

with cause-specific mortalities (2). More sophisticated statistical methods have been newly presented to efficiently assess the relationship of exposure with multiple outcomes such as cause-specific mortalities (3).

Second, the authors used the Cox proportional-hazards model to compare the hazard of diabetes mellitus among 3 treatment modalities. However, the proportional-hazards assumption—one of the most important assumptions in the Cox model—has been violated in their study, as shown in their Figure 3C (1). Hence, variants of this model, such as the stratified or extended Cox regression model, must be applied to avoid any misleading findings (4).

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REPLY: We thank Drs. Pakzad and Safiri for their interest in our paper (1). We agree that there are a variety of methodologic questions to potentially be discussed (2–4), but we disagree with their criticism of our paper.

First, they prefer an analysis of cause-specific survival over overall survival. Understanding causes of death is an important aim but is, perhaps, less pressing a question in oncology. We considered a cohort of patients with locally advanced, metastatic neuroendocrine tumors, for whom death would likely be related to this diagnosis and the subsequent disease course. Consequently, overall survival is the single most important time-to-event outcome in oncology. Pakzad and Safiri also argue that a cause-specific analysis would have required “newly presented” methodology, whereas, in fact, the required methodology falls within the realm of the well-established statistics of competing risks (5). We used such competing-risks methodology in our analysis of the incidence of diabetes after DOTATOC.

Second, they express concern about a possible misspecification of the Cox model. This is, in fact, a common concern in the analysis of time-to-event data. Cox regression is commonly used to study not only overall survival but composites such as progression-free survival and competing risks—that is, the single components of a composite outcome. It is impossible to correctly specify the Cox model for all these endpoints (6), and analyses must consequently be interpreted as time-averaged hazard ratios (7). We believe that the great usefulness of the Cox model is partly

due to the meaningful summaries of effect that such time-averaged hazard ratios provide. Pakzad and Safiri refer to our Figure 3C, illustrating no incident diabetes event in the ¹⁷⁷Lu-DOTATOC group, which theoretically corresponds to an infinite regression coefficient or a zero hazard ratio. In our analysis, we followed the advice of Therneau and Grambsch (section 3.4.1 (8)) in interpreting this result as representing a very pronounced reduction in the diabetes hazard.

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Brain ¹⁸F-FDG PET Metabolic Abnormalities in Macrophagic Myofasciitis: Are They Stable?

TO THE EDITOR: We are writing this letter as an addition to our recently published study (1). Our aim is to add some insight to the evolution of the brain abnormalities that are observed with macrophagic myofasciitis (MMF). MMF is a chronic disease whose evolution is slow and whose symptoms may first occur