
In Reply: Dr Crystal questions our assumption that the minimal detectable size of a breast tumor on MRI is 5 mm. However, 5-mm invasive breast tumors have been identified on MRI screening examinations. In our model, the size at which tumors are detected by screening depends on their minimal detectable size, their growth rate, and the frequency of screening. We found that at the time tumors are screened, most screen-detectable tumors are larger than their minimal detectable size. Our estimate for the tumor size distribution at detection (Table 5 in our article) is consistent with Crystal’s summary of published data; however, a statistical comparison is not meaningful due to the small sample sizes in each study.

The size at which a suspicious breast lesion is regarded as warranting diagnostic evaluation influences the false-positive rate. Liberman et al retrospectively reviewed a series of MRI-detected cancers among patients who were referred to MRI for reasons that included staging, and reported that the number of cancers found was 1 of 37 biopsied lesions measuring less than 5 mm and 44 of 254 biopsied lesions measuring 5 to 9 mm. However, there are no data that directly relate the minimum detectable tumor size on MRI to the false-positive rate of MRI screening. This relationship is complex because it varies with the population screened, the protocol and equipment used for MRI, the criteria for identifying a suspicious lesion, the diagnostic protocol following the screening examination, and the experience of the radiologist. Small lesions are not always subjected to biopsy immediately after their detection but may be followed up over time for change. Our model incorporates estimates for the rates and costs of diagnostic testing prompted by MRI screening, including short-interval follow-up and biopsy (Tables 2 and 3 in our article).

Our assumption that the minimal detectable breast tumor size on MRI is 5 mm does not have a large effect on our results, as we demonstrated in Figure 1 of the article. Because the dependence of survival on tumor size is not well characterized at the smaller tumor sizes, we stratified tumor sizes into the standard TNM staging categories of smaller than 2 cm, 2 to 5 cm, and larger than 5 cm when estimating the effectiveness of screening MRI. Consequently, the survival benefit that we estimated as attributable to MRI is conservative and mostly due to a shift from lymph-node positive to lymph-node negative disease status at diagnosis as opposed to a shift to smaller tumor sizes. More research is needed to understand the effect of tumor sizes that are detectable by MRI on both the false-positive outcomes and survival gain associated with breast MRI screening.

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CORRECTION
Incorrect Affiliation and Corresponding Author: In the Original Contribution entitled “Psychopathology in Young People With Intellectual Disability” published in the October 25, 2006, issue of JAMA (2006;296:1981-1989), an incorrect author affiliation and corresponding author address was printed at the time of publication. On page 1981, Dr Einfeld’s affiliation at the time of publication should have been “School of Psychiatry, University of New South Wales, Sydney, Australia (Dr Einfeld)”; and the corresponding author address should have been “Stewart L. Einfeld, MD, School of Psychiatry, University of New South Wales, 190 Russell Ave, Dolls Point, NSW 2219 Australia (s.einfeld@unsw.edu.au).” After mid-December 2006, the published author affiliation and corresponding author address is correct (Dr Einfeld is now with the Faculty of Health Sciences and Brain and Mind Research Institute, University of Sydney, Sydney, Australia).