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LETTER TO THE EDITOR

Intradural extramedullary primary hydatid cyst of the spine in a child: a very rare presentation

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Primary intradural extramedullary hydatid cyst is a rare form of parasitic infection, causing focal neurological signs, commonly observed in sheep-raising areas of the world, including Turkey [2, 3, 4, 6]. In their article that has passed peer review, Drs. Arif and Zaheer, pathologists, heighten our awareness about this uncommon but clinically challenging disease [1]. The authors nicely presented the radiological findings and surgical features of their case in detail, in addition to the pathological characteristics of the hydatid cyst. However, I would like to add the following important points regarding imaging features of the spinal hydatidosis to the discussion.

1. The authors note that the case is an example of "primary" hydatid cyst, but there is no statement about the radiological investigations for the possible diagnosis of hepatic or pulmonary hydatidosis. In such cases, it is impossible to exclude the presence of a "secondary" hydatid cyst without whole-body screening for systemic hydatidosis [3, 6]. Radiologically, CT scanning and ultrasonography is a useful combination both for achieving a correct diagnosis and for planning of appropriate treatment [2, 3, 5, 6].
2. They documented the findings of magnetic resonance imaging examination, with the statement of the presence of an intradural, extramedullary cystic lesion extending from L1 to L4 spine. From figure 1, however, it is obvious that the hyperintense cystic lesion was situated between the levels of Th12 and L3, not the levels of L1 and L4.
3. In figures 3 and 4, the authors clearly described the findings of histopathological examination of their case with characteristic cuticular layer of the cyst wall in the form of amorphous densely staining laminated chitinous material. Unfortunately, however, they did not give any explanation about the technique of staining of the material and the ratio of the magnification for each figure in the legends.
4. Surgical intervention preceded by careful neuroradiological evaluation remains the best surgical therapy, and this plus adjuvant chemotherapy is advocated in some cases as the gold standard for therapy [2, 3]. The authors report that postoperatively the patient received a minimum 6-month course of albendazole chemotherapy and the weakness of the lower limb gradually recovered during the follow-up. Nevertheless, I think that the readers of *European Spine Journal* want to know the dosage of postoperative albendazole treatment as well as the severity of weakness of the lower limb at the first neurological examination at the admission to the hospital. In addition, as a rule, long-term follow-up is mandatory in each case of central nervous hydatidosis before any conclusion can be drawn about the value of any therapeutic agent [2, 3, 6].

In conclusion, it would appear that the case report needs a further clarification for the missing clinical points, as aforementioned above in detail. More importantly, this report emphasizes the importance of contribution and inclusion of all clinicians in the scientific presentation of a case history, which had been investigated by radiologists

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and treated surgically by spinal surgeons, for publication in any international journal. It should be kept in mind that "author byline" is one of the most important components of an article, as exemplified in the current case.

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