A Rare Case of Simultaneous Multifocal Craniospinal Hemangiopericytomas

Abstract
First reported case of simultaneous occurrence of hemangiopericytomas (HCP) at multiple sites of craniospinal axis in a thirty-four year male is presented. Patient presented with neck pain for 1 year, and one episode of simple partial seizure involving his left lower limb. He was diagnosed as having HCP in right middle one third parasagittal region, and C4,5 vertebral bodies. Another lesion was present in L5 vertebra, which was radiologically similar to the cervical lesion, but not biopsy proven. High index of suspicion, and low threshold for screening, for coexistence of spinal HCP, in patients harboring cranial HCP’s and complaints of back pain.

Keywords: Craniospinal hemangiopericytomas, multiple hemangiopericytomas, simultaneous multifocal hemangiopericytomas

Introduction
Intracranial hemangiopericytomas (HPCs) are rare intracranial tumors, accounting for <1% of all intracranial tumors.[1] HPCs are soft tissue tumors composed of capillary blood vessels with one or more layers of rounded cells showing features of pericytic differentiation. The thick-walled, branching “stag-horn” vessels are easily identified.[2] Although previously thought to be a subtype of meningiomas, there are now well documented features to differentiate HPC from meningiomas. Intracranial HPC is known to metastasize both to the spinal axis and to extraneural sites as well. Metastasis from extraneural sites to the spine is also well known.[3-6] All the existing literature suggests metastasis after long-term follow-up. Whether, this represents metastasis or an underlying systemic predisposition to develop such tumors. We report a case of simultaneous occurrence of hypertrophic cranial pachymeningitis (HCP) in cranial, cervical, and lumbar locations.

Case Report
A 34-year-old male presented with neck pain for 1 year, and one episode of simple partial seizure involving his left lower limb. He was a known asthmatic. He did not have any neurological deficits. On investigations, he was found to be having the right middle one-third parasagittal extra-axial lesion. The lesion was well-defined, isointense on T1, isointense with multiple hypointensities on T2, and well enhancing on gadolinium administration. Cervical magnetic resonance imaging (MRI) showed a lytic lesion involving body and the right side posterior elements of C4, 5 vertebra. MRI also showed a lytic lesion in lumbar (L5) vertebra [Figure 1a and d]. He underwent parasagittal craniotomy and gross total excision of the lesion, with biopsy of the cervical lesion. On histopathological examination, similar picture was present from both the lesions. Sections showed proliferation of spindle cells with blunt vesicular nuclei and variably sized blood vessels embedded within it. No increase in mitosis, necrosis, or pleomorphism was noted. On immunohistochemistry (IHC), glial fibrillary acidic protein, epithelial membrane antigen (EMA), and S 100 were not found to be expressed. CD34 was expressed by the endothelial lining of the blood vessels and the spindle cells [Figure 1e and f]. Ki fraction was 6%. Postoperative he developed the right foot drop, which gradually improved. After the craniotomy, he underwent positron emission tomography–computed tomography Gallium 68 DOTANOC scan, which showed multiple areas of uptake in C4, C5, and L5 vertebrae. Two months after the
The high recurrence rate for those patients treated with complete excision was 72.7%, whereas that for those patients treated with incomplete excision was just 20.8%. The addition of postoperative radiotherapy is the norm and has shown a significant reduction in the rate of local recurrence when compared with surgery alone.[5] The high vascularity of HPC can be a challenge for the surgeon.[4]

Intracranial meningeal HPC is known for its high recurrence rate – up to 52.2% – and for its tendency to metastasize in as many as 23.4% of affected patients to extracranial bone (40.9%), liver (36.3%), and lung (36.3%) tissues.[1]

A few cases of meningeal HPCs metastasizing to the spine have been reported. The mean duration between onset of intracranial HPC and metastasis to the spine is 11 years, and the cervical, thoracic, and lumbar spine are equally involved.[1]

To the best of our knowledge, this is the second case where simultaneous cranial and spinal HPC have been reported. The first case reported had a meningeal HCP of the posterior fossa and a second lesion in the thoracic spinal epidural space.[9]

This is the first case where one cranial and two spinal HPCs have been reported concurrently.

The existing literature makes us believe that spinal lesions are metastatic. The spread of tumor cells from brain to different sites of spine is hypothesized to be through the network of venous dural channels. The other likely route of metastasis is through cerebrospinal fluid spread, as is known for benign “multifocal” meningiomas.[10] The first hypothesis seems more likely as these tumors are known to occur in close proximity to the venous sinuses which provide an easy access for metastasis, and that all the spinal HPC have been extradural lesions in both this and the earlier case report with simultaneous lesions.[9]

In the present case, the spinal lesion was present concurrently with the cranial lesion. Both the lumbar and cervical lesions showed significant involvement of the
vertebral bodies. Symptomatic period was longer for the cervical lesion than the cranial lesion.

**Conclusion**

HPCs are rare extra-axial meningeal tumors with a high propensity for local or distant recurrence. High index of suspicion is required to pick up multiple site involvement.

**Financial support and sponsorship**

Nil.

**Conflicts of interest**

There are no conflicts of interest.

**References**


