be debatable if standard EUS-FNA is easily available. Whatever the order of imaging, the bronchoscopist needs two scopes and must learn the techniques of doing EUS with an EUS scope and EBUS with an EBUS scope. Even if end results are satisfactory, the means may not be justified.

Malay Sharna, MD, DM
Uttar Pradesh, India

Affiliations: From Gastroenterology, Jayawant Rai Speciality Hospital.

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Correspondence to: Malay Sharma, MD, DM, Gastroenterology, Jayawant Rai Speciality Hospital, Opp Sports Stadium, Mawana Rd, Meerut, Pin-250001, Uttar Pradesh, India; e-mail sharmamalay@hotmail.com

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Response

To the Editor:

We note the comments of Dr Sharma in response to our initial publication on using combined endoscopic ultrasound-guided fine needle aspiration (EUS-FNA) and endobronchial ultrasound-guided fine needle aspiration (EBUS-FNA) in the diagnostic evaluation of benign diseases, such as TB, by an endobronchial ultrasound (EBUS) scope, EBUS-transbronchial needle aspiration (EBUS-TBNA), and endoscopic ultrasound bronchoscope-guided needle aspiration (EUS-B-FNA). To clarify the purpose of our observations, we were seeking to highlight the potential usefulness of EUS-B-FNA for those practitioners trained in this application, particularly in situations where EBUS-TBNA was not tolerated as well for reasons of refractory cough, poor lung function, or significant comorbid lung disease. In these situations, in particular for an enlarged subcarinal node or paraseophageal lesion, we would use EUS-B-FNA to sample the lesion at the same sitting, with the same equipment, to avoid a nondiagnostic procedure.

Our center currently does not have ready access to an endoscopic ultrasound (EUS) scope. If an EUS scope were available, however, we concur that this would allow greater access and scanning range for a complete EUS procedure, but that was not the purpose of our observation. We are not advocating EUS-B-FNA as a replacement or substitute for complete EUS-FNA, which requires training with an EUS scope, as the authors have stated. We also agree with the authors that EUS-B-FNA should not be performed unless the operator is trained in this particular application of the EBUS scope.

We do not agree that EUS should be the first investigation for suspected benign lymphadenopathy in all situations; EBUS-TBNA is also a safe and technically straightforward procedure (as is EUS-FNA), although cough (which is not encountered with EUS) may be an issue. In our opinion, the first minimally invasive needle aspiration procedure should be guided by the location and accessibility of the lymphadenopathy, which may mean EUS-FNA for some locations or EBUS-TBNA for others.

There are many centers that might have EBUS or EUS but not both modalities available, limited by the costs of these techniques. We suggest, therefore, that the available technique in the institution might also dictate which is the first-line investigation. If both are available, then, as discussed, anatomic factors should be considered. However, there is no evidence in the literature to clarify this choice, and, thus, we also agree that comparative studies are needed.

Andrew R. L. Medford, DM, FCCP
Bristol, England
Sanjay Agrawal, MBBS
Leicestershire, England

Affiliations: From the North Bristol Lung Centre, Southmead Hospital (Dr Medford); and the Institute for Lung Health (Dr Agrawal), Glenfield Hospital, University Hospitals of Leicester NHS Trust.

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Correspondence to: Andrew R. L. Medford, DM, FCCP, North Bristol Lung Centre, Southmead Hospital, Westbury-on-Trym, Bristol BS10 5NB, England; e-mail: andrewmedford@hotmail.com

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Rapid On-site Evaluation of Transbronchial Aspirates in Mediastinal Adenopathy Diagnosis

To the Editor:

The results of the randomized trial by Trisolini et al1 in a recent issue of CHEST (February 2011) are noted with interest. It is...
perhaps surprising that rapid on-site evaluation (ROSE) did not result in an increased diagnostic yield for transbronchial needle aspiration (TBNA) because the same number of needle attempts per lymph node for TBNA were performed (four each), and ROSE has been shown to improve sample quality. One possible explanation is that because the TBNA bronchoscopists were highly skilled and operating in a specialized center, this resulted in a high yield in the non-ROSE group (>75%), preventing a significant increase in yield with ROSE over and above this finding. Another possibility, however, could be that a higher proportion of TBNA samples were taken with a 19-gauge needle (rather than 22 gauge) in the TBNA vs the TBNA + ROSE group, because a histology-gauge TBNA needle gives superior results to a cytology-gauge needle. Can the authors provide any further information on the relative proportion of needle gauges used in each arm of the study to eliminate this possibility?

Andrew R. L. Medford, DM, FCCP
Bristol, England

Affiliations: From the North Bristol Lung Centre, Southmead Hospital.

Financial/nonfinancial disclosures: The author has reported to CHEST that no potential conflicts of interest exist with any companies/organizations whose products or services may be discussed in this article.

Correspondence to: Andrew R. L. Medford, DM, FCCP, North Bristol Lung Centre, Southmead Hospital, Westbury-on-Trym, Bristol, BS10 5NB, England; e-mail: andrew.medford@hotmail.com

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Response

To the Editor:

We thank Dr Medford for his interest in our study on the role of rapid on-site evaluation (ROSE) in patients undergoing transbronchial needle aspiration (TBNA) for lymphadenopathy. Unlike Dr Medford, we are not particularly surprised by the fact that ROSE did not result in an increased diagnostic yield for TBNA in the setting of lymphadenopathy. Trials suggesting that ROSE increases the yield and specimen accuracy of TBNA pooled the results from patients evaluated for very different indications, such as lymphadenopathy, peripheral pulmonary lesions, or both. Remarkably, ROSE was not associated with an increase in the diagnostic yield or accuracy of TBNA specimens in the only previous study where a subgroup analysis was performed for patients studied for lymphadenopathy alone.²

The thoughtful comment by Dr Medford on the needle types used in each arm of our study gives us the opportunity to clarify that the 19-gauge needle was used in a minority of patients (20 of 168 [12%]) and in similar proportions in the ROSE arm as in the TBNA arm (12 vs eight patients, P = .313). These data rule out the possibility that the needle type influenced in any way the study results.

We completely share Dr Medford’s view that the long-term experience of bronchoscopists and pathologists involved in our study may have contributed to the high yield of TBNA, thus preventing, to some degree, a significant increase in diagnostic success of TBNA in patients undergoing on-site review. However, the ability of ROSE to increase yield of TBNA in a less expert setting is all but certain and should be demonstrated in a randomized controlled trial to control the many variables (eg, size and position of the lymph nodes, underlying disease, needle type used), besides the examiner’s experience, that may influence the yield of TBNA.

In conclusion, we believe that judging the value of ROSE based exclusively on its capacity to increase the diagnostic yield is against the very interests of on-site review. The ongoing diffusion of endobronchial ultrasound-guided TBNA, which enables real-time visualization and sampling of lymph nodes, will likely reduce, in the near future, the use of ROSE to increase specimen accuracy and yield for TBNA. On the contrary, advantages such as the reduction of the complication rate of bronchoscopy without loss in diagnostic yield, the possible modification of the sampling strategy based on the on-site information, and the possible identification of the site where diagnostic material can be found and retrieved in sufficient amounts to enable molecular characterization of malignant diseases in the era of targeted treatments¹ will likely be the stimuli for its continued and successful future use.

Rocco Trisolini, MD, FCCP
Alessandra Cancellieri, MD
Marco Patelli, MD, FCCP
Bologna, Italy

Affiliations: From the Thoracic Endoscopy and Pulmonology Unit (Drs Trisolini and Patelli) and Pathology Unit (Dr Cancellieri), Maggiore Hospital.

Financial/nonfinancial disclosures: The authors have reported to CHEST that no potential conflicts of interest exist with any companies/organizations whose products or services may be discussed in this article.

Correspondence to: Rocco Trisolini, MD, FCCP, Thoracic Endoscopy and Pulmonology Unit, Maggiore Hospital, Largo B. Nigri 2, 40133 Bologna, Italy; e-mail: rocco.trisolini@ausl.bologna.it

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