fetal hypoxia and bradycardia during CPB. Thus, as remarked by Mr. Jahangiri, full maternal and fetal monitoring is critical for improving outcomes [3].

In our study, a 33-year-old pregnant woman with Marfan syndrome and her fetus (26 weeks of gestation) died after surgical treatment of acute type A aortic dissection. At the time of the patient’s presentation, we counseled the patient regarding the high risk of fetal loss if the procedure was performed with the fetus remaining in situ with deep hypothermia and circulatory arrest. However, in the year 1997, when this case was performed, there were no other alternative surgical techniques available to treat this condition. Thus, we recommended operative aortic repair following cesarean section of this immature fetus, but the patient and her family declined this treatment course.

Regardless, this case illustrated that minimization of deep hypothermic circulatory arrest was critical when performing this operation with the fetus remaining in situ, as was referred to by Mr. Jean Bachet in Appendix A. Editorial comment [4]. Mr. Bachet advised us that, in this situation, the aortic root and ascending aorta had to be replaced under full flow CPB with moderate hypothermia, even though the dissection involved the ascending aorta and the intimal tear was located in the ascending aorta. Further, careful attention must be made in regard to intraoperative malperfusion during CPB to maintain blood flow to both the mother and her fetus. These issues illustrate that surgery for acute aortic dissection in pregnant patients with Marfan syndrome poses many challenges, and the full availability of various surgical techniques are required to assure favorable outcomes for the mother and her fetus.

References


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doi:10.1016/j.ejcts.2005.11.009

Letter to the Editor

Preoperative statin use and in-hospital outcomes following heart surgery in patients with unstable angina

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Received 23 October 2005; accepted 3 November 2005

Keywords: Statins; Heart surgery; Statins and perioperative morbidity; Statins and perioperative mortality

While gathering data for a review article on the role of statins in reducing perioperative morbidity and mortality in patients undergoing vascular surgery operations, I read with interest the two articles by Ali and Buth [1,2] and found that the two manuscripts are almost identical. More precisely:

1. In the Introduction section, the whole first paragraph (The class of drugs ... preceding percutaneous interventions), a total of 23 lines, is identical in the two manuscripts.
2. The whole Materials and Methods (2.1. Patient selection – 38 lines), the whole Data Analysis and Statistics (25 lines), and most of the Results (40 lines) sections are identical; most parts are copied word by word in the two manuscripts.
3. In the Discussion section, there are also large parts which are identical in the two manuscripts, namely the parts: (a) “In a laboratory study, Lazar et al. ... and growth factor-mediated prosurvival signaling pathways” (20 lines), (b) “Based upon such theoretical concerns ... myocardial ischemia-reperfusion injury” (11 lines), (c) “Our results contradict those of a recent small observational study ... resulted in relevant biases in the previous study” (21 lines), and (d) “Another explanation of our results ... may not be ameliorated by pretreatment with statins” (15 lines).
4. In addition, most of the Limitations section is copied word by word, namely the parts: “Several limitations are apparent ... and be dose specific” (6 lines), and “Our study is a retrospective analysis ... following cardiac surgery” (8 lines).
5. Finally, the title (as well as the references) is almost identical (as expected).

I believe that such an action is unacceptable. It should be condemned and fiercely criticized. It insults not only the journal’s reputation, but also the intelligence of the journal’s readers.

References


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doi:10.1016/j.ejcts.2005.11.003

Reply to the Letter to the Editor

Reply to Paraskevas

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Received 2 November 2005; accepted 3 November 2005

Keywords: Statins; Outcomes; Pleitropic effects; Unstable angina