Brain Tumours in Children

Brain tumours are the most common site for solid tumours in childhood. A small peak in incidence of brain tumours in early childhood drops to a minimum in teenage years. Most childhood brain tumours (70-80%) are infratentorial (glial tumours, medulloblastoma) or in the midline (germ cell tumours, craniopharyngioma). Glial tumours in children are more frequently low-grade.\(^1\)

Brain tumours generally have a better outcome in children than in adults but children with brain tumours are frequently unwell for months prior to diagnosis and a prolonged period between symptom onset and diagnosis is associated with increased morbidity.\(^2\)

Epidemiology\(^3\)

- Brain and central nervous system (CNS) tumours (malignant and non-malignant) are the second most common group of cancers in children, accounting for a quarter of all childhood cancers. In the UK, brain tumours occur in about 5 per 100,000 of children between the ages of 0-9 years.
- The largest subgroup is astrocytoma (43% of all brain and CNS tumours in children). Astrocytomas are diagnosed throughout childhood. 76% of astrocytomas are diagnosed as 'low-grade' and 15% as 'high-grade'.
- The second most common subgroup is the intracranial and intraspinal embryonal tumours (19% of all childhood brain and CNS tumours). Most of these are primitive neuroectodermal tumours (PNETs) and about 73% are medulloblastomas. PNETs occur most frequently in younger children.
- About 10% of childhood brain and CNS tumours are ependymoma and choroid plexus tumours. The incidence is highest in 1-year-old children.

Aetiology

- The underlying cause of brain tumours is unknown. However, some tumours are more common with certain illnesses - eg, astrocytomas are seen with increased frequency in neurofibromatosis and haemangioblastomas are more prevalent in patients with von Hippel-Lindau disease.
- This suggests a genetic link and mutations in several genes have been proposed - including the retinoblastoma gene (RB1), neurofibromatosis genes (NF1 and NF2) and tuberous sclerosis gene (TSC1), which function as tumour suppressor genes.\(^4\) However, most cases of brain tumours are sporadic.
- Previous cranial irradiation also increases the risk of brain tumours - eg, meningeal leukaemia.\(^5\) A Canadian study looked at the correlation between early infections and brain tumours in 272 children and found an increased proportion of this group had a positive history of infections - eg, use of antibiotics during gestation, removal of tonsils or adenoids.\(^6\) However, further observational-based studies are required to draw any firm conclusions from this data.

Classification

**Types of brain tumours**

- Gliomas (gliomas are graded according to whether they are slow-growing (low-grade) or fast-growing (high-grade); grade 1 is the slowest-growing type and grade 4 is the fastest-growing):
  - Astrocytic tumour: low-grade astrocytoma, anaplastic astrocytoma, glioblastoma multiforme.
  - Oligodendroglialoma: benign or anaplastic.
  - Ependymoma: benign or anaplastic.
  - Mixed glioma: astrocytoma and oligodendroglioma.
  - Ganglioglioma: benign or anaplastic.
  - Choroid plexus tumour: papilloma or carcinoma.
- PNETs: supratentorial primitive neuroectodermal tumours, medulloblastoma, pineoblastoma.
- Congenital: teratoma, craniopharyngioma.
- Pineal tumours: germinoma, endodermal sinus tumour, embryonal cell carcinoma, choriocarcinoma, pineocytoma or pineoblastoma.
- Very rare tumours: primary CNS lymphoma.
- Benign tumours (more common in adults): meningioma, acoustic neuroma, pituitary tumour.

Localisation and frequency of childhood brain tumours
- Hemispheric: glioma.
- Midline: chiasmal gliomas, craniopharyngiomas, pineal region tumours.
- Posterior fossa: brainstem gliomas, medulloblastomas, ependymomas, cerebellar astrocytomas.

Presentation\(^7, 8\)
- Intracranial tumours:
  - Headache, nausea and vomiting, abnormalities of gait and co-ordination, and papilloedema. Headaches are usually recurrent, frequent and gradually worsening.\(^9\)
  - Headaches may be worse on waking, indicating raised intracranial pressure. Headaches are more common with infratentorial lesions.
- Children aged under 4 years with intracranial tumours:
  - Macrocephaly, nausea and vomiting, irritability and lethargy.
  - Children under the age of 2 years tend to have nonspecific presentation with vomiting, lethargy, failure to thrive and irritability. They may develop macrocephaly, hyperreflexia and cranial nerve palsies.
- Children with an intracranial tumour and neurofibromatosis:
  - Reduced visual acuity, exophthalmia and optic atrophy.
- Posterior fossa tumours:
  - Nausea and vomiting, headache, abnormal gait and co-ordination, and papilloedema.
  - The presentation of infratentorial tumours relates to blockage of the CSF flow, leading to hydrocephalus. Common signs and symptoms include morning headache, vomiting (may be the only symptom of an ependymoma), ataxic gait with unsteadiness, double vision and papilloedema.
  - Brainstem tumours may also present with facial or ocular muscle palsies and hemiparesis.
- Supratentorial tumours:
  - Unspecified symptoms and signs of raised intracranial pressure, seizures and papilloedema.
- Central brain tumours:
  - Headache, abnormal eye movements, squint, and nausea and vomiting.
- Brainstem tumours:
  - Abnormal gait and co-ordination, cranial nerve palsies, pyramidal signs, headache and squint.
- Other neurological features related to tumour location (eg, frontal lobe tumours are associated with personality change and occipital lobe tumours are associated with visual deficits). Other symptoms relating to type or location of brain tumour include:
  - Chiasmal tumours - visual field defects and hydrocephalus.
  - Craniopharyngiomas - short stature, visual field defects, hormonal abnormalities and hydrocephalus.
  - Pineal tumours - impaired upgaze, impaired accommodation and hydrocephalus.
  - Infratentorial tumours: features may include seizures, visual problems, headaches, muscle paralysis, respiratory changes, increased intracranial pressure, poor co-ordination and heating loss.
Other features included weight loss, growth failure and precocious puberty. Symptoms of raised intracranial pressure were absent in more than half of children with brain tumours.

Investigations

NB

- MRI and CT:
  - MRI is the preferred modality of imaging, as it provides better images and there is no radiation involved.\[7\]
  - However, compared to CT scanning it takes longer and the child may need sedating, as they are required to remain still for the entire procedure.
  - Usually contrast is also given to detect areas of damage to the blood brain barrier and highlight the extent of oedema around the tumour.
  - MRI will provide detailed information regarding the tumour size, location, extent, surrounding oedema and presence of hydrocephalus.

- Biopsy - often excision biopsy.
- Other investigations will depend on individual presentation but may include hearing tests and pituitary function tests.
- CSF analysis can reveal increased levels of human chorionic gonadotrophin (hCG) and alpha-fetoprotein (AFP) in pineal tumours and raised serial polyamines in recurrence of medulloblastoma before radiological detectable recurrence. However, lumbar puncture and CSF evaluation generally have little to add in the diagnosis of childhood brain tumours.

Management

Treatment will be determined by the tumour type and location as well as the age of the child. Treatment may involve surgery, chemotherapy and radiotherapy.\[7\]

Management also includes treatment of complications (eg, raised intracranial pressure, hydrocephalus, seizures, pituitary hormone deficiencies), support for the child and their family and addressing any associated psychological and educational difficulties.

Surgical resection

- Surgical resection is very important and recent data suggest that complete total resection, especially of gliomas, should always be the aim and is associated with improved survival in children.\[11\]
- However, complete resection of the tumour is very rarely achievable as the margins of most tumours are indistinct. This means that during surgical resection it becomes difficult to determine whether abnormal or normal tissue is being resected. Resection also allows for a biopsy to be taken which in some types of brain tumour alters therapy.
- Biopsy may be performed beforehand and usually direct open biopsy is preferred at the time of surgery although, for basal ganglia and brainstem lesions, stereotactic biopsies are taken. Pre-operatively, children may be given phenytoin to prevent seizures and corticosteroids to reduce brain oedema.
- Hydrocephalus is common postoperatively and therefore at the time of surgery an external ventricular drain or ventriculoperitoneal shunt is inserted which will be removed a few days later once the CSF clears.
- Very young children (under the age of 2 years) require radical resection as radiotherapy is delayed until they are older, as it will damage local normal tissue which is still developing. This is usually followed by chemotherapy.

Radiotherapy

- This is provided in low doses and to very localised areas to avoid damage to surrounding normal brain tissue. There are various techniques that can be employed - eg, gamma knife (used for slow-growing lesions) and interstitial seeds which are implanted during surgery.

Chemotherapy

- There are various chemotherapy regimens in use and they usually involve vincristine. In the rare primary CNS lymphoma, chemotherapy alone has been used with good outcomes.\[12\]
In low-grade gliomas, if residual disease remains after excision then chemotherapy has been used. Newer chemotherapeutic regimens are being used including vincristine, etoposide, cyclophosphamide and 5-fluorouracil.\textsuperscript{[13]}

Follow-up after treatment

Children have MRI scans every six months for the first two years and then annually (although this varies according to the centre and may become less frequent after the first few years).

Complications

- Intellectual decline - a recent study of 120 young patients with primary brain tumours showed a decline in sustained attention span and reaction times. This appeared to be caused by multiple factors including local tumour effects, surgery and radiotherapy. More recently, guidance on detecting and monitoring cognitive decline has been proposed.\textsuperscript{[14]}
- Growth hormone deficiency is common (thyroid hormone deficiency is less common).
- Neurological handicap may occur and be permanent.
- Increased risk of a second brain tumour 10-20 years down the line due to irradiation (eg, developing meningioma or sarcoma) - risk is increased if the brain is irradiated at a very young age.\textsuperscript{[15, 16]}
- Reduced bone mineral density of multifactorial origin.\textsuperscript{[17]}
- Cavernomas presenting as haemorrhagic lesions are increasingly being associated with CNS irradiation.\textsuperscript{[18]}

Prognosis\textsuperscript{[3]}

Earlier diagnosis of brain tumours in children and young adults improves long-term outcomes.\textsuperscript{[7]}

- Resection of the tumour may resolve seizures and headaches. The surgical mortality is 1% for a paediatric craniotomy. The morbidity is higher and depends on the child’s condition pre-operatively.
- Tumours of the brain and CNS are the most common cause of deaths from cancer in childhood, accounting for around a third of all cancer deaths in children.

Further reading & references

- Brain Tumours in Children Toolkit; Royal College of General Practitioners (2016)
- Children’s cancers incidence statistics; Cancer Research UK.


Disclaimer: This article is for information only and should not be used for the diagnosis or treatment of medical conditions. Patient Platform Limited has used all reasonable care in compiling the information but makes no warranty as to its accuracy. Consult a doctor or other healthcare professional for diagnosis and treatment of medical conditions. For details see our conditions.