of department for a positive reference. A "breach of appropriate authorship," which is an understatement, can be expected.

Possible signs for this breach could be as follows:

- More than 4 or 5 authors (if it is not a multicenter study)
- Authors whose names appear annually in more than 4 full articles

These signs, however, can depend on the type of research and local organization of the research group.

If these signs become apparent, a deep inquiry by the editor might be warranted. An alternative is to limit the number of authors. If acknowledgements are more detailed and, what is most important, valued by the supporting universities, the incentive for a breach of appropriate authorship might disappear or at least diminish.

Wilhelm P. Mistiaen, MSc, MD, PhD
The University College of Antwerp
Dept of Healthcare Sciences
Antwerp, Belgium

Reference

1. Consensus statement on surgery journal authorship—2006. *J Thorac Cardiovasc Surg.* 2006;131:1221-2.
doi:10.1016/j.jtcvs.2006.10.033

Reply to the Editor:

Thanks to Dr Mistiaen for well-focused questions and comments. They will help move the guidelines in the consensus statement closer to implementation in practice. I will try to answer them in practical terms.

1. *How will the statement be implemented?* By absorption into customary best practice, like the general compliance with our other Instructions to Authors about manuscript preparation, graphics, and references. Despite variations, compliance will steadily and iteratively improve.
2. *Can one rely on honesty of the co-authors?* Generally, yes. Honesty is a dominant value, and trust is the basis for most discourse in society and in science. Untrustworthy behavior is eventually exposed by peers, damaging reputations and reducing the level of respect in the community of scientists and surgeons.

3. *Is a simple statement of the authors' contributions to the paper sufficient?* Yes; explanations can be simple and clear, that is, as described in a recent editorial: "[Dr Author] was the primary author and was responsible for the design of the study and the analysis and interpretation of the data. [Dr Data] supervised the development of the database, provided input on the study design, and reviewed and approved the final manuscript. [Dr Investigator] was the principal investigator of the study, supervised the acquisition and interpretation of the data, and provided critical input to the manuscript."¹

4. *Isn't the grim reality that many universities require us to "publish or perish" an obstacle to honesty?* Promotion policies based on publication quantity have resulted in dilute resumes and an unsustainable multiplication of specialized journals.² Best practices for assessing scholarship are emerging and displacing unreflective quantitative measurement of published work, though progress is slow. In a recent issue of *Nature Medicine* largely devoted to exposition and extension of her seminal work, Karen Ashe,³ a world leader in Alzheimer research, recounts how she was promoted and supported by the University of Minnesota through three unpublished years as she developed her transgenic mouse model of the disease. The promotions committee of the University of Toronto Department of Surgery assigns little weight to publications that reflect ancillary authorship. Careers in departments that rely on publication volume alone for promotion are impoverished academic opportunities. The chair who insists on authorship in exchange for resources, support, or letters of reference will become an anachronism if accurate description of the role of authors becomes part of the culture of surgical publication.

The ethics of authorship¹ is a guide to what we should do on the basis of principles and values. *Journal* policy is a statement of what a reasonable group of representatives of the Association decide to adopt as standard practice for the organiza-

tion's publications. Such decisions should be made with criteria of reasonableness, transparency, appealability, and enforceability.⁴ I think the *Journal's* decision to adopt the consensus statement meets this standard, but the last criterion is where Dr Mistiaen's challenge finds the weakest point in the consensus statement as policy. The *Journal* can only encourage, and reinforce by occasional challenges or commentary, an authorship policy that depends primarily on the authors for implementation.

Dr Mistiaen, I am in favor of adopting the consensus statement as policy because it helps strengthen the authenticity and integrity of medical publication. Rather than an absolute limit on the number of authors, I favor your suggestion of deep and thoughtful inquiry by the editor to clarify or justify the number of authors. Inquiries from respected colleagues in our specialty have a salutary effect on practice and behavior. To implement your suggestion, I will enjoy passing this responsibility along to Editor Wechsler in his leadership role on the *Journal*.

Thank you for your insights and thoughtful suggestions.

Martin McKneally, MD
Department of Surgery
University of Toronto
Toronto, Ontario, Canada

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Extracorporeal life support: An effective and noninvasive way to treat acute necrotizing eosinophilic myocarditis

To the Editor:

We read with great interest the case report of Kohout and colleagues¹ describing the

Figure 1. Chest x-ray film before ECLS (*left*). It was done on the admission of the patient and shows bilateral pulmonary edema and heart enlargement, with a cardiothoracic index of 0.60. Chest x-ray film 1 day after ECLS institution (*right*). Pulmonary edema is already greatly reduced, and cardiothoracic index decreased to 0.45.

successful management of acute necrotizing eosinophilic myocarditis (ANEM) with a biventricular assist device (BIVAD) and steroids.

ANEM is indeed a dramatic condition often leading to a fatal issue unless promptly managed with circulatory support and steroid administration.² Endomyocardial biopsy is essential to diagnosis confirmation and rapid therapeutic choice making.

The particularity of ANEM is rapid and spectacular circulatory improvement when steroids are administered early enough.² Therefore, we think that a BIVAD is probably too aggressive and that a far less-invasive mean, such as extracorporeal life support (ECLS), is more appropriate for such a condition.

One month ago, we had a case similar to that described by Kohout and colleagues.¹ A 19-year-old woman presented to our department with abrupt onset of congestive heart failure and respiratory distress. She had been already intubated before admission, and echocardiography showed a much altered heart function, with moderately dilated left and right ventricles, and a left ventricular ejection fraction of less than 10%. Computed tomography scan ruled out pulmonary embolism and confirmed severe pulmonary edema. The girl had an unremarkable medical history, with no proof of drug abuse or medications. She had no other

symptoms suggesting a preexisting disorder except for mild abdominal pain 1 day earlier. Blood examination results showed no particularity. Serologic and polymerase chain reaction screening results for viral or other infectious diseases returned to normal later on.

In this context of severe congestive heart failure, a femoro-femoral ECLS was instituted in the special care unit at the patient's bedside, with a blood output of 3.5 L/min. Inotropic support with norepinephrine and dobutamine was also started. Adequate unloading of the left and right-sided heart chambers was assessed with a Swan–Ganz catheter and echocardiography.

On day 1, chest radiography showed a great reduction of the pulmonary edema (Figure 1). An endomyocardial biopsy was performed, which confirmed the diagnosis of ANEM on day 2. Steroids were immediately begun. The improvement was spectacular. As soon as day 6, echocardiography showed marked improvement of the cardiac function. Weaning from ECLS was begun on day 7 and removed on day 10. Cardiac echocardiography showed a completely normalized left ventricular function. The patient was discharged from the special care unit on day 13.

When ANEM is suspected, we think that ECLS is an excellent device for first-line circulatory support. Prompt endomyo-

cardial biopsy is mandatory to confirm the diagnosis and initiate intravenous steroids. This offers the advantage of avoiding the primary use of a far more aggressive mean of circulatory support, such as a BIVAD, in a condition that is likely to respond rapidly and favorably to steroids. In case the biopsy rules out ANEM, then ECLS, if insufficient, could be removed, and other more aggressive means of circulatory support instituted.³

Ziad Khabbaz, MD

Jean-Michel Grinda, MD

Jean-Noël Fabiani, MD

The Université René Descartes

AP-HP, Service de

Chirurgie Cardio-Vasculaire

Hôpital Européen Georges Pompidou

Paris, France

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Reply to the Editor:

We thank Dr Khabbaz and colleagues for their contribution to the management of acute necrotizing eosinophilic myocarditis with mechanical circulatory assist. In our article,¹ we make no attempt to suggest that ventricular assist device (VAD) support is the only method by which to properly manage the disease. On the contrary, we recognize the fact that this is a life-threatening disorder on the one hand, but responsive to steroid therapy on the other. Treatment strategies have ranged from steroid therapy alone² to transplantation.³ The main message in our article and others is to support the circulation while the diagnosis is made and treatment is initiated. The precise method by which to accomplish these ends varies according to the condition of the patient at the time of presentation, the tools and technologies available at the treating