

Of these, 69% were performed by a resident under direct faculty supervision, and roughly 31% done by faculty alone.<sup>6</sup> The report of zero incidence by residents-in-training lends further evidence to the efficacy of ultrasound in improving safety in precluding the complication of pneumothorax.

In conclusion, ultrasound-guided SCB can be translated into clinically useful benefits with an extremely low pneumothorax complication rate and should not be overlooked because of previous bias.

## Declaration of interest

None declared.

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## Academic anaesthesia: the trend in UK publishing in the BJA between 2004 and 2013

Editor—A crisis in UK academic anaesthesia was identified by Pandit<sup>1</sup> in 2005 and confirmed by Feneck and colleagues<sup>2</sup> in 2008, with a decline in UK published research demonstrated across seven anaesthetics journals, the most striking of which was the *BJA*. Much has changed since with the creation of the National Institute for Academic Anaesthesia (NIAA) in 2008 and subsequent identification of research priorities in 2012.<sup>3</sup> A further review of *BJA* UK publishing is therefore

justified to evaluate any positive effect of the NIAA, and is particularly relevant, given the recent NIAA HSRC trainee survey.

Data were drawn from the online *BJA* archive for the monthly journals 2004 to 2013 inclusive. The international origin of each article was identified and assigned to either: UK, other European countries, or rest of the world. All original articles were included (including supplements, special issues, and case reports but excluding review articles, book reviews, abstracts, and correspondence).

A total of 1997 publications were included. There is a near year-on-year decline in UK articles published in the *BJA* over the last decade, accompanied by a commensurate decline in UK percentage contribution (Table 1). The number of UK articles published in the most recent complete year (18 in 2013) was less than one-third of that published a decade ago (60 in 2004). There is also an increasing trend in annual percentage change (from the 2004 baseline) as the decade progresses with a 70% change demonstrated between 2004 and 2013. No clear relationship exists between contributions from the UK and other regions.

Despite Pandit's report and the evolution of the NIAA, the decline shown in 2008<sup>2</sup> has continued dramatically into the next decade. This is not necessarily analogous to a decline in academic anaesthesia across the UK or a reflection of any particular failing of the NIAA however: an optimistic viewpoint is that our most esteemed colleagues are publishing elsewhere in non-anaesthetic journals;<sup>4, 5</sup> articles are being shared across a wider field within anaesthesia through subspecialty journals; a trend unique to the *BJA* may have been revealed, indeed a bias towards overseas contributions could be responsible, although given the rigorous review process and strong UK editorial representation, this seems unlikely; more realistic is the profoundly negative effect of burgeoning assessments and rigid training structure that has resulted in research being reserved for the privileged few. As Moppett and Hardman demonstrated, more than 50% of UK anaesthesia publications originate from just four academic institutions,<sup>6</sup> supporting this notion and suggesting the current milieu is stifling non-academic departments. Anecdotally (for now, pending the NIAA survey results), and certainly from a full-time clinical trainee's perspective, meaningful research is largely restricted to those taking time out from clinical training to undertake a PhD, MD, or academic fellowships. The reality for trainees who have an interest in research but remain within full-time training is that the time-consuming nature of an increasing burden of assessments and constant rotation through hospitals on short-term placements<sup>7</sup> mean that undertaking and completing a significant research project is increasingly unrealistic (a contention that is likely to be confirmed by the NIAA survey results, published in May). Pandit acknowledged in 2006 that clinical trainees being marginalized from influential research was a distinct possibility, but argued that increasing their participation was not the solution to the academic crisis.<sup>8</sup> Funding short-term academic attachments for clinical trainees may not be the answer, but a review of current conventional clinical

**Table 1** Trend in UK original articles published in the *BJA*, 2004–2013

Country of origin	Year of publication in the <i>British Journal of Anaesthesia</i>									
	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
UK	60	62	38	46	44	36	27	28	27	18
Other European	90	107	97	96	91	76	87	101	92	74
Rest of world	66	64	81	63	62	78	67	69	58	92
Total number of articles	216	233	216	205	197	190	181	198	177	184
UK % of total contributions	0.278	0.266	0.176	0.224	0.223	0.189	0.149	0.141	0.153	0.098
% change from baseline	0	3.33	36.67	23.33	26.67	40	55	53.33	55	70

training pathways and subsequent adjustment (rather than investment) is urgently needed to enable these trainees to still contribute alongside their well-funded academic colleagues.

Some may argue, as Pandit<sup>4</sup> does, that any explanation for the decline in publishing numbers is superfluous, for it is the quality (impact factors, citation scores, *h*-scores, *g*-scores) that really matters. Unfortunately, all these measures are prone to manipulation and while one cannot argue that quality is paramount, it is difficult to disregard such a dramatic decline in actual publishing numbers. To countenance this, Pandit<sup>4</sup> suggests that publishing numbers may not be an accurate marker of academic output, preferring number of academic departments, academic staff, research trainees, and magnitude of any grants.<sup>1</sup> However, Feneck and colleagues suggest these are merely surrogate measures of academic activity<sup>2</sup> and that one cannot ignore a direct measure such as the number of published articles, particularly when the trend is so striking.

Inevitably by scrutinizing *BJA* publications alone, the generalizability of the results is reduced (while the trend remains arresting).

The process of discerning article origin is prone to occasional error particularly with multi-centre trials, but is unlikely to have impacted upon such a significant trend.

As a premier anaesthetic journal and the only one which all UK trainees receive monthly, the *BJA*'s decline in UK publications should not be ignored. The growing number of trainee assessments and constant rotation is surely contributory and must be addressed to enable continued participation in research by trainees that remain in busy clinical posts. Pandit acknowledges that much high-quality research comes from non-academic departments, and it is these clinical anaesthetists that must be facilitated alongside those pursuing full-time academia. Moppett and Hardman<sup>6</sup> distinguish between the 'anaesthesia research community' and the 'UK anaesthetic community as a whole' and it is the latter which the current structure of training and assessment is at risk of alienating. Ultimately, the RCoA and NIAA should be tasked with creating training pathways that ensure research remains accessible to all trainees.

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## Thrombus in left ventricle discovered by transoesophageal echocardiography (TOE) in a patient with acute abdomen: how TOE can be crucial for decision-making in non-cardiac surgery

Editor—A 58-year-old male presented to the emergency room with an acute abdomen requiring emergency laparotomy; the diagnosis was unclear. Preoperative work-up showed air-fluid levels in abdominal X-ray and elevated Troponin I. Since the induction of general anaesthesia was associated with extremely vulnerable haemodynamics, we decided to perform transoesophageal echocardiography (TOE). The TOE at the ME four-chamber view and the ME LAX view discovered a loose and mobile thrombus at size of 1 × 4 mm (Fig. 1A) at the bottom of left ventricle (LV). Additionally, we noticed that heart