Research Poster Layout Suggestions

If there is any confusion as to how to start or how to do something in PPT, call Sabra at x7904

Title: Bold 100 - 120 pt.

Authors/Institutes: Bold 60 - 80 pt.

Headers: Bold 48 - 72 pt.

Body Copy: 32 - 48 pt.

Suggested pt sizes for **FINAL output**.
Suggested pt sizes should be keyed in at 50% of desired output size. ie: body copy keyed in at 24 pts will be 48 pts when printed at 200%.

Logos can be downloaded from:
http://www.upstate.edu/marketing/brand-resources/logos.php
See examples below when considering file format to use.

UPSTATE
MEDICAL UNIVERSITY
(jpg or non-transparent tif)

UPSTATE
MEDICAL UNIVERSITY
(png or transparent tif)

Upstate's seal is not available to download but is appropriate for research.
A copy has been attached to this email.

Student Research Day/Celebration Posters are complimentary for this event ONLY and MUST follow these guidelines:

Posters must be set up at 50% of final size as PPT is limited to 56" max. Posters will be printed no larger than 36" x 60" so posters must be set up no larger than 18" x 30".
Your file will then be printed at 200%.
Author section should be listed in this order: Name, dept. or college, institute, location and contain Upstate seal or logo.

Embedded Example Poster

UNDIAGNOSED MYASTHENIA GRAVIS UNMASKED BY GENERAL ANESTHESIA IN A PATIENT WITH PERSISTENT WEIGHT LOSS

Luz Helena Gutierrez, MD; Manoochehr Karjoo, MD; Mirza B. Beg, MD
Department of Pediatrics, Golisano Children's Hospital, SUNY Upstate Medical University, Syracuse, New York

Introduction
- Myasthenia gravis (MG) is a neuromuscular disorder of autoimmune etiology:
  - Antibodies against acetylcholine receptors attack the post-synaptic membrane at the neuromuscular junction.
  - Resulting in skeletal muscle weakness and fatigue.
- MG is a rare disorder:
  - Highest reported prevalence rate of 20.4 per 100,000 population.[1]
  - Ocular symptoms such as ptosis and diplopia compromise 85% of the initial complaint reported by patients.[2]
  - Bulbar weakness (dysphagia, dysarthria, or fatigable chewing) are the presenting complaint in only 6% of the patients.[3]

Figure 1: Neuromuscular junction

Case Report
- 16 year old African American female presented with chest pain and unintentional weight loss of 15 kg over the past 5 months.
  - Chest pain was evaluated at an outside ED (Routine laboratory work and EKG were negative) and she was started on esomeprazole and referred to the GI clinic.
  - Patient denied emesis, diarrhea, constipation, difficulty swallowing and abdominal pain.

Figure 2: Ptosis seen in patients with Myasthenia Gravis

- Upper endoscopy, colonoscopy with biopsies and pH probe study were done. The procedures were performed without any complications and the results were normal.
- During the next year, the patient lost 4 kg despite the use of appetite stimulants such as megestrol acetate, and nutritional supplements.
- Extensive workup, including endocrine & rheumatology evaluations were normal.
- PEG tube was recommended for night feeding.

Figure 3: Patient's growth chart. (a) Represents the patient's weight on her first visit to the GI clinic, (b) represents the patient's weight 12 months after initial follow up as well as approximate time when PEG tube placement was performed.

- The patient underwent a PEG tube placement without any complications until it was time to extubate.
  - She failed to maintain spontaneous ventilation, which triggered the use of reversal anesthetic agents such as naloxone and flumazenil.
  - The patient was later extubated and moved to the recovery room. In the recovery room, the patient became lethargic and poorly responsive
    - She was treated again with naloxone and flumazenil, resulting in a gradual improvement.

- Neurology was consulted and her physical exam was unremarkable. Laboratory studies for metabolic abnormalities were normal and a CT head without contrast showed no abnormalities.
- The patient's mental and respiratory status deteriorated again, which le to a transfer to the pediatric intensive care unit (PICU) for intubation and mechanical ventilation.
- Further history from the family revealed diplopia, dysphagia and inability to climb multiple flights of stairs.
  - Bedside electromyography (EMG) was done which revealed findings supportive of MG.
  - An edrophonium test was performed which showed an increase in vital capacity.
  - The patient was finally successfully extubated on day 4 of her PICU admission.
  - She received treatment with intravenous immunoglobulin, oral prednisone and pyridostigmine.

Figure 4: EMG showing a decremental response of successive motor action potentials from the left abductor digiti minimi muscle after six stimuli of 3 Hz.

Discussion
- MG is an uncommon autoimmune disorder:
  - Estimated annual incidence: 10 to 20 cases per million.[4]
  - Onset: significantly earlier in women compared to men.[2]
  - Bimodal distribution with a peak in second and third decades, when women are affected the most, and a second peak in the sixth and seventh decades, when men are more affected.[5]
- Two main clinical subtypes: Primary ocular and generalized.[6]
- Respiratory muscle weakness can develop which could be life threatening.[6]
  - Myasthenia crisis (MC) is a medical emergency defined by respiratory failure requiring mechanical ventilation; approximately 15 to 20% of patients with MG go into MC.[7]
- Gastroenterological disorders are the second most common organic etiology (malignancy being number one) identified in patients with unintentional weight loss.[8]
  - An in-depth history and physical examination can usually reveal signs or symptoms of disorders such as inflammatory bowel disease, chronic pancreatitis, celiac disease, peptic ulcer disease, constipation, atrophic gastritis.[8]
- Upon reviewing the case one can appreciate the importance of a detailed and precise history.
  - It can be speculated that the patient's persistent weight loss was secondary to dysphagia.
  - The patient did not state having difficulty or painful swallowing on any of her visits to the clinic.
  - This case beautifully highlights the importance of a thorough history and the complexity of the differential diagnoses of a patient presenting with weight loss, which should include the rare but yet possible diagnosis of MG.

References
1. Phillips LH. The epidemiology of myasthenia gravis. Semin Neurol 2004; 24:17
2. Grob D, Brunner N, Namba T, Pagala M. Lifetime course of myasthenia gravis. Muscle Nerve 2008; 37:141
3. Burch J, Warren Gash C, Ingham V et al (2006) Myasthenia gravis, a rare presentation with tongue atrophy and fasciculation. Age and Ageing 2006; 35:87-88
4. Aragonés JM, Bolíbar I, Bonfill X, et al. Myasthenia gravis: a higher than expected incidence in the elderly. Neurology 2003; 60:1024.
5. Klax JS, Rochlani YM, Meena NK. Myasthenia gravis masquerading as dysphagia: unveiled by magnesium infusion BMJ Case Rep. 2014; bcr2014204163. Published online Apr 17, 2014. doi: 10.1136/bcr-2014-204163
6. Liew WK, Kang PB. Update on juvenile myasthenia gravis. Current opinion in pediatrics 2013 Dec;25(6):694-700
7. Thomas CE, Mayer SA, Gungor Y, et al. Myasthenic crisis: clinical features, mortality, complications, and risk factors for prolonged intubation. Neurology 1997; 48:1253-1260
8. Bouras EP, Lange SM, Scolapio JS. Rational approach to patients with unintentional weight loss. Mayo Clin Proc 2001; 76:923.

Suggestions:

- Greater contrast between background and text makes text easier to read, you don't want to lose your audience. Choose either dark backgrounds with white or pale yellow text or very light backgrounds with black text. Middleground colors will make text look muddy and harder to read. Applying color to text will also make it harder to read. If using color with text, use it sparingly. Stay away from red text.

- Insert new text boxes for each section of text. (Abstract, Methods...) then all are movable/resizable on their own and easier to re-form columns if necessary. Don't put section headers in separate text boxes like PPT prompts you to do, include them in the same box as their corresponding type. It's a waste of time and doubles the amount of elements you potentially have to move/manipulate.

- Set up clear, evenly spaced columns. Overlapping, messy columns lead to confusion in text flow.

- San serif fonts (Arial, Helvetica, Tahoma) are easier to read from a distance than serif fonts (Times, Garamond). Titles, authors and headers (brief text of importance) should be **bold**. Only use uppercase for shorts blocks of type such as title or headers. Large amounts of uppercase text are difficult for the eye to read. Text should never be justified (flush left and right), this makes large amounts of text difficult to read.

- **DO NOT assume if it's 'on the internet' that you can use illustrations or photos without paying for them or getting written permission to use them. Web images are usually 'web-quality' meaning 72 dots per inch (dpi) and almost always too small and of poor quality for print which needs to be 300 dpi.**

- If using photos, a brief description or title must be included explaining how it relates to your research or or why you are using it.

- If after all text (body copy), tables & images are placed and there is not enough space, text size can be decreased up to 8-10 points to make more room. If text still doesn't fit, consider condensing content. If there is too much space in your layout with all content placed, text size can also be increased up to 8-10 points to fill more area. Consider making poster area smaller if there is still too much dead space.

San Serif Aa
Serif Aa
In Times New Roman, notice all the flourishes that adorn the lettering.
In Arial, notice the clean, straight lines. There are no little pointy feet.