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Fluorescein sodium in the surgical treatment of recurrent glioblastoma multiforme

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Fluorescein-guided resection of recurrent glioblastoma

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Abstract

Background

Glioblastoma multiforme (GBM) is the most common primary brain tumor and has a high recurrence rate. Maximizing the extent of resection (EOR) in recurrent GBM has proved to be the cornerstone of neurosurgical re-treatment. The development of surgical microscopes fitted with fluorescein-specific filters has facilitated fluorescein-guided microsurgery and the identification of tumor tissue. Use of fluorescein sodium (FL) in primary high-grade glioma resection has shown promising results. Here, we present our experience with FL and the dedicated surgical microscope filter YELLOW 560 nm in 106 patients with recurrent GBM.

Methods

106 patients with recurrent GBM were included (53 women, 53 men, mean age 53 years). 5 mg/kg bodyweight of FL had been intravenously injected approximately 45 min. before craniotomy. A YELLOW 560 nm filter (Pentero 900, ZEISS Meditec, Germany) was used for microsurgical tumor resection and resection control. Surgical reports were reviewed regarding the degree of fluorescent staining. Postoperative MRIs were examined within 48 hours after surgery regarding the extent of resection and postoperative courses regarding neurological outcome, complications, and any adverse events.

Results

Bright fluorescent staining was present in all patients, which markedly enhanced tumor visibility and was deemed helpful for tumor resection. 17 patients (16%) showed residual tumor tissue on the postoperative MRI. Thus, gross-total resection (GTR) had been achieved in 89 (84%) of patients. No adverse events were registered postoperatively.

Conclusions

FL and YE560 are a readily available method for fluorescence-guided tumor resection, similar to contrast enhancement in T1-weighted MRI. FL may improve resection in recurrent GBM with minimal risk, and tumor margins are clearly visualized.

FL and the YELLOW 560 nm filter are safe and feasible tools for safe maximal resection of recurrent glioblastoma.
Introduction

Patients with glioblastoma multiforme (GBM) will inevitably experience recurrence of the disease, even after successful first treatment. This makes GBM one of the most aggressive forms of cancer. Surgical tumor resection and adjuvant treatment are widely regarded as first-line therapy, but no standard treatments are yet available in the case of recurrent disease. Re-surgery is common practice at many neurosurgical centers following tumor board reviews. The ultimate aim of surgery is safe gross-total tumor resection (GTR) while preserving function, because any deficit due to surgical intervention will lead to an undesirable risk/benefit ratio. Surgery has a fundamental role in the management of recurrent GBM because of the established incremental benefit of the EOR on progression free survival (PFS) and overall survival (OS).

Consequently, technical means to improve the EOR have emerged. Proven technical adjuncts aiding safe and complete resection of high grade gliomas are neuronavigation, intraoperative magnetic resonance imaging (iMRI), ultrasound, and fluorophores such as 5-ALA.

Another fluorophore, fluorescein sodium (FL), has been evaluated under white light and, more recently, under filtered light. It is over 40 years that fluorescent molecules have been evaluated and approved for diagnostic use in ophthalmology. Since the emergence of a fluorescein-specific microscope filter, FL has been evaluated in different pathologies of the central nervous system. The presumed mechanism of action is passive staining of the extracellular space in areas with a disrupted blood-brain barrier (BBB), corresponding to the Gadolinium uptake on MRI. Neira et al. showed that FL could mark tumor tissue beyond the limits of Gadolinium enhancement. This effect can also be exploited in glioma surgery, in which even single perivascular glioma cells disrupt the BBB. FL-guided resection has been safely shown in cases of high grade glioma. This retrospective study for the first time evaluates the use of low-dose FL, aided by a microscope-integrated filter, for the removal of recurrent GBM regarding the EOR, feasibility, and safety.
Methods

Patients
Patient records and neuropathological databases at the University of Regensburg, Germany, the Istituto Carlo Besta in Milan, Italy, Odense University Hospital, Denmark and the Liv Hospital in Istanbul, Turkey, were retrospectively reviewed to identify a consecutive series of all patients with recurrent GBM, who had undergone FL-guided tumor resection at either center between May 2012 and December 2016. Only patients with tumor recurrence eligible for GTR prior to re-operation were included. Patients were excluded from the study when complete removal of the contrast-enhancing lesion was deemed impossible. Eloquent areas were defined as lesions involving the language or motor system. Inclusion criteria were age 18 years and over, informed consent about the off-label use of FL, recurrent GBM in a non-eloquent area, and no known allergy to FL. The retrospective study was approved by the respective institutional review boards and in Denmark by the Danish Health Authority and the Danish Data Protection Agency. 106 patients, 53 women and 53 men, mean age 53 years (range 23-80) with recurrent GBM who had undergone fluorescence-guided tumor resection with FL, fulfilling inclusion/exclusion criteria, were identified and included for further analysis (table 1).

Surgical protocol
During the feasibility phase, patients of the three centers had intravenously received 200 mg or 5-10 mg/kg bodyweight of FL (Alcon Pharma, Freiburg im Breisgau, Germany; Monico SpA, Venice, Italy; Alcon Laboratuvarları, Istanbul, Turkey; Novartis Healthcare, Copenhagen, Denmark) after induction of anesthesia. After careful evaluation and in accordance with reports published in 2014, this dose was changed to a weight-adjusted dose (5 mg/kg bodyweight) administered approximately 30-45 minutes prior to craniotomy. Tumorous tissue was removed under FL-induced fluorescence with a YELLOW560 filter integrated into the microscope (PENTERO 900, ZEISS Meditec, Germany). When applicable, the Cavitron Ultrasonic Surgical Aspirator (CUSA) was used. Resection was stopped when the yellow-green staining of the enhancing tissue fainted and pinkish non-enhancing tissue appeared at the circumference of the tumor. Naturally FL-enhancing areas, such as the ventricular wall, were carefully identified. Unless continuation of surgery was deemed unsafe, for instance because of venturing into eloquent areas, surgical intervention was finished after removal of all fluorescing tissue as confirmed by filter view. Intraoperative monitoring, intraoperative ultrasound, and
neuro-navigation were used in selected cases.

Pre- and postoperative radiological assessment
Each patient had received a preoperative gadolinium-enhanced magnetic resonance imaging (MRI) scan and a postoperative MRI within 48 hours after surgery to rule out hemorrhage and to confirm the EOR.
A treatment-blinded neuro-radiologist distinguished between no residual enhancement >0.175 cm³ = GTR and residual tumor tissue = subtotal resection (STR).

Intraoperative fluorescence characteristics
Surgical reports were screened for subjective evaluation of the grade of fluorescent staining of the targeted lesion. Screening was conducted for any reference to the degree of fluorescent staining: ‘bright/helpful’ versus ‘effectively no fluorescence/not helpful’.
Furthermore, medical reports were evaluated for any possible adverse effect or allergic reaction to FL.

Results

Fluorescence
In all patients (n=106, 100%), intense yellow-green fluorescent staining of tumor tissue was noted. The Fluorophore accumulated in the tumor tissue providing distinct contrast between tumor and surrounding tissue and was deemed helpful for improved resection. Intraoperative fluorescent characteristics did not differ compared to primary GBM when recurrent tumor was encountered. Unspecific uptake of FL could be noted in scar tissue. No technical difficulties regarding the use of the microscope filter were encountered during the surgical interventions.

Extent of resection
17 patients (16%) showed residual tumor tissue on postoperative MRI. Thus, GTR (residual enhancement <0.175 cm³) was achieved in 89 (84%) of patients.
Adverse events

We did not encounter any morbidity or mortality attributable to the use of FL. Furthermore, no major side effects related to fluorescein were found throughout the observation period apart from yellow-colored urine and, in some patients, slight yellow discoloration of the skin.

Representative case

Figures 1+2

A 50-year old man underwent surgery because of a right fronto-temporal GBM. The preoperative image Gd-enhanced T1 MRI shows circular contrast-enhancement, the postoperative image does not show any residual enhancement.

Figures 3+4

Recurrent tumor was detected at routine follow-up 13 months after surgery resulting in subsequent reoperation. Postoperative imaging showed complete removal of the contrast-enhancing tumor.

Figures 5+6+7

Intraoperative pictures showing scar tissue under white light and under YE560 filter (*) with unspecific enhancement. After dissection, bright yellow staining of recurrent tumor tissue (+) can be seen.

Discussion

Ultimately, GBM is one of the most aggressive forms of cancer with devastating consequences for the patient. Only approximately 20-30% of patients with recurrent GBM are amenable to second surgery, which is recommended by the EANO guideline in large
but circumscribed tumors causing neurologic deterioration\textsuperscript{1}. The timing of repeat surgery in the case of tumor recurrence has failed to prove as a prognostic factor\textsuperscript{23}. Earlier reports advocated to aim for the maximum extent of resection\textsuperscript{24,25}, which seems to increase the rate of functional neurological deterioration in resections >80\%\textsuperscript{26}. Lately, the impact of EOR on survival has shown to be pivotal when conducting GTR\textsuperscript{27}. EOR ≥90 to <100 and ≥50 to <90 showed comparable survival rates (Median 9.3 vs 8.4 months). The effect of the EOR on survival in GBM surgery (6-month PFS ranging from 21.1\% to 41.0\%, OS did not reach significance) was shown by Stummer et al.\textsuperscript{6}.

Sanai et al. stated that OS incrementally improves with the percentage of tumor volume resected\textsuperscript{28}. A post-hoc analysis of the DIRECTOR-trial cohort\textsuperscript{29} by Suchorska et al. showed that, in comparison to incomplete resection, GTR significantly improves survival and leads to a smaller volume of recurrent tumor tissue\textsuperscript{30}. Marko et al. developed a mathematical model suggesting the superiority of a maximum safe resection strategy over rigid EOR thresholds\textsuperscript{31}. There is increasing evidence that GTR is superior to non-surgical treatment in recurrent GBM, but incomplete resection is non-inferior to the best medical treatment.

Seystahl et al.\textsuperscript{32} provided a flow chart facilitating the early diagnosis of recurrent tumor that can identify small-sized tumors in patients with good KPS. Surgical morbidity may be minimized through conducting regular follow-ups with MRI at 3-month intervals. A recent meta-analysis showed that GTR significantly improves PFS and OS compared to subtotal resection (STR) or biopsy alone. Thus, GTR should be preferred when clinically feasible\textsuperscript{33}.

In many cases, surgeons still have to rely on visual cues and tactile differentiation when resecting tumorous tissue. From a surgical point of view, treatment options become more and more limited over the course of the disease and can be reduced to safely maximize the extent of resection.

To maximize the EOR, the armamentarium available to neurosurgeons has been substantially extended over the past decades, for instance, through the operating microscope, Gadolinium-(Gd) enhanced MRI, ultrasound, and neuronavigation. The latest addition has been fluorescent agents to help surgeons to better distinguish between healthy and tumor tissue. The fluorescent agent 5-Aminolevulinic acid (5-ALA) and intraoperative MRI (iMRI) have both been reported as reliable means to maximize the EOR. When exploring the role of 5-ALA in combination with iMRI during GBM surgery, Gessler et al. found a slightly higher sensitivity of iMRI than of 5-ALA to detect residual tumor (75\% vs. 70\%)\textsuperscript{34}. In a further study using both means in recurrent GBM, they found decreased fluorescence of 5-ALA compared to Gadolinium-enhanced iMRI\textsuperscript{35}.

The benefit of FL-guided surgery in high grade glioma (HGG) and non-glioma surgery has
been extensively evaluated over the past years\textsuperscript{11,13}. Almost every author investigating this subject reported improved visualization and suggested a positive effect on the EOR\textsuperscript{12,20,21,36,37}. The recent results of the FLUOGLIO study, a multicentric prospective phase II trial, confirmed that FL-guided surgery is safe and enables a high percentage of contrast-enhancing tumor (82.6\%) in patients with primary HGG\textsuperscript{22}. GTR facilitated by the use of FL in our study (84\%) was much higher than the reported historic EOR in newly diagnosed GBM. Stummer et al. reported a GTR percentage of 36\% under white-light in the 5-ALA trial\textsuperscript{6}. McGirt et al. stated a GTR rate of 39\% in primary GBM\textsuperscript{24}. Both groups only included patients with tumors amenable to complete resection. A similar GTR percentage of 54.5\% was found for recurrent GBM by Ringel et al. in a large multicenter retrospective trial in which n=237 patients of 435 underwent re-resection at first recurrence\textsuperscript{27}. In a retrospective monocentric study of 107 patients by Bloch et al., GTR was initially achieved in 52 patients but only in 31 (60\%) patients at recurrent disease.

The rate of approximately 17\% of STR in our cohort was possibly due to surgical challenges, such as complete resection prevented by blind spots related to the approach or by proximity to eloquent areas detected by intraoperative monitoring. As with every other fluorophore, the added benefit relies on adequate exposure to visualize fluorescence.

We did not encounter any technical difficulties related to the use of FL or the filter, particularly with regard to the workflow or surgical ergonomics. Furthermore, no side effects attributable to the use of FL occurred intraoperatively or during the hospital stay, which is consistent with earlier experiences using FL for other intracranial pathologies.

What does FL achieve in the surgery of high grade gliomas? Experimental as well as clinical research has shown that glioma cells precipitate the breakdown of the blood-brain barrier (BBB), enabling FL to extravasate into the extracellular space via these disruptions. Such extravasation facilitates fluorescence, presumably making it a marker of the tumor path into the healthy brain\textsuperscript{9,16,18}. Vascular leakage and breakdown of the BBB is caused by increased blood vessel formation due to GBM\textsuperscript{38,39}. According to present knowledge, all intracerebral lesions enhancing Gadolinium on the preoperative MRI will also intraoperatively display fluorescence, because Gadolinium and FL are both distributed via increased vascular permeability. A recent study by Neira et al. suggests that objective intraoperative staining of FL is equivalent to the intensity of Gadolinium uptake on preoperative MRI\textsuperscript{17}. Furthermore, the authors found that FL-enhancement
extends beyond Gadolinium contrast-enhancing regions, which might be due to the smaller molecular weight of FL than that of Gadolinium. In primary GBM, the calculated sensitivity/specificity of FL ranges from 79/100% (Rey-Dios et al.\textsuperscript{40}) to 94/89.5% (Acerbi et al.\textsuperscript{41}), and 82.2/90.9\% (Diaz et al.\textsuperscript{9}). No data are available for recurrent GBM in this respect. The refinement of FL-guided surgery with a specific filter has made this technique inexpensive and safe, which is confirmed by a high percentage of GTR in primary GBM. Nevertheless, FL is still undergoing feasibility tests, particularly in combination with the Yellow 560 nm microscope filter. Approval of the drug by the respective competent authorities is pending. The recent evaluations of FL did not include any reports on relevant side effects, apart from yellowish discoloration of skin, scleras, and urine, which is usually fully reversible within 48 hours. FL has been extensively evaluated in ophthalmology, and very few adverse events have been registered during intracranial surgery\textsuperscript{42,43}.

In this multicentric retrospective feasibility study of 106 patients with recurrent GBM, we discovered bright and clear visualization of recurrent GBM lesions under FL-guidance, resulting in a high number of GTR. As stated in the surgical report, FL was useful for identifying recurrent GBM tissue, guided safe resection, and improved differentiation from non-contrast enhancing tissue. Many authors have evaluated the effect of the EOR on survival in GBM, also elucidating the benefit of resurgery. In a retrospective analysis, Lacroix et al. found an EOR of more than 98\% to impact survival (median survival 13 vs. 8.8 months)\textsuperscript{44}. Later, Sanai et al. found this effect with a threshold of 78\% of EOR in a cohort of 500 consecutive patients with primary GBM. More recently, Chaichana detected a minimum EOR threshold of 70\% for survival and recurrence in a retrospective analysis of 259 patients. At the same time, residual tumor volume was less than 5\%, resulting in prolonged survival\textsuperscript{45}. Grabowski et al. defined a residual contrast-enhancing tumor volume of less than 2 cm\textsuperscript{3} or an EOR larger than 98\% to significantly impact survival\textsuperscript{46}. In primary GBM, FL-guided resection resulted in an EOR between 75\% and 100\%\textsuperscript{17,20,21,36,37,41,47}. Furthermore, all authors noted improved visualization compared to white-light resection. Apart from better surgical adjuncts, other independent prognostic factors for identifying patients who will benefit from repeat surgery have come into focus. Age and the Karnofsky performance Scale (KPS) seem to play a major role\textsuperscript{48}. In a retrospective analysis of 204 patients with GBM, Tully et al. found that only 49 (24\%) patients received reoperation at recurrence. These patients were mainly younger and initially presented with smaller tumors, which resulted in an EOR of ≥50\%\textsuperscript{49}. Similarly, in a retrospective study by Ening et al., a KPS of >70 throughout the course of disease was
the threshold for patients to undergo a second operation\textsuperscript{50}.

This study has several limitations apart from its retrospective nature. Whether increasing GTR rates by means of FL improves survival is still subject to evaluation. Also, discerning pseudoprogression from recurrent GBM, i.e. evaluating the specificity and sensitivity for recurrent tumor tissue and scar tissue, needs to be investigated in future studies. Because of the multidisciplinary treatment of our cohort in multiple centers, no consistent data on adjuvant treatment were available.

To our knowledge, this is the first report evaluating FL in recurrent GBM.

Conclusions

We conclude that FL and the YELLOW 560 nm filter are safe and feasible tools for increasing the EOR in patients with recurrent GBM. However, this effect needs to be confirmed in a randomized controlled clinical trial with adequate power to precisely assess the outcomes within a pre-defined observation period.

Funding

No funding was received for this research.

Conflict of interest

Julius Höhne, Karl-Michael Schebesch, Alexander Brawanski, and Francesco Acerbi have received speaker’s fees from Carl Zeiss Meditec, Oberkochen, Germany. All other authors certify that they have no affiliations with or involvement in any organization or entity with any financial interest (such as honoraria; educational grants; participation in speakers' bureaus; membership, employment, consultancies, stock ownership, or other equity interest; and expert testimony or patent-licensing arrangements) or non-financial interest (such as personal or professional relationships, affiliations, knowledge or beliefs) in the subject matter or materials discussed in this manuscript.

Ethical approval

All procedures conducted in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and
with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Tables

Table 1. Demographic data (GTR=gross total resection, STR=subtotal resection)
References


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Table 1. Demographic data (GTR=gross total resection, STR=subtotal resection)
Abbreviations

GBM – glioblastoma multiforme

EOR - extent of resection

FL - fluorescein sodium

GTR – gross total resection

PFS – progression free survival

OS – overall survival

iMRI – intraoperative magnetic resonance imaging

BBB – blood-brain barrier

CUSA - Cavitron Ultrasonic Surgical Aspirator

MRI – magnetic resonance imaging

STR – subtotal resection

Gd – Gadolinium

HGG – high grade glioma