

# ABSTRACT SUBMISSIONS

## POLICIES WITH REGARD TO ABSTRACT SUBMISSION, REVIEW AND ACCEPTANCE FOR PRESENTATION AND PUBLICATION.

To submit an abstract at the Member or Associate Member rate, your membership dues must be current. **Only members of the AACA are entitled to submit.** Any first author whose abstract is submitted for presentation or presentation and publication **must register and attend the conference in order for his/her abstract to be published in Clinical Anatomy.** All first/presenting authors must be members of the AACA. Both the submitting and presenting author/s must be members of the AACA.

The abstract submission process will be facilitated through AACA's new website. This will allow for both payment and abstract submission to occur in one step. Participants will complete one of three online forms (one for Regular members, one for Associate members (Students and/or Post-Doctoral fellow) and one for International members). **All abstracts must be received by 5 pm EST, March 9, 2015. If a member wishes to submit an abstract after the deadline of March 9, they may do so until the Late Breaking abstract deadline of March 31. However, any abstracts received after the first initial deadline of March 9 will be ineligible for an award or for publication in *Clinical Anatomy*.**

A non-refundable submission processing fee must be paid via credit card **prior to or at the time** of submission of each abstract.\* When a PI is submitting an abstract on behalf of a student, the Associate Member form should be used. The rates per abstract submitted along with the link to the forms are as follows:

**\$30 AACA Member (Regular Member, Affiliate, Senior, Honored)**

Click [here](#) to complete the AACA Member Abstract Form

**\$25 AACA Associate Member (Student, Post-Doctoral Fellow)**

Click [here](#) to complete the AACA Associate Member Abstract Form

**\$25 or \$30 AACA International Member (Member (any type) located outside of the USA).**

Click [here](#) to complete the AACA Foreign Member Abstract Form

**\*Payment will need to be relayed to AACA headquarters after submitting the form.**

\*Currently, the AACA website is having difficulty accepting international credit cards. We are working on this issue. However, **if you are located outside of the US, please use the following form to submit your abstract:** After you submit the form, please email AACA Headquarters at [chyatt@asginfo.net](mailto:chyatt@asginfo.net) to coordinate your payment. Any abstracts that have not been paid for by **March 9th** will be considered **INCOMPLETE** and will not be reviewed.

Do NOT use your email address if you are submitting on behalf of your colleague or student. Please use the contact details for the **presenting author**.

Abstracts are to be identified and submitted in one of two categories:

**Research-Based** (e.g., Hypothesis/Data driven)

**Descriptive** (e.g., Conceptual, Case Report, Procedures, Historical, Technical, Anatomical Services related, Career Development related, etc.)

Abstracts are to disseminate **original** scholarship only.

Research Based Abstracts **must** consist of: (1) an INTRODUCTION that includes the purpose of the study; (2) METHODS and materials/subjects used; (3) a SUMMARY of findings and their clinical implications; and (4) CONCLUSIONS.

Descriptive Abstracts **must** consist of: (1) an INTRODUCTION that includes the purpose for the project; (2) RESOURCES used for the completion of the project; (3) a succinct DESCRIPTION of the work; (4) the SIGNIFICANCE to clinical anatomy.

**Failure to follow the applicable format means that the abstract will be returned to the author, without review, for correction. The corrected abstract must be returned to AACA headquarters within four days.**

**If the abstract has to be returned, there will be a \$20 fee for resubmission.**

Examples of the format for each of the two categories are given below.

All abstracts will undergo a two-step review process:

1) An initial review to determine that the title and authors have been appropriately formatted and that the appropriate format has been used in writing the abstract. If the abstract fails to follow the stated rules, it will be sent back to the first author for revision and resubmission. Thus, if the abstract is submitted at the last deadline and does not pass the initial review, it will not be accepted for the annual conference.

2) If the abstract passes the initial review, it will undergo a “blinded” review process by the Abstract Review Committee. During the abstract review process, abstracts will be recommended for:

- Acceptance for presentation and publication in our journal, *Clinical Anatomy*
- Acceptance for Presentation only
- Rejection

Failure to adhere to these submission policies will result in rejection of your abstract, so make sure you understand what is required and the timeline of submission to ensure that your abstract will reach the Abstract Review Committee on time.

Final caveats:

**1) Review your abstract carefully before clicking the Submit button. Failure to do so could result in a delay that would prevent it from being considered for presentation and publication.**

**2) If your poster abstract is accepted for publication, please note that poster presenter(s) must be at the poster for the full assigned presentation time or their abstract will not be published in Clinical Anatomy.**

**3. Submit your abstract at or before the stated submission deadline, even if you are unsure of funding to attend the meeting. If you don't receive funding, you can always withdraw your abstract.**

**4. Students: Make sure it is clear on your abstract submission that you are a student! All student abstracts, regardless of poster or platform presentation, will automatically be judged for either the Sandy Marks or Ralph Ger award, according to assignment to a poster or platform session, respectively. For award purposes, dual presenters will not be considered.**

### **Conference Registration**

Registration for the conference is a separate fee. **The PRESENTING AUTHOR must be registered for the conference by April 27th, 2015 or the abstract will be pulled from the meeting program. Additionally, any author that is accepted for presentation must register and attend the conference in order for their abstract to be published.**

We look forward to seeing you this summer in Henderson!

Sincerely,

David Porta and Sherry Downie, Co-Chairs

2015 AACA Meeting Planning Committee

Noelle Granger, Chair

Meeting Oversight and Program Planning Committee

## **Instructions for Preparing Abstracts**

### **Format of Abstracts**

1. **Author listing.** Type the presenter's last name first in CAPITAL letters, followed by the first name and middle initial. The remaining authors follow with their first name first, then middle initial, and finally, their last name (in all capital letters). CAPITALIZE last names, middle initials, and JR., SR., or III. For first names, capitalize only the first letter. Author listings must be submitted EXACTLY as you wish for publication, including full author institutional affiliation(s).
2. **Institutional affiliation.** Type the name(s) of the department/hospital and institution in which the work originated, followed by city, state, and country. Abbreviate names of states using the standard two letter postal abbreviations. Include postal/zip codes.
3. **Title.** Do not use capital letters in the title, except for the first letter of the first word and proper names.
4. **Body of the abstract.** The body of the abstract is to be composed as a single structured paragraph having embedded the following headings (in all capital letters): INTRODUCTION, METHODS, SUMMARY, and CONCLUSIONS for Researched Based Abstracts, or INTRODUCTION, RESOURCES, DESCRIPTION, and SIGNIFICANCE for Descriptive Abstracts, depending on the category of abstract you are submitting. The body of the abstract is limited to 2000 characters (including spaces). Do not indent the paragraph. The abstract should consist of text only. Do not include citations, tables or illustrations, or use undefined abbreviations. Place acknowledgments at the end in parentheses, e.g., "(Sponsored by Grant No. \_\_\_\_\_ from the \_\_\_\_\_ Association.)"

### **Examples of proper formatting for Research-based and Descriptive type abstracts:**

#### **Research-based abstract.**

TUBBS, R. Shane, and Marios LOUKAS. Children's Hospital, Birmingham, AL 35233, USA. A novel method for cerebrospinal fluid diversion utilizing the sternum: A cadaveric and animal study.  
INTRODUCTION. Additional distal sites for placement of cerebrospinal fluid (CSF) diversionary shunts may be necessary in some patients. The present study aimed to investigate the sternum as a

potential receptacle for CSF for potential application in patients with hydrocephalus. **METHODS.** Five fresh adult human cadavers less than four hours from time of death underwent cannulation of the manubrium in a suprasternal location. Tap water was infused via a metal trocar for approximately 60 minutes. Additionally, morphometric examination of the manubrium from 40 adult human skeletons was performed including the height, width, and thickness of this part of the sternum. Lastly, two anesthetized rhesus monkeys underwent cannulation of the manubrium with infusion of 50 cc of saline over approximately one hour while monitoring vital signs. **SUMMARY.** A total of 30 L of water was easily injected into all cadaveric specimens without overflow from the infusion site or noticeable edema of the body. Upon inspection of the thoracic and abdominal cavities, no fluid accumulation was identified insuring that all infused fluid had gone into the vascular system. The manubrium had a mean length, width, and thickness of 5.1 cm, 5.0 cm and 1 cm, respectively. The two animal specimens tolerated the infusion of saline into the sternum without vital sign changes or evidence of saline leakage into the pleural cavity. **CONCLUSIONS.** Based on our cadaveric, osteological, and animal study, the manubrium of the sternum is an ideal location for the placement of the distal end of a CSF diversionary shunt. In vivo human studies are now required to verify our findings.

ROBERTS, Shannon L.<sup>1</sup>, Joanna WEBER<sup>2</sup>, Zhi LI<sup>1</sup>, Adel FATTAH<sup>3</sup>, Michele OLIVER<sup>2</sup>, Anne M.R. AGUR<sup>1</sup>, and Karen GORDON<sup>2</sup>. <sup>1</sup>Division of Anatomy, Department of Surgery, University of Toronto, Toronto, ON M5S 1A8, Canada; <sup>2</sup>School of Engineering, University of Guelph, Guelph, ON N1G 2W1, Canada; <sup>3</sup>Department of Plastic Surgery, Alder Hey Children's NHS Foundation Trust, Liverpool L12 2AP, United Kingdom. [Morphology of human forearm muscles: fibre bundle architecture and tendon tissue properties.](#)

**INTRODUCTION.** The architecture and tissue properties of the musculotendinous unit are unique to each muscle and are integral to determining its functional attributes. Studies quantifying these properties are scarce and often relate to a single muscle group or a sampling of muscles. Without a thorough knowledge of normal musculotendinous morphology, it is difficult to assess pathology. The purpose of this study is to quantify and compare the architectural parameters and tendon tissue properties of 16 forearm muscles. **METHODS.** The fibre bundles and external/internal tendons of 16 forearm muscles from one cadaveric specimen were serially dissected, digitized with a Microscribe® G2X Digitizer and reconstructed in 3D with Autodesk® Maya®. Muscle architectural parameters (fibre bundle length/pennation angle/physiological cross-sectional area/volume) were computed. The tendon properties (cross-sectional area/ultimate stress and strain/stiffness/Young's modulus) were quantified in 5 unembalmed specimens using an Instron 8872 servo-hydraulic testing device with an attached laser reflectance system. **SUMMARY.** A comprehensive database of the normal architecture and tendon tissue properties of 16 forearm muscles was compiled. This database enables comparison of the musculotendinous morphology between the flexor and extensor muscles as functional groups, between individual muscles and within regions of a single muscle. **CONCLUSIONS.** Quantification of the architectural parameters and tendon tissue properties of the forearm muscles will enable more realistic dynamic simulation. Clinically, this data could be used as

a baseline for the diagnosis of pathology and to set target values for tendon repairs, and enable identification of muscles with similar properties for tendon transfers.

### **Descriptive abstract.**

GOGALNICEANU, Petrut, Peter ABRAHAMS, Andrew FLETCHER, Elizabeth MCEVOY, and Jamie ROEBUCK. St. George's Hospital, London W1U 6LD, United Kingdom. From Lister's tubercle to Rotter's nodes – A new experiment in clinical anatomy podcasting.

**INTRODUCTION.** Clinically integrated anatomy teaching requires a multitude of resources drawn from the bedside, the dissection room and the radiology unit. These vary in availability and location to such an extent that it is difficult for students to access all of them in a time efficient manner for revision purposes. **RESOURCES.** A series of anatomy podcasts compatible with MP3 players was designed, using high resolution digital imaging and three dimensional animations combined with narrative and visual explanations. We present two iPod Touch podcasts designed to teach the clinical anatomy of the breast and of the wrist. They incorporate three dimensional simulations, cadaveric dissection, schematic diagrams, angiograms, plain radiographs and computed tomography (CT) reconstructions. Audio and on-screen text commentary are used in conjunction with digital highlighting techniques to guide the student and explain the clinical relevance of anatomy. **DESCRIPTION.** To design a portable, handheld software package to provide an integrated method of revising clinical anatomy and radiology outside the conventional academic environment. **SIGNIFICANCE.** Anatomy podcasts provide an affordable and accessible method of teaching clinical anatomy, utilizing digital platforms that are increasingly available in the medical student population. Furthermore, they facilitate integration of basic and clinical sciences utilizing an extensive variety of anatomical imaging. Whilst podcasts cannot replace traditional methods of teaching, they provide a unique educational opportunity in an accessible, visually engaging and interactive environment.