Authorship for Journal articles

I appreciate and agree with the editors' comments regarding the issue of authorship in scientific papers (*Can J Surg* 2002;45[2]:84-5). I would like to raise 2 issues in relation to this topic: intimidation/peer pressure and verification.

Some authors may feel pressured to assign gift authorship to other members of their department. This pressure may originate directly from the recipients of gift authorship or from other authors. A so-called tradition of gift authorship likely exists and is passed on through generations of trainees and subsequent staff surgeons. As a resident, one may not wish to upset the status quo and deny gift authorship for fear of reprisals or penalties in the academic training program. A junior staff surgeon may fear being denied promotion or operating time, for example, if gift authorship is not given. A common platitude is that since the resident or the primary author of the paper is already given credit as first author, why should that author care how many other names appear on the work. However, we should all care, since this attitude perpetuates academic dishonesty.

The suggestion that manuscripts have a footnote explaining each author's specific contribution is a welcome one. I am concerned that editors would not always be able to verify an author's actual contribution. After all, if authors are willing to participate in gift authorship, what prevents them from exaggerating the gift author's contribution? The footnote detailing each author's contribution may be a victim of creative explanations just as much as the phenomenon of gift authorship.

Ultimately, only the authors know the exact contribution that each has made to a particular manuscript. Our scientific journals are based on an honour system. As scientists, our roles are to find and report the truth to the best of our ability. In the end, a battle of conscience is waged, and authors must decide what truths they can live with.

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Nasal tip metastasis from esophageal carcinoma

Cutaneous metastasis from esophageal cancer is relatively infrequent, and metastasis to the nasal tip is rare. We treated a patient who had nasal tip metastasis from squamous cell carcinoma of the esophagus that was found after repeated instrumentation.

A 54-year-old man presented with painless progessive dysphagia and weight loss. He had history of alcoholic liver cirrhosis. On physical examination, a lymph node 2 cm in dimension was palpable over the right supraclavicular fossa, and there was alcoholism-related rosacea. Endoscopy revealed a tumour at the mid-esophagus, and biopsy specimens obtained from the esophageal tumour and lymph node showed squamous cell carcinoma. In view of the distant metastasis and liver cirrhosis, palliative radiotherapy was given. Since the initial diagnosis he had relied on fine-bore nasogastric tube feeding because of persistent dysphagia. He suffered repeated esophageal blockage, for which he underwent multiple sessions of bronchoscopically guided feeding tube insertion.

Metastases in the nasal cavity were found on subsequent endoscopy. Four months after the initial diagnosis, we noticed a rapid increase in the area of the nasal rosacea with marked telangiectasia and central necrosis (Fig. 1). Biopsy confirmed metastatic squamous cell carcinoma.

Cutaneous metastasis of esophageal carcinoma is rare, accounting for only 1% of distant disease.[1] This is probably the first reported case of nasal tip metastasis from esophageal carcinoma. This unusual location of metastasis is probably secondary to tumour seeding of the traumatized nasal mucosa after repeated instrumentation and long-term use of a feeding tube. Another possibility is that the locally advanced tumour with cervical lymphadenopathy blocks the lymphatic drainage of the nose and causes retrograde spread of the disease. Sys-

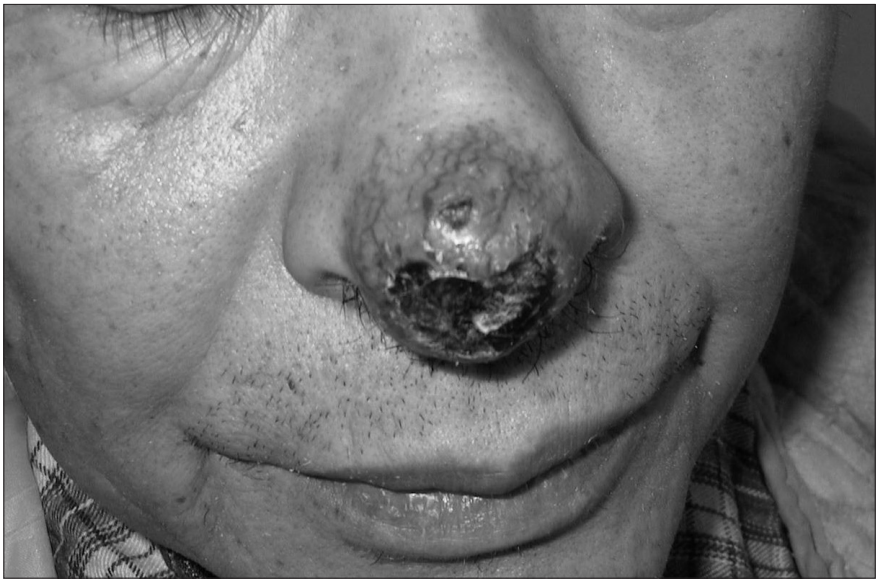

FIG. 1. Nasal tip metastasis from esophageal cancer.

temic spread of the tumour cells to a pre-existing vascular lesion (rosacea) is a remote possibility.

The differential diagnosis of nasal metastasis should include rosacea, rhinophyma, pseudolymphoma and sarcoidosis. In patients with malignant disease, biopsy should be performed for any suspicious skin lesion even if it is in an unusual location.

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Reference

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