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LETTER TO THE EDITOR

Optimizing the utility of high-resolution computed tomography in diagnosing cryptogenic organizing pneumonia

Dear Editor,

We congratulate Dr. Jara-Palomares et al.¹ for their elegant and important study, which discusses the utility of high-resolution computed tomography (HRCT) and bronchoalveolar lavage (BAL) in the diagnosis of cryptogenic organizing pneumonia (COP). They concluded that the association of the imaging findings and BAL could be useful for diagnosing COP in patients with appropriate clinical presentation, and for those whose transbronchial biopsy is negative or for whom a confirmatory biopsy cannot be performed. This conclusion is shared by other authors, such as Cordier et al.,² who suggested that a COP diagnosis without a surgical biopsy may be justifiable, and should be considered in critical patients (particularly elderly ones) provided that the clinical diagnosis is performed by expert clinicians.

However, we would like to highlight some aspects of concern that arise from this work. In using uncustomary radiological terms, the authors have failed to precisely define the most useful HRCT patterns for diagnosis. The glossary of terms for thoracic imaging published by the Fleischner Society³ is widely accepted and used for HRCT examination reports. Jara-Palomares et al. used the term “patchy infiltrate”, which they defined as two or more pathological dense areas in the lung, whether unilateral or bilateral. This definition is not recognized by the Fleischner Society and may confuse some readers; it does not specifically exclude parenchymatous consolidations and ground-glass opacities, which are also dense areas.

The idea of associating clinical, BAL, and HRCT data in special cases, and the goal of establishing criteria for diagnosing COP without pulmonary biopsy, are very interesting and opportune research pursuits. However, the use of imprecise HRCT patterns reduces the diagnostic value of the examination, as non-specific opacities can be seen in

a large variety of acute and chronic pulmonary disorders with diverse etiologies.

HRCT data can have stronger diagnostic value when used with meticulous criteria. It is well recognized in the literature that two HRCT patterns can be very useful for COP suspicion: the most common pattern is the finding of subpleural and/or peribronchovascular parenchymal consolidations.^{4,5} The other HRCT pattern, less common but more specific, is the reversed halo sign (RHS), defined as a focal, rounded area of ground-glass attenuation surrounded by a generally complete ring of consolidation.³ This sign is seen in 12%–19% of COP cases.^{4,6} In conclusion, the use of specific patterns for HRCT analysis will allow a more accurate and secure COP diagnosis in the absence of a lung biopsy.

Conflict of interest statement

None declared.

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