confirmed that aspirin was effective in at least some of them. In fact, resistance to aspirin in some patients might have actually hindered the real mean difference in bleeding and reduced the apparent long-term benefit of preoperative aspirin administration among the responders.

The separate unresolved issue remains the choice of platelet function assay to use in clinical practice and clinical trials. Let us finish by citing the conclusions of a unique report by Lordkipanidze and colleagues,⁵ who compared in the same population 6 major different methods used to test platelet function: "... conclusions drawn could be highly dependent on the test used and results from various assays are clearly not interchangeable. Hence, the clinical usefulness of the different platelet function tests to detect appropriately aspirin resistant patients remains uncertain."

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SARCOIDOSIS—NO BUSINESS OF THE BRONCHOSCOPIST

To the Editor:

We read with interest the report "Prospective study of endobronchial ultrasound-guided transbronchial needle aspiration of lymph nodes versus transbronchial lung biopsy of lung tissue for diagnosis of sarcoidosis" by Oki and colleagues,¹ which appeared in the June issue of the *Journal*. While congratulating them for their effort in clarifying this controversial and relevant topic, we want to share some significant concerns we had as we read their report.

Our first concern pertains to the selection of patients. To be valid, a diagnostic study should include patients with diagnostic uncertainty. This is, in part, because patients with an obvious diagnosis do not need diagnostic tests. Although the authors included patients with suspected stage I or II sarcoidosis (excluding those with biopsy proven disease), it is unclear whether they included consecutive patients or not. If they did not include consecutive patients by filtering out some individuals, it becomes crucial to know how many and why these patients were excluded. We believe their study could potentially have a spectrum bias, overestimating the diagnostic power of the test by including target-positive patients.²

Other potential problems in the validity of the study by Oki and colleagues¹ could also be inflating the results. One of these is that the tests being studied were a part of the reference standard.³ That explains why the specificities for both tests were 100%. All patients who had epithelioid cell granulomas were considered to have sarcoidosis using the clinical, radiologic, and pathologic criteria used as the reference standard. Although it is true a single reference standard is not available for sarcoidosis and a multidisciplinary meeting is recommended, a blind assessment from the adjudicators of outcome would have been preferred. It is not

stated in their report who adjudicated the diagnosis.

The lack of randomization regarding the order of the tests also raises a concern. This was acknowledged by the authors in their discussion. We can think of a few potential biases from performing endobronchial ultrasoundography first in every patient, and there might be many other biases that we have not considered. Randomizing the order of the tests would have been a great addition to the study protocol and would have decreased the chances of bias toward 1 procedure or the other. In addition, before the era of chest computed tomography, when mainly chest radiography was used to classify a patient as having stage I, transbronchial biopsy had a greater diagnostic yield.⁴ Currently, with high-resolution computed tomography of the chest widely available, the yield of transbronchial biopsy is understandably lower.⁵

As a final comment, we have to discuss the applicability of the data. Most patients included in the trial had stage I sarcoidosis. Physicians reading their report might leave with the message that all patients with suspected stage I sarcoidosis should undergo biopsy. We believe that because a bronchoscopy can be done does not mean it should be done. The decision to establish the diagnosis of sarcoidosis should remain in the domain of the clinician caring for the patient and not the bronchoscopist.

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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