Cochrane UK

Guide to writing abstracts for systematic reviews

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Introduction

Cochrane Abstracts are the only part of a Cochrane Review that many people read. They should be clearly written, contain all the most important and relevant material and be easy to translate into other languages. They should be similar across the Library and contain the same type of information, in the same location, so that readers will find the information they expect to find, and will know where to find it.

These notes are mainly relevant to reviews where the effects of a health intervention are compared to control/usual practice or where one intervention is compared to another.

General principles

We believe there are some fundamental questions that need to be asked – and answered - when considering Cochrane Abstracts.

1. Who are Cochrane Abstracts written for and – in the light of that – what type and level of language should be used?
We understand that the main body of a Cochrane Review should be written with the 'general medical reader' in mind. In contrast, the Plain Language Summary is specifically written in language that is suitable for a non-medical, lay reader. Even though the *language* of the abstract is designed to be read by the general medical reader, the *content* must reflect what is most important for patients.

Cochrane Abstracts should use the type and level of language that a general medical reader (physician, allied health professional, clinical researcher) is comfortable with.

2. Why should as much of the abstract as possible use 'standard' language and phrases?

The meaning of every word in a Cochrane Abstract should be clear and unambiguous. This meaning should be the same when a reader finds it in several different abstracts. This is particularly important for words used to 'quantify' things such as the certainty or strength of evidence. Our colleagues at GRADE have made recommendations about the use of language and we firmly believe Cochrane should support this approach. In other words, 'GRADE language' should be used in Cochrane Abstracts. The suggested phrases can be found on **page 54 of Cochrane's Dissemination Checklist**. These are used throughout this guide.

In each section of the abstract, standard words and phrases should be used as much as possible. This will ensure that is easier to translate abstracts accurately. A specific phrase or word can be translated in a way that has been agreed by native language speakers. This agreement will ensure that the sense and sentiment of a phrase is properly captured in the translation.

Cochrane Abstracts should use standard words and phrases, and the approved GRADE language when describing results.

3. What can safely be left out of the abstract?

All the detail that any reader could ever need is included in the *full* Cochrane Review. Cochrane is famous for the comprehensiveness of its methods and the way that those methods are reported.

However, space in the abstract is limited and precious. As much space as possible should be used to report those things that are most important to patients, and which should therefore be most important to readers. As people have become increasingly familiar with Cochrane methods, it has become less necessary to spell these out in the abstract. Of course, they are spelt out in detail – as they should be – in the main text. So, for example, for some time it has been acceptable to say, 'We used standard Cochrane methods'. We are now suggesting that this approach can be extended to other parts of the abstract.

Beware of giving too much methodological detail in the abstract. This can be achieved by using standard phrases.

Title

Approved text
[Intervention] for [condition/health problem] in [participants]
[Intervention A] versus [Intervention B] for [condition/health problem]
[Intervention] for [preventing, OR treating, OR preventing and treating] [condition/health problem]

Guidance for Abstract Writers

- The **Title** should be clear and as succinct as possible, but not so short that the contents of the review are uncertain.
- The **Title** should be accurate. For example, in a title such as:

  [Intervention] for [condition/health problem] in [participants]: <u>a network meta-analysis,</u> if you have not been able to do a network meta-analysis, do not include this in the title simply because it was in the protocol and it is your hope to do one at some point in the future.

  [Intervention] for [condition/health problem] in [adults and children], if you have not been able to include any trials with adult participants, consider not including this in the title simply because it was in the protocol and it is your hope to do so at some point in the future.

  We do not believe that the title of the full Review should necessarily be identical to the title of the Protocol.

Examples and notes

Text	Commentary
Original text Pharmacological and non-pharmacological strategies for obese women with subfertility **New, preferred text** Pharmacological and non-pharmacological *interventions* for *weight loss* in obese women with subfertility	Unclear from the original title what the strategies are intended to address.

Original text Pentoxifylline for intermittent claudication **New, preferred text** Pentoxifylline for *stable* intermittent claudication	Not clear from the title that participants were from a very specific group with relatively mild, stable symptoms.

Original text Adult patient access to electronic health records **New, preferred text** Patient access to electronic health records to improve management of their long-term health conditions	Unclear why access was being suggested. Stating 'adult' is unnecessary in the title.

Original text Walking for hypertension **New, preferred text** Regular walking for prevention and treatment of hypertension	Unclear what sort of walking, and that this was to both prevent and treat hypertension.

Background

Approved text
[Condition under investigation] is important because …….. [intervention] is …….. and works by [how intervention might work]. [Why important to do this review]. [Key uncertainties]. [Relation to previous review].

Guidance for Abstract Writers

The **Background** should answer the following questions, and only these:
- What is the **condition** and how common is it?
- How does the **condition** affect patients (and healthcare systems)?
- What is the **intervention**?
- How does the **intervention** work?
- What is the **population**?
- What are the *general* **outcome**(s)?
- Why do the review?

Compared to some of the Sections that follow (where we are very prescriptive about the text to be used), we expect the 'Approved text' (above) to be used less rigidly. What is *more* important is that all the **elements** are included, in – if possible – the same order.

- The background may need to repeat information that is in the title.
- The abstract should spell out the '**relationship to earlier reviews**' if appropriate.
- General comments about the existence of uncertainty are unhelpful and waste space.
- This section should be short. Not more than 80 to 100 words.

Examples and notes

Text	Commentary
Teeth brushing to prevent tooth loss in older people **Original text** [Not an original Cochrane Review] **Example of preferred text** Tooth loss is more common with increasing age and leads to poor nutrition in older people[1]. Regular brushing of the teeth[2] may remove dental plaque and thus reduce the risk of losing teeth because of decay. Older people with better dentition may maintain better nutritional status and so lead longer, healthier lives[3]. However, there is uncertainty about the number of teeth that people can avoid losing and the frequency and duration of brushing necessary to achieve the benefit[4,5]. This is an update of the 2016 review with 15 studies added[6].	1. Condition under investigation 2. Intervention 3. How intervention might work 4. Why important to do this review 5. Key uncertainties 6. Relationship to previous review

Text	Commentary
Wound cleansing to improve healing of venous leg ulcers **Original text** Leg ulcers are open skin wounds that occur below the knee but above the foot. The majority of leg ulcers are venous in origin, occurring as a result of venous insufficiency, where the flow of blood through the veins is impaired commonly arising due to blood clots and varicose veins. Compression therapy, using bandages, or stockings, is the primary treatment for venous leg ulcers. Wound cleansing is recommended to remove surface contaminants, bacteria, dead tissue and excess wound fluid from the wound bed and surrounding skin, however, there is uncertainty regarding the best method, or solution to use. **New, preferred text** Venous leg ulcers[1] are common in people with venous insufficiency. Poor and delayed ulcer healing[1] has a significant impact on patients and health systems[4]. Wound cleansing[2] removes surface contaminants, bacteria, dead tissue and excess wound fluid from the wound bed and surrounding skin and promotes healing[3]. There is uncertainty regarding the best cleansing solution and how best to use it[4, 5]. **Alternative new, preferred text** Poor and delayed healing of venous leg ulcers[1] has a significant impact on patients and health systems[4]. Wound cleansing[2] removes surface contaminants, bacteria, dead tissue and excess wound fluid from the wound bed and surrounding skin, and promotes healing[3]. There is uncertainty regarding the best cleansing solution and how best to use it[4, 5]	1. Condition under investigation 2. Intervention 3. How intervention might work 4. Why important to do this review 5. Key uncertainties 6. Relationship to previous review

Text	Commentary
Community pharmacy interventions for health promotion: effects on professional practice and health outcomes **Original text** Community pharmacies are an easily accessible and cost-effective platform for delivering health care worldwide, and the range of services provided has undergone rapid expansion in recent years. Thus, in addition to dispensing medication, pharmacy workers within community pharmacies now give advice on a range of health-promoting behaviours that aim to improve health and to optimise the management of long-term conditions. However, it remains uncertain whether these health-promotion interventions can change the professional practice of pharmacy workers, improve health behaviours and outcomes for pharmacy users and have the potential to address health inequalities. **New, preferred text** Health promotion advice may change patients' lifestyle behaviours leading to reduced risk of illness. Community pharmacies are an easily accessible and cost-effective platform for delivering health care worldwide.[1] Interventions to change the behaviour of community pharmacy teams[2] may improve the ability of pharmacy workers to give such advice which may then lead to improved health-related behaviours in people using the pharmacy.[3] However, it remains uncertain whether these interventions can in fact change the professional practice of pharmacy workers, and even if they do, whether they improve health behaviours and outcomes for pharmacy users, and have the potential to address health inequalities.[4, 5]	This is a complex review, addressing complex inter-related issues. Condition under investigation not clear. Intervention not clear. 1. Condition under investigation 2. Intervention 3. How intervention might work 4. Why important to do this review 5. Key uncertainties 6. Relationship to previous review

Text	Commentary
Computerized advice on drug dosage to improve prescribing practice **Original text** Maintaining therapeutic concentrations of drugs with a narrow therapeutic window is a complex task. Several computer systems have been designed to help doctors determine optimum drug dosage. Significant improvements in health care could be achieved if computer advice improved health outcomes and could be implemented in routine practice in a cost-effective fashion. This is an updated version of an earlier Cochrane systematic review, first published in 2001 and updated in 2008 **New, preferred text** Maintaining therapeutic concentrations of drugs[1] is a complex task often undertaken by clinicians using text references and algorithms. Computerized advice on drug dosage[2] integrates the necessary knowledge within the computer system used by the clinician and may help prescribers to maintain drug levels more accurately within a narrow therapeutic window, thus maintaining treatment benefits whilst reducing the risk of harm[3, 4]. However, it is uncertain whether computer advice can optimise drug levels, physiological parameters, clinical outcomes and healthcare usage[5]. This is an update of an earlier Cochrane Review[6].	Includes high level description of the outcomes in the review. 1. Condition under investigation 2. Intervention 3. How intervention might work 4. Why important to do this review 5. Key uncertainties 6. Relationship to previous review (No need to say 'systematic'.) Can use the word ‘update’ rather than 'updated version'.

Text	Commentary
Personalised care planning for adults with chronic or long-term health conditions **Original text** Personalised care planning is a collaborative process used in chronic condition management in which patients and clinicians identify and discuss problems caused by or related to the patient's condition, and develop a plan for tackling these. In essence it is a conversation, or series of conversations, in which they jointly agree goals and actions for managing the patient's condition. **New, preferred text** Long-term health conditions such as heart failure or kidney disease[1] are increasingly common as people live longer and can severely affect quality of life. Personalised care planning is a process for management of long-term conditions where patients and clinicians discuss problems related to the patient's condition, and develop a collaborative plan for tackling them.[2] Personalised care planning may help with optimising medicine use, monitoring symptoms, improving lifestyle behaviours, managing emotions, solving practical problems, knowing when and how to seek advice, and coping with the impact of the condition(s) on daily life.[3, 4] However, it is uncertain whether personalised care planning leads to increased confidence in managing conditions and to measurable improvements in physical and mental health.[4, 5]	No description of the condition under investigation. No mention of how the intervention might work. 1. Condition under investigation 2. Intervention 3. How intervention might work 4. Why important to do this review 5. Key uncertainties 6. Relationship to previous review

Objectives

Approved texts

Standard
To evaluate the benefits and harms of [intervention] for [health issue/problem] in [population] comparing [comparisons]

For head-to-head comparison
To evaluate the benefits and harms of [intervention] versus [comparator] for [health issue/problem] in [population]

For multiple comparisons
To evaluate the relative benefits and harms of [multiple interventions] for [health issue/problem] in [population].

Guidance for Abstract Writers

- This should be a short, concise sentence; there is no need to put anything else here.
- Unless there are very compelling reasons to do otherwise, these exact words should be used: '**To evaluate the benefits and harms'**
- If there are more than one objective these should be **numbered** so 1., 2., etc.
- If the second objective is related to subgroup analysis, a standard introductory text would include: '**To determine if the benefits and harms are different** ..'
- The objective(s) should be expressed in terms that relate to the population(s), intervention and comparator(s).
- The '**health issue/problem**' may be very similar to one or some of the outcomes, but the *specific* outcomes of interest will be listed in Data Collection.
- Always include the comparator here
- We do not recommend putting the outcomes here because we feel they sit better in Data Collection. (We acknowledge this goes against MECIR.)

Examples and notes

Text	Commentary
Effects of oral vitamin D supplementation on linear growth and other health outcomes among children under five years of age. **Original text** To assess effects of oral vitamin D supplementation on linear growth and other health outcomes among infants and children under five years of age. **New, preferred text** To evaluate the benefits and harms[1] of Vitamin D supplementation[2] on linear growth and other health outcomes[3] in infants and children under five years of age[4] compared to no intervention, placebo, a lower dose of Vitamin D or the same micronutrients without Vitamin D[5].	Non-standard introductory text. Some information missing. 1. 'To evaluate the benefits and harms' 2. Intervention 3. Health problem (which in this case does include – in general terms – some of the outcomes) 4. Participants 5. Comparators

Text	Commentary
Antidepressant treatment for postnatal depression **Original text** To assess the effectiveness and safety of antidepressant drugs in comparison with any other treatment (psychological, psychosocial, or pharmacological), placebo, or treatment as usual for postnatal depression (PND). **New, preferred text** To evaluate the benefits and harms[1] of antidepressant drugs[2] in women with postnatal depression[3,4] compared to any other treatment (psychological, psychosocial, or pharmacological), placebo or treatment as usual[5].	Non-standard introductory text. Some information missing or in non-standard order. 1. 'To evaluate the benefits and harms' 2. Intervention 3. Participants 4. Health problem combined 5. Comparators

More than one objective

Text	Commentary
Interventions for itch in people with advanced chronic kidney disease **Original text** We aimed to determine: 1) the benefits and harms (both absolute and relative) of all topical and systemic interventions for the treatment of uraemic itch, either alone or in combination, when compared with placebo or standard care; and, 2) the dose strength or frequency, stage of kidney disease or method of dialysis used (where applicable) in cases where the effects of these interventions vary depending on co-interventions. **New, preferred text** 1. To evaluate the benefits and harms[1] of all topical and systemic treatments (either alone or in combination)[2] for uraemic itch[3], in people with advanced kidney disease[4], compared to placebo or standard care[5] 2. To determine if the benefits and harms are different[6] with changes in: dose strength or frequency, stage of kidney disease or method of dialysis used (where applicable).	1. 'To evaluate the benefits and harms' 2. Intervention 3. Health problem 4. Participants 5. Comparators 6. Standard phrase to introduce subgroup analyses.

Multiple comparisons masquerading as more than one objective

Text	**Commentary**
Continuous glucose monitoring (CGM) for the prevention of morbidity and mortality in preterm infants **Original text** Objective one: to assess the benefits and harms of CGM alone versus standard method of glycaemic measure in preterm infants. Objective two: to assess the benefits and harms of CGM with automated algorithm versus standard method of glycaemic measure in preterm infants. Objective three: to assess the benefits and harms of CGM with automated algorithm versus CGM without automated algorithm in preterm infants. **New, preferred text** To evaluate the benefits and harms[1] of three different methods of glucose monitoring (CGM alone, CGM with automated algorithm, and standard methods)[2,5] for preventing morbidity and mortality[3] in pre-term infants[4] compared with each other[5].	This title does not completely reflect the objectives, in that it implies that CGM will be compared to standard methods, and omits to say that different *methods* of CGM will be compared to each other. 1. 'To evaluate the benefits and harms' 2. Intervention 3. Health problem (which in this case does include – in general terms – some of the outcomes) 4. Participants 5. Comparators

Search Methods

Approved text
We used standard, extensive Cochrane search methods. The latest search date was x/x/xx. [Add key limitations, if present]

Guidance for Abstract Writers

- The thoroughness of Cochrane's search methods are well-known and full details are available in the full text. They do not need to be repeated in the abstract.
- Key limitations might include:
    - Failure to include literature in languages other than English. Approved text sentence could also be modified.
    - Failure to include grey literature. Approved text sentence could also be modified.
    - Other, significant (that is, likely to impact on the results of the review) limitations.
    - Issues related to Rapid Reviews.

Examples and notes

Text	Commentary
Approaches for discontinuation versus continuation of long-term antidepressant use for depressive and anxiety disorders in adults **Original text** We searched the following databases for RCTs until April 2020: CCMD-CTR, MEDLINE, EMBASE, PsycINFO, CENTRAL, trial registers and sources of grey literature. **New, preferred text** We used standard, extensive Cochrane search methods. The latest search date was April 2020.	Unnecessary to state all databases searched. 'Extensive' indicates that all relevant sources were searched.

Vitamin E supplementation in people with cystic fibrosis **Original text** We searched the Cochrane Group's Cystic Fibrosis Trials Register and also searched international online trial registries for any ongoing clinical trials that were not identified during our register search. Date of last search of the Register: 11 August 2020. Date of last search of international online trial registries: 20 July 2020. **New, preferred text** We used standard, extensive Cochrane search methods. The latest search date was August 2020.	Unnecessary to state all databases searched. 'Extensive' indicates that all relevant sources were searched.

Selection criteria

Approved text
We included [study design] in [participants] comparing [intervention/s] with [comparator/s]. We excluded studies [characteristics].

We included [study design] in [participants] comparing [an intervention] with [each of x comparators: comparator 1, comparator 2, comparator 3 …..comparator x]. We excluded studies [characteristics].

Guidance for Abstract Writers

- The Selection Criteria section should focus clearly on three elements of the PICO, the types of studies, outlining those that were excluded, if appropriate.
    - S - studies
    - P - participants
    - I - intervention
    - C – comparators
    - E – exclusions
- In terms of [study design] the phrase 'randomized controlled trials (RCTs)' will usually be sufficient. It is not necessary to refer to – for example – 'parallel and cluster randomized' or 'cross-over' unless these factors are <u>important</u>, and/or are going to be referred to in the Results section of the Abstract.
- **Examples of exclusion statements:**
  We excluded studies:
    - with follow-up less than three months
    - which included people with advanced disease
    - with cluster-randomized design
- Outcomes should not be listed here.

Examples and notes

Text	Commentary
Effects of oral vitamin D supplementation on linear growth and other health outcomes among children under five years of age. **Original text** We included randomized controlled trials (RCTs) and quasi-RCTs assessing the effects of oral vitamin D supplementation, with or without other micronutrients, compared to no intervention, placebo, a lower dose of vitamin D, or the same micronutrients alone (and not vitamin D) in infants and children under five years of age who lived in any country. **New, preferred text** We included randomized controlled trials (RCTs) and quasi-RCTs[1] in infants and children under five years of age[2] comparing Vitamin D, with or without micronutrients[3], to no intervention, placebo or the same micronutrients (without Vitamin D)[4].	1. S – studies (using standard phrase) 2. P - participants 3. I - intervention 4. C – comparators 5. E - exclusions

Text	Commentary
Coenzyme Q10 for heart failure **Original text** We included randomized controlled trials of either parallel or cross-over design that assessed the beneficial and harmful effects of coenzyme Q10 in patients with heart failure. *When cross-over studies were identified, we considered data only from the first phase*. **New, preferred text** We included randomized controlled trials (RCTs)[1] in patients with heart failure[2] comparing coenzyme Q10[3] to placebo or conventional therapy[4].	This *italicised* statement is **not** about excluding a study, but relates to use of a set of data so should not be included here. 1. S – studies (using standard phrase) 2. P - participants 3. I - intervention 4. C – comparators 5. E - exclusions

Text	Commentary
Paravertebral anaesthesia with or without sedation versus general anaesthesia for women undergoing breast cancer surgery **Original text** We included randomized controlled trials (RCTs) conducted in adult women undergoing breast cancer surgery where paravertebral anaesthesia with or without sedation was compared to general anaesthesia. We did not include studies where paravertebral anaesthesia was an adjunct to general anaesthesia and compared to general anaesthesia. **Selection criteria** We included randomized controlled trials (RCTs)[1] conducted in adult women undergoing breast cancer surgery[2] where paravertebral anaesthesia with or without sedation[3] was compared to general anaesthesia[4]. We did not include studies where paravertebral anaesthesia was an adjunct to general anaesthesia and compared to general anaesthesia[5].	1. S – studies (using standard phrase) 2. P - participants 3. I - intervention 4. C – comparators 5. E – Exclusions

Text	Commentary
Metformin treatment before and during IVF or ICSI in women with polycystic ovary syndrome	
Original text Types of studies: randomized controlled trials (RCTs) comparing metformin treatment with placebo or no treatment in women with PCOS who underwent IVF or ICSI treatment. Types of participants: women of reproductive age with anovulation due to PCOS with or without co-existing infertility factors. Types of interventions: metformin administered before and during IVF or ICSI treatment. Types of outcome measures: live birth rate, incidence of ovarian hyperstimulation syndrome, clinical pregnancy rate, miscarriage rate, incidence of participant-reported side effects, serum oestradiol level on the day of trigger, serum androgen level, and fasting insulin and glucose levels.	This type of text is not common but has been used by some CRGs.
New, preferred text We included randomized controlled trials (RCTs)[1] in women of reproductive age, undergoing IVF or ICSI, with anovulation due to PCOS [2], comparing metformin administered before and during IVF or ICSI[3] with placebo or no treatment [4]. **Alternative version** **Studies**: randomized controlled trials (RCTs) **Participants**: women of reproductive age with anovulation due to PCOS with or without co-existing infertility factors. **Interventions**: metformin administered before and during IVF or ICSI treatment **Comparators:** placebo or no treatment **Exclusions**: none	1. S - studies 2. P - participants 3. I - intervention 4. C – comparisons 5. E - exclusions

Data collection and analysis

Approved text
We used standard Cochrane methods. Our primary outcomes were [1, 2, 3 adverse effects], secondary outcomes were [4, 5, 6, 7]. We used GRADE to assess certainty of evidence for each outcome.

Guidance for Abstract Writers

- This section can be very short if methods are indeed 'standard'. If they are not, further information should briefly be given. For example: 'We used a non-standard approach to ….'
- Use the term **adverse effects** rather than **adverse events**
- If the '***most serious*** adverse effect(s)' is the third primary outcome, that can be stated:
  3. Severe adverse effects: nausea and vomiting
  or
  3. Severe adverse effect: anaphylaxis

Examples and notes

Text	Commentary
Angioplasty versus stenting for iliac artery lesions **Original text** Two authors independently selected suitable trials, extracted data, assessed trial quality and performed data analyses. When there was disagreement, consensus would be reached first by discussion among both authors and, if needed, through consultation with a third author. We used GRADE criteria to assess the certainty of the evidence and presented the main results in a 'Summary of findings' table. The main outcomes of interest were technical success, complications, symptomatic improvement of PAD, patency, reinterventions, resolutions of symptoms and signs and improvement in walking distance as reported by the patient. **New, preferred text** We used standard Cochrane methods. Our primary outcomes were 1. technical success, 2. symptomatic improvement of PAD, 3. resolution of symptoms and signs, 4. improvement in walking distance as reported by the patient and 5. patency of treated vessel. Our secondary outcomes were 6. adverse effects (dissection, thrombosis, infection, distal embolization, worsening of disease, pseudoaneurysm formation), 7. need for reintervention. We used GRADE to assess the certainty of evidence for each outcome. *For this example, outcomes taken from full text* ***Primary outcomes*: clinical assessment of improvement (improvement in stage of PAOD, walking distance, resolution of symptoms and signs, improvement of quality of life, measured claudication distance, ankle brachial index, ulcer healing, major amputation-free survival); technical success of procedure; patency of treated vessel. *Secondary outcomes*: complications** *(dissection, thrombosis, infection, distal embolization, worsening of disease, pseudoaneurysm formation); reintervention of treated lesion.*	

Text	Commentary
Endometrial injury for pregnancy following sexual intercourse or intrauterine insemination **Original text** We used standard methodological procedures recommended by Cochrane. The primary outcomes were live birth/ongoing pregnancy and pain experienced during the procedure. Due to the high risk of bias associated with many of the studies, the primary analyses of all review outcomes were restricted to studies at a low risk of bias. Sensitivity analysis was then performed including all studies. **New, preferred text** We used standard Cochrane methods. Our primary outcomes were 1. live birth/ongoing pregnancy and 2. pain experienced during the procedure. Our secondary outcomes were 3. clinical pregnancy per woman, 4. miscarriage per clinical pregnancy, 5. multiple pregnancy per clinical pregnancy, 6. ectopic pregnancy per clinical pregnancy, 7. bleeding secondary to the procedure. We used GRADE to assess the certainty of evidence for each outcome. *The following to go in Results if decision to do this was made post hoc* Due to the high risk of bias associated with many of the studies, the primary analyses of all review outcomes were restricted to studies at a low risk of bias. Sensitivity analysis was then performed including all studies.	

Text	Commentary
Interventions for bacterial folliculitis and boils (furuncles and carbuncles) **Original text** We used standard methodological procedures expected by Cochrane. Our primary outcomes were 'clinical cure' and 'severe adverse events leading to withdrawal of treatment'; secondary outcomes were 'quality of life', 'recurrence of folliculitis or boil following completion of treatment', and 'minor adverse events not leading to withdrawal of treatment'. We used GRADE to assess the certainty of the evidence **New, preferred text** We used standard Cochrane methods. Our primary outcomes were 1. clinical cure and 2. severe adverse effects. Our secondary outcomes were 3. quality of life, 4. recurrence of folliculitis or boil following completion of treatment, and 5. minor adverse effects. We used GRADE to assess the certainty of evidence for each outcome.	

Text	Commentary
Walking for hypertension **Original text** We used standard methodological procedures expected by Cochrane. Where data were not available in the published reports, we contacted authors. Pooled results for blood pressure and heart rate were presented as mean differences (MDs) between groups with 95% confidence intervals (CIs). We undertook subgroup analyses for age and sex. We undertook sensitivity analyses to assess the effect of sample size on our findings. **New, preferred text** We used standard Cochrane methods. Our primary outcome was 1. systolic blood pressure. Our secondary outcomes were 2. diastolic blood pressure and 3. heart rate. We used GRADE to assess the certainty of evidence for each outcome.	

Results

Approved text

Opening sentence
We included [no. of studies] with [no. of participants] participants. (Data for meta analysis were available from [no. of participants in meta analysis]).

See below for subsequent sections.

Guidance for Abstract Writers

- **The introductory paragraph**
  'We included xx studies (xx participants)'. Use first person, active voice, past tense.
  In many cases the word 'studies' can be replaced by 'RCTs'.

- **Use of subheadings** is strongly encouraged**.** These might be: comparisons, or outcomes, or interventions.

- **Order of comparison** The order should be: intervention *then* comparator.

- **Risk of bias** should not normally be mentioned unless of special interest or importance as it is accounted for in the GRADE ratings**.**

- **Bracket contents and order** The contents of the brackets are standardized as is the order. For example, the following should not be included in the brackets: I^2 and p-values.
  Narrative statement giving absolute values or size of difference *followed by* '(Point estimate; 95% CI x to x; A studies; B participants; xxxx certainty; xxx point scale; minimal clinically important difference xx points)'
  or
  Narrative statement *followed by* '(absolute values or size of difference; point estimate; 95% CI x to x; A studies; B participants; xxxx certainty; xxx point scale; minimal clinically important difference xx points)'.
- **Primary outcomes & adverse effects** The results of the review's primary outcomes (which should always include the most significant adverse effect/s) should always be reported.

- **Adverse effects** The reporting of adverse effects requires special, careful attention because of the following four possibilities:

	AEs reported	**No AEs reported**
Trialists pre-specified that they would look for AEs as an Outcome	A: Report in standard fashion	B: ?? were there any?
Trialists did not pre-specify that they would look for AEs as an Outcome	C: So they must have done but ? how thoroughly	D: ?? were there any or not?

Examples of text to cover these four situations:

A: 'Aspirin is probably associated with an increased risk of serious adverse effects (RR …..).'
B1: 'The study authors reported that there were no adverse effects.'
B2: 'Although the study authors stated that they would look for adverse effects, none were reported. We are uncertain if this is because there were none as they do not specifically state that this was the case.'
C: 'The study authors reported adverse effects but their intention to collect these data was not pre-specified so we are uncertain if these were systematically sought and identified.'
D: 'It is uncertain if the absence of adverse effects is because none occurred or because they were not being identified and recorded.'

- **Missing outcome data** This should be reported: For example:
    - 'The studies did not report any data for the following primary outcome(s): XX, YY, etc.'
    - 'No data are available on the following outcomes as no studies evaluated or reported them: [intervention 1], [intervention 2], etc.'
- **Information on interventions** It may be important to list the specific interventions: 'The studies evaluated the following interventions: [intervention1], [intervention2], [intervention3], …. [intervention N].'
- **Specific characteristics of included studies** There may be specific characteristics that merit special mention, if they have an important bearing on the interpretation of the results.
- **What NOT to put in** Do not include information about the number of studies screened.

1. Small number of studies, small number of comparisons

1.1.1 Continuous outcomes – Example 1

Text	Commentary
Aspirin[7] probably[1] increases[9] stroke recovery scores[8] (mean final score placebo[10] group 74, mean difference in aspirin group 13 points[2] higher[9], MD 13, 95% CI 5 to 20; 3 studies[3]; 156 participants[4]; moderate certainty[1]; 100-point scale[5]; minimal clinically important difference 10 points[6]).	1. GRADE word and GRADE statement 2. Clear statement of absolute numbers and difference OR some explanation of significance of an SMD 3. Number of studies 4. Number of participants 5. Scale 6. MCID 7. Intervention 8. Outcome 9. Direction of effect 10. Comparator The point estimate and CI

1.1.2 Continuous outcomes – Example 2

Text	Commentary
Original text Compared to continuing cholinesterase inhibitors, discontinuing treatment may be associated with worse cognitive function in the short term (standardized mean difference (SMD) -0.42, 95% confidence interval (CI) -0.64 to -0.21; 4 studies; low certainty) **New, preferred text** Discontinuing treatment with cholinesterase inhibitors[7] compared to continuing[10] may[1] lead to worse[9] short-term cognitive function[8] (SMD -0.42, 95% CI -0.64 to -0.21; lower SMD means greater decline in cognitive function[9]; 4 studies[3]; 344 participants[4]; low certainty[1]). ***Note: This version is still not ideal because the meaning (significance) of the SMD is not clear to the reader. Backwards transformation of the SMD onto a suitable scale, would have been more helpful, with a statement such as:*** 'When transformed onto a suitable scale, this SMD is equivalent to 23 points[2] on the 100 point Smith and Jones cognitive function scale[5], with minimally important clinical difference of 15 points[6].'	No. of participants is not mentioned 1. GRADE word and GRADE statement 2. Clear statement of absolute numbers and difference OR some explanation of significance of an SMD 3. Number of studies 4. Number of participants 5. Scale 6. MCID 7. Intervention 8. Outcome 9. Direction of effect 10. Comparator The point estimate and CI

1.2.1 Dichotomous outcomes – Example 1

Text	Commentary
Waltonolol[7] versus placebo[10] Waltonolol[7] probably[1] increases[9] the likelihood of observing a reduction in systolic BP of >10 mm Hg[8] (waltonolol[7] 55%, placebo[10] 45%; RR 1.25, 95% CI 1.09 – 1.34; 3 studies[3]; 156 participants[4]; moderate certainty[1]).	1. GRADE word and GRADE statement 2. Clear statement of absolute numbers and difference OR some explanation of significance of an SMD 3. Number of studies 4. Number of participants 5. Scale ; not applicable here 6. MCID ; not applicable here 7. Intervention 8. Outcome 9. Direction of effect 10. Comparator The point estimate and CI

1.2.2 Dichotomous outcomes – Example 2

Text	Commentary
Original text There may be clinically meaningful differences in favour of NACT compared to PDS with regard to serious adverse effects (SAE grade 3+). These data suggest that NACT may reduce the risk of need for blood transfusion (risk ratio (RR) 0.80; 95% CI 0.64 to 0.99; four studies,1085 women; low-certainty evidence), ……. **New, preferred text** NACT[7] may[1] reduce[9] need for blood transfusion[8] when compared with PDS[10] (NACT 7 per 1000; PDS 9 per 1000[2], RR 0.80; 95% CI 0.64 to 0.99; 4 studies[3],1085 participants[4]; low certainty[1]).	1. GRADE word and GRADE statement 2. Clear statement of absolute numbers and difference OR some explanation of significance of an SMD 3. Number of studies 4. Number of participants 5. Scale ; not applicable here 6. MCID ; not applicable here 7. Intervention 8. Outcome 9. Direction of effect 10. Comparator The point estimate and CI

1.3 Survival analysis - Example

Text	Commentary
Original text We pooled results of the three studies where data were available and found little or no difference with regard to overall survival (OS) (1521 women; Hazard Ratio (HR) 0.95, 95% CI 0.84 to 1.07; I2 = 0%; moderate-certainty evidence) **New, preferred text** There is probably little or no difference[1, 9] in overall survival[8] between neo adjuvant chemotherapy[7] and conventional treatment[10] (HR 0.95, 95% CI 0.84 to 1.07; 3 studies[3]; 1521 participants[4]; moderate certainty[1]). **Note:** Absolute effects not available because no appropriate control group could be identified but it is likely not to be appropriate to state these when there is 'little or no difference'.	1. GRADE word and GRADE statement 2. Clear statement of absolute numbers and difference OR some explanation of significance of an SMD (see Note) 3. Number of studies 4. Number of participants 5. Scale ; not applicable here 6. MCID ; not applicable here 7. Intervention 8. Outcome 9. Direction of effect 10. Comparator The point estimate and CI

2. Single study(-ies) only

Text	Commentary
The effectiveness and adverse effects of D-cycloserine compared with placebo on social and communication skills in individuals with autism spectrum disorder **Original text** We included a single RCT (Minshawi 2016) funded by the United States Department of Defense. It was conducted at two sites, Indiana University School of Medicine and Cincinnati Children's Hospital Medical Centre, in the USA. In the included study, 67 children with ASD aged between 5 and 11 years were randomized to receive either 10 weeks (10 doses) of (50 mg) D-cycloserine plus social skills training or placebo plus social skills training in a 1:1 ratio, and outcome measures were recorded at one-week post-treatment. The 'Risk of bias' assessment for the included study was low for five domains and unclear for two domains. The study (67 participants) reported low-certainty evidence of little to no difference between the two groups for all outcomes measured: social interaction impairment (mean difference (MD) 3.61 (assessed with the Social Responsiveness Scale); 95% confidence interval (CI) −5.60 to 12.82); social communication impairment (MD -1.08 (measured using the inappropriate speech subscale of the Aberrant Behavior Checklist (ABC)); 95% CI −2.34 to 0.18); restricted, repetitive, stereotypes patterns of behaviour (MD 0.12 (measured by the ABC stereotypy subscale); 95% CI −1.71 to 1.95); serious adverse events (risk ratio (RR) 1.11; 95% CI 0.94 to 1.31); non-core symptoms of ASD (RR 0.97 (measured by the Clinical Global Impression-Improvement scale); 95% CI 0.49 to 1.93); and tolerability of D-cycloserine (RR 0.32 (assessed by the number of dropouts); 95% CI 0.01 to 7.68).	

New preferred version We included a single RCT[1] with 67[2] children aged between 5 and 11 with ASD[3]. It was publicly funded and conducted in two tertiary medical centers in the USA[4]. Participants received either 10 weeks (10 doses) of 50mg of D-cycloserine or placebo. Both groups also received social skills training[5]. Outcome measures were recorded one-week post-treatment. This is a single, small study and for all outcomes the certainty of evidence was low. We are unable to draw meaningful conclusions from the numerical results[6]. ***Notes:*** 1. In the case here a single study is being reported, and it may be appropriate – given availability of space – to say more about the study than is usual in an abstract. But this is not inevitable and need not be done if the study is of – for example – high risk of bias, and unlikely to contribute data to a future meta-analysis. 2. As policy, the **numerical results** as reported in a single study should **not** be reproduced in the abstract. To allow these data in an abstract almost always gives them more merit, and attention, than they deserve. 3. As the results are not presented for each outcome, it can be appropriate to mention risk of bias.	1. Standard phrase when only one study 2. Number of participants* 3. Key information about characteristics of participants* 4. Key information about the conduct of study* 5. Key information about intervention* 6. This statement reflects a decision not to include data from single, small studies. See Note * especially important in this 'single study' case

3. No studies at all

Text	Commentary
Internal iliac artery revascularisation versus internal iliac artery occlusion for endovascular treatment of aorto-iliac aneurysms **Original text** We identified no RCTs that met the inclusion criteria. **New preferred text** We identified no studies that met our inclusion criteria. OR We identified no RCTS that met our inclusion criteria but found two non-randomized studies.	Should talk of ‘studies’ and not 'trials’ If the review includes both RCTs and non-RCTs, a phrase like this may be appropriate. Continue use of first person.

4. No studies with useable data

Text	Commentary
Antimicrobial mouthwashes (gargling) and nasal sprays to protect healthcare workers when undertaking aerosol-generating procedures (AGPs) on patients without suspected or confirmed COVID-19 infection **Original text** We found no completed studies to include in this review. **New preferred text** We identified no completed studies that met our inclusion criteria. We identified xx registered studies that may meet our inclusion criteria.	This was the first iteration of a 'living' review. Wording adjusted. Possibility of mentioning registered studies (not the same as ongoing studies), if appropriate.

Authors' conclusions

Approved texts

Positive result
[Intervention] probably [appropriate GRADE language] reduces the chance of [primary outcome 1: stroke, death, etc] at [time point].

- Report the harm

There is probably an increased risk of [significant adverse event].

- State study limitations maybe? SEE BELOW

Negative result – 'little or no difference'/very low-certainty evidence
There may be little or no difference in the incidence of a significant adverse event.

Negative result – no studies or data/evidence addressing primary outcomes

- 'No studies evaluated our primary outcome(s).'
- 'No data are available relating to our primary outcome(s).'
- 'We found no [useable data] about our primary outcome.'
- 'There are inadequate data [to allow us] to draw conclusions about the effects of x compared to y on [primary outcome(s)].'

Adverse effects
'It was not clear if these were monitored and reported in the included studies.'

Guidance for Authors

- The **Conclusions** should be written in the first person OR third person. This is permissible notwithstanding the rest of the abstract is in the first person.
- The present tense should be used for conclusions and certainty (but use of past permissible – 'We found' – when appropriate).
- The word 'people' should be used (not patients).
- All abbreviations should be spelt out here.
- At, or towards, the end there should be a sentence about the limitations of the evidence (the underlying individual studies or the body of evidence – the review itself, for example).
- Also, an indication of where further research is needed. For example: 'Further research is needed to establish reliable outcome measures and minimal clinically important differences.'

Examples and notes

Text	Commentary
Ivabradine as adjuvant treatment for chronic heart failure **Original text** We found evidence of no difference in cardiovascular mortality and serious adverse events between long-term treatment with ivabradine and placebo/usual care/no treatment in participants with heart failure with HFrEF. Nevertheless, due to indirectness (male predominance), the certainty of the available evidence is rated as moderate. **New, preferred text** Long-term treatment with ivadradine[2] probably[5] makes little or no difference[5] to mortality[4] from cardiovascular causes in patients with heart failure and a reduced ejection fraction[1] when compared to placebo[3], usual care[3] or no treatment[3]. There may be little or no difference[5] in the incidence of serious adverse effects[7].	1. P – participants [condition/health problem] 2. I - intervention 3. C – comparators 4. O - outcome 5. GRADE language 6. Time point 7. Adverse effects 8. Limitations 9. Future research

Text	Commentary
Myofunctional therapy (oropharyngeal exercises) for obstructive sleep apnoea **Original text** Compared to sham therapy, myofunctional therapy probably reduces daytime sleepiness and may increase sleep quality in the short term. The certainty of the evidence for all comparisons ranges from moderate to very low, mainly due to lack of blinding of the assessors of subjective outcomes, incomplete outcome data and imprecision. More studies are needed. In future studies, outcome assessors should be blinded. New trials should recruit more participants, including more women and children, and have longer treatment and follow-up periods **New, preferred text** Myofunctional therapy[2] probably[5] reduces daytime sleepiness[4] [by a clinically meaningful amount*] compared to sham therapy[3], waiting list control[3] or standard medical treatment[3], in the short term[6]. There may be little or no difference[5] compared to CPAP[3] or to respiratory exercises plus a nasal dilator strip[3]. Most study participants were adult men[1,8] raising doubts about the applicability of these results to women and children[8]. No studies looked at the effects of treatment beyond four months[8]. None reported the harms of treatment[7,8]; it was not clear whether these were monitored and reported in all the included studies. Larger studies conducted over longer periods, and including more women and children, would reduce the current uncertainties[9].	1. P – participants [condition/health problem] 2. I - intervention 3. C – comparators 4. O - outcome 5. GRADE language 6. Time point 7. Adverse effects 8. Limitations 9. Future research * should be included *if true*

Text	Commentary
Intravitreal steroids for macular oedema in diabetes **Original text** Intravitreal steroids may improve vision in people with DME compared to sham or control. Effects were small, about one line of vision or less in most comparisons. More evidence is available for dexamethasone or fluocinolone implants when compared to sham, and the evidence is limited and inconsistent for the comparison of dexamethasone with anti-VEGF treatment. Any benefits should be weighed against IOP elevation, the use of IOP-lowering medication and, in phakic patients, the progression of cataract. The need for glaucoma surgery is also increased, but remains rare. **New, preferred text** Intravitreal dexamethasone implant 0.7mg[2] and fluocinolone implant 0.19mg[2] probably[5] improve vision[4] in people with DME[1] compared to sham[3] but the effects are small*. Both are probably[5] associated with cataract formation[4,7], raised IOP[4,7] and the need for IOP-lowering medication[4,7]. We found inconsistent evidence[8] for the comparison of dexamethasone[2] with anti-VEGF[2] treatment. We are uncertain[5] whether intravitreal triamcinolone acetonide injection 4mg[2] is beneficial compared to sham[3], laser photocoagulation[3] and intravitreal anti-VEGF[3] but we found moderate-certainty evidence[5] that it is associated with an increased risk of cataract formation[4,7] and need for IOP-lowering medication[4,7].	1. P – participants [condition/health problem] 2. I - intervention 3. C – comparators 4. O - outcome 5. GRADE language 6. Time point 7. Adverse effects 8. Limitations 9. Future research * uncertain if this is clinically significant; this should be stated

Text	Commentary
Pre- and postsurgical medical therapy for endometriosis surgery **Original text** Our results indicate that the data about the efficacy of medical therapy for endometriosis are inconclusive, related to the timing of hormonal suppression therapy relative to surgery for endometriosis. In our various comparisons of the timing of hormonal suppression therapy, women who receive postsurgical medical therapy compared with no medical therapy or placebo may experience benefit in terms of pain recurrence, disease recurrence, and pregnancy. There is insufficient evidence regarding hormonal suppression therapy at other time points in relation to surgery for women with endometriosis. **New, preferred text** The benefits of medical therapy for hormonal suppression[2] before, after or both before and after surgery for endometriosis[1,2] are uncertain[5]. Postsurgical treatment[1] may[5] decrease pain[4] and disease recurrence[4] at 12 months or less[6], and probably[5] increases pregnancy rate[4], compared to no medical treatment[3] or placebo[3]. There was insufficient evidence to draw conclusions regarding hormonal suppression at other time points[8] and for serious adverse effects[7,8].	1. P – participants [condition/health problem] 2. I - intervention 3. C – comparators 4. O - outcome 5. GRADE language 6. Time point 7. Adverse effects 8. Limitations 9. Future research

Text	Commentary
Iron chelators for acute stroke **Original text** We identified two eligible RCTs for assessment. We could not demonstrate any benefit for the use of iron chelators in spontaneous intracerebral haemorrhage. The added value of iron-chelating therapy in people with ischaemic stroke or subarachnoid haemorrhage remains unknown. **New preferred text** Low-certainty evidence[5] from two studies comparing deferoxamine[2] to placebo[3] in participants with spontaneous intracerebral haemorrhage[1] showed little or no difference[5] in deaths[4], clinical outcomes[4] and serious adverse events[7]. No data were found to evaluate the benefits and harms of iron-chelating therapy in participants with ischaemic stroke or subarachnoid haemorrhage[8,9]. **or** We identified two RCTs comparing desferoxamine[2] to placebo[3] in participants with spontaneous intracerebral haemorrhage[1]. We found low-certainty evidence[5] that there was little or no difference[5] in deaths[4], clinical outcomes[4] and serious adverse effects[7]. We found no studies evaluating the benefits and harms of iron-chelating therapy in participants with ischaemic stroke or subarachnoid haemorrhage[8,9].	Two different ways of writing conclusions: passive/ first person plural 1. P – participants [condition/health problem] 2. I - intervention 3. C – comparators 4. O - outcome 5. GRADE language 6. Time point 7. Adverse effects 8. Limitations 9. Future research

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