Goldfarb Clinical Conference Poster Competition
2017 Exhibit Guidelines

For consideration of your research to be presented via Poster Exhibition at the Goldfarb Clinical Conference, November 9-12, 2017, you should submit your application via our online submission system at **http://tinyurl.com/GoldfarbAbstractPoster**. Please keep in mind, that not all submissions are selected for exhibition.

Abstract submission deadline: **June 15, 2017**. No extensions will be granted.
Notification regarding acceptance: **August 4, 2017**

Submission Guidelines

Posters will be accepted into one of two divisions: Scientific or Case Division.

Scientific Division: The presentation of data, either prospective or retrospective that begins with a hypothesis and poses a questions to be answered. The research allows for drawing of conclusions to negate or validate the hypothesis.

Case Division: A collection and presentation of data regarding a particular patient or group of patients that presents conclusions only about that particular patient or patient group.

A Case Series can allow the authors to occasionally draw conclusions that may extrapolate to a larger patient population. For these situations, the scientific division should be considered for abstract submission.

Within each Division, research topics must be relevant to Podiatric Medicine and Surgery and should fall into one of the following classifications:

- Biomechanics/prosthetics/orthotics
- Diabetic foot/wounds
- Forefoot Reconstruction
- Rearfoot Reconstruction/Trauma
- Medicine/Other

Level of evidence should also be reported.

I	Randomized, controlled trials. Free from serious doubts about generalizability, bias and flaws in research design. Includes systematic review of other relevant published research to validate conclusions.
II	Prospective/Retrospective, non-randomized studies. Develop diagnostic criteria and treatment recommendations based on the results, but with a limited review of the published research.
III	Case-controlled and/or Retrospective comparative studies of lesser quality. Non-

	consecutive studies without consistently applied reference standards.
IV	Expert consensus, systematic reviews or clinical practice guidelines. Includes Case series/Case reports.
V	Expert opinion based on limited research, or the opinion of an individual based on non-researched evidence.

This chart was adapted from the following:

1. Centre for Evidenced-Based Medicine, Oxford, UK. www.cebm.net
2. Newhouse R, Dearholt S, Poe S, Pugh LC, White K. The Johns Hopkins Nursing Evidence-based Practice Rating Scale. 2005. Baltimore, MD, The Johns Hopkins Hospital; Johns Hopkins University School of Nursing.

Research should be complete by the time of submission.
Once the abstract is submitted titles cannot be changed and additional authors cannot be added.

All submissions *must* have at least one podiatric physician listed as an author.
At least one author must be a member in good standing with the American Podiatric Medical Association (APMA).
At least one author must register for and attend the Goldfarb Clinical Conference. Registration for this person will be complimentary; further instructions on how to register for this event will be included in the Notification of Acceptance, sent on or around August 4, 2017.

The corresponding author should be listed in the abstract. All communications regarding acceptance/denial and further instructions will be communicated to the corresponding author only.

Industry sponsored abstracts can be submitted for consideration. Abstracts are considered industry sponsored if grants, research support, or honoraria's or any other financial or material support have been provided.

Abstracts should not be commercial in nature or overtly promote any product or device.

An Author Disclosure must be completed by each author listed on the accepted poster.

ONSITE EXHIBIT GUIDELINES

Posters must be hung in your designated area within the exhibit hall by Friday, November 10, 2017 at 10:00 am.

Please bring your own pushpins or thumbtacks to secure your poster to the poster board provided.

Posters that are not displayed in the appropriate area by 10:00am will be eliminated from the competition.

Posters must be removed from your designated area within the exhibit hall by Saturday November 11, 2017 at 6:00pm.

Maximum allowable poster size: 3.5 feet high x 7.5 feet wide.

One author per poster is welcome to stand with their poster between 10:00-10:30am on Saturday November 11, 2017 to answer any questions from attendee's.

Judging of the research presented will be conducted throughout the morning of Saturday, November 11, 2017 and the winners will be announced just prior to the start of the last lecture session on Saturday at 3:30pm.

COMPETITION TIMELINE

- Abstract submission timeframe: March 15 – June 15, 2017
- Notification of acceptance in an email to corresponding author: August 4, 2017
- Posters on display: Thursday, November 9, 4:00 pm through Saturday, November 11, 6:00 pm
- Poster judging: Saturday, November 11, 8:00 am -12:00 pm
- Poster Q&A: Saturday, November 11, 10:00 am – 10:30 am
- Poster Winners announced: Prior to 3:30 pm lecture on Saturday, November 11
- Poster removal: by Saturday, November 11 at 6:00 pm

ABSTRACT FORMAT

Title:

Authors: (listed in the order you wish them to be published)

Corresponding Author Name/Email:

Format: Scientific or Case Division

Level of Evidence: I-V

Length of follow-up:

Classification:

- Biomechanics/prosthetics/orthotics
- Diabetic foot/wounds
- Forefoot Reconstruction
- Rearfoot Reconstruction/Trauma
- Medicine/Other

Purpose:

Methodology:

Procedures:

Results:

Discussions:

SAMPLE ABSTRACT (SCIENTIFIC)

Title: A radiographic evaluation of implant migration across time and between two generations of an implant

Authors: John Smith, DPM, Jane Doe DPM, Herbert Hoover, DPM.

Corresponding Author Name/Email: John Smith, DPM (JJSmithdpm@cyberspace.com)

Format: Scientific

Level of Evidence: III

Length of Follow-up: 24 months

Classification: Rearfoot & Ankle Reconstruction

Purpose: Aseptic loosening and talar subsidence have been identified as the primary causes of premature implant failure. The purpose of the present report was to compare the extent of implant migration across time and between two generations of the same implant. The authors hypothesized that implant migration would increase over and time and that this increase would be greater in the first generation implant.

Methodology: A retrospective review was performed to assess implant migration. Via anteroposterior radiographs, the distance from the apex of the tibial component was measured to the most distal aspect at the center of the talar stem or the mid-saddle of the non-stemmed component. Measurements were recorded from postoperative radiographs: the immediate postoperative, the 12 month, and the 24 month. Implant migration was defined as the change from the immediate postoperative radiograph.

Procedures: The TARs were implanted with an anterior ankle approach.

Results: Thirty-four consecutive patients were included (aged 58.59 ± 12.01 years, 22 men). Twenty (58.82%) patients were treated with the first generation of the implant and 14 (41.18%) with the second generation. Implant migration significantly increased across time (p = 0.008). However, there was no implant by time interaction (p = 0.069), indicating that implant migration was similar for the two implant groups across time.

Discussion: Although the present study demonstrated similar component migration between the two implants, significant findings may have been masked due to the small sample size. Additional investigations are needed to identify implant designs that prone to migration.

A RADIOGRAPHIC EVALUATION OF IMPLANT MIGRATION ACROSS TIME AND BETWEEN TWO GENERATIONS OF AN IMPLANT

John Smith, DPM, Jane Doe DPM, Herbert Hoover, DPM

STATEMENT OF PURPOSE

To compare the extent of implant migration across time and between two generations of the same total ankle replacement (TAR) system (INBONE® TAR, Wright Medical Technology, Inc., Arlington, TN).

LITERATURE REVIEW

Total ankle replacements were first introduced in the 1970s as an alternative to ankle arthrodesis. The initial results were encouraging, but subsequent reviews with long-term follow-up revealed unacceptable failure rates. Over the next several decades, areas of faulty implant design were modified, and over time, mid- to long-term survivorship improved (1-3).

As the final mid-sized, weight bearing joint, the ankle is inherently exposed to excessive stress. Following TAR, there are extreme compressive forces on the underlying cancellous bone and a small area for prosthetic support, which can result in aseptic loosening and implant migration; both of which have been shown to predict premature implant failure (4-7). Therefore, comparing implant migration as it relates to implant design is necessary to optimize the longevity and success of TAR.

Kärrholm and colleagues define implant migration as "the longitudinal movement of an implant with respect to the bone in which it is imbedded over time" (7). Although investigators recognize the need to better understand and quantify implant migration at the ankle, only preliminary reports have surfaced (8-12), and it remains unclear if specific implant designs are more prone to implant migration than others.

HYPOTHESIS

The authors hypothesized that implant migration would increase over and time and that this increase would be greater in the first generation implant.

METHODOLOGY & PROCEDURES

Level of Evidence: III

Study Design: Chart Review

A chart review was performed to identify consecutive patients that underwent TAR with either the first or second generation implant

Inclusion Criteria

- ≥18 years of age
- Diagnosed with end stage ankle arthritis
- Exhausted conservative treatments
- Elected to undergo TAR
- Either the first generation or second generation of a pre-identified TAR was implanted
- Minimum radiographic follow-up of 24 months

Outcomes

- Implant migration
  - Defined as the change from the immediate post-operative radiograph to the 24 month radiograph

Measurements

- Via anterior-posterior radiographs, the distance from the apex of the tibial component was measured to the most distal aspect at the center of the talar stem or the mid-saddle of the non-stemmed component
- Recorded from post-operative radiographs: the immediate post-operative and the 24 month

Statistical Analyses

- A repeated measure analysis of variance (ANOVA) with repeated measures for time (baseline, 24 months) and implant (first generation, second generation) was used to evaluate the dependent variable (implant migration).
- Statistical significance was set at the 5% level ($p \leq 0.05$)

RESULTS

Figure 1. Radiographic Measurements

A. First Generation Implant

B. Second Generation Implant

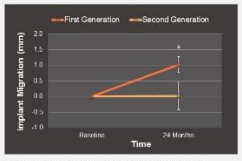
Table 1. Patient Demographics

Data presented as mean ± standard deviation or n (%).

Demographic	All Patients	First Generation Implant	Second Generation Implant
Patients	34 (100.0)	20 (58.8)	14 (41.2)
Age (years)	58.6 ± 12.0	59.3 ± 12.2	57.6 ± 12.1
Body Mass Index (kg/m^2)	31.9 ± 6.8	31.1 ± 7.3	32.3 ± 6.3
Gender			
Men	22 (64.7)	14 (70.0)	8 (57.1)
Women	12 (35.3)	6 (30.0)	6 (42.9)
Injury Side			
Left	15 (44.1)	10 (50.0)	5 (35.7)
Right	19 (55.9)	10 (50.0)	9 (64.3)

Figure 2. Implant Migration across Time by Implant

Data presented as mean ± standard error.



The repeated measures ANOVA revealed a main effect of time ($p = 0.03$), a main effect of implant ($p = 0.03$), and a time by implant interaction ($p = 0.03$). The time by implant interaction indicates that the rate of implant migration was significantly greater for the first generation implant (1.0 ± 1.1 mm) than the second generation implant (0.0 ± 1.6 mm).

*Statistically significant at the 5% level ($p \leq 0.05$).

DISCUSSION

Total ankle arthroplasty continues to gain popularity in the field of foot and ankle surgery. Despite improvements in implant design, implant migration continues to contribute to premature implant failure (4-7). Investigating the implant migration associated with various ankle implants may assist in identifying and filtering out inferior designs. The purpose of the present report was to compare implant migration between two generations of the same implant, two years after implantation. The present study demonstrated that implant migration increases over time and that the rate of implant migration was reduced with the newer generation implant.

While many features of the first generation implant were preserved, there were some substantial modifications (13). For example, the newer implant utilizes two talar pegs with an optional central stem, as opposed to a single talar stem. The two points of fixation are thought to increase axial stability (13). To increase stability in the coronal plane, the talar saddle design was replaced with a sulcus design. Additionally, the tibial base plate was elongated to increase coverage in the anteroposterior plane. Given the increased surface area, loads should be more evenly distributed throughout the tibial plafond (13).

A primary limitation of the present investigation was the small sample size (N = 34). To confirm that these generational modifications deter implant migration, additional studies with larger sample sizes are needed. Presumably, more appreciable differences in implant migration will exist between TAR systems with marked dissimilarities in design as opposed to generational modifications.

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SAMPLE POSTER (SCIENTIFIC)

SAMPLE ABSTRACT (CASE)

Title: Undiagnosed Unicameral Bone Cyst in a Pediatric Patient Treated with Excision and Allograft: A Case Report.

Authors: John Smith, DPM, Jane Doe DPM, Herbert Hoover, DPM.

Corresponding Author Name/Email: John Smith, DPM (JJSmithdpm@cyberspace.com)

Format: Case Division

Level of Evidence: IV

Length of follow-up: 11 months

Classification: Rearfoot Reconstruction/Trauma

Purpose: We present the case of a 10-year old female with chronic heel pain for one year duration and without resolution of symptoms after receiving treatment by 4 physicians prior to presentation at our office. We present this case to underline the importance of a complete and thorough evaluation of the pediatric patient without a history of trauma.

Methodology: This case was a retrospective chart review of a 10-year old female patient with a long history of unresolved heel pain who was eventually diagnosed and treated for a unicameral bone cyst in the calcaneus.

Procedures: Surgical excision of the cyst with allograft fill was performed for resolution.

Results: 11 months status post-surgical excision with allograft fill of the unicameral cyst in the right calcaneus, the patient has improved ACFAS and AOFAS scores. She currently ambulates without a noticeable gait disturbance, can tolerate walking longer distances and has no limitations to her daily activities, which is a vast improvement from her pre-operative status. The patient still complains of some residual discomfort and limitation with recreational activities but overall is very satisfied with her outcomes.

Discussions: Unicameral bone cysts comprise 3% of all bone lesions, and should be suspected in the pediatric patient with unresolved, unexplained pain without a history of trauma. It is important that obese pediatric patients who complain of pain are investigated thoroughly to assure that their body habitus is or is not the reason for their lower extremity pain. Considering our patient's clinical symptoms, high likelihood of pathologic fracture due to body habitus, and the size of the lesion, open excision and backfilling the lesion with allograft was chosen as the most appropriate treatment option and was successful.

Undiagnosed Unicameral Bone Cyst in a Pediatric Patient Treated with Excision and Allograft: A Case Report

John Smith, DPM, Jane Doe DPM, Herbert Hoover, DPM.

STATEMENT OF PURPOSE

The following case report outlines the treatment of a 10-year old female with chronic heel pain 1-year in duration. Prior to presentation to our office, the patient failed conservative treatment by 4 physicians. The patient noted vague, aching heel pain with walking and without a history of trauma to the area. After further radiographic and MRI evaluations, the patient was found to have a Unicameral Bone Cyst in the calcaneus and subsequently underwent operative intervention.

We present this case to underline the importance of a complete and thorough evaluation of the pediatric patient with unresolved heel pain without a history of trauma. In addition, excision and filling of the lesion with allograft was selected over percutaneous options given the patients clinical symptoms and a high likelihood of pathologic fracture due to patient body habitus and the size of the lesion.

LITERATURE REVIEW

Unicameral bone cysts (UBC), also referred to as simple bone cysts or solitary bone cysts, are benign, fluid filled bone defects typically found in children or adolescents.[1,8,10,14,16,19] The lesions occur most commonly in the femur and humerus, with the calcaneus ranking as the sixth most common site for the lesion.[9,13,15,17] Unicameral bone cysts comprise roughly 3% of all bone lesions, with a male to female ratio of 2:1.[2,7,8,10,18] Several theories have been described as to the pathogenesis of unicameral bone cysts but the etiology remains subject to discussion. Proposed etiologies include trauma, inflammation and dysplasia, venous obstruction, genetic causes, and increases in intra-cavity osseous pressure.[1, 7,10,18]

Although many lesions present as incidental findings on radiographs, patients may also present with pain and possible pathological fracture at the site of the lesion.[4-10,13,16] Many treatment options have been advocated for unicameral bone cysts, with significant discrepancy in the literature as to the gold standard.[2-4,6-17,19] Literature on unicameral bone cysts splits treatment options into steroid treatment and operative treatment. Literature focusing on treatment of unicameral bone cysts in the calcaneus is limited secondary to its low incidence in this location. Many authors advocate surgical treatment of calcaneal lesions even when asymptomatic secondary to the high weight-bearing load of the calcaneus and thus, an increased risk for pathologic fracture.[9] Other authors argue that asymptomatic lesions warrant non-operative treatment as they typically remain asymptomatic and do not enlarge.[15]

LITERATURE REVIEW (CONTINUED)

The current trend for treatment of symptomatic unicameral bone cysts of the calcaneus is for backfilling the lesions with allograft in an open or percutaneous fashion.[12,14,17,19] Recently a technique of endoscopic curettage and percutaneous allograft filling was described with promising results.[19] Although we agree percutaneous techniques are advantageous in their small incisions and decreased dissection, we chose an open approach in our patient secondary to the vast size of the lesion. We advocate the importance of filling the calcaneal defect with a bone graft substitute to prevent future pathological fracture.

OPERATIVE INTERVENTION

The patient presented to our office after a year of treatment by multiple other physicians for unresolved heel pain to the right side. Given the absence of a history of trauma, radiographs (Figure 1) followed by an MRI (Figure 2) were ordered to rule-out any additional pathology not previously identified.

A UBC was identified, and surgical excision with allograft fill was recommended and performed through an open approach. A lateral cortical window was created with an osteotome to access the lesion. This was secured with a staple following evacuation of the lesion and backfilling with allograft (Figure 3A,B).

Six weeks after the procedure the patient was transitioned from non-weight bearing to full weight-bearing in a Controlled Ankle Motion (CAM) boot and at nine weeks, was transitioned to normal shoe wear with activity increases to tolerance. Lateral radiographs immediately post-operative and at 9 months post-operatively demonstrate allograft at the previous cyst cavity as well as staple placement across the lateral cortical window, anterior to the growth plate (Figure 4A,B).

Figure 1: Initial radiograph reveals a large cystic area located in the neutral triangle of the calcaneus.

OPERATIVE INTERVENTION (CONTINUED)

Figure 2: Pre-operative MRI revealed a unicameral bone cyst involving the calcaneus without fracture or other pathology.

Figure 3: Intraoperative photographs demonstrating: A-Cortical window for evacuation of the lesion, and B-allograft fill into the cavity.

Figure 4: Lateral radiographs: A-immediately post-operative, and B-at nine months post-operative.

OUTCOMES

11 months status post surgical excision with allograft fill of the unicameral bone cyst in the right calcaneus, the patient has improved ACFAS and AOFAS scores. Pre-operative ACFAS score was 69 (Fair) and post-operatively improved to 86 (Excellent). Pre-operative AOFAS score was 47 (Fair) and post-operatively improved to 80 (Good).

The patient currently ambulates without a noticeable gait disturbance, can tolerate walking longer distances and has no limitations to her daily activities, which is a vast improvement from her pre-operative status. The patient still complains of some residual discomfort and limitation with high intensity recreational activities but overall is very satisfied with her outcomes.

DISCUSSION

Unicameral bone cysts comprise 3% of all bone lesions, and should be suspected in the pediatric patient with unresolved, unexplained pain without a history of trauma. It is important that obese pediatric patients who complain of pain are investigated thoroughly to assure whether their body habitus is, or is not, the reason for their lower extremity pain. In our patient, she had been seen and treated by several physicians without success, all of whom contributed her pain to obesity. It wasn't until we investigated further that the UBC was discovered and treated.

Controversy exists on the best treatment option for patients with UBC's. Considering our patient's clinical symptoms, high likelihood of pathologic fracture due to body habitus, and the size of the lesion, open excision and backfilling of the lesion with allograft was selected as the

REFERENCES

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SAMPLE POSTER (CASE)

JUDGING GUIDELINES

SCIENTIFIC DIVISION					Points per category
Poster # SCI-					
Poster Title:					
Title (3 points) -Does the title adequately convey the objectives of the research?	0	1	2	3	
Statement of Purpose (6 points) -Is the purpose of the research clearly stated? -Are the studied measures well defined?	0 0	1 1	2 2	3 3	
Literature Review (12 points) -Is there sufficient published support for the research question posed? -Is the published research presented current/updated? -Is the review well organized and succinct? -Is the reference list available?	0 0 0 0	1 1 1 1	2 2 2 2	3 3 3 3	
Methodology/Procedures (15 points) -Is the patient population well defined? -Was the rationale/data collection/analysis explained? -Were the subjects stratified? -Was the research method appropriate for the questions posed? -Were the subjects randomized?	0 0 0 0 0	1 1 1 1 1	2 2 2 2 2	3 3 3 3 3	
Results (6 points) -Is the data concisely reported? -Are the statistical methods utilized clearly explained?	0 0	1 1	2 2	3 3	
Analysis/Discussion (12 points) -Are the limitations of the data and/or analysis mentioned? -Are next steps/future directions discussed? -Are conclusions supported by the data presented? -Is the research question answered?	0 0 0 0	1 1 1 1	2 2 2 2	3 3 3 3	
Significance (6 points) -Is there educational value to the questions posed and the results presented? -Does this add value to the body of literature already available?	0 0	1 1	2 2	3 3	
Design (12 points) -Is it easy to follow the sequence of the presentation -Are there spelling/grammatical errors that take away from the presentation? -Is the font and color schematic easily readable? -Did the schematics/images aid the viewer in comprehension of the presented material?	0 0 0 0	1 1 1 1	2 2 2 2	3 3 3 3	
Commercialism (3 points) -Is commercialism overly evident?	If yes, subtract 3 points off total score				
					TOTAL_____/ 72

JUDGING GUIDELINES

CASE DIVISION					Points per category
Poster # C-					
Poster Title:					
Title (3 points) -Does the title adequately convey the objectives of the research?	0	1	2	3	
Statement of Purpose (6 points) -Is the purpose of the report clearly stated? -Is the rationale for reporting the case well defined?	0 0	1 1	2 2	3 3	
Literature Review (9 points) -Is the published research presented current/updated? -Is the review well organized and succinct? -Is the reference list available?	0 0 0	1 1 1	2 2 2	3 3 3	
Case Report (15 points) -Is there adequate information presented to fully understand the case? -Is the history of present illness complete? -Are the physical findings fully reported? -Is the presentation of the case chronological? -Is there adequate justification of the treatment selected?	0 0 0 0 0	1 1 1 1 1	2 2 2 2 2	3 3 3 3 3	
Discussion (6 points) -Are next steps/future directions discussed? -Are the recommendations made supported by the case presented?	0 0	1 1	2 2	3 3	
Significance (6 points) -Is there educational value to the case presented? -Does this add value to the body of literature already available?	0 0	1 1	2 2	3 3	
Design (12 points) -Is it easy to follow the sequence of the presentation -Are there spelling/grammatical errors that take away from the presentation? -Is the font and color schematic easily readable? -Did the schematics/images aid the viewer in comprehension of the presented material?	0 0 0 0	1 1 1 1	2 2 2 2	3 3 3 3	
Commercialism (-3 points) -Is commercialism overly evident?	If yes, subtract 3 points off total score				
TOTAL_____/ 57					