

## Original Investigation

# Efficacy Comparison of Microvascular Decompression and Rhizotomy in the Treatment of Glossopharyngeal Neuralgia: A Retrospective Analysis of 37 Cases

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## ABSTRACT

**AIM:** To evaluate and compare the long-term efficacy and safety of microvascular decompression (MVD) and glossopharyngeal nerve roots rhizotomy (GNR) in the treatment of glossopharyngeal neuralgia (GN).

**MATERIAL and METHODS:** The data of 37 patients with glossopharyngeal neuralgia undergoing MVD alone and MVD + GNR from July 2004 to March 2017 were analyzed retrospectively.

**RESULTS:** Efficacy: In the 22 cases of the MVD group, 19 cases were cured and 3 cases were improved. In the 15 cases of the MVD + GNR group, 14 cases were cured and 1 case improved. There was no significant difference between the two groups ( $\chi^2$  test,  $p>0.05$ ). Complications: Postoperative complications in the MVD group: 2 patients had short-term hoarseness and drinking cough, 1 case had cerebrospinal fluid leakage, 1 case had intracranial infection, and 1 case had ipsilateral hearing loss, with no deaths; Postoperative complications in the MVD + GNR group: permanent hoarseness in 2 cases, short-term drinking cough and hoarseness in 4 cases, ipsilateral facial paralysis in 1 case, and cerebrospinal fluid leakage in 1 case, with no intracranial infection or death. The incidence of postoperative hoarseness and drinking cough in the MVD + GNR group was higher than that in the MVD group ( $\chi^2$  test,  $p<0.05$ ).

**CONCLUSION:** MVD alone was a safe and effective method for the treatment of primary glossopharyngeal neuralgia. The efficacy was equivalent to MVD + GNR, and there was a lower incidence of hoarseness and drinking cough.

**KEYWORDS:** Glossopharyngeal neuralgia, Microvascular decompression surgery, Efficacy, Rhizotomy

## INTRODUCTION

The incidence of primary glossopharyngeal neuralgia (GN) is very low, and is about 0.2-1.3% of trigeminal neuralgia (5,7). Because of the swallowing pain and speech dysfunction, it has a great influence on the life quality of patients. The current operation method is still controversial, and the debate is on whether microvascular decompression (MVD) should be used alone or in combination with glossopharyngeal nerve roots rhizotomy (GNR) (3). This study retrospectively analyzed the data of 37 patients with glossopharyngeal neuralgia who were treated with MVD alone

or MVD + GNR, analyzed the cause of disease, and compared the curative effects to guide clinical practice.

## MATERIAL and METHODS

### General Materials

A retrospective analysis was made of a total of 37 cases of GN treated with MVD alone or MVD + GNR from July 2004 to March 2017. The MVD group included 22 cases, with a male:female ratio of 10:12, aged 40-81 years old, and followed up for 6 months to 6 years, with a median follow-up time of 48 months. These values in the MVD + GNR group were 15

cases, male:female ratio of 8:7, aged 42-78 years old, and followed up for 5 to 12 years with a median follow-up time of 7.5 years. A 1.5 T or 3.0 T MRI examination was used to detect compressing vessels near the root entry zone of the glossopharyngeal nerve (Figure 1A, B), and the diagnosis of GN was confirmed by the preoperative cocaine experiment.

### Surgical Methods

MVD surgery was performed under general anesthesia, via the retrosigmoid approach and keyhole craniotomy. The patient was routinely side-lying, and the skin incision was located behind the ear, about 5-6 cm long, using a drill or milling cutter to make a bone window with a diameter of about 2 cm, 1 cm below the star point. The inner edge of the sigmoid sinus was revealed, and the upper border of the bone window was 1 cm under the transverse sinus. A "U" shape cut was made in the dura mater, separating the layers under the operating microscope in the direction of the cerebellopontine angle. Arachnoid thickening and adhesion should be separated to fully reveal the lower cranial nerve fibers. The entire glossopharyngeal nerve is explored to prevent omission of responsible vessels and the entry of the glossopharyngeal nerve and vagus nerve into the brain stem should be observed in particular. Vessels located between the cranial nerve root and medulla oblongata should not be missed. The right place should be found to place the Teflon cotton, freeing the responsible blood vessel, and padding the Teflon cotton between the blood vessels and the glossopharyngeal nerve and vagus nerve (Figure 2A-C). After padding, it should be confirmed that the root entry zone (REZ) area has been fully decompressed, and the traction of the glossopharyngeal and vagus nerves should be minimized. The aim of MVD surgery for GN was full length decompression, not only decompression of the REZ zone, and the arachnoid adhesion around the nerve had to be fully loosened. In the early stage, in order to increase the efficacy, we selectively cut off the nerve fibers of the glossopharyngeal nerve and some vagal nerve roots

during surgery in most patients after we used Teflon cotton for padding. In recent years, we simply perform microvascular decompression only.

### Clinical Evaluation

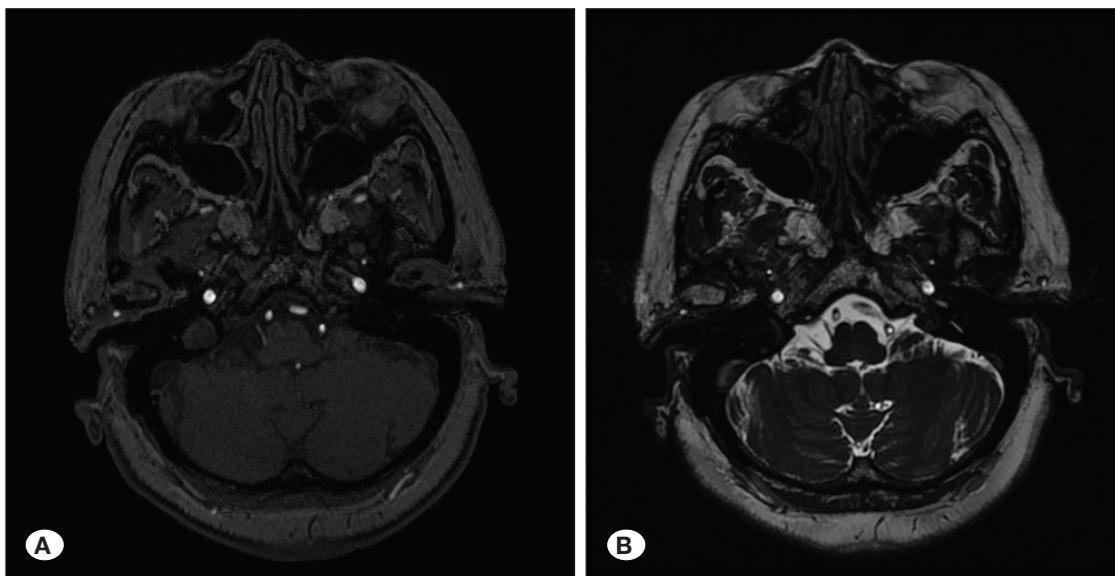
All patients were postoperatively followed up for more than 3 months, and the efficacy after 3 months was considered as the surgical effect. The Barrow Nerve Institute pain prognosis classification (BNI pain score) was used as follows: grade, painless; grade II, occasional episodes of pain, without medication; grade III, minor pain, the pain can be controlled; grade IV, moderate pain, the pain cannot be controlled; Grade V, severe pain, the pain cannot be controlled. In this study, the efficacy was divided into three levels: cure (grade), improved (grade II + III), invalid (grade IV + V). Recurrent pain during short-term postoperative follow-up (within 3 months) was considered invalid.

### RESULTS

**Responsible vessels:** Among the 37 surgical patients, there were 26 cases of posterior inferior cerebellar artery compression, 5 cases of anterior cerebellar artery compression, 4 cases of multivessel compression and 2 cases of vertebral artery compression. Surgical methods used were MVD in 22 cases and MVD + GNR in 15 cases.

**Surgical efficacy:** Among 15 cases of MVD + GNR group, 14 cases were cured, 1 case improved; Among 22 cases of MVD group, 19 cases were cured, 3 cases improved. No case was invalid in both groups, and the effect showed no significant difference ( $\chi^2$  test,  $p > 0.05$ ) (Table I).

**Postoperative complications in the MVD group:** 2 patients had short-term hoarseness and drinking cough, 1 case had cerebrospinal fluid leakage, 1 case had intracranial infection, 1 case had ipsilateral hearing loss and there was no intracranial infection or death. **Postoperative complications in the MVD + GNR group:** there was permanent hoarseness



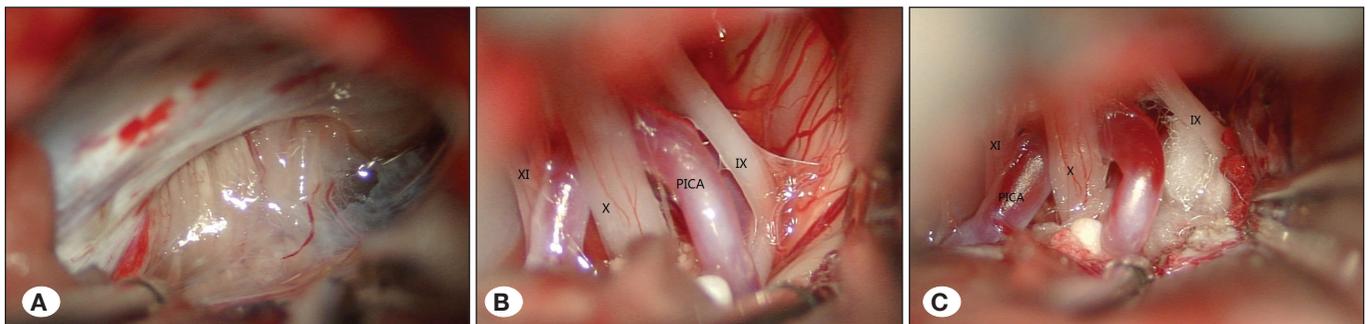
**Figure 1:** Magnetic resonance image of the right posterior inferior cerebellar artery in contact with the root entry zone of the glossopharyngeal nerve.

**A)** Three-dimensional time-of-flight magnetic resonance angiography (3D-TOF-MRA).  
**B)** Three-dimensional fast imaging employing steady-state acquisition (3D-FIESTA).

**Table I:** Comparison of Postoperative Efficacy and Complications of MVD and MVD+GNR

	n	Efficacy		Postoperative hoarseness and drinking cough
		cure	improved	
MVD	22	19	3	2
MVD+GNR	15	14	1	6
Total	37	33	4	8

\* There was no significant difference in postoperative efficacy between the MVD group and the MVD + GNR group ( $\chi^2$  test,  $p > 0.05$ ); the incidence of postoperative hoarseness and drinking cough in the MVD + GNR group was higher than that in the MVD group ( $\chi^2$  test,  $p < 0.05$ ).



**Figure 2:** Intraoperative images of microvascular decompression of left side glossopharyngeal neuralgia. **A)** Local arachnoid thickening of the cerebellopontine angle. **B)** Fully revealed lower cranial nerve fibers and the responsible blood vessel. **C)** Padding Teflon cotton between the blood vessels and the glossopharyngeal nerve and vagus nerve. **IX:** Glossopharyngeal nerve, **X:** Vagus nerve, **XI:** Accessory nerve, **PICA:** Posterior inferior cerebellar artery.

in 2 cases, short-term drinking cough and hoarseness in 4 cases, ipsilateral facial paralysis in 1 case, cerebrospinal fluid leakage in 1 case, and no intracranial infection or death. The incidence of postoperative hoarseness and drinking cough in the MVD + GNR group was higher than that in the MVD group ( $\chi^2$  test,  $p < 0.05$ ) (Table I).

Two cases of hoarseness and drinking cough in the MVD group recovered during hospitalization. One case of intracranial infection with *Staphylococcus epidermidis* confirmed by bacterial culture of cerebrospinal fluid was cured with linezolid. Of the 15 patients in the MVD + GNR group, 6 patients had hoarseness and choking symptoms after the operation; 4 of them recovered to normal within 3 months while no recovery occurred in 2 patients.

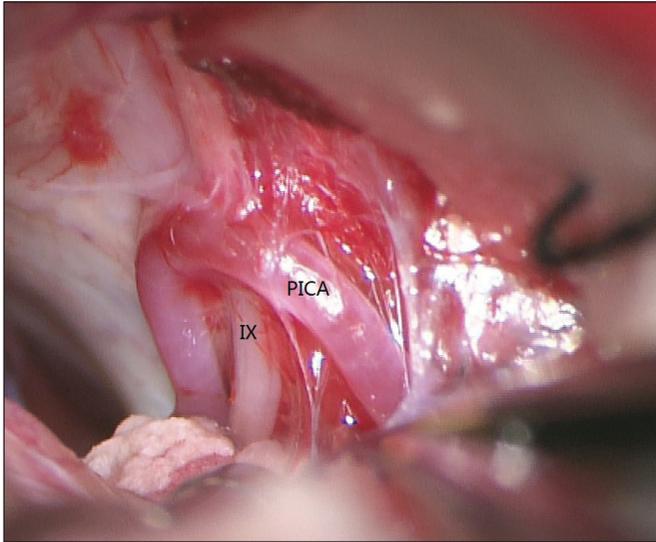
## DISCUSSION

Glossopharyngeal neuralgia is a relatively uncommon clinical neurological disorder and the incidence is only 0.2-0.7/10 million/year. The onset is mostly in patients 40 years old and above, and the incidence in men and women shows no significant difference (4). Clinical manifestations are recurrent tactile pain. The site is often confined to the area of the auricular branch and pharyngeal branch of the glossopharyngeal nerve or the vagus nerve, such as the tongue, pharynx, tonsil area and deep external auditory meatus. Swallowing, talking, coughing, yawning and other actions can induce the pain.

Some scholars believe that the pathogenesis of glossopharyngeal neuralgia is due to compression of the inferior cerebellar

artery or vertebral artery and other abnormal vascular structures, along with local thickening and adhesions of the arachnoid leading to glossopharyngeal nerve and vagus nerve root demyelination, so that a short circuit between the nerve fibers triggers the onset of pain (1). Our study also confirmed this point, as we saw severe arachnoid adhesions around most of glossopharyngeal nerve (Figure 3), while we did not find such adhesions during microvascular decompression surgery for trigeminal neuralgia, indicating that local arachnoid thickening and adhesions are an important pathogenic factor for glossopharyngeal neuralgia. Clinically, we observed in GN patients that the arachnoid thickening and adhesions got better with the surgical effect. None of the 4 patients with postoperative improvement had arachnoid adhesions, while all the patients with arachnoid adhesions were cured after MVD treatment, also showing the important role of arachnoid adhesion in the pathogenesis of GN and the possibility that arachnoid adhesions lead to more serious vascular compression. In addition, the vagus nerve also had a role in the pathogenesis of glossopharyngeal neuralgia. Anatomically, the vagus nerve and glossopharyngeal nerve originate from the nucleus tractus solitarius, but in the pharyngeal plexus distribution they often could not be clearly distinguished whether when the pain was located in pharyngitis and pharyngeal mucosa and the presence of vagal activation could not be ruled out in some patients with glossopharyngeal neuralgia (6).

For the treatment of glossopharyngeal neuralgia, Taha (9) and Ferrante (2) advocated the best surgery way microvascular decompression combined with glossopharyngeal nerve root



**Figure 3:** The arachnoid adhesions around glossopharyngeal nerve and the posterior inferior cerebellar artery was adhesion fixed. **IX:** Glossopharyngeal nerve, **PICA:** Posterior inferior cerebellar artery.

incision, but few patients had postoperative complications of dysphagia, hoarseness and other complications. Most scholars believe that simple microvascular decompression could ensure a high cure rate, and the incidence of cranial nerve injury may be further reduced with improvement of surgical technique. Sindou and Mertens reported the cure rate with MVD in trigeminal neuralgia was 91% in 420 cases, while the cure rate in glossopharyngeal neuralgia was 100% in 9 patients (8). Mi Kyung Kim (3), and Sampson et al. also hold the same view (7).

Our experience was: 1) It was not necessary to reveal the transverse sinus via a retrosigmoid approach, while the inner edge of the sigmoid sinus should be revealed, and the upper border of the bone window was 1 cm under the transverse sinus. 2) We did not recommend intraoperative exploration of other nerves except the lower cranial nerve fibers, due to the nourishing blood vessels around the nerves as surgery was likely to cause damage to them and lead to postoperative neurological dysfunction. 3) The arachnoid adhesions around cranial nerves must be fully loosened, as arachnoid adhesions are important pathogenic factors for GN. 4) For full length decompression and to explore the entire glossopharyngeal nerve in order to prevent the omission of responsible vessels, in particular, one needs to observe the REZ area of the glossopharyngeal nerve and vagus nerve, which is the most common positions for the responsible vessel.

## ■ CONCLUSION

MVD alone was a safe and effective method for the treatment of primary glossopharyngeal neuralgia. The efficacy was equivalent to MVD + GNR, and it had a lower incidence of hoarseness and drinking cough. Arachnoid adhesions constituted an important pathogenic factor for glossopharyngeal neuralgia and were related to the efficacy of surgery.

## ■ ACKNOWLEDGMENTS

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