Letters to the Editor

Giant Aneurysms of the Cavernous Carotid Artery

To the Editor:

The recent article by Dr. Alex Berenstein et al (SURGICAL NEUROLOGY 1984;21:3–12) is another step forward in the treatment of cerebrovascular disease. The problems of inserting a detachable balloon into a large aneurysm and then obliterating the aneurysm while preserving the parent artery are well known. Such may be accomplished routinely in the future, but at present these neuroradiologists are demonstrating impressive results with transvascular selective balloon occlusion of the parent artery just above and below the neck of the aneurysm.

I would like to suggest one more advantage to their technique of occlusion, an advantage that one does not get with the classical surgical trapping procedure. With the latter, the ophthalmic artery origin usually is compromised. In the transvascular method the external carotid artery and the ophthalmic artery are preserved. As the external-carotid-to-ophthalmic arterial pathway is capable of providing fairly large amounts of blood to the intracranial internal carotid system [1], there will be a much improved tolerance to occlusion of the internal carotid artery in the cavernous sinus. An additional benefit to simple cervical carotid artery occlusion may be a reduced incidence of embolic phenomena from an internal carotid artery stump [2].

Recently we reported two cases of intracavernous carotid artery aneurysm treated by surgical insertion of Ivalon sponge directly into the giant aneurysm itself [1]. We are disappointed that the adjacent internal carotid arteries thrombosed (asymptomatically) in both cases; but, as in the patients of Berenstein et al, the aneurysms were successfully obliterated with excellent distal internal carotid flow from blood coursing retrograde through the ophthalmic artery and from anastomotic pathways of the circle of Willis. There was no need for an intracranial–extracranial arterial bypass. In both cases the entry and exit openings of the internal carotid artery were clearly seen from within the cavity of the aneurysm. These openings were separated by a considerable distance. In such cases the preservation of internal carotid flow perhaps requires some reconstructive procedure that would improve upon the balloon or Ivalon sponge insertion techniques.

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1. Fox, JL. Intracranial aneurysms. Vol 2. New York: Springer-Verlag, 1983; 991,999–1011.
2. Heros RC. Thromboembolic complications after combined internal carotid ligation and extra-to-intracranial bypass. Surg Neurol 1984;21:75–9.

Treatment of Chronic Cerebral Ischemia

To the Editor:

The "new surgical technique for the treatment of cerebral ischemia" reported by F. Lesoin et al [1] is not so new. We reported this procedure in 1980 [2]. We agree with the authors that it is indeed a worthwhile alternative revascularization procedure to the superficial temporal artery–middle cerebral artery bypass, although we prefer the latter in the majority of patients.

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1. Lesoin F, Jomin M, Viaud C, et al. Encephaloarteriosynangiosis in the treatment of chronic cerebral ischemia: preliminary report based on 30 cases. Surg Neurol 1983;20:318–22.
2. Spetzler RF, Roski RA, Kopaniky DR. Alternative superficial temporal artery to middle cerebral artery revascularization procedure. Neurosurgery 1980;7.

Neurosurgeons Needed?

To the Editor:

I read with interest the letter by Berkley L. Risch, M.D. of Norfolk, Virginia in the May 1984 issue of SURGICAL NEUROLOGY. He points out the dilution of neurosurgical material created by the increase in the number of neurosurgeons practicing in the Norfolk area. He wonders whether this is a national problem and suggests one answer to the problem would be the reduction in neurosurgeons trained in order to reduce the dilution of the surgical case pool by neurosurgeons. However, he makes a substantial case for considerable dilution of neurosurgical material by the entrance of vascular surgeons, orthopedic surgeons, and plastic surgeons into the practice arena. The question that is never answered by individuals who call for a reduction of neurosurgeons is how does one reduce the number of nonneurosurgeons who are doing work traditionally performed by neurosurgeons? I am concerned that if we reverse the trend and decrease the number of neurosurgeons per population we will encourage more and more the care of patients with surgical diseases of the nervous system by nonneurosurgeons.

It seems to me that if an individual is concerned that his skills are becoming rusty because of a decreasing number of a particular type of surgical procedure that he is doing, he has three options. First, he can go to the nearest university and ask for time to practice those skills in the laboratory. In some

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