necrosis, but not apoptosis. We agree that HGF might induce neuroprotective effects through inhibition of apoptotic cascade. However, it was highly impossible that the observed neuroprotection of HGF in our study is due to its antiapoptotic effects.

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Apical cannulation for aortic perfusion

To the Editor:

I read with interest the article, "Transapical aortic cannulation for cardiopulmonary bypass in type A aortic dissection operations," by Wada and associates¹ in the November 2006 issue of the *Journal*. I agree with the authors that this time-tested method is indeed most suitable and safe in the management of type A aortic dissections. However, its applicability may be further enhanced by two additional maneuvers: The first technique is use of a special double-lumen catheter; the larger-caliber channel should have an apical port for perfusion and the shorter, smaller-caliber channel should have a port located about 10 cm proximal to the tip and be positioned

Figure 1. Application of the special "double-padded" clamp and perfusion cannula. The jaws of the instrument may be brought into a position to fully occlude the clamped aorta but still allow the passage of the unobstructed flow through the intra-aortic cannula. The double-barreled cannula allows perfusion through the larger, longer channel tip, which is placed into the aorta, and venting through the shorter, smaller channel, which terminates within the left ventricle. (From Robicsek F. Apical aortic cannulation: Application of an old method with new paraphernalia. *Ann Thorac Surg*. 1991;51:330-32. Reproduced with permission from The Society of Thoracic Surgeons).

in the left ventricle for removal of blood, which may be seeping into the left side of the heart. This arrangement eliminates the need for a separate vent through the right pulmonary vein as applied by the authors. The second technique is application of a "special" aortic crossclamp, the padded jaws of which hermetically occlude the aortic lumen but allow passage of the perfusion catheter.² This arrangement provides added versatility to apical perfusion, making continuous or intermittent arch perfusion possible even with the proximal aorta open (Figure 1).

The issue of bleeding that the authors experienced while placing a purse-string

suture into the apex may be effectively addressed by introducing the perfusion catheter through a simple stab wound and placing a 3-pledgeted purse-string suture after the heart is cold and fully relaxed.

The authors' addition transesophageal echo control of the catheter placement adds additional safety to the method.

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Can the consensus statement on surgery journal authorship be implemented?

To the Editor:

The "Consensus statement on surgery journal authorship" is of great interest, not only for the surgical scientific community, but for all biomedical research areas. Most important journals have it in some form and all agree on the fundamentals. This indicates that the problem, which is addressed, is widespread. Some questions, however, have to be added.

How will this statement be implemented? Can one rely on the honesty of the coauthors? Is a simple statement of the authors for which part they are responsible sufficient?

The attitude in many universities "to publish or to perish" is a grim reality and forms a serious obstacle for honesty. It is an incentive for one to have his or her name on as many articles as possible, because career opportunities and promotions depend on it.

This is especially a problem in a hierarchy where heads of departments have to authorize for funds and materials, or supervise but without taking part in the research as such. Young researchers, who want to build a career, usually depend on their head