LETTERS TO THE EDITOR

Residents with military obligation face discrimination

This is the time of year when surgical residents interested in a career in vascular surgery interview for fellowship positions, and vascular fellows about to finish their training, interview for practice opportunities. Naturally, the interviewing program directors and the department chairmen try to get the best residents or fellows.

Unfortunately, in this process, I have noticed that a subtle bias has developed in some programs against candidates who have a future military obligation. These candidates are recipients of military stipends and are required to serve in the reserves after completing their training. It is very rare that they are called to serve a tour of duty while they are in training. Should they be called, albeit rarely, it can cause an inconvenience to the program. The inconvenience and stress caused to the individual and his family is manifold. I speak from personal experience, having served in Kosovo, Afghanistan, and Iraq in the last 4 years while working as a vascular surgeon in a civilian group practice.

Every program is aware that it cannot discriminate on the basis of age and ethnicity and therefore asking about these is inappropriate and illegal. I would like to remind all the program directors and department chairmen that discriminating on the basis of military service or obligation is also illegal. In my opinion, it is also unethical and unpatriotic. I hope that after reading this letter, candidates will not be asked about their military affiliation, so that there is not even an appearance of bias. I am sure that the community of vascular surgeons, many of whom are veterans themselves, want the best care for our injured men and women in the battlefield.

Narayan Deshmukh, MD

Colonel (retired), US Army Reserve
Sayre, Penn

doi:10.1016/j.jvs.2005.04.002

Regarding "Compelling nature of arterial manifestations in Behçet disease"

I read with great interest the report from Iscan et al.[1] My experience supports the authors' conclusions concerning arterial complications of Behçet disease. I would like to point out, however, that this disease should be reported as Adamantiades-Behçet disease. This is because it was the Greek ophthalmologist Benedict Adamantiades (1875-1962) who in contemporary times first orally presented this disease at the Medical Society of Athens in 1930, and a year later he published it. [2] Six years later, the Turkish dermatologist Hulusi Behçet (1889-1948), independently from Adamantiades, described the disease for the second time. [3]

I have three questions for the authors. First, I have found it difficult to delineate normal from diseased artery segments when selecting a site for anastomosis in these patients, and I wonder how the authors advise doing this. Second, because pseudoaneurysms occur at the anastomoses of both prosthetic and vein grafts in these patients, I believe that endovascular reconstruction may be safer, as has been described by others.[4-6] Would the authors comment on the role of endovascular grafts in patients with Adamantiades-Behçet disease? Third, when a bypass is needed for limb salvage after arterial thrombosis, reinforcement of the anastomosis by wrapping it with a synthetic (Dacron [DuPont, Wilmington, Del] or polytetrafluoroethylene) band would offer a theoretical support against the development of pseudoaneurysms. Would the authors comment on this?

Athanasios D. Giannoukas, MSc, MD, PhD, EBSQ$_{VASC}$

Division of Vascular Surgery
University Hospital of Larissa
University of Thessaly Medical School
Larissa, Greece

REFERENCES

1. Iscan ZH, Vural KM, Bayazit M. Compelling nature of arterial manifestations in Behçet disease. J Vasc Surg 2005;41:53-8.
2. Adamantiades B. Sur un cas d'iritis a' hypopion re'cidivant. An Ocul (Paris) 1931;164:271-8.
3. Behçet H. Uber rezidivierende, aphthose, durch ein Virus verursachte Geschwure am Mund, am Auge und an den Genitalien. Dermat Wochenschr 1937;105:1152-7.
4. Vasseur M-A, Haulon S, Beregi JP, Le Tourneau T, Prat A, Warembourgh H. Endovascular treatment of abdominal aneurysmal aortitis in Behçet's disease. J Vasc Surg 1998;27:974-6.
5. Koo BK, Shim W-H, Yoon Y-S, Kwon YS, Kwon Lee B, Choi D, et al. Endovascular therapy combined with immunosuppressive treatment for pseudoaneurysms in patients with Behçet's disease. J Endovasc Ther 2003;10:75-80.
6. Silistreli E, Karabay O, Erdal C, Serbest O, Guzeloglu M, Catalyurek H, et al. Behçet's disease: treatment of popliteal pseudoaneurysm by an endovascular stent graft implantation. Ann Vasc Surg 2004;18:118-20.

doi:10.1016/j.jvs.2005.02.049

Reply

Despite such letters to the editor that typically appear after any scientific article on Behçet's disease, the medical literature widely recognizes the appropriateness of eponym "Behçet." A simple search in Medline retrieves more than 5,000 references for Behçet or Behçet's disease, compared with only about 70 for Adamantiades-Behçet disease. Many of the latter are letters written in a quite similar manner and concerned mainly with the eponym "Behçet" rather than scientific contribution.

The fact is, it was Dr Hulusi Behçet who first recognized the syndrome, correctly defined its characteristics, and described the classic triad that is still a worldwide guide in today's modern medicine.[1] He put special emphasis on the recurrent aphthous stomatitis (ie, oral ulcerations) that is considered the universal hallmark of the disease and a key to diagnosis. The International Society for Behçet's Disease acknowledges his contribution in the official web site as follows:

Origins of the disease:

A Greek physician called Hippocrates, writing in 500 BC, described a cluster of symptoms that seems to be that of Behçet's disease. However, although various researchers wrote about this disorder after that time, it wasn't until 1937 that it got its name. A Turkish dermatologist called Hulusi Behçet published an article in a German medical journal in which he said he had noticed a characteristic set of symptoms in some of his patients which he thought all belonged to a specific disorder. He listed the 'classical' set of symptoms of mouth and genital ulcers with eye inflammation that identified it. Since then, other symptoms have been added to the original list, but the name of Behçet has remained.[2]

After Hippocrates' descriptions as an endemic disease in the Middle East, very few observations of the unique symptoms appeared in the medical literature until the early 1900s. In the beginning, this complex was considered to be a manifestation of syphilis, but in 1937, Behçet proposed a separate disease entity that