

# Colloid cyst treatment

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Optimal treatment of [colloid cyst](#) remains controversial. Initially, shunting without treating the [cyst](#) was advocated <sup>1)</sup>.

The nature of the obstruction (both foramina of Monro) requires bilateral [ventricular shunts](#) (or, unilateral shunt with fenestration of the [septum pellucidum](#)). Presently, one form or another of direct surgical treatment is usually recommended for some or all of the following reasons:

1. to prevent shunt dependency
2. to reduce the possibility of tumor progression
3. since the mechanism of sudden neurologic deterioration may be due to factors such as cardiovascular instability from hypothalamic compression and not due to hydrocephalus.

## Options

Incidental colloid cysts are frequently managed with surveillance imaging rather than surgical excision. This approach is born out of their purported indolent growth pattern and the surgical morbidity associated with microsurgical removal. The advent of endoscopic colloid cyst removal may offer renewed assessment of these patients who carry a risk of acute neurological deterioration. An evidence-based recommendation should weigh the risks of operative treatment.

Age and cyst diameter were not correlated with the absence or presence of symptoms in patients with a colloid cyst of the third ventricle. Operative results were highly favorable in both groups and did not reveal a higher risk of morbidity in the patient presenting with an incidental lesion. The results support endoscopic resection as a legitimate therapeutic option for patients with incidental colloid cysts. Generalization of the operative results should be cautiously made, since this is a limited series and the results may depend on the degree of neuroendoscopic experience <sup>2)</sup>.

## Using natural history for treatment decisions

A review of 58 asymptomatic patients (average age 57 years) with incidentally discovered colloid cysts of the third ventricle with mean follow up of 79 months demonstrated the incidence of symptomatic worsening at 2, 5, and 10 year follow up to be 0%, 0%, and 8%, respectively. Of the 34 patients who obtained follow up imaging, 32 demonstrated no change in cyst size or ventricular caliber. The average age of these patients was significantly higher than that of the patients undergoing surgery for symptomatic lesions (57 vs. 41) and thus may reflect a patient cohort with differing natural histories <sup>3)</sup>

## Colloid cyst resection

see [Colloid cyst resection](#).

1)

Torkildsen A. Should Extirpation be Attempted in Cases of Neoplasm in or Near the Third Ventricle of the Brain? Experiences with a Palliative Method. J Neurosurg. 1948; 5:249-275

2)

Margetis K, Christos PJ, Souweidane M. Endoscopic resection of incidental colloid cysts. J Neurosurg. 2014 Jun;120(6):1259-67. doi: 10.3171/2014.3.JNS131289. Epub 2014 Apr 18. PubMed PMID: 24745712.

3)

Pollock BE, Huston J,3rd. Natural history of asymptomatic colloid cysts of the third ventricle. J Neurosurg. 1999; 91:364-369

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