Care for consequences in children treated for leukemia or brain tumor
Aukema, Eline

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CHAPTER 4

White Matter Fractional Anisotropy Correlates With Speed of Processing and Motor Speed in Young Childhood Cancer Survivors

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Abstract

Purpose: To determine if childhood medulloblastoma and acute lymphoblastic leukaemia (ALL) survivors have decreased white matter fractional anisotropy (WMFA) and whether WMFA is related to the speed of processing and motor speed.

Methods and Materials: For this study, 17 patients (6 medulloblastoma, 5 ALL treated with high dose methotrexate (MTX) (4 x 5 g/m2) and 6 with low dose MTX (3 x 2 g/m2) and 17 age-matched controls participated. On a 3.0-T magnetic resonance imaging (MRI) scanner, diffusion tensor imaging (DTI) was performed, and WMFA values were calculated, including specific regions of interest (ROIs), and correlated with the speed of processing and motor speed.

Results: Mean WMFA in the patient group, mean age 14 years old (range 8.9 – 16.9), was decreased compared to the control group (P=0.01), as well as WMFA in the right inferior fronto-occipital fasciculus (IFO) (P=0.03) and in the genu of the corpus callosum (gCC) (P=0.01). Based on neurocognitive results, significant positive correlations were present between processing speed and WMFA in the splenium (sCC) (r=0.53, P=0.03) and the body of the corpus callosum (bCC) (r=0.52, P=0.03), while the right IFO WMFA was related to motor speed (r=0.49, P < 0.05).

Conclusions: White matter tracts, using a 3.0-T MRI scanner, show impairment in childhood cancer survivors, medulloblastoma survivors, and also those treated with high doses of MTX. In particular, white matter tracts in the sCC, bCC and right IFO are positively correlated with speed of processing and motor speed.
**Introduction**

Today, in developed countries such as the U.S., about one in every 450 adolescents reaching the age of 20 will be a long-term cancer survivor [1]. Because of multimodal treatment strategies, the overall survival rate of children with brain tumors has increased dramatically [2]. Unfortunately, progress in treatment strategies has not been able to prevent treatment-related side effects, such as neurotoxicity. For instance, children treated with craniospinal radiotherapy (CSRT) and chemotherapy for a medulloblastoma often experience serious neurocognitive impairments. Deficits in attention, memory and speed of processing are commonly found in survivors [2-5]. Children treated for acute lymphoblastic leukaemia (ALL) have also shown treatment-induced neurotoxicity; this is probably caused by intrathecal and/or high dose intravenous methotrexate (MTX), which is a replacement for cranial radiation therapy as central nervous system (CNS) prophylaxis, although published data are inconsistent [6-8].

The neurocognitive impairments have been associated with white matter changes caused by craniospinal radiotherapy (CSRT), some chemotherapeutic agents including MTX, and other factors, such as tumor infiltration and hydrocephalus [9-11]. The treatment-induced neurotoxicity may be caused by either a failure of “normal” maturation and myelination of the brain at an age-appropriate rate or by damage to already-existing white matter tracts. In children treated for cancer, negative effects based on both assumptions seem likely.

Diffusion tensor imaging (DTI), an advanced brain imaging technology, enables the study of the integrity of white matter structures, which are most vulnerable for toxic treatment. The diffusion of water molecules is high along and low perpendicular to coherent white matter tracts, resulting in an anisotropic diffusion profile. The white matter fractional anisotropy (WMFA) value quantifies this anisotropy, with zero for isotropic and one for fully anisotropic diffusion profiles. WMFA reflects the myelination and axonal integrity [12]. Increase of WMFA during childhood and adolescence parallels the development of important basic cognitive functions [13,14]. Diminished WMFA seems potentially useful for detecting and monitoring white matter damage. Thereby, significant positive correlations were found for WMFA in different brain regions with intelligence and neuropsychological functions in medulloblastoma survivors [15-17]. Likewise, these positive correlations have been found in children with traumatic brain injury [18] and in patients suffering from a wide range of psychiatric disorders [19]. White matter plays an important role in the speed of processing, which is crucial for learning and coping in daily life—one of the main problems for childhood cancer survivors, especially brain tumor survivors. It is unknown whether diminished WMFA is related to these problems in speed of processing; increased insight into this relationship might help to predict neurocognitive decline in the future.
The aims of this study were 1) to estimate the functioning of cancer survivors (survivors from a medulloblastoma and ALL) with respect to intelligence, speed of processing and motor speed, 2) to measure WMFA by MRI in childhood cancer survivors after treatment with CRST and/or high dose intravenous MTX compared to peers, and 3) to relate neurocognitive function (intelligence, speed of processing and motor speed) with WMFA in different regions of interest (ROIs).

We prospectively studied WMFA using a 3.0-T MRI and neurocognitive functioning in a group of childhood cancer survivors compared with healthy peers.

### Methods and Materials

#### Patients

Survivors treated in the Emma Children’s Hospital for a medulloblastoma or ALL, between 8 and 16 years old and at least 3 years after the end of treatment in medulloblastoma survivors or 3 years after intravenous MTX as CNS prophylaxis in ALL survivors, were eligible for this study.

To compare different treatment modalities, our study design consisted of 3 subgroups of childhood cancer survivors (“patient group”); 6 medulloblastoma survivors treated with surgery, radiation (whole brain and spine: total dose ranging from 25.2 to 34.5 Gy; and posterior cranial fossa boost: ranging from 53.3 to 55.4 Gy) and chemotherapy, including lomustin, vincristin and cisplatin; 6 ALL survivors treated with 4 x 5 gr/m² intravenous MTX (“high dose ALL”) according to the DCLSG protocol 1993-1997; and 6 survivors treated with 3 x 2 gr/m² intravenous MTX (“low dose ALL”) according to the DCLSG ALL-9 protocol 1997-2004 as CNS prophylaxis [20-21].

Parents or adolescents were first contacted by phone and then received written information about the study.

We approached 8 medulloblastoma survivors and received 6 positive reactions. We then searched for age- and sex-matched survivors treated for ALL with comparable time after completion of treatment. A total of 20 ALL survivors were selected, of whom seven did not want to be confronted with their cancer history again. We received 13 approvals for participation, and they were divided into the two different treatment groups.

After inclusion of the survivors, we selected a “control group” of classmates of the participating survivors. A suitable classmate, matching the survivor as closely as possible according to age, sex and the level of education, was chosen by the school, unless survivors picked their own classmate for privacy reasons, or a suitable classmate of a different patient was approached by us.

The survivor and control were scheduled together for the MRI and neurocognitive evaluation to reduce possible anxiety through peer support and to increase participation. Age-specific illustrated information about the MRI procedure was...
provided, and professional child-directed support and the possibility of using a distracting audiotape or videotape were available during the MRI. Specific requirements as described by Dutch law and the behavioral research code of the Dutch Association for Pediatricians were met in this study design, which was approved by the local medical ethics committee.

Finally, 17 survivors (6 medulloblastoma; 5 high dose ALL and 6 low dose ALL) participated in this study, as one survivor was unable to finish his MRI session due to anxiety and one survivor had a steel splinter in his eye.

**Measurements**

Diffusion tensor imaging (DTI) was performed on a 3.0-T MRI scanner (Philips Intera, Philips Medical Systems, Best, the Netherlands). DTI acquisition was along 16 nonlinear and 16 antipodal directions. The other parameters were echo-time: 94 msec, repetition time: 4831-6248 msec, diffusion weighting parameter b: 1000 s/mm², FOV: 240 mm, scan matrix: 70 x 112, and slice thickness: 3 mm. Eddy current-induced morphing was corrected by a two-dimensional affine registration of the Diffusion Weighted Images to the B0-image [22].

The participants were only informed about the MRI results only if health-related data resulted, which was not the case in any of the children.

The neurocognitive tests were individually administered by two psychologists in approximately 2.5 h. All subjects completed a test battery to assess general intelligence, speed of processing and motor speed. This battery included the Dutch version of the Wechsler Intelligence Scale for Children, 3rd Edition [23], and the Purdue pegboard [24]. Participants were informed about their cognitive functioning and possible consequences for school and daily life.

The interval between neurocognitive testing and MRI ranged between 0.0 and 3.5 months.

**MRI Data Analyses**

Structural images were judged by an experienced neuroradiologist for macroscopic white matter lesions, atrophy, status of the primary tumor, if appropriate (i.e., in medulloblastoma survivors), and possible other new lesions. FA-images were computed using Teem-software (http://teem.sf.net). Further analysis was performed in Matlab using Statistical Parametric Mapping (SPM5)-software (Wellcome Department of Cognitive Neurology, London, England) and Matlab software (Mathworks). As an initialization, all data were co-registered to the Echo Planar Imaging-template available in the SPM-toolbox.

The data were segmented into white matter, gray matter and cerebral spinal fluid (CSF) based on the B0-image. A two-step procedure was performed. In the first iteration, the a priori white matter, gray matter and CSF-maps available in SPM were used to segment the data. After this segmentation, average maps of the cohort were
computed, and the second iteration was initiated using these maps. The resulting white matter mask was obtained using the following operation:
\[ i_2 > i_1 \text{ and } i_2 > i_3 \text{ and } i_2 > 1 - i_1 - i_2 - i_3, \]
where \( i_1, i_2 \) and \( i_3 \) are the grey, white and CSF-maps, respectively, resulting from the segmentation as shown in Fig. 1.

The WMFA-volumes were smoothed using a Gaussian kernel, with a size of 6 mm (FWHM). Next, all images were spatially normalized, using both an affine and non-rigid transformation. In this way, tiny segmentation errors could be corrected through pair-wise intersection of the masks.

Based on the literature [25, 26], white matter regions of interest (ROI) with a presumed relation with neurocognitive function were selected: the genu (gCC), the splenium (sCC) and the body of the corpus callosum (bCC) and the bilateral inferior fronto-occipital fasciculus (IFO). ROIs were outlined on color-coded WMFA maps.

We first used a control subject and manually drew the ROIs. The ROIs identified in this subject were then used as a guide to manually define ROIs for other subjects as reproducibly as possible; subsequently, the ROIs were outlined manually by one operator. Mean WMFA was measured in each ROI.

**Statistical analyses**

Overall WMFA (mean WMFA and mean ROI WMFA) was calculated, and correlations with cognitive functioning were analyzed using SPSS version 14.2 (SPSS Inc., Chicago, IL).

First, demographics and cognitive functioning of the participants were described. One-sample t-tests were performed to test whether mean scores on cognitive tests in the “patient group” (medulloblastoma, low dose ALL and high dose ALL) and the “control group” differed from the normal population [23, 24]. Differences in cognitive functioning between the patient subgroups were analyzed using multiple

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**Fig. 1 Overview of magnetic resonance imaging data analyses:**

(a) A priori white matter segmentation map provided by statistical parametric mapping software and (b) based on the data in this study. (c) Fractional anisotropy values averaged over all subjects after spatial normalization. (d) Voxels segmented into white matter of one patient-control pair, gray denoting either one of the two and white denoting both subjects, the latter being used in analysis.
univariate analyses of variance (ANOVA).

Second, we studied group differences in overall WMFA between the patient group and the control group using t-tests. If overall tests for differences in WMFA were significant, we further analyzed the differences among the 3 patient subgroups with ANOVA. For assurance of the results, we also performed nonparametric Mann-Whitney U tests because of the non-normal distribution of WMFA in these small subgroups.

Finally, we calculated correlations of overall WMFA with intelligence, speed of processing and motor speed in the patient group. We followed Cohen in considering correlation coefficients of 0.1 as small, 0.3 as medium and 0.5 as large [27].

Results

Participants

The characteristics of the participants are listed in Table 1. The control group was well-matched for age and sex. Within the patient group, the subgroups did not differ in ‘age at testing’ (F(2,14)=2.04, p=0.17) or in ‘age at diagnosis’ (F(2,14)=1.13, p =0.35). However, ‘interval since treatment’ differed significantly (F(2,14)=5.36, p= 0.02) between the patient subgroups. As expected, further analysis showed a longer interval for the high dose ALL group compared to the low dose ALL group (t=4.76, df=9, p=0.00). These results were confirmed by non-parametric Mann-Whitney U tests.

Table 1. Characteristics of the participants

<table>
<thead>
<tr>
<th></th>
<th>MED</th>
<th>High-dose ALL</th>
<th>Low-dose ALL</th>
<th>Patient group</th>
<th>Control group</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>6</td>
<td>5</td>
<td>6</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>5</td>
<td>0</td>
<td>6</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Male</td>
<td>1</td>
<td>5</td>
<td>0</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Age at study (y)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>13.6 (3.3)</td>
<td>15.4 (1.4)</td>
<td>13.2 (2.7)</td>
<td>14.0 (2.5)</td>
<td>13.9 (2.9)</td>
</tr>
<tr>
<td>Min, max</td>
<td>8.9, 16.8</td>
<td>13.4, 16.9</td>
<td>10.1, 16.7</td>
<td>8.9, 16.9</td>
<td>8.8, 17.0</td>
</tr>
<tr>
<td>Age at diagnosis (y)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>4.7 (1.3)</td>
<td>3.7 (1.5)</td>
<td>7.1 (4.5)</td>
<td>5.2 (3.1)</td>
<td>-</td>
</tr>
<tr>
<td>Min, max</td>
<td>2.9, 6.7</td>
<td>2.2, 5.7</td>
<td>2.0, 13.2</td>
<td>2.0, 13.2</td>
<td>-</td>
</tr>
<tr>
<td>Interval (y)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>8.8 (4.9)</td>
<td>11.5 (1.2)</td>
<td>5.9 (2.4)</td>
<td>8.4 (3.5)</td>
<td>-</td>
</tr>
<tr>
<td>Min, max</td>
<td>2.7, 13.3</td>
<td>10.6, 13.6</td>
<td>3.4, 9.9</td>
<td>2.7, 13.6</td>
<td>-</td>
</tr>
</tbody>
</table>

Abbreviations: MED = medulloblastoma group, High dose ALL = leukemia group, high dose MTX (4 x 5 gr/m2), low dose ALL = leukemia group, low dose MTX (3 x 2 gr/m2); Interval = time since end of treatment.
Neurocognitive functioning

Neurocognitive functioning and differences from the norm population are presented in Table 2. The medulloblastoma group scored the worst on almost all cognitive measures, especially on processing speed and motor speed compared with the norm population, followed by the high dose ALL group and the low dose ALL group. Lower scores were also found in the control group; moreover, cognitive functioning differed significantly from the norm scores.

Analysis of variance showed a trend toward a difference in full scale IQ ($F(2, 14)=3.19$, $p=0.07$) between the patient subgroups. Further analysis revealed significantly lower full scale IQ in the medulloblastoma group ($p=0.04$) compared to the low dose ALL group. The verbal comprehension index score and perceptual reasoning score did not differ between the patient subgroups.

Table 2: Cognitive functioning of the participants compared with the normal population group

<table>
<thead>
<tr>
<th></th>
<th>MED</th>
<th>High dose ALL</th>
<th>Low dose ALL</th>
<th>Patient group</th>
<th>Control group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intelligence</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FSIQ</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>82.8 (14.8)</td>
<td>97.4 (12.4)</td>
<td>102.2 (13.7)</td>
<td>93.9 (15.5)</td>
<td>88.4 (13.8)</td>
</tr>
<tr>
<td>Min, max</td>
<td>61, 104</td>
<td>81, 111</td>
<td>87, 123</td>
<td>61, 123</td>
<td>68, 123</td>
</tr>
<tr>
<td><strong>p</strong></td>
<td><strong>0.04</strong></td>
<td>0.66</td>
<td>0.71</td>
<td>0.13</td>
<td><strong>0.00</strong></td>
</tr>
<tr>
<td>VCF</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>88.8 (13.1)</td>
<td>96.6 (12.9)</td>
<td>98.0 (11.0)</td>
<td>94.4 (12.3)</td>
<td>90.1 (13.0)</td>
</tr>
<tr>
<td>Min, max</td>
<td>72, 109</td>
<td>80, 109</td>
<td>86, 114</td>
<td>72, 114</td>
<td>69, 120</td>
</tr>
<tr>
<td><strong>p</strong></td>
<td>0.09</td>
<td>0.59</td>
<td>0.67</td>
<td>0.08</td>
<td><strong>0.01</strong></td>
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<tr>
<td>POF</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Mean (SD)</td>
<td>88.0 (13.4)</td>
<td>102.8 (16.4)</td>
<td>106.2 (15.8)</td>
<td>98.8 (17.4)</td>
<td>89.9 (11.4)</td>
</tr>
<tr>
<td>Min, max</td>
<td>58, 108</td>
<td>80, 123</td>
<td>83, 123</td>
<td>58, 125</td>
<td>67, 110</td>
</tr>
<tr>
<td><strong>p</strong></td>
<td>0.13</td>
<td>0.73</td>
<td>0.38</td>
<td>0.77</td>
<td><strong>0.00</strong></td>
</tr>
<tr>
<td><strong>Processing speed</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSF</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>73.7 (11.6)</td>
<td>92.8 (12.7)</td>
<td>106.5 (7.3)</td>
<td>90.9 (17.4)</td>
<td>96.9 (14.9)</td>
</tr>
<tr>
<td>Min, max</td>
<td>55, 91</td>
<td>72, 105</td>
<td>99, 114</td>
<td>55, 114</td>
<td>72, 124</td>
</tr>
<tr>
<td><strong>p</strong></td>
<td><strong>0.00</strong></td>
<td>0.27</td>
<td>0.08</td>
<td>0.05</td>
<td>0.41</td>
</tr>
<tr>
<td><strong>Motor speed</strong></td>
<td></td>
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<td></td>
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<tr>
<td>MS (Z)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>-1.79 (1.43)</td>
<td>-1.07 (0.95)</td>
<td>-1.10 (0.53)</td>
<td>-1.34 (1.03)</td>
<td>-0.56 (0.98)</td>
</tr>
<tr>
<td>Min, max</td>
<td>-4.0, -10</td>
<td>-1.97, 0.46</td>
<td>-1.88, -48</td>
<td>-4.0, 0.46</td>
<td>-2.62, 1.24</td>
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<tr>
<td><strong>p</strong></td>
<td><strong>0.03</strong></td>
<td>0.06</td>
<td><strong>0.00</strong></td>
<td><strong>0.00</strong></td>
<td><strong>0.03</strong></td>
</tr>
</tbody>
</table>

Abbreviations: FSIQ=full scale IQ, VCF=verbal comprehension factor, POF=perceptual organization factor, PSF=processing speed factor, MS= motor speed score in Z-scores, MED=medulloblastoma group, high dose ALL=leukemia group high dose MTX (4 x 5 gr/m2), low dose ALL=leukemia group low dose MTX (3 x 2 gr/m2).

1 WISC-III-NL; mean =100, SD = 15; results of one sample t-tests with test value = 100

2 Processing speed; mean = 100, SD = 15; results of one sample t-tests with test value = 100

3 Motor speed; total Z-score; mean = 0, SD = 1 (-1 SD means worse, +1 SD means better); results of one sample t-tests with test value = 0.
In addition, ANOVA showed significant differences ($F(2,14)=14.50, p=0.00$) between the patient subgroups in the processing speed index score. Further analysis revealed significantly lower processing speed scores in the medulloblastoma group compared to the high dose ALL group ($p=0.03$) and the low dose ALL group ($p=0.00$). A trend toward a difference between the high dose ALL group compared to the low dose ALL group ($p=0.05$) was found in favor of the latter group. No group differences in motor speed were found ($F(2, 14)=0.90, p=0.43$). All results were confirmed by non-parametric Mann-Whitney U tests.

**Structural MR Images**

All controls and 12 patients (low dose ALL and high dose ALL) had normal findings for the T2-weighted and 3D-T1-weighted scans. Six patients, (medulloblastoma group) showed structural abnormalities on the T2-weighted and 3D-T1-weighted scans, including tissue loss of the cerebellar hemispheres ($n=4$) or vermis ($n=3$), hemosiderin deposits related to small previous occipital ($n=2$) or temporal ($n=2$) hemorrhages and subtle signal increases in the bilateral parietal white matter ($n=1$).

**WMFA findings**

WMFA is presented in Table 3. As anticipated, mean WMFA was lower in the patient group compared to the control group ($p=0.01$). WMFA was lower in the right IFO ($p=0.03$) and the gCC ($p=0.01$), and a trend was found in the bCC ($p=0.07$). These results were confirmed by non-parametric Mann-Whitney U tests. Analysis of variance showed significant differences in mean WMFA ($F(2, 14)=5.61, p=0.02$), sCC WMFA ($F(2, 14)=4.21, p=0.04$) and bCC WMFA ($F(2,14)=4.79, p=0.03$) between the patient subgroups. Further analyses revealed significantly lower mean WMFA ($p=0.01$), lower sCC WMFA ($p=0.03$) and lower bCC WMFA ($p=0.03$) in the medulloblastoma group compared with the high dose ALL group. Trends toward lower sCC ($p=0.10$) and bCC WMFA ($p=0.07$) compared with the low dose ALL group were found. No differences between the two ALL groups were found. With respect to the different patient groups, the medulloblastoma group had lower mean WMFA (mean difference=0.02, $p=0.00$) and lower bilateral IFO WMFA (mean difference right IFO=0.05, $p=0.01$ and mean difference left IFO=0.04, $p=0.00$) compared with their age- and sex matched controls. A trend was found toward a difference in the sCC WMFA (mean difference=0.13, $p=0.09$). The high dose ALL group had significantly lower gCC WMFA (mean difference=0.07, $p=0.01$) compared with their controls. No significant differences between the low dose ALL group and their controls were found. These results were confirmed by non-parametric Mann-Whitney U tests.
Correlations of WMFA with cognitive functioning

Correlations between WMFA and cognitive functioning in the patient group are presented in Table 4. Mean WMFA was not significantly correlated with total intelligence in the patient group. The sCC WMFA \((r=0.53, p=0.03)\) and the bCC WMFA \((r=0.52, p=0.03)\) showed a significantly positive correlation with the processing speed index score. The right IFO WMFA showed a significantly positive \((r=0.49, p < 0.045)\) correlation and a trend toward a positive correlation between sCC \((r=0.46, p=0.06)\) and motor speed score. No correlations between other ROI WMFA values and cognitive scores were found. The correlations were strong according to Cohen \((r=\text{around } 0.5)\).

In the control group the right IFO as well as the left IFO were also correlated to speed of processing \((r=0.55, p=0.02\) and \(r=0.58, p=0.02)\).
**Discussion**

To our knowledge, this is the first study reporting WMFA changes after childhood cancer using a 3.0-T MRI scanner. The results of this study showed that WMFA is decreased in childhood cancer survivors and is associated with neurocognitive skills, including speed of processing and motor speed. Mean WMFA and WMFA in ROIs, especially right IFO and gCC, were reduced. Because WMFA reflects the myelination and axonal integrity [12], these results indicate that the integrity of the white matter tracts are affected in childhood cancer survivors of medulloblastoma and survivors of ALL treated with high doses MTX. These findings are in agreement with a number of other studies showing white matter impairment [11, 28, 29] and, in particular, vulnerability of the frontal lobes and the corpus callosum [30, 31] after treatment for these types of cancer during childhood.

In addition, the current study showed evidence for positive correlations between detailed WMFA impairment, especially in the right IFO and the sCC and bCC, and neurocognitive impairment, especially speed of processing and motor speed. Lower WMFA in these regions correlated with slower speed of processing and motor speed. This supports the idea that more anisotropic white matter tracts facilitate more processing and faster processing of information. The splenium and body of the corpus callosum play important roles in the communication between the different brain areas, in particular the occipital and motor regions, and this could explain the

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**Table 4: Correlations of mean WMFA values with cognitive functioning in the patient group (N = 17)**

<table>
<thead>
<tr>
<th></th>
<th>Full scale intelligence</th>
<th>Processing speed factor</th>
<th>Motor speed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean WMFA</td>
<td>0.22</td>
<td>0.35</td>
<td>0.07</td>
</tr>
<tr>
<td>P - value</td>
<td>0.40</td>
<td>0.17</td>
<td>0.78</td>
</tr>
<tr>
<td>Right IFO WMFA</td>
<td>0.23</td>
<td>0.21</td>
<td>0.49</td>
</tr>
<tr>
<td>P - value</td>
<td>0.38</td>
<td>0.41</td>
<td>0.045</td>
</tr>
<tr>
<td>Left IFO WMFA</td>
<td>0.10</td>
<td>0.06</td>
<td>0.16</td>
</tr>
<tr>
<td>P - value</td>
<td>0.70</td>
<td>0.81</td>
<td>0.54</td>
</tr>
<tr>
<td>gCC WMFA</td>
<td>-0.16</td>
<td>0.22</td>
<td>-0.33</td>
</tr>
<tr>
<td>P - value</td>
<td>0.55</td>
<td>0.40</td>
<td>0.20</td>
</tr>
<tr>
<td>sCC WMFA</td>
<td>0.16</td>
<td>0.53</td>
<td>0.46</td>
</tr>
<tr>
<td>P - value</td>
<td>0.54</td>
<td><strong>0.03</strong></td>
<td><strong>0.06</strong></td>
</tr>
<tr>
<td>bCC WMFA</td>
<td>0.10</td>
<td>0.52</td>
<td>0.33</td>
</tr>
<tr>
<td>P - value</td>
<td>0.71</td>
<td><strong>0.03</strong></td>
<td>0.19</td>
</tr>
</tbody>
</table>

Abbreviations: WMFA = white matter fractional anisotropy, IFO = inferior fronto-occipital fasciculus, gCC, sCC, bCC = genu, splenium and body of the corpus callosum.
relation with visual speed of processing and motor speed [32]. Mabbot et al. (2006)
found that the right frontal–parietal region contributes to the speed of visual–spatial
searching [26]. In a wide range of childhood neuropsychiatric illnesses, including
attention-deficit/hyperactivity disorder (ADHD), size differences in the corpus
callosum have been reported [19]. In patients with traumatic brain injury (TBI),
which also usually induces diffuse axonal injury, damage in the corpus callosum is
related to a poorer neurocognitive outcome [33].

Several limitations to our study can be identified. First, the compilation of our control
group, derived from the same school level with a low average intelligence, hindered
the generalization of the patient data. Second, because many childhood brain tumors
are located infratentorially, the impact of cerebellar damage and hydrocephalus in
the past requires specific attention for its influence on motor speed, attention and
executive functions [34]. Thus, cerebellar damage may also have contributed to the
cognitive decline in our medulloblastoma subgroup. Third, we did not correct for
age, as we did not find any age-related increase of overall WMFA. WMFA increases
more rapidly during the first few years; in the corpus callosum, the increase occurs up
to the age of 6, and in the center semiovale, the increase occurs up to the age of 11
years [35]. The reason that we did not find age-related increases of WMFA is likely
because the majority of our patients were more than 12 years of age. However the
application of DTI at a 3.0-T MRI still enabled us to detect differences at a more
specific detailed level, despite the older age of our participants.

**Conclusion**

We conclude that DTI on a 3.0-T MRI is sensitive for the detection of region specific
changes in white matter integrity in pediatric cancer survivors, and WMFA correlates
with speed of processing and motor speed - both serious problems for childhood
brain tumor survivors.

The impact of different doses of MTX on neurocognitive functioning should be
studied more thoroughly, not only in childhood cancer survivors but also in patient
groups where MTX is a common treatment modality. Future longitudinal studies
with DTI collected from the start of the treatment for different types of malignancies
and treatment, integrated with neurocognitive measures, could lead to a better
understanding of causative neurotoxic factors and its relations with adverse cognitive
functions.

This could ultimately result in a predictive model of neurotoxicity on neurocognitive
outcome - leading to changes in treatment modalities or possibly white matter
protection, and thereby preventing these adverse late effects.
References


