Authorship is a responsibility as much as credit

Sir,
Research is a systemic way to advance current scientific knowledge and to guide further clinical management. The authors are collectively responsible for the accuracy and integrity of the conducted research work. Generally, the researcher thinks more of credit rather than responsibility while writing a research paper. Authorship not only confers credit but implies responsibility and accountability for published work.

The International Committee of Medical Journal Editors (ICMJE) recommends that each author should meet the following 4 criteria;
• Contributed to the conception or design; or involved in acquisition, analysis, or interpretation of data
• Drafting or revising the work
• Final approval of the version to be published
• Agreement to be accountable for all aspects of work.[1]

According to these recommendations, if the authors are equally contributing and are responsible for the final product of research then the credit should also be equal. Unfortunately, the criteria used to determine the order in which authors are listed on the byline and contribution may vary widely and are usually decided collectively by the author group. Although ICMJE guidelines are followed by many journals, these are deficient in many perspectives. For instance, no criteria have been outlined for defining the first author nor any recommendations have been made regarding author order. By tradition in medical literature, if not listed alphabetically, the first author makes the largest contribution, the last author is the most senior and the middle authors’ credit and contributions are vague unless mentioned in a contribution list. Despite this tradition, there are no firm guidelines in place to guarantee a fair interpretation of authors’ contributions.[2] In general, authorship order in a publication byline and contribution is thought to be consistent. Perhaps, the fact is rather controversial and there is no consensus among the scientific community regarding this issue. The author byline is an indispensable component of a scientific paper. However, the relationship between the authors’ order and contribution remains inconsistent. Different scientific fields have different ways of authorship order, contribution, and weighting credit. Yang et al. have compared three prominent journals to assess the relationship between the author byline and the contribution list. They concluded, that the relationship between the two remains unclear.[3] In another study, Baerlocher et al. have investigated four journals in a span of 3 years period. They found for most categories of contribution, the levels of participation were highest for first authors, followed by last and then second authors. Middle authors had lower levels particularly in conception, drafts of the manuscript, supervision, and being a guarantor.[4] Smith et al. have developed a five-step “best practice” that incorporates the distribution of both contributor-ship and authorship for multi/interdisciplinary research. This procedure involves continuous dialogue and the use of a detailed contributor-ship taxonomy ending with a declaration explaining contributor-ship, which is used to justify authorship order.[5]

We suggest The ICMJE authorship criteria should strictly be followed by the authors and the role of each author should be mentioned in the contribution list which should be consistent with the authors byline on the publication.

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There are no conflicts of interest.

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Sir,

Use of single-shot extraconal block has become an important strategy in managing pediatric postoperative pain after eye surgery. Herein, we present a case of local anesthetic systemic toxicity (LAST) in a 2-month-old boy (12 kg) with congenital glaucoma, undergoing right eye enucleation under general endotracheal anesthesia (GETA).

Before incision, the ophthalmologist performed a single-shot extraconal block [Figure 1], with 1.5 mL of 0.75% bupivacaine and 1.5 mL of 4% lidocaine and hyaluronidase 7.5 IU/mL (total of 3 mL). The surgery was uneventful and 3 h later a repeat block was done, for a total dose of 22.5 mg bupivacaine and 120 mg lidocaine. The child's trachea was extubated and transferred to the recovery room. However, 20 min later the patient became agitated, developed generalized tonic-clonic seizures associated with oxygen desaturation, and tachycardia. The electrocardiogram (ECG) displayed increased T-wave amplitude and ST-segment elevation. Fortunately, 100% oxygen and IV midazolam stopped the seizure activity and improved oxygen saturation with normal ECG waveform. A 6 mL bolus of 20% intravenous lipid emulsion (ILE) was administered given high-suspicion for LAST. The child's trachea was intubated for a short period for airway protection. The patient was later transferred to a pediatric intensive care unit for continued monitoring, post which he was discharged home the following day.

Pediatric LAST is a rare but life-threatening complication with an incidence of 0.76 per 10,000 cases. In children, the early signs and symptoms of LAST may go undetected under GETA. Therefore, the clinical signs of toxicity in children are likely to be seizures, tachyarrhythmias, or cardiovascular collapse. Following an eye block, LAST may occur due to injection into the ophthalmic artery or within the optic nerve sheath. In our case, the LAST and seizures were most likely secondary to excessive dosage. In children, the T-wave criterion after IV test dose containing lidocaine and bupivacaine is more reliable than either heart rate or systolic blood pressure for detecting intravascular injection. Children also have an increased risk due to lower plasma levels of alpha-1-acid glycoprotein (A1AG), increasing the amount of unbound plasma amino-amide LA. Consequently, weight-based submaximal dosing is a preferred, safe method and doses should be reduced by 15% in infants less than 4 months of age. Thus, the anesthesiologist and surgeons should be cognizant of the LA volume and concentration injected. Clebone et al. [3] developed a time-out checklist to mitigate factors that could lead to LAST. The American Society of Regional Anesthesia 2017 checklist update for managing LAST [4] recommends ILE 20% at the first sign of a serious LAST event. Our clinical priority should be to eliminate dosing errors, prevent LAST, and promote patient safety with a structured time-out procedure directed at LA dose. In conclusion, LAST continues to be a concern for all practitioners, and reducing the modifiable factors is thereby possible by educating the whole operating or procedural room personnel who uses or handles LA but is less aware of the potential risks and complications. Cross-checking of calculations and verbalization of dosages/kg prior to injection should be applied as a safeguard to prevent life-threatening and serious drug dosage errors.