Improving your Cochrane Review PDF

A guide to use alongside the Preview Published PDF service

Updated: 13 May 2019. Cochrane Informatics and Technology Services, Editorial and Methods Department, and Wiley

Contents

1 Introduction

1.1 About the PDF production process

The production of the PDF version of Cochrane Reviews (and protocols) published in the Cochrane Library is an automated process. While efforts are made to ensure that the review converts well to a PDF, sometimes there are problems with the display of the PDF. Most of these can be avoided by using the tips in this document; others need to be corrected manually by the Production Editor (Wiley) immediately after publication in the Library.

1.2 Preview Published PDF service

The Preview Published PDF service allows Cochrane authors to view an advance proof of the PDF version of a Cochrane Review, as it will appear in the Cochrane Library.

1.3 How to use this document

This document is intended to be used by Cochrane editorial staff to ensure the best display of the PDF version of their Cochrane Reviews (and protocols).

Part 2 provides examples of issues that can be rectified by making changes in Review Manager (RevMan). Editorial staff should consider sharing these issues with authors.

Part 2 provides tips to improve the appearance of a PDF. These tips refer to making changes to the review in Review Manager (RevMan) before publication that will affect the appearance of the PDF.

Part 3 provides examples of issues affecting the appearance of the PDF version that can only be rectified by the Wiley Production Editor following publication in the Cochrane Library. These need to be brought to the attention of the Production Editor (Wiley) as soon as possible so that the correction can be arranged.

1.4 Expectations of Cochrane editorial staff

The publisher of the Cochrane Library (Wiley) does not check the display of all PDFs before they are published in the Cochrane Library. It is expected that Cochrane editorial staff will check the PDFs using the PDF Published PDF service as part of their final checks on a review or protocol.

1.4.1 When should Cochrane editorial staff check the PDF?

This should be after copy-editing but before marking the review for publication

1.4.2 Should the authors be checking the PDF using the Preview Published PDF service?

This is a decision for the Cochrane editorial team. There are many issues below that can be fixed in RevMan, and editorial staff may wish to ask the authors to fix these, or editorial staff may wish to warn them in advance not to do these things. Editorial staff may share this document or sections of it with authors as needed.

1.5 Contacts

1.5.1 Queries about the Preview Published PDF service (see part 2)

Authors should contact their Cochrane Review Group (CRG) Managing Editor. Managing Editors should contact Managing Editor Support (mesupport@cochrane.org).

1.5.2 Alert the Production Editor to changes immediately after publication (see Part 3)

Authors should contact their CRG Managing Editor who should contact David Hives (dhives@wiley.com), Production Editor, Cochrane Library. To ensure quick resolution of the errors, please detail the following items:

- CD###### or MR######.
- Review/ Protocol Title.
- The PDF page number of the error.
- A brief description of the error.
- A screenshot/image snip of the error.

David Hives will contact the Managing Editor within 24 hours of the PDF error being corrected.

2 Issues that can be rectified by making changes to the file in RevMan

2.1 Tables (excluding Summary of Findings tables)

2.1.1 Keep the number of columns and rows to a minimum

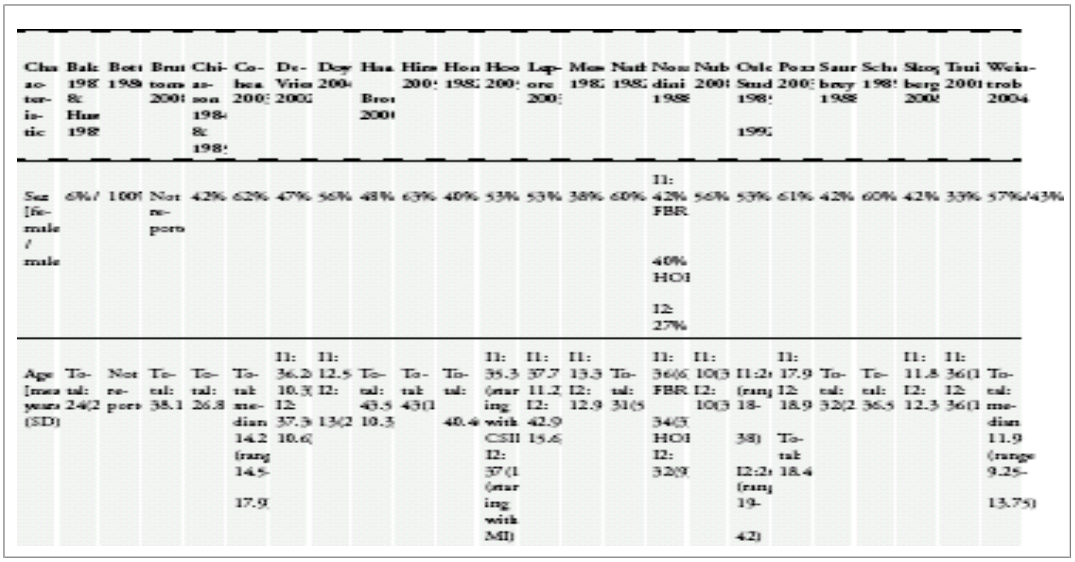
Table column widths are calculated automatically as the PDF is generated. The column widths will decrease as the number of columns increase. This can mean that columns are narrow and the content may be difficult to read (see Figure 1).

Therefore:

- Try and keep the number of columns to a minimum. (A maximum of 10 columns per table is recommended for uncluttered reading. However, a maximum of 25 columns is permitted).
- Try to avoid including lots of text in tables with many columns (see Figure 2).
- Longer text may be allocated in the last column as this usually appears the widest.
- Remove any empty columns or rows (see Figure 3 and Figure 4) because readers may think text is missing and the text alignment in the PDF versions may be detrimentally affected.

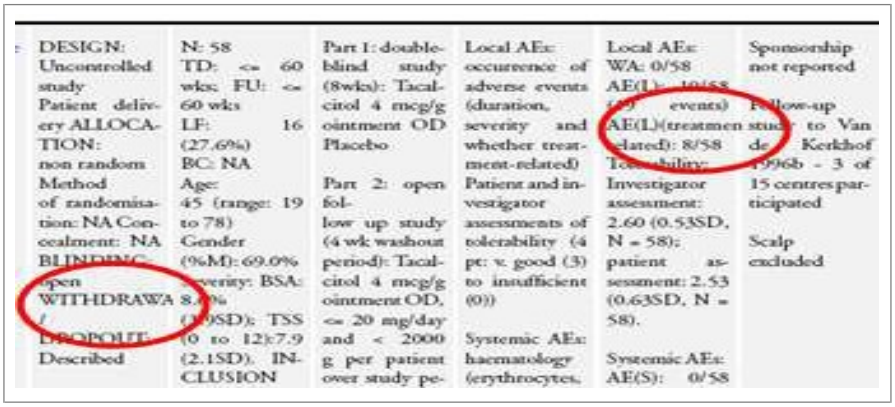
Be aware, the tables will not look the same in RevMan and the published PDF version (see Figure 5).

Figure 1. Example of table with many columns (narrow, cluttered reading and content bleeding out on right side of table column)



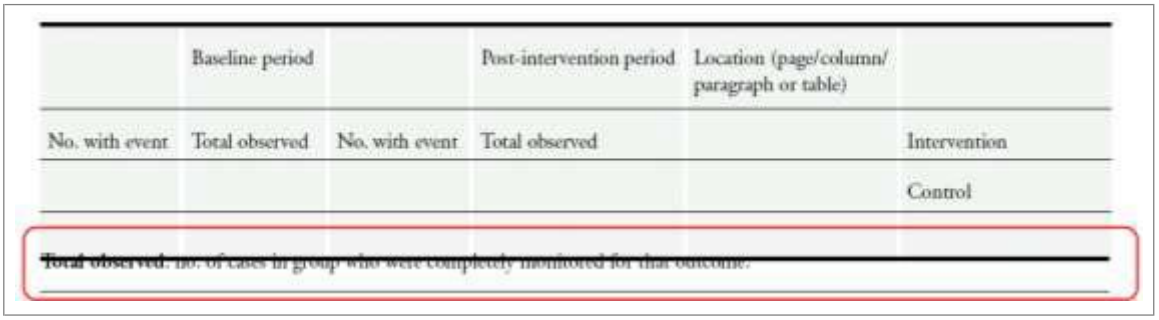
Characteristic	Bak 198 & Hus 198	Bost 198	Brut tom 200	Chi-as-son 198- & 198	Co-hea 200	De-Vrie 200	Doy 200	Haa Brot 200	Hire 200	Hon 198	Hoo 200	Lap-orc 200	Mos 198	Nath 198	Nou dini 1988	Nub 200	Oulc Stud 198 199	Poza 200	Saur bury 1988	Schu 198	Skoj berg 200	Trui 200	Wein-trob 2004
Sex [female / male	6%/	100	Not re-port	42%	62%	47%	56%	48%	63%	49%	53%	53%	38%	60%	I1: 42% FBR 40% HOI I2: 27%	56%	53%	61%	42%	60%	42%	33%	57%/43%
Age [mean years (SD)	To-tal: 24(2	Not re-port	To-tal: 38.1	To-tal: 26.8	To-tal me-dian 14.2 (rang 14.5- 17.9	I1: 36.2 10.3 I2: 37.3 10.6	I1: 12.5 I2: 13(2	To-tal: 43.5 10.3	To-tal: 43(1	To-tal: 40.4	I1: 35.3 (star ing with CSII I2: 37 (1 (star ing with MI)	I1: 37.7 I2: 42.9 15.6	I1: 13.3 I2: 12.9	To-tal: 31(5	I1: 36(6 FBR 34(5 HOI I2: 32(9	I1: 10(3 I2: 10(3	I1:2 (rang 18- 38) I2:2 (rang 19- 42)	I1: 17.9 I2: 18.9 To-tal 18.4	To-tal: 32(2	To-tal: 36.5	I1: 11.8 I2: 12.3	I1: 36(1 I2: 36(1	To-tal: me-dian 11.9 (range 9.25- 13.75)

Figure 2. Truncated text highlighted; due to lots of words in a column or columns combined with multiple columns



DESIGN: Uncontrolled study Patient delivery ALLOCATION: non random Method of randomisation: NA Concealment: NA BLINDING: open WITHDRAWA / DROPOUT: Described	N: 58 TD: <= 60 wks; FU: <= 60 wks LF: 16 (27.6%) BC: NA Age: 45 (range: 19 to 78) Gender (%M): 69.0% severity: BSA: 8.4% (3.9SD); TSS (0 to 12):7.9 (2.1SD). INCLUSION	Part 1: double-blind study (8wks): Tacalcitol 4 mcg/g ointment OD Placebo Part 2: open follow up study (4 wk washout period): Tacalcitol 4 mcg/g ointment OD, <= 20 mg/day and < 2000 g per patient over study pe-	Local AEs: occurence of adverse events (duration, severity and whether treatment-related) Patient and investigator assessments of tolerability (4 pt: v. good (3) to insufficient (0)) Systemic AEs: haematologr (erythrocytes,	Local AEs: WA: 0/58 AE(L): 10/58 (19 events) AE(L)(treatmen related): 8/58 Tolerability: Investigator assessment: 2.60 (0.53SD, N = 58); patient assessment: 2.53 (0.63SD, N = 58). Systemic AEs: AE(S): 0/58	Sponsorship not reported Follow-up study to Van de Kerkhof 1996b - 3 of 15 centres participated Scalp excluded

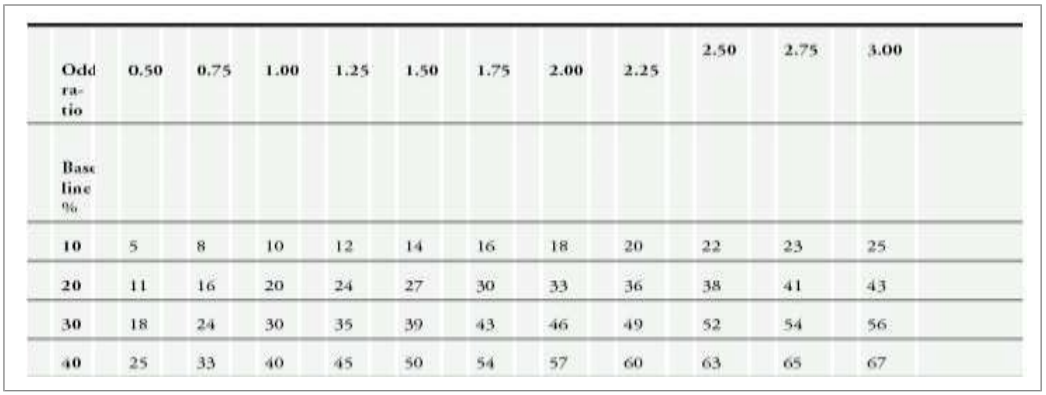
Figure 3. Example of PDF version with an empty row, resulting in the text that follows being obscured by the bottom line of the table



	Baseline period		Post-intervention period	Location (page/column/ paragraph or table)	
No. with event	Total observed	No. with event	Total observed		Intervention
					Control

Total observed: no. of cases in group who were completely monitored for that outcome.

Figure 4. Example of PDF version including empty columns



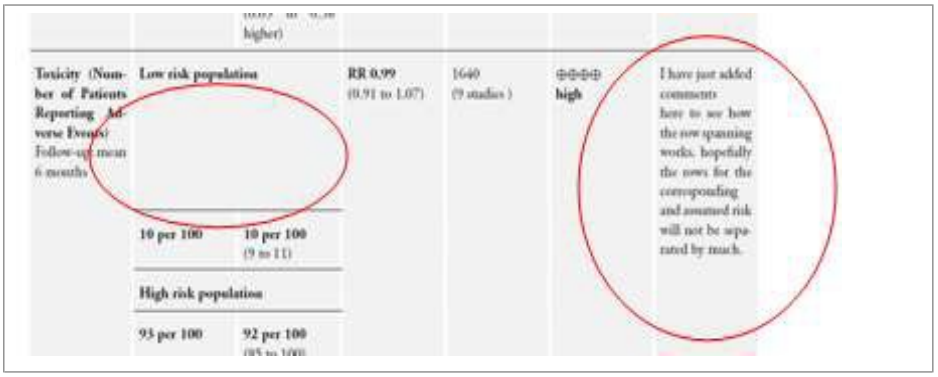
Odd ratio	0.50	0.75	1.00	1.25	1.50	1.75	2.00	2.25	2.50	2.75	3.00
Baseline %											
10	5	8	10	12	14	16	18	20	22	23	25
20	11	16	20	24	27	30	33	36	38	41	43
30	18	24	30	35	39	43	46	49	52	54	56
40	25	33	40	45	50	54	57	60	63	65	67

Figure 5. Example of layout differences between RevMan and published PDF versions (may occur when tables contain cells that are merged across rows or columns)

RevMan

Minimum Joint Space Width mm Follow-up: mean 3 years	The mean minimum joint space width in the control groups was 2.65 mm	The mean Minimum Joint Space Width in the intervention groups was 0.32 higher (0.06 to 0.58 higher)		414 (2 studies)	⊕⊕⊕⊕ high	MD 0.32 (95% CI 0.06 to 0.58, see outcome 3.6)
Toxicity (Number of Patients Reporting Adverse Events) Follow-up: mean 6 months	Low risk population 10 per 100	10 per 100 (9 to 11)	RR 0.99 (0.91 to 1.07)	1640 (9 studies)	⊕⊕⊕⊕ high	I have just added comments here to see how the row spanning works. Hopefully the rows for the corresponding and assumed risk are not too separated by much.
	High risk population 93 per 100	92 per 100 (85 to 100)				
Toxicity (Number of	Medium risk population		RR 0.78	1655	⊕⊕⊕⊕	

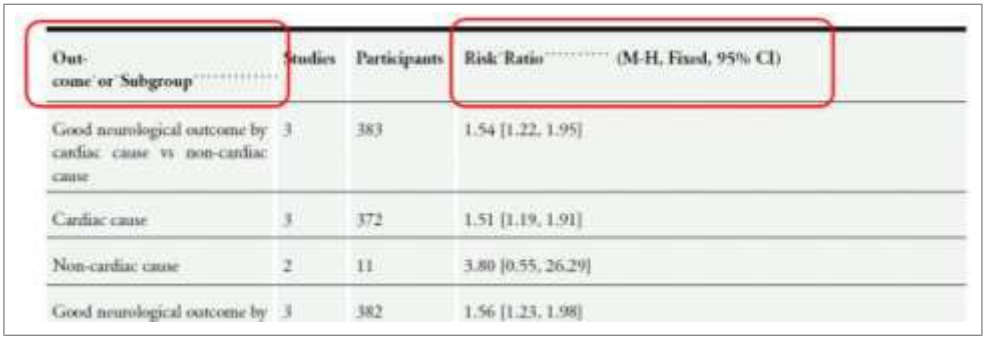
Published PDF version



2.1.2 Do not insert symbols, tabs or spaces in a table, as these can affect the final PDF

Avoid inserting symbols (e.g. spaces, dots, dashes) to adjust spacing, column widths, or layout as the effect on the published PDF is unpredictable; see Figure 6.

Figure 6. Symbols inserted into column headings

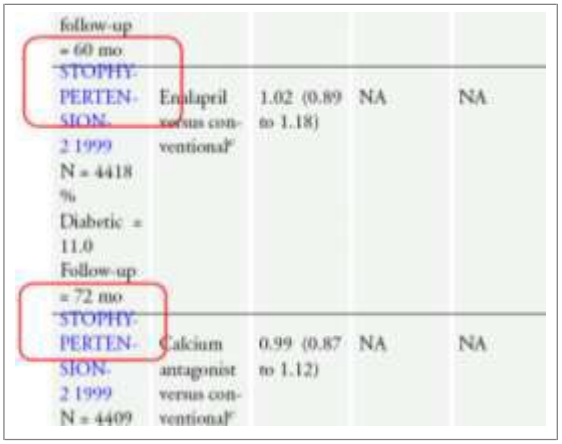


Out-come or Subgroup	Studies	Participants	Risk Ratio (M-H, Fixed, 95% CI)
Good neurological outcome by cardiac cause vs non-cardiac cause	3	383	1.54 [1.22, 1.95]
Cardiac cause	3	372	1.51 [1.19, 1.91]
Non-cardiac cause	2	11	3.80 [0.55, 26.29]
Good neurological outcome by	3	382	1.56 [1.23, 1.98]

2.1.3 Do not use hyperlinks as the first 'word' in the first column of a table

Do not use a hyperlink as the first word in the first column of a row. There is a risk that the hyperlink text will 'bleed' into other table rows; see Figure 7.

Figure 7. Example showing the hyperlink 'bleeding' into other table rows



follow-up = 60 mo				
STOPHY-PERTEN-SION-2 1999 N = 4418 % Diabetic = 11.0 Follow-up = 72 mo	Enalapril versus conventional	1.02 (0.89 to 1.18)	NA	NA
STOPHY-PERTEN-SION-2 1999 N = 4409	Calcium antagonist versus conventional	0.99 (0.87 to 1.12)	NA	NA

2.2 Summary of Findings (SoF) tables

Issues relating to the orientation of SoF tables in the PDF can only be handled by the Production Editor (Wiley). Do not try to adjust the layout of the SoF tables if you identify a problem; instead, the author should contact their Managing Editor who will report these to David Hives, Production Editor, Cochrane Library (dhives@wiley.com), who will arrange for the PDF to be adjusted upon publication of the review.

2.3 Text

2.3.1 Do not use tabs or multiple spaces within a block of text

Avoid using tabs or spaces to adjust text layout because this will affect the layout and formatting in the published version; see Figure 8 and Figure 9. This could happen unintentionally when you cut and paste text from other sources, so check the text carefully and if you notice extra spaces, either delete the spaces or type the information manually.

Figure 8. Example 1 of tabs or spaces used to adjust textlayout

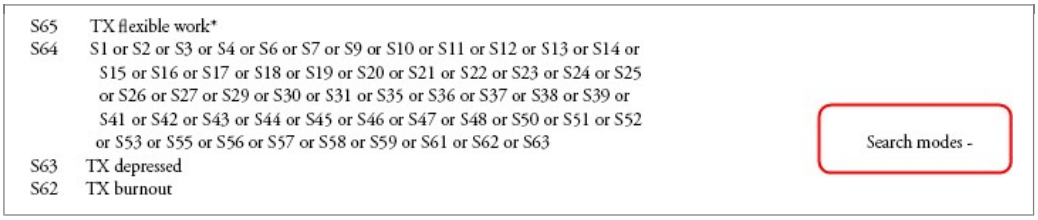
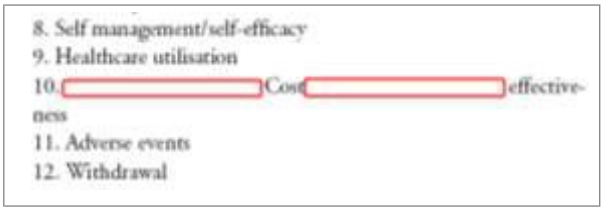


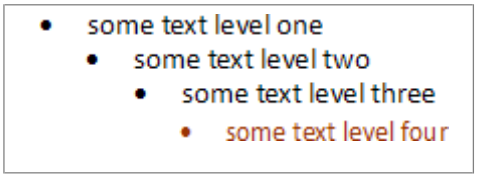
Figure 9. Example 2 of tabs or spaces used to adjust textlayout



2.3.2 Do not use lists with more than three levels

A maximum of three list nesting levels are published in the PDF review versions. Content in list levels greater than three will not reliably display (i.e. they will disappear or only partially appear); see Figure 10. Please note that the html version will display all levels.

Figure 10. Example of list nesting levels



3 Issues that can only be rectified by the publisher (Wiley) after the review is published

There are some layout issues with PDFs that cannot be corrected by making changes in the RevMan file, as shown in Part 2. These layout issues – the most common ones shown below – may be identified via the Preview Published PDF service, but they can only be corrected once the article is published in the CDSR. If you identify any of these issues, either before or after publication, bring them to the attention of the Production Editor (Wiley); see contact details above.

3.1 Summary of Findings (SoF) tables

3.1.1 Orientation of the page before or after the SoF table

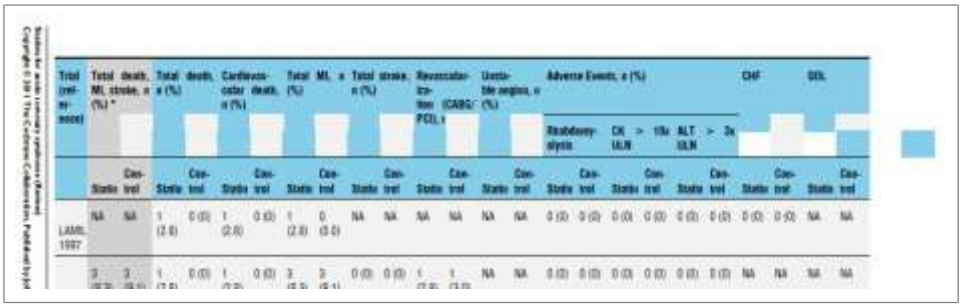
SoF tables are displayed in a landscape orientation, unlike the text, which uses a portrait orientation. Sometimes the landscape orientation carries on for an additional page either side of the SoF table (as shown in Figure 11).

Figure 11. Orientation of page before or after a SoF table

3.1.2 Summary of Findings table cell bleeding to right edge of page

Figure 12 shows an example of a table cell bleeding to the right edge of the page.

Figure 12. Table cell (shown in blue) bleeding to right edge of page

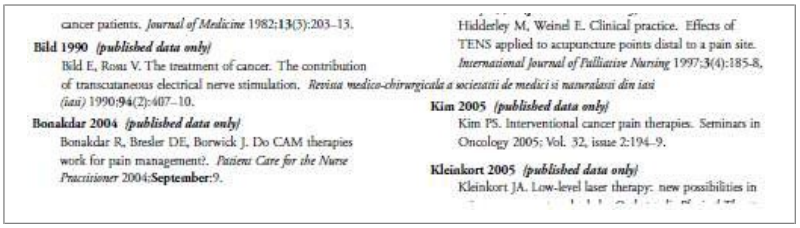


3.2 Text

3.2.1 Reference text bleeding into the second column of text

See example in Figure 13.

Figure 13. Reference text bleeding into the second column of text



cancer patients. *Journal of Medicine* 1982;**13**(3):203–13.

Bild 1990 ***(published data only)***
Bild E, Rosu V. The treatment of cancer. The contribution of transcutaneous electrical nerve stimulation. *Revista medico-chirurgicala a societatii de medici si naturalasti din iasi (iasi)* 1990;**94**(2):407–10.

Bonakdar 2004 ***(published data only)***
Bonakdar R, Bresler DE, Borwick J. Do CAM therapies work for pain management?. *Patient Care for the Nurse Practitioner* 2004;**September**:9.

Hiddeley M, Weinel E. Clinical practice. Effects of TENS applied to acupuncture points distal to a pain site. *International Journal of Palliative Nursing* 1997;**3**(4):185-8.

Kim 2005 ***(published data only)***
Kim PS. Interventional cancer pain therapies. Seminars in Oncology 2005; Vol. 32, issue 2:194–9.

Kleinkort 2005 ***(published data only)***
Kleinkort JA. Low-level laser therapy: new possibilities in

3.2.2 Text bleeding to right edge of the page

See example in Figure 14.

Figure 14. Text bleeding to right edge of the page

Blinding

In Gadsby 1997, both participants and the outcome assessor were adequately blinded. Although the researcher completing assessments and participants in Bennett 2010 were technically blind to the intervention, 10 of 19 patients correctly identified the placebo TENS. The assessor was adequately blinded in 15 of 19 participants. In Robb 2007, attempts were made to blind participants but not assessors. In this study it is commented that a minority of participants may have identified the placebo, but this was not formally analysed and numbers were not available.

Incomplete outcome data

In Bennett 2010, five participants did not complete the study. All withdrew from the study after the first treatment: two in the active TENS then placebo arm and three in the other arm. Three participants did not complete due to deteriorating health unrelated to TENS and two withdrew due to increasing pain during TENS application. The data of those who did not complete were excluded from primary analysis. Two participants in the placebo arm did not complete in Gadsby 1997. In both cases it was due to deteriorating health. In Robb 2007, eight participants did not complete. The distribution of these participants was not reported. In two participants withdrawal was due to increasing pain, in two decreasing pain and in one a skin reaction. Three withdrew for other reasons which were not described. There were no statistically significant differences in baseline data between participants lost to

-1.85 to 1.22), where higher scores indicated more intense pain. The study did not indicate that cancer bone pain at rest improved with TENS. Only five of the 22 adverse events were deemed at least possibly related to TENS. Only two withdrawals were related to pain during TENS application. Only one of these was during active TENS ap
Robb 2007 found no significant differences in pain relief scores between TENS or sham TSE. There were also no significant differences in any of the other outcome measures, except one dimension of a patient satisfaction questionnaire where TENS was considered significantly more effective than sham TSE. Twenty-six of 41 women (63%) who completed the study decided to continue with a device on completion of the trial and of these, the majority (n – 13) decided to continue with TENS, as opposed to sham TSE (n – six). The majority of the women continuing with TENS were still using it to good effect at three months (n – 14) and 12 months (n – 10), with those using sham TSE to good effect at three months and 12 months (n – 4 and n – 2 respectively). Overall, TENS appeared to be well tolerated; women found TENS easy to use and few reported difficulties with electrode placement. Adverse effects were monitored and reported and were minimal in this study.
Gadsby 1997 did not detect any statistically significant differences between AL-TENS and sham AL-TENS. However, the study was underpowered, with only five participants randomised into each of the three treatment groups and only 13 participants completing the study.

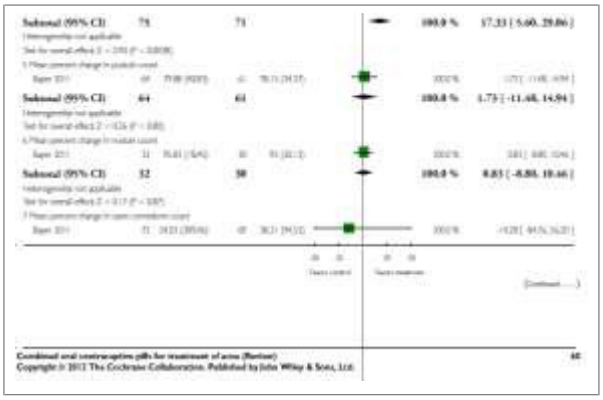
DISCUSSION

The results of this systematic review examining the effectiveness of

3.3 Forest plot: vertical line extending down through following pages

See example in Figure 15.

Figure 15. Forest plot vertical line extending down page



3.4 References: corruption of reference text

The reference text has been corrupted during the processing of the review's references; see example in Figure 16.

Figure 16. Corruption of reference text

3.5 Blank pages

These blank pages occur as text or images appear just before a page break; see example in Figure 17.

Figure 17. Unintended blank page