Projects

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Project 1

Make It HAPPen

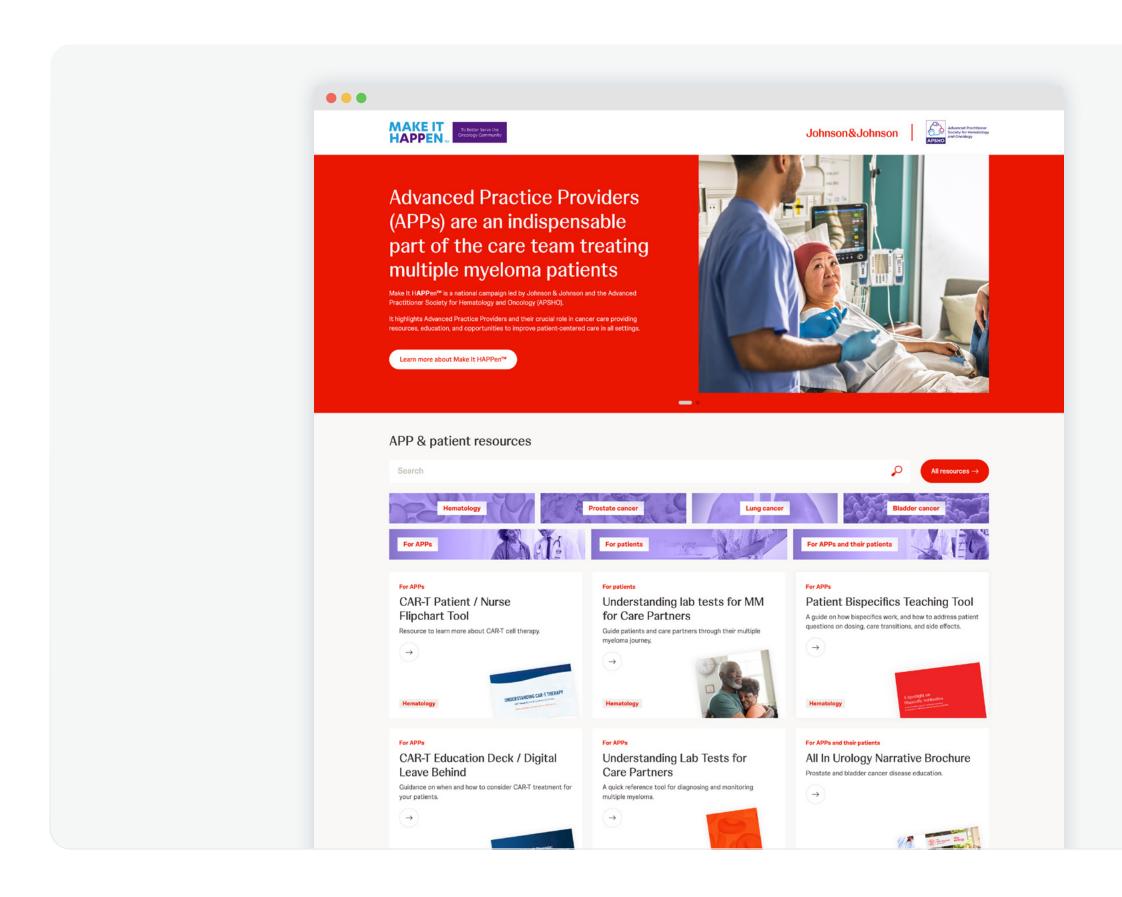
Website Design & Front-End Development

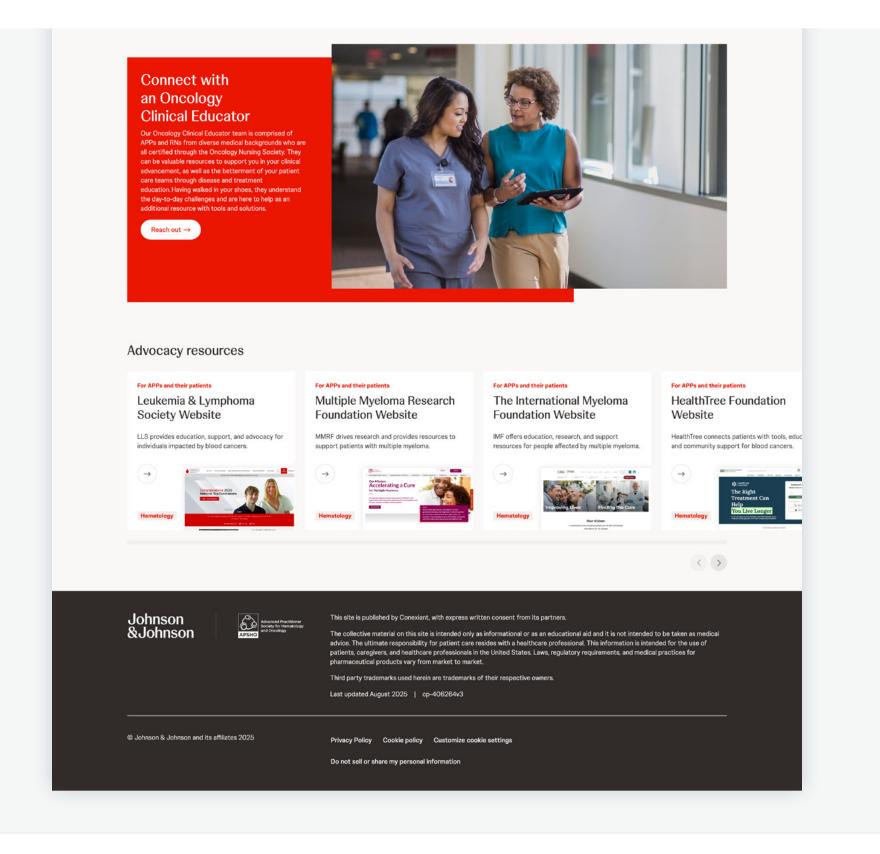
appsmakeithappen.com

Features

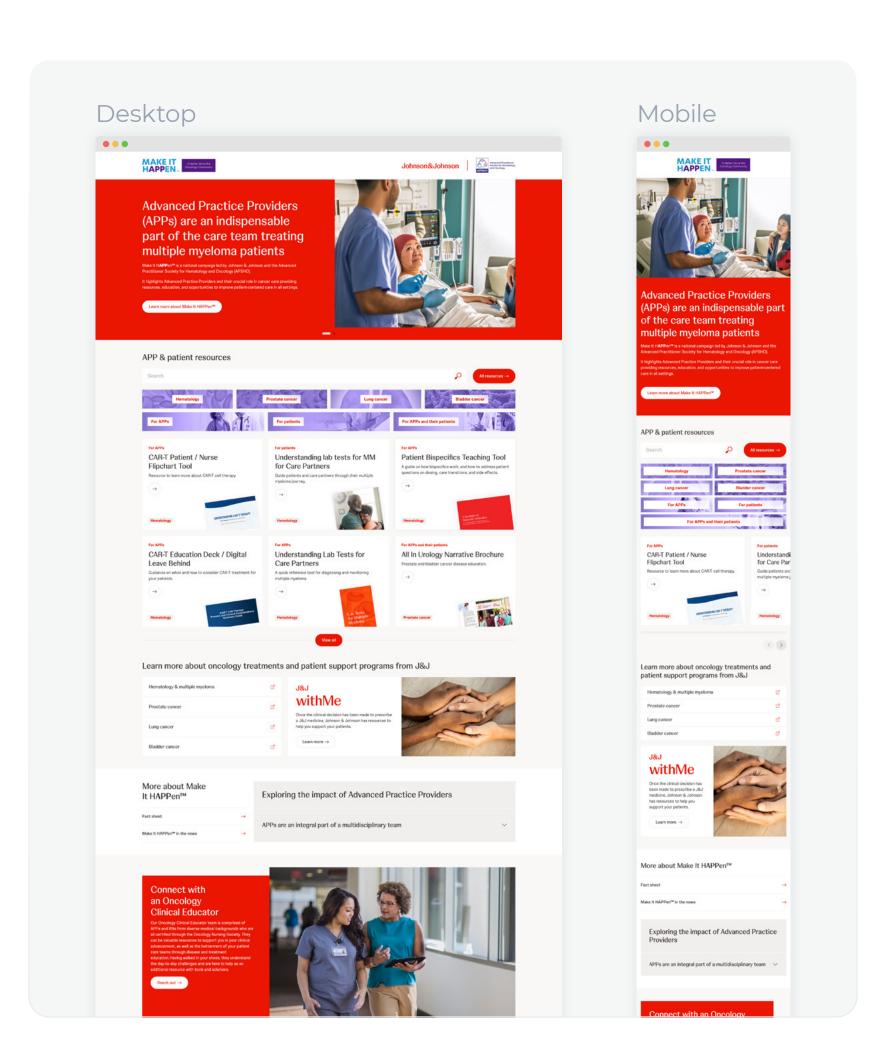
Responsive Layout Intuitive Design System Component Modules Make It HAPPen™ is a nation campaign led by Johnson & Johnson and the Advanced Practitioner Society for Hematology and Oncology (APSHO). It highlights Advanced Practice Providers and their cucial role in cancer care providing resources, education, and opportunities to improve patient-centered care in all settings.

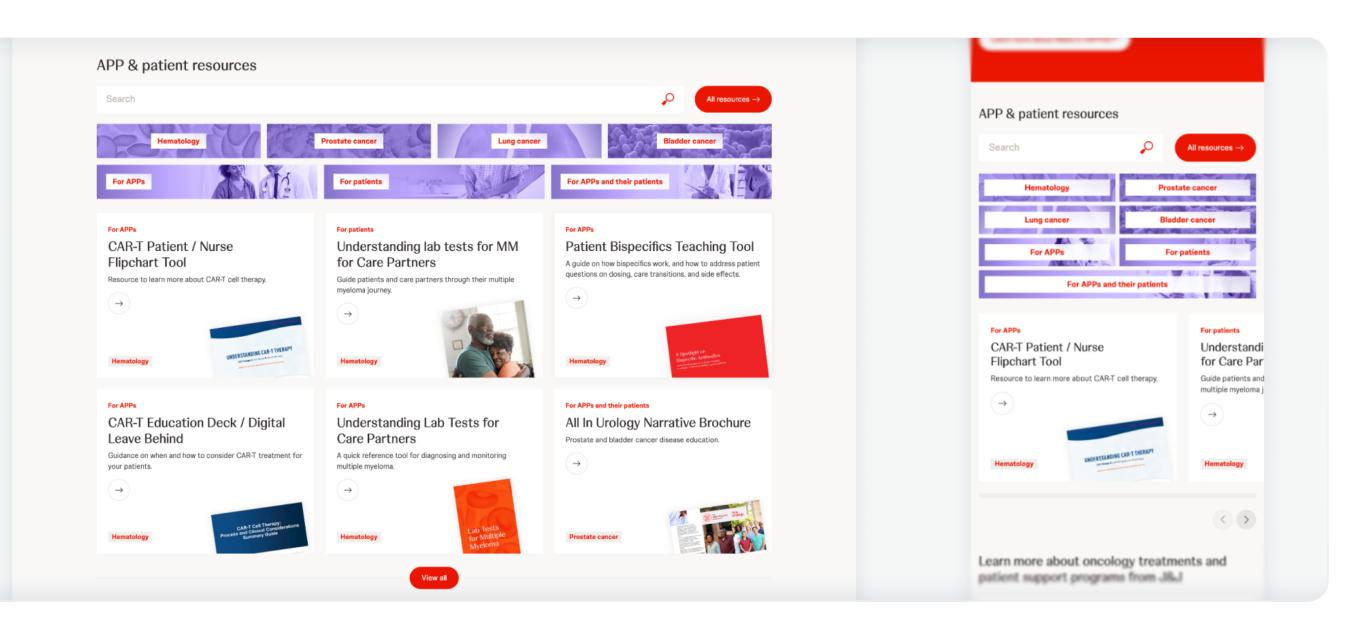
My role was to head the Web and UX design, as well as the front-end development. The goals being to increase conversions, align existing site with updated J&J branding, and improve the user experience.

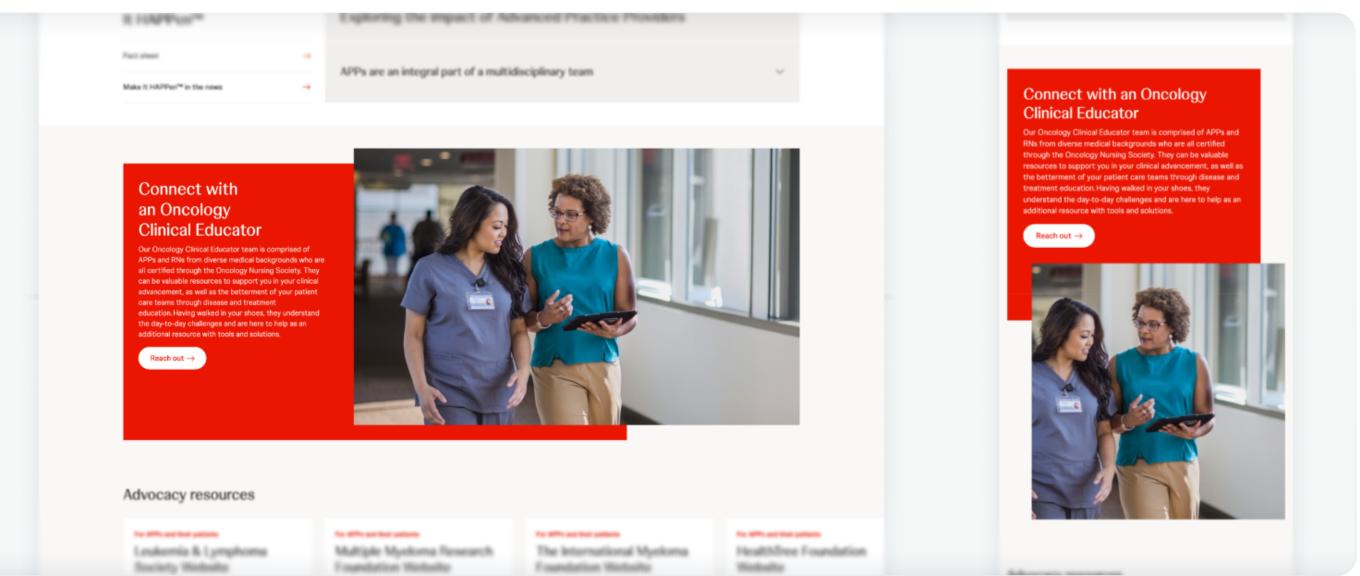




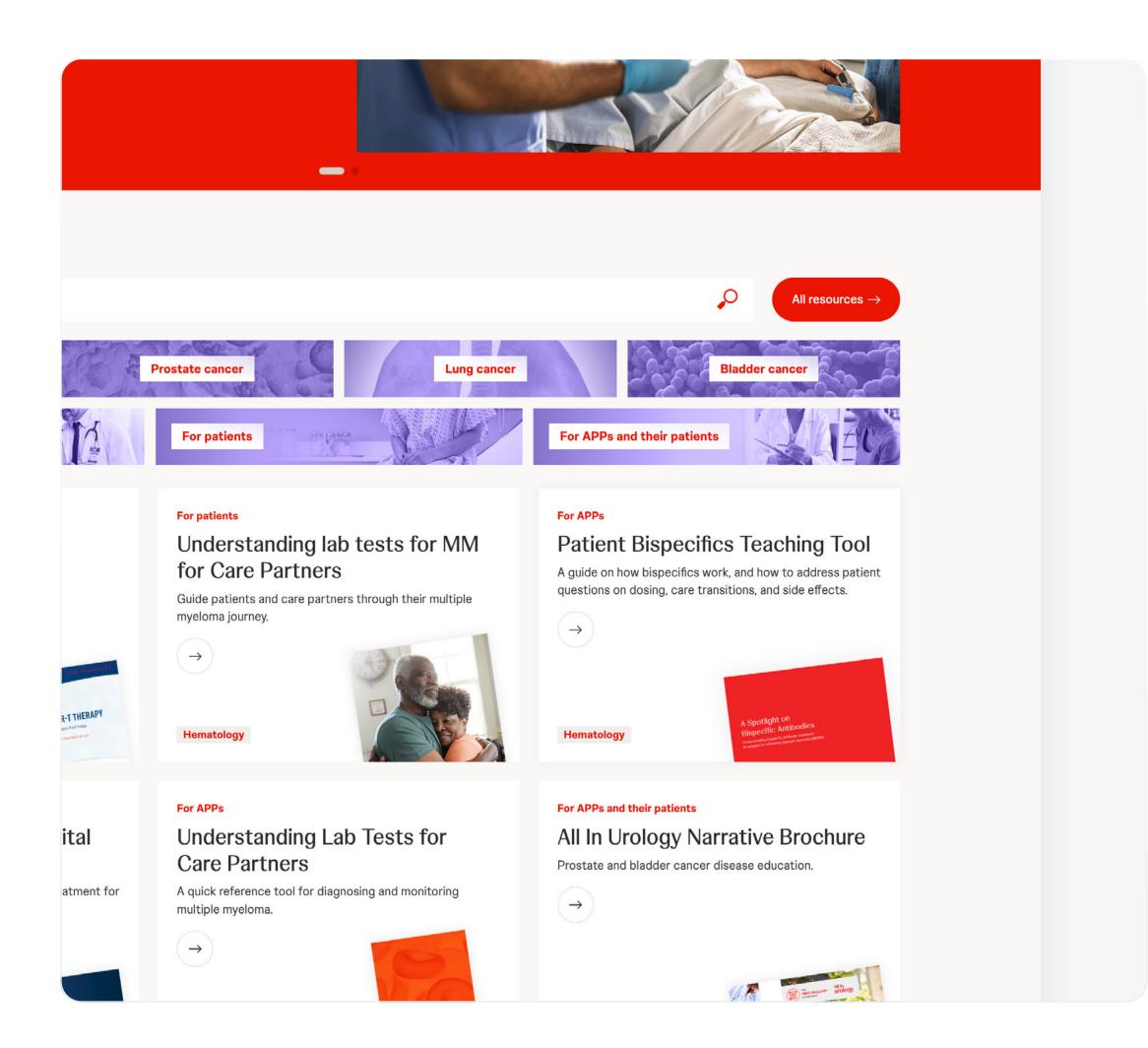
Responsive Layout

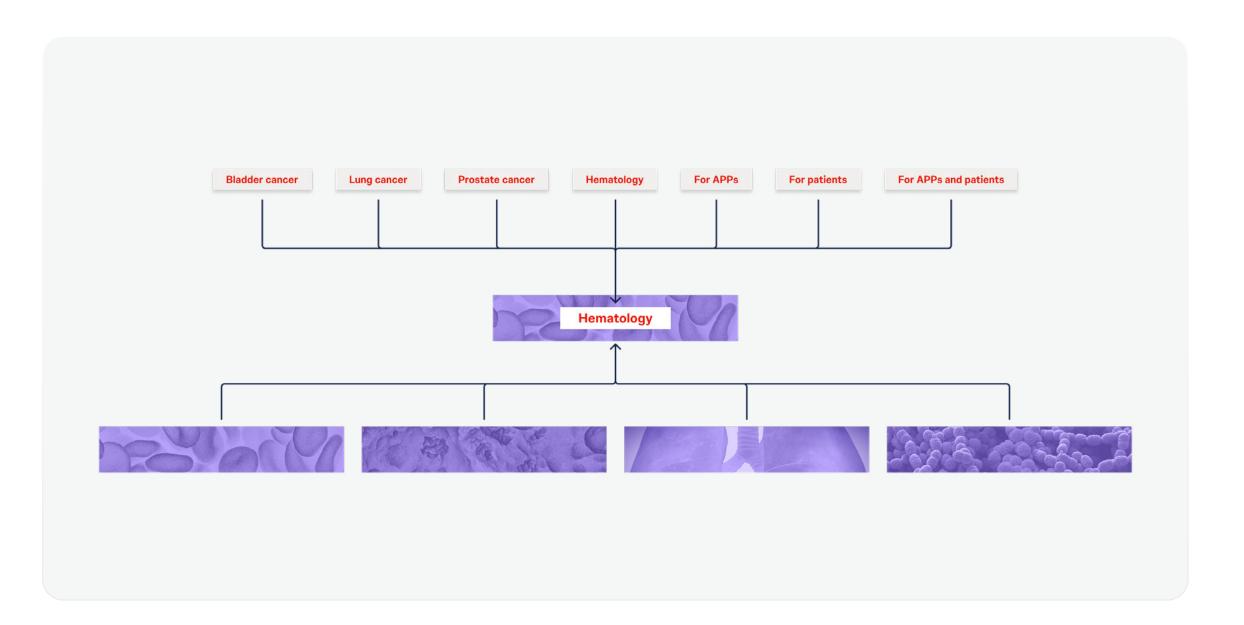


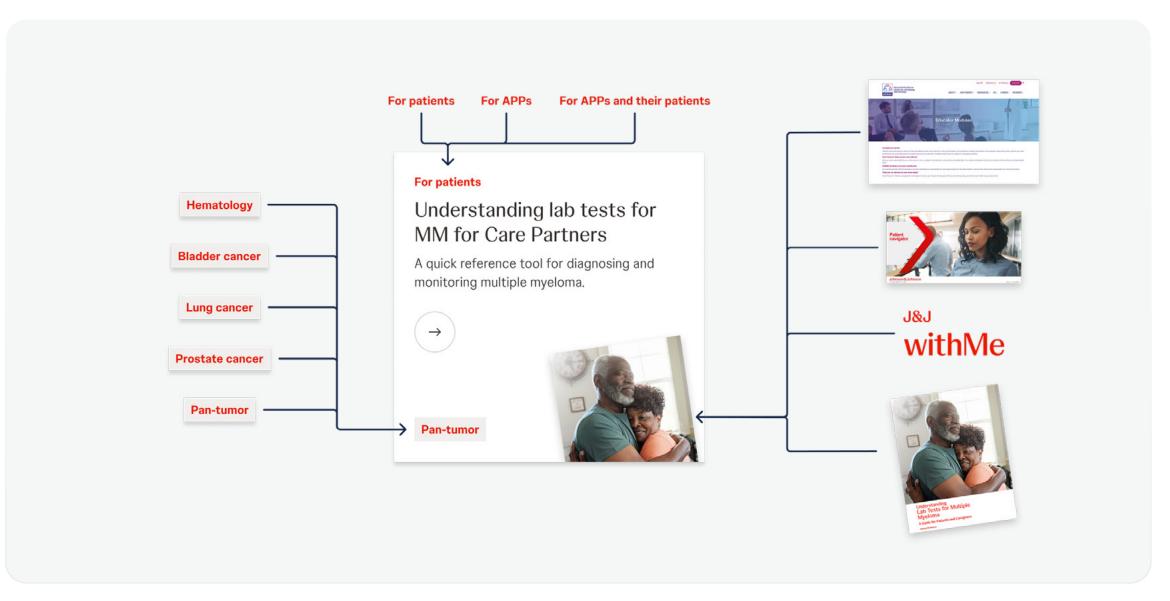




Component Modules

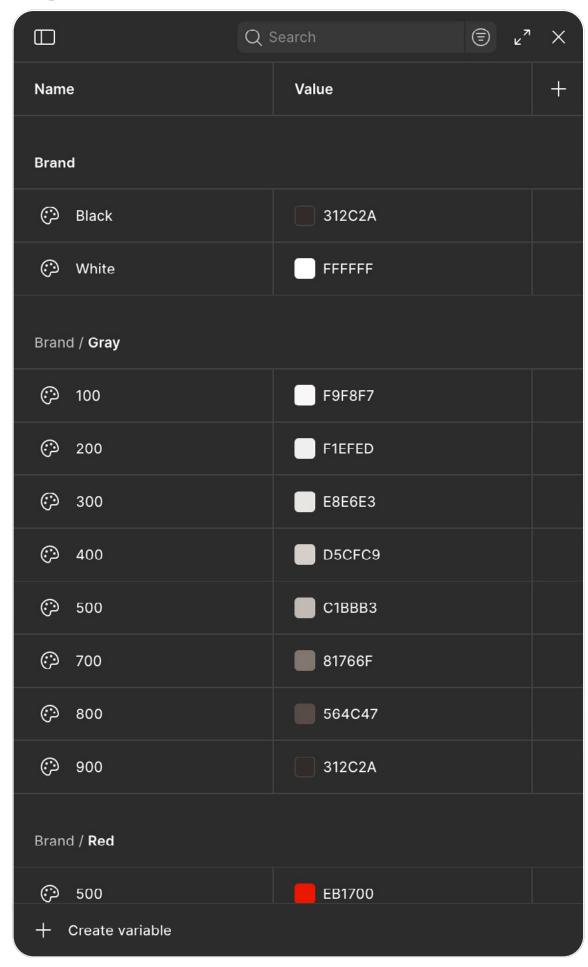




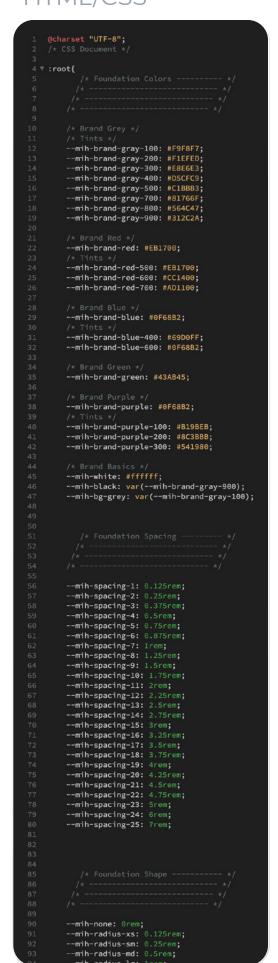


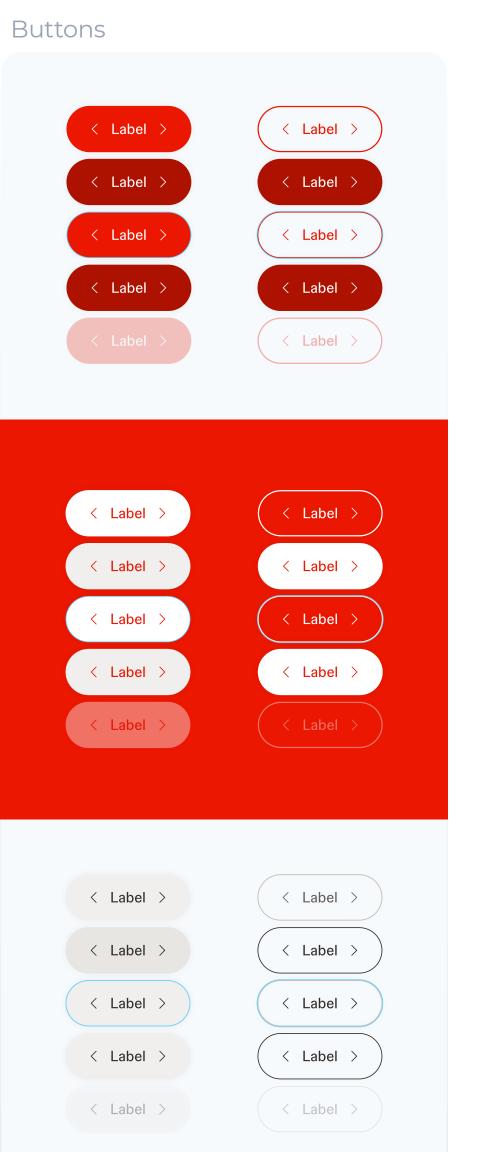
Intuitive Design System

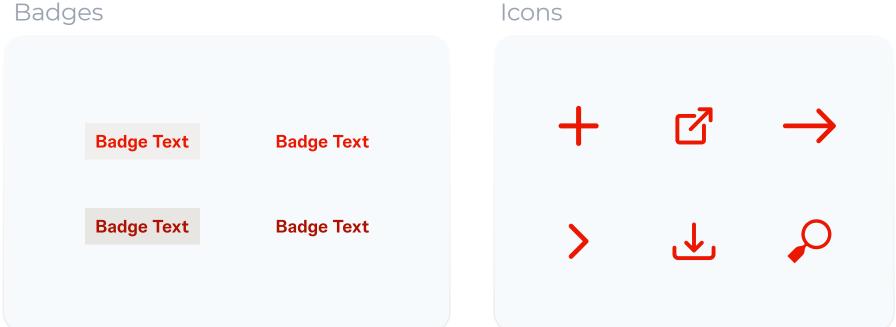
Figma Variables



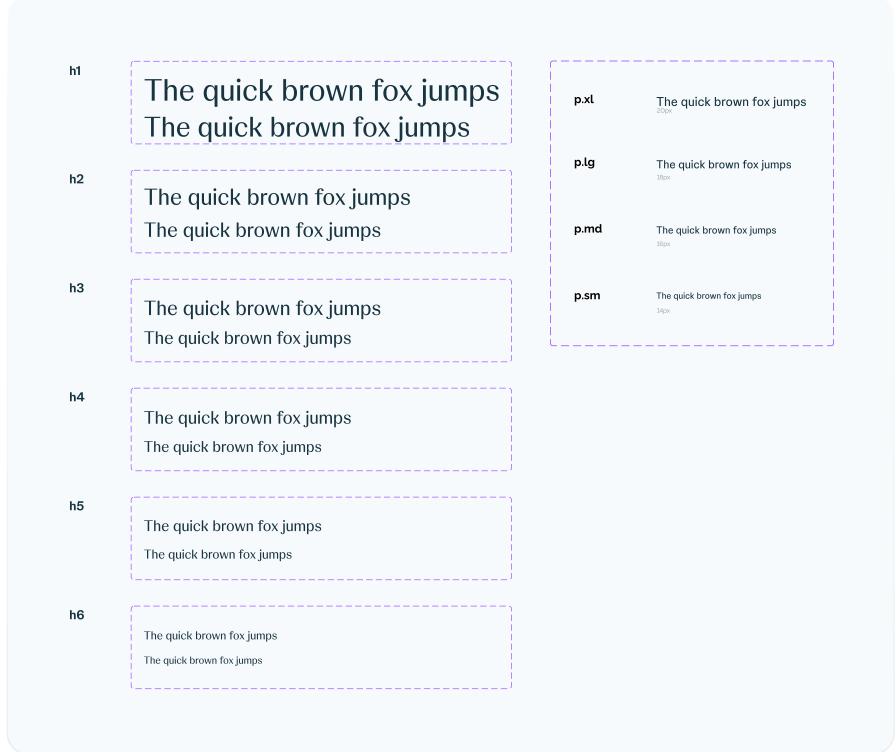












Project 2

JADPRO Live

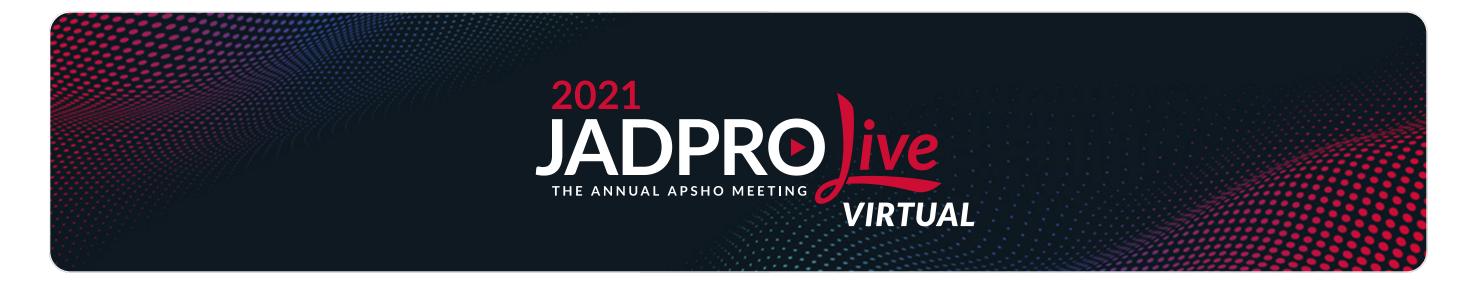
Conference Branding & Various Collateral

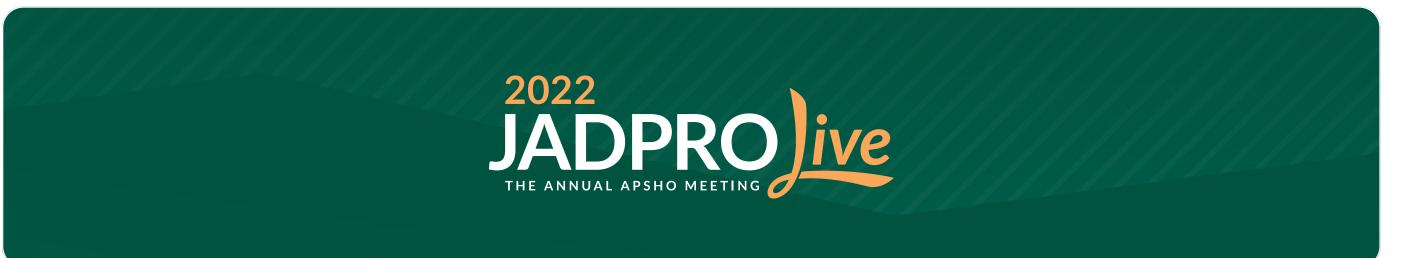
jadprolive.com

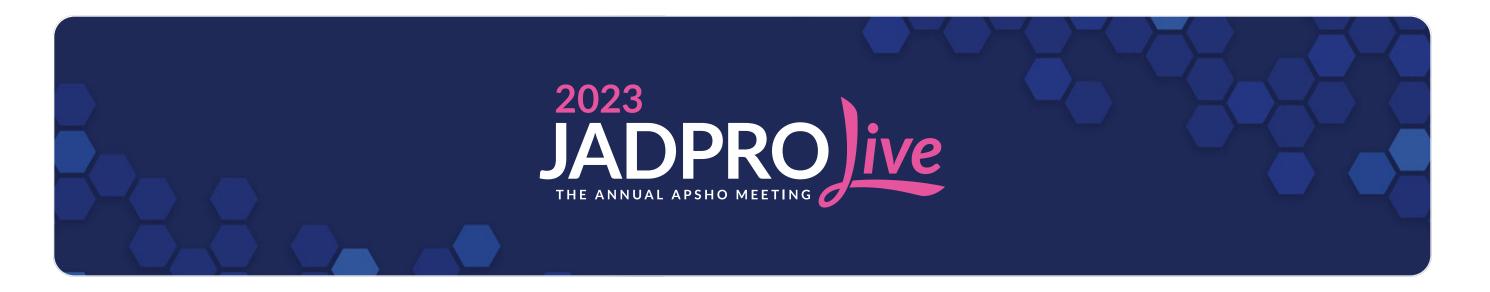
Deliverables

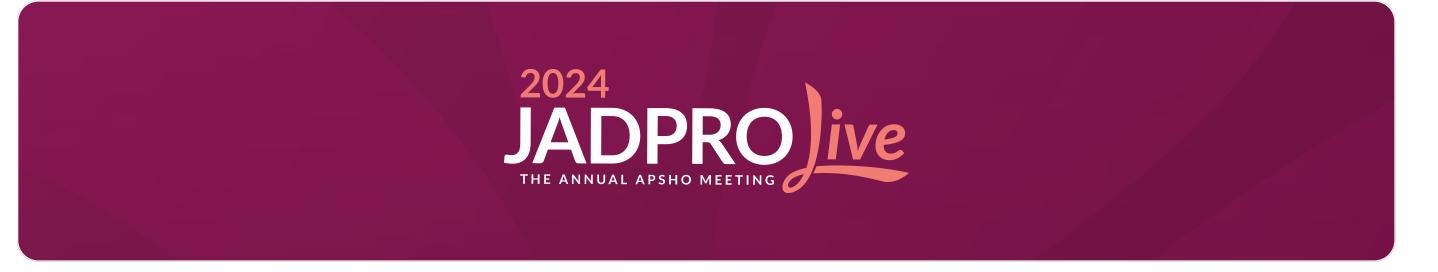
Direct Mailers
Print Advertisements
Digital Advertisements
Marketing Brochures

Conference Guides
Social Media Graphics
Conference Signage
And much more

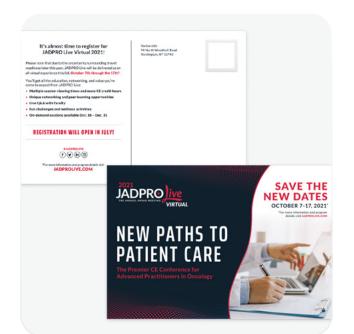








Direct Mailers









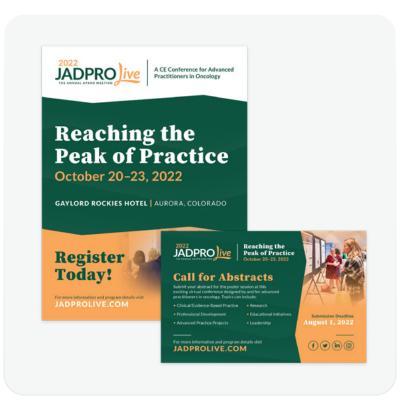


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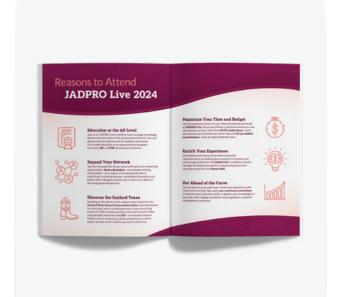


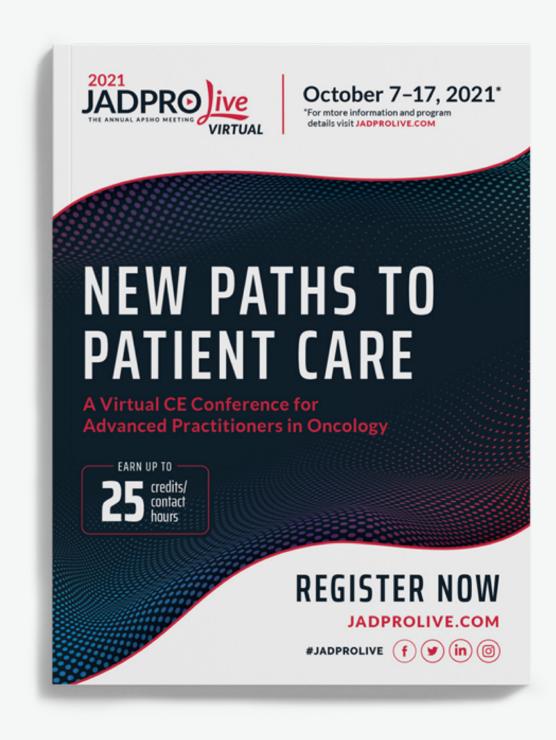
Marketing Brochures

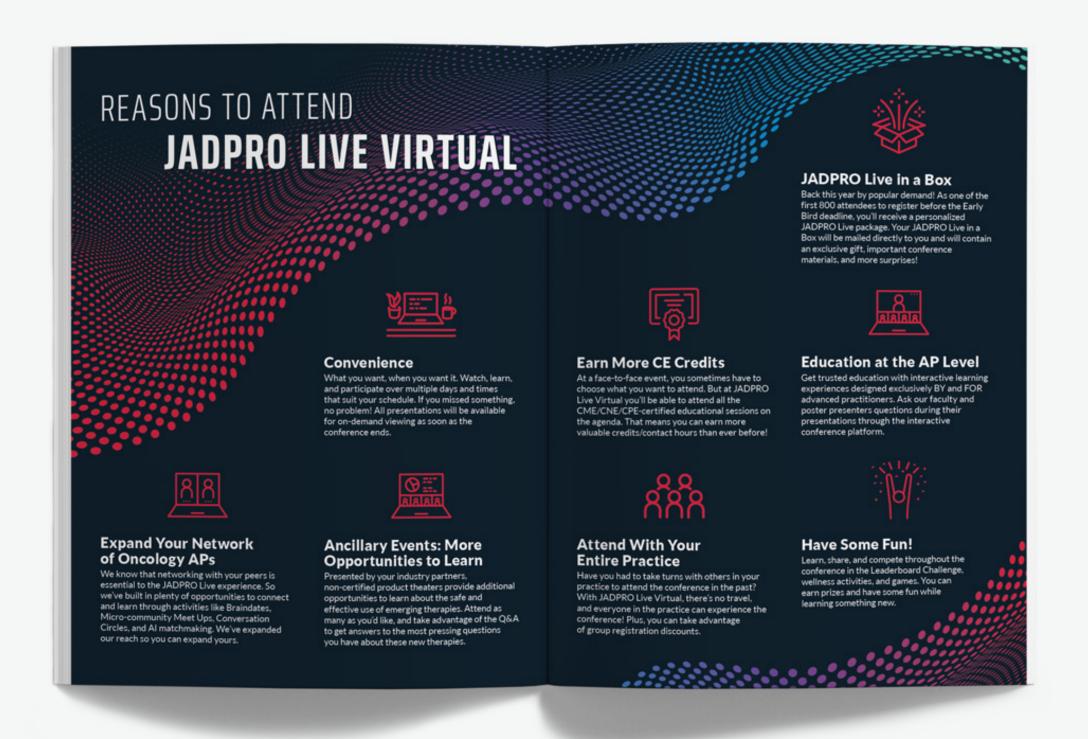






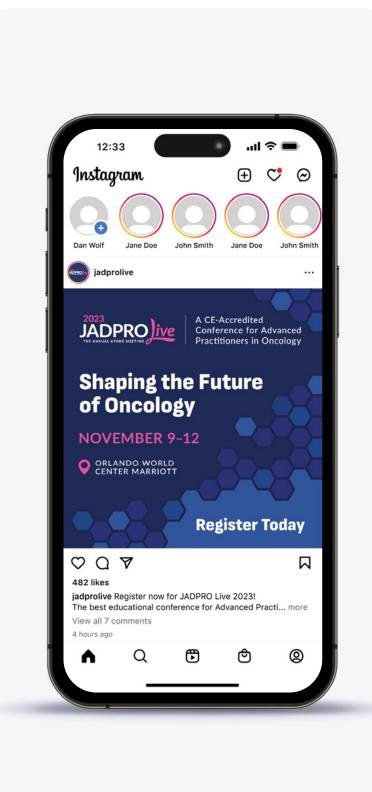






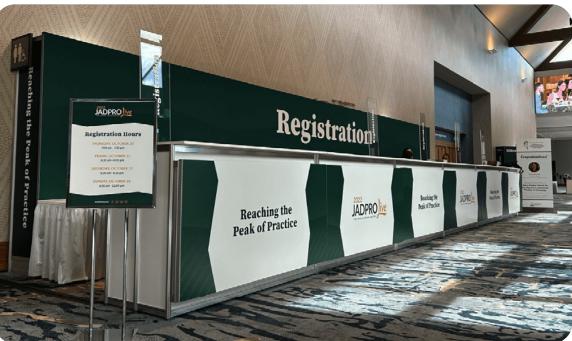
Other Miscellaneous Deliverables

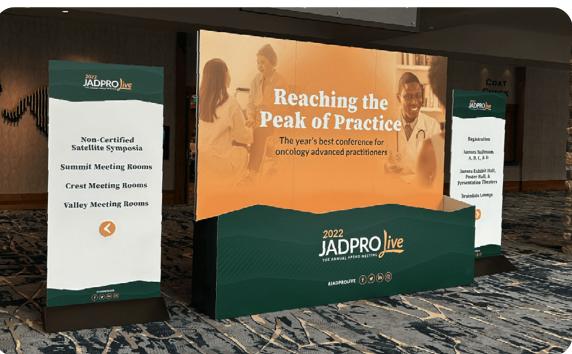
















Project 3

APSHO

Oncology Society Branding

apsho.org

Deliverables

Direct Mailers
Print Advertisements
Marketing Brochures
Conference Guides

Social Media Graphics Conference Signage Booth Graphics And much more



Promotional Tri-fold Brochure



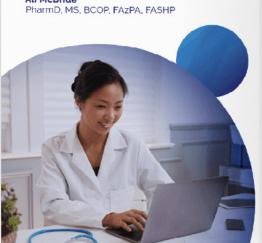
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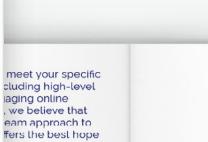
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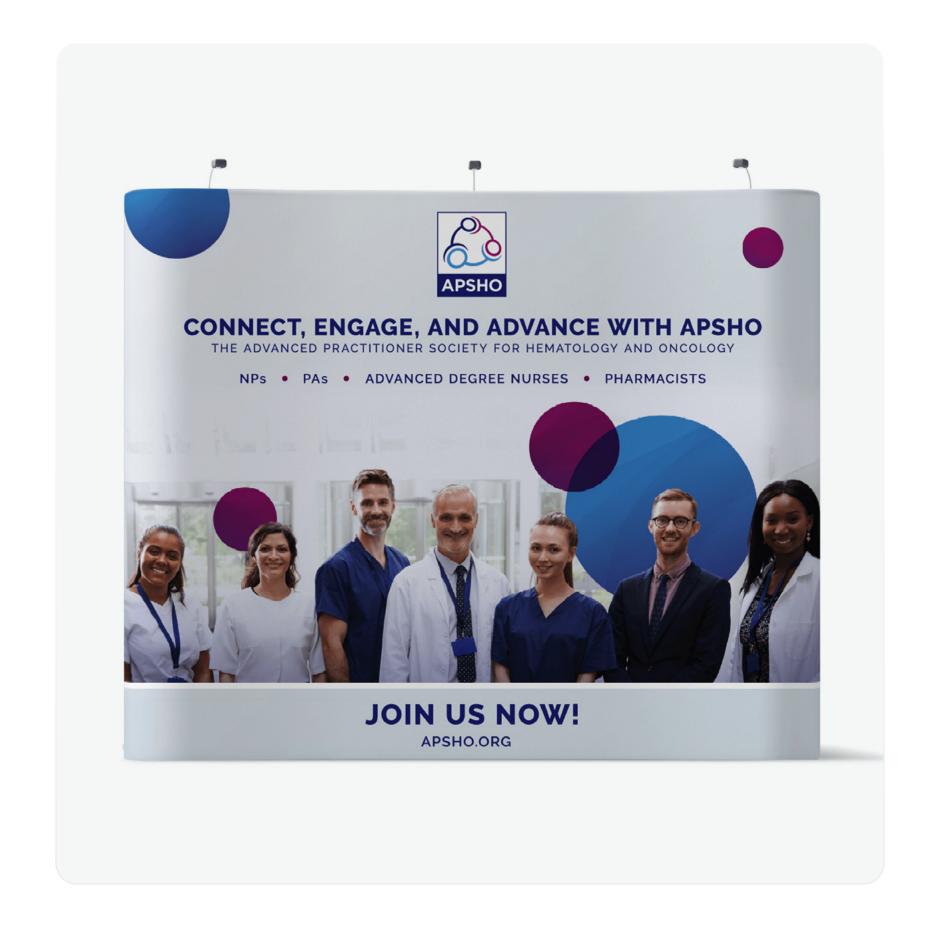
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Conference Signage

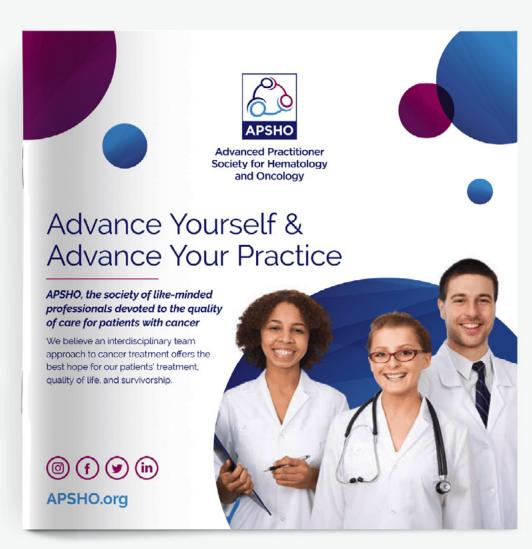






Membership Brochure









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Project 3

JNCCN 360

Oncology News & Info Hub Collateral

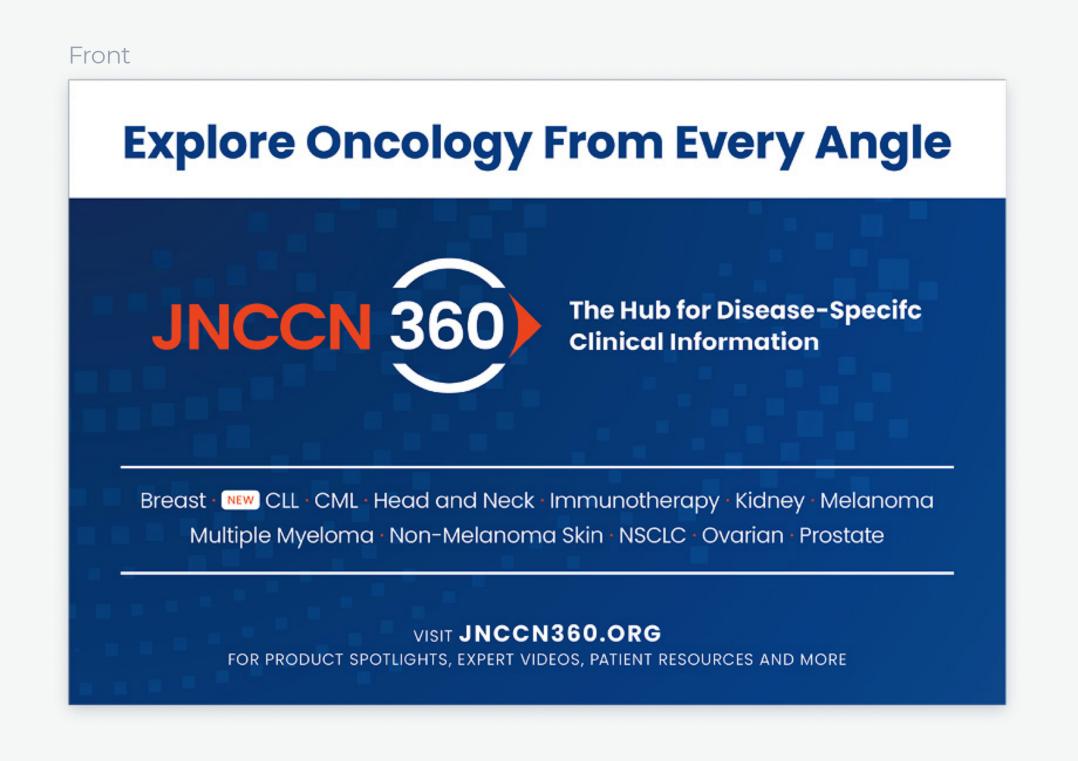
Deliverables

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Direct Mailers



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Print Supplement



Fulvestrant (Faslodex®)

An Oldie but Goody

Fulvestrant,1 an estrogen-receptor antagonist that belongs to a class of agents called selective estrogen-receptor down-regulators or "SERDs," was originally approved in 2002 as monotherapy for the treatment of postmenopausal women with hormone-receptor positive (HR+) metastatic breast cancer (MBC) whose cancer has progressed after antiestrogen therapy.^{2,3}

THE EVOLUTION OF FULVESTRANT-A

"In many ways, our thinking about fulvestrant has changed," explained Maura N. Dickler, MD, an associate attending physician and Interim Chief of the Breast Medicine Service at Memorial Sloan Kettering Cancer Center, New York City, "as evidence mounts about the prevalence of ESRI mutations and how they relate to emerging mechanisms of resistance in patients who are exposed to prior aromatase inhibitors (Als).4 The SERDs are having a 'renaissance' moment because of their mechanism of action—a drug that may degrade a mutant estrogen receptor-is attractive." This is a very active area of research, as investigators attempt to identify drugs that degrade the estrogen receptor,5.5 Dr. Dickler pointed out, "now that we have a better understanding of the selective pressure of AI therapy and the emergence of ESRI mutations that give rise to mutant receptors."

Initially, fulvestrant was approved in the second-line metastatic setting, after disease progression on a nonsteroidal Al. "We started with a 250-mg loading dose, followed by monthly 250-mg dose injections. Over the next 8 to 10 years, we learned that a higher loading dose was important, and then ultimately, we learned that high-dose fulvestrant was more effective than Als in an endocrine-naïve first-line

setting," Dr. Dickler said. The lower dose may have led clinicians "to believe that fulvestrant wasn't very active and that it did not matter which drug you chose-fulvestrant or exemestane, based on the EFECT trial-for treatment of patients with estrogen receptor-positive (ER+)/HER2-negative MBC after CONFIRM trial, however, which demonstrated that high-dose fulvestrant was better than the 'standard dose' that a difference was noted.8.9 Subsequently, the FIRST and FALCON trials showed that fulvestrant was superior to AI treatment in patients who had not been exposed to prior endocrine therapy.^{10,11}

Fulvestrant in Combination

The decision about which endocrine agent to pair with a cyclin-dependent kinase (CDK) 4/6 inhibitor for first-line treatment of a patient with HR+ MBC boils down to a distillation of prior therapy, the disease-free interval, and the time off hormone

Those who present with de novo stage IV disease haven't received any treatment, whereas others may have received years of adjuvant endocrine therapy with tamoxifen and Als, on a sequential strategy or

clinicians who choose palbociclib or ribociclib will opt to start patients on letrozole as the endocrine partner. 12,13 However, for those patients who experience relapse on a nonsteroidal AI in the adjuvant setting, data from PALOMA-3 and MONARCH 2, for example, support use of fulvestrant choice.14,15 [Editor's Note: See update at the end of

Data are also available about fulvestrant in combination with nonsteroidal Als (eg. fulvestrant plus anastrozole).16,17 which can inform clinician choice, especially in endocrine-naïve patients.

The preCOG study presented at the San Antonio Breast Cancer Symposium in 2016¹⁸ extended findings of the BOLERO-2 study (everolimus and SERD. This is a promising approach, but, Dr. Dickler cautioned that because the data have not been published or added to guidelines yet, it may be difficult to obtain third party coverage for it.

Administration of Fulvestrant-Voices of Experience

Together with the patient, the oncologist selects appropriate treatment and monitors efficacy and safety of the therapy. Prior to starting a regimen, the oncologist explains why the treatment is appropriate, how it is administered, and what to expect in terms of adverse effects. Despite these conversations with aware that treatment with fulvestrant comprises 2 injections for each visit, I in each buttock, observed Deborah Rimmele RN, BSN, OCN, Practice Manager Infusion at the Maggie Daley Center for Women's Cancer Care, Robert H. Lurie Comprehensive Cancer Center of Northwestern University in Chicago. "So, when the patient comes to me [the nurse], she generally is aware that I will be administering treatment as an injection. The fact that there will be

2 injections, however, may be a surprise!" PREPARING THE FULVESTRANT INJECTIONS

Each injection requires a bit of preparation, but mostly, because the drug is refrigerated, warming it before administration can be helpful, Ms. Rimmele explained. It's a very cold, oily injection. If you hold the syringe in your hand and rotate it a bit while you talk to the patient, you will be able to tell when it has warmed up sufficiently. It will feel warmer in your hand and you will see that the bubble at the top will move more easily. It's also gentler on the patient if the metal needle isn't ice cold," she said. "Imagine putting olive oil in the refrigerator. It's very thick and explained, "If I am injecting the right hip, the patient doesn't move very easily. Once you warm it up, it flows more readily." However, warming the solution

should not include shaking it vigorously or warming it in a water bath, which could affect the drug's

POSITIONING THE PATIENT

Simaya (Maya) Ausikaitis, RN, BSN, OCN, a colleague of Ms. Rimmele's in Chicago with decades of experience, commented that if the patient has a needle phobia, "you will want her to lie down on a bed or gurney. If she has been on therapy for a while and is not phobic, she may prefer just to lean forward, supporting her arms on a chair or a countertop-something stable. Whatever they choose, patients always hold on to something. Occasionally, a patient will feel faint or weak, so it's important to make sure that she has something to

The injection should be administered into the dorsogluteal region rather than into an area that school, we were taught 2 techniques for giving an intramuscular injection: one is in the hip area and one is in the gluteus maximus muscle, both of which avoid the sciatic nerve," Ms. Rimmele said.

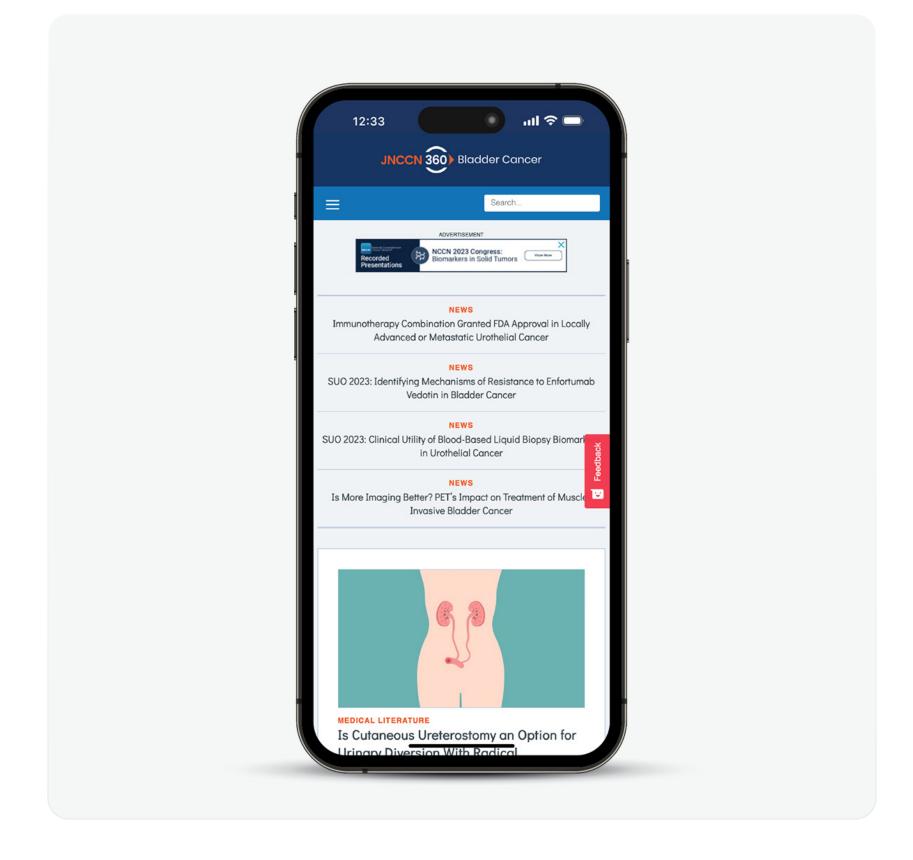
POSITIONING FOR PROVIDERS—AN IMPORTANT TIP

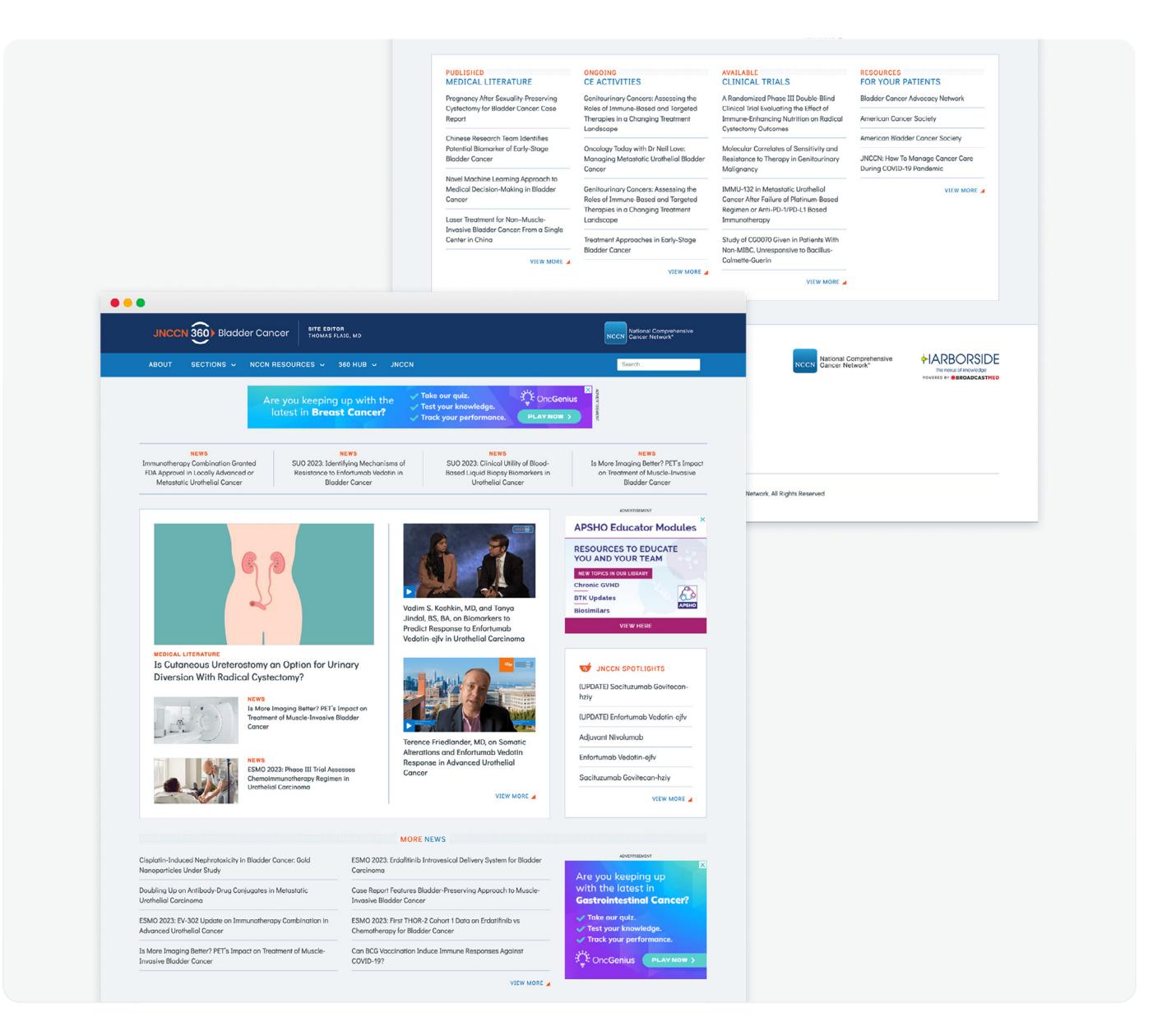
"After you've made the patient comfortable, try to make yourself comfortable," Ms. Rimmele suggested, before you start giving the injection. It is a timeconsuming injection, and it can be hard on your

"I usually sit on a stool. If you are leaning over, it's likely that your back will start to hurt. If you have to administer injections to 3 or 4 of these patients in a row, your thumb could get sore. You want to make sure that you are not positioned awkwardly," Ms. Rimmele suggested, "before you start giving

administration of the injection is to instruct the patient to relax the leg on the side where the injection is being given. "In other words," Ms. Rimmele should not have her weight on her right leg. Tensing the muscle makes it more difficult for me to give the

Website Design & Development





Other Miscellaneous Deliverables





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