TABLE OF CONTENTS

- Description p.1
- Impact Factor p.1
- Editorial Board p.1
- Guide for Authors p.6

DESCRIPTION

The journal, CHEST, the official publication of the American College of Chest Physicians®, features the best in peer-reviewed, cutting-edge original research in the multidisciplinary specialties of chest medicine: pulmonary, critical care, and sleep medicine; thoracic surgery; cardiorespiratory interactions; and related disciplines. Published since 1935, it is home to the highly regarded clinical practice guidelines and consensus statements. Readers find the latest research posted in the Online First section and access series that provide insight into relevant clinical areas, such as Recent Advances in Chest Medicine; Topics in Practice Management; Pulmonary, Critical Care, and Sleep Pearls; Ultrasound Corner; Chest Imaging and Pathology for Clinicians; and Contemporary Reviews. Point/Counterpoint Editorials and the CHEST Podcasts address controversial issues, fostering discussion among physicians. Access the journal CHEST online at chestjournal.org.

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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.

Figures
Figures Please make sure that artwork files are in an acceptable format (TIFF, JPEG, or EPS) and with the correct resolution. Color figures are published free of charge. For further information on figure preparation, please see https://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.

The journal encourages authors to supplement in-article microscopic images with corresponding high-resolution versions for use with the Virtual Microscope viewer. We also allow authors to enrich the online article by providing 3D radiological data in DICOM format. For more information on these Content Innovations, click here.

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.

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 (i.e., 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. 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 no longer appear in *CHEST* articles, but may be included as supplemental material, labeled e-Appendix. Lists of study participants and multicenter institutional review board data are examples of content that is appropriate for e-Appendices.

**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.

**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, e.g., 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.  
- **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.

**References**

References in supplemental material should be numbered consecutively beginning with 1; if a reference appears in the main article, it should 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.

**Style and Usage**

*CHEST* follows the *American Medical Association Manual of Style* (10th ed) in matters of editorial style and usage. All accepted manuscripts are subject to copyediting for conciseness, clarity, grammar, spelling, and *CHEST* style.
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 gender neutral (eg, “chairperson” instead of “chairman” and “flight attendant” instead of “stewardess”).

GUIDANCE FOR SPECIFIC ARTICLE TYPES

Guidance for Specific Article Types

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 Consider Unsolicited (Y/Na) Abstract (wd max) Textb (wd max) References (max) Original Research Y 300 3,200 50 Guidelines and Consensus Statements Y 300 4,000 150

Invited Contenta CHEST Reviews N 250 3,500 75 How I Do It N 250 3,000 50 Point Counterpoint N None 1,200 12 Editorials N None 1,000 12 Special Features N 250 3,500 75 Cases Novel Reports Y 150 750 20 Chest Imaging & Pathology for Clinicians Y None 1,600 10 CHEST Pearls Y None 1,600 10 Ultrasound Corner Y None 1,600 10 Correspondence Letter to the Editor Y None 400 5 Response to Letter to the Editor N None 400 5 Research Letter Y None 1,000 10 General Interest Commentary and Announcement Y None 750 50

a These article types are invited. Authors with ideas for topics are encouraged to contact CHEST with proposals via the Contact Us form.

b Text word counts exclude abstract, references, figure legends, and tables.

ORIGINAL RESEARCH

Original Research 1 Article Element Requirements Abstract length 300 words, structured format, include clinical trial information for randomized controlled trials Text length 3000 words Reference count 75 references

Format

A structured abstract should be provided. The abstract should be divided into the following sections: Background, Research Question, Study Design and Methods, Results, Interpretation, and Clinical Trial Registration Number (where applicable). The body of the text should be divided into the following sections: Introduction (not labeled), Methods, Results, Discussion, and Interpretation. Acknowledgements can follow (including author guarantor statement and contributions), then References. Finally, a Take Home Point pullout will be published. Please provide a sentence for the Study Question, Results, and Interpretation.

Institutional Review Board (IRB) Approval

Most Original Research manuscripts must include a statement relating to institutional review board (or equivalent) approval in the "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 (see Registration of Clinical Trials and Systematic Reviews below). 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 (see Registration of Clinical Trials and Systematic Reviews below). 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.

**Registration of Clinical Trials and Systematic Reviews**

Registration of Clinical Trials and Systematic Reviews: Authors of reports of clinical trials and systematic reviews should record their investigations in a viable registry (eg, ClinicalTrials.gov, PROSPERO [https://www.crd.york.ac.uk/prospero/]). 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.

Authors should update their registrations to reflect any changes in outcomes, including primary and secondary end points, or protocols before participants are enrolled. The methods described in the published report must accord with those previously published in the study registration to avoid even the appearance of scientific misconduct. Furthermore, any changes to the original registration (eg, substituting a secondary outcome as the primary outcome) should be described in detail in the methods section of the manuscript. Authors who modify their methods should post those changes on the online registry before submitting their manuscripts to CHEST.

**Surveys/Questionnaire-Based Studies**

Survey 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. 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. 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 should be expressed as the difference between groups with a confidence interval (CI) around that difference 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 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

**GUIDELINES AND CONSENSUS STATEMENTS**

Guidelines and Consensus Statements 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 300 words, structured format Text length 4,000 words (may be negotiated with CHEST)

CHEST Guidelines are generated by CHEST under a well-defined development process. Committees work closely with the Guideline Oversight Committee, the Editor in Chief of CHEST, and relevant Associate Editors in developing guideline articles intended for submission to CHEST.

CHEST will work with other guideline producing organizations where the possibility of mutual benefit exists. This includes guidelines and consensus statements where CHEST (the organization) has either agreed to participate in the development process, or has agreed to endorse the guideline or statement, or has been uninvolved in the development process.

Guideline producing organizations that are not connected to a journal may submit their guideline for publication in CHEST. The submission will undergo peer review to include review by an internal methodologist and member of the CHEST Guideline Oversight Committee. For guidelines produced by organizations that publish in a subspecialty journal, a summary of the guideline publication with implementation tools may be published in CHEST with the goal of reaching our broad clinical audience. For these types of projects authors should: Contact the Editor in Chief of CHEST prior to submission. Recognize that a formal review of the submission will take place before a publication decision is made. Consider including implementation tools in the document or as a supplement.


**INVITED CONTENT**

**CHEST Reviews**

CHEST Reviews 1 **Article Element Requirements** Abstract length 250 (narrative) Text length 3,500 words Reference count 75 max

CHEST reviews in “subspecialty” (eg, “Asthma”, or “COPD”, etc) can include clinical, translational, ethics, education, and practice management topics. When a topic does not neatly fit in a sub-specialty section it may be included in the Special Features section (see below).

CHEST reviews are state of the art concise reviews on focused clinical, translational, education, and practice management topics. These should include a description of the importance of the topic and a summary of what is known about the topic with special attention to the most recent advances impacting practice. When relevant, authors should consider including sections on anticipated future advances, the authors' perspective on the topic, and summary tools that could assist with the application of the review in practice (eg, summary tables, algorithms). Topics in this section are developed and invited by the CHEST Associate Editors and Editor in Chief. Authors with suggestions for a topic are encouraged to contact CHEST.

**How I Do It**

How I Do It 1 **Article Element Requirements** Abstract length 250 words (unstructured) Text length 3,000 words Reference count 50 max

The How I Do It Section includes practical reviews of well-defined clinical questions with tools to assist with addressing the question when faced in practice. A relevant clinical question may have good evidence and guidelines available to support the approach, but implementation assistance is needed, or have weak evidence to support an approach but is a question that clinicians struggle with in practice.
Articles should be organized as follows: A well-defined clinical or procedure related question. Case example. Review of relevant literature. Comment on nuances when applying to patient care. Review of relevant guidelines. Comment on nuances when applying to patient care. Include a summary table or algorithm whenever relevant. Summary of the approach to the question.

Suggestions for multimedia adjuncts to the article are welcome. Manuscript for the How I Do It section are invited by the subspecialty editorial teams. Unsolicited contributions will not commonly be considered. Authors with ideas for topics should contact the Editor in Chief before preparing a manuscript.

**Point/Counterpoint Editorials**

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 1,200 words Reference count 12 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 present a debate by content experts with different interpretations of the evidence supporting an approach to a topic. Each side of the debate develops a rationale for their stance and then is given an opportunity to view and respond to the rationale provided counter to their stance.

Point/Counterpoint Editorials are invited by the editorial team. Authors with suggestions for a topic should contact CHEST prior to developing a manuscript.

**Editorials**

Editorials 1 **Article Element Requirements** Abstract length None Text length 1,000 words Reference count 12 max

Editorials are invited by the editorial team. They are meant to allow a content expert to discuss the findings of an original research article, sharing their perspective on how the publication advances the field, impacts practice, and highlights further research needs.

**Special Features**

Special Features

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

Special Features are invited reviews, commentaries, and other items of interest 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.

**CASES**

**Novel Reports (Online only)**

Novel Reports 1 **Article Element Requirements** Abstract length 150 words, narrative format Text length 750 words, for a single case report; 1,600 words for multiple cases Reference count 20 references Format Introduction, Case Report(s), Discussion Other Written patient permission is required for publication
Case report submissions to CHEST should describe a new entity, mechanism, presentation, means of diagnosis, or treatment of a disease. All submissions to this section must be novel and/or unique. It is appropriate to submit a single cases or multiple cases highlighting the same message. Studies with a research question that is addressed by a case-series should be submitted as original research.

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)**

Chest Imaging 1 Article Element Requirements Abstract length None Text length 1,600 words (of which clinical, radiologic, and pathologic findings and discussion should be approximately 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); Bulleted list (3-4 lines at the most) of the take home message from the case. Other Written patient permission is required for publication

Chest Imaging and Pathology for Clinicians is designed to aid readers in understanding the connection between clinical, radiographic, and pathologic features of a disease state. Each submission should include distinct clinical, radiologic, and pathologic sections within the case presentation and the discussion.

The format for submission to this section is as follows: **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. The focus should be on the approach taken by the authors to make the diagnosis. Comments on the differential diagnosis and a table summarizing the clinical and radiologic features of the differential diagnoses are desirable. 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. The pathology presented should confirm the diagnosis. Gross pathology or high quality low power images that capture the radiologic and pathologic correlation is recommended. **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. In case of a rare disease, and brief description as well as diagnostic tests/criteria should be included. These may be tabulated. In the last paragraph, the outcomes of the case and the result of described intervention is useful. **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**, a bulleted list (3-4 lines at the most) of the take home message from the case for clinicians is encouraged. **Image Quality Considerations**

Sizing: Images should be appropriately sized to minimize superfluous information—including, in particular, any surrounding structures outside the body. Labelling/Figure legends: Legends should include baseline information: slice thickness (mm’s), orientation (axial, coronal), and reconstruction algorithm (in the case of lung —either “smooth” or “edge enhanced” or their equivalent). For contrast enhanced pulmonary artery studies the rate, timing, volume and type of contrast as appropriate. Additional Imaging techniques: of particular interest is the addition of “movie” files (AVI or their equivalent) when these augment image interpretation (eg, cardiac, aortic, or general vascular cases). The inclusion of other standard imaging formats, such as volumetrically rendered images and maximum (MIPS) and minimum (MinIPS) projection images, can be helpful.
CHEST Pearls

CHEST Pearls 1 Article Element Requirements Abstract length None Text length 1,600 words (of which case presentation should be under 300) Reference count Up to 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:** 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, approach to diagnosis, 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. Authors may consider including an algorithm describing an approach to the clinical presentation.

**Sample:** Kyle R. Brownback, MD; Michael S. Crosser, MD; Steven Q. Simpson, MD. A 49-year-old man with chest pain and fever after returning from France. Chest. 2012;141(6):1618-1621.

Ultrasound Corner

Ultrasound Corner 1 Article Element Requirements Abstract length None Text length 1,600 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). 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. 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 (do not describe the ultrasound in a manner that would provide the answer to your question in #2; do mention the part of the body the ultrasound was obtained from); 2) One question + one answer and follow-up ultrasonography video set; 3) Discussion + discussion video; 4) 3-4 “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.

\[Video clips may be combined as needed.\]

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

**CORRESPONDENCE**

**Letter to Editor, Response to Letter to Editor**

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1 **Article Element Requirements** Abstract length None Text length 400 words Reference count 5 references Other No **Supplemental material**. One figure or table permitted.

Letters to the Editor are intended for the clarification and edification of articles published in CHEST. 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. Letters should pertain to articles published within the preceding 6 weeks. 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 2 weeks of receiving the invitation. If they do not respond within this time frame, the original letter will be published without a response. 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 Commentary and Announcements**

General Interest Commentary and Announcements 1 **Article Element Requirements** Abstract length None Text length 1,000 words Reference count 5 references Other No **Supplemental material**. One figure or table permitted.

CHEST will consider correspondence in the form of commentary of potential interest to readers, or that serves to announce matters of importance to the pulmonary, critical care, and sleep medicine community.

**Research Letters**

Research Letters 1 **Article Element Requirements** Abstract length None Text length 1,000 words Reference count 10 references Other No **Supplemental material**. Up to two figures and/or tables permitted.
Research Letters should be descriptions of focused research findings. The findings should be of high quality, novelty, or potential clinical impact, but not advanced or large enough to warrant publication of a complete original research manuscript. Research Letters do not require an abstract. The text should include Introduction (not labeled), Methods, Results, and Discussion sections. They should follow the guidelines for Manuscript Preparation and Submission Requirements.