RESPONSE: We appreciate Dr. Sukoff's comments, as they are an indication of the continuing controversy surrounding chymopapain chemonucleolysis. It was the intention of our study to provide a rational basis for future discussions about this alternative to surgery in selected cases of radicular complaints referable to intervertebral disc disease. We have always restricted chemonucleolysis to those patients deemed appropriate candidates for an open surgical procedure by the evaluation of both a neurologist and a neurosurgeon in the presence of a significantly abnormal myelogram. Additional restrictive criteria are further detailed in our article. If Dr. Sukoff in fact intended to suggest that stenosis of the canal be included as an indication for chemonucleolysis, then we must disagree based on our results as well as on the mechanism of therapeutic action for chymopapain. Eight percent of our patients undergoing operative management for disc pathology were offered and received chymopapain; 92% of our patients did not fit our rigid criteria for inclusion in the chymopapain group, and they underwent formal open surgery for disc removal with or without fusion.

The overall success rates at 10 years for the total group of patients who underwent chymopapain injection were reported as 80.1% based upon relief of presenting radicular leg pain and 75% based upon employment at the same or a more vigorous level as compared to before injection; all patients who initially failed chemonucleolysis were deemed ultimate failures despite the fact that some improved with subsequent open surgical intervention. These data compare favorably with the analysis by Uihlein, et al., of a similar patient population undergoing laminectomy and followed for 8 years. In the 8% of our patients undergoing chemonucleolysis, the results approached what we would have expected if the patients had been offered an open surgical procedure instead.

To reiterate, no one with any experience in treating spinal disorders would intimate that there is only one effective treatment modality for all patients; chemonucleolysis is but one tool in the surgeon's armamentarium.

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Neuroanatomy of the Pyramidal Decussation

To the Editor: The cover picture on the July, 1986, issue of the Journal of Neurosurgery is a lovely piece of abstract art. I use the word "abstract" in the sense described in Webster's dictionary: "Disassociated from any specific instance; difficult to understand; insufficiently factual; expressing a quality apart from an object." The related paper by Dumitru and Lang (Dumitru D, Lang JE: Cruciate paralysis. Case report. J Neurosurg 65:108-110, July, 1986) concerns a case of closed head injury which develops into a grandiose mist of pseudoscience reminiscent of the surgeon in Shaw's The Doctor's Dilemma.

None of the papers cited in the references offers a glimpse of valid neuroanatomical or neuropathological evidence in man or beast to justify the thesis that the corticospinal fibers concerned with the upper extremity decussate more rostrally than do those headed for the lower extremity. Coxe and I have reported that monkey corticospinal fibers from upper extremity and from lower-extremity motor cortex are both diffusely distributed in the medullary pyramidal tract, and that there is no evidence of resegregation at the decussation.1 I know of no pertinent results to the contrary.

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Reference


RESPONSE: I am pleased that Dr. Landau enjoyed our cover illustration. Although it is true that a complete neuroanatomical description of the area in question is needed, great caution must be exercised in extrapolating findings in various animal species to man. The references cited explain quite adequately what we and others have observed clinically, and we stand by them.

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Reference