CASE No 8

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A 61-year-old male presented with a 2 week history of new onset severe frontal headaches, dizziness, intermittent loss of hearing, staring spells, decreased appetite and fatigue. The patient had no significant past personal or family history. Neurological examination was unremarkable. Magnetic resonance imaging (MRI) showed a heterogeneously enhancing solid mass (3.9 x 3.7 x 3.4 cm) in the anterior left temporal lobe associated with extensive peritumoral edema, as well as a left-to-right midline shift (0.8 cm) and subfalcine and uncal herniation. Furthermore, a subacute subdural hematoma was overlying the mass. The patient underwent a left craniotomy using a pterional incision. Gross total resection of the mass was achieved. The mass was moderately vascular, fungating, and while superficially had a well-defined plane, melted with white matter deep to the cerebral cortex. Post-operative recovery was uneventful and the patient was discharged home 3 days following surgery.

Materials submitted: H&E stained representative section

Questions: Diagnosis? Pathogenesis?