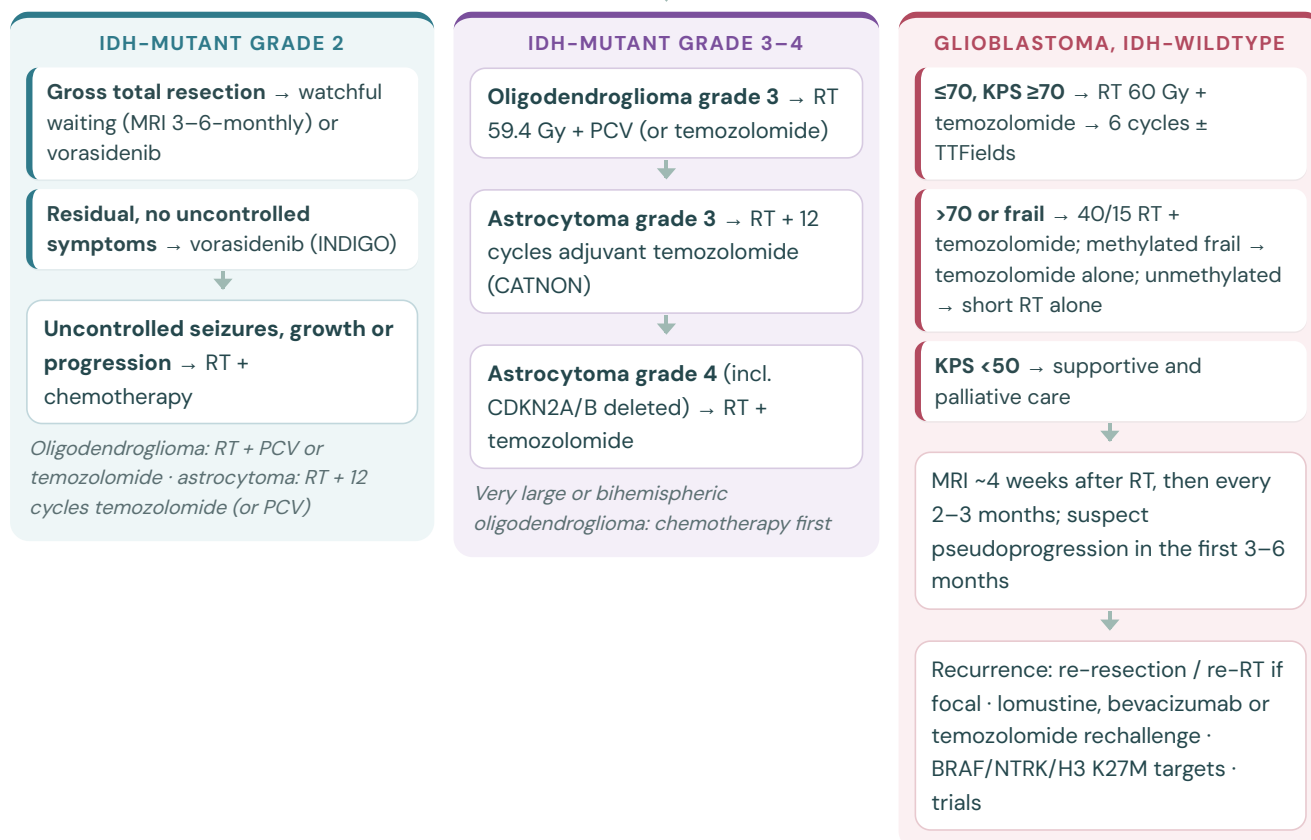


Brain Tumours: Adult diffuse glioma algorithm

Dr. Haritha Chiramana

MD, DM · Senior Medical Oncologist & Hemato-Oncologist

Suspected glioma on MRI: neuro-oncology MDT · steroids only if symptomatic · antiseizure drug only after a seizure · **maximal safe resection** (biopsy if deep or diffuse) · MRI in 24–48 h · integrated diagnosis: IDH, 1p/19q, CDKN2A/B, MGMT



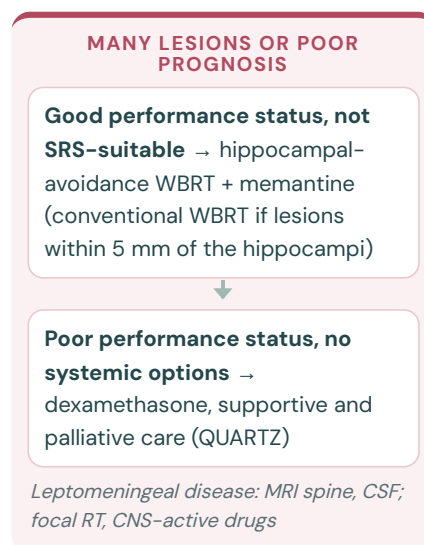
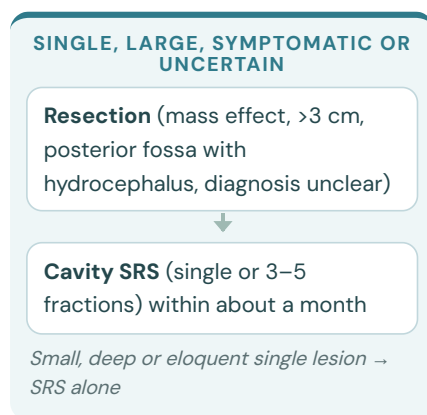
All patients: shared decisions about goals · driving and work advice after seizures · fertility and contraception · weekly counts and PJP prophylaxis (if steroids/lymphopenia) on daily temozolomide · avoid routine PPIs · rehabilitation and carer support · palliative care alongside, not instead.

Brain Tumours: Brain metastases algorithm

Dr. Haritha Chiramana

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New brain metastases: MRI with contrast (count and size) · systemic staging · tumour genotype · GPA · steroids only if symptomatic · neurosurgery and radiation oncology at the first MDT



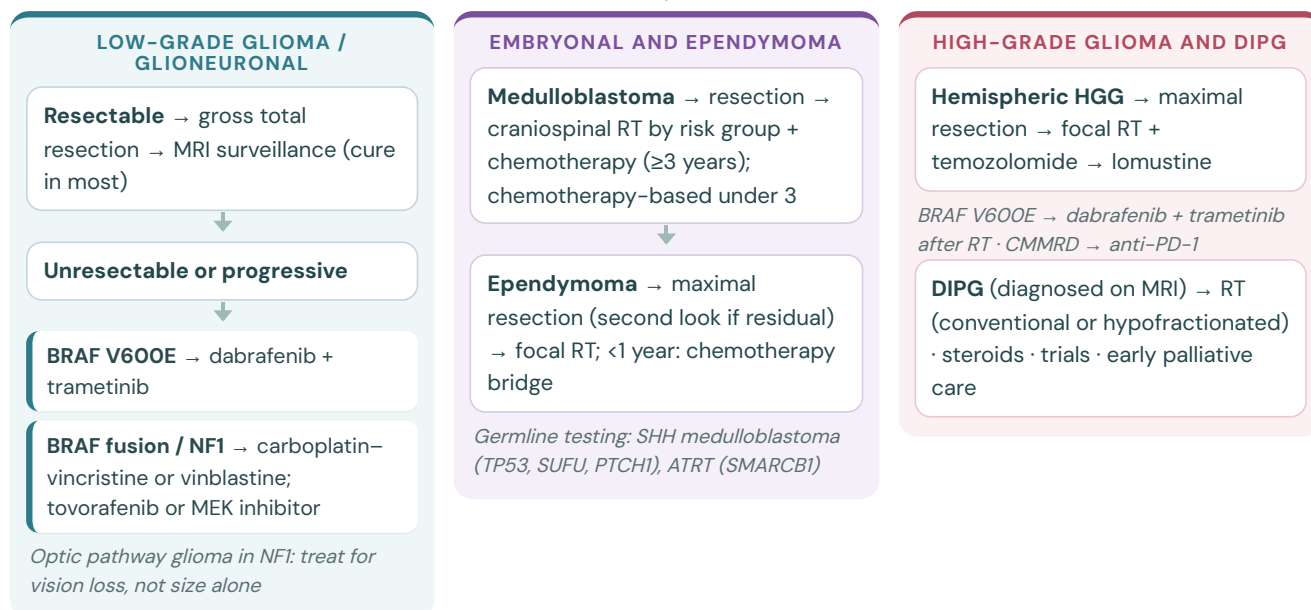
All patients: no prophylactic antiseizure drugs · DOAC or LMWH for VTE (individualise in melanoma, RCC, thyroid, choriocarcinoma) · taper steroids early, especially before immunotherapy · driving advice · discuss goals of care.

Brain Tumours: Paediatric brain tumour algorithm

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Red flags (morning vomiting, ataxia, squint, head tilt, regression, headache ≤ 6 years) → urgent MRI (CT if unavailable) → paediatric neurosurgery the same day if hydrocephalus · steroids for oedema · staging: spine MRI, CSF, AFP/ β -hCG where relevant · tissue + molecular (BRAF, H3, groups)



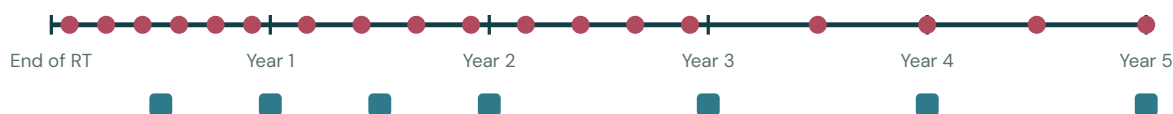
All children: paediatric neuro-oncology centre · fertility preservation where possible · school and neurocognitive support · lifelong late-effects clinic (endocrine, hearing, growth, second tumours) · family genetic counselling when a syndrome is suspected.

Brain Tumours: Follow-up and survivorship plan

Dr. Haritha Chiramana

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High-grade: MRI ~4 weeks after RT, then every 2–3 months for 2–3 years



● High-grade glioma: MRI + clinic (steroid dose, seizures, cognition, mood, blood counts on temozolomide)

■ Low-grade glioma: MRI every 3–6 months for 5 years, then 6–12-monthly for life (more often on vorasidenib early)

Metastases after SRS: MRI every 2–3 months for a year. Children: MRI per protocol; endocrine, hearing, growth, school and fertility review. Treat the person: driving and work advice, epilepsy safety, carer support, advance-care planning when appropriate.

A simple follow-up rhythm (NCCN, EANO). MRI drives follow-up; interpret early changes after chemoradiation with pseudoprogression in mind.

Safer everyday care

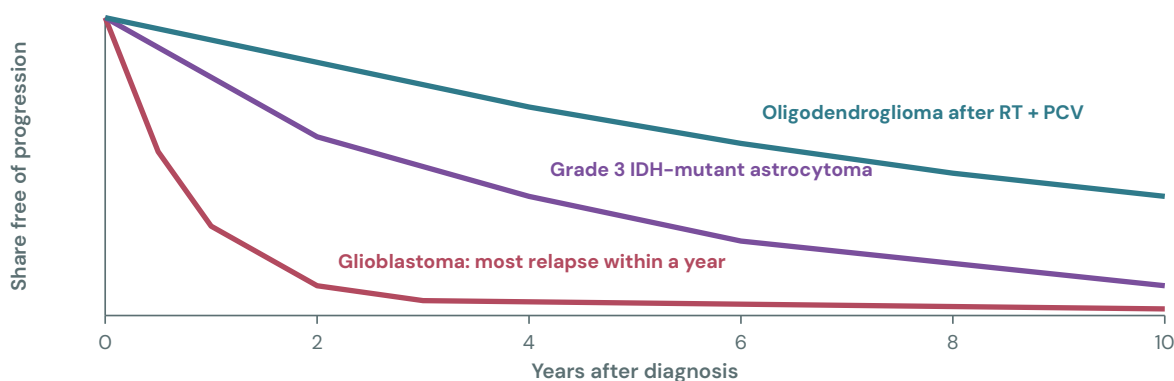
- Steroids only for symptoms; taper at every visit
- Antiseizure drug only after a seizure (levetiracetam)
- Weekly counts during RT with temozolomide
- PJP prophylaxis if on steroids or lymphopenic
- H2 blocker rather than routine PPI

Red flags to report

- New or worse headache, vomiting, drowsiness
- New weakness, speech or vision change
- Seizure, or a change in seizure pattern
- Calf swelling or sudden breathlessness
- Fever or cough on temozolomide and steroids

Do not forget

- Driving advice in writing after a seizure
- Fertility and contraception before chemotherapy
- Endocrine, hearing and school review for children
- Carer support and goals-of-care talk
- Genetic counselling for NF1, Li-Fraumeni, CMMRD



When relapses happen (illustrative shapes from trial medians, not to scale). The pace differs tenfold between glioma types, so follow-up intensity and the meaning of a “stable” scan differ too.