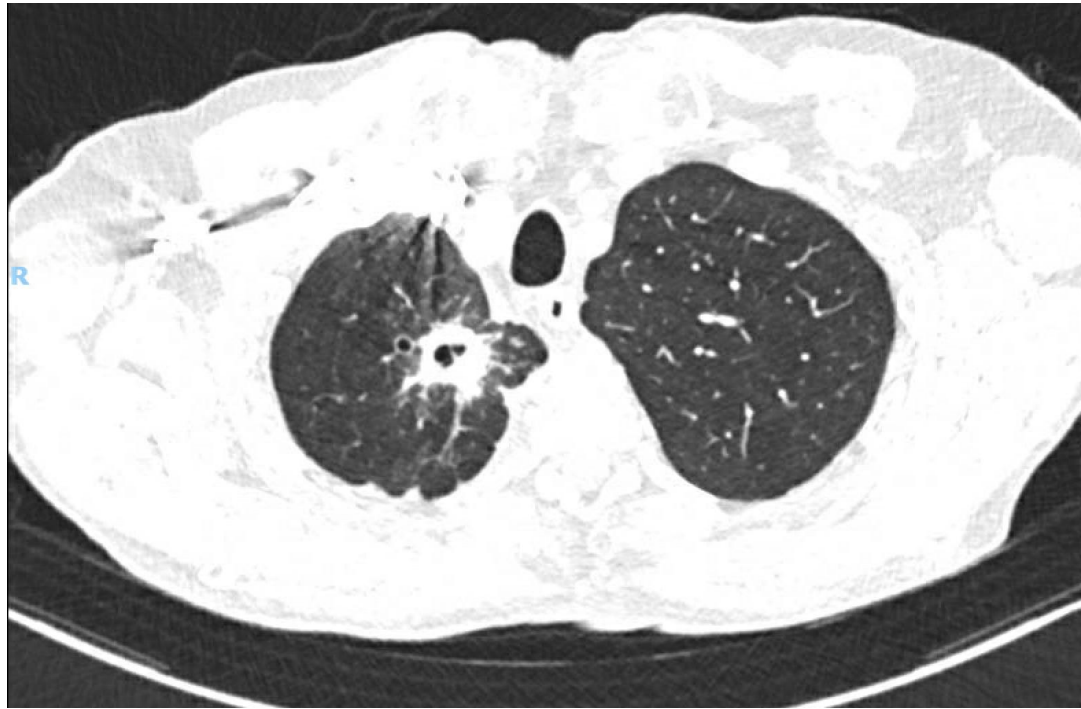


Pneumonitis?

✦ Biopsy
★ Complication

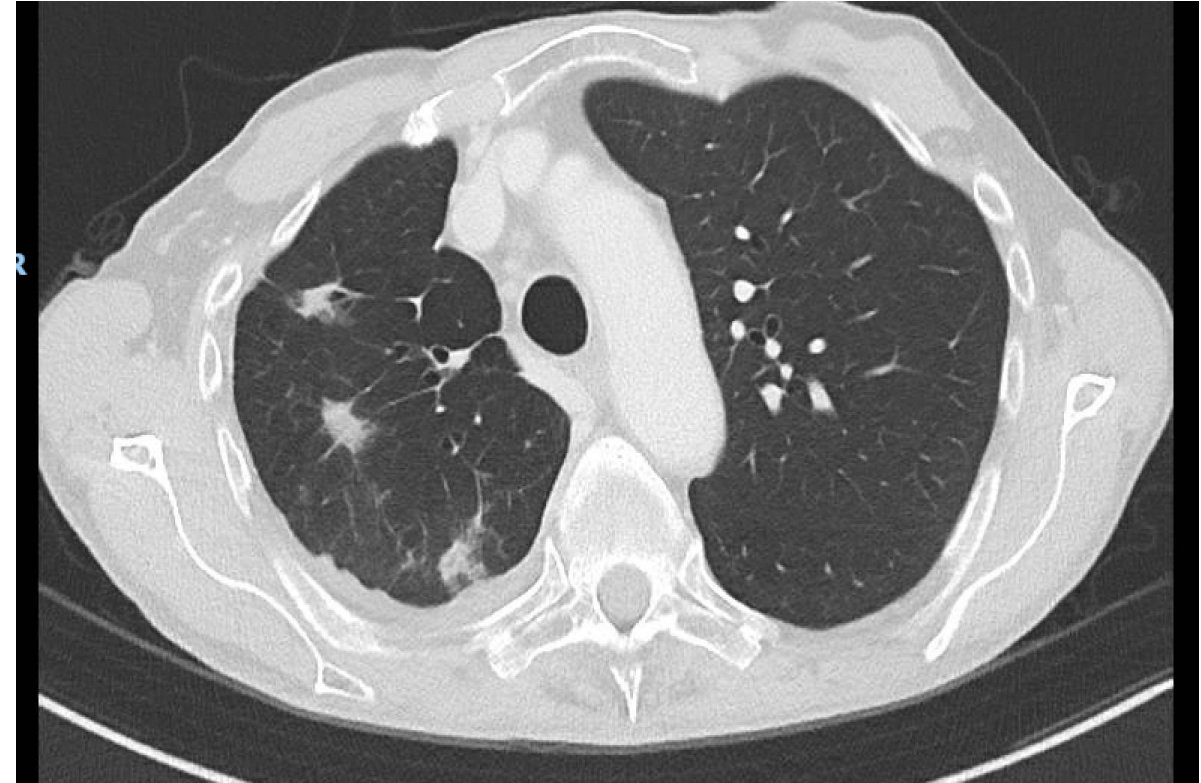
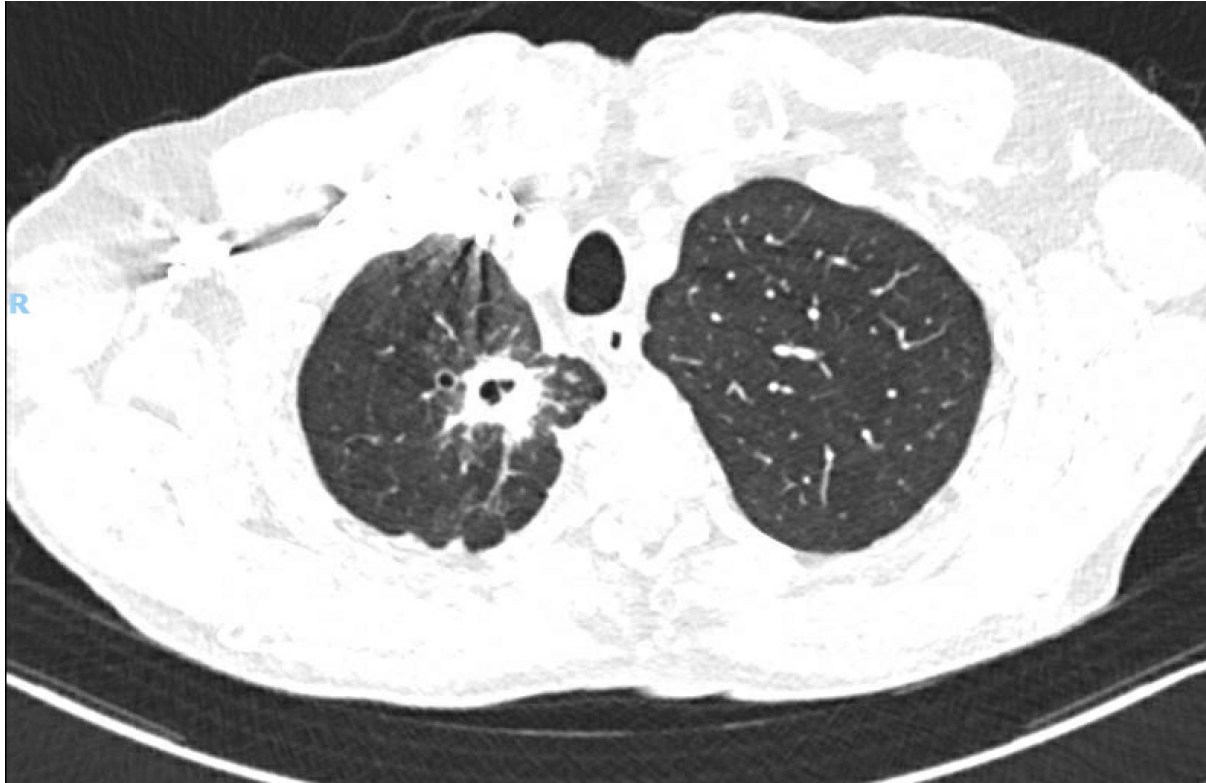
Question for the pulmonologist – Jules Derks

- ✓ How to manage potential pulmonary toxicity of Everolimus (pneumonitis – infection)?

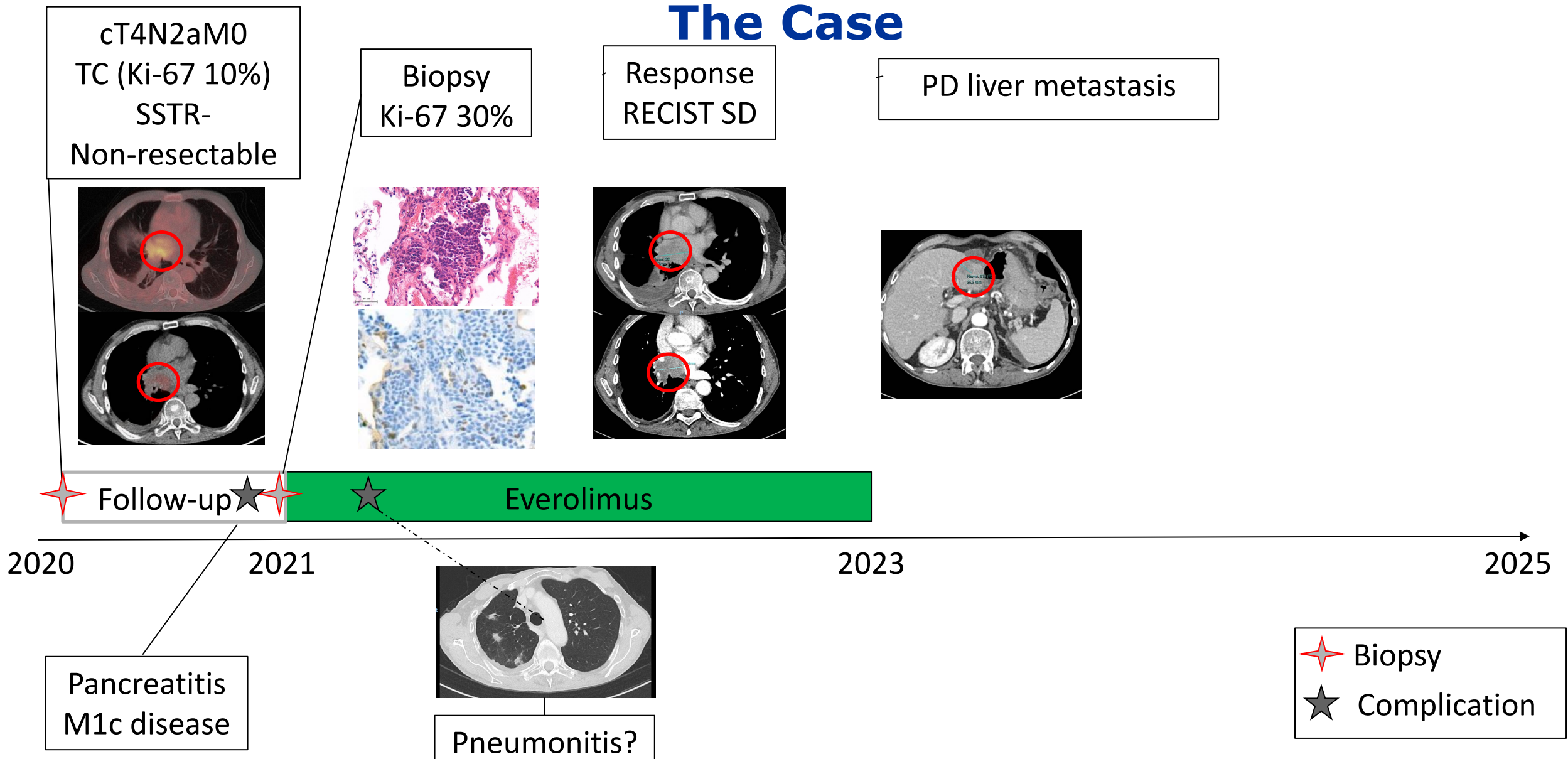


The Case: Infection, self limiting

Cavitating and nodular lesions; BAL: Aspergillus+, actinomyces/nocardia-, TBC-, path-.
Continued Everolimus and lesions regressed over 6 months; WD infectious

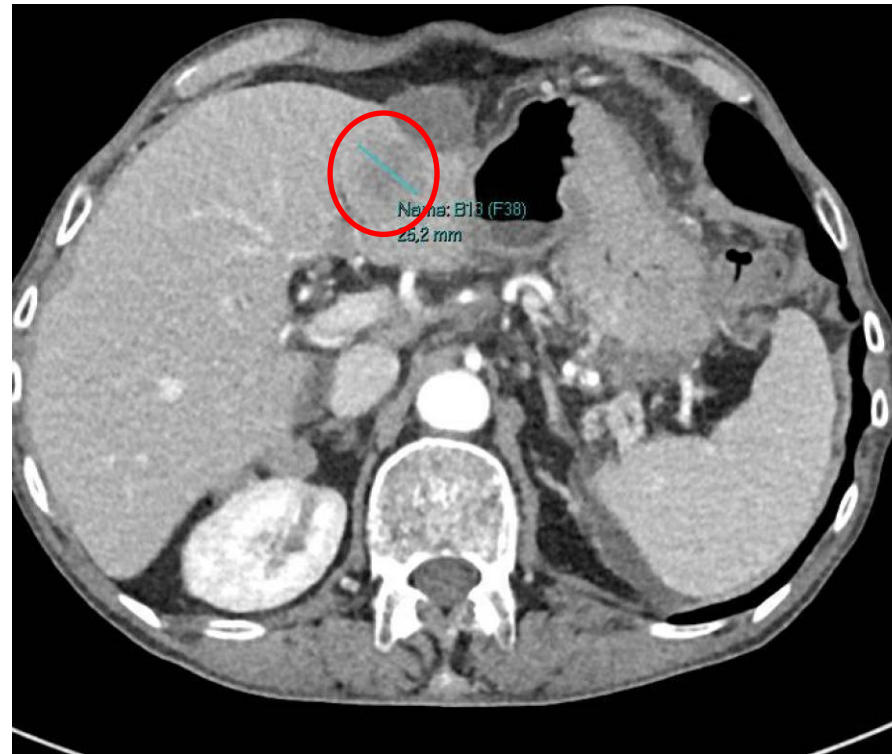


The Case



Question for the interventional radiologist – Dimitrios Filippiadis

- ✓ **Role for local therapy of the liver if single growing metastasis? RFA – Yttrium?**
 - ✓ What local options are available and when to consider in lung carcinoid?



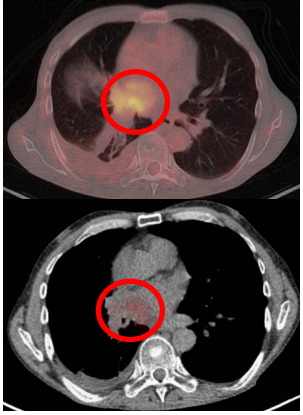
Live poll question for the Audience:

What would be your advice on treatment?

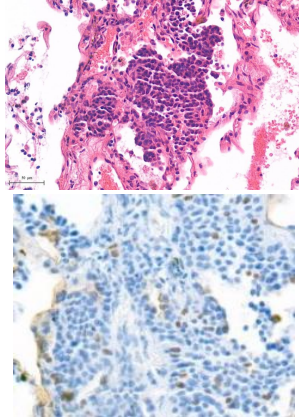
- Local therapy: RFA / Yttrium, then continue Everolimus
- Cabozantinib
- Chemotherapy treatment (capecitabine-temozolomide)
- Chemotherapy treatment (oxaliplatin-gemcitabine)

The Case

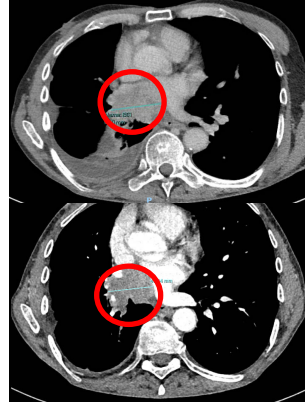
cT4N2aM0
TC (Ki-67 10%)
SSTR-
Non-resectable



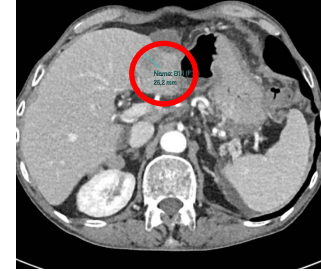
Biopsy
Ki-67 30%



Response
RECIST SD



PD liver metastasis



Follow-up

Everolimus

Capecitabine-Temozolomide

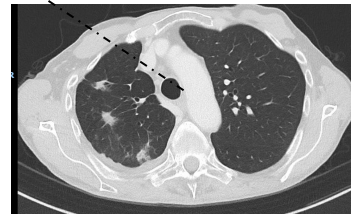
2020

2021

2023

2025

Pancreatitis
M1c disease

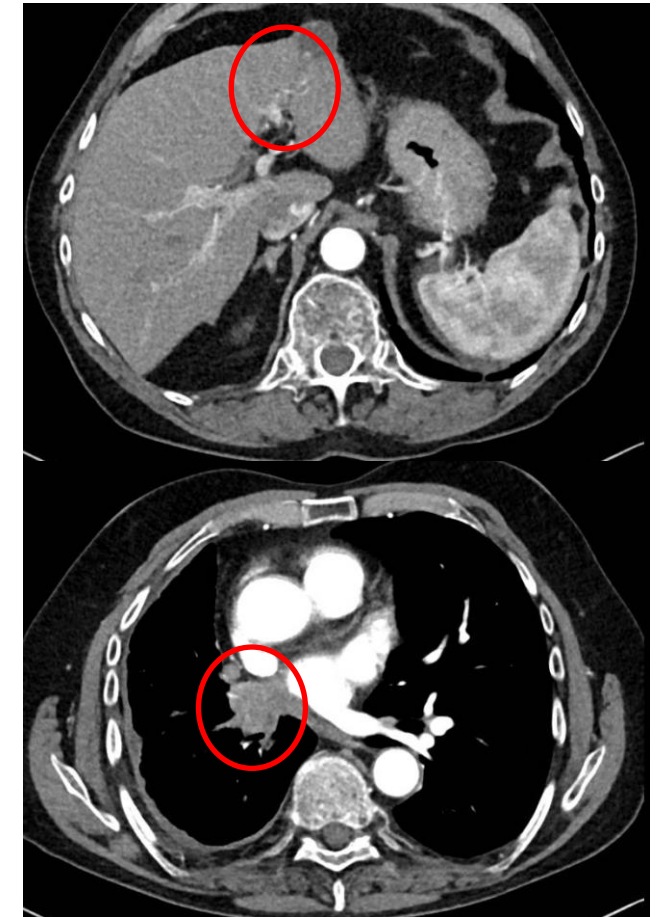
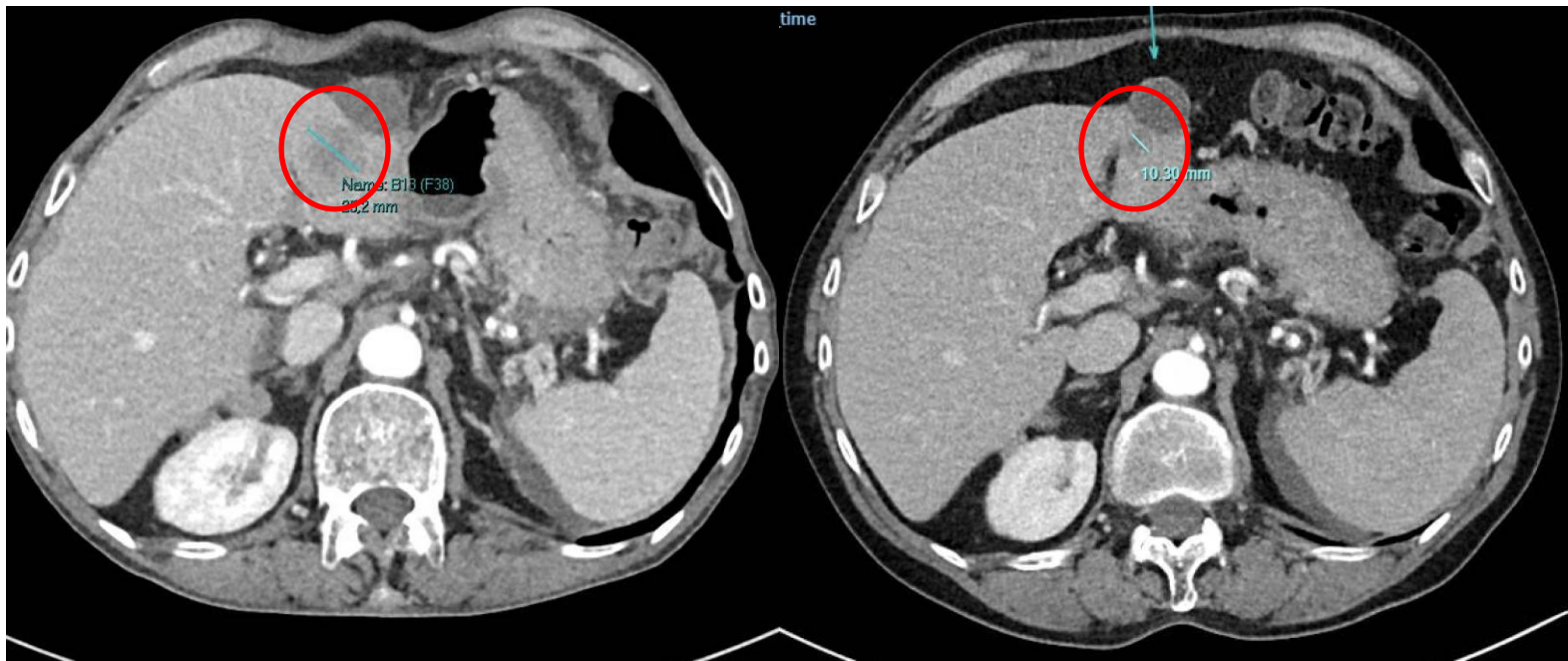


Pneumonitis?

✦ Biopsy
★ Complication

The Case: Response to chemotherapy

Response of liver metastasis and stable disease of the lung tumour



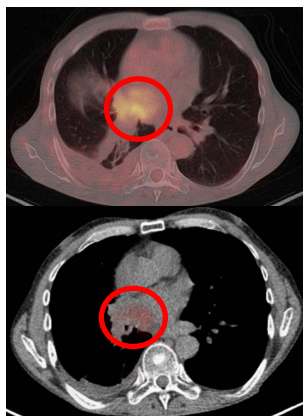
Question for the oncologist (2) – Anna Koumarianou

- ✓ **What is your preferred type of chemotherapy choice?**
 - ✓ Cap/tem vs. oxaliplatin-gemcitabine?
 - ✓ What if the patients has (asymptomatic) brain metastases?
- ✓ **When do you consider cabozantinib?**
 - ✓ How do you start cabozantinib (e.g. 40mg or 60mg)?

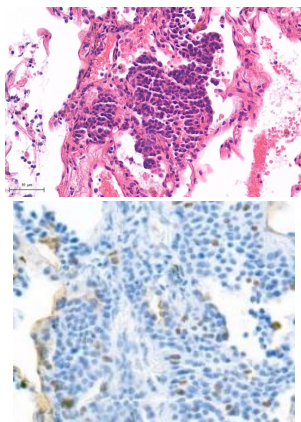
Sexton-Oates *et al*, medRxiv 2025

The Case

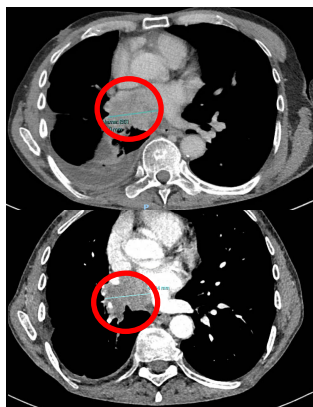
cT4N2aM0
TC (Ki-67 10%)
SSTR-
Non-resectable



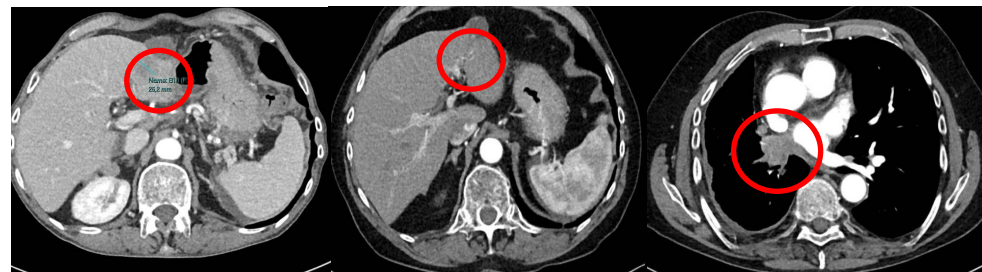
Biopsy
Ki-67 30%



Response
RECIST SD



PD liver metastasis
Response RECIST SD



Follow-up

Everolimus

Capecitabine-Temozolomide

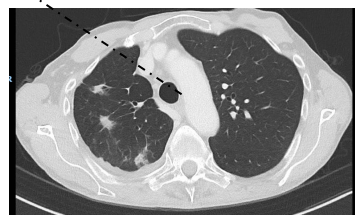
2020

2021

2023

2025

Pancreatitis
M1c disease



Pneumonitis?

✦ Biopsy
★ Complication

Panel discussion:

- ✓ **What is the role of NGS testing in metastatic lung carcinoid?**
 - ✓ If AGA found, start targeted drug 1st line?
- ✓ **Is there (any) role for immunotherapy?**
 - ✓ What if Ki-67 30-40% but well differentiated (i.e. GR-III NET like)?
- ✓ **Role of PRRT and rechallenge of PRRT (when SSTR++)?**



Closing comments

Take-home messages

- For Early-Stage Lung Carcinoids, surgery is the cornerstone of management. Anatomical lung resection (preferably lobectomy or sleeve resection) with systematic lymph node dissection remains the standard of care. Preoperative and longitudinal evaluation must be multimodal
- Advanced lung carcinoids are not static diseases—re-biopsy, re-image, and re-discuss in MDT as tumour biology evolves to optimize sequencing of systemic, local, and targeted therapies

A BIG "Thank You" to

- ✓ Our speakers and moderators
- ✓ The ENETS Office team: Martina FLESCHE, Ulrike KNELL, Anna MALDRYK & Leah MATTHEWS
- ✓ The ENETS Education Group
- ✓ YOU, our valued participants

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- ✓ **Dates:** 1 – 3 October 2026
- ✓ **Location:** Capolago, Lago di Varese, Italy
- ✓ **Target group:** Early-career NEN researchers (PhD/post-docs)
- ✓ **Capacity:** Limited to 20 participants
- ✓ **Deadline:** 18 June 2026 (23:59 CEST)
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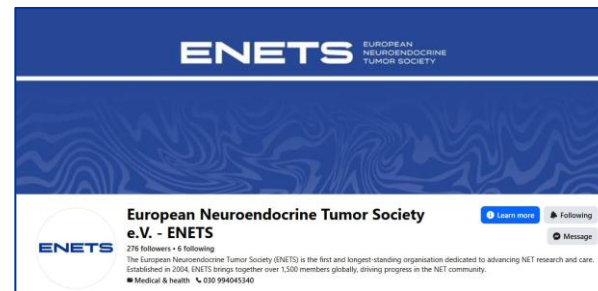
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