**MARC 2018 Clinical Case Study Submission Guidelines**

**DEADLINE: September 13, 2019**

*42th Annual Meeting*

*Mid-Atlantic Regional Chapter of the American College of Sports Medicine*

*November 1st – November 2nd 2019*

*Harrisburg/Hershey Sheraton, Harrisburg, Pennsylvania*

**Physician Coffee and Conversation:** Friday, November 1st, 7:30am – 8:30am

**Physician Specific Lectures:** Friday, November 1st, 8:30am – 12:00pm

**Podium Case Study Presentations:** Friday, November 1st, 1:00pm – 3:00pm

**Poster Case Study Presentations**\***:** Friday, November 1st, 3:00pm – 4:00pm

\**(Posters will only occur if too many CCS are received to fit into the podium session)*

**The deadline for submitting an abstract for the 2019 annual meeting is Friday, September 13, 2019. ONLY ELECTRONIC SUBMISSIONS PROVIDED VIA THE WEB LINK WILL BE ACCEPTED**. The web link to submit an abstract will close at 11:59PM on September 13th.

Abstracts will be submitted Online via a link at the MARC homepage. Abstract guidelines and requirements are similar to those in prior years and mirror the National ACSM Guidelines. Please review the guidelines and example to make sure your abstract meets the requirements for acceptance. **Abstracts not following the ACSM format will not be considered for acceptance** (See the example at the end of this document).

All submitted abstracts will be published in the MARC ACSM Conference Proceedings in the International Journal of Exercise Science.

Click on the “Submit Your Abstract Online” link, fill in the required fields, upload your abstract document (Microsoft Word format required), and submit. Make sure that you click Clinical Case Studies in appropriate field.

Abstracts must conform to a similar file naming convention to be considered for review. The file naming convention is as follows:

Group\_Last Name of 1st author\_4-5 words of abstract title\_institution

Group should be CCS for Clinical Case Studies

SAMPLE

CCS\_Ross\_ACL injuries in women\_LHU

An electronic confirmation that your abstract has been received will be sent to the first author and/or faculty sponsor on or before September 20st.

Electronic **confirmation of** **acceptance or rejection** will be provided on or before October 4th. A panel will review every abstract, and determine if a case is eligible for a podium presentation or poster presentation.

***Please note:***

* The first author **must present** the abstract at the MARC conference
* The first author **must register and pay the appropriate registration fee for the MARC conference.**
* You may only appear as first author on **ONE** abstract, but you may co-author as many abstracts as desired.
  + If a person submits, as first author, on more than one abstract, only one abstract will be accepted and all others will be rejected.
* Authors should note that this abstract may be submitted/presented both at the regional and national ACSM annual meetings.

**Preparing the Abstract: Guidelines & Example**

**General Directions:**

1. Please complete all of the fields in the Online Submission Form.
2. Prepare your abstract document following the **ABSTRACT FORMAT** instructions provided below. Abstracts must be prepared using Microsoft Word only. Abstracts will NOT be accepted if submitted using a different software application.
3. Abstracts must conform to a similar file naming convention to be considered for review. The file naming convention is as follows:

Group\_Last Name of 1st author\_4-5 words of abstract title\_institution

For example (undergraduate, master’s, doctoral and professionals/academicians):

CCS\_Ross\_ACL injuries in women\_LHU

1. Abstracts submitted by a student/resident/fellow must have a faculty sponsor. It is ultimately the first author’s responsibility to obtain approval from their faculty sponsor prior to submitting an abstract or to coordinate with their faculty sponsor to submit the abstract on the first author’s behalf. Noncompliance will be basis for one’s abstract to be rejected.
2. Please direct questions to Clinical Case Study Committee

**Preparing the Case Abstract**

* Case abstracts are limited to 2,000 characters (not including spaces, title, or author block). Please use the word count feature in Microsoft Word to check this prior to submission. This option can be found under “Tools” along the top ribbon. Failure to comply may result in the rejection of the abstract.
* Your clinical case abstract should include a synopsis of your case which includes the history and physical exam of the case to be discussed, an outline of the Differential Diagnosis, Test and Results, Final/Working Diagnosis, and Treatment/ Outcomes as it pertains to the case. Clinical case presentations will be presented in discussion format. It is recommended that the necessary data (i.e., EKG, X-rays, ECHOS, etc.) be in slide form.
* Do not use brand names in the case abstract.
* Indicate grant funding information at the bottom of the case abstract.
* **Title**: The title should be brief (limited to 15 words) and should be succinct and descriptive. The first part of the title should reflect the area of the problem and the second part, the sport or activity of the athlete, but should not include the diagnosis (example: Neck Injury—Football).
* Authors: First and last names of authors will be listed on the case abstract. If a Fellow sponsors without authoring or co-authoring the case abstract, you will provide the Fellow’s name in your on-line submission. Presenting author must have been involved with significant treatment of the patient and have a thorough understanding of the entire case and the outcome. Do not include degrees, as this affects online search functions.
* Institutions: Institutions of all authors will be included. Do not include departments.
* **Text**: The first paragraph should state the history of the case; the second paragraph should outline the physical exam, then list: • Differential Diagnosis Tests and Results • Final/Working Diagnosis • Treatment and Outcomes
* Suggested Categories

• Cardiovascular

• General Medicine

• Head, Neck and Spine

• Musculoskeletal

• Age and Gender Specific Issues

***Clinical Case Abstract Sample***

*(The abstract MUST be submitted in this format)*

Neck Injury — Football

Suzanne M.Tanner,University of Colorado Sports Medicine Center,Denver,CO

e-mail: aabbccdd@eeff.edu (Sponsor:William O.Roberts,FACSM)

**HISTORY**: A 17-year-old senior high school football defensive cornerback sustained a neck injury while tackling. During the third quarter of a midseason game, he unintentionally used a spearing technique for a successful tackle. As he drove his head into a ball carrier’s chest, his neck was forced into flexion and he developed moderate posterior neck pain. There was no numbness, tingling, weakness or radiation of pain into his upper extremities. Three tackles later, 11 plays later, and during the fourth quarter, he reported his neck pain to the athletic trainer.

**PHYSICAL EXAMINATION:** Examination on the sidelines revealed moderate tenderness over the spinous processes of C6-T1, mild tenderness of the adjacent paraspmal muscles bilaterally and normal sensation, reflexes and strength of his upper extremities There was full active range of motion of his neck but flexion and extension were painful. Over the next hour, his neck progressively became stiffer, but he had no neurological symptoms or signs.

**DIFFERENTIAL DIAGNOSIS:** 1. Strain of cervical paraspinal muscles 2. Fracture of cervical spine 3. Cervical sprain

**TEST AND RESULTS:** Cervical spine anterior-posterior and lateral radiographs: — obliquely horizontal fracture of C7 spinous process with 1/2 cm displacement of fracture fragments — 2 mm of forward subluxation of C6 vertebral body relative to C7 vertebral body Lateral cervical spine radiographs with neck actively flexed and extended: — no further subluxation of C6 vertebrae — increased distraction of spinous fracture fragments with neck flexion Cervical spine oblique radiographs: — normal orientation of facets and pedicles.

**FINAL/WORKING DIAGNOSIS:** Clay-shoveler’s fracture (avulsion fracture of spinous process of C7)

**TREATMENT AND OUTCOMES:** 1. Immobilization with Philadelphia collar for 6 weeks. 2. Repeat active extension and flexion radiographs at 3 and 6 weeks

post injury showed no delayed increase in stability. 3. Neck isometric exercises started 3 weeks post injury. 4. Range of motion and neck strengthening exercises started 6 weeks post injury. 5. Returned to sports 3 months post injury when he had full, painless ROM, normal strength and able to meet the demands of his sport.