



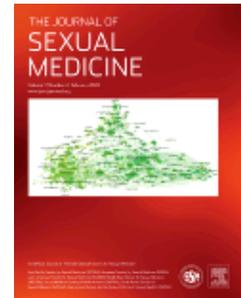
# THE JOURNAL OF SEXUAL MEDICINE

Official Journal of the [International Society for Sexual Medicine](#)

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### DESCRIPTION

*The Journal of Sexual Medicine* publishes multidisciplinary basic science and clinical research to define and understand the scientific basis of male, female, and couples sexual function and dysfunction. As an official journal of the [International Society for Sexual Medicine](#) and the [International Society for the Study of Women's Sexual Health](#), it provides healthcare professionals in sexual medicine with essential educational content and promotes the exchange of scientific information generated from experimental and clinical research.

*The Journal of Sexual Medicine* includes basic science and clinical research studies in the psychologic and biologic aspects of male, female, and couples sexual function and dysfunction, and highlights new observations and research, results with innovative treatments and all other topics relevant to clinical sexual medicine.

The objective of *The Journal of Sexual Medicine* is to serve as an interdisciplinary forum to integrate the exchange among disciplines concerned with the whole field of human sexuality. The journal accomplishes this objective by publishing original articles, as well as other scientific and educational documents that support the mission of the International Society for Sexual Medicine.

#### **International Society for Sexual Medicine Mission**

Specifically, the ISSM aims: To establish a scientific Society to benefit the public by encouraging the highest standards of practice, education and research in the field of human sexuality; To develop and assist in developing scientific methods for the diagnosis, prevention and treatment of conditions affecting human sexual function; To promote the publication and encourage contributions to the medical and scientific literature in the field of sexual function.

### IMPACT FACTOR

2018: 3.649 © Clarivate Analytics Journal Citation Reports 2019

## ABSTRACTING AND INDEXING

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Chemical Abstracts  
Current Contents - Clinical Medicine  
Embase  
Journal Citation Reports  
Science Citation Index Expanded  
PubMed/Medline  
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PsycINFO  
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## GUIDE FOR AUTHORS

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### **Aims and Scope**

*The Journal of Sexual Medicine* publishes multidisciplinary basic science and clinical research to define and understand the scientific basis of male, female, transgender, and couple's sexual function and dysfunction. As an official journal of the International Society for Sexual Medicine (ISSM) and the International Society for the Study of Women's Sexual Health, it provides healthcare professionals in sexual medicine with essential educational content and promotes the exchange of scientific information generated from experimental and clinical research.

The objective of *The Journal of Sexual Medicine* is to serve as an interdisciplinary forum to integrate the exchange among disciplines concerned with the whole field of human sexuality. *The Journal* accomplishes this objective by publishing original articles, as well as other scientific and educational documents that support the missions of the ISSM.

### **Manuscript Types**

*The Journal of Sexual Medicine* publishes several types of manuscripts. A brief description of each type follows:

*Peer reviewed article types:*

#### **Original Research**

Original research papers are scientific reports from original research in sexual medicine. There is no limit on article length or the number of figures or tables, though we do request the article include a structured abstract of 400 words. It required that you include completed reporting guideline(s) with your Original Research submission to demonstrate the completeness of reporting in your manuscript. Failure to adhere to reporting best practices will result in revisions being requested ahead of publication. For more information on relevant reporting guidelines, please see the section below entitled [Reporting Standards: Completeness and the Use of Reporting Guidelines](#).

#### **Review Article**

Review articles are timely, in-depth treatment of an issue. There is no limit on article length or the number of figures or tables, though we do request the article include an abstract of no more than 400 words. Though narrative reviews are welcomed, meta-analyses and systemic reviews are preferred complete with thorough adherence to the [PRISMA](#) reporting guidelines.

#### **ISSM Methods Update**

Methods updates present current best practice for research in an area of sexual medicine. They are typically commissioned by the Editors, but please contact the Chief Editor if you would like to suggest a topic. There is no limit on article length or the number of figures or tables, though we do request the article include an abstract of no more than 400 words.

#### **Surgeons' Corner**

Papers published in Surgeons' Corner will include those commissioned for the section, and those submitted as original research papers that focus on the technical aspects of a broad range of surgical procedures in male, female, and transgender sexual medicine. Manuscripts should adhere to the following structure: Abstract, Introduction/Background (including the rationale for a novel technique), Indications for procedure, Pre-operative preparation, Intra-operative considerations, Post-operative management and follow-up, Outcomes (including a brief review of the literature), Complications, Take-home message, References. The completed manuscript should not exceed 2500 words, excluding figures, tables, references, and the abstract.

#### **Brief Communication**

Brief Communications should be no more than 1,000 words, and include a structured abstract, 1 figure, and up to 10 references.

#### **Case Reports**

*The Journal of Sexual Medicine* no longer publishes Case Reports. Instead, please visit *Sexual Medicine*.

*Magazine article types:*

#### **Expert Opinion**

Opinions present potentially controversial viewpoints, with aim of encouraging debate. These are science-based, opinion pieces that may either be commissioned or directly submitted to the journal and are subjected to peer review. **Perspective**

Perspectives provide commentary and analysis of an article published in *The Journal Of Sexual Medicine*. Perspectives are directly solicited by our staff. They are limited to 500 words, with up to 5 references. **Letter to the Editor**

Unsolicited Comments on particular JSM articles (critical or laudatory) will be considered by the Editors and may be published after consultation or peer review. The authors of the original article will be given the option of providing a Response.

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Please see our information pages on [Ethics in publishing](#) and [Ethical guidelines for journal publication](#).

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Should possible scientific misconduct or dishonesty in research submitted for review be suspected or alleged, *The Journal of Sexual Medicine* reserves the right to forward any submitted manuscript to the sponsoring or funding institution or to other appropriate authorities for investigation.

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#### *Declaring Conflicts of Interest*

#### **Disclosure Statement**

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#### **Submitting declaration and verification**

Submission of an article implies that the work described has not been published previously (except in the form of an abstract, a published lecture or academic thesis, see '[Multiple, redundant or concurrent publication](#)' for more information), that it is not under consideration for publication elsewhere, that its publication is approved by all authors and tacitly or explicitly by the responsible authorities where the work was carried out, and that, if accepted, it will not be published elsewhere in the same form, in English or in any other language, including electronically without the written consent of the copyright-holder. To verify originality and to look for the presence of text copied from other articles, your article may be checked by the originality detection service [Crossref Similarity Check](#).

#### **Use of inclusive language**

Inclusive language acknowledges diversity, conveys respect to all people, is sensitive to differences, and promotes equal opportunities. Articles should make no assumptions about the beliefs or commitments of any reader, should contain nothing which might imply that one individual is superior to another on the grounds of race, sex, culture or any other characteristic, and should use inclusive language throughout. Authors should ensure that writing is free from bias, for instance by using 'he or she', 'his/her' instead of 'he' or 'his', and by making use of job titles that are free of stereotyping (e.g. 'chairperson' instead of 'chairman' and 'flight attendant' instead of 'stewardess').

#### **Contributors**

The submitting author is required to declare the contributions of each author to the article at the submission phase; this declaration should follow the [CRediT taxonomy](#). This Statement of Authorship will be added to the manuscript.

All persons designated as authors should qualify for authorship according to the [ICMJE criteria](#). Participation solely in the acquisition of funding or the collection of data does not justify authorship. General supervision of the research group is not sufficient for authorship. Any part of an article critical to its main conclusions must be the responsibility of at least one author.

Increasingly, multicenter trials are attributed to a corporate author. All members of the group who are named as authors, either in the authorship position below the title or in a footnote, should fully meet the above criteria for authorship. Group members who do not meet these criteria should be listed, with their permission, in the Acknowledgments or in an appendix. The order of authorship should be a joint decision of the coauthors. Because the order is assigned in different ways, its meaning cannot be inferred accurately unless it is stated by the authors. Authors may wish to explain the order of authorship in a footnote. In deciding on the order, authors should be aware that many journals limit the number of authors listed in the table of contents and that the U.S. National Library of Medicine (NLM) lists in MEDLINE only the first 24 plus the last author when there are more than 25 authors.

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Only in exceptional circumstances will the Editor consider the addition, deletion or rearrangement of authors **after** the manuscript has been accepted. While the Editor considers the request, publication of the manuscript will be suspended. If the manuscript has already been published in an online issue, any requests approved by the Editor will result in a corrigendum.

## Reporting Checklists

### Reporting Standards: Completeness and the Use of Reporting Guidelines

In an attempt to improve the quality of research reports in the journal, *The Journal of Sexual Medicine* now recommends a completed reporting guideline checklist is included with an article submission. The purpose of various reporting guidelines is to provide a guide—in the form of a checklist—to authors and editors alike on essential elements that should be included in a paper to ensure all stakeholders can properly validate results and replicate studies. We expect authors to not only use the reporting guidelines to improve the quality of reporting in their submission, but also use the associated guideline checklist to demonstrate the paper does include essential reporting criteria. Ultimately, this task is about improving a manuscript, not filling out a checklist for administrative purposes.

For Reviews and Original Research articles, authors are required to complete one of the reporting checklists listed below. This ensures a higher standard of reporting and will enhance the prospects of a manuscript being accepted for publication. Authors should upload a completed copy of the reporting checklist(s) with their submission.

#### 1 STUDY TYPE STUDY TYPE CATEGORY CHECKLIST FOR REPORTING STANDARDS

**CHECKLIST NAME** Any — JSM general manuscript standards JSM Checklist  
Randomized controlled pharmacotherapy trials RCT (Pharmacotherapy) CONSORT-Consolidated Standards of Reporting Trials [CONSORT Statement](#)  
Other pharmacotherapy and herbal medicinal trials (noninferiority trials, pragmatic trials, cluster trials, reporting of harms) RCT (Other) CONSORT extensions (tailored versions of the main CONSORT Statement produced by [CONSORT Checklist](#))  
Observational epidemiology studies Observational Epidemiological Studies STROBE-Strengthening the reporting of observational studies in epidemiology [STROBE Checklist](#)  
Qualitative Research Qualitative Research COREQ-Consolidated criteria for reporting qualitative research [COREQ Checklist](#)  
Diagnostic Accuracy Studies Diagnostic Accuracy Studies STARD-Standards for reporting diagnostic accuracy [STARD Checklist](#)  
Systematic reviews Systematic Reviews PRISMA (formerly known as QUOROM)-Improving the quality of reports of meta-analyses of randomized controlled trials [PRISMA Checklist](#)  
Meta-analyses of controlled trials Meta-analysis of Controlled Trials PRISMA (formerly known as QUOROM)-Improving the quality of reports of meta-analyses of randomized controlled trials [PRISMA Checklist](#)  
Meta-analyses of observational studies Meta-Analyses of Observational Studies MOOSE-Meta-analysis of observational studies in epidemiology [MOOSE Checklist](#)  
Quality improvement reports Quality Improvement Reports SQUIRE-Standards for quality improvement reporting excellence [SQUIRE Checklist](#)  
Erectile Function Recovery analysis following radical pelvic surgery All relevant studies ERF-Erectile Function Recovery Checklist [ERF Checklist](#)

#### 1 STUDY TYPE STUDY TYPE CATEGORY CHECKLIST FOR REPORTING STANDARDS

**CHECKLIST NAME** Systematic Reviews Systematic reviews (Pre-registered systematic reviews will be given priority for publication) PROSPERO (an international database of prospectively registered systematic reviews in health and social care [PROSPERO Animal Studies](#) [PROSPERO Human Studies](#))  
Pre-Clinical Studies Animal Studies Animal Research: Reporting In Vivo Experiments [ARRIVE](#)  
Studies Involving PCR or RT-PCR Data Studies involving PCR or RT-PCR data JSM Guidelines + MIQE Checklist [JSM PCR Guidelines and MIQE Checklist](#)

*The Journal of Sexual Medicine* expects that all prospective, randomized, controlled trials with patient enrollment starting on or after August 1, 2007, be registered in a public database that meets the requirements of the World Health Organization. Currently, such registries include the following: <http://www.actr.org.au>, <http://www.clinicaltrials.gov>, <http://www.ISRCTN.org>, <http://www.umin.ac.jp/ctr/index/htm>, and <http://www.trialregister.nl>.

For more information, please refer to the guidelines at [http://www.icmje.org/#clin\\_trials](http://www.icmje.org/#clin_trials). Upon submission, please provide the registration identification number and the URL for the trial's registry in your cover letter.

### **Cell Line Authentication**

To ensure the highest standards of quality and accuracy, *The Journal of Sexual Medicine* strongly encourages the authentication of cell lines used in the research submitted. Manuscripts based on research using cell lines must include a statement addressing the following points in the Methods section of the manuscript:

Where the cells were obtained from Whether the cell lines have been tested and authenticated The method by which the cells were tested

If cells were obtained directly from a cell bank that performs cell line characterizations and passaged in the user's laboratory for fewer than 6 months after receipt or resuscitation, re-authorization is not required. In these cases, please include the method of characterization used by the cell bank. If the cell lines were obtained from an alternate source, authors must provide authentication of the origin and identity of the cells. This is best achieved by DNA (STR) profiling. The DNA profile should be cross-checked with the DNA profile of the donor tissue (in case of a new cell line) or with the DNA profile of other continuous cell lines.

### **Gene names and genetic profiling data**

Please mark all gene names in italics. However, only the gene names should be written in italics, to distinguish them from gene products, gene segments, clusters, families, complexes, or groups. Authors should only use the official gene name as assigned by the respective gene nomenclature committee. Regarding comprehensive data sets of genetic profiling (microarray) studies, raw data must be in a publicly available database that requires MIAME format (for example, "GEO" or "Array Express") upon submission of a paper. Nucleotide sequence data can be submitted in electronic form to any of the three major collaborative databases: DDBJ, EMBL or GenBank. It is only necessary to submit to one database as data are exchanged between DDBJ, EMBL and GenBank on a daily basis. The suggested wording for referring to accession-number information is: 'These sequence data have been submitted to the DDBJ/EMBL/GenBank databases under accession number U12345.'

### **Drugs and Devices**

Use of generic drug names (or generic name followed by trade name in parentheses) may be used. Include manufacturer and their location (city and country) for drugs and devices.

### **Statistical Guidelines**

All submitted manuscripts containing data analyses will be evaluated for the integrity of the statistical methods as well as a sufficient description of the methodological approach. This will entail evaluation of the study design, statistical analysis and presentation, and interpretation of study results. As a general guideline, readers of the manuscript should be able to replicate the analysis with the same data based on the description given in the Methods section. Authors are encouraged to carefully select language in the Discussion that is appropriate given the study design and refrain from causal inferences from observational (nonrandomized) studies.

Authors should also be explicit about the limitations of the study. Failure to disclose important limitations upon submission may be grounds for rejecting the manuscript.

The editors of the *Journal of Sexual Medicine* recommend the shared set of "Guidelines for Reporting of Statistics for Clinical Research in Urology" by Assel et al<sup>1</sup>, and adopted by four leading urology journals (*European Urology*, *The Journal of Urology*, *Urology*, and *British Journal of Urology International*). While this guideline is not indented in any way to be prescriptive, it can serve as a didactic roadmap for researchers who seek to improve the quality of their reporting of statistics in urological manuscripts before submitting them for peer-review and publication.

The following are the key considerations when reporting statistics, adapted for JSM from the "Guidelines for Reporting of Statistics for Clinical Research in Urology" by Assel et al<sup>1</sup>:

## **1. The Golden Rule**

1.1 Break any of the guidelines if it makes scientific sense to do so.

## **2. Reporting Of Design And Statistical Analysis**

2.1 Follow existing reporting guidelines for the type of study you are reporting, such as CONSORT for randomized trials, ReMARK for marker studies, TRIPOD for prediction models, STROBE for observational studies, or AMSTAR for systematic reviews.

2.2 Describe cohort selection fully.

2.3 Describe the practical steps of randomization in randomized trials.

2.4 The statistical methods should describe the study questions and the statistical approaches used to address each question.

2.5 The statistical methods should be described in sufficient detail to allow replication by an independent statistician given the same data set.

## **3. Inference and P values**

3.1 Do not accept the null hypothesis.

3.2 *P* values just above 5% are not a trend, and they are not moving.

3.3 The *P* values and 95% confidence intervals do not quantify the probability of a hypothesis.

3.4 Do not use confidence intervals to test hypotheses.

3.5 Take care to interpret results when reporting multiple *P* values.

3.6 Do not report separate *P* values for each of two different groups in order to address the question of whether there is a difference between groups.

3.7 Use interaction terms in place of sub-group analyses.

3.8 Tests for change over time are generally uninteresting.

3.9 Avoid using statistical tests to determine the type of analysis to be conducted.

3.10 When reporting *P* values, be clear about the hypothesis tested and ensure that the hypothesis is a sensible one.

## **4. Reporting of study estimates**

4.1 Use appropriate levels of precision.

- Report *P* values to a single significant figure unless the *P* value is close to .05 (say, .01 - .2), in which case, report two significant figures. Do not report "not significant" for *P* values of .05 or higher. Very low *P* values can be reported as  $P < .001$  or similar. A *P* value can indeed be 1, although some investigators prefer to report this as  $> .9$ . For instance, the following *P* values are reported to appropriate precision:  $< .001$ , .004, .045, .13, .3, 1.

- Report percentages, rates, and probabilities to two significant figures, for example, 75%, 3.4%, 0.13%.

- Do not report *P* values of 0, as any experimental result has a non-zero probability.

- Do not give decimal places if a probability or proportion is 1 (eg, a *P* value of 1.00 or a percentage of 100.00%). The decimal places suggest that it is possible to have, say, a *P* value of 1.05. There is a similar consideration for data that can take only integer values. It makes sense to state that, for instance, the mean number of pregnancies was 2.4, but not that 29% of women reported 1.0 pregnancy.

- There is generally no need to report estimates to more than three significant figures.

- Hazard and odds ratios are normally reported to two decimal places, although this can be avoided for high odds ratios (eg, 18.2 rather than 18.17).

4.2 Avoid redundant statistics in cohort descriptions.

4.3 For descriptive statistics, median and quartiles are preferred over means and standard deviations (or standard errors).

4.4 Report estimates for the main study questions.

4.5 Report confidence intervals for the main estimates of interest.

4.6 Do not treat categorical variables as continuous.

4.7 Avoid categorization of continuous variables unless there is a convincing rationale.

4.8 Do not use statistical methods to obtain cut-points for clinical practice.

4.9 The association between a continuous predictor and outcome can be demonstrated graphically, particularly by using nonlinear modeling.

4.10 Do not ignore significant heterogeneity in meta-analyses.

- 4.11 For time-to-event variables, report the number of events but not the proportion.
- 4.12 For time-to-event analyses, report median follow-up for patients without the event or the number followed without an event at a given follow-up time.
- 4.13 For time-to-event analyses, describe when follow-up starts and when and how patients are censored.
- 4.14 For time-to-event analyses, avoid reporting mean follow-up or survival time, or estimates of survival in those who had the event.
- 4.15 For time-to-event analyses, make sure that all predictors are known at time zero or consider alternative approaches such as a landmark analysis or time-dependent covariates.
- 4.16 When presenting Kaplan-Meier figures, present the number at risk and truncate follow-up when numbers are low.

## 5. Multivariable models and diagnostic tests

- 5.1 Multivariable, propensity, and instrumental variable analyses are not a magic wand.
- 5.2 Avoid stepwise selection.
- 5.3 Avoid reporting estimates such as odds or hazard ratios for covariates when examining the effects of interventions.
- 5.4 Rescale predictors to obtain interpretable estimates.
- 5.5 Avoid reporting both univariate and multivariable analyses unless there is a good reason.
- 5.6 Avoid ranking predictors in terms of strength.
- 5.7 Discrimination is a property not of a multivariable model but rather of the predictors and the data set.
- 5.8 Correction for overfit is strongly recommended for internal validation.
- 5.9 Calibration should be reported and interpreted correctly.
- 5.10 Avoid reporting sensitivity and specificity for continuous predictors or a model.
- 5.11 Report the clinical consequences of using a test or a model.
- 5.12 Interpret decision curves with careful reference to threshold probabilities.

## 6. Conclusions and interpretation

- 6.1 Draw a conclusion, do not just repeat the results.
- 6.2 Avoid using words such as "may" or "might".
- 6.3 A statistically significant *P* value does not imply clinical significance.
- 6.4 Consider sources of potential bias and the mechanism for their effect on findings.
- 6.5 Consider the impact of missing data and patient selection.
- 6.6 Consider the possibility and impact of ascertainment bias.
- 6.7 Do not confuse outcome with response among subgroups of patients undergoing the same treatment: patients with poorer outcomes may still be good candidates for that treatment.
- 6.8 Be cautious about causal attribution: correlation does not imply causation.

## 7. Use and interpretation of *P* values

Refer to either the full statement:

[<https://www.tandfonline.com/doi/full/10.1080/00031305.2016.1154108>] or the summary [[https://www.amstat.org/asa/files/pdfs/P\\_ValueStatement.pdf](https://www.amstat.org/asa/files/pdfs/P_ValueStatement.pdf)] of the American Statistical Association statement on *P* values. In particular, we emphasize that a *P* value is just one statistic that helps interpret a study; it does not determine our interpretations. Drawing conclusions for research or clinical practice from a clinical research study requires evaluation of the strengths and weaknesses of study methodology, results of other pertinent data published in the literature, biological plausibility, and effect size. Sound and nuanced scientific judgment cannot be replaced by just checking whether one of the many statistics in a paper is or is not < .05.

For further information, please refer to the full paper:

Reference <sup>1</sup>Assel M, Sjoberg D, Elders A, Wang X, Huo D, Botchway A, Delfino K, Fan Y, Zhao Z, Koyama T, Hollenbeck B, Qin R, Zahnd W, Zabor EC, Kattan MW, Vickers AJ. Guidelines for Reporting of Statistics for Clinical Research in Urology. *Eur Urol.* 2019;75(3):358-67. PMID: 30580902; PMCID: PMC6391870.

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