



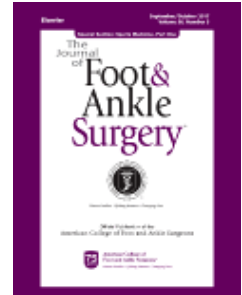
THE JOURNAL OF FOOT & ANKLE SURGERY

The Official Journal of the [American College of Foot and Ankle Surgeons](#)

AUTHOR INFORMATION PACK

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DESCRIPTION

The Journal of Foot & Ankle Surgery is the leading source for original, clinically-focused articles on the **surgical** and **medical** management of the **foot** and **ankle**. Each bi-monthly, peer-reviewed issue addresses relevant topics to the profession, such as: adult reconstruction of the forefoot; adult reconstruction of the hindfoot and ankle; diabetes; medicine/rheumatology; pediatrics; research; sports medicine; trauma; and tumors.

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Tips, Quips and Pearls—a brief and practical description of a useful clinical or surgical maneuver or procedure, accompanied by useful figure images.

Editorial or Commentary—an article expressing an opinion about a topic considered interesting to foot and ankle surgeons

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As a general rule, when describing activities that were part of the investigation, as well as the observed outcomes, use the past tense. Present tense is reserved for discussions of states of knowledge, which are considered ongoing (for example, "Open reduction and internal fixation is the treatment of choice for displaced, unstable fractures...").

Whenever uncertainty arises in regard to format, authors are encouraged to consult the following text: AMA Manual of Style: A Guide for Authors and Editors, 10th Edition.

Introduction

State the objectives of the work and provide an adequate background, avoiding a detailed literature survey or a summary of the results.

Material and methods

Provide sufficient detail to allow the work to be reproduced. Methods already published should be indicated by a reference: only relevant modifications should be described.

Patients and Methods versus Materials and Methods

If the study is a clinical investigation involving human participants, use the heading "Patients and Methods." If the study involves animals, cadavers, or *in vitro* or computer models of any sort, use the heading "Materials and Methods." In general, the Methods section should describe the following elements of the investigation: (1) Aims; (2) Study population; (3) Assessors and other members of the investigational team, population, or sample; (4) Intervention; (5) Endpoints (outcomes); (6) Statistical methods used to determine the meaning of the results

The Building Blocks of Good Clinical Evidence

(1) Explicitly defined research question, population, and endpoints; (2) Randomized treatment allocation and intention-to-treat analysis; (3) Participants and outcomes assessors blind to treatment allocation; (4) Use of a valid health measurement (quality of life) instrument; (5) Power and sample size determined *a priori*; (6) Statistical analyses compatible with type and distribution of the data; (7) Point estimate and 95% confidence interval reported (From Turlick MA, Kushner D, Stock D. J Am Podiatry Med Assoc 93:392-398, 2003.

Assessors

Describe members of the investigational team in regard to their participation in the study: (1) If they served as outcome assessors. (2) If they performed an intervention. (3) If they abstracted data from medical records, in the case of a retrospective study.

For studies in which subjective measurements are determined, such as measurements of radiographic angles, describe the method for breaking ties and determining an outcome when indecision or uncertainty exists.

If outcomes assessors were blind to treatment allocation, state this.

If outcomes assessors were participants in the intervention, such as members of the surgical team or treating clinicians, state this.

Study Population

The Methods section provides readers with an explicit description of the participant/patient population and the time period from which they were selected. The time period should delineate the month, day, year that the period started and the day, month, and year that the period ended (MM/DD/YYYY-MM/DD/YYYY). If the specific day is not known, it is acceptable to just use the month.

For Case Reports and Series and Cohort Studies, state whether or not the participants were enrolled consecutively, and clearly indicate inclusion and exclusion criteria.

Refer to subjects as "participants" if the diagnostic test or intervention is experimental and not yet approved for use by the US FDA. Refer to participants as "patients" for all other tests or interventions that are already known to be therapeutic, safe, and efficacious.

Intervention

Explicitly describe the intervention in any investigation.

If participants were randomized to an active therapy that was compared to standard therapy or to a placebo, you must describe each treatment arm.

Avoid presenting a detailed narrative report of an operative intervention for a standard procedure. Instead, cite a reference for that standard procedure. Describe variations on the procedure.

Thoroughly describe all novel interventions, notable variations on standard procedures, decision points related to an intervention, and adjunct procedures.

Use generic drug names where possible. When a brand name is used, include the name, city, state, country of the manufacturer in parentheses immediately after the proprietary name. Whenever medication use is described, provide complete dosing information: dose, method of administration, frequency of use, duration of use.

Endpoints (Outcomes)

Explicitly define outcome measures in terms of (1) how the variable was measured, (2) who made the measurement, and (3) whether or not the assessor was blind to the interventional (for an interventional trial).

Clearly state if outcomes were based on physical examination, chart review, telephone interview, questionnaire, radiographic films, or some other method.

Consider for analysis any variable that you consider to be important in regard to the treatment of patients, as it pertains to the investigation

"Hard" endpoints such as analytical measurements, clinical and microbiology laboratory results, and other specific measurements are preferred to "soft" endpoints. If "soft" endpoints such as quality of life (QOL) or foot-related QOL are used, it is preferred that health measurement instruments that have been previously shown to be reliable and provide valid information be used.

A health measurement instrument is not in and of itself valid, although the information gained from the use of the health measurement instrument should be used. QOL instruments should be specific to the foot and ankle (e.g., ACFAS, AOFAS, Bristol Foot Score, Foot Function Index).

Describe an investigator-derived questionnaire in terms of reliability and validity if such testing was undertaken by the investigators or if the questionnaire has been described in a previous publication.

For scales that rank categories (e.g., mild, moderate, severe), use an aggregate score. For measurements of pain, the 10-cm visual analog scale (VAS) is recommended.

Statistical Methods

Clearly describe the statistical plan. Include, at minimum, descriptive and inferential statistical analyses. Ideally, also include univariate and multiple variable statistical analyses.

In the descriptive statistical analysis, define parameters such as the measure of central tendency (mean or median average) and measures of dispersion (standard deviation or range).

Select the parameter, as well as the statistical test, based on the type and distribution of data.

Continuous numeric data that are normally distributed are suitable for representation using the mean and standard deviation and may be analyzed using mean-based statistical tests such as Student's *t* test.

Categorical data and data that are non-normally distributed are suitable for representation using the median and range and may be analyzed using median-based (nonparametric) methods such as the Wilcoxon matched-pairs signed-ranks test, sign test, Wilcoxon rank-sum test, and the Kruskal-Wallis equality-of-populations rank test and other null hypothesis tests and methods of estimation.

Use univariate analyses to describe the association of independent variables with the outcome of interest (dependent variable). Use multiple variable analyses to describe the association of all of the clinically important variables with the outcome of interest.

Present results with only as much precision as is of scientific value. For example, report measures of association (e.g., odds ratios, relative risks, risk differences) to 2 significant digits. Reserve the terms *significant* and *significantly* for when describing statistical differences. Do not make the statement "no significant difference was found" between 2 or more groups unless a power analysis was done and the value of alpha (level of significance typically 5% or p value $< .05$) or beta (the power to detect a statistically significant difference, usually 80% or 90%) is reported. Denote the probability of the null hypothesis using a lowercase italic p separated from the word "value" by a hyphen (specifically p value).

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The results of a sensitivity analysis, such as that described by Greenland (Maldonado G, Greenland S: Simulation study of confounder-selection strategies. *Amer J Epidemiol.* 1993; 138: 923-936.), or that described by Rosenbaum (Rosenbaum PR. Sensitivity analysis for matched case-control studies. *Biometrics.* 1991 Mar; 47(1): 87-100; and, Rosenbaum PR. Discussing hidden bias in observational studies. *Ann Intern Med.* 1991 Dec 1; 115(11): 901-5.), should be presented for retrospective studies where unmeasured independent variables may have potentially influenced the results.

Additional references that may be useful in regard to the description of the methods and the presentation of a statistical plan include:

Bailar JC III, Mosteller F. Guidelines for statistical reporting in articles for medical journals: amplifications and explanations. *Ann Intern Med* 1988; 108: 266-73.

Altman DG, Machin D, Bryant TN, Gardner MJ (eds). *Statistics with Confidence.* 2nd edition. London: BMJ Books, 2000, pp. 104-6.

Malay DS. Some thoughts about data type, distribution, and statistical significance. *J Foot Ankle Surg* 45: 57-9, 2006.

Malay DS. Levels of clinical evidence. *J Foot Ankle Surg* 46: 63-4, 2007.

Results: The results section should provide quantitative information about the data collected, in the form of descriptive and inferential statistics.

- Relevant information on the study population includes demographic information for each subgroup (control group and study groups), exclusions and attrition. Inferential statistics should be used to compare groups using appropriate statistical tests based on the size of the study population, type of variables under study (discrete vs. categorical), and the distribution of the data collected.

- Quantitative information should be summarized in the text, and readers should be referred to relevant tables for more detailed information. As a rule, a minimum of three results tables should be presented, and designated Tables 1, 2, and 3. Table 1 typically depicts the baseline demographic characteristics of the sample population, often categorizing the patients/participants by intervention or outcome, and showing whether or not statistically significant differences existed between the groups. For randomized controlled trials, it is not necessary to depict statistically significant differences at baseline, since randomization distributes the characteristics by chance. Table 2 generally depicts the results of the univariate analyses, and Table 3 generally depicts the results of the multiple variable analyses.

- For randomized controlled trials, the first figure should be the study flow chart.

- For meta-analyses and systematic reviews, a Christmas tree diagram should be included.

- Consistency and clarity is required when reporting results. As a rule, report means with standard deviations (using the \pm symbol) and medians with the range (either minimum and maximum or 25th and 75th percentiles), and always report the proportion of the whole when presenting count data (for instance, "...4 (3.25%) displayed wound dehiscence..."), and report calculations to 2 decimal places.

- It is also crucial that authors remain clear and consistent when they report denominators, with a particular emphasis on clarity in regard to the number of patients versus the number of feet or ankles or extremities, since these numbers vary based on unilateral versus bilateral cases.

Discussion: The discussion section offers the authors' interpretation of the results of their investigation. Authors should consider how their results fit into the general state of knowledge on the subject, as well as their clinical relevance. In addition, authors should acknowledge the limitations of their investigation that may have introduced bias, and they should discuss how the results could have been affected by bias.

Finally, suggestions for clinical applications and/or further research may be appropriate. Do not include a separate "Conclusion" subsection, as the final paragraph of the discussion should describe the authors' conclusions (and the paragraph can start with a sentence that states: "In conclusion, we found..." or something to this effect).

Acknowledgment: Acknowledgments should be made to those who have informally contributed their expertise or assisted in the investigation, rather than to those who have contributed to the manuscript while performing the role of their regular occupation.

References: References are cited in the body of the text by means of numeric citations listed parenthetically in the appropriate sentence, prior to the end of the sentence (usually just before the period ending the sentence). Reference citations are to appear in sequential numeric order, beginning with the number "1" and continuing in order the first time that a particular reference is cited, until the last citation is noted. In other words, supply references numbered in the exact order they appear in the text (not alphabetically).

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Examples of reference citations include:

Journal Article

1. Mendicino RW, Orsini RC, Whitman SE, Cantanzariti AR. Fibular groove deepening for recurrent peroneal subluxation. *J Foot Ankle Surg* 40:252-263, 2001.

Textbook

2. Trevino SG. Disorders of the hallux sesamoids. In *Foot and Ankle Disorders*, pp 379-398, edited by MS Myerson, WB Saunders, Philadelphia, 2000.

Electronic Version of Print Journal

3. Gardner MJ, Boraiah S, Hentel KD, Helfet DL, Lorich DG. The hyperplantarflexion ankle fracture variant. *J Foot Ankle Surg* [serial on the Internet] 46:256-60, 2007. Available at: <http://www.jfas.org/issues/contents>.

Web Page

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