Lipoma of trigeminal nerve in a patient with severe trigeminal neuralgia

Jyoti Sureka, MBBS, MD, FRCR
Sanuj Panwar, MBBS, DMRD
Ravi Kanth Jakkani, MBBS, MD, FRCR

Figure MRI

T1 coronal images show homogenous hyperintense lesion involving the right trigeminal nerve root (white arrows) in A and B and Meckel’s cave (white arrow) in C as compared to normal left trigeminal nerve (black arrows) and Meckel’s cave (yellow arrow). Axial T1 image also demonstrates the involvement of mandibular division in foramen ovale (white arrow) as compared to normal on left side (orange arrow) in D.
A 45-year-old man presented with severe spastic, lancinating facial pain typical of intractable trigeminal neuralgia in the right mandibular area. MRI revealed an elongated lesion involving the right trigeminal nerve with signal intensity equal to that of subcutaneous fat. The homogenous T1-weighted hyperintensity (figure, A–D) and intermediate signal intensity on T2-weighted images suggested a tissue-specific diagnosis of trigeminal nerve lipoma. The patient refused surgery and follow-up MRI 1 year later showed no interval change in the morphology and extension of the lesion.

DISCUSSION
Cerebellopontine angle (CPA) lipomas are rare, and fatty infiltration of the trigeminal nerve giving rise to intraneural lipoma is even more uncommon. Intracranial lipomas are generally considered incidental findings on MRI and most patients remain asymptomatic. Symptoms that do occur in association with CPA lipoma usually mimic those associated with acoustic neuromas. Trigeminal nerve lipomas typically cause progressive focal neurologic symptoms due to involvement with nerve fascicles and adjacent neural structures. Trigeminal lipomas infiltrate the nerve fascicles so that even partial surgical excision may result in neurologic deficit. MRI aids accurate localization and tissue characterization prior to surgical intervention, and also helps to differentiate the lipomatosis of nerve from similar T1-weighted hyperintense extraneural CPA lipoma. Limited surgery in the form of arachnoid adhesiolysis should be considered only if a patient has disabling neurologic symptoms.

REFERENCES

DISCLOSURES
The authors report no disclosures.

Department of Radiology, Christian Medical College and Hospital, Vellore, Tamilnadu, India.
Correspondence to: drjyoticmch@rediffmail.com
Lipoma of trigeminal nerve in a patient with severe trigeminal neuralgia

Jyoti Sureka, Sanuj Panwar and Ravi Kanth Jakkani

Neurol Clin Pract 2011;1:78-79
DOI 10.1212/CPJ.0b013e31823c0f4b

This information is current as of December 1, 2011

Updated Information & Services
including high resolution figures, can be found at:
http://cp.neurology.org/content/1/1/78.full.html

References
This article cites 4 articles, 0 of which you can access for free at:
http://cp.neurology.org/content/1/1/78.full.html##ref-list-1

Subspecialty Collections
This article, along with others on similar topics, appears in the following collection(s):
All Cerebrovascular disease/Stroke
http://cp.neurology.org/cgi/collection/all_cerebrovascular_disease_stroke
Arteriovenous malformation
http://cp.neurology.org/cgi/collection/arteriovenous_malformation
Cardiac
http://cp.neurology.org/cgi/collection/cardiac
Cerebral venous thrombosis
http://cp.neurology.org/cgi/collection/cerebral_venous_thrombosis
Infarction
http://cp.neurology.org/cgi/collection/infarction

Permissions & Licensing
Information about reproducing this article in parts (figures,tables) or in its entirety can be found online at:
http://cp.neurology.org/misc/about.xhtml#permissions

Reprints
Information about ordering reprints can be found online:
http://cp.neurology.org/misc/addir.xhtml#reprintsus