Craniopharyngioma: a roadmap for scientific translation

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OBJECTIVE Craniopharyngiomas are among the most challenging of intracranial tumors to manage because of their pattern of growth, associated morbidities, and high recurrence rate. Complete resection on initial encounter can be curative, but it may be impeded by the risks posed by the involved neurovascular structures. Recurrent craniopharyngiomas, in turn, are frequently refractory to additional surgery and adjuvant radiation or chemotherapy.

METHODS The authors conducted a review of primary literature.

RESULTS Recent advances in the understanding of craniopharyngioma biology have illuminated potential oncogenic targets for pharmacotherapy. Specifically, distinct molecular profiles define two histological subtypes of craniopharyngioma: adamantinomatous and papillary. The discovery of overactive B-Raf signaling in the adult papillary subtype has led to reports of targeted inhibitors, with a growing acceptance for refractory cases. An expanding knowledge of the biological underpinnings of craniopharyngioma will continue to drive development of targeted therapies and immunotherapies that are personalized to the molecular signature of each individual tumor.

CONCLUSIONS The rapid translation of genomic findings to medical therapies for recurrent craniopharyngiomas serves as a roadmap for other challenging neurooncological diseases.

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KEYWORDS craniopharyngioma; molecular biology; targeted therapy; BRAF; immunotherapy

Craniopharyngiomas are among the most challenging intracranial lesions to manage surgically and medically. Since the first successful resection over a century ago, innovations in operative technique and endocrinological care have improved the perioperative mortality rate from nearly 100% to 5%.8,40,41,73 Despite such advances, these tumors still carry a significant risk for recurrence and postoperative morbidity despite aggressive resection and adjuvant radiotherapy when indicated. Recent advances in the understanding of craniopharyngioma pathogenesis offer new promise in the treatment of this disease. The rapid translation of targeted inhibitors into clinical trials for craniopharyngioma serves as a model for therapeutic development for all intracranial tumors.

Craniopharyngioma is thought to arise from squamous cell crests of the embryonic hypophyseal-pharyngeal duct, also known as the craniopharyngeal duct. It represents 3% of overall and 4% of childhood cranial tumors, with an annual incidence ranging from 0.05 to 0.20 per 100,000.14,23,53 A bimodal peak incidence is observed between 5–14 years and 65–74 years of age. Two histologically and genetically distinct variants exist: adamantinomatous craniopharyngioma (ACP) and papillary craniopharyngioma (PCP).25 ACP is the most common subtype, especially in children, while PCP occurs almost exclusively in adults.18 Craniopharyngiomas may manifest with symptoms related to mass effect (e.g., headache, visual loss), hydrocephalus, or endocrine derangements (e.g., stunted growth, hypogonadism, and central diabetes insipidus). They present as mixed solid and cystic radiographic entities (Fig. 1). Gross-total resection is achievable in many cases; when gross-total resection is not achieved, subtotal resection followed by radiotherapy may provide disease control.21,42 Innovations in surgical approach and technique, including

ABBREVIATIONS ACP = adamantinomatous craniopharyngioma; ECM = extracellular matrix; EGFR = epidermal growth factor receptor; FGF = fibroblast growth factor; GH = growth hormone; IFNα = interferon-α; IGF = insulin-like growth factor; MAPK = mitogen-activated protein kinase; MMP = matrix metalloproteinases; PCP = papillary craniopharyngioma; RAR = retinoic acid receptor; VEGFR = endothelial growth factor receptor.


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endoscopic transsphenoidal strategies, have improved the anatomical corridors through which craniopharyngiomas can be resected. Nonetheless, recurrence remains a major risk for this pathology. In particular, 20% of adult craniopharyngioma patients experience further progression after resection of a recurrent tumor.

The risk for panhypopituitarism, hypothalamic dysfunction, hyperphagia leading to obesity, and diabetes insipidus may all increase with more aggressive resection. These and other postoperative morbidities can contribute to a low quality of life for craniopharyngioma patients. Craniopharyngioma requires multidisciplinary chronic management and presents a burden for childhood-onset patients well into adulthood. Furthermore, the mortality rate is markedly elevated, highlighting the need for additional effective treatment options.

Radiotherapy has traditionally been the most common neoadjuvant or adjuvant therapy administered to craniopharyngioma patients. For craniopharyngiomas that recur despite resection and radiotherapy, cytotoxic chemotherapy, intracystic drug, and radionucleotide therapies have been trialed. Case series of intracystic administration of bleomycin, a cytotoxic chemotherapy drug, demonstrated it to be well-tolerated and potentially effective in delaying the need for surgery, but its utility has been limited by a potentially serious side effect profile. Intracystic interferon-α (IFNα) therapy shows efficacy for the cystic, but not solid, components of ACPs. Systemic cisplatin has also only been reported to produce short-term response. On the whole, adjuvant options for recurrent and refractory craniopharyngiomas are limited.

In recent years, genomic and molecular biology advances have dramatically accelerated understanding of the pathogenesis of craniopharyngiomas. In this review, we summarize current knowledge of craniopharyngioma genomics and biology with an emphasis on novel targeted therapies.

**Papillary Craniopharyngioma**

**Pathogenesis**

PCPs arise almost exclusively in adults and share similar rates of postoperative morbidity as ACP, though some studies suggest that PCP may have a more indolent clinical course. Histological analysis of ACP and PCP reveals differences in cell type and cytokeratin profile (Fig. 2), and their genomic alterations provide a distinct signature for the two subtypes. BRAF mutations have been identified as a signature of most PCPs but not ACPs, while nucleocytoplasmic β-catenin is characteristic of ACP and is only present in the cytoplasm of PCP cells.

**B-Raf**

BRAF encodes B-Raf, a cytosolic kinase in the mitogen-activated protein kinase (MAPK) pathway. V600E point mutations in BRAF are rarely found in ACP but
were recently discovered to be present in approximately 95% of PCP cases. B-Raf signaling activates the MAPK pathway to promote transcription of prosurvival and growth genes. Hyperactivity of this pathway in PCP can disrupt hormone-producing cell development and encourage proliferation of pituitary stem cells (Fig. 3 left). This finding holds immediate therapeutic potential, as aberrant B-Raf protein generated by the BRAFV600E mutation has been targeted in melanoma with the kinase inhibitors vemurafenib and dabrafenib, leading to increases in overall survival. Targeted therapies against specific molecular drivers of oncogenic growth and survival have led to breakthroughs for multiple cancers; this concept may also be relevant in noncancerous tumors. Given the problem of resistance, testing of dual therapies consisting of dabrafenib and the MAPK kinase (MEK) inhibitor trametinib were conceived to target multiple elements of the MAPK pathway simultaneously.

The dramatic response to B-Raf inhibitors in melanoma has motivated 4 reports of targeted inhibitors of B-Raf in PCPs harboring BRAFV600E mutations (Table 1). Targeted B-Raf inhibitors dramatically reduced tumor volume and symptom burden while remaining well-tolerated by patients in all cases. The first case received one course of vemurafenib, which was discontinued due to a CSF leak produced by rapid tumor volume reduction. However, this patient experienced recurrence 6 weeks after initiating vemurafenib and showed no response to another trial of the same therapy. In a second case of recurrent PCP, combined dabrafenib and trametinib caused an 85%

**TABLE 1. Case reports of targeted therapies for refractory PCPs harboring BRAFV600E**

<table>
<thead>
<tr>
<th>Authors &amp; Year</th>
<th>Age (yrs), Sex</th>
<th>Prior RT/Op</th>
<th>Therapeutic Regimen</th>
<th>Radiographic Response</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brastianos et al., 2015</td>
<td>39, M</td>
<td>4</td>
<td>Dabrafenib 150 mg BID for 21 days; dabrafenib 150 mg BID/trametinib 2 mg QD for 52 days</td>
<td>PR (85%)</td>
<td>In remission 7 mos after discontinuing therapy</td>
</tr>
<tr>
<td>Aylwin et al., 2016</td>
<td>57, F</td>
<td>4</td>
<td>Vemurafenib 960 mg BID for 3 mos</td>
<td>PR</td>
<td>Recurrence 6 wks after discontinuing therapy; stable disease after restarting vemurafenib w/ progression at 7 mos</td>
</tr>
<tr>
<td>Roque &amp; Odia, 2017</td>
<td>47, F</td>
<td>3</td>
<td>Dabrafenib 150 BID for 7 mos; trametinib 2 mg QD for 7 mos</td>
<td>PR (&gt;75%)</td>
<td>In remission 7 mos after therapy</td>
</tr>
<tr>
<td>Rostami et al., 2017</td>
<td>65, M</td>
<td>1</td>
<td>Dabrafenib 150 mg BID for 21 days; dabrafenib 150 mg BID/trametinib 2 mg QD for 28 days</td>
<td>PR (91%)</td>
<td>In remission 15 wks after discontinuing therapy</td>
</tr>
</tbody>
</table>

BID = twice daily; PR = positive response (> 50%); QD = once daily; RT = radiotherapy.
radiographic reduction measured 5 weeks after initiating a therapy-positive radiographic response.13 Both cystic and solid components of the tumor decreased with this treatment. Encouraged by the success of dual dabrafenib and trametinib therapy, another group trialed the same regimen in a third case and achieved a 91% radiographic reduction after 4 weeks of treatment.57 A fourth case of recurrent PCP with panhypopituitarism also exhibited remarkable radiographic response and improvement in pituitary function following this same regimen.56

Future Directions

BRAF mutations remain the current focus in PCP cases and require further study. B-Raf inhibition and management of acquired resistance with dual therapy have been studied extensively in melanoma and provide a roadmap for adjuvant therapy for PCP (Fig. 2). Longer-term follow-up and clinical trials of these inhibitors in PCP will offer most robust evidence of their objective clinical efficacy. Multi-institutional efforts are critical to gathering data on molecular and genetic alterations in PCP, as well as therapeutic outcome data of this rare disease.

Adamantinomatous Craniopharyngioma

Pathogenesis

ACP is histologically characterized by collections of whorl-like nodules consisting of cytokeratin-enriched dysplastic epithelium.49 The pathogenic mechanism of ACP is not fully understood, though recent animal model studies suggest a paracrine model in which cells within peripheral nodular structures drive tumorigenesis by signaling nearby epithelial cells of Rathke’s pouch origin to proliferate.2,46 Proponents of the cancer stem cell model have proposed that tumors populate and repopulate upon recurrence from highly proliferative cancer stem cells.17 Interestingly, in vivo studies in mouse and rat ACP models have demonstrated that the pituitary stem cell markers SOX2 and SOX9 are expressed focally in the peripheral nodular clusters but not within the epithelial tumor mass itself.3,20 Increased SOX9 expression correlates with recurrence, consistent with a paracrine model in which pituitary stem cells drive dysplastic proliferation of nearby epithelial cells.16 This pathogenic model requires further investigation and validation, but provides a framework to consider potential avenues for therapeutic targeting.32

Wnt/β-Catenin Pathway

β-catenin is a cytoplasmic protein that mediates gene transcription and cell-cell adhesion. In the absence of the Wnt ligand, β-catenin undergoes proteasomal degradation as a result of interactions between Axin, glycogen synthase kinase 3 beta (GSK3β), and anaphase-promoting complex (APC) complex. β-catenin is prevented from activating the transcription factors T-cell factor (TCF) and lymphoid enhancer factor (LEF). Wnt binds the Frizzled receptor (Fz) and initiates a signaling cascade that causes inactivation of the Axin/GSK3/TCF complex. In the presence of Wnt, β-catenin is not degraded and induces TCF/LEF-mediated transcription. This signaling pathway regulates embryonic development, and mutations along the pathway are implicated in multiple disease processes.51 The Wnt/β-catenin signaling pathway is dysregulated in ACP. Activating mutations in exon 3 of CTNNB1, which encodes the signaling molecule β-catenin, are found in 94%-96% of ACPs.24,59 The CTNNB1 mutations observed may carry differential prognostic information.31 Nucleocytoplasmic β-catenin accumulation is a consistent and specific finding in ACP.34 A mouse model of ACP has shown that β-catenin accumulates in epithelial tumor cells even when an activating mutation in CTNNB1 is driven exclusively in SOX2-expressing pituitary stem cells localized in peripheral nodules.5 This suggests robust paracrine signaling from the peripheral nodular cluster cells to the epithelial cells that comprise the tumor.1

Aberrant membranous β-catenin expression patterns have been associated with worsened outcomes in ACP, so counteracting β-catenin provides an avenue for therapy.40 The ubiquity of Wnt/β-catenin dysregulation in other diseases has led to the production of dozens of pharmacological therapies that decrease Wnt/β-catenin signaling, including multiple small molecule inhibitors of β-catenin that could hold promise in the treatment of ACP.70

Growth Factor Signaling

Disrupted growth factor signaling is a hallmark of ACP. Increased expression of epidermal growth factor receptor (EGFR), vascular endothelial growth factor (VEGF), fibroblast growth factor (FGF), growth hormone (GH) receptor, and insulin-like growth factor (IGF) 1 receptor (IGF-1R) have been implicated in this disease.44,68 EGFR is immunohistologically detectable in the majority of ACP, and its activated form localizes to peripheral nodular cluster cells.24,36 EGFR mRNA is overexpressed in ACP compared to normal pituitary gland and other pituitary tumors.32 Gefitinib, an EGFR inhibitor, has been shown to decrease ACP cell motility and share its potential clinical utility.71

Recurrence in ACP is associated with increased VEGF expression.65 VEGF is a transcriptional target of Wnt/β-catenin signaling, and its gene expression is increased in ACP.32 Further study of the impact of VEGF signaling in ACP will help determine the potential clinical utility of VEGF inhibitors, such as bevacizumab, which have revolutionized cancer management as a first-line therapy across a variety of cancers.39,58,67 FGF localizes to peripheral nodular cluster cells, is overexpressed in ACP, and correlates with recurrence.32,62 Its mechanistic significance remains unknown, though the most highly expressed FGF isoform in ACP, FGF4, has been implicated in tumorigenesis and progression in other cancers.74,75

GH receptor (GHR) expression is associated with early progression.52,66 GH deficiency commonly presents postoperatively, so increased GH and GHR expression may more likely reflect an adaptive response.53 IGF-1R is present on the majority of ACPs.44
Developmental Morphogenesis

Bone morphogenetic protein (BMP) and sonic hedgehog (Shh) are paracrine growth-related signaling molecules that play a wide range of developmental and physiological roles. BMP4 is expressed in the peripheral nodular cells in human ACP and mouse models.2,37 ACP is characterized by high gene expression of genes encoding both BMP2 and BMP4, which are downstream of Wnt/β-catenin-mediated transcription.7,22 The expression of BMP2, which induces bone formation and remodeling, correlates with calcification in ACP.33 Likewise, BMP4, Shh also localizes to ACP peripheral nodular cluster cells.2 Shh signaling pathway genes are overexpressed in ACP as well, and its cleaved active form is highly expressed.32,38 Targeted inhibitors of Shh, including vismodegib and sonidegib, have been approved for basal cell carcinoma but have not been studied in craniopharyngioma.

Extracellular Matrix Proteolysis

Extracellular matrix (ECM) molecules regulate the microenvironment and tumor invasion across many cancers. Matrix metalloproteinases (MMPs) cleave ECM structural proteins such as collagen, fibronectin, elastin, and laminin to contribute to tissue development, remodeling, and repair.36 Their ability to alter the ECM environment also enhances the invasive capacity of cancers.22 MMP-7 and MMP-9 are transcriptional targets of Wnt/β-catenin signaling and their gene expression is elevated in ACP.32 Furthermore, gene expression of MMP-12 in craniopharyngioma is elevated 820-fold over normal pituitary tissue and other pituitary tumors,32 while MMP-9 protein expression is increased in recurrent ACP.37 Interestingly, while the latent forms of MMP-9 and MMP-12 are present in other pituitary tumors, their cleaved, active forms are present only in ACP.32 As novel MMP inhibitors develop, they may serve as therapeutic options to address recurrence in ACP.

Immune Microenvironment

The importance of the immune microenvironment is increasingly recognized in tumor pathogenesis. For instance, the discovery of increased immune suppression by PD-1 signaling in cancer motivated the development of the anti–PD-1 monoclonal antibody nivolumab, which has been successfully trialed in multiple cancers.4,21,64 The microenvironment of ACP has not been extensively characterized, but recent studies suggest disruptions in immune factors within these tumors. C-X-C motif chemokine 12 (CXCL12), a chemokine that activates leukocytes, and its receptor, CXCR4, are present in ACP and demonstrate increased expression in recurrent ACP.30 CXCL12 attracts lymphocytes robustly, but despite increased CXCL12 signaling in recurrent ACP, these lymphocytes are unable to suppress recurrence.10 This implies that recurrent ACP harbors an intrinsic mechanism to suppress the immune response. Expression of the interleukin-2 (IL-2) receptor (IL2R), which is normally present on lymphocytes to bind the IL-2 chemokine, is increased in ACP, suggesting that sequestration of IL2 may be another mechanism of immune evasion.32 The IL2R expression may instead reflect lymphocyte infiltration into the study’s ACP sample, suggesting that immune cells can localize to ACP but are rendered ineffective through checkpoint inhibition or another mechanism. Proteomic analysis of ACP cystic fluid reveals the presence of multiple inflammatory markers.48

Retinoic Acid Receptor

In addition to the aforementioned disruptions, ACP demonstrates immunoreactivity to retinoic acid receptors (RARs) RARα, RARβ, and RARγ, and the ratio of RARγ/RARβ immunoreactivity correlates with recurrence.45 All-trans retinoic acid (ATRA), the substrate of RAR, induces ACP cellular apoptosis in vitro.47 The presence of cathepsin K, a lysosomal cysteine protease, correlates with RARγ immunoreactivity and may be a downstream effector of RARγ signaling.47

Future Directions

Recent studies have partially clarified the pathogenesis of ACP, including the role of paracrine signaling of growth factors and microenvironment elements. Many of these findings include aberrancies that can be targeted with existing drugs, including therapies targeting β-catenin, EGFR, and VEGF (Fig. 3 right).

Most importantly, the adamantinomatous subtype, like its papillary counterpart, is characterized by a defining genetic alteration: the majority of cases harbor CTNNB1 mutations. However, a significant difference is that this alteration is not readily targetable. In this way, craniopharyngioma is a vignette of the promise and the challenge of the application of contemporary genomics approaches to identify therapeutic targets. PCPs illustrate the promise—detection of a known pathogenic allele (BRAF V600E) in nearly all tumors for which a widely used inhibitor is deployable—while the much more common ACP demonstrates the challenge, in which nearly all tumors are found to harbor a mutation that, though alluring, is currently untargetable.

Discussion

Management of craniopharyngioma remains difficult despite significant advances in operative technique, adjuvant therapies including radiotherapy, and medical management. Patient quality of life is significantly affected by significant metabolic and endocrine disturbances, neurocognitive and psychological sequelae, and the high risk of recurrence. The burden of craniopharyngioma on society in terms of years of productivity lost is especially large, given that the majority of cases are ACPs that have an early age of onset. Advances in therapeutics are needed to combat this aggressive disease.

While there are a variety of adjuvant therapies for craniopharyngioma that provide additional therapeutic response, including the use of bleomycin and IFNα, the morbidity rates for ACP and PCP remain significant. An alternatively alluring concept is the use of genomic tumor data to curate targets for therapy. By targeting the fundamental biological drivers of craniopharyngioma, these therapies hold promise for substantial effects on tumor growth and regrowth. A barrier for the development of
targeted therapies for craniopharyngioma may also trigger positive selection of resistant cancer cells, leading to tumor recurrence. Multidrug regimens combat this phenomenon and have been shown to delay disease relapse.26

Detailed genomic and molecular studies of ACP have begun to uncover the complex pathogenic nature of the disease. Histological studies suggest that ACPs arise from oral epithelial cells in the anterior pituitary in response to aberrant growth factor signaling from nearby pituitary stem cells. These stem cells are concentrated in peripheral nodular clusters. In ACP, overactive β-catenin signaling due to mutations in exon 3 of CTNNBI prompts the transcription of growth, morphogenetic, and ECM factors that then drive disease progression. Each point along this pathway provides an opportunity for therapeutic targeting, and inhibitors of β-catenin, EGFR, VEGF, RARs, and MMPs have been developed for and tested in patients with other cancers. Studies of these inhibitors on animal models of ACP are necessary to determine which therapies will be most effective, and in the pursuit of personalizing medication regimens, the histological and genomic profiles of each ACP should guide its management.

Genomic studies of PCP reveal that V600E mutations in B RAF cause the overactive B-Raf to upregulate transcription via the MAPK pathway. This exact mutation also drives melanoma growth and consequently, has motivated the development of targeted kinase inhibitors against B-Raf as well as inhibitors to use for recurrent tumors containing therapy-resistant mutations. Usage of targeted therapy against B-Raf has been reported in four PCPs with positive response, with its long-term efficacy to be determined in larger-scale clinical trials.

Conclusions
Craniopharyngioma is a complex tumor from both a surgical and medical standpoint. Novel operative techniques have brought the field closer toward safe gross-total resection, but studies into craniopharyngioma biology are necessary to combat tumor progression and recurrence. Major advances in the field of targeted therapies for use in oncology have recently been made. Coupled with new insight into craniopharyngioma pathogenesis with regard to genomic and molecular alterations, targeted therapeutic hold promise for clinical utility against this aggressive disease. Their validation, order of use in the sequence of contemporary treatment options, durability, and associated resistance susceptibility are just some of the major questions to be answered as targeted therapies for craniopharyngioma moves from promise to practice.

References

Disclosures
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