Correspondence

Publication Audit and handling publication misconduct

I have read with interest and enthusiasm your recent article entitled "Publication audit, handling publication misconduct and need for education of authors: A Pakistani perspective", published in the recent issue of the Pakistan Journal of Medical Sciences.[1] I found it extremely informative and useful.

However, I would like to comment on a point, regarding the case of plagiarism in an article from Jordan. I feel that your journal should have a strategy and arrangements that should be cascaded to all reviewers to trap such obvious cyber plagiarized cases. The capturing of salami publications, using sophisticated computer programms some of which are available online, is easy and save time as well. In addition, if the reviewers just use Google Scholar and check plagiarism by putting title of the article or use Pubmed, I think they will easily find out if it is salami or it involves plagiarism. Finally regarding reference 14, it is inadvertently written as 13 at the end of the references list.

REFERENCES

1. "Publication audit, handling publication misconduct and need for education of authors: A Pakistani perspective". Pak J Med Sci 2008;24(1):1-5.

Dr. Younis A. M. Skaik
Lecturer in Haematology and Transfusion Science
AL-Azhar University-Gaza, Palestine.
E mail: y_skaik@hotmail.com

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Hodgkin Lymphoma and Cervical Lymphadenopathy

We read with interest the article by Memon *et al*. published in the recent issue of *Pak J Med Sci* [1] reporting the prevalence of Hodgkin lymphoma (HL) in a large series of patients presenting with cervical lymphadenopathy. Hodgkin lymphoma is a malignant disorder first described by Thomas Hodgkin in 1832. The distinctive malignant cells of HL, the so called Reed-Sternberg cells were first described by Carl Sternberg and Dorothy Reed in 1898 and 1902 respectively. The cellular origin of these cells has however, remained enigmatic until very recently.[2] Molecular studies on isolated RS cells has indicated that these cells arise from germinal centre B-cells with crippling mutations.[3] Definitive diagnosis of HL is based on biopsy examination to demonstrate the presence of RS cells in the appropriate histological background.

Clinically, HL typically presents with lymphadenopathy, particularly cervical, but sometime axiliary or inguinal lymph nodes may be affected.[4] Enlargement of lymph nodes is often gradual with no apparent infection. A rapid enlargement of lymph nodes, typically seen in infectious conditions, is infrequent in HL. Although the enlarged lymph nodes are usually painless, occasionally these can be tender, especially after consumption of large amount of alcohol. Other common clinical symptoms of HL include fever, night sweats and weight loss, collectively referred to as B-symptoms.

In the study of Memon and colleagues, 498 patients presenting with cervical lymphadenopathy at Isra University Hospital were collected over a period of four years (January 2002 to December 2006). Off the 498 cases, 40 (12.5%) were subsequently found to have Hodgkin lymphoma. Although cervical lymphadenopathy is a common presenting feature of HL, it is by no means exclusive or even specific to HL. Cervical lymphadenopathy can be a presenting feature in a number of disorders of both, inflammatory or neoplastic nature (Table 1).[4-9] In majority of the cases, cervical lymphadenopathy is of benign inflammatory nature, often caused by bacterial or viral infections of the upper respiratory tract.[6,8,9] In developing countries, tuberculosis is amongst the most common cause of sub acute or chronic cervical lymphadenopathy, and malignant lymphomas constitute less the 10% of the

cases.[8,9] For differential diagnosis, what is important is to look at cervical lymphadenopathy in the context of other clinical features such as age of the patient, sex, involvement of other lymph nodes and presence of B-symptoms.

The average age of the patients in Memon *et al.*'s study was 23 years, with majority of the patients being male (72.5%). Furthermore, mixed cellularity subtype was the major histological type seen. These observations support the notion that in developing countries, where HL appears much earlier than in developed countries and mixed cellularity is the predominate subtype, most cases are associated with Epstein-Barr virus (EBV).[10,11] EBV is a large dsDNA virus belonging to the herpes family of viruses. The virus is well known for its oncogenic potential and it is aetiologically associated with a number of human malignancies, including Burkitt lymphoma, post-transplant lymphomas, nasopharyngeal carcinoma and Hodgkin lymphoma. Although, Memon *et al* did not do any viral analysis of their cases, it would be interesting to see how many of their cases are EBV-positive and if there is indeed a correlation with age and histological subtype, similar to what has been reported in studies from other developing countries. We are currently in the process of setting up a collaborative study to look at the association of EBV with Pakistani cases of HL. Understanding the molecular mechanism(s) of EBV-mediated pathogenesis of HL could lead to novel interventions for preventing this malignancy. That this is indeed possible is supported by the recent success of developing a vaccine for cervical cancer, another viral-associated malignancy.

REFERENCES

1. Memon W, Samad A, Sheikh GM. Hodgkin's lymphoma in cervical lymphadenopathy. Pak J Med Sci 2008;24:118-121.
2. Khan G. Epstein-Barr virus, cytokines and inflammation: A cocktail for the pathogenesis of Hodgkin Lymphoma. Exp Hematol 2006; 34: 399-406.
3. Kanzler H, Kuppers R, Hansmann ML, Rajewsky K. Hodgkin and Reed-Sternberg cells in Hodgkin's disease represent the outgrowth of a dominant tumor clone derived from (crippled) germinal center B cells. J Exp Med. 1996;184:1495–1505.
4. Hodgson DC, Gospodarowicz MK. Clinical Evaluation and Staging of Hodgkin Lymphoma. In: Mauch PM, Hoppe RT, Armitage JO, Diehl V, Weiss LM (editors). Hodgkin Lymphoma, 2nd Ed. Lippincott Williams & Wilkins; 2007. p125.
5. Bazemore AW, Smucker DR. Lymphadenopathy and malignancy. Am Fam Physician. 2002;66:2103-2110.
6. Leung AK, Robson WL. Childhood cervical lymphadenopathy. J Pediatr Health Care 2004;18:3-7.
7. Chong V. Cervical lymphadenopathy: what radiologists need to know. Cancer Imaging. 2004;4:116-120.
8. Moore SW, Schneider JW, Schaaf HS. Diagnostic aspects of cervical lymphadenopathy in children in the developing world: a study of 1,877 surgical specimens. Pediatr Surg Int. 2003;19:240-244.
9. Song JY, Cheong HJ, Kee SY, Lee J, Sohn JW, Kim MJ, et al. Disease spectrum of cervical lymphadenitis: analysis based on ultrasound-guided core-needle gun biopsy. J Infect. 2007;55:310-316.

Table 1: Common Causes of Cervical Lymphadenopathy

Malignant Disorders	*Non-Malignant Disorders*
* Neuroblastoma	* Viral upper respiratory tract infections e.g. rhinoviruses, influenza, RSV, EBV, CMV, HIV, rubella
* Leukaemia	* Bacterial upper respiratory tract infections e.g. ß-haemolytic streptococci, staphylococci.
* Hodgkin Lymphomas	* Brucellosis
* Non-Hodgkin Lymphomas	* Tuberculosis
* Carcinoma	* Sarcoidosis
* Rhabdomyosarcoma	* Toxoplasmosis
* Angioimmunoblastic lymphadenopathy	* Kawasaki disease
* Malignant histocytosis	* Castleman's Disease
* Kaposi's sarcoma	* Cat scratch disease
	* Kikuchi's lymphadenitis
	* Rosai-Dorman Disease

10. De Matteo E, Baron AV, Chabay P, Porta J, Dragosky M, Preciado MV. Comparison of Epstein-Barr virus presence in Hodgkin lymphoma in pediatric versus adult Argentine patients. Arch Pathol Lab Med. 2003;127:1325-1329.
11. Zarate-Osorno A, Roman LN, Kingma DW, Meneses-Garcia A, Jaffe ES. Hodgkin's disease in Mexico. Prevalence of Epstein-Barr virus sequences and correlations with histologic subtype. Cancer. 1995;75:1360-1366.

Dr Gulfaraz Khan, MSc, PhD, FRIPH
Senior Lecturer in Cellular Pathology
School of Life Sciences, Kingston University
Penrhyn Road, Kingston upon Thames
Surrey KT1 2EE, UK
E-mail: g.khan@kingston.ac.uk

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Attitude, belief and knowledge about blood donation and transfusion in Saudi population

This refers to the manuscript " Attitude, belief and knowledge about blood donation and transfusion in Saudi population", published in Pakistan Journal of Medical Sciences.[1] First, the aim of the study that is mentioned at the end of the introduction part should be rephrased. A small sample (609) cannot represent the whole Saudi population. At best it can reflect it in population of the city where this study was conducted. Another way could be to use one of the statistical formulas to calculate the sample size that can be considered as representative sample for the whole Saudi population.

As regards methodology, I would like to point out that first, the author conducted the study over a period of one year (2005-2006). Had the study been continued for two to three years, it could have been termed as good enough for all participants to change their concepts, attitudes, belief and their knowledge. Therefore, this study could be termed as retrospective one which doesn't represent the current attitudes of Saudi population. Secondly the author has not mentioned the type of randomization (simple, systematic). Finally, the SPSS is abbreviated for Statistical Package for Social Sciences and not Statistical analysis for social sciences. In addition, the preposition "the" is inadvertently missed in the first line of methodology, before Department. In the results section, table 1, page 76, an increment of 1 should be added to each age group (15-30, 31-45, 46-60, more than 60).

Regarding the discussion part, page 78, the author inadvertently cited reference number 2 to Maqbool et al, while at the bibliography list; reference number 2 refers to Alam and Masalmeh.

I would also like to take this opportunity to rephrase the proverb which says "speech is silver, but silence is gold", to speech is gold, but silence is silver. In a situation like academic plagiarism, candid speech is gold and not silver. Plagiarism and scientific misconduct are common and widely prevalent problems amongst both students and academics. Self-plagiarism, salami publications, fraudulent, falsification and fabrication, all are different types of plagiarism. [2] A wide spectrum of illegal recent and sophisticated ways[3] are used by some researchers to plagiarize. Recently, software programs have become freely available on the internet which are very easy to use. Babylon program is one of the most common translation software programs used. It has 18 different languages. Few minutes are needed to translate a paper from one language to another, but one should only revise grammatically the translated manuscript. Tackling this type of plagiarism is a Herculean task. However, all editors should be aware of this type of scientific misconduct. In addition, clear approaches and strategies should be on the Editor's agenda to check such type of plagiarism. Finally, I would like to nudge all researchers "Don't imitate, try to innovate".

REFERENCES

1. Al Drees AM. Attitude, belief and knowledge about blood donation and transfusion in Saudi population. Pak J Med Sci 2008;24(1):74-79.
2. Abraham, P. Duplicate and salami publications. JPGM 2000; 46 (2): 67-69.
3. Al Skaik, YA. Alert: A new paradigm to plagiarism. Correspondence- Pak J Med Sci 2006; 22 (4):509.

Younis A. M. Skaik
Lecturer in Haematology and Transfusion Science
AL-Azhar University-Gaza, Palestine
E mail: Y_skaik@hotmail.com