Primary pineal region tumors are rare, with an estimated incidence of approximately 1% of all intracranial neoplasms. They are more common in children than adults. In general, the most common pineal region tumors are germ cell and pineal parenchymal tumors. On the other hand, a tumor can arise from glial components of the pineal gland, including ganglioneuromas, gangliogliomas, and gliomas. Granular cell astrocytoma (GCA) is thought to represent an unusual astrocytoma originating from the pineal gland. There have been only 4 previously reported cases of GCA in the pineal region. In this report, we describe a surgical case of GCA in the pineal region. After a thorough review of the different epidemiological, clinical, and imaging features; treatments; and prognoses of GCAs in other intracranial localizations, the authors analyzed features of this tumor in the pineal region.
Approximately 70% of the tumor was resected; the rest was closely opposed to the basal and internal veins.

Posttreatment Course

Histological examination showed the specimen to be granular cell astrocytoma (GCA). Consequently, mild right paresis was newly observed, but there was no other neurological deficit, and the patient did not require any adjuvant therapies. Cranial MRI studies at 6 months, 1 year, and 3 years after treatment showed no signs of growth of the residual tumor (Fig. 3).

Discussion

Granular cell astrocytoma, which has also been called "granular cell gliomatous cell tumor" or "astrocytoma with granular cell differentiation," is a rare type of infiltrative brain tumor. It was first described by von Luthy and Klinger, in 1951, as a granular cell tumor (GCT). In the table 1. Literature summary of GCA cases

<table>
<thead>
<tr>
<th>Authors &amp; Year</th>
<th>Age (yrs), Sex</th>
<th>Onset of Symptoms</th>
<th>Symptoms</th>
<th>MRI Results</th>
<th>CSF Shunt</th>
<th>Approach/Tumor Appearance</th>
<th>Removal</th>
<th>RT</th>
<th>FU &amp; Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Snipes et al., 1992</td>
<td>25, F</td>
<td>6 yrs</td>
<td>Headache</td>
<td>Pineal tumor w/ 3rd ventricular obstruction</td>
<td>Yes</td>
<td>Occipital transtentorial approach/yellowish cystic tumor</td>
<td>70% resected</td>
<td>56 Gy</td>
<td>8 yrs; no signs of recurrence</td>
</tr>
<tr>
<td></td>
<td>38, M</td>
<td>5 days</td>
<td>Headaches, vertigo, &amp; occasional episodes of nausea &amp; vomiting</td>
<td>2 x 2 x 2-cm pineal mass causing extrinsic compression on quadrigeminal plate cistern &amp; obstructive hydrocephalus at level of aqueduct</td>
<td>Yes</td>
<td>Occipital transtentorial approach/thick gritty fibrotic tumor adherent to adjacent veins; yellow-tan &amp; only slightly vascular</td>
<td>Biopsy specimen &amp; 4 mos later total resection</td>
<td>45 Gy</td>
<td>1.5 yrs; possible residual tumor in lt tegmentum; patient alive &amp; well</td>
</tr>
<tr>
<td>Nitta et al., 2001</td>
<td>30, F</td>
<td>Suddenly</td>
<td>Rt paresis followed by loss of consciousness</td>
<td>2.0 x 1.5 x 1.3-cm partially Gd-enhanced mass in pineal region</td>
<td>Yes</td>
<td>Rt parietooccipital interhemispheric transtentorial route/reddish, soft, &amp; vascular w/ relatively clear border</td>
<td>Total resection</td>
<td>None</td>
<td>7 yrs; no signs of recurrence</td>
</tr>
<tr>
<td>Ohta et al., 2010</td>
<td>67, F</td>
<td>Progressive</td>
<td>Headache &amp; gait disturbance</td>
<td>3 x 3 x 4-cm low-intensity lesion &amp; homogeneous contrast enhancement</td>
<td>No</td>
<td>Occipital transtentorial approach/reddish, soft, &amp; vascular rich</td>
<td>Total resection</td>
<td>None</td>
<td>2 yrs; no progression</td>
</tr>
<tr>
<td>Present case</td>
<td>16, M</td>
<td>1 mo</td>
<td>Parinaud syndrome, raised intracranial tension</td>
<td>3 x 3 x 4-cm isointensity lesion &amp; homogeneous contrast enhancement</td>
<td>Yes</td>
<td>Subtemporal approach/reddish, gritty fibrotic, &amp; vascular</td>
<td>Subtotal resection</td>
<td>None</td>
<td>3 yrs; no progression</td>
</tr>
</tbody>
</table>

FU = follow-up; RT = radiotherapy.
central nervous system. Most reported cases occur in the suprasellar region. The pineal localization is extremely rare, with only 4 previously reported cases in the literature. The histogenesis of a GCT is debated. For tumors that arise from the peripheral nervous system, Schwann cells appear to be the most likely cells of origin. For GCTs in the sellar area, the pituicyte, a modified astrocyte and the principal posterior pituitary cell, is considered the cell of origin. Some authors now consider the GCT as a hamartomatous lesion; and other authors, as tumors of uncertain histogenesis. To date, no recognized common cell accounts for all types of GCT.

The age of tumor occurrence in 4 cases, including our patient, was under 40 years, and only 1 patient was 67 years of age. The cases to date occurred in 3 males and 2 females. Symptoms were generally related to the compression of adjacent structures. The most frequent symptoms, including in our case, were dysfunctions of eye movements (Parinaud syndrome) and signs of rising intracranial tension caused by hydrocephalus (Table 1). Sudden-onset diplopia or visual loss, short-term history of confusion, headache, and vomiting have been described by Snipes et al. and Nitta et al. The duration of symptoms has ranged from sudden onset (5 days) to 4 years. Spontaneous intratumoral hemorrhage and intraventricular hemorrhage have also been reported in suprasellar region GCAs.

The imaging findings of GCTs are relatively nonspecific given the broad range of attenuation and signal intensity of most common pineal region masses: germinoma, meningioma, pineocytoma, and glioma. In our case and in the case reported by Ohta et al., the tumor presented as a well-demarcated, low-intensity to isointense lesion in the pineal body and third ventricle wall with homogeneous contrast enhancement. In these cases the CT and MRI characteristics were similar to the appearance of a large meningioma. Snipes et al. described the CT scanning features of a case with a cystic component. On the other hand, a GCA in the pineal region has often been associated with increased signal intensity in the adjacent thalami on MRI, while GCAs elsewhere promote virtually no edema in the adjacent brain structures. The presence of calcification, which was reported by Snipes et al., was exceptionally reported in other localizations.

Granular cell tumor is generally a surprising finding in that it is seldom considered in the preoperative differential diagnosis of a pineal region lesion. They display a distinctive histological appearance characterized by the presence of neoplastic cells with large eosinophilic and granular cytoplasm. At the periphery of the tumor, gradual transition into classic astrocytoma is frequently found, although it can be subtle. Tumors can be entirely composed of granular cells, but more often granular cells coexist with conventional infiltrating astrocytoma. Immunohistochemical studies show that most GCAs are positive for GFAP and S100. Negative GFAP immunostaining was reported in a few articles. As in our case, GCAs are positive for CD68, PAS, and EMA.

The treatment of pineal region tumors remains one of the major intellectual and technical challenges facing neurosurgeons. The choice of the surgical approach depends...
Granular cell astrocytoma of the pineal region

References

Conclusions
A GCT should be considered in the differential diagnosis of an enhancing lesion in the pineal region. This tumor is commonly firm and vascular. However, the surgeon must be prepared to face a hemorrhagic unresectable tumor. The goal of decompression of the surrounding structures via subtotal resection may be reasonable. Although this tumor has been known as an aggressive astrocytic entity, our review of the pineal localization revealed a relative benign tumor prognosis. Thus, in our opinion, GCA in the pineal region must be managed with less aggressive therapeutic management.

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Conception and design: El Asri, Baallal, Boucetta, El Mostarchid. Acquisition of data: El Asri, Sinatra, Gazzaz. Analysis and interpretation of data: El Asri. Drafting the article: Sinatra. Critically revising the article: all authors. Reviewed submitted version of manuscript: all authors. Approved the final version of the manuscript on behalf of all authors: El Asri.

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on the size and histological nature of the tumor and the neurosurgeon’s habits. In our case, we used the subtemporal approach to achieve subtotal resection of the tumor. The parietooccipital interhemispheric transtentorial route was performed in the case described by Nitta et al., while the occipital transtentorial approach was used by Snipes et al. for subtotal resection in 2 cases and by Ohta et al. for total resection in 1 case.9,10,15 The firm and vascular nature of GCTs often encountered intraoperatively, along with the lack of an obvious dissection plane between the tumor and normal brain and adjacent vessels, often prohibits their gross-total resection.3,9,10,15 An attempt at subtotal resection of this slow-growing tumor may be justified in certain patients in whom gross-total removal was determined to be too risky at the time of surgery. In only 1 reported case, the tumor was considered soft and could be aspirated after radiation therapy.15 Nitta et al. found no signs of recurrence for 7 years postoperatively without any adjuvant therapy.9 For this reason, we did not administer adjuvant therapy to our patient.

The natural history of a GCT is poorly understood.3,9,12 Although no systematic studies of this tumor have been undertaken to date, GCTs of the neurohypophysis and pineal region, unlike GCAs of the cerebral hemisphere, seem to be typically benign and indolent despite occasional invasion and recurrence.2,3,10 Follow-up evaluation in our case, in the 4 previously reported pineal cases, and in cases in all other intracranial localizations has shown that subtotal resection is effective for symptomatic tumors.5,8–10,12,15 The role of radiation therapy for this benign, slow-growing tumor remains unclear. Outcomes analysis of the published cases treated using subtotal resection and with available follow-up data showed no difference in recurrence between patients who received radiation treatment and those who did not. Glazer et al. described 1 patient who underwent 3 weeks of postoperative radiation therapy consisting of 32 Grays after subtotal resection.4 The patient died 3 months postoperatively. No radiation effect on the tumor was noted at autopsy. Therefore, in light of the tumor’s slow growth, radiation therapy for these lesions remains controversial.5 However, adjuvant radiation treatment may be reasonable for tumors with atypical features.13

Conclusions
A GCT should be considered in the differential diagnosis of an enhancing lesion in the pineal region. This tumor is commonly firm and vascular. However, the surgeon must be prepared to face a hemorrhagic unresectable tumor. The goal of decompression of the surrounding structures via subtotal resection may be reasonable. Although this tumor has been known as an aggressive astrocytic entity, our review of the pineal localization revealed a relative benign tumor prognosis. Thus, in our opinion, GCA in the pineal region must be managed with less aggressive therapeutic management.

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