Recurrent glioblastoma treatment

Less than 10% of recurrent gliomas recur away from the original tumor site \(^1\).

Reoperation extends survival by an additional 36 weeks in patients with glioblastoma, and 88 weeks in anaplastic astrocytoma \(^2\) \(^3\) (duration of high quality survival was 10 weeks and 83 weeks, respectively, and was lower with pre-op Karnofsky score < 70). In addition to Karnofsky performance score, significant prognosticators for response to repeat surgery include: age and time from the first operation to reoperation (shorter times → worse prognosis) \(^4\). Morbidity is higher with reoperation (5–18%); the infection rate is ≈ 3x that for first operation, wound dehiscence is more likely

The standard of care management for newly diagnosed GBM includes surgery, radiation, temozolomide (TMZ) chemotherapy, and tumor treating fields \(^5\).

There is no consensus as to the standard of care as no therapeutic options have produced substantial survival benefit for recurrent glioblastomas (GBMs) \(^6\) \(^7\).

A purely radiological diagnosis of recurrence or progression can be hampered by flaws induced by pseudoprogression, pseudoresponse, or radionecrosis.

Based on parameters like localization and tumor volume, patient’s Karnofsky Performance Score, time from initial diagnosis, and availability of alternative salvage therapies, reoperation can be considered as a treatment option to extend the overall survival and quality of life of the patient.

The achieved extent of resection of the relapsed tumor—especially with the intention of having a safe, complete resection of the enhancing tumor—most likely plays a crucial role in the ultimate outcome and prognosis of the patient, regardless of other modes of treatment. Validated scores to predict the prognosis after reoperation of a patient with a recurrent glioblastoma can help to select suitable candidates for surgery. Safety issues and complication avoidance are pivotal to maximally preserve the patient’s quality of life. Besides a possible direct oncological effect, resampling of the recurrent tumor with detailed pathological and molecular analysis might have an impact on the development, testing, and validation of new salvage therapies \(^8\).

Options

Options include repeat surgical resection, repeat fractionated radiation, radiosurgery.

Bevacizumab (BEV) plus daily temozolomide (TMZ) as a salvage therapy have been recommended to recurrent glioma.

Given the lack of consensus on optimal management of recurrent GBM, knowledge of care patterns used for these patients and the criteria used to determine therapeutic strategy is germane to clinicians who care for these patients.

In a study, Hundsberger et al investigated which treatments are currently being used for recurrent GBM within a single nation (Switzerland) and how clinicians are deciding to use them \(^9\).
The authors surveyed Swiss hospitals with comprehensive multidisciplinary neuro-oncology practices (neurosurgery, radiation therapy, medical neuro-oncology, and a dedicated neuro-oncology tumor board) about treatment recommendations for recurrent GBM. They identified relevant clinical decision-making criteria, called diagnostic nodes or “dodes,” and compared treatment recommendations using a decision-tree format.

Eight hospitals participated. The most common treatment options for recurrent GBM were combination repeat surgical resection with temozolomide or bevacizumab, monotherapy temozolomide or bevacizumab, and best supportive care. Alternative therapies, including radiotherapy, were less common. Despite widespread disagreement between centers in clinical decision making, the decision-tree analysis found agreement (>63%) between most centers for only 4 specific clinical scenarios. Patients without an appropriate performance status were usually managed with best supportive care. Patients with rapid recurrence, nonresectable tumors, unmethylated O(6)-methylguanine DNA methyltransferase (MGMT) promoter, and high performance status were usually managed with bevacizumab. Patients with late recurrence, nonresectable tumors, overt clinical symptoms, methylated MGMT promoter, multifocal disease, and high performance status were usually managed with repeat temozolomide therapy. Patients with late recurrence, nonresectable tumors, no clinical symptoms, methylated MGMT promoter, tumor multifocality, and high performance status were usually managed with temozolomide. The findings of this study underscore the lack of effective first- and second-line treatments for GBM, and the interhospital variability in practice patterns is not surprising. It seems likely that similar heterogeneity would also be noted in a study of American neuro-oncology centers. It is interesting to note that despite the availability of an increasing number of molecular markers for GBM stratification, MGMT promoter methylation appears to be the only biological marker widely used across multiple centers in this study. It remains to be seen when and how broadly other markers such as the epidermal growth factor receptor variant III or isocitrate dehydrogenase mutations will be adopted for clinical decision making. The authors are to be congratulated for identifying core clinical decision-making criteria that may be useful in future studies of recurrent GBM. This decision tree is an excellent reference for clinical trial development, and several active clinical trials already target the dodes identified in this study. Subsequent studies may help to determine whether similar decision trees exist in American neuro-oncologic centers now or will exist in the future.¹⁰

Resection

see Recurrent glioblastoma resection.

Temozolomide

Temozolomide rechallenge is a treatment option for MGMT promoter-methylated recurrent glioblastoma. Alternative strategies need to be considered for patients with progressive glioblastoma without MGMT promoter methylation 11).
Intraarterial chemotherapy

Intraarterial chemotherapy is a viable methodology in recurrent GBM patients to prolong survival at the risk of procedure-related complications and in newly diagnosed patients with the benefit of decreased complications.[12]

Low-dose fractionated radiotherapy LD-FRT and chemotherapy for recurrent/progressive GBM have a good toxicity profile and clinical outcomes, even though further investigation of this novel palliative treatment approach is warranted.[13]

Second surgery plus carmustine wafers followed by intravenous fotemustine

Second surgery plus carmustine wafers followed by intravenous fotemustine in twenty-four patients were analyzed. The median age was 53.6; all patients had KPS between 90 and 100; 19 patients (79%) performed a gross total resection > 98% and 5 (21%) a gross total resection > 90%. The median progression-free survival from second surgery was 6 months (95% CI 3.9-8.05) and the median OS was 14 months (95% CI 11.1-16.8 months). Toxicity was predominantly haematological: 5 patients (21%) experienced grade 3-4 thrombocytopenia and 3 patients (12%) grade 3-4 leukopenia.

This multimodal strategy may be feasible in patients with recurrent glioblastoma, in particular, for patients in good clinical conditions.[14]

Immunotherapy

The HSPPC-96 vaccine is safe and warrants further study of efficacy for the treatment of recurrent GBM. Significant pretreatment lymphopenia may impact the outcomes of immunotherapy and deserves additional investigation.[15]

Laser induced interstitial thermotherapy

see Laser interstitial thermotherapy.

Galldiks et al monitored the metabolic effects of stereotaxy-guided LITT in a patient with a recurrent GBM using amino acid positron emission tomography (PET). Serial 11C-methyl-L-methionine positron emission tomography (MET-PET) and contrast-enhanced computed tomography (CT) were performed using a hybrid PET/CT system in a patient with recurrent GBM before and after LITT. To monitor the biologic activity of the effects of stereotaxy-guided LITT, a threshold-based volume of interest analysis of the metabolically active tumor volume (MET uptake index of ≥ 1.3) was performed. A continuous decline in metabolically active tumor volume after LITT could be observed. MET-PET seems to be useful for monitoring the short-term therapeutic effects of LITT, especially when patients have been pretreated with a multistep therapeutic regimen. MET-PET seems to be an appropriate tool to monitor and guide experimental LITT regimens and should be studied in a larger patient group to confirm its clinical value.[16]

Outcome

A more favorable prognosis following surgery for recurrence or progression is associated with younger age, smaller tumor volume (~50%), motor speech-middle cerebral artery scoring and preoperative Karnofsky performance score (KPS) >80%.[17][18]
Reviews

Optimal treatment for recurrent high grade glioma continues to evolve. Currently, however, there is no consensus in the literature on the role of reoperation in the management of these patients.

In a analysis, of reoperation in patients with World Health Organization grade III or IV recurrent gliomas, focusing on how reoperation affects outcome, perioperative complications, and quality of life. An extensive literature review was performed through the use of the PubMed and Ovid Medline databases for January 1980 through August 2013. A total 31 studies were included in the final analysis. Of the 31 studies with significant data from single or multiple institutions, 29 demonstrated a survival benefit or improved functional status after reoperation for recurrent high-grade glioma. Indications for reoperation included new focal neurological deficits, tumor mass effect, signs of elevated intracranial pressure, headaches, increased seizure frequency, and radiographic evidence of tumor progression. Age was not a contraindication to reoperation. Time interval of at least 6 months between operations and favorable performance status (Karnofsky Performance Status score ≥70) were important predictors of benefit from reoperation. Extent of resection at reoperation improved survival, even in patients with subtotal resection at initial operation. Careful patient selection such as avoiding those individuals with poor performance status and bevacizumab within 4 weeks of surgery is important. Although limited to retrospective analysis and patient selection bias, mounting evidence suggests a survival benefit in patients receiving a reoperation at the time of high-grade glioma recurrence.

Case series

2018

Twenty patients with recurrent glioma were treated with BEV (5-10 mg/kg, i.v. every 2 weeks) plus daily TMZ (daily, 50 mg/m2). The treatment response was evaluated via the RANO criteria. HRQL were measured using the European Organization for Research and Treatment of Cancer Quality of Life Questionnaire core 30 (QLQ-C30) and Brain Module (QLQ-BN20).

Twenty patients received a total of 85 cycles of BEV with a median number of 4 cycles (range: 2-10). No patients showed complete response (CR) to treatment. Twelve patients had partial response (PR), stable disease (SD) in 5 patients with, and 3 patients showed progressive disease (PD). In the functioning domains of QLQ-C30, physical functioning, cognitive functioning and emotional functioning significantly improved after the second cycle of BEV compared to baseline, with the mean score of 45.0 vs. 64.0 (p = 0.020), 55.8 vs. 71.7 (p = 0.020) and 48.3 vs. 67.5 (p = 0.015), respectively. In the symptom scales, the scores of pain and nausea/vomiting significantly decreased compared to baseline from the mean score of 39.1 to 20.0 (p = 0.020) and 29.2 to 16.7 (p = 0.049), respectively. Score of global health status also increased from 47.5 to 63.3 (p = 0.001). As determined with the QLQ-BN20, motor dysfunction (43.3 vs. 25.0, p = 0.021), weakness of legs (36.7 vs. 18.3, p = 0.049), headache (38.3 vs. 20.0, p = 0.040), and drowsiness (50.0 vs. 30.0, p = 0.026) after the second cycle of BEV also significantly improved compared to baseline.

BEV plus daily TMZ as a salvage therapy improved HRQL in patients with recurrent glioma.

References

2016

Quick-Weller et al. performed tumour resections in seven patients with rGBM, combining 5-ALA
(20 mg/kg bodyweight) with iMRI (0.15 T). Radiologically complete resections were intended in all seven patients.

They assessed intraoperative fluorescence findings and compared these with intraoperative imaging. All patients had early postoperative MRI (3 T) to verify final iMRI scans and received adjuvant treatment according to interdisciplinary tumour board decision.

Median patient age was 63 years. Median KPS score was 90, and median tumour volume was 8.2 cm(3). In six of seven patients (85%), 5-ALA induced fluorescence of tumour-tissue was detected intraoperatively. All tumours were good to visualise with iMRI and contrast media. One patient received additional resection of residual contrast enhancing tissue on intraoperative imaging, which did not show fluorescence. Radiologically complete resections according to early postoperative MRI were achieved in all patients. Median survival since second surgery was 7.6 months and overall survival since diagnosis was 27.8 months.

5-ALA and iMRI are important surgical tools to maximise tumour resection also in rGBM. However, not all rGBMs exhibit fluorescence after 5-ALA administration. They propose the combined use of 5-ALA and iMRI in the surgery of rGBM.1


