Sporadic Pituitary Stalk Hemangioblastoma: A Rare Case Report and Review of the Literature

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Abstract

Supratentorial hemangioblastomas have rarely been described in the literature. Pituitary stalk hemangioblastomas are extremely rare and almost always are associated with von Hippel Lindau disease. Herein, we report a sporadic case of pituitary stalk hemangioblastoma in a 36-year-old male and review the current literature regarding this pathology. In our case, complete resection of the lesion was achieved using the transglabellar approach.

Categories: Endocrinology/Diabetes/Metabolism, Pathology, Neurosurgery
Keywords: hemangioblastoma, sporadic, transglabellar approach, pituitary stalk, von hippel lindau

Introduction

Hemangioblastomas are histologically benign tumors of vascular origin that are usually cystic, occur in the cerebellum, and represent approximately 2% of all intracranial tumors [1-3]. Supratentorial hemangioblastomas are exceedingly rare, with only 116 cases reported in the literature from 1902 to 2004 [1,4-5]. In 50% of hemangioblastomas, there is an association with von Hippel Lindau (VHL) disease [2-3]. Von Hippel-Lindau complex, or von Hippel-Lindau syndrome, is a genetic disorder with an autosomal dominant inheritance pattern with variable penetrance characterized also by retinal angiomatosis, multiple renal, pancreatic, or hepatic cysts, pheochromocytoma, renal cancer, and the potential for malignant transformation in multiple organ systems. Sporadic pituitary stalk hemangioblastomas are extremely rare and almost always are associated with VHL disease.

Case Presentation

We present a 36-year-old male who was admitted to our department due to the gradual worsening of the left eye vision. Ophthalmologic evaluation of the patient’s retina showed no remarkable findings while ocular examination showed visual acuity 8/10 on the right eye and 1/10 on the left eye. The formal visual field testing, by using the standard goldman perimetry study, revealed a left upper temporal quadrant deficit. Further neurological examination was normal. No endocrine dysfunction was identified preoperatively. Brain computed tomography (CT) scan revealed a sellar mass with sellar enlargement and dorsum sella erosion (Figure 1). Further investigation with brain magnetic resonance imaging (MRI) demonstrated a 3 cm sellar mass, intensely and homogeneously enhancing after the intravenous (IV) administration of gadolinium, with suprasellar extension, inferior displacement of the infundibulum, and upward displacement of the optic chiasm and anterior communicating artery complex (Figures 2-4).
FIGURE 1: Preoperative CT

CT: computed tomography
FIGURE 2: Preoperative axial T2
FIGURE 3: Preoperative axial T1
The patient underwent a surgical operation via a transglabellar approach (Figures 5-6). A highly vascularized tumor was recognized and total resection was achieved (Figures 7-8). The excised surgical specimen was sent for histology (Figures 9-15).
**FIGURE 7: Intraoperative images demonstrating the optic chiasm, anterior cerebral artery, and tumor**

Intraoperative image showcasing the suprasellar tumor (black asterisk), the left A1 being displaced by the tumor (black arrow) and the left optic nerve and optic chiasm (white arrow).

**FIGURE 8: Intraoperative images demonstrating tumor removal**

Intraoperative image showing the left A1 artery (white arrow) and the left optic nerve and optic chiasm (black arrow) being decompressed after tumor resection.
FIGURE 9: H&E: no evidence of meningothelial differentiation is identified

H&E: hematoxylin and eosin

FIGURE 10: EGFR and NSE immunohistochemistry

Immunohistochemistry studies revealed: a) positive staining for epidermal growth factor receptor (EGFR) and b) limited staining for neuron-specific enolase (NSE)
FIGURE 11: H&E confluence of large, pleomorphic stromal cells interlaced by fine-caliber capillaries

Histological appearance of infundibulum hemangioblastoma with numerous stromal cells (white arrow) between thin-walled vessels (black arrow) and vacuolated histiocytes (black cross) (hematoxylin and eosin (H&E), original magnification x 200)

FIGURE 12: H&E: biphasic appearance of vascular structures and stromal cells

H&E: hematoxylin and eosin
FIGURE 13: The stromal cells reveal immunoreactivity for vimentin

FIGURE 14: Immunostain for pancytokeratin

Immunohistochemistry study revealed the nonreactivity of hemangioblastoma for pancytokeratin
Histopathological examination of the tumor showed a cellular proliferation of stromal cells, interlaced by numerous thin-walled vessels, foam, and vacuolated histiocytes. No mitoses were identified. In histochemical and immunohistochemical stains, stromal cells were positive to vimentin and epidermal growth factor receptor (EGFR) and in limited locations, also positive in EMA and neuron-specific enolase (NSE) while negative in CK7, CK20, CK 5/6, glial fibrillary acidic protein (GFAP), pancytokeratin, CK34βE12, S-100, and α-inhibin. The cellular proliferation index ki67 was less than 1%. Differential diagnosis included angiomatous meningioma, angioblastic meningioma, transitional angioblastic, and angioblastomatous meningioma. The overall histological diagnosis was capillary hemangioblastoma (World Health Organization (WHO) Grade I).

Postoperatively, the patient had considerable improvement in his visual acuity and temporal quadrant deficit. Except for transient diabetes insipidus, the rest of the postoperative course was uneventful, including any endocrine dysfunction.

After the histological diagnosis, initially, VHL syndrome was excluded via further imaging studies, including ophthalmic ultrasonography, abdominal, cervical, thoracic, and lumbar MRI. Although imaging studies were negative for other tumors and there was no known family history, genetic screening was suggested to the patient for von Hippel-Lindau gene mutations. No residual tumor was recognized in the brain MRI six months after surgery and the genetic test was negative for VHL mutations (Figure 16).
Hemangioblastomas are benign lesions that originate from the vascular system and have been reported in a variety of locations in the central nervous system. These tumors present as either isolated or multiple lesions. Isolated lesions occur in 80% of patients with VHL syndrome, and in 95% of patients without this disease. They are usually found in the cerebellum, but they have also been reported in the spinal cord, the brain stem, and, in rare cases, in the cerebrum. Typically, patients in the fourth and fifth decades are affected, but there are also reports of congenital lesions. There are only 132 previous reports in the literature of supratentorial hemangioblastomas [6]. Reports of intrasellar [7], suprasellar [8], and intraventricular locations [9] have been documented. Although histologically benign, occasionally, the tumor may spread along the subarachnoid space and especially after a surgical procedure, but no metastases have been testified. Histopathologically, they are characterized by two major components: vacuolated stromal cells and a capillary network. They do not have a true capsule, but the tumor margin is well-circumscribed and may be either cystic or solid.

Von Hippel-Lindau disease is positively correlated with supratentorial hemangioblastomas when compared with non-supratentorial central nervous system hemangioblastomas, particularly when present in the sellar/suprasellar region [6]. Pituitary stalk hemangioblastomas are strongly associated with VHL disease and their occurrence outside the VHL syndrome is a rare phenomenon. To our best of knowledge, after searching Pubmed/MEDLINE, only nine sporadic cases of pituitary stalk hemangioblastomas, including our case were found (summarized in Table 1) [10–20]. In general, pituitary stalk hemangioblastomas are indistinguishable from craniopharyngiomas based on MRI findings, making the preoperative diagnosis of hemangioblastoma extremely challenging. Both tumors can be isointense on T1-weighted sequences, hyperintense on T2-weighted sequences, or homogeneously enhancing after gadolinium administration. In some cases, flow voids can be identified, orientating the diagnosis towards hemangioblastoma. Angiography can be used as a tool for the differential diagnosis, revealing a highly vascularized tumor in the case of hemangioblastoma.
### Surgical resection (open or endoscopic) of these lesions is necessary when they become symptomatic, usually presenting with visual defects and endocrine dysfunction. Due to their high vascularity, open craniotomy is generally preferred in order to prevent uncontrolled bleeding and partial excision, but this approach results more often in pituitary stalk excision as compared to the transsphenoidal approach [7,9,16]. Total removal should be the main surgical goal, as these benign neoplasms tend to easily recur after partial excision. The role of radiotherapy is yet to be determined as an adjuvant treatment modality in cases of sporadic sellar/suprasellar hemangioblastomas [7,13].

## Conclusions

Our study reports the ninth case of sporadic pituitary stalk hemangioblastoma, in which total resection was achieved by the transglabellar approach that is not so commonly used. Preoperative imaging should be

<table>
<thead>
<tr>
<th>Study</th>
<th>Age (years), sex</th>
<th>Location of hemangioblastoma</th>
<th>Clinical presentation on admission</th>
<th>Endocrine disturbances on admission</th>
<th>Imaging</th>
<th>Management</th>
<th>Postoperative clinical presentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grisoli et al., 1984</td>
<td>26, F</td>
<td>Pituitary stalk</td>
<td>Bilateral galactorrhea, frontotemporal headaches</td>
<td>Mild elevation of PRL</td>
<td>CT, angiography</td>
<td>Right frontal craniotomy, GTR</td>
<td>Panhypopituitarism, PRL levels unchanged</td>
</tr>
<tr>
<td>Neumann et al., 1989</td>
<td>35, F</td>
<td>Pituitary stalk</td>
<td>Headache, amenorrhea, polyuria</td>
<td>Diabetes insipidus</td>
<td>CT, angiography</td>
<td>Not mentioned</td>
<td>Not mentioned</td>
</tr>
<tr>
<td>Sassen et al., 1988</td>
<td>11, F</td>
<td>Sellar &amp; suprasellar</td>
<td>Headache, bilateral temporal hemianopia</td>
<td>Low ACTH, low GH, mild elevation of PRL</td>
<td>MRI</td>
<td>Transphenoidal approach converted to right subfrontal craniotomy + adjuvant radiotherapy</td>
<td>Improvement of visual loss, hypothyroidism, central diabetes insipidus</td>
</tr>
<tr>
<td>Iseda et al., 2001</td>
<td>62, M</td>
<td>Sellar &amp; suprasellar</td>
<td>Visual disturbance of left eye</td>
<td>None</td>
<td>MRI, angiography</td>
<td>Not mentioned</td>
<td>Paraparesis due to concomitant thoracic tumor</td>
</tr>
<tr>
<td>Rumboldt et al., 2003</td>
<td>60, M</td>
<td>Sellar &amp; suprasellar</td>
<td>Bilateral hemianopia</td>
<td>None</td>
<td>MRI, MRA</td>
<td>Extended endoscopic transphenoidal approach, GTR</td>
<td>Uneventful</td>
</tr>
<tr>
<td>Peker et al., 2005</td>
<td>54, M</td>
<td>Pituitary stalk</td>
<td>Gradual visual loss of the right eye, temporal hemianopsia of the left eye</td>
<td>None</td>
<td>CT, MRI</td>
<td>Right pterional craniotomy, GTR</td>
<td>Improvement of vision in the left eye</td>
</tr>
<tr>
<td>Fu et al., 2011</td>
<td>40, M</td>
<td>Pituitary stalk</td>
<td>Headache, vomiting, polydipsia, polyuria</td>
<td>None</td>
<td>MRI</td>
<td>Right frontotemporal craniotomy, GTR</td>
<td>Panhypopituitarism</td>
</tr>
<tr>
<td>Xie et al., 2013</td>
<td>64, F</td>
<td>Sellar &amp; suprasellar</td>
<td>Headache, bilateral temporal hemianopsia</td>
<td>Low FSH, LH</td>
<td>CTA, MRI</td>
<td>Extended endoscopic transphenoidal approach, subtotal resection</td>
<td>Cerebrospinal fluid leak, communicating hydrocephalus, improvement of visual loss</td>
</tr>
<tr>
<td>Li et al., 2015</td>
<td>51, F</td>
<td>Pituitary stalk</td>
<td>Headache, bilateral visual disturbance, visual defect of the left eye</td>
<td>Mild hypocortisolism</td>
<td>MRI</td>
<td>Left pterional craniotomy, GTR</td>
<td>Improvement of left eye vision, panhypopituitarism</td>
</tr>
<tr>
<td>Lee et al., 2015</td>
<td>60, F</td>
<td>Pituitary stalk</td>
<td>Headache, dizziness</td>
<td>None</td>
<td>MRI</td>
<td>Right frontotemporal craniotomy, GTR</td>
<td>Improvement of symptoms</td>
</tr>
<tr>
<td>Pakdaman et al., 2017</td>
<td>38, F</td>
<td>Pituitary stalk</td>
<td>Headache, amenorrhea</td>
<td>Low FSH, LH</td>
<td>MRI</td>
<td>Endoscopic transnasal, transphenoidal approach, GTR</td>
<td>Not mentioned</td>
</tr>
<tr>
<td>Alsabati et al., 2016</td>
<td>60, F</td>
<td>Pituitary stalk</td>
<td>Headache, diplopia, left 6th nerve palsy</td>
<td>Hypocortisolism, low ACTH</td>
<td>MRI</td>
<td>Right orbitozygomatic craniotomy, GTR</td>
<td>Resolution of 6th cranial nerve palsy</td>
</tr>
<tr>
<td>Our case</td>
<td>36, M</td>
<td>Pituitary stalk</td>
<td>Visual loss of the left eye</td>
<td>None</td>
<td>MRI</td>
<td>Transglabellar approach</td>
<td>Transient diabetes insipidus, improvement of left eye vision</td>
</tr>
</tbody>
</table>

### TABLE 1: Literature review of sporadic pituitary stalk and suprasellar hemangioblastomas

CT: computed tomography; PRL: prolactin; GTR: gross total resection; ACTH: adrenocorticotropic hormone; GH: growth hormone; MRI: magnetic resonance imaging; MRA: magnetic resonance angiogram; FSH: follicle-stimulating hormone; LH: luteinizing hormone
References

Disclosures

Human subjects: Consent was obtained by all participants in this study. Conflicts of interest: In compliance with the ICMJE uniform disclosure form, all authors declare the following: Payment/services info: All authors have declared that no financial support was received from any organization for the submitted work. Financial relationships: All authors have declared that they have no financial relationships at present or within the previous three years with any organizations that might have an interest in the submitted work. Other relationships: All authors have declared that there are no other relationships or activities that could appear to have influenced the submitted work.

Additional Information