Commentary

Coment on the study “Abordaje contralateral en aneurismas de la arteria cerebral media con segmento M1 largo: a propósito de dos casos” de Arrese et al

Comentario al trabajo “Contralateral approach for middle cerebral artery aneurysms with long M1 segment: report of 2 cases” by Arrese et al

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This excellent article by X Arrese and colleagues reports their experience with contralateral clipping of middle cerebral aneurysms and provides an interesting overview of the critical steps of this approach. The authors describe this microsurgical technique for two cases with aneurysms located more than 2.5 cm away from the ICA bifurcation, challenging previous reports stating that contralateral MCA aneurysms on M1 segments longer than 1.4 cm are not clippable.

Contralateral clipping of MCA aneurysms is not widely practiced because the long dissection distances, limited view, and narrow surgical corridor make it seem dangerous. However, it might be a relevant technique given the high prevalence of MCA aneurysms, the limitations of endovascular therapy with this particular lesion, and increasing patient interest in less invasive aneurysm management. Both our experience and the one reported here by X and colleagues demonstrate that this technique is challenging but still safe. When the patients and the contralateral aneurysms are carefully selected, this technique yields excellent results, not only sparing the patient a second craniotomy but also decreasing the costs of the treatment.

Regarding the authors’ surgical technique, there are a few points worth mentioning. First, we position the head turned 15-20 degrees away from the side selected for the approach. This head position allows the frontal and temporal lobes to fall away naturally to either side as the sylvian fissure is split later. In our experience, a conventional head position with 30 degrees of lateral rotation often leaves the temporal lobe overlying the sylvian fissure and closing the dissection plane. Second, contralateral clipping of an MCA aneurysm in patients with SAH is not recommended, not only because brain swelling makes the dissection more difficult, but also because manipulation of a significant portion of the circle of Willis may induce or exacerbate vasospasm. Finally, it is important to note the contralateral aneurysm dome projection. Inferiorly and anteriorly projecting MCA aneurysms are well seen subfrontally, whereas laterally and superiorly projecting aneurysms are more difficult to deal with.

We are pleased to see others embracing contralateral clipping of MCA aneurysms and, in the end, saving their patients an extra craniotomy. We congratulate the authors for this valuable and courageous surgical experience, which reminds us of the important role of microsurgery for MCA aneurysms.