To the Editor: Intracranial solitary fibrous tumor (SFT) is a kind of rare tumor. It was first identified as a distinct entity in 1996 and included by the 2000 World Health Organization classification of tumors of the nervous system.[1]

A 22-year-old Chinese woman was admitted to the hospital with the chief complaints of headache, memory deterioration, and urine incontinence for 5 months. Five months ago, she gradually developed paroxysmal distending headache. The symptom exacerbated in recent 2 months. In addition, she began having weakness, memory deterioration, and urine incontinence. Physical examination showed: muscle strength: right arm IV−, left arm IV−, and both legs III; muscle tones: normal; and pathological reflexes: negative. Cranial magnetic resonance imaging (MRI) detected a 6 cm × 7 cm × 9 cm cerebral falx-based tumor with an irregular shape, iso-signal intensity on T1-weighted image (T1-WI), high-signal intensity on T2-WI, and inhomogeneous enhancement without obvious peritumoral edema. Based on the above findings, an admission diagnosis of meningioma was made.

The tumor was surgically accessed under general anesthesia through the frontal-parietal midline approach and found to be located in the middle of the frontal and parietal lobes, looking reddish with a clear boundary and rich blood supply, consisting of both soft and ductile components. The tumor was completely dissected from the brain tissue.

Hematoxylin and eosin (HE) staining showed that the tumor was composed of bland spindle cells with mitotic processes. Inside the collagen-rich matrix network, there were dozens of small vessels, some of which showed a “stag-horn” appearance. Immunohistochemical (IHC) staining showed positive for cluster of differentiation 34, B-cell lymphoma 2, vimentin and smooth muscle actin, myoepithelium, negative for epithelial membrane antigen, and S-100; the Ki-67 index was less than 1%. The tumor was confirmed as SFT by pathology.

After nearly a month’s recovery, the patient was discharged with no significant complications. Three months after surgery, she was conscious, speaking fluently without any sequela, and the muscle strength of limbs are V [Figure 1].

Intracranial SFT usually arises from the mesenchymal parenchyma; sometimes it can happen concurrently with other tumor-like meningioma.[2] Most SFT patients are adults. The diagnosis is based on both the pathomorphology and IHC staining. The diagnostic value of imagine evaluation remains controversial. The image hallmark of SFT on MRI includes a hypointensity T2 mass and strong enhancement of the mass after gadolinium diethylenetriamine pentaacetic acid administration, without enhancement of the adjacent meninges.[3] MRI might display hypointensity signal as compared with the muscle on the unenhanced computed tomography images while it is heterogeneously enhanced on the enhanced images.

The tumor has a relatively benign behavior but delayed extracranial metastasis can also be seen in some of the patients. It grows relatively slowly without the aggressive behavior of invasion and erosion. Its damage could be caused by compression on the adjacent structures or increased intracranial pressure.[4]

Surgery (including radiosurgery) remains the only and effective treatment for intracranial SFT. Radiotherapy can also be used in patients with incomplete resection. Long-time follow-up with MRI scans is necessary, especially for patients with incompletely resected SFT. Good prognosis can be expected after complete surgical resection although there is still likelihood of malignant conversion and local recurrence after subtotal resection in individual cases.[5]
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Conflicts of interest
There are no conflicts of interest.

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