case is placed between the brain stem and the artery and not touching the seventh or eighth cranial nerve. Further evidence that this is not trauma is the postoperative course, again discussed in the paper, which shows improvement in strength, which usually begins quite promptly and gradually comes to normal.

PETER J. JANNETTA, M.D.
Pittsburgh, Pennsylvania

Breaking of an Aneurysm Clip

TO THE EDITOR: The papers by Drs. Servo and Puranen (Servo A, Puranen M: Delayed breaking of a Heifetz aneurysm clip. Case report. J Neurosurg 47:463-465, September, 1977) and Drs. Quest and Countee (Quest DO, Countee RW: Fractured aneurysm clip. Case report. J Neurosurg 47:466-468, September, 1977) draw attention to three cases of aneurysm clip fracture. May I make the point that the application of a bead of methyl methacrylate to a well applied clip will prevent separation of the blades in the event of fracture and will also prevent the clip from slipping off the aneurysm? A disadvantage of this technique is that it makes surgical encores impossible, but these should not be necessary if clips are seen through the operating microscope to be accurately placed.

PATRICK CLARKE, M.D.
Middlesbrough, England

Commissurotomy for Pain

TO THE EDITOR: The articles by Drs. Cook and Kawakami (Cook AW, Kawakami Y: Commissural myelotomy. J Neurosurg 47:1-6, July, 1977) and Dr. King (King RB: Anterior commissurotomy for intractable pain. J Neurosurg 47:7-11, July, 1977) demonstrate that the postoperative sensory deficits are not in accord with the rationale currently accepted for commissural myelotomy. Nevertheless, the authors do not attempt to correlate these findings with the results of Hitchcock's stereotactic myelotomy,1,2 as do other papers they both refer to, nor is he quoted. The inconsistency of sensory changes is not discussed by Cook and Kawakami, but it is duly stressed by King, who finally suggests the possible involvement of a non-lemniscal system.

In 1973, I stated, based on the results of stereotactic myelotomy, that this is not a segmental commissural procedure but rather the interruption of an ascending nonspecific multisynaptic pathway, which can presumably be equated to other current extralemniscal targets such as the pulvinar or the centromedianum-parafascicularis complex at the thalamic level.3-5 These single first cervical central cord stereotaxic lesions produced a widespread alleviation of pain, which oddly included both the upper and lower halves of the body.1,5 Only subjective analgesia was usually induced, whereas the discrimination between sharp and blunt components as well as the ability to localize stimuli were preserved.3-5

King reports an interesting case of pain relief in a patient who already had a bilateral cordotomy with an adequate anesthesia. Similar results were obtained in three such cases in a series of 75 patients,4 further suggesting that fibers other than the spinothalamic are implicated. I agree with King's conclusion that myelotomy has a relevant place in the management of midline and/or bilateral pain, but I think that some of the developments he foresees have already been made.4 I do not agree, however, with many of Cook and Kawakami's conclusions: an open surgical procedure is not necessary, and therefore dysesthesiae and proprioceptive alterations can be avoided. Nor do I think that it can be stated based on only two cases that myelotomy is not indicated for bilateral pelvic pain due to malignancies. Indeed, satisfactory results were achieved in 33 of 42 cases with midline and/or bilateral lower body pain of neoplastic origin.4 Curiously enough, no follow-up time is mentioned in any of their cancer cases.

JORGE R. SCHVARCZ, M.D.
Buenos Aires, Argentina

References

4. Schvarcz JR: Spinal cord stereotactic techniques re trigeminal nucleotomy and extralemniscal myelotomy. Special Lecture, VIIth Sym...
Neurosurgical forum


RESPONSE: Dr. Schvarcz’s desire to emphasize the inconsistency with conventional neurological doctrine of sensory findings after so-called commissurotomy is indeed appropriate. There is no question in our experience not only in patients with myelotomy, but also in those with other spinal cord disease, that many problems exist with our concepts of pain and the mode of central transmission of this and other sensory modalities. We have a paper in preparation at this time discussing such problems. The fact is that the term “commissurotomy myelotomy” is a misnomer. The only purpose in retaining the term is that it serves to identify a subject. At operation the commissure is divided, but this may have little to do with pain relief other than that which is segmental. The probability is great that the manipulation carried out incidental to performing myelotomy interrupts other fiber systems which have more to do with the results than simply commissure section.

Dr. Schvarcz draws attention to his own work, with which I am familiar, as with the medical reports he mentions by Hitchcock. Their experiences are important to appraise in any general consideration of pain and so-called pain pathways, but have little relevance in consideration of the description of operative technique and results as we reported.

The reference to the two cases of failure in patients with cervical cancer is indeed our experience. Whether this would be the result in future cases in our hands or those of others is impossible to know. I do know that I will, because of this experience, think twice before suggesting this procedure for the next patient with a similar problem. This is not to say I feel broad generalizations are warranted; it simply states that our anticipated result in several cases was not realized.

ALBERT W. COOK, M.D.
Brooklyn, New York