1985-1987

The Brain Trauma Foundation (BTF) is a national non-profit organization founded in 1986 whose mission is to translate neuroscience into effective solutions.

Intracranial pial arteriovenous fistulas (AVFs) are rare cerebrovascular malformations. Intracranial pial AVFs have single or multiple arterial connections to a single venous channel.

Since 1986 they have been recognized as a distinct pathological entity from other intracranial cerebrovascular malformations ¹⁾.

The Spetzler-Martin AVM grading system published in 1986 assigned one to three points for AVM size, one point for involvement of eloquent cortex, and one point for deep venous drainage for a total of five points. In their retrospective study, Spetzler and Martin retrospectively applied their scoring scale to 100 AVM patients. Higher Spetzler-Martin grade demonstrated a direct correlation between postoperative neurologic deficit as well as an inverse correlation between likelihood of surgical resection 2)

In 1986, Heros ³⁾ introduced the far-lateral approach (FLA) for the management of the vertebral artery aneurysms (VA), the vertebrobasilar junction, and the proximal basilar trunk and for arteriovenous malformations of the inferolateral cerebellum.

In 1988, George et al. introduced the FLA for removal of lesions involving the anterior/anterolateral foramen magnum⁴⁾.

Maurice-Williams and Choksey reported in 1986 three cases of temporal horn entrapment: A recurrent glioma, a previous tuberculous meningitis and surgical excision of an intracranial arteriovenous malformation which extended into the trigone. Shunting of the trapped temporal horn provided satisfactory treatment ⁵⁾.

In 1986 the EORTC Radiotherapy and Brain Tumor Groups initiated a prospective trial to compare early radiotherapy with delayed radiotherapy.

After surgery, patients from 24 centres across Europe were randomly assigned to either early radiotherapy of 54 Gy in fractions of 1.8 Gy or deferred radiotherapy until the time to progression (control group). Patients with low-grade astrocytoma, oligodendroglioma, mixed oligoastrocytoma, and incompletely resected pilocytic astrocytoma, with a WHO performance status 0-2 were eligible. Analysis was by intention to treat, and primary endpoints were overall and progression-free survival.

1/3

157 patients were assigned early radiotherapy, and 157 control. Median progression-free survival was 5.3 years in the early radiotherapy group and 3.4 years in the control group (hazard ratio 0.59, 95% CI 0.45-0.77; p<0.0001). However, overall survival was similar between groups: median survival in the radiotherapy group was 7.4 years compared with 7.2 years in the control group (hazard ratio 0.97, 95% CI 0.71-1.34; p=0.872). In the control group, 65% of patients received radiotherapy at progression. At 1 year, seizures were better controlled in the early radiotherapy group.

Early radiotherapy after surgery lengthens the period without progression but does not affect overall survival. Because quality of life was not studied, it is not known whether time to progression reflects clinical deterioration. Radiotherapy could be deferred for patients with low-grade glioma who are in a good condition, provided they are carefully monitored ⁶⁾.

Since 1986 Friedman et al. employed a transpetrosal approach for access to selective basilar artery aneurysms. Removal of the petrous apex provided an expanded deep window through which infraclinoidal basilar artery aneurysms can be controlled ⁷⁾.

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