Meningioma is a common intracranial tumor derived from meningothelial cells; its frequency is around 13-26% of all primary intracranial tumors. Most meningiomas are benign (grade 1) and are associated with a good outcome. However, malignant behavior such as metastatic disease has also been described, with extra-cranial metastases reported sporadically. In this report we present a rare case of non-CNS metastases of malignant meningioma. In 1990 a young woman of 25 years old, underwent a complete resection of a large parasagittal meningoendothelial grade I meningioma. Well-being was observed during 20 years. Then in a few months, the patient became confused with episodes of spatial and temporal disorientation. A brain MRI revealed a local recurrence, and a second resection was performed, with diagnosis of “atypical meningioma with dural infiltration, nerve tissue and presence of foci of necrosis”. No other treatments were performed at that moment. One year later, in 2011, a voluminous recurrence was detected and a third resection was accomplished (histological diagnosis of “rhabdoid meningioma”). At that time a conformational radiation therapy, for a total of 38 Gy, and stereotactic radiotherapy, for a total of 12 Gy, were performed. Patient was clinically and radiologically stable until September 2012, when a MRI showed a pathological enhancing nodule in superior sagittal sinus, treated with CyberKnife. After one year, a significant cerebral lesion was detected again and it was decided to surgically remove it. However, during preoperative assessment, the chest x-ray showed, in right inferior lobe, a pulmonary parenchyma consolidation. Subsequent bronchoscopy suggested the presence of aspergillosis infection, then treated with specific antifungal therapies, without any improvement. A fibrobronchoscopy with biopsy and bronchial washing allowed to obtain the histological examination of the pulmonary lesion, compatible with anaplastic meningioma. Meantime an abdominal CT showed systemic involvement at splenic and renal level. For this reason a chemotherapy with hydroxyurea was begun without response. Sandostatin treatment was promptly started in consideration of somatostatin receptors expression, with the addition of temozolomide treatment, unfortunately with poor results. To date, patient is still alive, with important clinical and neurological deterioration, rapid growth of tumor and metastases. The uncommon ability of a brain tumor, both low and high grade or benign and malignant, to metastasize out of CNS and the incapacity to ensure a proper treatment to date, make it necessary to identify the pathophysiological mechanisms involved in the process, to provide in the future specific and effective medical care.