

adenoma) is somewhat less predictive (80%) for the absence of an adenoma. A normal pattern (negative test for any lesion), however, does not predict (41%) the absence of disease in the adrenal gland.

REFERENCE

1. Gross MD, Shapiro B, Francis IR, et al. Scintigraphic evaluation of clinically silent adrenal masses. *J Nucl Med* 1994; 35:1145-1152.

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REPLY: We appreciate the opportunity to correct errors that appeared in our recent article. In Table 1, the number of myelolipomas with discordant patterns of imaging (mass on CT with decreased or absent NP-59 uptake on the side of the mass) was 2 for a total of 44 as noted in the text. Fourteen adenomas demonstrated nonlocalizing imaging patterns with NP-59 uptake on the side of the mass) was 2 for a total of 44 as noted in the text. Fourteen adenomas demonstrated nonlocalizing imaging patterns with NP-59, for a total of 173 (159 adenomas localized + 14 not identified). There were 12 periadrenal masses identified by CT that were initially classified as "adrenal" (173 + 12 = 185) that demonstrated bilaterally symmetric patterns on NP-59 scintigraphy. Nevertheless, none of these errors have any affect on the efficacy of NP-59 scintigraphy in incidentally discovered adrenal masses as presented in Table 3. We regret these errors and any confusion that they may have caused.

As Dr. De Geeter correctly states, there are multiple ways in which this complex data can be analyzed. Because there are at least three scintigraphic imaging patterns (rather than simple "positive and negative"), calculations of efficacy will depend on how the scintigraphic patterns are defined and ultimately the purpose(s) to which the test is employed. We indeed, defined "true-

negative" as a concordant pattern in adenoma or a normal pattern in periadrenal or pseudoadrenal masses, because we believe that the most important diagnosis to make is that of a destructive adrenal lesion. It is this latter group that includes both primary and metastatic malignancies to the adrenal which are lesions requiring further diagnostic attention and/or therapy. We chose to identify the 14 small adenomas that demonstrated symmetrical imaging as false-negative because a small number of destructive, potentially malignant lesions gave an identical imaging pattern. The data analysis presented in De Geeter's table represents an equally valid interpretation given somewhat different criteria on how different groups are defined. These data again demonstrate the highly predictive nature of a discordant imaging pattern for destructive lesions. It is true that a normal pattern of imaging has a lower predictive value for the absence of disease in the adrenal, but this is not important because scintigraphy is not being used as the primary modality to determine the presence of adrenal masses. All our patients had CT imaging, which found an adrenal mass lesion. In this context, NP-59 scintigraphy is used to help characterize the nature of the lesions which were discovered on CT incidentally.

We thank Dr. De Geeter for his comments but we believe that despite differences in the manner in which our data can be manipulated, his analysis and conclusions are, in fact, not all that different from our own.

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