

HINTS ON PREPARING A GOOD ABSTRACT

Introduction

It sometimes happens that individuals submit an abstract for consideration for presentation at a CinC meeting only to be disappointed when it is rejected. They then seek advice on why the abstract was not accepted for the final program. This very short item tries to illustrate the difference between writing an abstract to show off results to their best advantage versus preparing an abstract which is relatively well written, but could be very much better. It has no relationship whatsoever to the short abstract at the beginning of a CinC manuscript.

Note: This discussion aims at assisting you in writing a high quality abstract, and not at formatting it precisely for CinC submission. Please refer to the abstract examples given at http://cinc.org/authors_kit/abstracts/pdf-abstract.shtml.

In the discussion below, the poor abstract is labelled “abstract A” and the better abstract is labelled “abstract B”.

- Reminder: full details of how to prepare an abstract can be found elsewhere at http://cinc.org/authors_kit/abstracts/pdf-abstract.shtml
- Formatting details for abstracts are found in the abstract examples. Please use those examples, and not this paper, to format your abstract.
- The title of the abstract should ideally be one line though two lines maximum will be accepted.
- Please use first names and surnames in the title as in Abstract B.
- Abstract A does not have much of a shape. Please bear in mind that a reviewer may be looking at the order of 50-60 abstracts and a mass of unstructured text does not initially create a good impression.
- To follow from the preceding point, it is often the case, though not always, that an abstract should contain sections that might, for example, be headed Aims, Methods, Results and Conclusion, as in Abstract B. Their use is not compulsory and there are certainly different opinions about this approach but use of this style does create more of a structure to assist the reviewer. This structure is sometimes best retained by using the pdf style of submission, which can be checked before it is sent. In short, the use of a structured abstract is strongly encouraged.
- Not all abstracts have a requirement for Methods and Results but if so, it is still recommended that an occasional heading is used to break up the text. Alternatively, create and indent new paragraphs 5mm to relieve the monotony of a solid block of left aligned text as in Abstract A. Again, the use of the pdf approach will assist in retaining the shape of the abstract.
- In Abstract A, abbreviations are used for positive predictive value (PPV) and so on. These are not referenced later in the abstract so using (PPV) is a waste of space.
- Conversely, CABG is used in abstract A with no explanation. It should be written in full on first use, i.e. all abbreviations need to be written in full on first use except for those few which are very commonly used and understood, such as ECG.

- Try to be precise in presenting data. For example, Abstract A states “most having an RCA occlusion”. The writer presumably knows the number and so it should be included rather than saying “most”.
- Data should be presented to 2 significant figures, e.g. 1.5% or 54%.
- Perhaps most important of all, NEVER state “full details will be presented at the meeting”. When a reviewer sees such a phrase, the abstract will immediately be rejected.
- Participants in the Challenge are instructed that preliminary results should be presented in the abstract. Abstracts from participants who have not shown that they are actively at work on the Challenge will be rejected.
- The new CinC abstract format allows the use of a table or a figure. Do not hesitate to use this facility.
- Choose a title that clarifies your work - compare the title of Abstract A v. Abstract B
- Not all abstracts report on a study of patients. However, those that present a methodology are still advised to present the benefit of the new approach and stress any originality that would encourage a reviewer to mark the abstract highly.
- It is suggested that the past tense is used to describe the work being presented. In reality, any study being reported should have been completed and so it is more logical to use the past tense for Methods and Results. However, Conclusions can be in the present tense as in abstract B, as this is the correct tense in this context.
- Please bear in mind that although reviewers are selected for expertise in specific areas, not every reviewer can know intimately the subject matter of every abstract to be reviewed so try to explain your work as clearly as possible.
- Blatantly commercial abstracts are discouraged.

Abstract A – poorly presented abstract

Use of the ECG in Acute Myocardial Infarction

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In this study, we wanted to have a look at current ECG criteria for locating a coronary artery that had caused an acute myocardial infarction (AMI). This could be the left anterior descending artery (LAD), the right coronary artery (RCA) and the left circumflex artery (LCx). We were not certain whether it would make sense to implement current AHA/ACC/ESC/HRS recommendations to state the culprit artery on an ECG interpretation. To try to answer the question, 12 lead ECGs recorded in two regions – one around Anywhere, Denmark and one around Somewhere, UK - were retrospectively analysed along with angiograms. Men and women of all ages were included if they had an occlusion, observed during angiography, in only one coronary vessel. Patients who had a CABG or insufficient data available were excluded. All eligible patients were suspected of having an acute coronary event. ST amplitude at the J-point, as measured by the University of Somewhere program, was used to test ECG criteria, identified from the literature, in order to assess their sensitivity (SE), specificity (SP), positive predictive value (PPV) and negative predictive value (NPV) with respect to locating the culprit artery. There were 379 patients included in this study with most having an RCA occlusion. A large number of criteria were identified and tested, of which 4 were designed to detect LAD occlusions while the remainder were supposed to detect LCx and RCA occlusions. There was a wide variation in sensitivity and specificity among the criteria though it was possible to identify a few criteria that could be used for routine purposes. Full details will be presented at the meeting. We concluded that there are ECG criteria which are quite good at predicting the culprit artery in AMI and it looks as if it will be possible to implement some of them in order to meet current recommendations.

Abstract B – improved abstract

Location of the Culprit Artery in Acute Myocardial Infarction using the ECG

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Aims: This study aimed to assess the accuracy of current ECG criteria for locating the coronary artery principally involved in an acute myocardial infarction (AMI), namely the left anterior descending coronary artery (LAD), the right coronary artery (RCA) and the left circumflex coronary artery (LCx), in order to assess the merits of implementing current AHA/ACC/ESC/HRS recommendations to determine and state the culprit artery on an ECG interpretation.

Methods: 12 lead ECGs taken by paramedics in two regions – one around Anywhere, Denmark and one around Somewhere, UK - were retrospectively analysed along with corresponding coronary angiograms. Men and women of all ages were included if they had an occlusion greater than 75%, observed during angiography, in only one coronary vessel. Patients who had a coronary artery bypass graft (CABG) or insufficient data available were excluded. All eligible patients were suspected of having an acute coronary event. ST amplitude at the J-point, as measured by computer techniques, was used to test ECG criteria, identified from the literature, in order to assess their sensitivity (SE), specificity (SP), positive predictive value (PPV) and negative predictive value (NPV) with respect to locating the culprit artery.

Results: Of the 379 patients included in this study, 147 had an LAD occlusion, 170 an RCA occlusion, 31 an LCx occlusion and 31 another occlusion. 51 criteria were identified and tested, of which 4 distinguished LAD occlusions and the remainder aimed to detect LCx and RCA occlusions. The best criterion for predicting LAD occlusion had SE 74%, SP 96%, PPV 92%, NPV 85%. For RCA and LCx, the best results were SE 74%. SP 90%, PPV 86%, NPV 81% and SE 35%, SP 95%, PPV 38%, NPV 94% respectively.

Conclusion: ECG criteria exist which predict the culprit artery in AMI with a modest degree of accuracy, making it meaningful to implement current recommendations.