should be evaluated for pulmonary pressure, and a careful therapy strategy should be evaluated before the occurrence of severe/moderate PAH.

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Disclosures

The authors indicated no financial relationships.

In Reply

Thank you for the opportunity to respond to the letter from Dr. Leonardo Campiotti et al. We very much appreciate the careful reading of our review [1] and thank Dr. Campiotti and his colleagues for their comments. In essence, Dr. Campiotti and colleagues suggest that dasatinib should be included in the list of tyrosine kinase inhibitors (TKIs) associated with cardiac adverse events. In particular, the authors cite the recently reported data that dasatinib is associated with pulmonary arterial hypertension (PAH) [2] in selected patients and furthermore that they are reporting similar findings in four patients. We agree with these authors that PAH is an important cardiovascular event and should be included in the complete description of all cardiovascular events that might be noted with TKI therapy. A thorough discussion of the incidence, monitoring, and treatment are certainly warranted in our opinion. However, we previously chose to limit the discussion in our review to the most common cardiac events encountered, which included systemic hypertension, left ventricular dysfunction, and QT prolongation [1]. The purpose of this review was to cover the major items in some detail but not be completely inclusive because that would have required a much longer article. With that concept in mind, we left out other cardiovascular events potentially encountered with TKI therapy that probably also deserve a careful discussion, including the potential development of atherosclerosis associated with nilotinib [3] or arterial thrombotic events

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<http://dx.doi.org/10.1634/theoncologist.2013-0397>

associated with ponatinib [4]. Thank you so much for your consideration of these points.

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Disclosures

Daniel J. Lenihan: Roche, Astra Zeneca, Singulex (C/A); Acorda, Inc. (RF); **Peter R. Kowey:** Astra Zeneca, Johnson & Johnson, Novartis (H).

(C/A) Consulting/advisory relationship; (RF) Research funding; (E) Employment; (ET) Expert testimony; (H) Honoraria received; (OI) Ownership interests; (IP) Intellectual property rights/inventor/patent holder; (SAB) Scientific advisory board

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