How to Give an Oral Presentation

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Before we begin

ACKNOWLEDGEMENTS

- David Spach
  - Slides

REFERENCES

- Hayne & McDaniel, Nursing Forum 2013; 48:4 (289-94)

Giving an effective oral presentation

PRESENTATION

- Clear
- Concise
- Organized
- Informative
- Relevant

SPEAKER

- Energetic
- Charismatic
- Passionate
- Humorous
- Knowledgeable

Outline

- Organizing your talk
- Enhancing your presentation
- Powerpoint tips and pitfalls
- Delivery

Types of "Fellow Talks"

- Case conference/clinical review
- Informal lab meeting/research group
- Research meeting
  - Division
  - Regional/national
- Formal venue
  - Job talk
  - Grand rounds

Approach to organizing your talk

- Know your audience
- Know your message
- Know your material
- What is the goal?

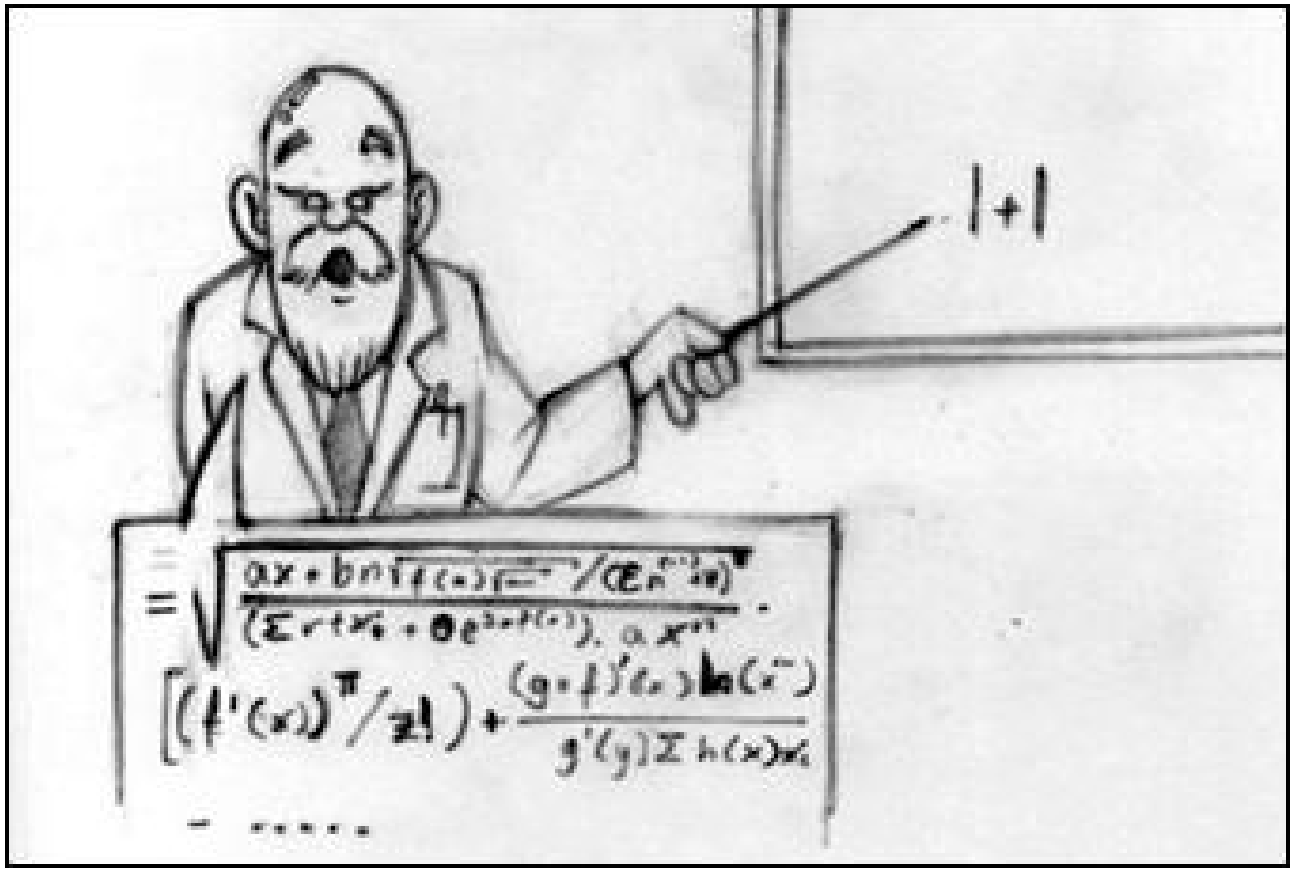
Audience

- Case conference/clinical review
  - Medical students, community providers, peers
- Informal lab meeting/research group
  - Scientists, epidemiologists, biostatisticians
- Research meeting
  - Division or Regional/national
    - Peers
- Formal venue
  - Peers, colleagues with broad expertise

Managing a mixed audience

- Use real examples
- Focus on key information
  - Do not provide extraneous level of detail
- Present material in a step-wise level of difficulty
  - Bring people along with you

Keep it simple



Define your message: Research Talk

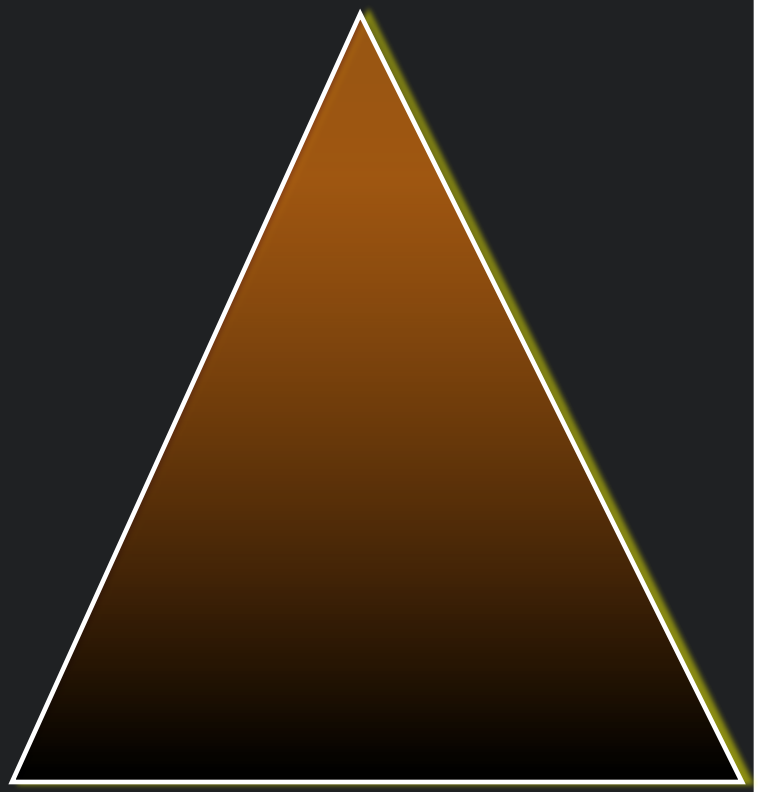
- Make it easy to understand
- Limit to 1 or 2 key messages
- Focus your content
  - Most important for background and results
- Don’t overwhelm with details
  - Laser focus your presentation

Goal of presentation

- Transfer of specific knowledge/information
- Enhance understanding of concepts
- Gain new insight
- Stimulate interest in subject
- Change behavior/practice

“Outcomes” Related to a Presentation

- Change behavior/practice
- Stimulate interest/motivate
- Gain new insight
- Enhance understanding of concepts
- Transfer of knowledge/information



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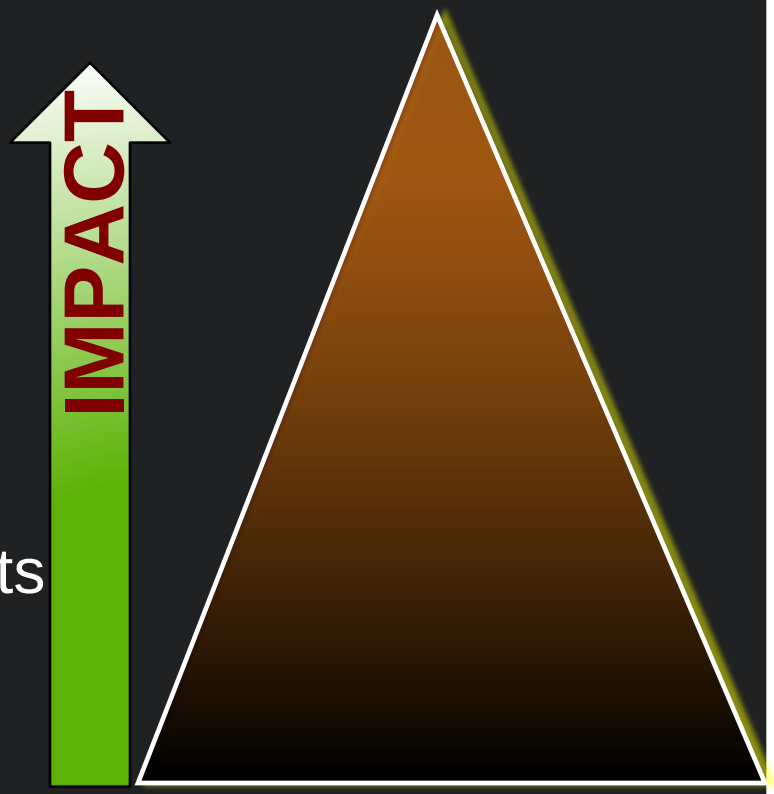

Enhancing Presentation Delivery The Four P's

- Preparation (room and AV equipment)
- Projection
- Pauses
- Performance

Presentation

- Beware of technical issues
  - Mac: PC
    - Especially animation and video
  - Advancing slides
    - Pointer or mouse
  - Microphone
  - Webcast
    - Use mouse instead of pointer, microphone
  - Back it up
    - Email, dropbox, flash drive

Projection

- Size of room and screen
- Make slides readable
- Fonts:
  - Title: 36 to 44 point size
  - Text: 28 or 32 point size
  - Nothing less than 20 point size
  - Sans-serif

Performance

- Be organized
  - Stay within time limits
  - Cut slides/concepts if needed to present in calm manner
    - ~1 minute per slide
      - Don’t go over time
      - Don’t rush

Performance

- Practice
  - Enough so you are comfortable and talk flows
  - Not so much that it is memorized/over-rehearsed
  - Know what works for you
    - I usually practice 3 times
      1. Cut, flow
      2. Refine
      3. Optimize: timing and pacing

Managing anxiety

- Memorize first few slides/transitions
- Bring an outline with you, but don’t read it
- Consider β-blocker if very anxious
  - Try it before the meeting/presentation

Use of the pointer

- Judicious use
- Do not allow pointer to distract
- Do not allow pointer to reveal anxiety
  - Use hand to steady –or-
  - Use mouse

Powerpoint

FRIEND OR FOE?

Speaker Goals for Session

- Change your approach to preparing for a lecture
- Increase use of images to enhance presentation
- Improve presentation delivery
- Stimulate your interest to improve as a speaker

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PRESENTATION SKILLS

2013 STATE OF THE ART

Table 3. Recommendations for the Treatment of Methicillin-Resistant *Staphylococcus aureus* (MRSA)

Manifestation	Treatment	Adult dose	Pediatric dose	Class[a]	Comment
Skin and soft-tissue infection (SSTI)					
Abscess, furuncles, carbuncles	Incision and drainage			All	For simple abscesses or boils, incision and drainage is likely adequate. Please refer to Table 2 for conditions in which antimicrobial therapy is recommended after incision and drainage of an abscess due to CA-MRSA.
Purulent cellulitis (defined as cellulitis associated with purulent drainage or exudate in the absence of a drainable abscess)	Clindamycin	300–450 mg PO TID	10–13 mg/kg/dose PO every 6–8 h, not to exceed 40 mg/kg/day	All	*Clostridium difficile*–associated disease may occur more frequently, compared with other oral agents.
	TMP-SMX	1–2 DS tab PO BID	Trimethoprim 4–6 mg/kg/dose, sulfamethoxazole 20–30 mg/kg/dose PO every 12 h	All	TMP-SMX is pregnancy category C/D and not rec ommended for women in the third trimester of pregnancy and for children <2 months of age.
	Doxycycline	100 mg PO BID	≤45kg: 2 mg/kg/dose PO every 12 h >45kg: adult dose	All	Tetracyclines are not recommended for children under 8 years of age and are pregnancy category D.
	Minocycline	200 mg × 1, then 100 mg PO BID	4 mg/kg PO × 1, then 2 mg/kg/dose PO every 12 h	All	
	Linezolid	600 mg PO BID	10 mg/kg/dose PO every 8 h, not to exceed 600 mg/dose	All	More expensive compared with other alternatives
Nonpurulent cellulitis (defined as cellulitis with no purulent drainage or exudate and no associated abscess)	β-lactam (eg, cephalexin and dicloxacillin)	500 mg PO QID	Please refer to Red Book	All	Empirical therapy for β-hemolytic streptococci is recommended (AII). Empirical coverage for CA-MRSA is rec-ommended in patients who do not respond to β-lactam ther-apy and may be considered in those with systemic toxicity.
	Clindamycin	300–450 mg PO TID	10–13 mg/kg/dose PO every 6–8 h, not to exceed 40 mg/kg/day	All	Provide coverage for both β-hemolytic streptococci and CA-MRSA
	β-lactam (eg, amoxicillin) and/or TMP-SMX or a tetracycline	Amoxicillin: 500 PO mg TID See above for TMP-SMX and tetracycline dosing	Please refer to Red Book See above for TMP-SMX and tetracycline dosing	All	Provide coverage for both β-hemolytic streptococci and CA-MRSA
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		160 mg PO BID	2 mg/kg/dose PO every 12 h		
	Linezolid	600 mg PO BID	10 mg/kg/dose PO every 8 h, not to exceed 600 mg/dose	All	More expensive compared with other alternatives
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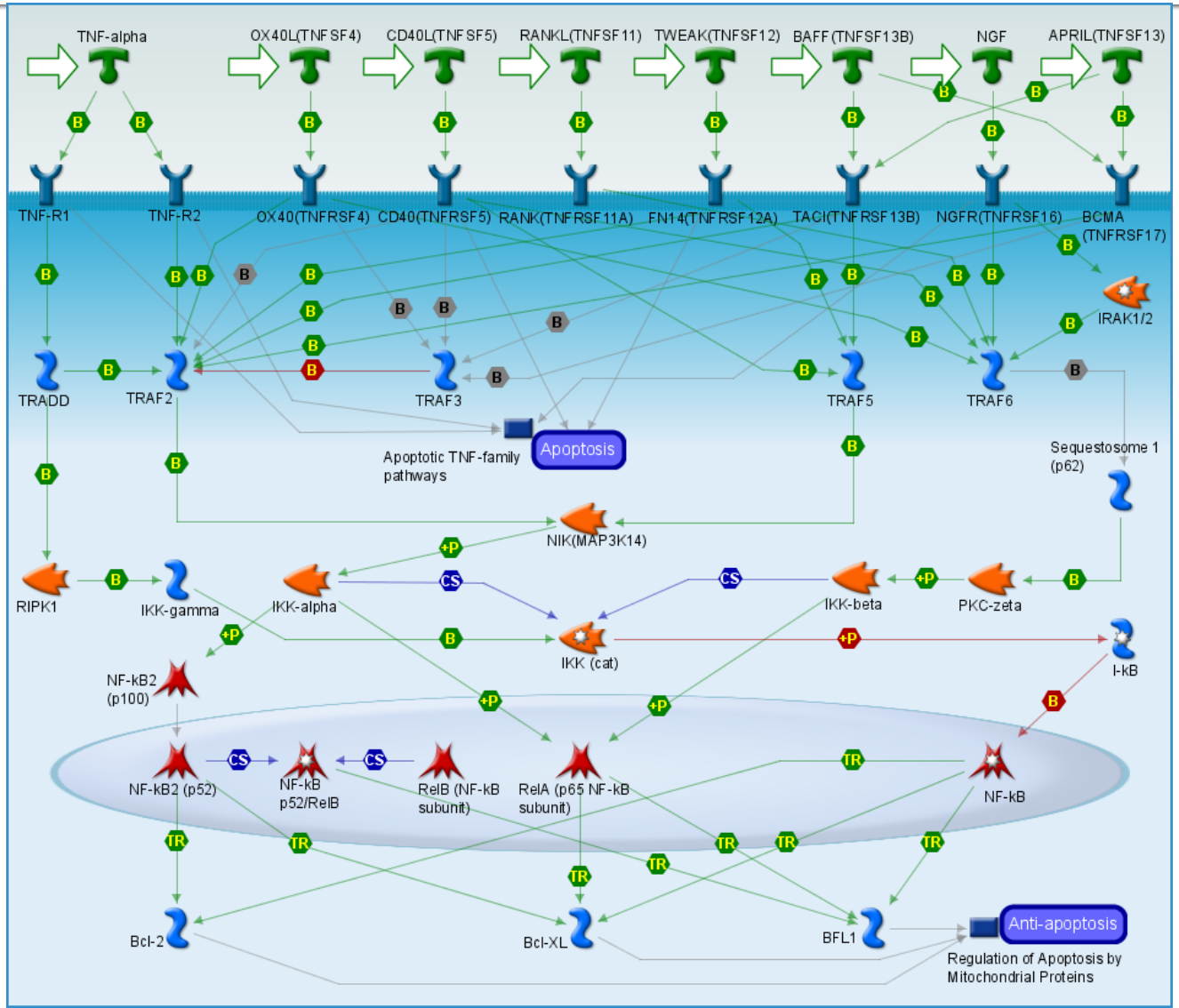
I know you can't read what is on this slide, but……

This slide is busy but…



Resolution

Table 2. Sensitivity of One-Time Colorectal-Cancer Screening Tests.

Test	Sensitivity		References
	Cancer	Advanced Adenomas*	
	percent		
Stool-based tests			
Standard guaiac fecal occult-blood test (three stool samples)	33–50	11	Mandel et al.,[13] Hardcastle et al.,[14] Kronborg et al.,[15] Imperiale et al.,[16] Ahlquist et al.[17]
Sensitive guaiac fecal occult-blood test (three stool samples)	50–75	20–25	Levin et al.,[2] Whitlock et al.,[4] Ahlquist et al.,[17] Allison et al.[18]
Immunochemical fecal occult-blood test (one–three stool samples)	60–85	20–50	Levin et al.,[2] Whitlock et al.[4]
Old stool DNA test (one stool sample)	51	18	Imperiale et al.[16]
New stool DNA test (one stool sample)	≥80	40	Allison et al.,[18] Itzkowitz et al.[19]
Structural examinations of the colon			
CT colonography	Uncertain; probably >90	90 (if ≥10 mm in diameter)	Johnson et al.[20]
Sigmoidoscopy	>95 (in the distal colon)	70†	Selby et al.,[21] Lieberman et al.[22]
Colonoscopy	>95	88–98	Lieberman et al.,[22] Imperiale et al.,[23] Schoenfeld et al.,[24] Lieberman et al.,[25] Pickhardt et al.,[26] Cotton et al.,[27] Rockey et al.[28]

* Advanced adenoma is defined as a tubular adenoma that is 10 mm or larger in diameter or an adenoma with villous histologic features or high-grade dysplasia.

† If an adenoma is detected in the distal colon, the patient would undergo complete colonoscopy, which would result in the detection of some proximal advanced adenomas.

Lieberman DA. NEJM 2009:361; 1179-1187

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Transitions

Transitions

Animations

Animations

Distracting

Use appear function for simplicity

Other Powerpoint pitfalls

- Multiple fonts
- INCONSISTENT FORMAT
  - Removes attention from the speaker and content

“Death by Powerpoint”

Aim 1 Correlation of magnitude, severity, breadth, and phenotype of blood CD8 responses with HSV severity. We will enroll 60 HSV-2-seropositive women. Thirty will have no recognized recurrent GH *and* measured shedding rates of 0 of 30 days (0%) (Group 1), and 30 will have 4 or more episodes/year *and* shedding rates of 6 or more out of 30 days (>19%) (Group 2). The shedding rates are low and high tertiles based on 396 participants who completed 454 shedding sessions >30 days long. These assignments are relatively consistent in repeated sessions and therefore reflect a biological phenomenon within-individual (see Clinical Core). HSV-2 shedding rates will be determined by daily pooled anogenital swab PCR for HSV-2 DNA as detailed in the Cores. Subjects will be immunocompetent adults, 18-55. The age limit reduces confounding from the gradual decrease of HSV severity over time [124]. We will study only women to access cervical samples for **Aim 2**. There will be 10 HSV-1/HSV-2 (-) double negative (DN) controls. Immune seronegative (IS) DN persons occasionally [50,51] have T-cells (CD4>CD8) that react to HSV-2 peptides at low EC_{50}. At screening, candidates will be screened for HIV-1, HBV, and HCV. These are immunomodulatory and disallow the cell sorting in **Aim 1**. Persons with immune suppression or who lack a cervix will be excluded. Subjects who have previously participated in daily PCR shedding studies will be eligible but will have a repeat shedding study. We will re-contact persons with group 1 or 2 phenotypes from previous studies and recruit new persons as needed. HSV-1/HSV-2 serology will be immunoblot [118]. Blood samples (150 ml for PBMC Ficoll/freeze) will be obtained at the beginning and end of a 30 day shedding study. As PCR specimen sets accrue, they will be analyzed to allow subject assignments to group 1, 2 or neither. Genomic DNA will be collected for HLA typing (Lab Core).

Cytobrush @ beginning and end too

Bottom line: 70 people (30 mild 30 severe 30 HSV neg), 2 bleeds for Ficoll; HLA type, 2 cervix per person

Study design

Design: Prospective observational cohort study

Population: HSV-2 seropositive women age 18-55
HIV, Hep B, Hep C seronegative

Cohort 1 (n=30): No prior history of symptomatic genital HSV

Cohort 2 (n=30): 4 or more recurrences in past year

Control (n=10): HSV-1/HSV-2 seronegative

Taking advantage of powerpoint

- Highlight
- Use pictures
- Use graphics

Physical Exam

- T=40, HR=100, BP 90/50, RR=20
- OP clear. No conjunctivitis
- Neck supple, normal ROM
- Lungs CTA B
- RRR, no m/g/r
- Abd: Soft. Guarding RUQ. No splenomegaly
- Skin: No rash
- Lymph node: No cervical, axillary LAN, shoddy inguinal LAN
- MS: No joint swelling/erythema

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HSV-2 is the leading cause of GUD

City	No. tested by M-PCR	*Haemophilus ducreyi* No. (%)	*Treponema pallidum* No. (%)	HSV No. (%)	*T. pallidum*/HSV No. (%)	Negative No. (%)
Birmingham	50	0	13 (26)	25 (50)	0	12 (24)
Chicago	49[a]	6 (12)	4 (8)	24 (49)	1 (2)	14 (29)
Cincinnati	52	0	1 (2)	41 (79)	0	10 (19)
Dallas	52	0	6 (12)	35 (67)	2 (4)	9 (17)
Houston	51	0	1 (2)	38 (75)	1 (2)	11 (22)
Los Angeles	54	0	0	41 (76)	0	13 (24)
Memphis	50	10 (20)[b]	15 (30)	14 (28)	6 (12)	5 (10)
New York	55	0	1 (2)	36 (65)	1 (2)	17 (31)
Philadelphia	50	0	3 (6)	38 (76)	1 (2)	8 (16)
St. Louis	53	0	7 (13)	28 (53)	1 (2)	17 (32)
Total	516	16 (3)[b]	51 (10)	320 (62)	13 (3)	116 (22)

[a] 50 patients were enrolled; 1 specimen was unsatisfactory and was not tested.

[b] Includes 1 participant with both *H. ducreyi*/herpes simplex virus (HSV) detected and 2 with both *H. ducreyi*/*T. pallidum* detected.

Similar findings in studies from around the world

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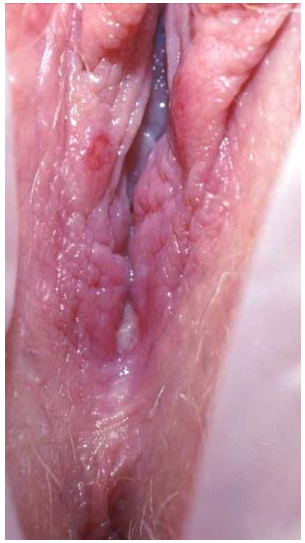
Similar findings in studies from around the world

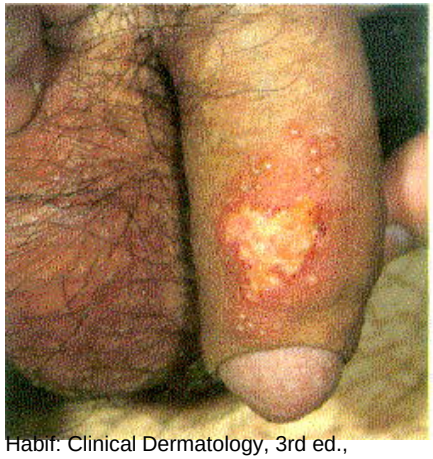
Impact of Genital Herpes

- Leading cause of genital ulcer disease
- Causes neonatal herpes
- Increases risk of HIV infection 2-3 fold

Impact of Genital Herpes

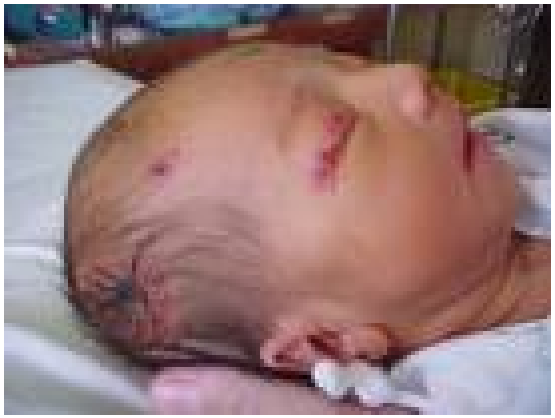
Genital ulcer disease

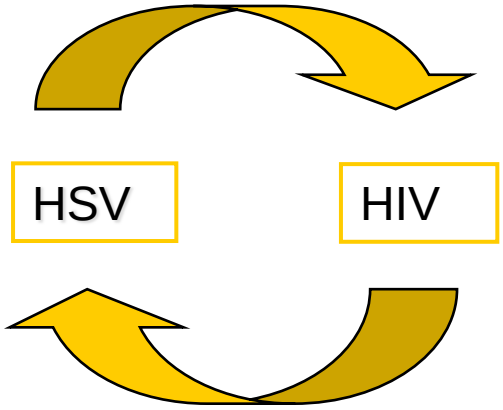




Habif: Clinical Dermatology, 3rd ed.,

Neonatal Herpes





Increases the risk of HIV-1 acquisition 2-3 fold

Genital ulcer disease increases risk of HIV-1 transmission

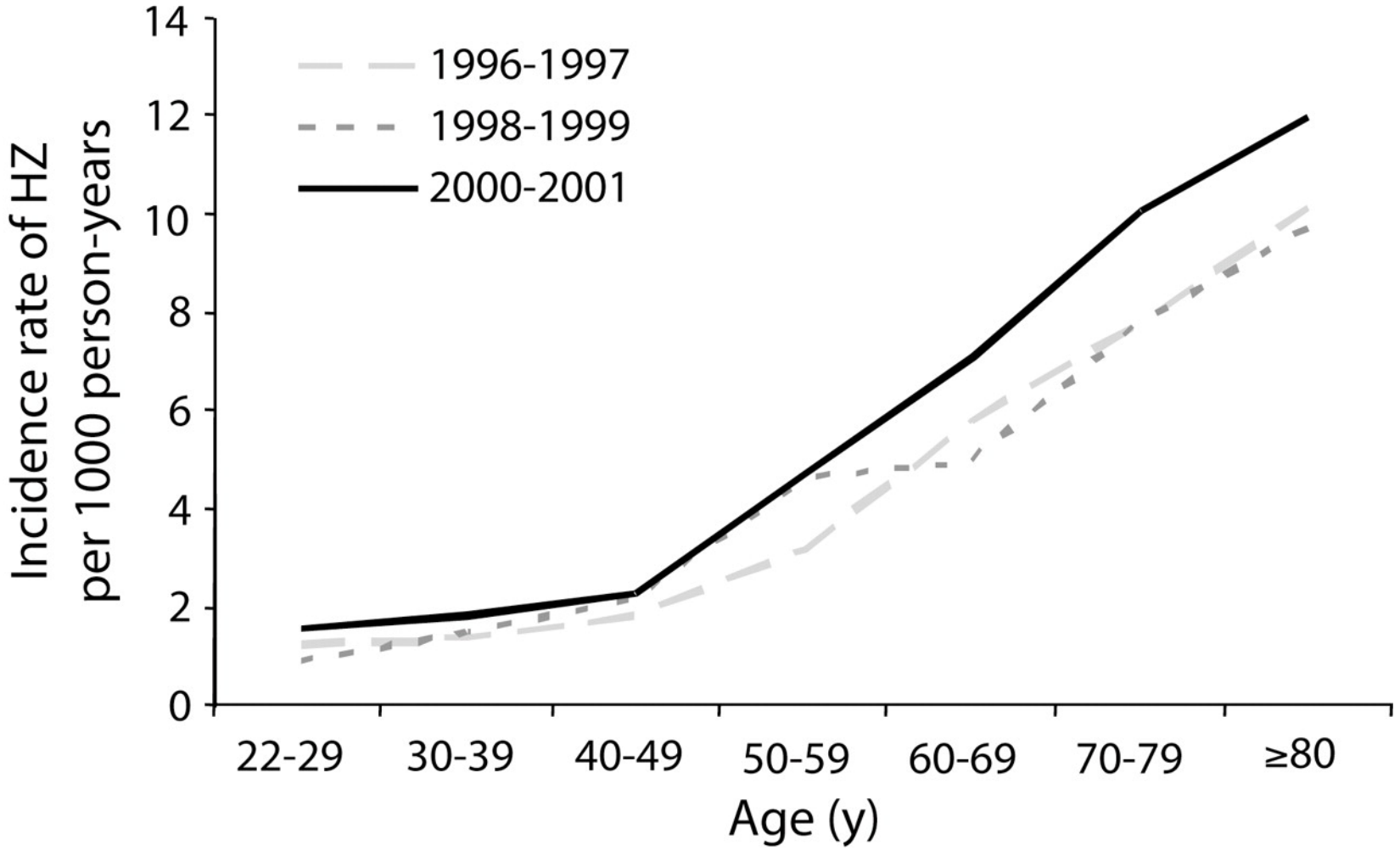
25%-50% of HIV infections attributable to HSV-2 in high prevalence settings

Herpes zoster epidemiology

- Incidence increases with age
  - 2 cases per 1,000 person-years in <40 yrs
  - 12 cases per 1,000 person-years in >80 yrs

Incidence has been increasing in elderly population over past 7 years

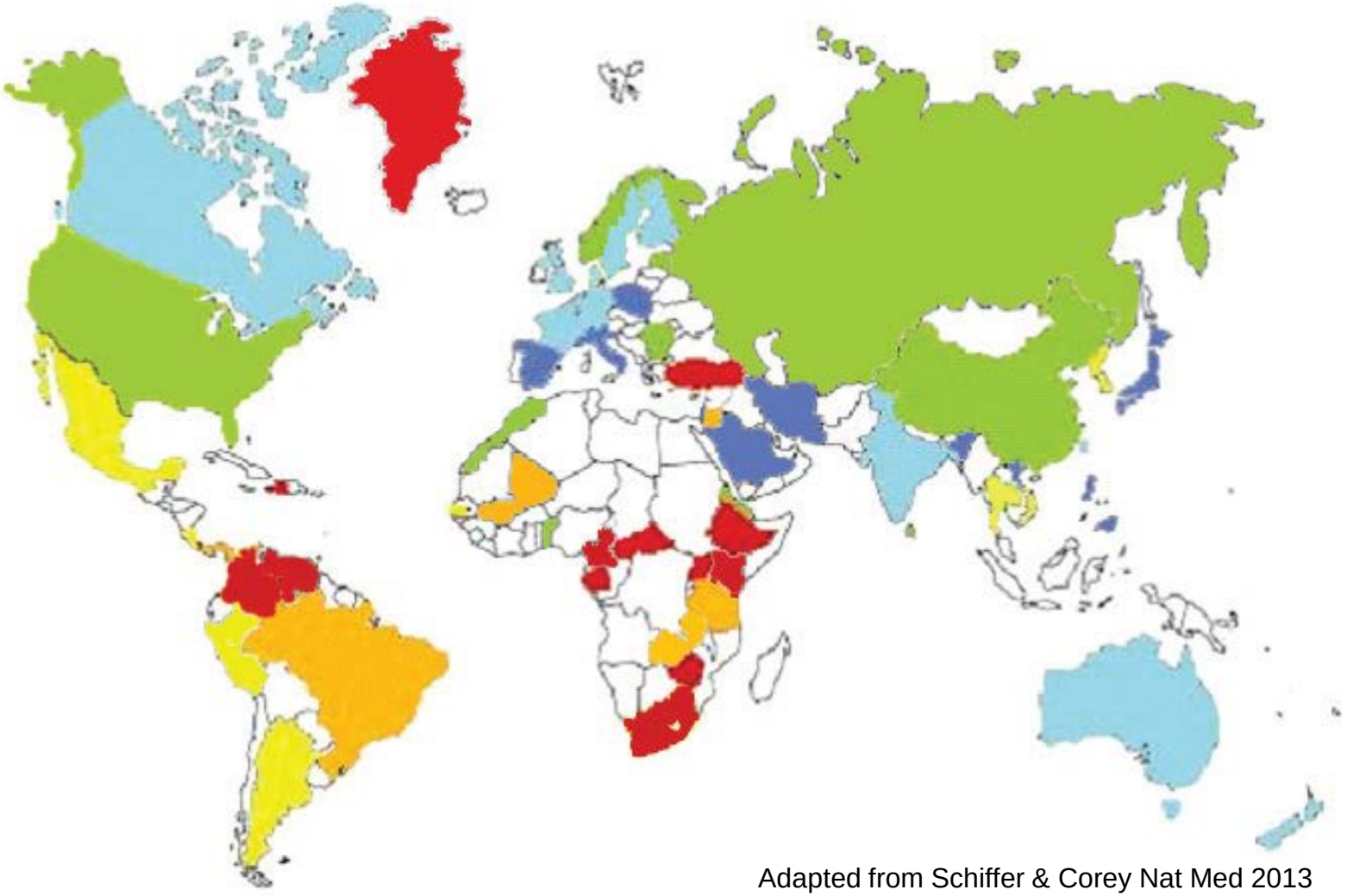
Incidence rates of herpes zoster (HZ) in Olmsted County, MN, adults from 1996 to 2001, in 2-y increments.



Yawn B P et al. Mayo Clin Proc. 2007;82:1341-1349

MAYO CLINIC
Mayo Clinic Proceedings

HSV-2 seroprevalence in women



Adapted from Schiffer & Corey Nat Med 2013

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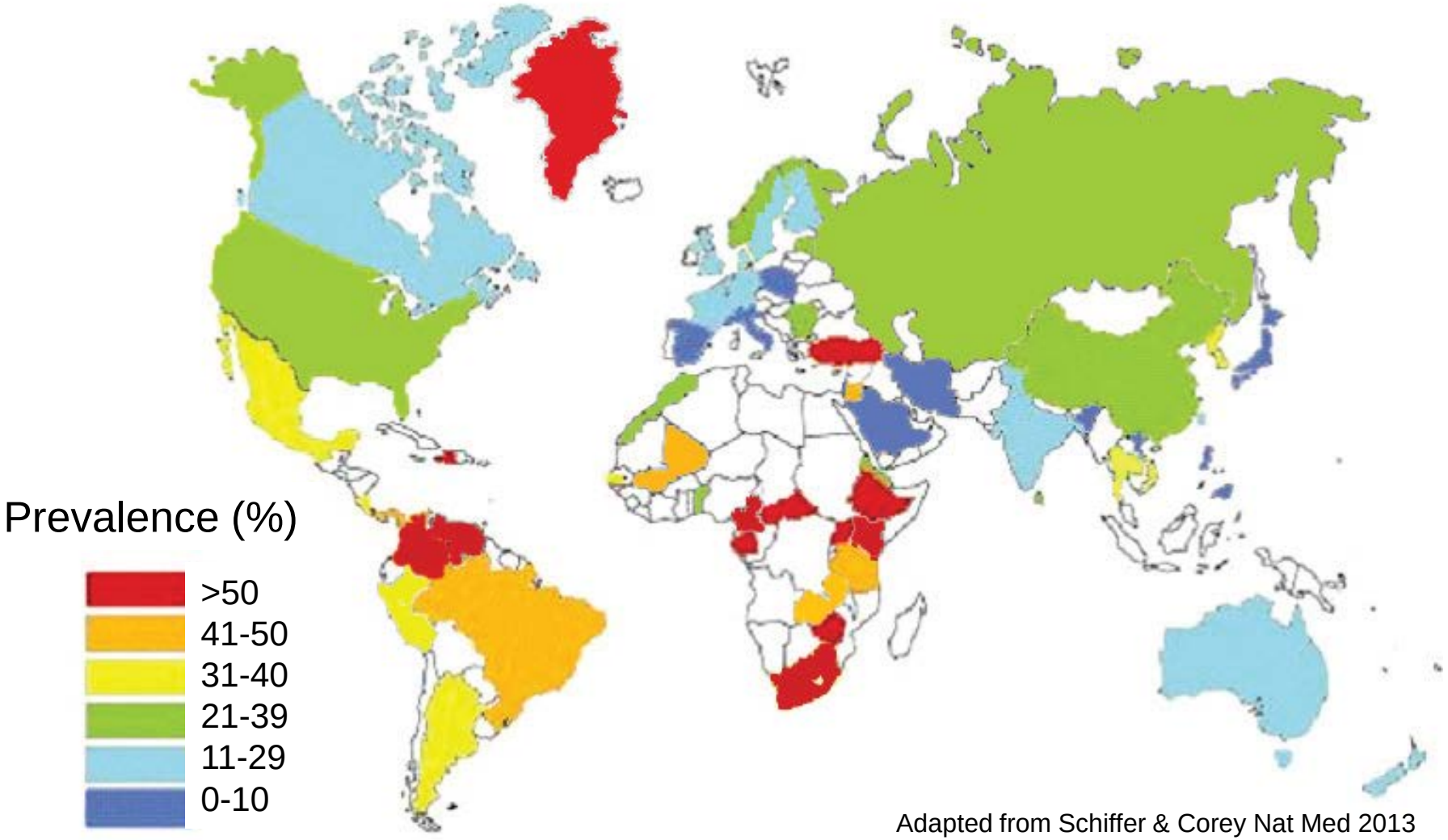

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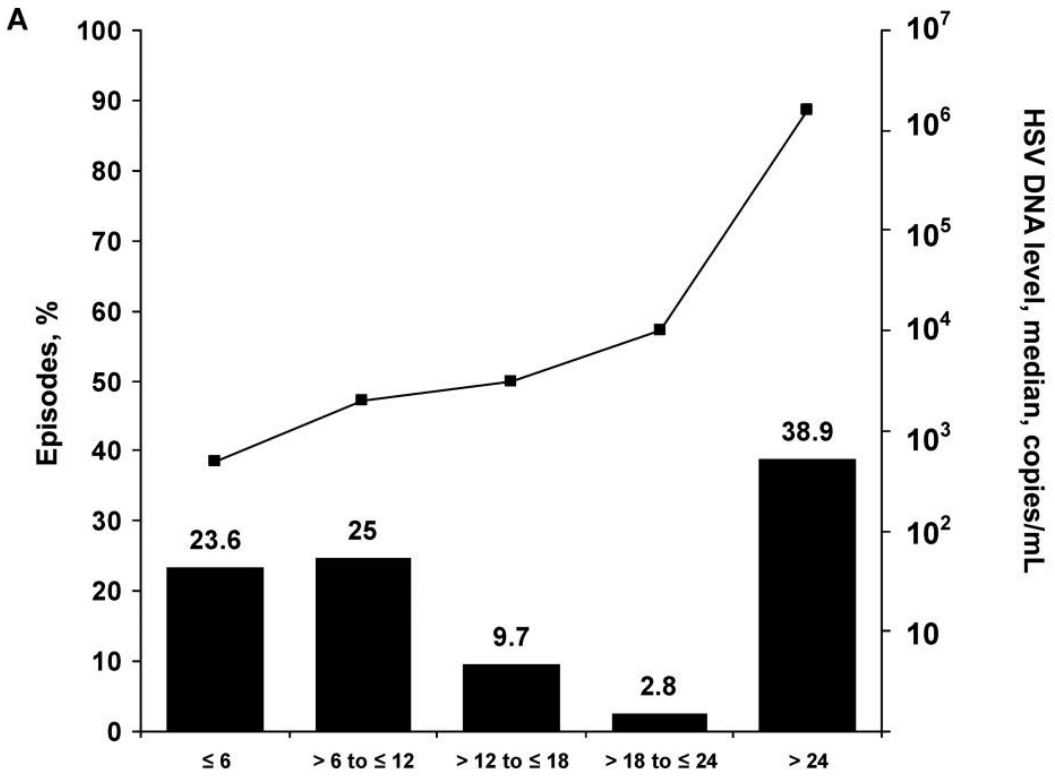
Tips: use of graphics

- Remember figure legends
- Explain axes
  - Take time to orient people to slide so they can interpret findings

HSV-2 shedding episodes are short



Median episode duration=13 hrs

HSV-2 reactivation occurs 3 times more often than previously thought

HSV-2 is leaked from neurons at a near constant rate

Mark *et al*, J Infec Dis 2008; 198:1141
Schiffer *et al*, Sci Transl Med 2009; 1(7)

Delivery

- Appearance
  - Dress appropriately for talk
- Mechanics
  - Aviod spelng mistaeks
  - Cite references appropriately
    - At beginning or end of talk, or on each slide

Delivery: 3 “E”s

- Eye contact
  - Goal: Maintain with minimal use of notes
- Engagement
  - Goal: Involve audience with different strategies
- Elocution
  - Goal: Clear, articulate presentation
    - Speak loudly
    - Avoid monotone
    - Avoid verbal clutter
      - Um, ah, you know

Delivery

- Movement
  - Avoid excessive movement
- Posture
  - Relaxed, facing audience
    - Do not face screen

Evolving in public speaking

- Read your reviews, and learn from them
- Ask for honest evaluation from mentors, peers
- Video and review your presentation:
  - Identify verbal clutter
  - Identify nervous behaviors
  - Worth the pain

Giving an effective oral presentation

PRESENTATION

- Clear
- Concise
- Organized
- Informative
- Relevant

SPEAKER

- Energetic
- Charismatic
- Passionate
- Humorous
- Knowledgeable

Conclusions

- Many opportunities to hone oral presentation skills during fellowship
  - Oral presentation skills are essential for academic research career
- It will take time to learn what strategies work best for you
  - Learn from each talk