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# Experience in 118 Consecutive Patients undergoing CT-Guided Stereotactic Surgery utilizing the Cosman-Robert-Wells (CRW) Frame

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## Abstract

**Aims:** To evaluate the efficacy of CT-guided neurosurgical procedures done on patients operated by this modality.

**Methods:** Between January 1997 and March 2000, 118 patients undergoing CT-guided stereotactic procedures were recruited to the study. The CRW III stereotactic system (Radionics, USA) and the TSX-00ZA CT Scanner (Toshiba, Japan) were used for all the procedures in the series. These procedures were directed to symptomatic brain lesions or for the treatment of Parkinsonian tremor.

**Results:** Of 118 patients, 109 had intra-cranial lesions and 9 had Parkinson's Disease. The stereotactic procedures performed on these patients were: biopsies in 62, guided mini-craniotomies in 22, haematoma evacuation in 11 cases, aspiration of abscess in 8 cases, 2 biopsy/aspiration of cysts, 4 placement of catheters and 9 thalamotomies. A histological diagnosis was made in 98.15% while no diagnosis was reached in 1.85%. Morbidity and mortality were 5.92% and 2.55% respectively.

**Conclusion:** CT-guided stereotactic surgery using the CRW frame is accurate, quick, safe and highly effective (JPMA 53:214;2003).

## Introduction

Advances in neuro-imaging techniques and improvements in stereotactic instrumentation have led to the increasing use of stereotactic surgery in the neurosurgical field. CT-guided stereotactic surgery is well recognized as a minimally invasive, low risk procedure with advantages for both the patient and neurosurgeon.<sup>1-5</sup>

The CRW (Cosman - Roberts - Wells) stereotactic system, was developed as a modification of the arc-radius design of the BRW (Brown - Robert - Wells) stereotactic system and utilises the existing fixation and fiducial components of the BRW system to localize and verify target data.<sup>6,7</sup> The CRW system is a target-centred arc design based on the Cartesian Principle. CT- guided stereotactic procedures using the CRW system have become well established in neurosurgery procedure and it is considered as one of the more simple, safe and reliable systems.<sup>6,7</sup> We studied 118 CT-guided stereotactic procedures using a CRW system in the Department of Neurosurgery, Jinnah Postgraduate Medical Centre, Karachi, Pakistan.

## Patients and Method

One hundred and eighteen patients underwent CT guided stereotactic operations at our Institute between January 1997 and March 2000. All the patients underwent preoperative CT scans and some had preoperative MRI scans. Out of 118 patients, 109 patients had intracranial lesions and 9 suffered from Parkinsonian tremor. Thirty four patients were operated under general anaesthesia and 84 under local anaesthesia. Patients who were operated under general anaesthesia were either children or adults who underwent guided mini-craniotomies for lesion excision.

CRW III frame (Radionics, Burlington, MA, USA) and new generation TSX - 002A series CT Scanner (Toshiba, Japan) was used for all the stereotactic procedures and a Nashold side cutting needle for biopsy which takes out a core of tissue of approximately 10x1.5 mm. Less often, Gildenberg biopsy cup forceps which has a cup size of approximately 2x2 mm was used for hard granular and surface lesions, while a coil biopsy spring was used occasionally to acquire tissue from cyst walls. Intracerebral haematomas were evacuated using a three-way cannula with an Archimedes screw device.

Preoperative MRI and CT scans were carried out in all the patients undergoing thalamotomy. Schaltenbrand and Wahren electronic brain atlas was utilized to determine the thalamic target coordinates during data acquisition. Physiological corroboration of the functional target was done using bipolar electrode with 1.1 mm diameter and 0.5 mm tip. Thalamic lesions have been made with a 3 mm bare tip of 1.1 mm diameter electrode using OWL Universal RF system (OWL instruments, Ltd, Markham, Ontario). Postoperative CT Scan or MRI were routinely performed to check the size and the location of the lesions.

Trajectory chosen for the stereotactic procedures were depended upon the site of the lesions and the nature of the procedure. Patients harbouring brain-stem lesions were biopsied either via transfrontal or transcerebellar approaches. A pre-coronal entry point was selected for thalamotomies.

Tissue obtained from each of the intracranial lesions biopsied was submitted for histopathological examination. Post-operative scans were obtained whenever indicated. All the patients were regularly followed up post-operatively.

## Results

Between January 1997 and March 2000, 118 patients underwent stereotactic procedures. There were 82 males and 36 females with age ranging from 5 to 70 years (Table 1). There were 21 children in this series, aged 5 to 16 years. Of the 118 stereotactic procedures; 62 were biopsies, 22 mini-craniotomies, 11 haematoma evacuation, 8 aspiration

**Table 1. Age distribution in cases of Stereotactic Surgery (n=118).**

Age	No. of cases
0 - 10	11
11 - 20	14
21 - 30	20
31 - 40	18
41 - 50	23
51 - 60	25
61 - 70	7
<b>Total</b>	<b>118</b>

**Table 2. Diagnosis of patients who underwent Stereotaxy (118).**

Diagnosis	No. of cases
<b>Functional</b>	
Parkinson's disease	9
<b>Non-functional</b>	
<b>Neoplastic</b>	
Gliomas	57 (45 from biopsies, 12 from mini-craniotomy)
Metastasis	10 (7 biopsies, 3 mini-craniotomy)
Primary CNS lymphoma	1
	<hr/>
	77
<b>Non neoplastic</b>	
AVM	1
Abscess	11 (8 aspiration, 1 biopsy, 2 mini-craniotomy)
Cotton Granuloma	1
Cysts (4 placement of catheter)	6
1 archanoid	
1 inflammatory	
Fungal	3
Haematoma	11
Infarction/Necrosis	3 (1 biopsy, 2 mini-craniotomy)
TB Granuloma	5 (4 biopsies, 1 mini-craniotomy)
<b>Total</b>	<b>118</b>

of abscesses, 2 biopsy/aspiration of cysts (with non-specific findings), 4 placement of catheters and 9 thalamotomies.

Of the 62 stereotactic biopsies, 50 were for supratentorial (of which 2 were temporal) and 12 for infratentorial lesions. Majority of patients undergoing stereotactic biopsy were diagnosed as glioma (45) and remaining were primary CNS lymphoma (1), metastases (7), fungal granuloma (3), tuberculoma (4), abscess (1) and infarction (1) (Table 2).

Twenty two patients underwent CT-guided stereotactic mini-craniotomy for gliomas (12), metastases (3), AVM (1), abscesses (2), cotton granuloma (1), tuberculoma (1) and infarctions (2).

**Table 3. Anatomical Location of Lesions in Patients Undergoing Stereotactic Operation (n=109).**

Anatomical location of lesion	No. of cases
<b>Supratentorial (n=96)</b>	
Lobar	
Frontal	19
Parietal	40
Temporal	7
Occipital	8
Basal Ganglia	10
Thalamus/Hypothalamus	12
<b>Intratentorial (n=13)</b>	
Mid brain	4
Pons	7
Cerebellar Hemispheres	2
<b>Total</b>	<b>109</b>

Out of 109 intracranial mass lesions, 96 were supratentorial and 13 were infratentorial (Table 3). In 105 patients (96.4%) the lesion was single and in 4 patients (3.6%) there were multiple lesions. Of the lesional cases, in 4 the intervention was for placement of a catheter in a cyst while a histological diagnosis was made in 103 cases (98.15%). A definite diagnosis could not be obtained in 2 cases (1.85%). The lesion was neoplastic in 68 cases (62.38%) and non-neoplastic in 35 cases (33.3%) (Table 4). The girl who had cotton granuloma was operated for convexity meningioma 8 years previously.

No complication was observed in 112 cases (94.08%). Over all morbidity and mortality, in this series, were 5.92% (7) and 2.55% (3) respectively. Two cases (1.7%) were complicated with intracerebral haematomas and both died within 48 hours of the stereotactic procedure. Two cases (1.7%) had developed brain edema, one died and one recovered with conservative management. One case (0.84%) developed diabetes insipidus which was controlled

**Table 4. Histological diagnosis in patients undergoing Stereotactic Procedures (n=109).**

I.	Neoplastic	68 (62.38%)
1.	Glioma	57 (52.31%) - 45 biopsies, 12 mini-craniotomies
	Grade I - II	21
	Grade III	15
	Grade IV	7
	Pilocystic Astrocytoma	4
	Gemistocytic Astrocytoma	2
	Xanthoastrocytoma	2
	Oligodendroglioma	3
	Ganglioglioma	2
2.	Primary CNS Lymphoma	1 (0.92%)
3.	Metastases	110 (9.1%) - 7 biopsies, 3 mini-craniotomies
	Adenocarcinoma	6
	Melanoma	2
	Large Cell tumour	1
	Renal Cell tumour	1
II	Non-neoplastic	39 (35.79%)
	Abscesses	11 (8 aspiration, 1 biopsy, 2 mini-craniotomies)
	AVM	1
	Cotton granuloma	1
	Cysts (Non specific inflammatory)	4 (Catheter placements)
	Fungal Granuloma	3 (Biopsy)
	Haematomas	11
	Infarctions	3 (1 biopsy, 2 mini-craniotomy)
	TB Granuloma	5 (4 biopsy, 1 mini-craniotomy)
III	No diagnosis	2 (1.85%).

with vasopressin.

Of 62 patients who underwent stereotactic biopsies complications encountered were one haematoma, one diabetes insipidus and two brain edema. The haematoma was evacuated successfully with stereotactic technique. Eleven patients with hypertensive intracerebral haematomas underwent stereotactic evacuation and one had re-accumulation of haematoma and died next day.

Nine patients underwent unilateral stereotactic thalamotomy for contralateral parkinsonian tremor. The tremor was abolished in 88.9% (8 cases) and one patient (11.1%) re-developed tremor one month after the procedure. The rigidity was reduced in 66.6%. One patient developed transient hemiparesis and another one chronic subdural haematoma, which was successfully evacuated at a later procedure. No death related to thalamotomy was observed.

No surgery related complications were noted among the patients who underwent stereotactic craniotomy, aspiration of cysts and abscesses and placement of catheter.

## Discussion

In the present study, there was 100% accuracy of target localization. The non-diagnostic biopsy rate 3.1% was and this occurred predominantly in non-neoplastic lesions. The expectations of stereotactic biopsy are less for non-neoplas. In our series, the morbidity and mortality following stereotactic procedure was 5.9% and 2.5% respectively; these rates are higher than those in literature where morbidity and mortality rates varied from 0.9% to 8.5% and 0 to 3.3% respectively.<sup>1-5,8,9,12,14-17</sup> Although the complication rate in this series is on the higher side, they compare favourably with the complication rates of other large series. Wild reported 8.5% morbidity and 1% mortality.<sup>12</sup> Kelly in 547 cases reported 2.9% morbidity and 0.3% mortality<sup>4</sup>, Barnstein in 300 cases, reported 4.7% morbidity and 1.7% mortality<sup>2</sup> and Gomez and Barnett observed 10.8% morbidity and 0% mortality in their series.<sup>3</sup> High mortality was observed in Bosch's series which was 3.3%.<sup>14</sup> Haemorrhages accounted for the majority of morbidity and death in previous series.<sup>2,5,8,10,12,14,16-19</sup> Other deaths were due to brain edema and herniation.<sup>4,11,16</sup> Same pattern of complications were noted in this series; they were haemorrhages (1.7%), brain edema (1.7%), neurological deficit (0.84%) and diabetes insipidus (0.84%). In our series there were two deaths from haematoma and one death from brain edema. These two patients who died of post-operative haematoma had similar solid, vascular and brilliantly enhancing lesions that were supplied directly from the anterior and middle cerebral arteries.

Of 11 patients with hypertensive intracerebral haematomas who underwent stereotactic evacuation, one died of rebleeding. Even with stereotactic evacuation, the operative results of hypertensive intracerebral haematomas have been unsatisfactory.<sup>20-32</sup> In Matsumoto's series complication associated with stereotactic aspiration of haematoma was 9.3% and post-operative re-accumulation of haematoma occurred in 5%.<sup>28</sup> Previous experiences have shown that with stereotactic method, 20 to 80% haematomas can be removed.<sup>28,29,33</sup> Backlund and Von Holst<sup>20</sup> and Higgins and Nashold<sup>23</sup> independently devised a double aspiration cannula, on the basis of the water - screw principle of Archimedes to remove the clotted blood. Even with this method, it is not possible to eliminate the haematoma completely. Matsumoto could remove up to 50% haematoma.<sup>28</sup> In our series, 60-70% of haematoma was evacuated using Archimedes screw device and this result is promising compared to the results of previous series.<sup>28,31-34</sup>

In our series, 9 patients underwent thalamotomy and tremor was abolished in 88.9%. The tremor re-occurred in one patient (11.1%) a month after the thalamotomy. Rigidity was reduced in 66.7%. Two patients developed complications; one suffered from transient hemiparesis and another developed chronic subdural haematoma. Our results are better than those of others. Jancovic reported disappearance of tremor in 86% and 58% suffered complications, 23% of which were persistent.<sup>35</sup> Siegfried and co-workers, reported complete disappearance of the tremor on the side contra-lateral to surgery in 85% and rigidity was considerably improved in 80% of the cases<sup>36</sup> with morbidity of 25% and mortality of 0.70%. Tasker reported abolition

of tremor in 80% of the patients with significant persistent tremor in 10-15%.<sup>37</sup> Goldmann, reported complete disappearance of tremor in 75% and permanent complication in 14%.<sup>38</sup> Likewise, Fox performed thalamotomy in 36 patients with parkinsonian tremor and obtained success rate of 86% with transient complications in 14% and permanent complications in 5%.<sup>39</sup>

CRW stereotactic system is based on 'centre of arc' design and was developed as a method of transforming the two dimensional CT data into three dimensional data related to a reference plane fixed to the skull. The CRW system has the advantage of allowing an infinite number of predetermined entry points, permitting the surgeon to use any entry point for a given target, as well as having capability to approach multiple target sites through the same entry point. These entry points can be chosen to avoid eloquent and vascular areas of the brain. Other major advantage of the CRW is that the arc may be rotated clear of the immediate operative field and re-introduced at anytime without loss of target localization. During the procedure, the target co-ordinates can be changed for a new target without a break in the sterility. The CRW system allows direct lateral approaches to any target because the arc side rings can be transposed from left to right orientation on the base plate to the anterior and posterior position. This is particularly useful for the temporal approaches for biopsy and craniotomy of the temporal lesion. The CRW system allows transfrontal and transcerebellar approaches for the biopsy of brain stem lesions to be carried out with ease. For the transcerebellar approaches, the base ring must be positioned low enough to allow the trajectory to the brain stem lesion. The CRW arc is easily positioned for posterior fossa surgery, as the probe holder can extend close enough to the frame to allow consistent suboccipital access. All these advantages of the CRW system makes this system suitable for stereotactic biopsy, craniotomy, thalamotomy, haematoma evacuation, aspiration of abscesses and cysts and placement of the catheter with minimum morbidity.

## References

1. Apuzzo MLJ, Chandrasoma PT, Cohen D, Zee CS, Zelmon V. Computed imaging stereotaxy: experience and perspective related to 500 procedures applied to brain masses. *Neurosurgery* 1987;20:930.
2. Bernstein M, Parrent AG. Complications of CT-guided stereotactic biopsy of intraxial brain lesions. *J Neurosurg* 1994;81:165-8.
3. Gomez H, Barnett GH, Estes ML, et al. Stereotactic and computer assisted neurosurgery at the Cleveland clinic: review of 501 consecutive cases. *Cleve Clin J Med* 1993;60:399-410.
4. Kelly PJ. Stereotactic biopsy procedures. In: Kelly PJ, (ed). *Tumour stereotaxis*. Philadelphia: Saunders 1992, pp.183-222.
5. Lundsford LD, Coffey RJ, Cojocar T, et al. Image guided stereotactic surgery: a 10 year evolutionary experience. *Stereotact Funct Neurosurg* 1989;54:375-87.
6. Pell MF. Techniques of CT directed stereotactic biopsy. In: Pell MF, Thomas DGT (eds). *Handbook of stereotaxy using CRW system*. Williams and Wilkins, 1994. pp. 53-72.
7. Pell MF, Thomas DGT. The initial experience with the Cosman-Robert-Wells Stereotactic system. *Br J Neurosurg* 1991;5:123-8.
8. Blauw G, Brakaman R. Pitfalls in diagnostic stereotactic neurosurgery. *Acta Neurochir* 1988;42:161-5.
9. Levin AB. Experience in the first 100 patients undergoing computerized tomography guided stereotactic procedures utilizing the Brown Roberts - Wells guidance system. *Appl Neuro Physiol* 1985;48:45-9.
10. Lobato RD, Rivas JJ, Carbello A, et al. Stereotactic biopsy of brain lesions visualized with computed tomography. *Appl Neurophysiol* 1982;45:426-30.
11. Niizuma H, Otsuki T, Yonemitsu T, et al. Experiences with CT guided stereotactic biopsies in 121 cases. *Acta Neurochir*; 1998;42:157-60.
12. Wild AM, Xuereb JH, Marks PV. Computerized tomographic stereotaxy in the management of 200 consecutive intracranial mass lesions, analysis of indications, benefits and outcome. *Br J Neurosurg* 1990;4:421-7.
13. Chin LS, Levy ML, Rabb CH, et al. Principles and pitfalls of image directed stereotactic biopsy of brain lesions. In: Thomas DGT (ed). *Stereotactic and image directed surgery of brain tumours*. Edinburgh: Churchill Livingstone, 1993, pp. 49-63.
14. Bosch DA. Indications of stereotactic biopsy in brain tumours. *Acta Neurochir* 1980;54:167-72.
15. Edner G. Stereotactic biopsies of intracranial space occupying lesions. *Acta Neurochir* 1981;57:213-34.
16. Hieburn MP, Brockmeyer D, Suerland P. Stereotactic surgery for mass lesions of the cranial vault. In: Apuzzo MLJ, (ed). *Brain Surgery*. New York: Churchill Livingstone 1993:390-431.
17. Mundinger F. CT stereotactic biopsy for optimizing the therapy of the intracranial processes. *Acta Neurochir* 1984;33:201-5.
18. Sedan R, Peragut JC, Farnarier PH, et al. Intracerebral stereotactic biopsies (309 patients/biopsies). *Acta Neurochir* 1998;42:157-60.
19. Scott RM, Brody JA, Copper IS. The effect of thalamotomy on the progress of unilateral Parkinson's disease. *J Neurosurg*; 1970;32:286-8.
20. Backlund EO, Von Holst H. Controlled subtotal evacuation of intracerebral haemorrhage by stereotactic technique. *Surg Neurol* 1978;99:99-101.
21. Amano K, Kawamuro H, Tanikawa T, et al. Surgical treatment of hypertensive intracerebral haematoma by CT-guided stereotactic surgery. *Acta Neurochir*; 1987;39:41-4.
22. Etou A, Mohadjer M, Braus D. Stereotactic evacuation and fibrinolysis of cerebellar haematomas. *Stereotact Funct Neurosurg* 1990;54:445-50.
23. Higgins AC, Nashold BS. Stereotactic evacuation of intracerebral haematoma. In: Lundsford LD (ed). *Modern stereotactic neurosurgery*. Boston: Martin Nijhoff. 1988, pp. 217-27.
24. Honod H. CT guided stereotactic evacuation of hypertensive intracerebral haematomas: a new operative approach. *Tokushima J Exp Med* 1983;30:25-39.
25. Horimoto C, Yamaga S, Toba T, et al. Stereotactic evacuation of massive hypertensive intracerebral haemorrhage. *J No Shinkei Geka* 1993;21:509-12.
26. Kandel EI, Peresedov VV. Stereotactic evacuation of spontaneous intracerebral haematomas. *J Neurosurg* 1985;62:206-13.
27. Kaufman HH. Stereotactic aspiration with fibrinolytic and mechanical assistance. In: Kaufman HH, (ed). *Intracerebral haematomas*. New York: Raven Press. 1992, pp.181-5.
28. Matsumoto K, Hondo H. CT-guided stereotactic evacuation of hypertensive intracerebral haematomas. *J Neurosurg* 1984;61:440-8.
29. Niizuma H, Otsuki T, Johkura H. CT-guided stereotactic aspiration of intracerebral haematoma - results of a haematoma - lysis method using urokinase. *Appl Neurophysiol* 1985;48:427-30.
30. Niizuma H, Shimzu Y, Yonemitsu T. Results of stereotactic aspiration in 175 cases of putaminal haemorrhage. *Neurosurgery* 1989;24:814-19.
31. Schichijo F, Matsumoto K. CT controlled stereotactic operation for the hypertensive intracerebral haemorrhage: cases with small haematomas in the thalamus and basal ganglia. *J No Shinkei Geka* 1985;3:945-52.
32. Tanikawa T, Amano K, Kawamura H, et al. CT-guided stereotactic surgery for evacuation of hypertensive intracerebral haematoma. *Surg Neurol* 1978;9:99-100.
33. Mohadjer M, Eggert R, May J, et al. CT-guided stereotactic fibrinolysis of spontaneous and hypertensive cerebellar haemorrhage: long term results. *J Neurosurg* 1990;73:217.
34. Ohye C. The new age of stereotaxis: toward the 21st century. *J Stereotact Funct Neurosurg* 1994;62:17-25.
35. Jonkovic J, Cardoso F, Grossman RF, et al. Outcome after stereotactic thalamotomy for parkinsonian, essential and other types of tremor. *Neurosurgery*, 1995;37:680-7.
36. Siegfried J, Blond S. Neurosurgical approaches. In: Siegfried J, Blond S, (eds). *The neurosurgical treatment of Parkinson's disease and other movement disorders*. London: Williams and Wilkins, 1997, p.100.
37. Ohye C, Tasker RR. Thalamotomy for Parkinson's disease and other types of tremor: Part I - History background and technique, part II - Outcome of thalamotomy for tremor In: Gildenberg PL, Tasker RR, (eds). *Text book of thalamotomy for tremor* In: Gildenberg PL, Tasker R, (eds). *Text book of Sterotactic and Functional Neurosurgery*. New York: McGraw - Hill: 1998, pp.167-79.
38. Goldman MS, Ahlskog JE, Kelly PJ. The symptomatic and functional outcome of stereotactic thalamotomy for medically intractable essential tremor. *J Neurosurg* 1992;76:924-8.
39. Fox M, Ahlskog J, Kelly P. Stereotactic ventrolateralis thalamotomy for medically refractory tremor in post-levodopa era Parkinson's disease patients. *J Neurosurg* 1991;75:723-30.