Falx meningioma of the anterior third

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Its a type of Falx meningioma anterior to the coronal suture.

Clinical Features

The falcine meningiomas arising anterior to the coronal suture are compromising relatively silent areas of the brain.

These tumors may be present as mass lesions with progressive organic mental syndromes and can be accompanied by generalized seizures, and sometimes with speech arrest, cognitive impairment such as amnesia and Weber syndrome has been also described in patients harboring falx meningiomas.

Diagnosis

Anterior falcine meningiomas are usually supplied by the ACA or by a tentorial branch of the ophthalmic artery.

Treatment

Falx meningioma of the anterior third treatment.

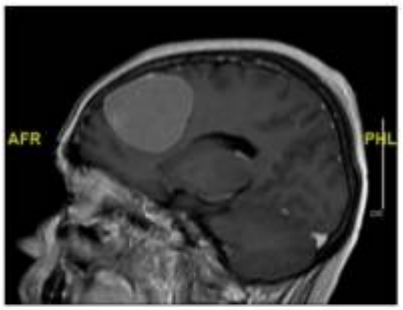
HGUA

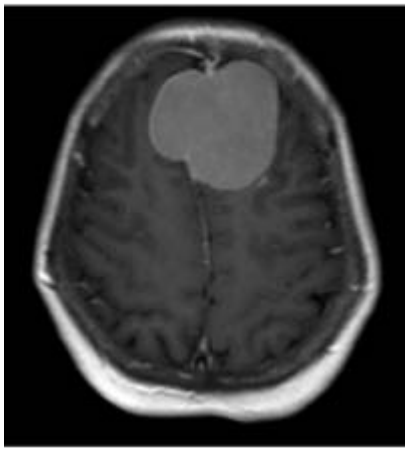
A 52-year-old woman with no significant medical history, toxic habits, hypertension, or diabetes. Personality disorder, agoraphobia, fibromyalgia, hyperthyroidism. Independent in activities of daily living. Family history of Sjögren's syndrome.

Regular Medication: Noctamid, Orfidal, Tirodril, Sertraline (non-compliance).

Current Illness: Inflammation in eyelids, palpebral ptosis, muscle pains, blurry vision. Fat hernia in the eyelid.

Physical Examination: Mild ptosis OD, joint stiffness in the right wrist.





Intraoperative picture after complete resection

54-year-old female

No previous cardiovascular events Risk factors for cardiovascular disease: Hypertension. No Diabetes. No Dyslipidemia. Toxic habits: Former smoker for [Number] years Relevant medical history: Hepatic hemangioma, renoureteral colic Previous surgeries: Myoma Current Condition A patient is admitted for a scheduled resection of a left falx meningioma. The patient has a history of holocranial headache for several years, attributed to chronic migraine with poor control using conventional analgesics. However, approximately a year ago, there have been changes in the characteristics of the pain, and it is currently described as radiating to the right trigeminal territory, but without clear characteristics of trigeminal neuralgia. Additionally, the patient reports worsening vision with blurry vision at both near and far distances. There are no symptoms suggestive of epileptic seizures or additional neurological focal signs.

Physical Examination NEUROLOGICAL EXAMINATION: The patient is awake and oriented. No alterations in the visual field. Blurred vision in any area of the visual field and distance focal. Normal eye movements, no trigeminal hypoesthesia, and no facial paralysis. The rest of the cranial nerves are normal. Strength and sensitivity are preserved in all four extremities. No claudication, specific neurological tests are not conducted.

Complementary Investigations

Cranial MRI: There is a lesion in the left extra-axial frontal space, with a wide base of implantation in the anterior cerebral falx and a small parafalcine extension to the right. The lesion exhibits intense homogeneous enhancement after intravenous contrast administration. It exerts mass effect on adjacent gyri, associated with a mild component of edema in the white matter on its lower side. Contact with the anterior aspect of the superior longitudinal sinus, which is patent. No significant increase in perfusion parameters. The findings are consistent with a meningioma. On its posterior aspect, it continues cranially with a parafalcine calcification. No other pathological foci are identified following contrast administration.

Diagnostic Impression: Extra-axial lesion compatible with left frontal parafalcine meningioma.

Justification for Surgical Indication The patient experiences poorly controlled headaches in the setting of a progressive growth of the meningioma observed on follow-up MRI.

Surgical Objective Resection of the lesion to alleviate headache and diagnose the lesion.

Approach Left parasagittal craniotomy

Positioning Left lateral decubitus with the head in a nearly neutral position on a head holder.

Incision A right bicoronal incision at a specific distance.

Technique Cutaneous dissection with an attempt to preserve the periosteum. Performance of a left frontal parasagittal craniotomy. Dural opening is pediculated in a C shape. Given the lesion's location, a dissection of the interhemispheric fissure will be performed to access the lesion. An initial devascularization of the surface and progressive detachment and coagulation of all adhesions to the falx cerebri will be performed with debulking using a Cavitron Ultrasonic Surgical Aspirator (CUSA). Once the volume is reduced, an attempt will be made to access the contralateral side. A dissection of the lesion will then be performed with sharp dissection of the surrounding parenchyma. Debulking of the lesion will continue until complete resection is possible.

After lesion resection, an attempt will be made to preserve the dura on which it rests. If it has ruptured, periosteum will be used. Careful hemostasis will be performed. Primary dural closure with specific suture. Bone replacement with specific equipment. Subcutaneous closure. Skin closure with staples.

Specific Surgical Equipment

Microscope Ultrasound machine (Ecógrafo) Cavitron Ultrasonic Surgical Aspirator (CUSA) Unopened dural substitute Expected Extension None

Possible Complications

Superior sagittal sinus injury Cerebral edema with worsening of previous symptoms Epileptic seizures Cerebrospinal fluid leak Surgical wound infection Postoperative Follow-up Investigations Control cranial MRI