

# The Obstetrician & Gynaecologist

## Instructions for Authors

Please note that, with the exception of Letters to the Editor, all journal articles are commissioned solely by the Editorial Board. However, if you would like to make a contribution, you should email your idea to the Editorial Office in the form of a synopsis of the proposed article (max 200 words) ([tog@rcog.org.uk](mailto:tog@rcog.org.uk)) together with details of your qualifications and your experience in the relevant area. Please note that all papers require at least one author to be at consultant level or equivalent in their specialty.

### Requirements for submission

The requirements for each type of article are detailed below. If you are unsure what is required for your particular submission, please refer to your commissioning letter or contact the Editorial Office ([tog@rcog.org.uk](mailto:tog@rcog.org.uk)) for further details. Please note that author photographs are no longer required.

### Title

Titles should be succinct and accurately represent the content of the article. There should be no more than 100 keystrokes (letters and spaces). The first version of your title may not be the final version: an apposite title requires careful thought and editing.

### Abstracts

All papers except Practice Points, Book Reviews and Letters to the Editor require a structured abstract up to 100 words in length in the following format:

- 1 Up to five bulleted ‘information points’ summarising the key content of the article**
- 2 Up to three bulleted ‘objectives’: these are pointers as to what anyone reading the article could reasonably hope to learn from it**
- 3 Up to three bulleted ethical issues raised specifically by the article or associated with the subject matter in general**

### Keywords

For all papers except Practice Points, Book Reviews and Letters, please list up to five keywords for indexing purposes.

### Types of article

Please note: WE DO NOT PUBLISH CASE REPORTS.

#### *Reviews*

These are up to 2500 words in length, with up to 25 references and 5 keywords. Reviews are articles discussing topics that are of importance to doctors working in obstetrics and gynaecology. They must be accompanied by 25 CPD questions (see ‘CPD questions’ section below).

#### *Clinical Governance*

These are usually between 2000-2500 words in length, with up to 25 references and 5 keywords. They must be accompanied by 25 CPD questions (see ‘CPD questions’ section below). Clinical governance articles aim to help obstetricians and gynaecologists to identify and reduce the risk of error resulting from clinical or organisational mistakes.

### *Education*

These are usually between 2000-2500 words in length, with up to 25 references. These articles concern current issues in the education and training of obstetricians and gynaecologists.

### *Ethics*

These are usually 1500-2000 words in length, with up to 25 references.

### *SAC Reviews*

These are up to 1500 words, with up to 20 references and 5 keywords. SAC reviews are commissioned and peer reviewed by the RCOG's Scientific Advisory Committee and not by TOG's Editorial Board.

### *Global Perspectives*

These can be up to 1500 words, with up to 20 references and 5 keywords. These articles relate to aspects of obstetrics and gynaecology as practised outside the UK and from a 'non-UK' perspective.

### *From the Consumers' Forum*

These can be up to 1500 words, with up to 10 references and 5 keywords. These articles are commissioned and peer reviewed by the Consumers' Forum of the RCOG and not TOG's Editorial Board.

### *New Developments*

These can be up to 1500 words, with up to 10 references and 5 keywords. New developments articles discuss advances in obstetrics and gynaecology - for example, in surgery and drug therapy. These articles are peer reviewed by the Editorial Board only.

### *Views and Counter Views*

These are about 1500-2000 words long, with up to 10 references and 5 keywords. In this section authors are invited to express their personal opinion about a subject and to argue why they believe they are right and perceived wisdom is wrong.

### *Lessons from Practice*

These can be up to 1500 words, with up to 10 references and 5 keywords. These articles should highlight interesting or difficult situations that have medico-legal or ethical implications. The resultant issues for clinical practice should be discussed, including the lessons that can be drawn to optimise current best practice. Case reports are not acceptable.

### *Practice Points*

These can be up to 400 words in length, with not more than one figure and up to 5 references and 5 keywords. They are short articles about ideas that will be of practical help to those working in obstetrics and gynaecology.

### *Book Reviews*

Authors should provide a review of up to 500 words in length. These are usually commissioned.

### *Letters and Emails to the Editor*

These can be up to 500 words in length. They can be in the form of a standard letter or simply sent as an email. They can be emailed or posted to the TOG Editorial Office. Authors are given the automatic right to reply to any correspondence about their articles before the correspondence is published.

### **Recommended websites**

If you would like to recommend any website(s) that are relevant to the topic covered by your article, but not referred to in your article (and therefore not included in your reference list), please list these separately, below your reference list, under a heading 'Recommended websites'.

### **Peer review**

All articles published in TOG are subject to peer review. On initial submission, the Editor-in-Chief and at least one member of the Editorial Board will review the article to decide whether or not it is broadly suitable. At this stage, revisions may be requested prior to external peer review. Most manuscripts are then reviewed by two peer reviewers who are not Editorial Board members. Articles in the 'Ethics' section are reviewed by the Editors and one external reviewer unless additional expert opinion is required by the Editors. Articles in the 'New Developments' and 'Views and Counter Views' sections are reviewed only by the Editors unless they require further expert opinion. Where there is disagreement, the Editor-in-Chief's decision is final.

### **CPD questions**

All reviews and clinical governance articles must be accompanied by 25 True/False style questions for the CPD component of the journal. All questions must have the answers listed and they must be accompanied by short discussions explaining each answer. Authors must ensure that the questions can be answered directly from the article and that further reading is not required in order to arrive at the correct answer. Guidelines and examples of CPD questions can be found at the end of this document.

### **Guidelines for submission**

The online manuscript submission system facilitates both the submission and peer review of articles, speeding up the process and allowing you to view the progress of your article from submission through to the Editor-in-Chief's final decision. We ask that, if at all possible, you use the online system, details of which will have been sent in your commissioning letter. Once submitted, it is important that the email address for the corresponding author is correct and updated as necessary, as all correspondence will go to that email address. Authors also need to make sure that all authors involved in writing the article have been included and that their consent for publication has been obtained. Please make sure that any conflict of interest has been declared.

A hard (paper) copy of the text may be required to check for formatting problems.

Artwork, figures and tables should be submitted as separate items but in DIGITAL (electronic) format.

### **We also need:**

**A completed copyright assignment form** signed by the corresponding or senior author on behalf of the other authors, to accompany all commissioned contributions. Copyright assignment forms are available from the editorial office ([tog@rcog.org.uk](mailto:tog@rcog.org.uk)) if you have not already been sent one.

At the point where the article is submitted electronically, the authors will be required to complete a 'conflict of interest' section.

Hard copies of figures, if requested, can be sent to the Editorial Office at the following address:

*The Obstetrician & Gynaecologist*  
Publications Department  
Royal College of Obstetricians and Gynaecologists  
27 Sussex Place, Regent's Park  
London NW1 4RG

### **Guidelines for writing CPD questions (required for all full-length reviews and clinical governance articles)**

The following hints are intended to help those setting True/False questions (CPD questions) for *The Obstetrician & Gynaecologist*. An example is included at the end.

1. Avoid using imprecise terms such as 'rare, uncommon, usually, often, etc'. Give an approximate percentage (see point 3 below).
2. Avoid using absolute terms such as 'always, never, sole, maybe, could, can etc.'
3. Percentages should never be given precisely. Use phrases such as 'up to', 'approximately', 'about' 'less than', 'more than' etc.
4. Avoid double negatives.
5. Majority or most means over 50%.
6. Do not use abbreviations unless they are defined.
7. Double-barrelled items containing two pieces of information must be avoided, e.g. 'Resolution of symptoms and restoration of the lung function tests lead to ...'
8. When setting questions, the first item is most commonly true. It is only later that the writer thinks of false items. It is wise, therefore, to scramble the items.
9. Biochemical measurements should be expressed as 'serum levels of '.... or 'serum concentrations', e.g. not 'Ca125 is elevated...'
10. The stem plus the item (twig) should form a grammatical sentence.
11. You may have as many or as few stems as you like. These do not count in the numbering. 'Twigs' should be numbered 1–25.

**Please note:** 25 questions (twigs) are needed for each article (on any number of stems – these are not counted).

### **Example CPD questions**

**Please note:** This example gives you six questions from one stem and four from another. You may have any number of stems, as long as your total number of questions adds up to 25. It is best to avoid having more than ten twigs to any one stem. Please also take care not to repeat stems.

### **Question (stem and twigs)**

### Following vaginal delivery,

- 1 greater than 50% of women have symptoms of anal incontinence. **FALSE**
- 2 about one-third of primiparous women have evidence of anal sphincter defect on anal endosonography six weeks after delivery. **TRUE**
- 3 about one-third of women suffer symptoms of urinary incontinence three months postpartum. **TRUE**
- 4 women are at greater risk of placenta praevia in a subsequent pregnancy than women who have had a caesarean section. **FALSE**
- 5 women delivered by forceps are at a lower risk of developing an anal sphincter defect than women undergoing a spontaneous vaginal delivery. **FALSE**
- 6 women are more likely to have symptoms of urinary incontinence than women who have had an elective caesarean section. **TRUE**

### Discussion

Vaginal delivery is associated with symptoms of anal incontinence postpartum in up to 22% of all primiparous women.<sup>1</sup> Two studies have shown that one-third of all primiparous women have evidence of an anal sphincter defect on anal endosonography six weeks postpartum<sup>1,2</sup> and this is more likely to occur following a forceps delivery (80%).<sup>2</sup> Urinary incontinence has been reported to affect 34% of women, when questioned three months postpartum, however, there was a significant reduction in the prevalence of incontinence in women who had a caesarean section.<sup>3</sup>

Caesarean section is associated with an increased risk of placenta praevia<sup>4</sup> in subsequent pregnancies and this risk rises in accordance with the number of previous caesarean sections.<sup>5</sup>

### The following are true statements about risks to the fetus in pregnancy and/or delivery:

- 7 The risk of unexpected antepartum stillbirth doubles from 37 weeks gestation to 43 weeks gestation. **FALSE**
- 8 The risk of fetal death from intrapartum events for babies weighing at least 1.5 kg is approximately 1 in 5000. **FALSE**
- 9 Intrapartum events account for 50% of all cases of neonatal ischaemic encephalopathy. **FALSE**
- 10 Pain and trauma experienced by the baby during labour and delivery have been associated with a risk of suicide by violent means in adult life. **TRUE**

### Discussion

The risk of unexpected antepartum stillbirth increases as gestation advances. Hilder *et al.* have demonstrated an eight-fold increased risk of unexpected antepartum stillbirth from 0.7 per 1000 ongoing pregnancies at 37 weeks of gestation to 5.8 per 1000 ongoing pregnancies at  $\geq 43$  weeks of gestation.<sup>6</sup> The risk of death of babies weighing at least 1.5 kg from intrapartum events is 1 in 1561.<sup>7</sup> Intrapartum events account for 15% of all cases of neonatal hypoxic ischaemic encephalopathy (i.e. 1 in 1780 deliveries).<sup>8</sup> A Swedish study by Jacobsen *et al.* demonstrated an association between pain and trauma at the time of labour and delivery with risk of suicide by violent means in adult life.<sup>9</sup>

### References

1. Fynes M, Donnelly V, Behan M, O'Connell PR, Herlihy CO. Effect of second vaginal delivery on anorectal physiology and faecal incontinence: a prospective study. *Lancet* 1999;**354**:983–6.
2. Sultan AH, Kamm MA, Hudson CN, Thomas JM, Bartram CI. Anal sphincter disruption during vaginal delivery. *N Engl J Med* 1993;**329**:1905–11.
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4. Taylor VM, Kramer MD, Vaughan TL, Peacock S. Placenta praevia and prior caesarean delivery: how strong is the association? *Obstet Gynecol* 1994;**84**:55–7.
5. Ananth CV, Smulian JC, Vintzileos AM. The association of placenta praevia with history of caesarean delivery and abortion: a metaanalysis. *Am J Obstet Gynecol* 1997;**177**:1071–8.
6. Hilder L, Costeloe K, Thilaganathan B. Prolonged pregnancy:evaluating gestation-specific risks of fetal and infant mortality. *Br J Obstet Gynaecol* 1998;**105**:169–73.
7. Maternal and Child Health Research Consortium. *Confidential Enquiry into Stillbirths and Deaths in Infancy 4<sup>th</sup> Annual Report*. Maternal and Child Health Research Consortium: London; 1997.
8. Adamson SJ, Alessandri LM, Burton PR, Pemberton PJ, Stanley F. Predictors of neonatal encephalopathy in full-term infants. *BMJ* 1995; **311**:598–602.
9. Jacobson B, Bygdeman M. Obstetric care and proneness of offspring to suicide as adults: case-control study. *BMJ* 1998;**317**:1346–9.