iJRASET
International Journal For Research in Applied Science and Engineering Technology



INTERNATIONAL JOURNAL FOR RESEARCH

IN APPLIED SCIENCE & ENGINEERING TECHNOLOGY

Volume: 13 **Issue:** IV **Month of publication:** April 2025

DOI: https://doi.org/10.22214/ijraset.2025.69836

www.ijraset.com

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International Journal for Research in Applied Science & Engineering Technology (IJRASET)
ISSN: 2321-9653; IC Value: 45.98; SJ Impact Factor: 7.538
Volume 13 Issue IV Apr 2025- Available at www.ijraset.com

Brain Tumour with Different Therapies

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Abstract: ***Rapid and unchecked cell development in the brain is what causes a tumor to continue growing. It may be lethal if treatment is not received in the early stages. Accurate segmentation and classification remain difficult despite many noteworthy attempts and promising results. Brain tumor detection is considerably made more difficult by variations in tumor location, shape, and size Tumors can develop in a variety of places, and their location can provide information about the sort of cells generating the tumor, which can help with further identification. The Issues with illumination, for example, that arise in nearly all digital photographs can make the process of detecting brain tumors more difficult.***

Keywords: Histology Of Brain Tumour, Epidemology, Classification, Risk Factor , Symptoms , Causes, Diagnosis, Prposed Method , Exploring Deep Feature , Treatment, Therapies , Prevention

I. INTRODUCTION

One of the most common diseases in the world today is cancer, which is defined by the body's cells proliferating out of control as a result of genetic abnormalities. Medical research has advanced significantly in the last 2700 years in terms of comprehending and treating This illness [1].

The human brain is an extraordinarily complex organ with a unique handling capacity that no computer system can match: it can simultaneously acquire and prepare an astounding number of distinct and mental commitments through location, smell, touch, taste, and hearing on a millisecond scale, store information in the brain and govern our thought processes, progress, activities, and speech. Our five senses—location, fragrance, touch, taste, and hearing—are how the brain gathers information. [2].

A mass of aberrant cells in your brain is called a brain tumor. Your brain is enclosed by a highly stiff skull. Any expansion in such a small area may result in issues . These brain tumors are a class of neoplasms, each with its own biology, prognosis, and treatment plan. These tumors are more appropriately referred to as "intracranial neoplasms," since some of them (including lymphomas and meningiomas) do not arise from brain tissue . Benign and malignant brain tumors are the two general categories into which BTs fall. Actually, the most popular grading system has been adopted by the World Health Organization [WHO] . [3]

It is outside the purview of this page to discuss every one of the more than 130 distinct kinds and classifications of brain tumors. This review instead concentrates on the four most prevalent forms of brain cancer: meningioma, astrocytoma, metastatic brain cancers, and Glioblastoma. The most common kind of brain tumors are metastatic ones. Between 10% and 26% of cancer-related deaths are caused by brain metastases . Meningioma is another kind of brain cancer that makes up about half of benign brain tumors, which are usually categorized as grade 1 tumors. The brain or spinal cord's meningeal layers are where these tumors form. Astrocytoma comes from a special type of glial cells called astrocytes, star-shaped brain cells in the cerebrum [1] These days, medical image processing and other related fields greatly benefit from MR images. Unusual tissue growth and uncontrolled growth are referred to as brain tumors.

The natural cycle of cell growth and death is disrupted as a result of cell proliferation. There are two stages to the brain tumor:

1) The first stage;
2) The second stage.

A tumor is referred to as a brain tumor when it spreads to any area of the brain. Brain tumors are now categorized as gliomas, medulloblastomas, epeldymomas, CNS lymphomas, and oligodendroglomas when a variety of symptoms, such as seizures, mood swings, trouble walking and hearing, vision, and motor movement, are detected.[4]

II. HISTIOLOGY

A. WHO grade IV GBM

Macroscopically, GBM alters the brain's typical structure.

Necrosis, bleeding, and cyst formation foci are combined with mucoid gray cancerous tissue. Typically, GBMs are spherical masses with a necrotic core that can be observed as a ring-enhancing mass on MRI.

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Known as a butterfl\ glioma, they frequently track down the corpus callosum, affecting the contralateral hemisphere, demonstrating that their growth is not limited to one hemisphere. Additionally, GBMs may spread via CSF routes.
Microscopically, the main characteristics that set GBM apart from the two other diasteroid neoplasms are necrosis and florid microvascular growth. The foci of necrosis are caused by flormi, which are frequently present in these arteries.[5]

III. EPIDEMIOLOGY

Secondary, or metastatic brain tumors (MBTs), are the most common malignancies of the central nervous system (CNS). MBTs usually originate from original tumor cells that either hematogenously migrate or by directly invading nearby tissue. Population studies estimate that there are 7–14 cases of MBTs for every 100,000 people in the US .. These national numbers probably understate the true incidence given the significant progress made in diagnostic imaging, preventive screening, and longer life expectancies in affluent nations .
Ten to thirty percent of patients with cancer who have already received a diagnosis will also experience brain metastases . This is partially caused by malignant tumor cells' innate ability to infiltrate, penetrate, and move across basement membranes to reach healthy tissue.[5]

IV. CLASSIFICATION OF TUMOUR

Over 120 distinct kinds of brain tumors exist.
They vary according on their type and the location of occurrence.of the cells that comprise them. Some tumor forms are normally benign, while others are typically cancerous. The brain
Brain tumors, another name for cancer, are the abnormal expansion of brain cells. These growths may be benign. either malignant(cancerous) or non-cancerous .
The pituitary gland, which regulates a number of bodily hormone processes, can develop tumors called pituitary adenomas. Signs of brain cancer
may include migraines, seizures, memory issues, changes in vision or hearing, trouble with balance and coordination, and personality changes, however these can vary according on the size and location of the tumor.
The kind, location, and general health of the patient are some of the variables that affect the prognosis for brain cancer. The location of some brain tumors and the possibility that they could impair vital brain functions make them difficult to cure.
When you or a loved one is exhibiting symptoms or has been diagnosed with brain cancer, it is critical to collaborate closely with a group of medical professionals, such as neurologists, neurosurgeons, oncologists,[6]

V. RISK FACTORS

There is still much to learn about the causation of brain cancer. Despite the fact that some environmental and genetic variables may lead to Compared to other malignancies in the body, the risk factors for brain cancer are far less well established. Additionally, there is extremely little chance of getting primary brain cancer. According to the American Cancer Society, the lifetime risk is less than 1%. It is crucial to keep in mind that a risk factor for brain cancer only influences the likelihood of .[7]
Proof of non-ionizing radiation exposure (such as electromagnetic radiation, cell phones, and radiofrequency radiation), which raises the risk of developing a Inconclusive is the primary brain tumor . There have been inconsistent findings about the increased risk of primary brain tumors associated with the assessment of other risk factors, such as head trauma, allergies, nutrition, alcohol, and tobacco use . In tandem with these research, exploration of viral and genetic factors is rising.[5]
Although a number of research have looked into risk factors for brain tumors, little is known about their origin. However, the sole distinct risk factor for meningeal and glial neoplasms that has been found is Some researchers have found correlations between ionizing radiation and possible risk factors for primary brain cancers (Table 2). In order to ascertain the relative risk of brain cancers without conclusive links to particular chemicals or exposures, numerous occupational studies have been carried out . There is conflicting evidence that radiation exposure, other than ionizing radiation, such as that from cell phones, electromagnetic radiation, and radiofrequency radiation, increases the risk of developing a primary brain tumor.[8]

VI. SYMPTOMS

The kind, location, and size of the tumor, as well as whether it is malignant or benign, all affect the symptoms of brain cancer. In general, the signs and symptoms include: severe headaches and seizures; abnormalities in vision, hearing, balance, and other cognitive functions; and changes in mood and personality, such as hallucinations and hostility.[9]

ISSN: 2321-9653; IC Value: 45.98; SJ Impact Factor: 7.538
Volume 13 Issue IV Apr 2025- Available at www.ijraset.com

VII. CAUSES

Although a number of risk factors have been thoroughly investigated, the exact causes of brain tumors cannot be determined. These consist of:

- Radiation, both ionizing and non-ionizing.
- Racial, genetic, and family history aspects.
- Lifestyle.
- Diet.
- Alcohol.
- Smoking.
- Aspartame .

The signs of brain cancer. [9]

VIII. DIAGNOSIS

The Edwin Smith Papyrus, the oldest medical literature, was written in the 17th century bce and details 48 battles. damage to the head and spine, but leaves out brain tumors . Brain tumors are likewise not mentioned in the more recent (but still ancient) Ebers Papyrus (1500 bce). Long-standing symptoms of headaches, convulsions, and coma preceded brain tumors, which in ancient times caused death. Skull trepanation was created by physicians in response to their recognition that these symptoms were brought on by elevated intracranial pressure. Ancient Africa and South America are most likely where skull trepanation, also known as trephination, first appeared. [10]

A. MRI

One of the most accurate technologies for diagnosing brain tumors in recent years has been MRI. An MRI creates precise images of the body by using magnetic fields rather than X-rays. Contrast media is a special dye that is typically used to produce a clearer image. This dye can be administered as a liquid or tablet, or it can be injected into the patient's vein [13]. An MRI of a chosen tissue or location (brain, spinal cord, or both) may be performed, depending on the type of tumor detected and the likelihood that it would spread to the brain. increased intravenous gadolinium. [11]

The symptoms worsen as the tumor expands and puts strain on the body. The extent of neurologic impairment is a crucial component. in organizing the therapeutic strategy. On the other hand, tumors of the most common anterior frontal, anterior temporal, or base of the skull lobes can grow to a large size with few or no symptoms, or with vague symptoms that are frequently confused with aging (e.g., memory loss, personality changes, or some gait difficulties). Imaging tests can differentiate acoustic neuromas from vertebrobasilar insufficiency, which causes symptoms such as unilateral hearing loss, vertigo, and mild facial paralysis. [12]

IX. PROPOSED METHOD

Computer-Aided Diagnosis (CAD) systems are automated systems that use MRI to detect brain tumors. The CAD program can offer a very precise reproduction of the original image, that is, the useful perspective and precision of previous brain tumor identification. There are two or more stages to it. Preprocessing is necessary in the first step, while postprocessing, or segmentation, is necessary in the following phases. Following that, performance analysis, feature extraction, feature selection, classification, and detection procedures and other data are examined and compared. Methods of pre-processing are employed to enhance picture quality and eliminate minor noise and artifacts for precise MRI region identification. Brain tumors are separated from MRI brain pictures using a variety of post-processing techniques. The appearance, grade, and general information that will be helpful in the identification, segmentation, and interpretation of brain tumors from MRI images are the main topics of this work. The fundamental system is composed of separate modules, each of which has a set of related techniques. [13]

X. EXPLORING DEEP FEATURES FOR BRAIN TUMOUR

In order to predict and diagnose brain tumors using radiological MRIs, it is crucial to explore and depict deep characteristics. In oncology, deep features are taken from MRI pictures for prognosis, treatment, and diagnosis. The photos' radiomic characteristics clearly link with significant biological traits and provide qualitative data that radiologists are accustomed to . When deep convolutional neural networks are pre-trained as feature extractors, they attain state-of-the-art performance in classification and prediction.

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For predicting the overall survival time of patients with tumors, deep feature extractor approaches and techniques are superior . In order to train CNN networks for classification and segmentation, features from ImageNet are extracted using the Deep Convolutional Neural Networks (CNNs) activation approach.. [14]

XI. TREATMENT

Surgery plays a significant role in the removal of brain tumors. Brain tumors can be successfully removed by both biopsy and resection. Removing the tumor surgically can extend the patient's life by almost six months . It is challenging to remove a tumor surgically when its boundaries are not well defined because it may extend into healthy brain tissue. Patients are also thought to benefit from partial resections since they lower brain pressure and enhance bodily function. Additionally, it can interfere with BBB and increase a chemotherapeutic agent's accessibility to malignant tissues . Recently, surgical techniques have also been used to implant shunts in brain cancer. [15]

A major factor in the morbidity that patients endure is the vasogenic edema that surrounds brain tumors. This edema is caused by fluid seeping into the brain parenchyma's extracellular space.via a blood–brain barrier (BBB) that is ineffective.

Erlich originally showed the BBB in 1885 when he discovered that all organs save the brain were stained when albumin-bound dyes were injected intravenously into rats . Lack of fenestration and endocytic vesicles in endothelial cells, which restrict transcellular transit, and an intact tight connection between endothelial cells produce the blood-brain barrier (BBB). Furthermore, pericytes that come into touch with endothelial cells and astrocytic foot processes that encircle brain microvessels likely release substances that give nearby endothelial cells BBB characterise . [16]

XII. THERAPY

A. Surgery

Operation For diagnostic purposes, the entire tumor or a portion of it along with some surrounding tissues is removed. therapeutic objectives, as previously stated. This could alleviate neurological symptoms by lessening the tumor's strain on adjacent brain regions. In cases where the tumor is confined and low-grade, surgery might be the only necessary treatment. Surgery's primary flaw is that it can overlook tumors that are too little to be seen, which could cause the illness to reoccur. [9]

The first line of treatment for any brain tumor is surgery, which entails removing the unwanted mass along with a few good tissues that are close by. To identify the tumor, do a genetic analysis, and create several brain tumors, the tumor must be removed. therapies more easily for improved clinical results. Research on brain tumor surgery has advanced significantly thanks to the combined use of fluorescent dyes, enhanced imaging, and cortical visualization . Aditionally, computer-assisted methods like image-guided surgery help the doctors accurately map out the location of malignancies. This technique involves giving the patient a fluorescent dye called 5 aminolevulinic acid orally before to surgery, which is then absorbed by the cells that are multiplying. [11]

B. Radiation Therapy

Radiation treatment employs charged particles, such as electrons, or megavoltage x-rays to destroy or sterilize tumor cells .When treating brain tumors, the most popular radiotherapy techniques are:

Radiation therapy using external beams, which includes

Traditional radiation treatment: The entire brain is irradiated in accordance with a treatment plan created by an oncology team (medical physicist, dosimeters, and oncologist) after the patient undergoes imaging using a simulator, for instance, to locate the tumor: position, size, and organs at danger. [9]

C. Chemotherapy

Drug resistance is widespread even though temozolomide is the conventional chemotherapy for treating gliomas (Hegi, Diserens et al. 2005, Stupp, Mason et al. 2005). According to topical studies, BTSCs interact with astrocytes and enhance a number of survival genes, giving the BTSCs the ability to withstand chemotherapy (Kim, Kim et al. 2011).

According to a recent study, glioma cells expressing CD133 exhibited increased transcriptional activity of the Notch and Sonic hedgehog pathways after treatment in vitro and were more resistant to temozolomide than unsorted glioma cells (Ulasov, Nandi et al. 2011). A recent study (Gong, Schwartz et al. 2011) examined the effects of temozolomide and other chemotherapeutic drugs on BTSCs against neural stem/progenitor cells (NSCs). Both cisplatin and temozolomide showed adverse cytotoxicity by effectively lowering the quantity of NSCs compared to BTSCs in in vitro (Schwartz, Gong, et al. 2011). However, BTSCs were reduced more than NSCs when single-agent treatment with the more recent chemotherapeutic drugs erlotinib or boratezomib was administered

(Gong, Schwartz et al. 2011). These results highlight how crucial medication selectivity is to patient treatment regimen optimization.

A tiny percentage of glioma cells with BTSCs are resistant to 1,3-bis(2-chloroethyl)-1-nitrosourea (BCNU), despite the fact that BCNU is a frequently used treatment for patients with glioblastoma multiforme (Kang and Kang 2007). [17]

D. Conventional Therapy

Traditional treatment

The standard treatment for gliomas includes chemotherapy, radiation therapy, and surgery 17–22. A random A study conducted by the National Cancer Institute of Canada (NCIC) and the European Organization for Research and Treatment of Cancer (EORTC) showed that adding temozolomide (TMZ) to radiation therapy (RT) and then administering TMZ for six monthly cycles greatly increased overall survival in patients with GBM diagnoses 42,43. For patients with GBM, this treatment plan is currently accepted as the standard of care. However, the majority of series of investigations rejected elderly patients. Other research, which excluded individuals over 70, has shown respectable survival rates for senior GBM patients treated with RT and TMZ treatment. [12]

E. Immunotherapy

The process of modifying a patient's T cells to express chimeric antigen receptors, which are capable of identifying particular tumor-associated antigens (TAAs), is known as chimeric antigen receptor (CAR) T-cell therapy. TAAs such as EGFRvIII, a mutant version of the epidermal growth factor receptor frequently expressed in GBM, are targeted for brain malignancies . Early findings from EGFRvIII-targeting CAR T-cell treatments have shown the Page | 14 viability of this strategy, while there are still issues in making sure CAR T-cells can cross the blood-brain barrier and survive long enough in the hostile tumor milieu to efficiently kill tumor cells . Work is being done to alleviate the constraints caused by tumor heterogeneity, enhance delivery techniques, and improve CAR T-cell design. Oncolytic Viruses: Oncolytic viruses trigger an immune response against the tumor while specifically infecting and killing tumor cells. The effectiveness of modified viruses, including poliovirus, adenovirus, and herpes simplex virus (HSV), in treating gliomas and GBMs has been studied . Tumor antigen can be enhanced by these viruses. Presentation and encourage regional inflammation, aiding in the defeat of immune evasion tactics . Although there are difficulties in maximizing viral distribution, preventing neurotoxicity, and obtaining reliable immune activation, clinical trials of oncolytic viruses such as Toca 511 and DNX-2401 have produced positive outcomes. [18]

F. Proton Therapy

Effectiveness, which frequently results in secondary cancers. Superconductors in the gantry for dose delivery have improved pencil beam scanning accuracy and decreased the possibility of radiation delivery to nearby organs . Current research The highly sensitive character of the phosphate group stretching in DNA has also been revealed by Raman spectroscopy, which has encouraged the use of Raman spectroscopy to enhance risk assessment in radiobiology research . When proton treatment was studied for oropharyngeal cancer, it was discovered that its normal tissue complication probability (NTCP) was lower than that of IMRT . The NTCP calculation results have further demonstrated the effectiveness of. [19]

XIII. PREVENTION

A. Avoidance

Preoperative: sufficient analgesia and anxiolysis.

Pre-induction: head up, head straight, no jugular vein, hyperventilate as needed compression.

Don't drink too much water. steroids and osmotic diuretics, such as mannitol and hypertonic saline.

Furosemide is a loop diuretic.

Optimize hemodynamics, including heart rate, pulmonary capillary wedge pressure, central venous pressure, and MAP; if required, use beta-blockers, clonidine, or lidocaine.

Ventilation: low intra-thoracic pressure, PaO2 >100, and Paco2 ~ 35 mm Hg.

Using intravenous anesthetics for induction and maintenance . [20]

XIV. CONCLUSION

This study gives readers detailed information about brain tumors, including their nature, causes, symptoms, and prevalence. Additionally, it imparts knowledge. regarding the various brain tumor diagnostic and treatment resources available. Additionally, it can help scholars save valuable time by directing them to many original and reviewed papers on the internet.

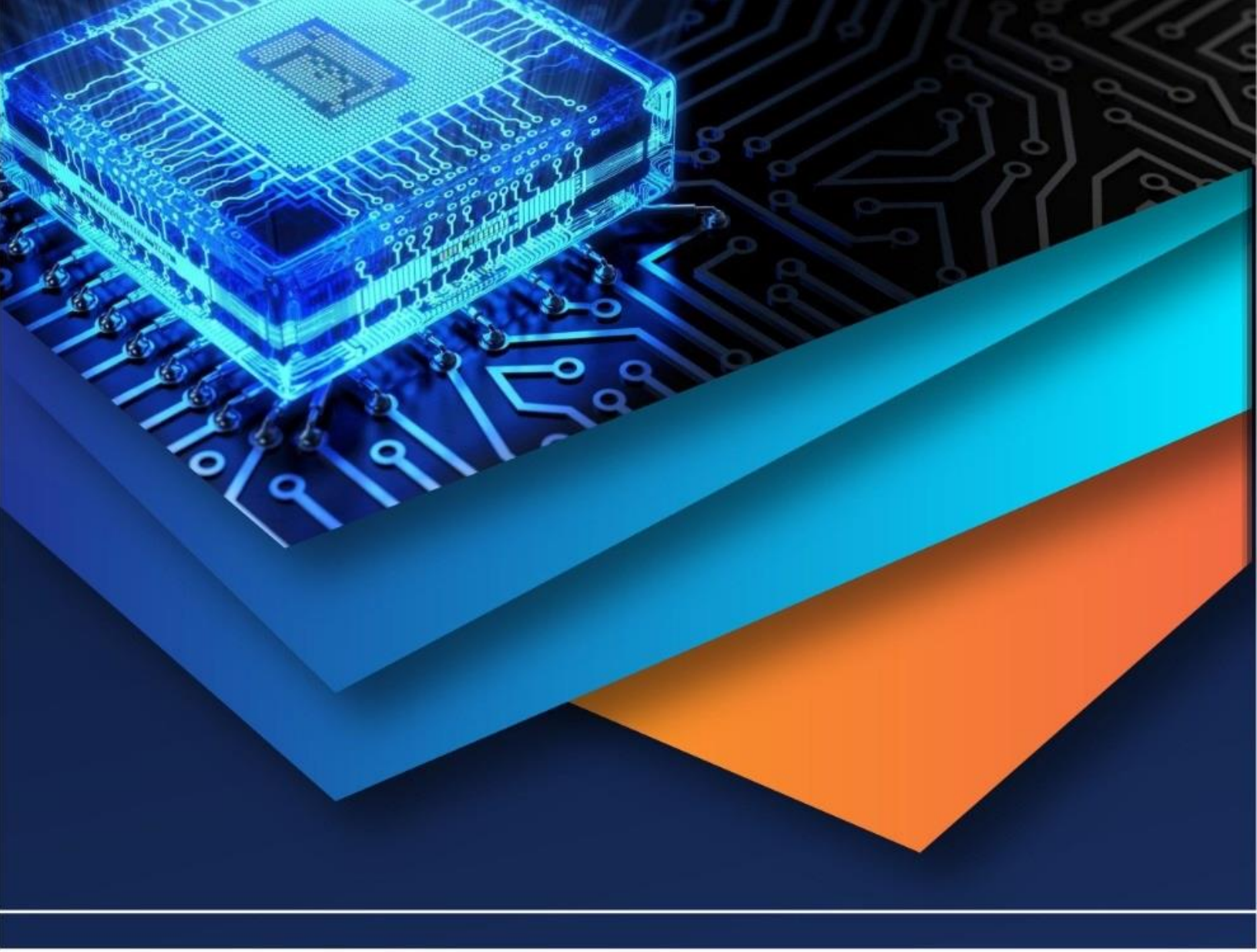
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The overall survival rate for patients with advanced brain tumors remains quite low. These figures are frightening, but new knowledge about the biology of brain tumors has given rise to hope that safer and more efficient treatments may be developed. Targeted therapy is the only alternative available to control the course of brain malignancies, and it must be thoroughly investigated in order to bring about some positive improvements in the future. It is a reality that surgery, radiation therapy, or traditional chemotherapy alone are insufficient to do so. Nevertheless, despite the striking rise in the amount of research on brain tumors, targeted therapy has not yet demonstrated any appreciable benefits over traditional treatments in terms of efficacy and safety. Recent advances in brain tumor immunotherapy have given promise for the treatment of malignant brain tumors, especially gliomas and glioblastoma multiforme (GBM).

Immunocheckpoint inhibitors, oncolytic viruses, cancer vaccines, and chimeric antigen receptor (CAR) T-cell therapy are among the treatments that have shown promise in activating the immune system to fight malignant cancers. The path to effective immunotherapy for brain tumors is still complicated, despite promising early results. The blood-brain barrier (BBB), the immunosuppressive tumor microenvironment, and the wide variety of brain malignancies are major obstacles. To overcome these obstacles, new techniques are needed to improve immune cell penetration into the brain, interfere with tumor-driven immunosuppression, and tailor treatment plans according to the unique features of each patient's tumor.

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