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Author contributions should define the individual contributions each author made to the development of the manuscript and should include at minimum the three criteria required for Authorship as defined by CHEST (required for Original Research). If several authors made the same type of contributions, it is acceptable to combine them. An example author contribution line is: "MLM had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis, including and especially any adverse effects. MLM, MT, NAW, DRG, VAD, and EG contributed substantially to the study design, data analysis and interpretation, and the writing of the manuscript."

Financial/nonfinancial disclosures should match those provided on the title page

Role of the sponsors should detail what input or contributions, if any, were provided by the funding sources in the development of the research and manuscript

Other contributions

Figures
Figures Please make sure that artwork files are in an acceptable format (TIFF (or JPEG), EPS or MS Office files) and with the correct resolution. If, together with your accepted article, you submit usable color figures then Elsevier will ensure, at no additional charge, that these figures will appear in color online (e.g., ScienceDirect and other sites) in addition to color reproduction in print. For further information on the preparation of electronic artwork, please see http://www.elsevier.com/artworkinstructions.

Radiologic or other diagnostic examination figures or other diagnostic testing figures should have all patient-related numbering (including test date or medical record numbers) or wording removed prior to submission.

Virtual Microscope (Content Innovations)
The journal encourages authors to supplement in-article microscopic images with corresponding high resolution versions for use with the Virtual Microscope viewer. The Virtual Microscope is a web-based viewer that enables users to view microscopic images at the highest level of detail and provides features such as zoom and pan. This feature for the first time gives authors the opportunity to share true high resolution microscopic images with their readers. More information and examples are available at http://www.elsevier.com/about/content-innovation/virtual-microscope. Authors of this journal will receive an invitation e-mail to create microscope images for use with the Virtual Microscope when their manuscript is first reviewed. If you opt to use this feature, please contact virtualmicroscope@elsevier.com for instructions on how to prepare and upload the required high resolution images.

3D Radiological Data (Content Innovations)
You can enrich your online article by providing 3D radiological data in DICOM format. Radiological data will be visualized for readers using the interactive viewer embedded within your article and will enable them to: browse through available radiological datasets; explore radiological data as 2D series, 2D orthogonal MPR, 3D volume rendering and 3D MIP; zoom, rotate, and pan 3D reconstructions; cut through the volume; change opacity and threshold level; and download the data. Multiple datasets can be submitted. Each dataset will have to be zipped and uploaded to the online submission system via the "3D radiological data" submission category. The recommended size of a single uncompressed dataset is 200 MB or less. Please provide a short informative description for each dataset by filling in the "Description" field when uploading each ZIP file. Note: all datasets will be available for download from the online article on ScienceDirect. So please ensure that all DICOM are anonymized prior to submission. For more information, see http://www.elsevier.com/about/content-innovation/radiological-data.

Figure Legends
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 of the manuscript, not on the figure itself. Stains and magnifications for all photomicrographs should be included in the legend. Any image manipulation (eg, splicing) should be described in the legend. Permissions for any republished figures and any required patient consent lines for identifiable images also should be noted in the legend.
**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').

**Graphical abstract**

Although a graphical abstract is optional, its use is encouraged as it draws more attention to the online article. The graphical abstract should summarize the contents of the article in a concise, pictorial form designed to capture the attention of a wide readership. Graphical abstracts should be submitted as a separate file in the online submission system. Image size: Please provide an image with a minimum of 531 × 1328 pixels (h × w) or proportionally more. The image should be readable at a size of 5 × 13 cm using a regular screen resolution of 96 dpi. Preferred file types: TIFF, EPS, PDF or MS Office files. You can view Example Graphical Abstracts on our information site. Authors can make use of Elsevier's Illustration Services to ensure the best presentation of their images and in accordance with all technical requirements.

**References**

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. If the first (or only) mention of a reference appears in a Table, place the reference number after the Table call out in text. For example, if a reference is in Table 3 and has not been called out any earlier in the text, then the text call out should be, eg, "Table 3...". This will preserve numbering in citation management software. The full citations must be listed in numerical order at the end of the text. Each reference must contain, in order, the following: Authors (last name initials, listing all when there are up to six; first three followed by et al in the case of more than six authors

Title of article (sentence case, no quotation marks)

Publication source (italicized), when referring to a journal, the journal name should be abbreviated according to Index Medicus

Year of publication

Volume number

Issue number

Page numbers (inclusive)

No spaces should be used from the year of publication through the final page number. References to published abstracts may be included but must be noted as such. Please note that no periods should be used after authors initials or after journal abbreviations; however, periods should be inserted after the publication name and at the end of each reference. Examples of commonly used reference types are noted below.

**Journal Article**


**In-Press Journal Article**


**Book**


**Book Chapter**

Abstract

For assistance in formatting other types of references, please refer to the American Medical Association Manual of Style.¹


Data References
This journal encourages you to cite underlying or relevant datasets in your manuscript by citing them in your text and including a data reference in your Reference List. Data references should include the following elements: author name(s), dataset title, data repository, version (where available), year, and global persistent identifier. Add [dataset] immediately before the reference so we can properly identify it as a data reference. The [dataset] identifier will not appear in your published article.

Data visualization
Include interactive data visualizations in your publication and let your readers interact and engage more closely with your research. Follow the instructions here to find out about available data visualization options and how to include them with your article.

Supplemental Material/Appendices
Supplemental material Authors may submit supplemental material (ie, material that will be published only with the online version of the journal) if it enhances a study. The main text must stand alone, and the use of supplemental material should be judicious.

The same standards for ethics, copyright, permissions, and publication quality for the full-text article apply to all supplemental material. Tables and figures for the main article should be integrated with the main manuscript. The inclusion of a single table and/or figure as supplemental material is not acceptable; that element should be integrated into the text. References in supplemental material should be numbered consecutively beginning with 1; if a reference appears in the main article, it must also be included in the supplemental material and will likely have a different reference number. Supplemental material should be thought of distinctly in this regard.

If any of the material included as supplemental material has been previously published, the authors are responsible for obtaining the required permissions and attributing the source material.

Appendices will no longer appear in CHEST articles, but may be included as supplemental material, labeled e-Appendix. Lists of study participants, multicenter institutional review board data, and the like are appropriate for e-Appendices.

Numbering
Each component of the supplemental material should be numbered and cited in consecutive order in the text of the article. Authors should not intersperse supplemental material consecutively with material for the print edition. The following convention should be used for labeling and numbering material: e-Table: number as e-Table 1, e-Table 2, etc

   e-Figure: number as e-Figure 1, e-Figure 2, etc
   e-Appendix: number as e-Appendix 1, e-Appendix 2, etc
   Audio: number as Audio 1, Audio 2, etc
   Video: number as Video 1, Video 2, etc (note, if shorter videos are combined into a single file, label each portion, eg, Video 1A, Video 1B, etc.)

Example: The distribution of missed bronchoscopy skills data points across centers and bronchoscopy milestones are depicted in e-Figure 1.

Formats
The manuscript title, author list, and heading Supplemental Material should be included at the beginning of each file. The following formats can be uploaded as Online Content Only in ScholarOne Manuscripts: Video: Quicktime (.mov), Windows media (.wmv), Audio Video Interleave (.avi), animated GIF (.gif), .mpeg, and .mp4. All movie clips should be provided at the desired size and...
length (10 MB or 5 min maximum). Before submitting, authors should verify that clips are viewable in Quicktime or Windows Media Player. In addition, a brief text description should be provided in a word processing document explaining the video. Authors are encouraged to supply a still image of the video file for inclusion as reference in the print version of the article.

**Audio:** .mp3, .wav, .au. In addition, a brief text description should be provided in a word processing document explaining the audio file.

**Tables:** Must be provided as Word files. The total size of the document cannot exceed 8.5 x 11 inches.

**Figures:** .tiff, .png, .jpeg, and .gif. One word processing file should be provided that contains brief captions for all figures.

**Text:** Microsoft Word (.doc, .docx), .rtf, and .txt files.

**Tables**
Tables should be self-explanatory and should not duplicate text material. They must be numbered and cited in consecutive order in the text. Each must have a succinct title, column and row headings, and (where appropriate) a legend describing abbreviations and lettered footnotes at the bottom of the table. Tables should not contain any shading or special symbols and any special formatting (bold, italics) must be explained in the legend. Tables consisting of more than 10 columns are unacceptable and will not be published. Tables should be provided as word processing documents, not in a spreadsheet file format or as an image file. Tables may be added at the end of the main document file.

Permissions for any republished tables should be noted in the legend.

See References for guidance on how to number and cite references that 1) appear only in tables or 2) are first cited in tables that are called out before other references.

Tables used to describe or compare literature should include a column with the following information from the source publication: lead author last name, year of publication, and a numbered citation that corresponds to the full reference in the manuscript reference list.

**Text**

**Subheadings Within Articles**

No more than 8 subheadings per article (in addition to headings such as Methods, Results, Discussion). Each subheading can consist of only 5 words, including words such as a, an, the, and, and.

Subheadings should be explanatory, but there is no need to repeat the title in every heading.

**Sample Original**

**Sample Revised**
Interdisciplinary Collaboration | Interdisciplinary Collaboration in Health-Care Delivery | Implementing Collaborative Models | Our Story | New Philosophy and Model | Building Blocks | Outcomes

The Guidance for Specific Article Types section provides more detail on how to format the text.

**Title Page**
The title page should be submitted as the first page of the main text word processing file and should include the following elements: Word counts for the text and abstract in the upper left-hand corner.

Title and short title/running head (of 50 characters or less)

Author list, showing all names in the order and format that they are to appear on publication. Also, include any middle initials and the highest degree obtained, as well as institutional affiliations. NOTE: Complete author information, including names, e-mail addresses, and institutional affiliations must also be entered in ScholarOne Manuscripts to facilitate the collection of the required forms.
Corresponding author information, with full mailing address and e-mail address (will appear on publication). Do not include phone or fax numbers on the title page.

Summary conflict of interest statements for each author (or a statement indicating no conflicts exist for the specified author[s])

Funding information, including any NIH grant numbers where applicable

Notation of prior abstract publication/presentation, including the name, date, and location of the relevant meeting

GUIDANCE FOR SPECIFIC ARTICLE TYPES

Guidance In addition to following the general manuscript preparation instructions, authors should refer to the specific instructions for the type of article they are submitting.

1 Section Title Consider Unsolicited (Y/N) Abstract (wd max) Textd (wd max) Reference (no. max) Ahead of the Curve N 250 2,500 25 Case Reports (Selected Reports) Y 150 750 20 Case Series Y 150 1,600 20 Chest Imaging & Pathology for Clinicians Y none 1,600 20 CHEST Guidelines Y 250 tbd tbd Commentary Y 250 2,500 25 Consensus Statementsa N 250c 3,800 75 Contemporary Reviews in Critical Care Medicine N 250 3,500 75 Contemporary Reviews in Sleep Medicine N 250 3,500 75 Correspondence Y none 400 5 Editorials N none 1,000 12 Errata Y none 400 n/a Medical Ethics Y 250 3,500 75 Original Research Y 250b 2,500 75 Point/Counterpoint Editorials N none 1,000 12 Pulmonary, Critical Care, and Sleep Medicine Pearls Y none 1,200 10 Recent Advances in Chest Medicine N 250 3,500 75 Retractions N none 400 n/a Special Featuresa Y 250 3,500 75

1 Topics in Practice Management N 250 2,500 50 Teaching, Education, and Career Hub (TEaCH) N none 2,500 30 Translating Basic Research Into Clinical Practice N 250 2,500 50 Ultrasound Corner Y none 1,200 10

These article types are solicited, but authors with ideas for topics are encouraged to contact CHEST with their proposal via the Contact Us form.

Original Research articles must have a structured abstract.

Consensus Statements must also be submitted with an executive summary.

text word counts exclude abstract, references, figure legends, and tables.

For case reports or commentaries follow instructions for those sections.

Ahead of the Curve

AoC 1 Article Element Requirements Abstract length None Text length 2,500 words Reference count 25 references

Ahead of the Curve papers serve to provide glimpses into research that may, in coming years, impact clinicians. "Ahead of the Curve" titles should make declarative statements that describe the topic and the author's perspective. They will be published in the Commentary Section, under the subtopic of "Ahead of the Curve." Topics in this section are developed and invited by the CHEST Section Editors and Editor in Chief. Authors with suggestions for a topic are encouraged to contact CHEST.

Case Reports/Case Series (Selected Reports) (Online only)

CRs 1 Article Element Requirements Abstract length 150 words, narrative format Text length 750 words, for a single report; 1,600 words for a series Reference count 20 references Format Either (1) Introduction, Case Reports, Discussion; or (2) Introduction, Materials and Methods, Results Other Written patient permission is required for publication

Case reports for CHEST are meant to describe a new entity, mechanism, or presentation of a disease state. All submissions to this section must be novel and/or unique. Any manuscripts submitted for publication should provide new insights for clinicians. In addition to standard case reports and case series, CHEST will also consider:

Case-based submissions to the Pulmonary, Critical Care and Sleep Medicine Pearls and Chest Imaging and Pathology for Clinicians sections, for cases that are not novel but which are instructive.
Case reports do not need institutional review board approval, but authors must preserve patient privacy and follow the Health Insurance Portability and Accountability Act or national equivalent rules in writing up the case. On acceptance, CHEST will require submission of written patient permission for publication. It is acceptable to submit case reports to CHEST that have been presented at meetings and congresses. This information should be disclosed on the title page and provided in the references.

Chest Imaging and Pathology for Clinicians (Online Only)
Imaging 1 Article Element Requirements Abstract length None Text length 1,600 words (of which clinical, radiologic, and pathologic findings and discussion should be 500 words each) Reference count 20 references Format Case Presentation (with distinct Clinical, Radiologic, and Pathologic Findings subsections); Q: What is the Diagnosis; A: Diagnosis; Discussion (with distinct Clinical, Radiologic, and Pathologic Discussion subsections); Conclusion Other Written patient permission is required for publication

Chest Imaging and Pathology for Clinicians is designed to aid readers in mastering the fundamentals of interpretation and ordering of chest imaging modalities, CHEST publishes case-based articles with characteristic chest imaging and related pathology. Pathology must be included in all cases submitted.

Selection of images should reflect state-of-the-art image quality. Pictures of plain chest radiographs and CT scans taken with a digital camera will not be accepted. For example, cases of interstitial lung disease must be imaged with high-resolution CT techniques. 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.

The format for this series is very important. Authors are encouraged to read the following instructions carefully: Title, should include a short summary of the presenting feature, but not the diagnosis (ie, Dyspnea with slow-growing mass of the left hemithorax)

Case Presentation, should include the following sections in sequence without the use of subheadings and without giving away the diagnosis: Clinical findings, should mention the relevant positives and negatives while avoiding detailed description of hospital course Radiologic findings, briefly detailing the plain chest radiograph (no corresponding figure need be submitted) and describing in detail the additional imaging studies performed, emphasizing findings that point to the diagnosis Pathologic findings, should be described in detail and should focus on correlations with the radiologic findings; Pathologic findings, should be described in detail and should focus on correlations with the radiologic findings

What is the diagnosis? Alternative questions may also be included (ie, What study should be conducted next?) in addition to the diagnosis question.

Diagnosis: XXX, should also include the answer to any other questions posed

Discussion, should include the following sections in sequence with the use of subheadings Clinical discussion, should illuminate how the clinical findings tie in with the diagnosis, addressing the typical and atypical case features. Authors are encouraged to highlight the clinical features that may alert the clinician to the diagnosis.

Radiologic discussion, should highlight specific findings from chest radiographs and CT, PET, MR scans. Authors are encouraged to highlight findings that exclude diagnosis and elaborate on the use of particular modalities.

Pathologic discussion, should highlight 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. Conclusion, should enumerate the patients clinical course and treatment given.

CHEST Guidelines
PGL 1 Article Element Requirements Executive summary Provided in bold text and including one to two paragraphs of introduction, followed by a summary of the data and a bulleted list of all recommendations and suggestions included in the document Abstract length 250 words, structured format Text length To be negotiated with CHEST
CHEST Guidelines are generated by the American College of Chest Physicians under a well-defined development process. Committees will work closely with the Section Editor of Guidelines and Consensus Statements and the Editor in Chief of CHEST in developing guideline articles intended for submission to CHEST.

Other organizations are discouraged from submitting guidelines to CHEST. If the authors strongly believe that CHEST is the proper forum for publishing these types of papers, authors should: Review the existing CHEST Guidelines to ensure there is no overlap; Contact the Editor in Chief of CHEST before embarking on such projects; and Be willing to use the same grading system, format, and development process followed by CHEST guidelines. CHEST will likely have any such submissions evaluated by the relevant committees of the organization as part of the review process.

**Commentary**
Commentary 1 Article Element Requirements Abstract length None Text length 2,500 words Reference count 25 references

Commentaries provide a forum for presenting an expert’s perspective on a specific topic to advance the field. CHEST invites authors to write commentaries who have in-depth knowledge of a topic of interest to the journal. CHEST will consider unsolicited commentaries submitted by authors who have a new or unique viewpoint on an important clinical or research topic. Authors of unsolicited commentaries, however, should contact CHEST with a proposal before submitting their manuscripts to avoid overlap with commentaries already invited but not yet published. Commentary titles should make declarative statements that describe the topic and the author’s perspective.

**Consensus Statements**
Consensus 1 Article Element Requirements Executive summary Provided in bold text and including one to two paragraphs of introduction, followed by a summary of the data and a bulleted list of all suggestions included in the document Abstract length 250 words, structured format Text length 3,800 words Reference count 70 references

Development Process
Development Process Development Process

Consensus Statements are developed by the American College of Chest Physicians and follow a detailed development process. See CHEST Guidelines above.

**Format**
NEW: Title, should begin with the topic name followed by a colon and the term "CHEST Guidelines."
Executive summary, should be provided in bold text and include one to two paragraphs of introduction, followed by a summary of the data and a bulleted list of all suggestions included in the document. At the discretion of the Journal and depending on the length of the full article, the Executive Summary may appear in print with the full article available online only.
Abstract, should be structured, utilizing labels (Background, Methods, Results, and Conclusions)
Text: writing committee members will be given writing instructions.
References
Tables, should adhere to CHEST table requirements

**Contemporary Reviews in Critical Care Medicine and Contemporary Reviews in Sleep Medicine**
CRCCM 1 Article Element Requirements Abstract length 250 words, narrative format Text length 3,500 words Reference count 75 references

The purpose of the Contemporary Reviews in Sleep Medicine and Critical Care sections is to publish concise reviews on important topics in medicine. These are to be state-of-the-art reviews, not exhaustive dissertations. There should be a summary of the field as well as a discussion of the most recent advances in the text, and if justifiable, a summary table that lists management advances based upon randomized controlled clinical trials. Topics in this section are developed and invited by the CHEST Section Editors and Editor in Chief. Authors with suggestions for a topic are encouraged to contact CHEST.
Correspondence
Corr 1 Article Element Requirements Abstract length None Text length 400 words Reference count 5 references Other Supplemental material may be included. One figure and one table permitted.

The correspondence section is primarily intended for the clarification and edification of articles published in CHEST. While letters that describe research in preliminary terms and announcements of general interest are uncommonly published as letters. It is up to the discretion of the Editor in Chief whether any Correspondence is sent for external peer review and whether to accept any letter for publication.

Commenting on Recent Articles
All letters commenting on previous articles should strive to provide constructive and respectful comments of the original work. Any correspondence discussing recent CHEST articles should include a short original title that does not duplicate the title of the article. Authors should include the full citation to the complete article in the reference list. For letters responding to articles published to the Online First section, CHEST will hold publication until the final version of the article is published in a numbered issue of CHEST. All accepted letters will be sent to the corresponding author of the original article with an invitation to submit a response for publication.

Response Letters
Authors are asked to submit all replies to letters on their work within four weeks of receiving the invitation. Authors should never correspond directly with the authors of correspondence. The replying author should also include the full reference to their original work and should submit the same conflict of interest information relevant to the original work. CHEST reserves the right to update the conflict of interest line in this regard as needed.

General Interest and Announcements
CHEST will occasionally consider correspondence that serves to announce matters of importance to the pulmonary, critical care, and sleep medicine community.

Reference:

Editorials
EDI 1 Article Element Requirements Abstract length None Text length 1,000 words Reference count 12 references

Editorials are invited by the Editor in Chief.

Errata
ERR Errata are published to communicate corrections necessary to previously published versions of articles. All errata are indexed by PubMed and attached to the original article citation.

To request a correction to a published article, authors should contact CHEST, providing details of the error, including the complete article citation, location of the error and corrected text. CHEST will publish corrections in the next available issue and will link the correction to the original article.

Medical Ethics
Ethics 1 Article Element Requirements Abstract length 250 words, narrative format Text length 3,500 words Reference count 75 references

Topics in this section are developed and invited by the CHEST Section Editors and Editor in Chief. Authors with suggestions for a topic are encouraged to contact CHEST.

Original Research
OR 1 Article Element Requirements Abstract length 250 words, structured format, include clinical trial information for randomized controlled trials Text length 2,500 words Reference count 75 references Format Text should include: Introduction, Materials and Methods, Results, Discussion, and Conclusions Acknowledgments Author guarantor statement and contributions required
Institutional Review Board (IRB) Approval
Most Original Research manuscripts must include a statement relating to institutional review board (or equivalent) approval in the "Materials and Methods" section. CHEST requires that authors include the committee name and approval number. In multicenter studies, the list of relevant committees and approval numbers may be included as an e-Appendix. See more information on IRB approval here.

Randomized Controlled Trials (RCT)
CHEST defines a randomized controlled trial (RCT) as "any research study that prospectively assigns human participants or groups of humans to one or more health-related interventions to evaluate the effects on health outcomes." Authors preparing RCTs for submission to CHEST should follow the CONSORT (Consolidated Standards of Reporting Trials) checklist and must include a CONSORT flowchart as Figure 1. Templates for the generation of CONSORT flowcharts are available online.

In addition to following CONSORT, CHEST requires investigators to register their clinical trials in an approved public trials registry. Approved public trials registries are those that meet the criteria established by the World Health Organization (WHO). To register a trial, authors must submit the details directly to any one of the WHO primary registries. CHEST reserves the right to reject papers if it deems the disclosure at the registry to be incomplete. An IRB statement is not a substitute for an approved clinical trial registration.

Purely observational studies (those in which the assignment of the medical intervention is not at the discretion of the investigator) do not require registration.

Systematic Reviews and Meta-analyses
Authors preparing systematic reviews and meta-analyses for submission to CHEST should follow the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-analyses) checklist and must include a PRISMA flow diagram as Figure 1 on submission. CHEST strongly encourages registration of systematic reviews with the PROSPERO registry. Additionally, authors are expected to address all items in the checklist in the writing of the manuscript. Those seeking additional guidance regarding the preparation of a systematic review can also consult the Cochrane Handbook for Systematic Reviews of Interventions at http://www.cochrane.org/handbook and the Institute of Medicine's Standards for Systematic Reviews available at http://www.nationalacademies.org/hmd/Reports/2011/Finding-What-Works-in-Health-Care-Standards-for-Systematic-Reviews.aspx. The Institute of Medicine's Standards for Developing Trustworthy Clinical Practice Guidelines should also be consulted for guidance when using systematic reviews as the basis for guideline recommendations, available at http://www.nationalacademies.org/hmd/Reports/2011/Clinical-Practice-Guidelines-We-Can-Trust.aspx.

Surveys/Questionnaire-Based Studies
Surveys 2 Investigators who administer surveys and questionnaires as part of their study should obtain copyright permission if needed; no surveys should be adapted without the permission of the developer. Any unapproved changes in how PRO instruments are used or approved changes that have not been psychometrically studied and found to be reliable and valid will invalidate the results.

Studies based on surveys or questionnaires should report on data that have been collected within two years of submission, include supporting reliability and validity data, and have response rates of at least 60%. All survey-based studies should describe the method used to achieve the response rate (eg, Dillman's tailored design method) and should provide a convincing rationale for why lower response rates provide important and generalizable information. Surveys with a response rate of less than 60% may be rejected. Nonrespondents should be characterized well enough to allow for assessment of potential for nonresponse. Authors are encouraged to report outcome rates for most surveys using standardized definitions and metrics (eg, those proposed by the American Association for Public Opinion Research. This information must be detailed in the methods section.©

Other Study Types
The Equator Network provides checklists for other types of studies such as the STROBE (Strengthening the Reporting of Observational Studies in Epidemiology) statement. Checklists are also available for cohort, case-control, and cross-sectional studies, and authors are encouraged to follow these.
Confidence Interval
For clinical studies, the primary outcome expressed as the difference between groups with a confidence interval (CI) on that difference should be provided in the Abstract and in the main article. In most cases, P values should not be presented without an accompanying effect estimate and CI. The CI is useful to readers because it indicates the precision of an estimated population value.

Matching Language to Level of Evidence
CHEST endorses the recently published HEART Group Statement calling for better matching language in Original Research to the evidence found in different study designs. In short, in observational studies investigators should use descriptive statements such as "we observed a lower risk" rather than a more definitive statement such as "reduced the risk by" that are more appropriate to RCTs. Editors of Heart Group Journals. Statement on matching language to the type of evidence used in describing outcomes data. J Am Coll Cardiol. 2012;60(23):2420. Kohli P, Cannon CP. The importance of matching language to type of evidence: Avoiding the pitfalls of reporting outcomes data. Clin Cardiol. 2012:35:714-717.

Poetry (Pectoriloquy)
Poems should not exceed 350 words, should not have been previously published, and should relate to concerns of health-care providers, patients and families, and medicine. Poems should not violate patient privacy (ie, they should be HIPAA compliant). Physicians should refrain from directly referencing specific identifiable situations in their poems. In case of doubt about appropriate content, check with your institution. Poems that have been previously published will be returned to the authors.

Submissions to the Pectoriloquy Section should be sent via e-mail to poetrychest@aol.com for review and preliminary acceptance by the Section Editor, Michael Zack, MD, FCCP. Authors of poems that Dr. Zack has approved will be asked to submit the final version to ScholarOne Manuscripts. Authors will be required to complete an Author Agreement form transferring copyright to CHEST. They will also be asked to provide two or three sentences about themselves and about their poem. Final acceptance for publication rests with the Editor in Chief.

All poems published in CHEST are free online, with PDF versions available for downloading.

Point/Counterpoint Editorials
P/CP Point/Counterpoint Editorials are submitted in two stages, each with distinct requirements: the point and counterpoint pieces have longer word limits. The rebuttals are intended to be more succinct.

Point/Counterpoint:
1 Article Element Requirements Abstract length None Text length 1,300 words Reference count 20 references Figure/table limits 3 total tables and figures (not 3 of each)

Rebuttals:
1 Article Element Requirements Abstract length None Text length 500 words Reference count 7 references Figure/table limits 1 figure or table

Point/Counterpoint Editorials are invited by the Editor in Chief. Authors with suggestions for a topic are encouraged to contact CHEST.

Pulmonary, Critical Care, and Sleep Pearls
Pearls 1 Article Element Requirements Abstract length None Text length 1,200 words (of which case presentation should be 150 to 250 words, with the discussion 850 words, excluding listing of pearls) Reference count <5 –10 references listed under a heading of "Suggested Readings." List in chronological order. No citations in text. Format See below Other Written patient permission is required for publication

Manuscripts for this section are designed to present a case, pose a question, provide the answer, and summarize the main teaching points as Pearls. Title, should include a short summary of the presenting feature, but not the diagnosis. History, provide the recent clinical presentation with relevant past medical history. Provide enough information regarding relevant positives and negatives to allow construction of a reasonable differential diagnosis.
Physical Examination Findings, should give the patient's vital signs and other physical findings labeled by organ system (eg, chest: bibasilar rales; cardiac: grade II/VI holosystolic murmur at the apex radiating to the axilla; abdomen: non-tender without organomegaly).

Diagnostic Studies, should list all of the relevant normal and abnormal studies required to construct a reasonable differential diagnosis: hemogram, blood chemistry, urine studies, arterial blood gases, microbiology results, tissue biopsy studies, miscellaneous studies (ECG, esophageal motility studies, etc), radiographic studies, polysomnographic studies. Authors should place normal values in parentheses when referring to unusual test results or values that have different normal ranges between laboratories.

What is the diagnosis? Additional questions may also be included (ie, What study should be conducted next?) in addition to the diagnosis question. Alternative questions may focus on management alone when a manuscript does not present a diagnostic question (eg, end-of-life management issues).

Diagnosis: XXX, state the diagnosis and the answers to any additional questions posed in the preceding "What is the diagnosis?" Do not provide explanatory text here but just mention the answers.

Discussion, using the present tense, present a clear discussion of the clinical condition that flows clearly from one topic to another. Most manuscripts should cover sequentially the topics of epidemiology, pathophysiology/etiology, clinical manifestations, treatment and outcomes. Exceptions, such as manuscripts on end-of-life decision-making, should retain a clearly organized sequence of topics. Do not refer to the present patient in the body of the general discussion but instead refer back to the present patient in the Clinical Course section. Avoid in the Discussion stating the findings or opinions of others (eg, Jones and Smith reported. . .); instead, authors should synthesize the literature and state their views on the topic.

Clinical Course, should take the general discussion back to the specific patient presented, informing readers how the diagnosis was established, how the patient was managed and what outcomes occurred.

Pearls, 3 to 5 important teaching points extracted from the Discussion. Pearls should represent concise, specific and clinically useful information rather than general statements of fact.

Suggested readings, should be listed in chronological order with the oldest first and include a mix of classic and recent journal or book citations. References to general medical or nursing textbooks should be avoided.

Figures are only needed for the case presentation. In discussing figures in the case report, simply refer to their 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, but in describing the figure do not provide the diagnosis or the answer to the question you will pose in the manuscript. 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 when referring in general to the condition and in the section on clinical course when providing follow-up for the patient presented.


Recent Advances in Chest Medicine
RACM 1 Article Element Requirements Abstract length 250 words, narrative format Text length 3,500 words Reference count 75 references

Recent Advances in Chest Medicine are state-of-the-art concise reviews intended to frame a topic and focus on the new developments in this field in the past 2 to 4 years. The audience is intended to be clinicians and clinician-scientists, with emphasis on information that will inform practice. Topics in this section are developed and invited by the CHEST Section Editors and Editor in Chief. Authors with suggestions for a topic are encouraged to contact CHEST.

Retractions
RET The main purpose of retractions is to correct the literature. According to the Committee on Publication Ethics, acceptable reasons for retraction include: Clear evidence that findings are unreliable (either as a result of misconduct or honest error); The findings have previously been published elsewhere without proper cross-referencing, permission, or justification; It constitutes plagiarism; or It reports unethical research.
In cases in which one of the above situations arises, authors are required to contact CHEST to explain the situation. Similarly, if CHEST learns of scientific misconduct and believes that an article must be retracted, the Editorial Office will contact all authors.

Published retractions will take the form of a letter, signed by all authors of the original work. The title of the letter will be "Notice of Retraction of" followed by the full title of the original publication. The letter will include the details on why the article is being retracted and will include the full publication information of the original article both in a parenthetical notation and as a reference. Prior to publication, all authors will be required to submit the Author Agreement and Conflict of Interest Disclosure form. All retractions will be indexed in PubMed and attached to the original article citation.

**Special Features**

**SF 1 Article Element Requirements** Abstract length 250 words, narrative format Text length 3,500 words Reference count 75 references

Special Features are solicited reviews that do not fit well into other categories. NOTE: Systematic reviews should be submitted as Original Research. CHEST will consider unsolicited Special Feature submissions, but authors must be aware that at any given time CHEST also has a long list of pending invited topics. Authors are encouraged to contact CHEST with a proposal on the topic prior to the writing or submission of any Special Feature articles.

**Supplement Issue Proposals**

Although CHEST will consider supplements sponsored by third parties for publication, it will publish only those supplements that advance the field or provide information that will significantly impact patient care in a novel way. **Proposal:** A complete draft table of contents, inclusive of titles, proposed authors, article lengths, and a brief description of what will be covered should be submitted to CHEST prior to the development of any further materials. Funding sources should also be disclosed. The material covered should have a broad interest to one or more constituents served by CHEST and the American College of Chest Physicians. (eg, pulmonologists, critical care physicians, and cardiovascular or thoracic surgeons). The Editor in Chief will make a preliminary determination as to whether the proposal is of interest to CHEST. Final manuscripts will be submitted to peer review, and no guarantee of acceptance can be made. **Funding:** Supplements must have a commitment of funding, ideally from a nongovernmental organization, philanthropic foundation, or government-funded health-care body. The supporting organization shall not in any way dictate or impact the editorial content of the supplement. No title or article shall have the appearance of a conflict of interest, paid advertisement, or proprietary study. The Editor in Chief will make such determinations. Supplements funded by single commercial entities are strongly discouraged and may not receive approval. **Draft Manuscripts:** Manuscripts should be written by the named authors. Ghost authorship is not permitted. Any editorial assistance and/or writing support should be noted in the acknowledgments of each article, as should the source of funding for this assistance. Typically, one or more of the organizers of the supplement will provide a preliminary review of all the papers in a supplement for suitability of content, initial quality control, and adherence to agreed-on format (the format will be a coordinated effort of the supplement organizers and CHEST). They will work with authors before papers are formally submitted to the Journal. Once the organizers have met their own standards for submission, they will provide the CHEST Editorial Office with a list of manuscripts, authors, and contact information for a Corresponding Author for each manuscript. **Peer Review:** A designated supplement material receipt date will be set by the CHEST Editorial Office. All manuscripts and materials must reach the Editorial Office by that date. CHEST will contact all corresponding authors with instructions on finalizing and uploading manuscripts into ScholarOne Manuscripts system. All CHEST requirements for authors also apply to authors of supplement papers. CHEST will send out all papers in a group to an external reviewer for final evaluation. Authors will be responsible for making the requested changes. **Editing:** CHEST will copyedit all articles for grammar and style. The corresponding author of each article will be responsible for review and approval of final page proofs. **Publication:** Publication date will be determined by CHEST. An estimated publication date will be set once CHEST offices have received all the supplement material. CHEST reserves the right to move up or delay publication. All supplements will appear online as a standalone issue of CHEST, available to all CHEST subscribers. **Reprints & Bulk Orders:** Single article reprints, e-prints, and bulk orders will be available on publication.
To submit a supplement proposal, contact CHEST.

**Topics in Practice Management**

TPM 1 **Article Element** Requirements Abstract length 250 words, narrative format Text length 2,500 words Reference count 50 references

The general concept of Topics in Practice Management is to create a short focused article, combining a brief review of a clinical topic with a practice management perspective. References in this section should include or even emphasize available website information from CMS, local Medicare contractors, and even the American College of Chest Physicians or other professional society websites if applicable. Topics in this section are developed and invited by the CHEST Section Editors and Editor in Chief. Authors with suggestions for a topic are encouraged to contact CHEST.

**Teaching, Education, and Career Hub (TEaCH)**

Teach 1 **Article Element Requirements** Abstract length none Text length 2,500 words Reference count <30 references listed under a heading of "Suggested Readings." List in chronological order. No citations in text.

Teaching, Education, and Career Hub papers focus on topics of interest to medical educators and trainees. Topics included focus on the process of educating pulmonary and critical care trainees, educational research in pulmonary and critical care, mentorship and mentoring, and career pathways within the field. While unsolicited articles and medical education research are encouraged, many of the topics in this section are developed and invited by the CHEST Section Editors and Editor in Chief. Authors with suggestions for a topic are encouraged to contact CHEST.

**Translating Basic Research Into Clinical Practice**

TBRCP 1 **Article Element Requirements** Abstract length 250 words, narrative format Text length 2,500 words Reference count 50 references

The purpose of Translating Basic Research into Clinical Practice is to publish short articles that present advances in basic research that are likely to be relevant to clinical practice in the respiratory field. Articles are to explain why this advance is (or will become) important to know about and how it may impact the management of respiratory disease in the future. Topics in this section are developed and invited by the CHEST Section Editors and Editor in Chief. Authors with suggestions for a topic are encouraged to contact CHEST.

**Ultrasound Corner**

USC 1 **Article Element Requirements** Abstract length None Text length 1,200 words (of which case presentation should up to 300 words, with the discussion 900 words, including take-home points, ie, "Reverberations") Reference count 10; no references should appear before the Discussion Videos 2 or 3 video file sets (more than 1 video clip may be compiled for use in each video set), a: sets typically include 1) first step in diagnosis; 2) next step by ultrasonography or determination of diagnosis; 3) discussion video. Authors are responsible for creation and editing of videos, including addition of captioning and labeling. b: Section editor will work with authors and CHEST to add voice-over narration of the discussion video on acceptance. Files names must be video1.XXX, video2.XXX, etc. and each Ultrasound Corner manuscript must have discussion video with the file name discussion.XXX (XXX is the file format). See past articles for the Discussion video format. Format 1) Introduction/case presentation + initial examination video set; 2) One question + one answer and follow-up ultrasonography video set; 3) Discussion + discussion video; 4) "reverberations" (ie, take-home points; 5) references; 6) captions for figures if included; 7) short description of each video Other Written patient permission is required for publication; waivers may be considered on a case-by-case basis and must be approved by the editor in chief.

aVideo clips may be combined as needed.
bAuthors should combine all needed video clips for each step into a single video file, using software such as Windows MovieMaker or Apple Final Cut Pro. For short ultrasound readings (eg, 2 or 3 seconds), authors should either loop the frames or copy the sequences several times so that viewers have a chance to absorb what they are seeing.

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