Case 5

Submitted by: Carlos A. Garcia, M.D•• Paul A. McGarry, M.D., and
Fred Rodriguez, M.D.
Division of Neuropathology
Louisiana State University Medical Center
1542 Tulane Avenue
New Orleans, Louisiana 70112

Clinical Abstract:

The patient was a 61-year-old man who had slowly progressive right-sided cranial nerve impairment over a period of eleven months. This began with facial weakness and dull frontal headache, followed by aching pain in the right temporomandibular joint and a metallic taste in right side of the tongue; then numbness of the right cheek, and deviation of the jaw to the right on opening the mouth, decreased hearing on right, and intermittent vertigo. Twenty-two months after the onset of symptoms the corneal reflex was diminished, there was decreased sensation on the right side of the face, the uvula deviated to the right, tandem gait was unsteady, an audiogram showed no response on the right at any test of frequency, and an electronystagmogram showed profound reduction of response to caloric stimulation of the right ear and downbeating nystagmus after hot water irrigation of the left ear. A C.T. scan showed a small round filling defect in the right cerebellopontine angle at the level of the internal auditory meatus that extended anteriorly toward the dorsum sella. The internal auditory canal was normal. CSF contained 4 red blood cells, 14 lymphocytes and 1 mononuclear cell per cubic millimeter, glucose 65 mg/100 ml, and protein 44 mg/100 ml. A biopsy was done at that time, and this was followed by local radiation therapy. The patient's symptoms were arrested for a few months, but progressive brain stem and cerebellar dysfunction followed, and signs of increased intracranial pressure were treated by ventriculo-pleural shunt. Death occurred 6 months after the shunt and 49 months after the onset of symptoms.

Autopsy findings: Abnormalities were limited to the central nervous system. No tumor was found outside the brain which weighed 1295 grams. There was an irregular solid greyish granular mass infiltrating and protruding from the right side of the brachium pontis and occupying the cerebellopontine angle, obscuring the 5th, 7th, and 8th cranial nerve roots. The lesion measured 4.1 cm. rostrocaudally and 2.7 cm. transversely. No cystic component was found. The edges of the lesion were nodular, firm, and sharply circumscribed.

Points for Discussion:

1. Histologic diagnosis of the tumor.

2. Histogenesis and origin of the tumor.