clinically sound recommendations. We urge the panel to consider such multidisciplinary input for the next iteration of the guidelines. Even weak recommendations formulated without scientific evidence can have a negative impact on patient care and future study design. It is quite possible that institutional review boards may identify these suggestions as the standard of care, affecting future study feasibility. As physicians and researchers involved in this field, we disagree with recommendation 4.2.2 and suggest that clinicians consider recommendations from cancer-focused guidelines, such as those of the American Society of Clinical Oncology and the National Comprehensive Cancer Network.

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Response

To the Editor:

We thank Dr Khorana and his colleagues for their thoughtful comments on our article.¹ As a point of clarification, our recommendation does not suggest that patients “should receive” prophylactic-dose heparin. In fact, it is a weak (level 2) recommendation, only suggesting the use of a prophylactic dose of heparin and only in subgroups of patients with cancer at high risk of VTE and low risk of bleeding. Indeed, within the Grading of Recommendation, Assessment, Development, and Evaluation framework, panel members make a weak recommendation when they conclude that the desirable effects of adherence to the recommendation probably outweigh the undesirable effects.² In those cases, the best action may differ depending on patient circumstances,³ and clinicians need to help each patient make a decision consistent with her or his values and preferences.²

The authors suggest that the recommendation is formulated without scientific evidence. The scientific evidence the panel considered is summarized in Table 15 of the article and in Table S18 of the online supplement.¹ It is based on a Cochrane systematic review,⁴ with a meta-analysis of nine trials at low risk of bias, enrolling 2,857 patients. The quality of evidence was rated high for symptomatic VTE; moderate for mortality, major bleeding, and minor bleeding; and low for quality of life. The recent publication of two trials^{5,6} has further increased the quality of evidence and the precision of effect estimates.⁷

The guideline panel carefully considered the balance of benefits and harms for this recommendation. According to the data in Table 15,¹ if 1,000 patients with cancer were to use a prophylactic dose of heparin, over a follow-up period of 12 months death would likely be averted in approximately 45 patients, symptomatic VTE would be averted in 13, and two would have a major bleeding episode. Considering this trade-off, along with the burden of a daily injection of heparin over a prolonged period of time, the panel made the judgment that patients are more likely to benefit than be harmed and issued a weak recommendation in favor.

The guideline panel was also very concerned with the issue raised by the authors (ie, the identification of patients who are more likely to benefit from heparin prophylaxis). Indeed, as we point out in the article, “the substantial clinical heterogeneity of the patients studied (different cancer types, different cancer treatments, and different durations of prophylaxis) raises questions about which groups of outpatients with cancer will benefit.”¹ Therefore, the panel issued a first recommendation (recommendation 4.2.1) that advises against routine prophylaxis with heparin in outpatients with cancer who have no additional risk factors for VTE. It then issued a second recommendation (recommendation 4.2.2) suggesting prophylactic dose heparin in a well-defined

subgroup of patients with solid tumors who are at high risk of VTE and at low risk of bleeding.

The panel referred to the eligibility criteria of the nine trials to identify the group of patients at a higher risk and who are likely to benefit. We welcome and strongly support the suggestion of the authors for clinicians to use structured and validated tools to risk stratify patients.⁸ An ideal tool would predict not only VTE but also major bleeding and mortality, the latter being the most important outcome for this specific intervention in this specific population.

The authors state, "It is quite possible that institutional review boards may identify these suggestions as a standard of care." Such misinterpretation would reflect a grave misunderstanding of guideline methodology as laid out clearly in relevant publications.^{2,3}

Finally, we hope that the transparency with which the panel made and reported its judgments will allow clinicians to interpret the recommendation in the individual patients' specific context and help them make the decisions that are appropriate for them.

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Responsiveness of the COPD Assessment Test

The Minimal Clinically Important Difference Does Matter

To the Editor:

With the inclusion of symptoms/health status in the most recent GOLD (Global Initiative for Chronic Obstructive Lung Disease) guidelines,¹ a large step has been made to involve the patient's view of the burden of disease in decision making. We welcome this development but wonder why the GOLD committee chose the COPD Assessment Test (CAT) by GlaxoSmithKline.

Clinicians and researchers need information on how to interpret scores, and the study by Jones et al² in this issue of *CHEST* (see page 134) provides important information about this topic. However, we would like to raise two issues. First, how much change in scores would one expect after exacerbations and pulmonary rehabilitation? Second, what would be the minimal clinically important difference (MCID) of the CAT based on this study?

Jones et al² describe the CAT score changes during an exacerbation and after rehabilitation. Exacerbation recovery resulted in a mean CAT score improvement of -1.4 points in all 67 patients