Facial nerve schwannomas (FNSs) are rare slow-growing tumors, accounting for less than 1% of all temporal bone tumors. They are typically solitary, unilateral, and sporadic in nature. FNSs may be bilateral as part of neurofibromatosis-2 spectrum (1, 2). Rarely, multiple schwannomas may involve peripheral branches of the facial nerve (FN) (3). The age of presentation varies from 5 to 84 years. No gender or side predilection is seen (4, 5).

Histologically, FNSs are neuroectodermal in origin. They are encapsulated, benign tumors arising from the Schwann cells. They may show intratumoral cystic change and hemorrhage (3, 4, 5). Malignant schwannoma of the FN is extremely rare (6). FNSs commonly present with peripheral facial neuropathy and/or various otologic symptoms including sensorineural and conducting hearing loss (2–5). Facial paralysis is often seen at a later stage or may not be seen at all. The reasons for this are thought to be neuronal tolerance induced by the extremely slow growth of the tumor, abundant tumor vascularity, and commonly associated dehiscence of adjacent bone (7).

Occasionally, FNSs may present as an intraparotid mass or as an intracranial lesion (2–5).

The clinical presentations and the imaging appearances of FNSs are influenced by the topographical anatomy of the FN and vary according to the segment(s) they involve. This pictorial essay illustrates the imaging features of facial nerve schwannomas according to their various anatomical locations and also reviews the pertinent differential diagnoses and potential diagnostic pitfalls.

**ABSTRACT**

Schwannomas are uncommon in the facial nerve and account for less than 1% of tumors of temporal bone. They can involve one or more than one segment of the facial nerve. The clinical presentations and the imaging appearances of facial nerve schwannomas are influenced by the topographical anatomy of the facial nerve and vary according to the segment(s) they involve. This pictorial essay illustrates the imaging features of facial nerve schwannomas according to their various anatomical locations and also reviews the pertinent differential diagnoses and potential diagnostic pitfalls.

**Segmental anatomy of the FN**

The course of the FN is divided into six segments and two genua which are as follows: 1) cerebellopontine cistern (CPC) segment; 2) internal acoustic canal (IAC) segment; 3) labyrinthine segment; 4) geniculate ganglion (GG)/anterior genu; 5) tympanic segment; 6) posterior genu; 7) intramastoid segment; 8) extracranial segment. Each segment of the FN is closely related to several important structures, which may get affected by the expansion of the FN canal caused by the FNS (Figs. 1–5). The FN gives several branches along its course which are as follows: the superficial petrosal nerve (GSPN), muscular branches to the stapedius, posterior belly of digastric and stylohyoid, the chorda tympani, the posterior auricular nerve, and five terminal branches (temporal, zygomatic, buccal, marginal mandibular, and cervical) (9, 10).
Imaging protocols and general imaging features of FNS

The commonly performed imaging protocol for the evaluation of FNS includes high-resolution CT (HRCT) scan of the temporal bone with multiplanar reconstructions and pre- and postcontrast multiplanar MRI sequences centered on the IAC (axial 2 mm T1-weighted imaging, three-dimensional 0.6 mm heavily weighted T2-weighted imaging, coronal 2 mm postcontrast T1-weighted fat-saturated imaging, and postcontrast isovoxel VIBE). A simultaneous MRI of the brain (5 mm imaging, and postcontrast isovoxel VIBE). The cerebellopontine cistern (CPC) segment of FN (a, dotted arrow) is related to the vestibulocochlear nerve posteriorly (a, arrow). The internal acoustic canal (IAC) segment of FN (b and c, dotted arrow) is related to the cochlear nerve inferiorly (c, arrowhead) and the superior vestibular nerve posteriorly (b and c, arrow).

Main points

- Knowledge of the complex anatomical landscape of the facial nerve (FN) is vital in the diagnosis of facial nerve schwannomas (FNS).
  - The FNS involving the cisternal and/or internal acoustic canal segments of the FN cannot be confidently differentiated from the vestibular schwannoma on imaging. Its inclusion in the differential diagnosis of the latter has important implication in presurgical counselling.
  - FNSs may present as a middle cranial fossa mass, a middle ear mass, an external auditory canal mass, or an intraparotid mass.
  - Demonstration of smooth scalloping of the FN canal and adjacent bony labyrinth on HRCT differentiates the FNS from the FN hemangioma. However, FNSs of mastoid segment can sometimes mimic aggressive tumors.
  - The differential diagnosis of an intraparotid mass with extension in the stylomastoid foramen includes FNS, parotid malignancy with perineural spread and, rarely, pleomorphic adenoma.

T1-weighted sequences) is also routinely performed. Contrast-enhanced CT has no role in the imaging of FNS (2, 4).

FNSs usually involve more than one segment of the FN. Like schwannomas occurring elsewhere, FNSs are typically fusiform solid tumors with well-circumscribed smooth margins. They usually grow along the path of least resistance. They appear iso- to hypointense to brain parenchyma on T1-weighted images and hyperintense on T2-weighted images. On diffusion-weighted imaging, there is usually no restriction. They generally show homogeneous postcontrast enhancement; however, cystic degeneration may result in heterogeneous enhancement (2, 4). FNSs can show a “target sign” on T2-weighted images; however, this feature is nonspecific, and may be seen in other benign and malignant neurogenic tumors (3). Small FNSs cause smooth, fusiform expansion of the FN canal, best seen on HRCT images. Large FNSs can cause pressure erosion of the adjacent bony labyrinth and ossicles. Bony erosions caused by FNSs are smooth and sharply margined, in keeping with long-standing bony compression rather than aggressive pathology (4, 5, 7).

Schwannomas involving the CPC segment and/or the IAC segment of the FN cannot be differentiated from a vestibular schwannoma unless the tumor extends to the labyrinthine segment of the FN (Fig. 6). Other signs like erosion of superior part of the internal auditory canal and eccentricity of tumor in relation to porus acusticus are not reliable. Hence, it is imperative to include the FNS in the differential diagnosis of vestibular schwannoma during preoperative planning and counseling (2, 4, 5).
FNS may acquire a “dumbbell” shape when it shows multisegmental involvement. The relatively narrow labyrinthine segment forms the isthmus of the dumbbell between the globular tumor components at the IAC and the GG (Fig. 7). Occasionally, the GG component of a dumbbell-shaped FNS erodes into the cochlea and thus mimics a transmodiolar acoustic schwannoma. However, unlike FNS, a transmodiolar schwannoma expands the cochlear nerve canal but not the FN canal (11).

The GG fossa is the most common location for the occurrence of FNS. FNSs in this location often show extension to the tympanic and/or the labyrinthine segments. Isolated involvement of the GG at the time of presentation is very rare (Fig. 8). This location is also common for the occurrence of FN hemangiomas. In about 50% cases, FN hemangiomas may not show their characteristic amorphous honeycomb appearance and/or internal bony spicules on CT. However, FN hemangiomas show poorly defined margins on HRCT, which differentiate them from FNSs with smooth margins (12, 13).

A large FNS at the GG can cause bulbous expansion of the GG fossa, erosion of its roof, and can eventually present as an extra-axial middle cranial fossa mass (Fig. 9). Alternatively, it may extend anteriorly along the course of GSPN through the widened facial hiatus (Fig. 10). Rarely, it may involve the GSPN alone. Involvement of the GSPN by the tumor may be seen as smooth scalloping along the anterolateral margin of the petrous bone on CT (Fig. 10b). Whenever a middle cranial fossa mass is associated with facial nerve dysfunction and/or otologic symptoms, an FNS should be suspected (4, 12).

FNS of tympanic segment sometimes extends to the middle ear cavity by eroding the lateral wall of the FN canal. It can appear as a white mass behind an intact tympanic membrane on otoscopy. It can cause smooth pressure erosion of the tympanic cavity walls and of the ossicles. The ossicular chain may be disrupted (Fig. 11). FNS of tympanic segment can extend superomedially to cause smooth pressure erosion of the lateral semicircular canal and vestibule. Congenital cholesteatoma and middle ear adenoma may mimic FNS on otoscopy and CT, but the former shows no postcontrast enhancement and the latter shows no extension into the FN canal. Glomus tympanicum appears red on otoscopy and does not extend into the FN canal (4, 8, 12).

FNS involving the mastoid segment can cause smooth expansion of the vertical FN.
Figure 5. a–c. Schematic representation of axial section through IAC (a) shows anatomical context of facial nerve schwannoma (FNS), involving the IAC segment, the labyrinthine segment, the GG, the GSPN, and the tympanic segment of the left FN (1 to 5, respectively). Schematic representation of the coronal section (b) through left IAC shows anatomical context of the FNS involving the IAC segment, the labyrinthine segment and the GG of the left FN and its extension to middle cranial fossa through the roof of the GG (1 to 3, respectively). Schematic representation of the coronal section through the mastoid (c) shows anatomical context of FNS involving the mastoid and the intraparotid segments of the left FN.

Figure 6. Contrast-enhanced axial T1-weighted image at the level of left IAC shows an intracanalicular enhancing mass (arrow). The CPC segment (arrowhead) and the labyrinthine segment (not shown) of the FN appear uninvolved. This mass, although proven to be an FNS on surgery, cannot be differentiated from a vestibular schwannoma on imaging.

Figure 7. Contrast-enhanced coronal T1-weighted image through pons, at the level of the left IAC shows a dumbbell-shaped FNS. The isthmus of dumbbell is formed by the narrow labyrinthine segment of the FN (bent arrow), which connects the globular components in the IAC (dotted arrow) and those at the GG (arrow). The CPC segment of the FN (arrowhead) is not involved.
canal and can erode into the external auditory canal (Fig. 12). Occasionally, FNS of the mastoid segment may mimic aggressive bony lesions (like lymphoma or metastasis) when it breaks through the thin-walled adjacent mastoid air cells or shows irregular shape and margins on HRCT and postcontrast MRI (Fig. 13). Perineural spread of parotid gland malignancy along the FN may mimic a mastoid segment FNS, when it is contiguous with the primary tumor or seen as a skip lesion. History of known parotid gland malignancy should suggest the diagnosis (4, 8, 12, 13).

Intraparotid FNS can mimic a pleomorphic adenoma clinically, as well as on imaging (Fig. 14). Extension to the stylomastoid foramen and the tumor location along the posterolateral aspect of the retromandibular vein favor the diagnosis of an FNS (Fig. 15). However, these findings are not diagnostic for the FNS since pleomorphic adenomas, albeit rarely, may show extension to the stylomastoid foramen. Presence of a target sign on T2-weighted images, if seen, excludes the possibility of a pleomorphic adenoma. Parotid malignancies often have infiltrating canal and can erode into the external auditory canal (Fig. 12). Occasionally, FNS of the mastoid segment may mimic aggressive bony lesions (like lymphoma or metastasis) when it breaks through the thin-walled adjacent mastoid air cells or shows irregular shape and margins on HRCT and postcontrast MRI (Fig. 13). Perineural spread of parotid gland malignancy along the FN may mimic a mastoid segment FNS, when it is contiguous with the primary tumor or seen as a skip lesion. History of known parotid gland malignancy should suggest the diagnosis (4, 8, 12, 13).

Intraparotid FNS can mimic a pleomorphic adenoma clinically, as well as on imaging (Fig. 14). Extension to the stylomastoid foramen and the tumor location along the posterolateral aspect of the retromandibular vein favor the diagnosis of an FNS (Fig. 15). However, these findings are not diagnostic for the FNS since pleomorphic adenomas, albeit rarely, may show extension to the stylomastoid foramen. Presence of a target sign on T2-weighted images, if seen, excludes the possibility of a pleomorphic adenoma. Parotid malignancies often have infiltrating
margins and heterogeneous appearance on T2-weighted images. Nevertheless, perineural spread of parotid malignancies should be included in the differential diagnosis of an intraparotid FNS showing extension along the stylomastoid foramen (3, 4, 14).

**Treatment options**

Treatment options for FNSs include surgical resection with nerve preservation, complete resection with nerve grafting, and decompression. The use of gamma knife radiosurgery is a relatively new and promising treatment option in cases of new or residual FNSs (15, 16).

**Conclusion**

Evaluation of the FNS requires a combined approach of correlating accurate clinical information with HRCT and MRI findings. Awareness of the imaging anatomy of the FN and the characteristic CT and MRI appearances of FNS involving different FN segments is crucial to arrive at the correct diagnosis. Finally, the possible imaging differentials at various locations must be borne in mind so as to avoid potential diagnostic pitfalls.

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**Conflict of interest disclosure**

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Imaging of facial nerve schwannomas