when compared with radiographs for the detection of pneumothorax. We agree that further research in this area may clarify the issue.

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A Closer Look at the Value Proposition for Endobronchial Ultrasound

To the Editor:

It is difficult to argue against the clinical usefulness of endobronchial ultrasound (EBUS). Moreover, the benefits of EBUS extend beyond the clinical scope of the patient, lowering the cost burden on the health-care system. However, the analysis by Pastis et al in an issue of CHEST (February 2012) of its financial impact leaves much to be desired in offering a realistic assessment.

Market conditions must be uniquely assessed when determining whether to invest in new technology or services. In this case, the strong reputation of the investigating institution likely created favorable conditions for an investment in EBUS to be successful. The primary flawed assumption in this model was that patients were referred strictly based on the presence of EBUS. No verification for this premise is offered (eg, questionnaire of patient or referring physician), and for this particular institution and catchment area there was no comparable alternative, suggesting perhaps these patients would have come to this institution based on a strong reputation independent of technology available. When deciding if any figure, in this case $2.4 million, is truly meaningful and applicable to other settings, other considerations must be addressed.

Discount rate must be used to account for net present value of future revenues. This issue is of significance because revenues are not captured for many months after services are rendered, and this delay is a costly one. It becomes of even more significance if this is undertaken at a lower-volume facility, for which the “break-even” point of their investment is delayed even further. An assessment of downstream revenue and the decision-making process is of critical importance, and this article is perhaps the first to raise the issue for EBUS. However, we must be cautious not to fall victim to the common fallacy of initially overstating the impact of a particular device. An analysis such as this must be rigorous in nature, and because of the importance of its implications, must be free from real or perceived conflicts of interest.

To do anything less than that would be a disservice to the field of interventional pulmonology and, most importantly, the patients.

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Response

To the Editor:

We appreciate the interest of Dr Fadul and colleagues in our article in CHEST but are disheartened by their conclusions, particularly the blanket, sweeping, and unsubstantiated statements suggesting a “disservice to the field of interventional pulmonology and, most importantly, the patients.” Paradoxically,