1981

1980-1982

Percutaneous retrogasserian glycerol rhizolysis (PRGR) became a diffuse and valuable method for the treatment of trigeminal neuralgia, following its introduction by Hakanson in 1981.

Vincent in 1981 first reported the angiographic finding of an anterior spinal artery rupture [1].

Currarino syndrome (CS) is an autosomal dominant disorder of embryonic development causing a rare malformating syndrome characterized by a triad of an anorectal malformations, presacral mass (most commonly an anterior sacral meningocele) and sacrum defect.

It results of an abnormal separation of the ectoderm from the endoderm caused by HLXB9 mutation in chromosome 7q36 in 50% of cases. The disorder is mostly hereditary as it can also be sporadic with a variable expression spectrum.

Tumors like teratoma, hamartoma, epidermoid cysts of the central nervous system have also been associated.

It was originally described by Guido Currarino in 1981 [2].

In 1981, Price et al., first reported the use of the pericranial flap for support of the brain following resection of the anterior skull base. Since the initial report, considerable experience has been gained with this flap.

It is deployed via a bifrontal craniotomy and is placed primarily as a support beneath the frontal lobes. The pericranial flap may also be used to repair dural laceration and defects. The sinonasal surface is routinely grafted with split-thickness skin or dermis. This technique provides an excellent barrier between the sinonasal cavity and the cerebrospinal fluid, establishing a tough, fibrous platform. Herniation of intracranial contents has not occurred. One major complication has been reported in which radiation necrosis occurred during postoperative therapy, leading to progressive devitalization of the pericranial flap. Ultimately, dural repair and closure with a latissimus dorsi free flap was required. The pericranial flap repair of anterior skull base defects has a 90% complication-free and 95% overall success rate. It is simple and extremely effective. Bone grafting has not been necessary in there experience [3].

Dravet syndrome, previously known as severe myoclonic epilepsy of infancy (SMEI), is a type of epilepsy with seizures that are often triggered by hot temperatures or fever.

Dravet and Bureau in 1981 described “benign myoclonic epilepsy in infancy” in 7 normal children with onset of myoclonic seizures in the first 3 years of life [4].

In 1981, the World Federation of Neurosurgical Societies Committee on Neurosurgical Education presented a report from the worldwide survey of neurosurgical training requirements and certifying mechanisms in 61 countries. A report of Mosberg et al., revealed that the training requirements and certifying mechanisms vary widely among nations; however, most of them use the classic assessment methods which include a written (Multiple Choice Questions/Essays) or an oral examinations, or both, in addition to a list of operative cases logbook after the completion of the period required [5].

Gibo et al. in 1981 studied Internal carotid artery segments, the microsurgical anatomy of the supraclinoid portion of the internal carotid artery (ICA) in 50 adult cadaver cerebral hemispheres using X 3 to X 40 magnification. The ICA was divided into four parts: the C1 or cervical portion; the C2 or petrous portion; the C3 or cavernous portion; and the C4 or supraclinoid portion.

The C4 portion was divided into three segments based on the origin of its major branches: the ophthalmic segment extended from the origin of the ophthalmic artery to the origin of the posterior communicating artery (PCoA); the communicating segment extended from the origin of the PCoA to the origin of the anterior choroidal artery (AChA); and the choroidal segment extended from the origin of the AChA to the bifurcation of the carotid artery. Each segment gave off a series of perforating branches with a relatively constant site of termination. The perforating branches arising from the ophthalmic segment passed to the optic nerve and chiasm, infundibulum, and the floor of the third ventricle. The perforating branches arising from the communicating segment passed to the optic tract and the floor of the third ventricle. The perforating branches arises from the choroidal segment passed upward and entered the brain through the anterior perforated substance. The anatomy of the ophthalmic, posterior communicating, anterior choroidal, and superior hypophyseal branches of the C4 portion was also examined. Gibo-Rothon (J Neurosurg 55:560-574, 1981) follow the blood flow, incorporated the cervical and petrous portions, and divided the subarachnoid course-supraclinoid-in ophthalmic, communicating, and choroidal segments, enhancing transcranial microscopic approaches [6].

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