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CHEST GUIDELINES FOR MANUSCRIPT PREPARATION

Authors should have read the *CHEST* Policies while writing their manuscript.

Manuscripts must be submitted online at http://mc.manuscriptcentral.com/CHEST. If you need guidance on how to submit online, go to Instructions for Online Submission.

Cover letter
Authors should include a cover letter to the Editor in Chief describing the rationale for submitting the paper. Please include any pertinent or specific information of which you would like the Editor in Chief to be aware. There is a field in CHEST Manuscript Central to paste in this text; alternatively, in CHEST Manuscript Central, authors have the option to attach the cover letter.

Format
All text must be double-spaced in 10 to 12 point typeface (Times Roman or Helvetica), including references and legends. The paper should be prepared in a word processing format (Microsoft Word preferred.) Each of the following parts should begin on a new page: title page, abstract, key words, abbreviation list, body of paper, references, figure legends, tables. Pages should be numbered consecutively and line numbered throughout the paper. Each figure should be prepared as a separate digital file and uploaded separately. See figure preparation instructions that follow.

Title Page
Each manuscript must include a title page including the following:
word counts for the abstract and text in the upper left-hand corner;
full article title;
full first and last names, highest academic degrees and e-mail addresses, and institutional affiliations for all authors;
corresponding author e-mail address;
the institution at which the work was performed;
disclosure of any personal or financial support or author involvement with organization(s) with financial interest in the subject matter – or any actual or potential conflict of interest – and if no conflicts exist, a statement to that effect must be included for each author.

Abstract
Provide a structured abstract not to exceed 250 words for original research. Structured abstracts should consist of four sections, labeled as Background, Methods, Results, and Conclusions. For a more detailed explanation of how to structure the sections, see Foote.[1] The sections should briefly describe, respectively, the problem being addressed in the study, how the study was performed (including numbers of patients or laboratory subjects), the significant results, and what the authors conclude from the results. The abstract should include the number of patients or number of laboratory animals used in the study. For all clinical trials (see *CHEST* Policies), the trial registration number must be stated at the end of the Abstract.

Please be sure that you include the abstract in the manuscript file that you upload to Manuscript Central in addition to pasting the abstract into the abstract field during the submission process.

Key Words
Please select key words that reflect the content of your manuscript. For additional guidance, consult the *Medical Subject Headings* (MeSH terms), available online at www.nlm.nih.gov/mesh/meshhome.html

Abbreviations
On a separate page in your manuscript, please provide an alphabetical list of all abbreviations used in the paper, followed by their full definitions. Each abbreviation should be expanded at first mention in the text and noted parenthetically after expansion. To facilitate reader comprehension, please use abbreviations sparingly.

Body of Paper

Subheads should be used to provide guidance for the reader; this format can be flexible, but the subheads in original research would ordinarily include sections such as Introduction, Methods and Materials, Results, and Discussion.

When mentioning products such as drugs or equipment, use the generic (nonproprietary) name, followed in parentheses by the brand or trade name, manufacturer name, and manufacturer location, as in the following example: The patient was treated with bilevel nasal positive pressure (BiPAP; Respironics Inc; Murrysville, PA).

References
Authors are responsible for the accuracy and completeness of citations. In text, references must be given as superscript numerals, numbered consecutively in the order in which they appear in the text. The full citations must be listed on a separate sheet in numerical order at the end of the text. Each reference must contain, in order, the following: first three authors (last name, initials) [followed by “et al” in the case of four or more authors], title of article (lower case, no quotation marks), source, year of publication, volume, and inclusive page numbers. References to abstracts or letters may be included but must be noted as such. Abbreviations of journal names must conform to *Index Medicus* style (available online at www.ncbi.nlm.nih.gov:80/entrez/jrbrowser.cgi). Please do not use programs such as Reference Manager within your word processing file. These programs have a history of duplicating citations. Please note that no periods should be used after authors’ initials, after journal abbreviations, or at the end of a reference. Following are examples of the most common formats.

Journal Article
1 Cordier JF, Chailleux E, Lauque D, et al. Primary lymphomas: a clinical study of 70 cases of nonimmunocompromised patients. Chest 1993; 103:201-208

Book
2 Cane RD, Shapiro BA, Davison R. Case studies in critical care medicine. 2nd ed. Chicago, IL: Mosby Yearbook, 1990; 193-195

Book Chapter
3 Tuchschmidt J, Akil B. The lung and AIDS in developing countries. In: Sharma OP, ed. Lung disease in the tropics. New York, NY: Marcel Dekker, 1991; 305-318

Abstract
4 Petrillo T, Fortenberry J, Linzer J, et al. Use of ketamine in status asthmaticus [abstract]. Chest 2000; 118 (suppl):80S

For assistance in formatting other types of references, please refer to the *American Medical Association (AMA) Manual of Style*.[2 (p 28-51)]

To ensure the quality of scientific literature, each author should check their reference list against the PubMed list of retracted articles (go to pubmed.gov, find the “Special Queries” in the left-hand toolbar, and scroll down to “Retracted Articles” to find the current list). If an article has been retracted, it should not be cited.

Figures
Figures should be professionally designed or photographed. They should be saved (by scanning if necessary), as .tiff, .jpg, or Powerpoint (.ppt) formats at these resolutions: 1200 dpi for line art (eg., graphs, drawings that have no gray tones), 300 dpi for black and white and color photographs with no labeling, and 600 dpi for combination figures (photographs with labeling).

All illustrations must be cited in consecutive numerical order within the text of the manuscript. A legend for each illustration should be provided on a separate page, not on the figure itself. Please identify stains and magnifications for all photomicrographs.

Signed statements of consent must accompany a photograph if there is a possibility the subject could be identified.[1 (p 83)]

Color Figures
CHEST encourages the inclusion of color illustrations and will share the expense of reproduction and printing. The author’s share of this cost is $500 per color figure. When submitting a color figure, please indicate in *CHEST* Manuscript

Central that it is to be published in color. By specifying that you want to publish a figure in color, you agree to share the reproduction costs. Do not send payment with the submission; these costs will be billed once an article has been accepted to *CHEST.*

Tables
Tables should be self-explanatory and should not duplicate textual material. They must be numbered and cited in consecutive order in the text, and each must have a succinct title, and (where appropriate) a legend describing abbreviations and footnotes at the bottom of the table. See past issues for guidance on how to format footnotes. Tables consisting of more than 10 columns are unacceptable. It is important to keep tables concise and easy to synthesize.

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Previously published figures, tables, or text must be accompanied by a signed permission from the copyright holder (usually the publisher), and complete reference citations must be provided to *CHEST* during the submission process so that appropriate credit can be given in accordance with copyright law. These permissions are the responsibility of the authors. Until the necessary written permissions are received, a manuscript cannot be published. Please fax the signed permission forms to 847-498-5460 (Attn: Editorial Department, Permissions) or scan them and upload them with the manuscript files.

Journal Sections
For a complete list of current sections for *CHEST*, see Table 1. Authors should review the information in this table, because requirements differ among the various sections. For example, each section contains its own maximum length requirements. When appropriate, authors should consult with the Editor in Chief with questions regarding relevancy of their submission to a particular section.

Special Instructions for Submission to the Chest Imaging and Pathology for Clinicians Section
Clinicians in our field rely heavily on chest radiology and interpretation of images to determine diagnoses. To aid our readers in mastering the fundamentals of interpretation and ordering of chest imaging modalities, *CHEST* will regularly publish case-based articles with characteristic chest imaging and related pathology. The editors of this section, Drs. Suhail Raoof, David Naidich, and William Travis, will oversee and coordinate the publication of a core of the most important chest imaging topics. In doing so, they encourage the submission of unsolicited manuscripts.

It cannot be overemphasized that both radiologic and pathologic images must be of excellent quality. As a rule, 600 DPI is sufficient for radiographic and pathologic images. Taking pictures of plain chest radiographs and CT scans with a digital camera is strongly discouraged. The figures should be cited in the text and numbered consecutively. The stain used for pathology specimens and magnification should be mentioned in the figure legend. Other requirements for manuscript submission are listed in the Instructions for Authors (put link to website).

The proposed format is given below for further clarification:

Title: This should entail a short summary of presenting feature (i.e. Dyspnea with slow growing mass of the left hemithorax)

What is the diagnosis? Alternative questions may replace asking for the correct diagnosis when these represent a more challenging or informative method for introducing cases.

Clinical Findings: Should briefly mention the pertinent positive and negatives. Any unnecessary investigations and detailed description of hospital course should be avoided.

Radiologic Findings: This discussion should usually begin with the plain chest radiograph when appropriate. With the advent of newer imaging modalities, plain chest radiograph interpretation is becoming an overlooked art. Normal chest radiographs, however, need not be submitted. A detailed description of additional imaging studies should be made. Subtle findings that help point towards the diagnosis should be emphasized. Clinicians should be able to suggest the correct diagnosis or a short differential based upon familiarity with the appearance of classic radiographic findings by themselves. Selection of images should reflect state-of-the-art image quality. For example, cases of interstitial lung

disease must be imaged with high-resolution CT technique. Similarly, CT or MR studies related to vascular disease must be performed with contrast enhancement. Cases illustrating advanced imaging techniques such as volumetric rendered images, or virtual endoscopy are also welcome provided that these techniques prove critical to radiologic diagnosis.

Pathologic Findings: A detailed description of the pathological findings should be included. This section should be fairly detailed and should reflect whenever possible *correlations with the above mentioned radiologic signs.*

Diagnosis: Self explanatory

Discussion: The discussion may be divided into three broad areas**:**

a) **Clinical discussion.** How do the clinical findings tie in with the diagnosis? Mention the typical and atypical features of the case. Highlight the two or three clinical features that may alert the clinician to the correct diagnosis. A detailed description of the differential diagnosis and a logical approach to exclude them would be useful.

b) **Radiological discussion.** Specific findings on plain chest radiographs and CT PET or MR scans should be highlighted. Radiographic findings that help exclude diagnoses or make them less likely should be mentioned. Finally, the reason(s) to select a particular imaging modality over another should be discussed.

c) **Pathology discussion.** Pathologic patterns of lung involvement that correspond to patterns seen on chest imaging and the pathologic differential diagnosis of the disease under discussion should be presented. Special staining techniques that may allow the diagnosis to be established should be addressed.

d) A **concluding** paragraph should enumerate the patient's clinical course and should mention the treatment given. Our aim is to give the readers condensed information about a particular disease, allow them to form a complete differential diagnosis, and to select imaging modalities that give the most useful information in a cost effective manner.

e) A six line **abstract** should be included at the end of the case. It should include the pertinent history and physical findings, and results of radiological and pathological findings and the diagnosis. The abstract should highlight the main teaching points of the case.

Two or three **keywords** that may facilitate a literature search should be included after the abstract. This should include the key diagnostic terms applicable for the entity presented.

Special Instructions for Submission to the Pulmonary and Critical Care Pearls Section

Manuscripts for this section are designed to present a case, pose a question, and provide the answer after the reader turns the page.

Refer to the patient's race only when pertinent to the case. Describe patients as man, woman, boy or girl rather than male or female. Avoid references to specific institutions: *A 65-year-old man presented with chest pain* rather than *A 65-year-old man presented to the University of Colorado Medical Center with chest pain.*

Organize the case report into an initial unlabeled paragraph containing concise historical content. If medical findings are presented, proceed to a second paragraph labeled Physical Examination and a third paragraph labeled Laboratory Findings. Begin the Physical Examination with the patient's vital signs, which may be abbreviated as *normal* when appropriate. List the physical findings in telegraphic form with each organ system labeled: *Chest: bibasilar rales. Cardiac: Grade II/VI holosystolic murmur at the apex radiating to the axilla. Abdomen: non-tender without organomegaly.* In the laboratory findings section refer to tests in the following order: hemogram, blood chemistry, urine studies, arterial blood gases, microbiology results, tissue biopsy studies, miscellaneous studies (ECG, esophageal motility studies, etc), radiographic studies. The order of the laboratory studies can be changed, when appropriate, to the flow of the material. Put normal values in parentheses when referring to unusual test results or values that have different normal ranges between laboratories. Some cases may not require presentation of physical or laboratory findings. These cases may be presented as narrative summaries in one or more paragraphs.

Refer to any figures used in the case report in one of the following manners:

Plain films of the abdomen shown below.

Plain film of the abdomen: Splenic calcifications (below)

In discussing the figure in the case report, simply refer to its presence when the findings are sufficiently obvious to challenge the reader. If the finding is subtle and difficult to detect, the abnormality can be described in the case report. When not mentioned in the case report, the abnormality in the figure should be discussed in the body of the discussion on the following page. End the case report with a question for the reader that leads into the discussion on the next page.

A new page should begin with the diagnosis or "answer" to a question followed by the discussion:

Diagnosis: Brain Death.
Discussion: Brain death is characterized by ....

The body of the discussion should be organized in the following manner: An initial general discussion of the condition or situation with only occasional, brief references to the patient (*eg*, as demonstrated by the present patient…) who is described in the case report. This general discussion should be written in a lively style with avoidance of the passive verb tense whenever possible. The final paragraph should typically begin with a phrase that brings the general discussion back to the patient. The usual example is: "The *present patient appeared to be recovering from ARDS and did not present issues of futility of care."* This final paragraph should inform readers how clinicians resolved any management issues and what outcome the patient and/or family experienced.

Each case should have three to five Clinical Pearls. The Pearls represent the salient points made in the discussion.

References should be a balanced mix of classic and recent up-to-date journal or book citations. Try to limit the number of references to three to five and never list more than 10. List references in chronological order. Avoid referring to general medical or nursing textbooks.

Figures are only needed for the case presentation. Follow-up figures to amplify points made in the discussion are not needed but can be used if they make important points. (See Table 1 for a breakdown of words per section.)

REFERENCES

1 Foote M. Some concrete ideas about manuscript abstracts. Chest 2006; 129:1375-1377.
2 Iverson CL, Flanagin A, Fontanarosa PB, et al. American Medical Association manual of style: a guide for authors and editors. 9th ed. Baltimore, MD: Williams & Wilkins, 1998

Table 1--Current sections of *CHEST* and maximum length requirements*
(As of September, 2006)

Section	Abstract (words)	Text (words)†	References (No.)
Editorials	N/A	750	12
Original Research	250	2500	50
Recent Advances in Chest Medicine	250	3500	75
Translating Basic Research into Clinical Practice	250	2500	30
Special Features	250	3500	75
Medical Ethics	250	3500	75
Topics in Practice Management	250	2500	30
Global Medicine	250	3500	75
Selected/Case Reports	150	750	5
Clinical Commentary	250	2500	50
Postgraduate Education Corner			
Contemporary Reviews in Sleep Medicine	250	3000	75
Contemporary Reviews in Critical Care Medicine	250	3000	75
Chest Imaging and Pathology for Clinicians‡	N/A	1600	20
Pulmonary and Critical Care Pearls§	N/A	1200	10
Case Records of the University of Colorado‖	N/A	N/A	N/A
Medical Writing Tip of the Month¶	N/A	1000	7
Correspondence	N/A	300	5

*Except for Original Research, Pearls, Case Reports, Chest Imaging for Clinicians, and Correspondence, sections reflect areas of invited papers. **Authors should consult with the Editor in Chief if they would like to write an unsolicited paper for that section.**
†Does not include title, abstract, or references. Refers to the body of the text.
‡An approximate breakdown of the clinical, radiological, and pathological findings and discussion should be approximately 500 words. Whenever appropriate, plain chest radiographs should be included. Up to two pathology images will be published in color without charge to the author.
§Case presentation 150 to 250 words, discussion 850 words, not counting pearls and references.
||Submitted by the Section Editor.
¶Submitted by professional medical writer and *CHEST* editors.

For more information, please contact:
Editorial Department, *CHEST*
3300 Dundee Road
Northbrook, IL 60062-2348
Telephone: (847) 498-1400
Fax: (847) 498-5460
Email: Editor@chestnet.org