There appears to be no group of findings suggestive of a diagnostic syndrome specific for arachnoid cysts of the posterior fossa. Numerous features, however, segregate these lesions from inflammatory arachnoiditis in the posterior fossa, and they are felt to constitute a distinct, pathological entity.

Appreciation is expressed to Charles Bridgman, Timothy Dodge and Thomas Masterson for their help in preparing the illustrations.

REFERENCES


COLOID CYST OF THE FOURTH VENTRICLE

REPORT OF A CASE OF TWO COLOID CYSTS OF THE FOURTH VENTRICLE

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(Received for publication February 11, 1952)

The term, “colloid cyst,” to the neurosurgeon invariably connotes the single cystic mass occurring always at the anterior portion of the 3rd ventricle adjacent to the foramen of Monro. The predilection of these cysts for this location and their absence from other portions of the ventricular system have been explained on the basis that they arise from the embryonic paraphysis.1,5,7,12,15 The paraphysis is an epithelial outpouching with numerous tubules from the telencephalic part of the roof of the 3rd ventricle just in front of the velum transversum. This structure is reportedly common to all vertebrates but not found beyond the 32 mm. stage in human embryos.1

These colloid cysts are commonly referred to as “paraphysial cysts,” although Dandy, who did most to bring them to medical attention, preferred the descriptive term, “colloid cyst,” without reference to their possible origin.

Various reasons have been offered for believing that these cysts arise from the paraphysis—the presence of numerous rudimentary tubules in the cyst wall,12 the presence of ciliated epithelium and the location of the cysts.

Not all reported cases have been similar nor have they necessarily all evidenced the above criteria. The lining has varied from fairly flat epithelium9 to single-layered cuboidal9,10,14 to columnar ciliated13,4,8 epithelium. Perhaps some of these

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are not true paraphysial cysts but more likely the amount of distention in each case alters the architecture of the lining epithelium.

The amount of the cyst wall that has been adherent to and covered by the choroid plexus has varied considerably in different cases also.

One cyst was apparently in the posterior part of the 3rd ventricle.\(^4\)

The following case is unusual in two respects. There were two colloid cysts and they were both in the 4th ventricle. The authors are not aware of any previous cases of colloid cyst of the 4th ventricle.\(^5\)

CASE REPORT

M.L., a male aged 28, was considered well until the latter part of June 1951, 8 weeks before admission. At that time he noted a sensation as though ants were crawling over the skin of his left occiput. Within the next day or two he began to stagger and notice blurring of his vision. In the latter part of July, he began to vomit and he was admitted to another hospital where he was investigated for disturbance of the intestinal tract until the time of admission to the Winnipeg General Hospital, Aug. 24, 1951. Headache was never a complaint, but the formation persisted until his operation.

Examination. He was a well built but haggard-appearing young male, rather reluctant to be disturbed from his curled-up position in bed. He walked with an ataxic gait. There was a fine, rapid nystagmus on lateral deviation, most marked to the right. There were bilateral acutely choked discs.

On Aug. 28, 1951, under local anaesthesia, ventriculography was performed with recovery of 30 cc. of clear CSF. There was free communication between the two lateral ventricles. Subsequent roentgenograms revealed a moderate degree of symmetrical dilatation of both lateral ventricles and of the 3rd ventricle. In spite of adequate manipulation of the head, the aqueduct of Sylvius was visualized only in its proximal 5 mm. This portion of the aqueduct was dilated, measuring 3.5 mm. in diameter. A small quantity of oxygen had passed beyond this point and it partially filled a considerably enlarged 4th ventricle. The basal cisterns were not outlined. These findings were interpreted as indicating a lesion that was obstructing the exit of CSF from the 4th ventricle and that was also extending up into and partially obstructing the aqueduct (Figs. 1, 2, and 3).

Operation. A midline cerebellar craniotomy was performed the same morning. The tonsils both extended down to the inferior edge of the arch of the atlas. As the tonsils were separated there was seen protruding through the foramen of Magendie a smooth-walled, fluctuant, blue-gray mass resembling a nasal polyp in appearance and consistency. This was gently teased out and delivered; it had no apparent attachment although the cyst wall broke in the process, releasing a homogeneous clear gelatinous fluid. When reexpanded this cyst measured 1.5 cm. in diameter. On reexamining the foramen another similar but smaller projection was seen to have taken the place of the first. This was removed easily without rupture and measured about 1 cm. in diameter. There was no bleeding associated with the removal and there was no irregularity on the surface of either cyst that could have represented a point of attachment. There was a free gush of CSF after the second cyst was removed. However, feeling that if there were two there might be more, the vermis was split and the entire surface of the 4th ventricle inspected. There were no more cysts visible nor was there any evidence of a point of attachment, although the midline of the roof was of course traumatized in the exposure. The aqueduct allowed passage of a #8 French catheter into the 3rd ventricle. The wound was closed.

Course. The patient made an uneventful recovery. He was last seen on Dec. 6, 1951 at which time he had gained 25 lbs. and had been working as a laborer in the woods since his discharge from the hospital. He was completely free of his intracranial symptoms. His nystagmus and papilloedema had disappeared.