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DESCRIPTION

CHEST is committed to advancing the care of patients served by multidisciplinary clinicians across pulmonary, critical care, and sleep medicine through the publication of clinical research relevant to today’s challenges and reflecting advances on the horizon. To provide context in a fast-changing landscape, CHEST also incorporates review articles, offers commentaries, and fosters debate on emerging controversies. CHEST applies strict peer review standards to ensure the scientific rigor and publishes all content online within two weeks of acceptance.

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**Title Page**

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Format
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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-Sy.

**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**

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.

Authors of studies based on surveys or questionnaires should report on data that have been collected within two years of submission, including 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 Guidelines**

*CHEST* endorses the HEART Group Statement\(^1\) calling for better matching language in original research to the evidence found in different study designs.\(^2\) 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.

**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. The Institute of Medicine's Standards for Developing Trustworthy Clinical Practice Guidelines should be consulted for guidance when using systematic reviews as the basis for guideline recommendations; these are available at [http://www.nationalacademies.org/hmd/Reports/2011/Clinical-Practice-Guidelines-We-Can-Trust.aspx](http://www.nationalacademies.org/hmd/Reports/2011/Clinical-Practice-Guidelines-We-Can-Trust.aspx).

**Invited Content**

Reviews

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

*CHEST* reviews in “sub-specialty” (eg, “Asthma”, or “COPD”) 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, ethics, 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* at editorialoffice@chestnet.org.

**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 with which clinicians struggle 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. 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 CHEST at editorialoffice@chestnet.org 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, and 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. Authors on each side of the debate develop a rationale for their stance and then are 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 at editorialoffice@chestnet.org prior to developing a manuscript.

**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**

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 at editorialoffice@chestnet.org with a proposal on the topic prior to the writing or submission of any Special Feature articles.

**Case Series**

Novel Reports
**Novel Reports (Online only)**

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 case 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)**

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 10 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: A clinical findings section 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. A radiologic findings section should briefly detail the plain chest radiograph (no corresponding figure need be submitted) and describe in detail the additional imaging studies performed, emphasizing findings that point to the diagnosis A pathologic findings section should describe these findings 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 are 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 are useful. **Radiologic discussion** should highlight specific findings from chest radiographs and CT, PET, and 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. Labeling/Figure legends: Legends should include baseline information: slice thickness (in mm), 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, provide the rate, timing, volume and type of contrast as appropriate. Additional Imaging techniques: of particular interest is the addition of “movie” files (AVI or 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.” 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 should provide the recent clinical presentation with relevant past medical history, with 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 according to 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 care 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 needed only 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.

Ultrasound Corner

1 Article Element Requirements
Abstract length None
Text length 1,600 words (of which case presentation should be up to 300 words, with the discussion being 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),\textsuperscript{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.\textsuperscript{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 (do not describe the ultrasonogram in a manner that would provide the answer to your question in #2; do mention the part of the body from which the ultrasonogram was obtained);
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.

\textsuperscript{a}Video clips may be combined as needed.

\textsuperscript{b}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

Correspondence
Letters

Letter to Editor, Response to Letter to Editor

1 Article Element Requirements
Abstract length None
Text length 400 words
Reference count 5
Other No
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 of 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.

Research Letters

1 Article Element Requirements
Abstract length None
Text length 1,000 words
Reference count 10
Other No
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, be novel, or have potential clinical impact, but should not be 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.

General Interest

General Interest Commentary and Announcements

1 Article Element Requirements Abstract length None Text length 1,000 words Reference count 5 references Other No 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.