

QUESTIONS TO ASK FOLLOWING A BRAIN TUMOUR DIAGNOSIS

A brain tumour diagnosis can be very overwhelming. Here are some questions to ask your neurosurgeon to improve understanding and help guide next steps

GENERAL QUESTIONS

- What part of the brain is the tumour in? What is this part of the brain responsible for? Is this area considered **eloquent** or **non-eloquent**?
- Are there any specific symptoms that I should be aware of?
- Is it possible that the tumour is a **metastasis** or is it a **primary** brain tumour?
- Does the tumour **enhance** with contrast?
- Do you specialize in brain tumour removal?



SERIAL MONITORING - "Watch & Wait"

- What will my scan interval be (number of months between MRIs)?
- What will be the next step if there is growth? *(If the answer is surgery, ask what the rationale is for waiting)*
- Are there any specific symptoms for which I should follow up with you or the ER if they show up in between scans (e.g. seizures*)?

BIOPSY

- Is **resection** not possible in this area?
- What tests will be run on the sample and how will this inform treatment?

What are the risks or expected side-effects? (Will they be permanent/how long are they expected to last?)

SURGERY

- Will I be awake or asleep for the procedure? (Why?/Why not?)
- How much of the tumour will be able to be removed?
- Is a **supratotal resection** possible?

RADIATION

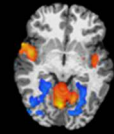
- Will it be a one-time **stereotactic radiosurgery** or **fractionated** (many smaller doses)?
- What are the expected short and long-term side effects and their respective timelines?

OTHER

- Are there any **clinical trials** available?
- Are there any tumour-specific supports available locally (physical, mental, emotional, financial)?
- If I wanted to learn more, what should I read?

**Not all brain tumours will cause seizures, but it is a common side-effect (especially in frontal and temporal lobes). The likelihood that a seizure will happen increases with: alcohol/drugs, stress, lack of sleep, menstruation/hormone changes, and illness (fever/vomiting/diarrhea) so try to be mindful in these situations and be cautious if you are at risk.*

GLOSSARY



Learning these terms might be helpful since this will be the jargon used by your doctor(s) in your radiology reports and patient notes. This will also be the terminology used in research studies that you might want to consult.

An **eloquent** region is an area in the brain that is involved in a very important function like speech or movement. An awake surgery is usually recommended in these areas to make sure that the function isn't impaired during the surgery.

A **primary brain tumour** means that it originated in the brain and is unlikely to travel elsewhere, while a **metastasis** originated somewhere else in the body and traveled to the brain. These should look different on an MRI.

During your MRI you should have had a scan with a contrast dye (gadolinium) injection. Tumours that are more advanced look different on an MRI with the dye – this is known as **contrast enhancement**. This helps indicate severity because **non-contrast enhancing** tumours tend to grow more slowly.

Resection refers to a surgery that removes as much of the tumour as is safe to, in comparison to a biopsy that only takes a small piece for laboratory testing.

Most tumours grow back in the same spot that they were removed from because inevitably some tumour cells get left behind. A **supratotal resection** means that some healthy tissue around the tumour will also be removed to try to get rid of as many diseased cells as possible. This is only possible in **non-eloquent** areas.

Stereotactic radiosurgery uses a specialized machine to deliver a high dose of radiation to a very precise area to prevent the tumour from growing. This generally is a one-time procedure, without any incisions, that is often used for small or hard to reach tumours. **Fractionated radiation therapy** uses smaller doses of radiation over many days (e.g. six weeks) that is often used to destroy tumour cells left behind from surgery.

Clinical trials are critical to improve the treatment for brain tumours. These are not only for drugs, but also devices and protocols. To develop new treatments scientists need to understand the underlying tumour biology. These studies could be looking at ways to improve the information gathered from medical imaging (MRI, CT, intraoperative ultrasound), whether or not new drugs even reach the tumour, where the cancer-causing mutation exists in the tumour, etc.