Case Study 3

1. Case Study 3

1.1 Case Study 3



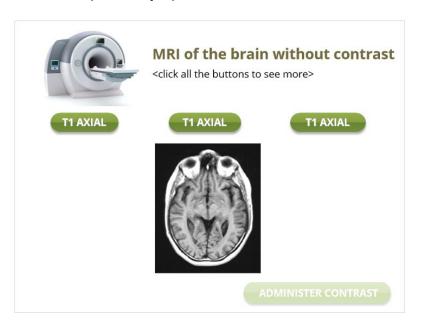
1.2 Pre-contrast MR



T1 Axial 3 (Slide Layer)



T2 Axial 2 (Slide Layer)

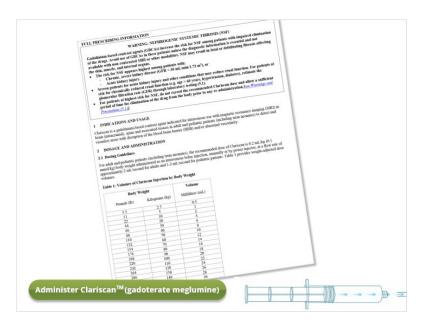


T1 Axial 1 (Slide Layer)



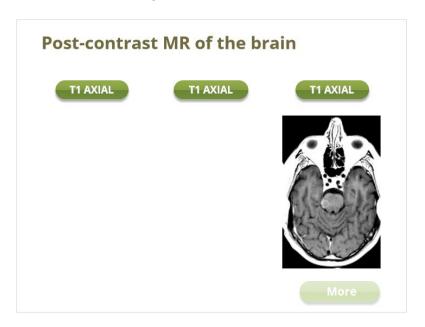
1.3 Administer Contrast

Syringe (Slide Layer)

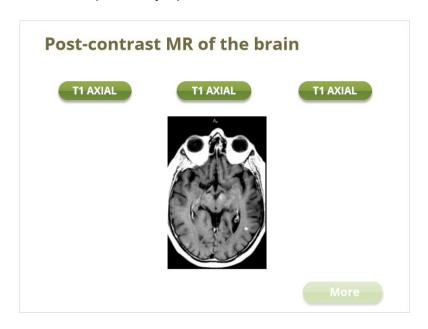


1.4 Post-contrast MR of the brain

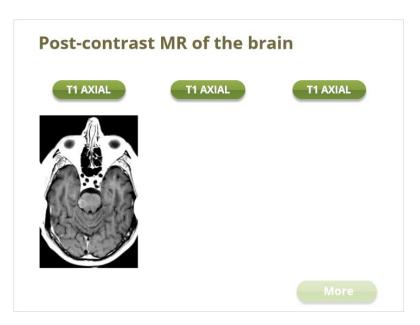
T1 Axial 3 (Slide Layer)



T1 Axial 2 (Slide Layer)

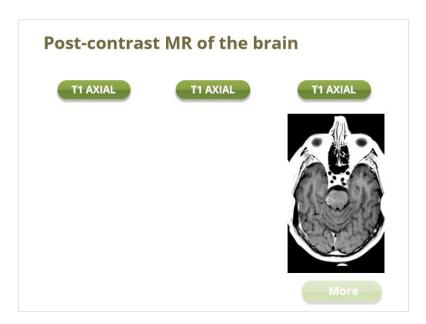


T1 Axial 1 (Slide Layer)

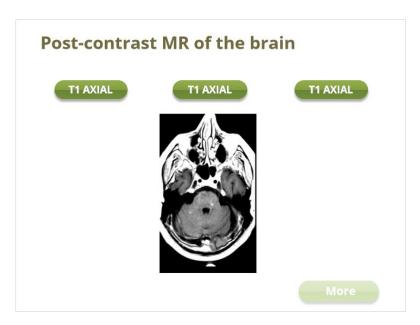


1.5 Post-contrast MR of the brain

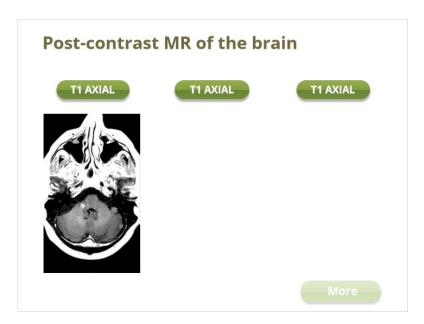
T1 Axial 3 (Slide Layer)



T1 Axial 2 (Slide Layer)



T1 Axial 1 (Slide Layer)

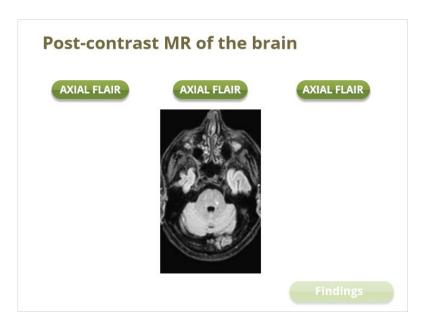


1.6 Post-contrast MR of the brain

T1 Axial 3 (Slide Layer)



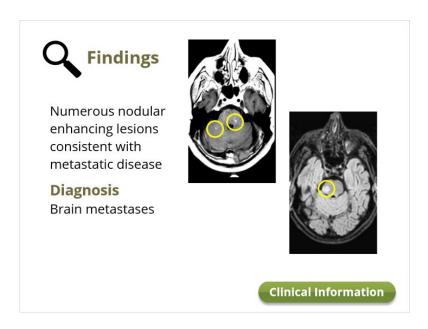
T1 Axial 2 (Slide Layer)



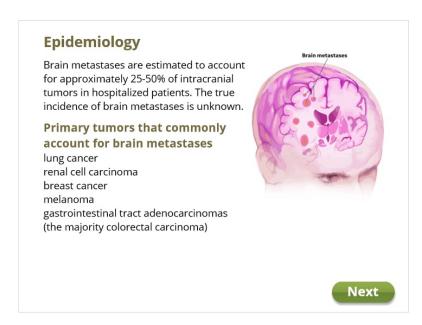
T1 Axial 1 (Slide Layer)



1.7 Findings



1.8 Clinical information



1.9 Clinical information

Clinical presentation

These patients can commonly present with headaches, seizures, mental status alterations, ataxia, nausea and vomiting, and visual disturbances. However, up to 60-75% of patients can be asymptomatic at the time of imaging.

Radiographic features

1.10 Radiographic features

Radiographic features: MRI

Brain metastases can vary in imaging appearance, make it challenging to evaluate these lesions on cross-sectional imaging. They often occur at the grey-white matter junction.

T1

Typically iso- to hypointense

T1 C+

Enhancement pattern can be uniform, punctate, or ringenhancing, but it is usually intense. Delayed sequences may show additional lesions, therefore contrast-enhanced MR is the current standard for small metastases detection

T2

Typically hypointense

FLAIR

Typically, hyperintense with hyperintense peri-tumoral edema

Treatment

1.11 Treatment and prognosis

Treatment and prognosis



Symptomatic treatment

Corticosteroids are given to limit the effects of peritumoral edema. Hyperosmolar agents (e.g., mannitol) can be given to decrease ICP and anticonvulsants are given to prevent seizures.

Therapeutic treatment

Radiation (whole brain external beam or stereotactic for smaller masses), chemotherapy, and surgical resection may be done to prolong survival and palliate symptoms.

Prognosis

Overall, patients with brain metastases typically have a mean survival of one month without treatment. With treatment, survival improves, but it is still dismal. The mean age of survival is still less than one year, although in some patients with solitary metastases longer survival is encountered.

References

1.12 References

References:

- Barnholtz-Sloan JS, Sloan AE, Davis FG et-al. Incidence proportions of brain metastases in patients diagnosed (1973 to 2001) in the Metropolitan Detroit Cancer Surveillance System. J Clin Oncol. 2004;22 (14): 2865-2872. doi:10.1200/JCO.2004.12.149
- 2. Fink KR, Fink JR. Imaging of brain metastases. Surg Neurol Int. 2013;4 (Suppl 4): S209-S219.
- 3. Soffietti R, Cornu P, Delattre JY et-al. EFNS Guidelines on diagnosis and treatment of brain metastases: report of an EFNS Task Force. *Eur J Neurol*. 2006;13 (7): 674-81. doi:10.1111/j.1468-1331.2006.01506.x
- Kaal EC, Taphoorn MJ, Vecht CJ. Symptomatic management and imaging of brain metastases. J Neurooncol. 2005;75 (1): 15-20. doi:10.1007/s11060-004-8094-5-Pubmed citation.



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