2020 has been an unprecedented year, not only for the world but also for JAMA Oncology. The coronavirus disease 2019 (COVID-19) pandemic dominated both the news and the medical literature. JAMA Oncology received more than 350 manuscripts related to the COVID-19 pandemic in 2020, including one of the first reports of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) transmission in patients with cancer from Wuhan province, China, which was published on March 25, 2020 (Table).1-6

I thank our authors, reviewers, and readers for the significant contributions made to the journal this past year, especially surrounding the pandemic. The editorial board, our JAMA Oncology editors, and I are honored to have the opportunity to serve the oncology community by offering original, innovative, and timely scientific content that has a direct impact on researchers, clinicians, and the patients we serve. Most importantly, we rapidly evaluated and published COVID-19-related articles to provide needed information for decision-making concerning the infection and its implications in patients with cancer and cancer treatment changes during the pandemic. The journal's impact factor of 24.8 places it as one of the highest-ranking oncology journals.

Evaluating and selecting the best manuscripts for publication in the journal was rewarding but challenging. JAMA Oncology received a total of 3777 manuscript submissions in 2020. These submissions included 2967 Original Investigations and 115 Reviews. In 2020, we published 412 total articles, including 102 Original Investigations, 23 Brief Reports, 39 Research Letters, 12 Reviews, 46 Viewpoints, and 1 Special Communication. I would like to thank our authors for choosing to submit their articles to JAMA Oncology. The quality of their published articles is reflected in the more than 4.6 million views they received in 2020.

In 2020, the overall acceptance rate was 11%. The acceptance rate for Original Investigations was 6%. We accepted 15% of Review articles, 11.6% of submitted Research Letters, 19% of Viewpoints, and 11.6% of Clinical Challenges. JAMA Oncology is indexed in PubMed/MEDLINE, Web of Science, Scopus, and other databases. More detailed statistics about the journal's content are displayed in the Table.

We are also very grateful to our global consortium of peer reviewers who contributed to the journal this year. I am pleased to acknowledge their contribution to JAMA Oncology by publishing the names of the 826 experts who completed a manuscript review in 2020.7 This group of renowned laboratory, clinical, quantitative, and statistical scientists rapidly provided comprehensive reviews of the submitted manuscripts.

The median time from the receipt of a manuscript to the first decision with peer review was 41 days in 2020. The ability to

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<th>Characteristic</th>
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<tr>
<td>Manuscript data</td>
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<td>All manuscripts received</td>
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Information dissemination data

Recipients of electronic table of contents per week >62 000
Full-text/PDF downloads per year >4.6 million
Twitter and Facebook followers >58 000
Top 3 articles by views/downloads
1. Lee et al, Assessment of Parking Fees at National Cancer Institute–Designated Cancer Treatment Centers 65 050
2. Mackintosh et al, Association of Coffee Intake With Survival in Patients With Advanced or Metastatic Colorectal Cancer 43 642
3. Gilchrist et al, Association of Sedentary Behavior With Cancer Mortality in Middle-aged and Older US Adults 43 086
Top 3 articles by Altmetric score
1. Yu et al, SARS-CoV-2 Transmission in Patients With Cancer at a Tertiary Care Hospital in Wuhan, China 896
2. Gilchrist et al, Association of Sedentary Behavior With Cancer Mortality in Middle-aged and Older US Adults 893
3. Mackintosh et al, Association of Coffee Intake With Survival in Patients With Advanced or Metastatic Colorectal Cancer 863
Top 3 articles by Web of Science citations
1. Yu et al, SARS-CoV-2 Transmission in Patients With Cancer at a Tertiary Care Hospital in Wuhan, China 254
3. Phillips et al, Outcomes of Observation vs Stereotactic Ablative Radiation for Oligometastatic Prostate Cancer: The ORIOLE Phase 2 Randomized Clinical Trial 48

Table. JAMA Oncology Statistics for 2020

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The 2021 US Preventive Services Task Force Recommendation on Lung Cancer Screening
The More Things Stay the Same...

Mayuko Ito Fukunaga, MD; Renda Söylemez Wiener, MD, MPH; Christopher G. Slatore, MD, MS

The United States Preventive Services Task Force (USPSTF) recently updated its recommendation statement regarding lung cancer screening (LCS) using low-dose computed tomography (LDCT).¹ This update was based on a systematic evidence synthesis,² including review of more than 220 publications, and informed by extensive decision analysis modeling by the Cancer Intervention and Surveillance Modeling Network (CISNET) Lung Cancer Working Group.³ As with its 2013 statement,⁴ the USPSTF gave LCS a B recommendation, meaning its consensus was that there is moderate certainty that annual screening for lung cancer with LDCT is of moderate net benefit.¹ Key changes from the 2013 statement include expansion of the recommended eligibility criteria to begin screening at age 50 years instead of 55 years and requiring 20 rather than 30 pack-years total first-hand cigarette smoke exposure. There was no change in the remaining recommendations, such as the modality and frequency of screening or when to discontinue LCS, and the USPSTF kept risk-factor eligibility criteria rather than switching to criteria determined by risk model.

This update is timely because many more studies regarding LCS have been published, and a host of questions about LCS have risen since the 2013 recommendation.⁵ The Dutch-Belgian lung cancer screening trial Nederlands–Leuvens Longkanker Screenings Onderzoek (NELSON),⁶ the second largest randomized clinical trial assessing lung cancer screening, was published in 2020 and confirmed the primary benefit found in the National Lung Screening Trial (NLST)⁷ that LCS with LDCT reduced lung cancer mortality. Lung-RADS (Lung CT Screening Reporting and Data System)⁸ has been widely adopted to improve protocol-based follow-up of screening-identified nodules, but the NELSON trial raised new questions about the optimal frequency of screening and when to stop, as well as the role of volumetric assessment in evaluat-

REFERENCES

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