Plagiarism and duplication / Two situations, which are difficult to differentiate from each other: plagiarism and duplication

Aşırma ve duplikasyon / Birbirinden ayrılaması zor iki durum: Aşırma ve Duplikasyon

Dear Editors,

The recent publication on plagiarism and duplication is really useful and interesting. Kıraç described for the difficulty in differentiation between the two scenarios (1). Indeed, any of the two scenarios are not acceptable in scientific publication. However, the important concept in judging of these problems should be based on the intention of the accused plagiarist. Sometimes, the problems might be due to some acceptable causes such as the accidental errors by the publisher. Not only the journal but also the reader can help identify and control of present widespread of plagiarism and duplication.

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References

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Maternal cardiovascular hemodynamics in a patient with mitral prosthetic heart valve evaluated with impedance cardiology and echocardiography

Mitra protez kalp kapağı olan bir hastada maternal kardiyovasküler hemodinaminin impedans kardiyografisi ve eokardiyografi ile değerlendirilmesi

Many prosthetic valves are yearly implanted in young women with rheumatic or congenital heart disease. Increased hemodynamic burden due to physiological circulatory changes, increased incidence of thromboembolic events, untoward effects caused by cardiovascular drugs and anticoagulation are major risks associated with pregnancy in a woman with mechanical prosthetic valve (1). Although hemodynamic changes during pregnancy are studied in detail (2), we do not know the hemodynamic changes in pregnancy complicated with prosthetic heart valve. Therefore, we investigated a 31-years-old woman with mitral mechanical valve prosthesis who demanded to get pregnant. The echocardiogram performed at hospital admission revealed functional prosthetic mechanical valve at mitral position with a diastolic gradient of 9/6 mmHg. We discussed the anti-coagulation regimen with the patient and started enoxaparin sodium as soon as pregnancy was achieved. Echocardiography and impedance cardiology were performed during the first, second and third trimester. Stroke volume (SV), stroke index (SI), cardiac index (CI), cardiac output (CO), index of contractility (IC) and total peripheral resistance (TPR) were measured by impedance cardiology (3). While heart rate and TPR were increased in 2nd and 3rd trimester, there was a decrease in SV, SI, CO, CI and IC (Table 1). With echocardiographic evaluation, we observed a slight increase in mitral diastolic gradients, peak systolic pulmonary arterial pressure and left atrial diameter (Table 1). While NYHA class of patient was I in the first trimester, functional class had continued to worsen until the 3rd trimester (class II-III) and low dose diuretic therapy was added to medical therapy. Possibility of thrombotic

<table>
<thead>
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<th>Variables</th>
<th>1st trimester</th>
<th>2nd trimester</th>
<th>3rd trimester</th>
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<tbody>
<tr>
<td>Peak mitral gradient, mmHg</td>
<td>10</td>
<td>16</td>
<td>16</td>
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<tr>
<td>Peak systolic PAP, mmHg</td>
<td>25</td>
<td>30</td>
<td>33</td>
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<td>Left atrium, cm</td>
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<td>4.6</td>
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<td>EF, %</td>
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<td>70</td>
<td>68</td>
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<tr>
<td>HR, beats/min</td>
<td>62</td>
<td>73</td>
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<td>CI, L/min/m²</td>
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<td>41.07</td>
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<td>1305.90</td>
<td>1538.09</td>
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<tr>
<td>IC</td>
<td>0.072</td>
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<td>0.058</td>
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CI - cardiac index, CO - cardiac output, EF - ejection fraction, HR - heart rate, IC - an index of myocardial contractility, MAP - mean arterial pressure, PAP - pulmonary arterial pressure, SI - stroke index, SV - stroke volume, TPR - total peripheral resistance

Table 1. Echocardiographic parameters and hemodynamic parameters by impedance cardiology

Author’s Reply

Dear Editor,

I would like to thank authors of the letter for their suggestions on my short review about plagiarism and duplication. We generally prefer to present our ethic cases and try to give short information and accepted ethic rules related with these cases. We are really glad to hear that Publication Ethics corner of the Anatolian Journal Cardiology is useful.

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Two-year results of primary coronary intervention performed in a medium-scale primary percutaneous coronary intervention center by two cardiologists who are not formally trained in interventional cardiology

Orta öçkeli bir primer perkütan girişim merkezinde resmi bir primer kardiyoloji eğitimi almamış iki kardiyolog tarafından yapılan primer PKG’lerin iki yıllık sonuçları

Primary percutaneous coronary intervention (PCI) is the preferred option when it can be performed in less than 90 min after the first medical contact, especially in patients with high-risk features such as cardio-genic shock or hemodynamically significant fatal ventricular arrhythmia in AMI (1). Current recommendations indicate that elective percutaneous transluminal coronary angioplasty (PTCA) be performed by operators with an annual volume of at least 75 procedures in institutions with annual volumes over 400. Furthermore, primary PTCA for AMI should be performed by operators who perform more than 75 elective PTCA procedures per year and at least 11 PTCA procedures for AMI in a year.

The purpose of the present study was to compare angiographic results and in-hospital outcomes in AMI patients undergoing primary PCI at moderate volume hospital by 2 operators without formal interventional cardiology training. From January 2007 to December 2008, 140 consecutive patients (110 male and 30 female) with a diagnosis of AMI, who were admitted to TDV 29 Mayıs İstanbul Hospital for primary PCI within 12 hours of chest pain were enrolled in the present study. We retrospectively analyzed clinical background, coronary risk factors, angiographic findings, acute results of primary PCI, and in-hospital prognosis in patients treated at our hospital. Primary PCI’s were performed by two operators without formal interventional cardiology training but with minimum experience suggested in guidelines. Both cardiologists received 5 years of basic cardiology training and acquired angioplasty skills through “on-the-job” experience under experienced supervisors. As of 2011, there is still no formal interventional cardiology training in our country and many physicians are trained through “on-the-job” experience. Data were analyzed using SPSS for Windows release 10 software (Chicago, Il, USA).

The study population consisted of 110 male and 30 female patients with a diagnosis of AMI. Average follow-up was 12.86 +/- 6.43 months. In-hospital mortality was 4.3% and 1-year mortality was 7.1%. Other clinical parameters and angiographic results are given in Table 1.

In some parts of the world, there is still no formal interventional cardiology training programs and coronary angioplasty technique is disseminated informally among physicians who are highly experienced at diagnostic cardiac catheterization. During this period, physicians acquire angioplasty skills through “on-the-job” experience, and no official standards exist for either training requirements or for demonstration of competence. Whether low volume hospitals/operators or operators without formal interventional cardiology training and certification should continue to perform primary PCI or patients receive early thrombolytic therapy is an important issue (2-4). In our small study group average hospital stay (4.14+2.62 days), in-hospital mortality (4.3%), 1 year mortality (7.1%), rate of in-hospital reinfarction (2.9%) and in-hospital cerebrovascular accident (0.7%) were all within acceptable limits. We ascribe these results to obsessive attention of inexperienced operators to optimal anticoagulant, antiaggregant use, detailed no-reflow treatment plan, high quality stent/ballon use, good cooperation with angiography and coronary care personnel. Regular meeting among two cardiologists and cardiovascular surgeons provided a quality check and stimulus for improving practice.

Our data showing low mortality, complication and hospital stay supports that there is not a significant relationship between operator volume over the threshold indicated by the guidelines and primary PCI early outcomes and complications. A minimum of 75 coronary interventions per operator per year may be enough in the future to obtain formal certification where there is no formal interventional cardiology training programs and larger studies are needed.

References


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