

the immunohistochemical analysis revealed lymphocytic infiltrate with predominance of T-cells.<sup>3</sup>

In conclusion, RPM should be considered in the differential diagnosis of patients over 50 years of age with pleural and/or pericardial effusion.<sup>4,5</sup> It is essential to identify the cause of effusion in patients with RPM due to the spectacular response to corticoid treatment.

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## Leukemic Pleural Effusion: Diagnostic Approach and Controversies in Pleurodesis<sup>☆</sup>



### Derrame pleural leucémico: aproximación diagnóstica y controversias en pleurodesis

To the Editor:

The most common causes of pleural effusion in patients with acute myeloid leukemia (AML) are infections (bacterial or viral), other malignancy, chemotherapy and those derived from the malignant process itself. Survival is determined by response to treatment of the hematological disease.<sup>1</sup>

A minimum sample volume of 60 mL is required for the cytomorphological diagnosis of malignancy in pleural fluid.<sup>2</sup>

In cases of pleural effusion refractory to treatment of the underlying disease, pleurodesis must be performed to control respiratory symptoms.

This letter reports the case of a 76-year-old patient with AML diagnosed 2 months previously with compatible bone marrow phenotype and normal cytogenetic results (46,XY[15]) who had received 3 cycles of 5-azacitidine.

He was admitted for dyspnea, 38 °C fever and tachycardia (120 bpm). He had leukocytosis ( $45 \times 10^9/L$ ), anemia (hemoglobin 88 g/L), thrombocytosis ( $719 \times 10^9/L$ ) and serum lactate dehydrogenase (LDH) 1.663 IU/L (normal: 125–220 IU/L). Chest X-ray and computed tomography showed significant left pleural effusion.

A total of 90 mL of pleural fluid were obtained by thoracentesis. This contained 1200 lymphocytes/ $\mu L$  (normal:  $<200/\mu L$ ), glucose 52 mg/dL (normal: 70–110 mg/dL), LDH 1724 IU/L (normal: 125–220 IU/L) and pH was 7.38. Microbiological cultures were negative. Cytocentrifugation and May-Grünwald/Giemsa staining of the pleural fluid were performed for microscopic examination (Fig. 1). The presence of myeloblasts in pleural fluid was confirmed by flow cytometry immunophenotyping (CD34, CD33, CD13 and CD117, but not CD14 or CD15). Cytogenetic examination with G-banding was normal, consistent with the patient's AML phenotype.

A diagnosis of leukemic pleural effusion was established and pleural drainage was performed, with little response. One week

later, the patient required pleurodesis with bleomycin to control dyspnea derived from worsening pleural effusion. His respiratory syndrome worsened progressively until exitus at 15 days.

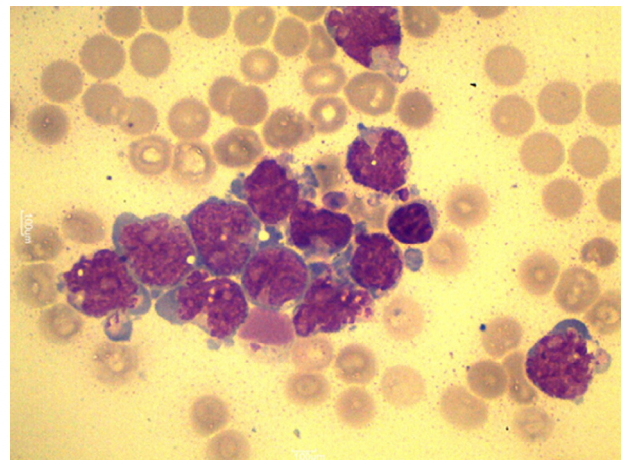
In the case of leukemic pleural effusion, the clonal cell line must be confirmed with fluorescence *in situ* hybridization (FISH).<sup>3</sup>

In the routine screening of these patients for the indication of pleurodesis, there is no clear correlation between pleural fluid pH and survival; clinical status appears to be the best predictor for post-pleurodesis survival.

In patients who have not previously undergone pleurodesis, no significant differences in dyspnea relief have been found between permanent pleural catheter drainage and talc pleurodesis.<sup>4</sup>

Both bleomycin and talc have been shown to be good sclerosing agents, with similar efficacy in pleurodesis for the control of symptomatic malignant pleural effusion. Although bleomycin was used in our patient, it is important to note that talc is cheaper and may have the same or better success rate in the reduction of recurrent malignant pleural effusion than bleomycin and other sclerosing agents, although this difference has not been shown to be statistically significant.<sup>5</sup>

The use of many sclerosing agents in pleurodesis has been reported, including iodized povidone, doxycycline, silver nitrate, interferon alpha-2b and others. Good results have been documented, but disparity in the design of these studies make



**Fig. 1.** Microscopic examination of pleural fluid, showing cells with lax and immature chromatin, raised nuclear-cytoplasmic ratio and visible nucleoli, compatible with myeloblasts (May-Grünwald/Giemsa staining, 1000 $\times$ ).

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comparison difficult. Future studies are required to reach a consensus on the best method of pleurodesis in these patients.

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## Should Self-Citation of Articles Be Penalized?\*



### ¿Debe penalizarse la autocitación de artículos?

Dear Editor:

De Granda-Orive et al.<sup>1</sup> recently published their thoughts on self-citation in medical journals, advocating the continued penalization or exclusion of self-citations from bibliometric indicators, the basic aim of which, they argue, is to prevent editors from attempting to manipulate these indexes. We believe that some reflections must be made on the legitimate use of self-citation that particularly affects journals such as ARCHIVOS DE BRONCONEUMOLOGÍA. Groups that aim not to publish in English have recourse to a very limited number of journals in other languages with a degree of international visibility. This is the case of publications in Spanish in the respiratory system setting: the Web of Science database that devised the impact factor lists 50 respiratory system journals, of which only one is in Spanish (accessed on <http://www.accesowok.fecyt.es/>), while of the 98 journals listed in the Scopus database, from which the *SCImago Journal Rank* (SJR) is calculated (accessed on <http://www.scimagojr.com/>), only 3 are in Spanish. Similarly, research papers from areas in which there are few specialized groups, even those of great scientific significance, necessarily tend to be published in a limited number of journals, making self-citation unavoidable. In this way, limiting self-citation in a journal widens the gap between journals of general interest in English, which receive more citations from different sources, and the more specialized or minority language journals. This is more a reflection of a difference in the interest in the field or knowledge of the journal's language than of the quality of that journal.<sup>2</sup>

In our opinion, the SJR calculation provides an excellent solution to this problem. This index, recently analyzed by the authors for use in respiratory system journals,<sup>3</sup> has some features that make it particularly useful. First, it limits the number of self-citations

used in its calculations, thus avoiding potential over-manipulation. Secondly, and perhaps more importantly, the SJR is applied by assigning citations a weighted value according to the influence of the citing journal. Thus, self-citations in a journal do not increase the influence of the journal and have little value in weighting that journal. Another alternative is to include other parameters, such as the *h*-index, in evaluating journals. This index, initially conceived to evaluate researcher activity, can also be applied to scientific journals<sup>4</sup> and its manipulation by self-citation is difficult when *h*-index values are relatively high.<sup>5</sup>

To conclude, self-citation may indicate a legitimate body of authors contributing to certain journals for the reasons of specialization or language discussed above. Even this letter contains self-citations of journals and authors that, as we see it, are inevitable.

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