

REVIEW

Open Access



Systematic review reveals lack of quality in reporting health-related quality of life in patients with gastroenteropancreatic neuroendocrine tumours

Caroline Martini¹, Eva-Maria Gamper^{1,2*}, Lisa Wintner¹, Bernhard Nilica², Barbara Sperner-Unterweger¹, Bernhard Holzner¹ and Irene Virgolini²

Abstract

Background: Gastroenteropancreatic neuroendocrine tumours (GEP-NET) are often slow-growing and patients may live for years with metastasised disease. Hence, along with increasing overall and progression-free survival, treatments aim at preserving patients' well-being and health-related quality of life (HRQoL). However, studies on systematic HRQoL assessment in patients with GEP-NET are scarce. Therefore, the purpose of the current review is to systematically evaluate the methodological quality of the identified studies.

Methods: A targeted database search was performed in PubMed, EMBASE, and CENTRAL. Data extraction was conducted by two independent researchers according to predefined criteria. For study evaluation, the Minimum Standard Checklist for Evaluating HRQoL Outcomes in Cancer Clinical Trials and the CONSORT Patient-Reported Outcome extension were adapted.

Results: The database search yielded 48 eligible studies. We found the awareness for the need of HRQoL measurement to be growing and application of cancer-specific instruments gaining acceptance. Overall, studies were too heterogeneous in terms of patient characteristics and treatment interventions to draw clear conclusions for clinical practice. More importantly, a range of methodological shortcomings has been identified which were mainly related to the assessment and statistical analysis, as well as the reporting and interpretation of HRQoL data.

Conclusion: Despite an increasing interest in HRQoL in GEP-NET patients, there is still a lack of knowledge on this issue. A transfer of HRQoL results into clinical practice is hindered not only by the scarceness of studies, but also by the often limited quality of HRQoL processing and reporting.

Keywords: Health-related quality of life, Gastroenteropancreatic neuroendocrine tumours, Patient-reported outcomes, Systematic review, Methodological quality

Abbreviations: CONSORT, Consolidated standards of reporting trials; EORTC, European Organisation for research and treatment of cancer; FACIT, Functional assessment of chronic illness therapy; GEP-NET, Gastroenteropancreatic neuroendocrine tumours; HRQoL, Health-related quality of life; ISOQOL, International society for quality of life research; Norfolk QOL-NET, Norfolk quality of life – neuroendocrine tumor questionnaire; PRISMA, Preferred reporting items of systematic reviews and meta-analyses; PRO, Patient-reported outcome; QLG, Quality of life group; QLQ-C30, Quality of life questionnaire core 30; QLQ-GI.NET21, Quality of life questionnaire – neuroendocrine carcinoid

* Correspondence: eva.gamper@tirol-kliniken.at

¹Department for Psychiatry, Psychotherapy and Psychosomatics, Medical University of Innsbruck, Anichstraße 35, 6020 Innsbruck, Austria

²Department for Nuclear Medicine, Medical University of Innsbruck, Anichstraße 35, 6020 Innsbruck, Austria

Background

With an incidence of 5.25 per 100,000 [1] gastroenteropancreatic neuroendocrine tumours (GEP-NET) are a relatively rare disease. They are usually slow-growing and often do not produce clear symptoms until they are metastasised. Currently, surgical tumour resection is the only curative treatment, and usually only in patients with localised disease [1–4]. The primary aims of available therapeutic options are to provide symptom relief, control tumour growth, improve long-term survival, and, not least, preserve psychosocial well-being and health-related quality of life (HRQoL) [2, 4].

The past two decades have shown that the patient's subjective perspective on his/her own health, quality of life, and treatment-related aspects plays an essential role in treatment evaluation. Traditional physician proxy ratings on morbidity correlate only poorly with several self-reported functional capacity and well-being domains [5] – areas which are of utmost importance for the individual patient in managing his/her everyday life with the disease. These aspects are represented in the concept of HRQoL. There is agreement that HRQoL describes “the extent to which one's usual or expected physical, emotional, and social well-being is affected by a medical condition or its treatment” ([6], p. 73) and needs to be assessed as a patient-reported outcome (PRO). PROs comprise any self-report of a patient's health status without interpretation by a third person [7].

The assessment of HRQoL as an important secondary outcome in clinical studies, using reliable and valid self-report instruments, has become the criterion standard in oncology [8–10]. To date, systematic assessments of HRQoL in patients with GEP-NET have hardly been performed. High-quality information on HRQoL serves a variety of purposes, from the development of targeted interventions to informed decision making about treatment options to the allocation of healthcare resources [11].

Based on the assumptions above, we conducted a systematic review on studies incorporating HRQoL in patients with GEP-NET to evaluate the methodological quality of HRQoL processing and reporting. In detail, this review aims at investigating (i) the amount of available information on HRQoL in patients with GEP-NET, (ii) how HRQoL was assessed and reported, and (iii) if the quality of HRQoL information provided meets agreed standards.

Methods

We applied a systematic approach to identify and appraise studies on HRQoL in GEP-NET patients. Criteria for the selection, description and evaluation of studies were based on the PRISMA (Preferred Reporting Items

of Systematic Reviews and Meta-Analyses) checklist [12], the Cochrane Consumers and Communication Review Group's Extraction Template [13], and the Minimum Standard Checklist for Evaluating HRQoL Outcomes in Cancer Clinical Trials [14].

Search strategy

A systematic literature search was conducted in September 2014 and updated in July 2016 using PubMed, EMBASE, and CENTRAL. We searched for original research articles published in English, Italian, French, or German and restricted the search to studies on humans. Combinations of the following MeSH and free text terms were used: neuroendocrine tumors, digestive system neoplasms, neuroendocrine, endocrine, NET, foregut, midgut, hindgut, quality of life, patient-reported, self-reported, well-being, psycho*. An exemplary search history for PubMed is provided in Appendix.

In addition, we also searched OpenGrey (<http://www.opengrey.eu>) and BIOSIS previews (<http://www.dimdi.de/static/de/db/dbinfo/ba70.htm>) for the identification of grey literature. Database searches were augmented by a manual search of reference lists of included articles to identify further eligible studies not detected by our search terms.

Inclusion criteria and data extraction

Due to the scarceness of studies on the topic of HRQoL in patients with GEP-NET, it was decided not to impose restriction criteria concerning study design in order to comprehensively capture the available information. Any study with a quantitative approach assessing self-reported HRQoL was considered eligible. Publications that were letters, editorials, narrative reviews, and case reports were excluded. Methodological studies on HRQoL in this patient group (e.g., instrument development) were considered not eligible. A data collection form was based on the Cochrane Consumers and Communication Review Group's Extraction Template, adapted to study requirements, pilot tested on five randomly selected reports and refined accordingly.

Eligibility assessment and data extraction were performed by two independent researchers. In the case of disagreement, a third reviewer was consulted to reach final consensus. For the assessment of interrater agreement a simple Kappa calculation was performed, with values between .61 and .80 indicating substantial and of > .81 almost perfect agreement [15].

Study evaluation

For study evaluation we adapted the Minimum Standard Checklist for Evaluating HRQoL Outcomes in Cancer Clinical Trials [14] and the Consolidated Standards of

Reporting Trials (CONSORT) PRO extension checklist [16] for our requirements (i.e., applicable to a range of different study designs in addition to randomised controlled trials (RCTs)). Multiple reports on the same study were linked together and were subsequently defined as one study.

Quality criteria were defined according to study design

For all studies it was documented if:

- HRQoL was identified as primary or secondary outcome in the abstract (for studies with more than one outcome parameter),
- there was an a priori hypothesis concerning HRQoL (not applicable if explorative),
- an explicit rationale for HRQoL instrument selection was provided,
- the instrument was validated or psychometric properties were reported or referenced,
- the HRQoL instrument was cancer-specific,
- the instrument administration was reported,
- missing data was documented or discussed,
- statistical considerations for dealing with missing data were provided,
- reports on HRQoL results were complete and scoring was correct,
- the issue of clinical significance had been addressed.

For cross-sectional studies it was additionally documented if:

- compliance was reported.

For all kinds of prospective studies it was additionally documented if:

- baseline compliance was documented,
- the timing of assessment was reported.

For prospective and comparative studies it was additionally documented if:

- statistical power or effect sizes for HRQoL results were reported.

For studies with HRQoL as secondary outcome it was additionally documented if:

- HRQoL results were considered in discussion section.

Results

Study selection and study characteristics

The literature search yielded a total of 1506 records (after removing duplicates). Figure 1 shows the flow-

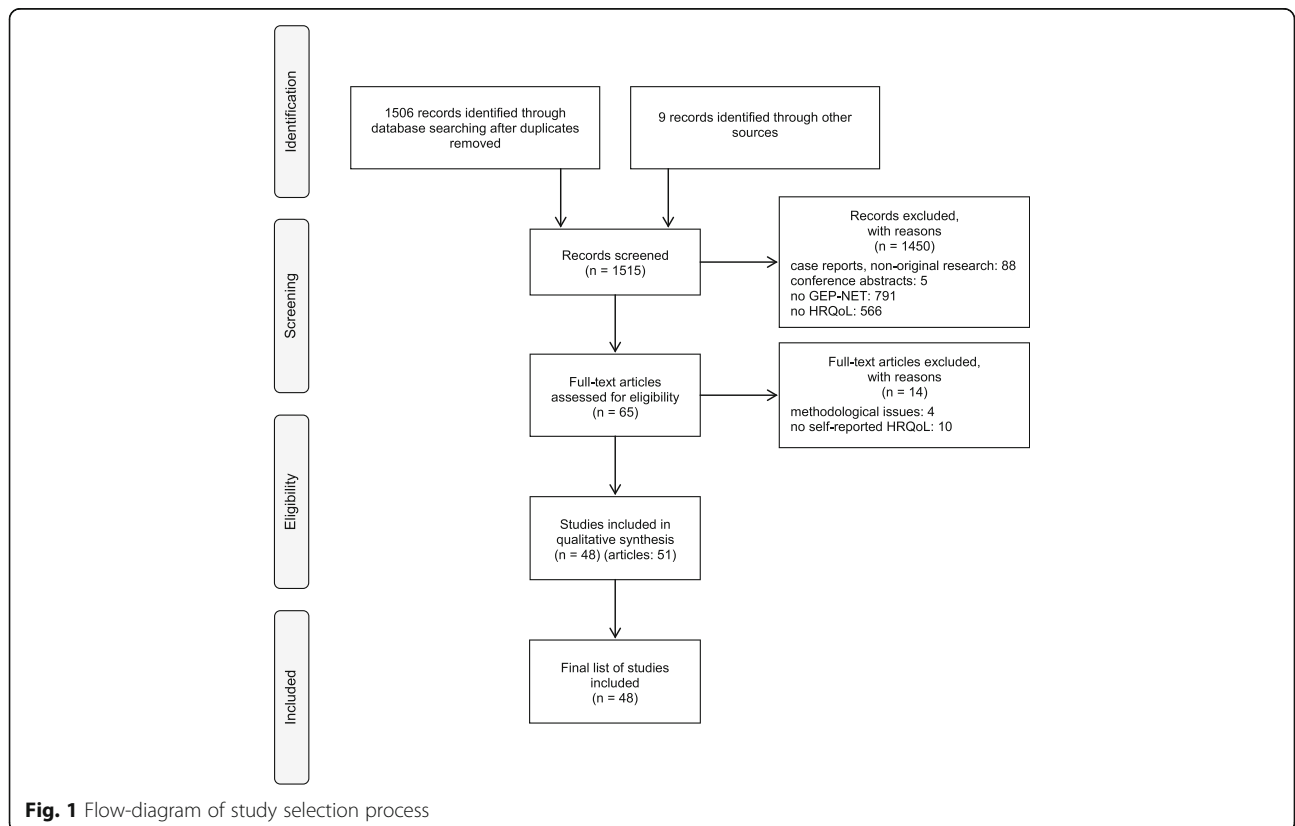


Fig. 1 Flow-diagram of study selection process

diagram of the selection process. We screened titles and abstracts and excluded 88 case-reports and non-original research reports such as comments and letters. Subsequently, 791 studies were excluded for not investigating GEP-NET, and 566 were excluded for not investigating HRQoL. Grey literature search yielded five conference abstracts reporting on studies dealing with HRQoL issues which were not (or not yet) published as full reports and, therefore, not included in the review. Four additional studies were identified by hand search of reference lists of relevant articles. After these selection steps, 65 potentially relevant full-text articles remained and were assessed for eligibility. Out of these, 14 articles were excluded from the review for the following reasons: ten did not measure self-reported HRQoL (e.g., used the Karnofsky Performance Score), and four were methodological studies either on HRQoL instrument development or comparison of instruments. With a Kappa of .818 ($p \leq .001$) the level of agreement between the two reviewers concerning inclusion or exclusion of a full-text article assessed for eligibility was high.

In total, 51 articles, which reported on 48 separate studies, were included. Eight were RCTs which assessed HRQoL as a secondary outcome to the primary endpoints response, progression-free survival, or time to progression. Additionally, 25 prospective studies, including 15 phase II trials, and 15 observational cross-sectional studies were identified.

Sample sizes ranged between 9 and 663 patients with a median of 51. Most of the studies investigated patients in an advanced stage of disease and administered the European Organisation for Research and Treatment of Cancer Quality of Life Questionnaire Core 30 (EORTC QLQ-C30) for assessing HRQoL. In total, 22 studies used either HRQoL or another PRO (e.g., fear of recurrence) as a primary outcome measure. Eight studies compared HRQoL scores with normative values from the national general population. For details on study characteristics see Table 1.

Applied instruments for measuring health-related quality of life

The majority of the reviewed studies (31/48) used the EORTC QLQ-C30 [17], which is one of the most widely used HRQoL questionnaire in oncology in Europe. It has been shown to have good validity and reliability and consists of 30 items incorporating five functional scales (physical, role, emotional, cognitive, social), three symptom scales (fatigue, nausea/vomiting, pain), six single items (dyspnoea, insomnia, appetite loss, constipation, diarrhoea, financial difficulties) and one scale assessing global health status/QoL. Scores are linearly transformed to a 0–100 scale with higher scores representing a higher level of functioning and a higher level of symptomatology, respectively.

As defined by Osoba et al. [18], mean changes in HRQoL scores over time of 5 to 10 points are considered as “small”, 10 to 20 points as “moderate”, and more than 20 points as “large” with regard to clinical relevance. The QLQ-C30 can be supplemented with disease- and treatment-specific modules. The NET-specific module, the QLQ-GI.NET21 [19], was used in four of the reviewed studies. It covers issues specific for GEP-NET and is applicable to patients suffering from endocrine or gastrointestinal symptoms. One study used the QLQ-LMC21, which is a module for patients with liver metastases from a colorectal tumour.

The same principle of adding disease- and treatment-specific modules to a generic questionnaire is applied by the Functional Assessment of Chronic Illness Therapy (FACIT) measures, which is one of the most frequently used HRQoL measurement systems in the US and Canada. The core questionnaire, the Functional Assessment of Cancer Therapy-General (FACT-G) [20], is composed of 27 items assessing physical, emotional, functional and social well-being. The FACT-G was used in five studies; applied modules were the FACT-Hepatobiliary, the FACT-Anemia, the FACIT-Diarrhea, and the FACIT-Fatigue.

One study used the Patient-Reported Outcome Measurement Information System 29-item Health Profile (PROMIS-29) which measures HRQoL in seven domains (depression, anxiety, physical function, pain interference, fatigue, sleep disturbance, ability to participate in social roles and activities) and was designed for patients with a wide range of chronic diseases [21]. In another study the Psychosocial Adjustment to Illness Scale (PAIS) was used. The PAIS was designed as a semi-structured clinical interview assessing a patient's psychosocial adjustment to medical illness in terms of multiple domains (health care orientation, vocational environment, domestic environment, sexual relationships, extended family relationships, social environment, psychological distress) [22].

Generic instruments, namely the 36-Item Short Form Health Survey (SF-36), the 12-Item Short Form Health Survey (SF-12), the Euroqol-5 Dimension (EQ-5D), the General Health Questionnaire 30 (GHQ-30) and 12 (GHQ-12), and the French version of the Nottingham Health Profile (ISPN), were used in 10 studies. These instruments assess physical, emotional, functional and social aspects that are applicable across patient groups and diseases and are therefore less suitable for the identification of cancer site- or problem-specific concerns [23].

Evaluation of methodological quality of HRQoL reporting

Detailed information for each study based on the Minimum Standard Checklist for Evaluating HRQoL Outcomes in Cancer Clinical Trials and the CONSORT PRO extension checklist is provided in Table 2.

Table 1 Study characteristics of identified studies

Author, year	Sample size, diagnosis (disease severity)	Treatment modality/ intervention	Comparison	PRO primary outcome	HRQoL measure
Randomised controlled trials					
Arnold et al., 2005 [52]	N = 109, foregut, midgut NET, CUP (locally advanced, metastatic)	octreotide	octreotide + INT	no	QLQ-C30
Bajetta et al., 2006 [53]	N = 60, well-differentiated intestinal, pancreatic, bronchial NET, other, CUP (low-grade malignancy)	lan ATG	lan MP	no	QLQ-C30
Caplin et al., 2014 [42] (CLARINET)	N = 204, well- or moderately differentiated pancreatic, midgut, hindgut NET, other, CUP (progressive, metastatic)	lan ATG	placebo	no	QLQ-C30, QLQ-GI.NET21
Jacobsen & Hanssen, 1995 [54]	N = 11, intestinal NET, PNET (liver metastases)	octreotide	placebo (cross-over design)	no	GHQ-30, PAIS
Meyer et al., 2014 [55]	N = 86, PNET, GI foregut NET, CUP (advanced, metastatic)	capecitabine + streptozocin + cisplatin	capecitabine + streptozocin	no	QLQ-C30
Raymond et al., 2011 [56]	N = 171, well-differentiated PNET (advanced, metastatic)	sunitinib	placebo	no	QLQ-C30
Rinke et al., 2009 [57] (PROMID)	N = 85, well-differentiated midgut NET (metastatic)	octreotide LAR	placebo	no	QLQ-C30
Yao et al., 2016 [45] (RADIANT-4)	N = 302, well-differentiated GI-NET, bronchopulmonary NET (advanced, progressive)	everolimus	placebo	no	FACT-G
Phase II studies					
Bodei et al., 2011 [58]	N = 51, bronchial, pancreatic, duodenal, ileal, appendicular, sigma-rectal NET, CUP (progressive, other)	¹⁷⁷ Lu-DOTATATE	-	no	QLQ-C30
Bushnell et al., 2010 [59]	N = 90, carcinoid (metastatic, refractory to octreotide)	⁹⁰ Y-DOTADOC	-	no	EQ-5D
Claringbold et al., 2011 [60]	N = 33, well-differentiated NET (progressive)	¹⁷⁷ Lu-DOTATATE	-	no	QLQ-C30
Cwikla et al., 2010 [61]	N = 60, GEP-NET (progressive, metastatic)	⁹⁰ Y-DOTATATE	-	no	QLQ-C30, QLQ-GI.NET21
Delpassand et al., 2014 [62]	N = 37, GEP-NET (progressive)	¹⁷⁷ Lu-DOTATATE	-	no	QLQ-C30
Ducreux et al., 2014 [43]; Mitry et al., 2014 [44] (BETTER)	N = 34, well-differentiated PNET (progressive, metastatic) N = 49, well-differentiated GI-NET (progressive, metastatic)	bevacizumab + 5-FU/streptozocin; bevacizumab + capecitabine	-	no	QLQ-C30
Frilling et al., 2006 [63]	N = 18, ileal, pancreatic NET, paraganglioma, gastrinoma, CUP (progressive, metastatic)	⁹⁰ Y-DOTATOC; ¹⁷⁷ Lu-DOTATOC	-	no	SF-36
Khan et al., 2011 [64]	N = 256, carcinoid, PNET, CUP, gastrinoma, glucagonoma, insulinoma, VIPoma (with and without metastases)	¹⁷⁷ Lu-DOTATATE	-	yes	QLQ-C30
Korse et al., 2009 [65]	N = 39, GI-NET (advanced, metastatic)	octreotide LAR	-	no	QLQ-C30
Kulke et al., 2008 [66]	N = 107, carcinoid, PNET (advanced)	sunitinib	-	no	EQ-5D, FACIT-Fatigue scale
Kvols et al., 2012 [67]	N = 45, GI-NET (advanced, metastatic)	pasireotide	-	no	FACIT-D
Martin-Richard et al., 2013 [68]	N = 30, well-differentiated GEP-NET, bronchopulmonary NET, CUP (progressive)	lan ATG	-	no	QLQ-C30

Table 1 Study characteristics of identified studies (Continued)

Ruszniewski et al., 2004 [69]	N = 71, foregut, midgut, hindgut NET, other (not terminally ill)	Ian PR	-	no	QLQ-C30
Wymenga et al., 1999 [70]	N = 55, carcinoid, gastrinoma, VIPoma (tumour stages III and IV)	Ian PR	-	no	QLQ-C30
Zuetenhorst et al., 2004 [71]	N = 26, well-differentiated ileo-cecal, gastric, bronchopulmonary NET, CUP (metastatic)	INT followed by unlabelled MIBG followed by ¹³¹ I-MIBG	-	no	QLQ-C30
Prospective studies					
Fröjd et al., 2007 [72]; Fröjd et al., 2009 [73]	N = 36, carcinoid (metastatic, other)	INT; octreotide; INT + octreotide; CTX; octreotide + CTX; no treatment	normative data (subsample)	yes	QLQ-C30
Haugland et al., 2013 [74]	N = 37, GI-NET (not terminally ill)	medical treatment (n.s.)	-	yes	SF-36
Kalinowski et al., 2009 [75]	N = 9, bronchial, jejunal, ileal, gastric NET, PNET, insulinoma (liver metastases)	⁹⁰ Y microspheres	-	no	QLQ-C30, QLQ-LMC21
Kwekkeboom et al., 2003 [76]	N = 35, GEP-NET (progressive, other)	¹⁷⁷ Lu-DOTATATE	-	no	QLQ-C30
Larsson & Janson, 2008 [77]	N = 18, midgut carcinoid (n.s.)	INT	-	yes	QLQ-C30, FACT-An
Larsson et al., 2001 [78]	N = 24, midgut carcinoid (metastatic, other)	INT; SSA; INT + SSA	normative data	yes	QLQ-C30
O'Toole et al., 2000 [79]	N = 33, intestinal NET, PNET, other (metastatic)	octreotide followed by lanreotide	lanreotide followed by octreotide	no	ISPN
Pasieka et al., 2004 [80]	N = 24, small bowel carcinoid, medullary thyroid cancer, CUP (progressive, metastatic)	¹³¹ I-MIBG; ¹¹¹ In-octreotide	-	no	ad hoc questionnaire
Spolverato et al., 2015 [81]	N = 85, intestinal, pancreatic, bronchial NET, CUP (neuroendocrine liver metastasis)	surgical vs. nonsurgical treatment	-	yes	self-constructed questionnaire
Teunissen et al., 2004 [82]	N = 50, carcinoid, PNET, CUP, gastrinoma, insulinoma (metastatic)	¹⁷⁷ Lu-DOTATATE	-	yes	QLQ-C30
Cross-sectional studies					
Beaumont et al., 2012 [83]; Pearman et al., 2016 [84]	N = 663, carcinoid, islet cell, "do not know or not sure which type" (local, regional, distant, currently not present)	surgery; surgery + SSA; other; no past/current treatment	normative data -	yes	SF-36, PROMIS global health short form, PROMIS-29
Gelhorn et al., 2016 [85]	N = 11, midgut, hindgut NET (metastatic)	telotristat etiprate	normative data	yes	QLQ-C30, QLQ-GI.NET21
Haugland et al., 2009 [86]	N = 96, GI-NET (not terminally ill)	INT; SSA; INT + SSA; CTX; no treatment	normative data	yes	SF-36
Haugland et al., 2016 [87]	N = 196, GI-NET (not terminally ill)	medical treatment (n.s.)	normative data	yes	SF-36
Larsson et al., 1998 [88]	N = 17, carcinoid, PNET (not terminally ill) (+ staff, N = 17)	INT; SSA; INT + SSA	-	yes	QLQ-C30
Larsson, Sjöden et al., 1999 [89]	N = 119, carcinoid, PNET (n.s.)	INT + octreotide; INT; octreotide; CTX; XTR; omeprazol; no treatment	-	yes	QLQ-C30
Larsson, von Essen et al., 1999 [90]	N = 99, carcinoid, PNET (not terminally ill)	INT; SSA; INT + SSA	-	yes	QLQ-C30

Table 1 Study characteristics of identified studies (Continued)

Larsson et al., 2003 [91]	N = 19, carcinoid (n.s.) (+ staff, N = 19)	INT; SSA; INT + SSA	-	yes	semi-structured interviews
Larsson et al., 2007 [92]	N = 83, carcinoid, PNET (n.s.)	INT/octreotide; CTX; XTR; omeprazol; no treatment	-	yes	QLQ-C30
Petzel et al., 2012 [93]	N = 240, PNET, periampullary neoplasms (disease-free after surgery)	no current treatment	-	yes	FACT-Hep
Pezzilli et al., 2009 [94]	N = 44 PNET (disease free, advanced)	SSA; SSA + other; no treatment	normative data	yes	SF-12, GHQ-12
Pezzilli et al., 2010 [95]	N = 44 ileal NET (disease free, advanced)	SSA; INT; CTX; SSA + other; no treatment		yes	SF-12
Ruszniewski et al., 2016 [96] (SYMNET)	N = 273, small bowel carcinoid, appendicular, colonic, bronchopulmonary NET, CUP (92 % with metastases)	lan ATG	-	yes	QLQ-C30, QLQ-GI.NET
van der Horst-Schrivers et al., 2009 [97]	N = 43, midgut NET (metastatic)	SSA; INT; SSA + INT	normative data	yes	QLQ-C30
von Essen et al., 2002 [98]	N = 85, GI-NET (n.s.)	INT; SSA; INT + SSA	-	yes	QLQ-C30
Grey literature					
Garcia-Hernandez et al., 2012 [99]	N = 74, GI-NET (n.a.)	n.a.	-	yes	QLQ-C30, QLQ-GI.NET21
Gyökeres et al., 2010 [100]	N = 93, GI-NET (59 % with metastases)	SSA	-	yes	QLQ-C30, QLQ-GI.NET21
Marinova et al., 2016 [101]	N = 68, PNET (n.a.)	PRRT (n.s.)	-	yes	QLQ-C30
Pavel et al., 2013 [102]	N = 126, PNET (advanced)	everolimus	-	no	QLQ-C30, QLQ-GI.NET21
Strosberg et al., 2015 [103]	N = 230, midgut NET (advanced, progressive, metastatic)	¹⁷⁷ Lu-DOTATATE	octreotide LAR	no	QLQ-C30, QLQ-GI.NET21

Note. CUP cancer with unknown primary, CTX chemotherapy, GEP-NET gastroenteropancreatic NET, GI-NET gastrointestinal NET, INT interferon- α , lan ATG lanreotide autogel, lan MP lanreotide microparticles, lan PR lanreotide prolonged-release, MIBG meta-iodobenzylguanidin, NET neuroendocrine tumours, n.a. not available, n.s. not specified, octreotide LAR octreotide long-acting repeatable, PNET pancreatic NET, XTR radiotherapy, SSA somatostatin analogues

Table 2 Study evaluation according to defined quality criteria

Author, year	HRQoL stated as prim./sec. aim ^a	A priori hypothesis	Instrument rational	Instrument validation ^b	Cancer-specific instrument	Instrument administration	(Baseline) compliance	Timing of assessments	Missing data reported	Statistical methods for missing data	Power or effect sizes (HRQoL)	Presentation of results adequate ^c	Clinical significance addressed	HRQoL results discussed
Randomised controlled trials														
Arnold et al., 2005 [52]	-	-	+	+	+	-	+	+	+	-	-	-	-	+
Bajetta et al., 2006 [53]	-	-	-	+	+	+	-	+	+	+	-	-	-	+
Caplin et al., 2014 [42] (CLARINET)	+	-	-	+	+	-	-	+	+	+	-	+	-	-
Jacobsen & Hanssen, 1995 [54]	+	-	-	+	- ^d	-	+	+	+	-	-	-	+	+
Meyer et al., 2014 [55]	+	-	-	+	+	-	+	+	+	-	-	-	-	-
Raymond et al., 2011 [56]	-	-	-	+	+	+	-	+	+	-	-	-	+	+
Rinke et al., 2009 [57] (PROMID)	-	-	-	+	+	-	+	+	-	-	-	-	-	-
Yao et al., 2016 [45] (RADIANT-4)	-	-	+	+	+	+	+	+	-	+	-	n.r.	+	n.r.
Phase II studies														
Bodei et al., 2011 [58]	-	-	-	+	+	-	-	+	-	-	-	-	-	+
Bushnell et al., 2010 [59]	-	-	-	+	-	-	+	+	+	-	-	-	-	-
Claringbold et al., 2011 [60]	-	-	-	+	+	-	-	+	+	-	-	-	-	+
Cwikla et al., 2010 [61]	-	-	-	+	+	+	-	+	+	-	-	-	-	-
Delpassand et al., 2014 [62]	-	-	-	+	+	-	-	+	+	-	-	-	-	-
Ducreux et al., 2014 [43];	+	-	-	+	+	-	-	+	+	-	-	-	-	-

Table 2 Study evaluation according to defined quality criteria (Continued)

Mitry et al., 2014 [44] (BETTER)														
Frilling et al., 2006 [63]	-	-	-	+	-	-	-	+	+	-	-	-	-	-
Khan et al., 2011 [64]	N/A	-	+	+	+	+	+	+	+	-	-	-	+	+
Korse et al., 2009 [65]	N/A	-	+	+	+ ^d	-	-	-	+	-	-	-	-	N/A
Kulke et al., 2008 [66]	-	-	-	+	-	+	-	+	+	-	-	-	-	+
Kvols et al., 2012 [67]	-	-	-	+	+	-	-	+	+	-	-	-	-	+
Martin-Richard et al., 2013 [68]	+	-	-	+	+	-	-	+	-	-	-	+	-	-
Ruszniewski et al., 2004 [69]	-	-	-	+	+	-	+	+	+	-	-	-	-	+
Wymenga et al., 1999 [70]	-	-	-	+	+	-	-	+	-	+	-	+	-	+
Zuetenhorst et al., 2004 [71]	-	+	-	+	+ ^d	-	-	+	+	-	-	-	-	+
Prospective studies														
Fröjd et al., 2007 [72]; Fröjd et al., 2009 [73]	N/A	N/A	-	+	+ ^d	+	+	+	+	+	-	+	+	N/A
Haugland et al., 2013 [74]	N/A	-	-	+	-	+	+	+	+	+	+	+	-	N/A
Kalinowski et al., 2009 [75]	-	-	+	+	+	-	-	+	-	-	-	-	-	+
Kwekkeboom et al., 2003 [76]	-	-	-	+	+	+	-	+	+	-	-	-	-	+
Larsson & Janson, 2008 [77]	N/A	N/A	+	+	+	-	-	+	+	-	-	+	+	N/A
	N/A	-	-	+	+ ^d	+	+	+	+	-	-	+	+	N/A

Table 2 Study evaluation according to defined quality criteria (Continued)

Larsson et al., 2001 [78]															
O'Toole et al., 2000 [79]	-	+	-	+	- ^d	+	-	+	-	-	-	+	-	+	
Pasieka et al., 2004 [80]	-	-	-	-	-	+	+	+	+	-	-	-	+	+	
Spolverato et al., 2015 [81]	N/A	+	+	-	+	+	+	+	+	-	-	-	-	N/A	
Teunissen et al., 2004 [82]	N/A	N/A	+	+	+	+	-	+	+	+	-	+	+	N/A	
Cross-sectional studies															
Beaumont et al., 2012 [83]; Pearman et al., 2016 [84]	N/A	N/A	-	+	-	+	+	N/A	+	-	+	+	+	+	N/A
Gelhorn et al., 2016 [85]	-	N/A	-	+	+	+	+	N/A	+	-	N/A	-	+	+	
Haugland et al., 2009 [86]	N/A	N/A	+	+	-	+	+	N/A	+	-	+	+	+	N/A	
Haugland et al., 2016 [87]	N/A	+	-	+	-	+	+	N/A	+	+	-	-	-	N/A	
Larsson et al., 1998 [88]	N/A	N/A	+	+	+ ^d	+	+	N/A	+	-	N/A	-	-	N/A	
Larsson, Sjöden et al., 1999 [89]	N/A	N/A	+	+	+	+	-	N/A	+	-	N/A	+	+	N/A	
Larsson, von Essen et al., 1999 [90]	N/A	N/A	+	+	+ ^d	+	+	N/A	+	-	N/A	+	+	N/A	
Larsson et al., 2003 [91]	N/A	N/A	N/A	N/A	N/A	+	-	N/A	+	N/A	N/A	N/A	N/A	N/A	
Larsson et al., 2007 [92]	N/A	N/A	+	+	+ ^d	+	+	N/A	+	-	N/A	+	-	N/A	
Petzal et al., 2012 [93]	N/A	+	+	+	+	+	-	N/A	+	+	N/A	+	-	N/A	
Pezzilli et al., 2009 [94]	N/A	-	-	+	-	+	+	N/A	+	-	-	-	-	N/A	
Pezzilli et al., 2010 [95]	N/A	-	-	+	-	+	-	N/A	-	-	-	-	-	N/A	
	-	N/A	-	+	+	+	-	N/A	-	+	+	-	-	+	

Table 2 Study evaluation according to defined quality criteria (*Continued*)

Ruszniewski et al., 2016 [96] (<i>SYMNET</i>)															
van der Horst-Schrivers et al., 2009 [97]	N/A	N/A	-	+	+	+	+	N/A	-	-	-	+	-	N/A	
von Essen et al., 2002 [98]	N/A	N/A	-	+	+	+	+	N/A	+	-	-	-	-	N/A	

Note. ^ain the abstract of the article; ^bor psychometric properties reported; ^cconsidered adequate if scoring has been performed correctly and if all assessed HRQoL domains were reported (including relevant *p*-values); ^dadditional ad hoc questions on symptoms added; *N/A* not applicable due to study design, *n.r.* not reported

Figure 2 shows the percentage of studies meeting the CONSORT PRO reporting criteria. The percentage of studies meeting additional quality criteria is depicted in Fig. 3. It should be noted that stated percentages do not always refer to all 48 extracted studies, but to the total number of studies that met the defined criteria.

Study evaluation revealed three major topics of concern. The first is a lack of knowledge on how to assess and process HRQoL data, and here particularly the absence of a priori hypotheses on HRQoL outcomes in 85 % and missing rationales for applied questionnaires in 70 % of studies. The second is a lack of adequate reporting of HRQoL results. For 65 % of studies, the presentation of results was rated inadequate, either due to incomplete reporting of HRQoL scores (only single scales or statistical significant results) or due to invalid score calculation (i.e., not according to the respective scoring manual). The third is related to the statistical methods as well as interpretation and discussion of HRQoL results. Information on the handling of missing data was not given in 79 % of studies. Less than one third of the studies (30 %) addressed the issue of clinical significance of findings. Further evaluation revealed that studies which investigated HRQoL as a primary outcome showed higher methodological quality of HRQoL data than those that included HRQoL as a secondary outcome measure. This was especially true for presentation and interpretation of results.

Overview on HRQoL outcomes

From our literature search, we identified 8 RCTs investigating a broad range of patient groups regarding cancer site and stage, disease duration, as well as

treatment modality. According to the predefined criteria, reporting of HRQoL data was of moderate to poor quality, especially in terms of completeness and adequate presentation of results. Thus, due to heterogeneity and methodological limitations of studies, no firm conclusions for clinical practice can be drawn.

There is evidence from non-RCTs including HRQoL as a primary outcome that patients with GEP-NET perceive their overall HRQoL as relatively good and stable. However, in-depth evaluation of these studies revealed a range of physical and psychosocial complaints primarily related to diarrhoea, flushing, and fatigue, as well as emotional, social, and role functioning when compared to the general population. Again, it has to be noted that these results should be interpreted with caution and not be considered as a basis for informing clinical practice and decision making. A brief summary of primary outcomes and HRQoL results of the reviewed studies is provided in Additional file 1.

Discussion

The evaluation of HRQoL in patients with GEP-NET has attracted increasing interest in recent years. Despite this positive trend, however, there is still little knowledge available on this topic, and existing studies have major methodological limitations that hinder the application of HRQoL findings in daily clinical practice. The aim of this review was to evaluate the methodological quality of studies on HRQoL in GEP-NET patients, from data collection through to interpretation of results.

Our literature search yielded 58 abstracts ostensibly dealing with HRQoL issues in GEP-NET patients. However, further evaluation reveals that ten of these studies did not assess HRQoL at all but rather performed proxy

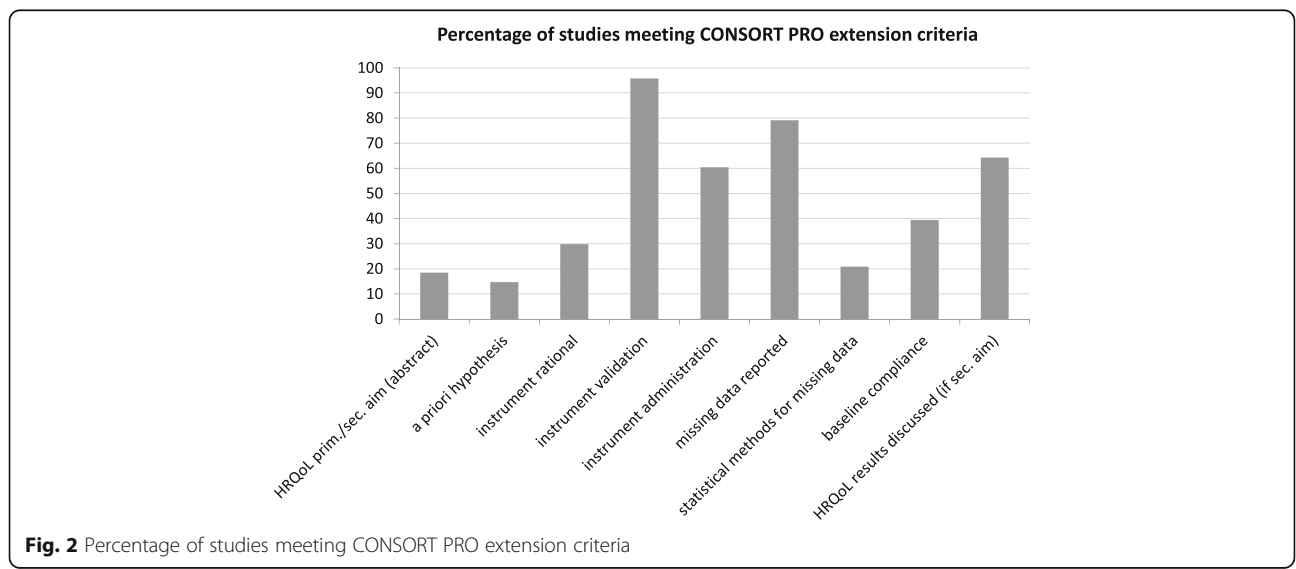
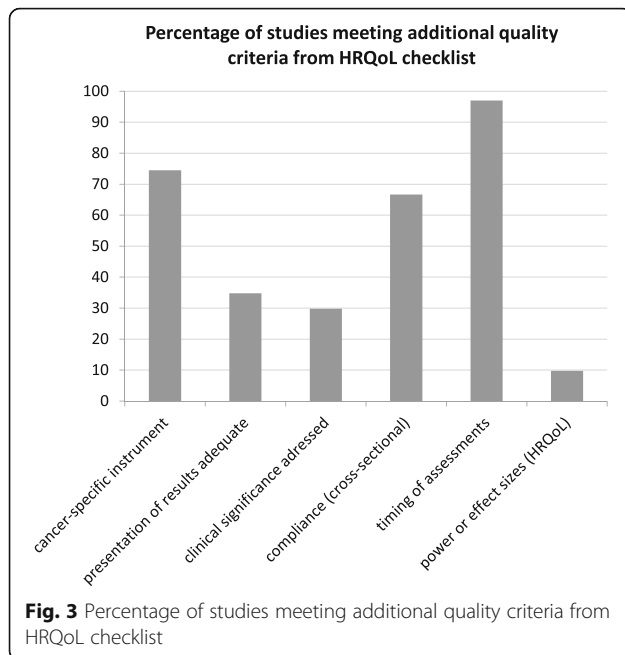


Fig. 2 Percentage of studies meeting CONSORT PRO extension criteria



ratings on physical functioning and self-care abilities. As the agreed definition of HRQoL is that it assesses a range of health issues beyond physical abilities and inevitably comprises patients' self-reports [7, 24–26], these studies were excluded from the systematic review.

The evaluation of the remaining 48 studies, on a positive note, revealed a consistent application of appropriate HRQoL instruments. The majority of studies (35/48) used a cancer-specific questionnaire with already proven reliability and validity. This finding is in line with previous studies on the quality of PRO reporting in oncology RCTs, indicating that a majority of studies including PROs used validated disease- or at least cancer-specific instruments [27–29]. In the current review, nine studies amended these questionnaires with ad hoc questions on NET-specific symptoms, such as diarrhoea and hot flushes. It should be noted, however, that this was done in the absence of validated NET-specific PRO instruments. One study, however, administered an ad hoc instrument alone (i.e., not in combination with another validated measure) and another study used a self-constructed questionnaire comprising elements of validated measures. The term 'ad hoc' refers to the fact that these questions were not formally developed and had not undergone psychometric testing. In order to ensure high methodological quality and improve comparability of data across different studies, ad hoc questions should be considered only, if there are no appropriate validated PRO instruments [30, 31]. There is awareness of the fact that novel treatment agents may entail a range of symptoms not currently covered by validated PRO/HRQoL instruments [32–34] and methodological approaches of

addressing this issue are being discussed. The EORTC Quality of Life Group (QLG) runs a database with an item pool including all questions from the disease-specific supplementary modules of the QLQ-C30, validated for cancer patients and different languages. Selecting suitable questions from such an item bank should be preferred over designing ad hoc questions. For patients with GEP-NET, two disease-specific questionnaires, the EORTC QLQ-GI.NET21 [19], a module to be applied together with the core questionnaire QLQ-C30, and the Norfolk QOL-NET [35], a NET-specific stand-alone measure, have become available only recently.

A range of methodological shortcomings were identified in assessing and processing as well as in reporting and interpreting HRQoL data. Most of the reviewed studies were heterogeneous in terms of study design and quality making it impossible to draw meaningful conclusions for clinical practice at this point. This refers primarily to studies investigating HRQoL as a secondary outcome. A large percentage of these studies provided only crude or incomplete presentations of HRQoL results or did not apply correct scoring procedures as prescribed by respective manuals. One of the included RCTs used HRQoL as a secondary outcome, as indicated in the clinical trial protocol as well as in the Methods section of the respective main publication, but failed to report on these issues both in the Results and Discussion section. Another common limitation was the lack of information on the statistical approach of handling missing HRQoL data, which was also found in previous reviews including different malignancies such as brain, bladder, prostate, and gynaecological cancers [27, 28, 36, 37]. These limitations were apparent even in high-evidence studies that are likely to impact on health policy and practice. None of the eight RCTs included in this review could provide HRQoL information in a way that would allow its use for informed decision making and planning future trials. Thus, while acknowledging the need for assessing HRQoL as an important secondary outcome in clinical studies, there seems to be an uncertainty about the processing of the collected data [14, 38–40]. Similar to the results of previous studies investigating the methodological quality of PRO reporting in patients with brain [27], prostate [36], and gynaecological [28] cancers, further problems were related to the interpretation of HRQoL results, especially regarding the clinical significance of HRQoL findings (e.g., changes over time, differences between treatment arms). Studies included in this review that used HRQoL as a primary outcome provided evidence that patients present with impairments in multiple domains such as emotional, role, and social functioning when compared to general population norms. This is in contrast to findings showing that GEP-NET patients generally perceived their HRQoL as relatively good. As mentioned above, to date, existing

studies do not allow for firm conclusions and call for further research to elucidate the time course of HRQoL in this patient group.

Two recent review articles [29, 39] evaluating the methodological quality of PRO reporting in high-evidence studies on different cancer types indicated that the overall level of reporting according to the CONSORT PRO extension criteria was poor. Exceptions were studies assessing HRQoL as a primary outcome and/or presenting a supplementary report on HRQoL issues which showed a better performance. The overall quality of PRO reporting might benefit from increasing familiarity with HRQoL issues and the development of the above mentioned guidelines [29, 36, 39]. However, in spite of this development, a recent review on the consistency of available PRO-specific guidance has identified a clear lack of respective recommendations for the appropriate implementation of PROs in clinical research [41]. Although the checklists applied in this review [14, 16] do not represent an exhaustive set of criteria for high-quality HRQoL assessment for studies including HRQoL either as a primary or secondary outcome, their application both during study planning and reporting would substantially enhance the quality of the assessed data.

Therefore, while agreeing that further guidance is required to make HRQoL assessment more feasible and – with increasing quality – accessible for clinical use, we emphasise the need to adhere to already existing quality standards. Important scientific societies that have shaped the field of HRQoL research in oncology over the past two decades, such as the EORTC QLG, the FACIT group and the International Society for Quality of Life Research (ISOQOL), provide a well-informed basis for the application of PROs and should therefore be consulted when considering their incorporation into clinical trials.

In the field of GEP-NET research, there is a growing number of clinical trials considering HRQoL as an

outcome measure [42–48]. However, two recent, not yet published, phase III trials fail to incorporate PRO or HRQoL assessments, as indicated in the respective study protocols [49, 50]. Furthermore, the methodological quality of information derived thus far is not satisfactory. Considering the fact that such studies have the potential to impact on health policy and practice, the importance of generating high-quality HRQoL data cannot be overstated. Poorly designed and/or reported PROs are likely to undermine the credibility of the results, which in turn hinders their application in daily clinical practice [9, 14, 27, 29, 37, 39, 40]. Especially with the movement towards a more patient-centred health care system, the incorporation of the patient's subjective perspective plays a pivotal role in facilitating patient involvement in health care, thereby enhancing patient empowerment and satisfaction [51].

Conclusions

Despite an increasing interest in assessing HRQoL in patients with GEP-NET, there is still little knowledge on the course of HRQoL over time, highlighting the need for high-quality longitudinal studies. Existing studies show methodological shortcomings in both processing and reporting of HRQoL data, especially when included as a secondary outcome in clinical trials. Methodological limitations were identified even for studies with high evidence level, which is considered problematic given their impact on health policy and medical practice. Thus, the valid application of HRQoL findings in clinical practice is hampered not only by lack of studies, but also by various methodological limitations of the existing ones. High-quality, well-reported HRQoL data is of utmost importance to make results accessible and useful to patients and their treating physicians. Therefore, it is strongly recommended to adhere to existing guidelines on the incorporation of PROs into clinical research.

Appendix

Table 3 Exemplary search history for PubMed

Search	Add to builder	Query	Items found
#16	Add	Search ((((((neuroendocrine tumor[MeSH Terms]) OR ((digestive system neoplasms[MeSH Terms]) AND (((neuroendocrine[Title/Abstract]) OR endocrine[Title/Abstract]) OR NET[Title/Abstract])) OR (((foregut[Title/Abstract]) OR midgut[Title/Abstract]) OR hindgut[Title/Abstract]))) AND (((quality of life) OR psycho*) OR well-being) OR patient-reported) OR self-reported))) NOT ((review) OR case-report))) NOT (((melanoma) OR schwannoma) OR ac*ustic neuroma) Filters: Classical Article; Clinical Study; Clinical Trial; Comparative Study; Controlled Clinical Trial; Multicenter Study; Observational Study; Randomized Controlled Trial; Humans; English; French; German; Italian; Spanish	796
#15	Add	Search ((((((neuroendocrine tumor[MeSH Terms]) OR ((digestive system neoplasms[MeSH Terms]) AND (((neuroendocrine[Title/Abstract]) OR endocrine[Title/Abstract]) OR NET[Title/Abstract])) OR (((foregut[Title/Abstract]) OR midgut[Title/Abstract]) OR hindgut[Title/Abstract]))) AND (((quality of life) OR psycho*) OR well-being) OR patient-reported) OR self-reported))) NOT ((review) OR case-report))) NOT (((melanoma) OR schwannoma) OR ac*ustic neuroma) Filters: Classical Article; Clinical Study; Clinical Trial; Comparative Study; Controlled Clinical Trial; Multicenter Study; Observational Study; Randomized Controlled Trial; Humans	815

Table 3 Exemplary search history for PubMed (*Continued*)

#14	Add	Search ((((((neuroendocrine tumor[MeSH Terms]) OR ((digestive system neoplasms[MeSH Terms]) AND (((((neuroendocrine[Title/Abstract]) OR endocrine[Title/Abstract]) OR NET[Title/Abstract])) OR (((foregut[Title/Abstract]) OR midgut[Title/Abstract]) OR hindgut[Title/Abstract])))) AND (((quality of life) OR psycho*) OR well-being) OR patient-reported) OR self-reported))) NOT ((review) OR case-report))) NOT (((melanoma) OR schwannoma) OR ac*ustic neuroma) Filters: Classical Article; Clinical Study; Clinical Trial; Comparative Study; Controlled Clinical Trial; Multicenter Study; Observational Study; Randomized Controlled Trial	858
#13	Add	Search ((((((neuroendocrine tumor[MeSH Terms]) OR ((digestive system neoplasms[MeSH Terms]) AND (((((neuroendocrine[Title/Abstract]) OR endocrine[Title/Abstract]) OR NET[Title/Abstract])) OR (((foregut[Title/Abstract]) OR midgut[Title/Abstract]) OR hindgut[Title/Abstract])))) AND (((quality of life) OR psycho*) OR well-being) OR patient-reported) OR self-reported))) NOT ((review) OR case-report))) NOT (((melanoma) OR schwannoma) OR ac*ustic neuroma)	4198
#12	Add	Search ((((((neuroendocrine tumor[MeSH Terms]) OR ((digestive system neoplasms[MeSH Terms]) AND (((((neuroendocrine[Title/Abstract]) OR endocrine[Title/Abstract]) OR NET[Title/Abstract])) OR (((foregut[Title/Abstract]) OR midgut[Title/Abstract]) OR hindgut[Title/Abstract])))) AND (((quality of life) OR psycho*) OR well-being) OR patient-reported) OR self-reported))) NOT ((review) OR case-report)))	15865
#11	Add	Search ((melanoma) OR schwannoma) OR ac*ustic neuroma	132755
#10	Add	Search (review) OR case-report	4299707
#9	Add	Search (((neuroendocrine tumor[MeSH Terms]) OR ((digestive system neoplasms[MeSH Terms]) AND (((((neuroendocrine[Title/Abstract]) OR endocrine[Title/Abstract]) OR NET[Title/Abstract])) OR (((foregut[Title/Abstract]) OR midgut[Title/Abstract]) OR hindgut[Title/Abstract])))) AND (((quality of life) OR psycho*) OR well-being) OR patient-reported) OR self-reported)	24382
#8	Add	Search (neuroendocrine tumor[MeSH Terms]) OR ((digestive system neoplasms[MeSH Terms]) AND (((((neuroendocrine[Title/Abstract]) OR endocrine[Title/Abstract]) OR NET[Title/Abstract])) OR (((foregut[Title/Abstract]) OR midgut[Title/Abstract]) OR hindgut[Title/Abstract]))))	151289
#7	Add	Search (digestive system neoplasms[MeSH Terms]) AND (((((neuroendocrine[Title/Abstract]) OR endocrine[Title/Abstract]) OR NET[Title/Abstract])) OR (((foregut[Title/Abstract]) OR midgut[Title/Abstract]) OR hindgut[Title/Abstract]))	11944
#6	Add	Search (((neuroendocrine[Title/Abstract]) OR endocrine[Title/Abstract]) OR NET[Title/Abstract]) OR (((foregut[Title/Abstract]) OR midgut[Title/Abstract]) OR hindgut[Title/Abstract])	241029
#5	Add	Search (((quality of life) OR psycho*) OR well-being) OR patient-reported) OR self-reported	5592512
#4	Add	Search ((foregut[Title/Abstract]) OR midgut[Title/Abstract]) OR hindgut[Title/Abstract]	12719
#3	Add	Search ((neuroendocrine[Title/Abstract]) OR endocrine[Title/Abstract]) OR NET[Title/Abstract]	229180
#2	Add	Search digestive system neoplasms[MeSH Terms]	512405
#1	Add	Search neuroendocrine tumor[MeSH Terms]	145008

Additional file

Additional file 1: Overview on primary outcomes and HRQoL results of studies included in systematic review. (DOCX 64 kb)

Acknowledgements

The work of CM was funded by the Austrian Science Fund (FWF): P26087-B24.

Funding

The work of CM was funded by the Austrian Science Fund (FWF): P26087-B24.

Availability of data and material

Data sharing not applicable to this article as no datasets were generated or analysed during the current study.

Authors' contributions

CM and EMG performed eligibility assessment and data extraction and drafted the manuscript. LW participated in eligibility assessment and data extraction and contributed to the revision of the manuscript. BN participated in drafting and revising the manuscript. BSU, BH, and IV made substantial contributions to conception and design and were involved in revising the manuscript critically for important intellectual content. All authors read and approved the final manuscript.

Competing interests

The authors declare that they have no competing interests.

Consent for publication

Not applicable.

Ethics approval and consent to participate

This article does not contain any studies with human participants or animals performed by any of the authors.

Received: 22 January 2016 Accepted: 2 September 2016

Published online: 10 September 2016

References

1. Yao JC, Hassan M, Phan A, Dagohoy C, Leary C, Mares JE, Abdalla EK, Fleming JB, Vauthey JN, Rashid A, et al. One hundred years after "carcinoid": Epidemiology of and prognostic factors for neuroendocrine tumors in 35,825 cases in the United States. *J Clin Oncol*. 2008;26:3063–72.
2. Scarsbrook AF, Ganesan A, Statham J, Thakker RV, Weaver A, Talbot D, Boardman P, Bradley KM, Gleeson FV, Phillips RR. Anatomic and functional imaging of metastatic carcinoid tumors. *RadioGraphics*. 2007;27:455–76.
3. Tomassetti P, Campana D, Piscitelli L, Casadei R, Santini D, Nori F, Morselli-Labate AM, Pezzilli R, Corinaldesi R. Endocrine pancreatic tumors: factors correlated with survival. *Ann Oncol*. 2005;16:1806–10.
4. Vinjamuri S, Gilbert TM, Banks M, McKane G, Maltby P, Poston G, Weissman H, Palmer DH, Vora J, Pritchard DM, et al. Peptide receptor radionuclide therapy with ⁹⁰Y-DOTATATE/⁹⁰Y-DOTATOC in patients with progressive metastatic neuroendocrine tumours: assessment of response, survival and toxicity. *Br J Cancer*. 2013;108:1440–8.
5. Basch E, Iasonos A, McDonough T, Barz A, Culkin A, Kris MG, Scher HI, Schrag D. Patient versus clinician symptom reporting using the National

- Cancer Institute Common Terminology Criteria for Adverse Events: results of a questionnaire-based study. *Lancet Oncol.* 2006;7:309–909.
6. Cella DF. Measuring quality of life in palliative care. *Semin Oncol.* 1995;22:73–81.
 7. U.S. Department of Health and Human Services FDA Center for Drug Evaluation and Research. Guidance for industry: patient-reported outcome measures: use in medical product development to support labeling claims: draft guidance. *Health Qual Life Outcomes.* 2006;4:79.
 8. Brundage M, Blazeby J, Revicki D, Bass B, de Vet H, Duffy H, Efficace F, King M, Lam CL, Moher D, et al. Patient-reported outcomes in randomized clinical trials: development of ISOQOL reporting standards. *Qual Life Res.* 2013;22:1161–75.
 9. Efficace F, Rees J, Fayers P, Pusic A, Taphoorn M, Greimel E, Reijneveld J, Whale K, Blazeby J. Overcoming barriers to the implementation of patient-reported outcomes in cancer clinical trials: the PROMOTION Registry. *Health Qual Life Outcomes.* 2014;12:86.
 10. Reeve BB, Mitchell SA, Dueck AC, Basch E, Cella D, Reilly CM, Minasian LM, Denicoff AM, O'Mara AM, Fisch MJ, et al. Recommended patient-reported core set of symptoms to measure in adult cancer treatment trials. *J Natl Cancer Inst.* 2014;106(7). doi:10.1093/jnci/dju129.
 11. Ramage JK, Ahmed A, Ardill J, Bax N, Breen DJ, Caplin ME, Corrie P, Davar J, Davies AH, Lewington V, et al. Guidelines for the management of gastroenteropancreatic neuroendocrine (including carcinoid) tumours (NETs). *Gut.* 2012;61:6–32.
 12. Moher D, Liberati A, Tetzlaff J, Altman DG. Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *Ann Intern Med.* 2009;151:264–9.
 13. Cochrane Consumers and Communication Group: Consumers and Communication Group resources for authors. Data extraction template. 2013. <https://cccrg.cochrane.org/author-resources>. Accessed 25 Sep 2014
 14. Efficace F, Bottomley A, Osoba D, Gotay C, Flechtner H, D'haese S, Zurlo A. Beyond the development of health-related quality-of-life (HRQL) measures: a checklist for evaluating HRQL outcomes in cancer clinical trials—does HRQL evaluation in prostate cancer research inform clinical decision making? *J Clin Oncol.* 2003;21:3502–11.
 15. Landis JR, Koch GG. The measurement of observer agreement for categorical data. *Biometrics.* 1977;33:159–74.
 16. Calvert M, Brundage M, Jacobsen PB, Schünemann HJ, Efficace F. The CONSORT patient-reported outcome (PRO) extension: implications for clinical trials and practice. *Health Qual Life Outcomes.* 2013;11:184.
 17. Aaronson NK, Ahmedzai S, Bergman B, Bullinger M, Cull A, Duez NJ, Filiberti A, Flechtner H, Fleishman SB, de Haes JC, et al. The European Organization for Research and Treatment of Cancer QLQ-C30: a quality-of-life instrument for use in international clinical trials in oncology. *J Natl Cancer Inst.* 1993;85:365–76.
 18. Osoba D, Rodrigues G, Myles J, Zee B, Pater J. Interpreting the significance of changes in health-related quality-of-life scores. *J Clin Oncol.* 1998;16:139–44.
 19. Yadegarfar G, Friend L, Jones L, Plum LM, Ardill J, Taal B, Larsson G, Jeziorski K, Kwekkeboom D, Ramage JK. Validation of the EORTC QLQ-GINET21 questionnaire for assessing quality of life of patients with gastrointestinal neuroendocrine tumours. *Br J Cancer.* 2013;108:301–10.
 20. Cella DF, Tulsy DS, Gray G, Sarafian B, Linn E, Bonomi A, Silberman M, Yellen SB, Winicour P, Brannon J, et al. The Functional Assessment of Cancer Therapy scale: development and validation of the general measure. *J Clin Oncol.* 1993;11:570–9.
 21. Cella DF, Riley W, Stone A, Rothrock N, Reeve B, Yount S, Amtmann D, Bode R, Buysse D, Choi S, et al. Initial adult health item banks and first wave testing of the Patient-Reported Outcomes Measurement Information System (PROMIS) Network: 2005–2008. *J Clin Epidemiol.* 2010;63:1179–94.
 22. Derogatis LR. The psychosocial adjustment to illness scale (PAIS). *J Psychosom Res.* 1986;30:77–91.
 23. Lipscomb J, Gotay CC, Snyder CF. Patient-reported outcomes in cancer: A review of recent research and policy initiatives. *CA Cancer J Clin.* 2007;57:278–300.
 24. Reeve BB, Wyrnich KW, Wu AW, Velikova G, Terwee CB, Snyder CF, Schwartz C, Revicki DA, Moynihan CM, McLeod LD, et al. ISOQOL recommends minimum standards for patient-reported outcome measures used in patient-centered outcomes and comparative effectiveness research. *Qual Life Res.* 2013;22:1889–905.
 25. Velikova G, Stark D, Selby P. Quality of life instruments in oncology. *Eur J Cancer.* 1999;35:1571–80.
 26. Wilson KA, Dowling AJ, Abdollell M, Tannock IF. Perception of quality of life by patients, partners and treating physicians. *Qual Life Res.* 2000;9:1041–52.
 27. Dirven L, Taphoorn MJ, Reijneveld JC, Blazeby J, Jacobs M, Pusic A, La Sala E, Stupp R, Fayers P, Efficace F. The level of patient-reported outcome reporting in randomised controlled trials of brain tumour patients: a systematic review. *Eur J Cancer.* 2014;50:2432–48.
 28. Efficace F, Jacobs M, Pusic A, Greimel E, Piciocchi A, Kieffer JM, Gilbert A, Fayers P, Blazeby J. Patient-reported outcomes in randomised controlled trials of gynaecological cancers: investigating methodological quality and impact on clinical decision-making. *Eur J Cancer.* 2014;50:1925–41.
 29. Efficace F, Fayers P, Pusic A, Cemal Y, Yanagawa J, Jacobs M, la Sala A, Cafaro V, Whale K, Rees J, Blazeby J. Quality of patient-reported outcome reporting across cancer randomized controlled trials according to the CONSORT patient-reported outcome extension: A pooled analysis of 557 trials. *Cancer.* 2015;121:3335–42.
 30. Pusic AL, Chen CM, Cano S, Klassen A, McCarthy C, Collins ED, Cordeiro PG. Measuring quality of life in cosmetic and reconstructive breast surgery: a systematic review of patient-reported outcomes instruments. *Plast Reconstr Surg.* 2007;120:823–37. discussion 838–829.
 31. Sears ED, Chung KC. A guide to interpreting a study of patient-reported outcomes. *Plast Reconstr Surg.* 2012;129:1200–7.
 32. Basch E, Reeve BB, Mitchell SA, Clauser SB, Minasian LM, Dueck AC, Mendoza TR, Hay J, Atkinson TM, Abernethy AP, et al. Development of the National Cancer Institute's Patient-Reported Outcomes Version of the Common Terminology Criteria for Adverse Events (PRO-CTCAE). *J Natl Cancer Inst.* 2014, 106
 33. Kluetz PG, Chingos DT, Basch EM, Mitchell SA. Patient-Reported Outcomes in Cancer Clinical Trials: Measuring Symptomatic Adverse Events With the National Cancer Institute's Patient-Reported Outcomes Version of the Common Terminology Criteria for Adverse Events (PRO-CTCAE). *Am Soc Clin Oncol Educ Book.* 2016;35:67–73.
 34. Kluetz PG, Slagle A, Papadopoulos EJ, Johnson LL, Donoghue M, Kwitkowski VE, Chen W-H, Sridhara R, Farrell AT, Keegan P, et al. Focusing on Core Patient-Reported Outcomes in Cancer Clinical Trials: Symptomatic Adverse Events, Physical Function, and Disease-Related Symptoms. *Clin Cancer Res.* 2016;22:1553–8.
 35. Vinik E, Carlton CA, Silva MP, Vinik AI. Development of the Norfolk quality of life tool for assessing patients with neuroendocrine tumors. *Pancreas.* 2009;38:e87–95.
 36. Efficace F, Feuerstein M, Fayers P, Cafaro V, Eastham J, Pusic A, Blazeby J. Patient-reported outcomes in randomised controlled trials of prostate cancer: methodological quality and impact on clinical decision making. *Eur Urol.* 2014;66:416–27.
 37. Feuerstein MA, Jacobs M, Piciocchi A, Bochner B, Pusic A, Fayers P, Blazeby J, Efficace F. Quality of life and symptom assessment in randomized clinical trials of bladder cancer: A systematic review. *Urol Oncol.* 2015;33:331. e317–323.
 38. Brundage M, Bass B, Davidson J, Queenan J, Bezjak A, Ringash J, Wilkinson A, Feldman-Stewart D. Patterns of reporting health-related quality of life outcomes in randomized clinical trials: implications for clinicians and quality of life researchers. *Qual Life Res.* 2011;20:653–64.
 39. Bylicki O, Gan HK, Joly F, Maillet D, You B, Péron J. Poor patient-reported outcomes reporting according to CONSORT guidelines in randomized clinical trials evaluating systemic cancer therapy. *Ann Oncol.* 2015;26:231–7.
 40. Rees JR, Whale K, Fish D, Fayers P, Cafaro V, Pusic A, Blazeby JM, Efficace F. Patient-reported outcomes in randomised controlled trials of colorectal cancer: an analysis determining the availability of robust data to inform clinical decision-making. *J Cancer Res Clin Oncol.* 2015;141:2181–92.
 41. Calvert M, Kyte D, Duffy H, Gheorghe A, Mercieca-Bebber R, Ives J, Draper H, Brundage M, Blazeby J, King M. Patient-reported outcome (PRO) assessment in clinical trials: a systematic review of guidance for trial protocol writers. *PLoS One.* 2014;9:e110216.
 42. Caplin ME, Pavel M, Cwikla JB, Phan AT, Raderer M, Sedlackova E, Cadiot G, Wolin EM, Capdevila J, Wall L, et al. Lanreotide in metastatic enteropancreatic neuroendocrine tumors. *N Engl J Med.* 2014;371:224–33.
 43. Ducreux M, Dahan L, Smith D, O'Toole D, Lepère C, Dromain C, Vilgrain V, Baudin E, Lombard-Bohas C, Scaozec JY, et al. Bevacizumab combined with 5-FU/streptozocin in patients with progressive metastatic well-differentiated pancreatic endocrine tumours (BETTER trial) – A phase II non-randomised trial. *Eur J Cancer.* 2014;50:3098–106.
 44. Mityr E, Walter T, Baudin E, Kurtz JE, Ruszniewski P, Dominguez-Tinajero S, Bengrine-Lefevre L, Cadiot G, Dromain C, Farace F, et al. Bevacizumab plus capecitabine in patients with progressive advanced well-differentiated

- neuroendocrine tumors of the gastro-intestinal (GI-NETS) tract (BETTER trial) – A phase II non-randomised trial. *Eur J Cancer*. 2014;50:3107–15.
45. Yao JC, Fazio N, Singh S, Buzzoni R, Carnaghi C, Wolin EM, Tomasek J, Raderer M, Lahner H, Voi M, et al. Everolimus for the treatment of advanced, non-functional neuroendocrine tumours of the lung or gastrointestinal tract (RADIANT-4): a randomised, placebo-controlled, phase 3 study. *Lancet*. 2016;387:968–77.
 46. Ipsen. Efficacy and safety study in pancreatic or midgut neuroendocrine tumours having progressed radiologically while previously treated with Lanreotide Autogel® 120 mg (CLARINET FORTE). In: *ClinicalTrials.gov* [Internet]. Bethesda: National Library of Medicine (US); 2000. [cited 2016 Jul 11]. Available from: <https://clinicaltrials.gov/ct2/show/NCT02651987>.
 47. Vinik AI, Wolin EM, Liyanage N, Gomez-Panzani E, Fisher GA: Evaluation of lanreotide depot/autogel efficacy and safety as a carcinoid syndrome treatment (ELECT): A randomized, double-blind, placebo-controlled trial. *Endocr Pract* in press.
 48. Advanced Accelerator Applications. A study comparing treatment with 177Lu-DOTA0-Tyr3-octreotate to octreotide LAR in patients with inoperable, progressive, somatostatin receptor positive midgut carcinoid tumours (NETTER-1). In: *ClinicalTrials.gov* [Internet]. Bethesda: National Library of Medicine (US); 2000. [cited 2016 Jul 11]. Available from: <https://clinicaltrials.gov/ct2/show/NCT01578239>.
 49. Lexicon Pharmaceuticals L. Telotristat etiprate for carcinoid syndrome therapy (TELECAST). In: *ClinicalTrials.gov* [Internet]. Bethesda: National Library of Medicine (US); 2000. [cited 2016 Jul 11]. Available from: <https://clinicaltrials.gov/ct2/show/NCT02063659>.
 50. Lexicon Pharmaceuticals L. TELESTAR (Telotristat etiprate for somatostatin analogue not adequately controlled carcinoid syndrome). In: *ClinicalTrials.gov* [Internet]. Bethesda: National Library of Medicine (US); 2000. [cited 2016 Jul 11]. Available from: <https://clinicaltrials.gov/ct2/show/NCT01677910>.
 51. Greenhalgh J. The applications of PROs in clinical practice: what are they, do they work, and why? *Qual Life Res*. 2009;18:115–23.
 52. Arnold R, Rinke A, Klose KJ, Müller HH, Wied M, Zamzow K, Schmidt C, Schade-Brittinger C, Barth P, Moll R, et al. Octreotide versus octreotide plus interferon-alpha in endocrine gastroenteropancreatic tumors: A randomized trial. *Clin Gastroenterol Hepatol*. 2005;3:761–71.
 53. Bajetta E, Procopio G, Catena L, Martinetti A, De Dosso S, Ricci S, Lecchi AS, Boscani PF, Iacobelli S, Carteni G, et al. Lanreotide Autogel every 6 weeks compared with lanreotide microparticles every 3 weeks in patients with well differentiated neuroendocrine tumors. *Cancer*. 2006;107:2474–81.
 54. Jacobsen MB, Hanssen LE. Clinical effects of octreotide compared to placebo in patients with gastrointestinal neuroendocrine tumours. Report on a double-blind, randomized trial. *J Intern Med*. 1995;237:269–75.
 55. Meyer T, Qian W, Caplin ME, Armstrong G, Lao-Sirieix SH, Hardy R, Valle JW, Talbot DC, Cunningham D, Reed N, et al. Capecitabine and streptozocin ± cisplatin in advanced gastroenteropancreatic neuroendocrine tumours. *Eur J Cancer*. 2014;50:902–11.
 56. Raymond E, Dahan L, Raoul J-L, Bang Y-J, Borbath I, Lombard-Bohas C, Valle J, Metrakos P, Smith D, Vinik A, et al. Sunitinib malate for the treatment of pancreatic neuroendocrine tumors. *N Engl J Med*. 2011;364:501–13.
 57. Rinke A, Müller HH, Schade-Brittinger C, Klose KJ, Barth P, Wied M, Mayer C, Aminossadati B, Pape UF, Bläker M, et al. Placebo-controlled, double-blind, prospective, randomized study on the effect of octreotide LAR in the control of tumor growth in patients with metastatic neuroendocrine midgut tumors: A report from the PROMID Study Group. *J Clin Oncol*. 2009;27:4656–63.
 58. Bodei L, Cremonesi M, Grana CM, Fazio N, Iodice S, Baio SM, Bartolomei M, Lombardo D, Ferrari ME, Sansovini, et al. Peptide receptor radionuclide therapy with ¹⁷⁷Lu-DOTATATE: The IEO phase I-II study. *Eur J Nucl Med Mol Imaging*. 2011;38:2125–35.
 59. Bushnell DL, O'Doriso TM, O'Doriso MS, Menda Y, Hicks RJ, Van Cutsem E, Baulieu JL, Borson-Chazot F, Anthony L, Benson AB, et al. ⁹⁰Y-Edotreotide for metastatic carcinoid refractory to octreotide. *J Clin Oncol*. 2010;28:1652–9.
 60. Claringbold PG, Brayshaw PA, Price RA, Turner JH. Phase II study of radiolabelled ¹⁷⁷Lu-octreotate and capecitabine therapy of progressive disseminated neuroendocrine tumours. *Eur J Nucl Med Mol Imaging*. 2011;38:302–11.
 61. Cwikla JB, Sankowski A, Seklecka N, Buscombe JR, Nasierowska-Guttmejer A, Jeziorski KG, Mikolajczak R, Pawlak D, Stepień K, Walecki J. Efficacy of radionuclide treatment DOTATATE Y-90 in patients with progressive metastatic gastroenteropancreatic neuroendocrine carcinomas (GEP-NETS): a phase II study. *Ann Oncol*. 2010;21:787–94.
 62. Delpassand ES, Samarghandi A, Zamanian S, Wolin EM, Hamiditabar M, Espenan GD, Erion JL, O'Doriso TM, Kvolis LK, Simon J, et al. Peptide receptor radionuclide therapy with ¹⁷⁷Lu-DOTATATE for patients with somatostatin receptor-expressing neuroendocrine tumors. *Pancreas*. 2014;43:518–25.
 63. Frilling A, Weber F, Saner F, Bockisch A, Hofmann M, Müller-Brand J, Brösch CE. Treatment with ⁹⁰Y- and ¹⁷⁷Lu-DOTATOC in patients with metastatic neuroendocrine tumors. *Surgery*. 2006;140:968–77.
 64. Khan S, Krenning EP, van Essen M, Kam BL, Teunissen JJ, Kwekkeboom DJ. Quality of life in 265 patients with gastroenteropancreatic or bronchial neuroendocrine tumors treated with [177Lu-DOTA0, Tyr3]Octreotate. *J Nucl Med*. 2011;52:1361–8.
 65. Korse CM, Bonfrer JM, Aaronson NK, Hart AA, Taal BG. Chromogranin A as an alternative to 5-hydroxyindoleacetic acid in the evaluation of symptoms during treatment of patients with neuroendocrine Tumors. *Neuroendocrinology*. 2009;89:296–301.
 66. Kulke MH, Lenz H-J, Meropol NJ, Posey J, Ryan DP, Picus J, Bergsland E, Stuart K, Tye L, Huang X, et al. Activity of sunitinib in patients with advanced neuroendocrine tumors. *J Clin Oncol*. 2008;26:3403–10.
 67. Kvolis LK, Oberg KE, O'Doriso TM, Mohideen P, de Herder WW, Arnold R, Hu K, Zhang Y, Hughes G, Anthony L, Wiedenmann B. Pasireotide (SOM230) shows efficacy and tolerability in the treatment of patients with advanced neuroendocrine tumors refractory or resistant to octreotide LAR: results from a phase II study. *Endocr Relat Cancer*. 2012;19:657–66.
 68. Martin-Richard M, Massuti B, Pineda E, Alonso V, Marmol M, Castellano D, Fonseca E, Galán A, Llanos M, Sala MA, et al. Antiproliferative effects of lanreotide autogel in patients with progressive, well-differentiated neuroendocrine tumours: a Spanish, multicentre, open-label, single arm phase II study. *BMC Cancer*. 2013;13:427.
 69. Ruzsniwski P, Ish-Shalom S, Wymenga M, O'Toole D, Arnold R, Tomassetti P, Bax N, Caplin M, Eriksson B, Glaser B, et al. Rapid and sustained relief from the symptoms of carcinoid syndrome: Results from an open 6-months study of the 28-day prolonged-release formulation of lanreotide. *Neuroendocrinology*. 2004;80:244–51.
 70. Wymenga AN, Eriksson B, Salmela PI, Jacobsen MB, Van Cutsem EJ, Fiasse RH, Välimäki MJ, Renstrup J, de Vries EG, Oberg KE. Efficacy and safety of prolonged-release lanreotide in patients with gastrointestinal neuroendocrine tumors and hormone-related symptoms. *J Clin Oncol*. 1999;17:1111–7.
 71. Zuetenhorst JM, Valdes Olmos RA, Müller M, Hoefnagel CA, Taal BG. Interferon and meta-iodobenzylguanidin combinations in the treatment of metastatic carcinoid tumours. *Endocr Relat Cancer*. 2004;11:553–61.
 72. Fröjd C, Larsson G, Lampic C, von Essen L. Health related quality of life and psychosocial function among patients with carcinoid tumours. A longitudinal, prospective, and comparative study. *Health Qual Life Outcomes*. 2007;5:18.
 73. Fröjd C, Lampic C, Larsson G, von Essen L. Is satisfaction with doctors' care related to health-related quality of life, anxiety and depression among patients with carcinoid tumours? A longitudinal report. *Scand J Caring Sci*. 2009;23:107–16.
 74. Haugland T, Veenstra M, Vatn MH, Wahl AK. Improvement in stress, general self-efficacy, and health related quality of life following patient education for patients with neuroendocrine tumors: A pilot study. *Nurs Res Pract*. 2013;2013:695820.
 75. Kalinowski M, Dressler M, König A, El-Sheik M, Rinke A, Höffken H, Gress TM, Arnold R, Klose KJ, Wagner HJ. Selective internal radiotherapy with Yttrium-90 microspheres for hepatic metastatic neuroendocrine tumors: A prospective single center study. *Digestion*. 2009;79:137–42.
 76. Kwekkeboom DJ, Bakker WH, Kam BL, Teunissen JJ, Kooij PP, de Herder WW, Feelders RA, van Eijck CH, de Jong M, Srinivasan A, et al. Treatment of patients with gastro-entero-pancreatic (GEP) tumours with the novel radiolabelled somatostatin analogue [177Lu-DOTA0, Tyr3]octreotate. *Eur J Nucl Med Mol Imaging*. 2003;30:417–22.
 77. Larsson G, Janson ET. Anemia in patients with midgut carcinoid, treated with alpha interferon: effects by erythropoietin treatment on the perceived quality of life. *Eur J Cancer Care (Engl)*. 2008;17:200–4.
 78. Larsson G, Sjöden PO, Oberg K, Eriksson B, von Essen L. Health-related quality of life, anxiety and depression in patients with midgut carcinoid tumours. *Acta Oncol*. 2001;40:825–31.
 79. O'Toole D, Ducreux M, Bommelaer G, Wemeau JL, Bouché O, Catus F, Blumberg J, Ruzsniwski P. Treatment of carcinoid syndrome: A prospective

- crossover evaluation of lanreotide versus octreotide in terms of efficacy, patient acceptability, and tolerance. *Cancer*. 2000;88:770–6.
80. Pasiaka JL, McEwan AJ, Rorstad O. The palliative role of ¹³¹I-MIBG and ¹¹¹In-octreotide therapy in patients with metastatic progressive neuroendocrine neoplasms. *Surgery*. 2004;136:1218–26.
 81. Spolverato G, Bagante F, Wagner D, Buettner S, Gupta R, Kim Y, Magsood H, Pawlik TM. Quality of life after treatment of neuroendocrine liver metastasis. *J Surg Res*. 2015;198:155–64.
 82. Teunissen JJ, Kwekkeboom DJ, Krenning EP. Quality of life in patients with gastroenteropancreatic tumors treated with [177Lu-DOTA0, Tyr3]octreotate. *J Clin Oncol*. 2004;22:2724–9.
 83. Beaumont JL, Cella D, Phan AT, Choi S, Liu Z, Yao JC. Comparison of health-related quality of life in patients with neuroendocrine tumors with quality of life in the general US population. *Pancreas*. 2012;41:461–6.
 84. Pearman TP, Beaumont JL, Cella D, Neary MP, Yao J. Health-related quality of life in patients with neuroendocrine tumors: an investigation of treatment type, disease status, and symptom burden. *Support Care Cancer*. 2016;24:3695–703.
 85. Gelhorn HL, Kulke MH, O'Dorisio T, Yang QM, Jackson J, Jackson S, Boehm KA, Law L, Kostelec J, Auguste P, Lapuerta P. Patient-reported Symptom Experiences in Patients With Carcinoid Syndrome After Participation in a Study of Telotristat Etiprate: A Qualitative Interview Approach. *Clin Ther*. 2016;38:759–68.
 86. Haugland T, Vatn MH, Veenstra M, Wahl AK, Natvig GK. Health related quality of life in patients with endocrine tumors compared with the general Norwegian population. *Qual Life Res*. 2009;18:719–26.
 87. Haugland T, Wahl AK, Hofoss D, DeVon HA. Association between general self-efficacy, social support, cancer-related stress and physical health-related quality of life: a path model study in patients with neuroendocrine tumors. *Health Qual Life Outcomes*. 2016;14:11.
 88. Larsson G, von Essen L, Sjöden PO. Quality of life in patients with endocrine tumors of the gastrointestinal tract: Patient and staff perceptions. *Cancer Nurs*. 1998;21:411–20.
 89. Larsson G, Sjöden PO, Oberg K, von Essen L. Importance-satisfaction discrepancies are associated with health-related quality of life in five-year survivors of endocrine gastrointestinal tumours. *Ann Oncol*. 1999;10:1321–7.
 90. Larsson G, von Essen L, Sjöden PO. Health-related quality of life in patients with endocrine tumours of the gastrointestinal tract. *Acta Oncol*. 1999;38:481–90.
 91. Larsson G, Haglund K, von Essen L. Distress, quality of life and strategies to 'keep a good mood' in patients with carcinoid tumours: patient and staff perceptions. *Eur J Cancer Care (Engl)*. 2003;12:46–57.
 92. Larsson G, von Essen L, Sjöden PO. Are importance-satisfaction discrepancies with regard to ratings of specific health-related quality-of-life aspects valid indicators of disease- and treatment-related distress among patients with endocrine gastrointestinal tumours? *Eur J Cancer Care (Engl)*. 2007;16:493–9.
 93. Petzel MQ, Parker NH, Valentine AD, Simard S, Noguera-Gonzalez GM, Lee JE, Pisters PW, Vauthey JN, Fleming JB, Katz MH. Fear of cancer recurrence after curative pancreatic resection: A cross-sectional study in survivors of pancreatic and periampullary tumors. *Ann Surg Oncol*. 2012;19:4078–84.
 94. Pezzilli R, Campana D, Morselli-Labate AM, Fabbri MC, Brocchi E, Tomassetti P. Patient-reported outcomes in subjects with neuroendocrine tumors of the pancreas. *World J Gastroenterol*. 2009;15:5067–73.
 95. Pezzilli R, Campana D, Morselli-Labate AM, Galassi E, Brocchi E, Nori F, Cipollini ML, Tomassetti P. Patient-reported outcomes in patients with endocrine tumors of the ileum. *Eur J Gastroenterol Hepatol*. 2010;22:689–94.
 96. Ruszniewski P, Valle JW, Lombard-Bohas C, Cuthbertson DJ, Perros P, Holubec L, Delle Fave G, Smith D, Niccoli P, Maisonobe P, et al. Patient-reported outcomes with lanreotide Autogel/Depot for carcinoid syndrome: An international observational study. *Dig Liver Dis*. 2016;48:552–8.
 97. van der Horst-Schrivers AN, van Ieperen E, Wymenga AN, Boezen HM, Weijmar-Schultz WC, Kema IP, Meijer WG, de Herder WW, Willemsse PH, Links TP, de Vries EG. Sexual function in patients with metastatic midgut carcinoid tumours. *Neuroendocrinology*. 2009;89:231–6.
 98. von Essen L, Larsson G, Oberg K, Sjöden PO. 'Satisfaction with care': associations with health-related quality of life and psychosocial function among Swedish patients with endocrine gastrointestinal tumours. *Eur J Cancer Care (Engl)*. 2002;11:91–9.
 99. Garcia-Hernandez J, Mohmaduvsh M, Davies P, Toumpanakis C, Goodhand JR, Caplin M: PMO-023 Assessment of quality of life, coping strategies and personal beliefs in neuroendocrine tumour patients. 2012. http://gut.bmj.com/content/61/Suppl_2/A82.2.short. Accessed 28 Sep 2015
 100. Gyökeres T. The use of validated quality of life questionnaires in patients with neuroendocrine tumors. The results of the national multicenter study (SAS-LAR-QOL) of 93 patients. *Z Gastroenterol* 2010, 48. <https://www.thieme-connect.de/products/ejournals/abstract/10.1055/s-0030-1254762>. Accessed 28 Sep 2015.
 101. Marinova M, Muecke M, Mahlberg L, Essler M, Cuhls H, Radbruch L, Ahmadzadehfah H. Quality of life assessment following peptide receptor radionuclide therapy (PRRT) of pancreatic neuroendocrine tumor (P-NET). *J Nucl Med*. 2016;57:1462. http://jnm.snmjournals.org/content/57/supplement_2/1462. Accessed 12 Jul 2016.
 102. Pavel M: NANETS 2013, Safety and quality-of-life (QOL) assessments in the open-label, multicenter, phase 3b, expanded access study of everolimus in patients with advanced neuroendocrine tumors (NET). 2013. https://www.nanets.net/nanets_cd/2013/pdfs/C27-pavelabstract.pdf. Accessed 28 Sep 2015
 103. Strosberg J: NANETS 2015, Neuroendocrine Tumor Symposium Abstracts: 177-Lu-Dotatate significantly improves progression-free survival in patients with mid-gut neuroendocrine tumours: Results of the phase III NETTER-1 trial. 2015. https://www.nanets.net/nanets_cd/2015/pdfs/C39.pdf. Accessed 12 Jul 2016

Submit your next manuscript to BioMed Central and we will help you at every step:

- We accept pre-submission inquiries
- Our selector tool helps you to find the most relevant journal
- We provide round the clock customer support
- Convenient online submission
- Thorough peer review
- Inclusion in PubMed and all major indexing services
- Maximum visibility for your research

Submit your manuscript at
www.biomedcentral.com/submit

