Intégrité scientifique et fraudes : des exemples incroyables

Marc SAMAMA
Directeur de l'Office de l'Intégrité Scientifique de l'AP-HP
Département Médico-Universitaire d'Anesthésie-Réanimation et de Médecine Périopératoire
AP-HP.Centre – Université Paris Cité, Paris, France
marc.samama@aphp.fr

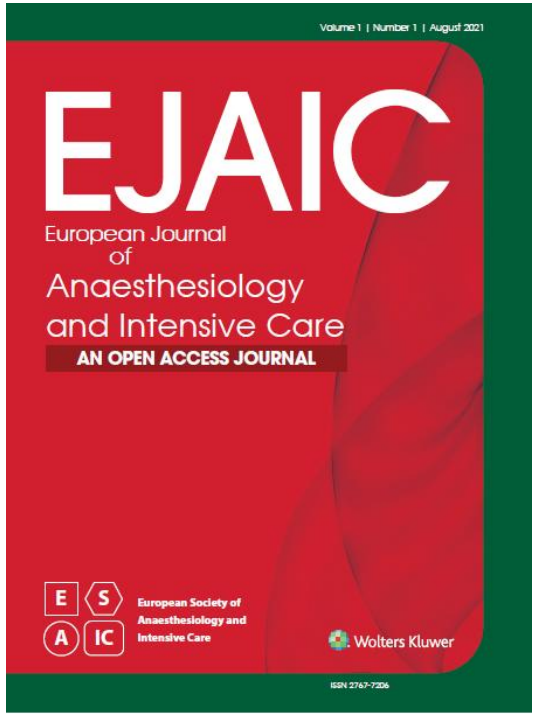
integrite-scientifique@aphp.fr

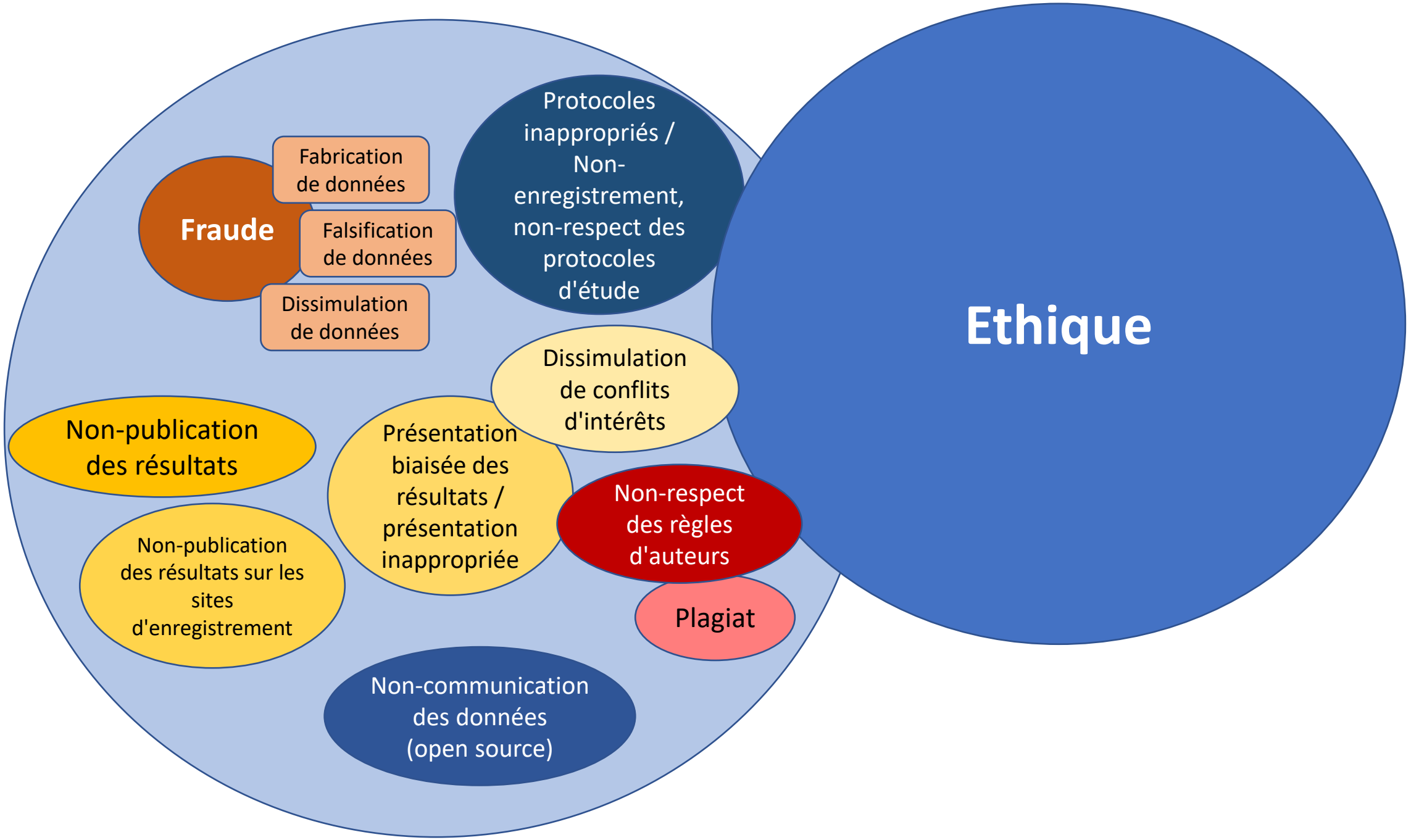
Liens d’intérêt

Firmes et produits (DCI):

Aucun

Journaux:




Ethique
Fraude
Fabrication de données
Falsification de données
Dissimulation de données
Protocoles inappropriés / Non-enregistrement, non-respect des protocoles d'étude
Dissimulation de conflits d'intérêts
Non-publication des résultats
Présentation biaisée des résultats / présentation inappropriée
Non-respect des règles d'auteurs
Plagiat
Non-publication des résultats sur les sites d'enregistrement
Non-communication des données (open source)

Publication integrity: what is it, why does it matter, how it is safeguarded and how could we do better?*

Mark J. Bolland [a], Alison Avenell [b] and Andrew Grey [a]

JOURNAL OF THE ROYAL SOCIETY OF NEW ZEALAND
https://doi.org/10.1080/03036758.2024.2325004

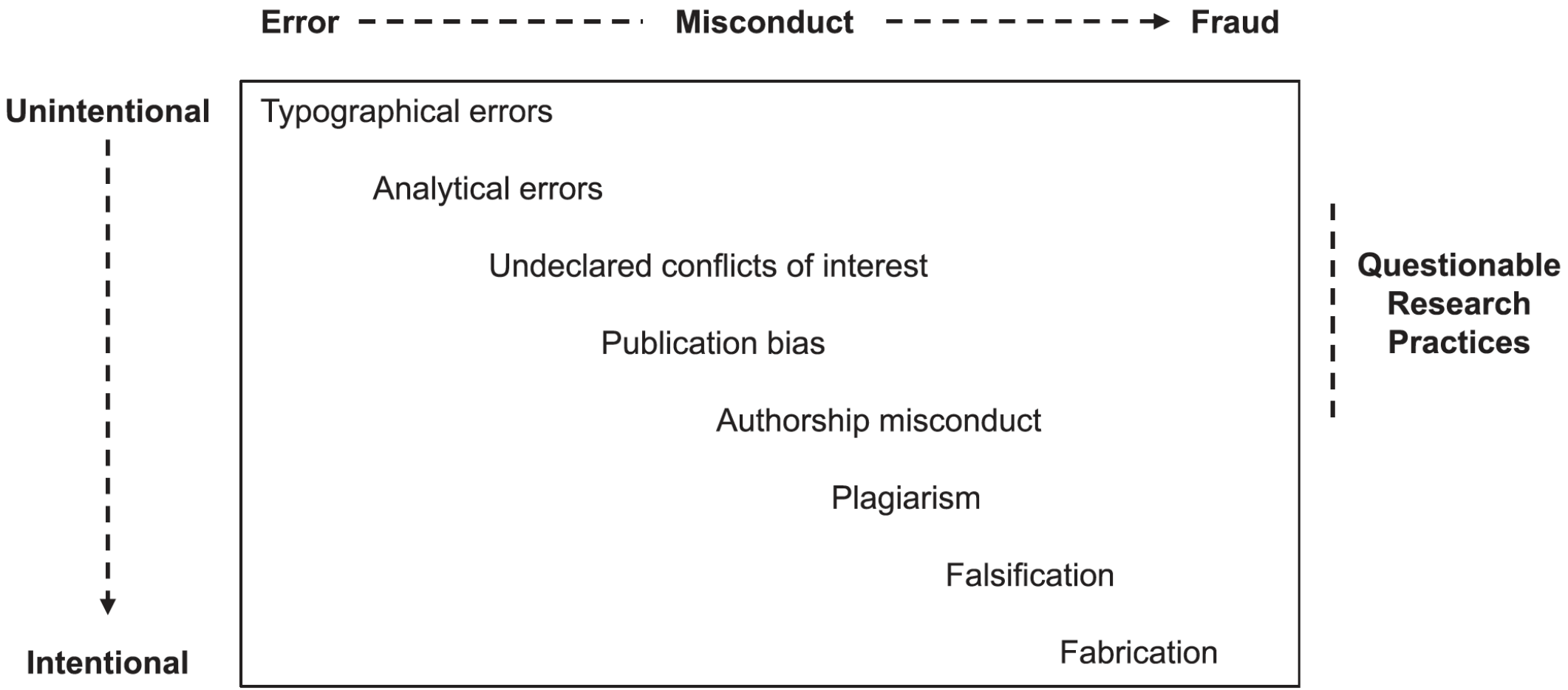


Figure 1. Range of issues causing compromised publication integrity. Adapted and modified from (Nylenna and Simonsen 2006).

Plagiat

Similarities and plagiarism - Suspicions of fraud or ethical concerns.

All manuscripts received by the Journal are checked for plagiarism using iThenticate's CrossCheck within the Editorial Manager submission system.

When minor plagiarism is detected (less than 20% similarities), the manuscript is sent back to the authors for revision and ask them to disclose all sources correctly. If major plagiarism is detected, the manuscript is rejected. The decision of the Editor-in-Chief is final. From Sept 2020 to December 2021 (about 1300 submissions), similarities have been identified in 129 manuscripts among which 56 have been immediately rejected with a letter including the following text:

> ***As part of our routine triage process, we have checked your report for overlap*** *against published reports. That test revealed that* ***X%*** *of your manuscript (excluding the methods section!) were overlapping with already existing texts. We do appreciate that English editing may be a major challenge for non-English speaking authors. However, you cannot possibly write one third of a paper, including the discussion (that actually should be a critical appraisal of your own findings, putting the data into their proper context) in taking pits and pieces, word for word, from other authors. At the end of the day there is not much that is original here. For obvious reasons we cannot send out papers for peer review if we are not 100% sure that their content is truly original.*

PCC characteristics

PCCs comprise a heterogeneous group of plasma-derived products containing partly purified vitamin k-dependant clotting factors. Three different types of these products are available for clinical use: three-factor PCCs (3F-PCCs), four-factor PCCs (4F-PCCs), and activated PCC. The 3F-PCCs contain the vitamin k-dependent clotting factors II, IX and X. The 4F-PCCs, compared to 3F-PCCs, also contain therapeutic amounts of factor VII. Activated PCC (Feiba®), compared to 3F-PCCs and 4F-PCCs, comprises the activated factor VII (VIIa) in addition to the proenzymes prothrombin (factor II), factor IX, and factor X. All products may or may not contain small quantities of anticoagulants like protein C, protein S, and protein Z, as well as small amounts of antithrombin (AT III) and heparin to mitigate thrombogenicity and prevent the activation of vitamin k-dependent clotting factors. In general, 3F-PCCs should be less effective than those products containing four clotting factors for the reversal of anticoagulation by vitamin K-antagonists, probably due to the lack of factor VII. PCCs are usually available as 500 or 1000 UI vials; the dosage refers to the factor IX content. In contrast, the potency of activated PCC is expressed in arbitrary units defined as the amount able to reduce the clotting time of factor VIII inhibitor to 50% of the normal amount in the reference plasma. According to the European Pharmacopoeia guidelines (15), a PCC should have a factor IX potency of at least 20 IU/mL, and the

of a coronary thrombus by angiography including intracoronary imaging or by autopsy[17].

Two different mechanisms lead to perioperative myocardial infarction (PMI)[18]. PMI type 1 is caused by spontaneous rupture of a vulnerable coronary plaque or, uncommonly by se-vere coronary vasospasm, leading to platelet aggregation, occlusive (ST-segment elevation, STEMI) or non-occlusive (ST-segment depression, NSTEMI) thrombus formation, and pro-longed myocardial ischemia resulting in cell death. Plaque disruption is demonstrated in autopsy studies in approximately 50% of patients who died of PMI.PMI type 2 usually re-sults from a sustained imbalance between decreased myocardial oxygen supply and in-creased oxygen demand combined with the presence of significant, obstructive, but not oc-clusive, CAD. Most patients with PMI type 2 have ST-segment depression (NSTEMI)[19,20,21]. Patients undergoing major operations are particularly prone to is-chemic adverse events because of the surgery-associated inflammation and hypercoagula-ble state, as well as perioperative factors that increase the risk of plaque rupture (pain, hy-pertension, elevated levels of catecholamine), increase myocardial oxygen demand (hyper-tension, tachycardia, elevated left ventricular [LV] diastolic pressure), or decrease myocar-dial oxygen supply (blood loss, anaemia, hypotension, hypoxia, tachycardia, coronary vaso-constriction)[18].NSTEMI is the most common type of PMI. Compared to patients with STEMI, patients with NSTEMI are generally older, have multivessel and/or left main CAD more frequently, and often have multiple risk factors and comorbidities[22]. Myocardial in-jury after non-cardiac surgery (MINS) is defined as (1) an elevation of postoperative serum troponin concentrations with an ischemic origin (2)

in Asia (2) bedside echocardiographic examination using a handheld or pocket ultrasound device can have great incremental value in emergent situations that may allow measures to optimize perioperative outcomes; (3) to obtain baseline information; and (4) medico-legal requirement.

Role of bedside electrocardiogram (ECG), chest-X-ray, and echocardiography:

Targeted history and physical examination provide a wealth of information and this cannot be substituted or undermined. However, its major limitations are that it is subjective and dependent on the clinical skills of the examining physician[29]. Additionally, some forms of cardiac impairment are asymptomatic and are inherently silent and may be missed on clinical impairment, for instance, asymptomatic left ventricular (LV) systolic dysfunction. Bedside echocardiography is available in most tertiary care hospitals for emergent or urgent care settings and hand-held or pocket ultrasound devices offer an attractive option in emergency and acute circumstances. Several studies indicate that the addition of an echocardiographic screening at the bedside to clinical examination, improves the diagnostic accuracy, is cost-effective, and facilitates optimal use of health care resources[29-32]. The hand-held echocardiography devices offer two-dimensional and colour Doppler imaging and usually a good quality of image, which permits an acceptable diagnostic accuracy comparable to that achieved with a larger echocardiography equipment[31,34,35,36]. It is shown that in patients undergoing non-cardiac surgery, the presence of unrecognized LV systolic dysfunction or valvular heart disease is associated with bad

Introduction

Optimal fluid therapy plays a significant role in increasing cardiac output because intraoperative systemic hypotension and hypovolemia are potential causes of organ hypoperfusion [1-3]. However, unnecessary fluid administration is counterproductive and increases mortality[4, 5]. Therefore, fluid management based on a reliable hemodynamic index is essential when considering the cardinal aspect of resuscitation[6, 7]. Traditionally, central venous pressure (CVP) and pulmonary capillary wedge pressure (PCWP) have been used as indicators to identify and manage intravascular volume [8]. However, these methods have the disadvantage of being invasive. Recently, dynamic preload indices, such as stroke volume variation (SVV), pulse pressure variation (PPV), or pulse variability index (PVI), derived from heart-lung interactions, have been proposed to predict fluid responsiveness in ventilated patients. These dynamic preload indices are less invasive than traditional methods, but are affected by chest and arterial conditions [9-11]. Taken together, the details of fluid therapy are limited to observing changes in the preload indices. If more diverse information is supplemented with fluid management, the accuracy of treatment can be increased.

Assessment of fluid responsiveness using cardiac power index in the prone position: a pilot study

JY Min (earlkain@naver.com)
Eunpyeong

Research Article

Keywords: Cardiac output, cardiac power index, monitoring, position, prone

Posted Date: March 21st, 2023

DOI: https://doi.org/10.21203/rs.3.rs-2694372/v1

European Journal of Cardio-Thoracic Surgery 2024, 66(1), ezae269
https://doi.org/10.1093/ejcts/ezae269 Advance Access publication 10 July 2024

REVIEW

Cite this article as: Thierry B, Arakelian L, Denoyelle F, Larghero J, Wurtz A. Full circumferential human tracheal replacement: a systematic review. Eur J Cardiothorac Surg 2024; doi:10.1093/ejcts/ezae269.

Full circumferential human tracheal replacement: a systematic review

Briac Thierry [a,b,*], Lousineh Arakelian[b,c], Françoise Denoyelle[a], Jérôme Larghero[b,c] and Alain Wurtz[d]

Integral Review on Total Circumferential Replacement of the Human Trachea

Journal:	*Ear, Nose & Throat Journal*
Manuscript ID	EAR-24-0847
Manuscript Type:	Review
Date Submitted by the Author:	05-Oct-2024
Complete List of Authors:	Liang, Yu; The First Hospital of Jilin University, The Third Operating Room Wei, Shixiong; The First Hospital of Jilin University, General Surgery Center Zhang, Kunyu; Jilin University, General Surgery Center Yin, Ming; The First Hospital of Jilin University, The Third Operating Room Zhang, Anling; Jilin Provincial FAW General Hospital, Department of Anesthesiology
Keywords:	Cancer, Head and neck, Tracheostomy, Surgery
	Comprehensive Circumferential Tracheal Reconstruction (CCTR) remains a formidable challenge in surgery, typically reserved for uncommon extensive tracheal resections, lacking standardized approaches in both

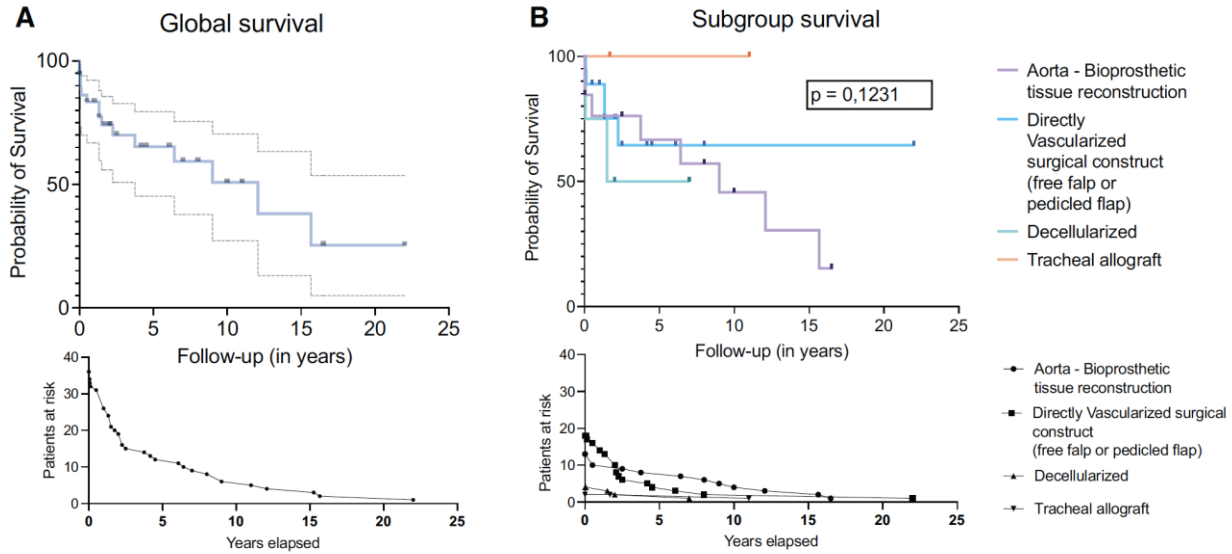


Figure 3: Kaplan–Meier survival graphs. (**A**) All cases (95% CI in dotted lines); (**B**) Subgroup analysis according to reconstruction technique. Lower charts stand for patients-at-risk. The dotted lines represent the 95% confidence interval. For reasons of clarity, they are not shown on the subgroup analysis curve. Marks on curves represent censored data.

Figure originale

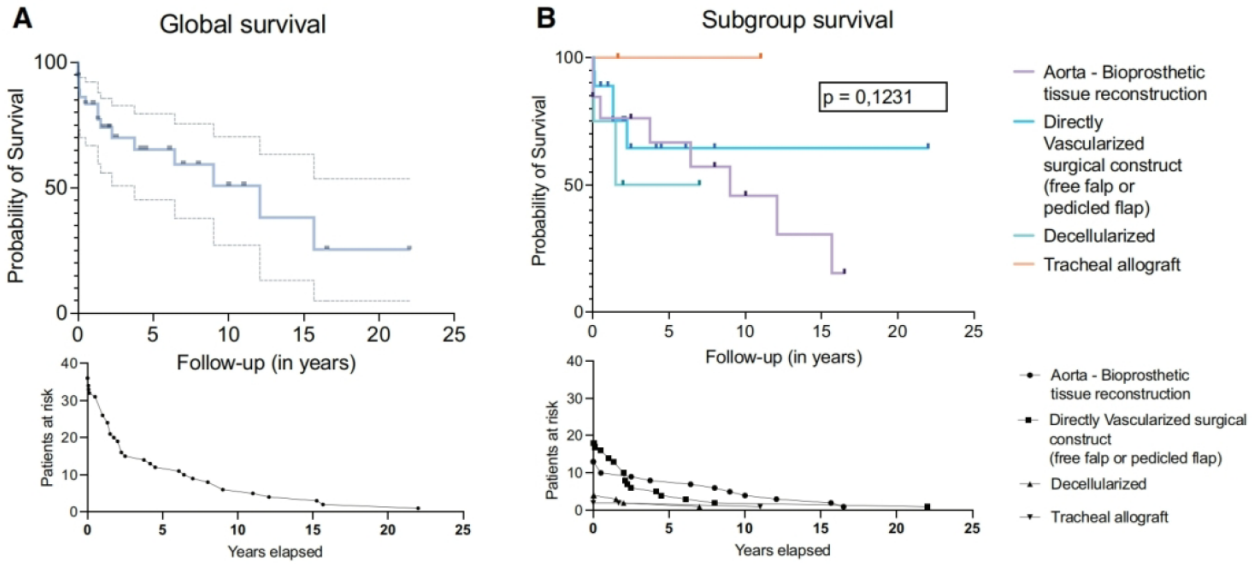


Figure 2. Kaplan-Meier survival Curves

Plagiat

Ithenticate software

ORIGINALITY REPORT

14%
SIMILARITY INDEX

PRIMARY SOURCES

1	Briac Thierry, Lousineh Arakelian, Françoise Denoyelle, Jérôme Larghero, Alain Wurtz. "Full circumferential human tracheal replacement: a systematic review", European Journal of Cardio-Thoracic Surgery, 2024 Crossref	649 words — 7%
2	Kihong Park, Wookyung Jeon, Pengzhan Liu, Sanghuck Jeon, Seokjun Hong, Sanghyeon Park, Taesung Kim. "Effects of Gas-Dissolved Water for Ceria Nanoparticles on the SiO2 Film Surface in Post-CMP Cleaning", ECS Journal of Solid State Science and Technology, 2024 Crossref	99 words — 1%
3	www.frontiersin.org Internet	66 words — 1%
4	www.research.manchester.ac.uk Internet	50 words — 1%

Data fabrication

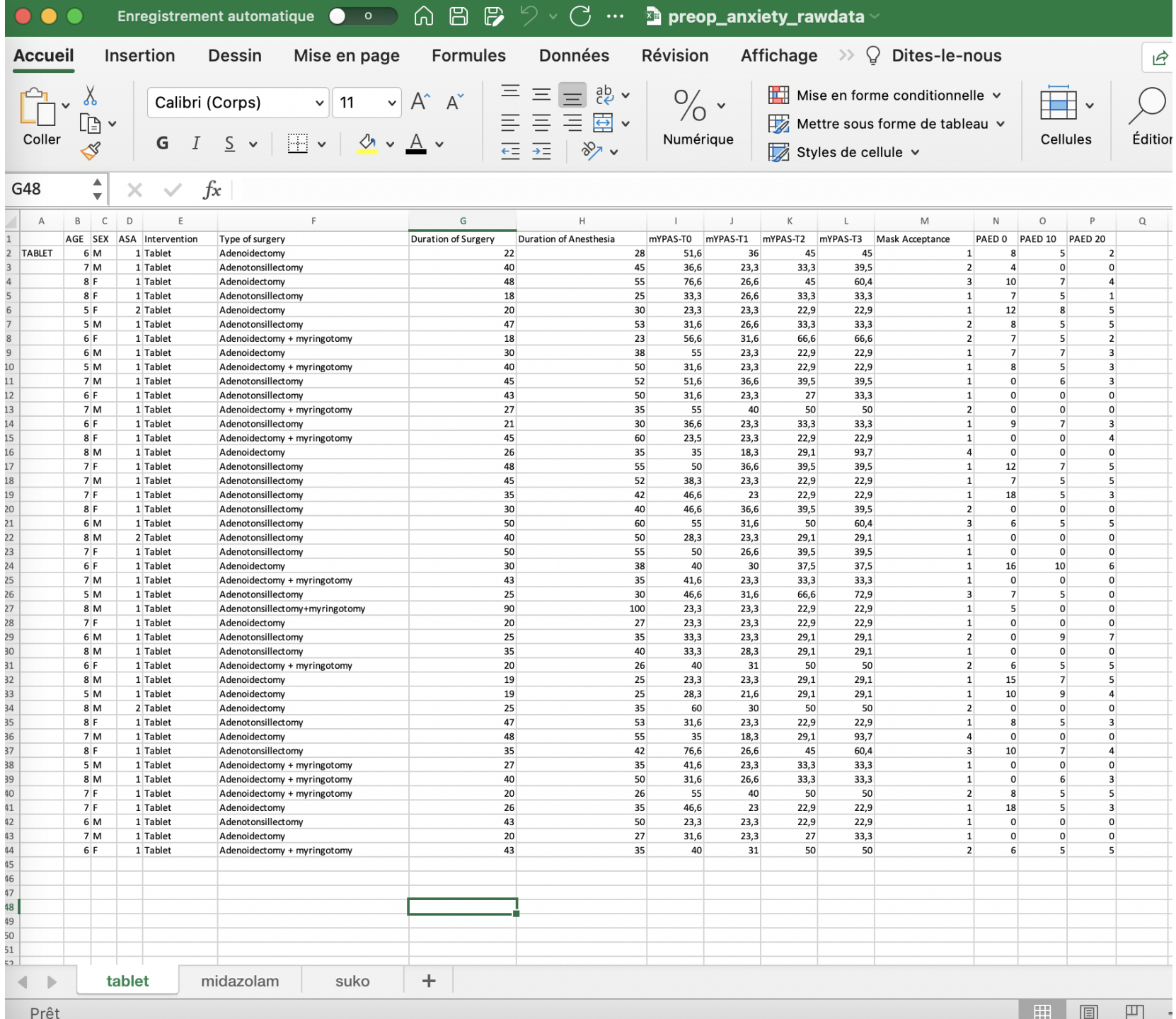
De: **SAMAMA Marc** marc.samama@aphp.fr
Objet: Request for raw data
Date: 28 octobre 2021 à 11:56
À: [redacted]@gmail.com
Cc: Daniel Hyde Daniel.Hyde@wolterskluwer.com

Sir,

We, in EJA, have strong and multiple contacts with all Editors-in-Chief of important Anaesthesiology journals.
As you know, Anaesthesia and Intensive Care recently requested your raw data for a manuscript that you submitted in July.
We have now some concerns on the veracity of your data, and may have to consider withdrawing your manuscript: [redacted]

Therefore we need your raw data.
Best wishes

Charles Marc SAMAMA, MD, PhD, FCCP
Professor of Anaesthesiology and Intensive Care
Editor-in-Chief, European Journal of Anaesthesiology (EJA) and European Journal of Anaesthesiology and Intensive Care (EJAIC)



	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
1		AGE	SEX	ASA	Intervention	Type of surgery	Duration of Surgery	Duration of Anesthesia	mYPAS-T0	mYPAS-T1	mYPAS-T2	mYPAS-T3	Mask Acceptance	PAED 0	PAED 10	PAED 20	
2	TABLET	6	M	1	Tablet	Adenoidectomy	22	28	51,6	36	45	45	1	8	5	2	
3		7	M	1	Tablet	Adenotonsillectomy	40	45	36,6	23,3	33,3	39,5	2	4	0	0	
4		8	F	1	Tablet	Adenoidectomy	48	55	76,6	26,6	45	60,4	3	10	7	4	
5		8	F	1	Tablet	Adenotonsillectomy	18	25	33,3	26,6	33,3	33,3	1	7	5	1	
6		5	F	2	Tablet	Adenoidectomy	20	30	23,3	23,3	22,9	22,9	1	12	8	5	
7		5	M	1	Tablet	Adenotonsillectomy	47	53	31,6	26,6	33,3	33,3	2	8	5	5	
8		6	F	1	Tablet	Adenoidectomy + myringotomy	18	23	56,6	31,6	66,6	66,6	2	7	5	2	
9		6	M	1	Tablet	Adenoidectomy	30	38	55	23,3	22,9	22,9	1	7	7	3	
10		5	M	1	Tablet	Adenoidectomy + myringotomy	40	50	31,6	23,3	22,9	22,9	1	8	5	3	
11		7	M	1	Tablet	Adenotonsillectomy	45	52	51,6	36,6	39,5	39,5	1	0	6	3	
12		6	F	1	Tablet	Adenotonsillectomy	43	50	31,6	23,3	27	33,3	1	0	0	0	
13		7	M	1	Tablet	Adenoidectomy + myringotomy	27	35	55	40	50	50	2	0	0	0	
14		6	F	1	Tablet	Adenotonsillectomy	21	30	36,6	23,3	33,3	33,3	1	9	7	3	
15		8	F	1	Tablet	Adenoidectomy + myringotomy	45	60	23,5	23,3	22,9	22,9	1	0	0	4	
16		8	M	1	Tablet	Adenoidectomy	26	35	35	18,3	29,1	93,7	4	0	0	0	
17		7	F	1	Tablet	Adenotonsillectomy	48	55	50	36,6	39,5	39,5	1	12	7	5	
18		7	M	1	Tablet	Adenotonsillectomy	45	52	38,3	23,3	22,9	22,9	1	7	5	5	
19		7	F	1	Tablet	Adenotonsillectomy	35	42	46,6	23	22,9	22,9	1	18	5	3	
20		8	F	1	Tablet	Adenotonsillectomy	30	40	46,6	36,6	39,5	39,5	2	0	0	0	
21		6	M	1	Tablet	Adenotonsillectomy	50	60	55	31,6	50	60,4	3	6	5	5	
22		8	M	2	Tablet	Adenotonsillectomy	40	50	28,3	23,3	29,1	29,1	1	0	0	0	
23		7	F	1	Tablet	Adenotonsillectomy	50	55	50	26,6	39,5	39,5	1	0	0	0	
24		6	F	1	Tablet	Adenoidectomy	30	38	40	30	37,5	37,5	1	16	10	6	
25		7	M	1	Tablet	Adenoidectomy + myringotomy	43	35	41,6	23,3	33,3	33,3	1	0	0	0	
26		5	M	1	Tablet	Adenotonsillectomy	25	30	46,6	31,6	66,6	72,9	3	7	5	0	
27		8	M	1	Tablet	Adenotonsillectomy+myringotomy	90	100	23,3	23,3	22,9	22,9	1	5	0	0	
28		7	F	1	Tablet	Adenoidectomy	20	27	23,3	23,3	22,9	22,9	1	0	0	0	
29		6	M	1	Tablet	Adenotonsillectomy	25	35	33,3	23,3	29,1	29,1	2	0	9	7	
30		8	M	1	Tablet	Adenotonsillectomy	35	40	33,3	28,3	29,1	29,1	1	0	0	0	
31		6	F	1	Tablet	Adenoidectomy + myringotomy	20	26	40	31	50	50	2	6	5	5	
32		8	M	1	Tablet	Adenoidectomy	19	25	23,3	23,3	29,1	29,1	1	15	7	5	
33		5	M	1	Tablet	Adenoidectomy	19	25	28,3	21,6	29,1	29,1	1	10	9	4	
34		8	M	2	Tablet	Adenoidectomy	25	35	60	30	50	50	2	0	0	0	
35		8	F	1	Tablet	Adenotonsillectomy	47	53	31,6	23,3	22,9	22,9	1	8	5	3	
36		7	M	1	Tablet	Adenoidectomy	48	55	35	18,3	29,1	93,7	4	0	0	0	
37		8	F	1	Tablet	Adenotonsillectomy	35	42	76,6	26,6	45	60,4	3	10	7	4	
38		5	M	1	Tablet	Adenoidectomy + myringotomy	27	35	41,6	23,3	33,3	33,3	1	0	0	0	
39		8	M	1	Tablet	Adenoidectomy + myringotomy	40	50	31,6	26,6	33,3	33,3	1	0	6	3	
40		7	F	1	Tablet	Adenoidectomy + myringotomy	20	26	55	40	50	50	2	8	5	5	
41		7	F	1	Tablet	Adenoidectomy	26	35	46,6	23	22,9	22,9	1	18	5	3	
42		6	M	1	Tablet	Adenotonsillectomy	43	50	23,3	23,3	22,9	22,9	1	0	0	0	
43		7	M	1	Tablet	Adenoidectomy	20	27	31,6	23,3	27	33,3	1	0	0	0	
44		6	F	1	Tablet	Adenoidectomy + myringotomy	43	35	40	31	50	50	2	6	5	5	
45																	
46																	
47																	
48																	
49																	
50																	
51																	

	AGE	SEX	ASA	Intervention	Type of surgery	Duration of Surgery	Duration of Anesthesia	mYPAS-T0	mYPAS-T1	mYPAS-T2	mYPAS-T3	Mask Acceptance
TABLET	6	M	1	Tablet	Adenoidectomy	22	28	51,6	36	45	45	1
	7	M	1	Tablet	Adenotonsillectomy	40	45	36,6	23,3	33,3	39,5	2
	8	F	1	Tablet	Adenoidectomy	48	55	76,6	26,6	45	60,4	3
	8	F	1	Tablet	Adenotonsillectomy	18	25	33,3	26,6	33,3	33,3	1
	5	F	2	Tablet	Adenoidectomy	20	30	23,3	23,3	22,9	22,9	1
	5	M	1	Tablet	Adenotonsillectomy	47	53	31,6	26,6	33,3	33,3	2
	6	F	1	Tablet	Adenoidectomy + myringotomy	18	23	56,6	31,6	66,6	66,6	2
	6	M	1	Tablet	Adenoidectomy	30	38	55	23,3	22,9	22,9	1
	5	M	1	Tablet	Adenoidectomy + myringotomy	40	50	31,6	23,3	22,9	22,9	1
	7	M	1	Tablet	Adenotonsillectomy	45	52	51,6	36,6	39,5	39,5	1
	6	F	1	Tablet	Adenotonsillectomy	43	50	31,6	23,3	27	33,3	1
	7	M	1	Tablet	Adenoidectomy + myringotomy	27	35	55	40	50	50	2
	6	F	1	Tablet	Adenotonsillectomy	21	30	36,6	23,3	33,3	33,3	1
	8	F	1	Tablet	Adenoidectomy + myringotomy	45	60	23,5	23,3	22,9	22,9	1
	8	M	1	Tablet	Adenoidectomy	26	35	35	18,3	29,1	93,7	4
	7	F	1	Tablet	Adenotonsillectomy	48	55	50	36,6	39,5	39,5	1
	7	M	1	Tablet	Adenotonsillectomy	45	52	38,3	23,3	22,9	22,9	1
	7	F	1	Tablet	Adenotonsillectomy	35	42	46,6	23	22,9	22,9	1
	8	F	1	Tablet	Adenotonsillectomy	30	40	46,6	36,6	39,5	39,5	2
	6	M	1	Tablet	Adenotonsillectomy	50	60	55	31,6	50	60,4	3
	8	M	2	Tablet	Adenotonsillectomy	40	50	28,3	23,3	29,1	29,1	1
	7	F	1	Tablet	Adenotonsillectomy	50	55	50	26,6	39,5	39,5	1
	6	F	1	Tablet	Adenoidectomy	30	38	40	30	37,5	37,5	1
	7	M	1	Tablet	Adenoidectomy + myringotomy	43	35	41,6	23,3	33,3	33,3	1
	5	M	1	Tablet	Adenotonsillectomy	25	30	46,6	31,6	66,6	72,9	3
	8	M	1	Tablet	Adenotonsillectomy+myringotomy	90	100	23,3	23,3	22,9	22,9	1
	7	F	1	Tablet	Adenoidectomy	20	27	23,3	23,3	22,9	22,9	1
	6	M	1	Tablet	Adenotonsillectomy	25	35	33,3	23,3	29,1	29,1	2
	8	M	1	Tablet	Adenotonsillectomy	35	40	33,3	28,3	29,1	29,1	1
	6	F	1	Tablet	Adenoidectomy + myringotomy	20	26	40	31	50	50	2
	8	M	1	Tablet	Adenoidectomy	19	25	23,3	23,3	29,1	29,1	1
	5	M	1	Tablet	Adenoidectomy	19	25	28,3	21,6	29,1	29,1	1
	8	M	2	Tablet	Adenoidectomy	25	35	60	30	50	50	2
	8	F	1	Tablet	Adenotonsillectomy	47	53	31,6	23,3	22,9	22,9	1
	7	M	1	Tablet	Adenoidectomy	48	55	35	18,3	29,1	93,7	4
	8	F	1	Tablet	Adenotonsillectomy	35	42	76,6	26,6	45	60,4	3
	5	M	1	Tablet	Adenoidectomy + myringotomy	27	35	41,6	23,3	33,3	33,3	1
	8	M	1	Tablet	Adenoidectomy + myringotomy	40	50	31,6	26,6	33,3	33,3	1
	7	F	1	Tablet	Adenoidectomy + myringotomy	20	26	55	40	50	50	2
	7	F	1	Tablet	Adenoidectomy	26	35	46,6	23	22,9	22,9	1
	6	M	1	Tablet	Adenotonsillectomy	43	50	23,3	23,3	22,9	22,9	1
	7	M	1	Tablet	Adenoidectomy	20	27	31,6	23,3	27	33,3	1
	6	F	1	Tablet	Adenoidectomy + myringotomy	43	35	40	31	50	50	2

De: [redacted]
Objet: Re: Request for raw data
Date: 4 novembre 2021 à 21:21
À: SAMAMA Marc marc.samama@aphp.fr

Dear Editor,

- I am sending you the same spreadsheet that I sent to you before.
  - I added only the PAED data to the spreadsheet. All other data are the same.
  - I thought that you might have not seen the whole data since all the data for 3 groups were on the same sheet and they were separated by empty lines. So, I created different sheets for each 3 groups in order you to observe them better.
- I attached 138 individual data sheets of all the patients included and excluded in 3 groups. The patient number 18, 25, 41 in the tablet group and the patient number 37 in the şuko group were excluded from the study. Although the datasheets of the excluded patients exist in the attachment, the data of the excluded patients do not exist on the spreadsheet since these patients were excluded.

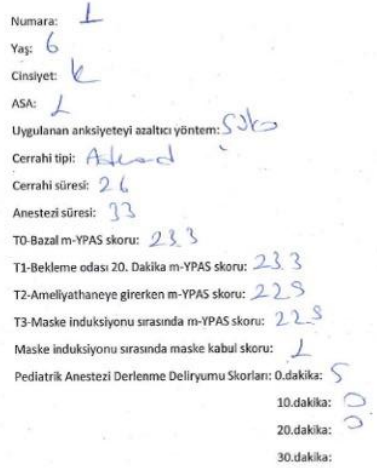
Notes:

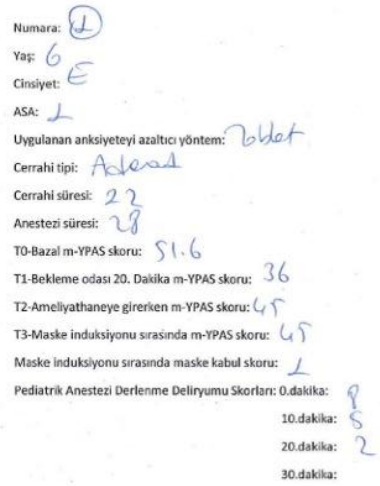
- **I worked really hard for this study, and I am really sorry and disappointed about finding myself in this posi9on. I am very willing to present to you any further data or documents to remove the doubts you have. I was the only one who collected the data and the handwri9ng on the datasheets belongs to me. That is why I can guarantee the veracity of our data.**
- In our study, emergence delirium was evaluated using the Pediatric Anesthesia Emergence Delirium (PAED) scale in the PACU. So, the datasheets include the PAED data. The first manuscript that we submitted to the journal included these PAED data. However, your reviewers criticized that we could not evaluate the emergence delirium without evaluating post-operative pain. So, we excluded the PAED data in the revised manuscript. That is why we did not put the PAED data in the first spreadsheet that we sent to you. In the spreadsheet that I am sending you in this email and on the datasheets, you can observe the PAED data also.
- In our study, mask acceptance was rated as excellent, good, moderate and poor. However, in the datasheets, you will observe numbers as 1, 2, 3 and 4. The meaning of the numbers are as follows:
  - 1: excellent
  - 2: good
  - 3: moderate
  - 4: poor

Your sincerely
[redacted]

SAMAMA Marc <marc.samama@aphp.fr>, 3 Kas 2021 Çar, 14:08 tarihinde şunu yazdı:

> Dear colleague,
>
> We just checked the raw data spreadsheet you sent us and, unfortunately, we are worried about the veracity of your data. Therefore, in order to remove any doubt, we need to receive a copy of the 134 individual data sheets from your study (attached) for all the children included (three groups).
> Best wishes
>
> Charles Marc SAMAMA, MD, PhD, FCCP
> Professor of Anaesthesiology and Intensive Care
> Editor-in-Chief, European Journal of Anaesthesiology (EJA) and European Journal of Anaesthesiology and Intensive Care (EJAIC)


Numara: 1
Yaş: 6
Cinsiyet: K
ASA: 1
Uygulanan anksiyeteyi azaltıcı yöntem: Şüko
Cerrahi tipi: Adenoid
Cerrahi süresi: 26
Anestezi süresi: 33
T0-Bazal m-YPAS skoru: 23.3
T1-Bekleme odası 20. Dakika m-YPAS skoru: 23.3
T2-Ameliyathaneye girerken m-YPAS skoru: 22.9
T3-Maske induksiyonu sırasında m-YPAS skoru: 22.9
Maske induksiyonu sırasında maske kabul skoru: 1
Pediatrik Anestezi Derlenme Deliryumu Skorları: 0.dakika: 5
10.dakika: 0
20.dakika: 0
30.dakika:


Numara: 41
Yaş: 6
Cinsiyet: E
ASA: 1
Uygulanan anksiyeteyi azaltıcı yöntem: Tablet
Cerrahi tipi: Adenoid
Cerrahi süresi: 22
Anestezi süresi: 28
T0-Bazal m-YPAS skoru: 51.6
T1-Bekleme odası 20. Dakika m-YPAS skoru: 36
T2-Ameliyathaneye girerken m-YPAS skoru: 45
T3-Maske induksiyonu sırasında m-YPAS skoru: 45
Maske induksiyonu sırasında maske kabul skoru: 1
Pediatrik Anestezi Derlenme Deliryumu Skorları: 0.dakika: 8
10.dakika: 5
20.dakika: 2
30.dakika:

De: [redacted]
Objet: Re: Request for raw data
Date: 8 novembre 2021 à 09:02
À: SAMAMA Marc marc.samama@aphp.fr

Dear Editor,
We used the m-YPAS scale in the Kain et al.'s article titled " The Yale Preoperative Anxiety Scale: How Does It Compare with a "Gold Standard"? ". We calculated the m-YPAS values as it is told in this article. ''The m-YPAS consists of 22 items in five categories (activity, emotional expressivity, state of arousal, vocalization, and use of parents). The highest behavioral level observed in each of the five m-YPAS categories is the score for that category. Because each category of the m-YPAS has a different number of items (either four or six), partial weights were calculated and then added to a total score. For example, for two categories containing four and six items, with a score of 1 in each category, the calculation is: (1/4 + 1/6) X 100/2 = total adjusted score.''

We used five categories for T0 and T1 and four categories for T2 and T3, since parents were not taken to the operating room. Although different scores are given for different categories, the calculated total score of different patients may be the same due to the calculation formula.

I will tell the calculation by giving you an example:

- In tablet group, the patient number 12 and the patient number 42 both have mYPAS-T0 value of 55. Although they are the same, their category values in the scale are different. As you can check from the scale data in the attachment, the patient number 12 has category values of 2-3-2-2-3 and the patient number 42 has category values of 3-3-2-2-2.
- If we calculate the mYPAS-T0 values for both of the patients according to the formula;
  - The patient number 12: (2/4 + 3/6 + 2/4 + 2/4 + 3/4) * 100 / 5 = 55.0
  - The patient number 42: (3/4 + 3/6 + 2/4 + 2/4 + 2/4) * 100 / 5 = 55.0

As you can see, although the category values of different patients are different, their total score might become the same. That is the reason for similarities in the spreadsheet that I sent to you before.
I attached the mYPAS scale for each patient included in the study. You can see that the patients with the same total scores do not have the same category values.

Yours sincerely
[redacted]

mypas

SAMAMA Marc <marc.samama@aphp.fr>, 5 Kas 2021 Cum, 16:02 tarihinde şunu yazdı:

> Dear colleague,
>
> It took me some time to check your individual data and I agree that the figures in the Excel sheet represent exactly the personal data. Our concern is about the replication of some columns or lines (see preop_anxiety_rawdata- analysis 1 and preop_anxiety_rawdata- analysis 2). How do you explain such similarities? Its almost impossible by chance. Could you please explain us how you calculate the mYPAS-T values, as the explanation may be found here

EJA

Eur J Anaesthesiol 2023; **40**:1–1

EXPRESSION OF CONCERN

Which is good for pre-operative anxiety? Midazolam, video games or teaching with cartoons. A randomised trial: Expression of concern

We regret to inform our readers that potentially uncertain data have been identified in the published article, "Which is good for pre-operative anxiety? Midazolam, video games or teaching with cartoons: A randomised trial".[1]

A review by several members of the anaesthesia community has revealed inconsistencies between the raw data and the published data, therefore, we have decided to publish an expression of concern as the data in this article can be used to influence clinical practice.

In the meantime, further investigation is ongoing.

Reference

1 Sakızcı Uyar B, Polat R, Bolat M, Donmez A. Which is good for pre-operative anxiety? Midazolam, video games or teaching with cartoons: A randomised trial. *Eur J Anaesthesiol* 2021; **38**:744–750.

grup	Patient	Age	bmi	asa	sex	anesth tim	surg tim	VAS 1 min	VAS 15 min	VAS30min	VAS 1 hr	VAS 2 hr	VAS 6hr	VAS 12 hr	VAS 24 hr	bks 30 dk
G	1	33	19	1	k	85	70	4	4	3	3	2	2	2	1	0
G	2	45	31	1	e	110	100	2	2	1	1	2	1	1	1	0
G	3	40	26	1	k	80	70	2	2	2	1	1	1	1	1	2
G	4	55	28	1	e	100	80	2	2	2	2	2	2	0	0	0
G	5	61	27	1	e	100	84	2	2	2	1	1	1	1	1	0
G	6	35	24	2	k	110	97	3	3	5	2	2	1	0	0	0
G	7	33	19	1	k	85	70	4	4	3	3	2	2	2	1	0
G	8	45	31	1	e	110	100	2	2	1	1	2	1	1	1	0
G	9	40	26	1	k	80	70	2	2	2	1	1	1	1	1	2
G	10	57	27	2	e	95	80	0	0	0	0	0	2	2	0	0
G	11	57	30	1	k	90	80	1	1	1	1	1	1	1	1	0
G	12	31	20	1	e	90	75	2	1	1	2	2	1	1	0	0
G	13	47	26	2	e	75	65	2	2	1	3	2	2	1	0	0
G	14	54	30	1	e	102	96	1	1	0	0	0	1	2	1	0
G	15	45	24	1	e	90	80	0	0	1	0	0	0	0	0	0
G	16	39	28	2	k	97	85	0	0	0	0	0	0	0	0	0
G	17	57	27	2	e	95	80	0	0	0	0	0	2	2	0	0
G	18	57	30	1	k	90	80	1	1	1	1	1	1	1	1	0
G	19	35	24	2	k	110	97	3	3	5	2	2	1	0	0	0
G	20	33	19	1	k	85	70	4	4	3	3	2	2	2	1	0
A	21	56	28	2	k	90	75	0	0	0	1	1	0	1	1	0
A	22	60	23	2	k	85	73	4	4	3	3	3	2	1	1	0
A	23	39	27	2	e	108	83	1	0	0	0	0	0	0	0	0
A	24	44	26	1	k	94	80	2	2	2	2	2	2	2	1	0
A	25	28	25	1	k	95	80	1	1	1	2	2	1	1	1	0
A	26	51	29	2	k	75	65	2	2	2	2	3	2	1	1	0
A	27	36	29	1	k	100	80	1	1	0	0	0	0	0	0	1
A	28	43		1	e	80	65	0	0	0	1	1	1	1	0	0
A	29	55	28	1	e	100	93	0	1	1	1	1	0	0	0	0
A	30	61	26	2	e	90	80	2	2	1	0	1	0	0	0	0
A	31	46	31	2	e	98	90	1	1	1	0	0	0	0	0	0
A	32	36	19	1	k	95	82	1	1	1	2	1	1	2	1	2
A	33	49	28	1	e	90	85	2	2	1	1	1	1	1	1	0
A	34	45	27	1	k	95	80	0	0	0	0	0	0	0	0	0
A	35	34	25	1	e	95	80	0	1	2	2	1	2	2	1	0
A	36	32	30	1	e	100	80	0	1	1	2	2	2	0	0	0
A	37	51	29	2	k	75	65	2	2	2	2	3	2	1	1	0
A	38	36	29	1	k	100	80	1	1	0	0	0	0	0	0	1
A	39	43		1	e	80	65	0	0	0	1	1	1	1	0	0
A	40	56	28	2	k	90	75	0	0	0	1	1	0	1	1	0
K	41	22	21	1	e	95	75	4	5	2	1	1	2	2	0	0

EJA

Eur J Anaesthesiol 2024; **41**:153

Which is good for pre-operative anxiety? Midazolam, video games or teaching with cartoons. A randomised trial: Retraction

Further to the publication of the Expression of Concern [1] concerning the article, ''Which is good for pre-operative anxiety? Midazolam, video games or teaching with cartoons: A randomised trial'',[2] the Editorial Board has decided to retract this article from the *European Journal of Anaesthesiology*.

Following careful analyses of the manuscript and the raw data, we have concluded that there are inconsistencies between the raw and published data.

After the Journal published the Expression of Concern, the Editorial Board requested an additional review and analysis from an international expert who confirmed the inconsistencies. The authors and the local Scientific Integrity Officer have been informed of this impending retraction, but we have not received a response.

This article is retracted.

References

1 Which is good for pre-operative anxiety? Midazolam, video games or teaching with cartoons. A randomised trial: Expression of concern. *Eur J Anaesthesiol* 2023; **40**:800.

2 Sakızcı Uyar B, Polat R, Bolat M, Donmez A. Which is good for pre-operative anxiety? Midazolam, video games or teaching with cartoons: A randomised trial. *Eur J Anaesthesiol* 2021; **38**:744–750.

Mauvaise qualité

European Journal of Anaesthesiology

Gender (dis)parity on editorial boards of anaesthesiology journals: a cross–sectional study

--Manuscript Draft--

Manuscript Number:	
Full Title:	Gender (dis)parity on editorial boards of anaesthesiology journals: a cross–sectional study
Short Title:	Women on anesthesiology journals' editorial boards
Article Type:	Original Article
Corresponding Author:	[redacted]

Setting: The data collected from the official websites of the journals between 15 August–September 2022.

Table 2. Gender Distribution of the Journals' Editorial Boards and Editors–in–Chief

Journals	Editorial board		Editor–in–chief		
	Women (*n*=502)	Men (*n*=1596)	Number (*n*=37)	Women (*n*=1)	Men (*n*=36)
European Journal of Anaesthesiology	1 (4.2)	23 (95.8)	1	0	1

14 femmes sur un total de 31 éditeurs à ce moment là (été 2022)= 45%

Date: 16-07-2023
To: "Mehmet Nuri Yakar" dr.nuriyakar@gmail.com
From: "" eja@theeditorialhub.com
Subject: EJA Decision

16-07-2023

Dear Mr. Yakar,

RE: EJA-D-23-00520, entitled "Gender (dis)parity on editorial boards of anaesthesiology journals: a cross–sectional study"

Thank you for submitting your paper to the European Journal of Anaesthesiology for review. The immediate decision was that it cannot be considered for publication. We publish studies that are likely to change the clinical practice and/or the education in the field, and only if they reach a minimal international scientific level. Your study does not fulfill these criteria as the figures related to EJA are completely wrong. In August 2022 there was not 1 woman and 23 men in the Editorial Board as you stated in table 2, but 14 women and 17 men (i.e. 45% of female editors). This was the highest parity score in anaesthesiology journals at that time. I'm anxious about the quality of your data for the other journals...

Yours sincerely

Prof. Charles Marc Samama
Editor in Chief
European Journal of Anaesthesiology

Anaesthesia 2020 doi:10.1111/anae.15263

Original Article

False individual patient data and zombie randomised controlled trials submitted to *Anaesthesia*

J. B. Carlisle[1,2]

1 Consultant, Department of Peri-operative Medicine and Anaesthesia, 2 Consultant, Department of Intensive Care Medicine, Torbay Hospital, Torquay, UK

Baseline summary data of randomised controlled trials when they were submitted **to Anaesthesia** from February 2017 to March 2020. Trials categorised with false data as 'zombie' if I thought that the trial was fatally flawed.

526 submitted trials: 73 (14%) had false data and 43 (8%) were categorised as zombie.

Individual patient data increased detection of false data and categorisation of trials as zombie compared with trials without individual patient data: 67/153 (44%) false vs. 6/373 (2%) false; and 40/153 (26%) zombie vs. 3/373 (1%) zombie, respectively.

« Journals should assume that all submitted papers are potentially flawed and editors should review individual patient data before publishing randomised controlled trials. »

Enregistrement

Low-dose esketamine infusion after spinal anesthesia improves the quality of recovery in patients undergoing elective cesarean section: A Randomized, Double-Blind, Controlled Trail

Qi Yu[a*], Zhou Meiyan[a*], Dong Yaqi[a*], Zheng Wenting[a], Li Weihua[b], Wang Xinghe[a], Sun Jia[a], Zhou Hai[a], Hu Zhengquan[a#], Wang Liwei[a#]

Trial registration: China Clinical Trial Registry, identifier: ChiCTR2200064235

ClinicalTrials.gov is a database of privately and publicly funded clinical studies conducted around the world.

Explore 464,375 research studies in all 50 states and in 221 countries.

See listed clinical studies related to the coronavirus disease (COVID-19)

ClinicalTrials.gov is a resource provided by the U.S. National Library of Medicine.

IMPORTANT: Listing a study does not mean it has been evaluated by the U.S. Federal Government. Read our disclaimer for details.

Before participating in a study, talk to your health care provider and learn about the risks and potential benefits.

Find a study (all fields optional)

Status

- ○ Recruiting and not yet recruiting studies
- ● All studies

Condition or disease (For example: breast cancer)

Other terms (For example: NCT number, drug name, investigator name)

Country

Search | Advanced Search

From: "SAMAMA Marc"<marc.samama@aphp.fr>;
Date: Fri, Jun 23, 2023 07:16 PM
To: "chictr001@chictr.org.cn"<chictr001@chictr.org.cn>; "chictr002@chictr.org.cn"<chictr002@chictr.org.cn>;
Subject: Wrong registration or fabricated data?

Sir,
The European Journal of Anesthesiology (EJA) has received the attached manuscript as a regular submission. As usual, we checked the registration number and found a completely different study. We are wondering whether the submitted study has been registered elsewhere or if the data are fabricated?
How could you explain that the authors submitted the study "*Effectiveness and safety of ciprofol for induction and maintenance of general anaesthesia in urological surgery patients: a randomized, single-blinded non-inferiority study* » although the registration number (ChiCTR2100049750) drives to a completely different study "*Clinical observational study of remimazolam tosilate combined with dexmedetomidine and butorphanol for sedation during ERCP in very elderly patients* »?
Do we need to notify this potential misconduct to the Wuhan authorities?

De: 郝园 chictr002@chictr.org.cn
Objet: Re:Wrong registration or fabricated data?
Date: 30 août 2023 à 10:11
À: SAMAMA Marc marc.samama@aphp.fr
Cc: 吴泰相 chictr001@chictr.org.cn, 孔翔瑜 chictr003@chictr.org.cn

郝

Dear Charles Marc SAMAMA,

Very sorry for the late reply because of the mountain of emails.

We've already contacted the corresponding author, Zhang Fan. Through a phone conversation, we learned that he provided the wrong registration number to the journal and that ChiCTR2100049750 was a completely different study. Dr. Zhang said he made a retrospective registration for ''Effectiveness and safety of ciprofol for induction and maintenance of general anaesthesia in urological surgery patients: a randomized, single-blinded non-inferiority study'' and got the registration number ChiCTR2300072767. However, the records show the study is observational, not interventional, and not even randomized design. We have already informed Director Wang (the Research Department of Wuhan Renmin Hospital) of what we have learned so far and hope to find the truth with her help.

Thanks for your feedback

Best Regards,

Yuan

中国临床试验注册中心
世界卫生组织国际临床试验平台一级注册机构
Chinese Clinical Trial Registry
A Primary Registry of International Clinical Trial Registry Platform, World Health Organization

Revues prédatrices

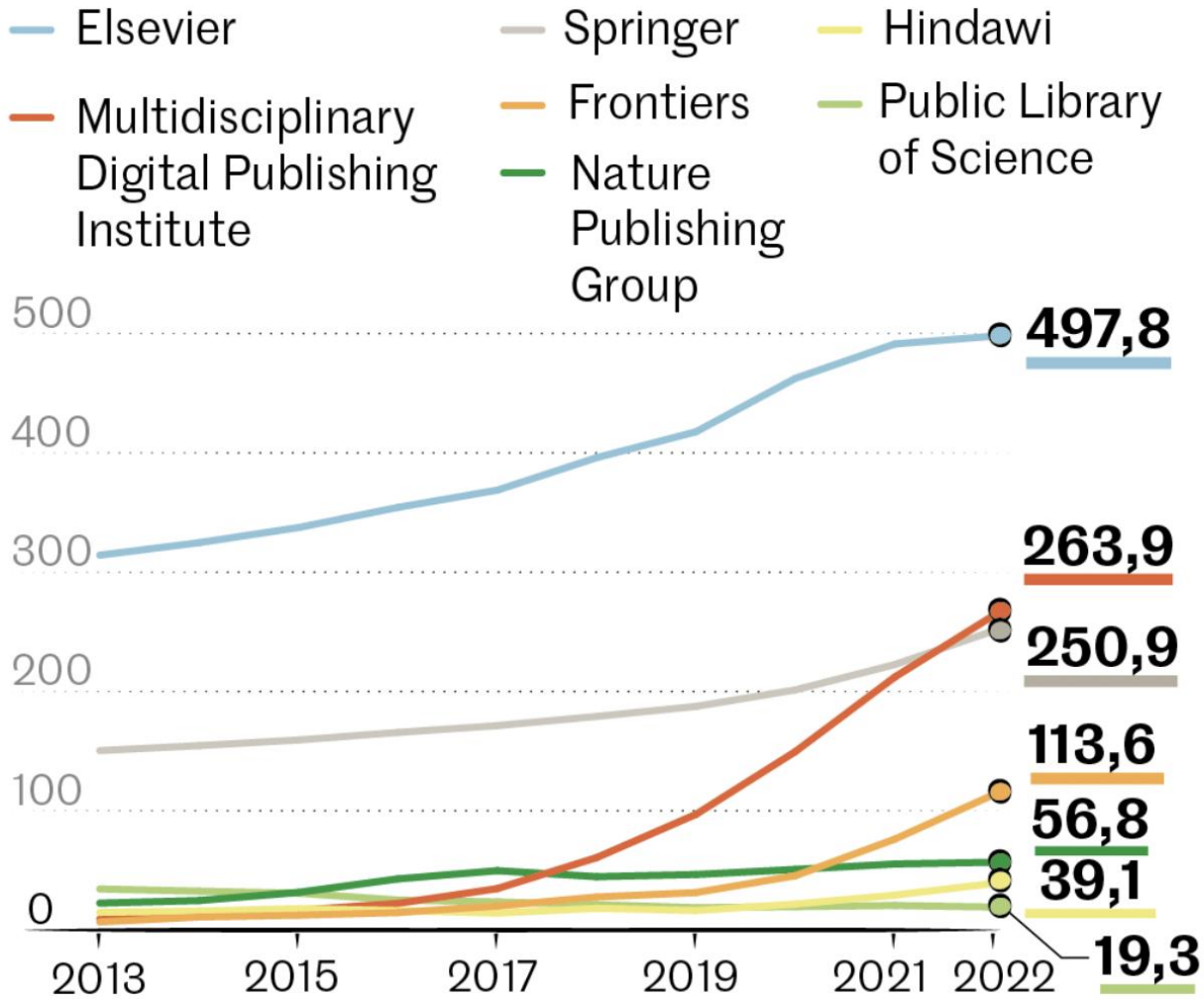
Juillet 2025

ENQUÊTE | **Plus de trois millions d'articles sont publiés chaque année dans les revues scientifiques, les chercheurs étant incités à les multiplier pour se distinguer. Une logique économique perverse s'est installée, qui profite d'abord aux grands éditeurs et encourage les fraudes les plus inattendues. Des propositions alternatives émergent pour sauver le partage des connaissances.**

Par David Larousserie

Trop d'articles

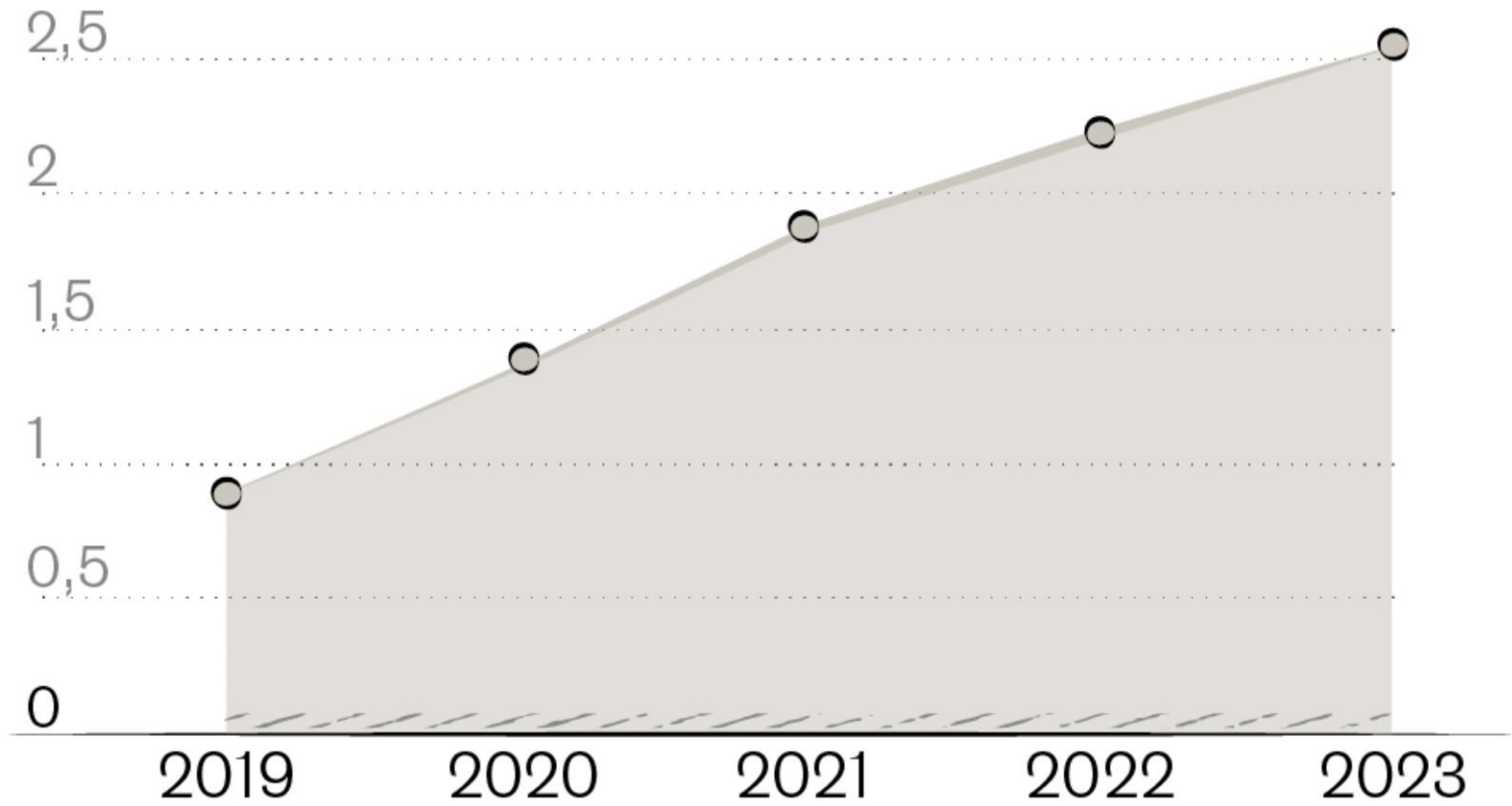
Nombre d'articles publiés par éditeur en milliers



Infographie *Le Monde*

Sources : Haustein et al. (2024) ; Hanson et al. (2024) ; Retraction Watch

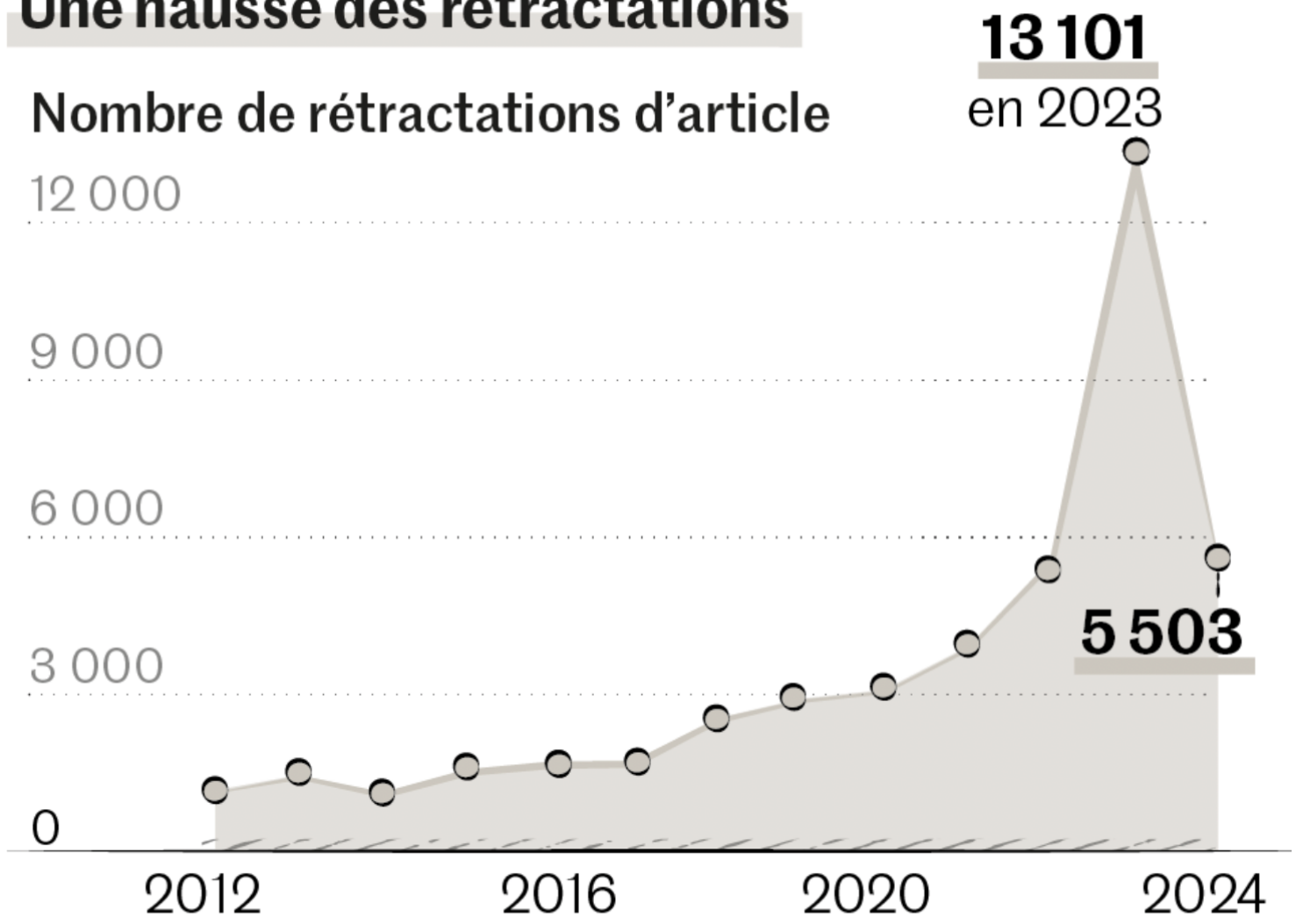
Estimation des frais de publication payés par les auteurs aux six plus grands éditeurs, en milliards de dollars



Infographie *Le Monde*

Sources : Haustein et al. (2024) ; Hanson et al. (2024) ; Retraction Watch

Une hausse des rétractations



Infographie *Le Monde*

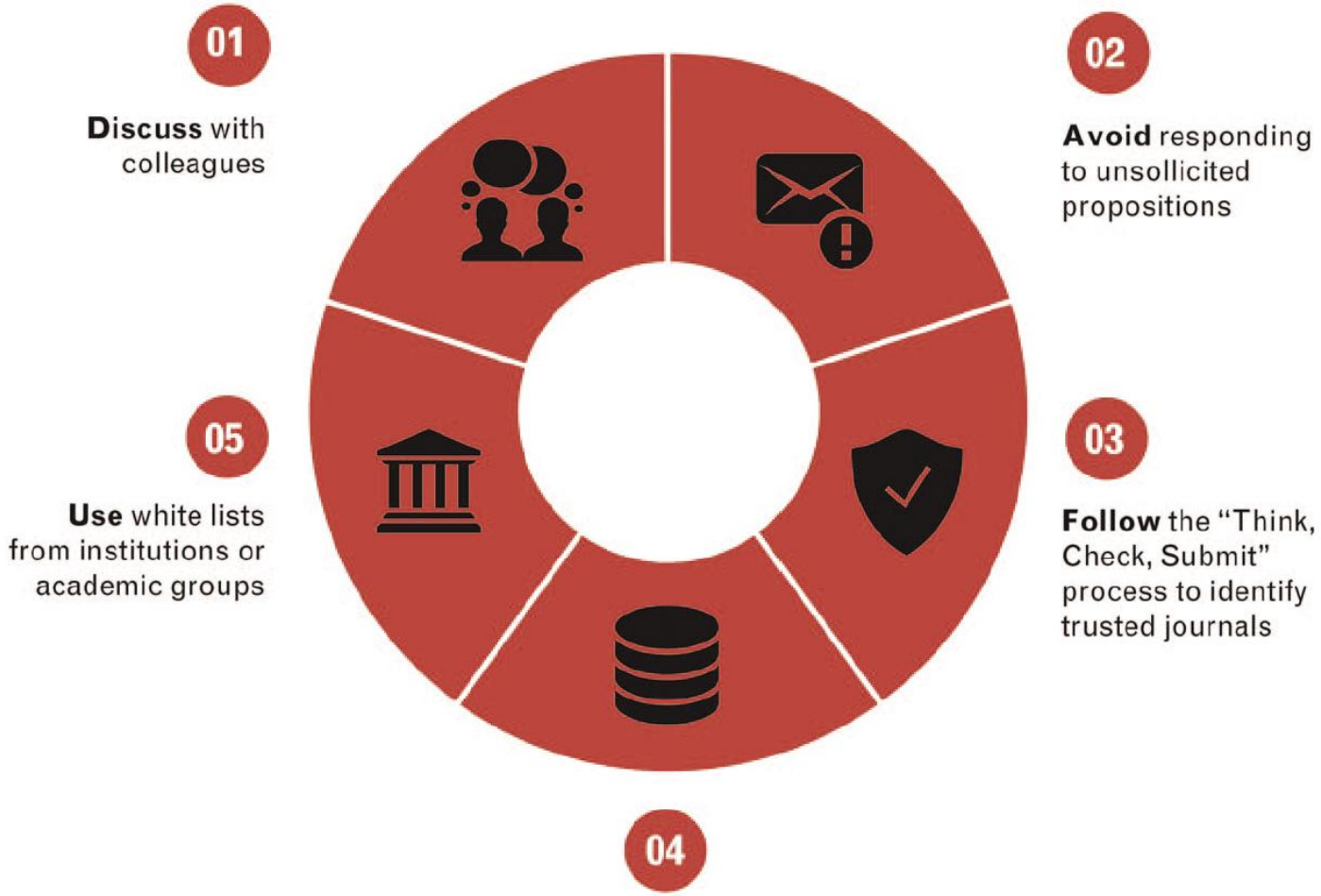
Sources : Haustein et al. (2024) ; Hanson et al. (2024) ; Retraction Watch

Predatory journals in anaesthesiology and critical care: what to know and how to avoid pitfalls!

Sacha Rozencwajg, Nathan Peiffer-Smadja, Arthur James and Elie Kantor

European Journal of Anaesthesiology 2022, 39:299–301

Fig. 1 Venn diagram of different tools proposed to avoid predatory journals



JCR (Journal Citation Reports)

https://jcr.clarivate.com/jcr/home?app=jcr&referrer=target%3Dhttps:%2F%2Fjcr.clarivate.com%2Fjcr%2Fhome&Init=Yes&authCode=BU1qn1ZkoGu92tWoC3Op-51Yak_gsM_AfaxygsOIqwA&SrcApp=IC2LS

- Printed Journal
- Refereed Journal
- Peer Reviewed Journal

P-ISSN: 2664-3766
E-ISSN: 2664-3774

International Journal of Medical Anesthesiology

Journal is inviting manuscripts for its coming issue. **Contact us** for more details.

Subscribe Print Journal

Recommend this journal TO YOUR LIBRARY

SIDEBAR
- Home
- Editorial Board
- Instructions to Author
- Archives
- Indexing and Abstracting
- Author's Certificate
- Contact Us

USEFUL LINKS
- Most Viewed Articles
- Most Downloaded Articles

ABSTRACTED AND INDEXED
- Index Copernicus
- Google Scholar
- ICMJE
- CrossRef

IDENTIFIER

crossref member
CROSSREF.ORG THE CITATION LINKING BACKBONE

Anesthesia Journal | International Journal of Medical Anesthesiology

Editor-in-Chief: Dr. Zafar Ali

P-ISSN: 2664-3766

E-ISSN: 2664-3774

Abbreviated Title: Int. J. Med. Anesthesiology

DOI: https://doi.org/10.33545/26643766

Indexing: Index Copernicus 2018: 79.83

International Journal of Medical Anesthesiology is an official publication of the Society of Anesthesiology Practice. The anesthesia journal publishes *original research articles, review articles, case reports, brief communications* and *clinical studies* in all areas/advances of anesthesia, pain and intensive care, which includes: Anesthetic administration, Preoperative, Postoperative considerations, Pain management, Basic Science, Cardiovascular and Thoracic Anesthesiology, Critical Care and Resuscitation, Analgesic Mechanisms, Pharmacokinetics, Pediatric Anesthesiology, Regional Anesthesia and Acute Pain Medicine, Ambulatory Anesthesiology, etc.

The anesthesia journal is indexed in *Index Copernicus, Google Scholar, ResearchBib, ICMJE, CrossRef, Research Gate and Scilit*.

This indexed anesthesia journal is available in print format and corresponding author will get hard copy through registered post/ courier.

The **International Journal of Medical Anesthesiology** follows the recommendations of the International Committee of Medical Journal Editors (ICMJE), the World Association of Medical Editors (WAME), the Council of Science Editors (CSE), the European Association of Science Editors (EASE), and the Committee on Publication Ethics (COPE).

Online submission of the manuscript is strongly recommended. A manuscript number will be mailed to the corresponding author within one week or earlier. Prospective authors can submit their manuscripts at anesthesiologypaper@gmail.com. All manuscripts are subjected to peer review process (which are not previously published and are not under consideration for publication by another journal) would be published without any delay in a subsequent issue after acceptance. Read Instructions to Author for more details.

Announcements

Fast Track Publication Service of Anesthesia Journal

The anesthesia journal provides fast track publication service to shorten the time to decision and publication. Authors if they wish can have their article published within 1 weeks of manuscript submission.

If you wish to use fast track publication service, please submit your manuscript and write to editor at anesthesiologypaper@gmail.com or call the editorial office at +91-9711224068.

On the behalf of the International Journal of Medical Anesthesiology, I would like to extend my regard to all fellow researchers and scholars and wish prosperity in their field.

(Editor-in-Chief)

USER'S LINK
- Login
- Signup

JOURNAL'S CODE
- P-ISSN: 2664-3766
- E-ISSN: 2664-3774

ISSUE BAR
- Past Issue
- Coming Issue

OPEN ACCESS POLICY
- Click Here for more Information

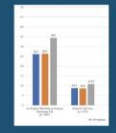
PUBLICATION POLICY
- Click Here for more Information

STATISTICS

Articles Published:	365
Articles Viewed:	334534
Articles Downloaded:	168568

International Journal of Anesthesia and Critical Care

ISSN: 2834-2887



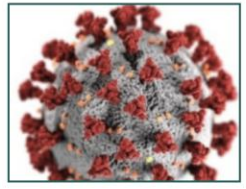
2022

Volume 1, Issue 1, p1-36

Current Issue | Archive | Latest Content

Commentary | Open Access

Therapeutic Values of Ketamine for COVID-19-Cared Patients: An Expert's Point of View



Avi A. Weinbroum

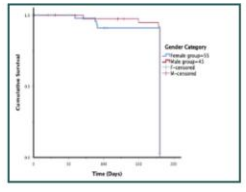
Ketamine has long been used in the field of anesthesia [1]. Its rapid and long-acting analgesic effects associated with its dissociative properties have also established its use in prehospital and emergency department patients.

Int J Anaesth Crit Care, 2022, Volume 1, Issue 1, p1-4 | DOI: 10.33696/Anesthesia.1.001

Abstract | Full Text | Cite | PDF

Research Article | Open Access

Gender Disparities in Outcomes Following Pulmonary Embolism Treatment in the Intensive Care Unit; A Multi-center Retrospective Cohort Study



Reubeni E. Mkama, Jin Peng, Yan Zhou, Tingfa Zhou, Jinyun Du, Guozhong Pang, Min Si, Yuan Li, Weidong Qin, Xiaomei Chen

Pulmonary embolism (PE) is a blockage of blood flow in the pulmonary artery bed that can result in a life-threatening and potentially reversible right ventricular failure [1]. PE remains one of the leading causes of poor prognosis and death, particularly when a shock or right ventricular failure occurs [2]. According to studies, PE is generally manifested in a nonspecific manner

Int J Anaesth Crit Care, 2022, Volume 1, Issue 1, p5-16 | DOI: 10.33696/Anesthesia.1.002

Abstract | Full Text | Cite | PDF

Recommended Articles

Therapeutic Values of Ketamine for COVID-19-Cared Patients: An Expert's Point of View

Ketamine has long been used in the field of anesthesia [1]. Its rapid and long-acting analgesic effects associated with its dissociative properties have also established its use in...

Gender Disparities in Outcomes Following Pulmonary Embolism Treatment in the Intensive Care Unit; A Multi-center Retrospective Cohort Study

Pulmonary embolism (PE) is a blockage of blood flow in the pulmonary artery bed that can result in a life-threatening and potentially reversible right ventricular failure [1]. PE remains one of th...

De: **Angela Katie** biomed@ijabpt.com
Objet: Re: In reply to "Representation of Women as Editors in
Date: 29 septembre 2025 à 15:39
À: marc.samama@aphp.fr

AK

20% de ces revues douteuses
sont indexées dans PubMed

Dear Professor,

I recently read your article, ***"In reply to "Representation of Women as Editors in Anesthesiology Journals" by McMullen et al,"*** and found it to be a valuable contribution to the field.

We would be pleased to consider a new manuscript from you for publication in the **Anesthesia and Critical Care (Impact Factor 3.1; indexed in PubMed/PMC).**

If you are interested or have any questions, please feel free to contact me.

Kind regards,
Angela Katie
Anesthesia and Critical Care

Anesthesia & Clinical Research
ISSN: 2155-6148
Open Access
+44 1223 790975

Editorial Board

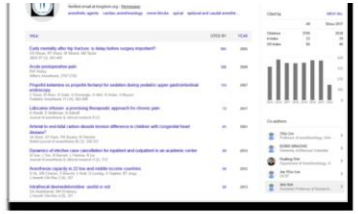
Michael A. E. Ramsay
Editor-in-Chief
Department of Anesthesiology
Chairman & Medical Director, Baylor University Medical Center, USA

Biography | Research Interest

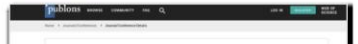
Longrois D

Department of Anesthesiology Surgical
Hospital Bichat-Claude Bernard Hospital in Paris University Paris VII, 46, rue Henri-Huchard, 75018 Paris, France

Biography | Research Interest



Anesthesia & Clinical Research peer review process verified at publons



Associate Professor, Departments of Outcomes Research and General Anesthesiology
Cleveland Clinic, USA

Biography | Research Interest

Peter J. Papadakos
Executive Editor
Professor
University of Rochester, Anesthesiology and Surgery, USA

Biography | Research Interest

De: **Andrew Stuart** andrew@globalcongressforum.com
Objet: Reversal of direct oral anticoagulants: Guidance from the SSC of the ISTH: R7
Date: 23 juillet 2024 à 12:45
À: marc.samama@aphp.fr

AS

Hello C Marc Samama

We would like to extend an invitation to you for the **Global Congress on Agriculture and Food Sciences**, October 28-29, 2024, in Dubai, UAE.

We found the article "Reversal of direct oral anticoagulants: Guidance from the SSC of the ISTH: R7" suitable for presentation at our conference. This event provides an excellent way to share your research findings and advancements in the fields of Agriculture and Food Sciences.

Distinguished speakers from the fields of Agriculture and Food Sciences will be present at this conference, which will feature plenary sessions, Session lectures, Poster presentations, Science Exhibitions, Panel Discussions, and B2B Meetings.

We can partially sponsor up-to 30% on Congress Registration, kindly avail this chance.

For more information and to submit your abstract, send an email to globalagriculturecongress@gmail.com

Best Regards
Andrew Stuart
Conference Organizing Team
Agriculture and Food Sciences Congress 2024

Invasion of the journal snatchers: How indexed journals are falling into questionable hands

Alberto Martín-Martín
albertomartin@ugr.es

Emilio Delgado López-Cózar
edelgado@ugr.es

Universidad de Granada, Spain

Version 1. 29 January 2025.

De: **vanya.huan** vanya.huan@gmail.com
Objet: Journal for Sale
Date: 13 mai 2022 à 03:54
À: marc.samama@aphp.fr

Dear Dr. Charles Marc Samama,

Hope you're doing well!!

I am Vanya, Market Manager of a publishing company in Singapore. While doing research I have found that your "**EUROPEAN JOURNAL OF ANAESTHESIOLOGY**" has tremendous potential. I would like to express our gratitude for the efforts you have taken for bolstering the journal which fascinates us to contact you for a proposition for your consideration.

We are willing to bid $500,000 for the journal "EUROPEAN JOURNAL OF ANAESTHESIOLOGY", May I kindly know your interest towards selling the journal?

Also please let me know your expectations.

I hope you're the best person for this discussion - If not, could you please provide me with the contact details.
Name:
Mail ID:

Looking forward to hearing from you.

Thanks & Regards
Vanya

De: **Richard Hales** richard.hales@frontiersin.com
Objet: European Journal of Anaesthesiology // Proposal for Collaboration
Date: 16 août 2022 à 09:17
À: marc.samama@aphp.fr

RH

To view this email as a web page, go here.

Dear Dr. Samama,

I represent the Open Access publisher Frontiers, currently the 3rd most-cited publisher in the world. We would be interested in pursuing a partnership with the European Journal of Anaesthesiology.

Frontiers has had great success collaborating with academic societies, and we would be eager to discuss how we can leverage this experience to build a successful partnership with the European Journal of Anaesthesiology. We partner with academic societies to publish their journals on their behalf, and also to engage both on policy collaboration and sponsorships.

Would you be interested in a short, informal discussion with our Society Partnerships Manager, Charlie Head, to explore this over the next month?

You can book a time that works best for you via Charlie's Google calendar here.

I look forward to hearing from you soon.

Best wishes,
Richard

Richard Hales
Partnerships Assistant
Publishing Partnerships
www.frontiersin.org
Frontiers | London

Evolution des pratiques des revues prédatrices

Corruption d'éditeurs

Les pratiques frauduleuses des paper mills : payer des rédacteurs en chef pour accepter des articles

Publié le 05/02/2024

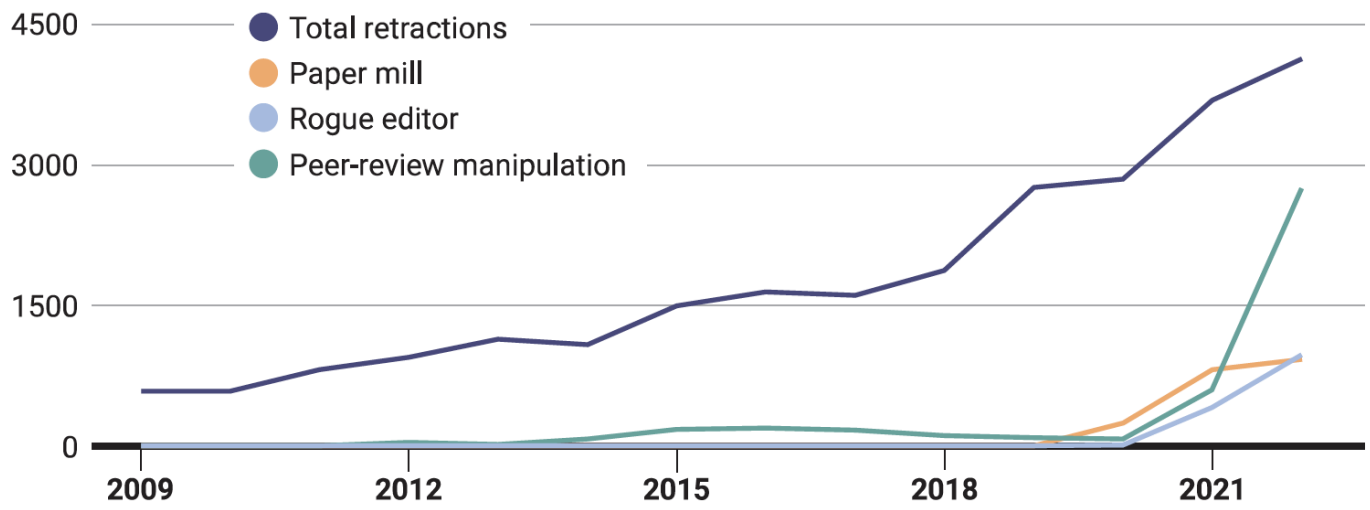
Newsletter Hervé Maisonneuve

PAPER TRAIL

In the latest twist of the publishing arms race, firms churning out fake papers have taken to bribing journal editors

Cet article (news) publié le 19 janvier 2024 dans Science décrit des fraudes majeures avec des exemples très précis. Nous avons souvent évoqué les 'paper mills', ces sociétés qui écrivent, reprennent, inventent des articles et proposent à des chercheurs de les signer, contre payement bien sûr. Le phénomène est mal connu, mal décrit et semble important.

20 000 dollars pour accepter de publier des articles



(GRAPHIC) D. AN-PHAM/*SCIENCE*; (DATA) RETRACTION WATCH

ASSISTANCE PUBLIQUE HÔPITAUX DE PARIS

Revues « recommandables » ou « honorables »

Liste initiée par Sorbonne Université et entérinée par la Conférence des Doyens et le CNU Santé, et gérée par Christian Funck-Brentano, Professeur Émérite à Sorbonne Université, RIS délégué de Sorbonne Université pour la Faculté de Santé - 3400 revues en mars 2024

https://conferencedesdoyensdemedecine.org/la-conference-des-doyens-de-medecine-et-du-cnu-sante-luttent-contre-les-revues-predatrices/

Revues honorables

Mise en place d'un groupe travail national avec une mise à jour trimestrielle de la liste

Medecine-Revues-Recommandees@sorbonne-universite.fr

Groupe d'experts (CDD/CNU)

Nom	Prénom	Institution	Spécialité
BEAUNE	Philippe	Université Paris Cité (RIS)	Biochimie
BOURIOT	Florence	Hospices civils de Lyon	Documentaliste
DAIEN	Claire	Faculté de Médecine de Montpellier	Rhumatologie
FRITZINGER	Anne-Catherine	Sorbonne Université - Paris	DGSA Diffusion des savoirs - Documentation
FUNCK-BRENTANO	**Christian**	**Sorbonne Université Santé - Paris (RIS délégué)**	**Pharmacologie / Cardiologie**
GAUSSEM	Pascale	Université Paris Cité (UFR Pharmacie)	Hématologie (sciences biologiques)
GILLIBERT	André	CHU de Rouen	Santé Publique - Biostatistiques
LOCHER	Clara	CHU de Rennes	Pharmacologie
MAISONNEUVE	Hervé	Rédacteur Scientifique (www.redactionmedicale.fr)	Santé Publique
SAMAMA	Marc	Faculté de Médecine Paris Cité (RIS AP-HP)	Anesthésie-Réanimation
SIBON	Igor	Université de Bordeaux	Neurologie
SMATI-GRANGEON	Sarra	Faculté de Médecine de Nantes	Endocrinologie
VABRET	Astrid	Université de Caen	Microbiologie, maladies transmissibles
VERMERSCH	Patrick	Université de Lille	ED Biologie Santé, Neurologue

Office de l’intégrité scientifique de l’AP-HP

Contexte et missions de l’office
Organisation et fonctionnement
Actions engagées
Perspectives

integrite-scientifique@aphp.fr

Composition de l'Office de l'intégrité scientifique (mai 2024)

–Les 6 référents universitaires intégrité scientifique

Catherine ADAMSBAUM
Christian FUNCK-BRENTANO
Frédéric LOFASO
Emilie SBIDIAN
Philippe BEAUNE
Laurent ZELEK

–Vice-Présidents recherche du directoire de l'AP-HP

Gabriel STEG
Tabassome SIMON
Eric VICAUT

– Deux représentants de la CME désignés par son Président

Sandrine HOUZÉ
Karine LACOMBE

– La présidente du collège de déontologie de l'AP-HP

Françoise TOME

– Le directeur de l'Office Français de l'Intégrité Scientifique

Michel DUBOIS

La représentante IS de l'INSERM

Ghislaine FILLIATREAU

– Personnalités qualifiées

Bruno FALISSARD
Marc SAMAMA
Hervé MAISONNEUVE

– Un représentant des usagers de l'AP-HP

Jacques WALCH

– Une journaliste

Solenne Le HEN

– Une représentante de la DAJ

Claire CHEDRU-BONHOMME

– Deux représentants de la DRCI

Serge BUREAU
Lauren DEMERVILLE

– Chargé de la mission de préfiguration de l'Office

Nicolas DANCHIN

Saisines de l'OIS lors des deux dernières années

- Réclamations sur un authorship
- Plagiat complet d'un article
- Plagiat de figures
- Pressions d'un industriel sur d'hypothétiques conflits d'intérêt
- Faux numéros de comité d'éthique dans quatre publications
- Faux en écriture sur une autorisation de CPP
- Diffamation
- Absence d'accord sur la publication de données d'une patiente

Coalition for Advancing Research Assessment

https://coara.eu

https://www.eua.eu/downloads/news/2022_07_19_rra_agreement_final.pdf

As of 15 September 2025, there are 773 CoARA member organisations from across the world.

AGREEMENT ON REFORMING RESEARCH ASSESSMENT

20 July 2022

Based on 10 commitments, establishes a common direction for research assessment reform, while respecting organisations' autonomy. The Agreement on Reforming Research Assessment sets a shared direction for changes in assessment practices for research, researchers and research performing organisations, with the overarching goal to maximise the quality and impact of research.

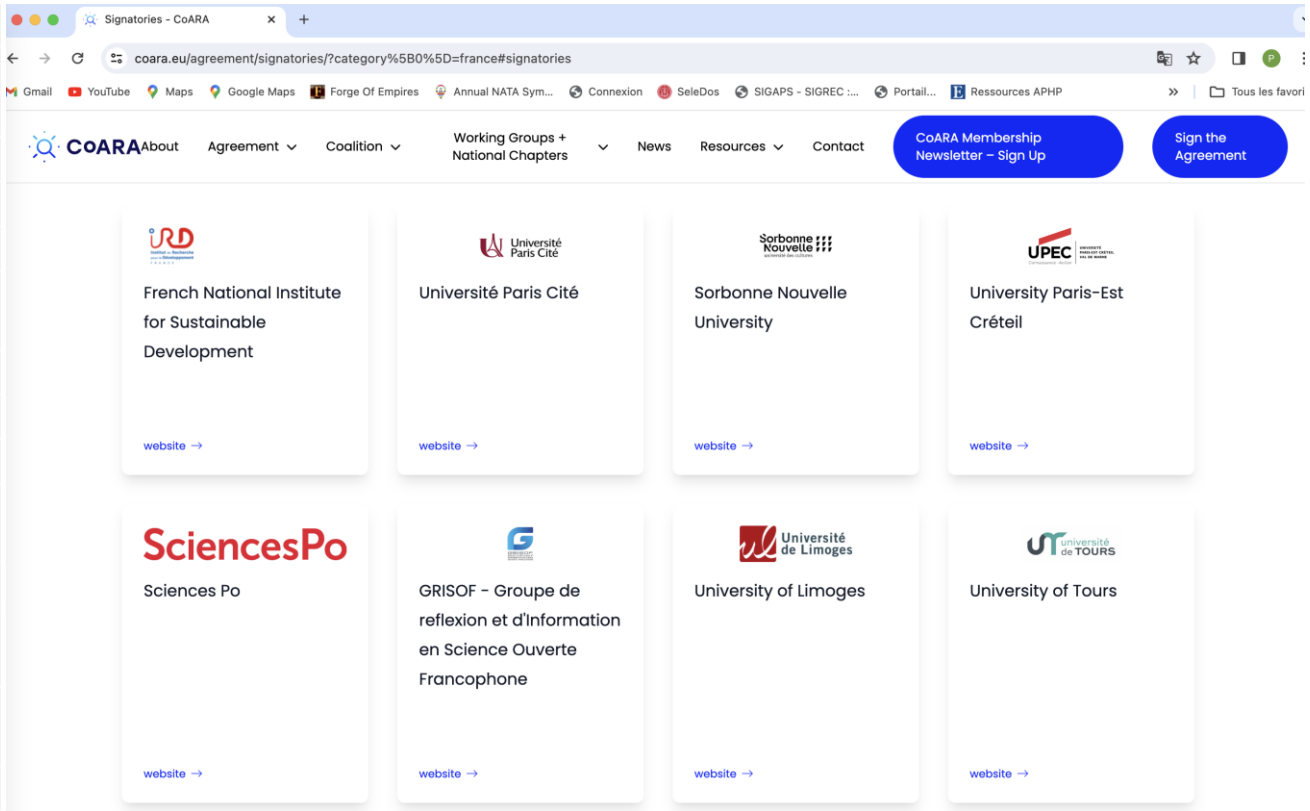
The Agreement includes the principles, commitments and timeframe for reforms and lays out the principles for a Coalition of organisations willing to work together in implementing the changes.

ASSISTANCE PUBLIQUE HÔPITAUX DE PARIS

European Commission

France: 63

Académie des sciences	France
AgroParisTech	France
Aix-Marseille Université	France
ANR - French National Research Agency	France
ANRS|Emerging infectious diseases	France
CDEFI - Conference of Deans of French Schools of Engineering	France
Cercle FSER - Cercle de la Fondation Schlumberger pour l'Education et la Recherche	France
Claude Bernard University Lyon 1	France
CNRS - French National Centre for Scientific Research	France
CPU - Conférence des présidents d'université	France
HCERES - Haut Conseil de l'évaluation de la recherche et de l'enseignement supérieur	France
IFREMER - Institut Français de Recherche pour l'Exploitation de la Mer	France
INED - Institut national d'études démographiques (National institute for demographic studies)	France
INRAE - French National Research Institute for Agriculture, Food and Environment	France
INRIA - National Institute for Research in Digital Science and Technology	France
INSA Toulouse	France
INSERM - National Institute of Health and Medical Research	France
Institut Français d'Archéologie Orientale	France
Institut National du Cancer	France



ASSISTANCE PUBLIQUE HÔPITAUX DE PARIS

En pratique

- Surpublications problématiques, amplifiées par l'IA
- Evolution des revues prédatrices vers des modèles plus sophistiqués de corruption d'éditeurs ou de reviewers ou d'achat de titres
- Décrédibilisation du contenu scientifique (plagiat, fabrication de données, enregistrements fallacieux, mauvaise qualité de la recherche)
- Travail éditorial devenu très compliqué avec l'IA
- Inflation du nombre de rétractions
- Un espoir : COaRA avec un complet changement de modèle d'évaluation de la recherche basé sur la qualité
- **Integrite-scientifique@aphp.fr**

Télégramme juif ashkénaze :

Start worrying, details will follow…