

Retrospective Study

Lumbar ganglion cyst: Nosology, surgical management and proposal of a new classification based on 34 personal cases and literature review

Maurizio Domenicucci, Alessandro Ramieri, Daniele Marruzzo, Paolo Missori, Massimo Miscusi, Roberto Tarantino, Roberto Delfini

Maurizio Domenicucci, Daniele Marruzzo, Paolo Missori, Roberto Tarantino, Roberto Delfini, Department of Neurological and Psychiatric, Sapienza University of Rome, 00185 Rome, Italy

Alessandro Ramieri, Orthopedic Division, Don Gnocchi Foundation, 20148 Milan, Italy

Massimo Miscusi, Department of Medico-Surgical Sciences and Biotechnologies, Sapienza University of Rome, 04100 Latina, Italy

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Correspondence to: Massimo Miscusi, MD, PhD, Department of Medico-Surgical Sciences and Biotechnologies, Sapienza University of Rome, Corso della Repubblica 79, 04100 Latina, Italy. massimo.miscusi@uniroma1.it
Telephone: +39-773-1757222

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Abstract**AIM**

To analyze different terms used in literature to identify lumbar extradural cysts and propose a common scientific terminology; to elaborate a new morphological classification of this pathology, useful for clinical and surgical purposes; and to describe the best surgical approach to remove these cysts, in order to avoid iatrogenic instability or treat the pre-existing one.

METHODS

We retrospectively reviewed 34 patients with symptomatic lumbar ganglion cysts treated with spinal canal decompression with or without spinal fixation. Microsurgical approach was the main procedure and spinal instrumentation was required only in case of evident pre-operative segmental instability.

RESULTS

The complete cystectomy with histological examination was performed in all cases. All patients presented an improvement of clinical conditions, evaluated by Visual Analogic Scale and Japanese Orthopaedic Association scoring.

CONCLUSION

Spinal ganglion cysts are generally found in the lumbar spine. The treatment of choice is the microsurgical cystectomy, which generally does not require stabilization.

The need for fusion must be carefully evaluated: Pre-operative spondylolisthesis or a wide joint resection, during the operation, are the main indications for spinal instrumentation. We propose the terms "ganglion cyst" to finally identify this spinal pathology and for the first time its morphological classification, clinically useful for all specialists.

Key words: Synovial cyst; Lumbar spine; Instability; Surgery; Ganglion

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Core tip: This paper is an original study that analyzes for the first time the many words and acronyms used in literature to describe lumbar extradural cysts, suggesting the term "ganglion cyst" in clinical practice. It also propose a morphological classification of these cysts, which could be useful for clinicians and surgeons. Finally, a description of microsurgical approaches to resect the cyst and avoid spinal instability is reported: As a guide to a common therapeutical strategy, we report a flow-chart, evaluating clinical conditions, mechanical stability and the most suitable treatment.

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INTRODUCTION

Ganglion cysts, more common in the hands and wrists^[1,2], have been described for more than 2 millennia^[3]. The Greek term "ganglion" indicates a knot of the tissues.

Ganglion cysts of the minor and major joints, especially at the level of the wrist and back of the hand, have been known since ancient times and were described by Hippocrates^[3] more than two millennia ago. These cysts have an high incidence: Burke *et al*^[1], reviewing the period 1990-2000, found between 44 and 55 new cases per 100000 inhabitants each year.

In the past century, similar cysts were also described as originated from lumbar zygapophyseal joints and occupying the spinal canal, most frequently in the lumbar spine and occasionally, in the cervical and thoracic spine^[4-6]. To define these spinal neoformations, many terms have been adopted in the literature, according to the site of development or to the supposed origin: Ganglion^[6], juxtafacet^[7], flavum^[8], cyfmos^[9] and synovial^[7,8,10-14].

The etiology of the cyst, not fully clear, could be strongly related to inflammatory phenomena secondary to facet hypermobility, which would produce modifications of the articular synovial membrane

leading to cyst formation^[13]. Microsurgical cystectomy is today the treatment of choice^[15], with or without arthrodesis: Generally, microsurgical approach does not produce vertebral instability and arthrodesis is required only in case of a clear pre-operative instability, such as spondylolisthesis.

Evaluating all etiological factors and all treatment options, we propose an original morphological classification of lumbar ganglion cysts, based on their relation with the other anatomical structures. Lastly, in order to clarify the confusing terminology that describes these particular cysts, we suggest "spinal ganglion cyst" (SGC) as definitive term to be applied in clinical practice.

MATERIALS AND METHODS

Thirty-four cases of symptomatic lumbar SGCs surgically treated from 1995 to 2011 were enrolled in this study. They include 18 previously published arthrodesis, with 3 hemorrhagic SGCs. All patients underwent preoperative magnetic resonance imaging (MRI) and computed tomography (CT) scan. To assess lumbar segmental instability, dynamic X-ray were also obtained in all patients but 4 cases, in which pain did not allow standing position.

Pain was evaluated by the Visual Analogic Scale (VAS score). Neurological examination was performed to assess signs of roots compression with any sensory and/or motor deficits.

All patients were operated through a microsurgical approach^[15], to maintain articular congruence and not jeopardize vertebral stability. Cystectomy was achieved through laminotomy or hemilaminectomy. In presence of demonstrated pre-operative or iatrogenic intraoperative segmental instability (wide resection of the articular process), instrumented arthrodesis was also performed.

Histological examination of the cyst was performed in all cases to confirm the diagnosis.

Average follow-up was 28.5 mo (range 12-60). All patients underwent MRI, plain X-rays and were evaluated by VAS and modified Japanese Orthopaedic Association score (JOA score) for neurological improvement in the lower limbs.

The Wilcoxon signed rank test was used for statistical analysis, considering *P* value equal to or less than 0.05 as significant.

Based on our experience and literature review, we were able to construct a new and original classification of the ganglion cysts. By some drawings, performed by the first author (Maurizio D), we reported for the first time the main locations of these cysts, summarizing and comparing our radiological and surgical data with those from the pertinent literature.

RESULTS

The data regarding our 34 cases are summarized in Table 1. Average age was 63 (range 50-76 years): 13 (38%)

Table 1 Data regarding our 34 cases

Case	Age and sex	Location (side)	Instability		Treatment		Other data
			Verified	Supposed	Type 1	Type 2	
1	68 M	L5-S1 (left internal)		a	y		
2	75 M	L4-L5 (right medium)		a, b, c	y		Re
3	50 F	L4-L5 (right medium-internal)		a, b	y		
4	63 F	L5-S1 (right medium)		b, c	y		
5	76 F	L4-L5 (left medium-internal)		a	y		
6	75 M	L5-S1 ¹ (right medium-lateral)		a, b, d	y		
7	75 F	L4-L5 (right medium-lateral)	y	b, c		y	
8	62 M	L4-L5 (right medium-internal)	y	a, b		y	
9	60 M	L4-L5 (right lateral)		a, b, c	y		
10	73 F	L5-S1 (right lateral)		a, b, d	y		
11	55 M	L2-L3 (left medium-lateral)		a	y		
12	55 M	L4-L5 (left medium)	y	a, b		y	
13	74 F	L3-L4 ¹ (right medium-lateral)		b, c	y		
14	56 F	L3-L4 (left medium-lateral)	y	a		y	
15	67 F	L4-L5 (left medium-lateral)		b	y		
16	56 F	L4-L5 (right medium-lateral)		b, c	y		
17	66 F	L4-L5 (left medium-internal)		b	y		IF
18	68 M	L4-L5 ¹ (left medium-lateral)		a	y		
19	73 F	L5-S1 ¹ (left medium)		a, b	y		
20	53 F	L5-S1 (left medium-lateral)		a, b, c, d		y	
21	60 F	L4-L5 (right internal)		a, b, c, d		y	
22	52 M	L4-L5 (right medium-internal)	y	a		y	
23	64 F	L5-S1 (left internal)	y	a, b		y	
24	53 M	L5-S1 (left medium)	y	a, b		y	
25	73 F	L4-L5 (left medium-lateral)		a, b, c		y	IF
26	54 F	L3-L4 (right medium-internal)	y	a, b		y	
27	61 M	L4-L5 (left medium)		a, b, c		y	
28	65 M	L5-S1 (left medium)		a, d	y		
29	71 M	L5-S1 (right medium-internal)		a	y		
30	52 F	L4-L5 (left medium-lateral)		a, b	y		
31	63 F	L4-L5 (right medium)		a, b	y		
32	72 F	L4-L5 (right lateral)		a, b, d	y		
33	56 F	L4-L5 (right lateral)		a	y		
34	62 F	L4-L5 (left medium-lateral)		a	y		

¹Hemorrhagic cyst; L: Left; R: Right; y: Yes; Type 1: Decompression; Type 2: Decompression with stabilization; Verified: Mobile olisthesis; a: Black disc; b: Interarticular liquid; c: Hyperintensity of the ligament on STIR MR images; d: Stable olisthesis; Re: Reoperated for postoperative instability with fusion; IF: Intraoperative fistula.

patients were males and 21 (62%) females. All patients had radicular pain, generally associated with lumbago. In 7 cases (21%), neurological deficits were also present. No cauda equina syndrome was detected. Duration of symptoms prior to surgical treatment varied from 1 to 3 years in 10 cases, whereas in the others average duration was 142 d (range 10-300 d). An acute onset, with a brief preoperative symptomatology, occurred in 4 hemorrhagic cysts.

Preoperative dynamic X-rays showed a mobile olisthesis in 8 cases (23%) and a stable one in 6 (18%). In all cases, preoperative CT and MRI showed signs of microinstability consisting of a reduced disc space and black disc (28 cases, 82%), increased interfacet synovial fluid (24 cases, 70%) and/or signal hyperintensity of the interspinous ligament on STIR sequences (10 cases, 29%).

All 14 pre-operative spondylolisthesis were submitted to arthrodesis. Instrumented fusion was achieved at the level of the cyst in 10 cases (Figure 1), while, in the remaining 4, it was extended to the level

above (Figure 2).

During surgery, we observed 2 dural laceration that were successfully repaired. Histology confirmed the nature of the lesions as ganglion or synovial cysts.

Based on neuroradiological investigations and operative findings, the lumbar SGCs were classified according to the scheme illustrated in Figures 3 and 4. Using this classification, 3 cysts were internal, 7 medium, 8 medium-internal, 12 medium-lateral and 4 lateral.

In the immediate post-operative period, all patients presented remission of pain, gradual recovery from radicular deficits or improvement of claudication. At 12-mo follow-up, one patient developed an olisthesis at the level of cystectomy with low back pain. Instability was correlated with an excessive demolition of the articular process. Therefore, stabilization and fusion achieved remission of pain and good long-term outcome. No recurrences or new contralateral or adjacent SGCs were observed.

At long-term follow-up, VAS reduced from $7.4 \pm$

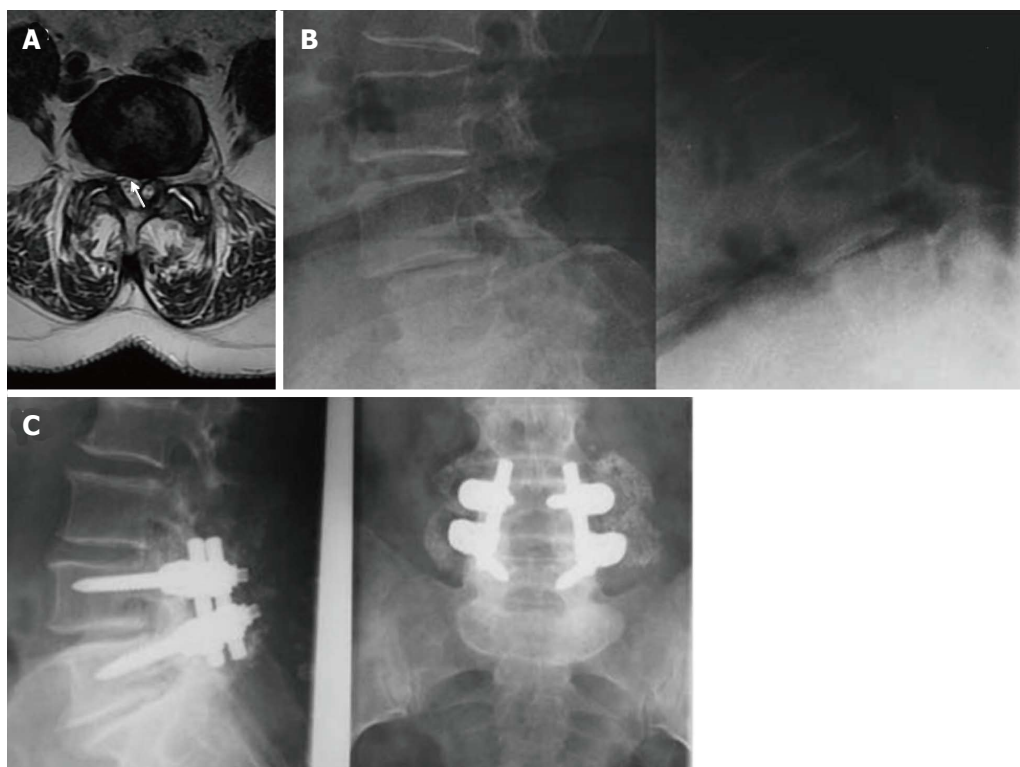


Figure 1 Case 2, Table 1. Preoperative axial T2-weighted MR image (A) showing a dehydrated and hypointense disk with a hyperintense cystic formation at right L4-L5 level (arrow). The cyst appeared to be of the internal or flavum type (see text for the classification). Sagittal dynamic images (B) 12 mo after the first surgical treatment showed an unstable olisthesis at L4-L5 level. Standard X-rays performed 1 year after surgical stabilization (C) showed the instrumentation to be well-positioned with an optimal profile and fusion at L4-L5.

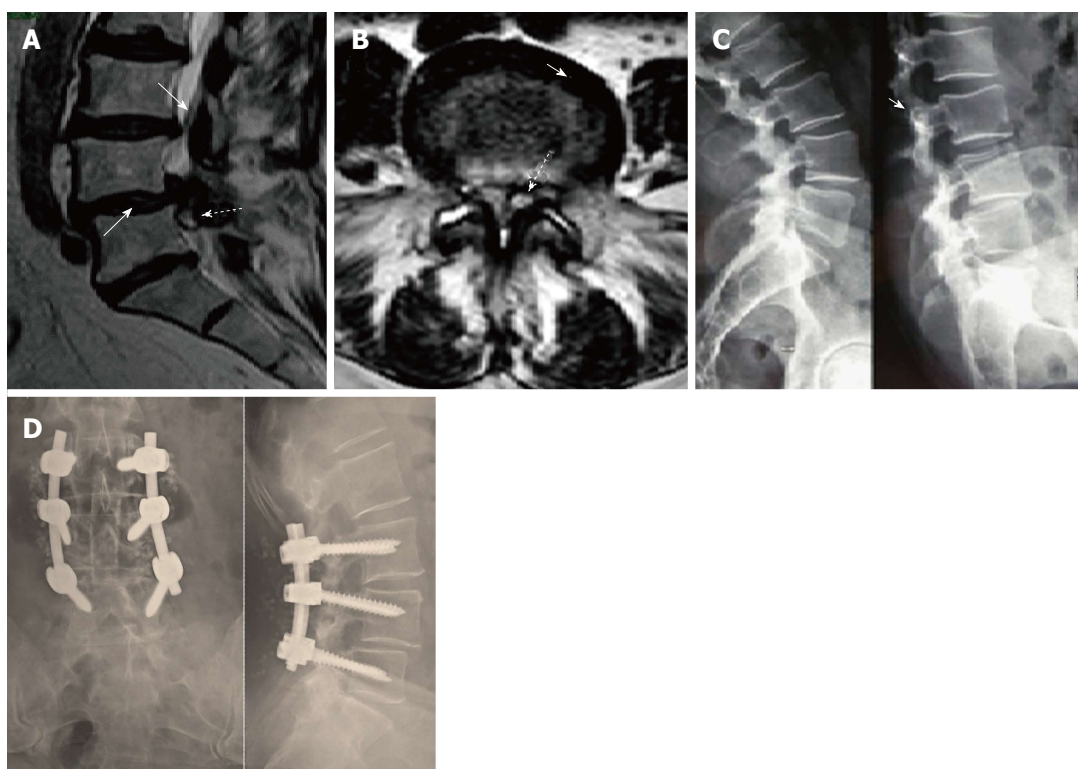


Figure 2 Case 12, Table 1. Preoperative sagittal T2-weighted MR image (A) showing a spinal ganglion cyst (dotted arrow) accompanied by olisthesis at L4/L5 with a dehydrated intervertebral disk (arrow), partially herniated into the spinal canal. On axial images (B) the cyst (dotted arrow) appeared to be of the medium or articular type (see text for classification). The interfacetal space contained an anomalous abundance of "sinovia" (commonly called synovial fluid), as the contralateral one did. Dynamic X-rays (C) showed an unstable olisthesis at L4/L5 and L3/L4. Postoperative outcome of the L3/L5 stabilization is documented by standard X-ray films (D) which confirmed good stability and fusion of the lumbar spine.

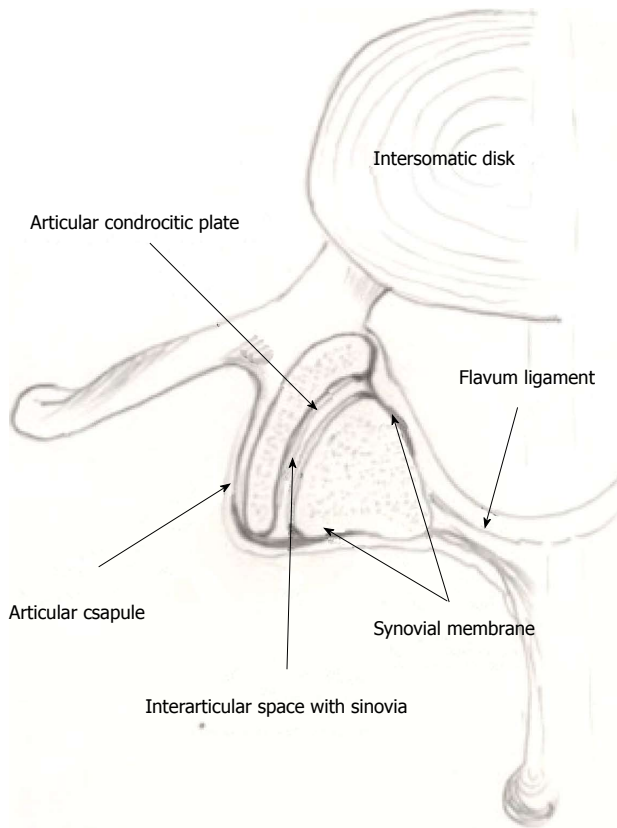


Figure 3 Schematic drawing of a lumbar facet joint showing the extension and distribution of the synovial membrane localized on the internal face of the articular capsule, extending to the external margins of the joint, up to the chondrocytic plates.

1.5 (6-10) to 1.3 ± 0.9 (0-2) ($P = 0.037$). JOA score improved from 7.6 ± 1.3 (7-9) to 2.5 ± 0.3 (0-3) ($P = 0.041$).

DISCUSSION

During the second half of the last century, articular cysts of the spine, prevalently lumbar, were likened to those of the wrist, hand, knee and hip and called, in the Greek language, *γαγγλιον* (ganglion). Hippocrate (460-377 a.C.), translated by Foesio *et al*^[3] in 1596, in the chapter "De Articulis" describes some cutaneous periarticular cysts as "...quae ganglia dominant, quaecunq; fluida sunt, et mucosam carnem continent..." (... these so-called ganglion, that contains a fluid or a mucous substance...). In 1930, Elmslie^[16], during a knee surgery, observed a communication between the cyst and the synovial membrane, and used for the first time the term "synovial cyst". In 1968, Kao *et al*^[6] described the first two cases of lumbar intraspinal extradural cyst, calling it "ganglion". In 1973, Sybert *et al*^[10] referred the possible origin from the synovial cells of the lumbar zygapophyseal joints. In 1974, Kao *et al*^[7], trying to establish terminology and nosology, published a review on spinal ganglion and synovial cysts, grouping them under a single definition: "Juxtafacet synovial cysts". This term was subsequently adopted by several

authors^[13,17-22], while others proposed other terms such as "flavum cyst"^[8] or "cyfmos"^[9], according respectively to the site of pathology or biomechanics of the mobile spine. They are all essentially correct, in relation to the tissue of origin^[6,10], site^[7-9] or etiology, but, in our hands, create some confusion. In order to identify this specific pathology in terms of pathogenesis, symptomatology and treatment, we reconsidered the ancient term of "ganglion": Spinal ganglion cyst (SGC) may be the term of choice if the cyst originates from the articular process: The distinction between ganglion and synovial cyst is in fact purely histological. Psaila and Mansel^[23] defined that a ganglion cyst "...mainly consists of sheets of collagen fibers arranged in multidirectional strata" and "the ganglion tissue may be produced by the multifunctional mesenchymal cells". The main histological feature of the ganglion is the loss of continuity with the capsule of the facet joints, that makes it free inside and/or outside the spinal canal. On the contrary, the real and conserved synovial cyst is always in continuity with the capsule and recurrently presents synovial villi.

SGCs originate from the joint capsule, more precisely from the mesenchymal tissue^[23] that constitutes the synovial membrane. This tissue covers the internal face of the capsule and also the external portion of the joint: This extension can explain the intra-articular or extra-articular development of SGCs. On the basis of these considerations, we propose an original classification that distinguishes the cysts between anterior or endocanal and posterior or extra-canal. The anterior variety can be subdivided into lateral or foraminal, medium or articular and internal or flavum.

To the best of the authors' knowledge, a comprehensive classification of SGCs has never been reported. Papers from the literature distinguished between synovial, posterior longitudinal ligament or flavum ligament cysts based on their location, origin or histopathological features. Our paper suggests for the first time the distinction between endo-canal and extra-canal SGC: The last one is posterior, generally asymptomatic and do not require treatment^[24]. On the contrary, endo-canal SGC is frequently symptomatic and neurological impairment is closely related to its position within the spinal canal, explaining different disorders ranging from single radiculopathy to cauda equina syndrome.

Factor responsible for proliferation of the synovial cells seems to be repeated articular micro-trauma that induces chronic inflammation, increase of synovial fluid and development of the cyst. Different grades of instability up toolisthesis can favor the weakening of the capsule and ultimately the cystic formation.

We observed lumbar degenerative olisthesis and SGC in more than 40% of our cases. These associated pathologies are frequently reported in the literature, in varying percentages from 30%^[13] to 50%^[25] of cases. Recently, Boviatis *et al*^[18], reviewing 499 SGCs, have found disc degeneration, osteoarthritis and spondylolisthesis. Many authors^[9,13,18,24-27] underlined that SGCs originate in the most mobile spinal segments,

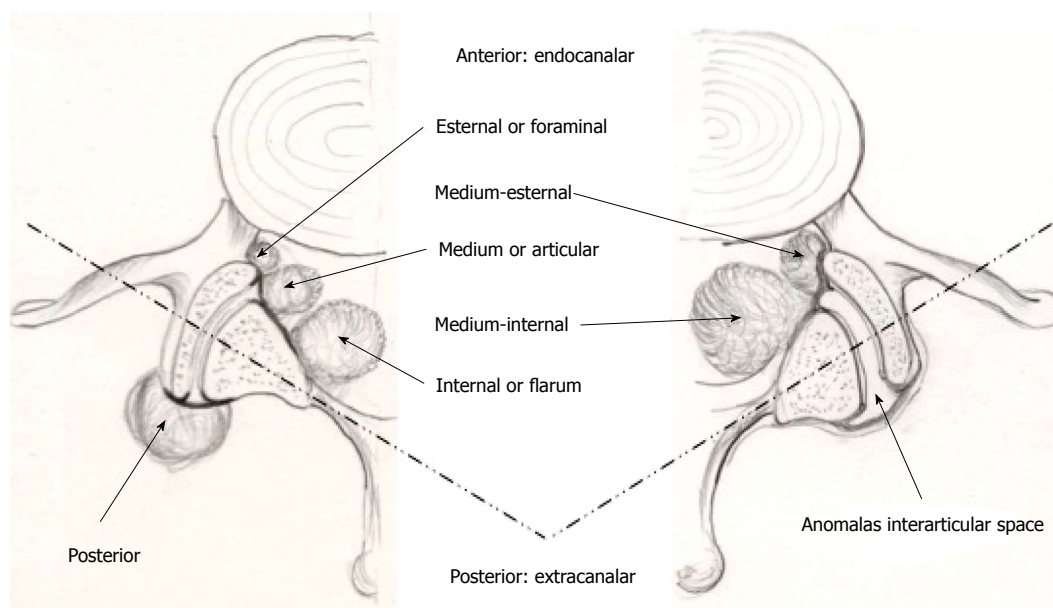


Figure 4 Localizations of lumbar spinal ganglion cysts (see text for the classification). The drawing on the right shows the joint with signs of instability (widened and misaligned interarticular space and increased amount of sinovia).

which are more susceptible to micro or macroinstability.

Cysts formation has been also presented in literature as consequence of an adjacent segment syndrome, due to the hypermobility of a segment just above or below other fixed vertebral segments; also in this case the mechanical stress would be the trigger necessary for mesenchimali tissue degeneration^[28].

In our series and in the literature^[9,13,18,24-26,29,30], SGCs were more frequent at L4-L5, which is notoriously the most mobile spinal level.

Clinical onset of SGCs is generally described as rapid and intense^[14,18,19,21,31], characterized by radicular type disturbances, severe impairment of deambulation due to painful symptoms or, less frequently, motor deficits. Occasionally, onset may be extremely acute and intractable due to intracystic hemorrhage. In agreement with other authors^[32-34], bleeding in such cysts is caused by neo-formed vessels following the repeated inflammations.

Radiological investigations mainly consist of MRI, which can visualize the SGC and relative degenerative phenomena, such as an increased quantity of "sinovia", more commonly described as interfacetal fluid, or inflammatory processes involving the interspinous ligament, which appears "shiny" mainly on T2 and STIR sequences^[35]. In our series these phenomena were present in all cases, either singly or, more often, in combination.

Conventional radiography can play an important role. Standard load-bearing and flexion-extension X-rays may identify hypermobility or instability otherwise unrecognized: However, the severe painful symptoms sometimes make it impossible to perform this type of pre-operative investigation.

Once a diagnosis of SGC has been made, treatment depends on clinical conditions and neurological sym-

ptoms. In the literature^[21], outcomes of different conservative treatments are reported. Surgery is indicated in case of severe pain resistant to medical therapy or when neurological deficits are present.

Operative approach has to totally remove the neoformation, taking into account the degree of instability of the spinal level involved by the cyst. Only when one part of the capsule appears tenaciously adherent to the dura mater it is advisable to perform a subtotal excision, to avoid risks of a CSF fistula. Microsurgical cystectomy seems to be able to maintain vertebral stability: Only one case developed vertebral slippage at follow-up. Fusion can be planned on the basis of preoperative investigations in presence of clear instability, as spondylolisthesis, or can be decided during surgery, evaluating the degree of joint demolition in order to achieve nerve roots decompression and radical cystectomy.

We limited posterior instrumented fusion to about a third of our cases, all suffering from spondylolisthesis: In the literature, fusion varies from over 50% of patients^[29] to a percentage similar or lower than ours^[9,12,13,17,25], whereas in other series surgery was performed without fusion^[15,22,30,36,37]. This variability in surgical strategy illustrates how the indication for fusion do not follow common guidelines. As a guide to a common therapeutical strategy, we have laid out a flow-chart (Figure 5), evaluating clinical conditions, mechanical stability and the most suitable treatment.

The long-term outcomes in patients surgically treated are usually good, with complete remission from pre-operative disturbances, in our series as in others^[9,11,12,13, 17,20,22,25,29,30,36,37]. Only one of our patients presented a symptomatic olisthesis about 1 year after treatment. This iatrogenic deformity, due to an excessive bone demolition, required posterior fusion to achieve resolution of symptoms. In the literature^[11,13,19,20,25,30] a

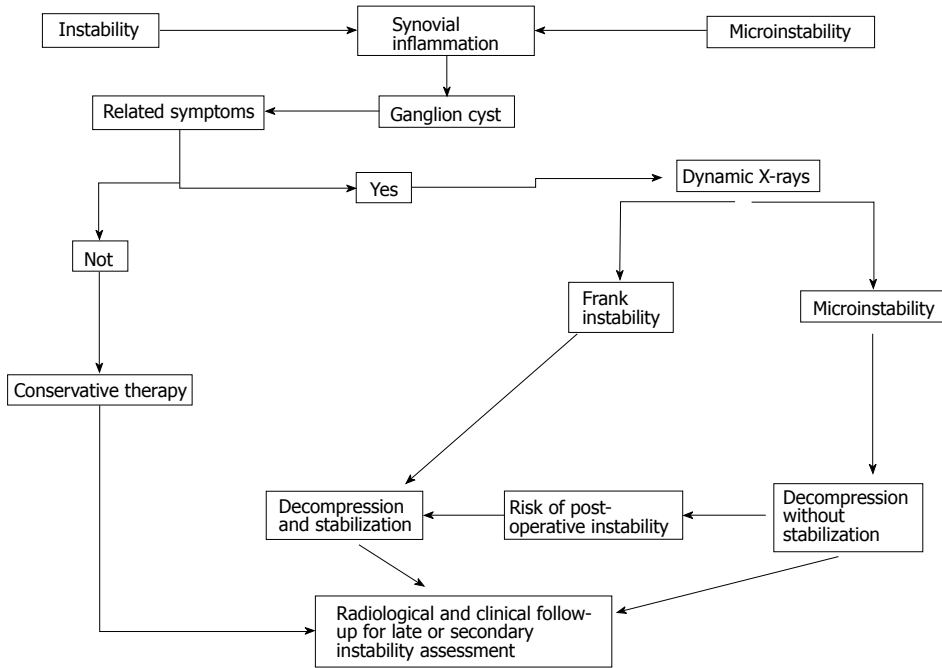


Figure 5 Flow-chart depicting options for the most appropriate approach to the lumbar spinal ganglion cysts.

similar complication was described with the same low incidence in the majority of the larger case series. A recurrence of an operated cyst is exceptional and only one case is described^[13]. The appearance of a new SGC, contralateral, higher or lower, is more frequent and occurred in 15 cases^[13,17,19,20,22,29,38]. No recurrences were observed in our case series.

In conclusion, spinal ganglion cysts are generally found in the lumbar spine. Over the past decades, a wide variety of terms used to describe them has generated confusion: For this reason, the authors decided to return to the ancient definition of "ganglion cyst". Their origin into the spine seems to be attributable to inflammatory phenomena, involving the synovial membrane and caused by repeated joint microtraumas, promoted by facet hypermobility or clear instability. The treatment of choice is microsurgical cystectomy, which generally does not require fusion. The need for fusion must be carefully evaluated: Pre-operative spondylolisthesis or a wide bone joint demolition are the main indications for fusion procedures. The proposal morphologic classification of SGCs is the first that clarifies different localizations of these cysts and may be clinically useful for radiologists and surgeons, together with the definition of ganglion, to speak the same scientific language.

COMMENTS

Background

Ganglion cysts of the minor and major joints, especially at the level of the wrist and back of the hand, have been known since ancient times. These cysts have a high incidence. In the past century, similar cysts were also described as originated from lumbar zygapophyseal joints and occupying the spinal canal, most frequently in the lumbar spine and occasionally, in the cervical and thoracic spine. To define these spinal neoformations, many terms have been adopted in the literature, according to the site of development or to the

supposed origin: Ganglion, juxtafacet, flavum, cyfmos and synovial.

Research frontiers

The etiology of the cyst was related to inflammatory phenomena secondary to facet hypermobility, which would produce modifications of the articular synovial membrane leading to cyst formation. Microsurgical cystectomy is today the treatment of choice. Generally, microsurgical approach does not produce vertebral instability and arthrodesis is required only in case of a clear pre-operative instability.

Innovations and breakthroughs

Evaluating all etiological factors and all treatment options, the authors propose an original morphological classification of lumbar ganglion cysts, based on their relation with the other anatomical structures. Lastly, in order to clarify the confusing terminology that describes these particular cysts, the authors suggest "spinal ganglion cyst" (SGC) as definitive term to be applied in clinical practice.

Applications

The proposal morphologic classification of SGCs is the first that clarifies different localizations of these cysts and may be clinically useful for radiologists and surgeons, together with the definition of ganglion, to speak the same scientific language.

Peer-review

The authors present a case series and a proposed standardized language for lumbar ganglion cysts. The paper is generally well-written and easy to read.

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