Improved ranking for *CMAJ*

A *CMAJ* news item recently reported that the journal's impact factor for 1999 is 2.4, placing *CMAJ* fifth among the world's medical journals.[1] Although the impact factor was correctly cited, the Institute for Scientific Information ranks *CMAJ* 14th among medical journals. The journal in fifth position is in fact the *Annual Review of Medicine*. How did the editors of *CMAJ* determine the new ranking for *CMAJ*?

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References

1. *CMAJ*'s impact factor improves. *CMAJ* 2000;163(9):1182.
2. Institute for Scientific Information. *1999 journal citation reports*. Philadelphia (PA): The Institute; 2000.

[The editor of *CMAJ* responds:]

Ah, impact factors. I think that most journal editors would rather do without them. The Institute for Scientific Information annually ranks about 8000 journals.[1] These are grouped into about 200 categories, such as allergy, emergency medicine and critical care, and developmental biology. This is done in part because citation practices vary across disciplines;[2,3] the categories represent an attempt to partly standardize the results. For example, in the geriatrics and gerontology category the leading journal has an impact factor of 3.4, whereas in the immunology category the leading journal has an impact factor of 47.6.[1] *CMAJ* is in the category of medicine, general and internal. When reviewing information on impact factors, we compare ourselves with similar journals. Thus, in the *CMAJ* article Etminan refers to, we ranked ourselves against other general medical journals.[4] The *Annual Review of Medicine*, which publishes 1 issue per year and contains only review articles, is not a general medical journal.

John Hoey

References

1. Institute for Scientific Information. *1999 journal citation reports*. Philadelphia (PA): The Institute; 2000.
2. Joseph KS, Hoey J. *CMAJ*'s impact factor: room for recalculation. *CMAJ* 1999;161(8):977-8.
3. Garfield E. Journal impact factor: a brief review. *CMAJ* 1999;161(8):979-80.
4. *CMAJ*'s impact factor improves. *CMAJ* 2000; 163(9):1182.

Preventing deaths from long QT syndrome

I write this letter following the tragic death of a 10-year-old child. The child presented with a syncopal episode on a school sports day. The ensuing investigation included a detailed cardiology examination. The child's electrocardiogram (ECG) was normal, but the possibility of an intermittent pattern of long QT syndrome was considered. Holter monitoring was being organized when the child suffered another syncopal episode while swimming and died.

Family members were tested for the markers for long QT syndrome by ECG examination. The ECG of one child, who was a close relative of the index child, showed long QT abnormalities. Thus, not only was the cause of death in the index child identified more definitively but the other child was treated and what could well have been another sudden and unexpected death was prevented.

Long QT syndrome is manifested in some people who are highly vulnerable to ventricular tachycardias and may progress to ventricular fibrillation, with frequently fatal results.[1] The ECGs of most patients with this pattern of polymorphic ventricular tachycardia (also known as torsades de pointes) show a long QT interval, even if the patient is in sinus rhythm at the time of testing.[2]

Some lives might be saved by considering the possibility of long QT syndrome in a young person presenting with syncopal symptoms.[3,4] Regrettably, some deaths will inevitably occur, as this syndrome frequently presents for the first time as a sudden death.

In all situations in which long QT syndrome is diagnosed or under serious consideration, it is important that physicians consider ordering a detailed ECG examination of the patient's family members, because in a small number of cases long QT syndrome has a hereditary component. Testing of asymptomatic family members may identify other children at risk for sudden death and allow preemptive intervention at low cost and with great effectiveness.

Although the death of the index child in this case was probably unavoidable, family testing did identify another child at risk of a preventable death from the same syndrome. We can make a difference if we all think about the possibility of long QT syndrome whenever a child dies suddenly and unexpectedly.

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References

1. Ackerman MJ. The long QT syndrome. *Pediatr Rev* 1998;19(7):232-8.
2. Roden DM. A practical approach to torsade de pointes. *Clin Cardiol* 1997;20(3):285-90.
3. Lewis DA. Syncope in the pediatric patient. The cardiologist's perspective. *Pediatr Clin North Am* 1999;46(2):205-19.
4. Berger S. Sudden cardiac death in infants, children, and adolescents. *Pediatr Clin North Am* 1999;46(2):221-34.

The stethoscope at ease

William Hanley and Anthony Hanley are quite correct to emphasize the importance of time management in their consideration of the traditional (T) versus the cool (C) position for resting stethoscope placement.[1] Before we adopt their recommendations, however, I will offer a word of caution via the following case report.

Forty years ago, I was called to the emergency department to examine an unconscious patient. Rapid assessment