

The abbreviated life of acronyms

Patricia A. French, BS, and E. Magnus Ohman, MD *Durham, NC*

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Man is the animal that abbreviates. Whether this reflects our belief that time is precious and would be better spent on more important matters is unclear. It began in the 15th century, when perhaps some poor scribe became tired of writing lengthy words over and over. He made a decision to write not the entire word, but only a portion of it, and thus gave birth to the abbreviation. This most common form of shorthand flourishes to this day, living on in such terms as fridge for refrigerator, telly for television, and bra for brassiere.

The mid-19th century saw the birth of initialism. Perhaps the Industrial Revolution spurred it on; we were far too busy to spend time pronouncing General Electric, British Petroleum, and Johnson & Johnson. Instead we began to use GE, BP, and J&J. Countless others have emerged since then, among them IBM (International Business Machines), the IRS (Internal Revenue Service), and the WWW (World Wide Web).

Medicine was quick to jump on this bandwagon, with such terms as SOB (that's "short of breath"), MVP (mitral valve prolapse), and URI (upper respiratory infection). Now medical records often contain text such as: "A 49-YO WF was admitted with CP and SOB. She was known to have MS and MI and had an MVR 2 years ago." The first question that arises is whether she is having chest pain or chest pressure. The poor woman also may have multiple sclerosis, but what if she has mitral stenosis? She could have a history of mitral stenosis and mitral incompetence, but maybe she has had a myocardial infarction. One hopes that the physician remembers that she had a mitral valve repair rather than a mitral valve replacement 2 years ago, so she doesn't receive anticoagulants unnecessarily, and so on. Like a physician's handwriting, the interpretation of medical abbreviations often is in the eye of the beholder.

Condensed communications have become even more sophisticated with the formation of one pronounceable "word" from the first letter (or first two letters) of successive words in a phrase. This practice, although it began in the early 20th century, had no name until 1943: the acronym.¹ These terms are now

Table I. Acronyms used in at least 4 different trials

ACT	EPIC	LIMIT	PACT	START(S)
BEST	ESPRIT	MAST	PART	STAR(S)
CARE	GUSTO	MUSIC	PASS	STOP(P)
CHS	HIS	MUST	PRIME	STEP(S)
DIAMOND	IMPACT	NHLBI-xx	SMART(T)	TOP(S)

ubiquitous in this era of instant communications; a recent search of the WWW for "acronym + dictionary" yielded more than 2000 "hits." As the article by Cheng² in this issue shows (see page 726), clinical trials of cardiology have contributed to this phenomenon.

As noted in the article, the list of these terms has grown 900% in the past 6 years. However, as the article also states, a large proportion of these terms are not true acronyms; of the more than 2000 terms that are spelled out, only 28% are words formed from the first (or first two) letters of every word in the phrase. At present, we have no name for the use of other letters of words (or the random skipping of major words) in the compression of a phrase or for the product of this process, but this and other types of constructions account for almost 60% of the "acronyms" listed (another 13% are initialisms). Perhaps "abstraction" could be used to describe this process, but we, like Cheng, believe that this counterintuitive method should not be encouraged.

Dr Cheng points out several of the drawbacks associated with these terms, whatever their true names. We would like to highlight another danger in the use of the same acronym for multiple trials, which occurs frequently (Table I). If a cardiologist hears that the BEST trial (as an example) is "positive," does this result in the prescription of bucindolol for patients with heart failure, or in the use of single-bolus duteplase in patients with myocardial infarction? In this case, both of these BEST trials (there also were two others) were "positive," but what if only 1 of them had been? Of course it is unlikely that the results of 2 trials with the same "acronym" would be released simultaneously, but even a small possibility would pose a danger to patients. Thus as stated in the article, existing acronyms should be an exception to the "reduce, reuse, recycle" philosophy.

We agree with Cheng that acronyms are here to stay, given their obvious advantages. We also hope that the drawbacks to their use can be reduced or eliminated. To aid in this effort, we show guidelines for the development and use of trial acronyms (Table II).

From the Duke Clinical Research Institute.

Reprint requests: Patricia A. French, Duke Clinical Research Institute, 2024 W Main St, Bay A-2, Durham, NC 27705.

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Table II. Guidelines for development and use of trial acronyms

1. Create a new, unique acronym for each trial if the trial requires one. Exception: using the same acronym for a series of trials (TAMI-1, TAMI-2, etc). In this case, the words making up the acronym should remain the same.
2. The new acronym should: Be as short as possible, reflect the goal of the trial (if possible), include only generic drug names, not include common MEDLINE search terms, not be offensive in other languages if possible, be derived from the first (or first 2) letters of each word in the phrase being condensed.
3. When using the acronym in a document, spell it out at first mention, in its native language, and capitalize it consistently.
4. Use the acronym in every publication resulting from the trial for more complete information retrieval.

Perhaps the ultimate test of an acronym's success is whether it passes into standard usage as a word itself. Such has happened with the former English acronyms scuba (Self-Contained Underwater Breathing Apparatus, 1952) and radar (Radio Detection and Ranging, 1941). These terms, dubbed anacronyms,³ have themselves become incorporated into new acronyms (NEXRAD, NEXt-generation weather RADar).⁴ If this process continues, we may abbreviate ourselves right out of a language.

References

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