Results: In all patients complete resection was achieved without neurological complications. Histological examination revealed a papillary tumor in the first case and a PNET in the second. The third patient had a recurrent colloid cyst.
Conclusion: Tumors located in the posterior part of the third ventricle are challenging for the neurosurgeon. A transcortical interthalamo-trigonal approach provides excellent access to this region allowing safe and complete resection.

Keywords: Interthalamo-trigonal approach; Third ventricle tumors

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Validation of RPA classification as a prognostic tool in 117 patients with relapsed high grade glioma, vaccinated at time of recurrence

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Introduction: Recursive Partitioning Analysis (RPA) in newly diagnosed High Grade Glioma (HGG) patients has originally been validated by RTOG as a prognostic tool. It classifies patients into 6 prognostic classes based on age, pathology, performance status, mental status, extent of surgical treatment and intensity of radiation therapy. We aimed to validate this classification as a prognostic tool in 117 patients with a relapsed HGG, re-operated and vaccinated at recurrence.
Material and methods: One hundred seventeen patients with a relapsed HGG were re-operated and vaccinated using autologous dendritic cell-based vaccines. After re-operation and before vaccination, each patient was classified according to the RPA classes I to VI. The prognostic value of the RPA classification was assessed after log rank analysis creating Kaplan Meier overall survival (OS) estimates.
Results: Median OS after the pre-vaccine re-operation for RPA class I to VI patients was not yet reached (>36 months, n = 4), 14.2 months (n = 10), 14 months (n = 28), 10.6 months (n = 51), 6 months (n = 15) and 4 months (n = 9) respectively. At time of last follow-up, 75%, 50%, 35.7%, 11.7%, 0% and 0% of patients from RPA class I to VI respectively are still alive. These differences in OS are highly significant ($P < .0001$).
Conclusion: We validated the original RTOG RPA classification as a good prognostic tool in a large group of patients with relapsed HGG, re-operated and vaccinated at time of recurrence.

Keywords: RPA; Malignant glioma; DC vaccination; Prognosis

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Treatment of acromegaly, results of 16 years experience

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Introduction: We report our experience in the treatment of 34 patients suffering from acromegaly and treated in our institution between 1993 and 2008. The first line treatment was always surgery. Repeated surgery, radiation therapy and medical treatment were considered in patients showing no remission after surgery.
Material and methods: Before 2000, two patients underwent first cranial surgery and 16 others underwent first microscopic transsphenoidal surgery followed by transcranial surgery in one patient and by endoscopic surgery in two others. From 2001 sixteen other patients underwent endoscopic transnasal surgery as first treatment, followed by transcranial surgery in two of them. Remission was assessed by normalisation of both serum GH and IGF-I and the suppression of GH (<1 ng/ml) after Oral Glucose Tolerance Test.
Mean follow up period was 57 months.
Results: Overall remission rate with surgery alone was 19/34 (56%). Cure rates in non invasive adenomas was 80% and only 13% in invasive adenomas. Recurrences after remission were observed in 6 cases (31, 5%).
Treatment of patients without remission after surgery included radiation therapy and/or medical therapy. Ten patients out of 17 could be controlled for their disease with these additional therapeutic modalities. The total number of patients under control was 29/34 (85%). There was no mortality. Complications were limited to one epistaxis after microscopic transsphenoidal surgery and one CSF leak treated with lumbar drainage after endoscopic surgery.
Conclusion: High recurrence rates of acromegalic disease were observed, even using strict criteria for remission. Surgery alone gave satisfactory results in non invasive adenomas, but additional treatments were required in most of the invasive lesions.

Keyword: Acromegaly

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Does radiation treatment delay affect survival in glioblastoma?

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Introduction: Recent literature suggests that delaying the initiation of radiation therapy after surgery for malignant glioma significantly worsens patients survival. These data are however based on retrospective studies of heterogeneous series of patients and can only be applied cautiously to other practices.
Material and methods: In order to analyze this relationship in our institution, we reviewed the charts of 161 patients who were fully treated at the Liège University Hospital for a histologically proven supratentorial de novo glioblastoma multiforme (WHO grade 4) between January 1997 and April 2008. Survival analyses were performed using the GraphPad and Statview softwares.
Results: Of these patients, 22 (13.7%) died prior to the initiation of radiation therapy or refused further therapy (Survival range: 1-190 days). Among the remaining 139 patients, accurate data regarding radiation therapy specifics and survival were obtained for 121 patients (87%). Radiation therapy was initiated within 1 month from diagnostic in 103 of these patients, and delayed by more than 31 days in 18 patients (14.8%). The median survival of these two groups of patients differed by ~17 weeks in favor of patients treated within 1 month of surgery (Hazard Ratio: 1.7, 95% CI: 0.87 to 3.41).
Conclusion: The influence of age, KPS, dose and selection bias on the significance of this result will be discussed, as well as the rationale to minimize the delay between surgery and radiation treatment in de novo glioblastoma.

Keywords: Glioblastoma; Radiation therapy; Delay; Survival

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Tumor-like MRS and PET findings in a case of radiation-induced brain necrosis, away from any tumor: an intriguing case report

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Introduction: Most data regarding the imaging characteristics of radiation necrosis stem from patients who previously presented with a tumor ay the