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MAJOR LOWER-EXTREMITY AMPUTATIONS IN DIABETES: A RESPONSE TO “A CANADIAN POPULATION-BASED DESCRIPTION OF THE INDICATIONS FOR LOWER-EXTREMITY AMPUTATIONS AND OUTCOMES”

After reading the report by Kayssi and colleagues¹ that describes the nontraumatic lower-limb amputations in Canada during the 2006–2009 period, I would like to stress the importance of population-based studies focused in disease outcomes.

Despite the lack of clinically detailed information being the main limitation in the use of administrative databases, the research in this field is quite necessary because it brings a large panorama of quality of health care delivery, allowing regional and international comparisons as well.

Two findings of the aforementioned study are worth noting: diabetes was the leading cause of nontraumatic amputation in Canada (about 80% of the cases), and 1 of 3 cases corresponded to above-knee amputation (i.e., major lower-extremity amputations).

Major lower-extremity amputation is considered a devastating outcome in diabetes that reflects longstanding inadequate glycemic control and constitutes a strong indicator of the need to carry out medical interventions.

The characterization and even the control of amputations in patients with diabetes has been reached in some high-income countries, but the lack of epidemiological studies in most middle- and low-income nations makes the management of the disease difficult.

In Mexico, major lower-extremity amputation in patients with diabetes

is considered a growing public health problem that poses important challenges in terms of prevention, epidemiological characterization, medical treatment, and physical, social and emotional rehabilitation.

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Competing interests: None declared.

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AUTHOR RESPONSE

We thank Dr. Ascencio-Montiel for his interest in our study and agree with his comments regarding both the strengths and weakness of administrative databases. We agree that major amputation in diabetic patients is a global public health crisis, and we, and others, are actively pursuing multidisciplinary limb-preservation strategies. We applaud Dr. Ascencio-Montiel’s efforts to do the same in Mexico.

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Competing interests: None declared.

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MY LATIN TEACHER: RESPONSE TO THE EDITORIAL “DATUM ISN’T, DATA ARE”

As I read the editorial “Datum isn’t; data are,”¹ I thought about why I already knew this: 4 years of Latin in high school. Although Latin was considered more a logic subject like mathematics than a foreign language course, as a

teenager I was fully in agreement with the popular adage:

Latin is a language as dead as dead can be. It killed the ancient Romans and now it’s killing me.

I had a teacher, Ms. Caughey, who taught *carpe diem* and *collige, virgo, rosa* (gather, girl, the roses) with a little extra emotion and put it on an exam, as I thought she would. I got a good mark on that test. It was only in medical school that I began to appreciate the value of her teaching, as I struggled to learn medicine and memorize the overload of data in seemingly endless didactic lectures. The medical vocabulary based on Latin was the only easy thing. Albino (*L. albus*), supinate (*L. supino*), pronate (*L. promo*), ulcer (*L. ulcus*) were just common sense and did not require study.

I did not thank her personally, and she is one of many teachers I should have thanked. She was a classic subject for this quote of Henry Adams’:

A teacher affects eternity. He/she can never tell where his/her influence stops.

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Competing Interests: None declared.

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A USEFUL SET OF GUIDELINES: A RESPONSE TO “TOWARD LATE CAREER TRANSITIONING: A PROPOSAL FOR ACADEMIC SURGEONS”

In this issue of *C7S*, Richards and colleagues¹ propose a series of guidelines regarding late career transitioning for academic surgeons as they approach the end of their academic surgical

careers. They stress the importance of solutions to ensure transition out of practice in a timely manner with grace and dignity. Mentoring new faculty recruits, increasing teaching and administrative activities and clinical job-sharing with young faculty members all remain part of a good transition plan.

These guidelines defined by the Department of Surgery at the University of Toronto will serve as a sound basis for ongoing conversations and discussion in our own institution. Thanks to the authors for helping surgeons and academic leaders to look at a difficult aspect of a normal surgical career.

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Affiliation: From Université de Montréal, Montreal, Que.

Competing interests: None declared.

DOI: 10.1503/cjs.1760055

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AUTHOR RESPONSE

We thank Dr. Carrier for his complimentary remarks regarding our guidelines on late career transitionning for academic surgeons. We agree that proper mentoring of new faculty recruits, increasing teaching and administrative activities, and job-sharing are important aspects of a graceful transition.

We fully appreciate that regional circumstances may dictate additional

approaches to late career transition planning. In this way, we hope our guidelines will serve as a starting point for important discussions among surgeons in academic centres across all provinces.

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SURGICAL RESEARCH AND INNOVATION DESPERATELY NEEDS SUPPORT: A REPOSE TO "TOWARD A NEW SCHOOL OF SURGICAL RESEARCH"

In the last issue of *CJS*, Dr. Vivian McAlister¹ suggested that surgical research needs a "New School" of thought and practice to progress. Facing the recent decline in successful grant applications for innovative surgical research, preclinical research from our academic surgical programs tends to disappear.

As usual, there is no simple solution to a difficult problem. There are opportunities, but no shortcuts to resolve this issue. In recent years, many of us have focused on improving the delivery of surgical health care to our patients and to the public while securing our own contracts and revenues from provincial governments. Have we forgotten to nurture clinical research?

It will always be difficult to combine a successful clinical career with competitive research. Grant applications, laboratory experiments, and manuscript preparation and submission combined with on-call

schedule, operating time and teaching duties remains a gigantic task. In my mind, it is the responsibility of group practices, hospital services and university departments to promote, train, support, and help those who wish to pursue a career of research and innovation in the field of surgery. There are so many unanswered questions that it is useless to list them; the real problem remains the source of funding to support research activities, laboratories and even newer technological applications.³ Independent surgical research activities, new technological development and related clinical applications will need to be promoted by health care decision-makers and supported by government agencies. The shortcoming of this will be not only a serious loss in our standing in research and academia at home and abroad, but also a true loss for the Canadian public in general. Surgical research and technological innovation needs support now.⁴

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Affiliation: From the University of Montreal, Montreal, Que.

Competing interests: none declared

DOI: 10.1503/cjs.1760057

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