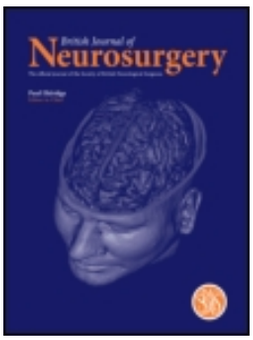

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LETTER TO THE EDITOR

Re to the letter: Adult idiopatic occlusion of Monro foramina: Intraoperative endoscopic reinterpretation of radiological data and review of the literature

Dear Dr Prontera,

We would like to thank you for your interest in our recent publication on "Adult Idiopatic occlusion of Monro foramina: intraoperative endoscopic reinterpretation of radiological data and review of the literature".

The cases you presented are very well described, with nice radiological and intraoperative images.

We agree about the unique opportunity during neuroendoscopic procedures to discover unsuspected anatomic changes causing pathologies, but, at the same time, we suggest prudence to avoid unnecessary iatrogenic complications.

With regard to the first case described in our paper, we explored the third ventricle and did not find any visible membrane/obstruction occluding the aqueduct; the third ventricle dilatation resolved after surgery, as you can see in the post-operative MRI.

In the first case we used a Decq Neuroendoscope, with 30° lens, and through a spontaneously widely fenestrated septum, with gentle instrument rotations, we visualized the right foramen of Monro, which appeared stenotic and atretic rather than occluded by a membrane.

In the second case, as detailed in our manuscript, the patient presented a marked dilatation of the right lateral ventricle and the septum was significantly shifted towards the left side. We did fenestrate the membrane occluding the right foramen of Monro and also performed a pellucidotomy. However, it was not felt necessary to visualize the left foramen of Monro as the pellucidotomy we carried out would also allow drainage of the left lateral ventricle.

Indeed, we think that it is not required, and it is not safe, to risk additional neural damages and postoperative deficits by trying to explore the contralateral foramen of Monro when using a rigid endoscope through a monolateral ventricular access, if a wide septum pellucidum opening is present. Postoperative imaging confirmed that both lateral ventricles improved in size and shape, although we did not explore the left foramen of Monro.

Yet, we prefer to use a rigid endoscope because of the quality of images it provides, as opposite to flexible ones.

Once again, we would like to thank Dr Prontera and colleagues for their interesting observations.

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