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EMERGENCIAS

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INFORMATION AND RECOMMENDATIONS FOR REVIEWERS OF ORIGINAL ARTICLES, BRIEF REPORTS, AND SCIENTIFIC LETTERS

(Spanish version available from http://emergencias.portalsemes.org/images/info-revisores-es.pdf)

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When reviewing a manuscript for EMERGENCIAS, referees are asked to bear in mind the following important aspects:

- The article should be formatted to comply with the journal's instructions for original articles or brief reports. These are available from http://emergencias.portalsemes.org/images/instructions_authors_en.pdf and are summarized here:

Original articles. Reports of original basic, epidemiologic, clinical, technical, analytical, or longitudinal research; studies will preferably be prospective in design. An original article should include the following sections: structured abstract (limit, 250 words), introduction, methods, results, discussion, and references. It should have a maximum of 3000 words (excluding the abstract and references), no more than 6 tables and/or figures and 30 references, and a maximum of 6 authors. (Multicenter studies are exceptions to this last rule.)

-Longitudinal observational studies (with cohort or case–control designs) should follow the STROBE (Strengthening the Reporting of Observational Studies in Epidemiology) reporting guidelines available from http://www.strobe-statement.org.

-Studies of predictive models should adhere to the TRIPOD (Transparent Reporting of a Multivariable Prediction Model for Individual Prognosis or Diagnosis) guidelines available from https://www.ncbi.nlm.nih.gov/pubmed/25560730.

-The CONSORT guidelines (Consolidated Standards of Reporting Trials), which should be used for reviewing clinical trials, are available from http://www.consort-statement.org. At the end of this letter we summarize the main STROBE and CONSORT components that the reviewer should evaluate.

-Studies to validate diagnostic tests should follow the STARD (Standards for Reporting of Diagnostic Accuracy) guidelines available from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5128957/.

-Randomized controlled clinical trials should follow the recommendations of the CONSORT (Consolidated Standards of Reporting Trials) statement available from http:www.equator-network.org.

Brief reports. Original research articles which have aims, designs, or results that can be conveniently published in shorter formats. Brief reports should be organized like original articles (see above) but have no more than 1500 words, a structured abstract (limit, 150 words), a maximum of 2 tables and/or figures, 15 references, and 6 authors.

Scientific letters. This section will consider letters that report original research with an objective of limited scope, a small number of participants or cases, and specific conclusions. Examples would be a series of patients treated in the same hospital or even a report of a single noteworthy case. Case report letters should have an introduction, case description, and discussion; authors of such letters are advised to follow the CARE case report guidelines available from http://data.care-statement.org/wp-content/uploads/2016/08/CAREchecklist-English-2016.pdf. Scientific letters are also the ideal way to report on survey studies whose findings cannot be generalized to a broad population - in other words surveys that answer highly specific questions or were done in limited geographic areas and that cannot provide data relevant to other populations. Scientific letters should be no more than 1200 words long and contain a maximum of 3 tables or figures, and 15 references. They may have up to 6 authors. Scientific letters will shortly replace the traditional article category of brief original research articles. Scientific letters will not have abstracts. Nor will they carry subtitles marking sections, although their content willl still follow the same traditional structure for reporting such research (introduction, objectives, methods, results, discussion, and conclusions). Small case series, in which patients might be recognizable, should be accompanied by the patients' informed consent (available from http://emergencias.portalsemes.org/images/consentimiento.es-pdf).

Submissions in these 3 categories must have been approved by the appropriate institutional review board or clinical research ethics committee of the authors' hospital or hospitals or for the region or country.

The Editorial Board is grateful for your effort and collaboration, which is a critical part of the journal's editorial process. Please accept our sincere thanks.

MODEL PEER REVIEW REPORT (the manuscript described is an imagined composite)

1. IDENTIFIERS

EM-9999

Title: PROGNOSTIC VALUE OF THE NIHSS SCORE AT 24 HOURS IN PATIENTS WITH ACUTE ISCHEMIC STROKE ON INTRAVENOUS FIBRINOLYSIS.

Section: Original articles

2. INTRODUCTORY REMARKS

This paper reports a descriptive study of 33 patients with acute-phase ischemic stroke. The patients were being treated in the emergency department of Hospital XXXXX. These patients met the criteria for intravenous fibrinolysis, so the stroke code was activated. The authors analyzed predictors of function 3 months after fibrinolysis.

3. GENERAL OBSERVATIONS

The writing and presentation leave much to be desired, and this aspect must clearly be improved. This reader was not even able to understand many sentences and paragraphs. The author should pay more attention to subject-verb relationships, sentence structure, and verb phrases. (Past and present tenses are mixed indiscriminately and shifts between first and third person subjects and verbs are not easy to follow.) The past tense is recommended for reporting in general).

The study was performed retrospectively and the choice of data gathered has not been clearly explained in relation to the objectives. To know if the study's design and initial planning is appropriate, we need to know the hypotheses behind variable selection and the inclusion and exclusion criteria for patient selection. We also note that since the patient sample was so small, the study is not robust.

Finally, I mention that results are repeated in the text and the large number of tables (too many). They are even repeated in the Discussion section. The conclusion paragraph seems to be a mere continuation of the Results section. This study does not offer new knowledge to the emergency medicine specialist. Nor does the paper offer conclusions that might be useful for clinical practice.

4. SPECIFIC OBSERVATIONS

4.1 Abstract

Too long. Reduce to 250 words. Do not include a discussion. Instead, write 1 or 2 im-

portant conclusions that are strictly related to the objective. The abstract should be structured into the following sections: Objective(s), Methods, Results, and Conclusions.

4.2 Introduction

A general observation is that this section is too long at present. It should be synthesized so that the reader quickly understands the current state of the question. The long historical account is not relevant. The authors cite and describe several prognostic scales that they never mention again in the rest of the article. These also contribute nothing, as they are unrelated to the development of the study or its discussion. Abbreviations should be explained the first time they appear in the text. For example, the authors have not explained the meaning of NIHSS or mRS. (Also note that the abbreviation should not be used in the title.) The modified Rankin Scale need not be explained in detail. Just refer to the appropriate reference. Nor do we need to know so much about the degrees of disability and functional dependence. Nor do the authors' subjective comments in the three Introduction paragraphs make a contribution. Finally, I am confused by the aim of the study because identifying and analyzing clinical or laboratory variables that might predict the degree of functional dependence at 3 months or even longer in these stroke patients-most of whom must have been ischemic since fibrinolysis was used-seems overly ambitious in a sample of only 33 patients.

4.3 Methods

Insufficient detail. We can deduce that the authors included the cases of 33 patients who were treated at the aforementioned hospital, but the reasons for including them or excluding others are not explained. For example, we are not told whether these were patients with anterior ischemic stroke (middle and/or anterior cerebral artery) or posterior ischemic stroke (vertebral or basilar artery). We also do not know if patients with stroke symptoms on awakening were included, or if some were unaware of when symptoms started. The authors do not say who made the initial assessment (emergency physician, neurologist, or both). Nor do we know if fibrinolysis was started in the emergency room or in an ICU. Did the patients sign their informed consent to fibrinolysis? Did an institutional review board or other clinical research ethics committee approve the study? The authors must comply with those ethical obligations before publication can be considered. The characteristics (clinical or epidemiologic) of the included patients need to be described, in a table for example. Treatments need to be described too. Since the results for some variables are not given in the Results section (where there are also some variables that are not mentioned in the Methods section), it is unclear which variables the authors took into consideration. Finally, regarding statistics, the authors do not explain how they described qualitative and quantitative variables or what tests they used to explore correlations between them and dependence at 3 months and beyond. We reiterate, however, the problem of the small sample size: the authors should be alert to the possible presence of an undetected beta error.

4.4 Results

A general remark is that this section is too long. It has 2 main problems. First, a great deal of the data mentioned in the text are repeated in the tables. The information can be removed from the text. Second, many interpretative comments are present. Interpretation should be placed in the Discussion section, not here. The tables contain a great deal of poorly organized information that has not been analyzed in detail (only descriptive statistics for frequencies and percentages are given). Confidence intervals and/or P values should be reported when the authors compare ischemic stroke patients to those with stroke mimics. The 2 figures repeat information in Tables 3 and 4. I think these figures offer no additional insight.

4.5 Discussion

This section is confusing at present. It lacks structure and seems to be only another review of the literature. The beginning of the Discussion seems to contain information that would have been more appropriate in the Introduction. The results are repeated, yet we see no discussion of their meaning. The authors have not interpreted their results in this section, nor discussed their potential application. There is no analysis of possible limitations, strengths, or biases. The authors should discuss similarities and differences between their findings and those reported in other similar publications.

My impression is that there is no novelty in this study-no new knowledge for the emergency medicine specialist. Nor are there conclusions useful for clinical practice.

4.6. Tables and figures

Overall, the presentation is careless. The table titles are very long, yet do not summarize the content well. So much data is grouped together that the tables are both unattractive and unclear. Furthermore, rather than complementing the text, they repeat information already listed there. The abbreviations used in Tables 2 and 3 should be explained in footnotes. Report the ages rounded to the nearest full years. (What sense does an age like 54.23 years make in this study?)

4.7 References

One aspect that stands out is that there are no references from within the past 3 years, even though there have been many recent publications on this topic. For example: Frindel C, Rouanet A, Giacalone M, Cho TH, Ostergaard L, Fiehler J, et al. Validity of shape as a predictive biomarker of final infarct volume in acute ischemic stroke. Stroke. 2015;46:976-81. Reference 2 on the list is not cited in the manuscript. Reference 6: year of publication is missing. Reference 11: name of the journal is incomplete. Reference 12 mentions only 1 author before et al. Up to 6 authors should appear.

4.8 Comments for the Editor (optional)

4.9 QUESTIONS ON COMPLETING THE REVIEW (Choose the answer that reflects your evaluation.)

In your opinion,

A. Overall, the writing and presentation of the manuscript is

1. Very poor (very carelessly done, difficult to understand and read)
2. Poor (careless, has clearly not been adequately revised)
3. Mixed (some parts or aspects are properly done, but others can be improved, or essential information has not been provided)
4. Good (carefully done, good presentation, comprehensible and readable)
5. Excellent (very carefully done, can be fully understood and is very readable)

B. The level of originality of the research question or hypothesis is

1. Very low (the topic has often been investigated before this)
2. Low (repeats earlier work, lacks novelty)
3. Average (though not very novel, there are some new aspects)
4. Acceptable (has original qualities)
5. Excellent (truly novel research idea)

C. The design and its execution were

1. Very poor (details or essential components, or there are fatal flaws)
2. Poor missing (missing important elements)
3. Average (defects are present but, can be improved on revision)
4. Good (correctly and clearly done in general)
5. Excellent (excellent detail, properly designed study, even contains innovative aspects)

D. The level of importance of the manuscript is

1. Very low (adds absolutely nothing to our knowledge or understanding of clinical practice)
2. Low (limited interest, adds little to our knowledge or understanding of practice)
3. Average (adds somewhat to our knowledge, although the contribution is modest)
4. Acceptable (adds information, findings that might prove important, plus reflections on the issues raised)
5. Excellent (important work that may change clinical practice and/or add substantially to our knowledge)

When uploading your review to the online management system, please do not forget to select one of the options summarizing your advice for the editors (accept, needs minor revision, needs major revision, or reject).

APPENDIX I

CHECKLIST OF KEY POINTS TO REVIEW (FROM THE STROBE AND CONSORT GUIDELINES)

When reviewing observational studies (STROBE), check the following aspects:

Title and Abstract

Is the study design identified in the title or abstract? Is the common term used? Does the abstract give an informative, balanced summary of what was done and found?

Introduction

Is the scientific background explained. And its rationale?

Are specific objectives stated? And are prespecified hypotheses, if any, made clear?

Methods

Is the study design declared?

Do the authors describe the setting, locations, relevant dates (including periods of recruitment, exposure, follow-up, and data collection)?

Are eligibility criteria explained? And the sources and methods for selecting of participants?

Check that all types of variables and sources of data are made clear for all the following categories: outcomes, exposures, predictors, potential confounders, and effect modifiers. If applicable, are diagnostic criteria given? For each variable of interest, do the authors give sources of data and details of methods of assessment (measurements).

Is there an explanation for the study size? Was ethics committee approval obtained and mentioned? Is the statistical analysis explained in detail?

Results

Regarding participants, do the authors clearly report the numbers of individuals at each stage of study? (For example, numbers potentially eligible, examined for eligibility, confirmed eligible, included in the study, completing follow-up.) Are the reasons for nonparticipation at each stage explained? Should a flow diagram be provided?

Regarding how results are presented, do the authors provide descriptive statistics, report data for all variables and give the main findings?

Discussion

Do the authors discuss the key results, interpret them (including their possible generalizability)? Is there a discussion of limitations? Are appropriate conclusions drawn?

References

Do the references comply with the style of EMERGENCIAS?

Tables and Figures

Are tables and figures presented according to the journal's instructions?

When reviewing clinical trials (CONSORT), check that the following information is present:

Title and Abstract

1. The method of patient assignment to interventions.

Introduction

2. The scientific background and rationale for the study.

3. Specific objectives or hypotheses.

Methods

4. Patient eligibility criteria, and the settings and locations where data were collected.

5. The interventions for each group with sufficient details to allow replication, including how and when they were actually administered.

6. Completely defined prespecified primary and secondary outcome measures, including how and when they were assessed. Do the authors explain any measures used to improve the quality of data collection, such as training of assessors?

7. How the sample size was determined.

8. Method used to generate the random allocation sequence.

9. Mechanism used to implement the random allocation sequence (such as sequentially numbered containers). Do the authors describe any steps taken to conceal the sequence until interventions were assigned?

10. An explanation of who generated the random allocation sequence, who enrolled participants, and who assigned participants to interventions.

11. Whether participants or assessors were blinded as to who received which intervention. If there was blinding, how was its success evaluated?

12. Statistical methods used to compare groups for primary and secondary outcomes as well as any additional analyses.

Results

13. Flow chart showing participants in each phase. For each group, the numbers of participants who were randomly assigned, received the intended treatment, and were analyzed for the primary outcome. For each group, losses and exclusions after randomization, together with reasons.

14. Dates defining the periods of recruitment and follow-up.

15. A table showing baseline demographic and clinical characteristics for each group.

16. For each group, number of participants (denominator) included in each analysis and whether or not the analysis was by original assigned groups (intention to treat analysis). Whenever possible, results should be presented with absolute numbers, not percentages alone.

17. For each primary and secondary outcome, results for each group, and the estimated effect size and its precision (such as 95% confidence interval).

18. Results of any other analyses performed, including subgroup analyses and adjusted analyses, distinguishing prespecified from exploratory.

19. All important harms or unintended effects in each group.

Discussion

20. Interpretation of results, in accordance with the study's hypothesis, addressing limitations and sources of potential bias, and, if relevant, any dangers arising from a multiplicity of analyses.

21. Generalizability (external validity) of the trial findings.

22. Interpretation consistent with results, considering other relevant evidence.