An Autopsy Case of Oligodendroglioma with Extracranial Metastases
— A Statistical Review of Reported Cases —

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ABSTRACT: An autopsy case of oligodendroglioma with extracranial metastases through blood vessels and cerebro-spinal fluid in a 44-year-old female is reported. Post-mortem examination revealed that the tumor involved the left frontal region, optic chiasma, cauda equina, spinal cord, subarachnoid space and bone (sternum, spine, ribs). Microscopic appearances showed the features of rapid anaplastic transformation. Glial fibrillary acidic protein (GFAP)-positive neoplastic oligodendrocytes were found in some areas of the honey-comb structure with prominent vascular stromata in recurrent and metastatic lesions. The histogenesis of this tumor may be interpreted as the constant or temporary production of GFAP by neoplastic oligodendrocytes as a sign of reversion to the fetal oligodendroglia without necessarily implying astrocytic histogenesis. The present case is the second case of oligodendroglioma with extracranial metastases reported in Japan.

INTRODUCTION

Extracranial metastases of primary brain tumors had until 1983 been reported for approximately two hundred cases in Japan (1). However, extracranial metastases of oligodendroglioma is very rare. In Japan, Nakamura et al. reported only one case of diffuse bone marrow metastasis by anaplastic oligodendroglioma in 1985 (2). In connection with this rare event, it has been pointed out that, in general, common factors in cases of remote metastases from cerebral tumor were; (1) multiple operations, (2) radiation, and (3) prolonged survival (3). Nevertheless, the mechanism involved in the appearance of distant metastases of a primary tumor of CNS has not been completely clear. We believe that a fundamental understanding of the oncogenesis of glial cells is essential in order to study the mechanism of extracranial metastases. This paper demonstrates convincingly by its histological and immunohistochemical documentation the extracranial metastases of an oligodendroglioma and reviews the relatively small number of previously documented similar cases.

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CASE REPORT

This 44-year-old woman had suffered from convulsion attacks since 1972. She had been given phenobarbital and diazepam, but symptoms of headache, nausea and vomiting occurred in May 1982. A calcified mass lesion of the right frontal area was revealed by CT scan (Fig. 1) and she was admitted to Nagasaki University Hospital for the first time in 1982 for removal of the tumor. In June, 1982, bifrontal osteoplastic craniotomy and partial removal of the tumor was performed. The surgical pathologic diagnosis was that of mixed oligodendroglioma and astrocytoma (Fig. 2). Subsequently, irradiation of 4200 rad was given to the frontal region and ACNU was administered. In August, 1982, gait disturbance occurred. Because a low density area was detected in the left frontal lobe by CT scan, she was admitted a second time to the same hospital. Radiation necrosis had been suspected and she had improved while on treatment with steroids. In December, 1984, speech and eye movement disturbance. Pancytopenia and fresh hemorrhagic area in the left frontal lobe was revealed by blood examination and CT scan. Moreover, it was especially noteworthy that the serum level for LDH was high. The value was 2423 IU/L in December, 1984. Aspiration biopsy of sternal bone marrow was carried out. The pathological report was malignant bone tumor with unknown origin. She had been put on steroids and her general condition had appeared fair, but in February, 1985, her condition rapidly deteriorated with occurrence of left hemipalsy and consciousness disturbance. On 13 March, she went into a shock condition and on the following day she died. Thirteen years had passed since her symptoms had begun. An autopsy was performed.

SURGICAL FINDINGS

Bifrontal osteoplastic craniotomy was performed. At first, the right side was observed. When the dura was opened, a tumor extending from the right superior frontal gyrus to the middle frontal gyrus was discovered. The tumor present at the surface measured approximately 2.5 × 1.5 cm in diameter. The boundaries of the tumor and the surrounding edematous brain tissue were ill-defined. When the left side was observed, another yellowish-brown tumor that was in contact with the interhemispheric fissure was found at a 3.0 cm depth from the surface of the cortex. The lesions were partially removed by means of suction. In the microscopical features of the lesions (Fig. 2), the tumor was cellular and composed of two sorts of cells. One element had compact collections of uniform cells with regular central nuclei and clear cytoplasmic halos. Alcian blue stain showed positiveness in the interstitium. In another element, there were large cells with abundant eosinophilic or vague cytoplasm. The latter cells were similar to those of fibrillary astrocytoma. The position of nuclei were eccentric or centric. Mitotic figures and pleomorphism were rarely seen in any area. GFAP stain was negative in the cytoplasm of typical oligodendroglioma cells with clear perinuclear halos, while it was diffusely positive in the cytoplasm of large cells with eosinophilic abundant cytoplasm and eccentric or centric nuclei. There were separate GFAP-negative cell and GFAP-positive cell populations. In addition, foci of calcification were seen throughout the tumor. Therefore, the tumor was diagnosed as mixed oligodendroglioma and astrocytoma.

AUTOPSY FINDINGS

Gross findings: The patient was 154 cm in height and 48 kg in weight. She appeared well-developed and well-nourished. The brain weighed 1150 gm, and there was a large cystic area with yellow fluid remaining in the right frontal lobe. Its internal wall was yellowish-brown in color. A hemorrhagic area was also present in the parenchyma of the brain adjacent to the cystic lesion and in contact with the lateral ventricle (Fig. 3). There also were multiple, ill-defined, grayish-brown small nodules with hemorrhages in the left frontal region, optic chiasma, cauda equina, spinal cord, and bone marrow of the spine (Fig. 4), sternum and ribs. The duodenum was acutely perforated and
fibrinous exudates covered the peritonium. In addition, bile stasis of the liver, severe pulmonary congestion and edema, and hemorrhagic diathesis were encountered.

Microscopical findings: There was a conspicuous proliferation of tumor cells around the hemorrhagic lesion in the right frontal lobe. The tumor cells had ill-defined cytoplasm with pleomorphic nuclei. In the lesion of the optic chiasma, tumor cells showed typical sphenoidal nuclear and clear perinuclear cytoplasmic halos suggesting oligodendroglioma (Fig. 5). A high density of cells forming perivascular pseudorosettes was found in parts. Each cell was oval or round in shape and the nuclei showed slight pleomorphism and hyperchromatism but the nucleoli were vague. In the lesion of the lumbar bone marrow (Fig. 6), the tumor cell density was higher. The rim of the cytoplasm was vague and gliofibrillary, and the N/C ratio was high. The nuclei were round or oval in shape and showed anaplasia and hyperchromatism. There were no perinuclear halos and they tended to be anaplastic. The lesions of the spinal cord (Fig. 7), cauda equina, sternum, and ribs were nearly the same.

GFAP stain was partially positive in the tumor of the lumbar bone marrow (Fig. 8); that is to say, GFAP-positive and GFAP-negative tumor cells were intermingled and random in the histologic section. GFAP positiveness was seen in the perinuclear narrow cytoplasmic rim. These findings were different from those at the operation. We thought that the tumor had transformed into an anaplastic one and metastasized to the bones. Including the present case, a total of 18 cases is listed in Table 3.

The age of patients ranged from 7 weeks to 58 years, with an average of 31.7 years. Twelve of the 18 cases (67%) occurred in patients between 20 and 50 years of age: six of the 18 were men and 11 were women. In one instance (case 6), the sex of the patient was not recorded. In 17 cases, the location of the primary tumor was supratentorial and in one case it was in the spinal cord. The distribution of the metastases was as follows: 12 (67%) in bone, six (33%) in lymph nodes, four (22%) in the lungs and pleura, two each in skeletal muscle and the liver, and one each in the peritonium, adrenal gland, and parotid gland. Bone metastases occurred in vertebrae (11 cases), iliac bone and ribs (three cases each), sternum (two cases) and femur (one case).

Fifteen of 18 patients underwent craniotomy and resection of their tumor. Radiation was performed on nine of 18 patients. Seven patients received radiotherapy in addition to surgical treatment. The survival time from onset to death among 17 of the patients ranged from eight months to 13 years, with an average of 4.5 years. The survival time in case 2 was unknown. In comparison with the average survival time (8.5 years) of oligodendroglioma without metastases reported by Roberts (6), shortening of survival time (4.3 years) occurred in cases of extracranial metastases.

Why did this rare, remote metastases in our case occur? Generally, it has been said that the two main factors to which extracranial metastases of glioma is most commonly attributed are surgical treatment or radiotherapy. The concrete hypothesis has been proposed that the negative pressure in the lumen of the cerebral veins and permeation of the meningeal venous tumor are rare, but in recent years are increasing. According to the report of BRAIN TUMOR REGISTRY IN JAPAN, the incidence of metastases in the spinal cord was 2.2% and that outside CNS was 0.6% (1). Smith et al. reported that in over 8000 tumors of neuroectodermal origin from the AFIP file, only 35 cases developed metastases outside the neuraxis (0.44%) (5). Of these, only one was oligodendroglioma with extracranial metastases. Including the present case, a total of 18 cases is listed in Table 3.

DISCUSSION

Generally, extracranial metastases of a brain tumor have been rare, but in recent years are increasing. According to the report of BRAIN TUMOR REGISTRY IN JAPAN, the incidence of metastases in the spinal cord was 2.2% and that outside CNS was 0.6%. Smith et al. reported that in over 8000 tumors of neuroectodermal origin from the AFIP file, only 35 cases developed metastases outside the neuraxis (0.44%). Of these, only one was oligodendroglioma with extracranial metastases. Including the present case, a total of 18 cases is listed in Table 3.

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system induced by craniotomy could cause suction of tumoral cells (7,8). Also, the effect of irradiation is not negligible (9). Although we do not clearly know its effect on glioma, it remains a matter for conjecture what part the radiotherapy played in the differentiation and metastasis of glioma. The present case involved both treatments, but we cannot document the mechanism involved in the appearance of the distant metastases of the recurrent glioma.

In addition, metastatic lesions displayed an alveolar pattern or epithelial-like structure (10) and showed morphologically rapid anaplastic transformation in comparison with the tumor at the operation: high density of cells, pseudorosette formation, and hyperchromatic and pleomorphic nuclei were noted. This may be one factor of metastases in our case. Schmitt in 1983 stated that rapid anaplastic transformation of glioma in adulthood occurred spontaneously because of genetic instability or repeated action of carcinogens, such as irradiation (11).

There have been many studies on the histogenesis of the oligodendroglial tumor. The presence of astrocytes in oligodendroglioma is well known; they may be regarded as reactive elements or as neoplastic components of mixed oligo-astrocytoma. Because immunoreaction to GFAP is mainly regarded as a sign of astroglial histogenesis and differentiation, we mainly used this protein and reviewed the result. In our case, GFAP stain of lumbar marrow showed some tumor cells with a narrow GFAP-positive cytoplasmic rim. Our findings resembled those of Herpers (12). We can provide convincing documentation that these GFAP-positive cells are neoplastic elements. Three main interpretations of these GFAP-positive cells of oligodendrogliomas have been proposed. First, GFAP-positive cells in oligodendrogliomas may be a type of gemistocytic astrocyte in which glial fibrils may not be demonstrated by classical stains for glia (Dearmond et al., 1980, Rubinstein, 1972.) (13)(14). Second, they may represent an intermediate or transitional tumor cell between the oligodendroglial and astroglial tumor (Van der Molen et al., 1978) (15). The third interpretation suggests the possibility of a bipotential glial precursor cell (Roff et al., 1983) (16). In 1984, Herpers et al. investigated 50 oligodendroglioma and 16 mixed glioma using an anti-GFAP serum in the peroxidase-anti-peroxidase (PAP) method (12). The specimen from the removed material in our case consisted of two distant neoplastic cell populations; that is, oligodendroglioma and astrocytoma. At autopsy, GFAP-positive oligodendrocytes were found in some areas of the classical honeycomb structure with a prominent vascular stroma. We would call the cells glio-fibrillary oligodendrocytoma or transitional oligoastrocytoma as subtypes of oligodendroglioma, as Herpers described previously (12). Also, we support the possibility of a bipotential glial precursor cell. GFAP-positive cells with morphological characteristics of oligodendroglia may be considered similar to transient GFAP expression by myelin-forming glia during normal development (Chow and KIm) (17). Therefore, our observations suggest a reversion to a fetal behaviour by some neoplastic oligodendrocytes.

In addition, we think that the relation between astroglial and oligodendroglial cells is closer than previously believed, and re-evaluation of the differentiation of glial cells should be performed on the basis of the reported investigations.

### Table 1. Immunohistochemical Indirect Method

<table>
<thead>
<tr>
<th>Antibody</th>
<th>Rt. frontal operation</th>
<th>Vertebrae autopsy</th>
</tr>
</thead>
<tbody>
<tr>
<td>GFAP</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>S-100 α</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>S-100 β</td>
<td>±</td>
<td>+</td>
</tr>
<tr>
<td>MBP</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Leu 7</td>
<td>–</td>
<td>–</td>
</tr>
</tbody>
</table>

List of antibodies and sera used in this study and their optimal dilution.

1) Primary antibodies.

- # Rabbit anti-human GFAP, 1 : 400, DAKO
- # Mouse monoclonal anti-bovine s-100 α, 1 : 800, JIMRO
- # Mouse monoclonal anti-bovine s-100 β, 1 : 400, JIMRO
- # Mouse monoclonal anti-bovine MBP, 1 : 800, Sero
- # Mouse monoclonal anti-Leu 7, 1 : 40, BECTON

2) Secondary antibodies.
Swine anti-rabbit/HRP, DAKO, 1:40  
Rabbit anti-mouse/HRP, DAKO, 1:40  
3) Others (for reduction of non-specific background staining)  
Normal swine serum, 1:20, DAKO  
Normal rabbit serum, 1:20, DAKO

Table 2. Final Pathological Diagnoses  
1. Brain tumor, mixed oligo-astrocytoma, rt. frontal lobe  
a) Postoperative state; bifrontal osteoplastic craniotomy and partial removal of the tumor (June 16, 1982)  
b) Postirradiative state; 4200 rad  
2. Recurrence of mixed oligo-astrocytoma with appearance of anaplastic oligodendroglioma and massive necrosis and hemorrhage, rt.

Table 3. Clinical Features of Patients with Extracranial Metastases of Oligodendroglioma

<table>
<thead>
<tr>
<th>Case</th>
<th>Age (yr)</th>
<th>Sex</th>
<th>Location of primary tumor</th>
<th>Metastases and/or invasions</th>
<th>Operation and/or Radiation</th>
<th>Survival</th>
</tr>
</thead>
<tbody>
<tr>
<td>James and Pagel</td>
<td>25</td>
<td>F</td>
<td>R parietal</td>
<td>Cervical lymph nodes, lungs, and hilar lymph</td>
<td>Two craniotomies, radiotherapy</td>
<td>84 mo</td>
</tr>
<tr>
<td>Strang and Nordenstam</td>
<td>30</td>
<td>M</td>
<td>R frontal</td>
<td>Cauda equina</td>
<td>One craniotomy and one laminectomy</td>
<td>unknown</td>
</tr>
<tr>
<td>Spataro and Sacks</td>
<td>7</td>
<td>F</td>
<td>L parietal</td>
<td>Lumbar vertebrae, ribs, psoas muscle, liver.</td>
<td>Four craniotomies, radiotherapy</td>
<td>33 mo</td>
</tr>
<tr>
<td>Smith et al.</td>
<td>45</td>
<td>M</td>
<td>L frontal</td>
<td>L iliac bone.</td>
<td>One craniotomy</td>
<td>17 mo</td>
</tr>
<tr>
<td>Jellinger et al.</td>
<td>58</td>
<td>F</td>
<td>L frontal</td>
<td>Lumbar vertebrae</td>
<td>One craniotomy</td>
<td>42 mo</td>
</tr>
<tr>
<td>Kernohan, 1971</td>
<td>3.5</td>
<td>?</td>
<td>R parietal</td>
<td>Lungs, hilar lymph nodes, R adrenal</td>
<td>Four craniotomies.</td>
<td>21 mo</td>
</tr>
<tr>
<td>Eade and Urich</td>
<td>21</td>
<td>F</td>
<td>Spinal cord</td>
<td>Thoracic vertebrae, sternum</td>
<td>Thoracic laminectomy, biopsy, fossae decompression and radiotherapy.</td>
<td>8 mo</td>
</tr>
<tr>
<td>Eade and Urich</td>
<td>23</td>
<td>M</td>
<td>L thalamus</td>
<td>Vertebrae</td>
<td>Needle biopsy, radiotherapy, VA shunt.</td>
<td>12 mo</td>
</tr>
<tr>
<td>Reggiani et al.</td>
<td>43</td>
<td>F</td>
<td>L frontal</td>
<td>Spinal cord. from T3 to T5.</td>
<td>Two craniotomies.</td>
<td>Over 11 yr</td>
</tr>
<tr>
<td>Cappelaere et al.</td>
<td>57</td>
<td>M</td>
<td>R frontal</td>
<td>R cervical lymph nodes, thoracic vertebrae</td>
<td>One craniotomy, radiotherapy.</td>
<td>20 mo</td>
</tr>
<tr>
<td>Case</td>
<td>Name (Year)</td>
<td>Age</td>
<td>Side</td>
<td>Tumor Sites</td>
<td>Treatment</td>
<td>Duration</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
<td>-----</td>
<td>------</td>
<td>-------------</td>
<td>-----------</td>
<td>----------</td>
</tr>
<tr>
<td>11.</td>
<td>Cappelaere et al. (1972)</td>
<td>22</td>
<td>L temporal</td>
<td>Cervical and thoracic vertebrae, cervical lymph nodes, and parotid gland</td>
<td>One craniotomy</td>
<td>25 mo</td>
</tr>
<tr>
<td>13.</td>
<td>Schuster et al. (1976)</td>
<td>58</td>
<td>F</td>
<td>L frontoparietal</td>
<td>3rd and 5th lumbar vertebrae</td>
<td>One craniotomy</td>
</tr>
<tr>
<td>14.</td>
<td>Kummer et al. (1977)</td>
<td>40</td>
<td>M</td>
<td>R parietal</td>
<td>Lungs and paratracheal lymph nodes, thoracic vertebrae, R femur</td>
<td>Two craniotomies and radiotherapy</td>
</tr>
<tr>
<td>15.</td>
<td>Becker et al. (1978)</td>
<td>7- weeks</td>
<td>F</td>
<td>R frontal</td>
<td>Peritonium</td>
<td>Ventriculoatrial and ventricuroabdominal shunt, one craniotomy</td>
</tr>
<tr>
<td>16.</td>
<td>Ordonez et al. (1981)</td>
<td>33</td>
<td>F</td>
<td>L frontal</td>
<td>L masseter muscle, L cervical lymph nodes, lumbar vertebrae, R iliac bone</td>
<td>Two craniotomies</td>
</tr>
<tr>
<td>17.</td>
<td>Nakamura et al. (1984)</td>
<td>32</td>
<td>F</td>
<td>L frontal</td>
<td>Vertebral ribs, iliac bone</td>
<td>Two craniotomies and radiotherapy, local radiation by after-loading</td>
</tr>
<tr>
<td>18.</td>
<td>Present case (1987)</td>
<td>44</td>
<td>F</td>
<td>R frontal</td>
<td>Cervical, thoracic, and lumbar vertebrae sternum, ribs, spinal cord (C4-8, Th 6-7, Th 9-11), cauda equina</td>
<td>One craniotomy and radiotherapy</td>
</tr>
</tbody>
</table>

REFERENCES


Fig. 3. There is a cystic space with a hemorrhagic lesion in the right frontal lobe. This lesion ruptures in the lateral ventricle.

Fig. 4. Gross appearance of lumbar spine. It shows some gray nodules with irregular border.

Fig. 5. Microscopic finding of optic chiasma shows rapid anaplastic transformation. H.E. ×400

Fig. 6. This spine specimen shows solid cellular area with round hyperchromatic nuclei and cytoplasm. (lumbar spine) H.E. ×400

Fig. 7. Alveolar pattern in meninges of spinal cord. H.E. ×200

Fig. 8. GFAP stain showing positive findings. (lumbar spine) ×400