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Cervicofacial Schwannomas Involving Trigeminal Nerve Branches: A Case Series of Three Patients

Ababacar Diegane Faye[1,2*], Romaric Pognonou Beheton[3,4], Abibou Ndiaye[5,6], Bredel Djeri Djor Mabika[7,8], Emile Malick Lette[1,2], Boubacar Dieng[1,2], Ndiasse Ndiaye[1]

[1]Department of Maxillofacial Surgery and Stomatology, Regional Hospital of Thiès, Thiès, Senegal
[2]Faculty of Health Sciences, Iba Der Thiam University of Thiès, Thiès, Senegal
[3]University Clinic of Maxillofacial Surgery and Odontostomatology, CNHU-HKM, Cotonou, Benin
[4]Hubert K. Maga National University Hospital, Cotonou, Benin
[5]Department of Maxillofacial Surgery, Principal Hospital of Dakar, Dakar, Senegal
[6]Faculty of Medicine, Pharmacy and Odontology, Cheikh Anta Diop University, Dakar, Senegal
[7]Department of Maxillofacial Surgery and Stomatology, University Hospital of Brazzaville, Brazzaville, Republic of the Congo
[8]Faculty of Health Sciences, Marien Ngouabi University, Brazzaville, Republic of the Congo
Email: *dieganefayemaxillo@gmail.com

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Abstract

Introduction: Schwannomas are rare benign tumors arising from Schwann cells of the peripheral nerve sheath. Although commonly found in the head and neck region, involvement of trigeminal nerve branches remains uncommon. This study aims to describe the clinical, radiological, therapeutic, and evolutionary features of cervicofacial schwannomas arising from trigeminal nerve branches. **Case Presentation:** We report a series of three patients aged 12, 27, and 38 years presenting with slow-growing, painless cervicofacial masses. The lesions involved the inferior alveolar nerve in one case and the infraorbital nerve in two cases. Imaging studies, including computed tomography (CT) and magnetic resonance imaging (MRI), revealed well-circumscribed masses, sometimes associated with bone erosion. Surgical excision was performed in all cases. Histopathological examination confirmed schwannoma in two patients, while the third case was considered a presumptive schwannoma based on clinical, radiological, and intraoperative findings. Postoperative outcomes were favorable, with no recurrence observed during a minimum follow-up period of six months. **Discussion:** Diagnosis was based on a combination of clinical, radiological, and intraoperative findings, with histopathological confirmation in two cases. Identification of the nerve of origin remained challenging in some cases. Surgical excision resulted in favorable short-term outcomes, with no recurrence observed during follow-up. **Conclusion:** Schwannomas of trigeminal nerve branches are rare tumors with variable clinical presentation. Diagnosis relies

on histopathology, and surgical excision remains the treatment of choice, with generally favorable outcomes.

Keywords

Schwannoma, Trigeminal Nerve Branches, Case Report, Cervicofacial Region

1. Introduction

Schwannomas, previously referred to as neurilemmomas, were first described in 1908 by the Uruguayan neuropathologist José Juan Verocay. They are benign tumors arising from Schwann cells of the peripheral or autonomic nervous system. These tumors most commonly occur sporadically but may also be associated with neurofibromatosis type 2. Histopathological diagnosis is based on the identification of characteristic architectural features, namely Antoni A areas (hypercellular, compact spindle-shaped cells forming Verocay bodies) and Antoni B areas (hypocellular, microcystic, loosely arranged regions), described in 1920 by the Swedish neurologist Nils Antoni [1] [2].

Schwannomas are slow-growing nerve sheath tumors that can occur at any age; however, most cases are observed between the third and fifth decades of life. The cervicofacial region is involved in approximately 25% - 50% of cases, most commonly in the lateral cervical region, particularly in the parapharyngeal space, and frequently involves the vagus nerve and the cervical sympathetic chain (lower cranial nerves) [3]-[5].

The risk of malignant transformation in benign schwannomas is extremely low, with malignant forms accounting for less than 5% of soft tissue sarcomas. Clinical manifestations mainly depend on tumor size and its relationship with adjacent anatomical structures. Surgical excision remains the treatment of choice [6]-[8].

We report a series of three clinical cases: one schwannoma of the inferior alveolar nerve diagnosed in a 12-year-old child, and two schwannomas of the infraorbital nerve observed in a 38-year-old man and a 27-year-old woman. Complete surgical excision was performed in all cases, with favorable postoperative outcomes.

The aim of this study is to describe the sociodemographic, clinical, diagnostic, therapeutic, and evolutionary characteristics of these rare schwannomas, and to compare our findings with data reported in the literature.

2. Case Presentation

- **Case 1:**

A 12-year-old boy presented with a painless right submental and submandibular mass that had been progressively increasing in size over approximately one year, without associated symptoms. There was no relevant personal or family medical history.

On general examination, the patient was in good general condition, cooperative, with normal-colored mucous membranes. Extraoral examination revealed a

large, firm, well-defined, painless oval mass measuring approximately 13 cm transversely, 8 cm anteroposteriorly, and 8 cm in height. The mass involved the submental and submandibular regions, predominantly on the right side. The overlying skin was normal, and the mass appeared fixed to the right mandibular basal border. No cervical lymphadenopathy was detected.

Intraoral examination showed no mucosal involvement, particularly in the sublingual region. Ipsilateral labiomental hypoesthesia was noted (**Figure 1**).

A prior biopsy suggested a peripheral nerve sheath tumor. Magnetic resonance imaging (MRI) demonstrated a large, well-circumscribed lesion with isointense signal on T1-weighted images and hyperintense signal on T2-weighted images, with heterogeneous enhancement after contrast administration. The mass displaced and compressed the deep cervical spaces (**Figure 2**).

Surgical management consisted of a transverse submandibular cervical incision followed by subplatysmal flap elevation. Tumor excision was performed using careful extracapsular dissection (**Figure 3**). Intraoperatively, significant erosion of the right mandibular basal border was observed, with exposure of the inferior alveolar canal (**Figure 4**). The inferior alveolar nerve could not be identified, suggesting a tumor originating from this nerve.

Macroscopic examination revealed a large, well-circumscribed, ovoid mass measuring approximately 12 cm at its greatest dimension, surrounded by a thin fibrous capsule. On sectioning, the tumor was firm, homogeneous, and grayish-yellow in color, with a glistening cut surface and no evidence of necrosis. These findings were consistent with a benign nerve sheath tumor (**Figure 5**).

Immunohistochemical analysis confirmed the diagnosis of schwannoma, showing Antoni A and Antoni B areas and diffuse positivity for S100 protein (**Figure 6(A)** and **Figure 6(B)**).

The postoperative course was uneventful. At one-month follow-up, the outcome was satisfactory, and no recurrence was observed at six months. However, persistent labiomental anesthesia was noted.

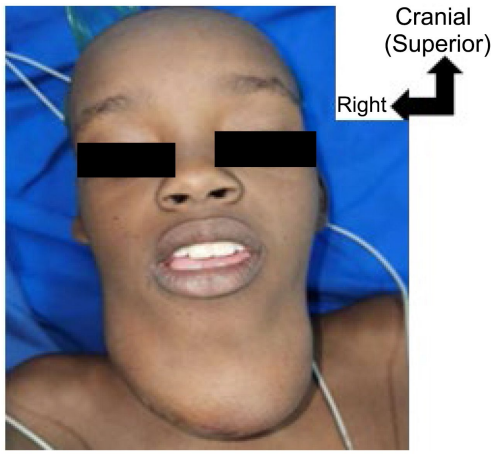


Figure 1. Clinical photograph showing a large, firm, painless bilateral submental and submandibular mass.

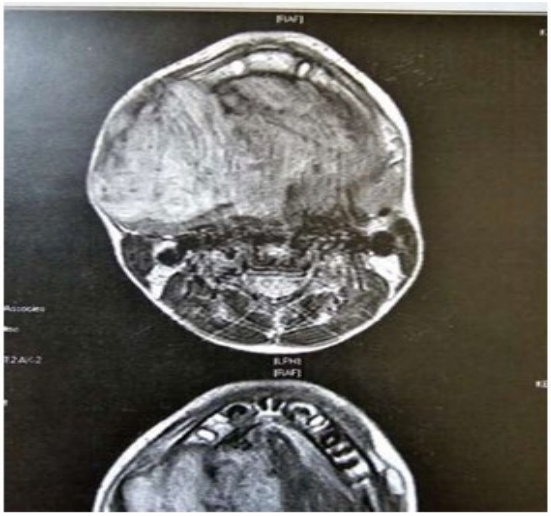


Figure 2. Cervical MRI demonstrating a well-defined T2 hyperintense mass exerting a mass effect on the upper aerodigestive tract.

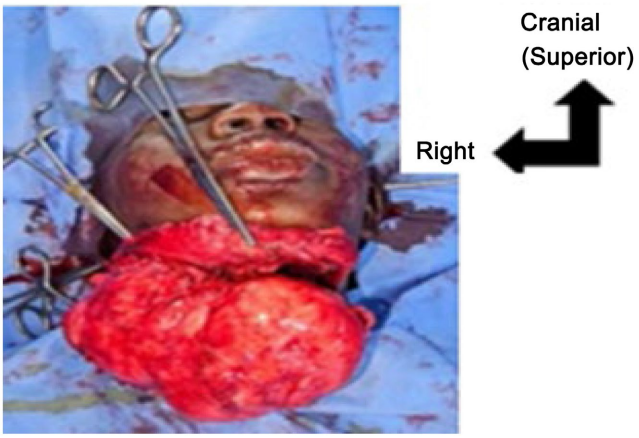


Figure 3. Intraoperative view demonstrating extracapsular dissection of the tumor attached to the right mandibular body.

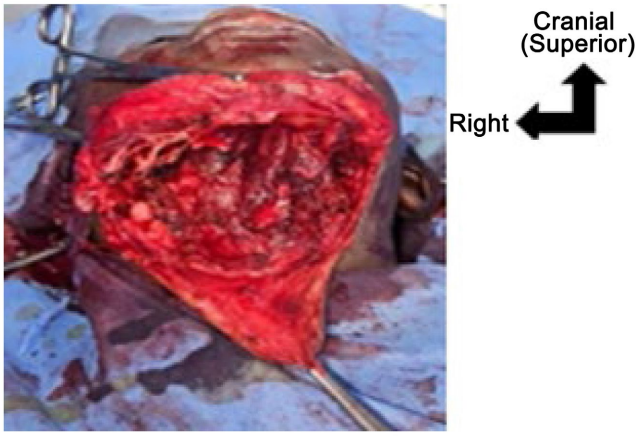


Figure 4. Postoperative view after tumor excision showing erosion of the right mandibular basal border.

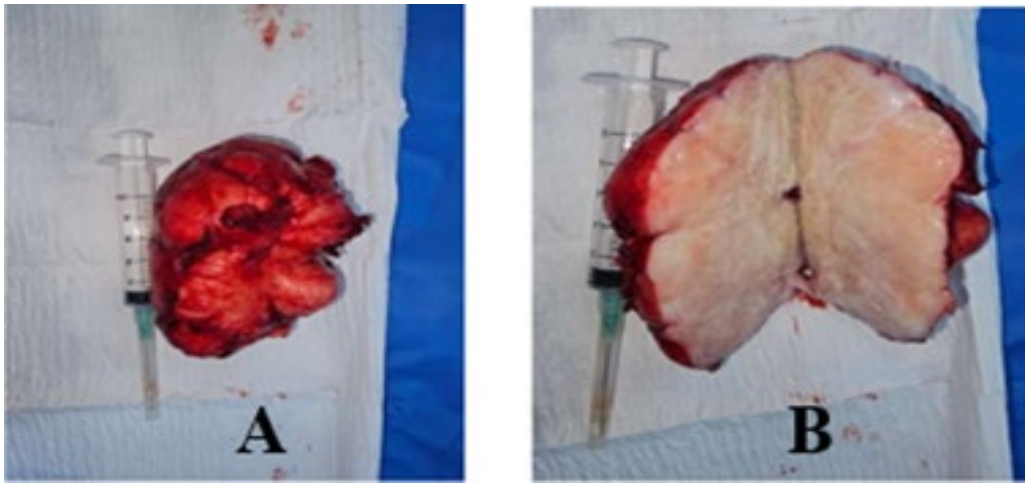
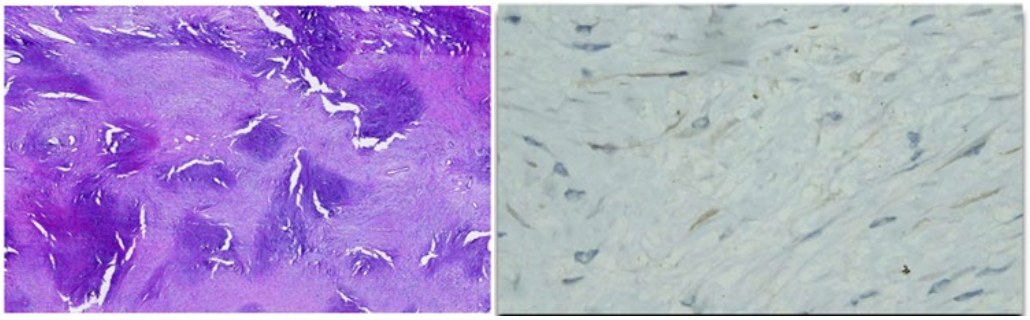


Figure 5. (A) Surgical specimen after complete excision measuring approximately 12 cm at its greatest dimension. (B) Cut surface showing a homogeneous grayish-yellow appearance.



(A) (B)

Figure 6. (A) Histopathological image demonstrating Antoni A (hypercellular) and Antoni B (hypocellular) areas characteristic of schwannoma. (B) Immunohistochemical staining demonstrating diffuse positivity for S100 protein, consistent with schwannoma.

- **Case 2:**

A 38-year-old man with no significant past medical history presented with a painless left cheek swelling that had been progressively increasing in size over approximately three years.

On general examination, the patient was in good general condition, with healthy and well-colored mucous membranes and no associated abnormalities. Extraoral examination revealed a firm, painless left cheek mass measuring approximately 6 × 4 cm, fixed to the deep plane, with no sensory disturbance or palpable cervical lymphadenopathy (**Figure 7(A)**).

Intraoral examination showed a posterior left vestibular bulge covered by normal-appearing mucosa (**Figure 7(B)**).

Computed tomography (CT) revealed an isodense soft tissue mass in the left infraorbital region, with no enhancement after contrast administration, associated with bone erosion involving the left pterygoid process and maxillary tuberosity (**Figure 8**).

Surgical management consisted of complete excision by intracapsular enuclea-

tion via a left upper vestibular approach. The infraorbital nerve could not be clearly identified intraoperatively. This lack of identification may be attributed to its intimate involvement within the tumor, supporting a neural origin (Figure 9).

The surgical specimen was a well-circumscribed, ovoid mass measuring approximately 6 cm, with a smooth and encapsulated external surface. On sectioning, the tumor appeared homogeneous, grayish-yellow in color, and firm in consistency, with no evidence of hemorrhagic or necrotic changes. These macroscopic features were consistent with a benign nerve sheath tumor (Figure 10(A) and Figure 10(B)).

Histopathological examination confirmed the diagnosis of a benign schwannoma. The tumor exhibited a characteristic architecture with alternating Antoni A and Antoni B areas. Immunohistochemical analysis showed strong, diffuse positivity for S100 protein, consistent with a tumor of nerve sheath origin, along with negative staining for smooth muscle actin (SMA), thereby excluding a muscular origin. The Ki-67 proliferation index was low (2%), supporting the benign nature of the lesion (Figure 11, Figure 12).

The postoperative course was uneventful, with a follow-up period of six months showing a favorable outcome, without sensory disturbances or recurrence.

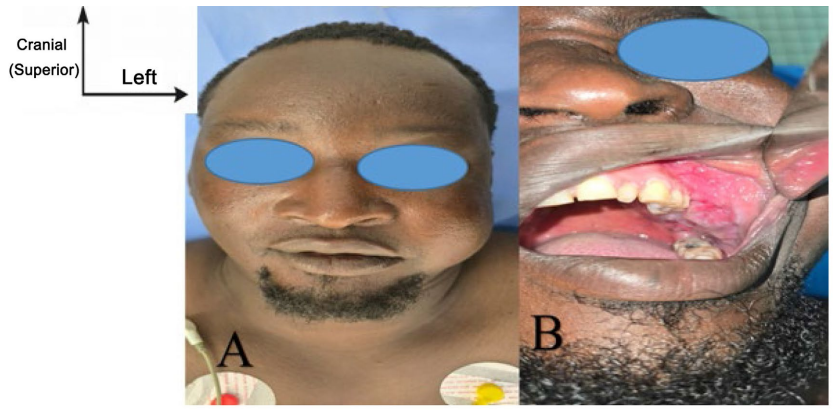


Figure 7. (A) Clinical photograph showing a left cheek mass. (B) Intraoral view demonstrating a posterior left vestibular bulge covered by normal mucosa.

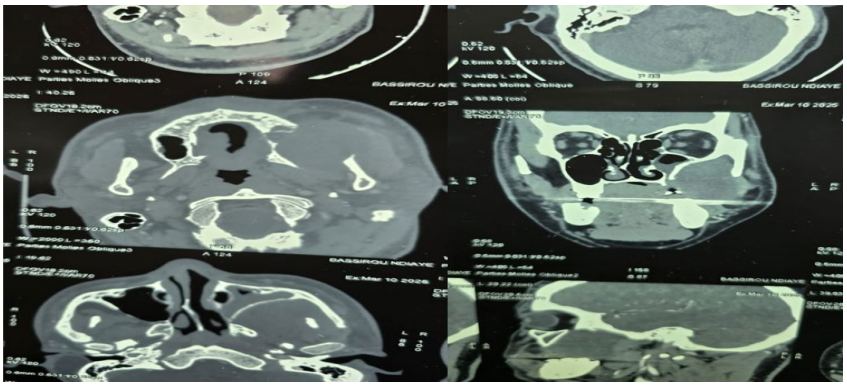


Figure 8. Computed tomography demonstrating a soft tissue mass in the left infraorbital region associated with adjacent bone erosion.

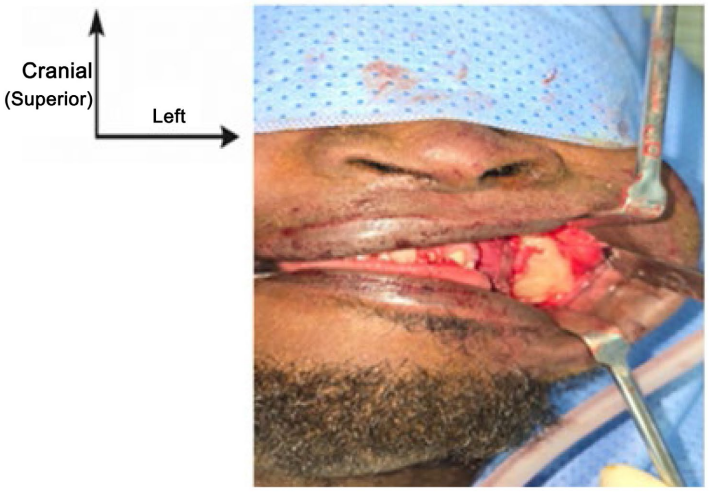


Figure 9. Intraoperative view demonstrating the left upper vestibular surgical approach.

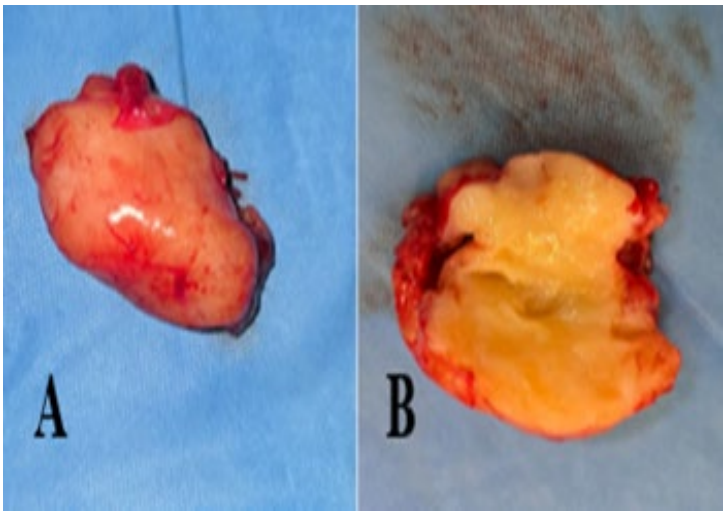


Figure 10. (A) Well-circumscribed, ovoid surgical specimen measuring approximately 6 cm in greatest dimension, with a smooth, encapsulated external surface. (B) Cut surface showing a homogeneous grayish-yellow appearance with firm consistency and no hemorrhagic or necrotic changes.

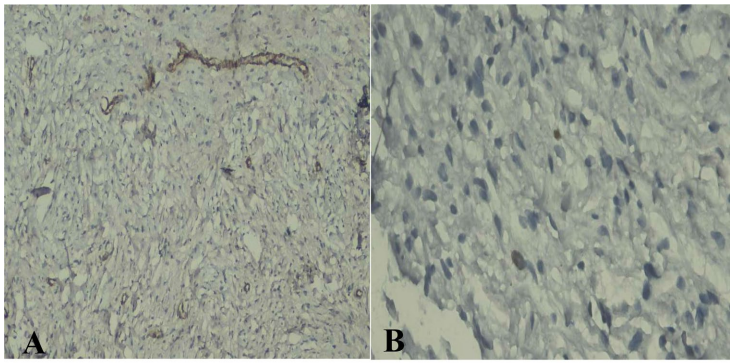


Figure 11. (A) Immunohistochemical staining showing negativity for smooth muscle actin (SMA). (B) Immunohistochemical staining showing a low Ki-67 proliferation index (2%).

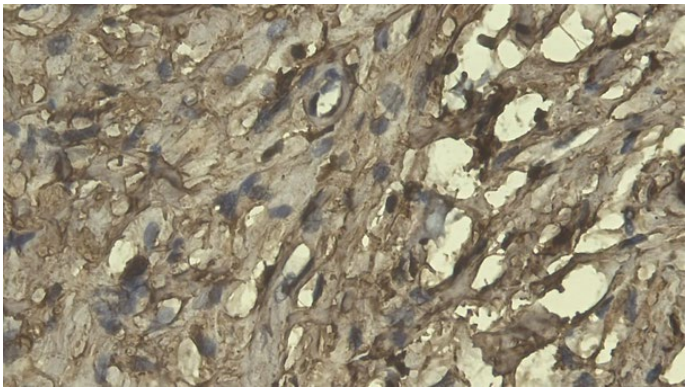


Figure 12. Immunohistochemical staining showing positivity for S100 protein.

- **Case 3:**

A 27-year-old woman with no significant medical or surgical history presented with a right paranasal swelling that had been progressively evolving over approximately one year.

On general examination, the patient was in good general condition, with healthy and well-colored mucous membranes and no associated abnormalities. Local examination revealed a firm, painless mass located at the right nasal vestibule, measuring approximately 4 × 3 cm, with no sensory disturbance. The lesion extended into both the nasal vestibule and the endonasal cavity (Figure 13). No cervical lymphadenopathy was detected.

Computed tomography (CT) demonstrated a well-defined, unilocular lesion with homogeneous content, in close contact with the roots of the right maxillary incisors and canine (teeth 11, 12, and 13) (Figure 14).

Surgical management consisted of complete excision by intracapsular enucleation via a right upper vestibular approach. The infraorbital nerve was not clearly identified intraoperatively. This may be attributed to its intimate involvement within the tumor, supporting a neural origin (Figure 15).

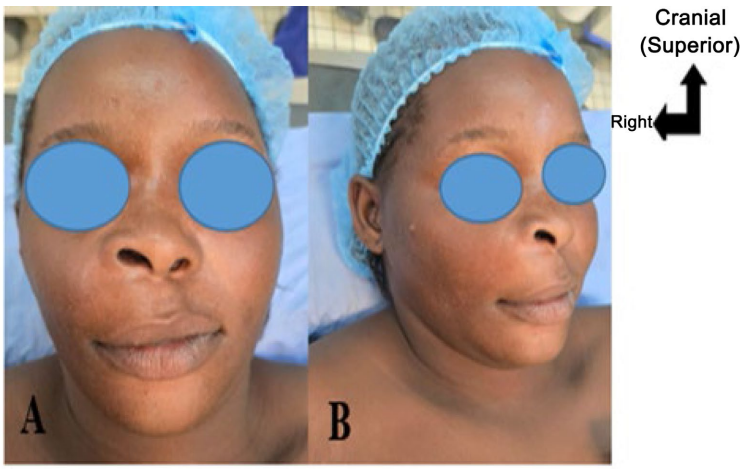


Figure 13. Clinical photographs showing a right nasal vestibular mass. (A) Frontal view. (B) Lateral view.

The surgical specimen was a well-circumscribed, ovoid lesion measuring approximately 3 cm, surrounded by a regular capsule. On sectioning, the tumor appeared homogeneous, grayish in color, and firm in consistency, with a fleshy cut surface and no macroscopic evidence of invasion of adjacent structures (Figure 16).

Although a surgical specimen was obtained, histopathological examination could not be performed due to financial constraints. Nevertheless, the presumptive diagnosis of schwannoma was strongly supported by the clinical presentation, radiological characteristics, intraoperative findings (well-encapsulated lesion), and its anatomical location along the infraorbital nerve.

The postoperative course was uneventful, and follow-up of six months demonstrated a favorable outcome, with no sensory deficit or evidence of recurrence.

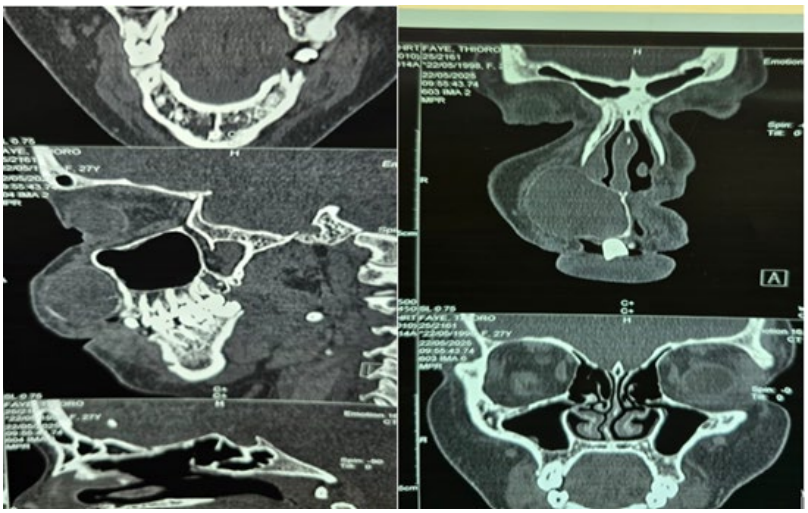


Figure 14. Computed tomography demonstrating a well-circumscribed, unilocular lesion with homogeneous content, in close contact with the roots of the right maxillary incisors and canine (teeth 11, 12, and 13).

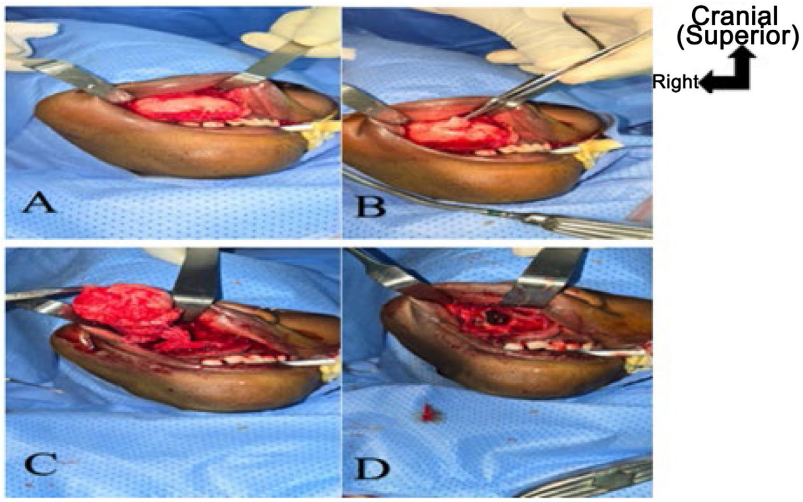


Figure 15. Intraoperative images showing tumor excision via a right upper vestibular approach. ((A) (B)) Surgical exposure of the lesion. (C) Tumor excision, enucleation. (D) Postoperative appearance of the vestibule.

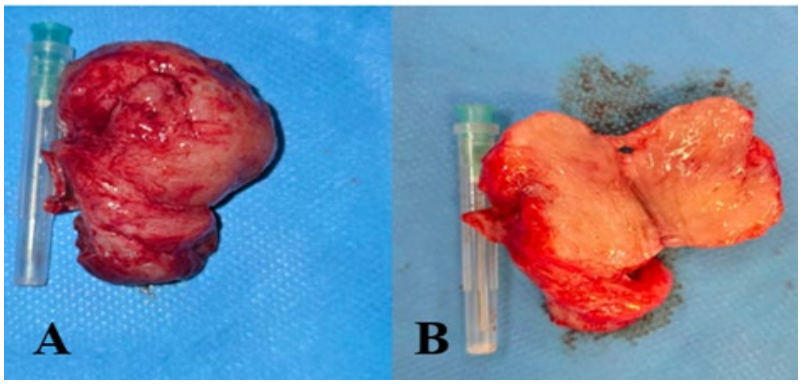


Figure 16. (A) Well-circumscribed ovoid mass measuring approximately 3 cm in greatest dimension, surrounded by a regular capsule. (B) Cut surface showing a homogeneous yellowish appearance with firm consistency and a fleshy texture.

A timeline of the cases is summarized in **Table 1**.

Table 1. Summary of clinical characteristics of the three cases.

Variables	Case 1	Case 2	Case 3
Symptom onset	1 year	3 years	Several years
Consultation	Delayed	Delayed	Delayed
Imaging	MRI	CT	CT
Surgery	YES	YES	YES
Clinical outcome	Favorable	Favorable	Favorable
Follow-up	No recurrence at six months	No recurrence at six months	No recurrence at six months
Immunohistochemistry	S100 protein-positive	S100 protein-positive	Not performed

3. Discussion

Schwannomas are benign tumors arising from Schwann cells of the peripheral nervous system, first described by Verocay in 1908. They are characterized by slow growth and an exceptionally low risk of malignant transformation [1] [9]. The head and neck region accounts for approximately 25% - 50% of cases, with a peak incidence between the second and fifth decades of life, whereas occurrence in children remains uncommon [3] [10].

Our study reports a series of three cases of schwannomas occurring in a 12-year-old boy, a 38-year-old man, and a 27-year-old woman, highlighting their potential to occur at any age. Consistent with the literature, these tumors do not exhibit a significant sex predilection [11].

Additionally, none of our patients had a significant medical or surgical history, supporting the predominantly sporadic nature of these tumors, except in cases associated with genetic conditions such as neurofibromatosis [8] [12].

Clinically, all patients presented with typical features of schwannoma, including a painless, firm, well-circumscribed, and slowly growing mass, without systemic

symptoms. The overlying skin and mucosa were unremarkable, and no cervical lymphadenopathy was detected. The variability in tumor location observed in our series—submental in the pediatric case, jugal in the adult male, and paranasal in the adult female—reflects the diversity of involvement depending on the nerve of origin. These findings are consistent with previous reports [13] [14].

The prolonged duration of symptoms observed in our patients likely reflects delayed consultation in our setting. The presence of labiomental hypoesthesia in one case is suggestive of neural involvement, although this finding is not constant. Schwannomas are often asymptomatic in early stages and may present with non-specific symptoms depending on their location [15].

Schwannomas account for approximately 8% of primary intracranial tumors, most commonly involving the vestibular nerve. Less frequently, they may affect other cranial nerves, including the trigeminal, facial, and glossopharyngeal nerves [11] [14] [16]. Schwannomas involving trigeminal nerve branches, particularly the maxillary division (V2), are rare, representing approximately 0.2% - 0.4% of intracranial tumors [17] [18]. Sinonasal localizations, which may originate from V2, account for approximately 4% of head and neck schwannomas [19] [20]. Intraosseous schwannomas of the jaws are extremely rare (<1% of bone tumors), and when they occur in the mandible, they most commonly arise from the inferior alveolar nerve [21] [22].

In this case series, schwannomas involved the maxillary and mandibular branches of the trigeminal nerve. The nerve of origin was inferred based on the correlation of clinical, radiological, and intraoperative findings.

In Case 1, labiomental hypoesthesia, together with intraoperative exposure of the inferior alveolar canal, strongly suggested involvement of the inferior alveolar nerve. In Cases 2 and 3, the infraorbital location, absence of an odontogenic origin, and intraoperative findings supported involvement of the infraorbital nerve, although direct visualization of nerve continuity was not consistently achieved.

Imaging plays a crucial role in the diagnostic workup but is not sufficient for definitive diagnosis. MRI is particularly useful, typically demonstrating a well-defined mass displacing adjacent structures without invasion. Lesions usually show heterogeneous enhancement after gadolinium administration on T1-weighted images and hyperintense signal on T2-weighted images, reflecting the presence of Antoni A and B areas [16]. CT imaging typically reveals a well-circumscribed mass that may be associated with bone erosion or remodeling [9] [23]. These radiological features were consistent with those observed in our patients.

Definitive diagnosis relies on histopathological examination. Macroscopically, schwannomas appear as well-circumscribed, encapsulated tumors with a grayish-yellow, firm, and homogeneous cut surface [16]. Histologically, they are characterized by Antoni A and Antoni B areas and strong immunohistochemical positivity for S100 protein.

The immunohistochemical profile is dominated by S100 positivity, while other markers have limited diagnostic specificity. CD34 expression is variable and non-

specific, and its positivity alone is insufficient for diagnosis. Similarly, NSE expression is inconsistent and not diagnostically discriminative. In contrast, a low Ki-67 proliferation index (typically < 5%) supports the benign nature of the tumor. In complex cases, an extended immunohistochemical panel, including muscle markers (actin, desmin, caldesmon), may be required to exclude myogenic tumors, while CD34 may assist in differentiating solitary fibrous tumors [8] [24].

Histopathological confirmation was obtained in two cases, with characteristic S100 positivity. The absence of histological confirmation in the third case represents a limitation, although clinical and radiological findings were strongly suggestive of schwannoma.

In our series, lesion topography played a pivotal role in guiding the diagnostic approach. The submentomandibular swelling in the child initially suggested lymphadenopathy, a submandibular gland tumor, or a cystic lesion. However, the presence of labiomental hypoesthesia associated with involvement of the mandibular canal strongly supported a neural origin, particularly from the inferior alveolar nerve.

The cheek swelling in the adult was suggestive of benign soft tissue lesions, such as lipoma or epidermoid cyst. Nevertheless, its location along the infraorbital nerve trajectory, together with its well-circumscribed, painless, and slow-growing characteristics, pointed toward a nerve sheath tumor, likely arising from this nerve.

The paranasal localization raised suspicion of tumoral or cystic lesions, especially of odontogenic or nasolabial origin. However, the absence of an odontogenic source, its close relationship with the infraorbital canal, and its clinical features (well-defined, painless, and slow-growing) supported involvement of the infraorbital nerve.

Overall, the combination of a well-defined, painless, slow-growing mass in relation to a nerve pathway allowed for the preoperative suspicion of schwannoma, which was later confirmed histologically.

Surgical excision is the treatment of choice and should ideally be performed using an extracapsular dissection technique, with preservation of nerve function whenever possible. Postoperative outcomes are generally favorable, with low recurrence rates. However, mild neurological deficits may persist, depending on the extent of nerve involvement [25].

In principle, identification and preservation of the affected nerve should be systematically pursued during schwannoma excision. However, the nerve could not be clearly identified in two cases, constituting a limitation of the surgical approach, despite generally uneventful postoperative outcomes. Residual functional impairment was nonetheless observed in one case, manifesting as persistent labiomental anesthesia.

No recurrence was observed during a minimum follow-up of six months; however, this relatively short duration does not allow definitive exclusion of long-term recurrence.

This study has several limitations. The small sample size restricts the strength of the conclusions. Additionally, the lack of histopathological confirmation in one case, due to financial constraints, resulted in a presumptive diagnosis.

4. Conclusions

Cervicofacial schwannomas are rare benign tumors with an often insidious clinical presentation, which may delay diagnosis and management. Through this case series, we highlight the diversity of clinical presentations and anatomical locations, particularly involving the maxillary and mandibular branches of the trigeminal nerve. Diagnosis relies on a combination of clinical and radiological findings; however, definitive confirmation requires histopathological examination. Complete surgical excision remains the treatment of choice, providing a generally favorable prognosis with a low risk of recurrence.

Therefore, schwannoma should be systematically considered in the differential diagnosis of any chronic, painless, well-circumscribed cervicofacial mass to ensure early and appropriate management.

Consent

Informed consent was obtained from all adult patients and from the parents of the minor patient for publication of this case report and accompanying images.

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Authors' Contributions

- Concept and design: Ababacar Diegane Faye, Abibou Ndiaye and Emile Malick Lette.
- Clinical management: Ababacar Diegane Faye, Abibou Ndiaye and Emile Malick Lette.
- Data collection: Boubacar Dieng.
- Data analysis: Bredel Djeri Djor Mabika.
- Manuscript drafting: Romaric Pognonou Beheton.
- Critical revision of the manuscript: Ndiasse Ndiaye.
- Final approval of the manuscript: Ndiasse Ndiaye.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

References

[1] Joshi, R. (2012) Learning from Eponyms: Jose Verocay and Verocay Bodies, Antoni a and B Areas, Nils Antoni and Schwannomas. *Indian Dermatology Online Journal*, **3**, 215-219. https://doi.org/10.4103/2229-5178.101826

[2] Rodriguez, F.J., Folpe, A.L., Giannini, C. and Perry, A. (2012) Pathology of Peripheral Nerve Sheath Tumors: Diagnostic Overview and Update on Selected Diagnostic Problems. *Acta Neuropathologica*, **123**, 295-319. https://doi.org/10.1007/s00401-012-0954-z

[3] Langner, E., Del Negro, A., Akashi, H.K., Araújo, P.P.C., Tincani, A.J. and Martins, A.S. (2007) Schwannomas in the Head and Neck: Retrospective Analysis of 21 Patients and Review of the Literature. *Sao Paulo Medical Journal*, **125**, 220-222. https://doi.org/10.1590/s1516-31802007000400005

[4] Aregawi, A.B. (2023) A Rare Case of Cervical Vagal Nerve Schwannoma in a 30-Year-Old Ethiopian Man. *International Medical Case Reports Journal*, **16**, 141-151. https://doi.org/10.2147/imcrj.s401858

[5] Behuria, S., Rout, T. and Pattanayak, S. (2015) Diagnosis and Management of Schwannomas Originating from the Cervical Vagus Nerve. *The Annals of the Royal College of Surgeons of England*, **97**, 92-97. https://doi.org/10.1308/003588414x14055925058355

[6] Prajapati, R., Thapa, A., Yadav, J.K., Lama, M., *et al.* (2022) Cervical Vagal Schwannoma: A Rare Differential Diagnosis of Neck Swelling. *Clinical Case Reports*, **10**, e6560.

[7] Sandler, M.L., Sims, J.R., Sinclair, C., Sharif, K.F., Ho, R., Yue, L.E., *et al.* (2019) Vagal Schwannomas of the Head and Neck: A Comprehensive Review and a Novel Approach to Preserving Vocal Cord Innervation and Function. *Head & Neck*, **41**, 2450-2466. https://doi.org/10.1002/hed.25758

[8] Galzignato, P.F., Chirumbolo, S., Cestaro, W., Scapinello, A., Bertossi, D. and Nocini, R. (2022) Surgical and Histological Evidence of Case Reports Showing Schwannomas in the Nasal Area. *International Journal of Surgery Case Reports*, **94**, Article 107165. https://doi.org/10.1016/j.ijscr.2022.107165

[9] Alrohaimi, F.A., Alsadah, S.A. and Althaqib, G.A. (2021) Lingual Schwannoma in an Adolescent Boy: A Case Report. *Annals of Medicine & Surgery*, **65**, Article 102216. https://doi.org/10.1016/j.amsu.2021.102216

[10] Savi De Tove, M.M. and N'Guessan, A.K. (2024) Intraosseous Mandibular Schwannoma: A Case in a Child of 7 Years and 2 Months. *Médecine Buccale Chirurgie Buccale*, **20**, 119-123.

[11] Nandoliya, K.R., Vignolles-Jeong, J., Karras, C.L., Govind, S., Finger, G., Thirunavu, V., *et al.* (2024) Clinical Characteristics and Outcomes after Trigeminal Schwannoma Resection: A Multi-Institutional Experience. *Neurosurgical Review*, **47**, Article No. 340. https://doi.org/10.1007/s10143-024-02550-6

[12] Lambade, P.N., Palve, D. and Lambade, D. (2015) Schwannoma of the Cheek: Clinical Case and Literature Review. *Journal of Maxillofacial and Oral Surgery*, **14**, 327-331. https://doi.org/10.1007/s12663-013-0488-5

[13] Gulia, J.S., Yadav, S.S., Basur, S.K. and Hooda, A. (2013) Schwannoma of the Membranous Nasal Septum. *Brazilian Journal of Otorhinolaryngology*, **79**, 789. https://doi.org/10.5935/1808-8694.20130140

[14] Gupta, M., Rao, N., Kour, C. and Kaur, I. (2017) Septal Schwannoma of the Nose: A Rare Case. *Turkish Archives of Otolaryngology*, **55**, 41-43. https://doi.org/10.5152/tao.2017.1929

[15] Bruner, J.M. (1987) Peripheral Nerve Sheath Tumors of the Head and Neck. *Seminars in Diagnostic Pathology*, **4**, 136-149.

[16] Freeman, E., Hecht, L., Crum, J. and Lutz, M. (2023) Anterior Nasal Schwannoma: A Rare Sinonasal Neoplasm. *Cureus*, **15**, e41300. https://doi.org/10.7759/cureus.41300

[17] Samii, M., Migliori, M.M., Tatagiba, M. and Babu, R. (1995) Surgical Treatment of Trigeminal Schwannomas. *Journal of Neurosurgery*, **82**, 711-718. https://doi.org/10.3171/jns.1995.82.5.0711

[18] Wanibuchi, M., Fukushima, T., Zomordi, A.R., Nonaka, Y. and Friedman, A.H. (2012) Trigeminal Schwannomas: Skull Base Approaches and Operative Results in 105 Patients. *Operative Neurosurgery*, **70**, 132-143. https://doi.org/10.1227/neu.0b013e31822efb21

[19] Buob, D., Wacrenier, A., Chevalier, D., Aubert, S., Quinchon, J., Gosselin, B., *et al.* (2003) Schwannoma of the Sinonasal Tract: A Clinicopathologic and Immunohistochemical Study of 5 Cases. *Archives of Pathology & Laboratory Medicine*, **127**, 1196-1199. https://doi.org/10.5858/2003-127-1196-sotsta

[20] Cakmak, O., Yavuz, H. and Yucel, T. (2003) Nasal and Paranasal Sinus Schwannomas. *European Archives of Oto-Rhino-Laryngology*, **260**, 195-197. https://doi.org/10.1007/s00405-002-0540-4

[21] Eversole, L.R. (1969) Central Benign and Malignant Neural Neoplasms of the Jaws: A Review. *Journal of Oral Surgery*, **27**, 716-721.

[22] Perkins, D., Stiharu, T.I., Swift, J.Q., Dao, T.V. and Mainville, G.N. (2018) Intraosseous Schwannoma of the Jaws: An Updated Review and Report of Two New Cases. *Journal of Oral and Maxillofacial Surgery*, **76**, 1226-1247.

[23] Pilavaki, M., Chourmouzi, D., Kiziridou, A., Skordalaki, A., Zarampoukas, T. and Drevelengas, A. (2004) Imaging of Peripheral Nerve Sheath Tumors with Pathologic Correlation: Pictorial Review. *European Journal of Radiology*, **52**, 229-239. https://doi.org/10.1016/j.ejrad.2003.12.001

[24] Sathar, R., Hallur, N., Siddiqua, A. and Kothari, C. (2022) Intra Osseous Schwannoma of Inferior Alveolar Nerve with Multilocular Radiolucency Crossing the Midline: A Case Report. *Journal of Clinical Images and Medical Case Reports*, **3**, 1849. https://doi.org/10.52768/2766-7820/1849

[25] Marcandella, E.S., Boscarelli, A., Murru, F., Abbracciavento, G., Spazzapan, P. and Schleef, J. (2024) Pediatric Schwannoma of the Hypoglossal Nerve: A Case Report and Narrative Literature Overview. *Frontiers in Oncology*, **14**, Article 1400335. https://doi.org/10.3389/fonc.2024.1400335