Welcome to the Christmas issue of the MJA, an annual tradition in which we publish unusual, witty, funny, and even astounding images, stories and non-serious studies in our “Christmas crackers” competition. All articles entered for this competition have undergone our usual rigorous publication process, and the best submission, as judged by our entire editorial team, wins a Christmas hamper. You may muse about the diagnosis for Santa’s red cheeks1 or chuckle at the collective nouns for your colleagues’ specialties (perhaps even your own); you might be enlightened by the thought of diagnosing Nutcracker syndrome,3 or, if Tchakovsky is not your beat, the effects of AC/DC on your surgical skills;4 while if you are saddened by a rejected grant application, reading the Journal’s most recent love letter may strike a chord.5 And the less said about hot dogs6 … The national and international interest in this light-hearted competition remains high; we thank everyone who contributed, and only regret we could not publish every entry. This year we are delighted to announce that the joint winners of our competition are Fancourt and her co-authors1 and Rouse and Radigan,6 while Ge and her colleagues achieved a distinguished third place.1

One of the missions of the MJA is to publish excellent original research that will positively change clinical practice or health policy. We particularly thank all of the dedicated MJA peer reviewers of the past year (listed on pages 496-497); we all recognise that you provide an essential contribution to the progress of medical science. All research published in the MJA undergoes blinded peer review, as well as detailed editorial and statistical reviews. We reject about 85% of original research submissions (Box), and authors who have achieved publication in the Journal can be assured that their work is highly regarded by their peers. Research published in the MJA has a national impact, and this impact is one of the metrics for our journal we will be monitoring in the future. The online version of the Journal is increasingly read internationally, with overseas “hits” at the MJA website now providing almost one-quarter of the enormous traffic to the site. Our primary goal is always excellence: to assist authors to present their data so that it has the greatest impact, and to help disseminate their findings widely in print, online, and through social media.

The 2016 MJA—MDA National Prize for Excellence in Medical Research, worth $10,000, will honour the authors of the best original clinical research article published by the MJA during the past year. The Journal editors will prepare a shortlist of the very best research published in 2016, as measured by five criteria: significance, novelty, study quality, research effort, and presentation quality. The MJA Expert Advisory Group, a panel of leading researchers and clinicians from around Australia and the world, will independently select the winner during the first quarter of 2017, and the prize will be awarded at the national conference of the Australian Medical Association in May 2017. We wish every author who has published a research article in the MJA during 2016 the very best during judging for the 2016 prize.

In preparation for this final issue of the year, the MJA editors have selected examples of the research we have published during 2016 that were highlights with respect to the breadth and depth of research excellence, and because the findings have important implications for health practice or policy.

Starting with cardiovascular disease: heart failure is still a leading cause of death in Australia. Newton and his colleagues5 observed that evidence-based therapies are underutilised despite several drugs having been established as being effective in patients with heart failure, and that there is wide variation in the length of hospitalisation for patients in different locations. Guidelines alone are not sufficient for driving effective practice change; concerted leadership from relevant experts is needed to optimise therapy for heart failure patients across the system and to improve their quality of life.

Exciting advances in treating cardiac disease were reported by Khan and his co-authors in their report8 about the remarkable outcomes for patients with ST-elevation (STEMI) myocardial infarctions in a New South Wales region (Hunter—New England) where large distances impede access to top quality treatment facilities. This is a model of care that should be adopted by other regions where timely primary percutaneous coronary intervention is not available for patients with a STEMI.

We know that sepsis can present very subtly, but also that it is still associated with high mortality. Burrell and his colleagues9 provided evidence that the SEPSIS KILLS program, implemented in 97 emergency departments across NSW, is reducing mortality, time in intensive care, and length of hospital stay for patients. The
implication is that the program should be rolled out in all Australian hospitals, and we look forward to updates on its implementation.

Turning to cancer research, Sampumo and her co-authors\(^\text{10}\) reported important findings about outcomes for patients receiving prostate cancer care in Victoria. This is a controversial area, especially because prostate-specific antigen (PSA) testing in healthy older men remains prevalent. Encouragingly, unnecessary active treatment of patients with low risk disease is decreasing in Victoria, and more appropriate treatment is being provided for men with high risk and metastatic disease. Overtreatment of men with positive PSA test results (and avoiding unnecessary testing) remains a priority health issue in Australia.

Colon cancer is still a serious scourge in our country, despite screening. Boyce and colleagues\(^\text{11}\) reported that the incidence of young-onset colorectal cancer (in patients under 50 years of age) has increased recently in the United States and Europe, but not in NSW. Even so, clinicians need to be aware that 6% of colon cancers are diagnosed in younger people, so that alarm symptoms in this age group should not be ignored. Cancers in younger patients were more commonly located in the rectum, and were more advanced at diagnosis than in those over 50, although 5-year cancer-specific survival, as might be expected, was better than for older patients.

Evidence-based, optimal treatment of burns is important, but, as Cleland and her co-authors\(^\text{12}\) highlight, there is a dearth of evidence about best practice management, with relatively few high quality clinical trials having been undertaken. Their large study of registry data for 10 of the 12 adult burns units in Australasia identified wide variations in practice and patient outcomes, suggesting there is significant scope for improvement by implementing practices supported by best evidence.

Finally, targets in the emergency department (ED) remain both political and health care problems in 2016. Sullivan and colleagues\(^\text{7}\) conducted a retrospective study of 59 Australian EDs, with 12.5 million episodes of ED care, and found that in-hospital mortality for emergency admissions decreased as compliance with the national emergency access target (NEAT) improved — until NEAT compliance reached 83%, beyond which the inverse linear relationship between mortality and NEAT compliance was lost. While this has implications for health policy, and some may argue that it vindicates the use of the NEAT, a cause-and-effect relationship cannot be established at the present time.

These and other studies will be considered for the MJA—MDA National Prize for Excellence in Medical Research, and we welcome your views about these and the other articles we publish. As part of our quality process, we have re-instated a vigorous Letters to the Editor section for the best correspondence we receive, but we also have an online forum for your immediate comments. We wish to ensure that any errors in our research articles that have been overlooked, despite our best efforts, are exposed, discussed and, where appropriate, corrected.

In 2017, you can expect further evolution of your Journal. We continue to welcome your feedback on all our articles and your ideas for new content.

From all of us here at the MJA, we wish you and your family a safe, healthy and joyous holiday season, and we look forward to welcoming back all of our readers, authors and reviewers in 2017.

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