Primary Spinal Glioblastoma Multiforme with Secondary Manifestation as a Cerebral “Angioglioma.” Literature Review and Case Report

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Abstract

Primary intramedullary spinal glioblastoma multiforme (sGBM) with a secondary cerebral manifestation is a very rare entity with a poor outcome. Case studies show a mean average of survival of 10 months after diagnosis. These tumors tend to develop at a young age. A combination with an arteriovenous malformation in the same location has never been published before. Vascular malformations in association with cerebral glioblastomas have only been reported in five cases so far. Proangiogenic factors are assumed to be involved in the appearance of both entities. We present a case study and a review of the literature.

Keywords

► spinal glioblastoma
► cerebral angioglioma
► arteriovenous malformation

Introduction

Primary intramedullary spinal glioblastoma multiforme (sGBM) is a rare disease entity and accounts for only 1 to 5% of all GBMs and only 1.5% of all spinal cord tumors. It develops from the spinal cord or as a secondary metastasis from the brain. It tends to have a predilection in the cervical region in primary cases and more often occurs in younger patients (<30 years of age). Despite the best treatment with surgery and adjuvant therapy, overall survival barely exceeds 6 to 16 months.¹⁻⁹ Twenty cases of primary sGBM with secondary cerebral manifestation have been reported since 1938.²⁻⁴,¹⁰⁻²²

Vascular malformations associated with gliomas are also extremely rare and include venous malformations, cavernous angiomas, or arteriovenous malformations (AVMs). AVM in combination with a cerebral GBM in the same location has been reported in only five cases so far.²³⁻²⁶

Methods

Databases Ovid Medline and PubMed were searched using a combination of thesaurus terms and relevant text words: intramedullary GBM, primary spinal GBM, spinal GBM with secondary manifestation, spinal glioblastoma and secondary cerebral manifestation, spinal GBM cerebral metastases, glioblastoma and vascular malformation, and angioglioma. Previously reported cases were reviewed and discussed in the light of our own observations. Mean age, gender distribution, and location of the GBM were calculated and analyzed based on the data we collected.

Case Report

A 35-year-old German male patient was transferred to our institution with a short history of progressive left-sided hemihypesthesia downward from the chest to the toes without motor deficits and gait disturbance.
The first diagnostic steps included cranial magnetic resonance imaging (MRI) showing a venous malformation in the left frontal lobe. There was no further evidence of a cranial manifestation of a tumor or a cerebral hemorrhage (Fig. 1).

The initial spinal MRI depicted alterations of the morphology and signal intensity of the spinal cord from T2 to T3 and a slight gadolinium (Gd) enhancement in this area (Fig. 2).

We performed laminotomy and laminoplasty between T2 and T3, and partial tumor removal under motor-evoked potential monitoring. The histopathologic study confirmed the diagnosis of GBM with typical histologic findings of pleomorphism, atypical cells, vascular proliferation, and a high expression of glial fibrillary acidic protein. There was also a high Ki-67 proliferation index of ~20%. Postoperatively, the patient showed right-sided hemihypesthesia distal dermatome T5, marked gait disturbances, reduced proprioception, and less superficial sensation mainly left sided. The patient received spinal radiotherapy between T4 and T5 (60 Gy) and six cycles of chemotherapy with temozolomide (TMZ).

Sixteen months after surgery, MRI showed stable disease without evidence of further tumor growth or a new spinal manifestation. Nineteen months after the operation, the patient was hospitalized due to a massive headache and progressive
fatigue. MRI revealed an intracranial tumor in the left frontal lobe with Gd enhancement and spread to the opposite hemisphere crossing the corpus callosum, still including radiologic signs for a venous malformation (►Fig. 3). Microsurgical biopsy and intraoperative ultrasonic guidance (►Fig. 4) revealed a cerebral GBM World Health Organization grade IV with close association with an AVM (►Fig. 5). The patient died a few days after the biopsy due to malignant brain edema.

**Discussion**

**Primary Spinal Glioblastoma with Cranial Manifestation**

The incidence of sGBM drop metastases secondary to cerebral GBM is extremely rare (0.4–1.1%), whereas 25% of all sGBMs are drop metastases.8 The reverse process is extraordinarily rare.4,27

![Fig. 3](image)

(A) Axial and (B) coronal T1-weighted magnetic resonance images enhanced with gadopentetate dimeglumine demonstrating an intracranial tumor in the left frontal lobe with spread to the opposite hemisphere crossing the corpus callosum and still including radiologic signs for a venous malformation.

![Fig. 4](image)

Intraoperative ultrasound demonstrating a tumor with close contact to an arteriovenous malformation.
We performed a review of the literature and, to the best of our knowledge, only 21 cases of primary sGBM with secondary cerebral manifestation have been previously reported since 1938 including this case.

The outcome of these cases was exceptionally poor with a mean average survival of 10.4 months from diagnosis (range: 1–36 months). These tumors have a tendency to develop at a young age (mean: 23.9 years) with a slight male predominance (52%) and location in the thoracic spine (38%). Overall, 19% were located either in the conus or cervical spine. The remaining cases were described as holocordal or diffuse spreading within the spinal column (Table 1).

Spinal cord astrocytoma frequently involves the cervical spine. Although cervical spine astrocytomas are common, metastases to the brain mostly occur from the thoracic spinal cord. Most of the patients received combined radiotherapy after surgical treatment (47%). Adjuvant chemotherapies have been described only in three cases since the early 1990s.

Patients with malignant spinal cord astrocytomas may develop disseminated disease mostly via the leptomeningeal route. Treatment strategies include tumor debulking and high-dose postoperative radiation that may exceed the radiation tolerance of the spinal cord. Most authors suggest focal spine radiotherapy and chemotherapy with TMZ. Others recommend a more aggressive course of whole-brain irradiation in addition to focal spine irradiation, even if there is no evidence of intracranial dissemination. Gd-enhanced MRI of the entire neuraxis is considered the gold standard imaging modality to diagnose intramedullary tumors. Fig. 5 (A–C) The histopathologic examination revealed a predominant glial (astrocytic) differentiated tumor, with increased cellularity, cellular pleomorphism, microvascular proliferation, and necrosis, corresponding to a glioblastoma World Health Organization grade IV. (A) Hematoxylin and eosin (×100). (B) Strong reactivity for glial fibrillary acidic protein (×100). (C) Area with high MIB-1 labeling index (×100).
Table 1 Literature review of 21 patients with spinal glioblastoma and secondary cerebral manifestation

<table>
<thead>
<tr>
<th>Case no.</th>
<th>Study</th>
<th>Age</th>
<th>Sex</th>
<th>Localization</th>
<th>Metastases</th>
<th>Treatment</th>
<th>Survival Time, mo</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Eden(^{13})</td>
<td>19</td>
<td>M</td>
<td>Spinal cord</td>
<td>Cerebral leptomeninges</td>
<td>Surg</td>
<td>7</td>
</tr>
<tr>
<td>2</td>
<td>O’Connell(^{17})</td>
<td>16</td>
<td>M</td>
<td>T7–T12</td>
<td>Ventricle, subarachnoid space</td>
<td>Biopsy, Rad</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>Russel and Rubenstein(^{9})</td>
<td>11</td>
<td>F</td>
<td>Cervical</td>
<td>Subarachnoid space, ventricles</td>
<td>Surg</td>
<td>6</td>
</tr>
<tr>
<td>4</td>
<td>Tashiro et al(^{21})</td>
<td>12</td>
<td>F</td>
<td>Conus</td>
<td>Cerebellum, hypothalamus, brainstem, thalamus</td>
<td>Surg</td>
<td>11</td>
</tr>
<tr>
<td>5</td>
<td>Andrews et al(^{2})</td>
<td>45</td>
<td>M</td>
<td>T12</td>
<td>Septal region, right ventricle</td>
<td>Surg, Rad</td>
<td>13</td>
</tr>
<tr>
<td>6</td>
<td>Hely 1985(^{30})</td>
<td>38</td>
<td>F</td>
<td>Dorsal cord</td>
<td>Subarachnoid space, ventricles</td>
<td>Surg, Rad</td>
<td>9</td>
</tr>
<tr>
<td>7</td>
<td>Takara et al(^{20})</td>
<td>20</td>
<td>M</td>
<td>T5–T8</td>
<td>Basal cisterns</td>
<td>Surg, Rad</td>
<td>5</td>
</tr>
<tr>
<td>8</td>
<td>Johnson and Schwarz(^{27})</td>
<td>9</td>
<td>F</td>
<td>Dorsal cord to conus</td>
<td>Subarachnoid space, ventricles</td>
<td>Surg, Rad</td>
<td>14</td>
</tr>
<tr>
<td>9</td>
<td>Cohen et al(^{4})</td>
<td>16</td>
<td>F</td>
<td>Conus</td>
<td>Septum pellucidum</td>
<td>Surg</td>
<td>6</td>
</tr>
<tr>
<td>10</td>
<td>Cohen et al(^{4})</td>
<td>14</td>
<td>M</td>
<td>Conus</td>
<td>Intracranial sites</td>
<td>Surg</td>
<td>4</td>
</tr>
<tr>
<td>11</td>
<td>Cohen et al(^{4})</td>
<td>9</td>
<td>M</td>
<td>Cervical</td>
<td>Brainstem</td>
<td>Surg</td>
<td>1</td>
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<tr>
<td>12</td>
<td>Asano et al(^{10})</td>
<td>23</td>
<td>F</td>
<td>T11–L1</td>
<td>Bilateral lateral ventricles</td>
<td>Surg, Rad</td>
<td>12</td>
</tr>
<tr>
<td>13</td>
<td>Yamazaki et al(^{22})</td>
<td>35</td>
<td>F</td>
<td>T9–L1</td>
<td>Cerebral</td>
<td>Surg, Rad, Chem</td>
<td>36</td>
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<tr>
<td>14</td>
<td>Kawanishi et al(^{14})</td>
<td>50</td>
<td>M</td>
<td>T11–T12</td>
<td>Cerebellum, cingulated gyrus, Sylvian fissure</td>
<td>Surg, Rad</td>
<td>25</td>
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<tr>
<td>15</td>
<td>Chida et al(^{11})</td>
<td>22</td>
<td>M</td>
<td>Diffuse</td>
<td>Subarachnoid space along brainstem and cerebellum</td>
<td>None</td>
<td>3</td>
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<tr>
<td>16</td>
<td>Cursiefen et al(^{12})</td>
<td>16</td>
<td>M</td>
<td>C5–T1</td>
<td>Bilateral supratentorial</td>
<td>Surg, Rad, Chem</td>
<td>5</td>
</tr>
<tr>
<td>17</td>
<td>Strik et al(^{19})</td>
<td>31</td>
<td>F</td>
<td>T11</td>
<td>Multiple intracranial and meningeal</td>
<td>Surg, Rad</td>
<td>13</td>
</tr>
<tr>
<td>18</td>
<td>Medhkour and Chan(^{19})</td>
<td>20</td>
<td>M</td>
<td>T12–L1</td>
<td>Pontomedullary junction, cerebellum, suprasellar cistern, left lateral ventricle</td>
<td>2 Surg, Rad</td>
<td>11</td>
</tr>
<tr>
<td>19</td>
<td>Mori et al(^{16})</td>
<td>10</td>
<td>F</td>
<td>Holocordal</td>
<td>Pituitary stalk, cervicomедullary junction</td>
<td>Chem</td>
<td>14</td>
</tr>
<tr>
<td>20</td>
<td>Ozigiray et al(^{18})</td>
<td>54</td>
<td>F</td>
<td>C3–C4</td>
<td>Cranial meningeal, pontine medullary junction, cerebellum, suprasellar cistern, left lateral ventricle</td>
<td>Surg, Rad (ceased)</td>
<td>2</td>
</tr>
<tr>
<td>21</td>
<td>Present case</td>
<td>33</td>
<td>M</td>
<td>T3–T4</td>
<td>Left frontal lobe</td>
<td>2 Surg, Rad, Chem</td>
<td>19</td>
</tr>
</tbody>
</table>

Abbreviations: C, cervical spine; Chem, chemotherapy; F, female; M, male; Rad, radiation; Surg, surgery; T, thoracic spine.
advocated to rule out cranial metastasis, evaluate treatment efficiency, and detect local relapse.\textsuperscript{16,31,32}

**Arteriovenous Malformation in Combination with Cerebral Glioblastoma**

None of these 20 cases showed a cerebral AVM within the same location in addition to the cranial manifestation. Generally, vascular malformations in association with cerebral glioblastomas in the same location have only been reported in five cases so far\textsuperscript{3,24,33–35} (\textsuperscript{–Table 2}).

These entities have a tendency to develop in older patients (average: 56 years of age) with a very clear male predominance (100%). The relation of affected hemispheres (right to left) was 50%. All the patients underwent surgical treatment. Precise information about the survival time was only given in three cases and was poor as previously described.

Vascular malformations associated with gliomas are very rare in general and include venous malformations, cavernous angiomas, or AVMs.\textsuperscript{25} It is supposed that the hyper-angiogenic environment of high-grade tumors induces abnormal arteriovenous connections.\textsuperscript{36} Some authors suggested a new term for these entities and named them angioiogliomas, historically first mentioned by Councilman who described a highly vascularized cerebellar tumor that is now regarded as the cellular variant of hemangioblastoma.\textsuperscript{37,38} However, only a very few brain neoplasms develop large arteriovenous connections as mentioned. Enhanced angiogenesis, thickened basement membranes, and highly proliferative endothelial cells mediated by proangiogenic factors such as vascular endothelial growth factor (VEGF) overexpressed by the tumor is essential to diagnose high-grade gliomas.\textsuperscript{39} VEGF secreted by tumor cells binds to endothelial cells expressing VEGF receptors with subsequent activation of neoangiogenesis.\textsuperscript{40} VEGF is expressed in both entities, GBM and AVM, and may be the link for the simultaneous occurrence.\textsuperscript{39} Thus adjuvant therapies with antiangiogenic factors may be preferred in this special situation of a combined occurrence of both entities.

**Conclusion**

A sGBM with secondary malformation is a very rare entity in mostly younger patients and has a poor outcome. Surgery, focal spine radiotherapy, and adjuvant chemotherapy with TMZ are recommended for treatment. MRI of the neuraxis is considered the gold standard for controlling treatment efficiency and detecting cranial metastasis and local relapse.

Cerebral AVMs in association with GBM represent a very rare entity with very few reports in the literature. Proangiogenic factors appear to be involved in the appearance of both entities in the same location.

A combination of a primary sGBM with secondary cerebral manifestation in association with a cerebral AVM in the same location is reported here for the first time.

**References**

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