Intracerebral schwannomas: a rare disease with varying natural history 

Report of 3 cases

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Although intracerebral schwannomas are typically regarded as benign intracranial tumors, malignancy and recurrence have been reported among patients harboring such neoplasms. The available literature consists of case reports and small series that present variable characteristics distinguishing these unusual lesions. Little advancement has been made to further the understanding and management of these tumors. The authors present 3 cases from their institution that highlight the difference between typical benign intracerebral schwannomas and histopathological variants that may portend more aggressive behavior. Also provided is a review of the literature in the hope of gaining a better understanding of these rare tumors.

Key Words • intracerebral schwannoma • malignancy • neurofibromatosis • oncology

Intracranial schwannomas most commonly arise from the vestibular portion of the eighth cranial nerve and account for approximately 8% of all primary brain tumors in adults.2,27 The presence of intracerebral schwannomas within the brain parenchyma is rare. They remain an elusive entity, with only a few case reports and small series available for review.3,11,14,18,21,44,48

In this paper we present 3 pediatric cases that were histologically diagnosed as intraparenchymal schwannomas. All patients underwent resection. The initial resection in 1 patient was performed at another facility and care was subsequently transferred to our institution. Conventional benign schwannomas were diagnosed in 2 patients, but the third had multifocal tumors with atypical histopathological features associated with rapid recurrence after initial complete resection, precipitating additional surgery and chemotherapy. In this latter case, the patient had a concomitant diagnosis of NF1.

Methods

A retrospective review of cases recorded in our neurooncology database between January 2002 and December 2012 yielded 3 patients with intracerebral schwannomas.

Abbreviations used in this paper: EMA = epithelial membrane antigen; GFAP = glial fibrillary acidic protein; MPNST = malignant peripheral nerve sheath tumor; NAA = N-acetylaspartate; NF1, NF2 = neurofibromatosis Types 1 and 2.

Medical records including imaging studies were reviewed. In 2 of these cases the surgery was performed at our institution and in 1 case a resection was performed elsewhere. This study was reviewed for human subject protection and confidentiality and was approved under the expedited review process by the University of Texas Southwestern Medical School’s institutional review board in accordance with the standards of the National Institutes of Health.

Case Reports

Case 1

History and Examination. This 9-month-old girl with an extensive family history of NF1 presented to our multidisciplinary neurofibromatosis clinic for confirmation of NF1 associated with multiple café-au-lait macules that were first noticed when she was between 1 and 2 months of age. Her examination was significant for more than 6 café-au-lait macules larger than 15 mm in diameter, axillary freckling, 4 dermal neurofibromas across her back and abdomen, an optic glioma, and a positive family history of NF1. The child was otherwise healthy, meeting all milestones, and was without focal neurological deficit. Significant macrocephaly was also identified, with a head circumference

This article contains some figures that are displayed in color online but in black-and-white in the print edition.
circumference measuring above the 98th percentile for her age. An MRI study of the brain was performed for evaluation of the macrocephaly.

The MRI study revealed multiple T2-weighted hypointense intraaxial abnormalities within the left medial parietal lobe. The lesions enhanced intensely on T1-weighted studies following the administration of gadolinium (Fig. 1). There were 5 discrete lesions, the largest measuring 2.2 cm in greatest transverse dimension. They were associated with extensive vasogenic edema. The enhancing tumors exhibited restricted diffusion when compared with the normal brain parenchyma, suggestive of increased cellularity. Single-voxel MR spectroscopy was performed. It demonstrated markedly elevated choline with diminutive NAA peaks. A differential diagnosis of leukemia was considered. However, no splenomegaly was noted on physical examination and a complete blood count was normal. The CT scans of the chest, abdomen, and pelvis found no additional masses.

First Operation and Postoperative Course. The patient underwent resection via a left parietal vertex craniotomy 6 days later. Frameless stereotactic guidance and intraoperative ultrasound were used to facilitate localization. Through an incision in the cingulate gyrus the lesions were encountered; they were described as tan, firm, and well circumscribed. The lesions were safely resected. The patient made a good postoperative recovery. A postoperative MRI study confirmed a complete resection.

Histopathological Findings. Histopathological analysis of the lesions demonstrated fascicular, cellular, spindle-cell neoplasms with moderate nuclear pleomorphism and readily evident mitoses, numbering up to 4–5/hpf (×40) (Fig. 2). There was no evidence of necrosis, vascular proliferation, or calcification. All of the resected tumors had identical morphological features. Immunohistochemistry for S100 protein was diffusely and strongly positive within the lesional cells. The MIB-1 (Ki 67) immunostain highlighted 11.2% of the tumor cells in the most proliferative area. The tumor cells were focally positive for GFAP and negative for EMA, desmin, muscle-specific...
antigen, and type IV collagen. Tumor cells showed diffuse strong nuclear reactivity with an immunostain for INI1. Exceptionally rare cells (< 1/1000 cells) showed reactivity for p53. Based on the unclear biological significance of the pathological findings, a diagnosis of atypical cellular NST was rendered and the patient was followed without adjuvant therapy.

**Second Operation and Postoperative Course.** Approximately 4 months later, surveillance imaging identified an enhancing mass measuring 2.6 × 1.2 cm in the left parietal lobe, consistent with local recurrence. The patient was returned to the operating room for microsurgical resection. Histopathological evaluation demonstrated no changes from the original tumor resection, again consistent with a cellular schwannoma. The patient had an uneventful postoperative course and was discharged home in stable condition. Although the histological features of this neoplasm were not consistent with the characteristic features of MPNST, given the rapidity of recurrence after complete resection, further therapy was recommended. The patient was started on a chemotherapy regimen for very young children with CNS malignancies, including cisplatin, cyclophosphamide, vincristine, and etoposide. Given her young age and the presence of NF1, this regimen was selected over radiation therapy or regimens containing anthracyclines given their potential long-term consequences. She has now completed 9 months of therapy without evidence of further tumor progression, and has tolerated the regimen well.

**Case 2**

**History and Examination.** This 12-year-old boy experienced a first-time seizure while playing football. He was taken to another hospital, where CT scans of the head revealed a right frontal mass with local calcification. A significant amount of edema and mass effect was observed. He was subsequently transferred to our facility for additional imaging and care. Admission MRI studies demonstrated a large right frontal tumor with extension into the right lateral ventricle (Fig. 3). He was placed on anticonvulsant medication and corticosteroids. His examination was otherwise without focal neurological findings.

**Operation and Postoperative Course.** The mass was resected via a right frontal craniotomy. On entering the corticotomy, the white matter was found to be extremely edematous. The tumor had a firm hypervascular surface and a well-defined plane of cleavage. On entering the tumor, it was found to be very fibrous, and although the exterior of the tumor was very vascular, the interior did not have much blood flow. Gross-total resection was achieved and postoperative MRI studies showed no evidence of residual tumor. He had an uneventful postoperative course and was discharged home in stable condition on the 2nd postoperative day.

**Histopathological Findings.** Histopathological analysis showed the classic features of intraparenchymal schwannoma, with alternating areas of compact elongated cells and less cellular, loosely textured areas (Antoni A and B areas) (Fig. 4). Verocay bodies were easily identified. Nuclear polymorphism was also present. Mitosis and necrosis were not seen. On immunohistochemistry, diffuse, strong positivity for S100 protein was identified and

![Fig. 2. Case 1. Photomicrographs show histopathological findings in a 9-month-old girl with multiple intraparenchymal schwannomas.](image1)

![Fig. 3. Case 2. This 12-year-old boy had an intracerebral schwannoma.](image2)
there was focal staining for GFAP and neuron-specific enolase. Tumor cells were negative for EMA, cytokeratin (AE1/AE3), and synaptophysin. The MIB-1 immunostain highlighted 2.4% of the tumor cells in the most proliferative area.

Follow-Up. Surveillance physical and MRI examinations were performed routinely over the next 2.5 years without recurrence of the tumor. No stigmata of neurofibromatosis have been identified. The patient did continue to have medically refractory seizures and was subsequently treated with invasive electrical monitoring and ultimately with resection of a right frontal lobe parenchymal seizure focus. He has since had excellent control of his epilepsy.

Case 3

History. This 10-year-old, previously healthy girl was evaluated for severe headaches at another facility. Neuroimaging at that facility demonstrated a solitary mass with extensive associated edema in the right frontal lobe. Conventional cerebral angiography was also performed. The study revealed extensive hypervascularity of the mass. The patient underwent gross-total resection of the tumor at the other facility. She had an uneventful postoperative course. An MRI study obtained 1 month after her tumor resection showed no evidence of residual tumor.

Pathological inspection demonstrated a spindle-cell neoplasm containing alternating hyper- and hypocellular areas typical for schwannoma. Verocay bodies were present, as was mild nuclear pleomorphism. Rare mitotic figures were seen (<1/50 hpf). There was no calcification or necrosis. On immunohistochemical investigation, tumor cells stained diffusely with S100 and focally with GFAP, but were negative for EMA, desmin, and synaptophysin. The MIB-1 immunostain highlighted up to 10% of cells focally.

Examination. The child was subsequently referred to our facility for further care and management. Unfortunately, only the neuroimaging reports without preoperative images were available for review. On initial examination, she was neurologically intact without evidence of focal deficit. She did not have headache at that time and the remainder of her physical examination and organ system review was unremarkable. She was finishing a perioperative steroid taper at that time.

Follow-Up. The patient underwent routine follow-up physical and brain MRI examinations every 3 months for the 1st year, and then every 6 months for the following 2 years. She has continued to suffer from frequent to daily headaches. Serial neuroimaging has revealed no recurrence of tumor. No findings to suggest neurofibromatosis have been seen.

Discussion

Although most reports comment on the benign nature of intracerebral schwannomas, with generally excellent outcomes following gross-total resection, malignancy and recurrence have been reported. Although schwannomas tend to occur in individuals with NF2 and schwannomatosis, studies have documented an association of intracerebral schwannomas with NF1. Most reported cases have been seen in children or young adults. Cases occurring in adults beyond the 3rd decade of life have been reported. There appears to be no sex predilection in cases of intracerebral schwanna.

The first report of these tumors was published in 1966. It described the case of a temporal lobe schwanna in a 6-year-old boy with a 1-year history of seizure disorder. Since that time, most reported cases have been in the supratentorial brain parenchyma, with a preference toward the periventricular regions. Cerebellar, peduncular, pontine, medullary, and lateral and fourth ventricular locations have been reported. The overwhelming majority of intracerebral schwannomas are solitary. Multiple intracerebral schwannomas, as in our first case, have rarely been reported.
The role of NF1 in the development of intracranial schwannomas is not clear and has not been well explored biologically. Overall, children with NF1 are clearly at increased risk for the development of CNS tumors. These tumors are predominately benign pilocytic astrocytomas, particularly of the optic apparatus or brainstem.13,16,19,42 Children with NF1 are also at risk for proliferation of Schwann cells and the development of MPNSTs. The majority of these tumors are benign in nature and include cutaneous and subcutaneous neurofibromas as well as plexiform neurofibromas, which are histologically distinct from schwannomas.15,26 Whereas conventional schwannomas are more commonly seen in patients with NF2, 4% of cases of the cellular schwannoma variant, as seen in Case 1, occur in patients with NF1.33 Patients with NF1 are also at risk for the development of MPNST, a high-grade soft-tissue sarcoma that can be quite difficult to cure. Patients with NF1 carry a 10% risk of development of an MPNST over their lifetime. The risk appears greatest in adults between 20 and 40 years of age; these lesions are quite rare in young childhood.10,42

Most symptoms associated with intracerebral schwannomas are directly related to the tumor location, as a result of mass effect from the tumor itself or from the peritumoral edema. Seizures are one of the most commonly reported symptoms,1,3,14,49 followed by symptoms of raised intracranial pressure and focal neurological deficits.14,16,23,32,46

The exact pathogenesis of intracerebral schwannomas remains unclear. Schwann cells are not indigenous to the brain parenchyma. It has been proposed that the tumors arise from the differentiation of multipotent mesenchymal elements into Schwann cells,20,21 conversion of the pial cells to Schwann cells, distorted embryogenesis,40 displaced neural crest cells,39 or misplaced myelinated nerve fibers.13,36,38 Based on the frequent perivascular location of these tumors, an alternative pathogenic hypothesis includes these tumors arising from Schwann cells within the adrenergic nerve fibers of cerebral arterioles and the larger arteries within the subarachnoid space.33,42,51 These perivascular nerve plexi are also common in the tela cho-roidea and could explain the predilection for the periven- tricular areas seen in many of these cases.41,51 This theory may also explain the presence of these tumors near larger cerebral vessels within the sylvian fissure.16 There have also been reports describing tumorigenesis secondary to metabolic or ischemic injury. Schwann cell proliferation has been observed in patients following stroke or in individuals with diabetes mellitus.8,34,40

On imaging, intracerebral schwannomas have been shown to display calcifications, cysts, and peritumoral edema.19,30,31,50,57 Noncystic tumors have also been reported, most commonly in the frontal lobes.3,14,49,50 Evidence of hypervascularity on angiography has been reported.79 On MRI studies, intracerebral schwannomas appear relatively isointense to gray matter on T2-weighted imag- es.12,26,36 Similar to these reports, our second case showed a thick rim of relative T2 isointensity to gray matter surrounding a central region of increased T2 signal intensity. Our first case also showed T2 isointensity to gray matter and restricted diffusion with respect to normal brain parenchyma, both of which are findings suggestive of hypercellularity. There are at least 2 reports of proton MR spectroscopy in intracerebral schwannomas.12,36 In both cases, although the choline peak was elevated, there was preservation of the NAA peak. Our first case showed a markedly elevated choline peak, suggestive of increased cellular proliferation. The solid components of the intracerebral schwannomas seem to demonstrate intense enhancement with intravenous contrast material administration.12,26,36

On gross pathological examination, intracerebral schwannomas have been described as gray, firm, rubbery; mildly to moderately vascular, occasionally gritty, not infrequently cystic, and with well-defined planes of cleavage.1,2,26,31,36 These characteristics were also seen in our case series, although in Case 2 it was the capsule of the tumor, much more than its interior, that demonstrated hypervascularity.

The histopathological spectrum of intracerebral schwannomas mirrors that of the peripheral system. The most common tumor type, the conventional schwannoma, is a variably cellular spindle-cell proliferation composed of compact so-called Antoni A areas, often alternating with loose myxoid areas (Antoni B) and with palisading nuclei known as Verocay bodies. Our Cases 2 and 3 typify the histopathological characteristics of conventional schwannoma, as do most of the cases in the literature. Cellular schwannoma is a less common variant, recognized as a hypercellular, mitotically active neoplasm with variable nuclear atypia. Tumor cells display predominantly compact, Antoni A–like architecture, and Verocay bodies are rarely seen.10,53–55 Tumor cells show nuclear pleomorphism and hyperchromasia, often prompting an erroneous diagnosis of malignancy.31,52,66 Recurrence has been documented in more than 20% of cases of cellular schwannoma in the peripheral nervous system, but data regarding CNS recurrence are lacking.42,56 Metastasis does not occur. Although conventional schwannomas are found in patients with NF1, cellular schwannoma occurs with increased incidence.55 Distinguishing a cellular schwannoma from an MPNST remains a challenge for pathologists. An MPNST often has a more infiltrative border than does cellular schwannoma. Palisading necrosis is a feature of MPNSTs, and while most cases of cellular schwannoma lack necrosis, when it is present it is circumscribed and focal.53,55 Mitoses are much more abundant in most cases of MPNST, often exceeding 10/ hpf. Immunohistochemistry may be of benefit in distinguishing these lesions. Strong diffuse immunoreactivity for S100 is characteristic of all types of benign schwannomas, but most MPNSTs show only weak, focal staining or are negative for this marker of neuronal differentiation.53 Widespread p53 immunoreactivity is often seen in MPNST, but it is often negative or very focal in schwannomas.10,53,56 The pathological features of the tumors in Case 1 fit best with a diagnosis of cellular schwannoma because they were circumscribed neoplasms that lacked necrosis; had a moderate mitotic rate; were diffusely, strongly positive by immunohistochemistry for S100; and showed almost no immunoreactivity for p53. Immunohistochemistry for INI1 (BAF-47) was performed in Case 1 because it has been reported that a dis-
Intracerebral schwannomas
tinctive mosaic pattern of reactivity has been seen in he-
reditary cases of schwannoma but not in sporadic tumors.37
The INI1 immunohistochemical reactivity is lost in atypi-
cal teratoid/rhabdoid tumors due to mutations in the INI1/
SMARCBI tumor suppressor gene. In most normal tissues
and in tumors not associated with the INI1/SMARCBI mu-
tation there is diffuse nuclear immunoreactivity. In a series
of cases of familial schwannomatosis and NF2-associated
schwannomas, INI1 immunohistochemistry showed zonal
loss of expression, providing evidence of a role for this
gene in some types of hereditary schwannoma.37 In our
case, and in 1 previously reported intracerebral MPNST in
a patient with NF1, there was diffuse immunoreactivity for
INI1, suggesting that INI1/SMARCBI mutations may not
be involved in NF1-associated NSTs.37
This series of 3 cases allows for contrast of the patho-
logical features of conventional intracerebral schwanno-
as, seen in Cases 2 and 3, with the much less common
and potentially more aggressive cellular schwannoma, as
typhed by Case 1. The histopathological differences be-
tween these cases may help predict which of these rare tu-
mors are at higher risk of recurrence. Once a CNS tumor
is recognized to be of nerve sheath origin, the presence
of Verocay bodies, varying areas of loose and dense cel-
ularity, and minimal mitotic activity suggest a low risk of
recurrence and a benign course. Tumors with features of
cellular schwannoma, as described above, are more likely
to recur, and they should be carefully assessed to rule out
MPNST. Tumor mitotic rate, but not the MIB1 prolifera-
tive index, has been shown to correlate with recurrence
risk in cellular schwannomas of the peripheral nervous
system.10 In our cases, the mitotic rate of Case 1 was
much higher than of the other cases, but both Cases 1 and
3 showed focal hot-spot areas with MIB1 proliferation
rates of 10%–11% of cells. It is not yet determined what
the eventual course will be for Case 1, a unique patient
with multifocal tumors identified in infancy. The rapid tu-
mor recurrence in this patient clearly suggests that these
neoplasms differ from the conventional intracerebral schwannomas seen in the other patients, who remain free
of disease after years of follow-up.

Conclusions
Intraparenchymal schwannomas are rare lesions with
several hypothesized theories about their tumorigenesis.
Although the majority of these tumors are biologically
benign, aggressive neoplasms have been reported, similar
to NSTs of the peripheral nervous system. Patients may
present with headache and seizures due to the significant
parenchymal edema and resultant peritumoral gliosis
related to these tumors. The MRI studies show a T2 iso-
tense mass and, on MR spectroscopy, a markedly elevated
choline peak corresponds with hypercellularity. Although
predicting the biological behavior of these rare neoplasms
based on the histopathological findings remains challeng-
ing, the outcomes in our cases suggest that tumors with
conventional schwannoma morphology will probably be-
have in a benign manner, but that those with features of
cellular schwannoma require close clinical and radiologi-
cal follow-up. Further analysis of larger numbers of these
tumors is warranted to be better able to predict patient
outcome and the need for adjuvant therapy.

Disclosure
The authors report no conflict of interest concerning the mate-
rials or methods used in this study or the findings specified in this
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