Tuberculum sellae meningioma (TSM)

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Suprasellar meningioma usually arises from the tuberculum sellae or the sulcus chiasmatis. Due to the close proximity to the optic apparatus, the same may be involved even when the lesions are small.

Tuberculum sellae meningiomas originate in the middle fossa (unlike planum sphenoidale meningiomas which are in the anterior fossa).

They are in a deep and sensitive location, proximity to critical neurovascular elements, hypothalamus with often dense and fibrous nature.

Characteristically lie in a suprasellar subchiasmal midline position, displacing the optic chiasm posteriorly and slightly superiorly, and the optic nerves laterally.

Although tuberculum sellae (TS) and diaphragma sellae meningiomas have different anatomical origins, they are frequently discussed as a single entity.

Epidemiology

They comprise approximately 3%-10% of all intracranial meningiomas.

The coexistence of a pituitary macroadenoma and a tuberculum sellae meningioma is very rare.

Classification

Tuberculum Sellae Meningioma Classification.

Clinical Features

Tuberculum sellae meningioma clinical features.

Evaluation

Ophthalmological examination include visual acuity, fundoscopy, and visual field.
All patients need evaluation by CT scanning and MR imaging, with intravenous administration of a contrast agent. The radiological parameters include tumor size, brain–tumor interface, peritumoral edema, arterial encasement, optic canal extension, hyperostosis, etc.

**MR**

Gadolinium-enhanced sagittal and coronal T1 weighted image demonstrating a tuberculum sellae meningioma with suprasellar and sellar involvement.

**Angiography**

Angiographic embolization of tuberculum sellae meningiomas is not routinely performed. The vascular supply tends to derive from small perforating branches from the posterior ethmoidal artery, ophthalmic artery, superior hypophyseal artery, and A1/A2 artery segments. Preoperative angiography can help demonstrate distorted vascular anatomy secondary to tumor mass effect, which usually reveals posterior displacement of the A1 and A2 segments of the ACA in 80% of patients and encasement of the A1 segment in 24%
Treatment

see Tuberculum sellae meningioma treatment.

Outcome

During the macrosurgical era, visual improvement varied between 40% and 63% \(5^1 \) 6\) 7\).

The range of improvement rates in microsurgical series is 25%-80% \(8^1 \) 9\) 10\) 11\) 12\) 13\).

In the series of Seol et al., seventy-four of 86 patients (86 %) underwent total removal of the tumor. In three of these cases (3.4 %), recurrence developed. Thirty patients were classified into the “Excellent” group, 21 into the “Good” group, 20 into the “Fair” group, and 15 into the “Poor” group. In multivariate analysis, adhesion to optic nerve was an independent and significant predictor of clinical outcome. Favorable visual outcomes in both short- and long-term postoperative periods were achieved in 80.8 % of cases. Preoperative and short-term visual outcomes were closely related to long-term visual outcome. Six of eight patients with preoperative CF status showed reversibility to a serviceable status after surgery. However, there was no conversion to serviceable status from no perception of light (NPL), to hand movement (HM) \(14^1\).

Han et al., hypothesized that changes in visual function after tumor removal may be related to changes in blood supply to the optic nerve that might be seen in the pial circulation at surgery. Indocyanine green (ICG) angiography was used to attempt to document these changes at surgery. The first patient in whom the technique was used had a left-sided, 1.4-cm, tuberculum meningioma. Time-lapse comparison of images was done postsurgery, and the comparison of video images revealed both faster initial filling and earlier complete filling of the ON pial circulation, suggesting improved pial blood flow after surgical decompression. In follow-up the patient had significant improvements in both visual acuity and visual fields function. Intraoperative ICG angiography of the ON can demonstrate measurable changes in pial vascular flow that may be predictive of postoperative visual outcome. The predictive value of this technique during neurosurgical procedures around the optic apparatus warrants further investigation in a larger cohort \(15^1\).

Case series

see Tuberculum sellae meningioma case series.

Videos

Tuberculum Sellae Meningioma Videos.

Case reports

2017

A 54-year-old otherwise healthy man presented with progressive bitemporal hemianopsia. Magnetic resonance imaging of the head revealed a large, homogeneously enhancing sellar and suprasellar mass consistent with a meningioma. An endoscopic endonasal transsphenoidal approach was performed to resect the tuberculum sellae meningioma. The patient developed basal bacterial meningitis secondary to a CSF leak, requiring repair on two separate occasions. At the time of both
repairs, there was evidence of necrosis of the nasoseptal flaps used for the repairs. Soon after the diagnosis of meningitis, the patient developed bilateral caudate infarcts.

This report discusses the possible underlying etiologies for the bilateral caudate infarcts and necrosed flaps including bacterial meningitis with associated local vasospasm of nearby vessels resulting in infarction. This case emphasizes the importance of concise management of postendoscopic CSF leak and discusses the guidelines regarding antimicrobial therapy and the management of lumbar drains.

A case of primary moyamoya disease coexisting with tuberculum sellae meningioma and left cavernous sinus hemangioma. Simultaneous management of tuberculum sellae meningioma and moyamoya disease was performed using left modified pterional incision. Two separate bone windows were opened to protect transdural anastomosis via the middle meningeal artery. Tuberculum sellae meningioma was successfully removed through a small frontal craniotomy, whereas encephalo-duro-myo-synangiosis (EDMS) was used to treat moyamoya disease through a temporoparietal craniotomy. Finally, CyberKnife radiotherapy was used to treat the left cavernous sinus hemangioma six weeks after operation. The patient recovered well without experiencing any complications. This is the first report of moyamoya disease associated with tuberculum sellae meningioma and cavernous sinus hemangioma.

With careful bone flap design, moyamoya disease and skull base tumors can be treated simultaneously. Cares should be taken to avoid interruption of critical dural-pial collaterals and injury to fragile moyamoya vessels.

References


