How to get your paper published in an English language Journal

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Editorial responsibilities

- Section Editor at ICM
Editorial responsibilities

- Section Editor at ICM
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ICM Editorial Board 2016
Reviewer

2014-present, American Journal of Clinical Nutrition
2014-present, Intensive Care Medicine Experimental
2014-present, Lipids in Health and Disease
2014-present, Advances in Medical Education and Practice
2013-present, Journal of Pain and Symptom Management
2013-present, Saudi Medical Journal
2013-present, Patient Preference and Adherence
2012-present, Journal of Clinical Epidemiology
2012-present, American Journal of Respiratory and Critical Care Medicine
2011-present, New England Journal of Medicine
2010-present, Acta Anaesthesiologica Scandinavica
2009-present, Canadian Medical Association Journal
2009-present, Journal of Parenteral and Enteral Nutrition

2009-present, Critical Care and Resuscitation
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2006-present, Journal of Critical Care
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2003-present, Intensive Care Medicine
2002-present, Critical Care Medicine
1999-present, Chest
Reviewer

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  - Never sent to external reviewers
  - Editor determines content not appropriate for journal, content not interesting to journal, very bad study, very poorly written.
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83 submissions accepted

• **8% (83/1,038) of total submissions!!!**
Summary of this talk

- Perspective of an Editor, Reviewer and Researcher.
- Avoiding rejection by the Editor
- Avoiding rejection by Reviewers
- Responding to Reviewers Comments
- General Insights
- Summary
Avoiding rejection by Editor

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Undertake journal selection before you start your research project.

- Identify a small number of candidate journals and retrieve 2 or 3 published papers from each.
- Use these papers as a guide for journal selection and study design.
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- Identify a small number of candidate journals and retrieve 2 or 3 published papers from each.
- Use these papers as a guide for journal selection **and** study design.

If you cannot find a project like your intended study published in your target journal, choose another journal.

- **Ex.** ICM does not publish animal laboratory work or single centre retrospective observational data.
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  - They can teach us journal preferences, good study design and good presentation styles.
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  - They have successfully made it through the review process!
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Ensure your study collects and presents information in a similar way to other papers published in your target journals.

- Severity of illness for ICU patients is traditionally captured with APACHE score in the US but SAPS score in Europe.
Avoiding rejection by Editor

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Journal Editors are very busy.
Avoiding rejection by Editor

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Journal Editors are very busy.

- Carry a clinical load, have their own research programs, usually not paid as Editors.
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- It is usually the section we write last, when we are tired.
- We put the least effort into it, yet it might be the most important section.
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If your Abstract is poorly written, you make it easy for the Editor to ‘Reject without Review’!
Lancet, Respiratory Medicine
Eltrombopag for children with chronic immune thrombocytopenia (PETIT2): a randomised, multicentre, placebo-controlled trial


Summary
The thrombopoietin receptor agonist eltrombopag has been shown to be safe, tolerable, and effective for adults with chronic immune thrombocytopenia. We aimed to investigate the safety and efficacy of eltrombopag for children with chronic immune thrombocytopenia.

Methods
PETIT2 was a two-part, randomised, multicentre, placebo-controlled study done at 38 centres in 12 countries (Argentina, Czech Republic, Germany, Hong Kong, Israel, Italy, Russia, Spain, Taiwan, Thailand, UK, and USA). Paediatric patients aged 1–17 years who had chronic immune thrombocytopenia and platelet counts less than 30 × 10⁹ per litre were randomly assigned (2:1) to receive eltrombopag or placebo. Patients were stratified by age into: those aged 1–7 years, 8–11 years, and 12–17 years; and 1–7 years before randomly entering into a 13-week randomised period. Patients aged 6–17 years were then allocated to two groups: those aged 1–7 years who received eltrombopag (80 mg/kg per day) and those aged 8–17 years who received placebo (2 mg/kg per day). Patients who completed the double-blind period entered a 24-week open-label treatment period in which all patients received eltrombopag, either the starting dose to which they were previously allocated or their established dose. The primary outcome was the proportion of patients achieving platelet counts of at least 50 × 10⁹ per litre in the absence of anti-trombocytopenic therapy for at least 8 weeks during the 24-week period. The intention-to-treat population included all patients who were randomly assigned to all the treatment groups, and the safety population included all patients who received at least one dose of study drug. This trial is registered with ClinicalTrials.gov, number NCT01529099.

Findings
Beginning on March 15, 2012, 92 patients were enrolled, and the trial was completed on Jun 3, 2014. 43 patients were assigned to receive eltrombopag and 39 were assigned to receive placebo. In the double-blind period, those patients discontinued treatment because of adverse events: two patients in the eltrombopag group withdrew because of increased liver aminotransferases and one in the placebo group withdrew because of abdominal hemorrhage. Of the 43 patients who received eltrombopag, 33 (77%) patients who received placebo achieved the primary outcome of platelet counts of at least 50 × 10⁹ per litre for 6 of the last 7 weeks of the double-blind period (p < 0.0001; 95% CI, 2.3–14.5; p < 0.0001). Responses were similar in all cohorts (eltrombopag vs placebo: 33% vs 30% for patients aged 1–7 years; 38% vs 33% for patients aged 8–11 years; and 40% vs 38% for patients aged 12–17 years). Proportionally fewer patients in the placebo group achieved the primary outcome than in the eltrombopag group (21 [41%] of 51 patients had platelet counts ≥ 30 × 10⁹ per litre for at least 6 weeks of the double-blind period vs 17 [37%] of 46 patients, p = 0.0004; 95% CI, 0.2–0.5). Patients in the placebo group had lower overall adverse events: 24–26% of patients who received placebo had ≥ 1 related adverse event vs 45% of patients who received eltrombopag. During the 24-week open-label treatment period, 76 (38%) of 17 patients achieved platelet counts of ≥ 50 × 10⁹ per litre for at least 8 weeks during the course of the double-blind period. Of the 10 patients who achieved platelet counts ≥ 50 × 10⁹ per litre for at least 8 weeks during the course of the double-blind period, 30% of patients who received placebo and 64% of patients who received eltrombopag achieved the primary outcome of platelet counts of ≥ 50 × 10⁹ per litre for at least 8 weeks during the course of the double-blind period. No deaths, malignancies, or thromboses occurred during the trial.

Interpretation
Eltrombopag, which produced a sustained platelet response in 40% of patients with chronic immune thrombocytopenia, is a suitable therapeutic option for children with chronic immune thrombocytopenia. We identified no new safety concerns and few patients discontinued treatment because of adverse events.
Journal Style Sheet

Lancet, Respiratory Medicine

# Etrombopag for children with chronic immune thrombocytopenia (PETIT2): a randomised, multicentre, placebo-controlled trial

John D'Grainger, Farooq Lodha, Ethiraj Cherian, Hwang, Hong, Kon, Isrd, Italy, Spain, Japan, Thailand, UK, and USA. Paediatric patients aged 1–7 years who had chronic immune thrombocytopenia and platelet counts less than 30 × 10⁹/l were randomly assigned (2:1) to receive etrombopag or placebo. We stratified patients by age into three cohorts (patients aged 1–3 years, 4–6 years, and 7–10 years) before randomly entering them into a 13-week, double-blind, randomised trial. Randomisation was done by the GlaxoSmithKline Registration and Medicines Outcomes System and allocated to treatment assignments. Patients who were allocated etrombopag received tablets (except for those aged 3–5 years who received an oral suspension formulation) once daily for 11 weeks. Patients who completed the double-blind period entered a 24-week open-label period in which all patients received etrombopag at the starting dose if they were followed by a participating centre or at their established dose. The primary outcome was the proportion of patients surviving and achieving platelet counts of at least 50 × 10⁹/l in the absence of transfusion therapy for 6 or more weeks from week 5 to 12 of the double-blind period. The intention-to-treat population included all patients who were randomised to one of the treatment groups, and the safety population included all patients who received at least one dose of study drug. This trial is registered with ClinicalTrials.gov, number NCT01028909.

# Findings

In March 15, 2012, 92 patients were enrolled, and the trial was completed on Jan 2, 2014. 43 patients were assigned to receive etrombopag and 29 were assigned to receive placebo. In the double-blind period, those patients discontinued treatment because of adverse events: two patients in the etrombopag group withdrew because of increased liver aminotransferase activity and one in the placebo group withdrew because of abdominal hemorrhage. 25 (40%) patients who received placebo compared with one (3%) patient who received placebo achieved the primary outcome of platelet counts of at least 50 × 10⁹/l for 6 of the 5 weeks of the double-blind period odds ratio 8.4, p = 0.004). Responses were similar in all cohorts (etrombopag vs placebo: 33% vs 15% for patients aged 1–3 years, 4–6 years, and 7–10 years). Proportionally fewer patients with severe etrombopag (31% [7%]) had platelet counts of 1.4 bleeding at the end of the double-blind period than those who received placebo (CD [15%] of 29 patients; grades 2–4 bleeding were similar (3% [5%] patients who received etrombopag vs 2% [15%] patients who received placebo). During the double-blind period, patients were transfused platelet counts of 10 × 10⁹/l for 6 of the last 5 weeks of the double-blind period (60% vs 64% of patients who received placebo). In contrast, patients in the open-label period were treated with etrombopag (40%) and placebo (60%) for 6 weeks. The study was not blinded to outcome measures. No deaths, malignancies, or thromboses occurred during the trial.

# Interpretation

Etrombopag, which produced a sustained platelet response in 40% of patients with chronic immune thrombocytopenia, is a suitable therapeutic option for children with chronic symptomatic immune thrombocytopenia. We identified no new safety concerns and few patients discontinued treatment because of adverse events.
Eltroomboag for children with chronic immune thrombocytopenia (PETIT2): a randomised, multicentre, placebo-controlled trial


Summary
The thrombopoietic receptor agonist eltroomboag has been shown to be safe, tolerable, and effective for adults with chronic immune thrombocytopenia. We aimed to investigate the safety and efficacy of eltroomboag for children with chronic immune thrombocytopenia.

Methods
PETIT2 was a two-part, randomised, multicentre, placebo-controlled study done at 38 centres in 12 countries (Argentina, Czech Republic, Germany, Hong Kong, Israel, Italy, Russia, Spain, Taiwan, Thailand, UK, and USA). Paediatric patients aged 1–17 years who had chronic immune thrombocytopenia and platelet counts less than 30 x 10^9 per l were randomly assigned (1:1) to receive eltroomboag or placebo. We stratified patients by age into three cohorts (patients aged 12–17 years, 5–11 years, and 3–5 years) before randomly assigning them to a 13-week double-blind period. Randomisation was done by the GlassSmithKline Registration and Medicines Ordering System and both patients and study personnel were masked to treatment assignments. Patients who were allocated eltroomboag received tablets (except for those aged 3–5 years who received an oral suspension formulation) once per day for 11 weeks. Staining doses for patients aged 6–17 years were based on body weight, and ethnic origin and ranged between 25 mg/d (dosing dose for patients aged 6–11 years) and 1 mg/kg/day or 0.5 mg/kg/day (for Asian patients). Patients who completed the double-blind period entered a 24-week open-label treatment period in which all patients received eltroomboag (at the starting dose if they were formerly on placebo) or their established dose. The primary outcome was the proportion of patients achieving platelet counts of at least 50 x 10^9 per l in the absence of secondary therapies for 6 or more weeks from weeks 5 to 12 of the double-blind period. The intention to treat population included all patients who were randomly assigned to one of the treatment groups, and the safety population included all patients who received at least one dose of study drug. This trial is registered with ClinicalTrials.gov, number NCT01529099.

Findings
Beginning on March 15, 2012, 92 patients were enrolled, and the trial was completed on Jan 1, 2014. 43 patients were assigned to receive eltroomboag and 49 were assigned to receive placebo. In the double-blind period, those patients discontinued treatment because of adverse events: two patients in the eltroomboag group withdrew because of increased liver aminotransferase and one in the placebo group withdrew because of abnormally high haematuria. 23 (48%) patients who received placebo achieved the primary outcome of platelet counts of at least 50 x 10^9 per l for 6 of the last 5 weeks of the double-blind period (p < 0.004). The proportion of adverse events was similar in patients receiving eltroomboag vs placebo: 33% for patients aged 14–17 years vs 4% for patients aged 6–11 years (p < 0.004). Adverse events that occurred more frequently in eltroomboag included increased liver aminotransferase and gastrointestinal events. Patients receiving eltroomboag and placebo were similar in demographics and treatment-related data. No deaths, malignancies, or thromboses occurred during the trial.

Interpretation
Eltrombopag, which produced a sustained platelet response in 40% of patients with chronic immune thrombocytopenia, is a suitable therapeutic option for children with chronic symptomatic immune thrombocytopenia. We identified no new safety concerns and few patients discontinued treatment because of adverse events.
Novel Efficient Algorithm for Image Segmentation

Introduction

Methodology

Results

Discussion

Conclusion
Eltrombopag for children with chronic immune thrombocytopenia (PETIT2): a randomised, multicentre, placebo-controlled trial

Summary

Background The thrombopoietic receptor agonist eltrombopag has been shown to be safe, tolerable, and effective for adults with chronic immune thrombocytopenia. We aimed to investigate the safety and efficacy of eltrombopag for children with chronic immune thrombocytopenia.

Methods PETIT2 was a 2 part, randomised, multicentre, placebo-controlled study done at 38 centres in 12 countries (Argentina, Czech Republic, Germany, Hong Kong, Israel, Italy, Russia, Spain, Thailand, USA, and UK). Paediatric patients aged 1–17 years who had chronic immune thrombocytopenia and platelet counts less than 30 × 10^9 per L were randomly assigned (1:1) to receive eltrombopag or placebo. We stratified patients by age into three cohorts (patients aged 12–17 years, 6–11 years, and 6–5 years) before randomly entering them into a 13-week, double-blind period. Randomisation was done by the Glimpse Medical Management of Clinical Trials. Outcome measures included the proportion of patients achieving at least 50% increase in platelet counts from baseline (primary outcome), and the proportion of patients achieving 30% increase in platelet counts from baseline.

Results Of 177 patients who were assigned to treatment in 144 centres, 175 (99%) received at least one dose of study drug. Efficacy outcomes were similar in both the eltrombopag and placebo groups. The primary outcome was the proportion of patients achieving platelet counts of at least 50% at week 13. In the absence of treatment, 4 of 32 patients had platelet counts of at least 50% at week 13 (2.5%).

Interpretation Eltrombopag, which produced a sustained platelet response in 40% of patients with chronic immune thrombocytopenia, is a suitable therapeutic option for children with chronic symptomatic immune thrombocytopenia. We identified no new safety concerns and few patients discontinued treatment because of adverse events.
Eltrombopag, which produced a sustained platelet response in 40% of patients with chronic immune thrombocytopenia is a suitable therapeutic option for children with chronic symptomatic immune thrombocytopenia. We identified no new safety concerns and few patients discontinued treatment because of adverse events.
**Conclusions** In patients with acute lung injury and the acute respiratory distress syndrome, mechanical ventilation with a lower tidal volume than is traditionally used results in decreased mortality and increases the number of days without ventilator use. (N Engl J Med 2000;342:1301-8.)

©2000, Massachusetts Medical Society.

**Interpretation** Eltrombopag, which produced a sustained platelet response in 40% of patients with chronic immune thrombocytopenia, is a suitable therapeutic option for children with chronic symptomatic immune thrombocytopenia. We identified no new safety concerns and few patients discontinued treatment because of adverse events.
Restricted versus continued standard caloric intake during the management of refeeding syndrome in critically ill adults: a randomised, parallel-group, multicentre, single-blind controlled trial

Gordon S Dolg, Fiona Simpson, Phillipa T Hughes, Rinaldo Bellomo, Douglas Chesher, Ian D Caterson, Michael C Reade, Peter W J Harrigan, on the Refeeding Syndrome Trial Investigators Group

Summary

Background Equipoise exists regarding the benefits of restricting caloric intake during electrolyte replacement for refeeding syndrome, with half of intensive care specialists choosing to continue normal caloric intake. We aimed to assess whether energy restriction affects the duration of critical illness, and other measures of morbidity, compared with standard care.

Methods We did a randomised, multicentre, single-blind clinical trial in 13 hospital intensive care units (ICUs) in Australia (11 sites) and New Zealand (two sites). Adult critically ill patients who developed refeeding syndrome within 72 h of commencing nutritional support in the ICU were enrolled and allocated to receive continued standard nutritional support or protocolised caloric restriction. 11 computer-based randomisation was done in blocks of variable size, stratified by enrolment serum phosphate concentration (>0.32 mmol/L vs ≤0.32 mmol/L) and body-mass index (BMI; >18 kg/m² vs ≤18 kg/m²). The primary outcome was the number of days alive after ICU discharge with 60-day follow-up, in a modified intention-to-treat population of all randomly allocated patients except those mistakenly enrolled. Days alive after ICU discharge was a composite outcome based on ICU length of stay, overall survival time, and mortality. The Refeeding Syndrome Trial was registered with the Austrakan and New Zealand Clinical Trials Registry (ANZCTR number 1200908104324).

Findings Between Dec 3, 2010, and Aug 13, 2014, we enrolled 339 adult critically ill patients: 176 were randomly allocated to continued standard nutritional support and 163 to protocolised caloric restriction. During the 60-day follow-up, the mean number of days alive after ICU discharge in 165 assessable patients in the standard care group was 39.9 (95% CI 36.4–43.7) compared with 44.8 (95% CI 40.9–49.1) in 166 assessable patients in the caloric restriction group (difference 4.9 days, 95% CI −2.9 to 13.6, p=0.01). Nevertheless, protocolised caloric restriction improved key individual components of the primary outcome: more patients were alive at day 60 (128 [73%] of 176 vs 139 [85%] of 163, p=0.002) and overall survival was increased (48.9 [SD 14.6] days vs 53.5 [0–97] days, log-rank p=0.002).

Interpretation Protocolised caloric restriction is a suitable therapeutic option for critically ill adults who develop refeeding syndrome. We did not identify any safety concerns associated with the use of protocolised caloric restriction.
Restricted versus continued standard caloric intake during the management of refeeding syndrome in critically ill adults: a randomised, parallel-group, multicentre, single-blind controlled trial

Gordon S Doyle, Fiona Stimpson, Phillip T Hughes, Rinaldo Bellomo, Douglas Chesher, Ian D Caterson, Michael C Reade, Peter W J Harrison, for the Refeeding Syndrome Trial Investigators Group

Summary
Background Equipoise exists regarding the benefits of restricting caloric intake during electrolyte replacement for refeeding syndrome. With half of intensive care specialists choosing to continue normal caloric intake, we aimed to assess whether energy restriction affects the duration of critical illness, and other measures of morbidity, compared with standard care.

Methods We did a randomised, multicentre, single-blind clinical trial in 13 intensive care units in Australia (11 sites) and New Zealand (two sites). Adult critically ill patients who developed refeeding syndrome within 72 h of commencing nutritional support in the ICU were enrolled and allocated to receive continued standard nutritional support or protocolised caloric restriction. 11 computer-based randomisation was done in blocks of variable size. stratified by enrolment serum phosphate concentration (>32 mmol/L vs ≤32 mmol/L) and body mass index (BMI; >18 kg/m² vs ≤18 kg/m²). The primary outcome was the number of days alive after ICU discharge with 60-day follow-up, in a modified intention-to-treat population of all randomly allocated patients except those mistakenly enrolled. Days alive after ICU discharge was a composite outcome based on ICU length of stay, overall survival time, and mortality. The Refeeding Syndrome Trial was registered with the Australian and New Zealand Clinical Trials Registry (ANZCTR number 12609081043224).

Findings Between Dec 3, 2010, and Aug 13, 2013, we enrolled 339 adult critically ill patients; 176 were randomly allocated to continued standard nutritional support and 163 to protocolised caloric restriction. During the 60-day follow-up, the mean number of days alive after ICU discharge in 165 assessable patients in the standard care group was 39.9 (95% CI 36.4–43.7) compared with 44.8 (95% CI 40.9–49.1) in 166 assessable patients in the caloric restriction group (difference 4.9 days, 95% CI –2.3 to 13.6; p=0.19). Nevertheless, protocolised caloric restriction improved key individual components of the primary outcome: more patients were alive at day 60 (128 [78.3%] of 163 vs 149 [91.3%] of 164; p=0.002) and overall survival time was increased (48.9 [SD 14.6] days vs 53.6–65 [97] days, log-rank p=0.002).

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Methods: We did a randomised, multicentre, single-blind clinical trial in 13 hospital intensive care units (ICUs) in Australia (11 sites) and New Zealand (two sites). Adult critically ill patients who developed refeeding syndrome within 72 h of commencing nutritional support in the ICU were enrolled and allocated to receive continued standard nutritional support or protocolised caloric restriction. 11 computer-based randomisation was done in blocks of variable size, stratified by enrolment serum phosphate concentration (<0.32 mmol/L vs ≥0.32 mmol/L) and body mass index (BMI; <18.5 kg/m² vs ≥18.5 kg/m²). The primary outcome was the number of days alive after ICU discharge with 60 day follow-up, in a modified intention-to-treat population of all randomly allocated patients except those mistakenly enrolled. Days alive after ICU discharge was a composite outcome based on ICU length of stay, overall survival time, and mortality. The Refeeding Syndrome Trial was registered with the Australasian and New Zealand Clinical Trials Registry (ANZCTR number 12607001043224).

Findings: Between Dec 3, 2010, and Aug 13, 2014, we enrolled 339 adult critically ill patients: 176 were randomly allocated to continued standard nutritional support and 163 to protocolised caloric restriction. During the 60 day follow-up, the mean number of days alive after ICU discharge in 165 assessable patients in the standard care group was 39.9 (95% CI 36.4–43.7) compared with 44.8 (95% CI 40.9–49.1) in 155 assessable patients in the caloric restriction group (difference 4.9 days, 95% CI −0.2 to 9.9, p=0.08). Nevertheless, protocolised caloric restriction improved key individual components of the primary outcome: more patients were alive at day 60 (128 [73%] of 163 vs 149 [91%] of 164, p=0.002) and overall survival time was increased (48.9 [SD 14.6] days vs 53.6 [0–97] days, log-rank p=0.02).

Interpretation: Protocolised caloric restriction is a suitable therapeutic option for critically ill adults who develop refeeding syndrome. We did not identify any safety concerns associated with the use of protocolised caloric restriction.
Restricted versus continued standard caloric intake during the management of refeeding syndrome in critically ill adults: a randomised, parallel-group, multicentre, single-blind controlled trial

Summary

Background  
Equipoise exists regarding the benefits of restricting caloric intake during electrolyte replacement for refeeding syndrome. Half of intensive care specialists choose to continue normal caloric intake. We aimed to assess whether energy restriction affects the duration of critical illness and other measures of mobility compared with standard care.

Methods  
We did a randomised, multicentre, single-blind clinical trial in 13 hospital intensive care units (ICUs) in Australia (11 sites) and New Zealand (2 sites). Adults critically ill patients who developed refeeding syndrome within 72 h of commencing nutritional support in the ICU were enrolled and allocated to receive continued standard nutritional support or protocolised caloric restriction. A computer-based randomisation was done in blocks of variable size, stratified by enrolment serum phosphate concentration (>32 mmol/L vs ≤32 mmol/L) and body mass index (BMI; >18 kg/m² vs ≤18 kg/m²). The primary outcome was the number of days alive after ICU discharge.

Interpretation  
Protocolised caloric restriction is a suitable therapeutic option for critically ill adults who develop refeeding syndrome. We did not identify any safety concerns associated with the use of protocolised caloric restriction.

Findings  
Between Dec 3, 2010, and Aug 15, 2013, we enrolled 339 critically ill patients; 178 were randomly allocated to continued standard nutritional support and 161 to protocolised caloric restriction. During the 60 day follow-up, the mean number of days alive after ICU discharge in 165 assessable patients in the standard care group was 39·9 (95% CI 36·4–43·7) compared with 44·8 (95% CI 40·9–49·1) in 166 assessable patients in the caloric restriction group (difference 4·9 days, 95% CI 0·3–9·5, p=0·02). Nevertheless, protocolised caloric restriction improved key individual components of the primary outcome: more patients were alive at day 60 (128 [78%] of 163 vs 149 [91%] of 164, p=0·002) and overall survival time was increased (48·9 [SD 1·46] days vs 53·6 [0·97] days, log-rank p=0·002).

Protocolised caloric restriction is a suitable therapeutic option for critically ill adults who develop refeeding syndrome. We did not identify any safety concerns associated with the use of protocolised caloric restriction.
Restricted versus continued standard caloric intake during the management of refeeding syndrome in critically ill adults: a randomised, parallel-group, multicentre, single-blind controlled trial

Gordon S Ding, Fiona Stimpson, Phillipa T Hughes, Rinaldo Bellmore, Douglas Cheser, Ian D Caterson, Michael C Reade, Peter W J Harrison, for the Refeeding Syndrome Trial Investigators Group

Summary
Background Equipoise exists regarding the benefits of restricting caloric intake during electrolyte replacement for refeeding syndrome, with half of intensive care specialists choosing to continue normal caloric intake. We aimed to assess whether energy restriction affects the duration of critical illness, and other measures of mobility, compared with standard care.

Methods We did a randomised, multicentre, single-blind clinical trial in 13 hospital intensive care units (ICUs) in Australia (11 sites) and New Zealand (two sites). Adult critically ill patients who developed refeeding syndrome within 72 h of commencing nutritional support in the ICU were enrolled and allocated to receive continued standard nutritional support or protocolised caloric restriction. 11 computer-based randomisation was done in blocks of variable size, stratified by enrolment serum phosphate concentration (>0.32 mmol/L vs ≤0.32 mmol/L) and body-mass index (BMI): >18 kg/m² vs ≤18 kg/m²). The primary outcome was the number of days alive after ICU discharge.

Findings Between Dec 3, 2010, and Aug 13, 2011, we enrolled 339 adult critically ill patients: 170 were randomly allocated to continued standard nutritional support and 169 to protocolised caloric restriction. During the 60 day follow-up, the mean number of days alive after ICU discharge in 165 assessable patients in the standard care group was 38.9 (95% CI 36–41.7) compared with 44.8 (95% CI 40–49.1) in 166 assessable patients in the caloric restriction group (difference 4.9 days, 95% CI −0.2–10.0; p=0.31). Nevertheless, protocolised caloric restriction improved key individual components of the primary outcome; more patients were alive at day 60 (128 [73%] of 163 vs 149 [91%] of 164, p=0.002) and overall survival time was increased (48.9 [SD 14.6] days vs 53.6 [SD 9.7] days, log-rank p=0.002).

Interpretation Protocolised caloric restriction is a suitable therapeutic option for critically ill adults who develop refeeding syndrome. We did not identify any safety concerns associated with the use of protocolised caloric restriction.

Public Health and Preventive Medicine, Monash University, Melbourne, VIC, Australia (Prof M Bellomo MD); New South Wales Health, Pathology, Sydney, NSW, Australia (DChester PhD); Burns, Trauma and Critical Care Research Centre, University of Queensland, Brisbane, QLD, Australia (Prof M Caterson DPhil); and John Hunter Hospital, New Lambton Heights, NSW.
Avoiding rejection by Editor

Editor determines content not appropriate for journal, content not interesting to journal, very bad study, very poorly written.

Journal Editors are very busy.

- Carry a clinical load, have their own research programs, usually not paid as Editors.
- The easiest decision for a Editor to make is ‘Reject without Review’.
  - Immediately removes work from their inbox.
  - Reduces future work, as they will never see the paper again!

Because Editors are busy, there is only one section of your paper you can guarantee an Editor will read:

- It is usually the section we write last, when we are tired.
- We put the least effort into it, yet it might be the most important section.

If your Abstract is poorly written, you make it easy for the Editor to ‘Reject without Review’!
Avoiding rejection by Reviewers

348 of 1,038 papers sent by Editor to external reviewers

• 86% (301/348) rejected after negative comments from reviewers
  • Reviewers determine bad study, poorly explained or poorly written.
  • Sometimes reviewers determine content not appropriate for journal or content not interesting to journal.
  • Sometimes reviewers recommend Reject after Authors fail to make recommended corrections!
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  - If your **paper** is poorly written and difficult to understand, they will stop reading and recommend ‘**Reject**’!
  - If your paper is difficult to understand, Reviewers do not usually provide objective reasons for Rejection. They just send a Confidential Comment to the Editor recommending Reject.
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- Every journal has its own unique conventions.
- Conversational English is different to Scientific English.
  - Have two translators: One who is good at conversational English and one who is a content area expert.
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Usually the Editor makes this decision before he/she sends your paper out for review.

The best way to address this issue is through good Journal selection before you submit your paper!
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If the Editor returns your paper and asks for Minor or Major Revisions based on Reviewers comments, you are almost published!

• 85% of submissions do not make it to this stage!
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• Make all 57 changes anyway or...
• Make 55 changes.... and point out politely why you can’t make the last 2 changes.
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If you use your country name in the title, the Editor or Reviewer may conclude your results apply only to your country and perhaps your paper is not interesting to their Journal!
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