Anterior Clinoid Metastasis Removed Extradurally: First Case Report

Mirza Pojskić1 Blaž Zbytek2,3 Kenan I. Arnautović4,5

1 Department of Neurosurgery, Philipps University of Marburg, Marburg, Germany
2 Department of Pathology and Laboratory Medicine, Center for Adult Cancer Research, University of Tennessee Health Science Center, Memphis, Tennessee, United States
3 Pathology Group of the MidSouth, Memphis, Tennessee, United States
4 Semmes Murphey Neurologic & Spine Institute, Memphis, Tennessee, United States
5 Department of Neurosurgery, University of Tennessee Health Science Center, Memphis, Tennessee, United States

Address for correspondence Kenan I. Arnautović, MD, PhD, Semmes Murphey Neurologic & Spine Institute, 6525 Humphreys Blvd., Memphis, TN 38120, United States (e-mail: kenanarnaut@yahoo.com).

Background and Importance
We report a first case of isolated metastasis on the anterior clinoid process (ACP) mimicking meningioma.

Clinical Presentation
A 58-year-old male presented with headaches, right-sided visual disturbances, and blurred and double vision. The cause of double vision was partial weakness of the right III nerve, resulting from compression of the nerve by "hypertrophied" tumor-involved right anterior clinoid. Medical history revealed two primary malignant tumors—male breast cancer and prostate cancer (diagnosed 6 and 18 months prior, respectively). The patient was treated with chemotherapy and showed no signs of active disease, recurrence, or metastasis. Postcontrast head magnetic resonance imaging (MRI) showed extra-axial well-bordered enhancing mass measuring 1.6 × 1.1 × 1 × 1 cm (anteroposterior, transverse, and craniocaudal dimensions) on the ACP, resembling a clinoidal meningioma. Extradural clinoidectomy with tumor resection was performed via right orbitozygomatic pretemporal skull base approach. Visual symptoms improved. Follow-up MRI showed no signs of tumor residual or recurrence.

Conclusion
This is the first case report of a metastasis of any kind on ACP. Metastasis should be included as a part of the differential diagnosis of lesions of the anterior clinoid. Extradural clinoidectomy is a safe and effective method in the treatment of these tumors.
Table 1 Nonmeningioma pathology of the anterior clinoid process

<table>
<thead>
<tr>
<th>Nonmeningioma pathology of the ACP</th>
<th>Author and year</th>
<th>Symptoms</th>
<th>Treatment and outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mucocele</strong> 21 cases</td>
<td>Nundkumar et al, 2012²⁴</td>
<td>Sudden painless loss of vision</td>
<td>Endoscopic transnasal approach, complete recovery</td>
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<td></td>
<td>Johnson et al, 1986¹⁸</td>
<td>Retrobulbar pain with loss of vision</td>
<td>Pterional approach; incomplete recovery</td>
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<td></td>
<td>Schwaighofer et al, 1989²⁷</td>
<td>Retro-orbital pain with loss of vision</td>
<td>Fronto-craniotomy, complete recovery</td>
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<td></td>
<td>Dunya et al, 1996¹¹</td>
<td>Double vision</td>
<td>Endoscopic transsphenoidal, subjective improvement</td>
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<td></td>
<td>Garaventa et al, 1997¹³</td>
<td>Retro-orbital pain with loss of vision</td>
<td>Endoscopic transnasal, complete recovery</td>
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<tr>
<td></td>
<td>Chou et al, 1999⁸</td>
<td>Progressive loss of vision</td>
<td>Supraorbital craniotomy, complete recovery</td>
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<td></td>
<td>Chung et al, 1999⁹</td>
<td>Headache, diplopia</td>
<td>Pterional approach, slight recovery with light perception</td>
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<td></td>
<td>Lim et al, 1999²¹</td>
<td>Diplopia, III nerve palsy</td>
<td>Frontotemporal orbitozygomatic approach, recovery of III nerve palsy</td>
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<td></td>
<td>Hejazi et al, 2001¹⁴</td>
<td>Ophthalmoplegia, visual loss</td>
<td>Transnasal, complete recovery</td>
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<td></td>
<td>Righini et al, 2006²⁶</td>
<td>Monocular blindness</td>
<td>Endoscopic, complete recovery</td>
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<td></td>
<td>Deshmukh and DeMonte, 2007¹⁰</td>
<td>Blind spot</td>
<td>Conservative treatment with oral antibiotics for sinusitis, complete recovery</td>
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<td></td>
<td>Thurtell et al, 2007²⁸</td>
<td>Painful visual loss</td>
<td>Pterional approach, no recovery</td>
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<tr>
<td></td>
<td>Vaphiades et al, 2007³¹</td>
<td>Painless visual loss</td>
<td>Endoscopic transnasal, slight recovery</td>
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<tr>
<td></td>
<td>Kwon et al, 2009²⁰</td>
<td>Sudden onset of blurry vision</td>
<td>Transnasal, slight recovery</td>
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<td></td>
<td>Arnavielle et al, 2010⁴</td>
<td>Painful optic neuropathy</td>
<td>Endoscopic, complete recovery</td>
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<td></td>
<td>Chagla et al, 2010⁵</td>
<td>Headache, visual loss</td>
<td>Supraorbital craniotomy, slight recovery</td>
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<td></td>
<td>Forer et al, 2010¹²</td>
<td>Unilateral ophthalmoplegia, eye redness</td>
<td>Image-guided endoscopic, complete recovery</td>
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<td>Moisseiev et al, 2013²³</td>
<td>Visual loss</td>
<td>Surgery, not specified</td>
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<td></td>
<td>Wang et al, 2013³²</td>
<td>Retro-orbital pain, double vision, III, IV, VI nerve palsy</td>
<td>Pterional approach, incomplete recovery</td>
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<td></td>
<td>Aoyama et al, 2014³</td>
<td>Headache, visual loss</td>
<td>Craniotomy (not specified), slight improvement</td>
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<td></td>
<td>Hopf-Jensen et al, 2014¹⁷</td>
<td>III nerve palsy, diplopia</td>
<td>Pterional approach, intradural clinoidectomy, complete recovery</td>
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<tr>
<td><strong>Cavernous hemangioma</strong> 2 cases</td>
<td>Mansour et al, 2017²²</td>
<td>Incidental finding</td>
<td>Pterional approach, no complications</td>
</tr>
<tr>
<td></td>
<td>Yamashita et al, 2006³³</td>
<td>Headache, visual impairment</td>
<td>Pterional approach, complete recovery</td>
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<tr>
<td><strong>Isolated fibrous dysplasia of the ACP</strong> 1 case</td>
<td>Chang, 2009⁶</td>
<td>One-sided blindness</td>
<td>Extracranial intervention via pterional approach</td>
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<td></td>
<td>Hong et al, 2014¹⁶</td>
<td>One-sided visual loss</td>
<td>in &quot;no drill&quot; technique, no recovery</td>
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</tbody>
</table>
carotid artery and ophthalmic aneurysms.\textsuperscript{34,35} It can be performed either intra- or extradural. Total clinoidectomy has been advocated in all neoplastic lesion of the clinoid, since at least a quarter of patients with radiographically negative imaging of ACP will have tumor involvement on pathological analysis.\textsuperscript{36}

**Clinical Presentation**

Appropriate consent was obtained from the patient.

**Symptoms**

A 58-year-old male presented with headaches, right-sided blurred vision, and double vision. The cause of double vision was partial weakness of the right III nerve resulting from compression of the nerve by “hypertrophied” tumor-involved right anterior clinoid. His previous medical history revealed existence of two primary malignant tumors: breast cancer (diagnosed 6 months prior) and prostate cancer (diagnosed 18 months prior). The patient was under treatment with chemotherapy due to breast cancer and showed no signs of active disease.

**Magnetic Resonance Imaging Presentation**

Postcontrast magnetic resonance imaging (MRI) of the head showed an extra-axial, well-bordered enhancing mass measuring $1.6 \times 1.1 \times 1.1$ cm of the ACP with involvement of the right optic canal (OC) along its superior lateral margin with dural tail typical for a meningioma. No other intracranial lesions were present. Meningioma was considered a primary differential diagnostic possibility preoperatively (►Fig. 1). The surgery was indicated due to symptomatic lesion, which progressively affected the vision on the right eye and to obtain the histological diagnosis.

**Surgical Technique**

Extradural clinoidectomy with tumor resection was performed by the senior author (K.I.A). The details of the orbitozygomatic pretemporal approach have been previously described.\textsuperscript{1,2,37–39} Skin incision and preparation of the temporalis muscle and orbitozygomatic craniotomy with drilling of the sphenoid ridge were performed in usual manner.\textsuperscript{37} The superior orbital fissure (SOF) was identified and unroofed, removing the bone overlying the superolateral margin of the SOF with rongeurs and a diamond burr. The meningi-orbital artery was coagulated and divided. Frontobasal and temporal dura were retracted with dural tack up sutures. Dura propria of the temporal lobe was peeled off from the SOF and the anteromedial aspect of the lateral wall of the cavernous sinus, exposing the third and the fourth cranial nerve as well as V1 and V2 of the fifth cranial nerve. Intraoperatively, the right III nerve was compressed by the hypertrophied

### Table 1 (Continued)

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<thead>
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</tr>
</thead>
<tbody>
<tr>
<td>Inflammatory pseudotumor 1 case</td>
<td>Kasliwal et al, 2008\textsuperscript{19}</td>
<td>Visual diminution and proptosis</td>
<td>Surgical decompression, high-dose steroids, complete recovery</td>
</tr>
<tr>
<td>Pyocele 1 case</td>
<td>O’Donnell et al, 2013\textsuperscript{25}</td>
<td>Fever, decreased vision, III and VI nerve palsy</td>
<td>Intravenous antibiotics followed by surgery, approach not specified, complete recovery</td>
</tr>
<tr>
<td>Dermoid cyst 1 case</td>
<td>Higgins and Schimdt, 1996\textsuperscript{15}</td>
<td>Not specified</td>
<td>Stereotactic biopsy followed by craniotomy and resection, not specified</td>
</tr>
<tr>
<td>Necrotizing sarcoid granuloma 1 case</td>
<td>Tobias et al, 2003\textsuperscript{29}</td>
<td>Left visual deterioration and proptosis</td>
<td>Frontotemporal craniotomy with extradural removal of the ACP; corticosteroid therapy, visual improvement, stable disease</td>
</tr>
<tr>
<td>Bony protuberance of the ACP leading to aneurysm of the ICA due to trauma</td>
<td>Cheong et al, 2011\textsuperscript{7}</td>
<td>Severe headache after craniofacial injury</td>
<td>Clipping and wrapping of the traumatic aneurysm, complete recovery</td>
</tr>
<tr>
<td>DAVF draining into the superficial middle cerebral vein 1 case</td>
<td>Ushikoshi et al, 2013\textsuperscript{30}</td>
<td>Sudden onset of altered consciousness</td>
<td>Frontotemporal craniotomy, clipping of the DAVF, complete recovery</td>
</tr>
<tr>
<td>Metastasis of the breast cancer 1 case</td>
<td>Pojskić et al (this case)</td>
<td>Blurry and double vision on the right side</td>
<td>Orbitozygomatic pretemporal craniotomy, extradural clinoidectomy, complete recovery</td>
</tr>
</tbody>
</table>

Abbreviations: ACP, anterior clinoid process; DAVF, dural arteriovenous fistula; ICA, internal carotid artery.
**Fig. 1** Preoperative postcontrast magnetic resonance imaging (MRI) of the brain. (A) T1-weighted postcontrast axial view demonstrating a contrast-enhancing lesion on the right anterior clinoid process. (B) T1-weighted postcontrast axial view. (C) T1-weighted postcontrast coronal view, lesion on the right clinoid process resembling a clinoidal meningioma. (D) Preoperative T-2 weighted coronal MRI of the brain showing anterior clinoid involved by tumor adjacent to right optic nerve. (E) Computed tomography (CT) scan of the head, axial view. (F) Intraoperative microsurgical drilling of the right anterior clinoid. (G) Microsurgical dissection of the clinoid from periorbita. (H) Tumor inside the clinoid below the right optic nerve (labeled CN II). (I) Resection of the tumor extending into the right sphenoid sinus below the right optic nerve (CN II). Note also the right internal carotid artery (ICA) genu. (J) Microsurgical picture after resection of the tumor-involved right anterior clinoid. Please note the CN II optic nerve, ICA genu, III, IV, V1, and V2 nerves, and sphenoid sinus (SS) after removal of the tumor.
tumor-involved anterior clinoid, but there was no evidence of dural or cavernous sinus tumor involvement.

The OC was then unroofed from a lateral to medial direction by using a 2-mm diamond burr with constant-cooling irrigation. The tumor was involving the right anterior clinoid. The dorsal cortex of the clinoid was preserved and the tumor was involved in the central portion, penetrating ventrally and medially toward the sphenoid sinus. The opening of the sphenoid sinus was thusly done to ensure complete tumor resection and later obliterated with a small piece of muscle. Also, the third root of the ACP, the optic strut, was drilled off. During this procedure, constant awareness was maintained to protect the optic nerve, the carotid artery, and the oculomotor nerve with reference to the ACP. After removing the tumor that infiltrated the ACP, it was sent for histological analysis (►Fig. 1f–j).

**Pathohistology**

Pathohistological report showed the diagnosis of the metastasis of the known infiltrating ductal carcinoma of the breast (►Fig. 2).

**Follow-Up**

The postcontrast MRI showed no signs of the residual tumor (►Fig. 3). Blurred vision improved and double vision resolved completely. The patient continued to receive chemotherapy for infiltrating ductal carcinoma of the breast by his oncologist. Also, radiation treatment was initiated.

**Discussion**

A literature review of the past 30 years using the PubMed database did not display any results for metastasis of the clinoid process. The most common lesions of ACP are meningiomas. There were more than 20 studies that included patients with surgically treated meningiomas of the ACP.1,2,29,41–58 The second most common lesion of the ACP is mucocele.24 Table 1 provides the overview of isolated non-meningioma lesions of the ACP reported so far in the literature.

**Magnetic Resonance Imaging Presentation**

Meningiomas demonstrate homogeneous enhancement on postcontrast MRI.59 Generally, there are several lesions that can mimic meningiomas, which usually present with pseudo-dural tail: breast cancer metastasis,60 cavernous hemangiomas,22,61 dural plasmocytoma,62,63 large capillary hemangioma,64 carcinoid tumor metastasis,65 pilocytic astrocytoma,66 liposarcoma,66 and metastatic thyroid carcinoma.67

**Breast Cancer and Brain Metastases**

Breast cancer represents the second most frequent cause of brain metastases, occurring in 10 to 16% of patients.68
Subgroups of patients with triple-negative and human epidermal growth factor receptor 2 (HER2)-positive breast cancer have an increased risk of developing brain metastases.\(^6\) Surgical resection of the brain metastasis is an important treatment option in patients with single or few (\(\leq 3\)) lesions.\(^70–72\) However, the breast cancer metastasis or any other metastasis on the ACP has not been reported so far to our knowledge.

**Surgical Technique**

The extradural removal of the anterior clinoid process was initially described by Dolenc for vascular lesions of the cavernous sinus.\(^73\) Its use for pituitary adenomas, craniopharyngiomas, and clinoideal and tuberculum sellae meningiomas has been described.\(^1,2\) Approach can be pterional,\(^74\) orbitozygomatic,\(^37,75\) modified pterional,\(^76\) modified orbitozygomatic,\(^40\) pretemporal transzygomatic transvenous,\(^39,77\) temporalpolar epidural transcavernous transpetrous,\(^78\) extended lateral supraorbital,\(^79\) and endoscopic transsphenoidal.\(^24\)

Extradural clinoidealectomy has several advantages over intradural clinoidealectomy. First, anatomical orientation is easily attained by identifying the dural extension into the SOF and the OC, and therefore a total ACP removal is possible. In contrast, when the intradural technique is used, both the extent of bone removal and the exposure that is gained may be limited. Second, the dura protects the intradural structures. Third, the procedure is performed during extradural exposure and also much faster than the intradural technique.\(^76\)

With our first case report on the isolated metastasis of the anterior clinoid process, we provide an additional argument in favor of extradural clinoidealectomy and in particular for malignant tumor pathology, since extradural resection minimizes the possibility of intradural tumor spread. Metastasis should now be included in the differential diagnosis of the lesions of the ACP. The possible spread of the metastatic disease intracranially in case of opening of the dura should be taken into consideration when planning a surgery.

**Conclusions**

This is the first case report of an ACP metastasis. It was treated successfully with extradural clinoidealectomy. Metastasis should now be included in the differential diagnosis on the lesions of the anterior clinoid process. Extradural clinoidealectomy is a safe and effective method in the treatment of these tumors, minimizing the risk of intradural tumor spread.

**Conflict of Interest**

No financial or material support was accepted as part of this study. None of the authors have any financial relationships to disclose.

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**References**


