Important changes to 2016 ASM Abstract Submission Guidelines:

- Abstract submission is an online process for 2016
- Tables will not be accepted for 2016 ASM abstracts

Instructions:

1. Length limits:
   a. Title: 20 words.
   b. Abstract: 350 words
      i. Including section labels (Background, Research question, Methods, etc.)
      ii. Not including authors or author affiliations.
   c. Author affiliations: Up to 2 per author

2. Deadline:
   a. Submissions will be accepted until 11:59 pm Eastern Standard Time, November 16, 2015. Late submissions cannot be accepted.

3. How to submit:
   a. Submit your abstract online via the following link:
      http://www.acmt.net/2016_ACMT_Abstract_Submission.html
   b. Confirmation will be delivered electronically immediately after submission.
   c. Abstract review and author notification will be conducted on a rolling basis.
      i. All authors will receive a decision about acceptance by mid-December.
   d. All communications will be made by email.
   e. If you have questions, please contact ASMresearch@acmt.net.

4. Type of Research:
   a. The ACMT Annual Scientific Meeting welcomes all types of original research of interest to medical toxicologists and their patients.
   b. For review purposes, please classify your study as one of the following:
      i. Research studies
      ii. Case reports
         1. The definition of a case report is a study involving fewer than three patients with a similar condition, presentation, or clinical feature and that does not involve an *a priori* planned novel medical / scientific intervention.
      iii. When in doubt, inquire at ASMresearch@acmt.net.

5. Encore presentation of research studies:
Toxicology research is presented at numerous educational/scientific gatherings each year. In an effort to provide ACMT ASM participants with access to the best available new research, the ACMT ASM supports “encore presentation” of research that has been presented at other scientific meetings, subject to the following policies:

i. **All prior presentation must be disclosed at the time of abstract submission (see examples)**
   1. This includes prior presentation of partial / preliminary results.

ii. **Prior presentation concerns presentation at a national or international meeting.**
   1. Presentation at local or regional meetings does not constitute prior presentation.

iii. **Studies presented on/before March 18, 2015, are not eligible for encore presentation at ACMT ASM 2016**

iv. **Research studies** presented (or scheduled for presentation) between March 20, 2015 and March 18, 2016, are eligible for encore presentation
   1. Case reports are not eligible for encore presentation

b. **When in doubt, inquire at ASMresearch@acmt.net.**

6. **Prior publication:**
   a. Studies that have been (or are scheduled to be) fully published (manuscript form) prior to March 18, 2016 are not eligible for presentation at ACMT ASM
   b. Research that has been published in abstract form only is eligible for presentation.
      i. For copyright reasons, previously published abstracts will be acknowledged in the *Journal of Medical Toxicology* with the abstract reference, but cannot be republished.
   c. **When in doubt, inquire at ASMresearch@acmt.net.**

7. **Style:**
   a. **Structure:** All original research and previously published original research abstracts should contain the following sections, underlined in the text:
      i. **Background:** 1 – 2 sentences explaining why the research is needed.
      ii. **Hypothesis or Research question:** 1 sentence.
         1. Optional (but encouraged) for case reports
      iii. **Methods:** Succinctly describe your study methods.
          1. Begin with a statement of your research type (e.g. this is a randomized clinical trial; this is a consecutive-patient case series; this is a convenience sample survey; this is a case report).
          2. Include setting/data source, method of obtaining data, and statistical analyses used.
          3. Even a case report should have basic methods! See example #2.
      iv. **Results:** Present your key results.
          1. Statements such as “results will be presented at the meeting” are not acceptable.
      v. **Discussion:**
1. 1 – 3 sentences, very succinctly explaining the significance of your results.
2. Where appropriate, state study limits here.
3. Do not present results in the discussion section, and avoid making statements in the discussion section that do not flow directly from your data.

vi. **Conclusion:** 1 sentence.

b. Statistics: Whenever appropriate, present the measure of central tendency followed by a description of certainty.
   i. **If a comparison is not significant, denote with “NS”, not the p value number.**
   ii. For parametric data, this is usually presented as measured result and 95% confidence interval (e.g. 150 mmHg (95% CI: 135 – 165 mmHg)).
   iii. For non-parametric data, this is usually presented as median and either range or 25th/75th percentile (e.g. median: 150 mmHg (IQR: 130 – 175 mmHg)).
   iv. For comparative tests:

   1. If the difference is statistically significant, at a minimum please present P value and test used (e.g. “mean pressure was 150 mmHg in the intervention group and 190 mmHg in the control group (P = 0.02, Chi-square)."
   2. If the difference is not statistically significant, do not present the P value (e.g. “mean pressure was 150 mmHg in the intervention group and 155 mmHg in the control group (P = NS, Chi-square))."
   3. It is strongly preferred to also present an estimate of the absolute difference (e.g. mean pressure was 150 mmHg in the intervention group and 190 mmHg in the control group (95% CI for difference: 25 – 55 mmHg; P = 0.02, Chi-square))."

c. Abbreviations and units of measure:
   i. Please minimize the use of unfamiliar abbreviations.
   ii. The first time an abbreviation is used, define it (e.g. 400 least publishable units (LPUs)).

   1. It is not necessary to define common, units of measure (cm; mmHg) or other very common abbreviations (US; PC; IQR).
   iii. We strongly encourage you to include SI units with all measurements (e.g. 12 inches (31.1 cm)).

d. Tables and figures:
   i. **Tables will not be accepted for the 2016 ASM abstracts, but are encouraged where appropriate in platform and poster presentations.**
   ii. Graphs, photographs, maps, and other figures are not permitted, but are encouraged where appropriate for platform and poster presentations.

e. Fonts and symbols:
   i. Please use only symbols from common Microsoft or Apple system fonts.
   ii. Use italics to designate scientific names or foreign words (e.g. *Crotalus, a priori*). Do not use italics or underlining for emphasis.
iii. Do not capitalize each word or all words of the abstract title
f. Proprietary names: Do not use proprietary (trade) names of any product unless necessary to convey specific information. Use standard/recognized generic names.
g. References: Do not include references in your abstract. It is appropriate to provide references in an eventual poster or platform presentation.

8. Authors:
a. All submissions must conform to the Internal Committee of Medical Journal Editors Authorship and Contributorship requirements, available here: http://www.icmje.org/ethical_1author.html.
b. Author names should be listed as last name and initials, separated by commas (e.g. Rumack BH, Goldfrank LR)
c. There is no limit to the number of authors
d. A maximum of 2 affiliations per author are permitted.
   i. Include: Institution, City, US State or Country (e.g. University of Sorghum, Smallville, NE)
   ii. Do not include department or division.

e. If the abstract involves reporting of Toxicology Investigator's Consortium (ToxIC) data, then ToxIC must be credited as an author using the following phrase: On Behalf of the Toxicology Investigator's Consortium (ToxIC)

9. Funding support:
a. All funding support must be disclosed.

10. Selection process and criteria:
a. All eligible abstracts will undergo blinded peer review by at least three members of the ACMT research committee
   i. Reviewers are required to disclose conflicts of interest and recuse themselves from review of any abstract involving a personal, professional, or financial conflict
b. Selection will be based on overall score
c. Selection for platform presentation will be based on overall score
   i. Encore presentations are eligible for platform presentation, with the limitation that research that was presented as a platform at a previous meeting geared primarily toward medical toxicologists will generally not be eligible for platform presentation at ACMT ASM.

11. The Research Committee will recognize one platform as Best Presentation

Thank you for choosing to submit your work to the 2016 ACMT Annual Scientific Meeting!
# EXAMPLE 1 (Research Study)

**Title**
Does Acetaminophen Poisoning Increase Risk of Allergy to Cats?

<table>
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<th>Abstract text</th>
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| **Background:** Epidemiologic studies have reported an association between acetaminophen use and allergy/atopy. Allergy to house cats (*F. catus*) is a common medical condition. It is not known whether exposure to acetaminophen in overdose increases the risk of subsequently developing house cat allergy.  

**Hypothesis:** Are acetaminophen overdose patients at increased risk of developing allergy to house cats?  

**Methods:** This is a retrospective study of consecutive patients presenting to a tertiary care hospital, and age/sex-matched controls. A search of our hospital’s electronic medical record system (1992 – September 1, 2011) was used to identify all patients discharged alive following hospital admission for acetaminophen overdose. Each case was age- and sex-matched 2:1 to control patients admitted for an overdose to a non-acetaminophen pharmaceutical product. An event was defined as any inpatient or outpatient encounter containing an ICD-9 code-family notation for asthma or allergic conditions and the word, “cat,” in the provider notes field. Subjects were censored 24 months after their last encounter in our system. Cox proportional hazards analysis was used to evaluate time-to-event.  

**Results:** A total of 84 patients admitted for acetaminophen overdosage were matched to 142 controls. During a median of 16 months of follow-up, 17 acetaminophen overdose patients and 12 controls developed cat allergy (HR: 2.5; 95% CI: 1.2 – 6.8; P = 0.02, Cox PH)  

**Discussion:** Our analysis is limited by the inability to control for prior or subsequent acetaminophen use.  

**Conclusion:** Patients who overdose on acetaminophen may be at increased risk of subsequent developing house cat allergy.
American College of Medical Toxicology  
2016 Annual Scientific Meeting  

EXAMPLE 2 (Case Report)

<table>
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<th>Title</th>
<th>Neutoprolol Extraction During High-Flux Hemodialysis</th>
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| Abstract text | Background: Neutoprolol is a new beta-receptor antagonist that produces life-threatening toxicity in overdose. It is not previously known whether neutoprolol is removed by hemodialysis.  
Hypothesis: High-flux hemodialysis increases clearance of neutoprolol compared with native elimination alone.  
Methods: This is a single patient chart review. A 42 year old woman with a history of hypertension ingested 28,000 mg of neutoprolol in a suicide attempt. Hypotension and bradycardia were refractory to therapy with glucagon, norepinephrine, and high dose insulin. High flux hemodialysis was initiated 7.2 hours after ingestion. Timed serum neutoprolol levels were obtained before, during, and after hemodialysis as part of routine clinical care. In addition, inlet and outlet neutoprolol levels were obtained from the dialysis circuit. Dialysis was performed using a Frensius 2008K machine and a Markum 6000 cellulose triacetate membrane. Pharmacokinetic calculations were made using SummitPK.  
Results: Three pre-dialysis, four intra-dialysis, and two post-dialysis serum neutoprolol measurements were obtained. All demonstrated first-order elimination kinetics. The serum half-life of neutoprolol was 8.4 hours pre-dialysis, 1.2 hours during dialysis, and 7.2 hours post-dialysis. Dialysis clearance of neutoprolol was 65 mL/min. At a time when the serum neutoprolol level was 78.5 mcg/mL, dialysis extraction of neutoprolol was 15.7 mg/min. Following 6 hours of dialysis, the patient was weaned from vasopressor support. She recovered fully and was transferred to psychiatry on 4 days after ingestion.  
Discussion: Although this study shows that dialysis increases neutoprolol elimination, whether this translates to clinical benefit is unproven. Because protein binding of neutoprolol is inversely related to serum levels, these results may not apply to the chronic care setting.  
Conclusion: High flux hemodialysis effectively removes neutoprolol under overdose conditions. |