Experience with 7.0 T MRI in Patients with Supratentorial Meningiomas

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Meningiomas are typically diagnosed by their characteristic appearance on conventional magnetic resonance imaging (MRI). However, detailed image findings regarding peri- and intra-tumoral anatomical structures, tumor consistency and vascularity are very important in pre-surgical planning and surgical outcomes. At the 7.0 T MRI achieving ultra-high resolution, it could be possible to obtain more useful information in surgical strategy. Four patients who were radiologically diagnosed with intracranial meningioma in 1.5 T MRI underwent a 7.0 T MRI. Three of them underwent surgery afterwards, and one received gamma knife radiosurgery. In our study, the advantages of 7.0 T MRI over 1.5 T MRI were a more detailed depiction of the peri- and intra-tumoral vasculature and a clear delineation of tumor-brain interface. In the safety issues, all patients received 7.0 T MRI without any adverse event. One disadvantage of 7.0 T MRI was the reduced image quality of skull base lesions. 7.0 T MRI in patients with meningiomas could provide useful information in surgical strategy, such as the peri-tumoral vasculature and the tumor-brain interface.

Key Words: 7.0 T MRI · Meningioma.

INTRODUCTION

Meningiomas are typically diagnosed by their characteristic appearance on conventional magnetic resonance imaging (MRI). However, detailed image findings regarding peri- and intra-tumoral anatomical structures, tumor consistency and vascularity are very important in pre-surgical planning and surgical outcomes. Since its clinical application in the 1980s, high-field MRIs have been progressively developed to improve the signal-to-noise ratio and contrast-to-noise ratio to yield higher-quality human brain images. The clinical use of higher-field MRIs is limited to 3.0 T because of concerns about safety. Recently, experimental studies using 7.0 T MRI have been performed, and there have been a few reports of MRI using high-field magnets for the visualization of brain tumors.

To the best of our knowledge, however, no report has explored the efficacy of 7.0 T MRI in intracranial meningioma. In this paper, we report our experiences with 7.0 T MRI in four cases of intracranial meningiomas.

Procedure for 7.0 T MRI

The 7.0 T MRI device (Magnetom 7.0T, Siemens, Munich, Germany) at the Neuroscience Research Institute of Gachon University of Medicine and Science was used for imaging. The 7.0 T magnet, with a clear bore of 90 cm, is equipped with a water-cooled gradient and RF coils. The gradient system operates at 2000 V/650 Amps, with a gradient amplitude of 40 mT/m, a maximum slew rate of 200 mT/m/ms, and a minimum gradient rise time of 200 microseconds. A home-made 8-channel TX/RX coil was used. The scanning parameters used in each image sequence are shown in Table 1. T1-weighted MRI was performed before and after the injection of a contrast agent. Magnevist (Bayer Healthcare Pharmaceuticals Inc., Berlin, Germany) was used as the contrast agent (0.01 mmol/kg).

CASE REPORT

Four patients underwent 7.0 T MRI before treatment between April 2009 and July 2009. All of them received 1.5 T MRI at 5 to 9 days before receiving 7.0 T MRI. Three of them under-
went surgery afterwards, and one received stereotactic radiosurgery. The pathological examination of surgical specimens revealed one benign fibrous meningioma and two atypical meningiomas. The patient who received radiosurgery was diagnosed with meningioma on the basis of MRI findings, such as a dural tail sign and extra-axial location.

All patients answered questionnaires after performing 7.0 T MRI. The survey asked whether the patient experienced following symptoms or not: claustrophobia; nausea; vertigo; headache; loss of balance; feeling of electric shocks or heating; skeletal muscle contractions; others. Overall, 7.0 T MRI with contrast enhancement can be safely performed in all patients without any adverse event.

Case 1
A 30-year-old woman presented with seizure and underwent brain MRI. On 1.5 T MRI, a well-enhanced mass was observed in the left parieto-occipital lobe (Fig. 1A, 2A). Surgical resection was chosen, and 29 days prior to surgery, 7.0 T MRI was also performed (Fig. 1C, 2C). Cerebral angiography showed that the middle meningeal artery was the tumor-feeding artery (Fig. 1B). Gross total resection was performed and pathological examination revealed a fibrous meningioma.

In Fig. 1C, a 7.0 T MRI shows the details of the intra- and peri-tumoral vasculature in a T2-weighted image compared with 1.5 T MRI (Fig. 1A). As shown in Fig. 2, the tumor-brain interface was more clearly delineated in 7.0 T MRI. The 7.0 T MRI showed that peri-tumoral edema had developed from areas without a cerebrospinal fluid cleft (Fig. 2C), but this finding could not be observed in 1.5 T MRI (Fig. 2A). Intraoperatively, some areas in which the tumor-brain interface was less obvious (Fig. 2B) were in line with the findings of 7.0 T MRI.

Case 2
A 41-year-old woman complained of a three-month history of recurrent seizure and was investigated with brain MRI. The 1.5 T MRI showed a well-enhanced mass in the right frontal lobe (Fig. 3A). Surgical resection was planned, and 23 days prior to surgery, she received 7.0 T MRI (Fig. 3C, D). Cerebral angiogram showed that enlarged middle meningeal arteries supplied the center of the tumor (Fig. 3B). Preoperative embolization was performed before subtotal resection of the tumor. The tumor was not removed from inside the superior sagittal sinus because of the risks of venous thrombosis. The pathological diagnosis was atypical meningioma.

The vessel appearance in 7.0 T MRI (Fig. 3D) closely resembled angiography, which is an accepted gold-standard mechanism of intra-cerebral vessel visualization (Fig. 3B).

Case 3
A 58-year-old man was referred to our hospital due to a mass in the right frontal convexity, which was radiologically diagnosed at the time as meningioma. Subsequently, he received Table 1. The scanning parameters of MRI in each image sequence

| Patient No. | Image        | TR (ms) | TE (ms) | Thickness (mm) | Gap (mm) | Flip angle | No. of slices | Voxel size (mm³) | Matrix size |
|------------|--------------|---------|---------|----------------|----------|------------|--------------|-----------------|-------------|
| 1          | T2 axial     | 1180    | 17.1    | 3.0            | 3.0      | 30         | 32           | 0.17×0.36×3.0    | 1024×704    |
|            | T1 axial     | 4000    | 2.7     | 2.5            | 0        | 8          | 20           | 0.66×0.86×2.5    | 256×224     |
|            | T1-CE axial  | 4000    | 2.7     | 2.5            | 0        | 8          | 20           | 0.66×0.86×2.5    | 256×224     |
| 2          | T2* axial    | 750     | 21.6    | 2.0            | 2.0      | 30         | 17           | 0.22×0.29×2.0    | 1024×896    |
|            | T2* sagittal | 750     | 21.6    | 2.0            | 2.0      | 30         | 17           | 0.22×0.29×2.0    | 1024×896    |
|            | MPRAGE3D coronal | 4000 | 3.9    | 0.8            | 0        | 10        | 240          | 0.80×0.80×0.8    | 192×192     |
|            | MPRAGE3D-CE coronal | 4000 | 3.9    | 0.8            | 0        | 10        | 240          | 0.80×0.80×0.8    | 192×192     |
| 3          | T2* sagittal | 750     | 21.6    | 2.0            | 0        | 10        | 17           | 0.20×0.20×2.0    | 1024×1024   |
|            | MPRAGE3D coronal | 4000 | 3.7    | 0.8            | 0        | 10        | 240          | 0.80×0.80×0.8    | 192×192     |
|            | MPRAGE3D-CE coronal | 4000 | 3.7    | 0.8            | 0        | 10        | 240          | 0.80×0.80×0.8    | 192×192     |
| 4          | MPRAGE3D coronal | 4000 | 3.9    | 0.8            | 0        | 10        | 240          | 0.80×0.80×0.8    | 192×192     |
|            | MPRAGE3D-CE coronal | 4000 | 3.9    | 0.8            | 0        | 10        | 240          | 0.80×0.80×0.8    | 192×192     |

TR: repetition time, TE: echo time, MPRAGE: magnetization-prepared rapid gradient echo, CE: contrast enhanced. The voxel size and matrix size were calculated from the slice thickness and gap size.
reotactic radiosurgery. At that time, the tumor size was 0.95 cm$^3$, and he received a dose of 15 Gy, which was prescribed to the 50% isodose line. However, the mass gradually grew to 1.5 cm$^3$ in the next 3 years (Fig. 4A). Surgical removal was decided, and 4 days before the surgery, he received 7.0 T MRI (Fig. 4B). On pathology, the tumor was confirmed as atypical meningioma.

In this case, 7.0 T MRI showed peri-tumoral vasculature, including the cortical draining veins (Fig. 4B), in the T2-weighted image.

Case 4

A 37-year-old woman presented with a 2-year history of progressive visual loss. The 1.5 T brain MRI revealed a well-enhanced mass in the right orbital apex (Fig. 5A). The mass had a wide dural base at the orbital apex. It was invading the cavernous sinus and encasing the internal cerebral artery. She received 7.0 T MRI (Fig. 5B) and was subsequently recommended for surgery but voluntarily opted for radiosurgery.

In this case, the image quality of skull base lesions on 7.0 T
Regarding 7.0 T MRI in patients with intracranial meningioma. However, there is no previous report of the potential resolution and increased sensitivity for susceptibility contrast in meningioma, the information regarding detailed characteristics of meningioma, such as tumor consistency, tumor vasculature and the tumor-brain interface are very important in pre-surgical planning. In that sense, 7.0 T MRI could provide a more detailed visualization of the tumor-brain interface and peri-tumoral vasculature compared with conventional MRI.

The presence of peri-tumoral edema correlates well to the loss of a patent arachnoid plane between the meningioma and surrounding normal brain. The breakage of the arachnoid plane between the meningioma and brain should be thoroughly evaluated and recognized to properly plan the extent of resection, with minimal injury to the adjacent brain parenchyma, especially in meningiomas that grow against eloquent regions of the brain. In this context, 7.0 T MRI is advantageous when delineating the tumor-brain interface and the neighboring compressed cortex. Our 7.0 T MRI results showed that peri-tumoral edema developed from areas without a cerebrospinal fluid cleft, but this finding could not be perceived in 1.5-T MRI (Fig. 2).

In the resection of meningioma, the veins around tumors must be preserved at all costs. In many cases, cerebral angiography is recommended for the evaluation of feeding vessels, adjacent veins and dural sinuses. The 7.0 T MRI showed detailed information regarding cortical draining veins, small veins around the tumor and intra-tumoral vessels that could not be visualized if the flow is low in 1.5 T MRI. The 7.0-T MRI is able to display the intra- and peri-tumoral vasculature (Fig. 1) and the cortical venous draining system (Fig. 5) in a T2-weighted image in greater detail in comparison with the current standard 1.5 T MRI. The vessel appearance closely resembles angiography, which is an accepted gold-standard mechanism of intracerebral vessel visualization (Fig. 3).

However, as a result of higher susceptibility in 7.0 T MRI, the image quality of skull base lesions could be reduced compared with 1.5 T MRI, as in case 4 (Fig. 5). Local magnetic field inhomogeneity close to the skull base and the paranasal sinuses and vascular shadows of carotid forks inevitably cause a decline in image quality. The adjustment of sequence parameters will be required in the future to overcome these spatial artifacts of 7.0 T MR.

CONCLUSION

7.0 T MRI in patients with meningiomas could provide useful information in surgical strategy, such as the peri-tumoral vasculature and the tumor-brain interface.

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