Abstract Submission and Presentation Instructions

Submission Deadline EXTENDED: Thursday, January 9, 2020

You are invited to submit abstracts related to all aspects of clinical microbiology and infectious disease including epidemiological, diagnostic, environmental, medical and basic sciences. Abstracts related to education in microbiology and infectious diseases are also welcome.

- Basic / experimental science
- Antimicrobials
- Antimicrobial Stewardship
- Diagnostic laboratory methods, studies, and surveillance
- HIV and AIDS
- Virology
- Bacteriology
- Mycology
- Parasitology
- Sexually transmitted infections
- Infection prevention and control / Health care epidemiology
- Travel medicine and tropical diseases
- Public health
- Clinical infectious diseases
- Education
- Environmental / Food microbiology
- Paediatrics
- Other

To be considered, an abstract must comply with the rules of submission set out by the Abstract Committee. Before submitting an abstract, it is strongly recommended that the entire “Guidelines for Submission of Abstracts” section be thoroughly reviewed. Submitted abstracts that do not conform to the prescribed format will be rejected.

Abstracts will be judged on scientific content, interest, and relevance to infectious diseases and microbiology.

The annual conference accommodates a fixed number of oral presentations and a limited number of posters. THE ABSTRACT COMMITTEE RESERVES THE RIGHT TO SELECT THE FINAL PRESENTATION FORMAT.

Guidelines for Submission of Abstracts

A. Preparation and Structure of Abstracts

Please read the following and refer to the Sample Abstract on page 12 of the Call for Abstracts brochure.

1. Abstracts cannot exceed 300 words as identified in the submission system. Submissions of abstracts exceeding 300 words will not be permitted. It is recommended that you prepare your abstract’s text prior to submission and save a copy on your PC. The text can later be copied and pasted into the online submission form. Please note that the submission site’s word counting mechanism may differ slightly from other word processors (i.e. MS Word). It is recommended that you prepare your abstract to be sufficiently under the word limit to accommodate if needed.

2. A “blinded” review and selection process will be used to identify abstracts for presentation. Therefore, no identifying features such as names of authors and their affiliations, names of hospitals, medical schools, clinics or cities may be listed in the title or text of the abstract. The names of authors and their affiliations (institutions) are entered separately when you submit the abstract online.
3. **Title:** Your title cannot exceed 50 words (submissions of titles exceeding 50 words will not be permitted). The title should be concise and clearly reflect the content of the abstract. Capitalize the first letter of each word, except prepositions, articles and species names. Spell out and italicize names of organisms. There should be no period at the end of the title.

4. **Abstract Text:** Your abstract text cannot exceed 300 words (submissions of text exceeding 300 words will not be permitted). Abstracts should state briefly and clearly the objectives, methods, results and conclusions of the work.

   - **Objective(s):** Clearly state the purpose of the work presented.
   - **Methods:** Describe your selection of observations or experimental subjects clearly and concisely.
   - **Results:** Present your results in a logical sequence in text and/or tables. Illustrations should be avoided.
   - **Conclusion(s):** Emphasize new and important aspects of the study and conclusions that are drawn from them.

   **Abstracts not written in the format illustrated in the Sample Abstract will be rejected.**

5. **Authors:** List the first and last names of ALL authors. Middle initials are optional.

6. **Affiliations:** List each author’s institution, city and province. Use standard abbreviations for the province (e.g. ON, AB, BC).

7. **Tables and Figures:** We discourage the use of tables and figures in abstracts. If using figures or tables listed data will be included in the abstracts count.

   **IF TABLES are necessary:**
   - A max of 4 columns is permitted. More than 4 columns will not be accepted.
   - Tables must be submitted in an editable format (i.e., in Word or Excel)

   **IF FIGURES are necessary:**
   - Limit of 1 figure per abstract
   - Must not exceed 3.5 inches in width
   - Must be legible at 3.5 inches in width
   - Must be a minimum of 120 dpi at 3.5 inches in width

B. **Important Information**

1. All abstracts must be submitted using the [online submission site/form](#). Amendments are permitted provided they are done online and by the submission deadline.

   - **New users:** Follow submission link to Oxford Abstracts Page, type in email which will open a drop down to create your account.

   - **Returning users:** Please sign in using the email and password you used to create your account.

2. When you click the “Log In” button you will be taken to a screen to create a new abstract submission. Please read the instructions on this screen carefully. If you have already submitted an abstract and you would like to make changes, you can click “Amend A Previous Submission”. Corrections to abstracts can only be made until the extended deadline for abstract submission, January 9, 2020.
3. You are permitted to submit more than one abstract using the same email address and password for each abstract.

4. Ensure that you have approval from all authors to submit your abstract.

5. Authors will be asked to indicate their preferred means of presentation. THE ABSTRACT COMMITTEE RESERVES THE RIGHT TO SELECT THE FINAL PRESENTATION FORMAT.

6. For poster presentations: the poster boards are 4' high x 8' wide (121.92 cm x 243.84 cm). The poster boards are Velcro and pin friendly. Each poster surface will be shared between two presenters. The maximum allowable poster size for each presenter is 44 inches high/tall by 45 inches wide.

7. Awards Competition for STUDENTS/TRAINEES: If you are STUDENT/TRAINEE and wish to submit an abstract for award consideration, you must be in training or have completed your training less than nine (9) months before the start of the annual conference. ONLY ONE ABSTRACT PER STUDENT/TRAINEE MAY BE SUBMITTED FOR THE AWARDS COMPETITION. THE PRESENTING AUTHOR MUST BE A STUDENT/TRAINEE.

8. The Secretariat and Abstract Review Committee will only correspond with the submitting author. The submitting author is the individual who registered and submitted the abstract. The system cannot change the contact information after submission.

9. The Abstract Committee will schedule all presentations. Presentations will take place on Thursday, April 30 or Friday May 1 or Saturday May 2. In the event of a scheduling conflict, the presentation can be made by a co-author.

10. Abstracts will not be printed for distribution at the conference. They will be made available online through the conference websites at www.ammi.ca or www.cacmid.ca. Abstracts will be published in the Journal of the Association of Medical Microbiology and Infectious Disease Canada (JAMMI) following the conference.

11. Upon Successful electronic submission of your abstract, you will receive a confirmation by email with your abstract’s reference code and a PDF preview of your submission. ONLY COMPLETE SUBMISSIONS WILL BE CONSIDERED AND PEER REVIEWED.

C. Acknowledgement

1. Abstracts will be subject to peer review by at least two (2) members of the Abstract Review Committee. Submitting authors will be notified of abstract acceptance/rejection, date, time and format of the presentation as determined by the Abstract Committee on or around February 17, 2020.

2. The presenting author must be registered for the conference by Monday, March 16, 2020. If registration is not completed by this date, the abstract will be removed and will not be published.

3. If and abstract is to be withdrawn, the AMMI Canada Secretariat must be advised in writing(meetings@ammi.ca) by Monday, March 16, 2020. Important: Cancelling your conference registration WILL NOT automatically withdraw your abstract.

4. If an abstract is accepted, an author must attend the conference and present the work in person(on Thursday, Friday or Saturday- as scheduled by the Abstract Committee and cannot be changed). If a presenting author withdraws an abstract after Monday, March 16, 2020, or does not attend the session for which he/she has been scheduled the author will be
SAMPLE ABSTRACT

Prevalence and Clinical Correlation of Indeterminate *Clostridium difficile* Tests Utilizing a 2-Step Algorithm

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OBJECTIVES: *Clostridium difficile* testing cannot distinguish infection from colonization, contributing to over-diagnosis and unnecessary treatment of *C. difficile* infection (CDI). A two-step algorithm (PCR followed by enzyme immunoassay (EIA) to confirm detectable toxin) can mitigate over-diagnosis but the clinical significance of indeterminate results (PCR+/Tox-) is unclear. We assessed the prevalence and clinical outcomes of indeterminate results.

METHODS: Retrospective chart review of *C. difficile* tests over 8-months at one community and one tertiary care hospital. The testing algorithm consisted of an in-house developed PCR targeting the *tcdC* gene, with all positive PCR’s tested with an EIA (GDH and toxin A/B). The Antimicrobial Stewardship (ASP) team assessed all patients, and CDI classification was based on the presence of symptoms or the decision by clinical providers to treat as CDI at the time of the positive result. A chart review of indeterminate results was conducted for clinical outcomes at 8-weeks after testing.

RESULTS: 1094 patients had *C. difficile* testing. 147 were PCR-positive, of which 46.3% (68/147) were indeterminate. Of those, CDI was classified in 42.6% (29/68). Thirty-nine patients were considered colonized, but 6 continued treatment despite ASP recommendations. At 8-weeks, treated asymptomatic indeterminate patients showed no significant differences in rates of relapse (0% vs. 3%, \(p = 0.99\)), positive follow-up testing (0% vs. 8.3%, \(p = 0.99\)), re-treatment (0% vs. 3%, \(p = 0.99\)), and all-cause mortality (16.7% vs. 6.1%, \(p = 0.81\)) compared to those who were untreated.

CONCLUSIONS: Almost half of positive PCR’s were EIA toxin-negative. Clinical assessment by ASP at the time of diagnosis identified 42.6% of indeterminate patients were consistent with CDI. Clinical outcomes were not significantly different when asymptomatic indeterminate patients were treated. Indeterminate results can assist in the clinical assessment of CDI, but should not be utilized in isolation for the determination of colonization or infection.