Lucien J. Rubinstein: enduring contributions to neuro-oncology

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Dr. Lucien Rubinstein is best remembered for his significant contributions to the field of neuropathology, particularly in the classification of nervous system tumors. His accomplishments in basic neuro-oncology and in the formulation of diagnostic principles reflected a unique talent for synthesizing fundamental clinicopathological concepts based on skillful diagnostic investigation and a thorough understanding of neurobiology. Dr. Rubinstein was the leader in the establishment of cell cultures from central nervous system (CNS) tumors. He meticulously analyzed both light and electron microscopic features of CNS tumors, recorded his findings, and patiently drew sketches to be shared generously with his colleagues and students. As a pioneer in neuropathology, in his work Dr. Rubinstein set the foundation for many enduring concepts in neurosurgery, neuro-oncology, neurology, and basic tumor biology.

KEY WORDS • Lucien Rubinstein • neuropathology • neuro-oncology • history of neurosurgery

BIOGRAPHICAL SKETCH

Lucien Rubinstein was born in Antwerp, Belgium on October 15, 1924, but immigrated to England during the Second World War. After a year at Queen Mary College, he was admitted to the Medical College of London Hospital, from which he graduated as an M.D. in 1952. After his military service, he joined the staff of the Bernhard Baron Institute of Pathology at the Royal London Hospital and collaborated with Professor Dorothy Russell. After a sabbatical year in which his time was split between the University of Minnesota and the National Institutes of Health, he moved to the US permanently in 1961. After 3 years at the Montefiore Hospital in New York, in 1964 he accepted a professorship in the Neuropathology Department at Stanford University. Dr. Rubinstein became the director of the Division of Neuropathology at the University of Virginia in April 1981.

Rubinstein had a very productive life; his contributions and collaboration with Dr. Dorothy S. Russell led to the textbook Pathology of Tumours of Nervous System, which was first published in 1959. This book has been the most authoritative and scholarly work in the field of neuro-oncology. As Urich states in Dr. Rubinstein's obituary, “...[the] completely rewritten fifth edition was entirely his own; the distillation of his experience and wisdom, and will remain his scientific testament.” Dr. Rubinstein wrote five editions of Pathology of Tumours of the Nervous System, the Atlas on Tumors of the Central Nervous System, 139 articles in the literature, 14 book chapters, more than 50 published papers presented at national and international meetings, and the translation of the Manual of Basic Neuropathology by Escourrolle and Poirier. He had editorial responsibilities for Neuropathology and Applied Neurobiology, the Journal of Neuropathology and Experimental Neurology, Acta Neuropathologica, Clinical Neuropathology, Journal of Neuro-oncology, Cancer, and Virchow's Archiv. He was an advisor to the Commission on the Histopathological Classification and Nomenclature of Tumors of the World Health Organization.

His professional life was dedicated to understanding the cytogenesis and differentiation of CNS tumors. He was a great teacher and a mentor who participated in the education of more than 50 trainees and visiting scholars from nine different countries. Neuropathology was his life and it was a pleasure so much above and beyond being a duty that he put all his soul into it; that could be well appreciated by his own words:

But what I missed most, perhaps, [at the conference at which he gave the talk] was [the] unashamed and hedonistic view that we’ve all concealed and which I will whisper to you. It is that neuropathology is an exquisitely enjoyable pursuit. That anything that is fun to do must obviously be fun to teach and it is by communicating this emotional involvement in

Abbreviations used in this paper: CNS = central nervous system; GBM = glioblastoma multiforme; GFAP = glial fibrillary acidic protein; NSE = neuron-specific enolase.
which we are wrapped, Mr. Chairman, that we can best fulfill

two of our imperatives, the obligation to pass on to others the

body of knowledge with which we have been entrusted and the

secret wish we all have replicate ourselves.14

Dr. Rubinstein shared his unrivaled experience in clinical

neuropathology and the applications of his novel ideas

and translational research in the field of neuro-oncology

(Fig. 1). He was the most consulted neuropathologist in

the world; he had more than 6500 consultation cases over

a period of 28 years.91

Dr. Rubinstein had diverse interests in life, including
classical music, literature, theater, and wine. He was a
good companion. Although English was not his native lan-

guage, he mastered it; his colleagues admired his ability to
describe morphological features with his precise English.
Dr. Rubinstein passed away in 1990 due to the complica-
tions of a basilar artery aneurysm. He was in peace when
he died. Just before his death he expressed to Dr. Van-
denberg, “I pine for nothing. My work is finished, the
book is done, and we’ve got research projects going but
this can be carried on.”14

CONTRIBUTIONS

We would like to discuss in more detail the concepts that
Dr. Rubinstein developed during his career. Rubinstein had
an infinite curiosity to elucidate the mechanisms of tumori-
genesis in CNS neoplasms; he and his wife, Dr. Mary M.
Herman, established cell culture systems for most of the
CNS tumors known at that time and observed the cellular

behavior of these lesions in vitro. In their most eminent
studies they assessed the growth kinetics of gliomas and
medulloblastomas in matrix culture. Rubinstein trans-

duled the experimental data into clinicopathological terms and
developed an algorithm for the lineages of cellular origin
for gliomas and other types of CNS tumors. He described

the importance of stromal and neural cell interactions in
mixed gliomas and sarcomas.

Dr. Rubinstein did pioneering work in the application of
GFAP to neuro-oncology, and he also performed immuno-
histochemical characterization of numerous CNS and peri-
nephral nervous system tumors. Moreover, he was the first
in the history of neuropathology to describe several tumor
entities, including true polar spongioblastoma, ependym-
blastoma, pleomorphic xanthoastrocytoma, and infantile
desmoplastic ganglioglioma. He analyzed desmoplast ic
medulloblastomas, cerebral neuroblastomas, astrocy-
toma variants, pineal parenchymal tumors, ependymal neo-
plasms, and meningeal tumors to define a thorough de-
scription of those lesions in the scheme of classification of
CNS tumors. Rubinstein relied on his own experience and
research to postulate that medulloblastomas had a unique
behavior and origin differentiating them from the rest of
the primitive neuroectodermal tumors.

Dr. Rubinstein always correlated his neuropathological
findings with clinical outcome, and he helped the clini-
cians by providing them with scholarly data about the
prognosis and precise therapeutic approaches to a given
tumor entity.1 Among hundreds of examples, we may
mention his extensive studies on the malignant evolution
of primary brain tumors; he carefully reserved the term
“anaplastic oligodendroglioma” as a diagnosis only in the
patients with rapidly growing, highly cellular, and poorly
derivatized oligodendrogliomas, relying on his longi-
tudinal follow up of those patients. Also, he exten-
sively studied the mechanism of extracranial metastasis of
GBMs. Important contributions beyond the description of
CNS tumors included characterization of the causative vi-
ruses of progressive multifocal leukoencephalopathy and
subacute sclerosing panencephalitis, and definition of the
 complications of radiation therapy in the CNS.76

Theories of Tumorigenesis in Nervous System Neoplasms

Dr. Rubinstein’s principal interest was in tumor patho-
genesis. He advanced the “neoplastic vulnerability” theory;
he believed that neoplastic transformation resulted from the
interaction of several factors: 1) the existence of a reserve
population of stem cells; 2) the capability of differentiated
cells to reenter the kinetic cycle; 3) the number of replicat-
ing cells at risk at a particular time; 4) the length of time
during which a particular cell population remained in the
cycle; 5) the state of current differentiation and the future
derivation potential of that population; and 6) the steps
of differentiation that were achieved in successive cell gen-
erations. He thought that the incidence of different types
of CNS tumors could be correlated with the width of the
window of neoplastic vulnerability. He proposed the existence
of a narrow window of vulnerability for rare tumors such as
medulloepitheliomas, cerebral neuroblastomas, gangliogli-
omas, and ependymoblastomas. By contrast, he wrote of a
relatively wider window for more common entities such as
medulloblastomas, astrocytomas, and mixed astrocytomas and

Fig. 1. Photograph of Dr. Rubinstein giving a lecture to his fel-
lows at Stanford University in 1977.
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oligodendrogiomas, and glioblastomas. With his theory, he tried to explain radiation-induced gliomas, in particular those arising after the apparently successful treatment of acute lymphocytic leukemia.63

Rubinstein properly documented the vascular proliferation of GBMs in vitro and in animal models. He postulated that mitogenic factors were secreted by GBM cells to promote angiogenesis. He was one of the first authors to describe the coexistence of gliomatous and sarcomatous elements in CNS tumors (gliosarcomas and sarcogliomas) that will be explained later in the text.66,72

Cell Cultures and Animal Models

One of Rubinstein’s greatest achievements in neuro-oncology was the development of reproducible tumor cell cultures from a variety of CNS lesions. Rubinstein believed that the organ culture technique was a suitable system for the study of cell kinetics in human malignant gliomas and for analysis of the in vitro effects of chemotherapeutic agents. He meticulously documented the immunohistochemical staining characteristics of various types of tumors in vitro to understand their structural and biochemical qualities. Immunohistochemical staining was applied to identify the various stages of neuronal and glial cell maturation in experimental neuro-oncogenesis.32,49,62 He studied growth kinetics in the human medulloblastoma and glioblastoma cell lines in vitro,27,49 and he investigated rat C-6 glioma in animal models in vivo.23 Moreover, cell cultures enabled him to comprehend the histogenesis of multinucleated giant cells in GBMs, the astrocytic nature of both the small cells and the giant multinucleated cells, and the capacity of both cell populations to synthesize DNA in culture and to demonstrate invasiveness.30 VandenBerg and Rubinstein developed a mouse teratoma model to elucidate the various stages of differentiation in neuroepithelial stem cells, and with their colleagues they explained neural differentiation in human embryonal CNS tumors.10,25,58,93 Immunohistochemical findings of differences between intracranial germinomas and their gonadal equivalents indicated that in the former, early epithelial or mesenchymal differentiation of the primordial germ cells might be present. These findings drew attention to the heterogeneous cellular composition of these otherwise morphologically homogeneous-appearing tumors and, especially in the posterior fossa, to their transitional links to the immature teratomas.59

Application of Immunohistochemistry

One of Dr. Rubinstein’s major contributions to diagnostic neuropathology was improving the diagnostic accuracy in challenging cases by application of immunohistochemical testing. He was one of the first investigators in the field of neuropathology who routinely applied immunohistochemical stains for neural markers, GFAP, NSE, the three protein subunits of neurofilaments, myelin basic protein, S100 protein, and the Leu-7 (HNK-1) and non-neuronal markers (vimentin, desmin, cytokertatins, Factor VIII, alpha-fetoprotein, human chorionic gonadotropin, and immunoglobulins) for the characterization of CNS tumors.5,13,18,36,58,67

Use of GFAP for Immunostaining

Rubinstein firmly established the recognition of GFAP expression as evidence of astroglial histogenesis and differentiation, and he established its applicability to the identification of tumors of astrocytic origin. He clearly demonstrated that GFAP was expressed in normal fibrillated astrocytes, and in reactive and neoplastic cells of astrocytic lineage. Its presence in nonastrocytic CNS tumors was related either to the development of glial fibrillarogenesis (ependymomas), to ontogenetic factors (oligodendrogliomas, chordoid plexus papillomas), or to uptake of the protein from adjacent reactive astrocytes (capsillary hemangioblastomas). Using GFAP, Rubinstein and Kepes66 described the pleomorphic xanthoastroctyoma as an astrocytic tumor, not one of meningothelial origin as others had postulated, and defined the GFAP expression in proliferating and invading cells in GBMs and medulloblastomas.31

Rubinstein tried to distinguish confusing phenomena of metastasis into gliomatous or epithelial differentiation of glial cells. Using immunohistochemical tools, he delicately distinguished aberrant epithelial neoplastic differentiation in a malignant glioma.46,48 He defined GFAP positivity in choroid plexus papillomas, stating that it is suggestive of a primitive neuroepithelial (ventricular) cell origin for these tumors, given the fact that normal choroid plexus epithelium lacks GFAP expression.77

Rubinstein defined GFAP immunostaining characteristics in GBM. He showed that the percentage of GFAP-positive cells was inversely related to the anaplastic character of the tumor. He used GFAP to define atypical variants of GBMs in which diagnostic difficulties were encountered. He was interested in a rare type of this lesion, namely a GBM with heavily lipidized (foamy) tumor cells that generally obscured their glial nature and distinguished them from the pleomorphic xanthoastrocytomas.74 The immunohistochemical characteristics of oligodendrogiomas were enigmatic for him and he tried to characterize them with the markers available at that time, describing these markers’ usefulness in oligodendrogliomas.15,51,55

Use of NSE as a Marker

Another marker of diagnostic importance frequently used by Rubinstein was NSE. He studied the cellular distribution and intracellular localization of NSE by immunoelectron microscopic findings in neurons of the cerebrum, cerebellum, and brainstem in rats and mice.30 He demonstrated differential expression of NSE in neural and non-neuronal tumor cell lines of rat and human origin, and interestingly, he found the expression of NSE in reactive astrocytes, schwannoma cells, and gliomas, in addition to neurons and neuroendocrine cells. He hypothesized that glial cells containing only the nonneural form of enolase might transform into neoplastic cells. When the transformation took place, the elevated metabolic demands imposed on neoplastic and reactive glial cells (and on some extraneural tumors) necessitated the opening up of metabolic pathways that were normally operative only in neurons and neuroendocrine cells, therefore resulting in the synthesis of the more stable neuron-specific form of enolase.96,97,99 He confirmed the positive reaction for NSE in a variety of glial and other cerebral neoplasms obtained intra-
operatively, including glioblastoma, astrocytoma, oligodendroglioma, ependymoma, medulloblastoma, pineocytoma, meningioma, and choroid plexus papilloma; peripheral neural tumors such as neuroblastoma, ganglioneuroma, and parangangioma; and endocrine and neuroendocrine tumors. Because it was expressed in many cells as well as in reactive astrocytes, he ultimately considered NSE to be of less value in the differential diagnosis of CNS tumors.95,100

Use of the Leu-7 Marker

The Leu-7 (HNK-1), a hematological marker, has been found to cross-react with cells of schwannian origin, and Rubinstein found it helpful in the differential diagnosis of schwannomas and neurofibromas from other soft-tissue neoplasms.34 He used several markers for peripheral nerve sheath tumors. Normal, reactive, and neoplastic perineurial cells stained consistently for epithelial membrane antigen, whereas only Schwann cells expressed S100 in addition to Leu 7.53 He suggested that human nerve sheath tumors contained cells with polypeptides that shared epitopes with GFAP; however, these polypeptides differed from astrocytic GFAP by at least one epitope.49

Clinical Applications for Diagnostic Advances and Classification Schemes

Pleomorphic Xanthoastrocytomas. Rubinstein, Kepes, and Eng were the first authors to describe “pleomorphic xanthoastrocytoma (PXA)” as a distinct entity.38 In their original description, pleomorphic xanthoastrocytoma was characterized as a tumor most often presenting superficially over the cerebral hemisphere of young patients, involving the leptomeninges extensively. These tumor cells displayed marked pleomorphism, including bizarre giant cells and a number of mitotic figures, but no necrosis. Many contained large amounts of lipid in their cytoplasm and were surrounded by reticulin fibers, thus simulating a mesenchymal tumor. Kepes, et al., suggested that subpial astrocytes could be the origin for this neoplasm. They established that pleomorphic xanthoastrocytoma was a glial neoplasm with GFAP positivity, and they provided the clinical evidence that described its transformation into a GBM on its recurrence.37 In their series of 35 patients, most had a good prognosis, even in the absence of postoperative radiation treatment. Most of the recurrent tumors did not reveal a change in histological character; malignant evolution was exceptional. Kepes56 reviewed the steps taken with Rubinstein that led to the recognition of the basic characteristics of this neoplasm and its designation as an independent entity.

Gangliogliomas and Ganglioneuromas. Rubinstein had a personal series of 120 ganglion cell tumors in which he studied the electron and light microscopic features, revealing three distinct tumor cell types. In addition to neuronal and astrocytic components, he clearly defined a mesenchymal component that could be responsible for the rich connective tissue stroma that was characteristic of the ganglion cell tumors in the CNS.40 As he did for all for other types of CNS tumors, Rubinstein explained the histogenesis and mode of development for these lesions and correlated this with their clinical evolution. In his series of 120 patients, gangliocytomas and gangliogliomas had a good prognosis due to their slow growth, well-differentiated cell-
cytogenetic scheme to serve as a frame of reference for a classification of embryonal CNS tumors that would account for the different histological entities and for the range of and the restrictions on their differentiating capabilities. Among the embryonal CNS neoplasms, the cerebral medullopithelioma, the cerebral and cerebellar neuroblastosomas, the primitive polar spongioblastoma, and theependymoblastoma showed characteristic morphological features and a correspondingly distinctive cellular differentiating potential. The differentiating capabilities of the cerebellar medulloblastoma, the pineoblastoma, and the retinoblastoma were also distinctive, and were determined by the cytogenesis of the area of the CNS in which the tumors originate. Rubinstein’s observations, which still preserve their validity, revealed that Flexner–Wintersteiner rosettes were common in retinoblastomas, infrequent in pineoblastomas, rare in medulloblastomas, and absent in cerebral neuroblastomas. Calcification was common in retinoblastomas and cerebral neuroblastomas, but absent in medulloblastomas. Pale islands of tumor cells, denoting some degree of neuronal maturation, were present in childhood medulloblastomas, and only occasionally in medullopithelioma. True ependymal rosettes were found in ependymoblastomas. Medullary rosettes and tubes defined the medullopithelioma. Recent developments in molecular and genetic diagnostic methods support Rubinstein’s theory that embryonal central neuroepithelial tumors are distinct from medulloblastoma (referred to later in the text).

Rubinstein had a major interest in medullopithelioma, desmoplastic infantile gangliogioma, pineoblastoma, and medulloblastoma. He defined them as “multipotential” in light of their capacity to undergo divergent differentiation. Nevertheless, he concluded that even in very primitive neoplastic neuroepithelium, immunohistochemical evidence of early commitment of some of the cells to either a neuronal or glial lineage could be demonstrated. He stated that the class III beta-tubulin isotype was a very early neuronal marker shown in cells with early neuronal commitment both in the normal neurocytogenesis and neoplastic processes in human embryonal tumors of the CNS. He defined the early stages of progressive neuroepithelial differentiation and neuronal commitment in primitive neuroepithelium in medullopithelial rosettes. He associated those lesions with other congenital renal tumors to understand their pathophysiological features. The aforementioned studies conducted by Rubinstein and VandenBerg in a mouse teratoma model with neuroepithelial stem cell precursors remain mitotically active even after birth and constitute potential targets for transforming insults.

Cerebral Medullopithelioma. The cerebral medullopithelioma is a rare, embryonal, multipotential, central neuroepithelial neoplasm of childhood. The microscopic appearance of medullopithelioma is highly distinctive, with pseudostratified columnar to cuboidal epithelium in a papillary or tubular pattern. Pale islands in the tumor were shown by Rubinstein to display the entire range of differentiation, from embryonal to mature cells of both glial and neuronal lineage (that is, primitive medullary epithelium, spongioblasts, astrocytes, oligodendroglia, ependymoblastic and ependymal cells, neuroblasts, and mature ganglion cells). The prognosis is poor, with a median survival of 6 months, and these tumors frequently cause cerebrospinal seeding. Cerebral medullopithelioma is rarely associated with other embryonal tumors.

Medulloblastoma. The medulloblastoma is essentially a cerebellar neoplasm with various degrees of maturation, chromosomal abnormalities, and clinical characteristics. Rubinstein was fascinated by these tumors and firmly insisted on maintaining a separation between the cerebellar medulloblastoma and the other embryonal neoplasms found elsewhere in the CNS, on both cytogenetic and practical grounds. He supported the hypothesis that the external granular layer is the origin of the medulloblastomas. Along with Kadin and Nelson, he reported the fetal granular layer adjacent to the tumor with marked neoplastic proliferation, which formed an irregular sawtooth pattern extending into the molecular layer in one patient with cerebellar medulloblastoma. A recently developed body of evidence based on molecular and genetic experimental studies delineated sonic hedgehog signaling as a contributor to medulloblastoma formation, and mutations of the sonic hedgehog receptor Patched are associated with medulloblastomas, which develop from the external granular layer.

Developmentally, the cerebellum has a unique pattern, with an external-to-internal migratory pathway and postnatal residuum of embryonal cells. Normally, granule cells arise from committed precursors that migrate during late embryonic development over the surface of the cerebellum to form a superficial germinal layer, the external granular layer. Perinatally, this layer expands dramatically as immature granule cell precursors in the outermost regions proliferate under the mitogenic influence of sonic hedgehog signaling. In the deeper region of the external granular layer, granule cells withdraw from the cell cycle and migrate inward, terminally differentiating in the internal granular cell layer. Unlike most neuronal populations, granule cell precursors remain mitotically active even after birth and constitute potential targets for transforming insults. Rubinstein established the concept of the differentiating bipotential of the cerebellar medulloblastoma by using experimental in vitro data. He developed an organ culture system from an undifferentiated human medulloblastoma and proved the ability of the tumor to differentiate into both astrocytes and neuroblasts in vitro.

Desmoplastic Medulloblastomas. In 1964, the term “desmoplastic” was first suggested by Rubinstein for the interpretation of fibrous connective tissue proliferation in the subarachnoid spaces due to tumor invasion. Neoplastic cells in the reticulin-free pale islands were shown to have features of predominantly neuronal and, to a lesser degree, astroglial differentiation by Rubinstein (Katsetos, et al.). This concept of a more differentiated cell population in desmoplastic medulloblastoma has been recently confirmed, and appears to be the basis for the better prognosis and treatment response in this category of medulloblastomas. This concept has initiated a new proposed classification of medulloblastomas.

Primary Cerebral Neuroblastoma. Horton and Rubinstein reported the largest series of primary cerebral neuroblastosomas and defined three subtypes: classic, transitional, and desmoplastic. The desmoplastic and the transitional forms were less likely to exhibit differentiation to mature ganglion cells, whereas the classic type was
similar to peripheral neuroblastomas and cerebellar medulloblastomas. Ganglionic differentiation was noted mostly in the classic variant. No correlation could be made in his series between survival times and histological variant of the tumor or the presence of ganglionic differentiation.\textsuperscript{2,28} He also described a pigmented olfactory neuroblastoma. The tumor contained a large amount of pigment, most of which had the histochemical reactions of melanin, but some of which had that of lipofuscin. The pigment was interpreted as presumably representing a modified catecholamine degradation product.\textsuperscript{13} Rubinstein’s series of 70 cases revealed a relatively better survival rate compared with other malignant central neuroepithelial tumors, with a 3-year survival in 60% of the patients. Nevertheless, recurrence was common and usually occurred within 3 years after surgical treatment. Whole craniospinal axis radiation was suggested because of the high rate of craniospinal seeding.

Desmoplastic Infantile Gangliogioma. Biologically this entity, which has a more favorable prognosis, was concluded to be closer to gangliogiomas than to neuroblastomas. VandenBerg and Rubinstein reclassified four of his previous cerebral neuroblastoma cases as “desmoplastic infantile gangliogiomas” with distinct pathological features, intense desmoplasia, and the frequent presence of divergent astrocytic and ganglionic differentiation. Despite the lesion’s voluminous size, he suggested that after the successful complete or subtotal resection, these tumors followed a favorable clinical course similar to gangliogiomas rather than primitive cerebral neuroblastomas.

True Polar Spongioblastoma. Rubinstein described this rare embryonal neoplasm with primitive characteristics, in which the tumor cells were aligned in parallel and pulsating fashion and separated by vascular stroma. He classified divergent lines of differentiation into astrocytoma or oligodendroglioma. Rubinstein believed in the malignant potential of polar spongioblastomas as the transitional stage in the evolution of diffuse astrocytomas into GBMs, despite the fact that there were patients with long survival times in his series.

Pineal Lesions. While demonstrating divergent differentiation in pineal parenchymal tumors, Rubinstein tried to explain the origin, structure, and function of the pineal gland. He showed that the human pineal gland retained some of the cytochemical characteristics of photoreceptor cells recognized by the monoclonal antibody A9-C6, and that S-antigen immunoreactivity might occasionally be expressed in pineal parenchymal tumors.\textsuperscript{37}

Rubinstein explained the differentiation of benign symptomatic pineal cysts from pineocytomas. In his series of pineoblastomas and pineocytomas he showed the potential of those tumors to differentiate along glial or ganglionic lines, or both, and defined the ultrastructure of one pineocytoma that had neuronal and astrocytic differentiation, which demonstrated the presence of numerous microtubules, clear-centered and dense-core vesicles, and synaptic complexes. He delineated the clinical behavior, therapeutic implications, and prognosis of pineocytomas according to the line of differentiation. He indicated that pineocytomas without cellular evidence of further differentiation were clinically malignant, but with a somewhat weaker tendency to metastasize than pineoblastomas; pineocytomas with astrocytic differentiation might be either slowly growing or malignant; pineocytomas with neuronal or with neuronal and astrocytic differentiation were relatively benign. According to the conclusions reached from his observations, he suggested as a management strategy for pineal region tumors that radiation should be administered to the entire neuraxis for patients with pineoblastomas and malignant pineocytomas. Pineal tumors are a clear example of how he used his expertise and unique talent to correlate the neuropathological findings with the patients’ prognosis.

Retinoblastomas. While showing positivity of neuron-associated class III beta-tubulin isoform (\(\beta\) 4), microtubule-associated protein 2, and synaptophysin in 26 retinoblastomas in situ and the human retinoblastoma cell line WERI-Rb1, Rubinstein proved early neuronal commitment with no evidence for a divergent (that is, neuronal and glial) differentiation capacity in retinoblastomas.\textsuperscript{2,35} His detailed work on immunohistochemical characteristics of different cell types of retinoblastoma (reactive astrocytes, undifferentiated neoplastic cells, differentiated cells forming Flexner–Wintersteiner rosettes) supported the view that retinoblastomas were composed of neuron-committed cells and favored the origin of these tumors from photoreceptor progenitor cells. Rubinstein correlated the neuropathological findings with the clinical picture and suggested a good prognosis for retinoblastomas; since then it has become known that retinoblastomas have a good response to treatment. Nevertheless, Rubinstein pointed out a very important aspect that clinicians should keep in mind: patients with retinoblastomas were prone to develop second malignancies, especially osteosarcoma, due to the genetic nature of heritable diseases.

Neurofibromatosis. Rubinstein defined the neuropathological features in 22 autopsies performed in cases of central and peripheral type neurofibromatosis. Besides the well-known cranial and spinal meningeal, nerve-sheath, and glial neoplasms in the central type of neurofibromatosis, he also defined very frequent and distinctive malformative CNS lesions (intramedullary and perivascular schwannomas, meningioangiomas, discrete ependymal eoptias, atypical glial cell nests in the gray matter, syringomyelia) associated with this type of the disease. In peripheral neurofibromatosis, he showed subependymal glioblastillary nodules, hyperplastic meningioencephalic gliosis, and micronodular capillary and arteriolar proliferations typical of the vascular form of this disease.\textsuperscript{7,13}

Papillary Meningioma and Primary Meningeal Mesenchymal Chondrosarcoma. Rubinstein had a keen interest in meningiomas in addition to primary intraparenchymal brain tumors. He described papillary meningiomas and reported the largest series of these tumors, which are invariably associated with other histological features of malignancy. In his series, a relatively large proportion of papillary meningiomas occurred in children. The histological features were composed of a perivascular pseudopapillary pattern and local invasion with a high rate of recurrence and metastasis. The tumors often displayed aggressive clinical behavior marked by a high rate of local recurrence or the development of distant metastases. Currently, in the World Health Organization classification,

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papillary meningiomas are classified as Grade III, malignant meningiomas.

Rubinstein personally reviewed eight cases of primary meningeval mesenchymal chondrosarcoma and four similar cases previously reported by others. He defined the clinicopathological features. There was an apparent correlation between the frequency of mitotic figures and the likelihood of recurrence and metastasis. After his electron microscopic assessment he concluded that the neoplastic cells represented primitive precartilaginous mesenchyme displaying focal cartilaginous differentiation.87

Sarcoma and Glioma. Rubinstein tried to explain the concurrent presence of gliomas and sarcomas in the CNS. He reported a series of mixed cerebral tumors histologically characterized by a peripheral distribution of the gliomatous elements in relation to a more centrally situated meningeval or intracerebral sarcoma. He suggested that these tumors be termed “sarcogliomas” to distinguish them from gliosarcoma.29 He also described mixed capillary hemangioblastoma and glioma and reserved the term “angioglioma” for only true mixed tumors of glial and vascular tissue origin.1

Hemangioblastoma. Rubinstein suggested that hemangiopericytoma, hemangioblastoma, or angioblastic meningioma were from the same source; from polyblastic mesenchymal cells originating in or derived from the meninges.29 He maintained in culture a capillary hemangioblastoma and glioma and reserved the term “angioglioma” for only true mixed tumors of glial and vascular tissue origin.1

Rubinstein considered many aspects of therapeutic ionizing radiation on the healthy brain or spinal cord. He described microscopic features: coagulative necrosis, demyelination, mononuclear response and perivascular lymphocytic infiltrate, fibrinoid necrosis of blood vessel wall, proliferation of endothelium, thrombotic occlusion, hyalinization of vessel wall, and extensive and relatively acellular fibrosis.20 Rubinstein emphasized that those changes occurred in white matter; furthermore, he noted cortical changes including neuronal loss, degeneration, calcification, and bizarre and binucleated neurons. He recognized markedly thickened gyri with laminar disorganization and many unusually large and abnormally shaped ganglion cells. Abnormally large, misshapen neurons contained excessive accumulations of cytoskeletal intermediate filaments related to therapeutic irradiation of the brain.182

Rubinstein was the first to describe radiation-induced changes in the cerebellum; the earliest change was the development of empty spaces in the Purkinje layer, confluence of those spaces to form vacuoles, loss of neurons, fibrillary gliosis, demyelination, extravasated fibrin material that spread radially along the molecular layer, and hyalinization of vessels. Rubinstein also reported secondary glial neoplasms, meningiomas, and neurofibrosarcomas following ionizing radiation therapy.20

CONCLUSIONS

Lucien Rubinstein’s remarkable career spanned four decades. Although he is most remembered for the classification of CNS tumors and publication of the authoritative textbook Pathology of Tumours of the Nervous System, he made invaluable contributions to modern neuro-oncology, including recognition of the importance of cell cultures and animal modeling, theories of tumorigenesis, description of new pathological entities, and careful classification of those previously known, by using innovative immunohistochemical techniques. Many of his correlations between the histopathological evaluations of tumors and outcome are just as valid today as when first proposed. His careful, systematic study of each tumor specimen and its relationship to the underlying neurobiological features set the standard for diagnosis and classification of CNS tumors.

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