Student

Poster Submission Rules & Format Guidelines

Ernest N. Morial Convention Center
New Orleans, LA
December 6-10, 2015

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DEADLINE: 11:59 pm Pacific – October 1, 2015
To submit your abstract, visit http://www.ashp.org/get_involved

Thank you for your interest in presenting at the 2015 ASHP Midyear Clinical Meeting to be held in New Orleans, LA, December 6-10, 2015.

This document is to assist you in the preparation of your abstract submission for a poster presentation. To ensure your abstract is accepted for presentation, please **read all the instructions carefully.** **Note that instructions have changed for this year.**

Important Information:

Deadline is October 1, 2015, 11:59 p.m. (Pacific). No exceptions.
This deadline is final! You may edit a submission any time prior to the deadline. No new submissions or edits will be accepted after the deadlines. ASHP will not edit abstracts. Incomplete submissions found after the deadline will be deleted.

- **You must either currently be a student** or your study was conducted while you were a student.
- **Incomplete submissions will not be considered**.
- **Primary Authors can only create one abstract;** however, they can be additional authors on other abstracts. (See page 3).
- **NEW! Student Poster sessions will be held on Monday, Tuesday, *and* Wednesday.** Session times will be decided after the submission site closes and will be dependent on the number of abstracts received. Posters will be grouped by state, but not necessarily in alphabetical order. **We cannot take special requests for dates or times**. (Please plan your travel accordingly).
- Sessions times vary **(*Please plan your travel accordingly*).**
- **An acceptance list by Primary Author Last Name will be posted in mid-October (~ October 21)** at http://www.ashp.org/Get_Involved. If your submission has been accepted, please read the Poster Presenter Handbook, also posted online.

Authorship

PRIMARY AUTHORS

The person entering the information online ***must be the Primary Author*** and will be responsible for providing the required information for **all** authors. We define the "Primary Author" as the leading author of the abstract and the one whose name appears first on the abstract. Therefore, the submitting author's name will *automatically* appear first on the citation and the abstract, and it is their contact information that will be printed on the published version of the abstract.

A Primary Author may submit only one abstract; however, they may be an additional author on other abstracts. Any Primary Author trying to submit more than one abstract will risk having ALL of their submissions rejected.

ADDITIONAL AUTHORS

Each submission may have up to **five (5) authors** – the Primary Author and **four (4) additional authors**. If you submit more than four additional authors ASHP will accept the first four and delete the rest. The Primary Author should check to make sure that all authors and their information are included and in the order they will appear on the abstract and citation. **ASHP will not add "forgotten" authors or make changes to the author order. Incomplete additional author information may cause the abstract to be rejected.**

Composing Your Abstract

Your abstract content and word limits are determined by the type of poster.

Poster abstracts are classified as one the following:

- **D = Descriptive Reports:** Describes new, improved or innovative roles or services in pharmacy practice, or unusual clinical cases in one or a few patients that have not been formally evaluated but are of such importance that they must be brought to the attention of practitioners. Descriptive reports must contain detailed rationale of the project or case, and the importance of the report to pharmacy practice. (**Example on page 7)**
- **E = Evaluative Study Reports:** Describes original research, including clinical research on drug effects in humans, drug-use evaluations, and evaluations of innovative pharmacy services. Evaluative study reports must include scientific results and/or data to support the conclusions, and indicate that all clinical research represented in the abstract was approved by the appropriate ethics committee or institutional review board, and if appropriate, informed consent was obtained for all subjects. (**Example on page 8)**
- **R = Research-in-Progress Report:** *Definition*: Uncompleted original research, including clinical research on drug effects in humans, drug-use evaluations, and evaluations of

innovative pharmacy services currently in progress. **Please note**: Results can be presented on your poster at the meeting. (**Example on page 9)**

- **C = Case Reports:** Describes an unusual *patient-specific* case that was not part of a study but the findings are of interest to clinical pharmacists. Case Reports do not need the headings Purpose, Methods, Results, or Conclusions but cannot be a research-in-progress. (**Example on page 10)**

WORD LIMITS

Your abstract must follow the designated word limits for your specific poster type:

Submission Types	Evaluative Study **(600 words)**	Descriptive Report **(600 words)**	Research-in-Progress **(300 words)**	Case Reports **(600 words)**
Title	25 words	25 words	25 words	25 words
Purpose	100 words	100 words	100 words	600 words
Methods	200 words	200 words	200 words	N/A
Results	200 words	200 words	N/A	N/A
Conclusion	100 words	100 words	N/A	N/A

NOTE: If your abstract is accepted, the presentation must not differ from the original accepted title and abstract content.

ABSTRACT TITLE

- Be sure your title accurately and concisely reflects the abstract content. Submissions with titles that are NOT in the correct format will be rejected. **IMPORTANT: Only put the title of the abstract in the title field. DO NOT put it in the abstract content field**.
  - **Title Format**
    - Do NOT use proprietary (brand) names in the title
    - Capitalize only the first letter of the first word in the title, all other words must be in lowercase letters; except in the case of acronyms or proper nouns (e.g. countries, etc.). Do not use ALL CAPS.
    - Do not use "A," "An," or "The" as the first word in the title

- **Title Format Examples**

Incorrect**:** IMPLEMENTATION OF COMPUTERIZED PRESCRIBER ORDER ENTRY (CPPOE) IN A SURGICAL UNIT: ONE YEAR LATER

Incorrect: Implementation Of Computerized Prescriber Order Entry (CPPOE) In A Surgical Unit: One Year Later

CORRECT: Implementation of computerized prescriber order entry (CPOE) in a surgical unit: one year later

ABSTRACT FORMAT:

- **Correctly** format your title.
- **Word Limits** – your entire abstract should be approximately 300-600 words depending on the poster type.
- **Do not** use special functions such as tabs, underlines, trademarks, superscript, subscript, bold, or italics.
- **Spell out** special symbols - Greek letters, degrees, plus and/or minus signs, greater than or less signs, percentage, etc. Use standard abbreviations.
- **Do not include** graphs, tables, or illustrations in your abstract.
- Spell out all pharmaceutical **acronyms**.
- Do not include the title or authors in the body of the abstract.
- **Abstracts in outline form will be rejected**.
- Submission Type – Your abstract must be a Descriptive, Evaluative Study, Research-in-Progress, or Case Report

Submitting Your Poster Abstract Online

Submissions will be accepted online only at: http://www.ashp.org/get_involved.

You will be asked for the following information:

First Name, Last name, Email, and Password (you will create your password when you login for the first time)

Important: The email that is used for logging into the submission site must be the Primary Author's—not an assistant's or a colleague's. This email will be the contact email and the one that appears with your printed abstract. **You must not delete or alter this email on the Primary Author Personal Details screen or the database will not function properly resulting in your submission not being reviewed.**

Read the **Welcome page** information carefully. It will tell you how to navigate through the submission site**.**

ENTERING AUTHOR INFORMATION

Click on "Primary Author Information" on the left menu. **Note: Abstracts fields in red must be completed in order to continue to the next step.** Your information must be in title case (meaning only the first letter is capitalized). Do not use all capital letters.

- Please do NOT add your degrees after your name or additional author(s) name. Examples: **Correct** John Smith, Jane Doe. **Incorrect** John Paul, PharmD, BS.
- If you entered more than four (4) additional authors, we will only use the first four (4) on the list. **No exceptions.**

Submission Confirmation

The last page is your Confirmation which lists everything you entered. **PRINT A COPY OF THIS PAGE**. – You will need the submission number to verify the status of your abstract.

Notifications and Contact Information

Notifications

- **A Student Poster acceptance list by Primary Author Last Name will be posted in mid-October (~ October 21)** at http://www.ashp.org/Get_Involved. If your submission has been accepted, please read the Poster Presenter Handbook, also posted online.

Contact Us

If you have a question regarding your submission, please send an email to educserv@ashp.org. Please include your name, the title of the submission and your **Submission Number**. ASHP will not give out information to anyone not listed as the Primary Author on the abstract.

Meeting Registrations and Cancellations

Meeting Registration

Presenting a poster at our meeting is a **voluntary** effort and ASHP cannot pay expenses for your participation. If your submission is accepted you are responsible for your own meeting registration fee and travel.

All presenters must be registered for the meeting, at least on the day of the presentation. No one will be allowed in the poster area without a badge.

Withdrawals/Cancellations

Written notification is required for all submission withdrawals. Only the Primary Author may withdraw a submission — third party withdrawals will not be accepted.

Send your withdrawal request to: educserv@ashp.org. Please include your full name and presentation title in your request.

Because of our early publication deadlines, if you withdraw after receiving your acceptance notice we cannot guarantee that your presentation citation and/or abstract will not appear in print, on the ASHP Website, or in other print or electronic media.

Sample Abstracts

DESCRIPTIVE REPORT POSTER ABSTRACT SAMPLE

PLEASE NOTE: Do not include the field names – Purpose, Methods, Results*, and Conclusion* – in the body of your abstract. Details may be excluded in Student abstracts.

Purpose: The avoidance of errors in the processing of chemotherapy orders is an important component in the pharmacy department's medication-use safety initiatives. Chemotherapy order processing was identified as a needed competency assessment to heighten awareness in recognizing and preventing chemotherapy medication errors. This project was designed to uncover and correct gaps in the knowledge that pharmacists needed for the safe processing of chemotherapy orders at a community hospital.

Methods: A pharmacist with advanced training (specialty residency) in oncology wrote a certification module and a competency assessment examination. The certification module included readings, the hospital policy on processing chemotherapy orders, and a chemotherapy order-processing checklist designed for the pharmacist. The assessment examination used three actual patient chemotherapy orders, each with specific patient demographics, laboratory values, and imbedded errors. Pharmacists taking the examination needed to identify the errors to process the orders safely. All staff pharmacists were required to complete the examination and instructed to work independently. A score of 100 percent was required to pass the competency assessment.

Results: Twelve pharmacists completed the module. Seven pharmacists correctly identified all the medication order errors in the competency assessment examination. Five pharmacists needed additional training in their identified areas of deficiency and took a customized assessment examination to address those areas specifically. All five pharmacists successfully completed the second assessment examination. The pharmacy director and clinical coordinators felt that the competency assessment examination was successful in identifying gaps in knowledge. The pharmacists indicated that they were more confident processing chemotherapy orders after successful completion of the module and competency assessment.

Conclusion: Competency assessment was helpful in identifying and correcting knowledge gaps and may be useful in medication order processing of high risk medications as part of the pharmacy department medication-use safety plan.

EVALUATIVE STUDY ABSTRACT SAMPLE

PLEASE NOTE: Do not include the field names – Purpose, Methods, Results, and Conclusion – in the body of your abstract.

Purpose: Beta-blockers decrease cardiovascular risk in patients with hypertension and diabetes mellitus (DM). However, their use has been associated with increased fasting glucose and HbAlc levels in these patients. The purpose of this study was to determine whether carvedilol or atenolol had more favorable glycemic effects on patients with diabetes and hypertension who were also using a renin-angiotensin (RAS) blocker, which is known to improve glycemic control.

Methods: The institutional review board approved this open-label, randomized group study. Men and women aged 18-65 who provided informed consent were enrolled if they had Type 2 DM and stage 1 or 2 hypertension controlled by medication. Patients taking a non-ocular beta-blocker within the past 3 months and those with pulmonary, cardiovascular, or kidney disease were excluded. Antihypertensive treatment must have included an RAS blocker, such as an angiotensin-converting enzyme (ACE) inhibitor or angiotensin II receptor blocker (ARB). Following a 2-4 week washout period to discontinue all other antihypertensive treatments, 48 patients were randomized to receive either carvedilol (n equals 25) or atenolol (n equals 23) for 24 weeks. Study medication was titrated from carvedilol 6.25 mg twice daily and atenolol 12.5 mg twice daily to a maximum dose of 25 mg and 100 mg twice daily, respectively, at two-week intervals toward target blood pressure levels (less than or equal to 130/80 mmHg). The primary outcome measure was a change from baseline in HbAlc after 6 months of treatment. Secondary outcomes included changes in blood pressure and heart rate. It was determined that 23 participants per treatment group would yield 80 percent power to detect a difference of 0.20 percent between groups for the primary outcome.

Results: The mean difference between carvedilol and atenolol in the change in HbAlc from baseline was 0.21 percent (95 percent CI, 0.04 percent to 0.27 percent, P equals 0.004). HbAlc levels increased with atenolol administration (0.23 percent; 95 percent CI, 0.08 percent to 0.31 percent, P less than 0.001) but did not change significantly with carvedilol (0.02 percent; 95 percent CI, -0.06 to 0.08 percent, P equals 0.65). Effects on blood pressure and heart rate were comparable.

Conclusions: Use of carvedilol in the presence of RAS blockade did not affect glycemic control. However, atenolol was associated with a slight increase in HbAlc after 6 months of treatment. The clinical significance of these effects must be determined in larger, long-term clinical trials.

Research-in-progress Abstract Sample

PLEASE NOTE: Do not include the field names – Purpose and Methods in the body of your abstract.

Purpose: The JNC 7 guidelines recognize that systemic blood pressure (SBP) elevations directly correlate with increased cardiovascular risk. The objective of this study is to determine the extent to which treatment provided to clinic patients with systolic hypertension complies with the JNC 7 guidelines.

Methods: This study will be submitted to the Institutional Review Board for approval. The electronic medical record system will identify patients who have had at least two blood pressure measurements in which systolic blood pressure (SBP) was greater than 139 mmHg and diastolic blood pressure (DBP) was less than 90 mmHg. The following data will be collected: patient age, gender, ethnicity, SBP, DBP, heart rate, physical examination findings, current medications, and reported adverse medication events. If available, results of renal and hepatic function tests and electrocardiograms will be collected. Provider documentation will be reviewed to determine if reasons for non-compliance with JNC 7 guidelines are documented. All data will be recorded without patient identifiers and maintained confidentially. Average SBP and DBP will be calculated. Data from patients with an average SBP of greater than 139 mmHg and an average DBP of less than 90 mmHg will be reviewed by a team of clinicians to rate compliance of treatment with the JNC 7 guidelines. The reviewers will rate each patient's care as compliant with JNC 7, noncompliant with JNC 7 but clinically appropriate, or noncompliant with JNC 7.

Results: N/A

Conclusions: N/A

Case Report Abstract - Sample

PLEASE NOTE: Do not include the field name **"Case Report"** in the body of your abstract. *The entire abstract is entered in the Case Report Field.*

Case Report: This case series illustrates the potential risk of transdermal alcohol application in patients on warfarin. Patient 1 is being treated with warfarin for heart failure. The patient has a goal INR between 2 and 3 and has had therapeutic INRs at the last twenty-two clinic visits. He presented to clinic with an INR of 4.2. He denied symptoms of heart failure exacerbation, changes in diet, or changes in medications. The patient reported that he had been applying rubbing alcohol to a back injury. At this visit, patient was instructed to discontinue rubbing alcohol, hold two doses of warfarin, and then resume his current warfarin regimen. He returned to clinic 4 weeks later and his INR was 2.3. His INR remained in the therapeutic range for the next 3 follow-up visits. Patient 2 has been prescribed warfarin secondary to an atrial valve replacement and has a goal INR range of 2 to 3. After 6 consecutive therapeutic visits, the patient presented with an INR of 3.2. She denied medication or diet changes, but reported that she had applied rubbing alcohol to sore legs several days prior to the clinic visit. At this visit she was told to discontinue the rubbing alcohol, hold one dose of warfarin, and then resume her previous regimen. The patient returned to clinic 4 weeks later and her INR was 1.8. Patient's INR remained in the therapeutic range for the next 5 visits. Patient 3 is being treated with warfarin for recurrent venous thromboembolism (VTE) and protein S deficiency. Her therapeutic INR range is 3.0 to 3.5 due to recurrent VTE despite therapeutic INR levels. Her INR in clinic was 4.3 following a recent dose increase of her warfarin. She reported that she had been using 4 ounces of hand sanitizer daily. She was asked to hold her warfarin dose that night, and then resume her current regimen. She returned to clinic 7 days later and her INR was 3.7. Despite being counselled on the risk associated with the alcohol-based hand sanitizer, she continued to use approximately 4 ounces daily. Over the next 2 months the patient's INR fluctuated greatly with all but one INR in the supratherapeutic range. The patient finally discontinued use of the instant hand sanitizer and her INR fell to 2.6. Although the patient's INR was never completely stable the 2 months following discontinuation of the hand sanitizer, the INR fluctuations were more predictable. As this case series suggests, the application of transdermal alcohol has the possibility to affect INRs in patients being treated with warfarin. Although more study is needed to further elucidate this interaction, it is important for providers to inquire about the topical application of alcohol and alcohol-containing products.

Methods: N/A

Results: N/A

Conclusions: N/A