

(A Health Awareness Initiative)

NEURO NEWSLINE

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COLLOID CYST - A benign cyst of the Brain

Colloid cysts are benign, epithelium lined cyst that arise from the anterior part of the third ventricle of the brain. As the name suggests, these cysts contain a gelatinous or mucinous material within it. Wallman was the first to report on colloid cysts in the year 1858, and the legendary neurosurgeon Sir Walter Dandy was the first to resect the cyst successfully in the year 1921. Most often these cysts are asymptomatic unless they obstruct the CSF flow pathways leading to hydrocephalus.

These are slow growing benign cysts (tumour) comprising of less than 1% of intracranial tumours. The age at diagnosis is usually between 20 and 50 years. These cysts attribute some movement within the ventricles and present with intermittent raised intracranial tension. There is no genetic predisposition seen, although familial occurrences of colloid cysts have been reported.

SYMPTOMS & SIGNS

68 % of the patients present

with headache which is typically worse in the morning and gets exacerbated by leaning the head forwards. 'Drop attacks' do occur which is a sudden weakness in the lower limbs associated with falls without loss of consciousness. Gait disturbances, short term

picked-up as an incidental finding when a patient undergoes a CT scan for head trauma. When the cyst is large, it causes obstruction to cerebrospinal fluid pathways resulting in hydrocephalus which is again visualised on imaging.



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CT scan showing the colloid cyst

memory loss, behavioural changes, nausea and vomiting are the other manifestations of this disease. Sometimes there may be additional problems like urinary incontinence. Sudden death has been reported with colloid cysts due to acute blockage of CSF pathways leading to hydrocephalus and herniation of the brain.

DIAGNOSIS & TREATMENT

CT scan and MR imaging is usually diagnostic of these colloid cysts. There are incidences when these are

Small colloid cysts which are asymptomatic without hydrocephalus and can be left alone and followed up periodically. Patients who present with symptoms need to undergo surgical excision of the cyst by microsurgical or endoscopic means. Some patients do undergo stereotactic aspirations of the cyst, and at times a ventriculo peritoneal shunt may be required in addition. The prognosis is good in most surgically treated cases with less chance of recurrence.



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