

Intracranial plasmacytoma mimicking meningioma

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A 45-year-old man presented with headache of 2 months. Magnetic resonance imaging brain showed a well-defined extraaxial left parietal lesion of size 7.5 × 7.5 × 4.5 cm causing compression and buckling of left parietal cortex [Figure 1]. Patient underwent excision of left parietal mass suspecting meningioma.

Histopathology showed plasmacytoma with CD 138 positivity and lambda light chain restriction. Myeloma work up was negative. Patient received radiotherapy of 46 Gy in 23 fractions to primary site and continues to be in remission.

Primary extramedullary plasmacytomas are uncommon, accounting for 4% of all plasma cell tumors, mainly arising in the head and neck, particularly the upper aerodigestive tract. Plasmacytoma is referred to a single lesion without any evidence of multiple myeloma in any other part of the body. Plasmacytoma is a myelomatous mass that may be solitary, in combination with multiple myeloma or may progress to a generalized disease. The craniocerebral lesion can arise from the skull, dura or rarely, the brain.

Solitary plasmacytoma of the skull without signs of systemic myelomatosis is rare and lacks neurological symptoms, except in cases of brain compression.^[1]

Plasmacytoma is a highly radiosensitive tumor. All cases of solitary plasmacytomas of the calvarium

reported in the literature have been treated by surgery and radiotherapy. When solitary plasmacytoma affects other bones, it tends to disseminate in later years; whereas the cranial lesion has a better prognosis if a strict criteria is employed in making the diagnosis. There are reports of multiple myeloma that developed within a period of 1-23 years after radical removal of a solitary plasmacytoma.^[2] The risk is greater for skull base plasmacytoma.

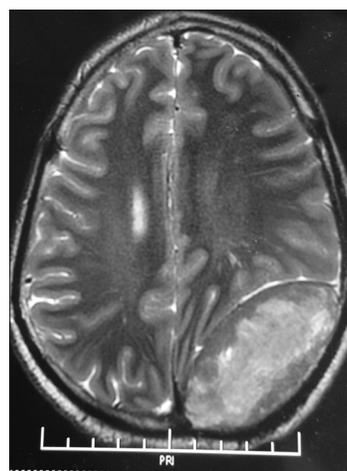


Figure 1: Magnetic resonance imaging brain of a patient with plasmacytoma showing a well-defined extraaxial left parietal lesion, causing compression and buckling of left parietal cortex

References

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