the immunohistochemical analysis revealed lymphocytic infiltrate with predominance of T-cells.3

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

References


Leukemic Pleural Effusion: Diagnostic Approach and Controversies in Pleurodesis

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.

A minimum sample volume of 60 mL is required for the cytological diagnosis of malignancy in pleural fluid.2 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-azacytidine.

He was admitted for dyspnea, 38 °C fever and tachycardia (120 bpm). He had leukocytosis (45 × 109/L), anemia (hemoglobin 88 g/L), thrombocytosis (719 × 109/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/μL (normal: <200/μL), 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).3 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.4 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.5

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


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Fig. 1. Microscopic examination of pleural fluid, showing cells with lax and immature chromatin, raised nuclear-cytoplasmic ratio and visible nucleioli, compatible with myeloblasts (May-Grünwald/Giemsa staining, 1000×).
comparison difficult. Future studies are required to reach a consensus on the best method of pleurodesis in these patients.

References


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Should Self-Citation of Articles Be Penalized?c

¿Debe penalizarse la autocitación de artículos?

Dear Editor:

De Granda-Orive et al.1 recently published their thoughts on self-citation in medical journals, advocating the continued penalization or exclusion of self-citations from bibliometric indices. The authors indicate that such self-citations are indeed common and should be penalized. However, the reasons for this are not clearly explained. In this commentary, we aim to provide some insights into the potential impact of self-citation on scientific communication.

Self-citation is a well-documented phenomenon in the scientific community. It is often seen as a sign of self-promotion or an attempt to inflate the impact of one’s own work. However, the potential benefits of self-citation should not be overlooked. For instance, self-citations can help authors build their reputations and establish their expertise in a particular field.

In conclusion, while self-citation does have some drawbacks, it is not necessarily a totally negative phenomenon. Further research is needed to better understand the role of self-citation in scientific communication and its impact on the scientific community.

References

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