CASE REPORTS

Synchronous ipsilateral cerebellopontine angle glossopharyngeal schwannoma and parotid adenoid cystic carcinoma

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The characteristics of schwannomas and salivary gland tumors are well documented in the literature as separate entities. Glossopharyngeal schwannomas are very rare; about 30 reports of these schwannomas exist in the literature.[1] This is the first report, to our knowledge, of a patient with synchronous ipsilateral glossopharyngeal schwannoma and parotid adenoid cystic carcinoma.

CASE REPORT

A 49-year-old woman presented to our clinic with a several-month history of right aural fullness, facial pain, headache, and a parotid mass. She had no symptoms of dysphagia, weight loss, hoarseness, or other otologic complaints. She denied changes in vision, gait, or coordination. Past medical history was significant for an ectopic pregnancy, adenotonsillectomy, and depression. Family history was noncontributory. Medications included Zoloft and Pepcid. Physical examination was remarkable for an ill-defined, tender, 2 × 2-cm right parotid mass without palpable cervical adenopathy. A right serous effusion was present. All cranial nerves were intact with no gross cerebellar findings.

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Preoperative brain magnetic resonance imaging (MRI) revealed a 2.4-cm enhancing lesion of the right cerebellopontine angle with fourth ventricle compression compatible with a vestibular schwannoma (Fig 1). Computed tomography scanning and MRI of the neck and skull base revealed a 2 × 3-cm right parotid mass with extension to the mastoid, middle ear, and marrow of the occipital condyle. The patient underwent a fine needle biopsy of the parotid mass and results were consistent with adenoid cystic carcinoma (Fig 2). In addition, a nonenhancing lytic lesion of the anterior midline vertebral body of C6 was noted. This lesion was suspicious for metastatic disease.

To relieve fourth ventricle compression, the cerebellopontine mass was removed through a posterior fossa craniotomy. Intraoperatively, the lesion was consistent with a glossopharyngeal schwannoma. On the first postoperative day, the patient had a grade 4/6 right facial paresis, a right tongue deviation, and an intact gag reflex. The patient had dysphagia with mild aspiration. Three weeks later, the patient underwent a right radical parotidectomy, modified lateral neck dissection (levels II and III), subtotal temporal bone resection, partial occipital condylectomy, and a C6 corpectomy. A microvascular rectus muscle free flap was used to reconstruct the surgical defect. Postoperatively the patient had deficits of cranial nerves VII, IX, and X. Postoperative radiation therapy is planned.

DISCUSSION

This is the first report of a patient with synchronous ipsilateral cerebellopontine glossopharyngeal