第39回日本脳神経外科国際学会フォーラム

The 39th Japan Neurosurgical English Forum (JNEF)

抄録集

JNEF 2025

2025年8月1日（金）～8月2日（土）

会場：九段会館テラス
　　バンケットホール鳳凰

会長：荒木　尚
　　埼玉県立小児医療センター
　　外傷診療科　科長
　　埼玉医科大学総合医療センター
　　高度救命救急センター　客員教授

https://www.jnef2025.jp

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E-mail：event-medical@tkp.jp

第 39 回日本脳神経外科国際学会フォーラム

The 39th Japan Neurosurgical English Forum

JNEF2025

プログラム・抄録集

2025 年 8 月 1 日(金)・2 日(土)

九段会館テラス バンケットホール鳳凰

当番世話人・会長：荒木 尚

（埼玉県立小児医療センター 外傷診療科 課長／埼玉医科大学総合医療センター 高度救命救急センター 客員教授）

ご挨拶

2025 年 8 月 1 日（金）・2 日（土）の 2 日間、第 39 回日本脳神経外科国際学会フォーラム（Japan Neurosurgical English Forum；第 38 回日本脳神経外科同時通訳夏季研修会を併催）を、東京都千代田区、九段会館テラス（東京都千代田区）で開催いたします。真夏の 2 日間とはなりますが、多くの脳神経外科医が英語に触れ、英語を学び、英語で交流することの素晴らしさを体感できるような機会となるよう、心から祈念いたします。

日本人にとって英語は、政治経済の面においても、日常生活においても避けて通ることのできない外国語でありながら、その習得に心破れて夢をあきらめ、挫折の記憶ともに「苦手意識」のみが終生付きまとう、そういうマイナスのイメージを拭い去ることのできない異文化でもあります。一方、海外で成功を治めたスポーツ選手の隣には常に英語通訳が寄り添っている姿を見て、非英語圏の人間が話す言葉のニュアンスを確かにするためには通訳の支援を必要とするのか、、どれほど英語の奥は深いのだろうか、いつになれば英語を自由に使いこなして自分自身を表現し、国際社会の一員としてしなやかに交流することができるのだろうか、そういう思いを抱くこともしばしばあるのではないでしょうか。いま日本のあらゆる街にはインバウンドの海外旅行客が溢れ、インターネットでは英語の動画や情報が絶え間なく流れ、そして AI の登場により自動翻訳ツールが現れる時代になりました。もう英語学習は必要ない、そんな未来が語られることもあります。どうして日本人は英語を苦手としているのでしょうか、どうすれば英語を愛することができるのでしょうか。

日本脳神経外科国際学会フォーラムは、学会員による同時通訳団が運営し、各種学会・研究会において海外招待演者や留学生に円滑に討論に参加していただけるよう、脳神経外科医が通訳業務を行いながら、同時通訳の技術を学び、向上させる機会であります。と同時に、日本人の国際学会に於けるプレゼンテーション能力やグローバルな情報発信力を磨くという理念も高らかに掲げられ、これまで続けられて参りました。また、この会は英語学習の場としての役割に加え、専門分野を超えた脳神経外科医同士の交流の場としても、学会の歴史に大切に位置付けられてきた集まりであります。歴史は四半世紀ごとに改定されていく、という言葉があります。AI テクノロジーが台頭する 2025 年、時代の変革により既成概念がパラダイムシフトを迎えるいま、39 回目を迎える国際学会フォーラムでは、脳神経外科医が対峙する目前の課題を通して、連綿と続けられてきた先人の努力の歴史を振り返りながら、JNEF/SIGNS の未来を考えたいと思います。先人が遺した足跡を真摯に学び、そして、過去からのメッセージを胸に、未来への挑戦に覚悟して臨まなくてはなりません。

海外新興国の急速な経済成長の影響を受け、まるで経済大国日本がかつての幻想であったかのような悲観論が蔓延する現在の日本社会ですが、私たちがいま英語を学び、悠々と世界で活躍し、新たに作り上げたいという未来への期待と熱意は、あたかも黒船来航に揺れた幕末の時代にありながら、急速に国家を一致させ近代国家の樹立に奔走する若き侍たちの姿に重なるようでもあります。会場から九段坂を上り、靖國神社一の鳥居を超えますとすぐに、巨大な侍の銅像が目に入ります。写実的で動きのある銅像。袴姿で刀を携え草鞋を履いた左足は前へと乗り出し、険しい表情で左の上野方面を向いた「大村益次郎像」を見上

げると、近代国家建設に生きた当時の人々の決意が伝わるかのようです。この大村益次郎こそ、緒方洪庵の適塾に学んだ医師であり、また明治学院大学の学祖ヘボン氏に師事し、一心不乱に英語を学んだ幕末の志士でありました。会場から少し足を延ばして、夏の日差しを感じながら、彼の眼差しに、同じ医師として、私たちの夢も重ねて頂けたらと思います。

未来を支える人材の育成を通して、わが国の脳神経外科学の発展と、国際競争力を高めて世界の医療に貢献することを目指したフォーラムの理念を、九段の青空に改めて描き、有意義な学びの機会を提供したいと思います。

末筆ではございますが、皆様の益々のご繁栄をお祈り申し上げます。一人でも多くのご参加をお待ちしています。

2024 年 12 月

第 39 回日本脳神経外科国際学会フォーラム（JNEF）
第 38 回日本脳神経外科同時通訳夏季研修会（SIGNS）
当番世話人・会長　荒木　尚
埼玉県立小児医療センター 外傷診療科 課長
埼玉医科大学総合医療センター 高度救命救急センター 客員教授

日本脳神経外科国際学会フォーラム

名誉会員（23 名）

阿部　俊昭	池﨑　清信	伊藤　昌徳	植村　研一	亀山　元信	小林　茂昭
近藤　　威	佐伯　直勝	佐藤　　修	茂野　　卓	平　　孝臣	竹井　　太
伊達　　勲	中川　洋	西澤　　茂	藤井　清孝	藤巻　高光	細田　浩道
本郷　　博	松村　　明	松山　純子	水野　順一	三原　千恵	

運営委員（24 名）

赤井　卓也	荒木　尚	遠藤　俊毅	大宅　宗一	荻野　雅宏	黒川　　龍
近　　貴志	斉藤　敦志	坂田　勝巳	柴田　靖	下地　一彰	末永　　潤
太組　一朗	田中　將太	谷口　理章	徳川　城治	棗田　学	名取　良弘
西岡　　宏	原　　淑恵	樋口　佳則	村垣　善浩	安田　宗義	綿谷　崇史

敬称略 氏名 50 音順

次期開催のご案内

第 40 回日本脳神経外科国際学会フォーラム
第 39 回日本脳神経外科同時通訳夏季研修会
会長：原 淑恵
（兵庫県災害医療センター・神戸赤十字病院　脳神経外科）
会期：2026 年 7 月 3 日（金）・4 日（土）
会場：淡路夢舞台国際会議場（兵庫県淡路市夢舞台 1 番地）

本学会に関する問い合わせ

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埼玉県立小児医療センター 外傷診療科内
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jnef39jimu@gmail.com

SNEF／JNEF のあゆみ

	President	Place	Date
第 1 回	細田 浩道	大磯プリンスホテル	1993.8.26
第 2 回	工藤 忠	ホテルコスモ横浜	1994.3.31
第 3 回	大井 静雄	大磯プリンスホテル	1994.8.25
第 4 回	藤本 司	ホテルコスモ横浜	1995.2.17
第 5 回	津金 隆一	大磯プリンスホテル	1995.9.8
第 6 回	千葉 康洋	新横浜プリンスホテル	1996.3.15
第 7 回	山本 勇夫	大磯プリンスホテル	1996.8.30
第 8 回	藤井 清孝	ホテルコスモ横浜	1997.3.28
第 9 回	森井 誠二	大磯プリンスホテル	1997.9.5
第 10 回	桑名 信匡	ホテルコスモ横浜	1998.3.20
第 11 回	阿部 俊昭	湘南国際村センター	1998.7.31
第 12 回	伊藤 昌徳	東京赤坂ザ・フォーラム	1999.3.31
第 13 回	平 孝臣	東京赤坂ザ・フォーラム	1999.7.30
第 14 回	佐伯 直勝	東洋日本都市センター会館	2000.3.10
第 15 回	森本 哲也	かしはら万葉ホール	2000.8.4
第 16 回	中洲 庸子	ピアザ淡海	2001.7.27
第 17 回	西澤 茂	ヤマハリゾートつま恋	2002.7.19
第 18 回	伊達 勲	岡山コンベンションセンター	2003.7.18
第 19 回	宝金 清博	札幌コンベンションセンター	2004.7.16
第 20 回	本郷 一博	長野県松本文化会館	2005.7.15
第 21 回	松村 明	つくば国際会議場	2006.7.21
第 22 回	佐伯 直勝	かずさアカデミアホール	2007.7.20
第 23 回	伊藤 昌徳	ホテルオークラ東京ベイ	2008.7.18-19
第 24 回	水野 順一	長良川国際会議場	2009.7.10
第 25 回	藤巻 高光	大宮ソニックシティ	2010.7.23-24
第 26 回	池崎 清信	ヒルトン福岡シーホーク	2011.7.22-23
第 27 回	赤井 卓也	石川県立音楽堂	2012.7.27-28
第 28 回	坂田 勝巳	横浜シンポジア	2013.7.26-27
第 29 回	村垣 善浩	学術総合センター	2014.7.25-26
第 30 回	近藤　威	淡路夢舞台国際会議場	2015.7.24-25
第 31 回	名取 良弘	嘉穂劇場	2016.7.22-23
第 32 回	荻野 雅宏	大宮ソニックシティ	2017.7.14-15
第 33 回	西岡　宏	一橋講堂	2018.7.20-21
第 34 回	太組 一朗	川崎市国際交流センター	2019.7.26-27
第 35 回	谷口 理章	淡路夢舞台国際会議場	2021.11.12-13
第 36 回	柴田　靖	つくば国際会議場	2022.7.22-23
第 37 回	近　貴志	パシフィコ横浜会議センター	2023.7.28-29
第 38 回	樋口　佳則	一橋講堂	2024.7.19-20

第1回から第10回までは、SNEF; Shonan Neurosurgery English Forum と称した
2020年度は新型コロナ感染症の影響で延期となった

歴代 Summary's Award 受賞者

		Winner	所属（受賞時）
第11回		木暮 太郎	東京慈恵会医科大学
第12回		美馬 達夫	高知医科大学
第13回		小山　徹	信州大学
第14回		石原正一郎	防衛医科大学
第15回	Senior	西澤　茂	浜松医科大学
	Junior	長島　久	信州大学
第16回	Senior	常喜 達裕	東京慈恵会医科大学
	Junior	藤井登志春	富山労災病院
第17回	Senior	赤井 卓也	金沢医科大学
	Junior	福住 曜子	東京慈恵会医科大学
第18回	1位	近藤　威	神戸大学
	2位	松山 純子	別府リハビリテーションセンター
	3位	安田 宗義	日立製作所水戸総合病院
第19回	1位	藤巻 高光	帝京大学
	2位	安田 宗義	日立製作所水戸総合病院
	3位	小股　整	新潟市信楽園病院
第20回	1位	安田 宗義	日立製作所水戸総合病院
	2位	藤本 礼尚	西新潟中央病院
	3位	森本 哲也	大阪警察病院
第21回	1位	Adam Tucker	西宮協立脳神経外科病院
	2位	水野 順一	愛知医科大学
	3位	大須賀　覚	筑波大学
第22回	1位	太組 一朗	日本医科大学千葉北総病院
	2位	廣野誠一郎	千葉大学
	3位	下地 一彰	順天堂大学練馬病院
第23回	1位	徳川 城治	順天堂大学
	2位	大宅 宗一	東京大学大学院医学系研究科
	3位	秋山 雅彦	富士市立中央病院
第24回	1位	Nunung Nur Rahmah	信州大学
	2位	遠藤 俊毅	東北大学
	3位	菊池 陽一郎	岡山大学
第25回	1位	遠藤 俊毅	東北大学
	2位	菊池 陽一郎	岡山大学
	3位	中村　聡	国際医療福祉大学
第26回	1位	大原 信司	福岡山王病院
	2位	近　貴志	新潟県立中央病院
	3位	下地 一彰	順天堂大学
第27回	1位	棗田　学	新潟大学
	2位	大宅 宗一	埼玉医科大学総合医療センター
	3位	中村　聡	国際福祉大学三田病院
第28回	1位	山下 麻美	鹿児島大学
	2位	Alexander Zaboronok	筑波大学
	3位	東田 哲博	小田原市立病院

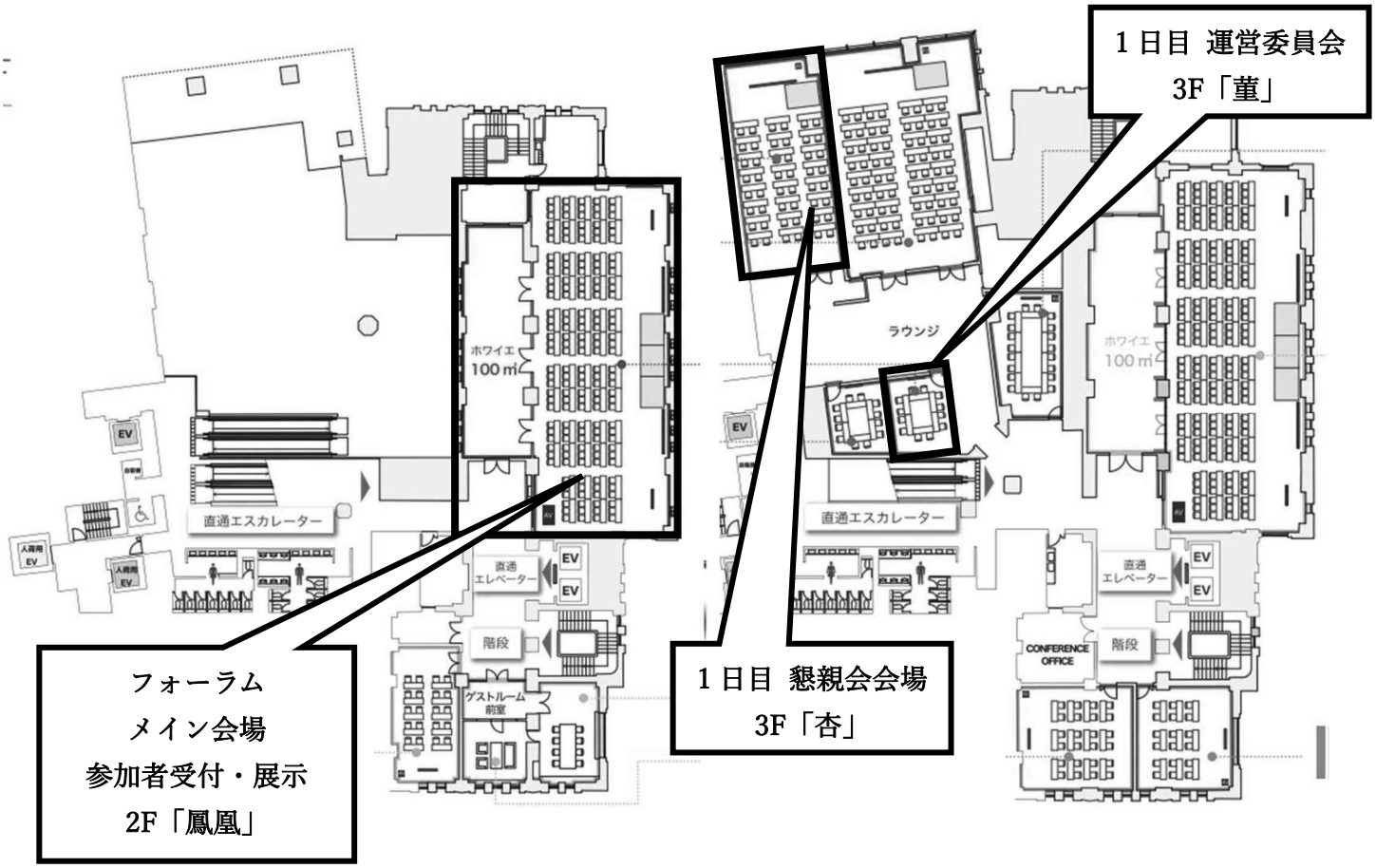
		Winner	所属（受賞時）
第29回	1位	田中 將太	東京大学
	2位	遠藤 俊毅	東北大学
	3位	荻野 雅宏	獨協医科大学
第30回	1位	大宅 宗一	埼玉医科大学総合医療センター
	2位	藤巻 光太郎	京都大学
	3位	荻野 雅宏	獨協医科大学
第31回	1位	下地 一彰	順天堂大学
	2位	丹羽 良子	埼玉医科大学総合医療センター
	3位	松原 鉄平	九州大学
第32回	1位	Alexander Zaboronok	筑波大学
	2位	綿谷 崇史	静岡県立こども病院
	3位	赤星　南	筑波大学
第33回	1位	松橋 阿子	国立成育医療研究センター
	2位	綿谷 崇史	静岡県立こども病院
	3位	折口 槙一	千葉大学
第34回 (2019)	1位	末永 潤	横浜市立大学
	2位	木下 裕介	中村記念病院
	3位	大倉 英浩	順天堂大学浦安病院
第35回 (2021)	1位	我那覇 さら	国立病院機構静岡医療センタ
	2位	胡谷 侑貴	岡山大学大学院脳神経外科
	3位	Alexander Zaboronok	筑波大学
第36回 (2022)	1位	三木 俊一郎	筑波メディカルセンター
	2位	朴 穂貞	横浜市立大学
	3位	髙橋 満里菜	埼玉医科大学総合医療センター
第37回 (2023)	1位	平田 容子	東邦大学医療センター大橋病院
	2位	木村 英仁	神戸大学
	3位	高木 悠輝	順天堂大学医学部附属静岡病院
第38回 (2024)	1位	中冨 浩文	杏林大学
	2位	平田 容子	東邦大学医療センター大橋病院
	3位	Haolan Yang	筑波大学

会場：九段会館テラス バンケットホール鳳凰

〒102-0074 東京都千代田区九段南 1 丁目 6-5　九段会館テラス 2 階・3 階

アクセス　https://www.tokyokudan.com/access/

九段下駅／東京メトロ半蔵門線・東西線・都営新宿線「九段下」駅 4 番出口より徒歩 1 分



ご案内

1．　参会受付

九段会館テラス 3 階「鳳凰」前ホワイエにて、8 月 1 日(金)午前 8:20 より受付を開始します。

事前に参加申込をいただきました Event Planner（https://event.event-planner.net/event/5fuugppt）のマイページより当日参加用 QR コードをご準備の上、本会の参加受付を行ってください。

参加費につきましては、上記参加受付申込の際に全てクレジットカード決済としております。当日会場内で現金でのお支払いはいただけません。

参加費区分：

① JNEF ＋ SIGNS ＋ 懇親会	20,000円
② JNEF ＋ SIGNS	15,000円
③ JNEF ＋ 懇親会	15,000円
④ SIGNS ＋ 懇親会	10,000円
⑤ JNEF のみ	10,000円
⑥ SIGNS のみ	5,000円
⑦ 懇親会 のみ	5,000円

●本会とは異なる学会年会費のお支払い（￥2,000）につきましては、同フロアに学会デスクの設置がございますため、別途現金にてお支払いはいただけます。

●領域講習の単位取得の受付は、同フロアに領域講習単位受付デスクの設置がございますため、会員カードをデスクの IC カードリーダーにお通しをお願いします。

2．　JNEF 演者の皆様へ

- スクリーン 1 面、ご連絡した発表時間にてご準備ください。プログラムの進行がございますため、時間厳守でお願いします。
- スクリーンサイズは 16：9 になります。
- データは事前に事務局サポート（jnef39jimu@gmail.com）までメールでお送りください。
  演台で準備している PC は Windows10 の Power Point2010 になります。
- OS 標準フォント（MS ゴシック、Arial など）をご使用ください。Power Point の発表者ツールは使用できません。
- Mac PC で発表される場合や、発表内で動画をご使用になる場合には、ご自身の PC をお持ちください。通常の学会同様、モニターは HDMI にのみ対応しています。必要に応じて変換ケーブル／コネクタをご準備ください。併せて、必ず電源アダプターをご持参ください。

- プレゼンテーション内に他のデータ（静止画、動画、グラフ等）をリンクさせている場合には、リンク先の元データも同一フォルダにコピー・保存し、作成した PC とは別の PC（Windows10）にて事前に動作確認をお済ませくださいますようお願いします。
- 発表時はレーザーポインターではなく、マウスを使用してください。
- データやメディアは、最新のウイルス駆除ソフトでチェックしてからお持ちください。お預かりしたデータは、学会終了後に責任を持って消去いたします。
- 発表の後、フロアやコメンテーターからの質問やコメントに対応してください。（ここまでは普通の学会と同様です）その後、プレゼンテーションについての講評を受けます。厳しい指摘があっても、どうかめげないでください。
- 今回のウェブサイトにある「参考資料集」から『檀上に立つ前のチェックリスト』をダウンロードし、準備にお役立てください。

3． ディスカッサントの皆様へ

2 分程度で 1 つ以上の質問をお願いします。この目的は、発表者になにかアドリブでのディスカッションを引き出すことにあります。もちろん、ディスカッション対応能力も採点対象です。手際よくお願いします。

4． 座長、Moderator の皆様へ

セッションごともアナウンスはありませんので、時間になりましたら開始してください。
各演題終了後に Discussant、floor からの質問を受けて、座長からも質問があればお願いします。

5． Sammy’s Award

それぞれの発表は、Scientific value, English ability, Presentation manner の 3 つのポイントで評価され、最優秀発表者には、Sammy’s Award が贈られます。（授与式は 2 日目の最後に行います）。周到に準備され、頂点を目指してください。講演時間の超過には減点が課されます。また、過去の最優秀賞受賞者は選考の対象外となります。予めご了承ください。

6． 運営委員会

8 月 1 日(金)のランチョンセミナー終了後、13:00～13:30、3 階「菫」にて運営委員会を開催いたします。委員の方は会場にお越しいただきご出席ください。

7． 懇親会

8 月 1 日(金)18:40 より、3 階「杏」にて開催いたします。
懇親会参加費：5,000 円

8． その他

服装は例年通り、ノーネクタイのビジネスカジュアルでお越しください。

タイムテーブル

1日目：8月1日（金）

九段会館テラス【鳳凰】/懇親会【301-杏】

9:00	9:00～9:20	開会、オリエンテーション、Sammy(佐藤修先生)からのメッセージ
9:30	9:20～9:30	Opening Remarks　荒木 尚
	9:30～10:50	Meet The Legends of JNEF/SIGNS 伊達 勲 先生 本郷 一博 先生 藤巻 高光 先生　座長：大宅 宗一 先生
10:00		
10:30		
11:00	11:00～12:00	特別講演 講師：国士舘大学 文学部 松野 敏之 教授 演題「吉田松陰の密航と挫折」 座長：荒木 尚
11:30		
12:00	12:00～13:00	ランチョンセミナー1　≪領域講習≫ テーマ：クライオ電子顕微鏡が解き明かすラセタム系抗てんかん発作薬とボツリヌス毒素の認識機構 演者：山形 敦史 先生(理化学研究所 生命機能科学研究センター) 座長：花谷 亮典 先生(鹿児島大学大学院 医歯学総合研究科) 共催：UCB Japan
12:30		
13:00	13:00～13:30	運営委員会／-休憩-
13:30	13:30～14:35	Session I Tumor 座長：赤井 卓也 先生／徳川 城治 先生
14:00		
14:30	14:35～14:45	-休憩-
15:00	14:45～15:50	Session II Cerebrovascular 座長：名取 良弘 先生／坂田 勝巳 先生
15:30		
16:00	15:50～16:00	-休憩-
	16:00～17:15	Session III Others 座長：黒川 龍 先生／安田 宗義 先生
16:30		
17:00		
17:30	17:15～17:30	-休憩-
	17:30～18:30	イブニングセミナー　≪領域講習≫ テーマ：片頭痛疾患の診断と治療 演者：島津 智一 先生(埼玉精神神経センター 脳神経内科) 座長：野下 展生 先生(さいたま赤十字病院 脳神経外科) 共催：第一三共株式会社
18:00		
18:30	18:30～18:40	団長総括　大宅 宗一先生
19:00	18:40～20:40	～懇親会～ ご挨拶　荒木 尚 乾杯　近 貴志 先生 Stand Up Talk 藤巻 高光 先生 Message for the next generation
19:30		
20:00		
20:30		
21:00		

2日目：8月2日（土）

九段会館テラス【鳳凰】

9:00	9:00～9:10	日英同時通訳研修オリエンテーション
	9:10～10:10	日英同時通訳研修 I 症例報告 座長：荻野 雅宏 先生／松山 純子 先生
9:30		
10:00		
	10:10～11:10	日英同時通訳研修 II 症例報告 座長：近 貴志 先生／田中 俊英 先生
10:30		
11:00	11:10～11:20	-休憩-
	11:20～12:00	教育講演 講師：東洋大学 ランゲージセンター Nora Alaboosi 先生 演題「Why I love teaching in Japan」 座長：荒木 尚
11:30		
12:00	12:00～13:00	ランチョンセミナー2 テーマ：脳を守る、その一手 ― 脳神経外科における“吸収性”の新常識 演題名：小児脳神経外科手術を極める：吸収性素材の性質と使い方 演者：栗原 淳 先生(埼玉県立小児医療センター) 座長：樋口 佳則 先生(千葉大学病院) 共催：INTEGRA JAPAN
12:30		
13:00	13:00～14:00	次期会長挨拶 原 淑恵 先生 表彰式・団長総括 近 貴志 先生／徳川 城治 先生 閉会挨拶 荒木 尚
13:30		
14:00	14:00～撤収	
14:30		

プログラム

8月1日(金)

9:00-9:20	**開会、オリエンテーション** **Sammy からのメッセージ**	**荒木　尚** **佐藤　修**
9:20-9:30	**Opening Remarks**	**荒木　尚**
9:30-10:50	**Meet The Legends of JNEF/SIGNS**	**伊達 勲／本郷 一博／藤巻 高光** **座長：大宅 宗一**
11:00-12:00	**特別講演** **「吉田松陰の密航と挫折」**	**松野 敏之（国士舘大学文学部教授）** **座長：荒木　尚**

12:00-13:00　**ランチョンセミナー1《領域講習》座長：花谷 亮典(鹿児島大学大学院 医歯学総合研究科)**

テーマ：クライオ電子顕微鏡が解き明かすラセタム系抗てんかん発作薬とボツリヌス毒素の認識機構

山形 敦史(理化学研究所 生命機能科学研究センター)

共催：UCB Japan

13:00-13:30　**運営委員会（break）**

13:30-14:35　**Session I　Tumor**

Moderators：Takuya Akai,　Joji Tokugawa

a-1　Discrimination of Cancer Cell Lines by Integration of Principal Component Analysis and Equivalent Circuit Modeling Using Electrical Impedance Spectroscopy.

Iori Kojima（Department of Neurosurgery, Chiba University Hospital）

Discussant：Takafumi Wataya

a-2　Long-term outcomes and recurrence factors in intracranial germinoma: a 40-year retrospective single-institution study

Masashi Higashino（Department of Neurosurgery, Kobe University Graduate School of Medicine）

Discussant：Takamitsu Fujimaki

a-3　Early Implementation of Comprehensive Cancer Genomic Profiling Enables　Improvement of Access to Therapies in Central Nervous System Tumors: A　comparative Study with Other Cancers.

Oka Chihiro（Department of Neurosurgery, Yokohama City University Graduate School of Medicine）

Discussant：Yusuke Kinoshita

a-4 Conus medullaris diffuse midline glioma, H3K27-altered, diagnosed via biopsy of a cauda equina invasive lesion without serious complications.

Yoshiyuki Kitayama（Department of Neurosurgery, University of Tsukuba Hospital）

Discussant：Jun Suenaga

a-5 Development of Carborane-Containing Iron Oxide@Gold Nanoparticles for Neutron Capture Therapy

Haolan Yang（Department of Neurosurgery, Institute of Medicine, University of Tsukuba）

Discussant：Isao Date

a-6 Combined endoscopic endonasal and transcranial approach for sinonasal neuroendocrine carcinoma with intracranial invasion: A feasible option

Toshiaki Furukawa（Department of Neurosurgery, Yokohama City University Medical Center）

Discussant：Muneyoshi Yasuda

a-7 Endoscopic-assisted contralateral interhemispheric transfalcine keyhole approach for falcine meningioma

Kouko Fujiwara（Department of Neurosurgery, Keio University）

Discussant：Junko Matsuyama

a-8 A Rare Case of Choroid Plexus Papilloma in the Cerebellopontine Angle of an Adult

Kotaro Tomioka（Chiba University School of Medicine）

Discussant：Yoshie Hara

14:45-15:50 **Session II Cerebrovascular**

Moderators：Yoshihiro Natori, Katsumi Sakata

b-1 Clinical picture of radiation-induced cerebral cavernous malformations

Hana Asagiri（Department of Neurological Surgery, Juntendo University Urayasu Hospital）

Discussant：Muneyoshi Yasuda

b-2 De novo Twig-like MCA treated with STA-MCA anastomosis

Shinichiro Matsuyama（Department of Neurosurgery, Hiratsuka Kyosai Hospital）

Discussant：Junko Matsuyama

b-3 How to diagnose and treat intracranial aneurysms with segmental arterial mediolysis

Fukutaro Ohgaki（Department of Neurosurgery, Yokohama Rosai Hospital）

Discussant：Tomoo Inoue

b-4 Understanding of the angio-architecture leads to correct diagnosis and proper management of spinal arteriovenous fistula

Takuya Yamaguchi（Department of Neurosurgery, Tohoku Medical and Pharmaceutical University）

Discussant：Manabu Natsumeda

b-5 Transarterial Venous Embolization（TAVE）: New Procedure Efficient for High-Flow dAVF

Rin Shinoda（Department of Neurosurgery, Ichinomiya-Nishi Hospital）

Discussant：Joji Tokugawa

b-6 Repetitive Simulation Training Improves Mechanical Thrombectomy Performance: Results from a Single-Center Pilot Study Using the VIST G7 Neuroendovascular Simulator

Ayumu Nishimura（Department of Neurosurgery, Yokohama City University）

Discussant：Masahiro Ogino

b-7 Clinical Features and Outcomes of Aneurysmal Subarachnoid Hemorrhage Occurring in the Toilet

Natsumi Ogawa（Department of Neurosurgery, Saiseikai Utsunomiya Hospital）

Discussant：Takamitsu Fujimaki

b-8 A case of intracranial mycotic aneurysm recurrence after endovascular treatment followed by spontaneous occlusion

Yasutoshi Akasaki（Department of Neurosurgery, Juntendo University Nerima Hospital）

Discussant：Takashi Kon

16:00-17:15 **SessionⅢ Others**

Moderators：Ryu Kurokawa, Muneyoshi Yasuda

c-1 Predicting good outcomes one year after shunt surgery in iNPH patients with mild gait disturbance: The role of instrumented timed-up go test score

Ryo Oike（Department of Neurosurgery, Nadogaya Hospital）

Discussant：Masahiro Ogino

c-2 Tumor-mimicking sarcoid-like reaction with lymphoid infiltration showing intracranial extension from the left jugular foramen: An illustrative case

Young Ju Kim（Department of Neurosurgery, Nishi-Kobe Medical Center）

Discussant：Joji Tokugawa

c-3　Appropriate positioning of surgical instruments in neuroendoscopic surgery

Kento Takahara（Department of Neurosurgery, Ashikaga Red Cross Hospital）

Discussant：Takashi Kon

c-4　Acute epidural hematoma complicated by pediatric immune thrombocytopenia

Miho Sakamoto（Department of Neurosurgery, Gunma University Graduate School of Medicine）

Discussant：Isao Date

c-5　Lesion guided RFTC: Minimally Invasive Strategy for Bottom-of-Sulcus Epilepsy Near the Arcuate Fasciculus

Yutaro Takayama（Department of Neurosurgery, Graduate School of Medicine, Yokohama City University）　*Discussant：Takeshi Kondo*

c-6　Linear skin incision, the primary dural closure and bone defect filling sufficient to idiopathic encephalomeningocele of the middle cranial fossa in an adult

Shin Naruse（Department of Neurosurgery, Ichinomiya-Nishi Hospital）

Discussant：Soichi Oya

c-7　Prolonged Laryngeal Edema Induced by Clazosentan: Clinical Experience and Management Strategies

Taiki Moriyama（Hyogo Emergency Medical Center, Department of Emergency）

Discussant：Takafumi Wataya

c-8　Comparison of Emergency Physicians' Work Styles in Japan and New Zealand　-A student point of view-

Saya Nitta（School of Medicine, International University of Health and Welfare）

Discussant：Jun Suenaga

c-9　Magnetic Resonance Imaging (MRI)-based Virtual Reality (VR) has the potential to significantly enhance preoperative planning for Endoscopic Third Ventriculostomy (ETV)

Shun Maenishi（School of Medicine, International University of Health and Welfare）

Discussant：Yusuke Kinoshita

17:30-18:30　**イブニングセミナー《領域講習》**　**座長：野下 展生(さいたま赤十字病院 脳神経外科)**

テーマ：片頭痛疾患の診断と治療

島津 智一(埼玉精神神経センター 脳神経内科)

共催：：第一三共株式会社

18:30-18:40　**団長総括**　**大宅　宗一**

プログラム

8月2日(土)

9:00-9:10　**日英同時通訳研修オリエンテーション**

9:10-10:10　**日英同時通訳研修Ⅰ　症例報告**　**座長：荻野 雅宏／松山 純子**

Ⅰ-1　小児頭部外傷に高率に合併する頚椎靭帯損傷
綿谷　崇史（東京都立小児総合医療センター 脳神経外科）

Ⅰ-2　悪性脳腫瘍手術における Image J を用いた 5-アミノレブリン酸陽性所見の輝度解析
近　貴志（昭和医科大学 脳神経外科）

Ⅰ-3　小児の脳死下臓器提供における被虐待児の除外ー国際比較からの検討
荒木　尚（埼玉県立小児医療ｾﾝﾀｰ脳神経外科、埼玉医科大学総合医療ｾﾝﾀｰ高度救命救急ｾﾝﾀｰ）

10:10-11:10　**日英同時通訳研修Ⅱ　症例報告**　**座長：近 貴志／田中 俊英**

Ⅱ-1　脳神経外科手術のエスプリ（心意気）～安全で美しい手技に必要なたったふたつの条件～
安田　宗義（一宮西病院脳神経外科）

Ⅱ-2　外傷センターにおける脳血管内治療の役割
原　淑恵（兵庫県災害医療センター・神戸赤十字病院　脳神経外科）

Ⅱ-3　脊髄動静脈瘻による脊髄症を急速に悪化させる要因
宮原　孝寛（公立八女総合病院脳神経外科／久留米大学脳神経外科）

11:10-11:20　**break**

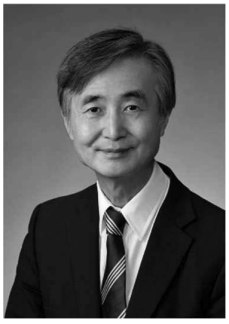
11:20-12:00　**教育講演**　**Nora Alaboosi（東洋大学ランゲージセンター）**
「Why I love teaching in Japan」　**座長：荒木　尚**

12:00-13:00　**ランチョンセミナー2**　**座長：樋口 佳則(千葉大学病院)**

テーマ：脳を守る、その一手 ― 脳神経外科における“吸収性”の新常識
演題名：小児脳神経外科手術を極める：吸収性素材の性質と使い方
栗原 淳（埼玉県立小児医療センター）
共催：Integra Japan 株式会社

13:00-14:00	**次期会長挨拶**	原 淑恵
	表彰式・団長総括	近 貴志／徳川 城治
	閉会挨拶	荒木 尚

Meet The Legends of JNEF/SIGNS



What learning English has given me
— To young doctors in the global era —

Isao Date, MD PhD
Director, Okayama Rosai Hospital
Professor Emeritus, Okayama University

The Japan Neurosurgical English Forum (JNEF) and the Simultaneous Interpreters Group in Neurosurgery (SIGNS) are organizations of neurosurgeons who aim to improve their English proficiency, present at international conferences, write academic papers in English, and ultimately pursue study abroad opportunities. I am one of them, and in this presentation, I would like to reflect on what learning English has brought to me, with the hope of encouraging young neurosurgeons on their journey of English learning.

During my study abroad at the University of Rochester in the United States, there were no other Japanese in the lab, so I was immersed in English in all aspects of research. As my research on cell transplantation progressed, I was able to publish many first-author papers in English. After returning to Japan, I actively presented basic and clinical research at international conferences, visited many countries, and made friends around the world. I also joined SIGNS and served as its head for 16 years, from 2003 to 2019. During this time, I was able to connect with many colleagues from other universities through English in the activities of JNEF/SIGNS.

Since 2014, I have served as the president of the Japan Society for Medical English Education (JASMEE), contributing to medical English education through Examination of Proficiency in English for Medical Purposes (EPEMP) and medical English seminars. I have published several books on medical English, including a phrase dictionary, a guide to writing emails in English, and conversational phrases. I have also organized symposiums on medical English at conferences, given lectures on the “12 principles for writing and presenting in English,” and recently presented the usefulness of interactive English conversation practice using ChatGPT4o.

The significance of JNEF/SIGNS lies in neurosurgeons themselves performing simultaneous interpretation of neurosurgical content. Competing with AI is not the goal. Rather, it requires a strong desire to acquire knowledge across all subspecialties in order to interpret effectively. The level of concentration required during simultaneous interpretation is comparable to that during surgery. Going forward, the mission and importance of JNEF/SIGNS will remain unchanged as a first step toward global engagement.

Where is the JNEF/SIGNS headed? - A message to the next generation -

Kazuhiro Hongo
Ina Central Hospital, Ina, Nagano, Japan

With the rapid emergence of generative artificial intelligence (AI) tools like ChatGPT and near real-time machine translation, the way we engage with English - especially in professional and academic communities - is undergoing a profound shift. For young medical professionals preparing to step onto the international stage, these technologies offer both exciting possibilities and new challenges.
In this evolving environment, what role can communities such as the Japan Neurosurgical English Forum (JNEF) and the Simultaneous Interpreters Group in Neurosurgery (SIGNS) continue to play? More importantly, how can the next generation find meaning, confidence, and purpose in developing their communication skills - beyond what AI alone can provide?
Even in an age of accelerating AI, the human effort to connect, express, and grow though language remains essential and irreplaceable. In this talk, I will share my personal experiences with English learning and my long-standing involvement with JNEF and SIGNS. Through this reflection, I hope to offer insights - and perhaps encouragement - to younger colleagues as they navigate their own paths in the age of AI. Where JNEF/SIGNS is headed may depend not only on technology, but also on your passion, commitment, and vision.

What I learned at the Japan Neurosurgical English Forum (JNEF) and the Simultaneous Interpreters Group in Neurosurgery (SIGNS) workshop was truly valuable!

Takamitsu Fujimaki
International Training and Education Center / Neurosurgery,　Saitama Medical University

Exchange of cutting-edge medical information primarily occurs in English.　While information gathering through scientific papers is reliable, the exchange of information at conferences is invaluable in terms of speed and interactivity.　Even with the advancements in Artificial Intelligence (AI), the importance of individual English communication skills has not diminished in the slightest.　I will describe situations where others struggled with English and situations where I personally felt challenged in English.　I will introduce the "Uemura-ism" and basic requirements for presentations learned through Japan Neurosurgical English Forum (JNEF) and Simultaneous Interpreters Group in Neurosurgery (SIGNS) workshop.　In my current experience as a simultaneous interpreter at neurosurgical conferences, my role is not limited to translating words but also includes facilitating the smooth progression of the session.　Additionally, I will compare human simultaneous interpreters with AI and share my personal perspective on the direction human interpreters should aim for in the future.　In conclusion, learning English communication skills such as simultaneous interpretation through JNEF/SIGNS workshop is an excellent way to grow as a neurosurgeon.

Key words: Simultaneous interpreter, Uemura-ism,　English,　Artificial Intelligence (AI),

特別講演

松野　敏之（まつのとしゆき）
国士舘大学 文学部　教授

【略歴】
早稲田大学大学院文学研究科博士後期課程単位取得退学。博士（文学）。
現在は、国士舘大学文学部教授。斯文会理事、日本儒教学会理事、
全国漢文教育学会事務局長など。
専門は儒学を中心とする中国近世思想・日本近世思想。
〔主要業績〕
・『朱熹『小学』研究』汲古書院、2021 年 9 月
・「孟子の革命説――十八世紀における日本・ヨーロッパでの展開」『多元文化』13 号、2024 年 2 月
・「吉田松陰の『孟子』解釈―梁恵王・斉宣王論に関して―」『斯文』139 号、2024 年 6 月

「吉田松陰の密航と挫折」

吉田松陰（1830～1859）は、混迷する幕末において「誠」の教えを実践しようと奔走した。日本との通商を求めてペリーが来航した時、幕府も庶民も狼狽するばかりで、現状を直視できなかった。その状況下において松陰は欧米の学問を学ぶため、密航を決意する。日本の将来のため、いま必要なのは欧米の学問であると考えてのことであった。

ペリーが二度目に来日した 1854 年 3 月、松陰は計画を実行に移した。深夜、ペリーの旗艦に乗り込み、アメリカに連れていって欲しいと懇願した。しかし、幕府と交渉中のペリーにとって、その要請は受け入れることのできないものであった。松陰は拒絶され、幕府に捕らえられた。江戸で取り調べを受けた後、故郷（山口県萩市）の野山獄に投獄された。

密航に失敗し、獄中の身となった松陰であるが、自暴自棄になることはなかった。挫折のなか、それでも今の自分に出来ることをしようとした。処刑を覚悟するなかで、松陰はこのような状況だからこそ学問に努めるべきだと考えた。さらには同じ牢獄の囚人たちと読書会が開催されるようになる。最も年若い松陰が主講となり、毎晩、囚人たちと議論を交わしあった。松陰によって野山獄の様相は一変した。

獄中での学問は、松陰にも変化をもたらした。現状の日本において重要なのは、日本が一つにまとまり、日本人という意識を形成することであると考えるようになった。それこそが諸外国と向き合うために必要なことであると論じる。松陰自身は、一度の赦免の後、松下村塾で教育にあたったが、再び収監され、刑死する。その後、松陰の教えを受けた門人たちが、幕末・明治に活躍していくこととなる。

なお、松陰の密航はペリー達にも強い印象を与えた。日本人は探究心の強い国民であり、この国の前途は可能性を秘めていると記録に残している。また松陰の密航依頼書は、通訳のウィリアムズが大切に持ち帰り、現在アメリカのイェール大学図書館に保管されている。

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ABSTRACT

a-1 Discrimination of Cancer Cell Lines by Integration of Principal Component Analysis and Equivalent Circuit Modeling Using Electrical Impedance Spectroscopy

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Background
Early discrimination of tumor cells is essential to improve treatment success rates. However, conventional identification methods require expensive and complex equipment and specialized technicians, making widespread use difficult. Electrical Impedance Spectroscopy (EIS), which utilizes the electrical characteristics of cells, is gaining attention as a diagnostic technique. In this study, we aim to improve the accuracy of cancer cell discrimination by integrating EIS and Principal Component Analysis (PCA) with an Equivalent Circuit Model (ECM).
Subjects and Methods
We performed EIS measurements in the frequency range of 0.1 MHz to 300 MHz on four cancer cell lines: U87 and U138 (glioblastoma), DLD-1 (colorectal cancer), and T.Tn (esophageal cancer). The collected data were analyzed using the ECM-PCA approach. Solution impedance was removed from the measured data to extract cell-specific impedance characteristics, which were then summarized as principal components.
Results
The ECM-PCA method demonstrated higher discrimination accuracy compared to conventional PCA and nonlinear kernel PCA (kPCA), achieving a classification accuracy of 93.6% when using phase angle as input. In the PC1–PC2 plane, the four cell lines were clearly separated, and discrimination between U87 and U138 was particularly improved.
Conclusion
The ECM-PCA method enables high-accuracy and interpretable discrimination of cancer cells by reflecting the frequency dependence of impedance data, while maintaining clustering performance comparable to conventional methods. This technique holds promise for applications in cancer detection and treatment support.
Keywords:
1. Electrical Impedance Spectroscopy (EIS) – 電気インピーダンス・スペクトロスコピー
2. Equivalent Circuit Model (ECM) – 等価回路モデル
3. Principal Component Analysis (PCA) – 主成分分析
4. Phase angle – 位相角
5. Cancer cell line – 癌細胞株
6. Glioblastoma (e.g., U87, U138) – 膠芽腫（例：U87, U138）
7. Colorectal / Esophageal cancer – 大腸癌 / 食道癌
8. Classification accuracy – 分類精度
9. Impedance characteristics – インピーダンス特性
10. Frequency dependence – 周波数依存性

a-2 Long-term outcomes and recurrence factors in intracranial germinoma: a 40-year retrospective single-institution study

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Objective: Intracranial germinomas have high cure rates with chemoradiotherapy. However, a small number of patients experience recurrence after long-term remission. This study aims to investigate long-term outcomes and recurrence factors.
Methods: This retrospective observational study analyzed germinoma at a single institution from January 1984 to July 2024. Patients diagnosed with germinoma were included in this study. Long-term overall survival (OS), progression-free survival (PFS) and late adverse effect of radiation therapy (RT) were assessed. Recurrence-related factors were evaluated by comparing recurrence and non-recurrence groups. In cases where whole ventricular or whole brain RT was performed, the irradiation fields were retrospectively reviewed to determine whether the entire ventricular system was definitely included; such cases were defined as RT including whole ventricular system.
Results: A total of 43 patients with germinoma were included in this study, with a median follow-up period of 11 years. The 10- and 20-year OS rates were 97.4% and 81.8%. The 10-, 20-year PFS rates were 86.1% and 58.1%. Four cases of meningioma, three cases of cavernoma, and one case of glioma were identified as secondary tumors. Recurrence was observed in eight cases (17.4%). Review of the irradiation fields in four cases treated before 2009 revealed that the fields did not extend to the foramen magnum. RT including whole ventricular system was associated with a significantly lower hazard ratio for recurrence (Hazard ratio: 0.060, 95% confidence interval: 0.012–0.312, $p < 0.001$) compared to cases without such coverage. Of the eight recurrence cases, three involved spinal cord recurrence after the long remission period to date—at 8.4, 17.5, and 18.1 years post-treatment, respectively.
Conclusions: RT including whole ventricular system contributes to prolonged PFS. Even after long-term remission, verifying the initial radiation field is essential. If the irradiation was insufficient, follow-up clinicians should consider the potential risk of recurrence.

Keywords: Germinoma ジャーミノーマ(胚腫), Whole ventricular system 全脳室系, Secondary tumor 二次癌

a-3 Early Implementation of Comprehensive Cancer Genomic Profiling Enables Improvement of Access toTherapies in Central Nervous System Tumors: A comparative Study with Other Cancers

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Background: Comprehensive cancer genomic profiling (CGP) is expected to be effective for central nervous system (CNS) tumor. However, in Japan, public health insurance covers it only once. As malignant CNS tumors have limited treatment options and poor prognosis, the timing of CGP is crucial to improve access to therapies. No clear recommendations exist regarding the optimal timing. This study aimed to compare CNS tumors and other cancers in terms of drug accessibility and survival to determine optimal CGP timing.
Methods: We retrospectively analyzed 463 patients who underwent CGP and expert panel (EP) review at our hospital between February 2020 and December 2023, with follow-up until December 2024. We compared treatment access and survival between 52 CNS tumor cases and 411 other cancer cases.
Results: Drug accessibility was 9.6% for CNS tumors and 8.5% for other cancers (p=0.80). Insurance-covered drug access was 1.9% (1/52) for CNS tumors and 7.5% (31/411) for other cancers (p=0.24). Access to non-insurance-covered drugs was significantly higher for CNS tumors: 5/52 (9.6%) vs. 4/411 (0.97%, p<0.01). Among patients recommended drugs but unable to receive them, poor general condition was the reason in 20% for CNS tumor cases and 41.7% of other cancer cases (p=0.63). Average survival from initial surgery was 1,341 days for CNS tumors vs. 1,201 days for others (p=0.58), and from EP review was 361 vs. 316 days (p=0.39). Mortality rates during follow-up were similar (55.8% vs. 58.9%).
Conclusion: Patients with CNS tumors had greater access to non-insurance-covered drugs than those with other cancers. Early CGP submission while maintaining good performance status may improve drug accessibility.

Keywords: central nervous system tumors 中枢神経系腫瘍, comprehensive cancer genomic profiling がん包括的ゲノムプロファイリング, drug accessibility rate 薬剤到達率, other cancer types その他のがん腫, performance status パフォーマンスステータス, recommendation 推奨.

a-4 Conus medullaris diffuse midline glioma, H3K27-altered, diagnosed via biopsy of a cauda equina invasive lesion without serious complications.

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INTRODUCTION: Diffuse midline glioma (DMG), H3K27-altered, is a general term for tumors with loss of H3K27me3. It often occurs in the pons and thalamus during childhood. Only 10-20% of DMGs occur in the spinal cord, and a few cases involving conus medullaris have been reported. Histological and molecular testing is required for DMG diagnosis, although biopsy from the spinal cord carries a high risk of complications. Here, we report a case of DMG successfully diagnosed by biopsy from a cauda equina invasive lesion without complications.

CASE PRESENTATION: A middle-aged woman presented with numbness and weakness in the right lower extremity. Magnetic resonance imaging showed an intramedullary lesion of the conus medullaris. Since glioma was suspected on preoperative examination, a tumor biopsy was performed. Intraoperative findings revealed an enlarged left cauda equina root extending from the swollen conus medullaris. A biopsy sample from the enlarged cauda equina was suspicious for high-grade glioma on rapid intraoperative histological diagnosis. Loss of H3K27me3 and the presence of an H3K27M mutation were confirmed by immunohistology and molecular analysis, leading to a diagnosis of DMG. No bladder or rectal dysfunction or motor paralysis was observed after surgery.

CONCLUSION: In our case, biopsy samples from the cauda equina were sufficient for diagnosis. In cases of conus medullaris DMG, considering cauda equina invasion as a biopsy site may help avoid serious complications.

Key Word: Diffuse midline glioma. H3K27Altered. H3K27me3 loss.
H3K27Mmutation. Conus medullaris DMG. Cauda equina invasion.

a-5 Development of Carborane-Containing Iron Oxide@Gold Nanoparticles for Neutron Capture Therapy

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Objective: Glioblastoma and other malignant brain tumors remain highly challenging to treat due to their resistance to conventional therapies. Boron neutron capture therapy (BNCT) offers a highly selective approach to destroying tumor cells while sparing healthy tissues. Still, its efficacy is limited by the insufficient accumulation of boron in tumors. We aimed to develop multifunctional iron oxide nanoparticles (NPs) containing boron and gold for improved boron delivery and potential theranostic use.

Materials and Methods: Fe_3O_4 nanoparticles were synthesized and coated with gold to form core–shell structures. After functionalization with APTES, a carborane compound was immobilized via protonation. The NPs were characterized using SEM, FTIR, DLS, BET, XRD, and EDX. Cytotoxicity was evaluated in U251MG cells using the MTS assay. Intracellular Fe, B, and Au concentrations were quantified via ICP-AES.

Results: The final NPs exhibited an average size of 40.4 nm and a stable zeta potential of –20 mV. Boron was stably retained on the NP surface. The NPs showed low cytotoxicity at concentrations up to 300 μg Fe/mL. Elemental analysis revealed 1.74×10^{10} boron atoms and 1.82×10^{10} gold atoms per cell after 24 h incubation, exceeding the threshold required for effective BNCT.

Conclusion: The developed Fe_3O_4@Au-carborane nanoparticles demonstrated promising boron delivery and potential for integrated therapy and diagnostics. Future work will focus on isotope enrichment with ^{10}B and tumor-targeted delivery optimization.

Key words: neutron capture therapy 中性子捕捉療法; drug delivery 薬物送達; nanoparticles ナノ粒子; iron oxide 酸化鉄; carborane カルボラン

a-6 Combined endoscopic endonasal and transcranial approach for sinonasal neuroendocrine carcinoma with intracranial invasion: A feasible option

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Background: Sinonasal neuroendocrine carcinoma (NEC) is a rare and aggressive cancer with a tendency for intracranial invasion. Optimal surgical strategies remain undefined due to its rarity. Achieving radical resection can be challenging, particularly for the intracranial portion of the cancer, when using a conventional endoscopic endonasal approach alone. While the combined endoscopic endonasal and transcranial approach is a well-established surgical strategy for olfactory neuroblastoma, its application in sinonasal NEC remains scarcely reported. We present a case of sinonasal NEC with intracranial invasion, treated with a combined endoscopic endonasal and transcranial approach to highlight the feasibility of the strategy.

Case presentation: A 75-year-old-woman presented with epistaxis and anosmia. The primary site of the cancer was ethmoid sinus, extending to the left middle and superior nasal meatus, with destruction of the anterior cranial base and extension into the left orbit. Preoperative cancer embolization was performed to reduce intraoperative bleeding. A combined endoscopic endonasal and transcranial approach was selected to achieve radical resection. The neurosurgical team performed a transcranial approach, enabling resection of the tumor en bloc along with the overlying brain tissue to prevent potential dissemination―an approach not possible via the endoscopic route alone. The patient showed no complications and was histopathologically diagnosed as NEC.

Conclusion: Combined endoscopic endonasal and transcranial approach may be a feasible option to achieve radical resection of sinonasal NEC even with intracranial invasion and can be essential to prevent dissemination of the cancer.

Key words: Sinonasal neuroendocrine carcinoma, intracranial invasion, combined nasal-endoscopic and transcranial approach, radical resection

キーワード：鼻副鼻腔神経内分泌癌、頭蓋内進展、経鼻内視鏡経頭蓋アプローチ、根治的切除

a-7 Endoscopic-assisted contralateral interhemispheric transfalcine keyhole approach for falcine meningioma

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Background: Falcine meningiomas (FMs) are challenging intracranial tumors located along the falx cerebri, often close to critical neurovascular structures. The traditional surgical strategy has been the ipsilateral interhemispheric approach, which carries certain risks including injury to bridging veins and cortical tissues.

Methods: We describe a successful resection of a falcine meningioma using a minimally invasive contralateral interhemispheric transfalcine approach with endoscopic assistance. A small craniotomy was performed opposite the lesion, reducing manipulation of the cerebral cortex and venous structures. Endoscopy provided clear visualization for effective dissection near the anterior cerebral artery (ACA) and superior sagittal sinus (SSS). This led to a Simpson Grade I gross total resection without any complications, and the patient was discharged on the postoperative day ten.

Conclusion: This case shows that the contralateral approach can effectively achieve complete tumor resection with minimal tissue damage, offering a safe and effective surgical option for selected falcine meningioma.

Keywords
bridging vein 架橋静脈, cortical damage 皮質損傷, endoscopy 内視鏡, minimally invasive surgery 低侵襲手術, small craniotomy 小開頭

a-8 A Rare Case of Choroid Plexus Papilloma in the Cerebellopontine Angle of an Adult

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Background: Choroid plexus papilloma (CPP) is a rare benign tumor commonly seen in the lateral or fourth ventricles of children. Its occurrence in adults, especially in the cerebellopontine angle (CPA), is extremely rare. Accurate preoperative diagnosis is often difficult due to non-specific imaging findings.

Case Presentation: A man in his 50s presented with a sensation of left aural fullness in early April 2024. Audiological evaluation revealed left-sided hearing loss, and imaging showed a 15-mm extra-axial mass near the left internal auditory canal. MRI did not reveal characteristic T2 hypointensity, making differentiation from vestibular schwannoma, meningioma, or ependymoma challenging. The patient underwent left retrosigmoid craniotomy in May. The tumor was located between the lower cranial nerves and the VII–VIII nerve complex. Postoperatively, he developed transient hoarseness, which resolved promptly.
Histopathological examination revealed papillary structures lined with monolayered columnar epithelial cells without nuclear atypia, necrosis, or mitotic figures. Immunohistochemistry showed a Ki-67 labeling index of approximately 1%, confirming the diagnosis of CPP. Postoperative hearing improved both subjectively and on pure tone audiometry.

Conclusion: CPP in the CPA of adults is extremely rare and may mimic more common CPA tumors on imaging. This case highlights the importance of considering CPP in the differential diagnosis of CPA masses. Early diagnosis from mild symptoms, appropriate surgical management, and careful postoperative monitoring contributed to a favorable outcome. The case carries high educational value due to its rarity and diagnostic challenges.

Key words: choroid plexus papilloma, adult, cerebellopontine angle, lateral suboccipital approach, Hearing impairment

b-1 Clinical picture of radiation-induced cerebral cavernous malformations

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Objective: Cerebral cavernous malformations (CCMs) are hamartomatous vascular lesions occasionally encountered in clinical practices. A part of CCMs is estimated to develop after cranial irradiation, in irradiated fields. However, there have been few studies documenting clinical picture of such radiation-induced CCMs. This study aimed to explore it.

Materials and Methods: A total of 51 patients with multiple CCMs, who visited to our hospital between 2006 and 2024, were explored. Among them, five were considered to have radiation-induced CCMs, four developing after cranial irradiation and one after endovascular therapy.

Results: The male-to-female ratio of radiation-induced CCM cases was 3:2. The mean time from radiation exposure to identification of CCM mutation was 31 years. Four patients developed symptomatic meningioma and underwent surgical resection. In all, pathological diagnosis was meningothelial meningioma. Genomic analysis confirmed a CCM1 mutation in five patients. In four, it was located in exon 5. In contrast, CCM1 mutation was identified in only one of the 46 patients who did not undergo previous radiation exposure.

Conclusion: Radiation-induced CCMs may develop through a mechanism different from common hereditary CCMs, showing a stable clinical course, and incidentally found with symptomatic secondary tumors. Exon 5 of the chromosome 7 may be more sensitive to radiation than other genomic loci.

Keywords: Cerebral cavernous malformations; Radiation-induced cavernous malformations; Genomic mutation; Meningioma.
キーワード：脳海綿状血管腫；放射線誘発性海綿状血管腫；遺伝子変異；髄膜腫.

b-2 De novo Twig-like MCA treated with STA-MCA anastomosis

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[Introduction] Twig-like middle cerebral artery (MCA) is a rare vascular anomaly characterized by stenosis of the MCA and an abnormal vascular network, generally considered congenital in origin. We present a rare case of symptomatic twig-like MCA with acquired progression, successfully treated with superficial temporal artery to MCA (STA–MCA) bypass.
[Case Presentation] A 54-year-old woman with a history of hypertension underwent brain MRI/MRA and cerebral angiography as part of the workup for a transient loss of consciousness. No abnormalities were initially detected, and regular imaging follow-up was planned. Nine years later, MRA revealed the onset of stenotic changes in the right M1 segment. Eleven years after the initial assessment, she developed transient left hemiparesis and dysarthria. MRA at that time showed progression of right M1 stenosis and poor visualization of distal M2 branches. Since cerebrovascular reserve was preserved, conservative medical management was chosen. Twelve years after the initial evaluation, she experienced another episode of transient left hemiparesis. Cerebral angiography revealed right M1 stenosis accompanied by a cluster of abnormal vessels at the same site, leading to a diagnosis of twig-like MCA. ^{123}I-IMP SPECT imaging revealed decreased cerebrovascular reserve in the right MCA territory. Therefore, STA–MCA bypass surgery was performed. Following the surgery, transient ischemic attacks resolved and cerebral perfusion improved.
[Conclusion] We report a rare case of symptomatic twig-like MCA with acquired progression that was effectively treated with STA–MCA bypass surgery. Careful radiological monitoring and differentiation from moyamoya disease are essential. In symptomatic cases, surgical revascularization may be a viable treatment option.

Key word: Twig-like MCA, Moyamoya disease, de novo, STA-MCA bypass

b-3 How to diagnose and treat intracranial aneurysms with segmental arterial mediolysis

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Objective
Segmental arterial mediolysis (SAM) is a nonatherosclerotic, noninflammatory vascular disease, initially reported in 1976 by Slavin and Gonzalez-Vitale. Although we sometimes see SAM suspected cases that have multiple intracranial aneurysms and visceral aneurysms, intracranial aneurysms with SAM have been reported in limited cases, and the disease entity is not fully understood. Therefore, we propose a diagnostic and treatment strategy with a systematic review of previously reported cases and our cases.

Materials and Methods
We systematically searched cases of intracranial aneurysms with SAM using an online database. The findings of each included study and our cases were systematically reviewed in terms of characteristics, aneurysm, and clinical course.

Results
In addition to our 2 cases, 41 cases from 32 publications were included. Intracranial aneurysms with SAM were common among East Asians, particularly Japanese, aged 40–50 years, and typically presented as subarachnoid hemorrhage (SAH; 86%). Most aneurysms (75%) were dissection aneurysms. Subarachnoid hemorrhage (SAH) cases had a higher risk of successive intra-abdominal hemorrhage (IAH) caused by visceral aneurysm rupture (59%), with a mortality of 41%. It was most likely to occur 8.2±7.3 days after SAH. If operations were accomplished, the prognosis was relatively good (modified Rankin Scale score 0−3; 71%).

Conclusion
Intracranial aneurysms with SAM can be life-threatening due to successive IAH after SAH. However, the prognosis is relatively good if an operation is successful. Therefore, precise diagnosis is required for suspected cases at first, and appropriate surgical treatment is required. Moreover, appropriate management of successive IAH is required among patients with SAH.

Key words
Segmental arterial mediolysis, intracranial aneurysm, subarachnoid hemorrhage, visceral aneurysm, intraabdominal hemorrhage, 分節型動脈中膜融解症, 脳動脈瘤, くも膜下出血, 内臓動脈瘤, 腹腔内出血

b-4 Understanding of the angio-architecture leads to correct diagnosis and proper management of spinal arteriovenous fistula

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Background: There are many types of diseases in spinal arteriovenous fistulas (SAVFs). The treatment is administered according to its type and the diagnosis. In particular, the diagnosis of SAVFs is based on the angioarchitectures including feeders and location of the shunt. Clinically, the angioarchitecture would determine the best treatment plan.
Case presentation: A 72-year-old man suffered progressive bilateral lower limb weakness, sensory impairment, and constipation over several months. The patient was referred to our hospital with suspicious of SAVF. Digital subtraction angiograms identified the shunt on the L3 nerve root which established the diagnosis of the radicular AVF. We performed a direct surgery to obliterate the fistula at L3 level. Postoperatively, the patient's symptoms improved over time. There has been no recurrence to date.
Conclusion: We experienced a case of radicular AVF. Understanding of angioarchitectures was important to make an accurate diagnosis. Direct surgery based on the diagnosis achieved favorable results. This case highlighted importance to understand the angioarchitectures in treating SAVFs.

Key word
Arteriovenous fistula（動静脈瘻）, Radicular Arteriovenous fistula（馬尾動静脈瘻）

b-5 Transarterial Venous Embolization（TAVE）: New Procedure Efficient for High-Flow dAVF

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Background:
Dural arteriovenous fistula (dAVF) is a potentially life-threatening condition, particularly when accompanied by cortical venous reflux. While transvenous embolization (TVE) and transarterial embolization (TAE) are standard treatments, both may be unfeasible in high-flow shunt (HFS) cases. An innovative approach, transarterial venous embolization (TAVE), may offer an alternative when a microcatheter can be navigated through the shunt from the arterial to the venous side.
Case Description:
A 50-year-old man was referred to our department with subarachnoid hemorrhage and subdural hematoma causing transient loss of consciousness. Angiography revealed a Cognard type IV, Borden type III dAVF near the left transverse sinus, fed by the middle meningeal and occipital arteries, with retrograde cortical venous reflux. TVE seemed impractical due to inaccessible venous anatomy. TAE using Onyx was aborted due to the risk of embolic migration caused by high-flow shunting. Suspecting a large fistula, a microcatheter was advanced from the arterial side into the venous side, allowing successful coil embolization and complete obliteration of the shunt without complications.
Discussion & Conclusion:
TAVE may provide a valuable and safe alternative for HFS-dAVFs when conventional approaches are limited. This technique combines the accessibility of arterial navigation with the curability of venous embolization. Favorable anatomical conditions for TAVE include a straight arterial feeder such as the middle meningeal artery and a large shunt permitting catheter passage. This case suggests that TAVE could become a novel procedure in the endovascular treatment of dAVFs. To fully establish the clinical value of TAVE, further studies are needed to clarify the anatomical and hemodynamic conditions.

Key Words: dural arteriovenous fistula 硬膜動静脈瘻, transvenous embolization 経静脈的塞栓術, transarterial embolization 経動脈的塞栓術, middle meningeal artery 中硬膜動脈, occipital artery 後頭動脈

b-6 Repetitive Simulation Training Improves Mechanical Thrombectomy Performance: Results from a Single-Center Pilot Study Using the VIST G7 Neuroendovascular Simulator

Ayumu Nishimura, Jun Suenaga, Yuko Gobayashi, Katsuhiro Takabayashi, Yuki Igarashi, Tomoaki Miyata, Takahiro Tanaka, Taisuke Akimoto, Yasunobu Nakai, and Tetsuya Yamamoto

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Background
Simulation-based training is an increasingly integral component of neurosurgical education, particularly for high-stakes procedures such as mechanical thrombectomy. Prior studies have demonstrated the utility of endovascular simulators in enhancing procedural skills and clinical readiness. This study investigates whether repeated practice using the VIST G7 neuroendovascular simulator improves performance metrics—specifically procedure time and technical error rate—among neurosurgical trainees.

Methods
A cohort of medical students, interns, neurosurgery residents, and attendings (n = 15) performed standardized mechanical thrombectomy simulations using the VIST G7 platform. Performance was evaluated based on total procedure time and the number of predefined technical errors. A subset of four participants underwent repeated sessions, enabling longitudinal performance tracking. Statistical analyses, including logarithmic fit and paired t-tests, were conducted to evaluate trends over time.

Results
All 15 participants completed the initial session, and four completed multiple sessions. Among repeated participants, a statistically significant reduction in clot retrieval time was observed ($p < 0.05$), with the steepest improvements occurring within the first 3–5 sessions, followed by a plateau effect around the 6th or 7th session. The learning curve was more apparent in novice trainees compared to attending level participant. Reductions in technical errors were noted but were less consistent and generally more modest compared to time-based improvements.

Conclusion
The VIST G7 simulator is effective for enhancing procedural efficiency and reducing errors in simulated thrombectomy. These findings support the incorporation of high-fidelity simulation into neurosurgical training programs to improve technical competency and procedural safety in endovascular neurosurgery.

Keywords:
neuroendovascular simulator, acute stroke, thrombectomy, resident training, education
血管内治療シミュレーション, 脳梗塞, 血栓回収, レジデントトレーニング, 教育

b-7 Clinical Features and Outcomes of Aneurysmal Subarachnoid Hemorrhage Occurring in the Toilet

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Objective: Elevated intrathoracic pressure and blood pressure during defecation are known triggers for cerebral aneurysm rupture, potentially resulting in subarachnoid hemorrhage (SAH). Nevertheless, few studies have focused on the clinical features and outcomes of patients with SAH occurring in the toilet. We conducted a retrospective study to elucidate these features.
Methods: We reviewed 519 SAH patients who had been admitted to our hospital between 2013 and 2024, categorizing them based on the locations where SAH had occurred. Patients were dichotomized to: those who developed SAH in a toilet (T group) and those who did elsewhere (non-T group). Demographics, in-hospital mortality, and favorable outcomes at discharge (modified Rankin Scale [mRS] < 4) were compared. Additionally, we evaluated the rate of self-initiated emergency calls among the T group.
Results: After excluding 66 cases with unknown onset location, 58 patients (12.8%) were in the T group and 395 patients were in the non-T group. Demographics did not differ significantly. The T group had higher in-hospital mortality (41% vs. 30%, p=0.09) and a significantly lower rate of favorable outcomes (24% vs. 43%, p<0.01). Only 4 patients (7%) in the T group called for help by themselves.
Conclusions: SAH occurring in the toilet accounted for 12.8 % in our cohort, disproportionately high relative to time spent there. Delayed detection and presentation to hospitals may have been associated with the poor outcomes in that group. Implementation of monitoring technologies in the toilet may contribute to the better outcomes. （Total words: 250 words）

Keywords: aneurysm, subarachnoid hemorrhage, defecation, toilet, onset, outcomes, in-hospital mortality, modified Rankin Scale (mRS), retrospective study

b-8 A case of intracranial mycotic aneurysm recurrence after endovascular treatment followed by spontaneous occlusion

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Background
Spontaneous occlusion of cerebral aneurysms has been reported in cases such as ruptured, giant, or dissecting aneurysms. However, reports regarding intracranial mycotic aneurysms (IMAs), particularly which recurred after endovascular treatment and spontaneously occluding within a few days, are extremely rare. We treated a patient with an IMA located in the proximal posterior cerebral artery (PCA), which recurred soon after endovascular treatment followed by spontaneous occlusion.

Clinical presentation
A 38-year-old man presented to the emergency department with subarachnoid hemorrhage (WFNS Grade II). He had a history of Streptococcus salivarius bacteremia and dental caries three months earlier. On admission, Staphylococcus haemolyticus bacteremia and bacterial meningitis were identified. A dissecting aneurysm in the right PCA was detected, which was treated with endovascular coiling on the following day. A small recurrence in the aneurysm neck was observed on day 7. On day 45, the enlargement of the recurrence was observed along with coil compaction and coil looping in the aneurysmal neck. Additional embolization was planned, but spontaneous occlusion was confirmed preoperatively. No recurrence of the aneurysm was observed thereafter, and the patient was discharged to subacute rehabilitation unit on day 70.

Conclusion
Spontaneous thrombosis of aneurysms may be promoted by several factors such as reduction of intra-aneurysmal flow, vasospasm, high aneurysm sac volume to orifice ratio, endothelial injury due to inflammation, and/or use of contrast material. In this case, infection related inflammation and coil compaction likely induced endothelial injury and flow reduction of the aneurysm, ultimately led to spontaneous thrombosis. Further study of similar cases is essential for a better understanding of the underlying pathogenesis.

Key Words
Intracranial mycotic aneurysm　頭蓋内感染性動脈瘤、spontaneous occlusion　自然閉塞、
dissecting aneurysm　解離性動脈瘤、endothelial injury　内膜損傷

c-1 Predicting good outcomes one year after shunt surgery in iNPH patients with mild gait disturbance: The role of instrumented timed-up go test score.

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Objective
The Instrumented Timed-Up Go test (iTUG) score, assessed using a smartphone app, has been reported as an effective way to evaluate the improvement in gait in idiopathic normal pressure hydrocephalus (iNPH) patients with mild gait disturbance. In this study, we examined to what extent improvement in iTUG score after the tap test predicts improvement in gait one year after shunt surgery in iNPH patients with mild gait disturbance.

Methods
Patients who underwent tap test between May 2020 and March 2023 and subsequently underwent shunt surgery, with a pre-tap TUG time of less than 20 seconds, were included. For these patients, TUG, iTUG score, MMSE, FAB, iNPH grading scale, and presence of DESH were recorded before and after the tap test, as well as one year postoperatively. Improvement in gait was defined as an increase of 1 or more in the score for gait in iNPH grading scale after tap test and one year postoperatively. By calculating the Area Under the Curve (AUC), we determined the cutoff value for improvement in iTUG score, predicting gait improvement one year later.

Results
A total of 76 patients were included. Among them, 54 individuals (median [IQR] age 77.5 years old [74-81], 33 men (61.1%), TUG time 14.2 sec [12.4-17.1]) showed improvement in gait one year postoperatively, while 22 individuals (age 78 years old [74.5-80], 13 men (59.1%), TUG time 13.6 sec [10.6-15.1]) did not. The maximum AUC was observed when iTUG score improved by 7 (AUC 0.72, 95% CI 0.58 - 0.87).

Conclusion
A cutoff value of 7 in iTUG score may effectively predict gait improvement one year after shunt surgery in iNPH patients with mild gait disturbance.

Keywords
Idiopathic normal pressure hydrocephalus (iNPH), shunt surgery, Timed up and Go test, tap test (TUG), gait disturbance, Area under the curve, Cutoff value

c-2 Tumor-mimicking sarcoid-like reaction with lymphoid infiltration showing intracranial extension from the left jugular foramen: An illustrative case

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Background: Accumulation of normal lymphocytes within the intradural extramedullary space is rare. To the best of our knowledge, no prior reports have described a sarcoid-like reaction with lymphoid infiltration arising around the jugular foramen and adhering to cranial nerves. Here, we present a tumor-mimicking sarcoid-like reaction with intracranial extension from the left jugular foramen, adherent to the cerebellum, medulla oblongata, and lower cranial nerves.
Case: A 64-year-old woman with a history of serous otitis media and presumed tuberculous meningitis presented with persistent headache, left-sided tinnitus, hearing loss, hoarseness, and progressive vertigo. Imaging revealed a 2-cm enhancing mass around the left jugular foramen, extending intracranially and adhering to the cerebellum and medulla oblongata. The preoperative differential diagnosis included schwannoma, glomus tumor, meningioma, lymphoma, and granuloma. A retrosigmoid approach was used for biopsy and partial resection. Intraoperative pathology revealed lymphocytic infiltration without malignancy. Definitive pathology confirmed sarcoid-like lymphoid infiltration without evidence of neoplastic or infectious etiology. The patient showed a remarkable response to corticosteroid therapy, with both clinical and radiographic improvement and no recurrence at 22 months.
Conclusion: Recognition of this rare entity and intraoperative identification of lymphocytic infiltration may support the use of corticosteroids and influence surgical decision-making.

Keywords: tumor-mimicking: 腫瘍類似病変, sarcoid-like reaction: サルコイド様反応, lymphoid infiltration: リンパ球浸潤, jugular foramen: 頸静脈孔, serous otitis media: 滲出性中耳炎, tinnitus: 耳鳴, adhering: 癒着している, cerebellum: 小脳, medulla oblongata: 延髄, biopsy: 生検

c-3 Appropriate positioning of surgical instruments in neuroendoscopic surgery

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Objective: In neuroendoscopic surgeries, interference between the instruments and the endoscope can prevent instruments from accessing certain areas visible within the endoscopic view, leading to the perception of a “restricted zone” (RZ). The objective of this study was to visualize the RZ and systematically examine the theoretical interference between endoscopes and instruments.
Methods: Using an endoscope and light source within a simulated surgical field, a light was projected from the instrument’s entry point, allowing illuminated regions to represent areas easily accessible by a straight instrument. Shadows cast by the endoscope or other instruments indicated inaccessible areas—RZs—that were visualized within the endoscopic view. The study examined changes in this RZ under various conditions. Additionally, cadaver studies revealed the typical distance between the endoscope tip and the target, one of the factors affecting RZ formation in actual surgical settings.
Results: The RZ consistently appeared on the side opposite the instrument in the endoscopic view and was primarily determined by the positional relationship between the instrument and the endoscope at the entry, as well as the endoscope’s proximity to the target. During three-hand operations, additional RZs were created by other instruments with increased interference. In cadaver experiments, the optimal distance between the endoscope tip and the target was found to be approximately 7–20 mm.
Conclusions: To avoid interference, the target area should be positioned within the hemisphere opposite the endoscope’s direction in the endoscopic view. Entry positions should be adjusted to accommodate each surgical field. Zooming may help reduce interference. Understanding these principles of endoscope-related interference supports safe and effective neuroendoscopic procedures, reducing reliance on surgical experience alone.

Keywords: neuroendoscope 神経内視鏡, instrument-endoscope interference 器具と内視鏡の干渉, restricted zone (RZ) 制限区域

c-4 Acute epidural hematoma complicated by pediatric immune thrombocytopenia.

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We report a rare case of acute epidural hematoma (AEDH) with no history of trauma, which led to the diagnosis of immune thrombocytopenia (ITP). A 14-year-old boy was admitted to our hospital with convulsion. His consciousness level was 3 Points on the Glasgow Coma Scale (E1V1M1). He was born preterm, with low birth weight, and as the second twin of a dichorionic diamniotic pair. He had a history of surgery at the age of one for a diagnosis of hypospadias and bifid scrotum; however, intraoperative bleeding findings were normal. Computed tomography (CT) of the head on admission demonstrated that the right frontal epidural hematoma was severely compressing the brain, prompting an emergency craniotomy for hematoma evacuation. Intraoperatively, there was no bleeding from the bone or middle meningeal artery (MMA), and no obvious bleeding source could be identified. The estimated intraoperative blood loss was approximately 1,500 mL. The patient exhibited hypotension, bruise at the puncture site and a decreased Platelets (PLT) count after surgery. PLT, red blood cells (RBC) and albumin (Alb) were transfused. He was discharged a month after surgery with a modified Rankin Scale (mRS) of 2 with mild working memory deficits. Subsequent postoperative investigations, prolonged low platelet counts indicated a high likelihood of ITP. Helicobacter pylori infection has been reported in more than half of adult patients with ITP. Platelet count was elevated after helicobacter pylori eradication. Although it is rare, the possibility of hematological diseases including ITP should be considered in cases of AEDH with unknown etiology.
Keywords: acute epidural hematoma, helicobacter pylori, hematological diseases, immune thrombocytopenia, pediatric,
急性硬膜外血腫，ヘリコバクター・ピロリ菌，血液疾患，小児，免疫性血小板減少症

c-5 Lesion guided RFTC: Minimally Invasive Strategy for Bottom-of-Sulcus Epilepsy Near the Arcuate Fasciculus

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Objective: Lesion-guided radiofrequency thermocoagulation (Lg-RFTC) is considered a promising minimally invasive treatment for epileptogenic lesions located at the bottom of the sulcus (BOS), with the goal of preserving neurological function. This study aimed to evaluate the safety and efficacy of Lg-RFTC for BOS epilepsy near the arcuate fasciculus, where resective surgery poses a high risk of language impairment.
Methods: We retrospectively analyzed three pediatric patients with drug-resistant epilepsy and suspected focal cortical dysplasia in the BOS near the arcuate fasciculus who were treated between 2021 and 2024. All patients underwent stereo-electroencephalography (SEEG) followed by RFTC and were observed for over one year postoperatively. RFTC was performed under a stereotactic frame according to preoperative planning based on a 5-mm spherical model. Coagulation efficiency was defined as the ratio of actual lesion volume to the planned volume and was assessed alongside seizure outcomes and postoperative complications.
Results: The median age at surgery was 4 years (range: 2–15 years), and the median follow-up duration was 876 days (range: 438–1,212 days). Two patients presented with daily tonic seizures, and one had monthly focal impaired awareness seizures. The median number of trajectories was 13 (range: 13–18), and the median number of coagulation points was 48 (range: 20–52). The median coagulation efficiency was 78.1% (range: 75.8–89.9%). One patient experienced seizure recurrence at 338 days postoperatively, while the remaining two patients maintained seizure freedom beyond two years. No permanent neurological deficits, including language impairments, were observed, and no acute ischemic changes were detected in the arcuate fasciculus.
Conclusion: Lg-RFTC appears to be a novel, effective, and function-preserving therapeutic option for BOS epilepsy near the arcuate fasciculus. This approach may help avoid the physical damage or ischemic risks to the arcuate fasciculus associated with resective surgery.

Keywords: Epilepsy, Radiofrequency thermocoagulation, Stereotacticelectroencephalography, Bottom of sulcus, Arcuate fasciculus, Ablation
キーワード：てんかん、ラジオ波温熱凝固療法、定位的電極留置、脳溝底部、弓状束、アブレーション

c-6 Linear skin incision, the primary dural closure and bone defect filling sufficient to idiopathic encephalomeningocele of the middle cranial fossa in an adult

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Objective:
Encephalomeningocele (EMC) is an uncommon entity in which a part of the cerebral parenchyma protrudes extracranially with the meningeal tissues. Idiopathic EMC in the middle cranial fossa is far rarer. In this report, an illustrative case is presented to propose a simple and effective surgical strategy.
Case presentation:
A 78-year-old man was referred to our neurosurgical department from an otorhinolaryngologist. He had been suffering from persistent right otorrhea for 3 months.
Other than fullness and hearing impairment of the right ear, he was otherwise neurologically asymptomatic without any signs of meningitis. Upon Magnetic Resonance Imaging, a small EMC was suspected in the right middle cranial fossa.
Surgical procedure and clinical outcome:
A linear skin incision was made on the right temporal surface. After minimum craniotomy, there was a dural and bony defect with the herniated cerebral cortex, which was coagulated and excised. The dura mater was closed with a fascial patch. The bony defect was filled with bone dust obtained during the craniotomy.
Immediately after the surgery, the right otorrhea and other symptoms disappeared. No recurrence has been observed for 6 months. The skin incision became indiscernible.
Discussion:
Idiopathic EMC in the middle cranial fossa is a rare condition. Antecedent chronic otitis media has been suggested as a causative factor, for it could result in osteolysis.
In the current case, the surgery was the primary dural closure with the bony defect filling, which seems to be the easiest and the most efficient.
Conclusion:
Although idiopathic EMC in the middle cranial fossa is unusual, the primary dural suture with linear skin incision should be enough. Bony defect can be filled by bone dust.
Key words:
Encephalomeningocele 脳髄膜瘤 middle cranial fossa 中頭蓋窩

c-7 Prolonged Laryngeal Edema Induced by Clazosentan: Clinical Experience and Management Strategies

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Introduction
Clazosentan, a novel endothelin receptor antagonist, was introduced in Japan in 2022 as a treatment for cerebral vasospasm—the most critical complication following aneurysmal subarachnoid hemorrhage (SAH). While fluid retention is a known side effect, laryngeal edema (LE) is a rare but potentially life-threatening adverse reaction. We report cases of prolonged LE requiring re-intubation, suspected to be associated with Clazosentan.

Patients and Methods
A retrospective chart review was conducted on 22 patients with aneurysmal SAH treated with Clazosentan between November 2022 and May 2025. We analyzed the incidence, clinical course, and airway management of LE.

Results
Four patients required re-intubation during hospitalization. In all cases, bronchoscopy revealed significant LE, with no other pulmonary or neurological cause identified. The duration of intubation ranged from 12 to 21 days.

Discussion & Conclusion
The edema may have been exacerbated by fluid retention from endothelin receptor blockade, combined with mechanical irritation from intubation. Notably, some patients with a positive cuff leak test still developed airway obstruction, suggesting that standard extubation criteria may be insufficient in the context of Clazosentan use.
LE requiring re-intubation occurred in 18% (4/22) of cases, underscoring the need for increased clinical vigilance, refined extubation protocols, and further case accumulation to improve management.

Key Words
Aneurysmal subarachnoid hemorrhage, vasospasm, Clazosentan, laryngeal edema, airway management

c-8 Comparison of Emergency Physicians' Work Styles in Japan and New Zealand -A student point of view-

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Department of Neurosurgery, International University of Health and Welfare[2]

Background:
As part of a six-week clinical elective at Christchurch Hospital in New Zealand, this study compares key differences in emergency medicine practice between Japan and New Zealand. The goal is to understand how work culture, patient care, and student involvement differ between the two systems.
Observations:
New Zealand's emergency medicine setting emphasizes multidisciplinary teamwork, with nurses, paramedics, and other healthcare professionals often exercising a high degree of autonomy. Communication between physicians and patients tends to be informal and empathetic, frequently incorporating shared decision-making. Medical students are encouraged to engage in clinical activities and are treated as junior members of the team. In contrast, Japan's emergency medicine system is generally more physician-centered, reflecting a stronger emphasis on responsibility. Hierarchical team structures are more common, and medical students often participate in a more observational role, shaped by cultural, legal, and institutional factors.
Conclusions:
These findings suggest several areas where Japan's emergency medicine system could evolve-particularly by promoting multidisciplinary collaboration and active student learning. These observations may inform future proposals to improve the educational environment and work culture in Japanese Emergency departments.
Keywords:
overseas clinical observership 海外臨床研修 emergency medicine 救急医療

c-9 Magnetic Resonance Imaging (MRI)-based Virtual Reality (VR) has the potential to significantly enhance preoperative planning for Endoscopic Third Ventriculostomy (ETV).

Shun Maenishi[1], Kazuaki Shimoji[2], Naoki Yoshioka[3], Takashi Sugawara[2], Keisuke Onoda[2], Akira Matsuno[2]

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Department of Radiology, International University of Health and Welfare[3]

Background:
Endoscopic third ventriculostomy (ETV) is a well-established surgical intervention for managing non-communicating hydrocephalus. Heavy T2-weighted sagittal MR images often guide its strategy. We had a chance to treat a case with limited prepontine space on preoperative images, raising concerns about the feasibility of ETV. To assess its potential in surgical planning, we retrospectively created an MRI-based virtual reality (VR) model.

Case Presentation:
A 6-year-old boy presented with headache and vomiting, initially thought to be gastroenteritis. Persistent symptoms led to an MR scan, revealing a 6 cm posterior fossa tumor with hydrocephalus. Despite two subtotal resections, hydrocephalus remained. Preoperative imaging indicated a narrow prepontine cistern, raising concerns about ETV feasibility. Intraoperatively, the cistern was wider than expected, enabling successful ETV. The patient was transferred for postoperative care. The patient was later transferred for postoperative therapy.

VR Image Construction:
The VR model was created from 3D T2-weighted MR images using the Marching Cubes algorithm, colorized in Blender (v3.3.6), and implemented in Unity (2021.3.1f1). It was visualized through Meta Quest 3 goggles, enabling interactive, semi-transparent viewing from the third ventricle floor to the prepontine cistern for anatomical assessment and ETV simulation.

Results and Conclusion:
The VR model closely replicated intraoperative endoscopic views, enhancing visualization of spatial relationships not fully appreciable on standard MRI. This approach may support preoperative planning in cases with unclear anatomy. Further validation is required.

Keywords: third ventriculostomy 第三脳室開窓術, prepontine space 橋前槽

日本脳神経外科国際学会フォーラム　会則

第 1 章　総則

第 1 条　本会は、日本脳神経外科国際学会フォーラム（Japan Neurosurgery English Forum、略称 JNEF）とする

第 2 条　本会の事務局を、群馬大学大学院医学系研究科脳神経外科学（〒371-8511　群馬県前橋市昭和町 3-39-22）に置く。

本会の所在地と事務局の所在地は同一である。

事務局は、会員名簿・会費を管理し、会の運営に必要な事務手続きを行う。

第 3 条　事務局の移転・変更に関しては、事務局代表からの申し出、あるいは事務局代表が 65 歳となった時点で、運営委員による新事務局代表の推薦を募り、運営委員会で決定する。

第 2 章　目的及び事業

第 4 条　本会は、診断・治療・研究に関して世界的水準を維持し、国際的にも活躍できる脳神経外科医育成を目的とする。

第 5 条　本会は、研究発表を通じ、英語論文執筆・発表力・同時通訳等の医学英語レベル向上を目指す。

第 6 条　本会は、前条の目的を達するため、次の事業を行う。

1. 学術集会の開催

　原則として毎年 1 回

2. 運営委員会の開催

3. 学会ホームページの運営

4. その他の目的達成に必要な事項　等

第 3 章　会員

第 7 条　本会の目的に賛同し、且つその達成に協力する脳神経外科医及び神経科学に従事する科学者をもって構成する。

第 8 条　本会に入会を希望する者は、所定の用紙に必要事項を記入し、事務局に申し込むものとする。

第 9 条　学術集会における発表および参加は、会員ならびに会長が認めた者に限る。

第 10 条　会員から、年会費を徴収し、事務局でそれを管理・運営する。

第 4 章　役員

第 11 条　本会は次の役員を置く。名誉会員　会長　運営委員

第 12 条　本会の会長は、運営委員会において運営委員より 1 名選出する。会長は、当該年度の学術集会を主催する。その任期は、当該事業年度とする。

第 13 条　本会の運営委員で 65 歳になったものを運営委員会の議を経て名誉会員とする。名誉会員は年会費・参会費を免除する。

第 14 条　新運営委員の選出にあたっては、現運営委員 2 名が推薦状を付けて事務局に推薦し、運営委員会で決定する。運営委員の年齢は 65 歳未満とする。

第 5 章　会議

第 15 条　運営委員会は、毎年 1 回学術集会の期間中に開催し、2 分の 1（委任状を含む）以上の出席をもって成立する。運営委員会の議決は出席会員（委任状を含む）の過半数をもって決する。

第 6 章　会計

第 16 条　　本会の事業年度は、毎年 1 月 1 日より 12 月 31 日までとする。

第 17 条　　本会の運営は、学術集会会費、協賛金、年会費、その他をもってあてる。

第 18 条　　本会の事務局経費の監査は、運営委員の中から運営委員会において選出する。

第 19 条　学術集会の会計は、会長在任の期間において会長が会計責任者を兼務し、
次年度の運営委員会においてその会計報告を行う。

第 20 条　　学術集会の会計監査は、前回会長が行う。

第 7 章　会則

第 21 条　　本会則ならびに細則は、運営委員会において改正することができる。

細則

1. 年会費は、2,000 円とする。また演題の筆頭演者は本学会の会員に限ることとする。
2. 4 年以上に渡り年会費が未納である会員に関しては、事務局より滞納された会費の請求と本会加入継続の意思を確認し、会費の納入を持って会員継続とする。返信のない場合や連絡のつかない場合は、自然退会とする。
3. 一度自然退会となった会員であっても新規会員として再入会は可能であり、その場合は以前の未納期間の会費納入は求めないこととする。

以上

作成日　平成 15 年 7 月 18 日

改定日　平成 24 年 7 月 27 日

改定日　令和 元年 7 月 26 日

改定日　令和 3 年 11 月 12 日

改定日　令和 4 年 9 月 11 日

改定日　令和 6 年 5 月 17 日

改定日　令和 6 年 7 月 22 日

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（2025 年 7 月 23 日現在）

まだないくすりを
創るしごと。

世界には、まだ治せない病気があります。

世界には、まだ治せない病気とたたかう人たちがいます。

明日を変える一錠を創る。

アステラスの、しごとです。

明日は変えられる。

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Our Service

診療案内

整形外科 >

老若男女様々な人のケガや慢性疾患、骨粗鬆症、交通事故、労災などの整形外科疾患の診療を行います。

リハビリテーション科 >

急なケガや慢性的な痛みに対して積極的にリハビリや運動療法を行っていきます

内科 >

風邪などの一般内科から生活習慣病まで幅広く診療を行います。

アレルギー科 >

アレルギーは思っているよりも身近なところにあります。花粉症やアトピーなどのアレルギー疾患に対して総合的な診療を行います。

スポーツ医学 >

スポーツ整形外科やスポーツ内科、運動に伴う症状、健康や予防のためのスポーツなど、運動療法やスポーツに関する診療を行います。

再生医療 >

近年では様々な再生医療が謳われるようになりましたが、種類も多くよくわからない人も多くなっています。再生医療についてしっかり説明し、効果が期待できる再生医療を実践します。

成長促進外来 >

子供の低身長は治療できるものもあります。低身長についてしっかりと考え、医学的な治療や運動、日常生活での注意など低身長にスポーツ医学の視点からアプローチし総合的な診療を行います。

健康診断・予防接種・自由診療 >

健康診断や予防接種など健康に必要な自由診療を行います。

池尻大橋 せらクリニック
内科・整形外科・リハビリテーション科

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休診： 日曜 / 祝日

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ARAKI EYE CLINIC

日本眼科学会認定 眼科専門医

院長　荒木 理子

土日・祝日診療

休診 月曜

TEL0942-50-9888

フレスポ鳥栖2F

第38回日本脳神経外科国際学会フォーラム

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ご盛会と併催研修会のご成功を心よりお祈り申し上げます。