CYSTIC DEGENERATION SCHWANNOMA CASE REPORT

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ABSTRACT

Spinal schwannomas are kind tumors emerging from spinal nerve root sheaths and are the most well-known intradural extramedullary spinal tumors [1, 2]. Schwannomas are homogeneous tumors and they consist only of Schwann cells. Most spinal schwannomas, which emerge from Schwann cells are strong or heterogeneous strong tumors and an absolutely cystic schwannoma is uncommon[3,4], and, luckily, it’s the most amiable to surgical cure with insignificant dismalness however changes BP and heartbeat rate amid tumor dismemberment like pheochromocytoma are not usual behaviour. To be precise, schwannoma is a benign tumor composed of Schwann cells, that usually produce the insulating myelin sheath covering peripheral nerves.

KEYWORDS: Cystic Degeneration Schwannoma, Schwann Cells are Solid or Heterogeneous Solid Tumors and a Totally Cystic Schwannoma

INTRODUCTION

Schwannomas constitute 8% of intracranial tumors and 29% of intraspinal tumours[5]. These tumors are good tumours (benign tumours), emerge from Schwann cells and are portrayed in essentially all body locations[6]. The lumbar region is a standout amongst the most widely recognized locales for the event of spinal schwannomas. Men and ladies are similarly impacted and influenced. The larger part of nerve sheath tumors emerge from a dorsal nerve root. Schwannomas seem totally as smooth globoid masses that don’t create enlargement of the nerve however are suspended whimsically from it with a discrete connection. The histological appearance comprises of prolonged bipolar cells with fusiform, hazily recoloring cores organized in smaller, joining fascicles with an inclination toward palisade development (Antoni-A).

CASE DESCRIPTION

A 40 year old male complaining from ill define mild backache, paraesthesia and numbness of both legs for one year duration. During the last one month he developed stress incontinence of urine with difficulty in defecation. The patient became unable to walk. He was diagnosed as a case of lumbosacral disc herniation Figure 1.
After L5-S1 laminectomy with discectomy, the patient can able to walk less than one month then he returned back to bed with massive parasthesia and numbness, more deterioration in sphincters control and more difficulty in defection. Clinical examination after 3 months postoperatively, revealed local tenderness at the site of previous operation, grade 3 power of hip flexors with L1 sensory level.

Figure 1: Lumbosacral MRI before First Surgery
Dorso-lumber MRI show a well define spindle shape mostly fluid signal intensity lesion, intrdural extramedullary in location at the level of D12 and L1 displacing the conus medullaris to left side. It measures about (3x2cm) and shows heterogeneous enhancement of the wall and solid part in post contrast study.

During surgery show well define intradural extramedullary cystic mass, 1 cc of yellowish fluid was aspirated. During dissection there were sudden shooting in pulse rate from 82 up to 148 b/m and the blood pressure from 110/70 mmhg up to 168/107 mmhg, these changes were temporary revert to baseline reading after stooping mass dissection with added carotid massage. The cycle of raising pulse and blood pressure with subsequent revert to baseline reading was continued until cauterization and cutting upper and lower pedicles of the mass.

REFERENCES


