CT-Guided Needle Aspiration Biopsy of an Intraspinal Synovial Cyst (Ganglion): Case Report and Review of the Literature

James J. Abrahams,1,2 Gary W. Wood, Fredrick A. Eames, and Richard W. Hicks

Ganglions (synovial cysts) are cystic or semicystic lesions found most commonly in the wrist, dorsum of the foot, or knee. They may or may not be continuous with the joint space and may or may not have a synovial lining [1]. Some authors make a distinction between ganglions and synovial cysts, the latter being synovial-lined. Recently, several studies have reported the identification of synovial cysts in the spinal canal in relation to the facet joints. A review of the literature reveals a total of 17 cases previously reported (Table I). Ten of these were surgically proved [2, 4-7], eight were evaluated by CT [6-8], and only two were evaluated by CT and subsequently proved at surgery [6, 7]. We report the first CT-guided needle aspiration biopsy of an intraspinal synovial cyst. This was subsequently proved at surgery.

Case Report

A 68-year-old woman presented with an 8-month history of right hip pain, which later radiated down the lateral aspect of the thigh and calf with numbness of the dorsum of the foot. There was no weakness, loss of bowel or bladder control, or exacerbation with coughing or sneezing. The pain improved with bed rest, but was not alleviated. Walking caused an increase in symptoms. Physical examination on admission revealed a right straight-leg raise to 60° with a positive Lasegue test. There was decreased sensation to the dorsum of the right foot after ambulation. The left side was normal.

Plain lumbosacral spine films were unremarkable except for mild hypertrophic changes. No destructive lesions were seen. A noncontrast-enhanced CT scan demonstrated a 1-cm round lesion in the posterior right lateral aspect of the spinal canal adjacent to the right L4-L5 facet joint (Fig. 1). The lesion had a slightly lower attenuation than the disk material and was surrounded by a ring of higher attenuation believed to represent mild calcification. The thecal sac was compressed and pushed in the anterior and left lateral directions. The facet joints demonstrated hypertrophic changes. Metrizamide lumbar myelography confirmed the round, smooth, extradural characteristics of this lesion and further delineated its posterior and right lateral position (Fig. 2). The L4-L5 disk was believed to be normal except for mild bulging (Fig. 2A). A CT-guided needle aspiration biopsy was subsequently performed for diagnostic confirmation and therapeutic decompression. With the patient in the prone position, a 22-gauge needle was inserted just to the right of the L4 spinous process and directed between the lamina of L4 and L5. CT confirmed proper needle location within the lesion and three drops of a tenacious, stringy, translucent, straw-colored fluid were aspirated and sent to cytology (Fig. 3A). This fluid was reported to have no malignant cells and a few mesothelial cells. The cyst was then opacified with 0.3 ml of metrizamide 190 mg/ml concentration (Fig. 3B), and an 18-gauge spinal needle was inserted into the cyst in an unsuccessful attempt to aspirate more fluid. Owing to the degree of the patient’s symptoms, a laminectomy and cystectomy were performed the next day. At surgery, an oval cystic lesion was seen to be incorporated into the ligamentum flavum and to extend from a hypertrophic L4-L5 facet joint. Pathologic evaluation demonstrated a thick, fibrous wall with calcium deposits and a few chronic inflammatory cells. The cyst contained an amorphous substance; no synovial lining was present (Fig. 4). Three weeks after surgery, the patient had made a complete recovery.

Discussion

The origin of intraspinal synovial cysts is disputed, with opinions ranging from herniation of synovium to cystic or mucinous degeneration of connective tissue [1, 9]. We believe that the intraspinal cysts described in the literature are all the same entity. The exception may be the case of a rheumatoid cyst described by Linquist et al. [10]. Whether or not these cysts are lined with synovium seems irrelevant, as chronic inflammatory reactions could erode or destroy the initial synovial lining. Also, cysts that once communicated with the joint could theoretically lose their communication. Therefore, whether these cysts are called synovial cysts or ganglion cysts is a matter of semantics. Either way, a review of the literature reveals a rather characteristic radiographic presentation.

The CT findings originally described by Hemminghytt et al. [6], and also reported by Casselman [7] and Mercader et al.

Received February 5, 1986; accepted February 26, 1986.

1 All authors: Department of Radiology, Albany Medical Center Hospital, New Scotland Ave., Albany, NY 12208.
2 Present address: Department of Neuroradiology, Yale-New Haven Medical Center, New Haven, CT 06510. Address reprint requests to J. J. Abrahams.

TABLE 1: Survey of Previously Reported Cases of Intraspinal Synovial Cysts

<table>
<thead>
<tr>
<th>Author</th>
<th>Number of Cases Reported</th>
<th>Number Surgically Evaluated</th>
<th>Number Demonstrating Spontaneous Resolution</th>
<th>Number Demonstrating Normal Disk</th>
<th>Number Demonstrating Calciumification</th>
<th>Number Demonstrating Myelography by CT</th>
<th>Number Demonstrating Calcification</th>
<th>Number with Normal Disk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kao et al., 1968</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>NA</td>
</tr>
<tr>
<td>Zoch, 1969</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>1</td>
</tr>
<tr>
<td>Sypert et al., 1973</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Bhushan et al., 1979</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>0</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>4</td>
</tr>
<tr>
<td>Hemminghytt et al., 1982</td>
<td>4</td>
<td>1</td>
<td>NA</td>
<td>4</td>
<td>3</td>
<td>NA</td>
<td>NA</td>
<td>3</td>
</tr>
<tr>
<td>Mercader et al., 1985</td>
<td>3</td>
<td>0</td>
<td>NA</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Casselman, 1985</td>
<td>1</td>
<td>1</td>
<td>NA</td>
<td>1</td>
<td>NA</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Note.—NA = no data available.

Fig. 1.—CT scan through L5 shows round, right, posterolateral lesion compressing dural sac. Note surrounding ring of high attenuation (white arrows), which was later shown to be caused by microscopic calcium deposits. The lesion arises from L4–L5 facet joint (curved black arrows) and appears to incorporate ligamentum flavum (straight black arrows) on right.

Fig. 2.—Metrizamide lumbar myelogram.
4, Lateral view shows posterior extradural defect (closed arrows) from the cyst and mild anterior extradural defect (open arrow) from bulging disk at L4–L5 level. No anterolateral defect is evident to suggest a herniated disk.
B, Oblique view again shows smooth, round, posterior extradural defect at L4–L5 level.

[8], are those of a round, roughly 1-cm extradural lesion located posterolaterally in relation to the L4–L5 facet. It is usually of lower attenuation than disk material and often has a surrounding rim of higher attenuation representing calcification within its wall. CT often reveals a normal disk and clearly demonstrates the facet joint arthrosis reported by most authors. On myelography, a smooth, rounded, posterolateral extradural defect will be seen [2, 5]. If large enough, it may cause a complete block [4]. All cases have been located at the L4–L5 facet joint except one, which was at the L3–L4 facet [8]. In this case there was an L4–S1 arthrodesis 12 years earlier. The fact that these cysts occur at the L4–L5 facet appears to be related to the increased mobility at this level. It is of interest that the only L3–L4 lesion reported was
introduce a components to which we attribute the
When opacifying the cyst, caution
nosis . The
avoiding surgery . We were unsuccessful in decompressing
formed with the intention of decompressing the
warranted .

In a patient with an arthrodensis. The radiographic presentation
is probably diagnostic; however, common lesions in the differen­
tial diagnosis to be excluded are malignancies and her­
niated nucleus pulposus. Malignancies may demonstrate an
associated soft-tissue mass or osseous destruction; circum­
erential calcification would be unlikely. A herniated nucleus
pulposus would not usually present with a posterior defect,
and demonstration of a normal disk on CT or myelography
virtually excludes this diagnosis. Other lesions in the differen­
tial diagnosis are arachnoid cysts, dermoid cysts, rheumatoid
ysts, and demonstration of a
on CT or

REFERENCES