Cerebellopontine angle abscess

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Case reports

An unusual presentation of a life-threatening cerebellopontine abscess shows the importance of re-evaluating existing diagnoses when the clinical picture changes. Despite being rare, brain abscess is a potentially fatal condition that requires early radiological and surgical intervention. It has a varied presentation, with many cases showing no localising typical features, making it hard to diagnose at presentation. A high index of suspicion should be applied to cases exhibiting rapidly changing neurology. This is the first reported case of cerebellopontine abscess with no primary infective foci [1)].

Yilmaz et al. reported one case [2)].

A 12-year-old female patient, presented with a history of fever, chills, headache, and convulsions for seven days and a history of altered sensorium and aphasia in the last two days. The patient had chronic suppurative otitis media of both ears following trauma and presented with ear discharge. The diagnosis of brain abscess was done by computerized tomography scan and the pus was aspirated by left suboccipital burr hole operation. Enterococcus species were cultured from the aspirated pus sample. The patient responded to surgical drainage and antibiotic treatment [3)].

A case of sterile abscess of unknown etiology in the CPA region, occurring 13 years after surgical excision of a vestibular schwannoma. The clinical and radiological features were suggestive of recurrent vestibular schwannoma or malignant transformation. We believe this is the first reported case of delayed occurrence of sterile abscess in the CPA region. Further the diagnostic difficulties of such rare lesions occurring in the CPA after vestibular schwannoma surgery are discussed [4)].

Chronic granulomatous abscess simulating cerebellopontine angle tumor [5].

A 5-year-old boy with a chronic petrous pyramid abscess and without a history of otitis media. Treatment by posterior fossa exploration and drainage with antibiotics was successful [6].

On a difficult differential diagnosis in a case of chronic abscess of the cerebellopontine angle [7]

1)
Walkden A, Shekhar H, Fouyas I, Gibson R. The diagnostic dilemma of cerebellopontine angle lesions: re-evaluating your diagnosis. BMJ Case Rep. 2013 Feb 8;2013:bcr2012008358. doi: 10.1136/bcr-2012-008358. PMID: 23396935; PMCID: PMC3603770.
2)
Yilmaz C, Altinors N, Sonmez E, Gulsen S, Caner H. Rare lesions of the cerebellopontine angle. Turk Neurosurg. 2010 Jul;20(3):390-7. doi: 10.5137/1019-5149.JTN.2961-10.0. PMID: 20669114.
3)
Sonavane A, Baradkar V, Kumar S. Enterococcal Cerebellopontine Angle Abscess in a 12-year-old Female. J Glob Infect Dis. 2010 Jan;2(1):67-9. doi: 10.4103/0974-777X.59255. PMID: 20300422; PMCID: PMC2840972.
4)
Srinivasan V, Anandacoomaraswamy KS, Atlas MD. Sterile abscess mimicking recurrent tumour in the cerebellopontine angle. J Laryngol Otol. 2002 May;116(5):379-81. doi: 10.1258/0022215021910843. PMID: 12080999.
5)
Cholankeril JV, Lieberman H. Chronic granulomatous abscess simulating cerebellopontine angle tumor. AJNR Am J Neuroradiol. 1984 Sep-Oct;5(5):637-8. PMID: 6435434; PMCID: PMC8335147.
6)
Glasauer FE, Grand W. Chronic petrous pyramid abscess presenting as a cerebellopontine angle mass. Case report. J Neurosurg. 1976 Jan;44(1):116-8. doi: 10.3171/jns.1976.44.1.0116. PMID: 1081589.
7)
WERNER A. [On a difficult differential diagnosis in a case of chronic abscess of the cerebellopontile angle]. Neurochirurgie. 1959 Jul-Sep;5:334-6. French. PMID: 13844029.