Optic nerve mobilization to enhance the exposure of the pituitary stalk during craniopharyngioma resection: early experience

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OBJECTIVE Preservation of the pituitary stalk and its vasculature is a key step in good postoperative endocrinological outcome in patients with craniopharyngiomas. In this article, the authors describe the surgical technique of medial optic nerve mobilization for better inspection and preservation of the pituitary stalk.

METHODS This operative technique has been applied in 3 patients. Following tumor exposure via a frontolateral approach, the pituitary stalk could be seen partially hidden under the optic nerve and the optic chiasm. The subchiasmatic and optico-carotid spaces were narrow, and tumor dissection from the pituitary stalk under direct vision was not possible. The optic canal was therefore unroofed, the falciform ligament was incised, and the lateral part of the tuberculum sellae was drilled medial to the optic nerve. The optic nerve could be mobilized medially to widen the optico-carotid triangle, which enhanced visualization of and access to the pituitary stalk.

RESULTS By using the optic nerve mobilization technique, the tumor could be removed completely, and the pituitary stalk and its vasculature were preserved in all patients. In 2 patients, vision improved after surgery, while in 1 patient it remained normal, as it was before surgery. The hormonal status remained normal after surgery in 2 patients. In the patient with preoperative hormonal deficiencies, improvement occurred early after surgery and hormonal levels were normal after 3 months. No approach-related complications occurred.

CONCLUSIONS This early experience shows that this technique is safe and could be used as a complementary step during microsurgery of craniopharyngiomas. It allows for tumor dissection from the pituitary stalk under direct vision. The pituitary stalk can thus be preserved without jeopardizing the optic nerve.

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KEY WORDS craniopharyngioma; microsurgery; optic nerve mobilization; outcome; pituitary stalk; surgical technique
configurations have been described in a previous work from our institution. The pituitary stalk has 2 critical points during the dissection of a craniopharyngioma: the inferior end of the pituitary stalk at its entry into the sella, and the upper end of the stalk at its attachment to the floor of the third ventricle. Both points are hidden and less mobile (Fig. 1A), which renders the dissection of the tumor from the stalk at these points significantly difficult. Unroofing of the optic canal, incision of the falciform ligament, and drilling of the tuberculum sellae medial to the optic nerve allow dorsal and lateral mobilization of the optic nerve and provide a space for dissection of the tumor from the lower part of the pituitary stalk (Fig. 1B). Furthermore, this procedure allows medial mobilization of the optic nerve and widens the optiocarotid triangle. Thus, the tumor can be dissected from the upper part of the pituitary stalk under vision (Fig. 1C).

The tuberculum sellae is directly related to the sphenoidal sinus. Drilling of the tuberculum sellae medial to the optic nerve can open the sphenoidal sinus with subsequent risk of CSF leak. This area should be reconstructed with fat tissue to avoid such a complication. Due to variation of the pneumatization of the sphenoidal sinus and the size of the tuberculum sellae, careful analysis of preoperative bone window CT is recommended. While mobilizing the optic nerve, the course of the ophthalmic artery should be kept in mind. Special consideration should also be given to the vasculature of the optic nerve and the optic chiasm.

Patient Sample

This optic nerve mobilization technique was used recently in 3 patients with supradiaphragmatic craniopharyngioma who were operated on by the senior author (R.F.). Preoperative hormonal status was normal in 2 patients. One patient had preoperative partial pituitary insufficiency. One patient had a normal preoperative visual field. One patient had peripheral scotoma, and the other had partial temporal hemianopsia. After 3 months, the patients were evaluated using hormonal assay, ophthalmological assessment, and MRI.

Surgical Technique

Skin Incision and Craniotomy

The approach is performed with the patient’s head extended and rotated slightly to the opposite side of the craniotomy. A hemiconoral skin incision is performed behind the hairline. The forehead skin is reflected inferiorly, exposing the orbital rim. The temporalis muscle is incised and then retracted downward, exposing the keyhole. A small basal frontolateral craniotomy (approximately 2.5 cm) reaching laterally using the keyhole is then performed.

Initial Subdural Dissection

A semilunar inferiorly based dural incision is performed. The frontal lobe is gently retracted, exposing the arachnoid of the sylvian fissure. The arachnoid of the proximal sylvian fissure is opened and the CSF is released. Adequate CSF release is required for adequate brain relaxation.

Tumor Resection

Tumor resection is performed through the usual pathways: the subchiasmatic, optiocarotid, and carotidotemporal windows. After initial internal decompression of the tumor via the subchiasmatic window, dissection proceeds in the optiocarotid triangle. The space created in the subchiasmatic window allows the surgeon to mobilize the lateral part of the tumor medially and to find the correct subarachnoid plane of dissection. Dissection of the tumor is continued, avoiding injury to the feeding vessels.
of the pituitary stalk. Bipolar coagulation should therefore be avoided whenever possible. In its area of origin, the craniopharyngioma is very adherent to the stalk. Dissection at this point should be sharp with microscissors. The pituitary stalk is partially hidden under the ipsilateral optic nerve and the optic chiasm. In some cases, the subchiasmatic space and the opticocarotid triangle are narrow, which additionally limits visualization of the pituitary stalk. Dissection of the tumor from the pituitary stalk is not possible under direct vision and can lead to excessive traction on the optic nerve. For better exposure and visualization of the pituitary stalk in these cases, we mobilize the optic nerve medially (Fig. 2A).

**Optic Nerve Mobilization**

The optic canal is opened superiorly and the falciform ligament incised. Then the lateral part of the tuberculum sellae is drilled (Fig. 2B). The amount of bone drilling of the tuberculum sellae medial to the optic nerve is variable, depending on the location of the pituitary stalk and the site of adherence of the tumor to the stalk. Accordingly, the surgeon can define intraoperatively how much to be drilled from the tuberculum sellae for safe medial mobilization of the optic nerve. The optic nerve is relatively freed and can be mobilized dorsally and laterally. The exposure of the lower end of the pituitary stalk is enhanced. The tumor attached to the lower end of the pituitary stalk can be removed under vision. Medial mobilization of the optic nerve widens the opticocarotid space and exposes the superior and inferior parts of the pituitary stalk (Fig. 2C and D). This offers the possibility of safe dissection of the tumor from the pituitary stalk under direct vision (Fig. 2E).

**Reconstruction**

The drilled area is in direct connection to the sphenoidal air sinus. This should be covered with subcutaneous fat and tissue glue to avoid a postoperative CSF leak (Fig. 2F).

**Results**

**Tumor Resection**

Complete tumor resection was achieved in all cases. The resection was confirmed by operative inspection by the neurosurgeon and by analysis of postoperative images by an independent neuroradiologist and the neurosurgeon. MRI control after 3 months was performed in all cases. The follow-up confirmed the total resection, and there was no early recurrence.

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**FIG. 2.** Intraoperative images. A: Identification of the pituitary stalk (S). The site of attachment of the craniopharyngioma is hidden by the right optic nerve (rt ON). B: Drilling of the roof of the optic canal and the lateral part of the tuberculum sellae (Dr). The falciform ligament (F) is incised. C: Medial mobilization of the optic nerve and exposure of the upper part of the pituitary stalk (S). Now the tumor (T) can be dissected under vision. D: Further dissection of the tumor medial to the optic nerve. E: Overview of the operative field showing the preserved pituitary stalk. F: Covering of the drilled area using a fat graft. Figure is available in color online only.
Endocrinological Outcome

The pituitary stalk was anatomically and functionally preserved in all patients. Two patients had normal hormonal status after surgery. One of these patients experienced transient postoperative hyponatremia, managed with fluid restrictions. The third patient had preoperative partial pituitary insufficiency, which remained unchanged initially. Within 3 months, however, she recovered and did not need hormonal substitution. None of the 3 patients experienced postoperative diabetes insipidus.

Visual Outcome

None of the patients experienced visual deterioration. One patient had preoperative incomplete hemianopsia on the right side, which partially recovered. Another patient with preoperative scotoma showed improvement after surgery. In the third patient, the visual acuity and field of vision remained normal.

Illustrative Case

A 49-year-old woman presented with progressive visual deterioration and headache. MRI of her brain showed a suprasellar lesion elevating the floor of the third ventricle (Fig. 3A and B). The radiological appearance was consistent with a craniopharyngioma, and surgical removal via the right frontolateral approach was planned. Following the operative steps described above, the tumor was exposed and internal decompression was performed, first through the subchiasmatic space and then through the opticocarotid space. The pituitary stalk was identified posteriorly at its attachment to the roof of the third ventricle, and later the origin of the tumor from the pituitary stalk was visualized. The access to this area was limited by the right optic nerve and further dissection would require either aggressive optic nerve mobilization or blind dissection. Therefore, at this stage, the roof of the optic canal was drilled and the falciform ligament incised. The lateral part of the tuberculum sellae was also drilled toward the sphenoid sinus, but the mucosa was preserved. The increased exposure allowed resection of the tumor completely under direct visual control via the subchiasmatic and opticocarotid spaces. After tumor resection, an autologous fat graft was used to cover the drilled area. The patient was operated on while under intraoperative MRI control (Fig. 3). The tumor was completely removed (Fig. 3C and D), and the drilled area can be seen in Fig. 3D.

The patient made an uneventful recovery and had no new neurological or hormonal deficits. Postoperative visual field examination showed improvement of the preoperative visual field defect (Fig. 4).

Discussion

Craniopharyngiomas are midline tumors originating in the hypothalamic pituitary region.32 Although total resection of the tumor results in better survival benefit, craniopharyngioma surgery can be associated with a high rate of hypothalamic/hypophysial dysfunction. The surgical procedure affects the pituitary stalk or its vasculature, resulting in postoperative endocrinological disturbance.11–13,15,16,18,34,35

The frontolateral approach is used at our institution as the standard transcranial approach for resection of the great majority of suprasellar craniopharyngiomas.12 In this article, we present a further refinement of the technique for better preservation of the pituitary stalk and its vasculature. After the usual frontolateral approach, the optic canal is opened together with drilling of the lateral part of the tuberculum sellae. This allows medial mobilization of the optic nerve and widening of the opticocarotid triangle. The site of origin of the craniopharyngioma from the pituitary stalk comes into view. Complete separation of the tumor from the pituitary stalk without excessive traction of the optic nerve can be achieved. Furthermore, drilling of the lateral part of the tuberculum sellae along with dorsal and lateral mobilization of the optic nerve improves the exposure of the lower part of the pituitary stalk and facilitates safe resection of the inferior part of the tumor.

Operative inspection of the pituitary stalk is possible using endoscopic-assisted transcranial approaches. Endoscopic-assisted tumor resection can expose the pituitary stalk, but the surgical accessibility for resection of the adherent part of the craniopharyngioma to the stalk is limited. In some cases, the introduction of the endoscope is difficult, because of the narrow spaces between the neurovascular structures in the suprasellar space. Transsphenoidal resection of the craniopharyngioma can expose and preserve the pituitary stalk but with a higher risk of a CSF leak and a less complete resection.5,21,22,26

The techniques of decompression and mobilization of the optic nerve vary depending on the pathology and the aim of the surgical procedure. Unroofing of the optic canal is a well-established procedure, especially during resection of tuberculum sellae meningiomas for decompression of the optic nerve and removal of the tumor extension into the optic canal.22,25 Anterior clinoidectomy and resection of the optic strut are also well established for resection of clinoidal meningioma or during clipping of aneurysms...
Related to the paraclinoidal internal carotid artery.\textsuperscript{3,6,29–31} Opening of the optic canal and optic nerve decompression have also been described during transsphenoidal surgery for suprasellar lesions.\textsuperscript{7,9} Optic nerve decompression with or without mobilization can be performed without compromise of visual outcome, especially if performed by an experienced surgeon.\textsuperscript{27–29,31}

For medial optic nerve mobilization, drilling of a part of the tuberculum sellae is necessary to avoid vigorous stretching of the optic nerve. The amount of drilling is variable, depending on the location of the stalk in relation to the optic nerve and optic chiasm. It is also dependent on the site of attachment of the tumor to the pituitary stalk. The surgeon should consider the course of the ophthalmic artery while mobilizing the optic nerve medially. This tailored technique is sufficient to expose the entire length of the pituitary stalk. It is also safe and not time consuming. Covering of the drilled area of the tuberculum sellae with fat is necessary to avoid CSF leak, which can happen due to opening of the mucosa of the sphenoidal sinus. In this technique, the drilled area is relatively small and a small piece of subcutaneous scalp fat is sufficient to cover the defect. It is unnecessary to make other incisions in the abdomen or the upper thigh to gain a larger fat graft.

The potential drawback of our technique would be risk of injury to the optic nerve or to the ophthalmic artery. In our experience, although limited to only 3 patients, we never observed visual or pituitary/hypothalamic complications. There is also a potential risk of CSF leak. Covering of the drilled area of the tuberculum sellae with a fat graft is mandatory to avoid CSF leak, which no patient experienced in this series.

Conclusions

The technique of medial optic nerve mobilization following optic nerve unroofing and drilling of the lateral part of the sphenoid can enhance the resection of supradianaphragmatic craniopharyngiomas. This technique provides better exposure of the pituitary stalk, allowing for safer tumor dissection from the stalk under direct vision. The pituitary stalk and its vasculature can thus be preserved. According to our early experience, the technique is safe. It can also be applied during resection of other suprasellar lesions.

References


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Disclosures
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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