MEDICAL MEMORANDA

Alcohol-induced Pain in Chordoma

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Since its first description in Hodgkin's disease, alcohol-induced pain has subsequently been described both in other neoplasms and in various non-malignant conditions. It does not appear to have been described in any intracranial lesion, including chordoma. It was a presenting symptom in our patient with an intracranial chordoma.

Case Report

A 34-year-old Egyptian was admitted to hospital on 8 February 1973. One year previously he began to develop a severe occipital pain about 10 minutes after ingestion of any type of alcohol, lasting up to two hours. Four months later he developed constant occipital and nuchal pain, exacerbated by alcohol and by straining. Six months before admission he developed ataxia, followed by dysphagia for solids and liquids, then left facial numbness. His condition deteriorated greatly in the week before admission.

On examination he was generally unwell. The skull and cervical spine were normal. The cranial nerves showed normal fundi, bilateral ptosis, left sixth nerve weakness, coarse horizontal nystagmus on right lateral gaze, impaired facial sensation on the left, bilateral peripheral facial weakness—more noticeable on the left, minimal palatal movement with deviation to the right, and a bilaterally wasted tongue with deviation to the right.

The sternomastoids were atrophic but not definitely weak. He showed mild limb ataxia—more pronounced on the left, the abdominal reflexes were absent, and the left plantar response was extensor. There was considerable gait ataxia.

Examination of the postnasal space under anaesthesia showed nothing abnormal. Vertebral angiography (see Fig.) showed a large prepontine mass.

His condition deteriorated after admission and he required tracheostomy. Craniotomy was performed on 16 February. A chordoma, confirmed histologically, was found extending from just within the foramen magnum to 1 cm short of the clivus superiorly. The ninth, tenth, and eleventh cranial nerves were tightly applied to the right hand margin of the tumour. The twelfth cranial nerve could not be identified. An extensive resection was performed but residual infiltration of the retropharyngeal space remained. His postoperative course was uneventful.

Though the sixth nerve weakness and tongue weakness remained, facial numbness disappeared, while facial and palatal movements improved. Postoperative deep x-ray therapy was carried out.

Three weeks after surgery the patient was given 15 ml of brandy in orange juice—this failed to produce any pain.

Comment

Apart from the presence of alcohol-induced pain, the presentation of this patient's tumour was similar to those cases of clivus

Angiogram showing prepontine mass.

chordoma previously described (Hass, 1934; Adson *et al.*, 1935; Poppen and King, 1952; Kamrin *et al.*, 1964).

Alcohol-induced pain sometimes followed by anaesthesia was first described by Hoster (1950) in Hodgkin's disease. It was subsequently described in a number of different carcinomata (James *et al.*, 1957; Braun and Shnider, 1958; Healy, 1959; Wanka, 1965) in several non-malignant conditions, particularly of bone (Alexander, 1953; Joske, 1955; Conn, 1957; Braun and Shnider, 1958; Lewes and Valentine, 1962), and in apparently normal persons (Conn, 1957; Snell, 1966).

In a review of 1,060 patients, Brewin (1966) found alcohol-induced pain in 14% with Hodgkin's or other lymphomas, and in 4% of patients with other malignancies.

The pain may be prevented by pretreatment with anti-histamines (Wanka, 1965), phenylbutazone, or steroids (Brewin, 1966).

The pain often occurs in the absence of bone destruction (James *et al.*, 1957) and the lack of previous reports of this association with chordoma, where bone destruction is so prominent, argues against this as the prime factor.

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