

suggests that caution should be exercised when ACEis, compared with ARBs, are used in sarcoidosis. However, we intend to share our insights about the topic.

First, we observed that the ARB cohort included more patients with heart failure and cardiac sarcoidosis before propensity score matching. We suggest performing the subgroup analyses focused on patients with heart failure and cardiac sarcoidosis to address the potential confounding by indication between ACEis and ARBs.

Second, the baseline differences in heart involvement between the 2 cohorts raise concerns regarding the potential for confounding bias. The heart involvement is a critical factor in the risk of death among patients with sarcoidosis.² To handle this, we recommend performing a sensitivity analysis with varying treatment durations, which could help determine whether these baseline differences, particularly in terms of heart involvement, had any significant impact on the primary and secondary outcomes, therefore ensuring that the conclusions are not influenced unduly by these initial differences.

Third, to account for dose accumulation effects of both medications, we recommend considering a time-varying Cox model. This approach would allow for changes in medication exposure over time and could enhance the accuracy of the analysis. Furthermore, providing further Kaplan-Meier plots could offer clearer visual insights for clinical application and aid physicians in understanding the long-term impact of ACEi and ARB use in sarcoidosis.

Last, detailed subgroup analyses stratified by age, sex, and different comorbidities could be considered to identify the most suitable target population in clinical practice. This would allow for a more precise understanding of which patient groups may benefit most from the use of ARBs or ACEis, which would help to tailor treatment strategies more effectively.

In conclusion, this study provides critical insights that are highly relevant to clinical practice and serves as a valuable addition to current guidelines. We hope our comments contribute to improving clinical care and to supporting the development of effective treatment strategies for patients with sarcoidosis.

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Response



To the Editor:

To address the issue of confounding by indication,¹ we conducted a subgroup analysis of mortality rates in patients with heart failure or sarcoid myocarditis who were treated with either ACE inhibitors (ACEis) or angiotensin receptor blockers (ARBs). After propensity scores were matched, both groups included approximately 875 patients with sarcoidosis. The 5-year survival probability was 68.3% for the ACEi group and 71.2% for the ARB group, a statistically significant difference (log-rank test, $P = .0201$). Cox proportional hazards model further confirmed a higher mortality risk for ACEs compared with ARBs (hazard ratio, 1.298; 95% CI, 1.041-1.619).

We agree that sensitivity analysis with varying treatment durations could provide additional insights. However, the TriNetx platform does not provide data on treatment duration, which limits our ability to perform this analysis. Additionally, the platform lacks time-varying Cox model capabilities because its analytic data set is structured cross-sectionally rather than longitudinally.

To identify the populations most suitable for ACEis vs ARBs, we performed a single subgroup analysis based on age. This study evaluated the impact of ACEis vs ARBs on all-cause death in patients with sarcoidosis across three distinct age groups (18-40 years; 40-60 years; > 60 years). After propensity score were matched, a total of 8,356 patients were included: 256 patients in the 20-40 year age group (128 per group), 3,024 patients

in the 40-60 year age group (1,512 per group), and 6,076 patients in the over 60 year age group (3,038 per group). Baseline characteristics were well-balanced between the ACEi and ARB groups within each age stratum.

In the 40-60 year and over 60 year age groups, ARB use was associated with significantly lower mortality rates. Specifically, the 40-60 age group showed an 87.1% higher mortality risk for ACEi users (hazard ratio, 1.871; $P = .0005$), and the over 60 group showed a 46% higher risk (hazard ratio, 1.460; $P = .0001$). No significant mortality rate difference was observed in the 20-40 year age group, likely because low event rates and a healthier baseline population. Future studies will perform additional subgroup analysis to further refine our understanding of populations suitable for receiving ACEis.

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Do Sex Disparities Impact Follower Perceptions of Leadership Styles During Clinical Emergencies?



To the Editor:

We read with great interest the article by Steinbach et al¹ that was published in the June 2024 issue of *CHEST*.

This study highlights 3 key themes for effective leadership during clinical emergencies, as perceived by those typically not in leadership positions. Although the study was not designed to evaluate effects of leader sex, we query whether there are potential learnings from the authors' data.

Leadership categorization theory postulates that individuals "create stereotypical cognitive representations around the characteristics perceived as inherent in a leader."² "Agentic" behaviors (eg, assertiveness) are more socially acceptable from men, whereas "communal" behaviors (eg, politeness) are more socially acceptable from women.³ In critical care settings, male resuscitation leaders are rated higher than their female counterparts in leadership skills, despite identical leader behaviors.⁴ Ju and van Shaik⁵ surveyed residents who identified men as their "ideal resuscitation leader" because of a perception of being more knowledgeable.⁵

We query whether the authors observed any sex-based disparities in the representation of leader pronouns in their interview data. For example, did the use and frequency of language like "him/his" by respondents correlate with the theme of control (ie, taking charge) and common understanding (ie, reasoning aloud)? Did the use of "she/her" imply more collaboration (ie, receiving input) and common understanding (ie, using closed loop communication)? We noted that many of the example quotes that were provided used "they/them" pronouns. We wonder whether this sex-neutral language was common among responses and whether it was prompted in any way. A descriptive analysis would help readers get a deeper appreciation of sex disparities in perceived leadership styles.

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