Correspondence

Editor's note:

The correspondence below addresses a serious issue concerning the publication of two very similar articles from the same group of investigators, one appearing first in the *Canadian Journal of Anesthesia* in October 2004, and subsequently in January 2005, in *Anesthesiology*. By mutual agreement of the Editors, these letters are published simultaneously in both journals.

Donald R. Miller MD, Editor-in-Chief

A lesson learned

(RE: Nielsen KC, Guller U, Steele SM, Klein SM, Greengrass RA, Pietrobon R. Influence of obesity on surgical regional anesthesia in the ambulatory setting: an analysis of 9,038 blocks. *Anesthesiology* 2005; 102: 181–7).

It was called to my attention by a reader that the article by Nielsen *et al.* published in the January 2005 issue of *Anesthesiology*,¹ was very similar in design and conclusions from another article published by the same authors in the October 2004 issue of the *Canadian Journal of Anesthesia*.² The authors' comments follow:

Reply to MS #200503055

Thank you for giving us this opportunity to respond. We wish to apologize to the editorial staff and readership of *Anesthesiology*¹ and the *Canadian Journal of Anesthesia*.²

In October 2004 we published a study in the *Canadian Journal of Anesthesia* and in January 2005 we published another article in *Anesthesiology*. At the time of the *Anesthesiology* submission we failed to notify the journal of the existence of the prior paper which utilized the same dataset and had similar methodology. Although the paper in *Anesthesiology* expanded upon the findings reported in the *Canadian Journal of Anesthesia*, this is inconsistent with our acknowledgement of the Instructions for Authors which states "Submitted manuscripts must not have been published elsewhere, in whole or in part...". We realize that journals must take this issue seriously. It is necessary to maintain integrity and provide the peer review process the complete information to

thoroughly evaluate a manuscript and arrive at the optimal decision. While not intended to hide the existence of another manuscript our actions did not allow this process to occur. We take the issue of academic integrity seriously. We are sincerely sorry for causing this situation.

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References

- 1 Nielsen KC, Guller U, Steele SM, Klein SM, Greengrass RA, Pietrobon R. Influence of obesity on surgical regional anesthesia in the ambulatory setting: an analysis of 9,038 blocks. *Anesthesiology* 2005; 102: 181–7.
- 2 Cotter JT, Nielsen KC, Guller U, Steele SM, Klein SM, Greengrass RA, Pietrobon R. Increased body mass index and ASA physical status IV are risk factors for block failure in ambulatory surgery - an analysis of 9,342 blocks. *Can J Anesth* 2004; 51: 810–6.

The first paragraph of the cover letter signed by authors submitting their work to *Anesthesiology* states that: "On behalf of my co-authors, I am submitting the enclosed material for possible publication in *Anesthesiology*. It has not been submitted for publica-

tion nor has it been published in whole or in part elsewhere. I acknowledge that both I and the other authors have read the Instructions for Authors and agree with its contents." Those Instructions, in turn, state that "Submitted manuscripts must not have been published elsewhere, in whole or in part, on paper or electronically. The Editor-in-Chief must be notified if another manuscript derived from the same experiment has been published previously, or has been submitted to another journal." Nearly identical statements and requirements can be found in the author instructions of most journals - including the Canadian Journal of Anesthesia.

While the authors signed cover letters, first to the Canadian Journal of Anesthesia and then to Anesthesiology, attesting to their compliance with the these conditions, they did not, in fact, comply - which resulted in the publication of two very similar articles. This has now resulted in embarrassment to both Journals and to the authors. While the articles are not identical, the overlap is substantial, and if either Dr. Miller or I had been aware of the other submission, the editorial and review process would have been entirely different.

This is unfortunate and unnecessary. Editors are fully aware that it is often impossible to summarize the results of large complex studies in a single manuscript. If I had been aware of the overlap, the authors would have been given the opportunity to explain the differences in the two papers - and by working with the editorial offices, they could easily have produced a second paper addressing a distinctly different (or complementary) aspect of their study. This is something that we do on a regular basis - all it requires is that the authors be forthcoming about their other work. The result would have benefited the authors, the Journal - and our readers.

This situation should serve as a lesson to all authors. Editors take their Instructions to Authors very seriously - and so should authors. Editors are also more flexible than some might believe. There is no reason to conceal other manuscripts from us. Like authors, we want to publish the results of high-quality science (and the quality of the work being done by Nielsen, *et al.* is not in question). In most cases, we are happy to work with authors toward achieving a mutually beneficial result. We simply ask that authors honor their signed statements and comply fully with the well accepted "rules" established by all journals.

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Subtle desaturation and perioperative methemoglobinemia. The need for continued vigilance

To the Editor:

A 32-yr old 60 kg diabetic patient presented for exploratory laparotomy. Her past medical history included renal and pancreatic transplantation, gastroparesis, peripheral neuropathy, retinopathy, necrobiosis diabetorum, and hypertension. She was receiving cyclosporine, prednisone, aspirin, ondansetron, dapsone, paroxetine, amitriptyline, nortriptyline, gabapentin, sirolimus, clotrimazole, metoclopramide, lansoprazole, and alendronate. Preoperative SpO₂ was 92 to 96% on air. Following *iv* clindamycin 600 mg and midazolam 2 mg, anesthesia was induced with fentanyl 150 µg, lidocaine 100 mg, propofol 100 mg and cisatracurium 10 mg *iv*. Her SpO₂ dropped to 84–88% despite effective hand ventilation on 100% oxygen. An endotracheal tube was placed and secured at 20 cm to the lips. There was minimal improvement in SpO₂ to 89%. The oximeter probe was checked for proper placement. Breath sounds were equal with no tracheal secretions on suctioning. Fiberoptic bronchoscopy revealed no obvious obstruction. The patient's oral mucosa appeared cyanotic. Arterial blood gas sample revealed pH 7.42, PaCO₂ 29 mmHg, PaO₂ 466 mmHg (FiO₂ 100%), BE -5, and SaO₂ 91% (pulse oximeter reading 85%). Methemoglobin (MHb) was measured using a multi-wavelength spectrometer (co-oximeter), was 6.5% (normal 0.4–1.5%). With hemodynamic stability, and improved SpO₂ towards the end of surgery, methylene blue treatment was withheld. The SpO₂ continued to improve in the recovery room (91–98% on 10 L·min⁻¹ O₂). Twelve hours after surgery, MHb level was 3.4%. The medical records revealed a two-year treatment on dapsone for pneumocystis carinii prophylaxis, and mildly elevated MHb (1.9%) during a previous anesthetic involving 60 mg lidocaine.

This case highlights the subtle presentation of methemoglobinemia as a cause of low SpO₂. Its diagnosis was established by the presence of three oxidizing

TABLE Common agents that may produce methemoglobinemia²

Aniline (dyes, inks)	Metoclopramide	Nitroprusside
Benzene derivatives	Methylene Blue	Phenacetin
Benzocaine	Nitrates	Phenol
Chlorates	Nitric oxide	Phenytoin
Chloroquine	Nitrites	Prilocaine
Dapsone	Nitrofurantoin	Phenytoin
Lidocaine	Nitroglycerin	Sulphonamides