similar to that of the gallium scan. The use of these studies coupled with the bone scan is extremely sensitive (approaching 100%). The specificity is also very high, probably over 90%, although the resolution capacity is obviously quite low.

We would again agree that the majority of cases of spinal osteomyelitis can be treated conservatively and without surgery as long as they are caught early before significant compressive or destructive changes have occurred. Nonetheless, in the month preceding receipt of this letter, we have encountered three additional cases of severe destructive osteomyelitis of the lumbar spine in elderly patients. In each of these, the diagnosis was missed and the patient underwent decompressive laminectomy for presumed lumbar stenosis.

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Masson’s Vegetant Intravascular Hemangioendothelioma

To The Editor: This is in reference to the recent article by Wen, et al. (Wen DY, Hardten DR, Wirtschafter JD, et al: Elevated intracranial pressure from cerebral venous obstruction by Masson’s vegetant intravascular hemangioendothelioma. Case report. J Neurosurg 75:787-790, November, 1991). In 1987, we reported a similar case (Figs. 1 and 2), with discussion of the pathophysiology of the lesion.1 The intracranial pressure and sagittal sinus pressure were measured and implicated the cyst as the cause of the intracranial hypertension. So, despite the operative risk, direct surgical procedure appeared to be the correct approach and was met with a favorable response.

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FIG. 1. Axial computerized tomography scan at the level of the torcular after intravenous infusion of contrast medium. The lumen of the venous structure is shifted forward by the development of the tumor.

FIG. 2. Digitalized subtracted left carotid angiogram-phlebogram, anteroposterior view. Note the poor opacification of the torcular due to compression of this structure by the tumor.

Reference


RESPONSE: We thank Professor Djindjian and his colleagues for bringing their case to our attention. Fortunately, their patient’s lesion was entirely extrinsic to the torcular, allowing for complete resolution of the problem with surgery. In contrast, our patient’s lesion was entirely intrinsic to the torcular and sagittal sinus, hence the added precaution of the optic sheathotomy.

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Third Ventriculostomy

To The Editor: The paper by Dr. Kelly (Kelly PJ: Stereotactic third ventriculostomy in patients with non-tumor adolescent/adult onset aqueductal stenosis and symptomatic hydrocephalus. J Neurosurg 75:865–873, December, 1991) is an excellent article and makes a number of interesting points. To me, the most interesting point is that he feels that the existing shunt should be occluded. This for me is new information, probably because I have usually performed this procedure in infants. I disagree, however, with his statement regarding case selection on page 871: “From a review of the literature it is clear that infants are not suitable candidates for third ventriculostomy.” I published an article in 1981 on that subject.1 Infants differ from adults in that the unmyelinated brain becomes swollen or waterlogged in response to untreated hydrocephalus and the