

## Sarcoidosis presenting with acute respiratory distress syndrome

Sir,

We read with interest the article by Arondi *et al.* (January–March 2016, Volume 11, Issue 1)<sup>[1]</sup> on pulmonary sarcoidosis presenting with acute respiratory distress syndrome (ARDS). As the authors referred, we had reported a case with sarcoidosis presenting with ARDS. We would like to hear from the authors three points. First, in the text, the authors reported that transbronchial biopsy (TBB) was positive for nonnecrotizing granulomas consistent with sarcoidosis. However, they showed in explanation of Figure 2 that some central necrosis revealing very active sarcoidosis can be identified. This is not consistent with each other. Which is correct either nonnecrotic or necrotic granuloma? Second, we do agree with the importance of bronchial alveolar lavage and TBB to establish correct diagnosis. Please let us know where the authors performed them. We suppose that these procedures were performed at the area showing ground-glass opacity on the chest computed tomography (CT) scan. How about bleeding as complication after TBB? Third, we appreciate hearing from the authors that whether there was any specific finding in rapidly progressive pulmonary sarcoidosis on the chest CT scan.

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Nil.

### Conflicts of interest

There are no conflicts of interest.

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### Reference

1. Arondi S, Valsecchi A, Borghesi A, Monti S. Pulmonary sarcoidosis presenting with acute respiratory distress syndrome. *Ann Thorac Med* 2016;11:79-81.

## Reply

Thank you very much for having appreciated the article; it is a pleasure for us answering your questions.

Regarding the first point, we precise that the dominant histologic pattern was nonnecrotizing granulomas and that the central necrosis was apparent only in a few granulomas as reported in the literature.<sup>[1]</sup> This pattern is consistent with sarcoidosis and in our opinion, it is related to very active process.

Second, bronchial alveolar lavage and transbronchial biopsy were performed in the lateral segment of middle lobe. This area showed diffuse ground-glass opacities with isolated or confluent small nodules on the chest computed tomography (CT) scan. No bleeding occurred.

Third, about the chest CT-specific findings, we clarify that, as reported in Figure 2, the chest CT showed a predominant ground-glass pattern with isolated or confluent small nodules. Although ground-glass opacities have been observed in CT (nearly 40% of patients with pulmonary sarcoidosis), an extensive ground-glass pattern is very uncommon.<sup>[2]</sup> Therefore, we believe that the detection of this radiological pattern of the presentation can only suggest the abrupt onset of an active disease.

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