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LETTER TO THE EDITOR

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Letter to the Editor: Pleural tail sign in computed tomography–guided lung biopsy: insights and considerations for clinical practice

Andrea Carolina Munive
Nicolás Guerrero Acosta
Isabella Andrea Bolaños Bermúdez
David Fernando Torres Cortés

Fundación Santa Fe de Bogotá, Department of Radiology, Bogotá, Colombia

Dear Editor,

We read with great interest the recent article by Hassan et al.[1] titled "Pleural tail sign in computed tomography–guided lung biopsy: an imaging predictor of severe pneumothorax requiring chest tube placement." The authors address a clinically relevant question and propose a practical refinement of the pleural tail sign (PTS), distinguishing between thin and triangular subtypes. This approach adds depth to the existing literature and reflects the increasing interest in imaging biomarkers as practical tools for improving preprocedural risk stratification in computed tomography (CT)–guided percutaneous transthoracic needle biopsy.[1]

The observation that the triangular PTS subtype is associated with a higher risk of severe pneumothorax requiring chest tube placement is particularly relevant. By focusing on clinically significant complications rather than overall pneumothorax rates, the study provides information that is directly applicable to daily practice.[1,2]

However, some aspects deserve further consideration. In particular, the potential role of patient-related factors is not fully explored. Although the analysis appropriately includes several technical variables, there is limited information on relevant comorbidities such as emphysema or other chronic lung diseases, which are well-known risk factors for pneumothorax following CT–guided biopsy.[3] In this setting, it is difficult to determine whether the association between triangular PTS and severe pneumothorax reflects a true imaging biomarker or, instead, an indirect indicator of underlying pulmonary vulnerability. Including more detailed clinical variables could help clarify this relationship.

Another aspect worth considering is how the main outcome was defined. Although the need for chest tube placement is clinically meaningful, it can also be influenced by operator judgment, local protocols, and individual patient factors. As such, it may not fully represent a standardized measure of pneumothorax severity, which could affect the interpretation of the results.

In addition, although the proposed subclassification of PTS is interesting and adds nuance, its application in everyday practice may be less straightforward. The reported interobserver agreement suggests only moderate consistency, raising the possibility that distinguishing between the thin and triangular subtypes may vary across readers, particularly outside specialized settings.

In conclusion, this study provides valuable insight into PTS and its potential role in identifying patients at higher risk of clinically significant complications. However, further information incorporating both imaging and clinical variables, along with standardized outcome definitions, would be helpful to better define its role in clinical practice.

Handling editor: Bahri Üstünsöz

Corresponding author: Andrea Carolina Munive

E-mail: andrecmunive@gmail.com

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Footnotes

Conflict of interest disclosure

The authors declared no conflicts of interest.

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