Brain and CNS Tumors

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Updated for 2012 Requirements and CSv02.03.02

Presentation Outline

- Overview
- Anatomy of the Human Brain
- Multiple Primary and Histology Coding Rules
- Collaborative Stage Data Collection System (CSv2)
- C.S. Site Specific Factors
- Treatment Options
Overview

Brain tumors are:

- **Primary brain tumors** – those that begin in the brain and tend to stay in the brain – occur in people of all ages, but they are statistically more frequent in children and older adults.

- **Metastatic brain tumors** – those that begin as a cancer elsewhere in the body and spread to the brain – are more common in adults than in children.

Source: American Brain Tumor Association Facts and Statistics http://abta.org
Brain tumors are:

- the second leading cause of cancer-related deaths in children (males and females) under age 20 (leukemia is the first)

- the second leading cause of cancer-related deaths in males ages 20-39

- the fifth leading cause of cancer-related deaths in females ages 20-39

Source: American Brain Tumor Association Facts and Statistics http://abta.org

Brain tumors are:

- Usually described as intracranial neoplasms with varying behaviors (benign, borderline, malignant)

- Are frequently grouped in discussions, statistics, training, treatment planning, and research to include pretty much any structure within the cranium (including hormone secreting ducts like the pineal and pituitary gland), the cranial nerves (optic nerve, olfactory nerve, acoustic nerve), the lining of the brain or meninges which also lines the rest of the central nervous system’s critically important feature capable of distributing chemically charged nerve impulses with incredible speed and accuracy and a critical component of the function of the central nervous system, the spinal cord.
Brain tumors are classified as either intra- or extra-cranial and both produce clinical/symptomatic effects that are similar in terms of mass effect, hemorrhage, seizure activity, and edema.

### Intracranial Sites
- Brain
- Cerebral meninges
- Cranial nerves and other intracranial parts of the CNS
- Cranio- or nasopharyngeal duct
- Pineal gland
- Pituitary gland

### Extracranial Sites
- Spinal cord
- Cauda equina
- Spinal meninges

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**ALL Brain Tumors are Reportable**

- Public Law 107-260, the [Benign Brain Tumor Cancer Registries Amendment Act](http://example.com) requires programs participating in the National Program for Cancer Registries (NPCR) to collect data on benign and borderline tumors of the central nervous system in addition to the previously required data on malignant tumors.

- In addition to NPCR, the National Cancer Institute's (NCI) Surveillance, Epidemiology and End Results (SEER) program and the American College of Surgeons' (ACoS) Commission on Cancer began requiring that these tumors be reported, starting with cases diagnosed on January 1, 2004.
Brain and CNS Tumors – All Ages

- 2011 estimates in the United States

- 64,540 new cancer cases

This includes:

- Malignant brain tumors (24,070)
- Non-malignant brain tumors (40,470)

Source: American Brain Tumor Association Facts and Statistics http://abta.org
Brain and CNS Tumors - Children

- Approximately 4,150 children younger than age 20 will be diagnosed with primary brain tumors in 2011

  - 2,960 will be less than 15 years of age
  - 1,190 will be between the ages of 15 and 19

- Gliomas represent a high percentage of childhood tumors

  - 55% of all tumors and 71% of malignant tumors in children age 0-14
  - 39% of all tumors and 74% of malignant tumors in children age 15-19

Source: American Brain Tumor Association Facts and Statistics http://abta.org

Brain and CNS Tumors

<table>
<thead>
<tr>
<th>STATE</th>
<th>2011 Estimated New Cases</th>
<th>2010 Estimated Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All</td>
<td>Malignant</td>
</tr>
<tr>
<td>Alabama</td>
<td>590</td>
<td>360</td>
</tr>
<tr>
<td>Alaska</td>
<td>150</td>
<td>50</td>
</tr>
<tr>
<td>Arizona</td>
<td>1,460</td>
<td>570</td>
</tr>
<tr>
<td>Arkansas</td>
<td>320</td>
<td>230</td>
</tr>
<tr>
<td>California</td>
<td>7,260</td>
<td>2,700</td>
</tr>
<tr>
<td>Colorado</td>
<td>1,040</td>
<td>400</td>
</tr>
<tr>
<td>Connecticut</td>
<td>770</td>
<td>290</td>
</tr>
<tr>
<td>Delaware</td>
<td>200</td>
<td>70</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>110</td>
<td>30</td>
</tr>
<tr>
<td>Florida</td>
<td>4,560</td>
<td>1,700</td>
</tr>
<tr>
<td>Georgia</td>
<td>120</td>
<td>690</td>
</tr>
<tr>
<td>Hawaii</td>
<td>260</td>
<td>80</td>
</tr>
<tr>
<td>Idaho</td>
<td>320</td>
<td>130</td>
</tr>
<tr>
<td>Illinois</td>
<td>2,810</td>
<td>970</td>
</tr>
<tr>
<td>Indiana</td>
<td>1,320</td>
<td>510</td>
</tr>
<tr>
<td>Iowa</td>
<td>660</td>
<td>250</td>
</tr>
<tr>
<td>Kansas</td>
<td>500</td>
<td>220</td>
</tr>
<tr>
<td>Kentucky</td>
<td>910</td>
<td>350</td>
</tr>
<tr>
<td>Louisiana</td>
<td>890</td>
<td>320</td>
</tr>
<tr>
<td>Maine</td>
<td>320</td>
<td>120</td>
</tr>
<tr>
<td>Maryland</td>
<td>1,200</td>
<td>420</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>1,430</td>
<td>540</td>
</tr>
<tr>
<td>Michigan</td>
<td>2,100</td>
<td>810</td>
</tr>
</tbody>
</table>

Source: American Brain Tumor Association Facts and Statistics http://abta.org
50% of childhood brain and CNS tumors are infratentorial, originating below the tentorium.
20+% of childhood CNS tumors are located in the sellar or suprasellar region around the sella turcica (the bone that contains the pituitary gland).
Remainder of tumors occur in spinal cord, brain stem, cranial nerves, etc.
Childhood Brain Tumors

<table>
<thead>
<tr>
<th>Supratentorial - childhood</th>
<th>Infratentorial - childhood</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Craniopharyngiomas.</td>
<td>• Cerebellar astrocytomas (usually high-grade).</td>
</tr>
<tr>
<td>• Diencephalic and hypothalamic gliomas.</td>
<td>• Medulloblastomas (primitive neuroectodermal tumors).</td>
</tr>
<tr>
<td>• Germ cell tumors.</td>
<td>• Ependymomas (low-grade or anaplastic).</td>
</tr>
<tr>
<td>• Low-grade astrocytomas.</td>
<td>• Brain stem gliomas (high-grade or low-grade).</td>
</tr>
<tr>
<td>• Anaplastic astrocytomas.</td>
<td>• Atypical teratoid tumors</td>
</tr>
<tr>
<td>• Glioblastoma multiforme.</td>
<td></td>
</tr>
<tr>
<td>• Mixed gliomas.</td>
<td></td>
</tr>
<tr>
<td>• Oligodendrogliomas.</td>
<td></td>
</tr>
<tr>
<td>• Primitive neuroectodermal tumors.</td>
<td></td>
</tr>
<tr>
<td>• Low-grade or anaplastic ependymomas.</td>
<td></td>
</tr>
<tr>
<td>• Meningiomas.</td>
<td></td>
</tr>
<tr>
<td>• Choroid plexus tumors.</td>
<td></td>
</tr>
</tbody>
</table>

Pilocytic Astrocytoma

- Synonyms include:
  - Juvenile pilocytic astrocytoma
  - Cystic cerebellar astrocytoma
  - Juvenile pilomyxoid astrocytoma

- Characteristics:
  - Usually slow growing, well-circumscribed neoplasm
  - Associated with the formation of a single (or multiple) cyst(s)
  - Arise in cerebellum near brainstem
  - Other common sites include hypothalamic region and optic chiasm
  - May occur in cerebral hemispheres and spinal cord
  - Associated with neurofibromatosis Type 1 (NF1)
  - 10 year survival greater than 90% with total removal
  - Not associated with recurrence with total removal
  - WHO Grade I - benign
Pilocytic Astrocytoma

- HOWEVER, when the ICD-O-3 was published, the behavior code for pilocytic astrocytoma downgraded from 3 (malignant behavior) to 1 (borderline behavior) as it still appears in the ICD-O-3 reference sitting on your desktop.

- Registrars in the United States were in 2000 and continue to be instructed by our national standard setting agencies to assign the behavior code 3 to these tumors despite the WHO downgrade.

- Rationale: To ensure complete reporting and data consistency, registrars should continue to assign the malignant behavior code (3) to pilocytic astrocytoma. This is the standard for all U.S. registries in all programs.

- Confusing to researchers and public health studies since we reference ICD-O as our primary coding reference and ICD-O-3 has never published the U.S. change and does not assign a malignant behavior to this type of astrocytoma.

Causes and Risk Factors

No single risk factor accounting for the majority of brain tumors has been identified even though many environmental and genetic factors are being studied.
Causes and Risk Factors

**ENVIRONMENTAL**

- Many studies have examined a wide spectrum of environmental factors as a cause for brain tumors. Of the long list of factors studied, only exposure to ionizing radiation has consistently been shown to put one at increased risk for developing a brain tumor.

**GENETIC**

- There are a few rare genetic syndromes that involve brain tumors.
  - NF1 (NF1 gene)
  - NF2 (NF2 gene)
  - Turcots (APC gene)
  - Gorlins (PTCH gene)
  - Tuberous sclerosis (TSC1 and TSC2 genes)
  - Li-Fraumeni syndrome (TP53 gene)

Range of tumors and symptoms

- There are over 120 different types of brain/CNS tumors.

- CNS tumors are associated with a range of symptoms and complications such as edema, seizures, endocrinopathy, fatigue, psychiatric disorder, venous thromboembolism that can seriously impact quality of life.

- Symptoms depend very much on the size and location of the tumor. General symptoms include persistent headaches which tend to be worse with activity, at night or early in the morning, convulsions, vomiting, subtle changes in personality, memory, mental ability, drowsiness, lethargy.
Range of tumors and symptoms

- Symptoms are often location specific or provide clues.
- Symptoms on the right side of the body may occur if the tumor is located on the left side of the brain and vice-versa.
  - The speech center in most people is on the left side of the brain. Symptoms of a tumor located here may include difficulty saying correct words while still capable of understanding what is being said.
  - If the tumor is located in the frontal lobe which controls intellectual function, thought process, behavior and memory, those activities may be affected.
- Similarity to closed head injury victims (motorcycle crash).
Midline Shift and Mass Effect

- The bony cranium protects the brain from outside impacts to the head. When swelling occurs in the brain, there isn’t much “give”.

- The swelling results in intracranial pressure and can cause a number of effects that begin to impact quality of life and comfort for the patient.

- The easiest way to describe midline shift is to bring to mind sitting in a movie theater. As soon as the person to one side of you puts his elbow onto the shared armrest between you, you tend to shift away.

Midline is a central boundary separating the left and right hemispheres.

- Midline Shift – Tumor crosses the brain to shift across the center line

- Mass Effect is – Edema or swelling causes the brain to shift across center line

- Both create new symptoms at cross-over
  - Depends on the size and location of the tumor and level of spread
  - Edema caused by many things
  - Either cause pushes midline out of alignment
The Brain is Incapable of Feeling Pain

- Surgeons are able to cut living brains without fear of hurting their patients.

- However, symptoms from tumors and their effect within the cranial cavity on various functions of the brain is a different story, altogether.

- Much is dependent upon tumor location and infiltration.

Source: National Geographic, courtesy of Fred Hossler/Getty Images

Benign/Borderline/Malignant ???

<table>
<thead>
<tr>
<th>BENIGN TUMORS</th>
<th>MALIGNANT TUMORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>slow growing</td>
<td>usually rapidly growing</td>
</tr>
<tr>
<td>distinct borders</td>
<td>invasive</td>
</tr>
<tr>
<td>rarely spread</td>
<td>life-threatening</td>
</tr>
</tbody>
</table>

Source: American Brain Tumor Association Facts and Statistics http://abta.org
Survival Trends

- SEER data from 1995-2007 5-year relative survival

  - Males 34%
  - Females 38%

- Children age 0-19 have the highest 5-year relative survival rate 72%

- The survival rate diminishes as age increases, down to 5% for persons age 75 and older

<table>
<thead>
<tr>
<th>Histology</th>
<th># Cases</th>
<th>1-Yr</th>
<th>2-Yr</th>
<th>3-Yr</th>
<th>4-Yr</th>
<th>5-Yr</th>
<th>6-Yr</th>
<th>7-Yr</th>
<th>8-Yr</th>
<th>9-Yr</th>
<th>10-Yr</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilocytic astrocytoma</td>
<td>2,294</td>
<td>97.79</td>
<td>96.80</td>
<td>95.00</td>
<td>94.04</td>
<td>94.40</td>
<td>92.10</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Protoplasmic &amp; fibrillary astrocytoma</td>
<td>626</td>
<td>74.30</td>
<td>68.97</td>
<td>65.29</td>
<td>61.09</td>
<td>48.10</td>
<td>36.35</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anaplastic astrocytoma</td>
<td>2,846</td>
<td>60.32</td>
<td>42.74</td>
<td>34.70</td>
<td>30.50</td>
<td>27.36</td>
<td>21.87</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Astrocytoma, NOS</td>
<td>3,280</td>
<td>70.01</td>
<td>65.14</td>
<td>54.52</td>
<td>50.95</td>
<td>48.16</td>
<td>39.10</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glioblastoma</td>
<td>19,797</td>
<td>34.60</td>
<td>12.63</td>
<td>7.31</td>
<td>5.40</td>
<td>4.75</td>
<td>2.80</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oligodendroglioma</td>
<td>2,453</td>
<td>94.17</td>
<td>89.92</td>
<td>86.25</td>
<td>82.77</td>
<td>79.48</td>
<td>63.58</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anaplastic oligodendroglioma</td>
<td>970</td>
<td>79.91</td>
<td>66.07</td>
<td>59.55</td>
<td>53.90</td>
<td>49.40</td>
<td>34.95</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ependymoma/anaplastic ependymoma</td>
<td>1,748</td>
<td>94.00</td>
<td>89.23</td>
<td>85.81</td>
<td>83.41</td>
<td>82.41</td>
<td>76.22</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Mixed glioma</td>
<td>1,296</td>
<td>87.52</td>
<td>74.86</td>
<td>67.56</td>
<td>61.74</td>
<td>57.32</td>
<td>46.37</td>
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</tr>
<tr>
<td>Glioma malignant, NOS</td>
<td>2,750</td>
<td>60.40</td>
<td>49.07</td>
<td>46.30</td>
<td>44.25</td>
<td>43.27</td>
<td>39.54</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neuroepithelial</td>
<td>118</td>
<td>54.10</td>
<td>42.58</td>
<td>41.98</td>
<td>36.34</td>
<td>33.02</td>
<td>29.74</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malignant neuronal/glial, Neuronal and mixed</td>
<td>526</td>
<td>88.48</td>
<td>79.55</td>
<td>76.48</td>
<td>71.69</td>
<td>70.66</td>
<td>59.33</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Embryonal/primitive/medulloblastoma</td>
<td>1,865</td>
<td>82.42</td>
<td>71.72</td>
<td>66.77</td>
<td>63.70</td>
<td>61.71</td>
<td>55.05</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lymphoma</td>
<td>3,421</td>
<td>47.48</td>
<td>38.09</td>
<td>34.23</td>
<td>31.01</td>
<td>28.52</td>
<td>21.61</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total: All Brain and CNS</strong></td>
<td>47,602</td>
<td>57.21</td>
<td>43.34</td>
<td>38.09</td>
<td>36.74</td>
<td>35.47</td>
<td>31.73</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*The cohort analysis of survival rates was utilized for calculating the survival estimates presented in this table. Long-term cohort-based survival estimates reflect the survival experience of individuals diagnosed over the time period, and they may not necessarily reflect the long-term survival outlook of newly diagnosed cases.

* Includes estimates of the percentage of patients alive at one, two, three, four, five, and ten years, respectively.

*Includes histologies not listed in this table.

# Tumor-Specific Statistics

<table>
<thead>
<tr>
<th>Tumor Type</th>
<th>Percentage of All Primary Brain Tumors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meningioma</td>
<td>14%</td>
</tr>
<tr>
<td>Glioma</td>
<td>31%</td>
</tr>
<tr>
<td>(80% of all malignant brain tumors)</td>
<td></td>
</tr>
<tr>
<td>Glioblastoma</td>
<td>17%</td>
</tr>
<tr>
<td>(54% of all gliomas)</td>
<td></td>
</tr>
<tr>
<td>Astrocytoma</td>
<td>7%</td>
</tr>
<tr>
<td>Oligodendroglioma</td>
<td>2%</td>
</tr>
<tr>
<td>Ependymoma</td>
<td>1%</td>
</tr>
<tr>
<td>Pituitary tumors</td>
<td>13%</td>
</tr>
<tr>
<td>Nerve sheath tumors</td>
<td>9%</td>
</tr>
<tr>
<td>Medulloblastoma/embryonal/and other tumors of primitive (developmental) nerve origin</td>
<td>3%</td>
</tr>
<tr>
<td>Lymphoma</td>
<td>2-3%</td>
</tr>
</tbody>
</table>

## Figure 5. Distribution of All Primary Brain and CNS Tumors by Histology (N=226,791)


- Gliomas (ICD-O-3: 9380-9, 9391-9460, 9480) account for 31% of all tumors and 80% of malignant tumors.
<table>
<thead>
<tr>
<th>CNS (1400-1520)</th>
<th>Nervous system</th>
<th>Neuronal origin</th>
<th>Glial types</th>
<th>Benign tumors</th>
<th>Malignant tumors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neural crest</td>
<td>Neuroepithelial</td>
<td>(brain tumor,</td>
<td>Glioma</td>
<td>Astrocytoma</td>
<td>Glioblastoma</td>
</tr>
<tr>
<td>Neural crest</td>
<td>Neuroepithelial</td>
<td>(brain tumor,</td>
<td>Oligodendroglioma</td>
<td>Oligodendroglia</td>
<td>Oligodendroglia</td>
</tr>
<tr>
<td>Neural crest</td>
<td>Neuroepithelial</td>
<td>(brain tumor,</td>
<td>Ependyma</td>
<td>Ependymoma</td>
<td>Ependymoma</td>
</tr>
<tr>
<td>Neural crest</td>
<td>Neuroepithelial</td>
<td>(brain tumor,</td>
<td>Chordoma</td>
<td>Chordoma</td>
<td>Chordoma</td>
</tr>
<tr>
<td>Neural crest</td>
<td>Neuroepithelial</td>
<td>(brain tumor,</td>
<td>Multiple</td>
<td>Multiple</td>
<td></td>
</tr>
<tr>
<td>Neural crest</td>
<td>Neuroepithelial</td>
<td>(brain tumor,</td>
<td>Meningioma</td>
<td>Meningioma</td>
<td>Meningioma</td>
</tr>
<tr>
<td>Neural crest</td>
<td>Neuroepithelial</td>
<td>(brain tumor,</td>
<td>Primitive</td>
<td>Primitive</td>
<td>Primitive</td>
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<tr>
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<td>(brain tumor,</td>
<td>Medulloblastoma</td>
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</tr>
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<td>Neural crest</td>
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<td>(brain tumor,</td>
<td>Glioblastoma</td>
<td>Glioblastoma</td>
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<tr>
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<td>Neuroepithelial</td>
<td>(brain tumor,</td>
<td>Glioma</td>
<td>Glioma</td>
<td>Glioma</td>
</tr>
</tbody>
</table>

Source: wikipedia.org and ccrcal.org
WHO Classification Groups

- Tumors of Neuroepithelial Tissue
- Tumors of Cranial and Paraspinal Nerves
- Tumors of Meninges
- Lymphomas and Hematopoietic Malignancies
- Germ Cell Tumors
- Tumors of the Sellar Region
- Metastatic Tumors
WHO Grade

- Four categories of tumor
  - Grade I slow growing, non-malignant, associated with long-term survival – benign tumors
  - Grade II relatively slow-growing, sometimes recur as higher grade tumors, can be malignant or non-malignant (borderline malignant)
  - Grade III malignant and often recur as higher grade tumors
  - Grade IV reproduce rapidly and are very aggressive malignant tumors

- WHO grade is not recorded as part of the histology
- WHO grade is used by the clinician to plan treatment and predict prognosis
ANATOMY OF THE HUMAN BRAIN

Source: National Geographic, courtesy of Fred Housler/Getty Images

THE HUMAN BRAIN

- The brain is the largest intracranial organ
- The brain is a 3-pound mass of jelly-like fats and tissues
- It is the most complex of all known living structures
- The skull or cranium is bone that covers the brain
- Up to one trillion nerve cells working together coordinate the physical actions and mental processes (voluntary and involuntary) that set humans apart from all other species

Source: CDC Data Collection of Primary CNS Tumors, NPCR Training Materials 2004
• The CNS includes both intracranial sites (inside the cranium) and extra-cranial sites (outside the cranium).
  • The pituitary gland, craniopharyngeal duct and pineal gland are found inside, alongside brain tissue
  • Cranial nerves directly link to brain tissue
  • The spinal cord is part of the CNS though not intracranial

• Any tumor that originates in the brain, spinal cord, the cranial nerves, one of the glands/ducts within the cranium (pineal, pituitary, craniopharyngeal), or the lining of the cranium (meninges) is reportable regardless of behavior (benign, borderline, or malignant).

Source: CDC Data Collection of Primary CNS Tumors, NPCR Training Materials 2004
ICD-O Topography Codes (Anatomic Site)

- Brain (C71.0 - C71.9)
- Cerebrum (C71.0)
- Frontal lobe (C71.1)
- Temporal lobe (C71.2)
- Parietal lobe (C71.3)
- Occipital lobe (C71.4)
- Ventricle (C71.5)
- Cerebellum (C71.6)
- Brain stem (C71.7)
- Overlapping lesion of the brain (C71.8)
- Brain NOS (C71.9)

- Meninges (C70.0 - C70.9)
  - Cerebral meninges (C70.0)
  - Spinal meninges (C70.1)
  - Meninges NOS (C70.9)
- Spinal cord (C72.0)
- Cauda equina (C72.1)
- Cranial nerves (C72.2 - C72.5)
  - Olfactory nerve (C72.2)
  - Optic nerve (C72.3)
  - Acoustic nerve (C72.4)
  - Cranial nerve NOS (C72.5)
- Other CNS (C72.8, C72.9)
- Pituitary gland (C75.1)
- Craniohypophyseal duct (C75.2)
- Pineal gland (C75.3)
Ventricular System of the Brain

Source: solarnavigator.net/human_brain
Meninges and Brain Stem

- The dura mater is the tough outer menbrane.
- The arachnoid is the middle web-like menbrane.
- The pia mater is the delicate, highly vascular, innermost menbrane.

Cranial Nerves

1. Olfactory - C2.2
2. Optic - C2.3
3. Oculomotor - C2.5
4. Trochlear - C2.5
5. Trigeminal - C2.5
6. Abducent - C2.5
7. Facial - C2.5
8. Vestibulocochlear - C2.4
9. Glossopharyngeal - C2.5
10. Vagus - C2.5
11. Spinal Accessory - C2.5
12. Hypoglossal - C2.5
Cranial Nerve Functions

<table>
<thead>
<tr>
<th>Cranial Nerve:</th>
<th>Major Functions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>I Olfactory</td>
<td>smell</td>
</tr>
<tr>
<td>II Optic</td>
<td>vision</td>
</tr>
<tr>
<td>III Oculomotor</td>
<td>eyelid and eyeball movement</td>
</tr>
<tr>
<td>IV Trochlear</td>
<td>turns eye downward and laterally, controls superior oblique muscles</td>
</tr>
<tr>
<td>V Trigeminal</td>
<td>chewing, face &amp; mouth touch &amp; pain</td>
</tr>
<tr>
<td>VI Abducens</td>
<td>turns eye laterally</td>
</tr>
<tr>
<td>VII Facial</td>
<td>facial expressions, taste, tears, saliva</td>
</tr>
<tr>
<td>VIII Vestibulocochlear</td>
<td>Also referred to as Auditory Nerve: hearing, equilibrium sensation</td>
</tr>
<tr>
<td>IX Glossopharyngeal</td>
<td>Taste, senses carotid blood pressure</td>
</tr>
<tr>
<td>X Vagus</td>
<td>aortic blood pressure, heart rate, stimulates digestive organs, taste</td>
</tr>
<tr>
<td>XI Spinal Accessory</td>
<td>controls trapezius &amp; sternocleidomastoid muscles, controls swallowing</td>
</tr>
<tr>
<td>XII Hypoglossal</td>
<td>controls tongue movements</td>
</tr>
</tbody>
</table>

Characteristics of Brain Tumors

- Start in the brain and grow steadily there.
- Very rarely spread to other organs through the bloodstream.
- Are named for the cells from which they arise, each having a certain function essential to normal physiological functioning of the brain. For example:
  - Gliomas arise from glial cells which support the CNS.
    - Astrocytomas arise from astrocytes
    - Ependymomas arise from ependymal cells which line the ventricles (fluid filled spaces within the brain) or central canal of the spinal cord.
    - Oligodendrogiomas arise from oligodendrocyte cells which make up the fatty substance called myelin that covers nerves like electrical insulation.
    - Brain Stem Gliomas arise in the lowest part of the brain.
Characteristics of Brain Tumors

Histologic Type - Glioma

- Most common category of primary brain tumors. They begin in glial cells (supporting cells of the CNS)
- Often spread into surrounding brain tissue along nerve fibers invading the spaces between nearby normal brain cells. Some invade the surrounding brain more than others.
- Difficulty obtaining complete surgical removal. MRI scans show the largest part of the glioma, but cannot reliably show areas of the brain where tumor cells have invaded. Aggressive efforts to remove small numbers of tumor cells within the brain could cause loss of neurologic function.
- When it is not possible to remove the entire glioma, post-op radiation therapy and chemotherapy may be advised.
- Even with maximum safe resection followed by radiation and chemotherapy, gliomas can grow back.

Source: medicalgeek.com/indian-post-graduate-exams
1. **Astrocytoma**: In adults most often arise in the cerebrum. In children they occur in the brain stem, cerebrum and cerebellum. Rarely in brain stem in adults. Felt to be most aggressive of brain tumors.

   - Grade I and II astrocytomas are low-grade astrocytomas.
   - Grade III astrocytoma is an “anaplastic astrocytoma”.
   - Grade IV astrocytoma is a “glioblastoma multiforme”.

2. **Oligodendroglioma**: Rare tumor that usually occurs in the cerebrum, grows slowly and usually does not spread into surrounding brain tissue like astrocytoma does. Most common in middle-aged adults.

3. **Ependymoma**: Most commonly arise in children and young adults. They are also seen with neurofibromatosis Type II. (which we will discuss in a bit)
Glioma – Other Subtypes

There are other subtypes of gliomas, each with their own specific characteristics and modes of growth.

- Brain Stem Glioma
- Juvenile Pilocytic Astrocytoma
- Pleomorphic Xanthoastrocytoma
- Subependymoma
- Ganglioglioma

Glioma Tumor Markers

<table>
<thead>
<tr>
<th>Biomarker</th>
<th>Molecular Compartment Purpose</th>
<th>Analytic Validity Demonstrated</th>
<th>Level of Evidence</th>
<th>NCCN Category of Evidence</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>1p/19q codeletion (unbalanced translocation)</td>
<td>Tumor DNA Diagnostic (gliomedulloblastoma)</td>
<td>FISH, aCGH, LOH, MBLA</td>
<td>IA</td>
<td>1</td>
<td>Smith et al.46</td>
</tr>
<tr>
<td>IDH mutation (IDH1 c.395 G→A p.R132H)</td>
<td>Tumor DNA, tumor protein</td>
<td>Positive is favorably prognostic; also a diagnostic marker</td>
<td>IHC, DNA sequencing</td>
<td>IIB</td>
<td>Houlle et al.46 Rubben et al.23</td>
</tr>
<tr>
<td>MGMT methylation</td>
<td>Tumor DNA</td>
<td>Prognostic, predictive (benefit for chemotherapy), pharmacodynamic (pseudorecurrence)</td>
<td>MS-PCR, MS-pyrosequencing, MS-MBLA</td>
<td>IIB</td>
<td>Heigl et al.53 Gilbert et al.273</td>
</tr>
<tr>
<td>BRAF fusion (pilocytic astrocytoma)</td>
<td>Tumor DNA Diagnostic (pilocytic astrocytoma)</td>
<td>LDI-PCR, 5’ RACE, FISH</td>
<td>IIB</td>
<td>Jeucken and Wesseling.74 Jones et al.52</td>
<td></td>
</tr>
<tr>
<td>OMP (CpG island methylator phenotype)</td>
<td>Tumor DNA</td>
<td>Positive is favorably prognostic</td>
<td>Gene expression microarray, pyrosequencing</td>
<td>IIB</td>
<td>Noushmehr et al.88 Gilbert et al.273</td>
</tr>
</tbody>
</table>
Non-Glial Tumors

- **Medulloblastoma**: Usually arises in the cerebrum, is the most common brain tumor in children, and is sometimes called a “primitive neuroectodermal tumor” or PNET.

- **Meningioma**: Arises from the meninges which are the outside coverings of the brain between the skull and the brain itself. It usually presses on the brain, but does not invade it and often grows slowly.

Non-Glial Tumors

- **Schwannoma**: Arises from Schwann cells present in certain nerves, including those that control balance and hearing.

  A common site is the vestibular nerve which carries signals from the inner ear to the brain stem.

  Tumors in this location are called “acoustic neuromas” (a.k.a. vestibular schwannoma), and occur most often in adults.
Non-Glial Tumors

- **Craniopharyngioma**: Grows at the base of the brain, arises from the tissue connecting the brain and the pituitary gland and occurs in both adults and children.

- **Pituitary Adenoma**: Arises from the pituitary gland and may cause compression of the optic nerves causing vision problems. Some produce excessive amounts of hormones that can disrupt the body’s metabolism.

---

Observing Migration of Glioma Cells

Source: Case Western Reserve University School of Medicine, public release 8/25/11
Neurofibromatosis

- The neurofibromatoses (NF) are a group of genetic disorders which cause tumors to grow along nerves and can also affect the development of non-nervous tissues such as bones and skin.

- Neurofibromatosis Type I (NF-I), also known as Peripheral NF and historically as von Recklinghausen Disease
  - Occurs in 1:4,000 births
  - Multiple cafe-au-lait spots (not reportable)
  - Many, many neurofibromas on or under the skin (not reportable)
  - Enlargement and deformation of bones and curvature of the spine
  - Tumors may develop in brain, on cranial nerves, or the spinal cord

Source Credit: Dr. Stanley B. Burns
http://www.cbsnews.com/2300-204_162-10007019-6.html#ixzz1clEzAchI
Other Manifestations of NF Type I

Lisch nodules on the eye
- Melanocytic hemartomas

Café-au-lait spots on skin
- Discolored birth marks

Source: Dermnet.com; Dermatologic Manifestations of NF Type I

Neurofibromatosis Type II

- Neurofibromatosis Type II (NFII), also known as Multiple Inherited Schwannomas, Meningiomas and Ependymomas (MISME) or Bilateral Acoustic Neurofibromatosis (BAN).

- Is a genetically inherited disease caused by mutations of the "Merlin" gene, which appears to influence the form and movement of cells.

- Primary manifestation is a development of non-malignant brain tumors in the region of the cranial nerves, frequently bilaterally. The eighth cranial nerve is the auditory-vestibular nerve which transmits sensory information from the inner ear to the brain and is commonly affected.

Source: California Ear Institute
Acoustic Neuroma/Schwannoma

Source: http://thrivingwithneurofibromatosis.blogspot.com

Multiple Primary Rules
Histology Coding Rules
Different Rules for Benign and Malignant Sequence Numbering for Brain Tumors

- **Malignant primary brain and CNS tumors** are assigned **Sequence Codes in the range 00-35**
  - Sequence Chronologically 00-35
  - Only count malignant tumors in the sequence
  - If only one malignant tumor occurs, it is coded 00
  - If subsequent (multiple) primary malignant and/or in situ neoplasms, the sequence number for the first tumor begins at 01, the sequence number for the second primary tumor is 02, and so forth.

- **Non-malignant primary brain and CNS tumors** are assigned **Sequence Codes in the range 60-87**.
  - Sequence Chronologically 60-87
  - Only count benign/borderline or reportable by agreement neoplasms in the sequence
  - If only one non-malignant tumor occurs, it is coded 60.
  - If subsequent (multiple) non-malignant neoplasms are diagnosed, the first tumor should be sequenced as 61, the second 62 and so forth.
Benign and Borderline Tumor Rules

- When multiple tumors are present registrars should identify and document specific characteristics for MPH Rules Text
  - Date of Diagnosis (Timing is not used to determine number of abstracts or primary neoplasms to abstract)
  - Method and Details of Diagnosis (some are never resected)
  - Location of Tumor
  - Laterality
  - Histologic Type – refer to Chart 1
  - Tumor Behavior
  - Multiple Meningioma’s (meningiomatosis)
  - Neurofibromatosis Characteristics (when applicable)
Malignant Tumor Rules

Chart 1 - Neoplastic Malignant Brain and Central Nervous System Tumors

Chart 2 - Neoplastic Malignant Brain and Central Nervous System Tumors
Malignant Tumor Rules

- When multiple tumors are present registrars should identify and document specific characteristics for MPH Rules Text
  - Date of Diagnosis (Timing is not used to determine number of abstracts or primary neoplasms to abstract)
  - Method and Details of Diagnosis (most attempt resection)
  - Location of Tumor (not spread or invasion — but bulk of tumor)
  - Histologic Type — refer to Chart 1 and/or Chart 2
  - Tumor Behavior
  - Variations or Combinations of One or More Glial Tumors Over Lifetime — astrocytoma, glioblastoma, ependymoma, or oligodendroglioma
    - Special rules for determining # abstracts
    - Special rules for determining whether or not is mixed glioma
  - Note: Recurrence, progression, or any reappearance of histologies on the same branch in Chart 1 or Chart 2 is always the same disease process.

---

Report /Sequence All Tumors Over Lifetime

REMINDER: Sequence numbers for malignant neoplasms and for benign, borderline, and other reportable-by-agreement cases are assigned over a lifetime.

- Therefore,

  IF A PATIENT WAS DIAGNOSED WITH A NON-MALIGNANT CNS NEOPLASM BEFORE REPORTING WAS REQUIRED (January 1, 2004),
  
  THE NEW (SECOND) NEOPLASM SHOULD BE ASSIGNED SEQUENCE NUMBER 62 AND THE FIRST NEOPLASM (Seq 61) IS REPORTABLE AS A HISTORICAL CASE TO FCDS.

  (An abstract/accession is not be required by CoC or SEER but is by FCDS)

- Any benign and/or borderline brain or CNS tumor(s) diagnosed before January 1, 2004 ARE REPORTABLE TO FCDS as historical cases when accompanied by another reportable primary.
Brain
Brain and Cerebral Meninges

C70.0, C71.0-C71.9
- C70.0 Cerebral meninges
- C71.0 Cerebrum
- C71.1 Frontal lobe
- C71.2 Temporal lobe
- C71.3 Parietal lobe
- C71.4 Occipital lobe
- C71.5 Vermis, NOS
- C71.6 Cerebellum, NOS
- C71.7 Brain stem
- C71.8 Overlapping Vocab
- C71.9 Brain, NOS

Note 1: This schema is in 7th edition. The AJCC 4th
Note 2: AJCC does not

CNSOther
Other Parts of Central Nervous System

C70.1, C70.9, C72.0-C72.9
- C70.1 Spinal meninges
- C70.9 Meninges, NOS
- C72.0 Spinal cord
- C72.1 Cauda equina
- C72.2 Olfactory nerve
- C72.3 Optic nerve
- C72.4 Acoustic nerve
- C72.5 Cranial nerves, NOS
- C72.6 Overlapping vocab
- C72.9 Nervous system

Note 1: This schema is in

IntracranialGland
Pituitary Gland, Cranioopharyngeal Duct, and Pineal Gland

C75.1, C75.2, C75.3
- C75.1 Pituitary gland
- C75.2 Cranioopharyngeal duct
- C75.3 Pineal gland

Note: AJCC does not define TNM staging for this schema.
Brain
Brain and Cerebral Meninges
C70.0, C71.0-C71.9

CS Extension

Note 1: The tentorium cerebelli is an extension of the dura mater that separates the cerebellum from the inferior portion of the occipital lobes. The location of the tumor above or below the tentorium can help in determining the type of tumor, and most adult brain tumors are supratentorial, and most pediatric brain tumors are infratentorial. In the following list, note that ICD-O-3 codes C71.0 and C71.9 include both supratentorial and infratentorial subtypes.

Supratentorial sites by ICD-O-3 codes:
- C71.0: except hypothalamus, pituitary, thalamus
- C71.5
- C71.8: Corpus callosum, tapetum
- C71.9: Anterior cranial fossa, middle cranial fossa, suprasellar

Infratentorial sites by ICD-O-3 codes:
- C71.0: Hypothalamus, pituitary, thalamus
- C71.6: C71.7
- C71.9: Posterior cranial fossa

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>TNM 7 Map</th>
<th>TNM 6 Map</th>
<th>S577 Map</th>
<th>S5200 Map</th>
</tr>
</thead>
<tbody>
<tr>
<td>500</td>
<td>Benign or borderline brain tumor</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>
| 100  | Supratentorial tumor confined to:
|      | Cerebral hemisphere (cerebellum) or Meninges of cerebral hemisphere (one side)
|      | Frontal lobe
|      | Occipital lobe
|      | Parietal lobe
|      | Temporal lobe |
| 110  | Infratentorial tumor confined to cerebellum or meninges of cerebellum (one side or median)
|      | Vermis
|      | Lateral lobes
|      | Median lobe of cerebellum |
| 120  | Infratentorial tumor confined to:
|      | Brain stem or meninges of brain stem (one side)
|      | Medulla oblongata
|      | Midbrain (mesencephalon) |

Revision Info: List of schemes
### Brain

**CS Mets at DX**

Note 1. According to AJCC, p. 354 “Tumors affecting the central nervous system rarely develop extraneural metastases, probably because of inherent biologic characteristics of these tumors, and also because the brain does not have a well-developed drainage system... Certain tumors do spread through cerebrospinal fluid (CSF) pathways, and such spread has a major impact on survival.”

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>TNM 7 Map</th>
<th>TNM 6 Map</th>
<th>SS77 Map</th>
<th>S32000 Map</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>No distant metastasis</td>
<td>NA</td>
<td>NA</td>
<td>NONE</td>
<td>NONE</td>
</tr>
<tr>
<td>10</td>
<td>OBSOLETE DATA RETAINED AND REVIEWED V203</td>
<td>NA</td>
<td>NA</td>
<td>D</td>
<td>D</td>
</tr>
<tr>
<td>20</td>
<td>Metastasis within CNS and CSF pathways</td>
<td>NA</td>
<td>NA</td>
<td>D</td>
<td>D</td>
</tr>
<tr>
<td>30</td>
<td>Metastasis outside the CNS</td>
<td>NA</td>
<td>NA</td>
<td>D</td>
<td>D</td>
</tr>
<tr>
<td>50</td>
<td>30+20</td>
<td>NA</td>
<td>NA</td>
<td>D</td>
<td>D</td>
</tr>
<tr>
<td>85</td>
<td>OBSOLETE DATA CONVERTED V203</td>
<td>ERROR</td>
<td>ERROR</td>
<td>ERROR</td>
<td>ERROR</td>
</tr>
<tr>
<td>99</td>
<td>Unknown, distant metastasis not stated</td>
<td>NA</td>
<td>NA</td>
<td>U</td>
<td>U</td>
</tr>
</tbody>
</table>

### IntracranialGland

**Pituitary Gland, Craniohypophyseal Duct, and Pineal Gland**

C75.1, C75.2, C75.3

Note: AJCC does not define TNM staging for this schema.
Treatment

Decisions regarding aggressiveness of surgery for primary brain lesions are complex and depend on the:

- Age and performance status of the patient
- Proximity to “eloquent” areas of the brain
- Feasibility of decreasing the mass effect with aggressive surgery
- Resectability of the tumor (including the number and location of lesions)
- In patients with recurrent disease, the time since the last surgery

Surgical options include:

- Stereotactic biopsy
- Open biopsy or debulking procedure
- Subtotal resection
- Maximal safe resection
Craniotomy

Any bony opening that is cut into the skull.

Craniotomy Procedure

A section of the skull, (called a bone flap) is removed to access the brain underneath.

Typically the bone flap is replaced.

If the flap is not replaced, the procedure is called a craniectomy.
Surgeon has drawn the cutline circle around the tumor location

Source: The Alien-a set on Flickr www.flickr.com/photos/woodcreeper/sets/598206

Surgeon has cut the scalp and pulled it back to expose the skull over the tumor

Source: The Alien-a set on Flickr www.flickr.com/photos/woodcreeper/sets/598206
The skull is removed revealing the dura layer under which is the brain and tumor.

Source: The Alien-a set on Flickr www.flickr.com/photos/woodcreeper/sets/598206

Here you see the circular cut through the dura layer with the brain and tumor exposed.

Source: The Alien-a set on Flickr www.flickr.com/photos/woodcreeper/sets/598206
Meningioma Resected

Source: The Alien-a set on Flickr www.flickr.com/photos/woodcreep/sets/598206

Pre- and Post-Operative Imaging

Pre-op tumor is outlined in red
Post-operative MRI shows complete resection of the tumor

Source: Desert Spine and Neurosurgical Institute
## Surgery Codes

**APPENDIX B: Site-Specific Surgery Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>Local excision of tumor, lesion or mass; excisional biopsy</td>
</tr>
<tr>
<td>21</td>
<td>Subtotal resection of tumor, lesion or mass in brain</td>
</tr>
<tr>
<td>22</td>
<td>Resection of tumor of spinal cord or nerve</td>
</tr>
<tr>
<td>30</td>
<td>Radical, total, gross resection of tumor, lesion or mass in brain</td>
</tr>
<tr>
<td>40</td>
<td>Partial resection of lobe of brain, when the surgery can not be coded as 20-30.</td>
</tr>
<tr>
<td>55</td>
<td>Gross total resection of lobe of brain (lobectomy)</td>
</tr>
</tbody>
</table>

*Codes 30 - 55 are not applicable for spinal cord or spinal nerve primary sites.*

Specimen sent to pathology from surgical events 20–55.
Radiation Therapies

- Primary XRT for brain tumors includes tumor volume/margins
- Tumor volume is defined by pre- and post-operative imaging
- Standard fractionated external beam radiation is most common
- Hypofractionation (daily dose given in smaller increments with 4 or 6 hours between treatments) is an emerging option
- Whole brain XRT and stereotactic radiosurgery for brain mets

Source: NCCN

Tumor Volume

- The larger the brain tumor, the more desirable “fractionation” (e.g. multiple smaller treatments, rather than one big one)
- Tumor size can determine schedule for fractionation and dose/tx
- Why: The "shell" of normal tissue outside the tumor volume will receive some part of the dose. For larger tumors, this "shell" volume increases rapidly as a function of tumor diameter
- Why: Fractionation spares this "shell" of normal tissue much more effectively than the single "shot" techniques

Source: Johns Hopkins Medicine
Stereotactic Radiosurgery (SRS)

- Despite name, SRS is an XRT treatment, not a surgical procedure

- Acoustic neuroma, pituitary tumors, spinal cord tumors and brain metastasis are candidates for this technique

- Special equipment focuses up to 200 beams of radiation on tumor

- Although each beam has very little effect on the brain tissue it passes through, a strong dose of radiation is delivered to the site where all the beams meet.

- Results in minimal damage to healthy tissues surrounding target.

Source: San Diego Gamma Knife Center
Chemotherapy

- Chemotherapy is not an effective initial treatment for low-grade brain tumors. Why? Because most standard chemo agents have a hard time passing into the brain because of how the brain protects itself (the blood-brain barrier)

- Not all types of brain tumors respond to chemotherapy

- In general, chemotherapy for brain tumors is usually administered following surgery or radiation therapy

- Participation in clinical trials should be encouraged

Blood Brain Barrier

- Composed of special cells that make up brain’s blood vessels

- Selectively prevents substances from entering the blood and brain, only allowing essential molecules such as amino acids, oxygen, glucose and water through

- Adenosine, a molecule produced by the body, seems to modulate the entry of large molecules into the brain

- When adenosine receptors are activated on cells that comprise the blood-brain barrier, a gateway into the barrier can be established

Science Daily Source: September 13, 2001
Approved Chemotherapy Agents

- Carmustine (BCNU) – IV or dissolvable wafers placed surgically
- Temozolomide (Temodar) – oral
- Lomustine (CCNU) – oral
- Carboplatin
- Cisplatin
- Etoposide
- Irinotecan
- Vincristine
- Procarbazine (Matulane) – oral
- Methotrexate – oral, by injection or intrathecally

NCCN Treatment Guidelines
Infiltrative Low-Grade Glioma

- Best management strategy has yet to be defined
- Small tumor samples can provide a lower histologic grade
- Rationale: Needle biopsies are often performed when lesions are in deep or critical regions of the brain, but can be misleading because gliomas often have varying degrees of cellularity, mitosis, or necrosis from one region to another

- General recommendation is to first attempt as complete an excision of tumor as possible (based on postsurgical MRI verification) without compromising function
- No consensus exists regarding proper timing of postoperative external beam radiation
- Chemotherapy is not a traditional upfront treatment modality

Infiltrative Low-Grade Glioma

- When possible, maximal safe resection

- If gross total resection is achieved, some patients may be observed without adjuvant therapy. However, close follow-up is essential as over half of patients will eventually progress

- These tumors behave aggressively in patients over 40 years old
  - Adjuvant radiation or chemotherapy is recommended

- If stereotactic biopsy, open biopsy, or other subtotal excision was done, immediate fractionated external beam RT or chemotherapy should be given
Anaplastic Glioma and Glioblastoma

- Whenever possible, major tumor removal should be performed.

- If glioblastoma is confirmed, options include radiation, chemotherapy, best supportive care, chemoradiation only if carmustine wafer was implanted.

- If high-grade glioma is confirmed, BCNU wafer is an option.
  - In patients with good Karnofsky score (70 or above) options include fractionated external beam radiation therapy, chemotherapy or chemoradiation in the context of a clinical trial.
  - In patients with poor Karnofsky score (below 70) management may include radiation, chemotherapy or best supportive care.

Intracranial Ependymoma

- Whenever possible, maximal safe resection should be attempted.

- Adjuvant treatment depends on the extent of surgical resection, histology and staging by cranial spinal MRI and CSF cytology.

- CSF dissemination occurs in up to 15% of intracranial ependymomas.

- If MRI spine / CSF reveal disease, craniospinal radiation is mandatory.

- If gross total resection with negative spinal MRI and CSF, adjuvant regional fractionated EBRT or observation may be considered.
Medulloblastoma and PNET (supratentorial)

- MRI is the gold standard to assess PNET
- Maximal safe resection is recommended when possible
- **Average Risk Patients:** craniospinal radiation alone or concurrent chemoradiation followed by chemotherapy are both options
- **High Risk Patients:** patients with large cell or anaplastic medulloblastoma, supratentorial PNET, disease dissemination, unresectable tumors, or residual tumors over 1.5cm post-surgery are high risk and should undergo radiation followed by chemotherapy

---

Primary CNS Lymphoma

- Treatment to be initiated as immediately following diagnosis
- Treatment options depend on patient overall health and age
- For healthier patients a high-dose methotrexate regimen
- RT after systemic treatment depends on the responsiveness of the disease to the chemotherapy
- However, one or both may increase neurotoxicity, especially in patients older than 60 years of age
Primary Spinal Cord Tumors

- MRI is the gold standard for diagnosis of spinal cord lesions
- Asymptomatic patients may be observed or resected
- Symptomatic patients should undergo some form of surgery
- Maximal safe resection should be attempted
- Post-operative adjuvant radiation is not recommended
- However, if symptoms persist after incomplete resection or biopsy, radiation should be administered

Meningioma

- Meningiomas are typically diagnosed by CT or MRI imaging
- Biopsy may be considered for confirmation
- Options stratified by presence/absence of symptoms and tumor size
- Most asymptomatic patients with small tumors (<30mm) may just be observed. If neurological impairment is imminent, surgery (if accessible) or radiotherapy (EBRT OR SRS) is feasible
- Asymptomatic tumors >30mm can be either resected or observed
Meningioma

- Symptomatic disease requires active treatment by surgery if possible

- Non-surgical candidates should undergo radiation

- All patients with surgically resected grade III meningiomas (even after gross total resection) should receive adjuvant radiation for local control regardless of tumor size and symptom status

Additional Resources

- NCCN Evidence Based Treatment Guidelines, nccn.org, 2011
- Collaborative Stage Data Collection System, AJCC, 2010
- Multiple Primary and Histology Coding Rules, SEER 2007
QUESTIONS ???