



Clinical Epidemiology,
Research Development and
Publication

Choosing the right journal and publishing your article

A practical approach

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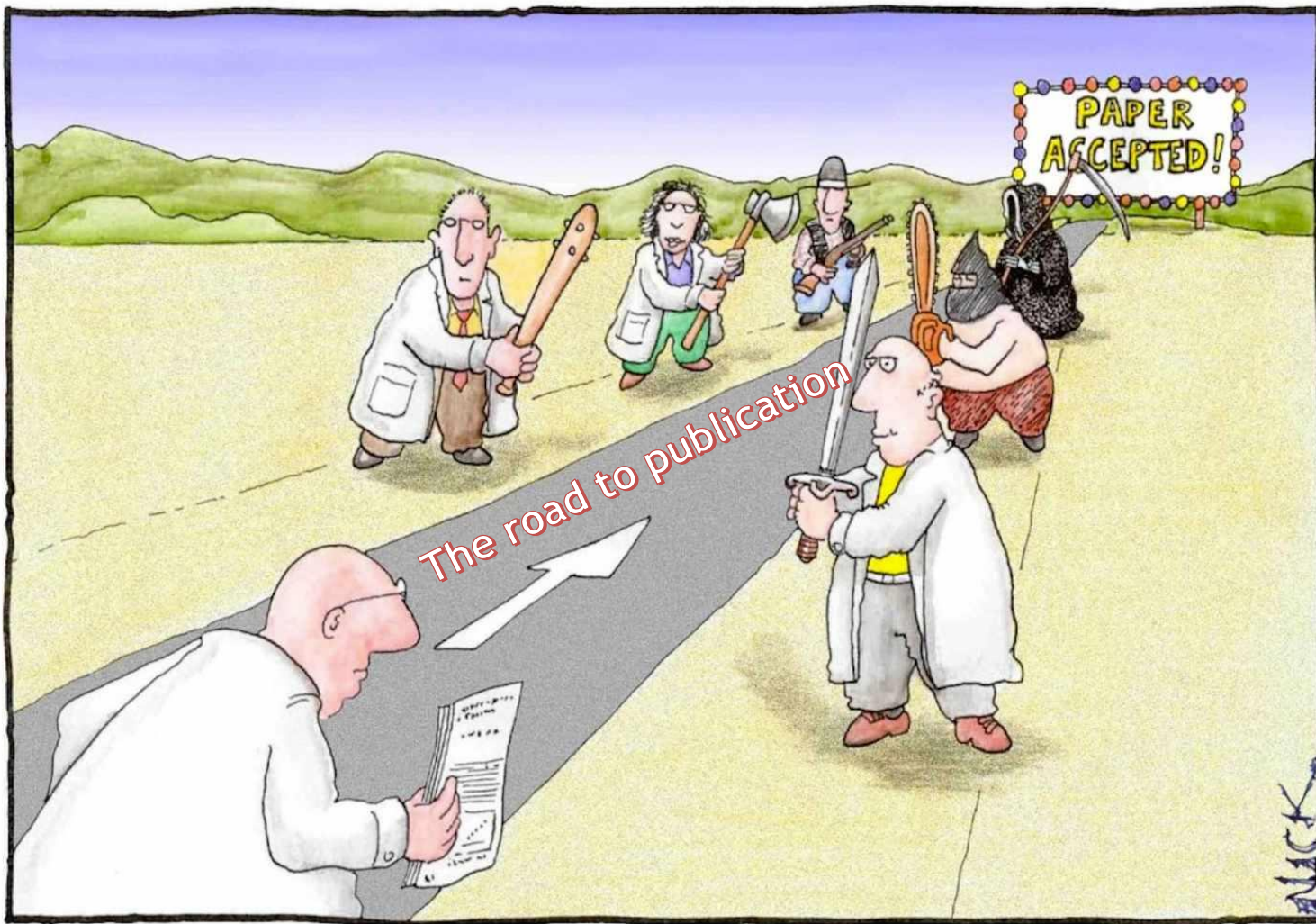
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Outline

- Journal quality and reputation
- Choosing the right journal
- Step-by step for article submission





Field/bench

Data
Analysis:
EUREKA!

Manuscript
writing

Article
Submission

Decision by
reviewer

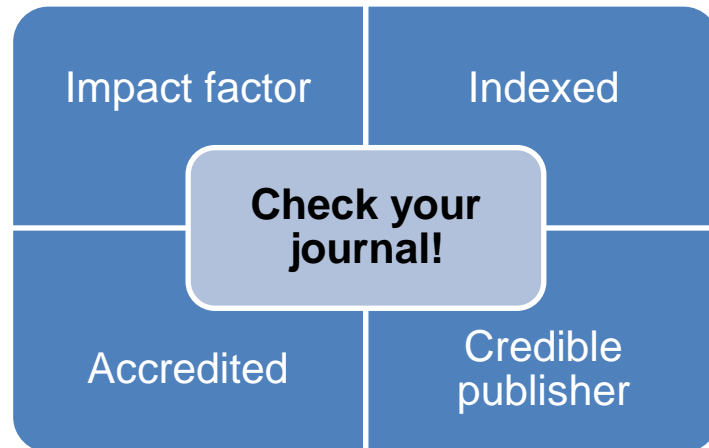
Paper
accepted

PUBLISHED!

Journals: quality and reputation

Journals are of a high academic standard due to being reviewed by academics in the field

-University of Melbourne Library Guide, 2018-



Avoid predatory journals

- Check the website thoroughly
 - Editorial board (recognized experts?)
 - Take a look at their peer review process and publication timelines.
 - Poorly indexed
- Read through past issues of the journal
 - Check editorial quality
- List of predatory journals: Beall's list
<https://predatoryjournals.com/journals/>
<https://beallslist.net>



Predatory journal according to ICJME

- High acceptance rate
- Claim to perform peer review but do not
- Often informing publication fees after your article accepted

How to choose the right journal?

- State your **message** (keywords, audience, type of article)
- Make a **shortlist** of journals in your field
- Aims and **scope**
- **Urgency** to publish (review process, acceptance rate, timeline)
- Journal **metrics** (impact factor, etc)

State your messages

- Keywords
 - e.g. allergy, atopy, children or BCG, vaccination, newborns, etc
- Type of article (Original research or Review; short or full article?)
 - Short communication, Brief report, Letter
 - Full article
 - Review article
 - Other type: dataset, methods, technique paper (e.g. novel surgery technique, etc), study protocol, etc

Make a shortlist

- Ask your peers/ colleagues/ supervisor/
- Check your article reference
- Journal finder:
<https://journalsuggester.springer.com/>
<https://journalfinder.elsevier.com/>

Full article, allergy, schoolchildren, epidemiology,
skin prick test, slgE

Journal	Aims and Scope	Acceptance rate	Impact Factor	Tier (Q1,..)
Journal A
Journal B
etc

How to choose the right journal?

Journal information

Aims and scope

Gut is a leading international journal in gastroenterology and hepatology. *Gut* describes novel mechanisms of disease and reports on the latest research findings from leading authorities.

Scope: match your field

Research of the alimentary tract, the biliary system and hepatology. Regular features include articles on basic science, clinical practice within the foreseeable future by

Editorial Board

For information about *Gut* Editor-in-Chief Professor Emad El-Omar and his editorial team, please refer to the [Editorial Board page](#).

Ownership

Gut is co-owned by the [British Society of Gastroenterology](#) and BMJ.

Journal information

Publication Model	Subscription; with hybrid open access option
Frequency	Monthly
Launch date	1960
Digital Archive	LOCKSS
Indexed by	Web of Science Core Collection: Science Citation Index, Science Citation Index Extended; BIOSIS Previews, Current Contents: Clinical Medicine, Life Sciences; MEDLINE (Index Medicus), PubMed Central (BMJ Open Access Special Collection), Scopus, Embase (Excerpta Medica), CINAHL, Google Scholar
Impact Factor	19.819 (ICR 2019), ranked 3/88 in Gastroenterology & Hepatology
Peer Review Model	Single blind; the names of reviewers are hidden from the author
Print ISSN	0017-5749
Online ISSN	1468-3288

Journal statistics (2019)

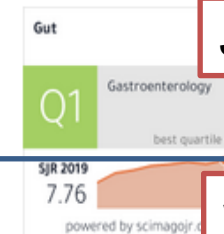
Acceptance rate	14%
Time from submission to first decision	11 days
Time from acceptance to publication	15 days

Urgency to publish:
-acceptance rate
-time to publication

Journal Metrics

Impact Factor	19.819 (2-year impact factor)
	17.751 (5-year impact factor)
	7.469 (immediacy index)
	3/88 (Gastroenterology & Hepatology)
	Q1 ranked (96th percentile)

Scimago Journal Rank



Journal metrics

www.scimagojr.com

Example:

Full article, allergy, schoolchildren, epidemiology, skin prick test, sIgE

Journal	Aims and Scope	Acceptance rate	Impact Factor	Tier (Q1, Q2,...), H-index
JACI (Elsevier)	+++	+	10.228 (#1 in allergy)	Q1, H 279
CEA (Wiley)	+++	+++	4.217 (#9 in allergy)	Q1, H 148
Pediatric Allergy Immunology (Wiley)	++	++	4.699 (#8 in allergy)	Q1, H 85
Pediatrics	+ (too broad)	+	5.417 (#8 in Pediatrics, Perinatology and Child Health)	Q1, H 331
IAAI (Karger)	++	+++	2.917	Q1, H 98

How to choose the right journal?

Step-by-step for submission



Step 1. Finalise content

- Data quality
- Correct analysis
- Clear methods
- Draw the conclusion before writing your manuscript
- Important to note: ethical statement, co-author agreement, authorship

Authorship

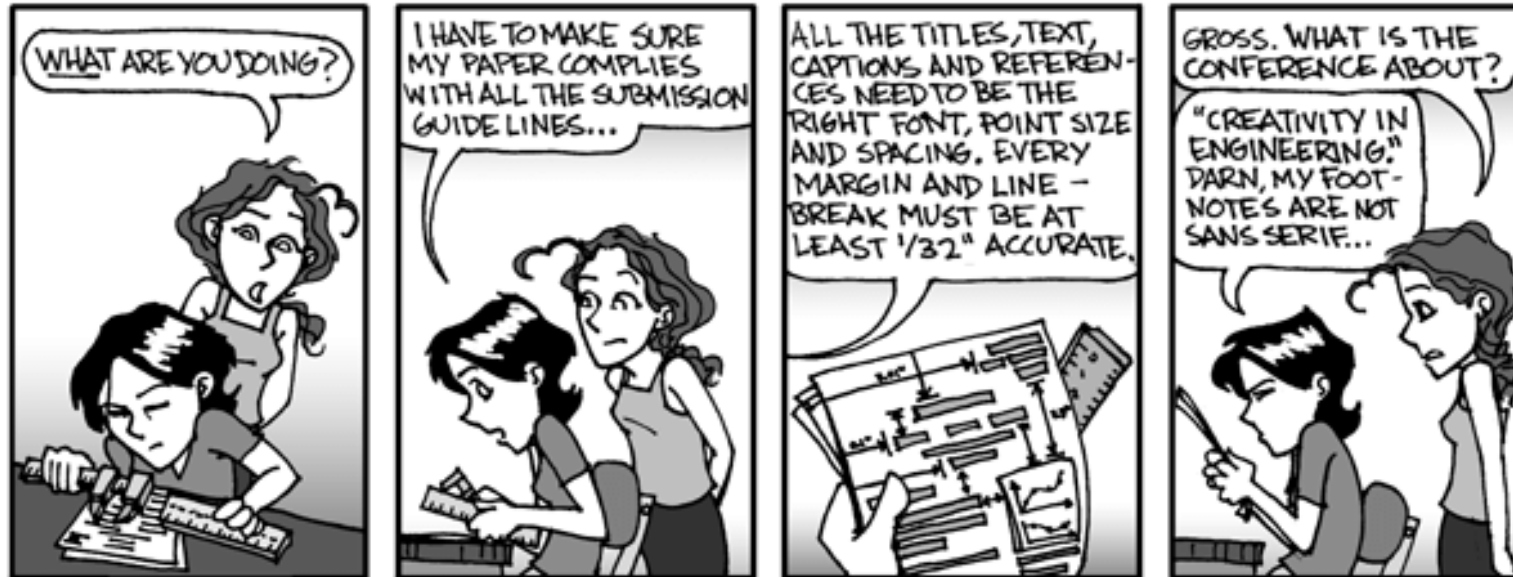
- **Authorship** should be clear before manuscript writing
 - Co-author agreement
 - Most journal ask for a signed authorship statement from each co-authors
- **Joint co-authorship** is possible
 - two or more **authors** who have worked together on a publication and **contributed equally**

Linda J. Wammes^{a,1,2}, Firdaus Hamid^{a,b,1}, Aprilianto Eddy Wiria^{a,c,1}, Linda May^a, Maria M. M. Kaisar^{a,c}, Margaretta A. Prasetyani-Gieseler^c, Yenny Djuardi^c, Heri Wibowo^c, Yvonne C. M. Kruize^a, Jaco J. Verweij^{a,d}, Sanne E. de Jong^a, Roula Tsonaka^e, Jeanine J. Houwing-Duistermaat^{e,f}, Erliyani Sartono^a, Adrian J. F. Luty^{g,3}, Taniawati Supali^c, and Maria Yazdanbakhsh^{a,4}

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Step 2. Check author guidelines



- Word limits, illustration limits, total references, etc
- Check and re-check; be thorough

Manuscript Format

Submission

Please read these instructions carefully and follow them closely to ensure that the review and publication of your paper is as efficient and quick as possible. The Editors reserve the right to return manuscripts that are not in accordance with these instructions.

All material to be considered for publication in *The Journal of Infectious Diseases* (JID) should be submitted in electronic form via the journal's online submission system. Once you have prepared your manuscript according to the instructions below, instructions on how to submit your manuscript online can be found by clicking on our [Submission Online page](#).

Note: PDF only submissions are not accepted, manuscripts should be in Microsoft Word, LaTeX, WordPerfect or Rich Text Format

Manuscript Format and Structure

Your manuscript will be returned if you do not do the following:

1. Specify the type of article and adhere to the following limits:

Major Article: 3500 words, 50 references, 7 inserts (tables and figures, with no more than 4 panels per figure) in print, and no more than 25 MB of online-only supplementary data.

Brief Report: 2000 words, 15 references, 2 inserts (with no more than 4 panels per figure) in print, and no more than 25 MB of online-only supplementary data.

2. Include a cover letter with the following information:

A statement that the manuscript has not been submitted or accepted elsewhere

A statement that all authors fulfill the criteria given in the Authorship paragraph (see



Latest Most Read Most Cited

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Bronchitis in Scotland, 2001–2016: A
National Retrospective Observational
Study

Respiratory Syncytial Virus Consortium
in Europe (RESCUE) Birth Cohort Study:
Defining the Burden of Infant
Respiratory Syncytial Virus Disease in
Europe

Unveiling the Risk Period for Death After
Respiratory Syncytial Virus Illness in
Young Children Using a Self-Controlled
Case Series Design

Presumed Risk Factors and Biomarkers
for Severe Respiratory Syncytial Virus
Disease and Related Sequelae: Protocol
for an Observational Multicenter, Case-
Control Study From the Respiratory

Anatomy of the manuscript:

- **Abstract/ Summary**, (200-300 words), keywords
- **Introduction** (background, gap in the knowledge, novelty)
- **Methods**, (recipe, detail, statistical approach)
- **Results**, (incl. tables and figures)
- **Discussion**, (interpretation, compare with previous study, limitation & strength, future direction)
- **Conclusions**
- **Disclosures**, (conflicts of interest, funding)

I M R a D



Step-by-step for submission

Abstract

- Summary of article
- 200-300 words
- Keywords (5-7 words)
- Check author guidelines

Allergic disorders and socio-economic status: a study of schoolchildren in an urban area of Makassar, Indonesia

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Summary

Background In urban centres of developing countries, there is great variation in socio-economic status (SES) and lifestyle; however, little information is available on allergic disorders in groups with high- or low-SES within the same urban area.

Objective To determine the prevalence of allergic disorders and investigate risk factors related to them among high- and low-SES schoolchildren in Makassar, the capital city of South Sulawesi, Indonesia.

Method This cross-sectional study was performed in 623 children originating from high- ($N = 349$) and low-SES ($N = 274$) schools. Information on reported allergic symptoms and potential factors associated with allergic disorders was obtained by questionnaire. Specific IgE and skin prick test (SPT) reactivity were determined against aeroallergens (*Derмато-phagoides pteronyssinus* (HDM) and cockroach). Total IgE and helminth infections were also assessed.

Result The prevalence of SPT to any aeroallergens was significantly higher in high-SES than in low-SES school (25% vs. 8%, $P < 0.001$, respectively). However, specific IgE against cockroach and total IgE were significantly lower in high- than in low-SES children. Allergic symptoms were reported more often in low- compared to high-SES children. Specific IgE to aeroallergens significantly increased the risk of SPT positivity to the same aeroallergen in the high-, but not in the low-SES children. In the high- but not in low-SES, there was a significant positive association between SPT to HDM and wheeze. Similarly, cockroach skin reactivity and elevated BMI increased the risk of eczema in the high-SES children only.

Conclusion and Clinical Relevance Skin prick test is higher in high-SES, whereas IgE and allergic symptoms are higher in low-SES children. Specific IgE is a risk factor for being SPT-positive, and SPT positivity is a risk factor for allergic symptoms but only in children of high- and not low-SES school. Therefore, the socio-economic status of a child might affect the diagnosis of allergic disease in a developing country.

Keywords allergy, atopy, helminths, IgE, risk factors, socio-economic status

Submitted 4 August 2014; revised 6 January 2015; accepted 3 February 2015

Introduction



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Introduction

It has long been known that allergic diseases cluster within families, and this is likely to be due to genetic predisposition. However, environmental factors may modulate expression of allergic disorders. A higher prevalence of allergies in developed countries compared to developing ones [1], and

in the world [1]. However, this study was conducted in only one centre in Java. A study which was conducted in 10 centres in India reported a large variation in the prevalence of asthma in the different centres (ranging from 3% to 17%), indicating that the information on allergic disorders in Indonesia reported by the published ISAAC study may not be representative of the whole country.

Several factors related to western lifestyle such as increase in exposure to outdoor pollutants [10], increased indoor allergen load [11], altered diet [12, 13] and changes in exposure to infection/microbial products [14, 15] have been hypothesized to explain the increase in allergic disorders. Socio-economic status (SES) also can affect allergic disorders, as studied in affluent countries [16–18]. However, there are not many studies addressing the pattern of allergic disorders within an urban centre in a developing country where large differences in SES and lifestyle are seen.

To investigate this, we initiated a study in two schools with different socio-economic backgrounds (high- and low-SES school) in an urban area of Makassar, South Sulawesi, to measure the prevalence of atopy and reported clinical allergy. Data on several factors such as parental education, parental occupation, the presence of smokers in house, pets in house, nutritional status and helminth infections were collected to determine how these factors influence the allergic phenotype.

What was already known

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Gap in the knowledge

Methods and Results

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(ref:0147/H4.8.4.5.31/PP36-KOMETIK/2005). In total, 274 children from the low-SES and 349 from high-SES were included in the study.

Questionnaire

Reported clinical symptoms of allergy were obtained by questionnaire. Clinical symptoms of asthma, allergic rhinitis and atopic dermatitis (eczema) in the previous 12 months were assessed using a modified ISAAC questionnaire (Questionnaire 1–3, Data S1), which had been translated into Bahasa Indonesia. Children were identified to have asthma symptoms (wheeze) if wheezing was reported in the past 12 months by parents or

Methods divided into several section:

- study design,
- procedure details (e.g: questionnaires, SPT, sIgE, etc)
- Statistical analysis

Method

Study area and design

The study was conducted in two elementary schools in Makassar, the capital city of South Sulawesi, Indonesia. Data were collected between October and December 2005. One school was attended by children from families with low-SES (SD Cambaya), and was located at the periphery of the city, near a port. The children from this school lived in the surrounding area and came from families with low education level who mostly worked as fishermen, menial labourers, or some that were skilled, but working in low-ranking jobs. The high-SES school (SD Mangkura) was located in the city centre, about 7 km from the low-SES school. The houses of these children were spread in different parts of the city and had good sanitary facilities. The children went to school by private vehicles or by a school bus.

A month prior to the start of the study, the parents of children in both schools from third to sixth grades were sent a letter informing them of the study and asking them to sign a letter if they agreed for their child to participate in the study. Only children who returned the signed letters were included in the study. The study was approved by the ethical committees of Faculty of Medicine, Hasanuddin University, Makassar, Indonesia

Skin prick testing

Skin prick test (SPT) was performed if children were free from antihistamine, anti-asthmatic or corticosteroid drugs for at least 7 days prior to the testing. SPT reactivity to aeroallergens was tested with extract of *Dermatophagoides pteronyssinus* [house dust mite (HDM); HAL Allergy BV, Leiden, the Netherlands] and *Blattella germanica* (cockroach; Lofarma, Milan, Italy). Histamine chloride (10 mg/mL) was used as the positive control and allergen diluents as the negative control. SPT was carried out on the volar side of the child's lower arm, using separate skin prick test. The results for each child were measured after 15 min. Skin prick reactivity was determined to be positive if the longest diameter plus the diameter perpendicular of weal size divided by two was at least 3 mm. Body height and weight were also measured.

Specific and total IgE

Serum level of mite- and cockroach-IgE was determined by radio allergosorbent test (RAST) as described previously [19]. Briefly, 50 μ L serum was incubated



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overnight with 1.5 mg of Sepharose-coupled allergen in a final volume of 300 μ L PBS, 3% BSA, 0.1% Tween-20. After washing away non-bound serum components, radiolabelled sheep antibodies (Sanguin, Amsterdam, the Netherlands) directed to human IgE were added. After overnight incubation and washing, bound radioactivity was measured. The outcomes were expressed as % binding.

Result

Characteristics of study participants

Among 917 children invited to the study, 71 (7.7%) refusals came from high-SES whereas 223 (24.3%) were from low-SES (Fig. S1). One of the reasons could have

Results: also divided into several section

- First section: characteristics of study population
- Second section, third section, etc
- Last section: usually main finding
- Chronologically ordered
- Structured and logic

Ascaris lumbricoides, *Trichuris trichiura* and hookworm were quantified using the Kato-Katz methods [22].

Statistical analysis

The collected data were analysed using IBM Statistical Package for Social Sciences (IBM SPSS Statistics for Windows; IBM Corp., Armonk, New York, USA) version 20. We investigated potential factors for allergic disorders separately for each school. Age-standardized z-scores of body mass index (z-BMI) were calculated according to WHO reference values [23]. Descriptive data were expressed as means (\pm standard deviations), frequency (percentage of collected data) and geometric means [95% confidence intervals (CI)]. Prevalence rates were calculated and compared for different schools using Pearson's chi-square tests, while comparisons of continuous data were analysed by using Student's *t*-tests. Specific IgE (s-IgE) and total IgE were normalized by log-transformation to obtain normally distributed data. Logistic regression was used to analyse the associations between the potential factors and development of SPT and reported clinical symptoms of allergy in the past 12 months. Linear regression was used for analysis of continuous outcomes which provided estimated regression coefficients (β) and their corresponding 95% CI. In multivariate analysis, we included age and sex as *a priori* confounders, as well as other variables that were significant in univariate analyses. All statistical tests were considered significant at $P < 0.05$.

infected with at least one species of helminth compared to 22% in high-SES school (Table 1). The most common helminth infections were *T. trichiura* (87% in low-SES and 19% in high-SES) and *A. lumbricoides* (low-SES: 77%, high-SES: 6%). The prevalence of hookworm infection was very low (9 of 611, 1.5%); therefore, hookworm infection was excluded from further analysis.

Prevalence of reported symptoms, skin prick test and IgE

The prevalence of reported wheeze in the previous 12 months was lower in the high-SES (7.5%) compared to the low-SES school (12.9%) as were the prevalence of reported symptoms of eczema (9.9% in high-SES school and 18.2% in low-SES school) and allergic rhinitis (26.6% vs. 41.3%, $P = 0.001$, respectively) in the past 12 months (Table 1).

For analysis of skin reactivity to aeroallergens, we included only children with a positive skin test (≥ 3 mm) to histamine (Table 1). There were no differences in age and sex distribution between histamine-negative population ($N = 133$ in high-SES and $N = 77$ in low-SES) and histamine-positive population (high-SES: 216 children, high-SES: 197 children). The prevalence of SPT was higher in the high-SES school compared to low-SES school; any aeroallergen (25% vs. 8.1%, $P < 0.001$, respectively), HDM (15.7% vs. 3%, $P < 0.001$, respectively) and cockroach (16.2% vs. 6.1%, $P = 0.001$, respectively). In contrast, the levels of sIgE to cockroach as well as total IgE were significantly lower in the high-SES than



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compared to the low-SES school. Conversely, the prevalence of reported allergic symptoms, IgE to cat as well as total IgE were higher in low-SES compared to high-SES school children. In the high-SES school, high sIgE to aeroallergens increased the risk of reactivity to the same aeroallergens, and moreover reactivity to HDM increased the risk of reported asthma. In contrast to the findings among the high-SES children, in the low-SES school, sIgE did not significantly increase the risk of being SPT-positive and SPT was not

paragraph, 1 main idea
your finding
compare with previous studies
is not the case.
Most studies on the association between BMI and

allergic disorders in children are in high-income countries [24–26] while little is known on this association

Between paragraph
linking back and linking forward

toach sensitization while a similar trend for association between eczema and BMI has been reported by Yao et al. [27].

The fact that the prevalence of wheeze, allergic rhinitis and atopic eczema symptoms was lower in high-SES school children was opposite to the finding from a previous study conducted in children attending 30 schools in socio-economically diverse areas of Cape Town, South Africa, which reported that the prevalence of asthma, recent wheeze and allergic rhinitis increased from lowest to highest SES [28, 29]. One of the possi-

to consider is that certain viral infections, which may be associated with allergy-like symptoms and difficult to differentiate from real allergy by parents, were more prevalent in the low-SES children of the current study [30, 31].

High parental education and occupation, which are part of the indicators of high-SES, have been reported to be associated with atopy [32, 33]. Here, we found no association between skin prick test reactivity or report clinical symptoms of allergy and parental education nor with parental occupation, most likely due to homogeneity of these variables in each of high- and low-SES schools in our setting.

We could not find any association between allergic outcome measured and exposure to tobacco smoke or

This study has investigated allergic disorders in high- and low-SES school children living in the same urban centre of a developing country, namely Makassar, Indonesia. We observed the prevalence of skin prick test reactivity to aeroallergen was higher in high-SES

analysis of data from high-SES school.

- **Last p**

- **Emph**
- **Make**
- **“further**

of this study is the relatively large number examined that lived in the same area.

Strength and limitation

the real cases of allergic diseases. The main of our current study was that the parasite rate particularly in low-SES was lower in the SES school, probably due to illiteracy but data on this. In addition, in the low-SES members of children with positive SPT were therefore our studies of associations involving it be underpowered. Confounding factors in the study were limited; therefore, it is possible that an important potential confounding factor, the presence of helminth infection was determined.

mined by single Kato-Katz, which might miss light infections.

In conclusion, there are large differences between children from high- and low-SES schools in an urban

- **Last paragraph: Conclusion**
- **Emphasize** your finding
- Make a **call to action**: e.g. "further research is needed..."

Acknowledgements

This study was funded by the European Commission (Glofal, FP6-2003-FOOD-2-B). FH has received an EA-ACI (the European Academy of Allergy and Clinical Immunology) Exchange Research Fellowship 2012 and a scholarship from the Directorate General of Higher Education (DIKTI) 2013 of the Ministry of Education Culture of the Republic of Indonesia. The authors thank Paul van Rijn at HAL Allergy BV (Leiden, the Netherlands) for providing SPT reagents for the study. We also thank Christine and Hasni for their laboratory assistance. This study would not been possible without enthusiastic cooperation of children, their parents and teachers.

Conflict of interest

The authors declare no conflict of interest.

overestimate the real cases of allergic diseases. The other limitation of our current study was that the participant response rate particularly in low-SES was lower than in high-SES school, probably due to illiteracy but we have no data on this. In addition, in the low-SES school, the numbers of children with positive SPT were lower and therefore our studies of associations involving SPT might be underpowered. Confounding factors included in the study were limited; therefore, it is possible that we missed important potential confounding factors. The presence of helminth infection was deter-

levels of sIgE to cockroach (adjusted $\beta = 0.22$; $P = 0.011$) as well as total IgE (adjusted $\beta = 0.23$; $P = 0.022$).

The fact that the prevalence of wheeze, allergic rhinitis and atopic eczema symptoms was lower in high-SES school children was opposite to the finding from a previous study conducted in children attending 30 schools in socio-economically diverse areas of Cape Town, South Africa, which reported that the prevalence of asthma, recent wheeze and allergic rhinitis increased from lowest to highest SES [28, 29]. One of the possibilities to consider is that certain viral infections, which have been associated with allergy-like symptoms and may be difficult to differentiate from real allergy by parents, are more prevalent in the low-SES children of the current study [30, 31].

- Follow author guidelines
- Use reference manager (EndNote, Mendeley, etc)

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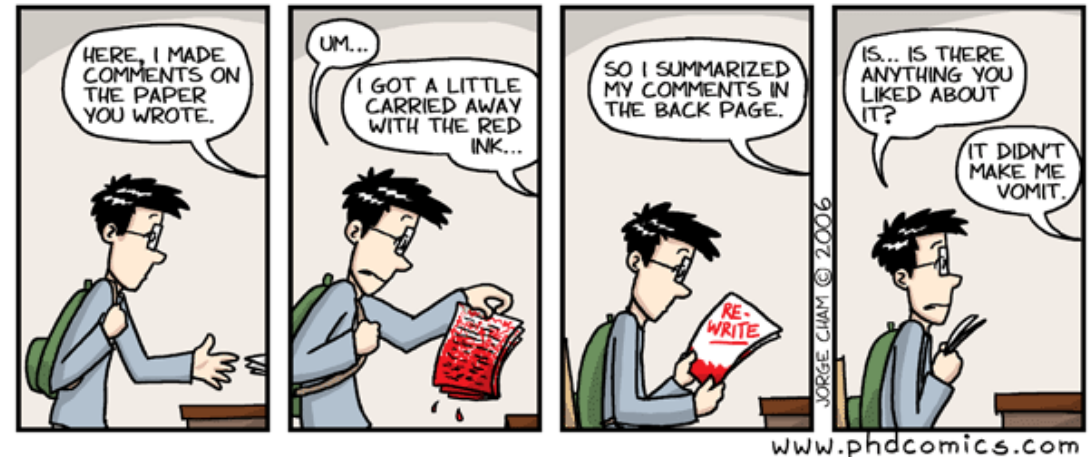
Step 3. Write the manuscript

1. Prepare the illustrations (figures and tables).
2. Write the **Methods**.
3. Write up the **Results**.
4. Write the **Discussion**.
5. Write a clear **Conclusion**.
6. Write a compelling **Introduction**.
7. Write the **Abstract**.
8. Compose a concise and descriptive **Title**

Step 4. Write, re-write, polish

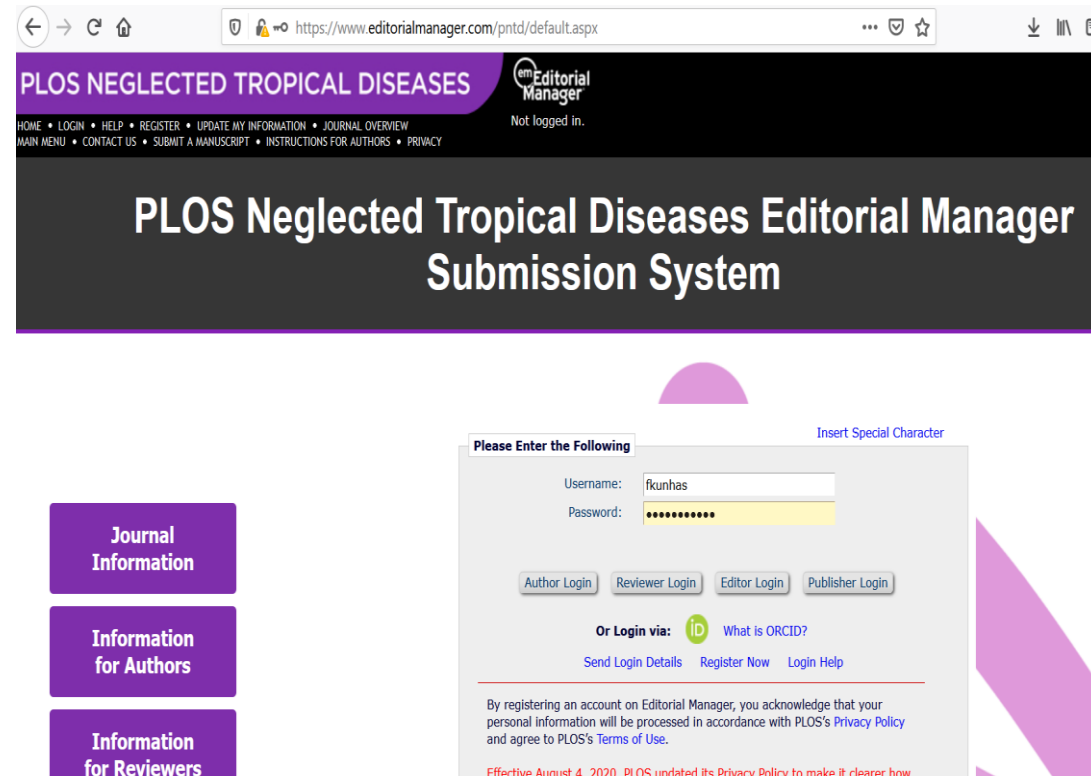
Good writing comes from rewriting

- Write first, edit later
- Re-write then polish
- Proof-read and revise (a lot)
- Involve co-authors



Step 5. Submit

- Prepare all documents needed
- Register: online submission system
- Check APC/ OA fees
- Double submit: **not allowed!**



The screenshot shows the login page for the PLOS Neglected Tropical Diseases Editorial Manager Submission System. The browser address bar shows the URL: <https://www.editorialmanager.com/pntd/default.aspx>. The page header includes the PLOS logo and the text "PLOS NEGLECTED TROPICAL DISEASES". Below the header, there is a navigation menu with links: HOME, LOGIN, HELP, REGISTER, UPDATE MY INFORMATION, JOURNAL OVERVIEW, MAIN MENU, CONTACT US, SUBMIT A MANUSCRIPT, INSTRUCTIONS FOR AUTHORS, and PRIVACY. The main heading reads "PLOS Neglected Tropical Diseases Editorial Manager Submission System". On the left side, there are three purple buttons: "Journal Information", "Information for Authors", and "Information for Reviewers". The login form on the right is titled "Please Enter the Following" and contains fields for "Username:" (with the value "fkunhas") and "Password:" (masked with dots). Below the password field, there are four buttons: "Author Login", "Reviewer Login", "Editor Login", and "Publisher Login". A section titled "Or Login via:" includes an ORCID icon and a link "What is ORCID?". Below this, there are links for "Send Login Details", "Register Now", and "Login Help". At the bottom, a disclaimer states: "By registering an account on Editorial Manager, you acknowledge that your personal information will be processed in accordance with PLOS's Privacy Policy and agree to PLOS's Terms of Use." A note at the very bottom indicates: "Effective August 4, 2020, PLOS updated its Privacy Policy to make it clearer how".

Final draft before submission



Clinical Epidemiology,
Research Development and
Publication

1 BCG scar, socioeconomic and nutritional status: a study of new-borns in urban area of
2 Makassar, Indonesia

3 Running head : BCG scar size in high and low SES infants

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Font type, size, etc

20 Abstract

21 Objective. To investigate factors that determine the response to BCG vaccination in urban
22 environments with respect to socioeconomic status (SES), prenatal exposure to infections or
23 new-born's nutritional status.

24 Methods. The study was conducted in an urban area, in Makassar, Indonesia. At baseline,
25 100 mother and new-borns pair from high and low SES communities were included.
26 Intestinal protozoa, soil transmitted helminths, total IgE, anti-Hepatitis A Virus IgG and anti-
27 Toxoplasma IgG were measured to determine exposure to infections. Information on
28 gestational age, birth weight/ height, and delivery status were collected. Weight-for-length
29 z-score, a proxy for new-borns adiposity, was calculated. Leptin and adiponectin from cord
30 sera were also measured. At 10 months of age, BCG scar size was measured from 59
31 infants. Statistical modelling was performed using multiple linear regression.

32 Results. Both SES and birth nutritional status shape the response towards BCG vaccination
33 at 10 months of age. Infants born to low SES families have smaller BCG scar size compared
34 to infants born from high SES families and total IgE contributed to the reduced scar size. On
35 the other hand, infants born with better nutritional status were found to have bigger BCG
36 scar size but this association was abolished by leptin levels at birth.

37 Conclusion. This study provides new insights into the importance of SES and leptin levels at
38 birth on the development of BCG scar in 10 months old infants.

39 Keywords : BCG scar, socioeconomic status, leptin, new-borns

40

Line numbers

41 Introduction

42 Tuberculosis (TB) is known as one of the top 10 diseases causing high mortality worldwide.
43 In 2017, with 391 new cases per 100,000 population, Indonesia was among the top 3
44 countries with absolute numbers of incident TB cases (1).

45 Bacille Calmette-Guérin (BCG) is a live attenuated *Mycobacterium bovis* vaccine. It is the
46 only available vaccine used to protect against TB disease, in particular meningitis and
47 disseminated TB in children (2). BCG is one of the most widely used vaccines worldwide. In
48 Indonesia, BCG vaccination is included in the Indonesian national immunization program
49 and it is given to new-borns at the age of 4-6 weeks. Beside its protective effects against TB,
50 BCG vaccination also has effects on the immune system and morbidity
51 during childhood (3-5). BCG is a type 1 response

52 irrespective of when in life it is given (6). Studies have shown that reactions at the site of the
53 BCG vaccination are associated with the production of Interferon gamma in response to the
54 mycobacterial antigens. BCG scarification has been mentioned as a marker to a better
55 survival and stronger immune response among BCG-vaccinated children living in countries
56 with higher mortality rates (7, 8).

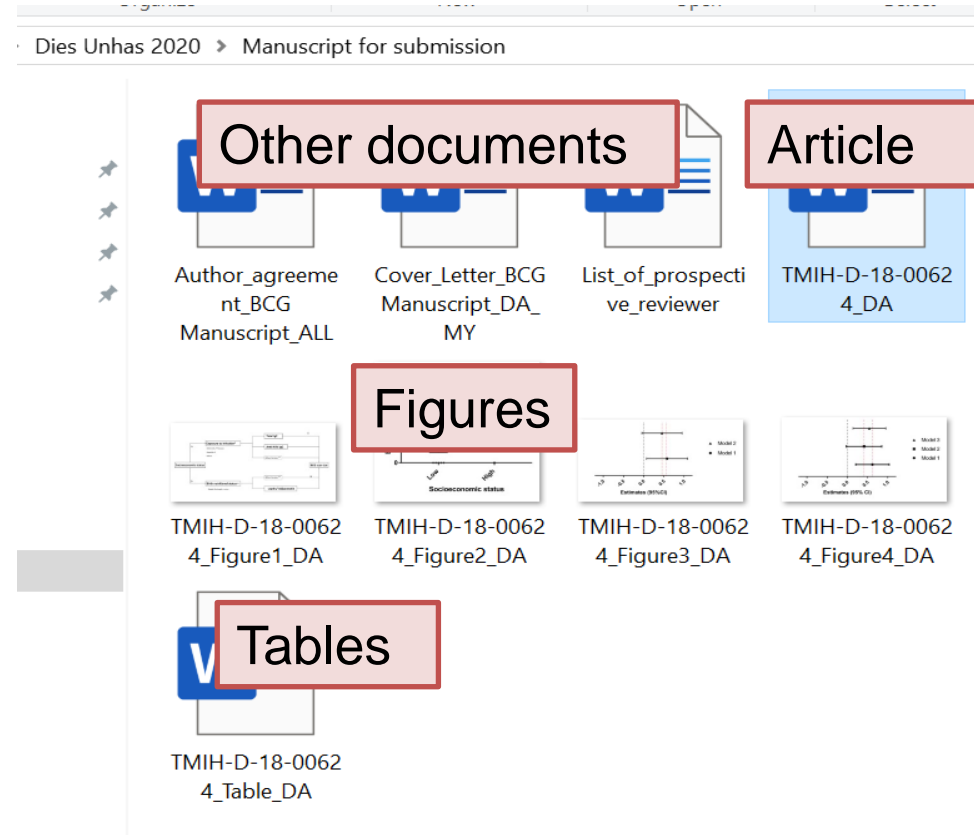
57 Immune responses to vaccines are associated with multiple factors such as economic status,
58 parasite infestation and nutrition. Nutritional status at birth reflects new-borns adiposity
59 and this might affect BCG vaccine response in these babies (9, 10). Adipocytes influence not
60 only the endocrine system but also the immune response through several cytokine-like
61 mediators known as adipokines, which include leptin and adiponectin (11, 12). Adiponectin
62 and leptin are considered the most important hormones related to adipose depots in
63 modulating metabolism and energy homeostasis. It is thought that leptin can directly link

Line spacing

Prepare all documents needed

Check submission guidelines

- Article rules
- References (use ref manager)
- Cover letter
- List of reviewer
- Author agreement
- Illustrations rules
- Other documents



Step 6. Decision Process



Desk Rejected:

- Check editor comments
- Send rebuttal/ appeal letter
- If you accept their decision:
 - Check your “journal shortlist”
 - Adjust your manuscript and other documents accordingly
 - Submit (#2)

Important to Note

Manuscript: scientific storytelling

Check and re-check:

- Originality (check with Turnitin, iThenticate, etc)
- Novelty (filling the gap?)
- Within scope of the journal
- Technicality: clear methods/ defective procedure?
- Grammar, too strong/weak statement?
- Structure, logic arguments

Take home messages

- Make a **shortlist of journal** in your field/scope of study
- Choose **credible**, good **quality** and **reputable** journal and **avoid predatory** journal
- Step 1: **Finalise content**, conclude before writing process begin
- Step 2-3: Check **author guidelines**
- Step 4: Starts write **Methods**, then **Results**, **Discussion**, **Introduction**, lastly **Abstract** and a descriptive yet concise **Title**
- Step 5: Prepare all **documents** needed (cover letter, authorship approval, manuscript, etc); follow the guidelines. **SUBMIT!**
- Step 6. Be **patient** (decision process)

Further reading

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