



FIGURE 1
Twenty-four-hour anterior image of the pelvis demonstrating activity along the right femoropopliteal graft.

labeled leukocytes (11), and it most likely accounts for the false-positive scan in this patient. In the second patient with a false-positive scan, angiography demonstrated a thrombosed graft which was placed 3 yr prior to scanning with no evidence of a pseudoaneurysm. A 20-wk clinical follow-up failed to demonstrate a graft infection and no definite cause for the positive scan was found.

Pertinent details of the hospitalization of six patients treated with antibiotics and studied with ¹¹¹In-labeled leukocyte scans were irretrievable. Thus, they were excluded from the study. If these patients' data were included (1 positive and 1 negative scan without clinical correlation, 2 true-positive and 2 true-negative scans proven by surgery and clinical correlation, but lacking data concerning specific antibiotics or time of treatment), there would be 12 true-positive, 13 true-negative, 2 false-positive, 0 false-negative, and 2 undetermined data. Under the worst case scenario (two scans without

clinical correlation assumed to be a false-positive and a false-negative scan), the resultant sensitivity and specificity would be 92% and 81%, respectively. Comparison of this sensitivity and specificity with those of 100% and 85% after exclusion of the six patients show that the differences in sensitivity and specificity are not significant ($p > 0.05$).

Thus, in this small series of patients with synthetic vascular grafts who have received prior antibiotic therapy, neither the sensitivity nor the specificity of ¹¹¹In-labeled leukocyte scan was adversely affected for detection of graft infection. As such, ¹¹¹In-labeled leukocyte scans remain a sensitive test for detection of synthetic vascular graft infection.

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ADDENDUM

In the October 1990 Laboratory Studies article, "Investigation of Physicochemical and In-Vivo Behavior of Diastereomeric Iron-59, Gallium-68, and Indium-111-EHPG Trivalent Metal Complexes," by Susan L. Madsen, Christopher J. Bannochie, Arthur E. Martell, Carla J. Mathias, and Michael J. Welch, The identification curves in Figure 2 (p. 1666) are as follows: ● liver, ▲ small intestine, and ◆ upper large intestine.