The oculomotor nerve: Clinical anatomy

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Citation

Abstract
In this article, we illustrate and briefly describe a medial approach, in the sagittally sectioned preserved human brain, to display the oculomotor nerve, in situ and in continuity. The method has been successfully used by Milanes-Rodriguez for several cohorts of our second-year medical students, and can be completed within a 90-min dissecting session. We also review the most common clinical manifestation of oculomotor disorder

INTRODUCTION
Despite congenital anomaly of oculomotor nerve is a rare condition some reports about oculomotor disorders due to nerve fenestration [1,2,3], abnormal course [4], hypoplasia in congenital fibrosis of the extraocular muscles [5,6], in Duane-Radial Ray Syndrome [7] in congenital extraocular muscle misinnervation [8], among others have been published [9,10,11,12,13].

The oculomotor nerve arises from the anterior aspect of mesencephalon (midbrain). There are two nuclei for the oculomotor nerve:
- The oculomotor nucleus originates at the level of the superior colliculus. The muscles it controls are the ciliary muscle (affecting accommodation), and all extraocular muscles except for the superior oblique muscle and the lateral rectus muscle.
- The Edinger-Westphal nucleus supplies parasympathetic fibres to the eye via the ciliary ganglion, and thus controls pupil constriction.

On emerging from the brain, the nerve is invested with a sheath of pia mater, and enclosed in a prolongation from the arachnoid.

It passes between the superior cerebellar (below) and posterior cerebral arteries (above), and then pierces the dura mater in front of and lateral to the posterior clinoid process, passing between the free and attached borders of the tentorium cerebelli.

It runs along the lateral wall of the cavernous sinus, above the other orbital nerves, receiving in its course one or two filaments from the cavernous plexus of the sympathetic, and a communicating branch from the ophthalmic division of the trigeminal.

It then divides into two branches, which enter the orbit through the superior orbital fissure, between the two heads of the lateral rectus.
Here the nerve is placed below the trochlear nerve and the frontal and lacrimal branches of the ophthalmic nerve, while the nasociliary nerve is placed between its two rami:

- superior branch of oculomotor nerve
- inferior branch of oculomotor nerve

As mentioned before the oculomotor nerve or cranial nerve number III is one of the cranial nerve that together with the trochlear (IV) and abducent (VI) supplies the extra ocular muscles that position the globes in the orbital cavity. Extraocular muscles paralyses result in failure of one eye to rotate in concern with the other producing misalignment of the visual axis with the resulting diplopia as a primary symptom.[19,20,21,22].

These two motor nuclei of origin located in each side of the midbrain tegmentum, under the cerebral aqueduct at the level of the superior colliculi as can see in Figure 1

The oculomotor nucleus: The axons of this nucleus contain somatic efferent fibers that supply the following muscles:

- Levator palpebrae superioris (elevates the upper eyelid)
- Superior, medial and inferior rectus and inferior oblique (all act on the eyeball)

Course of the nerve:

The nerve travel through the following parts:

1. Intraparechymal midbrain part: The axons of the cell bodies course ventrally in close relation with the red nucleus and exit from the midbrain at the medial side of the cerebral peduncle. Any lesion at this level can involved the red nucleus producing ipsilateral hand tremor

2. Subararacnoid part: Once the nerve exits is found in the subaracnoid space at the interpeduncular fossa, the nerve passes between the superior cerebellar and posterior cerebral arteries. Any aneurysm of these arteries can cause palsy of this nerve. (Figure 2)

3. Cavernous sinus part: The nerve runs in the lateral wall of the cavernous sinus Superiorly. Any masses at this level coming from the sella can cause dysfunction of the nerve. (Figure 3)

4. Orbital part: The nerve enters the orbit through the superior orbital fissure in the commom tendinous ring and divides into two branches one superior and one inferior.

The superior division innervates: (Figure 3)

- The levator palpebrae muscle.
- The superior rectus muscles.
- The middle rectus muscle

The inferior division innervates:

- The inferior oblique.
- Inferior rectus
- Also contain parasympathetic fiber for the ciliary and sphincther of the pupil muscles. [12,23,24,25]

**CLINICAL DEFICIT**

**SIGNS AND SYMPTOMS**

The patient will usually present with sudden onset unilateral ptosis (or rarely, a bilateral ptosis if the damage occurs to the third nerve nucleus), which is frequently accompanied by significant eye or head pain. The patient rarely complains of double vision because the ptosis obscures the vision in the affected eye; however, if the lid is manually elevated, the patient will experience diplopia. Acuity is typically unaffected unless damage occurs in the superior orbital fissure and cranial nerve II is also involved. The affected eye positions in a non-comitant exotropic, hypotropic position (down and out). [17,18]

There will be limitation of elevation, depression and adduction. There is an underaction of the superior, inferior, and medial recti muscles and inferior oblique muscle, which may be total or partial. The pupil may be dilated and minimally reactive to light (pupillary involvement), totally reactive and normal (pupillary non-involvement), or may be sluggishly responsive (partial pupillary involvement). The patient is frequently elderly and often has concurrent diabetes and/or hypertension. [12]

In a lesion at the level of the nucleus or nerve, the following signs will be seen in the patient:

1. Ptosis in the ipsilateral eye, because of loss of the
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1. Levetor palpebrae superioris. If the pupil is cover completely the patient will not see with the involved eye.

2. The globe is found fully abducted and downward, due to the action of the lateral rectus that is supplied by the abducent nerve, and the superior oblique supplied by the trochlear nerve.

3. The pupil is dilated (mydriasis) and unresponsive to light due to sphincter pupillae paralyses. The patient will complain of photophobia in bright light.

4. Accommodation difficulties due to ciliary muscle paralyses

5. Diplopia

The visceral oculomotor nucleus, also called Edinger-Westphal nucleus: The axons from this nucleus contain parasympathetic preganglionic fibers that make synapses in the ciliary ganglion. The postganglionic fibers innervates the following intraocular muscles: Pupillary sphincter. (Figure 4) and ciliary muscles

Aberrant regeneration occurs when damage to the CN III results in a resprouting and miscommunication of nerve to muscles. Fibers meant for certain muscles innervate the wrong muscles. The inferior rectus and medial rectus both communicate with the levator. As the medial rectus receives stimulation to contract and adduct the eye, it also stimulates the levator. Upon adduction, there will also be lid elevation and widening of the palpebral fissure. With attempted abduction, the medial rectus and the levator will be inhibited. The lid assumes a ptotic state when the eye abducts.

The inferior rectus shares fibers with the levator. When the patient looks down, the eyelid will retract, increasing the palpebral fissure. The medial rectus shares communication with the pupil. When the patient adducts, the pupil constricts.

There are two types of CN III aberrant regeneration: primary and secondary. The secondary form commonly occurs after CN III palsy, resulting from direct damage to CN III. Aneurysm, trauma and compression by tumor are typical causes. Inflammatory causes of CN III palsy may result in aberrant regeneration. Aberrant regeneration does not occur after CN III palsy from ischemic infarct.

Primary aberrant regeneration occurs independently of antecedent CN III palsy. A slow-growing mass, such as an aneurysm or meningioma within the cavernous sinus, causes this variant. The mass theoretically exerts subclinical compression on CN III, damaging the nerve fibers with a simultaneous regeneration and aberrant resprouting of fibers to incorrect muscles. The patient may not complain of diplopia or ptosis, or even be aware of the changes occurring.

Our last comment about eye movements and oculomotor pathology is related with the unexpected, strong persistence of the eye movements in the direction of action of the disinserted muscle indicates that anatomy insertion not only occur at the point at which the muscle blends into the sclera but also involves the surrounding connective tissue. Orbital connective tissue can be considered an additional and important locomotor system therefore conservation of some eye movements in oculomotor pathologies can be expected.

Figure 1

Figure 1: Cross-section of the midbrain at the level of the superior colliculi with the cerebellum attached posterior. The nuclei of origin situated in the central gray substance in front of the cerebral aqueduct. The axons travel through the midbrain tegmentum to exit medial to the cerebral peduncle. (Dissection made by Milanes-Rodriguez)
Figure 2
Figure 2: Base of the skull showing the exit of the oculomotor nerves and entrance in the cavernous sinus. (Dissection made by Milanes-Rodriguez)

Figure 3
Figure 3: Base of the skull, with the cavernous sinus opens showing the path follow by the oculomotor n at this level and entrance through the common tendinous ring to supply the extraocular muscles except superior oblique and lateral rectus muscles. (Dissection made by Milanes-Rodriguez)

Figure 4
Figure 4: Axons from Edinger- Westphal nucleus contain preganglionic parasympathetic fibers that make synapses in the ciliary ganglion. Those postganglionic fibers supply the ciliary muscle and the sphincter of the pupil. (Diagram made by Milanes-Rodriguez)

References
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