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Reply to Weber

From the Authors:

We thank Dr. Weber for his acclamation and important comments regarding our recent policy statement, in which our interprofessional, multidisciplinary expert committee provides clinicians and hospital administrators with recommendations for decision-making on behalf of unrepresented patients in the critical care setting (1).

We agree with Dr. Weber that the policy statement does not provide an algorithm for determining the exact point in every patient's treatment course at which an alternative decision-making process should be implemented. Dr. Weber wants a “comprehensive” and “systematic” approach to answering this question. But for two reasons, providing that type and level of direction dwelled outside the scope and purpose of this policy statement.

First, professional organization policy statements generally leave significant flexibility to individual institutions to adapt guidance to their local circumstances and conditions. For example, prior American Thoracic Society policy statements on healthcare policy, ethics, and end-of-life care are explicit that they offer only a “framework” or “proposed components of an institutional policy” (2–4). Similarly, this policy statement omits certain fine-grained details, noting that its six recommendations must be “tailored to the capabilities of the individual institution” and that “institutions should have flexibility” in how they implement the guidance. Indeed, at the heart of this policy statement is an explicit tradeoff between “excessive and insufficient procedural safeguards” (1). Although this policy statement sets some broad parameters, it is appropriate that various institutions will strike the balance between fairness and feasibility differently.

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Second, as Dr. Weber notes, this policy statement is focused on making life-sustaining treatment decisions for unrepresented patients in the ICU setting. Within this context, we describe an alternative decision-making process and unambiguously recommend its use except in time-pressured situations. Outside the context of life-sustaining treatment, the policy statement does not address when to use an alternative decision-making process. But we do suggest that “minor interventions that are less consequential. . . may require less process and oversight.” Most state laws and professional organization guidance agree that an alternative decision-making process is not required for routine treatments and procedures that are low-risk and within broadly accepted standards of medical practice (5). In sum, to answer Dr. Weber's direct question, an alternative decision-making process is required for decisions about life-sustaining treatment and is not required for decisions about routine treatment.

But Dr. Weber focuses on a third tier of interventions—“nonemergency but consent-requiring procedure[s].” He is correct that the policy statement does not directly address these interventions. But even if the policy statement does not provide precise trigger points, it still provides two types of helpful guidance in this domain. First, the recommendations on prevention remain the same. Because many seemingly unrepresented patients are not actually unrepresented, institutions should implement strategies for careful capacity assessments, diligent searches for potential surrogates, and proactive advance care planning.

Second, whether a decision concerns major medical treatment or life-sustaining treatment, the decision-making process should promote the same five ethical goals (1). At least for the subset of consent-requiring procedures that involve significant risk, institutions should approximate the decision-making process that the policy statement provides for life-sustaining treatment. This is the approach taken in several state statutes that specify separate levels of rules, which require increasing amounts of oversight for decisions about routine, major, and life-sustaining treatment (5).

Unrepresented patients are among the most vulnerable in the healthcare system (1). For decades, the dominant approach has prioritized efficiency over fairness and procedural due process. Dr. Weber is right to call attention to the need for recalibrating that balance not only with respect to life-sustaining treatment but also with respect to major medical treatment. ■

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6 Micronodular Pattern of Organizing Pneumonia or Hypersensitivity Pneumonia Induced by an Immune Checkpoint Inhibitor?

To the Editor:

I read with great interest the report entitled “Durvalumab-induced Organizing Pneumonia with a Diffuse Micronodular Pattern in a Patient with Lung Cancer” (1). In that report by Yamasaki and colleagues, diffuse centrilobular, primarily ground-glass micronodules on chest computed tomographic (CT) imaging was diagnosed as organizing pneumonia (OP) by transbronchial biopsy (TBB) with bronchoscopy. The authors proposed the importance of considering OP as a differential diagnosis in addition to hypersensitivity pneumonitis and infectious bronchiolitis in patients presenting with diffuse centrilobular micronodules during immune checkpoint

inhibitor (ICI) therapy. That report is important because immunotherapy has become a standard of care in oncology, and drug-induced pneumonia is more frequent and important. However, we have some concerns regarding their diagnosis and conclusion.

OP, cryptogenic or secondary, is a clinicopathological entity characterized by granulation tissue plugs in the lumen of small airways, alveolar ducts, and alveoli. An unusual radiological presentation corresponding to diffuse micronodular pattern mimicking miliary lung infiltration has been reported, and the prevalence of this micronodular pattern of OP (MNOP) in radiological series is estimated to range from 10% to 24% (2, 3). The typical MNOP on CT imaging is widespread lung micronodules without diffuse ground-glass opacities, airspace consolidation, or cavitation.

CT patterns of drug-induced pneumonia were classified based on the American Thoracic Society and European Respiratory Society international multidisciplinary classification of interstitial pneumonias as acute interstitial pneumonia/diffuse alveolar damage-like pattern, hypersensitivity pneumonia (HP)-like pattern, OP-like pattern, nonspecific interstitial pneumonia-like pattern, or others (4). It has been reported that ICIs induce the OP-like pattern in 19–65% and the HP-like pattern in 16–22% among drug-induced pneumonias (5). The HP-like pattern includes a centrilobular diffuse micronodular pattern and bronchiolitis-like appearance.

The radiographic HP-like pattern and MNOP are difficult to differentiate. In addition, it is occasionally hard to make a histologically precise diagnosis for OP or HP by TBB because of the small size of the specimen. In large series of OP, the histological diagnosis was obtained on TBB specimens from 31% to 67% of cases. Importantly, most cases of MNOP were diagnosed by surgical lung biopsy (2). Regarding HP, the meta-analysis of 11 studies on TBB revealed a diagnostic yield of 64.3% (6). My concern on the report by Yamasaki and colleagues (1) is that the diffuse centrilobular micronodules were of primarily ground-glass appearance and not well defined on chest CT imaging, suggesting rather an HP-like pattern. Another concern is that the diagnosis for this unusual entity of OP was made by TBB alone. If the case showed HP-type radiographic pattern, it is not rare in ICI therapy.

Finally, I agree with the authors’ message. During ICI therapy, considering drug-induced pneumonias, including OP or HP, as a differential diagnosis is important because they usually have a favorable response to steroid treatment. In addition to radiological examination, performing examination of BAL fluid and TBB is recommended whenever possible as a means of ruling out infections and neoplastic lesions. ■

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