

Conflict of Interests

The authors declare that they have no conflict of interests.

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Cardiogenic Shock and Pulmonary Embolism*

Shock cardiogénico y embolia de pulmón

To the Editor,

We read with interest the national consensus document for the diagnosis, risk stratification and treatment of patients with pulmonary thromboembolism (PTE).¹ The prognostic stratification of PTE patients is based on their hemodynamic status, and patients with hypotension (sustained systolic blood pressure less than 90 mmHg) or cardiogenic shock are considered high risk. The recommended treatment for cardiogenic shock is the administration of fibrinolytics.

The term “shock” describes a clinical situation with circulatory failure causing hypoperfusion and hypoxia.² We are indebted to Dr Max Harry Weil³ for his major contribution to the understanding of the physiopathology of shock and his proposed classification of stages of shock, published in the early 1970s.⁴ There are 4 potential, non-exclusive, forms of shock: hypovolemic, cardiogenic, obstructive and distributive (mainly associated with sepsis and anaphylaxis). Cardiogenic shock occurs as a consequence of heart failure associated with diminished cardiac output. It can be caused by acute myocardial infarction, end-stage myocardial or valve disease, myocarditis or arrhythmias.⁵ Obstructive shock is less common and comprises different entities: pulmonary embolism, cardiac tamponade, aortic dissection and tension pneumothorax. The basic mechanism is increased afterload.³ Our understanding is that the correct denomination would be obstructive shock, or simply shock.

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Nevertheless, the clinical presentation of pulmonary embolism can be similar to that of cardiogenic shock, and some authors consider the first as a form of the second. Indeed, there is no agreement on the denomination in the 2 referenced guidelines on the treatment of thromboembolic disease¹ from the American College of Chest Physicians and the National Institute for Health and Clinical Excellence. The former only refers to the term “shock”, while the latter calls it cardiogenic shock. Irrespective of how this entity is called, there is no doubt that the new consensus document is of invaluable help in patient management.

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Atypical Deep Venous Thrombosis as the First Manifestation of Pulmonary Neoplasm*

Trombosis venosa inusual como primera manifestación de neoplasia pulmonar

To the Editor,

Hypercoagulable states in cancer are well known to be closely associated with thromboembolic phenomena. After a thromboem-

bolic event, the incidence of malignant tumors, mainly of the blood, pancreas, ovary, liver, kidney and lung, ranges between 2% and 25%. The most common sites are venous thrombosis of the lower limbs and pulmonary thromboembolism, and reports of cases in other venous territories are unusual.

We report a 68-year-old man, smoker of more than 40 pack-years, who was seen in the ophthalmology clinic for a 20-day history of loss of sight in the right eye. Examination of the eye revealed bilateral venous thrombosis of the retina. Additional examinations were performed to rule out secondary systemic disease. Clinical laboratory, coagulation, serological and autoimmune examinations and computed tomography (CT) of the brain were performed; all results were negative. A chest X-ray was performed, revealing a nodule in the left upper lobe (LUL). Chest CT confirmed a

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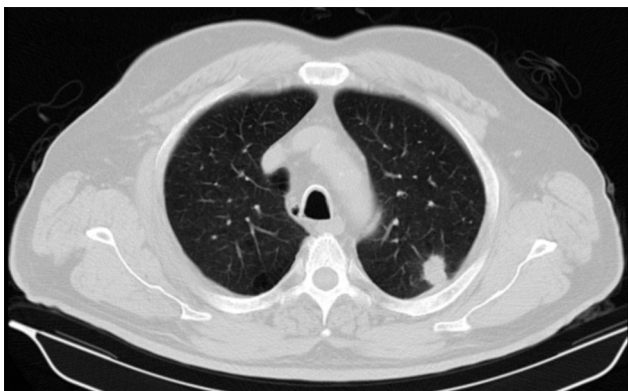


Fig. 1. Bilateral venous thrombosis and malignancy.

14 mm spiculated nodule in the posterior region of the LUL, indicative of malignancy (Fig. 1), and a diagnosis of lung adenocarcinoma was confirmed by the pathology report. No pathological contrast uptake was found in any other sites on PET-CT.

The merits of extensive screening for occult malignancy after idiopathic thromboembolic events are still widely debated. The latest evidence suggests that this practice is only justified in high-risk patients (recurrent thrombotic events in spite of anticoagulation, and portal or hepatic vein thrombosis) due to high healthcare costs, but basic screening studies with laboratory testing, protocolized according to age and chest X-ray results, may be beneficial.^{1–4} Finally, it is important to note that while the most commonly

affected territories are the veins of the lower limbs and the lungs, a small percentage of venous thrombosis in unusual sites may also indicate occult malignancy or other systemic diseases. Thus, each case should be evaluated on an individual basis, and minimal basic screening is a possible approach.

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The Open Access Movement: A Chance to Re-Evaluate the Peer Review Process?*

El movimiento Open Access: ¿oportunidad para re-evaluar el proceso de revisión por pares (peer review)?

To the Editor,

A recent editorial in *Archivos de Bronconeumología*¹ called into question the quality and scientific rigor of the peer review (PR) process in *Open Access* (OA) journals. We would like to add a few thoughts of our own. The OA model undoubtedly has some advantages, such as improving the visibility and accessibility of published content. This in turn increases the number of citations received, and consequently boosts the impact factor of these journals, giving them a competitive advantage over other publications.² The PR process is a system that evaluates the quality of the research before it is published. It analyses the scientific quality of the papers, and verifies whether the research is sound and the methodology appropriate. PR should be objective, independent and even parallel to the research itself, and it should be well established and monitored. The number of OA scientific journals has increased in recent years, and while this open system may change the PR editorial process, it should not impoverish the quality of the content.³ In fact, evidence shows that the underlying problem is financial. Although OA means removing barriers to accessing academic

papers, acquisition costs influence the scientific communication process; subscription-based publishing systems require a major investment from the scientific community, and the same is true of systems that enable users to access and retrieve the information they need.³ According to Alexandrov,⁴ the purpose of PR has changed over time: it was originally geared to selling articles to the reader, therefore publishers needed to evaluate how many readers would buy a particular manuscript, i.e. the market value of the original paper was an important factor in the editorial decision. In OA, in contrast, reviewers do not have to assess the market value of a manuscript, as publication costs have already been paid (by the author, institution or a third party) and do not need to be recuperated through subscriptions. This could lead to a more lenient approach to the PR process. Some authors believe that when the scientific community fully adopts an OA policy, together with an open PR system in which reviews are signed and published online, the level of transparency and quality in scientific publishing of research data will probably improve, and the PR process will reach levels of excellence.⁵ PR in OA should be a dynamic system in which online comments and suggestions are accepted. The OA initiative could benefit the PR process by creating an open system of communication between the author and the reviewer, and in-depth insight into the selection criteria used by the experts.³

The trend toward OA publishing is unstoppable, and in many cases levels of PR quality control do not differ greatly from subscription systems. Either way, the OA system, along with an increasingly open approach to science, will give the scientific community a chance to re-evaluate editorial transparency and the PR process.

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