A Primary Primitive Neuroectodermal Tumor of the Central Nervous System in a 51-year-old Woman: a Case Report and Literature Review

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Key words: primitive neuroectodermal tumor; central nervous system; magnetic resonance imaging; immunohistochemistry; CDKN2A gene deletion.

Summary. Primitive neuroectodermal tumors are a group of rare, aggressive, and highly malignant embryonal tumors of unknown etiology of the central and peripheral nervous systems. It is a term for a group of small round cell tumors thought to be derived from fetal neuroectodermal precursor cells. Primitive neuroectodermal tumor is usually described as a tumor of children younger than 15 years and is very rare in adults.

The article presents a short literature review and a rare case of a primary primitive neuroectodermal tumor of the central nervous system diagnosed in a 51-year-old woman.

Introduction

In 1973, Hart and Earle described the term of primitive neuroectodermal tumor (PNET) (1). PNET is a broad term that includes a wide array of lesions with varying differentiating potential affecting both the central and peripheral nervous systems. PNETs predominantly show a proliferation of undifferentiated or poorly differentiated neuroepithelial cells and, thus, are histologically similar to the much more common infratentorial medulloblastomas (2). These are small round cell tumors of neuroectodermal origin with high malignant potential (3). PNETs of the central nervous system (CNS) are uncommon malignant neoplasms of the cerebral hemispheres and suprasellar region and include supratentorial, infratentorial, brain stem, and spinal cord tumors (4). PNET usually occurs in children and only sporadically in adults (older than 20 years) (1) accounting for approximately 2.5% of brain tumors in children and 0.46% in adults (2). In the pediatric population, prognosis is worse than for infratentorial medulloblastoma. Older age appears to be prognostically favorable (5).

This article describes a rare case of a 51-year-old woman with a disseminated primary primitive neuroectodermal tumor of the CNS.

Case Report

A 51-year-old Lithuanian woman applied to a family doctor with progressive vision loss, vertigo, headache, and weakness in the legs lasting for two months. During clinical examinations, an ophthalmologist suspected a progressive edema in the ocular fundus, and a CT scan showed a tumor of the mesencephalic-pinealis region with internal occlusive hydrocephalus and brain edema. After such findings, the patient was referred to the Clinic of Neurosurgery, Hospital of the Lithuanian University of Health Sciences. Magnetic resonance imaging (MRI) revealed an irregularly shaped heterogeneous solid mass showing strong contrast enhancement and measuring 5 cm in maximal diameter in the quadrigeminal cistern. The tumor infiltrated the surrounding brain structures including the postero-medial temporal lobes and the posterior thalami, the quadrigeminal plate, and particularly the superior cerebellar vermis. The mass extended superiorly, but did not extensively infiltrate the pineal gland. The tumor showed protrusion into the posterior third and superior fourth cerebral ventricles causing mild occlusive hydrocephalus with mild periventricular edema (Fig. 1).

Pathological Findings. Histopathology revealed a highly cellular neoplasm. Tumor cells were small, poorly differentiated having hyperchromatic nuclei and little cytoplasm (Figs. 2A and 2B). In the pediatric population, prognosis is worse than for infratentorial medulloblastoma. Older age appears to be prognostically favorable (5).

This article describes a rare case of a 51-year-old woman with a disseminated primary primitive neuroectodermal tumor of the CNS.

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Medicina (Kaunas) 2011;47(8):440-5
for synaptophysin (Fig. 3B), chromogranin A (Fig. 3C), CD56, and neuron-specific enolase (Fig. 3D). Neurofilaments showed weak positivity. Some tumor cells expressed S-100 protein and glial fibrillary acidic protein. Tumor cells were negative for vimentin, CD99, and cytokeratin MNF116.

Molecular Genetics. Detection of Homozygous Deletion of CDKN2A. The status of cyclin-dependent kinase inhibitor 2A gene, CDKN2A, which regulates 2 cell cycle regulatory pathways, the p53 and RB (retinoblastoma) pathways, was also checked. The CDKN2A tumor suppressor locus on chromosome band 9p21 encodes p16INK4A protein, a negative regulator of cyclin-dependent kinases, and p14ARF protein, an activator of TP53 (p53), in an alternative reading frame. CDKN2A locus (p16INK4A and p14ARF) is inactivated in many human cancers by point mutation, promoter hypermethylation, and often deletion. Homozygous deletions are prevalent at this locus in very different human cancers.

Differential Polymerase Chain Reaction. Genomic DNA from frozen tumor tissue was extracted using a NucleoSpin Tissue® kit (Machery-Nagel, Germany). DNA from peripheral blood was extracted using the standard phenol-chloroform extraction method. Control blood DNA from peripheral blood of a healthy individual was used as a negative control, and DNA from human promyelocytic cell line NB4 was used as a positive control in each experiment. Screening for the homozygous deletion of p16INK4A (exon-1α) and p14ARF (exon-1β) was performed using the differential PCR analysis. β-Globin gene as an internal control was coamplified with either of the genes. The primer sequences were as follows: for detecting p16INK4A exon-1α, 5’-ACCGGAGGAAGAAAGGGAG-3’ (sense) and 5’-AGAATCGAAGCGCTACCTGA-3’ (antisense) (product size, 356 bp); p14ARF exon-1β, 5’-TCCCAGTCTGCAGTTAAGG-3’ (sense) and 5’-GTCTAAGTCGTTGTAACCCG-3’ (antisense) (product size, 447 bp); and β-globin, 5’-GAAGAGCCAAGGACAGGTAC-3’ (sense) and 5’-CAACTTCATCCACGTTCACC-3’ (antisense) (product size, 268 bp). The PCR reaction in a total volume of 25 µL for p16INK4A gene and 20 µL for p14ARF gene was carried out using 12.5 µL and 10 µL of PCR Master Mix (2X) (Thermo Fisher Scientific), respectively, 0.2 µM for each of p16INK4A primers, 0.25 µM for each of p14ARF primers, and 0.125 µM for each of β-globin primers. Besides, 2 µL of target DNA was added to the PCR reaction. In addition, 2.5% of DMSO was added to the PCR reaction of exon-1α of p16 gene. PCR conditions for the amplification of p16 gene consisted of 5-min denaturation at 95°C, 35 cycles of 30 s at 95°C, 1 min at 59.2°C, and 1 min at 72°C. PCR conditions for p14 gene consisted of 3-min denaturation at 95°C, 30 cycles of 1 min at 95°C, 1 min at 55°C,
Fig. 2. Photographs showing a cellular poorly differentiated tumor composed of small cells with hyperchromatic nuclei and little cytoplasm (hematoxylin-eosin).
A, magnification ×200; B, magnification ×400.

Fig. 3. Photographs of the tumors
A, Ki-67 staining (magnification ×200); B, immunohistochemical staining positive for synaptophysin (magnification ×400); C, immunohistochemical staining positive for chromogranin A (magnification ×400); and D, immunohistochemical staining positive for neuron-specific enolase (magnification ×400).
and 1 min at 72°C. PCR products were run on a 1.5% agarose gel and visualized under UV light after staining with ethidium bromide.

**Results**

Exon-1α of p16INK4A gene and exon-1β of p14ARF gene were amplified separately for homozygous deletions. No homozygous deletions were observed either for p16INK4A or p14ARF genes in the analyzed PNET (Fig. 4).

The bypass surgery with biopsy and partial tumor excision were performed. Postoperative period was comfortable and without complications. The patient refused to undergo chemotherapy. The patient was followed-up by specialists. Magnetic resonance imaging performed just 3 years after the surgery revealed tumor regrowth. The patient died 3 years and 8 months after the first surgery.

**Discussion**

Primitive neuroectodermal tumors (PNETs) include a heterogeneous group of tumors thought to originate from primitive or undifferentiated neuroepithelial cells that typically occur in pediatric patients and are rare in adult patients. The prototype of these tumors is a cerebellar medulloblastoma, which constitutes 13%–25% of all pediatric brain tumors (6) and, in contrast, only 1% of adult brain tumors. Hart and Earle described the term of primitive neuroectodermal tumor – PNET – in 1973 (1). Originally, PNET was considered as a cerebral high-grade undifferentiated neuroepithelial tumor of childhood, rarely demonstrating focal differentiation along glial and neuronal lines. However, the term was soon used for undifferentiated embryonal tumors of all CNS sites and all ages and was promoted by Rorke in 1983 (7, 8). According to literature, PNETs may occur in almost any location within or outside the central nervous system (9–11). PNETs recognized outside the CNS are diagnosed as peripheral PNETs (pPNET). CNS PNET and pPNET are different entities with different immunohistochemical profiles and genetic backgrounds. Clinically, they are both aggressive tumors, but exhibit different characteristics in their local manifestation and metastatic spread (CNS PNET metastasize rarely, <5%). However, the survival rates are quite similar (12). In the classification of tumors of the central nervous system provided by the WHO in 2007, the Working Group recommended to use a more general term PNET for similar tumors located in the brain stem and spinal cord and to add the prefix CNS to these entities in order to avoid any confusions concerning the localizations of extracerebral tumors (WHO grade IV) (13). CNS PNETs can be divided into 2 large groups: infratentorial tumors (medulloblastoma or iPNETs) and supratentorial tumors (sPNETs). All these tumor types are very rare in adult age. In the present case, the PNET tumor mass was disseminated and involved the supratentorial and infratentorial brain parts. Ohba et al. have recently reviewed 57 published cases of supratentorial PNETs (independently of tumor location). The mean age of these patients at diagnosis was 35.2 years with the peak between 20 and 30 years. Moreover, they also found a difference in the sex ratio (male:female, 32:23) (14). Primary intraspinal PNETs are an exceedingly rare entity.

![Fig. 4. CDKN2A locus (p16INK4A and p14ARF) study in the patient with primitive neuroectodermal tumor PNET, control blood sample, and NB4 cell line β-Globin gene (268 bp) was used as an internal control. Homozygous deletions of p16INK4A (A) and p14ARF (B).](image)

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These neoplasms can be found extradurally, extramedullary, intramedullary, and purely intramedullary (15). A recent literature research has revealed 28 cases reported (16). Only 10 cases of purely intraspinal PNETs have been reported with the mean age of 12.9 years, no sex differences, and no specific location in the spinal cord (4). Just few published cases reported PNETs of other localizations such as the kidneys, upper urinary tract (9), orbit (10), chest wall (11), and others (17).

Nowadays, PNET diagnostics is generally based on MRI and histological/immunohistochemical findings. Demonstrating the expression of MIC2 glycoprotein (CD99) by immunohistochemical staining showing the specific EWS-FLI1 chimeric gene presence in pPNET and PNET with mixed differentiation by other specific stainings (CD34, CD45, CD20, etc.) offers an easy way of making a differential diagnosis within and between CNS PNET and pPNET (12). These tumors, which express MIC2 gene (CD99), seem to be least aggressive after complete resection (10). Pfister et al. (2007) were interested in molecular genetic status of pediatric supratentorial PNETs and medulloblastomas (18). They found that CDKN2A deletions tended to be associated with metastatic disease at diagnosis (Fisher test, \(P=0.07\)). Heterozygous deletions of 9p21.3 were detected in 3.5% of medulloblastomas and in 14% of supratentorial PNETs, whereas homozygous deletions were not observed in any medulloblastoma, but in 19% of supratentorial PNETs (Fisher exact test, \(P<0.001\)). All patients with heterozygous deletions of 9p21.3 died within 4 years after surgical resection (18). Inda et al. reported no homozygous deletion of either p16INK4 or p14ARF in any of the PNET samples (19). Like in previously reported cases, no homozygous deletions of either p16INK4a or p14ARF were observed in the present case of PNET. In addition, the expression of genes p16INK4a and p14ARF can be measured at the protein level by immunohistochemistry (in this case, immunohistochemistry has not been performed because of lack of certain resources and possibilities). Pfister et al. (2007) identified other aberrations such as a copy-number gain of chromosome region 20q13.33 and UNC5C or UNC5B loci, and large-scale losses on chromosome arms 1p, 9p, 16q, and 17p, and others by applying fluorescence in situ hybridization and array-based comparative genomic hybridization. With reference to these findings, they suggested genetic differences existing between supratentorial PNETs and medulloblastomas, which will be an important line of future research to identify the cell origin for both the tumor entities and the molecular pathways in their development (18).

Conclusions

Primitive neuroectodermal tumors originate from primitive or undifferentiated neuroepithelial cells that usually occur in pediatric patients and are extremely rare in adult patients worldwide. Therefore, for the first time in Lithuania, one case of rare adult PNET of the central nervous system with typical immunohistochemical findings has been reported.

The diagnostics of primitive neuroectodermal tumors does not differ from other types of the central nervous system tumors. In accordance with patient clinical status, complete tumor excision, chemotherapy, and radiotherapy are performed as a treatment standard with different survival prognosis.

Acknowledgments

We thank Dr. Augustas Pivoriūnas from the Department of Experimental and Clinical Medicine, State Research Centre for Innovative Medicine, Lithuania, for kindly providing NB4 cell line. We also thank Evaldas Keleras from the Department of Radiology, Medical Academy, Lithuanian University of Health Sciences.

Statement of Conflict of Interest

The authors state no conflict of interest.

Medicina (Kaunas) 2011;47(8)
Primityvus neuroektoderminis centrinės nervų sistemos navikas, diagnozuotas 51 metų pacientei

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Raktažodžiai: primityvus neuroektoderminis navikas, centrinė nervų sistema, branduolinis magnetinis rezonansas, imunohistochemija, CDKN2A geno delecija.

Santrauka. Primityvus neuroektoderminis navikas (PNET) yra vienas iš retų ir itin agresyvių nežinomos etiologijos centrinės ir periferinės nervų sistemos navikų. Šiuo terminu apibūdinami navikai sudaryti iš apvalių, smulkųų ląstelių, kilusių iš pirminių neuroektoderminių vaisiaus audinių. PNET navikai dažniausiai diagnozuojami į jaunesniemis nei 15 metų vaikams, ypač retai svaigusiems. Straipsnyje aptariamas itin retas centrinės nervų sistemos primityvaus neuroektoderminio navikų diagnozuoto 51 metų pacientei, klininkis atvejis bei pateikiami trumpa literatūros apžvalga.

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