How to get your paper published in an English language Journal

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Editorial responsibilities

• Section Editor at ICM

ICM Editorial Board 2016
Editorial responsibilities

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Editorial responsibilities

- Section Editor at ICM
- Editorial Board Member for CCM
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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
2009-present, Injury
2009-present, Clinical Nutrition
2009-present, Respirology
2008-present, British Medical Journal
2008-present, Journal of the American Medical Association
2008-present, British Journal of Nutrition
2008-present, Asia Pacific Journal of Clinical Nutrition
2008-present, Hemodialysis International, 2008-present, Anesthesia & Analgesia
2006-present, Journal of Critical Care
2005-present, Critical Care
2004-present, Anaesthesia and Intensive Care
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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- **86% (301/348)** rejected after negative comments from reviewers
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  - *Sometimes* reviewers recommend Reject after Authors fail to make recommended corrections!
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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.
Avoiding rejection by Editor

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Undertake journal selection before you start your research project.

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- 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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Identify a small number of candidate journals and retrieve 2 or 3 published papers from each.

- Read these papers thoroughly:
  - They have successfully made it through the review process!
  - They can teach us journal preferences, good study design and good presentation styles.
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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.
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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.
Avoiding rejection by Editor

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- 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!
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Because Editors are busy, there is only **one** section of your paper you can guarantee an Editor will read:
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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.
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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 (PETT2): 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
PETT2 was a two-part, randomised, multicentre, placebo-controlled study done at 33 centres in 12 countries (Argentina, Czech Republic, Germany, Hong Kong, Israel, 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 L were randomly assigned (2:1) to receive eltrombopag or placebo. We stratified patients by age into three cohorts (patients aged 1–3 years, 4–6 years, and 7–17 years) before randomly enrolling them into a 13-week, double-blind period. Randomisation was done by the GlaxoSmithKline Registration and Medication Ordering System and both patients and study personnel were masked to treatment assignments. Patients who were allocated eltrombopag received tablets (except for those aged 1–5 years who received an oral suspension formulation) once per day for 13 weeks. Starting doses for patients aged 6–17 years were based on bodyweight, and ethnic origin and ranged between 50 mg/day and 23 mg/day (starting dose for patients aged 1–5 years was 1–2 mg/kg/day or 0.8 mg/kg/day for east Asian patients). Patients who completed the double-blind period entered a 24-week open-label treatment period in which all patients received eltrombopag at the either 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 × 10⁹ per L in the absence of rescue therapy for 6 or more weeks from weeks 5 to 12 of the double-blind period. The intention-to-treat population included in the efficacy assessment consisted of 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 NCT01820995.

Findings
Beginning in March 15, 2012, 92 patients were enrolled, and the trial was completed on Jan 2, 2014. 62 patients were assigned to receive eltrombopag, and 29 were assigned to receive placebo. In the double-blind period, three 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 abdominopelvic haematoma. 23 (46%) patients who received eltrombopag achieved the primary outcome of platelet counts of at least 50 × 10⁹ per L for 6 of the last 8 weeks of the double-blind period (pooled risk ratio 1.9, 95% CI 1.2–3.0; 140–14.9; 2000). Responses were similar in all cohorts (eltrombopag vs placebo 39% vs 10% for patients aged 1–3 years, 41% vs 12% for patients aged 4–10 years, and 63% vs 10% for patients aged 11–17 years). Proportionately fewer patients who received eltrombopag (23 [37%] of 61 patients) had WHO grades 1–4 bleeding at the end of the double-blind period than did those who received placebo (52 [33%] of 159 patients); grades 2–4 bleeding were similar (three [5%] patients who received eltrombopag vs two [0%] patients who received placebo). During the 24-week open-label treatment period, 10 (30%) of 33 patients achieved platelet counts of 50 × 10⁹ per L or more at least once. Adverse events that occurred more frequently with eltrombopag than with placebo included nasopharyngitis (11 [17%] patients), rhinitis (10 [16%] patients), upper respiratory tract infection (5 [7%] patients), and cough (5 [8%] patients). Serious adverse events occurred in five (8%) patients who received eltrombopag and four (1%) who received placebo. Safety was consistent with the open-label and double-blind periods. 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.
Journal Style Sheet

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


Summary
Background 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 x 10⁹/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 1–5 years) before randomly entering them into a 13-week, double-blind period. Randomisation was done by the GlaxoSmithKline Registration and Medication Ordering System and both patients and study personnel were masked to treatment assignments. Patients were allocated eltrombopag or placebo tablets (except for those aged 1–5 years who received an oral suspension formulation) once per day for 13 weeks. Starting doses for patients aged 6–17 were based on bodyweight, and ethnic origin and ranged between 5 mg/day and 25 mg/day (starting dose for patients aged 1–5 years was 1 mg/day/kg or 0.0 mg/kg/day for east Asian patients). Patients who completed the double-blind period entered a 24-week open label treatment period in which all patients received eltrombopag at the starting dose (if they were previously on placebo) or their established dose. The primary outcome was the proportion of patients achieving platelet counts of at least 50 x 10⁹/L in the absence of rescue therapy for 6 or more weeks from weeks 5 to 12 of the double-blind period. The intention to treat population included all the 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 NCT01520959.

Findings Beginning in March 15, 2012, 92 patients were enrolled, and the trial was completed on Jan 2, 2014. 43 patients were assigned to receive eltrombopag and 29 were assigned to receive placebo. In the double-blind period, three 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 haemorrhage. 23 (46%) patients who received eltrombopag achieved the primary outcome of platelet counts of at least 50 x 10⁹/L for 6 of the last 8 weeks of the double-blind period (p-value 0.0044). Responses were similar in all cohorts (eltrombopag vs placebo: 39% vs 34% for patients aged 12–17 years, 5% vs 4% for patients aged 6–11 years, and 0% vs 0% for patients aged 1–5 years). Proportionately fewer patients who received eltrombopag (23 [53%] of 43 patients) had WHO grades 1–4 bleeding at the end of the double-blind period than did those who received placebo (56 [53%] of 29 patients); grades 2–4 bleeding were similarly rare [5%] patients who received eltrombopag vs two [7%] patients who received placebo. During the 24-week open-label treatment period, 70 (80%) of 88 patients achieved platelet counts of 50 x 10⁹/L or more at least once. Adverse events that occurred more frequently with eltrombopag than with placebo included nasopharyngitis (11 [17%] of 61 patients), rhinitis (10 [16%] of 61 patients), upper respiratory tract infection (7 [11%] patients), and cough (7 [11%] patients). Serious adverse events occurred in five (6%) patients who received eltrombopag and four (13%) who received placebo. Safety was consistent between the open-label and double-blind periods. No deaths, malignancies, or thromboses occurred during the trial.

Interpretation Elitrombopag, which produced a sustained platelet response in 40% of patients with chronic immune thrombocytopenia, is a satisfactory therapeutic option for children with chronic symptomatic immune thrombocytopenia. We identified no new safety concerns and few patients discontinued treatment because of adverse events.
Background: The thrombopoenic receptor agonist etrombopag has been shown to be safe, tolerable, and effective for adults with chronic immune thrombocytopenia. We aimed to investigate the safety and efficacy of etrombopag 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, Russia, Spain, Taiwan, Thailand, UK, and USA). Paediatric patients aged 1–17 years who had chronic immune thrombocytopenia and platelet counts less than 30 × 10^9 per L were randomly assigned (2:1) to receive etrombopag or placebo. We stratified patients by age into three cohorts (patients aged 12–17 years, 6–11 years, and 1–5 years) before randomly enrolling them into a 13-week, double-blind period. Randomisation was done by the GlaxoSmithKline Registration and Medication Ordering System and both patients and study personnel were masked to treatment assignments. Patients who were allocated etrombopag received tablets (except for those aged 1–5 years who received an oral suspension formulation) once per day for 13 weeks. Starting doses for patients aged 6–17 years were based on bodyweight, and ethic origin and ranged between 59 mg/kg and 25 mg/kg/day (starting dose for patients aged 1–5 years was 1–2 mg/kg/day or 0.8–0.8 mg/kg/day for east Asian patients). Patients who completed the double-blind period entered a 24-week open-label treatment period in which all patients received etrombopag at either 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 × 10^9 per L in the absence of rescue therapy for 6 or more weeks from weeks 5 to 12 of the double-blind period. The intention-to-treat population included in the efficacy assessment consisted of 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 NCT01209065.

Findings: Beginning in March 15, 2012, 92 patients were enrolled, and the trial was completed on Jan 2, 2014. 62 patients were assigned to receive etrombopag, and 29 were assigned to receive placebo. In the double-blind period, three patients discontinued treatment because of adverse events: two patients in the etrombopag group withdrew because of increased liver aminotransferases and one in the placebo group withdrew because of abdominal haemorrhage. 23 (38%) patients who received etrombopag achieved the primary outcome of platelet counts of at least 50 × 10^9 per L for 6 of the last 8 weeks of the double-blind period (p<0.0001 vs 95% CI, 0.3–10.4: p=0.0001). Responses were similar in all cohorts (etrombopag vs placebo: 39% vs 10% for patients aged 12–17 years, 47% vs 10% for patients aged 6–11 years, and 36% vs 2% for patients aged 1–5 years). Proportionately fewer patients who received etrombopag (23 [37%] of 61 patients) had WHO grades 1–4 bleeding at the end of the double-blind period than did those who received placebo (36 [53%] of 29 patients). Grades 2–4 bleeding were similar (three [5%] patients who received etrombopag vs two [7%] patients who received placebo). During the 24-week open-label treatment period, 70 (90%) of 78 patients achieved platelet counts of 50 × 10^9 per L or more at least once. Adverse events that occurred more frequently with etrombopag than with placebo included nasopharyngitis (11 [17%] patients), rhinitis (10 [16%] patients), upper respiratory tract infection (7 [11%] patients), and cough (7 [11%] patients). Serious adverse events occurred in five (9%) patients who received etrombopag and four (13%) who received placebo. Safety was consistent between the open-label and double-blind periods. No deaths, malignancies, or thromboses occurred during the trial.

Conclusion: Etrombopag, which produced a sustained platelet response in 40% of patients with chronic immune thrombocytopenia, is a therapeutic option for children with chronic symptomatic immune thrombocytopenia. We identified no new safety concerns and few patients discontinued treatment because of adverse events.
**Background:** 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 x 10^9/l 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 1–5 years) before randomly entering them into a 13-week double-blind period. Randomisation was done by the GlaxoSmithKline Registration and Medication Ordering System and both patients and study personnel were masked to treatment assignment. Patients who had allocated eltrombopag tablets (except those aged 1–5 years who received an oral suspension formulation) once daily for 13 weeks. Starting doses for patients aged 6–17 years were based on bodyweight and ethnic origin, and ranged between 56 mg/day and 23 mg/day (starting dose for patients aged 1–5 years was 1–2 mg/kg/day or 0.8 mg/kg/day for east Asian patients). Patients who completed the double-blind period entered a 24-week open-label treatment period in which all patients received eltrombopag 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/l in the absence of rescue therapy for 6 or more weeks from weeks 5 to 12 of the double-blind period. The intention-to-treat population included all the 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 NCT01820995.

**Findings:** Beginning in March 2012, 92 patients were enrolled, and the trial was completed on Jan 2, 2014. 42 patients were assigned to receive eltrombopag, and 29 were assigned to receive placebo. In the double-blind period, three 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 haemorrhage. 23 (54%) patients who received eltrombopag achieved the primary outcome of platelet counts of at least 50 x 10^9/l per L for at least 6 of the last 8 weeks of the double-blind period (p<0.0001, OR 3.7, 2.4–5.9; p=0.0004). Responses were similar in all cohorts (eltrombopag vs placebo 39% vs 10%, respectively, for patients aged 6–17 years; 14% vs 0%, respectively, for patients aged 1–5 years). Proportionately fewer patients who received eltrombopag (23 [51%] of 43 patients) had WHO grades 1–4 bleeding at the end of the double-blind period than did those who received placebo (56 [58%] of 96 patients; grades 2–4 bleeding were similar (5%) patients who received eltrombopag vs two [2%] patients who received placebo). During the 24-week open-label treatment period, 70 (81%) of 87 patients achieved platelet counts of 50 x 10^9/l per L or more at least once. Adverse events that occurred more frequently with eltrombopag than with placebo included nasopharyngitis (11 [17%] patients), rhinitis (10 [16%] patients), upper respiratory tract infection (7 [11%] patients), and cough (7 [11%] patients). Serious adverse events occurred in five (9%) patients who received eltrombopag and four (4%) who received placebo. Safety was consistent between the open-label and double-blind periods. No deaths, malignancies, or thromboses occurred during the trial.

**Interpretation:** Eltrombopag, which produced a sustained platelet response in 46% of patients with chronic immune thrombocytopenia, is a 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 for children with chronic immune thrombocytopenia (PETIT2): a randomised, multicentre, placebo-controlled trial

John D'Grozinger, Frances Loveall, Thirurosshi Ohthumparamanan, Elena Donguy, Banchao Pengchareonkul, Poobee Kamprakul, Donner Southall, Guillelmo Drechja, Nongnuch Siriprasert, Susanne Vukicevic, Vladimir Lehto, Richard Lennox, Dagmar Priglinger, Ugo Romegni, James Rice, Kusum Rsarruk, Maolin Jeng, Geoffrey W Che, Karen D Corder, Delina Theodore, Lisa M Marcello, Christopher Ridley

Summary
Background 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 35 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 eltrombopag or placebo. We stratified patients by age into three cohorts (patients aged 12–17 years, 6–11 years, and 1–5 years) before randomly enrolling them into a 13-week, double-blind period. Randomisation was done by the GlaxoSmithKline Registration and Medication Ordering System and both patients and study personnel were masked to treatment assignments. Patients who were allocated eltrombopag received tablets (except for those aged 1–5 years who received an oral suspension formulation) once per day for 13 weeks. Starting doses for patients aged 6–17 were based on bodyweight, and ethnic origin and ranged between 50 mg/m^2 and 23 mg/day (starting dose for patients aged 1–5 years was 1–2 mg/kg/day or 0.8 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 eltrombopag at either the starting dose (if they were previously 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 rescue therapy for 6 or more weeks from week 5 to 12 of the double-blind period. The intention-to-treat population included in the efficacy assessment consisted of 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 NCT02520969.

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


Summary
Background 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 1.7–17 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 1–5 years) before randomly enrolling them into a 13-week, double-blind period. Randomisation was done by the GlaxoSmithKline Registration and Medication Ordering System and both patients and study personnel were masked to treatment assignments. Patients who were allocated eltrombopag received tablets (except for those aged 1–5 years who received an oral suspension formulation) once per day for 13 weeks. Starting doses for patients aged 6–17 years were based on bodyweight, and ethnic origin and ranged between 50 mg/day and 25 mg/day (starting dose for patients aged 1–5 years was 1.2 mg/kg/day or 0.8 mg/kg/day for east Asian patients). Patients who completed the double-blind period entered a 24-week open-label treatment period in which all patients received eltrombopag 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 50–10^9 per L in the absence of rescue therapy for 4 or more weeks from week 5 to 12 of the double-blind period. The intention-to-treat population included in the efficacy assessment consisted of 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 NCT01320969.

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.

During the 24-week open-label treatment period, 70 (5%) of 757 patients achieved platelet counts of 50–10^9 per L or more at least once. Adverse events that occurred more frequently with eltrombopag than with placebo included nasopharyngitis (11.7% vs 7.8%), rhinitis (9.8% vs 6.8%), upper respiratory tract infection (7.1% vs 3.7%), and cough (7.1% vs 3.7%). Serious adverse events occurred in five (0.6%) patients who received eltrombopag and four (0.5%) who received placebo. Safety was consistent between the open-label and double-blind periods. 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.
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 Doug, Fiona Simpson, Philippa J Heigens, Ronald Belforno, Douglas Chester, Ian D Caterson, Michael I Redel, 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 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. 1:1 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 Australian and New Zealand Clinical Trials Registry (ANZCTR number 12609001043224).

Findings Between Dec 3, 2010, and Aug 13, 2014, 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 39–9 (95% CI 36–43–7) compared with 44–8 (95% CI 40–49–1) in 166 assessable patients in the caloric restriction group (difference 4–9 days, 95% CI −2–3 to 13–6, p=0–19). Compared with unassessable patients, protocolised caloric restriction improved key individual components of the primary outcome: more patients were alive at day 60 (128 [75%] of 163 vs 149 [91%] of 164, p=0–002) and overall survival time was increased (48–9 [SD 1–4] days vs 53–65 [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.
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See Comment page 562
Use appendix for the full list of investigators
Northern Clinical School
Intensive Care Research Unit (G S Dalg, P Simpson MD, FT Heighes BSc), and The Hunter Institute of Obesity, Nutrition Exercise, and Eating Disorders (P WJ Harrigan FACP), University of Sydney, Sydney, NSW, Australia; School of Public Health and Preventive Medicine, Monash University, Melbourne, VIC, Australia (F T Heighes MD); New South Wales Health, Pathology, Sydney, NSW, Australia; South Australian Health Care Research Centre, University of Queensland, Brisbane, QD, Australia (P WJ Harrigan FACP), and John Hunter Hospital, Newcastle, NSW, Australia (G S Dalg).
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

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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!
Avoiding rejection by Reviewers

Reviewers determine **bad study, poorly explained or poorly written.**
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Reviewers are very busy.

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Reviewers are very busy.

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- Reviewers cannot ‘**Reject without Review**’. They must read your whole paper but:
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- Reviewers cannot ‘Reject without Review’. They must read your whole paper but:
  - 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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Reviewers are very busy.

- Make your papers easy to understand.
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Reviewers are very busy.

- Make your papers *easy* to understand.
- 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.
  - Use these papers as a guide for English language use.
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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.
General Insights
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99% of the Editors and Reviewers who read your paper have never been to an ICU in your country.
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- Admission APACHE for US journals / SAPS for European journals.
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Describe routine care using statements to demonstrate you are familiar with best practice:
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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!
Summary
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