2016 ACFAS Poster Exhibits Guidelines
(Policies & Instructions)

If you would like your research to be considered for presentation at the Annual Scientific Conference, February 11-14, 2016, in Austin, TX, submit your application and abstract via the online submission system at www.acfas.org. Remember, not all submissions are accepted.

**Abstract Submission Deadline:** September 1, 2015
The online poster abstract submission site will close at 11:59 pm Central Time on Tuesday, September 1, 2015. **No extensions of this deadline will be granted:** no appeals will be considered. **Notification regarding acceptance of posters** will be e-mailed by September 25, 2015.

**PDF Submission Deadline:** December 2, 2015
PDF of accepted poster must be submitted by December 2, 2015; **AND a paper poster** must also be brought to the annual conference for display on the assigned poster board. Instructions for uploading your poster PDF will be provided in the “accept” notification letter. **No extensions of the December 2nd submission deadline will be granted:** no appeals will be considered.

**IMPORTANT! BEFORE you begin your submission, carefully review the following policies and instructions.** Failure to adhere to the Guidelines will result in disqualification of your poster submission.

**POLICIES GOVERNING POSTER SUBMISSIONS**

- Posters must be original research, **not previously published**.
- Only **completed** studies will be accepted for consideration for presentation.
- **Literature Reviews** are NOT accepted.
- **Commercial terminology** (company/product name): Use of any commercial terminology will result in your poster being disqualified.
- **The same topic will not be accepted** for both oral presentation (manuscript/abstract) and as a poster exhibit.
- **Correspondence will ONLY be sent to the correspondent author** (the person identified in the submission as the correspondent author); it is the correspondent author's responsibility to communicate all information to their poster team.
- **Conference Registration**—At least one of the poster authors must register for and attend the Annual Conference in order for their poster to be displayed.
- **Mandatory Financial Disclosure**
  Conflict of Interest/FDA Relationship Disclosure is required of all authors of a poster abstract/exhibit. If a poster submission is accepted, the FDA disclosure(s) of all authors will be indicated in the Annual Scientific Conference final program.
- **Student Clubs:** Only one (1) ACFAS Student Club poster entry is accepted from each school. Student Club entries are to be a group effort, not an individual submission. Faculty members may not be listed as authors or co-authors of a Student Club poster. **No other posters with students listed as primary authors will be accepted** for exhibit.
2016 ACFAS Poster Exhibits Guidelines (Continued)

- Posters will **ONLY** be accepted in one of the following classifications:
  - Arthroscopy
  - Biomechanics and Anatomy
  - Diabetic Foot
  - Forefoot Reconstruction
  - Heel Pain
  - Orthotics/Prosthetics/Pedorthics
  - Peripheral Nerve Disorders
  - Physical Therapy/Rehabilitation
  - Rearfoot and Ankle Reconstruction
  - Trauma (Surgical/Conservative)
  - Wound Care/Infectious Diseases

- “Level of Evidence” must be included in the online submission for your abstract to be considered for presentation. (See Page 4)

- **Poster submissions** are required to have a **minimum follow-up of 10 months prior to submission, follow-up time must be entered** for your abstract to be considered for presentation.

  - Submitted abstracts will be reviewed to determine if the poster meets ACFAS standards for presentation. Not all submissions are accepted. Accepted abstracts are part of the judging process for the poster competition.

  - Once a poster abstract is submitted:
    - Poster titles cannot be changed.
    - Additional authors cannot be added and author names cannot be changed

- The **title** of your poster will appear in the program exactly as you enter it in the online submission.

- **Poster authors** will be listed in the Conference final program in the order their names are listed in the online submission.

**Helpful Hints:**
- Determine the lead/primary author before submission.
- Select the correct level of evidence for the case or scientific study. Is your study randomized, double blinded or a case series?
- Use appropriate statistical analysis if warranted.
- Number references consecutively in the order of their first use in the text (not alphabetically).
- Make sure pictures and graphs are legible and engaging.
- Keep captions and all posted written material to a minimum.
- Use appropriate color combinations. For instance, do not use yellow or red on a blue background.
- **Bring your own pushpins/thumbtacks to use to attach poster exhibits to the poster board.**
- Handout material may be provided by the author(s).

**Note:**
The ACFAS Board of Directors, members of the Judging Panel, chair of the Annual Scientific Conference, or employees/independent contractors of the College are ineligible to participate in the ACFAS Annual Scientific Poster Exhibit Competition; with the caveat that residents supervised by the above referenced parties may participate, but the above referenced parties may not receive any monetary award.

**Disclaimer:**
The ACFAS does not endorse any procedures/treatments represented in the posters displayed in the Annual Scientific Conference Poster Exhibit.
INSTRUCTIONS FOR SUBMITTING YOUR POSTER ABSTRACT

1. Before you begin your submission, determine the correct format (Case Study or Scientific) for your study.

FORMAT DEFINITIONS
- **Case Study** format refers to the collection and presentation of detailed information about a particular participant or small group, frequently including the accounts of subjects themselves. A form of qualitative descriptive research, the case study looks intensely at an individual or small participant pool, drawing conclusions only about that participant or group and only in that specific context. Researchers do not focus on the discovery of a universal, generalizable truth, nor do they typically look for cause-effect relationships; instead, emphasis is placed on exploration and description. (See example abstract on page 6.)

A **case series** is a group of case reports. It is preferred to use the scientific format in this situation if a conclusion about the subject is made by the author(s).

- **Scientific** format refers to the study/evaluation of a question and formation of a hypothesis and the development of methodology directed to addressing the hypothesis; it could be prospective or retrospective. It involves gathering information, testing the hypothesis, interpretation of the data and drawing conclusions that validate or negate the hypothesis. Meta-analysis research will be accepted; however, systematic review alone does not qualify. **Literature Reviews are NOT accepted.** (See example abstract on page 9.)

STUDENT CLUB CATEGORY DEFINITION
- **Student Club** entries are to be a group effort, not an individual submission. Only one (1) poster is accepted from each ACFAS Student Club. **Faculty members** may not be listed as authors or co-authors of a Student Club poster. **No other posters with students listed as primary authors will be accepted** for exhibit.

2. Submit your application/abstract online at: www.acfas.org.

All users must create a new account the first time they use the system for the 2016 manuscript competition.

3. Enter your abstract into the online submission system:
   - **Title:** Type the title of your poster abstract exactly as you would like it to be published (Upper/Lower Case, please). **The title should be brief and clearly indicate the nature of the study.**
   - **Author Name(s):** In the spaces provided, list full names of authors and their medical degree/designation.
   - **Abstract:** You must complete all sections; failure to do so will disqualify your submission. **Maximum 250 words** including the following:
     - **Statement of Purpose:** Statement that explains what you want to investigate and the rationale behind your choice of study.
     - **Methodology:** Methodology consists of a brief description of the target sample, including sample size and demographics if relevant, as well as the general design of the study (retrospective chart review, experimental design, survey-based design, qualitative research, etc.) and statistical analysis. (For a case-study, enter literature review in this section.)
     - **Procedures** (For a case-study, summarize the case in this section.)
     - **Results:** Results must be clearly presented and summarized.
     - **Discussion:** Must be based on the study results and integrated with the statement of Purpose, and the literature review.
     - **Level of evidence:** See chart on page 4.
   - Abbreviations may be used (Index Medicus). Please spell out the terminology, followed by the abbreviation in parentheses. Thereafter, abbreviations only may be used.
## Levels of Evidence for Primary Research Question

<table>
<thead>
<tr>
<th>Types of Studies</th>
<th>Therapeutic Studies-- Investigating the Results of Treatment</th>
<th>Prognostic Studies-- Investigating the Effect of a Patient Characteristic on the Outcome of Disease</th>
<th>Diagnostic Studies-- Investigating a Diagnostic Test</th>
<th>Economic and Decision Analyses-- Developing an Economic or Decision Model</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 1</strong></td>
<td>• High-quality randomized controlled trial with statistically significant difference or no statistically significant difference but narrow confidence intervals</td>
<td>• High-quality prospective study (all patients were enrolled at the same point in their disease with ≥80% follow-up of enrolled patients)</td>
<td>• Testing of previously developed diagnostic criteria in series of consecutive patients (with universally applied reference “gold” standard)</td>
<td>• Sensible costs and alternatives; values obtained from many studies; multiway sensitivity analyses</td>
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<tr>
<td></td>
<td>• Systematic review² of Level-1 randomized controlled trials (studies were homogeneous)</td>
<td>• Systematic review² of Level-1 studies</td>
<td>• Systematic review² of Level-1 studies</td>
<td>• Systematic review² of Level-1 studies</td>
</tr>
<tr>
<td><strong>Level 2</strong></td>
<td>• Lesser-quality randomized controlled trial (e.g. &lt;80% follow-up, no blinding, or improper randomization)</td>
<td>• Retrospective⁶ study</td>
<td>• Development of diagnostic criteria on basis of consecutive patients (with universally applied reference “gold” standard)</td>
<td>• Sensible costs and alternatives; values obtained from limited studies; multiway sensitivity analyses</td>
</tr>
<tr>
<td></td>
<td>• Prospective⁵ comparative study⁵</td>
<td>• Untreated controls from a randomized controlled trial</td>
<td>• Systematic review² of Level-2 studies</td>
<td>• Systematic review² of Level-2 studies</td>
</tr>
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<td></td>
<td>• Systematic review² of Level-2 studies or Level-1 studies with inconsistent results</td>
<td>• Lesser-quality prospective study (e.g., patients enrolled at different points in their disease or &lt;80% follow-up)</td>
<td>• Systematic review² of Level-2 studies</td>
<td>• Systematic review² of Level-2 studies</td>
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<tr>
<td><strong>Level 3</strong></td>
<td>• Case-control study⁷</td>
<td>• Case-control study⁷</td>
<td>• Study of nonconsecutive patients (without consistently applied reference “gold” standard)</td>
<td>• Analyses based on limited alternatives and costs; poor estimates</td>
</tr>
<tr>
<td></td>
<td>• Retrospective⁶ comparative study⁵</td>
<td></td>
<td>• Systematic review² of Level-3 studies</td>
<td>• Systematic review² of Level-3 studies</td>
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<td></td>
<td>• Systematic review² of Level-3 studies</td>
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<tr>
<td><strong>Level 4</strong></td>
<td>Case series⁸</td>
<td>Case series</td>
<td>• Case-control study</td>
<td>• No sensitivity analyses</td>
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<tr>
<td><strong>Level 5</strong></td>
<td>Expert opinion</td>
<td>Expert opinion</td>
<td>Expert opinion</td>
<td>Expert opinion</td>
</tr>
</tbody>
</table>

1. A complete assessment of the quality of individual studies requires critical appraisal of all aspects of the study design.
2. A combination of results from two or more prior studies.
3. Studies provided consistent results.
4. Study was started before the first patient enrolled.
5. Patients treated one way (e.g., with arthrodesis) compared with patients treated another way (e.g., with arthroplasty) at the same institution.
6. Study was started after the first patient enrolled.
7. Patients identified for the study on the basis of their outcome (e.g., failed arthrodesis), called “cases”, are compared with those who did not have the outcome (e.g., had a successful arthrodesis), called “controls”.
8. Patients treated one way with no comparison group of patients treated another way.

This chart was adapted from material published by the Centre for Evidence-Based Medicine, Oxford, UK. For more information, please see [www.cebm.net](http://www.cebm.net).
**Example of a Case Study Abstract**

**Title:** Minimally Invasive Soft Tissue Correction of Foot and Ankle Contracture Secondary to Stroke

**Authors:** Troy J. Boffeli, DPM, FACFAS; Rachel C. Collier, DPM

**Format:** Case Study

**Length of follow-up** (minimum 10 months prior to submission): 22 months

**Level of Evidence:** IV

**Classification:** Rearfoot and Ankle Reconstruction

**Purpose:** Stroke related contracture of the foot and ankle commonly results in a non-reducible, spastic equinovarus deformity. Residual contracture leads to gait instability, pain, bracing difficulties, and ulcerations. This case study presents our protocol for minimally invasive, ambulatory soft tissue release of contractures intended to create a supple foot and ankle to be supported with a neutral position ankle-foot orthosis (AFO).

**Methodology:** The classic surgical approach for stroke contracture has been combinations of tendon lengthening, tendon transfer, osteotomy and joint fusion procedures. Recovery requires non-weightbearing that is not practical for these patients. There is little focus in the literature on minimally invasive soft tissue procedures.

**Procedures:** A case is presented of a 61-year-old female with an equinovarus foot contracture secondary to stroke. Despite conservative treatment she continued to have pain and gait difficulties. The patient underwent Achilles lengthening, posterior tibial tendon Z lengthening, and digital flexor tenotomies. These procedures allowed immediate weightbearing in a walking boot for 2 weeks then a new AFO.

**Results:** Correction of deformity was noted immediately. The patient returned to independent living without pain. She was able to ambulate in the home without the brace and has had no recurrent deformity or overcorrection at 22 months postop.

**Discussion:** This case study details our minimally invasive approach to release of foot and ankle contracture caused by stroke. Surgical principles and technique tips are presented. The main goal is to improve foot and ankle alignment for ease of bracing, which in turn may improve gait and decrease pain and pressure sores.
Minimally Invasive Soft Tissue Correction of Foot and Ankle Contracture Secondary to Stroke

Troy J. Boiffe, DPM, FACFAS and Rachel C. Collier, DPM
Regions Hospital / HealthPartners Institute for Education and Research - Saint Paul, MN

POSTOPERATIVE PROTOCOL

The patient is allowed to bear weight immediately after surgery in a below knee walking boot. Immediate postoperative ambulation has the added benefits of maintaining tendon length, promoting stretch to other components of the contracture, deconditioning and decreases the risk of blood clot formation. Patients typically remain in the walking boot for 6 weeks and then transition to a weight bearing shoe with a posterior heel wedge for an additional 4 weeks. The patient is then weaned into AFO bivalves, as tolerated, during this time.

CASE EXAMPLE

A case is presented of a 61 year-old female with equinovarus foot and ankle contracture secondary to CVA that occurred 12 years ago. Despite long term treatment with a Botox pump, repeat Botox injections and use of an AFO, she continued to have pain and instability with each step. She suffered several falls due to spasticity and drop foot which caused injuries on separate occasions including ankle sprain, 3rd metatarsal fracture and2 falls. She had a right knee arthroplasty with an anterior cruciate ligament reconstruction surgery that was uneventful, she was not able to live independently. Other relevant medical history included deep vein thrombosis and past attempt correction of upper extremity contracture. She had normal vascular status and the skin was intact despite chronic pressure areas at the 5th metatarsal head and base as well as the lateral head of the tibia due to equino-varus foot position despite AFO bracing. The equinovarus foot and ankle contracture was non-reducible (Figure 5). Semi-reducible hammer toe deformity of the toes 1-5 of the left foot were noted. Gait exam revealed circulation of the leg with drop foot and evidence of weak hip extensors. An AFO was needed for ambulation, but she refused to fit her foot deformity. Preoperative radiographs demonstrated recent 5th metatarsal neck fracture. Lack of heel purchase to the ground was evident on radiographs as well as increased weightbearing on the 5th metatarsal (Figure 7). She underwent peroneal tendon lengthening, open ankle fusion and peroneus brevis tendon transfer. She was able to achieve a solid position to allow ease of bracing.

RESULTS:

Injuries were well healed at the 7 weeks postoperative visit. The patient was able to ambulate without pain or discomfort. She maintained the width and ankle in a reducible position (Figure 7b and 7c). At 6 weeks postoperative, the patient was able to ambulate without an AFO but she still needed to wear an AFO. However, she did wear the brace when ambulating in the community. She maintained the corrected position (Figure 7a and 7b). Long term follow up of 4.5 years demonstrated no postoperative complications and no recurrence of deformity. The patient returned to desired activities including swimming and gardening. She no longer had pain at the base of the 5th metatarsal and denied subsequent subjucts. Subjectively, the patient was happy with pain relief and foot position and was once again able to live independently (Figure 8).

ANALYSIS AND DISCUSSION

The classic surgical approach for treatment of stroke related foot deformity is major amputation which is a major procedure associated with significant complications and poor outcomes. AFOs and bracing are used as below knee amputation salvage. This is particularly true when the deformity is in the lower extremity or foot. Therefore, the use of bracing and AFOs can be considered for in cases where the patient's foot function recovery are significantly impaired. However, even with bracing and AFOs, the foot function recovery remains limited.

Critically, patients with a history of CVA are often times over looked for surgery. The benefits of a limited approach for soft tissue releases include less ischemic insult to the extremity, less operating room time, decreased anesthetic time, need for general anesthesia, immediate weight bearing, early range of motion and early return to AFO bracing. Stroke patients tend to be elderly with chronic lower extremity edema and/or decreased functional mobility (Spasticity) which can contribute to the challenges of recovery.

Our limited soft tissue approach allows less disruption to these fragile tissues. In addition, duration of anterior/posterior soft tissue release is limited in length as the INR is a less significant therapeutic level. This case report is presented to demonstrate our standard approach for ambulatory, minimally invasive treatment of correction of equinovarus deformity in adult patients with a history of CVA who may have previously been considered for surgical treatment due to the challenges of recovery, anesthesia time and other risks involved.

REFERENCES:

EXAMPLE OF POSTER – CASE STUDY FORMAT
Please remember, that the overall visual appearance will be assessed by the judges. Position each section sequentially beginning with the Purpose, Literature Review, Case Study, Analysis and Discussion, and References (references should be noted numerically in the order used in text). Use generic names whenever possible instead of proprietary/commercial names. Maximum poster size: 3.5 feet high x 7.5 feet wide.

Key questions Poster Judges will consider:

Case Study Posters

1. **Title (+1 point)**
   How well does the title capture the essence of the poster?

2. **Statement of Purpose & Study Relevance (+10 points)**
   - Is the statement of purpose clearly defined? (3 pts)
   - How well does the literature review provide adequate rationale for the presented case study? (3 pts)
   - Is the literature review presented in an organized manner? (2 pts)
   - Is the literature review current and up to date with the most recent data presented? (2 pts)

3. **Case Study (+20 points)**
   - Is the case study presented in an organized, chronological manner? (5 pts)
   - Is the past medical history and history of present illness clearly explained? (2 pts)
   - Are the physical findings fully explained? (2 pts)
   - Is there adequate information provided regarding test/lab results? (2 pts)
   - Are appropriate imaging studies presented? (2 pts)
   - Are the relevant positive and pertinent negative results reported? (2 pts)
   - Is the clinical decision making process well defined? (5 pts)

4. **Discussion (+10 points)**
   - How well does the discussion tie to the literature review? (5 pts)
   - How well does the discussion tie to the case study? (5 pts)

5. **Overall Educational Value (+6 points)**
   - How well does the poster exhibit provide an education value to the reader? (3 pts)
   - Is the case study interesting and does it present a novel pathology or treatment? (3 pts)

6. **Aesthetics (+4 points)**
   - Is the text free of grammatical and spelling errors? (1 pt)
   - Are the photos appropriate and do they visually complement the study? (1 pt)
   - Are all of the elements of the poster exhibit easy to follow? (Balance of design—layout, use of colors, lettering) (2 pts)

7. **Commercialism (-10 points)**
   - Is there any obvious product advertisement? If yes, take 10 points off the total score.
Example of a Scientific Abstract

Title: Tibiocalcaneal Fusion via Peg-in-Hole Technique with Combined Ilizarov External Fixation Method

Authors: Edgardo R. Rodriguez, DPM; Byron L. Hutchinson, DPM, FACFAS; Eric Powell, DPM

Format: Scientific

Length of follow-up (minimum 10 months prior to submission): Mean 34 months

Level of Evidence: III

Classification: Rearfoot and Ankle Reconstruction

Purpose: Tibiocalcaneal fusions are end-stage procedures performed for limb salvage in the diabetic patient due to Charcot Osteoarthropathy or osteomyelitis. Often times, poor vascular supply coupled with the metabolic imbalance of diabetes can bring bone healing and fusion site stability into question. We present a new technique for tibiocalcaneal fusion via Peg-in-Hole fusion site using the Ilizarov external fixation method on 52 patients.

Methodology: A retrospective review of 52 patients was performed with a mean follow-up of 34 months. Age, sex, fusion rate, time to fusion, and complication rate were all evaluated. Comorbidities were also identified.

Procedures: Tibiocalcaneal fusion using a Peg-in-Hole method with the peg formed in the distal tibia and the hold formed in the superior calcaneus. The fusion site was stabilized using external fixation via the Ilizarov method.

Results: There were 39 males, 13 females. The average age was 47 years. The overall fusion rate was 86%. Mean time to fusion was 17 weeks. The overall combined complication rate was 27%. Comorbidities identified prior to surgery were diabetes mellitus, smoking, and prior surgery.

Discussion: To the authors’ knowledge, there has never been a description of a Peg-in-Hole technique with use of Ilizarov external fixation for the fusion of the tibia and calcaneus. We explore the technique and concept of this method of tibiocalcaneal fusion. It is the hope of the authors that this becomes a viable option and tool for the foot and ankle surgeon for advanced reconstruction of the rearfoot and ankle in patients who require this procedure.
Tibiocalcaneal Fusion using a Peg-in-Hole Technique with Combined Iliac Bone Fixation Method
Edgarodromo Rodriguez, DPM Byron Hutchinson, DPM Eric Powell, DPM

Statement of Purpose
Tibiocalcaneal fusion (TCF) is an end-stage procedure performed for limb salvage in the diabetic patient due to Charcot osteoarthropathy or neuropathy, for patients who have sustained severe trauma to the talus, infection or revision of total ankle arthroplasty. Often times, these patients have comorbidities of diabetes, obesity, smoking, and/or renal disease. Inappropriate bone healing and implant stability are challenges to be confronted. The authors present a new technique for TCF as Peg-in-Hole Fusion using iliac iliac bone fixation (IEF) on 52 patients.

Methodology & Hypothesis
A retrospective review of 52 patients treated from March 2004 to March 2014. Age, sex, fusion rate, time to fusion, and complication rate were evaluated. Co-morbidities were also identified. The hypothesis was that the peg-in-hole TCF using the iliac iliac bone fixation is helpful in salvaging the ankle and tibiocalcaneal fusion.

Procedure
Peg-in-hole TCF with IEF was performed on 52 patients. The distal ligament was disrupted as a lateral approach. The talus was resected, and the fibula was tubed and placed into the distal tibia. In cases with poor bone stock, the fibula was used as bone graft. The fibula was then applied with standard methods. No internal fixation was used in the construct. The constructs were then immobilized, and the external fixator was composed. Abduction and rotation were used to allow for seamless fit of the bone ends. Standard frame and wound care to removal of the pin (2—5 mm) were used.

Results
There were 39 males, 13 females. The average age was 47 years. The overall fusion rate was 86% with 10 cases out of 52 cases not fused. Fusion rate, time to fusion, and complication rate were all evaluated. Co-morbidities were also identified. The authors present a new technique for TCF using a Peg-in-Hole Fusion using iliac iliac bone fixation (IEF) on 52 patients. The investigators reported a mean of 9 months follow-up. Complications encountered in our patient population were consistent with those described by other authors; however, none of our patients encountered pin tract infections. Only two patients developed pin tract infections. The authors report a new technique for TCF using a Peg-in-Hole technique at the fusion site. We feel that this is a technically demanding procedure that has the potential for high fusion rates and minimal complications. The authors report a new technique for TCF using a Peg-in-Hole technique at the fusion site.

Analysis & Discussion
We report on a new technique of creating a Peg-in-Hole type cut previously described for TCF. A V-type osteotomy has been described in the proximal tibia for critical bonealveolar, or valgus, but only a few studies have been published on its use in the distal tibia. In our experience, the iliac bone provides a stable, strong, and reliable source of bone. The hole cut into the talus exposes more cancellous bone for superior bone stock. We present a new technique for TCF using a Peg-in-Hole technique at the fusion site. The authors report a new technique for TCF using a Peg-in-Hole technique at the fusion site. We feel that this is a superior technique to the previously described planar resection for TCF.

Complications encountered in our patient population were consistent with those described by other authors. However, none of our patients encountered pin tract infections in contrast to other authors’ who reported several of their patients with pin tract infections ranging from local inflammation to systemic infection.

The authors report a new technique for TCF using a Peg-in-Hole osteotomy at the fusion site using an IEF. We feel that this is a technically demanding procedure that has the potential for high fusion rates and minimal complications. The authors report a new technique for TCF using a Peg-in-Hole technique at the fusion site.

Literature Review
TCF is well described in the literature for posterior arthroplasty in salvage. Charcot osteoarthropathy or failed total ankle arthroplasty [11, 12, 13, 15, 16]. The majority of descriptions involve the use of internal fixation. To this contrary, there are relatively few articles that discuss TCF with the use of IEF [3-5].

References
**Example of Poster – Scientific Format**

Please remember that the overall visual appearance will be assessed by the judges. Position each section sequentially beginning with the Purpose, Methods, Procedures, Literature Review, Results, Discussion, and References (references should be noted numerically in the order used in text). Use generic names whenever possible instead of proprietary/commercial names. **Maximum poster size: 3.5 feet high x 7.5 feet wide.**

### Key questions Poster Judges will consider:

<table>
<thead>
<tr>
<th>Scientific Posters</th>
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<tbody>
<tr>
<td><strong>1. Title (+1 point)</strong></td>
<td>How well does the title capture the essence of the poster?</td>
</tr>
<tr>
<td><strong>2. Statement of Purpose &amp; Study Relevance (+8 points)</strong></td>
<td>Is the purpose of the study concise and clearly stated? (3 pts) Are the study measures well defined (i.e. what is the study examining)? (2 pts) Does the review of the literature provide sufficient rationale for the study? (3 pts)</td>
</tr>
<tr>
<td><strong>3. Methodology &amp; Procedures (+12 points)</strong></td>
<td>Is the population of the study's interest well defined? (3 pts) Is there a selection bias for patients in the study? Subjects were randomized (3 pts); Subjects were controlled via matching (2 pts); The cohort was stratified (for example by age or diagnosis) (1 pt); Subjects were not controlled (0 pts) Are the study methods clear and concise? (3 pts) Is the statistical methodology well defined and appropriate? (3 pts)</td>
</tr>
<tr>
<td><strong>4. Results (+10 points)</strong></td>
<td>Is the data for the results clearly reported? (4 pts) Is the statistical-data analysis clearly explained? (3 pts) Do the tables and figures complement the statistical data properly? (3 pts)</td>
</tr>
<tr>
<td><strong>5. Analysis &amp; Discussion (+11 points)</strong></td>
<td>Do the data support the conclusions made in this study? (4 pts) Are the interpretations biased? (3 pts) Are the discussion and conclusion of the study consistent with results, interpretation of the data, and answers the research question? (4 pts)</td>
</tr>
<tr>
<td><strong>6. Overall Educational Value (+5 points)</strong></td>
<td>Overall, does the poster exhibit provide meaningful education value? (2 pts) Is the study novel and does it provide new data to the body of scientific literature? (2 pts) Is a clear conclusion reported? (1 pt)</td>
</tr>
<tr>
<td><strong>7. Aesthetics (+4 points)</strong></td>
<td>Is the text free of grammatical and spelling errors? (1 pt) Are the photos appropriate and do they visually complement the study? (1 pt) Are all of the elements of the poster exhibit easy to follow? (Balance of design—layout, use of colors, lettering) (2 pts)</td>
</tr>
<tr>
<td><strong>8. Commercialism (-10 points)</strong></td>
<td>Is there any obvious product advertisement? If yes, take 10 points off the total score.</td>
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### Scientific Poster Layout:

- **Title**
- **Statement of Purpose**
- **Methods & Hypothesis**
- **Procedures**
- **Literature Review**
- **Analysis & Discussion**
- **Results**
- **References**