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Exploring the Role of Resection Post-Radiation Therapy in Gliomas

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A 45-year-old man was incidentally found to have a T2 hyperintense expansile anterior right frontal lobe mass during evaluation for pansinusitis. The patient underwent craniotomy with partial resection of the T2 hyperintense mass with pathology consistent with a diffuse World Health Organization grade 2 glioma, positive IDH1 mutation and 1p/q19 codeletion. The treatment team deferred completion resection. They proceeded with conventionally fractionated radiation therapy (54 Gy in 1.8 Gy daily fractions) with concurrent and adjuvant temozolomide recommended per CATNON and RTOG 9802.[1,2] After 5 of 12 cycles of adjuvant temozolomide, post-chemoradiation magnetic resonance imaging was notable for a decreased expansile T2/FLAIR mass and persistent diffuse signal abnormality in the right frontal lobe. The patient's case was reviewed for a second opinion on maximally completion resection.

Question

1. For a 45-year-old with good Karnofsky performance status who has completed concurrent chemoradiation therapy for a World Health Organization grade 2 glioma (1DH1 mutation and 1p/q19 codeletion), would you consider interval maximally safe resection?

References

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