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INCIDENTAL FINDING OF INTRAVENTRICULAR MENINGIOMA: A CASE REPORT

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CASE PRESENTATION

Female patient, 28 years old, attended a consultation at a university neurology outpatient clinic complaining of headache. She reports that she had sporadic headaches, holocranial, of low intensity and that improved, most of the time, with the use of simple analgesics, with no impact on her life activities; it does not observe triggers, prodromes, aura or postdrome. Approximately 1 month ago, she presented a change in pattern, progressing with severe right hemicranial headache, associated with nausea and vomiting, facial paresthesia, low response to simple analgesics and significant limitation in her activities; she required frequent visits to the emergency room for pain control.

She opted to undergo neuroimaging due to the change in pain pattern. In a return consultation, with the result of magnetic resonance imaging (Images 1 and 2) of the skull, it was noted: incidental finding of intraventricular meningioma, in the posterior horn of the right lateral ventricle, without signs of changes in CSF management, obstructive hydrocephalus or suggestive signs of intracranial hypertension.

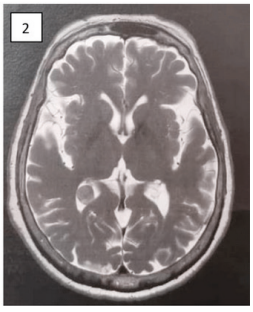

Image 1: Magnetic resonance imaging of the skull in T1, showing a nodular lesion in the posterior horn of the right lateral ventricle.
Image 2: Magnetic resonance imaging of the skull in T2, showing the same lesion.

DISCUSSION

Meningiomas are among the main tumors of the central nervous system, with an annual prevalence of 1.5-5.5 per 100,000 people, however, only 0.5-3% of meningiomas are intraventricular. In most cases, due to the large ventricular space, when symptomatic, intraventricular meningiomas are already considerable in size (image 3).

When symptomatic, the main complaints include: headache (generally of moderate-severe intensity, associated with visual disturbances), dizziness, blurred vision, tinnitus, movement disorders or convulsive crises; with most symptoms occurring due to increased intracranial pressure.

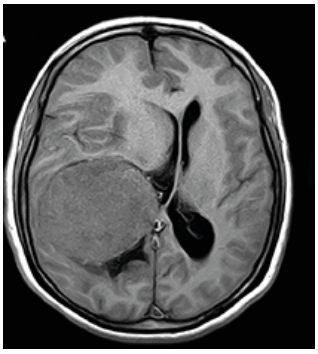

Image 3: Magnetic resonance imaging of the skull in T1 showing a large intraventricular meningioma, with midline shift, compromising CSF management.

In the case presented, it was possible to exclude a secondary etiology for the headache, as neuroimaging excluded changes that could cause signs and symptoms of intracranial hypertension or involvement of brain structures. Thus, the diagnosis of migraine was made; no correlation with meningioma. Based on the above, we opted for clinical-radiological monitoring of the meningioma, with periodic imaging exams and prophylactic treatment for migraines.