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Management of Brain Abscess

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Dear Editor,

Having reviewed the recent work by Sarmast et al (3), we would like to make the following observations on the basis of our personal experience (1).

First, the authors state that: "*A total of 67 (67%) patients received aspiration as a form of treatment after burr hole was made in the skull, whereas 30 (30%) patients underwent excision of their brain abscesses*…". Leaving aside that the percentages are incorrect, we note the high number of patients (58.7%) who were treated by burr hole puncture, making necessary two (25.7%) or three (1.4%) further punctures. We, as well as many authors, consider that, where possible, craniotomy with resection of the capsule is the best practice since it provides rapid improvement of neurological status, lower re-surgery rates, shorter duration of postoperative antibiotic use, and shorter hospital stays (2, 4). In addition, it would be important to know the comparative mortality rates of puncture and craniotomy patients.

Secondly, the authors have an unusually low index of negative cultures (18.4%), which is not usual in this type of pathology where negative results range between 20-50%. (1, 2). What explains this?

Thirdly, it would be important to know the duration of antibiotic treatment in both groups of patients, since it is known that patients treated with puncture and evacuation need to prolong treatment longer than patients treated with craniotomy, as the same authors state in a similar paper published previously (4).

Finally, we congratulate the authors on a wide-ranging review and for the use of a correct antibiotic policy with a uniform empirical guide which is modified only depending on culture results.

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