

Extended anterior petrosectomy

Petroclival tumors and ventrolateral lesions of the pons present unique surgical challenges. A cadaveric study provides a qualitative and quantitative anatomic comparison for an anterior petrous apicectomy through the transcranial middle fossa (TMF) and expanded endoscopic transsphenoidal-transclival (EETT) approaches.

In 10 silicone-injected heads, the petrous apex and clivus were drilled extradurally using middle fossa and endonasal approaches. With in situ and frameless stereotactic navigation, they defined consistent points to compare working areas, bone removal volumes, approach angles, and surgical freedom.

Mean exposed TMF area ($21.03 \pm 3.46 \text{ cm}^2$) achieved a $44.71 \pm 4.13^\circ$ working angle to the brainstem between cranial nerves (CNs) V and VI. Kawase's rhomboid area measured $1.76 \pm 0.34 \text{ cm}^2$ and bone removal averaged $1.20 \pm 0.12 \text{ cm}^3$ at the petrous apex. Surgical freedom on the lateral brainstem was higher halfway between CNs V and VI at the center of the rhomboid compared to midline at the basilar sulcus ($P < 0.01$). After clivectomy and petrous apicectomy, mean exposed EETT area was $5.29 \pm 0.66 \text{ cm}^2$. Approach from either nostril showed no statistically significant differences in surgical freedom at the foramen lacerum and midpoint basilar sulcus. At the petrous apex, bone volume removed and area exposed were significantly larger for TMF approach ($P < 0.001$).

Expanded transclival anterior petrosectomy through the TMF approach provides an adequate corridor to lesions in the upper ventro-lateral pons. The EETT approach better fits midline lesions not extending laterally beyond CN VI and C3 carotid when evaluating normal anatomical parameters ¹⁾.

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