



MSTS 2022 Abstract Submission Guidelines

The MSTS Program Committee welcomes abstracts relative to all aspects of musculoskeletal oncology and limb salvage.

If you are an MSTS member, or if you have submitted an abstract to MSTS in the past, you will begin your 2022 submission by entering your username and email address. This is necessary to tie your submission to your existing record. If you need to confirm your username, please contact MSTS staff as info@msts.org.

If you are not a member of MSTS and have not previously submitted an abstract, please enter your email address in the New User section of the form. You will then be able to provide the information needed to create non-member user record and to submit your abstract.

CLINICAL ORTHOPAEDICS AND RELATED RESEARCH (CORR®)

The MSTS Program Committee strongly encourages everyone submitting an abstract to also submit their manuscript as soon as possible to Clinical Orthopaedics and Related Research (*CORR*®), the official journal of MSTS. *CORR*® will consider any podium or poster presentation for publication in the MSTS proceedings of the 2022 Annual Meeting. Please note, that presentation at the meeting does not guarantee publication; *CORR*® publishes only those papers that pass editorial screening and peer review. (In the unusual circumstance that the abstract is not accepted for the meeting, but the manuscript is accepted by *CORR*®, it would be published in *CORR*® as a regular submission). The deadline for manuscript submission to be considered for the proceedings is January 2nd, one month after the conclusion of the MSTS Annual Meeting. The MSTS Program Committee cannot overemphasize the importance of submitting papers to *CORR*® so that there will be a written record of the meeting and so that others may benefit from your hard work, expertise, and findings. Manuscripts may be submitted at <http://www.editorialmanager.com/CORR>®.

Advantages of publishing in *CORR*®:

- *CORR*® publishes more musculoskeletal oncology papers than any other journal: Readers look to *CORR*® first for relevant musculoskeletal oncology research
- Average time from submission to electronic publication is fast – just about 4 months
- A robust MSTS proceedings issue in *CORR*® extends our societies' brands, and increases the visibility of the important work our societies do
- No longer a "five-author rule" – ICMJE's authorship guidelines apply
- Easy-to-use article template to help you write an informative paper
- *CORR*® promotes important papers with Editor's Spotlight features, Take-5 Interviews, and *CORR*® Insights commentaries

2022 MSTS ABSTRACT AWARDS

1. Young Investigator Award – Currently in training or within 5 years of completion of orthopaedic oncology fellowship. (1st Place \$1,000; 2nd Place, \$750; 3rd Place, \$500)
 - a. In the cover letter to the manuscript, describe your role in project, (i.e., who conceived of the idea, gathered the data, analyzed the data, and who wrote the abstract and manuscript). And indicate the stage of your training are you at or when you completed your fellowship.
2. Best Paper Presentation (1st Place, \$1,000; 2nd Place, \$750; 3rd Place, \$500)
3. Best Poster (1st Place, \$500; 2nd Place, \$250; 3rd Place, \$250)
4. Best Collaborative Study (\$1,000)

We require ELECTRONIC SUBMISSION of your abstract.

Note: Please be sure you have all necessary information, including your blinded and unblinded abstract file, ready before beginning the abstract submission. Once you submit your abstract, you will not have the option to add information or make any edits.

All online submissions must include:

1. The submitter, or at least one listed co-author, must be a current member of MSTs.
2. **You must have the full name and email address for every co-author on the abstract.** A maximum of ten co-authors can be included.
3. Industry representatives are not eligible to submit abstracts.
4. **Financial Disclosure is required for the submitter, presenter, and each co-author:** The disclosure must be on file with AAOS with a disclosure submission date on or after November 30, 2021. To verify if an existing disclosure on file is current, or to create a disclosure file, [please click here](#) for the AAOS Disclosure Program.
5. **Presenter Information:** In the event that your abstract is selected for presentation, the full name and email address of the person who will present your abstract at the 2022 MSTs Annual Meeting is required. Industry representatives are not permitted to present either a poster or podium presentation at the MSTs Annual Meeting.
6. **Levels of Evidence:** To refer to the Levels of Evidence table, please view the last page of these instructions.
7. **Uploading Abstracts:** you are required to upload **both** a blinded and unblinded version of your abstract. (Blinded = No Authors/Co-Authors or Institutions should be included. Unblinded - All Authors/Co-Authors and Institutions should be included).

Please see the following information regarding the content of your abstract:

1. Structure:
 - a. Background: include what is the rationale for the study; what is known; what is not known
 - b. Questions/Purposes: state 2-4 questions or purposes oriented around specific endpoints; logically follows background
 - c. Patients and Methods: include what is relevant: study design (in vivo, in vitro, prospective, retrospective, randomized, case-control, case series, etc.), controls, diagnostic criteria, inclusion and exclusion criteria, dates, treatment, follow-up,

methods, comparisons made, and statistical methods. Please use validated outcome instruments such as MSTs, TESS, ISOLS Classification of Limb-Sparing Reconstructions.

- d. Results: provide an answer to each question or purpose, provide an estimate of effect size (odds ratio, hazard ratio, or other metrics) and relevant statistical results and p values
 - e. Conclusions: synthesis of literature and findings, limitations, clinical relevance
2. Length: Please submit a Microsoft Word document that **does not exceed 750 words.**
 3. Font: Standard Calibri font, type size 10pt.
 4. Format: Abstract should be single spaced with a 1-inch margin both on the top and bottom as well as the left and right sides.
 5. Figures and Tables: Limit 2.
 6. References: Please omit any reference to authorship and/or institution within the body of the abstract.

Please contact the MSTs office with any questions via email at info@msts.org or by phone at (847) 698-1625

Thank you,

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Clinical Orthopaedics and Related Research[®]

Levels of Evidence for Primary Research Question^a

[This chart was adapted from material published by the Centre for Evidence-Based Medicine, Oxford, UK. For more information, please see www.cebm.net.]

Types of Studies

Level	Therapeutic Studies— Investigating the Results of Treatment	Prognostic Studies— Investigating the Effect of a Patient Characteristic on the Outcome of Disease	Diagnostic Studies— Investigating a Diagnostic Test	Economic and Decision Analyses—Developing an Economic or Decision Model
I	<ul style="list-style-type: none"> ▫ High quality randomized trial with statistically significant difference or no statistically significant difference but narrow confidence intervals ▫ Systematic review^b of Level I RCTs (and study results were homogenous^c) 	<ul style="list-style-type: none"> ▫ High quality prospective study^d (all patients were enrolled at the same point in their disease with ≥80% of enrolled patients) ▫ Systematic review^b of Level I studies 	<ul style="list-style-type: none"> ▫ Testing of previously developed diagnostic criteria on consecutive patients (with universally applied reference “gold” standard) ▫ Systematic review^b of Level I studies 	<ul style="list-style-type: none"> ▫ Sensible costs and alternatives; values obtained from many studies; with multiway sensitivity analyses ▫ Systematic review^b of Level I studies
II	<ul style="list-style-type: none"> ▫ Lesser quality RCT (e.g., <80% follow-up, no blinding, or improper randomization) ▫ Prospective^d comparative study^e ▫ Systematic review^b of Level II studies or Level I studies with inconsistent results 	<ul style="list-style-type: none"> ▫ Retrospective^f study ▫ Untreated controls from an RCT ▫ Lesser quality prospective study (e.g., patients enrolled at different points in their disease or <80% follow-up) ▫ Systematic review^b of Level II studies 	<ul style="list-style-type: none"> ▫ Development of diagnostic criteria on consecutive patients (with universally applied reference “gold” standard) ▫ Systematic review^b of Level II studies 	<ul style="list-style-type: none"> ▫ Sensible costs and alternatives; values obtained from limited studies; with multiway sensitivity analyses ▫ Systematic review^b of Level II studies
III	<ul style="list-style-type: none"> ▫ Case control study^g ▫ Retrospective^f comparative study^e ▫ Systematic review^b of Level III studies 	<ul style="list-style-type: none"> ▫ Case control study^g 	<ul style="list-style-type: none"> ▫ Study of nonconsecutive patients; without consistently applied reference “gold” standard ▫ Systematic review^b of Level III studies 	<ul style="list-style-type: none"> ▫ Analyses based on limited alternatives and costs; and poor estimates ▫ Systematic review^b of Level III studies
IV	<ul style="list-style-type: none"> ▫ Case series^h 	<ul style="list-style-type: none"> ▫ Case series 	<ul style="list-style-type: none"> ▫ Case-control study ▫ Poor reference standard 	<ul style="list-style-type: none"> ▫ Analyses with no sensitivity analyses
V	<ul style="list-style-type: none"> ▫ Expert opinion 	<ul style="list-style-type: none"> ▫ Expert opinion 	<ul style="list-style-type: none"> ▫ Expert opinion 	<ul style="list-style-type: none"> ▫ Expert opinion

^a A complete assessment of quality of individual studies requires critical appraisal of all aspects of the study design.

^b A combination of results from two or more prior studies.

^c Studies provided consistent results.

^d Study was started before the first patient enrolled.

^e Patients treated one way (e.g., cemented hip arthroplasty) compared with a group of patients treated in another way (e.g., uncemented hip arthroplasty) at the same institution.

^f The study was started after the first patient enrolled.

^g Patients identified for the study based on their outcome, called “cases” e.g., failed total arthroplasty, are compared with patients who did not have outcome, called “controls” e.g., successful total hip arthroplasty.

^h Patients treated one way with no comparison group of patients treated in another way.
