statements deserve further comment.

Although the noncaseating granuloma has traditionally been regarded as the *sine qua non* pathologic finding for the diagnosis of sarcoidosis, the presence of interstitial pneumonitis has been well described in the literature. Huang et al. studied the open lung biopsy specimens of 81 patients with sarcoidosis and observed both granulomata and interstitial pneumonitis in all cases. Assessment of the intensity of alveolitis (ie, the accumulation of mononuclear inflammatory and immune effector cells within the interstitium) is now routinely accomplished by the technique of bronchoalveolar lavage.² In addition, it has been well established that alveolitis or an interstitial pneumonitis most likely represent the initial lesion of sarcoidosis, preceding granuloma formation.³ This conclusion is based primarily upon the work of Rosen et al., who demonstrated that interstitial pneumonitis—predominant in 62 percent of 128 open lung biopsy specimens—was inversely related to the density of granulomata.

It is also a known fact that different lesions of sarcoidosis can coexist in the same lung. Crystal et al. have observed that the overall picture of sarcoidosis is a "montage of alveolar-capillary units in various stages of inflammation and derangement." At different times and at different rates, small foci of interstitial pneumonitis may either resolve or go on to granuloma formation. Similarly, granulomata may either resolve or progress to structural derangement and eventual fibrosis.

It is therefore not surprising that Aisner and Albin observed some degree of fibrosis as well as interstitial pneumonitis in their case. Rosen et al. noted some degree of fibrosis in 10 percent of cases in which interstitial pneumonitis was predominant. Huang et al. observed focal or diffuse fibrosis in more than half of their cases, including some with Type I radiographs. Aisner and Albin's contention that their case is unusual is perhaps not justified.

Finally, the authors' point that the diagnosis of sarcoidosis cannot be excluded by finding only interstitial pneumonitis on transbronchial biopsy is not new. Rosen et al. also concluded that the sampling of small amounts of tissue by transbronchial biopsy may reveal only interstitial pneumonitis if this is the predominant finding and granulomata are scarce.

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REFERENCES


Balloon Dilatation and the Laser

To the Editor:

Your attention to detail and accuracy in medical literature is well known. I would like to suggest that the article entitled "The Treatment of Endobronchial Stenosis Using Balloon Catheter Dilatation" (Chest 1986; 93:1145-51) is somewhat misleading in that the casual reader might feel that this is the definitive treatment for such a disease process. However, the abstract and the article detail that use of the YAG laser for definitive treatment of these lesions is an integral part of the procedure and probably should have been reflected in the title.

I am concerned, as you must be, that the noncritical practitioner may simply peruse the journals and take from them that which he feels would enhance his or her practice. I feel that the title of an article should accurately reflect its content and wonder whether or not it might have been more accurate to reflect the use of balloon dilatation as an adjunct to definitive care with the laser for these patients.

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