Neuroendoscopic unrestricted Access to and visualization of the important anatomical structures at the third ventricle: Surgical implications and image record.

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Neuroendoscopic Unrestricted Access to and Visualization of The Important Anatomical Structures at The Third Ventricle: Surgical Implications and Image Record

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INTRODUCTION

Neuroendoscopic surgery has become used on a wide range for treatment of many different pathologies as endoscopic third ventriculostomy for obstructive hydrocephalus, biopsy and tumor resection for intraventricular tumors, cystoventriculostomy for arachnoid cysts.1 Understanding the critical landmarks is very important to achieve successful neuroendoscopy. Besides, studying the accessibility and maneuverability for each target might necessitate modification of the current techniques in order to achieve “Safer surgical freedom”.

*Neuroendoscopic Anatomy:

Lateral ventricle (LV):
Through the coronal approach, the first part to face after entering the ventricular system is the central part of the LV near the frontal horn.2 LV consists of body, atrium and 3 horns; frontal, occipital and temporal. Regarding frontal horn, septum pellucidum forms the medial relation, while the caudate nucleus forms the lateral one. Corpus callosum forms the superior, inferior, and anterior boundaries. Frontal horn of LV is deprived of choroid plexus.2,3,4,5 Moving to the body of the LV, septum pellucidum and body of the fornix are considered the medial margin, while the body of caudate nucleus is the lateral margin. The superior structure is the trunk of corpus callosum, while the inferior one is the thalamus.2,3,4,5 About the atrium and occipital horn, their upper surface is formed by corpus callosum while the lower one is formed by collateral trigone. Their medial side consists of splenium of corpus callosum and calcar avis. Caudate nucleus and tapetum form the lateral margin of the atrium while the tapetum forms the lateral one of the occipital horn.4 Moving to the third ventricle, thalamus, tail of caudate nucleus, and tapetum, inferiorly by collateral eminence and hippocampus, laterally by tapetum, and medially by choroidal fissure.2,3,4,5 Choroid...
plexus is settled at the floor of the LV, along with the thalamostriate and septal veins.\(^6\)

- **Foramen of monro (FoM):**
  
  FoM connects the LVs with the 3\(^{rd}\) ventricle. Choroid plexus, thalamostriate, septal, and superior choroidal veins, and the distal branches of the medial posterior choroidal arteries pass through FoM.\(^6\)

- **Third Ventricle:**
  
  The 3\(^{rd}\) ventricle is a fissure-like space, bounded laterally by the thalamus and hypothalamus with the hypothalamic sulcus in between.\(^7\) Interthalamic adhesions connect the lateral walls.\(^7\) The anterior boundaries are from superior to inferior, columns of the fornix, FoM, anterior commissure, lamina terminalis, optic recess and lastly optic chiasm\(^7,10\). The upper margin is formed by tela chooroidea, choroid plexus, along with the velum interpositum\(^8\). The lower margin consists from anterior to posterior of the optic chiasma and recess, infundibular recess, tuber cinereum, mamillary bodies, Then the posterior perforated substance and the tegmentum of midbrain and finally the cerebral aqueduct.\(^4\) The posterior relations are the posterior commissure, pineal recess and the habenular commissure.\(^9\)

- **Velum Interpositum (VI):**
  
  The VI is a space located between the two layers of the tela chooroidea in the 3\(^{rd}\) ventricular roof.\(^10\) Tela chooroidea is attached through its upper layer to the fornix and through its lower layer to stria medullaris thalami anteriorly and the pineal body posteriorly.\(^10\)

- **Liliequist Membrane (LM):**
  
  LM is an arachnoid sheet present in the interpeduncular and prepontine cisterns, extending from the upper border of the dorsum sellae to the mamillary bodies and pontomesencephalic junction.\(^5,11\) It has 3 leaves: diencephalic, mesencephalic, and sellar leaves.\(^12,13\)

* **Surgical techniques:**

  **Endoscopic third-ventriculostomy (ETV):**
  
  Diversion of the CSF passage to pour in the subarachnoid space.\(^10\) Regarding the technique, the 3\(^{rd}\) ventricular floor and LM are opened to make the targeted passage.\(^10\)

**ILLUSTRATIVE CASES**

**Case 1**

A 14-year-old male patient presented with Headache, irritability, nervousness and decreased visual acuity. By examination, there is no sensory or motor affection. Visual acuity is 6/6 by glasses. Patient was diagnosed with obstructive hydrocephalus.

**Operation:** (ETV) (figs. 1,2,3,4,5)
cinereum (TC). (8) Fogarty catheter (5Fr size) dilates the stoma of ETV. (14) (©: Alhusain Nagm MD, MSc, PhD, FNE-Germany)

Fig. 4: Case 1: Neuroendoscopic video-captured image shows the dilated ETV stoma. We can see the delicate liliequist membrane (LM), Oculomotor nerve (ON) piercing the porus oculomotaris (blue arrow) between the anterior petroclinoid ligament (APCL), and the posterior petroclinoid ligament (PPCL). Dorsum sella (DS) and temporal lobe (TL) can be appreciated. (14) (©: Alhusain Nagm MD, MSc, PhD, FNE-Germany)

Figure (5): Case 1: Neuroendoscopic video-captured images taken from the ETV stoma showing the basilar artery (B), Dorsum Sella (DS) which is the uppermost part of the clivus with its anterior relation; Pituitary gland (PG), Oculomotor nerve (ON) entering porus oculomotaris (blue arrow) between the 2 folds of Petroclinoid ligament; anterior petroclinoid ligament (APCL), posterior petroclinoid ligament (PPCL). Temporal lobe (TL) can be appreciated. (14) (©: Alhusain Nagm MD, MSc, PhD, FNE-Germany)

Case 2

A 20-year-old female patient presented with Headache, irritability, nervousness. MRI shows aqueductal stenosis.

Operation: (Endoscopic Third Ventriculostomy) (figs. 6,7,8,9,10)

Fig. 6: Case 2: Neuroendoscopic video-captured images, right side approach: (1,2) The choroid plexus (CP) passing through Foramen of Monro (FoM), Thalamostriate (TS) and anterior septal (AS) veins joined at its lower end. Columns of fornix (P) form the anterior margin of FoM. Corpus callosum (CC) is located anterior to columns of the fornix. Anterolateral to FoM, we can appreciate the caudate Nucleus (CN), internal capsule (IC). Posterolateral to FoM, thalamus (TH) is present. Septum Pellucidum (SP) and Body of the fornix form the medial and posteromedial relation to FoM. (3,4) By looking at the floor of the 3rd ventricle, we can distinguish the two mammillary bodies (M) which are connected. They separate the middle segment (MS) posteriorly from tuber cinereum (TC) anteriorly. Here we can notice the floor is very thin and transparent, so that, the basilar apex and bifurcation (B) can be seen easily. Hypothalamus (HT) is seen at the inferior part of lateral 3rd ventricular wall. (13) (©: Alhusain Nagm MD, MSc, PhD, FNE-Germany)

Fig. 7: Case 2: Neuroendoscopic video-captured images: (5) shows the floor of the 3rd ventricle with the 2 mammillary bodies (M) and basilar artery bifurcation (BA) in front of them. Tuber cinereum (TC) is located anteriorly. (6,7) Dick forceps (DF) is making the stoma at the tuber cinereum and in front of the basilar artery. (8) here we can see the stoma (S) of ETV. Notice the orange color of the infundibulum (I). (14) (©: Alhusain Nagm MD, MSc, PhD, FNE-Germany)
RESULTS

In our included illustrative cases, we were able to detect the anatomical structures around the 3rd ventricle. Foramen of monro (FoM) was seen in 12 cases with its variations, we distinguished the small, wide, rotated types besides the dilated one because of a 3rd ventricular lesion filling it. FoM was of average size in 5 cases (42%), narrow in 3 cases (25%), wide and rotated in 4 cases (33%).

We were able to see the anatomical landmarks around the FoM; Thalamus, internal capsule, and caudate nucleus, choroid plexus were seen in 12 cases (all cases of ETV and tumor biopsies). Choroid plexus shows 2 variations as it was thick in 4 cases (29%) and thin in 8 cases (71%).

Anterior septal and thalamostriate veins were seen in 12 cases, which were thin in 7 cases, thick and engorged in 5 cases, as well as, corpus callosum, body and columns of the fornix. Septum pellucidum (SP) was detected in 9 cases (69%), absent in 3 cases (25%). Out of these 3 cases, velum interpositum was seen in 2 cases. Septostomy was indicated and done in 2 cases (15%). During septostomy, Cavum septum pellucidum was seen in one case. The frontal horn and atrium of the lateral ventricle were seen in 12 cases (92%). Temporal horn in 4 cases (31%) with the choroid plexus going through it, Occipital horn in (8%). In 10 cases, we were able to see 3rd ventricular floor from the lateral ventricle through FoM. Going through FoM, we were able to see the 3rd ventricular floor obviously. Optic chiasm was the most anterior part seen, the infundibular recess which is located anterior to tuber cinereum. Both were seen in 5 cases (38%). The 3rd ventricular floor was described in each of the 10 case with its variations. Out of these 10 cases, it was thin in 6 cases (60%), thick in 4 cases (40%). Also, it shows opacity in 6 cases (60%), transparency in 4 cases (40%). One of these cases, the transparent floor was very congested.

Mamillary bodies were seen in all cases of ETV (10 cases) (77%), with its 2 types separated and connected. Separated mamillary bodies were 5 cases (50%), while connected ones were 5 cases (50%).

We were also able to view the middle segment of the 3rd ventricular floor in 10 cases (77%), interthalamic adhesions ( massa intermedia) in one case (8%), cerebral aqueduct, posterior commissure, pineal recess, habenular commissure and roof of the 3rd ventricle were detected in 4 cases (31%). After penetrating the 3rd ventricular floor, we appreciated the liliequist membrane (LM) in 10 cases which was thin in 8 cases (80%) and thick in 2 cases (20%) (fig. 23). Thick LM was opened using scissors, bipolar coagulation electrode, and fogyarty catheter.

Basilar artery was seen in all cases of ETV (10 cases) (77%), Clivus in 6 cases (46%), Dorsum sella and pituitary gland in 4 cases (31%). Oculomotor nerve was detected in 3 cases (23%), in 2 of these 3 cases, we were able to see porus occultomotoris, besides, the anterior and posterior petroclinoid ligament. In 2 cases (15%), we detected a space occupying lesion filling the cerebral aqueduct. A biopsy was taken from one of them. In another illustrative case, a tumor was seen filling the 3rd ventricle, FoM, and cerebral aqueduct. We were able to extract this lesion and make CSF pathway patent. The lateral walls of the 3rd ventricle were seen which consists of the thalamus, hypothalamus
with the hypothalamic sulcus in between. The 3 structures were seen obviously in one case (8%). Temporal lobe was seen in one case (8%) after penetration of the 3rd ventricular floor during ETV, lateral to brain stem.

**DISCUSSION**

Nagm A et al. (15) reported neuroendoscopy through extremely narrow FoM. In our study, we have shown various FoMs as narrow, wide, rotated and obliterated. In our study, we accessed the right and left one. Especially in narrow FoM, we make sure not to injure the columns of the fornix, besides, having a second look on the boundaries of FoM before we finish. Zohdi et al. (19) has described the anatomy of the velum interpositum in the 3rd ventricular roof. In our study, we have shown velum interpositum in 2 cases of the mentioned illustrative cases with labeled images in which the septum pellucidum was not found as it cannot be seen with intact septum pellucidum. Anik et al. (16) has reported the anatomy of liliequist membrane (LM). In our research, we have viewed the LM with its parts (Diencephalic, mesencephalic and sellar parts), and its types (thin and thick). We also opened it during ETV in all cases of ETV using the foggary catheter alone in thin LM while in thick type, we used the scissors and bipolar electrode forceps besides fogarty catheter. From the literature, it is mandatory to be opened for successful ETV. Sughrue et al. (17) has reported the types of the 3rd ventricular floor. In our study, we have seen and viewed it in 10 cases with full description including its types. It was thin in 6 cases, thick in 4 cases. Also, it appears opaque in 6 cases, transparent in 4 cases. We used the scissors and bipolar electrode forceps besides scissors and bipolar electrode besides the previous tools.

**Limitation:** Number of cases is not too many. This is because the deficiency of recording, and we intended to include cases of a single surgeon to limit skill errors. Also, we have made our efforts to include valuable cases with obvious images of a wide range of anatomical variations and surgical techniques.

**CONCLUSION**

Our study has presented and described numerous varieties of normal and pathological neuroendoscopic anatomy in the form of neuroendoscopic video-captured images with labels and interpretation. Through viewing and describing these images, this study was able to participate in achieving safer surgical freedom. This freedom is represented in understanding the critical landmarks, besides, studying the accessibility and maneuverability for each target. It can help novice neurosurgeons to be ready and well prepared for several surgical challenges based on better anatomical understanding, necessary instrumentation, and skills.

**REFERENCES**


