The rationale for perioperative bridging is anchored on mitigating the risk of major cardiovascular events, including stent thrombosis, in patients who require surgery and in whom the associated risk of bridging-related bleeding is acceptably low. A number of agents, including unfractionated heparin, low-molecular-weight heparin, glycoprotein IIb/IIIa antagonists, direct thrombin inhibitors (bivalirudin), and reversible platelet P2Y12-receptor inhibitors, have been proposed and studied as bridging agents.

We recognize the foundational work at The Geelong Hospital and that carried out by Savonitto et al. These case reports and observational studies provide the impetus and rationale for future study in this area. Further encouraging evidence comes from a recent randomized, placebo-controlled trial of 210 patients with acute coronary syndromes or treated with a coronary stent on a thienopyridine, awaiting coronary artery bypass grafting. In this study, patients received IV cangrelor, a short-acting, reversible P2Y12-receptor inhibitor, or placebo for at least 48 h, which was stopped 1 to 6 h before surgery. Patients in the cangrelor group had lower levels of platelet reactivity with no significant increase in coronary artery bypass grafting-related bleeding. Whether this agent can be used safely in the noncardiac surgery setting has yet to be determined.

The current evidence points toward a lack of consensus regarding best practices for patients with coronary stents undergoing noncardiac surgery. This is particularly true for bridging strategies, where the majority of guidelines provide no recommendations. Well-designed prospective observational and randomized trial evidence is needed to help define future management strategies.


the lowest possible maintenance dose of inhaled corticosteroid to achieve the least potential for long-term systemic exposure in a given individual patient.

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Another Rare Finding of Lymphomatoid Granulomatosis on CT Scan

To the Editors:

We thank Hadid et al1 for their article in CHEST (January 2014). The authors wrote an excellent case report concerning a lung mass subsequently diagnosed as lymphomatoid granulomatosis (LYG). The authors reported that common findings on CT scan are peribronchovascular distribution of nodules, coarse irregular opacities, small thin-wall cysts, small nodules, and, rarely, a mass, as presented in this case.

We would like to share two other findings on CT scan in LYG, including reversed halo sign2 and air crescent sign.2 The reversed halo sign is a focal round area of ground-glass attenuation and surrounding airspace consolidation of crescent shape that is more commonly seen in cryptogenic organizing pneumonia.2 The air crescent sign is crescentic and radiolucent due to a lung cavity that is filled with air and has a round radiopaque mass that is most commonly found in pulmonary aspergillosis.3 Diagnosis of LYG is often a challenge, as it mimics many other more common pulmonary conditions3 and, therefore, the histologic triad of polymorphic lymphocytic infiltrate, angiitis, and granulomatosis with central necrosis is required for definitive diagnosis.7

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Response

To the Editor:

We thank Dr Srivali and colleagues for their letter regarding our case report.1 We appreciate their added contribution of two other CT scan findings that are more commonly seen in other disease processes and reiterate the important point that diagnosis of lymphomatoid granulomatosis (LYG) often is a challenge and confirm that there are no specific radiologic findings of LYG. We would like to note that despite the nomenclature, granulomas are not a histologic feature of this entity. The hallmark of LYG is a mixed mononuclear cell infiltrate containing large, variably atypical B cells and small T cells, often along with plasma cells and histiocytes, which replaces the lung parenchyma and shows vascular infiltration.