Structured Abstracts Required for Clinical Trials Published in the *Journal of Investigative Dermatology*

Abstracts are the most-read element of any scientific report (Pitkin and Branagan, 1998), yet they do not always convey the full message revealed in the body of a publication. As an example of this, Hopewell *et al.* (2008) noted that a physician in Africa unwittingly altered an effective perinatal HIV-prevention program to a less effective one solely on the basis of information provided in an abstract. The full text revealed weaknesses, including small sample size and incomplete data, and the results were unlikely to be applicable to a physician's situation; ultimately, the decision to alter practice based entirely on the abstract's conclusions may have resulted in increased perinatal HIV transmission. Although it is unfortunate that this physician did not have access to full reports, the example nevertheless illustrates the potential human cost of misleading abstracts.

Mounting evidence indicates that the quality and completeness of information included in structured abstracts are superior to that of traditional (unstructured) abstracts, at least for clinical studies. Taddio *et al.* (1994) compared the quality of 300 structured and unstructured abstracts published in the *British Medical Journal*, the *Canadian Medical Association Journal*, and the *Journal of the American Medical Association* in the 1980s (nonstructured abstracts) and 1990s (structured abstracts). The overall mean quality scores for nonstructured and structured abstracts were 0.57 and 0.74, respectively ($P < 0.001$). Study purpose, setting, number of dropouts, interventions, study variables, appropriate numeric and statistical values, and conclusions were especially poorly reported in unstructured abstracts. The same study, repeated 10 years later, indicated a sustained improvement in the quality of structured versus unstructured abstracts (Wong *et al.*, 2005). Investigators in smaller specialties have documented similar improvements in abstract quality after instituting structured abstracts (Sharma and Harrison, 2006). Despite initial skepticism about the value of structured abstracts, Dupuy *et al.* (2003) showed that the quality of structured abstracts was considerably higher than that of unstructured abstracts in three dermatology journals published in 2000 and called for structured abstract reporting to be more widely adopted in dermatology journals. It is also worth mentioning that some leading journals use abstracts to make quick decisions on content suitability for submitted manuscripts, so it pays to get the abstract right (Groves and Abbassi, 2004).

JID was an early adopter of clinical trial registration (Williams and Stern, 2005) and adherence to the CONSORT (Consolidated Standards of Reporting Trials) guidelines (Williams and Goldsmith, 2006), and it has established robust editorial procedures to ensure that these reporting standards are followed. In line with good reporting practice, *JID* will now require clinical trial reports to have structured abstracts, beginning with submissions made after January 1, 2011 and guidance on what to include will be added to our Instructions to Authors. There are two good reasons for limiting this requirement to reports of clinical trials. The first is that the work on structured abstracts for basic science is still under development. The second is that the CONSORT group has recently extended its guidance (Table 1) on what should be included in a structured abstract on clinical trials (Hopewell *et al.*, 2008).

Although *JID* does not publish many clinical trials, those that are published are well reported. It is our hope that those who read abstracts of clinical trials published in *JID* will be able to understand exactly what was done to whom and with what outcome.

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Table 1. Items to include when reporting randomized trials in journal or conference abstracts

Item		Description
Title		Identification of the study as randomized
Authors[1]		Contact details for the corresponding author
Trial design		Description of the trial design (e.g., parallel, cluster, noninferiority)
Methods		
	Participants	Eligibility criteria for participants and the settings where the data were collected
	Interventions	Interventions intended for each group
	Objective	Specific objective or hypothesis
	Outcome	Clearly defined primary outcome for this report
	Randomization	How participants were allocated to interventions
	Blinding	Whether participants, caregivers, and those assessing the outcomes (masking) were blinded to group assignment
Results		
	Numbers randomized	Number of participants randomized to each group
	Recruitment	Trial status
	Numbers analyzed	Number of participants analyzed in each group
	Outcome	For the primary outcome, a result for each group and the estimated effect size and its precision
	Harms	Important adverse events or side effects
Conclusions		General interpretation of the results
Trial registration		Registration number and name of trial register
Funding		Source of funding

[1]For conference abstracts.
Reprinted from Hopewell *et al.* (2008) with kind permission from the authors and *The Lancet.*

Further information on good reporting of health research studies may be found at the EQUATOR website (http://www.equator-network.org).

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