Gamma Knife Radiosurgery for Remnant or Recurred Craniohypophyseal Adenomas

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Objective: The authors assess the long term effectiveness of gamma knife radiosurgery (GKS) for remnant or recurrent craniohypophyseal adenomas on tumor control and possibly set proper radiation dose for tumor control with utmost preservation of the adjacent structures.

Methods: Sixteen GKS were done in 14 patients with recurring or remnant craniohypophyseal adenomas after surgery. Mean follow up duration was 44.2 months (range 11.3-123.6 months). Follow up MR imaging were analyzed.

Results: Mean tumor volume was 3.6 cm³ (range 0.6-18 cm³) and mean margin dose was 12.2 Gy (range 8-22.4 Gy). Tumor control was achieved in 87.5% (14 of 16 tumors) which were either solid or cystic in nature. Dose to optic apparatus was mean 7.9 Gy and no radiation related complications were observed.

Conclusion: GKS seems to be effective treatment modality for craniohypophyseal adenomas regardless of nature of tumor whether it is cystic or solid. Dose of 8 to 8.5 Gy may be sufficient to achieve long term tumor control for remnant or recurrent craniohypophyseal adenomas.

KEY WORDS: Radiosurgery · Gamma knife · Craniohypophyseal adenoma · Optic apparatus.

Introduction

The treatment of craniohypophyseal adenomas has been considered difficult. Although complete removal of the tumor is associated with a favorable outcome, mortality and morbidity increases with attempts at radical surgery. Even with complete tumor removal, recurrence rate is 10 to 18% after 2.5 to 10 years and continued tumor growth after partial removal is reported to be 63 to 90%. It is also known that morbidity and mortality increases with subsequent attempts at radical surgery. After the introduction of gamma knife radiosurgery (GKS), it became an effective and less invasive tool for neurosurgeons against benign and malignant tumors. First GKS for craniohypophyseal adenoma was done by Backlund et al in 1972 and following studies on GKS for remnant craniohypophyseal adenomas after surgical removal have been reported. Less radiation related complications and good tumor regression rate make surgeons less aggressive on surgical removal and give chance for multimodal treatment.

Our study was to assess the effectiveness of GKS for craniohypophyseal adenomas on tumor control and possibly set a proper radiation dose for tumor control with utmost preservation of adjacent structures.

Materials and Methods

From period of May 1993 to November 2002, total of 14 patients received GKS (201-source cobalt-60 gamma unit, Elekta Instruments, Stockholm, Sweden) with 13 patients receiving once and 1 patient receiving three times. Mean age of patients at time of GKS was 30.3 years (4.4-62.9 years). Five patients were male and 9 were female. All patients received surgical removal before GKS for histological confirmation and tumor debulking. All except one patient received cranietomy for removal of tumor and one exception being transphenoidal approach. All MR imaging for remnant or recurrent tumor were converted using GammaPlan software where tumor volumes were calculated. Enhanced T1 weighted MR
images were used to delineated tumor margin. All measurements were performed by one investigator (Y. K.). Radiologic outcomes were categorized into three groups: decreased (0–80% of original tumor volume), static (80–120%), and increased (more than 120% of original tumor volume). Tumor was considered as recurred if clinical symptom and sign worsened even when increase in tumor volume did not exceed 120%.

**Clinical and imaging follow up**

Visual and endocrinologic evaluations were routinely done preoperatively. Visual evaluation included visual acuity and field test (Humphrey perimetry) and endocrinologic evaluation was done with combined pituitary function test. Postoperatively, all patients returned for clinical evaluation every month. Patients were questioned subjectively for postoperative changes in vision and hormonal symptoms.

Mean follow up duration was 48.0 months (range 11.3–123.6 months). This study is a follow up version of preliminary study reported at 2001 with added patients and longer follow up period.

**Results**

**Radiological Outcome after GKS**

Total of 16 procedures were done in 14 patients. Tumor volume ranged from 0.4cm³ to 18.0cm³ (mean 3.6 cm³). Mean margin dose was 12.2 Gy (range 8–22.4Gy) and dose to optic chiasm was mean 7.9Gy (range 4–11Gy).

Of the 16 tumors treated with GKS, 12(75%) decreased in size (0–80% of the original tumor volume). Two (12.5%) of the 16 tumors were considered static (80–120% of the original tumor volume) thus the control rate (decreased and static volume) was 87.5% (14 of 16 tumors). For one patient who received GKS 3 times, the first was considered recurrent and the rest were considered controlled.

For the 14 tumors where tumor control was achieved, mean tumor volume was 3.8cm³ (range 0.6–18.0 cm³). For the 2 recurred tumors, mean tumor volume was 1.6cm³ (0.4 and 2.8cm³). Comparing the mean margin dose of controlled and recurred tumor, they were 11.8 and 13.3Gy respectively. For the two recurred cases, both tumors were solid in nature. As for the controlled cases, 4 were cystic and the rest were either solid or mixed. Mean follow up period for the controlled cases was 49.1 months (range 11.3–98.0 months) and for the recurred cases, 106.9 months (range 90.2–123.6 months). Time interval to recurrence for the two cases was 57.6 and 123.6 months (Table 1). Statistical significance between the tumor controlled group and recurred group was not tested due to small size of patient population. Tumor volume, radiation dose, and imaging outcome are summarized in Table 2.

One of the two recurred cases was a 15 year old female who

<table>
<thead>
<tr>
<th>Table 1. Comparison between controlled and recurred cases</th>
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<tbody>
<tr>
<td><strong>Parameters</strong></td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>Number of cases</td>
</tr>
<tr>
<td>Target volume (cm³)</td>
</tr>
<tr>
<td>Margin dose (Gy)</td>
</tr>
<tr>
<td>PreGKS Image</td>
</tr>
<tr>
<td>Follow-up duration (months)</td>
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<td>Recurrence (months)</td>
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*PreGKS: preoperative to Gamma knife surgery*
adjacent to the optic chiasm and 2nd GKS was done. (D) MRI image taken 43 months after 2nd GKS where recurrent tumor is found in area of initial remnant tumor. 3rd GKS was done. (E) No tumor is seen after 25 months follow up after the 3rd GKS.

Visual and Endocrinologic Outcome after GKS

Eight of 14 (57%) patients had preoperative visual impairment. In case where tumor was attached or adjacent to the optic apparatus, margin dose was restricted to 8 or 8.5 Gy (Case 1, 2, and 4). However, when patient's preoperative visual loss was severe, vision sparing was no longer a concern and dose as high as 22.4 Gy was used for better tumor control (Case 6). No patient had deterioration of vision postoperatively.

Seven of 14 (50%) patients had preoperative hormonal insufficiency. Hormonal replacement was done for these patients with 7.5 mg methylprednisolone, 100 mg levothyroxine sodium, and 0.05 mg desmopressin preoperatively. Hormonal status remained stable in all patients including patients without preoperative hormonal deficiency.

Volume response after GKS

Volume response of tumor after GKS varied among cases. Ten (62.5%) had progressive volume reduction (<80% of original volume), while two (Case 1 and case 14) had transient volume expansion followed by marked reduction at next follow up imaging (Fig. 3). For case 1, volume expansion began as
Table 3. The results of gamma knife radiosurgery for craniopharyngiomas reported in the literature

<table>
<thead>
<tr>
<th>Authors</th>
<th>Number of Patients/tumors</th>
<th>Mean or median volume (cm³)</th>
<th>Margin dose (Gy)</th>
<th>Control rate (%)</th>
<th>Follow-up (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proctor et al.</td>
<td>8</td>
<td>?</td>
<td>5–30</td>
<td>88</td>
<td>0.5–4</td>
</tr>
<tr>
<td>Mokri et al.</td>
<td>23</td>
<td>9</td>
<td>9–15.4</td>
<td>74</td>
<td>2</td>
</tr>
<tr>
<td>Kobayashi et al.</td>
<td>100</td>
<td>5.8</td>
<td>11.5</td>
<td>77</td>
<td>5.46</td>
</tr>
<tr>
<td>Chung et al.</td>
<td>31</td>
<td>9</td>
<td>9.5–16</td>
<td>87</td>
<td>2.7</td>
</tr>
<tr>
<td>Chou et al.</td>
<td>10/12</td>
<td>1.35</td>
<td>16</td>
<td>56</td>
<td>5.25</td>
</tr>
<tr>
<td>Ulffarsen et al.</td>
<td>21/22</td>
<td>7.8</td>
<td>&lt;3–25</td>
<td>53</td>
<td>7.5</td>
</tr>
<tr>
<td>Kim et al.</td>
<td>18</td>
<td>2.7</td>
<td>17.6 (4–35)</td>
<td>72.2</td>
<td>4.9</td>
</tr>
<tr>
<td>Baur et al.</td>
<td>7</td>
<td>?</td>
<td>14.2</td>
<td>83.3</td>
<td>5</td>
</tr>
<tr>
<td>Present</td>
<td>14/16</td>
<td>3.6</td>
<td>12.2 (8–22.4)</td>
<td>87.5</td>
<td>3.7</td>
</tr>
</tbody>
</table>

tumor control rate of 56% and Kobayashi et al.\(^9\) reported a much improved tumor control of 85% (Table 3). Although tumor control rate tends to fall with longer follow-up period, short term treatment failure of GKS is often observed in cystic tumors.\(^1,17\). Backlund et al.\(^13\) suggested the use of intracystic brachytherapy for cystic components, and Ulffarsen’s study\(^20\) also observed high rate of cystic enlargement after GKS. Although statistical difference is yet to be proven, many institutions defer the use of GKS in cystic craniopharyngiomas. Cystic tumors are result of diffusion of plasma from the capillaries of the tumor and Gardner\(^16\) suggested inability of brain getting rid of this fluid. In our study, the two recurred cases were both solid tumor in nature and we inferred that cystic recurrence can be minimized by surgically removing the tumor cyst and treating rest of the tumor with GKS. The principle is not just to puncture the cyst but to remove as much cyst wall as possible. Four cystic tumors and four mixed tumors did not show recurrence as long as 45.1 months follow up.

Discussion

Treatment modalities

Adjuvant therapy such as radiation therapy (RT) has shown good results. 10-year survival rates of 81 to 91% after subtotal removal followed by RT has been reported\(^15,29\) and adjuvant radiotherapy has been the preferred practice for neurosurgeons. However, radiotherapy is not without hazard. Radiation necrosis, optic neuritis, malignancies, and cognitive disturbances in young children following RT is reported to be 6 to 18% of patients\(^5,29\). Tumor recurrence is also reported to be 14 to 22% 5 to 10 years after RT\(^12,13,25,29\) and mortality rate of patients suffering recurrence after RT is 83 to 100%\(^12,13,25,29,30,34,35\).

Alternative treatments such as neuroendoscopy and intracavitary brachytherapy have been introduced to decrease surgery related mortality and morbidity\(^2,23,26,37\). Intracavitary radiation and chemotherapy can be effective modality for cystic tumors but it also harbors considerable hazards such as visual deterioration and tumor regression may not be satisfactory\(^2,24,26,38\).

Our institution has discarded the use of intracystic treatment and radiation therapy and substituted with surgical removal of tumor plus GKS for remnant or recurrent cases.

Tumor control and associated factors in GKS treated craniopharyngiomas

On tumor control of craniopharyngiomas after GKS, much have been mentioned on nature of tumor (whether solid or cystic), treated tumor volume, and radiation dose to tumor, but these characteristics are yet to be statistically proven and need prospective or controlled study with bigger patient population. Attempts at justifying radiosurgery for craniopharyngiomas have started since Backlund\(^2\) and subsequent reports followed supporting its effectiveness. Mokry et al.\(^22\) reported volume response after GKS

Much of the previous studies concentrate on tumor’s volume response following GKS. However, little is known about the actual microbiological change that affects the volume response. Benign tumors such as meningiomas, benign gliomas or schwannomas have transient periods of volume expansion which does not necessarily mean recurrence\(^27\). There are studies on vestibular schwannomas that after gamma knife surgery, transient increase in tumor volume is observed in 6–39% and decrease after 3 months to 5 years follow up\(^20,26,27,30\). We also noticed this transient volume expansion for craniopharyngiomas where transient volume expansion of tumor eventually decreased at follow up imaging (case 1 and case 14). This volume expansion was found to be as much as 200% of the original tumor volume, but fortunately did not produce neurological dysfunction thus enabling further observation. Whatever the cause may be, clinicians should be aware that increased volume response does not necessarily mean recurrence and should be open for observation until definite evidence of recurrence emerges.

Proper prescription dose between tumor control and optic pathway sparing

Majority of postoperative recurrence of craniopharyngiomas locate at optic apparatus and hypothalamus\(^27,31\). This reflects the difficulty of total resection of tumor in these adjacent
structures and importance of GKS adjacent to optic chiasm. Studies demonstrated tolerance of 8 to 12 Gy with incidence of radiation optic neuropathy as low as 0–1.8% [11,10]. Kobayashi et al. [9] used margin dose of 12.8 Gy and gradually reduced margin dose to 11.5 Gy, suggesting the optimal dose to be between 11 and 12 Gy. Chung et al. [18] demonstrated comparable tumor control of 87.2% with use of 9 to 12 Gy margin dose. Study of Ulfarsson et al. [22] found out that margin dose less than 6 Gy was suboptimal, and tumor progression rate was as high as 85%. They demonstrated statistically significant difference with cases using 6 Gy or more where tumor progression was 33%. Considering the minimal dose to optic apparatus to achieve tumor control without complication, 3 of our cases where margin dose of 8 and 8.5 Gy were used provided adequate tumor control as long as 98 months (mean 78.2 months). Although Ulfarsson [23] recommended optimal dose to be 6 Gy or more, we recommend marginal dose of 8 to 8.5 Gy for maximal tumor control and minimal radiation related complication.

The exact pathophysiology behind recurrence of craniohypophyseal after GKS is yet to be proven. In our study, target volume, nature of tumor and radiation dose did not provide reason behind recurrence of craniohypophyseoma. However, our study shares with previous reports that tendency of recurrence rate increases after longer follow up period. This implies that GKS for craniohypophyseoma is not yet a curative modality but a modality for control of tumor. Long term clinical and imaging follow up is mandatory for optimal treatment of tumor.

Conclusion

As difficult as treatment of craniohypophyseomas can be, many diverse tactics of treatment are being conducted. Less aggressive surgical removal and GKS seem to be effective treatment modality regardless of nature of tumor whether it's cystic or solid. Dose of 8 to 8.5 Gy may be sufficient to achieve long term tumor control for craniohypophyseomas.

References

Biol Phys 24: 611-617, 1992

Commentary

This is an attractive review about long term effect (mean 3.7 years, ranging 1 to 10 years) of GKS for 14 cases of remnant or recurrent craniopharyngiomas on tumor control and about suggesting proper radiation dose (8-8.5Gy) both for tumor control and preserving the nearby crucial structures (optic apparatus and hypothalamus).

Craniopharyngiomas, pathologically benign but clinically malignant neoplasia owing to their inevitable recurrence, impose considerable challenges on the operators who wish to remove tumors as much as possible while without residual deficits. In most cases, the primary cause for incomplete removal is a lack of anatomical dissection plane between tumor and the hypothalamus or optic apparatus. Concern for hypothalamic dysfunction or optic neuritis would also arise from radiation to these regions, irrespective of detailed delivery methods (whole brain irradiation, brachytherapy or GKS). Margin dose, showing maximum effect to withhold tumor regrowth whereas showing minimum adverse effect to the adjacent structures, has to be individualized, therefore. Eight to 8.5Gy, as suggested in this review, appears as a little bit smaller than any previous articles. In this point of view, it is very fortunate that your results showed very low rate of morbidity and I want to know the reason more specifically.

Authors have written that target volume, tumor nature (solid or cystic) and radiation dose did not seem to affect the post-operative recurrence for craniopharyngiomas. I agree with this conclusion in some aspects, however, due to the small cohort number and random allocation (tumor nature, individual surgical approach, main complaints), external validity and statistical verification (such as reducing type 2 error) should be established by multi-center prospectively designed study and enrolling a large volume of patients in near future. It is generally believed that the longer the follow up period, the more the number of recurrence after GKS (decrease in rate of tumor control). I think the accumulated effect of radiation has been diminished as time went by (i.e. more than 5 years post-GKS). For this reason, I'm on the same side with you that GKS for craniopharyngiomas is not yet a definite, curative method for tumor control especially only in a certain limited period of time.

I want to address congratulation on your excellent clinical outcome.

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References