appropriate length is chosen, while the waist accommodates the defect.

The ADO II is available in eight sizes with four waist diameters (3, 4, 5, and 6 mm) and there are two length options for each waist diameter (4 or 6 mm). In our case, [3] the device length was 4 mm and the waist diameter was 6 mm (with a circumference of ~18.84 mm). However, the height of the mechanical valve was standard and was ~5 mm, and its sewing cuff height was almost 4 mm with the suture and endothelial cover. The paravalvular defect width was 5 mm [3]. Although not mentioned in the article, the lateral diameter was ~3 mm, and the circular length ~16 mm, which was smaller than the waist circumference of the device. We think that the defect circumference should be a little bit smaller than the waist circumference of the device and the maximum length of the device should be up to the length of the defect. If a device with a larger waist circumference is chosen, it will fit the shape of the paravalvular defect perfectly with the help of its self-expanding property, while its length increases and both discs prevent embolization.

The self-expandability, a slightly larger waist circumference, localized convergence at each disc and appropriate device length allow device fixation and conformism within the paravalvular anatomical defect, provide protection from embolization and prevent the occurrence of new paravalvular leakages under 3D-TEE and fluoroscopic guidance.

**REFERENCES**


and tumour stage of TENs. Nevertheless, the ability to interpret the literature becomes vitiated without a deeper statistical analysis that could shed some light onto a widely used statistical procedure known as correlation analysis [4]. Based on the findings reported in the previous studies on haematological neoplasms [5], the determination of metabolic tumour volume as a volumetric parameter of 18F-FDG PET/CT could be, in future, an important independent factor for the preoperative evaluation of TENs. A new prognostic stratification based on the WHO stage or Masaoka staging system, and the volumetric parameter of 18F-FDG PET/CT might help optimize patient care by providing better prognostic information. Additional prospective studies with larger numbers of patients are needed to validate the prognostic utility of this promising functional biomarker derived from 18F-FDG PET/CT.

REFERENCES


LETTER TO THE EDITOR RESPONSE

Reply to Bertolaccini et al.

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We thank Bertolaccini et al. [1] for their interest in our paper [2] and appreciate the opportunity to reply. To begin with, we would like to point out some misunderstandings with regard to our paper. In our analysis, we divided 58 patients with thymic epithelial tumours into three groups according to a simplified histological classification: low-risk thymomas (Types A, AB and B1, n = 23), high-risk thymomas (Types B2 and B3, n = 21) and thymic carcinomas (n = 14). The maximum standardized uptake value (SUVmax) of the thymic carcinomas was significantly higher than those of the low-risk and high-risk thymomas (P < 0.001, respectively). No significant differences were observed between the low-risk thymomas and the high-risk thymomas (P = 0.204). In addition, as shown in Figure 3 in our article, the SUVmax of the Stages III and IV thymomas showed a higher trend towards Stages I and II thymomas (P = 0.060). We excluded thymic carcinoma cases in this analysis because the majority of them were in advanced stages. Although no significant differences were observed between the low-risk and the high-risk thymomas, we suppose that significant differences might appear if the number of patients increases. We think that the large confidence interval in our box-whisker plot is due to the small number of cases.

As often said, SUVmax is a very nonuniform value between institutions. It depends on the dose of radionucleotide that is given, the machine, the timing of scanning and the radiologist reading it and so on. Calculating the SUV tumour mediastinum (T/M) ratio is one of the methods to ensure the universality of SUVmax in 18F fluro-2-deoxy-d glucose positron emission tomography-computed tomography (18F-FDG PET-CT) [1]. We cannot provide these data in our cohort, as they were not available in our previous cases. However, as other authors have demonstrated [3–5], there is little difference between the results of SUVmax T/M ratio and nonadjusted SUVmax. We believe that nonadjusted SUVmax in 18F-FDG PET-CT can play an important role in the differential diagnosis between thymomas and thymic carcinomas. The area under the curve in receiver-operating curve for the differential diagnosis between thymomas and thymic carcinomas was 0.951 in our cohort (data is not shown), a result that is considered to be quite good.

We completely agree on the necessity of prospective studies with a larger number of patients, as thymic epithelial tumours are quite a rare disease. Discussions between not only thoracic surgeons, but also radiologists and pathologists are required to ensure the universality of radiological and pathological diagnoses.