the influence of the patients selected from any response to the dose of irradiations given in explaining the final results. As mentioned in our paper, the location of the tumor plays a role in prognosis. If future studies are able to demonstrate a dose response curve for glioblastoma multiforme, then this factor of location coupled with the ability to restrict irradiation to the diagnostically defined limits of the tumor may be exploited for selected patients.

It is difficult to evaluate the treatment alone as the means of judging results in brain tumor survival. Tumor volume and anatomical position, as well as aggressiveness of the tumor must also be taken into consideration. It does seem that the frontal lobe position appears to favorably influence survival. Position and tumor volume may ultimately be included in a staging format for brain tumors. Overall, however, radiotherapy does seem to lengthen survival times and it is possible to treat a smaller volume more accurately.

RUTH G. RAMSEY, M.D.
WILLIAM N. BRAND, M.D.
Urbana, Illinois

References

International Education in Neurological Surgery

TO THE EDITOR: Having recently become a trustee of the Foundation for International Education in Neurological Surgery, I have become aware of its need for funds. Although I had received information from the president, secretary, and trustees of the Foundation in the past asking me to become a member, I had never appreciated the importance of the support of the neurosurgical profession, having had the impression that the Foundation had plenty of money and was looking for places to dispense it. Nothing is further from the truth. Although there is support from the five major neurological societies and a handful of individual neurological surgeons, broad support from all neurological surgeons is really needed. I would like to bring this to the attention of the profession as it is a very worthwhile purpose. It is only $10 a year to become a member and $50 a year to become a sustaining member.

ERNEST SACHS, JR., M.D.
Hanover, New Hampshire

Cuatico Myelographic Needle

TO THE EDITOR: With respect to the "Cuatico myelographic needle" described in 1968 (W Cuatico, W Gannon, E Samouhos: A needle designed for myelography. Technical note. J Neurosurg 28:87-88, 1968) there have been isolated comments to the effect that occasionally fine nerve filaments have been found stuck to the side holes of the needle during removal of the needle. It should be pointed out that the diameter of the side holes of this needle is such that it would be a physical impossibility for an intact nerve root to be damaged in such a fashion. More likely, a thin filament of nerve fiber may have been separated from the main nerve itself or perhaps a sheath of arachnoid that may grossly look like nervous tissue. At any rate, the following is recommended to avoid any such occurrence:

1. At no time should a needle be removed while negative pressure is still being applied.
2. A few drops of the previously removed CSF should be injected through the needle to dislodge anything that may inadvertently have been stuck to the sideholes prior to needle removal.
3. It is recommended that the needle be placed as close to the midline as possible, preferably with the patient prone and under fluoroscopic control.

WILLIAM CUATICO, M.D.
New York, New York