This is the way to write a paper

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There is no innocence

The study ONLY persued because og academic curiosity, ONLY analysed because of curiosity and ONLY sought published because of importance

DOES NOT EXIST

- career, education, grants,
- Publish or perish!


I gotta be me,
oh I just gotta be me...

Who is the audience?

One editor – 2 referees

- Editor has little or no insight in the particular subject.
- Referees have some insight, but often little
- Revieweing has become electronic and you have to click several places to see any other material than the manuscript.
- The manuscript MUST sell you paper, not accompanying material

Reviewing

People are busy and probably allocate 30 minutes to 1 hour for a review – not the whole day people dream of!

Reviewers carefully seek the fastest way to get the main message!

Risk of bleeding in patients with acute myocardial infarction treated with different combinations of aspirin, clopidogrel, and vitamin K antagonists in Denmark: a retrospective analysis of nationwide registry data

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Summary

Background Combinations of aspirin, clopidogrel, and vitamin K antagonists are widely used in patients after myocardial infarction. However, data for the safety of combinations are sparse. We examined the risk of hospital admission for bleeding associated with different antithrombotic regimens.

Methods By use of nationwide registers from Denmark, we identified 40 812 patients aged 30 years or older who had been admitted to hospital with first-time myocardial infarction between 2000 and 2005. Claimed prescriptions starting at hospital discharge were used to determine the regimen prescribed according to the following groups: monotherapy with aspirin, clopidogrel, or vitamin K antagonist; dual therapy with aspirin plus clopidogrel, aspirin plus vitamin K antagonist, or clopidogrel plus vitamin K antagonist; or triple therapy including all three drugs. Risk of hospital admission for bleeding, recurrent myocardial infarction, and death were assessed by Cox proportional hazards models with the drug exposure groups as time-varying covariates.

Findings During a mean follow-up of 476·5 days (SD 142·0), 1891 (4·6%) patients were admitted to hospital with bleeding. The yearly incidence of bleeding was 2·6% for the aspirin group, 4·6% for clopidogrel, 4·3% for vitamin K antagonist, 3·7% for aspirin plus clopidogrel, 5·1% for aspirin plus vitamin K antagonist, 12·3% for clopidogrel plus vitamin K antagonist, and 12·0% for triple therapy. With aspirin as reference, adjusted hazard ratios for bleeding were 1·33 (95% CI 1·11–1·59) for clopidogrel, 1·23 (0·94–1·61) for vitamin K antagonist, 1·47 (1·28–1·69) for aspirin plus clopidogrel, 1·84 (1·51–2·23) for aspirin plus vitamin K antagonist, 3·52 (2·42–5·11) for clopidogrel plus vitamin K antagonist, and 4·05 (3·08–5·33) for triple therapy. Numbers needed to harm were 81·2 for aspirin plus clopidogrel, 45·4 for aspirin plus vitamin K antagonist, 15·2 for clopidogrel plus vitamin K antagonist, and 12·5 for triple therapy. 702 (37·9%) of 1852 patients with non-fatal bleeding had recurrent myocardial infarction or died during the study period compared with 7178 (18·4%) of 38 960 patients without non-fatal bleeding (HR 3·00, 2·75–3·27, p<0·0001).

Interpretation In patients with myocardial infarction, risk of hospital admission for bleeding increased with the number of antithrombotic drugs used. Treatment with triple therapy or dual therapy with clopidogrel plus vitamin K antagonist should be prescribed only after thorough individual risk assessment.

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See Comment page 1947

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Another abstract

Purpose: Under-treatment of heart failure (HF) patients is a well-known problem, and focus has been on a systematic effort to ensure optimal treatment. However, there is lack of knowledge regarding the benefit of specialized HF clinic. We studied initiation, persistence and dose pattern to the recommended pharmacotherapy in 10.533 patients attending HF clinics in Denmark from 2002 to 2009.

Methods: Information was obtained from the electronic patient file- and research database Hjerterplus and combined with prescription data from the Danish Registry of Medical Product Statistics.

Results: Initial adherence to treatment with Renin-Angiotensin System inhibitors (RASi; i.e. angiotensin-converting enzyme inhibitors or angiotensin-2 receptor blockers), beta-blockers and Spironolactone was 94.98%, 87.86% and 36.58%. Short breaks in therapy were common, but most patients reinitiated treatment within one year. Five years after initiation of treatment 80.3% of the patients were still on RASi, 78.7% on beta-blockers and 52.8% on Spironolactone. High adherence persisted after the patients were discharged to long-term follow up by their primary care physician.

Patients were up-titrated in the recommended medication and came close to target dose.

Conclusions: Patients were initiated in evidence-based pharmacotherapy and uptitrated to recommended dosages. Adherence to treatment was high and did not diminish after discontinuation in HF clinic to long-term follow-up by primary care physician. The high degree of adherence to the treatment and the close to recommended drug-doses is likely to provide long-term benefits for the patients.

Abstract formula

- One (or 2) sentences which explain the fundamental importance of the subject
- A brief method section – never read!
- A juicy result section – an abstract must have an impressive number of results
- A direct conclusion – no implication – only based on the results you can read in the abstract.

Abstract after John Camm

- A title with at least one ’buzz word’
- A strong first sentence
- A strong conclusion
- All that rest in the middle just becomes a blurr

Introduction - US-Carvedilol 1994

ACTIVATION of the sympathetic nervous system is one of the cardinal pathophysiologic abnormalities in patients with chronic heart failure. Levels of circulating catecholamines increase in patients with heart failure in proportion to the severity of disease, and those with the highest plasma levels of norepinephrine have the most unfavorable prognosis.

Norepinephrine can exert adverse effects on the circulation, both directly and inactivation of the sympathetic nervous system is one of the cardinal pathophysiologic abnormalities in patients with chronic heart failure. Levels of circulating catecholamines increase in patients with heart failure in proportion to the severity of disease, and those with the highest plasma levels of norepinephrine have the most unfavorable prognosis.

These observations have led to the hypothesis that sympathetic activation plays an important part in the progression of heart failure. Norepinephrine can exert adverse effects on the circulation, both directly and indirectly, and interference with its actions can retard the progression of heart failure in animal models of the disease. These findings have led investigators to propose that sympathetic antagonists (e.g., beta-blockers) might be useful in the management of heart failure. Such drugs were previously considered to be contraindicated in this disorder because of their short-term adverse effects, but studies in Sweden in the 1970s raised the possibility that long-term therapy with these drugs might produce hemodynamic and clinical benefits.

Controlled trials of several different beta-blockers have shown that these drugs can reduce symptoms, improve left ventricular function, and increase functional capacity, but recent large-scale studies have not clarified the effects of beta-blockers on morbidity and mortality in patients with heart failure.

Hence, when a large clinical trial program with carvedilol in heart failure was being designed in 1992, we prospectively defined an overall objective of the program to be an evaluation of the effect of the drug on survival. Our principal goal was to assess the safety of carvedilol while recognizing its potential to prolong life, demonstrated by the results of experimental studies. Carvedilol is a nonselective b-receptor antagonist that also blocks *α*1-receptors and, unlike other beta-blockers, exerts antioxidant effects, which may contribute to its actions in heart failure.

This report summarizes the effects of carvedilol on survival and on hospitalization for cardiovascular causes.

Introduction

1. The first sentence must explain that the subject is important WITHOUT stating primitive facts known to everyone
2. The main body of the abstract needs to delineate the catastrophic lack of information of a particular part of the subject
3. Finally the reader is reassured that this paper fille the gap!

- Referees actually read the introduction!

Methods

- Hack from other papers!
- Remember to rewrite ALL sentences to avoid copyright issues
- Methods is a boring section that can ALWAYS be shortened
- Statistics – Write HOW data are analyzed not WHAT is analyzed – this is a result

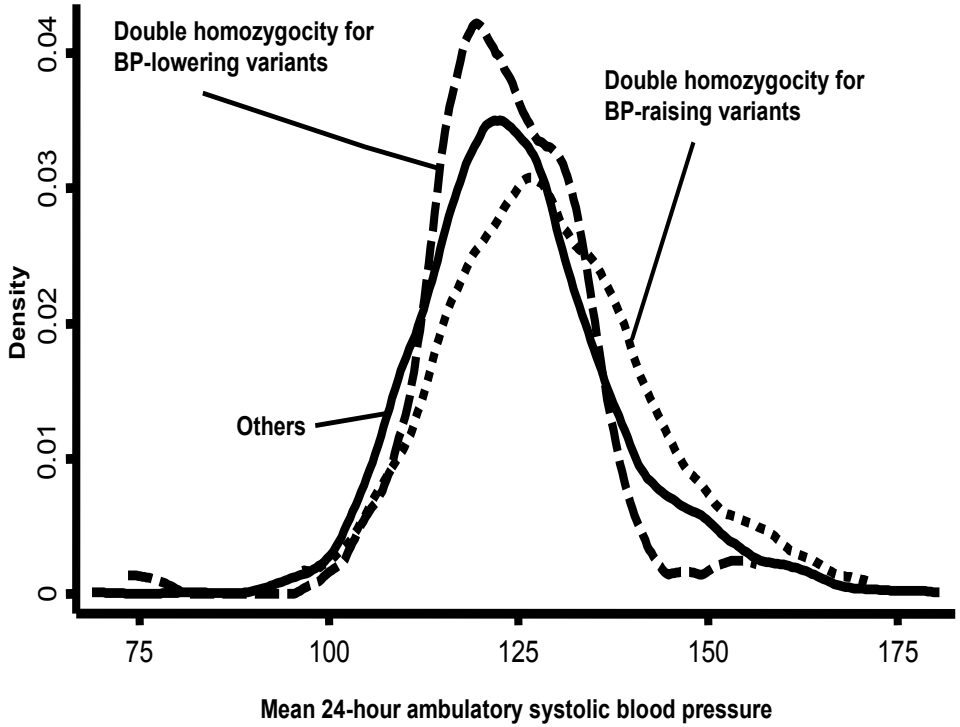
Formal rules

- A method section should be devoid of results
- It explains clearly how methods are employed to an extent where others should be able to duplicate

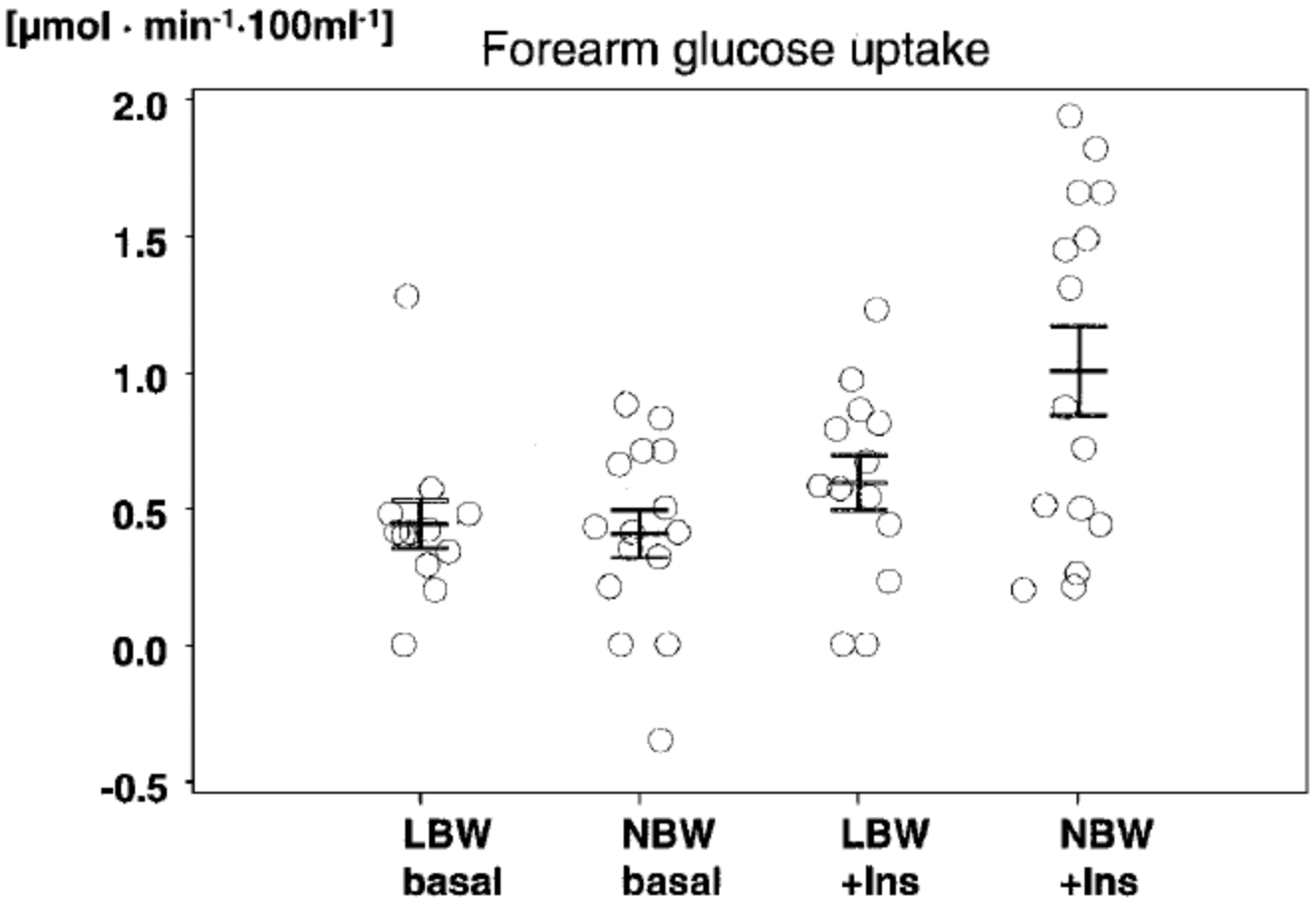
Results

- Present the population
- Do not repeat information
- Subdivide logically – prerefarably with subtitles
- Anticipate criticism
  ”Analyses of sensitivity”
  ”Other analyses”
- The key message MUST be graphically if in any way possible

Variables	*Homozygocity for both G:G and C:C variants (n=73)*	Other combinations of sequence variants (n=1249)	*Homozygocity for both A:A and T:T variants (n=88)*
Office systolic BP, mm Hg	128.7 (124.9-132.4)	129.3 (128.3-130.2)	132.5 (129.1-135.9)
Office diastolic BP, mm Hg	81.2 (78.9-83.5)	81.5 (80.9-82.0)	84.1 (82.0-86.2)*
Office heart rate, beats/min	66.1 (63.9-68.4)	65.1 (64.5-65.7)	67.4 (65.4-69.5)*
Mean 24-hr systolic BP, mm Hg	123.1 (120.2-125.9)	125.4 (124.7-126.1)	129.1 (126.5-131.6)†‡
Mean 24-hr diastolic BP, mm Hg	72.2 (70.3-74.1)	73.3 (72.8-73.8)	76.0 (74.3-77.7)†‡
Mean 24-hr heart rate, beats/min	69.1 (67.1-71.1)	70.6 (70.1-71.1)	72.3 (70.5-74.2)§
Mean daytime systolic BP, mm Hg	129.0 (126.1-131.9)	130.9 (130.2-131.6)	134.9 (132.2-137.5)†‡
Mean daytime diastolic BP, mm Hg	76.5	77.2	80.3


Double homozygocity for
BP-lowering variants
Double homozygocity for
BP-raising variants
Others
Density
0
0.01
0.02
0.03
0.04
75
100
125
150
175
Mean 24-hour ambulatory systolic blood pressure

Extra work on good graphics can be the difference between publication and rejection



Discussion

- Statement of principal findings
- Relation to other studies – The most common mistake is to briefly cite other studies for having contributed to the subject, rather than emphasize the weakness anda thereby your own strength.
- Methods issues
- Strengths and weaknesses
- Implication
- Conclusion

Statement of principal findings

- This is the first study to demonstrate….
  Not all journals like ”priority claims”
- The principal finding of this study

Relation to other studies

- Undgå brief sentences such as:
  Similar findings have also been found by ……
- Rather: A small study by ….
  Using a different technique ….
  An older study ….

Method issues

- Pleas write that your methods are optimal
- Never disappoint the reader. If there are weaknesses, mention these before strengths:

While the epidemiological approach has limitations, this study …….

Implication

- Critical importance – a study MUST have implications
- The choices are many – implacation for society, patients, methods, education, future studies.

Conclusion

- Principal findings - rewrapped

Go go go