ABSTRACT

Biphasic pattern of subependymal giant cell astrocytoma (SGCA) in an adult patient: a case report

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Abstract

A 35 year-old male presented with headache of 5 months duration. He also had a history of bilateral subacute otitis media. On examination, no focal neurological deficit was observed. Imaging revealed a well-circumscribed lesion with eccentric heterogeneity, predominantly hyperintense on T2WI and hypointense on T1WI with heterogeneous enhancement. It was located within the floor of the 3rd ventricle, extending into the left lateral ventricle. It measured 2.3 cm x 1.7 cm x 1.2 cm. The lesion was causing slight midline shift and mass effect with mild hydrocephalus. The lesion was excised via a left frontoparietal craniotomy. Postoperatively, the patient had immediate relief of headache. Histopathological examination revealed a biphasic pattern of SGCA. The patient was initiated on chemotherapy with temozolomide with subsequent regression of the lesion seen on follow-up imaging.

This is the first reported case of SGCA in an adult patient presenting with bilateral otitis media.

Keywords: SGCA, biphasic pattern, headache.

CASE REPORT

A 35 year-old male presented with headache of 5 months duration. He also had a history of bilateral subacute otitis media. On examination, no focal neurological deficit was observed. Imaging revealed a well-circumscribed lesion with eccentric heterogeneity, predominantly hyperintense on T2WI and hypointense on T1WI with heterogeneous enhancement. It was located within the floor of the 3rd ventricle, extending into the left lateral ventricle. It measured 2.3 cm x 1.7 cm x 1.2 cm. The lesion was causing slight midline shift and mass effect with mild hydrocephalus. The lesion was excised via a left frontoparietal craniotomy. Postoperatively, the patient had immediate relief of headache. Histopathological examination revealed a biphasic pattern of SGCA. The patient was initiated on chemotherapy with temozolomide with subsequent regression of the lesion seen on follow-up imaging.

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Clinical and radiological presentation of apocrine carcinoma is no different from that of invasive ductal carcinomas (NST).\textsuperscript{10,12} The mean tumour size is greater, 2 cm.\textsuperscript{1,9} It tends to be unilateral, but multifocality multicentricity is seen frequently.\textsuperscript{13} Apocrine carcinoma is associated with a lower frequency of axillary nodal involvement and less lymphovascular involvement.\textsuperscript{1,9} Our case, probably owing to the late presentation showed both these features.

Nagao et al.\textsuperscript{14} in their study have indicated a poor response to chemotherapy in patients with apocrine carcinomas, although HER-2/neu enriched carcinomas tend to have the highest rate of complete response to neoadjuvant chemotherapy. However, according to Tsutsumi\textsuperscript{5} there appears to be a potential unique response to androgen (fluoxymesterone) administration as a part of treatment which is under investigation.

The available prognostic data for apocrine carcinoma is contradictory with most studies showing no difference from stage matched invasive breast carcinoma- NST.\textsuperscript{8} However, some recent studies have shown significantly better prognosis of pure apocrine carcinoma (PIAC) with overall six-year survival of 72% as against 52% for IDC-NST.\textsuperscript{8} PIAC may be regarded as an independent clinico-pathological prognostic factor in early breast cancer.

CONCLUSION
Invasive apocrine carcinoma of breast is a distinct, albeit rare clinicopathological entity. Its characteristic steroid receptor expression profile might be a route for targeted therapy as well as a guide for management and prognosis. It thus justifies identifying apocrine carcinoma as a unit different from the common invasive ductal carcinoma.

FINAL DIAGNOSIS
Breast carcinoma - apocrine type.

REFERENCES