

TO THE EDITOR

RE: Neuroscience in Nazi Europe Part III: Victims of the Third Reich. Can J Neurol Sci. 2012;39:729-746.

As the authors of this article,¹ we wanted to make a small annotation to “Table 1. Berlin Jewish Neurologists, deported and killed in Nazi concentration camps.” The following line should be added regarding Dr. Ludwig Pick, who we also discuss in depth first in the Results section:

Pick, Ludwig	1868, Landsberg/Warthe	N/A	Professor, Friedrichshain Hospital	16.6.1943	Theresienstadt, died 3.2.1944, pneumonia
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In “Table 2: Viennese and Prague Neuroscience Victims of the Nazis,” we erroneously did not list the source, which is the following:

Hubenstorf M. Tote und/oder lebendige Wissenschaft: Die intellektuellen Netzwerke der NS-Patientenmordaktion in Österreich. In: Gabriel E, Neugebauer W, editors. Von der Zwangssterilisierung zur Ermordung: Zur Geschichte der NS-Euthanasie in Wien. Wien: Böhlau Verlag; 2002. p. 237-420.

Additionally, we did not notice that two Polish neurologist victims² were erroneously not included in “Table 3: Polish neurologist victims in the Third Reich.” The following should be added to that table:

Arnold Birenbaum (1897-1942; neurologist in Warsaw, murdered by the Nazis)
Maksymilian Biro (1870-1941; died in the Warsaw Ghetto)

By including these additional Polish neurologists, we remember their names and honor them. Whether there are better ways to honor the neurologists who were victims of the Holocaust is a topic we hope will be debated following publication of our article.

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REFERENCES

1. Zeidman LA, Kondziella D. Neuroscience in Nazi Europe Part III: victims of the Third Reich. *Can J Neurol Sci.* 2012;39:729-46.
2. Herman E. *Neurologzy Polscy*. Warsaw: Państwowy Zakład Wydawnictw Lekarskich; 1958.

TO THE EDITOR

RE: Intracranial Pressure Monitors in Traumatic Brain Injury: A Systematic Review. Can J Neurol Sci. 2012;39:571-576.**ICP Monitoring - Interpreting the Literature and Evaluating Practice**

I read with interest the recent paper in your journal by Mendelson et al ‘Intracranial pressure monitors in Traumatic brain Injury A Systematic Review’¹ and the accompanying editorial ‘Technology in Caring for Traumatic Brain Injury: Does What Make Sense Really Do?’². The authors are to be congratulated on contributing to the debate surrounding the use of intracranial pressure (ICP) monitors in traumatic brain injury (TBI). The major difficulty with this analysis of course, and which the authors recognize, is the quality of articles reviewed. The problem bedeviling the literature on ICP monitoring in trauma is the lack of randomized studies and the unequal groups that then get compared in observational, retrospective, or even worse – national database - studies, which account for all the articles reviewed here.

Unfortunately, the methodology of these studies is all too familiar – the comparison of those who were monitored for ICP versus those who were not; the clear problem being that patients who end up with an ICP monitor inevitably are very different from those who do not. Controlling for known factors that are associated with poor outcome is very important but does not necessarily make these two groups equivalent. The use of scoring systems is better than nothing but clinical decisions about

whether a patient should receive a monitor are not based on these, and with all their individual limitations scoring systems also do not necessarily reveal the true injury severity, nor do they adequately predict the later risk of secondary injury³.

The authors of the review acknowledge this ‘confounding by indication’. Indeed, many factors influence the decision to place an ICP monitor, singly or in combination: clinical signs of increased ICP, secondary clinical deterioration, degree of brain swelling, intracranial hematoma, presence of major systemic injury, etc. It is highly unlikely that statistical tools adequately adjust for the true differences between patients or account for why an ICP monitor was placed. Inevitably the patients who received ICP monitoring are described as more severely injured, but the degree to which this is true is likely not completely apparent. The referenced article by Shafi et al⁴ is an example of this: injury severity was greater in the ICP monitored group as was the number of patients who underwent craniotomy. Oddly, patients who died within 48 hours were excluded from analysis even though these patients may have benefited from ICP monitoring. A similar study in children suffers the same fate⁵: the ICP monitored group was more severely injured, had much higher requirements for ventilation, and needed central venous line insertion more often. The criticisms of these kinds of studies are extensive⁶⁻⁸.

On the other hand, it is true that interventions based on ICP monitoring may harm a patient especially when used indiscriminately, and the ICP number alone provides little information about the underlying disturbance in the brain. The authors importantly draw a distinction between the information obtained from the ICP monitor and the interventions instituted