SIOPEL 2025 Spring Conference
(International Childhood Liver Tumours Strategy Group)

13th - 15th March 2025
All Nations Centre, Cardiff, Wales, United Kingdom

ABSTRACT SUBMISSION GUIDELINES

I. Layout and Structure

1. All submitted abstracts should include the following:
    - Title [use capital letter for each word]
    - Name of author(s)
    - Institution/hospital where work was conducted or current institution/hospital
    - Email address[es] of the communicating author (mandatory)

2. The text of the abstract should be no more than 250 words (excluding title, name of authors, institution and email address)

3. Abstracts should follow the IMRaD format. The IMRAD format represents a structured framework for composing scientific abstracts and manuscripts, facilitating clarity and logical progression. It encompasses four principal sections—Introduction, Methods, Results, and Discussion—which collectively encapsulate the essence of empirical research.
    - Introduction
    - Methods
    - Results
    - Discussion

4. Abstracts should be submitted ONLY online in the template provided. No HTML, or other web formats will be accepted

5. Tables or images should not be used.

6. Formatting is not required since the template will format it automatically.

II. Marking:

Your abstract will be reviewed by designated members of the Committee, external clinicians and consultants, basic scientists and invited patrons. They will review the work based on the following criteria:
- Quality of work
- Originality and novelty
- Ground-breaking or cutting edge research
- Potential significance of the work to patient care and management, or clinical practice
- Clarity of writing and presentation
- Completed or nearly completed research/study/audit

All abstracts will be scored against the above criteria and a pre-prepared marking system.

III. Deadline:

The deadline for abstract submissions is at 23:59 hours on Friday 31st January 2025.

The IMRAD Format

The **IMRAD format** represents a structured framework for composing scientific abstracts and manuscripts, facilitating clarity and logical progression. It encompasses four principal sections—**Introduction, Methods, Results, and Discussion**—which collectively encapsulate the essence of empirical research.

Introduction delineates the research context, articulates the knowledge gap, and establishes the study's rationale and objectives. It integrates prior evidence to justify the investigation, often culminating in a precise hypothesis or research question.

Methods section rigorously outlines experimental design, sample selection, data acquisition protocols, and analytical methodologies employed, ensuring reproducibility and methodological transparency. Emphasis is placed on statistical paradigms and control mechanisms to validate reliability and mitigate bias.

Results provide an objective synthesis of findings, presenting quantitative data, inferential statistics, and graphical representations where applicable. This section abstains from interpretation, prioritizing factual accuracy and clarity.

Discussion extrapolates the significance of findings, correlating results with existing literature, acknowledging limitations, and proposing avenues for future inquiry. It contextualises implications for clinical practice, translational research, or mechanistic understanding.

When preparing abstracts in this format, conciseness and coherence are paramount, particularly given word constraints (250 words). Adhering to IMRAD ensures scientific rigor, accessibility, and alignment with peer-reviewed publication standards.

A Specific Example on Childhood Hepatoblastoma in IMRAD Format

Introduction

Hepatoblastoma, the most prevalent paediatric liver malignancy, constitutes approximately 1% of all paediatric cancers and predominantly affects children under 3 years of age. It arises from hepatocyte precursors and exhibits associations with prematurity, low birth weight, and Beckwith-Wiedemann syndrome. Despite advancements, survival disparities persist, necessitating refined prognostic biomarkers and therapeutic strategies. This study evaluates clinical, histopathological, and molecular predictors influencing outcomes in childhood hepatoblastoma.

Methods

A retrospective cohort study analysed 184 paediatric hepatoblastoma cases diagnosed between 2005 and 2020 at tertiary cancer centres. Tumour staging adhered to the PRETEXT system, and treatment regimens included cisplatin-based chemotherapy followed by surgical resection. Immunohistochemistry and next-generation sequencing (NGS) assessed molecular aberrations, including CTNNB1 mutations. Cox proportional hazards modelling evaluated survival predictors, and Kaplan–Meier analysis estimated event-free survival (EFS) and overall survival (OS).

Results

The 5-year OS and EFS were 88.4% (95% CI: 84.2–92.6) and 81.7% (95% CI: 76.1–87.3), respectively. Multivariate analysis identified vascular invasion (HR: 2.76, $p = 0.003$), metastatic disease (HR: 4.21, $p < 0.001$), and CTNNB1 mutations (HR: 1.89, $p = 0.015$) as independent predictors of poor prognosis. Tumour-free margin status correlated significantly with recurrence rates ($p = 0.008$).

Discussion

Childhood hepatoblastoma demonstrates favourable outcomes with early intervention, yet molecular heterogeneity portends differential prognoses. Stratified therapy targeting genetic aberrations, including Wnt/β-catenin pathway dysregulation, warrants further exploration. Future trials should integrate genomic profiling for risk-adapted treatment paradigms to mitigate relapse and therapy-associated toxicity.