COMMENTARIES

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From Paper to Web-Based Submission: The Evolution of *Pediatrics'* Manuscript Submission and Review

For some time now, *Pediatrics* has been grappling with one of the problems that every journal loves to have: a steadily increasing volume of manuscript submissions. Since 1995 computer software has helped us keep track of the whereabouts and history of this growing number of submissions. For more than half a decade this software has served us well, allowing us to find out, with just a few keystrokes, whether an article was with a reviewer, under revision with an author, waiting for a missing figure at our editorial office, or undergoing cosmetic surgery with one of our copyeditors. Although this software has been very good at telling us where a manuscript is located, it has not provided any help in getting it there. To move manuscripts back and forth, we have relied on a much older technology: the post. Although the system is generally reliable, it is either slow (in the case of standard mail) or expensive (in the case of express service). It is also labor-intensive. Our staff must open, address, mail, and track thousands of envelopes each year. In the years since the installation of our software, the Internet has developed to a point where a more efficient means of manuscript circulation is now practical.

In January 2004, *Pediatrics* will begin accepting manuscripts via ScholarOne's "Manuscript Central," a Web-based manuscript submission, tracking, and review system. This system will allow authors to submit their manuscripts electronically from any computer with Internet access. After submission, authors will be able to track the progress of their manuscripts through the review process and toward publication. Reviewers will be able to download manuscripts from the Internet and return their comments electronically. With far fewer envelopes to manage, our editorial staff will be able to focus on what they do best—ensuring that *Pediatrics* publishes content of the highest quality.

Eventually, we expect this system will decrease the time from submission to decision and from decision to publication. We will not expect reviewers to review manuscripts faster, nor will we expect authors to revise their manuscripts any more rapidly. We anticipate gains in speed to be realized through a reduction in the amount of time manuscripts spend in transit and through more efficient circulation. For example, we anticipate that Manuscript Central will help identify available reviewers more rapidly through an advance-notification function, thus expediting this sometimes-lengthy process.

Another advantage of moving to a Web-based system is that the cost of postage will be eliminated for all contributors—a cost that especially impacts authors outside of North America. The only cost of submission contributors will bear in the future will be that of connecting to the Internet. Research indicates that most potential contributors and reviewers connect to the Internet on a regular basis for other reasons; therefore, this expense should, in the majority of cases, be negligible.[1,2] However, should any contributor not have access to the Internet, due to either cost or temperament, *Pediatrics* will continue to accept a hard copy accompanied by a disk. Similarly, we will continue to value the participation of reviewers who wish to receive manuscripts via the more traditional route.

Pediatrics rigorously evaluated a number of potential vendors before deciding to partner with Virginia-based ScholarOne. A major consideration in this selection process was stability. ScholarOne's Manuscript Central has been online since 1999—the longest track record of any Web-based manuscript system. And with 435 journals hosted, it also handles the largest volume of submissions. *Pediatrics* will be among the first journals to feature the latest edition of Manuscript Central. Called "Version 3," this edition represents the state of the art in the industry, with a host of new functions and improvements from earlier versions.

Manuscript Central will provide an extremely high level of security. All data will be backed up to a remote location on a daily basis, ensuring that a systems failure or even a catastrophic event will not result in the loss of manuscripts or reviewers' comments. All information uploaded to Manuscript Central will be screened for viruses so that users will not have to fear downloading a virus along with a manuscript. Password protection will ensure that only authorized editors, editorial staff, and selected reviewers will have access to manuscripts. Confidential reviewers' comments will be accessible only to editors and editorial staff, and around-the-clock monitoring will ensure that the system is protected against hacking and other unauthorized access.

To reduce the time from acceptance to publication further and to reduce expenses for both the journal and its contributors, *Pediatrics* will also begin elec-

Received for publication Aug 19, 2003; accepted Aug 19, 2003.
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tronic delivery of page proofs in November. Similar to manuscript submission and review, *Pediatrics'* page proofs delivery will occur via a Web-based system. Called "Rapid Proof," our proof-delivery system was developed by our compositor, Cadmus Professional Communications. The Academy has tested Rapid Proof thoroughly over the last year with its online publication, *NeoReviews.org*. Authors of *NeoReviews.org* articles have reported positive experiences with it, and we are confident that the system can manage the larger volume of *Pediatrics* proofs.

Together, Manuscript Central and Rapid Proof will provide a more efficient means of manuscript circulation, which we expect will expedite publication and reduce expenses. The editors and staff of *Pediatrics* have taken care to ensure a smooth transition to these new systems and do not expect any great difficulties for either reviewers or authors. If electronic submission difficulties arise, live technical support will be available during normal business hours. We know that adjusting to new technologies can be a challenge. We ask authors and reviewers to be patient with any bumps in the road that may be encountered during this transition.

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Relationship Between Wilson-Mikity Syndrome and the New Bronchopulmonary Dysplasia

ABBREVIATIONS. WMS, Wilson-Mikity syndrome; BPD, bronchopulmonary dysplasia.

In 1960, Wilson and Mikity[1] published a report of 5 cases of a new form of respiratory disease in the premature infant. An additional 29 cases were reported from our center in 1969.[2] In the intervening years, similar cases had been reported from other centers in the United States, England, Canada, Australia, Switzerland, Italy, and Nigeria, indicating that these cases composed a definite clinical entity of wide geographic distribution. In the early 1960s, none of these infants had received assisted ventilation. Ventilatory support for premature infants became the standard of treatment in the late 1960s. The Wilson-Mikity syndrome (WMS) was swallowed up by bronchopulmonary dysplasia (BPD), the chronic effects of artificial ventilation first reported by Northway et al.[3] These were a result of damage to the lung resulting in fibrosis, inflammation, and metaplasia.

The reported infants of WMS all were premature with a medium weight of 1280 g.[1,2] The smallest was 830 g, and 26 of the 35 were <1500 g. Only 1 infant weighed >2000 g. Remember, this was from a period when infants <1000 g were considered nonviable and rarely survived. Severity of the illness correlated inversely with maturity. None of the infants was treated with assisted ventilation. None of the infants received >40% oxygen, and most were given oxygen for resuscitation only until after the onset of chronic symptoms. Radiographs in the first week were normal except for 3 infants who had typical respiratory distress syndrome from which they recovered before the onset of chronic symptoms. These early symptoms, which frequently were intermittent, appeared after the first week and consisted of cyanosis, tachypnea, and retractions. Chest radiographs during this stage showed well-expanded lungs with generalized cystic changes. The symptoms increased in severity over the space of several weeks. Twelve infants died in this stage. In those who recovered, the signs and symptoms slowly decreased over the next weeks to months. Radiographs at this time showed basilar hyperaeration and strand-like infiltrate in the upper lobes.

Eleven biopsies were performed, and each of the 12 infants who died was autopsied. Early biopsies (20 days) showed an immature pattern with thick, cellular alveolar septa. Late specimens showed hyperaeration with reduced alveolar septa. Only 1 case had fibrosis, and evidence of inflammation was minimal. The cause of the syndrome was considered to be an abnormal air distribution with a disturbance in ventilation/perfusion secondary to characteristics of the premature lung. Lung histology has been reported by Coalson et al[4] in extremely premature baboons that were killed after 71 days of carefully controlled assisted ventilation and oxygen administration. The enlarged air spaces surrounded by thin saccular/alveolar walls with only a few secondary crests was similar to that seen in the late stage of WMS.

Although WMS essentially disappeared from discussions of chronic respiratory problems, there are indications that it was still present. For example, in a study of O_2 consumption in 8 infants with the diagnosis of BPD done by Weinstein and Oh[5] in 1981, 2 of the infants had not received assisted ventilation. In a more recent study, Charafeddine et al[6] classified BPD as typical and atypical depending on the timing of assisted ventilation. In infants ≤1250 g birth weight, 31% were classified as atypical. These formed 2 groups: 1) infants whose first symptoms occurred after the first week and 2) infants who had recovered from respirator distress syndrome and

Received for publication Apr 21, 2003; accepted Apr 21, 2003.
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Pediatrics 2003;112;1413

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