Science World Publishing

Open Access Journal | Volume: 10.09

CURRENT TRENDS IN MEDICAL AND CLINICAL CASE REPORTS

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A Patient Surgically Treated for with Craniopharyngioma after Surgery at a her 25-Yyear Follow-up (Case Report)

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Article Information

Article Type: Case Report
Journal Type: Open Access
Volume: 3 **Issue:** 1
Manuscript ID: CTMCCR-V3-1140
Publisher: Science World Publishing

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Citation: Shi Xiangen (2026). A Patient Surgically Treated for with Craniopharyngioma after Surgery at a her 25-Yyear Follow-up (Case Report). *Current Trends Med Clin Case Rep*, 10(9);1-3

Received Date: 01 June 2026
Accepted Date: 17 June 2026
Published Date: 20 June 2026

1. Abstract

A 24-year-old female patient experienced amenorrhea for three months after surgical resection of a craniopharyngioma (CP). A CT scan revealed a calcified tumour in the suprasellar region and the anterior third ventricle. In a second surgery, the tumour was completely resected through an incision in the anterior corpus callosum. The patient returned to normal life and subsequently had a boy three years after surgery, followed by a girl six years later. At 25 years of follow-up, the patient was an elementary school teacher; the follow-up MR image showed no tumour growth. We believed this patient was surgically cured.

This The patient in this report is a woman who, at 24 years old, reported experiencing was a 24-year-old woman who experienced amenorrhea for three months following the surgical resection of a craniopharyngioma (CP) at a local medical centre. A CT scan imaging revealed a calcified tumour in the suprasellar region and the anterior third ventricle. The In a second surgery, surgical complete resection of the tumour was performed through an incision in the anterior corpus callosum, allowing access to the location of the tumoranterior third ventricle and the suprasellar region. The patient returned to a normal life and subsequently had a boy and a girl after the surgery. The patient resumed her normal life and had a boy three years after surgery, followed by a girl six years later. After 25 years of follow-up, during which the patient continued working as an elementary school teacher, and his her MRI scan showedrevealed no tumour growth. In conclusion, surgical treatment for CP seems to cure patients and restore their fertility.

It poses a challenge for recurrent CP and associated endocrine issues that may arise after surgical CP removal pose challenges. The patient in the current case report is a woman who, at 24 years old, reported three months of amenorrhea following surgical resection of a CP at a local medical centre. A preoperative CT scan revealed a calcified tumour in the anterior third ventricle, resulting in obstructive hydrocephalus (Figure 1A and B). The tumour was partially removed through an initial right frontal incision (Figure 1C and D). CP and associated endocrine issues that may arise after surgical CP removal pose challenges. There The patient in the current case report is a woman who, at was 24 years old, reported experiencing -year-old woman who experienced amenorrhea for three months following the surgical resection of a CP at a local medical centre. Preoperative preoperative CT scan showed revealed a calcified tumour in the anterior third ventricle, resulting in obstructive hydrocephalus (Figure 1A 1: A and B). A partial thetumour was partially removed through an initial incision in the right frontal area (Figure 1C 1: C and D).

Figure 1. A preoperative enhanced coronal CT scan (A) and axial CT scan (B) CT scans revealed a calcified tumour in the anterior third ventricle with obstructive hydrocephalus. An initial postoperative coronal (C) and axial (D)CT(D) CT scans showed a revealed partial tumour removal through a right frenotomy. The, arrowhead pointing indicates the tumourFigure 1. Preoperative enhanced coronal (A) and axial (B) CT scans revealed a calcified tumour in the anterior third ventricle, with obstructive hydrocephalus. Initial postoperative coronal (C) and axial (D) CT scans showed partial tumour removal via a right frenotomy. The arrowhead indicates the tumour.

A second surgical surgery for complete resection of the tumour in the anterior third ventricle and the suprasellar region was successfully performed through the finical columns via a 2-cm2 cm incision in the anterior corpus callosum using a via frontal craniotomy on June 4, 2001 (see Figure 2A2, A and B). The cystic fluid of the tumour was aspirated, and the solid part of the lesion was removed piecemeal from the centre to the periphery. The calcified mass,

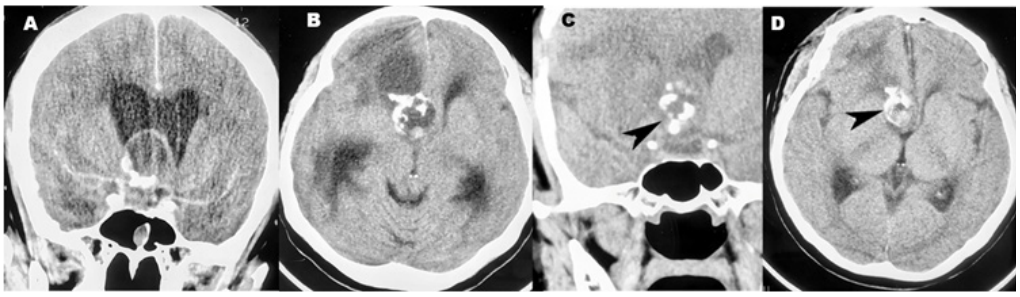


Figure 1: A preoperativeenhanced coronal CT scan (A) and axial CT scan (B) CT scans revealed a calcified tumour in the anterior third ventricle with obstructive hydrocephalus. An initial postoperative coronal (C) and axial (D)CT(D) CT scans showed a revealed partial tumour removal through a right frenotomy. The, arrowhead pointing indicates the tumour.

shaved by crushing, was divided using with micro scissors, and the freed fragments were removed. Finally reaching the tumour's edge after the tumour edge was reached, the tumour wall was carefully separated from the surrounding vital brain tissue. Preserve the The small perforating vessels feeding that fed the chiasm and tract, and the remaining pituitary stalk, infundibulum, and mammillary body were preserved, ensuring that no leptomeninges are were present between the tumour and hypothalamic structures, when possible. After surgery, the patient experienced a temporary decrease in loss of short-term memory but gradually recovered within aone week. They She also developed transient diabetes insipidus, which was treated with desmopressin. Postoperative MR images indicated that the lesion was completely removed, and that there was no sign of hydrocephalus (Figurehydrocephalus(Figure 2.C C and D). The postoperativehistopathological examination revealed an adamantinoma Tous- type of craniopharyngioma (CP), as shown in Figure 3.A second surgery for complete resection of the tumour in the anterior third ventricle and the suprasellar region was successfully performed on June 4, 2001, through the finical columns via a 2-cm incision in the anterior corpus callosum using a frontal craniotomy (see Figure 2A and B). The tumour's cystic fluid was aspirated, and the solid portion of the lesion was removed piecemeal from the centre to the periphery. The calcified mass was crushed and divided with micro scissors, and the freed fragments were removed. After the tumour edge was reached, the tumour wall was carefully separated from the surrounding vital brain tissue. The small perforating vessels feeding the chiasm and tract, and the remaining pituitary stalk, infundibulum, and mammillary body were preserved, and when possible, no leptomeninges were present between the tumour and hypothalamic structures. After surgery, the patient experienced a temporary loss of short-term memory but gradually recovered within one week. She also developed transient diabetes insipidus, which was treated with desmopressin. Postoperative MR images indicated complete removal of the lesion and no evidence of hydrocephalus (Figure 2C and D). Postoperative histopathological examination revealed an adamantinoma Tous-type craniopharyngioma (CP), as shown in Figure 3.

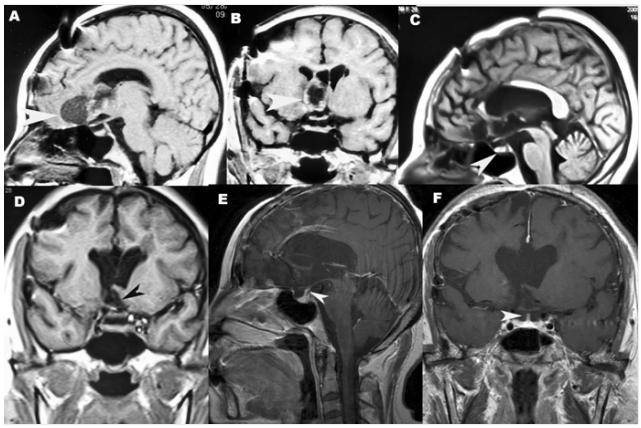
Figure 2. Second preoperative sagittal (A) and coronal (B) MR images revealed a mixed cystic and solid tumour in the anterior third ventricle and the suprasellar region, with the arrowhead pointing to the tumour. Second postoperative sagittal (C) and coronal (D) MR images showed tumour disappearance with from the third ventricular structure, with an arrowhead pointing to the pituitary gland and the third ventricular floor. At the 2625 -year follow-up, sagittal (E) and coronal (F) enhanced MR images showed no tumour growth with preservation of the hypothalamic structure. The arrowhead indicates, arrowhead pointing to the pituitary stalkFigure 2. Second preoperative sagittal (A) and coronal (B) MR images revealed a mixed cystic and solid tumour in the anterior third ventricle and suprasellar region, with the arrowhead pointing to the tumour. Second postoperative sagittal (C) and coronal (D) MR images showed the tumour's absence from the third ventricular structure, with an arrowhead pointing to the pituitary gland and the third ventricular floor. At the 25-year follow-up, sagittal (E) and coronal (F) enhanced MR images showed no tumour growth and preservation of the hypothalamic structure. The arrowhead indicates the pituitary stalk.

Figure 3. A histopathology slide stained with Hematoxylin hematoxylin and eosin (H&E)-stained histopathology slide from the centre of the tumour of the anterior third ventricle in this patient, showedshowing cords of squamous epithelium, a palisaded columnar epithelium, and wet and focal keratin, and focal keratin, which are consistent with the adamantinomatous type of CP; CP; (A) scale bar: 100 μmμm; and (B) scale bar:bar 250 μmμmFigure 3. A hematoxylin and eosin (H&E)-stained histopathology slide from the centre of the tumour in the anterior third ventricle of this patient, showing cords of squamous epithelium, a palisaded columnar epithelium, and focal keratin, which are consistent with adamantinoma Tous CP; (A) scale bar: 100 μm; (B) scale bar: 250 μm.

We conducted a 25-year follow-up review: of the patient.The postoperative course was uneventful, except for short-term memory loss that gradually recoveryresolved. The patient was discharged seven days after surgery. Her desmopressin, hydrocortisone, and levothyroxine prescriptions were stopped being prescribed three months after tapering off from the drugs. At 1.5 years after surgery, Patient entrancethe patient entered a local normal college while after pass nation high passing a national high-university examination. She served as a junior school math and English teacher after graduating from a the normal college for after three years of study. She had a lucky boy one year after gettingshe married following, with the recovery of her menstrual period, and a lovely girl nine years after surgery, producing in a happy family (Figure 4).We conducted a 25-year follow-up review of the patient. The postoperative course was uneventful, except for short-term memory loss that gradually resolved. The patient was discharged seven days after surgery. Her desmopressin, hydrocortisone, and levothyroxine prescriptions were discontinued three months after tapering. At 1.5 years after surgery, the patient entered a local normal college after passing a national university examination. She served as a junior school math and English teacher after graduating from the normal college after three years of study. She had a boy one year after she married, following the recovery of her menstrual period, and a girl nine years after surgery, producing a happy family (Figure 4).

Figure 34. Pictures showedshowing that the patient had a lucky boy at four years after surgery, and a lovely girl at nine years after surgery (A).Atthe 25-year follow-up, the patient saw the author at an outpatient clinic on January 19, 2026 (B).Figure 4. Pictures showing that the patient had a lucky boy four years after surgery and a lovely girl nine years after surgery (A). At the 25-year follow-up, the patient saw the author at an outpatient clinic on January 19, 2026 (B).

Few reports exist of patients with CP recoveringwho have recovered their normal lives and fertility after surgery, even overafter a 25 -years follow-up. One patient was tracked from a group ofamong 187 studied studies published between 1995 and 2025. Although CPs always causedcause some degree of endocrinological morbidity due tobecause of hypothalamic damage to a certain degree,1 the tumour can be classified into different types to optimize the there were several classifications of the tumour types for surgical



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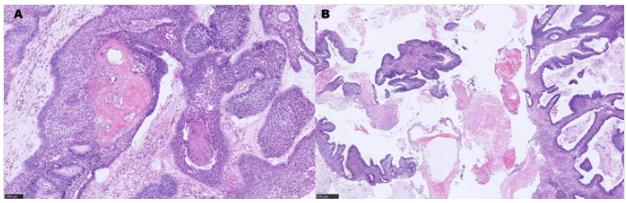

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Figure 4: Pictures showed showing that the patient had a lucky boy at four years after surgery, and a lovely girl at nine years after surgery (A). At the 25-year follow-up, the patient saw the author at an outpatient clinic on January 19, 2026 (B).

approach andto achieve maximal preservation of the hypothalamic structures. 2,3,4 Clearly identifying a dissection plane between the tumour and hypothalamic structures is essential to reducefor reducing the risk of injury to the hypothalamus. The thermalThermal injury to the hypothalamic structures of caused by bipolar cautery cannot be neglected in the hypothalamic structures. In the current patient, An an incision was made in the anterior corpus callosum through a frontal craniotomy, by utilizing the space between the finical columns. This approach allowed for access to the anterior third ventricle, facilitating the dissection of a the tumour, which was located above the floor of the third ventricle and in the suprasellar regionregion [5,6]. Few reports describe patients with CP who have regained normal lives and fertility after surgery, even after 25 years. One patient was followed among 187 studies published between 1995 and 2025. Although CPs always cause some degree of endocrinological morbidity due to hypothalamic damage,1 the tumour can be classified into different types to optimize the surgical approach and maximize preservation of the hypothalamic structures [2,3,4]. Clearly identifying a dissection plane between the tumour and hypothalamic structures is essential to reduce the risk of hypothalamic injury. Thermal injury to the hypothalamic structures caused by bipolar cautery cannot be neglected. In the current patient, an incision was made in the anterior corpus callosum through a frontal craniotomy, using the space between the finical columns. This approach provided access to the anterior third ventricle, facilitating dissection of the tumour, which was located above the floor of the third ventricle and in the suprasellar region [5,6].

In conclusion, surgical resection of CPs can offer a long-term cure and restore fertility, though although it carries is associated with risks of endocrinological complications and mortality. Preserving the hypothalamus is crucial during the surgical treatment of tumoursthe tumour. This procedure demands requires skilled techniques and should aims for complete tumour removal to avoid unnecessary re-treatments retreatments due to recurrence.In conclusion, surgical resection of CPs can offer a long-term cure and restore fertility, although it carries risks of endocrine complications and mortality. Preserving the hypothalamus is crucial during surgical treatment of the tumour. This procedure requires skilled techniques and should aim for complete tumour removal to avoid unnecessary retreatment due to recurrence.

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