RESPONSE: The clinical indications for the radical intracapsular approach included patients who were elderly and patients in whom it was vital to preserve facial and/or cochlear nerve function. Similar indications have been advanced for treatment with focused radiation. With regard to tumor size, some of the patients in our series had tumors sufficiently close to 3 cm in diameter to place them within the range of those lesions treated by others using stereotactic methods. It is therefore not inappropriate to consider radical intracapsular removal in the patient harboring a 3-cm tumor who desires a conservative approach. It is debatable whether radiosurgery would be beneficial as an adjunct to intracapsular removal, given the low recurrence rate seen without it and given the added risk to the facial and trigeminal nerves.

STEPHEN P. LOWNIE, M.D.
CHARLES G. DRAKE, M.D.
University of Western Ontario
London, Ontario, Canada

References

Accessory Limbs and Spinal Dysraphism

TO THE EDITOR: I am writing in regard to the article by Humphreys, et al. (Humphreys RP, Manwaring KH, Carroll NC: Accessory arm — dysraphism or disparity? *J Neurosurg* 74:297–300, February, 1991). They provide a very scholarly discussion of all the possible mechanisms proposed over the years. No doubt there is more than one basis for the wide variety of extra limbs and other parts that occur on occasion.

About 25 years ago Dr. Colin Ferguson, then Professor of Surgery here, presented me with the case of a newborn with a mass arising from the sacral region that included a partial leg and complete foot, a finger, a penis with a connecting bladder (probe in Fig. 1), and small intestine that was in constant active peristalsis (Fig. 1). The base of the mass was fatty tissue which constituted the roof of the open lumbosacral spinal canal. There was no evidence of any sharing of parts. The fatty base was adherent to numerous nerve roots and to the incomplete meninges. There was adequate skin and soft tissue for coverage. Removal was accomplished without damage to any of the normal child's nerves and that child has developed and remains normal as far as we know. Dr. Ferguson called this a "parasitic twin," which seemed quite an appropriate term. Unfortunately, exposure to drugs or radiation was not recorded beyond determining that the mother had not been taking Thalidomide.

DWIGHT PARKINSON, M.D.
University of Manitoba
Winnipeg, Manitoba, Canada

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**Fig. 1.** Photographs of the patient with the "parasitic twin." For a description, see the letter from Parkinson.
RESPONSE: I appreciate Dr. Parkinson's personal observation of another case representing an accessory leg. In that regard, it is quite akin to those outlined in earlier reports.1-3 He made a most useful observation, which has not been detailed in many of the earlier reports, that the accessory limb was associated with posterior canal spinal dysraphism. Specifically, his case like ours was characterized by a lipoma entangling nerve roots (presumably the cauda equina) and "incomplete meninges."

As rare as this particular entity is, and regardless of whether the accessory limb is representative of an arm or a leg, the treating team should be very suspicious that spinal dysraphism is at the base of the obvious superficial anomaly.

ROBIN P. HUMPHREYS, M.D., F.R.C.S.(C)
Hospital for Sick Children
Toronto, Ontario, Canada

References

Angiography Following Aneurysm Surgery

TO THE EDITOR: I noticed that some articles recently published in the Journal of Neurosurgery have commented about postoperative check angiograms. In particular, the paper by Ohman, et al. (Ohman J, Servo A, Heiskanen O: Risk factors for cerebral infarction in good-grade patients after aneurysmal subarachnoid hemorrhage and surgery: a prospective study. J Neurosurg 74:14-20, January, 1991), showed that this is one of the risk factors of postoperative cerebral infarction.

It has been the practice of some surgeons in the United Kingdom deliberately to excise the aneurysm or, at the very least, to puncture it after the application of a clip. Once this has been done it is immediately obvious whether the vessel has been satisfactorily excluded from the aneurysm, and there is no need for postoperative angiography. In view of Ohman's paper, I wonder whether there is any justification for the performance of postoperative angiograms.

D. A. CAMPBELL, F.R.C.S., F.R.C.S.(Ed)
North Staffordshire Royal Infirmary
Stroke-On-Trent, England

RESPONSE: I think that Mr. Campbell has misunderstood the concept of postoperative check angiography. The angiogram per se is not a risk factor for infarction, but the degree of vasospasm (moderate to severe vasospasm) as visualized angiographically (see page 18) was a significant prognostic factor for cerebral infarction.

It is our practice, too, to excise the aneurysm, especially in the case of a large aneurysm. However, we do not excise small aneurysms because we consider that this offers the potential risk of causing surgical injury. Because it is essential to exclude the aneurysm totally from the parent vessel, we consider a postoperative control angiogram necessary.

JUHA OHMAN, M.D.
Helsinki University Central Hospital
Helsinki, Finland