

Observational Study

Self plagiarism — and its utility to the reader

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Self-plagiarism is using ones own sentences again without proper citation. This practice is every now and then defended as harmless. This paper analyses a few recent scientific works that were published in orthopaedic and surgical journals which attract the clause of self-plagiarism. The apparently undamaging practice boosts the Curriculum Vitae of the author and actually causes harm in (i) wasting the time of the reader (ii) creating duplicate data in meta-analysis and (iii) consuming the space of original articles in the journals. With more journals going online and with gadgets available to identify repetition pattern such practices will surely decrease in future. Strict anti-plagiarism rules for journals and some soul-searching from the writers' side are the urgent need of the hour.

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Key words : Self-plagiarism, wasting time, reader, Citation, Journal, Meta-analysis.

The need to publish research articles is mounting. The worker has an urge to get benefits like salary hikes, remuneration and also promotion. This sometimes makes him to include names of others which are not part of the work. He also tries to publish the same case again and again, at least twice to boost up the Curriculum-vitae. Such practice of using one's own words again without proper citation is called self-plagiarism. "Self-plagiarism is the practice of an author using portions of their previous writings on the same topic in another of his publications, without specifically citing it formally in quotes"¹. This practice is also occasionally defended as normal as it does not cause any harm to anyone. This paper analyses scientific works from two authors that were published recently in orthopaedic and surgical journals which attracted this above clause of self-plagiarism.

MATERIALS AND METHODS

This section has details of two pairs of papers that were published in orthopaedic and surgical journals which attract the clause of self-plagiarism. First pair of papers^{2,3} were cases seen by same authors. The second pair of papers^{4,5} was a case study presented by different authors (maintaining the first author). Within each of the two pairs, there appeared strong similarity as to the region of the ailment, treatment methods etc. These two pairs of articles were analysed if these were double publications with regard to the content, text and figures.

OBSERVATIONS

First case :

The article 'Outcome of ankle arthrodesis in post-

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traumatic arthritis' in the Indian Journal of Orthopaedics² (IJO) by Narayana Gowda *et al* (A1) was similar to the one published as 'Ankle arthrodesis as a salvage procedure: A case of secondary ankle arthritis using Charnley's compression device' by the same authors in Foot and Ankle Online Journal (FAOJ) in February 2012³. It presents a study done in the same period by the same authors with even the same photographs. Finer points like sex distribution in study-period of study, centre of study, indication of arthrodesis, the apparatus used, figures, intra operative steps and follow up period are surprisingly the same and can be verified from Table 1. It is observed that certain words are not even rephrased from the original article. This shows the sheer callousness of the authors. Figures 1a and 1b show the lines which were similar in first pair of articles^{2,3}.

Second case :

The first of the second pair of articles titled Soft Tissue Textiloma- A Diagnostic Pitfall⁴ by Elyazid Moushine *et al* (A2) Department of Orthopedic Surgery, and Traumatology, University hospital, Lausanne, Switzerland published in the Canadian Journal of Surgery. This article had similarity with another article 'Leg – Textiloma' published by the same first author in the journal - Medicine Principles and Practice⁵. A detailed analysis of these two articles was done and tabulated in Table 2. The details shown in this table are patient age, sex, biochemical parameters, previous surgeries done with their dates, present clinical examination like the skin condition, size and shape of the swelling, findings of diagnostic imaging like the ultrasound and MRI, operative findings and histopathology were noted in these two papers^{4,5}. Figs 2a and 2b show the lines which were similar in the articles of the second pair of articles^{4,5}. It is observed that certain words are used verbatim from the article.

S.no	Detail	FAOJ	IJO
1	Journal name	Foot and ankle online Journal	Indian Journal of Orthopedics
2	Published month	February 1,2012	May-June 2012
3	Authors	Narayana B.S. Gowda, <u>J Mohan Kumar</u>	Narayana B.S. Gowda, <u>J Mohan Kumar</u>
4	Males in study	10	10
5	Females in study	5	5
6	Period of study	Jan 2006- Dec 2009	Jan 2006- Dec 2009
8	Centre	Department of orthopedics, People's Education Society (PES) Medical College and Research Center, Kuppam, Andhra Pradesh (AP)	Department of orthopedics, People's Education Society (PES) Medical College and Research Center, Kuppam, Andhra Pradesh (AP)
9	Indication of arthrodesis	6 cases of post traumatic AVN talus (Fig. 1), 4 cases malunited bimalleolar fracture, 3 cases of distal tibial plafond fractures, 2 cases of medial malleoli non-union	posttraumatic arthritis and/or avascular necrosis (AVN) talus (n=6), malunited bimalleolar fracture (n=4), distal tibial plafond fractures (n=3), medial malleoli nonunion (n=2).
10	Apparatus used	Charnley in all the cases	Charnley in all the cases
11	Figures and number in the journal	Fig 1	2a
12	"	Fig 3	3b
13	"	Fig 4	1c
14	"	Fig 5	2c
15	"	Fig 6	2d
16	Follow up period	2years and 8 months	2years and 8 months
17	Intra operative steps	All the fifteen patients who had secondary ankle arthritis have undergone open ankle fusion with anterolateral approach (Fig. 2) in supine position under tourniquet control and spinal anaesthesia.	All the 15 patients had undergone open ankle fusion by anterolateral approach [Figure 1]b in supine position under tourniquet control and spinal anaesthesia.
18	Limb length discrepancies	Limb length discrepancies were insignificant (0.5 to 1.5 cm) except in one patient who had 2.5 cm secondarily due to distal tibial plafond fracture.	Limb length discrepancies were insignificant (0.5-1.5 cm) except in one patient who had 2.5 cm secondarily due to distal tibial plafond fracture.
19	Reference section		No mention of Narayana Gowda B S, Kumar J M. Outcome of ankle arthrodesis in posttraumatic arthritis . Indian J Orthop [serial online] 2012 [cited 2013 Apr 5];46:317-20.

Table 1 — The Striking similarity between the two articles in FAOJ and IJO

DISCUSSION

The words and lines re-used in these two pair of articles²⁻⁵ are seen in Figs 1a, 1b and 2a, 2b. In the case of both authors A1 (Figs 1a and 1b) and A2 (Figs 2a and 2b) both have used similar words, not even rephrasing. Both these authors have chosen journals of high impact and Scopus value. Thus it is obvious that much of the text in Fig 1a matches that in Fig 1b and also much of the text in Fig 2a matches the text in Fig 2b.

Thenticate, defines Self-Plagiarism as a "type of plagiarism in which the writer republishes a work in its entirety or reuses portions of a previously written text while authoring a new work⁶." If in a composite laboratory experiment yield different results each one can be published individually maintaining the same methodology part for all these articles, if a prior work can be written in the literature review as a basis for the next work - ie, if the core of the theory can be exactly described in one sentence of the previous paper, if a component of the prior article must

be repeated to deal with new evidence or arguments or tell differently a second time or if the audience of the different set up for eg, surgeons on one hand and biomed engineers on the other. But only way out is to openly mention the article where the author used it first in the reference section of the second article^{7,8}.

In all these above two pairs of papers, Narayana Gowda *et al* (A1 -first authors of the first pair of articles^{2,3}) and Moushine *et al* (A2-first authors of the second pair^{4,5}) did not mention their prior work (ie, in the references section of the second paper^{3,5} there is no mention of the corresponding first papers^{2,4}) to claim (i) an extension of their work or (ii) one of more follow up or (ii) they want to reiterate something they have not told in the first report. If they actually want to get their own sentences republished they have to put them between inverted commas and suitable citation given in superscript and in references⁸.

Both these articles are case reports but on the same cases. It is therefore vital that both these first authors have not cited the first work in their second work. The

study and follow up period are the same and the authors nowhere have quoted their work which was published online in their second paper. It is obvious that the readers will not benefit from such republishing the same work including photographs and demographic details that too from the same authors in the same time period.

To find the validity of the diagnostic or treatment methods meta-analysis is commonly used. Double publications will reduce the validity of such studies⁹. Thus such practices will only increase worthless junk of scientific literature and will not only be of any use to the reader but also waste the time of the reader, confuse meta-analysis of intervention studies giving duplicate data. It is natural to feel that the editors should be ruthless on these authors to retrieve the articles or at least make public those letters which are sent citing the misconduct citing paucity of space in the journal. Presence of a few common characteristics between the same author's own papers are tolerable. The fresh paper should have a fresh outcome. One point of the

Journal	Can J Surg	Med Princ Pract
Article	Moushine E et al .Soft tissue textiloma : a potential pitfall ,Can J Surg 2005 december;48(6)495-6.	Moushine E et al 'Leg – Textiloma , med princ pract 2006, 15 ; 312-315
Patient profile	58 year male	58 year male
Duration of symptoms	1.5 year ³	[18 months ⁴]!!!
history	swelling and tethering of left leg.	swelling and tethering of left leg.
History of previous surgery	He had right side inguinal hernia surgery in 15 years back ³ (paper was in 2004)	He had right side inguinal hernia surgery in 1989 ⁴ 1989+15=2004
Previous surgery	left leg was operated for varicose veins in 8 years after that previous surgery ³	left leg was operated for varicose veins in 1997 ⁴ i.e 8 years after 1989
Other diseases	The patient has gout and high cholesterol.	The patient has gout and high cholesterol.
Gait	He had a normal gait without limp.	He had a normal gait without limp.
Local examination	There was slight edema of the left ankle and distal 1/3 rd of the left calf with ochre dermatitis. A 6x4 cm hard indolent mass was palpable in the antero internal aspect of the distal third of the leg. This mass was adherent to subcutaneous tissue and not to deep tissues.	There was slight edema of the left ankle and distal 1/3 rd of the left calf with ochre dermatitis. A 6x4 cm hard indolent mass was palpable in the antero internal aspect of the distal third of the leg. This mass was adherent to subcutaneous tissue and not to deep tissues.
Ultrasonography	Ultrasonography revealed the presence of a soft tissue shadow high echogenic mass 2 cm wide and 10 cm thick. This mass was surrounded by multiple blood vessels.	Ultrasonography revealed the presence of a soft tissue shadow high echogenic mass 2 cm wide and 10 cm thick. This mass was surrounded by multiple blood vessels.
MRI	MRI hypodense in T1 and hyperdense in T2 with relation to surrounding fatty tissue. The MRI also showed a central nucleus which may be most likely to be necrosis. With IV contrast of gadolinium, the mass enhanced and showed a strong vascular supply and large draining vessels.	MRI hypodense in T1 and hyperdense in T2 with relation to surrounding fatty tissue. The MRI also showed a central nucleus which may be most likely to be necrosis. With IV contrast of gadolinium, the mass enhanced and showed a strong vascular supply and large draining vessels.
MRI	MRI LS was shown in another. ³	figures MRI TS was shown in one article
Provisional diagnosis	tumour of mesenchymal origin	tumour of mesenchymal origin
findings at surgery	At surgery, old retained surgical gauze was found	At surgery, old retained surgical gauze was found
Histologic examination	large foreign body giant cells.	large foreign body giant cells.
Reference section	-	no mention of 'Moushine E et al .Soft tissue textiloma : a potential pitfall ,Can J Surg 2005 december;48(6)495-6.

Table 2 — The Striking similarity between the two articles in Canadian Journal of surgery and medical principle and practice

previous paper alone may be acceptable. However if the same paper as a whole is printed again, then it is atrocious⁶.

As far as the first case in the present paper, even though the materials are the same and they would have not used materials from other centre, they cannot defend writing the same material for two journals^{2,3}. For example if they describe the presence of cataract or dental caries or hypertension or cardiomyopathy in these patients, they need not quote the first work in the second work. But here in the second paper, they are again reporting on their same region and same modality of treatment and the same evaluation method. Is it correct to hide the first work², in the second work³ ?

In the case report published in foot and ankle online journal the authors of the first pair of case study Narayana *et al* can try a defense that they have highlighted the Charnley's compression device in the first relation to cost, simplicity and good outcome. They have incorporated a photograph and X-ray of one patient to show the fixator in situ and union of arthrodesis. However they have also repeated the same photos again in the second publication as it is obvious from the table and Figs 1 and 2. They (Narayana *et al*) cannot claim that they can write an article to the Indian Journal of Orthopaedics³ (their second paper) emphasizing the ankle arthrodesis procedure in post-traumatic arthritis and clinical and radiographic evaluation for which functional evaluation with American Orthopaedic Foot and Ankle Society (AOFAS) Ankle Hindfoot scale was done to indicate to find if ankle fusion will help to relieve pain and to improve overall function .

If they think the second paper³ (in the Indian Journal of Orthopaedics)the procedure of using compression device for ankle arthrodesis was described only as a procedure, in the first paper² (Foot and Ankle Online Journal) they have not at all used any other device other than Charnely compression clamp with a calcaneo tibial pin to justify the re –use of the published material. In both these

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Figure 3 Immediate post-operative radiograph showing Charley's compression device.

Clinical Evaluation

The clinical evaluation was based on a personal interview and physical examination. The patients were questioned as to their pain during daily activities such as running or walking on the level ground and going up and down the hills and stairs. A complete orthopaedic examination evaluated stance, gait, limb length discrepancy, circumference, range of motion of the knees, ankles, and subtalar joints, neuromuscular status, muscle strength and presence or absence of tenderness and swelling. Special attention was directed to the position of the fused ankle and the motion of the subtalar and mid tarsal joints. Any valgus or varus deformities of the heel and the presence of the calcaneus were also determined. The contralateral extremity was used as a control. Antero-posterior and lateral radiographs were taken to assess the fusion and position of the arthrodesis (Fig 5).

To quantify the results of the clinical examination the *American Orthopaedic Foot and Ankle Society (AOFA) Ankle-Hindfoot scale* was used. The main emphasis of this system was on pain and the functional activities. A normal person would score 100 points. Because of lack of ankle motion, the maximum score that the patient with an ankle fusion could have was 92, since they could not earn the 8 points given for the full range of motion.



Figure 4 Clinical photo showing Charley's compression device.

A score of 80 to 92 was considered an excellent result; 70 to 79, a good result; 60 to 69, a fair result; and score less than 60 was considered a poor result.

Results

All patients studied had a solidly fused ankle and had no complications related to the surgery (Fig 6). They were all improved as a result of ankle fusion and returned to their pre-injury activities. Wearing shoes with appropriate heels, all the patients could walk on level ground without support. All the patients stated that they could walk up and down the stairs without much difficulty. Limb length discrepancies were insignificant (0.5 to 1.5 cm) except in one patient who had 2.5 cm secondary due to distal tibia plateau fracture. The radiographs showed that 6 cases showed some evidence of degenerative changes in the subtalar joints which did not correlate with the symptoms.

Scoring the patients with the *American Orthopaedic Foot and Ankle Society (AOFA) Ankle-Hindfoot scale*, we found that eleven of the 15 had excellent results, two good, and two fair results. All of them could walk with relatively good velocity and with a consistently rhythmic gait.

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structurally and radiologically at 6 weeks and thibodeoncel Stratum's pin was removed and the patients were allowed to bear weight as tolerated with Charley's compression device in situ. The Charley's compression device was removed after 12 weeks and below knee walking cast was applied. Walking cast was removed once the radiological features showed bridging trabecular bone across the arthrodesis site (Figures 1a, 2c and 3c,d).

Cases with minimum follow-up of 1 year were considered for clinical evaluation. The patients were questioned for pain during daily activities. A complete self-specific examination to evaluate gait, limb length discrepancy, range of motion of the knees, ankles, and subtalar joints, neuromuscular status, muscle strength, and presence or absence of tenderness and swelling. Special attention was made to the position of the fused ankle and the motion of the subtalar and mid tarsal joints. Any valgus or varus deformities of the heel and the presence of the calcaneus were also determined. Ankle AP and lateral X-rays were taken to assess the fusion and

position of the arthrodesis. The opposite normal limb was used for comparison.

American Orthopaedic Foot and Ankle Society (AOFA) Ankle-Hindfoot scale was used to assess the results (Table 1). The main emphasis of this system was on pain and the functional activities. A normal person would score 100 points. Because of lack of ankle motion, the maximum score that the patient with an ankle fusion could have was 92, since they could not earn the 8 points given for the full range of motion. A score of 80-92 was considered an excellent result; 70-79 a good result; 60-69 a fair result; and score less than 60 was considered a poor result. This scoring system was modified similar to the one used by Monte et al.⁷

RESULTS

The sound union occurred in all patients. Ankle fusion was achieved at an average of 20.6 weeks (range 15-39 weeks). We had three cases of cellulitis of ankle and foot during the initial few weeks, which was treated successfully with antibiotics, and two cases of pin tract infection which was limited completely after fusion occurred. None of these led to deep infection. The mean age at the time of surgery was 40.52 years (range 28.5-56 years) and the mean time of follow-up was 2.8 years (range 1.5-7 years). There were no complications related to the surgery. They were all returned



Figure 1 (a) X-ray right ankle AP and lateral showing arthrodesis changes secondary to fracture neck of talus; (b) immediate postoperative X-ray ankle showing fusion in situ; (c) immediate postoperative X-ray ankle showing fusion in situ; (d) 1 year 3 months follow-up X-ray right ankle AP and lateral showing later of ankle arthrodesis.



Figure 2 (a) Postoperative X-ray right ankle AP and lateral showing arthrodesis changes secondary to fracture neck of talus; (b) immediate postoperative X-ray ankle with fusion in situ; (c) 1 year follow-up X-ray ankle showing solid union; (d) 2 year follow-up clinical photo showing no bony differences compared to left side.

Fig 1a

Fig 1b

Figs 1a and 1b — Showing few sample of lines which were similar in the first pair of articles in Foot and ankle online Journal and Indian Journal of Orthopedics respectively. The same figures are seen in both Articles



Fig. 1a Frontal view of the distal leg. Medial soft tissue mass (marker) No bony involvement.

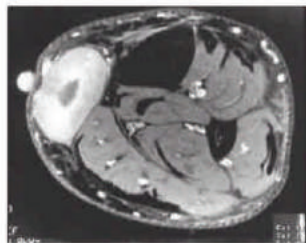


Fig. 2 Transverse T₂-weighted fat-saturated gadolinium-enhanced MR images. Well-defined soft tissue mass, limited to the subcutaneous tissue, hypointense in T₁-weighted fat-saturated MR images, and heterogeneous enhancement after i.v. gadolinium injection. No muscular or bony infiltration.



Fig. 3 Gross examination showing the surgical gauze embedded in a fibrotic reaction. The gauze was discovered 3 years later.

did not complain of any pain. Past medical and surgical history included a right inguinal hernia repaired in 1989, stripping of varicose veins in his left leg in 1997 and the presence of gout, as well as a high blood cholesterol level. The physical examination on presentation revealed a patient in good general condition, a normal gait without a limp and the presence of slight edema of the left ankle and distal third of the left calf with redness. A 4 x 8 cm hard and nodular mass was palpable in the antero-lateral side of the distal third of the left leg. This tumoral mass was adherent to the subcutaneous tissue but not to the deep soft tissues. A small surgical scar (5 mm) due to the surgical procedure for varicose veins appeared on top of the mass. The result of the examination and laboratory data were normal. A plain X-ray of the left lower extremity and ankle joint highlighting the soft tissue showed a non-calcified fragmentation of the soft tissue with normal underlying bony structures (Fig. 1a).

Ultrasound examination revealed a solid soft tissue, highly echogenic mass 2cm wide and 10cm thick. This mass appeared to be surrounded by multiple blood vessels. MRI confirmed the presence of a spindle-shaped mass 2 cm wide, 8 cm long and 13 cm thick, surrounded by fatty subcutaneous tissue. The mass revealed a T₂-weighted hypointense and a T₁-weighted hyperintense image with respect to the surrounding fat tissue. The MRI scan also revealed a small white nucleus, which appeared to be a central nucleus.

Fig 2a

Med Princ Pract 2006;15:312-313

Noles de cas



Fig. 1b MRI of the lower left leg shows a spindle-shaped mass, 2 cm wide, 8 cm long and 10 cm thick, surrounded by fatty subcutaneous tissue.

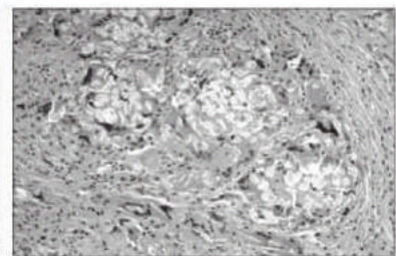


Fig. 2 Histologic section showing a large foreign-body granuloma.

ulcer of the left calf and distal third of the ipsilateral calf with the presence of calcifications. A 6 x 4 cm hard, nodular mass was palpable at the antero-lateral side of the distal third of the leg. This mass was adherent to subcutaneous tissue, though unattached to deep tissue. A small surgical scar (5 mm) from the varicose vein operation, appeared centered on the mass. Results of the rest of the physical examination and laboratory investigation were normal. A plain X-ray of the left lower extremity and ankle joint highlighting soft tissue showed a non-calcified fragmentation of the soft tissue with normal bony structure.

Ultrasonography revealed the presence of a soft tissue solid, high echogenic mass, 2 cm wide and 10 cm thick. This mass appeared to be surrounded by multiple blood vessels. MRI confirmed the presence of a spindle-shaped mass measuring 2 x 8 x 13 cm, well surrounded in depth by fatty subcutaneous tissue. There was a hypointense on T₂-weighted and hyperintense on T₁-weighted images with respect to the surrounding fatty tissue, with a small white nucleus, which seemed to be a central nucleus. The mass appeared to be fibrotic in nature. After ultrasound injection of gadolinium, the mass enhanced and showed a strong nodular enhancement with large draining veins. The post-

injury diagnosis was a tumor of mesenchymal origin.

At operation, an old surgical scar was found. Histologic examination revealed a large foreign-body granuloma (Fig. 2). There was no sign of malignancy.

Discussion

The clinical presentation of testicular tumor may be acute or insidiously delayed. The insidious onset usually presents with subtle clinical manifestations because of the possibility of secondary spermatic cord swelling in situ or because of the formation of a testis. The testicular tumor is benign and generally appear after about 2 years but may remain latent for many years. Testicular represents a complication of all forms of surgery, abdominal (82%), gynecologic (22%), anologic and vascular (10%), and orthopedic and spinal (9%).

The best approach to testis is preservation, which avoids castration. The principal preventive measure is to count the pieces of surgical gauze. A discrepancy in the count indicates that approximately 60-80 (70%) in a recent series of 40 cases of testis, only 2 of which were in a musculoalveolar area.⁸

It is interesting that osteomyelitis apert

was not implicated in such 20% of cases of testis, whereas 70% appear after elective operations. Although no real complications in a musculoalveolar site have been reported, the diagnosis is difficult and costly.

Depending on the clinical presentation, a differential diagnosis of focal myositis or infection should be considered in case of possible tumoral or pseudo-tumoral lesions.

Competing interests: None declared.

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Fig 2b

Figs 2a and 2b — Showing few sample of lines which were found similar in the second pair of articles in Canadian Journal of Surgery and Medicine Principle and Practice respectively

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papers (FAOJ and IJO) they have used only the ankle arthrodesis by Charnley's clamp and calcaneo-tibial pin and used AOFAS criteria in assessment of post operative status. But why they have not highlighted that they have already published an article on the same region on the same patients and on same period and in the same (their) centre. i.e. where is the citation of the work published in the first journal? As far as the copy right form of Indian Journal of Orthopedics, it is clearly printed, "Neither this manuscript or one with substantially similar content under our author ship has been published nor is being considered for publication except as described in the covering letter. We certify that all the data collected in the study is presented in this manuscript and no data from the study has been or will be published separately"¹⁰ Res ipsa loquitur. Obviously this is an attempt to hide facts.

It is surprising that common data and same figures are being used in such journals of high repute. This has been overlooked by the reviewers and editors alike. Obviously the scientific content of the work masqueraded the wanton copying in the second article. A section of people may feel that this repetition of words is harmless. But it is not so. It wastes the time of the reader. For eg when you search for articles textilomas you will waste time in reading same work of Moushine E *et al* over and over again for nothing. This obviously is an utter waste of time. This practice should be penalised whether there is open access or not. As (in a civil rights case involving the alleged stealing of three soda cans) Judge Posner says 'The law does not excuse crimes . . . merely because the harm inflicted is small'¹¹.

CONCLUSION

Summing up the seemingly harmless practice which enhances the Curriculum Vitae of the author actually causes harm in wasting the time of the reader causing mis-interpretation of meta-analysis of diagnostic or interventional

studies. With more journals going online and with gadgets available to identify pattern repetition such practice will decrease in future. But what is needed is some soul searching from the writers' side.

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