Journal of Oral and Maxillofacial Surgery

Notice to Contributors

The *Journal of Oral and Maxillofacial Surgery* (*JOMS*) publishes articles reflecting a wide range of ideas, results, and techniques, provided they are original, contribute new information, and meet the journal's standards of scientific thought, rational procedure, and literary presentation.

The *JOMS* uses EES, an online, electronic submission system. The Web site, http://ees.elsevier.com/joms, guides authors through the submission process. *JOMS* will be migrating to the EVISE submission system in 2017. Authors must specify the article type (full length article, perspectives, letter to the editor, etc.) and select from a set of classifications provided online.

Case reports. Routine case reports typically add little to our knowledge, but may be published if the report: *1)* contains new information; for example, new disease process, diagnostic technique or maneuver, treatment, or operative approach; or *2)* contains information that needs to be reinforced periodically; or *3)* includes a comprehensive review on a topic requiring an updated review; or *4)* reports an extremely unusual case.

Submissions to Perspective Section: Perspective articles represent succinct opinion pieces, survey results, and other shorter contributions that address various topics of relevance to oral-maxillofacial surgeons. These topics may include, for example, public policy, patient safety, health care or surgical trends, government actions, and commentaries on other subjects. Articles in this section are limited to no more than 1400 words, no more than 3 figures or tables, and no more than 5 references. Articles accepted for publication do not necessarily represent the views of the AAOMS or the editorial staff.

Correspondence. Authors may send queries concerning the submission process, manuscript status, or journal procedures to the Editorial Office at joms@aaoms.org. All correspondence, including the Editor's decision and request for revisions, will be via e-mail.

Letters to the Editor may be directed to the Editor-in-Chief: Dr James R. Hupp, Professor of Oral-Maxillofacial Surgery East Carolina University School of Dental Medicine and must be submitted via the EES system to be considered (http://ees.elsevier.com/joms).

Letters to the Editor must be in reference to a specific article or editorial that has been published by the JOMS on which you would like to comment; letters must be under 500 words (body of the letter, not including the references). One figure may accompany the letter if it is essential to understanding the subject. Please limit the number of references to fewer than 5.

Letters must be submitted within 8 weeks of the article's print publication or for online-only articles, within 8 weeks of the date they first appeared online.

Original articles are considered and accepted for publication on the condition that they have not been published in another journal or are not currently submitted or accepted for publication elsewhere. The Editor reserves the right to edit manuscripts to fit the space available and to ensure conciseness, clarity, and stylistic consistency.

Contributors to the *JOMS* must refer to the **Consort statement on clinical research design:** www.consort-statement.org and are expected to comply with its recommendations when reporting on a randomized clinical trial. When reporting observational studies, e.g. cohort or case-series, case-control, or cross-sectional studies the editors recommend that authors refer to the STROBE guidelines (http://www.strobe-statement.org/).

The *JOMS* requires compliance with the **World Medical Association Declaration of Helsinki** on medical research protocols and ethics. The *JOMS* requires **institutional review board** (IRB) approval of the study protocol of **all** prospective studies; retrospective studies and chart reviews may be granted exemption by an IRB by the author's institution or must be approved in accord with local IRB standards. The *JOMS* requires that a statement of such approval or exemption be provided in the Methods section of manuscripts. In some circumstances retrospective chart reviews may be considered without IRB review.

The Journal of Oral and Maxillofacial Surgery strongly encourages all interventional clinical trials be registered in a public trials registry that is in conformity with the International Committee of Medical Journal Editors (ICMJE). It is valuable to researchers hoping to eventually publish the results of their clinical trial to register their project at its inception since many major publications now require such registration in order for articles based on the investigation to be considered for acceptance. The Journal of Oral and Maxillofacial Surgery is considering implementing such a requirement. Registering a trial is easy, is free of charge, and helps improve scientific transparency among researchers, as well as for readers evaluating the results of clinical trials in peer-reviewed publications.

Trials can be registered in http://www.clinicaltrials.gov/ or in one of the registries meeting the ICMJE criteria that can be found listed at http://www.who.int/ictrp/network/primary/en/index.html

For example:

1) "This study was approved by the ___ Hospital IRB and all participants signed an informed consent agreement"; or
2) "This study followed the Declaration of Helsinki on medical protocol and ethics and the regional Ethical Review Board of ___ approved the study"; or
3) "Due to the retrospective nature of this study, it was granted an exemption in writing by the University of ___ IRB."

For authors in private practice, commercial or independent IRBs exist whose services should be sought; private practice does not exempt one from the responsibility to seek ethical approval of study protocols prospectively.

For studies featuring animal subjects, the *JOMS* requires confirmation that the research was approved by the appropriate animal care and use committee(s), and this information must be stated in the Methods section of the manuscript.

Declaration of Helsinki: http://www.wma.net/en/30publications/10policies/b3/index.html

Preparation of manuscripts. Submission of an article is the author's assurance that the article has not been accepted or published and is not under consideration by another publication.

Correct preparation of the manuscript by the author will expedite the reviewing and publication procedures. Authors who are not fluent in American English are strongly advised to seek help in the preparation of their manuscripts, in order to enhance the review process, improve the chance of acceptance, and greatly reduce the time until publication if the article is accepted.

Articles, including all tables, must be formatted in a recent version of Microsoft Word; the manuscript and references must be double-spaced. The use of appropriate subheadings throughout the body of the text (Abstract, Introduction, Methods, Results, and Discussion sections) is required. For ideas and suggestions to aid preparation of clinical research papers, consider this reference: Dodson TB. A guide for preparing a patient-oriented research manuscript. Oral Surg Oral Med Oral Pathol Oral Radiol Endod 104:307, 2007.

Abstracts are required for full-length and review articles. Abstracts should be submitted in the following format and must be limited to 250 words:

Purpose: One sentence background (if necessary) and one sentence purpose stated as a declarative sentence or as a research question: The investigators hypothesized [insert hypothesis statement].

Given the audience, commonly a background sentence is not necessary as it will be evident from the study purpose or research questions.

Methods: This can be as short as 5 or 6 declarative sentences: The investigators implemented a [insert type of study design]. The sample was composed of [describe eligible sample]. The predictor variable was... The outcome variable was... Other study variables were... Descriptive and bivariate statistics were computed and the *P* value was set at .05.

Results: This section can be as short as 2 sentences: The sample was composed of [insert sample size and a few representative descriptive statistics such as age and sex and any key differences between the study groups]. There was a statistically significant association between [insert the predictor and outcome variables and report the key statistics with *P* values and appropriate confidence intervals] after adjusting for [list other variables].

Conclusion: The results of this study suggest [insert key conclusion(s)]. Future studies will focus on [insert future research plans as indicated].

Examples of abstracts:

Example 1–Hypothesis driven patient-oriented research

After Dentoalveolar Surgery, Most Patients Are Satisfied With Telephone Follow-Up

Srinivas M. Susarla, DMD, MD, MPH, Rachel Black, Thomas B. Dodson, DMD, MPH

Purpose
To estimate patient satisfaction with telephone follow-up and compare the frequencies of postoperative complications between patients undergoing telephone and those undergoing clinical follow-up after ambulatory office-based dentoalveolar procedures.

Materials and Methods
Using a retrospective study design, the investigators enrolled a cohort of subjects who had had at least 1 tooth extracted during a 2-year period. The primary study variable was subject self-report of satisfaction with the telephone follow-up. For additional analyses, the predictor variable was follow-up type grouped as telephone versus clinical. The outcome variable was postoperative complications. To measure the relationships between the follow-up type and postoperative complications, bivariate and multiple logistic regression statistics were computed. $P < .05$ was considered significant.

Results
The sample was composed of 364 subjects, of whom 155 (42.6%) had received telephone follow-up. The sample's mean age was 28.6 $\pm$ 11.7 years, included 220 females (60.4%), and had had an average of 3.4 $\pm$ 2.1 teeth removed. The self-reported patient satisfaction rate with telephone follow-up was 95.9%. The overall complication frequency was 19.2%, with telephone follow-up subjects having a lower complication frequency (12.9%) than the clinical follow-up subjects (23.4%) ($P < .01$). After adjusting for differences between the 2 samples, no significant difference was found in the complication frequencies according to the method of follow-up ($P = .7$).

Conclusion
Patient satisfaction with telephone follow-up was high. The subjects scheduled for telephone follow-up had a complication rate that was similar to that of the clinical follow-up subjects.

Example 2–Literature Review type article

Do Perioperative Antibiotics Decrease Implant Failure?

Basel Sharaf, DDS, MD, Maher Jandali-Rifai, DMD, Srinivas M. Susarla, DMD, MD, MPH, Thomas B. Dodson, DMD, MPH

Purpose
To execute an evidence-based review answering the following question: "Among patients receiving dental implants, do those who receive perioperative antibiotic therapy, compared with those who do not, have a decreased likelihood of implant failure?"

Materials and Methods
We performed a literature review. The primary predictor variable was an antibiotic regimen, which was grouped into 3 categories: a single preoperative dose, a single preoperative dose and multiday postoperative therapy, and no antibiotic therapy. The primary and secondary outcome variables were implant failure and postoperative infection, respectively.

Results
Eight studies meeting the inclusion criteria were reviewed. Two studies assessed the effect of a single preoperative antibiotic dose and reported a reduction in implant failure by 1.3% to 2% compared with no antibiotics use. Two studies compared the effect of pre- and postoperative antibiotics and no antibiotic use and found a 4.2% decrease to 1.1% increase in the failure rates when antibiotics were used. Four studies considered the effect of different antibiotic regimens. Only 2 studies found a statistically significant reduction in implant failure (2.5% to 5.4%) when a single preoperative antibiotic dose was used in conjunction with multiday treatment, compared with postoperative multiday treatment only.

Conclusion
A single dose of preoperative antibiotic therapy may slightly decrease the failure rate of dental implants. However, the current data do not support the routine use of postoperative antibiotics, which can be tailored by the clinician to the patient's specific needs.

A **Title Page** must be included with each article that lists the title; the authors' names, degrees (e.g. DDS, DMD, PhD), titles (e.g. Professor, Department Head, Resident, Private Practitioner) and affiliations, and complete mailing address and telephone number, fax