firstly, the neuroblastic component—cell with intracytoplasmic neurotubuli and dense-core vesicle (Fig. 4a and b) and, secondly, the myoblastic component, cells with perivascular starting point, delimited by a basement membrane, showing cytoplasm rich in microfilaments with small osmiophilic thickenings and pinocytic vesicles along the cell membrane (Fig. 5a,b,c). We reiterate here what we said in the paper: ‘These aspects demonstrate that the medullomyoblastoma is a malignant bidermal teratoid tumour of the central nervous system’. As far as the primary intracranial origin of the tumour described by Shuangshoti and Phonprasert is concerned, no post-mortem study was carried out in this particular case. We must therefore be satisfied with the radiologically and intraoperative/macroscopically described aspects of this case. Here, we are obviously and evidently dealing with an orbital tumour which has infiltrated into the frontal sinuses, the subfrontal (extradural) area, and the dura mater secondarily.

In the light of the above, Shuangshoti and Phonprasert’s description of the tumour as being primarily intracranially developed appears to be unacceptable.

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