Glioblastoma mimicking an arteriovenous malformation

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INTRODUCTION
Subarachnoid hemorrhage (SAH) results from both traumatic and non-traumatic etiologies. While vascular malformations such as arteriovenous malformations (AVM) and aneurysms account for the majority of non-traumatic SAH, no specific cause can be found in many cases. Even with catheter-based diagnostic cerebral angiography, no causative etiology is seen in 15–30% of cases (1, 2). Among non-traumatic, non-aneurysmal SAH, neoplasms represent a minority (1–3%) of all cases (1). Herein, we report the case of a patient with angiography-negative SAH who re-presented 3 years later with rebleeding from what appeared to be de novo AVM. The patient was ultimately found to have a glioblastoma associated with tumor-related vasculature mimicking an AVM. We discuss challenges in the diagnosis of glioblastoma in the setting of intracranial hemorrhage (ICH) and tumor-associated vascular abnormalities that resemble AVM. We also argue for the use of contrast-enhanced magnetic resonance imaging to investigate the etiology of angiography-negative SAH when warranted based on clinical suspicion.

CASE REPORT
A 53-year-old male anticoagulated with warfarin for stroke prevention (atrial fibrillation) presented with blurry vision and headache that had progressively worsened over the course of 3 days following minor trauma to the head. Computed tomography (CT) demonstrated SAH in the right quadrigeminal and supracerebellar cisterns (Figure 1). Catheter-based angiography showed no evidence of intracranial aneurysm, AVM, arteriovenous (A-V) fistula, or other vascular malformation. The angiography-negative SAH was initially attributed to traumatic etiology. The patient developed renal insufficiency, required dialysis, and was discharged to home.

Three years later, following an episode of hemodialysis, the patient developed acute onset of unresponsiveness, lack of right pupillary response to light, and left-sided weakness. CT imaging demonstrated a large right temporal hematoma (Figure 2) that was emergently evacuated via craniotomy. CT and catheter angiography demonstrated a large region of abnormal vasculature in the right temporal, parietal, and occipital areas with a slow A-V shunt, suggestive of an AVM (Figure 3). The lesion was treated with Onyx-18 liquid embolic agent (eV3 Neurovascular Inc., Irvine, CA, USA) with partial obliteration of the A-V shunt. He was discharged to an inpatient rehabilitation hospital and prescribed anticoagulation for the majority of non-traumatic SAH, no specific cause can be found in many cases. Even with catheter-based diagnostic cerebral angiography, no causative etiology is seen in 15–30% of cases (1, 2). Among non-traumatic, non-aneurysmal SAH, neoplasms represent a minority (1–3%) of all cases (1). Herein, we report the case of a patient with angiography-negative SAH who re-presented 3 years later with rebleeding from what appeared to be de novo AVM. The patient was ultimately found to have a glioblastoma associated with tumor-related vasculature mimicking an AVM. We discuss challenges in the diagnosis of glioblastoma in the setting of intracranial hemorrhage (ICH) and tumor-associated vascular abnormalities that resemble AVM. We also argue for the use of contrast-enhanced magnetic resonance imaging to investigate the etiology of angiography-negative SAH when warranted based on clinical suspicion.

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Three weeks later, he again became acutely unresponsive with left-sided weakness. A head CT demonstrated new and extensive intraparenchymal hemorrhage centered in the right temporal lobe, extending into the right parietal, and occipital lobes measuring up to 7.8 cm × 3.7 cm (Figure 2). There was hemorrhage in the ventricular system, along with SAH in the area of the right parietal lobe. There was an extensive mass effect from the intraparenchymal component of the hemorrhage, causing midline shift of 7 mm, and right uncal herniation.

His anticoagulation was reversed emergently and he was stabilized in the intensive care unit. A CT-angiogram demonstrated a large region of abnormal vasculature centered in the right temporal lobe (Figure 3). The right posterior cerebral artery appeared to feed a portion of the lesion. Interpretation of the vascular imaging was complicated by the mass effect associated with the intraparenchymal hemorrhage, which distorted normal anatomy. While in the intensive care unit, the patient began experiencing

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seizures, prompting repeated imaging. A CT scan demonstrated the development of a new intraparenchymal hemorrhage within the region of the right basal ganglia, as well as an SAH in the right frontal lobe with significant associated edema and resultant 2 cm midline shift with uncal herniation. Given the significant risks of further neurosurgical intervention, poor neurological state, and low likelihood of recovery, the family elected to transition his goals of care to comfort measures only. The patient expired 5 days later.

Autopsy revealed no evidence for a vascular malformation; rather, an extensive glioblastoma involving the right parietal, occipital, and temporal lobes with significant associated hemorrhage and necrosis was found (Figure 4). The tumor contained many medium-caliber sclerotic vessels and large areas of necrosis. Grossly, there was increased prominence of veins over the right superior cerebellum and the inferior surface of the right temporal lobe. There were contusions in the right orbitofrontal region and bilateral temporal tips, and increased vascular markings over the surface of the right inferior temporal gyrus. A softening of the cortex (12 cm × 6 cm) spanning the right posterior temporal, right inferior parietal, and right anterior occipital regions was noted.

Histologically, this was a WHO grade IV glioblastoma with extensive infiltration of the white matter centered in the right temporal lobe and involving the parietal and occipital lobes. Classic pseudopalisading necrosis, along with frequent mitotic figures, microvascular proliferation, and reactive gliosis involving the cortex and white matter were noted (Figure 5). There were large areas of geographic necrosis, and scattered medium to large-sized vessels with intraluminal thrombi.
The incidence of ICH is greater in faster-growing tumors with subclinical and microscopic hemorrhage (14). Plasms cause large hemorrhage; the incidence approaches 15% of spontaneous ICH, and between 3 and 5% of intracranial neoplastic lesions (12, 13). Almost exclusively intraparenchymal, and only rarely enters the subarachnoid space (12, 13). Brain tumors represent 0.9–11% of perimesencephalic SAH with a similarly benign prognosis, although this categorization has been debated (8). Other non-aneurysmal causes of SAH include coagulopathy, hypertension, infection, venous occlusive disease, occult trauma, drug abuse, and cerebral neoplasia (9). Tumors are usually apparent on CT; however, at least one other case of occult glioma presenting solely as angiogram-negative SAH has been reported (10).

As there was no evidence of neoplasm on CT and the presented patient had a history of mild trauma before the onset of SAH, it was suspected that the original presentation of SAH 3 years prior to his admission was not inconsistent with a diagnosis of AVM in this patient. The normal angiogram obtained 3 years prior to his admission was not inconsistent with a diagnosis of AVM, as de novo AVMs are known to occur (24). In addition to vascular malformations, there can be significant A-V shunting on angiography. Indeed, in a retrospective study of 50 cases of spontaneous ICH caused by cerebral neoplasms, there was no preoperative radiological suspicion of neoplasm in half of cases (19). Nevertheless, there are some distinctive features of tumor-related ICH on CT that may help guide workup. Irregular shape and atypical location of an ICH may indicate neoplastic etiology (19), including cases of ICH precipitated by trauma (11). Heterogeneous appearance and multiple hemorrhage locations may also suggest a tumor (20). Enhanced peritumoral vascularization at tumor margins and vascular erosion of tissue around the tumor likely contribute to ring-like enhancement around the lesion that is particularly apparent on contrast-enhanced CT (21). Perilesional edema may be an important finding, because it is rare in acute ICH but common in expanding, space-occupying lesions (22, 23).

In the case presented, angiography to investigate the etiology of ICH demonstrated a large region of irregular vasculature (ultimately proving to be spatially coincident with glioblastoma) that demonstrated slow A-V shunting. The combination of ICH and abnormal vasculature with A-V shunting on angiography was highly suggestive of AVM in this patient. The normal angiogram obtained 3 years prior to his admission was not inconsistent with a diagnosis of AVM, as de novo AVMs are known to occur (24). In addition to vascular malformations, there can be significant A-V shunting in many brain tumors that can be visualized on angiography (25, 26). The relationship between development of glioblastoma and AVM-like angiopathy is unclear, but pro-angiogenic factors secreted by growing malignancies are suspected to play an important role in the development of vascular abnormalities, including A-V shunting, in glioblastoma and other cerebral neoplasms (27).

The radiographic features that would enable differentiation between AVM and glioblastoma are frequently obfuscated in the setting of acute hemorrhage. For example, a ruptured AVM with hematoma formation can exhibit a mass effect, making it difficult to distinguish from a tumor on CT. In one study, 33 of 60 cases of ruptured AVMs demonstrated significant mass effect (28).
Although rare, there have been a few reports of glioblastoma mimicking or associated with a vascular lesion in which initial imaging does not clearly distinguish between the two. In some cases, initial imaging indicates hemorrhage of uncertain etiology (11, 29–31); in others, CT or CT-angiogram is specifically suggestive of AVM (32, 33), as in the presented case. Some reports describe coincidence of GBM and AVM in the same patients, even occasionally without spatial overlap between the lesions (34, 35). In all of these cases, histopathological diagnosis ultimately confirmed GBM. One report highlights the importance of including perilesional tissue in biopsy whenever possible, describing a case in which diagnosis of GBM was initially missed because only a small minority of sections from a vascular-appearing lesion showed which diagnosis of GBM was initially missed because only a small minority of sections from a vascular-appearing lesion showed evidence of neoplasm (36). Taken together, these cases and ours highlight the importance of considering neoplasm in the differential diagnosis of ICH with uncertain etiology, and the need for careful monitoring when initial workup is inconclusive.

The anatomical coincidence of the first SAH and the large glioblastoma discovered 3 years later suggests that the etiology of the SAH may have been neoplastic. We suspect that a follow-up contrast-enhanced MRI to further investigate the cause of the SAH may have been neoplastic. We describe coincidence of GBM and AVM in the same patients, even occasionally without spatial overlap between the lesions (32, 33), as in the presented case. Some reports (11, 29–31); in others, CT or CT-angiogram is specifically suggestive of AVM (32, 33), as in the presented case. Some reports describe coincidence of GBM and AVM in the same patients, even occasionally without spatial overlap between the lesions (34, 35). In all of these cases, histopathological diagnosis ultimately confirmed GBM. One report highlights the importance of including perilesional tissue in biopsy whenever possible, describing a case in which diagnosis of GBM was initially missed because only a small minority of sections from a vascular-appearing lesion showed evidence of neoplasm (36). Taken together, these cases and ours highlight the importance of considering neoplasm in the differential diagnosis of ICH with uncertain etiology, and the need for careful monitoring when initial workup is inconclusive.

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