Partial seizures triggering infantile spasms in the presence of a basal ganglia glioma

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ABSTRACT – Infantile spasms associated with brain tumors have been reported. A focal cortical lesion can induce infantile spasms by triggering the brainstem and basal ganglia in this vulnerable age group. We report the case of a female infant with a low-grade glioma in the right basal ganglia, spreading to the cortical area. She presented at the age of five months with left hemiparesis and partial seizures. She developed infantile spasms at the age of 12 months. This is the first video clip report of partial seizures triggered by a basal ganglia glioma in a young child producing infantile spasms in series, secondary to a basal ganglia glioma extending to the cortex.

Case report

A 17-month-old girl was evaluated for intractable epilepsy and developmental delay. She was born at term to non-consanguineous parents. There was no family history of seizures or mental retardation. Birth weight was 2.8 kg and the Apgar score was 10 at five minutes. She was admitted to hospital at 12 months of age with headache, vomiting, and seizures. Physical examination revealed left hemiparesis and partial seizures. She was referred to a neurologist for further evaluation.

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for 30 minutes without fever. Subsequently she had recurrent partial seizures with variable frequency and duration. The partial seizures consisted of facial and eye deviation to the left side with tonic posturing followed by clonic movements of the left extremities.

At the age of 12 months, flexor spasms of upper extremities began in addition to the partial seizures. Partial seizures failed to respond to phenobarbital and oxcarbazepine. The spasms did not respond to pyridoxine and vigabatrin. At 17 months, she was able to sit for a few seconds without support and speak in disyllables. Her head circumference was 45 cm (50%). She had left hemiparesis. There were no neurocutaneous markers.

At the age of 16 months, a prolonged scalp video EEG (VEEG) monitoring was performed. Three clusters of seizures were captured over 3 days and all the seizures were identical. At the beginning of seizure No 3 (see video sequence), she was unresponsive, with her eyes open and resting left arm and leg. Automatisms of her right arm and leg followed. She regained consciousness and began to move her left limbs, 20 seconds after the beginning of seizure. Sixty seconds after the seizure onset, brief spasms consisting of quasiperiodic axial flexion, extension of arms and legs started at intervals of 10-15 seconds. The symptom of spasms was bilateral, but more prominent on the right side, presumably due to left hemiparesis. This series of spasms lasted around 2 minutes.

Seizure No 3 showed diffuse 2-2.5 Hz high amplitude spike-wave discharges and slow waves for one second at the beginning (figure 1A). Diffuse voltage attenuation of 15-20 Hz low amplitude fast activities followed. The frequency and amount of fast activities gradually decreased and were replaced by diffuse 2-3 Hz delta slow waves, 20 seconds after the beginning. Sixty seconds after the seizure onset, diffuse 2-3 Hz high amplitude slow waves started with superimposed 20 Hz fast waves at times, followed by low voltage, attenuated electroencephalographic activities (figure 1B). These complexes of slow and superimposed fast waves appeared quasiperiodically at intervals of 10-15 seconds, corresponding to each epileptic spasm. There were no asymmetrical EEG findings during the series of epileptic spasms.

High amplitude independent spike or sharp and slow waves were seen over the bilateral fronto-temporo-parietal regions, at times synchronized, and followed by low amplitude voltage attenuation of electroencephalographic periods. The chaotic interictal epileptiform discharges were consistent with modified hypsarrhythmia. Over the right hemisphere, polymorphic delta slow waves were intermittently seen corresponding to the structural abnormality. Four to 5 Hz theta wave background activity was preserved on the left hemisphere.

MR images (Signa GE Medical systems, 1.5 Tesla) at 11 months showed a lesion involving the right globus pallidus and lentiform nucleus, extending to the right external capsule and adjacent cortical region. The lesion was hypointense on T1-weighted images and hyperintense on T2 and fluid attenuated inversion recovery (FLAIR) T2 se-

<table>
<thead>
<tr>
<th>Patient No</th>
<th>Authors</th>
<th>Age at onset</th>
<th>Type of Sz</th>
<th>EEG</th>
<th>Pathology</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Aktan et al. 1997</td>
<td>15 mo</td>
<td>IS</td>
<td>No HA</td>
<td>Medullary epithelioma</td>
<td>Posterior fossa</td>
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<td>2</td>
<td>Asanuma et al. 1995</td>
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<td>HA</td>
<td>Hamartoma</td>
<td>Hypothalamus</td>
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<td>3</td>
<td>Asanuma et al. 1995</td>
<td>7 mo</td>
<td>IS</td>
<td>HA</td>
<td>Oligoastrocytoma</td>
<td>R-temporal</td>
</tr>
<tr>
<td>4</td>
<td>Askenasi and Snead 1991</td>
<td>4 mo</td>
<td>IS, CPS (at 7 yrs)</td>
<td>No HA</td>
<td>Ganglioglioma</td>
<td>R-frontal</td>
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<tr>
<td>5</td>
<td>Branch and Dyken 1979</td>
<td>7 mo</td>
<td>IS</td>
<td>HA</td>
<td>Choroid plexus papilloma</td>
<td>L-lat ventricle</td>
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<tr>
<td>6</td>
<td>Gabriel 1980</td>
<td>13 weeks</td>
<td>IS; PS</td>
<td>No HA</td>
<td>Glioma</td>
<td>R-hemispheric</td>
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<td>7</td>
<td>Gastaut et al. 1978</td>
<td>ND</td>
<td>IS</td>
<td>ND</td>
<td>Calcified mass</td>
<td>Basal ganglia</td>
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<td>8</td>
<td>Kurokawa et al. 1980</td>
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<td>ND</td>
<td>Glioma</td>
<td>Optic nerve</td>
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<td>9</td>
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<td>HA</td>
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<tr>
<td>10</td>
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<td>HA</td>
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<td>11</td>
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<td>R-temporal</td>
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<td>12</td>
<td>Ruggieri et al. 1989</td>
<td>4.5 mo</td>
<td>IS; PS</td>
<td>HA</td>
<td>Glioma</td>
<td>R-thalamus</td>
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<td>HA</td>
<td>Ependymoma</td>
<td>R-FTP</td>
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<td>HA</td>
<td>Astrocytoma</td>
<td>L-temporal</td>
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<td>16</td>
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<td>ND</td>
<td>IS, PS</td>
<td>HA</td>
<td>Ganglioglioma</td>
<td>L-frontal</td>
</tr>
<tr>
<td>17</td>
<td>RamachandraNair et al. 5 mo</td>
<td>5 mo</td>
<td>IS</td>
<td>HA</td>
<td>Glioma</td>
<td>R-basal ganglia</td>
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Sz- seizure, mo- months, IS- infantile spasm, PS- partial seizures, CPS- complex partial seizures, HA- hypsarrhythmia, ND-no details, R- right, L- left, FTP- frontotemporoparietal, Lat- lateral.
Figure 1. A) EEG showed diffuse 2-2.5 Hz high amplitude spike-wave discharges and slow waves for one second at the beginning of the seizure. Diffuse voltage attenuation of 15-20 Hz low amplitude fast activities followed. The frequency and amount of fast activities gradually decreased and the fast activities were replaced by diffuse 2-3 Hz delta slow waves 20 seconds after the beginning of seizure (low frequency filter 1.6Hz, high frequency filter 70Hz, Notch filter 60Hz).

B) Sixty seconds after the seizure onset, diffuse 2-3 Hz high amplitude slow waves (*) started with superimposed 20 Hz fast waves at times, followed by low voltage, attenuated electrodecremental activity. These complexes of slow and fast waves appeared quasiperiodically at intervals of 10-15 seconds, corresponding to each epileptic spasm. There were no asymmetrical EEG findings during the series of epileptic spasms (low frequency filter 1.6Hz, high frequency filter 70Hz, Notch filter 60Hz).
quences (figure 2A). Repeat MR images of brain at 17 months showed the lesion to involve the right putamen, pallidum, thalamus, peri-Sylvian region extending into the adjacent posterior right frontal and mesial right temporal lobes with mild mass effect and minimal patchy enhancement on contrast administration (figure 2B). A stereotaxic biopsy from the right basal ganglia at 17 months revealed a grade 2 glioma (WHO classification). The patient was started on chemotherapy, as the tumor was inoperable. She continued to have partial seizures and epileptic spasms. Topiramate was added to oxcarbazepine.

Discussion

Tumors are rare causes of infantile spasms. This is the first case of a child with infantile spasms secondary to a basal ganglia glioma spreading to the cortex. Table 1 describes 16 cases of infantile spasms associated with brain tumors reported in the English language indexed journals. Gastaut et al. reported a child with infantile spasms and a calcified brain mass in the basal ganglia detected by CT brain (patient 7) (Gastaut et al. 1978). However, the pathology of this calcified mass was not reported. The extensive lesion of the right basal ganglia was stereotactically biopsied, confirming a low grade glioma. Although chemotherapy was started, seizures persisted in this child. The location and type of brain tumor associated with infantile spasms may vary and can include ganglioma, ganglioglioma, glioma, ependymoma, choroid plexus papilloma, cavernous angioma and hypothalamic hamartoma (table 1). Glioma is the most common brain tumor in infants (Di Rocco et al. 1991). A low grade glioma in the basal ganglia extending to the cortex producing initial partial seizures and consecutive infantile spasms is reported for the first time.

In some children with infantile spasms, cortical lesions can induce both partial seizures and spasms (Ohtsuka et al. 1996). Ohtsuka et al. reported 18 children who had partial seizures when they had spasms. Spasms in series coexisted, preceded or were followed by partial seizures (Ohtsuka et al. 1996). Yamamoto et al. (1988) reported four cases with partial seizures evolving into infantile spasms. However, none of these children had a brain tumor. The incidence of partial seizures in infantile spasms was as high as 31% (Yamamoto et al. 1988, Donat and Wright 1991). Among the 16 children with infantile spasms and brain tumors, five had partial seizures (patients 4, 6, 11, 12, 16) (Askenasi and Snead 1991, Gabriel 1980, Otsubo et al 1999, Ruggieri et al. 1989, Ohtsuka et al. 1996). Only 2 children (patients 6, 16) (Gabriel 1980, Ohtsuka et al. 1996) had spasms and partial seizures.
during the same period. Seizures developed after the infantile spasms in other children (patients 4, 11, 12) (Askenasi and Snead 1991, Otsubo et al. 1999, Ruggieri et al. 1989). In our child, partial seizures developed 7 months prior to the onset of spasms. Partial seizures triggered the spasms in series with modified hypsarrhythmia since the age of 12 months. The origin of the spasms remains uncertain. Chugani (2002) postulated a cortical-subcortical interaction as the pathogenesis, based on PET results that patients with infantile spasms had hypermetabolism in the lenticular nuclei and brainstem and hypometabolism in focal cortical areas. There were strong arguments against a major contribution of the cortex to physiological mechanism of spasms; however, cortical or hemispheric resection provided good seizure control (Chugani 2002). Ten of the 16 children became seizure-free following excision of the tumor (patients 2, 4, 5, 9-11, 13-16) (table 1). Our previous report proved that interhemispheric interactions were led by the tumor side by coherence analysis during flexor spasms (Otsubo et al. 1999). The early right hemispheric activation was caused by the more excitable cortex, with the glioma extending from the right basal ganglia, in this child. Furthermore, bilateral modified hypsarrhythmia was recorded since infantile spasms appeared at the age of 12 months. The basal ganglia was damaged by the main part of the tumor. Hypsarrhythmia resulted from a cortico-subcortical diffusion of interictal epileptogenic phenomena. The infantile spasms in West syndrome seem to be the final manifestation of various processes, but are believed to start on a cortical level (Vigevano et al. 2001). The appearance of symmetrical spasms preceded by partial seizures in this child indicated that the epileptogenic cortex was the primary driver of the infantile spasms.

Conclusion

This is the first video clip report of infantile spasms in a child with a glioma of the basal ganglia. Symmetrical infantile spasms can originate from a focal lesion and be triggered by partial seizures at certain infantile ages.

References


