CONDITION

Arachnoidal fibroblastoma

Learn what the older term arachnoidal fibroblastoma may mean, how meningiomas are diagnosed and graded, and what to expect from treatment and follow-up.

WHAT IT IS
Older term for a meningioma arising from the meninges

BODY SYSTEM
Nervous system

MAIN SYMPTOMS
Headaches, seizures, one-sided weakness or numbness, vision or hearing changes

WHAT CAUSES IT
Usually unknown, sometimes inherited

HOW IT IS DIAGNOSED
Tissue examination after surgery or biopsy

MAIN TREATMENT
Observation, surgery, or radiation therapy

CAN IT BE CURED?
Sometimes, complete removal may be possible

IS IT AN EMERGENCY?
Sometimes, with a first seizure

LONG-TERM OUTLOOK
Often slow-growing but may recur years later

Overview

Arachnoidal fibroblastoma is an older term that has been used for a meningioma , a tumor arising from cells associated with the meninges, the protective tissue layers covering the brain and spinal cord.

"Arachnoidal fibroblastoma" is not a standard diagnosis in the current World Health Organization classification of brain and spinal cord tumors. If it appears in an older medical record or pathology report, ask what diagnosis it corresponds to under current terminology. Specialists often interpret it as a meningioma, but the original tissue findings and clinical context remain important.

Meningiomas usually grow from the inner surface of the skull or the coverings around the spinal cord. They do not normally begin within brain tissue, although they may press on or

involve nearby brain structures, nerves, blood vessels, or bone.

Many meningiomas grow slowly. Some are found by chance during imaging and never cause major problems. Others cause symptoms because of their size, location, surrounding swelling, or effect on important structures. Even a small tumor can cause significant symptoms if it is in a tight or sensitive area.

Modern pathology assigns meningiomas a World Health Organization grade. Grade 1 tumors generally have the least aggressive features. Grade 2 tumors have a higher risk of returning after treatment, while grade 3 tumors are more likely to grow quickly and recur. Grade helps guide care but does not guarantee an individual outcome.

Management should be based on the current diagnosis, grade, imaging findings, symptoms, and the person's overall health.

Symptoms

Symptoms depend mainly on the tumor's location and the structures it affects. Because many meningiomas grow slowly, symptoms may be subtle at first.

Possible symptoms include:

These symptoms have many possible causes and do not by themselves confirm a meningioma. Persistent, progressive, or unexplained symptoms should be assessed by a clinician.

Seek emergency care for a first seizure, a seizure lasting several minutes, repeated seizures without recovery, sudden weakness or numbness, sudden trouble speaking, loss of consciousness, or a severe and rapidly worsening headache with confusion or repeated vomiting. Prompt assessment is necessary even when the cause is unknown.

Gradually worsening headaches, mild balance problems, or changes in memory should be discussed at a routine or timely medical appointment rather than ignored.

- New, changing, or increasingly frequent headaches
- Seizures
- Weakness, numbness, or reduced coordination on one side
- Changes in vision, hearing, or sense of smell
- Balance or walking problems
- Difficulty speaking or understanding language
- Changes in memory, concentration, judgment, mood, or personality

- Nausea or vomiting associated with increased pressure inside the skull
- Facial numbness or weakness
- Limb, walking, bladder, or bowel problems from a spinal tumor

Causes and risk factors

Most meningiomas have no single identifiable cause. They develop when cells acquire changes that allow abnormal growth and division.

Exposure to ionizing radiation involving the head is an established risk factor, particularly after therapeutic radiation received at a younger age. Routine diagnostic imaging uses much lower doses and should not be assumed to have caused a tumor.

Certain inherited conditions increase risk. The best known is neurofibromatosis type 2-related schwannomatosis , or NF2-related schwannomatosis, caused by a harmful inherited change involving the NF2 gene. It may lead to multiple nervous system tumors, including meningiomas. Most people with a single meningioma do not have this condition.

Meningiomas are diagnosed more often in women and become more common with age. Some contain receptors responsive to hormones such as progesterone, but the effects of natural hormones and hormone-containing medicines remain under study. Do not start or stop prescribed hormone treatment solely because of this association; discuss the risks and benefits with the prescribing clinician.

Diagnosis

Diagnosis usually begins with a medical history and neurological examination. The clinician may assess strength, sensation, reflexes, balance, vision, hearing, speech, and memory.

Magnetic resonance imaging, or MRI, is the main imaging test. Contrast material may be injected into a vein to make the tumor and nearby tissues easier to see. MRI can show the tumor's size, location, relationship to nerves and blood vessels, and surrounding swelling. Tell the imaging team about implanted devices, metal fragments, pregnancy, kidney disease, or a previous contrast reaction so they can determine whether MRI and contrast are appropriate.

Computed tomography, or CT, can show changes in nearby bone or calcium within the tumor and may be used when MRI cannot be performed.

Imaging can strongly suggest a meningioma but cannot always confirm its exact type or grade. A definite diagnosis may require tissue obtained during surgery or, less commonly, a biopsy. A

pathologist examines the tissue and may test for specific proteins, chromosome changes, or gene alterations.

Current grading considers microscopic appearance, cell division, brain invasion, and certain molecular findings. The pathology report may include the grade, subtype, mitotic count, and markers that help estimate recurrence risk.

If an older report uses "arachnoidal fibroblastoma," a neuropathologist may review the slides or stored tissue to clarify the current diagnosis and grade. Cases are often discussed by a multidisciplinary team that may include a neurosurgeon, radiation oncologist, neuro-oncologist, neuroradiologist, and neuropathologist.

Treatment and management

Treatment depends on symptoms, tumor growth, location, grade, general health, treatment risks, and personal preferences.

Observation

A small tumor that is not causing symptoms may be monitored with clinical visits and regular MRI scans. Observation, also called active monitoring or watchful waiting, is a planned approach intended to detect meaningful growth or new symptoms.

The imaging schedule is individualized according to tumor size, growth pattern, known grade, and how long it has remained stable.

Surgery

Surgery may be recommended when a tumor is growing, causing symptoms, or threatening important structures. Goals can include relieving pressure, obtaining tissue, and removing as much tumor as is safely possible.

Complete removal is not always safe. Tumors may involve major blood vessels, cranial nerves, the skull base, or other sensitive structures. A surgeon may intentionally leave part of the tumor and recommend monitoring or radiation afterward.

Risks vary by location and may include bleeding, infection, seizures, blood clots, leakage of the fluid surrounding the brain, or changes in neurological function. The surgical team should explain expected benefits, preparation instructions, and location-specific risks before treatment.

Radiation therapy

Radiation therapy uses focused energy to damage tumor cells and limit growth. It may be considered when a tumor cannot be safely removed, remains after surgery, returns, or has

higher-grade features.

Stereotactic radiosurgery delivers highly focused radiation, generally to a small target, and does not involve an incision. Fractionated radiation divides treatment into multiple sessions and may be preferred for larger tumors or those near sensitive structures.

The technique depends on tumor size, location, grade, previous treatment, and surrounding tissues. Side effects can include fatigue, temporary hair loss in the treated area, skin changes, swelling, and delayed effects on nearby brain tissue or nerves.

Medicines and supportive care

Medicines are not usually the primary treatment for a localized meningioma. Corticosteroids like prednisone or hydrocortisone may reduce swelling, while antiseizure medicines may be prescribed after seizures. These medicines require medical supervision and should not be started or stopped without guidance.

No drug treatment reliably controls all meningiomas. For tumors that continue growing after surgery and radiation, a neuro-oncology team may discuss clinical trials or selected systemic treatments based on the tumor's features.

Rehabilitation can help address treatment or tumor effects. Physical therapy may support strength and balance, occupational therapy may improve daily functioning, and speech-language therapy may help with communication, thinking, or swallowing.

Complications

Complications may result from the tumor or its treatment. Tumor-related problems include seizures, persistent headaches, weakness, vision or hearing loss, cognitive or behavioral changes, and increased pressure inside the skull. A spinal meningioma can compress the spinal cord and affect movement, sensation, or bladder and bowel control.

Meningiomas can return after treatment. Recurrence risk depends on grade, location, extent of removal, and biological features. A tumor left in place may remain stable for years or resume growing.

Surgery and radiation may affect nearby nerves, blood vessels, brain tissue, hormone-producing structures, or bone. Some effects occur soon after treatment, while others develop later. The care team should explain the complications most relevant to the tumor's location and planned therapy.

Follow up

Long-term follow-up is important because meningiomas may change slowly or recur years after treatment. Follow-up commonly includes neurological examinations, symptom review, and MRI scans. The treating team should set the schedule.

Contact the care team between visits for a new seizure, increasing headaches, new weakness or numbness, worsening balance, vision or hearing changes, or noticeable changes in speech, memory, or behavior. An earlier examination or scan may be needed.

Seek emergency assessment for sudden stroke-like symptoms, prolonged or repeated seizures, loss of consciousness, severe confusion, or rapidly worsening symptoms.

Before routine visits, bring an updated medicine list and note any new symptoms. Ask whether older pathology should be reviewed under current classification standards. If you take antiseizure medicines, corticosteroids, or other supportive treatments, discuss side effects and whether continued treatment is necessary.

Sources

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