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## Self-citations Should be Counted<sup>☆</sup>



### Las autocitas deberían considerarse relevantes

Dear Editor,

De Granda-Orive et al.<sup>1</sup> argue that self-citations should *not* be counted when measuring the impact of publications. Garcia-Pachon et al.<sup>2</sup> 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.<sup>3</sup> They are briefly summarised as:

- The number of in-text citations indicates the weight attached to these references in an article (Hou et al.<sup>4</sup>) 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.

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- 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 article<sup>3</sup> I provide three examples of how this procedure might work.

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## Mediastinal Vagus Nerve Schwannoma Successfully Treated by a Biportal VATS Approach<sup>☆</sup>



### 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

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