Poster Sessions

20

Abstract

At international academic conferences, it is likely that attendees will also be engaging in events outside of the role of being a presenter. In this section, I will address some of the significant discourse features that were noted in these 'agnate' speech events, headed by the first chapter on poster sessions. Next to CPs, poster sessions are the most likely conference event in which novice academics will find themselves involved—indeed, hosting a poster can serve as an intermediary step before giving a fully fledged CP. At each conference I attended, I visited the poster area on at least two occasions. At about 50% of these sessions, the researchers were present and, in a handful of cases, I actively engaged them about their research and poster content. In other cases, I eavesdropped on other interactions and conversations. In yet other cases where the researcher was not present, I simply perused or read a total of 36 posters. The following chapter is based on observations and inquiries made at these poster sessions.

20.1 Overview

Scientific conferences tend to promote poster sessions far more than do humanities' conferences. Interestingly, this is often connected to saving face. Before a scientist builds up a sufficient academic background to perform a CP, the poster can serve as a less-threatening intermediate step. Within the humanities however, the novice academic may start giving CPs at a much earlier stage in their careers as the veracity and minutiae of the research are often less likely to come under immediate scrutiny.

At many conferences, researchers who suffer from stage fright or lack of confidence in performing CPs will often opt to present a poster. In fact, at some of the medical conferences I attended, researchers were not even present in the poster area

M. Guest, *Conferencing and Presentation English for Young Academics*,
Springer Texts in Education, https://doi.org/10.1007/978-981-13-2475-8_20

and, in many cases, were not required to be. Conversely, at applied linguistics/English education conferences there was always a set time at which the researcher was required to be present to interact with visitors. And while it may seem initially that one-on-one discussion with interested visitors will be less threatening than a large, fixed CP audience, managing posters can be made complex by the fact that they usually involve features of both free paper CPs *and* discussion sessions.

How so? Since the content of the poster is static, visitors are able to concentrate more upon those details which may not be absorbed in a CP. This can lead to more acute criticism or pointed questions by those who would not take the time to do so in a standard presentation discussion session. And while the poster session researcher is freed from the duty of preparing a thorough spoken explanation of the research process and contents that define most CPs, interactions are inherently more dynamic and open-ended. The aspect of the poster that a visitor asks you to elaborate upon or challenges will be unpredictable. Further, such interactions demand less formalized interactive protocol on behalf of the visitor than is typically expected in the more public setting of a CP discussion session.

It is noteworthy, however, that posters often depart from the textual formulas of CPs in that they typically minimize the introduction and methods/materials sections and tend to focus more on conveying new information in the results/discussion sections. Methods and materials are usually listed in point form or via other discrete visual units. Any written discussion section usually revolves around the data, and particularly its significance and/or applications within the field, rather than the minutiae of the research process. In this sense, the poster is often serving less as a written version of the published or soon-to-be published material but more as a forum for promoting or even advertising (not surprising given that the medium is more thoroughly visual than other conference events) one's research endeavors—in which case it is the results and discussion that are likely to have a more lasting impact on the visitor.

20.2 Poster Session Suggestions and Hints: Opening the Poster Discussion

Opening a poster session discussion is not always incumbent upon the host. As a conference attendee, you might well be perusing a poster as a visitor when the researcher is nearby, perhaps even making eye contact with you. If you do not have anything in particular to ask, simply smiling back is a sufficient form of politeness. However, if you do not actually have a comment or question then visitors would do well not to employ the type of body language that says, 'Excuse me! Can you come here and help me?'.

However, when it is clear that the visitor wishes to engage (Fig. 20.1), variations of the following were all frequent openers I observed from attendees:

Good morning. I see you did/researched X.
Hi. I'm very interested in X too.
Interesting. I've been researching X as well.

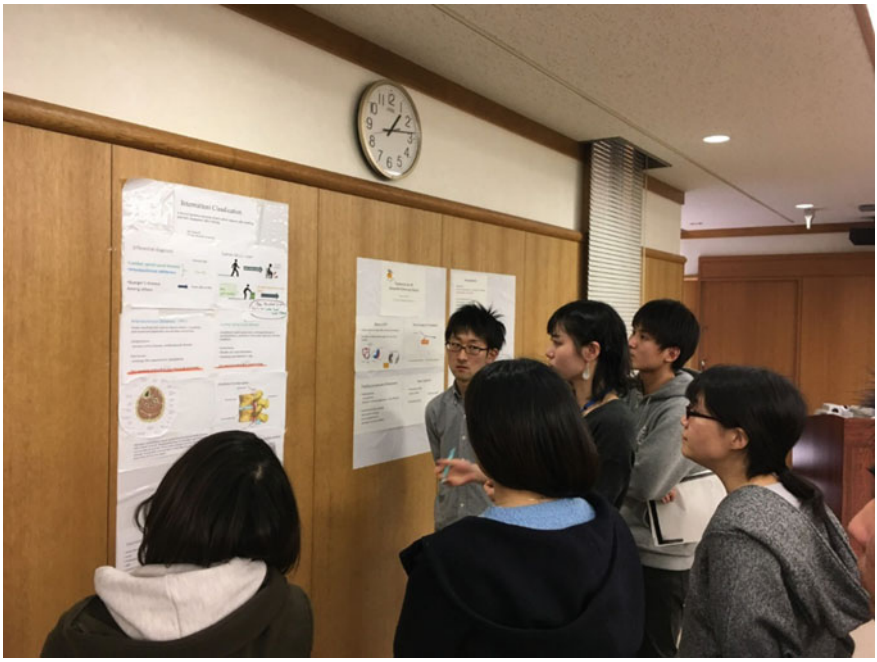

Fig. 20.1 Students/trainees can perform in-house poster sessions with peers as preparation for actual academic conference performance

These forms all worked well to establish discourse ground. One reason might be the explicit use of the term 'research' to create an immediate connection with the researcher. The evaluative term 'interesting'—or similar phrases—helped to establish an interpersonal tone. Readers should also note that '*Hello*' was *not* used very frequently as an opener.

If the host seems slightly busy, perhaps finishing another conversation, '*Sorry for bothering you.*' can serve as suitable opener, after which you can pose your actual question or comment (if you have one). The most frequently noted forms were:

Can I ask you about X?
Can you explain a little more about this part?
I don't quite understand (this section).

Obviously, once you have started the discussion you will have to manage or extend it by yourself (this book has no intention of teaching readers how to actually manage conversations). But how might such interactions close? What is an effective breakaway or finishing line? The most common and popular forms I heard were the

standard: '*I see. Thanks.*' But when lengthier conversations had taken place this was often extended with phrases like:

See you around the conference.
Can I give you my/get your business card/contact information?
Is it all right if I contact you?

Or even, '*Good luck in your research*,' particularly if the hosting researcher seems like a novice or newcomer to the field.

On just over half of the occasions I observed, the host initiated the discussion (another quality distinguishing poster sessions from CPs). Effective poster discussion openers from the host/researchers included the following:

If you have any questions, feel free to ask.
So, are you interested in (topic/product)?

Another opening tactic used by several host researchers was to elaborate upon a feature that the visitor seems interested in. For example, the following opening gambit was overheard when a visitor was looking at some statistical data on a poster:

We collected this data just over a year ago. We'll have new data available soon.

Yet another frequently noted opening gambit was:

Are you familiar with (the specialized area of research)?

This question appeared to be particularly effective in gauging the knowledge level of the interlocutor and thus aided the researcher in knowing how to pitch the tenor and level of the discourse.

As for closing moves from the researcher/host, the following were noted regularly:

Thanks for dropping by.
If you have any questions or comments, feel free to ask/email me.

This latter strategy allows the visitor to peruse the posters by themselves, as many wish to do, without completely being ignored. Accommodating the visitor by allowing them to read at will without any interference serves as a form of negative politeness.

20.3 The Combined e-Poster/Presentation

A newly emerging academic conference speech category, particularly within the hard sciences, is that of an e-poster being supplemented by a short presentation (generally under 10 min). In such cases, the e-poster has been submitted for display and is available online for other conference attendees to peruse, but a standard presentation slot is also allotted for those who submitted e-posters (supplementing the e-poster with an actual CP can bolster ones' academic record).

The greatest difficulty in adapting an e-poster to the verbal presentation format is the conflict or tension between the norms of the written mode and those of real-time speech. This is compounded by the fact that in such presentation sessions, standard PowerPoint slides are not displayed, which means that there may be a less visceral sense of narrative development. Only the e-poster itself is displayed to the audience on the large screen, making the use of animation in order to help direct or signal the audience's focus, to highlight features of order, and to establish clear rhetorical progression, nearly impossible.

This presents a major dilemma for e-poster presenters, and in the few (less than five) poster presentations I attended, the presenter, predictably, simply reread key points already contained in the poster text—these often already fully visible to the audience. Since the entire e-poster text is visible, and also as e-posters are written in such a way as to fully describe the minutiae of methods and results, the need for the contents to be 'presented' or otherwise verbalized is largely obviated. What to do then?

Some of the more successful e-poster presenters I observed altered the written text into more suitably audience-directed speech forms, rephrasing significant written texts by using some of the opening gambits and transitional forms we have covered in earlier in this book. Since using slides and animations was impossible, and knowing that audience members could see the entire text and thus may well be reading at their own pace regardless of the spoken text, more effective presenters focused particularly only on a few salient highlights in the each of the methods, results, and discussions sections, while typically paraphrasing the background/introduction and summary/conclusion segments.

This was invariably carried out with the help of a laser, focusing the audience's attention on what the speaker considered to be anchor spots in the text or sections otherwise considered to be of particular interest or significance. I would suggest that the role of the laser is more central to this type of combined presentation than it is for standard CPs.

More importantly, the combined poster/presentation format forces the speaker to consider which items in the written text are most representative of the whole research study. Which selected points help direct and expand the rhetoric? What written text can be safely omitted in the spoken mode? The poster presenter must also keep in mind that the allotted speaking period is even shorter than that found in standard FP/PSs. The resulting tendency might be to rush through all the written text verbatim, but this will likely become an acoustic blur to all but the most attentive audience members or be meaningful only those with an extremely specialized interest in the speaker's topic.

In order to allow both the speaker to breathe and focus, as well as the audience to adequately digest the content, it is advised that poster/presenters heavily edit the poster contents for speech mode, using paraphrase and focusing on rhetorical anchor points. As an example, let us look at the written text (with various visual images, data, and tables/charts removed) of an original, authentic e-poster presentation (Fig. 20.2) and compare/contrast this text with that of the presenter's oral rendition (see Fig. 20.3).

Epstein-Barr virus associated lymphoproliferative disorders complicated in adult T-cell leukemia/lymphoma

Dr. _____ et al, *(Department, Faculty, University)*

COI Disclosure

Regarding this presentation, I declare that there are no conflicts of interest

Introduction

Adult T-cell leukemia/lymphoma (ATLL) is a human T-lymphotropic virus type-1 (HTLV-1) associated T-cell malignancy and the prognosis for most patients is quite poor. It is endemic in south-west Japan and the Caribbean basin. ATLL is classified into clinical subtypes based on the following clinical manifestations: acute, lymphoma, chronic and smoldering. Reports on the simultaneous development of ATLL and Epstein-Barr virus-associated lymphoproliferative disorders (EBV-LPD) are quite rare. Here, We'll report on the rare morphologic variant of ATLL: ATLL complicated by EBV-LPD.

Case Report

A 75-year-old Japanese woman presented with a 3-month history of indurated erythematous plaques and nodules in the right femoral region and right precordium. Her general condition was good. She was found to have lymphadenopathy in the cervical and subclavicular regions. Serum anti-HTLV-1 antibody was positive. Laboratory examination demonstrated normal white blood cell counts with no atypical lymphocytes. Serum lactate dehydrogenase (LDH) and calcium levels were normal. Soluble interleukin-2 receptor (sIL-2R) level was 789U/ml (normal range, 145-519). A 18F-fluorodeoxyglucose positron emission tomography scan showed abnormal uptake at the skin and lymph nodes.

(Photo accompaniment)

Skin biopsy showed abnormal small to medium-sized lymphoid cells with irregularly shaped nuclei proliferating diffusely from epidermis to subcutis.

Fig. 20.2 Original e-poster text (Reproduced with permission from Dr. Ryoko Sasaki of Miyazaki University Hospital, Japan)

Immunohistochemically, abnormal lymphoid cells were positive diffusely for cCD3 and CD4, while they were negative for CD8, CD20. Southern blotting of biopsy obtained DNA and hybridization with a HTLV-1 provirus.

Lymph node biopsy showed involvement by ATLL cells with scattered EBV-positive cells, some of which resembled Hodgkin cells that had a B-cell phenotype, consistent with EBV-LPD.

Under immunohistological analysis the Hodgkin-like giant cells were positive for CD30, CD15 and negative for CD20, CD3, CCR4. Integrated proviral HTLV-1 was demonstrated in this lesion. In situ hybridization for EBV

Clinical diagnosis: Lymphoma type ATLL complicated by EBV-LPD

Histological diagnosis: Hodgkin-like ATLL

Discussion

Ohshima et al. in Japan, described four cases of ATLL with Hodgkin-like cells in lymph nodes. Later on, they reported on 18 cases of early ATLL with the Hodgkin-like cells, and demonstrated that these cells were reactive and not infected by HTLV-1.

The Hodgkin-like cells with a CD30+/CD15+ phenotype were EBV-infected in at least half of the cases and single cell PCR showed oligoclonal/polygonal IgH rearrangements. The infiltrating lymphocytes in the background had either no or minimal nuclear abnormalities with a CD4+ T-cell phenotype (Hodgkin-like ATLL, new WHO classification). Hodgkin-like ATLL were very frequently infected by EBV. They were noted to have an improved survival rate compared with other ATLL variants.

(Chart)

EBV-LPD has only rarely been reported in patients with ATLL. The frequency of coinfection with HTLV-1 and EBV in ATLL has been reported as 17%[6]. Coinfection with HTLV-1 and EBV may be associated with a greater likelihood of organ involvement and a more aggressive course. In a previous case report, we showed an EBV-associated primary central nervous system lymphoma with a smoldering-type ATLL patient. The patient was treated with chemotherapy but continued to deteriorate and died. This might be, at least in

Fig. 20.2 (continued)

part, due to immune deficiency of ATLL patients[7].

Bittencourt et al. reported a chronic ATLL as the first manifestation of Hodgkin-like ATLL. Their case was treated with chemotherapy but later progressed to acute type ATLL and the patient ultimately died. Our present case showed an indolent clinical course and a relatively good survival as long as 1.5 years. However, careful observation is important due to the risk of progression.

Conclusion

We recommend that clinicians confirm HTLV-1 infection before treatment, especially in HTLV-1 endemic areas. Moreover, dermatologists should be more aware of the morphologic variants, Hodgkin-like ATLL and EBV-LPD.

References omitted

Fig. 20.2 (continued)

Good morning and thank you for coming to this presentation.

As you probably know, Adult T-cell leukemia/lymphoma (or ATLL) is a human T-lymphotropic virus type-1 (HTLV-1) associated T-cell malignancy and the prognosis for most patients is quite poor. *Interestingly*, it is endemic to south-west Japan, *where I live and work.*

ATLL is classified into four clinical subtypes based on clinical manifestations: 1. acute 2. lymphoma, 3. chronic and 4. smoldering. *Until recently,* reports on the simultaneous development of ATLL and Epstein-Barr virus-associated lymphoproliferative disorders (EBV-LPD) have been quite rare. *As a result, today, I'll report* our recent case of the rare morphologic variant of ATLL: ATLL complicated by EBV-LPD.

So let's look at the case profile. A 75-year-old Japanese woman presented with a 3-month history of indurated erythematous plaques and nodules in the right femoral region and right precordium. Her general condition was good.

Fig. 20.3 How the presenter adjusted the above poster content into speech mode: e-poster adapted for speech mode

On examination, she was found to have lymphadenopathy in the cervical and subclavicular regions. The serum anti-HTLV-1 antibody was positive. We carried out laboratory examinations which revealed normal white blood cell counts with no atypical lymphocytes. Serum lactate dehydrogenase (LDH) and calcium levels were also normal. *However,* the sIL-2R level was high, 789U/ml (while the normal range is, 145-519). *Moreover,* an 18F-fluorodeoxyglucose positron emission tomography scan showed abnormal uptake at the skin and lymph nodes.

So what did we do? We performed a skin biopsy which showed abnormal small to medium-sized lymphoid cells with irregularly shaped nuclei proliferating diffusely from epidermis to subcutis.

We found that the immunohistochemically, abnormal lymphoid cells were positive diffusely for cCD3 and CD4, while they were negative for CD8, CD20. *We then carried out* a Southern blotting of biopsy DNA and hybridization with a HTLV-1 provirus.

The lymph node biopsy showed involvement by ATLL cells with scattered EBV-positive cells, some of which resembled Hodgkin cells that had a B-cell phenotype. *This is consistent with* EBV-LPD.

After the immunohistological analysis, as you can see (data on slide) the Hodgkin-like giant cells were found to be positive for CD30, CD15 and negative for CD20, CD3, CCR4. Integrated proviral HTLV-1 was revealed in the lesion.

As a result, we made the following diagnosis. (while using animation) The clinical diagnosis was Lymphoma type ATLL complicated by EBV-LPD, while the histological diagnosis was Hodgkin-like ATLL.

Why were able to make this diagnosis? Well, let me answer this by looking at some related studies. In 2014, Ohshima (while showing data on slide) reported on 18 cases of early ATLL with the Hodgkin-like cells, and demonstrated that these cells were reactive and not infected by HTLV-1.

What we found in our case though, was that the Hodgkin-like cells with a CD30+/CD15+ phenotype were EBV-infected in at least half of the cases and single cell

Fig. 20.3 (continued)

PCRs showed these (while using photo) rearrangements. The infiltrating lymphocytes in the background had either no or minimal nuclear abnormalities with a CD4+ T-cell phenotype.

In short, Hodgkin-like ATLL were very frequently infected by EBV. *We also noticed that they* have an improved survival rate when compared with other ATLL variants.

(While showing chart) This chart shows rates of coinfection. Until the present, EBV-LPD has only rarely been reported in patients with ATLL. The frequency of coinfection with HTLV-1 and EBV in ATLL has been reported as 17%[6]. Coinfection with HTLV-1 and EBV might be associated with a greater likelihood of organ involvement and a more aggressive course.

A previous case report (while referring to data on slide) showed an EBV-associated primary central nervous system lymphoma with a smoldering-type ATLL patient. The patient was treated with chemotherapy but continued to deteriorate and died. This might be, at least in part, due to immune deficiency of ATLL patients[7].

Some researchers have reported a chronic ATLL as the first manifestation of Hodgkin-like ATLL and these cases were treated with chemotherapy but later progressed to acute type ATLL and the patient ultimately died.

Our present case, on the other hand, was an indolent clinical course and indicated a relatively good survival period -- as long as 1.5 years. *However*, careful observation is always important due to the risk of progression.

Therefore, we recommend that clinicians confirm HTLV-1 infection before treatment, especially in HTLV-1 endemic areas. *Moreover, we believe that dermatologists should become more aware of* the morphologic variants Hodgkin-like ATLL and EBV-LPD.

Thank you.

Fig. 20.3 (continued)

Portions of the spoken mode of this poster that are discursively distinct from the written form, and thus illustrate the multimodal nature of CPs, are indicated in Fig. 20.3 in *italics*. As the observant reader will note, most of these alterations conform to the various strategies and rhetorical forms used in managing multimodal discourse that we noted earlier in this book on transitions.

In my limited experience thus far observing e-poster presentations, there have been no explicit follow-up discussion sessions (as they are not feasible for sessions which are often only 5 min in length), but potential discussants are invited to contact the presenter elsewhere at the conference or via email. This, at least, removes one anxiety-inducing aspect associated with standard CPs.

Questions and Exercises for Chapter 20

1. If one is giving an e-poster presentation, what are some techniques that can be used to avoid simply reading the poster contents verbatim?
2. In what three ways are poster texts structured differently than slide texts in CPs?
3. If a visitor was looking over your poster, what would be your preferred opening gambit in order to try and engage them?
4. The CP vs. the poster: Which do you consider more challenging and why?
5. Look at the speech script based on the sample e-poster content. Which sections underlined in italics can you connect to specific recommendations made elsewhere in this book?