patients). Similarly, determining the incidence of HIT in patients exposed to therapeutic treatment with heparin was supported by a paper reporting a retrospective study assessing the incidence of secondary thrombocytopenia recorded in the discharge boards of patients who were referred for a short stay in nonfederal US hospitals with a diagnostic code for thromboembolism and related outcomes. Beside the fact that the meta-analysis reported in this paper did not focus on HIT, it lacked most quality parameters.3,4 Although high-quality evidence from randomized controlled trials regarding the incidence of HIT in postoperative patients has, to date, been sparse,5 I believe the previous examples indicate that there is a need to explore this issue more carefully in the ACCP Guideline to prevent this dangerous, adverse drug reaction.

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**REFERENCES**


**Response**

To the Editor:

Dr Junqueira has brought to our attention that some of the studies referenced in Table 2 (regarding the incidence of heparin-induced thrombocytopenia [HIT]) in the “Treatment and Prevention of Heparin-Induced Thrombocytopenia” chapter in the most recent edition of the antithrombotic therapy and prevention of thrombosis clinical practice guidelines1 are of poor methodologic quality. Many of the studies in the HIT literature, including those that reported the incidence of HIT, are of similar poor quality. In preparing this topic, we did not conduct a formal meta-analysis of HIT incidence studies primarily because evaluating the incidence of HIT was not one of our objectives. The references provided in the table were only intended to be examples of the incidence in various patient populations and heparin exposure groups. It is noteworthy, however, that had we conducted a formal meta-analysis as Dr Junqueira did in a recently published review,2 the result would not have been significantly different from that we provided in the table.

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**REFERENCES**


**Significance of Lymphadenopathy in IgG4-Related Sclerosing Disease and Sarcoidosis**

To the Editor:

We read with interest the recent article in CHEST (November 2012) by Rho et al.1 The authors presented an interesting case of IgG4-related sclerosing disease.

We were wondering whether there was any significant lymphadenopathy. Asymptomatic IgG4-related lymphadenopathy is

Cough and dyspnea could be clinical manifestations of pulmonary sarcoidosis. Also, lymphadenopathy and pulmonary nodules are common in sarcoidosis. Interestingly, there was a biopsy specimen-proven report of the association between IgG4-related disease and sarcoidosis. This association is fascinating and we may have overlooked the diagnosis of IgG4-related sclerosing disease in the past in patients with or without sarcoidosis.

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