ABOUT THE JOURNAL

Trauma Surgery & Acute Care Open (*TSACO*), an official online publication by the American Association for the Surgery of Trauma, provides an interdisciplinary forum for global issues in trauma and acute care surgery.

The journal is characterized by a streamlined peer-review process, which facilitates the rapid reporting of research. As an international, peer-reviewed, open access journal, *TSACO* is dedicated to covering all aspects of trauma surgery including epidemiological, educational, and socio-economic facets of trauma management and injury prevention.

As an online-only publication, *TSACO* will cover topics of interest and relevance to the global acute care surgery community, as well as affiliated subspecialty physicians and advanced practitioners. Manuscripts of interest include the reporting of clinical studies, training and implementation reports, survey-based research, and reviews. Topics of special interest may include injury prevention, public health, global systems development, disaster and mass casualty management, orthopaedic injuries, neurological trauma and the use of new technologies as they relate to trauma education and treatment. Reports of patient management in resource-poor settings, pilot studies of new technologies or techniques, and clinical case series are also encouraged.

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TSACO is a member journal of the Committee on Publication Ethics (COPE) and recommends following the EQUATOR Network's international initiative that promotes transparent, accurate reporting of research studies.

GENERAL ARTICLE FORMAT

Please review the following descriptions of manuscript types and the required article lengths, illustrations, table limits and references counts in **Table 1**.

ARTICLE TYPES

Original Articles and Plenary Papers
Original articles and Plenary Papers include randomized-controlled trials, laboratory and animal research, outcome studies, economic and cost analyses. These should include a clearly-stated objective or hypothesis and information on study design and methodology, participation, interventions, outcome measurements, and study results. Authors must indicate a level of evidence and study type in the abstract as outlined above.

Note word limit does not include abstract, authorship statement, references, tables or figures. Also note that Original articles and Plenary Papers follow the same format but should be submitted under their respective article type on our submission site ScholarOne.

Systematic Reviews
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Table 1 – Article Types

Manuscript Type	Abstract Style	Word Limit	Figure/Table Limit	Reference Limit
Original Article/Plenary Paper	Structured	4,000	6	50
Systematic Review	Structured	4,000	6	80
Review Article	Summary	5,000	8	100
Guidelines/Algorithms	None	5,000	8	100
Current Opinion	Summary	3,000	6	40
Brief Report	Structured	2,000	6	20
Challenges in Trauma and Acute Care Surgery	None	800	3	0
Editorial	None	350	0	0

Review Articles
General review articles provide an overview of our current understanding of a subject and may highlight new areas of development and discovery. Review articles may contain a summary abstract.

Guidelines/Algorithms
Guidelines/Algorithms represent consensus-based clinical practice guidelines with appropriate references to support the recommendations. Guidelines may include an unstructured abstract, but this is not required.

Current Opinion
Current Opinion papers present the unique perspectives of contributors in articles that are not rigorously scientific and may include topics of special interest to the readership. The abstract is optional.

Brief Reports
Brief Reports provide short descriptions of clinical or laboratory research observations that are not sufficiently developed to scientifically test hypotheses. Clinically-oriented reports should provide synthesized results. Authors should not describe a single case or a description of unusual cases.

Challenges in Trauma and Acute Care Surgery
Challenges in Trauma and Acute Care Surgery are meant to provide concise overviews of surgical dilemmas. Presentation of the case and sample answers to the question, "What would you do?" should not exceed 300 words. The answer to this question, labeled "What we did and why," along with a description of clinical management should be limited to 500 words.

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TSACO will consider publishing supplements. Supplement proposals should be submitted to the Editorial Office.

MANUSCRIPT PREPARATION

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- Details of related papers by the same author(s) already published or under consideration for publication
- If you previously submitted to *Journal of Trauma & Acute Care Surgery* and your article was rejected please include your previous manuscript ID

- Details of previous reviews of the submitted article
- IRB board approval statement if applicable

Copies of related papers, previous Editors' and reviewers' comments, and responses to those comments can be submitted using the File Designation "Supplementary file for Editors only". Editors encourage authors to submit previous communications to expedite the review process.

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- Full name, department, institution, city, country, email address of all co-authors
- Up to five keywords relevant to your manuscript
- Word count, excluding title page, abstract, references, figures and tables
- Unique clinical trial number and the name of the registry if applicable
- List of meetings at which the paper was presented, if any

MANUSCRIPT FORMAT

The manuscript must be submitted as a Word document. A PDF will not be accepted.

The manuscript should be presented in the following order:

- Title page
- Abstract (Note: references should not be included in abstracts). Structured Abstracts should be limited to 300 words and include the following subheads: Background, Methods, Results, Conclusions and Level of Evidence. Abstracts should indicate the study type (prognostic, therapeutic, diagnostic test, economic/decision) after level and three to five keywords.
- Main text separated under appropriate headings and subheadings (for content with structured abstracts: **Background, Methods, Results**, and **Discussion**) using the following hierarchy: **BOLD CAPS, bold lower case**, plain text, *italics*
- Tables should be in Word format and placed in the main text where the table is first cited. Tables must be cited in the main text in numerical order.
- Acknowledgments, Competing Interests, Funding and all other required statements
- References

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Ensure that the figure files are labeled with the correct File Designation of "Mono Image" for black and white figures and "Color Image" for color figures. Figures are checked using automated quality control and if they are below the minimum standard you will be alerted and asked to resupply them.

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Please list all authors. If a reference contains more than ten contributors, name only the first ten authors and then use et al. If a reference cites a consortium or mutli-center trials group, list up to ten authors followed by et al. and the official name of the study group.

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Shackford SR, Kahl JE, Calvo RY, Kozar RA, Haugen CE, Kaups KL, Willey M, Tibbs BM, Mutto SM, Rizzo AG, et al. Gunshot wounds and blast injuries to the face are associated with significant morbidity and mortality: results of an 11-year multi-institutional study of 720 patients. *J Trauma Acute Care Surg* 2014;**76**:347-52

Hargestam M, Lindkvist M, Jacobsson M, Brulin C, Hultin M. Trauma teams and time to early management during in situ trauma team training. *BMJ Open* 2016;**6**:e009911

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- **Diagnostic accuracy studies**: STARD guidelines
- **Quality improvement studies**: SQUIRE guidelines
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- **References**: Have all of the references been cited in the text?

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TSACO also defines duplicate publication, lack of declaration of competing interests and of funding/sponsorship, and other failures of transparency to be forms of misconduct.

Table 2 – Levels of Evidence

	Therapeutic/Care Management	Prognostic and Epidemiological	Diagnostic Tests or Criteria	Economic & Value-based Evaluations	Systematic Reviews & Meta-analyses
Level I	RCT with no negative criteria*	Prospective† study with large effect‡ and no negative criteria*	Testing of previously developed diagnostic criteria in consecutive patients (all compared to "gold" standard) and no negative criteria	Sensible costs and alternatives; values obtained from many sources; multi-way sensitivity analyses	Systematic Review (SR) or meta-analysis (MA) of predominantly level I studies and no SR/MA negative criteria§
Level II	• RCT with significant difference and only one negative criterion*• Prospective† comparative study without negative criteria*• Prospective/retrospective† study with large effect‡ and only one negative criterion*	• Prospective† study with less than large effect‡ and no negative criteria*• Untreated controls from RCT	Development of diagnostic criteria on consecutive patients (all compared to "gold" standard) and only one negative criterion	Sensible costs and alternatives; values obtained from limited sources; multi-way sensitivity analyses	SR/MA or predominantly level II studies with no SR/MA negative criteria§
Level III	• Case-control study without negative criteria*• Prospective† comparative study with only one negative criterion*• Retrospective† comparative study without negative criteria*	• Case-control study without negative criteria*• Prospective/retrospective† study with up to two negative criteria*	Non-consecutive patients (without consistently applied "gold" standard) with up to two negative criteria	Analyses based on limited alternatives and costs; poor estimates	SR/MA with up to two negative criteria§
Level IV	Prospective/retrospective† study using historical controls or having more than one negative criterion*	Prospective/retrospective† study with up to three negative criteria*	Case-control study with no negative criteria* or other designs with up to three negative criteria	No sensitivity analyses	SR/MA with more than two negative criteria§
Level V	• Case series • Studies with quality worse than level IV	• Case series • Studies with quality worse than level IV	No or poor "gold" standard		

***** Negative criteria decreasing level of evidence include: **(1)** <80% follow up; **(2)** >20% missing data or missing data not at random without proper use of missing data statistical techniques; **(3)** limited control of confounding (e.g., mortality comparisons with inadequate risk adjustment); **(4)** more than minimal bias (selection bias, publication bias, report bias, etc.); **(5)** heterogeneous populations (e.g., instructions with distinct protocols/patient volume, conditions caused by distinct pathogenic mechanisms); and **(6)** for RCT only, no blinding or improper randomization; **(7)** inadequate statistical power: this only applies to studies NOT finding statistical differences and it is defined as power <80% for declaring "failure to detect a significant difference" or power <90% for declaring "bio-equivalence or non-inferiority or comparative effectiveness" or Receiver Operating Characteristic curve <80% or both sensitivity and specificity <80%.

† Prospective versus retrospective: studies with data collected to answer predefined questions are prospective; studies with data collected for questions unrelated to the original question for which the data were gathered are retrospective.

‡ Large effect is defined as: **(1)** study with large RR (>5 or >0.2) about condition of low-to-moderate morbidity/mortality and **(2)** study with moderate-to-large RR (2-5 or 0.2-0.5) about condition of high morbidity/mortality.

§ Negative criteria for SR/MS (decreases level of evidence): **(1)** no or inadequate standard search protocol, **(2)** more than minor chance of publication bias or publication bias not assessed, **(3)** moderate heterogeneity of included studies and/or populations (e.g., elective operation and acute operation), **(4)** predominance of level III or lower studies, and **(5)** no measures or inappropriate measures of pooled risk (for meta-analysis only).

II Adequate statistical power: this only applies to studies not finding statistical differences, and it is defined as power 980% for declaring "failure to detect a significant difference" or power 990% for declaring "bioequivalence or noninferiority or comparative effectiveness."

In addition to the level, studies will receive a + to designate whether standard reporting format was followed (e.g., CONSORT for RCTs). Authors can find reporting guidelines for most studies at the international EQUATOR Network.