LETTERS TO THE EDITOR

FIG. 1. Anterior (top) and right lateral (bottom) gallium scans of head showing increased activity within salivary glands.

apy and also may be found in patients who have received doses less than 4,000 rads made this case informative.

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REFERENCE


Reply

We have read with interest the comments concerning our paper “Salivary gland uptake of 67Ga-citrate following radiation therapy.” Although our original series did not include any patients who received less than 4,000 rads, we have subsequently observed salivary gland uptake in patients receiving lower radiation doses to the neck due to interruption of planned treatment and are happy to see the case documented in the preceding letter.

The authors of the letter, however, did misinterpret the section of the original article dealing with the five postradiation scans done during the chronic clinical period (2–5 years). All five scans were positive for salivary gland uptake and, as we originally observed, “The activity in the parotid gland was relatively higher in the scans performed within one year after irradiation . . . No such relative decrease in activity (with time) was noted for the submandibular glands.”

We still feel that our report serves to alert physicians to postradiation changes and may thereby avoid false-positive interpretations.

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Scintiagniographic Visualization of an Occipitoparietal, Extradural Hematoma

In November 1976, the Journal reported two cases in which cerebral angioscintigrams contributed significantly to the diagnosis of extradural hematoma (1–3). These reports and Dr. Ronai’s editorial (4) have led us to submit the following case report as additional data supporting the utility of radionuclide dynamic images in detecting an extradural hematoma.

A 36-year-old man fell on a wet floor, striking the occipital region of his head on concrete. Because of persistent nausea and vomiting, occipital headaches, and decreased hearing in the left ear, he was referred to the medical center 4 days after the accident.

Blood was found behind the left tympanic membrane, but the neurologic examination was normal. The pulse rate was 46 and regular. X-rays of the skull showed a left basilar skull fracture. An echoencephalogram showed no midline shift. An electroencephalogram was diffusely irregular and slow, with no lateralization or localization.

On the day after admission, a cerebral angioscintigram and head scan were performed with a scintillation camera. The studies were obtained after intravenous injection of 20 mCi of pertechnetate, preceded by an oral dose of 200 mg of potassium perchlorate to block the choroid plexus. The angioscintigrams were taken in the posterior projection because of the history of occipital trauma and subsequent headaches in that area. The perfusion study was recorded on a computerized data-acquisition and processing system. Photographs of the dynamic images presented on the display were made at 2-sec intervals.

Scintiagniography (Fig. 1) showed decreased activity in the left occipitoparietal region throughout the study. Static brain images were performed at 2 hr, but they showed no definite abnormality. Because of the left occipitoparietal abnormality on the cerebral angioscintigram, an extracerebral hematoma was suspected posteriorly on the left. Similar scintiagniographic findings could have resulted from an occlusion of the posterior cerebral artery or from the presence of a hypovascular intracerebral mass, such as an intracerebral hemorrhage or hypovascular neoplasm.

 Cranial computed tomography (Fig. 2) showed a lens-