

# Preface

As patients' requirements of the quality of surgical procedures are increasing, the techniques of surgery should always be evolving in order to provide better outcomes. Now having performed almost 3500 procedures on posterior fossa lesions and more than 2000 on acoustic neurinomas, we feel strongly that we need to update the techniques as well as the results obtained with this kind of surgery.

The second edition of *Atlas of Acoustic Neurinoma Microsurgery* comes to fruition 10 years after the first edition. During the past decade we have introduced some technical modifications into acoustic neurinoma microsurgery and in this second edition we have attempted to devote more pages to these refinements.

We have added two new chapters in response to requests that have been made over that period. Since the role of functional surgery has become established, intraoperative monitoring of the facial nerve and the cochlear nerve is now essential in removal of acoustic neurinoma. Great technological advance in implantable devices (i. e., cochlear and brainstem implants) has allowed deaf patients to regain hearing. In the light of these changes, we can offer more treatment options to patients with neurofibromatosis type 2 and patients with neurinoma in the only hearing ear, situations that have long bothered both patients and surgeons. These changes have, furthermore, introduced new concepts in the policy of follow-up, which has changed from a simple wait-and-scan route.

The initial milestone of skull base surgery was laid by William House together with William Hitselberger. They pioneered and systematized the techniques needed for removal of acoustic neurinomas and made the way for future generations to develop subsequent advances. Acoustic neurinomas nowadays represent a specialist field of pathology. Surgeons treating this pathology must be specialists, whether otolaryngologists or neurosurgeons. Additionally, removal of acoustic neurinoma is to be performed by a team, in which two or more surgeons should be involved. The ideal may be a team consisting of one otologist and one neurosurgeon at minimum, but this is not absolutely necessary – our work demonstrated here has been achieved by a team including

only otologists. It is important to note that if two surgeons of different specialties are involved in a team, both of them must know how to perform all the steps from setting to closure. All the surgeons must know all the approaches that can be appropriate for the patient with an acoustic neurinoma. In other words, we must apply the best procedure to our patients, not the opposite, as required by a true individualized management.

We believe that this new book will be of great help to all readers in becoming and being specialists and performing excellent surgery on patients with acoustic neurinoma.

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Finally, I would like to thank and dedicate this book to all the families of the people who have kindly agreed to their photographs being used for educational purposes. Their help has made our work possible.

Mario Sanna, MD