From iDea to Reputation: The unconventional

Ahmed Samir Alfaar
Why to research

Q: How many questions do you ask yourself in clinic?
Q: How do you get answers?

Training: - on asking questions
- on finding answers

“You can not manage what you can not measure.”
Finding where we are, measuring the gap, crossing it
**مادة (3): تكاليف النشر الدولي**

1. يتم صرف تكاليف نشر الإحصاءات العلمية المنشورة دولياً بنسبة 50% من الكلية و 50% من حساب تطوير الدراسات العليا والبحث وفقاً للقواعد التالية:
2. في حالة وجود الدورية ضمن قائمة بيانات Thomson Reuters ولم تتم تأثير Impact Factor (تعادل تأثير)均匀 تأثير) (Impact Factor) بمقدار 4000 جنيه كحد أقصى من كلية أو المعهد وإدارة الجامعة.
3. في حالة وجود الدورية ضمن قائمة بيانات Thomson Reuters ولم تتم تأثير Impact Factor (تعادل تأثير) (Impact Factor) بمقدار 5000 جنيه كحد أقصى بين كلية أو المعهد وإدارة الجامعة.

**مادة (2): قواعد الصرف**

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
<th>Rate (L.E)</th>
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<tbody>
<tr>
<td>0.01</td>
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<td>1000</td>
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<tr>
<td>&lt;20.01</td>
<td></td>
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</table>
Research Domains and types
Domains

Basic

- Laboratory
- In-silico

Translational

- Bridging all, from bench to bedside

Clinical

- Phases I, II, III, IV

Health economics, Quality, etc.,
Experimental and Exploratory Research

Descriptive
- Cohort studies
- Case-Control studies
- Correlational vs. Predictive
- Methodological
- Historical

Data sources: Secondary Analysis

Exploratory

Experimental
- Randomized Controlled Clinical Trials
- Quasi-Experiments
- Single-subject designs
Exploratory: Relation to Time

- Prospective Research
- Retrospective Research
- Longitudinal Research
- Cross-sectional Research

Past → Present → Future
Descriptive Research

- Developmental
- Normative
- Qualitative
- Descriptive surveys
- Case Study

- Descriptive
- Exploratory
- Experimental

- Secondary Analysis
- Surveys and Questionnaires
### Systematic Reviews and Meta-analysis

<table>
<thead>
<tr>
<th>Level</th>
<th>Therapy/Prevention, Antiology/Name</th>
<th>Prognosis</th>
<th>Diagnosis</th>
<th>Differential diagnosis/prevalence</th>
<th>Economic and decision analyses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1A</strong></td>
<td>SR with homogeneity** of RCTs</td>
<td>SR with homogeneity** of inception cohort studies; DORI <strong>can</strong> differ in different populations</td>
<td>SR with homogeneity** of Level 1 diagnostic studies; DORI <strong>can</strong> differ from different clinical centres</td>
<td>SR with homogeneity** of prospective cohort studies</td>
<td>SR with homogeneity** of Level 1 economic studies</td>
</tr>
<tr>
<td><strong>1b</strong></td>
<td>Individual RCT <strong>with narrow Confidence Interval</strong></td>
<td>Individual inception cohort study with &gt;80% follow-up; DORI <strong>can</strong> differ in single population</td>
<td>Individual inception cohort study with good reference standards; DORI <strong>can</strong> differ within one clinical centre</td>
<td>Prospective cohort study with good follow-up**</td>
<td>Analysis based on clinically sensible costs or alternatives; systematic review(s) of the evidence including multi-way sensitivity analyses</td>
</tr>
<tr>
<td><strong>1c</strong></td>
<td>All or better</td>
<td>All or better case series</td>
<td>Absolute SpPins and Snihanns**</td>
<td>Absolute better value in non-value analyses **</td>
<td></td>
</tr>
<tr>
<td><strong>2a</strong></td>
<td>SR with homogeneity** of cohort studies</td>
<td>SR with homogeneity** of either retrospective cohort studies or unreported control groups in RCT’s</td>
<td>SR with homogeneity** of Level 2 diagnostic studies</td>
<td>SR with homogeneity** of 2b and better studies</td>
<td>SR with homogeneity** of Level 2 economic studies</td>
</tr>
<tr>
<td><strong>2b</strong></td>
<td>Individual cohort study (inclusion criteria I C T. e.g. &gt;80% follow-up)</td>
<td>Retrospective cohort study or follow-up of unreported control patients in an RCT; Derivation of DORI or validated or split sample 88% only</td>
<td>Retrospective cohort study with good 111 reference standards; DORI after derivation, or validated only or split sample 88% or databases</td>
<td>Retrospective cohort study, or poor follow-up</td>
<td>Analysis based on clinically sensible costs or alternatives; limited review(s) of the evidence, or single studies; and including multi-way sensitivity analyses</td>
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<tr>
<td><strong>2c</strong></td>
<td>“Outcomes” Research; Ecological studies</td>
<td>“Outcomes” Research</td>
<td>Ecological studies</td>
<td>Audit or outcomes research</td>
<td></td>
</tr>
<tr>
<td><strong>3a</strong></td>
<td>SR with homogeneity** of case-control studies</td>
<td>SR with homogeneity** of 3b and better studies</td>
<td>SR with homogeneity** of 3b and better studies</td>
<td>SR with homogeneity** of 3b and better studies</td>
<td></td>
</tr>
<tr>
<td><strong>3b</strong></td>
<td>Individual Case-Control Study</td>
<td>Non-consecutive study, or without consistently applied reference standards</td>
<td>Non-consecutive cohort study, or very limited population</td>
<td>Analysis based on limited alternative or costs, poor quality estimates of data, but including sensitivity analyses and postulating clinically sensible variations</td>
<td></td>
</tr>
<tr>
<td><strong>4</strong></td>
<td>Case-series (and poor quality cohort and case-control studies**</td>
<td>Case-series (and poor quality diagnostic cohort studies**</td>
<td>Case-control study, poor or non-independent reference standard</td>
<td>Case-series or superordinate reference standards</td>
<td>Analysis with no sensitivity analysis</td>
</tr>
<tr>
<td><strong>5</strong></td>
<td>Expert opinion without explicit critical appraisal, or based on physiology, bench research or “first principle” expert opinion without explicit critical appraisal, or based on physiology, bench research or “first principle” expert opinion without explicit critical appraisal, or based on physiology, bench research or “first principle”</td>
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<td>Expert opinion without explicit critical appraisal, or based on physiology, bench research or “first principle”</td>
<td></td>
</tr>
</tbody>
</table>
Study design

What can we do with two eyes?
Study vs. ADDIE model

Idea
Study Design
Prepare settings
Clinical Trial
Interim and Final analysis
Publishing

Creative ideas
Data sources
Analysis
Design
Development
Implementation
Evaluation
Research question

**The conventional →**

**Question**
Important/useful
Answerable
Feasible

**Hypothesis**
Deductive vs. Inductive
Null hypothesis (statistical)
Non-directional vs. directional

Select topic of Interest

Clinical Experience
Clinical Theory
Professional literature

State The Research Problem

Define Research Question

Evaluate the Research Problem

Identify Target Population
State Research Rationale – Background
Identify Variables—Operational Definitions

Clarify Research Objectives
State Specific Purpose or Hypothesis

Review of Literature
The Data or the Idea; Who does come first?

Hypothesis then collect
Data and explore
Getting an innovative start point

If your processor is OFF, we can start here
Identify Dimensions
Dimensionality

How many solutions may meet with each dimension?

How to move systematically between possible solutions?
Creativity, mimicking evolution, to survive

- Desert Example, Traffic Example
- Evolution
  - Population
  - Hereditary
  - Crossover
  - Mutation
  - Natural selection
- Don’t say no .. Let it survive
- >> Evolutionary Algorithms / Genetic Algorithms
Creating a cataract model

Is it one problem? One Disease? Cortical vs. nuclear vs PSC?

A mono dimensional study: lens proteins (crystallins)
Adding osmosis/electrolyte imbalance, adenosine triphosphate, glutathione disulfide, sorbitol dehydrogenase dimensions

Solution Targets: Single dimension, two dimensions,
A possible innovative question

**Extremes**
- Surg | Med | Genetic
- Muscles
- Extra-oc
- Choroid
- Cil. Body
- Retina

**Dimension Domain**
- Management
- Muscles
- Extra-oc
- Choroid
- Cil. Body
- Retina

- Osmolarity | Cont.
- Content
- Structure
- Stiffness | ..
- Composition | PH | ..
- Size | shape | ..
- Angle | chromatog | ..
- Depth | ..
- Thickness | OCT prop. | Conj.
- Vitreous
- Lens
- Lens capsule
- Sclera
- Post. Cham.
- Iris
- Angle
- AC
- Cornea
- Conj.
Evolution comes with

Allowing randomness
Make your own chromosome and start the breeding

Source: http://www.slideshare.net/jihunparkalpha/seke-2014
Think ..

? Problem

? Solution space

? Pick an idea
Team-up

• Agree on objectives
• Learn to be a team member, recruit *youngsters* as “your project” managers
• Stand on shoulder of *giants*
• Run multiple *concurrent* projects in different fields with different roles
• Include team members with *relevant* skills
• One importance skill; *ability to achieve*
• Keep an *event log* for each project
Funding

Sometimes NO required funding

Sources

- National vs. International
- Gov.: ASRT, RDI, STDF
- Univ.: CU
- Intl.: Horizon2020/EU, Grants.Gov/US
- Societies/Foundations/Companies: e.g. MisrElkhir, Citadel, Sawiris, etc.,
- Celebrities/Families
- Search scival.com

Proposals

- Learn how to dream

Consortia

- Build your national and international network of success
Clinical documents

Clinical Sheets
Photography
Radiological
Pathological
Other sources
Surveys

Patient reported outcomes
Quality of life
Knowledge/Awareness Assessment
Brief Communication

International Telepharmacy Education: Another Venue to Improve Cancer Care in the Developing World

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Abstract

Objective. In developed countries, pharmacists play a crucial role in designing and implementing cancer treatments as part of a multidisciplinary oncology team. However, developing countries have a shortage of pharmacists, and their role is generally limited to dispensing and selling drugs. The aim of this study was to investigate the feasibility of providing clinical pharmacy educational activities via international telepharmacy to improve cancer care in developing countries. Methods and Methods: Motivations for the initiation and success of the telepharmacy project were detailed in a previous manuscript.2,3 The current investigation reports on the specific problems of 17 countries where telepharmacy was implemented.

Introduction

Pharmacists play a major role in improving healthcare and patient safety while reducing cost, especially for oncology patients.1 The role of pharmacists in part of the treatment team is widely established in developed world.1,2 However, in some general hospitals in developing countries, the lack of the clinical pharmacy is a major concern.1,2 This shortage has prompted New Zealand to employ an additional salary scale in which all pharmacists would be required to complete one of their training in rural areas.1 In the United States, Wisconsin has created new laws that allow the use of telepharmacy for patients as a solution to the pharmacist shortage in that state.1 In the developing world, the shortage of clinical pharmacists is even more pronounced because their role is usually marginalized and they are often responsible only for dispensing medications and compounding.1,2

Purpose: To evaluate the feasibility of providing clinical pharmacy educational activities via international telepharmacy to improve cancer care in developing countries.

Methods: A total of 17 countries were identified as having critical needs for clinical pharmacy following a recent survey. The goals of the project were to: 1) identify the sites, 2) develop telepharmacy arrangements, 3) conduct educational sessions, and 4) evaluate the outcomes. The countries were divided into four regional clusters: North Africa, Middle East, South Pacific, and Asia.

Results: In total, 108 educational sessions were conducted at the sites. The sessions were conducted using videoconferencing software. The topics included: the role of the pharmacist in cancer care; the use of telepharmacy to improve medication management; and the impact of cancer on the quality of life.

Conclusions: The project demonstrated the feasibility of providing clinical pharmacy educational activities via international telepharmacy to improve cancer care in developing countries. Further research is needed to evaluate the long-term impact of these educational sessions on patient outcomes.
Integrating Web 2.0 in Clinical Research Education in a Developing Country

Mohamed Amgad - Ahmad Salem Al Farawi

Abstract
Categorial data were presented in terms of frequencies and percentages. Comparison between more than two groups was done using Kruskal-Wallis test. Pair-wise comparison between different groups was carried out using Bonferroni correction for multiple comparisons. IBM SPSS software version 20 was used for statistical analysis.

Results
The course administration enrolled 176 students, 142 of whom committed to attend the whole course. The evaluation survey was filled in by 156 respondents, 134 of whom were course candidates (response rate=94.4 %) and 22 of whom were course coordinators (response rate=81.5 %). The course participants came from 14 different universities throughout Egypt, including the Cairo University, Am Shams University, Alexandria University, Al-Azhar University, Assiut University, Beni Suef University, Fayoum University, Mansoura University, Menoufia University, Suez Canal University, Tanta University, and Zagazig University. Most respondents study medicine (150, 96.2 %), but there were respondents from the faculties of pharmacy (4, 2.6 %) and science (2, 1.3 %) as well. One hundred five (68.2 %) of respondents knew about the course via the Internet.

The mean attendance for all 142 students was 82.6 % (median 88 %) of all days; 20.4 % of the students attended 100 % of the course sessions, while 21.8 % attended 90-99 %, 35.2 % attended 80-89 %, and 22.3 % attended 79 % or less of the sessions.

When asked to give their general impression about the course, 129 (82.7 %) of respondents either agreed or strongly agreed that the course was appropriate and that it will be useful to students when compared to each of the other tools except Google Hangout and online application (P<0.01).

We developed a tool whereby the student is asked to move a scale using the computer cursor, where one end represents the worse outcome and another represents the better outcome. When asked to imagine what would be the course would have looked like if the online tools were not used (as a percentage of what it really was like), student ratings had a median of 16 % (mean of 22.1 %), further supporting their satisfaction on the use of Web 2.0 technology in education.

One hundred fifty-three (98.1 %) of students said that they would recommend the use of Web 2.0 technologies if the course was to be repeated, and 150 (96.2 %) agreed that the use of Web 2.0 technologies and social media made the course
SEER

Surveillance, Epidemiology, and End Results Program

Cancer Statistics
- Cancer Sites
- by State, Ethnicity
- by Sex
- by Race and Sex
- by Age at Diagnosis/Death
- by Data Type
- Fast Stats Help
- Fast Stats Resources
- State Cancer Profiles
- Confidence Intervals for Ranks
- Cancer Statistics Animator
- Geographic Information System Portal
- Prevalence and Cost of Care Projections
- Cancer Query Systems

Compare Statistics by Age

Step 1: Select a data type, statistic and population of interest
- Data Type: SEER Incidence
- Statistical Type: Age-Adjusted Rates
- Year Range: 1975-2011 (SEER 9)
- Cancer Sites: All Cancer Sites Combined
- Sub-site: N/A
- Race/Ethnicity: All Races (Includes Hispanic)
- Sex: Both Sexes

Step 2: Select rows to show on graph table (Rows 10)
- Ages < 20
- Ages 20-69
- Ages 60-64
- Ages 65-74
- Ages 75+
- Ages < 65
- Ages 60+
- Ages 65+

Age-Adjusted SEER Incidence Rates
By Age at Diagnosis/Death
All Sites, All Races, Both Sexes
1975-2011 (SEER 9)

Cancer sites include invasive cases only unless otherwise noted.
Races are per 100,000 and are age-adjusted to the 2000 US Std Population (10 age groups – Census-PEPS 11.0). Regression lines are calculated using the Joinpoint Regression Program Version 4.1.0, April 2014, National Cancer Institute.

Incidence source: SEER 9 areas (San Francisco, Connecticut, Detroit, Hawaii, Iowa, New Mexico, Seattle, Utah, and Atlanta).
Orbital tumors in USA: Difference in survival patterns

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1Department of Research, Children’s Cancer Hospital Egypt (CCH), Cairo, Egypt
2Laurea University School of Medicine, Cairo, Egypt
3Fried University, Asilo clinic, Jadouen Wittmamberg, Germany
4National Liver Institute, Menoufa University, Shubra El-Kheir, Egypt

ARTICLE INFO
Article history:
Received 17 November 2013
Revised in revised form 30 June 2014
Accepted 1 July 2014
Available online 29 July 2014

Keywords:
SEER
Orbit
Lymphoma
Carcinoma
Rhabdomyosarcoma
Melanoma

ABSTRACT
Introduction: There is a wide range of tumors affecting the orbital adnexa. Key tumor subtypes include lymphomas, carcinomas, melanomas and rhabdomyosarcomas. Several studies have proposed that these histological subtypes differ in their survival outcomes. In this study we aim to describe the difference in survival outcomes between such subtypes. Methods: The SEER database was used to gather patient information. All 18 SEER registries were used. Patients diagnosed from 1996 to 2005 were included in the analysis. Observed 5-year survival rate was calculated using the SEERStat software version 8.1.2. Data were extracted into IBM SPSS version 20 to generate Kaplan Meier curves for each group. Results: There were 2189 patients in the SEER database who met the selection criteria. Lymphomas were the most common histology in adults. The overall five-year observed survival for all lymphoma patients was 75.8% (95% CI: 73.7–78.1). There was statistically significant difference between observed survival rates of lymphoma subtypes. Carcinomas were the second most common tumors. Their five-year observed survival rate in our study was 68.4%. There was no statistically significant difference between carcinoma subtypes’ observed survival rates in the 20–40 age group, while in the older age group, five differences were found to be statistically significant. Rhabdomyosarcomas were the most common tumors in children. The overall five-year observed survival rate for rhabdomyosarcoma patients was 53.8%. There was no statistically significant difference between observed survival rates of rhabdomyosarcoma subtypes. There was no statistically significant difference between relative survival rates according to gender and treatment received except within melanoma. Conclusion: In adults, lymphomas have better survival rates than carcinomas. Whereas the lymphoma subtype can be used as a dominant prognostic factor in any age, the carcinoma subtype can be used as such a determinant in older age groups only. In children, rhabdomyosarcoma are the predominant tumors affecting the orbital adnexa. Further studies are needed to determine if the difference between entactoid rhabdomyosarcoma and alveolar rhabdomyosarcoma observed survival rates is statistically significant.

Table 1

<table>
<thead>
<tr>
<th>Age group</th>
<th>0–15 years</th>
<th>16–24 years</th>
<th>25–44 years</th>
<th>45–59 years</th>
<th>60–&lt;90 years</th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
<th>Relative Survival</th>
<th>Radiation</th>
<th>Surgery</th>
<th>Death</th>
<th>Unknown</th>
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</thead>
<tbody>
<tr>
<td>SEER2016</td>
<td>Carcinoma</td>
<td>60</td>
<td>17</td>
<td>6</td>
<td>9</td>
<td>90</td>
<td>18</td>
<td>73</td>
<td>37.7</td>
<td>35.3</td>
<td>10.1</td>
<td>4.7</td>
<td>4.7</td>
</tr>
<tr>
<td>SEER2016</td>
<td>Lymphoma</td>
<td>60</td>
<td>17</td>
<td>6</td>
<td>9</td>
<td>90</td>
<td>18</td>
<td>73</td>
<td>37.7</td>
<td>35.3</td>
<td>10.1</td>
<td>4.7</td>
<td>4.7</td>
</tr>
<tr>
<td>SEER2016</td>
<td>Melanoma</td>
<td>60</td>
<td>17</td>
<td>6</td>
<td>9</td>
<td>90</td>
<td>18</td>
<td>73</td>
<td>37.7</td>
<td>35.3</td>
<td>10.1</td>
<td>4.7</td>
<td>4.7</td>
</tr>
<tr>
<td>SEER2016</td>
<td>Rhabdomyos</td>
<td>60</td>
<td>17</td>
<td>6</td>
<td>9</td>
<td>90</td>
<td>18</td>
<td>73</td>
<td>37.7</td>
<td>35.3</td>
<td>10.1</td>
<td>4.7</td>
<td>4.7</td>
</tr>
</tbody>
</table>

No statistically significant difference was detected between relative survival of ocular melanoma patients with regards to sex or race. Surgery has shown significantly higher relative survival rates (79.7%, 95% CI: 78.5–80.9) when compared to radiation (76.4%, 95% CI: 75.4–77.5) and with no difference with respect to sex (80.6, 95% CI: 79.5–81.7) as shown in Table 2.

3.1. Melanoma

Melanoma were 92% of the total cases. In the 20–40 age group and the 50–64 age group, there was only one major subtype identified: malignant melanoma. In the 20–44 age group, the five-year observed survival rate was 61.5% (95% CI: 59.0–64.2), while in the 50–64 age group it was 52.6% (95% CI: 48.8–56.5). The five-year observed survival rates for all melanoma patients in this study was 64.6% (95% CI: 62.6–66.7), while the relative survival rate was 75.6% (95% CI: 69.9–82.4). Fig. 3 shows Kaplan Meier curves for observed survival of melanoma patients.

No statistically significant difference was detected between relative survival of ocular melanoma patients with regards to sex or race. Surgery has shown significantly higher relative survival rates (80.6, 95% CI: 79.5–81.7) compared to radiation (76.4, 95% CI: 75.4–77.5) and with no difference with respect to sex (80.6, 95% CI: 79.5–81.7) as shown in Table 2.

3.4. Rhabdomyosarcoma

Rhabdomyosarcoma affected the 0–19 age group only. They represented 21% of the total number of cases. Rhabdomyosarcoma were divided in this study into three subtypes, entactoid, alveolar rhabdomyosarcoma was the most common subtype. They had high survival rate with statistically significant difference between the subtypes. The overall five-year observed survival rate for rhabdomyosarcoma patients was 78.9% (95% CI: 75.7–82.1), while the relative survival rate was 93.9% (95% CI: 89.5–97.0). Fig. 4 shows Kaplan Meier curve for observed survival of rhabdomyosarcoma patients.
GEO, Gene Expression Omnibus
An Investigation of Global Gene Expression Patterns in Glaucoma and Ocular Hypertension Derived Optic Nerve Heads

Purpose: The optic nerve head (ONH) is the likely site of initial damage in the glaucomatous eye. Despite the recognition of elevated intraocular pressure (IOP) as a leading risk factor for the development of glaucoma, ocular hypertension (OHT) eyes displaying consistently elevated IOP do not experience ONH damage. This study aims to identify global gene expression variations in glaucomatous ONHs and their relationship to those identified in OHT derived ONHs in order to improve our understanding of IOP-induced ONH damage.

Methods: (N=5) ONHs were collected from clinically confirmed glaucoma, OHT and age-matched control donor eyes. Total RNA extracted from ONHs was reverse transcribed and assayed using the Affymetrix Human Exon 1.0 ST array. Differentially expressed genes in glaucoma versus control and OHT derived ONHs were identified using an ANOVA analysis with a 1.25 fold change limit and p-value < 0.05. Quantitative RT-PCR was performed to validate selected differentially expressed genes.

Results: Microarray analysis revealed 148 under-expressed genes in POAG versus control ONHs, many of which are involved in ion transport, axonogenesis and macromolecular catalytic processes. 297 genes were over-expressed in OHT versus glaucoma derived ONHs. Mediators of oxodoben-reduction and chemical homeostasis were among the most prominent gene groups identified. The over expression of prostaglandin-endoperoxide synthase 2, integrin, beta-like 1 and fibrin S in glaucomatous ONHs was confirmed by qRT-PCR.

Conclusions: Our data demonstrates marked alteration in global gene expression patterns in the glaucomatous ONH, likely due to extensive tissue injury. The observed overlapping of several differentially expressed genes in glaucoma and OHT derived ONHs suggests the induction of common mechanisms in response to elevated IOP. Preferential over-expression of certain gene groups in OHT but not glaucoma derived ONHs may confer possible protection against IOP-induced ONH damage, which remains to be investigated in future studies.

Overall design: (N=6) Glaucoma, ocular hypertension and age-matched control ONHs were assayed to investigate and compare global gene expression patterns in each sample group.
Ordinal Classification of Pediatric Tumor Samples

Master's Thesis

Submitted By
Ahmed Samir Ahmed Allam

Figure 3: A comparison of several classifiers (Suicide-lab, 2014).

Figure 6: Comparison between top 10 algorithms in data mining using WEKA (Koh et al., 2014; Michel et al., 2011).

Figure 8: Graph representing the ranking through finding thresholds.

Figure 11: Studying data in a multi-dimension space.

Data Source, Comparing Methods, Term Enrichment
Search engines
Google Trends
Machine data

Phaco-
Ret-Cam
Ultra-sound
OCT
Log sheets

Attendance
Clinic visits table
Referral log

... Any tabular data
? OCR
Sources

Surveys
Website reports
Open databases: SEER, GEO (and other NCBI’s), TCGA, ..
Google trends (and other open sources)
Machine data
Any tabular log ..
Writing

Choosing Journal:
- Indexing status
- Journals used by yourself
- Desired audience
- Impact and ranking
- Acceptance/Rejection rate
- Peer review
- Length of the review
- Type of manuscript
- Review or publication fees
- Funding agency policies
- Supplementary data
- Size of the manuscript
Referencing

Mendeley and Zotero
- Building project library
- Collaboration
- Easy citation, rapid revision

What a reference manager can add for a physician in web 2.0 era
Ahmad Samir Alfaar, Radwa Nour

Keywords:
- reference management, research support, scientific writing, citation

Egypt J Cardiothorac Anesth 6:55-66
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1687-9009
Position yourself

Review (start with very simple ideas) or case reports >> Exploratory Research / Second analysis >> Proposal and Funding >> Research >> Publishing >> Build a track

e.g. German Cancer Registry Story.
Profiling

PubMed: your name
Scopus: scopus.com
Google Scholar: scholar.google.com
ORCid: orcid.org
University Scholar: scholar.cu.edu.eg
ResearchGate: www.researchgate.net
Citing

The coin
The team
Impact factor
Eigenfactor
H-Index
Final advice

Keep a record of your questions/ideas

- Start with an empty folder and a line in sheet

Put a research/publication plan for next three years

Team-up
References


http://libguides.usc.edu/writingguide
Thank you

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