

Traccia prova informatica

Il candidato provveda a eseguire le seguenti operazioni:

- creare una nuova cartella nel desktop e rinominarla cognome nome candidato;
- copiare all'interno della nuova cartella "cognome nome candidato" il file Excel denominato "DATABASE INFERMIERI";
- aprire il file Excel "DATABASE INFERMIERI" e ordinare la tabella infermieri per cognome in ordine alfabetico;
- evidenziare in grassetto la colonna "SEDE DI LAVORO";
- salvare le modifiche apportate senza cambiare la denominazione del file.



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	COGNOME E NOME	DATA NASCITA	ESITO IDONEO /NON IDONEO
1.	ALTANA CHIARA	01/11/1992	IDONEO
2.	ARCA MICHELE	13/03/1984	IDONEO
3.	CADELANO SILVIA	19/01/1995	IDONEO
4.	CAMBONI MARILA	13/08/1994	IDONEO
5.	CAPPAL ELISA	23/04/1981	IDONEO
6.	CHESSA CARLA	28/01/1982	IDONEO
7.	COLOMBO SARA	27/01/1988	IDONEO
8.	CRUCIOTTI VERONICA	27/12/1987	IDONEO
9.	DI MAURO MARTINA	18/12/1995	IDONEO
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11.	DONADU MATTHEW GAVINO	19/07/1990	IDONEO
12.	FANCELLU ELISABETTA	18/03/1992	IDONEO
13.	FERRANDU FRANCESCO	07/11/1991	IDONEO
14.	FERRARI ALESSANDRA	07/07/1991	IDONEO

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16.	IAGROSSI ALIDA	24/09/1995	IDONEO
17.	LECIS MARCO	23/02/1992	IDONEO
18.	LIARDI LAURA	27/06/1993	IDONEO
19.	LUCARIELLO GIUSEPPE	01/11/1991	IDONEO
20.	MARINO DAVIDE	27/10/1988	IDONEO
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28.	PORCU ELENA PIERA	04/12/1988	IDONEO
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30.	RUGGIU PAOLA	06/02/1995	1 DOVEO
31.	SARDU ELENA	28/07/1995	1 DOVEO
32.	SCALIA ELENA	28/12/1991	1 DOVEO
33.	SCARAMELLA STEFANIA	22/08/1979	1 DOVEO
34.	SCINTU VALERIA	11/12/1980	1 DOVEO
35.	SICURANZA STEFANIA	27/01/1989	1 DOVEO
36.	SOLINAS DAVIDE	24/12/1993	1 DOVEO
37.	SORBARA EMANUELA ELISA	10/06/1993	1 DOVEO
38.	UDA MARIA ELISABETTA	10/06/1995	1 DOVEO
39.	UTZERI FABIO	27/01/1993	1 DOVEO

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40.	VANCHERI NOEMI	10/08/1996	IDONEO
41.	ZUCCARELLI MARTA	05/10/1991	IDONEO

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IL COMPONENTE

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Dott. Davide Zenoni



IL SEGRETARIO Dott. Piergiacomo Gambella



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REVIEW ARTICLE



Robert C. Sternier¹ and Rosalie M. Sternier²

CAR-T cell therapy: current limitations and potential strategies

Abstract

Chimeric antigen receptor (CAR)-T cell therapy is a revolutionary new pillar in cancer treatment. Although treatment with CAR-T cells has produced remarkable clinical responses with certain subsets of B cell leukemia or lymphoma, many challenges limit the therapeutic efficacy of CAR-T cells in solid tumors and hematological malignancies. Barriers to effective CAR-T cell therapy include severe life-threatening toxicities, modest anti-tumor activity, antigen escape, restricted trafficking, and limited tumor infiltration. In addition, the host and tumor microenvironment interactions with CAR-T cells critically alter CAR-T cell function. Furthermore, a complex workforce is required to develop and implement these treatments. In order to overcome these significant challenges, innovative strategies and approaches to engineer more powerful CAR-T cells with improved anti-tumor activity and decreased toxicity are necessary. In this review, we discuss recent innovations in CAR-T cell engineering to improve clinical efficacy in both hematological malignancy and solid tumors and strategies to overcome limitations of CAR-T cell therapy in both hematological malignancy and solid tumors.

Introduction

Chimeric antigen receptor (CAR)-T cell therapy has been revolutionary as it has produced remarkably effective and durable clinical responses¹. CARs are engineered synthetic receptors that function to redirect lymphocytes, most commonly T cells, to recognize and eliminate cells expressing a specific target antigen. CAR binding to target antigens expressed on the cell surface is independent from the MHC receptor resulting in vigorous T cell activation and powerful anti-tumor responses². The unprecedented success of anti-CD19 CAR-T cell therapy against B cell malignancies resulted in its approval by the US Food and Drug Administration (FDA) in 2017^{3–5}. However, there are major limitations to CAR-T cell therapy that still must be addressed including life-threatening CAR-T cell-associated toxicities, limited efficacy against solid tumors, inhibition and resistance in B cell malignancies, antigen escape, limited persistence, poor trafficking and

tumor infiltration, and the immunosuppressive micro-environment. In addition, the workforce must adapt to meet the needs of this growing and evolving field by developing educational programs to train a workforce⁶. Many approaches including combining CAR-T cell therapy with other anticancer therapies or employing innovative CAR engineering strategies to improve anti-tumor efficacy, expand clinical efficacy, and limit toxicities have been proposed. In this review, we discuss recent innovations in CAR-T cell engineering to improve clinical efficacy in both hematological malignancy and solid tumors and strategies to overcome current limitations (Table 1), including antigen escape, CAR-T cell trafficking, tumor infiltration, the immunosuppressive microenvironment, and CAR-T cell-associated toxicities (Fig. 1).

CAR Structure

CARs are modular synthetic receptors that consist of four main components: (1) an extracellular target antigen-binding domain, (2) a hinge region, (3) a transmembrane domain, and (4) one or more intracellular signaling

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