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SUPPLEMENT

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CORRESPONDENCE

Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

Neurological and neurosurgical approaches in the management of malignant brain tumours

SIR,—Dr S J Wroe and colleagues have provided an interesting account of the attitudes, policies, and practices in the management of malignant glial brain tumours in a single clinical neurosciences centre (18 October, p 1015). Although their comparison of the approaches by neurologists and neurosurgeons showed a difference in the readiness to obtain histological confirmation of the diagnosis by biospy, the numbers of patients submitted to formal craniotomy and surgical decompression were rather lower in both groups than would be the case in several other neurosurgical units. This is only one of the reasons why we are concerned lest the findings of this study be taken as recommendations, rather than as an account of the practice in a single centre.

Their 95% accuracy of computed tomography in diagnosing malignant brain tumour may be impressive, but the authors make no mention of the accuracy with which tumour type and grade could be predicted. This is important when the predicted survival may range from a few months to many years. With increasing numbers of scanners installed outside neuroscience centres such high diagnostic accuracy is unlikely to be maintained. In any case, for the small number of cases with a wrong diagnosis on computed tomography the consequences may be profound.

Failure to perform biopsies on solitary brain tumours diagnosed by computed tomography can lead to serious errors. In a survey by this department of all cases of solitary brain tumour diagnosed by computed tomography and isotopic brain scan in south east Scotland in one year half of the patients diagnosed on computed tomography as having a solitary metastasis and then submitted to biopsy had a different diagnosis on biopsy, carrying a better prognosis. Eleven per cent of patients diagnosed on computed tomography as having glioma and submitted to biopsy had other diagnoses. Of most concern in our series was that in over half the patients diagnosed by computed tomography or radioisotope scanning as harbouring a solitary brain tumour no referral to a neurosciences centre was made and no histological diagnosis was ever obtained.

We disagree with their statement about the high morbidity of biopsy for brain tumour. Introduction of steroid cover has made the procedure acceptably safe and the figures quoted by the authors in support of their assertion refer largely to older studies carried out before the introduction of steroid therapy and computed tomography.

If the morbidity of burrhole biopsy—a diagnostic, not a therapeutic, procedure—is worse than that of no treatment, surely alternative measures that combine diagnosis with treatment, even of a palliative nature, are to be preferred? Recent reports suggest that surgical decompressive and cytoreductive procedures in selected patients improve the quality of life.[1 2]

We also disagree with the assertion that radiotherapy is of no value. On the contrary, it is at present the most consistently effective treatment for malignant gliomas, doubling mean survival time and increasing two year survival from less than 1% to 11%.[2-4]

Everyone knows that the outlook is poor for patients with malignant brain tumours. If a nihilistic policy of no diagnostic confirmation and no treatment is advocated this will always remain the case. Surely the public deserve something better than this from the medical profession?

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1 Ransohoff J, Kelly P, Laws E. The role of intracranial surgery for the treatment of malignant gliomas. *Semin Oncol* 1986;**13**: 27-37.
2 Shapiro WR. Therapy of adult malignant brain tumours; what have the clinical trials taught us? *Semin Oncol* 1986;**13**: 38-45.
3 Saleman M. Survival in glioblastoma; historical perspective. *Neurosurgery* 1980;7:435-9.
4 Walker MD, Green SB, Byar DP. Randomised comparisons of radiotherapy and nitrosamines for the treatment of malignant glioma after surgery. *N Engl J Med* 1980;**303**:1323-9.

SIR,—Dr S J Wroe and colleagues comment that patients referred to neurologists were more likely to leave hospital with only moderate or lesser disability, yet scrutiny of the relevant table reveals that those in the surgical group were even less likely to have moderate disability at discharge (9% compared with 21% of neurological cases). We note that there is a misprint in the table and the statistical significance refers to these cases and not those making a good recovery, but nevertheless almost twice as many surgical cases as neurological ones made a good recovery, and, whereas 79% of medically managed patients were disabled to some degree, only 63% of surgically managed patients were in this category. The difference is obviously due to the higher incidence of death and good recovery in the neurosurgical group. The claim that "short term morbidity in patients referred to neurologists is rather less" is therefore unfounded.

The higher mortality rate before discharge among the surgically managed patients is, we would suggest, due to the higher incidence of raised intracranial pressure in cases referred to the neurosurgeons, since this is known to be an important factor in mortality from burrhole biopsy.[1] The figures in table II support this, showing that patients with focal signs tended to be referred to a neurologist, whereas the incidence of papilloedema was almost 10% more in those