CASE 1998 - 5

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Clinical History:

The patient is a 52 year old gentleman who works as a machinist. He presented with left eye pain without visual deficit and intermittent mild headaches for approximately one year. He underwent surgery for a right scleral/lacrimal gland lesion. The pathologic diagnosis was reported as: "inflammatory nodule with stromal fibrosis and histiocytic response; special stains negative for organisms". As part of the workup, he had a MRI scan which showed an apparently incidental, 3 cm, dural-based, contrast enhancing, left temporal mass without any obvious bony involvement. This was felt to be suspicious for meningioma.

Other medical problems include hypertension and gout for which he takes an ACE inhibitor, Zesteril, and allopurinol, respectively. The patient smokes and drinks (amounts not known). His family history is positive for diabetes and tuberculosis. His review of systems was significant only for the mild headaches with no difficulties with vision, hearing, or weakness.

On physical exam he had: BP - 140/70, pulse - 80, resp. rate - 20, afebrile. He was generally alert and cooperative in no acute distress. His HEENT, chest and lung, cardiac, abdominal, and neurologic exams were normal.

Laboratory values showed: glucose - 81 mg/dL, K - 4.2 mEq/L, Na - 143 mEq/L, WBC - 14 K/uL, HCT - 43.1%, MCV - 101 fL, Plt - 476 K/uL, granulocytes - 67%, lymphs - 24%, monos - 8%, eos - 1%, baso - 0%.

The temporal lesion was resected one month after the eye surgery.

Material submitted: 1 H&E stained section from the intracranial mass.

Points for discussion: Differential diagnosis, prognosis