

## EDITORIAL

# Making *Heart* better

R Hall, Editor, on behalf of the editorial team

### Important changes are coming to *Heart*

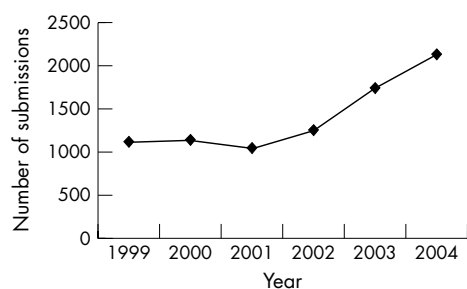
Like all editorial teams, our primary aim is to produce a high quality journal. This is followed closely by a desire to review and publish papers quickly. Getting quick but good quality reviews is every editor's nightmare; we all seem to be getting busier and our reviewers are no exception.

#### SPEEDING UP REVIEW

We are introducing several measures to reduce the review time. First we are overhauling and cleaning up our reviewer database. Second we are casting our net wider: our editorial board members have recommended young active reviewers who are being added to the database. In addition every paper will be reviewed by an editorial board member—this opinion will be very helpful but will also be a backup should the other reviewers fail to deliver the goods on time, sadly a not uncommon occurrence. Finally we intend to pursue even more diligently a course we are already taking of rejecting papers without review within three weeks if the editorial team believes a particular paper has no hope of publication in *Heart*.

#### SPEEDING UP PUBLICATION

Our other big problem is the delay between acceptance and publication, which currently stands at about eight months. We have been the victims of our own success: since the present editorial team took over *Heart* in mid 1999 we have experienced an ever rising submission rate (fig 1) but have a relatively fixed amount of space in the journal. This rise in submissions has necessitated an increase in the rejection rate; last year alone the rejection rate for full papers rose from 70% to 83%. Fortunately, the rise in submissions has brought us higher quality



**Figure 1** Number of manuscripts submitted to *Heart* 1999 to 2004 (electronic submission system introduced in 2002); 20% of submissions come from the UK.

material and there has been a steady rise in the impact factor, which now stands at 3.2 (fig 2). It is not financially possible simply to add more pages to each issue to clear the backlog, nor is web only publication a viable option as this reduces costs over print publication by just 20%. We have therefore taken a series of measures in an attempt to deal with the backlog or to lessen its impact.

#### Publish ahead of print

An accepted paper (full original articles) will be published on the web within two weeks of acceptance in the form it is submitted as part of the BMJ Publishing Group's Online First programme. This version is immediately citable and can be found on PubMed. Once the fully typeset version appears in the print journal it "replaces" the initial version (but previous versions are still available).

#### Shorter full papers

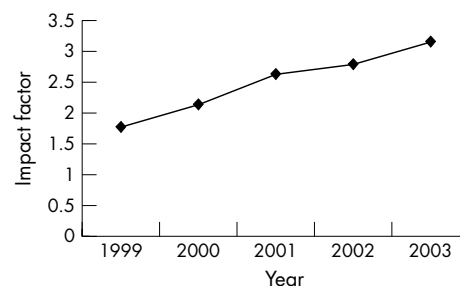
We are introducing and intend to enforce a word limit of 3000 words for original articles with four figures and/or tables. Additional material can be submitted as "data supplements" which will be published on the web only. Papers that are over the word limit will be sent back to the authors without consideration by the editorial team. Scientific letters will remain in their present format.

#### Case reports—the end

Case reports currently appear only on the web as what are known as ePages and cost 80% of a full print page. We are stopping publishing case reports and will use the liberated resources to publish more of our original research material. Much of the material that is sent in as case reports could be included in a carefully crafted image and we will now allow two references per image.

#### Images

This format is very popular and we are going to continue to publish images in the paper journal



**Figure 2** Growing impact factor for *Heart* 1999 to 2003.

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to fill in the space between articles, what is known by publishers as “white space”. We receive far more high quality images than we can include in the print journal; we are now going to offer web only publication to outstanding additional images. These images will be organised on the *Heart* website into a searchable and downloadable library of images. We hope this will have considerable educational value.

### WHAT WILL STAY THE SAME?

Editorials, reviews, mini-symposia and JournalScan will remain important parts of the journal, as will Education in

Heart, including interactive web based case reports; we hope to build on the success of these valuable sections.

These changes will be introduced from the date of publication of this editorial and the changes will be reflected in the newly designed instructions to authors (<http://heart.bmjournals.com/misc/fora>). We hope that these modifications will help remedy what we see as the biggest problems facing *Heart*, and improve the quality of the journal both for our authors and readers. As ever, we remain open to suggestions from our readership and these can be emailed to me on [heartjournal@bmjgroup.com](mailto:heartjournal@bmjgroup.com).

## IMAGES IN CARDIOLOGY .....

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### Posterior mitral valve leaflet prolapse diagnosed with multislice spiral computed tomography

A 67 year old woman who had conflicting findings on stress echocardiography and myocardial scintigraphy with technetium Tc 99m sestamibi presented for participation in a clinical trial of minimally invasive coronary angiography with contrast enhanced, retrospectively gated, multislice (16 slice) spiral computed tomography (MSCT). MSCT images gated in diastole showed severe coronary calcification but no luminal narrowing of > 70% in coronary segments that could be assessed. As per the study protocol, 20 transaxial MSCT images every 5% of the R-to-R interval were reconstructed in horizontal long axis at one intermediate level for qualitative assessment of global and regional left ventricular function. MSCT image reconstructions showed previously unrecognised displacement of the posterior mitral valve leaflet into the left atrium during systole. An

echocardiogram, interpreted by a cardiologist unaware of the MSCT findings, subsequently confirmed posterior mitral valve leaflet prolapse. Associated mild mitral regurgitation was documented, and the patient was advised of the need for endocarditis prophylaxis.

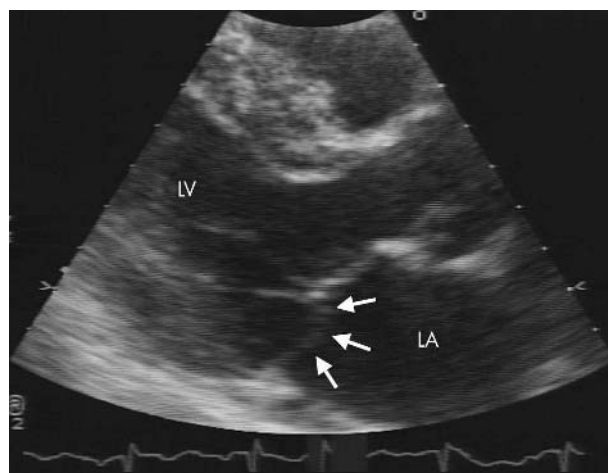
For minimally invasive coronary angiography, MSCT data are usually reconstructed in diastole to minimise the influence of cardiac motion on image quality. Using image data reconstructed at other time points in the cardiac cycle can result in common, clinically relevant diagnoses such as abnormalities of mitral valve morphology and function.



To view video footage of these images, please visit the *Heart* website—[www.heartjnl.com/supplement](http://www.heartjnl.com/supplement)



Multiplanar reformation of multislice spiral computed tomographic images in horizontal long axis orientation. The reconstruction window begins at 25% of the R-to-R interval, which corresponds to the late phase of isovolumic contraction. Atrial displacement of the posterior mitral valve leaflet (arrows) was most pronounced at this time point. LA, left atrium; LV, left ventricle; RA, right atrium; RV, right ventricle.



Magnified echocardiographic parasternal long axis view, end systolic frame, shows the posterior mitral valve leaflet prolapse (arrows).

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