Anterior Clinoid Metastasis Removed Extradurally: First Case Report

Mirza Pojskić1  Blazej 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, 6325 Humphreys Blvd., Memphis, TN 38120, United States (e-mail: kenanarnaut@yahoo.com).

J Neurol Surg Rep 2018;79:e55–e62.

Abstract

Background  We report a 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. Extraludal clinoidectomy with tumor resecion 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. Extraludal clinoidectomy is a safe and effective method in the treatment of these tumors.

Keywords

► anterior clinoid process
► extradural clinoidectomy
► metastasis
► anterior clinoid metastasis
► case report

Background and Importance

We report a first case of isolated metastasis on the anterior clinoid process (ACP) mimicking a meningioma, which should be added to the differential diagnosis of the processes of ACP. The most common lesions of the anterior clinoid process are meningiomas.1,2 There are 11 different pathological entities described so far on the ACP other than meningioma (► Table 1).3–33

Clinoidectomy is the key element of the surgical treatment of neoplastic lesions of the ACP. It was developed initially as an intradural technique for approach to internal...
| Nonmeningioma pathology of the ACP | Author and year | Symptoms | Treatment and outcome |
|-----------------------------------|----------------|----------|-----------------------|
| Mucocele 21 cases                 | Nundkumar et al, 2012 | Sudden painless loss of vision | Endoscopic transnasal approach, complete recovery |
|                                  | Johnson et al, 1986 | Retrobulbar pain with loss of vision | Pterional approach; incomplete recovery |
|                                  | Schwaighofer et al, 1989 | Retro-orbital pain with loss of vision | Frontal craniotomy, complete recovery |
|                                  | Dunya et al, 1996 | Double vision | Endoscopic transsphenoidal, subjective improvement |
|                                  | Garaventa et al, 1997 | Retro-orbital pain with loss of vision | Endoscopic transnasal, complete recovery |
|                                  | Chou et al, 1999 | Progressive loss of vision | Supraorbital craniotomy, complete recovery |
|                                  | Chung et al, 1999 | Headache, diplopia | Pterional approach, slight recovery with light perception |
|                                  | Lim et al, 1999 | Diplopia, III nerve palsy | Frontotemporal orbitozygomatic approach, recovery of III nerve palsy |
|                                  | Hejazi et al, 2001 | Ophthalmoplegia, visual loss | Transnasal, complete recovery |
|                                  | Righini et al, 2006 | Monocular blindness | Endoscopic, complete recovery |
|                                  | Deshmukh and DeMonte, 2007 | Blind spot | Conservative treatment with oral antibiotics for sinusitis, complete recovery |
|                                  | Thurtell et al, 2007 | Painful visual loss | Pterional approach, no recovery |
|                                  | Vaphiades et al, 2007 | Painless visual loss | Endoscopic transnasal, slight recovery |
|                                  | Kwon et al, 2009 | Sudden onset of blurry vision | Transnasal, slight recovery |
|                                  | Arnavielle et al, 2010 | Painful optic neuropathy | Endoscopic, complete recovery |
|                                  | Chagla et al, 2010 | Headache, visual loss | Supraorbital craniotomy, slight recovery |
|                                  | Forer et al, 2010 | Unilateral ophthalmoplegia, eye redness | Image-guided endoscopic, complete recovery |
|                                  | Moisseiev et al, 2013 | Visual loss | Surgery, not specified |
|                                  | Wang et al, 2013 | Retro-orbital pain, double vision, III, IV, VI nerve palsy | Pterional approach, incomplete recovery |
|                                  | Aoyama et al, 2014 | Headache, visual loss | Craniotomy (not specified), slight improvement |
|                                  | Hopf-Jensen et al, 2014 | III nerve palsy, diplopia | Pterional approach, intradural clinoidectomy, complete recovery |
| Cavernous hemangioma 2 cases     | Mansour et al, 2017 | Incidental finding | Pterional approach, no complications |
|                                  | Yamashita et al, 2006 | Headache, visual impairment | Pterional approach, complete recovery |
| Isolated fibrous dysplasia of the ACP 1 case | Chang, 2009 | One-sided blindness | Extradural clinoidectomy via pterional approach in "no drill" technique, no recovery |
| Pilocytic astrocytoma 1 case      | Hong et al, 2014 | One-sided visual loss | Frontotemporal craniotomy, improved vision |
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 meningo-orbital artery was coagulated and divided. Fronto basal 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)

| Nonmeningioma pathology of the ACP | Author and year | Symptoms | Treatment and outcome |
|-----------------------------------|----------------|----------|----------------------|
| Inflammatory pseudotumor 1 case   | Kasliwal et al, 2008\textsuperscript{19} | Visual diminution and proptosis | Surgical decompression, high-dose steroids, complete recovery |
| Pyocele 1 case                    | O’Donnell et al, 2013\textsuperscript{25} | Fever, decreased vision, III and VI nerve palsy | Intravenous antibiotics followed by surgery, approach not specified, complete recovery |
| Dermoid cyst 1 case               | Higgins and Schmidt, 1996\textsuperscript{16} | Not specified | Stereotactic biopsy followed by craniotomy and resection, not specified |
| Necrotizing sarcomatous granuloma 1 case | Tobias et al, 2003\textsuperscript{29} | Left visual deterioration and proptosis | Frontotemporal craniotomy with extradural removal of the ACP; corticosteroid therapy, visual improvement, stable disease |
| Bony protuberance of the ACP due to trauma | Cheong et al, 2011\textsuperscript{7} | Severe headache after craniofacial injury | Clipping and wrapping of the traumatic aneurysm, complete recovery |
| DAVF draining into the superficial middle cerebral vein 1 case | Ushikoshi et al, 2013\textsuperscript{30} | Sudden onset of altered consciousness | Frontotemporal craniotomy, clipping of the DAVF, complete recovery |
| Metastasis of the breast cancer 1 case | Pojskić et al (this case) | Blurry and double vision on the right side | Orbitozygomatic pretemporal craniectomy, extradural clinoidectomy, complete recovery |

Abbreviations: ACP, anterior clinoid process; DAVF, dural arteriovenous fistula; ICA, internal carotid artery.
Anterior Clinoid Metastasis

Pojskić et al.

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. \cite{1,2,29,41–58} The second most common lesion of the ACP is mucocele. \cite{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 post-contrast MRI. \cite{59} Generally, there are several lesions that can mimic meningiomas, which usually present with pseudo-dural tail: breast cancer metastasis, \cite{60} cavernous hemangiomas, \cite{22,61} dural plasmocytoma, \cite{62,63} large capillary hemangioma, \cite{64} carcinoid tumor metastasis, \cite{65} pilocytic astrocytoma, \cite{16} liposarcoma, \cite{66} and metastatic thyroid carcinoma. \cite{67}

Breast Cancer and Brain Metastases
Breast cancer represents the second most frequent cause of brain metastases, occurring in 10 to 16% of patients. \cite{68}

![Fig. 2](image1.png)

**Fig. 2** Pathohistology specimens. (A) Tumor in the breast. Tumor consists of highly pleomorphic epithelial cells and corresponds to infiltrating ductal carcinoma of breast, poorly differentiated (Nottingham combined grade III). Hematoxylin and eosin (H&E). Magnification 200×. (B) Tumor in clinoid bone. Tumor consists of highly pleomorphic epithelial cells in desmoplastic stroma. H&E. Magnification 100×. (C) Tumor in clinoid bone. Tumor cells are strongly cytokeratin 7 positive. Cytokeratin 7 immunostaining. Magnification 200×.

![Fig. 3](image2.png)

**Fig. 3** Postoperative postcontrast magnetic resonance imaging (MRI) of the brain. (A) T1-weighted postcontrast axial view demonstrating a complete resection of the metastasis. (B) T1-weighted postcontrast axial view. (C) T1-weighted postcontrast coronal view, complete resection of the anterior clinoid. (D) Computed tomography (CT) scan of the head, axial view, demonstrating complete removal of the anterior clinoid process.
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.\textsuperscript{69} Surgical resection of the brain metastasis is an important treatment option in patients with single or few (\(\leq 3\)) lesions.\textsuperscript{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.\textsuperscript{73} Its use for pituitary adenomas, craniopharyngiomas, and clinoideal and tuberculum sellae meningiomas has been described.\textsuperscript{1,2} Approach can be pterional,\textsuperscript{74} orbitozygomatic,\textsuperscript{37,75} modified pterional,\textsuperscript{76} modified orbitozygomatic,\textsuperscript{40} pretemporal transzygomatic transcavernous,\textsuperscript{39,77} temporo-polar epidural transcavernous transpetrous,\textsuperscript{78} extended lateral supraorbital,\textsuperscript{79} and endoscopic transphenoidal.\textsuperscript{24}

Extradural clinoidealectomy has several advantages over intradural clinoidealectomy. First, anatomical orientation is easily attained by identifying the dural extension into the SOF and therefore a total ACP removal is possible. In contrast, when the extradural 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.\textsuperscript{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.

**Acknowledgments**

The authors wish to thank Andrew J. Gienapp, BA (Department of Medical Education, Methodist University Hospital, Memphis, Tennessee, United States, and Department of Neurosurgery, University of Tennessee Health Science Center, Memphis, Tennessee, United States), for copy editing, preparation of the manuscript, table, and figures for publishing, and publication assistance with this manuscript.

**References**

1. Al-Mefty O. Cylindrical meningiomas. J Neurosurg 1990;73(06):840–849
2. al-Mefty O, Ayoubi S. Cylindrical meningiomas. Acta Neurochir Suppl (Wien) 1991;53:92–97
3. Aoyama Y, Ohtomo K, Sawamura H. Recurrent optic neuropathy caused by a mucocele of the anterior clinoid process after a 5-year remission: a case report and literature review. Neuroophthalmology 2014;38(05):281–285
4. Arnaville S, Vignal-Clermont C, Galatoire O, et al. Compressive optic neuropathy related to an anterior clinoid mucocele [in French]. J Fr Ophtalmol 2010;33(03):208.e1–208.e6
5. Chagla AS, Bhagangare A, Kansal R, Tyagi D. Complete recovery of visual loss following surgical treatment of mucocele of the anterior clinoid process. J Clin Neurosci 2010;17(05):670–672
6. Chang DJ. The “no-drill” technique of anterior clinoidealoidectomy: a cranial base approach to the paraclinoid and parasellar region. Neurosurgery 2009;64(3, Suppl):ons96–ons105, discussion ons105–ons106
7. Cheong JH, Kim JM, Kim CH. Bony protuberances on the anterior and posterior clinoid processes lead to traumatic internal carotid artery aneuysm following craniofacial injury. J Korean Neurosurg Soc 2011;49(01):49–52
8. Chou PI, Chang YS, Feldon SE, Chen JT. Optic canal mucocele from anterior clinoid pneumatisation. Br J Ophthalmol 1999;83(11):1306–1307
9. Chung DS, Park YS, Lee JH, Kang JK. Mucocele of the anterior clinoid process: case report. Neurosurgery 1999;45(02):376–378
10. Deshmukh S, DeMonte F. Anterior clinoidal mucocele causing optic neuropathy: resolution with nonsurgical therapy. Case report. J Neurosurg 2007;106(06):1091–1093
11. Dunya JM, Frangieh GT, Heilman CB, Miranda MR, Rand LJ, Hedges TR. Anterior clinoid mucocele masquerading as retrobulbar neuritis. Ophthal Plast Reconstr Surg 1996;12(03):171–173
12. Forer B, Hui NY, Sethi DS. Unilateral ophthalmoplegia secondary to anterior clinoid process mucocele. J Neuroophthalmol 2010;30(04):321–324
13. Garaventa G, Arcuri T, Schiavoni S, Fonzari M. Anterior clinoid mucocele: a trans-nasal endoscopic approach. Minim Invasive Neurosurg 1997;40(04):144–147
14. Hejazi N, Witzmann A, Hassler W. Ocular manifestations of sphenoid mucoceles: clinical features and neurosurgical management of three cases and review of the literature. Surg Neurol 2001;56(05):338–343
15. Higgins HL, Schimdt JH III. Atypical presentation of a dermoid brain cyst. W V Med J 1996;92(06):312–315
16. Hong CS, Lehman NL, Sauvageau E. A pilocytic astrocytoma mimicking a clinoideal meningioma. Case Rep Radiol 2014;2014:524574
17. Hopf-Jensen S, Rubarth O, von D Ahe I, et al. Isolated oculumotor nerve palsy caused by a mucocele of an aerated anterior clinoid process. Clin Neuroradiol 2014;24(02):161–164
18. Johnson LN, Hepler RS, Yee RD, Batzdorf U. Sphenoid sinus mucocele (anterior clinoid variant) mimicking diabetic ophthalmoplegia and retrobulbar neuritis. Am J Ophthalmol 1986;102(01):111–115
19. Kasiilwa MK, Suri A, Gupta DK, Suri V, Rishi A, Sharma BS. Sphenoid wing inflammatory pseudotumor mimicking a clinoideal meningioma: case report and review of the literature. Surg Neurol 2008;70(05):509–513, discussion 513
20. Kwon SH, Kim SH, Yoon JH. Anterior clinoid mucocele coexisting with sphenoid sinus mucocele. Auris Nasus Larynx 2009;36(05):598–600
64 Yang G, Li C, Chen X, et al. Large capillary hemangioma of the temporal bone with a dural tail sign: a case report. Oncol Lett 2014;8(01):183–186
65 Harrison CJ, Martin SC, Hofer M, Corkill R, Jeyaretna DS, Griffiths SJ. More than meets the MRI: case report of a carcinoid tumour metastasis mimicking a meningioma. Br J Neurosurg 2017;1–2. doi: 10.1080/02688697.2017.1327018
66 Zagzoog N, Ra G, Koziarz A, et al. Metastatic liposarcoma of the skull base: a case report and review of literature. Neurosurgery 2017;80(04):219–223
67 Malhotra G, Asopa RV, Sridhar E. Unusual case of isolated parasellar metastasis from carcinoma of thyroid. Clin Nucl Med 2013;38(02):145–148
68 Lin NU, Bellon JR, Winer EP. CNS metastases in breast cancer. J Clin Oncol 2004;22(17):3608–3617
69 Gabos Z, Sinha R, Hanson J, et al. Prognostic significance of human epidermal growth factor receptor positivity for the development of brain metastasis after newly diagnosed breast cancer. J Clin Oncol 2006;24(36):5658–5663
70 Aversa C, Rossi V, Geuna E, et al. Metastatic breast cancer subtypes and central nervous system metastases. Breast 2014;23(05):623–628
71 Leone JP, Lee AV, Bruksky AM. Prognostic factors and survival of patients with brain metastasis from breast cancer who underwent craniotomy. Cancer Med 2015;4(07):989–994
72 Leone JP, Leone BA. Breast cancer brain metastases: the last frontier. Exp Hematol Oncol 2015;4:33
73 Dolenc V. Direct microsurgical repair of intracavernous vascular lesions. J Neurosurg 1983;58(06):824–831
74 Dolenc VV. A combined epi- and subdural direct approach to carotid-ophthalmic artery aneurysms. J Neurosurg 1985;62(05):667–672
75 Day JD, Giannotta SL, Fukushima T. Extradural temporopolar approach to lesions of the upper basilar artery and infrachiasmatic region. J Neurosurg 1994;81(02):230–235
76 Yonekawa Y, Ogata N, Imhof HG, et al. Selective extradural anterior clinoidectomy for supra- and parasellar processes. Technical note. J Neurosurg 1997;87(04):636–642
77 Krisht AF, Kadri PA. Surgical clipping of complex basilar apex aneurysms: a strategy for successful outcome using the pretemporal transzygomatic transcavernous approach. Neurosurgery 2005;56(2, Suppl):261–273, discussion 261–273
78 Roche PH, Mercier P, Fournier HD. Temporopolar epidural transcavernous transpetrous approach. Technique and indications [in French]. Neurochirurgie 2007;53(01):23–31
79 Andrade-Barazarte H, Jägersberg M, Belkhair S, et al. The extended lateral supraorbital approach and extradural anterior clinoidectomy through a frontopterio-orbital window: technical note and pilot surgical series. World Neurosurg 2017;100:159–166