

Your Poster Title

Names of authors & affiliations

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Introduction

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Conclusions & Discussions

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Results

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Key Messages

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Your Poster Title

Names of authors & affiliations

Introduction / Background

Case Study

Results / Findings



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Your Poster Title

Names of authors & affiliations

Introduction

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Conclusions & Discussions

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Method

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Results

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Key Messages

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References:

Poster Example 1



Diabetes treatment deintensification in a non-palliative geriatric cohort during subacute admission

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INTRODUCTION

- Hypoglycaemia and polypharmacy cause considerable morbidity in older populations¹
- Subacute settings facilitate deintensification of diabetes treatment in frail older adults²
- Subacute settings, an interface between hospital and outpatient care, represent an opportunity for diabetes treatment deintensification
- Patterns and predictors of treatment deintensification during subacute admission largely managed by geriatricians, but poorly described
- We analysed which frail non-palliative geriatric patients to identify determinants of diabetes treatment deintensification during subacute admission

AIM

- To identify determinants of diabetes treatment deintensification in the subacute setting

METHODS

- Patients aged ≥ 75 years, with diabetes or two hyperglycaemia random capillary blood glucose (RCBG) ≥ 11.1 mmol/L without known diabetes, transferred to subacute care following acute admission (between 1st and August 2016), were identified from an existing register³
- A retrospective chart review identified patient characteristics and diabetes treatment at acute admission, subacute admission and subacute discharge
- Capillary BG values during subacute care (from admission until discharge or day 31 for long-stayers) were reviewed, to assess glycaemic control and occurrence of hypoglycaemia (BG < 4 mmol/L)
- Deintensification was defined as reduction in the number of insulin analogs and antidiabetic agents (OADs)
- Differences in clinical characteristics between patients who had their diabetes treatment deintensified (DTC) and those who did not (NDTC) were compared. Means, non-parametric tests and chi-square tests were used as appropriate
- Multivariable logistic regression analysis was performed to determine clinical features independently associated with deintensification

RESULTS

- Seventy-eight patients were included. Clinical characteristics are summarised in Table 1.
- The use of insulin, OADs and diet control was different at acute admission, subacute admission and subacute discharge (Figure 1)
- During subacute admission, diabetes treatment was deintensified in 28 (36%) patients (Figure 2)
- Diabetes treatment deintensification was associated with higher HbA1c at acute admission, hypoglycaemia during subacute admission, involvement of subacute admission, and longer length of subacute admission
- Age, modified Charlson Comorbidity Index (CCI), cognitive impairment and discharge to residential care were not associated with treatment deintensification
- On multivariable logistic regression analysis, insulin treatment at subacute admission (OR 13.6, 95%CI 3.345, 60.228; $p < 0.001$), and subacute length of stay (OR 1.02 (1.007), 1.038); $p < 0.014$) were independent determinants of treatment deintensification

RESULTS (Table 1)

Table 1. Characteristics of patients cohort
Data presented as mean \pm SD, median (IQR) or n (%).

Patient characteristics (n=78)	
Age (years)	86.1 (8.5)
Sex	46 (59%)
Male/Female	22/24
Comorbidity (n=78)	246 (315)
Type 1 diabetes mellitus	15 (19%)
Comorbidity score	103.4
1 Modified CCI score	103.4
Characteristics at acute admission	
1 Insulin treatment only	40 (51%)
1 Insulin, OADs and diet management	38 (49%)
Admission type	
1 Home care	20 (26%)
1 Home with care	40 (51%)
1 Residential care	18 (23%)
1 Non-residential care (admission from hospital)	10 (13%)
Capillary BG (mmol/L)	
1 At admission (median)	10.0 (7)
1 Subacute admission (median)	10.0 (7)
1 At discharge (median)	10.0 (7)
1 HbA1c (%)	7.4 (1.1)
Length of acute admission (days)	4 (2-4)
Length of subacute admission (days)	20 (14-26)
Length of subacute admission (days)	20 (14-26)

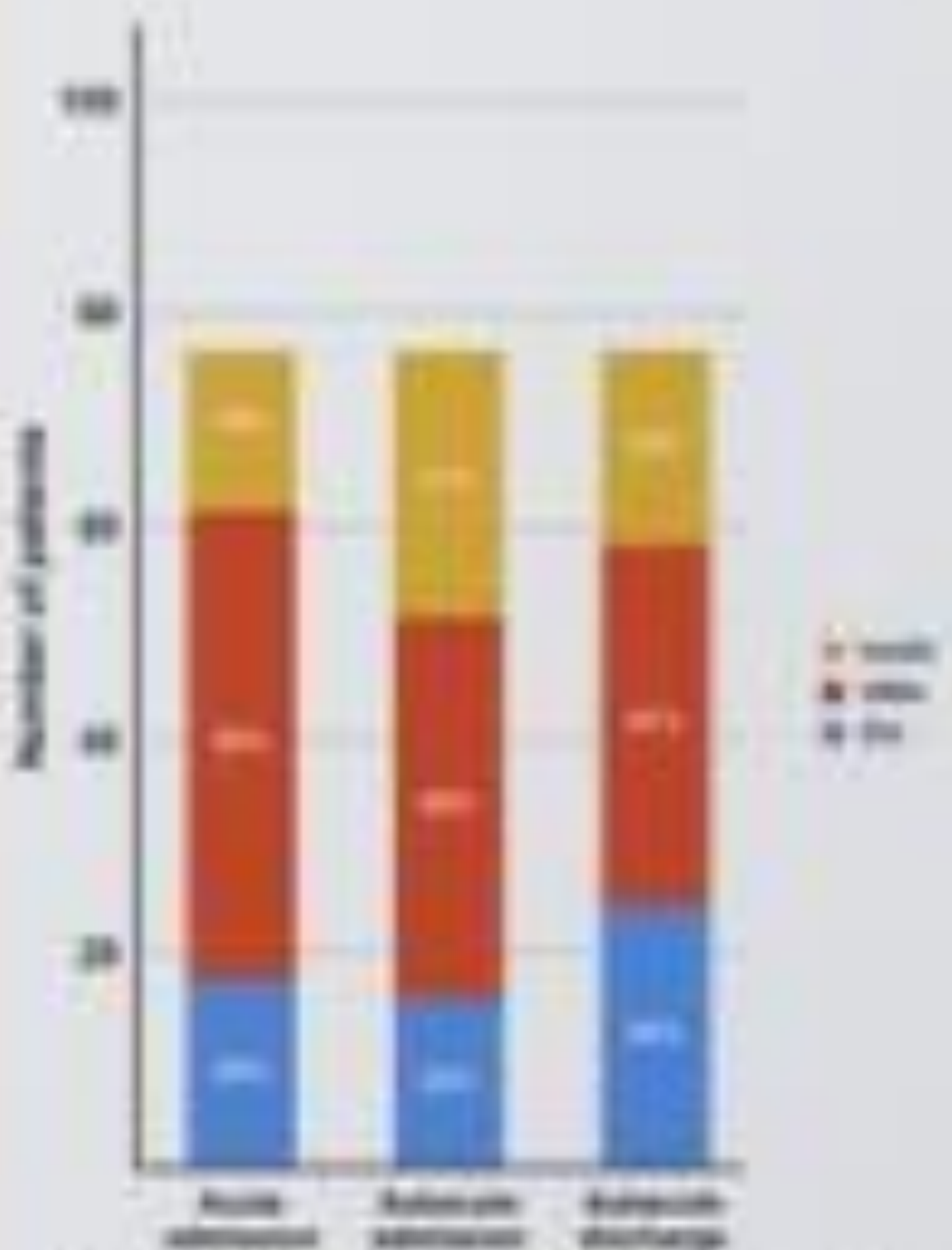


Figure 1. Diabetes treatment at acute admission, subacute admission and subacute discharge

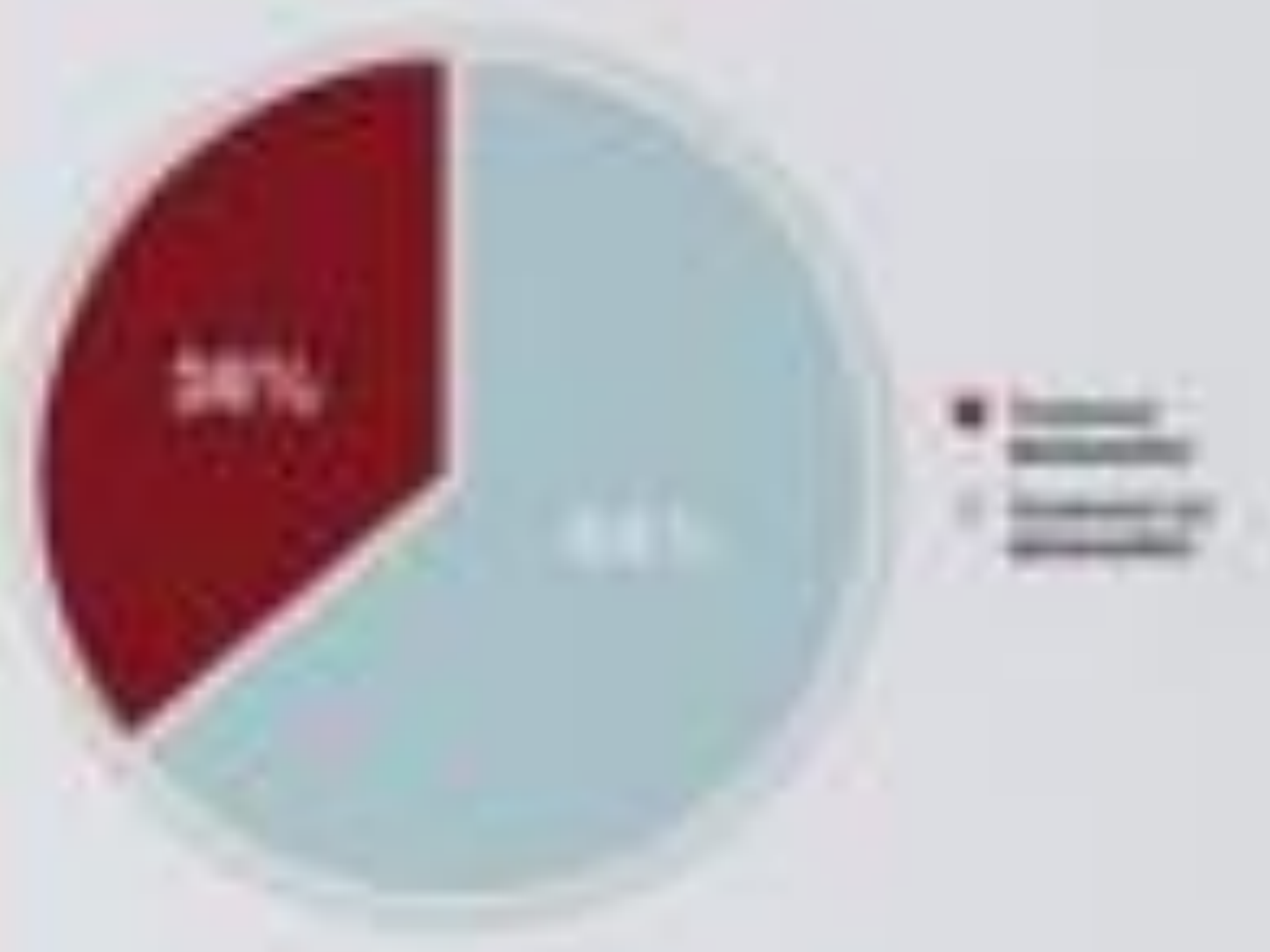


Figure 2. Diabetes treatment deintensification during subacute admission

RESULTS (Table 2)

Table 2. Association between clinical characteristics and changes in diabetes treatment in the subacute setting

	OR	95% CI	p
Demographic parameters			
1 Male sex	0.9 (1.4)	0.1 (1.9)	0.888
1 Hypertensive (non-pharmacological)	0.9 (1.2)	0.5 (1.8)	0.987
1 Hypertensive	0.2 (0.5)	0.05	0.008
1 Hypoglycaemic			
1 HbA1c ≥ 7.5 mmol/mol at 1st day	0.2 (0.5)	0.02 (0.7)	0.002
1 HbA1c ≥ 7.5 mmol/mol at 31st day	0.2 (0.5)	0.04 (0.7)	0.005
Non-glycaemic parameters			
1 Age (years)	0.9 (1.4)	0.1 (1.9)	0.888
1 Modified CCI	1.1 (1.1)	0.1 (1.2)	0.987
1 Cognitive impairment	0.2 (0.5)	0.02 (0.7)	0.002
1 Discharge to residential care	0.2 (0.5)	0.04 (0.7)	0.005
1 Length of subacute admission	1.02 (1.01)	1.01 (1.04)	0.004

Table 3. Determinants of diabetes treatment deintensification in the subacute setting. Multivariable logistic regression

	OR	95% CI	p
Demographic parameters			
1 Male sex	1.0 (0.9)	0.1 (0.9)	0.988
1 Hypertensive	0.2 (0.5)	0.02 (0.7)	0.002
Non-glycaemic parameters			
1 Age	1.0 (1.4)	0.1 (1.9)	0.888
1 Modified CCI	1.0 (1.1)	0.1 (1.2)	0.987
1 Cognitive impairment	0.2 (0.5)	0.02 (0.7)	0.002
1 Discharge to residential care	0.2 (0.5)	0.04 (0.7)	0.005
1 Length of subacute admission	1.02 (1.01)	1.01 (1.04)	0.004

CONCLUSION

- Diabetes treatment deintensification occurred in more than one-third of geriatric subacute care patients
- Deintensification was more likely to occur with insulin treatment and longer length of subacute admission
- Curiously, comorbidity, cognitive impairment and discharge to residential care were not factors affecting deintensification
- Further studies are required on the outcomes of diabetes treatment deintensification, particularly hypoglycaemia events and geriatric symptoms

ACKNOWLEDGEMENTS

- [1] Brown A, Durrig T, and Furlanos Spiros S. Diabetes in older people: new insights and remaining challenges. *Current Diabetes Reviews*. 2015; 11(1): 275-85.
- [2] Kinnear M, Brown V, Clark R, et al. Diabetes in older adults. *Diabetes Care*. 2012; 35(12):2050-64.
- [3] Gu H, Gorman P, Wright P, Hall J, et al. *Diabetes*. 2017;36(27):2421.

Poster Example 2



THE SVUH RAPID ACCESS CLINIC FOR SUSPICIOUS NECK LUMPS:

AN AUDIT OF PATIENTS' TIMELINES AND OUTCOMES

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BACKGROUND & OBJECTIVES

The Rapid Access Clinic for patients with suspicious neck lumps was set up at St Vincent's University Hospital in order and the speedy diagnosis of malignancy in patients with Head & Neck Cancer. This is the first clinic of its kind for Head & Neck Cancer in Ireland. The aim of this audit was to evaluate the clinic's output and analyse new referrals to the clinic in a 6-month period with considerations for patients' timelines and outcomes.

METHODOLOGY

A retrospective cohort of **new referrals** seen in the Rapid Access Neck Lump Clinic was identified from clinic lists over a period of **6 months** between September 2012 and January 2013. Of the 73 patients identified 12 did not attend the first consultation at the clinic and hence were excluded from the study giving a final sample of **43 patients**. Audit data was obtained from clinical notes via a **retrospective chart review**. Patients' demographics, referring diagnosis, timelines, and outcomes were recorded and data analysed in Excel® Microsoft, Redmond, WA, USA.

RESULTS

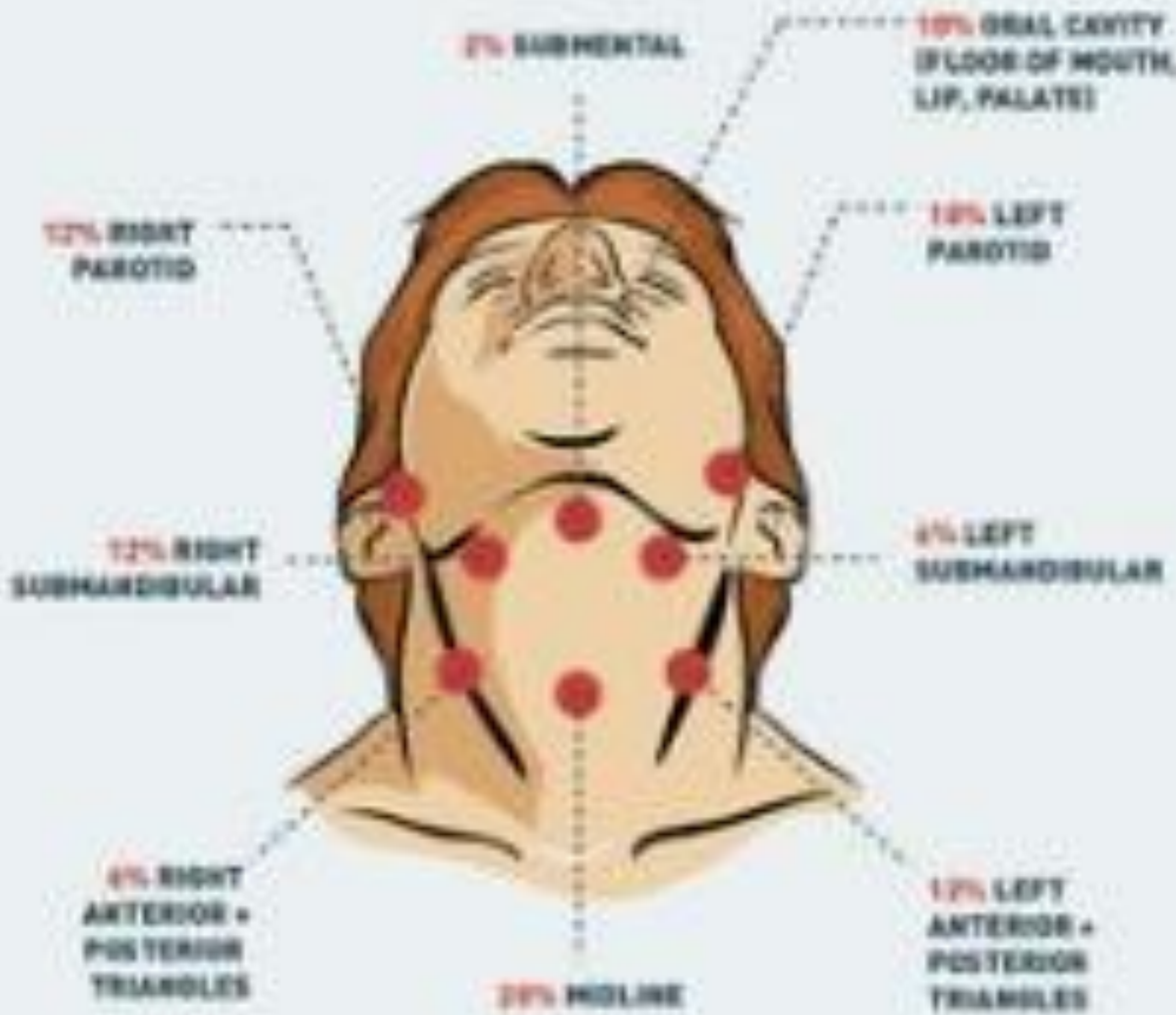
PATIENT DEMOGRAPHICS

48%

52%

AVERAGE AGE AT PRESENTATION
50 YEARS
 (RANGE: 17-88 YEARS)

SIZE OF LUMP*



* 14 out of the 43 patients in the study cohort presented with NO LUMPS

REFERRAL SOURCE



OUTCOME FOLLOWING FIRST CONSULTATION



TIMELINES



Average waiting time from receipt of referral letter to first clinic consultation



Average time to obtain imaging results



Average time to obtain histology results

DIAGNOSIS OF 37 HEAD AND NECK LUMPS

21% were salivary gland pathologies

46%

had either a **reactive lymphadenopathy** or **no abnormality**

13% were non-ENT diagnosis

18% were lumps in or related to the thyroid

2% were lymph node metastases

DISCUSSION & CONCLUSION

Waiting times for patients to be seen (average 44 days) and to obtain routine investigations is unacceptable (the NICE guidelines on cancer services "Improving Outcomes in Head and Neck Cancers" recommends that all cancer referrals be seen within 2 weeks¹). There is evidence in the literature² that the "one-stop neck lump assessment clinic" model (in a broadly similar fashion to one-stop triple assessment breast clinic) offers the opportunity to eliminate many of the delays along the diagnostic pathway as seen in this audit, hence the implementation of such is worth considering resources permitting. The **malignancy pick-up rate of 3%**, which is significantly lower than in comparable studies^{3,4} may be partially explained by a high number of inappropriate "urgent" referrals, the extent of which will need further investigation and addressing, however more encouragingly this could also allude to the team's clinical acumen in discerning worthy clinical presentations that show up through alternative admission pathways e.g. other routine ENT clinics or A&E referrals.

¹ National Institute for Health and Care Excellence (NICE) Guidelines on Cancer Services: Improving Outcomes in Head and Neck Cancers. Available at: <http://www.nice.org.uk/guidance/CG141>.
² National Institute for Health and Care Excellence (NICE) Guidelines on Cancer Services: Improving Outcomes in Head and Neck Cancers. Available at: <http://www.nice.org.uk/guidance/CG141>.
³ Lee JH, Williams JH, Taylor JH. The management of neck lumps: a comparison of the results of the one-stop neck lump assessment clinic with the results of the traditional referral pathway. *Head Neck*. 2010;32(10):1000-1005.
⁴ Williams JH, Taylor JH, Lee JH. The management of neck lumps: a comparison of the results of the one-stop neck lump assessment clinic with the results of the traditional referral pathway. *Head Neck*. 2010;32(10):1000-1005.



Poster Example 3



TITLE OF THE RESEARCH

First name Last name¹
¹ Affiliation

INTRODUCTION

Start by providing background context and briefly explain the topic or problem you are addressing. This helps set the stage for your research and provides a foundation for understanding the significance of your work. Explain why your research is important and why it is relevant to the field or discipline. In the aim section of your research poster, succinctly state your research question and objectives, outlining what you intend to investigate or achieve. This section should provide a clear direction for your study, highlighting its purpose and significance in a concise manner.

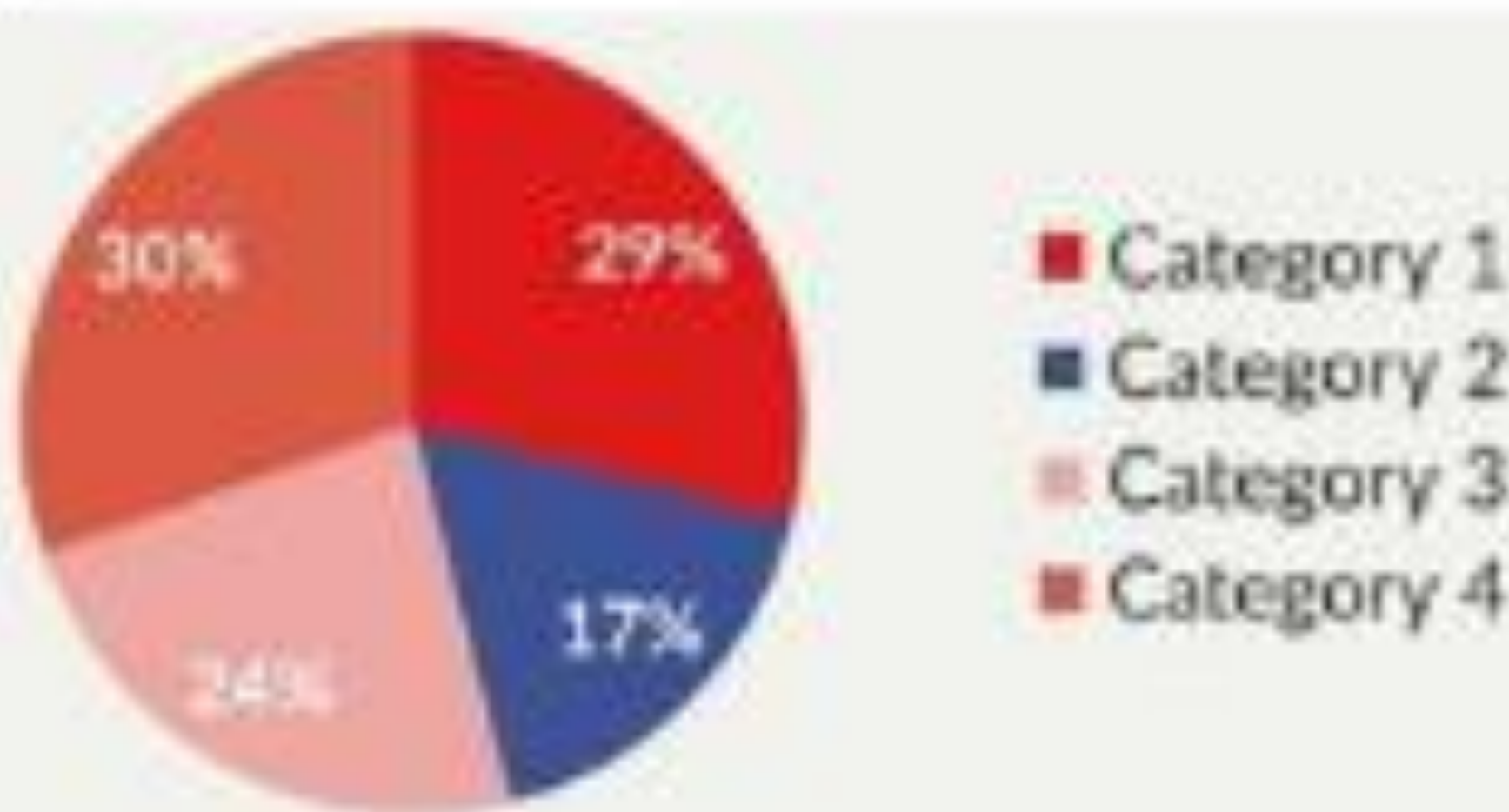


Figure 1: Use this figure to support the problem statement.

BACKGROUND

You can use this space to provide some extra background information on the topic. Make sure that you cover any theoretical concepts before stating the aim of the study. This will help the reader to understand the poster. A flow chart is often used but also figures or photographs can help the reader to understand more of the background and the research you are working on.

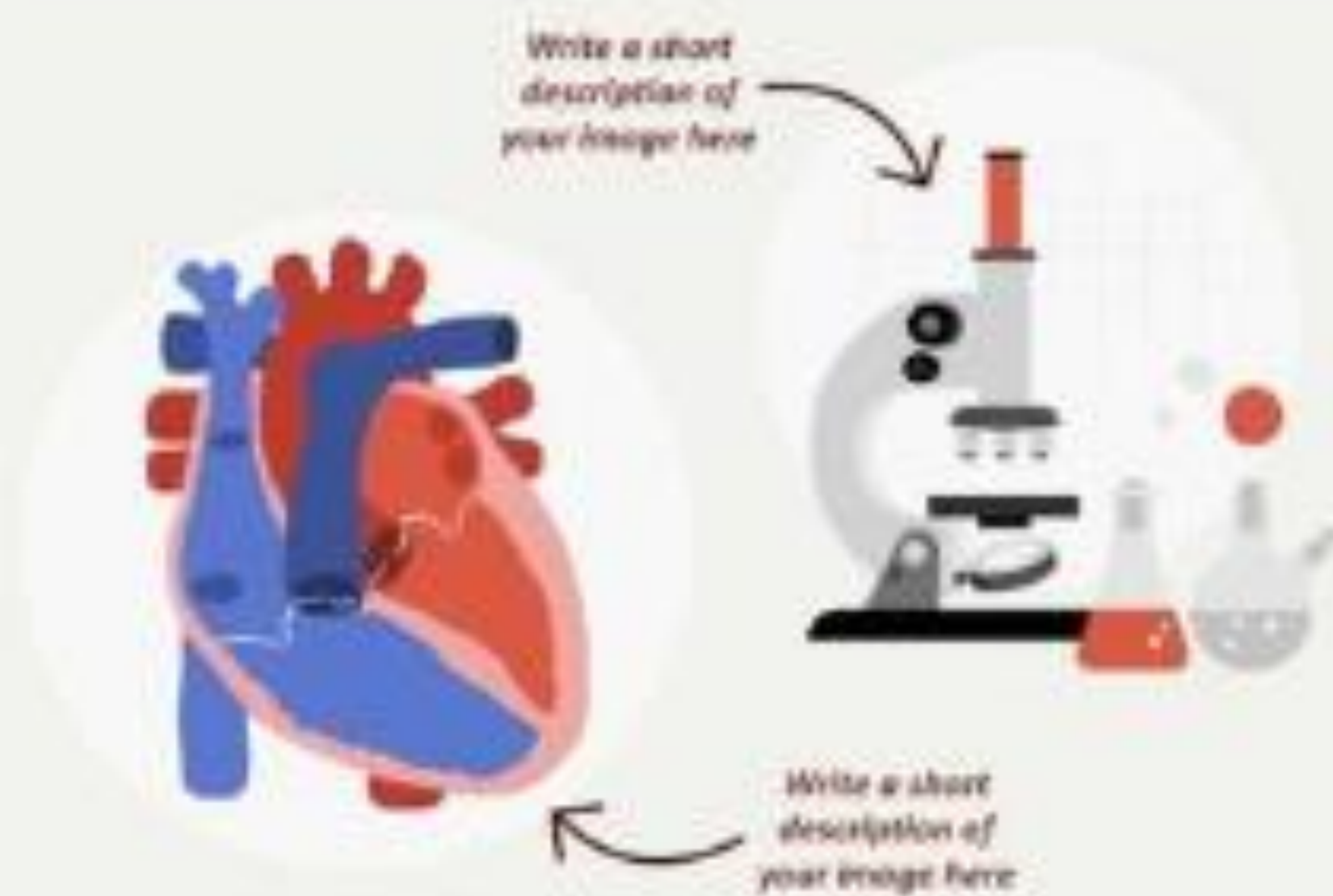


Figure 2: Put a nice infographic that supports your background.



Figure 3: Use this space to add a figure or flowchart of your methodology.

METHODOLOGY

Describe the overall research strategy and the rationale for the approach you've chosen to address the research question.

Methods Subheading

- **Participants/Samples:** Detail who or what was studied.
- **Materials/Instruments:** List the tools, technologies, materials, or instruments used to collect data, such as surveys, laboratory equipment, or databases.
- **Procedure:** Briefly explain the steps taken during the study, including data collection and any experimental protocols followed.
- **Data Analysis:** Describe the methods used to analyze the data, mentioning specific statistical tests, software used for analysis, or qualitative analysis methods.

RESULTS

Present your results in a clear and concise manner. Use tables, charts, graphs, or other visual aids to effectively communicate your findings. Visual representations can enhance the understanding of complex data and make it easier for the reader to grasp the main points at a glance. Complement your visuals with brief textual descriptions that highlight the key patterns, trends, or significant findings. Point out any noteworthy observations or relationships between variables. However, avoid excessive detail or unnecessary elaboration. The text should provide a summary of the most important results, while the visuals provide the supporting evidence.

Table 1: Make sure you explain what is in the table

#	SVM	RF	MLP	KNN
3	78.2	68.0	78.3	85.6
4	77.3	69.2	77.6	86.4
5	76.8	68.2	78.5	84.2

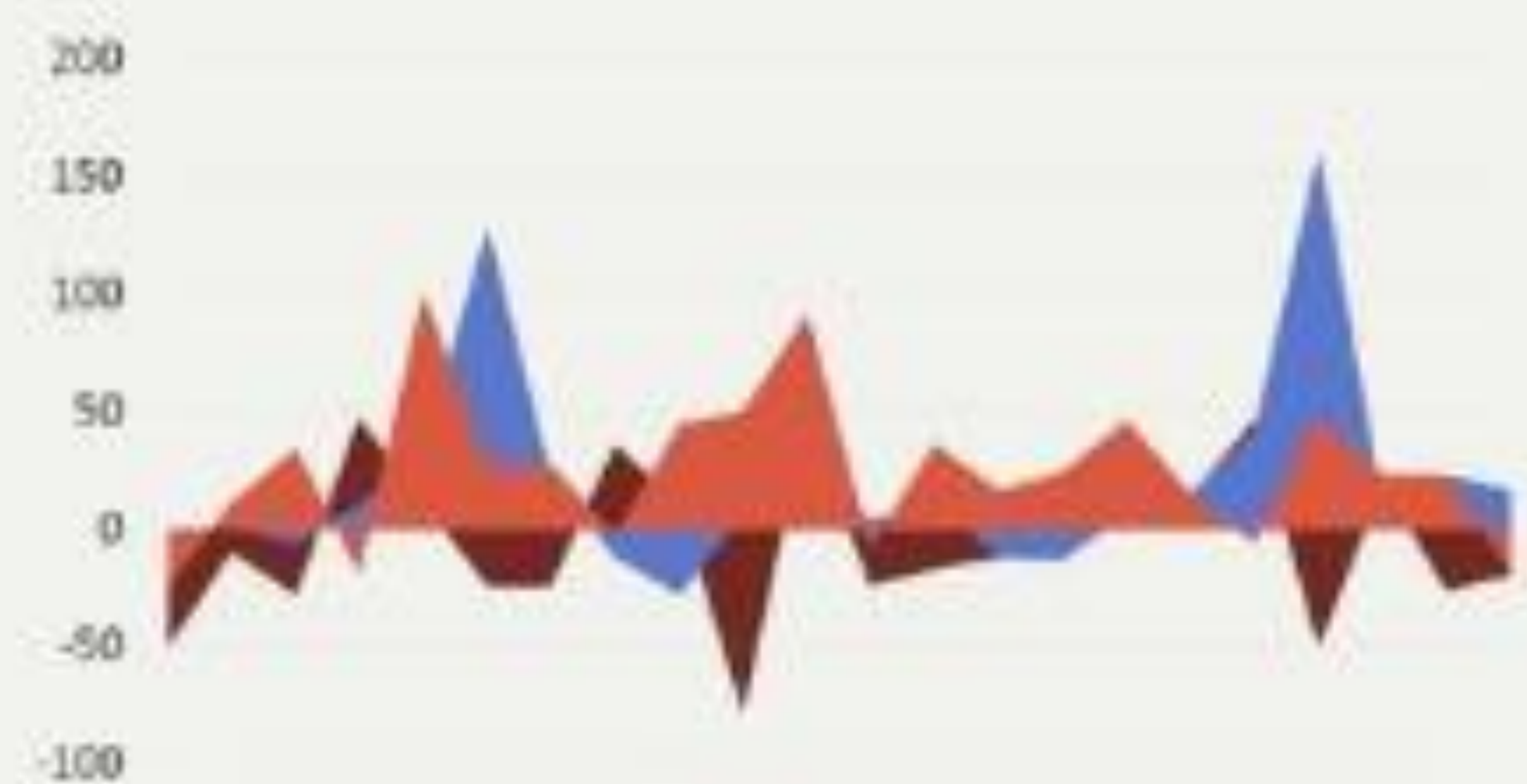


Figure 4: You can use this space for another graph or table

CONCLUSION

The conclusion of a poster presentation should succinctly synthesize the main findings or contributions of your research. It's important to, briefly restate the research question and the answers your work provides, emphasizing the most significant results. And discuss the broader implications of your findings for the field of study or potential practical applications.

REFERENCES

Smith, J. A., & Lee, B. (2012). Advances in solar panel efficiency: A ten-year review. *Journal of Solar Energy*, 135(1), 1-10.
Chen, K., Foster, T., & Lopez, A. (2018). Harnessing wind power: Innovations in turbine technology. *Energy*, 150, 1-15.

