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Scientific literature review conclusion

Recall from the initial discussion of Review papers that these publications make two kinds of contribution: 1) an organized synthesis of the current state of an area of research according to a (novel) perspective; 2) critical commentary from the writer who eventually recommends directions for further research and/or application. There are two ways of furnishing critical commentary. First, critique may be provided at the end of each topical subsection. Sometimes, recommendations are also provided, especially if the Review is particularly complex. Second, all critique/recommendations are saved for the conclusion. Which is the best pattern? As always, consider the reader. The more complicated the reading task, the more difficult it is for the reader to absorb the writer's message. If the topical subsections are fairly straightforward, with little controversy/conflict involved, then it's okay to save all critique/recommendations for the end of the paper. Many published review papers save the critique until the end, in the concluding section of the paper. Often, the topics are not so straightforward. In that case, it is easier for the reader (and also for the writer) to finish each section with the writer's critical evaluation of the material. In this manner, each topical subsection reads like a fairly complete mini-essay; the reader can pause, grab a cup of coffee and a Snickers, and return to the review without sacrificing comprehension. Note that all critical evaluation comes at the END of a subsection. If you find yourself logically needing to provide some critique before continuing on within a particular section, then you need to create a second-level subsection (a subtopic within your main topic subsection - for the visual thinkers, these are the child nodes connections coming off a main/parent node). Keep in mind: the prime directive here is that all critical evaluation is written in a separate paragraph at the end of a section. Example of Critique and Recommendations How does all of this relate to the conclusion? In a review paper, the conclusion is a short, bottom-line piece of writing. First, the conclusion offers a brief summary of the main ideas of each topic subsection (generally, only a single sentence or so per MAIN subheaded section) - this is the summary function of a conclusion. (NOTE: If critique is included in the body of the paper, then you can also add a short summary of the critique. This is not required, and depends on the length and complexity of the paper; the longer and harder it is to read, the more likely the author is to include a summary of the critique in the conclusion.) Second, assuming that critique is NOT in the body of the paper, you'll write the critique. This is an important step for the reader: they've just read your synthesis, and now would like to know what you think about all the work you've done! Much like a research report, the reader wants to know how the reviewed information impacts the field. This is what your critique helps provide. Finally, the review conclusion ends with your recommendations based on the reviewed research and critique - what should happen next? Be as targeted as you can here, but do not make suggestions outside the constraints of the perspective you stated in the introduction. For example, if you reviewed the efficacy of a particular activity in terms of its economic impact, you need to make recommendations related to that idea. You'll also find that recommendations for future research can be quite general and bland, e.g. "This area merits further investigation". Thus, your conclusion will depend partly on the decisions made about critique. If critical evaluation is provided in the body of the paper, it need not be repeated in the conclusion, though it can be. If critical evaluation is not provided in the body of the paper, then it must be provided in the conclusion. Organization of Conclusion Situation 1: Critique and/or Recommendations in Body of paper - Thus, the Conclusion consists of the summary + recommendations for further research. Legend Summary of Info Summary of Critique Recommendations CONCLUSIONS Early hypotheses on DBS mechanisms proposed that stimulation inhibited neuronal activity at the site of stimulation, imitating the effects of surgical ablation. Recent studies have challenged that view and suggested that while somatic activity near the DBS electrode may be suppressed, high frequency stimulation increases and regularizes the output from the stimulated nucleus by directly activating axons of local projection neurons. It now appears that suprathreshold currents spreading into regions comprised of axonal fibers passing near or through the target structure as well as surrounding nuclei may also contribute to the beneficial effects of DBS. Together, the stimulation-induced regularization of neuronal output patterns are thought to prevent transmission of pathologic bursting and oscillatory activity within the basal ganglia thalamocortical network, thereby enabling compensatory mechanisms that facilitate normal movements. This theory, however, does not entirely explain why therapeutic latencies differ between motor symptoms and why after turning off a DBS system the reemergence of motor symptoms differs among patients. Understanding these processes on a physiological level will be critically important if we are to reach the full potential of DBS as a surgical therapy and will in turn undoubtedly lead us to technological and clinical advancements in the treatment of other neurological disorders. Situation 2: Critique in Conclusion of Paper - there are two organizational patterns #1 - The first paragraph is summary, second paragraph is critique, third paragraph is recommendations (note: second paragraph is more properly understood as a functional section as you may need more than one paragraph!) Conclusions In summary, during the normal ageing process, animals experience age-related cognitive decline. Historically, it was thought that primary contributions to the aetiology of this decline were massive cell loss and deterioration of dendritic branching17, 18. However, we now know that the changes occurring during normal ageing are more subtle and selective than was once believed. In fact, the general pattern seems to be that most age-associated behavioural impairments result from region-specific changes in dendritic morphology, cellular connectivity, Ca2+ dysregulation, gene expression or other factors that affect plasticity and ultimately alter the network dynamics of neural ensembles that support cognition. Of the brain regions affected by ageing, the hippocampus and the PFC seem to be particularly vulnerable, but even within and between these regions the impact of ageing on neuronal function can differ. The morphology of neurons in the PFC is more susceptible to age-related change, as these cells show a decrease in dendritic branching in rats30, 31 and humans32, 33. There is also evidence of a small but significant decline in cell number in area BA of monkeys that is correlated with working memory impairments16. Although there is evidence of Ca2+ dysregulation in aged PFC neurons65, the functional consequences of this are not yet known. Moreover, so far, there are no reports of multiple single unit recordings in the PFC of awake behaving animals. More is known about the impact of ageing on hippocampal function. Ca2+ dysregulation51, 53, 54 and changes in synaptic connectivity69, 74 might affect plasticity and gene expression, resulting in altered dynamics of hippocampal neuronal ensembles. Because more is known about the neurobiology of ageing in this brain region, there are therapeutic approaches on the horizon that might modify hippocampal neurobiology and slow age-related cognitive decline or partially restore mechanisms of plasticity. For example, agents that reduce intracellular Ca2+ concentration following neural activity could modulate the ratio of LTD and LTP induction, thereby partially restoring normal network dynamics. Considering that the average lifespan is increasing worldwide, understanding the brain mechanisms that are responsible for age-related cognitive impairment, and finding therapeutic agents that might curb this decline, becomes increasingly important. #2 - Each paragraph consists of summary of a particular section, the critique for that section, then the recommendations for that section. The number and order of paragraphs parallels the number and order of main topical sections of the paper. Legend Summary of Info Summary of Critique Recommendations Other Statements What have these reviews indicated about the efficacy of specific CAM therapies for pain from arthritis and related diseases? First, there are a sufficient number of studies in some areas despite claims often heard about the lack of evidence for CAM. Second, research findings for some of the CAM therapies reviewed here have demonstrated consistent beneficial outcomes for patients with arthritis and related diseases. Specifically, there is moderate support for acupuncture in reducing pain as compared with sham acupuncture and limited support for acupuncture as compared with a wait list for OA of the knee. However, no claims can be made for the superiority of acupuncture across locations of OA and across comparison groups. Further, only limited support exists for the efficacy of acupuncture for FMS with the caveat that acupuncture may actually exacerbate the pain for some patients with FMS. At this point, little is known about acupuncture for patients with RA. Homeopathy has been demonstrated to be twice as efficacious as placebo for rheumatic conditions, but the outcome was not specifically pain. Furthermore, the interventions included both simple and complex homeopathy as well as individualized and standard treatments and may not represent the system of homeopathy as practiced. More research is needed in this area. Some herbs and nutraceuticals are also beneficial in reducing pain. Both avocado/soybean unsaponifiables and devil's claw demonstrated promising support for pain of OA with moderate support for Phytodolor and topical capsaicin. Among the herbs used for or promoted for RA, there is strong support for GLA as found, for example, in borage seed oil, evening primrose oil, and blackcurrant seed oil. However, evidence is lacking for other herbs and more high quality research is needed. Research findings also support the benefits of chondroitin sulfate, glucosamine, and SAME in reducing pain, particularly pain related to OA of the knee. Furthermore, these treatments appear safe to use. For another example of marked-up conclusion, see this doc. END

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