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Survey of Head and Neck Practice

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AJNR Am J Neuroradiol 2017, 38 (1) E9

doi: <https://doi.org/10.3174/ajnr.A4985>

<http://www.ajnr.org/content/38/1/E9>

This information is current as
of April 20, 2024.

Survey of Head and Neck Practice

I read with curiosity the article by Ko et al¹ regarding the survey of TNM staging by radiologists.

Two statements were made that I believe need clarification.

1) The claim is made in the “Results” that “Subspecialization in head and neck radiology was reported by 72.1% of respondents.”¹ How is this defined? Obviously, the survey results may reflect the bias of the respondents. Selecting only members of the American Society of Head and Neck Radiology is a bias. Does “subspecialization in head and neck radiology” refer to a neuro-radiology fellowship? If so, the results may be believable. Otherwise, I am skeptical that that many people are practicing head and neck radiology exclusively as a subspecialist.

2) In the “Discussion,” the authors state, “It has been reported that the short axial diameter of lymph nodes is the most accurate indicator of metastatic versus normal or reactive nodes.”¹ These data are cited from sonography² and postmortem examination³ studies, not studies of CT and MR imaging, with which most American radiologists examine head and neck cancers. In his seminal review, Peter M. Som⁴ wrote in 1987, “It should be noted that most cervical lymph nodes are ovoid or lima bean shaped, and the determination of nodal size is based on the greatest nodal diameter.” Similarly, in the largest multi-institutional study written in the radiology literature looking at head and neck lymph nodes, Curtin et al⁵ state in their methodology, “On axial images, the readers noted the largest dimension of the largest node in each zone of the neck” for their data.

It is true that there is no consensus regarding what dimension is best to assess whether a node is pathologic or not. It is also true that size criteria alone are flawed as guidelines. However, I thought that having statement number 2 above in the literature without at least some caveats would not be appropriate.

Disclosures: David Yousem—UNRELATED: Payment for Lectures (including service on Speakers Bureaus): ACR Educational Center; Royalties: Elsevier; Payment for Development of Educational Presentations: CMEInfo.com.* *Money paid to the institution.

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<http://dx.doi.org/10.3174/ajnr.A4985>