



IACLE
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of Contact Lens Educators

How to Write and Submit an Abstract


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Learning Objectives

1. Know the components of a publishable abstract
2. Appreciate that each meeting/journal has their own specific requirements
3. Be able to construct an abstract after the end of the experiment or study or interesting case.




Before you start.....




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1. Look up the 'abstract submission guidelines' for the conference you are interested in.
2. Title
3. Authors
4. Biography
5. Conflict of interest
6. Previous publications
7. Language/Spelling/Grammar
8. Begin to construct your abstract



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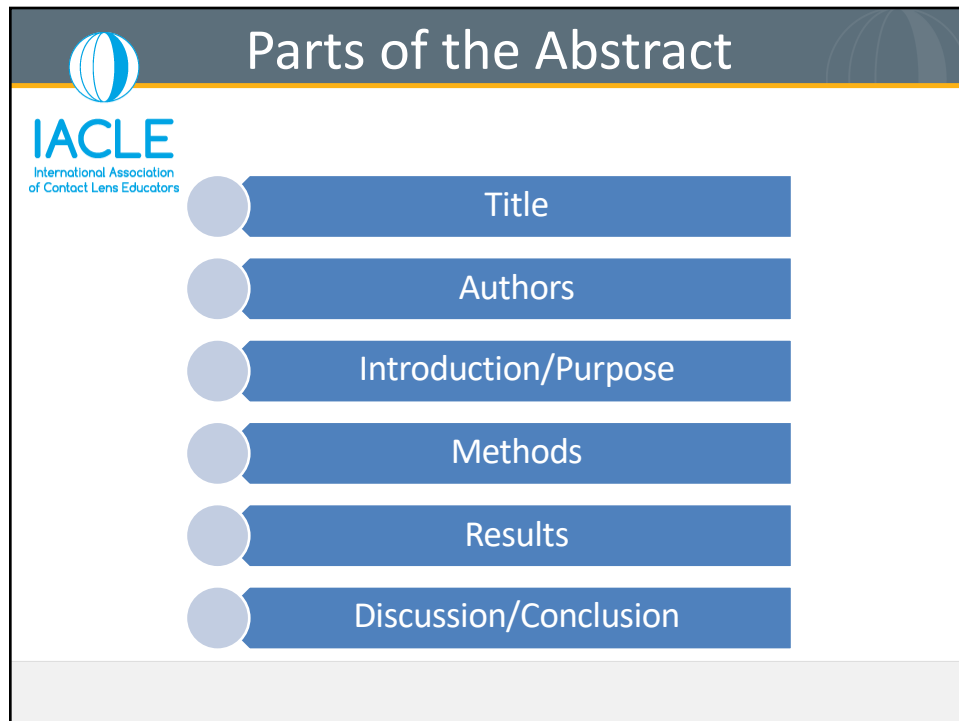
Submission Guidelines



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Read the guidelines to look for;

- Submission limits per author (ie. can only be the first author once, or no more than 3 abstracts per author)
- Maximum amount of words /characters for the title
- Maximum amount of words/characters for the abstract
- Respect the deadline!
 - Preferably do not wait for the last day.
 - Be aware of time differences between countries (ie. 5pm in the USA, is not the same as 5pm in Europe)




The table is titled "Title" and features the IACLE logo (International Association of Contact Lens Educators) on the left. It provides guidelines for writing an abstract title, organized into two columns: "Do's" and "Don'ts".

Do's	Don'ts
<ul style="list-style-type: none">Title should reflect the content of the studyMake your title interesting (jury members/conference attendees)Words should be succinct in the description of the studyYour title can be in the form of a question	<ul style="list-style-type: none">Excessively long titleUse of acronymsOveruse of technical terms (conference dependent)




Authors




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- List authors by their contribution to the study
- First author has the most responsibility in the study (design, data collection, interpretation)
- Last author is usually the coordinator of the study
- Authors should be listed by their last name followed by the initial of their first name, separated by commas
 - Bitton E, Sorbara L, Naroo S
- Responsibilities of authorship guidelines by ICMJE (International Committee of Medical Journal Editors)
(<http://www.icmje.org/recommendations/browse/roles-and-responsibilities/defining-the-role-of-authors-and-contributors.html>)




Introduction/Purpose




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- In 4 to 8 lines, offer some background to introduce your topic (ie. dry eye, scleral lenses, contact lens complications, etc) and lead the reader towards the objective of your study.
- What is the study question ?
- If a word or phrase is used often, use known acronyms in the rest of the abstract to limit the amount of characters (ex. contact lens=CL; dry eye disease=DED)




Methods




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- This section should provide enough detail to determine how the study was performed in about 4-5 lines. No results should be in this section. Provide details on the following;
- **Participants**
 - CL vs non-CL wearers, DE or non-DE participants, symptomatic vs asymptomatic?;
 - Age and Sex inclusion (ie. young vs older population; only females?);
 - Ethics approval for human subjects
- Describe how the participants were determined to be DE/CLW/symptomatic
- How did you justify the sample size? (sample size evaluator programs ex. G*Power)




Methods




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- Describe the **test/tool/instrument** used
 - questionnaire, tear meniscus height, ocular redness, keratometry readings, etc?
- Describe the **statistics** used
 - parametric vs non-parametric
 - Correlations or other analysis performed
 - Statistical software used




Results




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- This section should provide only results of the study (no interpretation of data)
- Provide details on the following;
- **Participants** (total number of participants, mean age \pm SD, # of males and females)
- **Results of tests** measured with mean \pm SD, when appropriate
- **Statistical tests** (t-tests, ANOVA, correlations, etc) with p values (shows the jury that the study is complete)
- Incomplete studies should not be submitted as this section will have no or poor data. Comments like 'the study is still ongoing' serves little purpose for the jury members evaluating your abstract

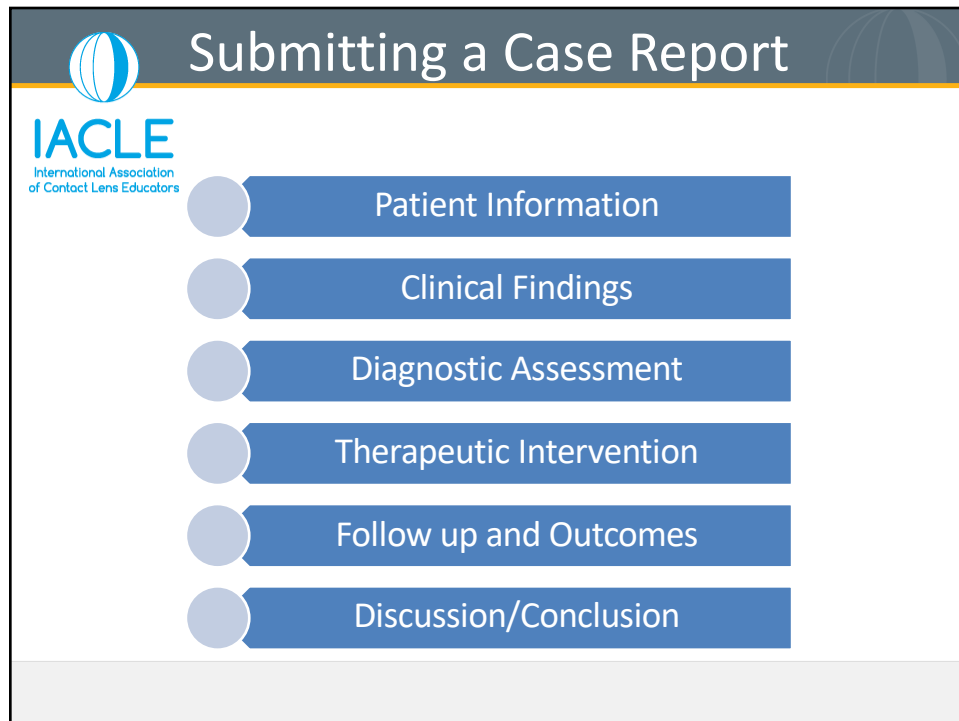


Discussion/Conclusion



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- This section should discuss how the results of your study adds to the existing literature.
- Do not introduce any new results.
- Does it answer the purpose of the study?
- Does it enforce what is already known on the subject?
- Does it provide an opposing view?
- Does it provide something new?
- How can these results impact clinical practice?
- Remember that your results are from your population base and may not be extended to the general public unless you have a very large sample size. So don't extrapolate.




Case Report: Getting started....


The diagram outlines the steps to get started with a case report, presented as a bulleted list. The steps include: keeping in mind the rules for the PHIPA (Personal Health Information Protection Act), gathering information (including case history, physical examination, imaging, and diagnostic testing), management plan and follow-up, and conducting a literature search (including making a reference list and reviewing target journals).

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- Keep in mind the rules for the PHIPA (Personal Health Information Protection Act) ---may need the patient's signed permission
- Information gathering;
 - Case history, physical examination, imaging and diagnostic testing
 - Management plan and Follow up
- Do a literature search
 - Make a Reference List of relevant articles to keep organized
 - Review target journals



Poster Abstracts




From AAO Scientific Program

Abstracts evaluated on the following:


- The level of scientific or clinical novelty
- The methodological soundness
- If a quantitative description of the results is present
- If conclusions are supported by results

From CARE guidelines

- Rationale for the case report (why is the case unique and reportable)
- Presenting concerns of the patient (chief complaint or symptoms, diagnoses)
- Interventions – such as diagnostic, preventative, prognostic, therapeutic
- Outcomes
- MAIN LESSON to learn from the report
- 200 words max.




Case Report Outline




- **Patient information**
 - De-identified demographic and other patient specific information
 - Main concerns and symptoms of the patient
 - Medical, family, and psychosocial history including relevant genetic information (this should also appear in the timeline)
 - Relevant past interventions and their outcomes
- **Clinical Findings**
 - Describe the relevant physical examination (PE) and other significant clinical findings
- **Diagnostic Assessment**
 - Diagnostic methods (PE, laboratory testing, imaging, surveys)
 - Diagnostic challenges (access, financial, cultural)
 - Diagnostic reasoning including other diagnoses considered
 - Prognostic characteristics when applicable (staging)

- **Therapeutic Intervention**
 - Types of intervention (pharmacologic, surgical, preventive)
 - Administration of intervention (dosage, strength, duration)
 - Any changes in the interventions (with rationale)
- **Follow-up and Outcomes**
 - Clinician and patient-assessed outcomes (when appropriate)
 - Important follow-up diagnostic and other test results
 - Intervention adherence and tolerability (how was this assessed)
 - Adverse and unanticipated events
- **Discussion**
 - Strengths and limitations in your approach to this case
 - Discussion of the relevant medical literature
 - The rationale for your conclusions (a causality assessment)
 - *The primary “take-away” lessons from this case report*



Creating a timeline - example




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Timeline Table Created Using Microsoft Word

Dates	Relevant Past Medical History and Interventions		
	Relevant personal, family and psychosocial history including important past interventions, outcomes, and follow-up. Genetic information should be included if available.		
Dates	Summaries from Initial and Follow-up Visits	Diagnostic Testing (including dates)	Interventions
	Patient's primary concerns as well as clinical initiated diagnostic assessments and diagnoses.	Relevant testing (imaging laboratory surveys). Include dates of testing.	Pharmaceuticals, lifestyle recommendations, dietary supplements and procedures
	Follow-up visits: <ul style="list-style-type: none"> Important outcomes and follow-up information Report adherence to interventions, how was this assessed Were there any unanticipated or adverse events 	Relevant testing such as laboratory, imaging, and surveys. Include dates of testing.	Pharmaceuticals, lifestyle recommendations, dietary supplements and procedures
	Add additional rows as needed for follow-up visits		
	Final outcome for this episode of care		

<http://data.care-statement.org/wp-content/uploads/2016/08/Timeline-Instructions-English-2015.pdf>



Creating a timeline - example



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Sample of Prolonged Timeline

Symptoms / Diagnosis

Symptoms:
Transient diplopia, headache onset

Findings:
Bilateral disc edema

Diagnosis:
IIH

Treatment:
Oral acetazolamide (500 mg daily)

Diagnostic Procedure:
MRI: empty sella;
MRV: no CVST;
Lumbar puncture: high opening pressure

Symptoms:
Vision loss

Time (days)

1 2 3 // 90 // 180 //

Interventions / Outcome


Treatment:
Transverse sinus stent placed

Outcome:
Resolution of papilledema


Treatment:
Oral acetazolamide (1 g daily)

Outcome:
Vision loss stabilized

Example Figure Legend:
 Clinical Timeline: 23 year old white female diagnosed and surgically treated for IIH. MRI= magnetic resonance imaging; MRV= magnetic resonance venography; CVST= cerebral venous sinus thrombosis; IIH= idiopathic intracranial hypertension.



Sample of a Template for CR



CASE REPORT WRITING TEMPLATE FOR AUTHORS

General Considerations. Please ensure that all patient data has been de-identified and that you obtained the necessary approval, if necessary, from an ethics commission or an institutional review board. Do you have any competing interests?

Title. Include the words "case report" in the title. Describe what is of greatest interest to you the author. This could be the presentation, the diagnosis, a test result, the intervention, or the outcome.

Abstract. In about 200 words summarize the following information if relevant: (1) Rationale for this case report, (2) Presenting concerns of the patient (such as chief complaints or symptoms, diagnoses), (3) Interventions (such as diagnostic, preventive, prognostic, therapeutic exchange), (3) Outcomes, and (4) Main lesson(s) to learn from this case report.

Key Words. Provide 2 to 5 key words that will help potential readers search for and find this case report.

Introduction. Briefly summarize the background and context of this case report.


Presenting Concerns. Describe the patient characteristics (such as the relevant demographics—age, gender, ethnicity, occupation) and their presenting concerns with relevant details of related past interventions.

Clinical Findings. Describe the (1) medical, family, and psychosocial history including lifestyle and genetic information; (2) other pertinent co-morbidities and interventions (other therapies including self-care); and (3) the physical examination (PE) focused on the important findings including results from testing.

Timeline. Create a timeline that includes specific dates and times in a table, figure, or graphic. Visit www.care-statement.org/case-report-examples for one example of a case report timeline.

Diagnostic Focus and Assessment. Provide an assessment of the (1) diagnostic methods (including laboratory testing, imaging results, questionnaires, referral diagnostic information); (2) diagnostic challenges (such as limited ability to complete an evaluation, patient availability, cultural); (3) diagnostic reasoning including other diagnoses considered, and (4) prognostic characteristics (such as staging in oncology) where applicable.

Therapeutic Focus and Assessment. Describe the (1) types of interventions (such as pharmacologic, surgical, preventive, lifestyle, self-care) and (2) administration and intensity of the intervention (including dosage, strength, duration, frequency).




Follow-up and Outcomes. Please describe the clinical course of this case including all follow-up visits as well as (1) intervention modification, interruption, or discontinuation, and the reasons; (2) adherence to the intervention and how this was assessed; and (3) adverse effects or unanticipated events. Please describe (1) patient-reported outcomes, (2) clinician assessed and reported outcomes, and (3) important positive and negative test results.


Discussion. Please describe the strengths and limitations of this case report including case management, and the scientific and medical literature related to this case report. Discuss the rationale for your conclusions such as potential causation and the ways this case might be generalized to a larger population. Finally, what are the main findings of this case report and what are the 'take-away' messages?

Patient Perspective. Whenever appropriate the patient should share their experience of their care in a narrative published within this case report or accompanying this case report.

Informed Consent. Ensure that the patient provided their informed consent for the publication of this case report.



Biography



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- Make sure you have a short biography (max 100 words) ready. Several conferences want a description of their presenters
- Update your biography often (at least 1X/year)
- Write your biography as if someone was presenting you (ie. do not use 'I' in the biography, write it in the third person)
- Add your academic affiliation, rank, administrative titles and any special awards/recognition



Conflict of Interest (CI)



- Most abstract submission ask if you have any conflict of interests with the study that you are presenting. This includes if you've received any of the following for the study;
 - Research funds (for materials, or participants, instrumentation)
 - 'Gifts in kind' to carry out the study (CL, artificial tears, or any other consumables)
 - Honoraria
 - If you are a consultant for the same company that you are presenting research on
 - If you have any shares or financial interests within the company whose products you are presenting on
- Prepare and update regularly a list of 'conflict of interest' for all the companies that you are involved with.
- CI applies to all authors, so ask them to send you their CI prior to the abstract submission.



Previous Publication



- Most conferences want an abstract of a study that has not been presented elsewhere.
- If you are only presenting part of a larger study, and another part has been presented elsewhere, then this needs to be divulged (describe the conference, date, venue and where it was presented)
 - Ex. This study was presented in part at the British Contact Lens Association conference in May 2017 as a poster presentation, Liverpool, UK. E-abstract # XXXXX



Language/Spelling



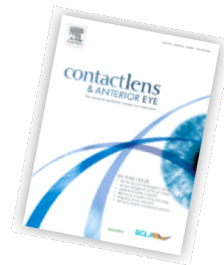
- Most conferences require English submissions. These are typically evaluated by jury committee members to assess if your submission is appropriate and relevant for the conference.
- Grammatical and syntax errors are amongst the major reasons for dismissal/refusal of an abstract, so it is of the outmost importance that your abstract, biography and any information that you provide be reviewed by someone else who is much more comfortable with the English language
- Use spell check



After Acceptance and Presentation



- Use feedback from your poster or paper (oral) presentation and then write it up as a publication!
- Every journal has a 'GUIDE FOR AUTHORS' describing each section of an article and the submission process
- Publishing enhances;
 - Your CV
 - The visibility of your institution
 - Your chances at meeting or maintaining Fellowship requirements (FAAO, FBCLA, FIACLE, etc)





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