



ACOUSTIC SCHWANOMA: VARIED PRESENTATION IN PSYCHIATRY

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ABSTRACT

Acoustic shwanomma may present in myriad ways to the clinician. Acoustic neuromas are intracranial, extra-axial tumors that arise from the Schwann cell sheath investing either the vestibular or cochlear nerve. As acoustic neuromas increase in size, they eventually occupy a large portion of the cerebellopontine angle. Acoustic neuromas account for approximately 80% of tumors found within the cerebellopontine angle. They may present with hearing loss, headache, giddiness, tinnitus, facial numbing and in this particular case report with elementary hallucinations. Unilateral hearing loss is overwhelmingly the most common symptom present at the time of diagnosis and is generally the symptom that leads to diagnosis. We can almost safely assume that any unilateral sensorineural hearing loss is caused by an acoustic neuroma until proven otherwise. In the case reported in a 75 year old lady who presented with memory loss, ataxia, unilateral hearing loss with elementary hallucinations leading to sleep deprivation, she was managed on the lines of dementia with psychotic features. Following is the detailed report of case and the manner in which it presented to our clinic.

KEYWORDS: Acoustic shwanomma, hearing loss, ataxia, hallucinations, cognitive loss, tinnitus.

INTRODUCTION

Acoustic shwanommas are common intracranial entities that may present with symptoms of hearing loss which may be unilateral with ataxia, facial weakness, vertigo depending on lesion size.^[1] In geriatric cases, the presentation of this entity may get blurred when the patient is seen without a high index of suspicion to rule out organic cause for her illness.

Acoustic shwanommas are known to present with hearing loss with tinnitus which when aggravated may resemble elementary hallucinations that may mimic psychotic features when seen by family practitioner.^[2] The emphasis may then be seen on just the patients symptomatology and the etiology may get a backseat for an intracranial space occupying lesion as the probable cause as seen in this case because of other associated features the patient presented with besides having an acoustic shwanomma.^[3]

CASE REPORT

A 75 year old lady presented to the psychiatric OPD with features of prominent memory loss, difficulty in hearing in right ear with strange noises in forms of bells ringing in the affected ear and gait disturbance for last 6 years. She had been examined earlier by family physician who advised a hearing aid and some medicines for giddiness.

After few weeks patient developed headache with elementary hallucinations occurring in the form of hearing bells ringing initially and as the weeks passed she was unable to sleep as the intensity and frequency of the sound kept increasing. She would at times hear noises of birds or some strange whisting sounds that kept her awake. As the condition of her hearing loss worsened in right ear, patient noted subjectively that she was unable to recall names of people she knew well.

The memory loss as reported by the relatives only led to her mounting apprehension as she had difficulty in her sleep and would demand sleeping pills to fall asleep. She was noted to be remaining aloof, sad, having prominent guilt ideas as to how she had slowly become dependent on her family members. She received antihistaminics for her giddiness and her hearing aid was kept in place and she was put on sedatives.

When she was seen by another practitioner who noted her to be sad and preoccupied with sleep deprivation, she was prescribed antidepressants, antipsychotics with some cognitive enhancers for her memory loss. However no improvement in her clinical status was noted.

After 7 years of her condition never improving she was finally brought to our tertiary care centre with unilateral memory loss, worsening elementary hallucinations,

memory loss with features of anxiety and depression. She had a hearing aid and appeared forlorn.

Initial examination revealed no features of syndromal depression or anxiety. She was kempt and had adequate judgement and insight into her problem. No abnormal behavior was visible. MMSE score was 23 and Beck Depression Inventory was 11. PGI BBD done revealed mild cognitive loss. She accepted hearing noises that were elementary in nature. Sleep and appetite were reduced.

Initial hematological and biochemical parameters revealed no abnormality. MRI brain revealed a large right sided acoustic schwannoma measuring 26mm by 18 mm in CP angle. She was taken off the antipsychotics and sedatives. A neurological consult and ENT consultation suggested that the tumor be removed electively.

4 weeks after tumor removal, patient announced that she had no longer features of ataxia or hearing loss and the elementary hallucinations had stopped altogether. Patient's cognition showed steady improvement as the sensory stimuli from her sound ear had improved and she was able to be more receptive to her surroundings.

After 6 months of follow-up, the individual remained asymptomatic and there were no incidents of ataxia, facial numbness or headache. There was no evidence of prominent depressive cognitions.

DISCUSSION

As seen in this case, the symptoms were markedly present on the background of an intracranial lesion which was producing the symptoms for which the patient was wrongfully been getting antipsychotics and antihistaminics. The symptoms subsided when tumor removal was done. This case highlights the importance of complete and thorough evaluation of patient with both neuroimaging and having high index of suspicion for non psychiatric causes for hallucination and ataxia with cognitive loss as was seen in this case.

Acoustic schwannoma are curable conditions which can respond with timely intracranial approach and removal.^[4] When sizes of these schwannomas are allowed to increase then due to the pressure effects on the auditory nerve it results not only in permanent sensori neural hearing loss but also disturbing tinnitus and at times elementary hallucinations maybe experienced by the patient.^[5]

Acoustic schwannoma are commonly seen in the CP angle area but production of symptoms mimicking psychosis or dementia are not that commonly seen.^[6]

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