Radiographic and clinical responses were assessed at approximately 3 months intervals after SRS. Results: The two cohorts were comparable in pertinent pre-treatment aspects with the exception of SRS timing relative to ipilimumab. Local recurrence free duration (LRFD) was significantly longer in Group-A patients (19.6 months, range 1.1-34.7 months) as compared to group-B patients (3 months, range 0.4-20.4 months), respectively (p=0.002). Post-SRS perilesional edema was more significant in Group-A. Conclusions: The effect of SRS and ipilimumab in attaining LRFD seems greater when SRS is performed before or during ipilimumab treatments. The timing of immunotherapy and SRS may effect LRFD and post-radiosurgical edema. The interactions between immunotherapy and SRS warrant further investigation so as to optimize the therapeutic benefits and mitigate the risks associated with multimodality, targeted therapy.

PS1 – 159

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A Case of Intracranial Metastases from Renal Pelvic Carcinoma and Review of Literature

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Transitional cell carcinoma (TCC) of the renal pelvis is a rare urological malignancy, with only a handful of cases of metastases to the brain reported in literature. We aim to present a case of intracranial metastasis in a female patient with history of renal pelvic carcinoma, and review existing literature of brain metastases from renal pelvic TCC. Methods: We searched PubMed, EMBASE, and MEDLINE from 1966 to January 2016 for published case reports written in English. Results: Five published case reports describe intracranial metastases from renal pelvic TCC. Our case is a 56-year-old woman with known high grade renal pelvic carcinoma and pulmonary metastases, who presented nine years after her initial diagnosis with mild left side weakness and headaches. She was found to have two lesions in the right cerebral hemisphere and underwent surgical resection of the larger right frontal lobe mass. Her neurologic symptoms improved postoperatively. She declined whole brain radiotherapy and remains stable at 6 months' follow-up. This is the first published case of presentation of brain metastases from pelvic TCC more than 12 months after diagnosis of the primary cancer. Conclusion: There is minimal literature of renal pelvic TCC metastasizing to the brain. However, as systemic chemotherapy leads to improved survival from the primary cancer, it is possible for more cases to appear, necessitating increased awareness from the healthcare team.

PS1 – 177

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Diagnosing and Treating Leptomeningeal Metastasis across Europe: A Web-Based Survey

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Leptomeningeal metastasis is a serious complication of systemic cancer commonly occurring in later disease stages which affects approximately 10% of patients with solid tumors. The risk is highest for patients with lung cancer, melanoma and breast cancer. Survival at one year is in the range of 10%. Cerebrospinal fluid analysis and magnetic resonance imaging are the most important diagnostic measures. Treatment recommendations vary by primary tumor and pattern of disease, that is, e.g., the absence or presence of concurrent systemic or solid brain metastasis. To explore the current practice of diagnosing and treating leptomeningeal metastasis across Europe, a web-based survey was sent to members of the European Association of Neuro-Oncology (EANO) and the Brain Tumor Group of the European Organisation for Research and Treatment of Cancer (EORTC) in April 2016 which contains 24 questions on current practice patterns as well as 8 case presentations. The results of this survey will be presented for the first time. They shall serve as the basis for treatment recommendations for this complication of systemic cancer that reflects current knowledge as well as current practice.

PS1 – 181

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Dural Metastases from Breast Cancer: A Case Series

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Intracranial metastases from solid tumors are increasingly common, often brain or leptomeningeal metastases. Dural metastases are under-reported, present diagnostic and therapeutic challenges, and may mimic subdural hematoma or meningioma. This report describes 4 recent patients with dural metastases from breast cancer. A 60 year old woman, without known cancer, had 5 months of increasing headaches, left weakness, and focal seizures. Imaging showed an enlarging right frontal extra-axial enhancing mass with edema, initially thought to be a meningioma. At surgery the tumor involved overlying bone, replaced the dura, and invaded brain. Pathology was metastatic adenocarcinoma, ER/PR positive and Her-2 negative. Investigations showed a right breast primary, and lung and bone metastases. She received cranial radiotherapy (RT), letrozole and pamidronate. The tumor remains controlled after 40 months. The 3 other patients all had prior known breast cancer, 2 ER/PR positive and Her-2 negative, and 1 triple negative, ages 45-70 years. Two had known systemic metastases prior to neurological presentation. Presenting symptoms included headache, seizures, focal weakness, and confusion. All had new or progressive systemic metastases, including bone, at diagnosis of dural metastases. Two had resection of dural metastases, 1 with complicated postoperative course, with eventual improvement in both. Two received cranial RT, 1 refused RT, and all received hormonal or chemotherapy, with ongoing clinical or MRI control. These cases illustrate the complexity of dural metastases. Although patients often have extensive metastatic disease, treatment can improve symptoms and prolong survival.