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## Review

# An audit of best evidence topic reviews in the International Journal of Surgery



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## HIGHLIGHTS

- IJS has published best evidence topic reviews (BETs) since 2011.
- Adherence to the journal's BET guidelines is unknown.
- Adherence to guidelines has, mostly, been good.
- The quantity of citations to BETs is comparable to that of non-BET IJS articles.

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## ABSTRACT

**Introduction:** IJS launched best evidence topic reviews (BETs) in 2011, when the guidelines for conducting and reporting these reviews were published in the journal.

**Aims:** (1) Audit the adherence of all published BETs in IJS to these guidelines. (2) Assess the reach and impact of BETs published in IJS.

**Methods:** BETs published between 2011 and February 2014 were identified from <http://www.journal-surgery.net/>. Standards audited included: completeness of description of study attrition, and independent verification of searches. Other extracted data included: relevant subspecialty, duration between searches and publication, and between acceptance and publication. Each BET's number of citations (<http://scholar.google.co.uk/>), number of tweets (<http://www.altmetric.com/>) and number of Researchgate views (<https://www.researchgate.net/>) were recorded.

**Results:** Thirty-four BETs were identified: the majority, 19 (56%), relating to upper gastrointestinal surgery and none to cardiothoracic, orthopaedic or paediatric surgery. Twenty-nine BETs (82%) fully described study attrition. Twenty-one (62%) had independently verified search results. The mean times from literature searching to publication and acceptance to publication were 38.5 weeks and 13 days respectively. There were a mean 40 (range 0–89) Researchgate views/article, mean 2 (range 0–7) citations/article and mean 0.36 (range 0–2) tweets/article.

**Conclusions:** Adherence to BET guidelines has been variable. Authors are encouraged to adhere to journal guidelines and reviewers and editors to enforce them. BETs have received similar citation levels to other IJS articles. Means of increasing the visibility of published BETs such as social media sharing, conference presentation and deposition of abstracts in public repositories should be explored. More work is required to encourage more submissions from other surgical subspecialties other than gastrointestinal specialties.

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## 1. Introduction

Best evidence topic articles (BETs) are concise and pragmatic reviews that were developed to teach the principles of evidence based medicine (EBM) and to answer specific clinical questions faced in clinical practice, and for which meta-analysis with

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statistical pooling of available evidence was not feasible [1,2]. BET development follows a structured protocol by which the literature is searched and critically appraised to answer a 3-part clinical question. Emergency medicine BETs were first published in the *Journal of Accident and Emergency Medicine (now Emergency Medicine Journal)* in 1998 and since 2000 have also been listed on the BestBET website (<http://bestbets.org/>) [3]. The BET format has now been adopted by other specialties, and respective specialty-specific journals, including cardiothoracic surgery in *Interactive Cardiovascular and Thoracic Surgery (ICVTS)*, paediatrics in *Archives of Disease in Childhood* [4] and now surgery in the *International Journal of Surgery (IJS)* since 2011 [5].

*International Journal of Surgery* published a guide for authors wishing to submit BETs in 2011 [5]. The aim of this study was to audit the adherence of currently published surgical BETs to these guidelines. A secondary aim was to assess the reach and impact of these published BETs.

## 2. Methods

All BETs published in IJS were identified from the journal's website (<http://www.journal-surgery.net/>) in February 2014.

The subspecialty relating to each BET was recorded. Where more than one subspecialty was relevant, all relevant subspecialties were recorded.

The following data were recorded from each BET:

- number of databases searched;
- completeness of study attrition description;
- number of articles included;
- declared level of evidence of articles included (Table 1);
- whether search outcomes were independently verified.

The durations between the following dates were calculated from BETs:

- date when literature searches were performed and when articles were published online (*where the exact date was not recorded, the 1st of the month was used as an estimate*);
- date when articles were accepted and when articles were published online;
- For BETs that included level 1 articles, the time elapsed from when the latest level 1 article was published and the date the BET itself was published.

The following data were recorded as surrogates for the reach and impact of each BET:

- number of citations (via <http://scholar.google.co.uk/>);
- citation in textbooks and/or guidelines (via <http://scholar.google.co.uk/>);
- number of tweets (via <http://www.altmetric.com/>);
- number of Researchgate views (<https://www.researchgate.net/>);

- whether a BET had been presented at scientific conferences as declared by the authors.

Initial data collection was performed by a single author (SK) and independently verified by two authors (NTM and MDE).

## 3. Results

Thirty four BETs were published in IJS between 2011 and February 2014 (Table 2) [6–38] at a rate of 11.3 BETs/year. The majority of BETs [19/34 (56%)] related to upper gastrointestinal (UGI), followed by colorectal surgery (14%) (Fig. 1). The 19 UGI BETs consisted of 16 (47% of all 34 BETs) oesophagogastric and 3 (9% of all 34 BETs) hepatobiliary surgery (HPB) articles. There were no BETs relating to cardiothoracic, orthopaedic or paediatric surgery.

Thirty out of the 34 BETs (88.2%) performed literature searches using Medline only. Twenty-eight BETs (82%) fully described the attrition of studies from the initial search results to included studies i.e. how they arrived at their final list of included studies. The search results of 21 (62%) BETs had been verified by a second author.

Thirty-two BETs reported the month and year when searches were performed. Of these, the median time taken from when searches were performed to when articles were published online was 35 weeks (range 2–112 weeks). The median time taken for accepted BETs to be published online was 11 days (range 5–57).

The mean number of articles included per BET was 6 (range 2–13). Of the total 209 papers included for analysis in all BETs, 14 (6.7%) were level 1, 72 (34.4%) were level 2, 82 (39.2%) were level 3 and 41 (19.6%) were level 4 studies. There were no level 5 studies included in any of the BETs. The median duration between publication of level 1 articles included in BETs and the BETs themselves was 829 days (range 124–1505).

All BETs were listed on Researchgate with a mean of 40 views/BET (range 0–89). There were a mean 0.36 tweets/article (range 0–2). The mean number of citations/BET was 2 (range 0–7). One BET had been cited in a textbook and two in guidelines (Table 2).

Only three (8.8%) BETs were presented at conferences prior to submission, according to authors' disclosures.

## 4. Discussion

The majority of BETs have addressed gastrointestinal surgery topics. A potential explanation for this is that general surgery is a large subspecialty with, potentially, a larger pool of authors. A potential explanation for the lack of cardiothoracic BETs is that ICVTS has been publishing cardiothoracic-related BETs since 2003 and cardiothoracic surgeons may therefore perceive this cardiothoracic-specific journal to be more suited to their submissions. There is a need to actively promote BETs in other subspecialties as the EBM principles used in BETs are relevant to all surgeons.

### 4.1. Levels of evidence

The finding in this audit that evidence level 3 articles are most

**Table 1**  
Oxford Level of Evidence Scale for studies therapeutic efficacy [2].

Level of evidence	Eligible articles
1	Systematic reviews of homogenous randomised controlled trials (RCTs) with and well-designed RCTs with narrow confidence interval
2	Systematic reviews of homogenous cohort studies, outcomes research and individual cohort studies (including low quality RCTs)
3	Individual case-control studies and systematic reviews of homogenous case-control studies
4	Case-series, poor quality cohort studies and poor quality case-control studies
5	Expert opinion articles

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