Disabling hearing loss in children is a symptom frequently ignored by parents. It is a symptom often disregarded apart from otalgia or otorrhea; until symptoms are severe enough to be a burden in everyday life, moreover until it manifests with complications and even life-threatening conditions. Bilateral Sensorineural Hearing loss have been well established with more than 50% cases attributable to genetic causes; while more than 50% of children with unilateral hearing loss have no identifiable cause. Although almost always an acoustic schwannoma should always be considered unless proven otherwise in patient’s presenting with unilateral sensorineural hearing loss.  

Case report:  
An 11 year-old, female came in for a consult due to unilateral hearing loss, left; with no concomitant otalgia, otorrhoea, fever, tinnitus, facial asymmetry, headache, vertigo and problems with balance. She was noted to have hearing loss at the age of 5 manifested by not responding to conversations, instructions and commands given to her. The condition persisted to be more pronounced and noticeable to be laterally isolated to the left ear. This prompted the parents to seek consult to an otorhinolaryngologist.  

Tuning fork test revealed Weber Right and Rinne Positive. This is suggestive of Sensorineural Hearing Loss, AS. Pure tone audiometry revealed Moderately Severe Sensorineural Hearing Loss, AS and Normal hearing threshold, AD. (Fig 2)  

Further investigation with Magnetic Resonance Imaging T1-T2 weighted with gadolinium contrast of the brain and internal auditory canal revealed: A hyperintense focus approximately 0.4 x 0.6 x 0.7cm on pre-contrast T1 and T2-weighted imaging surrounding the facial and vestibulocochlear nerve at the left cerebellopontine angle region, which has a consistent signal dropout with T2 fat saturation sequence. There is no enhancement detected on the post contrast T1 fat saturation images. These radiographic features are consistent with Lipoma. (Fig 3)  

Lipomas are one of the most common benign mesenchymal tissue neoplasms in our body, however, intracranially it occurs extremely rare which only accounts to 0.08%, moreover only 0.15% of these intracranial tumors are located in the CPA/IAC.  

The characteristic radiographic features of CPA/IAC lipoma are hyperdensity in T1-weighted images that do not enhance with Gadolinum contrast administration, hypo/intense on T2-weighted images, paralleling subcutaneous fat, and a distinguishing signal drop in fat-saturated MRI relative to surrounding cerebrospinal fluid, orbital and subcutaneous fat. This is in contrast with other most common CPA/IAC mass as summarized in Table 1.  

Table 1: Comparison between MRI Features of Lipoma with other common CPA/IAC lesions.  

<table>
<thead>
<tr>
<th>Feature</th>
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Case Discussion:  
CPA/IAC mass comprises an approximately 10% of intracranial tumors; an estimated 90% of these are acoustic neuromas/ vestibular schwannomas and the remainder accounts to 1 to 3% namely meningomas, primary cholesteatomas, facial nerve schwannomas, and other less common lesions such as lipomas and teratomas.  

Discussion:  
A COMMON LESION IN AN UNUSUAL LOCATION:  
LIPOMA in THE CEREBELLOPONTINE ANGLE  

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Introduction  
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Literature review recommends a conservative "watch and scan" policy due to its benign symptomatology and high morbidity following resection. Serial MRI is recommended for monitoring progression of lesion, engulfment of adjacent structures and for monitoring progressive neurologic symptoms such as vertigo, facial asymmetry and spasms.