Neuroenteric cyst of the cerebellum

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Summary

Intracranial neuroenteric cysts are rarely encountered and no more than 13 cases have been reported in the literature. This paper reports another case located in the cerebellum. These occur mostly in adults and there is no typical clinical presentation. The computed tomographic scan shows them as low attenuating lesions with no peripheral contrast enhancement. These cysts are believed to be developmental in origin.

KEY WORDS: headache, optic atrophy.

Introduction

Neuroenteric cysts (synonyms: enterogenous cysts, neuroepithelial cysts, gastrocytoma) are usually defined as cysts lined by a single layer of mucin containing columnar or cuboidal epithelium which are generally non-ciliated. These have been mostly reported in the spinal canal either in the dorsal or lower cervical region (Hirano et al., 1971). Their occurrence in the posterior fossa is rare and no more than 13 cases have been reported in the literature (see below).

This paper reports one more case which was located in the vermis of the cerebellum. The controversies of its origin and the differential diagnosis are discussed.

Case report

A 48-year-old man was admitted in February 1980 with occipital headaches for 2-5 years and deteriorating vision, giddiness and unsteadiness of gait for 3-5 months. Examination revealed minimal proptosis of the left eye and a café-au-lait patch on the right chest wall. He was conscious and oriented but had no vision in the right eye and only perception of hand movement in the left eye. Fundus showed bilateral secondary optic atrophy. There was no other cranial nerve deficit. The deep tendon reflexes on the right were brisker and the plantar response was extensor. No motor weakness or sensory loss was detected, and except for mild unsteadiness of gait no other cerebellar signs could be elicited.

X-rays of the skull showed rarefaction of the dorsum sellae. A left carotid angiogram suggested dilated lateral ventricles. Computed tomography with contrast enhancement showed a moderate degree of hydrocephalus with a well-defined round low attenuating lesion in the region of the 4th ventricle with no peripheral enhancement (Fig. 1). An air cum Amipaque® ventriculogram showed a filling defect in right lateral recess of the 4th ventricle and an upward displacement of the inferior medullary velum (Fig. 2).

A ventriculo-peritoneal shunt relieved his headache. A fortnight later a midline sub-occipital

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cerebro-pontine angle. Microscopically, the cyst was lined by a single layer of columnar epithelium. The cells had round basally situated nuclei, with clear vacuolated cytoplasm, and no cilia were identified. No pleomorphism or mitosis was seen. The epithelium rested on an outer coat of collagen and the lining cells contained mucin which was confirmed by mucicarmin stain.

Discussion

The common non-neoplastic cystic lesions encountered in the posterior fossa include the Dandy-Walker cyst, an arachnoidal cyst, and a large cisterna magna. An epithelial lined cyst in the posterior fossa is seldom considered in the differential diagnosis. Dandy-Walker cysts are common in infants with hydrocephalus and arachnoidal cysts are encountered in somewhat older children and only occasionally in adults (Matson, 1969). In contrast, all the posterior fossa neuroepithelial cysts reported in the literature have been in adults (Table 1); the youngest reported patient was 22 years of age and the oldest 68 years, with a striking male preponderance (9 males: 2 females). These cysts are generally located in the midline but may also lie in the cerebello-pontine angle. Details of the clinical presentation are available only in 10 cases and among them two were asymptomatic. The duration of symptoms ranged from 2 months to 4 years with four of the eight cases having symptoms for less than 1 year. The most frequent complaint was nuchal pain (seven cases). Papilloedema and impairment of vision was less frequent and was present in only three cases. Symptoms and signs of cerebellar involvement were

![Fig. 2. Lateral view of Amipaque ventriculogram showing an upward displacement of the inferior medullary velum.](http://pmj.bmj.com/)

<table>
<thead>
<tr>
<th>Author</th>
<th>Location</th>
<th>Age Sex</th>
<th>Findings</th>
<th>Histology</th>
<th>PAS stain</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dandy, 1969</td>
<td>CPA*</td>
<td>Adult</td>
<td>Two cysts, gelatinous fluid. Excised</td>
<td>Columnar ciliated epithelium</td>
<td>-</td>
<td>Improved</td>
</tr>
<tr>
<td>Parkinson and Childe, 1952</td>
<td>4th ventricle</td>
<td>28 M</td>
<td>Pedunculated single cyst, 8 mm diameter</td>
<td>Simple cuboidal</td>
<td>+</td>
<td>Autopsy</td>
</tr>
<tr>
<td>Shuangshoti and Netsky, 1966</td>
<td>4th ventricle</td>
<td>48 M</td>
<td>Cyst, 4 mm diameter</td>
<td>Simple cuboidal</td>
<td>-</td>
<td>Autopsy</td>
</tr>
<tr>
<td>Shuangshoti and Netsky, 1966</td>
<td>4th ventricle</td>
<td>60 M</td>
<td>Cyst, 2 mm diameter</td>
<td>Simple cuboidal</td>
<td>+</td>
<td>Autopsy</td>
</tr>
<tr>
<td>Shuangshoti and Netsky, 1966</td>
<td>4th ventricle</td>
<td>50 M</td>
<td>Multiple cysts</td>
<td>Low cuboidal/cuboidal epithelium</td>
<td>+</td>
<td>Autopsy</td>
</tr>
<tr>
<td>Hoenig et al., 1967</td>
<td>4th ventricle</td>
<td>68 M</td>
<td>Clear colourless fluid excised</td>
<td>Non-ciliated cuboidal epithelium</td>
<td>+</td>
<td>Improved</td>
</tr>
<tr>
<td>Small, 1962</td>
<td>Preponine</td>
<td>-</td>
<td>Improved</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Small, 1962</td>
<td>Preponine</td>
<td>-</td>
<td>Improved</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Hirai et al., 1981</td>
<td>Preponine</td>
<td>30 F</td>
<td>Tubid fluid. Excised</td>
<td>Cuboidal or columnar epithelium Occ. cilia</td>
<td>+</td>
<td>Improved</td>
</tr>
<tr>
<td>Giombini and Lodrini, 1981</td>
<td>Vermis</td>
<td>37 M</td>
<td>Xanthochromic fluid</td>
<td>Columnar or cuboidal epithelium</td>
<td>+</td>
<td>Improved</td>
</tr>
<tr>
<td>Hasegawa et al., 1966</td>
<td>Vermis</td>
<td>22 M</td>
<td>Clear fluid. Excised</td>
<td>Ciliated non-ciliated cuboidal epithelium</td>
<td>?</td>
<td>Improved</td>
</tr>
<tr>
<td>Present case, 1982</td>
<td>Vermis</td>
<td>48 M</td>
<td>Thick gelatinous fluid, Excised</td>
<td>Non-ciliated columnar epithelium</td>
<td>+</td>
<td>Improved</td>
</tr>
</tbody>
</table>

* Cerebello-pontine angle.
present in the majority. The involvement of the 5th nerve in two patients is not easily explicable, except by direct pressure. One patient had bilateral sensory neural deafness which was attributed to raised intracranial pressure (Saxena et al., 1969).

The fluid in these cysts was either clear, gelatinous, mucoid or xanthochronic. In seven cases the cells of the cyst wall contained P.A.S. positive material within the cytoplasm. In three cases the authors fail to mention the details about the staining.

It is usually difficult to diagnose these lesions preoperatively even after ventriculography. Computed tomography shows these cysts as clearly defined round areas of low attenuation but with no peripheral contrast enhancement. The 4th ventricle may not be clearly made out as in our case. Associated hydrocephalus was present in four of the 10 reported cases. Cystic arachnoida and hemangioblastoma may be confused with these lesions but these generally contain areas of increased attenuation within them.

The origin of these cysts has been a matter of some debate. They have been considered as a form of developmental anomaly because of an incomplete separation of the primitive gut from the neural groove. The enterogenous cysts of the spinal canal are usually associated with bony anomalies of the vertebrae (Beardmore and Winglesworth, 1958; Bremer, 1952; McLetchie et al., 1954), but these may occasionally be absent (Fabinyi and Adams, 1979; Guilburd, Ben Arieh and Peyser, 1980; Scoville et al., 1963). Their origin from ectopic ependymal cells has also been postulated; a part of the ventricular ependymal lining becoming pinched off and sequestrated during embryogenesis (Shuangshoti and Netsky, 1966). Sequestrated ependymal cells have been seen well away from the lining of the ventricles as in the occipital lobes (Cooper and Kernohan, 1951).

Phospho-tungstic acid haematoxylin stain failed to show any glial fibres in the wall of the present case to suggest a possible glial origin. The lining in our case was non-ciliated and mucicarmine positive which is unlike an ependymal or an arachnoidal cysts. We concur with the view expressed by Giombini and Lodrini (1981) that these cyst originate from the most cranial portion of the primitive intestine.

References


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