


In Reply We really appreciate the interest shared by Loli regarding our recent article that discussed, for the first time to our knowledge, the incidence of postoperative adrenal insufficiency after adrenalectomy in the context of retroperitoneal sarcoma surgery. We would like to address the 2 issues raised in the Letter.

First, the definition of adrenal insufficiency is actually consistent throughout our article, ie, peak serum cortisol value of 20 μg/dL or lower after low-dose adrenocorticotropic hormone (ACTH) stimulation test. Differently, preoperative screening did not have the purpose of identifying individuals with a diagnosis of adrenal insufficiency; it was aimed at excluding any confounding factor for altered response to the ACTH test after surgery (namely, patients with primary adrenal disease, undergoing chronic steroid therapy, or affected by clinically relevant heart disease or thyroid dysfunction). For this reason, a basal cortisol level below 7 μg/dL was set as an easy and reliable measure for screening of adrenal impairment, being probably even unethical to perform a stimulation test in the absence of any clinical reason to suspect an adrenal disease. However, it would be misleading to compare this preoperative cutoff with the postoperative levels of cortisol acquired during the ACTH test, as the aim of these 2 assessments was different.

Second, the choice of low-dose ACTH stimulation test to diagnose adrenal insufficiency was made giving the real-life concern for safety on physiological alterations caused by insulin tolerance test or high-dose ACTH test in surgical patients, freshly treated with extensive multivisceral resection. Moreover, the cutoff to determine positivity was set at 20 μg/dL per technical requirement of our laboratory and literature evidence. As acknowledged in our article, there is no universal agreement on the test threshold to be used, especially in surgical patients. In any case, we ran an exploratory analysis using the same lower cutoff of 18 μg/dL suggested in the article referenced by Loli, and this was performed to ensure that the rate of patients with false negatives would not impair the final findings. We found that there were no relevant changes in the analysis even with the lower cutoff.

We are conscious of the limits of our study, with no claim to draw the final word on this delicate matter. We have been in the unprecedented situation of studying adrenal function in surgical patients receiving adrenalectomy for nonendocrine disease and tried to apply the best available evidence derived from different study models such as endocrine diseases, surgical stress (irrespective of adrenalectomy), and critically ill patients. Luckily, the investigation of secondary outcomes confirmed the safety of multivisceral resection, even considering the intrinsic limit of definition of adrenal insufficiency in our specific setting, and therefore advocating the constant enthusiasm for best and safe practice of this procedure in surgical oncology whenever indicated.

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Conflict of Interest Disclosures: None reported.


CORRECTION

Errors in a Figure: In the article titled “Long-term Efficacy of Neoadjuvant Chemoradiotherapy Plus Surgery for the Treatment of Locally Advanced Esophageal Squamous Cell Carcinoma: The NEOCRTEnO Randomized Clinical Trial,” published online June 23, 2021, in JAMA Surgery,1 the numbers of individuals at risk were given incorrectly in Figure 3. These errors did not affect the authors’ conclusions. The article has been corrected.1


Errors in Byline: In the Original Investigation titled “Therapeutic Value of Sentinel Lymph Node Biopsy in Patients With Melanoma: A Randomized Clinical Trial,” published online August 3, 2022, there were 2 errors in the byline. The middle initial was added to Rogerio I. Neves’s name, and the spelling of Cristina O’Donoghue’s first name was corrected. This article was corrected online.