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A rare case report of *Arbuda* (*schwannoma*)

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Abstract:

In *Ayurveda Sushruta* explained the concept of *Arbuda* (Tumour) in *Sushrut Samhita Nidansthan*. *Arbuda* is developed anywhere in the body due to *mamsa dushti* by vitiated *dosha*. We are reporting an unusual case of *Arbuda* at *Greeva* region (Ancient Schwannoma at posterior triangle of neck) that remains asymptomatic for many years.

Schwannoma is a tumour that develops from *schwann* cells (Nerve sheath). The diagnosis was based on Histopathology report. Surgical removal is usually curative. The asymptomatic character of the *tumour* and slow evolution remain an essential factor in diagnosis delays. This *tumour* has a good prognosis with low recurrence rate and potential for malignant transformation.

INTRODUCTION:

गात्रप्रदेशे क्वचिदेव दोषाः सम्मूर्च्छिता मांसमभिप्रदूष्य ।
वृत्तं स्थिर मन्दरुजं महान्तमनल्पमूलं चिरवृध्यपाकम ॥
कुर्वन्ति मांसोपचयं तु शोफं तदर्बुदं शास्त्रविदो वदन्ति ।
वातेन पित्तेन कफेन चापि रक्तेन मांसेन च मेदसा च ॥
तज्जायते तस्य च लक्षणानि ग्रन्थेः समानानि सदा भवन्ति ॥[4]

सु.नि. ११/१३, १४, १५

Aggravated *doshas* causing vitiation of muscle tissue, produce muscular swelling, anywhere in the body which is round, static (immovable) with mild pain , big size, deep rooted growing slowly and not ripening(forming pus) this disease is called as *Arbuda* (tumour)[5]. *Sushruta* explained 6 types of *Arbuda* in *Sushruta Samhita Nidansthan* which are as follows[6] –

1) ***Vataja Arbuda***
2) ***Pittaja Arbuda***
3) ***Kaphaja Arbuda***
4) ***Raktaja Arbuda***
5) ***Mamsaja Arbuda***
6) ***Medoja Arbuda***

Sharkara Arbuda also one type which one described in *Kshudra roga* by *Sushruta*. *Sushruta* described *chikitsa* (treatment) of *Arbuda* in *Sushruta Samahita Cikitsasthan* 18th according to types.

Type of *Arbuda*	***Bahya Chikitsa***	***Panchakarma***	***Abhyantara Chikitsa***
Vataja	***Swedana*** - *Karkaruk, Ervaruk, narikel, priyaladi siddha dugadha* ***Upanah*** - *mamsa, veswar* ***Nadi sweda*** - *uparokta aushadhisiddha kwatha*	***Raktamokshan – Shrunga***	*Vatghna dravya kwatha, dudha va kanji siddha shatpaki trivrutta sneha pan.*
Pittaja	***Swedana*** – *Mrudu , Upanah. Udumbara, shak , goji patrane arbuda gharshana tatpaschat sarjaras , priyangu, lodhradi churna + madhu* yacha *lepa.*	***Virechana***	*Shyama, girivha, anjanki, draksha, saptalika rasa , klitaka kalka samyaka siddha ghruta pan.*
Kaphaja	***Lepa-*** *raktamokshan paschat urdhwa adho doshahara dravya, ksharyukta gomutra.*	***Vamana, Raktamokshan - Alabu***	

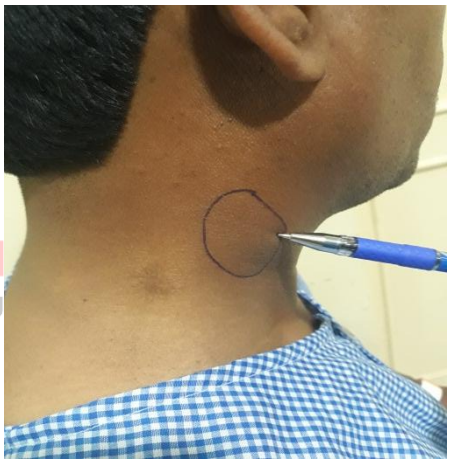
According to *Sushruta Raktaja* and *Mamsaja arbuda* are *Asadhya* .

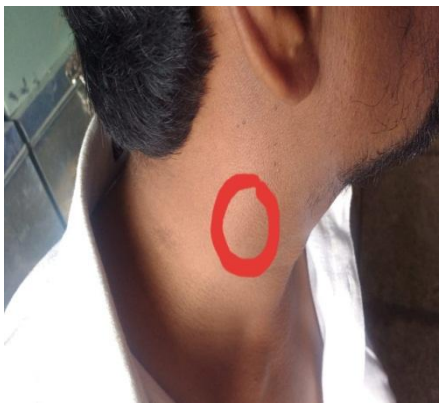
Medoja arbuda – *Swedana, vidarana, sivana;*
Lepa - haridra , gruhdhum, lodhra, manshila, hartal churna + madhu
Karanja tail application after *vrana shuddhi*.
Shesha dosha in *arbuda - Uchhedana*

Schhwannoma is the benign tumour of the peripheral nerves, also referred as neurilemomas or *neurinomas*(.[1]) It derived from *schwann* cells. *Schwannomas* are white to grey, firm, circumscribed well capsulated lesions rarely causing neurological deficit.[(3)] Commonly appear as solitary lesions, occasionally there can be multiple lesions or associated with neurofibromatosis. The commonest site is Acoustic nerve (*vestibulocochlear* nerve). *Accoustic neuromas* account for 7.5% of intracranial *neoplasms*.[(2)] The tumor usually seen as painless, asymptomatic mass , hence the risk of diagnostic delay. Pain, *parasthesis* and motor weakness may occur when *tumour* reaches sufficient size. MRI (Magnetic Resonance Imaging), CT Scan (Computer Tomography) and USG (*Ultrasonography*) are helpful in diagnosis. Surgical removal is usually curative. We report an unusual case of ancient schwannoma whose diagnosis was made after many years of appearance of swelling.

CASE REPORT:

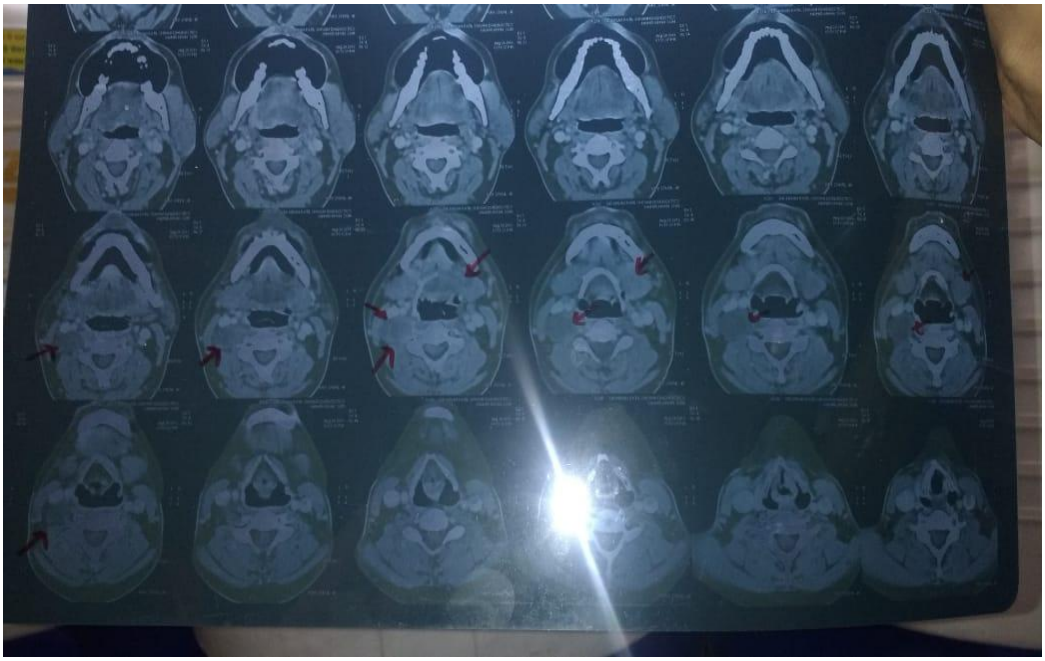
A 40 years old man presented with complaints of mass at right posterior triangle of neck since childhood. On clinical examination there was a painless solid mass of size approximately 3×2×2 cm, little sensitive to pressure, firmly attached to deeper tissues. Patient complaints of right shoulder joint pain. The pain was not severe enough to disturb sleep or to hinder physical activities. The patient reported that he first palpated the nodule 20 years ago that grew up very slowly to the current size. There was a no family history of neurofibromatosis and no associated clinical features. Patient had no history of any major illness and surgical history.





USG showed that a lesion of size approximately 42× 23× 32mm in right posterior triangle of neck mostly suggestive of the *Lymphangioma* is high other tare possibility of nerve sheath

tumour. CT Scan PNS and Neck region showed that, cystic soft tissue mass seen in right posterior triangle region of size approximately 24 × 22× 23 mm. it is located posterior to the carotid sheath and underneath the right *sterno* mastoid muscle. It is well encapsulated. The central HU value is 40 to 45. The walls and internal septae shows intense enhancement on post contrast study. Patient was operated for excision of *tumour* under General *anaesthesia* after physician fitness surgical exploration brought to light an encapsulated tumour firmly attached to Spinal Accessory Nerve, which was easily respected. After surgery the sample sent for histopathology examination. HPE report showed - excised swelling *Schwannoma*. At 12 days follow up wound healed well with no pain/ sensory/ motor deficit.



DISCUSSION:

Schwannomas are rare peripheral nerve *tumours*; about 1/3rd occur in head and neck region. Clinically they present as asymptomatic slow growing lateral neck masses that can be palpated along the medial border of the *sternocleidomastoid* muscle. Preoperative diagnosis of *Schwannoma* is difficult because most of *Schwannoma* do not present with neurological deficit[7] and several D/D for tumour of neck may be considered, including Lipoma, Branchial cleft cyst, Malignant Lymphoma, Cervical *Lymphadenopathy*. Furthermore due to their rarity, these tumours are often not even taken into consideration in the D/D. Schwannomas are sthira (Firm), *Manda vedanayukta* (slightly painful), *Apaki* (non suppurative)

Malignant transformation of *Schwannoma* is unusual. The slow growth pattern (*Chirvruddhi*) of benign nerve *tumours* allows for adaptation of the nerve function to the pressure effects. The slow growth and nervous adaptation to the

increased volume of the *tumour* is often the factor responsible for the diagnostic delay. MRI and CT SCAN provide useful information about morphological data on the MN *tumours* and also provide information regarding *tumour* extent , anatomical location, *tumour* size and relationship of peripheral nerve and appropriate planning of surgical therapy and preoperative diagnosis.

Surgical excision is the treatment of choice.[8] Schwannoma are theoretically removable because they repulse fascicular groups without penetrating them, thus allowing their enucleation while preserving nerve continuity. Some authors recommend excision of only symptomatic tumours or those demonstrating enlargement during follow up. Other authors showed that the size of the tumour, long history, or presence of preoperative neurological symptoms correlated with the incidence of neurological deficit, hence we recommended early surgical excision to have better clinical outcome and to avoid postoperative neurological deficits. This is the reason why early diagnosis is important for this type of tumour. Paresthesia is the most frequent postoperative complication. Nerve grafting may also be required in some malignant forms of these tumours.

CONCLUSION:

Schwannomas are benign nerve tumors [9]. There is often delaying in diagnosis of *Schwannomas* by the absence of clinical symptoms due to the nervous adaptation to the increased volume of the *tumour*. Hence, there is need to think about this type of *tumour* before any mass in the path of peripheral nerve.

REFFERENCES:

1) Schwartz's Principles Of SURGERY 8th Edition page no. 1645
2) Bailey and Love's Short Practice of Surgery 22nd Edition page no. 403
3) A Concise Textbook Of Surgery Somen Das 9th Edition page no. 122
4) *Sushruta Samhita* Part 1 Chaukhambha Sanskrit Sansthan Edition reprint 2015 page no. 352, 367
5) *Sushruta Samhita* Part 1 Chaukhambha Oriental Edition reprint 2010 page no. 534.
6) *Shalyashalakya Tantra* Vd. S. G. Joshi Edition 3rd page no. 615
7) https://www.ncbi.nlm.nih.gov.>articles,case report of Schwannoma.
8) www.ajnr.org, case report and brief literature review of Schwannoma.
9) europepmc.org> articles, Cervical vagal Schwannoma. A case report.

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