glucose tolerance test (IVGTT) in man has been the target of an awesome amount of research over the past 30 years and more recently has come back into sharp focus due to possibilities that this maneuver, or some variant thereof, may be an important predictor of B-cell failure associated with Type 1 (insulin-dependent) diabetes.

Just as beauty is in the mind of the beholder, high variability (a difficult statistical concept and a more difficult one to quantify) may also be in the mind of the beholder. Many data sets when viewed by one investigator may be thought to be highly variable, whereas another group may construe the same data set as being quite reproducible.

The study by Smith and colleagues focussed upon an important statistical aspect; however, there are some components of that study that deserve careful examination. As biological functions are usually anticipated to be variable, studies performed on eight subjects may be insufficient in number to derive meaningful conclusions. Earlier [3] we had attempted to quantify variability with 42 normal control subjects and 36 study subjects. We felt uncomfortable at such low numbers of subjects at that time.

With such a limited number ($n=8$) of subjects and without any background studies of single IVGTT that the laboratory might have performed in a larger group of healthy control subjects, it is uncertain whether the eight subjects selected represent sampling that is typical of the normal distribution, or whether they cluster toward the high or low end. Magnitude effects upon the variability might therefore be an important consideration which is masked in the design of this current study.

Although we are grateful that one of our previous studies on this subject was cited [4], a survey of six of our other publications (see 5, a review) may have allowed for the development of a different posture. We have examined early phase insulin responses after IVGTT in various high risk groups defining the high risk as not only a strong hereditary tendency to Type 1 diabetes (monozygotic twin or first degree relative) but have also insisted upon the presence in serum of some autoimmune abnormality such as the presence of islet cell autoantibodies. Using these subjects for IVGTT studies, it has been demonstrated that as a group, the early phase insulin response is significantly reduced when compared to a global normal population [6]. In addition, repeated assessments of early phase insulin response to glucose in such subjects shows either a tendency to be reproducible (i.e. to show on repeat testing an impaired insulin response similar to the impairment of the initial one) or an early phase insulin response that is reduced even further [4]. One might construe that "poor reproducibility" with variability equally positive and negative of a large magnitude might be a sign of "normality" whereas "good reproducibility" or "poor reproducibility but with a chronic negative bias" may be the hallmark of "non-normality".

Smith and colleagues state that the IVGTT capability of discriminating normal from abnormal results is largely dependent on the degree of between- and within-subject variation. Firstly, it is doubtful, even if this is true, that this could be established in studies focussed on eight healthy subjects. Secondly, when IVGTT-induced early-phase insulin release is equal or less than the fifth percentile of that established in normal control subjects (hundreds of them), as we found in 17 of 28 (61%) high risk subjects on their initial test [7] and in 12 of 14 such individuals on repeat testing, then reproducibility per se appears to not be a relevent component of the assessment.

As more data is presented and published from a large number of laboratories, a reduced and fixed or consistently falling early-phase insulin release (1) in a subject with an appropriate genetic connection (2) to Type 1 diabetes and an autoimmune defect (3) consistent with Type 1 diabetes mellitus may be the key and critical marker that will serve not only to predict the onset of Type 1 diabetes but also, on the other hand, in immunosuppresive trials, to be the ultimate measure of the degree of success. I doubt that the biological variability of this exhibit of insulin release will cloud these issues.

Yours sincerely,
J.S. Soeldner

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How do I get that abstract accepted?

Dear Sir,

Since the very start of our EASD meetings, the number of submitted abstracts has increased steadily. Even this year, facing competition with the IDF meeting in Australia, the Programme Committee received more than 1000 abstracts for evaluation.

For the undersigned, it is the end of a 5-year tenure, the first two years as a member and the following three years as chairman of the Programme Committee. Each year, the end of March has been characterised by an increased weight of the envelopes arriving from Jim Jackson at the EASD Secretariat. More importantly, 1988 also marks the 5th anniversary of the Programme Committee evaluating the abstracts anonymously, i.e., without knowing who submitted the study. This is a remarkable procedure, and I have often been asked how a committee of five people is able to give a fair judgment of the quality of work and suitability for presentation when given over 1000 abstracts to read in a few weeks' time. The task would perhaps have been easier if the number of papers accepted for presentation had increased in direct proportion to the increasing number of abstracts submitted. However, this has not been the case. The number of papers to be presented has remained constant, at about 500-600, depending on the number of posters which the local organisers have been able to fit into the area designated for posters. As you all remember, the poster area may be spacious, as in Rome, or zig-zag cramped, as in Leipzig. Therefore, unless the EASD Council and the General Assembly decide to add an extra day or two (God forbid!) to our meeting, the number of presentations will remain constant. So, if the number of abstracts submitted continues to grow, *how do you get your work accepted for presentation?*

As the outgoing chairman of the Progarmme Committee, I would like to offer some advice for future submissions. There is no guarantee that it will work, since who knows what the new Honorary Secretary will come up with to change the procedure in selecting abstracts.

During the past 3 years, I have had the pleasure to work with eleven eminent diabetologists from 7 different European countries.

The following instructions were given to these Programme Committee members:

1. Score each abstract on a scale from 1 to 5. Superb papers to be presented, e.g. at a plenary session, are given a 1. Outstanding contributions absolutely to be presented are 2. Good abstracts are 3, abstracts to be presented only if there is room are 4, and those not suitable for presentation are 5.
2. Solicit help from colleagues to score the abstracts, but take responsibility for the final score, since the abstract may be discussed at the meeting of the Programme Committee.
3. Complete your scoring at least 5 days before the meeting of the Programme Committee in order to have all mean values computed at the start of the meeting. In this way, no one could be influenced by the scores of the other members.
4. Don't waste time trying to find out who the authors are. Contrary to the belief of many EASD members, names of authors are not discussed at the Programme Committee meetings and identities are not disclosed until the entire programme has been finalised.

So how do you get a good score from each one of the members of the Programme Committee?

During the last 3 years, the vote has been very close. The average vote on the entire lot of around 1000 abstracts has followed a gaussian distribution. Less than 2% of the abstracts have been given 1 and 5 at the same time. Five abstracts, added twice (the authors did, in fact, send the same abstract twice), received average scores that were not statistically different.

The following advice is given:

1. Make sure that you do not exceed the 200-word limit. A committee member pressed for time to read more than 1000 abstracts develops an immaculate sensitivity for numbers of words.
2. Clearly state the hypothesis or the purpose of the study. Do you ask a specific question or what is your message?
3. Keep methods to a minimum. Do not use jargon or take for granted that the Programme Committee members are able to grasp a telegraphic and overloaded text. If different types of diabetic patients have been studied, explain why you investigated a heterogenous group of patients. Always give duration of diabetes. In general, cross-sectional studies are less enthusiastically received than prospective investigations.
4. Describe your controls carefully. Papers on diabetes education have been particularly vulnerable in this respect.
5. Give numbers and show the results of your statistical analysis. Leave out numbers and p-values when there was no difference between tests and controls. There is no correlation between high acceptance rate and the number of different measurements or parameters studied.
6. Avoid statements that indicate major effects without showing the data. Although attractive to read, these abstracts usually receive low scores. In the old days, Dr. Famous usually could get by with sweeping statements, but this is no longer true when the name of the author is not known.
7. Make a firm and clear conclusion based on the data given. Leave out speculations. Did you answer the question posed in the introduction or not? Did you prove or disprove your hypothesis?
8. Abstracts with statements such as "further data will be presented at the meeting", "the results will be discussed", or "additional patients will be studied before the meeting" usually do not fare well with Programme Committee members.
9. Programme Committee members have been found to be sensitive to "work cut-ups", i.e., studies divided into several smaller abstracts. Most of them are spotted *despite* the extra burden laid on the EASD Secretariat to shuffle the abstracts to prevent that abstracts typed on the same typewriter appear in sequence on the desks of the Programme Committee members.
10. Laboratories sending more than 4 or 5 abstracts may wish to use different typewriters, typewriter heads, or word processor fonts.

Review of manuscripts without knowing the authors has yet to be developed for scientific journals. However, I am a firm believer in this system in the selection of abstracts for presentation at meetings. Since all Programme Committee members have to read all abstracts, it forces every author to write the paper in such a way that it can be understood by any diabetologist. I hope this system, introduced by my prodecessor, George Alberti, is here to stay and will continue to be further developed to improve the quality of the EASD meetings and the excitement for everyone to come and see and hear the work presented. There have been disappointments: both complaints from authors whose abstracts have been rejected and complaints from members of the Programme Committee after the paper was presented ("How on *earth* could we have accepted that abstract?"). Overall, I think the system is working well and I wish my successor, Rudiger Landgraf, the best of luck in improving our annual meetings in the future and thereby advancing diabetes research in general.

Sincerely yours,

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