Comments on the utility of endorbonchial ultrasound-guided transbronchial needle aspiration in mediastinal or hilar lymph node evaluation in extrathoracic malignancy: Benign or malignant?

Sir,

I read with interest the article "The utility of EBUS-guided TBNA in mediastinal or hilar lymph node evaluation in extra thoracic malignancy: Benign or malignant."[1] The primary end point of study in reference[1] was to determine the etiology and prevalence of malignancy for hypermetabolic and enlarged hilar/mediastinal lymph nodes in patients with previously diagnosed extra pulmonary malignancy. The article is very well written. The study is relevant in today's era of semi-invasive procedures with utmost importance given to safety and patient care. I would like to highlight one or two points related to the study in discussion. First, authors had suggested that sensitivity and specificity of endorbonchial ultrasound (EUS)-guided transbronchial needle aspiration (TBNA) is lower than that of EBUS, considering the number of lymph node (LN) which are accessible via EBUS.[1] But as per the literature, EUS is a more safe procedure and does not require mechanical ventilation.[2] Endorbonchial ultrasound-guided fine needle aspiration (EUS-FNA) has been shown to be particularly useful in the analysis of lesions in the aortopulmonary window (station 5), the subcarinal area (station 7) the lower paraoesophageal LN (station 8), and those in the ligamentum pulmonale (station 9).[2] Due to unavailability of EBUS in our hospital, we refer our patients for EUS which is done by Gastroenterologist. In our experience, we found that if performed for selected LN stations[2] the yield of EUS is similar to EBUS with lesser procedure-related risk (93% sensitivity and 100% specificity * unpublished data).

The sensitivity of positron emission tomography (PET) scanning in staging the mediastinum is reported to vary from 0.5 to 1.0 in previous studies.[3] The cut-off values of SUV max of mediastinal lymph node recommended by various studies ranges from 2.5 to 5.3.[4] With this background, I would like to know whether authors observe any particular cut-off value of SUV max over positron emission tomography–computed

tomography (PET-CT) among the 18 patients with proven malignancy. I understand that it was not one of the objectives of present study to determine cut-off value of SUV max over PET CT, but if authors would share this information, it will be very helpful to us, as in our hospital unlike EBUS, PET-CT is available.

I once again would like to congratulate Parmakisz E T and colleagues for their work.

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