a 41-yr-old female with a history of right-sided facial numbness associated with pain around the ear. Magnetic resonance imaging demonstrated a lesion in the right tentorium edge closely related with the porus trigeminus, suggestive of a meningioma. Because of worsening of symptoms the patient underwent surgery for tumor removal. A standard temporo-zygomatic craniotomy was performed, followed by an extradural peeling of the middle fossa; the petrous apex was drilled allowing access to the posterior fossa dura. Dural opening was carried connecting the temporal and posterior fossa, and the tentorium was then cut to the incisura. The tumor was identified and completely removed reaching Simpson grade I resection. Postoperatively, the patient presented a right dry eye in the first days that fully improved, and also a right-sided facial paralysis (House-Brackmann grade IV) and diplopia, both recovered completely after 4 mo. We believe that facial paralysis was the result of an undesired traction of the geniculate ganglion, or upon the nerve itself. To avoid such complication, dissection over the GSPN must be carried parallel to that nerve. Facial numbness and pain improved with no neurological other deficits. Tentorial meningiomas are complex deep-seated lesions that can be successfully approached through an anterior transpetrosal route in selected cases. Informed consent was obtained from the patient for publication of this operative video. Anatomical images were a courtesy of the Rhoton Collection, American Association of Neurological Surgeons/Neurosurgical Research and Education Foundation [1)].

2018

A 23-year-old female presented at 37 weeks of pregnancy with 1-month history of fluctuating severe left-sided headaches, periodic blurry vision, nausea and vomiting. She had two previous pregnancies without complication. Magnetic resonance Imaging (MRI) revealed a dural-based, heterogeneously enhancing mass along the left tentorium, just posterior to the transverse sinus, with supratentorial extension and surrounding edema. Differential diagnoses included meningioma vs hemangioma vs hemangiopericytoma. The patient followed up with neurosurgery one month after delivery. She had continued left-sided headaches but no longer complained of visual changes. A postpartum surgical resection via left occipital and suboccipital craniotomy was planned. Approximately one month later (now about 3 months after delivery) a repeat MRI demonstrated a marked decrease in meningioma size and the previously seen edema had resolved. In light of the sudden disappearance of the meningioma, no further surgical intervention was pursued.

Since meningioma shrinkage or disappearance may occur after pregnancy, repeat imaging is advised as part of preoperative evaluation. Additionally, it is possible that an undetermined amount of meningioma removal surgeries may be avoided with further research into monitoring hormone levels connected to meningioma growth [2)].

2009

A rare case of hemifacial spasm caused by an ipsilateral tentorial meningioma is described. Magnetic resonance imaging showed a huge tumor in the right cerebellar hemisphere, distant to the cerebello-pontine cistern. The facial-vestibulocochlear nerve complex was stretched by the shift of the brainstem and the right cerebello-pontine cistern was effaced. After removing the tumor, the hemifacial spasm resolved completely. We review our case with the pertinent literature regarding the etiological mechanism [3)].

Perrini et al. describe a patient with a large paramedian tentorial meningioma associated with

acquired Chiari malformation who presented with trigeminal neuralgia TN. Trigeminal pain resolved after gross total tumour resection and postoperative magnetic resonance images disclosed a minimal residual tumour in the torcular region as well as ascent of cerebellar tonsils. In this article, we investigate the physiopathological hypotheses for this unusual association with emphasis on the role of tonsillar prolapse as neuropathological basis of neuropathic pain in this patient [4)].

2007

Guan et al. report a spontaneous cerebrospinal fluid rhinorrhea in a patient with tectorial meningioma [5)].

2006

Tentorial meningioma on follow-up presenting with sudden deterioration due to intra- and peritumoral hemorrhage [6)].

2005

A 45-year-old woman suffering from hemifacial spasm, who dramatically improved after surgical removal of a tentorial paramedic meningioma [7)].

Concomitant ectatic posterior communicating artery and tentorial meningioma as a source of oculomotor palsy: case report [8)].

2002

Santoro et al. describe the case of patient who underwent subtotal resection of a chromophobe pituitary neuroendocrine tumor at the age of 18 years, who was successively treated by conventional fractionated radiotherapy with gamma rays emitted by a source of 60Co until a total dose of 41 Gy. Over the next 30 years the patient experienced all the known late effects of radiation, including panhypopituitarism, cranial-nerve deficits (II, III and VI), massive radiation necrosis involving the left cerebral hemisphere and causing right hemiparesis and aphasia and, ultimately, an atypical tentorial meningioma with early recurrence after total resection [9)].

Secondary syringomyelia disappearing after removal of tectorial meningioma [10)].

2001

A 35-year-old right-handed woman presented with a generalized convulsion. Magnetic resonance

imaging scans revealed a left medial tentorial meningioma with supratentorial extension at the dominant hemisphere. The main venous drainage route from the ipsilateral temporal lobe was a sphenopetrosal vein.

An operation was performed with the patient in a sitting position, and the tumor was resected totally via the paramedian supracerebellar transtentorial approach without perioperative complications.

The paramedian supracerebellar transtentorial approach is useful for supratentorially located medial tentorial meningiomas without retraction of the temporal lobe and without damage to the vein of Labbé or the sphenopetrosal vein [11].

2000

A 33-year-old male presented with involuntary and inappropriate laughter. Neuroimaging revealed a meningioma ventrolateral to the pons and midbrain, attached to the medial middle tentorium on the left side. The pathological laughter ceased immediately after subtotal removal of the tumor. Pathological laughter may be an early focal sign of a mass compressing ventrolateral brainstem [12].

A 73-year-old female case with tentorial meningioma suffering from pure word deafness is reported. The patient initially presented with hydrocephalus, and was treated with a ventriculo-peritoneal(V-P) shunt. A year after the V-P shunt, she suffered from a symptom of deafness. On admission, her repetition and auditory comprehension were severely impaired, while reading and visual comprehension were almost normal. Auditory brain stem response(ABR) revealed normal latency between wave I and V, while wave VI and VII was disappeared. Middle latency response(MLR) showed no wave peak. On MRI, tentorial meningioma compressed bilateral medial geniculate bodies, but not auditory radiation or temporal lobe. 99mTc-HMPAO Single-photon emission computed tomography(SPECT) showed hypoperfusion in the left temporal lobe, considered as a diaschisis resulting from the isolation of left temporal lobe from auditory input via bilateral medial geniculate bodies [13].

1999

A 62-year-old woman was evaluated for tinnitis and headache. Magnetic resonance imaging and angiography revealed the coexistence of a tentorial tumor encroaching the junction of the right transverse-sigmoid sinuses, and dural arteriovenous fistulous malformation (AVFM) of the right transverse sinus. AVFM was not manipulated at all during the surgery. The pathology was fibroblastic meningioma. Postoperatively, the dural AVFM completely disappeared on follow-up angiography. The fistulas were occluded also after surgery, even though there was no manipulation of the AVFM. It is suggested that the right dominant transverse-sigmoid sinuses are partially occluded by tentorial meningioma, developing the dural arteriovenous fistula of the right transverse sinus. An acquired origin of the dural AVFM was suggested in this case [14].

1996

Resolution of chronic cluster headache after resection of a tentorial meningioma: case report [15].

1995

A 28-year-old male was admitted to our hospital with the complaints of numbness of the left upper limb and gait disturbance. Neurological examination disclosed slight left dysmetria, truncal ataxia and sensory disturbance at the dermatome of C8 and Th1. CT and MRI scans showed a large mass lesion in the left posterior fossa, ventricular dilatation, cavum septi pellucidi and cavum Vergae, empty sella, cervical syringomyelia and left tonsilar herniation. The tumor which attached to cerebellar tentorium was totally removed and a histological diagnosis of meningothelial meningioma was made. Postoperative MRI scan demonstrated a disappearing of syringomyelia with the improved tonsillar herniation. Association of syringomyelia with brain tumor is relatively rare, so its pathogenesis was discussed [16].

A patient who had chronic cluster headache for more than 20 years. The headache immediately resolved upon resection of a tentorial meningioma. Prior reports of cluster headache as a manifestation of structural disease are briefly reviewed. In the patient described, the pain was referred from the right tentorium cerebelli to the right side of the face, in accordance with reported studies on the subjective localization of pain referred from posterior fossa structures. The accompanying abnormalities of autonomic function may have been mediated by central autonomic reflexes that are also involved in the pathogenesis of idiopathic cluster headache [17].

Embolization with temporary balloon occlusion of the internal carotid artery and in vivo proton spectroscopy improves radical removal of petrous-tensorial meningioma [18].

A case is presented of painful tic convulsif caused by a posterior fossa meningioma, with right trigeminal neuralgia and ipsilateral hemifacial spasm. Magnetic resonance images showed an ectatic right vertebral artery as a signal-void area in the right cerebellopontine angle. At operation the tentorial meningioma, which did not compress either the fifth or the seventh cranial nerves directly, was totally removed via a suboccipital craniectomy. The patient had complete postoperative relief from the trigeminal neuralgia and her hemifacial spasm improved markedly with decreased frequency. From a pathophysiological standpoint, the painful tic convulsif in this case was probably produced by the tumor compressing and displacing the brainstem directly, with secondary neurovascular compression of the fifth and seventh nerves (the so-called “remote effect”) [19].

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