The European Heart Journal: parting thoughts after 6 years of editorship

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When I took over the editorial office of the European Heart Journal in the autumn of 2002, the flow of papers was mainly handled manually, and online submission did not even exist. Today more papers are read on the website of the journal than on paper, and an efficient electronic platform distributes manuscripts for review around the world in a few seconds. The use of the internet had a tremendous impact on the review process and the speed of publication. This is not the end of the electronic revolution. Let me give you one example. Even today, most papers are published several months (and, in the case of a cumbersome review, sometimes a year) after submission, thus hampering progress especially in rapidly evolving fields. Furthermore, debates on important published study results usually take place at meetings or webcasts organized several months after publication. Writing a letter to the editor is another possible way of commenting on published results, but few people read these letters besides the correspondent and the authors of the paper involved. It seems therefore likely that, in the future, authors may want to discuss their work with colleagues on a website, similar to Facebook, which could become a kind of electronic journal club allowing discussions among researchers shortly after publication. Other electronic revolutions are pending, and journals, medical societies, and industry will have to take advantage of these opportunities.

A departing editor is usually allowed to give some reflections. These 6 years of editorship have been both challenging and very stimulating. I started the job without any experience. In his last editorial the famous editor of the BMJ, Richard Smith, wrote: ‘One day you’re a professor of cardiology, the next—without any training and often little support—you’re the editor of a million pound journal; it wouldn’t be possible the other way around’. This is exactly what happened to me. I learned a lot during my editorship. Not only from the submitted research itself but also from the people who performed it and the ‘circumstances’ in which it was carried out. What has become very clear to me, and I fully realize that this is stating the obvious, is that the selection of the best papers and thus the scientific value of a journal is critically dependent on the peer-review process. This process, rightly called ‘sacred’ by Richard Smith, is far from perfect, sometimes biased, and often much delayed, upsetting authors (and editors).

Yet I strongly believe it is the best available system and that without peer-review will undermine the credibility of research. Good reviewers are able to detect fraud or subtle duplicate publications (as I sometimes witnessed during my editorship). I also believe that all papers should undergo a careful statistical review before being accepted. Using inappropriate statistical analyses is a kind of hidden (intentional or unintentional) fraud.

Reflecting on the European Heart Journal, I am pleased with what has been achieved over the last 6 years (see Table). Although it has never been our intention to ‘beat’ the AHA and ACC journals, it is fair to say that ESC leaders and editors of ESC journals are a bit frustrated that the best papers always go first to the USA, including those authored by Europeans. European authors should not be criticized for this as authors always try to get their papers published in the best journals. The bottom line is that it is up to the ESC and the editors of the ESC journals to make their journals better and more attractive to authors. This process will require a lot of effort (and money). With the support of the ESC and the publisher, Oxford Journals, the European Heart Journal has come a long way and has now become a major player in the field of clinical cardiology, and we are very pleased to have contributed to this progress.

Running this journal would never have been possible without the invaluable help of my deputy editors: Stefan Janssens, Frank Rademakers, Johan Vanhaecke, and, for a few years, also George Sutherland, and of all the associate editors at the university of Leuven. Special thanks go to Ann Belmans for excellent and very tough statistical reviews (sometimes at the despair of the

| Table 1 |
|---------|---------|---------|
| Total submissions | 800     | 1200    | 3350    |
| Individual subscriptions | 3000    | 14 750  | 18 230* |
| Time to first decision (days) | –       | –       | 20      |
| Publication time (weeks) | 34      | 26      | 3       |
| Impact factor | 1.43    | 5.15    | 7.92    |

*There are an additional 5000 institutions with access to the Journal.
Cardiac magnetic resonance demonstrates the three-layer involvement in Churg–Strauss syndrome

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A 35-year-old man was referred to the Cardiology ICU for chest pain and fever (39°C). His medical records included a 2-year history of asthma and sinusitis and a recent asthenia and weight loss. ECG showed T waves inversion in V2, V3 and V4 derivations and a right bundle branch block. Troponin level was increased (48 μg/L). Blood analysis disclosed severe hypereosinophilia (6350 mm\(^2\)3) and an increased C-reactive protein (76 mg/dL). Antineutrophilic cytoplasmic antibodies were negative.

Transsthoracic echocardiography showed a slightly decreased left ventricular ejection fraction (45%), interventricular septum hypokinesia and small pericardial effusion. MSCT coronary angiography was normal.

A cardiac MR examination was performed (Symphony, Syngo 1.5T, Siemens, Erlangen, Germany) to investigate this myocarditis. The cine sequences confirmed sonographic findings. LV end-diastolic and end-systolic volumes were moderately increased (respectively, 210 and 121 mL). Three-dimensional and 2D (PSIR) delayed enhancement (DE) sequences were performed 10 min after injection of 0.2 mmol/kg of gadolinium chelate. They showed a three-layer involvement of the heart including:

1. Septal and inferior subendocardial DE involving the inferior papillary muscle (Panel A, white arrowheads), primarily evocative of endomyocardial fibrosis (EMF).
2. Diffuse intramural and subepicardial myocardial DE (Panel B, white arrows).
3. A thickened enhanced pericardium (Panels A and B, dashed white arrows).

A Churg–Strauss syndrome (CSS) was diagnosed and oral corticosteroid therapy was introduced.

Six months later, a follow-up cardiac MR demonstrated unchanged LV functional parameters with persistent myocardial and sub-endocardial foci of DE (Panel C, white arrowheads and Panel D, white arrows). On the contrary, pericardium had returned to normal (Panels C and D, dashed white arrows).

Cardiac involvement is a leading cause of mortality in patients with CSS. It can associate various conditions such as eosinophilic EMF, coronary vasculitis, myocarditis, and pericarditis.

In this case, cardiac magnetic resonance was able to show an extensive cardiac involvement and demonstrate the pericardial disease improvement under corticosteroid therapy.