

On getting published in the SAMJ



'Work; finish; publish' (Michael Faraday^[1])

The SAMJ proudly publishes research that impacts on clinical practice in (South) Africa, reflecting the journal's byline 'Leading research impacting clinical care in Africa', which implies that we have been pleased, as readers will know, to have entertained work from researchers in other countries in Africa (see 'Sources of articles published in SAMJ/CME during 2014'^[2]).

One of the pleasures of my role as Editor is to accept and publish the work of (South) Africa's young clinical scientists, recently established in their chosen field and embarking on their research, or even having undertaken research during community service. Common to the manuscript that is successful is clear evidence of mentorship^[3] in the undertaking of the research. It is interesting to note *The Lancet's* growing insistence on what they term 'Research in context'^[4] offering a description of all the evidence that the author(s) considered before undertaking the study, a description of how the findings add value to the existing evidence, and a statement of the implications for practice or policy, and future research, of their study.

In the generation of the article submitted for publication, some fundamental rules need to be followed: going into the SAMJ's website and reading the Author Guidelines, and submitting in the belief that the research is a good 'fit' for the journal, whose readership is 'generalist' at a general practice and specialist level; ensuring that the abstract is crafted with special attention (given that it is all that may be read, it must convey the 'whole story' of the research); and accepting with grace and humility the comments of reviewers who suggest revisions, and complying – as far as is possible – with those suggestions.

The SAMJ rejects some 50 - 70% of submissions, and authors need to prepare for, and graciously accept, the journal's decision not to publish an article. The chief reason for rejection is that an article is not suitable for the journal ... that its subject matter is too parochial and not generalisable, or too highly specialised for the readership and more suited to a specialist journal. Clear evidence that the Author Guidelines have not been read, or even that previous SAMJs and similar articles have not been studied for the 'SAMJ format', immediately signals problems. Also, shorter is always better! We have good reasons for not accepting lengthy articles with countless references, which, if they were to be accepted, would delay publication of others in the queue and add to the copyediting, and proofreading, workload. Simply put ... research the SAMJ before submission, and research again. The best response to rejection is to consider whether another journal, perhaps one of the SAMJ's siblings,^[5] might not be a better choice and getting on with rewriting the article with that journal in mind, paying heed to the advice of reviewers, if available. It bears mentioning that the SAMJ will entertain a request for reconsideration following rejection, if soundly motivated.

Some 10 - 20% of submissions are accepted at 'first-pass review' by the journal's Editorial Advisory Committee, the remainder proceeding to review by expert, discipline-specific peer reviewers, of whom, it must be said, there is an insufficient number willing to spend the 4 - 8 hours (typically of down and relaxation time) on the academic task of adjudicating a paper's worthiness and scientific strength. **We are grateful to those generous national**

and international colleagues who support the journal by undertaking peer review for us, seeing it as part of their academic endeavour. Our expert reviewers criticise lack of originality, unclear hypotheses, poor or weak design, a too-small sample, inappropriate or misapplied statistics, unjustified conclusions and outdated or overlooked references. A rash of MMed theses, offered for publication, all too often reveal these deficiencies, and importantly absence of the mentorship referred to above. We are on the lookout for conflicts of interest^[6] and ethical breaches (though these are rare).

Too often, local authors have a tendency to lean heavily on differences between racial cohorts without sound reasons. The SAMJ's Emeritus Editor Daniel J Ncayiyana has offered advice:^[7] 'In unequal societies with a history of institutionalised racism, particular health and medical problems have a particular prevalence in ethnic groups that are longstanding victims of material deprivation and health care inequities. In this context, research into health disparities of social groups that are victims of discrimination is both legitimate and important. However, the researcher should be quite clear as to what is being measured. The research should not lead to "social and economic variables [being] mixed up with, and confused with genetic determinants" in the mind of the researcher, and should not lead to the misperception that being black (for example) – rather than poverty, limited education, poor housing, lack of sanitation, poor nutrition and other deprivations – is the "explanation" for ill health.'

Then there are author 'crimes': duplicate publication (the same article, modestly reframed and offered to more than one journal), 'salami' publishing (the same body of work divided into several segments in an attempt to achieve multiple publications), and plagiarism, especially from websites. All articles submitted to all the HMPG titles are 'seen' by the iThenticate plagiarism screening system, which screens submitted papers for originality and can tell whether a paper contains passages of text that also appear in other publications or resources.^[8] This means that we can (generally, but not always) catch articles with plagiarised content.

Publishing worldwide has run into financial difficulties for a number of reasons. And, for a journal that is circulated by post to some 17 000 SAMA members, it does not help that postal and distribution costs are escalating and that the postal service fails because of strikes. Moreover, cost containment requires that the *print* volume of the journal is held to a finite page allocation, limiting the number of research papers that can be published in any one print edition. This is why, since January 2014, *CME* has been co-joined with *SAMJ* and is limited to printed summaries, the full articles being published online, and why, since November 2014, the *SAMJ* has published printed abstracts of papers (randomly selected) with the full paper available online. A loose canvassing of the opinion of one's younger, and even older, colleagues reveals their comfort with this, and unashamed admission that the journal often remains in its plastic sleeve and is read instead on one or another computer platform. As suggested in my inaugural editorial,^[9] the entire journal will in time go this way.

In 2005, George D Lundberg, former Editor of *JAMA*, provided advice during a seminar to hundreds of student authors^[1] on 'How to write a medical paper to get it published in a good journal' (the video that accompanies this reference is worth looking at). Lundberg says this: 'Writing is hard work. So you want to write a paper? What

do you have to say? Is it worth writing? Has the information already been published? What format should it be? What is the audience? What journal is appropriate? *Expect* peer review, a process that began some 300 years ago in France and in England and revolutionized science by creating a culture of peer criticism and self-criticism. Peer reviewers are asked: Is the manuscript original, important, interesting; are the data valid; are the conclusions justified by the data; is the writing clear; and what is the priority and timing? Is it new? Is it true? All journals make messes. They clean them up in the letters column and by corrections and retractions.⁷

Lundberg goes on to highlight the presence of a *vade mecum* for would-be authors adapted from Tierney of Indiana University and available by clicking on <http://images.medscape.com/images/515/525/mgm515525.attachment.doc>

In his Offline commentary entitled 'Think English',^[10] the Editor of *The Lancet* last year addressed a question frequently posed to him: 'How can I publish my paper in *The Lancet*?' Horton's answer was 'But the question is ridiculous. Who cares about getting published in *The Lancet*?' Invoking Michael Faraday, one of the world's greatest scientists, Horton stated: 'Getting published at all is what ought to count for a young scientist.'

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EDITOR'S CHOICE

CME: Case reports

February's CME consists of a series of case reports that have been received over the past 12 months. Many journals, local and international, feature case reports within their pages, and younger doctors in particular are encouraged to write up their more interesting cases in this format.

According to Wikipedia, 'in medicine, a case report is a detailed report of the symptoms, signs, diagnosis, treatment and follow-up of an individual patient'. Case reports are usually written to provide an unusual or novel occurrence of a set of signs and symptoms, or, as is the case in some of the reports published this month, unusual presentations of a particular disease entity. Case reports often contain some kind of literature review of other reported cases, even if only to say that the report is of a rare occurrence.

Case reports are, by their very nature, anecdotal and are placed at the foot of the hierarchy of clinical evidence, together with case series. However, case reports are usually thought to have genuinely useful roles in medical research and in evidence-based medicine.

However, one of the most useful roles of case reports is that of medical education, both formally, providing a structure for case-based learning (which we all did at medical school), and informally, for the general reader. In both cases, interesting and unusual presentations are helpful to day-to-day practice and will often trigger recognition of a diagnosis or pathology in a puzzling clinical case.

All the case reports presented in this issue of CME are local, and selected for their particular usefulness to our younger and less experienced colleagues.

Renal disease and haemodialysis in HIV-positive patients

An article on morbidity and mortality of black HIV-positive patients with end-stage kidney disease receiving chronic haemodialysis in South Africa (SA)^[1] and an accompanying editorial^[2] reveal the extent

of renal disease in the HIV-positive population. Renal disease affects up to 30% of HIV-infected patients. HIV-associated nephropathy (HIVAN) is most common and, unless treated with antiretroviral therapy (ART), progresses rapidly to end-stage renal disease (ESRD). ESRD is projected to increase further now that HIV-positive patients are living longer on ART and are increasingly manifesting the diseases of lifestyle, including hypertension and diabetes.

All HIV-positive patients should be screened for chronic kidney disease at first encounter with any health service. This is particularly important in view of the fact that HIVAN can occur with high CD4 counts. Screening should include urinalysis and measurement of kidney function. Patients manifesting renal involvement should be fast-tracked for ART. Furthermore, being HIV-positive is no longer a contraindication to renal transplantation, provided patients are established on ART and achieve acceptable CD4 counts and suppressed viral loads.

Linking cervical cancer screening to human papillomavirus (HPV) vaccination

This issue of *SAMJ* features the second article on the Vaccine and Cervical Cancer Screen (VACCS) project, on linking cervical cancer screening to HPV vaccination in the South-West District of Tshwane, Gauteng, SA.^[3] This study provided the novel opportunity to investigate the outcome of cervical cancer screening in mothers and guardians by linking this to the vaccination of the grade 4 - 7 girls in their care. New molecular screening technology was utilised, permitting self-sampling in a home setting with a screen kit offered to female parents and guardians (plus an extra one for a friend or family member). The screen kit consisted of a tampon with user instructions: women inserted the tampon vaginally and removed it after one hour. The used tampon was placed in a container with buffer and, together with personal information, was returned to the school in a sealed envelope. DNA

was extracted from the tampon specimens and tested for any of the 15 high-risk viral types (16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68, 73, 82), HPV 16 and 18 being the two most oncogenic. Roughly half of the women took up the screening opportunity, and molecular screening identified cervical cancer risk in 30% and a high risk of future disease in 9.1%. Using the school infrastructure as well as mobile phone technology, all women received their screen results.

This is an important development, given the limited success registered by the national cervical cancer prevention programme, launched in 2000, which offers three Papanicolaou smears per lifetime (starting after the age of 30, at 10-year intervals).

Digitalis reappraised

Still here today, but gone tomorrow? Opie^[4] suggests that there are very few arguments left in favour of the use of digitalis in the control of heart rate in atrial fibrillation. Following negative mortality data from one large recent study of digitalis in heart failure (HF), enthusiasm for further testing for the benefit of digitalis that would necessitate a large, multicentre, prospective randomised controlled trial is waning. Opie suggests that digoxin, for the indication of HF, would not be passed by regulatory agencies on the basis of present data. (See also in CME 'Digoxin therapy in the modern management of cardiovascular disease: An unusual but serious complication'^[5].)

Why is cancer not a priority in South Africa?

An editorial asks the above question.^[6] The National Cancer Registry (NCR) is an invaluable source of cancer data for the country. Established in 1986 as a voluntary, pathology-based cancer reporting system, the Registry within the National Health Laboratory Service is the principal cancer surveillance system in SA. Regulation 380 of the 2011 National Health Act formally established the NCR as the main cancer surveillance agency and mandated reporting of all confirmed cancers in SA to the NCR.

The NCR receives over 100 000 cancer reports annually; approximately 80 000 are new cases, on the basis of which cancer incidence is calculated. Registry data have been used to highlight cancers of importance in the SA context. Data from the Johannesburg Cancer Case Control Study (JCCCS), conducted by the Cancer Epidemiology Research Group, have been used to extensively describe the epidemiology of HIV-related cancers and particularly to explore the relationship between Kaposi's sarcoma and HIV. The JCCCS has also contributed to risk factor analysis in the International Collaboration of Epidemiological Studies of Cervical Cancer.

The NCR manages cancer surveillance in the context of SA's dual health system, comprising a large public health infrastructure serving approximately 84% of the population and a smaller private health system catering to 16%. It is dismaying to learn from Singh *et al.*^[7] that private laboratory cancer data reporting, which was consistent throughout the early 2000s, was withheld from 2005 to 2007, resulting in a 28% under-reporting from private healthcare centres (see Fig. 1, reproduced below). Fortunately the impact of withheld private data appears to have been minimal in that there was only a 4% decrease in overall cancer reporting, reflecting the reality that four out of every five SA citizens receive care in public healthcare systems. Fortunately, too, relationships with private sector laboratories have been renewed and a standard system has been established to receive private sector pathology data electronically.

In an era of growing prioritisation of NCDs and with global cancer burdens estimated to increase significantly, the NCR has an invaluable role to play in the health and health planning landscape of SA. In view of the progressive health developments in the country,

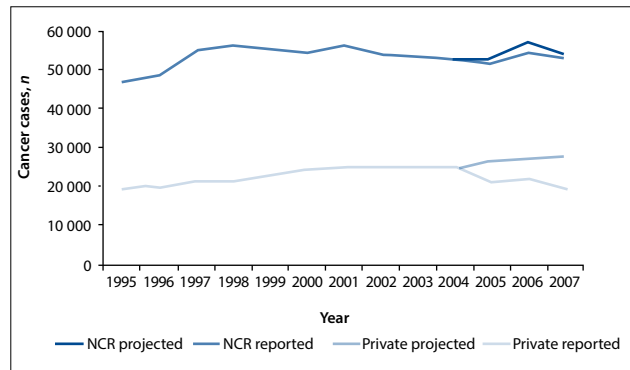


Fig. 1. Actual and projected case reporting from private laboratories and to the NCR, 1995 - 2007.

such as the introduction of National Health Insurance, there is an imperative to accurately quantify the cancer burden, and thus the cost of cancer services to be provided to the SA population.

Non-communicable diseases (NCDs)

Two articles in this issue address comorbidity and multimorbidity in NCDs in the SA setting,^[8,9] the former suggesting that future clinical guidelines, training of primary care nurses and involvement of doctors in the continuum of care should address the complexity of patients with NCDs and multimorbidity, and the latter warning against mobilisation of scarce resources to implement mass screening for diabetes and hypertension in the absence of adequate evidence of benefit.

As is well recognised, the SA healthcare system faces a quadruple burden of disease, characterised by HIV/AIDS and tuberculosis, injury and violence, maternal and child health issues and NCDs. The World Health Organization estimates the burden of NCDs to be two to three times higher in SA than in high-income countries. NCDs are estimated to contribute 28% to the total burden of disease, and this is predicted to increase substantially over the next few decades. In the Western Cape, NCDs account for five of the ten leading causes of death: ischaemic heart disease, diabetes, cerebrovascular disease, lung cancer and chronic obstructive pulmonary disease. NCD distribution reflects socioeconomic disparities, with the heaviest burden among poor communities in urban areas, posing a developmental challenge to the country.^[10]

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