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lymph nodes was not ultimately ascertained via a histologic specimen, the RT-only group and the OPS-only group may well have included pathologically node-positive patients who were understaged originally.\(^{[p243]}\)

As Drs Sperry and Pagedar correctly imply, 30% of the patients in the radiation-only group were likely higher than stage II because of occult nodal metastasis—and this we fully acknowledge. However, this was our point exactly and highlights one of the benefits of primary surgery. One of the advantages of surgery over radiation is that performing a neck dissection helps determine the true nodal status and, thus, the true stage.

We also acknowledged other limitations such as the inherent issues of a retrospective review using SEER data and the unknown effect of expertise on radiotherapy quality. For these reasons, we tempered our conclusion by not proclaiming that surgery is the best option but by saying that surgery should be considered a viable and preferred treatment option. Although the commenters dismiss our conclusions, we feel that the article makes a meaningful contribution to the body of data concerning this very interesting problem.

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We read with interest the systematic review by Khoueir et al on the endoscopic resection of juvenile nasopharyngeal angiofibroma (JNA). They performed a literature review for articles from 1995 to 2012 using the search terms angiofibroma and endoscopic. Only purely endoscopic series of patients were included in the final analysis. The authors, however, do not define the terms open, endoscopic, and endoscopic assisted, and the classification of cases where the resection is performed endoscopically through an open incision is not addressed. In our opinion, the classification of an intraoral incision (anterior transmaxillary approach) as an open approach misses the point. The key point is that endoscopic visualization is being used to perform the tumor dissection. Benefits of endoscopy include superior visualization, less dissection of normal tissues, and the potential for decreased morbidity. Large JNAs that extend lateral to the pterygopalatine space and involve the skull base need the additional access and multiple ports for instruments that a combination of endonasal and transmaxillary approaches provides.

The authors state, “A good staging system should be universal, have a prognostic value, and have a therapeutic correlation.”\(^{[p354]}\) Previously, we proposed a new staging system for JNA that incorporates the residual vascularity of the tumor following embolization as a major prognostic factor.\(^{[2]}\)

Most of the cases analyzed (77%) were endoscopic resections. We would like to see more centers test the validity of the UPMC staging system in their own patient populations to see if it has wide applicability.

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References
In response, we thank Drs Snyderman and Gardner for their insightful comments and the opportunity to clarify a number of points from our work. The series published by Snyderman et al1 in 2010 includes 35 patients with juvenile nasopharyngeal angiofibroma (JNA) treated by 3 surgical approaches: endoscopic, open, and combined. Since they did not differentiate in their results between the 3 approaches, they were not included in our systematic review of exclusive endoscopic treatment of JNA.2 As they mentioned in their letter to the editor, we also believe that the combined approach is necessary in some advanced cases, offering superior visualization, less dissection of normal tissues, and the potential for decreased morbidity compared with the classic open approach. However, we consider that by adding an intraoral incision, the surgical approach cannot be classified as an exclusive endoscopic one. This reflects the existence of anatomical boundaries to an exclusive endoscopic treatment that can only be overcome by combining the 2 approaches. A new staging system that defines these boundaries is thus still needed.

The University of Pittsburgh Medical Center (UPMC) staging system for JNA1 showed a better prediction of immediate morbidity, residual tumor, and recurrence compared with other staging systems. It was not discussed in our systematic review since it was not reported by the studies included. We also believe that more centers should test its validity in their own patient populations to see if it has wide applicability.

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