

Trigeminal Neuralgia Caused by Cerebellopontine Angle Tumors: Surgical Series

Neuralgia trigeminal causada por tumor do ângulo pontocerebelar: série de casos cirúrgicos

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Abstract

Introduction Cerebellopontine angle (CPA) tumors represent an important cause of persistent and refractory trigeminal neuralgia (TN). It is believed that ~ between 1 and 9.9% of the cases of patients presenting with TN painful manifestation are caused by space-occupying lesions.

Objective The objective of the present study is to describe the clinical and surgical experience of the operative management of patients presenting with secondary type TN associated with CPA tumors.

Method An observational investigation was conducted with data collection from patients with secondary type TN associated with CPA tumors who were treated with surgical resection of the space-occupying lesion and decompression of the trigeminal nerve from January 2013 to November 2016 in 2 different centers in the western region of the state of São Paulo, Brazil.

Results We operated on 11 consecutive cases in which TN was associated with CPA during the period of analysis. Seven (63.6%) patients were female, and 4 (36.4%) were male. Seven (63.6%) patients presented with right-side symptoms, and 4 (36.4%) presented with left-side symptoms. After 2 years of follow-up, we observed that 8 (72.7%) patients showed a complete improvement of the symptoms, with an excellent outcome, and that 3 (27.3%) patients showed an incomplete improvement, with a good outcome. No patient reported partial improvement or poor outcome after the follow-up. There was no operative mortality.

Conclusion Cerebellopontine angle tumors represent an important cause of TN and must be included in the differential diagnosis of patients presenting with refractory and persistent symptoms. Surgical treatment with total resection of the expansive lesion and effective decompression of the trigeminal nerve are essential steps to control the symptoms.

Keywords

- trigeminal neuralgia
- cerebellopontine angle tumors

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Resumo

Introdução Os tumores de ângulo pontocerebelar (APC) representam uma importante causa de neuralgia do nervo trigêmeo (NT) persistente e refratária. Cerca de 1 a 9,9% dos casos de pacientes com manifestação dolorosa do trigêmeo são causados por lesões expansivas.

Objetivo O objetivo do presente estudo é descrever a experiência clínica e cirúrgica do tratamento de pacientes que apresentam tipo secundário de NT associada a tumores de APC.

Método Foi realizada uma investigação observacional com coleta de dados de pacientes com NT secundária associada a tumor de APC tratados com ressecção cirúrgica de lesão expansiva e descompressão do nervo trigêmeo entre janeiro de 2013 e novembro de 2016, em 2 diferentes centros da região oeste do estado de São Paulo, Brasil.

Resultados Foram abordados 11 casos consecutivos nos quais NT foi associada a tumores de APC durante o período de análise. Sete (63,6%) pacientes eram do sexo feminino, e 4 (36,4%) do sexo masculino. Sete (63,6%) pacientes apresentaram sintomas no lado direito, e 4 (36,4%) apresentaram sintomas no lado esquerdo. Após 2 anos de seguimento, 8 (72,7%) pacientes apresentaram melhora completa dos sintomas com excelente resultado, e 3 (27,3%) pacientes apresentaram melhora incompleta com boa evolução. Não houve mortalidade operatória.

Conclusão Os tumores de APC representam uma importante causa de NT e devem ser incluídos no diagnóstico diferencial de pacientes com sintomas refratários e persistentes. O tratamento cirúrgico com ressecção total da lesão expansiva e descompressão efetiva do nervo trigêmeo são etapas essenciais para o controle dos sintomas.

Palavras-chave

- neuralgia trigeminal
- tumor do ângulo pontocerebelar

Introduction

Although the classical type of trigeminal neuralgia (TN) is the most common symptom of neurovascular conflict, some patients have the secondary type of TN, in which space-occupying lesions are responsible for the symptoms.¹⁻³ It is believed that ~ between 1 and 9.9% of the cases of patients presenting with TN painful manifestation are caused by cerebellopontine angle (CPA) tumors.⁴ Meningiomas, schwannomas, and heman-gioblastomas are extremely common posterior fossa tumors that may cause TN by directly compressing the trigeminal nerve or by being close to vascular structures around the nerve entry zone.⁵⁻⁷

The aim of the present study is to describe the clinical and surgical experience of the operative management of patients presenting with the secondary type of TN associated with CPA tumors.

Method

Delineation of the Study

An observational investigation was conducted with data collection from patients with the secondary type of TN associated with CPA tumors who were treated with surgical resection of the space-occupying lesion and decompression of the trigeminal nerve from January 2013 to November 2016 in 2 different centers in the western region of the state of São Paulo, Brazil. Clinical data were obtained retrospectively from the records and files of the patients. For all of the patients with the diagnosis of TN and radiological evidence of

CPA tumor on magnetic resonance imaging (MRI), the following data were collected: gender, age at surgery, side of pain, type of the conflict/compression, type and number of medications used.

Presurgical Evaluation

An MRI of the brain was obtained from all of the patients with TN associated with CPA according to a specific protocol using a 1.5 Tesla MRI Scanner (Philips, Amsterdam, Netherlands) at the department of neuroradiology at our institution. All of the MRIs were analyzed by an experienced neuroradiologist who confirmed the visual radiological diagnosis of space-occupying lesion. High-resolution MRIs were performed to view the CPA anatomy of the patients and to exclude the presence of any additional neurovascular conflict.

Surgical Technique

The surgical approach was similar for all of the patients, and all of the procedures were performed by neurosurgeons experienced in microvascular decompression (MVD) surgery for TN. The surgery was performed under general anesthesia with a flexible spiral tracheal tube to allow the flexion of the neck while securing the airways. All of the patients were placed in the lateral position with the head supported with a three-pin Mayfield head fixation. A 5- to 7-cm curvilinear incision was made obliquely inside the hairline at the upper retromastoid area. A 1.5- to 2-cm diameter keyhole bone opening or small craniectomy or craniotomy was performed using a 4- and 4-mm extra-coarse power Diamond drill

system, EM 100-A Midas Rex Legend EHS, manufactured by Medtronic Powered Surgical Solutions - Memphis, TN, USA. The keyhole was located at the inner corner of the transverse sinus and the sigmoid sinus. Before the dural opening, precise hemostasis was accomplished with bone wax, Surgicel (Ethicon Inc., Bridgewater, NJ, USA) and cautery. The mastoid air cells were sealed with bone wax. The dura was opened in an inverted-T fashion, and small dural flaps were stitched to make a maximal dural opening (5 to 10 mm). The cerebrospinal fluid (CSF) was gradually aspirated and, under the operating microscope, an infratentorial lateral supra-cerebellar dissection was advanced to expose the petrosal vein (one to three bridging veins). Sufficient arachnoid dissection was performed around the petrosal veins and caudally to carefully expose the facial nerve and any offending vessels around the neural structures from proximal to distal. The space-occupying lesions were easily identified in all of the cases, and a circumferential dissection was initially performed whenever possible in order to carefully identify all of the neural and vascular structures before the debulking/resection of the tumor. Any additional compressing arterial loops or venous contacts were carefully dissected and mobilized off of the nerve root. A nonabsorbable material was interposed between the any vessel and the entry zone of the trigeminal nerve. Cerebellar retraction was judiciously used when necessary. A meticulous hemostasis and cleanup of the operating field was often achieved. Watertight dural closure with or without fascial graft was performed, and the cranioplasty was completed whenever possible. Cutaneous layers were routinely closed.

Outcome Assessment and Follow-Up

A 2-year follow-up investigation was performed in all of the patients included in the present study. The patients were clinically reassessed at 6, 12 and 24 months after the surgery, regarding the subjective improvement in the preoperative facial pain. They were included in 3 different groups according to the percentage of amelioration of pain, as follows: excellent

—complete improvement (> 90%); good—incomplete improvement (75–90%); and poor—partial improvement (< 75%).

Ethical Statement

The ethical committee of our institution analyzed the project and approved the performance of our investigations. All of the patients have given their informed consent for participation in the research study. The present study complied with the Declarations of Helsinki and Nuremberg. Informed consent for surgery was acquired from all of the patients.

Statistical Analysis

The data collected from all of the patients were organized in tables. The data are expressed as the means \pm the standard deviation (SD) for parametric variables, and as the median values for nonparametric variables. A normal distribution to sample collected data was assumed. The statistical analyses and the review of the numerical results obtained in the present investigation were performed by a mathematical team, and a p -value < 0.05 was considered statistically significant.

Results

We have operated on 11 consecutive cases in which TN was associated with a CPA tumor during the period of analysis. Seven (63.6%) patients were female, and 4 (36.4%) were male. Age distribution and duration of the symptoms are presented in ► **Table 1**. Seven (63.6%) patients presented with right-side symptoms, and 4 (36.4%) patients presented with left-side symptoms. After 2 years of follow-up, we observed that 8 (72.7%) patients showed a complete improvement of the symptoms, with an excellent outcome, and that 3 (27.3%) patients showed an incomplete improvement, with a good outcome. No patient reported partial improvement or poor outcome after the follow-up. There was no operative mortality. One (9.09%) patient presented with CSF leak, which was surgically treated on the 7th postoperative day, and 2 (18.2%) patients presented with temporary facial palsy.

Table 1 Clinical details of patients with trigeminal neuralgia and cerebellopontine angle tumors

Patient	Age (years old)	Gender	Duration of the symptoms (months)	Side	Outcome	Complication	Tumor
1	63	Female	24	Right	Excellent	–	Meningioma
2	59	Female	36	Right	Good	–	Meningioma
3	67	Female	18	Left	Excellent	CSF leak	Meningioma
4	61	Male	33	Right	Excellent	–	Meningioma
5	64	Female	27	Right	Excellent	–	Meningioma
6	52	Male	31	Left	Good	Facial palsy	Schwannoma
7	47	Male	19	Left	Excellent	–	Schwannoma
8	61	Female	42	Right	Good	Facial palsy	Schwannoma
9	49	Male	18	Left	Excellent	–	Schwannoma
10	33	Female	14	Right	Excellent	–	Hemangioblastoma
11	37	Female	16	Right	Excellent	–	Hemangioblastoma

Abbreviations: CSF, cerebrospinal fluid.

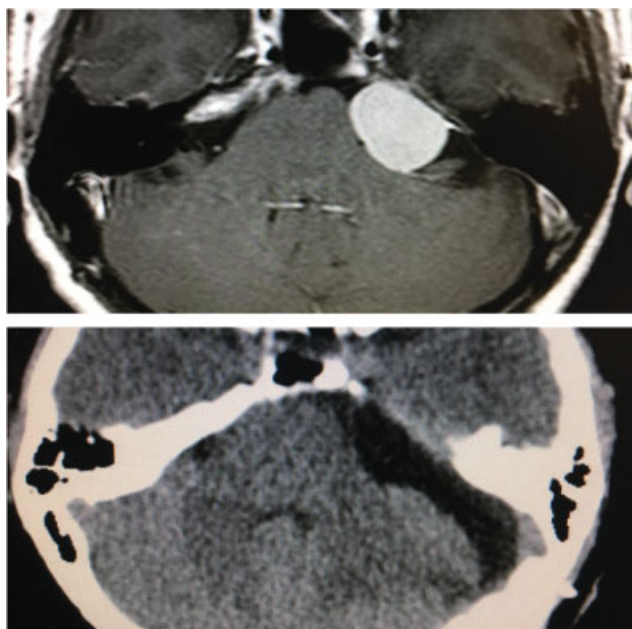


Fig. 1 Cerebellopontine angle tumor meningioma compressing the trigeminal nerve. Postoperative computed tomography.

Discussion

Several types of pathologies occur in the posterior fossa, and the specific diagnosis relies on the location of the lesion, on the age of the patient, on the associated clinical history, including signs, symptoms and duration, and on imaging studies.⁸⁻¹¹ Painful manifestation of posterior fossa tumors compressing the TN is a frequent manifestation of expansive lesions occupying the CPA.⁹⁻¹² It is believed that ~ between 1 and 9.9% of the cases of patients presenting with trigeminal painful manifestations are caused by CPA tumors, including meningiomas, schwannomas, and hemangioblastomas.⁴⁻⁷ In the present study, we describe our clinical and surgical experience treating patients with TN secondary to posterior fossa tumors located at the CPA.

Vestibular schwannomas and meningiomas are the 2 most frequent lesions of the CPA and account for ~ between 85 and 90% of all of the posterior fossa tumors.⁵ ▶ **Figure 1** and **2** exemplifies CPA tumor meningioma and a large vestibular schwannoma, respectively. Liu et al (2017) found CPA meningiomas as the most common causes of tumor-induced TN, accounting for 45.7% of the patients with symptomatic TN in this study.⁷ According to the authors, meningiomas tended to displace the nerve with or without vascular compression on

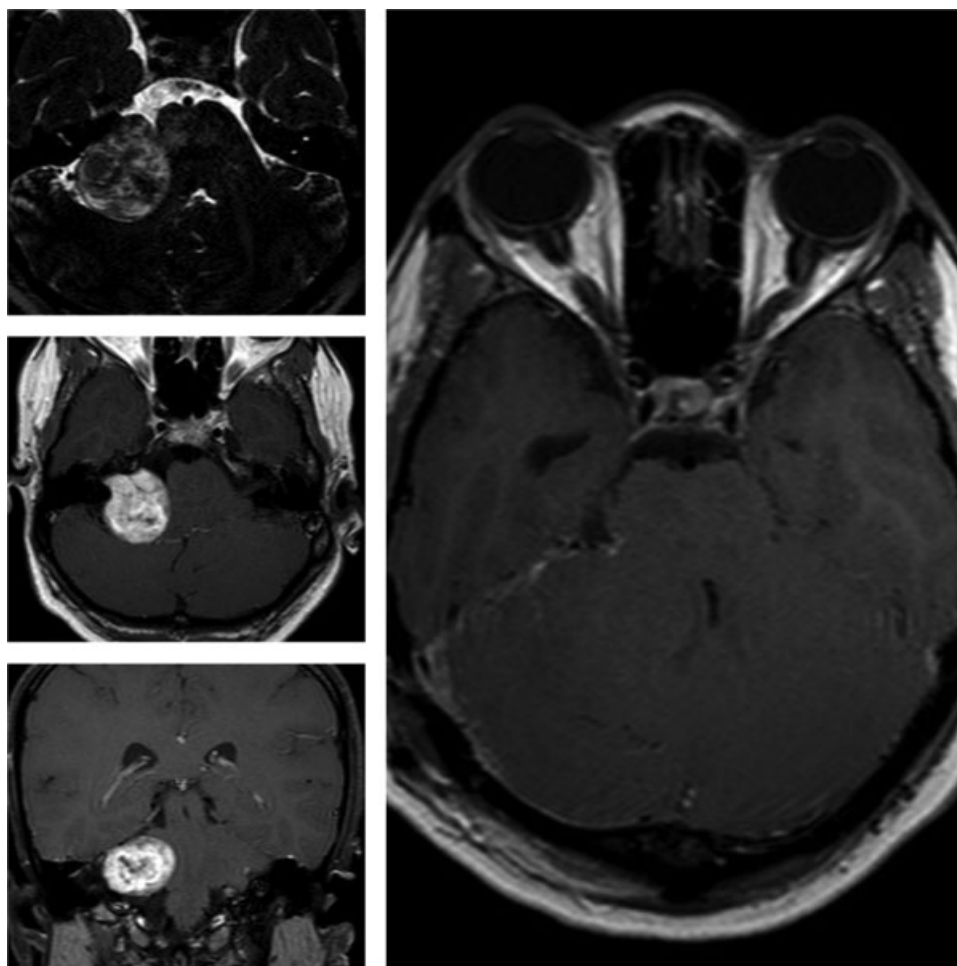


Fig. 2 Large vestibular schwannoma compressing the trigeminal nerve. Postoperative magnetic resonance imaging.

the entry zone.⁷ In our investigation, meningiomas were also found as the most frequent posterior fossa tumors associated with TN, accounting for 45.5% of the patients with symptomatic TN. In accordance with previous publications, we have verified that tumor removal produces > 95% of symptom control in most patients.^{7,13,14}

Large vestibular schwannomas are also described as potentially expansive lesions associated with TN that usually present no symptom improvement after stereotactic radiosurgery.¹⁵ Neff et al (2017) showed that 16% of the patients with large vestibular schwannomas present with TN, and that the removal of the tumor alleviated pain in 70% of the cases.¹⁵ Twenty-five percent of the patients did not show any change in the intensity of the neuralgia after the operation.¹⁵ In the present study, we have observed that an excellent outcome regarding pain relief was achieved in 50% of the patients. Postoperative facial palsy was directly related with limitations in the control of the symptoms, as observed by others.^{7,15}

Hemangioblastomas are tumors less frequently associated with TN.⁷ They represent < 1% of the cases in some series.⁷ However, tumor resection is usually associated with few complications and satisfactory symptom control.⁷ In our investigation, we could operate on two young women with short symptom duration, resulting in an excellent control of the neuralgia after the surgery. Also, no complication related to the procedure was noted.

Complications associated with tumor removal to treat TN due to compressive symptoms are not rare. Liu et al (2017) described CSF leak, hearing disturbances, facial palsy, facial numbness, and oculomotor paralysis as possible complications when trying to decompress the trigeminal nerve from expansive lesions.⁷ In the present study, we observed 1 (9.1%) case of CSF leak, which was treated with reoperation, and 2 (18.2%) cases of temporary facial palsy in large vestibular schwannomas. All of the patients with schwannomas included in the present investigation were preoperatively deaf, and their hearing status did not change after the surgery. There was no operative mortality.

Conclusion

Cerebellopontine angle tumors represent an important cause of TN and must be included in the differential diagnosis of patients presenting refractory and persistent symptoms. Surgical treatment with total resection of the expansive lesion and effective decompression of the trigeminal nerve are essential steps to control the symptoms.

Conflicts of Interest

The authors have no conflicts of interest to declare.

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