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A RARE CASE OF GARCIN SYNDROME

General Medicine

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ABSTRACT

This is a case of 54-year male with complaints of headache, dysphagia, double vision, ptosis, with decreased sensations over face. Clinical examination showed involvement of right 3rd, 4th, 5th, 6th, 7th, 9th, 10th cranial nerves without motor and sensory involvement suggesting Garcin syndrome. On further imaging was found to have base of skull tumor likely Chordoma.

KEYWORDS

Garcin Syndrome, Chordoma, Cranial nerve palsy.

INTRODUCTION

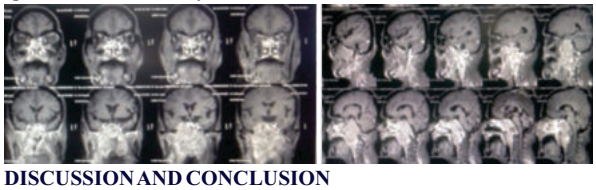
Garcin syndrome consists of progressive unilateral palsies of most of the cranial nerves without sensory, motor, long tract signs, and intracranial hypertension. It can be caused by primary tumors of skull base [1] or intracranial metastasis. It was first reported by Garcin in 1926. [2]

CASE PRESENTATION

A 54-year-old male presented with complaints of headache since 1 month, difficulty in swallowing since 20 days which is sudden in onset more for liquids, difficulty in manipulating food inside mouth, followed by drooling of saliva from left side of mouth and deviation of angle of mouth to right side, hoarseness of voice, reduced sensation on right side of face while washing face, double vision on looking on right side, drooping of eye lid on right side since 10 days. No history of involvement of other cranial nerves, weakness of limbs, reduced sensations over the rest of the body, bowel bladder and autonomic involvement. On examination– higher mental functions were normal. Patient was oriented to time, place and person. Speech- flaccid dysarthria was present with comprehension, fluency, repetition, naming, reading, writing being normal.

Cranial nerves	Right	Left
Olfactory	Normal	Normal
Optic nerve	Normal	Normal
Occulomotor, trochlear abducens		
Eyelid	Ptosis present	Absent
Extraocular movements	Movements restricted	Abduction
Pupils	Mid dilated not reacting light	restricted Normal
Direct light reflex	Absent	Present
Consensual reflex	Absent	Present
Accomodation reflex	Absent	Present
Trigeminal nerve		
Sensory	Decreased	Present
Motor	Weak	Normal
Jaw deviated towards right side		
Facial nerve		
Deviation angle mouth to left		
Ability to raise the eyebrows	Absent	Present
Ability to close eyes tightly	Absent	Present
Taste sensation over anterior 2/3 of tongue	Lost	Intact
Vestibular nerve	Normal	Normal
Glossopharyngeal and vagus Palatal asymmetry On phonation	Uvula deviated to left Decreased palatal movements on right	
Gag reflex	Absent	Present
Spinal accessory	Normal	Normal
Hypoglossal nerve	No atrophy, fasciculation. No deviation of tongue.	

Motor, Sensory, Autonomic Nervous System was normal. Other system examination was normal. Mri Brain report: Heterogeneously enhancing large lesion in clivus extending inferiorly into nasopharynx, anteriorly into sphenoid sinus, superiorly into right cavernous sinus and petrous apex on both sides. It is encasing right carotid artery with evidence of erosion of clivus, posterior wall of sphenoid sinus, petrous apex on both sides likely Chordoma.



DISCUSSION AND CONCLUSION

Many reports of Garcin syndrome originate from a bone invading malignant tumor such as a tumor of the nucleus skull base and nasopharynx or metastasis from remote organ. There are Collet-Sicard syndrome, cavernous sinus syndrome, Tolosa-Hunt syndrome which have similar clinical findings with Garcin syndrome, but these syndromes are paralysis of a certain cranial nerves only. Chordoma which is a locally invasive and slow growing tumor that arises from remnants of notochord, the most common location being sacrococcygeal region (50%), followed by 35% in spheno-occipital region, and the remaining chordomas (about 10% to 15%) located along the length of spine. [3] Chordomas cause cranial nerve compression at their exit. Treatment is usually by surgical resection followed by high dose conformal radiation therapy i.e., Proton beam radiation, With an overall 5-year survival rate of 50%.[3-4]

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