Natural history of elderly patients with asymptomatic meningiomas

Masaki Niiro, Kazutaka Yatsushiro, Katsumi Nakamura, Yoshihiro Kawahara, Jun-ichi Kuratsu

Abstracts

Objective—For the treatment of elderly patients with asymptomatic meningiomas, it is important to determine their natural history. Based on results of follow up examinations, the natural history of such patients was clarified and prognostic factors concerning the potential of tumour growth in the aged were identified.

Methods—The clinical records and imaging studies of 40 elderly (over 70 years) patients with asymptomatic meningiomas were analysed. The patients were followed up with repeated imaging studies, and changes in tumour size, clinical signs, and outcomes were evaluated.

Results—There were 32 women and eight men with a mean age of 76.1 years. The mean follow up period was 38.4 months, ranging from 6 to 97 months. Six patients died during the follow up period from disorders other than the tumours, and one patient died as a result of the tumour. Twenty six patients (mean follow up period 41.8 months, range 10–97 months) showed no tumour growth. Fourteen patients showed tumour growth (mean follow up period 32.1 months, range 6–88 months). Five (four men and one woman) of these patients became symptomatic. Based on imaging analysis (1) calcification of the tumour was associated with no tumour growth (p=0.036), and (2) the tumour size at the initial diagnosis was related to subsequent tumour growth (p=0.016). Other possible factors related to tumour growth included sex and hyper-intensity on MRI T2 weighted images.

Conclusion—In elderly patients with asymptomatic meningiomas, careful clinical follow up with imaging studies is important. The imaging features mentioned may contribute to prediction of tumour growth.

Keywords: aged; asymptomatic meningioma; natural history

With the increase in the number of elderly people and advances in diagnostic imaging modalities, the frequency of detection of brain tumours in aged patients is increasing. It has been reported that the frequency of incidental detection of meningiomas is higher in aged patients than in non-aged patients.

Patients and methods
A total of 92 aged (over 70 years) patients with meningiomas were investigated at the Department of Neurosurgery, Kagoshima University Hospital and its affiliated hospitals over the past 5 years. Among them, 69 were asymptomatic and 23 were symptomatic. We retrospectively analysed the clinical records and imaging studies of patients with asymptomatic meningiomas. Patients who were newly diagnosed during this time and patients with asymptomatic meningiomas who were still receiving follow up examination were included. The earliest patient included in this study had been first seen 6 years before the above mentioned study period. Among the patients with asymptomatic meningiomas, 16 patients who were not studied and 13 patients who were selected for surgery or radiosurgery at the time of the initial diagnosis were excluded. The other 40 patients, who had repeated imaging studies, were included. Meningioma was diagnosed by the presence of an extra-axial dural based mass that was uniformly and markedly enhanced by contrast agent. We analysed the clinical features of these patients at diagnosis, taking into account the following items: major complaint(s) or reasons for initial examination which led to meningioma detection, tumour location, and tumour size. Tumour size was defined as the maximum diameter on CT or MRI. Tumour growth was defined by the judgement of more than two persons among the coauthors. In judging the slight changes in tumour size, such as <5 mm, volumetric assessment by MRI was used to exclude interobserver variability. The changes in tumour size, the clinical signs, and outcomes were evaluated.
The mean follow up period was 32.1 months (6–88 months). The average age was 74.5 years. The mean initial tumour size was 30.9 (18–60) mm in diameter.

<table>
<thead>
<tr>
<th>No</th>
<th>Age and sex</th>
<th>Tumour location</th>
<th>Initial size (mm)</th>
<th>Final size (mm)</th>
<th>Follow up period (months)</th>
<th>Outcome and treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>70/F</td>
<td>Lt clinoid</td>
<td>18</td>
<td>21</td>
<td>24</td>
<td>Asymptomatic, radiosurgery</td>
</tr>
<tr>
<td>2</td>
<td>72/F</td>
<td>Rt parietal falx</td>
<td>20</td>
<td>30</td>
<td>60</td>
<td>Asymptomatic, followed up</td>
</tr>
<tr>
<td>3</td>
<td>78/F</td>
<td>Lt cerebellar convexity</td>
<td>24</td>
<td>27</td>
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</tr>
<tr>
<td>4</td>
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<td>25</td>
<td>30</td>
<td>38</td>
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</tr>
<tr>
<td>5</td>
<td>74/F</td>
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<td>35</td>
<td>48</td>
<td>Asymptomatic, radiosurgery</td>
</tr>
<tr>
<td>6</td>
<td>79/F</td>
<td>Lt cerebellar convexity</td>
<td>28</td>
<td>31</td>
<td>6</td>
<td>Asymptomatic, radiosurgery, operation</td>
</tr>
<tr>
<td>7</td>
<td>74/M</td>
<td>Rt frontal convexity</td>
<td>30</td>
<td>65</td>
<td>6</td>
<td>Symptomatic, operation</td>
</tr>
<tr>
<td>8</td>
<td>72/M</td>
<td>Rt frontal falx</td>
<td>30</td>
<td>58</td>
<td>18</td>
<td>Asymptomatic, operation</td>
</tr>
<tr>
<td>9</td>
<td>73/M</td>
<td>Rt frontal base</td>
<td>30</td>
<td>35</td>
<td>48</td>
<td>Asymptomatic, radiosurgery, operation</td>
</tr>
<tr>
<td>10</td>
<td>76/F</td>
<td>Rt tentorium</td>
<td>30</td>
<td>34</td>
<td>24</td>
<td>Asymptomatic, followed up</td>
</tr>
<tr>
<td>11</td>
<td>73/F</td>
<td>Rt frontal falx</td>
<td>30</td>
<td>38</td>
<td>29</td>
<td>Symptomatic, operation</td>
</tr>
<tr>
<td>12</td>
<td>70/F</td>
<td>Rt cavernous</td>
<td>38</td>
<td>42</td>
<td>6</td>
<td>Asymptomatic, radiosurgery</td>
</tr>
<tr>
<td>13</td>
<td>74/M</td>
<td>Lt sphenoid ridge</td>
<td>45</td>
<td>82</td>
<td>88</td>
<td>Symptomatic, died from tumour</td>
</tr>
<tr>
<td>14</td>
<td>85/M</td>
<td>Rt frontal convexity</td>
<td>60</td>
<td>72</td>
<td>36</td>
<td>Symptomatic, followed up</td>
</tr>
</tbody>
</table>

Average age was 74.5 years. The mean initial tumour size was 30.9 (18–60) mm in diameter. The mean follow up period was 32.1 months (6–88 months).
associated with brain oedema. However, brain oedema at the initial diagnosis showed no relation to tumour growth. Twenty seven patients underwent MRI; 14 with growing tumours, and 13 with non-growing tumours. Seven of 14 growing tumours showed hyperintensity on T2 weighted images. By contrast, only three non-growing tumours showed hyperintensity on T2 weighted images. Although a significant difference was not found, the meningiomas in aged men tended to grow.

Discussion
Among incidentally detected brain tumours, the most common benign primary brain tumour is meningioma, and incidental detection is more frequent in elderly persons than in young persons. With advances in surgical techniques and the medical management of aged patients, surgical treatment for symptomatic meningiomas may be indicated even for elderly patients. However, the resection of meningiomas in elderly patients is reported to be associated with significant morbidity and mortality. Therefore, the advisability of surgery should be carefully considered in asymptomatic patients. Many cases of meningioma are detected during investigation for other CNS disorders such as cerebral infarction, parkinsonism, and dementia. In addition, other elderly patients may have a large tumour not associated with any focal neurological signs.

An important problem is the lack of information about the natural history of asymptomatic meningiomas. Asymptomatic meningiomas tend to be detected in elderly and female patients. Among symptomatic patients, a large proportion of unoperated aged patients died or their condition worsened from causes related to intracranial pathology within 1 to 5 years after the diagnosis. In aged asymptomatic subjects, the natural history has not been examined. It has been reported that most asymptomatic meningiomas, including those in young patients, remain asymptomatic and have a zero or slow growth rate after follow up periods varying from 21 months to 8.8 years. In a study of relatively aged subjects (mean age 67 years) with relatively long follow up periods (mean of 74 months), four of 35 tumours had become enlarged, and one patient developed symptoms related to the tumour. Considering the clinical courses of the asymptomatic meningiomas in our study, two thirds of the patients with asymptomatic tumours did not show tumour growth for several years. On the other hand, one third of patients showed tumour growth, and about 10 % of patients who were initially asymptomatic became symptomatic. Most of the tumours that showed clear growth grew between 6 months to 2 years of diagnosis. In our study, the earliest observation period to confirm tumour growth was 2 months. This patient showed rapid tumour growth. The tumour was located in the right

Table 3 The imaging features of 40 asymptomatic meningiomas and the factors related to tumour growth

<table>
<thead>
<tr>
<th></th>
<th>Tumour growth (n=14)</th>
<th>No tumour growth (n=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tumour size at initial diagnosis*</td>
<td>30.9 (10.9)</td>
<td>23.3 (8.1)</td>
</tr>
<tr>
<td>Calcification†</td>
<td>3/14</td>
<td>16/26</td>
</tr>
<tr>
<td>Brain oedema</td>
<td>2/14</td>
<td>7/26</td>
</tr>
<tr>
<td>Hyperintensity on MRI T2 weighted image</td>
<td>7/14</td>
<td>3/13</td>
</tr>
<tr>
<td>Sex (M:F)</td>
<td>5:9</td>
<td>4:22</td>
</tr>
</tbody>
</table>

Tumour growth v no tumour growth.

*p=0.016 unpaired Student t test.
†p=0.037 χ² test.
frontal convexity, grew to 65 mm in diameter 6 months after the initial diagnosis, and was removed surgically. The pathology of the surgical specimen indicated a transitional meningioma, but a high rate of positive MIB-1 stained cells was obtained.

The accuracy of measurement of tumours is a fundamental issue. Slight change in size on sequential imaging might possibly be due to slight differences in positioning of patients and timing of contrast administration. We attempted to get the same slice as that of the previous scan as much as possible. However, slight changes, such as those of several mm could not be regarded as definitive. By measurement on CT, most tumour growth was defined as an increase in diameter >5 mm. The slight changes, such as those <5 mm, were defined by MRI. In judging such slight changes, three dimensional measurement or volumetric assessment using MRI was helpful to exclude interobserver variability.

Some factors are considered to be associated with tumour growth. One characteristic finding of the imaging studies of our series was calcification of the tumour. Such tumours usually do not grow because of reduced proliferating potential, as verified by the MIB-1 staining index. One of the characteristic features of patients who showed tumour growth was the initial tumour size. In our study, moderate or large tumours (over 30 mm) showed a greater propensity to grow. Based on the clinicopathological MIB-1 staining index, a weak correlation was found between tumour size (>3.5 cm) and proliferative index. We should, therefore, recognise that a non-calcified meningioma with a moderate to large size has the potential to grow. Signal intensity on T2 weighted images has a fairly strong correlation with the histological subtype. Hypointensity reflects a fibrous and hard component. A fibrous and hard tumour may show low proliferating potential. The meaning of hyperintensity is uncertain, but it might relate to proliferating potential. In our study, seven of 14 growing meningiomas showed hyperintensity or mixed hyperintensity on T2 weighted images. Considering the above mentioned imaging features, calcification, initial tumour size>30 mm, and signal intensity on T2 weighted images are thought to provide useful information to predict the growth potential of meningiomas.

Asymptomatic meningiomas were four times more often detected in women than in men in our study. In growing tumours, the number of male patients tended to increase, compared to non-growing tumours. In particular, asymptomatic patients were male dominant.

For the treatment of asymptomatic meningiomas, careful clinical follow up with repeated imaging studies is important. Because malignant meningiomas may grow rapidly and these tumours cannot be definitively diagnosed by imaging studies alone, we recommend follow up study for 2 or 3 months after the initial diagnosis. If the absence of malignancy can be confirmed, 6 month or 1 year follow up intervals would be sufficient.

Conclusion

In elderly patients with asymptomatic meningiomas, because some tumours did grow and became symptomatic, careful clinical observation with repeated imaging studies is of primary importance. The imaging study findings mentioned above contribute to the prediction of tumour growth potential.

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