Redação de trabalhos científicos

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Tópicos da apresentação

- Introdução
- Como realizar a escrita de artigos para publicação
- Escrita estruturada em Introdução, Objetivos, Métodos, resultados, discussão e conclusão
- Referências bibliográficas

Tópicos da apresentação

- A importância do título adequado
- Como montar o resumo do artigo científico
- Diferenças entre artigos, TCC, dissertação de mestrado e tese de doutorado

Redação do Trabalho Científico

Escrita de artigos

- Etapa final do projeto de pesquisa
- Idioma (idealmente em inglês)
- Linguagem adequada ao publico alvo
- Escolha da revista e processo de submissão do artigo
- Visibilidade
  - Maior chance de conseguir novos projetos, empregos, estágios, valorização por parte da sociedade, etc

Importância de escrever/publicar

- Avanço do conhecimento científico em um determinado tema
- Valorização da ciência perante o público leigo
- Visibilidade
  - Maior chance de conseguir novos projetos, empregos, estágios, valorização por parte da sociedade, etc

Escrita estruturada em Introdução, Objetivos, MM, resultados, discussão e conclusão

Estrutura de um artigo científico

- Título
- Autores (e como ordená-los) e filiação
- Fontes de financiamento
- Resumo
- Introdução
- Materiais e métodos
- Resultados (tabelas, figuras, gráficos)
- Discussão
- Referências

Estrutura de um artigo científico- exemplo

Título

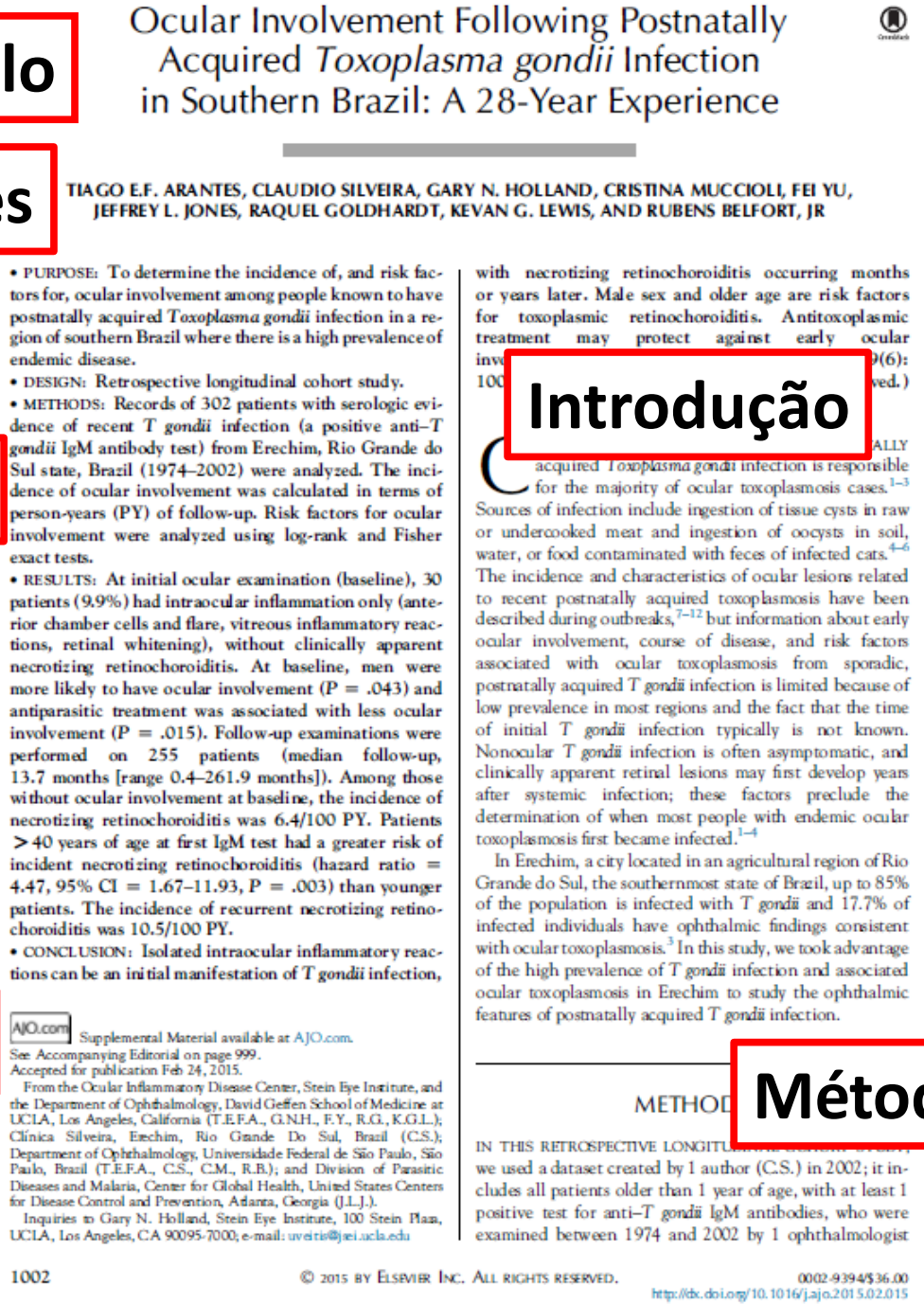
Autores

Resumo estruturado

Filiação

Introdução

Métodos



Ocular Involvement Following Postnatally Acquired *Toxoplasma gondii* Infection in Southern Brazil: A 28-Year Experience

TIAGO E.F. ARANTES, CLAUDIO SILVEIRA, GARY N. HOLLAND, CRISTINA MUCCIOLI, FEI YU, JEFFREY L. JONES, RAQUEL GOLDHARDT, KEVAN G. LEWIS, AND RUBENS BELFORT, JR

• PURPOSE: To determine the incidence of, and risk factors for, ocular involvement among people known to have postnatally acquired *Toxoplasma gondii* infection in a region of southern Brazil where there is a high prevalence of endemic disease.
• DESIGN: Retrospective longitudinal cohort study.
• METHODS: Records of 302 patients with serologic evidence of recent *T gondii* infection (a positive anti–*T gondii* IgM antibody test) from Erechim, Rio Grande do Sul state, Brazil (1974–2002) were analyzed. The incidence of ocular involvement was calculated in terms of person-years (PY) of follow-up. Risk factors for ocular involvement were analyzed using log-rank and Fisher exact tests.
• RESULTS: At initial ocular examination (baseline), 30 patients (9.9%) had intraocular inflammation only (anterior chamber cells and flare, vitreous inflammatory reactions, retinal whitening), without clinically apparent necrotizing retinochoroiditis. At baseline, men were more likely to have ocular involvement ($P = .043$) and antiparasitic treatment was associated with less ocular involvement ($P = .015$). Follow-up examinations were performed on 255 patients (median follow-up, 13.7 months [range 0.4–261.9 months]). Among those without ocular involvement at baseline, the incidence of necrotizing retinochoroiditis was 6.4/100 PY. Patients >40 years of age at first IgM test had a greater risk of incident necrotizing retinochoroiditis (hazard ratio = 4.47, 95% CI = 1.67–11.93, $P = .003$) than younger patients. The incidence of recurrent necrotizing retinochoroiditis was 10.5/100 PY.
• CONCLUSION: Isolated intraocular inflammatory reactions can be an initial manifestation of *T gondii* infection, with necrotizing retinochoroiditis occurring months or years later. Male sex and older age are risk factors for toxoplasmic retinochoroiditis. Antitoxoplasmic treatment may protect against early ocular inv 9(6): 100 ved.)

C ALLY acquired *Toxoplasma gondii* infection is responsible for the majority of ocular toxoplasmosis cases.[1–3] Sources of infection include ingestion of tissue cysts in raw or undercooked meat and ingestion of oocysts in soil, water, or food contaminated with feces of infected cats.[4–6] The incidence and characteristics of ocular lesions related to recent postnatally acquired toxoplasmosis have been described during outbreaks,[7–12] but information about early ocular involvement, course of disease, and risk factors associated with ocular toxoplasmosis from sporadic, postnatally acquired *T gondii* infection is limited because of low prevalence in most regions and the fact that the time of initial *T gondii* infection typically is not known. Nonocular *T gondii* infection is often asymptomatic, and clinically apparent retinal lesions may first develop years after systemic infection; these factors preclude the determination of when most people with endemic ocular toxoplasmosis first became infected.[1–4]

In Erechim, a city located in an agricultural region of Rio Grande do Sul, the southernmost state of Brazil, up to 85% of the population is infected with *T gondii* and 17.7% of infected individuals have ophthalmic findings consistent with ocular toxoplasmosis.[3] In this study, we took advantage of the high prevalence of *T gondii* infection and associated ocular toxoplasmosis in Erechim to study the ophthalmic features of postnatally acquired *T gondii* infection.

METHOD

IN THIS RETROSPECTIVE LONGITU we used a dataset created by 1 author (C.S.) in 2002; it includes all patients older than 1 year of age, with at least 1 positive test for anti–*T gondii* IgM antibodies, who were examined between 1974 and 2002 by 1 ophthalmologist

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(author C.S.) at Clínica Silveira in Erechim, Rio Grande do Sul, Brazil. Patients either had been referred to Clinica Silveira because of a positive IgM antibody test ordered by a non-ophthalmologist for reasons other than eye disease, or had undergone IgM antibody testing as evaluation of presumed toxoplasmic retinochoroiditis without evidence of prior infection that was identified at Clinica Silveira. The specific reason that IgM testing was ordered for those patients referred to Clinica Silveira with positive tests was not recorded. A known reason for such testing is screening of women during pregnancy, especially for those who have lymphadenopathy and other constitutional signs and symptoms, because of high prevalence of *T gondii* infection in the general population. Individuals with positive anti–*T gondii* IgM tests are routinely referred by internists or obstetricians for ocular examination, whether or not they have visual symptoms, because of the high prevalence of ocular involvement among people with *T gondii* infection in that area. Not included in the dataset were individuals with acquired immunodeficiency syndrome (AIDS) or other immune system diseases and those receiving immunosuppressive drugs (other than corticosteroids for ocular toxoplasmosis). This study was approved by the Institutional Review Board (IRB) of the Universidade Federal de São Paulo (Comitê de Ética em Pesquisa da Universidade Federal de São Paulo–UNIFESP/EPM) prior to retrospective data collection, and analysis of previously collected, de-identified data was approved by the IRBs at the University of California, Los Angeles and the United States Centers for Disease Control and Prevention.

Anti–*T gondii* IgM antibody tests were performed at the Laboratório Fleury (São Paulo, Brazil), using either an indirect immunofluorescence assay or a microparticle enzyme immunoassay (Abbot AxSYM; Abbott Laboratories, Abbott Park, Illinois, USA). For the immunofluorescence assay, a titer ≥1:16 was considered positive. For the immunoenzymatic assay, values ≤0.499 were considered negative; values between 0.500 and 0.599 were considered indeterminant; and values ≥0.600 were considered positive. For the immunoenzymatic assay, the reported test sensitivity is 96.3% and specificity is 99.8% (package insert for Abbot AxSYM anti–*T gondii* IgM antibody assay), although sensitivity and specificity of the test has not been determined specifically for the population studied. The aforementioned values pertain to published test standards at the time of data collection. Although test kits may have changed with different cut-off values during the 28-year period of data collection, recording of positive results was always in reference to contemporary cut-off values.

• **DATA COLLECTION:** The following demographic and medical data were collected: age at time of first anti–*T gondii* IgM antibody test; age at first identification of ocular involvement related to *T gondii* infection (intraocular inflammatory reactions, necrotizing retinochoroiditis, retinochoroidal scars); age at diagnosis of recurrent toxoplasmic retinochoroiditis; sex; presence of signs or symptoms of nonocular toxoplasmosis at time of IgM testing; and use of systemic anti–*T gondii* treatment at or before baseline. The following information was collected for each involved eye at each examination: presence or absence of intraocular inflammatory reactions (anterior chamber cells and flare, vitreous inflammatory reactions, retinal vascular sheathing, or focal retinal whitening without clinical evidence of retinal necrosis); presence or absence of necrotizing retinochoroiditis; and presence or absence of retinochoroidal scars. In a previous publication, the phenomenon of isolated focal retinal whitening in people with serologic evidence of recent *T gondii* infection has been shown to resolve without clinically apparent scar formation.[13] We have hypothesized that lesions represent foci of retinal infiltration where *T gondii* tissue cysts have colonized the retina.[13] In contrast to a study of epidemic disease,[12] retinal whitening was not categorized separately from other intraocular inflammatory reactions. For eyes with necrotizing retinochoroiditis, the size of the largest lesion (<1 optic disc area [da] vs ≥1 da) and the presence or absence of macular and foveal involvement were determined. Data on intraocular pressure and visual acuity were not analyzed, as these were not relevant to the purpose of this study.

• **CONVENTIONS AND DEFINITIONS:** Baseline was defined as the date of the first eye examination that was performed either within 3 months before or at any time after the first positive anti–*T gondii* IgM antibody test. Ocular involvement that occurred within the window of 3 months before or 3 months after the first positive anti–*T gondii* IgM antibody test was considered to be "immediate" for purposes of the study. We used the same definitions of terms and study conventions that were used in our study of epidemic *T gondii* infection.[12] On the basis of these definitions, we categorized ophthalmic findings further using 1 or more of the following terms: necrotizing retinochoroiditis (denoting active disease); retinochoroidal scars consistent with healed *T gondii* retinal infection; isolated intraocular inflammatory reactions; initial necrotizing retinochoroiditis; recurrent necrotizing retinochoroiditis; primary lesions; satellite lesions; and first incident ocular disease.

• **DATA ANALYSIS AND STATISTICAL TECHNIQUES:** Incidence of ocular involvement was calculated in terms of events per 100 person-years (PY) of follow-up. For comparison of outcomes between those with and those without intraocular inflammatory reactions at baseline, Time 0 was defined as the baseline date. For other longitudinal analyses, Time 0 was defined as the date of first positive anti–*T gondii* IgM antibody test. Primary necrotizing retinochoroiditis lesions that occurred 6 months or longer after first positive anti–*T gondii* IgM antibody test were considered incident lesions, whether or not a prior eye examination had been performed. If primary necrotizing retinochoroiditis lesions were identified on a baseline examination that was performed between 3 and 6 months after the first positive anti–*T gondii* IgM antibody test, we felt that they could not be categorized reliably as being immediate or incident, and they were excluded from some analyses. For individuals with new retinochoroidal scars during follow-up, ocular disease was assumed to have occurred when the scar was identified, for purposes of calculating intervals.

Because only women were screened routinely for anti–*T gondii* IgM antibodies during pregnancy, there was the possibility of ascertainment bias, in which more women without disease were examined than men without disease. To address this issue and to investigate whether it was likely to influence relationships between sex or age and ocular disease, we compared men and women for the following factors: age at baseline; percent with ocular involvement at baseline; percent with systemic disease, but no ocular involvement at baseline; and treatment at baseline. Because of the possibility that age at presentation could vary by indication for examination, we also compared the percent on treatment at baseline between younger (≤40 years of age) and older (>40 years of age) patients.

Statistical analysis was performed using SAS software version 9.3 (SAS, Inc, Cary, North Carolina, USA). Cumulative risk of ocular involvement was estimated using the Kaplan-Meier method and compared using the log-rank test. Relative risks were expressed as hazard ratios (HR), estimated from Cox proportional hazards regression models. The Fisher exact test was performed to evaluate relationships between categorical variables, and the student *t* test was used in the analysis of continuous variables. A *P* value of $< .05$ was considered to be statistically significant.

TABLE 1. Demographic and Medical Data for 302 Individuals With Serologic Evidence of Postnatally Acquired *Toxoplasma gondii* Infection in Erechim, Brazil

Characteristics	Value
Sex, n (%)	
Male	129 (42.7%)
Female	173 (57.3%)
Age at baseline (y)	
Mean ± SD	21.9 ± 14.4
Median (range)	21 (1–63)
Clinically apparent nonocular toxoplasmosis at baseline,[a] n (%)	183 (68.3%) (total n = 268)[b]
Ophthalmic findings at baseline, n (%)	
Active disease	134 (44.4%)
Isolated intraocular inflammation[c]	30 (9.9%)
Initial, primary necrotizing retinochoroiditis	104 (34.4%)
Retinochoroidal scar only	5 (1.7%)
Antitoxoplasmic treatment at or before baseline, n (%)	159 (54.5%) (total n = 292)[b]
Follow-up data available after infection (n = 297),[d] n (%)	255 (85.9%)
Duration of follow-up after infection (mo)	
Mean ± SD	33.7 ± 49.8
Median (range)	13.7 (0.4–261.9)

SD = standard deviation.

[a]Arthralgia, fatigue, fever, malaise, lymphadenopathy, sore throat, or a combination of these disorders at the time of positive anti–*T gondii* IgM antibody testing.

[b]Number of individuals for whom values were known, if different than 302.

[c]Anterior chamber cells, retinal vitreous humor cells or haze, retinal vascular sheathing, retinal infiltrates without retinal necrosis, or a combination of these findings in the absence of necrotizing retinochoroiditis.

[d]Excluding those with scars at baseline (n = 5).

RESULTS

A TOTAL OF 302 PATIENTS MET INCLUSION CRITERIA. AT baseline, 5 patients had inactive retinochoroidal scars, suggesting remote healed disease; these patients were excluded from analysis. The majority of patients (n = 239, 79.1%) had been referred for ocular evaluation because of a positive anti–*T gondii* IgM antibody test; for the other 63 patients (20.9%), the IgM test had been ordered by the examining ophthalmologist during investigation of initial primary necrotizing retinochoroiditis lesions. Ocular examination was performed within 3 months of, or at the same time as, the first positive anti–*T gondii* IgM antibody test in 258 patients (85.4%). Follow-up examinations after first positive anti–*T gondii* IgM antibody test were performed on 255 patients (median follow-up: 13.7 months [range 0.4–261.9 months]). During follow-up, persistence of anti–*T gondii* IgM antibodies for 1 year or longer on repeat testing was known to have occurred in 25 patients; they did not differ in demographic or clinical characteristics from the rest of the study population (data not shown).

Table 1 lists demographic, medical, and ophthalmic characteristics for the studied population. Isolated intraocular inflammation was present in 30 patients (9.9%) at baseline; inflammation was unilateral in 27 patients. In all but 2 patients, intraocular inflammation was observed within 3 months of the first positive IgM test (5 months in 1 case; 8 months in another). Women were more likely than men not to have clinically apparent systemic disease or ocular involvement at baseline (25.7% [38 of 148 patients] vs 5.0% [6 of 120 patients], respectively, $P <$ .001), as might be expected because of serologic screening during pregnancy. There were no significant differences, however, between men and women for the following factors at baseline: percent with ocular involvement; percent with systemic disease, but no ocular involvement; and treatment (Supplemental Table, available at www.ajo.

Estrutura de um artigo científico- exemplo

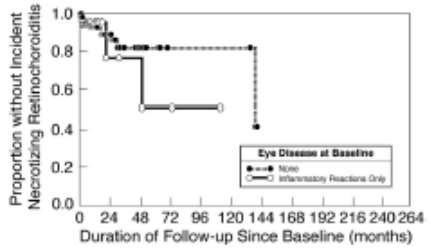

FIGURE 2. Kaplan-Meier plots showing the proportion of individuals with serologic evidence of postnatally acquired *T gondii* infection (anti–*T gondii* IgM antibodies) who remained free of necrotizing retinochoroiditis. No statistically significant difference was identified in risk of necrotizing retinochoroiditis between individuals with intraocular inflammation at initial eye examination (solid line) and those without (dotted line) intraocular inflammation at initial eye examination (hazard ratio = 1.63, 95% confidence interval = 0.44-6.05, $P = 0.46$). Time 0 corresponds to the initial eye examination (baseline).

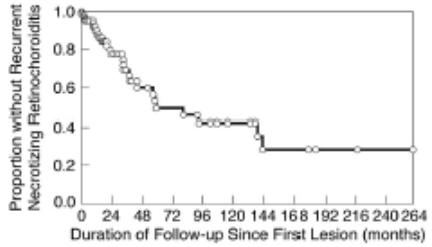

FIGURE 3. Kaplan-Meier plot showing the proportion of individuals with serologic evidence of postnatally acquired *T gondii* infection (anti–*T gondii* IgM antibodies) and necrotizing retinochoroiditis lesions who remained free of recurrences. Time 0 corresponds to the first identification of necrotizing retinochoroiditis.

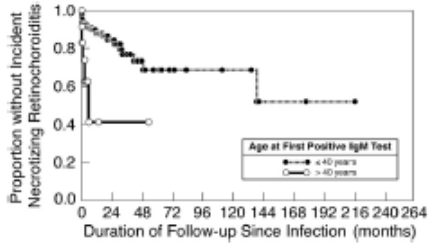

FIGURE 4. Kaplan-Meier plots showing the proportion of individuals with serologic evidence of postnatally acquired *T gondii* infection (anti–*T gondii* IgM antibodies) who remained free of necrotizing retinochoroiditis, grouped by age at first positive anti–*T gondii* IgM antibody test. There was a significantly increased risk of necrotizing retinochoroiditis among individuals older than 40 years (solid line; hazard ratio = 4.47, 95% confidence interval = 1.67–11.93, $P = .003$) vs those 40 years of age or younger (dotted line). Time 0 corresponds to the first positive anti–*T gondii* IgM antibody test.

of selected host factors and retinal lesion characteristics. Older patients (>40 years) had larger retinal lesions ($P = .044$), but no other associations were identified. In 3-way comparisons (ages 1–20 years; 21–40 years; >40 years), statistical differences were not identified when considering either risk for development of retinal lesions or the size of lesions; findings were similar for the 2 youngest age groups in each assessment (data not shown).

DISCUSSION

STUDIES OF TOXOPLASMOSIS IN ERECHIM HAVE PROVIDED valuable information regarding the epidemiology, course, and characteristics of disease.[3,5,13–17] Approximately 85% of the population in this area has serologic evidence of *T gondii* infection, and the majority is thought to have been infected postnatally.[3] In support of this belief is the observation that <2% of cord blood specimens collected from hospitals in Erechim during 1990 contained anti–*T gondii* IgM antibodies, and more recent neonatal screening revealed the prevalence of *T gondii* infection to be only 1 per 3000 live births.[18] A population-based household survey in Erechim revealed that 17.7% of *T gondii*–infected individuals have retinochoroidal lesions consistent with ocular toxoplasmosis,[3] confirming a high prevalence of eye disease among individuals with postnatally acquired toxoplasmosis. The even higher cumulative risk of necrotizing retinochoroiditis in our study population (41.2% after 48 months) may be attributable to referral and ascertainment bias (with those having eye disease more likely to present for evaluation) or to differential loss to follow-up (with those having eye disease more likely to return for re-examination) or a combination of these factors. An artifactually high prevalence estimate will not necessarily influence the relationships between risk factors and timing or severity of disease, however.

The prevalence of *T gondii* infection and risk of ocular disease is substantially different in southern Brazil than in the United States, where only 14% of the general population is infected with *T gondii* by age 40 years,[19] and the prevalence of ocular toxoplasmosis among infected individuals has been estimated to be only 2%.[2] It has been hypothesized that these discrepancies are related to a difference in endemic parasite genotypes; there is a greater diversity of genotypes in southern Brazil than in North

Estrutura de um artigo científico- exemplo

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Introdução

- Idealmente 4-6 parágrafos em um artigo, mais longa em teses
- Deve contextualizar o leitor no assunto, o que é sabido e as lacunas no conhecimento
- “Fechar” a introdução caminhando para a descrição dos objetivos do estudo

Objetivos

- Devem ser claros, escritos de maneira sucinta
- Devem ser mensuráveis
- Um ou poucos objetivos por estudo

Materiais e métodos

- “Receita de bolo”: descrição detalhada da metodologia utilizada, e dos materiais/equipamentos usados

- Devem ser desenhados de maneira que consigamos responder as hipóteses levantadas

- Idealmente escritos de uma maneira que outros pesquisadores possam ler, entender e replicar o estudo

Resultados

- Podem ser descritos em texto, tabelas ou figuras
- Artigo: normalmente 4-5 figuras/tabelas
- Somente o mais importante deve constar nas tabelas; o menos importante pode estar descrito no texto
- Devem estar alinhados com os objetivos propostos

Discussão/conclusão

- Deve resumidamente descrever os achados mais importantes
- Comparação com estudos feitos anteriormente
- Descrição de limitações do estudo
- Conclusão com sugestão de novos estudos que completem o projeto em questão

Plágio

- Com ou sem intenção

BOAS PRÁTICAS

Universidades brasileiras contra o plágio

Campanhas, softwares e treinamento são utilizados por grandes instituições de ensino superior no país para coibir a cópia de trabalhos acadêmicos

Algumas das maiores universidades brasileiras se mobilizam para coibir o plágio em trabalhos acadêmicos de estudantes e professores. Em março, a Pontifícia Universidade Católica do Rio de Janeiro (PUC-Rio) lançou uma campanha com peças publicitárias que exibem frases como "troquei seis por meia dúzia", "aproveitei só um pedacinho do texto" e "só usei uma vez essa imagem". "São expressões frequentemente utilizadas pelos alunos para justificar a prática. Adotamos uma linguagem simples e direta para mostrar aos estudantes que plágio é crime", diz José Ricardo Bergmann, vice-reitor da PUC-Rio. Ele explica que o esforço da instituição não se

a integridade científica, mas diz que é preciso se preparar para agir diante de problemas concretos. Ele ainda faz um alerta: "O plágio pode ser fruto de má-fé, mas muitas vezes ocorre por falta de preparo do aluno, que não sabe como fazer citações e referências nem compreende bem o conceito de autoria."

Na Universidade de São Paulo (USP), por exemplo, um estudante de mestrado da área de biologia também teve a dissertação cancelada, pois havia utilizado dados levantados por um colega de laboratório sem dar os créditos. "O aluno justificou que não sabia que estava cometendo plágio", relata Carlos Gilberto Carlotti Junior, pró-reitor

www.fapesp.br

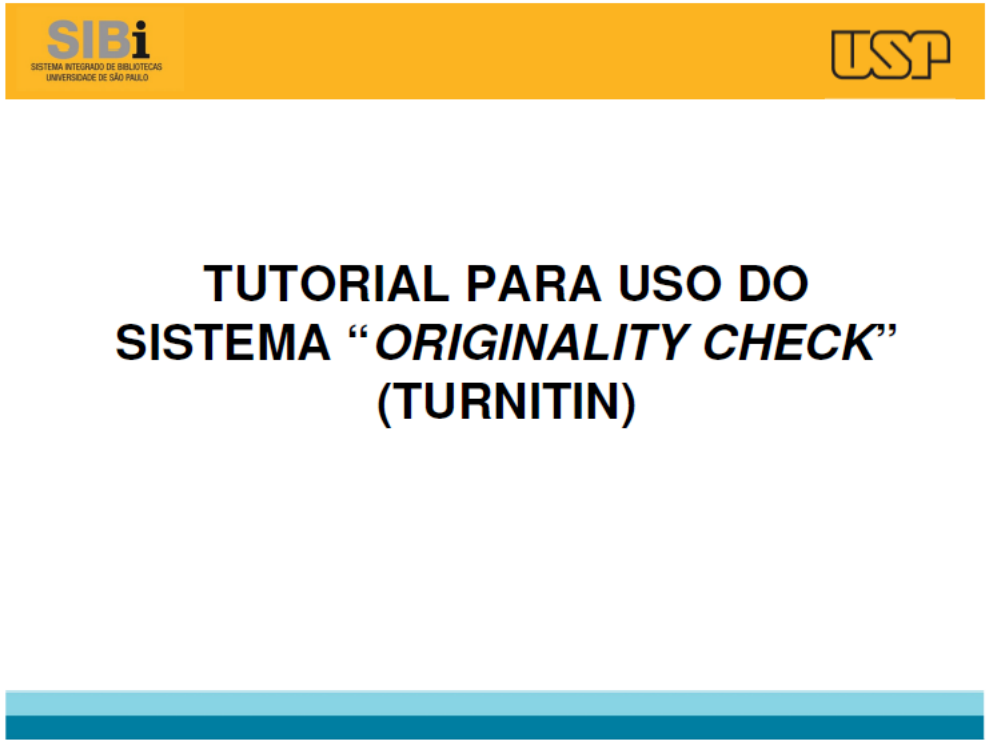
Como citar um artigo (não plagiá-lo)

- Citar- dar crédito a um grupo que estudou/descreveu algo
- Plágio
- Implicações relacionadas ao plágio
- Mecanismos de detecção de similaridades em textos (Turnitin, Grammarly)

Turnitin

http://turnitin.com/pt

Turnitin



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Turnitin

Semiologia e exame físico oftalmológico

Introdução

A oftalmologia é a ciência que se dedica ao estudo da visão. Trata-se de uma área da medicina bastante ampla. O oftalmologista deverá, como qualquer ramo da medicina, estabelecer relação médico-paciente adequada, visando colaboração mútua, o que será de grande valia para a obtenção de uma boa história clínica pelo profissional, quanto na adesão do paciente ao tratamento. Um bom relacionamento entre ambos inicia-se com médico chamando o paciente pelo nome e cumprimentando-o com um aperto de mãos. O contato físico é de extrema importância, pois muitas vezes, o profissional da saúde estará lidando com pessoas que possuem baixa acuidade visual.

Anamnese

A anamnese é uma importante parte da consulta oftalmológica para a investigação sobre a queixa e duração dos sintomas que fizeram com que o paciente procurasse o médico, da história pregressa desse problema, antecedentes pessoais, oculares e sistêmicos e os antecedentes familiares.

É importante caracterizar com clareza os sintomas, no sentido de investigar a forma de aparecimento do problema, se foi insidioso ou agudo, s e houve perdas visuais, escurecimento, embaçamento e alteração de campo visual. Outros fatores relevantes que se fazem necessários em uma boa anamnese é questionar o paciente acerca de surgimento de dor e hiperemia oculares, associação da dor ao piscar, entre outras.

De forma mais detalhada em relação aos antecedentes pessoais e familiares, é de extrema importância investigar antecedentes com possível repercussão direta com o quadro clínico atual do paciente, uso de óculos ou lentes de contato, cirurgias prévias, traumas e doenças oculares, diagnóstico de Diabetes Mellitus, hipertensão arterial, doenças essas que podem cursar com repercussões oftalmológicas que se não tratadas, podem levar à

Anatomia do olho humano

Para a realização de um exame físico adequado, é necessário que o examinador domine o conhecimento anatômico funcional das estruturas normais da visão, para não diagnosticar como alterado o que está dentro dos padrões da normalidade e vice-versa.

O olho é o órgão sensorial da visão, por meio dele o ser humano recebe cerca de 80 % de seu aporte sensorial, suas partes principais são:
Cristalino - é a lente dos olhos, se localiza entre a íris e o vítreo;
Pupila – localiza-se no centro da íris, é a porta de entrada; é ela quem regula o fluxo de luz para a retina;
Íris - é a parte mais visível (e colorida) do olho;
Córnea – camada externa do olho é a parte anterior transparente e protetora do olho;
Retina - é a parte do olho responsável pela formação de imagens, ou seja, pelo sentido da visão;
Mácula – é uma região da retina onde se encontra a maior densidade de células fotorreceptoras do tipo Cones do olho, responsáveis pela visão de cores.

A musculatura ocular extrínseca é composta por quatro músculos retos (superior, inferior, lateral e medial) e dois oblíquos (superior e inferior). O nervo abducente é responsável pela inervação do músculo reto lateral, o nervo troclear inerva o oblíquo superior e os demais são inervados pelo oculomotor.

Turnitin

Neste item, o examinador avaliará a movimentação ocular através do funcionamento dos seis músculos extra-oculares, já citados no subitem de anatomia do olho humano, de cada olho (ducções) e dos dois olhos funcionando em conjunto (versões). Pede-se para o paciente fixar um ponto luminoso, assim, é testada a função de cada músculo extrínseco. A fusão binocular, pela qual os eixos são automática e simultaneamente ajustados ao ponto de fixação nas diversas distâncias, é um dos principais mecanismos de controle motor do sistema visual do sistema nervoso central. O teste da cobertura ("cover test") é utilizado para a verificação de estrabismos ou de heteroforias, através desvio do eixo visual pela oclusão de um dos olhos, que deve, também, ser feita de maneira alternada. Por exemplo, se uma pessoa for ortofórica e tiver um de seus olhos cobertos, o outro olho continua fixando a mira (localizada a aproximadamente 30 centímetros, se o teste for para perto, ou 5m se for para longe) e não aparecerão movimentos oculares, mesmo no teste alternante. Se o paciente tiver uma heteroforia (endoforia ou exoforia), quando os olhos forem ocluídos alternadamente, o olho que está descoberto vai realizar um pequeno movimento para fixar a mira, fato que pode ocorrer, também, quando o olho dominante for ocluído. Já nos estrabismos, a oclusão de um dos olhos será seguida de um movimento do outro, para fora ou para dentro, a menos que haja supressão ou que o olho não tenha visão. O teste de Hirschberg é útil para a medida dos desvios oculares, durante a fixação para

RELATÓRIO DE ORIGINALIDADE

14%	14%	8%	0%
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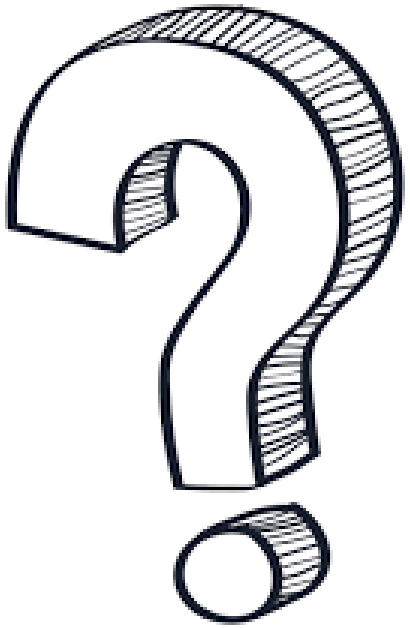
FONTES PRIMÁRIAS

1	docplayer.com.br Fonte da Internet	8%
2	www.centrodeoftalmologia.com.br Fonte da Internet	5%
3	ranieralph.weebly.com Fonte da Internet	<1%
4	Pinheiro Júnior, Manuel Neuzimar(Santos, Regina Cândido do Carmo). "Uso oral do óleo de linhaça (linum usitatissimum) no tratamento do olho seco de pacientes portadores da Síndrome de Sjögren", RIUnB, 2007. Publicação	<1%

No exemplo acima:

- É plágio? Por que?

- No caso de plágio, o que fazer para evita-lo?



Referências bibliográficas

Referências

- Antes de iniciar a escrita, checar quais são as normas de referencias requisitadas pela revista científica, comissão de graduação ou pós graduação

- Exemplo: estilo Vancouver

- Exemplo: Medrano MJ, Cerrato E, Boix R, Delgado-Rodríguez M. Factores de risco cardiovascular na população espanhola: metaanálises de estudos transversais. Med Clin (Barc). 2005; 124(16): 606-12.
- Exemplo: Sosa Henríquez M, Filgueira Loiro J, López-Harce Cid JA, Díaz Curiel M, Lozano Tonkin C, do Castillo Roda A et a o. Que opinam os internistas espanhóis da osteoporosis?. Rev Clin Esp. 2005; 205(8): 379-82.

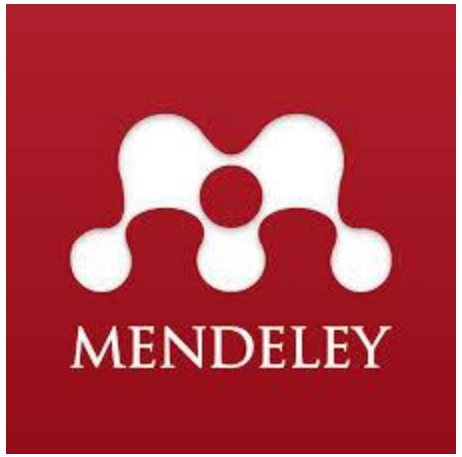
Referências

- Na maioria dos estilos, são citadas em ordem crescente numérica conforme aparecem no texto

- Programas que auxiliam na organização de referências

Programas de organização de referências

- Programas de organização de referências



A importância do título adequado

O que chama a atenção em um artigo?

- Título
- .....
- ....
- Resumo
- ....
- ....
- ...

- ..
- ..
- .
- .
- Artigo em si

Título

- Tentar captar a atenção do leitor
- Escrito de maneira sucinta, que resuma a ideia do estudo
- Se o leitor se interessar, ele vai abrir e ler o resumo

Como montar o resumo do artigo científico

Resumo

- Checar normas da revista em questão
  - Número de palavras, estruturação, etc
- Deve contar somente dados descritos no texto principal

- Somente o que é mais importante deve constar no resumo

- Idealmente escrevê-lo após a finalização do texto principal, pois mudanças no texto podem impactar também no resumo

Diferenças entre artigos, TCC, dissertação de mestrado e tese de doutorado

Diferenças

- TCC, teses e dissertações: mais espaço para escrita, lista de abreviaturas, resumo em inglês e português, dedicatória, capa

- Artigos: maior limitação em relação ao limite de palavras, normalmente em um idioma só

Dicas de como escrever (e publicar) bem

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PLoS COMPUTATIONAL BIOLOGY

Editorial

Ten Simple Rules for Getting Published

Philip E. Bourne

The student council (http://www.iscbsc.org/) of the International Society for Computational Biology asked me to present my thoughts on getting published in the field of computational biology at the Intelligent Systems in Molecular Biology conference held in Detroit in late June of 2005. Close to 200 bright young souls (and a few not so young) crammed into a small room for what proved to be a wonderful interchange among a group of whom approximately one-half had yet to publish their first paper. The advice I gave that day I have modified and present as ten rules for getting published.

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Bourne PLoS Comp Biology 2005

Dicas

- 1) Leia constantemente
  - Aprenda com os exemplos bons e ruins
- 2) Seja objetivo
- 3) Bons revisores serão objetivos em relação ao seu trabalho
- 4) Faça aulas de inglês

Dicas

- 5) Acostume-se a ter artigos recusados por revistas científicas
- 6) Faça o óbvio: boa organização do artigo, uso apropriado de figuras e tabelas, tamanho adequado, escrever para a audiência adequada
- 7) Escreva constantemente
- 8) Qualidade é tudo

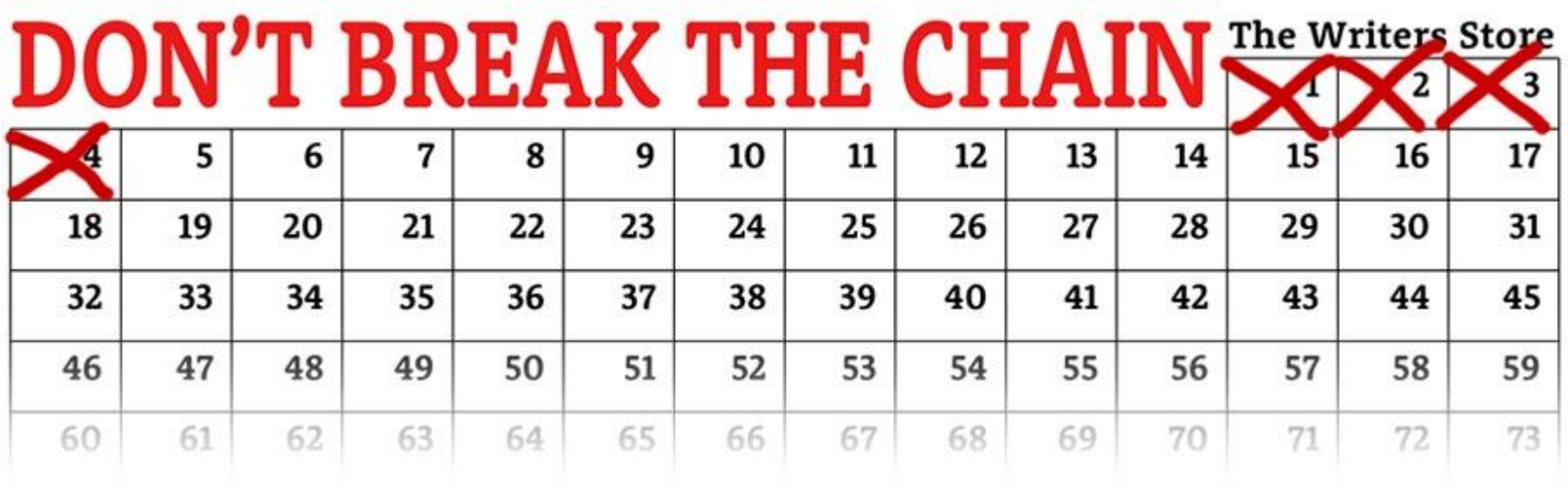
Passos (sugestão)

Ordem da escrita

- Outline
- Métodos
- Resultados (e tabelas, figuras)
- Discussão/Introdução
- Título
- Abstract

Quando e quanto escrever?

- Sempre
- Um pouco por dia se possível
- Tempo “protegido” para escrita
- Pensar em horário de maior rendimento

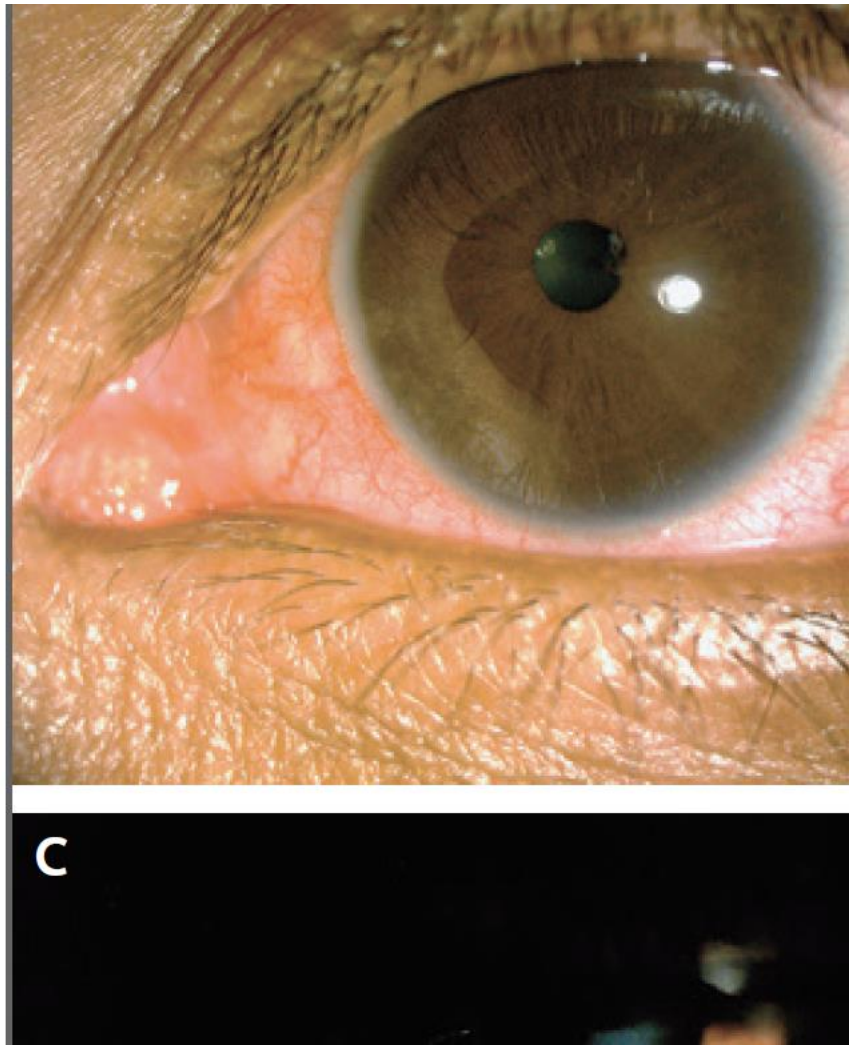


1) Definir revista-alvo e seguir seu formato

- Número de palavras, referências, tabelas, figuras, autores
- Revista paga ou não
- Idioma → Inglês sempre
- Fator de impacto
- Público-alvo

Descrevendo inflamação intraocular: revista de saúde geral

Eight days after the onset of systemic symptoms, ophthalmic evaluation showed a visual acuity of 20/20 in the patient's right eye and 20/40 in his left eye (the latter acuity was attributed to amblyopia that had been detected in the patient at a young age). The examination also showed conjunctival hyperemia bilaterally (Fig. 1A and 1B), bilateral nongranulomatous keratic precipitates, and grade 0.5+ leukocytes (on a scale of 0 to 4+, with higher grades indicating more cells per field)[5] in the anterior chamber of the right eye and grade 2+ flare (on a scale of 0 to 4+, with higher grades indicating more intense flare)[5] in the left eye.



Descrevendo inflamação intraocular: Revista de inflamação ocular

INTRODUCTION

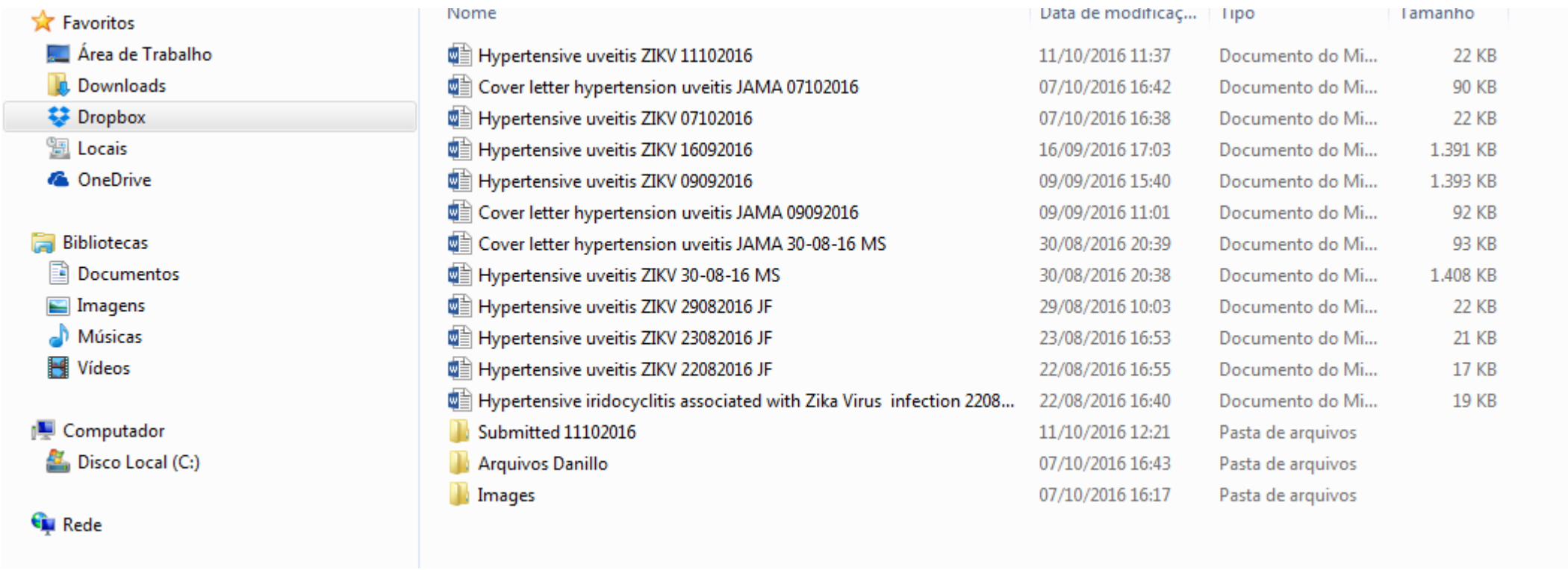
Roth spots, white-centered retinal hemorrhages, were first described in patients presenting with bacterial endocarditis, and over the years were also associated with other medical conditions such as diabetic retinopathy,[1] multiple myeloma,[2] anemia,[3] and others. We report an unusual case of ocular toxoplasmosis (OT) associated with Roth spots and describe optical coherence tomography (OCT) findings.

CASE REPORT

A 20-year-old Caucasian man presented to the local eye clinic with a sudden decrease of visual acuity (VA) in his right eye, associated with conjunctival hyperemia, pain and floaters. He denied local trauma, and besides a presumed OT retinochoroidal scar in his left eye diagnosed by an ophthalmologist in his hometown during a check-up, his ocular and general medical history was unremarkable, and so was his family history of ocular diseases. His best corrected VA was 20/32 OD and 20/20 OS. On slit-lamp examination, his right eye (OD) presented a mild diffuse conjunctival hyperemia, 2+ cells in the anterior chamber with fine keratic precipitates; his intraocular (IOP) pressure was 37 mmHg OD and 10 mmHg OS. In his OD, indirect ophthalmoscopy revealed an active retinochoroidal lesion on the upper nasal border of the optic disc associated with local hemorrhage and vitreous haze. The posterior pole presented flame-shaped retinal hemorrhages, and some of them were white-centered (Figure 1). In his left eye, only a

Outras sugestões

- Salvando rascunhos



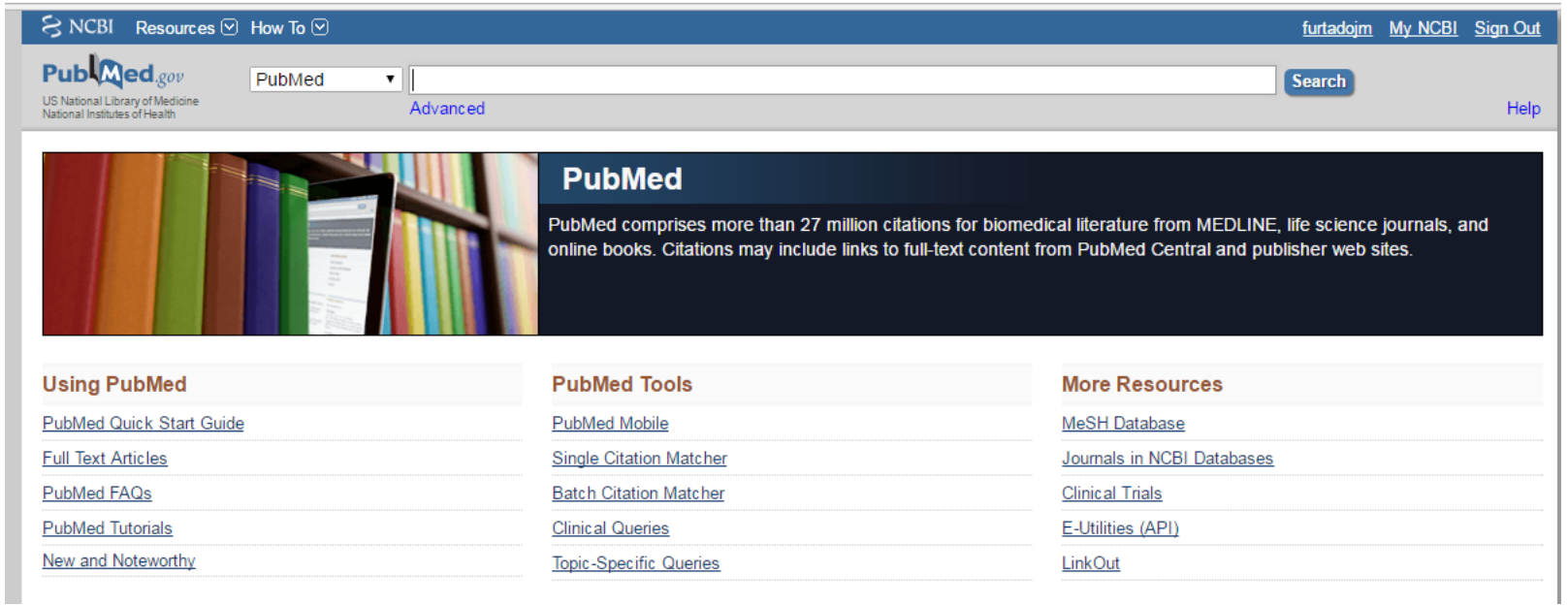
Outras sugestões

- Pesquisa Pubmed

- https://pt.slideshare.net/bibliotecaee/tutorial-pubmed-mdulo-bsico

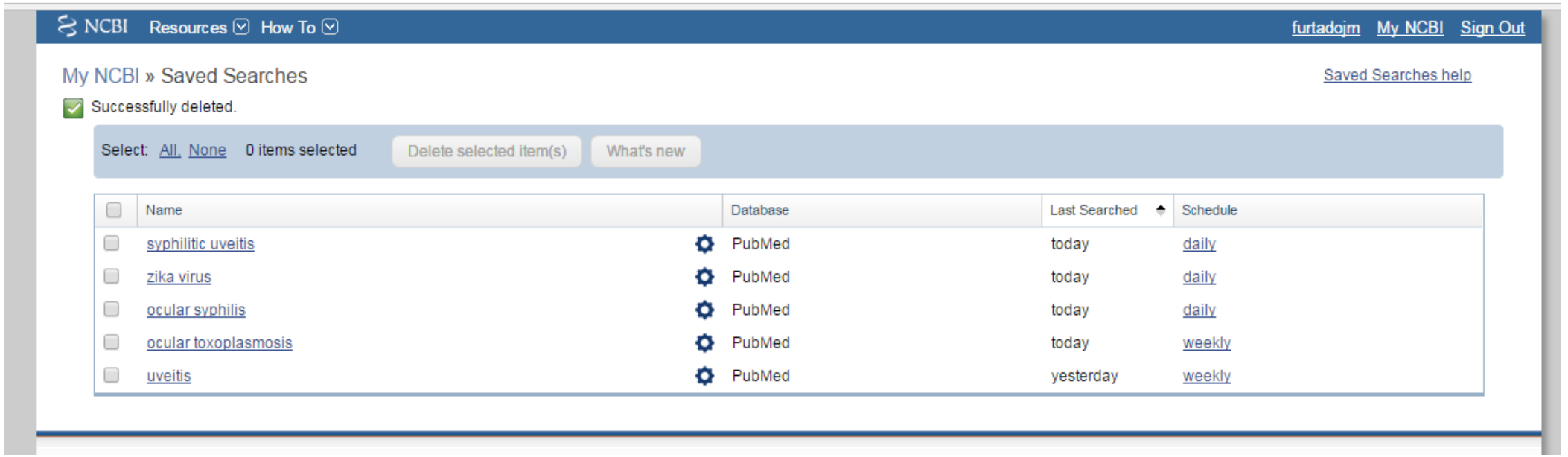
Outras sugestões

- Pesquisa Pubmed



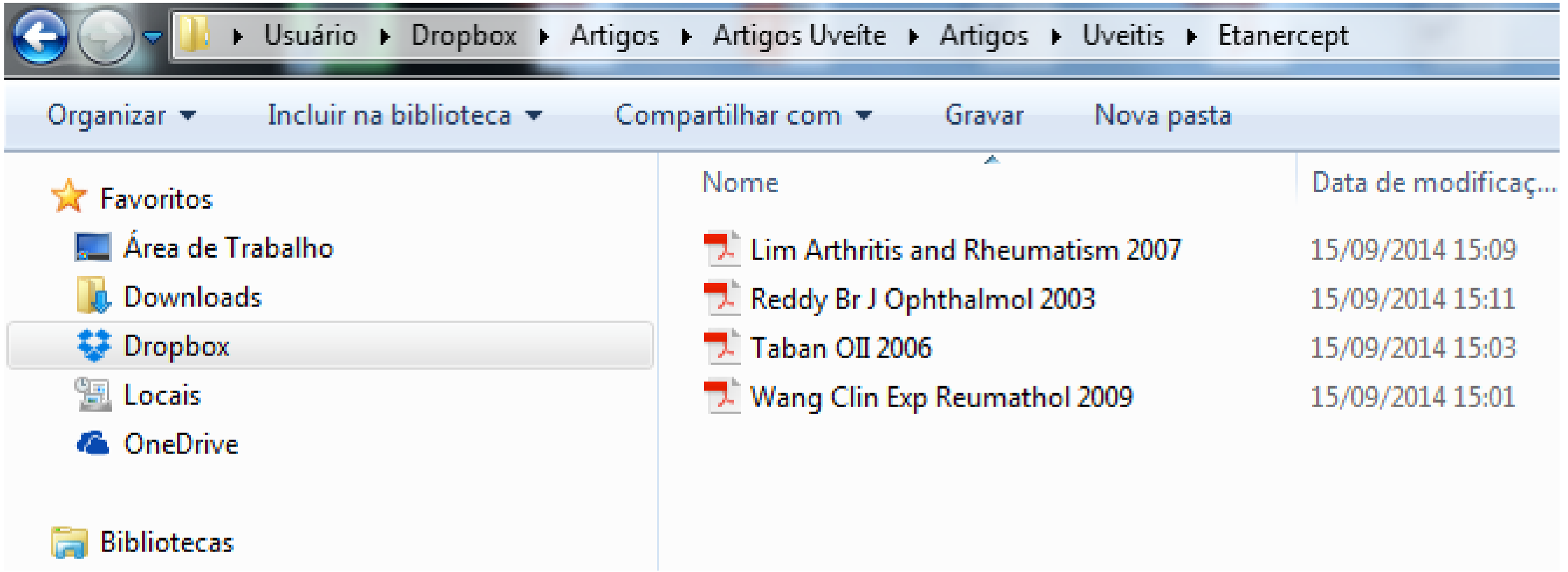
Outras sugestões

- Pesquisa Pubmed

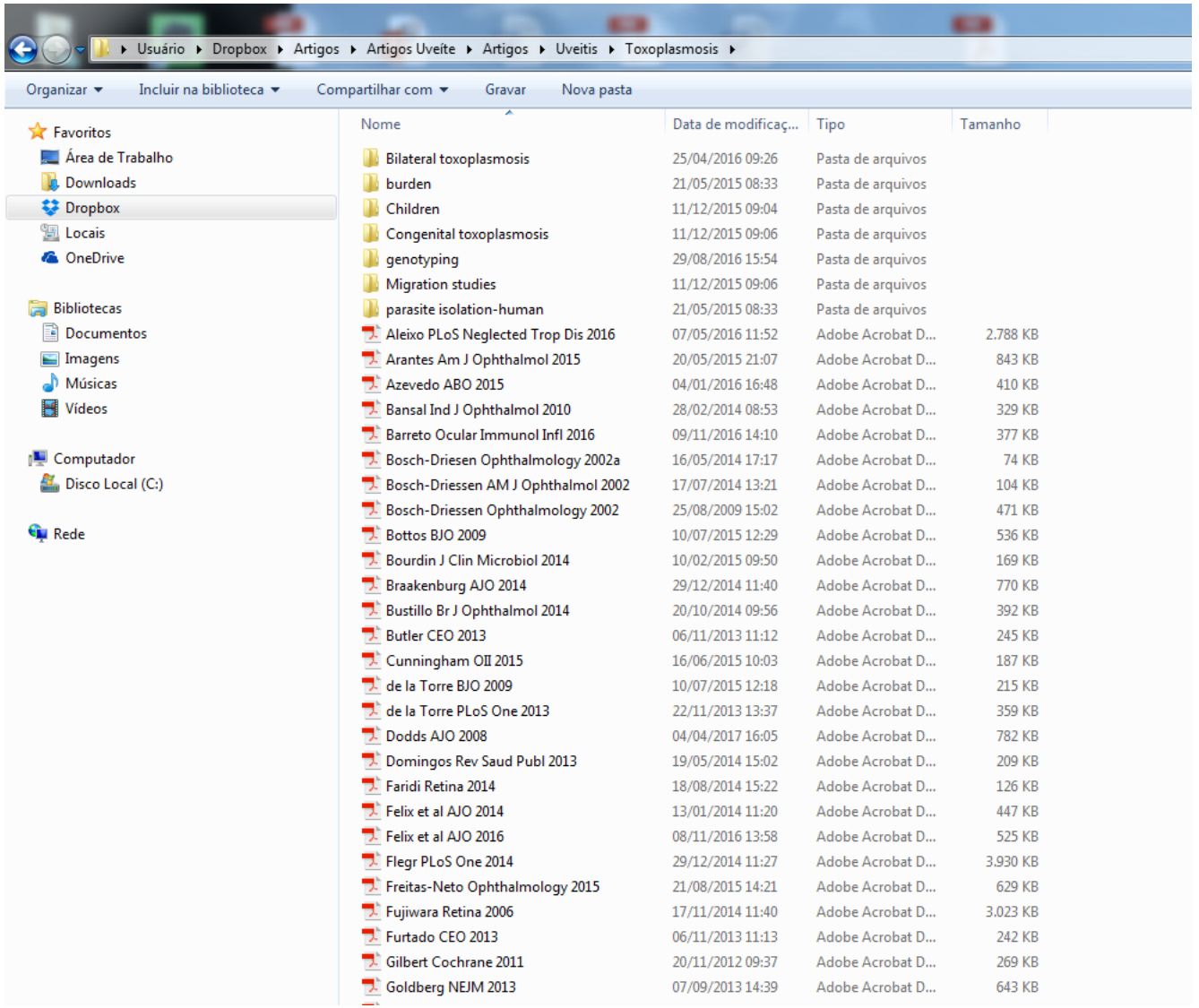


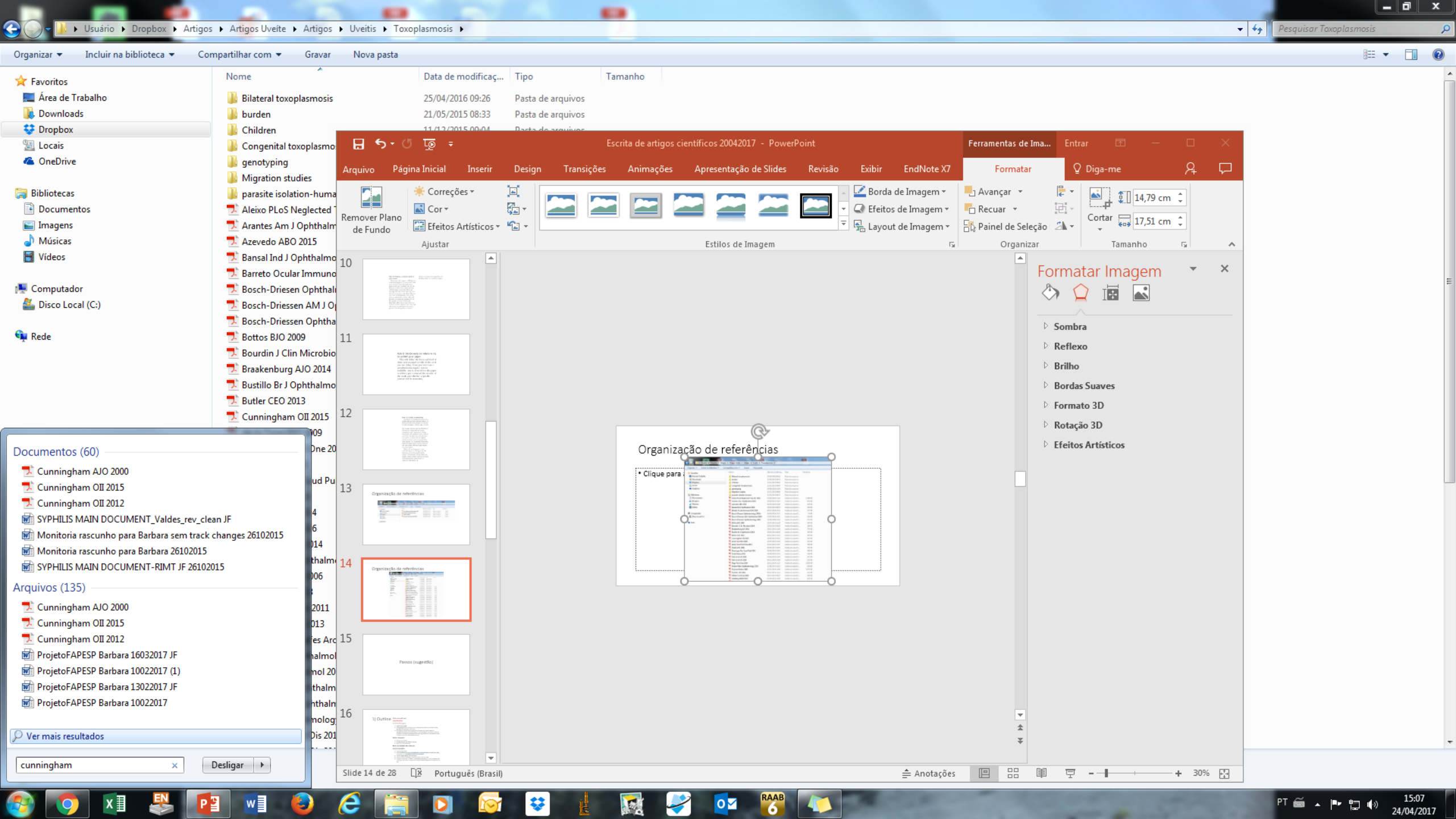
Outras sugestões

- Maneira de organizar referências



Organização de referências

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Conclusões

- Importância da escrita de artigos
- Dificuldades e dicas
- Estruturação

Sugestão de leitura

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Bourne PLoS Comp Biology 2005

Muito obrigado!

- furtadojm@gmail.com