Анализ программных средств. Результаты для студентов,ученых, клинических врачей и других!

Pr G. Noël
University Radiation Department (URD)
Strasbourg

Конфликты интересов

У меня нет конфликта интересов, кроме одного: интерес к науке и жизни

ВВЕДЕНИЕ

Цель

- **Как работать и анализировать самостоятельно, без чьей-либо помощи**

- **Другими словами вы совсем один в Сибири зимой! И вы хотите опубликоваться**

Зачем анализировать?

- Потому что вы лучший, но никто этого не знает… пока!

- Потому что вы хотите сравнить ваши результаты с результатами соперников
- Потому что критика рецензента помогает вам стать лучше
- Потому что это будущее вашей работы
- Потому что пациенты хотят знать о наших достижениях
- Чтобы получить грант (напр. НАСА)

Анализ – это философия подчинения

Что нужно анализировать?

- **Ваш опыт**
- **Ваши новые способы лечения, методы, эксперименты…**
- **Но в соответствии с международными правилами: план работы и законы**

Как анализировать?

- В соответствии с государственным и международным стандартом
- Используя знания о болезнях, техники, методов и т.д.
- Точная методология!
- В самое короткое время
- С высокой повторяемостью

Время между идеей и анализом/публикацией

- Идея: 30 секунд
- Введение в статью: 1 - 3 месяца
- Сбор данных: 1 - 6 месяцев
- Статистика:
  - Кафедра: 1 - 12 месяцев
  - Самостоятельно: один день
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- Рецензирование :3 месяца
- Исправление : 1 месяц
- Соглашение: 24 часа
  - Общее: 6 – 12 месяцев

Зачем использовать программные средства?

- Потому что эти средства помогут сэкономить время
- Потому что все в мире ими пользуются и их использование поможет вам быть в со всеми в одном мире
- Врачи могут регулярно обновлять результаты для конгресса, новых публикаций, норм своей больницы, клиники
- Сравнивать личные результаты

Список программ

- **Интернет и Pubmed (бесплатно)**
- **Adobe reader (бесплатно)**
- **Статистические программы**
  - **Mathematica**
  - **Statview**
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  - **End note**
  - **Reference manager**
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- **Word или подобные (бесплатно)**
- **Excel или подобные (бесплатно)**
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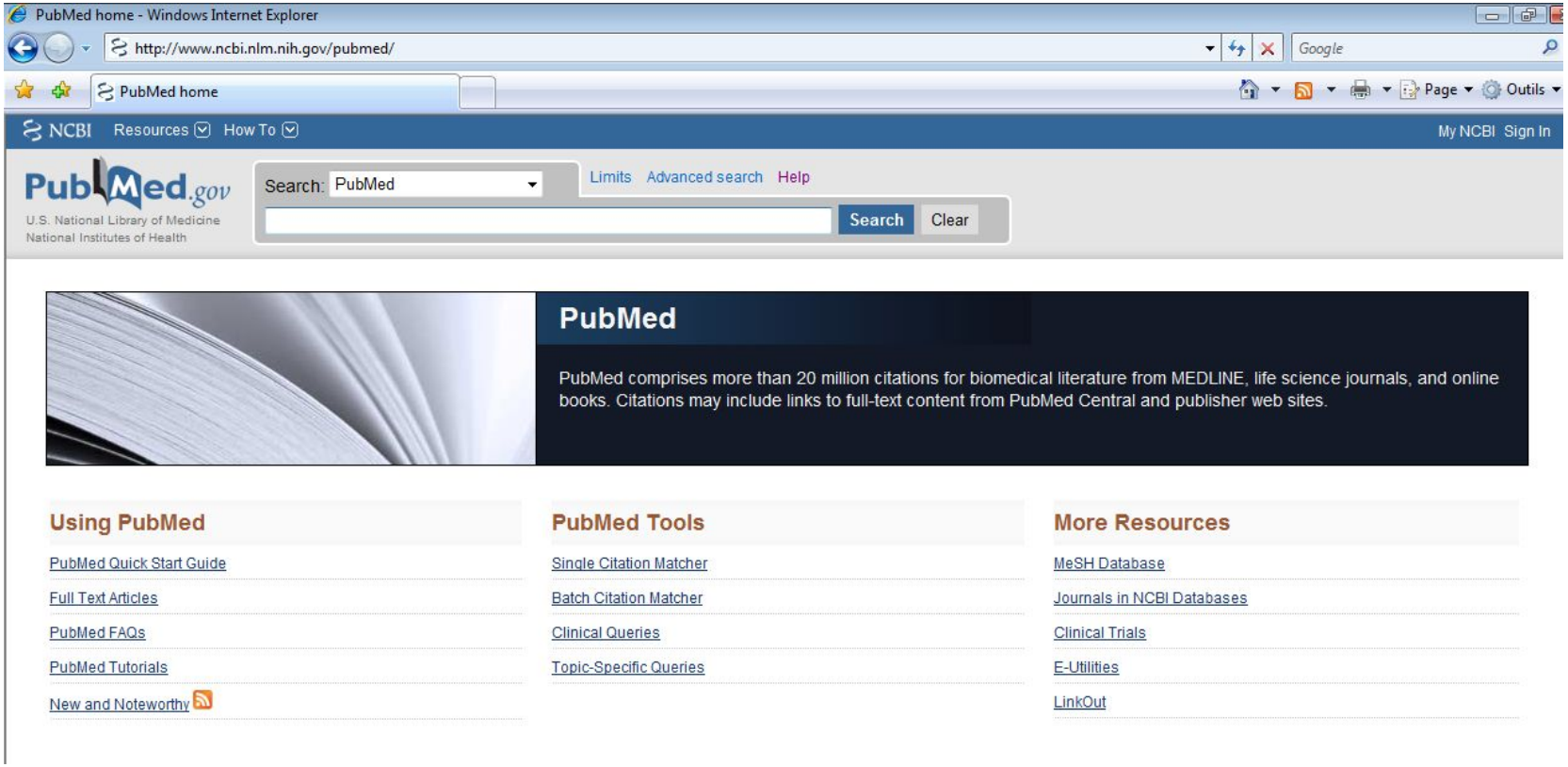

Книга для помощи

Скачайте ее: это бесплатно!

Фоновые знания

- **Они нужны, чтобы:**
  - **Избежать неадекватных исследований**
  - **Перечислить важные пункты исследования**
  - **Начать введение статьи**
  - **Обсуждать собственные достижения**

Поиск

- **Два главных метода**
  - **Ключевые слова**
  - **Авторский поиск**

Поиск по ключевым словам

- ясно
- Не слишком много

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- **Сокращает область поиска**

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2. High-Dose-Rate Monotherapy: Safe and Effective Brachytherapy for Patients with Localized Prostate Cancer.
   Demanes DJ, Martinez AA, Ghilezan M, Hill DR, Schour L, Brandt D, Gustafson G.
   Int J Radiat Oncol Biol Phys. 2011 Feb 9. [Epub ahead of print]
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3. High-dose-rate brachytherapy boost to the dominant intra-prostatic tumor region: Hemi-irradiation of prostate cancer.
   Schick U, Popowski Y, Nouet P, Bieri S, Rouzaud M, Khan H, Weber DC, Miralbell R.
   Prostate. 2011 Feb 9. doi: 10.1002/pros.21347. [Epub ahead of print]
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4. Displacement of periurethral stranded seeds and its dosimetric consequences in prostate brachytherapy.
   Vassiliev ON, Kudchadker RJ, Swanson DA, Bruno TL, van Vulpen M, Frank SJ.
   Brachytherapy. 2011 Feb 8. [Epub ahead of print]
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Поиск по ключевым словам

- **Ограничивает область поиска**

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   Curr Opin Urol. 2011 Feb 9. [Epub ahead of print]
   PMID: 21311335 [PubMed - as supplied by publisher]
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2. High-Dose-Rate Monotherapy: Safe and Effective Brachytherapy for Patients with Localized Prostate Cancer.
   Demanes DJ, Martinez AA, Ghilezan M, Hill DR, Schour L, Brandt D, Gustafson G.
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   PMID: 21310546 [PubMed - as supplied by publisher]
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   Schick U, Popowski Y, Nouet P, Bieri S, Rouzaud M, Khan H, Weber DC, Miralbell R.
   Prostate. 2011 Feb 9. doi: 10.1002/pros.21347. [Epub ahead of print]
   PMID: 21308714 [PubMed - as supplied by publisher]
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   Neviani CB, Miziara MA, de Andrade Carvalho H.
   Radiother Oncol. 2011 Feb 4. [Epub ahead of print]
   PMID: 21296444 [PubMed - as supplied by publisher]
   Related citations
5. HDR monotherapy for prostate cancer: A simulation study to determine the effect of catheter displacement on target coverage and normal tissue irradiation.

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1. Dose escalation improves cancer-related events at 10 years for intermediate- and high-risk prostate cancer patients treated with hypofractionated high-dose-rate boost and external beam radiotherapy.
   Martinez AA, Gonzalez J, Ye H, Ghilezan M, Shetty S, Kernen K, Gustafson G, Krauss D, Vicini F, Kestin L.
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   PMID: 21195875 [PubMed - indexed for MEDLINE]
   Related citations
2. Assessment of normal tissue complications following prostate cancer irradiation: comparison of radiation treatment modalities using NTCP models.
   Takam R, Bezak E, Yeoh EE, Marcu L.
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3. High dose rate and external beam radiotherapy in locally advanced prostate cancer.
   Viani GA, Pellizzon AC, Guimarães FS, Jacinto AA, dos Santos Novaes PE, Salvajoli JV.
   Am J Clin Oncol. 2009 Apr;32(2):187-90.
   PMID: 19307949 [PubMed - indexed for MEDLINE]
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4. Transperineal injection of hyaluronic acid in anterior perirectal fat to decrease rectal toxicity from radiation delivered with intensity modulated brachytherapy or EBRT for prostate cancer patients.
   Prada PJ, Fernández J, Martinez AA, de la Rúa A, Gonzalez JM, Fernandez JM, Juan G.
   Int J Radiat Oncol Biol Phys. 2007 Sep 1;69(1):95-102.
   PMID: 17707267 [PubMed - indexed for MEDLINE]
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Авторский поиск

- **Потому что вы хотите сделать свой собственный список публикаций**
- **Потому что вы хотите показать будущим коллегам, что писать статьи это нужно**
- **Потому что автор – это ссылка!**

Авторский поиск

- **Слишком обширный ?**

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1. Bilateral macular ischemia and severe visual loss following trastuzumab therapy. — yes
   Saleh M, Bourcier T, Noel G, Speeg-Schatz C, Gaucher D.
   Acta Oncol. 2011 Feb 8. [Epub ahead of print] No abstract available.
   PMID: 21303229 [PubMed - as supplied by publisher]
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2. Retrospective Comparison of Chemoradiotherapy Followed by Adjuvant Chemotherapy, With or Without Prior Gliadel Implantation (Carmustine) After Initial Surgery in Patients With Newly Diagnosed High-Grade Gliomas. — yes
   Noël G, Schott R, Froelich S, Gaub MP, Boyer P, Fischer-Lokou D, Dufour P, Kehrli P, Maitrot D.
   Int J Radiat Oncol Biol Phys. 2011 Feb 5. [Epub ahead of print]
   PMID: 21300471 [PubMed - as supplied by publisher]
   Related citations
3. Radiobiological Characterization of Two Therapeutic Proton Beams with Different Initial Energy Spectra Used at the Institut Curie Proton Therapy Center in Orsay. — yes
   Calugaru V, Nauraye C, Noël G, Giocanti N, Favaudon V, Mégnin-Chanet F.
   Int J Radiat Oncol Biol Phys. 2010 Nov 13. [Epub ahead of print]
   PMID: 21075549 [PubMed - as supplied by publisher]
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4. [Reirradiation in primary or secondary brain tumors]. — yes
   Noël G, Mazeron JJ.
   Cancer Radiother. 2010 Oct;14(6-7):421-37. Epub 2010 Aug 24. Review. French.
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5. [Systematic review of stereotactic radiotherapy for high-grade gliomas]. — yes
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   Cancer Radiother. 2010 Dec;14(8):739-54. Epub 2010 Aug 17. Review. French.
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6. [Leishmaniasis treatment]. — Probably not
   Minodier P, Jurquet AL, Noël G, Uters M, Laporte R, Garnier JM.
   Arch Pediatr. 2010 Jun;17(6):838-9. Review. French. No abstract available.
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   Noël G, Schott R, Froelich S, Gaub MP, Boyer P, Fischer-Lokou D, Dufour P, Kehrli P, Maitrot D.
   Int J Radiat Oncol Biol Phys. 2011 Feb 5. [Epub ahead of print]
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2. [Reirradiation in primary or secondary brain tumors].
   Noël G, Mazeron JJ.
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3. [Systematic review of stereotactic radiotherapy for high-grade gliomas].
   Clavier JB, Voirin J, Kehrli P, Noël G.
   Cancer Radiother. 2010 Dec;14(8):739-54. Epub 2010 Aug 17. Review. French.
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4. Pharmacological enhancement of autophagy induced in a hepatocellular carcinoma cell line by high-LET radiation.
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5. [Comparison of three dosimetric techniques for lung tumor irradiation].
   Beneyton V, Billaud G, Niederst C, Meyer P, Bourhala K, Schumacher C, Karamanoukian D, Noël G.
   Cancer Radiother. 2010 Jan;14(1):50-8. Epub 2009 Dec 16. French.
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6. Combined proton and photon conformal radiotherapy for intracranial atypical and malignant meningioma.
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   Int J Radiat Oncol Biol Phys. 2009 Oct 1;75(2):399-406. Epub 2009 Feb 7.
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   Noël G, Schott R, Froelich S, Gaub MP, Boyer P, Fischer-Lokou D, Dufour P, Kehrli P, Maitrot D.
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Noël G, Schott R, Froelich S, Gaub MP, Boyer P, Fischer-Lokou D, Dufour P, Kehrli P, Maitrot D.
Radiation Oncology Department, Centre de lutte contre le cancer Paul Strauss, Strasbourg, France.

Abstract

PURPOSE: Retrospective study of patients treated for high-grade glioma, with or without biodegradable carmustine wafers and according to the Stupp protocol.

METHODS AND MATERIALS: Between May 2007 and June 2008, 65 patients underwent surgery for high-grade glioma, 28 had implantation of Gliadel and 37 patients did not. Patients received radiotherapy with concomitant temozolomide followed by 5 consecutive days of temozolomide every month for 6 months.

RESULTS: Overall median follow-up was 17.1 months; the median relapse-free survival (RFS) was 14 months with a RFS of 54% at 12 months, and 38% at 24 months. For patient with and without Gliadel, median and 1-year RFS were 12.9 months and 52% vs. 14 months and 42%, respectively (p = 0.89). According to pathology, Gliadel did not influence RFS of patients with Grade III or glioblastoma. However, for all patients, in multivariate analysis, non-methylated methylguanine methyltransferase (MGMT) was the only unfavorable prognostic factor of RFS (p = 0.017; HR 2.8; CI [1.2-7]). Median overall survival (OS) was 20.8 months; the OS rate at 12 months was 78.5%, and at 24 months 35.4%. For patients treated with and without Gliadel, median and 1-year OS were 20.6 months and 78.6% vs. 20.8 months and 78.4%, respectively. According to pathology, Gliadel did not influence OS of patients with Grade III or glioblastoma. For all patients, in multivariate analysis, unfavorable prognosticators for OS were non-methylated MGMT (p = 0.001; HR: 6.5; CI [2-20]) and irradiation dose <60 Gy (p = 0.02; HR: 6.3; CI [2-20]). With carmustine wafers, before irradiation, median gross tumor volume plus edema was 84 mL (27-229), whereas it was 68 mL (10-362) without carmustine (p = nonsignificant). Four cases of Grade 3 thrombopenia occurred, all in the carmustine wafer group.

CONCLUSION: In patients with high-grade gliomas, adding Gliadel before performing a Stupp protocol did not improve survival.

Related citations

Review The effectiveness and cost-effectiveness of ([Health Technol Assess. 2007]

Gliadel (BCNU) wafer plus concomitant temozolomide therapy after [J Neurosurg. 2009]

Clinical course and pathologic findings after Gliadel and radiotherapy fc [Cancer Invest. 2004]

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Retrospective Comparison of Chemoradiotherapy Followed by Adjuvant Chemotherapy, With or Without Prior Gliadel Implantation (Carmustine) After Initial Surgery in Patients With Newly Diagnosed High-Grade Gliomas.

Noël G, Schott R, Froelich S, Gaub MP, Boyer P, Fischer-Lokou D, Dufour P, Kehrli P, Maitrot D.

Radiation Oncology Department, Centre de lutte contre le cancer Paul Strauss, Strasbourg, France.

Abstract

PURPOSE: Retrospective study of patients treated for high-grade glioma, with or without biodegradable carmustine wafers and according to the Stupp protocol.

METHODS AND MATERIALS: Between May 2007 and June 2008, 65 patients underwent surgery for high-grade glioma, 28 had implantation of Gliadel and 37 patients did not. Patients received radiotherapy with concomitant temozolomide followed by 5 consecutive days of temozolomide every month for 6 months.

RESULTS: Overall median follow-up was 17.1 months; the median relapse-free survival (RFS) was 14 months with a RFS of 54% at 12 months, and 38% at 24 months. For patient with and without Gliadel, median and 1-year RFS were 12.9 months and 52% vs. 14 months and 42%, respectively (p = 0.89). According to pathology, Gliadel did not influence RFS of patients with Grade III or glioblastoma. However, for all patients, in multivariate analysis, non-methylated methylguanine methyltransferase (MGMT) was the only unfavorable prognostic factor of RFS (p = 0.017; HR 2.8; CI [1.2-7]). Median overall survival (OS) was 20.8 months; the OS rate at 12 months was 78.5%, and at 24 months 35.4%. For patients treated with and without Gliadel, median and 1-year OS were 20.6 months and 78.6% vs. 20.8 months and 78.4%, respectively. According to pathology, Gliadel did not influence OS of patients with Grade III or glioblastoma. For all patients, in multivariate analysis, unfavorable prognosticators for OS were non-methylated MGMT (p = 0.001; HR: 6.5; CI [2-20]) and irradiation dose <60 Gy (p = 0.02; HR: 6.3; CI [2-20]). With carmustine wafers, before irradiation, median gross tumor volume plus edema was 84 mL (27-229), whereas it was 68 mL (10-362) without carmustine (p = nonsignificant). Four cases of Grade 3 thrombopenia occurred, all in the carmustine wafer group.

CONCLUSION: In patients with high-grade gliomas, adding Gliadel before performing a Stupp protocol did not improve survival.

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Georges Noël M.D., Ph.D.[*], Roland Schott M.D.[†], Sébastien Froelich M.D.[‡], Marie-Pierre Gaub

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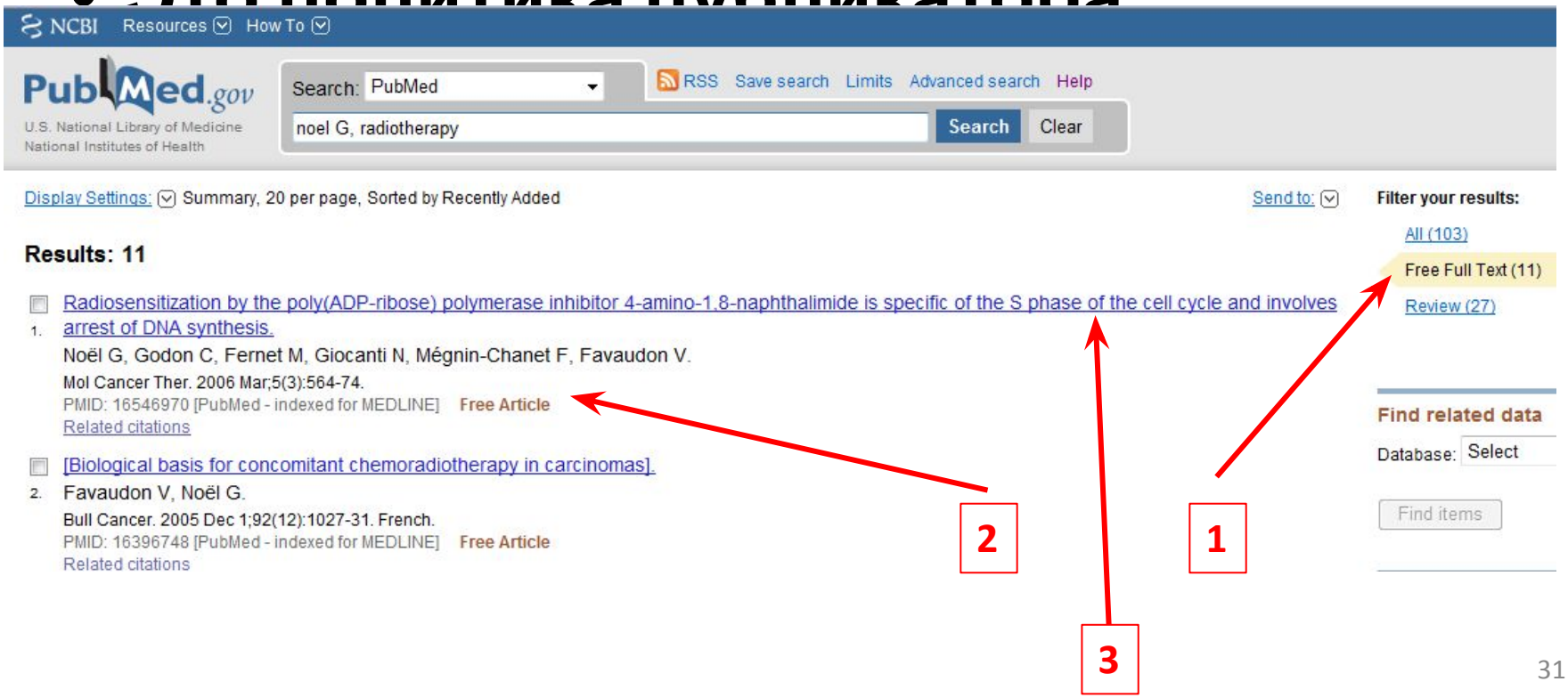

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INSERM U 612, Institut Curie-Recherche, Laboratoires 110-112, Centre Universitaire, 91405 Orsay Cedex, France.

Abstract

Radiosensitization caused by the poly(ADP-ribose) polymerase (PARP) inhibitor 4-amino-1,8-naphthalimide (ANI) was investigated in 10 asynchronously growing rodent (V79, CHO-Xrs6, CHO-K1, PARP-1+/+ 3T3, and PARP-1-/- 3T3) or human (HeLa, MRC5VI, IMR90, M059J, and M059K) cell lines, either repair proficient or defective in DNA-PK (CHO-Xrs6 and M059J) or PARP-1 (PARP-1-/- 3T3). Pulse exposure to ANI (1-hour contact) potentiated radiation response in rodent cells except in PARP-1(-/-) 3T3 fibroblasts. In contrast, ANI did not significantly enhance radiation susceptibility in asynchronously dividing human cells; yet, single-strand break rejoining was lengthened by ca. 7-fold in all but mouse PARP-1-/- 3T3s. Circumstantial evidence suggested that radiosensitization by ANI occurs in rapidly dividing cells only. Experiments using synchronized HeLa cells consistently showed that ANI-induced radiosensitization is specific of the S phase of the cell cycle and involves stalled replication forks. Under these conditions, prolonged contact with ANI ended in the formation of de novo DNA double-strand breaks hours after irradiation, evoking collision with uncontrolled replication forks of DNA lesions whose repair was impaired by inhibition of the PARP catalytic activity. The data suggest that increased response to radiotherapy by PARP inhibitors may be achieved only in rapidly growing tumors with a high S-phase content.

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Georges Noël, Camille Godon, Marie Fernet, Nicole Giocanti, Frédérique Mégnin-Chanet and Vincent Favaudon

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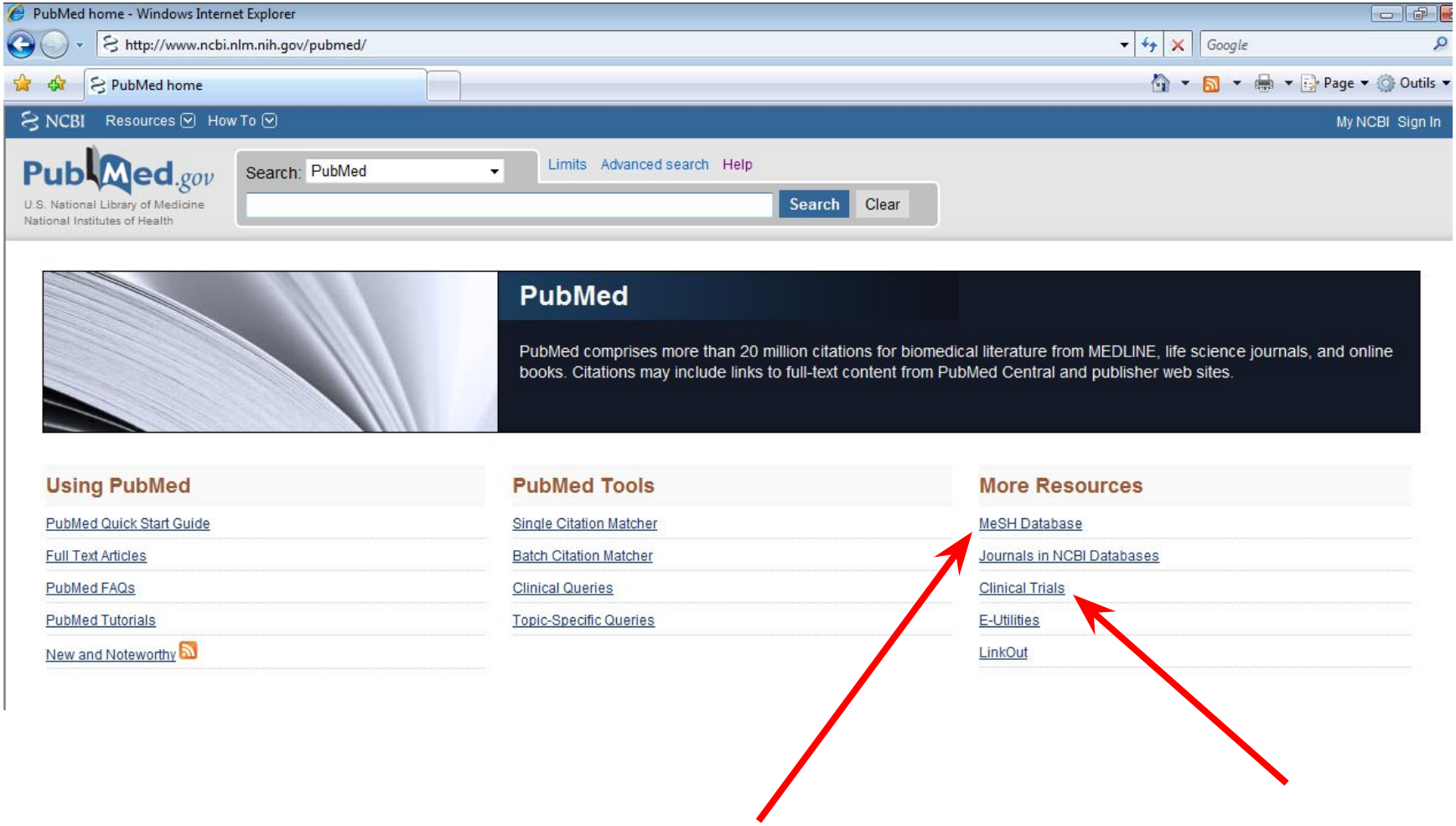
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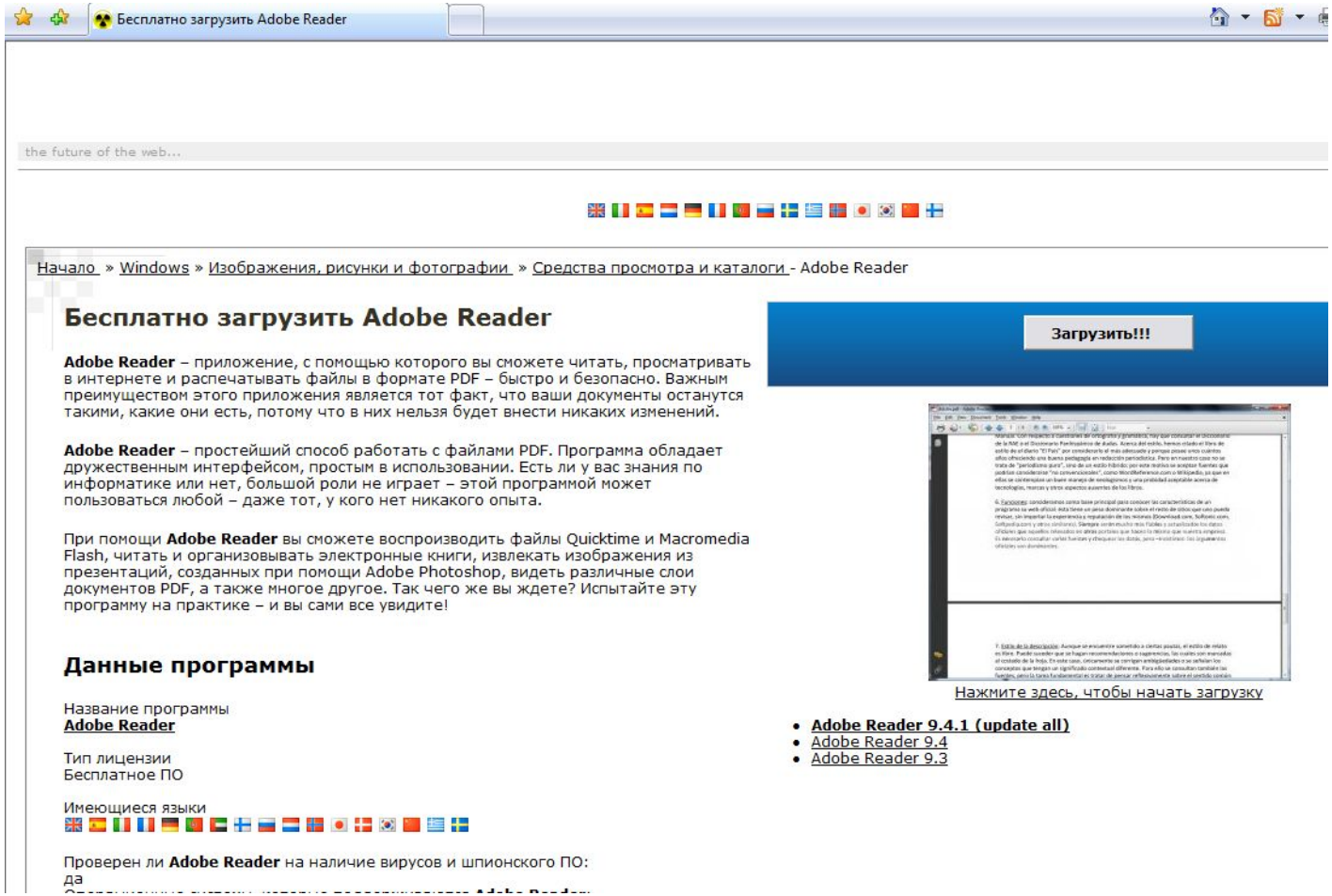

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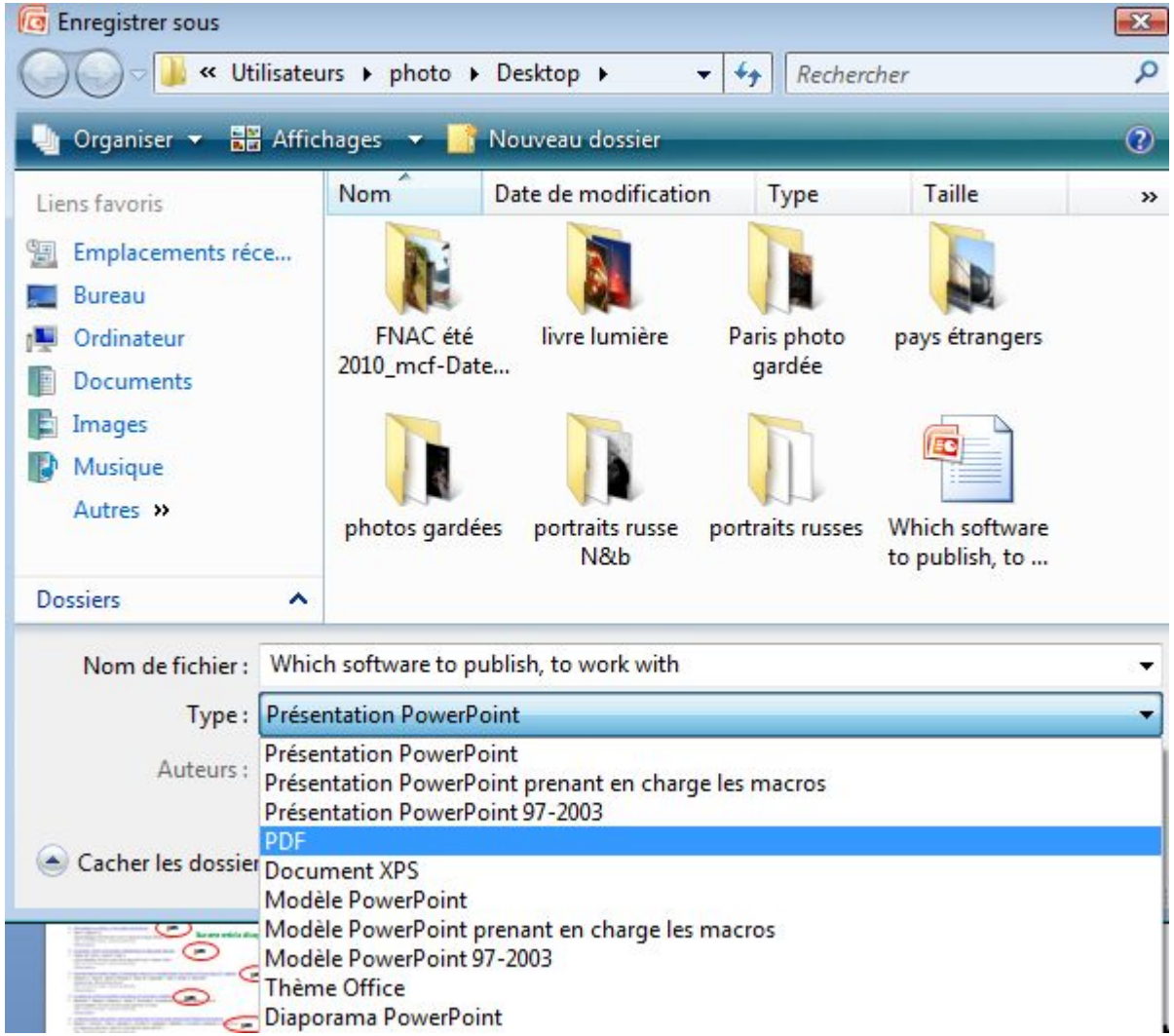

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Introduction

Poly(ADP-ribose) polymerases (PARP) are present in higher eukaryotes only (for a review, see ref. 1). PARP-1, the founding family member, has been the most extensively studied. PARP-1 is a nuclear 113-kDa enzyme that detects and binds DNA single-strand breaks (SSB) through a zinc-finger domain located at its NH_2-terminal end (2). PARP-1 is involved in many important cellular

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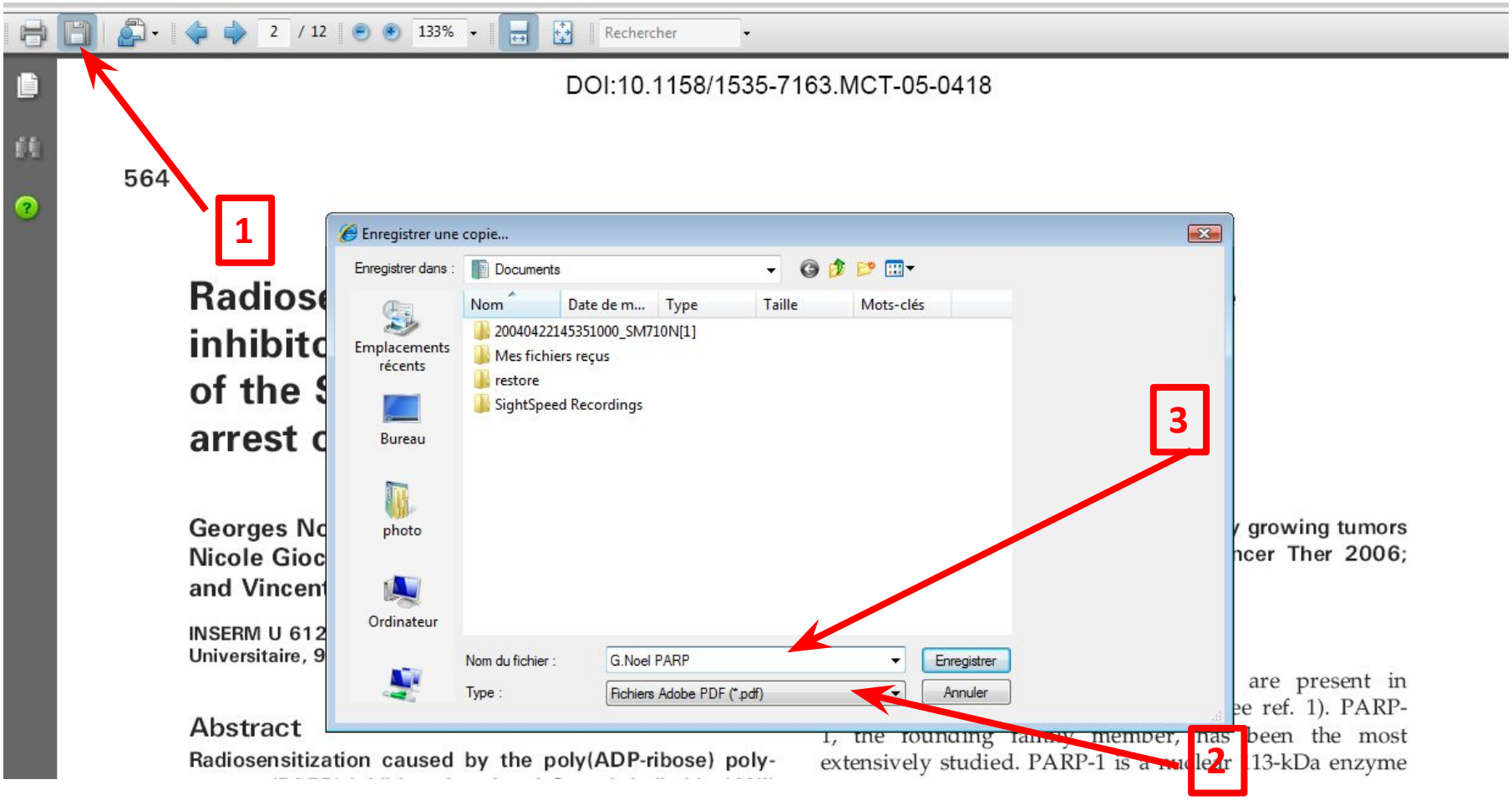

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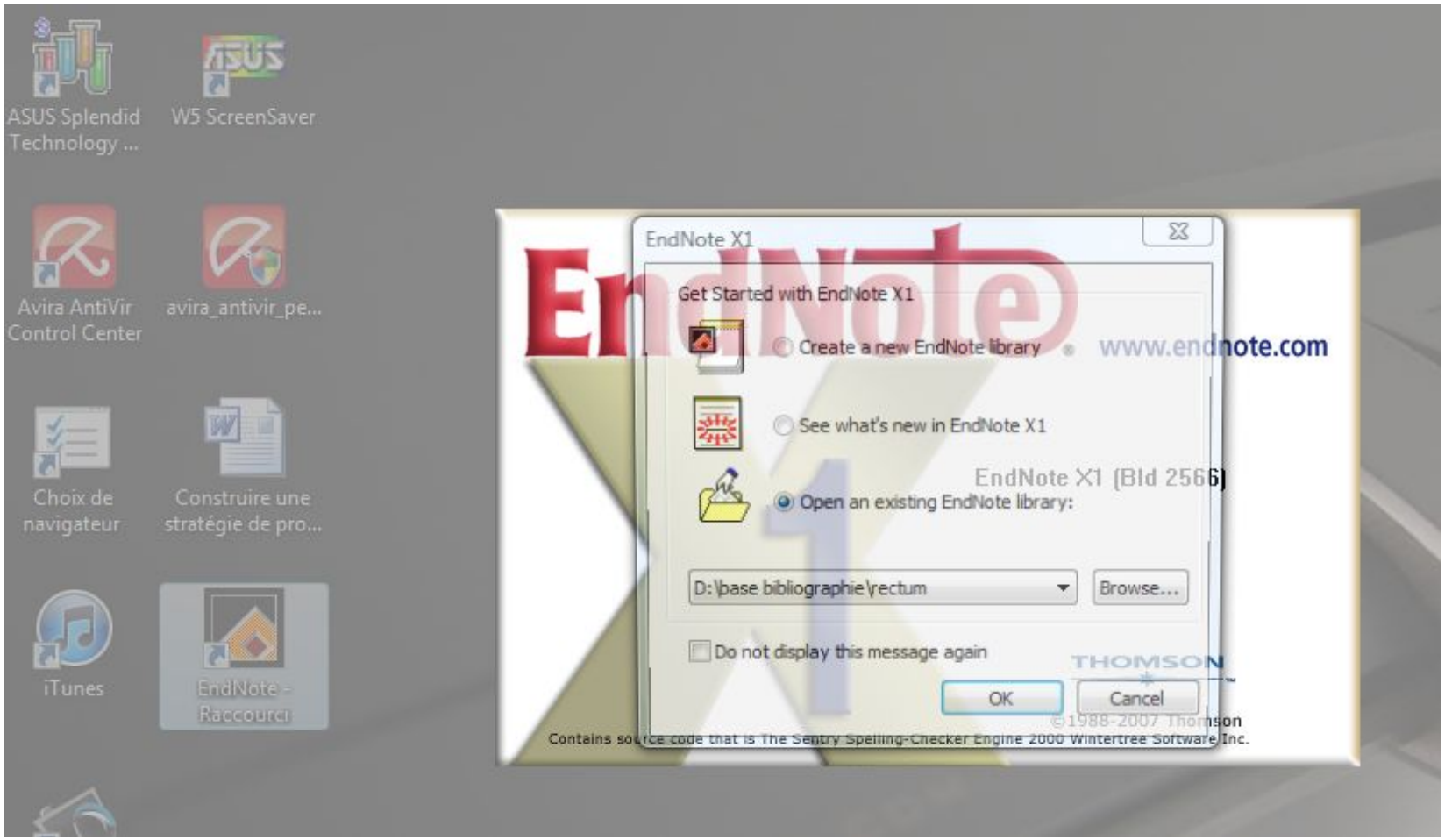

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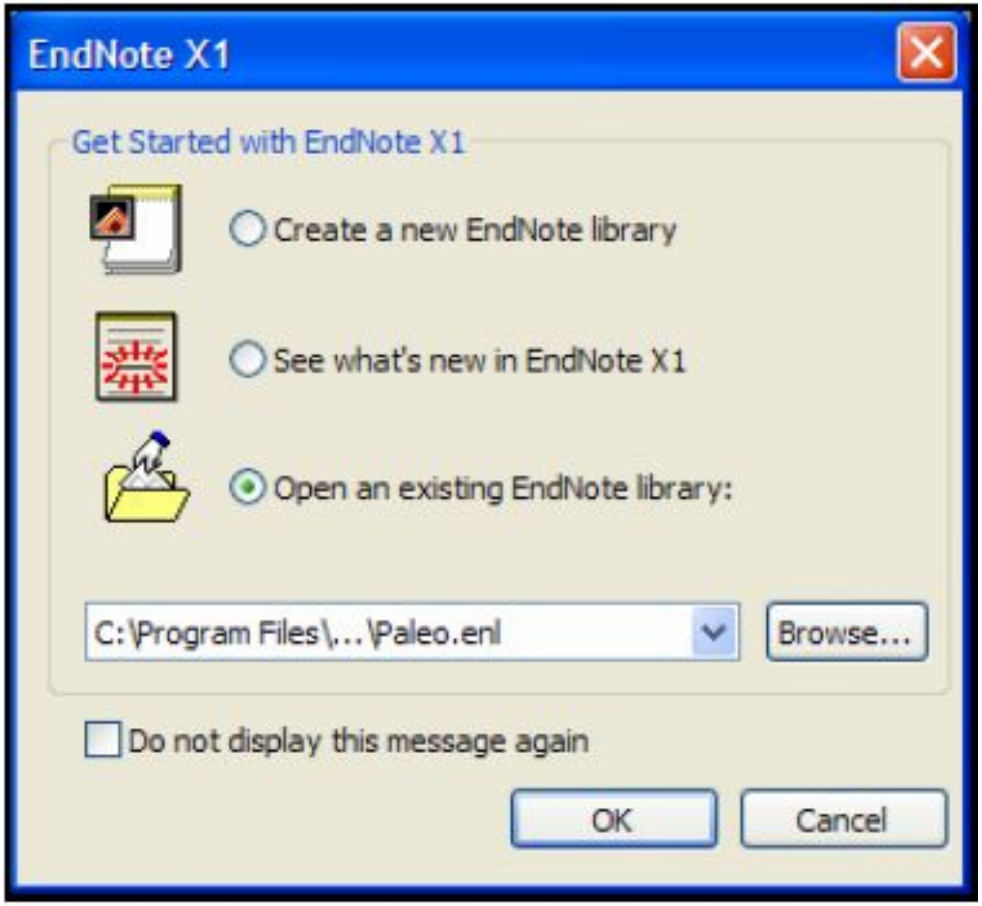

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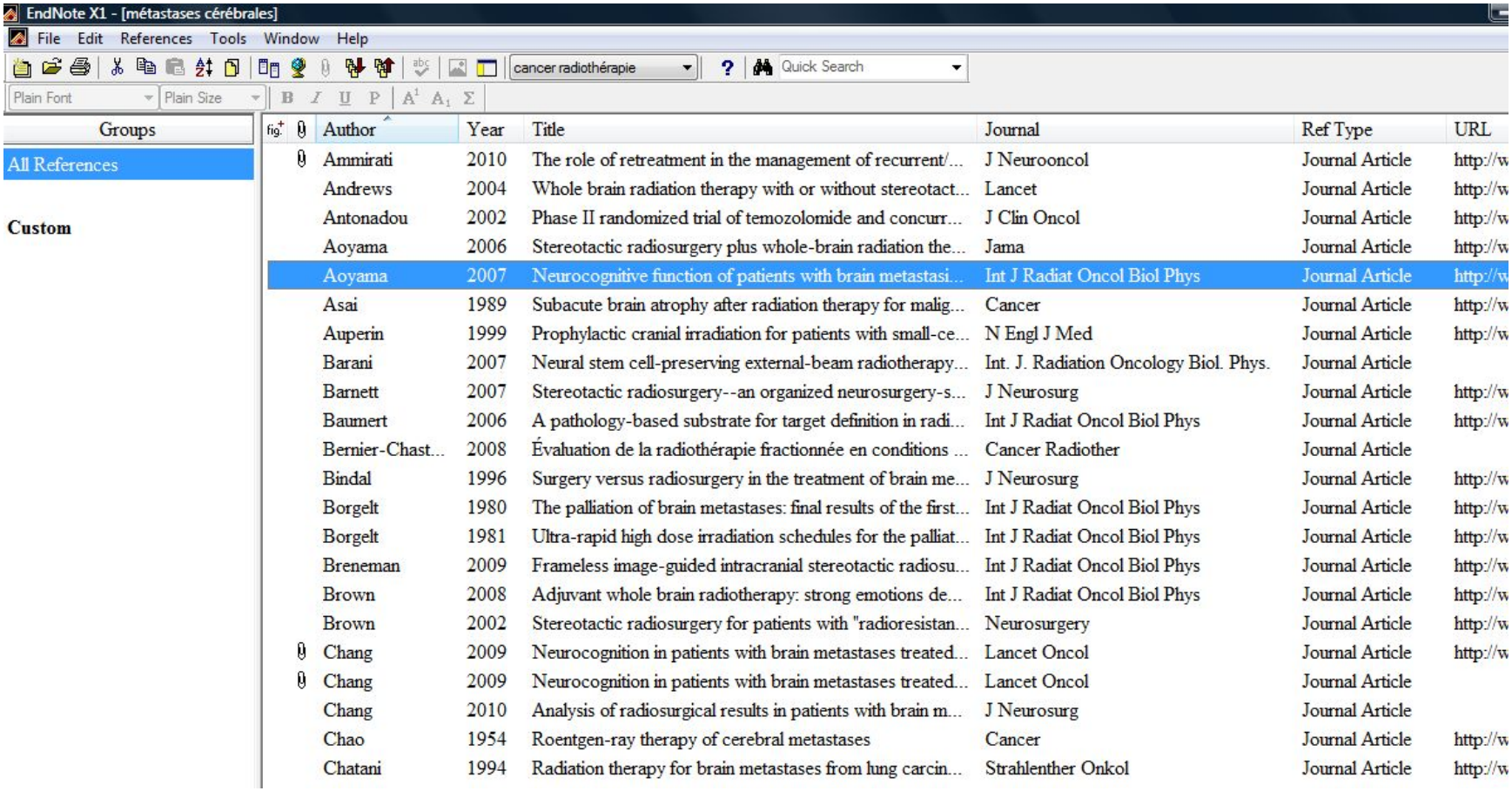

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Articles

Neurocognition in patients with brain metastases treated with radiosurgery or radiosurgery plus whole-brain irradiation: a randomised controlled trial

Eric L Chang, Jeffrey S Wefel, Kenneth R Hess, Pamela K Allen, Frederick F Lang, David G Kornguth, Rebecca B Arbuckle, J Michael Swint, Almon S Shiu, Moshe H Maor, Christina A Meyers

Summary

Background It is unclear whether the benefit of adding whole-brain radiation therapy (WBRT) to stereotactic radiosurgery (SRS) for the control of brain-tumours outweighs the potential neurocognitive risks. We proposed that the learning and memory functions of patients who undergo SRS plus WBRT are worse than those of patients who undergo SRS alone. We did a randomised controlled trial to test our prediction.

Methods Patients with one to three newly diagnosed brain metastases were randomly assigned using a standard permutated block algorithm with random block sizes to SRS plus WBRT or SRS alone from Jan 2, 2001, to Sept 14, 2007. Patients were stratified by recursive partitioning analysis class, number of brain metastases, and radioresistant histology. The randomisation sequence was masked until assignation, at which point both clinicians and patients were

Lancet Oncol 2009; 10: 1037–44

Published Online October 5, 2009 DOI:10.1016/S1470-2045(09)70263-3

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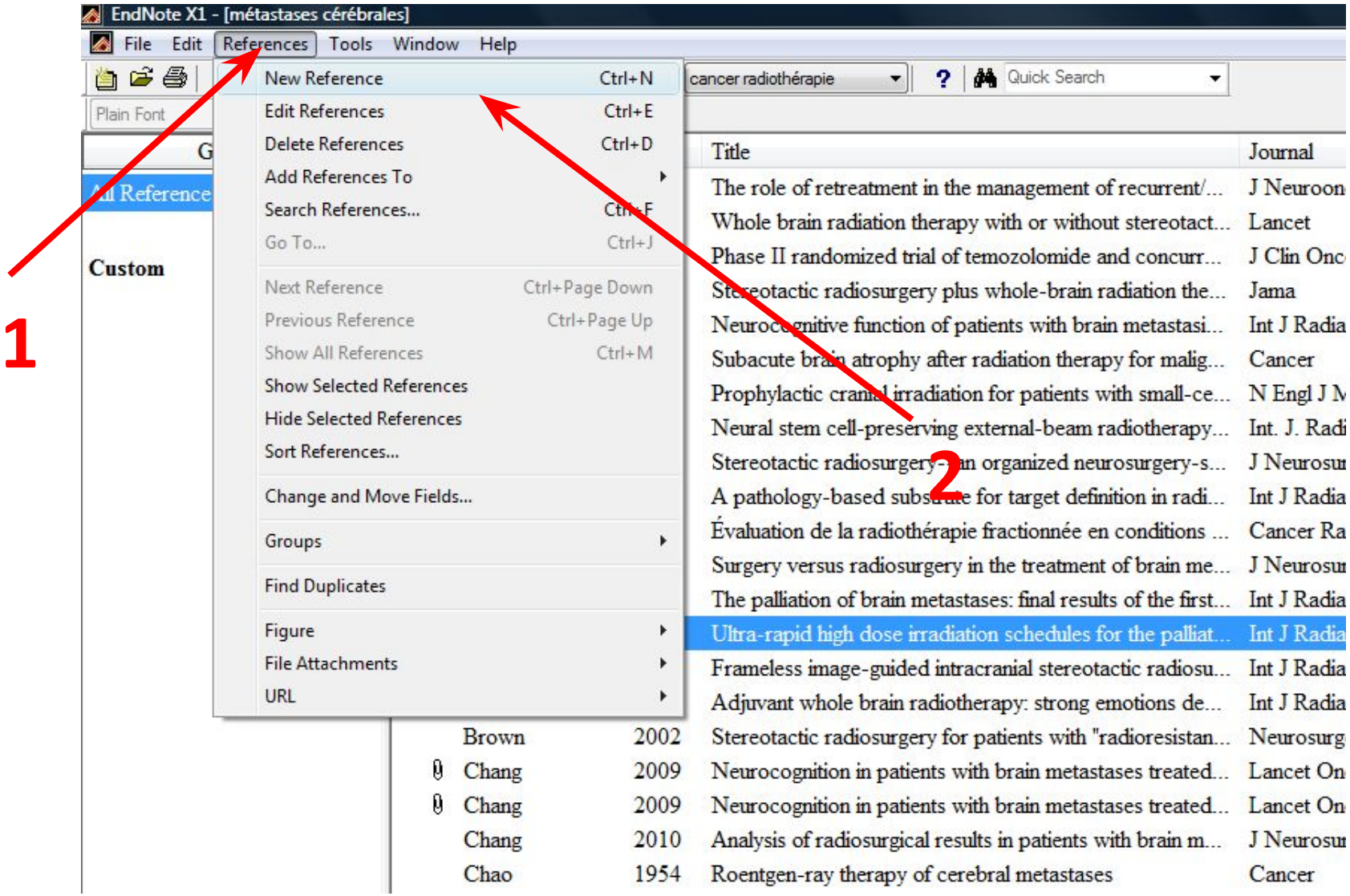

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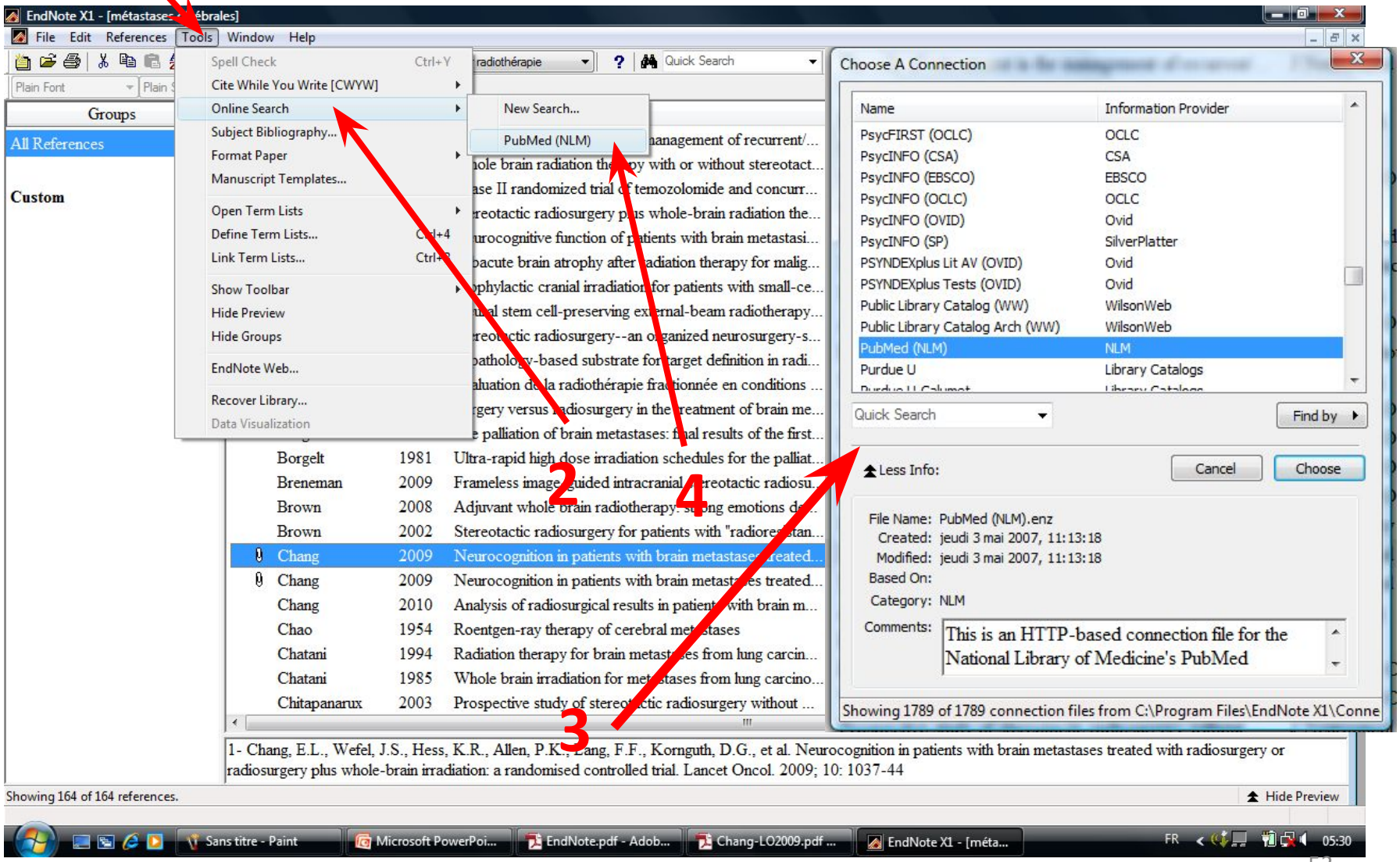

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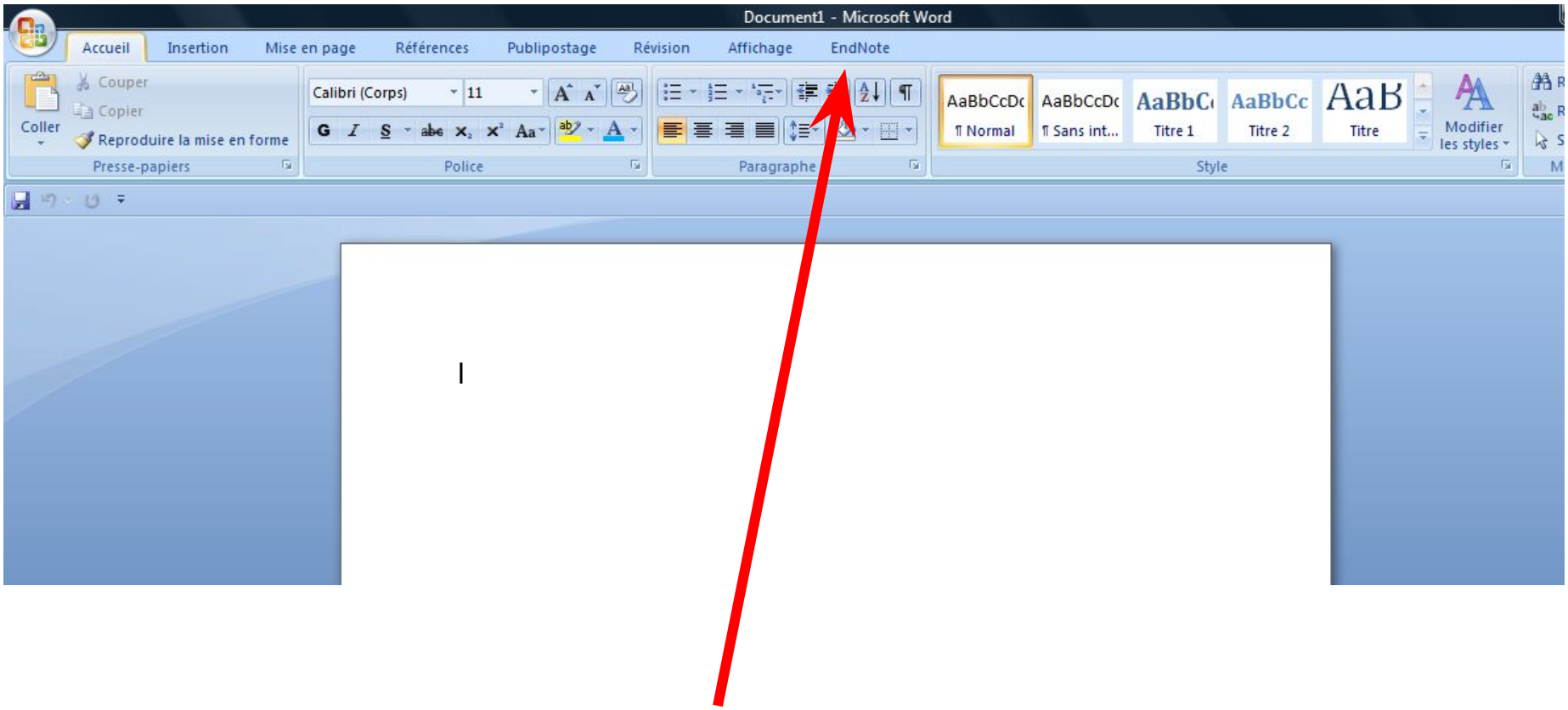

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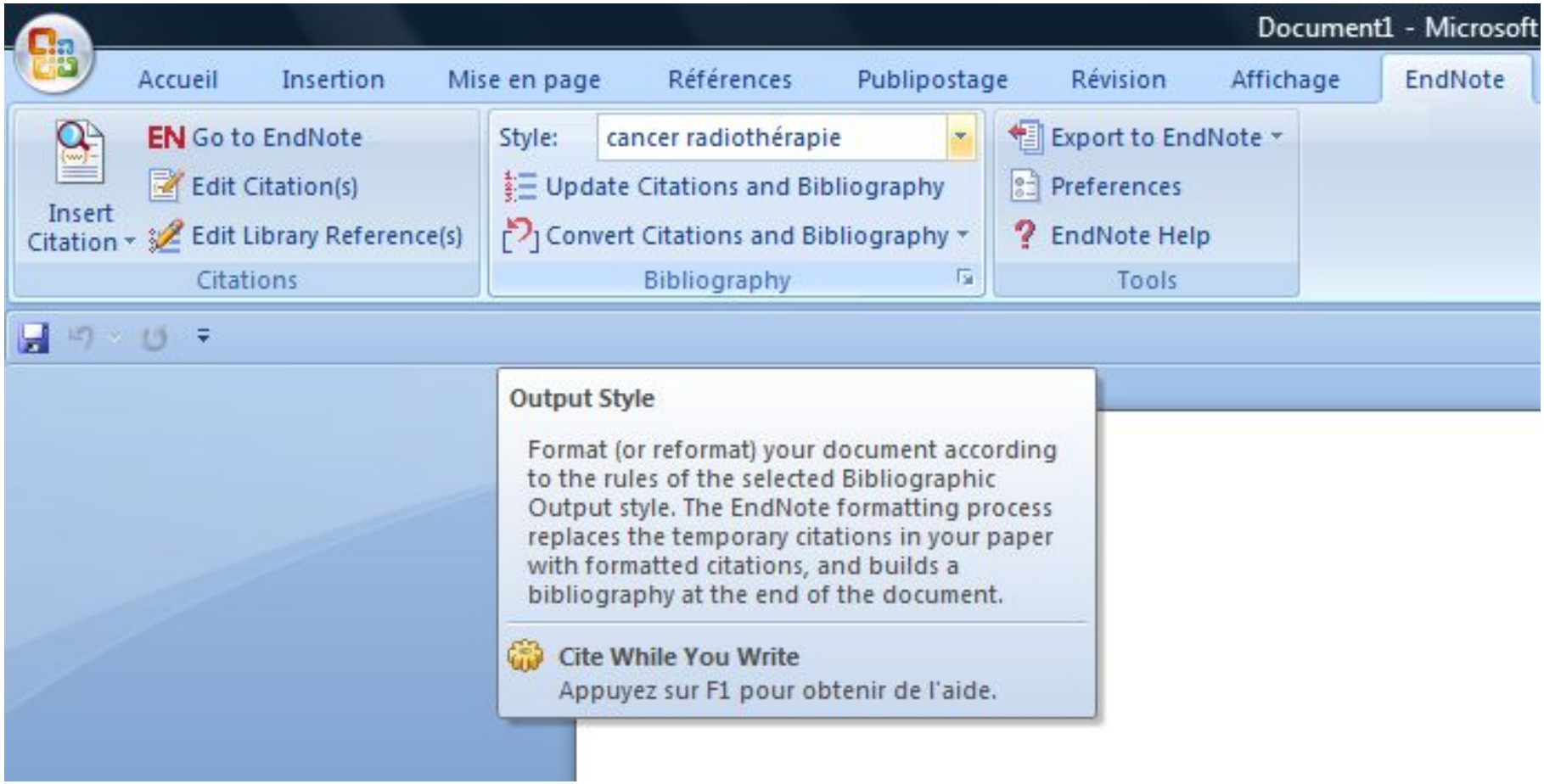

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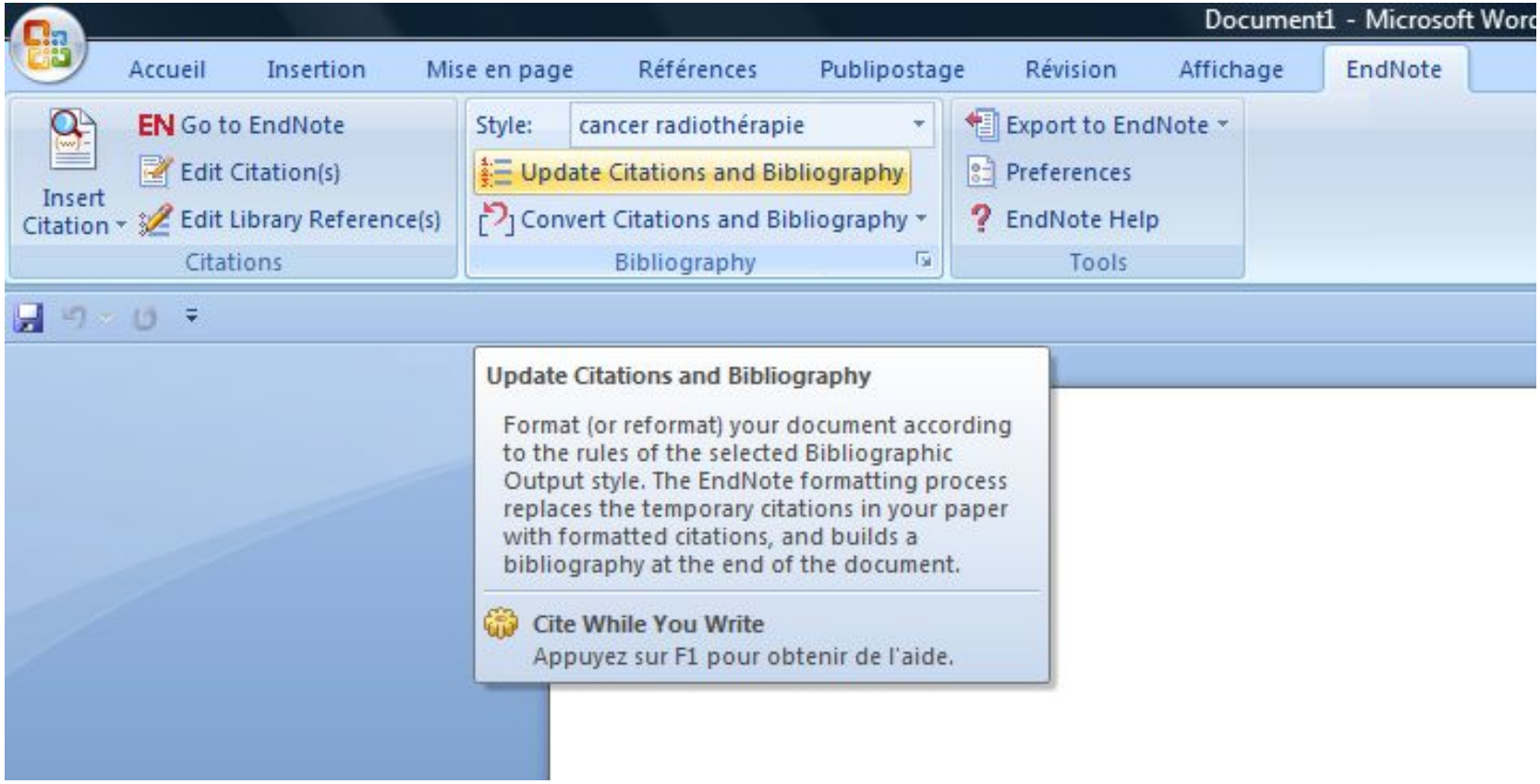

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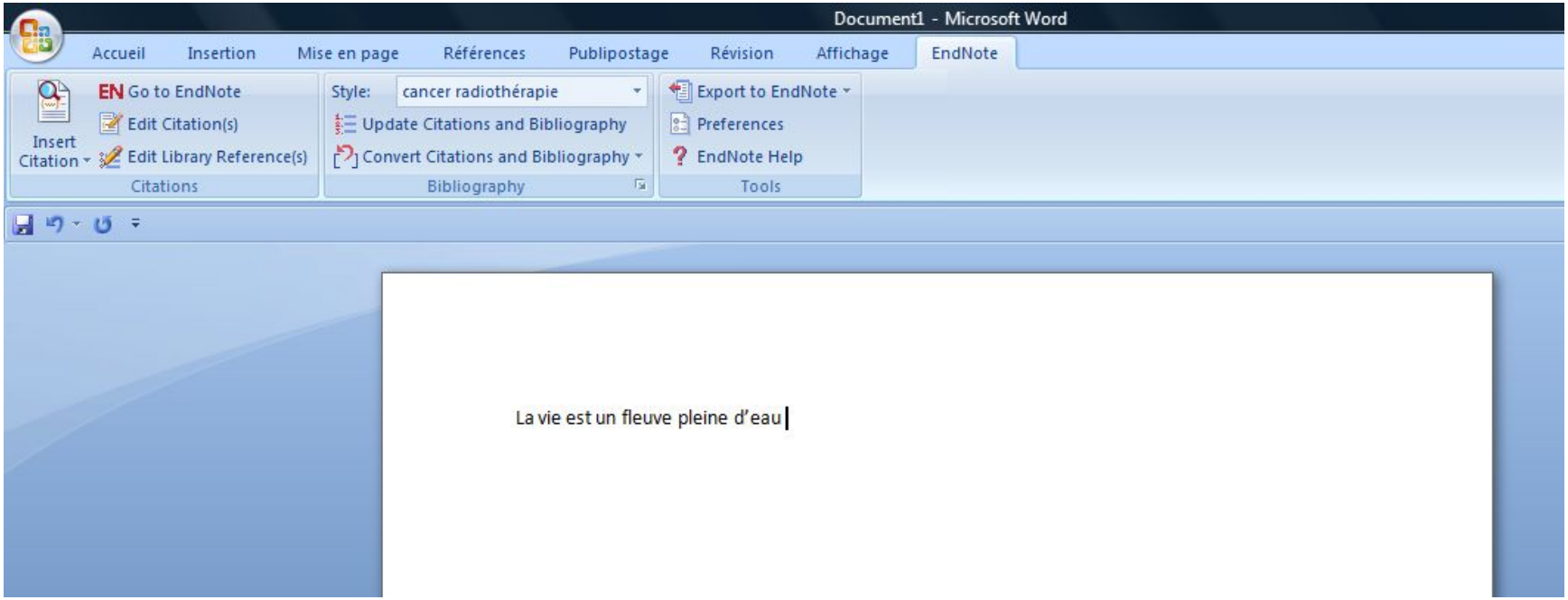

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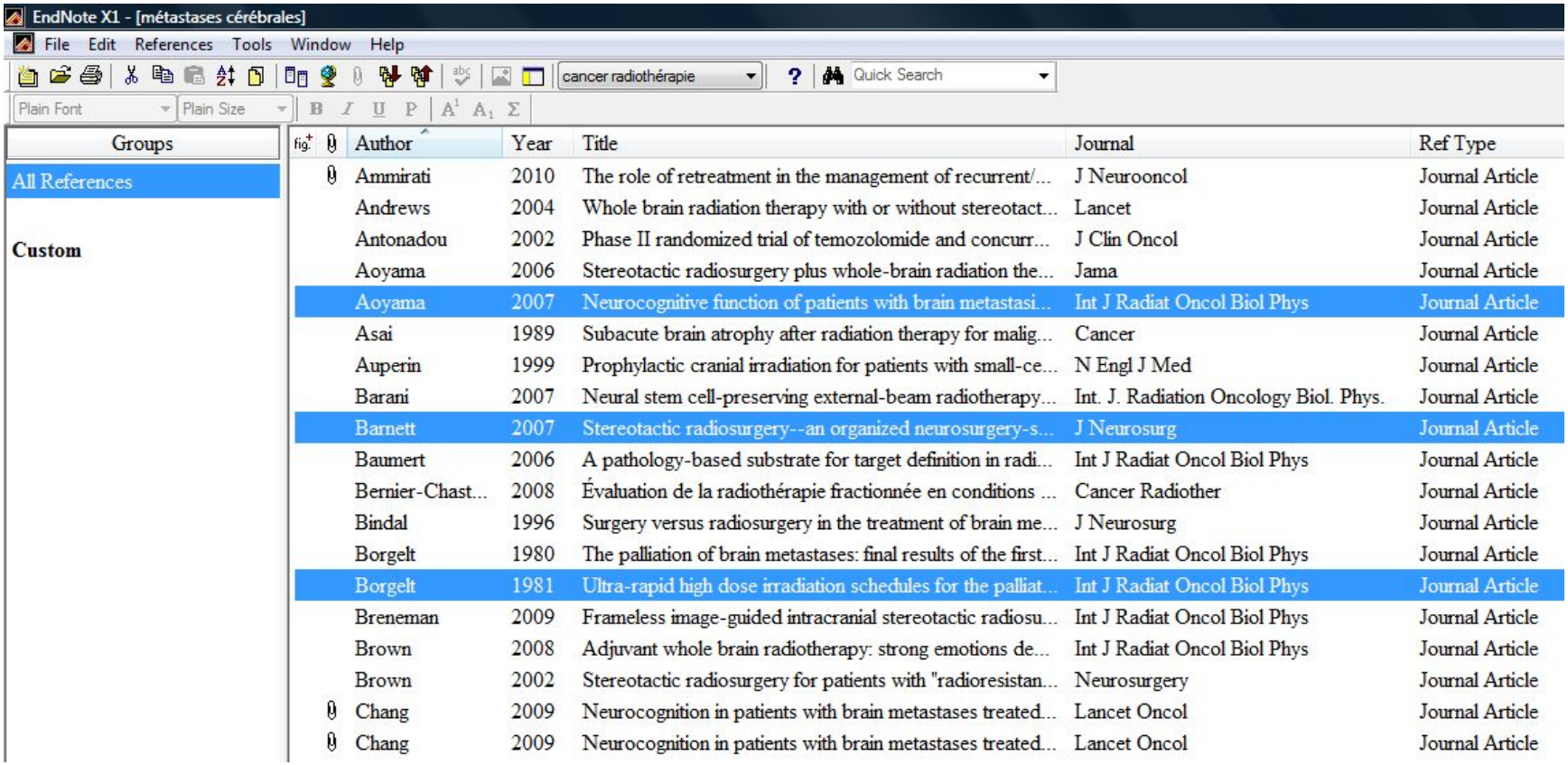

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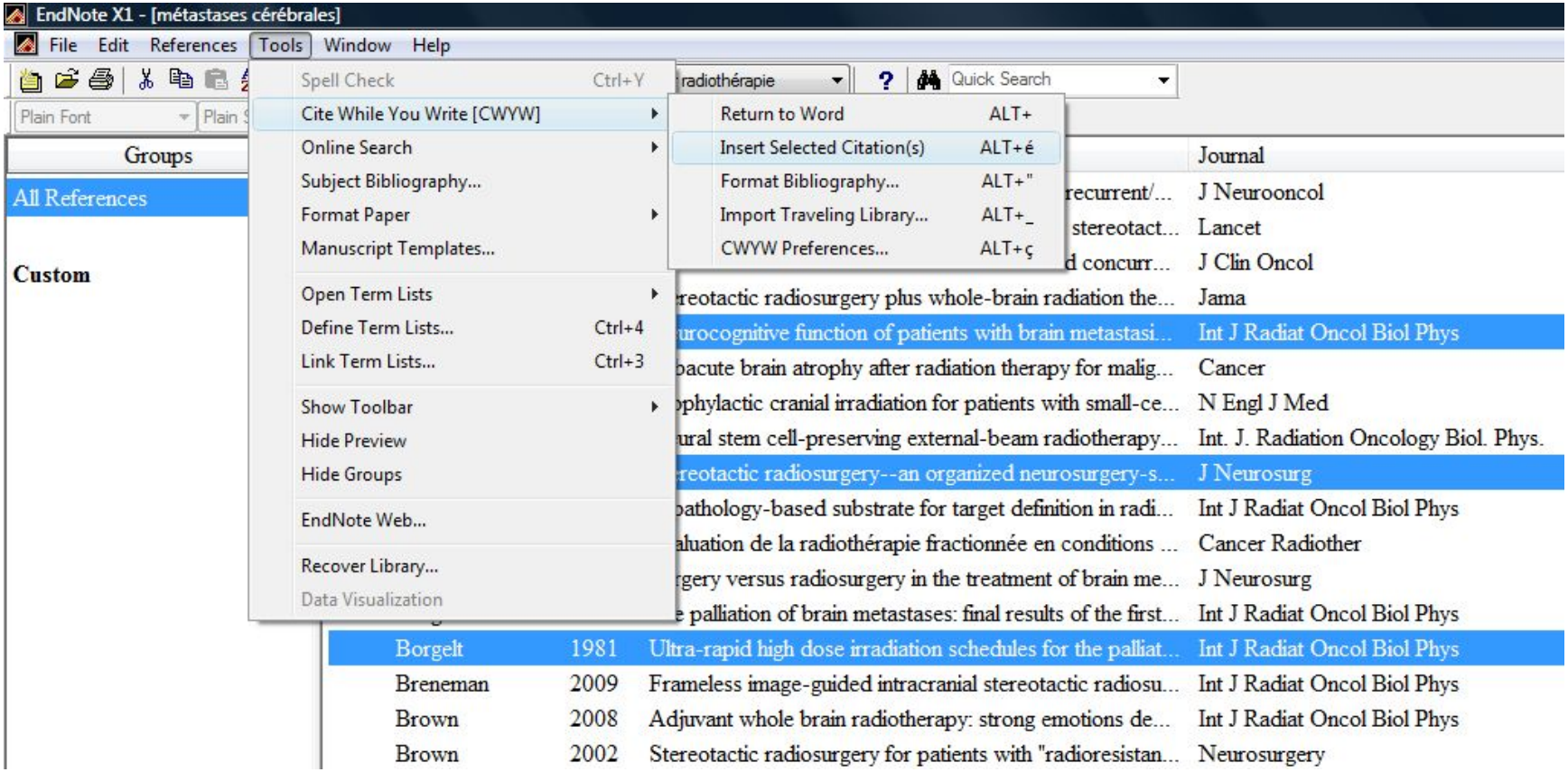

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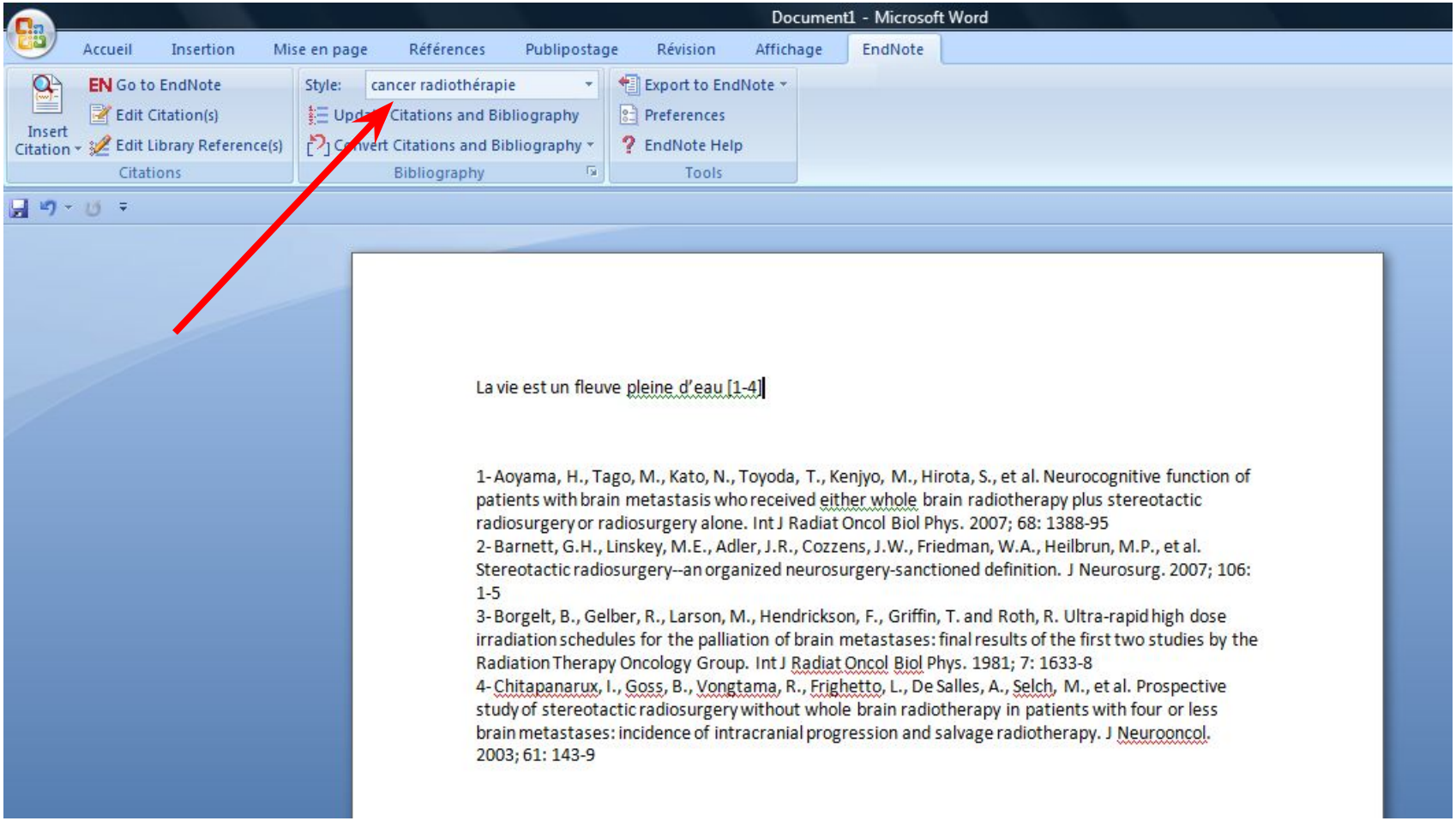
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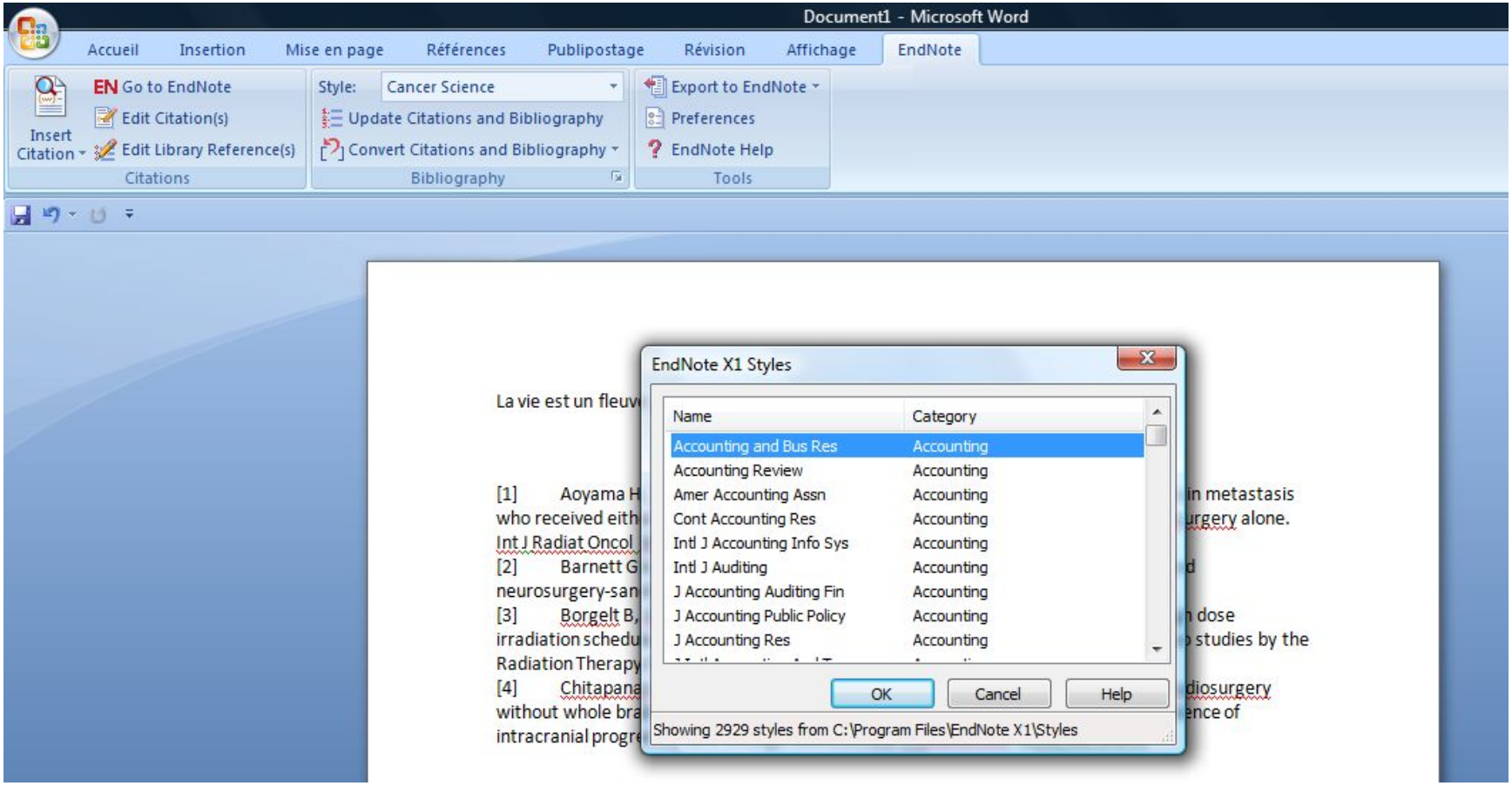

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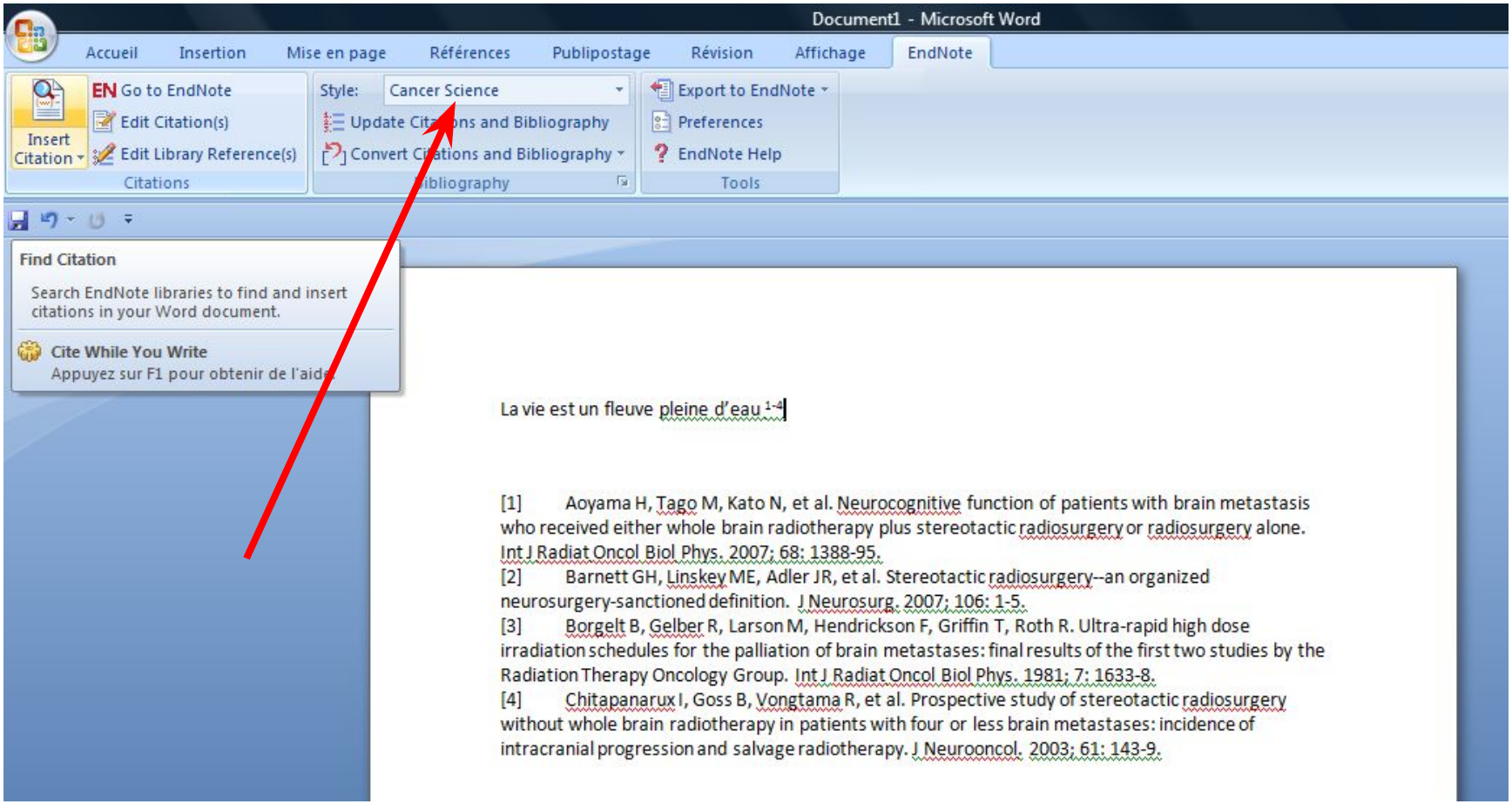
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[2] Barnett GH, Linskey ME, Adler JR, et al. Stereotactic radiosurgery--an organized neurosurgery-sanctioned definition. J Neurosurg. 2007; 106: 1-5.
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- **1/ курсы статистики**
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Статистика и статистика

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- А некоторые понятны для студентов и научных исследователей

Какой вид статистики?

- **Professional – randomized trials**

Adjuvant Whole-Brain Radiotherapy Versus Observation After Radiosurgery or Surgical Resection of One to Three Cerebral Metastases: Results of the EORTC 22952-26001 Study

Martin Kocher, Riccardo Soffietti, Ufuk Abacioglu, Salvador Villà, Francois Fauchon, Brigitta G. Baumert, Laura Fariselli, Tzahala Tzuk-Shina, Rolf-Dieter Kortmann, Christian Carrie, Mohamed Ben Hassel, Mauri Kouri, Egils Valeinis, Dirk van den Berge, Sandra Collette, Laurence Collette, and Rolf-Peter Mueller

Clinical neurological outcome and quality of life among patients with limited small-cell cancer treated with two different doses of prophylactic cranial irradiation in the intergroup phase III trial (PCI99-01, EORTC 22003-08004, RTOG 0212 and IFCT 99-01)

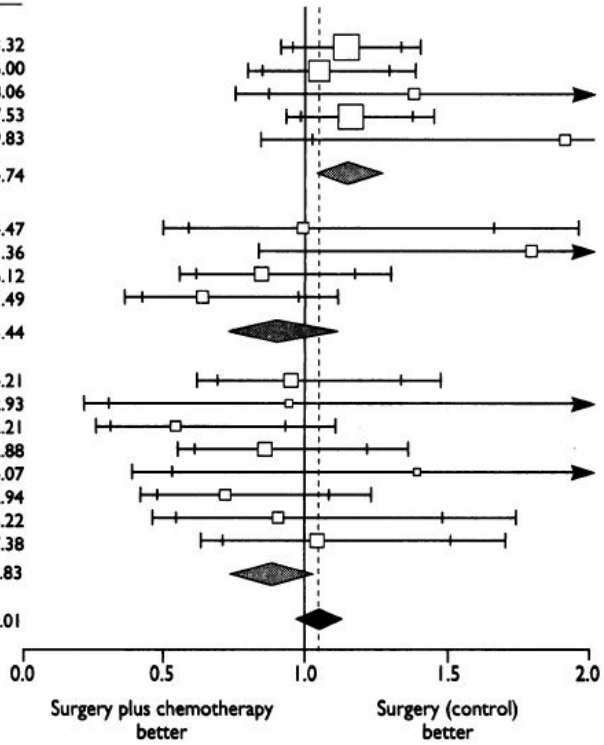
C. Le Péchoux[1*], A. Laplanche[2], C. Faivre-Finn[3], T. Ciuleanu[4], R. Wanders[5], D. Lerouge[6], R. Keus[7], M. Hatton[8], G.M. Videtic[9], S. Senan[10], A. Wolfson[11], R. Jones[12], R. Arriagada[13], E. Quoix[14] & A. Dunant[2] on behalf of the Prophylactic Cranial Irradiation (PCI) Collaborative Group[†]

Какой вид статистики?

Chemotherapy in non-small cell lung cancer: a meta-analysis using updated data on individual patients from 52 randomised clinical trials

Non-small Cell Lung Cancer Collaborative Group

Trial	No of events/ No of patients entered: Surgery plus chemotherapy	No of events/ No of patients entered: Surgery	Observed – expected deaths	Variance
Long term alkylating agents:				
MRC LUO2	415/428	209/215	18.22	143.32
VASAG	251/291	128/152	4,50	86.00
EORTC 08741	38/71	36/75	5.82	18.06
VASOG 5	292/424	261/417	20.63	137.53
WPL 7351	25/36	15/36	6.36	9.83
Subtotal	1021/1250	649/895	55.53	394.74
Other drugs:				
OLCSG 1a	30/163	28/158	-0.09	14.47
OLCSG 1b	27/41	21/42	6.59	11.36
SGACLC ACTLC 1	70/154	75/152	-6.10	36.12
WJSG 2 (2 and 3)	38/108	49/100	-9.79	21.49
Subtotal	165/466	173/452	-9.39	83.44
Cisplatin based:				
LCSG 801	66/140	71/143	-1.81	34.21
OLCSG 1c	5/12	7/16	-0.19	2.93
FLCSG 1	20/54	30/56	-7.79	12.21
SGACLC ACTLC2	64/165	68/167	-4.80	32.88
IPCR Chiba	11/15	7/14	1.33	4.07
WJSG 2 (1 and 3)	44/115	49/100	-7.66	22.94
LCSG 853	29/94	32/94	-1.65	15.22
JLCSSG	59/111	52/98	0.98	27.38
Subtotal	298/706	316/688	-21.58	151.83
Total	1484/2422	1138/2035	24.57	630.01



Ретроспективное обучение

Actuarial data for axillary control, disease-free, distant metastasis-free, overall, and edema-free survivals were calculated using the Kaplan–Meier method (11) and tests of significance were based on the log–rank statistic. The completion of radiotherapy was used as time zero. The significance of differences between proportions was tested with the chi-square statistic or with Fisher's exact test, as appropriate (12). Multivariate analysis was done with the proportional hazards model, using the log-linear relative hazard function of Cox (11). The expected survival curve for the

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  - **У статистиков нет времени, чтобы проводить «незначительные» ретроспективные исследования**
  - **Некоторые больницы и клиники не открывают кафедры статистики**

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  - Один вид данных о пациенте или болезни

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  - промежуток/интервал
  - категории
  - нумерация …/…

Программа Statview

Данные в любом виде

Список данных

StatView

Fichier Edition Vue Texte Analyse Présentation Gestion Fenêtre Aide

Données délai statview version 2 article.svd

Compact. Décomp. Critère : étude avec bon critères

	RT	dose RT	dose par fract..	CH concomitante	protocole concomitant	chimioadjuvante	protocole adju...	nombre de cu...	état DDN	etat r			délai
369	2	59,40	1,80	1	1	1	1	9,00	1				dix
370	2	52,00	2,00	1	1	1	1	2,00	2				dix
371	2	60,00	2,00	1	1	1	3	3,00	1				dix
372	2	40,00	3,00	2	•	2	•	•	1				dix
373	2	60,00	2,00	1	1	1	1	7,00	1				dix
374	2	65,00	•	1	1	1	1	6,00	2				dix
375	2	60,00	2,00	1	1	2	•	•	1				dix
376	2	60,00	2,00	1	1	1	1	2,00	2				dix
377	2	60,00	2,00	1	1				2				dix
378	2	42,00	3,00	2	•				1				dix
379	2	59,40	1,80	1	1				3				dix
380	2	60,00	3,00	2	•				1				dix
381	2	60,00	2,00	2	•				1				dix
382	1	60,00	2,00	2	•				2				dix
383	2	60,00	2,00	1	1				1				dix
384	2	•	•	•	•				2				dix
385	2	59,40	1,80	2	•				3				dix
386	1	54,00	2,00	1	2				1				dix
387	2	51,00	3,00	1	1				1				dix
388	2	60,00	2,00	2	•	2	•	•	1				dix
389	2	60,00	2,00	1	1	1	1	1,00	1				dix
390	1	61,00	1,85	1	1	1	1	3,00	3				dix
391	2	59,40	1,80	1	1	1	1	19,00	1				dix
392	2	60,00	2,00	1	1	1	1	•	1				dix
393	2	60,00	2,00	1	1	1	1	4,00	2				dix
394	1	60,00	2,00	1	1	1	1	•	1				dix
395	1	60,00	2,00	1	3	1	•	4,00	1				dix
396	2	42,00	3,00	2	•	2	•	•	1				dix
397	1	34,00	2,00	2	•	2	•	•	2				dix
398	1	49,00	2,23	1	1	1	1	16,00	2				dix
399	1	60,00	2,00	1	1	2	•	•	1				dix
400	2	•	•	2	•	2	•	•	1	1	63,00	neuf-onze s...	220,00	dix

Aide

Welcome to the StatView dataset. New columns and rows are automatically created as you add data. Control each column's format, type, and class and view descriptive statistics using the Column Attribute pane at the top of the data window. Open the Attribute pane using the control at the top of the right hand scroll bar. For more information on the dataset, see your manual.

Variables

Afficher

Compact.

Décomp.

Données : Données délai statview version 2 arl

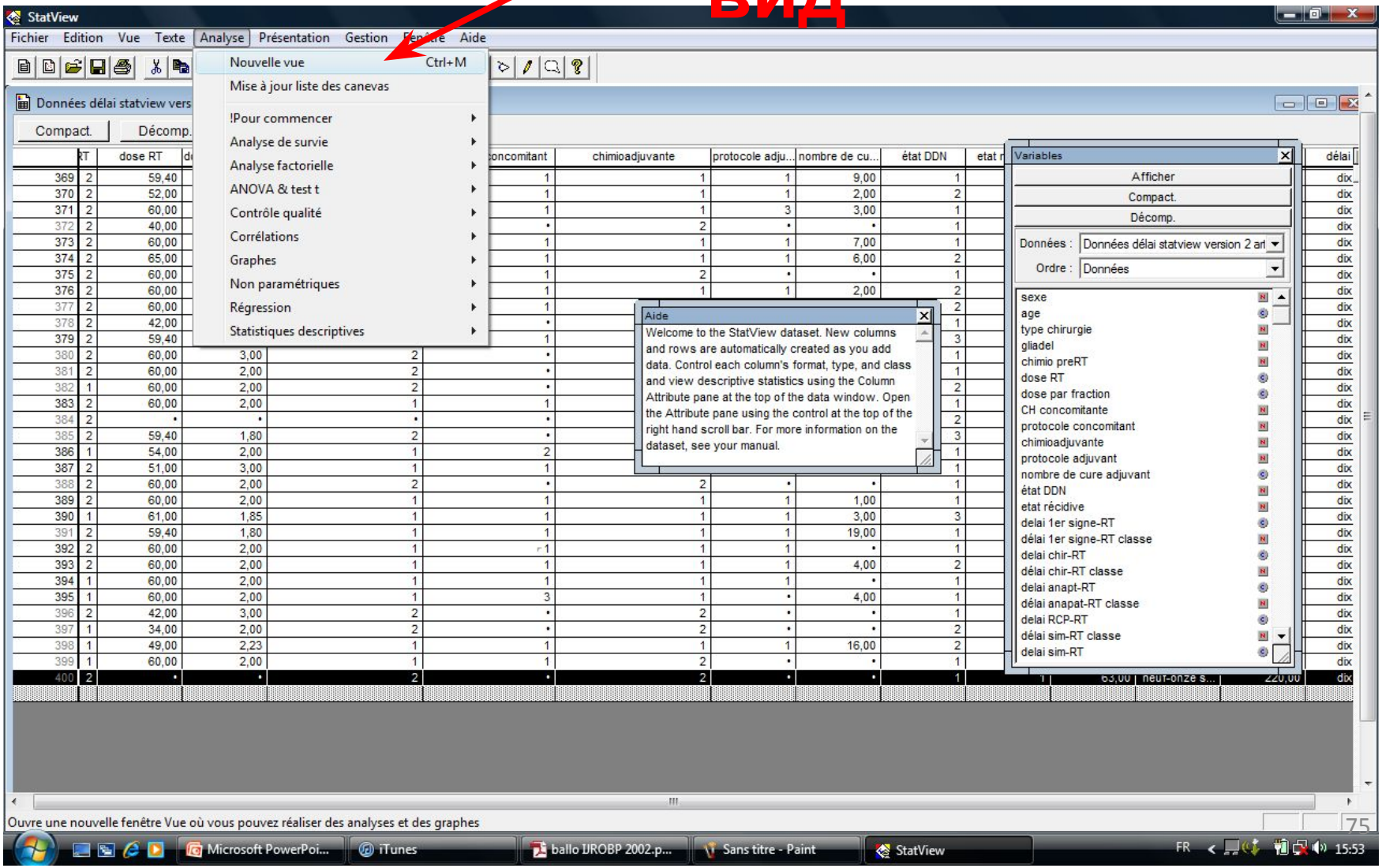
Ordre : Données

- sexe
- age
- type chirurgie
- gliadel
- chimio preRT
- dose RT
- dose par fraction
- CH concomitante
- protocole concomitant
- chimioadjuvante
- protocole adjuvant
- nombre de cure adjuvant
- état DDN
- etat récidive
- delai 1er signe-RT
- délai 1er signe-RT classe
- delai chir-RT
- délai chir-RT classe
- delai anapt-RT
- délai anapat-RT classe
- delai RCP-RT
- délai sim-RT classe
- delai sim-RT

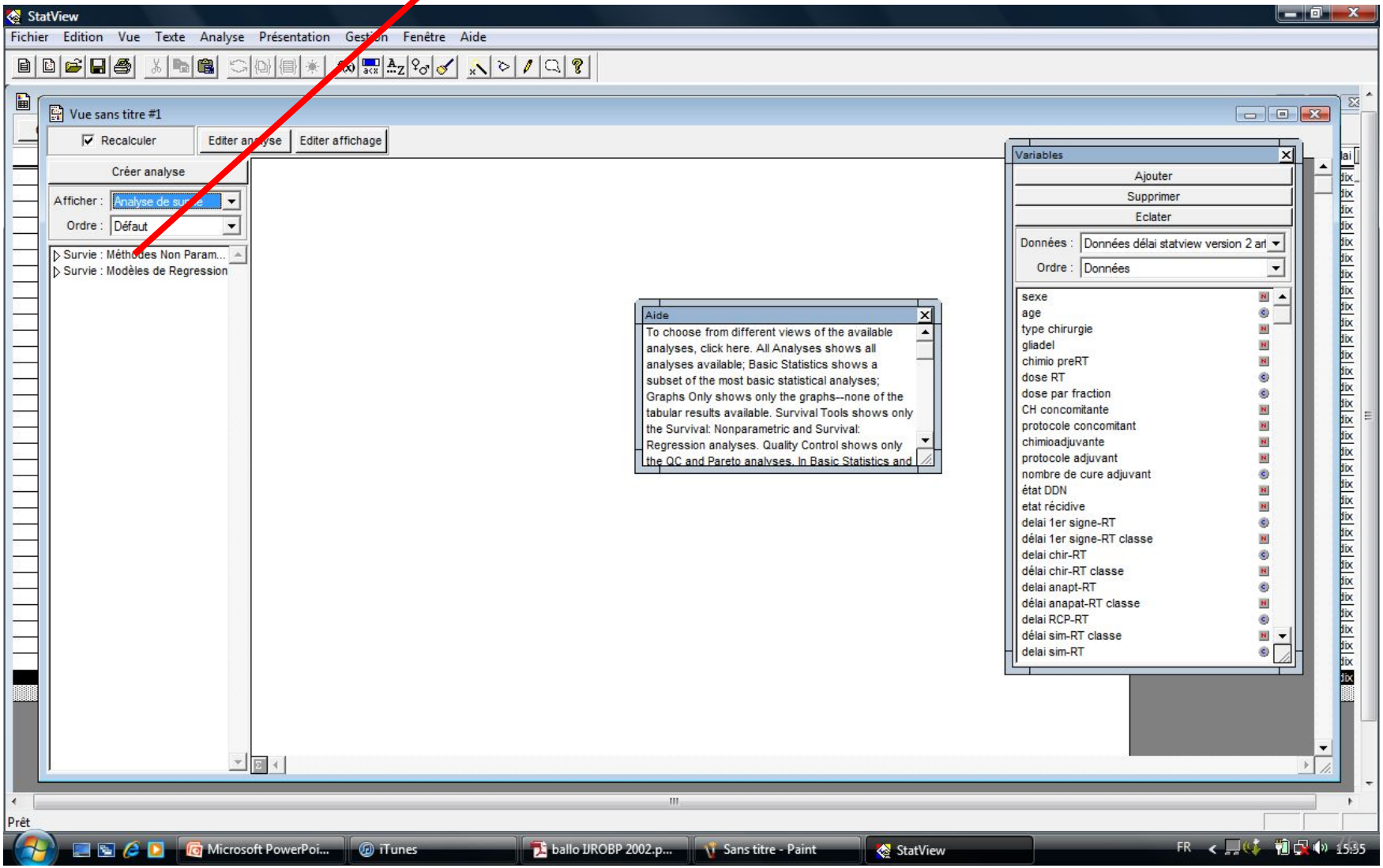
Prêt

Microsoft PowerPoi... iTunes ballo IJROBP 2002.p... Sans titre - Paint StatView FR 15:50

Новый вид


StatView
Fichier Edition Vue Texte Analyse Présentation Gestion Fenêtre Aide
Nouvelle vue Ctrl+M
Mise à jour liste des canevas
!Pour commencer
Analyse de survie
Analyse factorielle
ANOVA & test t
Contrôle qualité
Corrélations
Graphes
Non paramétriques
Régression
Statistiques descriptives
Données délai statview vers
Compact.
Décomp.
Aide
Welcome to the StatView dataset. New columns and rows are automatically created as you add data. Control each column's format, type, and class and view descriptive statistics using the Column Attribute pane at the top of the data window. Open the Attribute pane using the control at the top of the right hand scroll bar. For more information on the dataset, see your manual.
Variables
Afficher
Compact.
Décomp.
Données : Données délai statview version 2 arl
Ordre : Données
sexe
age
type chirurgie
gliadel
chimio preRT
dose RT
dose par fraction
CH concomitante
protocole concomitant
chimioadjuvante
protocole adjuvant
nombre de cure adjuvant
état DDN
etat récidive
delai 1er signe-RT
délai 1er signe-RT classe
delai chir-RT
délai chir-RT classe
delai anapt-RT
délai anapat-RT classe
delai RCP-RT
délai sim-RT classe
delai sim-RT
Ouvre une nouvelle fenêtre Vue où vous pouvez réaliser des analyses et des graphes
Microsoft PowerPoi...
iTunes
ballo IJROBP 2002.p...
Sans titre - Paint
StatView
FR
15:53

Тип анализа:
Не параметриальное выживание



Mentel-Cox

текст

Kaplan-Meier

метод

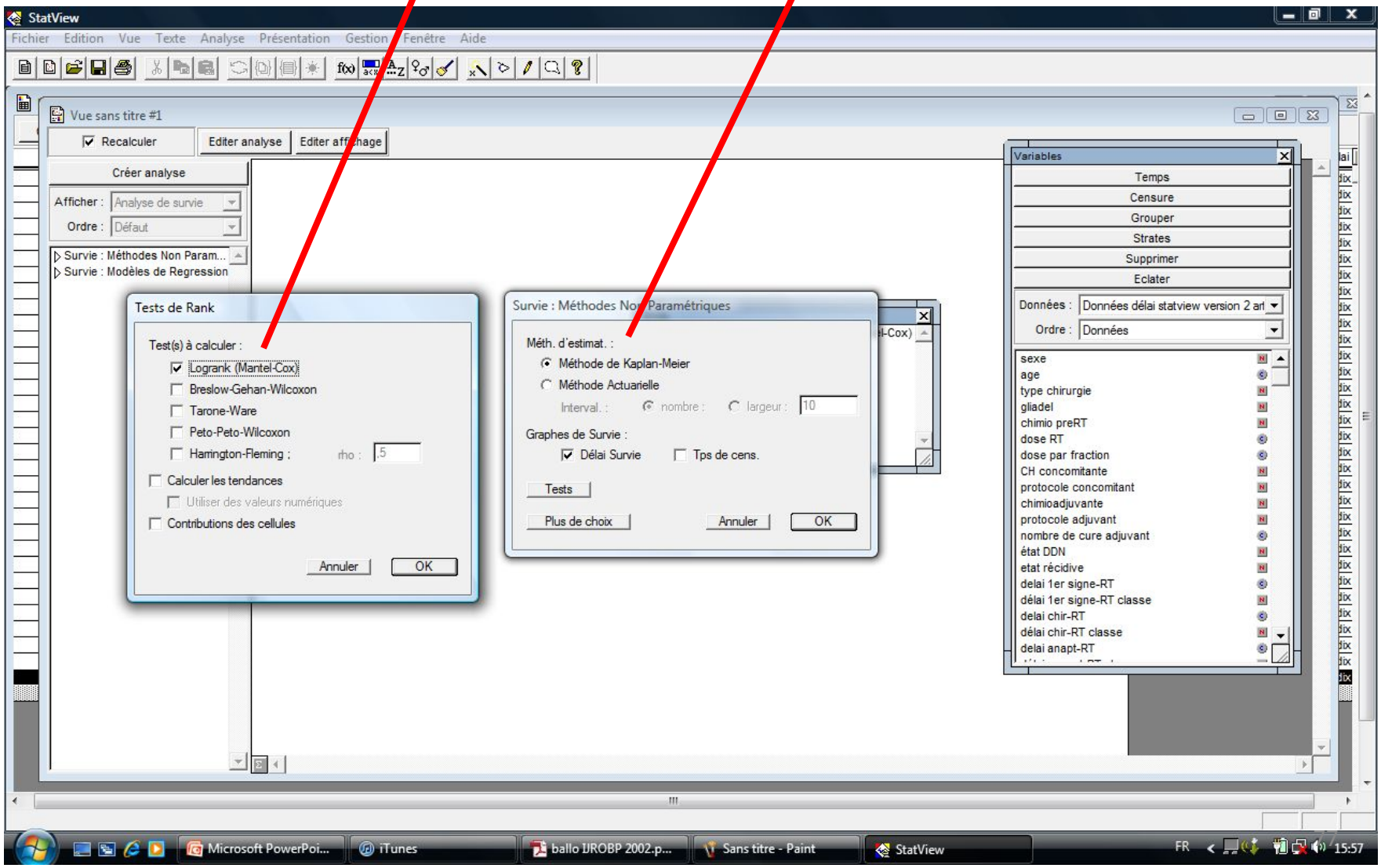


Tableau de Survie résumé pour delai DDN
Variable censure : dernière nouvelle
Facteur : type chirurgie

	# Obs.	# Evénements	# Censurée	% Censurée	# Manquant	# Non Valide
1	164	101	63	38,415	0	0
2	143	104	39	27,273	0	0
3	90	67	23	25,556	0	0
Total	397	272	125	31,486	3	0

Le nombre total de # manquants (es) n'est pas en accord avec ceux qui figurent pour chaque strates/groupes du fait que certaines valeurs manquent pour les variables strates/groupes.

Распределение на классы

Kaplan-Meier Statistiques de Survie pour delai DDN
Variable censure : dernière nouvelle
Facteur : type chirurgie

	Estimation	Erreur Standard
1: 25%	308,000	28,060
1: 50%	522,000	15,622
1: 75%	924,000	113,315
1: Moyenne	598,548	30,526
2: 25%	148,000	60,412
2: 50%	291,000	46,797
2: 75%	498,000	53,089
2: Moyenne	432,709	36,873
3: 25%	234,000	23,516
3: 50%	404,000	57,955
3: 75%	624,000	149,151
3: Moyenne	459,646	32,354

Kaplan-Meier Graphe de Survie Cum. pour delai DDN
Variable censure : dernière nouvelle
Facteur : type chirurgie

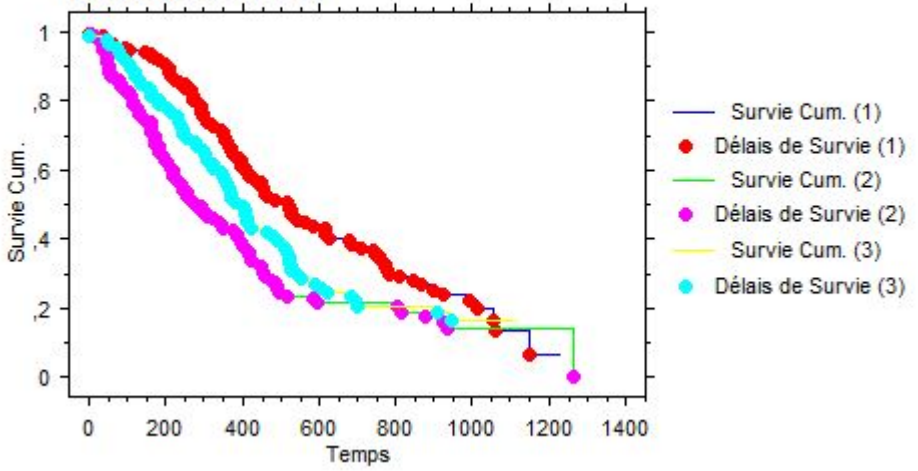


Схема выживания

Продолжительность выживания

Logrank (Mantel-Cox) Test pour delai DDN
Variable censure : dernière nouvelle
Facteur : type chirurgie

Chi-2	DDL	P
15,481	2	,0004

Статистические обозначения

Заключения

- **Основные программные средства необходимы, чтобы улучшать знания**

- **Хотя средств не так много, чтобы не научиться пользоваться, тем не менее преподаватели и будущие пользователи слабо владеют ими**