Pretreatment hematologic markers as prognostic predictors of gastroenteropancreatic neuroendocrine tumors: a systematic review and meta-analysis

Background: Systemic inflammation can be reflected by peripheral hematologic parameters and combined index like the lymphocyte count, neutrophil count, platelet count, neutrophil-to-lymphocyte ratio (NLR), and platelet-to-lymphocyte ratio (PLR). This systematic review and meta-analysis aimed to summarize the association between the hematologic markers and prognosis of gastroenteropancreatic neuroendocrine tumors (GEP–NETs).

Methods: A computerized systematic search of PubMed, Embase, and Web of Science was conducted up to August 2016. Studies evaluating prognosis value of hematologic parameters in patients with GEP–NETs were retrieved. For meta-analysis, hazard ratios (HRs) with 95% confidence intervals (95% CIs) were extracted and synthesized using Review Manager software.

Results: We identified eight retrospective cohort studies comprising a total of 724 cases. The majority of included studies focused on pancreatic neuroendocrine tumors (PNETs). The prognostic values of NLR, PLR, and platelet count were reported in six studies, two studies, and one study, respectively. All the parameters were associated with prognostic outcomes in patients with GEP–NETs. A high NLR was significantly associated with poor prognosis in GEP–NETs (pooled HR 3.05, 95% CI 1.96–4.76, $P < 0.0001$ for overall survival (OS); pooled HR 3.30, 95% CI 2.04–5.32, $F = 0\%, P < 0.00001$ for recurrence-free survival (RFS)). In PNETs, pooled-analyses also showed significant superiority of a low NLR on OS (pooled HR 4.21, 95% CI 1.95–9.13, $P = 0\%, P = 0.0003$) and RFS (pooled HR 5.37, 95% CI 2.14–13.47, $F = 0\%, P = 0.003$).

Conclusions: These findings suggest that the elevated NLR could be an adverse prognosis factor for GEP–NETs. The conclusion should be mainly limited to PNETs as the majority of included cases were PNET patients. The prognostic value of other hematologic parameters deserves further investigation. We recommend that further studies should use a continuous NLR variable and adopt a prospective and matched study design.

Keywords: neuroendocrine tumor, blood cell, lymphocyte, neutrophil, platelet, prognosis

Introduction

Gastroenteropancreatic neuroendocrine tumors (GEP–NETs) are biologically diverse neoplasms that arise from the diffuse endocrine system in the gastrointestinal tract and/or pancreas. In recent decades, GEP–NETs have exhibited a significantly increased incidence, and today comprise approximately 2% of all malignant gastrointestinal tumors. Due to the highly heterogeneous features and unpredictable biological behaviors of GEP–NETs, discovery of markers with efficient diagnosis and/or prognosis...
effect could help determine optimal clinical managements and follow-up strategies.4–7

The link between chronic inflammation and cancer has been established for a long time.8,9 Numerous epidemiologic studies support a clear connection between chronic inflammation and the development of many cancers. In turn, the tumor itself can initiate and maintain inflammatory processes that foster tumor growth and development. Many inflammation-related cytokines and chemokines have been extensively documented in cancers of the stomach, liver, lung, esophagus, breast, and prostate. In addition, an important hallmark of cancer is that cancer cells evade immunological attack, and recent studies have identified that chronic inflammation is associated with immunosuppression, mediated primarily by immature myeloid-derived suppressor cells.10–12

Studies in the past decades have identified a close connection between GEP–NETs and chronic inflammation. It was shown that chronic inflammation can lead to hyperplasia and neoplastic transformation of enteroendocrine cells.13–15 Additionally, single nucleotide polymorphisms of some inflammatory cytokines, such as TNF-α–1031T/C, IL-6 –174 C/G, and IL-2 –330T/G allele, have been identified to be associated with the overall susceptibility to develop GEP–NETs.16–18 Nowadays, many typical factors of systematic inflammation, such as C-reactive protein, interleukin, some growth factors and chemokines have been validated as predictive in various types of cancer.19–21 Recently, emerging studies have focused upon the prognosis value of hematologic parameters of systemic inflammation, including leukocyte counts, neutrophil counts, platelet counts, and the ratios between them such as neutrophil-to-lymphocyte ratio (NLR) and platelet-to-lymphocyte ratio (PLR) because they are cheap and easily acquired markers during clinical practice.22–26 Hence, we aimed to conduct a systematic review and meta-analysis to evaluate the prognostic value of hematologic parameters in patients with GEP–NETs.

Methods

Study identification and selection
A systematic literature search of PubMed, Embase, and the Institute for Scientific Information (ISI) Web of Knowledge was conducted in August, 2017, by two independent reviewers (Yu Zhou & Dezhi Li) to retrieve potential relevant studies with restriction to English language. We used Mesh terms and text words to retrieve potential eligible studies with the following retrieval logic: (“neutrophil” or “lymphocyte” or “leukomonocyte” or “monocyte” or “platelet” or “thrombocyte” or “blood cell” or “blood routine” or “hematologic” or “hematological”) and (“neuroendocrine tumor” or “neuroendocrine tumour” or “neuroendocrine neoplasm” or “neoplasm cancer” or “neoplasm malignancy” or “carcinoid” or “insulinoma” or “vipoma” or “gastrinoma” or “paraganglioma”). We did not limit the search based on tumor site of gastroenteropancreatic organs in case of missing articles. Reference lists of the retrieved articles were also searched for relevant studies. The initial selection was performed to eliminate obviously irrelevant articles, reviews, meeting abstracts, comments, letters, and basic research. We retained potentially relevant articles about hematologic parameters or GEP–NET prognostic risk factors by reviewing the titles and abstracts. Thereafter, the full-text was reviewed. Studies of patients with GEP–NETs that evaluated the effect of at least one of the hematologic parameters on prognosis were included.

Data extraction and quality assessment
The investigators (Yu Zhou & Dezhi Li) extracted information independently using a standardized data extraction table. The information about the basic characteristics of included studies and population, details of methodological characteristics, and relevant outcomes were recorded, including first author, year of publication, study period, study design, sample size, clinicopathologic characters of the study cohort, cut-off value of hematologic parameters, method of statistical analysis, and clinical outcomes. The hazard ratio (HR) was preferred for evaluating the survival outcome since it is time-to-event data. The values of HRs, 95% CIs, and P-values were extracted. For studies that did not provide sufficient data, the HR values were obtained by contacting the corresponding authors or were estimated by the methods described by Tierney et al.42 The primary outcomes were cancer-specific survival (CSS) and overall survival (OS). The secondary outcomes included recurrence-free survival (RFS), distal metastasis-free survival (DMFS), local relapse-free survival (LRFS), and progression-free survival (PFS). There are no standard quality-assessment tools for prognostic studies in systematic reviews. The Newcastle-Ottawa Quality Assessment Scale (NOS) was adopted to assess the quality of each included study independently by our two investigators. NOS scores more than 6 were considered as high-quality studies. The two investigators had discussions to reach a consensus when there was any disagreement.

Statistical analysis
All the synthesis analyses were carried out using the Review Manager software (Version 5.3, The Cochrane Collaboration,
Copenhagen, Denmark). A two-tailed \( p \)-value \(< 0.05\) was considered statistically significant. HRs with 95% CIs were used to evaluate the prognosis value of hematological parameters (high level vs low level). When the study reported both univariate and multivariate results, we chose multivariate analysis for final calculation. Cochran’s \( Q \) test and Higgins \( I^2 \) statistic were performed for evaluating heterogeneity among studies. Studies with a \( p \geq 0.1 \) or \( I^2 < 50\% \) were considered to have low heterogeneity and the fixed-effects model was used. Otherwise, the random-effects model was applied. A funnel plot was performed to assess publication bias.

**Ethics approval**
Since this was a protocol for a systematic review based upon available evidence, ethics approval was not required.

**Results**

**Data retrieval**
Figure 1 shows the flow chart for study search and selection. After searching the database of PubMed, Embase, and ISI Web of Knowledge, we finally identified 716 relevant references, of which 226 were duplicated. After removing duplicate articles, and further screening titles and abstracts, 389 articles were excluded, including laboratory investigations, case reports, meeting abstracts, comments, letters, reviews, and other articles irrelevant to our topic. After the full-text review, a total of eight studies were ultimately included.

**Characteristics of studies and data quality**
Tables 1 and 2 show the characteristics of included studies. The eight eligible studies were published between 2009 and 2017, and all were retrospective analysis. A total of 724 cases were involved, and the sample sizes of included studies ranged from 34 to 165. Five studies only enrolled PNETs patients,\(^{27–30,34}\) one study only enrolled patients with gastric neuroendocrine tumors (G–NETs),\(^{31}\) one study enrolled patients with gastro-entero-pancreatic neuroendocrine tumors (GEP–NETs),\(^{32}\) and another study enrolled patients with neuroendocrine tumors regardless of the primary site.\(^{33}\) The prognosis values of NLR were reported in six articles,\(^{27–29,31–33}\) the prognosis values of PLR were reported
Table 1 Basic characteristics of included studies

| Author/year          | Disease composition | Index | Cut-off value | Sample size | Age (years) | Gender (M/F) | Tumor size (cm) | Functioning (non-functional) | Tumor histology[^1] | Treatment |
|----------------------|--------------------|-------|---------------|-------------|-------------|--------------|-----------------|-----------------------------|---------------------|-----------|
| Arima et al, 2017[27] | 100% PNET          | NLR   | 2.4           | 58          | 58 (17–81)^[^2] | 27/31        | 1.5 (0.5–9.0)^[^2] | 31/27                       | 46/9/3 (G1/G2/G3)    | 100% SR   |
| Luo et al, 2017[28]  | 100% PNET          | NLR   | 2.4           | 165         | 165 (50, 69 cases) | 76/89        | 3.0 (50 cases)   | 147/18                      | 63/58/15 (G1/G2/G3)    | 53% SR |
| Tong et al, 2017[29] | 100% PNET          | NLR   | 1.4           | 95          | 54.4 ± 12.1[^2] | 39/56        | NA              | 74/21                       | 52/12/11 (G1/G2/G3)    | 100% SR   |
| Kaltenborn et al, 2016[30] | 100% PNET     | P count | 228          | 41          | 55 (20–70)^[^2] | 22/19        | NA              | NA                         | 20/21/36 (NET/NEC/NEC) | 100% SR   |
| Cao et al, 2016[31]  | 100% G–NET         | NLR   | 2.2           | 147         | 70, 114 cases | 106/41       | 3.5, 50 cases    | NA                         | 44/44/47 (G1/G2/G3)    | 100% CR |
| Salman et al, 2016[32] | 37.9% PNET and 62.1% GE–NET | NLR | 2.17          | 132         | 56.7 ± 12.8[^2] | 72/60        | NA              | NA                         | 33/1 (G1–G2/G3)        | 52% SR |
| Yucel et al, 2014[33] | 55.8% GEP–NET and 44.2% NET of other sites | PLR | 181.5         | 52          | 58 (26–88)^[^2] | 22/30        | NA              | NA                         | 33/1 (G1–G2/G3)        | 100% SR |
| Sakka et al, 2009[34] | 100% PNET          | PLR   | 300           | 34          | 54 (44–71)^[^2] | 12/22        | 20 (14–38)       | 24/10 (median IQR)          | 33/1 (well/poor-differentiated) | 100% SR |

Notes: Histologic grades of the tumors were assessed according to the World Health Organization (WHO) 2010 classification; median (range); *mean ± standard deviation. Functioning refers to whether the tumor is functional or not. Non refers to a non-functional neuroendocrine tumor, and functional denotes a functional neuroendocrine tumor.

Abbreviations: M/F, male/female; NLR, neutrophil-to-lymphocyte ratio; PLR, platelet-to-lymphocyte ratio; P count, platelet count; NA, not available; PNET, pancreatic neuroendocrine tumor; GEP–NET, gastroenteropancreatic neuroendocrine tumor; NET, neuroendocrine tumor; NEC, neuroendocrine carcinoma; MANEC, mixed adenoneuroendocrine carcinoma; SR, surgical resection; CR, chemotherapy; IQR, interquartile range; G–NET, gastric neuroendocrine tumors; GE–NET, gastroentero-pancreatic neuroendocrine tumors.

Correlation between survival outcomes and hematologic parameters

Table 3 summarizes the results of the prognostic value of each hematologic parameter. Most studies focused on the effect of NLR on OS. Four studies determined the cut-off values of NLR, and only one study reported the prognosis value of platelet count. Most studies determined the cut-off value of hematologic markers by using receiver operating characteristic (ROC) curves to select the most significant points. The HRs for survival outcomes were provided in seven studies[27–31,33,34]. All of them were adjusted for potential confounders using the Cox proportional-hazard model.

The major inadequacies among the included studies were incomparability between groups.
Hematologic markers as prognostic predictors of GEP–NEts

Only one study reported the prognosis value of platelet count. The study by Kaltenborn et al found the OS was significantly different between patients with low platelet counts and those with high platelet counts and showed that patients with higher platelet counts had better OS.\(^{30}\)

**P count**

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**NLR in PNET**

Five studies enrolled only PNET patients. Among them, two studies\(^{27,28}\) provided sufficient data on OS,\(^{27–30,34}\) and two studies provided sufficient data on RFS outcome for the pooled estimate.\(^{27,29}\) As shown in Figure 2, the result of meta-analysis showed significant superiority of a low NLR on OS

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**Table 2** Methodology characters of included studies

| Author/year | Index | Cut-off value | Method to determine the cut-off value | Reported survival outcomes | Methods for survival analysis | Adjusted factors | NOS score |
|-------------|-------|---------------|--------------------------------------|----------------------------|-----------------------------|-----------------|----------|
| Arima et al, 2017\(^{27}\) | NLR | 2.4 | ROC curve | OS, RFS, LMFS | KMC, MR | Age, gender, tumor size, functioning | 6 |
| Luo et al, 2017\(^{28}\) | NLR | 2.4 | ROC curve | OS | KMC, MR | TNM stage, histologic grade, symptom | 7 |
| Tong et al, 2017\(^{29}\) | NLR | 1.4 | ROC curve | RFS | KMC, MR | Histologic grade, TNM stage, lymph node metastasis, tumor thrombus differentiation, Ki-67 index, lymph node metastasis, liver metastasis, and other distal metastasis | 7 |
| Kaltenborn et al, 2016\(^{30}\) | P count | 228 | ROC curve | OS | KMC, MR | Tumor size, depth of invasion, lymph node ratio, Ki-67 | 7 |
| Cao et al, 2016\(^{31}\) | NLR | 2.2 | ROC curve | OS, RFS | MR | – | 6 |
| Salman et al, 2015\(^{32}\) | NLR | 2.17 | Median value | PFS | ROC | Age, albumin, alkaline phosphatase, alanine aminotransferase | 7 |
| Sakka et al, 2009\(^{34}\) | PLR | 181.5 | Median value | PFS | ROC | Histologic grade, TnM stage, lymph node metastasis, tumor thrombus differentiation, Ki-67 index, lymph node metastasis, liver metastasis, and other distal metastasis | 7 |
| Yucel et al, 2013\(^{33}\) | NLR | 5 | NA | OS | MR | Age, sex, performance status, histologic grade, primary site, surgical treatment | 6 |

**Table 3** Reported outcomes in each study

| Biomarkers | Study | OS | RFS | LMFS |
|------------|-------|----|-----|------|
| **NLR**    |       |    |     |      |
| Reported HRs |       |    |     |      |
| Arima, 2017\(^{27}\) | 5.35 (1.57–18.23)\(^{f}\) | 6.01 (1.84–21.2)\(^{f}\) | 7.57 (2.17–30.2)\(^{f}\) |
| Cao, 2016\(^{31}\) | 2.334 (1.286–4.237)\(^{f}\) | 2.751 (1.572–4.813)\(^{f}\) | NR |
| Luo, 2017\(^{28}\) | 3.60 (1.33–9.71)\(^{f}\) | NR | NR |
| Tong, 2017\(^{29}\) | NR | 4.516 (1.048–19.468)\(^{f}\) | NR |
| Yucel, 2013\(^{33}\) | 4.4 (1.2–15.7)\(^{f}\) | NR | NR |
| Reported ROC curves |       |    |     |      |
| Salman, 2015\(^{32}\) | NR | A median NLR of 2.17 accurately predicted a PFS of 11.5 months (AUC 0.94, \(P < 0.001\)) with 98.5% sensitivity and 53.7% specificity | NR |
| **P count** |       |    |     |      |
| Reported HRs |       |    |     |      |
| Kaltenborn, 2016\(^{30}\) | 0.985 (0.972–0.998) | NR | NR |

**Note:** Functioning refers to whether the tumor is functional or not.

**Abbreviations:** ROC, receiver operator characteristic; OS, overall survival; RFS, recurrence-free survival; PFS, progression-free survival; LMFS, liver-metastasis-free survival; KMC, Kaplan–Meier curve; MR, multivariate cox regression analysis; NLR, neutrophil-to-lymphocyte ratio; PLR, platelet-to-lymphocyte ratio; P count, platelet count; NOS, Newcastle-Ottawa Scale.
Zhou et al (pooled HR 4.21, 95% CI 1.95–9.13, $I^2 = 0\%$, $P = 0.0003$). Meanwhile, the pooled HR for RFS also favored patients with a low NLR (pooled HR 5.37, 95% CI 2.14–13.47, $I^2 = 0\%$, $P = 0.003$) (Figure 3).

**Publication bias**

The funnel plot showed an unsymmetrical distribution around the vertical axis (Figure 4). However, because the number of included studies was small, the funnel plots may make little sense.

**Discussion**

Several hematologic parameters of systemic inflammation, such as lymphocyte counts, neutrophil counts, platelet counts, NLR, LMR, and PLR, have emerged as prognostic factors for a variety of cancer types. Because these markers can be easily acquired from blood routine test, they are cheap and easily acquired prognostic markers with a potential for widespread clinical use, many studies have focused on the association between these markers and prognosis in kinds of cancers. GEP–NETs are a type of relatively rare tumor, and the prognostic factors and surveillance strategy for GEP–NETs patients have not been well established due to the complexity and rarity of this disease. Therefore, a clear demonstration of the prognosis values of these easily applicable markers in GEP–NETs patients may help predict individual outcome and guide clinical decisions. In this study, we have summarized the published evidence on the association between the hematologic parameters and GEP–NETs outcomes. We found, in the field of this rare tumor, NLR, PLR, and platelet counts were all correlated with prognosis. Our pooled-analysis identified that NLR is an effective prognosis factor in GEP–NETs patients. The prognosis value of other hematologic parameters warrants interest and further study.

Most patients involved in the present study were PNET patients. The management of PNETs remains a big challenge because of their heterogeneous pathologic features and unpredictable clinical behaviors. Several markers have been identified as diagnosis markers or prognosis factors in PNETs. Chromogranin A (CgA) is the most commonly used biomarker and has been reported to be elevated in 50%–80% of PNET patients. However, its prognosis value has been questioned due to some studies which showed there was no association between CgA and survival in PNETs. Other potential markers include neurokinin A, pancreatic polypeptide, serotonin, neuron-specific enolase, etc., but their role is still unclear. Future research is needed to discover new markers and to determine which markers provide better prognostic information. Although the number of studies investigating the predictive value of NLR in PNETs is much less than studies for other tumors, they all revealed that NLR was a remarkable prognosis marker for predicting both survival and recurrence in PNETs. Therefore, NLR has the potential to serve as a supplemental prognostic marker.

| Study or subgroup | Log (hazard ratio) | SE | Weight (%) | Hazard ratio IV, fixed, 95% CI | Hazard ratio IV, fixed, 95% CI |
|-------------------|-------------------|----|------------|-----------------------------|-----------------------------|
| Arima et al 201727 | 1.7938            | 0.6041 | 60.4 | 6.01 (1.84, 19.64)     | 6.01 (1.84, 19.64)      |
| Zhou et al 201627 | 1.5076            | 0.7453 | 39.6 | 4.52 (1.05, 19.46)     | 4.52 (1.05, 19.46)      |
| Total (95% CI)    |                   |      | 100    | 5.37 (2.14, 13.47)     | 5.37 (2.14, 13.47)      |

Heterogeneity: $\chi^2 = 0.09, df = 1 (P = 0.77); I^2 = 0\%$. Test for overall effect: $Z = 3.58 (P = 0.0003)$

**Figure 3** Forest plot of HR and 95% CI for predictive effect of NLR on recurrence-free survival in patients with PNETs.

**Abbreviations:** HR, hazard ratio; NLR, neutrophil-to-lymphocyte ratio; PNETs, pancreatic neuroendocrine tumors.
Besides, NLR is an easily available marker obtained from routine blood tests, which enhances the practicality.

There are some limitations in the present study. Most of the included studies used ROC curve to determine a cut-off value for hematologic parameters.\textsuperscript{27–31} Therefore, the NLR and PLR were used as dichotomous variables. Additionally, since the cut-off values were artificially chosen, the clinicopathological characters between groups in each study were incomparable. Moreover, the hematologic parameters could be affected by different conditions and diseases, and the survival time of NETs is usually longer than other cancers because most NETs are biologically less aggressive, but all studies only used one result before treatment and did not monitor hematologic parameters during follow-up. Besides, because G3 tumors are invariably lethal, and the malignant potentials of G1 and G2 tumors were relative indolent, it is better for further studies to give additional information regarding the association between hematologic markers and prognosis in G1/G2 patients and G3 patients separately. We also noted that no study reported cancer-specific survival, which is a better outcome indicator than OS because of the relatively long survival time of patients with GEP–NETs. Last but importantly, due to the retrospective nature of the current study, patients may be prone to potential selection bias. Prospective and larger studies with a longer follow-up are required to confirm these findings.

In conclusion, this present systematic review and meta-analysis summarized the current evidence on the prognosis values of hematologic parameters in GEP–NETs. Our results showed that NLR was an effective prognostic predictor. The prognostic value of other hematologic parameters deserves further investigation. The conclusion should be limited mainly to PNETs due to the majority of included cases being PNETs. We recommend that future studies should use a continuous NLR variable and adopt a prospective and matched study design.

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**Disclosure**

The authors report no conflicts of interest in this work.

**References**

1. Modlin IM, Oberg K, Chung DC, et al. Gastroenteropancreatic neuroendocrine tumours. *Lancet Oncol*. 2008;9(1):61–72.
2. Fraenkel M, Kim M, Faggiano A, de Herder WW, Valk GD, Knowledge NETwork. Incidence of gastroenteropancreatic neuroendocrine tumours: a systematic review of the literature. *Endocr Relat Cancer*. 2014;21(3):R153–R163.
3. Turaga KK, Kvols LK. Recent progress in the understanding, diagnosis, and treatment of gastroenteropancreatic neuroendocrine tumours. *CA Cancer J Clin*. 2011;61(2):113–132.
4. Oggera G, Krokidis M, Cappucci M, et al. Current status of interventional radiology in the management of gastro-entero-pancreatic neuroendocrine tumours (GEP–NETs). *Cardiovasc Intervent Radiol*. 2015;38(1):13–24.
5. Cives M, Soares HP, Strosberg J. Will clinical heterogeneity of neuroendocrine tumors impact their management in the future? Lessons from recent trials. *Curr Opin Oncol*. 2016;28(4):359–366.
6. Landry CS, Cavaness K, Celinski S, Preskitt J. Biochemical prognostic indicators for pancreatic neuroendocrine tumors and small bowel neuroendocrine tumors. *Gland Surg*. 2014;3(4):215–218.
7. Kanakis G, Kaltas S. Biochemical markers for gastroenteropancreatic neuroendocrine tumours (GEP–NETs). *Best Pract Res Clin Gastroenterol*. 2012;26(6):791–802.
8. Grivennikov SI, Greten FR, Karin M. Immunity, inflammation, and cancer. *Cell*. 2010;140(6):883–899.
9. Sethi G, Shanmugam MK, Ramachandran L, Kumar AP, Tergaonkar V. Multifaceted link between cancer and inflammation. *Biosci Rep*. 2012;32(1):1–15.
10. Baniyash M, Sade-Feldman M, Kanterman J. Chronic inflammation and cancer: suppressing the suppressors. *Cancer Immunol Immunother*. 2014;63(1):11–20.
11. Bunt SK, Clements VK, Hanson EM, Sinha P, Ostrand-Rosenberg S. Inflammation enhances myeloid-derived suppressor cell cross-talk by signaling through Toll-like receptor 4. *J Leukoc Biol*. 2009;85(6):996–1004.
12. Gabrilovich DI, Nagaraj S. Myeloid-derived suppressor cells as regulators of the immune system. *Nature Rev Immunol*. 2009;9(3):162–174.
13. Cadden I, Johnston BT, Turner G, McCance D, Ardill J, McGinty A. An evaluation of cyclooxygenase-2 as a prognostic biomarker in mid-gut carcinoid tumours. *Neuroendocrinology*. 2007;86(2):104–111.
14. Klöppel G, Clemens A. The biological relevance of gastric neuroendocrine tumors. *Yale J Biol Med*. 1996;69(1):69–74.
15. Le Marc’hadour F, Bost F, Poëc’h M, Roux JJ, Pasquier D, Pasquier B. Carcinoid tumour complicating inflammatory bowel disease. *A study of two cases with review of the literature*. *Pathol Res Pract*. 1994;190(12):1185–1192; discussion 1193–1200.
16. Haukin N, Bidwell JL, Smith AJ, et al. Cytokine gene polymorphism in human disease: on-line databases, supplement 2. *Genes Immun*. 2002;3(6):313–330.
17. Berkovic MC, Jokic M, Marout J, Radosavic S, Zujic-Rtokvic V, Kapitanovic S. IL-6-174 C/G polymorphism in the gastroenteropancreatic neuroendocrine tumours (GEP–NETs). *Experim Molec Pathol*. 2007;83(3):474–479.
18. Berkovic MC, Jokic M, Marout J, Radosovic S, Zjazic-Rotkvic V, Kapitanovic S. IL-2 -330 T/G SNP and serum values-potential new tumor markers in neuroendocrine tumors of the gastrointestinal tract and pancreas (GEP–NETs). J Molec Med (Berlin). 2010;88(4):423–429.

19. Clarke SJ, Chua W, Moore M, et al. Use of inflammatory markers to guide cancer treatment. Clin Pharmacol Therapeut. 2011;90(3):475–478.

20. Schubert C, Hong S, Natarajan L, Mills PJ, Dinsdale JE. The association between fatigue and inflammatory marker levels in cancer patients: a quantitative review. Brain Behav Immun. 2007;21(4):413–427.

21. Vermeire S, Van Assche G, Rutgeerts P. The role of C-reactive protein as an inflammatory marker in gastrointestinal diseases. Nat Clin Pract Gastroenterol Hepatol. 2005;2(12):580–586.

22. Perrata LF, Ristow K, Colgan JP, et al. Peripheral blood lymphocyte/monocyte ratio at diagnosis and survival in classical Hodgkin’s lymphoma. Haematologica. 2012;97(2):262–269.

23. Stotz M, Gerger A, Eisner F, et al. Increased neutrophil-lymphocyte ratio is a poor prognostic factor in patients with primary operable and inoperable pancreatic cancer. Br J Cancer. 2013;109(2):416–421.

24. Cho H, Hur HW, Kim SW, et al. Pre-treatment neutrophil to lymphocyte ratio is elevated in epithelial ovarian cancer and predicts survival after treatment. Cancer Immunol Immunother. 2009;58(1):15–23.

25. Tao S, Haug U, Kuhn K, Brenner H. Comparison and combination of blood-based inflammatory markers with faecal occult blood tests for non-invasive colorectal cancer screening. Br J Cancer. 2012;106(8):1424–1430.

26. Tomita M, Shimizu T, Ayabe T, Nakamura K, Onitsuka T. Elevated preoperative inflammatory markers based on neutrophil-to-lymphocyte ratio and C-reactive protein predict poor survival in resected non-small cell lung cancer. Anticancer Res. 2012;32(8):3535–3538.

27. Arima K, Okabe H, Hashimoto D, et al. Neutrophil-to-lymphocyte ratio predicts metachronous liver metastasis of pancreatic neuroendocrine tumors. Int J Clin Oncol. 2017;22(4):734–739.

28. Luo G, Liu C, Cheng H, et al. Neutrophil-lymphocyte ratio predicts survival in pancreatic neuroendocrine tumors. Oncol Lett. 2017;13(4):2454–2458.

29. Tong Z, Liu L, Zheng Y, et al. Predictive value of preoperative peripheral blood neutrophil/lymphocyte ratio for lymph node metastasis in patients of resectable pancreatic neuroendocrine tumors: a nomogram-based study. World J Surg Oncol. 2017;15(1):108.

30. Kaltenborn A, Mateke S, Kleine M, et al. Prediction of survival and tumor recurrence in patients undergoing surgery for pancreatic neuroendocrine neoplasms. J Surg Oncol. 2016;113(2):194–202.

31. Cao LL, Lu J, Lin JX, et al. A novel predictive model based on preoperative blood neutrophil-to-lymphocyte ratio for survival prognosis in patients with gastric neuroendocrine neoplasms. Oncotarget. 2016;7(27):42045–42058.

32. Salman T, Kazaz SN, Varol U, et al. Prognostic value of the pretreatment neutrophil-to-lymphocyte ratio and platelet-to-lymphocyte ratio for patients with neuroendocrine tumors: an Izmir Oncology Group Study. Chemotherapy. 2016;61(6):281–286.

33. Yucel B, Babacan NA, Kacan T, et al. Survival analysis and prognostic factors for neuroendocrine tumors in Turkey. Asian Pacific J Cancer Prevent. 2014;14(11):6687–6692.

34. Saikka N, Smith RA, Whelan P, et al. A preoperative prognostic score for resected pancreatic and periampullary neuroendocrine tumours. Pancreatology. 2009;9(5):670–676.

35. Zhou L, Zhang M, Zhang W, Cai C, Hong J. Pretreatment hematologic markers as prognostic factors in patients with nasopharyngeal carcinoma. A systematic review and meta-analysis. Medicine. 2017;96(11):e6364.

36. Gnijatic S, Bronte V, Brunet LR, et al. Identifying baseline immune-related biomarkers to predict clinical outcome of immunotherapy. J Immunother Cancer. 2017;5:44.

37. Zhou X, Xu L, Huang Z, et al. The hematologic markers as prognostic factors in patients with resectable gastric cancer. Cancer Biomark. 2016;17(3):359–367.

38. Ashrafjanieu T, Mohamadianamiri M, Farzaneh F, Hosseini MS, Arab M. Investigating preoperative hematologic markers for prediction of ovarian cancer surgical outcome. Asian Pacific J Cancer Prevent. 2016;17(3):1445–1448.

39. Kidd M, Bodei L, Modlin IM. Chromogranin A: any relevance in neuroendocrine tumors? Curr Opin Endocrinol Diabetes Obesity. 2016;23(1):28–37.

40. Sherman SK, Maxwell JE, O’Dorisio MS, O’Dorisio TM, Howe JR. Pancreastatin predicts survival in neuroendocrine tumors. Ann Surg Oncol. 2014;21(9):2971–2980.

41. Yao JC, Pavel M, Phan AT, et al. Chromogranin A and neuron-specific enolase as prognostic markers in patients with advanced pNET treated with everolimus. J Clin Endocrinol Metabolism. 2011;96(12):3741–3749.

42. McCall CM, Shi C, Klein AP, et al. Serotonin expression in pancreatic neuroendocrine tumors correlates with a trabecular histologic pattern and large duct involvement. Human Pathol. 2012;43(8):1169–1176.

43. Zandee WT, van Adrichem RC, Kamp K, Feelders RA, van Velthuysen MF, de Herder WW. Incidence and prognostic value of serotonin secretion in pancreatic neuroendocrine tumours. Clin Endocrinol. 2017;87(2):165–170.

44. Tierney JF, Stewart LA, Ghersi D, Burdett S, Sydes MR. Practical methods for incorporating summary time-to-event data into meta-analysis. Trials. 2007;8:16.