

Author's Reply

Dear Sir,

We appreciate the interest shown by Vikas *et al.* in our article. Some of the points highlighted regarding diagnosis of solitary fibrous tumor of pleura (SFTP) have already been discussed in our article.^[1]

As SFTP can be sessile or pedunculated, one should not heavily rely on demonstration of change in position by repeat CT scan in prone position. Yes, we do agree that demonstration of change in position clinches the diagnosis.^[2]

Round atelectasis is a close differential only when it mimics a pleural-based lesion on chest radiograph. However, CT is diagnostic and no further tests are required.

The causes and associations of pleural effusion have been highlighted in Table 4 of our article published in November 2013 issue.^[1] We agree that simple pleural fluid aspiration and gross appearance of the pleural fluid may substantially narrow the radiological differential diagnosis of pleural tumors. To add further, the ADA isoenzyme that increases in tuberculous pleural effusions is ADA-2 and in nontuberculous effusions, it is ADA-1. However, even the combined use of ADA, ADA-2, and the 2'-deoxyadenosine deaminase/ADA ratio does not fully distinguish between tuberculous and nontuberculous effusions sometimes. Therefore, ADA analysis is more important in the study of pleural effusions in patients aged under 35 years.^[3]

There are a number of causes of hemothorax. The most common are traumatic and iatrogenic causes. Apart from malignant causes, even necrotizing infections,

blood dyscrasias, vascular causes, etc., can present as hemothorax.^[4]

To conclude, only biopsy or fine needle aspiration cytology (FNAC) is definitive.

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