Case Report

Recurrent Solitary Fibrous Tumor in Intradaural Extramedullary Space: Case Report and Review of the Literature

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Solitary fibrous tumor/hemangiopericytoma (SFT/HPC) is a rare neoplasm arising from spindle cells and most commonly arising from pleura. Spinal SFT/HPC is a rare entity; hence, it is not on the top of the differential diagnosis list when a clinician faces a spinal lesion. In the review of the literature, there exist less than 50 case reports of intradural extramedullary SFT/HPC. Here, we present a 54-year-old female patient who underwent subtotal surgical excision of an intradural extramedullary spinal mass pathologically reported to be SFT/HPC and had symptomatic recurrence in the 3rd year of follow-up. Surgical intervention was unachievable and the patient was given 45 Gy to the surgical cavity followed by a 5.4 Gy boost to visible tumor with external radiotherapy. Patient reported significant relief of her symptoms. We aim to contribute to the formation of a treatment algorithm for this rare entity.

1. Introduction

Solitary fibrous tumors (SFT) (formerly known as hemangiopericytoma (HPC)) are rare mesenchymal neoplasms originating from spindle cells [1]. Although the majority arise from pleura, 60% of SFTs originate outside the pleura [2], and SFTs are deemed to arise anywhere in the body. CD34 is a sensitive marker though it is not specific, and lately specific markers are identified [3]. Although surgery with negative margins is the mainstay treatment, the role of chemotherapy and radiotherapy is under debate [4]. This report presents a case of intradural extramedullary (IDEM) SFT in the thoracic spine.

2. Case Report

Our patient is a 54-year-old female with a past medical history including asthma and peptic ulcer disease. Her family history is free of malignant diseases. In 2016, patient’s chest X-ray examination found a suspicious lesion. Magnetic resonance imaging (MRI) was ordered for further investigation in November 2017 since the patient was complaining of back pain. MRI revealed a spinal lesion 12 × 10 mm in diameter at the level of second thoracic vertebra (T2) (Figures 1(a) and 1(b)). The patient was referred to surgery and one month later underwent subtotal surgical excision of an intradural extramedullary spinal mass pathologically reported to be SFT/HPC and had symptomatic recurrence in the 3rd year of follow-up. Surgical intervention was unachievable and the patient was given 45 Gy to the surgical cavity followed by a 5.4 Gy boost to visible tumor with external radiotherapy. Patient reported significant relief of her symptoms. We aim to contribute to the formation of a treatment algorithm for this rare entity.
for CD34 and negative for S100, epithelial membrane antigen (EMA), and p53 (Figure 2). Thereafter, the patient underwent routine follow-up. MRI was performed 45 days after the surgery, and it was consistent with a remnant paracentral mass (Figures 1(c) and 1(d)). Control MRI a year after showed regression of the lesion (Figures 1(e) and 1(f)). In June 2020, no intraspinal mass lesion was revealed on MRI. In January 2021, the patient came for routine follow-up with a complaint of bilateral pain in her upper extremities as well as back pain. MRI examination of the
patient was consistent with an intradural extramedullary lesion 10 \times 5 \text{ mm} in diameter which was compressing the spinal canal in the left paramedian area at the level of T2.

The patient was presented at the multidisciplinary tumor board for treatment options. Given the critical anatomic location and close involvement with nerve roots, the patient was found unsuitable for surgery. Eventually, the board decided on the referral to the radiation oncology clinic. A repeat contrasted thin-slice MRI of cervical and thoracic spine was performed (Figures 1(g) and 1(h)). The report confirmed the recent findings. Patient underwent 1 mm thin slice treatment-planning computer tomography (CT) with intravenous contrast infusion. CT-MRI image fusion was acquired with the preoperative and present MRI for better discrimination of the resection cavity and the boundaries of the present lesion to achieve improved target delineation for treatment planning [5]. Gross tumor volume (GTV) was defined as the postoperative surgical cavity and clinical target volume (CTV) was extended 2 cm above and below the GTV. Planned RT dose was 45 Gray (Gy) in 25 fractions (1.8 Gy/fraction) and a boost of 5.4 Gy in 3 fractions (1.8 Gy/fraction). Organs at risk (OAR) were determined as the spinal cord, lungs, and esophagus in accordance with the atlas of dose constraints in thoracic radiotherapy published by Kong et al. [6]. Maximum point dose constraint to the spinal cord was determined to be 45 Gray (Gy) in accordance with the Quantitative Analyses of Normal Tissue Effects in the Clinic (QUANTEC) model to avoid any radiation-related side effect, namely, myelopathy [7]. Treatment planning was done with conformal three-dimensional (3D), intensity-modified radiation therapy (IMRT), and volumetric modulated arc therapy (VMAT, hereinafter referred to as ARC) approach, respectively (Figure 3). QUANTEC normal tissue tolerances were taken into consideration and the calculations were made accordingly (Table 1) [8]. ARC was the chosen modality with optimal spinal cord protection compared to 3D and tolerable treatment duration for patient comfort and cooperation to stand immobile during the treatment compared to IMRT.

3. Discussion

Primary spinal cord tumors are rare neoplasms that constitute 4.5% of central nervous system (CNS) tumors in adults [9]. Their primary treatment is surgical resection if possible [10], and radiotherapy can ensue if total resection is not achieved [11]. They are classified according to their location as extradural, intradural extramedullary and intramedullary. Extradural tumors are most common followed by intradural extramedullary (IDEM) tumors. Meningioma, schwannoma, and neurofibroma comprise the majority of intradural extramedullary tumors [12]. Solitary fibrous tumors of intradural extramedullary space is a rare entity. They correspond to the

![Figure 2: Pathology slides. (a) Hematoxylin and eosin staining of z200 magnification reveals spindloid nuclei and thin vascular structures. (b) Diffuse staining with CD34 at \times 200 magnification. (c) 1-2% proliferation index with Ki-67 at \times 200 magnification.](image-url)
Figure 3: Plan summations and dose volume histogram (DVH) of 3DCRT, IMRT, and ARC. (a) Plan summations on axial (upper left), frontal (lower left), and sagittal (lower right) views and DVH graph (upper right) of conformal three-dimensional plan. Outer red line of plan summations represents 50% (25.2 Gy) isodose line, green line represents 42.84 Gy, and blue line represents 50.4 Gy. Red dots represent maximum point doses on each view. (b) Plan summations on axial (upper left), frontal (lower left), and sagittal (lower right) views and DVH graph (upper right) of intensity-modulated radiation therapy plan. Outer red line of plan summations represents 50% (25.2 Gy) isodose line, green line represents 42.84 Gy, and blue line represents 50.4 Gy. Red dots represent maximum point doses on each view. (c) Plan summations on axial (upper left), frontal (lower left), and sagittal (lower right) views and DVH graph (upper right) of volumetric modulated arc therapy plan. Outer red line of plan summations represents 50% (25.2 Gy) isodose line, green line represents 42.84 Gy, and blue line represents 50.4 Gy. Red dots represent maximum point doses on each view.
group IIA in the classification of Liu et al. [13] (Table 2). The majority of type IIA spinal SFTs arise at the thoracic spine [12]. Table 3 summarizes the cases present in the PUBMED database.

Due to their rareness, SFTs are not on the top of the differential diagnoses list when the clinician is faced with a lesion in the spinal cord [14]. MRI is the preferred modality to delineate the tumor and evaluate for invasion, but the imaging findings are variable and nonspecific [15]. Nevertheless, the diagnosis is less of a challenge with the advances in knowledge in pathological markers. CD34, although not specific, is deemed to be the histological hallmark of SFTs and has been found to be expressed in 79% of cases [16, 17]. A retrospective study with 16 SFTs located in the spinal cord confirmed this finding with 100% SFTs being positive for CD34 and negative for EMA, GFAP, and MBP staining. S-100 positivity varied with 5 of the patients staining positive [18]. Lately, STAT6 and GRIA2 are proposed to be distinguishing markers for SFTs [19, 20]. STAT6 expression is driven by NAB2-STAT6 gene fusion, and STAT6 has lately been sought to be a specific marker for SFT [19, 21, 22]. STAT6 positivity in SFTs and HPCs is considered as finding that supports the abolishment of the thin boundary between these 2 entities in late 1990s [3, 23, 24].

Achieving complete surgical resection is the main goal in extrathoracic SFTs, and it is associated with improved local control and survival. Routine long-term follow-ups must be ensured for the early detection of recurrence [25]. Although there are no standardized follow-up routines for these patients. The anatomical location of the tumor may not allow the total resection in some cases [4]. The role of radiotherapy is under debate in SFTs. There are studies advocating that RT is not strictly indicated after complete resection due to close follow-up and low recurrence rate [4] and that adjuvant radiotherapy can be considered in the case of subtotal resection [26–28] or if we are facing a high grade SFT [29]. There are studies advocating adjuvant radiotherapy be standard of treatment [18, 30]. Complete resection, low-grade tumor and young age were reported to be factors that led the clinicians to omit radiotherapy [31]. Krengli et al. revised 151 extrathoracic SFT patients while Wang et al. reviewed 16 spinal SFT patients in terms of the effect of GTR vs. GTR+RT on local recurrence (LC), disease-free survival (DFS), and overall survival (OS), and they both came up with the same conclusion: addition of adjuvant RT improved LS and DFS while GTR was the main predictor of OS [18, 32]. While a retrospective review reveals that the median radiation dose for extracranial SFTs is 60 Gy [32], this dose seems to be unachievable in the spinal SFTs due to dose constraints of the spinal cord, which is 45-50 Gy. Retrospective single center study of Wang et al. reported a median dose of 40 Gy in patients with spinal SFT [18]. The treatment plan must be tailored according to location and extent of the tumor. Radiation doses may vary in between patients if the plan cannot limit spinal cord doses in the desired limits.

Herein, we present a case of IDEM SFT who had STR 27 months prior to presentation to our clinic with bilateral pain over the arms and legs and newly developed radiological evidence of recurrence. Radiotherapy was the treatment of choice for this patient due to the location of the tumor. To our knowledge, we present the 5th case of a recurrent SFT treated with radiotherapy [18, 33–35].

| Table 1: Comparison of treatment plans. |
|----------------------------------------|
| Type | PTV | D50 (cGy) | D98 (cGy) | D2 (cGy) | D2 (cGy) | V20 (%) | V5 (%) | Mean (cGy) | Mean (cGy) | Monitor unit (MU) |
|------|-----|-----------|-----------|----------|----------|---------|--------|-------------|-------------|------------------|
| 3D   |     | 5370      | 5090      | 5468     | 5437     | 1.7     | 12.5   | 230        | 839         | 562              | 455              |
| IMRT (5 field) |   | 5182      | 5067      | 5302     | 5226     | 2       | 10     | 190        | 385         | 255              | 1353             |
| ARC  |     | 5200      | 4950      | 5333     | 5220     | 1       | 12     | 207        | 540         | 326              | 1060             |

3D: conformal three-dimensional; IMRT: intensity-modified radiation therapy; ARC: volumetric modulated arc therapy; PTV: planning target volume; D95: dose covering 95% of the PTV; D50: median dose, D98: near-minimum dose, D2: near-maximum dose; cGy: centigray; V20: lung volume that received a dose of 20 Gy or more; V5: lung volume that received a dose of 5 Gy or more; 33%: dose received by 33% of esophagus.

| Table 2: Liu classification for localization of spinal SFTs [13]. |
|-------------------|
| Type              | Subtype                   |
| Type 1: extradural | IA, intracanal type       |
| Type II: intradural | IB, intra- and extracanal type |
| Type III: intra- to extradural and paravertebral type | IIA, extramedullary type |
|                   | IIB, intramedullary invasion type |

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Table 3: Reported cases of spinal intradural extramedullary solitary fibrous tumor/hemangiopericytoma.

| Case report, year | Age/sex | Chief complaint at presentation | Level | T1-W | T2-W | Contrast enhancement | Treatment | RT regimen (if performed) | Outcome | Treatment of recurrence |
|-------------------|---------|--------------------------------|-------|------|------|----------------------|-----------|---------------------------|---------|------------------------|
| Pitlyk et al., 1965 [36] | 39/M | Total paraplegia | T8 | N/A | N/A | N/A | GTR | N/A | Tumor recurred 4 times in 8 years | Reoperation |
| Pitlyk et al., 1965 [36] | 60/M | Paresthesia and weakness of RL | C4 | N/A | N/A | N/A | GTR | N/A | — |
| Pitlyk et al., 1965 [36] | 49/F | Left-sided weakness and paresthesias | C3 | N/A | N/A | N/A | GTR | N/A | 10 years NED |
| Kitanaka et al., 1993 [37] | 59/F | Gait disturbance | T6 | Isointense | N/A | HomE | EBR | N/A | 16 months NED |
| Malek et al., 1997 [38] | 33/M | Back pain Progressive myelopathy LE dysesthesias | T7-T8 | — | — | Hypointense | Mild enhancement | Resection, NS | N/A | N/A |
| Kanahara et al., 1998 [39] | 62/M | Sensory disturbance of bilateral lower extremity | C6-C7 | Hypointense | Hypointense | Marginal enhancement | GTR | N/A | N/A |
| Brunori et al., 1999 [40] | 46/F | Left sciatalgia | T12-L1 | T1 görüntü | NS | HomE | GTR | N/A | 4 months NED |
| Vorster et al. 2000 [41] | 51/M | Burning sensation and numbness in both thighs weakness in the LLE | T2-T3 | Well-circumscribed mass at T2-3, which enhanced homogeneously on T1-weighted MR imaging with gadolinium | NS | HomE | GTR | N/A | 7 months NED |
| Kurtkaya et al. 2001 [42] | 70/F | RL weakness | T3 | Irregular isointensity | Irregular hypointensity | E | CR | N/A | No recurrence until the report |
| Dufour et al., 2001 [43] | 45/M | Paraparesis | Cervical (not specified) | N/A | N/A | N/A | CR | N/A | 2 years NED |
| Dufour et al., 2001 [43] | 18/F | Dorsalgia | Thoracic (not specified) | NM | N/A | N/A | STR + RT | 40 Gy | Alive after 4.6 years of f/u |
| Dufour et al., 2001 [43] | 43/F | Intercostal neuralgia | Thoracic (not specified) | NM | N/A | N/A | CR | N/A | 4.1 years NED |
| Case report, year | Age/sex | Chief complaint at presentation | Level | T1-W | T2-W | Contrast enhancement | Treatment | RT regimen (if performed) | Outcome | Treatment of recurrence |
|------------------|---------|----------------------------------|-------|------|------|----------------------|-----------|--------------------------|---------|-------------------------|
| Dufour et al., 2001 [43] | 38/ M | Intercostal neuralgia | Thoracic (NS) | N/A | N/A | N/A | CR + RT | 40 Gy | 12.8 years NED |
| Betchen et al., 2002 [44] | 31/ M | B/L leg paresthesia LE cramping and fatigue | L4 | Intermediate signal | Increased signal | Diffuse enhancement | EBR | N/A | No recurrence at the time |
| Pizzolitto et al., 2004 [45] | 36/ M | LE weakness Urinary loss and rectal incontinence | T7/T8 | NS | NS | HomE | CR | N/A | 12 months NED |
| Bohinski et al., 2004 [46] | 49/ F | Neck pain and stiffness | C4 | Isointense | Hypointense | HomE | EBR | NA | 10 months NED |
| Piana et al., 2004 [47] | 67/ M | Lumbar pain Weakness in RLE | L1-L2 | NS | NS | HetE | GTR | — | — |
| Ogawa et al., 2005 [48] | 63/ F | Sensory disturbance of LE | T11 | Mildly hypointense | Hypointense | HomE | GTR | — | 18 months NED |
| Pakasa et al., 2005 [49] | 27/ M | Back pain | T5-T7 | — | — | — | STR | — | Surgery |
| Munoz et al., 2008 [33] | 35/ M | Hypoesthesia | Sacral | — | — | — | CR | — | Observation |
| Fitzpatrick et al., 2009 [50] | 54/ M | Left paraspinal, buttock, and anterolateral thigh pain radiating down the anterior shin and left foot | L4-L5 | Soft tissue signal intensity | Soft tissue signal intensity | NS | GTR + RT | NS | N/A |
| Case report, year | Age/sex | Chief complaint at presentation | Level | T1-W | T2-W | Contrast enhancement | Treatment | RT regimen (if performed) | Outcome | Treatment of recurrence |
|-----------------|---------|---------------------------------|-------|------|------|---------------------|-----------|------------------------|---------|------------------------|
| Arantes et al., 2009 [22] | 22/ M | Dorsal pain associated with B/L hypoesthesia and weakness of the LE | T1-T2 | Isointense | Isointense | HomE | GTR | — | 18 months | NED |
| Moscovici et al., 2011 [51] | 20/ M | Mild thoracic back pain radiating to the LL progressive paraparesis fecal and urinary incontinence | T9-T10 | Isointense | Isointense | HomE | GTR | Patient was referred to RT but declined and went with imaging and clinical follow-up | Patient declined the treatment | 2 years | NED |
| Ackerman et al. 2011 [52] | 58/ M | Acute weakness of the LE bladder and bowel incontinence | T10 | Isodense | Hyperdense | E | EBR | — | N/A |
| Kirkbride et al., 2011 [53] | 72/ M | Acute urinary retention | C3 | NS | Moderately hyperintense | HomE | CR | — | — | — |
| Bisciglia et al. [54] | 47/ M | Weakness in RLE | T3-T4 | NS | NS | — | GTR | — | 11.6 years | NED |
| Brigui et al., 2012 [55] | 56/ M | Neuropathic pain of the RLE LL pain and gait difficulties | T6-T7 | Isointense | Isointense | HomE | GTR | — | 29 months | NED |
| Mariniella et al., 2012 [56] | 67/ M | Pain dysesthesia and weakness in left arm and leg | C3-7 | Isointense | Hypointense | HomE | GTR | — | 1 year | NED |
| Shirzadi et al., 2013 [31] | 49/ M | Patient with a history of SFT presented with left LE weakness and B/L radicular pain | T9-T12 | NS | NS | E | Debunking | — | Recurred in postoperative month 4 with multiple metastases | No intervention |
| Shirzadi et al., 2013 [31] | 57/ M | Lower back pain | T9-T10 | NS | NS | E | Preoperative embolization followed by microdissection + adjuvant RT | (IMRT of 5580 cGy over 48 elapsed days) to his resection cavity | Radiosurgery was performed on recurrence (month 6- T2-3 level) | 3 years | NED |
| Shirzadi et al., 2013 [31] | 56/ M | Neck discomfort radiating into head and both shoulders | C3-C4 | NS | NS | E | GTR | — | 3 years | NED |
Table 3: Continued.

| Case report, year | Age/sex | Chief complaint at presentation | Level | T1-W | T2-W | Contrast enhancement | Treatment | RT regimen (if performed) | Outcome | Treatment of recurrence |
|------------------|---------|---------------------------------|-------|------|------|----------------------|-----------|--------------------------|---------|------------------------|
| Drazin et al., 2013 [34] | 56/M | Neck pain radiating to head and shoulders | C0-C4 | NS | NS | E | CR | — | — | Metastasis at T2-T3 6 months postoperative |
| Lee et al., 2013 [57] | 21/M | Neck pain B/L tingling sensation in both hands | C1-C2 | Isointense | Hyperintense | HomE | CR | — | 1 year NED |
| Kobayashi et al., 2014 [58] | 40/M | Gait disturbance and numbness in both hands | C4-C5 | Hypointense | NS | HomE | Resection, NS | — | Recurrence after 17.7 years STR |
| Sade et al., 2015 [59] | 43/M | Weakness of LE | NS | Hypointense | HomE | Resection, NS | N/A | NM |
| Das et al., 2015 [60] | 50/M | Quadripareisis, numbness in B/L UE | C4-C5 | NS | NS | E | GTR + adjuvant RT (EBRT) + adjuvant CT | NS | 23 months NED |
| Das et al., 2015 [60] | 12/F | Paraparesis | T11-L1 | NS | NS | E | GTR + RT | NS | 9 months NED |
| Kaur et al., 2015 [11] | 16/M | Loss of strength in LE | T9 | N/A | N/A | N/A | Excision, NS followed by RT | f 45 Gy in 25 fractions over a period of 5 weeks | 5 years NED |
| Basaran et al., 2015 [61] | 67/M | Walking disability | L3 | NS | Hypointense | HomE | Surgery, NS | — | 12 months NED |
| Biswas et al., 2017 [62] | 35/F | Backache LE weakness | T10-T11 | Hypointense | Hyperintense | NM | STR + metastasectomy | 20 Gy in five fractions over 1 week to the primary residual site | — |
| Chew et al., 2017 [63] | 63/M | Back pain Paraparesis Sensory deficit of LE | T9 | NS | NS | E | GTR | N/A | 12 months NED |
| Albert et al., 2017 [64] | 10/M | RUE weakness | C1-C3 | Hypointense | Hypointense | HomE | GTR | — | 1 year NED |
| Tomamatsu et al., 2019 [65] | 68/F | Incidental lesion on imaging | T9 | Isointense | Hypointense | HetE | GTR | N/A | 3 years NED |
| Wang et al., 2019 [18] | 21/M | Backache | T3-T4 | NS | Slightly hyperintense | NS | GTR + RT | Not specified for the patient; median dose is | 96 months NED | — |
| Case report, year | Age/sex | Chief complaint at presentation | Level | T1-W | T2-W | Contrast enhancement | Treatment | RT regimen (if performed) | Outcome | Treatment of recurrence |
|------------------|---------|---------------------------------|-------|------|------|----------------------|-----------|--------------------------|---------|------------------------|
| Wang et al., 2019 [18] 43/F | Backache | T8 | NS | Slightly hyperintense | NS | GTR + RT | 40 Gy (35-45 Gy) | Not specified for the patient; median dose is 40 Gy (35-45 Gy) | N/A | N/A |
| Wang et al., 2019 [18] 35/F | Neck pain UE numbness | C4-C6 | NS | Slightly hyperintense | NS | STR | N/A | Recurrence at month 32 postoperatively | N/A | N/A |
| Wang et al., 2019 [18] 33/F | Backache | T9 | NS | Slightly hyperintense | NS | GTR + RT | Not specified for the patient; median dose is 40 Gy (35-45 Gy) | 70 months NED | N/A | N/A |
| Wang et al., 2019 [18] 57/M | Backache | T3-T4 | NS | Slightly hyperintense | NS | GTR | N/A | 67 months NED | N/A | N/A |
| Wang et al., 2019 [18] 37/F | Backache | T6 | NS | Slightly hyperintense | NS | GTR | Not specified for the patient; median dose is 40 Gy (35-45 Gy) | 42 months NED | N/A | N/A |
| Wang et al., 2019 [18] 40/F | Backache LE weakness | T11-T12 | NS | Slightly hyperintense | NS | STR + RT | Not specified for the patient; median dose is 40 Gy (35-45 Gy) | 35 months NED | N/A | N/A |
| Wang et al., 2019 [18] 49/M | Backache | T4 | NS | Slightly hyperintense | NS | GTR | Not specified for the patient; median dose is 40 Gy (35-45 Gy) | 24 months NED | N/A | N/A |
| Murata et al., 2020 [35] | 49/F | Chest pain | T6 | Isointense | Hypointense | NS | GTR | — | Recurrence at 12 month postoperatively | Carbon ion radiotherapy-64 Gy |
| Kim et al., 2020 [66] | 64/M | RL pain | Hypointense | Hypointense | HetE | Surgical removal, NS | N/A | 1 year NED | N/A | N/A |
| Glauser et al., 2020 [67] | 72/M | LE weakness, pain and numbness | C5-C7 | T1w hypointense (?) | NS | NS | GTR | N/A | N/A | N/A |
| Case report, year | Age/sex | Chief complaint at presentation | Level | T1-W | T2-W | Contrast enhancement | Treatment | RT regimen (if performed) | Outcome | Treatment of recurrence |
|------------------|---------|---------------------------------|-------|------|------|---------------------|-----------|--------------------------|---------|------------------------|
| Singla et al., 2020 [68] | 50/M | Quadriparesis, numbness in B/L UE | C4-C5 | N/A | N/A | N/A | GTR + adjuvant RT + adjuvant CT | Not specified | Recurrence at 62 months postoperatively |
| Singla et al., 2020 [68] | 12/F | Acute conus cauda syndrome | T11-L1 | N/A | N/A | N/A | GTR + adjuvant RT | NS | 52 months NED |
| Singla et al., 2020 [68] | 38/M | Spastic paraplegia bladder dysfunction | C7-T1 | N/A | N/A | N/A | GTR | N/A | 50 months NED |
| Koduru et al., 2020 [69] | 16/F | Weakness of RUE and RLE | C5-C7 | Hypointense | Hyperintense | HomE | CR | N/A | N/A |
| Dauleac et al., 2020 [70] | 67/M | Asthenia and weakness RLE | T8-T9 | NS | Hyposignal | NS | CR | N/A | 1 year NED |

Abbreviations are as follows: M: male; F: female; LE: lower extremity; RLE: right lower extremity; LLE: left lower extremity; UE: upper extremity; RUE: right upper extremity; LUE: left upper extremity; C: cervical; T: thoracic vertebra; L: lombar vertebra; HomE: homogenous enhancement; HetE: heterogenous enhancement; E: enhancement (not specified); GTR: gross total resection; STR: subtotal resection; CR: complete resection; EBR: en bloc resection; NS: not specified; RT: radiotherapy; CT: chemotherapy; N/A: not applicable; NED: no evidence of disease; Gy: gray.
4. Conclusion

Spinal type IIA SFT is a rare entity with less than 50 case reports in the literature. GTR is the required treatment option while the role of adjuvant radiotherapy and its indications is yet to be discussed. We contribute to the literature by presenting a rare case in which close follow-up ensued STR, and radiotherapy was performed when the lesion recurred. We believe that the increase in the number of cases in the literature will help and contribute to the embodiment of the therapeutic algorithm of the disease in question.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

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