Hypertensive intracerebral hemorrhage (ICH) is a very common neurosurgical condition encountered in clinical practice. Evacuation of the hematoma has recently been performed endoscopically, instead of via open craniotomy, to minimize brain injury. However, the 2D visualization of the hematoma that is afforded by an endoscope provides only limited information on intracerebral orientation. Intraoperative ultrasonography is a noninvasive diagnostic 2D imaging technique that can be used to provide 3D virtual imaging by moving the probe. The skull disturbs the penetration of ultrasound, but this problem can be resolved by placement of another bur hole. This study was undertaken to evaluate the utility of real-time ultrasound-guided endoscopic surgery for treatment of patients with putaminal hemorrhage.

Methods

This study was approved by the institutional review board of Yamaguchi University Hospital.

Patients with hypertensive putaminal hemorrhage were prospectively enrolled into the study between November 2012 and March 2014. Patients with preoperative hematoma volume $>30 \text{ cm}^3$ were included in this study. Real-time ultrasound guidance was performed with a bur-hole-type probe that was advanced via a second bur hole, which was placed in the temporal region. Ultrasound was used to guide insertion of the endoscope sheath as well as to provide information regarding the location of the hematoma during surgical evacuation. Finally, the cavity was irrigated with artificial cerebrospinal fluid and was observed as a low-echoic space, which facilitated detection of residual hematoma.

Results

Ten patients with putaminal hemorrhage $>30 \text{ cm}^3$ were included in this study. Their mean age (± SD) was 60.9 ± 8.6 years, and the mean preoperative hematoma volume was 65.2 ± 37.1 cm$^3$. The mean percentage of hematoma that was evacuated was 96% ± 3%. None of the patients exhibited rebleeding after surgery.

Conclusions

This navigation method was effective in demonstrating both the real-time location of the endoscope and real-time viewing of the residual hematoma. Use of ultrasound guidance minimized the occurrence of brain injury due to hematoma evacuation.

http://thejns.org/doi/abs/10.3171/2014.11.JNS141508

Key Words intracerebral hemorrhage; ultrasound; endoscopic surgery; real-time; bur hole; surgical technique; vascular disorders

Abbreviations

GCS = Glasgow Coma Scale; GOS = Glasgow Outcome Scale; ICH = intracerebral hemorrhage.


Include When Citing Published online June 5, 2015; DOI: 10.3171/2014.11.JNS141508.

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

Endoscopic surgery was performed using a rigid endoscope (Oi-Handy Pro, Karl Storz), and intraoperative ultrasonography was performed using a Prosound α-7 system (Hitachi-Aloka Medical) and a 3- to 8-MHz sector probe for the bur hole (Hitachi-Aloka Medical) (Fig. 1). General anesthesia was induced with the patients in the supine position. The endoscope bur hole was placed 10–12 cm above the nasion and 2.5–4 cm lateral to midline to achieve the frontal approach, and the ultrasound bur hole was made in the temporal region (Fig. 2). Two linear skin incisions were made at each bur hole. The location of each of the bur holes was adjusted slightly in accordance with the hematoma location. For the ultrasound bur hole, no dural incision was made because the dura permitted penetration of the ultrasound and protected the brain surface from probe damage. The sonographer applied the probe at the ultrasound bur hole to provide navigation guidance for the surgeon. Initially, the hematoma was observed using ultrasound from the endoscope bur hole to determine the direction of the endoscope tract, and the endoscope sheath (Neurosheath 17.5 F; Medikit) was then inserted to the core of the hematoma under ultrasound guidance from the ultrasound bur hole. Throughout the operation, real-time ultrasound was performed via the ultrasound bur hole. Endoscopic evacuation was performed in a dry field. The sonographer informed the surgeon of the location of the endoscope relative to the hematoma. If there was active bleeding from the cavity surface, the bleeding vessel was ablated using monopolar cautery. After sufficient evacuation was achieved, removal of the hematoma was confirmed by using the endoscope on a wet field with artificial cerebrospinal fluid. The extent of hematoma removal was also confirmed using ultrasound.

All study protocols were conducted in accordance with the principles of the Declaration of Helsinki. Informed consent was obtained from each patient or the family. The study was approved by our institutional review board.

Results

We included 10 patients with hypertensive putaminal hemorrhages that were estimated to be greater than 30 cm³ in volume (Table 1). Five of the patients were female and 5 male. The patients’ mean age (± SD) was 60.9 ± 8.6 years. The hemorrhage was on the right side in 8 cases. The mean preoperative hematoma volume was 65.2 ± 37.1 cm³, and the mean percentage of hematoma evacuated was 96% ± 3%. Ninety days after the operation, 7 patients were moderately disabled (GOS Score 4), 1 was severely disabled (GOS Score 3), and 2 were in a vegetative state (GOS Score 2). The 2 patients who were in a vegetative state had hematomas volumes greater than 100 cm³ on admission.

Illustrative Case

Case 10

This 58-year-old woman exhibited hypertensive putaminal hemorrhage with a GCS score of 13. A CT scan showed a right putaminal hemorrhage that was estimated to be 99 cm³ in volume (Fig. 3F). Endoscopic evacuation of the hematoma was performed. The endoscope bur hole was placed 12 cm above the nasion and 3 cm lateral to midline, and the ultrasound bur hole was placed at the temporal region. The endoscope sheath was inserted to the center of the hematoma (Fig. 3A), and the hematoma was evacuated under real-time ultrasound guidance in the dry field (Fig. 3B and C). Ultrasound showed that during evacuation with the sheath placed at the center of the hematoma, the residual hematoma moved centripetally. Being able to keep the sheath at the center of the hematoma allowed us to avoid contact with the brain parenchyma and the potential for additional damage. After sufficient evacuation of the hematoma was achieved, a wet field was adopted to confirm the degree of evacuation. The cavity was filled with artificial cerebrospinal fluid, creating a low-echoic space (Fig. 3D), which showed no residual hematoma, and no bleeding was observed in the hematoma cavity with the endoscopic view (Fig. 3E). The postoperative CT scan showed that the hematoma was almost completely evacuated (Fig. 3G).

Discussion

This is the first report of endoscopic evacuation of ICH-
related hematomas using real-time ultrasound guidance. Intraoperative navigation with MRI has become widely popular for brain tumor surgery. However, MRI navigation is based upon static preoperative information; therefore, intraoperative brain shifting and decrease in hematoma volume cannot be followed. Intraoperative CT or MRI can be used to demonstrate residual hematoma, but these modalities require a break in the surgery and thus cannot be used to confirm the location of the endoscope. Intraoperative ultrasonography performed using the endoscope bur hole is considered useful, but because the probe is applied via the same bur hole as the endoscope, the endoscopic location cannot be observed and the hematoma can be observed only intermittently. In this study, real-time ultrasonography aided in navigation by providing real-time information on the locations of both the endoscope and the residual hematoma. Although our method requires an additional skin incision and bur hole, minimal invasion can be achieved without redundant movement of the sheath or brain injury.

We propose that the sheath should be always placed at the center of the hematoma to avoid brain damage. Kuo et al. recommended that suction be applied via the long axis of the hematoma, because the hematoma could then be evacuated during gradual withdrawal of the sheath. Their proposal is similar to our own, because they recommended that the sheath should not be moved roughly and that suction should not be applied to the brain, to avoid brain

### Table 1. Summary of clinical and demographic characteristics of 10 patients with putaminal hemorrhage

<table>
<thead>
<tr>
<th>Case No.</th>
<th>Age (yrs)</th>
<th>Sex</th>
<th>Side</th>
<th>Time to Op (hrs)</th>
<th>Hematoma Vol (cm³)</th>
<th>Hematoma Evacuation Rate (%)</th>
<th>Duration of Op (min)</th>
<th>GCS Score Day 0</th>
<th>GCS Score Day 7</th>
<th>90-Day Outcome</th>
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<tr>
<td>1</td>
<td>69</td>
<td>F</td>
<td>Right</td>
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<td>96</td>
<td>130</td>
<td>5</td>
<td>7</td>
<td>MD</td>
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<tr>
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<td>M</td>
<td>Right</td>
<td>1.5</td>
<td>127</td>
<td>91</td>
<td>120</td>
<td>7</td>
<td>8</td>
<td>VS</td>
</tr>
<tr>
<td>3</td>
<td>54</td>
<td>M</td>
<td>Right</td>
<td>2</td>
<td>111</td>
<td>99</td>
<td>150</td>
<td>4</td>
<td>4</td>
<td>VS</td>
</tr>
<tr>
<td>4</td>
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<td>Right</td>
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<td>31</td>
<td>100</td>
<td>90</td>
<td>11</td>
<td>11</td>
<td>MD</td>
</tr>
<tr>
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<td>F</td>
<td>Right</td>
<td>10</td>
<td>32</td>
<td>94</td>
<td>110</td>
<td>10</td>
<td>15</td>
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</tr>
<tr>
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<td>Right</td>
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<td>70</td>
<td>13</td>
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</tbody>
</table>

MD = moderately disabled (GOS Score 4); SD = severely disabled (GOS Score 3); VS = vegetative state (GOS Score 2).
Damage or bleeding from the cavity surface. In our study, ultrasound demonstrated that the sheath was inserted to the center of the hematoma; moreover, the intraoperative placement of the sheath was always identified. Evacuation of the central hematoma led to centripetal shrinking of the hematoma, which avoided brain injury. It is very important that real-time navigation allowed for intraoperative compensation of the sheath location, despite brain shift.

In applying this technique, the sonographer must be aware of how to analyze the ultrasound images. Regarding interpretation of the ultrasound findings, the sonographer should work in cooperation with the surgeon, taking the following considerations into account: 1) The endoscope and aspirator are observed as high-echoic objects with acoustic shadows. 2) Intracerebral air can disturb penetration of the ultrasound. 3) When the wall of the hematoma cavity is rough, diffuse reflection of the ultrasound can occur. 4) The sonographer must generate a 3D virtual image from the 2D sonogram to navigate on behalf of the surgeon. Intraoperative ultrasonography is distinct from routine examination because of the use of artificial instruments and air containment; furthermore, the irregular surface of the surgical cavity is quite specific. Despite these complications, when the cavity was filled with artificial cerebrospinal fluid, it was observed as a low-echoic space and the residual hematoma as a higher-echoic space, which could provide simple information regarding the residual hematoma. At present, the ultrasound and endoscope displays are separate; thus, the sonographer and operator cannot watch both displays simultaneously. We propose that in the future, both views should be present in the same display, which might reduce the need for extra time and allow for more cooperation between the surgeon and the sonographer.

There are several problems with and limitations to this study. 1) The endoscope and the application of suction could lead to an acoustic shadow, and it is essential to avoid missing any residual hematoma that is located within the endoscope. 2) The wall of the evacuated hematoma cavity is rough, which could lead to scattering of the ultrasound. In the wet field, the wall was observed as a high, thin, echoic lesion, which could be distinguished from a hematoma based upon the endoscopic view. 3) Evacuation of the hematoma leads to shrinkage of the brain; thus, air enters the subdural space, which disturbs the penetration of ultrasound. This problem can, however, be resolved by infusion of artificial cerebrospinal fluid through the endoscope bur hole. 4) This study did not include a control group. Thus, a future randomized study is desirable.

Conclusions

In endoscopic surgery for putaminal hemorrhage, real-time navigation with ultrasound can demonstrate the location of the endoscope and the residual hematoma, which can thus minimize brain damage. Furthermore, it might decrease brain injury due to the use of an additional bur hole for real-time ultrasonography.

Reference

1. Chen CC, Cho DY, Chang CS, Chen JT, Lee WY, Lee HC: A

**Author Contributions**
Conception and design: Sadahiro. Acquisition of data: Sadahiro, Nomura, Goto, Sugimoto, Inamura, Fujiyama, Yamane, Oku. Drafting the article: Sadahiro, Shinoyama. Study supervision: Nomura, Suzuki.

**Correspondence**
Hirokazu Sadahiro, Department of Neurosurgery and Clinical Neuroscience, Yamaguchi University School of Medicine, 1-1-1 Minami-Kogushi, Ube, Yamaguchi, Japan. email: sadapiro@yamaguchi-u.ac.jp.