Stereotactic neurosurgery has a rich history beginning with the first stereotactic frame described by Horsley and Clarke in 1908. Stereotactic neurosurgery began with intracranial targeting for psychiatric and functional disorders (such as movement disorders). With the discovery of levodopa in 1968 for the treatment of Parkinson disease, the interest in stereotactic surgery plummeted. However, the advent of CT scanning and other advanced imaging techniques led to the revival of stereotactic neurosurgery with even more applications. It is now widely used for delivery of radiation, surgical targeting of electrodes, and resection to treat tumors, epilepsy, vascular malformations, and pain syndromes. These treatments are now available due to the pioneering efforts of neurosurgeons and scientists in the beginning of the 20th century. Their efforts focused on the development of stereotactic instruments for accurate lesion targeting. In this paper, the authors review the history of the stereotactic apparatus in the early 20th century, with a focus on the fascinating people key to its development.

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tury, correlating specific areas of the brain with external skull landmarks, resulted in models such as Wilson’s cyr- notometer, Kroenlein and Kohler’s cephalometers, Broca’s craniograph, and Kocher’s craniometer (Fig. 4).8,14,19,35 All of these devices were built to localize cerebral structures, although they varied in their specific purpose. Kohler’s cephalometer was designed to localize the central sulcus, while Kroenlein’s device was made to localize the central and sylvian fissures as well as trepanation points for evacuation of hematomas and abscesses. On the other hand, Kocher’s craniometer, which was designed after he exchanged ideas with Horsley, consisted of a malleable steel band. This device could be molded to different head shapes and sizes and could localize several structures depending on how it was angled on the head.35 Later, in a chapter that Cushing wrote called “Surgery of the Head,” Cushing wrote called “Surgery of the Head,” Cushing described Kocher’s craniometer as one of the four best devices available.35 Despite this enthusiasm, these devices were inaccurate because of the variability of brain structures’ correlation with external skull landmarks.

This problem was the research focus of Spiegel et al.37 who described stereotaxy in relation to landmarks inside of the skull by using radiographs (the ventricles using pneumoencephalograms and the calcified pineal gland). Their apparatus was similar to the Horsley and Clarke version with an electrode carrier suspended above the head, to be adjusted in all 3 planes independently. They coined to term “stereoecephalotomy” to describe intracranial surgery 3D targeting based on the brain itself.37 In 1936, as Nazi influence was growing, Spiegel left Austria and took a position at Temple Medical School in Philadelphia. He recruited Wycis who worked in Spiegel’s lab as a medical student and neurosurgical resident. Interestingly, Wycis funded his way through school by playing semiprofessional baseball and poker.11 They described the first use of stereotactic devices in humans with the stereoecephalotome in 1947.37 They were amazingly productive and over 20 years published on almost every area of functional neurosurgery.6 Their collaboration was very close, and Wycis once described Spiegel as “the only man I know who must have three frontal lobes.”11

Other neurosurgeons were working on similar projects at that time including Jean Talairach in Paris.25,39 Talairach moved to Paris after completing medical school to specialize in psychiatry. He was interested in neuroanatomy, and he found work in the Sainte Anne Hospital, where he would work for almost 70 years until he died in a room that used to be his office.38 He participated in World War II, where he earned 3 military medals. Following the war, he was introduced to a neurosurgeon, Marcel David, by 2 famous neurologists, Henri Hacaen and Julian De Ajurriaguera. Given his interest in neuroanatomy, they asked him to design a method to localize deep gray matter structures in the brain. He subsequently switched from psychiatry to neurosurgery, with the specific task of developing a stereotactic frame.25 In 1949 he published his initial experiments using a frame based on a rectangular coordinate system that involved grids through which electrodes could be inserted.39 The apparatus was designed for targeting the temporal lobes for epilepsy and allowed lateral access.13 The grids minimized radiographic image distortion during ventriculograms. To decrease distortion even more, he used the apparatus in a large operating...
room (called the “chapel”) so the x-ray tube was placed up to 5 m away from the grids. In 1952, Talairach proposed the use of the anterior and posterior commissures as reference points for the brain coordinate system. He subsequently used his frame and reference points to map first the gray nuclei and then the entire telencephalon. He continued to work even after his retirement in 1978 until the age of 96 years.25

Across the globe, Hirotaro Narabayashi was also developing a frame adapted from the original Horsley and Clarke orthogonal design in Japan.40 However, because of Japan’s limited exposure to the rest of the world after the war, he was completely unaware of the concurrent work in the US, France, Germany, and Sweden.29 In response to Narabayashi’s publication “Procain oil blocking of the globus pallidus” in 1956,27 Spiegel and Wycis wrote, “In this way they try to create the impression that they were the first who performed stereotactic operations on the basal ganglia, not even mentioning with a single word the fact that we have reported such operations repeatedly since 1949.”29 However, the tension between Narabayashi and Spiegel and Wycis ended when they met at the First International meeting of neurology and neurosurgery in Brussels in 1957. An additional interesting fact is that Narabayashi achieved all of this success at the young age of 35 years. In fact, at the meeting he was asked by one of the meeting participants if he was the son of the famous Dr. Narabayashi.29

In the US, Bailey and Stein3 exhibited a stereotactic device for intracranial surgery in Atlantic City, New Jersey, in 1951. In the same year, despite isolation similar to Narabayashi, the Germans Riechert and Wolff33 described a stereotactic system with a phantom base to indicate the position of the target to verify proper adjustment of the apparatus (Fig. 5). Their system was based on an arc system, like that of Lars Leksell.22

Prior to his description of radiosurgery in 1951, Leksell developed a stereotactic frame with skull pin fixation for rigid frame immobilization.22,23 Unlike the orthogonal system of Horsley and Clarke, the electrode advanced along a radius of an arc to which the electrode carrier was attached. The position of the arc was adjustable and the electrode pointed to the target, regardless of the angle.
of insertion.\(^1\) He called this the “arc-radius” and said, “I was born under the sign of the ‘archer’ and look forward to sharpshooting into the brain.” (Fig. 6).\(^2\) The arc-radius system was subsequently developed into the Todd-Wells stereotactic system (developed by American neurosurgeon Edwin Todd and engineer Trent Wells). The addition of a phantom base to the arc-radius system (similar to Riechert and Wolff’s apparatus), led to the Brown-Roberts-Wells frame.\(^3\)

Not all early stereotactic surgical techniques were successful. One such method was the bur hole fixed system.\(^2\) The instruments were fixed to the skull through a bur hole and allowed electrode movement in the horizontal and vertical planes and depth. This technique was fraught with error since a fraction of a degree in error in the angle at the bur hole site would translate into millimeters of error when the electrode was advanced to its depth.\(^11\)

The art of “sharpshooting into the brain” continued to be advanced through the efforts of multiple neurosurgeons and scientists worldwide including Hecaen et al.\(^6\) and Guiot et al.\(^11\) in France, Gillingham\(^2\) in England, Laitinen and Toivakka\(^10\) in Finland, Bertrand and Jasper in Canada, Velasco Suarez and Escobedo\(^4\) in Mexico, Obrador\(^28\) in Spain, and Bechtereva et al.\(^4\) in Russia, among others.\(^11\) The leaders in the field of stereotaxy created the International Society for Research in Stereoecephalotomy during an international symposium in Philadelphia in 1961. As the word “stereotaxic” was replaced with the word “stereotactic” (ending in the Latin word for touch), this society changed its name to the World Society for Stereotactic and Functional Neurosurgery.\(^11\)

Stereotactic neurosurgery continued to evolve in the 1970s and 1980s with the advent of CT scanning and MR imaging. Using traditional reference points such as anterior and posterior commissures as well as skull landmarks, precise imaging has precluded the use of a stereotactic frame. Frameless stereotaxy is becoming an increasingly common tool for neurosurgeons. Stereotactic neurosurgery now covers much more than functional neurosurgery and lays claim to multiple, sophisticated stereotactic frames, apparatuses, and frameless localization techniques. The utility of these instruments would not exist without the vision and dedication of our early pioneers.

### Conclusions

Stereotactic neurosurgery began with the development of an orthogonal frame for animal use by Horsley and Clarke and has become an active field of research and treatment for human pathology. Advances in stereotaxy have allowed for targeting of intra- and extracranial lesions that were untreatable in the past. The early neurosurgeons and scientists of stereotaxy have laid the groundwork for future innovation. Due to their efforts, stereotactic neurosurgery is now an independent and growing field of study.

### Disclaimer

The authors report no conflict of interest concerning the materials or methods used in this study or the findings specified in this paper.

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