

Correspondence

We will try to publish authors' responses in the same edition with readers' comments. Time constraints may prevent this in some cases. The problem is compounded in the case of a quarterly journal where continuity of comment and redress is difficult to achieve. When the redress appears 3 months after the comment, 6 months will have passed since the original article was published. Therefore, we would suggest to our readers that their correspondence about published papers be submitted as soon as possible after the article appears.

Thromboembolic Disorders

To the Editor: As a Diplomate of the American Board of Family Practice who has made a transition to diagnostic radiology, I wish to add two important points to the otherwise excellent review of thromboembolic disorders by Dr. Brunader (April – June 1989).¹

The first is the advent of lower-extremity compression ultrasound (synonyms: real-time B-mode ultrasonography, duplex B-mode ultrasonography) for the diagnosis of deep-venous thrombosis.²⁻⁵ With this technique, the femoral and popliteal veins are visualized under real-time ultrasound scanning. The absence (or presence) of intraluminal thrombus is established by noting complete obliteration (or lack thereof) of the vein lumen by direct compression with the ultrasound transducer. Occasionally, echogenic thrombus can be visualized within the lumen; however, fresh clot can be as sonolucent as flowing blood, and, therefore, lack of compressibility is the reliable positive finding. This noninvasive technique, which requires a minimum of time to perform, has been shown to be comparable in sensitivity and specificity with contrast venography in the popliteal and femoral veins.^{6,7} Reliability falls off in the calf veins, but, as Dr. Brunader points out, calf deep-venous thrombi rarely become embolic. Patients for whom there is a high degree of clinical suspicion can easily undergo serial scanning to evaluate for clot propagation into the popliteal and femoral veins. In addition, visualized augmentation of popliteal vein caliber with manual squeezing of the calf and of femoral vein caliber with the Valsalva maneuver indirectly assess for occlusive disease in the calf and iliac veins, respectively. The problem of differentiating acute from chronic disease persists, but combined with the assessment of history and clinical status, an informed approach can be established.

Second, radionuclide venography can be combined with perfusion lung scanning using the same dose of technetium 99m macro-aggregated albumin by dividing the dose and injecting half in a dorsal vein of each foot. Subsequent imaging over the lower extremities and pelvis is accurate for the diagnosis of occlusive disease in the popliteal, femoral, or iliac veins as manifested by failure to visualize tracer proximal to the occlusive site.^{8,9} Proceeding to imaging over the lungs provides the perfusion lung scan. This technique is useful in patients suspected of

pulmonary embolism but without a clinically evident source, in whom lower extremity deep-venous thrombosis is, therefore, most likely.

Especially in light of current advances in thrombolytic therapy, the accuracy of both techniques, their noninvasiveness, ease of performance, and relative minimal expense make them important additions to the diagnostic approach to deep-venous thrombosis.

Elliot M. Sacks, M.D.
The University of Arizona
Tucson, AZ

References

1. Brunader RE. Diagnosis and evaluation of thromboembolic disorders. *J Am Bd Fam Pract* 1989; 2:106-18.
2. Cronan JJ, Dorfman GS, Scola FH, Schepps B, Alexander J. Deep venous thrombosis: US assessment using vein compression. *Radiology* 1987; 162:191-4.
3. Cronan JJ, Dorfman GS, Grusmark J. Lower-extremity deep venous thrombosis: further experience with and refinements of US assessment. *Radiology* 1988; 168:101-7.
4. Raghavendra BN, Horii SC, Hilton S, Subramanyam BR, Rosen RJ, Lam S. Deep venous thrombosis: detection by probe compression of veins. *J Ultrasound Med* 1986; 5:89-95.
5. Lensing AW, Prandoni P, Brandjes D, et al. Detection of deep-vein thrombosis by real-time B-mode ultrasonography. *N Engl J Med* 1989; 320:342-5.
6. Langsfeld M, Hershey FB, Thorpe L, et al. Duplex B-mode imaging for the diagnosis of deep venous thrombosis. *Arch Surg* 1987; 122:587-91.
7. Aitken AG, Godden DJ. Real-time ultrasound diagnosis of deep vein thrombosis: comparison with venography. *Clin Radiol* 1987; 38:309-13.
8. Kramer FL, Teitelbaum G, Merli GJ. Panvenography and pulmonary angiography in the diagnosis of deep venous thrombosis. *Radiol Clin North Am* 1986; 24:397-418.
9. de Hodge P. Detection and location of lower extremity deep venous thrombosis with radionuclide venography. *Diagn Imaging* 1981; 50:191-6.

The above letter was referred to the author of the article in question, who offers the following reply.

To the Editor: I very much appreciate Dr. Sacks's interesting and appropriate contributions to this article.

Richard E.A. Brunader, M.D.
Silas B. Hays Army Community Hospital
Fort Ord, CA

Refereed Journals

To the Editor: Thank you for explaining and endorsing the referee system of manuscript review (April – June 1989).¹ While not perfect, it is the best system we have for maintaining the scientific basis of medicine. I disagree, however, with the statement that most refereed medical journals use blinded reviewers. Cleary and Alexander recently surveyed the editors of 114 medicine-related English language journals to determine whether the ref-

erees who review manuscripts are blinded to the identity of the authors.² They found that only 18.6 percent of the responding journals currently blind referees. Two family medicine journals were surveyed: *American Family Physician* does not use blinded referees, whereas *Journal of Family Practice* does. Other pertinent journals that do not blind reviewers include the following:

American Journal of Diseases of Children
Annals of Internal Medicine
British Medical Journal
Geriatrics
Journal of the American Medical Association
Journal of Pediatrics
New England Journal of Medicine
Pediatrics
Southern Medical Journal

Some of the largest and most influential journals are on this list.

In their classic study, Peters and Ceci evaluated 10 psychology journals that used nonblind review by resubmitting manuscripts that previously had been published in the same journal 2 years before, changing only the names of the authors and their institutions. Only 2 out of 14 reviewers believed that the previously published papers were suitable for publication.³

It seems that it would be easy to blind reviewers to an author's identity by removing the author identification page before sending a paper out for review. As pointed out in the editorial, this will not guarantee anonymity, but it may help. Decisions made by reviewers and editors affect careers, funding, and the course of medicine. The process of publication is as important as the data published, and this process should be made as objective as possible.

Allen F. Shaughnessy, Pharm.D.
Saint Margaret Memorial Hospital
Pittsburgh, PA

References

1. Young PR. A case for refereed journals. *J Am Bd Fam Pract* 1989; 2:77.
2. Cleary JD, Alexander B. Blind versus nonblind review: survey of selected medical journals. *Drug Intell Clin Pharm* 1988; 22:601-2.
3. Peters DP, Ceci SJ. A manuscript masquerade. *The Sciences* 1980; 20(7):16-19, 35.

Bibliographic Databases

To the Editor: As Shearer, et al.¹ correctly note, a number of excellent systems are available for computer access to MEDLINE and related databases. Any of those mentioned are suitable for use by medical librarians and researchers with high levels of sophistication and extensive experience in working with MEDLINE. In my view, however, the system of greatest value to practicing physicians and residency programs was mentioned last and without the attention it deserves.

Its somewhat frivolous name notwithstanding, "Grateful Med" provides rapid, easy access by less sophisticated

users to MEDLINE, AIDSLINE, and other MEDLARS databases.² This system is particularly useful when one wants information quickly or lacks ready access to medical library services. The price is right, the instructions are lucid and reasonably simple, and a computer-based tutorial program is supplied. Informative monthly bulletins are published, and annual system upgrades have been provided without additional cost.

One potential pitfall with self-administered literature searches, whether using "Grateful Med" or another approach, is the definition of search terms. It is important to have access to a copy of the *Medical Subject Headings (MeSH)* book, and a telephone call to a medical librarian or other source of advice will be needed occasionally until one becomes familiar with the system.

The software can be ordered for \$29.95 plus \$3.00 for shipping from National Technical Information Service, 5285 Port Royal Road, Springfield VA 22161.

Robert D. Gillette, M.D.
St. Elizabeth Hospital Medical Center
Youngstown, OH

References

1. Shearer B, McCann L, Crump WJ. A primer for users of medical bibliographic databases. *J Am Bd Fam Pract* 1989; 2:191-5.
2. Gillette RD. Software review: Grateful Med. *Fam Med* 1987; 19:475.

Editors' Comment

Ms. Shearer and colleagues have written a companion article, "Grateful Med: Getting Started," which will be published in the January - March 1990 issue.

Effort Thrombosis

To the Editor: I read, with great interest, Aquino and Barone's article, "Effort Thrombosis of the Axillary and Subclavian Vein Associated with Cervical Rib and Oral Contraceptives in a Young Woman Athlete," (July - September 1989). I was surprised that they had found only 52 cases in which effort thrombosis was related to sports participation. I wish to add a similar case that presented to our family practice residency program in March 1989.

A previously healthy 24-year-old woman presented with abrupt swelling and discoloration of her right hand and arm, which had become progressively worse during the 6 days prior to admission. She denied any trauma to that extremity but had been taking oral contraceptives for 6 years. She had increased her athletic activities 3 weeks earlier, participating in aerobics 3 times a week and volleyball twice a week. Her history was otherwise negative. Family history was negative for any thromboembolic diseases.

On admission to the hospital, her blood pressure was 140/90 mmHg, pulse 88, heart rate and rhythm were regular with no murmurs, and her chest was clear. Her right upper extremity, from the shoulder down was swollen and had purple-bluish discoloration. It measured 2 to 3 cm greater in circumference than the left upper extremity at the hand, forearm, and arm.