GENERAL GUIDELINES FOR WRITING ABSTRACTS

PART A: Guidelines for Writing a Case Report Abstract

Title: The title is a summary of the abstract itself and should convince the reader that the topic is important, relevant, and innovative.

Authors: Include name, degree and institutional affiliation. The authors included should be those who contribute significantly to the intellectual content of the case report.

Introduction: Describe the context of the case and explain its relevance and importance.

- Describe whether the case is unique. If not, does the case have an unusual diagnosis, prognosis, therapy or harm?
- Is the case an unusual presentation of a common condition? Or an unusual complication of a disease or management?
- Describe the instructive or teaching points that add value to this case. Does it demonstrate a cost-effective approach to management or alternative diagnostic/treatment strategy? Does it increase awareness of a rare condition?

Case description: Follow the basic rules of medical communication. Report the case in sequence.

- Describe the history, examination and investigations adequately. Is the cause of the patient's illness clear-cut? What are other plausible explanations?
- Describe the treatments adequately. Have all available therapeutic options been considered? Are outcomes related to treatments? Include the patient's progress and outcome.

Discussion: Discuss rationale for decisions that were made and the lesson from the case.

- Report a literature review of other similar cases. Describe how this case is different from those previously reported.
- Explain the rationale for reporting the case. What is unusual about the case? Does it challenge prevailing wisdom?
- In the future, could things be done differently in a similar case?

PART A: Sample Case Report Abstract

Title: Ergotism Masquerading as Arteritis

Authors: Alexander J. Scumpia, D.O.[(1)], Daniel A. Aronovich, D.O.[(1)], Vanitha Vasudevan, M.D.[(1)], Ryan M. Shadis, M.D.[(2)] and Mauricio Lynn, M.D.[(2)].

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Introduction: Ergotism is a condition characterized by intense generalized vasoconstriction. The infrequency with which it is encountered makes ergot poisoning a formidable diagnostic challenge.

Case Presentation: A 34-year-old woman consulted her doctor because of headaches, dyspnea, and burning leg pain. A clinical diagnosis of mitral stenosis was made. Within a month, she had a cardiac catheterization because of progressive dyspnea. At catheterization, severe mitral stenosis was confirmed and an elective mitral value commisurotomy was scheduled. She presented to the hospital one day early because of increased burning in her feet and new onset right leg pain. In addition to mitral stenosis, the physical examination revealed a cool, pulseless right leg. An arteriogram showed subtotal stenosis and a pseudoaneurysm of the popliteal artery. At the time of the commisurotomy, a right femoral artery balloon dilation followed by patch graft repair of the stenosis was performed. On the fifth postoperative day, she experienced a return of the burning leg pain and the leg was again found to be cool and pulseless. An emergency arteriogram showed smooth segmental narrowing and bilateral vasospasm suggestive of severe, generalized large-vessel arteritis. Treatment was initiated with high-dose corticosteroids, anticoagulants, antiplatelet drugs, and vasodilators. Despite this, her condition worsened, with both legs becoming cool and pulseless. Additional history revealed that she had been abusing ergotamine preparations for a number of years to relieve chronic headache symptoms, and she continued to receive these medications during hospitalization. At this point, the ergotamine preparations were discontinued, and an intravenous infusion of nitroprusside was begun, resulting in significant improvement within 2 hours and her symptoms completely resolved within 24 hours. The patient remained symptom-free after the nitroprusside was discontinued and was discharged from the hospital.

Discussion: This case illustrates the prompt and accurate diagnosis of diaphragmatic rupture leading to optimal patient outcome.

PART B. Guidelines for Writing a Research Study Abstract

Title: The title should reflect and concisely describe your research project.

Authors: Include authors name, degree and institutional affiliation

Introduction/Background: Why is the topic you have selected a problem that needs to be addressed? What is missing from the field of study that your study is going to address? Provide a one-sentence summary of the rationale for the study question. End this section with a a one-sentence description of the study's primary objective(s) (e.g., "To determine…," "To establish…").

Methods: A short paragraph discussing the design, setting, patients, and interventions (Refer to the descriptions below). This section describes how the study was carried out.

- Design: A statement of the study's basic design (e.g., randomized controlled trial, double-blind, cohort, survey, cost-effectiveness analysis). Note: Make sure you include in the design statement a notation that the research study was approved by the IRB (institutional review board)
- Setting: A one-sentence description of the clinical circumstances of the setting (e.g., general community, primary care center, hospitalized care).
- Patients (or other participants): A brief description of the key eligibility criteria of the study's participants. The total number of the participants must be included and how many participants were included in each group of the study (i.e., study group(s), control group).
- Interventions: A brief description of any interventions administered. (e.g., OMM, medications, etc.)
- Main Outcome Measure(s): A brief description of the study's outcome measurements. (e.g., blood pressure, symptom scores, patient satisfaction scales)

Results: A brief summary of the main results along with declarations and explanations of any important findings. Authors should include the study's relevant statistical information (e.g. confidence intervals, levels of statistical significance).

Conclusion: How does this study add to the body of knowledge on the topic? Provide a brief summary of the study's conclusions directly supported by the reported evidence. Authors may include clinical applications and any recommendations for additional study.

PART B. Sample Research Study Abstract

Title: Cutaneous squamous cell carcinoma in epidermolysis bullosa: A 28-year retrospective study

Authors: SJ Robertson[1], E Orrin[2], MK Lakhan[2], G O'Sullivan[2], J Felton[3], DT. Greenblatt[2], C Bernardis[2], JA McGrath[2], AE. Martinez[4] and JE. Mellerio[2].

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Introduction: Some forms of epidermolysis bullosa (EB), notably severe generalized recessive dystrophic EB (RDEB-SG), are associated with increased risk of developing mucocutaneous squamous cell carcinomas (SCCs) which behave aggressively and are the major cause of mortality in early to mid-adulthood. We report our centers' experience of EB-associated SCCs over the last 28 years.

Methods: An observational, retrospective case record review of EB patients diagnosed with SCC between July 1991-June 2019.

Results: Forty-four EB patients with SCC were identified. They comprised: 31 (70%) with RDEB-SG, 1 (2.3%) with RDEB-pruriginosa, 1 with RDEB-inversa (2.3%), 2 (4.5%) with RDEB-generalized intermediate, 3 (6.8%) with junctional EB generalized intermediate (JEB-GI), 5 (11.4%) with dominant dystrophic EB, and 1 (2.3%) with Kindler syndrome. Diagnosis of first SCC was earlier in the RDEB-SG group (median 29.5 years (range 13-52 years)) compared to other groups collectively (median 47.1 years (range 30-89 years)). Most SCCs occurred in the RDEB-SG group, and the majority had multiple tumors (mean 5.8 (range 1-44)). Metastatic disease occurred in 16 of 31 (51.6%) RDEB-SG patients and 1 with JEB-GI. Treatments for metastatic disease included lymph node dissection (n=6), radiotherapy (n=5), chemotherapy (n=3), electrochemotherapy (n=2), and targeted cancer therapies erlotinib (n=1), cetuximab (n=2) and cemiplimab (n=1).

Conclusion: EB-associated SCCs differ from those in the general population: they affect a younger age group and there are often multiple primaries. They behave aggressively and metastasize early despite well-differentiated histopathology. The median survival after diagnosis of first SCC in RDEB-SG patients of just 2.4 years underscores the poor prognosis in this group. As the largest cohort of EB SCC patients with comprehensive data regarding clinical course and management to date, our data reinforce the need for regular clinical surveillance for SCCs in EB patients, starting from adolescence in RDEB-SG and from the 3rd or 4th decade for other at-risk groups.

References

https://www.aacp.org.uk/assets/ckfinder_library/files/Guidance%20Writing%20an%20Abstract%20-%20AACP.pdf

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