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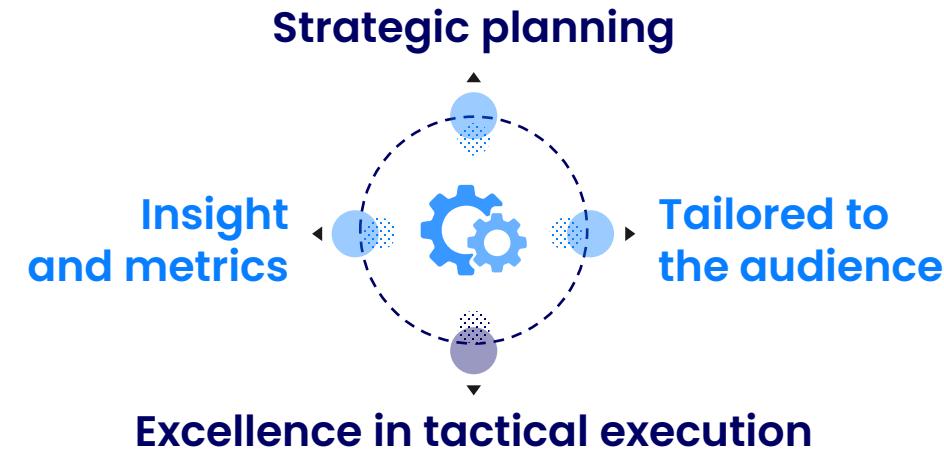
Global integrated **medical communications strategy** using an omnichannel approach

Scientific communication platform and lexicon

Strategic publication planning by asset and cross-portfolio

Multichannel **regional/affiliate engagement planning**

- Stakeholder mapping
- Literature and gap analysis
- Industry analytics
- Competitor intelligence
- KPI assessment



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- Patients
- Field medical
- Payers
- Policy makers
- Investors

Live events

- Symposia
- Strategic workshops
- Advisory boards
- Roundtables
- Webinars

Content generation

- Publications
- Enhancers/extenders
- Consensus, SLRs and reviews
- Podcasts, videos, animations
- MILs/SDRs
- Websites and portals

Patient engagement/advocacy

- Patient-centric publications
- Digital platforms
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- Plain language materials
- Interactive educational tools

Internal materials

- e-learning materials/platform
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Integrated evidence planning and Patient strategy

Interactive digital posters

Adding tislelizumab to chemotherapy significantly improved the survival of patients with advanced or metastatic esophageal squamous cell carcinoma, without compromising patient safety

Lead Presenter: Jane Doe¹; **Authors:** Gregory House¹, Allison Cameron¹, Lisa Cuddy¹, James Wilson¹, Eric Foreman¹, Robert Chase¹, Chris Taub¹, Lawrence Kutner¹, Chi Park¹, Amber Volakis¹, Stacy Warner¹, and Edward Vogler¹; **Affiliation:** 1. Princeton Plainsboro Hospital.

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Abstract #123

Safety

Treatment-related treatment-emergent adverse events

Adverse Event	Tislelizumab group (%)	Placebo group (%)
Hypotension	~15	~5
Hypokalemia	~10	~5
Neutropenia	~10	~5
Hypothyroidism	~10	~5
Hypothroidism	~5	~5
Asthenia	~5	~5
Pneumitis	~5	~5
Malaise	~5	~5
Fatigue	~5	~5
Hypoalbuminemia	~5	~5
Increased alanine aminotransferase	~5	~5
Increased aspartate aminotransferase	~5	~5
Constipation	~5	~5
Increased blood creatinine	~5	~5
Decreased weight	~5	~5
Stomatitis	~5	~5
Decreased platelet count	~5	~5
Vomiting	~5	~5
Decreased neutrophil count	~5	~5
Diarrhea	~5	~5
Alopecia	~5	~5
Peripheral sensory neuropathy	~5	~5
Nausea	~5	~5
Decreased appetite	~5	~5
Decreased white blood cell count	~5	~5
Anemia	~5	~5
Any event	~5	~5

12% and 5% of patients in the tislelizumab group remained on study treatment as of data cutoff

Placebo group

Events Median overall survival, months: Tislelizumab plus chemotherapy (166 (60% CI 138-202)) vs Placebo plus chemotherapy (226 (70% CI 193-121)).

Efficacy

6.6 month improvement in median OS observed for groups with tislelizumab (0.66 hazard ratio)

Events Median overall survival, months: Tislelizumab plus chemotherapy (166 (60% CI 138-202)) vs Placebo plus chemotherapy (226 (70% CI 193-121)).

2.7 month improvement in median PFS was observed with tislelizumab (0.60 hazard ratio)

Events Median PFS, months: Tislelizumab plus chemotherapy (177 (54-318)) vs Placebo plus chemotherapy (208 (64-415)).

ORR was higher in patients in the tislelizumab group when combined with either chemotherapy regimen

Percentage of patients with an investigator-assessed ORR

Regimen	Response	Percentage of patients
Tislelizumab plus chemotherapy	Response	~70
Tislelizumab plus chemotherapy	Not responded	~30
Placebo plus chemotherapy	Response	~60
Placebo plus chemotherapy	Not responded	~40
Tislelizumab plus chemotherapy with paclitaxel	Response	~70
Tislelizumab plus chemotherapy with paclitaxel	Not responded	~30
Placebo plus chemotherapy with paclitaxel	Response	~60
Placebo plus chemotherapy with paclitaxel	Not responded	~40

Interactive poster

Safety

12% and 5% of patients in the tislelizumab group remained on study treatment as of data cutoff

Efficacy

6.6 month improvement in median OS observed for groups with tislelizumab (0.66 hazard ratio)

2.7 month improvement in median PFS was observed with tislelizumab (0.60 hazard ratio)

Events

ORR was higher in patients in the tislelizumab group when combined with either chemotherapy regimen

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Association of medical writing support with time to publication

Key findings:
 Medical writing support may facilitate more timely publication of phase II oncology clinical trial results. The redirection of journal and healthcare resources and focus due to the Covid-19 pandemic may have impacted time to publication. This is also suggested by the fluctuating number of papers during the pandemic years before a recovery in 2023.

Further research would be needed to investigate whether similar trends were observed for publication of phase III trials in other journals and therapy areas, as well as publications of early phase clinical trials.

Introduction

- Timely reporting of clinical research is important for informing clinical practice.
- The World Health Organization recommends submission of the main findings of a clinical trial to a journal within 12 months of initial completion.¹
- Medical writers may help authors with the timely, efficient, and accurate disclosure of research findings.
- During the coronavirus disease 2019 (Covid-19) pandemic, there was a substantial decrease in the initiation of new clinical trials in cancer.²
- We explored the association between medical writing support and time to publication of phase II oncology clinical trials published in 2019 to 2023 in two high-tier general medical journals, as well as the impact of the Covid-19 pandemic on publication volume.

Methods

- We searched for published phase II clinical trials published in *N Engl J Med* and the *Journal of Clinical Oncology* between January 1, 2019, and December 31, 2023.
- Therapy, publication date, and journal were documented for each publication.
- Papers were subcategorized into oncology, Covid-19-related, and other therapy areas.
- Information on medical writing support was collected from the journal submission acknowledgement of medical writing support, the data cut-off date, study type, number of participants randomized, outcome of the primary/secondary endpoint, and the number of citations.
- Characteristics of publications were summarized using descriptive statistics.
- Time from trial data cut-off, or similar key date, to publication date was compared for publications with and without medical writing support in the overall analysis set, using an unpaired *t*-test (GraphPad Prism version 8.0.2 [2018]).

Additional detail on the methods can be found in the mobile-friendly version of this poster 

Results

- We identified a total of 442 papers reporting results from phase II clinical trials published in *N Engl J Med* and the *Journal of Clinical Oncology* between January 1, 2019, and December 31, 2023, of which 164 (37%) reported oncology clinical trials.
- Additional information on the trials screened can be found in the mobile-friendly version of this poster 
- Key characteristics of publications included in the analysis are summarized in Table 1.
- Mean time to publication was significantly shorter for papers that disclosed medical writing support than those that did not (307 ± 496 days; P -value <0.0001 ; Figure 1).
- Median time to publication for papers with medical writing support appeared earlier from 2019 to 2023 (Figure 2).
- Median time to publication for oncology clinical trials papers published in 2023 was the highest in the analysis period (Figure 3).
- The total number of phase II trials published in *N Engl J Med* and the *Journal of Clinical Oncology* between 2019 and 2023 was lowest in 2020 ($n=10$) and highest in 2023 ($n=10$) (Figure 4).

Limitations

- The published creation date was used to represent the publication date for each paper, as this was the closest date when trials were identified using the side bar filter function in PubMed.
- The analysis reports a snapshot of the Alternative publication score and the number of citations for papers published in 2023, which may change over time.
- The primary analysis was confined to one therapy area (oncology). Another limitation is the focus on phase II trials published in only two medical journals.
- Differences in the design of trials reported in papers with medical writing support versus those without were not explored. For trials reported in papers with medical writing support, it is not clear how to have a more informed comparison, as some publications investigate pharmacogenomic interventions, and how different regimen comparisons, investigate pharmacogenomic interventions, and how different regimen comparisons.

Table 1. Characteristics of publications reporting phase II clinical trials in oncology

Characteristic	With medical writing support ($n=222$)	Without medical writing support ($n=219$)	Overall ($n=441$)
Journal, <i>n</i> (%)	161 (59) 40 (18)	15 (13) 26 (12)	161 (59) 66 (15)
Publication year, <i>n</i> (%)	2019 (25) 2020 (22) 2021 (17) 2022 (14) 2023 (10)	14 (13) 4 (2) 3 (2) 10 (24) (20-34)	2019 (25) 2020 (22) 2021 (17) 2022 (14) 2023 (10)
Number of randomized patients, <i>mean</i> (range)	300 (20-1000)	600 (30-4446)	600 (30-4446)
Percent accepted, <i>n</i> (%)	108 (51) 77 (35)	33 (26) 7 (3)	108 (51) 8 (4)
Alternative publication score, <i>mean</i> (range)	(20-100) (20-34)	(20-100) (20-34)	(20-100) (20-34)
Number of citations, <i>mean</i> (range)	301 (4-20) (4-20)	108 (4-20) (4-20)	260 (4-20) (4-20)

Figure 1. Time from reported cut-off date to publication

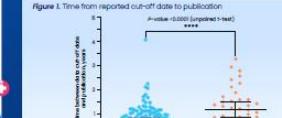
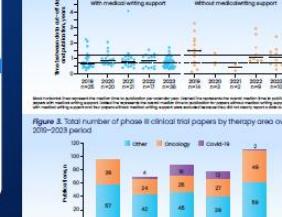
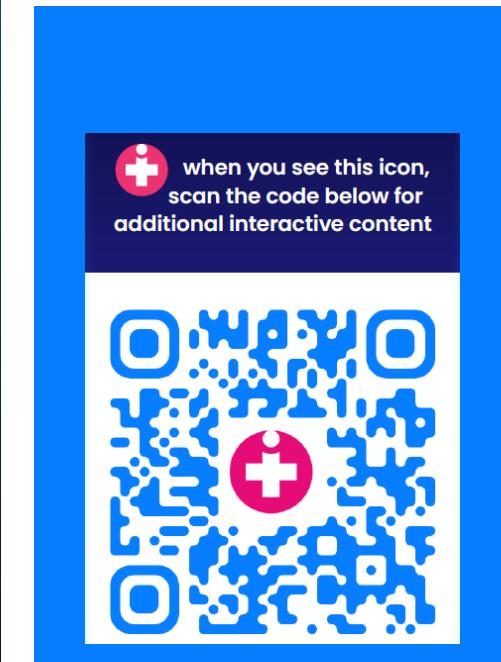
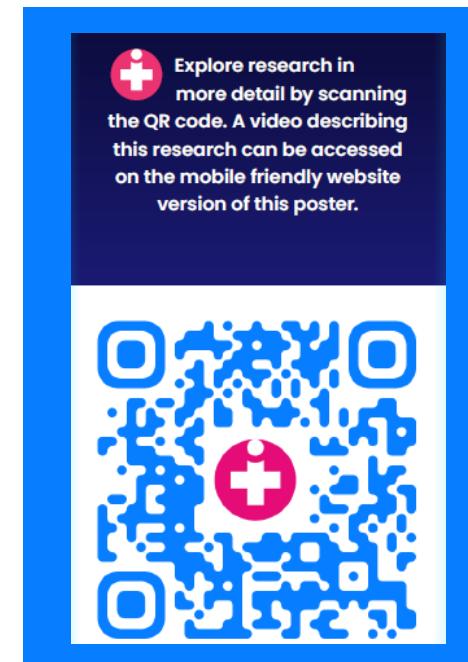


Figure 2. Time from reported cut-off date to publication



Figure 3. Total number of phase II clinical trial papers by therapy area over the 2019-2023 period





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Barriers and solutions to working with patient authors: A survey of publication professionals

Valerie Moss, Jon Hoggard and Emma Sutcliffe. Prime Global, London, UK

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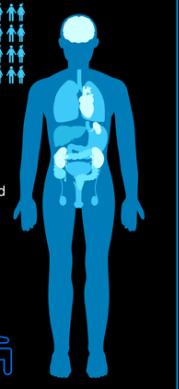
Objectives

- To identify the level of experience among agency publication professionals in working with patient authors on scientific publications.
- To gauge understanding of existing guidelines, and to identify what barriers are preventing more widespread involvement of patient authors in publications.

Methods

We distributed a confidential survey (which can be viewed via the QR code) to members of publications teams across a medical communications agency, with questions covering their recent publications practices, perceived barriers and solutions to patient authorship.

40



Forty publication professionals of varying levels of experience were included

Several therapeutic areas were represented

The publication work covers various stages of the product lifecycle



Results

How many publication professionals have worked with a patient author in the last 12 months?



Frequency	Percentage
Never	85%
Once or twice	12.5%
3-10 times	2.5%
More than 10 times	0%

The majority of those surveyed did not know, or were unsure about, what a patient would need to do to meet ICMJE authorship criteria.

Yes: 14 (35%) **No: 12 (30%)**

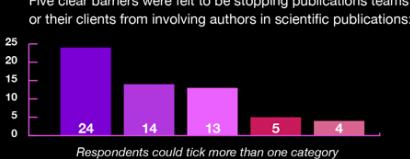
Not sure: 14 (35%)

Better awareness is needed of journals that accept or actively encourage patient authorship. Of the 40 respondents, 35 (87.5%) could not name a specific journal that actively encourages patient authorship.

Suggestions for improving rates of patient authorship included:

- Improved awareness
- Training for agencies and study sponsors
- Clearer guidelines
- Visible leadership from journals and external experts

Five clear barriers were felt to be stopping publications teams or their clients from involving authors in scientific publications:



Barrier	Number of respondents
Lack of experience working with patient authors	24
Lack of/unclear official guidelines	14
Unsure of the value of having patient authors	13
Patient authorship is inappropriate for scientific publications	5
Lack of time to implement new style of authorship	4

Changing the perception that all patient content is emotional and poorly researched, and locating these good influential patients with an accurate and worthy voice, is key.

"I suspect clients are wary because they're unsure that patients will be able to follow the authorship process."

"It's difficult finding appropriate patient authors."

"I think more training, and an understanding of the value, would help both us and the client."

"An industry-wide push to recognise patient experts as legitimate subject matter experts."

"Pharma companies need to see the value of investing in these types of publications. Agencies also need guidance on how these projects would work from a guidelines perspective if we are to recommend them to our clients."

"Greater knowledge of what patient authors can contribute to publications ... clear guidance on what topics/types of publications patient authors can provide a meaningful contribution to..."

Conclusions

- Although patient authorship is not a completely new concept to publication professionals, it is not yet commonplace in publication practices and the level of experience in working with patient authors is low.
- There is some confusion around how a patient author could meet the existing ICMJE authorship criteria, which has led to a call for clearer guidelines to tackle the issue.
- Furthermore, practical training on how to find and work with patient authors would be welcomed.
- As well as overcoming these barriers with clearer guidelines and training, publication professionals would like to see an improved awareness of the value and importance of involving patient authors.

Limitations

These data are representative of a short survey distributed to 40 publications professionals within one medical communications group in which publications and strategic publication planning are core offerings. Additional research is needed across a greater sample size of professionals working in other agencies and within pharmaceutical companies to draw conclusions across the whole industry. Responses were anonymised and no questions were asked about level of experience/years working in publications, and we are unable to draw comparisons between experience level and level of knowledge of working with, or attitudes towards, patient authors.

Disclosures

All authors are employees of Prime Global, a medical communications agency.





Banners and solutions to working with patient authors:
A survey of publication professionals

Valerie Moss, Jon Hoggard and Emma Sutcliffe. Prime Global, London, UK

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TYPE Review
PUBLISHED 04 January 2023
DOI 10.3389/fonc.2022.975473

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SPECIALTY SECTION
This article was submitted to
Thoracic Oncology,
a section of the journal
Frontiers in Oncology

RECEIVED: 22 June 2022
ACCEPTED: 23 September 2022
PUBLISHED: 04 January 2023

CITATION
Anadkat MJ, Lacouture M,
Friedman A, Horne ZD, Jung J,
Kaffenberger B, Kalmadi S,
Ovington L, Kotecha R, Abdullah HI
and Grosso F (2023) Expert guidance
on prophylaxis and treatment of
dermatologic adverse events with
Tumor Treating Fields (TTFields)
therapy in the thoracic region.
Front. Oncol. 12:975473.
doi: 10.3389/fonc.2022.975473

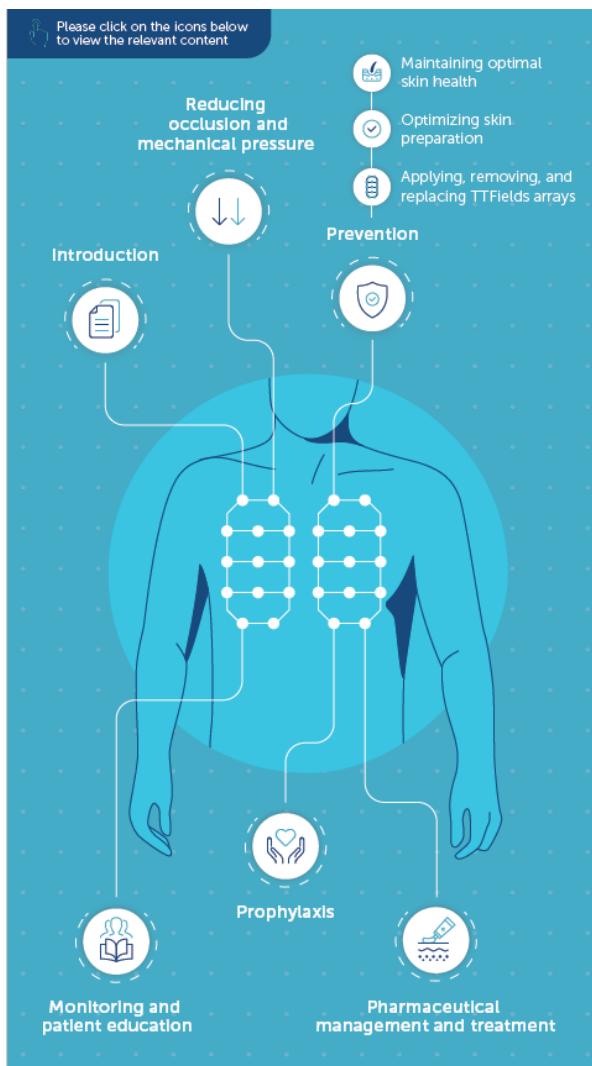
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**Expert guidance on prophylaxis
and treatment of dermatologic
adverse events with Tumor
Treating Fields (TTFields)
therapy in the thoracic region**

Milan J. Anadkat^{1†}, Mario Lacouture^{2†}, Adam Friedman³,
Zachary D. Horne⁴, Jae Jung⁵, Benjamin Kaffenberger⁶,
Sujith Kalmadi⁷, Liza Ovington⁸, Rupesh Kotecha⁹,
Huda Ismail Abdullah¹⁰ and Federica Grosso¹¹

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

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ARTICLE OPEN

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

Daniel J. George^{1,2}, Neeraj Agarwal³, Krishnan Ramaswamy⁴, Zachary Klaassen⁵, Rhonda L. Bitting^{6,7,8}, David Russell⁹, Rickard Sandin¹⁰, Birol Emir¹¹, Hongbo Yang⁷, Wei Song⁷, Yiliu Lin⁹, Agnes Hong^{12,9}, Wei Gao⁷ and Stephen J. Freedland^{10,11}

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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 Medicare 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 antiandrogen (NSAA) [14–21], despite guidelines recommending first-generation NSAA 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 [23–30], however, this has been explored during the NHT + ADT era, but not the NHT + ADT + docetaxel era, concerning because Black men are more likely to develop mCSPC.

What are the key takeaways from this study?

In this real-world study of patients with mCSPC, researchers found that:

• Few Black patients and White patients received combined treatment with ADT + NHT or ADT + docetaxel, even though it is recommended by guidelines to help patients with mCSPC live longer.

• Fewer Black patients received combined treatment than White patients. This was true for patients enrolled in Medicare and for patients enrolled in the VHA.

• Among patients enrolled in the VHA, there was no difference in how long Black patients and White patients lived.

• Medicaid patients who have a low income included a higher percentage of Black patients than Medicare patients.

• Patients with a lower income did not live as long as patients with a higher income. This was true for both Black patients and White patients.

• For patients with a lower income, there was no difference between Black patients and White patients in the treatment received or how long a patient lived.

• However, Black patients enrolled in Medicare who had Medicaid coverage received combined treatment than patients enrolled in Medicare alone.

• This might show that a low income can affect a patient's cancer care and how long they live, regardless of race.

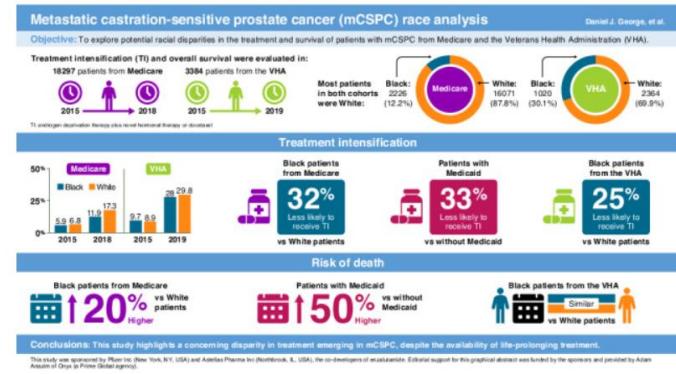
This research shows that both income status and race may be linked with the quality of care that patients with mCSPC receive in the United States. Work needs to be done to make sure that patients of all races and incomes receive the right treatments at the right time.

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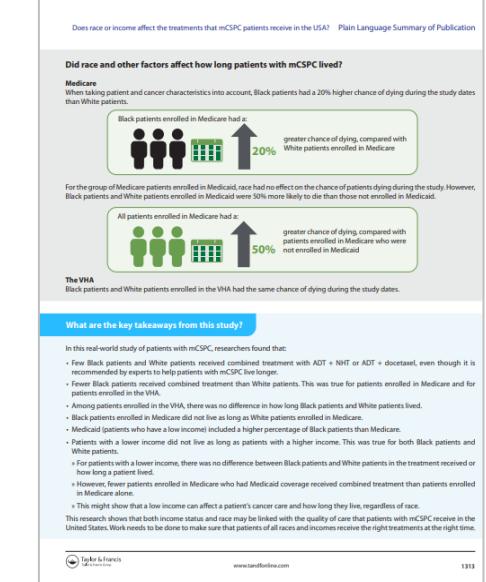
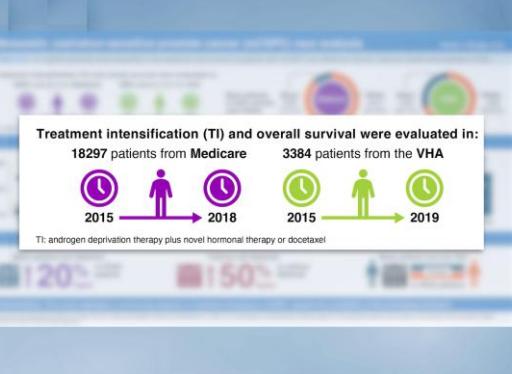
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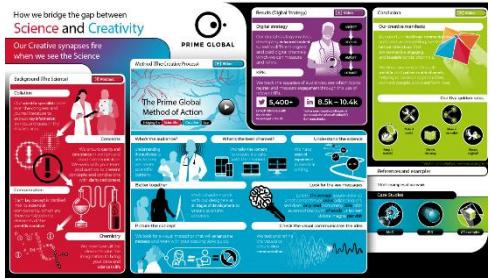


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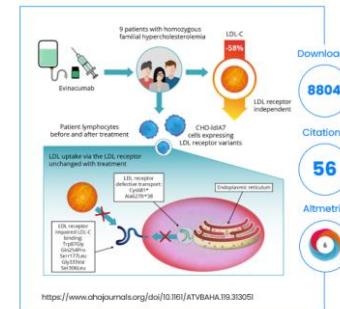


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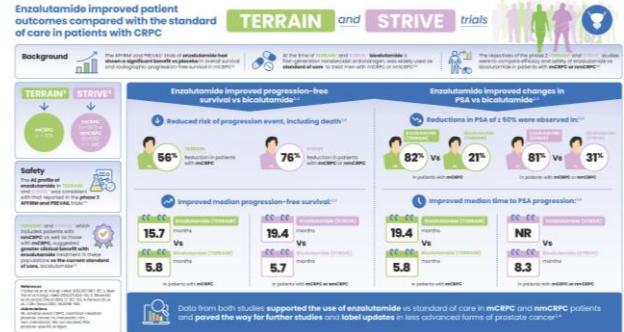
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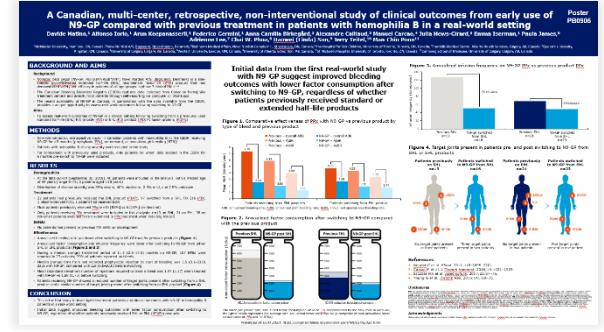
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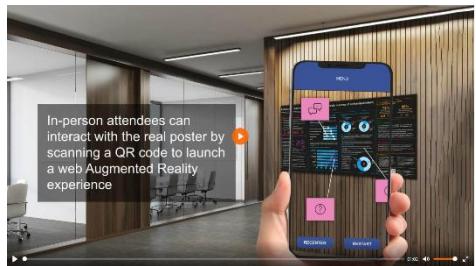
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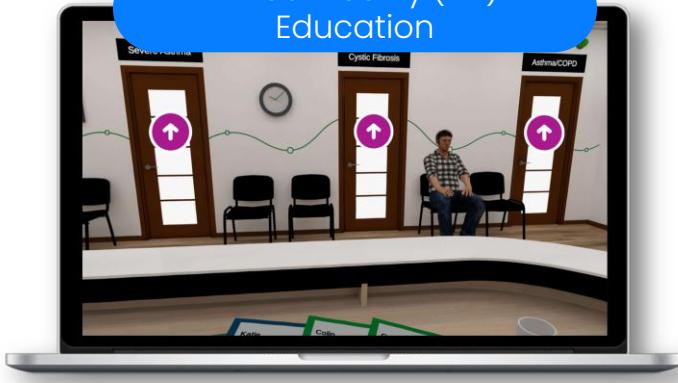


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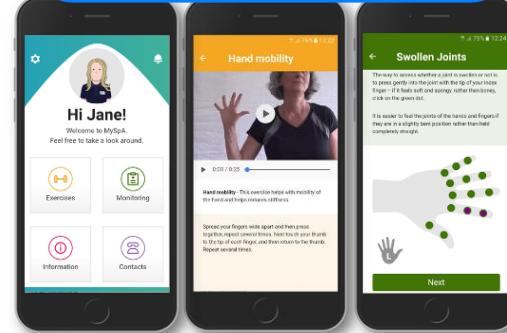
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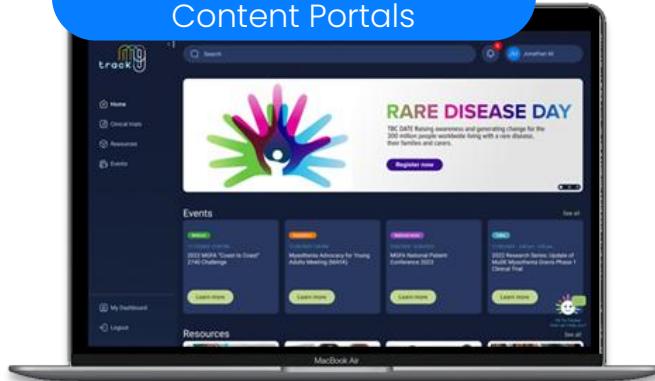
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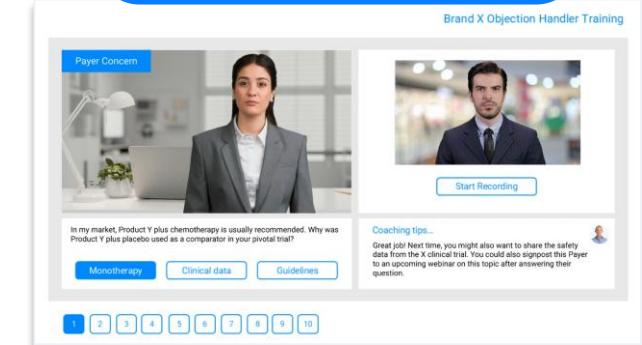
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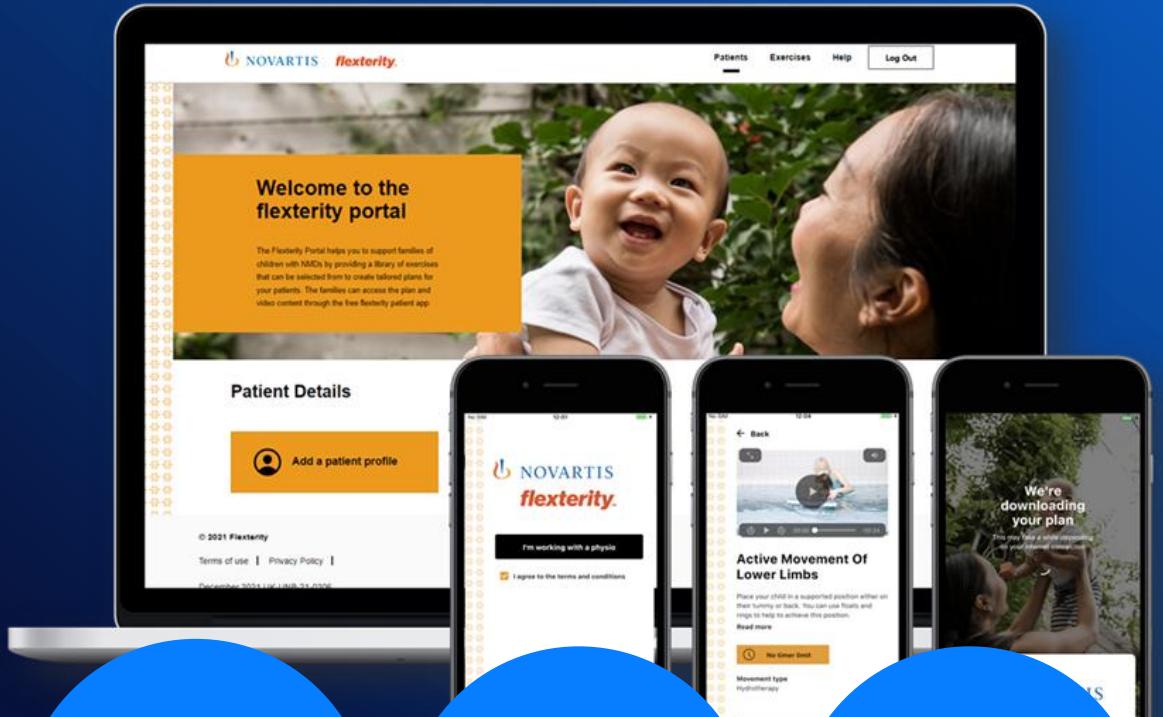
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Patient
Programs

"We are delighted that the Flexterity app has been so well received, and we would like to thank everyone who contributed to this ground-breaking project which helps to enable access to physiotherapy for children affected by NMD. The future is now looking brighter for those families, whose need for this app was a priority in the NMD community."

Client, VP and General Manager

DermaPro - Revolutionizing PASI assessments in psoriasis



176%
HCP users per year
vs target

316%
User sessions per
year vs target

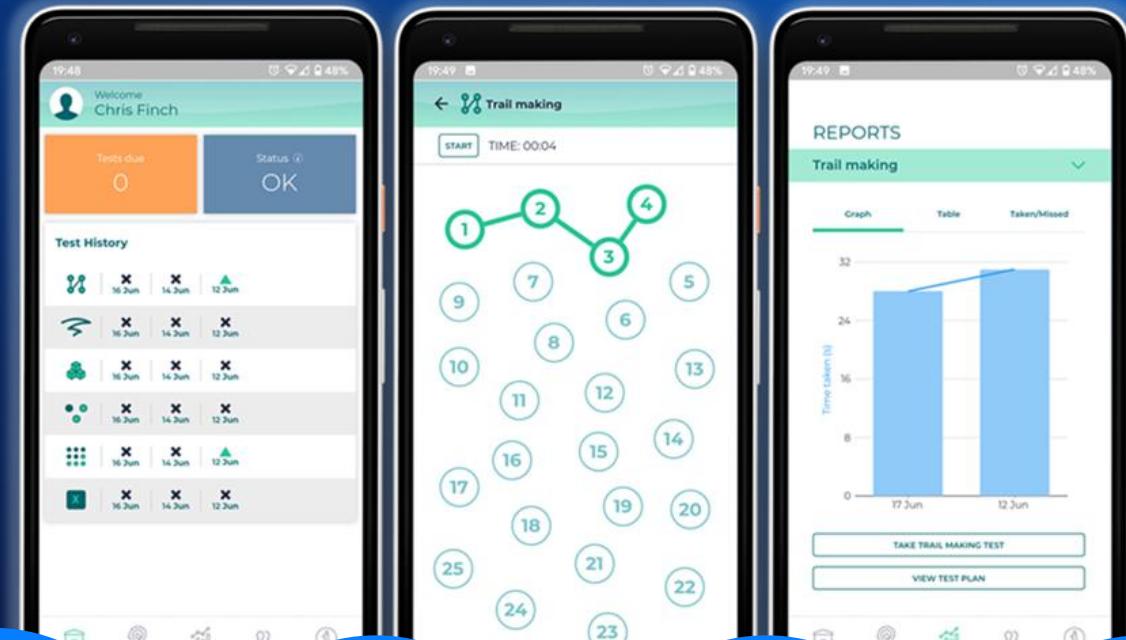
Gold
PM Society Digital
awards
HCP Education

Finalist
Communique
awards
Progress in
Healthcare and
Sci Comms

"DermaPro's user-friendly interface and design have proved to be a great resource for colleagues who do not use PASI scoring very often. Its ability to precisely color in affected areas gives more consistent and reliable results, which provides confidence when discussing treatment options with patients.

**Dr Thomas King – Consultant
Dermatologist, Sheffield
Teaching Hospitals NHS
Foundation Trust**

Brain function monitoring medical device for early detection of Hepatic Encephalopathy (HE)



7
Countries

5
Languages

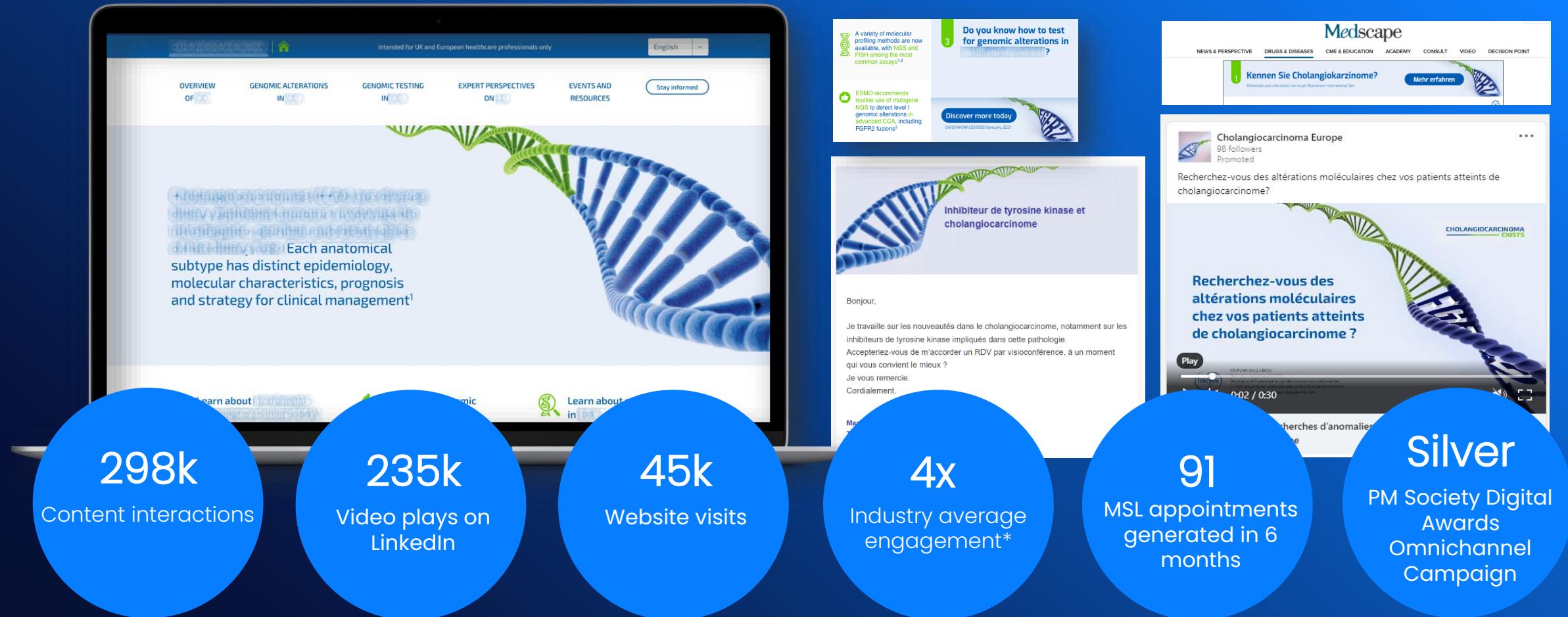
Gold
PM Society Digital awards
Patient Programs

Finalist
Commuque awards
Progress in
Healthcare and
Sci Comms

"This was our first software as a medical device. We chose Prime to be our partners because I know I can trust them to be honest and helpful throughout. We have a great relationship with the team that allows us to get things done efficiently as a true partnership."

Client - Head of Global Digital Centre of Excellence

Rare Oncology launch – European omnichannel campaign across multiple affiliates



*Benchmarks provided by Four Health Media



For more information contact:

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