TABLE OF CONTENTS

- Description p.1
- Impact Factor p.1
- Editorial Board p.1
- Guide for Authors p.4

DESCRIPTION

The *Journal of Minimally Invasive Gynecology*, formerly titled *The Journal of the American Association of Gynecologic Laparoscopists*, is an international clinical forum for the exchange and dissemination of ideas, findings and techniques relevant to **gynecologic endoscopy** and other **minimally invasive** procedures. The Journal, which presents research, clinical opinions and case reports from the brightest minds in **gynecologic surgery**, is an authoritative source informing practicing physicians of the latest, cutting-edge developments occurring in this emerging field.

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GUIDE FOR AUTHORS

INTRODUCTION
The Journal of Minimally Invasive Gynecology is a bimonthly periodical devoted to the health care of women.

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For any questions, you may contact the Journal office by telephone or email at the following:

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Types of Articles
The Journal of Minimally Invasive Gynecology, formerly titled The Journal of the American Association of Gynecologic Laparoscopists, is an international clinical forum for the exchange and dissemination of ideas, findings, and techniques relevant to gynecologic endoscopy and other minimally invasive procedures. The Journal of Minimally Invasive Gynecology, which presents research, clinical opinions and case reports from the brightest minds in gynecologic surgery, is an authoritative source informing practicing physicians of the latest, cutting-edge developments occurring in this emerging field.

The Journal of Minimally Invasive Gynecology publishes original articles on research as well as images in gynecologic surgery, case reports, instruments and techniques (no longer available for submission after January 4, 2021), review articles, and letters to the editors.

Written Manuscripts (Traditional Method): Written manuscripts require the author(s) to submit a structured abstract, along with a full written manuscript. The article may contain images, graphs, statistics and even video to support or demonstrate the findings of the article.

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BEFORE YOU BEGIN

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**Introduction of all articles should not exceed 250 words; the discussion should not exceed 750 words.**

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Scientific (generic) names of drugs should be used at all times. Weights and measures must be expressed in metric values and temperatures in Celsius (centigrade). Prior presentation as an abstract or at a professional meeting should be described fully on the title page.

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American English or British English spelling should be used throughout the manuscript (including the illustrations, tables, and supplemental material), but a mixture of the two is not allowed.

**Acknowledgments**

It is acceptable to acknowledge others in acknowledgments. Please limit acknowledgments to those who are directly and scientifically involved in the preparation of the manuscript.

**Manuscript Preparation, Specific**

**Original Articles:** The Original Articles section of JMIG is reserved for manuscripts that represent original research. Abstracts for these manuscripts have a 300 word limit and must appear in structured format, as follows: Study Objective, Design, Setting, Patients, Interventions, Measurements and Main Results, and Conclusion. All abstract sections must be complete.

**Original Articles Checklist** (Word limit 4,000; Reference limit 30).

Manuscripts that do not contain original research are placed in the section of JMIG that is most appropriate; for example, Review Articles, Case Reports, Images in Gynecology, Letters to the Editor, and Video Articles. Special Articles, Perspectives, and Editorials are also considered by invitation only.

**Review articles:** a comprehensive review and evaluation of current evidence and previously published literature regarding condition, diagnosis, and/or technique considering the progress toward resolution of a problem in minimally invasive gynecology. Because non-systematic reviews often include an element of selection bias, a Systematic Review, as opposed to traditional narrative review, is required.

Systematic Review articles must follow the structured abstracts (outlined below) and MUST follow PRISMA Guidelines (http://prisma-statement.org/). All Review articles must include a completed PRISMA Flow Diagram and Checklist with their submission items. When feasible, a meta-analysis is highly preferred. Please see Review Article Checklist (Word limit 3,000; Reference limit 60).

Review Abstract format: Objective: Statement of purpose of the review. Data Sources: Sources searched, including dates, terms, and constraints. Methods of Study Selection: Number of studies reviewed and selection criteria. Tabulation, Integration, and Results: Guidelines for extracting data, methods of correlating, and results of review. Conclusion: Primary conclusions and their clinical applications. Registration of Systematic Reviews

PROSPERO aims to provide a comprehensive listing of systematic reviews registered at inception to help avoid duplication and reduce opportunity for reporting bias by enabling comparison of the completed review with what was planned in the protocol. We recommend registration...
with PROSPERO for all systematic reviews to improve the transparency and rigor of secondary research but at present it is not a requirement. Information on registering can be found at https://www.crd.york.ac.uk/prospero/#aboutregpage.

- Item 12 of the checklist states: Risk of bias in individual studies - (Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis. An example of study assessment tool can be found here: https://www.nhlbi.nih.gov/health-topics/study-quality-assessment-tools.

**Case reports:** a brief description up to 3 cases of a particular condition that reports an unusual presentation or novel diagnostic or therapeutic approach. Case Reports require an unstructured abstract in paragraph form. Only exceptional case reports are considered by the Journal and both novelty and educational value are important for this type of submission. Please see Case Report Checklist (Word limit 2,000; Reference limit 10; Author limit 6).

**Images in gynecologic surgery:** Up to 3 images that are novel, of high quality, and pertinent to minimally invasive gynecology. Images in gynecology do not include an abstract. See the Images in Gynecologic Surgery Checklist (Word limit 300; Reference limit 10; Figure Limit 3). (Word limit 300; Reference limit 10; Figure Limit 3)

**Letters to the Editor:** comments and opinions regarding recently published articles in JMIG. (Word limit 300; Reference limit 4; Author limit: 6).

**Special articles:** by invitation only.

**Perspectives:** a short article of current interest of the minimally invasive community; by invitation only. Perspectives do not include an abstract. (Word limit 2,000; Reference limit 5)

**Editorials:** a commentary or a topic assigned by the Editor in Chief; by invitation only. (Word limit 750; Reference limit 5; Author limit 4).

**Video Articles:**
The Journal of Minimally Invasive Gynecology now accepts Video Articles. What exactly is a Video Article? A Video Article contains all elements outlined in a structured abstract and full written manuscript but is presented in video form. Using video, authors now can present scientific findings through visual media without having to write a paper. Instead the video provides the viewer with all the elements supporting the findings of the data, but in a visual way. See the Video Articles Checklist.

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All the rules and guidelines governing how and what can be included in written manuscripts apply to Videos Articles. Work must be original and not published elsewhere, and all portions of the video clips must be the property of the author(s). A structured abstract is required. Section headings should include Objective, Design, Setting, interventions, and Conclusion. Narration is mandatory and must be in English. Video may not contain music. Videos should be approximately 6 to 8 minutes long. Please ensure videos are uploaded in a single file. Videos may include slides, such as a title slide and slide(s) containing all or some elements provided in the structured abstract. All the slides should be no more than 1 minute in viewing length. The video should be focused on surgical technique. Occasionally, a very important educational video may be selected for publication, if considered to be of high importance for scientific proposes. Videos that have been previously posted online, including on social media sites or YouTube, will not be considered.
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If your video is not in one of these formats, please contact our office and we may be able to assist you with converting the video.

Below is an example of an accepted Structured Abstract.

**Video Article Abstract Sample.**

**When Writing Your Research Paper**
Please keep in mind the following when writing your clinical manuscript. Each submission is peer reviewed and the reviewers are looking for the following to ensure that your research is of the highest value.

*Title/Abstract* Why was the study performed? How is this study different from others? Can the study be replicated? Will the study results and publication improve patient care? If not, the paper is not relevant. Is it novel and suitable to fill the gap of existing publications? The abstract must be able to stand alone and be understood without reading the manuscript. The objective must be clear.

*Introduction must include* The rationale, or motivation for the current investigation; what is the problem that the authors are trying to answer? Is it the next logical step in a line of an investigation or have prior studies been deficient in some way that the current study addresses? Coherent and comprehensive background information as to why the study was performed, including gaps in current knowledge. Previous relevant publications. Study hypothesis.

*The methodology must include* Inclusion and exclusion criteria. One single primary endpoint (outcome measure). Secondary endpoints (when appropriate). Tests, procedures, interventions, analyses. Institutional review board approval statement. Could another investigator replicate the study?

*Results* Logical and systemic presentation of data mirroring the same sequence as in the methods. If one author does not have a statistical background, a statistician should have been consulted. Values of measured variables to be shown with error limits (standard deviations). Tables and figures presented here. *Conclusion* Summary of main findings balanced to the stated hypothesis and objectives. How does this article change what the reader recommends to patients? Comparison to other previous publications on the topic. Discussion of alternative explanations for the observations. Clinical relevance. Limitations of the study; explanation of unexpected findings. Rational defensible conclusion or take-home message. Is the conclusion justified by the results?

*Electrosurgery Terminology*  
**JMIG** has specific electrosurgery terminology:  
ELECTROSURGERY TERMINOLOGY.JPG Electrosurgery Terminology

*Statistics*  
The statistical section must only include the tests needed for the particular study data. It must be written based on the appropriate design or data collection methods as appropriate. Multiple comparison tests must be used when needed and the type I error level should be listed. In particular:

**For all studies:** The statistical section of all manuscripts should contain a brief description of sample size and power considerations for the study, as well as a brief description of the methods for primary and secondary analyses. Evidence must show that the data are independent or correlated with the appropriate test. A clear distinction between correlated observations and independent...
observations. Significance tests should be accompanied by confidence intervals for estimated effect sizes, measures of association, or other parameters of interest. The confidence intervals should be adjusted to match any adjustment made to significance levels in the corresponding test. When comparing outcomes in two or more groups, investigators should use the testing procedures specified in the statistical analysis section to control overall type I error? Post hoc analyses should be clearly labeled as post hoc in the manuscript. If subgroups are small, however, formal inferences about the homogeneity of treatment effects may not be feasible. A list of P values for treatment by subgroup interactions is subject to the problems of multiplicity and has limited value for inference.

**For clinical trials:** All protocols and the statistical models should be submitted along with the manuscript, and details of changes made during the process. Analyses of the data should conform to the protocol. The statistical models must be in agreement with the data collection. The editors may ask for additional analyses that are not specified in the protocol. When comparing outcomes in two or more groups, investigators should use appropriate multiple comparison tests as specified in the protocol with control overall type I error. Hierarchical data structures should address the intraclass correlation at each stage. The p values adjusted for multiple comparisons should be reported when appropriate and labeled as such in the manuscript. If the study team believes a post hoc analysis of subgroups is important, the rationale for conducting that analysis should be stated. Post hoc analyses should be clearly labeled as post hoc in the manuscript. Plots can be a useful display of estimated treatment effects across subgroups, and the journal recommends that they be included for important subgroups. If subgroups are small, however, formal inferences about the homogeneity of treatment effects may not be feasible. Therefore, in most cases, no p values for interaction should be provided in the plots or in cases of small sample sizes. The same can be said of large sample sizes although it is less observable in clinical trials. Editors request that p values be reported for comparisons of the frequency of adverse events among treatment groups, regardless of whether such comparisons were known in advanced. When possible, the editors prefer that absolute event counts or rates be reported before relative risks or hazard ratios. The goal is to provide the reader with both the actual event frequency and the relative frequency. Odds ratios should not be listed without the sample sizes and how the data were obtained, Odds ratios may overestimate the relative risks in certain cases and be misinterpreted. The editors also encourage authors to submit all the relevant information included in the study. Although, all of this information may not be published with the manuscript, it should be provided in a supplementary appendix at the time of submission. The Journal requires authors to deposit data for clinical trials in one of the online repositories designed for this purpose. All clinical trials must be prospectively registered prior to the first patient being enrolled at the website ClinicalTrials.gov or a similar website.

**For observational studies:**

The validity of findings from observational studies depends on several important assumptions, including those relating to sample selection, measured and unmeasured confounding, and the adequacy of methods used to control for confounding, independent observations versus correlated observations. The statistical section of observational studies should describe fully how these and other relevant issues were managed in the design and statistical analysis.

The *Journal* encourages authors to deposit the statistical analyses as conducted for observational studies in one of the online repositories designed for this purpose. When appropriate, observational studies should use prespecified accepted methods for controlling family-wise error rate or false discovery rate when multiple tests are conducted. In manuscripts reporting observational studies without a prespecified method for error control, summary statistics should be limited to point estimates and 95% confidence intervals. No P values should be reported for these analyses. If no prespecified analysis plan exists, the Methods section should provide an outline for the planned method of analysis, including eligibility criteria for the selection of cases and method of sampling from the data, with a diagram as appropriate. A description of the association or causal effect to be estimated and the rationale for this choice. The prespecified method of analysis to draw inference about treatment or exposure effect or association. Studies reporting the effect of a treatment or exposure should show the distribution of potential confounders and other variables, stratified by exposure or intervention group. When the analysis depends on the confounders being balanced by exposure group, differences between groups should be summarized with point estimates and 95% confidence intervals when appropriate. Complex models and their diagnostics can often be best
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