relapse he received Temozolomide monthly for 2 years. Twelve years after diagnosis of glioma left radical nephrectomy was done due to CCRC. Patient 2: Male. Oligodendroglioma’s diagnosis at 53y. IDH1+ No codelo- 
ated. He was treated with Surgery and Stupp protocol. Five years after diagnosis of glioma right partial nephrectomy was done due to CCRC. Patient 3: Male. Oligodendroglioma’s diagnosis at 36y. IDH1+ No codelo- 
ated 1p19q. He was treated with Surgery and Stupp protocol. Five years after diagnosis of glioma right radical nephrectomy was done due to CCRC. All three patients had mutated IDH1 and were alive at 19, 8 and 9 years from initial glioma diagnosis. We did not find in the literature and PubMed any reports associating CCRC with Oligodendrogliomas. These results could suggest than CCRC may have an association with Oligodendrogliomas. We don’t know if the presence of kidney cancer in patients with oligodendro- 

### P09.14 CLONAL AND SUBCLONAL EVOLUTION OF 1P/19Q CO-DELETED OLGIDENDROGLOMIAS

**Abstract:**

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**BACKGROUND:**

Time and space molecular heterogeneities are a major challenge to overcome to understand biological behavior of cancer and to design new anti-tumor therapeutic strategies. 1p19q co-deleted oligoden- drogliomas (CoDelO) is a particular subgroup of WHO grades II and III gliomas with well-described clinical and histomolecular features. However, to the best of our knowledge, the mutational and genomic evolution patterns of CoDelO has not been fully elucidated.

**MATERIAL AND METHODS:** We have performed 12 whole-exome sequencing (WES) at initial diagnosis and at recurrence of 5 CoDelO with available fresh-frozen tissue (two of them had 2 recurrences). Deoxyribonucleic acid (DNA) and blood. Raw sequence data was aligned to hg38 genome build. Copy-number clonality, clonal mutations, subclonal mutations, ploidy and genomic signature analyses were conducted using R, Bioconductor and Python packages.

**RESULTS:**

The somatic mutation burden of CoDelO at initial diag- nosis is ~1 mutation/megabase and it increases at recurrence and mainly after alkylating agents (4–10/megabase). Interestingly, even though some recurrences harbored a hypermutated phenotype we did not found a high microsatellite instability status within CoDelO using WES data. In addition, multiple subclonal mutations were functionally neutral. Finally, clonal and subclonal copy numbers at chromosomes 4 and 13 were frequently found.

**CONCLUSION:** Our study participates to a better deciphering of the clonal and subclonal evolutions of CoDelO. Our findings warrant further validation in a larger series of CoDelO.

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### P09.15 LOW GRADE GLIOMA: A SURVEY OF UK NATIONAL PRACTICE

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**INTRODUCTION:** Brain tumours are the leading cause of cancer death in the under 40 years old in the United Kingdom. Over the last 15–20 years there has been a significant shift in the management of Low Grade Gliomas (LGG), with increasing evidence that upfront resection can improve outcome. However, there remains a perceived variation in management between clini- cal teams across the UK. We sought to obtain information about how LGG Neurosurgery & Oncology services are provided across the UK by means of a survey. Methods. Neurosurgical units in the UK were distributed a Society of British Neurological Surgeons approved questionnaire asking about LGG practices in their area. Paediatric hospitals were excluded. Results. There was a 5% response rate. 41% of units undertook upfront surgery. Five units (35%) use neuro-oncology clinics, while 24% review LGG patients in general neurosurgery clinics. On average, 4 specialties will attend specialised clinics. 2 - neuro-oncology clinics, and only a neurosurgeon - general clinics. 76% of the units aim for primary resection where possible; only 12% (2 units) will start by observing the tumours even if focal and deemed resectable. Units seeing patients in general clinics have more tendency to biopsy routinely at presentation (p=0.027). Most centres (88%) offer surgery via awake cranio- nomy - with a variety of testing methods used. A positive correlation between operative numbers and the ability to offer awake surgery was noted. Following surgery for LGG, 65% initially follow their patients with serial scans while the remainder may refer patients for consideration of adjuvant therapy. Conclu- sions, Five years after guidelines were published by the European Association for Neuro-Oncology, a large proportion of respondents confirmed that they provide specialist LGG services in established multidisciplinary environments. Whilst there is heterogeneity in the approaches to the management of these tumours, the majority of centres do recognise the value of upfront surgery with the aim of achieving significant biological response. The methodology surrounding awake craniotomy varies markedly across the UK centres. A unit-to-unit vari- ation in the post-operative care of LGG patients was also noted, with disparity in which patients are referred for adjuvant therapy. This survey supports the establishment of a UK National LGG Working Group who can setup a regular National outcome audit & establish a National LGG Database.

### P10 PEDIATRIC BRAIN TUMOURS

**P10.01 ADOLESCENT AND YOUNG ADULTS (AYAS) BRAIN TUMOR NATIONAL WEB CONFERENCE**


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The skills of adult versus pediatric neuro-oncologists are not completely similar though additive. Because the tumors are different (mostly gloma and meningiomas in adults, versus medulloblastomas, germ cell tumors and ependymomas), And because the tolerance and expected sequelae are spec- ific. Multidisciplinary meetings including adult and pediatric neuro oncologi- gists are warranted to share expertise.

Method since 2008, a weekly national web based conference was held in France. Any patient with the following criteria could be discussed: Adoles- cent and Young Adults aged between 15 and 25 years, and any adult with a pediatric type pathology.

**RESULTS:**

Attendance during the year 2015 was as follows: 42 meetings were held; the median number of cases discussed at each meeting was 4 (1 to 8); the mean number of attendants was 7 (3 to 12) including adult neuro oncologists (2 from 1 to 7), pediatric neuro oncologists (2 from 1 to 3), radiotherapists (from 1 to 3), surgeons (1) and pathologist (1). 147 cases were held; the median number of cases discussed at each meeting was 4 (1 to 8); the mean number of attendants was 7 (3 to 12) including adult neuro oncologists (2 from 1 to 7), pediatric neuro oncologists (2 from 1 to 3), radiotherapists (from 1 to 3), surgeons (1) and pathologist (1). 147 cases were discussed, with 82 were discussed at diagnosis, 65 at time of relapse; The patients had mostly medulloblastomas (38), germ cell tumors (14), ependymomas (10) gliomas (13), pineal tumors (11).

The rate of inclusion in protocols was increased since the opening of the web conference, especially for germ cell tumor SIOP protocol that is opened without age restriction: half of the french patients were older than 19 Year. And the inclusion rate in RSMA standard risk adult medulloblastoma proto- col was also increased.

**CONCLUSION:** Multidisciplinary Web conference for AYAs is feasible and increases the inclusion rate in protocols. It should be developed further.

### P10.02 RETROSPECTIVE ANALYSIS ON CHEMOTHERAPY FOR PEDIATRIC HIGH-GRADE GLIOMAS: THE EXPERIENCE AT MEYER CHILDREN’S HOSPITAL

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**INTRODUCTION:**

When feasible, the current treatment paradigm for pediatric high-grade gliomas (HGG) includes surgery with maximal safe resection as the primary treatment, followed by radiotherapy and chemo- therapy. Unlike adults, in children there is no standard chemotherapy.

**MATERIALS AND METHODS:** To compare with a retrospective analy- sis the efficacy of different chemotherapy schemes for the treatment of pedi- atric HGG.

**RESULTS:** From 2008 to 2015, forty-one patients underwent to multi- modal treatment for pediatric HGG at our institution. The median age was