ments may be necessary to aid speech, chewing, and swallowing.

Osteoradionecrosis, another severe complication, can usually be prevented with appropriate pre- and postirradiation management. When present, this condition is best managed with hyperbaric oxygen, either alone or with surgical debridement. There are also many complications involving growth and development of the oral, head, and neck tissues, particularly in children. These patients will have lifelong dental problems requiring the involvement of many specialists, and increased attention and early intervention can have beneficial effects.

The panel also recommended that studies of oral complications of cancer therapies be incorporated into ongoing cooperative group protocols and that more accurate, quantifiable, and reproducible criteria for assessing and classifying oral complications be developed.

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Reference


Accuracy of ICP Monitoring in Posterior Fossa Lesions

To The Editor: We read with great interest the paper by Rosenwasser, et al. (Rosenwasser RH, Kleiner LI, Krzeminski JP, et al: Intracranial pressure monitoring in the posterior fossa: a preliminary report. J Neurosurg 71:503–505, October, 1989). Their description of direct monitoring and drainage of the posterior fossa enhances our knowledge of the postoperative management of patients with surgery in that region. All but two of their patients had extra-axial posterior fossa lesions.

We would like to suggest two points based on our experience. Since early 1989, we have operated on four patients for an intra-axial lesion such as cerebellar hemorrhage or cerebellar astrocytoma. These patients showed neurological deterioration and severe cerebellar edema with obliteration of the cisterns surrounding the brain stem on computerized tomography scans 3 to 7 days postoperatively, in spite of an intracranial pressure (ICP) of around 10 mm Hg, monitored by a supratentorial ventricular catheter. In these cases, brain-stem auditory evoked potentials (BAEP's) helped to monitor the patients and to direct postoperative care (Fig. 1), even though direct ICP monitoring within the posterior fossa had not been carried out. In patients with a posterior fossa lesion, BAEP is a good an alternative method of postoperative monitoring because systems involving a subdural catheter have a tendency to become obstructed, particularly in cases of severe cerebellar edema.

Fig. 1. Representative brain-stem auditory evoked potential (BAEP) recordings obtained postoperatively from a patient who was operated on for a right-sided spontaneous cerebellar hematoma. Five days following surgical removal of the hematoma, the patient showed neurological deterioration with abnormal respiration, and the BAEP’s revealed loss of normal wave patterns even with the intraventricular pressure at approximately 10 mm Hg. The patient received hyperventilation therapy for four days, and began to improve neurologically as also indicated on her BAEP recordings. POD = postoperative day.

With regard to the period of intercompartmental difference in pressure between the infra- and supratentorial fossae, it must be noted that the supratentorial pressure may not reflect the infratentorial data in patients with an intra-axial posterior fossa lesion until at least 7 days postoperatively.

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Reference


Response: We agree that brain-stem auditory evoked responses are extremely useful in detecting pressure changes in the posterior fossa. We routinely use them to assess brain-stem function in patients who have been in barbiturate coma. There is no question that this would be beneficial in picking up a potential problem in the posterior fossa.

In regard to Dr. Park’s last point, we wholeheartedly agree that there is an intercompartmental difference in pressure between the supra- and infratentorial fossa.
Giant Acoustic Neurinomas

To the Editor: The paper by Sawamura and his colleagues (Sawamura Y, Nakagawa Y, Ikota T, et al: Surgical removal of giant acoustic neurinomas involving the skull base. Report of two cases. J Neurosurg 71:611–615, October, 1989) was interesting. It threw some light on the problem of interpreting the origin of intrapetrous neurinomas, which have occasionally been reported in the past, 1,2 and of extradural acoustic nerve tumors, which have been described previously by Hullay. 2 The authors suggest that, in their cases, the tumor arose in the cochlea or vestibule.

I wonder why they did not consider that these lesions were unusually large jugular neurinomas. Their first patient presented with a recurrent laryngeal nerve palsy and the coronal scans they included in their report can easily be interpreted in this way; the only unusual feature was the degree to which the tumor extended up toward the middle fossa. However, this extension is easier to reconcile with the diagnosis of a jugular tumor than is a cervical extension with an acoustic nerve tumor. Growth below the base of the skull is, of course, a common feature of jugular foramen tumors, and that diagnosis would appear to fit at least the first case very well.

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References

Myelopathy and Spinal Cord AVM

To the Editor: We have read the interesting article by Criscuolo, et al., on necrotic myelopathies (Criscuolo GR, Oldfield EH, Doppman JL: Reversible acute and subacute myelopathy in patients with dural arteriovenous fistulas. Foix-Alajouanine syndrome reconsidered. J Neurosurg 70:354–359, March, 1989). According to the authors, progressive worsening of the myelopathy is related to venous congestion caused by a dural arteriovenous (AV) fistula. Although it may be difficult to identify, a fistula should be actively looked for, since a good therapeutic response depends on early diagnosis and surgery. Although the case described by Lhermitte, et al., clearly involves an AV malformation, the same is not true for the first two cases in Foix and Alajouanine’s original report. 2 The vascular abnormality evidenced was a very significant proliferation of vessel walls without thrombosis (“hypertro-