Letters to the Editor

[The Editor is not responsible for the views expressed by the correspondents]

Manuscript Writer : Are they Eligible for Authorship in Scientific Article ? If yes then which place ?

Sir, — Reading, writing and speaking are the skill which can be developed by personal interest and training. Everyone doesn't have skill and all person cannot have all skills. Good writing with appropriate words makes excellent effect on the readers and reviewers too. Previously writing was not much important but in current busy word, writing gets more weightage compare to past decades. Many people who have that good writing skill, can convert it into their profession which is a good use of the skill[1].

Research works are being done for benefits to human and other lives, it will be a success when it reaches to other people, not from same institute or same city but whole globe, so we need to publish the data. With the help of internet, that work has become rather easy as compared to past decades[2]. Though it has their own drawbacks like copy the idea, plagiarism, fake data etc. Various journals are rejecting the manuscript in first screening, if it has plagiarism more than their set limits or not written in proper way. All clinical researcher and scientist don't have the skill of good writing and presentation. To publish the data and findings, they are taking the help of the medical or research writer. Those writers use their skill with available data and present it with good writing and nice way which can be accepted in the journal easily[3].

Everyone has rights to use their skill for their self-use. Professional Manuscript writers are doing writing work either for some economic purpose or for some ethical purpose. There are many professionals who are available who are writing on behalf of the authors and submit it to appropriate journals. Data owner just have to give the data and have to explain the concept to the writer. This type of professional asks only for money and they do not want any authorship. Many journals asked about the medical writer details during the manuscript submission. Those journals are taking consent for same from all/ corresponding authors. We are also recommended that professionals are not eligible for authorship in any type of manuscript[4].

Another non-professional medical writer who writes for that friends/relatives/departments or else. Those are eligible for authorship as and when all investigators agreed to give authorship. We know that writer is not a part of investigator team but to write they have to search and read the many related articles. They give their efforts without any economic benefits. So, to write it they are fitted in to international journal authorship criteria. However, there are some types of articles doesn't require medical writer. Original article, case repots, case series or brief repots are based on the departmental data where medical writer doesn't have to allowed to front authorship. Their name can be added after giving departmental authors their due. Letter to editor or concept discussion doesn't require medical writer, it is mostly by avoid writers[5].

So, we suggest that writers cannot be eligible for the first authorship because they are using someone else's concepts. If writer is not a part of data collection. Sample selection, concept and study designing, analysis or investigator, not eligible for first place authorship. As per the guidelines, innovative concept and idea given authors are most appropriate for the first author. Only searching review of literature and writing from data (Supplied by principal investigator) doesn't make sense to appoint as first author. If all cases/ patient's investigation and data collection done before the involvement of writers, he/she are eligible for back side place not for first authors. Person can be a corresponding author between the journal and investigator team. We hope everyone will agree with us.

References

1 Liumbruno GM, Velati C, Pasqualetti P, Franchini M — How to write a scientific manuscript for publication. *Blood Transfus* 2013; **11(2):** 217-26.

2 Resnik DB — Social Benefits of Human Subjects Research. *J Clin Res Best Pract* 2008; **4(11):** 1-7. PMID: 24526930; PMCID: PMC3920587.

3 Singhal S, Kalra BS — Publication ethics: Role and responsibility of authors. *Indian J Gastroenterol* 2021; **40:** 65-71. https://doi.org/10.1007/s12664-020-01129-5

4 Defining the Role of Authors and Contributors issued by International Committee of Medical Journal Editors https://www.icmje.org/recommendations/browse/roles-and-responsibilities/defining-the-role-of-authors-and-contributors.htmlLast accessed on 30 December 2022.

5 Bhattacharya S — Authorship issue explained. *Indian J Plast Surg* 2010; **43(2):** 233-4.

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What is Essential to know in Heart Failure Patients

Sir, — As heart failure prevalence increases globally, there is a growing need for new innovative solutions. Nearly 64 million people worldwide are living with Heart Failure (HF). It is estimated that half of patients living with HF will die within five years of diagnosis. It creates divesting impact on healthcare systems and the global economy.

Heart failure is a complex syndrome with current treatments helping to slow HF risks and progression in some, but not all patients. These unmet medical needs underscore the urgency to increase awareness, early detection and development of life-saving medicines to address these complexities with straightforward solutions. It is crucial to develop and deliver innovative solutions to

address the gaps that currently exist in the treatment of heart failure. So it is imperative to be aware of what is essential to know in heart failure patients for proper care.

In many clinical trials it has been reviled that Torsemide was not superior to furosemide in improving survival among patients treated for decompensated HF. For diuretics it has shown there are no differences in cardiovascular outcomes between chlorthalidone and HCTZ among elderly veterans with HTN. Patients suffering from bad lipid profile Pemafibrate did not improve cardiovascular outcomes among patients with diabetes and hypertriglyceridemia.

Iron deficiency is a very common symptom among HF patients for them, Iron (ferric derisomaltose) infusion is not superior to usual care. Empagliflozin has salutary effects on renal function and CV mortality among patients with CKD, with or without DM, who are already on appropriate doses of ACEi/ARB. Highly purified eicosapentaenoic acid showed borderline statistical sig in reducing the risk of adverse CV events in Japanese w/ c/c CAD who were being treated with statins, whereas Olpasiran significantly reduced lipoprotein (a) in established ASCVD. Rosuvastatin 5 mg daily lowered LDL-C significantly >placebo, fish oil, cinnamon, garlic, turmeric, plant sterols in those with increased 10-year risk for ASCVD.

For invasive cardiac procedures, Radial artery bypass graft improves adverse CV outcomes v/s R internal thoracic artery BG. Hypertension management protocol of 4 drugs, quarter-dose BP-lowering combination of candesartan, amlodipine, indapamide and bisoprolol led to a greater reduction in change in BP from baseline to 12 weeks compared with standard-dose ARB immunotherapy in patients with mild to moderate HTN. Adults with HTN who participated in a mindfulness behaviour program for 8 weeks had significantly lower BP levels & greatly reduced sedentary time, at 6 months follow-up V/S those who received enhanced usual care (home BP monitor/BP edu/facilitated access to a physician).

Systematic use of a hospital-based POC tool to support clinical decision-making, followed by rapid follow-up in an outpatient clinic, led to a lower risk of death or hospitalization for CV causes within 30 days among patients with acute HF seeking emergency care. A single IV infusion of NTLA-2001, a novel gene-editing therapy based on CRISPR/Cas9, significantly reduced abnormal levels of the TTR protein by > 90% in patients with ATTR amyloid CM after 28 days. Routine collection of patient-reported health status using KCCQ-12 in the HF clinic improved accuracy of clinician assessments of patients' health status.

Prophylactic methylprednisolone in infants undergoing cardiopulmonary bypass heart surgery did not improve post-operative outcomes compared with placebo.

Bivalirudin w/ a median 3hr post-PCI high-dose infusion significantly reduced the 30d composite rate of all-cause mortality/ BARC types 3-5 major bleeding compared with heparin monotherapy in Chinese patients with STEMI undergoing primary PCI w/ radial artery access.

DAPT with indobufen plus clopidogrel significantly reduced the risk of 1 year net clinical outcomes in Chinese patients with negative cardiac troponin undergoing DES implantation, compared to conventional DAPT of aspirin plus clopidogrel. A personalized "precision" testing approach led to more efficient evaluations for cardiovascular disease risk and improved diagnosis and treatment of CAD when compared to usual care in more than 2,000 adults with stable chest pain. Early initiation of rivaroxaban, prescribed for 35 days in non-hospitalized patients with symptomatic COVID-19 at-risk for thrombosis, was not found to reduce a composite endpoint of venous and arterial thrombotic events, hospitalization, and death. A universal EHR integrated CDS tool using a validated VTE risk model significantly increased rates of in-hospital appropriate thromboprophylaxis & significantly reduced major thromboembolic events w/o an increase in major bleeding at 30d post-discharge VS usual care.

First-line catheter ablation was associated with a significantly lower progression to persistent Afib, when compared to initial antiarrhythmic drug therapy. No significant differences in the rate of postoperative Afib in cardiac surgery patients who received either 125U or 250U doses of botulinum toxin type A (AGN-151607) compared with placebo. Implementation of a novel shared decision-making toolkit designed for low health literacy achieved significantly lower decisional conflict and improved preparation for decision-making compared to usual care in patients with AFib. Among patients with resistant HTN, Aprocitentan resulted in short-term and sustained BP-lowering effects. Among patients with treatment-resistant HTN aldosterone synthase inhibition with Baxdrostat led to dose-dependent reductions in SBP.

In patients with CLTI surgical revascularization with a great saphenous venous conduit was superior to endovascular intervention in reducing major adverse limb events or death. Greater QOL improve in those undergoing endovascular interventions versus surgery. Etripamil nasal spray was effective in termination of spontaneous PSVT in patients experiencing an episode in an at-home setting. Catheter ablation reduces the incidence of persistent AFib/recurrent atrial tachyarrhythmia v/s antiarrhythmic therapy.

An intensive treatment strategy of rapid up-titration of GDMT and close follow-up after an acute HF admission reduced symptoms, improved QOL and reduced the risk of 180-day all-cause death or HF readmission compared with usual care. Among patients with stable ischemic heart disease and moderate to severe ischemia on non-invasive stress testing, routine invasive therapy failed to reduce major adverse cardiac events compared with optimal medical therapy.

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The Road not Taken : A Perspective of a Medical Professional's Inability to Choose between Clinical Practice or Postgraduation Degree after Internship

Sir, — A Postgraduation (PG) degree has almost become a requisite to pursue medical profession in India. A major part of such degrees rely on the clinical mastery of the doctors but to our dismay, the clinical exposure we get during our MBBS courses and

internship does not adequately prepare us for such bigger roles. Patients' outlook has gradually changed over time and it has been often seen that a doctor with a MD or DM degree is preferred over a "suboptimal" MBBS degree, as stated by a few patients . This has subjected the young doctors into a fierce academic competition to crack entrance examinations like NEET, INICET etc. The race is getting tougher day by day in a constant crescendo so much so that it has almost become a norm to dedicate a year or two only for "PG preparation". A vast majority of the aspirants are getting enrolled in various online courses completely sacrificing the clinical exposure of working in a hospital. The internship courses showcase a mere orientation programme with scanty clinical exposure. In most of the hospitals internees are made to fill up charts, perform phlebotomy, insert catheter, write requisitions etc and are almost never a part of the clinical decision making process. After completing the internship, if we are again detaching ourselves from clinical exposure and devoting years to post graduation entrance, is it compromising our clinical acumen further? Having said that, now if we take into account a budding doctor's point of view, the need for post-graduation in India has outweighed the requirement of clinical practice in a doctor's career. The question pattern keeps changing every now and then, leaving them with meagre time to balance between their yearning for clinical experience and simultaneously preparing for the mutating Multiple Choice Question (MCQ) pattern. For example, just a few years ago image based questions were rarely asked but with the commencement of computer based tests, questions with CT scan, Xray, clinical images are commonly asked and without a rigorous practice it is not possible to get success in these entrance tests. After getting into a MD course it is very difficult to have the necessary experience of the other specialities, which is a sine-qua-non to become a successful physician of any speciality. After joining a PG course in a clinical branch the doctors with sparse clinical experience are suddenly given the huge responsibility of treating patients which ultimately results in compromised patient-care at times. Moreover, there is heterogeneity in the work culture or duties of internees in different states. So, the degree of clinical exposure keeps varying from one Post Graduate trainee to another. The regulatory authority should take this issue into account to ensure optimum patient care. A mandatory and uniform clinical orientation course for the post graduate trainees all over India can probably bridge the gap of clinical experience and align them better into the clinical practice.

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Monkeypox as a Global Health Emergency — A Threat after COVID-19 Pandemic

Sir, — Monkeypox is a rare zoonotic disease caused by the monkeypox virus that belongs to the Poxviridae family (1). While the source of infection is primarily zoonotic, and the disease condition is usually seen in Central and West Africa since the 1970s. Recently, there is a rapid spread of Monkeypox all over the world due to climatic change, widespread global travel, and waning herd immunity due to the cessation of smallpox vaccination (2). Re-emergence of monkeypox across nations had made World Health Organization declare it a public health emergency of international concern (PHEIC) in July 2022 (3). As the disease is mild and not fatal, there are debates on declaring it as a PHEIC as it creates panic among the public but considering the reservoir of infection,pandemic potential and susceptible population declaring monkeypox as PHEIC is the need of the hour. India has reported nine confirmed cases of Monkeypox, including one death (4th August 2022) (4). In India, the recent COVID-19 pandemic has equipped us to battle any outbreaks in the future. As we expect more emerging and re-emerging infections in the future, strengthening molecular laboratories will help in the early detection of the disease and containment. Currently, around 70% of the human population issusceptible to Monkeypox infection (2). During the COVID-19 pandemic, a significant gamechanger in controlling the outbreak was a quick roll-out of mass vaccination campaigns.As per the CDC recommendations, two FDA-approved vaccines namely JYNNEOS (Imvamune or Imvanex) and ACAM2000 may be used for the prevention of Monkeypox infection (5). But the data regarding the effectiveness of these two vaccines in the current outbreak is not available. Hence it is imperative that budget allocation for conducting vaccination effectiveness studies should be implemented in endemic countries where we have an increased incidence of Monkeypox infection.

References

1 Cho CT, Wenner HA — Monkeypox virus. *Bacteriol Rev* 1973; **37(1):** 1-18.
2 Simpson K, Heymann D, Brown CS, Edmunds WJ, Elsgaard J, Fine P, *et al* — Human monkeypox – After 40 years, an unintended consequence of smallpox eradication. *Vaccine* 2020; **38(33):** 5077-81.
3 Monkeypox outbreak 2022 [Internet]. [cited 2022 Aug 4]. Available from: https://www.who.int/emergencies/situations/monkeypox-oubreak-2022
4 India Monkeypox Cases: Govt to hold experts' meeting after India reports 9 monkeypox cases | India News - Times of India [Internet]. [cited 2022 Aug 4]. Available from: https://timesofindia.indiatimes.com/india/monkeypox-govt-to-hold-meeting-of-experts-today/articleshow/93333192.cms
5 CDC. Monkeypox in the U.S. [Internet]. Centers for Disease Control and Prevention. 2022 [cited 2022 Aug 4]. Available from: https://www.cdc.gov/poxvirus/monkeypox/considerations-for-monkeypox-vaccination.html

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