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Edson Marchiori,* Miriam Menna Barreto, Gláucia Zanetti

Departamento de Radiología, Universidad Federal de Río de Janeiro, Río de Janeiro, Brazil

* Corresponding author.

E-mail address: edmarchiori@gmail.com (E. Marchiori).

Self-citations Should be Counted[☆]



Las autocitas deberían considerarse relevantes

Dear Editor,

De Granda-Orive et al.¹ argue that self-citations should *not* be counted when measuring the impact of publications. Garcia-Pachon et al.² argue that self-citations *should* be counted in journals with limited distributions—particularly those that are not published in English. I want to propose a third alternative. This is that the *in-text citations should* be counted *rather* than those in the *reference lists*—and more than once if they occur more than once in the text.

I have published my reasons for suggesting this elsewhere.³ They are briefly summarised as:

- The number of in-text citations indicates the weight attached to these references in an article (Hou et al.⁴) This weight is reduced if there are many in-text citations but only one or two in the reference list at the end. This reasoning applies both to self-citations as well as conventional ones.

[☆] Please cite this article as: Hartley J. Las autocitas deberían considerarse relevantes. *Arch Bronconeumol*. 2015;51:102.

- Not all self-citations are there just for self-enhancement: they can tell the reader where to find a key publication; provide evidence for the writer's claims; draw the reader's attention to little-known (and unknown) work; indicate to the reader the scholarship and experience of the writer; align the author with a particular school of thought; and show the development of thought.

Thus the best way, I submit, to count the references in an article is to count their frequency in the text (not the list) *according to their purposes*. In my article³ I provide three examples of how this procedure might work.

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James Hartley

E-mail address: j.hartley@keele.ac.uk

Mediastinal Vagus Nerve Schwannoma Successfully Treated by a Biportal VATS Approach[☆]



Schwannoma del nervio vago mediastínico tratado exitosamente con toracoscopia biportal videoasistida

Dear Editor,

In March 2010, a 60-year-old male non-smoker was referred to our Thoracic Surgery Unit with a history of dyspepsia during the previous three months and two episodes of syncope.

Past medical history included left hemicolectomy resection for pT1pN0 adenocarcinoma of the sigma more than 10 years previously. Colonoscopy was performed 6 months before our observation during a routine follow-up appointment and proved negative. Electrocardiogram (EKG) revealed sinus bradycardia;

transthoracic echocardiography (TTE) showed normal left ventricular function with no segmental kinetic changes, no valvular stenosis or insufficiency and normal ejection fraction. Tilt test was negative. Neurologic examination and computed tomography (CT) scan of the head were also negative for expansive or ischemic/hemorrhagic lesions.

Chest X-ray revealed mild prominence of the right heart border. Subsequent chest CT scan with iodine contrast medium showed a soft, well-defined, encapsulated paratracheal and retrocaval lesion measuring 24 mm × 26 mm (Fig. 1A), located in the proximity of the azygos vein arch. An 18F-FDG PET scan (Fig. 1B) revealed an increased uptake value corresponding with the lesion [standard uptake value (SUV) = 5.91]. After the weekly discussion meeting, we decided to perform transbronchial needle aspiration (TBNA); biopsy revealed nerve cells, compatible with low-grade nerve tissue tumor.

The patient was scheduled for surgery and underwent successful enucleation of the mediastinal lesion using a biportal thoracoscopic approach. The patient was placed in left lateral decubitus. Single lung ventilation was achieved using a double-lumen endobronchial tube positioned under fiberoptic guidance. A 4-centimeter surgical access was made in the 4th intercostal space and a second thoracotomy for the camera was made under

[☆] Please cite this article as: Roncon A, Davoli F, Casadio C, Baietto G, Rena O, Turello D. Schwannoma del nervio vago mediastínico tratado exitosamente con toracoscopia biportal videoasistida. *Arch Bronconeumol*. 2015;51:102–103.

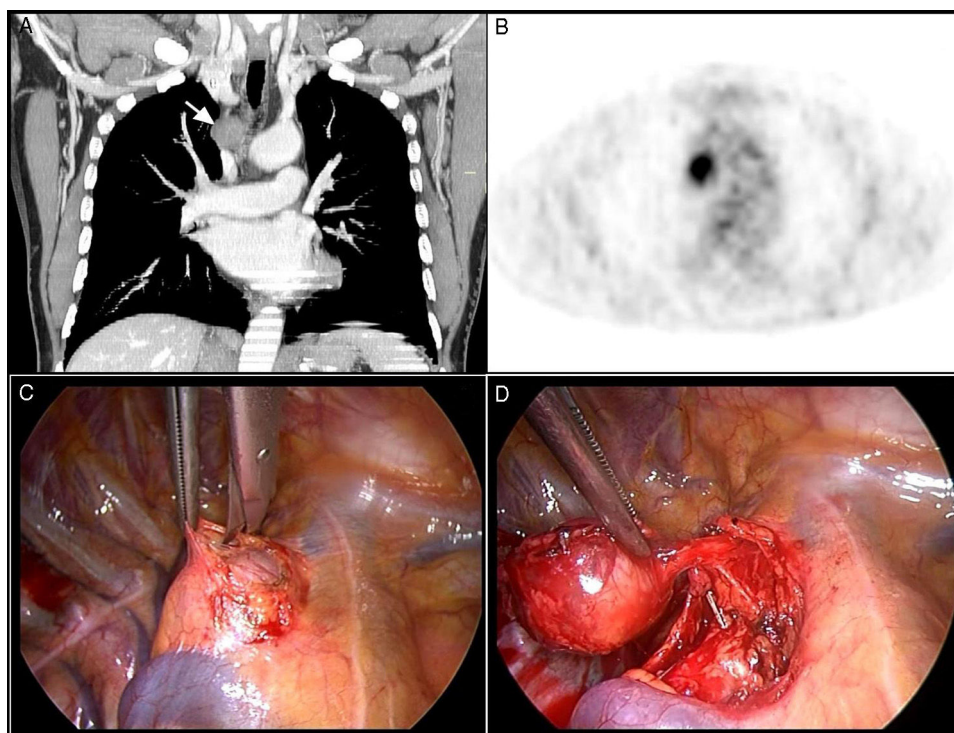


Fig. 1. (A) Chest CT-Scan showing a well-defined paratracheal and retrocaval soft lesion, 24 mm × 26 mm, located in the proximity of the azygos vein arch, characterized by medium contrast uptake. (B) 18F FDG-PET scan showing increased spot uptake located in correspondence of the lesion (SUV = 5.91). (C) Intraoperative thoracoscopic view; (D) intracapsular enucleation of the lesion after opening the mediastinal pleura.

direct vision in the 8th intercostal space on the mid-axillary line.

The nodule was identified on the right vagus nerve just above the azygos vein arch and excised by intracapsular enucleation (Figs. 1C and D); the anatomical integrity of the right vagus nerve could not be preserved and it was sacrificed. Continuous EKG monitoring was performed during the post-operative period to monitor for bradycardia due to vagus nerve injury. No atropine administration was required.

At the end of the surgical procedures, a 24 Ch chest tube was placed to guarantee lung re-expansion through the lower thoracotomy.

The post-operative period was uneventful and the patient was discharged after four days. Visual analog scale (VAS) for pain on day 1 post-surgery was 1 (range 0–10).

Histopathology of the specimen showed fascicles of spindle cells in a loose stroma. Strong positivity of the tumor cells for S-100 protein confirmed the diagnosis of schwannoma Antoni type A.¹

The patient reported resolution of symptoms and EKG revealed sinus rhythm at 78 bpm, probably linked to reduction of the parasympathetic effect on the heart rhythm caused by vagus nerve stimulation due to the mass. No recurrence was observed after a 4-year follow-up.

Schwannomas are uncommon, mainly benign, tumors that can arise from all myelinated nerve fibers. Vagus nerve schwannomas are rare mediastinal masses, accounting for 2% of all mediastinal

neurological tumors, arising typically from the nerve sheath and extrinsically compressing the nerve fibers.²

Biportal VATS is a safe approach for excision of this kind of lesion and produces less post-operative pain and a shorter hospital stay.³

To conclude, this was a rare symptomatic mediastinal lesion, successfully treated by a minimally invasive surgical approach.

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Alberto Roncon, Fabio Davoli,* Caterina Casadio, Guido Baietto, Ottavio Rena, Davide Turello

Unidad de Cirugía Torácica, Universidad de Piamonte Orientale, Azienda Ospedaliero-Universitaria "Maggiore della Carità", Novara, Italy

* Corresponding author.

E-mail address: fab_78_16l@hotmail.com (F. Davoli).