Journal of the American College of Emergency Physicians Open: Images in Emergency Medicine

Overview:
Photographs of interesting or classic presentations of disease, accompanied by a 1-paragraph description of the patient's presentation and a 1-2-paragraph discussion of the final diagnosis and relevant teaching points. Images may include radiographs or microscopy. ECGs are accepted. Each figure and/or table should be cited in the text and a figure and table legend should be included.

Title: Provide a vivid title that does not reveal diagnosis of the image, eg, "Man With Chest Pain and Dyspnea," not "A Case of STEMI."

Image quality: Please submit photographs and figures with a resolution of at least 300 dots per inch. Figures are easiest for us to process if submitted in TIFF or EPS format. Combinations of grayscale and line art should be at least 500 to 600 dpi. Line art (black and white or color) should be at least 1200 dpi. Upload figures as separate high-resolution figure files. Figures should be camera-ready; use Arial or Arial Narrow font, exclude title from the figure, and label all axes.

Word count: 250 words (excluding references and legends).

Photo consent: You attest you have obtained informed consent on all photographic images of patients with identifying material in one of the following written forms:

- Completion of appropriate institutional permission or consent form.
- Completion of institutional HIPAA release form.
- Signed letter from the patient.
- Completion of the JACEP Open standard patient consent form.

Images should exhibit the minimum body exposure necessary to convey the key finding. Non-essential identifying details should be omitted. Masking the eye region in photographs of patients is inadequate protection of anonymity. Follow guidelines described by the **Publications Ethics Guidelines**. If you cannot reach the patient to complete the form, please contact the editorial team at **jacepopen@acep.org**.
Radiographic images (ie, x-rays and CT scans) do not require patient permission.

For original research, use JACEP Open's subheadings: Introduction (Background, Importance, Goals); Methods (Design, Setting, Selection of Subjects, Interventions, Measures/Outcomes, Data Analysis). Results. Limitations. Discussion. Do not include a separate Conclusion section.

If you are transferring a paper from Annals of Emergency Medicine, indicate in the cover letter how you plan to edit the paper; do not make detailed edits to the paper.

All manuscripts should be submitted through Editorial Manager, our Web-based peer review system. As part of the submission process, you will be asked to select the article category, enter

the manuscript title, and provide author information. Answer the questions regarding authorship, conflicts of interest, and other special evaluation concerns (See our "Standard Submission Questions)". Please remove all author, institution, and author team identifiers from the main manuscript text. Identifiers may be retained on the title page.

Order of Sections: The main text file should be presented in the following order:

Abstract
Main text
References
Tables (each table complete with title, legend and footnotes);
Figures
Figure legend

References: References should be numbered consecutively in the order in which they are first mentioned in the text and should be formatted in AMA style (3 authors then "et al"). Avoid referencing abstracts or citing a "personal communication" unless it provides essential information not available from a public source.
Example: Gaul C, Dietrich W, Friedrich I, et al. Neurological symptoms in type A aortic dissections. *Stroke*. 2007; 38(2): 292–
297. https://doi.org/10.1161/01.STR.0000254594.33408.b1
Footnotes to the text are not allowed; any such material should be incorporated into the text.

Figure Legends: Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

Submit a separate title page.

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Case Example

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IMAGES IN EMERGENCY MEDICINE

Gastroenterology

Man with chest discomfort

Molly Hartrich MD, MPH[1] | **Wesley Eilbert MD**[1] | **Amy Eisenberg DO**[2]

[1]Department of Emergency Medicine, University of Illinois at Chicago Hospital and Health Sciences System, Chicago, Illinois, USA

[2]Combined Emergency Medicine/Internal Medicine Residency, University of Illinois at Chicago Hospital and Health Sciences System, Chicago, Illinois, USA

Correspondence
Molly Hartrich, MD, MPH, Department of Emergency Medicine, University of Illinois at Chicago Hospital and Health Sciences System, 808 S Wood St MC 724, Suite 470, Chicago, IL 60612, USA.
Email: Mhartr2@uic.edu

1 | CASE PRESENTATION

A 76-year-old man presented to the emergency department complaining of intermittent chest tightness during the preceding day that had resolved "after passing gas." His physical examination was unremarkable, and his electrocardiogram (ECG) showed no acute ischemic changes. Standard posterior–anterior and lateral radiographs of the chest were obtained (Figures 1 and 2).

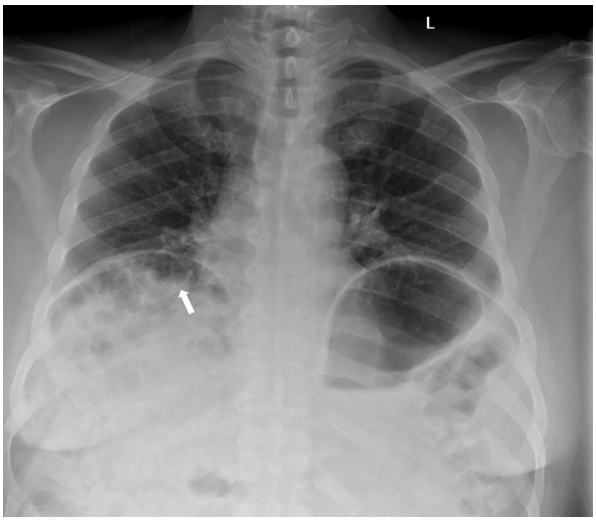

FIGURE 1 Posterior–anterior view of the chest showing interposition of a segment of the large colon between the liver and the diaphragm

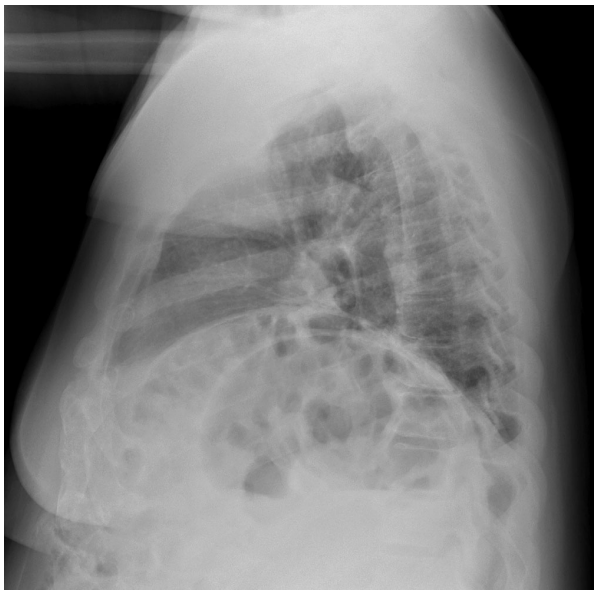

FIGURE 2 Lateral view of the chest showing interposition of a segment of the large colon between the liver and the diaphragm

2 | DIAGNOSIS

2.1 | Chilaiditi syndrome

Chilaiditi sign describes the radiographic findings of interposition of a segment of large or small bowel between the liver and the diaphragm.

Anatomic variations that lead to this condition include the absence or laxity of the suspensory ligaments of the transverse colon or falciform ligament. Chilaiditi sign is rare with an incidence of 0.025% to 0.28% and a male to female ratio of 4:1.[1] The diagnosis of Chilaiditi sign is made based on the following radiologic findings: the right hemidiaphragm is elevated above the liver by the intestine, the interposed bowel segment is distended by air mimicking pseudopneumoperitoneum, and the superior margin of the liver is depressed below the level of the left hemidiaphragm.[2] Chilaiditi sign may be misinterpreted as a diaphragmatic hernia or pneumoperitoneum, resulting in unnecessary surgical intervention.[3,4] The presence of plicae circulares or haustral markings under the diaphragm can help rule out free intraperitoneal air.

Chilaiditi sign is typically asymptomatic and requires no intervention. Chilaiditi syndrome is the result of complications from Chilaiditi sign, manifesting as abdominal pain, vomiting, or constipation, although there are reports of respiratory symptoms and chest pain.[3] Complications of the syndrome include internal herniation, colonic volvulus, bowel obstruction, and perforation.[1,3,5]

ORCID

Molly Hartrich MD, MPH https://orcid.org/0000-0001-6657-8110

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