How to Conduct Effective Public Speaking and Slide Presentation

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Outline

• Why important

• Reasons for failure

• Top ten tips for talks

• The 15 minutes of fame

• Giving the long talk

• Conclusions
Why is the Topic Important?

- Scientific talk one of the most important communication forums
- Proliferation of meetings
- Reputation is influenced
- It is a must to be able to do it
Reasons for Failure

- Not meeting needs of the audience
- Lack of clear organization
- Unclear purpose
- Too much information
- Poor delivery
- Bad visual aids ineffectively used

Casella PJ, 2001
Top Ten Tips for Talks

10. Be prepared
9. Learn by example
8. Know your audience
7. Identify your key message
6. Use visual aids effectively
5. A little personality is good
4. Knowing your talk ≠ reading It
3. Ten minutes is not 12
2. Stand and deliver
1. Be prepared

Morrow M, 2009
Be Prepared

Begin planning the timeline for your work as soon as your talk is accepted

• Additional data collection
• Data analysis
• Literature review
• Slide preparation

Slides should be done 1 month before your talk

Morrow M, 2009
Be Prepared

• Prepare material carefully and logically and tell a story (in particular in long talks)
  – Introduction
  – Method
  – Results
  – Conclusion/summary
  – Future research

If you procrastinate on the paper, you double your workload
Learn By Example

If you think someone is an effective speaker, pay attention to what it is you like
Know Your Audience

• For all audiences, avoid jargon, obscure abbreviations, and talking down to people

• Clinical talks (→ diverse/general audience) should emphasize standard care, supporting evidence, unsolved problems, work in progress
Identify Your Key Message

Particular important for the long talk

• What is the purpose of the talk?

• Why is this important or interesting?

• What is the background necessary to understand this?

Answer these questions and the introduction to your talk is done
Use Visual Aids Effectively

Purpose

• Supplement what you are saying

• Help the audience, not you

• Keep it simple

Morrow M, 2009
Pathways differentially activated in luminal epithelial and myoepithelial cells

- TGFB
- Hh
- Integrins
- ECM-adhesion
- Lipid metabolism
ASCO Guidelines on Preparing Slides

• Use no more than 5 to 8 lines per slide and 5 to 7 words per line
• Use upper and lowercase lettering
• Preferred fonts: Arial or Tahoma
  – Alternatives: Times New Roman or Courier
• Tables, graphs, diagrams clear & simple
• Avoid many colors, patterns, graphs on 1 slide
• Orient all type horizontally
MODERN CANCER RESEARCH

• Requires more scientists in cancer-related fields
  – Bioinformatics and computational molecular biology
  – Mathematical modeling
  – Systems biology
  – Structural and chemical biology, and chemical genetics
  – Physics
  – Nanotechnology
  – Engineering
  – Chemistry
  – Other
Modern Cancer Research

Requires more scientists in cancer-related fields

- Bioinformatics and computational molecular biology
- Mathematical modeling
- Systems biology
- Structural and chemical biology, and chemical genetics

- Physics
- Nanotechnology
- Engineering
- Chemistry
- Other
Use Visual Aids Effectively

• Make sure slides are legible in the back even if you believe everyone important is sitting in the front

• The phrase “I know you can’t read this…” should never pass your lips
Effect of local therapy on isolated local recurrence risk by year 5

<table>
<thead>
<tr>
<th>Type of local treatment comparison</th>
<th>Isolated local recurrence: cumulative risk by year 5 after randomisation</th>
<th>5-year risk (actuarial %)</th>
<th>Absolute reduction in 5-year risk (%)</th>
<th>Control Active Redn. (SE) Reduction and 99% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Radiotherapy vs. no radiotherapy, but same surgery</strong></td>
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<tr>
<td>BCS ± RT (13 trials)</td>
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<tr>
<td>Node −ve</td>
<td>233/3821 701/3754 5.8 20.0 14.2% (0.8)</td>
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<tr>
<td>Node +ve</td>
<td>69/755 226/758 9.2 33.7 24.5% (2.3)</td>
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<tr>
<td>Mast + AC ± RT (26 trials)</td>
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<tr>
<td>Node −ve</td>
<td>13/664 35/692 2.1 5.5 3.4% (1.1)</td>
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<tr>
<td>Node +ve</td>
<td>213/4168 815/4169 5.8 23.5 17.8% (0.9)</td>
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<tr>
<td>Mast + AS ± RT (4 trials)</td>
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<tr>
<td>Node −ve</td>
<td>13/225 52/223 6.1 24.3 18.2% (3.5)</td>
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<tr>
<td>Node +ve</td>
<td>11/65 43/104 13.5 48.8 35.3% (7.3)</td>
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<tr>
<td>Mast alone ± RT (6 trials)</td>
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<tr>
<td>Node −ve</td>
<td>120/1427 375/1477 9.9 28.1 18.2% (1.6)</td>
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<tr>
<td>Node +ve</td>
<td>109/837 270/836 14.9 36.6 21.7% (2.4)</td>
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<tr>
<td><strong>More surgery vs. less surgery, but same (or no) radiotherapy</strong></td>
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<tr>
<td>IMC removal vs. not, neither with RT (2 trials)</td>
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<tr>
<td>Node −ve</td>
<td>11/243 9/251 4.9 3.8 −1.1% (1.9)</td>
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<tr>
<td>Node +ve</td>
<td>42/286 50/302 18.9 21.1 2.2% (3.9)</td>
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<tr>
<td>Pectoral removal vs. not, both with same RT or no RT (4 trials)</td>
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<tr>
<td>Node −ve</td>
<td>1/49 2/56 2.2 3.9 1.7% (3.3)</td>
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<tr>
<td>Node +ve</td>
<td>59/330 60/309 21.7 23.1 1.4% (3.8)</td>
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<tr>
<td>AC vs. not, in N+ disease, both with some RT (2 trials)</td>
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<tr>
<td>Node −ve</td>
<td>7/129 13/137 7.9 12.7 4.8% (4.6)</td>
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<tr>
<td>AC vs. not, in N− disease, neither with axillary RT (6 trials)</td>
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<tr>
<td>Node −ve</td>
<td>66/929 136/937 8.5 16.3 7.7% (1.7)</td>
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<tr>
<td>Mast + AC vs. BCS + AC, neither with RT (NSABP B-08)</td>
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<tr>
<td>Node −ve</td>
<td>46/432 149/432 11.0 36.3 25.3% (3.3)</td>
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<tr>
<td>Node +ve</td>
<td>46/281 128/287 20.0 51.0 31.0% (5.0)</td>
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<tr>
<td>Mast + AC vs. BCS + AC, both with RT (2 trials)</td>
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<tr>
<td>Node −ve</td>
<td>2/58 4/60 — — — (−)</td>
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</tr>
<tr>
<td>Node +ve</td>
<td>5/154 10/156 3.9 8.1 4.2% (3.1)</td>
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<tr>
<td><strong>More surgery (active) vs. less surgery plus radiotherapy (control)</strong></td>
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<tr>
<td>Nodal surgery vs. RT (9 trials)</td>
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<td></td>
</tr>
<tr>
<td>Node −ve</td>
<td>114/1220 103/1213 11.0 9.8 −1.2% (1.4)</td>
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</tr>
<tr>
<td>Node +ve</td>
<td>208/863 163/848 28.0 23.4 −4.6% (2.5)</td>
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<tr>
<td>Mast + AC vs. BCS alone + RT (Guy’s Hospital)</td>
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</tr>
<tr>
<td>Node −ve</td>
<td>9/235 44/226 4.5 21.5 16.9% (3.5)</td>
<td></td>
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</tr>
<tr>
<td>Node +ve</td>
<td>8/91 23/78 10.9 33.8 22.8% (7.9)</td>
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</tr>
<tr>
<td>Mast vs. BCS + RT, both with AC (7 trials)</td>
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</tr>
<tr>
<td>Node −ve</td>
<td>59/1429 101/1436 4.4 7.5 3.1% (0.9)</td>
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<tr>
<td>Node +ve</td>
<td>41/613 22/647 8.0 3.9 −4.0% (1.5)</td>
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</tr>
</tbody>
</table>

AC = axillary clearance, AS = axillary sampling, BCS = breast-conserving surgery, IMC = internal mammary chain, Mast = mastectomy, N+− = node positive/negative, Pectoral = pectoral muscle, RT = radiotherapy.

Note: 5–year probabilities of isolated local recurrence are from actuarial analyses, stratified for trial and age.
A Little Personality Is Good

- Avoid jokes about religion, race, ethnicity, politics, sex
- Do not act like you have cured cancer
- Never be disrespectful of questions
- Give credits to others

Morrow M, 2009
**Fibonacci Escalation**

**Fibonacci series:**
- first 2 terms are 1, then each term equal to sum of 2 predecessors; ratio between terms becomes 1.618
- This ratio appears in high frequency in nature

Leonardo Pisano Fibonacci (1175 – 1250)
Fibonacci Escalation:
“Modified” Fibonacci

• There is no generally agreed “modified” scheme.

• Often: Double first 2 terms. Then increases at decreasing ratio to fixed ratio between 1.25 to 1.5

• An example:

<table>
<thead>
<tr>
<th>Ratio</th>
<th>1</th>
<th>2</th>
<th>4</th>
<th>6</th>
<th>9</th>
<th>14</th>
<th>21</th>
<th>48</th>
<th>72</th>
<th>108</th>
<th>162</th>
<th>etc</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.0</td>
<td>2.0</td>
<td>2.0</td>
<td>1.5</td>
<td>1.5</td>
<td>1.55</td>
<td>1.52</td>
<td>1.5</td>
<td>1.5</td>
<td>1.5</td>
<td>1.5</td>
<td>etc</td>
</tr>
</tbody>
</table>
Knowing Your Talk Doesn’t Mean Reading It

- Gives the impression you don’t know what you are talking about
- Too easy to get out of synch with slides
- Slides should contain the data which need to be precisely conveyed
- Do not read slides word for word
10 Minutes Doesn’t Mean 12

• Time limit is not a suggestion
• Prepare outline adequately and practice
• Try not to exceed 7 to 8 data-intensive slides
• Do not try to compensate by talking faster
Stand and Deliver

- Talk to the audience, not to the screen
- Make eye contact
- Avoid making distracting sounds
- Take care your telephone is off
- Stand up straight, hold still
- Overcome fear by good preparation
Be Prepared

- Avoid staying out all night prior to your talk
- Look professional
Be Prepared

On the big day

• Allow lots of time to get to the room, load your talk, check the podium

• Introduce yourself to the moderator

• Do NOT sit in the back changing your slides at the last minute
  Knowing what’s coming next is key for smooth transitions
The 15 Minutes of Fame

The proffered ASCO abstract presentation is:

• Timed
• Choreographed
• Interrogated
• Discussed

It's a capital crime to exceed your allotted time

Sledge GW, 2009
10 Minutes to Present: Format

- Title and Disclosure
- Background/Introduction
- Methods/Study Design
- Results
- Discussion/Conclusions
- Acknowledgements

Sledge GW, 2009
Mistakes in Background: Introduction

- Spending too much time
- Not clearly delineating the problem
- Pretending no one else exists

Sledge GW, 2009
Methods/Study Design

• Study population and endpoints

• Always include statistical design, especially power calculations

• Good presentation skills will not make up for bad study design

Sledge GW, 2009
Results

• Focus on pre-defined endpoints
• Don’t torture the data
• Don’t obfuscate
• Keep it simple
• Don’t rush through the data
Discussion/Conclusions

• Be brief (1-2 slides)
• Focus on main points
• Don’t claim too much
• Don’t emphasize secondary endpoints
• Don’t make wild conjectures
Acknowledgements

- Brief and to the point
- Do not read every name
- Avoid false piety
The Q & A:
How to Make a Mess of It

- Be arrogant
- Be argumentative
- Lose your temper
- Don’t prepare
The Discussant

• The discussant can be friend or foe

• Use, don’t anger your discussant
  – Get your presentation to the discussant in a timely fashion
  – Offer to explain/provide data
  – Be willing to take tips

Sledge GW, 2009
Giving the Long Talk: Main Points

• Tell a story

• Prepare the main points that you want to make

• Take the different steps in a logic sequence

• Make it easy for them to follow

• Don’t rush and try to enjoy it
Basics: Focus on Main Points

• Keep in focus the main points that you want to deliver

• At the beginning of the talk, provide the topics or main points

• Summarize after each section and summarize key points at the end

Harris JR, 2009
A successful strategy is to

1 - tell them what you're going to tell them (forecast),

2 - tell them, and then

3 - tell them what you told them (summary)
Optimal Treatment of Ovarian Cancer

Jan B. Vermorken, MD, PhD
Department of Medical Oncology
Antwerp University Hospital
Edegem, Belgium

XXII Curso Avanzado de Oncologia Médica, San Lorenzo de El Escorial
Madrid, October 2, 2010
Outline

• Milestones in the treatment of ovarian cancer
• Standard management of advanced ovarian cancer
• Various ways to improve results beyond PAC-CARBO
• Potential roles of targeted therapies
• Strategies towards treatment of relapsed disease
• Take-home messages
Take-home messages for ADOVCA

- Upfront surgery followed by 6 cycles of Pt-Tax-based CT is still standard
- Paclitaxel + carboplatin (TC) generally agreed standard
- NACT followed by surgery in stages IIIc-IV OC showed the same survival as PDS with less morbidity in (GCIG trial)
- A dose-dense therapy approach may be of benefit
- Intraperitoneal chemotherapy suitable for selected patients
- Targeted therapy is promising (in particular anti-angiogenic approaches), but not yet standard
Take-home messages for ROC

For the management of recurrent ovarian cancer the factors that need to be taken in consideration are:

- Platinum sensitivity
- Toxicity from prior treatment
- Toxicity of available agents
- Combinations vs single agents
- Patients’ preference
- Cost of treatment
Basics: Simplicity and Clarity

• Don’t overwhelm the audience with too much detail

• Don’t deliver a ‘laundry list’ of data and studies

• Keep the concepts and your major points in focus throughout the talk
Conclusions

• Take note of the most frequent reasons of failure

• The Tope Ten Tips for Talks may be of help

• Remember the format of a short scientific presentation and how guide your audience when giving a long one

• Respect those who raise questions about your talk

• Even though you might nervous, try to enjoy it