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Abstract: less than 250 words; Text: up to 3000 words

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**New Drug Approvals:** Brief reviews of single drug entities that have recently received FDA approval.

Abstract: less than 250 words; Text: up to 2500 words.

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Abstract: less than 250 words; Text: 4000 words.

In addition to general reviews of pharmacotherapy used in specific conditions, the following categories may be considered for focused reviews:

**New Drug Approvals:** Brief reviews of single drug entities that have recently received FDA approval.

Abstract: less than 250 words; Text: up to 2500 words.
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1. Article title (concise, but indicating main focus of paper);
2. Name of each author in line-by-line fashion. Please ensure that the appearance and spelling of author names and surnames is correct and in accordance with previous publications;
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7. Statement pertaining to funding and conflict of interest (see “Conflict of Interest Statement”);
8. Information about presentation of the work as an abstract or poster, if applicable;
9. Separate word counts of abstract, main text, and references; and
10. Key words for purposes of indexing and searching.

STRUCTURED ABSTRACT

Abstracts should be no more than 250 words. All manuscripts submitted to Annals, with the exception of Editorials, Commentaries, and Letters, require an abstract that is structured with the appropriate headings as shown below. (Editorials and Commentaries require an unstructured abstract up to 100 words in length.)

RESEARCH REPORTS

Background

Brief (2–3 sentences) description of why the study is needed and its importance to the field.

Objective

1. Concise (1–2 sentences) statement of the objective or hypothesis to be addressed.
2. Primary objective identified and stated first, followed by any key secondary objectives.

Methods

1. **Design:** Clear statement of the study’s design, including all aspects (eg. parallel group, randomized, blinded). Indicate if Institutional Review Board or other ethical considerations were needed and/or approved.

2. **Participants and setting:** The most pertinent inclusion and exclusion criteria, and the setting within which the study was conducted.

3. **Interventions:** Complete details on treatment (eg. drug dose, route of administration, and duration of administration) and, if pertinent, control interventions.

4. **Outcome:** Primary and secondary outcome measures, identified as such.

Results

1. **Number of participants:** Total number, with breakdown into defined groups (eg. treatment, control) shown, followed by number of participants analyzed, again with breakdown into defined groups shown.

2. **Outcome:** Numbers of participants and events shown, with summary of the outcome in each group reported as effect size (eg. relative risk, odds ratio) and precision (confidence interval). Data on all outcome measures and any negative and/or non-significant findings must be included.

3. **Adverse events/safety:** Any unintended effects shown; if none, that should be stated.

4. **Limitations:** Factors affecting accuracy or generalizability of results (eg. small sample size, open-label design).

Conclusion and Relevance

1. Conclusions (not summary) of the study, based only on the results shown, with balance of benefits and harms.

2. What is new about the report and how do these results affect both our knowledge of the medical condition under discussion and future clinical treatment of the disorder? What is the clinical application of the findings, based only on the data obtained (ie. avoid over-generalization)?

Research Report Abstract example:

**Background:** There is inadequate guidance for clinicians on selection of the optimal dextrose 50% (D_{50}W) dose for hypoglycemia correction in critically ill patients. **Objective:** The purpose of this study was to determine the blood glucose (BG) response to D_{50}W in critically ill patients.

**Methods:** A retrospective analysis was conducted of critically ill patients who received D_{50}W for hypoglycemia (BG < 70 mg/dL) while on an insulin infusion. The primary objective of this study was to determine the BG response to D_{50}W. The relationship between participant characteristics and the dose-adjusted change in BG following D_{50}W was analyzed using simple and multiple linear mixed-effects models. **Results:** There were 470 hypoglycemic events (BG < 70 mg/dL) corrected with D_{50}W. The overall median BG response was 4.0 (2.53, 6.08) mg/dL per gram of D_{50}W administered. Administration of D_{50}W per protocol resulted in 32 episodes of hyperglycemia (BG > 150 mg/dL), resulting in a 6.8% rate of overcorrection; 49% of hypoglycemic episodes (230/470) corrected to a BG >100 mg/dL. A multivariable GEE analysis showed a significantly higher BG response in participants with diabetes (0.002) but a lower response in those with recurrent hypoglycemia (P=0.049). The response to D_{50}W increased with increasing insulin infusion rate (P = 0.022). Burn patients experienced a significantly larger BG response compared with cardiac, medical, neurosurgical, or surgical patients. **Conclusion and Relevance:** This represents the first report of the BG response to D_{50}W in critically ill patients and the observed median effect of D_{50}W on BG was approximately 4 mg/dL per gram of D_{50}W administered. Application of these data may aid in rescue protocol development that may reduce glucose variability associated with hypoglycemic episodes and the correction.

**REVIEW ARTICLES**

**Objective**

Explain the rationale and goals for the review.

**Data Sources**

Provide specific search details in the abstract and specify the resources employed in the search and include date ranges, search terms, and limits.

**Study Selection and Data Extraction**

Quantify the original reports included and how they were chosen, as well as the methods used for abstracting the data.

**Data Synthesis**

Summarize main results and provide interpretation of the data from various studies.

**Relevance to Patient Care and Clinical Practice**

What is new about the review article and how do the evaluated findings affect both our knowledge of the medical condition under discussion and future clinical treatment of the disorder?

**Conclusions**

Summarize the key “take-home” points from the review. NOTE: Reviews that can only conclude with the suggestion that “additional studies are needed” will be of a lower priority.
than reviews that can provide direct clinical recommendations or assessments as based on the literature being reviewed.

**Review Article Abstract example:**

**Objective:** To describe properties of cobicistat and ritonavir; compare boosting data with atazanavir, darunavir, and elvitegravir; and summarize antiretroviral and comedication interaction studies, with a focus on similarities and differences between ritonavir and cobicistat. Considerations when switching from one booster to another are discussed. **Data Sources:** A literature search of MEDLINE was performed (1985 to April 2017) using the following search terms: cobicistat, ritonavir, pharmacokinetic, drug interactions, booster, pharmacokinetic enhancer, HIV, antiretrovirals. Abstracts from conferences, article bibliographies, and product monographs were reviewed. **Study Selection and Data Extraction:** Relevant English-language studies or those conducted in humans were considered. **Data Synthesis:** Similar exposures of elvitegravir, darunavir, and atazanavir are achieved when combined with cobicistat or ritonavir. Cobicistat may not be as potent a CYP3A4 inhibitor as ritonavir in the presence of a concomitant inducer. Ritonavir induces CYP1A2, 2B6, 2C9, 2C19, and uridine 5′-diphospho-glucuronosyltransferase, whereas cobicistat does not. Therefore, recommendations for cobicistat with comedications that are extrapolated from studies using ritonavir may not be valid. Pharmacokinetic properties of the boosted antiretroviral can also affect interaction outcomes with comedications. Problems can arise when switching patients from ritonavir to cobicistat regimens, particularly with medications that have a narrow therapeutic index such as warfarin. **Relevance to Patient Care and Clinical Practice:** This review compares and contrast the pharmacological, pharmacokinetics, and drug interaction studies for ritonavir and cobicistat and a discussion on considerations when switching from one booster to another is included to guide clinicians. **Conclusions:** When assessing and managing potential interactions with ritonavir or cobicistat-based regimens, clinicians need to be aware of important differences and distinctions between these agents. This is especially important for patients with multiple comorbidities and concomitant medications. Additional monitoring or medication dose adjustments may be needed when switching from one booster to another.

**Text:** Appropriate headings and subheadings should be used liberally throughout the text. For research reports the final subsection of the text should be titled “Conclusion and Relevance” (instead of just “Conclusion”) and contain information in more detail as outlined on page 5 of these author guidelines for the abstract section of this heading.

For review articles, a new subsection in the text just prior to the “Summary” section should be added and titled “Relevance to Patient Care and Clinical Practice” and similarly contain information in more detail as outlined on page 5 of these author guidelines for the abstract section of this heading.

Abbreviations must be defined upon first use in the text. Use of abbreviations should be limited to, for example, lengthy terms; the majority of drug names should not be abbreviated.

**REFERENCES:** All references, including those related primarily to figures and tables, must appear in the text and be cited consecutively. References in text, tables, and figure legends should be denoted with superscript Arabic numerals. Personal communications (ie. unpublished data) may not be used as numbered references. Information obtained through personal communication must be inserted in parentheses within the text and include the contact person’s name, academic degree, affiliation, and date of communication. Signed permission letters from quoted sources indicating the content of the personal communication must be provided to the Editorial Office (aop@sagepub.com). Abstracts and Letters to the Editor may be used as numbered references but must be identified as such in the citations. Inclusive pagination must be provided for all references. Journal names should be abbreviated as they appear in PubMed. Those not appearing in PubMed should be spelled out. Referenced articles that are cited as “in press” must include the title of the journal that has accepted the paper. List all authors when there are 6 or fewer; with 7 or more authors, list the first 3, followed by “et al.” To facilitate online retrieval of references, include a citation’s digital object identifier (DOI) if available. More information about DOIs can be obtained at www.crossref.org or dx.doi.org. When citing articles that have been published online prior to print, authors are encouraged to include the date published online (Epub date) in addition to the full print information. When the article has appeared in print, the URL will not be used; however, a DOI should be included if available. Some examples of correct referencing style are given below.

**Article**


**Article with URL**

Abstract

Journal Supplement

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TABLES: Each table must be double-spaced on a separate page. Please do not submit tables in image format. Tables must be editable and submitted in either Microsoft Word or Excel. Do not send pdfs or images of tables. A brief title must be provided for each table. Each column requires a brief descriptive heading. Explanations and full terms for abbreviations used should appear alphabetically below the body of the table. Statistical measures of variation (i.e. standard deviation) should be identified in footnotes (designated as a, b, c, etc.). The units of measure used for all data in a column should be indicated in parentheses in the column heading. Internal horizontal or vertical rules should not be used. Duplication of table content within text should be minimized.

FIGURES: Figures and artwork should be submitted in their original file formats and with minimum resolution of 300 DPI (600 DPI for line art). Letters, numbers, and symbols should be clear, uniform in size, and large and dark enough to be legible when the size of the figure is reduced to fit column width in the journal. Titles and detailed explanations should appear in the legends rather than in the figures. Bar graphs or pie charts should be in black and white only and not contain gray shading as filler or background; distinctive fillings should be used instead (e.g. white or solid black; horizontal, vertical, or slanted stripes; cross-hatching; dots). Dotted lines and decimal points should be dark enough to reproduce well. Background horizontal or vertical lines should not be used. Figures should have labels on their margins indicating file number, figure number, and corresponding author’s name at top of figure. The top of a figure should also be designated if the figure lacks distinguishing features. Legends should be double-spaced, and each abbreviation and symbol used must be defined. Duplication of figure content within the text should be minimized.