

CASE #12

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CLINICAL HISTORY: The patient was a 27-year-old woman, a Ph.D. in economics and teaching at a University, referred to our hospital for evaluation of two spells. The first occurred one month earlier and the second about three weeks later. At both events, she awoke with a wet bed and had bitten her tongue. She had had headaches lately and vomited once. She complained of difficulty concentrating, difficulty with her balance, diminished smell over the last 3-6 years, though her taste had been normal. EEG performed at the age of 10 revealed no abnormality. On physical examination, the patient was alert and oriented. Cranial nerve (II-XII) modalities were intact with the exception of bilateral papilledema. Motor examination was essentially normal and so was sensory examination. She had equivocal plantar response on the right and negative on the left.

The patient was taken for immediate CT scan of the head with contrast which revealed a large intraventricular tumor. The patient was admitted, placed on IV steroids, underwent MRI scan of the head which again revealed a large intraventricular tumor. Using the compass head ring system, stereotactic localization of this tumor was performed. She underwent a stereotactic volumetric resection of the tumor via an intraventricular right frontal horn approach as well as placement of ventriculostomy. A large amount of grayish and highly vascular tumor was removed, cauterized, suctioned or removed with cavitron. The remainder of the tumor was then removed "completely" from the right lateral ventricle, occipital horn and also from the third ventricle.

Four months after the surgery, the patient was able to carry out most of her daily chores, including teaching, and was free from seizures.

MATERIALS SUBMITTED:

1. H&E section of the surgical specimens
2. Unstained section

POINTS FOR DISCUSSION:

1. Diagnosis and prognosis
2. Significance of angiomatous components