Sacral hemangioblastoma

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Treatment

Although surgery can cure the majority of HBs, the disease shows a treatment-refractory challenge upon recurrence. HBs express a high amount of vascular endothelial growth factor (VEGF) which is responsible for angiogenesis and subsequently tumor progression. Anti-angiogenic treatment like bevacizumab has showed effect on HB, so we hypothesized that anlotinib could trigger HB regression via its inhibitory effect on VEGF.

Case reports

A 62-year-old woman with multiple recurrent lumbar and sacral cord HBs. She was treated with anlotinib (8mg qd d1-14, q3w) for three months and her follow up radiological examination demonstrated marked tumor regression which was evaluated as having partial response pursuant to RECIST 1.1 system. She is currently still receiving treatment of anlotinib orally and the lesions continuously reduced.

Anlotinib can cause significant radiographic response in a patient with multiple recurrent lumbar and sacral cord HBs for the first time. This might enable a novel therapeutic approach for patients with multiple recurrent HB or those with multiple lesions such as in VHL disease which are difficult to resect surgically [1)].

A 38-year-old woman with von Hippel-Lindau disease and a 10-year history of progressive back pain, as well as left lower-extremity pain and numbness. Neurological examination revealed decreased sensation in the left S-1 and S-2 dermatomes. Magnetic resonance imaging demonstrated a large enhancing lesion in the sacral region, with associated erosion of the sacrum. The patient underwent

arteriography and embolization of the tumor and then resection. The histopathological diagnosis was consistent with hemangioblastoma and showed intrafascicular tumor infiltration of the S-2 nerve root. At 1-year follow-up examination, pain had resolved and numbness improved. Sacral nerve root hemangioblastomas may be safely removed in most patients, resulting in stabilization or improvement in symptomatology. Generally, hemangioblastomas of the sacral nerve roots should be removed when they cause symptoms. Because they originate from the nerve root, the nerve root from which the hemangioblastoma originates must be sacrificed to achieve complete resection.

Case report from HGUA

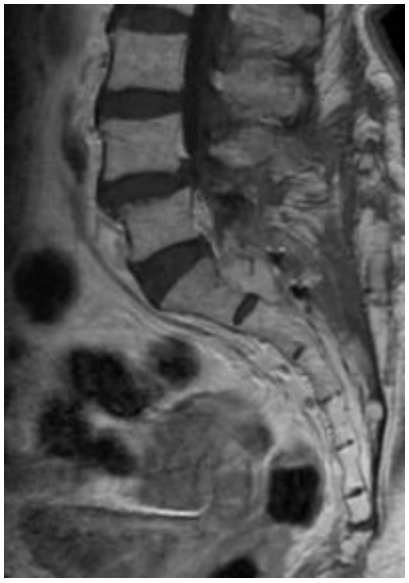
An 81-year-old woman She has hypothyroidism, chronic low back pain, and osteoporosis.

The patient underwent prone positioning on a Wilson's frame and underwent a laminectomy at L5 and laminoplasty at S1-S2. Flavectomy was performed at L4-L5-S1, and a lesion was found in the dural sac.

Excision of the lesion in multiple fragments (highly adhered to sacral roots although it seems to depend on the filum terminale, which is coagulated and cut. Bleeding lesion with difficult hemostasis throughout the surgery). Engorged vessels surrounding the lesion and adjacent roots are observed. Once the resection is finished (minimal tumor residue adhered to roots), surgical bed hemostasis is performed.

The dura mater was closed with Goretex and reinforced with Tachosil. Bone fragment S1-S2 was replaced with screws and plates. The muscles and subcutaneous tissue were closed with absorbable sutures, and the skin was closed with staples.

A review showed the growing of the residual hemangioblastoma on MRI.



Later there is significant radiological progression with an increase in size and extension of the tumor in the spinal canal at the S1-S2 level, showing signs of current infiltration of the sacrum affecting both the S1 vertebral body and, to a lesser extent, the S2, and extending towards the left sacral wing obliterating the left S1/S2 sacral foramen. Although the morphology of the tumor is convoluted, it measures at least 6.3 cm in cranio-caudal diameter, extending up to the superior endplate of L5 and the lower half of S2. The transverse diameter measures at least 6 cm and the antero-posterior diameter 4 cm, including sacral involvement.

1)

Jin N, Sun C, Hua Y, Wu X, Li W, Yin Y. Anlotinib for the Treatment of Multiple Recurrent Lumbar and Sacral Cord Hemangioblastomas: A Case Report. Front Oncol. 2022 Apr 27;12:859157. doi: 10.3389/fonc.2022.859157. PMID: 35574394; PMCID: PMC9092942.