



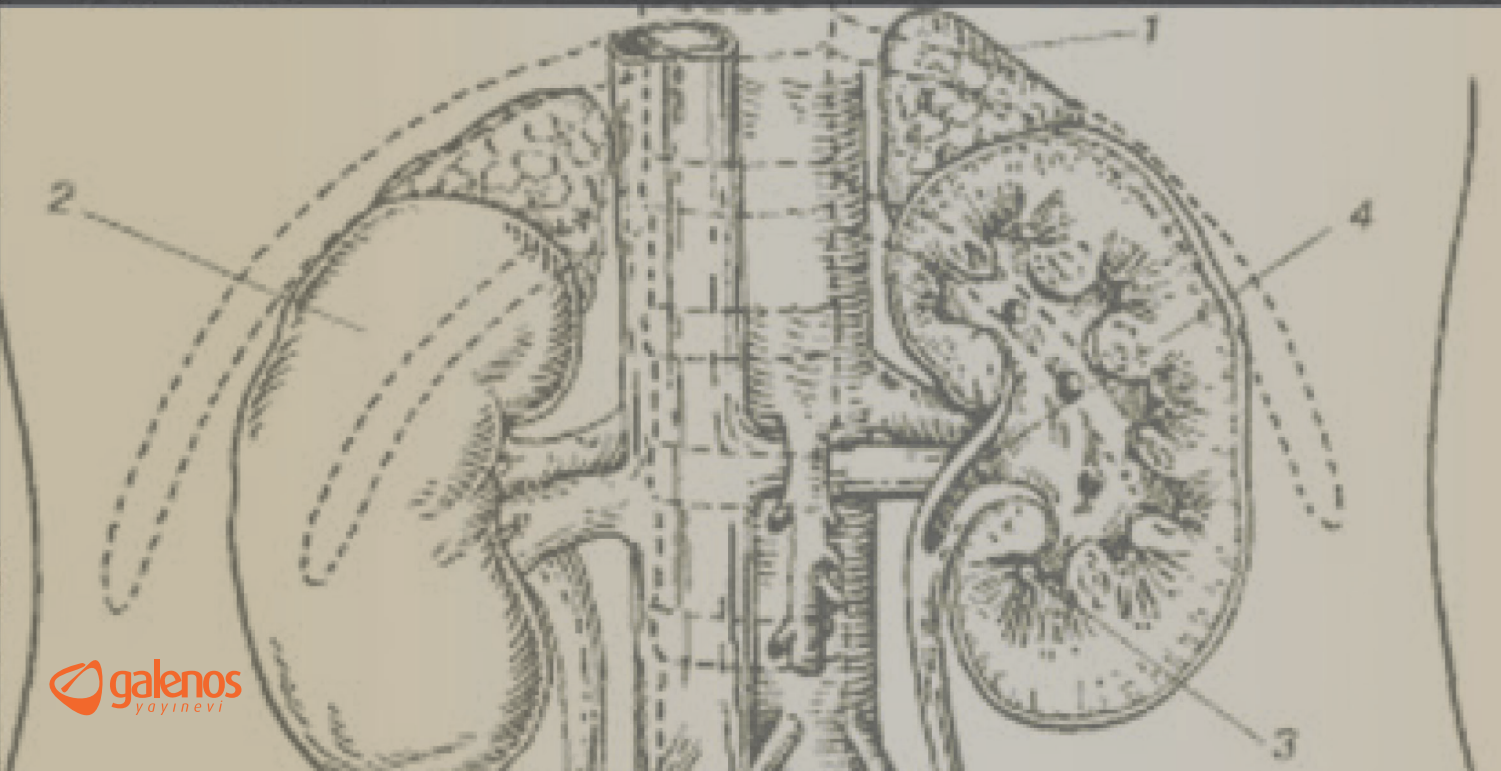
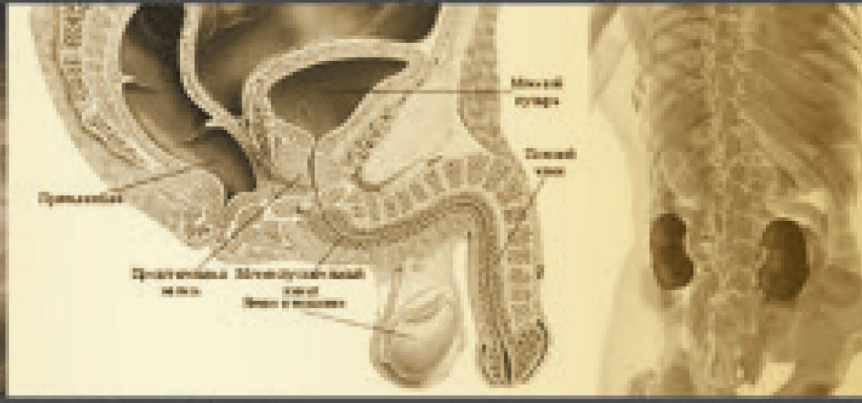
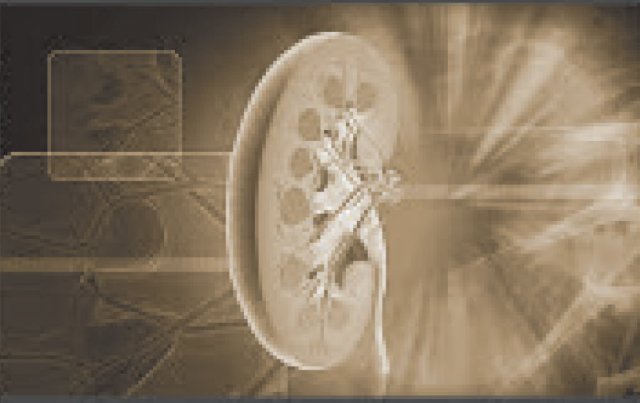
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The target audience of the journal includes physicians working in the fields of urology and all other health professionals who are interested in these topics.

The editorial processes of the journal are shaped in accordance with the guidelines of the international organizations such as the International Council of Medical Journal Editors (ICMJE) (<http://www.icmje.org>) and the Committee on Publication Ethics (COPE) (<http://publicationethics.org>).

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The journal should be abbreviated as “J Urol Surg” when referenced.

The Journal of Urological Surgery accepts invited review articles, research articles, brief reports, case reports, letters to the editor, and images that are relevant to the scope of urology, on the condition that they have not been previously published elsewhere. Basic science manuscripts, such as randomized, cohort, cross-sectional, and case control studies, are given preference. All manuscripts are subject to editorial revision to ensure they conform to the style adopted by the journal. There is a single blind kind of reviewing system.

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The Journal of Urological Surgery’s editor and Editorial Board members are active researchers. It is possible that they would desire to submit their manuscript to the Journal of Urological Surgery. This may be creating a conflict of interest. These manuscripts will not be evaluated by the submitting editor(s). The review process will be managed and decisions made by editor-in-chief who will act independently. In some situation, this process will be overseen by an outside independent expert in reviewing submissions from editors.

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Manuscripts should be prepared according to ICMJE guidelines (<http://www.icmje.org/>).

Original manuscripts require a structured abstract. Label each section of the structured abstract with the appropriate subheading (Objective, Materials and Methods, Results, and Conclusion). Case reports require short unstructured abstracts. Letters to the editor do not require an abstract. Research or project support should be acknowledged as a footnote on the title page.

Technical and other assistance should be provided on the title page.

Title Page

Title: The title should provide important information regarding the manuscript’s content.

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Word Count: A word count for the manuscript, excluding abstract, acknowledgments, figure and table legends, and references, should be provided not exceed 3000 words. The word count for an abstract should be not exceed 250 words.

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Objective: The abstract should state the objective (the purpose of the study and hypothesis) and summarize the rationale for the study.

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Results: Important findings and results should be provided here.

Conclusion: The study's new and important findings should be highlighted and interpreted.

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Abstract length: Not to exceed 250 words. "What is known on the subject and what does the study add" not exceed 100 words.

Article length: Not to exceed 3000 words.

Original researches should have the following sections:

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Statistics: Describe the statistical methods used in enough detail to enable a knowledgeable reader with access to the original data to verify the reported results. Statistically important data should be given in the text, tables and figures. Provide details about randomization, describe treatment complications, provide the number of observations, and specify all computer programs used.

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Comparisons, and statistically important values (i.e. p value and confidence interval) should be provided.

Discussion: This section should include a discussion of the data. New and important findings/results, and the conclusions they lead to should be emphasized. Link the conclusions with the goals of the study, but avoid unqualified statements and conclusions not completely supported by the data. Do not repeat the findings/results in detail; important findings/results should be compared with those of similar studies in the literature, along with a summarization. In other words, similarities or differences in the obtained findings/results with those previously reported should be discussed.

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Ghoneim IA, Miocinovic R, Stephenson AJ, Garcia JA, Gong MC, Campbell SC, Hansel DE, Fergany AF. Neoadjuvant systemic therapy or early cystectomy? Singlecenter analysis of outcomes after therapy for patients with clinically localized micropapillary urothelial carcinoma of the bladder. *Urology* 2011;77:867-870.

2. Organization as Author

Yaycioglu O, Eskicorapci S, Karabulut E, Soyupak B, Gogus C, Divrik T, Turkeri L, Yazici S, Ozen H; Society of Urooncology Study Group for Kidney Cancer Prognosis. A preoperative prognostic model predicting recurrence-free survival for patients with kidney cancer. *Jpn J Clin Oncol* 2013;43:63-68.

3. Complete Book

Wein AJ, Kavoussi LR, Novick AC, Partin AW, Peters CA. *Campbell-Walsh Urology*, 10th ed. Philadelphia, Elsevier&Saunders, 2012.

4. Chapter in Book

Pearle MS, Lotan Y. Urinary lithiasis: etiology, epidemiology, and pathogenesis. In: Wein AJ, Kavoussi LR, Novick AC, Partin AW, Peters CA. *Campbell-Walsh Urology*, 10th ed. Philadelphia, Elsevier&Saunders, 2012, pp 1257-1323.

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5. Abstract

Nguyen CT, Fu AZ, Gilligan TD, Kattan MW, Wells BJ, Klein EA. Decision analysis model for clinical stage I nonseminomatous germ cell testicular cancer. *J Urol* 2008;179:495a (abstract).

6. Letter to the Editor

Lingeman JE. Holmium laser enucleation of the prostate-If not now, when? *J Urol* 2011;186:1762-1763.

7. Supplement

Fine MS, Smith KM, Shrivastava D, Cook ME, Shukla AR. Posterior Urethral Valve Treatments and Outcomes in Children Receiving Kidney Transplants. *J Urol* 2011;185(Suppl):2491-2496.

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How I do?

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