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Direct Intracranial Sagittal and Coronal CT Scanning: Anatomy and Pathology

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The application of whole-body scanners with a wide aperture cone to neuroradiology permits examination of the head in the sagittal plane. This method yields better definition of anatomic structures such as the inner and outer supra- and infratentorial cerebrospinal fluid spaces, the major vessels, and all structures of the posterior fossa close to the midline with negligible artifacts. By mono-, bi-, or triplanar approaches, intracranial pathology can be demonstrated exactly with respect to the major anatomic landmarks, without the disadvantages of multplanar reconstructed views. In combination with an altered positioning for coronal scanning, optimal biplane evaluation of the sellar region is possible. Additional cisternal enhancement studies in variants of empty sella and brainstem tumors may not always be necessary. The sagittal section, like the coronal, can be placed lateral to metallic clips for early detection of tumor recurrence. Limitations are discomfort in positioning and a degradation of image quality caused by metal amalgam fillings.

It has recently been demonstrated [1, 2] that direct (positional) computed tomographic (CT) scanning of the head in the sagittal plane eliminates the well known hypodense artifact within the sella, the hypodense "Hounsfield bars" between the petrous bones, and the hyperdense streaks arising from the internal occipital protuberance. This is due to a more "homogenous" sampling volume. In our practice we have observed a number of situations in which the sagittal and longitudinal sections provide additional and sometimes invaluable information [3–7] with respect to the axial and direct coronal scans. This report summarizes our experience with more than 150 patients, aged 5–75 years, examined by this method to obtain neurologic, neurosurgical, endocrinologic, and maxillofacial surgical information.

Materials and Methods

Our scanner is a Philips Tomoscan 300. This scanner can obtain six to eight 6-mm-thick slices in 78–104 sec, at 8 sec intervals. It has 288 xenon detectors, a primary geometric enlargement field of view of 32 cm diameter, 4 and 8 sec scan times, 600 pulses/scan, 2 msec pulse width, and operates at 120 kVp.

The patient is placed prone, right or left anterior oblique, on an inclined plane at the rear side of the scanner. This keeps the shoulders out of the fan beam. Arms are stretched along the hips, and the right or left cheek lies against a foam plastic head support fixed at the top of the regular examination table. This helps to parallel the longitudinal plane of the head with the scan plane (+ 20° tilt), ensuring that the head accurately follows the automatic table index. To eliminate or reduce angulations between the anatomic features and the scan plane it is advisable to use a light pencil in the inner ring of the gantry, a cap on the patient's head labeled with longitudinal strips, and to scan directly the area of interest. Because of the uncomfortable neck position, the duration of the examination should be kept short by using a batch mode procedure. To obtain coronal sections of the sella nearly perpendicular to the sellar floor without greater hyperextension of the neck, the patient's position is modified. The head is turned 90° vertically to the scanning plane, the head holder is replaced by a normal device for coronal scanning, and the body is put in a complete prone position.

For collimations of 6 mm or 3 mm, 300 mA or 428 mA settings were used, respectively. Contrast agents used were megluminio­dotrizoate (306 mg/kg) and iopromide (300 mg I/kg of body weight).

Results

The sagittal projection obtained approximates a true sagittal section through the intracranial and facial structures, and is comparable to a longitudinally reconstructed nuclear magnetic resonance (NMR) image. The most interesting anatomy is located in the midline region (fig. 1). The soft tissue above and below the tentorium, in relation to the inner and outer cerebrospinal fluid (CSF) spaces, and in the vicinity of the calvarium and the skull base (including the paranasal sinus), is easily visualized on a 3-mm-thick precontrast midsagittal scan. The scan is tangential to the falx cerebi and the gyri of either side are not clearly seen. The third ventricle, the sylvian aqueduct, and the triangular fourth ventricle are well delineated. The brainstem (composed of the mesencephalon,pons, and the medulla oblongata) is separated from the clivus by the interpeduncular, pontine, and medullary cisterns. The pontomedullary notch is often well visualized. The cisterna cerebellomedullaris separates the inferior vermis from the occipital bone; the superior vermis is well outlined by the vermian cistern. The normal quadrigeminal cistern is perfectly delineated. The major vascular structures of the posterior fossa are easily identified with or without contrast enhancement. The entire length of the basilar artery is seen in the subarachnoid cisterns in front of the brainstem. The

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straight sinus and the great vein of Galen form the superior border of the posterior fossa; thus, the free edge of the tentorium is clear.

An angio-CT study of another patient (fig. 2) a few millimeters lateral to the midline demonstrates branches of the postcommunicating anterior cerebral artery and inner cerebral veins. The superior surface is demarcated by the thin callosal artery (steal effect of the enlarged proximal branches, leading to a frontoparietal angioma, not shown in the figure), and parts of the corpus callosum are therefore better visualized. Note also the enhancement of the choroid plexus of the third and fourth ventricles. The gyri of the ipsilateral hemisphere can be better visualized because the falk cerebri is medial to the section.

The relative position or accurate site of intracranial lesions (especially those that are medial or parasagittal with respect to the major external anatomic landmarks) cannot be determined on axial scans alone. The longitudinal view of a 62-year-old patient (fig. 3) indicates where a calvarial meningioma is located with regard to the skull base. The longitudinal and vertical dimensions between the tentorium and the foramen magnum are clearly visualized.

The supra-/infratentorial parts of mesencephalic masses can be outlined more precisely than on coronal scans (fig. 6). In this case the cystic tumor compresses the aqueduct and the quadrigeminal cistern but not the interpudendural and pontine cisterns. The upper part of the fourth ventricle is displaced inferiorly.

Even the so-called half-axial section +25° maximally to the canthomeatal line is limited by interfering metallic dental fillings and degraded by interpetrosal artifacts. In a 43-year-old patient with left-sided central hemiparesis a hypodense lesion secondary to infarction could be clearly defined only in a right parasagittal slice close to the midline (fig. 7).

**Discussion**

The clinically useful application of direct sagittal CT of the brain extends from the midline to the lateral border of the basal ganglia. Structures described in figures 1–3 can be more easily discriminated and pathologic involvement better delineated in the sagittal projection, according to the principle of sectioning perpendicular to the plane of the object of interest. This also avoids density averaging of rather small soft-tissue structures (e.g., the pituitary gland) with the adjacent bone. The individual combination of scans in the sagittal, coronal, and axial planes allows a mono- , bi-, and triplanar approach to complex lesions—intra-/extraorbital [5, 6]; intra-/suprasellar; intra-/extraventricular; supra-/infratentorial (fig. 6); intra-/extraxial (fig. 7)—adjacent to the skull base [5, 6], arising from the calvarium or dura, and congenital anomalies [4, 7], even in areas of high attenuation differences [6, 8, 9]. In this way the
neurosurgeon or radiotherapist can be provided with all necessary information.

As does sagittal CT, coronal scanning of the sellar region as described in this paper produces negligible artifacts, so an optimal biplanar evaluation of all anatomic and pathologic conditions of the sellar area is possible. The diagnostic criteria ruled out by means of different investigational techniques [1, 10-13] can be easily applied. In our opinion, variants of an empty sella do not necessarily require an additional metrizamide or air study. Situations and complications before and after transphenoidal surgery can be easily determined on sagittal sections [4, 6, 7] as far as the operative route, the filling material after tumor removal, and leakage of CSF or air are concerned.

Except for NMR, sagittal CT is the only technique by which interpetrosal artifacts do not occur. To date, different approaches to this problem have failed to offer a definite solution [12, 14]. This underscores its value for the assessment of lesions related to the brainstem (e.g., pontomedullary and extrinsic brainstem tumors arising from the clivus). As it facilitates the definition of tumors of the entire posterior fossa in combination with selected axial and coronal sections, it may be an alternative to cisternal metrizamide-enhanced studies [15].

The detection of cerebellar and brainstem atrophy is notably improved by midsagittal slices (fig. 7) [6, 17], but, to explore the entire posterior fossa sagittal reconstruction, at least 24 and often 34 overlapping 5-mm-thick axial scans have to be obtained [18]. The sylvian aqueduct and the third ventricle are normally not seen on these computer-rearranged views [18]. To apply 1.5 mm overlapping axial slices does not seem routinely practicable. Linear interpolation [2] (greater image size than display matrix pixel area) accounts for the coarse and blurred structure contours (fig. 5B). For this reason and the striplike view, topography is less easily delineated than on a direct section with complete information. Therefore, whenever possible, a lesion should be examined directly.

Tumors and malformations in the midline predominate in infantile intracranial pathology [11]. Sagittal scans are easily obtained in children, since the motility of their cervical spine is normal. The results are excellent with regard to tumor stagings and definition of primary and secondary lesions in the region of the aqueduct. The understanding of complex malformations and their rudimentary variants is better [7]. Also, the radiation dose received by the lenses of the eye during sagittal scanning is significantly lower in the midline region [19]. This has been confirmed by our own thermoluminescent dosimetric data.
Like the coronal section, sagittal CT may be especially helpful if set lateral to metallic clips, so that streaks degrading the image may be avoided. This can be very important for early detection of tumor recurrence.

But sagittal CT has its limitations. Difficulty is experienced with large or obese patients and those who have inflexible cervical spines because of preexisting degenerative pathology. Also, amalgam fillings and other metallic tooth implantations may cause streak artifacts that detract from the image quality. Fortunately, the incisions usually have fewer implants than the molars.

Editor's Note: Structures demonstrated here by direct sagittal section are also often visualized by multiplanar reconstructed images on high-resolution instruments.

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