

Abstract Submission

Deadline for Abstracts Submission: February 22, 2019 (Friday) 23:59 (TH).

Notifications of acceptance and guidelines for presentation will be available by March 1, 2019.

All participants whom abstracts are accepted must regularly register for the RCRT 2019 conference. Failure to do so may result in exclusion from the final program and the abstract may be automatically deleted.

Radiologist or In-training or Radiographer who submit an abstract for electronic scientific poster will be eligible to receive 50% off registration for RCRT 2019.

Radiologist or In-training or Radiographer who submit an abstract for scientific oral presentation will be eligible to receive a free registration for RCRT 2019.

Awards:

“Best scientific oral presentation” awards will be evaluated by subcommittee on March 28, 2019 (Thursday) 15.00-16.30 (TH). Recipients will be informed via e-mail and receive a certification at Gala dinner. Presenters will be granted as following: Platinum award: 6000 Thai Baht Gold award: 4000 Thai Baht and Silver award: 2000 Thai Baht.

“Best Electronic Scientific Poster” awards will be evaluated by subcommittee. Recipients will be informed via e-mail and receive a certification at Gala dinner. Presenters will be granted as following: Platinum award: 6000 Thai Baht Gold award: 4000 Thai Baht and Silver award: 2000 Thai Baht.

Abstract Submission Instructions:

A properly submitted abstract will include the following elements:

- Title
- Author(s)
- Purpose
- Methods and Materials
- Results
- Conclusion
- Disclosure statement

Abstract body ($\leq$ 300 words)

Please do not include references, acknowledgements, graphics, tables or figures in your abstract. Text should be submitted using Cordia New front.

Detailed notifications of acceptance and guidelines for presentation will be sent by e-mail by February 15, 2018.

To submit the abstract or any question you may have, please contact vivian@kku.ac.th

Sample Abstract:

Title: Comparison between the Radiographic Findings in Pulmonary Tuberculosis of Children with or without HIV Infection

Authors:

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Purpose/Objective: Identify the difference between radiographic findings in children with pulmonary tuberculosis with and without HIV infection.

Material and Method: The authors retrospectively reviewed the chest radiography of 93 children (under 15 years of age) with pulmonary tuberculosis between January 2000 and June 2005. Fifty-two of the children had an HIV co-infection while the remaining 41 children did not. The chest radiographic findings were assessed for parenchymal changes, lymphadenopathy, and pleural effusion.

Results: The radiographic manifestations in the HIV-infected group included interstitial infiltration in 39 patients (75%), alveolar infiltration in five patients (9.6%), combined interstitial and alveolar infiltration in seven patients (13.4%), military infiltration in one patient (1.9%), and hilar/mediastinal lymphadenopathy in 17 patients (32.6%). One patient had extensive alveolar infiltration in conjunction with multiple cavitary formations. The findings in the non-HIV-infected group were interstitial infiltration in 30 patients (73.1%), hilar/mediastinal lymphadenopathy in 13 patients (31.7%, 3 of whom had adenopathy without parenchymal infiltration), and pleural effusion in two patients (4.8%). Other less frequent abnormalities included bronchiectasis, peribronchial thickening in the HIV-infected group, and atelectasis and granuloma in the non-HIV-infected group. There was no statistically significant difference in the radiographic findings between the two groups, except the association of hilar/mediastinal lymphadenopathy and pulmonary infiltration. Regarding hilar/mediastinal lymphadenopathy with or without pulmonary infiltration between the two groups, all cases in the HIV-infected group with hilar/mediastinal lymphadenopathy were significantly more associated with pulmonary infiltration (17 patients) than the other group (8 patients) ($p = 0.009$).

Conclusion: Hilar/mediastinal lymphadenopathy with pulmonary infiltration strongly suggests the presence of HIV infection in children with pulmonary tuberculosis.