Calcifying Pseudoneoplasm of the Neuraxis in the Posterior Fossa: A Case Report and Literature Review

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Abstract
Calcifying pseudoneoplasm of the neuraxis are rare fibro-osseous lesions that can occur throughout the central nervous system. This paper reports one case of this lesion within the posterior fossa and contains a literature review of all cases documented within the posterior fossa to date. A 53-year-old female patient with a history of epiphora, facial irritation, and headaches was found to have a mass centered in the posterior fossa. The patient underwent surgical resection for removal of the mass. Upon review by pathology, the final diagnosis was consistent with calcifying pseudoneoplasm of the neuraxis.

Categories: Pathology, Neurosurgery
Keywords: rare, central nervous system, posterior fossa, capnon, calcifying pseudoneoplasm of the neuraxis

Introduction
Calcifying pseudoneoplasm of the neuraxis (CAPNON) are rare fibro-osseous lesions first described by Rhodes and Davis in 1978 [1]. Originally suspected to be neoplastic [1] or metastatic [2] in origin, recent data suggests that the granulomatous inflammation present in many CAPNONs reflects a reactive proliferative pathogenesis [3]. Although CAPNON lesions have been most commonly identified in the supratentorial regions of the CNS, they can occur throughout the central nervous system (CNS) with cases documented in the brain parenchyma, dura, and spine [3-10]. Cranial lesions most commonly present with headaches and seizures [4]. Notably, radiographic diagnosis remains difficult as these rare lesions are often mistaken for other intracranial etiologies given their appearance on radiologic analyses. Thus, tissue biopsy is required for accurate diagnosis.

CAPNON affects patients between the ages of 30 and 64 years with a slight predilection for males. Little is otherwise known regarding this rare lesion. Surgical resection remains the current mainstay of treatment for symptomatic CAPNONs for diagnostic and therapeutic purposes. Here we present a case of a posterior fossa CAPNON treated with surgical resection and review the literature on this rare disease.

Case Presentation
A 53-year-old female presented with a 4-year history of epiphora of the right eye, facial irritation, and remote ipsilateral brief headaches with a non-contributory past medical history. This irritation progressed to a persistent burning sensation along with episodes of shooting pain of the right face that were refractory to gabapentin. Persistence of the patient’s pain prompted an MRI brain that revealed a predominantly T1 and T2 hypointense extra-axial mass (Figures 1A-1E) and non-contrast CT head that demonstrated a predominately calcified mass (Figure 1F) centered in the posterior fossa on the right at the level of the lateral cerebellomedullary cistern.
FIGURE 1: Preoperative imaging of a right posterior fossa calcifying pseudoneoplasm of the neuraxis (CAPNON).

Axial T2 (A), T1 (B), and GRE (C)-weighted MRI of the brain demonstrates a predominantly T1 and T2 hypointense extra-axial mass centered in the posterior fossa on the right at the level of the lateral cerebellomedullary cistern. There is mass effect and T2 hyperintensity in the medulla compatible with vasogenic edema (arrow, A). There is blooming artifact on GRE (C) compatible with calcification. Axial (D) and coronal (E) post contrast T1-weighted images demonstrate heterogeneous enhancement. Axial non-contrast CT head demonstrates a predominantly calcified mass centered in the posterior fossa in the right lateral cerebellomedullary cistern (F).

Upon completion of imaging, management options were discussed, including a recommendation for surgical resection, but the patient opted for further monitoring of the lesion. The patient returned after two months with increased frequency and severity headaches and new-onset numbness in her right thumb and toes. Follow-up MR brain scan revealed no appreciable interval progression in size, enhancing characteristics or localized mass effect associated with the right posterior fossa enhancing mass. However, due to progression of symptoms, the patient ultimately decided to proceed with surgical intervention.

A far-right lateral approach was performed for suboccipital craniectomy and C1 laminectomy with electrophysiological monitoring of somatosensory and motor potentials of cranial nerves. The ipsilateral vertebral artery was identified and preserved. The dura was opened to expose the lateral cerebellum and then extended down to the level of C1 to expose the upper cervical spinal cord. A firm tumor outside the brainstem was encountered shortly after dissection in the cerebellopontine (CP) angle was initiated. A reduction in sensory potential response for the right arm was noted after successful removal of tumor tissue. No further manipulation was carried out in the brain stem region. The remainder of the extra-axial portion of the tumor, originating from the dura, was removed subsequently. Following the operation, the resected specimen was submitted to pathology for review.

Grossly, the specimen consisted of multiple fragments of tan-pink to white partially calcified tissue measuring 2.0 × 1.7 × 0.7 cm in aggregate. Histology examination showed extensive calcifications with a reactive proliferation of spindled mesenchymal cells (Figure 2), giant cell reaction, chondromyxoid matrix, ossification, and focal florid proliferation of spindle (piloid) astrocytes.
Differential diagnoses included meningioma, schwannoma, and glial neoplasm with calcifications. The spindle cells were negative for immune stains glial fibrillary acidic protein (GFAP) ruling out a glial neoplasm, epithelial membrane antigen (EMA), and progesterone receptor (PR) ruling out meningioma, and S100 excluding neural origin. The final diagnosis was consistent with CAPNON. Though CAPNONs have rarely been reported in association with low-grade gliomas and meningiomas, the astrocytic component, in this case, was interpreted as reactive as they did not label for BRAF V600 E and there was no intra-axial mass radiologically.

In the immediate postoperative course, the patient was neurologically stable with persistent right-sided facial, arm, and leg numbness. Postoperative MRI showed no evidence of residual posterior fossa mass (Figure 3).

She developed right-sided neuropathic pain a week later and was started on Lyrica and advised to start Kessler Rehab. At six-month follow-up, the patient showed residual weakness, proprioceptive deficit, and numbness of the right arm and leg. Additionally, she experienced loss of left-sided temperature sensation. Patient reported continued guided physical therapy and the reintroduction of preoperative activities.

**Discussion**

CAPNONs remain rare and mysterious entities despite an expanding body of literature characterizing their clinicopathologic features. CAPNON typically affects individuals with a median age of 47 years, although lesions have been identified in children as young as 2 years and adults as old as 83 years [4]. With little sex predilection, there is a slight male predominance (53.4%) [4]. Of the cases reported, 59.2% occur cranially and 40.8% occur in the spine. With cranial occurrence, 62% arise supratentorial with 33% occurring in the posterior fossa [4].
CAPNON presents with ambiguous symptoms mostly related to the location where it arises. The most common presenting symptoms with cranial CAPNON include headaches, neck pain, and/or seizures [3,4,11-19]. In cases limited to the spine, over half of patients report axial pain in the region of the lesion [4]. CAPNON in the posterior fossa often presents with cranial nerve defects due to the proximity of critical neurovascular structures [5,6,11-15,18,20-26]. Most commonly CN XI is affected, but these lesions affect a wide range of cranial nerves due to mass effect. These deficits can range from hoarseness and decreased hearing to gait disturbances and nerve paralysis, as outlined in Table 1.

Because clinical presentations are nonspecific, it is important to understand the imaging and lab diagnostics that can help identify these lesions.

<table>
<thead>
<tr>
<th>Case</th>
<th>Source</th>
<th>Year</th>
<th>Age</th>
<th>Sex</th>
<th>Location</th>
<th>Presenting symptoms</th>
<th>Cranial nerve deficits</th>
<th>Initial treatment</th>
<th>Complications and adoptions</th>
<th>Progression</th>
<th>Follow-up (months)</th>
<th>Adjacent treatment</th>
<th>Overall survival</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Genter et al. [20]</td>
<td>1989</td>
<td>44</td>
<td>M</td>
<td>Right trigeminal ganglion</td>
<td>R stringing facial pain, in all three divisions of CN V</td>
<td>None</td>
<td>Gross-total resection</td>
<td>Mandibular division of the fifth nerve was sacrificed during surgery</td>
<td>No recurrence</td>
<td>132</td>
<td>None</td>
<td>N/R</td>
</tr>
<tr>
<td>2</td>
<td>Bertoni et al. [3]</td>
<td>1990</td>
<td>40</td>
<td>M</td>
<td>Left cerebellopontine angle, jugular foramen, vertebral canal, mesopharynx</td>
<td>Headache, hoarseness, jugular foramen syndrome</td>
<td>CN XI, X, and XII paraplegia involving the jugular foramen</td>
<td>Subtotal resection</td>
<td>None</td>
<td>Disease Recurrence 3 years after initial resection</td>
<td>None</td>
<td>156</td>
<td>Second debulking surgery</td>
</tr>
<tr>
<td>3</td>
<td>Bartoli et al. [12]</td>
<td>1986</td>
<td>50</td>
<td>M</td>
<td>Foramen magnum</td>
<td>R neck and occipital area pain</td>
<td>None</td>
<td>Subtotal resection</td>
<td>None</td>
<td>No recurrence</td>
<td>42</td>
<td>None</td>
<td>N/R</td>
</tr>
<tr>
<td>4</td>
<td>48</td>
<td>1990</td>
<td>40</td>
<td>M</td>
<td>Right carotid, spinal accessory nerve involvement</td>
<td>R XI nerve paralysis</td>
<td>R XI nerve paralysis</td>
<td>Gross-total resection</td>
<td>None</td>
<td>No recurrence</td>
<td>228</td>
<td>None</td>
<td>N/R</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>1990</td>
<td>58</td>
<td>M</td>
<td>Jugular foramen</td>
<td>Hoarseness, decreased hearing</td>
<td>None</td>
<td>Intracranial excision</td>
<td>None</td>
<td>No recurrence</td>
<td>N/A</td>
<td>N/R</td>
<td>N/R</td>
</tr>
<tr>
<td>6</td>
<td>59</td>
<td>1990</td>
<td>40</td>
<td>F</td>
<td>Foramen magnum</td>
<td>Neck pain, stuffy gait, decreased L hand sensation</td>
<td>None</td>
<td>Gross-total resection</td>
<td>None</td>
<td>No recurrence (stable after surgery with a stable gait disturbance)</td>
<td>24</td>
<td>None</td>
<td>N/R</td>
</tr>
<tr>
<td>7</td>
<td>Rodriguez et al. [21]</td>
<td>2006</td>
<td>67</td>
<td>F</td>
<td>Right cerebellar hemisphere (intracerebral)</td>
<td>Slightly brisk reflexes, (CAPNON was revealed incidentally)</td>
<td>None</td>
<td>Gross-total resection of the lesion and adjacent ependymoma</td>
<td>None</td>
<td>N/R</td>
<td>N/R</td>
<td>N/R</td>
<td>N/R</td>
</tr>
<tr>
<td>8</td>
<td>Costello et al. [20]</td>
<td>2011</td>
<td>53</td>
<td>M</td>
<td>Foramen magnum</td>
<td>L facial pain, L leg monoparesis, gait disturbance</td>
<td>None</td>
<td>Gross-total resection</td>
<td>None</td>
<td>No recurrence</td>
<td>N/R</td>
<td>N/R</td>
<td>N/R</td>
</tr>
<tr>
<td>9</td>
<td>Hodges et al. [11]</td>
<td>2011</td>
<td>34</td>
<td>M</td>
<td>Left posterior fossa, left cisis (mass effect on the brainstem and cerebellum)</td>
<td>Headache, tinnitus, fatigue, dizziness, blurry vision, L tongue deviation, tongue atrophy, L arm atrophy</td>
<td>CN XII paraplegia (hypoglossal palsy)</td>
<td>Subtotal resection</td>
<td>None</td>
<td>No recurrence (stable after surgery)</td>
<td>7</td>
<td>None</td>
<td>N/R</td>
</tr>
<tr>
<td>10</td>
<td>Muscio et al. [13]</td>
<td>2012</td>
<td>55</td>
<td>F</td>
<td>Right foramen magnum</td>
<td>Neck pain and hypesthesia, hypesthesia the right hemiarea</td>
<td>None</td>
<td>Gross-total resection</td>
<td>None</td>
<td>No recurrence (stable after surgery)</td>
<td>14</td>
<td>None</td>
<td>N/R</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ID</th>
<th>First Name</th>
<th>Last Name</th>
<th>Year</th>
<th>Age</th>
<th>Gender</th>
<th>Site</th>
<th>Symptoms</th>
<th>Surgery Type</th>
<th>Complications</th>
<th>Recurrence</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Kerr et al.</td>
<td>2013</td>
<td>56</td>
<td>M</td>
<td>Cerebellomedullary angle (mass effect on the brainstem)</td>
<td>Suboccipital approach</td>
<td>None</td>
<td>Subtotal resection</td>
<td>Lower cranial nerves and the brainstem; however, the portion was not resected in order to prevent damage</td>
<td>Disease recurrence free (dysphagia and hoarseness after surgery)</td>
<td>6</td>
</tr>
<tr>
<td>12</td>
<td>Faith et al.</td>
<td>2014</td>
<td>59</td>
<td>F</td>
<td>Cerebellomedullary cistern</td>
<td>Headaches</td>
<td>None</td>
<td>Gross-total resection</td>
<td>None</td>
<td>NR</td>
<td>6</td>
</tr>
<tr>
<td>13</td>
<td>Lu et al.</td>
<td>2015</td>
<td>N/A</td>
<td>N/A</td>
<td>Right cerebellomedullary angle</td>
<td>Suboccipital approach</td>
<td>None</td>
<td>Gross-total resection</td>
<td>None</td>
<td>NR</td>
<td>NR</td>
</tr>
<tr>
<td>14</td>
<td>Wilke et al.</td>
<td>2015</td>
<td>29</td>
<td>M</td>
<td>Right foramen magnum</td>
<td>Headaches, limited L rotation of the head</td>
<td>None</td>
<td>Gross-total resection</td>
<td>None</td>
<td>No recurrence (stable after surgery)</td>
<td>24</td>
</tr>
<tr>
<td>15</td>
<td>Ghaemi et al.</td>
<td>2016</td>
<td>18</td>
<td>M</td>
<td>Interpeduncular cistern</td>
<td>Headaches, intermittent diplopia, limited adduction of the eye, sluggish L pupillary response</td>
<td>Craniopharyngioma</td>
<td>Resection (Unspecified)</td>
<td>None</td>
<td>None</td>
<td>N/R (Experienced persisting diplopia after surgery)</td>
</tr>
<tr>
<td>16</td>
<td>Alshareef et al.</td>
<td>2016</td>
<td>59</td>
<td>F</td>
<td>Right cerebellomedullary angle, foramen magnum, intradural, extramedullary</td>
<td>Gait instability, balance difficulty, burning sensation of R face, itching sensation of R eye with watering, R deviation of palate</td>
<td>None</td>
<td>Subtotal resection</td>
<td>None</td>
<td>Disease recurrence free (stable after surgery, symptoms completely resolved 2 months after treatment)</td>
<td>12</td>
</tr>
<tr>
<td>17</td>
<td>Brasileñas et al.</td>
<td>2017</td>
<td>67</td>
<td>F</td>
<td>Brain stem, frontal lobe</td>
<td>Recurrent focal seizures with impaired consciousness</td>
<td>None</td>
<td>Grostotal resection of the frontal lobe lesion (the brainstem lesion was not removed)</td>
<td>None</td>
<td>No recurrence and no evident change or growth in the brainstem lesion (seizure-free after surgery)</td>
<td>4</td>
</tr>
<tr>
<td>18</td>
<td>Koo et al.</td>
<td>2018</td>
<td>39</td>
<td>F</td>
<td>Right jugular foramen, region of the pars nervosa, right petrous apex, internal auditory canal</td>
<td>Right hearing loss with intrusive right-side tinnitus</td>
<td>None</td>
<td>Gross-total resection</td>
<td>The labyrinth was resected in order to expose the lesion causing right-sided hearing loss</td>
<td>N/R right-sided complete hearing loss after surgery</td>
<td>NR</td>
</tr>
<tr>
<td>19</td>
<td>Pakar et al.</td>
<td>2018</td>
<td>58</td>
<td>F</td>
<td>Left lateral cerebellomedullary junction</td>
<td>Recurrent dizziness</td>
<td>None</td>
<td>Total resection</td>
<td>None</td>
<td>Dizziness resolved 2 months post-surgery. No recurrence after 12 months follow-up</td>
<td>12</td>
</tr>
<tr>
<td>20</td>
<td>Yang et al.</td>
<td>2020</td>
<td>57</td>
<td>M</td>
<td>Right cerebellopontine angle</td>
<td>Hoarseness, dysphagia, gait imbalance, gait ataxia, R cranial nerve IX, X, XI, and XII palsies</td>
<td>CN IX, X, XI, and XII palsy</td>
<td>Subtotal resection</td>
<td>Only the part of the lesion compressing the medulla was removed to avoid worsening cranial neuropathies</td>
<td>Slight disease progression, however, the patient remained clinically well overall (stable after surgery with persisting cranial neuropathies and improvement of ataxia)</td>
<td>15</td>
</tr>
<tr>
<td>21</td>
<td>Yan et al.</td>
<td>2021</td>
<td>44</td>
<td>F</td>
<td>Right posterior CP skull base, clivus, jugular foramen</td>
<td>Occipital headaches, neck pain</td>
<td>None</td>
<td>Subtotal resection</td>
<td>None</td>
<td>Neck pain 2 months post-resection</td>
<td>12</td>
</tr>
</tbody>
</table>
When arising at the skull base, the radiographic differential associated with a CAPNON diagnosis has included chordoma, chordosarcoma, vestibular schwannoma, and meningioma [3]. Despite this, a uniform T2 hypointensity without enhancement can help to rule out all but meningiomas [5]. This leaves calcified meningioma as the most common diagnosis that is still confused with CAPNON [5,6,15,20]. Absence of a dural tail can help separate CAPNON from calcified meningioma [24], but it can sometimes be difficult to definitively identify CAPNON from imaging alone.

Histopathologically, CAPNON displays distinctive histology that commonly feature: chondromyxoid regions, palisading spindle cells, fibrous stroma, calcifications, and psammoma bodies [4,12,24]. This helps differentiate these rare lesions from more common neoplasms on the differential.

Symptomatic CAPNON remain benign lesions and symptoms arise from mass effect on critical neurovascular structures. Evidence supports safe, maximal resection in symptomatic patients. These data can be extrapolated to posterior fossa CAPNON where published reports have pursued gross total or subtotal resection was performed to relieve symptoms (Table 1). Twelve of the 22 identified cases listed had no disease recurrence at median follow-up of 14 months [3,6,11-14,17,19,20,22]. In seven of the 20 cases, recurrence was not reported, or patients were clinically improved with minimal recurrence over the duration of follow-up [3,5,15,16,18,21,25,24]. Only one of the reported cases had a recurrence at three years that required a second debulking surgery [3]. In all of the cases covered in this review, resection led to either stabilization of symptoms after surgery, or complete relief in some cases with only three recurrences over the average observation period of 37 months. No lesions required adjuvant treatment with chemotherapy or radiation. As a result, the efficacy of radiation therapy or radiosurgery to manage recurrences remains unknown. While data are limited by duration of published observations, safe maximal resection appears to be a safe and effective means of management of symptomatic disease. Resection however is not without complications. Postoperative deficits were identified in 20% of patients in posterior-fossa cases which likely reflect the proximity of symptomatic lesions to critical neurovascular structures and difficulties with resection of these calcified lesions. Given the benign nature of the disease and documented lack of recurrences following resection, preservation of neurologic function remains paramount to any surgical decision making.

Conclusions
CAPNON is a rare nonneoplastic lesion that can manifest across the entire CNS. The paucity of information on CAPNON coupled with its radiographically nonspecific features makes diagnosis a challenge, often leading to misdiagnoses as other types of neoplastic lesions. As such, increasing awareness of this lesion can help avoid unnecessary and harmful management.

Additional Information

Disclosures

Human subjects: Consent was obtained or waived by all participants in this study. Conflicts of interest: In compliance with the ICMJE uniform disclosure form, all authors declare the following: Payment/services info: All authors have declared that no financial support was received from any organization for the submitted work. Financial relationships: All authors have declared that they have no financial relationships at present or within the previous three years with any organizations that might have an interest in the submitted work. Other relationships: All authors have declared that there are no other relationships or activities that could appear to have influenced the submitted work.

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case report and a literature review. World Neurosurg. 2016, 85:364.e11-e8. 10.1016/j.wneu.2015.08.055