以大腦假性腫瘤為首要表現的轉移性肺腺癌

Pseudotumor cerebri as a first manifestation of metastatic adenocarcinoma of the lung

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Introduction:

Pseudotumor cerebri (PTC) is a syndrome characterized by elevated intracranial pressure of unknown cause. The syndrome classically manifests with headaches, transient visual obscurations, and pulsatile tinnitus in the overweight women. There is normal cerebrospinal fluid (CSF) composition, and no hydrocephalus or other cause of intracranial hypertension evident on neuroimage. We report a case of newly diagnosed adenocarcinoma of the lung metastatic to meninges presenting symptoms and signs consistent with pseudotumor cerebri.

Case presentation:

A previously healthy 47-year-old woman came to our emergent department for deteriorated headache since 1 month ago. About one month ago, gradual onset of neck tightness, occipital and bi-temporal headache developed. The pain was improved slightly with acetaminophen at the beginning. Two weeks ago, the frequency and the severity of headache increased, and episodes of nausea/vomiting, transient visual change and left tinnitus were associated. Headache aggravated at midnight and sometimes awaked her from sleep, and it was also enhanced by Valsalva maneuver. One week ago, double vision occurred. On examination, the patient was afebrile without meningismus at admission. Extraocular movement revealed bilateral abducens palsy. A funduscopic examination demonstrated mild bilateral papilledema. On pure tone audiometry, left-sided buzzing tinnitus with mild sensorineural hearing loss was detected. The CSF profiles demonstrated an opening pressure of 36 cm H_2O, white blood cells 4/μl, red blood cells 2/μl, micro protein 21 mg/dl and glucose 41 mg/dL. CSF cytology revealed no malignant cell. Initial brain CT showed unremarkable findings (fig 1). The symptoms were temporarily subsided after the lumbar puncture, so pseudotumor cerebri was impressed. Whereas, headache got worse, and complicated with generalized seizure in the following days. She was treated with ventriculoperitoneal shunt. Brain DWI and T_2 flair MRI(fig 2) showed increased intensity in anterior cisterna around pons and one small enhanced nodule (about 8mm in diameter) in the left parietal lobe. CEA was elevated (491ng/mL). Stereotactic biopsy demonstrated as metastatic adenocarcinoma. Malignancy survey revealed pathology-proved adenocarcinoma of the left lung(fig 3). Oral gefitinib (IRESSA) was used in combination with whole-brain radiotherapy (WBRT). Her headaches resolved much and no abducens palsy was noted at follow up.

Discussion:

PTC is a diagnosis of exclusion. The modified Dandy criteria proposed for diagnosis are (1) Symptoms and signs of increased intracranial pressure (2) No other neurologic abnormalities or impaired level of consciousness (3) CSF pressure greater than 200 mmH_2O with normal composition (4) Normal brain CT scan. The clinical manifestation and examination of our case correspond with the modified Dandy criteria. Whereas, PTC has been reported with other potential secondary causes, such as vitamin A excessive intake, steroid withdrawal, oral contraceptives, hypoparathyroidism, obstructive sleep apnea, obstruction of cerebral venous drainage, infection, carcinomatous or lymphomatous meningitis. In our case, brain MRI (DWI and flair T_2) showed significant abnormal findings compatible with carcinomatous meningitis and further examination proved the origin as adenocarcinoma in the lung. Friedman and Jacobson updated the criteria and emphasized

the importance of MRI and MR venography. In summary, our findings emphasized the significance of MRI (especially DWI and flair T2) in a case of pseudotumor cerebri, even normal CSF profile with negative finding of malignant cells.

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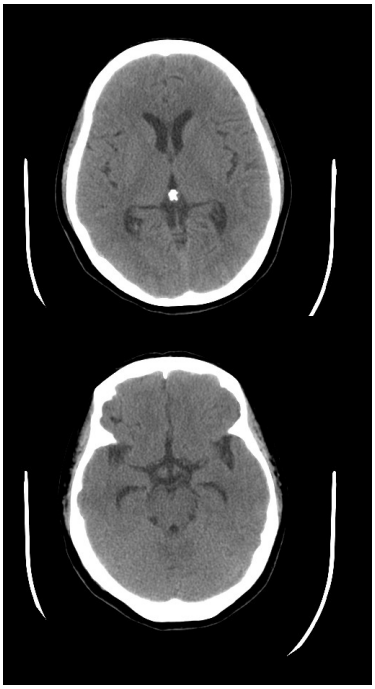

Fig 1

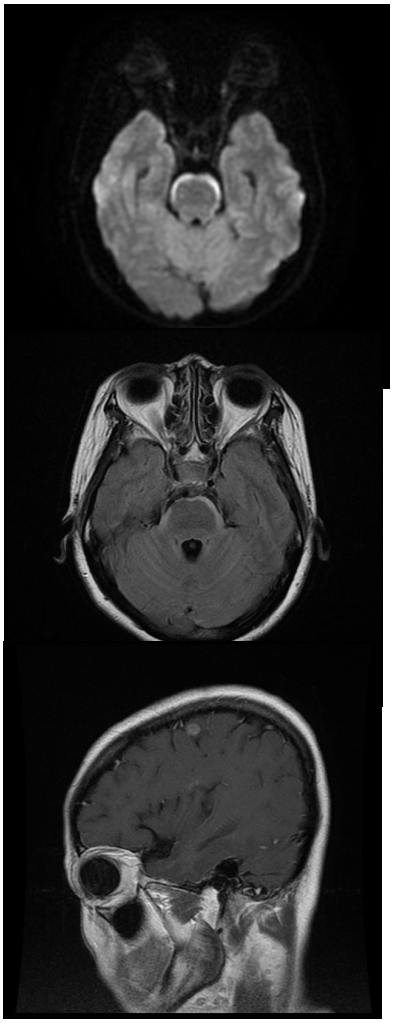

Fig 2

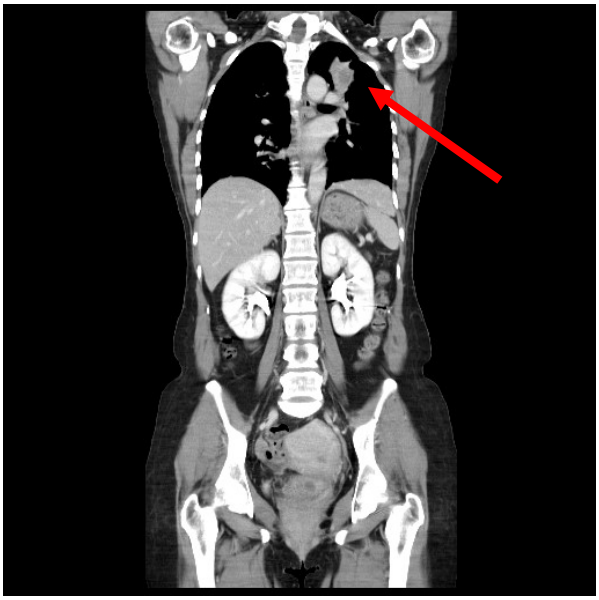

Fig 3