All attendees will be muted and will remain in Listen Only Mode.

Type your questions here so that the moderator can see them. Not all questions will be answered but we will get to as many as possible.
How to Receive CME and MOC Points

LIVE VIRTUAL GRAND ROUNDS WEBINAR
ACG will send a link to a CME & MOC evaluation to all attendees on the live webinar.

ABIM Board Certified physicians need to complete their MOC activities by December 31, 2021 in order for the MOC points to count toward any MOC requirements that are due by the end of the year. No MOC credit may be awarded after March 1, 2022 for this activity.

MOC QUESTION
If you plan to claim MOC Points for this activity, you will be asked to: Please list specific changes you will make in your practice as a result of the information you received from this activity.

Include specific strategies or changes that you plan to implement. THESE ANSWERS WILL BE REVIEWED.
ACG Virtual Grand Rounds
Join us for upcoming Virtual Grand Rounds!

Week 16, 2021
Opioid Induced Esophageal Dysfunction: What to Know and How to Manage It
Marcelo F. Vela, MD, MSCR, FACG
April 22, 2021 at Noon Eastern

Week 17, 2021
Chromoendoscopy in IBD Surveillance: Always, Sometimes or Never?
Samir A. Shah, MD, FACG
April 29, 2021 at Noon Eastern

Visit gi.org/ACGVGR to Register

Disclosures:

Speaker: Thomas F. Imperiale, MD
Dr. Imperiale, speaker for this educational event, has no relevant financial relationships with ineligible companies to disclose.

Moderator: Rabia A. De Latour, MD
Dr. De Latour, moderator for this educational event, has no relevant financial relationships with ineligible companies to disclose.

Panelist: Isabel A. Hujoel, MD
Dr. Hujoel, panelist for this educational event, has no relevant financial relationships with ineligible companies to disclose.

Panelist: Brooks D. Cash, MD, FACG
Consultant and Speaker for AbbVie, Takeda, Salix, QOL.
Consultant to Medtronic.
Speaker for RedHill, AlfaSigma.

*All of the relevant financial relationships listed for these individuals have been mitigated.
How to write an abstract and a case report / series

Thomas F. Imperiale, MD
Indiana University School of Medicine
American College of Gastroenterology
April 21, 2021

Outline for this session

• How to prepare an abstract
  • For a manuscript
  • For a meeting

• How to write a case report / case series
What is an Abstract?

• A condensed, stand-alone version of a full scientific project or paper
• It conveys to one’s peers:
  • Why the study was done (background / introduction)
  • What was done; how it was done (methods)
  • What was found (results)
  • What the implications are (conclusion)
• The most important part of a manuscript / summary report
  • Nearly all who “read” the paper will read only abstract
• For a scientific meeting, it’s a work in progress

Writing an Abstract for a Manuscript

• De novo – not submitted or presented
  • Save it for last
  • Start with sentences from the manuscript
  • Modify these to fit requirements
• Abstract from a submission or presentation
  • Start with it as a rough guide
  • Modify it liberally based on
    • How the manuscript evolves
    • Requirements of the target journal
Writing an Abstract for a Meeting

• Consider the audience / the evaluators
• Start early
  • Read and follow the instructions
    • Format requirements, restrictions
  • Write certain sections well before crunch time
    • Background
    • Aim(s)
    • Methods
• Results flow from Methods; Conclusions from Results
• Emphasize clarity over word count (initially)
• Have a neutral colleague read it before submitting

Abstract Title

• 10-12 words
  • Scope, study design, +/- take home message
• Be specific: “A survey of...” rather than “A study of...”
• Avoid plays on words, cute / provocative expressions
Authors & Affiliations

• Restrict to those who actually did some work
  • Conception, design, data gathering/management, analysis/interpretation, and writing/editing
• 1st author – conceived / developed the study
  • Did most of the work
  • and will present it
• Have all authors’ information correct
  • Name, degrees, affiliations
  • Complete (at least) several days prior to deadline

Introduction / Background & Aim(s)

• Why was the study done?
  • What is the problem / gap in current knowledge?
  • 1-3 contextualizing sentences
• Study aim / objective or question
  • “The purpose/aim/objective of this study was...”
  • “...we answer the following question: ...”
  • Hypotheses are usually omitted
• Aim or question – should include 4 elements
  • Population
  • Intervention
  • Comparator
  • Outcome
Methods

• What was done? How was it done?
• Include the following
  • Study design
  • Sampling frame / study population (+/- inclusion / exclusion)
  • Intervention(s), exposures
  • Outcomes
  • Timeframe for conduct / sampling
  • Data sources & measures
  • Analysis
• 1st or 2nd longest section of the abstract

Results

• What was found?
• Should / must reflect aim(s) and methods
  • Focus on primary aim (even if “⊖”)
• Descriptive, analytic (bivariate), multivariate
• Use a table + / - figure only to convey results effectively
• Avoid extraneous results, “trend”, “nearly SS”
• 1st or 2nd longest section of abstract
Conclusion / Implications

• May contain up to 3 elements
  • The primary “take home” message
  • Additional findings of (potential) importance
  • The perspective – what does it mean?
• 1-3 sentences
• Must reflect aim(s) and results
• Avoid overstatement

What to Include & What Not to Include

• Include
  • Simple declarative sentences
  • Active voice
  • Generic names
  • Limit abbreviations
  • CIs instead of P-values

• Don’t Include
  • References
  • A promise of results
  • Too much detail on statistics and software
  • Unnecessary statistical results – $\chi^2$, d.f., etc.
Before submitting

• Re-read instructions
• Assess flow
• Eliminate spelling and grammatical errors
• Eliminate unnecessary results, words
• Have an outsider read it
METHODS
This analysis includes 137,851 participants between the ages of 35 and 70 years living on five continents, with a median follow-up of 9.5 years. We used country-specific food-frequency questionnaires to determine dietary intake and estimated the glycemic index and glycemic load on the basis of the consumption of seven categories of carbohydrate foods. We calculated hazard ratios using multivariable Cox frailty models. The primary outcome was a composite of a major cardiovascular event (cardiovascular death, nonfatal myocardial infarction, stroke, and heart failure) or death from any cause.

RESULTS
In the study population, 8780 deaths and 8252 major cardiovascular events occurred during the follow-up period. After performing extensive adjustments comparing the lowest and highest glycemic-index quintiles, we found that a diet with a high glycemic index was associated with an increased risk of a major cardiovascular event or death, both among participants with preexisting cardiovascular disease (hazard ratio, 1.51; 95% confidence interval [CI], 1.25 to 1.82) and among those without such disease (hazard ratio, 1.21; 95% CI, 1.11 to 1.34). Among the components of the primary outcome, a high glycemic index was also associated with an increased risk of death from cardiovascular causes. The results with respect to glycemic load were similar to the findings regarding the glycemic index among the participants with cardiovascular disease at baseline, but the association was not significant among those without preexisting cardiovascular disease.
CONCLUSIONS
In this study, a diet with a high glycemic index was associated with an increased risk of cardiovascular disease and death. (Funded by the Population Health Research Institute and others.)

Conversion of Propranolol to Carvedilol Improves Renal Perfusion and Outcome in Patients With Cirrhosis and Ascites

• Background: In recent years, concerns have been raised on the potential adverse effects of nonselective beta-blockers, and particularly carvedilol, on renal perfusion and survival in decompensated cirrhosis with ascites. We investigated the long-term impact of converting propranolol to carvedilol on systemic hemodynamics and renal function, and on the outcome of patients with stable cirrhosis and grade II/III nonrefractory ascites.

Patients and Methods

Ninety-six patients treated with propranolol for esophageal varices’ bleeding prophylaxis were prospectively evaluated. These patients were randomized in a 2:1 ratio to switch to carvedilol at 12.5 mg/d (CARVE group; n=64) or continue propranolol (PROPRA group; n=32). Systemic vascular resistance, vasoactive factors, glomerular filtration rate, and renal blood flow were evaluated at baseline before switching to carvedilol and after 6 and 12 months. Further decompensation and survival were evaluated at 2 years.

Results

During a 12-month follow-up, carvedilol induced an ongoing improvement of systemic vascular resistance (1372 ± 34 vs. 1254 ± 33 dynes/c/cm5; P=0.02) along with significant decreases in plasma renin activity (4.05 ± 0.66 vs. 6.57 ± 0.98 ng/mL/h; P=0.01) and serum noradrenaline (76.7 ± 8.2 vs. 101.9 ± 10.5 pg/mL; P=0.03) and significant improvement of glomerular filtration rate (87.3 ± 2.7 vs. 78.7 ± 2.3 mL/min; P=0.03) and renal blood flow (703 ± 17 vs. 631 ± 12 mL/min; P=0.03); no significant effects were noted in the PROPRA group. The 2-year occurrence of further decompensation was significantly lower in the CARVE group than in the PROPRA group (10.5% vs. 35.9%; P=0.003); survival at 2 years was significantly higher in the CARVE group (86% vs. 64.1%; P=0.01, respectively).
Conclusion

Carvedilol at the dose of 12.5 mg/d should be the nonselective beta-blocker treatment of choice in patients with cirrhosis and nonrefractory ascites, as it improves renal perfusion and outcome.

BACKGROUND
Infection and increased systemic inflammation cause organ dysfunction and death in patients with decompensated cirrhosis. Preclinical studies provide support for an antiinflammatory role of albumin, but confirmatory large-scale clinical trials are lacking. Whether targeting a serum albumin level of 30 g per liter or greater in these patients with repeated daily infusions of 20% human albumin solution, as compared with standard care, would reduce the incidences of infection, kidney dysfunction, and death is unknown.

METHODS
We conducted a randomized, multicenter, open-label, parallel-group trial involving hospitalized patients with decompensated cirrhosis who had a serum albumin level of less than 30 g per liter at enrollment. Patients were randomly assigned to receive either targeted 20% human albumin solution for up to 14 days or until discharge, whichever came first, or standard care. Treatment commenced within 3 days after admission. The composite primary end point was new infection, kidney dysfunction, or death between days 3 and 15 after the initiation of treatment.

RESULTS
A total of 777 patients underwent randomization, and alcohol was reported to be a cause of cirrhosis in most of these patients. A median total infusion of albumin of 200 g (interquartile range, 140 to 280) per patient was administered to the targeted albumin group (increasing the albumin level to ≥30 g per liter), as compared with a median of 20 g (interquartile range, 0 to 120) per patient administered to the standard-care group (adjusted mean difference, 143 g; 95% confidence interval [CI], 127 to 158.2). The percentage of patients with a primary end-point event did not differ significantly between the targeted albumin group (113 of 380 patients [29.7%]) and the standard-care group (120 of 397 patients [30.2%]) (adjusted odds ratio, 0.98; 95% CI, 0.71 to 1.33; P=0.87). A time-to-event analysis in which data were censored at the time of discharge or at day 15 also showed no significant between-group difference (hazard ratio, 1.04; 95% CI, 0.81 to 1.35). More severe or life-threatening serious adverse events occurred in the albumin group than in the standard-care group.
CONCLUSIONS
In patients hospitalized with decompensated cirrhosis, albumin infusions to increase the albumin level to a target of 30 g per liter or more was not more beneficial than the current standard care in the United Kingdom. (Funded by the Health Innovation Challenge Fund; ATTIRE EudraCT number, 2014-002300-24; ISRCT number, N14174793.)

Take Home Points – Writing an Abstract

• Know (and follow) the rules
• Start early – do background, aim(s), methods
• Results flow from Methods; Conclusions from Results
• Have uninvolved colleague(s) read it
Part II – How to Write a Case Report / Series

Why Write a Case Report / Case Series?

• Awareness-raising
  • A specific learning point in diagnosis, management
• Cognitive purpose – a here-to-fore unrecognized / undescribed entity (ex. “Heyde’s syndrome”)
• Exceptions to the expected
• Hypothesis-generation – a “new” adverse drug effect
• “Doctors’ stories”

What Cases to Report?

• Fascinomas – less useful
• Unusual features of common disease
  • “broadening the phenotype”
• Differential diagnosis and rationale to the diagnosis
  • Example - Case records of the MGH
• Initial diagnostic errors, cognitive errors
• Therapeutic dilemmas – deficiencies in evidence
• Prolonged follow-up of case (series) – natural history
Before doing, consider the following:

• Identify the **message** you want to convey
  • What’s the lesson?

• Identify the target journal
  • Content and guidelines (word count, figures, refs, etc.)
  • Patient consent form / IRB approval

Steps to Writing a Case Report / Series

1. Identify a case (series)
2. Search the literature – has one been published?
   – Does your case have a unique aspect to it?
3. Collect information related to the case
   – IRB approval + / - informed consent
   – Clinical, endoscopic, radiographic, etc.
4. Organize, summarize & write
5. Edit / Revise
Sections of a Case Report / Series

• Introduction
• Case Report
  • History / physical examination
  • Clinical features
  • Investigations
  • Treatment & Outcome
• Discussion
  • Review of literature
  • The message / lesson
  • Recommendations

Structure / Parts of a Case Report I

• Title
  • Short, catchy, intriguing
  • Includes the message
  • Avoid “A case of ... disease”

• Abstract
  • Not always required
  • Brief, make reader want to read more
  • Include what the case is, what the point is
Structure / Parts of a Case Report II

• Introduction
  • Background
  • What is already known (contextualize)
  • Identify the nuance / issue / limitation
  • Keep brief

• Clinical narrative – the report itself
  • H&P, investigative findings
  • Present chronologically from symptom onset
  • Avoid dates & extraneous material
  • Highest quality photos – radiology, endoscopy, etc.

Structure / Parts of a Case Report III

• Discussion
  • Summarize briefly
  • Contextualize ... in light of other, similar cases
    • How different?
    • How similar?
  • Clearly state the “take home” message
    • Recommendations for practice
      • Work-up, management, thought process, other
Pragmatic Considerations

- You’ll need passion / motivation because...
- It will take longer than you think
  - From idea to publication - ≤ 1 year or more
  - There will be >1 draft, >1 submission
  - Limit # of co-authors and ensure that all contribute

International Committee of Medical Journal (2013)

- Substantial contribution to the conception or design, or acquisition, analysis or interpretation of data
- Drafting or revising the work for important intellectual content
- Final approval of the version to be published
- Agreement to be accountable for all aspects of the work
Take Home Points: Writing a Case Report

• Have a good reason for doing it – know what’s been done and what it could add
• Know the message, convey it clearly
  • Have a neutral colleague read it
• Identify the target journal, follow its rubric
• Be patient and persistent

Thanks for your attention!
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