nearly normal lives. The imbalance in the supply and demand for organs is an extremely critical problem that must be corrected to achieve 10,000 kidney transplants a year and to increase the availability of organs to patients who require heart or liver transplants. Transplantation currently represents the preferred therapeutic and economic alternative to conventional therapies for many of these desperate patients. The medical cost of transplantation can be expected to decline further as new drugs and better use of presently available immunosuppressive drugs reduce the need for rehospitalization for the management of rejection episodes and complications. Obviously the value of rehabilitation must also be considered, since successful transplantation returns more individuals to productive lives than is possible with any of the alternative therapies.

Aside from a recognition of the need for more awareness of the current status of transplantation, two other problem areas surfaced during discussions at the ASTS meeting. One relates to establishing simple criteria by which a potential donor might readily be identified, and the other concerns the question of reimbursement for donor-related costs. The most important point to underscore is that, if there is a potential donor, physicians should immediately contact the Transplant Program, which should have its telephone number available in all intensive care units and emergency rooms. A transplant surgeon should be available at once to consult with the neurosurgeon regarding the suitability of a donor organ so that the transplant decision process is not prolonged. The costs related to the determination of brain death and the subsequent tests should be borne by the Transplant Program rather than the donor’s family.

Organ donation is a responsibility that involves potential donors, their families, their primary physicians, and transplant surgeons. Transplant surgeons are committed to being responsive to calls from neurosurgeons and trauma surgeons, and to assisting them in every manner possible. The primary beneficiaries of these efforts are the recipients of organ transplants and the families of organ donors, who find solace in providing life to others at a time of personal tragedy.


to the trivial nature of the injury. L2 When dealing with trauma in infants it is essential to maintain a degree of skepticism with regard to the trivial nature of the injury.3,4

It is inconceivable that bilateral SDH’s with retinal hemorrhages could result from such minor head injuries.

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RESPONSE: We thank Dr. Rekate for his comments and his interest in our paper. The most common cause of trauma in our series was a fall backward while sitting or standing. About one-half of the injuries occurred when the child hit his occiput against a tatami mat, which is rather soft and is commonly used in Japanese houses. This observation was made mainly by the child’s mother, and the alleged history in each case was not always critically evaluated. However, we do not believe that the injuries were caused by battering or shaking because the mode of injury was one that is frequently noted in infants and toddlers in our country, and because the history presented by the mother was quite plausible in the situation. In addition, in Japan the mode of child abuse is almost exclusively a blow or throw, not shaking as in the United States, and results in external wounds in all cases: no bruise or excoriation was noted in any infant in our series. Reports on acute subdural hematoma (SDH) due to child abuse are extremely rare in Japan. We are now preparing for

Subdural Hematomas in Infants

To THE EDITOR: Drs. Aoki and Masuzawa, in their article on infantile subdural hematomas (SDH’s) (Aoki N, Masuzawa H: Infantile acute subdural hematomas. Clinical analysis of 26 cases. J Neurosurg 61:273–280, August, 1984), have presented the clinical, radiological, and surgical aspects of this rather common condition. They have failed to recognize that most, if not all, of these babies suffered from the “whiplash shake syndrome” and are victims of child abuse. While not totally pathognomonic of shaking, the constellation of SDH and retinal hemorrhage in the context of a historically trivial injury should be regarded as whiplash shake syndrome unless another etiology can be determined.1,2 When dealing with trauma in infants it is essential to maintain a degree of skepticism with regard to the trivial nature of the injury.3,4

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publication a paper on our own experience as well as on the reported cases in Japan of child abuse causing acute SDH.

We are very interested in the articles published in the United States since Caffey's report in 1972 in which the majority of cases of acute SDH in infants were caused by abuse and not by a fall as in Japan. While our series might include some injuries caused by abuse, we do not agree with the concept held in the United States that the coexistence of retinal hemorrhage and SDH almost always results from child abuse. We suspect that in series of child abuse cases with acute SDH reported in the United States some cases might be due to an accident, such as a fall. Differences in social conditions between the United States and Japan may play some role in the incidence of child abuse. In any event, we would like to know why reports on acute SDH in infants caused by factors other than abuse are so rare in the United States.

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Reference

Suprasellar Recurrence of Third Nerve Neurinoma

To the Editor: In 1982, we reported our experience with four cases of neurinoma of the oculomotor nerve (Leunda G, Vaquero J, Cabezudo J, et al: Schwannoma of the oculomotor nerves. Report of four cases. J Neurosurg 57:563-565, October, 1982). Recently, one of those patients (Case 2) came to our attention again because of suprasellar recurrence of the neurinoma 13 years after radical operation.

This patient was 11 years old when treated by us in 1971. At that time, a solid neurinoma, 5.5 cm in diameter and arising from the left third nerve, was totally resected via a subtemporal approach. The patient was well when last examined in 1973. In 1980, he informed us by letter that he was in good health and leading a normal life. However, in June, 1984, he was admitted because of progressively severe headaches of 2 months duration. Computerized tomography scanning disclosed a cystic suprasellar lesion with peripheral enhancement after contrast administration, suggesting a craniopharyngioma (Fig. 1). A cystic collection in the left temporal region was also observed, and was considered to be secondary to the previous surgery. Endocrinological studies revealed deficiencies in gonadotropins and growth hormone. X-ray films of the sella turcica were normal. In July, 1984, the patient was operated on again via a left subtemporal approach, and the cystic suprasellar lesion was resected. Pathological study of the capsule revealed a typical neurinoma. We believe that this report of the long-term evolution of a third nerve neurinoma may be of interest because of the rarity of these tumors.

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Fig. 1. Computerized tomography scans after administration of contrast material. There is a cystic rounded lesion occupying the suprasellar cistern, and the posterior wall of the cyst is enhanced. Another cystic zone associated with the previous surgical procedure can be seen over the left subtemporal region.