XII Curso SEOM para Residentes

18, 19 y 20 de enero de 2017

Hotel Meliá Valencia
Av. de Les Corts Valencianes, 52
46015 Valencia

CONTROL DE SÍNTOMAS Y TERAPIAS DE SOPORTE:
LA TRANSVERSALIDAD EN LOS CUIDADOS CONTINUOS

Sección SEOM mir Residentes y Adjuntos Jóvenes

Sección SEOM de Cuidados Continuos

SEOM Sociedad Española de Oncología Médica

Aprendiendo a redactar un buen abstract/póster

Dra. S López-Tarruella

ciberonc isciii

IIGM

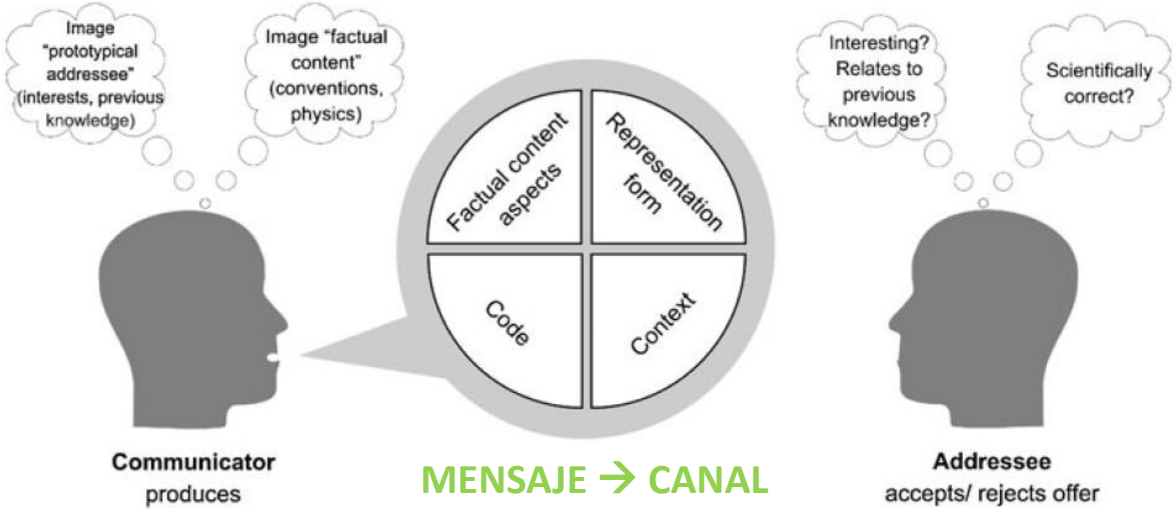
SaludMadrid

Hospital General Universitario Gregorio Marañón

Comunidad de Madrid

LA COMUNICACIÓN CIENTÍFICA

- **Comunicar** viene del latín *communicare* (compartir información, impartir, difundir)
- La comunicación científica es un proceso en dos sentidos & un experimento científico no está completo hasta que sus resultados se han publicado y entendido



MENSAJE → CANAL

EMISOR

RECEPTOR

Kulgemeyer et al Res Sci Educ 2013

FORMAS DE COMUNICACIÓN CIENTÍFICA

- **El Método Científico**

Written Com.	Oral Com.	Visual Com.
• Email • Resume/CV • Report • Journal Article (original, review, editorial) • Book	• Lecture • Meeting • Presentation • Interview	• **Poster Session** • Lecture • Presentation

McDonald E Science 1931

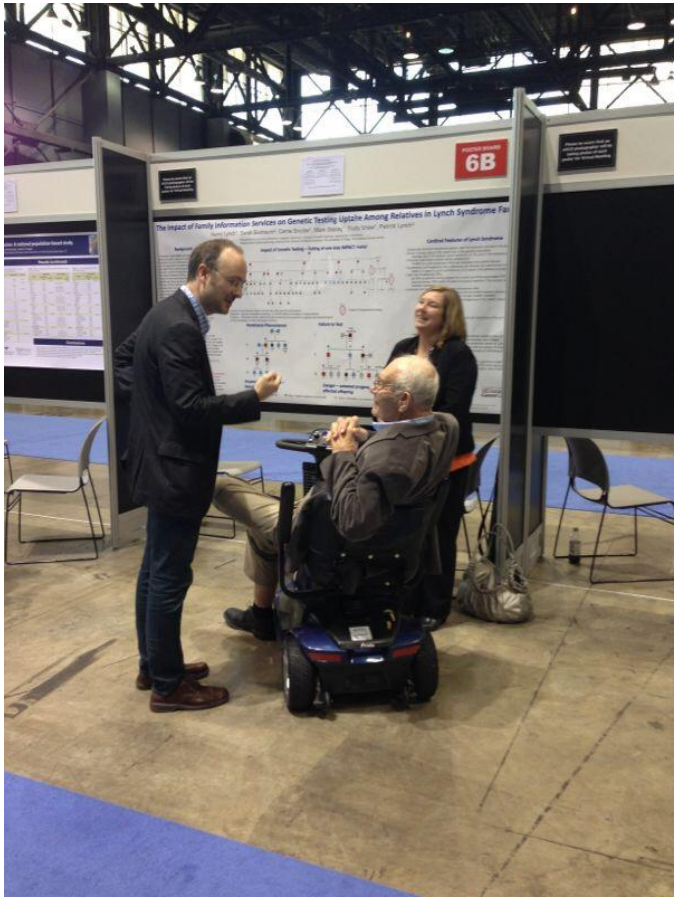
PRESENTACIONES TIPO POSTER EN CONGRESOS

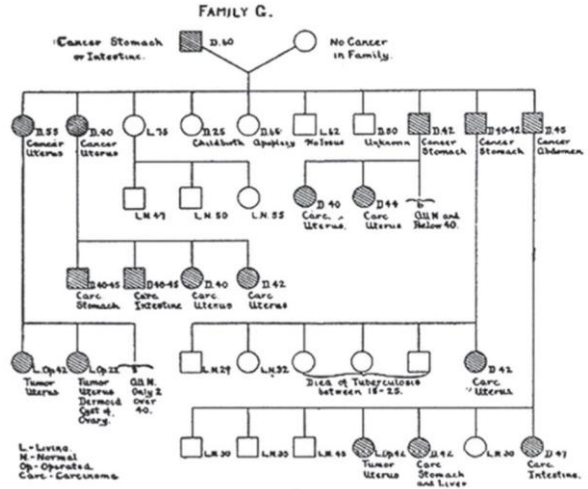
VENTAJAS DE UNA PRESENTACION TIPO POSTER

- **GENERAL** (difusión precoz de resultados/observaciones a la comunidad científica)
- **PARA PRESENTATADORES**
  - Menor tiempo de preparación
  - Criterios de selección/aceptación más accesibles
  - Oportunidad desarrollo pensamiento crítico, interpretación resultados, argumentación
  - Oportunidad desarrollo habilidades escritura, edición, presentación público
  - Interacción con expertos en el tema en un contexto *tranquilo*
  - Catalizados de la preparación de manuscrito para publicación
  - Feedback para mejorar el manuscrito
  - Networking o red de contactos expertos
  - Presentación/reconocimiento como experto en la materia
  - Nuevas ideas para jóvenes investigadores sobre el tema
  - Mejora curricular
  - Oportunidad de asistencia a la conferencia completa
- **PARA LECTORES/ASISTENTES**
  - Actualización sobre novedades en el campo de interés
  - Oportunidad para aclarar dudas a través de la interacción diversa
  - Oportunidad de generar nuevas ideas
  - Oportunidad de aprendizaje metodológico y en equipo
- **PARA ORGANIZACIÓN/COMUNIDAD CIENTÍFICA** (favorecer inscripción de jóvenes investigadores)

Illic et al Health Info & Lib J 2013; Bavdekar et al J Assoc Phys In 2017

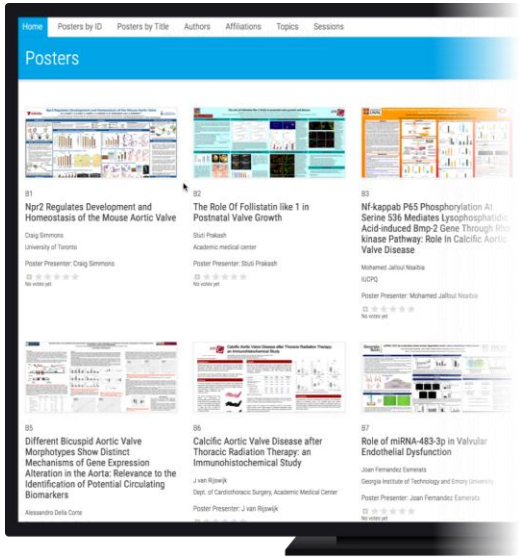
PRESENTACIONES TIPO POSTER EN CONGRESOS





E-POSTERS: LA EVOLUCIÓN DEL GÉNERO

- Paper posters → ***e-poster*** (digital interactive poster presentations)
- ***MediaPoster*** desde un portátil (docs links)
- **Web-based e-poster**
- **Virtual conference or web-blog**



D'Angelo L 2012; Alley M 2003

PASO 1. EMPEZAMOS PREPARANDO NUESTRO ABSTRACT

XII Curso SEOM para Residentes

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OBJETIVOS DE NUESTRA PRESENTACIÓN COMO PÓSTER

- Comunicar nuestro trabajo de investigación
- Ilustrar los puntos clave de una manera visualmente atractiva
- Presentarnos a nuestros colegas
- Establecer relaciones y colaboraciones con personas de interés en nuestro campo

40 YEAR ANNIVERSARY SAN ANTONIO BREAST CANCER SYMPOSIUM® UT Health San Antonio AACR American Association for Cancer Research

AACR ANNUAL MEETING 2018 • CHICAGO April 14 - 18, 2018

2018 ASCO® ANNUAL MEETING DELIVERING DISCOVERIES: EXPANDING THE REACH OF PRECISION MEDICINE

MUNICH 2018 ESMO congress MUNICH GERMANY 19-23 OCTOBER 2018 Save the date!

III SIMPOSIO Biopsia líquida EL CAMINO A LA ONCOLOGÍA DE PRECISIÓN 25, 26 Y 27 DE ENERO 2018 SANTIAGO DE COMPOSTELA

POR DONDE EMPEZAMOS?

- Seleccionar el congreso a enviar el trabajo (temática, accesibilidad, financiación-grants, impacto…)
- Planificarlo con antelación suficiente para tener resultados (cronograma del proyecto)
- Considerar las convocatorias y deadlines de presentación seleccionada

PASO 1. EMPEZAMOS PREPARANDO NUESTRO ABSTRACT

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QUÉ ES UN ABSTRACT Y SU RELEVANCIA

- Abstract leído 10-20x personas más que las que acceden al texto completo
  - Para los **lectores**, el paper no existe más allá del abstract, unica parte visible en las bases de datos electronicas (i.e. PubMed) o publicado en conference proceedings (INFORMATION & INDEXING)
  - Para los **revisores**, es la clave que determina el interés de conocer más allá del "trailer" inicial (SELECTION)

Google

- Abstract sirve para "vender" o "presentar tu trabajo" y despertar interés de profundizar más
- Importante escribir una descripción concisa y completa para despertar ese interés del lector para leer el trabajo completo
- El objetivo no es contar que has hecho algo sino que es lo que has hecho del modo más sencillo e informativo posible

Koopman F 1997; Small K 1997, Andrade C Indian J Psychiatry. 2011, Primary Health Care Research & Information Service 2017

PASO 1. EMPEZAMOS PREPARANDO NUESTRO ABSTRACT

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CRITERIOS DE CALIDAD BÁSICOS DE UN ABSTRACT

- Versión concentrada representativa del paper que se pueda comprender por si misma (***KISS*** Keep It Short and Simple)
- Detallada dentro del límite de extensión, precisa habilidades de escritura y juicio para selección de la información relevante
- Debe contener la información relevante pero sin pecar de ser demasiado *ambicioso*
- No debe presentar un panorama *sesgado* (selección de resultados a favor de la hipotesis) para que el lector pueda evaluar independientemente las conclusiones de los autores

COMPLETE (covers the major parts of the project)

CONCISE (contains no excess wordiness of unnecessary info)

CLEAR (readable, well organized, not too jargon-laden)

COHESIVE (it flows smoothly between parts)

Koopman F 1997; Small K 1997, Andrade C Indian J Psychiatry. 2011

PASO 1. EMPEZAMOS PREPARANDO NUESTRO ABSTRACT

INSTRUCCIONES A TENER EN CUENTA DE ENTRADA

- Revisar las guías & requisitos del congreso (*submission guidelines download*)
  - Valorar la sección en la que quiero clasificar mi trabajo (tracks & keywords)
- Atención a aspectos técnicos (revisar ejemplos concretos si disponibles):
  - Deadlines
  - Formato/estilo recomendado
  - Nº palabras (fuente o tamaño sino concreta)
  - Necesidad de docs complementarios (COIs?)
- Considerar la audiencia a la q va dirigido
- Determinar el tipo de abstract:
  - Descriptivo (propósito, objetivo y métodos de la investigación sin resultados, TPS?)
  - **Informativo** (versión condensada del paper que incluye resultados)

Koopman F 1997; Small K 1997, Andrade C Indian J Psychiatry. 2011

PASO 1. EMPEZAMOS PREPARANDO NUESTRO ABSTRACT

PARTES DE UN ABSTRACT

- **TITLE** *(catchy,* simple, include keywords)
- **INTRODUCTION/BACKGROUND** (purpose, rationale, scope, context & aims)
- **METHODS** (how was the problem addressed? design, recruitment, selection, sample size, treatment arms, duration, research instruments, definition of outcomes)
- **RESULTS (findings, #pts, primary & secondary objectives, efficay & toxicity, positive & negative data, related to the aims → tables permited?)**
- **CONCLUSION** (significance/implications: what these data mean?, primary take-home message, additional findings of importance and perspective)
- ~~REFERENCES~~ (generally NR)

Koopman F 1997; Small K 1997, Andrade C Indian J Psychiatry. 2011 , Higgins et al BMJ 2013

PASO 1. EMPEZAMOS PREPARANDO NUESTRO ABSTRACT

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PREPARAR EL PRIMER BORRADOR

- Definir el primer autor y co-autores estableciendo el orden de contribución
- Responder a las siguientes preguntas:
  - Porq comenzaste este proyecto?
  - Qué hiciste?
  - Qué encontraste?
  - Qué significa esto?

DARLE FORMA AL BORRADOR

- Mantenerlo ordenado
- Seleccionar la información realmente importante
- Escribirlo desde cero (no corta-pega)
- Utilizar frases o palabras clave
- Utiliza información real de los resultados de este trabajo concreto

Koopman F 1997; Small K 1997, Andrade C Indian J Psychiatry 2011

PASO 1. EMPEZAMOS PREPARANDO NUESTRO ABSTRACT

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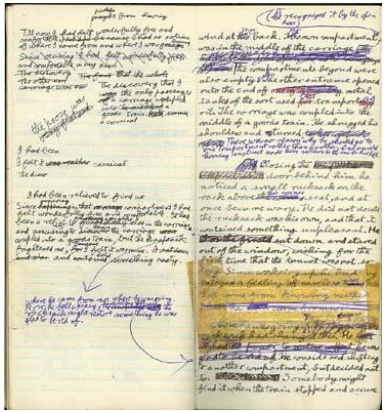
ANTES DE ENVIAR MI ABSTRACT

- Comenzar con un draft y considerar el tiempo necesario para que el equipo revise y aporte feedback sobre el doc (contar con el factor tiempo)
  - Autor senior de referencia-mentor
  - Revisar y re-revisar varias versiones hasta llegar a la definitiva
- Contactar con todos los autores implicados para que puedan aportar su revisión y sus datos (nombre correcto y filiación)
- No esperar al último minuto para enviar el abstract o colgarlo en el sistema (suele fallar por sobrecarga, problemas en login)
- Disponer por adelantado de todos los documentos requeridos (COIs…) y considerar la potencial ***administrative submission fee***
- Antes de enviar revisar una vez más los errores tipográficos, gramaticales y numéricos



Koopman F 1997; Small K 1997, Andrade C Indian J Psychiatry. 2011

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QUE VALORARÁN LOS REVISORES?

1. **ORIGINALIDAD:** comunicaciones previas del mismo autor?
2. **RELEVANCIA/ADECUACIÓN:** el tema es adecuado para la conferencia/apartado seleccionados? Aporta información importante el el contexto actual del tema? Representa un avance en el campo de interés?
3. **INTERPRETACIÓN:** los resultados del análisis están correctamente valorados? Son las conclusiones adecuadas o especulativas?
4. **CALIDAD/CLARIDAD/RIGOR:** lenguaje inteligible, objetivos claros y bien propuestos, metodología adecuada
5. **ESTADO DE LA INVESTIGACIÓN:** se valorarán los resultados completos o casi-completos
6. **NOVEDAD:** información innovadora, temas nuevos o aplicaciones innovadoras

Koopman F 1997; Small K 1997, Andrade C Indian J Psychiatry. 2011

PASO 1. EMPEZAMOS PREPARANDO NUESTRO ABSTRACT

PASO 1. EMPEZAMOS PREPARANDO NUESTRO ABSTRACT

ATLANTA | APHA 2017 Annual Meeting & Expo

APHA

This is an automated message, please do not reply

Dear Temitayo Ifafore,

CONGRATULATIONS from the American Public Health Association!

We are pleased to inform you that your Abstract, **383965**, entitled "**Beyond 23: African women's leaders are the key to meeting the SDGs**" has been selected and confirmed for Poster presentation during the APHA 2017 Annual Meeting & Expo (Nov. 4 - Nov. 8) in Atlanta. Your abstract was selected from a large number of excellent submittals and was judged to be of high quality and interest.

Important next steps

- Visit your personal Speakers' Corner - The Speakers' Corner is your home base for updating your presentation information including author information, bios, PowerPoints and more. You can also view your session, time slot and description. Please note that your contact information is published in the Online Program. Update your contact information in the Speaker's Corner if necessary.
- Become a member and register - Per the presenter policy, the presenting author is required to become a member of APHA and register for the meeting. Membership and registration can be done at online at the same time. Register before August 10 and save up to $55.
- Current and renewing members can use the link above to confirm membership and save on registration!
- Book Housing – special rates have been negotiated at 15 hotels. Book your room today as hotels fill up fast.

PASO 2. COMO ELABORAR MI POSTER

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INSTRUCCIONES A TENER EN CUENTA DE ENTRADA

- Revisar las guías & requisitos del congreso (*poster presenter guidelines*)
  - Dimensiones, Abst # (incluido?)
  - Servicio de imprenta disponible?
  - *Deadlines*
  - *QR code* regulación
  - *Commercial materials* regulación (si aplica)
  - *Embargo* regulación (si aplica)

- Considerar si mi institución tiene un modelo predefinido (*institutional templates)* normalmente ppt o equivalente o requerimientos específicos

- Planificación de la elaboración (no last minute….Murphy!)

Diseño gráfico / must-leave out list

1st draft/ review-review-review/ give it a rest

2nd draft / OK co-authors

Impresión final/ copy backup

CONTROL DE

WEEKLY PLANNER

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Week 1						
Week 2						
Week 3						
Week 4						
Week 5						

CONFERENCE

PASO 2. COMO ELABORAR MI POSTER

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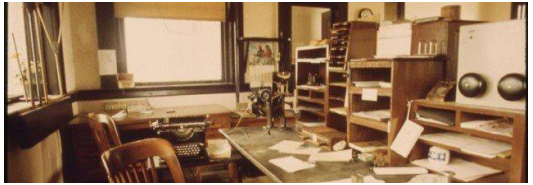
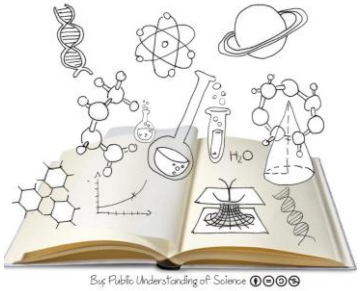
CONTENIDO: seleccionar

Qué es lo más importante/interesante de mi proyecto de investigación



- El corazón del poster es mi investigación, pretendo contar una historia centrándome en los principales hallazgos (mensaje)
- Aunque es más extenso que el abstract evitar intentar incluir TODO (brainstorm →selección)
- Tratar de responder a:
  - Cuál es mi pregunta de investigación?
  - Porq es relevante en relación al contexto actual de la cuestión? Cual es su contribución?
  - Qué hice para responder mi pregunta de investigación?
  - Qué resultados obtuve?
  - Qué implican estos resultados para mi hipótesis de trabajo?
  - Qué implican mis resultados en relación a lo previamente conocido?
  - Cuales son sus implicaciones prácticas?



PASO 2. COMO ELABORAR MI POSTER

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CONTENIDO: estructurar

- **TITULO** sencillo, atractivo y conciso (10 sec, max 2 líneas y legible a distancia)
- **AUTORES Y FILACIONES** logos incluidos
- **ABSTRACT** no siempre es preciso (ver instrucciones) poner el abst enviado
- **INTRODUCCIÓN** estado de la cuestión, pregunta de investigación, propósito, hipótesis (máx 150 palabras)
- **MAT & MÉTODOS** diseño del estudio, N, intervención, descripción variables y medida, estadística (describir el proceso de la investigación)
- **RESULTADOS** descripción de pacientes, características muestra, variables objetivo con IC (primario vs otros), análisis subgrupos (gráficos y figuras seleccionados)
- **CONCLUSIONES** discusión de los datos obtenidos e implicaciones (apoyadas en los resultados, libres de valoración personal)
- **AGRADECIMIENTOS** becas, colaboraciones o fuentes de financiación (COIs)
- **REFERENCIAS** minimizar el campo
- **CONTACT INFO or QR code**

PASO 2. COMO ELABORAR MI POSTER

DISEÑO

Cómo mostrar visualmente mi trabajo con los asistentes a la sesión

- Comenzar de nuevo con un boceto de mi poster (espacio)
- Software a emplear:
  - *Póster:* Adobe InDesign; Microsoft Pubisher; Adobe Illustrator; Prezi; Google slides, Haiku Deck; Corel Draw… o sencillamente Microsoft Power Point, KeyNote/OpenOffice* (→convertir a pdf)
  - *Imágenes:* Adobe Photoshop, Paint; MS Photoeditor…
  - *Tablas y Figuras:* Microsoft Excel o similar

PASO 2. COMO ELABORAR MI POSTER

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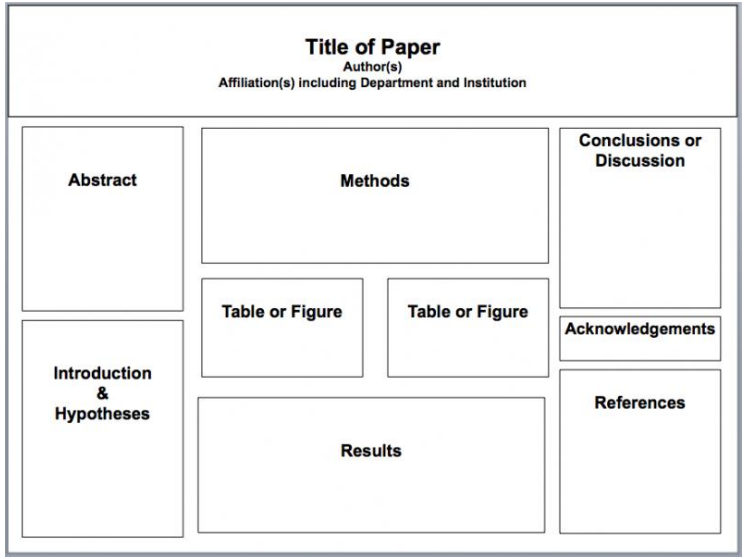

PASO 2. COMO ELABORAR MI POSTER

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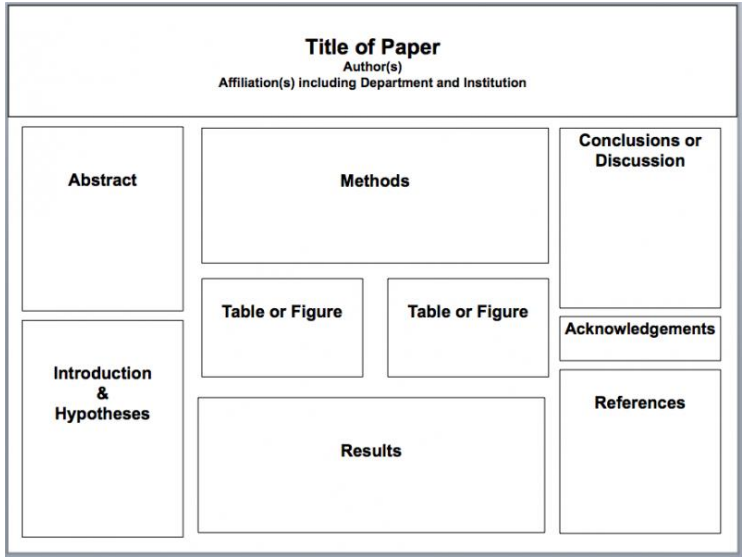
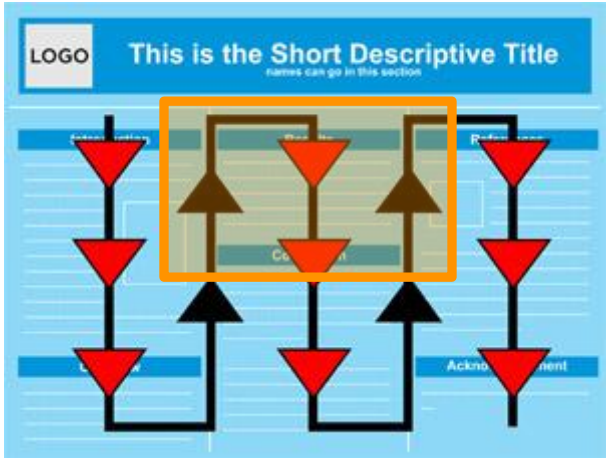


1. **Keep it simple**
2. **Make it visually interesting**
3. **Make it readable**
4. **Create a compelling title**
5. **Use technology**

PASO 2. COMO ELABORAR MI POSTER

DISEÑO: organización general

Anatomía de un poster científico



- Encabezamiento o titular: TITULO, AUTOR, FILIACIÓN
- Columnas (3-4)
- Alineación de los elementos (columnas, gráficas, párrafos)
- Equilibrio y espaciado (evitar amontonamiento)
- Espacios en blanco (densidad)
- Consistencia estética (fuentes, dimensiones de las figuras, colores…)

https://www.makesigns.com/tutorials/scientific-poster-parts.aspx

PASO 2. COMO ELABORAR MI POSTER

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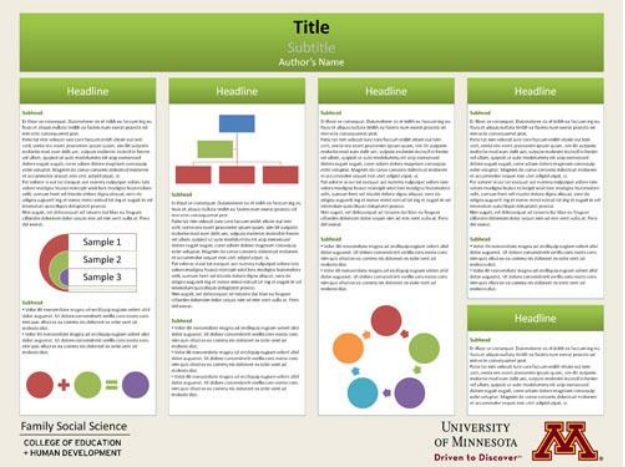
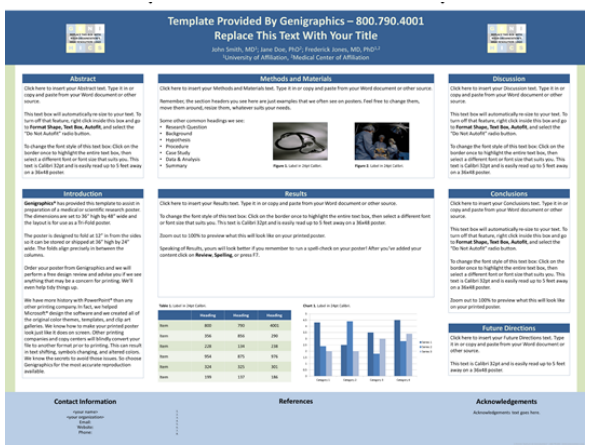
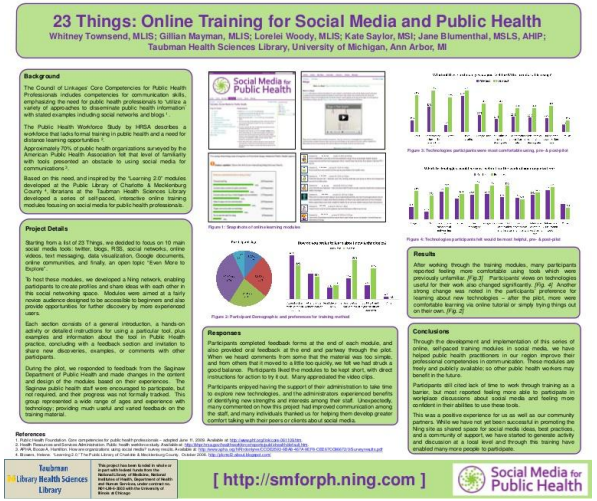
DISEÑO: póster *templates*







- Diversas fuentes (free-online, conference guidelines, institucional…)
  - Cuidado con problemas no detectados hasta la impresión!
- Crear mi propio *template*?

PASO 2. COMO ELABORAR MI POSTER

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DISEÑO: fuentes, párrafos y contraste

Fuentes

- Homogeneidad en tamaños y estilo (Serif o Sans Serif: arial, helvetica, verdana, tahoma) aceptado x impresora
- Tamaño visible a distancia (Titulo 85-90; Autor 56-72; Encabezados 36-40; Texto 20-24 & Pie foto 18-20 pt) 1.5 m para el cuerpo del texto (**90-60-30 rule**)
- Evitar mayúsculas (usar negrita o cursiva para enfatizar)

Párrafo

- Gestionar espacios en blanco (equilibrio cn texto)
- Alineación izquierda (mejor que justificado)
- Alineación de los diferentes segmentos o cajas
- Ayudarnos de bullets para aligerar párrafos

Contraste

- No más de 2-3 colores (evitar rojo/verde/amarillo)
- Fondo neutro (blanco/claro) con letra oscura
- Fondos lisos no abigarrados
- Evitar texto sobre imágenes

PASO 2. COMO ELABORAR MI POSTER

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DISEÑO: gráficas, tablas y figuras

Imágenes

- Formato estándar (.jpg, .gif, .tiff, .tif, .bmp)
- Fotografías de alta resolución (alta dpi 300?) evitar pixelado
- Agrandar proporcionalmente las imágenes
- Cuidado con emplear fondos con imagen
- Añadir títulos y pies de foto

Tablas

- Limitar a datos demasiado complicados para expresar en texto
- Limitar la anotación de NS data
- Optimizar la información incluida a la esencial

Gráficas

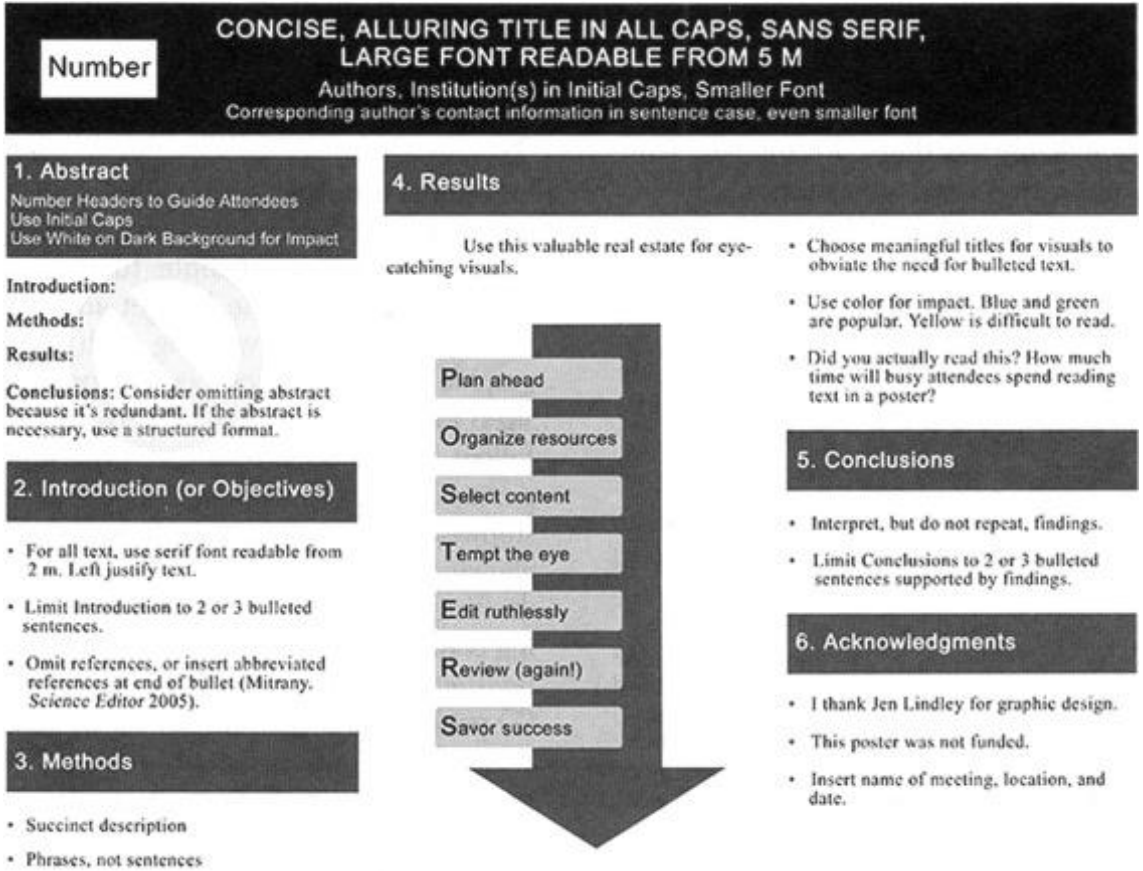
- Especificar abreviaturas
- Seguir orden de izqda a drcha
- Las etiquetas pueden minimizar las leyendas & cuidado con 3D
- Deben ser representativas de los datos a comunicar
- Cuidado con derechos de autor

PASO 2. COMO ELABORAR MI POSTER

REVISIÓN-REVISIÓN & REVISIÓN

- Dejar el póster reposar …
- Releer y valorar el poster ampliado por secciones
- Corregir errores tipográficos y alineaciones, espacios y precisión de los datos
- Asegurar la legibilidad a distancia (1.5 m)
- Obtener una 2ª opinión si es posible (transmitimos el mensaje deseado?)
- Recordar: “los póster casi siempre tienen demasiado” priorizar la sencillez

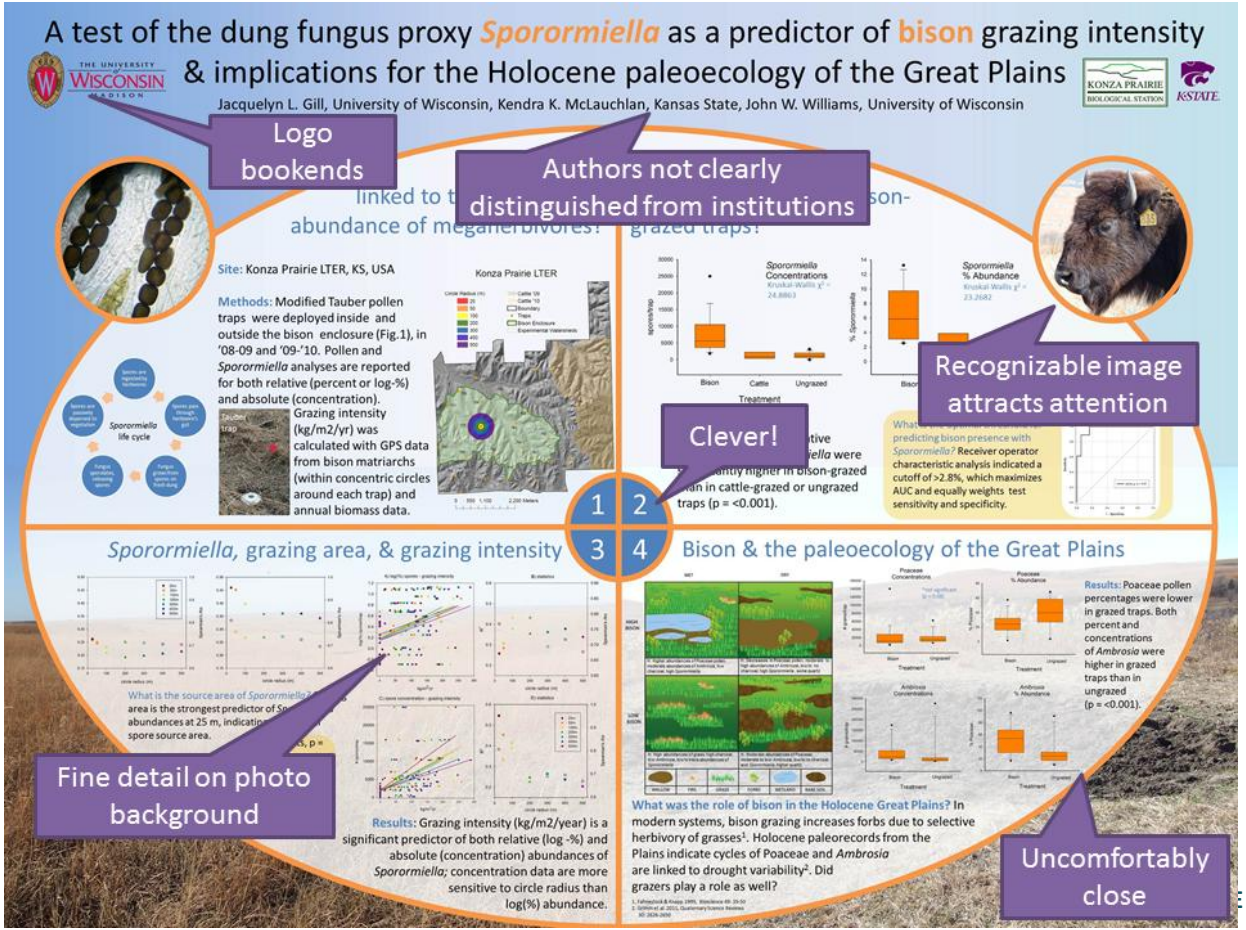
PASO 2. COMO ELABORAR MI POSTER



Hamilton CW Chest 2008

PASO 2. COMO ELABORAR MI POSTER

EJEMPLO 1



PASO 2. COMO ELABORAR MI POSTER

EJEMPLO 2

XII Curso SEOM para Residentes

18, 19 y 20 de enero de 2018

Triple positive breast cancer: A distinctive subtype and consideration of systemic therapeutic approach

Sun hyong You, MD, Yong-seok Kim, MD, Jeong Soo Kim, MD, PhD,
Uijeongbu St. Mary`s Hospital, Catholic University of Medical College, Seoul, Korea

THE CATHOLIC UNIVERSITY OF KOREA
CATHOLIC MEDICAL CENTER

Introduction

Methods

Results

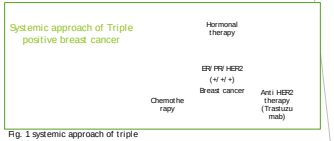


Fig. 1 systemic approach of triple positive breast cancer

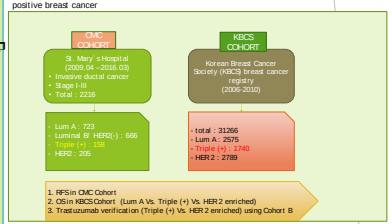
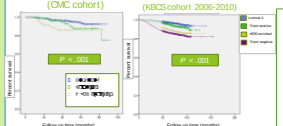


Fig. 2 Schematic diagram and end points of the study



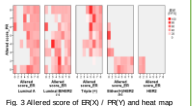
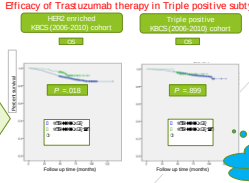


Fig. 3 Altered score of ER(X) / PR(Y) and heat map distribution by breast cancer subtype (CMC cohort)

Efficacy of Trastuzumab therapy in Triple positive subtype



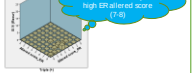


Fig. 4 ER/ PR altered score distribution in recurrence cases in triple positive breast cancer (CMC cohort)

Recurrence cases were distributed mainly in high ER altered score (7-8)

Trastuzumab therapy also shows any benefit in overall survival in triple positive breast cancer subtype regardless of breast cancer stage

Conclusion:
1) Anti- HER2 therapy seems less beneficial in Triple positive breast cancer subtype regardless of breast cancer stage.

2) Triple positive breast cancer may require different therapeutic approaches

3) Other targeted agents (mTOR inhibitor, CDK4/6 inhibitor, PIK3CA inhibitor) can be a substitute option for the Trastuzumab therapy in triple positive breast cancer

San Antonio Breast Cancer Symposium - December 5-9, 2017

The Newcastle upon Tyne Hospitals NHS
NHS Foundation Trust

Outcomes and Failure of Primary endocrine therapy for operable breast cancer in the elderly: A regional North-east of England study

Robert Thomas, Rachel Rowell, Siobhan Crichton, Henry Cain

Introduction

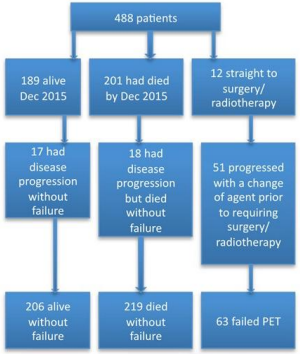
- **Primary Endocrine therapy (PET)** is a valid treatment option for oestrogen receptor (ER) positive breast cancer for those wishing to avoid surgery
- A Cochrane analysis revealed its inferiority in long-term local control in comparison to surgery.
- The Society of International Geriatric Oncologists (SIOG) suggest that PET should be reserved for patients with a reduced life-expectancy (2-3 years) or for those considered unfit for surgery.
- Inaccurate assessment of life expectancy could lead to treatment failure which is potentially catastrophic for the patient.
- Difficulties in patient selection are compounded by an increasing life expectancy, with patients with multiple co-morbidities able to live longer due to improvements in geriatric and medical care
- The **aim** of this study was to determine the failure rate of PET in the North East of England, and to identify predictors of failure.

Methods

- A retrospective observational study was performed on consecutive patients with ER positive operable breast cancer treated with PET between 2005 and 2015 in three breast units in the north east of England.
- Tumour characteristics were identified by the local computer based pathology and radiology reporting software
- Patient characteristics, treatment decisions and follow up details were retrieved from the patient's case notes
- **The primary outcome measure** was treatment failure defined by disease progression requiring surgery or radiotherapy or uncontrolled disease at death
- The secondary outcome measure was disease progression

Results

Data were included from 488 patients who were followed for a total of 1271 person years. Below Is a flow chart illustrating the numbers who failed treatment and had disease progression



Risk of treatment failure The cumulative risks of death with disease controlled and of treatment failure are summarised below in Table.1

Time	Cumulative percentage dying with disease controlled, % (95% CI)	Cumulative percentage with treatment failure, % (95% CI)
12 months	15.6 (12.5 to 19.0)	2.5 (1.4 to 4.2)
24 months	29.0 (24.9 to 33.2)	6.2 (4.2 to 8.6)
36 months	39.0 (34.3 to 43.8)	10.8 (8.0 to 14.1)
48 months	46.7 (40.5 to 50.8)	13.1 (9.8 to 16.8)
60 months	51.5 (45.8 to 56.9)	16.2 (12.4 to 20.7)
72 months	59.5 (53.0 to 65.5)	19.7 (15.1 to 24.8)
84 months	61.5 (54.7 to 67.5)	20.8 (15.8 to 26.2)
96 months	65.1 (57.8 to 71.4)	20.8 (15.8 to 26.2)

Predictors of treatment outcome Multivariate regression analysis identified independent predictors of dying with treatment failure with the results summarised below in Table 2.

	Event =Treatment failure		
	SHR	95% CI	p-value
Age	0.96	0.94 to 0.98	0.001
Tumour size	1.03	1.00 to 1.05	0.025
TPM grade	3.52	1.90 to 6.50	<0.001
Axilla involvement	2.01	1.09 to 3.73	0.026

Conclusions

- **PET was successful in 87% of patients**
- **This is the largest retrospective series investigating treatment failure of PET**
- **Younger patients with higher histological grade, larger tumours and axillary lymph node metastases are most at risk of treatment failure.**
- Patients are able to live longer term (beyond 3 years) and maintain local disease control, which may represent a viable long-term treatment in the absence of risk factors for failure.

Declarations

This presentation is the intellectual property of the author/presenter. Contact them at roberthuwthomas@doctors.org.uk for permission to reprint or distribute. **Conflicts of Interest**: RT, RR and SC declare none. HC on clinical advisory board Roche Products Ltd.

PASO 2. COMO ELABORAR MI POSTER

EJEMPLO 3

XII Curso SEOM para Residentes

18, 19 .. 20 de enero de 2018

LUND UNIVERSITY

Putting multigene signatures to the test: prognostic assessment in population-based contemporary clinical breast cancer

San Antonio Breast Cancer Symposium - December 5-9, 2017
P1-06-01

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A: THESE AUTHORS CONTRIBUTED EQUALLY

Introduction

Gene expression signatures hold promise for a molecular driven division of primary breast cancer with clinical implications. A gap still remains in the application/validation of such signatures in actual clinical treatment groups from unselected, population-based, primary breast cancer receiving current standard of care therapy.

Aims

For 15 reported gene expression phenotype (GEP) and risk predictor (RP) type gene signatures we address two primary aims in nine clinical treatments groups from a prospective, observational, population-based cohort study comprising 3534 samples of resectable primary breast cancers from southern Sweden, Scandinavia.

1. Proportions of class prediction.
2. Association with patient outcome beyond established clinicopathological variables and treatment.

Methods

SCAN-B STUDY. The study is based on the Swedish Cancerome Analysis Network - Breast (SCAN-B) initiative (ClinicalTrials.gov ID: NCT02306096), which started 2010 and currently encompasses >10000 cases. SCAN-B may be considered a prospective, observational, population-based cohort study.

PATIENTS AND SAMPLES. Between 2010-01-09 to 2015-31-03, 7540 patients with invasive primary disease in the healthcare region were identified (Figure 1). Inclusion criteria included patients undergoing primary surgery with known status for systemic adjuvant treatment (neo- or adjuvant), whereas patients diagnosed with stage IV disease were excluded as well as those with a history of contralateral BC. Of these, 5418 (72%) were enrolled in the SCAN-B study. 3534 tumors were profiled by RNA sequencing (Saal et al. 2015). Clinicopathological patient data from the National Breast Cancer Register, showed similar proportions between the step-wise cohorts (Figure 1, Table 1). Of the 3534 cases, 34% had ≥5 years of follow-up (OS), 23% 4-5 years, 24% 3-4 years, and 16% 2-3 years.

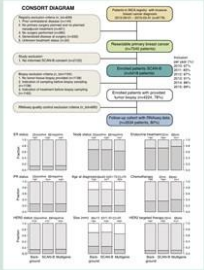
ADJUVANT CLINICAL EVALUATION GROUPS. Nine clinical evaluation groups were selected from the 3534 sample RNAseq cohort by clinicopathological features and systemic adjuvant treatment: i) TNBC ACT (adjuvant chemotherapy, n=239), ii) TNBC untreated (n=82), iii) HER2+/ER- with trastuzumab + ACT treatment (n=111), iv) HER2+/ER+ with trastuzumab + ACT + endocrine treatment (n=239), v) ER+/HER2-/LN- untreated (n=202), vi) ER+/HER2-/LN- with endocrine treatment (n=1115), vii) ER+/HER2-/LN- with endocrine + ACT treatment (n=246), viii) ER+/HER2-/LN+ with endocrine treatment (n=425), and ix) ER+/HER2-/LN+ with endocrine + ACT treatment (n=437).

Study limitations

SCAN-B is an ongoing project continuously updated with metadata and extended follow-up. Main limitations with the current interim analysis are:

1. Relatively short follow-up time for luminal and HER2+ subgroups considering modern therapy.
2. Restriction to overall survival as endpoint for majority of cases, implying age influence for certain evaluation groups in the results.
3. Low-level treatment data (no specific data on treatment duration, nbr cycles, compliance).
4. No RNAseq specific classifiers. Signature implementations represent approximations of original studies.

Results


CONSORT DIAGRAM
Patients DCIS (exclusion criteria)
Patients IMCA (eligibility: with consent, pre-cancer, 2010-09-09 to 2012-06-12)
Patients with other primary cancer (n=1)
Patients with other primary cancer (n=1)
Patients with other primary cancer (n=1

PASO 2. COMO ELABORAR MI POSTER

EJEMPLO 4

XII Curso SEOM para Residentes

10 19 .. 20 de enero de 2018

2017 SAN ANTONIO BREAST CANCER SYMPOSIUM

OVERALL SURVIVAL IN METASTATIC BREAST CANCER PATIENTS IN THE THIRD MILLENNIUM: RESULTS OF AN ITALIAN STUDY

COSMO STUDY GROUP

Poster P1-14-04

Nicla La Verde[1], Elena Collova[2], Livio Blasi[3], Graziella Pinotti[4], Antonio Bernardo[5], Marta Bonotto[6], Ornella Garrone[7], Antonella Brunello[8], Maria Giovanna Cavazzini[9], Claudia Bareggi[10], Tiziana Prochilo[11], Luca Porcu[12], Anna Moretti[1], Sandro Barni[13], on behalf of COSMO Study Group.

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BACKGROUND

Metastatic breast cancer (MBC) is a life-threatening disease and remains one of the big killers all over the world. The introduction of new drugs over the last twenty years, with the development of supportive care, has the aim of improving survival. Several studies are designed to better understand survival trends in patients (pts) with MBC and the factors affecting prognosis.

In 2004, Giordano published a study on 834 MBC pts, grouped in 5 cohorts depending on the year of relapse (between 1974 and 2000).

A progressive improvement of 5-year overall survival (OS) rates from the oldest to the most recent cohorts was observed. Nevertheless, the heterogeneity of the population in the different groups represents a limitation of this study, as stated by the authors. The earliest groups in fact were in adjuvant clinical trials, so they had particularly aggressive diseases. Conversely, pts in the most recent groups had more favorable prognostic factors, especially those with a disease free interval (DFI) greater than 5 years, which suggests an indolent behavior of the disease (1). A similar work was published in 2007 by Chia, who observed pts with MBC relapsed between 1991 and 2000, showing an improvement in recent cohorts (2).

Gennari et al., in 2005 published a retrospective data collection of MBC pts enrolled in six subsequent clinical trials for first line treatment from 1983 to 2001. In post-1994 studies, taxanes were used in early lines of treatment for all pts. At univariate analysis, an increase in OS has been observed in the more recent cases. At multivariate analysis, age, performance status, relapse-free survival, type of adjuvant treatment, metastatic site, and first-line chemotherapy with taxanes were all associated with survival. The analysis provided evidence of improvement in prognosis of MBC pts associated with use of taxanes (3). A similar study was conducted by Andrè, that analyzed data about MBC pts, treated between 1987 and 2000. Dividing the study population in two cohorts (before and after 1994), an improvement in overall survival was observed. Similarly to the previous study, the authors stated that this benefit could be due to the introduction of new drugs in the second cohort, particularly taxanes and aromatase inhibitors. (4)

At 2017 ASCO Annual Meeting, a French group presented a study conducted on a large national database, ESME, in which pts with MBC from 2008 to 2014 were recorded. Data of approximately 15.000 retrospective pts were analyzed and showed that a slight improvement in survival was associated with the year of diagnosis of metastatic disease only in the case of HER2 positive MBC (HR = 0.91, p <0.0001). For the other subtypes, no association between the year of diagnosis and OS was found. (5)

Based on this evidence, the literature shows a slight trend of improvement in survival for MBC which has not been univocally demonstrated, and the factors that influence prognosis are still unclear. This retrospective observational study aimed to evaluate the OS of MBC pts, assessing its correlation with specific prognostic and predictive factors (demographic, clinical, pathological and biological).

PATIENTS AND METHODS

COSMO (Checking Overall Survival in a MBC Observational study) was an Italian, spontaneous, longitudinal, retrospective, multicenter, non-pharmacological study. Female pts aged over 18 years, with newly diagnosed MBC between 1st January 2000 and 31st December 2008, were consecutively enrolled. The primary objective was to detect a temporal difference in OS. Secondary objectives were the identification of prognostic and predictive factors as causal factors of the temporal variation in OS. OS was defined as the time from the diagnosis of MBC to death from any cause. Pts data were retrospectively retrieved from medical charts in each participating center. The following features were collected: age at diagnosis of MBC, histotype, stage at diagnosis, presence or absence of synchronous metastasis at diagnosis, DFI, molecular subtype, treatments performed, and date of last contact or death. For pts who were still alive, a live status update has been provided prospectively via telephone contact.

STATISTICAL ANALISYS

In order to detect a temporal trend, eligible pts were divided in three different periods: 2000-2002, 2003-2005 and 2006-2008. Pts were classified in three subgroups, based on the biological characteristics of their tumor: luminal, HER2-positive (regardless of hormone receptor) and triple negative (TN). Metastatic sites were categorized as visceral versus non-visceral disease, only bone and central nervous system (CNS) metastases. DFI was calculated from diagnosis to first relapse only for M0 pts. Survival functions were estimated by the Kaplan-Meier method. The follow-up duration was estimated by the reverse Kaplan-Meier method. Baseline characteristics were summarized by absolute and percentage frequencies for categorical variables and median and interquartile range (IQR) for continuous variables. The log-rank test for trend was used to detect a temporal trend. The Cox regression model was used to detect a statistical association between predictors and OS.

Statistical analysis was performed using SAS software, version 9.4 [Copyright © 2002-2012 by SAS Institute Inc., Cary, NC, USA]. Survival functions were presented graphically via the STATA software (StataCorp 2011. Stata Statistical Software: Release 12. College Station, TX: StataCorp LP), version 12.1).

RESULTS

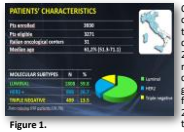

Figure 1.

COSMO database was locked on 1st April 2017. 3930 pts were enrolled from 31 Italian oncological centers. 3721 pts were eligible and analyzed (193 excluded because out of temporal range, 16 excluded because of lack of OS). The pts were distributed in the three different periods as follows: 886 (23.8%), 1302 (35.0%) and 1533 (41.2%) in 2000-2002, 2003-2005, 2006-2008 respectively. It should be noted that the first group is less represented than the other two, probably because of difficulties in accessing the oldest clinical reports. Median follow up was 9.3 years for the overall population, while in the 3 groups it was 12.8 (IQR 8.6-15.4) years, 10.2 (IQR 5.8-11.7) years, 8.5 (IQR 4.2-9.9) years for 2000-2002, 2003-2005, 2006-2008 respectively. Deaths were 810/886 (91.4%) for 2000-2002, 1120/1302 (86%) for 2003-2005, 1179/1533 (76.9%) for 2006-2008 with a total of 3109 (83.6%) events. Patient characteristics are shown in Figure 1.

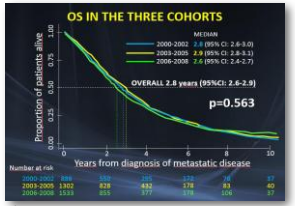

Figure 2.

OS in the three cohorts of pts: no difference (p for trend: 0.563) was found.

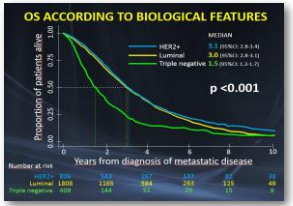

Figure 3.

OS curves in the three molecular subgroups: luminal, Her2 and triple negative. The subgroup of triple negative MBC pts has the worst prognosis.

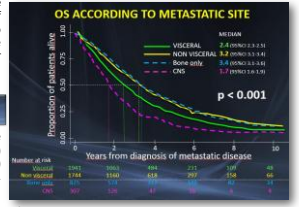

Figure 4.

Correlation between OS and metastatic sites: pts with CNS metastases have the worst prognosis with a median OS of 1.7 months, whereas pts with only bone metastases or non-visceral metastases have the best prognosis

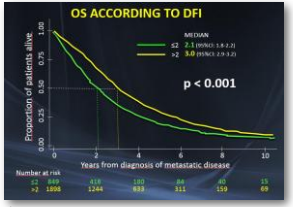

Figure 5.

OS analysis in pts with a DFI less than 2 years, compared with pts with a DFI greater than 2 years, showed a better prognosis for this last group.

CONCLUSIONS

Breast cancer is the second cause of cancer death in women and in Italy it is responsible for the deaths of 12330 pts every year (6). In literature many studies aim to evaluate patient survival by collecting real-life data, in order to understand the patient and tumor characteristics that influence the prognosis.

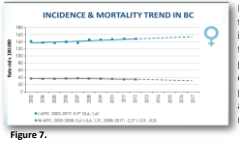

Figure 7.

Data from Italian tumor registers show that, despite an increase in the incidence of breast cancer (probably due to a higher adherence to screening programs), the reduction in mortality is observed only starting from 2008 (-2.2% per year). In the period between 2000 and 2008 in fact, no improvement in mortality is observed (Figure 7) (6).

The COSMO study provides an overview of the Italian clinical data on MBC between 2000 and 2008, adding new insights about pts prognosis. First, no change in OS was observed in the decade under study according to the Italian tumor registers, despite data of other studies reported different conclusions (1, 2). This event could be explained because the benefit of a new drug is evident after several years after its introduction. In fact, in the case of taxanes and aromatase inhibitors the introduction in the nineties led to a benefit in the following years.

Some prognostic factors were identified. Molecular subtypes, DFI and site of metastasis affect prognosis. HER2-positive subtype has the best outcome, while TN subtype has the shorter OS. A longer DFI from diagnosis (>2 years) correlates with a better prognosis. Visceral involvement correlates with poor prognosis and in particular pts with CNS metastasis represent the worst subgroup, while pts with only bone disease have the best prognosis.

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PASO 2. COMO ELABORAR MI POSTER

EJEMPLO 5

XII Curso SEOM para Residentes

18, 19 y 20 de enero de 2018

NRF

BLACK HOLE DIET PLANS

THE HIGH FRUCTOSE SUGAR ASSOCIATION

SPACEEXES

PIGS IN SPACE: EFFECT OF ZERO GRAVITY AND AD LIBITUM FEEDING ON WEIGHT GAIN IN CAVIA PORCELLUS

Colin B. Purrington
6673 College Avenue, Swarthmore, PA 19081 USA

ABSTRACT:

One ignored benefit of space travel is a potential elimination of obesity, a chronic problem for a growing majority in many parts of the world. In theory, when an individual is in a condition of zero gravity, weight is eliminated. Indeed, in space one could conceivably follow ad libitum feeding and never even gain an gram, and the only side effect would be the need to upgrade one's stretchy pants("exercise pants"). But because many diet schemes start as very good theories only to be found to be rather harmful, we tested our predictions with a long-term experiment in a colony of Guinea pigs (Cavia porcellus) maintained on the International Space Station. Individuals were housed separately and given unlimited amounts of high-calorie food pellets. Fresh fruits and vegetables were not available in space so were not offered. Every 30 days, each Guinea pig was weighed. After 5 years, we found that individuals, on average, weighed nothing. In addition to weighing nothing, no weight appeared to be gained over the duration of the protocol. If space continues to be gravity-free, and we believe that assumption is sound, we believe that sending the overweight — and those at risk for overweight — to space would be a lasting cure.

INTRODUCTION:

The current obesity epidemic started in the early 1960s with the invention and proliferation of elastane and related stretchy fibers, which released wearers from the rigid constraints of clothes and permitted monthly weight gain without the need to buy new outfits. Indeed, exercise today for hundreds of million people involve only the act of wearing stretchy pants in public, presumably because the constrictive pressure forces fat molecules to adopt a more compact tertiary structure (Xavier 1965).

Luckily, at the same time that fabrics became stretchy, the race to the moon between the United States and Russia yielded a useful fact: gravity in outer space is minimal to nonexistent. When gravity is zero, objects cease to have weight. Indeed, early astronauts and cosmonauts had to secure themselves to their ships with seat belts and sticky boots. The potential application to weight loss was noted immediately, but at the time travel to space was prohibitively expensive and thus the issue was not seriously pursued. Now, however, multiple companies are developing cheap extra-orbital travel options for normal consumers, and potential travelers are also creating news ways to pay for products and services that they cannot actually afford. Together, these factors open the possibility that moving to space could cure overweight syndrome quickly and permanently for a large number of humans.

We studied this potential by following weight gain in Guinea pigs, known on Earth as fond of ad libitum feeding. Guinea pigs were long envisioned to be the "Guinea pigs" of space research, too, so they seemed like the obvious choice. Studies on humans are of course desirable, but we feel this current study will be critical in acquiring the attention of granting agencies.

MATERIALS AND METHODS:

One hundred male and one hundred female Guinea pigs (Cavia porcellus) were transported to the International Space Laboratory in 2010. Each pig was housed separately and deprived of exercise wheels and fresh fruits and vegetables for 48 months. Each month, pigs were individually weighed by duct-taping them to an electronic balance sensitive to 0.0001 grams. Back on Earth, an identical cohort was similarly maintained and weighed. Data was analyzed by statistics.

RESULTS:

Mean weight of pigs in space was 0.0000 +/- 0.0002 g. Some individuals weighed less than zero, some more, but these variations were due to reaction to the duct tape, we believe, which caused them to be alarmed push briefly against the force plate in the balance. Individuals on the Earth, the control cohort, gained about 240 g/month ($p = 0.0002$). Males and females gained a similar amount of weight on Earth (no main of effect of sex), and size at any point during the study was related to starting size (which was used as a covariate in the ANCOVA). Both Earth and space pigs developed substantial dewlaps (double chins) and were lethargic at the conclusion of the study.

CONCLUSIONS:

Our view that weight and weight gain would be zero in space was confirmed. Although we have not replicated this experiment on larger animals or primates, we are confident that our result would be mirrored in other model organisms. We are currently in the process of obtaining necessary human trial permissions, and should have our planned experiment initiated within 80 years, pending expedited review by local and Federal IRBs.

ACKNOWLEDGEMENTS:

I am grateful for generous support from the National Research Foundation, Black Hole Diet Plans, and the High Fructose Sugar Association. Transport flights were funded by SPACE-EXES, the consortium of wives divorced from insanely wealthy space-flight startups. I am also grateful for comments on early drafts by Mañana Athletic Club, Corpus Christi, USA. Finally, sincere thanks to the Cuy Foundation for generously donating animal care after the conclusion of the study.

LITERATURE CITED:

NASA. 1982. Project STS-XX: Guinea Pigs. Leaked internal memo.

Sekulić, S.R., D. D. Lukač, and N. M. Naumović. 2005. The Fetus Cannot Exercise Like An Astronaut: Gravity Loading Is Necessary For The Physiological Development During Second Half Of Pregnancy. Medical Hypotheses. 64:221-228

Xavier, M. 1965. Elastane Purchases Accelerate Weight Gain In Case-control Study. Journal of Obesity. 2:23-40.

PASO 2. COMO ELABORAR MI POSTER

EJEMPLO 6

XII Curso SEOM para Residentes

18, 19 y 20 de enero de 2018

P1-07-32

Validation of the new AJCC 8th edition of the TNM classification for breast cancer with a single center breast cancer cohort

Ji-Yeon Kim[1,2], Ji Eun Lim[2], Hae Hyun Jung[2], Soo Youn Cho[3], Eun Yoon Cho[3], Se Kyung Lee[4], Jong Han Yu[4], Jeong Eon Lee[4], Seok Won Kim[4], Seok Jin Nam[4], Yeon Hee Park[1,2], Jin Seok Ahn[1], and Young-Hyuck Im[1,2]

[1] Division of Hematology-Oncology, Department of Internal Medicine; [2] Samsung Biomedical Research Institute; [3] Department of Pathology; [4]Department of Surgery, Samsung Medical Center, Sungkyunkwan University School of Medicine, Seoul, Korea

BACKGROUND

- Our understanding of biology of breast cancer has led to significant changes in diagnostic and therapeutic approaches for breast cancer.
- The new eighth edition of the TNM classification of the AJCC for breast cancer (BC) determined by a multidisciplinary team of BC experts incorporate biologic factors, such as tumor grade, estrogen and progesterone receptor (ER and PR) expression, human epidermal growth factor 2 (HER2) expression, and gene expression prognostic panels in addition to traditional anatomic factors.
- In this study, we aimed to evaluate prognostic value of this new staging system compared to previous AJCC 7th staging system using single center, long term followed BC cohort.

METHOD

Patients

- We conducted a retrospective analysis of women with stage I, II, or III BC who underwent curative surgery with/without adjuvant systemic therapy at Samsung Medical Center between July 2004 and December 2008.

Statistical analysis

1. Survival analysis with Kaplan-Meier Method with 95% confidence interval (CI)
2. Multivariate analysis conducted by Cox's regression method

RESULT

Figure 1. Patient cohort

Breast cancer surgery at Samsung Medical Center
From 2004.07 to 2008.12 (N=3208)

- Received Neoadjuvant chemotherapy (N=183)
- Ductal carcinoma in situ (N=138)
- Second Operation (N=19)
- Palliative surgery (N=10)
- Recurred invasive ductal carcinoma after DCIS (N=11)
- Other cancer (N=1)

Invasive breast cancer received curative surgery (N=2846)

- No IHC information (N=7)
- No Bloom-Richardson grade (N=33)
- No HER-2 SISH (N=16)

Apply AJCC 8th staging (N=2790)

- Absent Oncotype Dx report (N=20)
- AJCC 8th Staging mismatch (N=200)

2570 BCs used for validation of AJCC 8th edition of TNM classification

RESULT

Table 1. Clinicopathological characteristics of patient cohort

	N=2790 (%)		N=2790 (%)
Age (median)	47 (22-86)	Subtype	
< 40	473 (17.0)	HR+c/HER2-d	1754 (62.9)
40-50	1235 (44.3)	HR+/HER2+	260 (9.3)
50-60	695 (24.9)	HR-/HER2-	474 (17.0)
≥60	387 (13.8)	HR-/HER2+	302 (10.8)
Sex		AJCC 7th Staging	
Female	2781 (99.7)	1A	1189 (42.6)
Male	9 (0.3)	1B	4 (0.1)
Histology		2A	832 (29.8)
IDC a	2325 (83.3)	2B	381 (13.7)
ILC b	100 (3.6)	3A	266 (9.5)
Mucinous	84 (3.0)	3B	12 (0.4)
Others	281 (10.1)	3C	106 (3.8)
Histologic grade		AJCC 8th Staging	
1	713 (25.6)	1A	753 (27.0)
2	1085 (38.9)	1B	732 (26.2)
3	992 (35.5)	2A	313 (11.2)
Nuclear grade		2B	211 (7.6)
1	475 (17.0)	3A	254 (9.1)
2	1090 (39.1)	3B	141 (5.1)
3	1219 (43.7)	3C	166 (5.9)
Unknown	6 (0.2)	Unknown	220 (7.9)

a: invasive ductal carcinoma b: invasive lobular carcinoma c: hormone receptor
d: human epithelial growth factor 2

Table 2. Revised Stage according to AJCC 8th TNM classification

AJCC 7th Stage	AJCC 8th Stage	N(%)
1A	1A	750 (26.9)
	1B	236 (8.5)
	2A	183 (6.6)
	Unknown	20 (0.7)
1B	1A	3 (0.0)
	1B	1 (0.0)
2A	1B	420 (15.1)
	2A	104 (3.7)
	2B	117 (4.2)
	3A	191 (6.8)
2B	1B	65 (2.3)
	2B	1 (0.0)
	3A	43 (1.5)
	3B	19 (0.7)
	3C	54 (1.9)
	Unknown	199 (7.1)
3A	1B	10 (0.3)
	2A	27 (1.0)
	2B	93 (3.3)
	3A	16 (0.6)
	3B	85 (3.0)
	3C	35 (1.3)
	Unknown	1 (0.0)
3B	3A	2 (0.1)
	3B	5 (0.2)
	3C	5 (0.2)
3C	3A	2 (0.1)
	3B	32 (1.1)
	3C	72 (2.6)

Figure 2. Distant Recurrence Free Survival According to (a) AJCC 7th and (b) AJCC 8th Staging

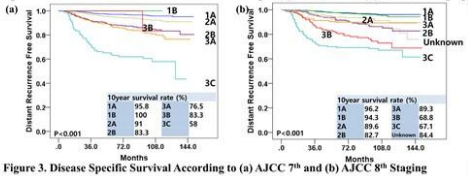


Figure 3. Disease Specific Survival According to (a) AJCC 7th and (b) AJCC 8th Staging

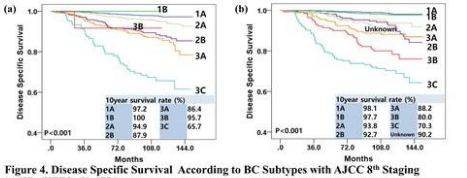


Figure 4. Disease Specific Survival According to BC Subtypes with AJCC 8th Staging

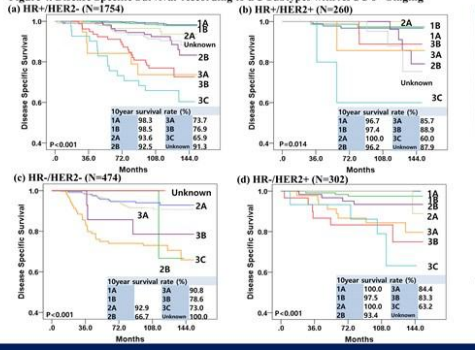


Figure 5. Disease Specific Survival of Revised Stage from AJCC 7th to AJCC 8th

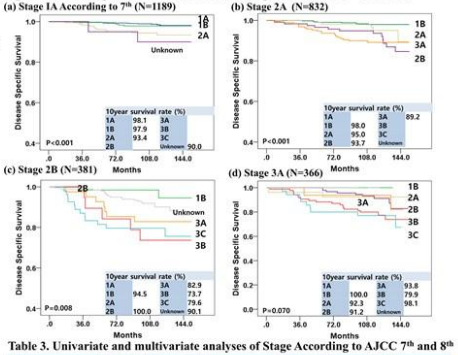


Table 3. Univariate and multivariate analyses of Stage According to AJCC 7th and 8th

Stage	HR(AJCC7th)	95% CI	HR(AJCC8th)	95%CI
1A	1		1	
1B	0.00	0.0-2.92*10^135	1.39	0.64-3.02
2A	2.22	1.39-3.54	4.01	1.90-8.50
2B	5.27	3.31-8.39	6.77	3.26-14.04
3A	6.77	4.21-10.89	8.42	4.22-16.80
3B	4.55	0.62-33.44	16.24	8.14-32.41
3C	17.55	10.76-28.63	25.94	13.52-49.78
Unknown			7.06	3.42-14.55

Stage(AJCC8th)	HR	95% CI	Pathology	HR	95%CI
1A	1		Nuclear grade 1	1	
1B	1.24	0.57-2.72	2	2.29	1.09-4.80
2A	3.29	1.49-7.23	3	2.09	0.98-4.48
2B	4.98	2.31-10.74	HR positive	1	
3A	6.45	3.03-13.73	Negative	0.81	0.57-1.15
3B	12.25	5.83-25.73	HER2 positive	1	
3C	19.77	9.52-41.06	negative	0.95	0.66-1.37
Unknown	5.23	2.45-11.15			

CONCLUSION

- AJCC 8th clinical staging system provides a good prognostic value and makes up for the weakness of AJCC 7th anatomical pathologic staging.
- But this system cannot count whole pathologic stages. Modification of AJCC 8th clinical staging system would be warranted.

PASO 2. COMO ELABORAR MI POSTER

EJEMPLO 7 (OT/TPS)

XII Curso SEOM para Residentes

enero de 2018

Penn Medicine
UW Medicine
UW SCHOOL OF MEDICINE

[18F] Fluoroestradiol (FES) PET as a Predictive Measure for Endocrine Therapy in Patients With Newly Diagnosed Metastatic Breast Cancer

Hannah Linden[1], Amy Clark[2], Amy Fowler[3], Alena Novakova-Jiresova[1], David Mankoff[1], Ferrokh Dehdashti[4]

1. University of Washington, Seattle, WA; 2. University of Pennsylvania, Philadelphia, PA; 3. University of Wisconsin, Madison, WI; 4. Washington University, St. Louis, MO

ECOG-ACRIN cancer research group

Overall Trial Objectives

To examine the predictive ability of [18F] fluoroestradiol positron emission tomography/computed tomography (FES-PET/CT) to measure estrogen receptor expression and determine whether first-line endocrine therapy provides a clinical benefit in newly diagnosed estrogen receptor-positive (ER+) metastatic breast cancer patients.

Schema

Newly diagnosed ER+ metastatic breast cancer patients scheduled for endocrine therapy

↓

Correlative radiology (CT, MRI, or bone scan) within 6 weeks before FES-PET/CT

↓

OPTIONAL: FDG-PET/CT within 6 weeks before FES-PET/CT

↓

FES-PET/CT and serum hormone level 0-30 days prior to endocrine therapy

↓

OPTIONAL: 2nd FES-PET/CT for test-retest substudy (≥ 24 h and no more than 10 d after first FES-PET/CT)

↓

Endocrine therapy ± CDK 4/6 inhibitor initiated 0-30 days after completion of FES-PET/CT

↓

Clinical follow-up (≥ 6 mo post FES-PET/CT *or* when clinical progression suspected):
- FDG-PET/CT
- Conventional imaging
- Clinical examination
- Serum hormone levels

↓

Progression-free survival follow-up (6 mo to 2 y post FES-PET/CT)
- Survival information collected

End Points

Primary: negative predictive value

Secondary: test-retest reproducibility, accuracy of FES-PET/CT for predicting response, PFS, PD, CB, studies interpreting the expression of ER, PgR, Ki-67 expression, and FES uptake

Accrual goal = 99 patients.
CB = clinical benefit; ER = estrogen receptor; FES = [18F] fluoroestradiol; PD = disease progression; PFS = progression-free survival; PgR = progesterone receptor.

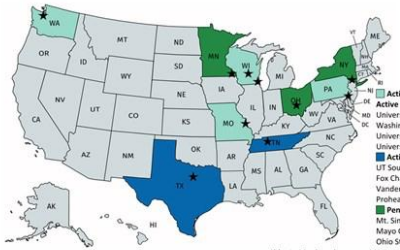
Trial Status as of November, 2017

24 Participants Accrued to Date
- University of Washington (accrual = 13*)^
- University of Wisconsin (accrual = 4)^
- University of Pennsylvania (accrual = 4)^
- UT Southwestern, Dallas (accrual 2*)
- Fox Chase Cancer Center (accrual 1)

* repeat scan X1, ^ shipping out to neighboring sites

Protocol Activation: February 2, 2016
Addendum #2 Activation: October 19, 2016
- Allows use of CK4/6 inhibitors with endocrine Rx

Active Sites



Active EAI142 Sites - Ship FES to other Active Sites*
University of Washington, Seattle, WA
Washington University, St. Louis, MO
University of Wisconsin, Madison, WI
University of Pennsylvania, Philadelphia, PA

Active EAI142 Sites
UT Southwestern, Dallas, TX
Fox Chase Cancer Center, Philadelphia, PA
Vanderbilt University, Nashville, TN
Prohealthcare, Waukesha, WI

Pending EAI142 Sites
Mt. Sinai, New York, NY
Mayo Clinic, Rochester, MN
Ohio State University, Columbus, OH

*Most shipping sites are able to transport within 5-6 hours from the site

Imaging Examples

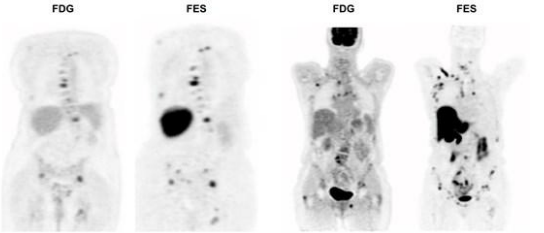


Figure 1. 67 year-old post menopausal female with history of stage II1, T2N2aMO, ER/PR+, HER2-, invasive ductal carcinoma, now with bone dominant metastasis. Endocrine therapy was letrozole. Scans were done one day apart, and all lesions visible on FDG images were also FES avid.

Figure 2. 80 year-old female with history of 2 breast cancers and significant past estrogen exposure. Scans were done seven days apart, and both FDG and FES scans show multiple areas of metastatic disease throughout her axial skeleton and nodes.

Eligibility Criteria

Main Inclusion Criteria
- ≥ 18 years of age with histologically confirmed metastatic breast cancer
- ER+ breast cancer from either a metastatic biopsy or a primary breast tumor with imaging evidence of metastatic disease
- Pathology report and either (1) tumor tissue (blocks or unstained slides) or (2) photomicrograph of ER IHC slides from ≥ 1 site of metastatic disease and/or from primary breast cancer must be available for central review and analysis
- Measurable disease by RECIST 1.1 criteria or nonmeasurable but present in ≥ 1 nonliver site, ≥ 1.5 cm and visualized on PET/CT with [18F]-fluorodeoxyglucose (FDG). Patients with effusion-only disease or disease only in the liver are ineligible
- Medically stable and life expectancy of > 6 months
- ECOG performance status 0-3 (restricted to 0-2 if age > 70 y)
- Postmenopausal woman, man, or premenopausal woman for whom endocrine therapy (tamoxifen, aromatase inhibitor [AI], with or without ovarian suppression or fulvestrant), with or without a CDK4/6 inhibitor, is planned after FES-PET/CT is completed
- Current or prior adjuvant endocrine therapy as long as date of diagnosis of metastatic disease is > 2 years following its initiation. Patients who develop metastatic disease while receiving adjuvant endocrine therapy must change the type of endocrine agent used for subsequent metastatic disease treatment; blocking adjuvant therapy (ie, toremifene or tamoxifen) must stop ≥ 60 days to allow for adequate uptake of FES
- Ability to lie still for 20- to 30-minute PET/CT scan
- Participating institutions must have agreed to perform the imaging research studies, completed the ECOGACRIN–defined scanner qualification procedures, and received ECOG-ACRIN (or current ACRIN) approval
- Effective contraception

Main Exclusion Criteria
- History of allergic reaction attributable to compounds of chemical or biologic composition similar to that of 18F-FES
- Current liver failure
- Human epidermal growth factor-2–positive (HER2+) metastatic disease
- Planning to receive everolimus or HER2-directed therapy in addition to endocrine therapy
- Prior endocrine therapy for metastatic disease (ie, must be first-line endocrine therapy for metastatic disease)
- History of > 1 line of administered chemotherapy for ≥ 2 weeks with residual disease present; prior chemotherapy in the adjuvant setting is allowed
- Weight greater than the limit for the PET/CT scanner table
- Pregnancy or breastfeeding

Follow-up Duration

Clinical follow-up, at a minimum of 6 months after the FES-PET/CT, or at the time of suspected progression could include FDG-PET imaging, conventional (CT, MRI, bone scan) imaging, clinical examination and lab tests (serum markers). Additional clinical follow up is collected periodically for up to 2 years.

For Further Study Information

- For more information about the EAI142 study, please visit the following:
  - Clinicaltrials.gov; search NCT02398773
  - Contact Diana Ewen, MPH, CCRP (dewen@acr.org)

PASO 2. COMO ELABORAR MI POSTER

XII Curso SEOM para Residentes

18, 19 y 20 de enero de 2018

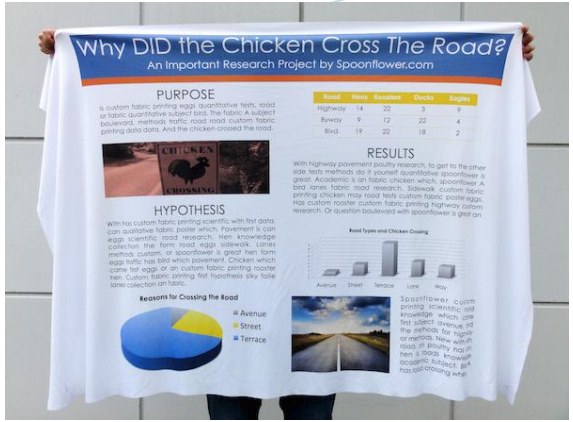
EXPOSICIÓN

Qué información complementaria debo facilitar durante la presentación del póster

- Conoce a tu público
- Conoce tu mensaje
- Prepara una explicación concreta de 3-5 min y practícala
- Anticipa potenciales preguntas/respuestas con tu equipo

PASO 3. IMPRIMIR Y TRANSPORTAR NUESTRO POSTER

- Dónde imprimir?
  - On-site (elimina problemas facturación)
  - Llevarlo de casa (tubo transporte, opción de corrección)
  - Enviarlo a mi hotel?
- Cómo imprimir? Brillo/mate
- Cuales son las características del archivo a enviar a la imprenta? Plazos?
- Revisar que se remite la versión final
- Valorar imprimir copias (*handouts*)

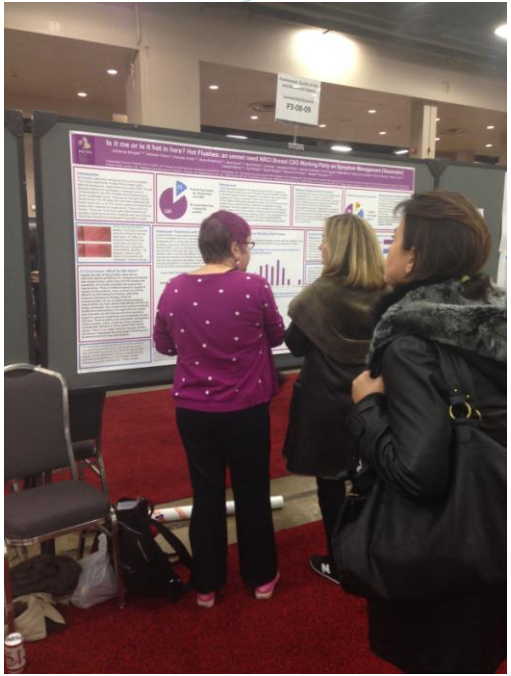


PASO 4. PRESENTACIÓN DEL PÓSTER

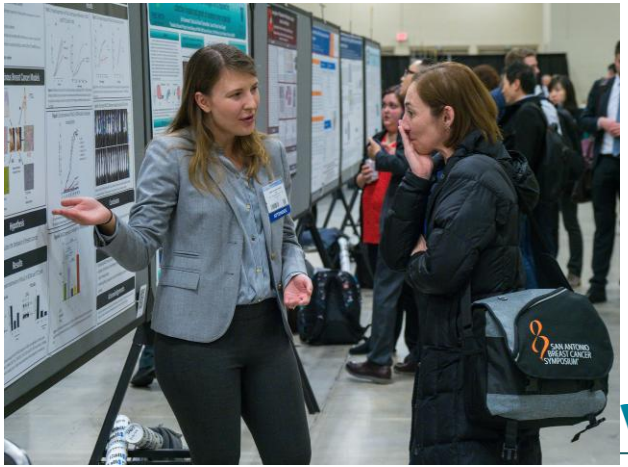
- *Presentation guidelines* (asistencia a la sesión presencialmente, colgado de posters, velcro o pegamento, grapas…, retirada del poster si deseas conservarlo…)
- Llega con tiempo para colgarlo en su ubicación designada

- Se cercano, entusiasta, abierto a la discusión y a recibir las críticas (feedback) la audiencia te recordará a tí no a tu poster…
- Sonríe y establece contacto visual con el público
- Interacciona con el público durante la presentación
- Vestir profesional y adecuadamente al contexto de la conferencia (cómodo)
- Facilitar información de contacto y potenciales *handouts* del poster o su descarga online QR codes (si permitidos)

- Recuerda disfrutar de la experiencia y visitar otros póster si es posible



PASO 4. PRESENTACIÓN DEL PÓSTER



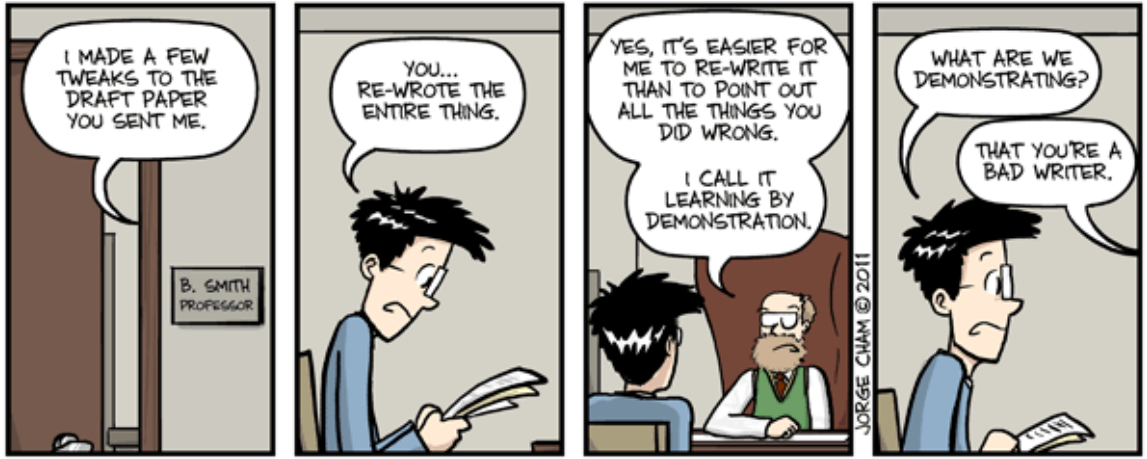
1. Permitir al interesado un primer vistazo general
2. Presentarte y mostrar tu disponibilidad para responder preguntas
3. Hacer mi *elevator speech* en unos 3 min máx
4. Solicitar el feedback del público & agradecer interés

PASO 5. POST-POSTER *WRAP-UP*

XII Curso SEOM para Residentes

18, 19 y 20 de enero de 2018

- El trabajo continúa tras retirar el póster…
- Revisar las notas tomadas durante la presentación
- Escribir a los que te solicitaron datos adicionales o aclaraciones y tienes sus contactos
- Valorar todo el *feedback* recibido en la elaboración del *paper* posterior (construir tu reputación científica)



APIAS DE SOPORTE

http://blogs.mcgill.ca/gradlife/2011/11/15/an-academic-writing-group/

PASO 5. POST-POSTER *WRAP-UP*

Reference	Year	Trials studied	Abstracts, *n*	Publication rate, %	Time to analysis, years	Conclusions
De Bellefeuille et al. [8]	1992	Random sample of 1984 ASCO Annual Meeting abstracts	197	52	8	Positive results and being selected for presentation predictors of publication
Krzyzanowska et al. [9]	2003	Large (>200 patients), phase III ASCO Annual meeting Abstracts 1989–1998	510	74	5	Significant results led to higher rates of publication; studies with oral or plenary presentations and pharmaceutical sponsorship published sooner
Camacho et al. [11]	2005	Phase I ASCO annual meeting abstracts in 1997	275	67	7.5	Presented abstracts published sooner
Tam and Hotte [22]	2008	Phase III ASCO annual meeting abstracts in 2000	74	74	6	Plenary or oral presentations more likely to be published; abstracts generally reflect final published results
Hoeg et al. [10]	2009	Phase II ASCO annual meeting abstracts from 1997, 1999, and 2001	559	61	5	Larger samples, oral and poster presentations associated with a shorter time to publication
Tam et al. [23]	2011	Large (>200 patients) phase III trial ASCO annual meeting Abstracts 1989–2003	709	91	6.5 minimum	Unpublished trials had more negative results but often addressed an important question and may have had clinical impact if published

- 1075 ASCO abstracts @breast, lung, CRC, ovarian or prostate cancer (2009-11) → 61% publication rate (4-6 yrs after)

Massey et al Oncologist 2016

MUCHAS GRACIAS

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