CALIFORNIA MEDICAL JOURNAL

A title should be the fewest possible words that accurately describe the content of the paper, no more than 16 words (Times New Roman, center, bold, 16pt)

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Article History :
Received date : DDMMYY
Revised date : DDMMYY
Accepted date : DDMMYY
Published date : DDMMYY

ABSTRACT

A well-prepared abstract allows readers to quickly and accurately identify the basic content of a document, determine its relevance to their interests, and thereby decide whether to read the document in its entirety. The abstract must be informative and clear enough, written clearly, and provide a clear statement of the problem, research objectives, research methods, findings, and conclusions. Abstracts should consist of 100 to 200 words. The abstract must be written in the past tense. Standard nomenclature should be used, and abbreviations should be avoided. No literature may be cited. Keyword lists provide the opportunity to add keywords used by indexing and abstracting services in addition to the keywords already present in the title. Wise use of keywords can increase the ease with which interested parties find our articles (12pt).

Keyword: The first keyword; the second keyword; the third keyword; The fourth keyword; The fifth keywords. (There are a minimum of five keywords and a maximum of six keywords)

INTRODUCTION (Capital, bold , Times new romance 12 pt)

This section explains the three main components. First, to describe the phenomenon being studied, the introduction must contain the research background and research context. Second, the author explains the relationship between the phenomenon and existing theories (at least the journal cited must be less than ten years old), along with gap analysis and the novelty of the research, and finally explains the research objectives. All introductions should be presented in paragraph form, not pointers, with a proportion of 15-20% of the overall length of the article.

The introduction should not be divided into background sub-chapters, problem formulation, and objectives. Beginning of paragraph once tab. Citations are written in body note format and are relevant to the bibliography (recommended using the Mendeley application or other reference management application programs such as EndNote, Reference Manager, or Zotero) (12pt, spacing 1.5, spacing after paragraph 6pt).

The manuscript should be written as concisely, consistently, and as directly as possible. The number of pages consists of 10–20 (twenty) pages (including figures and tables). Manuscripts are written single-spaced on one side of A4-sized paper (210 x 297 mm). Manuscripts must have normal margins, or top, bottom, right, and left margins, namely 2.54 cm. The font used is Times New Roman. 12pt. Manuscripts must be written in English.

METHODS

The Methods section must be short but must include sufficient technical information and contain the type of research, research population, research samples or subjects, and data analysis techniques. Only new methods have to be described in detail. Cite previously published procedures in References.

Table 1. Search Strategy

Database	Search Strategy	Hits
PubMed	("subcutaneous rituximab" OR "NHL" AND "non-Hodgkin lymphoma")	980
ScienceDirect	("subcutaneous rituximab" AND "NHL")	145
SagePub	("R-CHOP" AND "NHL")	37

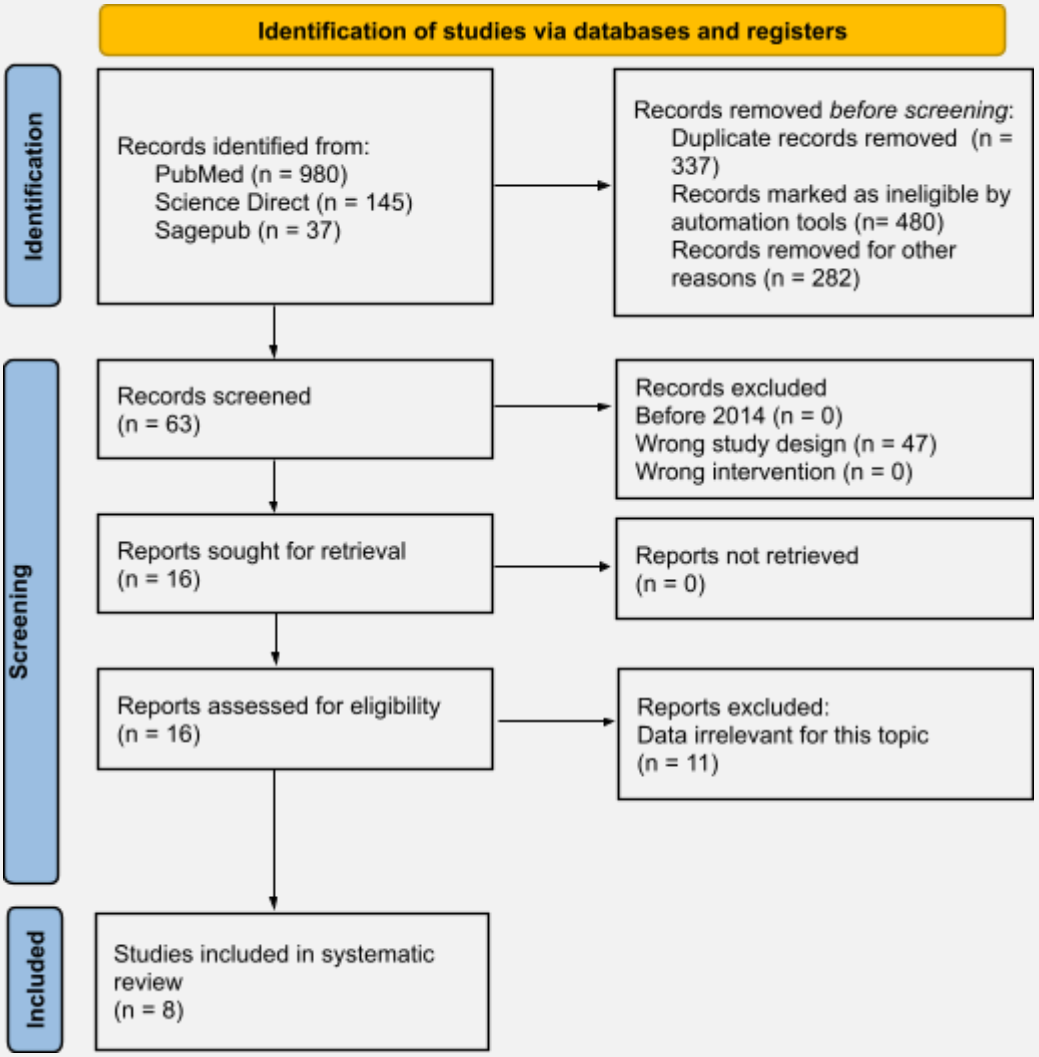

Figure 1. Article search flow chart

Table 2. Critical appraisal of Study

Parameters	Düring wt al., 2023.	García et al., 2020.	Petrini et al., 2022.	Rummel et al., 2017.	Rule et al., 2022.
1. Bias related to temporal precedence					

Is it clear in the study what is the "cause" and what is the "effect" (ie, there is no confusion about which variable comes first)?	Yes	Yes	Yes	Yes	Yes
2. Bias related to selection and allocation					
Was there a control group?	No	No	No	Yes	Yes
3. Bias related to confounding factors					
Were participants included in any comparisons similar?	Unclear	Limited information	Limited information	Yes	Yes
4. Bias related to administration of intervention/exposure					
Were the participants included in any comparisons receiving similar treatment/care, other than the exposure or intervention of interest?	Yes	Yes	Yes	Yes	Yes.
5. Bias related to assessment, detection, and measurement of the outcome					
Were there multiple measurements of the outcome, both pre and post the intervention/exposure?	No	Yes	No	Yes	Unclear
Were the outcomes of participants included in any comparisons measured in the same way?	Yes	Unclear	Yes	Yes	Yes
Were outcomes measured in a reliable way?	Yes	Yes	Unclear	Yes	Unclear
6. Bias related to participant retention					
Was follow-up complete and, if not, were differences between groups in terms of their follow-up adequately described and analyzed?	No	Unclear	Unclear	Yes	Unclear
7. Statistical conclusion validity					
Was appropriate statistical analysis used?	Unclear	Unclear	Unclear	Yes	Yes

RESULT

Results should include the rationale or design of the experiment as well as the results of the experiment. Results can be presented in the form of images, tables, and text. Research findings must be supported by adequate data. This section must answer the research hypothesis.

The discussion should be an interpretation of the results, not a repetition of the results. This discussion includes at least: an explanation of the meaning of the findings and why the findings are important; Support the answer with the results. Explain how your results relate to expectations and the literature; state clearly why the results are acceptable and whether there is any agreement or conflict with previous research results; consider alternative explanations for the findings; consider research implications; study limitations; and provide suggestions for further research.

Avoid writing in the form of bullet numbering or item list style; it is best to write it in the form of a descriptive paragraph, even though it is a list item. If it contains tables and figures, the numbering is a continuation of the previous number. Each table and figure must be given a title.

Table

The table is in the middle. Use Times New Roman and font sizes 8 to 11. Horizontal lines in the middle of the table do not need to be displayed; only display the heading and the very end, and there should also be no vertical lines. Make sure you create the table correctly via the Insert Table menu. Tables should be referenced in the text by writing something like: '... (Tables are written with a capital 'T').

Table 3. The literature included in this study

Dürig wt al., 2023.[9]	Germany	Non-comparative, multi-center NIS prospective study.	Overall 583 patients (247 FL; 336 DLBCL) were evaluated.	CR/CRu rates were 51.4% (95% CI: 45.2; 57.6) in the FL set and 48.5% (95% CI: 43.2; 53.8) in the DLBCL set. Regarding progression-free survival in the FL group, the probability of being event-free was 94.2% in the first year and 86.2% in the second year. An overall response was achieved in 85.8% (FL) and 85.4% patients (DLBCL). Patient satisfaction at the end of study with the time saving simplification of the SC vs. intravenous route was 98% for FL and 97% for DLBCL. 45.3% of FL and 47.0% of DLBCL patients experienced an adverse

				event of grade ≥3. Serious adverse events of grade ≥3 occurred in 27.9% FL and 32.4% DLBCL patients, with the highest incidences for leucopenia, anemia, nausea, and fatigue. No new safety signals were detected.
García et al., 2020.[10]	India	Open-label, single-arm, phase IIIb	The study included 140 patients.	Ninety‐five percent of patients experienced adverse events, reaching grade ≥3 in 38·6% and were serious in 30·0%. AARs occurred in 48·6%, mostly (84·9%) at the injection site, with only 2·1% of patients reaching grade 3. The end‐of‐induction complete/unconfirmed complete response rate was 69·6%. After a median follow‐up of 33·5 months, median disease‐/event‐/progression‐free and overall survivals were not attained. The Rituximab Administration Satisfaction Questionnaire showed improvements in overall satisfaction and the EuroQoL‐5D a good quality‐of‐life perception at induction/maintenance end.
Petrini et al., 2022.[11]	Italy	Open-label, single-arm, phase IIIb trial.	159 patients	ARRs were reported in 10 patients (6.3%), 3 (4.2%) with DLBCL and 7 (8.1%) with FL, all of mild severity, and resolved without dose delay/ discontinuation. Treatment-emergent adverse events (TEAEs) and serious adverse events occurred in 41 (25.9%) and 14 patients (8.9%), respectively. Two patients

				with DLBCL had fatal events: Klebsiella infection (related to rituximab) and septic shock (related to chemotherapy). Neutropenia (14 patients, 8.9%) was the most common treatment-related TEAE. Two patients with DLBCL (2.8%) and 6 with FL (7.0%) discontinued rituximab due to TEAEs. 65.2% and 69.7% of patients with DLBCL and 67.9% and 73.6% of patients with FL had complete response (CR) and CR uncon/rmed, respectively. &e median time to events (EFS, PFS, and OS) was not estimable due to the low rate of events. At a median follow-up of 29.5 and 47.8 months in patients with DLBCL and FL, respectively, EFS, PFS, and OS were 70.8%, 70.8%, and 80.6% in patients with DLBCL and 77.9%, 77.9%, and 95.3% in patients with FL, respectively. The switch from IV to SC rituximab in patients with DLBCL and FL was associated with low risk of ARRs and satisfactory response in both groups. &is trial was registered with NCT01987505
Rummel et al., 2017. [12]	UK	International, phase IIIb, prospective, multi-center, open-label crossover study.	743 patients	The majority had DLBCL (63%) and baseline characteristics were balanced between arms. At cycle 8, 81% of patients completing the PPQ preferred rituximab s.c. Preference was not

				impacted by treatment sequence or disease type. Patient satisfaction as measured by RASQ was higher for s.c. versus i.v. CTSQ scores were similar between arms. Adverse events were generally balanced between administration routes and no new safety signals were detected.
Rule et al., 2022. [13]	Germany	phase III, open-label, multicenter, international, randomized interventional study	The phase III MabCute study enrolled 692 patients with relapsed or refractory indolent non-Hodgkin lymphoma.	Patients who responded to induction with rituximab plus chemotherapy and were still responding after up to 2 years' initial maintenance with subcutaneous rituximab were randomized to extended maintenance with subcutaneous rituximab (n=138) or observation only (n=138). The primary endpoint of investigator-assessed progression-free survival in the randomized population was un-addressed by the end of study because of an insufficient number of events (129 events were needed for 80% power at 5% significance if approximately 330 patients were randomized). In total, there were 46 progression-free survival events, 19 and 27 in the rituximab and observation arms, respectively (P=0.410 by stratified log-rank test; hazard ratio

				0.76 [95% confidence interval: 0.37– 1.53]).

CONCLUSION

The conclusion must contain confirmation of the problems that have been analyzed in the results and discussion sections. Write a conclusion concisely and clearly. It is not recommended that the conclusion be written in several parts or points. The conclusion is intended to help readers understand why your research is important to them after they have finished reading the manuscript. A conclusion is not simply a summary of the main topics discussed or a restatement of your research problem, but rather a synthesis of the important points. It is important that the conclusion does not leave any questions unanswered.

DISCLOSURE STATEMENT

Disclosure Statement : The authors have no conflicts of Interest to declare.

REFERENCES

References should be listed in the order of their appearance in the text. Each cited source must include the author's name, article title, journal name, year of publication, volume, issue number, page numbers, and DOI (if available). Example of reference format:

1. Thandra KC, Barsouk A, Saginala K, et al. Epidemiology of non-Hodgkin's lymphoma. Med Sci (Basel). 2021 Jan 30;9(1):5. doi:10.3390/medsci9010005.
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