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Reply to the Editor:

We thank Drs Ribeiro Neto, Culver, and Mehta for their comments regarding our study comparing the diagnostic yield of endobronchial ultrasound-guided transbronchial needle aspiration (EBUS-TBNA) and transbronchial lung biopsy (TBLB) by showing non-caseating granulomas for stage I and II sarcoidosis.¹ We would like to address the issues raised by Dr Ribeiro Neto and colleagues.

The first issue raised concerned patient selection. Our study included consecutive patients with suspected stage I or II sarcoidosis, regardless of symptoms. We agree that observation without biopsy for definitive diagnosis in patients with suspected typical asymptomatic stage I sarcoidosis is reasonable; however, we think pathologic confirmation of a definitive or differential diagnosis using a minimally invasive and highly accurate procedure is another valid choice. In fact, 33 of the 62 patients enrolled in our study were referred to our institution for EBUS-TBNA from physicians at 21 hospitals at which TBLB was available but not EBUS-TBNA. We assume this means that many physicians empirically know the diagnostic yield of TBLB is not sufficient, especially for stage I sarcoidosis. Moreover, many of them prefer to have a pathologic diagnosis for the treatment of patients with sarcoidosis, even with asymptomatic stage I

sarcoidosis, if a highly accurate and minimally invasive procedure is available.

The second issue raised regarded the method of obtaining a final diagnosis of sarcoidosis. As we mentioned, many patients enrolled in our study were referred for diagnosis and returned to be followed up by the referring physicians. We conducted a follow-up survey of the patients asking the physicians regarding the clinico-radiologic compatibility for having sarcoidosis. For patients who were followed up at our institution, we carefully reviewed the medical records and radiographs. Finally, the diagnosis of sarcoidosis was made by pulmonologists (M.O., H.S.). In Japan, the frequency of diseases (eg, histoplasmosis) other than sarcoidosis in patients with multiple hilar-mediastinal lymphadenopathy presenting with noncaseating epithelioid cell granulomas is quite low, and a similar result was also reported by another Japanese group.²

The third issue raised was the limitation of the nonrandomized design. As we reported in the "Discussion" section, the order of these procedures could affect the results. A large international multicenter comparative study would elucidate more detail on ultrasound-guided needle aspiration procedures versus conventional bronchoscopy.³

At a time when only conventional procedures (eg, TBLB or mediastinoscopy) were available for the pathologic diagnosis of stage I sarcoidosis, simple observation without confirmatory biopsy was recommended because of risk/benefit and cost/benefit considerations.⁴ However, a new approach, EBUS-TBNA, is a much less-invasive and more accurate procedure than these conventional procedures. We investigators must clarify the role of this new procedure, even for asymptomatic patients with stage I sarcoidosis, in a prospective trial approved by an institutional review board.

Arguments advocating for confirmatory biopsy for asymptomatic stage I sarcoidosis were not the aim of our study; however, the indications should be debated whenever a promising procedure is developed.

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REGARDING "VANCOUVER SIMPLIFIED GRADING SYSTEM WITH COMPUTED TOMOGRAPHIC ANGIOGRAPHY FOR BLUNT AORTIC INJURY"

To the Editor:

We read with interest the study on blunt aortic injury by Lamarche and colleagues¹ and found that the classification of traumatic aortic injuries reported in their study was very similar to the one we published in 2009.² Since then, our report has been cited 22 times.³ Among the studies citing our classification system was the 2011 Clinical Practice Guidelines of the Society for Vascular Surgery.⁴ We would like the authors to comment on the differences between

Vancouver grading system and the classification scheme we previously reported. We thank them for their contribution and look forward to their response.

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Reply to the Editor:

We thank Azizzadeh and colleagues¹ for their comments and commend them for their work on refining the definition of acute, traumatic aortic injury. Their classification, published in 2009,¹ was preceded by at least 3,²⁻⁴ and followed by at least 3,⁵⁻⁷ other classifications of traumatic aortic injury, all emphasizing the importance of a more detailed descriptive strategy to delineate the extent of injury after trauma.

The approach described by our group (Figure 1) includes 4 grades of injury, including intimal flap, thrombus, or hematoma of less (grade 1) or more (grade 2) than 1 cm, any pseudoaneurysm (grade 3), or any contrast extravasation (grade 4). It was postulated that this simplified classification could be easily reproducible among radiologists, and this was confirmed by our study.

Although both Azizzadeh's and our classification scheme recognize 4 grades of injury, the major difference between them is that theirs assigns a higher grade of injury to a mural hematoma (grade 2) than to an intimal flap (grade 1). Ours stipulates that

the extent of each of these 2 common findings should also be accounted for, such that a large intimal flap warrants more concern than a small mural hematoma. We found that this important distinction was directive in the management approach applied and was reflected by our results.

The Stanford⁷ and Seattle⁶ groups also published their classification of aortic injury in 2010 and 2011. The Stanford group used a detailed descriptive strategy, including the proportion of aortic circumference involved in a pseudoaneurysm. The Seattle group used a definition very similar to ours, including thrombi of small size in the minimal aortic injury group (grade 1). They did not retain mural hematoma, because they suggested it is sometimes poorly defined and difficult to reliably identify.

The fact that 4 similar classifications of aortic injury were published within a 3-year period illustrates the complexity of the patients with aortic injury and the necessity for a better radiologic description at a time when the role of medical, surgical, or endovascular treatment strategies

FIGURE 1. Vancouver classification of traumatic aortic injury.