Planum sphenoidale meningioma clinical features

- Clinical and radiological presentation of meningiomas
- Fully Endoscopic Supraorbital Approach for Anterior Cranial Base Meningiomas
- Endonasal versus supraorbital approach for anterior skull base meningiomas: Results and quality of life assessment from a single-surgeon cohort
- Hemorrhagic Atypical Planum Sphenoidale Meningioma with Intermittent Vision Loss-Rare Presentation of Apoplexy
- Selection of endoscopic or transcranial surgery for tuberculum sellae meningiomas according to specific anatomical features: a retrospective multicenter analysis (KOSEN-002)
- Cranial aspergilloma masquerading as meningioma
- Carcinoma of the breast metastatic to the optic nerve mimicking an optic nerve sheath meningioma: case report and review of the literature
- Dumbbell tumor of the anterior skull base. Meningioma? No, adenoid cystic carcinoma!

Clinical presentation and diagnosis often occur in the late stage, as many patients are asymptomatic before the meningioma reaches a sufficient size (> 4 cm) to compress the frontal lobe and optic nerve or optic chiasm [1].

As the first point of contact with the health care system, primary care physicians must recognize dysexecutive syndrome as potentially being caused by a meningioma. Although olfactory meningiomas are rare, they are treatable and the expected outcome is good for reversal of dementialike symptoms. The family physician’s role is to provide definitive care to patients with undifferentiated symptoms and to provide continuity of care [2].

Patients with meningiomas of the planum sphenoidale and tuberculum sella often present with insidious vision loss in one or both eyes as the only sign or symptom of their disease, although other sensory, oculomotor, and even endocrine abnormalities may be seen in a minority of cases. Incidentally discovered tumors also are common, as patients may undergo neuroimaging for unrelated symptoms or events. Depending on the size and orientation of the tumor, central vision loss from optic nerve compression may be a later sign, and loss of peripheral vision in one or both eyes may not be recognized until it has progressed to areas closer to fixation. A thorough neuroophthalmologic assessment including visual field testing will help to define the extent of optic pathway involvement. Both fundus examination and optical coherence tomography of the retinal nerve fiber layer and macular ganglion cell complex will aid in determining prognosis after treatment of the tumor [3]

A patient with a planum sphenoidale meningioma mimicking a classic case of pituitary apoplexy is

reported [4].

1)
Ojemann RG. Olfactory groove meningiomas. In: Al-Mefty O, editor. Meningiomas. New York, NY: Raven; 1991. pp. 383–93.
2)
Chiang GS, Goh LG. Olfactory groove and planum sphenoidale meningioma: Dementia masquerade. Can Fam Physician. 2017 Apr;63(4):288-291. PubMed PMID: 28404703; PubMed Central PMCID: PMC5389759.
3)
Echalier EL, Subramanian PS. Meningiomas of the Planum Sphenoidale and Tuberculum Sella. J Neurol Surg B Skull Base. 2021 Feb;82(1):72-80. doi: 10.1055/s-0040-1722703. Epub 2021 Feb 12. PMID: 33777619; PMCID: PMC7987389.
4)
Marano SR, Sonntag VK, Spetzler RF. Planum sphenoidale meningioma mimicking pituitary apoplexy: a case report. Neurosurgery. 1984 Dec;15(6):859-62. PubMed PMID: 6514160.