asma hypoplasia and an absence or dysgenesis of the septum pellucidum. Clinically it presents as variable partial pituitary insufficiency, varying degrees of psychomotor retardation and visual impairment, thermoregulatory disturbances, jaundice and seizure. It may be associated with schizencephaly, white matter hypoplasia, pituitary hypoplasia and cortical dysplasia. Septo-optic dysplasia may be regarded as a mild form of lobar holoprosencephaly.[11–12]

It can be concluded that aventriculi is another rare variant of holoprosencephaly with absent ventricles in addition to varying degrees of fusion of the cerebral hemisphere. We report the third case of aventriculi associated with holoprosencephaly.

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Lintene granuloma following microvascular decompression mimicking a cerebellopontine angle tumour

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Abstract

We describe a case of foreign body granuloma caused by lintene (cotton gauze), placed during microvascular decompression of the fifth nerve for trigeminal neuralgia. At presentation, the clinical and radiological findings were suggestive of a tumor. This is only the second case in the literature of a foreign body granuloma occurring owing to the placement of a lintene pledget during microvascular decompression.

Keywords: Foreign body granuloma; Microvascular decompression; Trigeminal neuralgia

1. Introduction

Microvascular decompression is widely recognised as an effective treatment for trigeminal neuralgia.[1] Various materials are used to separate the trigeminal nerve from

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the offending vessel. Intracranial foreign body granulomas secondary to surgical materials are rare. Herein, we describe a case of lintene (cotton gauze)-induced foreign body granuloma following microvascular decompression of the trigeminal nerve.

1.1. Case study

A 59-year-old man presented at another hospital with a 2-year history of right trigeminal neuralgia in the maxillary (V2) and mandibular (V3) nerve distribution that was resistant to medical treatment. He underwent microvascular decompression with a lintene (cotton gauze) pledget. Prior to surgery, he did not undergo any radiological investigations in view of the typical nature of his presenting symptoms. The surgeons did not note any abnormality during the microvascular decompression procedure other than vascular compression by the superior cerebellar artery on the root entry zone of the trigeminal nerve. Postoperatively, the patient developed a slight loss of sensation in his face and some impairment of hearing on the right side. These symptoms improved gradually over the subsequent 4 weeks. He also developed bacterial meningitis, which was treated successfully with intravenous antibiotics.

Over the next 3 months, the facial numbness in the V2 and V3 distribution and the hearing loss started to increase. The patient also developed recurrent headaches, ipsilateral facial weakness and unsteadiness during walking.

Magnetic resonance (MR) scanning performed 5 months following surgery revealed a lesion in the right cerebellopontine angle. The lesion was in the region of the internal auditory meatus, but was not causing any expansion of the meatus. Following gadolinium administration, there was patchy enhancement with central areas of low-signal intensity. No enhancement was noted within the internal auditory canal. The patient, at this point, moved to a different part of the country, and hence, presented to our hospital.

Neurological examination at our hospital revealed severe right lower motor neuron facial nerve paresis (House-Brackmann Grade 4) and sensory deficit of all three divisions of the trigeminal nerve. The patient also had right sensorineural deafness and gait ataxia. He had no nystagmus or limb ataxia. There was no papilloedema. The remainder of the physical examination was unremarkable. Serial CT (Fig. 1) and MR scanning (Figs. 2, 3) confirmed the lesion to be persistent and enlarging. Differential diagnoses of meningioma, glioma and acoustic neuroma were considered.

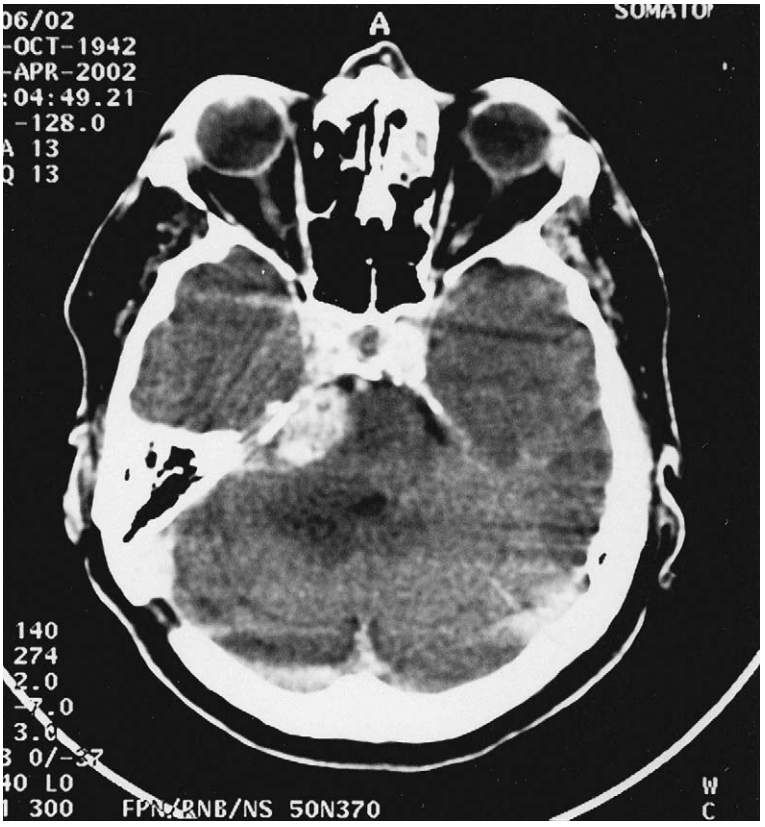

Fig. 1. Contrast-enhanced axial CT scan. A 1.5×2 cm heterogeneously enhancing mass is seen in the right cerebellopontine angle without surrounding oedema and with a mild mass effect.