

### 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.

Submissions should be made through the journal's new [online submission system](#). Articles should not be under review or under consideration by any other journal when submitted to TSACO.

Although the editors and referees make every effort to ensure the validity of published manuscripts, the final responsibility rests with the authors, not with the journal, its editors, or the publisher.

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

Systematic Reviews document the selection, discovery, critique, and synthesis of evidence relevant to well-defined research questions. Please indicate inclusion of a meta-analysis in the title. Structured abstract should include background; objectives; data sources; study eligibility criteria, participants, and interventions; study appraisal and synthesis methods; results; limitations; conclusions and implications of key findings; systematic review registration number. [PRISMA](#) checklist should be followed throughout and the checklist included as a figure.

### 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.

### Supplements

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

### MANUSCRIPT PREPARATION

#### COVER LETTER

Your cover letter should inform the Editor of any special considerations regarding your submission, including but not limited to:

- 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

**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

- 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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Manuscripts authored or co-authored by one or more NIH employee must be submitted with a completed and signed NIH Publishing Agreement and Manuscript Cover Sheet according to [NIH's Employee Procedures](#).

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The title page must contain the following information:

- Title of the article
- Short title (running head) of not more than 45 characters
- Full name, highest academic degrees and affiliations, mailing address, e-mail and telephone number of the corresponding author
- 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

Images must be uploaded as separate files (view further details under the Figures/illustrations section). All images must be cited within the main text in numerical order and legends should be provided at the end of the manuscript.

Appendices should be uploaded using the File Designation "Supplementary File" and cited in the main text. Please remove any hidden text headers or footers from your file before submission.

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Abbreviations and symbols must be standard. Units of measure should be expressed in the metric system. SI units should be used throughout, except for blood pressure values, which should be reported in mm Hg. Temperatures should be expressed in degrees Celsius.

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### FIGURES/ILLUSTRATIONS

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Authors are encouraged to supply color illustrations; no additional charges apply.

### FILE TYPES

Figures should be submitted in TIFF or EPS format. JPEG files are acceptable in some cases. A minimum resolution of 300 dpi is required, except for line art, which should be 1200 dpi. Histograms should be presented in a simple, two-dimensional format, with no background grid.

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.

Please ensure that any specific patient/hospital details are removed or blacked out (e.g. X-rays, MRI scans, etc). Figures that use a black bar to obscure a patient's identity are NOT accepted and the standard is not to show a patient's face at all.

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Tables should be self-explanatory, and the data they contain must not be duplicated in the text or figures. Any tables that are longer/larger than 2 pages will not be typeset and will be published only as a supplementary file.

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References must be numbered sequentially as they appear in the text. References cited in figures or tables (or in their legends and footnotes) should be numbered according to the place in the text where that table or figure is first cited. Reference numbers in the text should be inserted immediately after punctuation (with no word spacing).

Where more than one reference is cited, these should be separated by a comma, for example, [1, 4, 39]. For sequences of consecutive numbers, provide the first and last number of the sequence separated by a hyphen, for example, [22-25]. References provided in this format are translated during the production process to superscript type and act as hyperlinks from the text to the quoted references in electronic forms of the article.

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References must be numbered consecutively in the order in which they are mentioned in the text.

Only papers published or in press should be included in the reference list. Personal communications or unpublished data must be cited in parentheses in the text with the name(s) of the source(s) and the year. Authors should request permission from the source to cite unpublished data.

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 multi-center trials group, list up to ten authors followed by et al. and the official name of the study group.

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### Sample References:

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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Additional figures and tables, methodology, raw data, etc., may be published online as supplementary material. If your paper exceeds the word count you should consider if any parts of the article could be published as supplementary material. Please note that these files will not be copyedited or typeset and will be published as supplied. Therefore, PDF files are preferred.

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Statistical analyses must explain the methods used.

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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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- Details of any co-authors (name, institution, city, country and email address)
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- Competing interest statement
- Contributorship statement

Additional information that may be required:

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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
<b>Level I</b>	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§
<b>Level II</b>	<ul style="list-style-type: none"> <li>• RCT with significant difference and only one negative criterion*</li> <li>• Prospective† comparative study without negative criteria*</li> <li>• Prospective/retrospective† study with large effect‡ and only one negative criterion*</li> </ul>	<ul style="list-style-type: none"> <li>• Prospective† study with less than large effect‡ and no negative criteria*</li> <li>• Untreated controls from RCT</li> </ul>	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§
<b>Level III</b>	<ul style="list-style-type: none"> <li>• Case-control study without negative criteria*</li> <li>• Prospective† comparative study with only one negative criterion*</li> <li>• Retrospective† comparative study without negative criteria*</li> </ul>	<ul style="list-style-type: none"> <li>• Case-control study without negative criteria*</li> <li>• Prospective/retrospective† study with up to two negative criteria*</li> </ul>	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§
<b>Level IV</b>	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§
<b>Level V</b>	<ul style="list-style-type: none"> <li>• Case series</li> <li>• Studies with quality worse than level IV</li> </ul>	<ul style="list-style-type: none"> <li>• Case series</li> <li>• Studies with quality worse than level IV</li> </ul>	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).

¶ 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 99% 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](#).