JBR–BTR, 2012, 95: 332-333.

# LETTERS TO THE EDITOR

**Concerns: Trampoline fracture of the proximal tibia**

Dear Editor,

It was interesting to see the report by Bruyeer et al about trampoline fracture of the proximal tibia (1). I had the opportunity to publish a report of 7 cases with similar fracture few months following your report (2).

Prior reports suggested high percentage of valgus deformity following proximal tibial metaphyseal fracture in children. However in only two reports; one by Boyer (3) in 1986 and another by Kakel (2) in 2012 suggested such a complication is unlikely if the fracture was trampoline-associated. It is interesting to see if any of your patients developed valgus deformity on follow-up radiographs.

Thank you

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**References**

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2. Kakel R.: Trampoline fracture of the proximal tibial metaphysis in children may not progress into valgus: A report of seven cases and a brief review. *Orthop Traumatol Surg Res*, 2012, 98: 446-449.
3. Boyer R.S., Jaffe R.B., Nixon G.W., Condon V.R.: Trampoline fracture of the proximal tibia in children. *AJR*, 1986, 146: 83-85.

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**Concerns: The role of diffusion-weighted MR imaging and ADC values in the diagnosis of gastric tumors**

Dear Editor,

I read with interest recently published article entitled "The Role of Diffüsion-Weighted MR Imaging and ADC Values in The Diagnosis of Gastric Tumors"(1). This study is one of the few study about diffusion-weighted MRI for gastric malignancies. But we want to mention a few points about the study. All of seventy patients who are included to study have gasric malignancy and control group are healthy people. This method is not completely randomized and absence of benign gastric lesions in the study population can change the sensitivity and specificity. How to localized of unique ADC measurements of gastric malignant tumors was not explained. There are also some differences in the measurements of ROI area between patient and control group and this situation can cause different ADC values.

C section of third figure isn't included in the manuscript. Numbers after ± should have calculated twice of standard error instead of standard deviation from the average ADC values in abstract and conclusion.

Dilatation of the stomach in the patient and control group was provided by drinking water. Gastric fluid intervening of gastric folds can create mistakes of the ADC measurements of the gastric wall if enough dilatation of gastric wall doesn't happen. Nevertheless, overdistended thin gastric wall may cause differences in ADC values. ADC measurements of the control group can be showed with a picture in the manuscript. Subgroups of adenocarcinoma of stomach cancers also was not defined in the manuscipt.

Although all of these things, differences of ADC values between control and malignant group and statistical differences between the gastric adenocarcinoma and lymphoma provide useful information in guiding the radiologist and clinician in this manuscript.

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**Reference**

1. Avcu S., Arslan H., Una O., Kotan C., Izmirli M.: The Role of Diffüsion-Weighted MR Imaging and ADC Values in The Diagnosis of Gastric Tumors. *JBR-BTR*, 2012, 95: 1-5.

**REPLY BY THE AUTHOR**

I would like to reply in a few sentences the letter to the editor.

First of all, among gastric tumors, benign ones are rare compared with malignant lesions, and that was why all of our study population was composed of malignant gastric lesions. The patient group in our study was composed of 70 consecutive patients having a gastric tumor.

Query 1: How to localized of unique ADC measurements of gastric malignant tumors was not explained. There are also some differences in the measurements of ROI area between patient and control group and this situation can cause different ADC values.

Answer 1: 'The ADC measurements were done from the most hypointense region of the gastric tumor by placing circular region of interest (ROI) on the lesion in patient group and from the normal gastric wall in control group. The areas of ROI 45-70 $mm^2$ in the patient group and 3.2-7 $mm^2$ in the control group.' As seen in the text of our paper, the ROI areas of patient and control groups are different. This is due to the difference in the thickness of a tumor and normal gastric wall. If you select a large ROI in normal gastric wall, it would give wrong ADC values due to the involvement of gastric content or mucosa in the measurement.

Query 2: C section of third figure isn't included in the manuscript.

Answer 2: I think it is not mandatory to include all the c-section figures, we included some of them as examples.

Query 3: Dilatation of the stomach

Query 3: Dilatation of the stomach in the patient and control group was provided by drinking water. Gastric fluid intervening of gastric folds can create mistakes of the ADC measurements of the gastric wall if enough dilatation of gastric wall doesn't happen. Nevertheless, overdistended thin gastric wall may cause differences in ADC values. ADC measurements of the control group can be showed with a picture in the manuscript. Subgroups of adenocarcinoma of stomach cancers also was not defined in the manuscipt.

Answer 3: We tried to obtain enough dilatation of the stomach in patient and control groups without causing overdistension. We did not need to insert a picture to show the ADC measurement in normal gastric wall. As there was no significant difference among the subgroups of gastric tumors and their mean ADC values, we did not mention the subgroups in the manuscript. We concluded that further studies with a wide range of cases having different histopathologic subgroups should be carried out.

With best regards,
S. Avcu