



Spheno-orbital meningiomas

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Dear Editor,

Reading with interest the manuscript “A single centre’s experience of managing spheno-orbital meningiomas: lessons for recurrent tumour surgery” *Acta Neurochirurgica* <https://doi.org/10.1007/s00701-019-03977-3> [2], the researchers have retrospectively analyzed the medical records of 31 consecutive patients who underwent surgery for spheno-orbital meningioma at a single tertiary center between 2005 and 2016. Nineteen primary cases and 15 repeat surgeries were included in this series. Seven patients had a pterional craniotomy, 19 had orbitozygomatic craniotomy, and 8 underwent a modified mini-orbitozygomatic craniotomy. Different techniques for reconstruction of the orbit were undertaken in some of the cases. The authors have come to a nice: “good clinical and cosmetic outcomes may be achieved with a smaller craniotomy and custom-made implants, irrespective of whether the operation is the patient’s first procedure.”

Unfortunately, in their table 6 -Management of spheno-orbital meningiomas—a summary of the literature—the authors have missed our communication “Lateral orbitotomy approach for removing hyperostosing en plaque sphenoid wing meningiomas. Description of surgical strategy and analysis of findings in a series of 88 patients with longterm follow up” A. Amirjamshidi, et al., *Surg Neurol Int.* 2015; 6: 79, <https://doi.org/10.1007/s00701-019-03977-3> [1].

In that clinical article, we have concluded that using lateral orbitotomy technique, the risky corners involved by the tumor can be visualized from the latero-inferior side rather than from the latero-superior avenue. This is suggested as the crucial milestone to achieve aggressive removal of all the involved

compartments of the lesion in the first approach (LO technique). In the discussion, we concluded that neither pterional nor OZ craniotomy is necessary to achieve the necessary decompression of the orbit. On the other hand, the authors have not stressed on the tumoral involvement of the bony compartment as an important variant for tumor recurrence in the follow-up. Histopathological examination of the hyperostotic bone is one of the main variants in prediction of the outcome in these cases.

Satisfactory cosmetic result is reported using mini LO technique in our communication, after widely exposing and removing the hyperostotic bone down to the subtemporal fossa with only simple repair of the dura without cranioplasty. We confirmed that no bony reconstruction would be necessary.

Including our paper in the list of references might have changed the protocol of the authors in their discussion.

References

1. Amirjamshidi A, Abbassioun K, Shams Amiri R, Ardalan A, Ramak Hashemi SM (2015) Lateral orbitotomy approach for removing hyperostosing en plaque sphenoid wing meningiomas. Description of surgical strategy and analysis of findings in a series of 88 patients with long-term follow up. *Surg Neurol Int* 6:79. <https://doi.org/10.4103/2152-7806.157074>
2. Shapey J, Jung J, Barkas K, Gullan R, Barazi S, Bentley R, Huppa C, Thomas W A single centre’s experience of managing spheno-orbital meningiomas: lessons for recurrent tumour surgery. *Acta Neurochir.* <https://doi.org/10.1007/s00701-019-03977-3>

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