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From the authors:

We read with interest the correspondence from Mohapatra and colleagues regarding our paper "Effectiveness of infliximab in refractory FDG PET-positive sarcoidosis" [1]. We agree with Mohapatra and colleagues that the term refractory sarcoidosis is still under discussion. We defined refractory sarcoidosis in the methods section as "patients with severe sarcoidosis, unresponsive to first- and second-line treatment, or who have experienced severe side-effects from these agents". Diagnosis of sarcoidosis was made according to American Thoracic Society/European Respiratory Society criteria [2], including biopsy. These criteria also describe exclusion of other differential diagnoses. Using the described definition for refractory sarcoidosis yields a very heterogeneous group of patients, consisting of sarcoidosis patients that need third line immunosuppressive therapies, *e.g.* biologicals such as infliximab.

Mohapatra and colleagues also mention the costs of routinely performing 18F-fluorodeoxyglucose (FDG) positron emission tomography (PET) scans in sarcoidosis. Because of costs, but also radiation exposure, we do not recommend routine use of FDG PET scans in all patients with sarcoidosis. However, infliximab is a very expensive drug and our study does show additional benefit of performing an FDG PET scan prior to the start of treatment to predict treatment response [1]. This, in our opinion, justifies the use of FDG PET for individualised therapeutic decision-making in selected patients with severe sarcoidosis.

Furthermore, the authors point out the risk of tuberculosis in patients treated with infliximab. We agree that infliximab treatment is associated with an increased risk of reactivation of tuberculosis [3]. Therefore, all patients were screened for active or latent tuberculosis prior to treatment initiation, as noted in the exclusion criteria in the methods section [1]. Screening was performed by interferon-γ release assay, and latent or active tuberculosis were not found in any of the patients. In the Netherlands tuberculosis is not endemic, however, in other parts of the world this problem might be of a different magnitude [4].

Lastly, the authors raise a very interesting question regarding the aetiology of sarcoidosis and mention *Mycobacterium tuberculosis* as one of the aetiological agents for sarcoidosis. Although the aetiology of sarcoidosis remains unresolved, we agree that mycobacterial antigens are an interesting candidate [5]. However, many other infectious causes, such as fungi, *Borrelia*, and *Propionibacterium acnes* have previously been shown to be associated with sarcoidosis [6–9]. Furthermore, non-infectious causes, such as inorganic substances and genetics, have also been implicated in the aetiology of this disease [6, 10]. As current treatment for sarcoidosis, including infliximab, is not considered curative and merely reduces inflammation, elusive insights into disease aetiology will probably lead to new, possibly curative therapies in the future [11].

@ERSpublications
Considerations in managing FDG PET-positive sarcoidosis with infliximab therapy http://ow.ly/U0qUr

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Haemoptysis: a frequent diagnostic challenge

To the Editor:

We read with interest the article by Abdulmalak *et al.* [1] recently published in the *European Respiratory Journal*. The authors reported the results of an observational, retrospective, 5-year, nationwide, multicentre study based on the medical information collected from a French database. The epidemiology of haemoptysis was evaluated through the hospital discharge diagnosis codes, focusing on incidence, aetiology, seasonal distribution, relapses and mortality in a 3-year follow-up analysis. The authors made a great effort to provide findings on the largest national cohort of hospitalised patients with haemoptysis (~15 000 per year) and update the current epidemiological understanding of this frequent symptom in high-income countries. However, some of the results described in the manuscript deserve a more detailed analysis and careful interpretation.

The authors found that cryptogenic or idiopathic haemoptysis, defined as haemoptysis without an established cause [2, 3], was the most frequent aetiology ranging from 48.9% in 2012 to 52% in 2008. Although the epidemiology of haemoptysis has changed in the last decades, these data are significantly different to those described in other European hospitalised cohorts. In two prospective series, idiopathic haemoptysis had an incidence range of 5.4–13% [2, 4], whilst three retrospective studies detected an