Guidelines on Formatting Tables in *AJHP* Style

Authors should use the table creation function of the word processing program used to prepare the manuscript text; Microsoft Word (Microsoft Corporation, Redmond, WA) is strongly preferred. Each table should be saved as a separate electronic file, with clean printouts of all tables submitted to guide the journal's production staff.

NOTES: ***Do not*** embed tables in the manuscript file; ***do not*** submit tables embedded in a graphic presentation file such as a PowerPoint document or PDF unless requested to do so by the editors. ***Do not*** use the space bar or the tab key to create tables; this will require that journal staff completely recreate the table, which can result in data entry errors and potential publication delays.

Follow these general guidelines to help ensure that table formatting conforms to *AJHP* style:

1. To reduce the need for reformatting, ***key all data into table cells flush left*** (as in Table 1); proper indentation and alignment will be done by the journal's design staff. ***Do not use the space bar or hard returns to indent, align, or "stack" data within cells;*** instead, place each item of data in a separate cell.

2. Format the table to emphasize the primary outcome of interest; for example, to show a change over time, list successive years from left to right in the column headings. While row headings should often list variables alphabetically, it may be desirable to order row headings to highlight key findings. Note that in Table 1, the racial/ethnic characteristics and comorbidities are listed in descending order of frequency; in Table 5, the risk factors are listed by relative importance. In general, the most effective and visually appealing tables have fewer column headings than row headings.

3. If the body of the table consists entirely or primarily of numerical values, designate all units of measure or quantification (e.g., %, mg, $, µg/mL) in row headings (as in Table 1) or column headings (Tables 4 and 5) rather than repeating the units or symbols throughout the body. If most or all numerical data in multiple columns are of the same type (e.g., mean ± S.D., number and percentage of patients), this can be indicated above a straddle rule, as in Tables 2 and 3, or in the title (Table4).

4. ***Present related data in the same column.*** Examples include the number and percentage of patients, the mean or median value and corresponding measure of variability or precision (e.g., S.D., range), and the odds ratio and confidence interval (see Tables 1–3 and 5). When appropriate, p values are presented in a separate column (Table 2); alternatively, a footnote may be used to highlight only the findings that are statistically significant (Table 5).

5. In general, use only standard abbreviations for units of measure (e.g., g, mg, µg, cm^2, L, mL, dL), other commonly used abbreviations such as vs. (versus) and S.D. (standard deviation), and well-known initialisms introduced in the text of the article (e.g., ADR, COPD, ESRD). To quantify time, use the following abbreviations: sec, min, hr, wk, mo, yr ("day" is not abbreviated); these abbreviations are never plural (e.g., not 12 hrs, but 12 hr). None of these abbreviations need to be defined in a footnote.

6. Use only standard signs and symbols (e.g., + = ≤). ***Do not use nonstandard symbols*** (e.g., ↑ ↓ Δ; instead, spell out increase, decrease, and change).

7. Quantify medication dosages in the preferred format (dose, route, and frequency), as in 1 g i.v. daily, 10 mg i.m., or 200 mg orally twice daily. Do not use the abbreviations p.o. or s.c./s.q.; instead, specify "orally" and "subcutaneous/subcutaneously." The use of b.i.d., t.i.d., and other established abbreviations for frequency of administration (e.g., q 8 hr) is permissible. None of these abbreviations require definition in a footnote.

8. Use leading and trailing zeroes, as applicable, and carry out and/or round like values (generally those in the same row or column) to the same number of decimal places. Decimal points should always be preceded by a number or zero (e.g., 2.5 mg, $p < 0.123$).

9. Use superscript lowercase letters ([a, b, c, d]) instead of numbers or symbols (* † ** ‡) for footnotes. Avoid abbreviations in table titles. Unless no abbreviations requiring a definition are used in the title or body, all abbreviations are defined in the first footnote (i.e., footnote a) in order of appearance in the table (from top to bottom and left to right). If the first footnote is used to define abbreviations, it is cited with a superscript letter in the table title (as in the examples below) and the footnote itself should contain only abbreviations and the corresponding definitions.

10. Except in very unusual circumstances, there should be no empty cells in the body of the table. As necessary, enter ellipses with an explanatory footnote (e.g., data unavailable, not reported, not applicable), as in Table 3.

Refer to the following examples in formatting tables:

Table 1. **Demographic and Clinical Variables in Study Populations, by Year[a]**

Variable	2004 (*n* = 1000)	2014 (*n* = 1000)
Mean ± S.D. age, yr	59 ± 2.3	57 ± 3.6
Female, no. (%)	567 (56.7)	610 (6. 1)
Race/ethnicity, no. (%)		
White	650 (65)	640 (64)
Black	200 (20)	190 (19)
Hispanic	150 (15)	170 (17)
Comorbidities		
Hypertension, no. (%)	603 (60.3)	581 (58.1)
Cardiovascular disease, no. (%)	312 (31.2)	338 (33.8)
COPD, no. (%)	135 (1.35)	124 (1.24)
Mean ± S.D. hospital days per patient	5.1 ± 2.3	4.5 ± 1.9
Median (range) hospital LOS, days	4.2 (1–5)	5.7 (1–7)

[a]COPD = chronic obstructive pulmonary disease, LOS = length of stay.

[NOTE: Column headings, row headings, and all data are keyed into table cells flush left, with each item of data in a separate cell and no stacking of data within individual cells.]

[NOTE: In Tables 2–6 below, indentation and alignment are shown for illustrative purposes only; *in creating tables, authors should key all column/row headings and tabular data into table cells flush left.*]

Table 2. **Outcomes in Patients With Diabetes Before and After Pharmacist Intervention[a]**

| Variable | Mean ± S.D. | | p |
	Before (*n* = 500)	After (*n* = 500)	
HbA$_{1c}$ concentration, %	7.8 ± 1.6	7.1 ± 1.2	<0.01
Weight, kg	103.7 ± 28.2	103.5 ± 28.9	0.70
BMI, kg/m^2	36.7 ± 9.1	34.5 ± 8.6	0.99
Blood pressure, mm Hg			
Systolic	128.8 ± 14.4	124.9 ± 13.8	<0.01
Diastolic	77.6 ± 9.5	74.2 ± 10.5	<0.01

[a]HbA$_{1c}$ = glycosylated hemoglobin, BMI = body mass index.

[NOTE: A straddle rule is used to specify a unit of measure applicable to multiple data columns.]

Table 3. **Pharmacokinetics of Drug Z in Healthy Persons and Patients With Renal Impairment[a]**

| Variable | Mean ± S.D. | |
	Healthy (*n* = 100)	Renally Impaired (*n* = 100)
$t_{1/2}$ (hr)	11.21 ± 3.64	12.8 ± 2.30
CL (L/hr)	17.19 ± 2.12	. . .[b]
C_{max} (µg/mL)	2.23 ± 0.55	3.12 ± 0.85
t_{max} (hr)[c]	4.0, 1.3–6.8	1.7, 0.5–2.5
V_{ss}	90.82 ± 23.10	. . .
AUC (µg · hr/mL)	25.2 ± 9.2	29.8 ± 8.9

[a]$t_{1/2}$ = half-life, CL = clearance, C_{max} = maximum concentration, t_{max} = time to maximum concentration, V_{ss} = volume of distribution at steady state, AUC = area under the concentration–time curve.

[b]Not reported.

[c]Reported as median and range.

Table 4. **Antimicrobial Therapy Costs ($) in Study Groups, Stratified by Patient Risk**

Risk Level	Group A	Group B	Group C
Low	107.79	114.53	68.76
Medium	154.83	146.81	77.43
High	201.39	194.55	90.32

Table 5. **Patient and Hospitalization Factors Associated With Postdischarge Thromboembolism[a]**

Characteristic	No. (%) Patients	Odds Ratio (95% CI)[b]
Patient risk factor		
Prior VTE	7,335 (91.68)	8.21 (7.49–9.29)[c]
Sepsis	1,435 (17.93)	2.67 (1.93–3.70)
Cancer	6,970 (87.12)	2.47 (2.05–2.97)
Hospitalization factor		
Admission in urban setting	3,302 (41.27)	1.15 (0.89–1.49)
Multiple admissions in 1 yr	2,345 (29.31)	1.11 (0.27–4.49)

[a]CI = confidence interval, VTE = venous thromboembolism.
[b]Relative to control group.
[c]$p < 0.01$.

[NOTE: Related data (i.e., numbers and percentages of patients, odds ratios and confidence intervals) are presented in the same column, with units of measure/quantification specified in column headings.]

Table 6.
Summary Data from Clinical Trials of Drug Y for Disease Z[a]

Study	Design	Regimen	Primary Endpoint(s)	Outcome(s)
EXCITE I[13]	Phase I dose-ranging study	0.5–1.5 mg/kg daily ($n = 45$)	Minimum effective dose	Minimum effective dose established at 1.25 mg/kg
EXCITE II[14]	Phase II randomized controlled trial	1.25 mg/kg per day ($n = 88$) vs. daily placebo ($n = 88$)	Rates of disease progression at 3, 6, and 9 mo	Drug Y superior to placebo at 3 and 6 mo ($p < 0.05$) and also at 9 mo ($p < 0.01$)
EXCITE III[15]	Phase III international, multisite randomized controlled trial	1.25 mg/kg per day ($n = 767$) for 4 wk vs. daily placebo ($n = 769$)	% of patients with stage 5 disease at 12 mo; mean no. ADEs per wk	Rate of stage 5 disease reduced with drug Y vs. placebo (37% vs. 78%); mean no. ADEs per wk lower with drug Y (2.1 vs. 0.9, $p < 0.01$)

[a]ADE = adverse drug event.

[NOTE: The superscript numerals in the left-hand column correspond to those for references cited in the text of the article. References that appear <u>only</u> in a table (i.e., are not cited in the text) should be numbered according to placement of first mention of the table in the text; for example, if the table callout "(Table 6)" in the text of the article appears after 10 other references are cited, the three references cited in this table would be numbered 11, 12, and 13, with subsequent citations <u>in text</u> numbered 14, 15, 16, etc.]