



# Top Journals, PubMed, Scholars Peers and Robert Hahn: A Conspiracy, Being Unfair or Just Destiny? Contrasting Volume Kinetic (VC) to Volumetric Overload (VO) Inducing VO Shocks (VOS) Causing ARDS: Testimony for History and Quest 1

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## Abstract

**Objectives:** To demonstrate a new standard of peer reviewing that should not be blind.

**Materials and Methods:** Using a new standard of peer reviewing the author critically analyses an article sent to him by another editor written by his competitor about the TUR syndrome and complications of fluid therapy. The author contrasts and compares an article he was requested to review to his own article specially written for comparison.

**Results:** The author resolves the huge multi-dimension puzzles while comparing Professor Hahn to Ghanem without sounding condescending or insulting. It is only with God's help I consider myself a special one of his creature that has achieved miracles and has repeatedly won gambles with an odd of <1% against majority of 99% or even 99.99%, yet he cured himself from all addictions and gambles. He has resolved the puzzles of the TUR syndrome, Hyponatraemia and ARDS.

**Conclusion:** The new standard of peer reviewing is clearly superior but never blind. It should be adopted for future standard in true science after changing faulty laws and regulations in all and every country for the eternal piece on earth to take effect immediately. It is destiny and destiny that operates all the time in marriage and divorce with our individual choices driven by seeking our own love of life. Conspiracy cannot be excluded and this the true challenge and danger ahead. May God help us all, Amen.

**Keywords:** Blind; Hyponatraemia; TUR syndrome

## Introduction

When the respected Editor of the Journal of Basic and Clinical Physiology and Pharmacology (JBCPP) kindly sent me this article by Professor Robert Hahn to review for the second time in 5 months, I thought of declining to review it first as I have retired from peer reviewing, and I had previously reviewed it in February anyway (Please, see reviewer's comment on Hahn article [1]. However, I decided to review it for the second time after reading the article Twice plus another mainly to remind myself why did I do that and why is there a huge gap of misunderstanding of the TUR syndrome between Robert Hahn and "I" [2-4]. I dragged

myself out of my retirement and convalescence period being recovering from my recent illness and hospital admission followed by nurses' follow up twice daily for a total of 3 months in the UK, and now I am in Egypt. I also dragged myself out from a hectic extremely busy schedule under extremes of pressures fighting another WAR (Multitasking at Multidimensional level-curtsey of Late Great GD Chisholm EDITOR OF BJU in 1990 (Figure 1) who he was so visionary to publish both Hahn's article and ours side by side in 1990 (10\*+Nobel- if Nobel agreed) - with a promise to return later with remarks on Plagiarism v Quoted text and over-referencing oneself v Hahn and who was first at

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what?) I am just happy to review the article for my friend Robert for the second time. In the first review I judged after only reading the abstract that the article should be accepted and reported without having to comment on it. This is because the article is impeccable by current peer reviewing standard and top journals requirements of rules and regulations and instruction to authors as concerns study objectives, material & methods, and results, but leaves much to be desired on the twisted wrong conclusion, discussion, and references regarding the pathogenesis of the TUR syndrome and Volume Kinetic (VK) v Volumetric Overload (VO). Can you see it Hahn and the respected reader the difference between VK and VO particularly that of the TUR syndrome as cause of the cardiovascular shock (VOS)? Also, I have been so disappointed and upset with Robert who I still consider my best correspondence friend and most knowledgeable authority on fluid therapy and the TUR syndrome that I have known since 1990 to date, whom I have the highest admiration, respect and regards for his person and work acknowledging his massive contributions on the subject discussed here. I do not aim to teach or breach you or anybody here. I am not asking you or anybody to change your own religion either. I shall steer well clear of debates on religions, politics and prejudice but I may be trying something that is perhaps much harder than that: I am trying to correct wrong believes that are impediments and cause for misunderstanding in order to get you out of the loss of wanderings to wake you up from your deep intellectual coma-17/07/2021 -07:07:52.(bold text and yellow highlighted text realized long ago from my need to cure my stuttering in spelling and grammar editing I learned from pdf galley proof reviewing). Due to lack of understanding as a final attempt to cure these embodiments of mine some goes back to high school like the difference between B and P and remains until I write the (End) of this document and all previous articles until I realized my need to see it listed in PubMed!/? Oh yes, professional peer reviewing and Plagiarism checker which I tried my best to buy one and use or twice by hiring professionals at BMJ and SAGE Respiratory Medicine when I asked nicely if they would do it with a promise on belated payment when I have the money. Both said NO- and I could not, and I can't afford it and I am sorry I do not think that I personally need it now anyway [5-7]. After the rejection of an article from Brazil as peer reviewer advising the authors to use such a wonderful service for those who need it after knowing it is acceptable by all Top-Rated Journals with high Impact Factor, when will they admit to their embodiment and ask for help not that or because of that that I had received in most honest and truthful one from BJU and BJUI. Open Access Journals (OAJ) came to my rescue risqué (I could have corrected all the words right here in Microsoft Word without risking forgetting it by the time it takes to go to Google! I also realized that I need both Google, Google Scholars, PubMed, and Microsoft Word having finished my purpose to Use Except,

Excel, EXCEL, and may be even PowerPoint PowerPoint (PP). My son's year rent of Office 365 had finished just before I was admitted to the hospital and neither me nor my sun could afford it, but I am and only me responsible for using version 2010 which came free with the restoration (Reinstalling Windows with complete formatting of HD) after the 4-5th crash of my Laptop Windows and Office 2010- everybody in Egypt is doing it legally anyway. Now with the affordable fees by Microsoft for Office 365 I have bought it as family pack. I am back from my break I had for a cigarette in my hand and a cup of coffee I had in the balcony for which I did not find Coffee Mate, nor milk but I found Baby milk in the cupboard where I was Looking for a possible new Coffee mate (my personal favourite as excuse to explain my just discovered new embodiment. My wife since she volunteered to be my nurse as well as serving me as housewife since we got married 33 years ago) caught me sleeping in the balcony with cigarettes in my hand and a burn in my Frock." I could not or dare not tell her that my bad habit caused it while asleep having another Cigarette break [8-11]. The Cigarette has proved to be my Moses' stick as have been proved to be my apparent saver. The majority of OAJ accepted to report my articles for free > 100 articles as new samples and only 2 OAJ accepted to be the first and second whose kind editors and editorial managers accepted minimum APC of \$30 for DOI charges the FIRST was ECEC [this good lady editor was so shy to allow me to mention her names and I think she wants to say yes but she said only "Just Happy to help" I made her a big promise that I know I cannot keep unless my dreams come true on the G tube and more self-references without any plagiarism, and second (PAUSE to get the full names of the Journals not for A Cigarette and Cup of tea this time but also until I read Hahn Articles for the second time in full) [12-17]. I have 2 journals that would accept \$30 for reporting my articles such as ECEC. There were also other journals that would not accept <\$65 USD [17]. That is enough to prove that I committed repeatedly "Quoted text" and possible Plagiarism as the checkers call it so did Hahn (as I shall show later), but surprise, surprise, it was Professor Starling first who did that in the Lancet X3 and 10 years later in J Physiol 1896 [18,19].

- Stela showing "Isis the Great Goddess" sitting and holding a was-sceptre. A man, the head of necropolis workers, adores her. Middle Kingdom of Egypt, Petrie Museum of Egyptian Archaeology, London (Figure 1-3).

Other snakes and parted the sea for Moses and Jews to pass while the Pharaoh and army drowned. Thanks to the Editor of Journal of Basic and Clinical Physiology and Pharmacology (JBCPP) for giving me the second chance to review Hahn's articles and mine knowing this time for sure it deserved to be (Rejected) but I could not possibly miss my last chance to read it again, to get my MD THESIS of mine out and scan it again although I know by Heart

what is in it but just to satisfy my Heart and Brain both are needed for (Complete Science- The Stage of Science Philosophy that has already started with no distractions of any kind- except a fly I had to kill now by the insect killer and was about to but it disappeared before doing so). I can honestly say if you can read these 4 articles of mine you have read the whole Thesis and what is missing are only a quote at the beginning on “If we have stopped dreaming. We are old” [20-23] (Figure 4).



Figure 1: Geoffrey D Chisholm ChM, FRCS, FRCS Ed.

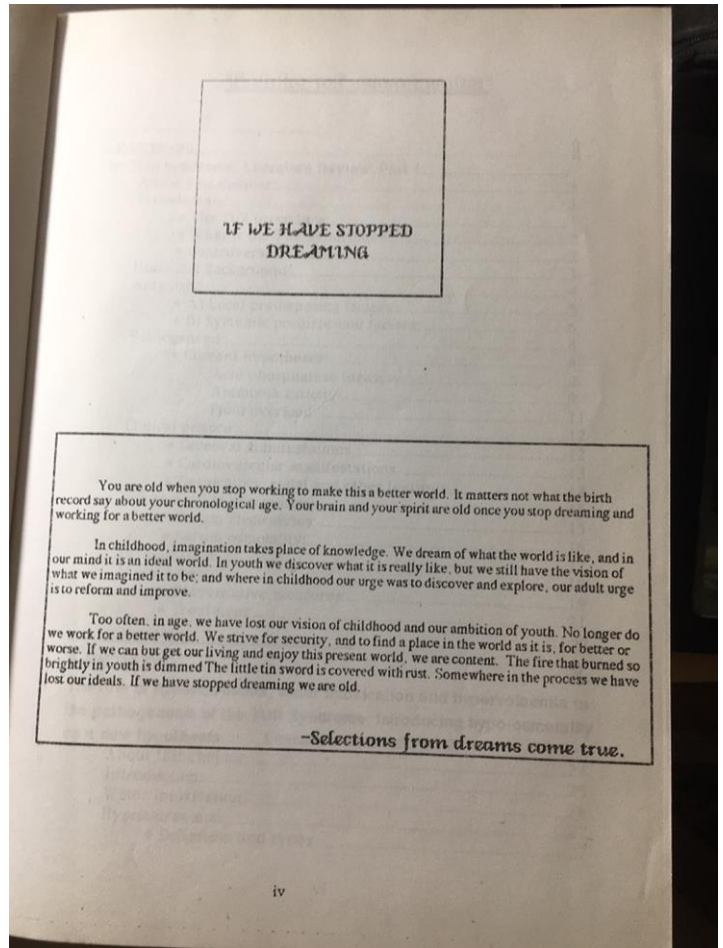


Figure 4: If we have stopped dreaming.....we are old!



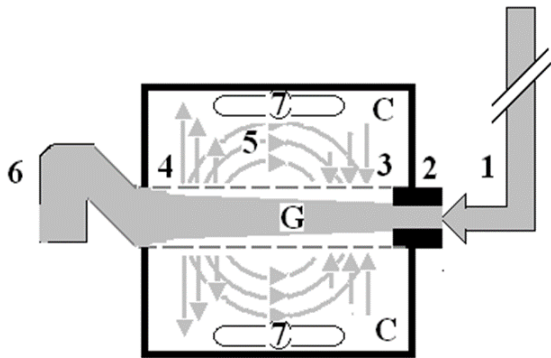
Figure 2: The Pharaoh stick.



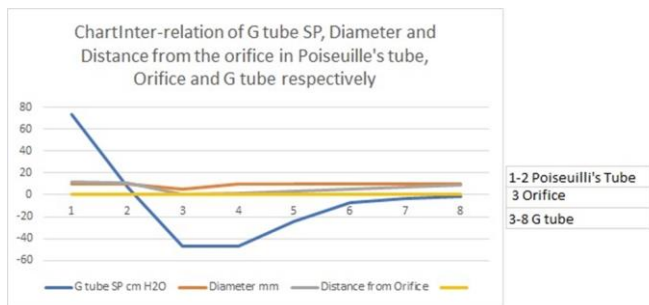
Figure 3: Pharaoh Staff that belongs to an ancient pharaoh long before Moses' but that of Moses had a special power of God that turned into snake eating all other snakes and parted the sea for Moses and Jews to pass while the Pharaoh and army drowned.



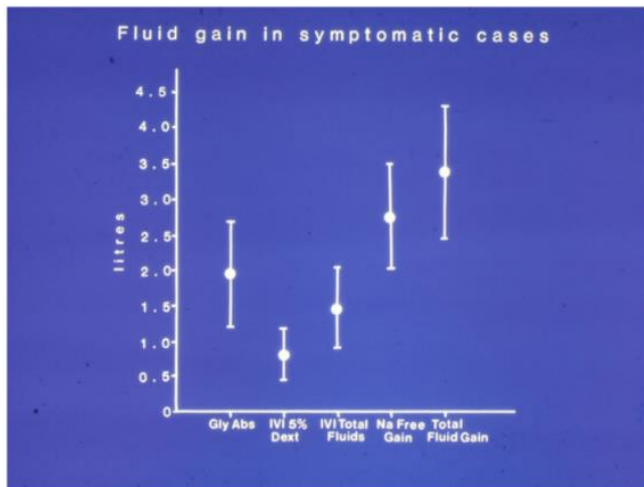
Figure 5: Shows the Best of British Editors of BJUI.



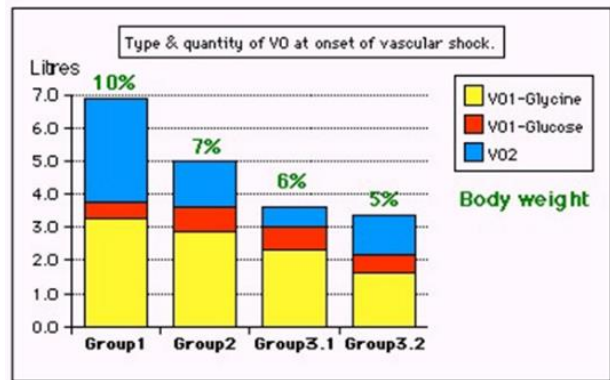
**Figure 6:** Shows a diagrammatic representation of the hydrodynamic of G tube based on G tubes and chamber C.



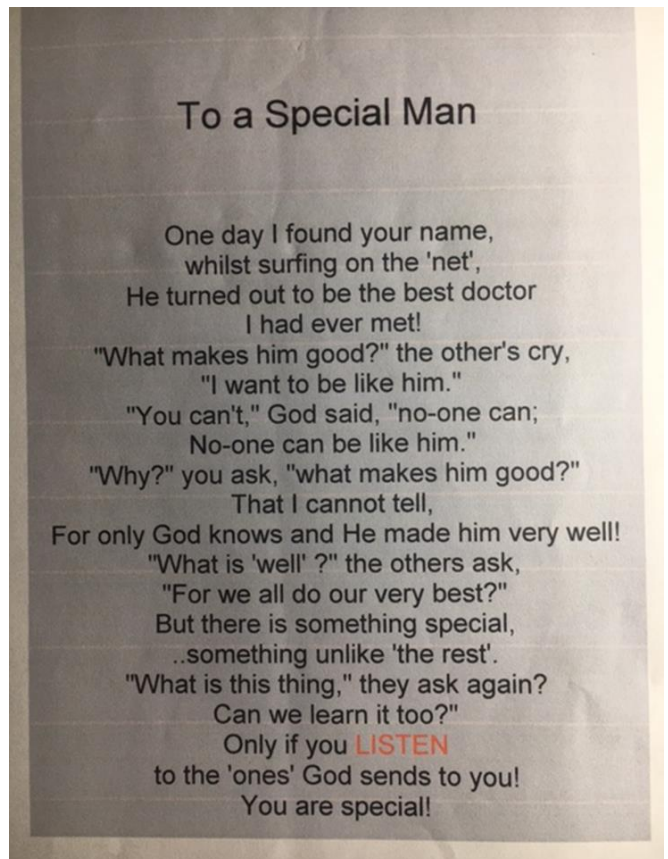
**Figure 7:** Shows the relationship between SP to the Diameter and length of the G tube which demonstrate a negative SP starting at the orifice (Point 2) (akin to precapillary sphincter) and extends as high negative pressure gradient over the proximal part of the G tube (Point 2-6) to cross 0 line at point 8 and then turn positive of 7 cm water at Point 9.



**Figure 8:** Shows the means and standard deviations of volumetric overload in 10 symptomatic patients presenting with shock and hyponatraemia among 100 consecutive patients during a prospective study on transurethral resection of the prostate. The fluids were of Glycine absorbed (Gly abs), intravenously infused 5% Dextrose (IVI Dext) Total IVI fluids, Total Sodium-free fluid gained (Na Free Gain) and total fluid gain in litres.



**Figure 9:** Shows volumetric overload (VO) quantity (in liters and as percent of body weight) and types of fluids. Group 1 was the 3 patients who died in the case series as they were misdiagnosed as one of the previously known shocks and treated with further volume expansion. Group 2 were 10 patients from the series who were correctly diagnosed as volumetric overload shock and treated with hypertonic sodium therapy (HST). Group 3 were 10 patients who were seen in the prospective study and subdivided into 2 groups; Group 3.1 of 5 patients treated with HST and Group 3.2 of 5 patients who were treated with guarded volume.



**Figure 10:** Shows a poem on a special man Written and gifted to me by Alison Banister.



**Figure 11:** Shows Dr Richard Horton the Editor-in-Chief of the Lancet.

After considering all criticisms and comments by the anonymous peer reviewer comments (Supplementary Information (SI)), the article became ridiculously too long and I had to split it into two substantial articles [6,7]. Hahn must not understand that there is nothing personal here, nor is there a vendetta. I have been fighting several wars at multilevel multi dimensions on the subject but never a selfish one. I cannot humiliate, attack, insult, or harm you or be offensive, insulting or condescending to anyone at all—except for the tyrants, arrogant and utterly stupid’s including or starting with myself. I cannot put the “poison in honey” for anyone but I might have to give you some bitter tasting medicine to help you recover from a serious dark state such as the long state of intellectual coma and being absolutely lost in wanderings and chasing mirage for 3 decades since we met, even before that: 40-years ago. Most humbly and with utmost respect and polite manner I shall proceed in this critical, analytical criticism review of your article, may I please? Robert Hahn has a big problem that he must cure himself from if he can or allow me to help him curing it. That is Impediment! I trust he can overcome it by himself but have to say it just in case he needed help. Either he never read any of my articles and the book at all, despite me, being (envious!) of his work results, or has a mental block that prevent him from receiving, understanding, and comprehending my writing in simple, plain, and good English. What is the matter with you Robert? You fooled me 4 times by sending me articles of yours that made me think you have come close enough to my level of understanding, only to discover that you remain where you were 30 years ago when I met with you in Cairo in 1990 in our only hello and goodbye meeting. This has happened once on the complication of fluid therapy on which I shall reproduce your abstract later [2]. The second on your opinion of the porous orifice (G) tube discovery when you said you were impressed in January 2020 while in 1990 you shunned it and me down, looking the other way and refused to allow me to tell all about it and the

TUR syndrome [3]. On that 3rd time you sent me your article on the Revised Starling Principle (RSP) based on which I wrote my reply article Revised Starling’s Principle (RSP): a misnomer as Starling’s law is proved wrong [5,21]. The fourth when you repeatedly reported and talked about volumetric kinetic (VK) in the pathogenesis of the TUR syndrome as you do in the discussion of this article but never referenced me as the originator of the concept of VO shock (VOS) causing both types of ARDS 1 and 2 [24]. Come on Hahn. Open your mind and eyes up and pull your socks up so I may be able to help you get out of the trap you locked yourself within and the state of impediment or “intellectual coma” you have been in for 30 years now. Please, forget about your useless contributions on Glycine toxicity and alcohol monitoring, the fancy looking but wrong formulae and figures. That is a mirage man that you have been chasing in vain for >3 decades now. Look at the real issue of Volume kinetic you keep repeatedly talking about in similar reports as shown in your discussion. You have done lots of research on it with excellent results but twisted discussion, conclusions, and references as demonstrated in your article that is critically analysed, criticized, and discussed here [1]. Try to better understand me well here, please. Now allow me to refresh your memory but before I do that allow me to precisely define the questions and objectives of this new debate just opened now.

## Material and Methods

- What is difference and relevance between fluid absorption overload and VK in the aetiology of the TUR syndrome?
- I was ordered to come here and continue my story with the TUR Syndrome (The TURP Syndrome). The other reason is being you must have become too bored and tired and sick of me whether those who know or those who do not know. Date today: 17 July 2120 I (During the breaks I have reached an acceptable agreement between my wife and me that I shall avoid any arguments of religious and political relevance- including not to mention those alive and dead who or their inheritor may feel offended by naming them even as references to the scientific subject of the TUR Syndrome’ affirming that both her and my son and daughters do not want to be mentioned and in return to agree to read an Arabic translation of what I write to read both she and whoever she trusts in Egypt).
- Because of heat wave in Cairo and finishing installation of the new air conditions I could go first in the absence of internet connection and correct all the spelling and grammar errors I have intentionally left till now. I prefer to start with another miracle of good GOD Almighty God not me. (My daughter Sarah or rather SARA as she prefers was apparently happy still playing with her two Mobiles: One is Apple iPhone she bought new for >1200 GBP and another

Android mobile for slightly less of only >1000 GBP. She is apparently happy now because she will be seeing her psychiatrist (for what I thought is depression) and taking her medicines by a good psychiatrist in Cairo who she chooses from the internet and who will prescribe the right medicine for her depression to review her (IN 3 Weeks' Time).

- I did not stop telling her jokes most of the way from Al-Mansoura to Cairo (2.5-3 hours car journey) on which Sara was laughing while her mother was so upset and angry. She tried her best to keep me quite and to stop talking while I keep my promises not to mention her or her children Khalid in particular. I wrongly thought that Sara was still in love with her divorcee but in fact she hates him. My wife gets angry because I keep poking her wounds or like squeezing a big abscess or massaging prostatitis that only can be cured with a Lancet incision and a TURP surgery, respectively! I understood and stayed quite the rest of the journey while Sara was playing for me the most popular songs called Medley songs on my request. The word Medley answered a question in my mind on the best capitalism to prevent Karl Marks's dreaded prediction theory of violently collapsing to communism!
- (The curser refused to move until I correct the spelling of Khalid, Sara and the unmentioned one). (Break by Nannah's order to come for breakfast and insulin injection now- I have forgotten all about insulin, injector with so fine needle that I never felt pain, but she turns her face away If I try to inject myself in belly or thigh?) This all I am allowed to say now but may be less as she will decide (Editors decide). So, my request and letter of desperation is withdrawn from Mr Kitchen- if only for any reason there is to make you unable to respond and the first one not seeing me for >10 years.
- Later in the evening while in my wife's flat in Cairo I did the worst blunder in my life. While my wife and her sister Mimi were talking, I said excuse me I have something to say. I started by saying to Mimi: "Do you remember me saying to you that you are like a fax machine that have a good sender and bad receiver?" She responded laughing in a sweet helpless apology: "Yes. What can I do? I am alone by myself all day and night since my husband died and the children are busy with their lives having grown up. Once I can talk to anyone I do it none stop over the phone and in real face to face conversations". I said, "That is why your sister loves you but every day she complained to God why does she has to put up with two stupid women friends in her life?" Mimi Laughed but Nannah stared at me in disbelief and told me later: "Why did you have to be so bluntly cruel" I said sorry never again. I thought you told her that. If you

ever have a secret do not tell me or ask me directly not to reveal it.

- What is the difference between a physiological VK (of <2 L as Hahn reported in the article under review [1]) and the pathological VO of 3.5-5 L causing the TUR Syndrome as we reported [3,11]. You may stop there but I shall point out here the role VO of sodium-based fluids of up to 7-10 L in surviving ARDS patients that you have not even started to consider or think about yet while being fully realized and understood by me.
- Let us agree that some old debates are now completely obsolete, and these debates have already been closed only to open a new worthwhile one here.
- Let us agree that the debate on saline versus albumin is now obsolete based on adequate substantial affirmative and currently available evidence provided by other eminent authors with prospective and other types of studies and validated humbly by me that Starling's law is wrong [4,8-11].
- Let's agree that Starling's law is the main reason and the scientific basis of fluid therapy in shock, acutely ill patients and during prolonged major surgery in current surgical and clinical practice, if it is something that should be understood.
- Let us agree and identify what is misleading physicians into giving too much sodium-based fluids that include saline, Hartman, Ringers, plasma and plasma substitutes, and blood during shock management [25,26].
- Let us agree or even assume or pretend that Starling's law is wrong thus Revised Starling Principle (RSP) and the equations must be also wrong based on 21 one reasons using references that are mostly not mine but by great giants before me who allowed me to stand at their shoulder so I can see clearly.
- Let me mention some more self-references here some of which that make Robert may feel I am being unfair to him and provoke him- I look forward to him self-referencing himself with justifications in his reply and testimony [27-33].
- Please, do not take my views on statistics for granted [6]. Invite the best statisticians available to explain to us what does the significance of  $p < 0.05$ ,  $p = 0.001$  and  $p = 0.0007$  really mean in plain simple English we can all understand!
- Let the statisticians experts also explain what is the power of statistics for 100 patients undergoing the TURP surgery who have 10% morbidity with a possible (definite near death) 1% mortality such as our reported study (our patient was saved) and a previous study from the same Urology Department at DGH Eastbourne in which 1% mortality was reported with 7% morbidity [34]. It was done also under the supervision of



the late great Mr KC Perry and JP Ward in which they reported 7% morbidity and 1% mortality while our study had 10% incidence of the TUR syndrome morbidity among whom we saved one patient from near death- literally bringing him (1%) back from the dead by using hypertonic sodium therapy (HST) of 5%NaCl and/or 8.4 % NaCo3 and self-references are listed in [34-36].

- How many patients are needed for a cohort prospective study to obtain statistical significance to give the above correct data about the TURP syndrome and ARDS?
- Do we need more prospective studies here or just reanalyse the available data from Hahn own research as well as others using the same methods you used in your article being critically analysed and criticised here [1]?
- Read our articles again to appreciate what I am talking about here- I have done so as I write now here.
- Your study was on 12 cases, among which 10 cases (85%) had the TUR syndrome but you never said among whom how many died?

### Lies, Damned Lies, and Statistics

This is a phrase describing the persuasive power of numbers, particularly the use of statistics to bolster weak arguments. It is also sometimes colloquially used to doubt statistics used to prove an opponent's point. This is a quote from the internet now that was not available before 1985.

There was no internet on Apple Mackintosh I bought in 1985 but it has Wonderful Stat View 500+ programme that I bought and served me just fine. However, I consulted with 3 Statisticians before and after the study and the editor consulted the BJU statistician. Have you ever thought about what were you looking for Hahn? These questions I asked myself since I planned my prospective study in 1981 and despite trying very hard there was no answers there despite my prayers being answered by GOD allowing me access to the best 3 statisticians before, during and after my study for MD Thesis [22].

- I cannot wait for you Hahn another 30 years so let us do it now and with or without validation on the TUR syndrome and RSP. Be careful, vigilant and make no mistake about the issues that require validation:
- VK versus VOS is the urgent most important question now, not albumin versus saline, and certainly not RSP that is another never ending debate that I have already done with (Terminated) [5]. Did you read my article on that Hahn that was my response to one of the two articles on RSP you sent me in 2020 [20,21]?

No one with the type of utter stupidity, ignorance and arrogance represented by 2 Professor from London should enter this debate for their own sake. If they are determined I shall recommend to

the editor to accept their testimony and report it with or without me commenting on it.

### Results and Discussion

#### Back to the TUR syndrome: understanding misunderstanding Hahn's understanding of VK and the TUR syndrome!?

The distribution and elimination kinetics of the water volume in infusion fluids can be studied by volume kinetics. The approach is a modification of drug pharmacokinetics and uses repeated measurements of blood haemoglobin and urinary excretion as input variables in (usually) a two-compartment model with expandable walls. Study results show that crystalloid fluid has a distribution phase that gives these fluids a plasma volume expansion amounting to 50%-60% of the infused volume as long as the infusion lasts, while the fraction is reduced to 15%-20% within 30 minutes after the infusion ends. Small volumes of crystalloid barely distribute to the interstitium, whereas rapid infusions tend to cause edema. Fluid elimination is very slow during general anaesthesia due to the vasodilatation-induced reduction of the arterial pressure, whereas elimination is less affected by haemorrhage. The half-life is twice as long for saline as for Ringer solutions. Elimination is slower in conscious males than conscious females, and high red blood cell and thrombocyte counts retard both distribution and re-distribution. Children have faster turnover than adults. Plasma volume expansions are similar for glucose solutions and Ringer's, but the expansion duration is shorter for glucose. Concentrated urine before and during infusion slows down the elimination of crystalloid fluid. Colloid fluids have no distribution phase, an intravascular persistence half-life of 2-3 hours, and—at least for hydroxyethyl starch—the ability to reduce the effect of subsequently infused crystalloids. Accelerated distribution due to degradation of the endothelial glycocalyx layer has not yet been demonstrated

### Editorial Comment

In this narrative review concerning intravascular fluid kinetics, perioperative theoretical and practical perspectives are presented and explained. Avenues for future research in this subject area are also presented.

#### This reviewer's comments (No more Blind reviews please- the story later)

Hahn did not mention any quantification of the pathological VO. What he talks about above is volume kinetic (VK) of physiological VO of <2 L in < 1 hour. Irrespective of the type of fluid he uses the maximum volume he can use in the awake volunteers and patients by IV fluid infusion is <2 L in one hour- Guided by the correct Ethics and regulations of the Ethical



committees. Hahn must show us the VO of type 1 (VO 1) of sodium-free fluid of 3.5-5 L as documented in the patho-aetiology of the TURP syndrome. (Break AZAN EL-ASR in the near Mosque-curtsey of my Father and Mother Bob and Freda Prentice of Eastbourne and their true Son Mark- The story elsewhere) [37-45]. Hahn and all multicentre trials on ARDS must show us the

VO 2 of >3 L and up to 7-10 L for surviving ARDS patients and >12 L for the dead of mainly sodium-based fluids such as saline, Hartman, Ringer and plasma and substitutes and blood which he may give to anaesthetized patients on using both types of fluid regimen of Early Goal Directive Therapy (EGDT) of the Liberal regimen and Conservative of Bolus Fluid Therapy (BFT) [46-48].

**Table 1:** The manifestations of VOS 1 of the TURP syndrome for comparison with ARDS manifestations induced by VOS2. The manifestations are the same but one vital organ-system may predominate.

Cerebral	Cardiovascular	Respiratory	Renal	Hepatic & GIT
Numbness Tingling SBB <sup>1</sup> COC <sup>2</sup> Convulsions Coma PMBCI <sup>3</sup>	Hypotension Bradycardia Dysrhythmia CV Shock* Cardiac Arrest Sudden Death	Cyanosis. FAM <sup>4</sup> APO <sup>5</sup> RA <sup>6</sup> Arrest CPA <sup>7</sup> Shock lung ARDS <sup>8</sup>	Oliguria Anuria <sup>8</sup> Renal failure or AKI <sup>9</sup> Urea ↑ Creatinine ↑	Dysfunction: Bilirubin ↑ SGOT ↑ Alkaline Phosph. GIT symptoms. DGR <sup>10</sup> Paralytic ileus Nausea & Vomiting.

**Table 2:** The mean summary of data, therapy and outcome comparing the 3 groups of 23 case series patients who's (whose) VO.

1	Gr1	Gr2	Gr3	Gr3.1	Gr3.2	Normal	Units	
2	Number of patients	3	10	10	5	5	mean	
3	Age	71	70	75	72	78	72 Years	
4	Body weight (BW)	69	70	68	71	65	69 Kg	
5	Postoperative serum solute concentration						Preoperative	
6	Osmolality	271	234	276	282	271	292 Mosm/1	
7	Na+	110	108	120	119	121	139 Mmol/1	
8	Ca++	1.69	1.79	1.85	1.84	1.86	2.22 "	
9	K+ (P<.05)	5.6	4.8	5.0	4.9	5.0	4.46 "	
10	Co <sub>2</sub> (P=.002)	23.0	23.0	25.5	24.0	26.4	27.30 "	
11	Glucose	13.2	17.3	16.4	15.9	16.9	6.20 "	
12	Urea (P=.0726)	26.5	9.0	6.6	6.8	6.4	6.7 "	
13	Bilirubin (P<.05)	19	16	8	6	9	7 "	
14	AST	124	32	20	18	21	20 "	
15	Protein	43	52	48	44	52	62 g/l	
16	Albumin	23	30	30	28	32	39 "	
17	Hb (P=.0018)	119.3	127.9	114.5	105.2	123.8	123.8 "	
18	WCC (P<.005)	18.9	16.2	7.5	7.8	7.2	8.0 per HPF	
19	Glycine			10499			293 μmol/1	
20	Therapy	CT	HST	Randomized:	HST	CT©		
21	Outcome	Death	Full Recovery		Full Recovery	Morbidity		

It is ironic that the only evidence on mortality for the TUR syndrome till now by other authors is a letter to the editor, from introduction as haemolytic reaction till reported in women as hyponatraemia after massive infusion of 5%Glucose during major prolonged surgery [49-51]. I have known Robert ever since 1990 when he wrote to me after the publications of our articles side by side in the British Journal of Urology (BJU) and now

International (BJUI) that was deliberately intended by the great late professor G D Chisholm the editor of BJU An editor with a vision (10\*+ Nobel). After a thoughtful and considerable consideration and self-deliberation, I decided to write this review imitating the anonymous reviewer's comment (SI) and standard review attached to Hahn's article (and this standalone article pending the BJUI editor's decision for kind consideration,

acceptance and reporting with Hahn's article and mine side by side). This is intended for the sake of this Journal's readers who should be well informed and highlighted, and the benefit of patients who are being killed in hundreds of thousands per year from VO as complication of fluid therapy for shock in clinical practice that induce VOS and cause the acute respiratory distress syndrome (ARDS), or the multiple organ dysfunction syndrome (MODS) [42]. Problems and medical conditions that I have finalized while Hahn remains lost in his wanderings and own impediments are: The TUR syndrome, HN and ARDS. All are problems that have been resolved and must be prevented and stopped immediately by informing physicians all over the world to become aware of the exact patho-aetiology and the currently available 100% successful preventative and curative therapy of these conditions [6]. I hope Hahn will finally cooperate and collaborate with me here. I do need his help as much as he does need mine. I know it will make a few late professors who were visionary mentors of mine happy in their graves (see Acknowledgements later) and currently alive consultants and professors, authorities and administrators who helped me greatly during my career including editors who are indeed Best of the British (Figure 5).

I also believe that I have fulfilled my promise to pledge an investigation to explain to the not only 3 patients I witnessed being killed by the TUR syndrome back in 1981 but also all five of them: to find out exactly what killed them, how and why. Also, to explain and understand why my death certificates for the 3 patients were first rejected because I put the TURP syndrome as their cause of death. I had to change to shock and cardiac arrest or cardiorespiratory arrest which was true enough and the death certificates were accepted. So here is the "Best of British" virtual issue, a selection of the most cited papers from UK in the BJUI in 2012-13. There are articles from every part of the British Isles proving that geography is not a barrier to quality [52,53].

### **The TUR syndrome from the beginning: Destiny, Livelihood, and Fortune**

My beginning with the TURP syndrome started in 1981 after I attended postmortem examinations (PM) on 3 patients who died of the syndrome. I was only an SHO in urology working for the late Mr. KC Perry and JP Ward at DGH in Eastbourne. At the PM examination it was clear and very obvious to me that these patients died of internal drowning as result of massive VO of fluids used for resuscitation of a cardiovascular shock they had, and the VO fluid was retained in their bodies. When I asked the pathologist why doesn't he mention that retained VO in his report? He replied: "because it offends treating physicians"? The word offends hit me right on my face and head like a hammer. My next question to myself was if it offends them why do physicians do it? This had led me to immediately replace the term

fluid overload with the new and original Volumetric Overload (VO) after adding the cardiovascular Shock to it (VOS) that was introduced to avoid the word offends. Another few questions such as: "What is misleading physicians into giving too much fluid during the resuscitation of shock? What shock is it? I communicated with Richard Harrison III (who may be late now) (7\* and Nobel) who is the originator of the word hyponatraemic shock of the TUR syndrome and 5%NaCl therapy for years during his retirement until he was sick and tired of me. I reported later the true originators of this shock and therapy in dogs (7\* each+ Nobil). He advised me to put the poison in the honey that I could not accept. I stopped immediately after the PM examination I suspected and incriminated Starling's law being the scientific basis of fluid therapy in shock which I have proved that it dictates the wrong rules on fluid therapy for shock management in books [53-57]. I felt so strongly about it that I wrote a letter to the late great professor of physiology Eric Neil (7\* + Nobel) and author of Sampson Wright Textbook of Physiology later in 1983 [58,59]. He nicely replied in handwritten letter as he was in retirement asking: Why and how may Starling's law cause death of patients? The answer is there now [56].

### **Robert Hahn, I and the TURP syndrome, hyponatraemia (HN) and ARDS, and VK vs VO**

My story with Robert G Hahn goes back to 1990. Both Robert and I communicated by email since our articles appeared side by side at the British Journal of Urology (BJU) 1in 990 then and International to become BJUI now. We had the same interest of investigating a clinical condition named the TUR syndrome that evolved to VK by Hahn and VOS by me as complication of fluid therapy [58,60]. I thought the late great Professor G D Chisholm was visionary and had thoughtfully and deliberately put our articles on the TURP syndrome side by side for a good reason [53-57]. I thought perhaps he wanted us to get together and collaborate. Hence, I was delighted to receive an email from Robert soon after the publication of our articles. His email had just arrived me while I was thinking of what to write to him if he has my article and I immediately and positively responded. We later agreed to meet at a conference in Cairo and discuss the issues involved in pathogenesis of the TURP syndrome and VK in more details. Hahn gave me a pile of his articles to read which I did. It allowed me to decide he is my man to share my discoveries with. But, if he carries on, on his own he needs about 30 to 40-years to catch up with me. Now is the time. Now or never! In the Cairo Urological Conference in 1990, our presentations on the TURP syndrome were based on the 2 articles reported side by side in BJU in 1990 but I called it then Hypo-osmotic shock. My second presentation was on the newly discovered link between the loin pain haematuria syndromes (LPHS) and symptomatic Nephroptosis (SN). My best ever friend



and colleague since medical school, the late Dr. Khaled El-Hamaky, (MD), who I loved and trusted and was a most successful Consultant Urologist Surgeon in Al-Mehalla Al-Kobra, Egypt, after whose name I named my son Khalid (KOKO). He told me that my 2 topics were the only new subjects in the conference book and all others are repetitions of all the previous years he has been attending this conference for many years. I said to him you are kind enough to boosting my morals as he came later this evening after my failure presentation: He said: “No this is the truth”. I went to my first ever Conference full of hope and excitement that became little disappointment after finding my two accepted abstracts to be the last on the conference book! I said perhaps I joined in the last minute. I went and had a look at the room where I shall be delivering my 1st oral presentation just 5 minutes before start time. Nobody was there. Most of the attendees were walking home or had already left before I started! I started to get worried and quickly I asked Khaled and 2 other friends of mine who were there in the conference to attend my presentation, and they were the only 3 audience for my presentation. The day before, the main room was full of audience attending Hahn’s presentation, including me. I just could not believe that none of the conference attendees were interested in any of my presentations that most upset, disappointed and dispirited me! Before my presentation I met for the first and last time my correspondence friend Professor Robert Hahn from Sweden and the author of the article discussed, analyzed, and criticized here [1]. On whom I wrote about him in an article of mine saying: “You may hear and know more about him in the future perhaps as a Noble Prize winner for a career life achievement of massive contributions in medical research with publication of >500 articles, most of it on the TURP syndrome that I have read most of it. Hahn has reported >340 articles on the TURP syndrome alone and 532 articles in total. Here is what Robert Hahn, Professor of Anaesthesia and Intensive Care, Head of the National Fluid Academy (NFA) and Editor-in-Chief of a book on fluid therapy, concluded in abstract of a recent review article in 2017. I said that as prediction as he has not even nominated for a Noble yet. In a fair, just, and ideal world I deserve Noble prize this year for my 40-years career life achievements of 15 new scientific discoveries in physics, physiology, and medicine with publication of >120 articles and 6 published books, but self-nomination is not allowed [56-60]. I dare also say that each and all my listed above 15+ discoveries is a worth a Noble on its own. The achievement of each one of them is certainly greater than that of Barak Obama- the man himself said that in his speech at the ceremony. It is also greater than that The Nobel winner from Japan who observed a tree that follows the sun like a Sunflower- it is called the flower that worships the sun in Arabic (ABAAD ALSHAMS)! So, what? Having said that and a little more later addressing the issues on self-nomination

and an “Encouragement Award” for the bright intelligent children and aspiring young scientists. No noble is intended for “Encouragement Award” or for self-nominated adults or for bright children and aspiring young scientists. I respect that this was his will (Noble) and the nomination committee does its best in an impossible task of selecting the right candidates (Figure 5,6) (Table 1-3).

## Understanding and Précising the Problem

### The main misunderstanding between Hahn and me Why should everyone have 3 IDs to eradicate SMAFs?

I most humbly request that all scholars’ peers of professors and doctors including Robert Hahn and colleagues in Sweden with interest in the science of physics, physiology and medicine to nominate me for this year’s Nobel Prize Award. This prize is not offered to a deserved candidate after his death and at my age of >71-years with serious comorbidities there is not much time left to go. I have previously won Princess Alice Memorial Award Eastbourne, UK 1988, the best presentation award and Winner of X-ray Quiz in 1999 in Saudi Arabia (the hall full of audience were laughing at me when I raised my hand saying “Yes Sir that is me”, and lately the best presentation award at a Nursing Conference 2021 on the subject of the G tube discussed here (Figure 6,7).

The porous orifice (G) tube was built on a scale to ultrastructure anatomy of the capillary tube that has porous wall that allow the passage of plasma proteins and pre-capillary sphincter encircling its inlet [61,62]. Please, do not get me wrong as this not for the money, I have already promised my wife that she will get the money and I shall proudly and honourably keep the medal for a reason. God willing I may live to see the day and my health allow me to be able to travel for a Noble Ceremony in Sweden. Each one of us, Hahn and I, pursued his career interest based on his own believe and theory on the pathogenesis of the TUR syndrome: Hahn is a firm believer in the toxicity of glycine, while I persevered to prove the VO theory is correct. Ironically, the VO theory of mine has been so obvious that it has remained invisible even to Hahn himself and all physicians involved with and prescribed fluid therapy till today. I only became aware in January 2020 that Hahn has become interested in Volume Kinetic (VK) and wrote a few articles on it, but has he accepted, recognized and understood as Volumetric Overload Shock (VOS) and realized, and acknowledged the pathological VO that cause the TUR syndrome and appreciated its link with ARDS yet? His article analyzed here testifies: No. His stand, concept, understanding and theory have remained today exactly as it was back in 1990. This made me predict at the time that he needs another 30 years to understand. I shall go to him. I did wrongly think that VK and VO are the same. I said to myself he has come

around far enough to discuss issues on VO kinetic despite failing to appreciate the huge difference between physiological VK and pathological VO of VOS! Please allow me to explain humbly with all due respect and hopefully without sounding disrespectful, offending, arrogant or patronizing who is teaching and breaching us! I shall explain what is the difference between VK and VOS now? I made the error by thinking that both Hahn and I are talking about the same thing and some competition shouldn't cause any harm to use by anyone. So far at the time of writing this

article I thought that both VK after Hahn that appeared to be the same as VOS of mine are the same!?! That is the most important error I made that showed in a title of book of mine changing it from VOS in 2018 to VK and VOS 2021 [53]. It will be immediately rectified here and in the next edition back to VOS. Before I report the difference discovered during the writing of this article, please allow me to summarize what is the TUR syndrome [63-70].

**Table 3:** The multiple regression analysis of total per-operative fluid gain, drop in measured serum osmolality (OsmM), sodium, albumin, Hb and increase in serum glycine occurring immediately post-operatively in relation to signs of the TURP syndrome. Volumetric gain and hypo-osmolality are the only significant factors.

Parameter	Value	Std. Err	Std. Value	T Value	P
Intercept			0.773		
Fluid Gain (l)	0.847	0.228	1.044	3.721	0.0007
Osmolality	0.033	00.014	-0.375	2.42	0.0212
Na+ (C_B)	0.095	0.049	0.616	1.95	0.0597
Alb (C_B)	0.062	0.087	0.239	0.713	0.4809
Hb (C_B)	-0.282	0.246	-0.368	1.149	0.2587
Glycine (C_B)	-4.973E-5	5.975E-5	-0.242	0.832	0.4112

**What is the TUR Syndrome? And what is causing the “Understanding Gap” here?**

The TURP syndrome is a condition induced by gaining large volume of sodium-free fluid overloading the cardiovascular system and spilling into the interstitial fluid space of vital organs and subcutaneous. The fluid of 1.5%Glycine used as irrigating fluid gets absorbed during the TURP surgery as well as all endoscopic surgeries performed under sodium-free fluid irrigation of any type, BUT intravenous infusion of 5% Glucose considerably and significantly contributes to it- as well as saline. What is more saline or any sodium-based fluid such as Saline, Hartman, Ringer, plasma, and plasma substitutes, and blood worsens it transferring the shock being treated from VOS 1 into VOS 2 and causing ARDS 1 and 2 with its high morbidity and mortality later. The TUR syndrome has a characteristic severe drop of serum sodium level causing acute dilution hyponatraemia (HN) with severe clinical symptoms affecting all vital organs causing the multiple organ dysfunction syndromes (MODS), or ARDS with recognizable clinical picture but one system may predominate such as AKI. The HN of <120 mmol/l has 2 paradoxes and 2 nadirs that have eluded authorities and physicians on HN, and that has made the TUR syndrome most elusive and invisible with 2 paradoxes making it though obvious it has remained invisible even to authorities on HN. Professors and consultant urologists who are swift good resection experts have testified that the TUR syndrome does not exist with a

negative prospective study of 100 patients [68]. Off course no such hyponatraemia occur when the irrigating fluid is saline whatever the volume absorbed and infused. Another reason that prevent massive 1.5% glycine absorption and the TUR syndrome is not to open the prostate capsule and venous sinuses. There was also an urologist who did >1000 consecutive TURP surgeries without seeing the TUR syndrome. The TURP syndrome starts by presenting with cardiovascular shock to anesthetists and surgeons in theatre and at times by cardiac or cardiopulmonary arrest and sudden death. By next morning the surviving patients present with coma, convulsion and bizarre paralysis to physicians, neurologists and ICU specialists and the characteristic serum hypo-osmolality BUT other solute contents dilutions seem to be apparently improving due to water shift into cells. The HN of <120 mmol/l causes cardiovascular shock. Volumetric overload (VO) is the most highly significant factor causing its patho-aetiology with a (p=0.0007). Osmolality was also significant (p=0.02) while all other serum solute changes including sodium and glycine did not reach statistical significance in the multiple regression analysis yet it did alone when pre and post-operative levels are compared. This cardiovascular shock is easily confused with hemorrhagic or septicemia shock and treated with further massive volume expansion [71-80].

Figure 6 shows a diagrammatic representation of the hydrodynamic of G tube based on G tubes and chamber C. This 37-years old diagrammatic representation of the hydrodynamic of G tube in chamber C is based on several photographs. The G tube is the plastic tube with narrow inlet and pores in its wall built on a



scale to capillary ultra-structure of pre-capillary sphincter and wide inter cellular cleft pores, and the chamber C around it is another bigger plastic tube to form the G-C apparatus. The chamber C represents the ISF space. The diagram represents a capillary-ISF unit that should replace Starling's law in every future physiology, medical and surgical textbooks, and added to chapters on hydrodynamics in physics textbooks. The numbers should read as follows:

- The inflow pressure pushes fluid through the orifice.
- Creating fluid jet in the lumen of the G tube\*\*.
- The fluid jet creates negative side pressure gradient causing suction maximal over the
- Proximal part of the G tube near the inlet that sucks fluid into lumen.
- The side pressure gradient turns positive pushing fluid out of lumen over the distal
- Part maximally near the outlet.
- Thus, the fluid around G tube inside C moves in magnetic field-like circulation (5)
- Taking an opposite direction to lumen flow of G tube.
- The inflow pressure 1 and orifice 2 induce the negative side pressure creating the dynamic G-C circulation phenomenon that is rapid, autonomous, and efficient in moving fluid and particles out from the G tube lumen at 4, irrigating C at 5, then sucking it back again at 3,
- Maintaining net negative energy pressure inside chamber C.
- \*\*Note the shape of the fluid jet inside the G tube (Cone shaped), having a diameter of the inlet on right hand side and the diameter of the exit at left hand side (G tube diameter). I lost the photo on which the fluid jet was drawn, using tea leaves of fine and coarse sizes that run in the centre of G tube leaving the outer zone near the wall of G tube clear. This may explain the finding in real capillary of the protein-free (and erythrocyte-free) sub-endothelial zone in the Glycocalyx paradigm. It was also noted that fine tea leaves exit the distal pores in small amount maintaining a higher concentration in the circulatory system than that in the C chamber- akin to plasma proteins.
- Figure 7 shows the relationship between SP to the Diameter and length of the G tube which demonstrate a negative SP starting at the orifice (Point 2) (akin to precapillary sphincter) and extends as high negative pressure gradient over the proximal part of the G tube (Point 2-6) to cross 0 line at point 8 and then turn positive of 7 cm water at Point 9. This SP gradient from orifice at Point 2 to G tube lumen {Points 2-6) is negative to become positive DP at point 9 of 7 cm H2O water along the G tube. The wide section diameter of G tube is 7 mm all along the entire tube. The orifice is 5 mm while the distance from orifice to exit represent the tube' length in

which the Fluid jet diameter change with increasing gradient (Figure 1a). Neither Poiseuille's law nor Bernoulli's equation can predict SP neither at orifice of Venturi's effect nor at the G tube proximal part know as Bernoulli's effect. Thus, the RBCs speed or CBS depend on the dynamic fluid jet diameter not the G tube diameter. Hence the equation in and graph are wrong giving low RBCs speed or CBS over the capillary length but is correct only at point of the G tube where the jet diameter equals the tube diameter

- Groip-1 was the 3 patients who died and had post-mortem examination, Group-2 were a series of severe TURP syndrome cases successfully treated with hypertonic sodium therapy (HST), and Group-3 were 10 patients encountered in the prospective study who were randomized between HST (3.1) and conservative treatment (CT) (3.2). The significant changes of serum solute contents are shown in bold font with the corresponding p- value. Most of the patients showed manifestation of ARDS of which the cerebral manifestation predominated, being on initial presentation (Regional Anesthesia) and representation of VOS 1 (General Anaesthesia). However, most patients were given large volume of saline that elevated serum sodium to near normal while clinical picture became worse. They suffered VOS2 that caused ARDS. The VO of patients to whom these data belong is shown 9.
- We, Robert Hahn and I, became good friends but had no correspondence after our hello-goodbye meeting in Cairo 1990 till Robert got in touch in Feb. 2020 after I sent him some of my articles as it does not show on PubMed search. I thought he was probably unaware of my contributions to the field of interest to us both. When we agreed to meet in Cairo in 1990 where he came to give oral presentation on the TUR syndrome at the same mentioned above Urology Conference [9]. Although one of my 2 presentations was on the same subject, I called the TUR syndrome then "Hypo-Osmotic Shock" (p=0.02) then soon latter rectified, named and reported it appropriately and correctly as VO complication of fluid therapy or VOS, reported many years later in many articles and books [53-57] as based on statistical significance of VO with p= 0.0007 and osmolality p=0.02. The multiple regression analysis on State View 500+ and Apple Mackintosh® did also show that the changes in other serum solutes such as Glycine, Sodium, Calcium, Hb and Albumin did not reach a statistical significance in the multiple regression analysis - despite the markedly high level of glycine and low serum sodium in the blood. What is the meaning of a VO has a p=0.0007? Ask statisticians not me as I have clearly replied to this question [6].



- I was so excited by this discovery of mine eagerly awaiting to see Robert in 1990 so I can share with him my knowledge and discoveries about not only VOS but also my new discovery of the hydrodynamics of the porous orifice (G) tube that was 11 years later preliminary reported at Medical Hypothesis in 2001 with great and most appreciated help of its editor Professor of Physiology Dr. David Horrobin, who was the Editor-in-Chief of the journal Medical Hypotheses and founder in 1975 until his death in 2003 for accepting my article in 2001 free of charge. The same study without any plagiarism has just been fully reported in a OAJs in 2021. The late Professor Horrobin (May God bless his soul) did also warn me, and explained what it means, about the “Tall Puppy Syndrome” [81-84].
- After repeated rejection of many articles by all top Science, Physics, Physiology and Medical journals around I decided to throw the towel on them recently. To my disappointment I checked for my publications on PubMed under my name “Ghanem AN”, I was horrified when got (0) returned. Only the old previously reported 24 articles before 2013 in closed access PubMed list of journals were found. I realized that my articles remain invisible to the scholar peers of medical scientific community; hence I sent Robert a sample in full text PDF format and full list of my articles in reference format. He reciprocated by sending me 2 most interesting articles of his. One that I made me believe that Robert has finally grasped the concept of a pathological VO kinetic and its relation to VOS and the ARDS syndrome, but his article analyzed here testifies that he remained as he was in 1990. The second article was on the revised Starling’s principle (RSP) calling for validation based on which I reported this article [21].
- I tried to show Robert the G tube in 1990 and wanted to let him know all about it and VOS but while keeping it in my hand under the table as we were having lunch, he shunned it down then and snorted me looking the other way. I said he knows what I said about VO and the TURP syndrome, but did not bother then to ask him why. He wrote me an email recently in January 2020 saying he is impressed with the G tube work. I had hoped he may attend my presentation on the role of VO in the pathogenesis of the TUR syndrome, but disappointedly he did not.
- Out of disappointment, upset, and embarrassment I felt during my presentation at the Urology Conference in 1990 in Cairo I had a frozen mind during my presentation. I just could not stop talking while the chairman was shouting at me to stop. The chairman and committee walked out of the room and left me behind still talking until I finished 2 minutes later. I felt also most upset, humiliated and annoyed by the wasted 1200 USA Dollars plus the cost of travel and hotel accommodation that was a lot of money 30 years ago. I went up to my hotel

room and cried. This is how I gained the immunity against any farther repeated rejections by top journals of the world that repeatedly followed later till today. I am just curious to know why?

Khaled my friend gave me just enough time then he came and joined me in the room we shared. Immediately after booking in a small cheaper hotel nearby, he came and asked for the refund of my money. He bent to carry my suit case for me while I am speechless. . After some negotiation he allowed it, then he said: “take back your hotel money”. No way can I accept that I am working in Saudi Arabia now you now. He said: “and I am not giving you money that I paid myself. It is a drug company that pays for me and my family each year to attend but my family could not come with me this year. Wow good for you Khaled, why do they do that. He said because I prescribe the company’s good antibiotic for my patients. You deserve it. I said sorry khaled I cannot accept that. “It is perfectly OK and everyone does it. It is Halal money.” I took the money from him and put it in my pocket and went with him to our 5\* hotel room with a beautiful, serene view on the Nile. I said now I know the meaning of the statement: Egypt is the Gift of the Nile from Allah. Nobody, whoever who is, is allowed to deprive us from it. He came back to our room and knocked on the door giving me enough time to finish crying before he entered. He saw the residual of tears in my eyes and the upset on my face. He started talking and I just listened, he said: “Do not be upset, please my friend. Do you know that most of these conferences’ attendees come each year here for and on whose expense? Nobody comes for science or learning anything new! They come for a holiday, socializing and food! Do you know the London professor you told me about before? I have seen him in one of these Cairo conferences before giving a lecture, He is such a brilliant Urologist Surgeon and resectionest that: “actually his scissors and resectoscope have eyes that can see! He may never have seen a case of the TUR syndrome before and may never will.” I asked Khaled the question that begged itself: “How come he authored a book on the subject, and who wrote it for him? Khaled said: “I do not know that as I have never read the book or seen it. I do not know and I have not read the book. Come on let us go out to the Balcony where we can enjoy looking at the beautiful Nile view so you can have some benefit from attending this conference and you can have a cigarette or two while we are talking.” This is when I decided to forget and forgive the man. Khaled cheered me up and we talked till 4:00 am. Dr. Khaled Al-Hamaky, (MD) never could find the time to write up his Thesis Book after completing the clinical study work even though he had the full support and the promise of Professors and Drs. Mustafa Alrifai and MA Ghoneim he will be granted one if he only submitted the book. He was loved by me, my wife, many other friends, and all his



patients may God bless his soul. In my book on Layla's award, he has earned it and that is the reason for putting MD after his name plus (10\*) even if it is worth nothing now but it may please his 3 children. All of my >120 articles since my own re-incarnation in 2016 till now have been reported without any further editing. All have been accepted and reported by OAJs after being rejected by all top Science, Physics, Physiological, Medical, Urological and Surgical top-rated journals of the world. All my articles remain unlisted in PubMed. I said happily to myself OAJs came to risqué me. Now these articles have also been reported in 6 published books plus 2 other books that remain unpublished and another forthcoming 9th book on a totally different subject based on currently undergoing investigations declaring another solo self-financed war against SMAFs (Scam Master Artists and Fraudsters). The book will have the title of: "Money, Scam, Fraud and Stupidity". The first of a series of articles for the book has just been reported [60]. I hope to complete the series of 3 articles and more that will complete the book that aims to confront Karl Marks' Theory on the threat to Capitalism and challenge his great theories about "the threat converting capitalism violently to communism [85,86].

## Hahn's Understanding of Volume Kinetic?

### Therapy of the TUR syndrome and ARDS [6]

**Prevention:** Based on the above discussion, ARDS is an iatrogenic complication of fluid therapy in hospital, never in community, that is overlooked and underestimated. Being iatrogenic; means it is preventable. In order to prevent VOS and ARDS a limit to the maximum amount of fluid used during shock resuscitation or major surgery must be agreed upon. Professor Hahn found that infusing 2 L of saline to human volunteers produces symptoms. Infusing >3 L is pathological. More than 5 L is associated with deleterious morbidity [38,39]. So, the maximum volume of fluids that can be infused safely to an adult patient is 3 L which is the daily fluid requirement and no more fluid of any kind is given for 24 hours except replacing the actual loss that does not include urine loss. The patient should be put on a weighing scale every day from hospital admission till discharge or death. Any retained volume of fluid above his body weight on admission is pathological. On using CVP for monitoring fluid therapy, please refrain from persisting to elevate CVP to levels above 12 and up to 18-22 cm saline [81]. This is a major cause for inducing VO and VOS and ARDS during shock resuscitation, particularly septic shock [40]. Look up any physiology textbook to find out that the normal CVP is 0 and it swings between -7 and +7 cm saline which is the level that should be aimed at in monitoring fluid replacement in shock of sepsis, trauma and bleeding, acutely ill and during major surgery. Elevating CVP is not synonymous with elevating arterial pressure. If hypotension develops later during ICU stay, inotropic drugs, hydrocortisone

200 mg and HST should be used. The latter restores the pre-capillary sphincter tone (peripheral resistance) so that the capillary works as normal G tube again, but no isotonic crystalloids or colloids infusions of above the daily fluid requirement should be given. If persistence with the current liberal regimen of Early Goal-Directed Therapy (EGDT) and conservative Bolus Fluid Therapy (BFT) regime continues, then more reports on ARDS will continue. Future authors will be hopefully taking into consideration the mentioned above data concerning VO/Time, or the retained fluid VO at the time of inducing ARDS or death on reporting new trials or case reports. Treatment of ARDS [6]. Hypertonic sodium therapy(HST) of 5%NaCl and/or 8.4%NaCo3 has truly proved lifesaving therapy for the TUR syndrome and acute dilution HN as well as Secondary VOS 2 that complicates fluid therapy of VOS 1 causing ARDS. It works by inducing massive diuresis; being a potent suppressor of antidiuretic hormone. My experience in using it for treating established ARDS with sepsis and primary VOS 2 that causes ARDS is limited. However, evidence on HST suggests it will prove successful if given early, promptly and adequately to ARDS patients while refraining from any further isotonic crystalloid or colloid fluid infusions using saline, Hartman. Ringer, Hydroxyethyle starch and/or plasma therapy- just give the normal daily fluid requirement and no more. After giving HST over one hour using the CVP catheter already inserted, the patient recovers from AKI and produces through a urinary catheter massive amount of urine of 4-5 L as you watch. THIS URINE OUTPUT SHOULD NOT BE REPLACED. Just observe the patient recovering from his AKI, coma and ARDS and asks for a drink. This is done in addition to the cardiovascular, respiratory, and renal support on ICU. Patients with AKI on dialysis, the treating nephrologist should aim at and set the machine for inducing negative fluid balance. The HST of 5%NaCl and/or 8.4%NaCo3 is given in 200 ml doses over 10 minutes and repeated. I did not have to use more than 1000 ml during the successful treatment of 16 patients. Any other hypertonic sodium concentration is not recommended- I know Hahn tried 1.8%NaCl and it does not work. A dose of intravenous diuretic may be given but it does not work in a double or triple the normal dose. A dose of 200 mg of hydrocortisone is most useful. Antibiotic prophylactic therapy is given in appropriate and adequate doses to prevent sepsis and septic shock. No further fluid infusions of any kind of crystalloids, colloids and blood is given. The urinary loss should not be replaced as this defeats the objective of treatment

### Cohort Prospective 100 patient's study

I would recommend a small pilot prospective controlled cohort study on 100 patients as a start to try HST in established ARDS cases that would be something to look forward to reading a report



on it, hopefully soon. No multicentre trial or highly expensive study is needed for that. Not much time is required either. If you cannot do it on a hundred patients, you probably can't (as Mr. JP Ward put it to me before the start of our prospective study [20]). I can assure the investigators that no harm will come to patients. It is a guaranteed win bit; you may win but you do not lose anything. In the worst-case scenario, the patient may not respond because of chronicity of ARDS or after sepsis complicates ARDS and gets the capillary damage established. As the author of all self-referenced articles here, published in open access journals, and as copyright holder I give open permission to any interested investigator to use any of my articles as template, particularly recommended article and this report after getting the appropriate permission from the editor.

### **To a special man**

The affirmative proof, a poem

### **The affirmative proof on the Theory of ARDS, validated.**

I have a special surprise for the great Editor of the Lancet Dr Richard Horton, who I discovered only yesterday his remarkable comments on fraudulent research in science and Medicine. WOW amazing. This is Job very well done, Sir! "Our World is nothing but a big Theatre" said a great late Egyptian actor Yosif BeK Wahby, in which every actor plays his role well- The Good, The Bad, and The Ugly! The surprise for the Lancet editor is 2 original essays written before the mid-eighties and submitted by mail but rejected. They remain available which need only updating to show that the theory on ARDS has been proved and validated. The essay on Egypt, the mother of all countries in the World, is another is another prediction of Egypt today.

My Affiliation: NHS

It was only discovered yesterday my true affiliation is MOH, and there is a card to prove it and my name remains on the GMC register and the card was issued when I worked at Kings College Hospital, London.

### **The main differences on comparing and contrasting Hahn v Ghanem are:**

Hahn is the received "system's chosen spoilt boy" who follows blindly, faithfully and sincerely obeys all the rules of the currently received laws, rules and regulations of high impact factor Journals without questions or understanding. Hahn has contributed massively by his studies in the results section but his discussion and conclusions were and remain twisted and wrong by following the mirage of the toxic theory of glycine in the TUR syndrome and possibly the septic hypothesis in his views and practice on using fluid therapy and patho-aetiology of ARDS. Hahn had his chances, but he declined. Hahn has never had any problems with getting grants or having access to the major top-rated journals of the world. He is a great university professor who deserves due

respect and recognition for his work and contributions during his career life. Knowingly or unknowingly Hahn's results (not discussion and conclusion) has been a major mine source of data for Ghanem's use in proving, validating and confirmation of his new theory on ARDS and the presented scientific discoveries. Ghanem is a dreamer and white revolutionary, independent investigator scientist and free-lance author who despite trying to be good and obedient he wanted to understand and have spotted loopholes in the system that he must/have had to overcome, ignore, or break to proceed with his endeavors for new discoveries in science reported above in physics, physiology and medicine. Ghanem has remained a humble dreamer, white revolutionary thinker who aspires to change the world into a better place for all of us and future generations to live in peace and love. Status wise nobody. He ran away, declined or refused 3-4 chances to become a Professor. No regrets. No anger. No disappointments that can upset me. It is a destiny and destiny. I am content with my fortune and livelihood. I did it my way and I am happy with my stupid brain. Evidence is provided to demonstrate that Hahn remains lagging behind about 40 years in understanding the patho-aetiology of ARDS, entrapped and lost in wanderings of his own wrong believes on the pathogenesis of the TUR Syndrome of glycine toxicity despite having a missed chance 30 years ago to know all about it from Ghanem. There is glimpse of light through the locked Door at the end of the Tunnel (Figure 7-9).

### **Summary**

VOS causes ARDS. It may present with cardiopulmonary arrest in theatre and ARDS later. It is an iatrogenic complication of fluid therapy in hospitals that is overlooked and under-estimated. VOS is 2 types: VOS 1 and VOS 2. VOS 1 is induced by 3.5-5 L of mostly sodium-free fluid and is characterized with dilution HN that has 2 nadirs and 2 paradoxes, is most dynamic and illusive and currently has a lifesaving therapy of HST. VOS 2 may complicate VOS 1 or may be de novo complicating sodium-based fluid therapy during resuscitation of shock, acutely ill patients, and prolonged surgery. It has no obvious serological markers or none. Many errors and misconceptions mislead physicians into giving too much fluid for resuscitation due to faulty rules on fluid therapy dictated by the wrong Starling's law that induces VOS 2 causing ARDS. The correct replacement for this law is the hydrodynamic of the G tube. Discovery of VOS has resolved the puzzles of TUR Syndrome, HN and ARDS. A new therapy for ARDS using HST of 5%NaCl and/or 8.4%NaCo<sub>3</sub> is recommended.

### **Conclusion**

The article presents the author's view on medical scientific issues as well as the newly presented peer review standard based on an

anonymous peer reviewer the author had received previously. The author also presents a critical analytical review of an article sent to him by the editor of this journal and authored by Robert Hahn, a world leading authority on fluid therapy and volume kinetic and the TUR syndrome, the author presents his views on suggested new conflict of interest and acknowledgements relevant to the subjects discussed. In the presented new standard for peer reviewing using critical analytical criticism method aimed to precise the main questions and objectives of the article and related debates. A proven most effective method of determination and/or abortion of obsolete and unnecessary debates on subjects such as albumin versus saline and RSP that is based on the wrong Starling's law. A precise definition of volume kinetic (VK) and Volumetric Overload (VO) with quantification of the physiological VK of <2 L, and the pathological VO of >3 L and up to 10-12 L retained in the body of the patients, clearly separates and segregates the major difference between VK and VO with reference to Time. The pathological VO is of two types VO1 and VO2 responsible for the pathogenesis of the TUR syndrome and ARDS, a link observed by the author 40-years ago and has been substantially and affirmatively proven. Both the sodium-free fluid (VO1) and sodium-based-fluid (VO2) are responsible for the patho-aetiology of the TUR syndrome and ARDS, respectively, while VK has nothing to do with it. Understanding the above point has been a cause for the enormous gap of thinking and receiving the new theory on the pathogenesis of the TUR syndrome and ARDS identifying causes for major hindrance and blockade by top journal's firewall are presented. A contrast and comparison of the two world authorities and leaders on the contrast and comparison of the two world authorities and leaders on the subject of the TUR syndrome and fluid dynamics is presented in an attempt to understand the huge difference between Hahn and the author.

## Conflicts of Interest

The authors do not declare any conflicts of interest.

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