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Authors' Names in a Globalized *American Journal of Neuroradiology*

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We at the *American Journal of Neuroradiology* (*AJNR*) have the responsibility of correctly publishing the names of our authors. Apart from being a courtesy to them, adequate and consistent name presentation (particularly from authors who repeatedly contribute) leads to their recognition, easier accessibility to their articles, and increased citations. Lack of uniformity is generally not an issue with English names, but with *AJNR* becoming more and more international, understanding and correctly displaying the names of our authors can be complicated. I urge our authors to follow some simple rules when submitting their articles to *AJNR* to ensure that their names are correctly mentioned. *AJNR* generally publishes only initials for first and middle ("given") names and spells out last ("family") name(s). Ordering of names is generally different from country to country and follows rules that are generally historical and cultural in nature. Let me briefly review the structure of names from the zones of the world where most of our authors originate. To avoid confusion, I will use the terms family name instead of last name or surname and given name instead of first name or middle name.

Anglophone names. These generally comprise 1 or 2 given names (first and middle) followed by the paternal family name (eg, Robert Francis Kennedy). In some cases, the maternal family name may be used as a middle name, but this is mostly a personal preference. On occasion, individuals may have only a first but no middle name (eg, Edward Jenner).

Chinese names. The Chinese use different systems that allow them transliteration of their names to English, such as pinyin and the Wade-Giles system.[1] The first is mostly used in mainland China and the second in Hong Kong. Their family name precedes their given name(s). Family names are generally monosyllabic (eg, Wang) but occasionally contain 2 syllables (ie, Ou-Yang), whereas given names may have 1 syllable (eg, Song) or 2 syllables (eg, Zhi Yong). Given names may be spelled separately or hyphenated. Most Chinese authors submit their names in English format, but when they send it to us in its original order, confusion may arise.

Korean names. In Korea, the family name comes first and is followed by a duosyllabic given name (eg, Kim Daejung).[2] Family names are generally monosyllabic but occasionally they contain 2 syllables. Transliteration to English is generally done by use of the McCune-Resichauer system or the government-created Revised Romanization of Korean system. When most Koreans write their names in English, they follow Western order (this is true in most medical journals).

Japanese and Vietnamese names. In Japan and Vietnam, the family name also comes first and is followed by a given name.[3] Many Japanese family names take root in features of rural landscape and are extremely varied. Middle given names are not used in Japan, but when used, they become one with the first given name because a space is not a permitted character. Middle given names are, however, used in Vietnam. Although given and family names are easily recognizable in Japanese, they may coincide and become indistinguishable when romanized. Most Japanese and Vietnamese academics whose work is published in English journals follow the Western order when listing their names.

Spanish and Portuguese names. These names follow a more complicated structure. Spanish persons may have 1 or 2 given names followed by 2 family names. Family names are organized as follows: paternal first and maternal second. Some of us have "Americanized" our names (I legally changed mine from *Mauricio Castillo Gonzalez* to only *Mauricio Castillo*) to avoid confusion. For Spanish-speaking authors, I have the following suggestion: use only your paternal family name or hyphenate both family names (look at the names of the authors listed below in reference 5).[4,5] If I had retained my original name, it is possible that I would be mentioned as *M.C. Gonzalez* in the literature. A married woman may adopt her husband's paternal family name and drop her maternal family name but retain her paternal one. This is evident to readers because the newly acquired family name will be separated from the previous one by the preposition *de* ("of"), as in *Maria Victoria Mendoza de Perez* (in *AJNR*, her name would be listed as *M.V.M. de Perez*). This tends to create a problem when *de Perez* is dropped, and she becomes, again, *M.V. Mendoza Rivas*. In Portuguese, family names are also compound, but the maternal name comes first. As a tradition, when a woman marries, she drops the maternal name and keeps the paternal one while adding her husband's paternal last name. When Portuguese names are indexed, their last family name is used.

Indian names. As a tradition, Indians did not have the concept of using family names, but during British occupation they integrated them into family life.[6] A traditional Indian name comprises the name of the native (ancestral) village, father's name, given name, and sometimes the caste title (ie, *Rasipuram Krishnaswami Ayyar Narayanan*). Married women may use their husband's name as their family name. This is particularly true in the southern regions of India. For example, *C.V. Raman* is a famous physicist, but *Raman* is his given and not family name. We urge our Indian contributors to list their family name last so it can be correctly quoted. Send us your name exactly as you wish to see it in *AJNR*.

Arabic names. Traditional Arabic names consist of 5 parts (but may have more) as follows: given name (in males it may be preceded by one of the attributes of Allah), honorific name (generally does not appear in print), paternal family name (starting with *bin* or *ibn* meaning "son of" or "daughter of," respectively), a religious or descriptive epithet, a last name that may be a true family name or a short phrase that stands for occupation, geographic location, or tribe.[7] This complex traditional practice is declining, particularly in countries with Western influences such as Lebanon and some African countries. Women do not take their husband's family name when they marry. Christian Arabs may use a combination of names derived from the Bible.

I have not specifically mentioned Western European names because most French, German, Italian, and other names comprise a simple or compound given name and a patronymic family name. English is not the most commonly used language in the world, but it is certainly the de facto language for science. More than 90% of all scientific and med-

ical journals in the world are published completely or partly in English.

We at *AJNR* do our best to publish author's names correctly, but because of an increasing number of articles originating from outside of the United States, we urge authors to take responsibility and to let us know exactly how they want their name to appear. In this editorial, I have attempted to give our readers an idea about the complexity involved.

References

1. Sun XL, Zhou J. **English versions of Chinese author's names in biomedical journals: observations and recommendations.** *Science Editor* 2002;25:3–4
2. Han S. **Formats of Korean author's names.** *Science Editor* 2005;28:189–90
3. **Japanese name.** From Wikipedia, the free encyclopedia. Available at: http://en.wikipedia.org/wiki/Japanese_name. Accessed September 12, 2008.
4. Black B. **Indexing the names of authors from Spanish- and Portuguese-speaking countries.** *Science Editor* 2003;26:118–21
5. Ruiz-Perez R, Delgado Lopez-Cozar E, Jimenez-Contreras E. **Spanish personal name variations in national and international biomedical databases: implications for information retrieval and bibliometric studies.** *J Med Libr Assoc* 2002;90:411–30
6. Kidambi M. **Indian names: a guide for science editors.** *Science Editor* 2208;31:120–21
7. Notzon B, Nesom G. **The Arabic naming system.** *Science Editor* 2005;28:20–21

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EDITORIAL

Closing the Uncertainty Gap in the Diagnosis of Parotid Tumors

In this issue of the *AJNR American Journal of Neuroradiology*, Habermann et al[1] assess the value of diffusion-weighted echo-planar MR imaging in differentiating various types of primary parotid gland tumors in a large group of patients with a lesion of the parotid gland. They claim that, to a certain extent, diffusion-weighted echo-planar MR imaging has the potential for differentiation between various primary tumors of the parotid gland.

Parotid gland tumors are relatively rare and include a large variety of histologic types. Therefore, imaging of those tumors is a major challenge for radiologists.

The management of tumors of the parotid gland requires a detailed understanding of the anatomy and the pathologic processes affecting these glands and surrounding structures. Patients with these diseases are usually referred to a specialist from a head and neck center, where multidisciplinary management is possible. Management by the clinician, usually a surgical specialist for head and neck diseases, is based on history, physical examination, and, always, imaging modalities (most notably, MR imaging) and other investigations if indicated, such as sonography-guided fine-needle aspiration cytology (USgFNAC). In general, FNAC by experienced clinicians or radiologists (under sonography guidance) is able to give certain diagnoses with high, albeit not 100%, accuracy.

The most important division between diagnosis groups lies between benign and malignant (roughly 20%) lesions. Treat-ment is usually by surgical excision, but the extent is dictated by the pathologic process. The preoperative information on whether a parotid gland tumor is benign or malignant may be helpful to prevent treatment delay in the case of a malignant tumor and in patient counseling as to likely treatment and possible sequels. Also, there are well-established indications for performing an elective neck dissection in the case of high-grade malignant tumors.

All aforementioned methods can help to establish a working diagnosis, but ultimately often only histopathologic assessment after removal of the lesion yields a definite diagnosis on which additional management, if indicated, may be based. Also, within the benign category a distinction between the 2 most frequent tumors (ie, pleomorphic adenoma and Warthin tumor) is valuable because a Warthin tumor, especially in elderly patients or those reluctant to submit to surgery, can be observed with repeated clinical or radiologic measurements.

Therefore, every effort to close the uncertainty gap is highly valuable in patient management, though everyday practice often makes extensive work-up impractical and unnecessary. This is because in many patients, removal is indicated or patients elect to have surgery. Also, if waiting lists for surgery do not dictate otherwise, this is often the most practical and rapid solution. On the other hand, if waiting lists are long, less uncertainty about the diagnosis is extremely helpful to expedite surgery in those in whom high suspicion of a malignant tumor is present.

In contrast to FNAC, a noninvasive examination such as MR imaging might not only be helpful in providing a diagnosis but also with regard to staging by providing information on the exact localization and extent of the lesion. Differentiation between benign and malignant disease is often possible on the basis of morphologic appearance alone.[2] However, even the combined accuracy of the modalities USgFNAC and conventional MR imaging may still be imperfect.

New MR imaging modalities such as proton MR spectroscopy,[3] dynamic contrast-enhanced MR imaging,[4] and diffusion-weighted MR imaging[5] have all shown promising results in the differentiation between benign and malignant salivary disease. Regarding diffusion-MR imaging, one should cope with some major challenges. First, diffusion-weighted MR imaging should be, in principle, independent from the MR imaging machine that is used, but it is not entirely certain if this is really true. Hein et al[6] applied some type of standardization of apparent diffusion coefficient (ADC) values by comparing it with ADC values of healthy tissues. This may be difficult to realize in the head and neck region because it may be difficult to find reliable tissue for reference. Second, there is some specificity of ADC values for certain tumor types, but these reports are not unequivocal. Therefore, more studies with large patient groups need to be performed. It is reported that the choice of b-value might be helpful in the differentiation of benign and malignant tumors.[7] The lower the applied b-values, the higher the influence of perfusion, whereas applying only the ADC by high b-values reflects mainly diffusion.

The value of Habermann's study is that it is the first to report on patients with parotid tumors examined with diffusion-weighted MR imaging. The main limitation of this study