

INSTRUCTIONS FOR THE PREPARATION OF ABSTRACTS

INTRODUCTION

The file should be Word (.doc). Use single line spacing. Set the tab to a five-character indent.

All abstracts should be emailed, after proper formatting to following instructions, to Jane.McGregor@gjnh.scot.nhs.uk

TEXT FORMAT

Starting Text

- **Title**
- **Subtitle (if appropriate)**
- **Authors (initials and surnames only)**
- **ONE COMPLETE POSTAL OR EMAIL ADDRESS per abstract**
- **Indent text at start of paragraphs**

The title should be in bold capitals (upper case), flush to the left margin. On a new line the authors' names should start with their initials, each followed by a full stop before the surname (eg. F. Smith, A.C.N. Gray, etc). ***No medical degrees or appointments should be included. After the authors' names there should be just one FULL address for correspondence.*** Leave one line space before beginning abstract.

Paragraphs

Indent the text at the beginning of each new paragraph except the first. Do not leave any space between paragraphs.

PLEASE NOTE THE FOLLOWING IMPORTANT POINTS:

- The text of each abstract should be approximately 250 words, and ideally no more than 500
- Each abstract **MUST** be set on a new page and **MUST** fit on a single page
- Each abstract must include one complete postal or email address for a nominated author, for reader queries
- Each abstract must include the source of study (minimum: town/city and country)
- The following items are **NOT** permitted and will be deleted from submitted files if found:
illustrations, tables, references, author qualifications, session titles/numbers
- Please do not use bullet points – they have a tendency to corrupt or convert into question marks or square boxes, which then require to be deleted.

Posters - We do NOT publish posters; if found in the file, they will be deleted.

Spelling - For English spelling, if possible use the Concise Oxford Dictionary or The Oxford Dictionary for Writers and Editors. Note, however, the following:

Use “ise” not “ize” spellings.

Underlining/Italic Type - Underlining, or italic type may be used to stress words or phrases. Latin names should be underlined, or set in italics if available.

Capitals - Use capitals for proper names, titles, geographical names, trade names.

Abbreviations - Abbreviations not in common use should be spelled out in full the first time they occur in a typescript, followed by the abbreviation in brackets.

Examples: Greenwich Mean Time (GMT).

Short names (of countries, institutions, honours) and well-known acronyms are abbreviated without full stops and without a space between the letters.

Examples: USA, UK, PM (Prime Minister), ESR, WBC, FRS, BA

Decimals

6.9 (point on line), 0.78 (not 78), 1.5), 20 g (not 20.0 g);

one-half, three-quarters (in text only)

EXAMPLE ABSTRACT

The following page shows an example of a correctly typed abstract. Please take a look:

CHANGE IN TUMOUR VOLUME AS A MEASURE OF CHEMOTHERAPY INDUCED NECROSIS IN EWING'S SARCOMA OF THE BONE

A. Abudu, R.J. Grimer, M. Davies, P. Pynsent, D.C. Mangham, R.M. Tillman and S.R. Carter

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Reduction in tumour volume following chemotherapy may in part be due to necrosis of neoplastic cells, reduction of the supporting stroma or resolution of tumour-induced inflammation. We analysed the CT/MRI scans and histology of 50 patients with Ewing's sarcoma of the bone treated between 1983 and 1993 to determine the correlation between change in tumour volume and tumour necrosis following chemotherapy; and determine the influence of tumour necrosis and change in tumour volume on prognosis. The mean age was 18 years (range 5 to 40 years), 40 of the tumours were located in the extremities and 10 centrally. The volume at diagnosis varied from 31 to 1790 ml.

There was a negative correlation between observed change in volume and necrosis ($r = 0.73$, $p = 0.0001$). Tumour progression, despite chemotherapy, was only seen in those with less than 60% necrosis. The relapse-free survival and overall survival were 71% and 78% respectively for those with more than 90% necrosis and 37% and 59% respectively for those with less than 90% necrosis ($p = < 0.05$). Though the outcome in patients with more than 40% tumour volume reduction was better than those with less than 40% reduction this did not reach statistical significance. We found no relationship between tumour volume and serum lactate dehydrogenase levels at diagnosis. Patient's weight, sex, body mass and index and tumour site did not affect change in tumour volume following chemotherapy or the observed tumour necrosis.

We conclude that change in tumour volume is a good predictor of chemotherapy induced necrosis and that necrosis is a strong prognostic factor in Ewing's sarcoma of the bone.