Intradural spinal tumours: a pictorial review

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Learning Objectives

- To summarize the range of intramedullary and intradural extramedullary spinal tumours in the adult and paediatric populations.
- To provide an approach for distinguishing tumours from lesions that mimic tumours and for narrowing the differential diagnosis according to imaging findings.

Background

Intradural spinal tumours, although relatively uncommon, can be diagnostically challenging and often result in significant morbidity. They can be subdivided according to their cell of origin and whether they are within the cord (intramedullary) or intradural but extramedullary in location. The differential diagnosis for masses of the cauda equina region is often considered separately. In addition, some inflammatory processes, cysts, benign tumour-like masses and vascular malformations may mimic intradural tumours. Although in many instances a precise preoperative diagnosis is not possible as many of the imaging findings overlap, some features may strongly suggest one diagnosis over others.

Imaging Findings OR Procedure Details

INTRAMEDULLARY TUMOURS

Intramedullary spinal tumours represent 4-10% of all central nervous system (CNS) tumours. They account for 20% of all intradural tumours in adults and 35% of all intradural tumours in children [1]. The vast majority (95%) are glial tumours.

Three general characteristics of intramedullary neoplasms are recognised on MRI: they cause spinal cord expansion, they produce high signal intensity on T2 weighted images and the majority show at least some contrast enhancement. Intramedullary tumours are also commonly associated with cysts and syringohydromyelia, and may have evidence of prior haemorrhage.

Ependymoma

Ependymomas are the most common intramedullary neoplasm in adults and the most common intramedullary tumour overall, comprising approximately 60% of all glial spinal cord tumours [2]. They represent 30% of paediatric intramedullary neoplasms, making
them the second most common paediatric intramedullary neoplasm, after astrocytomas. Although most are sporadic, there is an increased incidence in neurofibromatosis type 2 (NF2).

The majority are WHO grade II lesions, however anaplastic grade III lesions are encountered. They are generally slow-growing and tend to compress adjacent spinal cord tissue rather than infiltrate it, almost always leaving a cleavage plane between tumour and spinal cord tissue.

**Radiographic features**

Ependymomas can occur anywhere along the spinal cord, however the cervical cord is the most common site [3]. The myxopapillary variant almost exclusively appears as an extramedullary mass in the region of the cauda equina and is discussed separately.

As ependymomas arise from ependymal cells lining the central canal, they tend to occupy the central portion of the spinal cord and cause symmetric cord expansion (figure 1). Although uncencapsulated, they are well-circumscribed, and are frequently associated with cysts (tumoral and non-tumoral) and syringohydromyelia. In contrast to intracranial ependymomas, calcification is uncommon. Most ependymomas are isointense to hypointense on T1, however mixed signal may be seen if cyst formation, tumour necrosis or haemorrhage has occurred. Virtually all enhance strongly. They are typically hyperintense on T2 and most demonstrate peritumoural oedema. Associated haemorrhage leads to a hypointense haemosiderin rim above and / or below the mass ("cap sign") in approximately one third of cases. The cap sign is suggestive of but not pathognomonic of ependymoma as it may also be seen in hemangioblastomas and paragangliomas. Scoliosis and bony remodelling may occur and are more commonly seen in association with ependymomas than astrocytomas.

**Astrocytoma**

Astrocytomas are the second most common intramedullary tumour overall, representing approximately 40% of such lesions [3]. They are associated with neurofibromatosis type 1 (NF1). They generally have a lower histologic grade than astrocytomas in the brain, with approximately 75% being either grade I or II lesions [2].

Spinal cord astrocytomas account for 60% of paediatric intramedullary tumours, making them the most common spinal cord tumour in children [4]. Pilocytic astrocytomas are a subtype of astrocytoma found predominantly in children and young adults. They are WHO grade I lesions and are associated with an excellent prognosis as they behave much like grade I cerebellar pilocytic astrocytomas and displace neural tissue rather than infiltrate it.

Diffuse astrocytomas are generally faster growing than ependymomas and typically have a worse prognosis. They are characterised by hypercellularity and the absence of a surrounding capsule and, in contrast to cord ependymomas, a cleavage plane is
Surgical excision is usually the treatment of choice, however due to their infiltrative nature, resection is almost always histologically incomplete.

**Radiographic features**

The most common location of astrocytomas is the thoracic cord, followed by the cervical cord. Isolated involvement of the conus medullaris and filum terminale is rare. Astrocytomas are typically long intramedullary masses that cause diffuse cord expansion. Involvement of the entire spinal cord (holocord presentation) may occur. It is more common in children than in adults and is more frequent with pilocytic astrocytomas.

As astrocytomas arise from cord parenchyma, they typically have an eccentric location (figure 2) and may be exophytic, sometimes even appearing largely extramedullary. They usually have poorly defined margins and, like ependymomas, are typically isointense to hypointense on T1 with variable and patchy contrast enhancement. They are hyperintense on T2. Haemorrhage is uncommon, and associated peritumoural edema and cysts are less prominent than with ependymomas.

**Hemangioblastoma**

Hemangioblastomas are the third most common intramedullary spinal neoplasm, representing 2% of such tumours [5]. Two thirds are sporadic, with a peak presentation in the fourth decade. One third of patients have von Hippel-Lindau Syndrome. These patients typically present earlier and with multiple tumours.

Haemangioblastomas are vascular WHO grade I lesions and are usually treated by surgical resection, sometimes with preceding endovascular embolisation to reduce intraoperative blood loss.

**Radiographic features**

The most common location is the thoracic cord. Although they usually appear as discrete nodules, there can be diffuse cord expansion. They have a variable appearance on T1, however the majority are isointense to hypointense and difficult to differentiate from normal spinal cord. They are isointense to hyperintense on T2 with associated tumour cyst or syrinx being common. Contrast enhancement is vivid, haemosiderin capping may be present and focal flow voids are often seen (figure 3). The characteristic angiographic finding is a densely enhancing nidus with associated dilated arteries and prominent draining veins.

**Ganglioglioma**
Spinal gangliogliomas are rare, comprising 1.1% of all spinal cord neoplasms [3]. They are most frequently encountered in children, representing 15% of paediatric intramedullary neoplasms [4]. They are WHO grade I or II neoplasms composed of both ganglion cells and glial elements, and are most frequently located eccentrically in the cervical region, although they often involve long segments of the cord. Their imaging features are non-specific with heterogenous T1 signal, patchy contrast enhancement and hyperintense T2 signal. Calcification is common and approximately half contain tumoural cysts.

**Intramedullary metastases**

Intramedullary metastases are less common than leptomeningeal metastases, occurring in approximately 0.9%-2.1% of cancer patients [6]. They are most frequently found in the cervical cord. Lung cancer is the most common primary tumour, accounting for approximately 50% of cases. One third of patients have concomitant brain metastasis and one quarter have leptomeningeal metastases [7]. They are typically well-defined, hypointense on T1, hyperintense on T2 and demonstrate avid homogeneous enhancement. Prominent oedema commonly surrounds the tumour nodule. In contrast to primary intramedullary neoplasms, associated cysts are rare. Intramedullary metastases generally occur in the setting of advanced disease, and as such are rarely the presenting lesion. They are not surprisingly associated with a poor prognosis, mostly related to systemic disease.

**Primary intramedullary lymphoma**

Lymphoma of the spinal cord is uncommon, accounting for 3.3% of all CNS lymphoma, which constitutes only 1% of all lymphomas in the body [2]. Eighty five percent are non-Hodgkin lymphomas [1]. Most are solitary lesions located within the cervical region, however there may be multiple lesions throughout the cord. Cord expansion is usually present. Lesions are generally poorly defined, isointense on T1 with homogeneous contrast enhancement and, in contrast to the characteristic low T2 signal intensity seen in intracranial lesions, are hyperintense on T2. Haemorrhage, tumoural cysts and syringomyelia are generally not present. The prognosis for patients with intramedullary spinal lymphoma is poor.

**Primitive neuroendocrine tumour (PNET)**

The majority of spinal PNETs are secondary to metastatic spread through the subarachnoid space from a primary intracranial tumour, although cases of primary spinal PNETs have been reported. Unlike intracranial PNETs, those involving the spine are slightly more common in adults than in children [8]. The lesions are usually located in the region of the filum terminale and cauda equina, are hypointense on T1, hyperintense on T2 and demonstrate heterogeneous enhancement. CSF seeding may produce leptomeningeal enhancement. Spinal PNETs are associated with a poor prognosis [2].
Dissemination through the CSF may produce secondary intracranial deposits; distant metastatic spread may occur to lungs, bone and lymph nodes.

**Solitary fibrous tumour (SFT)**

SFTs are rare spindle-cell neoplasms of probable mesenchymal origin. Although most intradural spinal SFTs are intramedullary, intradural extramedullary lesions may occur [9]. The majority of cases of are considered benign, however malignant CNS SFTs have also been reported [10]. The lesions are usually well-circumscribed and encapsulated, isointense to hypointense on T1, and demonstrate avid homogeneous enhancement. Marked hypointensity is demonstrated on T2, a feature which helps distinguish SFTs from other spinal cord tumours and which is thought to be due to the presence of abundant collagen fibres. Whilst surgical resection is curative in most cases, recurrence has been reported.

**INTRADURAL EXTRAMEDULLARY TUMOURS**

Intradural extramedullary tumours are far more common than intramedullary tumours, representing 80% of all intradural tumours in adults and 65% of all intradural tumours in children [1].

On MRI, intradural extramedullary lesions are characterised by displacement of the cord to the contralateral side and widening of the ipsilateral cerebrospinal fluid space immediately above and below the lesion.

**Schwannoma**

Schwannomas are the most common intradural extramedullary spinal tumours, representing 30% of such lesions [1]. They are WHO grade I tumours and usually arise from the dorsal sensory roots. They are most frequently seen in the cervical cord but may also occur in the cauda equina region, where they are the second most commonly encountered tumour after myxopapillary ependymomas. The majority are solitary and sporadic, however there is an association with NF2.

Surgery is the treatment of choice and gross total resection is usually curative, although in patients with NF2 there is a high incidence of new tumour formation.

*Radiographic features*

In general, schwannomas appear as rounded lesions. When large, they may either align themselves with the long axis of the cord, forming a sausage shaped mass which can extend over several levels, or may protrude out of the neural exit foramen, forming a dumbbell shaped mass (figure 4). Bone remodelling may be seen, with widening of the
neural exit foramen, thinning of the pedicle and posterior vertebral body scalloping. They are isointense to hypointense on T1 and hyperintense on T2, often with mixed signal. Virtually all enhance. Although they are often indistinguishable from neurofibromas, schwannomas are more frequently associated with haemorrhage, cyst formation and fatty degeneration. These findings are rare in neurofibromas.

**Meningioma**

Meningiomas are the second most common intradural extramedullary spinal tumours, representing 25% of such lesions [11]. The vast majority are WHO grade I lesions. In the adult population, females are approximately ten times more commonly affected than males, although in children there does not appear to be a sex predilection. The female preponderance in the adult population is even stronger than that associated with intracranial meningiomas, and is thought to be due the effect of oestrogen, although the exact mechanism remains unclear. Except when seen in the setting of NF2, nearly all are solitary lesions.

Surgery is the treatment of choice, with complete tumour removal able to be achieved in most patients.

**Radiographic features**

Meningiomas are most frequently found in the thoracic region. They are often located posterolaterally in the thoracic region and anteriorly in the cervical region.

They are well-circumscribed with a broad dural attachment, and share the imaging features of intracranial meningiomas; they are usually isointense to slightly hypointense on T1 with vivid homogenous enhancement. A dural tail sign is often present (figure 5). They are isointense to slightly hyperintense on T2. Occasionally, densely calcified meningiomas are hypointense on both T1 and T2, and show only minimal contrast enhancement.

**Neurofibroma**

Spinal neurofibromas are WHO grade I peripheral nerve sheath tumours. There is an association with NF1. Surgery is the treatment of choice for symptomatic lesions; however, as neurofibromas tend to encase the nerve roots, they usually cannot be dissected from the parent nerve. Five to ten percent undergo malignant change, which may be indicated by rapid growth [12].

**Radiographic features**
Spinal neurofibromas are often indistinguishable from schwannomas, although a number of features may help suggest the diagnosis. They are most commonly fusiform in shape, unlike schwannomas which are characteristically round. They tend to encase the nerve roots, in contrast to schwannomas which commonly displace the nerve root due to their asymmetric growth. They are generally hypointense on T1 and hyperintense on T2, although a T2 hyperintense rim and central area of low signal ("target sign") may be seen. This sign is thought to be due to a dense central area of collagenous stroma and although highly suggestive of neurofibroma, is occasionally also seen in schwannomas and malignant peripheral nerve sheath tumours. Heterogenous enhancement with areas of low signal is more characteristic of a neurofibroma than a schwannoma. As with schwannomas, bone remodelling may be seen.

**Myxopapillary ependymoma**

Although strictly speaking myxopapillary ependymomas are intramedulary tumours, they appear radiologically as extramedullary masses in the region of the cauda equina (figure 6). They are WHO grade I lesions which arise from the ependymal cells lining the inferior continuation of the central canal within the filum terminale and represent more than 90% of tumours in the cauda equina region [13]. They most commonly present in young adult males.

*Radiographic features*

They are usually hypointense on T1, although T1 hyperintensity is occasionally demonstrated due to a prominent mucinous component. They are typically hyperintense on T2, however are prone to haemorrhage and thus often demonstrate low intensity at the tumour margins. Enhancement is virtually always seen.

**Paraganglioma**

Spinal paragangliomas are rare WHO grade I neoplasms that occur almost exclusively in the cauda equina region. Neuroendocrine symptoms are usually absent, with presentation most commonly being due to mass effect. Surgical resection is the treatment of choice, sometimes with preoperative embolization to reduce intra-operative blood loss.

*Radiographic features*

Paragangliomas are usually well-circumscribed masses that are isointense on T1, hyperintense on T2 and intensely enhancing on post-contrast images. Flow voids are typically seen along the surface of and within the tumour nodule (figure 7). Haemorrhage is common, leading to a "cap sign". Occasionally the characteristic "salt-and-pepper" appearance of head and neck paragangliomas may also be demonstrated. Conventional
angiography reveals an intense early blush that persists into the late arterial and early venous phases.

**Leptomeningeal metastases**

Although intradural extramedullary metastases are rare overall, they are the most common intradural extramedullary neoplasm in children. In the paediatric population, leptomeningeal metastases usually result from primary brain tumours ("drop metastases"); in adults non-CNS tumours are more frequently encountered. The most commonly affected site is the lumbosacral spine, and multiple lesions are often seen. Prognosis depends on the primary tumour but is generally poor.

*Radiographic features*

T1 weighted images may demonstrate thickened nerve roots or nodular lesions that are isointense with the spinal cord. Cord edema may be seen with more extensive disease, especially if there is an intramedullary component. Contrast-enhanced images reveal enhancing tumour nodules on the spinal cord, nerve roots or cauda equina. Innumerable small enhancing nodules may also be seen along the spinal cord and nerve roots ("sugar coating") (figure 8).

**LESIONS THAT MIMIC INTRADURAL TUMOURS**

Various lesions may mimic intradural tumours. The differential diagnosis of intramedullary tumours includes vascular lesions such as cavernous malformations, dural arteriovenous fistulas and spinal cord infarction, inflammatory disorders such as demyelination, transverse myelitis and spinal cord abscesses, and spinal cord contusions (figure 9). The differential diagnosis for intradural extramedullary tumours includes intradural spinal lipomas, epidermoid cysts, dermoid cysts, neurenteric cysts and arachnoid cysts (figure 10).

*Images for this section:*
Fig. 1: Ependymoma. (A) and (B) T2 weighted images demonstrate a heterogeneous mass located centrally, displacing normal cord laterally (white arrow heads) with associated peritumoural cysts/syrinx (white arrow) and prominent inferior haemosiderin capping (black arrow) (C) T1 weighted. (D) T1 weighted with gadolinium demonstrating prominent tumoural enhancement.
Fig. 2: Astrocytoma. (A) T1 weighted. (B) T1 weighted image with gadolinium demonstrates an ill-defined heterogeneously enhancing mass (white arrows) extending over four segments. It is of high T2 signal (C) and (D) and is located eccentrically within the cord, displacing the cord posteriorly and to the left. There is no definite evidence of haemorrhage.
Fig. 3: Rare intramedullary tumours. (A) Hemangioblastoma; T2 weighted image demonstrates peritumoural cysts (white arrow), posterior serpiginous flow void (black arrow) and cord oedema. (B) Ganglioglioma; T2 weighted image demonstrates an eccentrically located hyperintense mass (white arrow). Evidence of prior surgery for a biopsy is noted posteriorly (white arrow heads). (C) Intramedullary metastasis; a ring enhancing lesion is demonstrated within the conus on post-gadolinium T1 weighted image. Extensive cord oedema is seen as low signal on this image and confirmed on T2 weighted images (not shown). (D) Primary intramedullary lymphoma; post-gadolinium T1 weighted image demonstrates a large enhancing mass with thickening and enhancement of the cauda equina (white arrows) and enhancing tissue in the thecal cul-de-sac (black arrow).
Fig. 4: Dumbbell-shaped schwannoma. (A) and (B) Fat-saturated post-gadolinium T1 weighted images demonstrate a vividly enhancing dumbbell shaped mass (black arrows) which passes out of the neural exit foramen. The cord is compressed and displaced towards the right (white arrow head). T2 weighted images demonstrate marked expansion of the neural exit foramen by the hyperintense mass (white arrow heads) (C) and faint increased signal within the cord substance (white arrow) (D).
Fig. 5: Meningioma. (A) T1 weighted image demonstrates a well-circumscribed intradural extramedullary mass that is isointense to the spinal cord. (B) and (C) Fat-saturated post-gadolinium T1 weighted images; the mass demonstrates homogenous enhancement and a broad dural base. Dural tails are seen extending above and below the mass (white arrows). The spinal cord is markedly compressed (white arrow head). (D) The mass is slightly hyperintense on T2 weighted image.
Fig. 6: Myxopapillary ependymoma. (A) and (B) T2 weighted images demonstrate a central intrathecal mass in the region of the cauda equina that is of heterogenous increased signal. The filum terminale is seen running in the midline behind the mass on the axial image (white arrow head). There is near complete effacement of the CSF space. (C) The mass demonstrates intermediate signal on the T1 weighted image and homogeneously enhances on the post-contrast image (D).
Fig. 7: Paraganglioma. (A) T2 weighted image demonstrates an intermediate signal intradural extramedullary mass which causes posterior vertebral body scalloping. A prominent flow void is seen anterior to the conus (white arrow). (B) The mass is also of intermediate signal on the T1 weighted image; high T1 and T2 signal fluid inferior to the mass most likely represents proteinaceous material (black arrows). (C) and (D) The mass vividly enhances post-gadolinium. Spinal paragangliomas occur almost exclusively in the cauda equina region.
Fig. 8: Leptomeningeal metastases. (A) and (B) Fat-saturated post-gadolinium T1 weighted images demonstrate multiple enhancing nodules scattered along the cauda equina (black arrows) with extensive leptomeningeal enhancement of the conus (white arrows). (C) and (D) T2 weighted images; note liver (white stars) and widespread bony metastatic disease.
Fig. 9: Lesions that mimic intramedullary tumours. (A) Cavernous malformation; gradient echo image demonstrates characteristic blooming of the haemosiderin ring (white arrow). Cavernous malformations typically demonstrate heterogenous signal on T1 and T2 weighted images due to blood products of varying ages. (B) Dural arteriovenous fistula; T2 weighted image demonstrates increased signal within the lower thoracic cord (white arrow heads) as well as numerous tortuous filling defects along the dorsal aspect of the cord (white arrows). The site of maximal MRI abnormality is not a reliable indicator of the location of the fistula; a complete spinal angiogram is therefore required. (C) Demyelination; T2 weighted image demonstrates a hyperintense lesion (white arrow) that does not cause significant spinal cord enlargement. The plaques are typically isointense to hypointense on T1 weighted images and demonstrate variable enhancement depending on acute activity. In most patients additional lesions of variable
enhancement are present in the brain and spinal cord. (D) Transverse myelitis; T2 weighted image demonstrates increased signal and mild swelling involving most of the conus (white arrows). Lesions characteristically occupy greater than two thirds of the cross-sectional area of the cord. An acute clinical course is typical, in contrast to that of most spinal cord tumours.

Fig. 10: Lesions that mimic intradural extramedullary tumours. (A) Lipoma; T1 weighted sequence demonstrates a sharply circumscribed hyperintense mass (white arrow). The mass follows fat intensity on all sequences, does not enhance and may cause a chemical shift artefact. (B) Dermoid; T2 weighted image demonstrates a heterogenous mass posterior to the cord which contains fat and demonstrates prominent chemical shift artefact, seen as anterior dark and posterior white bounding lines (arrow heads). (C)
Arachnoid cyst; T2 weighted image demonstrates anterior displacement of the thoracic cord by a mass that is isointense to CSF (black arrow). The mass follows CSF intensity on all sequences and may require myelography to distinguish it from ventral herniation of the cord. (D) Disc sequestrated fragment / extrusion; T2 weighted image demonstrates a large L5/S1 disc extrusion (white arrows). Although extradural in location, the appearance can mimic an intradural mass. Rarely calcified disc fragments can perforate the dura.
Conclusion

The differential diagnosis of intradural spinal tumours depends upon their location as intramedullary, intradural extramedullary or related to the cauda equina/filum terminale. Although the differential is wide and there is significant overlap of the imaging appearances, a few entities make up the majority of cases. Knowledge of certain characteristics may help differentiate between lesions and aid in pre-operative planning.

Personal Information

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