Role of Asleep Surgery for Supplementary Motor Area Tumors

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Abstract

Background The supplementary motor area (SMA) is involved in planning of voluntary motor activities. Tumors in SMA usually present with seizures and, rarely, motor deficits. Postoperatively, these patients may develop SMA syndrome. Patients with SMA tumors usually undergo awake craniotomy along with neuromonitoring for maximal safe resection, and some of these patients tend to have residual tumor.

Objective To completely excise the SMA region tumors under general anesthesia without causing any permanent neurological deficits.

Methods We operated upon four patients with SMA region tumor under general anesthesia (GA) with direct electrocortical stimulation (DES). Motor-evoked potential was used to monitor corticospinal tracts through corkscrew or strip electrodes. Intraoperative MRI was done to assess the tumor excision.

Results All four patients had complete resection of tumor and, postoperatively, all four developed SMA syndrome. All of them recovered completely over a period of time.

Conclusion SMA tumors can be excised completely under GA with DES, thereby increasing progression-free survival.

Keywords ► SMA tumor
► SMA syndrome
► GA-DES

Key message

One can achieve maximum safe resection or complete tumor excision with GA-DES for supplementary motor area (SMA) tumors.

Introduction

SMA controls the planning and execution of voluntary motor activities. Tumors of the SMA usually present with seizure and, rarely, motor deficits. Low-grade gliomas are the most common tumors of this region. Postoperatively, some of these patients may develop transient deficits like reversible SMA syndrome or, rarely, permanent motor deficits.\textsuperscript{1,2}

Gliomas pose a challenge for achieving complete tumor resection due to its infiltration along the white matter tracts. For functional preservation, awake craniotomy with mapping by direct electrical stimulation (DES) is practiced for SMA tumor resections.\textsuperscript{2–4}

In awake craniotomy, resection of the tumor is performed as long as there are no deficits or till complete tumor excision. As the motor deficits/speech abnormalities appear, further resection is stopped, leaving some amount of residual tumor and decreased tumor progression-free survival (PFS).
In this article, we share our institutional experience of four patients with tumor involving SMA region with postoperative SMA syndrome. All these patients underwent tumor resection under general anesthesia (GA) along with DES.

**Methods**

We selected patients with SMA region intra-axial tumor. All the four patient’s clinical histories and examinations were documented. Preoperatively, all these patients underwent MRI with tumor protocol, diffusion tensor imaging (DTI), functional MRI, and neuronavigation protocol (see Table 1).

All four patients were operated under GA with neuronavigation, transcranial motor-evoked potential (MEP) by cortkscrew, mapping with strip electrodes, and DES. Intraoperative MRI (3T) was used to assess the extent of tumor resection. For baseline MEP, we used screw stimulation with high-frequency train of seven stimuli, with current starting from 150 mA. Using strip electrodes, we mapped the central sulcus with somatosensory-evoked potential (SSEP) from contralateral shoulder; then, we mapped the cortical motor areas by DES. Motor mapping was done by anodal stimulation with a return electrode placed at the contralateral shoulder. High-frequency train stimulation with five pulses of 333 Hz and 500 us pulse width was used with increasing current intensity from 2 to 10 mA. After mapping the motor area, the tumor surface is also stimulated for any motor activity. Then tumor resection is started from the noneloquent area, that is, away from motor cortex, from anterior to posterior. As we went inferior and posterior, tumor resection was done along with DES. For subcortical mapping, the stimulation pattern was changed to cathodal stimulation with similar settings. Resection was done till we got positive stimulation with 6 to 8 mA or tumor was completely removed. Intermittently, we checked MEP with corkscrews or strip electrodes.

**Results**

We operated upon all four patients by this protocol, and we achieved complete tumor resection in all four patients, which was confirmed with intraoperative MRI. MEP was intact at the end of tumor resection, but all four patients developed SMA syndrome postoperatively, and all of them recovered completely. Two patients recovered by 5 days and one by a week. The patient who had dysphasia along with hemiparesis and left-sided, high-grade tumor recovered by 1 month (see Figs. 1-3).

**Discussion**

SMA syndrome is characterized by contralateral motor deficits with or without speech deficits (dominant side) following complete or incomplete resection of tumors involving SMA region. It is a disorder of executive function. SMA syndrome may be complete or partial by the extent of deficit developed following surgery. A complete or almost complete recovery of functions occurs within few weeks or months.

The possible explanation for SMA syndrome is disruption of neuronal interconnections between the ipsilateral SMA and primary motor and sensory areas. The recovery of functions depends upon the interhemispheric connectivity between the contralateral SMA region with ipsilateral primary motor and sensory areas. This is best assessed by

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**Table 1** Details of patients with tumors involving SMA region

<table>
<thead>
<tr>
<th></th>
<th>Case 1</th>
<th>Case 2</th>
<th>Case 3</th>
<th>Case 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age/sex</strong></td>
<td>27/F</td>
<td>35/F</td>
<td>55/M</td>
<td>26/M</td>
</tr>
<tr>
<td><strong>Symptoms</strong></td>
<td>Seizure</td>
<td>Seizure</td>
<td>Headache</td>
<td>Seizure</td>
</tr>
<tr>
<td><strong>Location of tumor</strong></td>
<td>Right premotor region</td>
<td>Right prefrontal and premotor region</td>
<td>Left posterior frontal extending up to corpus callosum</td>
<td>Left premotor region</td>
</tr>
<tr>
<td><strong>Technique</strong></td>
<td>GA-DES</td>
<td>GA-DES</td>
<td>GA-DES</td>
<td>GA-DES</td>
</tr>
<tr>
<td><strong>Postresection MEP</strong></td>
<td>Intact</td>
<td>Intact</td>
<td>Intact</td>
<td>Intact</td>
</tr>
<tr>
<td><strong>IO-MRI</strong></td>
<td>No residue</td>
<td>No residue</td>
<td>No residue</td>
<td>No residue</td>
</tr>
<tr>
<td><strong>3 months MRI</strong></td>
<td>No recurrence</td>
<td>No recurrence</td>
<td>Recurrence +</td>
<td>No recurrence</td>
</tr>
<tr>
<td><strong>SMA syndrome</strong></td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td><strong>Recovery from SMA syndrome</strong></td>
<td>Complete recovery</td>
<td>Complete recovery</td>
<td>Complete recovery</td>
<td>Complete recovery</td>
</tr>
<tr>
<td><strong>Time of recovery from SMA syndrome</strong></td>
<td>1 week</td>
<td>5 days</td>
<td>1 month</td>
<td>5 days</td>
</tr>
<tr>
<td><strong>Histopathology</strong></td>
<td>WHO gr 2 astrocytoma</td>
<td>WHO gr 2 astrocytoma</td>
<td>WHO gr 4 glioblastoma</td>
<td>WHO gr 2 astrocytoma</td>
</tr>
<tr>
<td><strong>Postop RT/chemotherapy</strong></td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Abbreviations: GA, general anesthesia; DES, direct electrocortical stimulation; MEP, motor-evoked potential; SMA, supplementary motor area.
DTI; if the number of nerve fiber tracts is less than 8,000, then the recovery is delayed, that is, more than 7 days.\(^6\)

Vassal et al did functional MRI in the patients with SMA region diffuse low-grade gliomas. After surgery, reorganization of sensorimotor cortex was observed, which resulted in recovery of SMA syndrome. They demonstrated that interhemispheric connectivity is both inversely correlated to preoperative deficit and positively correlated with postoperative recovery in SMA syndrome.\(^7\)

Awake craniotomy is preferred for SMA region tumors. Even though the SMA syndrome is transient, some patients are unable to execute complex movement or bimanual
coordination, which may be detrimental. Awake mapping was done to identify and preserve these tracts. In awake mapping, when patient continuously moves the contralateral side, stimulation induces an arrest or an acceleration of that movement. By this method, one can avoid deficits like bimanual coordination postoperatively.\(^8,9\)

In awake craniotomy, we tend to prematurely stop resection when the patient develops weakness (motor or speech) intraoperatively, which may be due to SMA syndrome (likely to improve), thereby decreasing tumor PFS. There are other factors like patient cooperation, seizure, intraoperative bleeding, etc., which also come into play for achieving complete tumor resection (\textit{\textbf{Table 2}}).\(^4,10\)

A complete resection of tumor increases the overall survival significantly in low-grade gliomas.\(^9\) Tumor or the entire SMA region can be removed completely until the pyramidal tracts have been detected by DES and MEP. Under GA, MEP is possible, which gives us the real-time confirmation of intactness of corticospinal tracts during and at the end of procedure. But the information on bimanual coordination is not possible. In our series, complete resection of tumor was done, but all four patients developed SMA syndrome postoperatively despite intact MEP. We can reassure patients that their weakness is likely to be transient, which will improve over the period of time, based on the MEP information. All resections were limited only to the tumor area.

In patients having an occupation where bimanual coordination is essential, and in those tumors extending into primary speech area/cognitive connections, awake surgery with monitoring is mandatory.\(^8,9\) In patients where tumor is limited to SMA area only and where bimanual coordination is not an issue, it may be wiser to do it under GA with monitoring to maximize the resection.

**Conclusions**

Under GA-DES with MEP for SMA region tumors, one may achieve maximum/complete safe resection, taking cognitive, language, and profession of the patient into consideration. This protocol needs to be evaluated in a large set of patients for better outcome.

**Authors’ Contributions**

K.K.G. and C.C. contributed in concepts, design, definition of intellectual content, literature search, clinical studies, data acquisition, data analysis, manuscript preparation, manuscript editing, and manuscript review. A.B. and B.J.R.
contributed in concepts, design, definition of intellectual content, literature search, clinical studies, data acquisition, data analysis, manuscript preparation, manuscript editing, manuscript review, and as guarantors. N.M. provided definition of intellectual content; conducted literature search and clinical studies; and performed data analysis, manuscript editing, and manuscript review.

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None.

Conflict of Interest
None declared.

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References