Although brainstem tumors are extremely rare in adults, they comprise approximately 10%–20% of all pediatric brain tumors. Diffuse intrinsic pontine gliomas (DIPGs), the most common subtype of pediatric brainstem tumors (pedBSTs), are associated with an invariably fatal prognosis, and fewer than 10% of children with these tumors survive 2 years from diagnosis. The role of stereotactic biopsy for patients with pedBSTs in general, and DIPG specifically, has been controversial. In 1993, Albright et al. reported the results of the Children's...
Cancer Group DIPG study and concluded that MRI was adequate in making the diagnosis, since tissue sampling did not alter the treatment or impact outcome.² Based on this conclusion and the presumed risk profile of stereotactic biopsy procedures in the brainstem, referring to studies reporting transient or permanent morbidity rates of up to 28% and 9%, respectively,³,⁷ and mortality rates of up to 4%,³¹ tissue sampling has been rarely performed. Thus, very little information on the molecular biology of DIPG has been available until very recently, when collaborative efforts allowed for the collect of a critical number of specimens, primarily derived from autopsy tissue, for molecular characterization of these tumors.⁴,¹² These analyses unraveled a unique genetic makeup of DIPG that is distinct from other pediatric high-grade gliomas or adult high-grade gliomas.²⁸ Moreover, DIPGs were found to constitute a heterogeneous entity with 3 molecularly distinct subgroups (H3-K27 M, silent, and MYCN) identified with whole-genome sequencing with methylation, expression, and copy number profiling.⁴ This complexity needs to be considered when designing new therapeutic approaches, since each subgroup potentially requires a different treatment to improve outcome for these children.⁴ Therefore, stereotactic biopsy–driven molecular characterization may become an important prerequisite for the management of these tumors. We conducted a systemic review and meta-analysis to precisely determine the safety and diagnostic success of stereotactic biopsy for pedBSTs.

Methods

Search Strategy and Study Identification

The study was conducted in accordance with Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines;¹⁸ no protocol for this meta-analysis has been published or registered. Appropriate studies were identified by searching the electronic databases PubMed, EMBASE, and Web of Science. Search terms included: “pediatric” or “paediatric” or “children” or “child” or “adolescent” in combination with “biopsy” or “biopsies” or “stereotactic” and in combination with “brainstem” or “brain stem” or “pons” or “pontine” or “mesencephalon” or “midbrain” or “medulla oblongata” or “posterior fossa” or “infratentorial” or “brain” or “intracranial.” Searches were limited to human studies published in English from 1980 and 2015. Reference lists from publications retrieved were also examined to identify additional studies. The websites of the American Association of Neurological Surgeons (AANS; 1997–2010), the Congress of Neurological Surgeons (CNS; 1997–2012), the American Society of Clinical Oncology (ASCO; meeting abstracts, 2004–2012; educational books, 2002–2012), and German Medical Science (GMS; 2003–2012) were also searched for relevant abstracts that met our inclusion criteria. In addition, we also evaluated our own institutional series on patients undergoing stereotactic biopsy for the diagnosis of pedBSTs over the period of 1994 to 2012 and included the results in the present meta-analysis (Supplementary Table 1 encompasses detailed characteristic and procedural metrics, e.g., diagnostic yield, morbidity, mortality) of patients in the local dataset; treatment planning and surgical procedure were performed as described previously²⁷). The institutional review board of the University Hospital Cologne approved this retrospective data evaluation, and the requirement for patient informed consent was waived.

Selection Criteria

Selection of abstracts for full review was conducted by 2 independent investigators (P.K. and M.I.R.) based on predefined inclusion and exclusion criteria. Studies were eligible if they reported original data on stereotactic biopsy of brainstem tumors (defined as tumors located in the midbrain, pons, or medulla oblongata) in pediatric patients (age < 21 years) including details on procedure-related complications (morbidity and mortality) and diagnostic
success rates. Studies were excluded if they 1) presented a reanalysis of subpopulations already included in other studies; 2) reported on biopsy procedures unrestricted to a certain location, not separately addressing the outcome for the brainstem subpopulation; 3) reported on a group of less than 10 patients; or 4) were commentaries, technical notes, or review articles summarizing the results of previous series. Furthermore, we excluded those series reporting on nonstereotactic (open) biopsies, since this approach has generally been replaced by stereotactically guided biopsies for diagnosing BSTs.1,3,5,6,14,24,30 Each person reviewed the abstracts independently and generated a list of studies to retrieve for full-text review. Lists were then compared and discrepancies resolved by consensus.

**Data Extraction**

Extraction of data was independently performed by 2 authors (P.K. and M.I.R.) and subsequently verified between the 2 authors, with discrepancies settled through consensus discussion. The following details were extracted: treatment institution, year of publication, duration of study, number of patients, age (mean or median age of the study population), and the applied biopsy trajectory (transfrontal or transcerebellar). Furthermore, diagnostic success rates (number of patients with a valid histopathological diagnosis), detailed histopathological results, and procedure-related (overall and permanent) morbidity and mortality rates were extracted.

In a previously published paper, we also performed a literature review and meta-analysis of stereotactic biopsy for brainstem tumors.15 The focus of that paper was the diagnostic value and safety of the method in the pediatric and adult population, and the research was limited to the period from 1980 to 2012. In this manuscript, we focused on the pediatric population only, updated the literature (1980–2015) and added data from our own case series.

**Statistical Analysis**

Statistical analysis was performed as described previously.15 In brief, study-specific proportions of outcome measures (diagnostic success, overall morbidity, permanent morbidity, and mortality) were transformed using the Freeman-Tukey variant of the arcsine square10 and then combined using DerSimonian-Laird random-effects meta-analyses. Study heterogeneity was assessed by the I² statistic, with values of 25%, 50%, and 75% representing mild, moderate, and severe inconsistency, respectively.13 Meta-regression was used for subgroup analysis at the study level. Evidence of publication bias was assessed with funnel plots. Sensitivity analysis was conducted by repeatedly calculating the effect size with 1 study omitted per iteration. All analyses were performed with Stata.

![Flowchart for search strategy and study selection](FIG. 1).

**TABLE 2. Pooled pathological diagnoses (of 735 patients) from the 18 studies included in the present meta-analysis**

<table>
<thead>
<tr>
<th>Pathology</th>
<th>No. ofPts</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neoplastic disease</td>
<td>676</td>
<td>92.0</td>
</tr>
<tr>
<td>Glioma</td>
<td>620</td>
<td>84.4</td>
</tr>
<tr>
<td>Low grade (WHO Grade I–II)</td>
<td>206</td>
<td>28.0</td>
</tr>
<tr>
<td>High grade (WHO Grade III–IV)</td>
<td>169</td>
<td>23.0</td>
</tr>
<tr>
<td>Information regarding WHO grade not provided</td>
<td>245</td>
<td>33.3</td>
</tr>
<tr>
<td>PNET</td>
<td>22</td>
<td>3.0</td>
</tr>
<tr>
<td>Ependymoma</td>
<td>16</td>
<td>2.2</td>
</tr>
<tr>
<td>Other tumors</td>
<td>18</td>
<td>2.4</td>
</tr>
<tr>
<td>Nonneoplastic disease</td>
<td>33</td>
<td>4.5</td>
</tr>
<tr>
<td>Infectious disease</td>
<td>16</td>
<td>2.2</td>
</tr>
<tr>
<td>Inflammatory disease</td>
<td>3</td>
<td>0.4</td>
</tr>
<tr>
<td>Other nonneoplastic diseases</td>
<td>14</td>
<td>1.9</td>
</tr>
<tr>
<td>Nondiagnostic biopsy procedure</td>
<td>26</td>
<td>3.5</td>
</tr>
</tbody>
</table>

PNET = primitive neuroectodermal tumor.

[FIG. 1. Flowchart for search strategy and study selection; n refers to number of studies.]
statistical software, release 12 (StataCorp LP). Statistical tests were 2-sided and used a significance level of \( p < 0.05 \).

**Results**

**Search Results**

The search strategy retrieved 945 publications (Fig. 1). Screening of the titles and abstracts showed that 907 articles did not meet criteria for inclusion in the meta-analysis. Full text was retrieved for 38 studies. Review of these studies led to the elimination of 21 for not meeting inclusion criteria for the meta-analysis. Thus, including our own institutional series, a total of 18 studies were included in the present meta-analysis.

**Study Population**

The key characteristics of the patients and studies analyzed are listed in Table 1. The studies comprised a sample of 735 patients. The cohorts varied between 10 and 130 patients, with a median of 24 patients per study. Annually, a median of 3.1 patients received stereotactic biopsy for BSTs in the individual institutions (range 1.4–10.0 patients per year). The chosen biopsy trajectory was transfrontal in 60% of patients and transcerebellar in 40%. However, when comparing the biopsy trajectories at a study level it became evident that several institutions almost exclusively performed biopsies with only 1 of these trajectories (interquartile range [IQR] of 7%–88% for the transfrontal approach and 12%–93% for the transcerebellar approach).

**Meta-Analysis**

The weighted proportions for diagnostic success and procedure-related complications (overall and permanent morbidity and mortality) across the studies are shown in Figs. 2–5. In detail, the weighted average proportion

<table>
<thead>
<tr>
<th>Study</th>
<th>Proportion (95% CI)</th>
<th>Weight, % (random)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albright et al. (1993)</td>
<td>100.0 (85.8, 100.0)</td>
<td>3.3</td>
</tr>
<tr>
<td>Cartmill et al. (1999)</td>
<td>100.0 (81.5, 100.0)</td>
<td>2.5</td>
</tr>
<tr>
<td>Chico-Ponce de León et al. (2003)</td>
<td>96.0 (86.3, 99.5)</td>
<td>6.8</td>
</tr>
<tr>
<td>Delaretti et al. (2011)</td>
<td>93.2 (81.3, 98.6)</td>
<td>6.0</td>
</tr>
<tr>
<td>Frank et al. (1988)</td>
<td>100.0 (69.2, 100.0)</td>
<td>1.5</td>
</tr>
<tr>
<td>Giunta et al. (1988)</td>
<td>92.9 (66.1, 99.8)</td>
<td>2.0</td>
</tr>
<tr>
<td>Kratimenos et al. (1993)</td>
<td>100.0 (73.5, 100.0)</td>
<td>1.7</td>
</tr>
<tr>
<td>Manoj et al. (2014)</td>
<td>95.1 (83.5, 99.4)</td>
<td>5.6</td>
</tr>
<tr>
<td>Own data (2015)</td>
<td>95.1 (83.5, 99.4)</td>
<td>5.6</td>
</tr>
<tr>
<td>Patel et al. (2009)</td>
<td>95.8 (78.9, 99.9)</td>
<td>3.3</td>
</tr>
<tr>
<td>Pincus et al. (2006)</td>
<td>100.0 (69.2, 100.0)</td>
<td>1.5</td>
</tr>
<tr>
<td>Pirotte et al. (2007)</td>
<td>100.0 (83.2, 100.0)</td>
<td>2.8</td>
</tr>
<tr>
<td>Puget et al. (2015)</td>
<td>100.0 (97.2, 100.0)</td>
<td>17.4</td>
</tr>
<tr>
<td>Pérez-Gómez et al. (2010)</td>
<td>90.0 (68.3, 98.8)</td>
<td>2.8</td>
</tr>
<tr>
<td>Rajsheshkar et al. (2010)</td>
<td>100.0 (96.6, 100.0)</td>
<td>14.2</td>
</tr>
<tr>
<td>Schumacher et al. (2007)</td>
<td>94.4 (88.9, 97.7)</td>
<td>16.9</td>
</tr>
<tr>
<td>Valdés-García et al. (1998)</td>
<td>80.0 (61.4, 92.3)</td>
<td>4.1</td>
</tr>
<tr>
<td>Wang et al. (2015)</td>
<td>100.0 (78.2, 100.0)</td>
<td>2.1</td>
</tr>
</tbody>
</table>

**Fig. 2.** Forest plot of diagnostic success, as assessed in the present meta-analysis. Squares and horizontal bars indicate point estimates and 95% confidence intervals of weighted proportions in the individual studies. The last line indicates the pooled proportions with 95% confidence intervals calculated with random-effects meta-analysis.
calculated by random-effects modeling was 96.1% (95% CI 93.5%–98.1%) for diagnostic success, 6.7% (95% CI 4.2%–9.6%) for overall morbidity, 0.6% (95% CI 0.2%–1.4%) for permanent morbidity, and 0.6% (95% CI 0.2%–1.3%) for mortality. Death was reported for only 1 patient within the analyzed cohort and was attributed to development of progressive brainstem edema.32

Sensitivity analysis for random-effects models that calculated pooled proportions upon exclusion of single studies in turn showed similar results, indicating that overall estimates were not driven by the findings of single studies (Supplementary Fig. 1). Between-study heterogeneity was absent for mortality ($I^2 = 0.0\%$, 95% CI 0.0%–50.0%) and permanent morbidity ($I^2 = 0.0\%$, 95% CI 0.0%–53.6%), mild for overall morbidity ($I^2 = 48.4\%$, 95% CI 9.5%–70.6%), and moderate for diagnostic success ($I^2 = 56.9\%$, 95% CI 27.1%–74.5%) (Fig. 2–5). Funnel plots of study-specific proportions were approximately symmetrical, and most data points were within the funnel area, indicating low evidence for presence of publication bias (Supplementary Fig. 2).

Subgroup Analyses

Meta-regression for subgroup analysis at the study level identified no significant correlation between the analyzed outcome measures and the distribution of chosen biopsy trajectories (transfrontal vs transcerebellar), distribution of the mean patient age in the individual studies, the year of publication, or the number of biopsy procedures performed annually in each center (Supplementary Table 2).

Pathological Results

A detailed list of the pathological entities diagnosed throughout the studies included in the present meta-analysis is shown in Table 2. In brief, histopathological evaluation revealed brain tumors in 92.0% of brainstem lesions.
Glial neoplasms were found in 84.4% of biopsy samples, primitive neuroectodermal tumors in 3.0%, and ependymomas in 2.2%. Nonneoplastic lesions—most commonly originating from infectious disease—accounted for 4.5% of biopsy samples. Stereotactic biopsy was nondiagnostic in the remaining 3.5% of patients.

**Discussion**

Our meta-analysis of 735 patients with pedBSTs indicates that stereotactic biopsy is a safe diagnostic procedure and is associated with a low rate of procedure-related complications (overall morbidity 6.7%, permanent morbidity 0.6%, mortality 0.6%). Furthermore, it allows adequate tissue sampling in 96.1% of cases, which is a prerequisite for histological diagnosis as well as for the molecular characterization of these tumors.

Over the last decade, there has been an increasing understanding of the molecular, biological, and genetic make-up of pedBSTs in general and DIPGs specifically, which has revealed that these tumors are not a homogeneous entity, but rather comprise several distinct molecular subgroups, and that they are different from other pediatric gliomas and also different from adult gliomas.\(^4,12,28\) This strongly suggests that effective therapies for pediatric DIPGs may be distinct from effective therapies for other high-grade gliomas in pediatric or adult patients and highlights the problems of the past decades where clinical trials for pediatric DIPG were primarily chosen based on antitumor activity defined in adult high-grade gliomas.\(^28\) The latter is nowadays considered to be one of the reasons why no molecularly targeted agent has been shown to significantly improve survival in a clinical trial for pediatric DIPG. Given this demonstration of safety, along with the significant information obtained, the ability to perform molecular testing on small biopsy specimens, the identification of potentially druggable targets, and the heterogeneity of these tumors, stereotactic biopsy may become an important prerequisite for the molecular characterization.
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of pedBSTs in general and DIPGs specifically as a crucial first step toward more individualized treatment concepts to improve the outcome for children harboring such lesions.

References


FIG. 5. Forest plot of permanent morbidity, as assessed in the present meta-analysis. Squares and horizontal bars indicate point estimates and 95% confidence intervals of weighted proportions in the individual studies. The last line indicates the pooled proportions with 95% confidence intervals calculated with random-effects meta-analysis.


Disclosures
The authors report no conflict of interest concerning the materials or methods used in this study or the findings specified in this paper.

Author Contributions
Conception and design: Kickingereder, Ruge. Acquisition of data: Kickingereder, Hamisch, Fischer, Ruge. Analysis and interpretation of data: Kickingereder, Ruge. Drafting the article: all authors. 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: Kickingereder. Statistical analysis: Kickingereder. Administrative/technical/material support: Kickingereder. Study supervision: Kickingereder, Ruge.

Supplemental Information
Online-Only Content
Supplemental material is available with the online version of the article.


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