

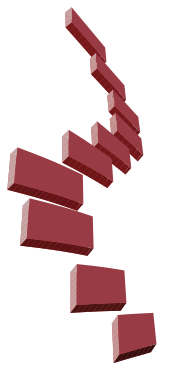
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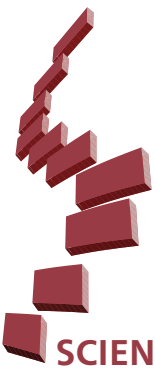
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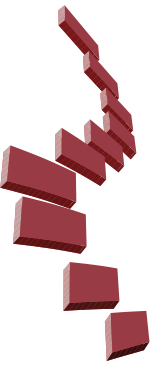
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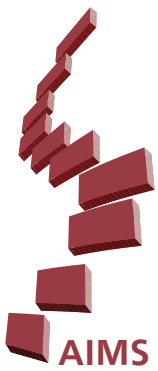
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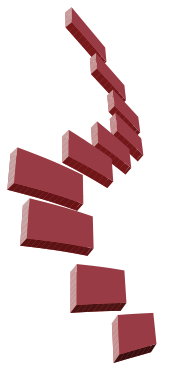
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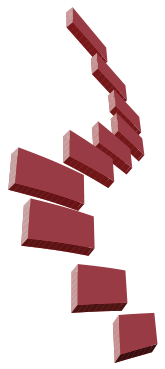
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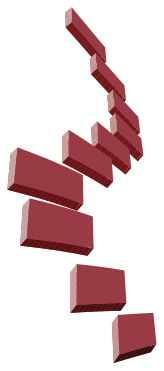
The "Level of Evidence" should certainly be indicated in the title page (see Table-1 in the appendix). Also, the field of study should be pointed out as outlined in Table-2 (maximum three fields).

- **Abstract:** A150 to 250 word abstract should be included at the second page. The abstract should be written in English and for all articles. The main topics to be included in Abstract section are as follows: Background Data, Purpose, Materials- Methods, Results and Conclusion. The Abstract should be identical in meaning. Generally, an Abstract should be written after the entire manuscript is completed. The reason relates to how the process of writing changes thought and perhaps even purpose. Only after careful consideration of the data and a synthesis of the literature can author(s) write an effective abstract. Many readers now access medical and scientific information via Web-based databases rather than browsing hard copy material. Since the reader's introduction occurs through titles and abstracts, substantive titles and abstracts more effectively capture a reader's attention regardless of the method of access. Whether reader will examine an entire article often will depend on an abstract with compelling information. A compelling Abstract contains the questions or purposes, the methods, the results (most often quantitative data), and the conclusions. Each of these may be conveyed in one or two statements. Comments such as "this report describes..." convey little useful information.

- **Keywords :** Standard wording used in scientific indexes and search engines should be preferred. The minimum number for keywords is three and the maximum is five.

- **Introduction (250 – 750 words):** It should contain information on historical literature data on the relevant issue; the problem should be defined; and the objective of the study along with the problem-solving methods should be mentioned.

Most studies, however, are published to: (1) report entirely novel findings (frequently case reports, but sometimes substantive basic or clinical studies); (2) confirm previously reported work (eg, case reports, small preliminary series) when such confirmation remains questionable; and (3) introduce or address controversies in the literature when data and/or conclusions conflict. Apart from reviews and other special articles, one of these three purposes generally should be apparent (and often explicit) in the Introduction.



INSTRUCTIONS to AUTHORS

The first paragraph should introduce the general topic or problem and emphasize its importance, a second and perhaps a third paragraph should provide the rationale of the study, and a final paragraph should state the questions, hypotheses, or purposes.

One may think of formulating rationale and hypotheses as Aristotelian logic (a modal syllogism) taking the form: If A, B, and C, then D, E, or F. The premises A, B, and C, reflect accepted facts, whereas D, E, or F reflect logical outcomes or predictions. The premises best come from published data, but when data are not available, published observations (typically qualitative), logical arguments or consensus of opinion can be used. The strength of these premises is roughly in descending order from data to observations or argument to opinion. D, E, or F reflects logical consequences. For any set of observations, any number of explanations (D, E, or F) logically follows. Therefore, when formulating hypotheses (explanations), researchers designing experiments and reporting results should not rely on a single explanation.

With the rare exception of truly novel material, when establishing rationale authors should generously reference representative (although not necessarily exhaustive) literature. This rationale establishes the novelty and validity of the questions and places it within the body of literature. Writers should merely state the premises with relevant citations (superscripted) and avoid describing cited works and authors' names. The exceptions to this approach include a description of past methods when essential to developing rationale for a new method, or a mention of authors' names when important to establish historical precedent. Amplification of the citations may follow in the Discussion when appropriate. In establishing a rationale, new interventions of any sort are intended to solve certain problems. For example, new implants (unless conceptually novel) typically will be designed according to certain criteria to eliminate problems with previous implants. If the purpose is to report a new treatment, the premises of the study should include those explicitly stated problems (with quantitative frequencies when possible), and they should be referenced generously.

The final paragraph logically flows from the earlier ones, and should explicitly state the questions or hypotheses to be addressed in terms of the study (independent, dependent) variables. Any issue not posed in terms of study variables cannot be addressed meaningfully. Focus of the report relates to focus of these questions, and the report should avoid questions

for which answers are well described in the literature (e.g., dislocation rates for an implant designed to minimize stress shielding). Only if there are new and unexpected information should data be reported apart from that essential to answer the stated questions.

- Materials - Methods (1000-1500 words): Epidemiological/demographic data regarding the study subjects; clinical and radiological investigations; surgical technique applied; evaluation methods; and statistical analyses should be described in detail.

In principle, the Materials and Methods should contain adequate detail for another investigator to replicate the study. In practice, such detail is neither practical nor desirable because many methods will have been published previously (and in greater detail), and because long descriptions make reading difficult. Nonetheless, the Materials and Methods section typically will be the longest section. When reporting clinical studies, authors must state approval of the institutional review board or ethics committees according to the laws and regulations of their countries. Informed consent must be stated where appropriate. Such approval should be stated in the first paragraph of Materials and Methods. At the outset, the reader should grasp the basic study design. Authors should only briefly describe and reference previously reported methods. When authors modify those methods, the modifications require additional description.

In clinical studies, the patient population and demographics should be outlined at the outset. Clinical reports must state inclusion and exclusion criteria and whether the series is consecutive or selected; if selected, criteria for selection should be stated. The reader should understand from this description all potential sources of bias such as referral, diagnosis, exclusion, recall, or treatment bias. Given the expense and effort for substantial prospective studies, it is not surprising that most published clinical studies are retrospective.

Such studies often are criticized unfairly for being retrospective, but that does not negate the validity or value of a study. Carefully designed retrospective studies provide most of the information available to clinicians. However, authors should describe potential problems such as loss to follow-up, difficulty in matching, missing data, and the various forms of bias more common with retrospective studies.

If authors use statistical analysis, a paragraph should appear at the end of Materials and Methods stating all statistical tests used. When multiple tests are used, authors should state which



INSTRUCTIONS to AUTHORS

tests are used for which sets of data. All statistical tests are associated with assumptions, and when it is not obvious the data would meet those assumptions, the authors either should provide the supporting data (e.g., data are normally distributed, variances in groups are similar) or use alternative tests. Choice of level of significance should be justified. Although it is common to choose a level of alpha of 0.05 and a beta of 0.80, these levels are somewhat arbitrary and not always appropriate. In the case where the implications of an error are very serious (e.g., missing the diagnosis of cancer), different alpha and beta levels might be chosen in the study design to assess clinical or biological significance.

- Results (250-750 words): "Results" section should be written in an explicit manner, and the details should be described in the tables. The results section can be divided into sub-sections for a more clear understanding.

If the questions or issues are adequately focused in the Introduction section, the Results section needs not to belong. Generally, one may need a paragraph or two to persuade the reader of the validity of the methods, one paragraph addressing each explicitly raised question or hypothesis, and finally, any paragraphs to report new and unexpected findings. The first (topic) sentence of each paragraph should state the point or answer the question. When the reader considers only the first sentence in each paragraph in Results, the logic of the authors' interpretations should be clear. Parenthetical reference to all figures and tables forces the author to textually state the interpretation of the data; the important material is the authors' interpretation of the data, not the data.

Statistical reporting of data deserves special consideration. Stating some outcome is increased or decreased (or greater or lesser) and parenthetically stating the p (or other statistical) value immediately after the comparative terms more effectively conveys information than stating something is or is not statistically significantly different from something else (different in what way? the reader may ask). Additionally, avoiding the terms 'statistically different' or 'significantly different' lets the reader determine whether they will consider the statistical value biologically or clinically significant, regardless of statistical significance.

Although a matter of philosophy and style, actual p values convey more information than stating a value less than some preset level. Furthermore, as Motulsky notes, "When you read that a result is not significant, don't stop thinking... First, look at the confidence interval... Second, ask about the power of

the study to find a significant difference if it were there." This approach will give the reader a much greater sense of biological or clinical significance.

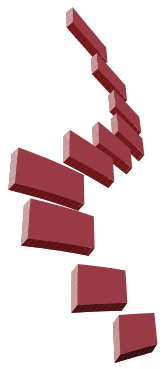
- Discussion (750 - 1250 words): The Discussion section should contain specific elements: a restatement of the problem or question, an exploration of limitations and assumptions, a comparison and/or contrast with information (data, opinion) in the literature, and a synthesis of the comparison and the author's new data to arrive at conclusions. The restatement of the problem or questions should only be a brief emphasis. Exploration of assumptions and limitations are preferred to be next rather than at the end of the manuscript because the interpretation of what will follow depends on these limitations. Failure to explore limitations suggests the author(s) either do not know or choose to ignore them, potentially misleading the reader. Exploration of these limitations should be brief, but all critical issues must be discussed, and the reader should be persuaded they do not jeopardize the conclusions.

Next, the authors should compare and/or contrast their data with data reported in the literature. Generally, many of these reports will include those cited as a rationale in the Introduction. Because of the peculiarities of a given study the data or observations might not be strictly comparable to that in the literature, it is unusual that the literature (including that cited in the Introduction as rationale) would not contain at least trends. Quantitative comparisons most effectively persuade the reader that the data in the study are "in the ballpark," and tables or figures efficiently convey that information. Discrepancies should be stated and explained when possible; when an explanation of a discrepancy is not clear that also should be stated. Conclusions based solely on data in the paper seldom are warranted because the literature almost always contains previous information.

Finally, the author(s) should interpret their data in light of the literature. No critical data should be overlooked because contrary data might effectively refute an argument. That is, the final conclusions must be consistent not only with the new data presented, but also that in the literature.

- Conclusion: The conclusions and recommendations by the authors should be described briefly. Sentences containing personal opinions or hypotheses that are not based on the scientific data obtained from the study should be avoided.

- References: References are numbered (Arabic numerals) consecutively in the order in which they appear in the text (note



INSTRUCTIONS to AUTHORS

that references should not appear in the abstract) and listed double-spaced at the end of the manuscript. The preferred method for identifying citations in the text is using within parentheses. Use the form of the "Uniform Requirements for Manuscripts" (<http://www.icmje.org/about-icmje/faqs/icmje-recommendations/>). If the number of authors exceeds seven, list first 6 authors followed by et al.

Use references found published in peer-reviewed publications that are generally accessible. Unpublished data, personal communications, statistical programs, papers presented at meetings and symposia, abstracts, letters, and manuscripts submitted for publication cannot be listed in the references. Papers accepted by peer-reviewed publications but not yet published ("in press") are not acceptable as references.

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Please note the following examples of journal, book and other reference styles:

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Berk H, Akçalı Ö, Kiter E, Alıcı E. Does anterior spinal instrument rotation cause rethrolisthesis of the lower instrumented vertebra? J Turk Spinal Surg. 1997;8:5-9.

Book chapter:

Wedge IH, Kirkaldy-Willis WH, Kinnard P. Lumbar spinal stenosis. Chapter 5. In: Helfet A, Grubel DM (Eds.). Disorders of the Lumbar Spine. JB Lippincott, Philadelphia 1978;pp:61-8.

Entire book:

Paul LW, Juhl IH (Eds.). The Essentials of Roentgen Interpretation. Second Edition, Harper and Row, New York 1965;pp:294-311.

Book with volume number:

Stauffer ES, Kaufer H, Kling THF. Fractures and dislocations of the spine. In: Rock-wood CA, Green DP (Eds.). Fractures in Adults. Vol. 2, JB Lippincott, Philadelphia 1984;pp:987-1092.

Journal article in press:

Arslantaş A, Durmaz R, Coşan E, Tel E. Aneurysmal bone cysts of the cervical spine. J Turk Spinal Surg. (In press).

Book in press :

Condon RH. Modalities in the treatment of acute and chronic low back pain. In: Finnison BE (Ed.). Low Back Pain. JB Lippincott (In press).

Symposium:

Raycroft IF, Curtis BH. Spinal curvature in myelomeningocele: natural history and etiology. Proceedings of the American Academy of Orthopaedic Surgeons Symposium on Myelomeningocele, Hartford, Connecticut, November 1970, CV Mosby, St. Louis 1972;pp:186-201.

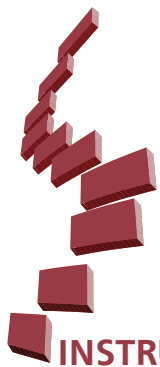
Papers presented at the meeting:

Rhoton AL. Microsurgery of the Arnold-Chiari malformation with and without hydromyelia in adults. Presented at the Annual Meeting of the American Association of Neuro-logical Surgeons, Miami, Florida, April 7, 1975.

- Tables: They should be numbered consecutively in the text with Arabic numbers. Each table with its number and title should be typed on a separate sheet of paper. Each table must be able to stand alone; all necessary information must be contained in the caption and the table itself so that it can be understood independent from the text. Information should be presented explicitly in "Tables" so that the reader can obtain a clear idea about its content. Information presented in "Tables" should not be repeated within the text. If possible, information in "Tables" should contain statistical means, standard deviations, and t and p values for possibility. Abbreviations used in the table should be explained as a footnote.

Tables should complement not duplicate material in the text. They compactly present information, which would be difficult to describe in text form. (Material which may be succinctly described in text should rarely be placed in tables or figures.) Clinical studies for example, often contain complementary tables of demographic data, which although important for interpreting the results, are not critical for the questions raised in the paper. Well focused papers contain only one or two tables or figures for every question or hypothesis explicitly posed in the Introduction section. Additional material may be used for unexpected results. Well-constructed tables are self-explanatory and require only a title. Every column contains a header with units when appropriate.

- Figures: All figures should be numbered consecutively throughout the text. Each figure should have a label pasted on its back indicating the number of the figure, an arrow to show the top edge of the figure and the name of the first author. Black-and-white illustrations should be in the form of glossy prints (9x13 cm). The letter size on the figure should be large enough to be readable after the figure is reduced to its actual printing size. Unprofessional typewritten characters are not



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accepted. Legends to figures should be written on a separate sheet of paper after the references.

The journal accepts color figures for publication if they enhance the article. Authors who submit color figures will receive an estimate of the cost for color reproduction. If they decide not to pay for color reproduction, they can request that the figures be converted to black and white at no charge. For studies submitted by electronic means, the figures should be in jpeg and tiff formats with a resolution greater than 300 dpi. Figures should be numbered and must be cited in the text.

- Style: For manuscript style, American Medical Association Manual of Style (9th edition). Stedman's Medical Dictionary (27th edition) and Merriam Webster's Collegiate Dictionary (10th edition) should be used as standard references. The drugs and therapeutic agents must be referred by their accepted generic or chemical names, without abbreviations. Code numbers must be used only when a generic name is not yet available. In that case, the chemical name and a figure giving the chemical structure of the drug should be given. The trade names of drugs should be capitalized and placed in parentheses after the generic names. To comply with trademark law, the name and location (city and state/country) of the manufacturer of any drug, supply, or equipment mentioned in the manuscript should be included. The metric system must be used to express the units of measure and degrees Celsius to express temperatures, and SI units rather than conventional units should be preferred.

The abbreviations should be defined when they first appear in the text and in each table and figure. If a brand name is cited, the manufacturer's name and address (city and state/country) must be supplied.

The address, "Council of Biology Editors Style Guide" (Council of Science Editors, 9650 Rockville Pike, Bethesda, MD 20814) can be consulted for the standard list of abbreviations.

-Acknowledgments: Note any non-financial acknowledgments. Begin with, "The Authors wish to thank..." All forms of support, including pharmaceutical industry support should also be stated in the Acknowledgments section.

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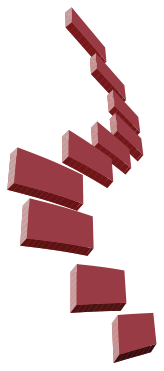
- Practical Tips:

1. Read only the first sentence in each paragraph throughout the text to ascertain whether those statements contain all critical material and the logical flow is clear.
2. Avoid in the Abstract comments such as, "... this report describes..." Such statements convey no substantive information for the reader.
3. Avoid references and statistical values in the Abstract.
4. Avoid using the names of cited authors except to establish a historical precedent. Instead, indicate the point in the manuscript by providing citation by superscribing.
5. Avoid in the final paragraph of the Introduction purposes such as, "... we report our data..." Such statements fail to focus the reader's (and author's!) attention on the critical issues (and do not mention study variables).
6. Parenthetically refer to tables and figures and avoid statements in which a table of the figure is either subject or object of a sentence. Parenthetic reference places interpretation of the information in the table or figure and not the table or figure.
7. Regularly count words from the Introduction through Discussion.

TABLE-1. LEVELS OF EVIDENCE

LEVEL- I.

- 1) Randomized, double-blind, controlled trials for which tests of statistical significance have been performed
- 2) Prospective clinical trials comparing criteria for diagnosis, treatment and prognosis with tests of statistical significance where compliance rate to study exceeds 80%
- 3) Prospective clinical trials where tests of statistical significance for consecutive subjects are based on predefined criteria and a comparison with universal (gold standard) reference is performed
- 4) Systematic meta-analyses which compare two or more studies with Level I evidence using pre-defined methods and statistical comparisons.
- 5) Multi-center, randomized, prospective studies



INSTRUCTIONS to AUTHORS

LEVEL – II.

- 1) Randomized, prospective studies where compliance rate is less than 80%
- 2) All Level-I studies with no randomization
- 3) Randomized retrospective clinical studies
- 4) Meta-analysis of Level-II studies

LEVEL– III.

- 1) Level-II studies with no randomization (prospective clinical studies etc.)
- 2) Clinical studies comparing non-consecutive cases (without a consistent reference range)
- 3) Meta-analysis of Level III studies

LEVEL- IV.

- 1) Case presentations
- 2) Case series with weak reference range and with no statistical tests of significance

LEVEL – V.

- 1) Expert opinion and review articles
- 2) Anecdotal reports of personal experience regarding a study, with no scientific basis

TABLE-2. CLINICAL AREAS

Anatomy

1. Morphometric analysis

Anesthesiology

Animal study

Basic Science

1. Biology
2. Biochemistry
3. Biomaterials
4. Bone mechanics
5. Bone regeneration
6. Bone graft
7. Bone graft substitutes
8. Drugs

Disc

1. Disc Degeneration
2. Herniated Disc
3. Disc Pathology
4. Disc Replacement
5. IDET

Disease/Disorder

1. Congenital
2. Genetics
3. Degenerative disease
4. Destructive (Spinal Tumors)
5. Metabolic bone disease
6. Rheumatologic

Biomechanics Cervical Spine

1. Cervical myelopathy
2. Cervical reconstruction
3. Cervical disc disease
4. Cervical Trauma
5. Degenerative disease

Complications

1. Early
2. Late
3. Postoperative

Deformity

1. Adolescent idiopathic scoliosis
2. Kyphosis
3. Congenital spine
4. Degenerative spine conditions

Diagnostics

1. Radiology
2. MRI
3. CT scan
4. Others



INSTRUCTIONS to AUTHORS

Epidemiology

Etiology

Examination

Experimental study

Fusion

1. Anterior
2. Posterior
3. Combined
4. With instrumentation

Infection of the spine

1. Postoperative
2. Rare infections
3. Spondylitis
4. Spondylodiscitis
5. Tuberculosis

Instrumentation

Meta-Analysis

Osteoporosis

1. Bone density
2. Fractures
3. Kyphoplasty
4. Medical Treatment
5. Surgical Treatment

Outcomes

1. Conservative care
2. Patient Care
3. Primary care
4. Quality of life research
5. Surgical

Pain

1. Chronic pain
2. Discogenic pain

3. Injections

4. Low back pain

5. Management of pain

6. Postoperative pain

7. Pain measurement

Physical Therapy

1. Motion Analysis
2. Manipulation
3. Non-Operative Treatment

Surgery

1. Minimal invasive
2. Others
3. Reconstructive surgery

Thoracic Spine

Thoracolumbar Spine

Lumbar Spine

Lumbosacral Spine

Psychology

Trauma

1. Fractures
2. Dislocations

Spinal cord

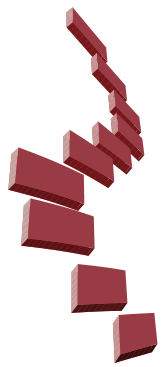
1. Spinal Cord Injury

Spinal stenosis

1. Cervical
2. Lumbar
3. Lumbosacral

Tumors

1. Metastatic tumors
2. Primary benign tumors
3. Primary malign tumors



INSTRUCTIONS to AUTHORS

APPLICATION LETTER EXAMPLE:

Editor-in-Chief

Journal of Turkish Spinal Surgery

Dear Editor,

We enclose the manuscript titled '....' for consideration to publish in the Journal of Turkish Spinal Surgery.

The following authors have designed the study (AU: Parenthetically insert names of the appropriate authors), gathered the data (AU: Parenthetically insert names of the appropriate authors), analyzed the data (AU: Parenthetically insert names of the appropriate authors), wrote the initial drafts (AU: Parenthetically insert initials of the appropriate authors), and ensure the accuracy of the data and analysis (AU: Parenthetically insert names of the appropriate authors).

I confirm that all authors have seen and agree with the contents of the manuscript and agree that the work has not been submitted or published elsewhere in whole or in part.

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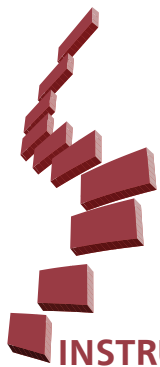
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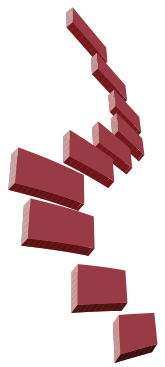
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PEER REVIEW, PUBLICATION ETHICS and MALPRACTICE STATEMENT

Peer-Review

Submission is considered on the conditions that papers are previously unpublished and are not offered simultaneously elsewhere; that authors have read and approved the content, and all authors have also declared all competing interests; and that the work complies with the Ethical Approval and has been conducted under internationally accepted ethical standards. If ethical misconduct is suspected, the Editorial Board will act in accordance with the relevant international rules of publication ethics (i.e., COPE guidelines).

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The approval of the ethics committee, statement on the adherence to international guidelines mentioned above and that the patient's informed consent is obtained should be indicated in the 'Material and Method' section and is required for case reports whenever data/media used could reveal the identity of the patient. The declaration of the conflict of interest between authors, institutions, acknowledgement of any financial or material support, aid is mandatory for authors

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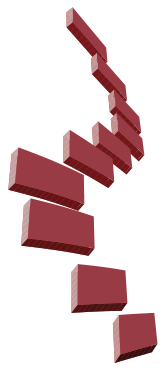
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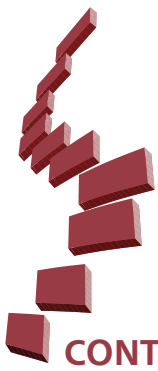
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