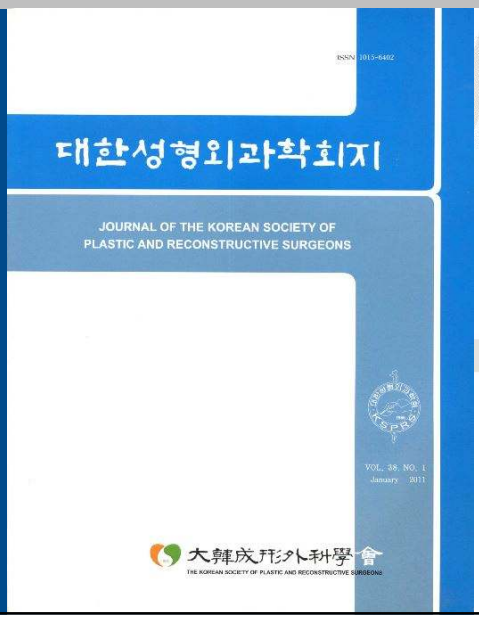
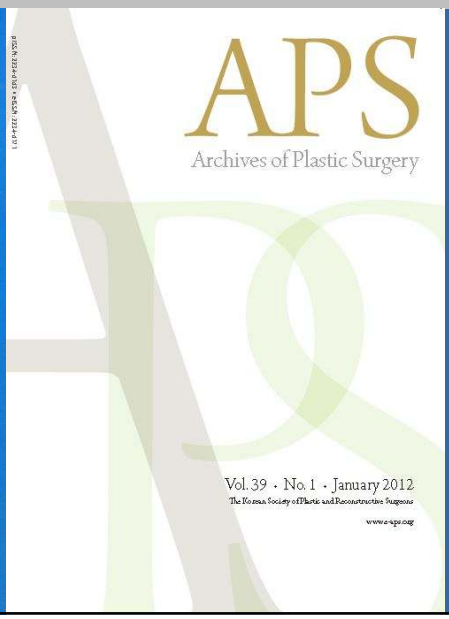
CrossCheck for APS articles

이장현
Archives of Plastic Surgery, deputy editor
Hanyang University Guri Hospital

Archives of Plastic Surgery





Archives of Plastic Surgery

Archives of Plastic Surgery

Submission

- **Similarity index ≥ 40% : send a paper back to the author**
- **Similarity index < 40% : review process**

- **2012 : 17 papers**
- **2013 : 6 Papers**
- **Reject : 11/23 (48 %)**
- **Foreign : 4 (non-English)**

Contents

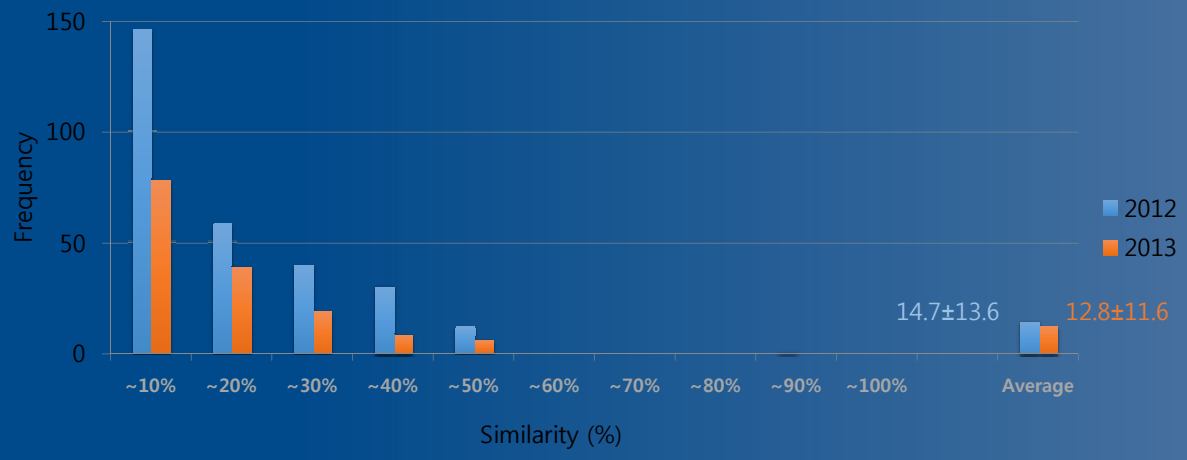
- Archives of Plastic Surgery data
- Reviewers' opinion
- Editor's opinion

Contents

- Archives of Plastic Surgery data
- Reviewers' opinion
- Editor's opinion

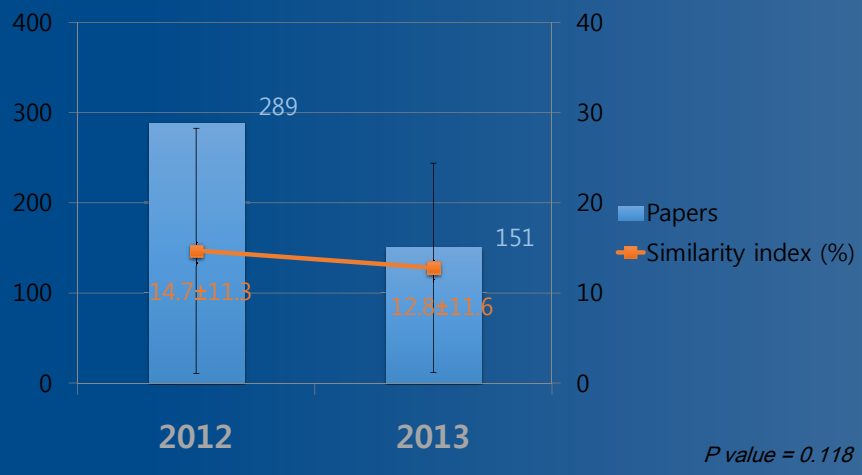
APS data

Similarity index of manuscripts



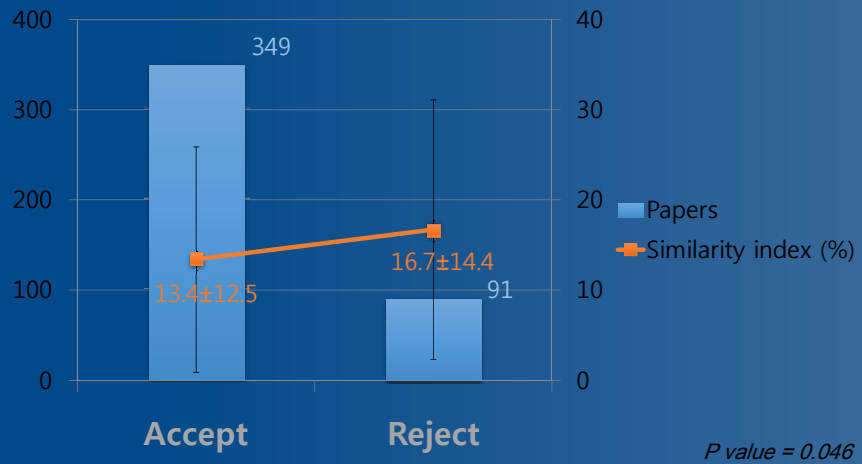
APS data

Period



APS data

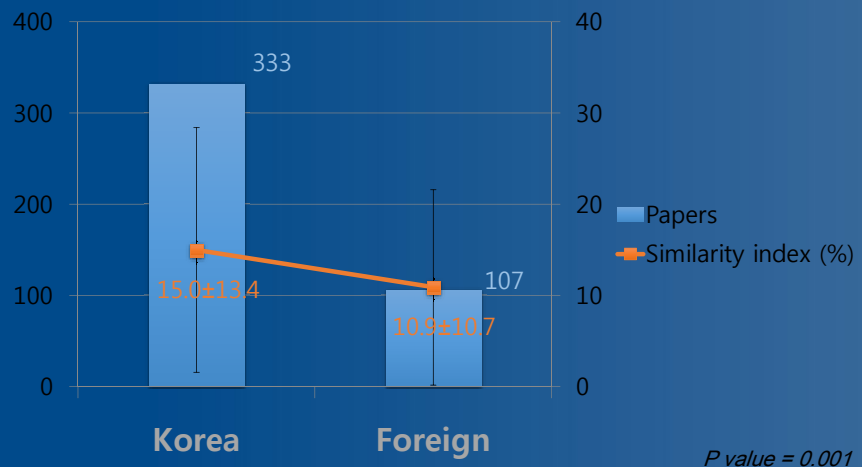
Editorial decision



P value = 0.046

APS data

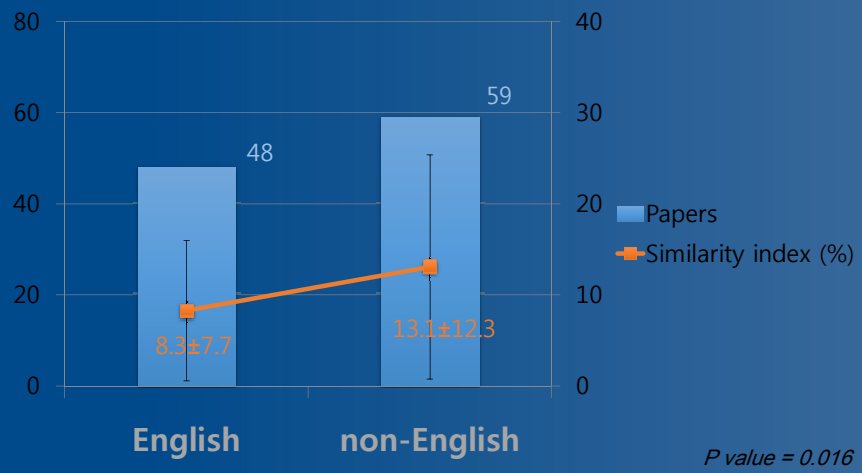
Nationality



P value = 0.001

APS data

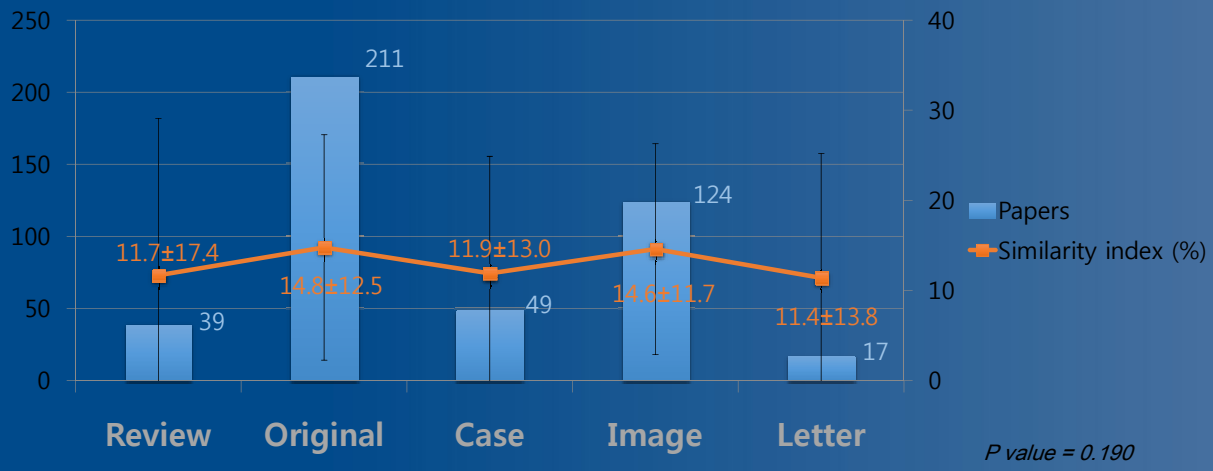
Language



P value = 0.016

APS data

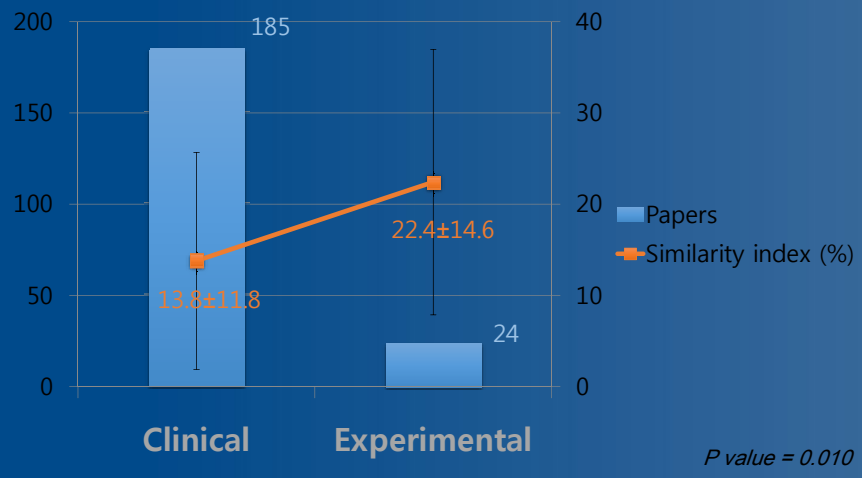
Publication type



P value = 0.190

APS data

Original article



APS data

Summary

- **2012년도에 비해서 2013년에 유사도가 감소하고 있다.**
- **유사도가 높은 논문들은 게재 불가의 가능성이 높았다.**
- **국내 논문이 유사도가 높고 특히 영어권 국가에서 유사도가 낮았다.**
- **종설 논문보다 원저에서 유사도가 높았는데 실험 논문의 높은 유사도가 원인으로 생각된다.**

Contents

- Archives of Plastic Surgery data
- Reviewers' opinion
- Editor's opinion

Reviewers' opinion

Questionnaires

- 117 reviews: 8 questions
- Period: 2014-6-5 ~ 6-27
- 54 responded (46%)

1. APS에서는 논문 심사 시에 Crosscheck 결과지를 첨부하고 있습니다. 이에 대해 알고 있습니까?
   1) 예
   2) 아니오

2. 심사 시 첨부되는 Crosscheck 결과 해석에 대해 어느 정도 알고 있습니까?
   1) 결과지를 해석하는 것에 대해 잘 알고 있다.
   2) 결과지를 해석하는 것에 대해 대략적으로 알고 있다.
   3) 결과지를 해석하는 것에 대해 잘 모르겠다.
   4) 기타 ( )

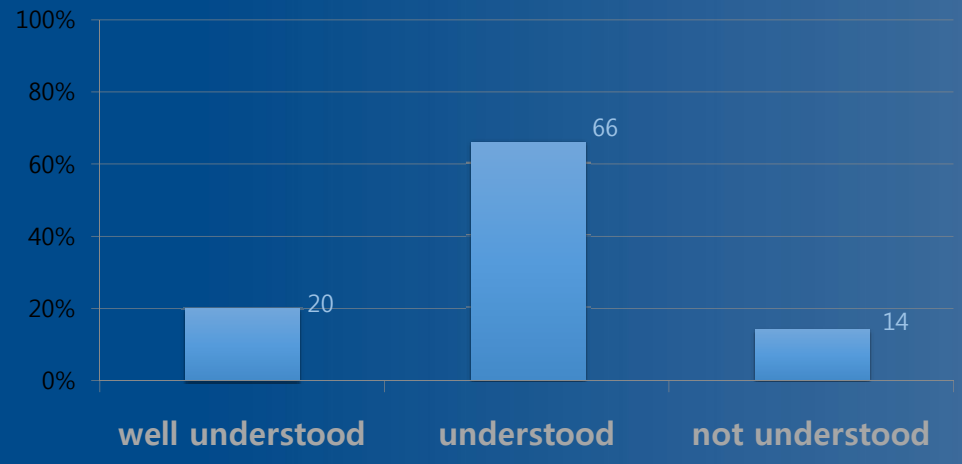
3. 논문 심사 시에 Crosscheck 결과지를 어느 정도 이용하고 있습니까?
   1) 전혀 이용하고 있지 않다.
   2) 결과지의 총 유사도(%) 정도만을 참고한다.
   3) 결과지에서 유사하게 체크된 내용에 대해 자세히 살펴본다.
   4) 결과지에서 유사하게 체크된 내용의 논문을 직접 모두 찾아서 참고하려고 한다.
   5) 기타 ( )

4. 논문 심사 시에 Crosscheck 결과지가 어느 정도 도움이 된다고 생각하십니까?
   1) 매우 도움이 된다.
   2) 대체적으로 도움이 된다.
   3) 도움이 되지 못한다.
   4) 잘 모르겠다.
   5) 기타 ( )

5. 총 유사도(%)가 몇 %가 넘었을 경우 논문이 게재되는데 문제가 있다고 생각하십니까?
   1) 20-30%

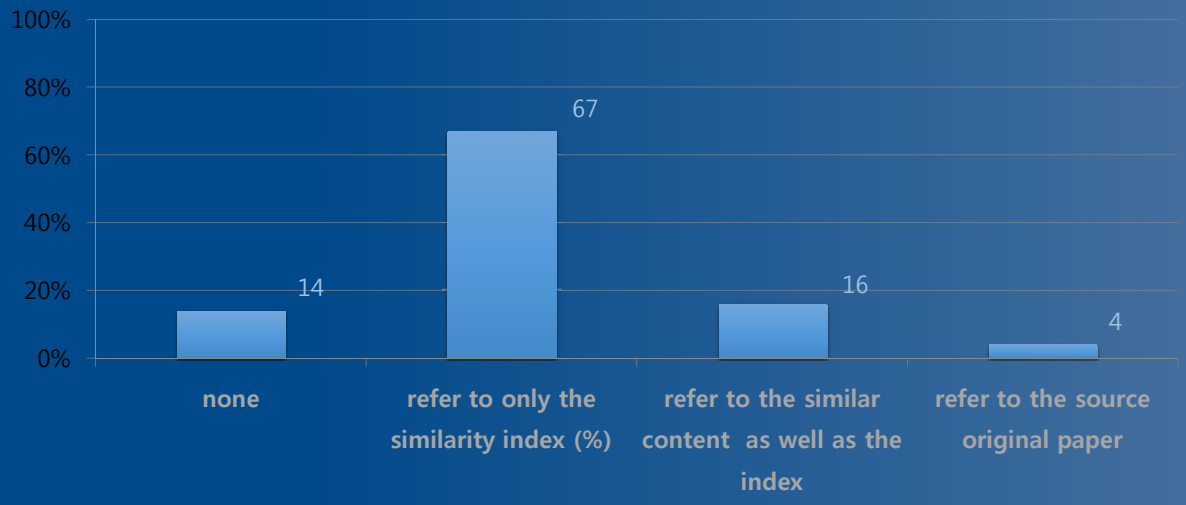
Reviewers' opinion

Comprehension about similarity report



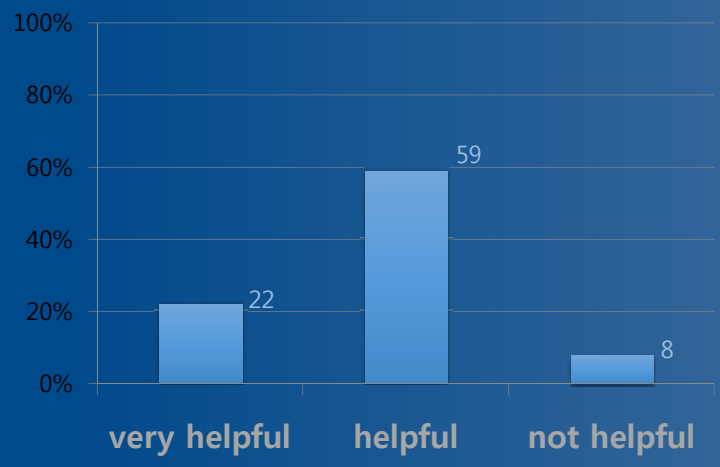
Reviewers' opinion

Utilization of similarity report



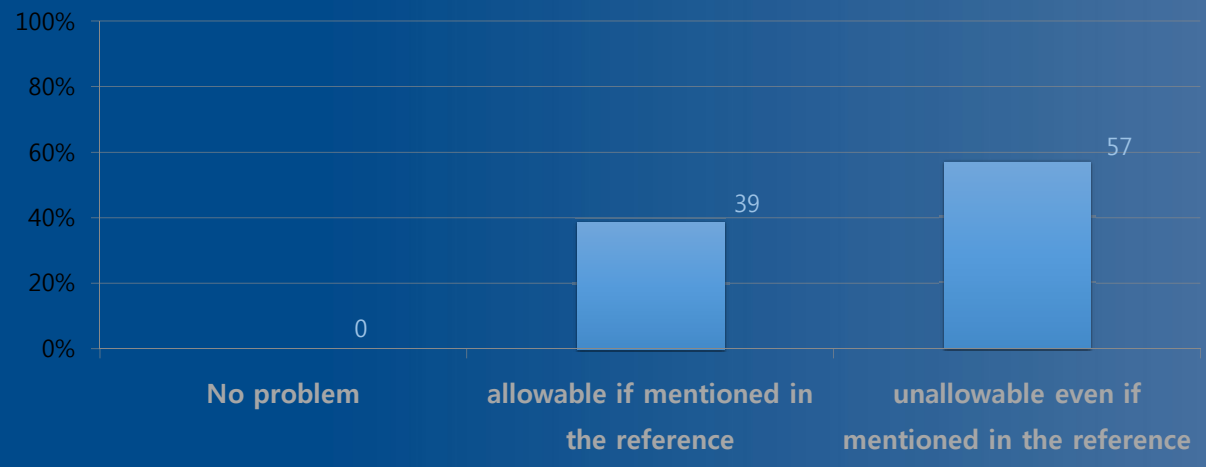
Reviewers' opinion

Usefulness of the report



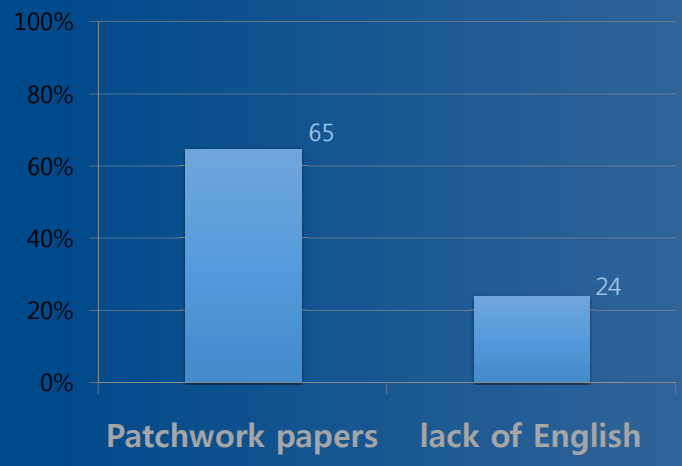
Reviewers' opinion

High similarity index manuscripts



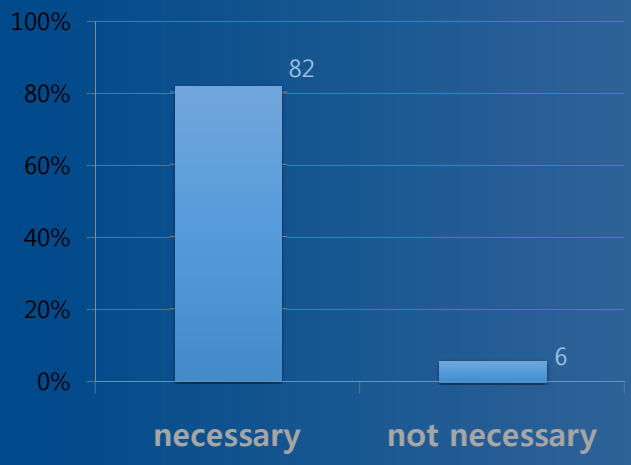
Reviewers' opinion

Reason for high similarity index



Reviewers' opinion

Maintenance of CrossCheck reports



Reviewers' opinion

기타 의견

- 어떤 부분이 유사한지가 더 중요, 내용에 따라 다르다.
- 고찰에서 기존 문헌을 인용하다 보면 유사도가 높게 나올 수 있다. (짜깁기와 구분)
- 인용하면서 다르게 고쳐서 원래의 의미를 변질 시킬 가능성이 있다.
- 일부로 문장을 고쳐 인용하는 것은 시간 낭비이다.
- 너무 심한 규제는 바람직하지 않다.

- 고찰에서 저자의 논지보다 불필요하게 발표된 논문 기술
- 일정 비율 이상이면 초기 심사에서 자동탈락도 고려해 볼만하다.

Contents

- Archives of Plastic Surgery data
- Reviewers' opinion
- **Editor's opinion**

Editor's opinion

High similarity index manuscripts

Editor's opinion

Long terms

Editor's opinion

Text books

"Plastic surgery", Elsevier, 2013

Despite the excitement generated around iPS cells, methods for their derivation and use need to be further tested and improved. The pectoralis major musculocutaneous flap has been **one of the most versatile flaps** used in **head and neck reconstruction.** Many investigators have studied the surgical delay phenomenon in laboratory animals in order to gain insight into the pathogenesis and pharmacological treatment for skin flap ischemic necrosis. Flap failure has profound implications for both patient and surgeon and represents one of the most challenging aspects of reconstructive microsurgery. It is important to avoid dissecting the serratus anterior muscle too far laterally, regardless of the location of the muscle incision, for this would allow displacement of the implant into the axilla. When excision of a primary melanoma with appropriate margins is not possible, adjuvant radiation might be considered, though it is not generally recommended for the primary treatment of cutaneous melanoma. Methods are available to predict the compatibility of donor tissue to a particular recipient. The **current strategy for the posttransplant management of composite tissue allograft is to treat them with well-established regimens of immunosuppression used in solid-organ transplantation.**

Plastic surgeons can use simulation not only to practice new procedures on a virtual patients, but also for patient-specific surgical planning. All of these conduits can be used as primary conduits or as nerve wraps. The omentum can be harvested laparoscopically, obviating the need for a large abdominal incision. Gross trimming of the adventitia is performed around the area of the anastomosis, allowing sufficient length of trimmed vessel for application of the vascular clamp.

Editor's opinion

Text books

"Grabb's encyclopedia of flap", Lippincott, 2009

The sensory nerve to the flap is first sought with the aid of loupe magnification through an oblique incision over its course in the donor finger. A transposition flap consists of a rectangular segment of skin and subcutaneous tissue that is turned on its pivot point to reach the defect to be closed. All five patients in whom flaps were converted into island flaps successfully achieved primary wound healing within 2 weeks. Each was able to return to his or her original work within 6 weeks. Complete dissection of the vascular supply to the toe could be achieved from the dorsal aspect of the foot in the majority of cases. The incision parallels the thenar wrist crease and extends transversely across the distal flexion crease of the wrist. Classically, the flap is centered on the emergence of the artery in the posterior compartment in the proximal forearm. Small flaps should be designed distally to the point of emergence of the PIA, in order to include the septocutaneous perforator in the lower two-thirds of the forearm. Flaps originating on the anterior chest wall can also be based medially. The blood supply to these flaps is provided by perforating vessels from the internal thoracic artery and/or the superior epigastric artery. All burned tissue is widely excised and the procedure is competed by tenolysis of the extensors and sometimes by arthrolysis. We stress placing the fingers in optimal position, i.e., in a state of mild flexion, allowing them to rest on the curvature of the donor arm. ↵

Editor's opinion

Text books

"Green's operative hand surgery", Lippincott, 2011

Flexion of the thumb into the palm of the hand is one of the greatest deterrents to good hand function in patients with cerebral palsy. The cause of thumb-in-pam deformity is multifactorial. Conventional goals in patients with pan-plexus injury include a stable shoulder and elbow flexion with or without some hand sensation. In all patients, we explore the supraclavicular brachial plexus in the hope of finding some viable and usable nerves from the proximal stumps; even in cases with evidence of multiple avulsions based on preoperative testing, exploration may occasionally reveal a usable nerve stump. We have staged the release of severely deformed hands by releasing the distal osseous fusion and dividing the common nail plate through dorsal incisions between the distal digits. This converts a complex syndactyly on a simple syndactyly and releases the digits from the osseous tether. The peroneal vessels are then ligated at the level of the distal osteotomy. The tourniquet is deflated to ensure perfusion to the fibular segment. Frequent irrigation of the vessel with heparinized saline or lactated Ringer's solution is necessary during anastomosis to remove small clots and visualize the lumen. We are firmly committed to the belief that definitive skin coverage at the time of injury is preferable to delayed closure, provided only that debridement is adequate. As is evident from the earlier account of local, regional, and distant flaps, all with both random and axial designs, we have a rich store-house from which to select that skin cover. Like many others, I have used various strategies to activate the intercostal nerves during early reinnervation, including forced inspiration, forced expiration, trunk flexion, and attempted elbow flexion. ↵

Editor's opinion

Text books

"Surgery of the breast", Elsevier, 2013

Ascertaining whether the patient is content with her breast size is an important step in meeting her expectation. Asking the patient if she likes the size and shape of her breast when wearing a bra helps to determine this. Since **plastic surgeons have been trained to produce the best possible results on the table,** there is a **reluctance of many surgeons to adopt this** method because of the unusual

appearance of the breasts at the end of the operation. In case of large breasts with a wide base, it is often useful to associate to this vertical and central resection a circumferential excision ant the base of the breast. In case of breast asymmetry, the surgery should always commence on the larger side. This allows maximal reduction on the larger side, which can be matched on the smaller breast. The patient should be prepped and draped with the arms properly secured to arm boards extended at right angles from the operating table. Although many of the women presenting after MWL feel that they need a breast reduction, the majority of these woman have adequate volume to give them the size and shape they desire. When the breast and nearby excess tissue volume is inadequate to fill the desired breast volume, then silicone gel implant augmentation is required. The principal advantage of this incision is that the resulting scar is usually well camouflaged and quite inconspicuous. The lateral edge of the muscle is carefully elevated to gain access to the subpectoral pocket. For decades preoperative decisions in breast augmentation, including implant selection, pocket location, and incisions, were based on either a surgeon's subjective preferences or the desires of the patient.

Editor's opinion

Text books

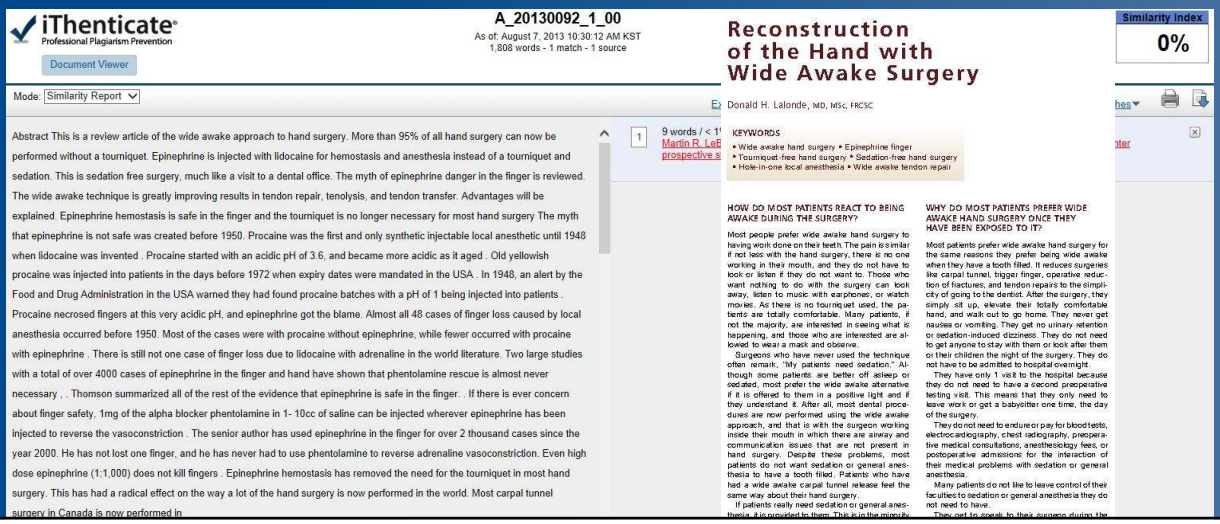
"Midface and neck aesthetic plastic surgery", SEE, 2012

The infraorbital pedicle must absolutely not be injured in any way, and for this reason it should be first identified by palpation by referring to the usual anatomical landmarks. This consists of excising any excess soft tissues to create an adequately deep and clean eyelid crease. Skin is resected following the markings which are traced pre- operatively, and which define the peripheral borders. The eyelid skin is very thin and any kind of suture can keep the margins of the wound together, as long as the resection carried out was not too aggressive. On the contrary, an eyelid with difficulties in closing over the eye nearly always has a defect in the anterior lamella and therefore needs to be lengthened on the surface, prevalently at the level of the skin. Also this temporal lift is carried out through a short incision, a few cms behind the hairline, near the temporal crest. The lateral fat bag in turn is often covered by a layer of fat, which can be mistaken for the lateral bag itself by an inexperienced surgeon. Also the orbicularis has an important role I the canthal structure. In fact, a hypotone of its caudal component could be responsible for lateral canthus and lower eyelid margin displacements. To conclude this paragraph on dynamic canthopexies, once again we would like to insist on the necessity of being careful in choosing the case to operate on, and in deciding how far to lift the canthi. Surgery should be carried out for functional reasons or, at least, for correcting concrete objective imperfections, without meeting eccentric or unreasonable requests.

Editor's opinion

Low similarity index, but…

"Tumescent local anesthesia for hand surgery"



iThenticate
Professional Plagiarism Prevention
Document Viewer

A_20130092_1_00
As of: August 7, 2013 10:30:12 AM KST
1,808 words - 1 match - 1 source

Similarity Index
0%

Mode: Similarity Report

Abstract This is a review article of the wide awake approach to hand surgery. More than 95% of all hand surgery can now be performed without a tourniquet. Epinephrine is injected with lidocaine for hemostasis and anesthesia instead of a tourniquet and sedation. This is sedation free surgery, much like a visit to a dental office. The myth of epinephrine danger in the finger is reviewed. The wide awake technique is greatly improving results in tendon repair, tenolysis, and tendon transfer. Advantages will be explained. Epinephrine hemostasis is safe in the finger and the tourniquet is no longer necessary for most hand surgery The myth that epinephrine is not safe was created before 1950. Procaine was the first and only synthetic injectable local anesthetic until 1948 when lidocaine was invented . Procaine started with an acidic pH of 3.6, and became more acidic as it aged . Old yellowish procaine was injected into patients in the days before 1972 when expiry dates were mandated in the USA . In 1948, an alert by the Food and Drug Administration in the USA warned they had found procaine batches with a pH of 1 being injected into patients . Procaine necrosed fingers at this very acidic pH, and epinephrine got the blame. Almost all 48 cases of finger loss caused by local anesthesia occurred before 1950. Most of the cases were with procaine without epinephrine, while fewer occurred with procaine with epinephrine . There is still not one case of finger loss due to lidocaine with adrenaline in the world literature. Two large studies with a total of over 4000 cases of epinephrine in the finger and hand have shown that phentolamine rescue is almost never necessary , . Thomson summarized all of the rest of the evidence that epinephrine is safe in the finger. . If there is ever concern about finger safety, 1mg of the alpha blocker phentolamine in 1- 10cc of saline can be injected wherever epinephrine has been injected to reverse the vasoconstriction . The senior author has used epinephrine in the finger for over 2 thousand cases since the year 2000. He has not lost one finger, and he has never had to use phentolamine to reverse adrenaline vasoconstriction. Even high dose epinephrine (1:1,000) does not kill fingers . Epinephrine hemostasis has removed the need for the tourniquet in most hand surgery. This has had a radical effect on the way a lot of the hand surgery is now performed in the world. Most carpal tunnel surgery in Canada is now performed in

Reconstruction of the Hand with Wide Awake Surgery

Donald H. Lalonde, MD, MSc, FRCSC

KEYWORDS
• Wide awake hand surgery • Epinephrine finger
• Tourniquet-free hand surgery • Sedation-free hand surgery
• Hole-in-one local anesthesia • Wide awake tendon repair

HOW DO MOST PATIENTS REACT TO BEING AWAKE DURING THE SURGERY?

Most people prefer wide awake hand surgery to having work done on their teeth. The pain is similar if not less with the hand surgery, there is no one working in their mouth, and they do not have to look or listen if they do not want to. Those who want nothing to do with the surgery can look away, listen to music with earphones, or watch movies. As there is no tourniquet used, the patients are totally comfortable. Many patients, if not the majority, are interested in seeing what is happening, and those who are interested are allowed to wear a mask and observe.

Surgeons who have never used the technique often remark, "My patients need sedation." Although some patients are better off asleep or sedated, most prefer the wide awake alternative if it is offered to them in a positive light and if they understand it. After all, most dental procedures are now performed using the wide awake approach, and that is with the surgeon working inside their mouth in which there are airway and communication issues that are not present in hand surgery. Despite these problems, most patients do not want sedation or general anesthesia to have a tooth filled. Patients who have had a wide awake carpal tunnel release feel the same way about their hand surgery.

If patients really need sedation or general anesthesia, it is provided to them. This is in the minority

WHY DO MOST PATIENTS PREFER WIDE AWAKE HAND SURGERY ONCE THEY HAVE BEEN EXPOSED TO IT?

Most patients prefer wide awake hand surgery for the same reasons they prefer being wide awake when they have a tooth filled. It reduces surgeries like carpal tunnel, trigger finger, operative reduction of fractures, and tendon repairs to the simplicity of going to the dentist. After the surgery, they simply sit up, elevate their totally comfortable hand, and walk out to go home. They never get nausea or vomiting. They get no urinary retention or sedation-induced dizziness. They do not need to get anyone to stay with them or look after them or their children the night of the surgery. They do not have to be admitted to hospital overnight.

They have only 1 visit to the hospital because they do not need to have a second preoperative testing visit. This means that they only need to leave work or get a babysitter one time, the day of the surgery.

They do not need to endure or pay for blood tests, electrocardiography, chest radiography, preoperative medical consultations, anesthesiology fees, or postoperative admissions for the interaction of their medical problems with sedation or general anesthesia.

Many patients do not like to leave control of their faculties to sedation or general anesthesia they do not need to have.

They get to speak to their surgeon during the

Editor's opinion

Conclusions

- **CrossCheck**은 논문 심사 시에 심사위원에게 매우 유용한 자료
- **CrossCheck**에 대해 심사위원의 교육이 필요
- **CrossCheck** 결과를 **100%** 맹신하는 것은 위험
- 유사도가 상당히 높은 논문은 좋은 논문일 가능성이 낮다.
- 인용 표시 없는 표절에 대한 확인과 짜깁기 논문을 가려내는데 효과적