

been reported to be associated with acute myocardial infarction¹¹.

CONCLUSION

This is a case report of a right atrial myxoma prolapsing through tricuspid valve into right ventricle, presenting in the medical emergency department of GND Hospital/ GMC Amritsar with acute myocardial infarction. Transthoracic echocardiography and gadolinium enhanced MRI remains invaluable tool in the initial workup of myxoma, whereas cardiac catheterisation and excision biopsy are the Gold standard for its diagnosis.

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Cervical Vagal Schwannoma: A Case Report and Review of Literature

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Abstract : Schwannoma originating from the cervical vagus nerve is an extremely rare neoplasm. This tumour most often presents as a slow growing asymptomatic solitary neck mass which rarely undergoes malignant transformation. Vagal nerve schwannoma usually occurs between the third and fifth decades of life. It does not show gender predilection. Diagnosis is based on clinical suspicion and histopathology. The treatment of choice is complete surgical excision with preservation of the neural pathway, when possible. A case of a cervical vagal schwannoma, in a 33-year old male is described. The clinical features, diagnosis, management and pathological findings of cervical vagal schwannoma are discussed. **Keywords:** Schwannoma, Vagus nerve, Benign tumours

INTRODUCTION

Cervical vagal schwannomas are rare, slow-growing tumours usually reported to occur in patients between 30 and 50 years of age with no sex-related predisposition. Schwannoma arising from the vagus is an uncommon (2–5%) benign nerve tumour and rarely undergoes malignant transformation. Investigations such as fine needle aspiration cytology (FNAC) have low specificity. Diagnosis is based on clinical suspicion and confirmation obtained by means of surgical pathology. Imaging plays a central role in diagnosing vagal nerve neoplasm. Schwannomas of the vagus nerve must be differentiated from the carotid body and glomus vagale tumors because the distinction may influence treatment planning. Surgical excision is the treatment of choice for vagal schwannoma, with recurrence being rare.

CASE REPORT

A 33 year old male patient presented with a gradually progressive swelling in right side of the neck for 4 years, with no history of pain or weakness of upper limb. Examination showed 6 × 4 cm oval, smooth surfaced, non-tender firm swelling posterior to the upper part of right sternocleidomastoid muscle. The mass was mobile in the horizontal but not in vertical direction. The right carotid artery was displaced anteriorly.

Ultrasound of the neck showed a well defined heterogenous mass measuring 6.8 x 5.6 cm adjacent to the right lobe of thyroid and compressing it. Microcalcification with increase in central and peripheral vascularity was also noted in the mass. The mass was seen to compress and displace the internal jugular vein and carotid vessels on the right side. The visualized portion of right and left thyroid lobes and isthmus appeared normal.

The FNAC report was inconclusive. Computerized tomography showed a 8.2 x 4.7 x 7.5 cm well-defined soft tissue mass deep to the right sternocleidomastoid muscle extending from the right para-pharyngeal space up to the supraclavicular fossa. The mass was seen to displace the

internal jugular vein and carotid vessels anteriorly. (Fig. 1).

The operative findings revealed a well encapsulated tumor arising from the vagus nerve. The right carotid artery and the internal jugular vein were displaced anteriorly. The tumor was enucleated with sparing of the nerve. Post-operative period was uneventful with no evidence of IX cranial nerve paresis on follow up.

Histopathology showed a biphasic tumour composed of Antony-A and Antony-B areas. The former were composed of spindle shaped cells arranged in bundles and fascicles with palisading of nuclei forming Verocay bodies. The latter areas showed haphazardly arranged cells in a loose myxoid stroma. Degenerative nuclei with areas of hemorrhage and cystic change were also seen. There was no increase in mitosis. These features were suggestive of schwannoma with degenerative changes (ancient schwannoma). (Fig. 2).

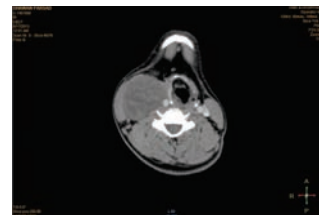


Fig. 1: CECT Neck – Cut Section showing well-defined mass with anterior displacement of the common and internal carotid artery

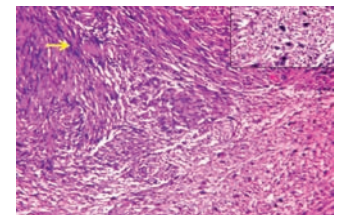


Fig. 2: Ancient schwannoma with Antoni-A areas (arrow). Inset shows bizarre hyperchromatic degenerative nuclei. Hematoxylin & Eosin 200 x

DISCUSSION

Schwannomas are rare peripheral nerve tumours; about one third occur in the head and neck region. They present as asymptomatic slow-growing lateral neck masses¹. Schwannoma arising from the vagus is an uncommon (2–5%) benign nerve tumour. These tumours rarely undergoes malignant transformation².

Pre-operative diagnosis of vagal schwannoma is difficult owing to a paucity of neurological deficits. Several common differential diagnoses

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