

Nature saw fit to enclose the central nervous system in a bony box lined by a tough, protecting membrane, and within this case she concealed a tiny organ which lies enveloped by an additional bony capsule and membrane like the nugget in the innermost of a series of Chinese boxes.'

Harvey Cushing (1869-1939), Professor of Surgery, Harvard

Since the introduction of rigid nasal endoscopy in the 1970's, the possibility of applying the improved visualisation to a range of procedures began to be explored. Thus we saw the evolution of 'FESS' to 'ESS' with an endoscopic approach competing and in many cases replacing conventional techniques particularly those utilising external incisions. This has been especially apparent at the interfaces between the sinuses, orbit and skull base and this issue contains several interesting articles exploring the latter.

A sublabial trans-septal route to the pituitary was established nearly 100 years ago by Cushing and many modifications followed, via the maxillary sinus, palate, ethmoids and/or sphenoid. These approaches were aided by improvements in imaging, (both per- and peri-operatively) and by improved visualisation particularly with the advent of the binocular microscope. Initially considered a neurosurgical operation, the procedure was increasingly undertaken by otolaryngologists especially during the 1950's when removal of the pituitary in the treatment of prostate and breast cancer was being advocated. However, it was clear that an endonasal endoscopic approach could be employed, avoiding some of the complications associated with the standard operations and Eloy et al. [p 271] describe their experience. The authors explain how the potential disadvantages of a parasagittal single-handed approach can be overcome, using more than one surgeon and/or combining endoscopic and microscopic techniques, providing an excellent example of interdisciplinary collaboration with the neurosurgeons.

Interestingly persistent CSF leakage following pituitary surgery has never been a significant problem whereas CSF rhinorrhoea from congenital skull base dehiscences and trauma have proved problematic, associated, as is often the case, with meningitis. Previously the preserve of the neurosurgical community, endoscopic rhinologic surgeons are increasingly asked by their neurosurgical colleagues to undertake these repairs as the first line of treatment. In the literature a wide range of materials and repair techniques have been described though in the absence of a proper comparative trial, all seem equally effective. Indeed in the literature the overall success rate for endoscopic repair is well in excess of 90% and the cohort presented by Bernal-Sprekelsen [p 277] is no exception. These results equal those reported in the neurosurgical literature whilst avoiding the associated morbidity of a formal craniotomy. It could be argued that the patient has nothing to lose and much to gain from an endoscopic repair of a CSF leak. Furthermore, the positive experience accrued from this application has undoubtedly contributed to the increasing use of endoscopic resection of skull base tumours in appropriately selected cases.

Valerie J. Lund
Editor in Chief

