from inspiration to publication

professor domhnall mac auley

The British Medical Journal
the most valuable commodity in research?
the most valuable commodity in research- the idea

If you have an apple and I have an apple and we exchange these apples, then you and I will still each have one apple. If you have an idea and I have an idea and we exchange these ideas, then each of us will have two ideas.

George Bernard Shaw
Editorial

Why submit your research to the BMJ?

Rapid decision and publication times
High impact factor: 9.245 (9.023 in 2005)
Highest impact of any journal publishing original primary care research every week
Fast track appraisal for articles of exceptional importance and urgency
Online first publication

http://www.bmj.com/cgi/content/full/334/7583/4-a
Editorial

Why submit your research to the BMJ?

*Immediate transfer of all articles to PubMed Central

Policies of the US National Institutes of Health, the UK Medical Research Council, the Wellcome Trust, and other funding bodies in making publicly funded research available to all

http://www.bmj.com/cgi/content/full/334/7583/4-a
what are you looking for?

• Researchers and journals have slightly different priorities.

• *Both aim to increase knowledge to improve health*

• Researchers seek publication increasingly, for personal and institutional esteem.

• Journals seek to communicate the best quality research to their readers.
what are we looking for?

Pure academic interest isn't enough for BMJ editors or most importantly for readers, who mainly comprise doctors-whether they're practising clinical medicine, working in public health, developing and implementing health policy, or working mostly as researchers.

We aim to provide our readers with articles that will help them *to make better decisions.*

http://www.bmj.com/cgi/content/full/334/7583/4-a
the day to day decisions doctors make with their patients:

- randomised controlled trials of treatments and other clinical interventions for patients with common diseases,
- studies on diagnostic tests,
- basic clinical observational studies,
- qualitative studies that help to explain why and how doctors and patients do things, and
- systematic reviews of all of these study types.

http://www.bmj.com/cgi/content/full/334/7583/4-a
is it for the BMJ?

• Editorials
• Original research papers, primary care
• Commentaries on original research
• 10 minute consultations
• Clinical review

• Reviews
• Evidence based case reports
• Lesson of the week
• Drug points
• Interactive case reports
• Quality improvement reports
• Letters to the editor

• http://bmj.bmjjournals.com/advice/sections.shtml#10
is this for the BMJ?

- Personal view
- Fillers
- Minerva
- BMJ careers
- Student BMJ
- Obituaries
Hierarchy of research and where it fits with the BMJ
methods

1. Case report (must tell the world)
2. Case series (clinic/surgery?)
3. Questionnaire (I have a sample)
4. Case control (try my idea)
5. Cohort (serious idea)
6. Double blind randomised controlled trial
7. Meta-analysis (is it really true?)
1&2. case report and case series

- Retrospective single case or a number of cases.
- Choose your journal. Must be novel, interesting, and excite the reader
- May be the first publication along a research theme
you have to start somewhere!


Why published?
lesson of the week

Case report or case series alerting readers to potential clinical problems. They should be less than 1200 words long and accompanied by a single sentence of up to 15 words stating the lesson. We welcome illustrations. The lesson should be as specific as possible and aimed at general readers. The BMJ's editors and peer reviewers use the following questions to assess lessons of the week:

• How common is the condition? (It should not be so rare that it is irrelevant to most BMJ readers).
• How commonly is the condition missed?
• How serious is it if missed?
• Will this report contribute to preventing missed cases?
ten minute consultations

- Advise general practitioners on the best way to use the first consultation for a common clinical problem: the whole point is to cover what can be said and done in 10 minutes.

- Evidence based and should, when appropriate, refer readers to valid and well written patient information.

- Articles should be no longer than 600 words, with one box, figure, or table plus a box of three or four suggestions for further reading. No formal list of references. Three sections:

  A short case history
  What you should cover
  What you should do
A 45 year old Pakistani man with type 2 diabetes mellitus consults to discuss how he might fast safely during Ramadan.

- What issues should you cover
- What should you do
3. Cross sectional study

- A snapshot
- Describes a particular group of patients at a given time
- If done well, then it is possible to compare associations across groups
- But, the associations must be interpreted carefully, an association may be spurious and does not imply causation
Research
Diagnostic scope of and exposure to primary care physicians in Australia, New Zealand, and the United States: cross sectional analysis of results from three national surveys

Andrew B Bindman, professor¹, Christopher B Forrest, professor², Helena Britt, associate professor and director³, Peter Crampton, professor⁴, Azeem Majeed, professor⁵
Correspondence to: A B Bindman abindman@medsfgh.ucsf.edu

Objectives To compare mix of patients, scope of practice, and duration of visit in primary care physicians in Australia, New Zealand, and the United States.
4. Questionnaire study

• Define the question!
• **Questionnaire.**
  – Content validity, face validity
  – Pilot
  – Temporal stability, reproducibility

• **Sample frame**
  – response rate, non responders, compare

• **Structure**
  – length, format, recording answers
  (is a questionnaire the best method?)
Research

Public information needs after the poisoning of Alexander Litvinenko with polonium-210 in London: cross sectional telephone survey and qualitative analysis

G James Rubin, lecturer¹, Lisa Page, NIH research fellow¹, Oliver Morgan, locum regional epidemiologist², Richard J Pinder, medical student¹, Paul Riley, medical student¹, Stephani Hatch, lecturer¹, Helen Maguire, consultant regional epidemiologist², Mike Catchpole, deputy director (public health)³, John Simpson, deputy director (emergency response)⁴, Simon Wessely, professor of epidemiological and liaison psychiatry¹

Objectives To identify public perceptions of the risk to health after the poisoning of Alexander Litvinenko with polonium-210 (²¹⁰Po) in London and to assess the impact of public health communications.
5. Case-control

- Advantages and disadvantages
- Compare two groups similar in every way but for the feature being studied
- An injury/physiological feature
- Compare the odds of being present (In a very large population the odds approach the risk)
- Cheap and results quickly
Research

Folic acid supplements and risk of facial clefts: national population based case-control study

Allen J Wilcox, senior investigator¹, Rolv Terje Lie, professor², Kari Solvoll, retired³, Jack Taylor, senior investigator¹, D Robert McConnaughey, senior programmer⁴, Frank Åbyholm, professor⁵, Hallvard Vindenes, consultant plastic surgeon⁶, Stein Emil Vollset, professor², Christian A Drevon, professor³

Correspondence to: A J Wilcox wilcox@niehs.nih.gov

Objective To explore the role of folic acid supplements, dietary folates, and multivitamins in the prevention of facial clefts.
6. Cohort study

• Advantages
• Follow up a population for a period of time.
• Population must be closely observed, takes time, and cost more
Research

Derivation and validation of QRISK, a new cardiovascular disease risk score for the United Kingdom: prospective open cohort study

Julia Hippisley-Cox, professor of clinical epidemiology and general practice1, Carol Coupland, senior lecturer in medical statistics1, Yana Vinogradova, research fellow in medical statistics1, John Robson, senior lecturer in general practice2, Margaret May, research fellow in medical statistics3, Peter Brindle, research and development strategy lead4

Objective To derive a new cardiovascular disease risk score (QRISK) for the United Kingdom and to validate its performance against the established Framingham cardiovascular disease algorithm and a newly developed Scottish score (ASSIGN).
Cancer risk among users of oral contraceptives: cohort data from the Royal College of General Practitioner's oral contraception study

Philip C Hannaford, professor¹, Sivasubramaniam Selvaraj, research fellow², Alison M Elliott, senior research fellow¹, Valerie Angus, data manager³, Lisa Iversen, research fellow¹, Amanda J Lee, professor of medical statistics¹

Objective To examine the absolute risks or benefits on cancer associated with oral contraception, using incident data.
7. Double blind randomised controlled trial

- The gold standard in researching any intervention
- Difficult
- Funding
- Personnel
- Difficult in clinical medicine
Research

Antibiotic treatment for pyelonephritis in children: multicentre randomised controlled non-inferiority trial

Giovanni Montini, consultant in paediatric nephrology1, Antonella Toffolo, consultant in paediatrics2, Pietro Zucchetta, consultant in nuclear medicine3, Roberto Dall’Amico, consultant in paediatrics4, Daniela Gobber, senior lecturer in epidemiology5, Alessandro Calderan, general practitioner6, Francesca Maschio, consultant in paediatrics7, Luigi Pavanello, consultant in paediatrics8, Pier Paolo Molinari, consultant in paediatrics9, Dante Scorrano, consultant in paediatrics10, Sergio Zanchetta, consultant in paediatrics11, Walburga Cassar, consultant in paediatrics12, Paolo Brisotto, consultant in paediatrics13, Andrea Corsini, consultant in paediatrics14, Stefano Sartori, fellow in paediatrics1, Liviana Da Dalt, associate professor, paediatric emergency15, Luisa Murer, consultant in paediatric nephrology1, Graziella Zacchello, associate professor, paediatric nephrology1

Objective To compare the efficacy of oral antibiotic treatment alone with treatment started parenterally and completed orally in children with a first episode of acute pyelonephritis.
Research

Problems with use of composite end points in cardiovascular trials: systematic review of randomised controlled trials

Ignacio Ferreira-González, research fellow1, Gaiet Permanyer-Miralda, senior consultant2, Antònia Domingo-Salvany, senior scientist10, Jason W Busse, research associate3, Diane Heels-Ansdell, statistician3, Victor M Montori, associate professor5, Elie A Akl, assistant professor6, Dianne M Bryant, clinical epidemiologist8, Pablo Alonso-Coello, general practitioner9, Jordi Alonso, general practitioner10, Andrew Worster, associate professor3, Suneel Upadhye, associate member3, Roman Jaeschke, clinical professor4, Holger J Schünemann, associate professor7, Valeria Pacheco-Huergo, research fellow1, Ping Wu, senior scientist11, Edward J Mills, assistant professor12, Gordon H Guyatt, professor3

Objective To explore the extent to which components of composite end points in randomised controlled trials vary in importance to patients, the frequency of events in the more and less important components, and the extent of variability in the relative risk reductions across components.
8. Meta-analysis

• Search the literature in a structured way using a strategy that captures all the relevant papers
• Select papers that measure up to certain quality marks- for example RCTs
• Cochrane database
Research

Dressings for venous leg ulcers: systematic review and meta-analysis

Simon Palfreyman, research nurse/Smith and Nephew Foundation doctoral student1, E Andrea Nelson, reader2, Jonathan A Michaels, professor of vascular surgery1

Objective To review the evidence of effectiveness of dressings applied to venous leg ulcers.
Research

Outcomes of stenting after uncomplicated ureteroscopy: systematic review and meta-analysis

Ghulam Nabi, clinical lecturer1, J Cook, Statistician2, J N'Dow, professor of urology1, S McClinton, consultant urological surgeon1

Objective To investigate the potential beneficial and adverse effects of routine ureteric stent placement after ureteroscopy.
Analysis

Uncertainty in heterogeneity estimates in meta-analyses

John P A Ioannidis, professor, Nikolaos A Patsopoulos, research associate, Evangelos Evangelou, research associate

Clinical Trials and Evidence-Based Medicine Unit, Department of Hygiene and Epidemiology, University of Ioannina School of Medicine, Ioannina 45110, Greece

Correspondence to: J P A Ioannidis jioannid@cc.uoi.gr

John Ioannidis, Nikolaos Patsopoulos, and Evangelos Evangelou argue that, although meta-analyses often measure heterogeneity between studies, these estimates can have large uncertainty, which must be taken into account when interpreting evidence
Writing the paper…….

- Think about what you want to do
- Choose the right method
- Take care with the data
- Write it up carefully
- Target a journal
- And……..
Evidence based learning resources

Are you looking for up to date and evidence based learning resources

http://www.bmjlearning.com/planrecord/index.jsp
Letter from the editor
Welcome to the new, enhanced BMJ Clinical Evidence website. Our latest release of features and redesigned user interface have been developed to further support you in quickly accessing the very latest medical knowledge to inform your treatment decisions.

http://www.clinicalevidence.org/ceweb/conditions/index.jsp
primary care:

49 papers (24.7%) of all papers in 2006

[2005- 63 primary care papers published (24%).]
• Of all papers published in 2005, 18% described RCTs and 12% were reviews. Six of the 10 most highly cited full length papers in year of print publication were from the UK, two were from North America and three of the top five most highly cited full length papers in year of print publication were from primary care.
Top five primary care papers in 2006

1. Partner notification of chlamydia infection in primary care: randomised controlled trial and analysis of resource use
2. Randomised placebo controlled multicentre trial to assess short term clarithromycin for patients with stable coronary heart disease: CLARICOR trial
3. Lifetime effects, costs, and cost effectiveness of testing for human papillomavirus to manage low grade cytological abnormalities: results of the NHS pilot studies
4. Effect of testing for human papillomavirus as a triage during screening for cervical cancer: observational before and after study
5. Impact of adverse events on prescribing warfarin in patients with atrial fibrillation: matched pair analysis
Papers 5-10 in 2006

6. Secondary prevention of coronary heart disease in older patients after the national service framework: population based study

7. Effects of a web based decision aid on parental attitudes to MMR vaccination: a before and after study

8. Impact of Helicobacter pylori eradication on dyspepsia, health resource use, and quality of life in the Bristol helicobacter project: randomised controlled trial

9. Long term outcomes from the IMPACT randomised trial for depressed elderly patients in primary care

10. Predicting prognosis in stable angina—results from the Euro heart survey of stable angina: prospective observational study
### Origin of the Papers (2006):

<table>
<thead>
<tr>
<th>Region</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK</td>
<td>26</td>
<td>53.1</td>
</tr>
<tr>
<td>Europe (ex UK and Scandinavia)</td>
<td>6</td>
<td>12.2</td>
</tr>
<tr>
<td>North America</td>
<td>6</td>
<td>12.2</td>
</tr>
<tr>
<td>Australia / New Zealand</td>
<td>3</td>
<td>6.1</td>
</tr>
<tr>
<td>Asia</td>
<td>2</td>
<td>4.1</td>
</tr>
<tr>
<td>South &amp; Central America</td>
<td>1</td>
<td>2.0</td>
</tr>
<tr>
<td>Scandinavia</td>
<td>5</td>
<td>10.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>49</td>
<td><strong>100.</strong></td>
</tr>
</tbody>
</table>
• In 2005, 54% of research papers were from the UK, 16 (6%) of papers were from the US, 28 (11%) Scandinavia, and 36 (14%) Europe (exc. UK & Scandinavia).
papers picked up in secondary sources

- Primary care 49, (others 149)
- BMJ Updates 15 (54)
- Journal watch (General medicine) 14 (39)
- ACP Journal club 0 (6)
- EBM Journal 0 (4)
- EB Mental Health 2 (2)
readership:

April 2007
Total Number of Visits 1,715,046
Total Number of Visitors (IP) 809,019
Average Pages Per Visit 3.60
<table>
<thead>
<tr>
<th>Metric</th>
<th>Value</th>
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<tr>
<td>Rapid responses</td>
<td>6.8</td>
</tr>
<tr>
<td>Citations in 2006</td>
<td>3.1</td>
</tr>
<tr>
<td>Page impressions in 1 week</td>
<td>1830</td>
</tr>
<tr>
<td>Access in 12 months after print</td>
<td>8509</td>
</tr>
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</table>
non primary care papers (149)

- Rapid responses: 5.7
- Citations in 2006: 3.0
- Page impressions in 1 week: 1709
- Access in 12 months after print: 8062
Peer review process

the average time from submission to first decision is two to three weeks and from acceptance to publication eight to 10 weeks. These times are usually shorter for original research articles.
taking your work of art to the gallery
general criteria-
is it new, is it true, will it help make better decisions?

• Originality — does the work add enough to what is already in the published literature? If so, what does it add? If not, please cite relevant references.

• Importance of the work to general readers — does this work matter to clinicians, patients, teachers, or policymakers? Is a general journal the right place for it?

• Scientific reliability
The *BMJ*'s mission is to lead the debate on health, and to engage, inform, and stimulate doctors, researchers and other health professionals in ways that will improve outcomes for patients.

To achieve these aims we publish original scientific studies, review and educational articles, and papers commenting on the clinical, scientific, social, political, and economic factors affecting health.
<table>
<thead>
<tr>
<th>Brit J Sports Med</th>
<th>BMJ</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Approx 480(289-471x-700) papers with a 25% reject rate</em></td>
<td><em>Approx 8000 papers with a 6% response rate</em></td>
</tr>
<tr>
<td><em>Reading to improve-identify papers with potential</em></td>
<td><em>Reading to find a reason to reject</em></td>
</tr>
<tr>
<td><em>Help authors reach the required standard</em></td>
<td><em>80% without review</em></td>
</tr>
<tr>
<td><em>25% without review</em></td>
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Editors - Turnaround -- 1 Jan 2006 to 1 Jan 2007

<table>
<thead>
<tr>
<th>Editor</th>
<th>Action</th>
<th>Suggest Revs</th>
<th>2nd Reader</th>
<th>Review</th>
<th>Decision</th>
<th>Revise</th>
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</thead>
<tbody>
<tr>
<td>Jocalyn Clark</td>
<td>589</td>
<td>4</td>
<td>7</td>
<td>585</td>
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<td>0</td>
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<tr>
<td>Rajendra D Kale</td>
<td>617</td>
<td>23</td>
<td>45</td>
<td>604</td>
<td>79</td>
<td>113</td>
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<tr>
<td>Abi Berger</td>
<td>623</td>
<td>2</td>
<td>1</td>
<td>619</td>
<td>14</td>
<td>65</td>
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<tr>
<td>Domhnall MacAuley</td>
<td>643</td>
<td>29</td>
<td>14</td>
<td>625</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Harvey Marcovitch</td>
<td>776</td>
<td>8</td>
<td>7</td>
<td>768</td>
<td>12</td>
<td>89</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>9128</td>
<td>268</td>
<td>198</td>
<td>8848</td>
<td>714</td>
<td>1074</td>
</tr>
</tbody>
</table>
# Editors - Turnaround -- 1 Jan 2006 to 1 Jan 2007

<table>
<thead>
<tr>
<th>Editor</th>
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<th>Revise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domhnall MacAuley</td>
<td>0.6</td>
<td>2.5</td>
<td>13.9</td>
<td>17.9</td>
<td>14.9</td>
<td>7.0</td>
</tr>
<tr>
<td>Harvey Marcovitch</td>
<td>0.7</td>
<td>2.4</td>
<td>0.9</td>
<td>12.2</td>
<td>10.3</td>
<td>3.6</td>
</tr>
<tr>
<td>Kristina Fister</td>
<td>1.0</td>
<td>1.0</td>
<td>8.7</td>
<td>13.0</td>
<td>20.0</td>
<td>16.5</td>
</tr>
<tr>
<td>Christiane Rehwagen</td>
<td>1.3</td>
<td>1.0</td>
<td>13.2</td>
<td>10.1</td>
<td>8.4</td>
<td>3.3</td>
</tr>
</tbody>
</table>
Will we hang your painting (what happens at the journal)?

Three hurdles to clear:
peer review process-step 1

The BMJ's team of research editors aims to read 98% of newly submitted research articles within two working days.

We rejected two thirds of submissions after review in house, usually by two medical editors. The usual reasons for rejection at this stage are insufficient originality, serious scientific flaws, or the absence of a message that is important to a general medical audience.

We may screen it by reading only the structured abstract, so please ensure that the abstract is as complete, accurate, and clear as possible—but not unnecessarily long—and has been approved by all authors.
If your article is potentially suitable for the BMJ that editor will ask a senior colleague (screening editor) to approve it and, if that succeeds, he or she will send your article to two external peer reviewers.

The BMJ now has a system of open peer review. This means that reviewers have to sign their reports, saying briefly who they are and where they work. We also ask authors to declare to the editors any competing interests that might relate to articles we have asked them to review.

One editor will usually take each article through from start to finish.
If it is still in the running after peer review it is sent for assessment by the BMJ's clinical epidemiology editor and then to full appraisal at our weekly research manuscript meeting.

A statistician, an external editorial adviser, your paper's editor, and the BMJ research team will read and discuss your article's importance, originality, and scientific quality and the editor will make the final decision.
READER method of critical reading

- R-Relevance assess in context
- E-Education challenge current belief
- A-Applicability change your behaviour
- D-Discrimination valid message [method]
- E-Evaluation scoring system
- R-Reaction how to react

MacAuley D. B J Gen Pract 1994
Getting authors to help us triage papers.

Probably the commonest reason that we reject a paper is that we, as editors, feel it does not add enough to what is already known.

1. Is your paper in a different format to one of our standard paper types? (Hyperlink to short report, paper, lesson of the week, E&D etc).
2. Is it an audit using routine data?
3. Is it a case report?
4. Is the response rate (in a questionnaire) or follow up rate (in a cohort study of trial) less than 50%?
5. Is this pure laboratory research or has only healthy volunteers or is on animals?
6. Is the study design a second choice design to answer the research question?
<table>
<thead>
<tr>
<th>Research question</th>
<th>1st choice study design</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cause and effect association (etiology)</td>
<td>Cohort or case control study</td>
</tr>
<tr>
<td>Effect of an intervention</td>
<td>Randomised controlled trial</td>
</tr>
<tr>
<td>Prognostic score or decision rule</td>
<td>Two independent samples of patients used to firstly, derive the decision rule and secondly, test its performance.</td>
</tr>
<tr>
<td>Diagnostic test, symptom or sign</td>
<td>All patients assessed with the test, symptom or sign and also independently against a “gold standard”.</td>
</tr>
</tbody>
</table>
Critical appraisal questions

What is the paper about?
Why was the study done?
What type of study was done?
Was it primary research (experiment, RCT, cohort, case-control, cross-sectional, longitudinal, case report/series)?
Was it secondary research (overview, systematic review, meta-analysis, decision analysis, guidelines development, economic analysis)?
Was the design appropriate (for study on treatment, diagnosis, screening, prognosis, or causation)?
Was the study ethical?
Is the design right (see table below)?

http://resources.bmj.com/bmj/authors/checklists-forms/editors-checklists
## Critical appraisal questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Study Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does this treatment work?</td>
<td>systematic review, RCT</td>
</tr>
<tr>
<td>How good is a diagnostic test?</td>
<td>(prospective) cohort study</td>
</tr>
<tr>
<td>Should we screen?</td>
<td>RCT</td>
</tr>
<tr>
<td>What causes this disease?</td>
<td>RCT, prospective cohort study, case control study (rare diseases)</td>
</tr>
<tr>
<td>What did people think or do?</td>
<td>cohort study, cross-sectional survey, qualitative study</td>
</tr>
</tbody>
</table>

http://resources.bmj.com/bmj/authors/checklists-forms/editors-checklists
BMJ editors should also consider these more general points about such papers:
Is the research question important?
Is the economic importance of the question stated?
Is the topic of interest to BMJ readers?
Is there enough economic detail to allow peer review?
If the economic content is sound, would we want to publish the paper?
Is there a reasonable chance that the economic content is sound?

http://resources.bmj.com/bmj/authors/checklists-forms/editors-checklists
Welcome to checklists & forms

- Patient consent form
- Licence for publication
- Competing interests
- Title page
- Technical Editor's checklists
- Peer review checklist
- Editor's checklists
- Statistician's checklist
- Clinical management guidelines
- Health economics
- Drug points
- Lessons of the week
- Qualitative research

http://resources.bmj.com/bmj/authors/checklists-forms
Reports of randomised controlled trials “the CONSORT statement” (1)

Design features

• Objective of the trial sufficiently described?
• Satisfactory statement of diagnostic criteria for entry to the trial?
• Satisfactory statement of the source of participants?
• Concurrent (not historical) controls used?
• Interventions well defined?
• Random allocation to intervention used?
• Method of randomisation described?
• Acceptably short delay from allocation to start of intervention?
• Potential degree of blindness used?
• Satisfactory statement of criteria for outcome measures?
• Outcome measures appropriate?
• Pre-study calculation of sample size reported?
• Duration of post-intervention follow up stated?
Reports of randomised controlled trials “the CONSORT statement”(2)

Conduct of trial

- Intervention and control groups comparable in relevant measures?
- High proportion of participants followed up?
- High proportion of participants complete intervention?
- Were participants who dropped out from intervention and control groups described adequately?
- Adverse effects of intervention reported?
- Analysis and presentation
  - All statistical procedures adequately described or referenced?
  - Statistical analyses appropriate?
  - Prognostic factors adequately considered?
  - Presentation of statistical material satisfactory?
  - Confidence intervals given for the main results?
  - Conclusions drawn from the statistical analysis justified?
- Recommendation on paper
  - Is the paper of acceptable statistical standard for publication?
  - If "No", could it become acceptable with suitable revision?
“the QUOROM guidelines”

“the STARD guidelines”

• Please report these in accordance with the STARD (Standards for Reporting of Diagnostic Accuracy) initiative. See: