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REPLY:

B. Hill, K. Padgett, V. Karla and R. Quencer

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REPLY:

Thank you very much for your interest and insight regarding our study. We agree that any potential clinical implementation of contrast-enhanced MR neurography for trauma would require a thoughtful risk-benefit analysis. However, the current widespread use and established safety profile of Gd-DTPA would be conducive to implementation. Regarding our noncontrast data, at your suggestion, we performed ROI-based SNR measurements on our T2-weighted sequences using the same approach described in the original article.

Between days 3 and 7, forceps-injured nerves did indeed demonstrate higher T2 signal compared with clip-injured nerves, both when comparing mean SNR of each group ($P = .02$) and when directly comparing injured nerves with their contralateral, nonoperative counterparts ($P = .04$). This difference was best detected using the contralateral, normal nerve as an internal control: Using this methodology, we found that forceps-injured nerves demonstrated 44% more T2 signal, while clip-injured nerves demonstrated 31% more T2 signal.

We agree that the relationship between T2 signal changes and Gd-DTPA enhancement warrants further investigation. Potentially, a multiparametric approach including T2 signal hyperintensity, enhancement data, and diffusion tractography would yield the greatest prognostic value.

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