Poster Preparation 101

Vanderbilt Medical Center

Hearts and Minds

Qualities of a Great Poster

Achieves Goals:

1) Attracts onlookers' attention so they stop for a second look
2) Concisely communicates the results of research

Concise:

A poster is not a journal article. A viewer should get your message in 3-5 minutes and be able to read ALL the text in 10 minutes. A good rule of thumb is that text should be about 1,000 words.

Communicates Visually:

Even it if only consists of text, it needs to be clean, uncluttered and evenly spaced. Graphic elements should also be clean, not distracting and clearly supportive of conclusions. Don't include "throw-away" graphics just to have visuals.

Plan Your Poster

- Read & follow ALL meeting instructions regarding poster production and presentation.
- Do not wait until the last minute! If this is your FIRST poster, plan on at least a week's time to be satisfied with all your poster elements.
- Sketch it out. Since your poster is 4' x 6', 4" x 6" index cards are great, to-scale planning tools.
- Arrange the contents in a series of organized columns, grouped by headers.

Getting Started

REMEMBER: Before beginning any work, find out if the meeting has poster size guidelines or restrictions.

- Use the Departmental Poster Template. It will be posted on the Employee Intranet for use in the future.
- Turn on guidelines to assist in lining up figures and text boxes. Click **View** >> **Gridlines**. These lines will NOT appear in your poster. If using a PC, turn guidelines on and off by right-clicking the mouse.
- Turn on rulers to maintain a 1 to 1.5" margin of white space on all sides of your poster. Click **View** >> **Ruler** to display rulers. PC users can turn rulers on and off by right-clicking the mouse.
- Create new sections and headings by adding text boxes and resizing the text boxes as need. Click **Insert** >> **Text Box**

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About the Design

- Colored backgrounds increase print cost. If used at all, muted shades are best for backgrounds. **Do not overuse color.** It can distract from the data.
- A single emphasis color is best, particularly for headers. **Never use more than three colors as design elements.**
- Most poster sessions are in halls with florescent lights. Your colors may become distorted, and bright colors are affected the most by florescent lighting.
- Graphics should be well-labeled, but with minimal text, and should be easily visible from six feet away.
- Use empty space ***evenly*** between poster elements to differentiate between the elements.

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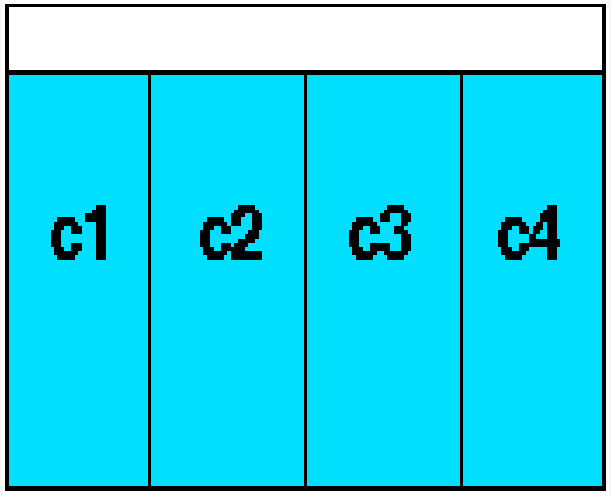
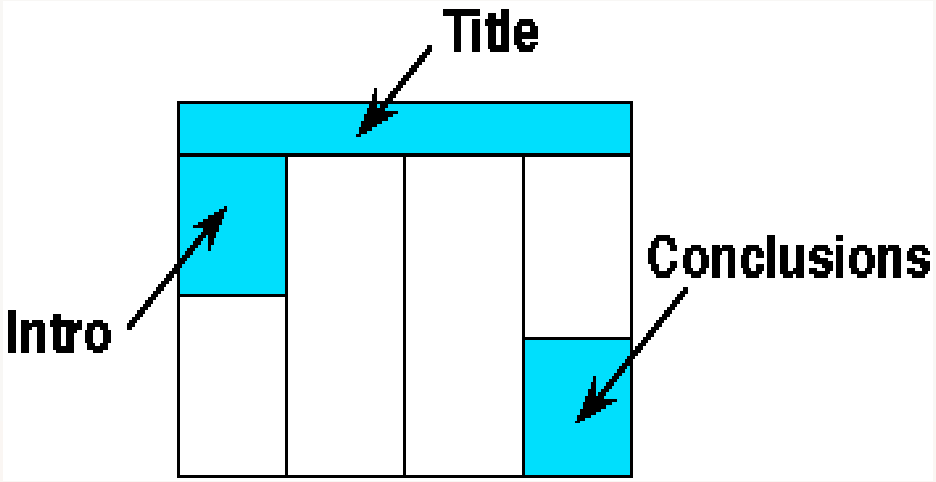
About the Design

- Double-space text, using left justification. **It is easier to read.**
- San serif fonts (no shelves or curls) are easier to read, but there are a few serif fonts that are acceptable. Try Helvetica, Arial, Geneva, Times Roman, Palatino or Century Schoolbook. **Do NOT use a specialty font.**
- Use one font throughout the poster. Create emphasis by using bold, underlining or color (limited). Avoid italic text; it is harder to read.
- Body text should be readable **from six feet away**.
- Section headers should be no smaller than 50 point, Bold, Helvetica.
- Supporting text should be no smaller than 40 point Helvetica.
- Narrative, if necessary, should be BRIEF and no smaller than 32 point plain text. If you need more narrative support, provide handouts.

Poster Flow

Flow of information on a poster is for a reader's eyes, from left to right. Don't jump around!





Title Banner

The title banner should be readable from 20 feet away!

This means the letters should be a minimum of 1 inch high. Different fonts will be take up different space, but try:

72 pt BOLD for the title
54 pt BOLD for the authors
38 pt BOLD for the institution

Include in the title:

- **Title** of the work
- **Author(s**) names (including first names, if possible)
- **Institutional affiliations** (city names or states can be dropped for space considerations)
- **Poster number** (if provided)

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Poster Content

All content should be readable from six feet away!

Different fonts take up different space vertically and horizontally,
but these point sizes are standards:

- **Introduction:**
  Title: 50-60 pt BOLD, Text: 40 pt
- **Materials/Methods:**
  Title: 50-60 pt, Text : 40 pt
- **Figures:**
  Title: 50-60 pt
- **Figure Legend:**
  Title: 40 BOLD, Text: 32 pt
- **Tables**:
  Text: 32-40 pt

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PowerPoint Pointers

- Add a **1 to 1.5" border of white space** on all sides to accommodate printing variations.
- Use **standard fonts**; specialty fonts may not print correctly.
- **Type special characters (e.g. Greek/mathematical symbols) directly in PowerPoint** rather than copying and pasting from another document. Special characters pasted into PowerPoint can print incorrectly *even though the character displays correctly on the monitor.* Insert special characters by clicking **Insert** >> **Symbol** >> **[character].**
- PowerPoint won't wrap text around inserted figures. To do this, create the paragraph as a separate Word file (which you can then use to wrap text), and then insert the Word file into your poster.

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PowerPoint Pointers

- **Make sure text boxes are completely on the page**. Even if text appears on the page, the text box (shown by ghosted outline) may extend beyond the slide's edge and may cause text to shift when printed.
- **Insert figures and graphs using the "Insert" function**, not by copying and pasting the image or figure into the document. Click Insert >> Picture >> From file >> [filename].
- **Use a graphics program, not PowerPoint, to resize your images to the size you want them to appear on the poster.**
- Images will look small when you view the entire poster at once. To get an idea of how the actual picture looks, **view your poster at 100%**. ***If it's fuzzy on the monitor, it will be fuzzy when it prints.***

PowerPoint Pointers

- **Minimum resolution for printed images is 300 dots per inch (DPI)**. If you take a 2" X 2" image at 300 DPI and resize it to 4" X 4", you have halved the resolution to 150 DPI. **It will be FUZZY!**
- **Macintosh users who insert graphs created in Excel:** Copy and paste graph from Excel into a new large document (e.g. 2000 X 1300) in Graphic converter. Under **Edit** menu, choose **Trim Selection** and then save graph in .pct format (not .pict). Import into PowerPoint as above.
- **To use a graph created in GraphPad**, select the graph (in GraphPad) that you want use. Click **File** >> **Export** >> and **Save As Type** (pull-down menu). Save image, then insert it into the PowerPoint as outlined above.

More to Remember

- Don’t use colons with titles. Looks clunky!
- Don’t add bullets or punctuate section headers.
- Avoid long blocks of text - about 10 sentences, maximum.
- When using acronyms or numbers in the body text, scale down the font size to keep from overpowering the rest of the text.
- Create the entire poster in one environment (Mac or PC). Switching between can cause lost images, botched graphs, etc.
- Use only a single space after sentences!
- Don’t display two-dimensional data in 3-D. Three-dimensional graphs obscure the true difference between bar heights.
- If you include a photograph, add a thin gray or black border.

Poster Resources at Vanderbilt

POSTER PRINTING ONLY

Karen Pride at Biomedical Research Education & Training Poster Printing, 307 Light Hall **Email:** karen.pride@vanderbilt.edu
Phone: 322-3835

http://bret.mc.vanderbilt.edu/bret/php_files/poster2.php

- BRET Poster Printing supports PC and Mac. Posters can be submitted in finalized form on a CD, via a jump drive or emailed to bret.poster@vanderbilt.edu . If BRET must modify the poster, the cost is $60/hour for design time, in addition to print charge. Posters must be submitted for printing **at least two business days in advance** of when they are needed. Additional time should be allowed prior to large conferences.
- There is a **$10 surcharge** for posters with a colored background.
- Posters are priced according to length. The price is $49 for any poster up to 12" long. Add;l length is priced according to table at right.

Length (in)	Price
13 - 18	$62.00
19 - 24	$66.00
25 - 30	$70.00
31 - 36	$74.00
37 - 42	$78.00
43 - 48	$80.00
49 - 56	$82.00
57 - 64	$90.00
65 - 72	$94.00
72 - 80	$96.00

black = PDF format only

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Poster Resources at Vanderbilt

POSTER DESIGN & PRINTING

Tim Peck at Medical Arts Group, T-5200 Medical Center North
Phone: 322-2353

- Submitters must provide a sketch layout – handwritten or electronic.
- All text for poster must be provided in a Word document. Images (jpgs) and tables must be submitted in separate files on disc or attached to email. They cannot be embedded in a Word file.
- 11 by 17 proof is provided for corrections.
- Final poster is output and rolled in a tube in approx 1.5 weeks. Allow more time prior to large conferences.
- All-inclusive costs for design and production:
  6 x 3.5 feet = $400 4 x 3.5 feet = $300
  Just art time = $180 Just a poster tube = $20

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Sample Poster:Medical Arts Group

A Randomized Prospective Trial of Endoscopic Ultrasound (EUS) to Guide Combination Medical and Surgical Treatment for Crohn's Perianal Fistulas

Natalie M. Spradlin MD • Paul Wise MD • Alan Herline MD • Roberta Muldoon MD • Michael Rosen MD • David A. Schwartz MD

Inflammatory Bowel Disease Center, Vanderbilt University Medical Center, Nashville, Tennessee

Purpose

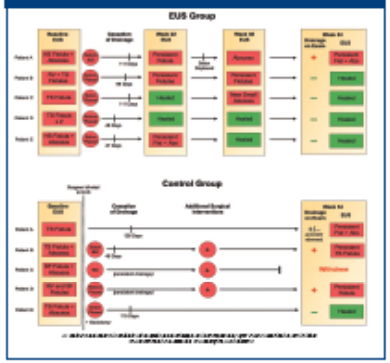
- Endorectal ultrasound and MRI have demonstrated excellent accuracy in the assessment of Crohn's perianal fistulas [1]. Retrospective data exists supporting that utilizing EUS to guide combination medical and surgical therapy seemed to improve long term fistula healing rates [2]
- To provide prospective randomized data examining the use of EUS to guide combination medical and surgical therapy to effect durable fistula healing in patients with Crohn's perianal fistulas

Methods

- 10 patients with perianal Crohn's disease were prospectively randomized to either the EUS intervention or control cohorts.
- All patients underwent a rectal EUS followed by an EUA with treatment given as indicated. The surgeon was blinded to the initial EUS results of patients in the control group.
- Medical treatment was maximized as below
  - Azathioprine (2-2.5 mg/kg) or 6-Mp (1-1.5 mg/kg)
  - Antibiotics (ciprofloxacin 1000 mg/ daily or metronidazole 1500 mg daily)
  - Infliximab 5 mg/kg at 0,2 and 6 weeks and the every 8 weeks
- Control group patients had additional interventions at the discretion of the surgeon without EUS assistance
- EUS cohort patients had EUS performed again at weeks 22 and 38 with additional surgical interventions based on EUS findings. Setons were not removed until EUS demonstrated fistula inactivity
- The primary endpoint was complete cessation of drainage at week 54. All patients had a repeat EUS performed at week 54 to determine fistula status (secondary endpoint).

Results

Flow Diagram of Outcomes in EUS and Control Groups



Demographics

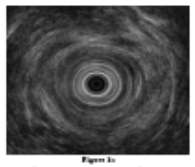
- Median age was 29.5 years old
- 8 (80%) of the participants were female
- All 10 of the participants had documented complex fistulas upon entering the study and 50% of study participants had an associated abscess at presentation (See Diagram)

Fistula healing

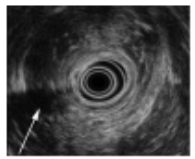
- 1/5 (20%) in control group and 4/5 (80 %) in the EUS group had complete cessation of drainage at study completion. (See Diagram)
- From the control group, 3 patients failed due to repeat surgery and 1 had persistent drainage at week 54.
- In the EUS cohort, 1 patient had recurrent abscess after the seton fell out prematurely.
- For the EUS cohort, the median time to cessation of drainage was 99 days and the time to EUS evidence of fistula inactivity was 229 days (median difference of 130 days)
- EUS is more sensitive than physical exam for detecting persisting abnormalities. 5 patients in this study had persistent disease activity at the completion of 54 weeks and 60% (3/5) of the time the EUS method detected disease that was not found on physical exam.

Representative EUS Cohort Cases

Patient C



Patient A



Conclusion

- In this pilot study, using EUS to guide combination medical and surgical therapy for perianal fistulizing Crohn's disease is associated with improved fistula response rates
- When comparing reliability of the physical exam to EUS for detection of continued perianal disease activity, EUS is more sensitive for detecting persisting abnormalities

References

1. Schwartz, D.A., et al., A comparison of endoscopic ultrasound, magnetic resonance imaging, and exam under anesthesia for evaluation of Crohn's perianal fistulas. Gastroenterology, 2001. 121(5): p. 1064-72.
2. Schwartz, D.A., et al., Use of endoscopic ultrasound to guide combination medical and surgical therapy for patients with Crohn's perianal fistulas. Inflamm Bowel Dis, 2005. 11(8): p. 727-32.

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… And Finally

- Don’t procrastinate. Your first poster may take a week or more just to compile the content!
- Type up all content, proof read, then have a friend proof read! The cost for printing goes up if changes continue to be made after a proof is produced.
- Sketch out a layout.
- If all else fails, get a second opinion or call in the experts for design assistance.
- Get a strong tube to protect your work! Weather, airlines, etc., can destroy a poster.

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If you need additional poster tips, email Anesthesiology Department Communications & Marketing Coordinator Jill Clendening
jill.clendening@vanderbilt.edu

Good Luck & Happy Postering!

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A LIDOCAINE LOLLYPOP FOR TOPICALIZATION OF THE OROPHARYNX

Pratik Pandharipande MD, MSCI, Arna Banerjee MD, John Barwise MB, ChB and C.Lee Parmley MD, JD
Vanderbilt University Medical Center, Nashville, TN and Veterans Affairs Medical Center, Nashville, TN

THE CASE

- **A 75 year old male status-post a recent radical neck dissection and irradiation, was scheduled for a percutaneous gastrostomy tube placement.**

CHALLENGE

- **The patient was unable to open his mouth beyond a single finger breadth.**

OPTIONS/ PLAN

- **Two missing front teeth provided an opening for an awake fiberoptic intubation, but that was the only space available for the gastroscope.**
- **Nasal fiberoptic**
- **An elective tracheostomy was contemplated, but given the patients overall prognosis, it was decided to topicalize the oropharynx.**

ANESTHETIC

- **Bilateral nares were anesthetized and dilated with nasal trumpets as a back up just in case a nasal fiberoptic needed to be performed**

ANESTHETIC (CONTINUED)

- **The patient was asked to suck on a gauze piece with 4% lidocaine, initially to topicalize the anterior portion of his tongue.**
- **This was then attached to a tongue depressor and advanced to anesthetize the posterior tongue**
- **This lidocaine lollipop was gradually advanced to anesthetize the oropharynx.**
- **A tongue depressor with 5% Lidocaine cream was then introduced to further anesthetize the posterior pharynx.**
- **Patient asked to swallow secretions during the process**

PROCEDURE

- **Patient brought to the operating room and placed on standard monitors**
- **Oxygen provided by nasal canula**

PROCEDURE (CONTINUED)

•Gastroscope advanced via opening provided by missing teeth, with no cough or gag reflexes noted

•Local anesthetic infiltration performed over incision site for the gastrostomy tube

•The procedure was completed without any problems