NEVVSLE I I



((Our Reader Is Our Leader

The broad aim of this newsletter is to advance the science of neurological surgery and enhance patient's safety

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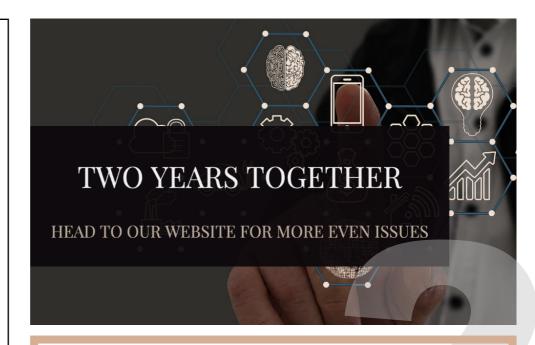
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Two years have already passed since we first launched SANS Newsletter! We must thank all members, your contributions to the newsletter have been invaluable.

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Issue's Message

Welcome to the fourth issue of the SANS Newsletter for this year.

We have asked Professor Imad Kanaan some questions related to neurosurgery and the profession in general.

We are appreciative that Professor Imad was able to spend some time to answer these question. You can read it all below.

Among the many highlights in the current newsletter, you will read an article about the Saudi Board in Neurosurgery written by professor Abdulhakim Jamjoom

We are excited to introduce a new section that will be incorporated in future issues of SANS Newsletter. This section aims to focus on ethical issues of particular importance to neurosurgeons.

In addition to this section, we also have a number of our usual columns. In Arabic section, you will read about the Trigeminal nerve. In our Neurosurgical Guidelines section, We want to draw your attention to the guidelines on the Management of Idiopathic Normal Pressure Hydrocephalus.

In Resident's Corner, Dr. Aimun Jamjoom reflects on his experience of Neurosurgery research collaboratives.

If you are interested in how a neurosurgeon would pass his journey, refer to Dr. Elarjani's article.

As always, the newsletter covers recent and upcoming SANS activities and events as well as selected news from our local neurosurgery community.

We welcome your contributions, feedback and suggestions as we continue to improve upon our newsletter. Please click **HERE** to contact us about submitting your contribution.



We are glad to announce that SANS Newsletter will issue **Certificates of Contributions** for residents. The final decision on what gets published and who earns a certificate is with the editorial board members.

THE EXPERT'S VOICE

An Interview with A Neurosurgeon

Professor Imad N. Kanaan

We had the pleasure of interviewing a prominent neurosurgeon and Professor in King Faisal Specialist Hospital and Research Centre: Dr. Imad Kanaan. We are appreciative that Professor Imad was able to take time out of his busy schedule to answer some questions related to neurosurgery and the profession in general. It is our pleasure to hear his perspectives on neurosurgery. Here's the interview:

SANS Newsletter (SN): What are you most proud of personally?

Imad Kanaan (IK): Lead the Department of Neuroscience at King Faisal Specialist Hospital & Research Centre in Riyadh to become an internationally recognised centre of excellence, introduce the neuroscience curriculum at Alfaisal University, and contribute to place the Kingdom of Saudi Arabia on the world map for its high-quality neurosurgical education and advanced clinical practice.

(SN): Describe yourself using three words.

(IK): That's a nice question, but one that I find difficult to answer myself! However, that's how I see myself: Dedicated, passionate, and sincere.

(SN): What are you passionate about?

(IK): Art of neurosurgical practice and innovation.

(SN): How do you handle stressful situations?

(IK): Mindfulness and Serenity. Turn adversity into advantage, stress into strength, and tension into triumph...

(SN): What are you known for?

(IK): Human qualities and neurosurgical expertise and professional mentorship.

(SN): Most overused phrase.

(IK): "He's lucky": success is attributed to luck. A misconception used by some to undermine the true success of someone known for their great dedication and hard work! Of course, a smart person is the one who raises the bar on their performance, seizes the opportunity and challenges themselves to succeed. "Carpe diem" "Pluck the day"

(SN): What was the best advice anyone ever gave you? (IK): Stick to your values; be honest with yourself and others.

(**SN):** When / how did you know neurosurgery was the right path for you?

(IK): Fifth year medical school. Thanks to my mentors and advances in the field (microsurgery, neuroimaging)

(SN): If you were not a neurosurgeon, what career would you choose?

(IK): As a medical discipline, I could become a cardiologist, and as an unrelated career, I could become a musician.

(SN): How do you spend your spare time?

(IK): With my family, sports and reading. In parallel, I prepare scientific papers and educational webinars. In summary, I embrace the concept of "Ageless body timeless mind".

SN): We are wondering about what is your genetic background. Do you have doctors in your family? How do your children look at you as a dad and neurosurgeon?

(**IK):** My father was a dentist, my brother is a dentist (endodontics), my uncle was a physician (dermatologist) and two of my cousins were orthopaedic surgeon and a general surgeon. My two daughters see me as a devoted medical artist, loving and caring father.

SN): Which neurosurgeon (living or deceased) most influenced your neurosurgical career?

(IK): The legendary professor M. Gazi Yasargil

in Phoenix.

(SN): Can you please share some of your experiences in the early days of your practice?

(IK): I started my training 1977 in general surgery for two years in Niedersaxon, Germany, commenced my specialty toward the board certification in Neurosurgery at the academic central teaching hospital in Bremerhaven, affiliated to the University of Gottingen, Germany which was completed March 1985. I complemented my training with three short visiting fellowships, Epilepsy at Radcliff infirmary in Oxford, Skull base and vascular neurosurgery at University hospital Zurich and Barrow neurological Institute

Interview with Prof. Imad Kanaan 2/4

(SN): As a successful neurosurgeon, professor and director, how did you strike a balance among these roles and duties?

(IK): The first image that comes to my mind in answering this beautiful question is the Chinese symbol of "yin and yang," that dualism between the two noble functions that complement and crossfertilize each other. The great surgeon Dr. Halsted once said, "The best environment to teach the art of practice is the sick bay." My humble response to this question is to have a great passion for both roles, practice efficient time management, and consider the wards, clinics, and neurosurgical OR as the best place to be successful in both functions.

(SN): In your position now, knowing what you do, what would you say to yourself when you were beginning your medical career?

(**IK**): Spare no time and effort to expand your knowledge and experience. A successful medical career is a dynamic process that requires constant updating with more clinical experience, using mirror neurons to learn from the masters at work, and incorporating the concept of "thinking outside the box" to innovate.

(SN): Where did you do your medical residency? Could you describe your journey?

(**IK**): I started my training in general surgery in 1977 for two years in Niedersaxon/Germany and started my specialisation in neurosurgery in early 1980 at the academic central teaching hospital in Bremerhaven, Germany, affiliated with the College of Goettingen/Germany.

(SN): What was your first experience actually working on the brain surgically, and do you remember it, and what did you feel about it?

(**IK**): I was involved in the surgical treatment of a comatose patient with severe poly trauma after a serious motorcycle accident. This resulted in a complex skull base, open fractures and a severe laceration of the ICA with subsequent intracranial hematoma and leakage of brain tissue from the nostrils and through the fracture site. Attempts to save this unfortunate patient were unsuccessful and he succumbed to his fate on the table. It was a terrible and sad experience to witness such a condition in a very young resident.

At that time CTA, MRI/MRA were not available and we did not have an interventional radiologist.

(SN): Describe the biggest issue you see challenging your practice?

(IK): Confronting complex and advanced neurosurgical lesions. Nowadays, increased public health education at various levels, as well as an improved referral system and medical digital network, are helping to alleviate this problem through early detection and rapid referral. In addition, the negative impact of the Covid19 pandemic on health facilities has led to a delay in the provision of needed surgical equipment, which in turn has led to budget constraints and bureaucratic regulations.

(SN): What is the majority of your surgical practice?

(IK): Brain tumours and vascular tumours in general, but skull base and pituitary tumours today in particular.

(SN): Are you particular about the instruments that you use?

(IK): Neurosurgeons, like other artists, need their special tools to safely perform their artwork and achieve a better result.

(SN): How do you feel about taking responsibility for choices that you know will profoundly affect your patient's life?

(IK): I never consent a patient for something I feel I can not help them with or that I am convinced will help. I have learned and teach, "Put yourself or a loved one in your patient's shoes to make the right decision!"

(SN): Could you tell us about your experience as Chairman of the WFNS Neuroanatomy Committees?

(IK): The WFNS Neuroanatomy Committee continues to play an important role in teaching and training worldwide. It is an accepted fact that neuroanatomy is the cornerstone of medical and surgical knowledge and skill. The Neuroanatomy Committee was able to mitigate the negative impact of the Covid 19 pandemic on its performance by launching its successful educational webinars, which are aimed at trainees, residents and young neurosurgeons and respect no boundaries or limitations. This initiative has proven to be a costeffective academic endeavour, is free of charge, and is a great place to connect with world-leading neurosurgeons. The committee has also created a library of video recordings that are easily accessible on YouTube. The committee plans to hold hands-on courses at the site in the near future.

Interview with Prof. Imad Kanaan 3/4

(**SN):** Upon the occasion of the 11th Annual Meeting of the Saudi Association of Neurological Surgery in 2017, the SANS Medal was awarded to You. Could you tell us more about it?

(**IK**): It was my great pleasure to receive this special medal from the Saudi Association of Neurological Surgeon in recognition of my contribution to teaching and professional achievement. I greatly appreciate this honour, which holds a special place in my heart.

(SN): What future do you envision in neurosurgery?

(IK): The future of the international neurosurgical community is bright and promising, with more collaboration between societies, stronger teaching efforts, advances in research and technology. It is reassuring to witness the great leap in neurosurgical practice and training in the Kingdom, led by a new generation of talented returning scientists and bright, dedicated neurosurgeons.

(SN): As a successful neurosurgeon and professor, what is important in neurosurgical training?

(IK): An excellent training program should focus on a comprehensive clinical experience, foster trainees' critical thinking, sound judgment, emotional intelligence, and patient-physician relationships. Encouraging fruitful external experience and international collaboration (elective rotation) and fostering a spirit for research and scholarship in the early stages of training.

(SN): What advice would you give to students who aspire to be in neurosurgery?

(IK): Early immersion in neurosurgical science and build a solid foundation of knowledge in the field such as "neuroanatomy, embryology and other related disciplines". Use the 5+1 senses to improve their routine practice in performing careful clinical examinations. Attend hands-on courses and conferences and participate in external electives to watch the great masters at work.

(SN): Is there anything you can tell us that might surprise people reading the article?

(IK): I would like to thank you very much for your kind invitation to this particular interview. In general, I hate being surprised in the neurosurgical theatre, and I have decided to spare you such an experience.



Dr. Imad Kanaan is the Chair of the Department of Neurosciences at King Faisal Specialist Hospital and Research Centre (KFSH&RC), and Professor of Neurosurgery at Alfaisal University. He has a strong interest in education and has received national and international recognition through his contributions in the field. Dr. Imad co-initiated the first neurosurgical fellowship program and the first neurosurgical residency training program in Saudi Arabia.

SAUDI BOARD IN NEUROSURGERY



By Abdulhakim B. Jamjoom FRCS(SN)

Professor of Neurosurgery King Khalid National Guards Hospital and King Saud bin Abdulaziz University for Health Sciences

Algahtani AY, Jamjoom AB, Al Rabie A, Jamjoom ZB (September 24, 2021)

Attrition and success rates in the Saudi Board in Neurosurgery: Analysis of 115 consecutive residents who started training from 2001 to 2014. *Cureus 13(9): e18235 doi: 10.7759/cureus.18235*

The Saudi Board in Neurosurgery (SBNS) training program is a standardised curriculum that is set and administered by the Saudi Commission for Health Specialties. The SBNS was established in 1995. In October 2020, we felt the timing was appropriate for a review of the outcome of the trainees that started the SBNS during 2001-2014 to allow for the latter to complete their training by 2020. We are pleased that the SBNS review was recently published. This report is based on the findings of the above article.

Objectives

At present, the literature lacks data on the outcome of neurosurgery training in the Saudi Arabia and the Middle East. The aim was to determine the attrition, completion of training and success rates in the final SBNS examination and to ascertain whether the outcome was impacted by several trainee and training centre characteristics.

Methods

A cohort of 115 trainees who started SBNS training during 2001-2014 was reviewed.

Attrition rate was defined as the proportion of trainees who dropped out of the SBNS training any time after starting and before completion of training. The following data was collected: age at starting training, gender, nationality, medical college attended, year of graduation, GPA score, SMLE score, year of starting training, duration from graduation to starting training, training region, sponsoring hospital, attrition to neurosurgery elsewhere, attrition to non-neurosurgery, year of completion of training, year of passing the final SBNS examination, number of attempts, and passing of other neurosurgery qualifications. The outcome was the rates of attrition, completion of training and passing of the final SBNS examination. The impact of several trainee and training centre characteristics on the outcome were assessed by dividing the cohort into domains or groups based on the value of the median and comparing them statistically. The comparison was carried out using a chi-squared test with significance being achieved at P < 0.05.

Results Cohorts' Characteristics

Feature	Findings (%)		
Total number of trainees	115		
Median (range) age	25 (24- 32) years		
Median (range) year of graduation	2009 (2000- 2013).		
Median (range) year of starting training	2011 (2001- 2014)		
Median (range) duration from graduation	1 (1- 7) year		
Median (range) annual number of trainees	7(2- 21)		
Gender	Male: 91(79%), Female: 24(21%)		
Nationality	Saudi: 103(90%), Non-Saudi: 12(10%)		
Training Region	Central: 70(61%), Western: 27(24%), Eastern: 18(16%)		
Sponsoring Hospital	Ministry of Health Hospitals (MOHH): 32(28%)		
	King Fahad Medical City (KFMC): 20 (17%)		
	King Faisal Specialist Hospital (KFSH & RC): 19(17%)		
	University Hospitals (UH): 16(14%)		
	Prince Sultan Military Medical City (PSMMC): 14(12%)		
	King Abdulaziz Medical City (KAMC): 7(6%)		
	Unknown: 7(6%)		

Attrition Rates

The overall attrition rate was 33(29%). The rate of attrition to neurosurgery elsewhere and to non-neurosurgery were 16(14%) and 17(15%) respectively. The median (range) year of attrition was 2011 (2003-2014). The median (range) residency level at the time of attrition was R2 (R1-R5). The overall rate of completion of SBNS training was 82(71%). The median (range) duration of completion of training was 6 (6-9) years. The median (range) year of completion of training was 2017 (2007-2020). Trainees sponsored by University Hospitals compared to others had a statistically significantly higher rates of attrition to neurosurgery elsewhere (38% vs. 10%), and lower rates of attrition to non-neurosurgery (0% vs. 17%) (P=0.006). None of the other parameters (age, gender, nationality, GPA score, SMLE score, year of starting training, duration from graduation to starting and training region) reached significance.

Success Rates

The overall success rate in the SBNS final examination after completion of training was 61(74%). The pass rates on the first attempt and after the first attempt were 49(60%) and 12(15%) respectively. Success rates in the final examination for 82 residents who completed training were as follows:

Saudi Board in Neurosurgery Continued

Feature	Tota I Nu mbe r	Completed Training in 6 Years	Completed Training in > 6 Years
Completed SBNS Training Program	82	55(67%)	27(33%)
Passed SBNS final examination (all)	61	43(70%)	18(30%)
Passed SBNS final examination (first attempt)	49	36(73%)	13(27%)
Not passed SBNS final examination	21	12(57%)	9(43%)

The rate of passing another neurosurgery qualification among trainees who completed the SBNS training was 15/82(18%). The rate among those who attrited to neurosurgery elsewhere was 10/16(63%). The overall rate of passing another neurosurgery qualification was 25/98(26%). Four (4%) trainees had more than one other qualification. Trainees starting during the period 2011-2014 compared to those that started during 2001-2010 had a statistically significantly higher rates of passing the final examination on first attempt (68% vs. 51%) (P=.0.041). Furthermore, trainees sponsored by KFMC compared to others had a statistically significantly higher rates of passing the final examination on first attempt (92% vs. 54%) (P=.0.027). Conversely, trainees sponsored by MOHH had a statistically significantly higher rates of not passing the final examination (44% vs. 18%) (P= 0.041). None of the other parameters (age, gender, nationality, GPA score, SMLE score, duration from graduation to starting and training region) reached significance.

Discussion

We observed a relatively high attrition rate to neurosurgery elsewhere (14%) that was significantly higher among University Hospitals sponsored trainees (38% vs. 10%). This can be attributed to the active government-sponsored scholarship program that gave distinguished graduates the opportunity to train abroad. Also, to the Saudi universities' preference for their future faculty to acquire an international qualification

The overall pass rate in the SBNS final examination was 74% and first attempt pass rate was 60%. This was lower than the Canadian FRCS(C) (98% during 2017-2019) and lower than the American Board in Neurosurgery oral examination (81%-85% during 2017-2019). However, higher than the UK's FRCS(SN) (50% in 2017). First attempt pass rate of SBNS trainees was significantly impacted by being trained at certain hospital. The SBNS program is centralized, nevertheless trainees spend longer periods of training at their sponsoring hospital. It is possible that the lower performance of certain trainees may be related to the selection process. However, the variation could be a sign of the diverging standard of neurosurgical expertise provided by the various hospitals in KSA. This is not surprising as the regional and national unfair distribution of work force and workload in neurosurgery is recognized worldwide. We believe that the impact of the training hospitals on success rate in SBNS is something the program developers and trainers must address to avoid having a two-tier standard of graduates. A strict rotation system that allows trainees to spend equal periods of training at the major high-volume neurosurgical centres should be implemented.

There was a statistically significantly higher first attempt success rate among trainees who started SBNS training during 2011- 2014 compared to those that started during 2001-2010 (68% vs. 51%). The temporal changes in attrition and success rates are influenced by many factors such as competition ratio, selection policy, and the availability of overseas scholarship opportunities. However, it is possible that some of the superior success rates are attributed to progress in workload, work force and quality of training in the SBNS program.

The study has several limitations. Being retrospective, some of the data relating to age, GPA, and SMLE scores were incomplete. During the long study period, changes may have occurred in selection policy, training rotations, working conditions, scholarship opportunities and inclusion of new training hospitals which may have affected the outcome. The cohort had a diverse background relating to their medical degree hence the impact of the medical college on success rates could not be assessed. Trainees who completed training in 2020 and did not pass on the first attempt were considered as did not pass. The outcome was based on passing the SBNS examination, particularly on first attempt, which may not necessarily reflect the quality of training

Conclusions

SBNS attrition rate was high due to access to training opportunities abroad particularly for university-sponsored trainees. Success rate in the final examination was considered comparable to some other neurosurgical qualifications. First attempt pass rate was significantly impacted by being sponsored by certain hospitals. Trainees should spend equal periods of training at the major neurosurgical centres. Factors contributing to attrition and failure should be identified and addressed at the selection process and during training.

NEUROSURGICAL GUIDELINES

By Dr. Arwa Al Shamikh

Neurosurgery Resident

Summary of the Guidelines for Management of Idiopathic Normal Pressure Hydrocephalus (Third Edition)

Endorsed by the Japanese Society of Normal Pressure Hydrocephalus

Normal pressure hydrocephalus, first described by Dr. Hakim and Dr. Adams in 1965, is a syndrome of ventricular enlargement in the presence of normal intracranial pressure associated with the eponymous triad of gait disturbance, cognitive decline, and urinary incontinence. There are two variants, secondary NPH (sNPH) and idiopathic NPH (iNPH), the latter being more difficult to diagnose due to the multitude of differential diagnoses and similar imaging features as in cerebral atrophy. Diagnosis and treatment options are followed in a "stepwise" process in which NPH is further subdivided into suspected, possible, or probable NPH. Due to the complexity and variability of diagnosis and treatment decisions, the first clinical guidelines were published in 2004 to address these inconsistencies. The third edition of these guidelines was updated and published in 2021 to establish appropriate diagnostic criteria for identifying iNPH patients who are improving after CSF shunt and to promote higher clinical suspicion in the elderly. This issue also incorporated the new findings from several recent publications on this topic.

Table 1 Levels of evidence and recommendation grades

Recommended	
Suggested	
Strong	
Medium	
Weak	
Very weak	

Summary of Guidelines:

1). Clinical presentation and initial imaging data

- What methods are available to assess gait abnormalities characteristic of iNPH?

Gait abnormalities can be assessed using the iNPH Grading Scale (iNPHGS) and other quantitative methods such as the Timed Up & Go Test (TUG) and the Short Distance Straight Walking Test.

Recommendation grade 2, Level of Evidence C

- What methods are available to assess cognitive impairment in iNPH?

Recommended cognitive tests: MMSE, Wechsler Adult Intelligence Scale- III digit symbol encoding and symbol search tasks, and the frontal assessment battery Recommended memory test: Rivermead Behavioral Memory Test

Recommendation grade 2, Level of Evidence C.

Insufficient evidence to make recommendations for the assessment of urinary incontinence, psychological symptoms of dementia, and symptoms other than triad.

Neurosurgical Guidelines Continued

2) Brain imaging in iNPH

- What images are useful in assessing the characteristic findings of iNPH?

MRI images evaluating DESH (disproportionately enlarged hydrocephalus in the subarachnoid space) are specific iNPH findings with a high positive predictive value but a low negative predictive value.

Increase in callosal angle (< 900), an indirect index of DESH, is useful for predicting outcome after shunt. Recommendation grade 2, Level of Evidence C.

- Is it recommended to perform extended diffusion MRI in addition to standard MRI examinations in patients with suspected iNPH?

Characteristic findings include deep white matter and periventricular nerve fiber changes (leukoaraiosis) in the diffusion index and increased fractional anisotropy of the corticospinal tract.

Recommendation grade 2, Level of Evidence C.

- What are the characteristic nuclear medicine findings in iNPH?

SPECT findings include low blood flow in the anterior hemispheres and periphery of the sylvian fissure and increased blood flow in the higher cortical areas (CAPPAH, convexity sign, apparent hyperperfusion). Recommendation grade 2, Level of Evidence B

3) CSF testing: CSF sample, drainage test, and examination of CSF dynamics.

Do the CSF tap test and continuous drainage test have predictive therapeutic efficacy?

-The CSF tap test is useful for diagnosing iNPH and predicting the efficacy of shunt intervention Recommendation Grade 1, Level of Evidence B.

There is insufficient evidence that continuous drainage is better than the tap test.

- How soon after a CSF drainage test should the results be evaluated?

The CSF drainage test should be evaluated within 24 hours of CSF removal, with multiple evaluations within the first week. Improvement in gait is usually followed by improvement in cognitive ability and urinary incontinence, but there is insufficient evidence to determine the timing.

Recommendation grade 2, Level of Evidence C

- Are intracranial pressure monitoring and CSF dynamics testing useful in diagnosing iNPH and determining the indication for placement of a CSF shunt?

Monitoring intracranial pressure and evaluating CSF dynamics help determine indicators of a CSF shunt, including elevated basal CSF pressure, high B-wave frequency during sleep, and high CSF pulse waves.

A CSF infusion test showing high outflow resistance (Rout) indicates effective shunt intervention.

Recommendation grade 2, Level of Evidence C

- What CSF tests are useful for diagnosing iNPH and predicting prognosis?

Measurement of AB42, p-tau, and t-tau in CSF is useful for assessing Alzheimer's disease as a differential (iNPH patients have lower levels in CSF compared to healthy individuals).

Recommendation grade 2, Level of Evidence B.

Predicting the efficacy of shunt interventions can be correlated with measurement of AB42, p-tau, t-tau, neurofilament light chain, and leucine-rich $\alpha 2$ glycoprotein in the CSF, however, not highly specific or sensitive.

Recommendation grade 2, e Level of Evidence C

Neurosurgical Guidelines

4) Surgical treatment

- What surgical methods are most effective in relieving the symptoms of iNPH?
- CSF shunt is effective. No specific recommendation regarding the use of a VP shunt or LP.

Recommendation grade 1, Level of Evidence B

- What type of CSF shunt should be used in the treatment of iNPH?

The use of a programmable pressure valve is recommended.

An anti-syphon/gravity mechanism is recommended if overdrainage/hypotension is observed.

Recommendation Grade 1, Level of Evidence B

- What are the strategies to minimise shunt complications?

Preoperative preparation and planning and vigilance for shunt malfunction/infection/ overdrainage symptoms.

Recommendation grade 1, Level of Evidence C

Start with a high pressure and gradually lower it until clinical improvement occurs or symptoms of intracranial hypotension develop. Another approach is to adjust the initial pressure according to the weight/height and gender table.

Recommendation grade 2, Level of Evidence C.

 What are the short- and long-term outcomes of iNPH and what level of improvement can be expected for each symptom?

Surgery provides symptomatic improvement, but short-term outcomes are influenced by postoperative complications, disease severity and duration, CSF tap test response, and DESH imaging findings.

Long-term outcomes are influenced by the presence of other comorbidities. - Improvement in gait is most commonly observed, followed by improvement in cognitive abilities and urinary continence.

Recommendation grade 2, Level of Evidence C

 Is shunt placement for iNPH effective from a healthcare cost-effectiveness perspective?
 Yes, medically and economically effective.
 Recommendation grade 2, level of Evidence B

5) Postoperative management and prognosis

- How should initial pressure settings of programmable pressure valves be configured in iNPH patients?

Reference:

https://www.jstage.jst.go.jp/article/nmc/61/2/61_st.2020-0292/_article

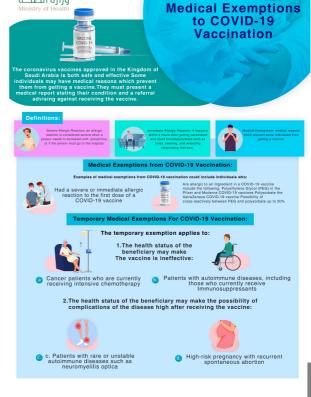


PUBLIC EDUCATION









وزارة الصحة

THE ARABIC CORNER

ألم العصب الخامس

العصب الخامس هو إحدى أعصاب القحفية الاثنى عشر و التي تنشأ من الدماغ أو جذع الدماغ. تعرف على أسبابها وطرق علاجها في المقال التالي.

> کتب بواسطة د / ندى النفيعي طبيبة مقيمة مدينة الملك فهد الطبية

يحمل العصب الخامس المعلومات الحسية من الوجه و الجيوب الأنفية و الأغشية المخاطية و الأسنان بالإضافة إلى المعلومات الحركية لعضلات

يتميّز اضطراب ألم العصب الخامس بنوبات حاده من الألم في واحد أو أكثر من فروع العصب الخامس الثلاثة و التي تغذي الجبهة, منطقة وسط الوجه و الفك (صورة ١).

تستمرالنوبات لمدة أقصاها دقيقتين و في بعض الحالات يكون ألم الوجه

الأعراض ؟

- ألم حاد و مفاجئ يشبه الصدمةٍ الكهربائية و في بعض الأحيان الحرق في جهة واحده من الوجه, و نادراً ما يصيب الجهتين.

- يمكن لنوبة الألم أن تستثار بالكلام و المضغ و تفريش الأسنان, والتعرض لنسيم اللهواء أو لمس الوجه في

> - تستمر النوبات لمدة تتراوح ما بين ثواني الى دقائق معدودة تعود بعدها وظائف العصب التي طبيعتها ويختفي الألم بين النوبات في أغلب الحالات.

الأسباب؟

- وجود شريان دموي ضاغط على جـذر الـعصب الـخامـس وهـو السبب الأكثر شيوعا في 80 إلى 90% من الحالات.
- ورم في التجويف الخلفي للجمجمة ضاغط على جذر .2 العصب أو أحد فروعه.
- الأمراض المزيله للميالنين مثال ذلك التصلُّب اللويدي.
- وجود تشوه أو تمدد وعائي دموي ضاغط. .4
 - مسبب مجهول.

عوامل تزيد من خطر الإصابة؟

- ألتقدم في العمر
- التصلّب أللويحي
- الإناث أكثر عرضة للإصابة من الذكور
- ارتفاع ضغط الدم إلا أنه لا يزال البرهان في دورة في الإصابة

التشخيص ؟

يشخص اضطراب ألم العصب الخامس سريريا حيث يعتمد التشخيص على التاريخ المرضي و الفحص السريري لوظائف

العصب و الأعصاب الأخرى ذو العلاقة. قد يلجأ الطبيب إلى طلب أشعة الرنين للتأكد من عدم وجود وعاء دموي أو ورم ضاغط.

العلاج؟ 1. العلاج الدوائي:

وهو الخيار العلاجي المبدئي حيث أثبتت الدراسات السريرية التجريبية بأن حوالي 75% من المصابين شعروا بتحسن كامل أو جزئي بعد استخدام أنواع معينه من مضادات الإختلاج/التشنج مثل کاربامازیبین و اوکس کاربزبین.

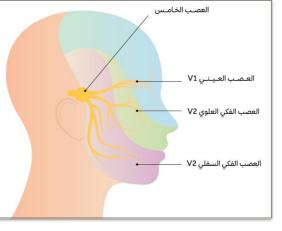
في حال فشلت مضادات التشنج في التحكم بالأعراض أو في حال اصبحت اثارها الجانبية غيرمستحمله فإن بعض الأدوية المرخية للعضلات مثل الباكلوفين أو حقن البوتوكس قد تستخدم في الحد أو

التخفيف من الأعراض. يستثنى من هذا المصابون بالتصلُّب اللويحي أو من لديهم ورم ضاغط على جذر العصب أو أحد فروعه حيث أن العلاج في مثل هذه الحالات يستهدف المسبب الرئيسي.

2.التدخل الجراحي لإزالة ضغط الشريان الدموي عن جذر العصب عن طريق إدخال بطانه فاصله بين الشريان و العصب. الجدير بالذكر هنا أن أهداف العملية و تفاصيلها قد تتغير و تتضمن استئصال العصب في حالات معينه و هو ما سيشرحه الجراح لك بالتفصيل عند أخذ موافقتك على

3.الجراحات الإشعاعية الموجهة إلى جذر العصب. إذ تعتبر أقل فعالية من الإجراء الجراحي و تقدم كخيار للمرضى الذين يرفضون الإجراء الجراحي أو لديهم ظروف صحية تمنع التدخل الجراحي أو التخدير العام.

- تدمير الألياف العصبية الناقلة للألم. يتضمن هذا الخيار العلاجي عدة إجراءات مختلفة تحمل مخاطر أعلى و مضاعفات قد تستمر لمدة طويلة مع احتمالية عودة اضطراب الألم.
- التحفيز العصبي إذ يعتبر علاج ناشئ نسبيا و لا يوجد برهان كافي لفعاليته إلا انه قد يقدم كخيار لعلاج الحالات المستعصية التي لم تستجيب لأي من العلاجات الدوائية أو الجراحية. في مثل هذه الحالات فإن المختصين في طب الألم قد ينضمون للفريق المعالج بهدف التحكم في الأعراض و تحسين جودة





ETHICS MATTERS

Medical ethics from bookshelves to hospital wards



By Professor Ahmed Ammar

King Fahd Hospital of the University | KFHU

Dammam

THE TASKS AND DUTIES OF NEUROSURGEONS-VALUES-BASED MEDICINE (1)

It has been my great pleasure and honour to receive a request to present the various aspects of medical ethics in a very practical way and to illustrate the implementation of ethical principles in our daily work. Indeed, ethics is an integral part and should be incorporated into every step of daily practice. In each issue, I will present a particular ethical issue that is very relevant to our work. To illustrate the ethical issue, I will present a real-life case. I would very much appreciate your questions and opinions. Open two-way discussion is very important to resolve many contentious issues. I thought it appropriate to present and of course discuss the ethics of our duties and tasks as the first topic.

1.1 Definition of the topic

There is general agreement on the duties and responsibilities of neurosurgeons as set forth in various neurosurgical codes, practice guidelines, and job descriptions. .

A neurosurgeon should provide the best possible care to his or her neurosurgical patients. It is essential for every neurosurgeon to update their knowledge and acquire new skills. In the field of neurosurgery, it is well known and accepted that following the guide of evidence-based medicine is the best way to help the patient choose the best treatment plan. To some extent, modern medicine evaluates and weights the various approaches according to or with reference to the results of evidence-based medicine.

The importance of finding and following evidence cannot be overstated, especially for young neurosurgeons or for a neurosurgeon who may be working alone in a remote area. Neurosurgeons are also required to adhere to the principles of medical ethics such as:

- A. Autonomy; the patient has the right to refuse or choose his treatment.
- B. Beneficence; we should act in the best interest of the patient.
- C. Non-Malfeasance; do no harm.
- D. Justice; the equitable distribution of health care resources and deciding who should be admitted, operated on, and treated first.
- E. Dignity; patients and treating medical and paramedical personnel have the right to be treated with dignity.
- F. Truthfulness and honesty between the patient and their treating medical personnel.

1.2 Analysis of current reality

Most neurosurgical training programs around the world insist that trainees master the skills required to find evidence for various neurosurgical problems. Young neurosurgeons tend to adopt ethics according to their own values and what they see and learn from teachers. Neurosurgeons are generally aware of ethical codes and patients' rights. Because of the principle of beneficence, the physician is first and

foremost obligated to build a relationship with the patient in order to understand their best interest. In order to apply the principle of beneficence, it is necessary to know and build a relationship with the patient. When discussing risks and benefits during informed consent, the neurosurgeon can gain valuable insight into the patient's culture and beliefs. Culture and beliefs play a critical role in the discussion of benefits and harms. A particular treatment may produce the best physical outcome but may cause irreparable psychological harm if it contradicts the patient's culture or moral beliefs. The neurosurgeon should assist the patient in weighing the pros and cons without exerting pressure or influence. Meaningful informed consent can only be achieved when autonomy and beneficence go hand in hand.

In almost all countries, medical graduates are required to take the Hippocratic Oath, or a variation of the Hippocratic Oath (Medical Oath), as the final step before officially qualifying as a physician or medical practitioner.

Illustrative cases

A 21-year-old male patient was admitted to the hospital unconscious, GCS 4, intubated, with an 8-cm wound in the left tempo-parietal region and evidence of a comminuted fracture in the left tempo-parietal region. According to CT, the patient underwent emergency surgery to elevate the comminuted fracture and remove the associated ICH, closing the dura and wound. The patient was kept in the intensive care unit for 32 days. He did not progress well. He developed post-traumatic hydrocephalus, so a V-P shunt was placed. A few weeks later, the patient made limited progress and began breathing through a tracheostomy and exhibited grade 3 movements on the left side. He was transferred to a special care room where he was evaluated by the neurosurgical team (resident and specialist). The patient's father and family were informed about the details of the case and the expected unfavourable outcome. The specialist visited once or twice a week and met with the father several times. The father complained to the hospital administration that the consultant did not visit his son every day.

Ethical approach in this case

Families of patients who are in a serious condition, especially long-term stays, are exposed to tremendous stress that can lead to post-traumatic stress disorder and is certain to cause anxiety and an altered mental state. It is important for the treatment team to be understanding and compassionate and to pay special attention to these families. It is recommended that meetings and treatment be arranged with psychologists or even psychiatrists. Unfortunately, some of them refuse this recommendation. The

neurosurgeon has a duty to give enough attention and care to these families. The reaction of patients and their families to bad news may vary depending on their cultural background. It is therefore recommended that the treatment team be aware of the patient's cultural background and consider it as one of the elements in developing a strategy for dealing with this particular patient.

The principle of beneficence dictates that the neurosurgeon should establish good communication with the patient in order to identify and understand the patient's needs and act in the patient's best interest. This communication usually begins when the patient first appears in the neurosurgery department, either in the outpatient clinic or in the emergency department and trauma unit. Good communication should be improved during the patient's stay in the hospital. This communication is based on face-to-face conversation. On discharge, the patient should always be given a follow-up appointment in the outpatient clinic. The date of the appointment depends on several factors, such as: a. the clinical condition and the need for adjuvant treatment; b. the availability of appointments within the hospital; c. the allotted time for outpatient clinics. It is understandable that some patients become anxious and want an earlier appointment.

It is impossible for a neurosurgeon to be available all the time to answer his patients' calls. The principle of justice as one of the most important principles of medical ethics can be used to resolve this conflict.

It is important that the attending neurosurgeon spend sufficient time with the patient before discharge to explain the possible course of recovery and any complications or new complaints, and to describe clearly what the patient should do in such situations. It is also helpful to set up a system that routes patient calls to the neurosurgeon's secretary or to the neurosurgeon on duty.

In cases of unexpected complaints that require an urgent hospital visit, the patient may find his/her way to the emergency room, where the neurosurgeon on call can examine him\her. Different patients' attitudes toward their serious medical problems may vary depending on their culture and beliefs. The neurosurgeon should be aware of this and show respect for the patient's culture and beliefs.

1.5 Communication

In a busy neurosurgical service, it is helpful to have a member of the patient relations staff act as a liaison between the patient and the neurosurgeon. Rather than patients contacting the neurosurgeon individually, the administrator can address multiple patients' complaints and concerns about appointment scheduling and lack of direct communication in a meeting with the neurosurgeon.

1.6 Pearl

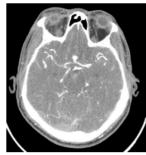
Good communication, including multiple lines of communication, is essential for monitoring the patient's clinical condition and for early intervention in emergencies. Good communication builds a strong foundation of trust and partnership with the patient and family to win the battle against the patient's disease. The neurosurgeon should show compassion and understanding for the cultural differences of the patient and his family, as this is an important part of the treatment strategy.

CLINICAL CHALLENGE

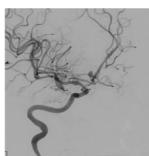


By Dr. Mohammed BafaquhKing Fahad Medical City | KFMC
Riyadh









46-year-old male, right-handed, and smoker. Police report: Developed headaches, neck pain (meningismus), nausea, and vomiting while driving, followed by loss of consciousness. Upon arrival to the ER his GCS 13 and agitated. Patient seemed that his vision is decreased. Patient is intubated by the ER team.

Question: 1

The best description of images above?

- A. There is a diffuse subarachnoid hemorrhage and moderate vasospasm.
- B. There is cortical hypodensity in the frontal lobes and mild vasospasm.
- Two aneurysms can be seen (Acom and ICA bifurcation aneurysms)
- D. None of the above.

Question: 2

Which one of the following is correct?

- E. The Hunt and Hiss for this patient is 3
- F. The Modified Fisher scale in this case is 3.
- G. World Federation of Neurological Societies grade 2.
- H. All of the above.

Question: 3

All of the following syndromes can be associated with Subarachnoid hemorrhage **EXCEPT**:

- A. Ehlers-Danlos syndrome.
- B. Pseudoxanthoma elasticum.
- C. Polycystic kidney disease and
- D. Neurofibromatosis type II.

Question: 4

What statement is correct in regard to the Sentinel hemorrhage.

- A. It usually takes place within 1–5 days prior to SΔH
- B. It is reported in 30-50% of patients with SAH.
- C. It is usually present as a mild bleed.
- D. Visual field disturbance is a typical sing.

Ouestion: 5

Which statement is **not correct** in regard to aneurysmal rupture and Cranial nerve palsies:

- A. PCOM; CN III.
- B. Basilar; CN VI.
- C. Acom; optic nerve and optic chiasm.
- D. Cavernous ICA; CN III, IV, V and VI.

Question: 6

The rate of rebleeding in this patient is:

- A. 4.1% in the first 24 hours.
- B. 2% daily in the first five days.
- C. 1% in the first 24 hours.

Question: 7

In regard to the first segment of the anterior cerebral artery, which of the following is correct?

- A. It is located under the anterior perforated substance.
- B. It is lateral to the optic tract.
- C. It is located in front of the lamina terminalis.
- D. It is the most common origin of the Recurrent Artery of Heubner.

RESIDENT'S CORNER

Neurosurgery Trainee Research Collaboratives: The British experience

By Dr. Aimun Jamjoom Royal Infirmary of Edinburgh | UK

ST8 Trainee in Neurosurgery, Royal Infirmary of Edinburgh Edinburgh, UK

Clinical research in neurosurgery has a long and rich history. However, because it is a small discipline, there are challenges to conduct large, powerful clinical trails. Collaboration at both a national and international level is essential to ensure that trials recruit sufficient patients and that the results are generalisable on a global scale. The United Kingdom (UK) neurosurgical community has a long-standing track record of conducting high-quality, practisechanging clinical research studies. This success has been made possible by close collaboration between the various neurosurgical departments and between clinicians and clinical scientists at all levels of leadership. Key UK-led randomised controlled trials (RCTs) include the British Aneurysm Nimodipine Trial (1989), the International Subarachnoid Aneurysm Trial (2002), the STICH Trial (2005 and 2013) and more recently the RESCUEicp Trial (2016), BASICS Study (2019), Dex-CSDH Trial (2020) and the NERVES Trial (2021).

The involvement of neurosurgery trainees has had a positive impact on the design, set-up and delivery of many of these successful trials. To promote a culture of collaboration and enhance the research experience of trainees, the British Neurosurgical Trainee Research Collaborative (BNTRC) was established in 2012 under the auspices of the Society of British Neurological Surgeons (SBNS) and the British Neurosurgical Trainees Association (BNTA). It was inspired by the success of the West Midlands Research Collaborative, a collaborative research group led by general surgery trainees that designed, funded and delivered a randomised controlled trial ahead of schedule.

The BNTRC model involves 2-3 trainees taking the lead for each study. For prospective observational studies, these leaders coordinate a study management committee that usually includes consultants (attendings) as well as trainees. Each neurosurgical unit has local



trainees and consultant leaders, as well as local staff responsible for centre set-up, recruitment, and/or data collection (Figure 1). The leaders of each project form a central BNTRC committee. From this committee, a chairperson is elected to lead the entire organisation for one year. This rotation ensures a constant exchange of new ideas for the organisation.

The BNTRC initially focused on prospective observational cohort studies using only routinely clinically collected data. These studies examined conditions or procedures predominantly treated by trainees, namely chronic subdural haematoma (CSDH) and external ventricular drains (EVDs). The multicentre studies recruited large cohorts, 1205 patients in the CSDH study and 452 patients in the EVD study. The trials were conducted under the umbrella of clinical audit and performance evaluation and were approved at each participating hospital.

Neurosurgery Trainee Research Continued

They have fulfilled a number of important roles. First, they have provided evidence that a national network can be established and that it is possible to conduct multicentre trainee-led trials within the UK neurosurgery framework. Second, they have identified practise variations and factors associated with key outcome measures, which has provided useful information for both cohorts for subsequent randomised clinical trial proposals and funding applications.

Since then, more complex study designs have been introduced in the form of prospective observational studies with patient-reported outcomes. These studies, involving cauda equina syndrome and Chiari-1 malformations, have demonstrated the ability of the organisation and study teams to manage the national

ethical review process and provide the infrastructure for reliable recording of patient-reported outcomes. The cauda equina syndrome study is also an example of multidisciplinary collaboration as cauda equina syndrome is treated by both neurosurgical and orthopaedic surgeons in the UK and both specialties and professional organisations were involved in the design, data collection and analysis.

The BNTRC has also played a central role in the design and conduct of two large randomised controlled trials - the Dex-CSDH and the Rescue-ASDH trials. Several members of the BNTRC were part of the co-applicant team and played a central role in writing the protocols, securing funding, recruiting patients, and writing the main manuscripts (Rescue-ASDH is yet to be

published). In particular, the Dex-CSDH study has been hailed as a major step in the trainee collaboration 'movement' in the UK, being the first RCT by a trainee collaboration to be published in the New England Journal of Medicine.

The BNTRC model of trainee-led collaborative research, which has produced important research projects in the UK over nearly a decade, has now been emulated in other countries, e.g. Canadian Neurosurgery Research Collaborative. Encouragingly, Saudi Arabian neurosurgical trainees have also collaborated on a joint study investigating external ventricular drainage.

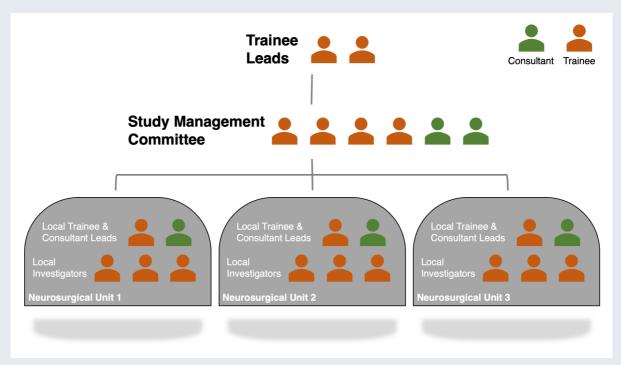


Figure 1: Structure of BNTRC study team (taken from Chari et al, 2018)

RESIDENT'S CORNER

Neurosurgeons Are Made, not Born

By Dr. Turki ElarjaniUniversity of Migmi Miller LUSA

Half an hour has already passed!

I look at my dive watch to check the amount of oxygen remaining and my current depth.

Diving requires detailed planning and precise execution. When preparing for a dive, careful consideration must be given to the dive site, the maximum dive depth, and the anticipated time one will spend underwater. During the dive, divers simultaneously adjust their buoyancy and oxygen consumption underwater, exploring the unknown with a calm and passionate attitude.

Similarly, neurosurgery requires meticulous preoperative planning of the surgical anatomy, approach, and surgical instruments to be used. Neurosurgery requires a calm and confident demeanour to execute the surgical plan and face unexpected events with a calm and passionate attitude.

As a high school student, I always thought that surgeons were naturally gifted or gifted by God and knew how to operate from the start. We tend to forget the steep mountain that surgeons climb "behind the scenes" to master their specialty. We have all had to face our own challenges that have expanded our learning arsenal, and we continue to evolve.

Active learning during residency is key to achieve safe and successful neurosurgeon status. Active learning



techniques include: noting (and drawing) surgical nuances of different attendings in your notebook, reverse engineering a neurosurgery role model, and continually developing skills in the cadaver club.

Residents should not make excuses during training, such as "we do not have a lab for training." A resident can simply buy a \$400 microscope and train by dissecting grapes, eggshell membranes, chicken wings, and

silicone tubes (which mimic bypass procedures). This is how you develop your microsurgical skills. An article published by a good friend, Josh Abecassis, in the Journal of Neurosurgery shows you how to make your own surgical microscope

to use at home. Remember, you are responsible for your own education. So take responsibility and do not blame external factors for your shortcomings. It is never too late to do anything. You can achieve what you desire if you are fully committed to success. Learning neurosurgery can be like other professions, such as scuba diving mentioned above. You can certainly use the skills acquired in other professions/sports to maximise your efficiency.

4

Neurosurgeons are made through resilient and unprecedented active learning, not born with skills.



RESIDENT'S CORNER

CERTIFICATES OF PARTICIPATION

For Residents

Our editorial board members have issued Certificates of Contributions for residents, who contributed to our newsletter in May 2021 issue.





CLINICAL CHALLENGE

The Answer

Question: 1

The best description of the images?

- A. There is a diffuse subarachnoid hemorrhage and moderate vasospasm.
- **B.** There is cortical hypodensity in the frontal lobes and mild vasospasm.

CT scan showed a Gyrus rectus "cortical" hypodensity and in the CTA/DSA images there are clear mild vasospasm.

- C. Two aneurysms can be seen (Acom and ICA bifurcation aneurysms)
- D. None of the above.

Question: 2

Which one of the following is correct?

- E. The Hunt and Hiss for this patient is 3
- F. The Modified Fisher scale in this case is 3.
- G. World Federation of Neurological Societies grade 2.
- H. All of the above.

H&H grade 3 (Drowsiness, confusion, or mild focal deficit), Modified Fisher scale: grade 3 (Focal or diffuse thick (>1mm) SAH, no IVH), and WFNS grade 2 (Glasgow coma score 13 to 14, no motor deficit).

Question: 3

All of the following syndromes can be associated with Subarachnoid hemorrhage **EXCEPT**:

- A. Ehlers-Danlos syndrome.
- B. Pseudoxanthoma elasticum.
- C. Polycystic kidney disease and
- **D. Neurofibromatosis type II.** NFI; not NFII.

Question: 4

What statement is correct in regard to the Sentinel hemorrhage.

- A. It usually takes place within 1–5 days prior to SAH.
- B. It is reported in 30–50% of patients with SAH.

 The Sentinel

hemorrhage (warning) is reported to occur in 40–50% of patients with SAH, is usually noted within 2–8 weeks prior to SAH, and not necessary associated with small or bleed; it could be related to the sudden enlargement of the aneurysm (stretched wall). It has no specific association with any neurological deficit.

- C. It is usually present as a mild bleed.
- D. Visual field disturbance is a typical sing.



CLINICAL CHALLENGE

The Answer

Question: 5

Which statement is **not correct** in regard to aneurysmal rupture and Cranial nerve palsies:

A. PCOM; CN III.

B. Basilar; CN VI.

The abducens nerve originates from the ventral portion of the pons. It attends a ventral course and leaves the brainstem in the pontomedullary sulcus. In the cistern it has an anterior and superior trajectory, before it travels and passes through the petrous portion of the temporal bone (through the Dorello's canal, between the petroclinoid ligament "Gruber's ligament"), then entering in the cavernous sinus.

The abducens nerve is part of the middle neurovascular complex that includes the anterior inferior cerebellar artery (AICA), pons, and middle cerebellar peduncle.

- C. Acom; optic chiasm.
- D. Cavernous ICA; CN III, IV, V and VI.

Question: 6

The rate of rebleeding in this patient is:

A. 4.1% in the first 24 hours.

Case review and prospective cohorts have shown that the natural history of untreated, ruptured aneurysms, is at least a **3% to 4%**

risk of rebleeding in the first 24 hours—and possibly significantly higher—with a high percentage occurring immediately (within 2 to 12 hours) after the initial ictus, a 1%/day to 2% /day risk in the <u>first month</u>, and a long-term risk of 3% per year after 3 months. 50% in the first week. (Class 1, level B; evidence)

- B. 2% daily in the first five days.
- C. 1% in the first 24 hours.

Question: 7

In regard to the first segment of the anterior cerebral artery, which of the following is correct?

A. It is located under the anterior perforated substance.

- The first segment of the anterior cerebral artery (ACA: A1) is located under the anterior perforated substance, lateral to the optic chiasm. The recurrent artery of Heubner often arising from the A1-A2 junction (44%) or the proximal A2 segment (43%), and much less commonly from the A1 segment.
- B. It is lateral to the optic tract.
- C. It is located in front of the lamina terminalis.
- D. It is the most common origin of the Recurrent Artery of Heubner.



NEUROSURGERY COMMUNITY

LATEST NEWS



Moroccan neurosurgeon Najia El Abbadi elected President of the World Federation of Neurosurgical Societies

Dr Najia El Abbadi, a Moroccan neurosurgeon, has been elected president of the World Federation of Neurosurgical Societies (WFNS) for 2021-2023.

El Abbadi received 127 votes (50.4%) in the second round of elections for the WFNS presidency.

Dr. Najia El Abbadi has been a professor and head of the Department of Neurosurgery at Cheikh Zaid Hospital since 2016.

She is Chair of the Department of Surgery at Abulcasis University of Health Sciences in Rabat. Professor El Abbadi is the head of the Stretacitic Programme at the Faculty of Medicine in Rabat. Her interests include skull base, stereotactic, functional and spine surgery. She is the author of more than 100 scientific publications in international and national journals, as well as chapters in books of neurosurgery and more than 500 lectures and presentations in

international and national congresses. She is the editor-in-chief of the Moroccan Journal of Neurosurgery.



Professor El-Ghandor was elected as WFNS Treasurer

Dr. Nasser El-Ghandour is a Professor of Neurosurgery at the Faculty of Medicine, Cairo University. He is the Chairman of the Committee for the Promotion of Neurosurgery, High Council of Universities, Egypt.

He is president of the Egyptian Society of Neurological Surgeons (ESNS) and current treasurer of the World Federation of Neurosurgical Societies (WFNS).

Dr. El-Ghandour's clinical interests include hydrocephalus, intraventricular and intracranial cysts.

He has lectured extensively at international congresses, published numerous articles in peer-reviewed international journals, and authored five book chapters on intracranial endoscopy and skull base surgery.

NEUROSURGERY COMMUNITY



Congratulations to Dr. Abdullah Alobaid on completing his fellowship!

Dr. Abdullah Alobaid is a consultant neurosurgeon at King Fahd Medical City (KFMC). He completed his undergraduate medical degree at King Saud University then completed his neurosurgery residency at McMaster University. Dr. Alobaid recently completed a cerebrovascular/endovascular neurosurgical fellowship at Swedish Medical Centre in Seattle, Washington, USA.

Dr. Alobaid's special interest areas include Skull Base, Cerebrovascular surgery, Neuro-Oncology, and Upper Cervical spine.



Professor Saleh Baeesa Named Editor-in-Chief of Spine Practice

Our congratulation to Professor Saleh Baeesa on his appointment as Editorin-Chief of Spine Practice by the Saudi Spine Society.

The Journal of Spine Practice (JSP) aims to promote spine care excellence by disseminating high-quality research in spine care.

Professor Saleh Baeesa is a consultan neurosurgeon at King Abdulaziz University Hospital (KAUH) and King Faisal Specialist Hospital & Research Centre – Jeddah (KFSH&RC).

OBITUARY



By Professor Ahmed Ammar King Fahd Hospital of the University | KFHU Dammam



Professor Samir El Molla 1945-2021



Professor Mohamed Lotfi 1945-2021

The neurosurgical family has lost two great neurosurgeons within a week (September 7 and 15, 2021). May Allah bless professors Samir El Molla and Mohammed Lotfi. They shared a long and noble journey and contributed significantly to the development of neurosurgery in Egypt and Arab and African countries. Both were gifted neurosurgeons and teachers and trained hundreds of neurosurgeons. Both were outstanding personalities, humble to the extreme and kept a confident smile even in very difficult times. Both have other talents for which they find time to develop.

Professor Samir became interested in acting at a certain stage of his life and wrote scripts for films and television series. His most famous role was in the famous series TV Rafatt El Hagan. By chance, I discovered that he was the founder of one of the most important Egyptian charities that distributed food, treated poor people for free and paid for

the education of more than 100 students and orphans from primary school to university and told them they would get married. He never talked about this big, hidden part of his life. When I found out and tried to talk to him about it, he was very upset and said we should not discuss this matter at all.

Professor Mohamed Lotfi was an active member of the Egyptian Society of Writers and Literatures, he wrote and published dozens of poems. I am sure he was involved in charity work, especially for the people of his home village and surrounding villages. He also gave important encouragement and perhaps more to Arab students and trainees, especially from Palestine, Sudan and Yamen. He also refused to talk about this good work.

Their neurosurgery experiences have been invaluable to us and have taught us a lot. Perhaps we should learn more from their lives, their dedication, and their willingness to always give.

May Allah reward them both



TWO NOBLE KNIGHTS



Professor Samir El Molla

Professor El Molla studied neurosurgery at Ain Shams University and received the FRCS (NS) from the University of Leeds, UK in 1972. For many years, he was Chairman of the Department of Neurosurgery at Ain Shams Hospital, Ain Shams University, Cairo. He was also President of the Egyptian Society of Neurosurgery for several years.



Professor Mohamed Lotfi

Dr. Mohamed Lotfi was Professor of Neurosurgery at Kaser Al Aini Hospital, Faculty of Medicine, Cairo University from 1980 to 2021.

He was also a member of the Egyptian Society of writers and Literature.

Professor Lotfi was Chairman of the Department of Neurosurgery for many years. He was also President of the Egyptian Neurosurgical Society for 4 years (1978-1982).

66

Great nations write their autobiographies in three manuscripts - the book of their deeds, the book of their words and the book of their art.

- John Ruskin-

What Our Readers Say!



Thank you @SansMed for your support of the young neurosurgeons community!









کر خاص

سعادة رئيس الجمعية السعودية لجراحة المخ والأعصاب. حفظه الله

السلام عليكم ورحمة الله وبركاة

يسرني بالأمسالة عن نفسي ونيابة عن كافة أسرة آل بردي أن أفقاهم لكم بخالص عبارات الشكر والعرفان والامتثار خاصة ولمهميع منسوبين الجمعية السعودية لمواشة الدخ والأعصاب لما قدمتوه من وقاء ومشاعر مسافقة من خلا ما قدمتم في مجلة الجمعية من نمازي وسيرة عطرة عن فقيننا التكثور فوك بن عبدالعزيز بردي، وكذلك بالإنساء

سائلين الله العلي القدير أن يكتب لكم الأجر والمثوبة، وأن يُسبغ عليكم وعلى ذويكم دوام الصحة والعافية.

وتفضلوا بقبول خالص الشكر والتقدير،،،

رئيس مجلس إدارة مجوعة الفؤاد لتنظيم المؤتمرات والمعارض



مهندس/ واتل بن عبدالعزبز بردی





رقم السجل التجار ي **4650027963** مدینة المنورة - طریق العوالی - مجمع البساتین
 https://me-events.meevent/ar



SANS ACADEMIC ACTIVITES

THE 4TH ANNUAL NEUROSURGERY RESIDENT TRAINING BOOT CAMP

September17-19, 2021

The 4th Annual Neurosurgery Resident Training Boot Camp was conducted virtually from September 17-19, 2021.

The boot camp was specifically designed for incoming residents in neurosurgery training programme. The aim of this course is to facilitate the residents' entry into residency training and to provide basic knowledge of the general aspects of the specialty and the key principles of the occurring and related pathologies.

The three-day course has been accredited by the Saudi Commission for Health Specialties (SCFHS). The regional programme directors of the Saudi Board of Clinical Neurosurgery Training Programmes have been invited.

The course director, Dr. Wisam Al-Issawi, welcomed all bootcamp participants and the Chairman of the Scientific Counsel of Neurosurgery, Professor Ahmed Alkhani, started the bootcamp with an introduction to residency training and gave a short keynote lecture on neurosurgery. At the end of the first day, a special session was held to introduce the residents, and two of the senior residents from the Saudi Board of Clinical



Neurosurgery Training Programme were invited to give pep talks to the new residents about the specialty and the training programme.

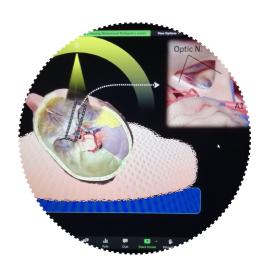
The bootcamp was led by a number of faculty members from different institutions who gave important lectures on various aspects of neurosurgery and patient care.

Twenty-nine participants attended the bootcamp, including an interested international neurosurgery resident.

At the end of the bootcamp, a special session was held to discuss clinical history taking and its importance with the participants.

THE 4TH ANNUAL NEUROSURGERY RESIDENT TRAINING BOOT CAMP

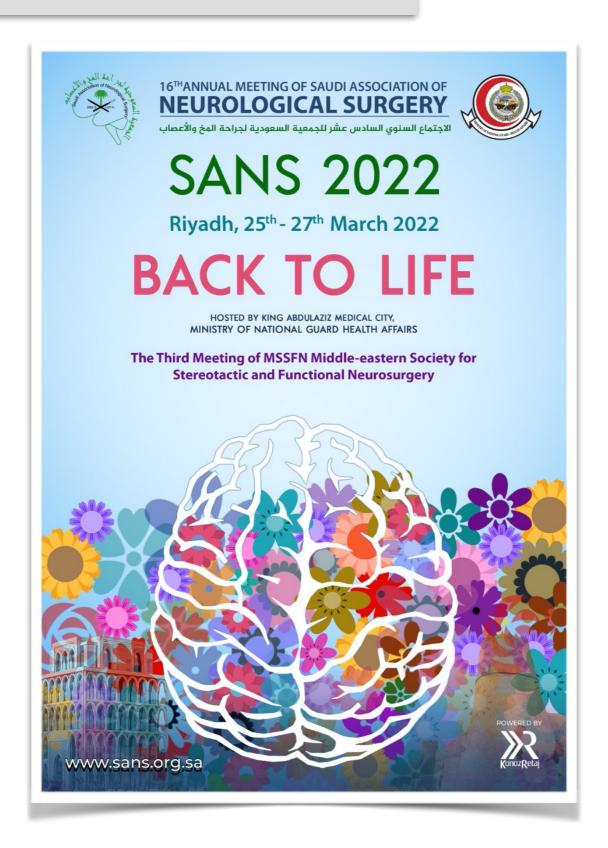
Pictures from THE EVENT







SANS UPCOMING EVENTS



Important Dates

Abstract Submission Deadline: January 1, 2022 **Early Registration Deadline:** February 1, 2022

SANS UPCOMING EVENTS



Please visit our website for further details.



LOCAL UPCOMING EVENTS





TARGET AUDIENCE

- Orthopedic Surgery
- Neurosurgery
- · Anesthesia, Pain Management
- Physical Medicine & Rehabilitation
- Radiology
- Neurology
- Rheumatology
- Physiotherapy
- Nursing
- Others









GUEST SOCIETIES























info@saudispine.org









UPCOMING EVENTS

Add these important dates to your calendar and plan to be a part of it.



• XVII WFNS World Congress of Neurosurgery - Bogota, Colombia: March.13-18, 2022

Learn more

• 16th Annual Meeting of The Saudi Association of Neurological Surgery (BACK TO LIFE)

March.25-27,2021

• EANS Congress - Belgrade, Serbia: OCTOBER, 2022

NEWSLETTER

Volume 2

Issue 4

SANS

Saudi Arabia

For more information ,you can reach us at:



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http://www.sans.org.sa



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articles and reviewing research. We always strive to make our newsletter more than just a newsletter by being informative and using them to serve the field of Neurological Surgery. We are always open to any ideas that will help us improve our newsletter.