

Reply to A. Crocoli et al regarding percutaneous sclerotherapy with absolute alcohol of primary aneurismal bone cysts in children

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Sir,

We thank Dr. Alessandro Crocoli and colleagues [1] for their interest in our work on the treatment of aneurysmal bone cysts in children [2].

Concerning our biopsy technique, we probably have not been clear enough. Open biopsy was practiced several weeks before percutaneous sclerotherapy. In the intervening period, a histological diagnosis was obtained (decalcification of the samples can take time) and we ensured, with a radiograph, that biopsy had not been the starter of aneurysmal bone cyst healing, avoiding further treatment. Moreover, for histological diagnosis, adequate sample size is important and the percutaneous procedure does not allow this.

We agree that MRI is not specific enough to differentiate aneurysmal bone cysts from telangiectasic osteosarcoma. Fluid–fluid levels are characteristic of aneurysmal bone cyst, but are not specific.

We agree that there is a need to use the multiple needles technique, to minimize the per-procedure venous escape,

when present. Indeed, we published this technique several years ago (see reference 13 in our paper [2]).

We think that follow-up can be done successfully with radiograph, as the expected result is cyst ossification. MRI is useful in partial response to localize residual cysts.

We hope that we have answered Dr. Alessandro Crocoli's questions. Since the publication of our paper, we have treated 75 children using this approach.

References

1. Crocoli, A, Fassari, FM, Natali GL et al (2012) Sclerotherapy of primary aneurysmal bone cysts: comment to Lambot-Juhan et al. *Pediatr Radiol*. doi:10.1007/s00247-012-2556-2
2. Lambot-Juhan K, Pannier S, Grévent D et al (2012) Primary aneurysmal bone cysts in children: percutaneous sclerotherapy with absolute alcohol and proposal of a vascular classification. *Pediatr Radiol* 42:599–605

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