

Editor's Note: Authors are invited to respond to Correspondence that cites their previously published work. Those responses appear after the related letter. In cases where there is no response, the author of the original article declined to respond or did not reply to our invitation.

A “ROSE” in Every “EBUS” Keeps Transbronchial Lung Biopsy Away

To the Editor:

We read with great interest the article by Gupta et al¹ in this issue of *CHEST* (see page 547) on endobronchial ultrasound-guided transbronchial needle aspiration (EBUS-TBNA). We agree with the authors that, individually, EBUS-TBNA has the highest diagnostic yield in sarcoidosis. However, we are concerned about the conclusion of combining EBUS-TBNA with transbronchial lung biopsy (TBLB) for the optimal yield.

Interestingly, rapid on-site evaluation (ROSE) was not used in either arm in the study. According to our research, studies that have not used ROSE have reported a diagnostic yield of EBUS-TBNA of 83% to 85%, against 87% to 92% with ROSE, in the diagnosis of sarcoidosis.^{2,3} EBUS-TBNA with ROSE, thus, has a higher diagnostic yield compared with standard cytologic processing. Additionally, it provides a sufficiently robust diagnostic yield to inform the bronchoscopist as to whether additional lymph node passes or TBLB are needed prior to the patient leaving the theater.

In a study by Plit et al,³ granulomas were seen on ROSE in 46 patients, out of which 43 were sarcoidosis (hence, these 43 were subjected to unnecessary TBLB). In the remaining three cases, two were diagnosed to be anthracosis on ROSE and one as cancer. Hence, 46 patients in total underwent unnecessary TBLB when diagnosis was already made on ROSE. In contrast, only four patients (8%) with nondiagnostic ROSE had sarcoidosis confirmed on TBLB or endobronchial biopsy, thus, justifying the undertaking of additional procedures in this subgroup of patients. EBUS-TBNA with ROSE not only prevented the need to undertake unnecessary TBLB, but informed the bronchoscopist at the same session as to when additional passes and procedures were likely to benefit the patient.³ EBUS-TBNA with ROSE followed by TBLB in a few cases, rather than EBUS-TBNA with TBLB in all cases, would, therefore, provide sufficiently robust diagnostic information with a safety profile that would

consolidate its role as the first-line investigation in patients with suspected sarcoidosis. More importantly, it might obviate the need for subjecting patients to unwarranted TBLB and its attendant risks.

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Response

To the Editor:

We thank Drs Kumar and Chandra for their interest in our article.¹ We agree that the application of rapid on-site cytologic evaluation (ROSE) would have negated the need for transbronchial lung biopsy and, hence, its antecedent complications.^{2,3} The use of ROSE has been shown to reduce the number of lymph node passes without loss in procedural yield in some,⁴⁻⁷ but not all,⁸ studies. Despite its purported benefits, ROSE is not a widely used technique because of a lack of time and availability of certified cytologists. In fact, some pulmonologists have trained themselves to assess the adequacy of cytologic smears on-site.⁷ Thus, if ROSE is available, it should be used routinely during endobronchial