Abstract

Ependymoblastoma is a malignant rarely reported neuroectodermal tumor. The authors describe a further case of cerebral ependymoblastoma and examine the clinical-prognostic aspects of this tumor in the light of the published data.

Keywords: Ependymoblastoma, primitive neuroectodermal tumor.

1 Introduction

Ependymoblastoma is a rare, highly malignant, neuroectodermal tumor, histologically distinctive and well-differentiated from anaplastic ependymoma [4, 6, 12]. Ependymoblastomas have a remarkably uniform appearance, consisting of an arrangement of densely-packed sheets of small cells intersected by numerous thin-walled blood vessels and forming numerous rosettes. The tumor cells are poorly differentiated, oval or spindle-shaped, with ill-defined cytoplasm and wispy polar processes. The nuclei are round to oval and contain coarse chromatin nodes. Mitotic figures are numerous. The most characteristic feature is the presence of ependymal rosettes and tubules lined with columnar cells: the rosettes are composed of cells forming multiple layers; mitotic figures are frequently demonstrable in a juxtaluminal position [4, 6, 7, 10, 12–14].

Ependymoblastoma, first described by Bailey and Cushing in 1926 [2], was identified as a distinct tumor by Rubinstein in 1970 [14]. Since then, 40 more cases have been reported, 27 complete with clinical details [1–14].

We report a further case of ependymoblastoma, bringing the total of detailed reports to 28, and analyze the clinical-prognostic aspects in this group of patients.

2 Case report

This 5-year-old girl was hospitalized with a 2-month history of gait difficulty accompanied by headache and vomiting during the second month. A CT scan showed a median, hyperdense lesion invading the IV ventricle with moderate, homogenous enhancement; triventricular hydrocephalus was also present (Figure 1). The patient presented ataxia and bilateral papilledema at neuro-
logical examination. She was submitted to surgery and an apparently total removal of a grayish, fleshy and circumscribed tumor invading the IV ventricle was achieved. Histologically, the tumor was hypercellular and composed of cells with hyperchromatic nuclei and small central-lumen multilayered rosettes and canals (true rosettes). In the more compact areas, undifferentiated hyperchromatic cells were present and mitoses were numerous. Histological diagnosis was ependymoblastoma (Figures 2, 3 a, b).

The child’s parents did not give permission for further chemo- or radiotherapy and she died 3 months after surgery from a recurrence.

3 Discussion

In 82% of cases, ependymoblastoma manifests during the first 5 years of life (range: birth to 36 years; median 3 years); in rare cases it was congenital (3 cases; 11%) or appeared in adulthood (3 cases; 11%). Males and females was affected similarly (M : F ratio; 1.1 : 1). Clinical history was generally brief (range 1 week to 7 months; median 3 months). Symptoms and signs are reported in figure 4.

All ependymoblastomas described were intracranial: in 20 (71%) the tumor was situated within the supratentorial compartment, in 7 (25%) in the subtentorial one, and in 1 (4%) in both with infiltration of the tentorium (9). Seventy-nine percent of ependymoblastomas inv

![Figure 2](image1.png)

Figure 2. Photomicrograph showed uniform tumor cells with rosettes and mitotic figures. Rosettes possessed multiple layers of nuclei and mitosis. H & E, × 200.

![Figure 3 a, b](image2.png)

Figure 3 a, b. The neoplasm composed of uniform neuroepithelial cells (3a) forming perivascular pseudorosettes, ependymoblastic rosettes (3b). H & E, × 165.

In our case, the site of the tumor (posterior cranial fossa) and its neuroradiological appearance (hurdydense tumor with moderate enhancement) ini-