

Intracranial epidermoid cyst treatment

STR is associated with a significantly higher rate of epidermoid tumor recurrence compared to GTR. Attempts at GTR should be made during the initial surgery with efforts to optimize success. Surgical expertise, as well as the use of adjuncts, such as [Intraoperative magnetic resonance imaging](#) and [neuromonitoring](#), may increase the likelihood of completing a safe GTR and decreasing the long-term risk of recurrence. The most common surgical [complications](#) were transient cranial nerve palsies, occurring equally in STR and GTR cases when reported. In all postoperative epidermoid tumor cases, but particularly following STR, close follow-up with serial MRI, even years after surgery, is recommended ¹⁾.

Earlier diagnosis and complete excision or near total excision of a [epidermoid cyst](#) can cure the patient with the expectation of normal life ²⁾.

Caution when removing [epidermoid cysts](#) to minimize spilling contents as they are quite irritating and may cause severe [chemical meningitis](#).

Berger ³⁾ advocates intraoperative irrigation with hydrocortisone (100 mg/L of LR) to reduce the risk of postop communicating hydrocephalus. Peri-operative IV steroids and copious saline irrigation during surgery may provide similar results. The tumor is not in the cyst wall, and the surgical plan is generally to remove as much as possible but to leave capsule adherent to critical structures such as brainstem and blood vessels as the morbidity of removal is high and a small residual does not preclude satisfactory outcome. In spite of adequate removal, it is not unusual to see persistent brainstem distortion on post-op imaging ⁴⁾. Post-op radiation is not indicated as the tumor is benign and XRT does not prevent recurrence ⁵⁾.

A conservative attitude in handling the tumor capsule is common given concerns about capsule adherence to neurovascular structures, and thus the possibility of recurrence is accepted with the intent of minimizing complications ⁶⁾.

References

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