

Fig. 14a

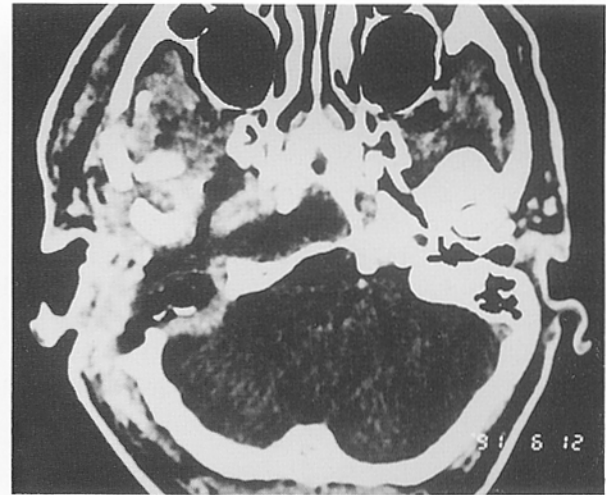


Fig. 16

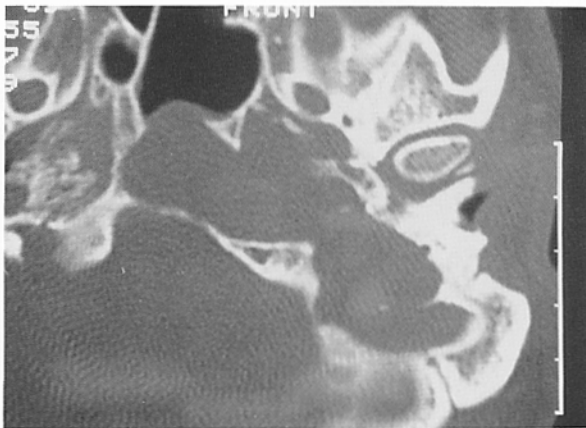


Fig. 15



Fig. 17

sis. Rhinoscopy showed the presence of a nasopharyngeal swelling that extended into the left nasal cavity. During surgery, the tumor invaded the infratemporal fossa, the pterygopalatine fossa, extending to the sphenoid sinus, posterior ethmoid cells and nasal cavities.

Figure 18. MRI, coronal view, showing lateral extension of the tumoral mass to the infratemporal fossa. After embolization, the tumor was removed using a type C infratemporal fossa approach.

Figure 19. Postoperative CT scan, axial view, showing complete tumor removal and obliteration of the surgical cavity with rotated temporalis muscle. Until now (2 years of follow up) no recurrence is evident.

Case 4

Figure 20. CT scan, axial view, of a giant trigeminal neurinoma. The patient, a 70 years old woman complained of right esophthalmus and diplopia of 2 years duration. One year before diagnosis right ear fullness appeared. Right nasal obstruction and right zygomatic and parietal paresthesia were also present. Otoscopy revealed middle ear effusion. Rhinoscopy showed a

nonpulsatile mass in the middle meatus protruding towards the nasal fossa. A biopsy was performed and the diagnosis of trigeminal neurinoma was achieved. The tumor extended from the maxillary sinus to the ethmoid, the sphenoid, cavernous sinus and infratemporal fossa, involving the retro- and infraorbital region.

Figure 21. CT scan, coronal view, of the previous case. The tumor occupies the nasal cavity, the ethmoid and the maxillary sinus invading the orbit.

Figure 22. MRI, axial view. The tumor extends to the carotid and the cavernous sinus. A type D infra-temporal fossa approach was performed for total removal of the tumor and for reconstruction of the floor and the lateral wall of the orbit. A postoperative temporary paresis of the oculomotor nerves was present (due to the packing of the cavernous sinus with Surgicel) that recovered in few months.