Case Report

Cerebellar Liponeurocytoma: A Rare Fatty Tumor and its Literature Review

Harsh Deora, A. R. Prabhuraj, Jitender Saini, T. C. Yasha, Arivazhagan Arimappamagan

INTRODUCTION

Cerebellar liponeurocytoma is a rarely encountered tumor, reported first by Bechtel et al. (1978) in a 44-year-old male who named it “lipomatous medulloblastoma,” thus referring to its significantly better prognostic nature. Since then, various authors have reported it using different names as follows: neurolipocytoma, medullocytoma, lipidized medulloblastoma, and lipomatous glioneurocytoma. Later, in the World Health Organization (2000) classification, it was denoted as a separate Grade I entity. However, due to multiple reported recurrences and atypical features, it was then upgraded to Grade II in the updated WHO classification of 2007. We report a case of liponeurocytoma in a 55-year-old male with more than 4 years follow-up after surgery along with a literature review of previously reported cases.

CASE REPORT

Clinical presentation

A 55-year-old male presented with 5 months’ history of dull aching occipital headache associated with vomiting and visual blurring at the peak of headache. He also complained of inability to maintain balance while walking or standing. On examination, he had papilledema and tandem gait ataxia.

Computed tomography (CT) scan of the brain revealed a heterodense lesion in the 4th ventricle, with hypodense central component with mild hydrocephalus. MRI brain with contrast showed a lesion, measuring 3.9 cm × 3.1 cm × 4.5 cm, arising from the vermis of the cerebellum completely effacing the fourth ventricle, heterogeneous on T1-weighted and T2-weighted imaging with patchy contrast enhancement with perilesional edema and obstructive hydrocephalus.

He underwent midline suboccipital craniectomy, C1 posterior arch excision, and near-total resection of the lesion. The tumor was soft, vascular with dense septae, adherent to the floor of the fourth ventricle thus necessitating a near-total resection. The patient had transient right VI cranial nerve palsy in the postoperative period, which resolved over 7 days.

ADDRESS

Address for correspondence: Dr. Arivazhagan Arimappamagan, Department of Neurosurgery, National Institute of Mental Health and Neurosciences, Hosur Road, Bengaluru - 560 029, Karnataka, India. E-mail: arivazhagan.a@gmail.com

This is an open access journal, and articles are distributed under the terms of the Creative Commons Attribution-NonCommercial-ShareAlike 4.0 License, which allows others to remix, tweak, and build upon the work non-commercially, as long as appropriate credit is given and the new creations are licensed under the identical terms.

For reprints contact: reprints@medknow.com

How to cite this article: Deora H, Prabhuraj AR, Saini J, Yasha TC, Arimappamagan A. Cerebellar liponeurocytoma: A rare fatty tumor and its literature review. J Neurosci Rural Pract 2019;10:360-3.
The resected tumor tissue revealed a moderately cellular tumor with variable morphology [Figure 2]. Large lobules of relatively rounded cells with clear to eosinophilic cytoplasm were separated partially by branching vessels. Focal perivascular arrangement by columnar cells was seen. The nuclei were medium sized, round, and vesicular. Focal areas showed hypercellularity and mild hyperchromasia and atypia. Admixed with the neurocytic component in several foci were large islands of mature adipocyte cells composed of cells with abundant clear

Figure 1: Computed tomography brain (a and b) plain and contrast-enhanced (c) images show a mass lesion in the posterior fossa, with hyperdense superior component, with moderate enhancement. The inferior component is hypodense, has Hounsfield unit of -31, suggesting fat. Magnetic resonance imaging brain T1 axial images (d and e) showed heterointense lesion involving vermis and fourth ventricle, with hyperintense inferior component and isointense superior component, with similar signal changes in T2 sagittal images (f). Mild enhancement was noted with contrast (g and h). Few areas of restricted diffusion were noted (i). Gradient echo sequence showed abundant blooming of the hyperintense component, suggesting fat (k). MRS showed lipid peak in the region of 1.3 ppm (i). Follow-up magnetic resonance imaging brain 42 months after surgery showed a small asymptomatic residue in the vermis (l and m)
In the two samples of cerebellar na familial predisposition has = 73) until 2018, noted that these tumors had [17,19] Recent reports also exist Wolf 2]. [15‑17] [16] Histologically, classic medulloblastoma [16] These Germline Gembruch [16,18] and one case of intraspinal lumbar Figure 1m and n]. [9‑13] [11] [10,11] low MIB‑1 proliferation index (3.73 ± 4.01%). cases (et al., in a systematic review of all the reported cases of liponeurocytoma and ependymoma, which can rarely demonstrate T1 hyperintensity. [16] Histologically, classic medulloblastoma can demonstrate foamy histiocytes along with primitive neuroectodermal cells. However, a high proliferative index will clearly indicate the malignant nature of tumor in medulloblastoma. As can probably be understood, differentiation between these entities is critical for decision-making.

In recent articles, [10,11] a familial predisposition has been suggested with possibly an autosomal dominant mode of inheritance. However, a causative genetic mutation as well the cell of origin of liponeurocytoma is yet to be ascertained. There are certain findings that have come to be associated with liponeurocytomas and their inheritance. A NEUROG1 transcript along with the absence of the ATOH1 transcript has been reported by Anghileri et al. [17] In the two samples of cerebellar liponeurocytoma, they also noted an overexpression of fatty acid‑binding protein 4. These findings have led the authors to conclude that liponeurocytoma may be the consequence of a transformation of progenitor cells of the cerebellum to adipose tumor cells by possible aberrant differentiation. These are different from the cerebellar granular progenitor cells which were initially considered as the cell of origin for these tumors. [17,19] Wolf et al. have suggested a germline mutation predisposing to the formation of liponeurocytomas. [11] Germline mutations are usually seen in a gene with a proven role in oncogenesis, and such an understanding would be beneficial to the other family members to ascertain their risk of tumor occurrence.

Optimum treatment modality, however, continues to be surgical. Considering the low proliferation index (<5%) reported by most authors, radiotherapy does not seem a pertinent option. Gembruch et al.
reported that tumor recurrence was observed in 8.33% of cases after adjuvant radiotherapy. This was in stark contrast to the recurrence rates seen in cases that did not undergo radiotherapy (13/29 or 44.83%).[14] However, the indications of considering adjuvant therapy in an individual case are not clear, keeping in mind the benign nature of the tumor. A lack of knowledge of the tumor’s natural history contributes to such lacunae in our understanding.

The management of recurrence needs to be patient specific with recurrent symptoms or significant growth of lesion requiring resurgery. Since the longest reported survival was 18 years in two patients,[15,16] a slow growth rate can be assumed, and thus observation for “silent” recurrences is advocated. Thus, there is a need to report and follow-up these cases to better our understanding of this rare entity and to establish guidelines regarding treatment.

**Declaration of patient consent**

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

**Financial support and sponsorship**

Nil.

**Conflicts of interest**

There are no conflicts of interest.

**REFERENCES**