Schepens has a good experience without administration of heparin and it may be a point of further investigation.

The second comment was regarding segmental clamping. He mentions placing a clamp at level T7, T8, T9. We do not place a clamp at this level. We place our first clamp 5 to 10 cm distal to the proximal anastomosis. The next clamp then is placed just above the celiac artery, and occasionally even below the celiac artery, between it and the superior mesenteric artery. This gives us access to what we believe are the very important intercostal arteries for reimplantation, that is, those arteries arising from the T10 to L1, L2 inner spaces.

Segmental cooling of the spinal cord has been brought up before by the editors. In my reply to the editors, we believe, if there are isolated intercostal arteries that give most of the blood flow to the spinal cord in a segmental area that is cooled, it should have an effect on spinal cord cooling. If we are reestablishing flow to these vessels that rewarms the cord and supply collateral flow to the next segment that is cooled, we do not believe that the cooling creates any detriment to the patient. If collateral vessels rewarm that section of cord, then they also supply adequate oxygenation and prevent ischemic injury. If there is not adequate collateral circulation to the segment that we have cooled, then I believe the cooling effect would be more prolonged and may be an adjunct to spinal cord protection. We are presently involved in an animal laboratory project with cooling of a segment of thoracic aorta and comparing this with paraplegia in the dog model. Results are extremely preliminary. Of interest, two dogs that had cooling did not have permanent paraplegia. The one surviving dog, which did not have cooling, was paraplegic. As I mentioned, the results are entirely too preliminary to make any scientific recommendations. It is hoped that this will shed some light on this problem in the future.

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An act of plagiarism: Postscript and conclusion

March 1, 1994

Dear Sirs:

On the issue of plagiarism, as described in the Letters to the Editors section of the January issue of the journal, I wish to state that I accept sole responsibility. I wish to apologize to the JOURNAL OF VASCULAR SURGERY, Dr. O'Mara and his coauthors, and the scientific community as a whole for this incident.

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February 22, 1994

Dear Sirs:

In the Letters to the Editors section of the January issue of the JOURNAL, we stated our intent to conduct a full review of the plagiarism incident related to an article by Drs. DeRose, Harris, and Jamieson. A committee was convened in November 1993 and was chaired by an external adviser. In their report, the integrity of the authors' data was confirmed from direct review of the rough work and the hospital charts. The committee was satisfied that the plagiarism was unintentional. They concluded that Drs. Harris and Jamieson were unaware that Dr. DeRose had plagiarized parts of O'Mara's text in preparing his manuscript and that they had no practical means of detecting it. The committee made other valuable recommendations concerning policies pertinent to the responsibility of authorship. Their recommendations will be developed and implemented by the Department of Surgery and the Faculty of Medicine.

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Superior vena cava occlusion after filter insertion

To the Editors:

In selected cases with upper extremity deep vein thrombosis (DVT), placement of an appropriately oriented filter in the superior vena cava (SVC) seems indicated as we acknowledge the increasing frequency of upper extremity DVT and its potential for pulmonary embolism (PE).1-4 Patients with adenocarcinoma of the lung may be at special risk for PE.

A 67-year-old man had the combined problems of atrial fibrillation, recurrent lower extremity DVT while receiving appropriate coumadin therapy, and newly diagnosed adenocarcinoma of the left upper lobe of the lung. Inferior vena cava filter (VCF) insertion and left upper lobectomy were advised. The patient initially declined operation. He was represcribed coumadin therapy after initial treatment with heparin and was discharged with plans for further consultation. He returned to the emergency department after development of new shortness of breath and further extension of the lower extremity DVT. PE was confirmed by xenon-technetium ventilation/perfusion lung scanning, and further heparin therapy was given intravenously. He then underwent VCF (Greenfield) insertion into the inferior vena cava and left upper lobectomy. Subcutaneous heparin was given after operation.

On the sixth postoperative day, swelling of the left arm and engorgement of the left anterior chest wall veins developed in the patient. Repeat ventilation/perfusion lung scanning showed new unmatched defects. At this time another VCF (Greenfield) was inserted and placed with the
prongs between the azygos vein and the right atrium. It was inserted percutaneously through the right internal jugular vein with use of the femoral insertion kit to obtain proper orientation of the filter in the SVC. Preliminary venacavography was performed. The swelling of the left arm decreased with arm elevation and intravenous heparin therapy; the patient was discharged receiving 7500 units subcutaneous heparin twice daily.

The patient returned 2 weeks after discharge with progressive neck swelling and lightheadedness and now had prominent neck and chest wall veins bilaterally, periorbital edema, and new edema of his right arm. Computed tomography scanning revealed the VCF in the SVC with thrombosis in the left internal jugular, left subclavian, and innominate veins and in the SVC extending to within 2 cm of the VCF. The response to thrombolytic therapy was minimal; the patient died several days later.

The family refused autopsy examination.

Our poor result and that of Black\(^4\) (both with early patient death and SVC thrombosis in patients with adenocarcinoma of the lung) raise questions about application of SVC filters in such cases. Other issues that need to be addressed include the site for ideal placement (above or below the azygos vein) and the role, if any, for continued anticoagulation (full- or low-dose) after placement of VCF in the SVC.

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REFERENCES