Best Practices for High Impact Scholarly Presentations

Department of Anesthesiology & Perioperative Medicine

Faculty Development Series

11/22/2022

Keith M. Vogt, MD, PhD, FASA

University of Pittsburgh

How do I make my presentations awesome?

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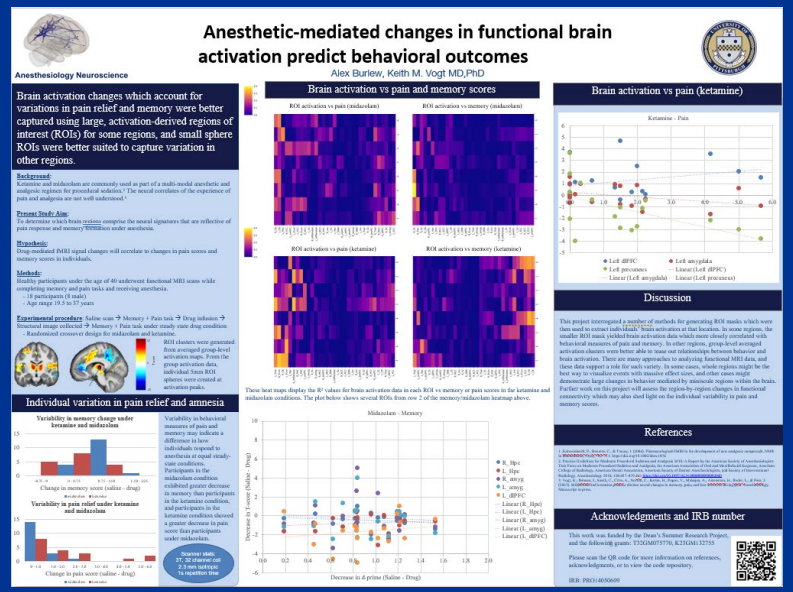
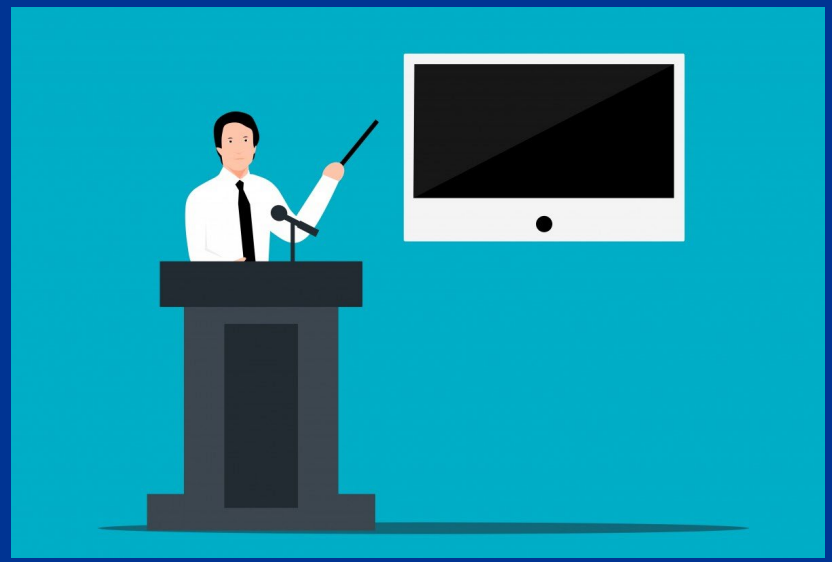
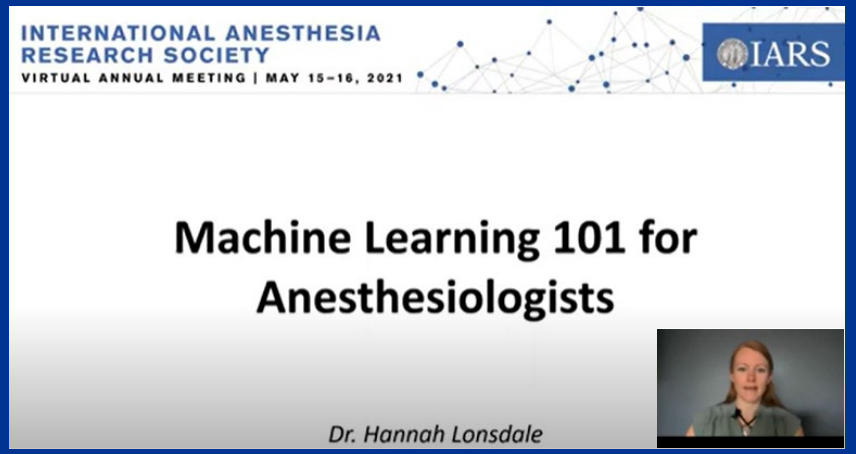
Goal: Share (my) recommendations for best practices when presenting at a professional meeting

Including….







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Poster Presentations

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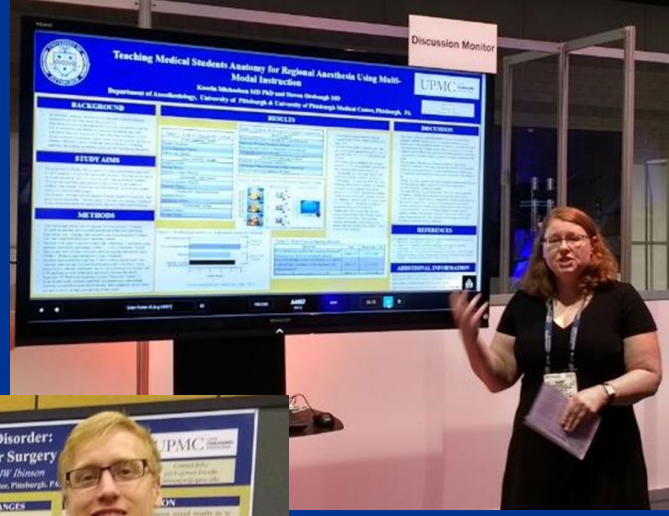
Poster Preparation Tips



- Create in PowerPoint
- Don’t waste space
- Focus on figures & tables
- Use bullet points
- Use large font
- **Highlight:** Summary & Key Points

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Poster templates are available (should be on SharePoint)

TITLE

AUTHORS

Affiliations

INTRODUCTION

This is where the introduction goes.

MAIN DIAGNOSES/INTERVENTIONS

- This is where main findings/interventions go

OUTCOME/SUMMARY

- This is where the summary goes.

CLINICAL FINDINGS

- This is where clinical findings go.

FIGURES/IMAGES

- This is where figures/images/tables go

REFERENCES

1.This is where the references go.

ACKNOWLEDGEMENTS

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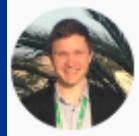
The #BetterPoster "movement" advocates for less content

#betterposter

How to create a better research poster in less time (including templates)

323,739 views • Mar 25, 2019

6.8K 145



Mike Morrison
1.43K subscribers

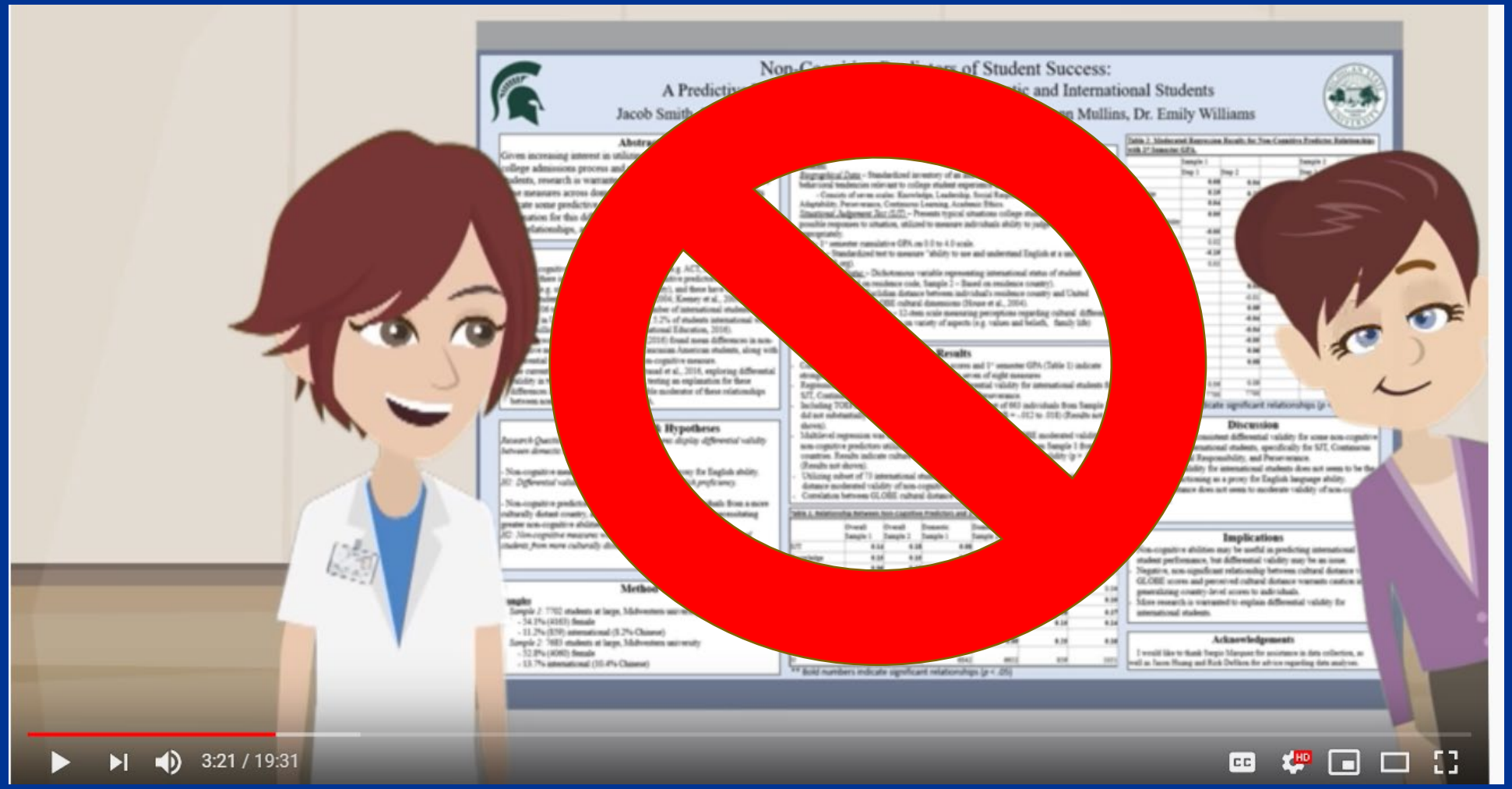
MICHIGAN STATE UNIVERSITY
Department of Psychology
College of Social Science

Template here: https://osf.io/ef53g/ | Examples on Twitter: https://twitter.com/mikemorrison

Every field in science uses the same, old, wall-of-text poster design. If we can improve the knowledge transfer efficiency of that design even by a little bit, it could have massive ripple effects on all of science.

Also, poster sessions tend to suck, so here's my pitch to make them more efficient AND more fun with a new approach to designing scientific posters/academic posters that is both more usable, and easier to create!

The #BetterPoster “movement” advocates for less content



https://www.youtube.com/watch?v=1RwJbhkCA58

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Non-Cognitive Predictors of Student Success: A Predictive Validity Comparison Between Domestic and International Students

Jacob Smith, Dr. Thea Schofield, Dr. Antonio Ibarra, Ianis Choi, Benn Mullins, Dr. Emily Williams

INTRO

- Increasing interest in utilizing non-cognitive predictors in the college admissions process
- Rising enrollment of international students

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- We compare the predictive validity of these measures across domestic and international students.
- Results indicate some predictive validity differences do exist and an explanation for this differential validity, as well as a moderator of these relationships, are tested.

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- Consistent differential validity for some non-cognitive measures for international students, specifically for SJT, Continuous Learning, Social Responsibility, and Perseverance.
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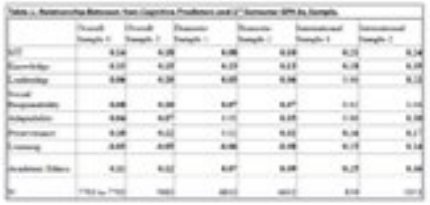
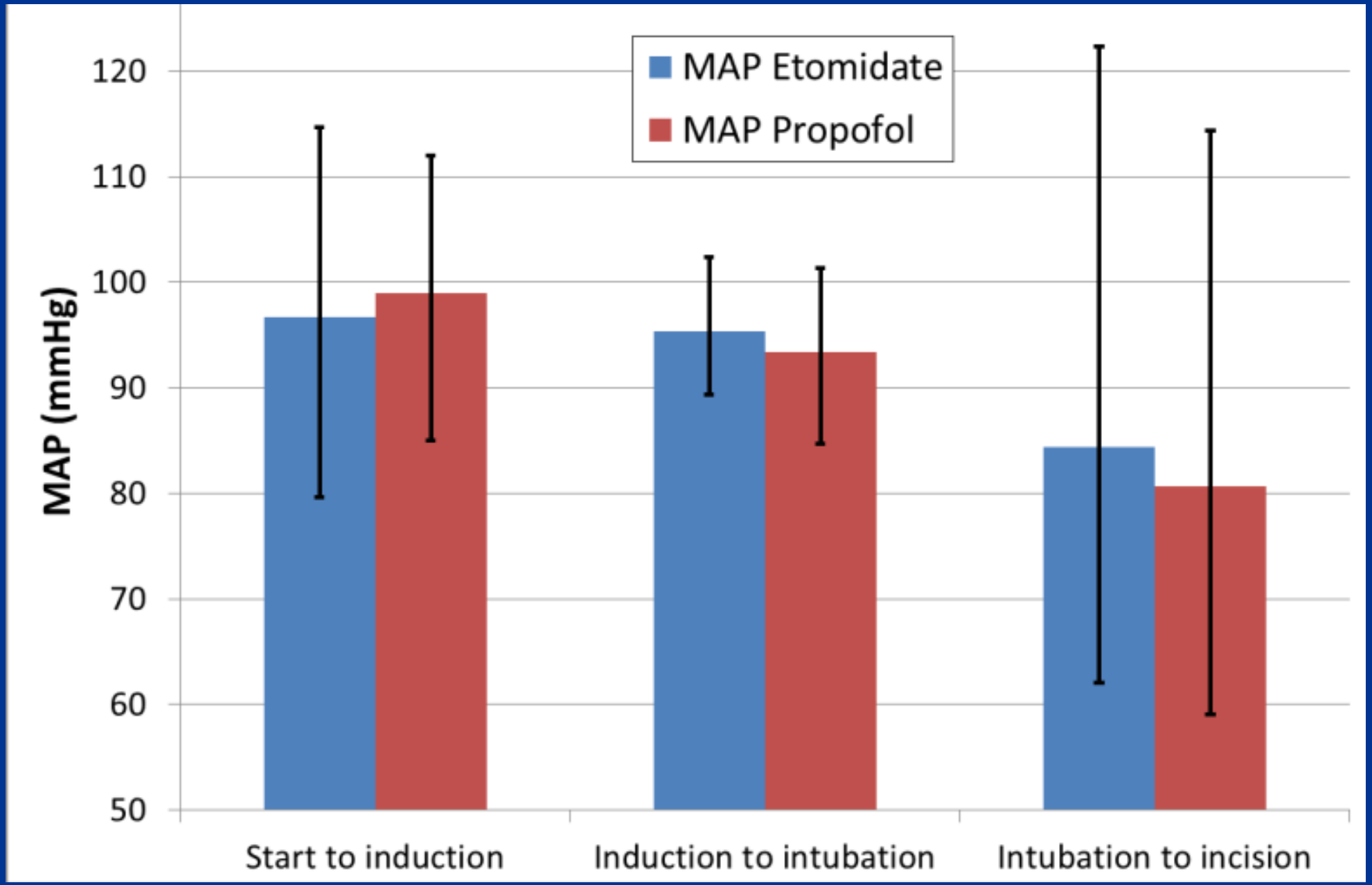


Table 5. Summary of Intraoperative Systolic and Diastolic Blood Pressure Between the Propensity-Matched Groups

Anesth Analg 2013;117:1329–37

	Systolic blood pressure				Diastolic blood pressure			
Time period	Etomidate (*N* = 2144)	Propofol (*N* = 5233)	STD[a]	*P*	Etomidate (*N* = 2144)	Propofol (*N* = 5233)	STD[a]	*P*
Start case to induction								
Average	142 ± 27	145 ± 25	−0.10	<0.001	74 ± 17	76 ± 15	−0.12	<0.001
Minimum	115 ± 37	123 ± 32	−0.23	<0.001	62 ± 16	66 ± 15	−0.26	<0.001
Maximum	164 ± 32	162 ± 29	0.06	0.02	90 ± 33	87 ± 23	0.12	<0.001
Induction to intubation								
Average	146 ± 31	138 ± 30	0.26	<0.001	70 ± 16	71 ± 16	−0.03	0.29
Minimum	136 ± 33	124 ± 36	0.34	<0.001	66 ± 16	65 ± 17	0.02	0.43
Maximum	155 ± 33	150 ± 32	0.14	<0.001	76 ± 22	77 ± 19	−0.02	0.42
Intubation to incision								
Average	127 ± 22	118 ± 20	0.47	<0.001	63 ± 12	62 ± 11	0.11	<0.001
Minimum	92 ± 24	83 ± 22	0.38	<0.001	47 ± 11	47 ± 11	0.06	0.02
Maximum	175 ± 34	161 ± 33	0.40	<0.001	96 ± 34	91 ± 32	0.15	<0.001
Incision to closing								
Average	123 ± 17	121 ± 16	0.12	<0.001	62 ± 10	63 ± 10	−0.14	<0.001
Minimum	89 ± 19	87 ± 17	0.12	<0.001	46 ± 10	47 ± 9	−0.09	0.001
Maximum	173 ± 35	168 ± 35	0.15	<0.001	110 ± 52	104 ± 47	0.11	<0.001
Closing to emergence								
Average	124 ± 19	122 ± 19	0.12	<0.001	61 ± 11	63 ± 11	−0.17	<0.001
Minimum	108 ± 20	106 ± 20	0.08	0.02	53 ± 11	55 ± 12	−0.19	<0.001
Maximum	145 ± 27	141 ± 27	0.12	<0.001	73 ± 22	75 ± 23	−0.07	0.03
Emergence to end case								
Average	142 ± 24	140 ± 24	0.06	0.05	69 ± 14	71 ± 14	−0.16	<0.001
Minimum	118 ± 26	118 ± 25	0.01	0.84	56 ± 14	59 ± 13	−0.22	<0.001
Maximum	164 ± 30	161 ± 30	0.10	0.001	86 ± 30	86 ± 26	0.01	0.76

[a]Standardized differences (STDs) (etomidate – propofol): the difference in proportions divided by the pooled standard deviation; >0.10 in absolute value indicates slight different.



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Data plotted by me, but taken from: Anesth Analg. 2013; 117:1329-37.

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For **international students**, **perseverance** and a sense of **social responsibility** are extra important for predicting first-year **GPA.**

THE POSTERIOR INSULA REVEALS PAIN VS. REST FUNCTIONAL CONNECTIVITY DIFFERENCES NOT PRESENT WITH THE ANTERIOR INSULA

Keith M. Vogt, M.D., Ph.D.[1]; James W. Ibinson, M.D., Ph.D.[1,2]

[1]Department of Anesthesiology, [2]Pittsburgh Center for Pain Research
University of Pittsburgh, Pittsburgh, Pennsylvania, USA

International Anesthesia Research Society
Annual Meeting - May 2014

SUMMARY

The portion of the insula chosen as the seed region for functional connectivity MRI (fcMRI) analysis dramatically affects the resulting maps. This is particularly important when comparing maps obtained during rest to those during experimental pain. In this study, the posterior insula is a seed region that can differentiate the experience of acute pain from rest.

fcMRI METHODOLOGY

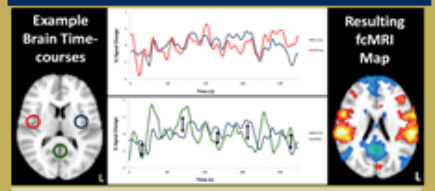

Fig 1. Using the left insula (L-Ins) as the seed, areas of correlation (red-yellow) such as the right insula (R-Ins) and areas of anti-correlation (blue-green) such as the posterior cingulate cortex (PCC) are identified.

BACKGROUND

- The insula plays a key role in pain processing.[1]
- fcMRI during painful and innocuous thermal stimulation demonstrated anatomically different connectivity:[2]
  - The anterior insula (aIns) was more correlated to the anterior cingulate cortex (ACC).
  - The posterior insula (pIns) was more correlated to the primary somatosensory (S1) and motor (M1) cortices.
- Our work[3,4,5] optimizing fcMRI analysis showed increased pIns connectivity to the ACC during pain versus rest.

STUDY AIMS

Goal: Directly compare fcMRI maps between rest and experimental pain for seed regions in the left (contralateral) anterior and posterior insula.

Hypothesis: Increased insula-ACC connectivity would be seen during pain processing, and this difference would be greater for the anterior compared to the posterior insula.

METHODS

- 3 T BOLD data was acquired in 14 healthy adults during REST and while painful ENS (PAIN), self-rated at 7/10, was delivered to the right index finger.
- Seed time courses for the contralateral aIns and pIns were extracted from the anatomic locations shown in Fig. 2.
- Functional connectivity was determined for both seed regions in both data sets using FSL 5.0 (//www.fmrib.ox.ac.uk).
- An optimized analysis pipeline was used, including low pass filtering, spatial smoothing, and regression of the global signal,[3] motion parameters, and the pain stimulation[4] as effects of no interest.
- Group average maps, including anti-correlations,[5] and PAIN vs. REST difference maps were generated with thresholds $Z > 4$ and $p < 0.0001$.

Fig. 2 Oblique slice through the insula showing the locations of the anterior and posterior seed regions for the functional connectivity analysis.

RESULTS

- Group average functional connectivity maps for the left insula seeds (Fig. 3) show:
  - The aIns was correlated to the ACC in both REST and PAIN.
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  - Both aIns and pIns were correlated to the right insula in both REST and PAIN.
  - Both aIns and pIns were correlated to S1 and M1 bilaterally in both PAIN and REST.
  - The pIns was anti-correlated to the posterior cingulate cortex during REST.
- The difference maps (Fig. 4) show almost no statistically significant PAIN vs. REST differences in aIns connectivity.
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  - Connectivity was stronger to the PCC in PAIN compared to REST.

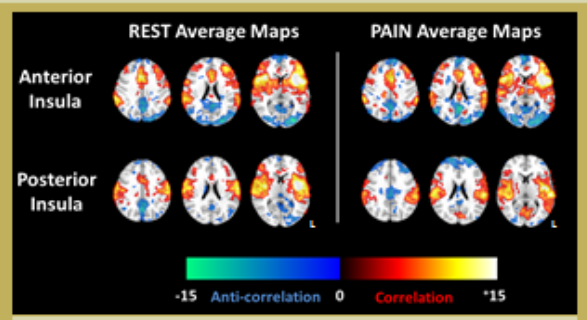

Fig. 3. Group average functional connectivity maps, in radiologic orientation, with color bar showing Z-score of significant correlations (red-yellow) or anti-correlations (blue-green) to the two left insula seed regions.

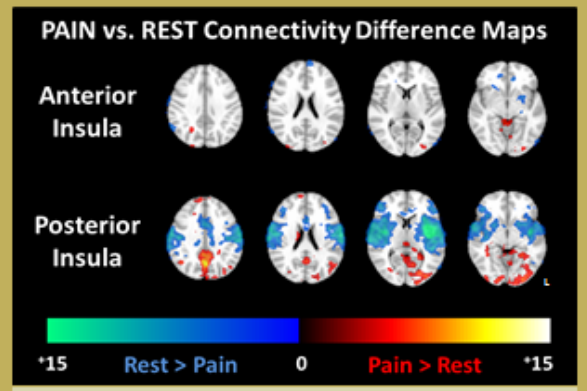

Fig. 4. Maps, in radiologic orientation, of significant connectivity differences for the Pain > Rest (red-yellow) and Rest > Pain (blue-green) comparisons, with Z-scores as shown on the color bars.

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- This study comparing fcMRI between resting-state and the experience of pain showed:
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CONCLUSIONS

- The choice of a anatomic seed region in fcMRI analysis has a dramatic effect on the resulting connectivity maps.
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REFERENCES

1) Apkarian AV, et al. Human brain mechanisms of pain perception and regulation in health and disease. Eur J Pain 2005;9:463-84.
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5) Ibinson JW, Vogt KM. Effect of anti-correlations on statistical comparisons between pain task and resting fcMRI datasets. J Pain 2014;15:858.

ADDITIONAL INFORMATION

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Funding Support by: NIH Grant Number T32GM075770, a Department of Anesthesiology Seed Grant, and Grant Number 5UL1 RR024153-04 from the National Center for Research Resources (NCRR, a component of the NIH), and NIH Roadmap for Medical Research.
Note: This work is solely the responsibility of the authors and does not represent the official view of NCRR or NIH.

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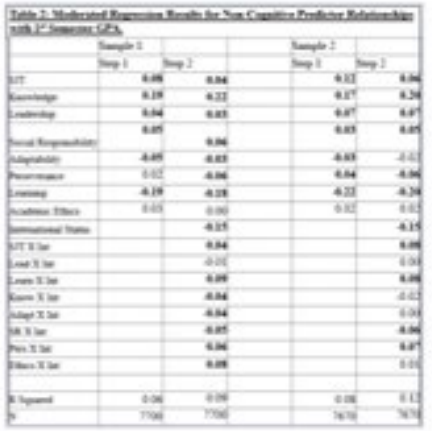

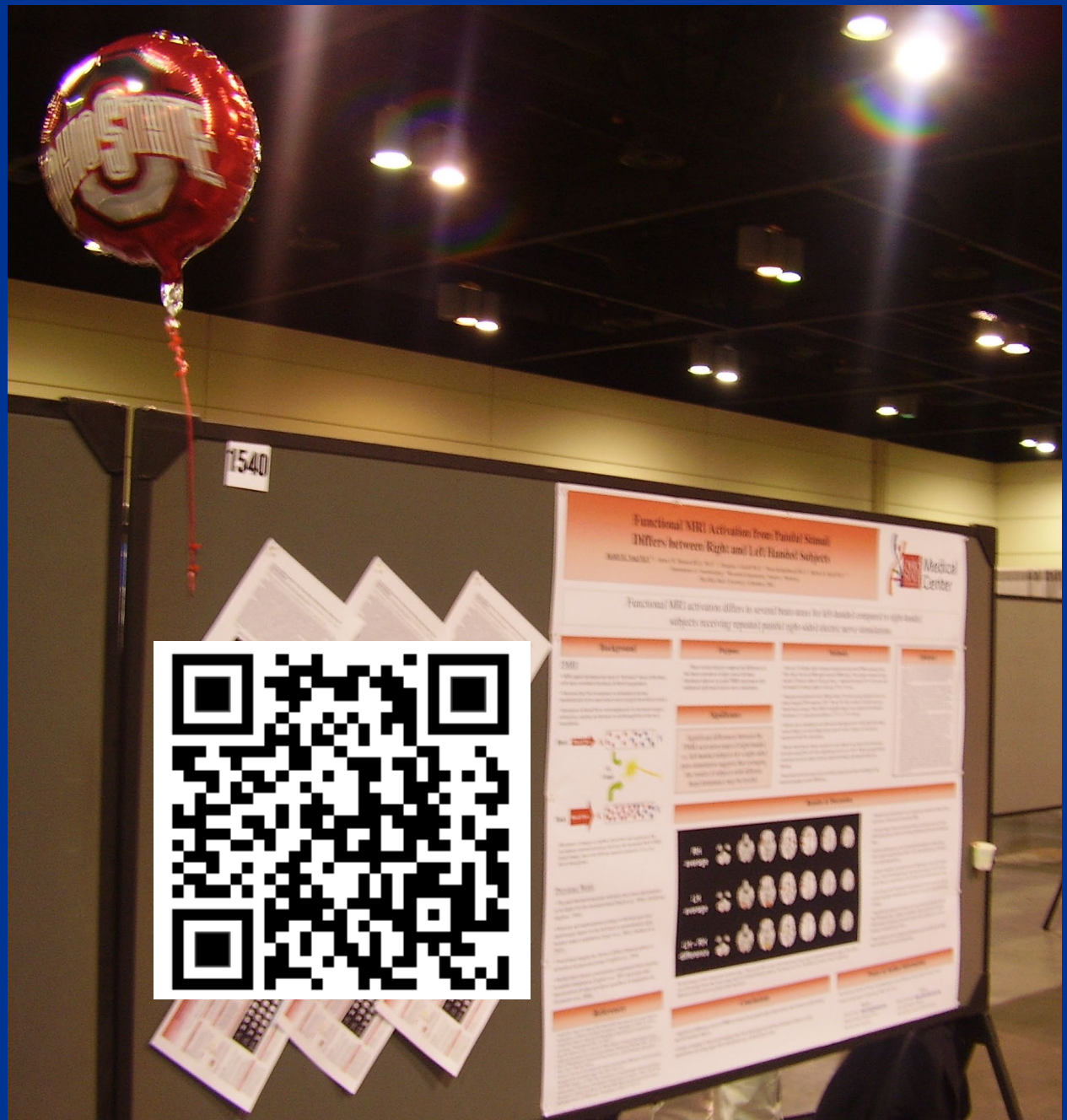

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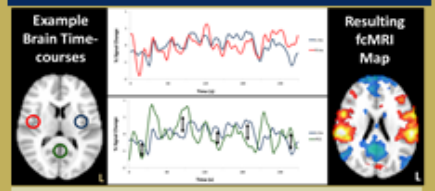

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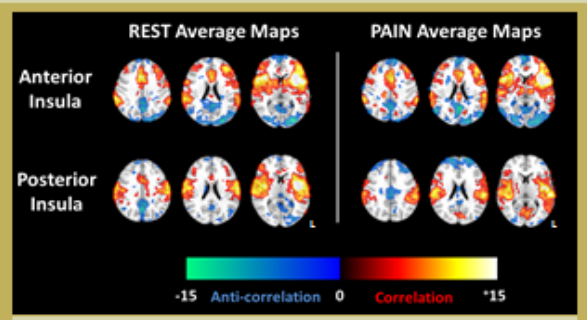

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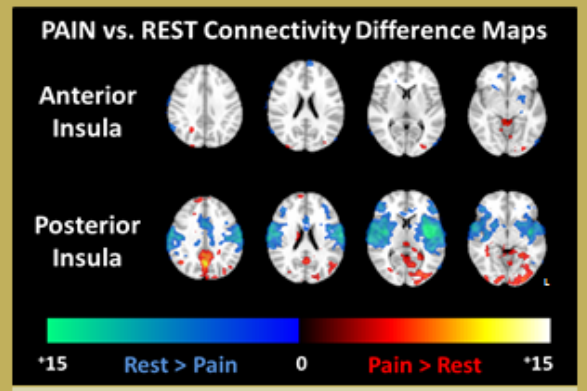

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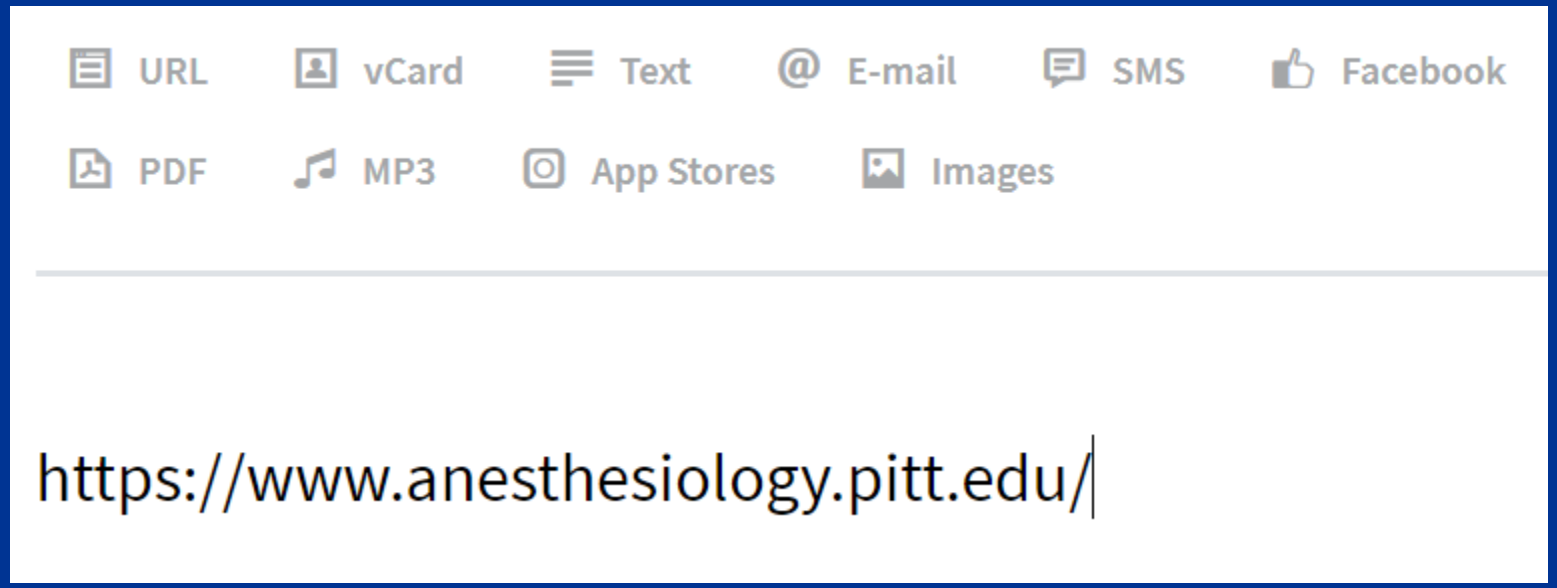

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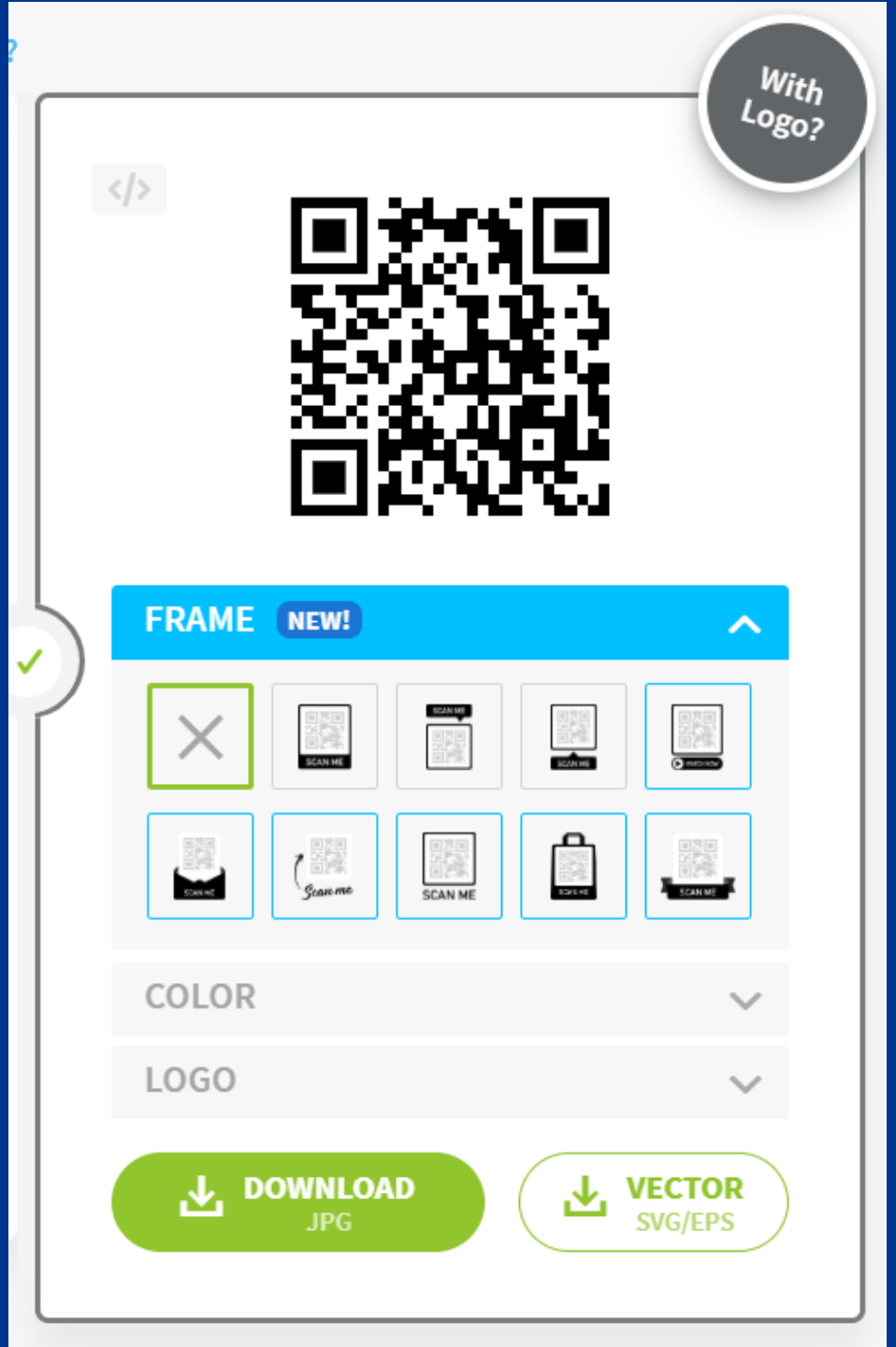

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Co-director, Anesthesiology Professional Practice Rotation
Director, Center for Neuroscience Research

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- The Ohio State University, MS, Biomedical Engineering
- The Ohio State University, PhD, Biomedical Engineering
- The Ohio State University School of Medicine, MD
- Riverside Methodist Hospital, Preliminary Medicine Internship
- UPMC, Anesthesiology Residency
- University of Pittsburgh, Department of Anesthesiology, T32 Postdoctoral Research Fellowship
- UPMC/University of Pittsburgh Joseph M. Katz Graduate School of Business, Marshall W. Webster Physician Leadership Program

Representative Publications

Dr. Vogt's publications can be reviewed through the National Library of Medicine's publication database.

Research, clinical, and/or academic interests

Research Program

- Determining the neural effects of diverse anesthetics on memory formation and the experience of pain
- Development of functional connectivity MRI as a neurosignature for pain and cognitive vulnerability
- Use of perioperative data to predict/prevent adverse outcomes, with a particular interest in neurologic and psychiatric data/outcomes

Dr. Vogt's research broadly applies bioengineering principles to better understand human neuroscience relevant to anesthesiology and perioperative medicine. The focus of his currently-funded project is on how human memory is affected by sedation with diverse anesthetic agents while concomitantly experiencing painful stimulation. Specifically, his group is determining the neural correlates of successful memory encoding during drug-induced sedation. He is further examining what physiologic measurements could reveal a learned sympathetic response to aversive stimuli, despite no explicit recollection of the event. This human experimental model is particularly relevant to the experience of surgery and anesthesia, where aversive experiences may be experienced with impaired contextualization. Dr. Vogt's research comparing midazolam and ketamine was a featured article in *Anesthesiology*, and his functional connectivity work was recognized with a best-in-category Kosaka award at the 2021 IARS annual meeting.

Educational Interests

Dr. Vogt is strongly committed to advancing scholarly education during clinical training programs. He has helped develop the curriculum and continues to co-direct the novel Anesthesiology Professional Practice rotation for our PGY1 residents. Additionally, he directs the Pittsburgh ANesTHEsiology Research (PANTHER) track for training future physician scientists. He is committed to the mentorship of diverse graduate and medical trainees at all levels and supports faculty colleagues interested in advancement in academic medicine.

Research Grants

- Foundation for Anesthesia Education and Research, Clinical/Translational Mentored Research Training Grant, 2017 - 2019
- National Institutes of Health, K23GM132755-01A1 (PI: Vogt), Anesthetic Modulation of Human Memory During Acute Pain, 2019-2023

Michael Schnetz, MD, PhD

Assistant Professor
Coordinator, Data Sciences Research

Education & Training

- Anesthesiology Residency, UPMC
- T32 Postdoctoral Research Fellowship, University of Pittsburgh Department of Anesthesiology and Perioperative Medicine
- MD, Case Western Reserve University School of Medicine

Contact

UPMC Horizon/UPMC Jameson
schnetzmp@upmc.edu

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36 x 60	$160	42 x 96	$267
36 x 72	$185	45 x 45	$152
36 x 84	$209	48 x 48	$168

International Size

Size (cm)	Price
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A0	$129
70 x 100	$100
90 x 120	$135
90 x 150	$160
90 x 180	$185
100 x 100	$128

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Wednesday	Friday	
Thursday	Monday	

UPS FedEx

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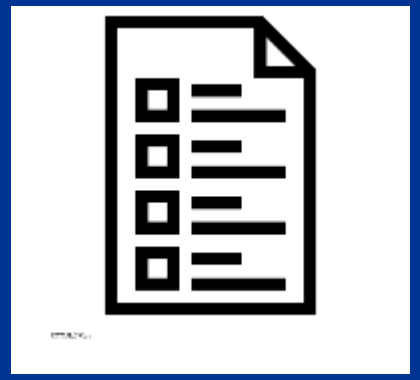
Questions about Poster Presentations?

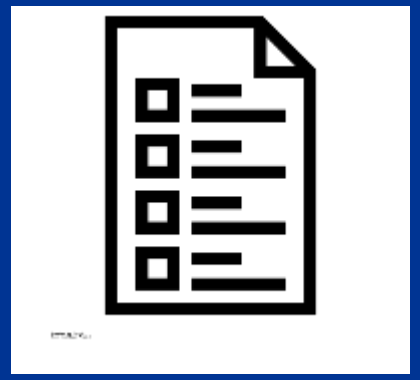
Oral Presentations

Successful oral presentations should:

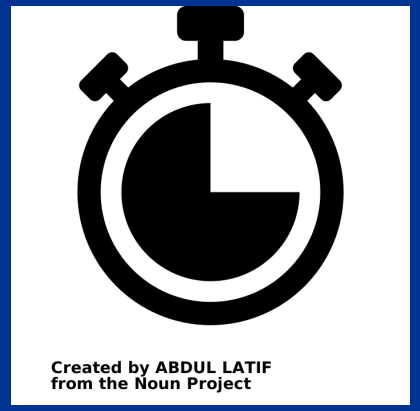


Concisely summarize your work

Successful oral presentations should:



Concisely summarize your work



Fit comfortably into the time allotted

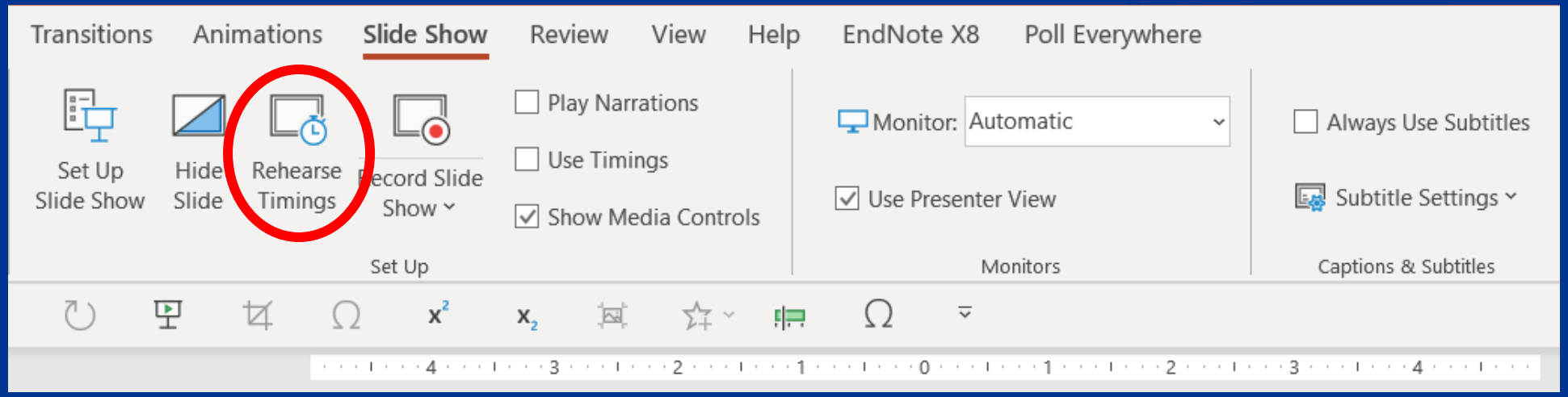
When presenting, be cognizant of everything your body is doing.

- Body language:
  - Hand movement
  - Posture
  - Eye contact
- Voice: volume, rate, direction → clarity
- Avoid stumbling words: Uh/um, like
- Avoid other noises, bumping mic

My main advice:

PRACTICE

PowerPoint can time your rehearsal.



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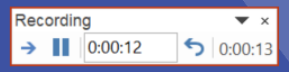
FAER/eSAS Panel:
Team Science and Pathways to Productivity as an Academic Anesthesiologist

Part 3: Collaboration with Neuroscientists and Bioengineers - Finding Relevance and Sustainability in a Research Team



the ANESTHESIOLOGY® annual meeting

American Society of Anesthesiologists™

Keith M. Vogt, MD, PhD
Assistant Professor
University of Pittsburgh
Keith.Vogt@Pitt.edu

FAER Foundation for Anesthesia Education and Research

eSAS early-stage anesthesiology scholars

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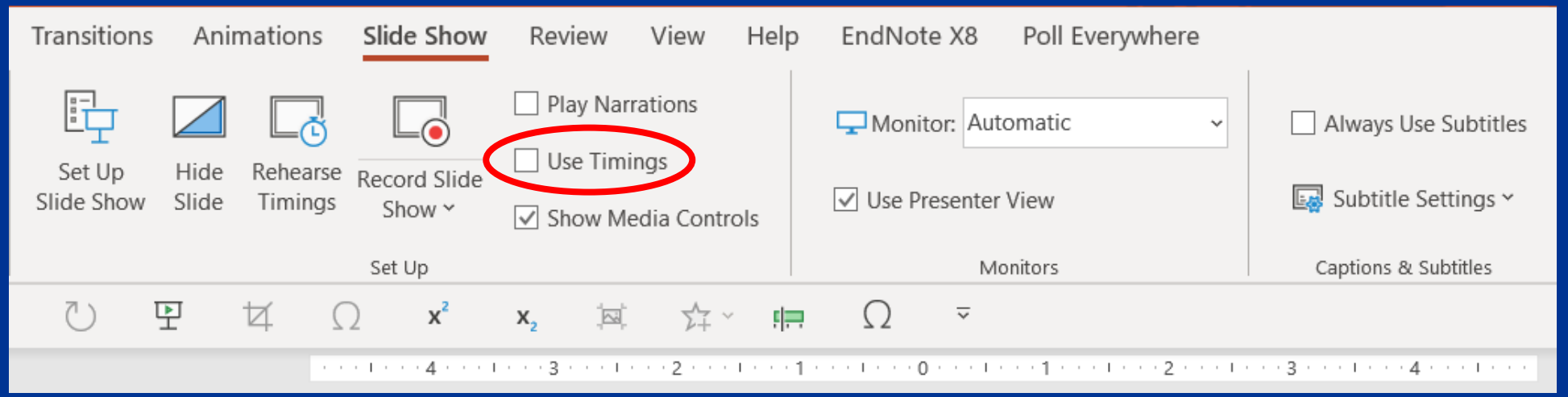
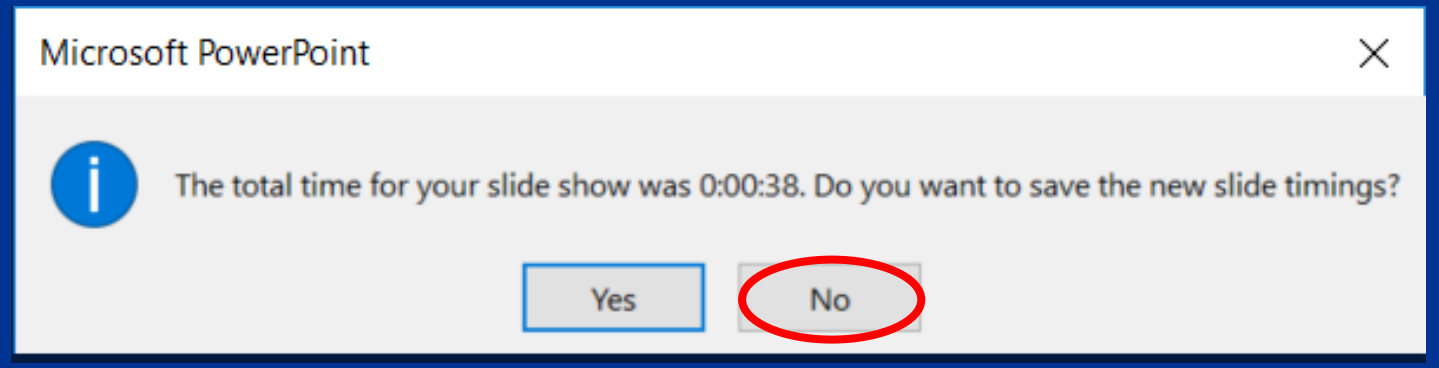
Beware of auto-advance of slides.





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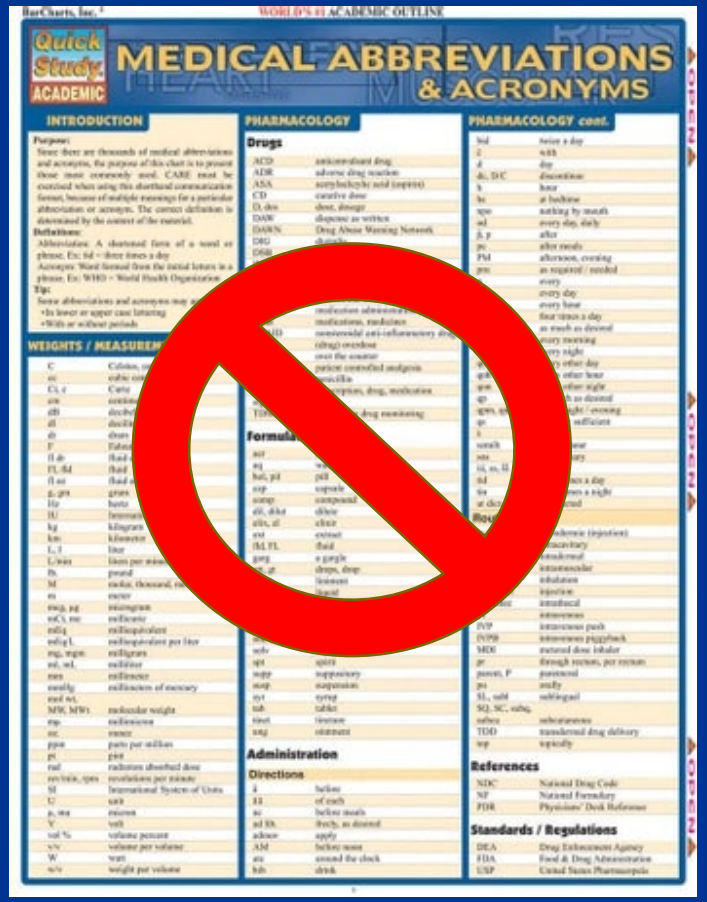
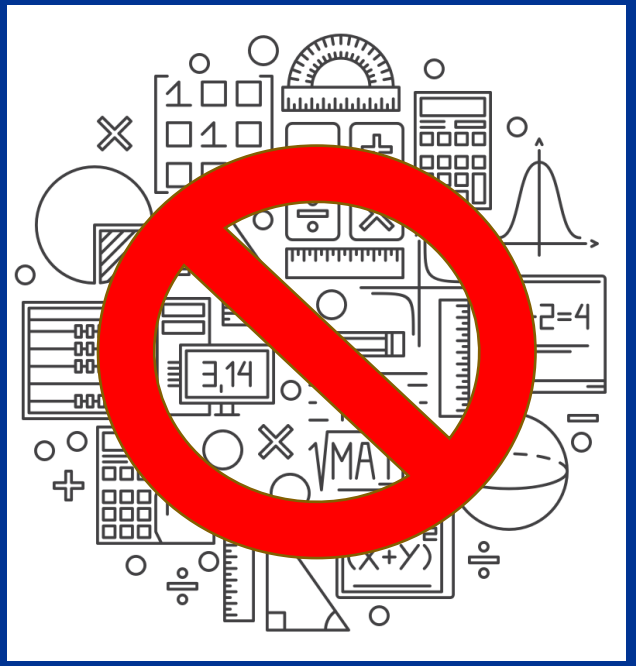
Each part of a presentation should be thoughtfully constructed.

- Provide compelling introduction → Generate excitement
- State hypothesis/aims → Frame your question
- Figures and tables: → Clearly explain findings
  - Content should be obvious at a glance
  - Text should be minimal and readable
- Summarize with concise impactful conclusions → Drive the point home

Know your audience.





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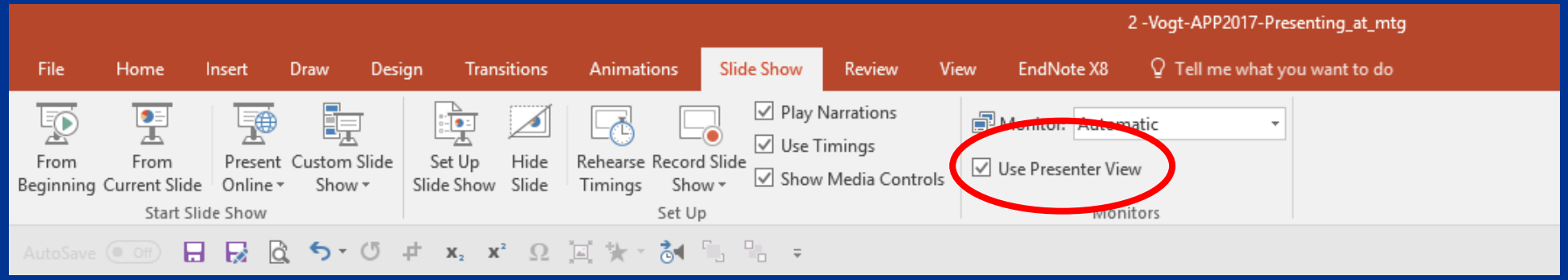
If you must…

- Add brief reminder prompts to the poster/slide content
- If you feel like you need note cards, what you probably actually need is more… PRACTICE

Presenter View is enabled from the PowerPoint Slide Show tab.



Only works with extended-display video setup

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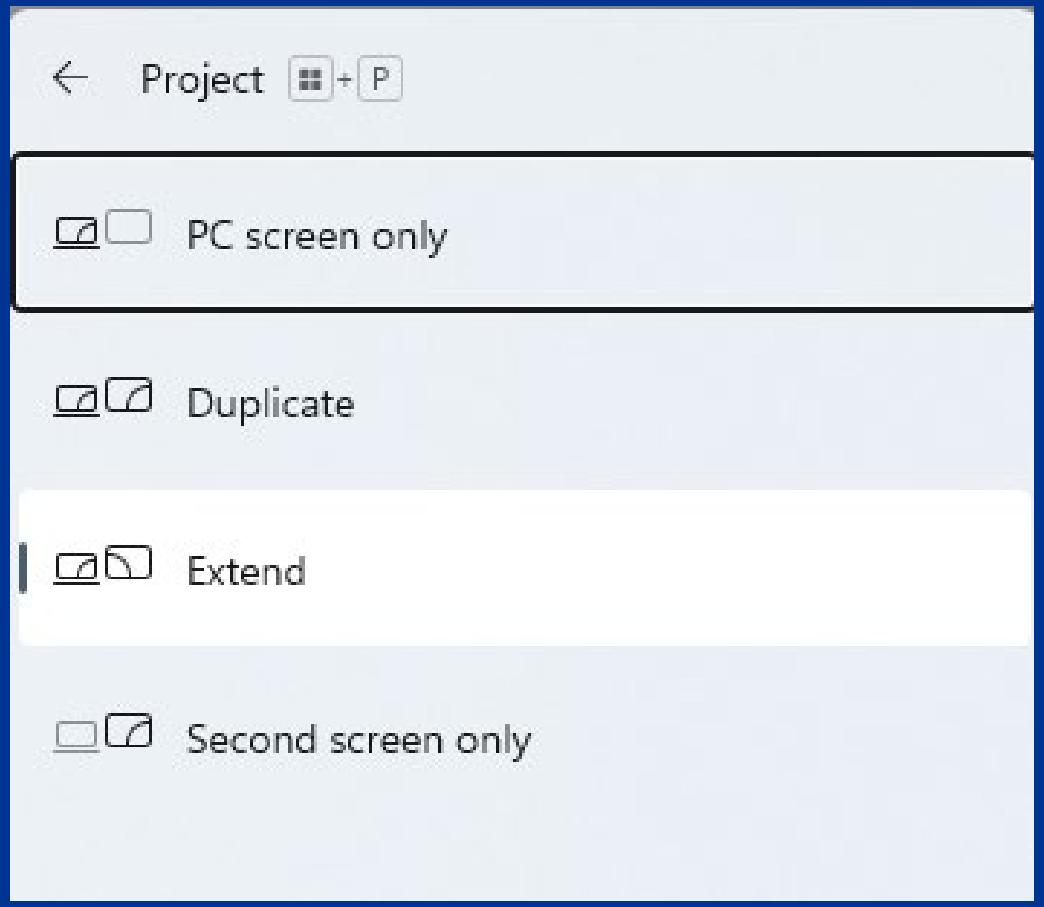
If screens are cloned, press Windows + P.



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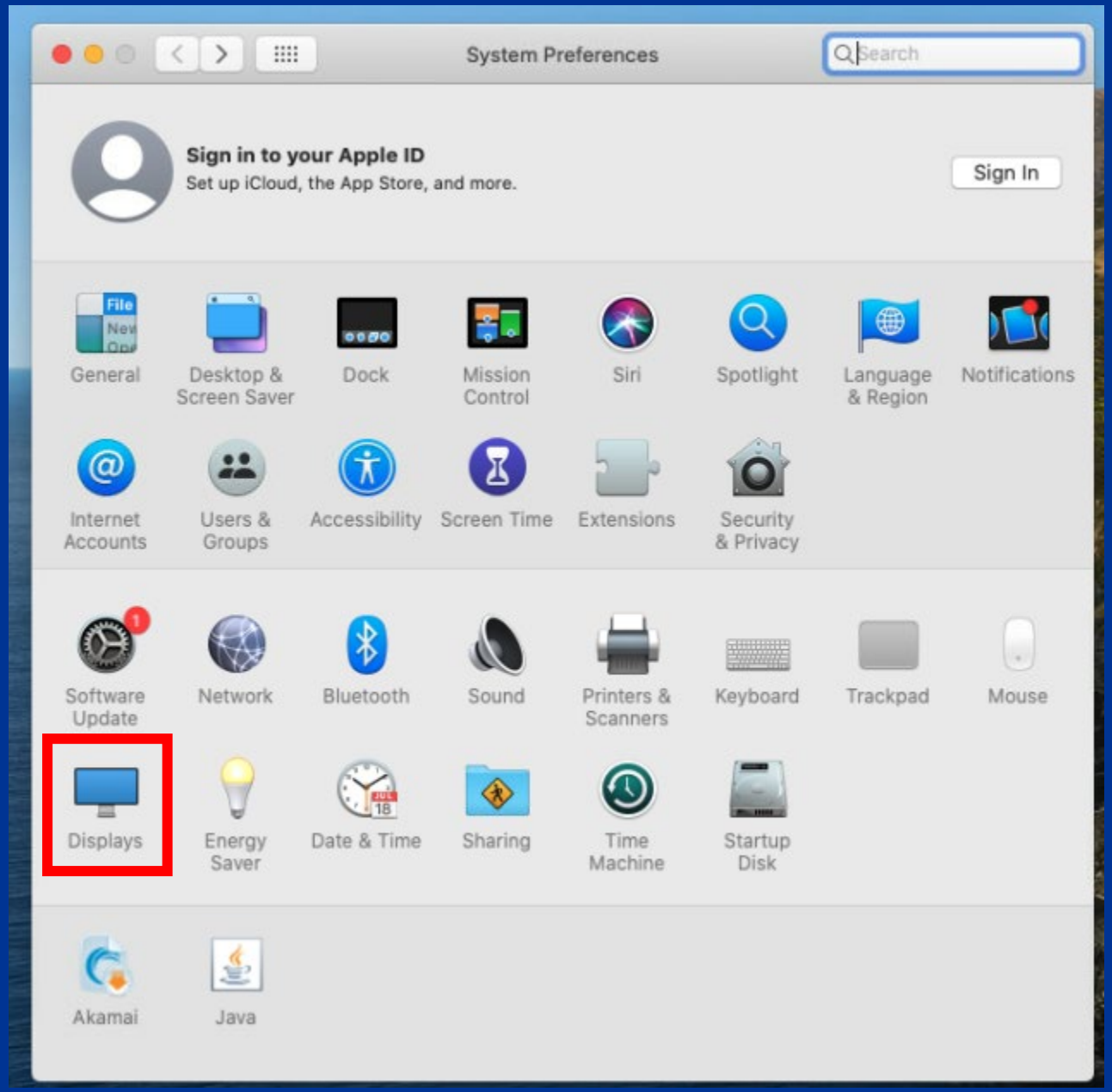

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Recorded Presentations

Remote presentations are here to stay.

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Remote presentations use different platforms.

webex by CISCO

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Presenting remotely has some unique considerations.

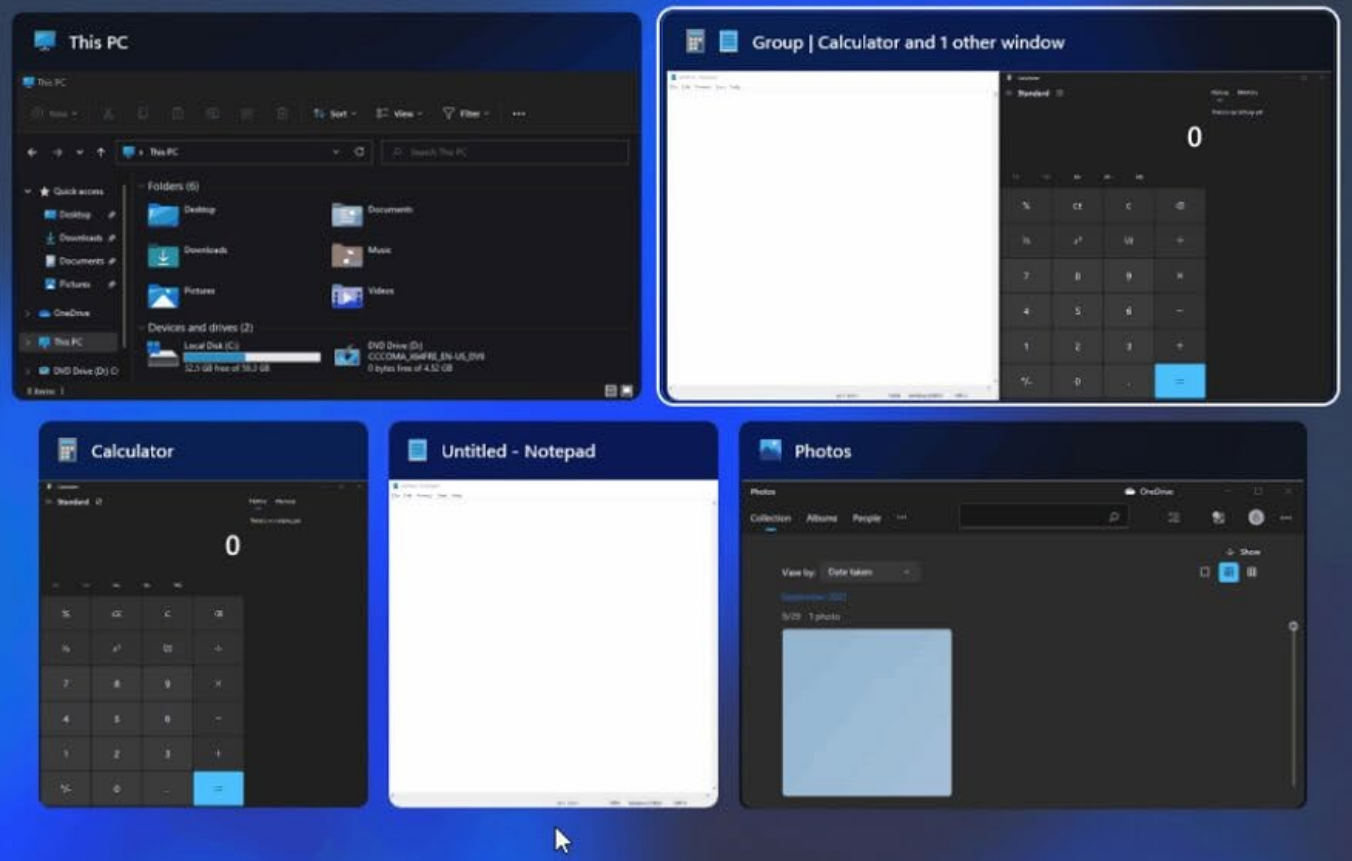
Best Practices - setup:

- Test in advance
- Second screen strongly recommended
- Stable internet is a must

Presenting remotely has some unique considerations.

Best Practices - presentation:

- Connect to meeting
- Start PowerPoint Slideshow
- **Alt-Tab** (PC) back to meeting app



How to quickly switch between windows on your Mac computer using 4 different shortcuts

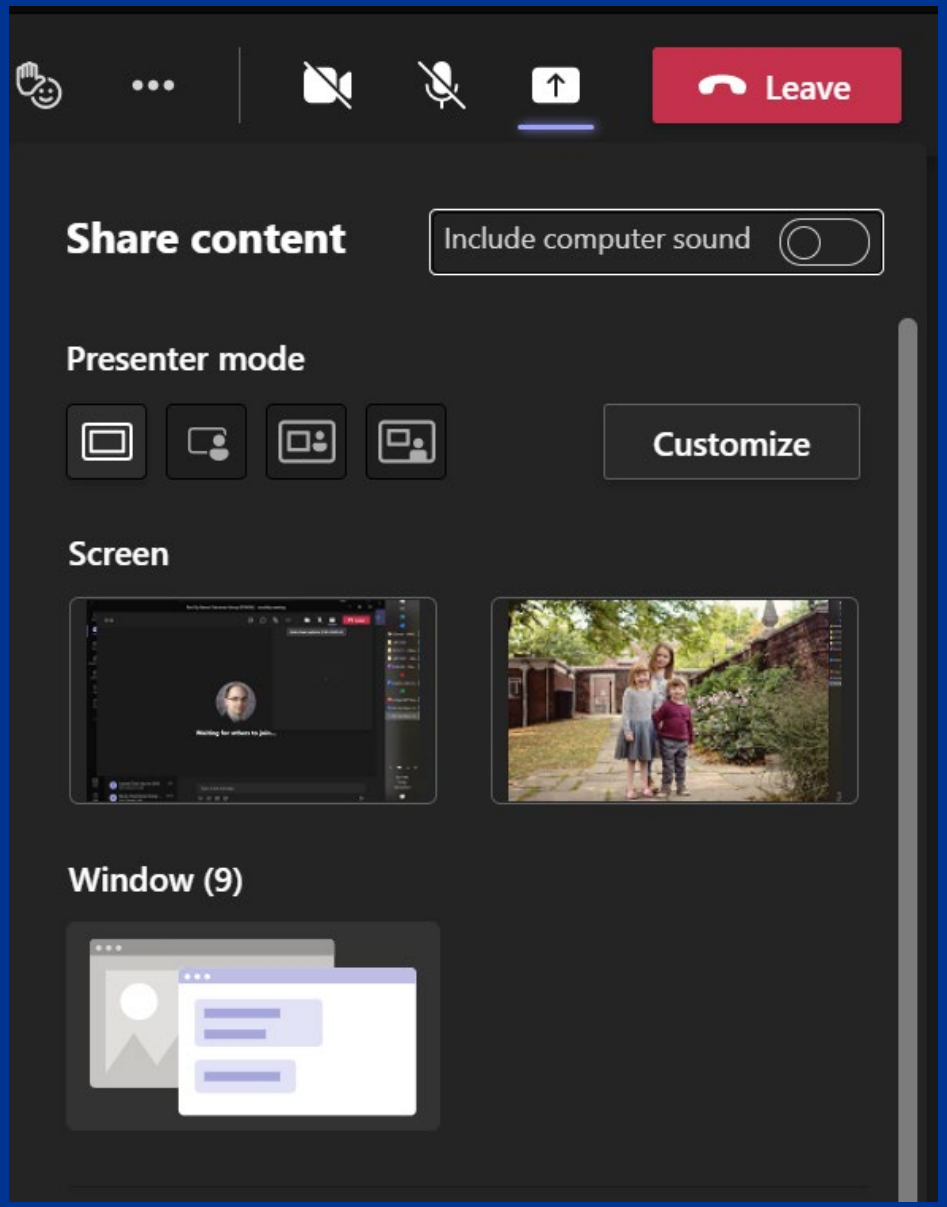
- Hitting the F3 button at the top of your Mac's keyboard, for example, will display all the windows you have open quickly click on the one you want front and center.
- You can also use the Mac's Command key to switch windows in two different ways, or you can swipe up trackpad on a MacBook to open Mission Control.

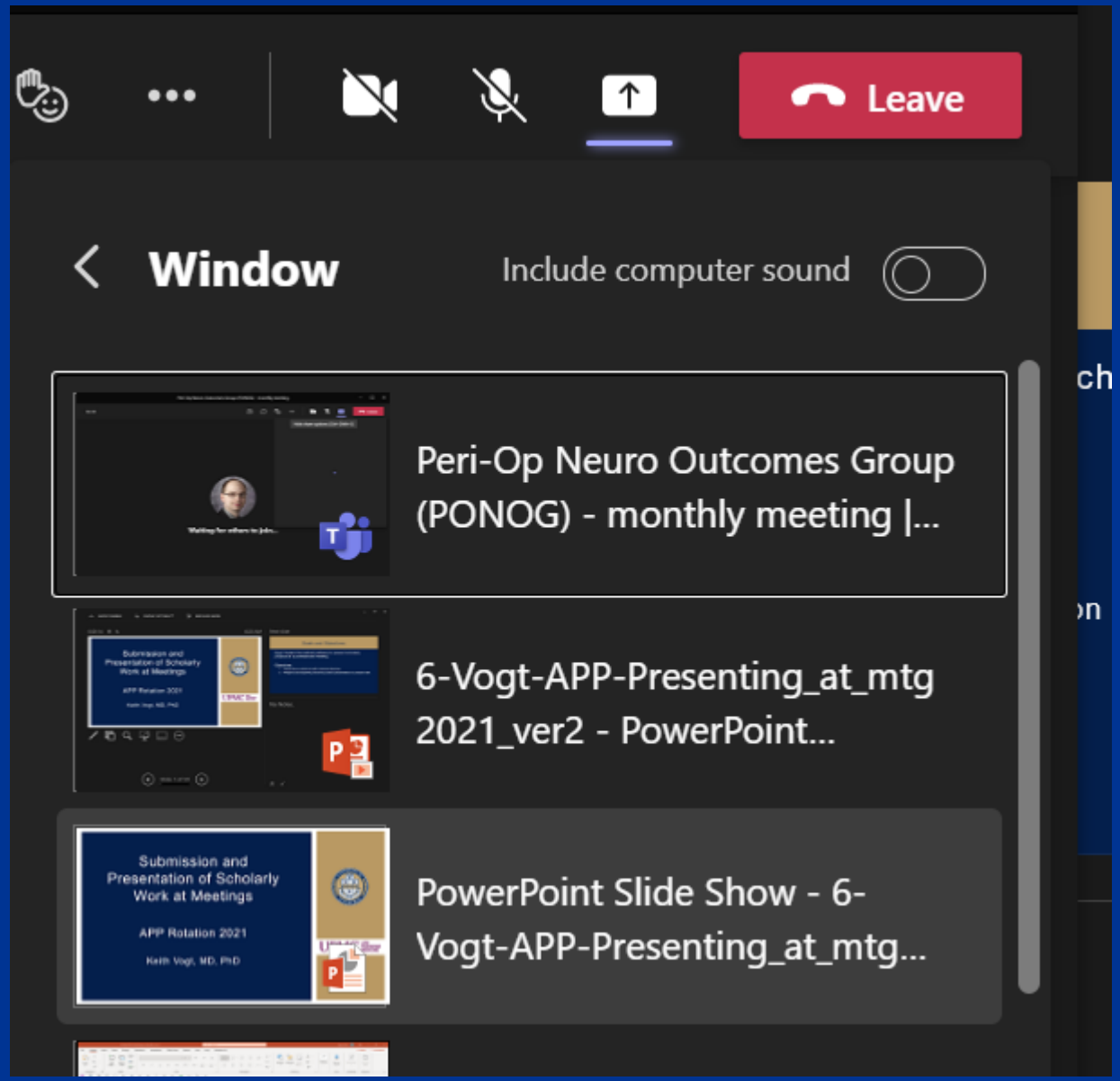
https://www.businessinsider.com/guides/tech/how-to-switch-between-windows-on-mac

Presenting remotely has some unique considerations.

Best Practices - presentation:

- Connect to meeting
- Start PowerPoint Slideshow
- Alt-Tab back to meeting app
- Click “share”, select Slideshow window





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Presenting remotely has some unique considerations.

Best Practices - presentation:

- Connect to meeting
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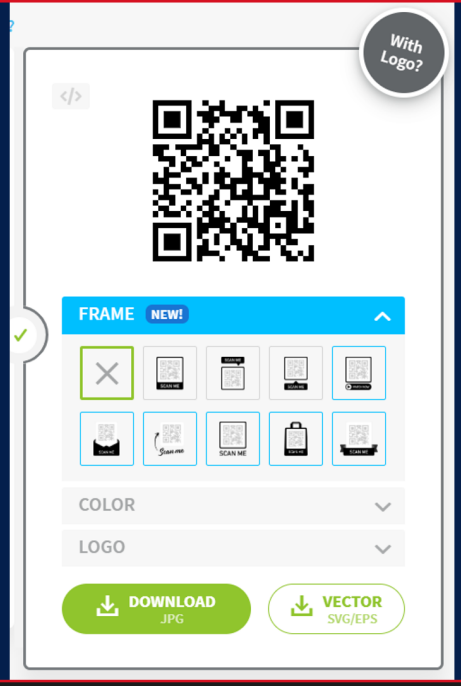
- Click “share”, select Slideshow window
- Minimize meeting app
- Give talk from Presenter View window



It works!

SHOW TASKBAR DISPLAY SETTINGS END SLIDE SHOW

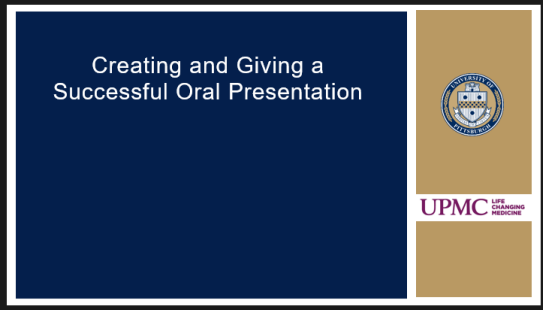
0:01:19 8:23 AM

Peri-Op Neuro Outcomes G... 09:47

Call is in progress. Click here to go back to the call screen.

Slide 23 of 60

Next slide



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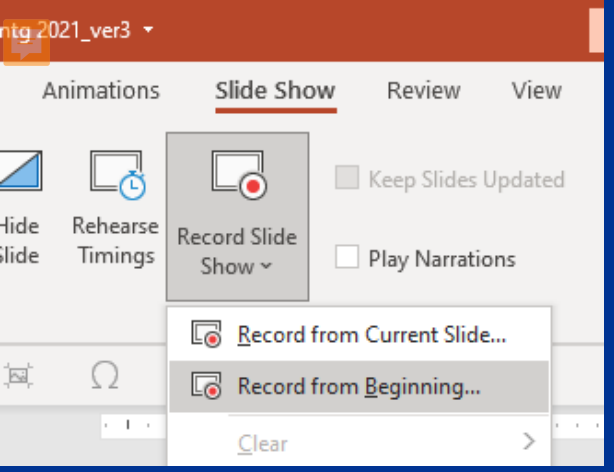
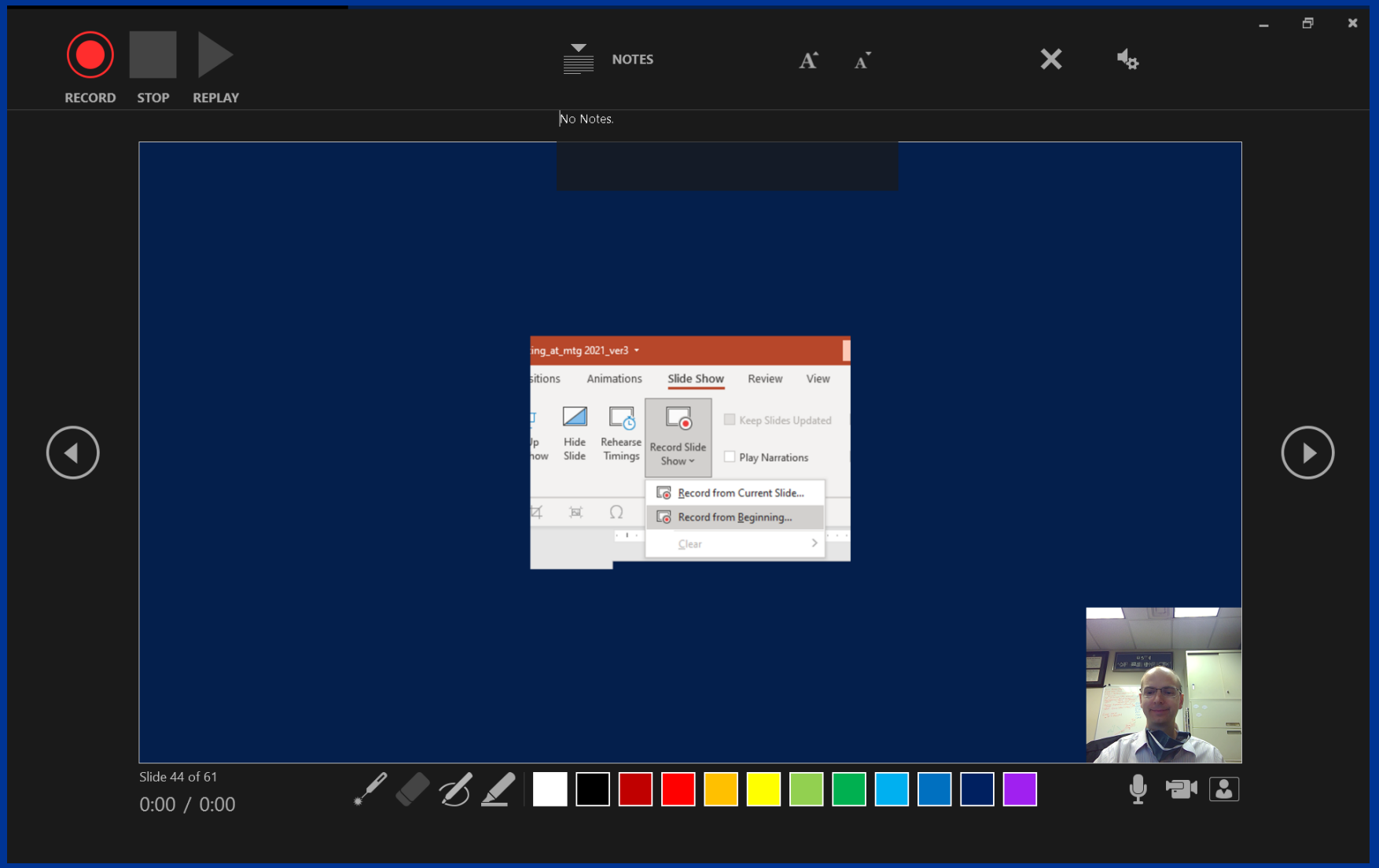
Many conferences will require that pre-recorded presentation (videos) be submitted in advance.

This can be done in PowerPoint too!





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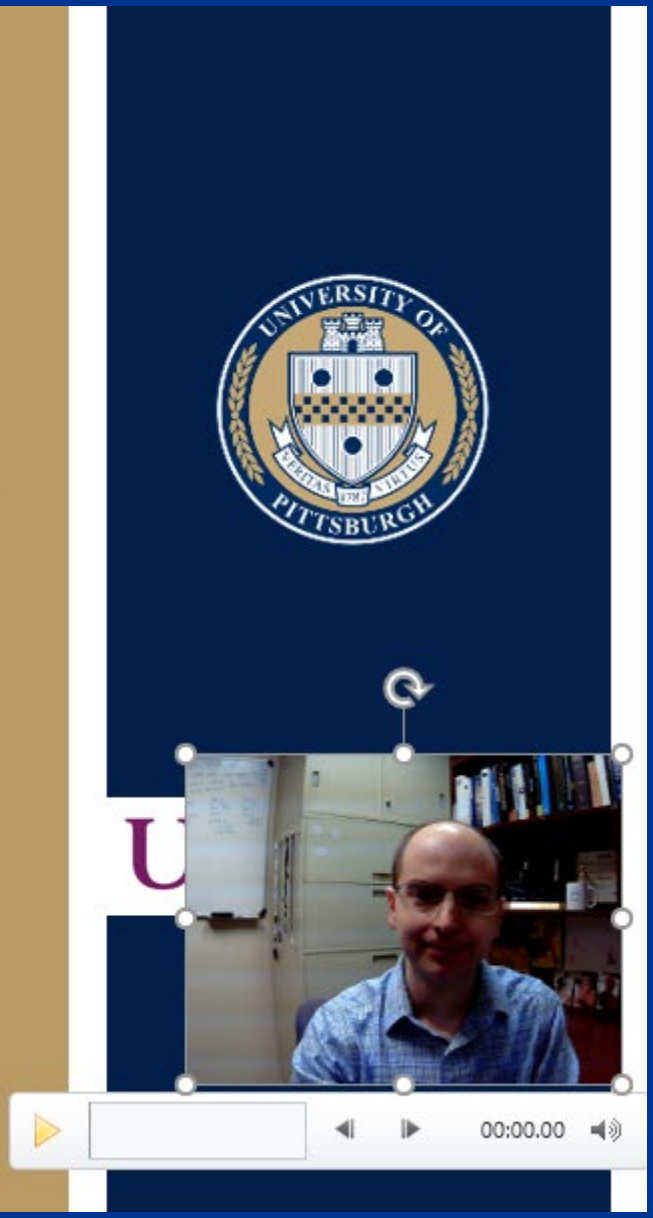
Ongoing Research: a video montage

APP 2021



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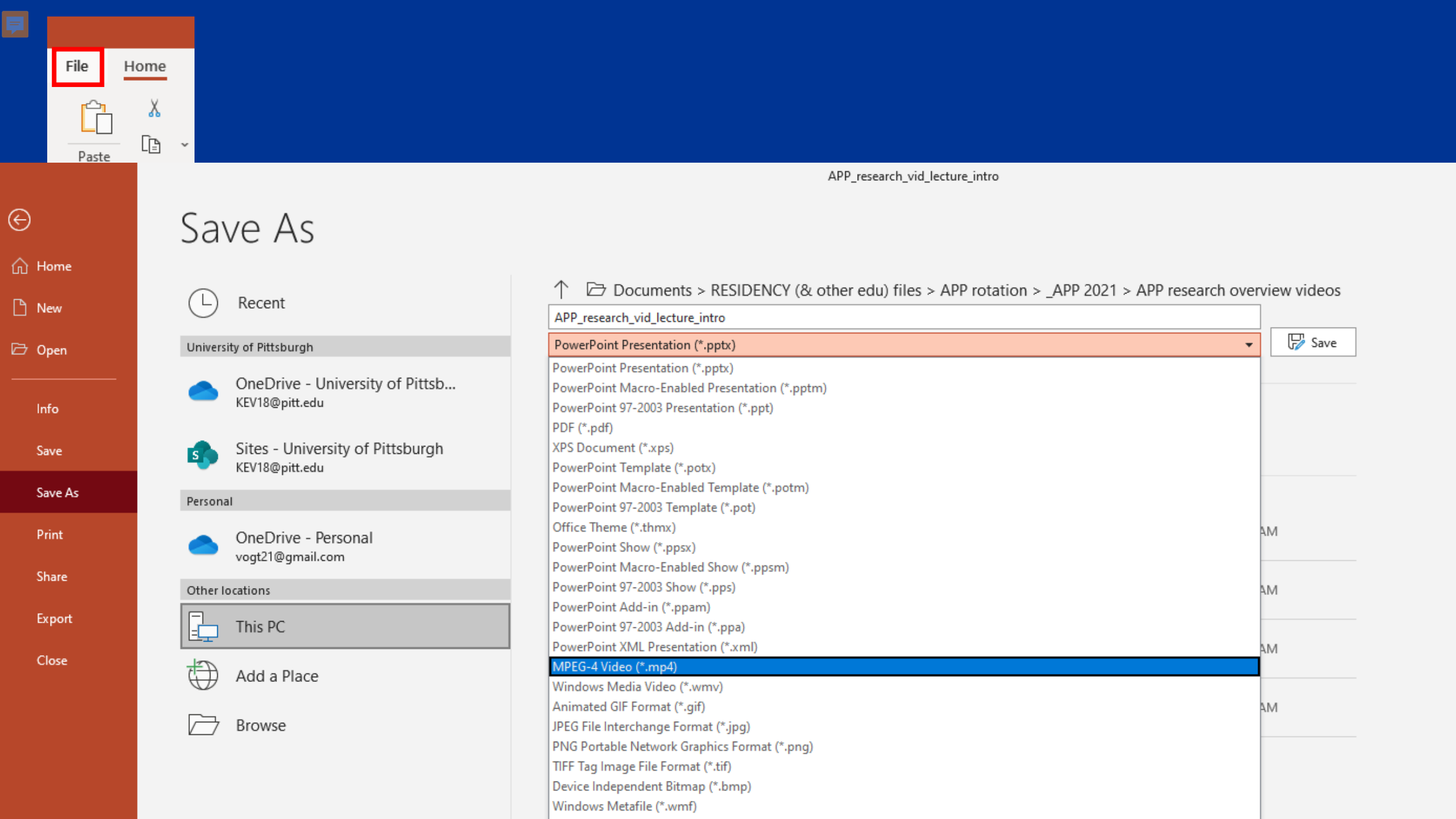
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PowerPoint fails - Don’t do these:

- Mix too many formatting options

Forming the Question-1

- **P – Patient or Population:**
  - Patients undergoing CABG
- **I – Intervention:**
- Estimated fibrinogen (FLEV) by ff-TEG ?
- **C – Comparison :**

  -Plasma Fibrinogen by Von Clauss Method(Gold standard)
- **O – Outcome :**
  - Do they correlate?

PowerPoint fails - Don’t do these:

- Mix too many formatting options
- Write paragraphs

Clarke et al. The prevention of Chronic postsurgical pain using gabapentin and pregabalin: A Combined systematic Review and Meta-Analyis. *Anesthesia & analgesia* 2012; 115(2): 428-442.

- Systematic review, meta analysis
- Aim: Systematic review of published literature pertaining to prevention of chronic post surgical pain (CPSP) after perioperative administration of gabapentin and pregabalin.
- 11 studies (8 gabapentin, 3 pregabalin). Total 930 pts included in trials (755 gabapentin, 175 pregabalin). Sample sizes ranged from n = 30 to n = 240, median n = 50.
- Surgical types included: breast, total knee arthroplasty, total hip arthroplasty, caesarean, thyroidectomy, cardiac surgery, lumbar discectomy, inguinal herniorraphy, abdominal hysterectomy.
- Methods: Gabapentin dosing: 3 studies single preop dose 1200 mg, 2 600 mg; rest 1200 mg qD x 8-10 days or 300 mg x10 days. Pregabalin dosing: 2 studies 300 mg preop dose, either continued for 2 more doses or 50-150 mg qD x14d. 1 gave preop dose 150 mg plus 75 mg qD x5 days.
- Outcomes: Pain scores 3, 6 mos and disability assessment 3, 6 mos.

PowerPoint fails - Don’t do these:

- Mix too many formatting options
- Write paragraphs
- Overcrowd slides

- Baseline opioid requirement calculated by preceding 24h requirement per pt report
- Pain rated by a visual analog scale
- Post-op pain treated w/ PCA (morphine, fentanyl, hydromorphone) – transitioned to PO meds PRN POD #1 (after 24h)
- Results – total morphine consumption was significantly reduced in the treatment group at 24h, 48h and weeks post-op. Pain intensity scores were also significantly reduced in the PACU and 6 weeks post-op. No difference in side effects.
  - 24% less intra-op opiate use
  - 37% less morphine during 48h post-op
  - 26% reduction in pain intensity in the PACU
  - 71% reduction in opiate consumption at 6 week f/u
  - 52% reduction in 48h consumption in patients w/ baseline morphine equivalents >0.5 mg/h IV
- Strengths
  - Power of 0.9 to detect a 40% reduction in analgesic requirements was met with 102 patients (96 required)
  - Standard protocol for administration of intra-op drugs
  - All participants blinded
- Limitations
  - Standard protocol for which drugs were given during surgery – "all additional adjuncts administered were tracked" – deviations from the protocol never discussed

Classen et al. The timing of prophylactic administration of antibiotics and the risk of surgical wound infection. (1992)

Table 1. Temporal Relation between the Administration of Prophylactic Antibiotics and Rates of Surgical-Wound Infection.

Time of Administration*	No. of Patients	No. (%) of Infections	Relative Risk (95% CI)	Odds Ratio† (95% CI)
Early	369	14 (3.8)‡	6.7 (2.9–14.7)	4.3§ (1.8–10.4)
Preoperative	1708	10 (0.59)	1.0	
Perioperative	282	4 (1.4)¶	2.4 (0.9–7.9)	2.1‖ (0.6–7.4)
Postoperative	488	16 (3.3)‡	5.8‡ (2.6–12.3)	5.8** (2.4–13.8)
All	2847	44 (1.5)	—	—

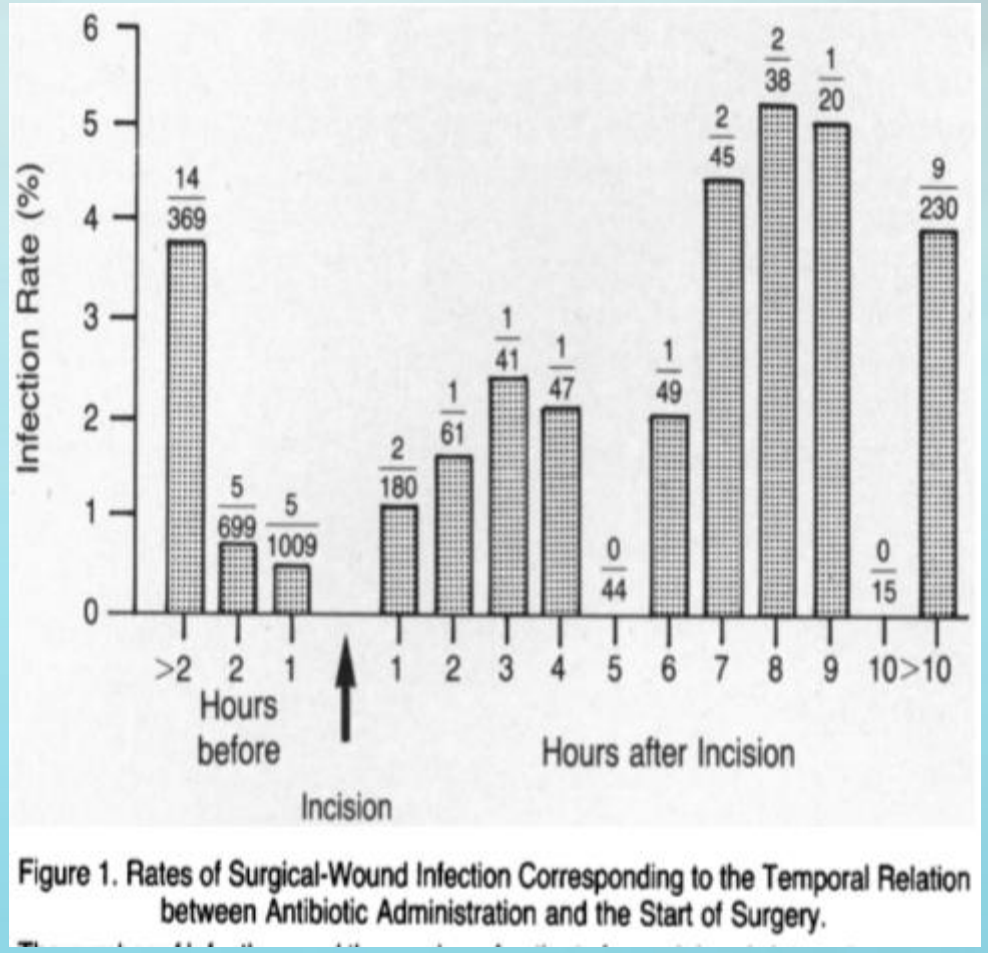

Figure 1. Rates of Surgical-Wound Infection Corresponding to the Temporal Relation between Antibiotic Administration and the Start of Surgery.

PowerPoint fails - Don’t do these:

- Mix too many formatting options
- Write paragraphs
- Overcrowd slides
- Have poor text/background contrast.

APP:
Evidence – Based Medicine

PICO – based approach

Bullets points are easy.

- But exceedingly long lists
- of bullet points
- are not pleasant for the audience
- and, frankly,
- having too many
- is totally lame

Bullets points are easy.

- But exceeding lists
- of bullet poi
- are not plea t for t dience
- and, frankl
- having too
- is totally lam

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Pictures speak louder than words.

https://www.presentyourscience.com/

https://www.ted.com/talks/melissa_marshall_talk_nerdy_to_me

https://www.assertion-evidence.com/

https://templates.office.com/en-us/assertion-evidence-presentation-tm33940113

https://www.youtube.com/watch?v=Iwpi1Lm6dFo

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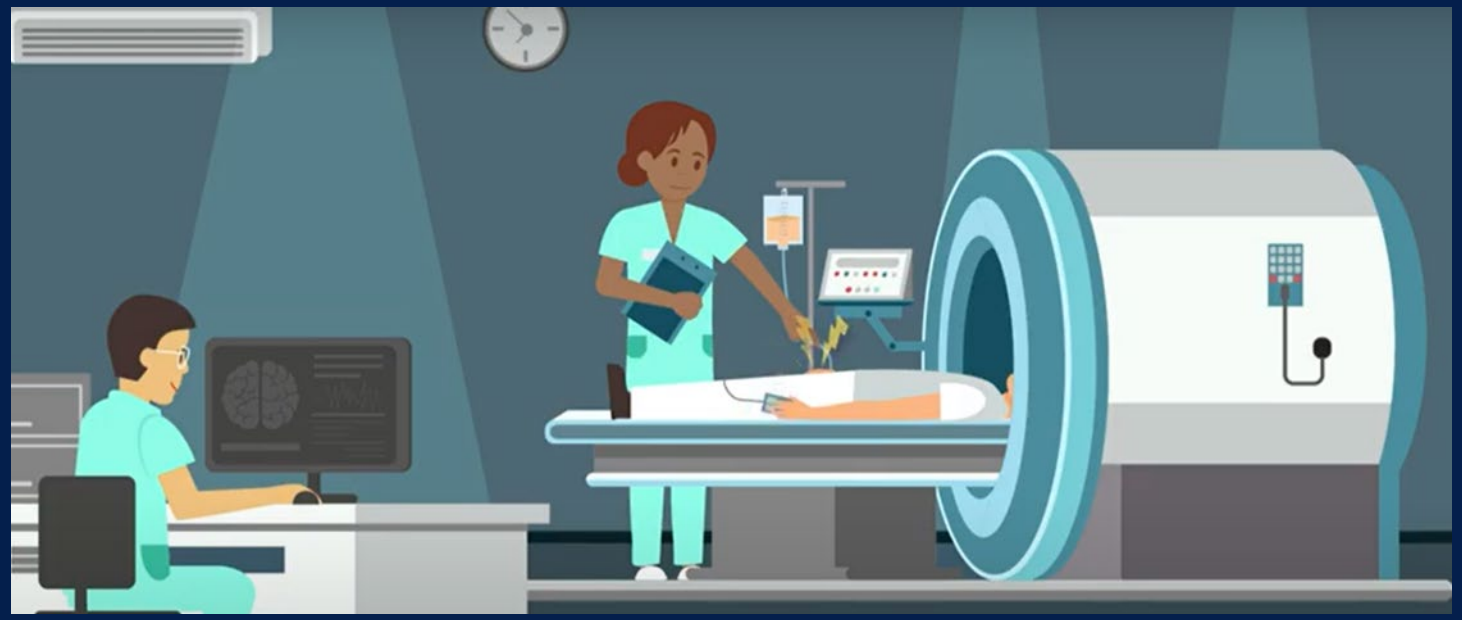
Title

Name
Title
University of Pittsburgh Medical Center

Department of Anesthesiology & Perioperative Medicine

Replace this box with key image to introduce talk's scope, importance, or background

Anesthesia and cognition: Neural correlates of pain, consciousness, and memory modulation



Keith Vogt, MD, PhD

Assistant Professor
University of Pittsburgh

- Department of Anesthesiology & Perioperative Medicine
- Department of Bioengineering
- Center for the Neural Basis of Cognition

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Anesthetic modulation of memory, pain, and fear centers in the human brain

MAA11 2022 PRATO ITALY

Keith Vogt, MD, PhD

Assistant Professor

University of Pittsburgh

- Department of Anesthesiology & Perioperative Medicine
- Department of Bioengineering
- Center for the Neural Basis of Cognition

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This presentation focuses on… (complete sentence, but go no more than two lines)

Image for Topic 1

Topic 1

Image for Topic 2

Topic 2

Image for Topic 3

Topic 3

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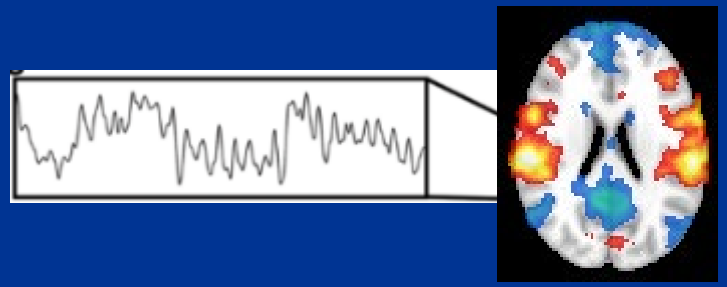
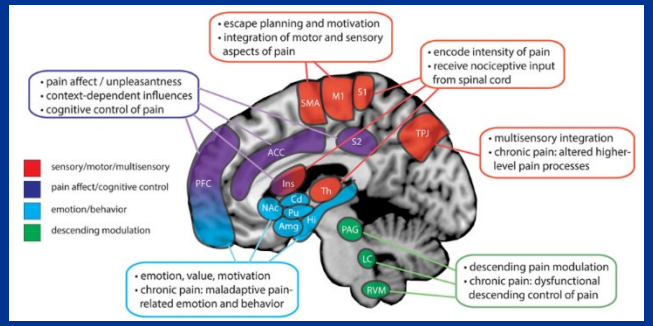
This talk focuses on how anesthetics affect cognition, particularly the interaction between pain and memory.



EEG & fMRI techniques



Human
Cognitive
Function

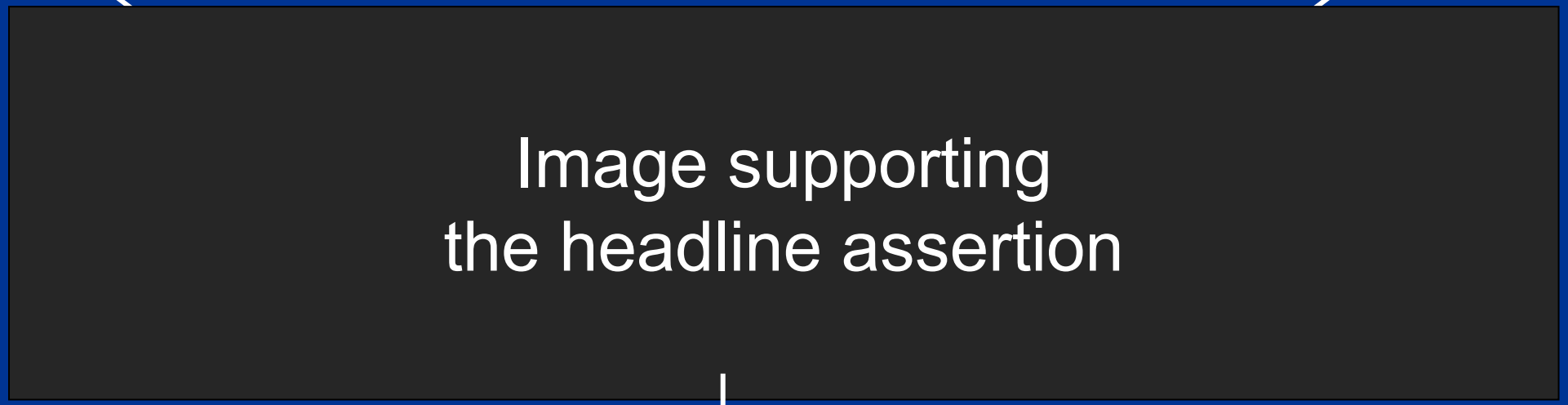
- Pain perception
- Consciousness
- Memory

My current work on pain, memory, & anesthesia

Title is a sentence that makes an assertion in no more than two lines.

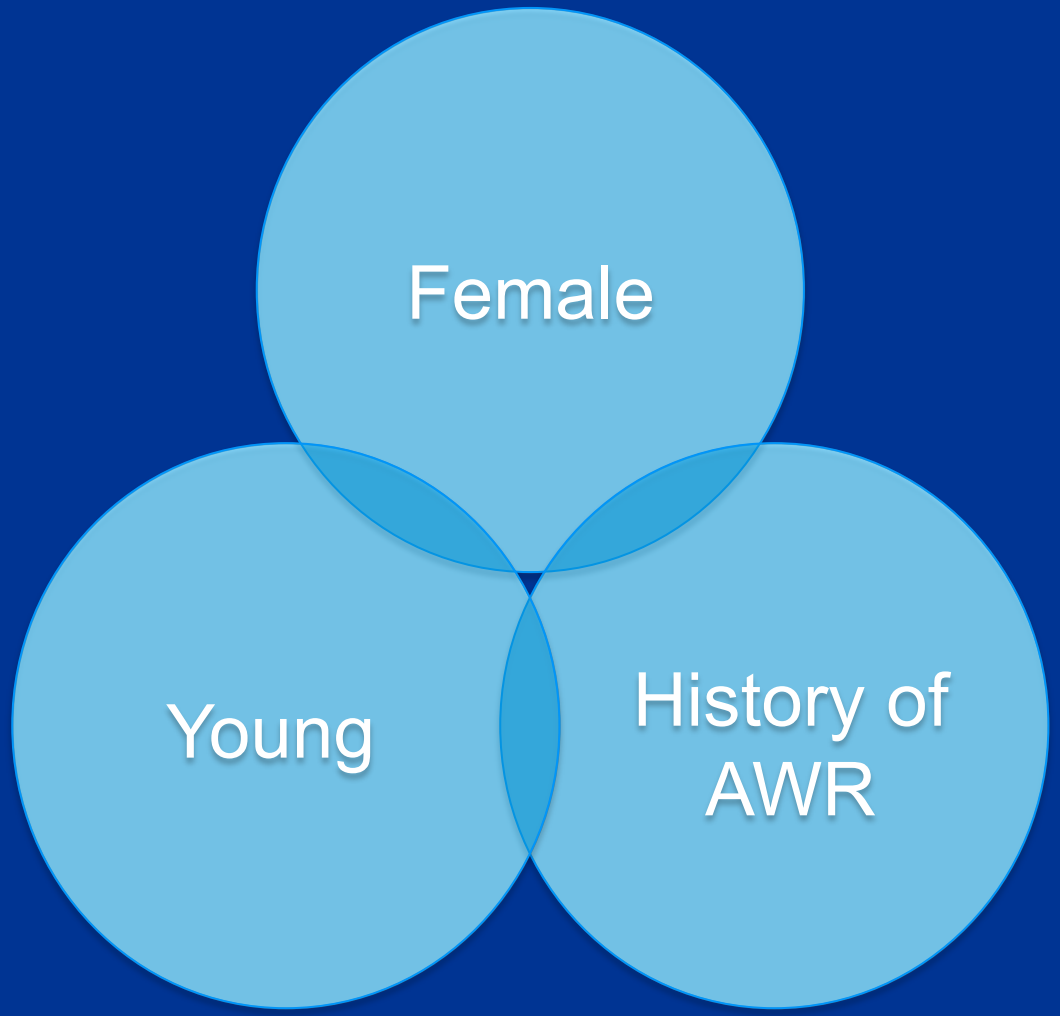
Call-out, if necessary: keep to one or two lines

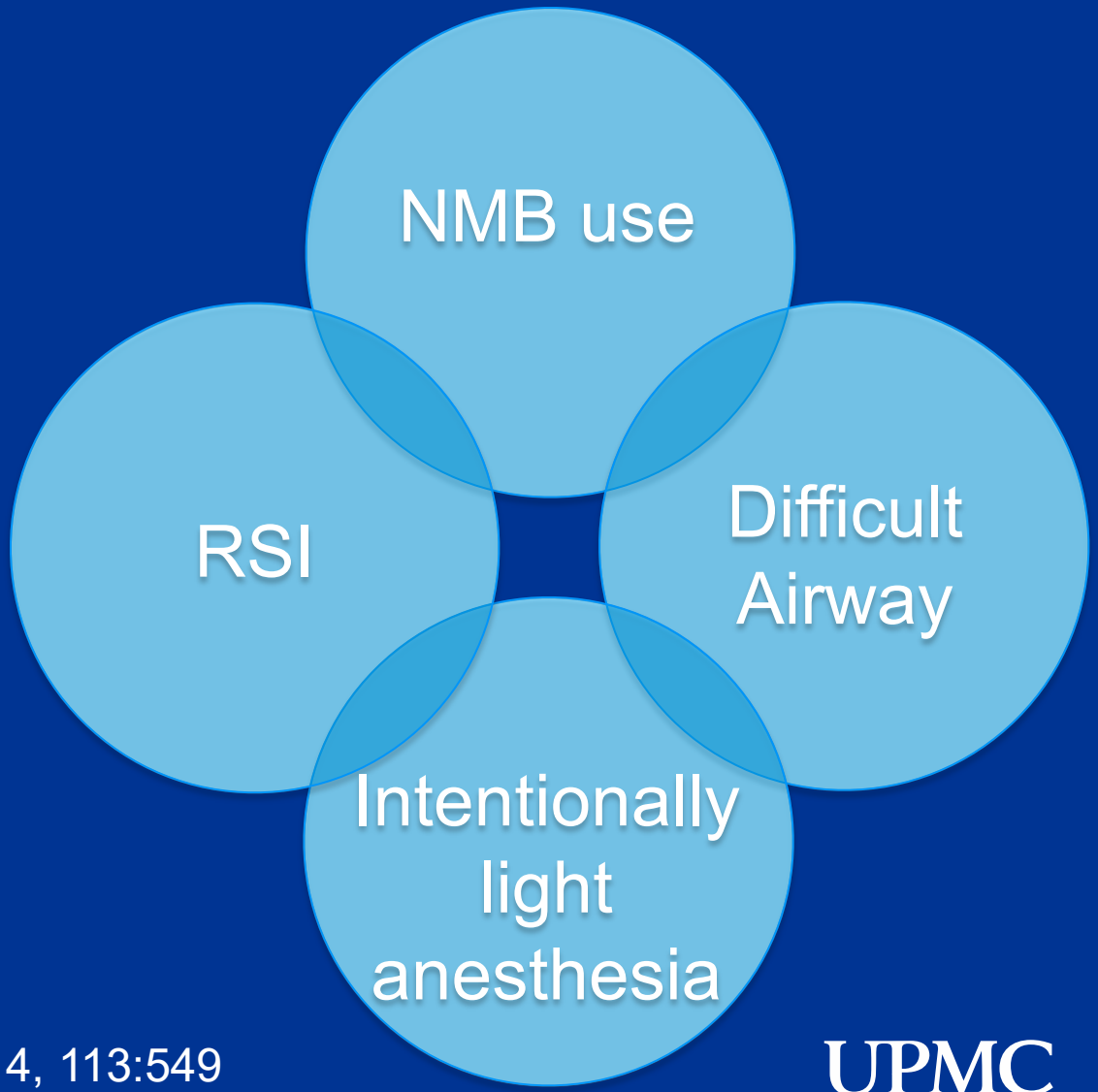
Call-out, if necessary: keep to one or two lines



Call-out, if necessary: keep to one or two lines

“Classic” anesthetic awareness risk factors are non-modifiable.





University of Pittsburgh

Br J Anaesth 2014, 113:549
Anesth Analg 2009, 108:527

UPMC
LIFE CHANGING MEDICINE

Stroke and delirium have significant clinical impact.

Stroke

- Incidence: 2-3%
- Mortality: 8x

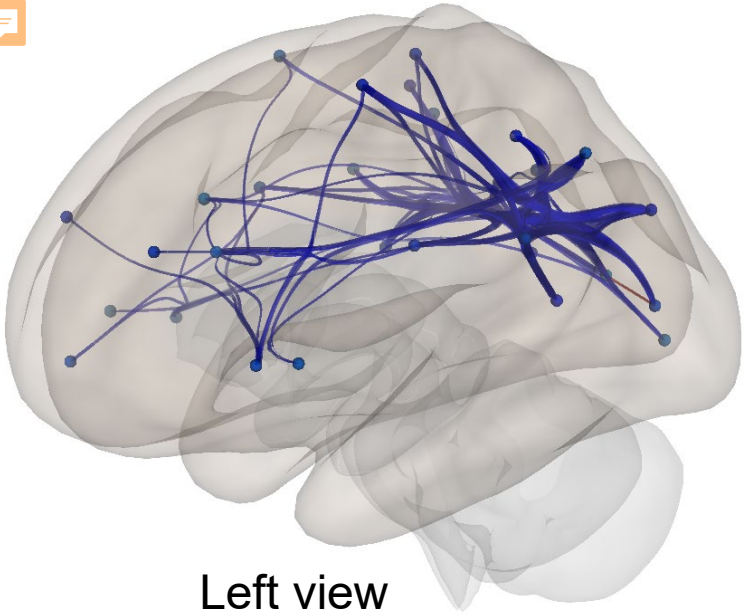
Delirium

- Incidence: 20-50%
- ↑ Mortality
- ↑ Length of stay

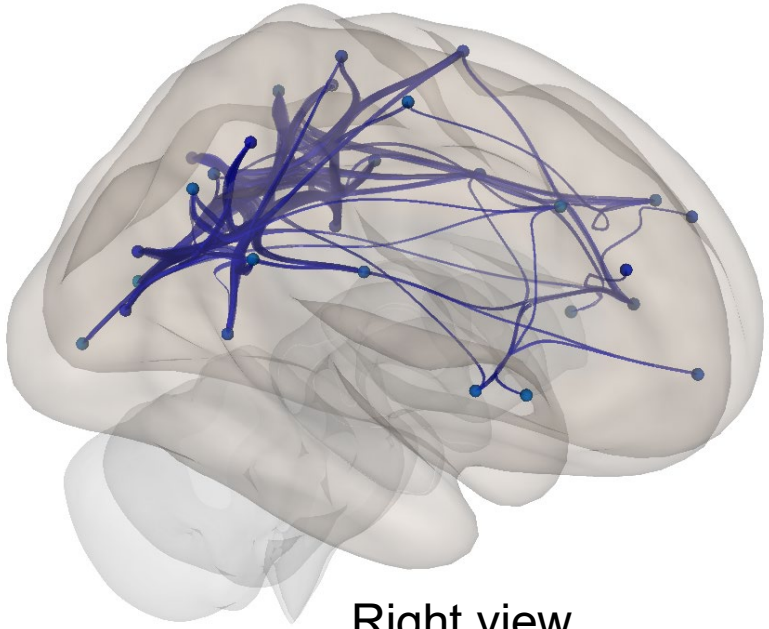
Vlisides, et al (SNACC Taskforce on Peri-op Stroke) 2020 Guidelines, In prep for *JNA*

Vlisides & Avidan 2019. *F1000Research* 8:607

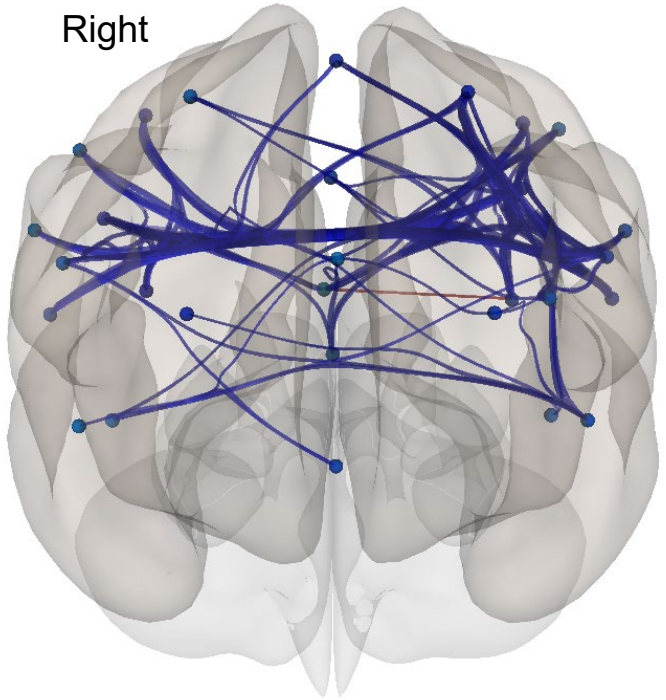
Under midazolam, the pattern of network-network connectivity change was **bilateral**, with **posterior predominance**.



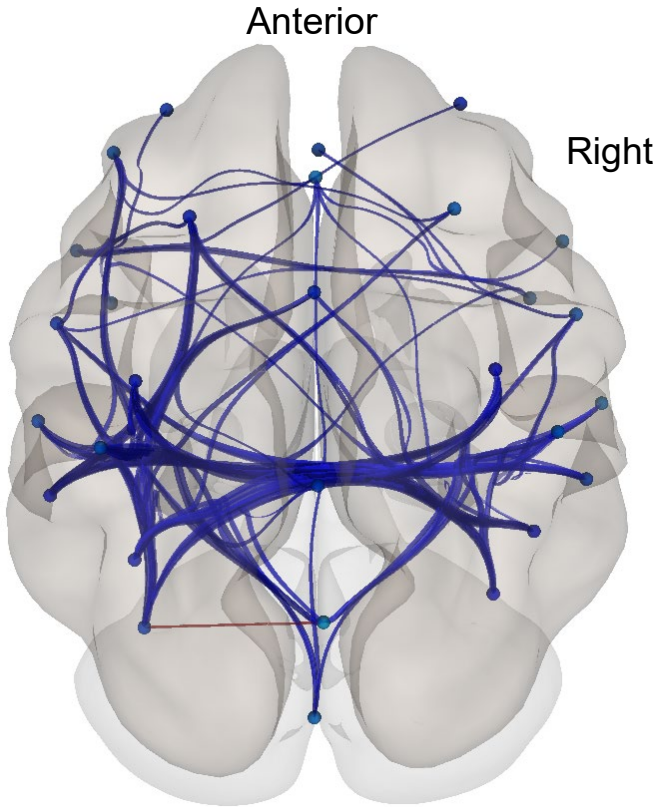
Left view



Right view



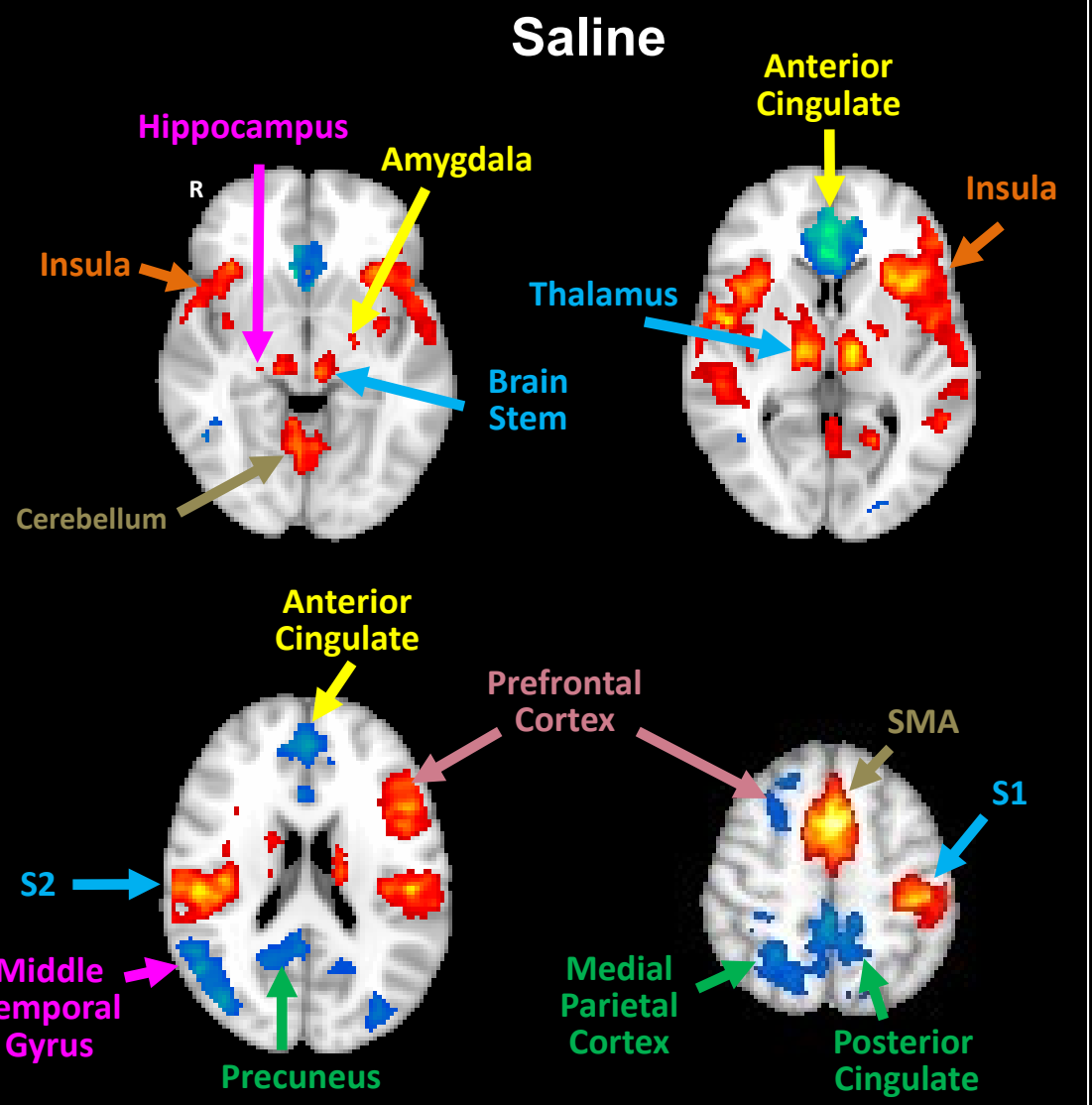
Anterior (coronal) view

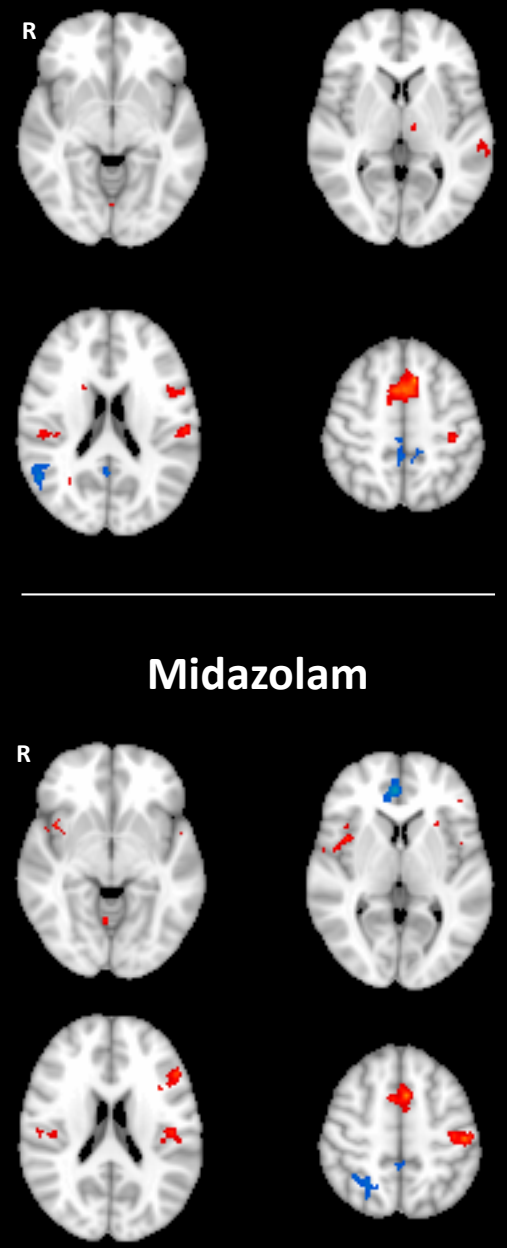


Superior (axial) view

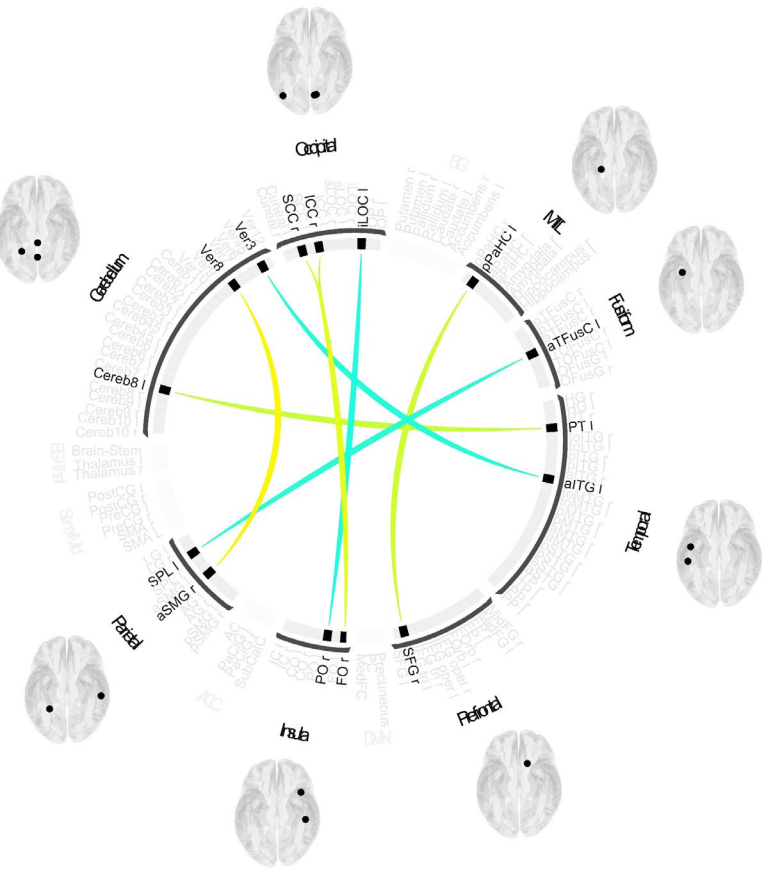
Activation was broadly reduced under both drugs.

Systems/Areas:
Memory
Fear learning
Pain processing
Somatosensory processing
Prefrontal cortex
Default mode Network

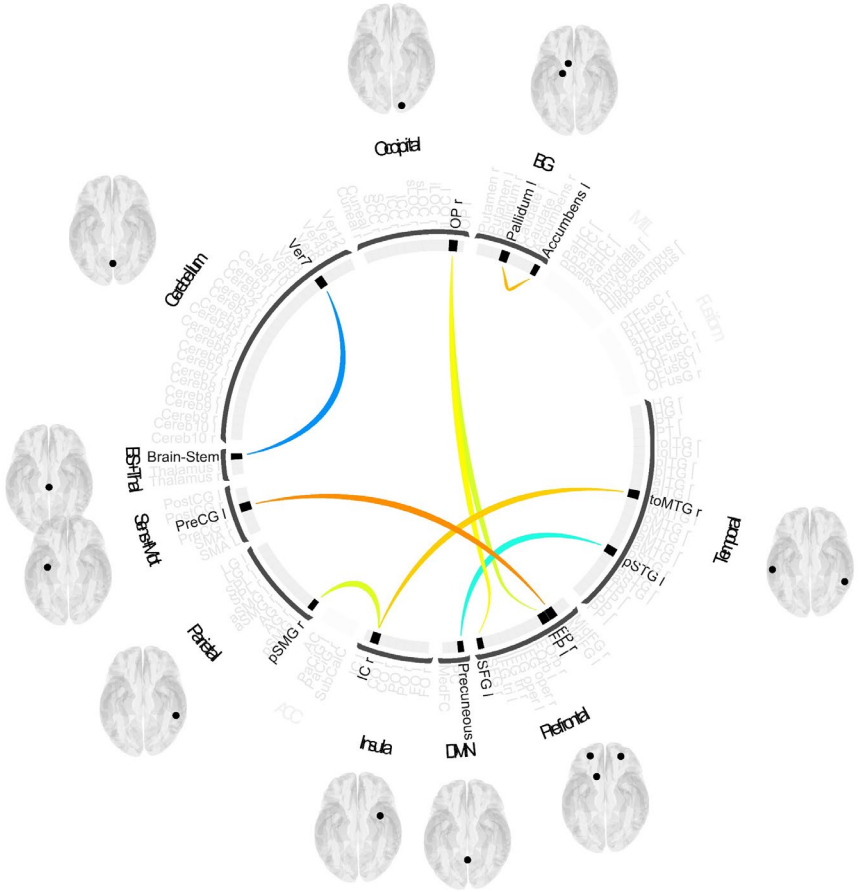




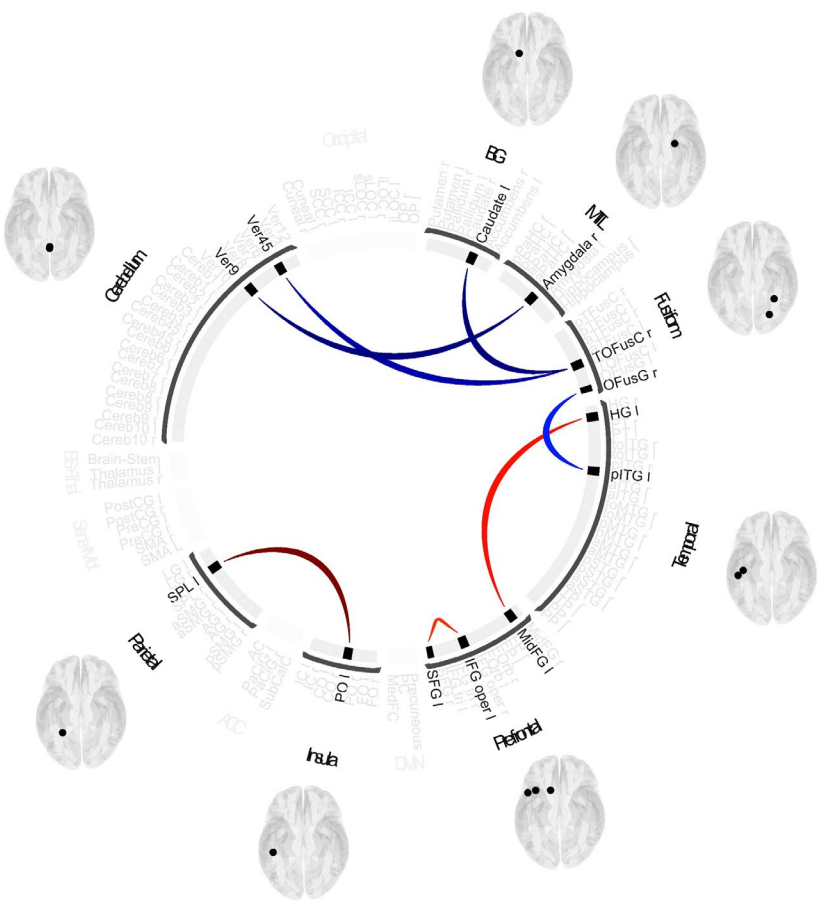
Preliminary patterns of connectivity change differ between drugs.



Saline (n=18) vs. Propofol (n=8)



Saline (n=18) vs. Dexmedetomidine (n=6)



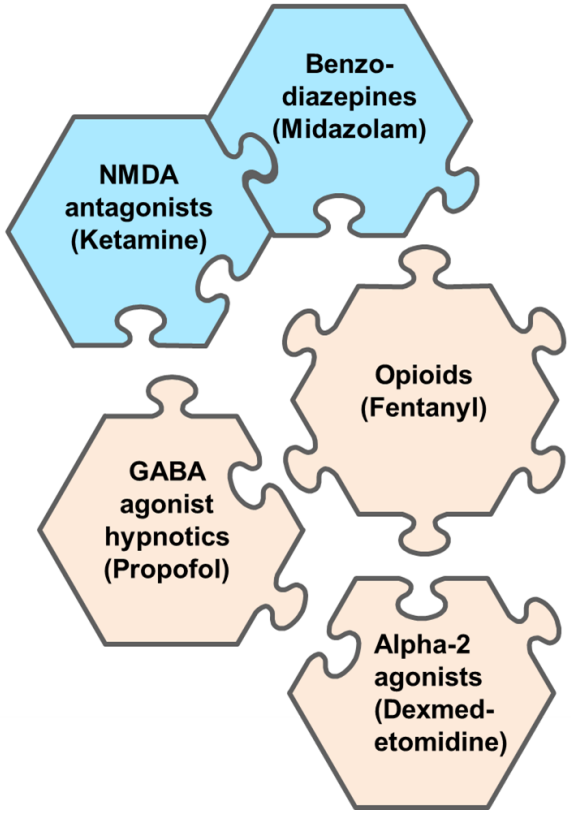
Saline (n=18) vs. Fentanyl (n=4)

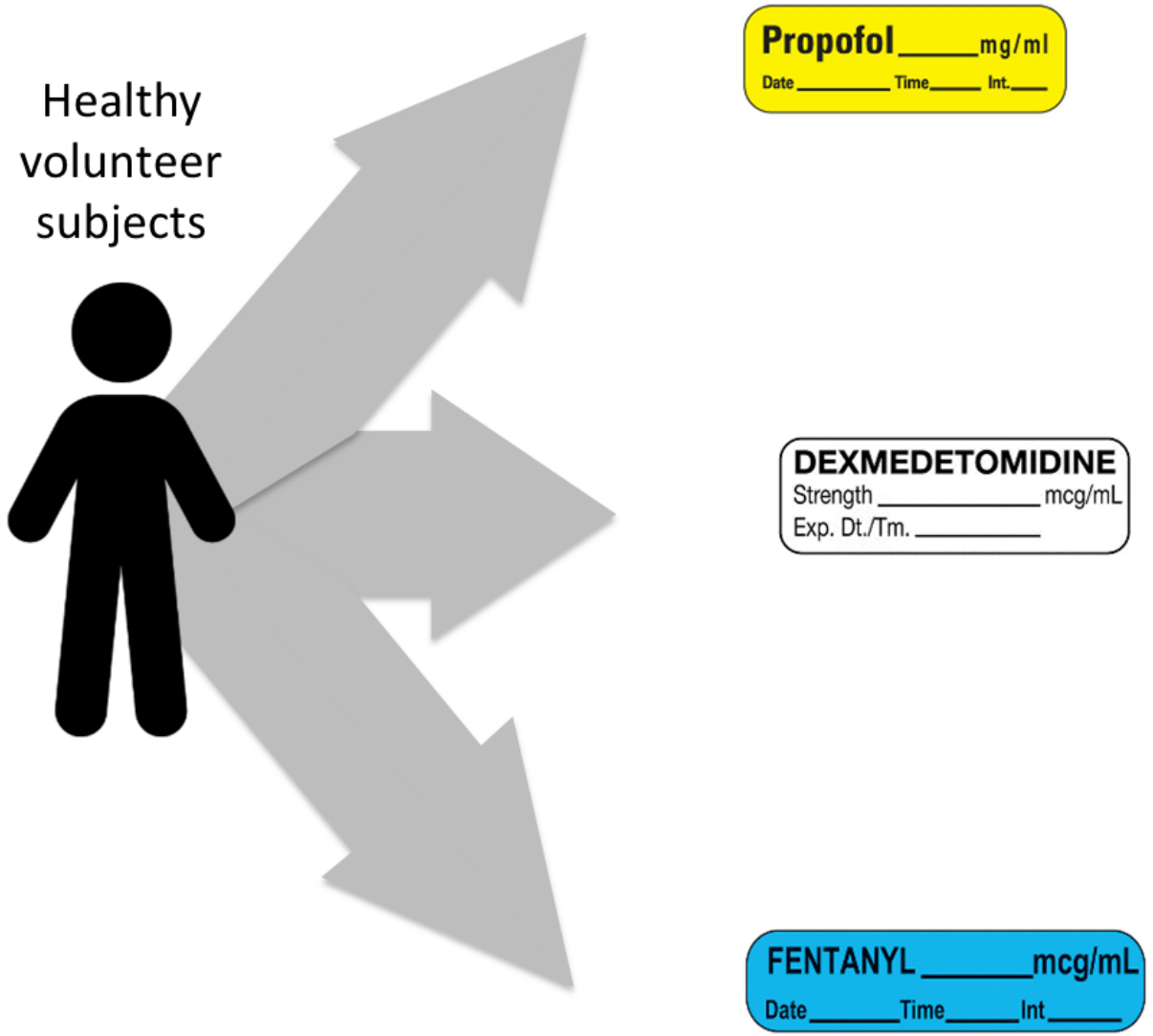
Saline > Drug Contrast

-50 50

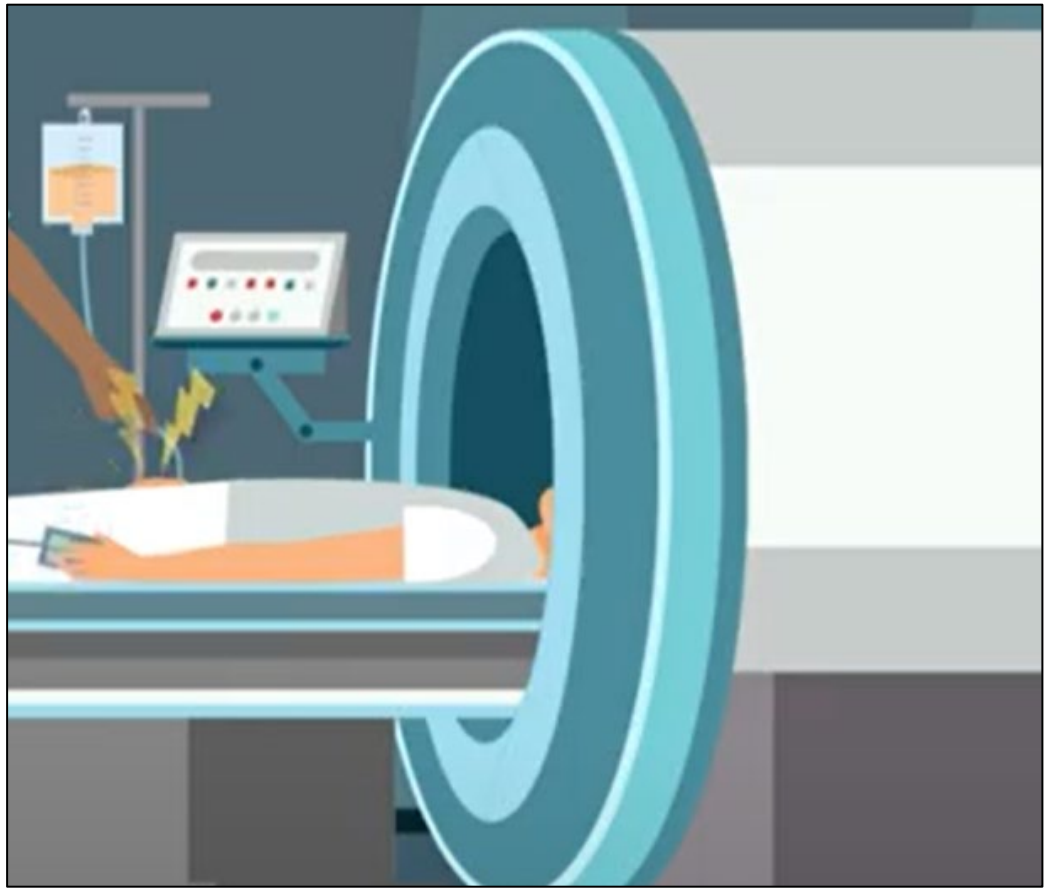
T-statistic: 0

My current work builds on the FAER-funded study.

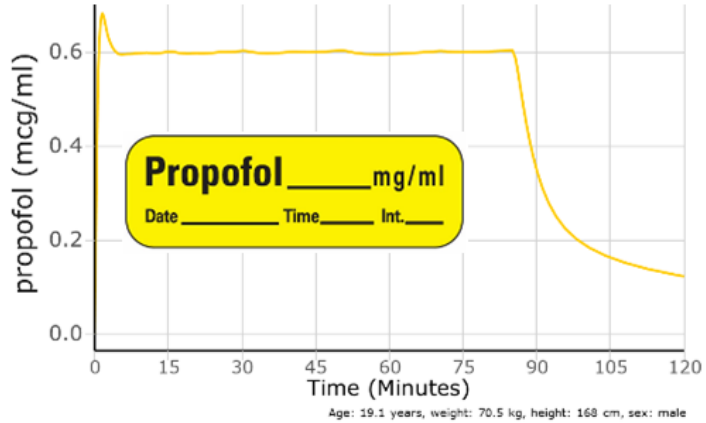


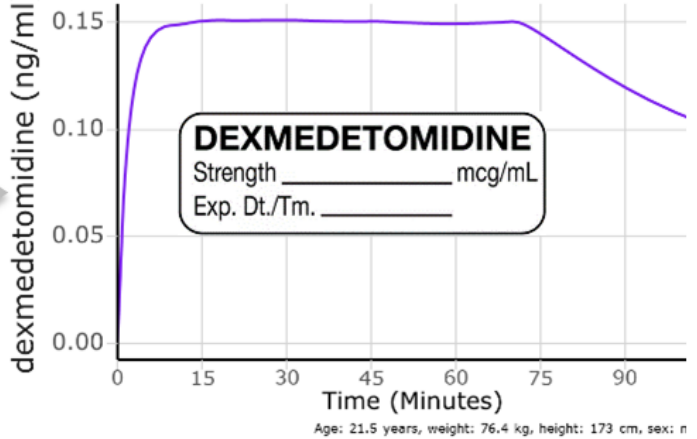


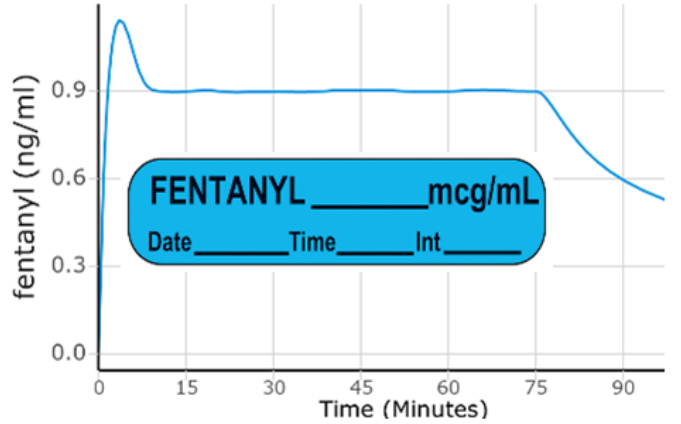
My current work builds on the FA



Healthy volunteer subjects







Additional slide graphic resources:

- https://diagrammer.duarte.com/
- https://thenounproject.com/

Questions?