Letter to the Editor
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Type 1.5 Split Cord Malformations : Bridging the Gap

Ramesh Doddamani, Rajesh Meena

Department of Neurosurgery, All India Institute of Medical Sciences, New Delhi, India

To the Editor,

Type 1.5 split cord malformation (SCM) comprises of a unique variety of SCM, which incorporates features of both the classical SCM types described primarily by Dias and Pang[2]. Sun et al.[9], recently added two cases of type 1.5 SCM with dorsal and ventral bony spurs representing types 1.5 A and 1.5 B respectively, which we had proposed for the first time[6]. There have been 15 cases reported in the literature on this entity till date[5,6,9]. We proposed the diagnostic criteria to classify this rare entity previously, in a reply to the letter by Sarica et al.[7] challenging our classification scheme[5]. Mahapatra and Gupta[4] reported the largest single centre experience of classical SCMs involving 254 patients from our institution, however no cases of type 1.5 SCM was noted. Five of the total 15 cases reported in the literature at different time points belong to our institution, constituting one third of the total reported cases[1,3,6,8,10].

The subtypes; type 1.5 A and B, were included owing to the difficulty encountered during the removal of the ventral bony spur seen in our previous case. We used bone Cavitron Ultrasonic Aspirator, for removing the spur safely without injuring the hemicords, as working in the narrow and deep corridor between both the hemi cords was extremely challenging. Therefore, type 1.5 B remains to be a surgical challenge compared to type 1.5 A variety, which is relatively easier to be excised[5,6]. Regarding the pathogenesis, we had already discussed in detail in our previous article, various plausible embryological possibilities. This included the uneven distribution and regression, as well as the concentration of the meninx primitive cells dorsally as postulated by Chandra et al.[1]. We would like to add the report by Sarica et al.[7], which need to be acknowledged and included in the list, summing up the tally of SCM type 1.5 to 15 cases.

We are glad and appreciate Sun et al, for acknowledging our proposed classification of type 1.5 SCMs. This would promote uniform nomenclature of SCMs in the neurosurgical community, thereby avoiding confusing terminologies like; intermediate, composite, mixed SCMs. Future reporting using this nomenclature would also promote further identification of these cases and augmenting the literature with more cases, thereby complementing our understanding.

AUTHORS' DECLARATION

Conflicts of interest

No potential conflict of interest relevant to this article was reported.

Author contributions

Conceptualization : RD; Data curation : RD; Formal analy-

• Address for reprints : **Ramesh Doddamani**
Department of Neurosurgery, All India Institute of Medical Sciences, Ansari Nagar, New Delhi 110029, India
Tel : +91986893663, Fax : +91-11-26593890, E-mail : drsdramesh@gmail.com, ORCID : https://orcid.org/0000-0001-6338-0061

sis : RD, RM; Methodology : RD, RM; Visualization : RD, RM; Writing - original draft : RD; Writing - review & editing : RD, RM

ORCID

Ramesh Doddamani https://orcid.org/0000-0001-6338-0061
Rajesh Meena https://orcid.org/0000-0002-2726-5557

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