

an exhaustive recent review,⁵ not even in an extensive series⁶ of surgical treatment of MAI cases was there mention of a similar case. What we find striking is the good therapeutic response obtained with completely conservative management, conditioned by the baseline situation of the patient, while the favorable evolution could be explained by the spontaneous drainage of the cavitated lesion of the LUL.

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What is the Technique of Choice for Diagnosing Mediastinal Lesions?

¿Cuál es la técnica de elección para diagnosticar lesiones mediastínicas?

To the Editor:

The objective of the useful article by Pérez Dueñas et al.,¹ recently published in your journal, is to "evaluate the diagnostic accuracy of CT-guided percutaneous fine needle aspiration cytology (FNAC) for detecting malignant mediastinal lesions". The study raises interest and demonstrates, in a series of 126 patients with no control group, that this technique is viable, quite safe and diagnostically efficient (sensitivity 95%). The authors conclude that the technique "should be considered the diagnostic procedure of choice when there is suspicion of malignancy of a mediastinal lesion; more aggressive techniques such as endoscopic procedures should be left for difficult cases". We believe, however, that the results of the study are not sufficient in order to reach such a conclusion.

First of all, it is a series of selected patients, with no comparative control group using other techniques, constituting a population that is different from the studies carried out with endoscopy;^{2,3} thus, the results cannot be compared. In order to do so, it would be necessary to design a clinical assay, with a control group, including variables such as the type and location of the mediastinal lesion, risk factors (emphysema, etc.), radiological exposure and cost-efficiency. With these data, patient groups could be established, as could the order of choice for the most adequate procedure for each case.

Second of all, we would like to give consideration to the aggressive nature of these tests. Applying proper methodology, flexible bronchoscopy allows for the bronchial tree to be examined and to obtain samples from proximal mediastinal lesions both efficiently and safely, with hardly any contraindications. Recent studies using scales with variables for pain and discomfort demonstrate that it is a

test that is very well tolerated by most patients.⁴ Therefore, bronchoscopy can currently be considered a minimally invasive technique. The study at hand does not analyze this aspect, nor does it use any variables that evaluate or compare the aggressiveness of the procedures. Therefore, it cannot be concluded that one or the other procedure is better depending on this criterion.

In short, we believe that the data provided are very interesting and useful, but, as we have explained, they are not sufficient to establish the diagnostic procedure of choice for studying mediastinal lesions. The choice should probably be based on which is most adequate (bronchoscopy, mediastinoscopy or CT-guided aspiration) depending on the location of the lesion, etiological suspicion and patient characteristics.

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