(HU), no further workup is necessary. If the lesion is small and the attenuation is between 0 and 18 HU, a follow-up examination might be helpful. Even for lesions for which the threshold of 18 HU is used, the specificity of diagnosing the lesion as benign is reportedly up to 100%.[4]

Indeterminate lesions may benefit from MRI, including chemical-shift imaging for the assessment of subtle intracytoplasmic lipid, which commonly occurs in benign adenomas. If MRI is unavailable, then follow-up imaging after an appropriate interval is reasonable. In rare circumstances biopsy may be required.

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[The author responds:]

The main point made by Drs. Rappaport and Merchant seems to be that imaging techniques are getting better at distinguishing between benign and malignant adrenal masses, an encouraging view that was perhaps inadequately emphasized in my editorial. Although I appreciate the comments of Rappaport and Merchant, I wish to make 2 points in response.

First, Rappaport and Merchant have misread my position concerning the value of fine-needle aspiration biopsy. I stated that this technique was useful in detecting metastatic disease in the adrenal gland but was "not useful in distinguishing benign from malignant primary adrenal tumours." In a clinical situation where metastatic disease is not suspected, I do *not* advocate biopsy, and I agree that biopsy is rarely needed in the context of an incidentally discovered adrenal mass.

Second, I was simply stating a fact when I said that imaging reports on incidentally discovered adrenal masses "sometimes" (not "often," as misquoted in the letter) state categorically that the masses are benign and inactive and that no further investigation is required. In light of the points made by Rappaport and Merchant, it might be considered somewhat inappropriate to pronounce on the benign nature of a mass, but it is certainly inappropriate to pronounce on the function of the mass. In such a situation, a radiologist's statement that no further investigation is required may be misleading.

Allow me to reiterate the point that the term "adrenal incidentaloma" should not be used to mean "benign, nonfunctioning adrenocortical tumour." As the title of my editorial states, the mass is incidental only in its detection, not in its ultimate pathologic characteristics and function. Once an adrenal incidentaloma has been detected, further investigation can reveal it to be benign or malignant, hormonally active or inactive.

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