Endobronchial Ultrasonography vs Conventional Transbronchial Needle Aspiration in the Diagnosis of Sarcoidosis

To the Editor:

We read with interest the recent article in CHEST (August 2009) by Dr Alain Tremblay and colleagues titled “A Randomized Controlled Trial of Standard vs Endobronchial Ultrasonography-Guided Transbronchial Needle Aspiration in Patients With Suspected Sarcoidosis.” It was a well-designed study in terms of the pathologic analysis; however, in the “Methods” section, the authors did not describe the bronchoscopic techniques for conventional transbronchial needle dissection (TBNA) and endobronchial ultrasonography-guided transbronchial needle aspiration (EBUS-TBNA). There were more lymph node stations sampled with EBUS-TBNA than with the conventional TBNA. This we believe is a result of the study design, which left the decision regarding the site to sample at the discretion of the bronchoscopist. The diagnostic yield of conventional TBNA from specialized centers ranges from 72% to 90%, which is much higher than the 53.8% yield in this study. This difference can be explained by the fact that more lymph node stations were sampled per patient in other studies, and the majority of them included station 4R (right paratracheal) and station 7 (subcarinal). These lymph node stations are known to be enlarged in patients with stage I and II sarcoidosis. Many experts will agree with the notion that conventional TBNA, compared with EBUS-TBNA, is easier to perform in lymph node stations 4R and 7. A pathologist not specialized in the field of pulmonary pathology may find it difficult to analyze samples obtained via a 22-gauge EBUS-TBNA needle vs a 19-gauge conventional TBNA needle. This is because a diagnosis of sarcoidosis by histologic analysis is well standardized and easier to make, compared with cytopathologic analysis. Considering the low cost, availability, low complication rate, and ease of performance, conventional TBNA, in our opinion, should be considered the preferred technique in clinical practice.

Gustavo Ferrer, MD
Rahul Khosla, MD
Washington, DC

Endobronchial Ultrasonography-Guided Transbronchial Needle Aspiration in Patients With Suspected Sarcoidosis

To the Editor:

Although the objective of the authors in a recent CHEST article (August 2009) was to ascertain which method most efficiently provided tissue confirmation of sarcoidosis in persons with bilateral hilar adenopathy, the investigation tacitly assumed its necessity, or at least its desirability. Following the seminal analysis of Winterbauer et al, we estimated a positive predictive value of ≥99.95% for a clinical-radiographic presentation of stage I sarcoidosis (S1S). A back-of-the-envelope computation shows this estimate to be conservative: assuming a sarcoidosis incidence of 3 × 10⁻³, half with S1S, and a combined 1.3-billion population of regions—Europe, United States, Canada, Japan, and the United Kingdom—likely to report its simulation by alternative diagnoses (ADs), the annual number of S1S cases in these regions would be 20,000, or 720,000 in the 36 years since publication of Winterbauer’s dictum. If five cases in 10,000 were due to an AD, there would have been an opportunity to report on 360; none has appeared. Thus, AD with S1S, and a combined 1.3-billion population of regions—Europe, United States, Canada, Japan, and the United Kingdom—likely to report its simulation by alternative diagnoses (ADs), the annual number of S1S cases in these regions would be 20,000, or 720,000 in the 36 years since publication of Winterbauer’s dictum. If five cases in 10,000 were due to an AD, there would have been an opportunity to report on 360; none has appeared. Thus, AD with S1S, and a combined 1.3-billion population of regions—Europe, United States, Canada, Japan, and the United Kingdom—likely to report its simulation by alternative diagnoses (ADs), the annual number of S1S cases in these regions would be 20,000, or 720,000 in the 36 years since publication of Winterbauer’s dictum.