Lumbar Intraspinal Extradural Ganglion Cysts

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The lumbar intraspinal epidural ganglion cyst has been a rare cause of the low back pain or leg pain. Ganglion cysts and synovial cysts compose the juxtafacet cysts. Extensive studies have been performed about the synovial cyst, however, very little has been known about the ganglion cyst. Current report is about two ganglion cysts associated with implicative findings in young male patients. We discuss about the underlying pathology of the ganglion cyst based on intraoperative evidences, associated disc herniation at the same location or severe degeneration of the ligament flavum that the cyst originated from in young patients.

KEY WORDS: Ganglion cyst · Synovial cyst.

INTRODUCTION

Intraspinal cystic lesions have been noted to be as high as 1-10% in patients having low back pain or radiculopathy.3,8,17,21) The “juxtafacet cyst” has been the most common entity of intraspinal cysts and encompasses the synovial cyst and ganglion cyst.12) Extensive studies have been performed about the synovial cyst, however, very little has been known about the intraspinal extradural ganglion cyst.1,2,19) Two types of cysts share common symptomatic and radiologic characteristics but different histological background. Therefore, new name has been introduced to replace the “juxtafacet cyst” widely used since Kao first employed6,12). Regarding the ganglion cyst, many authors used various names including facet cyst, posterior longitudinal ligament (PLL) cyst, disc cyst or ligament flavum (LF) cyst depending on the origin.1,10,11,19) On the other hand, some authors used the synovial cyst as a representative of the juxtafacet cysts including the ganglion cyst.20,22) Synovial cysts are based on the laxity of the synovial capsule of the facet joints and frequently associate with spinal instability.6) The ganglion cyst is believed to arise from degenerated ligaments including the PLL and LF in the mobile spine.1,2,15,19) We use “ganglion cyst”, if the cyst originated from the ligamentous structures and lacked a true synovial lining without continuity to the facet joint, because they have common pathology regardless of the origin.

We report two cases of the ganglion cyst with intraoperative images matched to radiologic findings. To our knowledge, there has been no report with intraoperative images of underlying ligamentous degeneration or associated herniated disc at the same location.

We reviewed the literatures with focus on the underlying pathology of the ganglion cyst distinguished from the synovial cyst.

CASE REPORT

Case 1

A 37-year-old man presented with suddenly developed lower back pain and left leg pain after slip down during playing soccer 3 weeks ago. The pain radiated to the left L4 dermatome. Straight leg raise capacity was diminished to 45 degrees on the left. Sensation was diminished in the left L4 and L5 dermatomes. Motor function was normal. Magnetic resonance imaging (MRI) demonstrated a large cystic lesion and extruded disc at L3-L4 level. The cyst was noted along the L4 upper end plate and pressed down by the disc herniation. The cyst compressed the dural sac and left L4 root traversing the L3-L4 level. The lesion was isointense on a T1-weighted image and hyperintense on a T2-weighted image (Fig. 1A-C). Based on these findings, provisional
Fig. 1. Images of case 1. A and B: Preoperative sagittal T2-weighted magnetic resonance images showing a cystic lesion adjacent to the extruded disc material at L3-4. C: Preoperative axial T2-weighted magnetic resonance image showing disc herniation medial to the cystic lesion. D: Intraoperative photograph showing a large cystic mass filled with dark fluid. E: Intraoperative photograph showing the herniated disc material (arrow) just above the origin of the shrank cyst (arrow head). F: Photomicrograph shows thick fibromembranous tissue with no lining epithelium. The thick walls show some fibroblasts and mild myxoid stromal change. H & E, original magnification ×100. *: Nerve root. C: cyst, D: dura, L: lamina, SP: spinous process.

Fig. 2. Images of case 2. A and B: Preoperative sagittal magnetic resonance images showing a large round mass with high signal on T1-weighted image and heterogeneous high and low signal intensity on T2-weighted image. C: Preoperative axial T1-weighted magnetic resonance image showing the mass arising from the right ligamentum flavum of L5. D: Intraoperative photograph showing severely degenerated darkened yellow ligament (arrow). E: Intraoperative photograph showing fresh hematoma through an eye of a needle (arrow). F: Photomicrograph shows an irregular thick-walled cystic space with no lining epithelium. Old hemorrhagic areas are noted in the fibrotic stoma. H & E, original magnification ×40.
diagnosis was herniated intervertebral disc combined with a hematoma or ganglion cyst. A standard microsurgical approach for the subtotal laminectomy was performed. The facet joint and the LF were grossly normal. 1.5 cm sized cystic mass was noted to compress the nerve root and has no connection to the facet joint capsule (Fig. 1D). The cyst was filled with thick yellowish fluid with dark brown colored components suggesting old hemorrhage. The cyst was aspirated and shrunken. The origin of the cyst was traced to the midline of the PLL under the surgical microscope. Herniated disc material and annular defect just above the origin of the cyst were identified (Fig. 1E). The origin of the cyst was completely excised from the beneath the thecal sac without complication. Histological examination of the resected material showed a wall of fibrous connective tissue with no lining epithelium. The thick walls had some fibroblasts and mild myxoid stromal changes (Fig. 1F). The radiating pain alleviated immediately after surgery without neurological deficit.

Case 2

A 39-year-old man visited a clinic with spontaneously developed acute leg pain 3 days prior to admission. He denied the history of low back pain. He was a cook working at a ski resort and physically active. Neurological examination demonstrated severe paresthesia on the right L5 dermatome and slight weakness of extensor hallucis longus was noted. The straight leg raising test was limited to lesser degree than 30 in the right leg. MRI demonstrated about 2 × 1.8 × 1.2 cm sized round mass with broad base to the ligamentum flavum at the L5 body level (Fig. 2A-C). The cyst has high signal on T1-weighted images and heterogeneously mixed signal on T2-weighted images without contrast enhancement. The mass severely compressed the right L5 nerve root. Based on these findings, provisional diagnosis was juxtafacet cyst complicated with acute hemorrhage. A partial hemi-laminectomy was performed. The yellow ligament seemed severely degenerated. The ligament was loose and dark (Fig. 2D). A large cyst was noted to compress the L5 nerve root. The cyst was adherent to the dura but dissection was easily achieved. There was no obvious attachment to the adjacent facet joints. The cyst was filled with dark reddish hematoma that was not aspirated through the 18 gauge needle (Fig. 2E). The cyst was cleaved with a surgical blade and the hematoma was aspirated. The cyst was originated from the LF around the foramen. Photomicrograph showed an irregular thick-walled cystic space without a synovial lining. Old hemorrhagic areas were noted in the fibrotic stroma (Fig. 2F). The postoperative course was uneventful.

DISCUSSION

Juxtafacet cysts including the synovial cyst and ganglion cyst are uncommon cause of low back pain or leg pain in elderly. The synovial cyst is the most common cystic lesion in the lumbar spine and the ganglion cyst has been rarely reported. For the reason, main understanding about the clinical characteristics of juxtafacet cysts has been acquired through the investigation about the synovial cysts. Recently, more cases of ganglion cysts have been reported in detail under the histopathological evidence.

Common clinical manifestations of the intraspinal cysts are usually resulted from root compression or cauda equina syndrome. Radiologically, a typical cysts appears with low-intensity signal in T1-weighted images and a high-intensity signal in T2-weighted sequences. However, the signal can vary depending on the proteinaceous concentration of the fluid or even the presence of blood like in our second patient. Acute herniation of the disc can be associated with epidural hemorrhage, and the hemorrhage must be differentiated from the cystic lesion like in our first patient.

The differentiation between two types of the cysts is only of histological value, as they share clinical and radiological characteristics. Synovial cysts are thought to arise from periarticular tissue such as synovial herniation through weakened or destroyed facet joint capsule with continued direct communication with the joint. Synovial cysts have a pseud stratified columnar synovial cell lining and are supported by layers of villous nodular hyperplastic vascularized connective tissue. On the other hands, typical pathological findings of the ganglion cyst are membranous and fibrocollagenous tissue with myxoid degeneration. There were also some degenerative clefts representing chronic granular formation. Necrotic tissues, histiocyte infiltration, hemosiderin deposits, and neovascularization were also present in the wall. There should not be a true synovial lining.

The involvement of the facet joints associated with intraspinal cysts may influence on the treatment of strategy. Ganglion cysts develop from mucinous degeneration of ligamentous tissue in the mobile spine and they have no direct communication with the facet joint. However, synovial cysts arise from laxity of synovium of the facet joints. Therefore, they have high correlation with segmental instability. Regarding to the ganglion cysts, to our knowledge, there is no report in patients with spinal instability.

Though the etiology of the synovial cyst remains controversial, segmental instability and trauma play a major role in the cyst formation. Synovial cysts are located most commonly at the L4-L5 level, the most mobile level, and common at the L3-L4 level and L5-S1 level in ord-
When they do appear in the cervical spine, it arise from the most mobile segments, C5-C6 or C7-T1, the level where a mobile segment is attached to a non-mobile. In addition, factors influencing the segmental instability such as disc degeneration, facet joint osteoarthritis, and sagittal orientation of facet joint are commonly identified in patients with synovial cyst at the level.

Lumbar intraspinal ganglion cysts are also most commonly identified at the L4-5 level. They are suggested to arise from the degeneration of the ligamentous structure in the mobile segments. We presented intraoperative photographs from the degeneration of the ligamentous structure in the mobile spine in young patients could be an important risk factor of the ganglion cyst.

In terms of surgical strategy, instrumentation has been frequently required for the synovial cysts because of wide frequent minimal access. However, the ganglion cysts have no correlation with segmental instability and connection to facet joints. Therefore, simple excision of the ganglion cyst could be successful through minimal access.

**CONCLUSION**

We presented two cases of lumbar intraspinal ganglion cyst showing clear evidences that the cysts originate from degenerated ligamentous structures in young patients. The patients could be successfully treated through the minimal access.

**References**


59