TITLE CENTERED, BOLD CAPS

First Name[a], Second Name[b]
[a] Department, institution, city, country
[b] Department, institution, city, country

AIM: *Text.*
BACKGROUND: *Text.*
METHOD AND MATERIALS: *Text.*
RESULTS: *Text.*
CONCLUSIONS: *Text.*
SUPPORT: *Text.*

REFERENCES

Cite in the text by reference number. Prepare a numbered reference list. Examples:
Journal: Harry J, Ashton N. The pathology of tumours of the lacrimal sac. Trans Ophthalmol Soc UK 1968;88:19–35.
Book: Bill A, Maepea O. Mechanisms and Routes of Aqueous Humor Drainage. Philadelphia: WB Saunders; 1975;206–226.
Contribution to a Book: Weinstein L, Swartz MN. Pathologic properties of invading microorganisms. In: Sodeman WA Jr, Sodeman WA, editors. Pathologic Physiology, Mechanisms of Disease. Philadelphia: WB Saunders, 1974;457–478.

Example abstract:

I-O 4: THE VALUE OF ETHNICITY IN DETERMINING THE APPROPRIATE TREATMENT REGIMEN IN A FIRST PRESENTATION OF ISOLATED OPTIC NEURITIS

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AIM: This study provides an epidemiological profile of patients presenting with isolated optic neuritis (ON) in London and uncovers population-based predispositions to particular ON subtypes.

BACKGROUND AND METHODS: We have recently described the incidence of NMO IgG seropositivity in a cohort of 102 patients who presented to our hospital with isolated idiopathic ON[1]. Of these patients, 21% were diagnosed with neuromyelitis optica (NMO), 22% were diagnosed with multiple sclerosis related ON (MS ON) and the remainder fell into one of three categories: chronic relapsing inflammatory ON (CRION, 18%), relapsing isolated ON (RION, 12%) and unclassified ON with no evidence to date of a relationship to multiple sclerosis (non-MS ON, 28%). In this paper we explore the epidemiological profile of the same patient cohort which has since been expanded. After excluding the unclassified ON group our cohort size is 107. The use of corticosteroids in optic neuritis varies around the world and the regimens advocated for MS ON are unsuitable for patients with NMO or CRION where long-term immunosuppression is mandatory both for visual recovery and prophylaxis.

RESULTS: If the range of isolated ON subtypes is seen as a continuous spectrum where MS ON is the mildest form and NMO is the most severe form requiring treatment, we find that particular ethnic groups are clustered at specific points along this spectrum. Almost 70% of the patient cohort belonging to the MS ON group was white. The majority of the patients from an Asian background were diagnosed with CRION (43%). African or African Caribbean patients were the group most affected by NMO (over 60%).

CONCLUSIONS: CRION and NMO warrant long term immunosuppressive therapy. Our findings suggest that an Asian patient who presents with isolated idiopathic optic neuritis has a 63% chance of suffering from a form of optic neuritis which requires steroid therapy. In the case of an African or African Caribbean patient this chance is 79%. It has been recently been shown that the ideal time window for steroid therapy in optic neuritis is approximately forty eight hours. These observations provide a case for sight-saving immunosuppressive therapy at presentation for patients of African Caribbean and Asian backgrounds who present with isolated ON - likely before the results of any diagnostic tests are available - and therefore have important implications on patients' treatment profiles.

SUPPPORT: Fight for Sight Fellowship Award

REFERENCE

[1]Petzold A, Pittock S, Lennon V, Maggiore C, Weinshenker BG, Plant GT. Neuromyelitis optica IgG (aquaporin 4) autoantibodies in immune mediated optic neuritis. *J Neurol Neurosurg Psychiatry* 2010 Jan;84(1):109-11