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Authors' Reply

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We thank Dr. Kuwal for his interest in and comments on our study [1]. In our randomized, prospective study, we aimed to compare computed tomography scan-guided pleural biopsy using an Abrams' needle (CT-ANPB) with ultrasonography-assisted pleural biopsy using a cutting needle (US-CNPB) with respect to both diagnostic yield and safety [2].

Biopsies were not performed in 'real time'. In our study, a CT scan had already been obtained for all patients, as per current guidelines [3]. As mentioned in the text, we used these CT scan images when we performed the biopsy.

Image-guided needle biopsy using ultrasonography or CT is increasingly used to evaluate pleural pathologies. As mentioned by Dr. Kuwal, each modality has its advantages and disadvantages. There are two main types of needles that are more commonly used for performing pleural biopsies: Abrams' needles or cutting needles. For the most accurate diagnoses, subtypes of needles can be selected depending on local expertise and practice patterns. Most interventional radiologists use cutting biopsy needles, such as the Tru-Cut biopsy needle. In our study, we aimed to compare CT-ANPB, which chest physicians routinely use in the bedside setting, and US-CNPB with a Tru-Cut cutting needle in terms of their diagnostic yield. If the CT-ANPB method detailed in the paper is

successful, a procedure with a high diagnostic yield is performed without the patient having to leave the pulmonary department and with no need for a second CT scan.

In our study, the 'freehand technique' was used in all patients undergoing US-CNPB, not the real-time technique. The technique used for US-CNPB in our study is similar to that utilized in some previous comprehensive studies and is preferred by many experts [4–8].

References

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