ABSTRACT SUBMISSION GUIDELINES

2025 Annual Scientific Meeting
Fairmont Hotel Vancouver, Vancouver BC | In Person
April 4-6, 2025

Detailed Guidelines for Abstract Preparation

Abstracts will be accepted from September 1, 2024 until November 15, 2024 at 11:59 pm EST. Corresponding authors will be notified in mid-December.

The 2025 ACMT Annual Scientific Meeting will be an in-person event in Vancouver BC. Authors should plan to attend in-person to present their research should their abstract be selected for presentation.

The only funding offered by ACMT is through the travel awards and this can be applied for during the submission process.

How to Submit

Click here to submit your abstract by the deadline: November 15, 2024

Register a New Account with Oxford Abstracts
Oxford Abstracts has updated their system since last year, so if you have not used Oxford Abstracts since then, you will have to create a new login. You may create the login at any time. You will receive email confirmation immediately after submission.

Abstract Guidelines

Eligibility

The ACMT Research Committee welcomes all types of original research of interest to medical toxicologists and their patients. For abstract scoring purposes, please classify your submission as one of the following:

- Research studies
    - Research studies should be original research of interest to the field of Medical Toxicology.
    - *Please note that literature reviews or opinion pieces or method/concept studies will not be considered as original research and will not be considered eligible. If you have any questions regarding this, please contact* asmresearch@acmt.net.
- Case reports

- The definition of a case report is a study involving fewer than three patients. The case(s) should describe a timely or unique or rare clinical finding or toxicological disease process of interest and add value to the specialty of Medical Toxicology. Cases describing unique/novel pharmacokinetic data, analytical methods, diagnostic tests, or therapeutic modalities are also appropriate.

Encore Presentation of Research Studies

Toxicology research is presented at numerous educational / scientific gatherings each year. To provide ACMT ASM participants access to the best available new research, the ACMT ASM also supports "encore presentation" of research that has been presented at other scientific meetings, subject to the following policies:

1. Prior presentations are defined as presentations at a national or international meeting. Presentation at a local or regional meeting does not constitute a prior presentation.
2. Any prior presentation at the North American Congress of Clinical Toxicology (NACCT) will not be eligible for an encore presentation at ASM.
3. Research studies presented (or scheduled for presentation) between April 4, 2024 and April 4, 2025, are eligible for encore presentation.
    1. Studies presented before April 4, 2024 are not eligible for encore presentation at 2025 ACMT Annual Scientific Meeting.
    2. Case reports and case series are not eligible for encore presentation.
4. Any prior presentation must be disclosed at the time of abstract submission. This includes prior presentation of partial / preliminary results.

Prior Publication

Studies or case reports/series (including encore presentations) that have been (or are scheduled to be) fully published (manuscript form) prior to April 4, 2025 are NOT eligible for presentation at ACMT ASM.

Research that has been published in abstract form only is eligible for presentation. For copyright reasons, previously published abstracts will be acknowledged in the *Journal of Medical Toxicology* with the abstract reference, but cannot be republished.

ToxIC Presentation

Studies or case reports/series (including encore presentations) that use ToxIC data must check off that this is a ToxIC presentation and ToxIC should be included as an author, on the abstract submission form.

Length limits

1. Title: 20 words
2. Abstract: 400 words
    1. Including section labels (Background, Methods, Results, Conclusion)
    2. Not including authors or author affiliations

3. Author affiliations: Maximum two per author

Structure

All original research and previously published original research abstracts should contain the following sections in the text. The text is required to have all of these sections and headers clearly identified:

1. **Background:** 1 – 2 sentences explaining why the research is needed.
2. **Hypothesis or Research Question:** 1 sentence.
    1. Optional (but encouraged) for case reports.
3. **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 and method of obtaining data.
    3. Even a case report should have basic methods! See example #2.
4. **Results:** Present your key results.
    1. Statements such as, “Results will be presented at the meeting,” are not acceptable.
    2. Data tables and/or figures are not permitted in the abstract but are encouraged in the platform or poster presentation.
    3. Clinical images, such as radiographs, ECGs, or photos are also not permitted in the abstract.
5. **Conclusion:** 1-3 sentences.

Statistics

Whenever appropriate, present the measure of central tendency followed by a description of certainty.

1. If a comparison is not significant, denote with “NS,” not the p value number.
2. For parametric data, this is usually presented as a measured result and 95% confidence interval (e.g., 150 mmHg (95% CI: 135-165 mmHg)).
3. 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)).
4. For comparative tests:
    1. If the difference is statistically significant, at a minimum, present p value (e.g., “mean pressure was 150 mmHg in the intervention group and 190 mmHg in the control group (p = 0.02).”)
    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).”

3. It is strongly preferred also to 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)).

Abbreviations and Units of Measure

1. Minimize the use of unfamiliar abbreviations.
2. 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; CI).
    2. When comparing items with “versus,” use “vs.” (e.g., 150 mmHg vs. 190 mmHg,” or 150 vs. 190 mmHg).
3. We encourage you to include SI units with common measurements (e.g. 12 inches (31.1 cm)).

Spacing

1. Use only one space after a period or colon in the text.
2. Place a space between a number and its units (e.g., Sodium 119 mEq/L).

Tables and Figures

1. Tables will not be accepted in ASM abstracts, but are encouraged where appropriate in platform and poster presentations.
2. Graphs, photographs, maps, and other figures are not permitted, but are encouraged where appropriate for platform and poster presentations after acceptance.

Fonts and Symbols

1. Use only symbols from common Microsoft or Apple system fonts.
2. Use italics for emphasis.
3. Capitalize the first letter of words in the abstract title (e.g., “Intravenous Magnesium Compared to Calcium for Hydrofluoric Acid Treatment: A Randomized, Controlled Trial”).

Proprietary Names

Do not use proprietary (trade) names of any product unless necessary to convey specific information. Use standard/recognized generic names.

References

Do not include references in your abstract.

General

1. When starting sentences with numbers, spell out numbers (e.g., “Seven hundred and ninety-five patients were enrolled in the study”).
2. Spell out numbers between zero and nine. Use numerals for 10 and over.

Authors

1. All submissions must conform to the International Committee of Medical Journal Editors Authorship and Contributorship requirements available here: http://www.icmje.org/recommendations/browse/roles-and-responsibilities/defining-the-role-of-authors-and-contributors.html
2. List author names as initials of the first and middle name and full last name (e.g., BH Rumack, LR Goldfrank).
3. Identify one author as the presenter. The presenter must be able to register for and attend the Annual Scientific Meeting.
4. You may only submit a maximum of 10 author names. For any larger consortiums, include participants as an appendix.
5. Only two affiliations per author are permitted.
    1. Include: Institution, City, US State or Country (e.g., University of Sorghum, Smallville, NE)
    2. Do not include department or division.
6. If the abstract involves reporting of Toxicology Investigators Consortium (ToxIC) data, then ToxIC must be credited as an author using the following phrase: “On behalf of the Toxicology Investigators Consortium (ToxIC)”

Funding Support

Authors must disclose ALL funding support.

Questions?

ASMresearch@acmt.net

Sample Abstract: Research Study

Does Acetaminophen Poisoning Increase Risk of Allergy to Cats?

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 overdose 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)
Conclusion: Patients who overdose on acetaminophen may be at increased risk of subsequently developing house cat allergy.

Sample Abstract: Case Study

Neutoprolol Extraction During High-Flux Hemodialysis

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 increased 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 day 4 after ingestion.
Conclusion: High flux hemodialysis effectively removes neutoprolol under overdose conditions.