The endoscopic endonasal transpterygoid approach is a lateral extension of the midline endonasal route; although it was initially described to access only the lateral recess of the sphenoid sinus, currently this route is used to reach the most lateral aspect of the skull base. In this surgical scenario, injury to the internal carotid artery (ICA) is one of the most feared complications.

The vidian nerve (VN) has been clearly described as a critical landmark for the safe identification of the petrous ICA in the foramen lacerum (FL) during the endoscopic

**ABBREVIATIONS**
ET = eustachian tube; FL = foramen lacerum; ICA = internal carotid artery; VC = vidian canal; VELPPHA = vidian nerve, eustachian tube, foramen lacerum, petroclival fissure, and pharyngobasilar fascia; VN = vidian nerve.

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endonasal transpterygoid approach, especially in patients with poorly pneumatized sinuses.10

The VN travels through the pterygoid or vidian canal (VC) in the sphenoid bone, so it can be localized during the initial steps of the endoscopic endonasal approach. Hence, dissection of the VN from its opening in the sphenoid bone naturally leads to the anterior genu of the petrous ICA.10 Many publications focus on different anatomical landmarks of the anterior end of the VC and how the endonasal transpterygoid approach may be performed safely.3–5,16,17,19,23 However, the literature is lacking a thorough anatomical description of the posterior and inferior limits of the endonasal transpterygoid avenue. Although the identification of the VN in the proximal aspect of its canal may permit us to safely identify the anterior genu of the ICA, the endoscopic anatomy of the most inferior and posterior area surrounding the ICA in this region—that is, the deepest and most posterior limit of the endoscopic endonasal transpterygoid route—has not been well documented.11,12

Accordingly, the main goal of this study is to detail and quantify the anatomical relationship between the posterior end of the VN, the posterior end of the VC, and the neuro-fibrocartilaginous components of the FL and highlight how such peri-lacerum anatomy is crucial for safe endoscopic endonasal transpterygoid surgery.

Methods

Anatomical Dissections

Eight human anatomical specimens (16 sides) were used for this study. All specimens were injected with red and blue silicone via the ICAs and internal jugular veins, respectively. The surgical dissections were performed using parasanal sinus and skull base/neurosurgical endoscopic instruments (Karl Storz) and a high-speed drill with an angled handpiece as well as diamond cutting burrs (Medtronic Inc.). The dissections were achieved via a pure endonasal endoscopic approach. Visualization was accomplished with rod-lens endoscopes (4-mm diameter, 18-cm length) with 0°, 30°, and 45° lenses (Karl Storz Endoscopy; Karl Storz), coupled to a high-definition camera and video monitor. Both video and standard digital images were obtained during dissections using the AIDA recording system (Karl Storz).

Endoscopic Endonasal Transpterygoid Approach

An endoscopic endonasal transpterygoid approach was performed as described in the pertinent literature.2,6,7,18–21 The surgical corridor was created by removing both middle turbinates and resecting the posterior nasal septum in order to create conditions that allow use of the endoscope and instruments through both nostrils. The medial wall of the maxillary sinus was removed to gain access to its posterior wall, which constitutes the anterior wall of the pterygopalatine fossa, and to the sphenopalatine foramen, through which the sphenopalatine artery reaches the nasal cavity; inferior turbinectomy and removal of the lateral nasal wall down to the level of the nasal floor were performed as well.

The orbital process of the palatine bone was removed, and the sphenopalatine foramen was enlarged to expose the anterior portion of the pterygoid process. The posterior wall of the maxillary sinus was dissected laterally, and the pterygopalatine fossa contents were displaced laterally as well (Fig. 1).

After performing the initial part of the endoscopic endonasal transpterygoid approach, dissection proceeds in a stepwise fashion, according to the following 3 main steps.

Step 1: Exposure of the Anterior End of the VC

The anterior end of the VC is located inferomedially to the foramen rotundum, on the upper medial part of the pterygoid process anterior surface (Fig. 2A), which opens into the medial part of the pterygopalatine fossa posterior wall.

After endoscopic endonasal exposure of the pterygopalatine fossa, the anterior edge of the VC can be observed. After lateral transposition of the neurovascular compartment of the pterygopalatine fossa, the VN can be isolated and followed posteriorly inside its canal, which is located at the intersection of the lateral wall of the sphenoid and the medial pterygoid plate.
In our stepwise dissection, the identification of the most anterior part of the VC represents step 1 (Fig. 2B).

Step 2: Follow the VC

In step 2 of our dissection, the VC is followed with the aim of reaching the posterior end of the endonasal transpterygoid approach.

The dissection proceeds with drilling of the pterygoid process base around the VC in an anterior to posterior direction to expose the fibrocartilaginous area surrounding the foramen lacerum (FL). Specifically, the circumferential drilling of the VC starts in the inferomedial quadrant and then moves on to the infravidian segment.

The inferior remnants of the pterygoid plates are removed in order to expose the eustachian tube (ET). Muscles related to the ET, namely the tensor veli palatini and the levator veli palatini muscles, can then be visualized. Once the depth of the VC is clearly determined, drilling is performed in the most superolateral aspect of the canal. The clivus and the petrous apex are progressively drilled from medial to lateral, and the FL and the anterior genu of the ICA are seen, bound together by fibrous tissue. This second step is finished once the bone of the VC has been completely drilled out (Fig. 2C).

Step 3: Posterior End of the VC—the VELPPHA Area

In the last step of our dissection, the region that we refer to as the VELPPHA area is exposed. This area represents the posterior limit of the transpterygoid approach, and it is formed by multiple cartilaginous fibers that surround the petrous segment of the ICA at the level of the FL. Hence, during this third step of our dissection, the key anatomical relationships between the VC, ET, FL, petroclival fissure, and pharyngobasilar fascia can be identified (Fig. 2D).

Quantitative Assessment and Statistical Analysis

The anteroposterior lengths of the VN and VC were quantified after endoscopic endonasal dissections. Measurements were obtained in 3 different planes as follows in order to evaluate the working space: FL₁, the distance between the posterior end of the VC and the posterior edge of the lacerum ICA in the axial plane; FL₂, the distance between the VN at the petrous ICA and a vertical line parallel to the lacerum ICA in the coronal plane; and FL₃, the distance between the anterior genu of the petrous ICA and the eustachian tube [ET] in the craniocaudal plane. The navigation system (Medtronic Inc.) showed the point coordinates and was used for measuring the distances (Fig.
Results

Detailed Description of the VELPPHA Area Components

Our dissections show that there are 5 main anatomical structures surrounding the anterior genu of the petrous ICA in the posterior limit of the endoscopic endonasal transpterygoid approach: the end of the vidian canal (VC), the eustachian tube (ET), the foramen lacerum (FL), the petroclival fissure, and the pharyngobasilar fascia. We designed a novel acronym with the aim of underscoring the importance of the described anatomical structures that represent the posterior limit of the endoscopic endonasal transpterygoid approach—namely VELPPHA (with V standing for vidian canal, E for eustachian tube, L for foramen lacerum, P for petroclival fissure, and PHA for pharyngobasilar fascia). Each single component of the VELPPHA area is described in detail below. This area is formed by multiple cartilaginous fibers adhering to the VC, the ET, the inferior part of the FL, the petroclival fissure, and the pharyngobasilar fascia. All these structures are below the horizontal segment of the petrous ICA. Of utmost importance, no neurovascular structures are observed within the VELPPHA area, thus making it a safe zone for surgery in the posterior end of the endoscopic endonasal transpterygoid approach (Video 1).

VIDEO 1. Refining the anatomical boundaries of the transpterygoid approach: the VELPPHA area concept. The transpterygoid approach is the usual route to access the petrous apex, petroclival fissure, Meckel’s cave, or cavernous sinus. The vidian canal (VC) is a critical surgical landmark to localize the anterior genu of the horizontal segment of the petrous ICA. The VC connects the pterygopalatine fossa and the foramen lacerum (FL) has 3 parts. 1) The anterior opening of the VC is located on the anterior surface of the pterygoid process. 2) The canal goes from anterior to posterior in a straight course with a trumpet shape, open toward the front. 3) The posterior opening of the VC is filled with cartilaginous tissue from 5 different anatomical structures surrounding the anterior genu of the petrous ICA. VELPPHA is an acronym for the combination of the following anatomical structures: the posterior end of the VC, the eustachian tube (ET), the foramen lacerum (FL), the petroclival fissure, and the pharyngobasilar fascia. The transpterygoid approach can be classified in 3 steps. Step 1: The first step is to look for the anterior edge of the VC that is usually hidden behind the pterygopalatine fossa. In the early dissection of the right nasal fossa in this video clip, one can see why we need to open the pterygopalatine fossa to access the anterior end of the VC. In the more advanced endoscopic dissection view, the dissector pushes the pterygopalatine contents laterally and identifies the medial pterygoid “wedge” where the vidian nerve (VN) is located. Step 2: Once the anterior end of the VN is identified, we can move to the second step, “follow the vidian canal.” We start drilling the inferior and medial aspect of the VC, then the inferolateral quadrant. The “infra-vidian” bone is a safe drilling area throughout the extent of the VC. Considering the VC as a clockface, drilling of the right VC should be initiated from the 3 to 6 o’clock position. In this sequential dissection where the bone is removed along the inferior and medial aspect of the VC, the depth of the pterygoid wedge helps us to understand where the VC ends. Step 3: After the drilling of the VC bone is completed, we move on to step 3. The VELPPHA area represents the posterior limit of the transpterygoid approach and is formed by multiple cartilaginous fibers adhering to the VC, the ET, the inferior part of the foramen lacerum, the petroclival fissure, and the pharyngobasilar fascia. In this advanced dissection we can identify the 3 different fibers of the VELPPHA ligament: anterior, medial, and posterior. It should be noted that all these structures are below the horizontal segment of the petrous ICA. Copyright Ariel Kaen. Published with permission. Click here to view.

Vidian Nerve and Vidian Canal

The vidian nerve (VN) is formed by the union of the greater petrosal nerve and the deep petrosal nerve. It is located on the superior surface of the most medial segment of the horizontal petrous of the ICA, and if followed...
from its origin, it courses from posterior to anterior and from superior to inferior through the cartilaginous tissue in the upper part of the anterolateral margin of the FL to enter the posterior end of the VC. The proximal portion of the VN is encased by the fibrocartilaginous tissue that forms the lower portion of the FL; a complex set of vertical fibers of the FL encloses the nerve before it reaches the posterior end of the VC. The anteroposterior length of the VN averaged 23.12 mm (range 21.1–25.0 mm) on the right and 23.90 mm (range 22.0–24.9 mm) on the left (Table 1 and Fig. 3).

On the other hand, the VC is located inside the base of the pterygoid process and connects the FL with the pterygopalatine fossa. It has a slightly curved pathway, which is directed posterolaterally when seen from an endonasal view. Accordingly, when the VC is reached from the endonasal perspective, its anterior opening is placed in a most medial position when compared with its posterior end. The posterior opening of the VC was situated in all dissections superior to the ET and below the horizontal petrous ICA. The anteroposterior length of the VC averaged 14.18 mm (range 13.0–15.1 mm) on the right and 13.90 mm (range 12.9–14.6 mm) on the left (Table 1 and Fig. 4).

Eustachian Tube, Petroclival Fissure, and Pharyngobasilar Fascia

The eustachian tube (ET), with its cartilaginous portion and torus tubarius, is in a strict relationship with the posterior border of the medial pterygoid process anteriorly, while it is attached to the clival region and FL posteriorly. Multiple vertical cartilaginous fibers strongly attach the superior and medial border of the ET to the lacerum area. These fibers are longer in the medial portion and very short in the lateral region (Fig. 5). In this triangular space, namely the supratubaric space, no anatomical or vascular structure was observed in the cadaveric dissections.

The petroclival fissure, which sits along the lateral edge of the clivus, separates the occipital bone and the petrous part of the temporal bone. This fissure extends from the FL above up to the jugular foramen below. The inferior petrosal sinus runs along the petroclival fissure on the intracranial surface. Horizontal cartilaginous fibers join the petrous part of the temporal bone to the occipital and sphenoid bones. These fibers are more extensive in the FL and decrease progressively toward the jugular foramen (Fig. 6).

The pharyngobasilar fascia, also known as the pharyngeal aponeurosis, originates from the pharyngeal tubercle and runs laterally across the clivus to the petrous temporal bone, immediately anterior to the carotid foramen, and then passes anteromedially to reach its insertion along the cartilaginous ET and the posterior edge of the medial pterygoid plate, at the level of the hamulus. This aponeurosis represents a horizontal fiber as we observed on the

TABLE 1. Measurements of the VN, VC, and FL

<table>
<thead>
<tr>
<th>Measurement</th>
<th>Right</th>
<th>Left</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>VN, mm</td>
<td>23.12 (1.95)</td>
<td>23.90 (1.45)</td>
<td>0.209</td>
</tr>
<tr>
<td>VC, mm</td>
<td>14.18 (1.05)</td>
<td>13.9 (0.85)</td>
<td>0.413</td>
</tr>
<tr>
<td>FLᵡ, mm</td>
<td>6.1 (2)</td>
<td>5.9 (2.1)</td>
<td>0.784</td>
</tr>
<tr>
<td>FLᵧ, mm</td>
<td>5.8 (1.25)</td>
<td>5.6 (1.1)</td>
<td>0.634</td>
</tr>
<tr>
<td>FLᵢ, mm</td>
<td>8.4 (0.55)</td>
<td>8.3 (0.55)</td>
<td>0.610</td>
</tr>
<tr>
<td>FL vol, mm³</td>
<td>99 (63.3)</td>
<td>91 (56.6)</td>
<td>0.708</td>
</tr>
</tbody>
</table>

FL = foramen lacerum; FLᵡ = FL in axial plane; FLᵧ = FL in coronal plane; FLᵢ = FL in craniocaudal plane; VC = vidian canal; VN = vidian nerve.

Data are mean (SD).

FIG. 4. A: A 45° endoscopic view of the endonasal transpterygoid cadaveric dissection showing the VN going from the pterygopalatine fossa to the FL. Due to the trajectory from medial to lateral and from inferior to superior, in the posterior limits of the transpterygoid approach, the nerve crosses in front of the horizontal portion of the carotid and is then placed on top. B: Lateral schematic illustration facilitating understanding of the posterior limit of the VC along the pterygoid wedge. The VN passes along the anterior half of the upper surface of the horizontal segment of the ICA before turning downward along the anterior surface of the artery to reach the FL. pICA = parasellar ICA; pICCA = paracaval ICA; Pw = pterygoid wedge. Copyright Ariel Kaen. Published with permission. Figure is available in color online only.
petroclival fissure, but less hard and more superficial when we work from the nose.

Foramen Lacerum

The foramen lacerum (FL) is bound anteriorly by the junction of the body, lingular process of the greater sphenoid wing, and adjoining roots of the pterygoid wedge of the sphenoid bone; posterolaterally by the petrous apex of the temporal bone; and medially by the clival portion of the occipital bone. The petrous ICA, after exiting the petrous apex, occupies the upper part of the FL. The anterior genu of the ICA sits above the anterior half and does not pass through the foramen.

The anatomical measurements of the FL were as follows: FL_1 averaged 6.1 mm (range 4.2–8.4 mm) on the right and 5.9 mm (range 4.0–8.2 mm) on the left; FL_2 averaged 5.8 mm (range 4.4–6.9 mm) on the right and 5.6 mm (range 4.2–6.4 mm) on the left; FL_3 averaged 8.4 mm (range 8.0–9.1 mm) on the right and 8.3 mm (range 7.9–9.0 mm) on the left; and the total volume averaged 99 mm^3 (range 49.2–175.8 mm^3) on the right and 91 mm^3 (range 44.2–157.4 mm^3) on the left (Table 1). (See the Quantitative Assessment and Statistical Analysis subsection of Methods for definitions of FL_1, FL_2, and FL_3.)

The dense fibrocartilaginous tissue of the FL presents 4 different fibrous attachments, simulating skull base ligaments (i.e., vertical ligaments and horizontal ligaments) (Fig. 7). Three vertical ligaments can be identified: 1) the anterior ligament between the anterior lip of the FL and the posterior wall of the pterygoid wedge; posterolaterally by the petrous apex of the temporal bone; and medially by the clival portion of the occipital bone. The petrous ICA, after exiting the petrous apex, occupies the upper part of the FL. The anterior genu of the ICA sits above the anterior half and does not pass through the foramen.

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VN before it enters the posterior end of the VC; 2) the middle ligament located from the anterior lip of the FL to the superior portions of the ET, reaching the FL between the body of the sphenoid sinus and the pterygoid wedge; and 3) the posterior ligament (the smallest of the vertical fibers), which extends from the posterior lip of the FL to the most medial and superior segment of the petroclival synchondrosis.

Finally, horizontal ligaments are part of the fibrocartilaginous fibers that go from the medial to the lateral area of the FL. These ligaments have 2 layers, a superficial one coming from the pharyngobasilar fascia and another that originates from the petroclival fissure.

During the transpterygoid approach, we remove most of the pterygoid wedge around the VC following the VN. However, the diamond drill stops prematurely in the posterior end of the VC in a dense fibrocartilaginous tissue.

**Discussion**

Recent advancement in endoscopic endonasal skull base surgery has widened the target of the technique to the coronal plane approaches described as Kassam zones. A comprehensive transpterygoid approach involves identification and exposure of the cavernous, paraclival, and horizontal segments of the ICA (lacerum and petrous). All these neurovascular structures usually require a transpterygoid route. The anterior genu of the ICA, the bend where the horizontal segment turns upward around the medial edge of the petrous apex to end in the anterior vertical segment, is inferomedial to the trigeminal nerve and Gasserian ganglion, above the foramen lacerum (FL), and in the lateral wall of the sphenoid sinus. The anterior genu and anterior vertical segment are referred to as the lacerum segment by Bouthillier et al. Many studies have reported how to find the anterior end of the VC and follow the VN toward the lacerum segment of the petrous horizontal ICA.

The VC is a useful landmark to reach the lacerum segment of the ICA at its transition from the horizontal petrous segment to its vertical paraclival segment, especially in patients with poor sphenoid sinus pneumatization or those with recurrent pathology in whom the conventional surgical anatomy may be distorted. Moreover, exposure of the VN allows further exposure of the pterygoid base and lateral wall of the sphenoid sinus, as part of the transpterygoid approach. In the transnasal endoscopic procedure, the VN can be followed backward in the pterygopalatine fossa under a prominence over the nerve in the floor of the sphenoid sinus to the area above the FL and the lower edge of the anterior genu.

However, even if it is well accepted in the pertinent literature, care should be taken when dealing with the concept of “following the vidian nerve” and considering it the main anatomical landmark to check for petrous ICA position. The so-called VELPPHA area (for vidian nerve, eustachian tube, foramen lacerum, petroclival fissure, and pharyngobasilar fascia) is a group of skull base fibrocartilaginous tissues that join together and represent an easy anatomical landmark at the posterior limits of the endonasal transpterygoid approach.

In this contribution we detailed and showed a stepwise dissection aimed at reaching the VELPPHA area. The technique herewith described includes drilling medially and inferiorly to the VC; afterwards dissection proceeds in a posterior direction until a fibrocartilaginous tissue is identified, which marks the attachment to the FL and the anterior border of the second genu of the ICA. Moving in a medial to lateral direction along the anteroinferior border of the horizontal ICA, the anterior genu of the ICA can be exposed after removal of the cartilaginous ET. Recently Taniguchi et al. described the supra-eustachian triangle, a space bordered by the inferior aspect of the horizontal segment of the petrous ICA, by the superior aspect of the ET, and inferiorly by a vertical line along the medial aspect of the lacerum ICA. However, to access this triangular space, it is mandatory to identify the posterior border of the transpterygoid approach. Accordingly, the VELPPHA area represents not only the “safe area” located at the posterior limit of the transpterygoid approach but also the content...
of the supra-eustachian triangle. Oakley et al. define the vidian-eustachian junction as a secure area in which to find the ICA. Unfortunately, using the VN as a guide in the posterior limits of the transpterygoid approach, we may not be able to totally identify a safe anatomical landmark, since the nerve usually crosses the anterosuperior surface of the horizontal portion of the ICA.

Hence, in our dissections we described the fibrocartilaginous complex that fills the lower portion of the FL as a set of intercrossed fibers that mainly form 3 vertical beams and 1 horizontal beam. We are aware of the limitations of these dissections, given the strong adherence of these fibers to each other and the enormous intercrossing of fibers that prevents the proper categorization of the whole. However, the described ligaments represent the most consistent portions in the dissected specimens as well as a set of fibers with a constant and recognizable direction. We have observed that the fibers that represent the vertical medial ligament coming from the ET are especially vigorous and can be recognized early when drilling the VC, always below the VN plane, and they anticipate the VELPPHA area. Dissection of this area is difficult due to the strong attachments, but in most clinical cases we only need to know where the posterior limit of our approach is, rather than needing to enter the VELPPHA area. Accordingly, we may refine the “classic” concept from “following the vidian nerve” to “following the vidian canal” from anterior to posterior (endonasal view); therefore, the transpterygoid approach may end when the VELPPHA area (transition between bone and dense fibrocartilaginous tissue) is encountered. The VELPPHA area is an important anatomical landmark if there is the need to displace the petrous ICA (at the level of the FL). No nervous or vascular structures pass through the FL. Hence, it is safe to separate the lacerum segment of the cartilaginous ET from the FL by transecting the soft tissue just below the level of the VC.

Conclusions

The concept of the VELPPHA area is described in this anatomical report to further advance the knowledge of the endoscopic endonasal transpterygoid approach. The area herewith described represents the posterior limit of the transpterygoid route and, given that it is free of neurovascular structures, it could be thought as a safe zone for surgery in the posterior end of the endoscopic endonasal transpterygoid approach. Early identification of the VELPPHA area can contribute to safely performing such an endoscopic endonasal corridor approach expanded to the lateral aspect of the skull base, especially in patients with poorly pneumatized sphenoid sinuses.

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References


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Conception and design: Kaen, Cárdenas Ruiz-Valdepeñas. Acquisition of data: Kaen, Cárdenas Ruiz-Valdepeñas. Analysis and interpretation of data: Kaen, Cárdenas Ruiz-Valdepeñas. Drafting the article: Kaen, Cárdenas Ruiz-Valdepeñas, Di Somma. Critically revising the article: Kaen, Cárdenas Ruiz-Valdepeñas, Di Somma. Reviewed submitted version of manuscript: Kaen, Cárdenas Ruiz-Valdepeñas, Di Somma. Approved the final version of the manuscript on behalf of all authors: Kaen. Statistical analysis: Kaen, Di Somma. Administrative/technical/material support: Kaen, Di Somma. Study supervision: all authors.

Supplemental Information
Videos

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