Deep brain stimulation of the subthalamic nucleus in Parkinson’s disease: evaluation of active electrode contacts

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Background: The subthalamic nucleus is the preferred target for deep brain stimulation in patients with advanced Parkinson’s disease. The site of permanent stimulation is the subject of ongoing debate, as stimulation both within and adjacent to the subthalamic nucleus may be effective.

Objective: To assess the position of active electrode contacts in relation to the dorsal margin of the subthalamic nucleus as determined by intraoperative microrecordings and magnetic resonance imaging (MRI).

Methods: In 25 patients suffering from severe levodopa sensitive parkinsonism, deep brain stimulating electrodes (n = 49) were implanted following mapping of the subthalamic nucleus by microrerecordings and microstimulation along five parallel tracks. Postoperative stereotactic radiography and fusion of pre- and postoperative MRI studies were used to determine the stereotactic position relative to the midcommissural point of the most effective electrode contacts selected for permanent stimulation (n = 49). Intraoperative microrecordings were analysed retrospectively to define the dorsal margin of the subthalamic nucleus. In cases where the dorsal margin could be defined in at least three microrecording tracks (n = 37) it was correlated with the position of the active contact using an algorithm developed for direct three dimensional comparisons.

Results: Stimulation of the subthalamic nucleus resulted in marked improvement in levodopa sensitive parkinsonian symptoms and levodopa induced dyskinesias, with significant improvement in UPDRS III scores. In several instances, projection of the electrode artefacts onto the T2 weighted MRI visualised subthalamic nucleus of individual patients suggested that the electrodes had passed through the subthalamic nucleus. When the actual position of active electrode contacts (n = 35) was correlated with the dorsal margin of the subthalamic nucleus as defined neurophysiologically, most contacts were located either in proximity (± 1.0 mm) to the dorsal border of the subthalamic nucleus (32.4%) or further dorsal within the subthalamic region (37.8%). The other active contacts (27.7%) were detected within the dorsal (sensorimotor) subthalamic nucleus. The average position of all active contacts (n = 49) was 12.8 mm (± 1.0) lateral, 1.9 mm (± 1.4) posterior, and 1.6 mm (± 2.1) ventral to the midcommissural point.

Conclusions: Subthalamic nucleus stimulation appears to be most effective in the border area between the upper subthalamic nucleus (sensorimotor part) and the subthalamic area containing the zona incerta, fields of Forel, and subthalamic nucleus projections.

High frequency stimulation of the subthalamic nucleus has proven to be a highly effective treatment for motor fluctuations and dyskinesias in advanced Parkinson’s disease. The exact mechanisms underlying deep brain stimulation have not been resolved yet and may involve various physiological and biochemical phenomena. The net effect of deep brain stimulation is considered to result in functional inhibition of target structures, which is suggested by the fact that it mimics several clinical effects elicited by lesions in the same target areas. To define the optimal site for electrode implantation, multimodal approaches for surgical targeting and intraoperative refinement of the implantation site are favoured by most centres and involve different imaging and neurophysiological mapping modes. Following surgery, additional spatial adjustments will be made by identifying the optimal contacts for chronic stimulation in individual patients.

To date there is little evidence regarding the optimal site for permanent stimulation. In particular, detailed analysis of the stereotactic position of active contacts in reference to the border of the subthalamic nucleus, as defined neurophysiologically, is lacking. This information, however, is important for understanding whether it is the subthalamic nucleus proper, as is widely assumed, or adjacent structures—especially in the subthalamic area—that modulate the antiparkinsonian effects. The latter is suggested by the fact that ablative procedures in the subthalamic area (so called subthalamotomy) had been promulgated some decades ago by certain surgeons for the treatment of rigidity and tremor in Parkinson patients.

In the present study, we correlated the position of active electrode contacts with the dorsal boundary of the subthalamic nucleus using an algorithm allowing for direct three dimensional comparisons. The dorsal margin of the subthalamic nucleus was defined by microneurode recordings, which is regarded as the most accurate method of delineating basal ganglia nuclei on an individual basis, especially when multielectrode recordings are made using five tracks in parallel.

Abbreviations: MPTP, 1-methyl-4-phenyl-1,2,3,6-tetrahydropyridine; UPDRS, unified Parkinson’s disease rating scale

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**METHODS**

**Patients**
We evaluated the position of the stimulating electrodes in 25 patients (12 male, 13 female; median age 61 years) with idiopathic levodopa sensitive Parkinson’s disease who had undergone bilateral implantations into the subthalamic nucleus at the University of Kiel. Only patients meeting the inclusion criteria, and with none of the exclusion criteria, of the ongoing German multicentre study “Kompetenznetz Parkinson” had been considered for this procedure. All patients were operated on between May 1999 and March 2002. Patient selection for the present study was based on the availability of data regarding the stereotactic positioning of the electrode contacts, which was determined as described previously. Preoperative evaluation included repeated assessment of the levodopa response as rated by the unified Parkinson’s disease rating scale (UPDRS III), magnetic resonance imaging (MRI), and additional neurological and neuropsychological examinations.

All patients provided written informed consent before surgical intervention, and the procedures were approved by the local ethics committee.

Forty nine electrodes were implanted in one unilateral operation. In one patient, unilateral electrode implantation into the ventrolateral thalamus had been done previously at another institution. Bilateral Itrel II or unilateral Kineta neurostimulators (Medtronic, Minneapolis, Minnesota, USA) were implanted one to five days after electrode implantation. In another patient a unilateral thalamotomy had been done more than 10 years before as palliation for tremor dominant Parkinson’s disease; in that patient continuous good relief of contralateral tremor was observed, but there had been progression of the disease and the development of levodopa induced side effects over recent years.

**Surgical procedure**
Deep brain stimulating electrodes were implanted under local anaesthesia following mapping of the subthalamic nucleus by microrecording and microstimulation. Microrecordings were done with five stainless steel microelectrodes with an impedance of 10 MΩ (FHC, Bowdoinham, Maine, USA), advanced in parallel using a multielectrode advancing system (MEAS, Stryker Leibinger, Freiburg, Germany). Recordings were started above the intercommissural level and rated semiquantitatively after five-channel analogue to digital conversion and on-line assessment of activity displayed by oscilloscopes and the Axsoscope software (Axon Instruments, Union City, California, USA), as well as by audio monitoring.

In addition to continuous on-line analysis during electrode advancement, recordings of one to two minutes’ duration of all five tracks were done at intervals of 0.5 mm. These data were reassessed with the Spike 2 software (CED, Cambridge, UK) to identify the level at which subthalamic nucleus activity was first detected. This allowed for discrimination of subthalamic nucleus activity from cellular activity in the zona incerta and substantia nigra.

With regard to spontaneous discharge frequency and (irregular) firing pattern—including an increase in background noise when entering the subthalamic nucleus—our results were in accordance with previous studies and will be reported separately (Weinert D, Fietzek U; in preparation).

Modulation of cellular activity, in particular of single unit activity, synchronous with passive and active movements was assessed during surgery. Such movement related activity has been detected predominantly in the upper part of the subthalamic nucleus, which is consistent with previous reports in which sensorimotor activity has been mapped to the dorsolateral subthalamic nucleus.

As there is a considerable degree of individual variability within the basal ganglia and subthalamic region (see Zhu et al) the position of active electrode contacts relative to the dorsal margin of the subthalamic nucleus will best be determined on an individual basis. The area where subthalamic nucleus activity was first recorded indicated the dorsal margin of the subthalamic nucleus and was depicted in three dimensions relative to the tracks and (active) electrode contacts. This was done with an algorithm developed by one of us (AM) using the MATLAB software (The MathWorks Inc, Natick, New Jersey, USA) which is the stereotactic coordinates defining the tracks and position of electrode contacts were projected into the commissure based coordinate system of the patient being analysed.

Microrecording was followed by microstimulation at 130 Hz and 0.1 to 10 mA (Accupulser A310 and Stimulus Isolator A365, World Precision Instruments, Sarasota, Florida, USA) at different levels, with assessment of rigidity and testing for side effects. Drug treatment had been discontinued or reduced before the operation so that patients were in the “off” state during surgery. The effects of intraoperative microstimulation—that is, the best alleviation of rigidity with least side effects—were regarded as more informative for permanent electrode implantation than the results of microrecordings. For example, subthalamic nucleus activity may have been recorded over similar distances from different tracks. In general, microrecordings and microstimulation did not lead to...
weighted MRI allowed for projection of the electrode artefact of postoperative T1 weighted MRI with preoperative T2 to the patient’s MRI. In addition, landmark based correlations ear adjustment and rotational correction of the atlas to adapt landmarks. These included the anterior commissures, the pos-

Postoperative evaluation

The stereotactic coordinates of single electrode contacts (cen-
tre of contact) were determined by different approaches—that is, correlation of preoperative and postoperative T1 weighted MRI (0.98 mm voxel size) or postoperative stereotactic skull x ray as described. Selection of the best contacts for permanent stimulation was based on elaborate clinical testing as described previously. The UPDRS ratings and active contacts reported here are based on clinical assessments three months postsurgery. The results proved stable in those patients examined one and two years after electrode implantation. Correla-
tion of MRI with a digitised Schaltenbrand and Wahren atlas integrated into the “Neuro Navigation System” (Stryker Leibinger, Freiburg, Germany) was done by referencing different landmarks. These included the anterior commissures, the poster-
ior commissures, and a mid-sagittal point, allowing for lin-
ear adjustment and rotational correction of the atlas to adapt to the patient’s MRI. In addition, landmark based correlations of postoperative T1 weighted MRI with preoperative T2 weighted MRI allowed for projection of the electrode artefact onto the preoperatively delineated subthalamic nucleus.

RESULTS

Surgical procedure and clinical results

The intraoperative results of microrecording and microstimu-
lation were used to direct macroelectrode implantation into one of the five tracks investigated. The central track was chosen more often (73.5%) than the anterior (6.1%), medial (8.2%), lateral (8.2%), or posterior tracks (4.1%) (table 1).

Following implantation of the quadrupolar electrode (model 3389, Medtronic), contacts resulting in the best alleviation of rigidity with the lowest voltage and without side effects were considered optimal and selected for permanent stimulation. As shown in table 2, contact 2 (43.9%) was chosen most often for permanent stimulation. Contacts 1 (26.5%) and 3 (23.5%) were also often selected, whereas contact 0 was rarely chosen (6%). Only one of 25 patients required unilateral stimulation in a bipolar mode.

Three and 12 months postsurgery, marked improvements in UPDRS III motor score by stimulation alone were observed, resulting in scores comparable with those achievable with levodopa (fig 1). The stimulation parameters (mean (SD)) at the 12 months follow up for 48 patients with Parkinson’s dis-

Postoperative MRI based evaluation of deep brain stimulating electrodes

Correlations of preoperative and postoperative MRI can be used to delineate the deep brain stimulating electrodes with respect to the subthalamic nucleus, as depicted by T2 weighted spin echo imaging. This is best done with MRI of high resolution and devoid of artefacts, a situation achievable by the acquisition of the preoperative images under general anaesthesia. As demonstrated for a representative patient in fig 2, the subthalamic nucleus can be clearly delineated in preoperative axial spin echo images (panel A) as well as in coronal (panels G,H,P and Q) and sagittal (panels L,N, and O) reconstructions derived therefrom. The planning tracks are indicated by red lines (right) and blue lines (left). The implanted electrodes can be visualised relative to the subthalamic nucleus using different image fusion modes—that is, a detail of the postoperative image shows part of the electrode overlaying the preoperative image (panel D), or intermediate weighting of images reveals both the electrode and the subthalamic nucleus (panel F).

Sagittal (panel L) and coronal (panels G and H) T2 weighted MRI reconstructions correlated with postoperative T1 weighted MRI (panels M,J, and K), indicate placement of the left electrode along the planning track within the subtha-
lamic nucleus, whereas the right electrode had been posi-
tioned along the anterior and ventral aspect of the subtha-
lamic nucleus. By correlating the T2 weighted MRI with a patient-adapted Schaltenbrand and Wahren atlas, the MRI delineated subthalamic nucleus is congruent with the borders of the atlas-defined subthalamic nucleus in both sagittal and coronal reconstructions (panels N to Q). The patient matched atlas has then been used to evaluate the electrode artefact from postoperative T1 weighted MRI at different levels, also indicating positioning of the left electrode within the subthalamic nucleus (panels R to U). MRI may also be valuable for the analysis of electrodes implanted in patients who previously had ablative procedures within the basal ganglia. In one patient a thalamo-
subthalamotomy had been placed within and towards the base of the Vop (nucleus ventralis oralis posterior thalami) according to the Schaltenbrand and Wahren atlas, which had been correlated with the T1 weighted MRI (fig 3). In this patient deep brain stimulation was done in the vicinity of, but in an area clearly distinct from, the site lesioned previously.

### Table 1

<table>
<thead>
<tr>
<th>Track</th>
<th>Electrodes (n=49)</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Central</td>
<td>36</td>
<td>73.5%</td>
</tr>
<tr>
<td>Medial</td>
<td>4</td>
<td>8.2%</td>
</tr>
<tr>
<td>Lateral</td>
<td>4</td>
<td>8.2%</td>
</tr>
<tr>
<td>Posterior</td>
<td>2</td>
<td>4.1%</td>
</tr>
<tr>
<td>Anterior</td>
<td>3</td>
<td>6.1%</td>
</tr>
</tbody>
</table>

The decision for one of the five tracks was based on the results of microrecordings and microstimulation.

### Table 2

<table>
<thead>
<tr>
<th>Contact</th>
<th>Per cent of evaluated electrodes (n=49)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3*</td>
<td>23.5</td>
</tr>
<tr>
<td>2*</td>
<td>43.9</td>
</tr>
<tr>
<td>1</td>
<td>26.5</td>
</tr>
<tr>
<td>0</td>
<td>6.1</td>
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*One of the 49 electrodes was employed for bipolar stimulation using contacts 2 and 3.
Coordinates of active electrode contacts

Retrospective analysis of the stereotactic position of the active electrode contacts was done in 25 patients for whom postoperative T1 weighted MRI of sufficient quality or stereotactic radiographic examinations were available. Such analyses could not be undertaken in other patients (n = 15) implanted with subthalamic nucleus electrodes during the same period because of motion artefacts in the postoperative MRI, missing postoperative T1 weighted MRI, or missing postoperative stereotactic x-rays. For the 25 patients evaluated, the mean and median coordinates (relative to the midcommissural point) of all active contacts are summarised in table 3. The mean (SD) laterality of all active electrode contacts (12.8 (1.0) mm; median 12.7 mm) correlated well with the laterality of the subthalamic nucleus, as determined 3 mm ventral to the intercommissural plane in T2 weighted MRI of 35 patients (12.7 (1.3) mm). However, in the dorso-ventral direction the mean (−1.6 mm) and median (−1.8 mm) z coordinate (table 3) of all active contacts do not project within the subthalamic nucleus proper, but suggest an area between the dorsal margin of the subthalamic nucleus and the subthalamic region according to different stereotactic brain atlases. Moreover, 12 of 49 active contacts (24.5%) were located within 0.5 mm of the intercommissural plane or further dorsal; they were thus most probably in the subthalamic area.

Correlation of active electrode contacts with microrecordings

To account for individual variability within the basal ganglia and the subthalamic area, the position of single (active) electrode contacts should preferentially be put in relation to the location of the structures of interest. For that purpose, we developed an algorithm for three dimensional plotting of the (active) electrode contact within the same stereotactic (commissure based) coordinate system, showing the microrecording tracks explored intraoperatively (fig 4). The intercommissural plane is indicated (fig 4, grey square) for orientation purposes, while the three dimensional plots can be rotated to be viewed from different angles of interest. The area where subthalamic nucleus activity was first recorded (fig 4, green lines) and which corresponds to its dorsal margin was defined by retrospective off-line analysis of intraoperative microrecordings (Spike2 software; as described in Methods). Despite continuous on-line analysis during the operation, recordings of longer duration (one to two minutes) used for off-line reassessments had been made at intervals of 0.5 mm. This results in some uncertainty over the exact location of the border. Taking the length (1.5 mm) of single electrode contacts into account as well (the coordinates refer to the centre of the contact), contacts located within ±1.0 mm from the neurophysiologically mapped subthalamic nucleus margin (indicated by

![Figure 1](https://example.com/figure1.png)

**Figure 1** Unified Parkinson’s disease rating scale (UPDRS III) motor score determined preoperatively and three and 12 months after surgery. MED, suprathreshold dose of levodopa; DBS, stimulation with optimal contacts and stimulation parameters.

![Figure 2](https://example.com/figure2.png)

**Figure 2** Multimodal magnetic resonance image (MRI) based evaluation of deep brain stimulating electrodes in one illustrative case. The subthalamic nucleus can be delineated in an axial slice 3 mm ventral to the intercommissural plane (panels A and C) as well as in coronal (panel B) and sagittal (L) reconstructions derived from the same sequence. The planning tracks for the left electrode (blue line) and the right electrode (red line) are indicated, as well as AC and PC (green line intersections) in several images. An evaluation of the position of the electrodes 3 mm ventral to the intercommissural plane, using different modes of preoperative and postoperative MRI correlation is shown in panels C to F. Compared with the preoperative image (panel C), this reveals positioning of the left electrode within, and of the right electrode slightly anterior to, the subthalamic nucleus, as indicated by superimposition of a detail of the postoperative MRI (panel E) onto the preoperative image depicting part of the electrode (panel D) or by intermediate image weighting (panel F). Analyses of coronal reconstructions at two different levels illustrate the position of both electrodes (panels J and K) relative to the subthalamic nucleus (panels G and H). The anatomy of the subthalamic nucleus according to T2 weighted MRI was congruent with correlated slices of the Schaltenbrand and Wahren atlas (panels N to Q). More detailed analysis of the left electrode (panels L to U) suggested passing of the electrode through the more dorsal aspect of the STN (panels T and U). In (L) and (M), the surgical planning tracks (blue lines) were superimposed. See overleaf.
green lines in fig 4) were categorised as being located in the border area.

The findings in the representative patients show a heterogeneous pattern of localisation of active contacts (fig 4). Although fewer electrode contacts selected for permanent stimulation were located within the subthalamic nucleus (for example, patient 3, left electrode), most active contacts project onto the upper margin of the subthalamic nucleus or above the nucleus into the subthalamic area. Interestingly, such contacts were selected despite the fact that other electrode contacts were located within the subthalamic nucleus (fig 4). The position of active contacts relative to the border of the subthalamic nucleus was classified into three categories,

Table 3  Active electrode contacts (n = 49) relative to the mid-commissural point

<table>
<thead>
<tr>
<th></th>
<th>x</th>
<th>y</th>
<th>z</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean (95% CI)</td>
<td>12.8</td>
<td>-1.9</td>
<td>-1.6</td>
</tr>
<tr>
<td>SD</td>
<td>1.0</td>
<td>1.4</td>
<td>2.1</td>
</tr>
<tr>
<td>Median</td>
<td>12.7</td>
<td>-1.5</td>
<td>-1.8</td>
</tr>
</tbody>
</table>

Values [mm] of 49 electrodes implanted in 25 patients. CI, confidence interval.
which are summarised in table 4. To make this analysis most accurate, only procedures in which the dorsal border could be clearly determined from at least three microelectrode tracks were included (37 of 49 implanted electrodes; see table 4). As summarised in table 4, most active contacts were detected above (38%) or at the dorsal margin of the subthalamic nucleus (32%).Only 30% of the active contacts were located within the subthalamic nucleus. Most of these contacts appeared to be located in the upper, that is the sensorimotor, part of the subthalamic nucleus.

### DISCUSSION

To obtain information about the actual site of chronic stimulation and the anatomical structures that might be involved in the therapeutic effects of subthalamic nuclear stimulation, we have evaluated the spatial position of electrode contacts selected for permanent stimulation. In all patients, deep brain stimulation resulted in marked improvements in UPDRS III scores, to an extent similar to that reported by others, and both levodopa induced dyskinesias and dopaminergic treatment could be reduced. We observed that UPDRS III scores at three and 12 months after surgery were improved without stimulation and medication when compared with the preoperative state. Possible explanations include the following: carryover effects of long acting dopamine agonist (cabergoline), despite the fact that the drug was discontinued approximately two days before evaluation; carryover effects after cessation of stimulation approximately one hour before clinical rating; and long lasting thalamicotomy-like effects still present three and 12 months after the operation, though this seems rather unlikely.

Projection of electrode artefacts from postoperative T1 weighted MRI onto the subthalamic nucleus, as visualised by preoperative T2 weighted MRI, provided direct evidence for electrode placement into the subthalamic nucleus. With this method, the position of the electrode can be assessed relative to the MRI defined anatomy of the subthalamic nucleus in individual patients. This approach has been useful for postoperative routine evaluation preceding implantation of impulse generators to document the correct placement of electrodes. Such analysis, however, appears to be of limited value for assessments in the dorso-ventral axis and with respect to defining the dorsal border of the subthalamic nucleus—particularly as the axial T2 weighted MRI used had a slice thickness of 3 mm. This is in accordance with the perception that surgical targeting of the subthalamic nucleus based solely on its appearance in T2 weighted MRI is imprecise, and the relevance of intraoperative microrecordings for best target definition has always been stressed. Similarly, individual anatomy is defined more precisely by microrecordings than by correlation with different stereotactic brain atlases, although complex morphometric adjustments may improve upon correlation of atlas with patient data.

In delineating the basal ganglia nuclei—that is, mapping the boundaries of the subthalamic nucleus on an individual basis—-intraoperative neurophysiology has to be regarded as the most accurate procedure. For this purpose, we reviewed the results of elaborate microrecordings, including detailed off-line reassessment. As we routinely record from five tracks in parallel, an area of 4.6 × 4.6 mm was mapped systematically in intervals of 0.5 mm. To be suitable for three dimensional analysis, a minimum of at least three informative tracks was required, which exceeds the number of micro electrode tracks evaluated for similar purposes by another centre. This allowed the precise delineation of the dorsal border of the subthalamic nucleus in the vast majority of procedures (37 or 49 electrodes). As the average position of all active contacts suggested scattering in the upper subthalamic nucleus/subthalamic area, we focused on the dorsal margin of the subthalamic nucleus instead of defining the whole nucleus or its ventral margin towards the substantia nigra.

The stereotactic position of single electrode contacts was determined from postoperative stereotactic x ray examinations and MRI done with high resolution (that is, 0.98 mm voxel size). These methods allow one to directly determine the definitive localisation of single electrode contacts, which otherwise may be done by intraoperative teleradiography when available. In general, methods based on postoperative imaging are preferable to procedures in which the position of electrode contacts is merely extrapolated from the position intended intraoperatively.

A novel algorithm was developed allowing for detailed patient by patient analysis in which the definitive position of the active electrode contact was compared with the dorsal margin of the subthalamic nucleus at a glance. Despite a considerable degree of variation with respect to active contact localisation, 70% of the active contacts were observed either at the margin of the subthalamic nucleus or clearly above the nucleus within the subthalamic region. Less than one third of the active contacts (29.7%) clearly projected within the subthalamic nucleus. Several of these contacts appeared to be located in the upper (sensorimotor) subthalamic nucleus.

This pattern of active contact localisation is reflected by the mean coordinates of the active contacts in all 25 patients...
(n = 49 electrodes) which may serve as an approximation for a “best target at an average.” This was located 12.8 mm lateral, 1.9 mm posterior, 1.5 mm posterior, and 1.6 mm ventral (median 1.8 mm) to the midcommissural point. These coordinates compare well with recent studies in which the average position of the active contacts relative to the midcommissural point had been estimated at 12.3 mm lateral, 1.7 mm posterior, and 1.7 mm ventral, and 1.17 mm lateral, 1.6 mm posterior, and 2.5 mm ventral. However, Benabid reported somewhat different coordinates for more than 150 patients: the average location of the contacts leading to the best clinical responses was more ventral to the intercommissural plane (~3.16 mm) and slightly more medial (12.1 mm). A similar frequency (163 (25) Hz), and the variances of both parameters described recently by Starr et al.11 that is, 11.8 mm lateral, 2.4 mm posterior, and 3.8 mm ventral to the midcommissural point.

According to different stereotactic atlases for basal ganglia anatomy,14–20 the average position of all active contacts in our patients coincides with the interface formed by the antero-dorso-lateral margin of the subthalamic nucleus, the zona incerta, and fields of Forel. This is consistent with recent studies using MRI based techniques to determine the position of active contacts,13–15 although in another study most active contacts had rather been mapped more ventrally into the (sensorimotor) subthalamic nucleus. In these studies frequent stimulation at the dorsal margin of the subthalamic nucleus and within the subthalamic area has been observed.14–16 The volume of tissue stimulated with deep brain stimulating electrodes has been estimated to be in the range of 2 to 3 mm around the electrode contact.14 This is in agreement with estimations of Saint-Cyr et al., undertaking deep brain stimulation with amplitudes (2.8 V) similar to those used in our patients, although pulse width (89 (38) μs), frequency (163 (25) Hz), and the variances of both parameters were higher than in our patients.

Without doubt, the exact mechanisms of deep brain stimulation will remain a matter of debate.4 Nevertheless, it is worthwhile considering the position of active contacts with respect to structures located at the interface between the subthalamic nucleus and the subthalamic area, as several of these may be involved in the therapeutic effects of subthalamic nuclear stimulation. High frequency stimulation within the subthalamic nucleus mimics the effect of a lesion, and inhibition of subthalamic nuclear neuronal activity may in fact be based on a rather direct effect on neuronal cell bodies (for example, modulation of membrane potential) within the sensorimotor region of the subthalamic nucleus. This concept is supported by studies in parkinsonian monkeys, where lesions placed directly within the subthalamic nucleus improved parkinsonian symptoms.17–19 In addition, reversal of parkinsonian symptoms has been observed intraoperatively following microinjection of lignocaine (lidocaine) or muscimol into the subthalamic nucleus proper.19 Taking the current spread around the electrode contact and with monopolar stimulation (48 of 49 electrodes) towards the infralavicular stimulator in agreements, modulation of subthalamic nuclear neuronal activity may well occur with electrode contacts located at the dorsal margin of the nucleus.

However, if only the nucleus and not other subthalamic structures represents the appropriate target, one has to expect more active contacts to be located within in the nucleus. Furthermore, as the excitability of axons is greater than that of the soma, (additional) modulation of subthalamic projections is very likely. In fact, modulation of fibre tracks rather than cell bodies was strongly suggested by assessments of the energy required for alleviating parkinsonian symptoms in postoperative testing.10 On the other hand, excitation of afferent axons to the subthalamic nucleus (for example, from the globus pallidus) may lead to indirect inhibition of subthalamic nuclear neuronal activity by the release of γ-amino butyric acid (GABA). Similarly, the axons of subthalamic nuclear efferents may be excited by deep brain stimulation despite inhibition of proper neuronal activity within the nucleus.10 Such axonal high frequency stimulation of subthalamic nuclear efferents may modulate the activity of projection nuclei, perhaps by disturbing (“jamming”) basal ganglia circuits.5,46–48

Beyond modulation of projections from or to the subthalamic nucleus, other structures located in the subthalamic area have to be considered for the therapeutic effects of deep brain stimulation, for example the pallidothalamic fibre tracks (fields of Forel) and the zona incerta. Both structures represent important historical deep brain lesioning targets. Half a century ago, interruptions within the pallidofugal fibre system, including anotomy in the zona incerta (fields of Forel), was often undertaken and represent the earliest stereotactic procedures for Parkinson’s disease, mainly parkinsonian tremor.21–24 In camptopaty, both principal pallidofugal fibre tracts—the ansa lenticularis and the lenticular fasciculus—which reach the fields of Forel and eventually join into the thalamic fasciculus (field of Forel H2) are targetted. Although, it may be speculated that high frequency stimulation encompassing the fields of Forel should in fact increase the activation of pallidothalamic projections (in the parkinsonian state, the globus pallidus internus is already hyperactive), deep brain stimulation may lead to a lesion-like effect by altering the pattern of pallidal output.

Another target for the surgical treatment of parkinsonian tremor and for various hyperkinetic disorders, the ventrolateral thalamus, was introduced by Hassler and Riechert, and was modified by Mundinger to include the zona incerta. This has been referred to as subthalatomy. Such lesions primarily included the zona incerta and probably also the fields of Forel, the prelemniscal radiation, and perirubral fibre tracks. Similar lesions in the subthalamic area have been described by others, mainly for parkinsonian tremor, although the concomitant effects on other parkinsonian symptoms have been noted.25–29 Interestingly, several functions that have been linked to the zona incerta in rodents are affected in Parkinson’s disease, including disturbed somatosensory perception, locomotion, feeding and drinking, and arousal and attention. The zona incerta in rodents has widespread reciprocal neural connections with all levels of the neouraxis, including afferents from different regions of the cerebral cortex, diencephalon, basal ganglia, and brain stem nuclei, and its major projections are to the dorsal thalamus.30 The dorsal sector of zona incerta is a major zone for termination of ascending axons from brain stem nuclei and also the origin for reciprocal innervation, and this may exert relay functions before transmitting information to the dorsal thalamus (that is, the intralaminar nuclei) and cortex.31–34 Interestingly, nigrostriatal denervation induced by 6-hydroxydopamine (6-OHDA) lesioning in the substantia nigra of rodents caused hyperactivity in the dorsolateral zona incerta neurons. From this it may be hypothesised that functional inhibition of such neurons by high frequency stimulation may be involved in the therapeutic effects of deep brain stimulation. Moreover, subthalamic nucleus stimulation may also act by direct modulation of brain stem motor nuclei, in particular the pedunculopontine nucleus.35–37

Although the precise relevance of the different structures discussed cannot be unravelled at present, it is possible that the beneficial effects of subthalamic nuclear stimulation depend on simultaneous modulation of several structures at once. Correlations between the anatomical site of stimulation and clinical improvements are subject to an ongoing study which is based on lateralised UPDRS III scores, as bilateral stimulation often involves different contacts on the left and right sides. Contacts located outside the subthalamic nucleus (more than 3 mm posterior to the margin) appear to be less effective in terms of motor improvement and energy consumption than contacts located in the border area or
within the subthalamic nucleus (Herzog et al, in preparation). Nevertheless, the border area may be regarded as superior because stimulation was more often given in this area than within the subthalamic nucleus, although more ventral because stimulation was more often given in this area (motion). Nevertheless, the border area may be regarded as superior.

ACKNOWLEDGEMENTS

We are indebted to Hans Schieppi and others at Stryker Leibinger (Freiburg, Germany) for making available the Neuronavigation software. We thank Dr G Brinkmann (department of radiology) for his advice and committed help in establishing the MRI sequences into clinical routine, and Professor O Jansen (neuroradiology section, department of neurosurgery) and the technical staff of both departments for their great support. The cooperation of our nursing staff and of the colleagues from the department of anaesthesiology is greatly appreciated.

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Competing interests: none declared

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