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Cell free DNA methylation patterns for early detection and management of ovarian and breast cancer

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ABSTRACT

Background: Based on the characteristics of systemic lupus erythematosus-associated pulmonary arterial hypertension (SLE-PAH), Sun et al has put forward a scoring system to distinguish two clinical phenotypes as vasculitic and vasculopathic subtypes[1]. A weighted score ≥2 suggested a vasculitic subtype by combining two factors: The time interval between SLE and PAH diagnosis <2 years and ≥2 years were 1 and 0 point; SLE Disease Activity Index (SLEDAI) >9, 5-9 and <5 were 2, 1, 0 point, respectively. While the vasculitic subtype seemed to have poorer prognosis in Sun's research, other study has shown controversial result [2]. Objectives: To find out the prognosis of two distinct clinical phenotypes of SLE-PAH.

Methods: Between 2008 and 2019, a SLE-PAH cohort confirmed by right heart catheterization (RHC) from Guangdong Provincial People's Hospital was included. Other groups of pulmonary hypertension were excluded. Based on the scoring system, patients were divided into vasculitic (weighted score≥2) and vasculopathic subtypes (weighted score<2). The endpoint was PAH-related mortality. Survival status were confirmed by clinic follow-up data or phone call.

Results: A total of 53 SLE-PAH patients were enrolled. The cases of vasculitic and vasculopathic subtype were 14 and 39, respectively. Ten endpoint events occurred. Eight attributed to PAH and the cause could not be traced in two which were still included in study. The pooled 1-, 3-, 5-year survival rates were 85.7%, 78.6%, 65.5% in vasculitic subtype, and 93.9%, 87.5%, 87.5% in vasculopathic subtype, respectively. Kaplan-Meier analysis showed vasculitic subtype tended to have a poorer prognosis than vasculopathic (p=0.16, HR 2.4, 95%CI 0.5-13.8, figure 1).

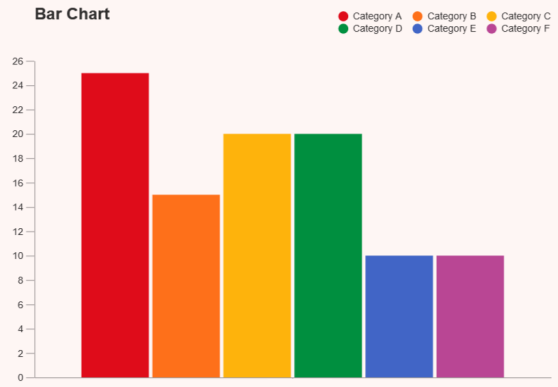

Fig.1: Prepare all figures and abstract

CONCLUSION

If authors can accomplish the writing of the 18 paragraphs of text described in this article, they will produce a manuscript that is properly organized, correct in its essentials, and ready for the finishing hand of a seasoned writer and mentor. The secret of getting ahead is getting started. Attributed to Mark Twain (source unknown). Young investigators often finish the data collection and analysis phases of their projects flush with the enthusiasm of finally arriving at an answer, only to find that enthusiasm dwindle as they make their first attempts to write the manuscript. Indeed, the number of abstracts presented at national meetings far exceeds the number of manuscripts that ultimately are published in the medical literature [1]. Such failure to bring good work to publication stems in part from the confusion and perplexity that besets inexperienced writers as they attempt to begin the process of manuscript preparation.

Create a Timetable

It is commonplace that large jobs should be divided into smaller steps with provisional completion dates. Some psychologists recommend conditioned response strategies (defined workplace, timers) to help bring concerted effort to the defined subtask and to keep you from the temptation (and disillusionment) of viewing the project as one mon- umental and arduous whole. Here is one timetable:

• Session 1: Make notes on the literature, outline template papers

• Session 2: Devise an outline and title for your paper.

• Session 3: Create a rough first draft.

• Sessions 4 and 5: Write revisions one and two.

• Session 6: Write third revision, prepare tables and graphs, then give to coauthors.

• Session 7: Incorporate suggestions from coauthors into the text.

• Session 8: Prepare all figures and abstract.

• Session 9: Proof all changes, check all numbers and units, and review the final product with mentor.

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ANNEX