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The Authors Reply

To the Editor—We would like to thank Dr Sabour for his interest in our research[1] and apparently in the work of many other scientists around the world.[2–5] Discussions within the community are an essential source of growth and scientific improvement, so we are more than happy to respond to his comments on our article.

First, Sabour correctly highlighted that sensitivity and negative predictive value are estimates used to judge the diagnostic accuracy of a single test vis-à-vis a gold standard,[6] exactly as we did in our study. We took the histological results (ie, negative or positive mesorectal lymph nodes at histology) for reference. Because we adopted a per-patient approach to imaging (ie, each irradiated patient was considered positive for lymph nodal involvement using as a cutoff a 70% reduction in overall lymph node size on imaging), as well as histology (ie, all of each patient's mesorectal lymph nodes were examined and, if at least one showed signs of disease, the patient was classified as node-positive), our method is justified and consistent.

Sabour is right about the need to use 2 cohorts, and we complied with this need in our project too.[6] Fourteen of the 64 patients examined were positive for mesorectal lymph node involvement on comparing the MRIs obtained before and after preoperative chemoradiotherapy, and 15 were positive at histology. Referring to our reference standard (ie, histology), 15 patients thus belonged to the "positive" cohort, and 49 to the "negative" one.

Regarding the second issue raised (ie, how to validate prediction models), we politely beg to disagree. As we stated in our article, our main aim was to maximize the negative predictive value and sensitivity of mesorectal lymph node imaging after chemoradiotherapy, not to validate any complex prediction model (as Sabour said in his letter). We acknowledge that further studies are needed to obtain complex prediction models to better explain the factors significantly affecting the prediction of N0 irradiated rectal cancer.

In light of the above, we believe that the conclusions drawn in our article, as published, are perfectly valid, with little room for misinterpretation.

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