FORM
AND
SUBSTANCE:

A GUIDEBOOK FOR
BIOMEDICAL JOURNAL EDITORS

PJSS EDITORIAL BOARD 2008

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PREFACE

The Philippine Journal of Surgical Specialties (PJSS) has been in existence since 1946 and has distinguished itself as the premier biomedical journal in the country. Being the official journal publication of the Philippine College of Surgeons, it is the preferred venue for publication of completed researches from nineteen surgical specialties.

In the last six decades, the PJSS has undergone major changes. While it was initially conceived as a journal mainly for general surgery, it later catered to all the surgical specialties. This evolution paralleled the transformation of the Philippine College of Surgeons (PCS) into an umbrella organization of all the specialties in surgery. In the early years of the journal, case reports and surgical techniques dominated the publication. Today, we prioritize the publication of cohort studies, randomized clinical trials, systematic reviews, meta-analyses, and evidence-based clinical practice guidelines: articles that provide a higher level of scientific evidence. A reputable set of editorial consultants evaluates all articles in terms of their scientific merit, technical aspects and clinical utility.

Continuous efforts have been exerted to further improve the quality of the journal. In 1998, under the editorial aegis of Dr. Adriano V. Laudico, the PJSS and the PCS entered into an agreement with the Philippine Council for Health Research Development (PCHRD) to make the journal available in digital format and in full text through the Health Research and Development Information Network (HERDIN). This made the journal articles accessible nationwide. In 2001, a panel of international peer reviewers, composed of luminaries in the various surgical specialties, was formed to meet international editorial standards.

In the last quarter of 2006, the World Health Organization established a web portal to feature publications from leading journals in the Asia Pacific rim. The PCHRD, the country's lead agency in this program, chose to include the PJSS as one of the journals in this on-line scientific resource because of its stringent editorial process and the quality of its articles. Today, its readership includes 2,300 active as well as international honorary PCS fellows. The PJSS may be accessed through libraries of major universities in the Philippines, the PCS website, HERDIN, and the WHO Asia Pacific Rim Index Medicus (WPRIM).

At present, the PJSS has added to its mandate the improvement of the research capability of surgeons. Towards this end, workshops and lectures on scientific paper writing have been conducted by the Editorial Board. Likewise, to maintain the high level of the editorial process, standardize the journal format and guide prospective editors, the PJSS Board, with the concurrence of the PCS Board of Regents, has decided to publish the PJSS Editorial Guide Book.

The PJSS Editorial Guide Book presents in detail its preferred format and editorial process. It is hoped that this publication can serve as a handy reference for current and aspiring journal editors. This book will likewise be useful for prospective contributors in preparing their manuscripts.

Comment [tsv1]: Edit to final title of the guidebook

This publication is the inspired product of the collective minds and experience of the 2007 PJSS Editorial Board. It is dedicated to all the former Editors-in-Chief of the PJSS, the 2007 and 2008 PCS Board of Regents led by Dr. Rey Melchor Santos M.D. and Dr. Armando C. Crisostomo, respectively, Fellows of the Philippine College of Surgeons, prospective scientific journal editors and all those interested in surgical research.

Edgardo R. Cortez, MD, FPCS
Editor-in-Chief

THE PHILIPPINE JOURNAL OF SURGICAL SPECIALTIES

VISION:

To be an internationally recognized journal in surgery

MISSION:

As the official journal of the Philippine College of Surgeons, The Philippine Journal of Surgical Specialties aims to publish quality world class research papers from all surgical specialties in the country, through internationally accepted standards of editing and peer review.

ROLES OF THE PJSS:

1. To be a venue for the publication of research papers in surgery
2. To assist in the development of surgical research
3. To publish evidence-based clinical practice guidelines in surgery

CHAPTER 1. WHAT EDITORS DO

The objective of this chapter is to highlight the role of each member of the editorial staff and the value of the editorial process in the course of an article's consideration for publication.

Definition: Editing means to modify, reformat, improve or even change to conform to a predetermined standard.

Every literary work aims to convey a message, whether it is about lifestyle, psychology or scientific research. For the author to succeed, the article must be interesting and properly written, the different ideas and issues must be presented in an organized and logical sequence, the contents should be based on accurate facts, and the literary style must conform to a level previously defined by the publisher. Only then can the interest of the reader be captured from the beginning and sustained until the end.

Editing is a vital step in making scientific publications more understandable, credible and interesting to the reader. Even if a research study should offer new knowledge relevant to clinical practice, it will remain unused if it is not fully appreciated and understood by the reader. The responsibility of ensuring that an article is properly written, an interesting read, yet soundly based upon fact, rests upon the Editorial Board.

The Editorial Board sets the criteria that contributed manuscripts must meet to see print. These standards ensure that the articles are readable and their results are reproducible. It is inevitable that submitted articles will undergo modification. This concept of editing must be clearly understood. With the permission of the author, extensive rewrites beyond grammar and style may even be performed. After all, manuscripts accepted for publication become the property of the journal. The editors are duty-bound to modify, reformat, or refine these to conform to the set standards of the journal.

THE EDITORIAL BOARD

The Editorial Board is responsible for the content of the journal from the choice of articles for publication to the actual presentation of the research output in the written form. This process involves the participation of each member of the board at every step, each one playing his own unique role. To ensure the smooth and efficient process of publication of the journal, it is important to describe the role played by each member of the Board.

The Editorial Board is composed of the following:

1. Editor-in-Chief
2. Co-Editors
3. Associate Editors
4. Editorial Consultants
5. Peer Reviewers
6. Editorial Assistant
7. Managing Editor

Role of each Editorial Board Member

Editor-in-Chief

The Editor-in-Chief is the head of the board. He assigns the submitted articles to an Associate Editor, Editorial Consultant, Co-Editor and International Peer Reviewer for preliminary editing. He performs the final editing and decides if the manuscript is ready for first proof, if additional proofs are necessary, and if the article is ready for printing. He reviews articles which were initially rejected by the Associate Editor or Co-Editor prior to presentation to the Board for final disposition. He assumes the final responsibility of the content of each issue.

All communications which pertain to the journal including letters of requests for reprints and letters of intent to submit articles for publication are addressed to the Editor-in-Chief.

Co-Editor

The Co-Editor is second in command to the Editor-in-Chief and takes over in the latter's absence. He reviews the manuscripts previously edited by the Associate Editor and evaluates the comments of the Editorial Consultant and Peer Reviewer. He recommends the article for publication to the Editor-in-Chief or communicates directly with the authors and other editors should further revision be necessary. He also recommends to the Editor-in-Chief whether the article is ready for preparation of the first proof. He does the proofreading of all articles before final checking by the Editor-in-Chief. He is likewise expected to give feedback on specific papers presented during the regular Editorial Board meetings.

Associate Editor

The Associate Editor is responsible for evaluating and editing the technical aspect of articles assigned to him by the Editor-in-Chief. He is expected to be knowledgeable in research methodology, data analysis, drawing of scientific conclusions as well as grammar, syntax and literary style. He need not be a clinical expert on the topic he is editing since he is more concerned with the technical aspects of scientific paper writing. He recommends the paper for publication to the Co-Editor after initial review and editing. He is likewise expected to comment on specific papers he reviewed during board meetings.

Editorial Consultant

The Editorial Consultant is responsible for evaluating the content and the clinical relevance of articles assigned to him by the Editor-in-Chief. He has expertise and experience in a specific surgical specialty. Affiliation with an academic institution and membership in a specialty certifying board are preferred qualifications.

The Editorial Consultant reviews the submitted manuscript and is expected to give comments on the relevance of the subject matter and the clinical utility of the research. He recommends to the Co-Editor whether the article is worth publishing or not.

International Peer Reviewer

The International Peer Reviewer, like the Editorial Consultant, is a content expert. He must be an internationally renowned researcher and a respected active practitioner in his field of expertise. Academic appointment and membership in the certifying board of his specialty are desirable qualifications.

The International Peer Reviewer comments on the importance of the research, its applicability in actual practice and the strength of the conclusions based on the data presented. He may also give suggestions on current knowledge gaps that should be studied in order to contribute to the current pool of data.

Editorial Assistant
The Editorial Assistant helps complete the publication of the journal issue. All approved manuscripts are submitted to him for the preparation of the proofs. This includes the layout of text and the incorporation of tables and figures within the text of the article. He is also expected to initially review all proofs prior to submission to the Co-Editor and Editor-in-Chief. He coordinates with the printer on the number of pages and ensures that deadlines are met for the smooth publication of each issue. He is expected to report on the progress of the technical aspects of the publication process during board meetings.

Managing Editor
The Managing Editor is responsible for the business end of the publication. He markets the journal to potential advertisers, subscribers and takes care of the budget for the calendar year. Financial management and the viability of the journal are his main concerns.

THE EDITORIAL PROCESS

The process begins when submitted articles are assigned to a specific Associate Editor, Editorial Consultant, Co-Editor and International Peer Reviewer.

A copy of the manuscript is simultaneously given to an Associate Editor and an Editorial Consultant for initial review. If the Associate Editor deems the article fit for possible publication, he edits the manuscript. If he rejects the article, he forwards it to the Editor-in-Chief who will determine if the article can be modified and presented in a different manner. Final disposition lies with the Board during its regular en-banc meeting.

In case additional expertise like consultation with a clinical epidemiologist or a biostatistician is needed, the Board makes the initiative with the concurrence of the author.

To ensure that the editorial process is thorough, the Associate Editor is required to fill out a checklist of items (see Appendix A) that should be included in the manuscript, from the Introduction to the References. After editing by the Associate Editor, the article is submitted to the Co-Editor for further editing and consideration of the feedback of the Editorial Consultant. The article is then sent to the Editor-in-Chief for additional comments and if revisions are necessary, it is sent back to the author.

The revised manuscript is again reviewed by the Co-Editor and the Editor-in-Chief. Once approved, it is sent to an International Peer Reviewer for review and additional comments.

The comments of the International Peer Reviewer are considered in the final editing by the Editor-in-Chief and these are shown to the author. If both the author and the International Peer Reviewer mutually agree to publish the comments, a short commentary is printed at the end of the article. If neither the author nor the Peer Reviewer agrees, the commentary is just noted by the author and Editor-in-Chief and no commentary is printed.

Once all the revisions are completed, the Co-Editor recommends the preparation of the first proof to the Editor-in-Chief. The proof is then prepared by the Editorial Assistant who incorporates the tables and figures in the lay-out. It is then reviewed by the Co-Editor and the Editor-in-Chief who decide if subsequent proofs are necessary prior to printing. The persons responsible for proofreading are the Editorial Assistant, Co-Editors and the Editor-in-Chief. These steps assure the completion of the comprehensive editorial process prior to publication.

CHAPTER 2. JUDGING SUBSTANCE

After reading this chapter, the reader should be able to identify and assess the different methods of research that he may come upon. He will be able to employ current tools used to improve the reporting of observational studies and clinical trials. Finally, the reader will be familiar with the concept of plagiarism, and he will be able to detect instances of such in manuscripts submitted to him.

SECTION A. METHODS OF RESEARCH

An editor's first task is to evaluate substance.

His first stop is a reading of the Methods section. This is the most important section of a manuscript because it determines the validity of the research. If a research paper has significant bias which was not sufficiently controlled by the authors, it is not worthy of publication. The results are false and the study is essentially useless. However, if the topic is interesting or novel, the editor must help the author salvage the work by perhaps converting it to a less powerful study design, or removing the parts that introduce the bias.

Study Designs

Basically, study designs are broadly classified as descriptive or analytic.

Descriptive studies, also called observational, do not make any data comparisons between study groups. If ever statistical tests are used, these are solely to determine group rates, mean (or median), with corresponding standard deviations and ranges (minimum value-maximum value). Descriptive studies can further be divided into the following:

a. Case report: description of only 1-3 cases of a disease;
b. Case series: description of several cases of a disease;
c. Cross-sectional: description of several cases of a disease, and its possible risk factors and outcome, at a particular point in time or time period. The most common example is a survey or a description of data from a disease databank or registry. A cross-sectional study can also be of the analytic type (see below).

Analytic studies make data comparisons of the outcomes between groups and statistical tests are then used to detect for significant differences. A useful way to better understand the study methodology is to pre-identify the independent and dependent variables of the research. The independent variable is either an intervention or treatment applied to the subjects or a factor to which the subjects are exposed. Common examples are an experimental drug, type of operation, or risk factors like smoking status or alcohol intake. The dependent variable is the outcome that results from manipulation of the independent variable/intervention/factor. Common examples are survival, morbidity rates, and pain scores. Analytic research studies can further be divided into the following:

a. Cross-sectional: the most basic type of analytic study. Unlike the descriptive type of cross-sectional study, the analytic type goes further and actually attempts to determine association between the risk factors and the outcome.

b. Case control: this used to be commonly known as the “retrospective study”. In this type of study, the data are obtained from medical records to look for cases of the disease (or outcome). From these records, the presence or absence of exposure/treatment in patients is identified. A group of patients without the outcome (control) are then obtained and the presence or absence of exposure/treatment is patients also identified. The exposures are then compared between the group with the outcome (cases) and the group without the outcome (control).
c. Cohort: this used to be commonly known as the “prospective study”. The key element of a cohort study is the presence of a follow-up period that is done for the subjects. In this type of study, subjects with and without the exposure, are first identified. They are then followed up over time to determine those who will develop the outcome or not. If the data are prospectively gathered, the study is called a prospective cohort. If the data were obtained retrospectively, it is a retrospective cohort.
d. Experimental study/clinical trial/randomized clinical trial (RCT): this study starts with subjects without the outcome. The main difference from the cohort mentioned above, is that the investigators artificially assign the exposure/treatment to a group of subjects without the disease. The assignment may either be done randomly (as in RCT), or not.

There are also are other analytic study types referred to as integrative studies. These analyze not patients or animals, but other research studies. These include:

a. Review article: combination of several studies on a subject or topic without a focused clinical question
b. Overview or systematic review: combination of several studies with a definite, focused research question
c. Meta-analysis: a systematic review wherein the results of the individual studies are statistically combined
d. Clinical practice guidelines: combination of several studies with focused research question/s, and actual recommendations are made.

There are also hybrid study types, which are combinations of several designs, such as cross-sectional combined with cohort, but these cannot be adequately covered here.

Subject Selection

Ideally, the manuscript must clearly state the presence of approval by the Institutional Review Board of all study sites. An Ethics Committee should review and approve any research where an intervention or exposure is to be performed on human subjects. A copy of this approval should be submitted with the manuscript. The process of informed consent should be adequately described.

Methods of Controlling Bias

Study groups should be similar in all baseline characteristics except for the factor (or treatment) being studied. For a study to be valid, bias has to be controlled. There are generally three sources of bias: selection, information, and confounding factors

Selection bias occurs when study subjects for the experimental and control groups are defectively assigned. There is a preference in choosing subjects. For example, patients in a high risk group, patients who survive an illness, or patients in a private hospital, would differ from the general population with the disease. This type of bias can be controlled by:

a. Random allocation: equalizes the characteristics between/among study groups
b. Restrictions in the inclusion/exclusion criteria: eliminates the characteristic/s from the study groups
c. Data analysis via stratified or regression analysis, or subgroup analysis

Information bias happens when there problems in the way data are collected, either in measuring the exposure or outcome. The general rules are that the data should be collected objectively, and all study groups should be treated equally. This type of bias can be controlled by:

a. Blinding of the subjects
b. Use of objective outcomes, i.e., those that are not subject to observer interpretation, such as mortality, survival

Confounding factors can falsely influence the relationship (or association) between the exposure (or intervention or independent variable) and the outcome (dependent variable). Confounders can be controlled by:

a. Random allocation (which balances the distortion of confounders)
b. Restriction of inclusion/exclusion criteria (which limits the presence of confounders)
c. Data analysis

Data Analysis

Variables for analysis are usually either nominal (or categorical), continuous (such as comparison of means), or ordinal (usually scores or ranks). Generally, for categorical variables, some form of chi square or Fisher exact test is used. For continuous variables, the T test is used when comparing 1-2 groups, and some form of ANOVA (analysis of variance) when more than 2 groups are being compared. Ordinal variables usually require more advanced statistical testing. The acceptable range of level of significance for most clinical studies should 0.05 or 0.01.

Data is first analyzed using a singular or univariate analysis, to see the individual influence of each factor. This is part of a "crude analysis." When the least influential factors are weeded out, the more important and relevant factors are subjected to a multiple analysis.

Regression analysis is probably the most complicated yet the most powerful statistical tool for analytic studies. This is because it can control for multiple factors (confounders) simultaneously; it can also be used to predict outcomes based on given factors, making it very useful when scoring systems are to be formulated by the authors. The main drawback, however, is that it usually requires a larger sample size.

Another method of controlling confounders in the data analysis is by stratified analysis or subgroup analysis. This involves separately calculating for the outcome rate for the confounders. For example, in a study where cancer stage is an identified confounder for the outcome of overall survival, stratified analysis would involve calculating for stage I survival, stage II survival, and so on, for both the experimental and control groups. The survival by stage is then compared between the study groups to determine significant differences.

Articles on Diagnostic Tests
The general objective of this type of research paper is to determine the accuracy of a test in diagnosing disease or for testing validity. Its specific objectives are to determine the different test parameters as compared to the gold standard. The usual parameters are sensitivity, specificity, predictive values. Likelihood ratios are ideally also calculated.

The validity of a study on a diagnostic test depends on several factors. First, all subjects where the test was done should also undergo the gold standard of diagnosis or the most definitive method of identifying the disease. Second, all stages of the disease to which the test will be applied in clinical practice should be represented in the subject sample. Third, the comparisons between the test and the gold standard should be blind and independent, i.e., the person performing/reading the test and the person performing/reading the gold standard should be unaware of each other's results. The procedure/s for performing the test should be described in sufficient detail in the manuscript.

Sensitivity refers to the ability of the test to label as positive those who really have the disease, while specificity is the ability of the test to label as negative those who do not have the disease. Positive predictive value is the probability of having the disease when the test result is positive, while negative predictive value is the probability of being free of disease when the test result is negative. Accuracy is calculated as the number of true positives and true negatives divided by the total number of subjects. However, remember that the above parameters can only be calculated when there are only 2 possible test results. Confidence intervals can be determined, but statistical significance cannot be determined.

Likelihood ratios express the odds that a subject with a condition tests positive against the odds a subject without the condition tests positive. It has several advantages over sensitivity and specificity described above. First, they can be used even when there are more than 2 possible test results. Second, the statistical significance can be determined from its confidence intervals. Third, a likelihood ratio can be calculated for each category of test result, so that an optimum cut-off value can be obtained. Fourth, post-test probabilities can be calculated from pre-test probabilities using likelihood ratios.

A more complicated test is the ROC (Receiver Operating Characteristics) Curve; this is a way of determining the optimum levels or cut-offs of a test result. It is used to evaluate scoring systems. It presents the sensitivity, true positive and false positive rates for different values of the test result in a single graph.

SECTION B. REPORTING RESEARCH

Inadequate reporting of study data may lead to bias. In this section we examine reporting guidelines currently adopted by the PJSS.

Before the 1980's, the publication of research articles has depended heavily on the originality of a study. Topics deemed to be interesting were given priority to the soundness of methodology. However, in the last 2 decades, there has been a shift in this paradigm, in a large way due to the advent of evidence-based medicine (EBM). Today, emphasis is placed heavily on the validity of analytic research studies. The main reason for this is the so-called GIGO or "garbage in, garbage out" principle. In essence, this means that if the methodology of a research study is not valid, i.e., it has significant bias, the results cannot be true, making its conclusions useless in influencing health care, no matter how interesting or novel the topic of the study is.

Analytic Studies

Clinical epidemiologists attempted to make the process of determining a study's validity easier for the layman by formulating easy to answer questions that can be used as Users' Guides. Journal editors throughout the world have adopted the principles of EBM to ensure that published research articles are methodologically sound.

The PJSS is in complete agreement with these moves. For example, studies[1, 2] have shown that a lack of adequately reported data has been associated with bias in estimating the effectiveness of interventions. To assess the strengths and limitations of an analytic study, readers need and deserve to know the quality of its methodology. Research studies must, therefore, report their data adequately. Fortunately, reporting guidelines have been developed for the more powerful analytic study designs. Authors are encouraged to use these guidelines in the writing of their manuscripts. The websites for known reporting guidelines are tabulated below.

Reporting Guidelines[3]

Initiative	Type of study	Source
CONSORT	randomized controlled trials	http://www.consort-statement.org
STARD	studies of diagnostic accuracy	http://www.consort-statement.org/stardstatement.htm
QUOROM	systematic reviews and meta-analyses	http://www.consort-statement.org/Initiatives/MOOSE/moose.pdf
STROBE	observational studies in epidemiology	http://www.strobe-statement.org
MOOSE	meta-analyses of observational studies in epidemiology	http://www.consort-statement.org/Initiatives/MOOSE/moose.pdf

Presently, the PJSS has adopted the reporting guidelines for randomized controlled trials (RCTs) known as the CONSORT statement. This statement is an abbreviation for

Consolidated Standards of Reporting Trials. It is primarily intended to improve the reporting of randomized controlled trials (RCTs) enabling readers to understand a trail's design, conduct, analysis and interpretation, and to assess the validity of its results. It emphasizes that this can only be achieved through complete transparency from authors. The CONSORT statement was developed by investigators and authors to help improve reporting by using a checklist and flow diagram. This is shown below.

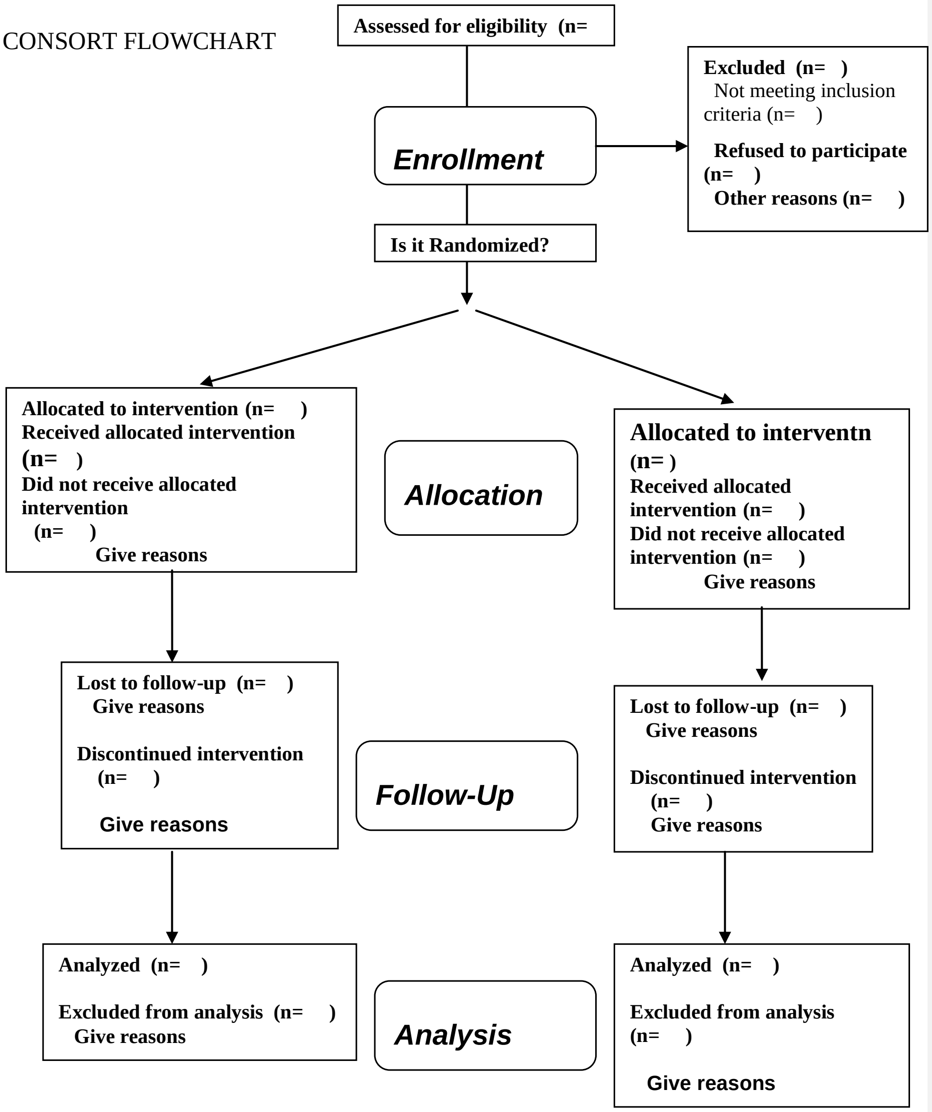
CONSORT[4] checklist of items contained in a manuscript of a randomized clinical trial.

PAPER SECTION AND TOPIC	**Item**	**Description**
TITLE & ABSTRACT	1	How participants were allocated to interventions (*e.g.*, "random allocation", "randomized", or "randomly assigned").
INTRODUCTION		
Background	2	Scientific background and explanation of rationale.
METHODS		
Participants	3	Eligibility criteria for participants and the settings and locations where the data were collected.
Interventions	4	Precise details of the interventions intended for each group and how and when they were actually administered.
Objectives	5	Specific objectives and hypotheses.
Outcomes	6	Clearly defined primary and secondary outcome measures and, when applicable, any methods used to enhance the quality of measurements (*e.g.*, multiple observations, training of assessors).
Sample size	7	How sample size was determined and, when applicable, explanation of any interim analyses and stopping rules.
Randomization		
Sequence generation	8	Method used to generate the random allocation sequence, including details of any restrictions (*e.g*., blocking, stratification)
Allocation concealment	9	Method used to implement the random allocation sequence (*e.g*., numbered containers or central telephone), clarifying whether the sequence was concealed until interventions were assigned.
Implementation	10	Who generated the allocation sequence, who enrolled participants, and who assigned participants to their groups.
Blinding (masking)	11	Whether or not participants, those administering the interventions, and those assessing the outcomes were blinded to group assignment. When relevant, how the success of blinding was evaluated.
Statistical methods	12	Statistical methods used to compare groups for primary outcome(s); Methods for additional analyses, such as subgroup analyses and adjusted analyses.
RESULTS		
Participant flow	13	Flow of participants through each stage (a diagram is strongly recommended). Specifically, for each group report the numbers of participants randomly assigned, receiving

		intended treatment, completing the study protocol, and analyzed for the primary outcome. Describe protocol deviations from study as planned, together with reasons.
Recruitment	14	Dates defining the periods of recruitment and follow-up.
Baseline data	15	Baseline demographic and clinical characteristics of each group.
Numbers analyzed	16	Number of participants (denominator) in each group included in each analysis and whether the analysis was by "intention-to-treat". State the results in absolute numbers when feasible (*e.g.*, 10/20, not 50%).
Outcomes and estimation	17	For each primary and secondary outcome, a summary of results for each group, and the estimated effect size and its precision (*e.g.*, 95% confidence interval).
Ancillary analyses	18	Address multiplicity by reporting any other analyses performed, including subgroup analyses and adjusted analyses, indicating those pre-specified and those exploratory.
Adverse events	19	All important adverse events or side effects in each intervention group.
DISCUSSION		
Interpretation	20	Interpretation of the results, taking into account study hypotheses, sources of potential bias or imprecision and the dangers associated with multiplicity of analyses and outcomes.
Generalizability	21	Generalizability (external validity) of the trial findings.
Overall evidence	22	General interpretation of the results in the context of current evidence.

The CONSORT statement further requires that a flow chart, illustrating the flow of subjects in the study, from the time of determination of eligibility to the time of data analysis, should be included in the manuscript. This is shown below.

CONSORT FLOWCHART



Clinical Practice Guidelines

The Philippine College of Surgeons, through the Committee on Surgical Research, has recently formulated a standard format for the reporting of Evidence-based Clinical Practice Guidelines (EBCPG). This was intended to standardize the reporting of EBCPGs for publication in the PJSS. The format is as follows:

PCS FORMAT IN THE REPORTING OF EVIDENCE-BASED CLINICAL PRACTICE GUIDELINES

TITLE:
1. The title should specify that the guidelines are “Evidence-based Clinical Practice Guidelines”
2. If the lead organization is a PCS Committee, the title should specify the PCS and stated as “The PCS Evidence-based …”
3. If the lead organization is a specialty society, the title should specify both the name of the PCS and the specialty society. For example, if the SOSP is the lead society, the title should state “The PCS-SOSP Evidence-based …”

AUTHOR/S:
The names of all individual authors who satisfy the criteria for authorship should be stated (see PJSS criteria for authorship). Generally, all members of the Technical Working Group (TWG) qualify as authors.

INTRODUCTORY STATEMENT
This section should contain the following points:
1. General objectives
2. Organization/s and/or Sponsor/s
3. General statement on the limitations on the role of pharmaceutical companies in the formulation of the guidelines
4. Specific statements that the Guidelines:
    a. must be complemented by clinical expertise
    b. intended to inform but not replace clinical judgement
    c. do not necessarily apply to all patients with the disease
5. Rejoinder that the Guidelines are not intended for use as evidence in medicolegal cases.

EXECUTIVE SUMMARY
This should include a summary of the entire study, and should contain the following sections:
1. Clinical questions addressed by the Guidelines
2. Search terms used & medical databases searched
3. Composition of TWG in paragraph format
4. Operational definitions of:
    a. Disease/s under study
    b. Levels of evidence used
    c. Categories of recommendation
5. Brief description of processes (steps) followed from preparation of evidence-based draft, convening of Expert Panel and its composition, to the Public Forum and approval by the BOR. The different stakeholder groups represented in the Public Forum should also be specified.
6. Summary of Recommendations, with level of evidence and category of recommendation

INTRODUCTION
This section should contain the following items:

1. Rationale for the study
2. Relevant theoretical issues on the disease/s under study
3. Objectives
4. Other relevant items stated previously in the Introductory Statement

METHODS

This section should contain a more detailed description of items 1-5 in the Executive Summary, as follows:

1. Clinical questions addressed by the Guidelines
2. Search terms used & medical databases searched
3. Composition of TWG (enumerated)
4. Operational definitions of:
    a. Disease/s under study
    b. Levels of evidence used
    c. Categories of recommendation
5. Description of all the processes (steps) followed from preparation of evidence-based draft, convening of Expert Panel and its composition, to the Public Forum and approval by the BOR. The different stakeholder groups represented in the Public Forum should also be specified.

RESULTS

The format for this section should be as follows:

Each clinical question is stated, followed by the guideline/s that answer that clinical question, with the level of evidence and category of recommendation, followed by the Summary of Evidence for that guidelines.

Example:

A. Clinical Question 1
    1. Guideline 1
    2. Guideline 2

Summary of Evidence for Guideline 1 & Guideline 2

B. Clinical Question 2
    1. Guideline 3

Summary of evidence for Guideline 3

2. Guideline 4

Summary of evidence for Guideline 4

REFERENCES

There are 2 acceptable ways of writing the References:

1. Place all references at the end of the paper, appropriately footnoted in the text.
2. Place references used for all guidelines that answer a clinical question at the end of the Summary of Evidence for that section.

Example:

A. Clinical Question 1
    1. Guideline 1
    2. Guideline 2

Summary of Evidence for Guideline 1 & Guideline 2

References for Clinical Question 1

B. Clinical Question 2
    1. Guideline 3

Summary of evidence for Guideline 3
2. Guideline 4
Summary of evidence for Guideline 4
References for Clinical Question 2

SECTION C. PLAGIARISM

A young university radiologist recognized his own writing in a professional journal under another's authorship, without attribution to himself, and had no idea what to do about it. He finally wrote to the author of the article who answered something to the effect that it was indeed a "remarkable coincidence" and that "great minds think alike."[5]

The term plagiarism originates from the Latin word, *plagiarius*, meaning kidnapper.[6] A plagiarist usurps the words and ideas of others and passes them off as his own. The guilty may dismiss the offence by resorting to patronizing behavior (as in the anecdote above). Others trivialize it by calling it "borrowing." Unfortunately, it is not a petty matter.

Definition

The Council of Science Editors' white paper discusses plagiarism in the chapter on research misconduct. They define plagiarism as "a form of piracy that involves the use of text or other items (figures, images, tables) without permission or acknowledgment of the source of these materials."[7]

Plagiarism occurs when: (1) material is copied verbatim without quotes whether cited or not, (2) material is quoted without citation, (3) passages are paraphrased without citation, and (4) passages are cited but poorly paraphrased.

Types of Plagiarism

Plagiarism on a small scale is oftentimes accidental or unintended. In this case, it is a sign of a shabby system of research or perhaps academic absent-mindedness.

When it occurs on a large scale, it is often deliberate, malicious and with intent to deceive. Here, plagiarism is intellectual dishonesty and fraud. Large portions of source articles can be copied and passed off as original. Likewise, portions from different sources can be copied then shuffled like a deck of cards to create what may seem to be new work. Selective citation happens when authors cite only portions of their sources, then pass off other material as original. More canny authors resort to inaccurate citation. These writers deviously bury source articles by citing the wrong page number, the wrong volume, or the even wrong journal. Table 1 presents a colorful classification of the different types of plagiarism.

Table 1. A Classification of types of plagiarism[8]

Sources not cited	
"The Ghost Writer"	The writer turns in another's work, word-for-word, as his or her own.
"The Photocopy"	The writer copies significant portions of text straight from a

	single source, without alteration
"The Potluck Paper"	The writer tries to disguise plagiarism by copying from several different sources, tweaking the sentences to make them fit together while retaining most of the original phrasing.
"The Poor Disguise"	Although the writer has retained the essential content of the source, he or she has altered the paper's appearance slightly by changing key words and phrases
"The Labor of Laziness"	The writer takes the time to paraphrase most of the paper from other sources and make it all fit together, instead of spending the same effort on original work.
"The Self-Stealer"	The writer "borrows" generously from his or her previous work, violating policies concerning the expectation of originality adopted by most academic institutions.
Uncited Sources	
"The Forgotten Footnote"	The writer mentions an author's name for a source, but neglects to include specific information on the location of the material referenced. This often masks other forms of plagiarism by obscuring source locations.
"The Misinformer"	The writer provides inaccurate information regarding the sources, making it impossible to find them.
"The Too-Perfect Paraphrase"	The writer properly cites a source, but neglects to put in quotation marks text that has been copied word-for-word, or close to it. Although attributing the basic ideas to the source, the writer is falsely claiming original presentation and interpretation of the information.
"The Resourceful Citer"	The writer properly cites all sources, paraphrasing and using quotations appropriately. The catch? The paper contains almost no original work! It is sometimes difficult to spot this form of plagiarism because it looks like any other well-researched document.
"The Perfect Crime"	Well, we all know it doesn't exist. In this case, the writer properly quotes and cites sources in some places, but goes on to paraphrase other arguments from those sources without citation. This way, the writer tries to pass off the paraphrased material as his or her own analysis of the cited material.

How Writers Can Avoid Plagiarism

Sources should always be credited by proper citation. Citations must follow direct quotes from other material. They should follow material retold in your own words or paraphrased. Ideas of others, especially those critical to the progress or evolution of a research question must be cited.[8] There is a separate section in this handbook that deals with the correct form of a citation.

A paraphrase is used if a writer wishes to use an idea without using his source's exact words. This process of restating also ensures that the writer understands the concepts he borrows. When paraphrasing, a different wording and sentence structure is used without changing the original material's sense. When used properly, it "makes the ideas of the original source fit smoothly… emphasizing the most relevant points and leaving out unrelated information."[8]

Read the following passage:

> If a patient is neurologically compromised as a result of pituitary adenoma–induced mass effect, microresection is usually the procedure of choice. Microsurgery also allows for the most rapid reduction in excessive hormone levels.[9]

The following is a poor paraphrase of the passage above and can be considered plagiarism:

> If a patient is neurologically at risk because of compression from a pituitary adenoma, microresection is usually the preferred course of action. Microsurgery also allows for the quickest drop in excessive hormone values.

This is a better paraphrase:

> Microsurgery is the preferred intervention for patients with pituitary adenomas with mass effect causing neurologic deficit. It provides the fastest means of normalizing hormone levels.

Dealing with Plagiarism

A sentence or phrase may find its way into a paper if the writer is careless or prepares manuscript poorly. These blunders can be minimized by taking meticulous notes and writing well-organized drafts. A vigilant editor should be able to distinguish inconsistencies in writing style and query the author during the process of vetting the manuscript.

Unfortunately deliberate and more systematic plagiarism may escape notice until after publication. It may be called to the editor's attention, perhaps by the aggrieved author or a third party. After studying and confirming the allegation, the editor may publish a critical editorial exposing the offense. Editors may ban the offender from further publication. The plagiarist sullies not only his professional integrity, but also harms the careers of his colleagues and endangers the academic reputation of his institution. The plagiarist may even be sued for infringement of intellectual property rights.

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CHAPTER 3. EVALUATING WRITING STYLE

Great literature may be worth reading for its own sake, even if it is difficult to read, but if scientific papers are unnecessarily hard reading they are probably not worth reading at all. The scientific writer who… ignore(s) the reader's wants will likely have but one reader—the editor who rejects the manuscript.[1]

Communication is the rationale of all scientific writing.[2] Articles are submitted to a journal to convey an idea, a concept, or a message to an audience. That audience is your reader. The exercise of publishing is a waste if your journal is ignored because its language is so opaque that it is a pain to read. Therefore, disregard the reader at your peril!

After having read this chapter, the potential editor should be able to recognize and correct common errors in punctuation and grammar. He should also be able to distinguish good usage from bad.

As a prospective editor, we assume you have a fundamental command of the English language. It is the details of the language, however, that can befuddle writers and editors alike. Some of those details we hope to clarify here without recreating a textbook of freshman English.

SECTION A. LANGUAGE USAGE

Subject-Verb Agreement

A sentence is composed of a subject, predicate verb, indirect object, and a direct object. The subject of a sentence must agree in number with the verb of the sentence.

> *A favorable prognosis is associated with pineocytomas.*
> *Patients usually die of respiratory failure.*

Subjects joined by "and" are followed by a plural verb.

> *Rapid diagnosis and treatment are the main concern in the management of hemorrhagic shock.*

If both a singular and a plural is joined by "or" or "nor", the verb should agree with the subject closer to it.

> *Neither the draining vein nor the feeding arteries were considered for ligation.*
> *Neither the feeding arteries nor the draining vein was considered for ligation.*

The problem arises when a phrase modifier is mistaken for the subject.

> *Inflammatory causes of painful ophthalmoplegia is rare.*
> *A subset of pineocytomas are prone to recur.*

These sentences should be written as:

> *Inflammatory causes of painful ophthalmoplegia are rare.*
> *A subset of pineocytomas is prone to recur.*

Tense

Writers should use the past tense in the Abstract, Methods, and Results sections. In the Discussion section, reference will dictate the tense. The present tense is used when writing about theory or the findings of others.

> *Current protocols favor the use of crystalloids in trauma resuscitation.*
> *Montano has reported the use of albumin in the resuscitation of patients with severe head injury.*

The past tense is used when writers discuss their findings.

> *Our study failed to show a difference in outcome between the group given hetastarch and the group given normal saline.*

Voice

The voice of the verb indicates whether the subject performs or receives the action. Use the active voice; it results in clear dynamic writing.

> *Less than 30 percent of the control group met the criteria.* (active)
> *The criteria were met by less than 30 percent of the control group.* (passive)
> *The study coordinator assessed the clinical reports.* (active)
> *The clinical reports were assessed by the study coordinator.* (passive)

The passive may be used if the doer of the action is understood, unknown, unimportant or when the receiver of the action should be emphasized.[3]

> *The patients were randomly distributed into two groups.* (That the investigators performed the randomization is understood.)
> *DNA was extracted from spermatozoa, hair follicles, and buccal mucosa by the laboratory technicians*. (Emphasis is on what was extracted rather than who did the extracting.)

Avoid the "coward's passive," where the writer hides his identity or responsibility for an action.[4]

> *The possibility is acknowledged that the use of retrospective data may underrepresent the frequency and severity of post-concussion headache after mild traumatic brain injury.* (Translation: The use of retrospective data skewed the outcome of the study, but I had nothing to do with it.)

Person

Use of the third person construction is preferred.

> *The investigators reviewed the records of 143 patients with appendicitis.*

The first person may be used in the Introduction and Discussion sections. Its use, however, should be limited in order to avoid sounding egocentric and self-important.

> *I chose disease-free survival as the primary end point. After tumor recurrence, I decided that patients could be treated with any other modality. I found that disease-free survival in the surgery-plus-*

chemotherapy arm was superior to that with surgery alone. I determined the difference to be statistically significant, even though no difference was shown for overall survival. I propose to explain the discrepancy between disease-free survival and overall survival with two hypotheses.

Sentence Length

Avoid long sentences. Don't lose your reader in a surge of verbal diarrhea. Keep one thought per sentence, and cut long sentences up for clarity. Sentences should be about 18 words long on the average.[4]

Compare the next sentence with the original version below it.

> *The first neurotransmitter, identified about 75 years ago, was acetylcholine, a chemical released by neurons that connected to voluntary muscles and caused them to contract, that connected to the heart and controlled rhythm, and that served as a transmitter in many regions of the brain.*
>
> *The first neurotransmitter, identified about 75 years ago, was acetylcholine (ACh). This chemical is released by neurons connected to voluntary muscles (causing them to contract) and by neurons that control the heartbeat. ACh also serves as a transmitter in many regions of the brain.*[5]

Verbiage/Verbosity

The Merriam-Webster on-line dictionary defines verbiage as "a profusion of words usually of little content."[6] Inconsequential words are to be avoided. Stripping your language of word gunk will facilitate the flow of ideas. "Vigorous writing is concise. A sentence should contain no unnecessary words…for the same reason that a drawing should have no unnecessary lines and a machine no unnecessary parts. This requires not that the writer make all his sentences short, or that he avoid all detail and treat his subjects only in outline, but that every word tell."[7] This classic advice from Messrs Strunk and White holds especially true when writing for the sciences.

Stay away from the "double negative dodge."[4] This verbal ploy involves the negating a negative to get a positive. The word "common" is transformed into "not infrequent". Writers who employ this to appear elegant only succeed in sounding affected. Compare the following two sentences:

> *Jejunal access, in critically ill patients at risk for gastric motility dysfunction, is not unhelpful.*
>
> *Jejunal access is practical in critically ill patients with dysfunctional gastric motility.*

Avoid padded phrases. Stay away from five words if one will do.

Instead of this:	Use this:

at this point in time	Now
in view of the fact that	Because
in the event that	If
has been shown to be	Is

Remove redundant words. We are familiar with "repeat again", here are a few more:

Instead of this:	**Trim to:**
mix together	Mix
continue to remain	Remain
period of time	Period
basic fundamentals	fundamentals

Do not write zeroes. Certain terms have no meaning and their use merely confounds thought.

It is significant to note the fact that nalbuphine reaches a ceiling effect at doses greater than 0.4 mg/kg, thus making it a poor alternative choice for the control of significantly severe pain.

The phrases "it is significant to note" and "the fact that" add nothing to the sense of the sentence. The phrases "alternative choice" and "significantly severe" contain redundancies. This sentence can be revised to:

Nalbuphine is a poor choice for controlling severe pain because it reaches a ceiling effect at doses greater than 0.4 mg/kg.

Here are other examples of empty phrases.

as a matter of fact,
it should be pointed out that,
in the course of
it should be noted that

SECTION B. PUNCTUATION

Punctuation is a collection of marks used to clarify the meaning of written words. We have included some punctuation rules commonly forgotten or violated. Most of the usage that follows is adapted from the AMA style.[9]

Comma

The comma is an invitation to pause. It is a short break that groups words to help avoid a muddled message.

Commas are used before conjunctions in a compound sentence.

Reyes and coworkers found that 79 percent of thyrotoxic patients developed malignant hyperthermia, and death occurred within 48 hours of the onset of fever.

If the compound sentence is short and unambiguous, the comma may be omitted.

The control arm survived 6 months longer but their morbidity scores were 35 higher.

The comma is used to set off phrases that introduce the main action of the sentence.

After a 6 hour interval, the head-injured patient improved.

Only 4mm in diameter, the endoscope passed through the foramen of Monroe easily.

The serial comma is used to separate three or more similar items in a list.

The symptoms of hoarseness, dyspnea, dysphagia, and neck pain are common in anaplastic carcinoma of the thyroid.

The attending physician ordered a chest radiograph, an abdominal ultrasonogram, an electrocardiogram, and a cranial CT scan.

The MRI examination clearly showed changes in the basal ganglia, the cortical sulci, and the ventricles.

An appositive is a noun or noun phrase that renames an adjacent noun. A pair of commas is used to enclose parenthetic expressions and appositives.

Remember that, as you plan your investigation, appropriate exclusion criteria are the foundation of a homogenous study population.

Dr. Banzon, the chief investigator, performed all the surgeries in this study.

Pancreaticoduodenectomy, Whipple's procedure, is indicated for tumors of the pancreatic head.

Commas separate a relative clause giving incidental information from its antecedent. The meaning will determine usage.

The technique, which was developed in our laboratory, was the key to the success of the experiment. (Here, the place where the technique was developed is incidental and may be omitted from the sentence.)

The technique which was developed in our laboratory was the key to the success of the experiment. (This statement underscores the importance of the where the technique was developed.)

Commas are used to introduce a quote.

It was William Halstead who said, "The only weapon with which the unconscious patient can immediately retaliate upon the incompetent surgeon is hemorrhage."

Colon

A colon is commonly used to introduce a list of items, usually after "following," "as follows," or "in sum."

The chemotherapeutic agents used were the following: methotrexate, 5-fluorouracil, and cisplatin.

Colons are also used as follows: to tell time, 12:23 PM; to cite the Bible, Matthew 6:9-15; to show a proportion, the ratio of men to women was 1:1.2; to separate the place and name of a publisher (Manila: Tahanan Books).

When emphasis is required, a colon can replace a coma to introduce speech or material quoted. The word that follows the colon is capitalized.

Harvey Cushing wrote: "I would like to see the day when somebody would be appointed surgeon somewhere who had no hands, for the operative part is the least part of the work."

Colons may be used to segue between related clauses.[8] Unless it is a proper noun, the first word after the colon should not be capitalized.

The procedure was complicated: to begin, we had to create a rat model of Parkinson's disease. (from statement to example)

The experimental arm of the study had a survival rate 60 higher than the control arm: the intervention must be effective. (from premise to conclusion)

Succeeding patients received prophylactic antibiotic coverage: the postoperative infection rate fell from 22 to 0.3. (from cause to effect)

Semicolon

A semicolon is used to link independent clauses.

The quality of life of patients in this series was excellent; the performance scores changed an average of only 2.3 points.

A semicolon can be used to group lists that already contain commas. This example is from above.

Colons are also used as follows: to tell time, 12:23 PM; to cite the Bible, Matthew 6:9-15; to indicate a ratio or proportion, the odds of winning were 1:5000; to separate the place and name of a publisher (Manila: Tahanan Books).

Apostrophe

The apostrophe is used to form contractions. The editors discourage the use of contractions for the journal. Use "did not" rather than "didn't".

The apostrophe is also used to form the possessive case of words. For most words, the possessive is formed by adding "'s." The plural possessive is formed by just adding the apostrophe.

patient's chart, patients' charts

The plural of words ending in ch, j, sh, x, or z is formed by adding "es." The possessive plural is formed by adding an apostrophe after the "es." T

witches' brews

the Reyeses' library

There is no apostrophe in the following posessive pronouns: its, hers, theirs, ours, and yours. Note that "it's" is a contraction of "it is."

It's a requirement to sign an informed consent form.
The mouse shed its hair after exposure to the chemical.

Plural numbers are written without an apostrophe.

Theodor Billroth was an occasional guest conductor of the Zurich Symphony Orchestra in the 1880s.

Write the plural of abbreviation without an apostrophe.

Two teams of investigators initially announced the successful isolation of human pluripotential stem cells (PSCs).

If a full term is possessive, its abbreviation in parentheses should also be possessive.

Philippine Journal of Surgical Specialties' (PJSS's) style manual

Parentheses

Gramatically, a "qualifiying, explanatory, or appositive word, phrase, clause or sentence" may be set off by parentheses or rounded brackets.[8] These are also used to introduce abbreviations and to insert statistics.

partial thromboplastin time (PTT)
demonstrated no correlation (P = .3102)

When parentheses are imbedded in a sentence, punctuation stands outside.

Though the differences were not statistically significant (P = .1209), there were trends that could not be ignored.

If parentheses enclose an entire sentence, terminal punctuation is included.

(The orange blight was first seen in 1985.)

SECTION C. ABBREVIATIONS

With the exception of standard medical terms (see Table 1) and units of measure, the editors prefer that all terms be written in full. However, if a term is cumbersome and recurs more than five times in the article, then it may be abbreviated after its first appearance in the text of the paper.

We discourage the use of abbreviations in the abstract. Abbreviations should not begin a sentence, unless the expanded form is awkward. Do not use an abbreviation in a heading if it is the only term. Likewise, do not introduce one in a heading. Write the term out and define it in text that follows.

When introducing an abbreviation, use lower case letters for the expanded form, unless it contains a proper noun, a formal name, or begins the begins a sentence. Enclose the abbreviation in parentheses. Use no periods.

Gamma knife radiosurgery (GKRS) is used to treat ...
The intake of methylphenyltetrahydropyridine (MPTP) was the …
The early manifestations of Jakob-Creutzfeldt disease (JCD) were …

SECTION D. NUMBERS AND UNITS OF MEASURE

In the running text of an article, a number should be written in numerical form unless it begins a sentence. Dates are an exception. Beginning a sentence with a number can be awkward; rewrite sentences to avoid this problem.

Thirty-four subjects in the control group developed diarrhea.
In the control group, 34 subjects developed diarrhea.
1972 was the year martial law was declared.

Full dates should be written in the month-day-year format.

September 12, 2007

When numbers appear consecutively in a sentence, spell the number that allows the sentence to be read with less confusion.

The subjects are asked to move 5 12.5 kg weights across the room.

The sentence above is better understood if written as:

The subjects are asked to move five 12.5 kg weights across the room.

Do not express abbreviated units of measurement in plural form.

125.5 kgs (wrong)
125.5 kg (correct)

Spell out numbers in idiomatic expressions and numbers used as pronouns.

“A stitch in time saves nine.”
When using an endoscope, one must be mindful of structures outside of the field of vision.

A combination of numerals and words may be used to express large rounded numbers.

In 1980, about 5 million people were affected by AIDS in …

Use “to” or “through” when referring to an inclusive range of numbers. Do not use a dash or hyphen. These can easily be misinterpreted as a negative sign or a minus operation.

The pain scores ranged from 5 to 8 on the visual analog scale.

The first through the ninth ordinals are spelled out. Numerals are used from the 10^{th} ordinal and above.

The fourth case survived but had significant neurological deficits.
The 42nd patient …

Common fractions are spelled out. A hyphen is used only if the fraction is used as an adjective.

One third of the patients developed abdominal distension.
Two-thirds majority voted to shelve the study. (The fraction is an adjective, hence the hyphen.)

Whole numbers combined with common fractions may be written in numerical form. However, avoid substituting a decimal for a fraction. Decimal notation implies precision when none may be intended.
Avoid writing,

The population was exposed to the toxin for 9.5 years.

Instead use,

The population was exposed to the toxin for 9½ years.

When decimals are used, a zero should precede the decimal point. Write "0.25" not ".25." The zero is omitted, however, if the number represented is a statistical probability, proportion or correlation. Write "P < .05."

In the text, the word "percent" should be spelled out except when enclosed in parentheses after citing an exact numerator and denominator, "12/100 (12%);" or when expressing a concentration of a solution, "10% H_2O_2."

When percentages are represented by an Arabic numeral and the mark "%," there should be no space between the number and the mark. If a series of percentages is presented, the mark should be repeated with each percentage.

Spell out the number and the word "percent" if a percentage starts a sentence.

Ninety-three percent of the children with mild head injury will require no surgery.

When percentages derived from study data appear in the text, they should be enclosed in parentheses beside the value they were derived from.

Of 103 patients treated, 12 (11.6%) were lost to follow-up.

The journal uses the International System of Units (SI, from French, *Le Système International d'Unités*) which is the internationally accepted measurement system in the sciences.[11] Tables 2 and 3 shows the standard symbols and prefixes used. The standard symbols are combined with the prefixes obtain smaller units.

cm^3	*cubic centimeter*
dL	*deciliter*
mL	*milliliter*
mm	*millimeter*
mm^3	*cubic millimeter*
mol	*mole*
mmol	*millimole*

The kilogram is the only base unit that is expressed with a prefix. Form the names and symbols for of the units of mass of different orders of magnitude by attaching the appropriate prefix to the term "gram" or the symbol "g."

kg	*kilogram*
g	*gram*

mg *milligram*
µg *microgram*

Weights and measures must be written consistently. Do not write, “The cells were incubated at thirty-seven ºC.” Use “37ºC” or spell out “thirty-seven degrees centigrade.”

No periods are used with SI unit symbols. Letters within a symbol are not separated by spaces. Except when indicating temperature, a space is always used between the number and the SI symbol.

66 kg not 66 k g or 66 k. g.
40ºC not 40 ºC

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Table 1. A partial list of standard medical abbreviations[10]

Abbreviation	Meaning
ACE	Angiotensin-converting enzyme
ACTH	Adrenocorticotropic hormone
AIDS	Acquired immunodeficiency syndrome
ALT	Alanine aminotransferase (SGPT)
ANA	Antinuclear antibody
AST	Aspartate aminotransferase (SGOT)
Bid	Twice a day
BP	Blood pressure
bpm	Beats per minute
BS	Blood sugar
BUN	Blood urea nitrogen
CBC	Complete blood count
CHF	Congestive heart failure
Cl^-	Chloride
CO2	Carbon dioxide
COPD	Chronic obstructive pulmonary disease
CPR	Cardiopulmonary resuscitation
CSF	Cerebrospinal fluid
CT	Computed tomography
CXR	Chest x-ray
d	Day, daily
DM	Diabetes mellitus
ECG	Electrocardiogram
ESR	Erythrocyte sedimentation rate
GI	Gastrointestinal
Hb	Hemoglobin
Hg	Mercury
HIV	Human immunodeficiency virus
HMO	Health maintenance organization
h	Hour
hs	Hours of sleep, at bedtime
HTN	Hypertension
IM	Intramuscular
INR	International normalized ratio
IU	International unit
IV	Intravenous
K^+	Potassium
L	Liter
LDH	Lactate dehydrogenase
MRI	Magnetic resonance imaging
Min	Minute
Na^+	Sodium
NSAID	Nonsteroidal antiinflammatory drug
po	By mouth (per os)
PT	Prothrombin time
PTT	Partial thromboplastin time
q	Every
qd	Every day; daily
Qid	Four times a day
Qod	Every other day
RBC	Red blood cell, red blood count
SC	Subcutaneous
Sec	Second
SGOT	See AST
SGPT	See ALT
STD	Sexually transmitted disease
TB	Tuberculosis

tid	Three times a day
TSH	Thyroid-stimulating hormone
U	Unit
UA	Urine analysis
WBC	White blood cell, white blood count

Table 2. SI base units[11]

Base quantity	Name	Symbol
length	meter	m
mass	kilogram	kg
time	second	s
electric current	ampere	A
thermodynamic temperature	kelvin	K
amount of substance	mole	mol
luminous intensity	candela	cd

Table 3. SI prefixes[11]

Factor	Name	Symbol
10^{24}	yotta	Y
10^{21}	zetta	Z
10^{18}	exa	E
10^{15}	peta	P
10^{12}	tera	T
10^{9}	giga	G
10^{6}	mega	M
10^{3}	kilo	k
10^{2}	hecto	h
10^{1}	deka	da
10^{-1}	deci	D
10^{-2}	centi	C
10^{-3}	milli	M
10^{-6}	micro	µ
10^{-9}	nano	N
10^{-12}	pico	P
10^{-15}	femto	F
10^{-18}	atto	A
10^{-21}	zepto	Z
10^{-24}	yocto	Y

CHAPTER 4. ORGANIZING THE MANUSCRIPT

Having examined the content and the language of the manuscript, the editor's final task is to make certain that it is organized such that it can be read and understood with the least difficulty. A manuscript has a Title, an Abstract, an Introduction, a Methods section, a Results section, a Discussion, and a Conclusion. A section on references cited ends the manuscript. The PJSS editors' checklist criteria are shown after each section of this chapter to familiarize the reader with them.

After reading this chapter, the reader should be able to identify and assess the different sections of a journal manuscript. He will be identify the components of each section and understand the relation of the parts to the whole.

SECTION A. THE TITLE

The title is an important part of any scientific report as many readers of surgical journals, particularly busy surgical practitioners, will base their decision on whether or not to proceed with reading the article if the title elicits their interest. Thus, a good title is often described as the fewest possible words that adequately describe the contents of the paper.

The most common errors observed are titles that are either too short: "Action of Antibiotics on Bacteria", "Rectal Cancer in the Young" or "Appendicitis in the Elderly"; or too long: "On the Addition to the New Method of Scientific Research by a New Way of Producing Color-Contrast Between an Object and its Background or Between Definite Parts of the Object itself". In the examples of the short titles, the reader is provided very little specific information on what the articles are all about; and/or they tend to be very general. In the latter example of a long title, the reader is deluged with so many details that he may lose interest in the article.

An often overlooked error in writing titles is the use of incorrect syntax or "faulty word order". Examples are: 1) "Preliminary Canine and Clinical Evaluation of a New Anti-tumor Agent Streptovitacin"; or 2) "Isolation of Antigens from Monkeys Using Complement Fixation Techniques". Based on these examples, it would appear that dogs and monkeys now possess incredible scientific abilities!

The use of abbreviations, chemical formulae, proprietary names and jargon in the title is discouraged. Watch out also for so-called hanging titles or those that utilize questions (Example: "Use of IVP in Patients with Rectal Cancer: Is It Necessary?"). In fact, there is a trend in many scientific journals to use complete sentences that provide nearly a summary of what the article was all about. Examples include: 1) "Neorectal Reservoir is Not the Functional Principle of the Colonic J-Pouch" and 2) "Molecular Markers are Predictors of Recurrence and Survival in Patients with Dukes B and C Colorectal Adenocarcinoma". In the examples shown, even the conclusion of the article is already revealed in the title, providing the interested reader an overview of what to expect when he reads the article.

SECTION B. THE ABSTRACT PAGE

This section aims to describe the different parts of the Abstract Page, explain how this is edited for publication, and review pertinent concepts.

All research papers for publication should contain an abstract. The abstract should be written completely in paragraph form. It should contain a summary of the study objectives, methods, main results and conclusions. There are 2 general types of abstracts:

1. unstructured: written in 1 continuous paragraph from beginning to end. An example of an unstructured abstract is as follows:

   The peculiarities in the surgical management of acute abdomen on two patients with situs inversus totalis were presented. The first patient was a 24 - year old male presenting with left lower quadrant abdominal pain. Appendiceal rupture occurred due to delay in diagnosis. The second patient was a 32 - year old female diagnosed to have calculous cholecystitis and situs inversus totalis who underwent laparoscopic cholecystectomy. This is the first reported case of laparoscopic cholecystectomy in a situs inversus totalis patient in the Philippines.

   Key words: situs inversus totalis, acute abdomen, laparoscopic cholecystectomy

2. structured: divided by a space or a line into the different sections of rationale/objectives, methods, results and conclusion/s. An example of a structured abstract, using the PJSS format is as follows:

   BACKGROUND/PURPOSE: The routine use of interval appendectomy for the treatment of perforated appendicitis remains controversial. The purpose of this study was to determine the efficacy of this approach and to identify factors associated with failures and complications.

   METHODS: All patients (n = 101) with clinical diagnosis of perforated appendicitis confirmed by imaging were treated prospectively with fluids and intravenous antibiotics (clindamycin, ceftazidime) and were discharged on oral fluids and analgesics, Intravenous antibiotics were continued at home until the patients were afebrile for 48 hours, and WBC counts were normal. Patients were readmitted at 8 to 12 weeks for an interval appendectomy. Data analysis was done using by chi(2) and Student's t test.

   RESULTS: The 79 patients (78%) successfully treated with interval appendectomy had 6.3percent complication rate, and total hospitalization averaged 5.2 days. The treatment in 21 of 22 patients (22%) requiring early appendectomy failed because of a clinical picture suggesting small bowel obstruction. Patients with the failed procedures had a complication rate of 50% and were hospitalized an average of 12.8 days. Patients requiring early appendectomy had a more frequent finding resembling a small bowel obstruction on their initial x-ray (50% v 13%, p =0.004) and a higher percent WBC band count (22.6% v 7.6%, P<0.0001) An initial band count <15 percent was predictive of an uncomplicated course (84% positive predictive value).

CONCLUSIONS: Interval appendectomy without complications is successful in the majority of patients with perforated appendicitis. An elevated initial band count of at least 15% is associated with an increased likelihood of failure and complications.

The PJSS requires the abstract to be structured and should be approximately 250 words or less. The exception is for case reports, where an unstructured abstract may suffice, as long as it is composed of 150 words or less.

In addition to the abstract itself, there should be a subsection on “key words”. These are terms that will be used in indexing the article. There should be 2-4 stated key words and they should preferably be MeSH (Medical subject heading) terms. MeSH terms are terms that are used by the US National Library of Medicine to group related articles in the Medline database of journals. With this system, a researcher who wants to retrieve articles on a particular topic could efficiently search using all possible synonyms for the topic. Using the assigned MeSH term for a topic, all articles indexed under that MeSH term can automatically be retrieved, along with possible synonyms for the topic. For example, for searching thyroid cancer, if the MeSH term is not used, the researcher must search for thyroid cancer, thyroid carcinoma, thyroid neoplasms, papillary cancer, papillary carcinoma, follicular cancer, follicular carcinoma and all other possible types and terms for thyroid cancer. Using the term “thyroid neoplasms” (the MeSH term for thyroid cancer), he may just simply use this term and all related articles will automatically be retrieved.

Exact MeSH terms can be counterchecked at the website of the U.S. National Libraries of Health: http://www.nlm.nih.gov/mesh/MBrowser.html

SECTION C. THE INTRODUCTION

The introduction, being the first statement of the paper is supposed to catch the attention of the reader and may be the crucial point to continue reading the rest of the paper. If it is too short, the reader may not fully grasp the concept of the paper. If too long, it may be too laborious to read and irritate the reader.
This section states the research problem, question or hypothesis. The introduction provides the rationale behind the study, what it intends to accomplish and the importance of the expected results. It should provide a précis of current knowledge on the research problem rather than an extensive literature review.

The General Objective states what is expected to be achieved by the study in over all terms. The Specific Objectives break down the General Objective into smaller logically connected parts that specify how the General Objectives are achieved.

The editor should make sure that the authors observed the SMART (Specific, Measurable, Achievable, Realistic and Time bound) criteria when formulating their objectives. Furthermore, the objectives should be stated in a coherent and logical sequence. They should use appropriate action verbs like “determine, compare, describe, calculate, or establish” and avoid vague terminologies like “appreciate, understand, or study”.

SECTION D. METHODS

In the PJSS, this section is called "METHODS." It is not "Materials and Methods", "Subjects and Methods" or "Methodology". This is to ensure uniformity of manuscripts.
The section should describe the study type, the time period and where the study was conducted. Inclusion criteria, which all of the subjects should possess, and exclusion criteria, which none of the subjects should have, should be explicit. The inclusion criteria should have a stem like "all of the following" and the exclusion criteria should contain a phrase like "none of the following".

Operational definitions of inclusion and exclusion items, exposure, outcome, and other terms used should be stated if the authors did not adopt standard definitions or criteria. These are not the "textbook" definitions but descriptions of how they are used for the purposes of the study. For example, early breast cancer can be operationally defined as any invasive ductal breast carcinoma from stage I to III-A, or liver disease as at least a two-fold elevation of serum transaminases. Pain relief can be operationally defined as any decrease in Visual Analog Scale (VAS) pain score from baseline.

If there are subjects randomized, the method of randomization must be explicitly stated. The manner of data analysis should also be described in enough detail, so anyone who wishes to replicate the study or verify the results may be able to do so.

When describing equipment the proper format should be: Equipment (manufacturer's name, address).

Example: Cobalt-60 teletherapy unit (Theratron, Hitachi, Japan)

The generic name should be indicated for pharmaceuticals: Generic name (brand name, manufacturer).

Example: Ceftazidime (Zeptrigen, Westmont)

SECTION E. RESULTS

The Results Section of the manuscript contains the outcomes that the authors wish to present. This should be guided by the objectives of the study, prioritizing the presentation of data to answer the general and the specific objectives.

The description of the study results should be limited to describing, tabulating and/or illustrating the data with purely objective statements of cursory comparison. Actual values should be stated rather than using the terms "most" or "majority" to present data. Attempts to explain the results should be avoided and limited to superficial comparisons to emphasize the results. Explanations of the results should be described in the Discussion section of the manuscript.

The first part of the Results section is the description of the sample populations in the study. The following data should be described: total number of subjects included in the study; the number of subjects included per group; the number of excluded subjects and the reasons for exclusions; the number of subjects included in the final analysis.

The use of a flow chart (as described in the CONSORT statement on page ---), is recommended, especially for clinical trials.

Comment [tsv2]: Fill in page number.

In descriptive, case-control studies, cohort studies as well as randomized controlled trials, the first table is usually a detailed description of the sample group or groups selected for the study.

For descriptive studies, a simple table, with only 3 horizontal lines, listing the significant characteristics may be presented as shown in Table 1.

Table 1. Demographic characteristics, 120 subjects with thyroid cancer, UP-PGH, 2004-2007.

	n
Mean Age	
Male/ Female	
Mean Weight	
Mean Height	

For comparative studies, as in case-control studies, cohort studies, and randomized trials, a similar 4-column table, again utilizing only 3 horizontal lines, is used to tabulate the characteristics of the control and the experimental group or groups, followed by the P-value to indicate if the characteristic is significantly different for the groups (Table 2).

Table 2. Demographic characteristics of 120 subjects with thyroid cancer by type of surgery, UP-PGH, 2004-2007.

	Control Group	Experimental Group	P
n			
Mean Age			
Gender Ratio (M/F)			
Mean Weight			
Mean Height			

Comment [tsv3]: Clean up table.

The next part of the Results section presents primary outcome measures data followed by those of the secondary outcomes. Overall results (crude or unadjusted analysis) should be presented first; the results of subgroup analyses (stratified analysis, sensitivity analysis, worst case scenario analysis) are appropriately described next.

Results of continuous variables (e.g. age in years) should be presented using the format: mean +/- standard deviation, and range (minimum and maximum value).

Examples: Mean age +/- SD (Range)
42 years +/- 2 years (Range: 30-60 years)

Results of nominal (categorical) variables, or counts, should be presented as ratios or percentages. Absolute numbers should be accompanied by the corresponding percentages (or totals), since numbers alone may be misleading. In the running text, spelling out the word "percent" is preferred (see also the section on Writing Style in this chapter).

Examples: Male/ Female ratio: **1: 2 or ½**
Percent in Population (n / N): 23/50 as **23 (54.64 %)**
or **54.64 percent (n=23)**

For consistency, number of decimal places should be the same throughout the manuscript, including their descriptions in the tables and figures.

To present the results of statistical testing or analysis, the actual P value is written followed by the statistical test used.

Example: Actual P-value, statistical test
The difference was statistically significant (P=.003, chi square).

Relative Risk (RR) and Odds Ratio (OR) should always be accompanied by the corresponding 95% confidence interval calculations or P values.

Example: RR (95% CI)
The relative risk was 12.23(95%CI= 2.50-18.93)

When regression analysis is used in a manuscript that you are editing, look for the tables on univariate and multivariate analysis. Univariate analysis compares each factor separately with the outcome. Multivariate analysis contains the main results of the regression analysis, where each factor is compared to the outcome, controlling for the effect of the other factors. Look for the corresponding P values (or confidence intervals) per factor to see which of them are significantly associated with the outcome. The tables on univariate and multivariate analyses in the manuscript should contain at least a column on the different factors analyzed and a column on the corresponding p values (or confidence intervals), as follows:

Factor	P value

or

Factor	RR or OR	95% confidence interval

Results may be presented in text form or appropriate tables, graphs, diagrams or figures. Textual descriptions may be appropriate for descriptions of only a few categories (1 – 3 categories):

> *Of the 200 subjects included, 100 (50%) had severe malnutrition, 62 (31%) were moderately undernourished and 38 (19%) had mild disease. Fifty percent (100/200) had severe malnutrition, 31 percent (62/200) were moderately undernourished and 19 percent (38/200) had mild disease.*

More complex data involving numerous categories should be described using tables and figures. Tables are generally preferred because they can present the data in greater detail than figures. Figures are usually indicated if there is a need to present more clearly the trends from baseline colored. Photographs are expensive to reproduce and should be used only when the authors cannot adequately present the data using tables and figures. Photographs are usually numbered and labeled in the appendix of the manuscript, as figures.

Comment [tsv4]: Clarify, not sure what this is trying to say.

When a table, graph or figure is presented, there is no need to duplicate the data in the text. However, if the main result as found in a table or figure, it should still be described in the text for emphasis.

All tables and figures should have titles that contain all of the following: table/figure number, description of the table/figure contents, institutions where the research took place, and, the time period of the study.

Titles should appear above tables, and underneath figures. Titles should not start with numbers.

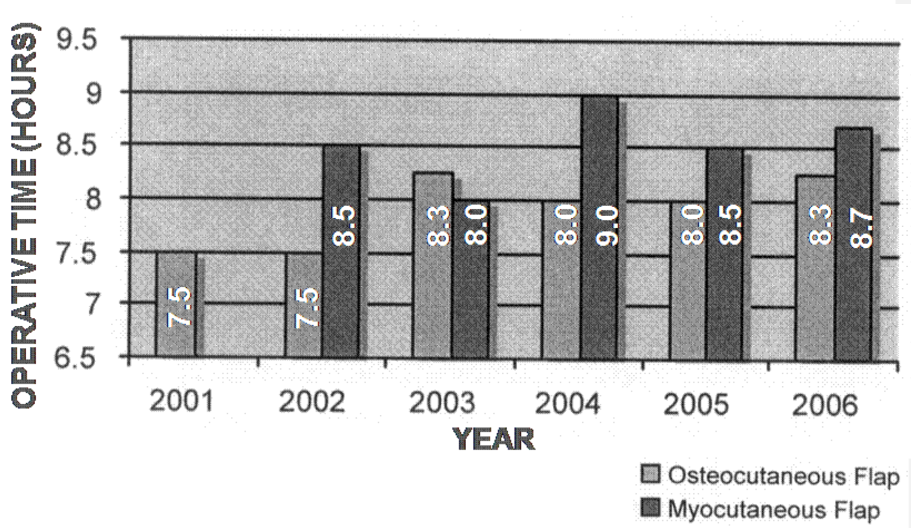
There should be no internal horizontal and vertical lines in the table. A Legend should be placed in the bottom part of the table when needed, as in the use of abbreviations, acronyms, or for proper footnoting of references in the table.

In the submission of manuscripts, tables are placed in the appendix. There should be only 1 table per page, appropriately double-spaced like the rest of the manuscript. Make sure that calculations in the Results section are accurate and that they match the numbers in the tables and figures. Table 3 and Figure 1 show the appropriate format.

Table 3. ***Distribution of symptoms of 121 cases of acute appendicitis, UERM, 1998.***

Symptoms	**number(%)**	
Abdominal Pain	**121**	**(100)**
Anorexia	**101**	**(83.47)**
Vomiting	**98**	**(80.99)**
Fever	**39**	**(32.33)**
Nausea	**25**	**(20.66)**
Diarrhea	**24**	**(19.83)**

Figure 1. Average operating times based on flap type per year in patients who underwent microvascular free flap reconstruction under the Division of Plastic Surgery of the Philippine General Hospital from January 2001 to August 2006.



SECTION F. THE DISCUSSION AND CONCLUSION

The Discussion is the part of the manuscript where the authors are expected to provide the following: 1) Explanation of the results, 2) Description of the limitations, 3) Comparison with published data, 4) Significance and clinical utility and 5) Conclusion, if appropriate. A manuscript reviewer should consider specific points in each of these areas.

Explanation of results

The authors should summarize the results and avoid repeating data or material already presented in the Results section.[1] They should discuss how the findings either verify or disprove their hypothesis. If no hypothesis was given, they should state whether the findings provide an answer to the research question.[2] All the findings should be considered. In a good manuscript, the authors will attempt to explain unexpected findings rather than simply ignore them. This is particularly important for findings that are not supportive of the authors' claims or their hypothesis. To fail to do this is to risk unjustifiably emphasizing only some of the results and reaching inappropriate conclusions.[2]

The editor should judge whether the discussions are adequately supported by the findings. Unjustified extrapolation of the data is a common weakness among authors and a good editor should be able to point out speculative, unsubstantiated or unsupported comments.[3] Another responsibility of the reviewer is to identify and develop arguments that may offer alternative explanations to the authors' conclusions[4] and ideally, provide explicit justification for such argument (e.g., literature citations). Unjustified biases on the part of the reviewer have no place in peer review. [5]

Limitations

It is important to determine if the limitations of a study are clearly identified. Many studies make fundamental assumptions that may be erroneous or impose limitations that alter the manner in which data are collected and analyzed. This can be something as simple as the choice of patient inclusion criteria or as complicated as the use of an analysis program. Therefore, the absence of a limitations statement suggests that the authors did not prospectively take these factors into account when they designed the study or did not retrospectively assess these features when they reviewed their data.[2] In some instances, although the authors have acknowledged the limitations, a reviewer may be able to identify additional limitations that were not considered by the authors.

Comparison With Published Data

The Discussion allows the authors to discuss their findings against the background of previously published work. The authors should not only state concurrence of the results with those of other authors but should explain the discrepancies with them as well. It is not necessary to review the entire medical literature on the subject; what is needed is to cite only specifically relevant data. Occasionally, some authors become too engrossed with the myriad of details but forget to answer the basic question of whether or not their hypothesis was proven or the research question was answered [2]

Significance and Clinical Utility

Depending on the study design, authors may sometimes ascribe clinical importance to the findings of their work. New hypotheses may be stated as such when warranted and recommendations included. However, the reviewer must be on the lookout for unqualified statements and conclusions not completely supported by the data. For example, authors should avoid making statements on economic benefits and costs unless their manuscript includes economic data and analyses.[1]

Conclusions
Not all manuscripts are required to state a conclusion. Conclusions should be supported by the findings as mentioned in the discussion. The conclusion statement may be an affirmation or a nullification of the hypothesis or an answer to the research question. Recommendations for future research may also be included in the Conclusion.

To help organize your review of the Discussion, a checklist and listing of common errors is provided in Tables 3 and 4 respectively.

Table 4. Points to consider when critiquing the Discussion.

1) Is the discussion concise? If not, how can it be shortened? [2]

2) If a hypothesis was proposed, do the authors state whether it was verified or nullified? Alternatively, if no hypothesis was proposed, do the authors state whether their research question was answered? [2]

3) Are the major new findings of the study clearly described and properly emphasized? [4]

4) Are the key conclusions supported by the data? [4]

5) Is there any other way to interpret the data other than that suggested by the authors? [4]

6) Do the authors explain the unexpected findings of the study? [2]

7) Is the significance of the results well described? [4]

8) Do the authors support their statements with appropriate references? [4]

9) Is the review of literature adequate, updated and relevant?

10) Are the unique aspects and strengths of the study properly highlighted? [4]

11) Are the limitations of the study properly described? [4] Are there additional limitations that should be noted? [2]

Table 5. Common errors among authors when writing the Discussion

1. Repetition of the data that has been presented in the Results

2. Repetition of the background literature as stated in the Introduction

3. Unjustified extrapolation of the data

4. Failure to explain unexpected findings or data inconsistent with the hypothesis

5. Failure to recognize the study limitations

6. Citing voluminous published data not relevant to the findings

6. Making unqualified or sweeping conclusions

7. Making conclusions not substantiated by the results

SECTION G. REFERENCES SECTION

The references are arranged in the order of citation in text (or tables or legends). Use arabic numerals and arrange in sequence of appearance not alphabetically. The average number of references ranges from 10 to 25.

Emphasize recent references; in general, avoid references that are older than 10 years, of historic interest only, letters to the editor or editorials. Do not cite abstracts, unpublished observations, manuscripts in preparation or submitted for publication, personal communications or references from obscure or non-English language journals.

Reference listing should use the form adopted by the US National Library of Medicine and used in Index Medicus. Examples of correct forms of references are provided in the PJSS Instructions to Authors (Appendix B). A comprehensive resource for medical citation can be found at the NLM website.[6]

REFERENCES

1. Uniform Requirements for Manuscripts Submitted to Biomedical Journals: Writing and Editing for Biomedical Publication [homepage on the Internet]. Philadelphia: International Committee of Medical Journal Editors; [updated 2007 Oct; cited 2008 Apr]. Available from: http://www.icmje.org.

2. Provenzale, JM, Stanley RJ. A systematic guide to reviewing a manuscript. American Journal of Roentgenology 2005; 185:848-854.

3.Bordage G. Reasons reviewers reject and accept manuscripts: the strengths and weaknesses in medical education reports. Academic Medicine 2001; 76:889-896.

4. Seals DR, Tanaka H. Manuscript peer review: a helpful checklist for students and novice referees. Advances in Physiology Education 2000; 22:52-58.

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6. Patrias, Karen. Citing medicine: the NLM style guide for authors, editors, and publishers [Internet]. 2nd ed. Wendling, Daniel L., technical editor. Bethesda (MD): National Library of Medicine (US); 2007 [cited 2008 May 14]. Available from: http://www.nlm.nih.gov/citing medicine.

Appendix A

PJSS Article Review Form

Title of Paper:

Comments	Yes	No	NA
1. Title			
1.1 adequate gives gist of paper	☐	☐	☐
1.2 appropriate length & syntax	☐	☐	☐
2. Abstract			
2.1 well structured	☐	☐	☐
2.2 contains ≤ 250 words	☐	☐	☐
2.3 with correct key words/mesh terms	☐	☐	☐
3. Introduction			
3.1 clearly presents nature and scope of problem	☐	☐	☐
3.2 concise and pertinent review of literature	☐	☐	☐
3.3 clearly states objectives of study	☐	☐	☐
4. Methods			
4.1 well described study design	☐	☐	☐

4.2	well-defined study population (inclusion/exclusion criteria)	☐	☐	☐
4.3	inclusives dates & place of study	☐	☐	☐
4.4	clearly operational definitions	☐	☐	☐
4.5	well-described study measures	☐	☐	☐
4.6	clearly defined outcome measures	☐	☐	☐
4.7	appropriate data analysis (statistical tests, level of significance)	☐	☐	☐

5. Results

5.1	adequate description of demographic features	☐	☐	☐
5.2	organized presentation of results	☐	☐	☐
5.3	utilized appropriate method of data presentation (text, tables, figures, graphs)	☐	☐	☐
5.4	tables, figures and graphs are appropriate labeled and formatted	☐	☐	☐

6. Discussion

6.1	presents principles & relationships shown by results	☐	☐	☐
6.2	points out limitations, exceptions, lack of correlation and unsettled points	☐	☐	☐
6.3	adequately shows how results agree or contrast with previous work	☐	☐	☐
6.4	discusses implications and practical applications of study	☐	☐	☐
6.5	conclusions clearly stated with summarized evidence for each conclusion	☐	☐	☐

7. References

7.1	follows prescribed PJSS format			
	- citation order system	☐	☐	☐
	- appropriate form & style	☐	☐	☐
7.2	all references are updated and significant	☐	☐	☐

8. For Clinical Trials

8.1	Good Clinical Practice (GCP)			
	- complies with GCP	☐	☐	☐

- Ethics committee approval ☐ ☐ ☐

Other comments:

____
____
____
____

Recommendation:

☐ Accepted for publication, with minor revisions

☐ Accepted for publication, with major revisions

☐ Rejected

Main justification for rejection
____
____
____
____
____

Reviewed by: ________________________

Position: ________________________

Appendix B

INSTRUCTIONS TO AUTHORS

The Philippine Journal of Surgical Specialties (PJSS) is a quarterly journal that considers for publication original articles related to surgery. It will also consider for publication studies done in the Philippines that had been published in other journals, in either original, modified or abstract form with the permission of the publisher and principal author. It may also publish case reports, "how I do it articles", abstracts and collective reviews.

Contributions are reviewed by a group of surgeons and physicians with a recognized academic record who make up the Editorial Board, Editorial Consultants and International Peer Reviewers. The journal aims to provide readers with knowledge on current scientific investigation in surgery and related fields in the Philippines.

CONTRIBUTIONS

Copies of the manuscript and illustrations should be sent to the Editor-in-Chief, Philippine Journal of Surgical Specialties.

Edgardo R. Cortez, M.D.
Philippine Journal of Surgical Specialties
PCS Building, 992 EDSA
Quezon City, Philippines

The criteria for preparation of manuscripts are adopted from the "Uniform Requirements for Manuscripts Submitted to Biomedical Journals", established by an agreement among a number of editors of clinical journals in the United States, Canada and the United Kingdom.

Contributors must comply with these standard criteria to facilitate editing and publication of submitted articles.

SUMMARY OF REQUIREMENTS

The authors should submit one printed and one electronic (diskette or CD) copy of the manuscript. Type manuscript double spaced, including title page, abstract, text, acknowledgements, references, tables and legends.

Each section of the manuscript should begin on a new page, in this sequence:

Title page
Abstract
Text
Acknowledgements
References
Tables: each table, complete with title and footnotes, on a separate page
Legends for illustrations
Illustrations must be of good quality, unmounted glossy prints, usually 5 by 7 inches, but not larger than 8 by 10 inches.
Digital copies must be submitted in diskette or CD if available.

PREPARATION OF MANUSCRIPT

Type manuscript on an 8 ½” x 11” inches white bond paper with margins of at least 1 inch. Use font size 12 for Times New Roman and font size 10 for Arial. Use double spacing throughout, including title page, abstract, text, acknowledgements, references, tables, and legends for illustrations. Begin each of the following sections on separate pages: title page, abstract, text, acknowledgements, references, individual tables, and figures/illustrations. Number pages consecutively, beginning with the title page. Type the page number in the upper right-hand corner of each page.

Manuscripts will be reviewed for possible publication with the understanding that they are being submitted to one journal at a time and have not been published, simultaneously submitted, or already accepted for publication elsewhere. This does not preclude considerations of a manuscript that has been rejected by another journal or of a complete report that follows publication of preliminary findings elsewhere, usually in the form of an abstract. Copies of any possibly duplicative published material should be submitted with the manuscript that is being sent for consideration.

TITLE PAGE

The title page should contain (1) the title of the article, which should be concise but informative; (2) a short running head or footnote of no more than 40 characters (counting letters and spaces) placed at the foot of the title page and identified; (3) first name, middle initial, and last name of each author, with highest academic degree(s); (4) name of department(s) and institution(s) to which the work should be attributed; (5) disclaimer, if any; (6) name and address of author responsible for correspondence about the manuscript; (7) name and address of author to whom requests for reprints should be addressed, or statement that reprints will not be available from the author; (8) the source(s) of support in the form of grants, equipment, drugs or others.

AUTHORSHIP

All persons designated as authors should qualify for authorship. Each author should have participated sufficiently in the work to take public responsibility for the content.

Authorship credit should be based only on substantial contributions to all of the following: (a) conception and design; or analysis and interpretation of data; (b) drafting the article or revising it critically for important intellectual content; and on (c) final approval of the version to be published. Participation solely in the acquisition of funding or the collection of data does not justify authorship. General supervision of the research group is also not sufficient for authorship. Any part of an article critical to its main conclusions must be the responsibility of at least one author.

A paper with corporate (collective) authorship must specify the key persons responsible for the article; others contributing to the work should be recognized separately (see Acknowledgements and Other Information).

Editors may require authors to justify the assignment of authorship.

ABSTRACT AND KEY WORDS

The second page should carry a structured abstract of not more than 250 words. The abstract shall be divided into the: objectives, methods, results, discussion and conclusion. Each section should be separated by appropriate indentation. Emphasize new abbreviations.

Below the abstract, provide and identify as such, 3 to 10 key words or short phrases that will assist indexers in cross indexing your article and that may be published with the abstract. Use terms from the Medical Subject Headings (MeSH) list of Medline. If suitable MeSH terms are not yet available for recently introduced terms, present terms may be used.

TEXT

The text of observational and experimental articles is usually, but not necessarily, divided into sections with the headings: Introduction, Methods, Results, and Discussion. Long articles may need subheadings within some sections to clarity their content, especially the Results, and Discussion sections. Other types of articles such as case reports, reviews, and editorials may need other formats, and the authors should consult the journal for further guidance.

Introduction: Clearly state the purpose of the article. Summarize the rationale for the study or observation. Give only strictly pertinent references, and do not review the subject extensively.

Methods: Describe your selection of the observational or experimental subjects (patients or experimental animals, including controls) clearly. Identify the methods, apparatus (manufacturer's name and address in parenthesis), and procedures in sufficient detail to allow other workers to reproduce the results. Give references to established methods, including statistical methods; provide references and brief descriptions of methods that have been published but are not well known; describe new or substantially modified methods, give reasons for using them, and evaluate their limitations.

When reporting experiments on human subjects, indicate whether the procedures followed were in accord with the ethical standards of the Institutional Review Board of the institution in which the experiments were done or in accord with the Helsinki Declaration of 1975. When reporting experiments on animal subjects, indicate whether the institution's or the National Research Council's guide for the care and use of laboratory animals was followed. Identify precisely all drugs and chemicals used, including generic name(s), dosage(s), and route(s) of administration. Do not use patient's names, initials, or hospital numbers.

Include numbers of observations and the statistical significance of the findings when appropriate. Detailed statistical analyses, mathematical derivations, and the like sometimes may be suitably presented in the form of one or more appendices.

Statistics: Describe statistical methods with enough detail to enable a knowledgeable reader with access to the original data to verify the reported results. When possible, quantify findings and present them with appropriate indicators of measurement of error or uncertainty (such as confidence intervals). Avoid sole reliance on statistical hypothesis testing, such as the use of p values, which fails to convey important quantitative information. Discuss eligibility of experimental subjects.

Give details about randomization. Describe the methods for, and success of any blinding of observations. Report losses to observation (such as dropouts from a clinical trial). References for study design and statistical methods should be to standard works (with pages stated) when possible rather than to papers where designs or methods were originally reported. Specify any general computer programs used.

Put general descriptions of methods in the Methods section. When data are summarized in the Results section, specify the statistical methods used to analyze them. Restrict tables and figures to those needed to explain the argument of the paper and to assess its support. Use graphs as an alternative to tables with many entries; do not duplicate data in graphs and tables. Avoid non-technical uses of technical terms in statistics, such as "random" (which implies a randomizing device), "normal,” "significant," correlation," and "sample." Define statistical terms, abbreviations, and most symbols.

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avoid unqualified statements and conclusions not completely supported by your data/results. Avoid claiming priority and alluding to work that has not been completed. State new hypotheses when warranted, but clearly label them as
such. Recommendations, when appropriate, may be included.

ACKNOWLEDGEMENTS

Acknowledge only persons who have made substantive contribution to the study. Authors are responsible for obtaining written permission from everyone acknowledged by name because readers may infer their endorsement of the data and conclusions.

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Ona ET, Rosete-Liquete RMO. Elective conversion from cyclosporine A to azathioprine in renal transplant patients. J PMA 1989;65:154-158.

2. Corporate Author
Pulmonary Carcinoma Task Force, Epidemiology of Lung Cancer. State of the Art: Cancer 1991:11.

3. No Author Given
Anonymous. Coffee drinking and cancer of the pancreas (Editorial), Br Med J 1981; 283-628.

4. Journal Supplement
Laudico AV, De Vera RL, dela Pena AS, Velmonte AA. In vitro and in vivo activity of ciprofloxacin in surgical infections. International Journal of Clinical Practice 1990; 6 (Suppl 1): 88-91.

5. Journal Paginated by Issue
Montalban AM, Dumlao AJM, Alegre A. Patch skin grafting for small ulcers. Phil J Ortho 1990; 9(1):31-35.

Books and Other Monographs

6. Personal Author(s)
Caedo, Jr. JP. Operative Surgical Procedures in General Surgery, 1st ed. Parañaque: Donnel Carlo Printing Press, 1985:49-53.

7. Editor, Compiler, Chairman as Author
Limson AA, Castor NM, Hilvano SC, et al. A Handbook on Total Parenteral Nutrition. Mandaluyong: Abbott Laboratories, 1979:22-24.

8. Chapter in a Book
Eufemio GG, Laudico AV, Liquete MJ, Rosete-Liquete RMO, de Jesus RS. Breast. In: Eufemio GG, Philippine Textbook of Surgery, 1st ed. Quezon City: JMC Press, 1990:243-266.

9. Published Proceedings Paper
Agcaoili NR. Lecture on tissue banking in orthopedic surgery. In: Lagdameo WN, ed. Proceedings of the 16th mid-year convention of the Philippine College of Surgeons. Baguio City: Philippine College of Surgeons, 1990:18-19

10. Monograph in a Series
Laudico AV, dela Pena AS, Cabaluna ND, Ngelangel CA. Diagnosis of thyroid cancer. In:Laudico AV, ed, State of the Art: Cancer. Technical Report Series No. 10 Metro Manila: Philippine Council for Health Research and
Development, 1991:17-18.

11. Agency Publications
Laudico AV, Esteban D, Parkin DM. Cancer in the Philippines. International Agency for Research on Cancer Technical Report No. 5, Lyon, 1989.

12. Dissertation or Thesis
Ramirez AT. Experimental wound healing in man (Dissertation). Boston, MA: Tufts University. 1965,128 p.

13. Newspaper Article
Salang NT. Breast cancer in men and women. Manila Bulletin 1991 March 30:7.

14. Magazine Article
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