that has been in use for several years in our institution for patients with PVT.

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Response:

Anticoagulation in splanchnic vein thrombosis

In response to Spahr et al,[1,2] we would like to point out that the "How I treat" *Blood* articles are meant to feature therapeutic aspects for which evidence from randomized trials is lacking. These articles are based on opinions of experts who have a large clinical experience in the specific fields.[3-5] With this as preamble, we believe that the main disagreement between Spahr et al[1] and us[2] is on whether or not indefinite anticoagulation should be always prescribed to patients with previous splanchnic vein thrombosis (SVT), because there is no disagreement—although data stem from studies with various limits—on the indication for anticoagulants in the acute phase of SVT.[6-8] In the acute phase, anticoagulants are meant to avoid the extension of thrombosis and thereby decrease the risk of portal hypertension and its related complications, mainly gastrointestinal bleeding from ruptured esophagogastric varices.

What about the use of these drugs beyond the acute phase, particularly when portal hypertension has developed despite anticoagulation? In this instance the risk of thrombosis recurrence must be carefully weighted against the risk of bleeding. Thrombosis recurrence, the prevention of which is the true goal of anticoagulation, is not frequent in SVT,[2] being the main reason for our "shyness" to recommend this therapy in these patients at high risk of bleeding. Barring a slightly higher cutoff in platelet count, the difference between our algorithm[2] and that promoted by Spahr et al[1] is that we do envisage the possibility that beta blockers and endoscopic therapies fail to prevent variceal bleeding. Because the latter is life-threatening, we find it important to avoid the additional risk that anticoagulants entail. Thrombocytopenia, so frequent in these patients, is a strong risk factor for bleeding, superimposed on that carried by anticoagulants themselves.

In conclusion, we are reluctant to recommend indefinite anticoagulation in the majority of patients with SVT. But of course, as in all clinical conditions where therapeutic evidence is lacking, each SVT case must be considered in itself, with an accurate balance of the pros for anticoagulation (thrombophilia abnormalities and inflammatory conditions) against the cons (severe thrombocytopenia and large gastroesophageal varices).

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To the editor:

Scientific profiling

We regret to read that the editors at *Blood* would outright reject a review manuscript, regardless of its scientific merit, if someone employed by a pharmaceutical company had any role in the development of that manuscript.[1] This stance implies that all scientists employed by a pharmaceutical company do not have the ability to be unbiased while writing or contributing to a manuscript.

We have extensive experience working closely with many scientists from a variety of pharmaceutical companies (as well as with academic-based authors) in the development of scientific publications. We have found that these scientists are typically highly trained physicians and postdoctoral scientists who have been trained by or worked alongside their academic-based counterparts. They made a life decision to leave academia for any number of reasons—tired of the endless pursuit of grants from an ever-dwindling pool, underwhelmed by the unpredictable and uncertain career path—and now, having left the academic setting, find themselves the object of disparaging accusations.

The expertise of scientists employed by a pharmaceutical company is frequently recognized and called upon by academic physicians. These scientists have focused their careers on drug research and have extensive knowledge of the resulting clinical data as well as the therapeutic area. In addition, it would not be uncommon for an author preparing to write a review article to contact the medical information department of a pharmaceutical company and request relevant data. Either may be the case in the example cited in the "Ghostbusting" editorial, where the clinical investigator was provided several data sources from the pharmaceutical company. Apparently the author considered the data and wrote a manuscript that was deemed after the *Blood* peer review process to be "well-written, informative, and balanced." The fact that the manuscript, which reviewers found to be balanced, was rejected because of acknowledged pharmaceutical company involvement suggests that the editorial review process has fallen to "scientific profiling." Has the editorial review process become prejudiced against scientists from a different form of employment than their own?

In no way do we advocate ghosts of any sort, and by the same token we should recognize that there has been a positive shift during the last 4 to 5 years within the pharmaceutical and biotech environment to improve transparency of roles involved in the preparation of manuscripts. There is now widespread endorsement by these companies of Good Publication Practice (GPP) guidelines[2] and increasing development of rigorous company-specific publication policies that recognize new and evolving regulations and guidance from the government (eg, the Food and Drug Administration Amendments Act of 2007 [FDAAA]) and various professional societies (eg, the International Society for Medical Publication Professionals [ISMPP]).

The peer review process—an assessment of the scientific content by qualified experts—remains the best method to evaluate the scientific merit of a publication; we urge editors of journals such as *Blood* to continue to use this method without profiling. The true measure of progress in medical publishing will be when the finger-pointing stops and we judge a submission based on content, strength of science, and methodology first and foremost, not on an inherent anti-industry bias.

Daniel Donovan, Sue Sutch, Neil Baker, and Jeanette Cook

Conflict-of-interest disclosure: D.D. is the founder of Envision Pharma, a medical publications specialty agency, and is currently a senior vice president at United BioSource Corporation. He also spent over a decade in the pharmaceutical industry. S.S., PharmD, is a senior manager at Envision Pharma. She has worked for 13 years in the medical communications arena, prior to which she was employed in the pharmaceutical industry and in academia as a researcher and teacher. N.B., PhD, MRPharmS, is a senior manager at Envision Pharma. He has worked for 15 years in the medical communications arena, prior to which he was employed in both academia as a researcher and the pharmaceutical industry in research and commercial roles. J.C., PhD, is a senior manager at Envision Pharma. She has worked for 12 years in the medical communications arena, prior to which she was an academic researcher in both the United Kingdom and United States.

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Response

More on ghostbusting

We appreciate the comments made by Dr Donovan and colleagues[1] at Envision Pharma (a medical communications company) responding to our recent editorial entitled, "Ghostbusting at *Blood*." We want to clarify several points in response. First, we did not suggest that a review article (or any other manuscript) would be summarily rejected because of any involvement by an employee of a pharmaceutical company, but rather that a manuscript should be rejected because of undisclosed involvement. This is particularly pertinent if a drug discussed in the manuscript is a product associated with the company paying for the editorial, writing, or research assistance, because of real or perceived conflict of interest. *Blood* editors have a responsibility as part of the review process to identify these conflicts so that the readers can evaluate the merits of the scientific contribution without such confounding undisclosed factors. Transparency should be in place whether an author is from industry or academia. Second, no one disputes the important contributions made by talented scientists in industry. Indeed, we emphasized this point in our editorial. Productive collaborations between the two will only become more important in the future as the elucidation of the mechanism(s) of action and determination of clinical efficacy of new therapeutic agents are jointly studied. In our editorial, we distinguished between primary research articles carried out collaboratively between academia and industry, or by industry scientists, which are treated no differently from those without industry involvement, versus Review Articles or How I Treat pieces, which are designed to give readers broad and hopefully unbiased summaries and interpretations of the state of our understanding of a particular disease or therapeutic approach. Avoiding real or perceived bias in these articles is particularly important because they involve more subjective choices regarding which primary sources to discuss and synthesize. It is possible that a pharmaceutical company author would be appropriate for such an article based on his or her general experience, but it is unlikely that *Blood* would solicit or publish a review article from such an author or allow involvement of a company-sponsored medical communciations company on a topic that encompasses the use of a product marketed by that company. Third, we believe that requesting new data from industry or a university or any other source for an author to incorporate and interpret in a review article is one thing, but the provision of complete tables of complied data is another. *Blood*