

Quantification of temporal lobe resections: a new approach

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■ Extent of resection in temporal lobectomy has been traditionally based on intraoperative linear measurements. The complex geometrical contour of the temporal lobe limits the precision and accuracy of such measurements, and it is often difficult to verify the extent of actual resection after surgery. The authors propose a new method of evaluating extent of resection based on a 20-compartment model of the temporal lobe. The temporal lobe is divided into five anteroposterior coronal sections in relation to the anterior and posterior borders of the mesencephalon. Each section is then divided into superior lateral, inferior lateral, basal, and medial quadrants. The resulting compartments are easily identified on postoperative magnetic resonance images obtained along the coronal plane. Resection within each compartment is noted as none (0), partial (1), or complete (2). An index of resection can then be computed for superior lateral, inferior lateral, basal, and medial quadrants and for the whole temporal lobe. Potentially, this technique can be used to evaluate surgical failures and correlate extent of resection with surgical outcome and neurologic complications. It also allows objective and semiquantitative comparison of surgical approaches practiced at different institutions.

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TEMPORAL LOBECTOMY has become a widely accepted surgical treatment for intractable epilepsy of temporal-lobe origin. However, surgical procedures, and thus the extent of resection of different temporal-lobe anatomic structures, differ from center to center.¹⁻³ At a single institution, it is difficult to verify that resection has been consistently done according to plan. Precise assessment of extent of resection of various portions of the temporal

lobe is essential to analyze surgical outcome, as well as to evaluate different surgical approaches and to plan possible future modifications.

Several authors have correlated postoperative seizure outcome, memory changes, and neurologic complications (visual, speech, and motor deficits) with extent of resection of the temporal lobe, as estimated from drawings and measurements performed at surgery.⁴⁻¹⁴ These estimates, however, were based on linear and, at best, two-dimensional representations from which volumetric conclusions were drawn. The fate of the deep medial structures (amygdala and hippocampus) has been deduced from these surface measurements or from the surgeon's impression. Because many centers use a surgical technique in which the medial structures are aspirated,² pathological identification of excised medial structures

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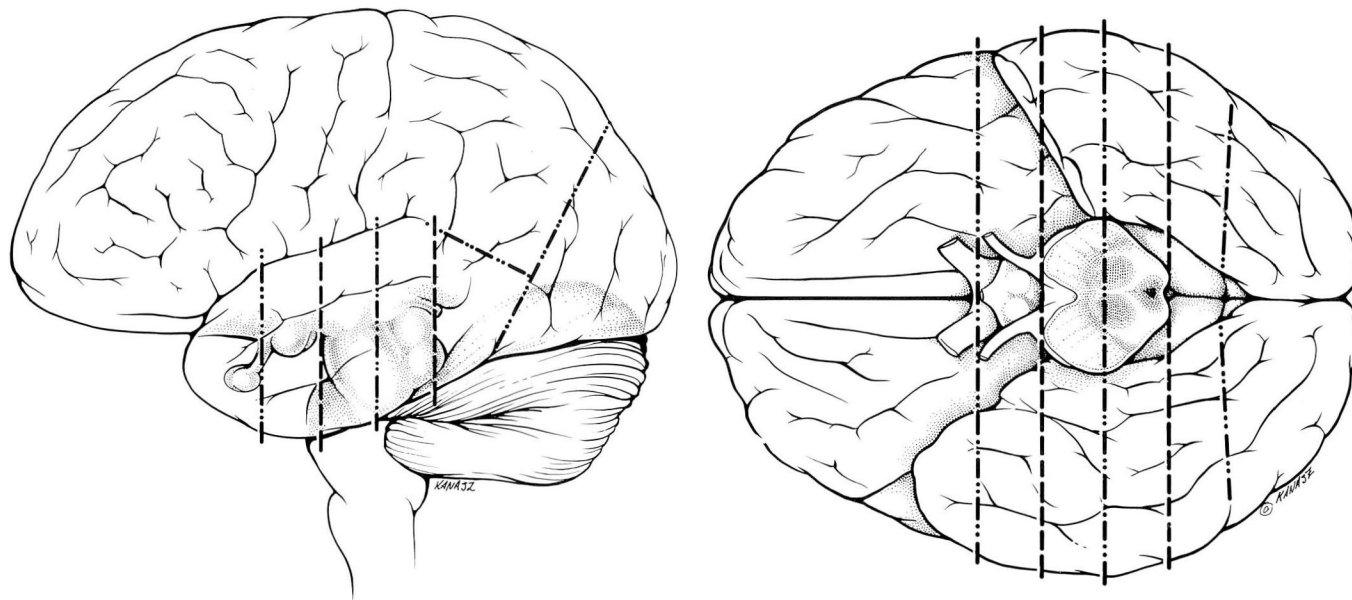


FIGURE 1. Five coronal layers of the temporal lobe. FIGURE 1A. Basal view. FIGURE 1B. Lateral view. Primary coronal planes are delineated by dashes. The secondary coronal planes are delineated by dots and dashes.

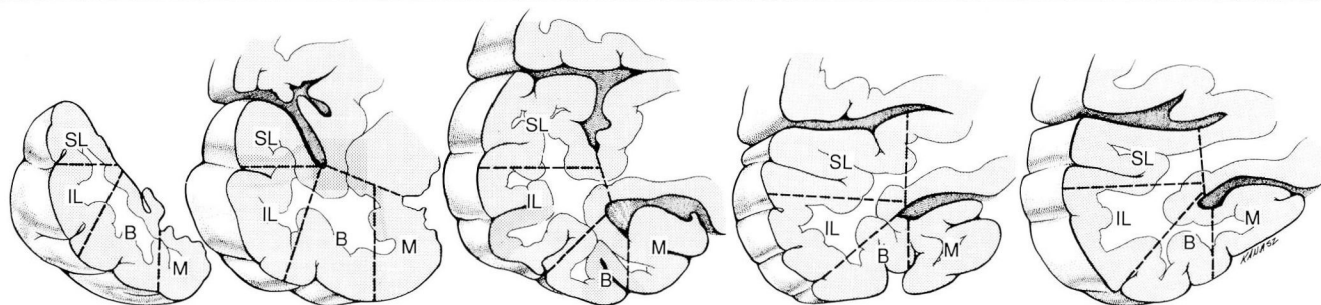


FIGURE 2. Compartmental model of the temporal lobe. The five coronal layers are subdivided into four quadrants. B = basal; IL = inferior lateral; M = medial; SL = superior lateral.

is often suboptimal.

Intraoperative linear measurements are limited by gross imprecisions since the temporal lobe has a complex contour that does not lend itself to simple geometric approximation. Cerebrospinal fluid drainage and intraoperative brain shifts further limit the precision and accuracy of these measurements. Also, a given lateral resection border can be beveled in various directions, producing widely different excisions of basal and medial structures. Lastly, ischemic or compressive damage to unresected brain can go unrecognized at surgery

but can affect the extent of “actual resection.”

Postoperative imaging provides the most accurate and reliable means of assessing extent of resection. Precise volumetric calculations can be performed with available software and postoperative computed-tomographic (CT) scans or magnetic resonance images (MRI).^{15,16} Yet, the volume of tissue resected does not necessarily reflect specific structures excised. Because of these considerations, we have developed a three-dimensional model of the temporal lobe with 20 compartments easily recognizable on routine postoperative MRI.

carries particular anatomic relevance: the posterior pre-mesencephalic level (section 2) contains most of the amygdaloid nucleus, while the paramesencephalic levels (sections 3 and 4) contain the hippocampal formation. Our method does not require special equipment or software and allows easy comparison of resections from different institutions.

Other potential applications of this method include correlation of extent of resection with seizure outcome, memory changes, visual field defects, and other neurologic complications following temporal lobectomy. These correlations can be performed blindly and in a semiquantitative fashion and can potentially address the role of medial *v* lateral resections in prospective trials.

Asymmetry and dysmorphism of the temporal lobe, shifting of unresected tissue into the lobectomy cavity, and progressive postoperative dilation of the ipsilateral temporal horn are potential problems with this method. To our knowledge, however, this technique represents the first serious attempt at quantifying extent of temporal lobectomy in an objective, anatomically relevant, and widely applicable fashion.

We have used this approach at the Cleveland Clinic for one-and-a-half years and are currently submitting it to rigorous reliability, reproducibility, and interobserver validation studies. The results of these studies and of preliminary outcome correlations are beyond the scope of this technical report and will be published separately.

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