Case Report

Cervical Dystonia - A Rare Presentation of Cerebello Pontine Angle Tumor

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Introduction

Cervical dystonia is the commonest focal dystonia. Adult onset cervical dystonias are usually idiopathic. We report a case of adult onset cervical dystonia secondary to cerebello pontine angle tumor. This 52 year old man presented to us with cervical dystonia and on evaluation was found to have a right cerebello pontine angle tumor. Cervical dystonia as the presenting manifestation of a cerebello pontine angle tumor is a rarity.

Case Report

A 52 year old gentleman presented with 6 month history of progressive abnormal posturing of neck. There was no preceding head or neck trauma, encephalitic illness or stroke. Drug history was unremarkable. He did not give any history of headache, loss of hearing, tinnitus, ataxia or vertigo. On examination he had a right laterocollis with mild torticollis. He had sensorineural deafness in right ear. Rest of the neurological examination was unremarkable. KF ring was absent bilaterally. MRI brain showed a right cerebello pontine angle tumor. Laboratory investigations including serum ceruloplasmin and thyroid function tests were normal. Patient underwent excision of the tumor. Histopathology was suggestive of schwannoma. Post operative his cervical dystonia improved.

Fig 1. Patient with right laterocollis with mild torticollis

Fig 2. MRI Brain T1 coronal image showing right cerebello pontine angle tumor

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Discussion

Cerebello pontine angle tumors usually present with insidious onset cochlear dysfunction characterized by unilateral high pitched tinnitus and progressive sensori-neural hearing loss associated with vertigo, ipsilateral cerebellar dysfunction and dysfunction of adjacent cranial nerves (commonly fifth, sixth and seventh cranial nerves).

Dystonias are classified into early onset (less than 26 yrs) and late onset (more than 26 years) based on age of onset. Late onset cervical Dystonias are usually idiopathic.

The combination of cervical dystonia with right sensorineural hearing loss, temporal relationship of their appearance and improvement of the dystonia with surgery suggests a causal relationship between right cerebello pontine angle tumor and the dystonia in our case. Our case is unique in two ways- (1) Cervical dystonia as the presenting manifestation of a cerebello pontine angle tumor is rare (2) Cranial onset dystonia in adulthood due to a secondary cause is also a rarity.

Although cervical dystonia secondary to tumors is rarely seen, it is to be kept in mind in the differential diagnosis. Early recognition of such cases prevents progressive neurological deterioration and increase in tumor size. A complete resolution of the dystonia may be possible if dealt with early.

References