Correspondence

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Received by email

References

[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 adenocortical 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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