Clivus tumor

- Clival Chordoma Metastatic to Lymph Node: Brachyury Staining Insights
- Quantitative Analysis of the Working Windows for Sitting and Park Bench Positions Through the Retrosigmoid Approach Evaluated in a Cadaver Model
- Hypertrophic olivary degeneration after posterior cranial fossa tumor resection in adults: illustrative case
- Visual-Motor Functions and Associated Cognitive Outcomes in Pediatric Cancer Survivors
- A case report of malignant paraganglioma with lymph node and liver metastasis in the jugular foramen area
- Mucoepidermoid carcinoma of the parotid gland with invasion of the jugular foramen region: A case report
- A rare clinic in hepatocellular cancer: Metastasis of the nasopharynx
- Diverse accessory techniques and working corridors to enhance the retrosigmoid approach: a versatile option for the treatment of meningiomas of the petroclival region

Endoscopic transnasal approach is an alternative approach to the treatment of clivus lesions, and, in expert hands, this technique can obtain good results. Lateral extension and previous treatment were factors that could make the surgery more difficult. The intradural extension did not limit the radicality of the removal [1].

Solitary non-chordomatous lesions of the clivus are rare pathologies, which represent a diagnostic challenge.

Twenty-two non-chordomatous lesions of the clivus were collected. A retrospective analysis of clinical and radiological patterns as well as survival data was conducted.

Clinical presentation was a result of local mass effect. Imaging features, although mainly specific, were not always diagnostic. Extent of surgery was gross total in 45.5 % of cases. Depending on the histology, biological behaviour and presence of seeding, adjuvant treatment was performed, tailoring the treatment strategy to the single patient.

Solitary non-chordomatous lesions of the clival bone are more prevalent than expected. They should be approached with a correct differential diagnosis, considering specific epidemiological, radiological, and histopathological characteristics, to minimise diagnostic bias and allow the planning of the best treatment strategy [2].

Lower clivus

Approaching lesions located in the lower clivus and at the anterior edge of foramen magnum have always presented as a challenge to the neurosurgeon. The majority of these lesions have been approached posteriorly by suboccipital or retrosigmoid craniotomy and anteriorly by transoral and through the paranasal sinus approaches. Nevertheless all of then have disadvantages including a great depth of surgical field and an extremely limited lateral exposure [3].

Epidemiology

Tumors of the clivus are extremely rare, representing only 0.1-0.4% of all intracranial tumors, with chordomas and chondrosarcomas being the most frequent tumors of this region [4)]

Diagnosis

Biopsy

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- A rare clinic in hepatocellular cancer: Metastasis of the nasopharynx
- Chondrosarcoma of the Jugular Foramen: A Case Report
- A case of hypoglossal nerve palsy with evolving cranial nerve involvement in renal cell carcinoma: a case report
- Skull Base Rhabdomyosarcoma Mimicking Osteomyelitis in a Pediatric Patient
- Fungal skull base lesion masquerading as malignancy: a diagnostic dilemma. Illustrative case report

Differential diagnosis

- Mucoepidermoid carcinoma of the parotid gland with invasion of the jugular foramen region: A case report
- A rare clinic in hepatocellular cancer: Metastasis of the nasopharynx
- A case of hypoglossal nerve palsy with evolving cranial nerve involvement in renal cell carcinoma: a case report
- A retroclival endodermal cyst mimicking an arachnoid cyst: illustrative case
- Fungal skull base lesion masquerading as malignancy: a diagnostic dilemma. Illustrative case report
- Ectopic dopamine agonist-resistant macroprolactinoma to the clivus masquerading as a chordoma - A case report
- Nonenhancing Prepontine Chordoma with Diffusion Restriction Mimicking an Epidermoid Cyst
- Clival fibrous dysplasia in which short interval disease progression posed a diagnostic challenge in a skeletally mature patient: a case report

Clivus chordoma

see Clivus chordoma

Clivus myeloma

see Clivus myeloma.

Clivus lymphoma

Clivus lymphoma.

Clivus metastases

Clivus metastases

Case reports

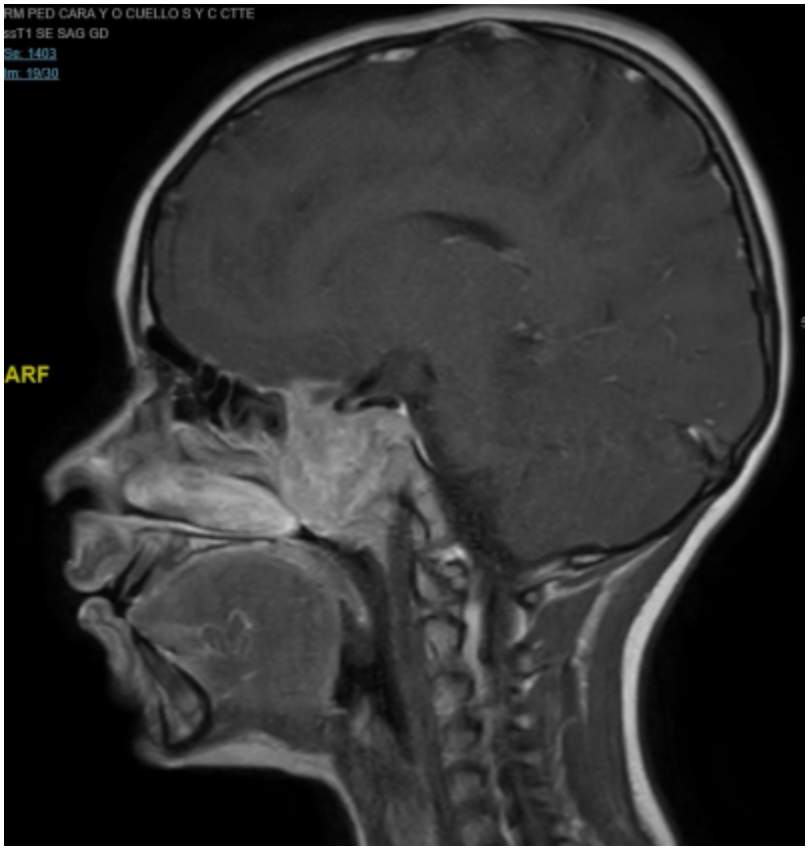
An 83-year-old woman presented with 4 weeks of headaches and blurry vision. Examination revealed partial right abducens and left oculomotor palsies. Magnetic resonance imaging (MRI) identified a large, weakly enhancing sellar and clival mass with sphenoid sinus extension. An aggressive subtotal endoscopic endonasal resection was performed with removal of all sphenoid, clival, and sellar disease without cavernous sinus wall resection. Pathology confirmed colorectal adenocarcinoma; computed tomography (CT) imaging identified an ascending colon mass with metastases to the liver and mesenteric nodes. Palliative oncologic therapies were recommended, but she elected hospice, and died 3 months after initial presentation. Gastrointestinal clival metastases are exceedingly rare among sellar and clival pathologies, with eight prior cases reported, most of which presented with diplopia from abducens nerve involvement. Conclusion Clival masses are uncommon skull base lesions that are associated with more aggressive diseases. We present a consolidated framework for decision-making in these challenging patients, alongside an unusual case example that illustrates the importance of increased suspicion for malignant clinical entities in this setting [5)]

Case report from the HGUA

7 years Child transferred from another hospital due to a mass in the nasal fossa and right cavum.

Constant headache, not relieved with paracetamol. Diplopia

Magnetic Resonance Imaging (MRI):



Lytic, expansive, and aggressive tumor centered on the clivus. Invasion of multiple holes at the base of the skull, including the optic canal and right superior orbital fissure. Tumoral involvement with stenosis of the cavernous portion of the internal carotid artery. Destruction of the walls of the right optic canal and right superior orbital fissure. Extension towards pterygoid processes, cavernous sinuses, with probable tumor infiltration of the pituitary.

Physical Examination:

Visual acuity: 1/1 in both eyes. Intraocular pressure (IOP): 16/15 mmHg. No deviation from the normal position of the eyes (proptosis). Mild torticollis to the right. Endotropia of approximately 15º in the right eye (OD). Complete limitation in abduction, supradextroversion, and infradextroversion in OD. Fundus Examination (FO):

Clear vitreous, retina flat. Optic disc with well-defined borders; slight congestion of the vascularization of the papilla in the right eye. Ophthalmological Clinical Findings:

Paralysis of the sixth cranial nerve (VI) in the right eye in the context of a mass in the cavum.

Treatment Plan:

Alternating occlusion to alleviate binocular diplopia.

Follow-up for post-surgical assessment of FO and limitation of ocular movements in OD. Additional Notes:

A biopsy is suggested to confirm the diagnosis and determine the most appropriate treatment plan. Continuous evaluation is required to monitor post-surgical evolution and adjust management as needed. Ophthalmological collaboration is essential to address visual symptoms and ensure comprehensive care.

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4)
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