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Innovations in Publications

April 2026

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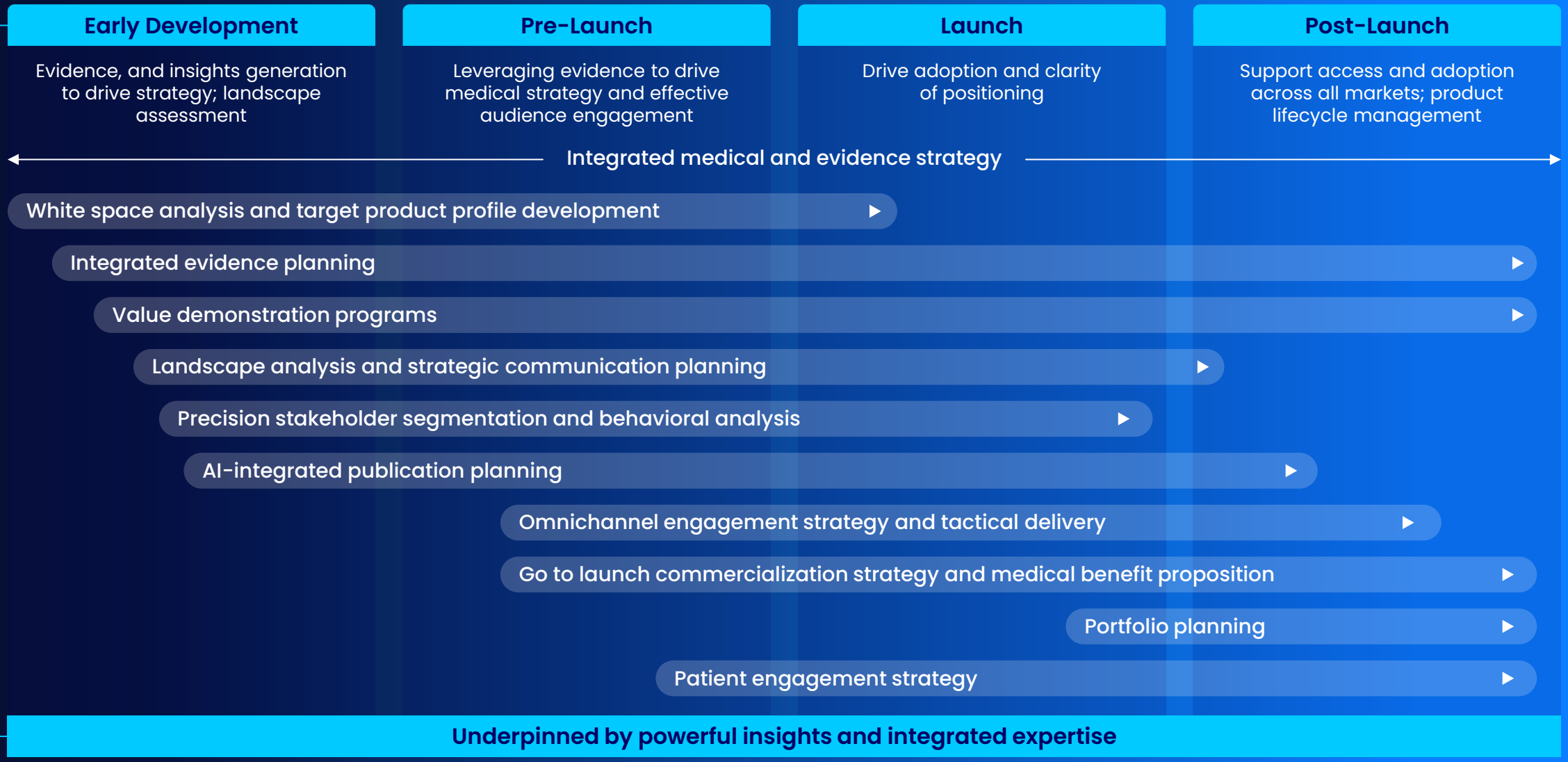

And our expertise includes the full spectrum of publication activities

Publication strategy

- Strategic publications planning
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- Publication planning workshops
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- Journal recommendations

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- ICMJE/GPP2022 adherence/ compliance guidance
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We are well placed to drive the next wave of impact through thought leadership and innovation

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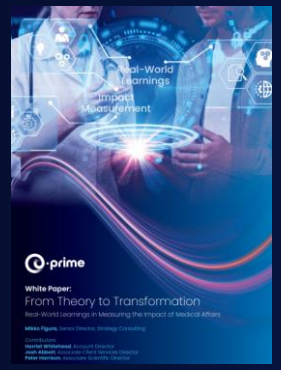

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Valerie Moss

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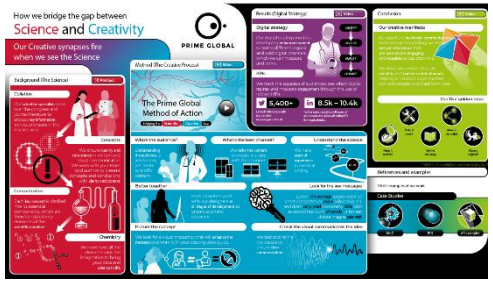
Innovation in publications

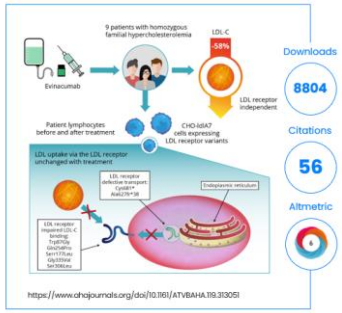
Examples

We utilize new technologies to extend the reach of your data in formats preferred by your audiences

INTERACTIVE POSTERS



GRAPHICAL SUMMARIES



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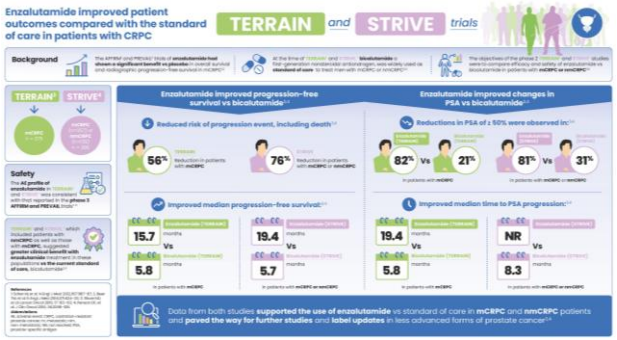

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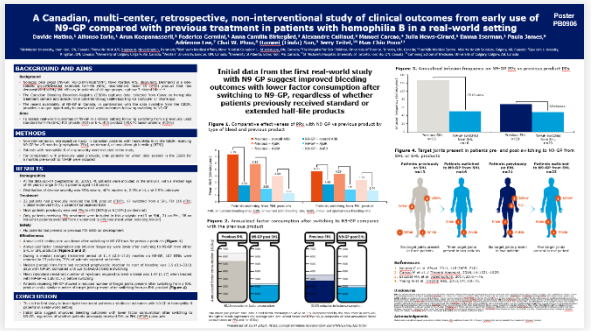

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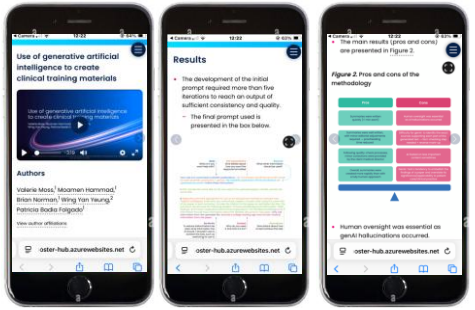

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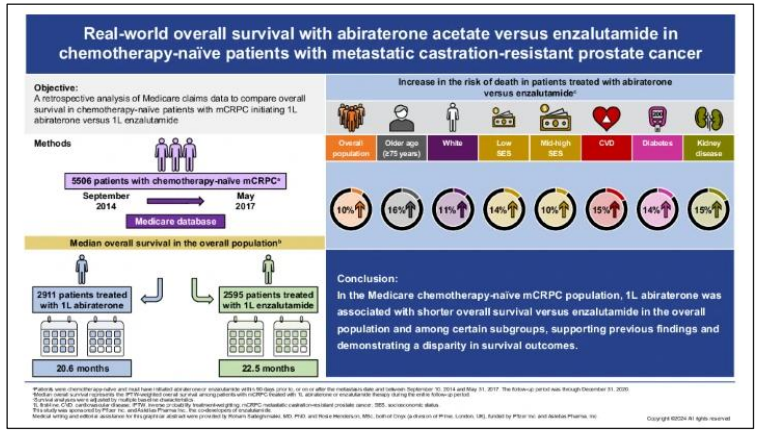

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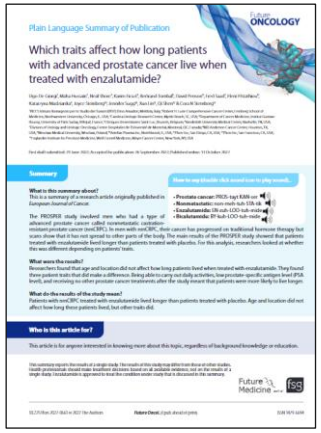

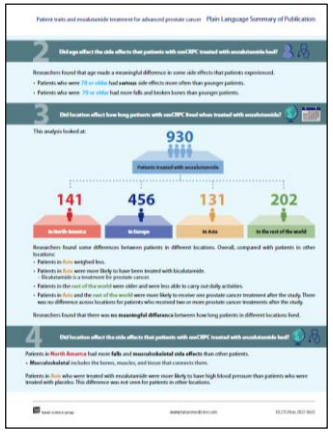

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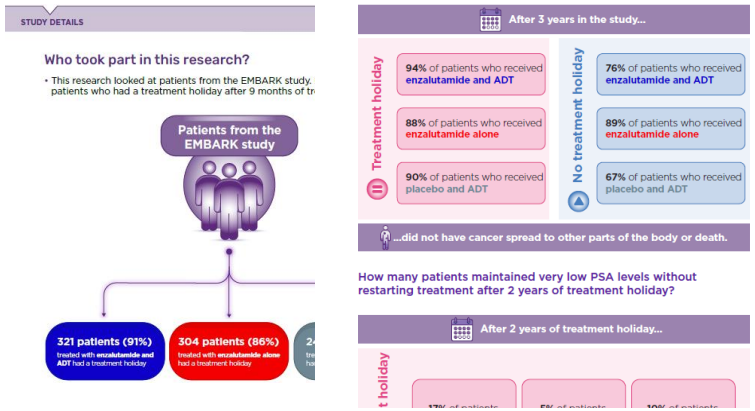
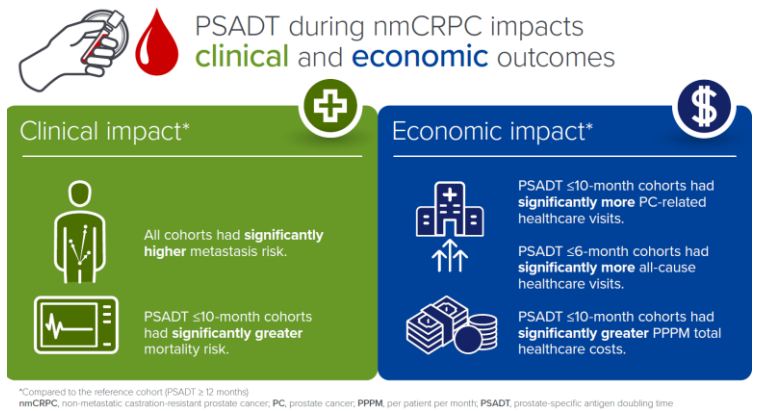
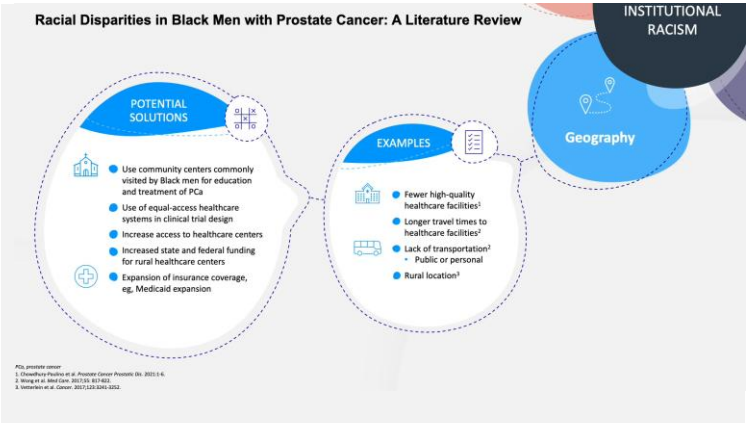


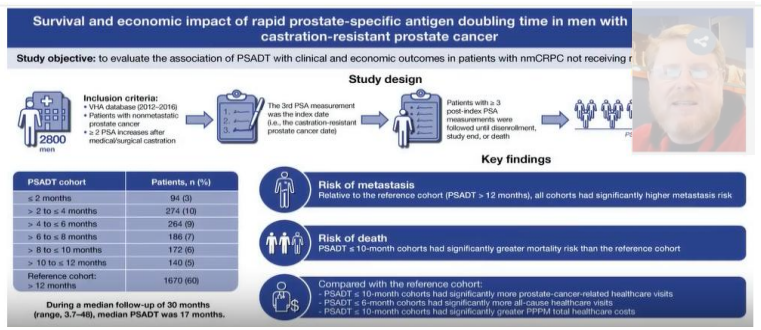
Invited commentaries



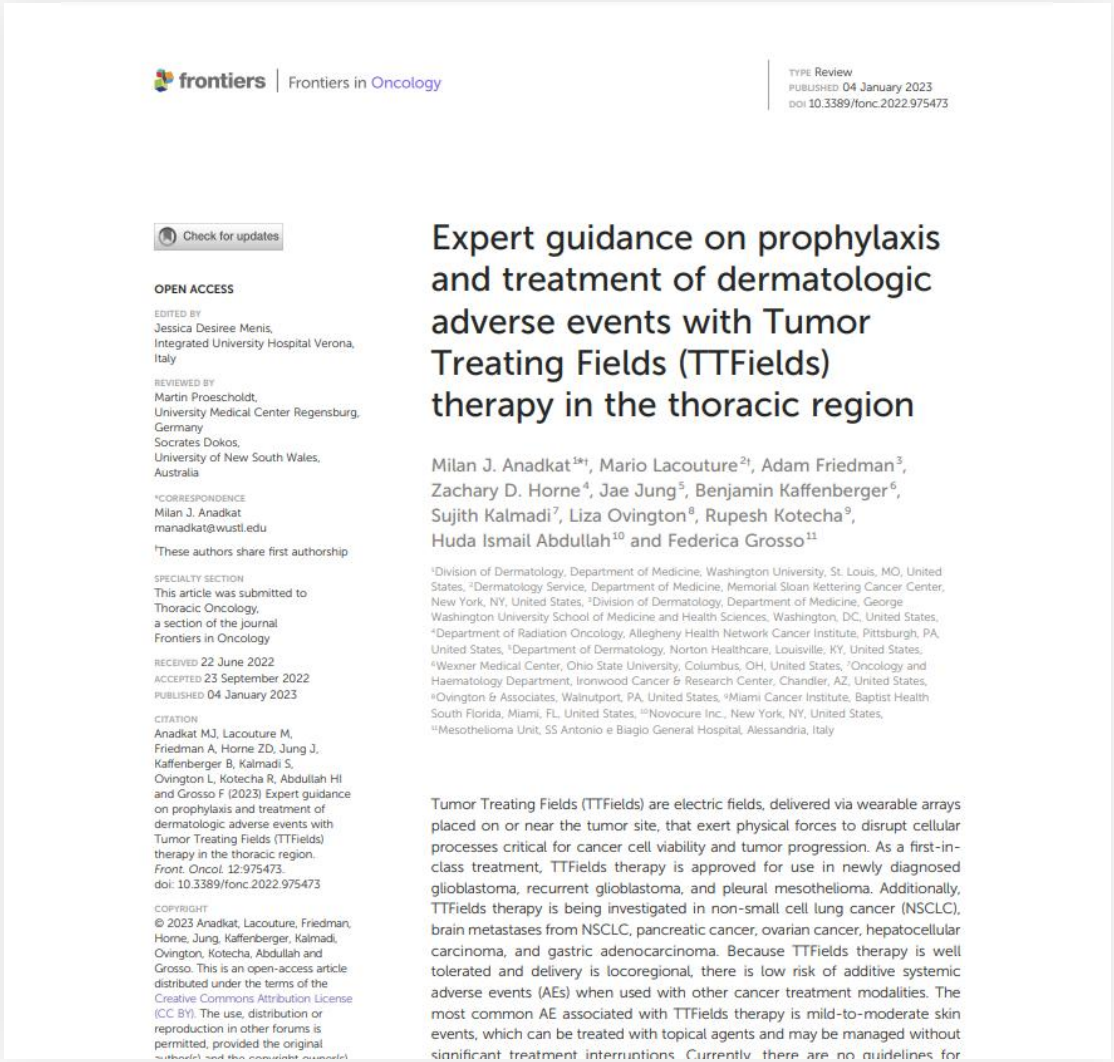
Videos and video figures



Congress videos



Interactive publication content



frontiers | Frontiers in Oncology

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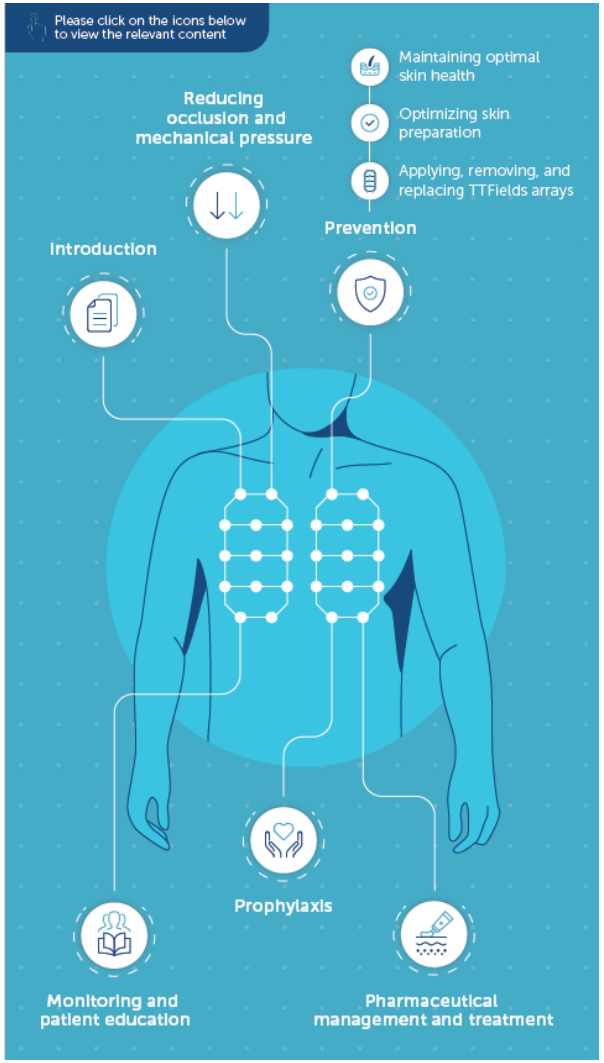
Expert guidance on prophylaxis and treatment of dermatologic adverse events with Tumor Treating Fields (TTFields) therapy in the thoracic region

Milan J. Anadkat[1*†], Mario Lacouture[2†], Adam Friedman[3], Zachary D. Horne[4], Jae Jung[5], Benjamin Kaffenberger[6], Sujith Kalmadi[7], Liza Ovington[8], Rupesh Kotecha[9], Huda Ismail Abdullah[10] and Federica Grosso[11]

[1]Division of Dermatology, Department of Medicine, Washington University, St. Louis, MO, United States, [2]Dermatology Service, Department of Medicine, Memorial Sloan Kettering Cancer Center, New York, NY, United States, [3]Division of Dermatology, Department of Medicine, George Washington University School of Medicine and Health Sciences, Washington, DC, United States, [4]Department of Radiation Oncology, Allegheny Health Network Cancer Institute, Pittsburgh, PA, United States, [5]Department of Dermatology, Norton Healthcare, Louisville, KY, United States, [6]Wexner Medical Center, Ohio State University, Columbus, OH, United States, [7]Oncology and Haematology Department, Ironwood Cancer & Research Center, Chandler, AZ, United States, [8]Ovington & Associates, Walnutport, PA, United States, [9]Miami Cancer Institute, Baptist Health South Florida, Miami, FL, United States, [10]Novocure Inc., New York, NY, United States, [11]Mesothelioma Unit, SS Antonio e Biagio General Hospital, Alessandria, Italy

Tumor Treating Fields (TTFields) are electric fields, delivered via wearable arrays placed on or near the tumor site, that exert physical forces to disrupt cellular processes critical for cancer cell viability and tumor progression. As a first-in-class treatment, TTFields therapy is approved for use in newly diagnosed glioblastoma, recurrent glioblastoma, and pleural mesothelioma. Additionally, TTFields therapy is being investigated in non-small cell lung cancer (NSCLC), brain metastases from NSCLC, pancreatic cancer, ovarian cancer, hepatocellular carcinoma, and gastric adenocarcinoma. Because TTFields therapy is well tolerated and delivery is locoregional, there is low risk of additive systemic adverse events (AEs) when used with other cancer treatment modalities. The most common AE associated with TTFields therapy is mild-to-moderate skin events, which can be treated with topical agents and may be managed without significant treatment interruptions. Currently, there are no guidelines for



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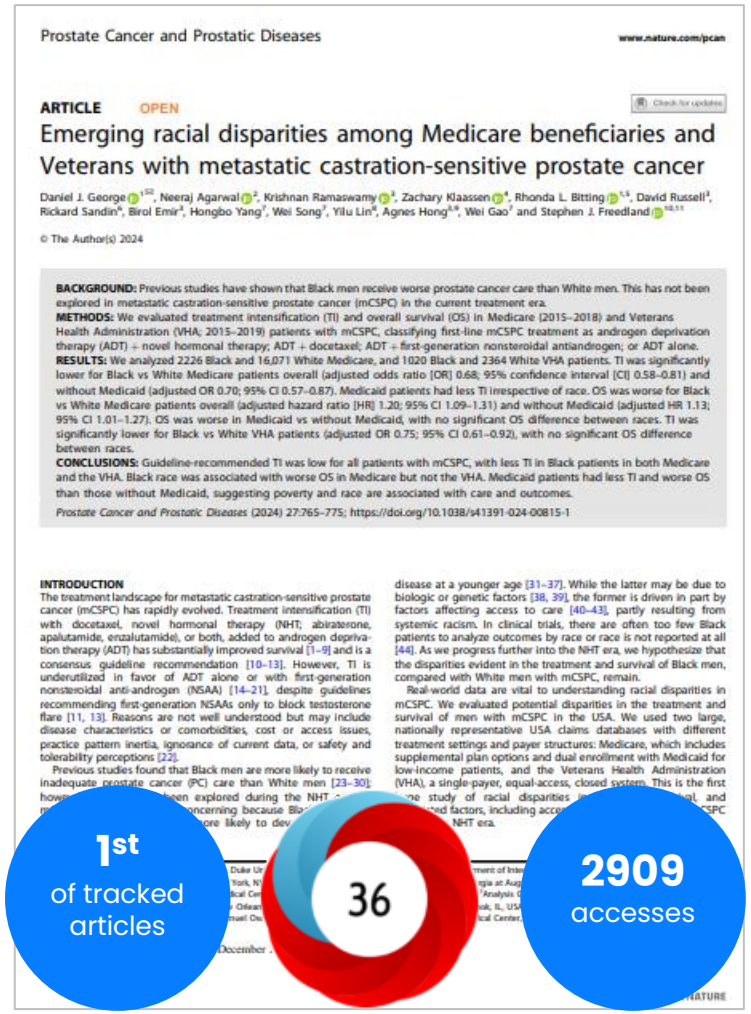
Making the most of study data


Prostate Cancer and Prostatic Diseases

www.nature.com/pcan

ARTICLE OPEN

Emerging racial disparities among Medicare beneficiaries and Veterans with metastatic castration-sensitive prostate cancer

Daniel J. George, Neeraj Agarwal, Krishnan Ramaswamy, Zachary Klaassen, Rhonda L. Bitting, David Russell, Rickard Sandin, Birol Emir, Hongbo Yang, Wei Song, Yilu Lin, Agnes Hong, Wei Gao and Stephen J. Freedland

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BACKGROUND: Previous studies have shown that Black men receive worse prostate cancer care than White men. This has not been explored in metastatic castration-sensitive prostate cancer (mCSPC) in the current treatment era.
METHODS: We evaluated treatment intensification (TI) and overall survival (OS) in Medicare (2015–2018) and Veterans Health Administration (VHA; 2015–2019) patients with mCSPC, classifying first-line mCSPC treatment as androgen deprivation therapy (ADT) + novel hormonal therapy; ADT + docetaxel; ADT + first-generation nonsteroidal antiandrogen; or ADT alone.
RESULTS: We analyzed 2226 Black and 16,071 White Medicare, and 1020 Black and 2364 White VHA patients. TI was significantly lower for Black vs White Medicare patients overall (adjusted odds ratio [OR] 0.68; 95% confidence interval [CI] 0.58–0.81) and without Medicaid (adjusted OR 0.70; 95% CI 0.57–0.87). Medicaid patients had less TI irrespective of race. OS was worse for Black vs White Medicare patients overall (adjusted hazard ratio [HR] 1.20; 95% CI 1.09–1.31) and without Medicaid (adjusted HR 1.13; 95% CI 1.01–1.27). OS was worse in Medicaid vs without Medicaid, with no significant OS difference between races. TI was significantly lower for Black vs White VHA patients (adjusted OR 0.75; 95% CI 0.61–0.92), with no significant OS difference between races.
CONCLUSIONS: Guideline-recommended TI was low for all patients with mCSPC, with less TI in Black patients in both Medicare and the VHA. Black race was associated with worse OS in Medicare but not the VHA. Medicaid patients had less TI and worse OS than those without Medicaid, suggesting poverty and race are associated with care and outcomes.

Prostate Cancer and Prostatic Diseases (2024) 27:765–775; https://doi.org/10.1038/s41391-024-00815-1

INTRODUCTION

The treatment landscape for metastatic castration-sensitive prostate cancer (mCSPC) has rapidly evolved. Treatment intensification (TI) with docetaxel, novel hormonal therapy (NHT; abiraterone, apalutamide, enzalutamide), or both, added to androgen deprivation therapy (ADT) has substantially improved survival [1–9] and is a consensus guideline recommendation [10–13]. However, TI is underutilized in favor of ADT alone or with first-generation nonsteroidal anti-androgen (NSAA) [14–21], despite guidelines recommending first-generation NSAAs only to block testosterone flare [11, 13]. Reasons are not well understood but may include disease characteristics or comorbidities, cost or access issues, practice pattern inertia, ignorance of current data, or safety and tolerability perceptions [22].

Previous studies found that Black men are more likely to receive inadequate prostate cancer (PC) care than White men [23–30]; [illegible] concerning because Bla[illegible] more likely to dev[illegible] disease at a younger age [31–37]. While the latter may be due to biologic or genetic factors [38, 39], the former is driven in part by factors affecting access to care [40–43], partly resulting from systemic racism. In clinical trials, there are often too few Black patients to analyze outcomes by race or race is not reported at all [44]. As we progress further into the NHT era, we hypothesize that the disparities evident in the treatment and survival of Black men, compared with White men with mCSPC, remain.

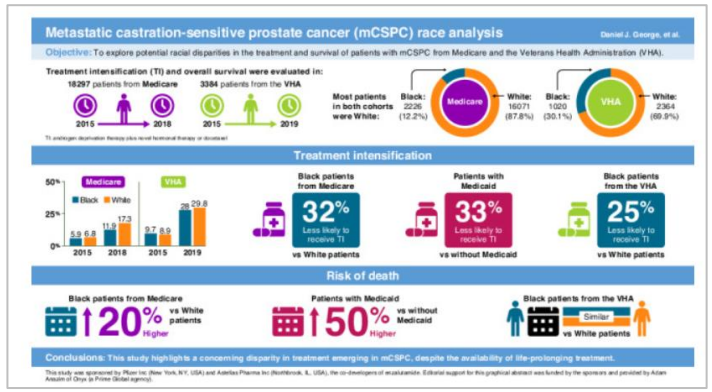
Real-world data are vital to understanding racial disparities in mCSPC. We evaluated potential disparities in the treatment and survival of men with mCSPC in the USA. We used two large, nationally representative USA claims databases with different treatment settings and payer structures: Medicare, which includes supplemental plan options and dual enrollment with Medicaid for low-income patients, and the Veterans Health Administration (VHA), a single-payer, equal-access, closed system. This is the first [illegible] study of racial disparities [illegible] factors, including acce[illegible] NHT era.

1st of tracked articles

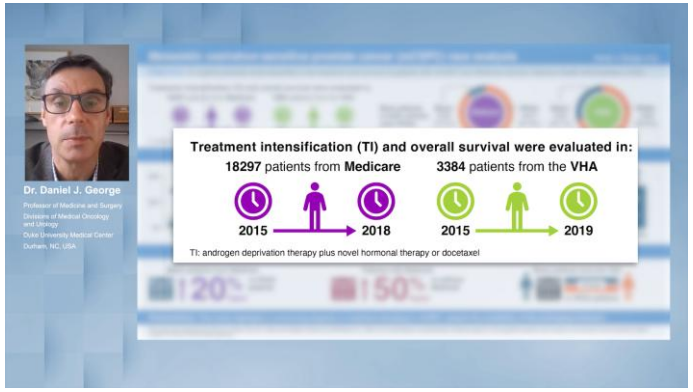
36

2909 accesses

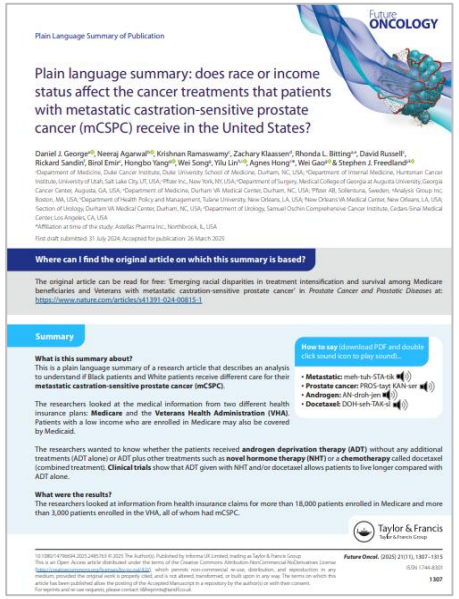
Graphical abstract



Video abstract



PLSP


Plain Language Summary of Publication

Future ONCOLOGY

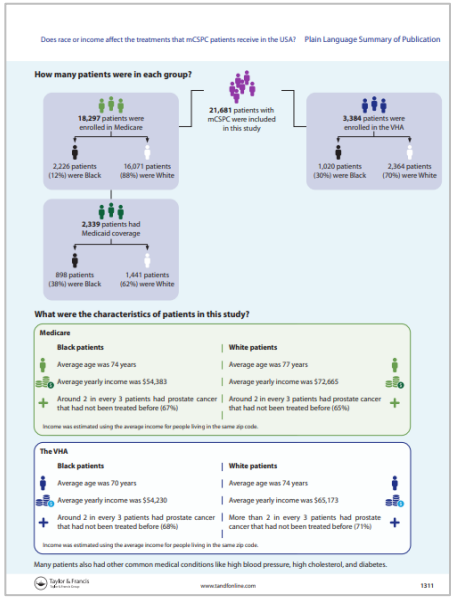
Plain language summary: does race or income status affect the cancer treatments that patients with metastatic castration-sensitive prostate cancer (mCSPC) receive in the United States?

Where can I find the original article on which this summary is based?

Summary

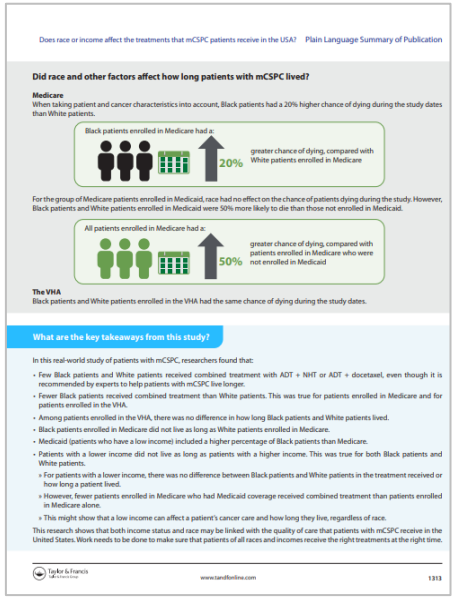
What is this summary about?

What were the results?


Does race or income affect the treatments that mCSPC patients receive in the USA? Plain Language Summary of Publication

How many patients were in each group?

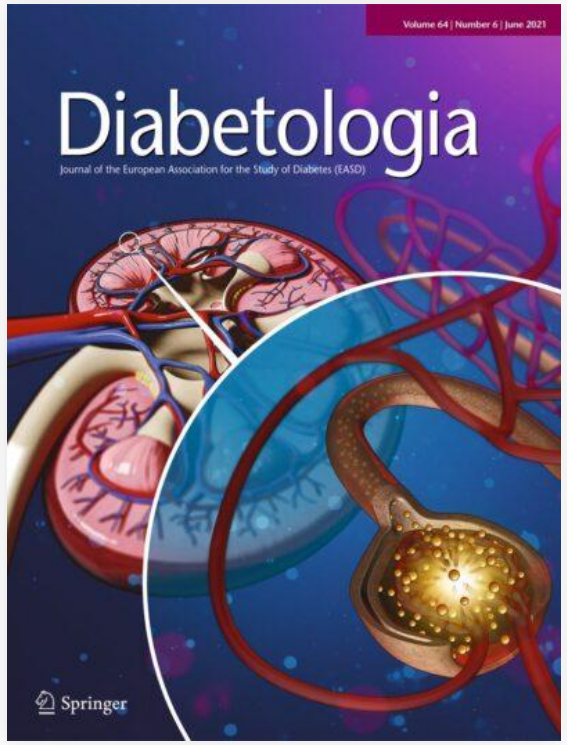
What were the characteristics of patients in this study?


Does race or income affect the treatments that mCSPC patients receive in the USA? Plain Language Summary of Publication

Did race and other factors affect how long patients with mCSPC lived?

What are the key takeaways from this study?

Journal front cover and graphical abstract to accompany a high-profile manuscript



Diabetologia (2021) 64:1256–1267
https://doi.org/10.1007/s00125-021-05407-5

ARTICLE

Effects of ertugliflozin on kidney composite outcomes, renal function and albuminuria in patients with type 2 diabetes mellitus: an analysis from the randomised VERTIS CV trial

David Z. I. Cherney[1] · Bernard Charbonnel[2] · Francesco Cosentino[3] · Samuel Dagogo-Jack[4] · Darren K. McGuire[5,6] · Richard Pratley[7] · Weichung J. Shih[8,9] · Robert Frederich[10] · Mario Maldonado[11] · Annpey Pong[12] · Christopher P. Cannon[13] · on behalf of the VERTIS CV Investigators

Received: 25 August 2020 / Accepted: 11 December 2020 / Published online: 4 March 2021

Research in context

What is already known about this subject?

- Sodium–glucose cotransporter 2 (SGLT2) inhibitors have demonstrated reductions in atherosclerotic CVD, hospitalisation for heart failure and diabetic kidney disease risk in individuals with type 2 diabetes mellitus
- In the VERTIS CV trial, the HR (95% CI) with ertugliflozin compared with placebo in the secondary kidney composite endpoint (doubling of serum creatinine, kidney dialysis/transplant or renal death) was 0.81 (0.63, 1.04)

What is the key question?

- What is the impact of the SGLT2 inhibitor ertugliflozin on the following endpoints: (1) a pre-specified exploratory kidney composite endpoint from VERTIS CV comprising sustained 40% decline in eGFR, renal replacement therapy or death; (2) eGFR and albuminuria over time; and (3) kidney-related variables?

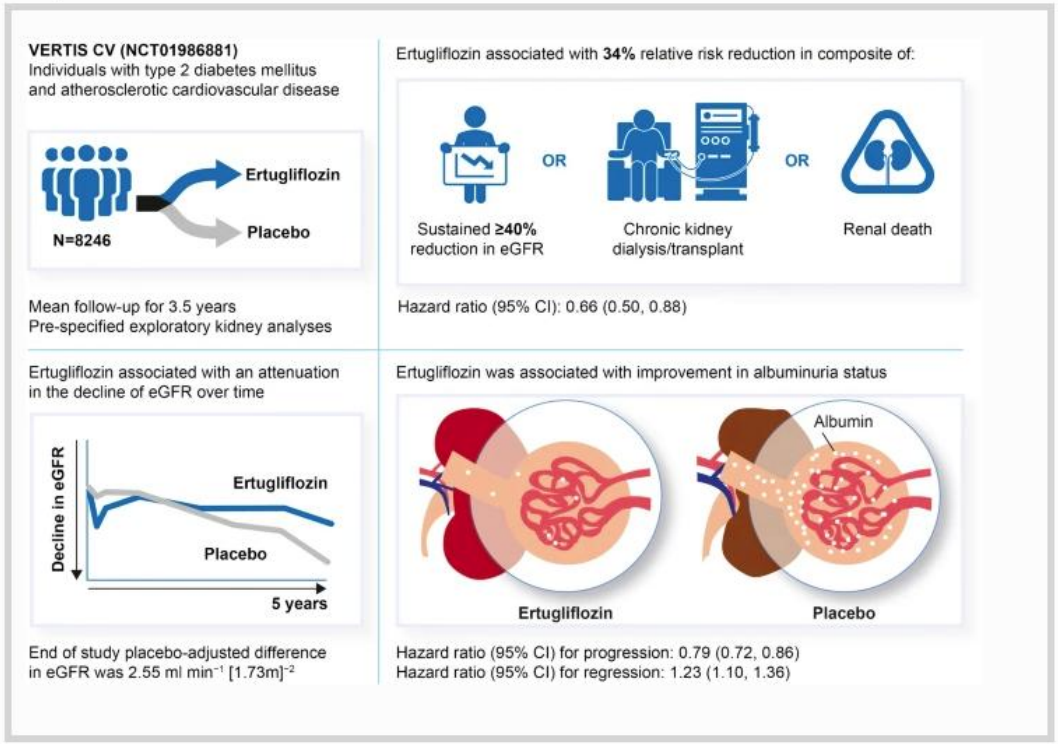
What are the new findings?

- The HR (95% CI) for ertugliflozin vs placebo for the risk of the pre-specified exploratory composite endpoint (sustained 40% decline in eGFR, chronic kidney dialysis/transplant or renal death) was 0.66 (0.50, 0.88)
- Ertugliflozin reduced albuminuria in individuals with micro- or macroalbuminuria at baseline, and attenuated the progression of eGFR decline

How might this impact on clinical practice in the foreseeable future?

- The totality of the data available for SGLT2 inhibitors, including ertugliflozin, emphasises that treatment with these agents in type 2 diabetes is effective in reducing the risk for composite outcomes reflecting incidence and progression of diabetic kidney disease, attenuating incidence and progression of albuminuria and having no deleterious effect on the incidence of acute kidney injury

Graphical abstract



Results

- **78** tweeters
- **26** Mendeley
- **2** news outlets

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https://link.springer.com/article/10.1007/s00125-021-05407-5

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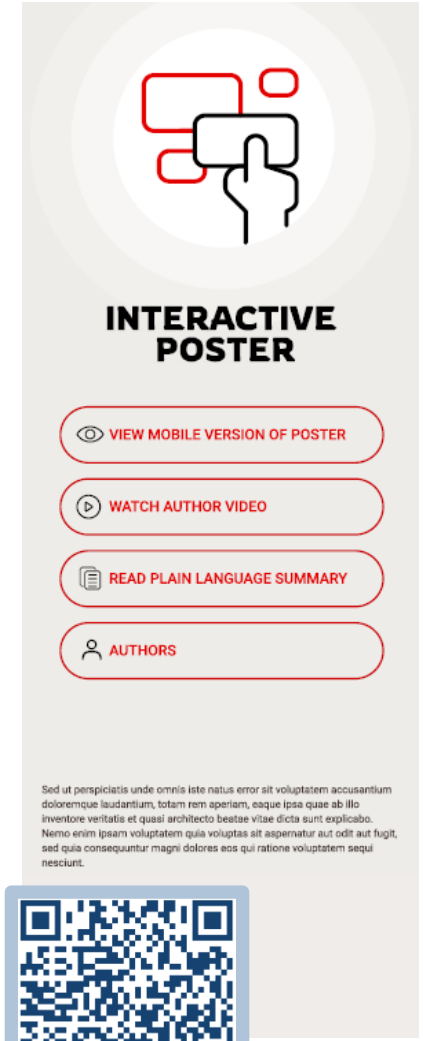

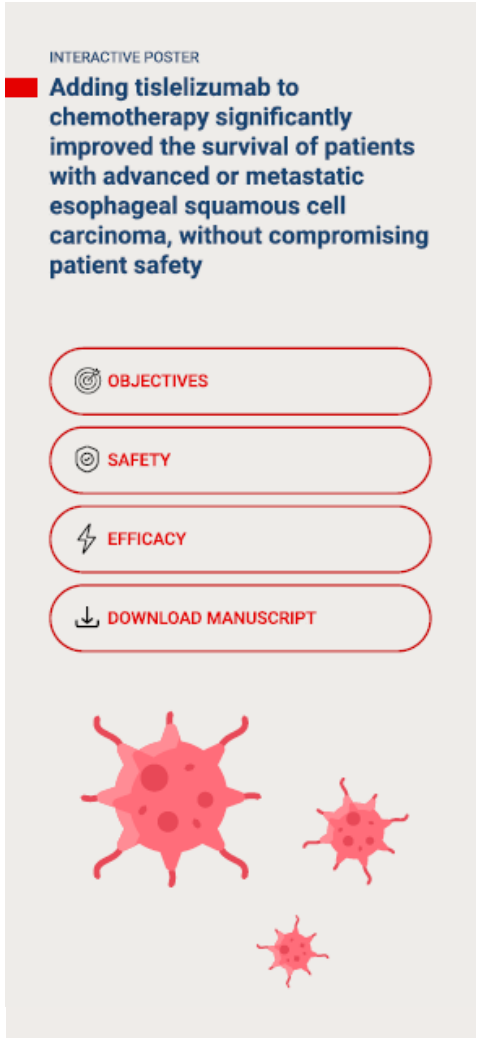

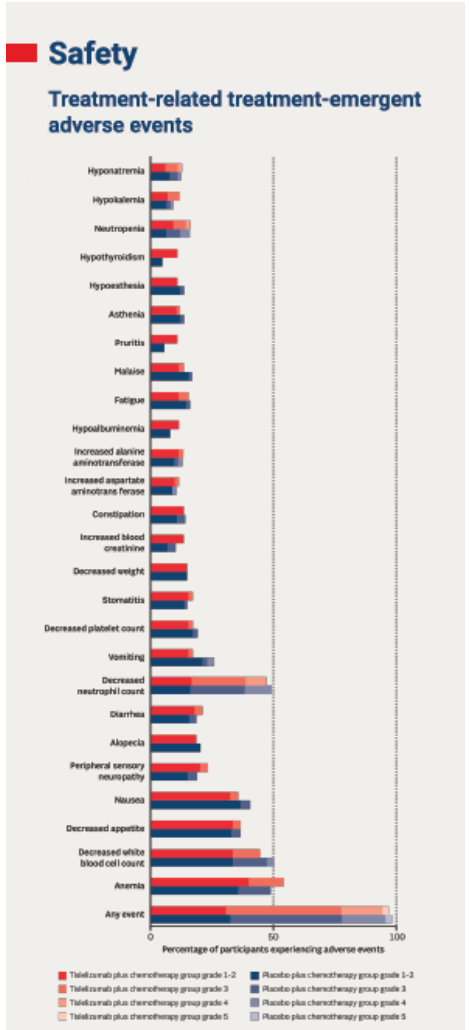

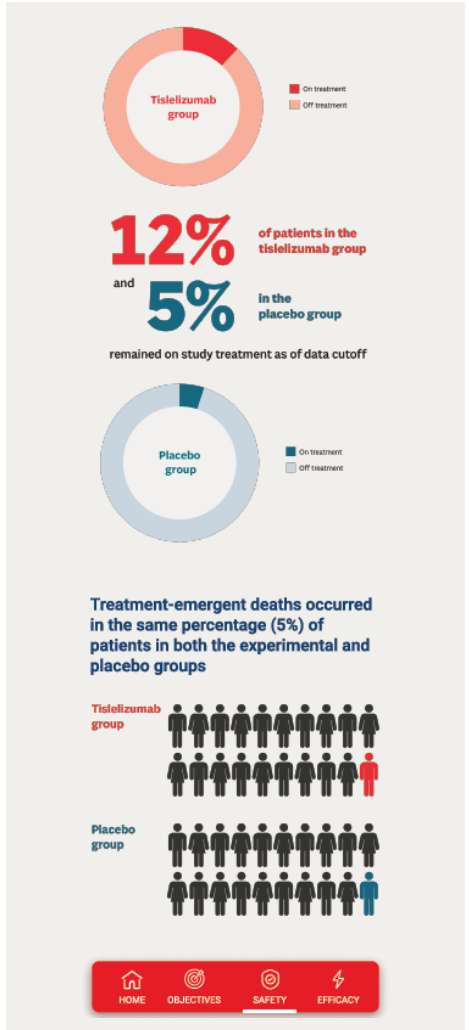

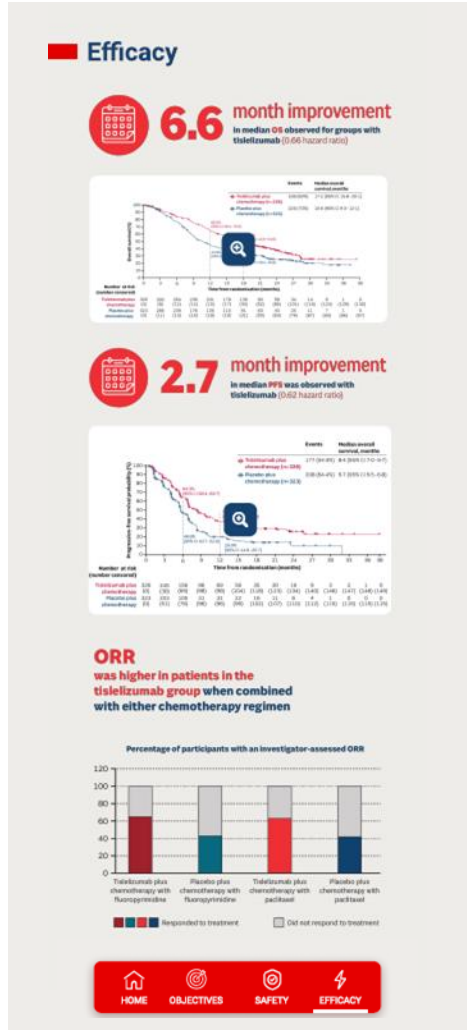

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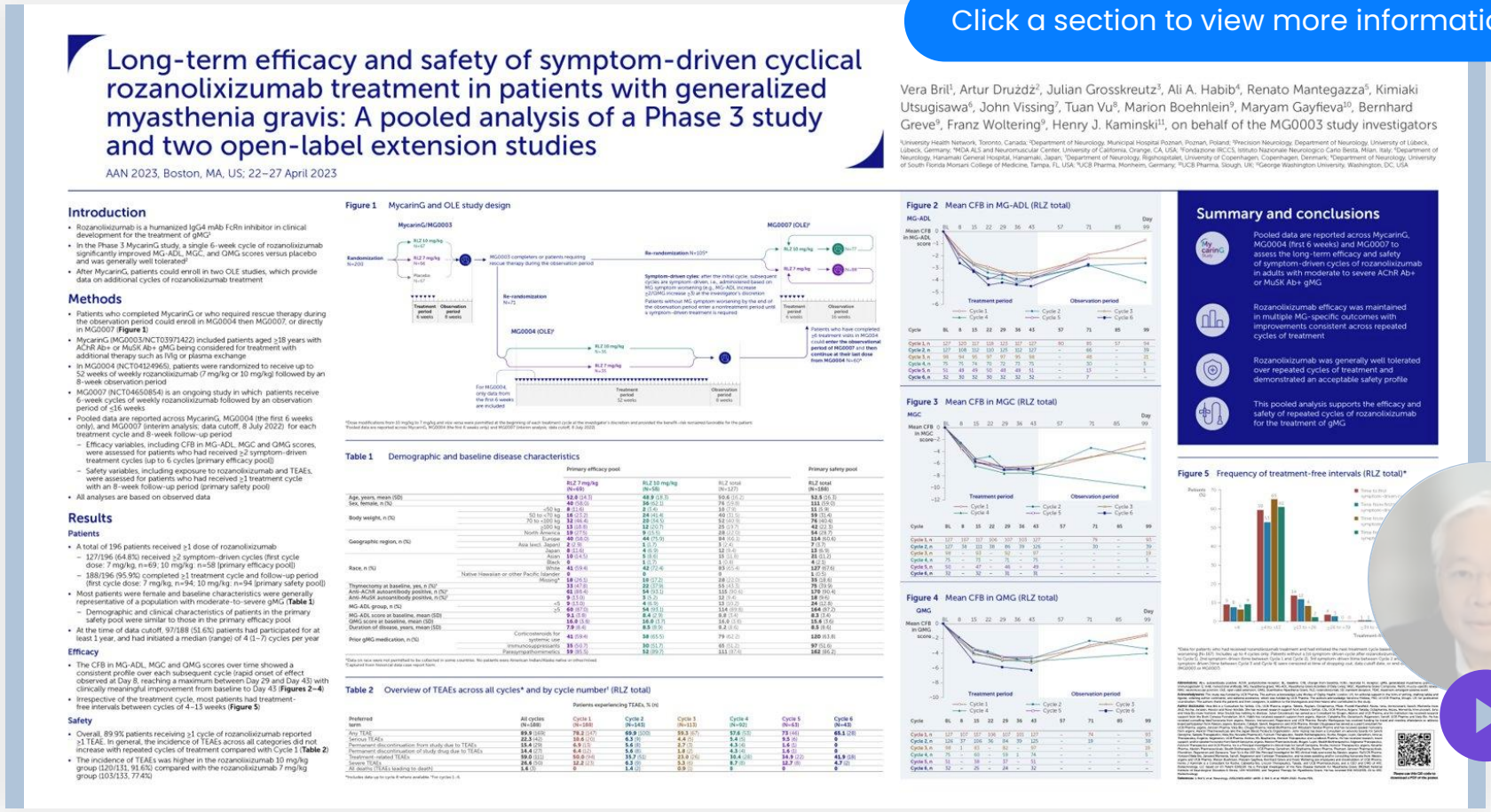


Long-term efficacy and safety of symptom-driven cyclical rozanolixizumab treatment in patients with generalized myasthenia gravis: A pooled analysis of a Phase 3 study and two open-label extension studies

AAN 2023, Boston, MA, US; 22–27 April 2023

Vera Bril[1], Artur Drużdż[2], Julian Grosskreutz[3], Ali A. Habib[4], Renato Mantegazza[5], Kimiaki Utsugisawa[6], John Vissing[7], Tuan Vu[8], Marion Boehnlein[9], Maryam Gayfieva[10], Bernhard Greve[9], Franz Woltering[9], Henry J. Kaminski[11], on behalf of the MG0003 study investigators

Introduction

Methods

Results

Patients

Efficacy

Safety

Figure 1 MycarinG and OLE study design

Figure 2 Mean CFB in MG-ADL (RLZ total)

Figure 3 Mean CFB in MGC (RLZ total)

Figure 4 Mean CFB in QMG (RLZ total)

Figure 5 Frequency of treatment-free intervals (RLZ total)*

Table 1 Demographic and baseline disease characteristics

Table 2 Overview of TEAEs across all cycles* and by cycle number† (RLZ total)

Summary and conclusions

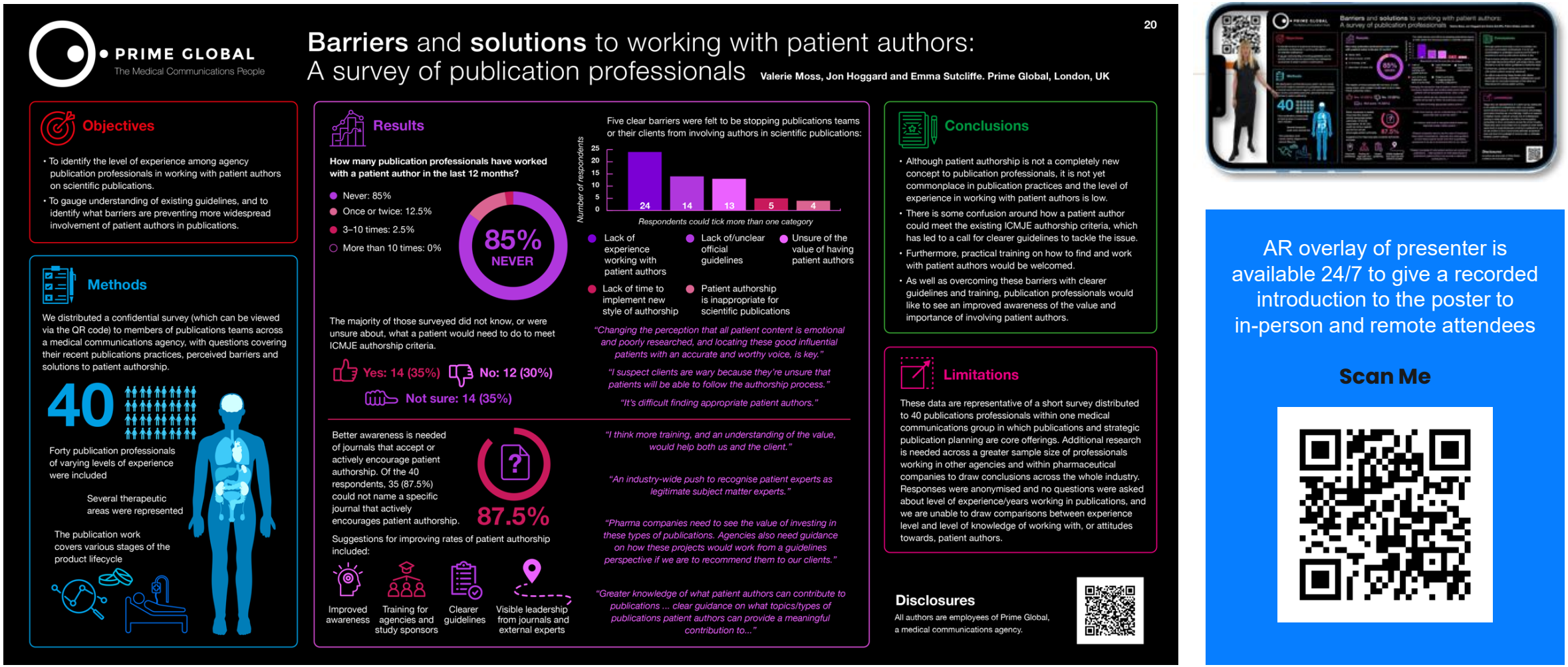
Pooled data are reported across MycarinG, MG0004 (first 6 weeks) and MG0007 to assess the long-term efficacy and safety of symptom-driven cycles of rozanolixizumab in adults with moderate to severe AChR Ab+ or MuSK Ab+ gMG

Rozanolixizumab efficacy was maintained in multiple MG-specific outcomes with improvements consistent across repeated cycles of treatment

Rozanolixizumab was generally well tolerated over repeated cycles of treatment and demonstrated an acceptable safety profile

This pooled analysis supports the efficacy and safety of repeated cycles of rozanolixizumab for the treatment of gMG

Using avatars to extend the life and reach of poster data



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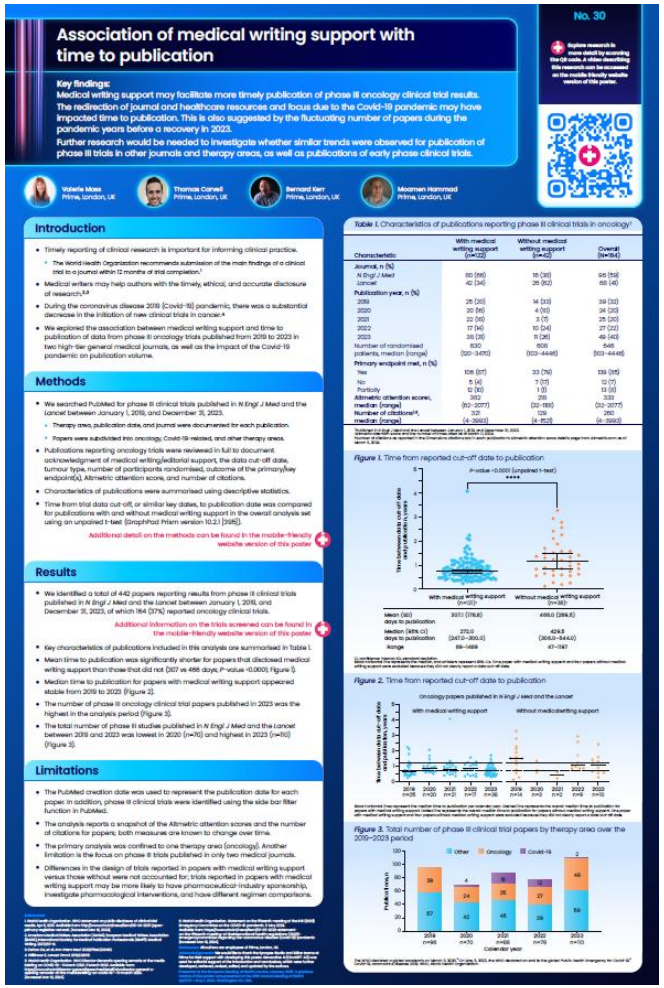

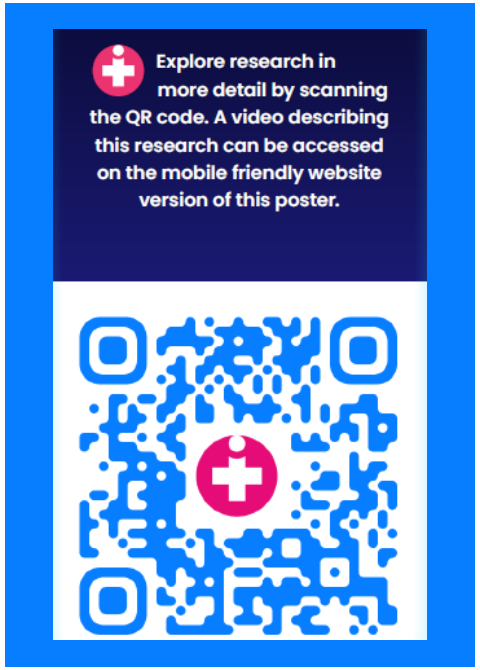

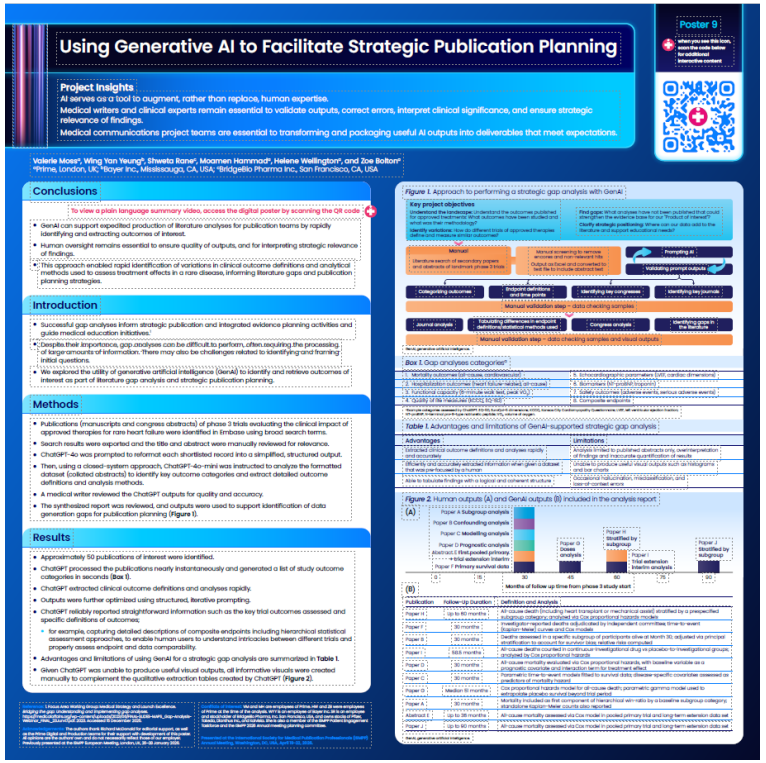

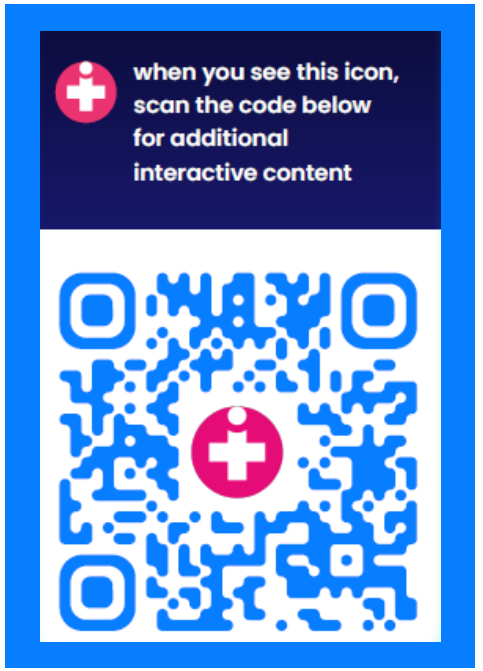

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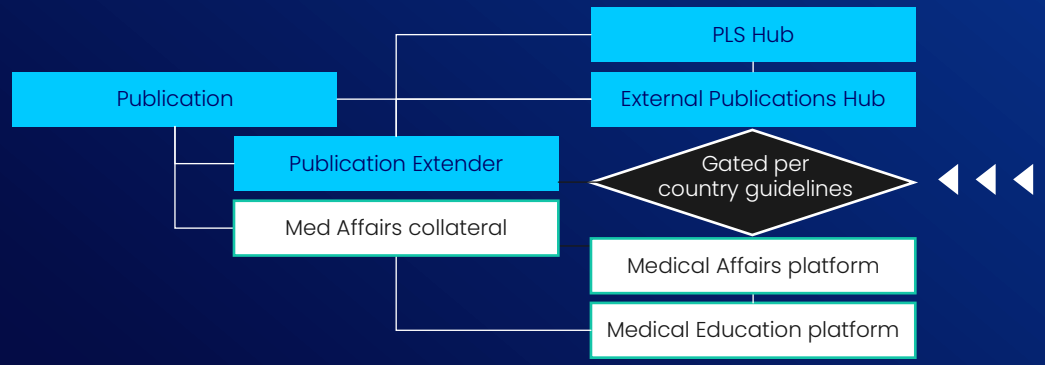

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Thank you!

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