Medically resistant pediatric insular-opercular/perisylvian epilepsy. Part 1: invasive monitoring using the parasagittal transinsular apex depth electrode

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OBJECTIVE Insular lobe epilepsy (ILE) is an under-recognized cause of extratemporal epilepsy and explains some epilepsy surgery failures in children with drug-resistant epilepsy. The diagnosis of ILE usually requires invasive investigation with insular sampling; however, the location of the insula below the opercula and the dense middle cerebral artery vasculature renders its sampling challenging. Several techniques have been described, ranging from open direct placement of orthogonal subpial depth and strip electrodes through a craniotomy to frame-based stereotactic placement of orthogonal or oblique electrodes using stereo-electroencephalography principles. The authors describe an alternative method for sampling the insula, which involves placing insular depth electrodes along the long axis of the insula through the insular apex following dissection of the sylvian fissure in conjunction with subdural electrodes over the lateral hemisphere/opercular region. The authors report the feasibility, advantages, disadvantages, and role of this approach in investigating pediatric insular-opercular refractory epilepsy.

METHODS The authors performed a retrospective analysis of all children (< 18 years old) who underwent invasive intracranial studies involving the insula between 2002 and 2015.

RESULTS Eleven patients were included in the study (5 boys). The mean age at surgery was 7.6 years (range 0.5–16 years). All patients had drug-resistant epilepsy as defined by the International League Against Epilepsy and underwent comprehensive noninvasive epilepsy surgery workup. Intracranial monitoring was performed in all patients using 1 parasagittal insular electrode (1 patient had 2 electrodes) in addition to subdural grids and strips tailored to the suspected epileptogenic zone. In 10 patients, extraoperative monitoring was used; in 1 patient, intraoperative electrocorticography was used alone without extraoperative monitoring. The mean number of insular contacts was 6.8 (range 4–8), and the mean number of fronto-parieto-temporal hemispheric contacts was 61.7 (range 40–92). There were no complications related to placement of these depth electrodes. All 11 patients underwent subsequent resective surgery involving the insula.

CONCLUSIONS Parasagittal transinsular apex depth electrode placement is a feasible alternative to orthogonally placed open or oblique-placed stereotactic methodologies. This method is safe and best suited for suspected unilateral cases with a possible extensive insular-opercular epileptogenic zone.

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KEY WORDS insula; refractory epilepsy; surgery

Recent evidence has suggested that failure to recognize seizures arising from the insular cortex could be responsible for some cases of surgical failure in patients with frontal, temporal, or parietal lobe epilepsy.29,15–17,20,23,29,30 Insular seizures may mimic or coexist with seizures due to temporal or perisylvian epilepsy.29,30 Although a standard presurgical investigation may aid in suggesting an insular ictal onset zone (IOZ), confirmation of insular cortex epilepsy usually requires invasive investigation with insular coverage.9,15,16,23,33 This is espe-
cially true in children, in whom invasive investigation has been recommended to confirm insular lobe epilepsy (ILE) in all cases.13

Recent studies have justified invasive sampling of the insula, as insulectomy has been shown to be both safe and effective in treating ILE when performed alone or in combination with perisylvian corticectomy.10,12,14,19,20,24,28,33,37 However, the vast majority of literature pertains to adults, with few reports documenting the safety and efficacy of insular investigation or resection in children.13

Several methods have been used to perform invasive insular sampling for investigating drug-resistant epilepsy, each with their own advantages, disadvantages, and risks.1,8,9,13,24,33 Insular depth electrode electroencephalography (EEG) approaches include either orthogonal or oblique frame-based stereotactic methods1,15,16,27 or open, direct transsylvian implantation of orthogonally placed depth electrodes in,13 or strip24 electrodes on, the insula following microsurgical opening of the sylvian fissure. Frame-based stereotactic techniques include the stereotactic orthogonal transopercular (OTO) Talairach method,1,12–16 or stereotactic parasagittal techniques through the frontal lobe (transfrontal oblique [TFO]),1,8,9 parietal lobe (transparietal oblique [TPO]),1,27 and any combinations of these stereotactic methods (TFO-TPO, TFO-TPO-OTO).26

We describe an alternative method for sampling the insula, in which an insular depth electrode is placed parasagittally down the long axis of the insula through the insular apex/limen insula following dissection of the sylvian fissure in conjunction with tailored hemispheric/opercular coverage with subdural electrodes. We report the feasibility and advantages and disadvantages of this approach in children with insular-opercular refractory epilepsy.

### Methods

We performed a retrospective chart review of all patients who, between May 2009 and April 2015, underwent invasive investigation of the insula and perisylvian regions for drug-resistant epilepsy using the parasagittal transinsular apex electrode in addition to perisylvian strips/grids at Miami Children’s Hospital. Miami Children’s Hospital is a tertiary-care national and international referral hospital for drug-resistant epilepsy in children. All operations in this series were performed by a single surgeon (S.B.). We included all consecutive patients undergoing invasive insular investigation using the parasagittal transinsular apex depth electrode. All patients underwent a comprehensive epilepsy surgical workup as described previously.11,18 Briefly, this workup includes taking a complete history and performing neurological examination, neuropsychological evaluation, scalp video-electroencephalography (EEG) monitoring, and 3-T MRI. Ancillary testing with SPECT, FDG-PET, and source localization was performed in all cases.

### Patient Selection and Indications

Invasive investigation and extent of resective surgery were decided in each case after discussion in a multidisciplinary epilepsy conference. In accordance with prior studies, indications for insular sampling included insular/peri-sylvian lesion and noninvasive, discordant data; perisylvian lesion with atypical semiology suggestive of an insular IOZ (e.g., laryngeal constriction and/or sensory symptoms); and prior failed nonlesional resective surgery with presurgical data indicating an insular IOZ.13,15,16,23 Based on these criteria, the decision to proceed with insular sampling during invasive investigation was based on a very high degree of suspicion of insular involvement, including a combination of early insular semiology, lesion involving the insula as exhibited on MRI, and suspected insula involvement as exhibited on PET and/or SPECT.

### Operative Technique

#### Surgical Anatomy of the Insular Lobe

Detailed working knowledge of the insular lobe and sylvian fissure is critical for carrying out this technique. The surgical anatomy of the insular lobe and perisylvian region has been described in detail elsewhere (Fig. 1).34 The insula is a pyramid-shaped structure located in the depth of the sylvian fissure, as it forms the medial wall of the deep (operculo-insular) compartment of the sylvian fissure. Insular surface anatomy is important for planning electrode placement. The insula harbors 5 gyri, including 3 short gyri and 2 long gyri. Important insular surface landmarks are the insular pole, limen insulae, and insular apex. The insular pole is the most anteroinferior edge of the insula, essentially the point of the pyramid, located at the convergence of the 3 short gyri, which radiate superoposteriorly from the insular pole. The insular pole is superior and lateral to the limen insulae, the site of the middle cerebral artery (MCA) bifurcation. The insular apex is the highest and most prominent portion of the insula laterally on the insular convexity and is usually located on the middle short gyrus, above and posterior to the insular apex, and above the limen insulae and MCA bifurcation. It is thus a readily available site for electrode insertion.

Knowledge of the relationship of the insular topographical anatomy to the sylvian fissure is also important. Whereas the limen insulae is located deep to the temporal operculum, the superior anterior and middle short gyri are usually located below the pars opercularis. The pars triangularis covers mostly the upper anterior short gyrus. Thus, the posterior ramus of the superficial sylvian fissure, adjacent to the pars triangularis, will expose the anterior/middle short gyrus and anteroinferior insula. The insular apex is essentially located directly below the sylvian fissure, between the temporal operculum and pars triangularis/opercularis. Figure 2 is a medical illustration demonstrating the different techniques for insular sampling.

#### Patient Positioning and Craniotomy

With the patient supine, the head is rotated 45° to 60° to the contralateral side and fixed in place with a 3-point Mayfield head holder (Video 1 and Fig. 3B).

[Video 1. Video illustrating technique for placement of transsylvian parasagittal insular depth electrode for suspected ILE. alg = anterior long gyrus; asg = anterior short gyrus; ftp = fronto-temporo-parietal; ia = insular apex; msg = middle short gyrus; pig = posterior long gyrus; psg = posterior short gyrus.; Copyright Sanjiv Bhatia. Published with permission. Click here to view.]
A large unilateral fronto-parieto-temporal scalp incision and craniotomy are performed centered on the perisylvian region (Fig. 3C). The lesser wing of the sphenoid is drilled to facilitate exposure of the sylvian fissure and obtain a flat access to the insular apex for insertion of depth electrodes (Fig. 3D). This is a very important step that should not be ignored.

Exposure and Electrode Implantation

Using the surgical microscope, the vertical ascending segment of the sylvian fissure is dissected and opened widely using standard microsurgical technique (Fig. 3E). An attempt is made to preserve the M3 arteries and veins. Exposure is performed in 3 steps. The ascending portion of the sylvian fissure is opened longitudinally. Sylvian fissure dissection should be started at the pars triangularis apex, as this is the largest opening of the superior sylvian fissure (Fig. 3F). Furthermore, opening the posterior ramus below the pars triangularis will expose the anterior/middle short gyri and anteroinferior insula, which lead down to the insular apex. The MCA branches are followed down to the deep portion of the fissure until the M2 branches overlying the insula are reached (Fig. 3G). At this stage, the deep operculo-insular fissure is dissected, exposing the inferior and then superior insula all the way to the inferior and superior sulci, respectively. The sylvian dissection may be carried out as far posteriorly as possible so that the entire extent of the insula can be exposed (Fig. 3H). This exposes the insular cortex beneath the opercula of the frontal, temporal, and parietal lobes. Finally, the relatively avascular insular apex and pole are exposed (Fig. 3I). The insular apex is the most prominent laterally projecting surface on the insula just above and behind the insular pole, the most anteroinferior point of the insula.

The insular depth electrode was then inserted starting at an avascular surface of the insular apex above the MCA branches after pial incision with a microblade (Fig. 3J and K). The electrode was directed posterosuperiorly to follow the sagittal axis of the insula, staying parallel to the insular cortex in the subpial region. Drilling down the lesser wing of sphenoid helps in holding the depth electrode in the direction of the insula prior to insertion. This can also be performed using ultrasound guidance (Fig. 3M). One 8-contact electrode was inserted in all but 1 case, in which two 4-contact electrodes were used. The electrodes (Spencer depth electrodes, Ad-Tech Medical Instrument Corp.) contain 8 contacts of 2.3 mm length separated by 5 mm from center to center. Papaverine (30 mg/ml) was instilled
over the sylvian vessels to prevent spasm of the M2 and M3 vessels. Subdural grids and strips were then placed over the adjacent opercula and cortical convexities of the frontal, parietal, and temporal lobes based on the presurgical evaluation (Fig. 3L). The insular electrodes were sutured to the dura mater to prevent electrode migration. Additional depth electrodes were inserted in 1 patient into a frontal tuber. The electrodes were tunneled through the skin and sutured to the scalp with purse-string sutures to prevent postoperative cerebrospinal fluid leakage. The bone flap was replaced in all cases. Postoperative imaging was used to confirm the electrode position in all patients (Fig. 3N–P), and extraoperative video-EEG monitoring and functional mapping were performed in all patients.

Results

Patient Population

During the study period, 13 patients underwent invasive insular investigation for suspected insular-opercular/perisylvian refractory epilepsy. Of these, 2 patients were excluded as insular sampling was done without the transinsular apex electrodes: stereo-EEG was used in one patient and MR-guided transfrontal depth electrode placement in the other. Overall, 11 patients (5 boys) underwent invasive insular investigation with the transinsular apex depth electrode and perisylvian grids/strips for drug-resistant focal epilepsy of suspected insular/perisylvian origin (Table 1). The average age at surgery was 7.6 years (range 0.5–16.0 years).

Phase 1: Implantation: Electrodes and Safety

All 11 patients underwent invasive investigation, with 1 depth electrode directly implanted into the insula in 10 cases and 2 insular electrodes in 1 case (Table 1). Additional subdural grids and strips were placed to cover the suspected epileptogenic area of the perisylvian region (Fig. 2). Postoperative imaging confirmed adequate placement of the electrodes in all cases (Fig. 3). Long-term monitoring confirmed localization of the epileptogenic focus to the insular lobe and various perisylvian regions in all cases (Fig 4). There were no invasive implantation procedure–related complications.

Phase 2: Resection

All patients underwent subsequent insulectomy in addition to various degrees of concomitant cortical topectomy of the frontal, parietal, and temporal opercula in all patients. Four patients required repeat epilepsy surgery for persistent seizures, all of which included completion of insulectomy. Of these 4 patients, 1 underwent an additional insulectomy, 1 underwent insulectomy with concomitant fronto-opercular topectomy, and 2 patients underwent 2 additional procedures each (both of which included further completion of insular resection).

Discussion

In the early 1950s, Penfield and Faulk suggested that the insula may mimic temporal lobe seizures and could explain some failures following temporal lobe surgery. However, interest in insular lobe cortex epilepsy (ILE) and
surgery was abandoned for almost half a century following Silfvenius’ report that the addition of insulectomy to temporal lobe resection did not improve seizure control but increased surgical morbidity as a result of MCA vessel manipulation. The deep anatomical location of the insular cortex below the opercular cortices, combined with the dense sylvian vasculature that drapes over it, makes surgical treatment challenging and explains why neurosurgeons avoided invasive studies and resective surgery of the insula for a period of time. However, with advances in microsurgical and stereotactic techniques, there has been a renewed interest in insular surgery in adults over the past 30 years. Contemporary series have shown insular surgery to be both feasible and safe in adults, but there is limited evidence beyond a few reports in the pediatric literature. The goal of the current study was to demonstrate a
### Table 1. Patient population undergoing insular investigation

<table>
<thead>
<tr>
<th>Case No.</th>
<th>Age (yrs), Sex</th>
<th>No. of Insular Electrodes</th>
<th>No. of Extrainsular Electrodes</th>
<th>No. of Extrainsular Contacts &amp; Cortical Regions</th>
<th>Total No. of Contacts</th>
<th>Initial Invasive Monitoring</th>
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<tbody>
<tr>
<td>1</td>
<td>4, F</td>
<td>2</td>
<td>8</td>
<td>0 1 1 1 0 32 8 0 0 48</td>
<td>72</td>
<td>Rt posterior insula</td>
</tr>
<tr>
<td>2</td>
<td>13.5, F</td>
<td>1</td>
<td>8</td>
<td>0 1 2 0 32 29 3 0 0 72</td>
<td></td>
<td>Lt MTG, postero inferior insula</td>
</tr>
<tr>
<td>3</td>
<td>7, F</td>
<td>1</td>
<td>8</td>
<td>0 2 2 4 48 13 3 0 0 82</td>
<td></td>
<td>Lt ATL (STG, MTG, ITG), MTL of temporal pole behind prior resection, posterior insula</td>
</tr>
<tr>
<td>4</td>
<td>6, F</td>
<td>1</td>
<td>4</td>
<td>1 (in tuber) 1 2 0 30 6 0 0 0 40</td>
<td></td>
<td>ECoG: rt frontal operculum &amp; insula</td>
</tr>
<tr>
<td>5</td>
<td>0.5, M</td>
<td>1</td>
<td>8</td>
<td>0 1 3 4 24 24 0 0 0 60</td>
<td></td>
<td>ECoG: no ictal events</td>
</tr>
<tr>
<td>6</td>
<td>8, F</td>
<td>1</td>
<td>4</td>
<td>0 1 2 4 24 14 0 0 0 46</td>
<td></td>
<td>Rt FO, TO, OF, &amp; insula</td>
</tr>
<tr>
<td>7</td>
<td>10, M</td>
<td>1</td>
<td>7</td>
<td>0 1 2 4 32 0 0 0 0 43</td>
<td></td>
<td>Lt OF,insula</td>
</tr>
<tr>
<td>8</td>
<td>8, F</td>
<td>1</td>
<td>8</td>
<td>0 1 4 4 54 18 4 4 4 92</td>
<td></td>
<td>Lt FO, PO, ATL (MTG, ITG), middle insula</td>
</tr>
<tr>
<td>9</td>
<td>8, M</td>
<td>1</td>
<td>8</td>
<td>0 1 1 4 48 12 0 0 0 72</td>
<td></td>
<td>Rt SMG of PL, posterior TO of STG &amp; superior insula</td>
</tr>
<tr>
<td>10</td>
<td>16, M</td>
<td>1</td>
<td>8</td>
<td>0 1 2 4 45 19 4 0 0 80</td>
<td></td>
<td>Rt PO, TO</td>
</tr>
<tr>
<td>11</td>
<td>2.5, M</td>
<td>1</td>
<td>4</td>
<td>2 1 1 0 8 24 0 0 8 44</td>
<td></td>
<td>Rt ATL (SMG, MTG, ITG), posterior insula</td>
</tr>
<tr>
<td>Mean</td>
<td>7.6</td>
<td>1.1</td>
<td>6.8</td>
<td>1.5 1.1 2 2.5 34 13 1.3 1.6</td>
<td></td>
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<tr>
<td>Min</td>
<td>0.5</td>
<td>1</td>
<td>4</td>
<td>1 1 1 0 8 0 0 0 0 40</td>
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<td></td>
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<tr>
<td>Max</td>
<td>16</td>
<td>2</td>
<td>8</td>
<td>2 2 4 4 54 29 4 8 8 92</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ATL = anterior temporal lobe; FO = frontal operculum; ITG = inferior temporal gyrus; MTG = middle temporal gyrus; MTL = mesial temporal lobe; OF = orbitofrontal; PL = parietal lobe; PO = parietal operculum; SMG = supramarginal gyrus; STG = superior temporal gyrus; Sz = seizure; TO = temporal operculum.
new technique for invasive sampling of the insula, compare it to other techniques for invasive insular coverage, and discuss the role that insular sampling plays in focal drug-resistant extratemporal pediatric epilepsy.

**When Should Insular-Opercular/Perisylvian Investigation Be Performed?**

Intracranial electrode implantation with insular coverage is probably best reserved for pediatric patients with 1) early “insular/perisylvian” ictal manifestations in the context of nonlesional, drug-resistant temporal, parietal, or frontal lobe epilepsy based on noninvasive data; 2) lesional insular cases with discordant noninvasive presurgical data; 3) persisting disabling seizures following temporal, parietal, or frontal lobectomy; and 4) drug-resistant lesional temporal lobe epilepsy (TLE)/parietal lobe epilepsy (PLE)/frontal lobe epilepsy (FLE) with clinical and imaging features suggesting insular involvement. Whether drug-resistant, lesional TLE/PLE/FLE without clinical and imaging features suggesting insular involvement warrants invasive investigation during the initial surgery, or whether this should be withheld until after failed surgery, is still a matter of debate. Some authors advocate covering the insula in all cases of refractory TLE/PLE/FLE, but with this strategy only 10%–16% of patients have ILE and undergo subsequent insular resection.
have reported higher rates of insular seizures (up to 37%) in patients undergoing insular sampling.33

Alternatively, surgery for ILE can be performed without invasive sampling. Intracranial electrode investigation was necessary in only about 19 (68%) pediatric ILE patients undergoing insulectomy in the literature.19,24,28,37 The remaining 32% of patients had lesional ILE as seen on MRI, and most went on to develop a good outcome (Engel Class I) following insular resection without long-term extraoperative intracranial recordings.37 In these lesional cases in which invasive monitoring with extraoperative monitoring is not performed, electrocorticography (ECoG) has been used to confirm involvement of the insula and map the epileptogenic area during surgery; this was done in 1 patient in this series.37 However, presurgical noninvasive studies have significant limitations, especially in children, and cannot always be used to reliably rule out ILE. Intraoperative ECoG should be reserved for cases with convergent clinical, radiological, and physiological noninvasive data. In children, young age and/or developmental and language delay render communication of initial/early subjective ictal symptoms (e.g., laryngeal discomfort) suboptimal in most cases.13 Also, insular epilepsy occurs in patients with nonlesional epilepsy and even patients with MRI lesions outside the insula.22,25,33 Insular epilepsy has been shown to coexist with independent extrainsular (e.g., temporal) epilepsy.33 Finally, lesions are often ill defined on MRI and may not give a reliable depiction of the extent of the epileptogenic zone, especially in children younger than 3 years.38 Several studies have shown that ictal or interictal scalp EEG has insufficient spatial resolution and cannot differentiate insular from overlying frontal, parietal, or temporal lobe epilepsy.15,16,23 Ictal SPECT and interictal PET rarely provide unequivocal evidence of ILE.16,33 Interestingly, magnetoencephalography has recently been shown to be superior to interictal PET and ictal SPECT in detecting ILE, although it is costly and is not available in most centers.21 The limitations of noninvasive presurgical evaluation in confirming ILE, combined with limited clinical information in children, has led some authors to advocate invasive monitoring with insular sampling in all suspected cases.33 The patients underwent insular placement of the depth electrode when there was a high clinical suspicion of insular onset. In our experience, the parasagittal transinsular apex electrode allowed confirmation of those suspicions and provided a guide to the extent of resection needed.

Options for Insular-Opercual Sampling

Previously described insular-opercular sampling methods include frame-based stereotactic methods15,16,27 and open microsurgical placement of orthogonally placed subpial insular depth electrodes in,23 or strip electrodes on,34 the insula following microsurgical opening of the sylvian fissure (Fig. 3, Table 2). Frame-based stereotactic techniques include the Talairach method, in which orthogonal electrodes are placed perpendicular to the sagittal plane using a Talairach stereotactic grid coregistered with angiography to avoid MCA branches.3,15,16,26 The Talairach method involves transperisulcular electrodes, which are placed through the opercula and into the insula, allowing recording from both the insula and the opercular cortex.3,15,16 Other newer stereo-EEG frame-based stereotactic insular depth electrodes include the transfrontal oblique electrode through the middle frontal gyrus (TFO),19,27,33 stereotactic TPO electrode through the inferior parietal lobule,1,27 and combined TFO-TPO methods.8

Efficacy/Coverage

Insular sampling with a parasagittal insular depth electrode through an open craniotomy combines the advantages of both the open direct transsylvian orthogonal method33 and stereo-EEG TFO/TPO methods,1 which provide excellent perisylvian/hemispheric coverage and good insular coverage, respectively (Fig. 2). Stereo-EEG techniques have gained in popularity over recent years. However, the ability to perform a wide coverage for epileptogenic zone and functional mapping is a vital differentiation, as the coverage and spatial resolution is greater with open techniques utilizing large grids than with stereo-EEG. The open techniques are thus favored when the suspected focus is thought to be both unilateral and either extending beyond the insula or involving the opercula/perisylvian structures and convexity, which is often the case in children.8,33 These techniques are particularly applicable in pediatric ILE, where the epileptogenic zone almost always involves cortex beyond the insula, typically the opercula or frontal/temporal cortex.13 The insertion point at the insular apex or pole and parasagittal orientation posterosuperiorly allow for extensive coverage along the length of the insula, from the most anterior short gyrus to the posterior long gyrus. However, our electrode was limited in its ability to cover the more anteroinferior portion of the insula. Coverage from these techniques is greater than that achieved with the TFO and orthogonally placed electrodes (open transsylvian or transperisulcular), which have a 5.2:1 and 2:1 contact-to-electrode ratio within the insula, respectively. The orthogonal techniques are limited because the insular gray matter is thin (<5 mm),1 and they typically require additional electrodes to optimize coverage; however, they provide better mediolateral coverage than the oblique/parasagittal techniques.33

This study includes only 1 technique of insular sampling; thus, we cannot objectively compare or conclude on the relative efficiency of detecting insular seizures using other techniques, other than discussing the theoretical benefits and pitfalls of each technique. However, because interictal activity and ictal activity were detected in 10 and 9 of our 11 patients, respectively, this study suggests that this sampling method is an overall sensitive method for detecting insular seizures in well-selected candidates. The patients had a high suspicion of insular epilepsy based on the clinical semiology, electrophysiological changes, and failure of initial extrainsular surgery in some cases. The depth electrode provided a direct sampling of the insular cortex and confirmation of interictal/ictal onset, although most certainly it did not give a complete assessment of the spatial extent of its involvement.

An additional disadvantage of the orthogonal (open or stereotactic transperisulcular) technique is that electrode placement may not have the appropriate contact-to-electrode ratio (average 6.8:1) to the TPO method, as both techniques follow the length of the insula. However, even with the TPO electrode, there are other techniques, other than discussing the theoretical benefits and pitfalls of each technique. However, because open microsurgical placement of orthogonally placed subpial insular depth electrodes in,23 or strip electrodes on,34 the insula following microsurgical opening of the sylvian fissure (Fig. 3, Table 2). Frame-based stereotactic techniques include the Talairach method, in which orthogonal electrodes are placed perpendicular to the sagittal plane using a Talairach stereotactic grid coregistered with angiography to avoid MCA branches.3,15,16,26 The Talairach method involves transperisulcular electrodes, which are placed through the opercula and into the insula, allowing recording from both the insula and the opercular cortex.
<table>
<thead>
<tr>
<th>Type of Technique &amp; Electrode</th>
<th>Advantages</th>
<th>Disadvantages</th>
<th>Authors &amp; Year</th>
<th>No. of Pts</th>
<th>No. of Insular Electrodes*</th>
<th>No. of Insular Contacts*</th>
<th>No. w/ Insular Sz Involvement (%)</th>
<th>No. of Insulectomies (%)</th>
<th>No. of Complications (%)</th>
<th>Related to Insular Depth Electrode</th>
<th>Related to Other Electrodes</th>
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<tr>
<td>Open/direct Frameless</td>
<td></td>
<td></td>
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<tr>
<td>Transsylvian orthogonal depth</td>
<td>Allows extensive ipsilateral hemispheric/opercular coverage; good medial &amp; lateral insular coverage; electrode used as landmark during 2nd phase for subpial insular resection</td>
<td>When bilateral coverage is required; MCA vascular injury (hemiparesis), opercular retraction injury; lower contact/electrode ratio (n = 2) compared to oblique/parasagittal techniques</td>
<td>Surbeck et al., 2011</td>
<td>16</td>
<td>Mean 3.5 (range 1–3)</td>
<td>Mean 3.5 (range 1–6)</td>
<td>7/19 (37)</td>
<td>6/19 (32)</td>
<td>2 (12.5) temporary: 1 foot drop from migration to internal capsule, 1 temporary dysphasia from opercular retraction</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Park et al., 2009</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>3 (100)</td>
<td>3 (100)</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Transsylvian strip</td>
<td>Allows extensive ipsilateral hemispheric/opercular coverage; follows long axis of insula: high contact/electrode ratio</td>
<td>MCA vascular injury (hemiparesis), retraction injury; limited coverage; bulky strip narrow space</td>
<td>Park et al., 2009</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1 (100)</td>
<td>1 (100)</td>
<td>0</td>
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<td></td>
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<tr>
<td>TPO depth electrode</td>
<td>Noneloquent corridor; avoids craniotomy, sylvian fissure dissection, opercular retraction; avoids passage through MCA &amp; eloquent opercular; parietal; follows long axis of insula: high contact/electrode ratio</td>
<td>Worse mediolateral insular coverage; limited anterior insula coverage</td>
<td>Afif et al., 2008 (combined TPO, TFO)</td>
<td>30</td>
<td>Mean 1.2</td>
<td>Mean 7.5</td>
<td>15 (50)</td>
<td>5 (15)</td>
<td>3 (10)</td>
<td>0 (0)</td>
<td>1 (3): intracerebral hemorrhage</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Robles et al., 2009</td>
<td>9</td>
<td>1</td>
<td>≥4</td>
<td>8 (89)</td>
<td>1 (11)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Park et al., 2009</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2 (100)</td>
<td>2 (100)</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>TFO depth electrode</td>
<td>Same as TPO except better w/ suspected frontal focus</td>
<td>Worse mediolateral coverage; limited posterior insula coverage; lower contact/electrode ratio than TPO approach</td>
<td>Afif et al., 2008</td>
<td>30</td>
<td>Mean 1.2</td>
<td>Mean 7.5</td>
<td>15 (50)</td>
<td>5 (15)</td>
<td>3 (10)</td>
<td>0 (0)</td>
<td>1 (3): intracerebral hemorrhage</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Desai et al., 2011</td>
<td>20</td>
<td>29 total</td>
<td>Mean 1.45 (range 1–2)</td>
<td>2 (10)</td>
<td>5 (25)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ryvlin et al., 2006</td>
<td>2</td>
<td>1</td>
<td>Mean 6.5 (range 6–7)</td>
<td>2 (100)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

CONTINUED ON PAGE 520 »
### Table 2. Review of techniques for insular sampling

<table>
<thead>
<tr>
<th>Type of Technique &amp; Electrode</th>
<th>Advantages</th>
<th>Disadvantages</th>
<th>Authors &amp; Year</th>
<th>No. of Insular Electrodes&lt;sup&gt;*&lt;/sup&gt;</th>
<th>No. of Insular Contacts&lt;sup&gt;*&lt;/sup&gt;</th>
<th>Coverage</th>
<th>No. w/ Insular Sz Involvement (%)</th>
<th>No. of Insular Electectomies (%)</th>
<th>No. of Complications (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open/direct (continued)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Frame-based (continued)</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Combined TFO/TPO</td>
<td>Combined advantages of TFO &amp; TPO</td>
<td>Combined disadvantages of TFO &amp; TPO</td>
<td>Surbeck et al., 2011</td>
<td>3</td>
<td>2</td>
<td>Mean 8 (range 2–4 TFO, 5–7 TPO)</td>
<td>7/19 (37)</td>
<td>6/19 (32)</td>
<td>0</td>
</tr>
<tr>
<td>OTO w/ teleangiography</td>
<td>Most well established method; opercular coverage (involved in most adult cases of ILE); medial &amp; lateral insular coverage; landmark for subpial insular resection</td>
<td>MCA vascular injury or sulcal injury; lower contact/electrode ratio (n = 2); lower insular coverage, particularly anteroinferior insula from overlying MCA; time consuming; less hemispheric coverage</td>
<td>Isnard et al., 2000</td>
<td>21</td>
<td>Mean 3.1 (range 2–5)</td>
<td>NA</td>
<td>2 (10)</td>
<td>19 (90)</td>
<td>0 (0)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Isnard et al., 2004</td>
<td>50</td>
<td>2.9</td>
<td>NA</td>
<td>5 (10)</td>
<td>1 (2)</td>
<td>2 (4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Dylgjeri et al., 2014</td>
<td>10</td>
<td>Mean 4.3 (range 2–6)</td>
<td>Mean 10 (range 5–16)</td>
<td>10 (100)</td>
<td>0 (0)</td>
<td>10 (100)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ryvlin et al., 2006</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1 (100)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Combined TFO/TPO/O TOO</td>
<td>Combined advantages of TPO, TFO, &amp; OTO</td>
<td>Combined disadvantages of TPO, TFO, &amp; OTO</td>
<td>Proserpio et al., 2011</td>
<td>8</td>
<td>NA</td>
<td>Mean 11 (range 2–31)</td>
<td>8 (100)</td>
<td>6/8 (75)</td>
<td>0 (0)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Blauwblomme et al., 2013</td>
<td>17</td>
<td>Mean 1.3 (range 1–2)</td>
<td>Mean 11 (range 4–18)</td>
<td>2 (12)</td>
<td>17 (100)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Transysylvian transsylvin parasagittal</td>
<td>Hemispheric/opercular coverage; follows long axis of insula; high contact-to-electrode ratio</td>
<td>Requires craniotomy; opercular retraction; worse anteroinferior coverage</td>
<td>Current study</td>
<td>10 (ECoG in 1)</td>
<td>Mean 1.1 (range 1–2)</td>
<td>Mean 7.1 (range 4–8)</td>
<td>9 (90)</td>
<td>0 (0)</td>
<td>10 (100)</td>
</tr>
</tbody>
</table>

NA = not available; NS = not specified; pt = patient.
* Number per patient, unless otherwise noted.
placement relies on insertion at avascular sites, which lim-
its sampling of the insula due to the presence of the MCA
vasculature, especially in the anteroinferior portion. The
stereotactic transopercular technique allows simultaneous
coverage of the frontal, temporal, and parietal opercula;
however, some authors have found that insular depth re-
cordings are contaminated by the presence of opercular
waveforms. In our study, the opercula were investigated
with subdural grid and strip electrodes as opposed to plac-
ing transopercular depth electrodes through the insula.
These subdural strip/grids placed over the opercula have
the advantage of greater spatial coverage than multiple
transopercular depth electrodes and the potential of re-
duced risk of damaging the M3 MCA branches that wrap
around the opercula. Finally, the parasagittal electrode
along the length of the insula is an excellent landmark to
guide safe second-stage subpial insular resection.

Electrode Safety
Our technique compares favorably to other open and
stereo-EEG methods of insular sampling. Although the
complication rate of the open method is reportedly higher
than that of stereotactic techniques, including 12.5% and
19% rates of transient deficit related to the insular depth
and subdural electrodes, respectively, there have been no
permanent complications, suggesting its safety profile is
acceptable. In our study, there were no transient or per-
manent complications related to placement of the insular
depth electrode, sylvian fissure dissection, or concomitant
subdural strip/grid electrode placement. However, edema,
hemorrhage, and infection are well-documented risks as-
associated with subdural electrodes, especially with an
increasing number of electrodes used. Compared with the
open orthogonal transtympanic technique described by Sur-
beck et al., the parasagittal implantation along the axis of
the insula may help avoid migration into deeper neurologi-
cal structures, such as the internal capsule or basal gan-
glia, which may result in transient hemiparesis. Although
the open parasagittal insular electrode technique is more
invasive than stereo-EEG, due to the requisite craniotomy,
the associated risks may be mitigated by more accurate
electrode placement, as the surgeon does not need to rely
on stereotaxy. It does, however, mandate excellent knowl-
edge of microsurgical anatomy and is associated with a
learning curve. In addition, it facilitates brain mapping of
eloquent cortex. The main concern with stereo-EEG
techniques is intracerebral hemorrhage, which has been
reported to occur in up to 2.9% of cases, especially when
multiple electrodes are used. Overall, stereo-EEG is as-
associated with a 1%–2% severe morbidity of permanent
deficit; however, this is based on studies utilizing a very
high number of electrodes. There are no reported com-
lications specifically caused by insular depth electrodes
placed using stereo-EEG through TFO, TPO, or tran-
sopercular approaches.

Conclusions
The parasagittal transinsular apex electrode is a feasible
alternative to orthogonally placed open or oblique-placed
stereotactic methods for sampling the insula. This method
is safe and best suited for suspected unilateral cases with
a suspected ictal onset zone extending beyond the insular
cortex, as hemispheric grids and strips provide excellent
coverage of these areas. The excellent hemispheric cov-
verage and spatial resolution also allows for reliable brain
mapping of eloquent cortex, which may be difficult with
stereotactically placed depth electrodes.

Acknowledgments
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Disclosures
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Author Contributions
Conception and design: Bhatia, Weil. Acquisition of data: Weil. Analysis and interpretation of data: Weil, Fallah. Drafting the article: Weil, Fallah. Critically revising the article: all authors. Administrative/technical/material support: Weil.

Supplemental Information
Videos

Companion Papers

Previous Presentations
This technique was presented at the Annual Epilepsy Surgery meeting in July 2014 in Gothenburg, Sweden.

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