How to get your paper published in an English language Journal

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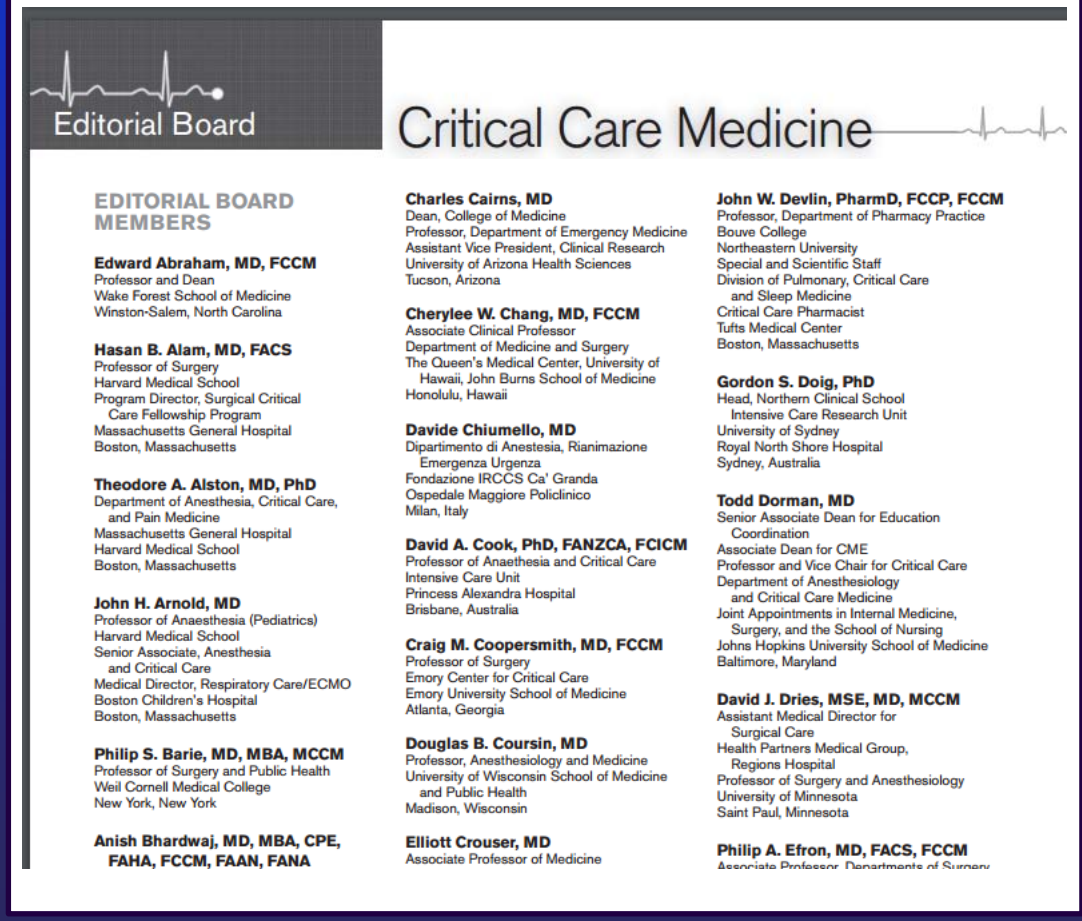
- Editorial Board Member for CCM



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Critical Care Medicine

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2003-present, Intensive Care Medicine

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1,038 original research papers (observational study, RCT) were received in 2015

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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

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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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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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- 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

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

John D Grainger, Franco Locatelli, Thirachit Chotsampancharoen, Elena Donyush, Bunchoo Pongtanakul, Patcharee Komvilaisak, Darintr Sosothikul, Guillermo Drelichman, Nongnuch Sirachainan, Susanne Holzhauer, Vladimir Lebedev, Richard Lemons, Dagmar Pospisilova, Ugo Ramenghi, James B Bussel, Kalpana K Bakshi, Malini Iyengar, Geoffrey W Chan, Karen D Chagin, Dickens Theodore, Lisa M Marcello, Christine K Bailey

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 30×10^9 per L were randomly assigned (2:1) 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 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/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 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 NCT01520909.

Findings Beginning in March 15, 2012, 92 patients were enrolled, and the trial was completed on Jan 2, 2014. 63 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. 25 (40%) patients who received eltrombopag compared with one (3%) patient who received placebo 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 (odds ratio 18·0, 95% CI, 2·3–140·9; p=0·0004). Responses were similar in all cohorts (eltrombopag *vs* placebo: 39% *vs* 10% for patients aged 12–17 years, 42% *vs* 0% for patients aged 6–11 years, and 36% *vs* 0% for patients aged 1–5 years). Proportionately fewer patients who received eltrombopag (23 [37%] of 63 patients) had WHO grades 1–4 bleeding at the end of the double-blind period than did those who received placebo (16 [55%] of 29 patients); grades 2–4 bleeding were similar (three [5%] patients who received eltrombopag *vs* two [7%] patients who received placebo). During the 24-week open-label treatment period, 70 [80%] of 87 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 [17%] patients), rhinitis (10 [16%] patients), upper respiratory tract infection (7 [11%] patients), and cough (7 [11%] patients). Serious adverse events occurred in five (8%) patients who received eltrombopag and four (14%) 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.

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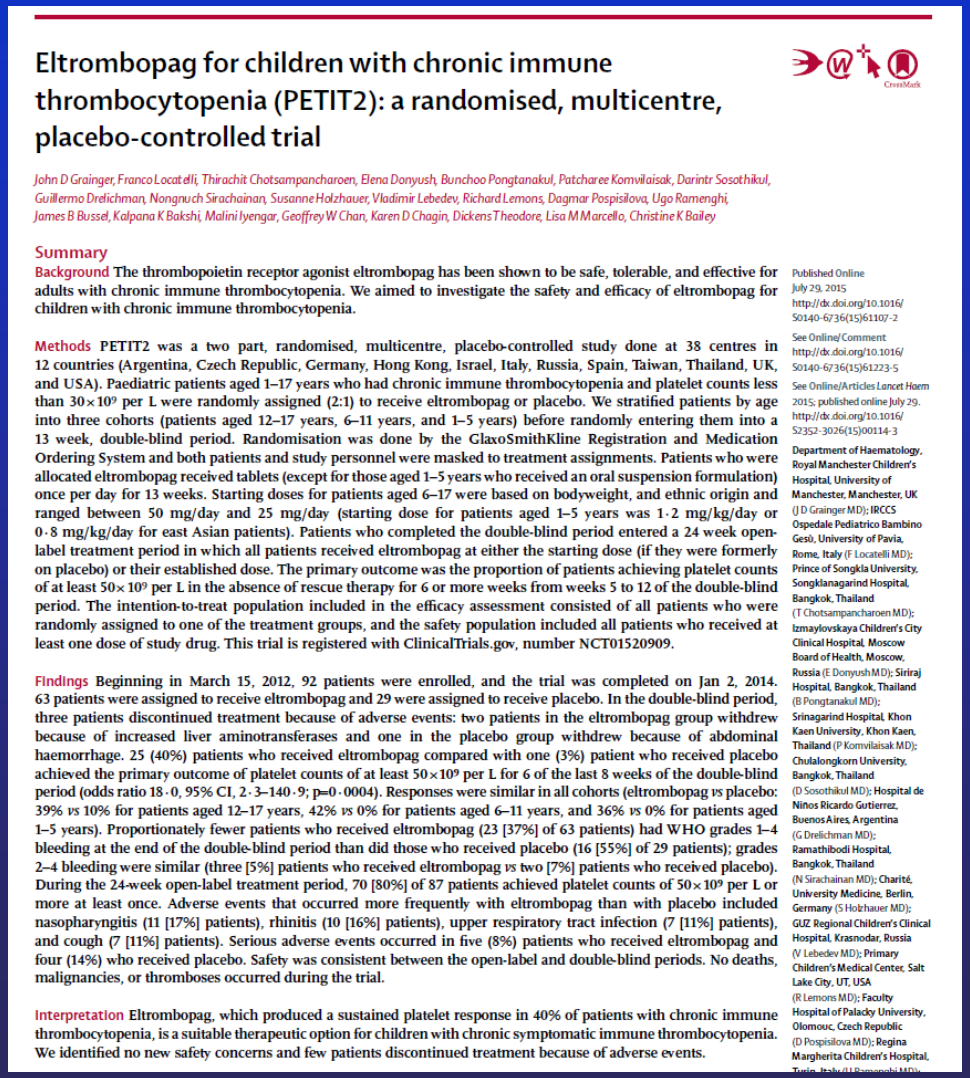
Journal Style Sheet



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Lancet, Respiratory Medicine

Journal Style Sheet

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~~Introduction~~

Findings:

~~Results:~~

Interpretation:

~~Conclusions:~~

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Findings Beginning in March 15, 2012, 92 patients were enrolled, and the trial was completed on Jan 2, 2014. 63 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. 25 (40%) patients who received eltrombopag compared with one (3%) patient who received placebo 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 (odds ratio 18·0, 95% CI, 2·3–140·9; p=0·0004). Responses were similar in all cohorts (eltrombopag *vs* placebo: 39% *vs* 10% for patients aged 12–17 years, 42% *vs* 0% for patients aged 6–11 years, and 36% *vs* 0% for patients aged 1–5 years). Proportionately fewer patients who received eltrombopag (23 [37%] of 63 patients) had WHO grades 1–4 bleeding at the end of the double-blind period than did those who received placebo (16 [55%] of 29 patients); grades 2–4 bleeding were similar (three [5%] patients who received eltrombopag *vs* two [7%] patients who received placebo). During the 24-week open-label treatment period, 70 [80%] of 87 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 [17%] patients), rhinitis (10 [16%] patients), upper respiratory tract infection (7 [11%] patients), and cough (7 [11%] patients). Serious adverse events occurred in five (8%) patients who received eltrombopag and four (14%) who received placebo. Safety was consistent between the open-label and double-blind periods. No deaths, malignancies, or thromboses occurred during the trial.

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Lancet, Respiratory Medicine

Journal Style Sheet

Background:

~~Introduction~~

Findings:

~~Results:~~

Interpretation:

~~Conclusions:~~

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

John D Grainger, Franco Locatelli, Thirachit Chotsampancharoen, Elena Donyush, Bunchoo Pongtanakul, Patcharee Komvilaisak, Darintr Sosothikul, Guillermo Drelichman, Nongnuch Sirachainan, Susanne Holzhauer, Vladimir Lebedev, Richard Lemons, Dagmar Pospisilova, Ugo Ramenghi, James B Bussel, Kalpana K Bakshi, Malini Iyengar, Geoffrey W Chan, Karen D Chagin, Dickens Theodore, Lisa M Marcello, Christine K Bailey

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Lancet, Respiratory Medicine

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

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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.

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Lancet, Respiratory Medicine

Eltrombopag for children with chronic immune

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.)

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Lancet, Respiratory Medicine

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 Doig, Fiona Simpson, Philippa T Heighes, Rinaldo Bellomo, Douglas Chesher, Ian D Caterson, Michael C Reade, Peter W J Harrigan, 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 36·4–43·7) 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%] of 163 *vs* 149 [91%] of 164, p=0·002) and overall survival time was increased (48·9 [SD 1·46] 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 904

*see appendix for the full list of investigators

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Lancet, Respiratory Medicine

Journal Style Sheet

Background:

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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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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 36·4–43·7) 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%] of 163 *vs* 149 [91%] of 164, p=0·002) and overall survival time was increased (48·9 [SD 1·46] days *vs* 53·65 [0·97] days, log-rank p=0·002).

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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 36·4–43·7) 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%] of 163 *vs* 149 [91%] of 164, p=0·002) and overall survival time was increased (48·9 [SD 1·46] 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.

Lancet Respir Med 2015; 3: 943–52

Published Online November 17, 2015 http://dx.doi.org/10.1016/S2213-2600(15)00418-X

See Comment page 904

*see appendix for the full list of investigators

Northern Clinical School Intensive Care Research Unit (G S Doig PhD, F Simpson PhD, P T Heighes MNE), **and The Boden Institute of Obesity, Nutrition Exercise, and Eating Disorders** (Prof I D Caterson FRACP), **University of Sydney, Sydney, NSW, Australia; School of Public Health and Preventive Medicine, Monash University, Melbourne, VIC, Australia** (Prof R Bellomo MD); **New South Wales Health, Pathology, Sydney, NSW, Australia** (D Chesher PhD); **Burns, Trauma and Critical Care Research Centre, University of Queensland, Brisbane, QLD, Australia** (Prof M C Reade DPhil); **and John Hunter Hospital, New Lambton Heights, NSW,**

Lancet, Respiratory Medicine

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!

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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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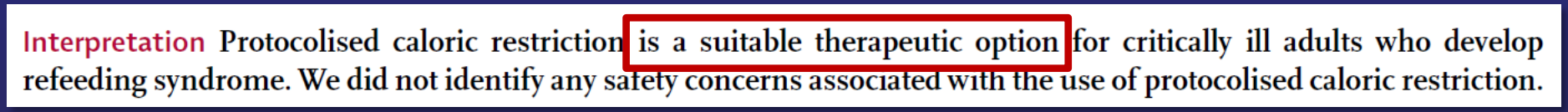
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Usually the Editor makes this decision before he/she sends your paper out for review.

The best way to address this issue is through good Journal selection before you submit your paper!

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- 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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