Clinical case

Uncal decompression in gliomatosis cerebri

Décompression de l’uncus dans la gliomatose cérébrale

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**Article Info**

Received 1st November 2012
Accepted 25 February 2013

**Keywords:**
Gliomatosis cerebri
Temporal lobectomy
Decompressive surgery

**Abstract**

Gliomatosis cerebri is defined as an infiltration, by an infiltrative glioma, of more than two cerebral lobes. Depending on response to treatment (chemotherapy and radiotherapy), clinical course may prolong over several months. Surgical excision has a very limited role in the management of this diagnosis. We present the case of a 48 year-old woman in whom a decompressive temporal lobectomy was performed in the context of a gliomatosis. Relief of intracranial hypertension allowed further treatment and a survival of 23 months. Relevant literature on the subject has been reviewed. There is the possibility of offering a decompressive lobectomy in selected cases of gliomatosis, allowing to undergo other treatment modalities.

**Résumé**

Les gliomatoses cérébrales sont définies comme une infiltration, par un gliome infiltrant, de plus de deux lobes cérébraux. Dépendante de la réponse aux traitements (chimio- et radiothérapie), l’évolution peut être prolongée sur plusieurs mois. La chirurgie d’exérèse a très peu de place dans la prise en charge de ce type d’affections. Nous présentons le cas d’une femme de 48 ans chez laquelle a été réalisée une lobectomie temporaire de décharge dans un contexte de gliomatose. L’amélioration de l’hypertension intracrânienne a été suffisamment satisfaite pour mettre en place une chimiothérapie et obtenir une survie de 23 mois. Les principales données de la littérature ont été revues. Il est possible de proposer une lobectomie de décharge dans certains cas de gliomatose, permettant ainsi la mise en route des autres modalités thérapeutiques.

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1. Introduction

Gliomatosis cerebri (GC) is a diffuse glial neoplasm, usually astrocytic [1–3], defined by the presence of a continuous infiltrative disease in more than two cerebral lobes. Clinical course depends on initial and evolutive tumor grade, with 3 months of median time between initial symptoms and diagnosis, and months to 2 years of survival after diagnosis [4–7]. The World Health Organization (WHO) classifies GC as a grade III neoplasm [1]. Actual histology can correspond to that of grade II, III or IV glioma, thus influencing evolutive course and prognosis [6]. A tumor biopsy is required to obtain a histological diagnosis, but the extension of the neoplasm usually excludes surgical resection [6]. Current treatment is based on radiotherapy and chemotherapy [4,6,7]. Surgery has been indicated only sporadically, although information regarding surgical treatment is limited to short and heterogeneous series. We present a case of GC with acute symptoms of raised intracranial pressure (ICP). Considering that rapid deterioration due to brain herniation was conditioning the prognosis, a decompressive surgery was performed.

2. Case report

A 48-year-old, previously healthy woman presented at the emergency room for sudden loss of consciousness after a Valsalva maneuver. Her relatives reported that in the previous year, she had presented anorexia and a personality disorder that were considered to have a depressive, psychiatric etiology. On neurologic exploration, she had a Glasgow Coma Scale (GCS) 14 and presented right hemiparesis and multiple cranial nerve palsies, including...
facial asymmetry, anisocoria due to right midiasis, and persistent hiccups. Urgent CT and MR scans were performed, showing an infiltrative, non-contrast enhancement lesion affecting the left temporal and parietal lobes, the right frontal and temporal lobes, the left thalamus and hippocampus and the basal ganglia bilaterally. The left hemisphere lesion caused severe mass effect, as well as hydrocephalus (Fig. 1). The patient was monitored at the intensive care unit. Level of consciousness fluctuated and was strictly dependent on the administration of dexamethasone, mannitol and furosemide to maintain a GCS over 13. Episodes of severe decline in level of consciousness were accompanied by anisocoria, requiring the mentioned drugs for its reversal. In this setting, we considered that the relatively prolonged survival that is generally attributed to GC was hampered in the short term due to an acute deterioration. We believed that the patient could benefit from additional oncologic therapies and drastically improve outcome if the acute, life-threatening brain stem symptoms could be reversed. A decompressive surgery was therefore considered. Hippocampectomy was discarded to obviate neurological impairment in the context of a malignant neoplasm. Decompressive craniectomy was not considered to be an adequate procedure for neoplastic patients. A left temporal lobectomy was decided, with the intention to relieve the uncal and brain stem herniation. The surgical intervention was uneventful. The lobectomy was limited by the usual anatomic landmarks, and was performed through a fronto-temporal osteoplastic craniotomy. After the operation, level of consciousness was maintained on GCS 15, and the initial focal deficits slowly improved. Radiological follow-up with CT and MR showed a progressive, dramatic improvement of the herniations and mass effect previously described (Fig. 2). Histopathological analysis confirmed the diagnosis of GC, WHO grade II. The patient underwent radiation therapy, and survived for 23 months after diagnosis and surgical treatment.

3. Discussion

GC is, by definition, a diffuse neoplasm, affecting more than two cerebral lobes in a continuous manner. In that setting, surgical treatment is not considered an adequate treatment, and studies are based almost universally on response to chemotherapy and radiation therapy [4,6,8,9]. The relative rarity of the diagnosis, with about 300 cases reported in the literature, contributes to the scarcity of data [5]. Open or stereotactic biopsy can be considered part of the usual management of GC, but resective surgery has been very rarely indicated [6]. A systematic analysis of surgical treatment has never been performed. We have reviewed the available literature on surgical cases (Table 1). Most authors describe patients in which surgery was performed as part of the oncologic treatment. Only the reports by Kim et al., Fukushima et al. Tancredi et al., and Weinberg et al. describe cases in which surgery had an explicit decompressive objective [2,3,10,11].

To our knowledge, the issue of surgical treatment in GC has not been specifically addressed in other studies. Moreover, current literature on the subject shows a lack of consensus regarding clinical and radiological definition of the disease, complicating any analysis of treatment and outcome. Strict definition considers GC as a particular type of glial neoplasm, with the aforementioned biological behavior and radiological appearance. Some authors, however, consider that any progression of focal gliomas of any grade can be labelled as GC when they affect more than two cerebral lobes in a diffuse manner. In the most complete review on GC, Taillibert et al. acknowledged the need for restrictive diagnostic criteria and definition, and consider that the important variability in reported outcomes may be caused by the lack of homogenization in the diagnosis [5]. This review, however, does not provide information on surgical treatment.

GC can follow a relatively prolonged clinical course. Prognosis may be better in oligodendroglial histology, young age and male sex [5]. As a diffuse neoplasm with extensive brain infiltration, surgical removal is only sporadically performed. Even so, selected cases may benefit from surgical treatment. The patient we describe represents one such case. Surgical options in malignant neoplasms are influenced by ethical issues. Simple decompressive
Table 1
Cases of surgically treated gliomatosis cerebri (oncologic and decompressive surgery).
Revue des cas de gliomatose cérébrale traités chirurgicalement (chirurgie oncologique et décompressive).

<table>
<thead>
<tr>
<th>Author, year</th>
<th>Age, sex</th>
<th>Duration of symptoms (months)*</th>
<th>Extent of lesion</th>
<th>Contrast enhancement</th>
<th>Surgery</th>
<th>Other treatments</th>
<th>Outcome(^d)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fukushima et al., 2004 [2]</td>
<td>49-year-old, female Unknown</td>
<td>Bifrontal, corpus callosum (^b)</td>
<td>No</td>
<td>Right front lobectomy (partial)</td>
<td>Radiotherapy</td>
<td>Chemotherapy</td>
<td>Alive at 26 months follow-up</td>
</tr>
<tr>
<td>Kim et al., 1998 [3]</td>
<td>30-year-old, male 2</td>
<td>Bifrontal, left temporal, left parietal</td>
<td>No</td>
<td>Left front lobectomy</td>
<td>Radiotherapy</td>
<td>Alive at 46 months follow-up</td>
<td></td>
</tr>
<tr>
<td>Kim et al., 1998 [3]</td>
<td>62-year-old, male 6</td>
<td>Left temporal, thalamus, basal ganglia</td>
<td>Yes</td>
<td>Partial resection</td>
<td>Radiotherapy</td>
<td>1’6 months survival</td>
<td></td>
</tr>
<tr>
<td>Kim et al., 1998 [3]</td>
<td>50-year-old, female 2</td>
<td>Bitemporal, basal ganglia, thalamus, brain stem</td>
<td>No</td>
<td>Right temporal lobectomy</td>
<td>Radiotherapy</td>
<td>Alive at 8 months follow-up</td>
<td></td>
</tr>
<tr>
<td>Kim et al., 1998 [3]</td>
<td>31-year-old, male 37</td>
<td>Bifrontal, bitemporal</td>
<td>No</td>
<td>Left front lobectomy</td>
<td>Radiotherapy</td>
<td>18 months survival</td>
<td></td>
</tr>
<tr>
<td>Kim et al., 1998 [3]</td>
<td>21-year-old, male 2</td>
<td>Right front temporal, parietal, thalamus, basal ganglia, brain stem</td>
<td>Yes</td>
<td>Right front lobectomy</td>
<td>Radiotherapy</td>
<td>9 months survival</td>
<td></td>
</tr>
<tr>
<td>Kim et al., 1998 [3]</td>
<td>37-year-old, male 0,3</td>
<td>Bifrontal, left temporal, left parietal</td>
<td>Unknown(^b)</td>
<td>Partial resection</td>
<td>Radiotherapy</td>
<td>Alive at 16 months follow-up</td>
<td></td>
</tr>
<tr>
<td>Artigas et al., 1985 [12]</td>
<td>47-year-old, female Unknown</td>
<td>Biparietal, right cerebellar hemisphere (^b)</td>
<td>Unknown(^b)</td>
<td>Partial resection</td>
<td>Unknown</td>
<td>Post-operative death</td>
<td></td>
</tr>
<tr>
<td>Tancredi et al., 2000 [10]</td>
<td>61-year-old, male Acute onset</td>
<td>Bilobar, left temporal, right parietal, frontal, thalamus, brain stem, cerebellum (^b)</td>
<td>No</td>
<td>Right temporal lobectomy</td>
<td>None</td>
<td>Post-operative death</td>
<td></td>
</tr>
<tr>
<td>Weinberg et al., 2003 [11]</td>
<td>35-year-old, male 33 months</td>
<td>Left frontal, corpus callosum, brain stem, cerebellum (^b)</td>
<td>Yes</td>
<td>Suboccipital craniectomy and C1 laminectomy</td>
<td>Two partial resections months before decompression</td>
<td>Radiotherapy, Chemotherapy</td>
<td>4 months survival</td>
</tr>
<tr>
<td>Weinberg et al., 2003 [11]</td>
<td>40-year-old, female 3 years</td>
<td>Left frontal, left parietal, right temporal, cerebellum (^b)</td>
<td>Unknown</td>
<td>Suboccipital craniectomy and C1 laminectomy</td>
<td>Radiotherapy</td>
<td>Chemotherapy</td>
<td>Alive at 1 year follow-up</td>
</tr>
<tr>
<td>Weinberg et al., 2003 [11]</td>
<td>50-year-old, female 5 years</td>
<td>Bifrontal, biparietal, bitemporal, corpus callosum, brain stem, cerebellum (^b)</td>
<td>No</td>
<td>Suboccipital craniectomy and C1 laminectomy</td>
<td>Radiotherapy</td>
<td>Chemotherapy</td>
<td>Alive at 4 weeks follow-up</td>
</tr>
<tr>
<td>Present case</td>
<td>48-year-old, female 1 year</td>
<td>Left temporal, left parietal, right frontal, right temporal, thalamus, basal ganglia</td>
<td>No</td>
<td>Left temporal lobectomy</td>
<td>Radiotherapy</td>
<td>23 months survival</td>
<td></td>
</tr>
</tbody>
</table>

Series by Kong et al., 2010 [8], Sanson et al., 2004 [6], Yates et al., 2003 [7] and Perkins et al., 2003 [9] have been excluded since information regarding lesion characteristics, surgical technique or influence on outcome has not been specified.

\(^a\) Duration of symptoms before decompressive surgery.
\(^b\) Durée des symptômes avant la chirurgie décompressive.
\(^c\) Oligodendrogial gliomatosis cerebri.
\(^d\) Gliomatose cérébrale oligodendrogiale.
\(^e\) Secondary gliomatosis cerebri.
\(^f\) Gliomatose cérébrale secondaire.
\(^d\) Outcome after decompressive surgery.
\(^d\) Résultats après chirurgie décompressive.
procedures without oncologic benefits are not usually considered acceptable. That is, also, our institutional approach. But the present case represents a patient that displayed not invalidating, slowly progressive symptoms, in whom acute deterioration due to raised ICP hampered short-term prognosis. In that particular context, decompressive surgery provided resolution of acute life-threatening symptoms and long-term stabilization of the patient, who was able to receive chemotherapy and radiotherapy. We kept in mind the diagnosis of malignancy when choosing among the different surgical approaches that would have provided decompression. Decompressive craniectomy was discarded as a palliative treatment technically and ethically not indicated in gliomas. Hippocampectomy would have resected substantial neoplastic tissue, but was not an adequate procedure for a malignant neoplasm in a critical patient. Temporal lobectomy was chosen as a standardized and relatively simple procedure that could provide clinical and radiological decompression of severe uncal herniation and brain stem mass effect, without raising the ethical issues of decompressive craniectomy, and obtaining a large tissue sample for accurate histological grading.

4. Conclusions

Despite the diffuse, extensive infiltration of GC, this neoplasm can follow a relatively long clinical course. If short-term prognosis is conditioned by acute deterioration due to raised ICP, we suggest that surgical decompression can be a therapeutic option in selected patients. These would include newly diagnosed patients with acute life-threatening symptoms and already diagnosed patients that maintain good performance scores. We also consider that temporal lobectomy, a standardized and relatively simple procedure, allows for clinical and radiological decompression of severe uncal herniation and brain stem mass effect.

Disclosure of interest

The authors declare that they have no conflicts of interest concerning this article.

References