Endoscopic Endonasal Resection of Cholesterol Granuloma of the Petrous Apex

Introduction

The petrous apex is one of the most inaccessible areas to reach in the skull base. The most common type of lesion is cholesterol granuloma [1]. The cause of the lesions still remain unknown and small lesions can be asymptomatic. Historically, surgery to the petrous apex has been addressed via craniotomy and open microscopic anterior petrosectomy [2]. The endoscopic endonasal approach offers a minimally invasive alternative to traditional surgical approaches in the treatment of cholesterol granulomas of the petrous apex. The indications and applicability of endoscopic skull base surgery have rapidly advanced over the last decades from resection of benign in nasal and pituitary tumours to the resection of lesions involving the cribiform plate to the upper cervical vertebrae and extending to the petrous apex and infra temporal fossa [3]. The purpose of this study is to describe how we perform the endoscopic resection of cholesterol granuloma of the petrous apex using an unilateral approach. Recently then asosseptal flap has been used to permit long-term patency of drainage site [4].

Material and Methods

A 43-years-old man presented with 6 month history of intermittent right hemicranial headache and ipsilateral conductive hearing loss. The patient had no history of head trauma. The MRI demonstrated a large and expansile right petrous apex lesion hyper intense on both T1- and T2-weighted scans, without diffusion restriction or internal contrast enhancement. The CT scan showed and expansile and lytic lesion with surrounded bony erosion (Figures 1-4).

Surgical technique

A medial and unilateral trans sphenoidal trans clival approach with internal carotid artery lateralization combined with transpterygoid infrapetrous approach was indicated because of the location of the lesion. Team surgery is mandatory when there is manipulation of the internal carotid artery and a risk of vascular injury [5]. Bilateral sphenoidotomies provides more room for instrumentation and allow four-hand surgery by a team of surgeons an otolaryngology and a neurosurgeon, however unilateral sphenoidotomie approach can be a viable option and less invasive alternative. The sinonasal mucosa was de congested with topical epinephrine 1:2000. The partial...
inferior turbinectomy was done to facilitate the visualization. The maxillary antrostomy and ethmoidectomy was performed on the posterior wall of the maxillary sinus to expose the contents of the pterygopalatine fossa. The sphenopalatine artery was isolated, cauterized, and transected to fully expose the base of the pterygoids. Medially, the palatovaginal artery, a terminal branch of the maxillary artery, was transected, and soft tissue of the pterygopalatine fossa were mobilized laterally to facilitate identification of the vidian nerve and artery [6]. The pterygoid base was drilled out using a diamond burr 3.2 mm, preserving the vidian nerve, until the foramen lacerum soft tissue and anterior genu of the internal carotid artery were reached [6]. The course and location of the ICA is confirmed with neuronavigation system. The bone between the horizontal petrous ICA and Eustachian tube was drilled out.

Results

The patient was discharged 5 days post-operatively and at 2-month follow-up the silastic tube was removed under endoscopic visualization at the office. The patient demonstrated significant improvement of pre-operatively symptoms including resolution of headaches and improvement on his hearing loss.

Discussion

With the recent advances in minimally invasive surgery and intraoperatively image guidance systems, skull base endoscopy has led to new treatment options for petrous Apex lesions [9]. Most lesions are clinically silent until they adhere to cranial nerves, further this lesion can present with headaches, hearing loss, imbalance, facial weakness, and/or diplopia [8]. Principal treatment is surgical drainage and permanent aeration to prevent recurrence [5]. The treatment strategies depend on the location and size of the lesion, based on drainage or complete excision of the capsule or cyst drainage. Recently, petrous apex cholesterol granuloma have been treated via end on as al transsphenoidal approach using silicone tube to create drainage, prevent route occlusion. Obstruction of the drainage outlet has led to problem with recurrence [9]. The endoscopic endonasal approach provides a minimally invasive approach with wide operation field direct access to the midline and potential to extend approach to the superior and inferior PA.

Others advantages of the endoscopic endonasal approach include wide drainage window into the petrous apex connected with the natural corridor and sinonasal mucociliary system and postoperatively endoscopic surveillance in the office [10]. The internal carotid arteridary is of critical importance for endoscopic endonasal approaches to the petrous apex, and it is useful to categorize these approaches based on the irrelationship to the internal carotid arteridary [5]. The use of high speed drills with a diamond burr and image guidance allow precise removal of bone over the internal carotid arteridary and cyst wall [11].

Conclusion

The endoscopic endonasal approach to petrous apex lesions is a safe and minimally invasive technique for adequately selected patients. This approach provide wide access to the cyst, outpatient follow-up in office and if necessary, reopening with little morbidity in cases of recurrence. This approach is significantly less invasive than traditional trancranial procedures with overall reduced morbidity, shortened procedure time, reduced hospital stay and better cosmetic results and lower recurrence rates.

References


