

Editorial

Toward an Integrated Science of Injury: Launching the Journal of Clinical and Forensic Traumatology

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Citation: Aquila, I.; Sacco, M.A. Toward an Integrated Science of Injury: Launching the Journal of Clinical and Forensic Traumatology. *J. Clin. Forensic Traumatol.* 2026, 1, 1. <https://doi.org/10.65716/c7ja2p11>

Received: 18 October 2026

Published: 21 October 2026

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Keywords: clinical forensic medicine; forensic pathology; traumatology; injury documentation; post-mortem imaging; violence; open access

1. Two Examinations of the Same Injury

Injury is one of the great and still underestimated public health problems of our time. The World Health Organization estimates that injuries take the lives of about 4.4 million people every year, nearly 8% of all deaths worldwide, with 3.16 million deaths attributable to unintentional injuries and 1.25 million to violence [1]. The Global Burden of Disease Study 2019 shows that this burden extends well beyond mortality, since road injuries, falls and interpersonal violence continue to account for a considerable share of disability-adjusted life years, especially among adolescents and young adults [2].

Behind each of these figures there is an injured body that may be examined in two very different settings. The clinician examines it in order to treat it, often under pressure of time, and records the findings that guide resuscitation, surgery and rehabilitation. When the injury acquires legal relevance, or when it leads to death, the same body is examined again by a forensic physician, who has to reconstruct how, when and by what means the lesions were produced and to translate these findings into answers for prosecutors, judges and families. Both examinations concern the same wounds, fractures and haemorrhages, yet they are usually performed by different specialists, at different times and with different vocabularies and standards of documentation, and their results are published in journals that rarely address the same readers.

The Journal of Clinical and Forensic Traumatology (JCFT) was founded on the conviction that this separation is no longer justified, neither scientifically nor in terms of the service that medicine owes to patients and to justice. Trauma is a continuum that begins at the scene of the event, passes through prehospital care, the emergency department, the operating theatre and the intensive care unit, and may end in recovery, in permanent impairment or on the autopsy table. Each step of this continuum produces information that is valuable for all the others, and JCFT aims to be the place where this information is shared.

2. What Each Side Can Learn from the Other

The cost of the current fragmentation is well documented. In a review of 515 emergency department files of patients admitted with wounds in South Africa, Filmlalter and colleagues found that the type and site of the wound were always recorded, whereas its size was described in only 15% of cases, blood loss in 18.1%, and the shape of the wound and the condition of the surrounding skin in none, so that the documentation could hardly support any subsequent forensic interpretation [3]. Similar concerns have led emergency medicine educators to introduce clinical forensic medicine into the training of residents, in recognition of the fact that medico-legal processes remain unfamiliar to most clinicians [4]. The classic review of 300 cases of attempted strangulation submitted for prosecution in San Diego showed that most victims had no visible injuries, or injuries too minor to be photographed, so that opportunities for an adequate prosecution were missed whenever police officers and clinicians relied on visible signs alone [5]. Conversely, a careful clinical description of the findings may become decisive for the subsequent medico-legal reconstruction, as illustrated by cases in which the observations of the treating physicians guided the forensic assessment of a suspected illegal abortion [6]. In paediatrics, the evaluation of suspected physical abuse requires a structured approach that integrates history, physical examination, skeletal survey and laboratory investigations, as recommended by the American Academy of Pediatrics

[7], and its reliability depends directly on the accuracy with which the first clinicians describe and image the injuries.

Knowledge also flows in the opposite direction. Forensic pathology has accumulated a detailed understanding of wound vitality and wound age, which is now supported by immunohistochemical and molecular markers of inflammation, proliferation and repair [8]. These tools are of obvious interest to the clinicians who must date injuries in living victims of violence and to the surgeons who study tissue healing. Post-mortem imaging offers another example. In the feasibility study that introduced the concept of virtopsy, post-mortem multislice computed tomography and magnetic resonance imaging independently identified 55% of the causes of death diagnosed at autopsy in 40 forensic cases and proved superior to dissection for some cranial, skeletal and soft tissue injuries [9]. Post-mortem multislice computed tomography has since proved valuable also in the evaluation of single gunshot injuries [10]. These techniques, now widely available in forensic institutes, speak the same language as trauma radiology and allow a direct comparison between ante-mortem and post-mortem findings.

The systematic analysis of trauma deaths gives trauma systems a feedback that cannot be obtained in any other way. A prospective study of all 440 trauma-related deaths that occurred in Berlin in 2010, based on the integration of forensic and clinical data, showed that 58.7% of the victims died at the scene and that falls from a height greater than three metres were the leading mechanism of injury, findings that direct attention towards prevention and prehospital care rather than towards in-hospital treatment alone [11]. Studies of this kind show how much clinical traumatology can gain from the forensic examination of those who did not survive, and how much forensic practice can gain from a clinical understanding of injury mechanisms and treatment.

3. Scope, Standards and Editorial Commitments

JCFT publishes original articles, reviews, systematic reviews and meta-analyses, case reports and short communications on trauma across this whole continuum. The journal is organised into five thematic sections devoted to clinical traumatology and emergency medicine, surgical traumatology and critical interventions, forensic traumatology and injury analysis, psychological and psychiatric traumatology, and translational and experimental trauma research. We particularly welcome studies conceived jointly by clinicians and forensic specialists, work on the documentation, interpretation and dating of injuries in living and deceased persons, research on clinical and post-mortem imaging, analyses of violence, abuse and neglect, and studies on preventable deaths and on the quality of trauma care. The psychological consequences of trauma are part of the scope as well, because they often determine the long-term outcome of victims and are a frequent object of medico-legal evaluation.

All research articles undergo double-anonymous peer review by at least two independent reviewers, and editorials such as the present one are the only items published without external review, in a dedicated and clearly identified section. Authors are asked to follow the reporting guidelines appropriate to their study design, including CONSORT, STROBE, PRISMA, CARE, STARD and ARRIVE, to describe the contribution of each author according to the CRediT taxonomy, and to disclose funding, conflicts of interest, ethical approval and any use of generative artificial intelligence. Articles are published in open access under a Creative Commons Attribution 4.0 licence, receive a Crossref DOI and appear online as soon as they are accepted, within an annual volume. In line with the Principles of Transparency and Best Practice in Scholarly Publishing issued jointly by COPE, DOAJ, OASPA and WAME [12], the policies of the journal on peer review, publication ethics, corrections, retractions and complaints are publicly available on its website. No article processing charge applies to the papers of Volume 1 and to all manuscripts submitted by 31 January 2027, so that the quality of a contribution, and not the resources of its authors, decides whether it is published.

4. An Invitation

A new journal is, above all, a promise to its readers and authors. We are building an international editorial board and a network of reviewers from many countries, chosen among researchers who are active in the field and who share the idea that clinical and forensic traumatology are two faces of the same discipline. We invite emergency physicians, trauma and orthopaedic surgeons, intensivists, radiologists, psychiatrists, forensic pathologists, clinical forensic physicians, forensic anthropologists and all researchers who study injury to submit their work to JCFT and to help us build a journal in which the bedside and the autopsy room speak the same language.

We thank the authors who have entrusted their manuscripts to the journal, the reviewers who have generously given their time, and all those who have supported the launch of JCFT.

Author Contributions: Conceptualization, I.A. and M.A.S.; writing—original draft preparation, M.A.S.; writing—review and editing, I.A. and M.A.S. All authors have read and agreed to the published version of the manuscript.

Funding: This research received no external funding.

Institutional Review Board Statement: Not applicable.

Informed Consent Statement: Not applicable.

Data Availability Statement: No new data were created or analysed in this study. Data sharing is not applicable to this article.

Conflicts of Interest: I.A. and M.A.S. are the Editors-in-Chief of the Journal of Clinical and Forensic Traumatology. This editorial was not subject to external peer review.

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