Radiation Treatment for WHO Grade II and III Meningiomas

Citation

Published Version
doi:10.3389/fonc.2013.00227

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Accessibility
The treatment of meningiomas is tailored to their histological grade. While World Health Organization (WHO) grade I lesions can be treated with either surgery or external beam radiation, WHO Grade II and III lesions often require a combination of the two modalities. For these high-grade lesions, conventional external beam radiation is delivered to either the residual tumor or the surgical resection margin. The optimal timing of radiation, either immediately following surgical resection or at the time of recurrence, is yet to be determined. Additionally, another method of radiation delivery, brachytherapy, can be administered locally at the time of surgery for recurrent lesions. Altogether, the complex nature of WHO grade II and III meningiomas requires careful treatment planning and delivery by a multidisciplinary team.

Keywords: meningioma, radiosurgery, proton therapy, surgery, brachytherapy
FIGURE 1 | Management strategy for WHO grade II and III meningioma.

In the typical patient, diagnosis is first obtained by surgery. Post-operative radiation is administered to decrease the likelihood of recurrence in many cases and almost universally in cases of subtotal resection. If recurrence occurs, retreatment with radiation and/or surgery are both viable options and should be individualized based on the unique clinical scenario.

FIGURE 2 | Pre-operative MRI. MRI (l–r, sagittal, axial, coronal) demonstrates an avidly enhancing, complex falcine meningioma involving both sides of the superior sagittal sinus.

FIGURE 3 | Post-operative CT scan. Three-dimensional reconstruction demonstrates both prior craniotomies with microplate fixation, as well as radioactive brachytherapy seeds placed in the resection cavity.

FIGURE 4 | Top: Intra-operative photograph of tumor removal. Bottom: Digital subtraction angiogram (DSA) showing the tumor supplied by the meningohypophyseal artery. (Reproduced with permission.)

and non-irradiated patients did not reach statistical significance. For the entire cohort, the actuarial recurrence rates at 1, 5, and 10 years were 7, 41, and 48%, underscoring the propensity of these lesions to recur. Disease-specific survival after first recurrence was 86 and 69% at 5 and 10 years, respectively.

In comparison to grade II meningiomas, grade III meningiomas have a more dismal prognosis, as illustrated in several case series. In a group of 13 patients with WHO grade III meningiomas who underwent surgical resection, recurrence occurred in 92% of patients at a time interval of 0.4–2.8 years (29). The 5- and 8-year actuarial survival in this group was 47 and 12%, respectively. Only three of the initial cohort received adjuvant radiation therapy following primary resection. In another study of grade III meningiomas, the 5- and 10-year survival rates were found to be slightly higher at 64.3 and 34.5%, respectively (9). Despite the aggressive nature of these tumors, adjuvant radiation therapy is not routinely administered. One survey reported that only 9 of the 56 studied centers recommended radiation after gross total resection of an atypical meningioma (30).

Undoubtedly, treatment plans for patients are individualized and based on a multitude of factors. Recent elucidation of the genomic landscape of these lesions has identified several genetic subtypes of tumors that may prove to have distinct clinical characteristics and even the potential for response to targeted therapeutics (31–33). Additionally, atypical meningiomas (WHO grade II) with osseous involvement are associated with poorer outcomes. In 47 patients with atypical meningiomas treated at our institution, bony involvement was associated with an increased rate of disease progression and decreased survival (34). Therefore, bone assessment radiographically and histologically is important, and further
studies should assess the effectiveness of bone resection and/or targeted radiation therapy to the bone to improve outcome.

**BRACHYTHERAPY**

Brachytherapy, the local implantation of a radiation source, is considered "salvage" therapy for the recurrence of aggressive atypical and anaplastic meningiomas. At the time of re-operation, radioactive sources or "seeds" of iodine-125 are implanted in the resection cavity in an array that generally generates a median total activity of between 20 and 60 mCi. Success has been reported with this type of radiation treatment modality, with early reports of two patients with recurrent malignant meningiomas having long term remission after interstitial brachytherapy (35). The largest series to date (21 patients) reported a median survival following implantation of 1.6 years for atypical meningioma and 2.4 years for anaplastic meningioma (36). In this same series, a very high complication rate was reported, with 27% of patients experiencing radiation necrosis and 27% with wound complications requiring re-operation.

**ONGOING STUDIES**

Several trials are studying the role of radiation therapy in the management of patients with atypical or anaplastic meningiomas. Some studies are evaluating differences in radiation delivery modalities and techniques, such as UPCC 24309 (ClinicalTrials.gov Identifier: NCT01117844). In this trial, outcomes from proton beam therapy will be compared to historical controls associated with conventional photon beam treatment. Other studies aim to determine the efficacy of immediate post-operative radiation therapy.
therapy of meningiomas following resection. One trial conducted by the Radiation Therapy Oncology Group (protocol RTOG 0539, ClinicalTrials.gov Identifier: NCT00895622) is monitoring low-grade meningiomas (WHO Grade I) with clinical observation following initial surgery, while those with intermediate or high-risk disease (such as all WHO grade II and III meningiomas) receive 6 weeks of radiation therapy using either three-dimensional conformal RT or intensity-modulated radiation therapy.

The other study, run by the European Organization for Research and Treatment of Cancer (protocol EORTC 22042, ClinicalTrials.gov Identifier NCT00626730), has patients with atypical or malignant meningioma being treated with adjuvant radiation therapy following surgical resection. While we eagerly await the results of these trials to optimize patient care, current management of patients is based on the best evidence available. While randomized trials do not exist, adjuvant radiation therapy immediately following initial surgery for WHO Grade II and III meningioma should be considered given the high rate of local recurrence (Figure 1). Radiation should also be administered for patients undergoing subtotal resection. These recommendations are congruent with National Comprehensive Cancer Network Clinical Practice Guidelines in Oncology (37).

**CASE ILLUSTRATION 1**
A 50-year-old female initially presented 8 years prior with a 5 cm × 5.5 cm × 5 cm enhancing parasagittal lesion with osseous invasion and left sided motor weakness. She underwent a subtotal resection; the pathological diagnosis was consistent with meningioma WHO grade I with no atypical features and a MIB index of 5% (38). Postoperatively, her weakness resolved, but 2 months later she was found to have a new nodular enhancing component in the inferior aspect of the resection site measuring 1.5 cm × 1.5 cm × 1.3 cm. She underwent intensity-modulated radiation therapy 6000 cGy without complication. Six years following radiation, she presented with right-sided weakness and was found to have very aggressive interval growth of the residual tumor (Figure 2). Given the suspicion that her tumor had undergone either atypical or anaplastic transformation, she underwent subtotal resection and placement of interstitial brachytherapy I(125) seeds (Figures 3 and 4). Pathological diagnosis of the tumor removed at the time of the second surgery revealed an atypical meningioma, WHO Grade II of III with high cell density, architectural sheeting, and prominent nucleoli. This case highlights the unique scenario of tumor of progression following treatment. When atypical or malignant progression is suspected on pre-operative imaging, brachytherapy can be considered at the time of re-operation.

**CASE ILLUSTRATION 2**
A 60-year-old woman underwent gross total resection of her right frontal convexity meningioma; and received post-operative
radiation for the pathological diagnosis of atypical meningioma. Two years later on routine follow-up, she was found to have a new lesion invading the torcular. An MRI venogram was obtained that demonstrated an unfavorable dural sinuses configuration; her left transverse sinus was atretic and her right transverse sinus was dominant (Figure 5).

In weighing the risks and benefits of open surgery versus stereotactic radiosurgery, it was decided that radiosurgery would be the best treatment option for her. She underwent stereotactic radiosurgery to the lesion, presumed to be an atypical meningioma based on her previously pathologic diagnosis from the first surgery (Figure 6). From a technical aspect, given the sinus involvement on pre-operative imaging, it was likely that a gross total resection would not be able to be achieved and any tumor left remaining on the sinus would need to be treated with radiation, regardless. Stereotactic radiosurgery provides the benefit of treating the entire lesion while minimizing the risk of a potentially catastrophic venous infarct or hemorrhage associated with open surgery.

CONCLUSION

World Health Organization grade II and III meningiomas can have a malignant clinical course. Multidisciplinary strategies of care involving aggressive surgical resection and post-operative radiation therapy may reduce recurrence rates. Studies to assess the optimal timing and modality of post-operative radiation are underway.

REFERENCES


www.frontiersin.org September 2013 | Volume 3 | Article 227 | 5


Conflict of Interest Statement: The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

Received: 28 June 2013; paper pending published: 26 July 2013; accepted: 16 August 2013; published online: 02 September 2013.


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