

Introduction

Methods

nTMS

The image shows the Nexstim nTMS software interface. On the left, there is a 3D brain model with a green highlighted area on the left hemisphere. Below the model, there is a table with the following data:

Stimulus	Intensity	Duration	Frequency	Waveform	Stimulus	Intensity	Duration	Frequency	Waveform
1	32	1.1	14	22	2	32	1.1	14	22

On the right, there are four stacked waveforms showing the magnetic field strength over time. The top waveform is labeled 169µV and 15.3ms. The second waveform is labeled 677µV and 20.0ms. The bottom two waveforms are labeled 0µV and 0.0ms. The bottom status bar shows '3' and '54.5'.

Of the 11 patients 63% were High Grade Gliomas, 27% Low Grade Gliomas and 10% metastasis respectively. In 73% of patients a positive response with nTMS (either upper or lower extremity), correlated well with those generated by DCS. However, of these, the correlation in the upper extremity, alone was 91% (n=11) of cases, and 100% (n=5) in the lower extremity. In 3(36%) cases nTMS was superior to DCS in isolating the lower extremity response while in 1(10%) case DCS isolated the upper extremity response when nTMS failed. There were no adverse events to patients during the stimulation. The mean time for generating a preoperative nTMS map was 20 minutes.

A 3D pie chart illustrating the distribution of different brain tumor types. The chart is divided into five segments of varying sizes and colors. The largest segment is red, representing Anaplastic Astrocytoma (grade III). The second largest is blue, representing Glioblastoma (grade IV). The third largest is dark blue, representing Metastases. The fourth largest is green, representing Oligodendrogliomas (grade III). The smallest segment is purple, representing Low Grade Glioma (grade II). A legend to the right of the chart identifies each segment with a colored square and text.

Tumor Type	Grade	Approximate Percentage
Glioblastoma	grade IV	25%
Anaplastic Astrocytoma	grade III	35%
Oligodendrogliomas	grade III	10%
Low Grade Glioma	grade II	5%
Metastases		25%

Group	Number of Subjects
nTMS x DCS	80
upper	100
lower	110

Navigated transcranial magnetic stimulation (nTMS) can be safely used in the presurgical mapping of the motor cortex involving both the upper or lower extremity and the results correlate well with intraoperative direct cortical stimulation (DCS).

correlation between brain mapping by navigated transcranial magnetic stimulation and direct cortical stimulation

1. Petrella JR, Shah LM, Harris KM, Friedman AH, George TM, Sampson JH, Pekala JS, Voyvodic JT (2006) Preoperative functional mr imaging localization of language and motor areas: effect on therapeutic decision making in patients with potentially resectable brain tumors. *Radiology* 240(3):793–802;
2. Duffau H, Capelle L, Sichez J, Faillot T, abdenmour L, Law Koune JD, et al: Intra-operative direct electrical stimulations of the central nervous system: the Salpetriere experience with 60 patients. *Acta Neurochir (Wien)* 141:1157-1167, 1999;
3. Keles GE, Lundin DA, Lamborn KR, Chang EF, Ojemann G, Berger MS: Intraoperative subcortical stimulation mapping for hemispherical perirolandic gliomas located within or adjacent to the descending motor pathways: evaluation of morbidity and assessment of functional outcome in 294 patients. *J Neurosurg* 100:369–375, 2004;
4. Sanai N, Berger MS: Intraoperative stimulation techniques for functional pathway preservation and glioma resection. *Neurosurg Focus* 28(2):E1, 2010;
5. Picht T, Wachter D, Mularski S, et al. Functional magnetic resonance imaging and cortical mapping in motor cortex tumor surgery: complementary methods. *Zentralbl Neurochir.* 2008;69(1):1-6.;
6. Rutten GJ, Ramsey NF. The role of functional magnetic resonance imaging in brain surgery. *Neurosurg Focus.* 2010;28(2):E4.