The evolution of surgical management for craniosynostosis

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Craniosynostosis, the premature closure of cranial sutures, has been known to exist for centuries, but modern surgical management has only emerged and evolved over the past 100 years. The success of surgery for this condition has been based on the recognition of scientific principles that dictate brain and cranial growth in early infancy and childhood. The evolution of strip craniectomies and suturectomies to extensive calvarial remodeling and endoscopic suturectomies has been driven by a growing understanding of how a prematurely fused cranial suture can affect the growth and shape of the entire skull. In this review, the authors discuss the early descriptions of craniosynostosis, describe the scientific principles upon which surgical intervention was based, and briefly summarize the eras of surgical management and their evolution to present day. (DOI: 10.3171/2010.9.FOCUS10204)

Key Words • craniosynostosis • surgical management • suture

Early Descriptions of Cranial Deformity

The aberrant congenital deformities of the skull have been known to exist for centuries and were well-recognized and described as early as the time of antiquity. In the Iliad, Homer describes the warrior Thersites as “the ugliest man who came before Troy...his head ran up to a point...” a description characteristic of oxycephaly.20 The recognition of cranial vault deformities by the ancient physician Galen, and some early understanding of the role of cranial sutures by Hippocrates, have also been reported.5,55 By the 16th century, it appears that anatomists appreciated the existence of cranial sutures by Galen, and some early understanding of the role of cranial sutures by Hippocrates, have also been reported.5,55 By the 16th century, it appears that anatomists appreciated the existence of cranial sutures and had documented a broad range of the characteristics of the deformity, from an appreciation of suture pattern and premature suture fusion in a variety of configurations by Hundt,21 specific abnormal varieties of sagittal and coronal sutures by Dryander,13 and what would now be described as oxycephaly and brachycephaly by della Croce60 and Vesalius58 (Fig. 1). However, von Sömmering62 in the late 1790s was the first to go beyond simple descriptions and apply scientific principles to the study of abnormal cranial suture growth. He recognized the importance of sutures in active skull growth and the consequences of premature fusion, thus laying the foundation for our modern understanding of craniosynostosis and the subsequent surgical and nonsurgical interventions.62,63

Early Scientific Exploration

In his first scientific descriptions of craniosynostosis, von Sömmering sought to not only describe the primary defect and the cosmetic consequences, but also to elucidate the secondary global cranial impact. He aimed to develop a unifying mechanistic theory describing the pathogenesis with a clear intent on developing a treatment. Soon after von Sömmering, Otto43—based on his observations in humans and animals—proposed that a consequence of premature suture fusion was a compensatory cranial expansion along another trajectory in the skull, providing the first explanation for the global cranial abnormalities observed. In 1851, Virchow59 published a landmark paper in the history of craniosynostosis in which he described the fundamental aberrant growth patterns in this condition, which he termed Virchow’s law. Virchow’s law stated that the observed deformities occurred as a result of “cessation of growth across a prematurely fused suture,” with “compensatory growth” along nonfused sutures in a direction parallel to the affected suture, causing obstruction of normal brain growth.3 This was the first accurate and generalizable principle applicable to all patterns of premature suture fusion. Virchow59 initially described this disorder in 1851 as craniostenosis, meaning a structured or narrowed skull, but was convinced by Sear47 to instead call this entity
craniosynostosis, which more accurately indicated suture involvement and encompassed all varieties of suture disease. Virchow’s impact was significant, as the first surgical interventions and subsequent iterations were based directly on his observations and principles. By the early 1900s, craniosynostosis was recognized as one component of complex syndromic deformities, most notably by Apert4 in 1906 and Crouzon7 in 1912, whose names bare two of the most well-known syndromic deformities, of which there are now more than 60.

Nearly a century later, Moss became very interested in craniosynostosis but categorically rejected Virchow’s law. Instead, in an attempt to unify all types of craniosynostosis, he proposed that the cranial base, not the suture, was the primary site of abnormality, with suture fusion being a secondary consequence.12,40,41 He based this theory on 4 observations: 1) sutures were often patent at surgery, even when there was a high degree of preoperative suspicion of suture fusion; 2) there were characteristic abnormalities at the cranial base that occurred with certain suture fusion patterns; 3) excision of the fused suture did not always improve the cranial shape; and 4) embryologically, skull development occurred after cranial base development.

Moss’ theory fell out of favor as surgical treatment in humans directed at the prematurely fused sutures demonstrated reversal of the deformity. Unfortunately, some surgeons attempted complex cranial base expansion based on these theories. Moss’s theory was later definitively disproven when it was shown that the suture itself was the primary site of abnormality in craniosynostosis, that cranial base and facial abnormalities responded to opportunities for suturing,44,46 and that abnormalities in the cranial base could resolve completely with suture release.96 However, a lasting contribution of Moss’ work was his recognition that the active growth of the underlying brain dictated the passive cranial growth along the suture lines. He termed this the “functional matrix theory” and it would later form part of the justification for the minimally invasive approach early in life.

**Early Attempts at Surgical Intervention**

By the late 1800s, the understanding of sutures and the consequences of premature fusion was growing, but surgical intervention was not attempted until it was reliably recognized that craniosynostosis could lead to impaired neurological and cognitive growth, blindness, and hydrocephalus.18 The first reported surgical interventions for craniosynostosis were strip craniectomies, first by Lannelongue in Paris in 189033 followed shortly by Lane in San Francisco in 1892.31 Lannelongue performed bilateral strip craniectomies for sagittal synostosis and strongly advocated for release, not resection, of the fused suture. Lane reports being approached by the mother of a child who pleaded to him: “Can you not unlock my poor child’s brain and let it grow?” Lane performed a strip craniectomy with removal of a stenosed sagittal suture along with lateral strip of parietal bone bilaterally (Fig. 2). However, the patient died 14 hours postoperatively, reportedly from complications of anesthesia. Despite these isolated reports with limited outcome data, it appears that this technique was quickly adopted and used for the treatment of craniosynostosis. An atlas with figures demonstrating a variety of craniectomies for craniosynostosis was published just 5 years after Lannelongue’s first report,1 along

**Fig. 1.** Illustrations of abnormal skull shapes by Vesalius in 1543 in *De Humani Corporis Fabrica*. Abnormalities were described in terms of prominences, not sutures. **A:** Loss of posterior eminence. **B:** Loss of anterior and posterior eminence. **C:** Loss of eminence at sides. Image credit: William H. Welch Medical Library, Johns Hopkins Medical Institutions.

**Fig. 2.** Lane’s early report of surgical repair for presumed craniosynostosis published in the *Journal of the American Medical Association*. Reproduced with permission from Lane LC: JAMA XVIII:49–50, 1892.
Advances at Children’s Hospital Boston

Once an effective approach for early craniosynostosis was in widespread use, much of the research focus, which was primarily taking place at Children’s Hospital Boston, shifted to addressing the limitations of surgical intervention for children who presented late in the disease course or in children who had experienced reossification at the synostectomy site. The primary concern was that surgery at suture sites that have recurrent fusion required extensive and difficult secondary cranial reconstruction operations that were technically challenging and associated with high morbidity and mortality rates.

In one of the first attempts to minimize reossification, Donald Matson and Frank Ingraham proposed the use of a polyethylene film at the edges of cut bone following strip craniectomy. One year prior to Matson and Ingraham’s report of polyethylene film, Simmons and Peyton reported on the use of tantalum film. The use of a polyethylene film at the edges of cut bone followed by Zenker’s solution was applied directly onto the dura. This served to cauterize the ossifying elements within the meningies and increased the incidence of suture patency, but was found to cause seizures. Matson and Ingraham’s simple craniosynostectomy became widely popular and replaced strip craniectomies as the treatment of choice in most pediatric neurosurgery texts and was one of the most common approaches of this era. Their technique consisted of removing a 1-cm strip of bone at the site of the involved suture, extending the craniectomy across the adjacent normal suture, and excising the pericranium to prevent reossification. The importance of restoring natural skull shape early to allow a proper rate of expansion for normal brain development was again recognized in this era, particularly by Shillito and Matson.

By the mid-1950s, there had been significant advances in anesthesia, blood transfusion, and surgical technique at high-volume centers such as Children’s Hospital Boston, and surgery for craniosynostosis became very safe. In one of their largest series, Shillito and Matson reported only 2 deaths in 394 operations, a stark contrast to the results reviewed by Jacobi just decades prior. This allowed the consideration of cosmesis (which Shillito and Matson strongly argued for) as a primary indication for surgical intervention, inviting Paul Tessier and other craniofacial surgeons to pioneer techniques with more focus on cosmesis and the correction of associated facial anomalies. Although simple craniosynostectomy and strip craniectomy produced excellent results in very young infants, these were inadequate approaches for older children with advanced disease, and the pioneers of the next era were challenged to develop procedures to treat their disease.
Extensive Calvarial Remodeling

The early 1960s to mid-1990s marked an era in which the limitations of simple suturectomies and strip craniectomies for advanced late disease were recognized, challenging surgeons to develop novel procedures for complex calvarial vault remodeling. The innovation of these procedures was driven by the need for immediate deformity correction to prevent impending neurological dysfunction in nonneonates, as well as the need to treat the secondary compensatory changes at sites away from the diseased suture that had taken place. Also fueling this movement was the discovery by Jane et al. that the major cause of the global cranial deformity was compensatory overgrowth at adjacent sutures. Some of the most popular procedures included wide-strip craniectomy with bilateral wedge parietal craniectomy, sagittal craniectomy with biparietal morcellation, extended vertex craniectomy, midline craniectomy with occiput resection, and complete calvarial remodeling via the pi procedure for advanced sagittal synostosis and orbitofrontal advancement for metopic, unicoronal, or bicoronal synostosis.

For the most common form of craniosynostosis—isolated sagittal synostosis—Jane and colleagues developed the pi procedure, named after the shape of bone that is removed (Fig. 3). In this technique, the sagittal, bilateral coronal, and lambdoid sutures are first removed and the parietal bones are outfractured to increase the skull width. The sagittal suture is then removed and used as a strut to maintain the outward position of the parietal bones. Finally, the frontal and occipital bones are secured to the parietal bones with adjustments of anterior-posterior dimension and frontal bossing. The pi procedure and its variations and modifications have the advantages of addressing the primary suture fusion and also the global cranial deformity, including anterior-posterior dimension and frontal bossing, and providing immediate correction without the need for a postoperative helmet.

In 1982, Epstein et al. described total vertex craniectomy, a hybrid of the midline craniectomy procedure of Stein and Schut and the occipital and coronal prominence excision of Venes and Sayers. Epstein et al. further modified this approach by extending the width of bone removed to 6–8 cm, which eliminated the need for interpositional Silastic, a common technique of the time. They reported excellent cosmetic and functional outcome without any morbidity and deaths. Summarizing the experience of this era, McComb and colleagues at Children’s Hospital Los Angeles published one of the most significant articles on contemporary surgical management in the journal *Pediatrics*, describing their institutional experience with 250 patients over 6 years. Of the many important findings, they describe the prevalence of fused suture patterns, the morbidity and mortality of extensive calvarial remodeling, and describe a novel 7-category outcome classification system for more scientific analysis of outcomes. Additional contributions during this era from Children’s Hospital Los Angeles include McComb’s approach for management of sagittal synostosis in the older infant, in which a reduced rate of brain growth provides an insufficient force for passive cranial vault expansion. In this technique, termed “occipital reduction–biparietal widening,” the occipital protuberance is reduced, the biparietal diameter widened, and the height of the vertex is lowered (Fig. 4). Employing this technique in a large series of infants > 6 months of age, McComb reported excellent cosmetic outcomes, no bone defects, and no need for reoperation.

As the efficacy of these procedures became apparent, they gained widespread acceptance as the preferred method of treatment for nonneonates, despite the perioperative limitations. Another significant advance during this era was the contributions of Paul Tessier, who is widely regarded as the father of craniofacial surgery. He developed the principles that define modern craniofacial surgery, as well as sophisticated techniques and tools that...
The evolution of surgical management for craniosynostosis led to significant improvements in cosmetic outcomes, particularly for those with facial abnormalities. The advances of extensive calvarial remodeling allowed for normal neurological development and excellent cosmetic results, particularly for those with the most complex of multiple-suture disease. However, these advances were associated with significant operative time, hospital stay, blood loss requiring transfusion, and complications that were well described even in modern literature of the 1990s. These limitations became the impetus for the most recent endoscopic advances.

Modern Endoscopic Strip Craniectomy

In the early 1990s, Jimenez, a pediatric neurosurgeon, and Barone, a plastic surgeon, recognized the limitation of the approaches of the past quarter century, including extensive operations in young children, prolonged operative time, blood loss and need for blood transfusion, significant scalp mobilization, and need for subsequent reconstructive procedures. They proposed a novel technique: simple suturectomy via an endoscopic approach (Fig. 5). The success of this approach can be attributed to...
Jimenez and Barone’s consideration of 3 basic principles of craniosynostosis. First, as recognized by Farber and Towne, they recommended surgery early in life. Second, as described by Moss’s functional matrix theory, they recognized that if timely intervention occurred, the rapidly growing brain would cause expansion of the skull into a normal shape. Third, to counteract the tendency of the cranial vault to revert to a premolar shape as described by Otto and Virchow, they employed an adjunct vault remodeling helmet introduced by Persing et al. in 1986, into which the brain would shape the skull. They first presented this work in a small series of 4 patients, all with sagittal synostosis, treated with early endoscopic strip craniectomy with adjunct postoperative cranial molding helmets. They were able to demonstrate minimal blood loss, short operative times, early hospital discharge, and excellent functional and cosmetic results, although with limited follow-up. Subsequent studies with progressively larger patient samples and a wide variety of fused suture patterns with long-term follow-up confirmed the efficacy and safety of this approach.

The collective outcomes from these studies show remarkable results with short operative times, minimal blood loss, early hospital discharge, and minimal operative and perioperative risks, including extremely rare cases of infection, dural sinus tears, CSF leaks, or neurological injury. A collective review of their technique from the past 11 years in infants with a variety of multiple-suture nonsyndromic craniosynostoses demonstrates results superior to those achieved with more invasive procedures of the prior era. This most recent advancement, founded upon the principles of the natural history and pathophysiology of craniosynostosis, has led to dramatically improved outcomes and has fundamentally changed the treatment of these patients.

Disclosure

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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