stretcher with the nasotracheal tube still in place. The patient is extubated when appropriate.

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VANCOMYCIN AND BRAIN ABSCESS

To the Editor: Although the article concerning brain abscess penetration by vancomycin by Levy et al. (1) is appreciated, a word of caution concerning the use of this drug is indicated. Phlebitis, nephrotoxicity, ototoxicity, and myocardial depression are significant adverse reactions from this drug, and there have been several case reports of profound cardiovascular collapse associated with the administration of vancomycin, often during general anesthesia (2-4).

At our institution, a 4-year-old boy undergoing the placement of a phrenic nerve stimulator was given vancomycin intravenously. Severe bronchospasm resulting in the inability to ventilate the patient was shortly followed by profound hypotension. Resuscitation with generous amounts of intravenous fluid, sodium bicarbonate, and epinephrine was carried out, and the patient slowly returned to his base line status.

Most untoward reactions to vancomycin occur within 10 minutes after the commencement of the infusion. These reactions can result either from too rapid administration of the drug or from an anaphylactoid reaction whereby the vancomycin elicits the release of vasoactive substances from basophils and mast cells.

Because of the apparent increasing use of vancomycin for central nervous system infections, the physician should be aware of its adverse affects upon the cardiovascular system. Strict adherence to the recommended rate of administration should be maintained, and this should not exceed 500 mg over 60 minutes. Furthermore, frequent monitoring of the patient's blood pressure and heart rate is recommended during and after the infusion.

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To the Editor: At the close of their recent report concerning vancomycin penetration into brain abscesses (Neurosurgery 18:632-636, 1986), Levy et al. questioned the penetration of vancomycin into brain abscesses unassociated with concomitant malignancy. We recently treated a 53-year-old Mexican woman who presented with multiple blood cultures positive for coagulase-positive Staphylococcus. Her multiple septic emboli resulted in multiple bacterial abscesses. Initial treatment with methicillin was switched to vancomycin when the patient continued to experience fevers in spite of antibiotic therapy. The abscesses matured during vancomycin therapy, and subsequently three abscesses were aspirated with intraoperative ultrasound guidance.

Preoperative vancomycin peak and trough levels were 42.2 and 18.0 μg/ml. Postoperative peak and trough levels were 23.9 and 10.6 μg/ml. Vancomycin levels from the three aspirated abscesses were, respectively, (a) 21.3, (b) 22.3, and (c) 16.1 μg/ml (Fig. 1). These vancomycin levels support Levy's conclusion of good penetration of vancomycin into brain abscesses.

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SKULL GRANULOMA VS. HEMATOMA

To the Editor: I was interested in the report by Patalkins, Liccardo, and Di Lorenzo entitled “Chronic Subperiosteal Hematoma of the Skull in an Adult: A Case Report” (Neurosurgery 19:294-296, 1986). In my opinion, the authors did not adequately defend their diagnosis or consider other possibilities in addition to those suggested by Drs. Campbell and Eisenberg in the comment. First, it must be highly unusual for subperiosteal hematomas to produce the erosion or destruction demonstrated in their Figure 3 and described in their operative report. More often, subperiosteal hematomas evoke the laying down of additional bone or thickening of bone rather than destruction of bone.

The two considerations that I call to their attention are those of Garza-Mercado et al. (2). In that report, the question is raised as to whether the lesion could result from traumatic interosseous hemorrhage. Even in that case, the inner table was intact. I also refer the authors to the often-forgotten report by Chorobski and Davis (1). The statement made by the authors in their second paragraph, “Chronic hematomas in the adult have been reported only in the subgaleal space,” could be considered misleading. It is an error to confuse subgaleal hematomas with subperiosteal hematomas. Anatomically, pathologically, and clinically, these are lesions of different characteristics.

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2. Garza-Mercado R, Cavazos E, Hernández-Bates F: Giant repar-