

Screening

In Standard Screening, one user screens each record. Inclusion sends the record forward for gathering, such as tagging, extraction, and Risk of Bias assessment. Exclusion does not queue the record for gathering.

In Dual Screening, two users independently screen each record, and then all screening determinations are reviewed by an administrator. The administrator adjudicates any disagreement between the original screeners to set the final determination for each record.

In Two Pass Screening, all records are first rapidly screened using only title and abstract. Records may be advanced from title/abstract screening to more intensive full text screening, where final inclusion is determined.

In Dual Two Pass Screening, two users rapidly screen all records using only title/abstract and these determinations are reviewed and advanced by an administrator. Two users then screen all full texts and final inclusion is determined by the administrator.

Choose Mode:

☐ Standard

☒ Two Pass

Choose number of reviewers:

☐ Single

☒ Dual



Note: Toggling back from Dual Screening to Standard Screening (or switching to Two-Pass Screening) will **ONLY** save final adjudications, so all records without an adjudicated Include or Exclude decision will be reverted to Unscreened and **all data associated with individual users' decisions will be lost!**

Dual Two-Pass Screening Steps:

1. Screen each study twice at the abstract level.

Two independent reviewers will need to review the abstract of every study and **screen** the abstracts using the same approach as Standard Screening Mode with the exception that studies are only advanced to full-text screening at this stage instead of included. AutoLit automatically queues the abstracts to all users until two screening decisions are made; then, the abstracts are sent forward for adjudication.

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Abstract Screening

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Tian, 2022

Clinical and Imaging Indicators of Hemorrhagic Transformation in Acute Ischemic Stroke After Endovascular Thrombectomy.

BACKGROUND Prior studies have investigated the clinical and imaging factors for hemorrhagic transformation (HT), especially **symptomatic intracranial hemorrhage** (sICH); however, whether alteplase increases the risk of HT after endovascular **thrombectomy** (EVT) is unknown. This study aimed to assess clinical and imaging features associated with **HT, sICH, and parenchymal hematoma (PH)** in patients with acute ischemic stroke after EVT, with and without intravenous alteplase in DIRECT-MT (Direct Intraarterial Thrombectomy to Revascularize Acute Ischemic Stroke Patients with Large Vessel Occlusion Efficiently in Chinese Tertiary Hospitals: a Multicenter Randomized Clinical Trial). METHODS The DIRECT-MT trial is a randomized trial of **EVT alone versus intravenous thrombolysis combined with EVT**. HT, sICH, and PH was evaluated on follow-up computed tomography. Multivariable ordinal logistic regression analysis was used to test the association of stepwise selected determinants with HT, sICH, and PH. RESULTS In total, 633 patients were analyzed; 261 (41.2%) had HT; 34 (5.4%) had sICH; and 85 (13.4%) had PH. The median age was 69, and 56.7% were men. The median National Institutes of Health Stroke Scale score was 18, and 320 patients were in combination-therapy group. Symptomatic intracranial hemorrhage was associated with higher baseline National Institutes of Health Stroke Scale score (adjusted odds ratio [OR], 1.06 [95% CI, 1.10-1.12]) and higher glucose level at hospital arrival (adjusted OR, 1.14 [95% CI, 1.00-1.29]). No association was found between alteplase treatment and HT, sICH, or PH. The independent predictor of sICH was higher baseline National Institutes of Health Stroke Scale score (adjusted OR, 1.09 [95% CI, 1.01-1.18]) in EVT alone group, and history of anticoagulant drugs (adjusted OR, 3.75 [95% CI, 1.07-13.06]), higher glucose level at hospital arrival (adjusted OR, 1.19 [95% CI, 1.03-1.38]), >3 passes of device (adjusted OR, 4.42 [95% CI, 1.36-14.32]) in combination-therapy group. CONCLUSIONS In DIRECT-MT, independent predictors of sICH were baseline National Institutes of Health Stroke Scale score and glucose level at hospital arrival. Alteplase treatment did not increase the risk of HT, sICH, or PH after EVT. The independent predictor of sICH was different in EVT alone group and combination-therapy group. REGISTRATION URL: <https://www.CLINICALTRIALS.gov>; Unique identifier: NCT03469206.

Population/Problem

Intervention

Outcome

Your Keywords

Keywords

Bibliographic fields

Edit

Navigation

Back

Skip

Abstract Screening

Full Text Review

Train Inclusion Model

Upload Full Text

Exclude:

Search Reasons

Select Reason

Does not compare MT alone to MT plus thrombolysis

Does not relate to AIS

Published Before 2010-01-01

Does not report patient outcomes

Not Published in English

Not an RCT

Does not differentiate IVT eligibility

Advance:

Advance

Tagging

Comments (0)

History

In Dual modes, it can be useful to view the number of prior reviewers for the current record. This is displayed to the right of the advance button (see below). It is also displayed next to the include button in Full Text screening. 0 means no decisions have been made about the current record, 1 means 1 reviewer has made a decision, and so on.

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Configure Extraction

Study Inspector

Synthesis

Manuscript Editor

Abstract Editor

Export

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Related Reports

Armstrong, 2020

Vericiguat in Patients with Heart Failure and Reduced Ejection Fraction.

BACKGROUND The effect of vericiguat, a novel oral soluble guanylate cyclase stimulator, in patients with heart failure and reduced ejection fraction who had recently been hospitalized or had received intravenous diuretic therapy is unclear. METHODS In this phase 3, randomized, double-blind, placebo-controlled trial, we assigned 5050 patients with chronic heart failure (New York Heart Association class II, III, or IV) and an ejection fraction of less than 45% to receive vericiguat (target dose, 10 mg once daily) or placebo, in addition to guideline-based medical therapy. The primary outcome was a composite of death from cardiovascular causes or first hospitalization for heart failure. RESULTS Over a median of 10.8 months, a primary-outcome event occurred in 897 of 2526 patients (35.5%) in the vericiguat group and in 972 of 2524 patients (38.5%) in the placebo group (hazard ratio, 0.90; 95% confidence interval [CI], 0.82 to 0.98; P = 0.02). A total of 691 patients (27.4%) in the vericiguat group and 747 patients (29.6%) in the placebo group were hospitalized for heart failure (hazard ratio, 0.90; 95% CI, 0.81 to 1.00). Death from cardiovascular causes occurred in 414 patients (16.4%) in the vericiguat group and in 441 patients (17.5%) in the placebo group (hazard ratio, 0.93; 95% CI, 0.81 to 1.06). The composite of death from any cause or hospitalization for heart failure occurred in 957 patients (37.9%) in the vericiguat group and in 1032 patients (40.9%) in the placebo group (hazard ratio, 0.90; 95% CI, 0.83 to 0.98; P = 0.02). Symptomatic hypotension occurred in 9.1% of the patients in the vericiguat group and in 7.9% of the patients in the placebo group (P = 0.12), and syncope occurred in 4.0% of the patients in the vericiguat group and in 3.5% of the patients in the placebo group (P = 0.30). CONCLUSIONS Among patients with high-risk heart failure, the incidence of death from cardiovascular causes or hospitalization for heart failure was lower among those who received vericiguat than among those who received placebo. (Funded by Merck Sharp & Dohme [a subsidiary of Merck] and Bayer; VICTORIA ClinicalTrials.gov number, NCT02861534).

Population/Problem

Intervention

Outcome

Your Keywords

Keywords

Bibliographic fields

Edit

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Abstract Screening

Full Text Review

Train Inclusion Model

Exclude:

Search Reasons

Select Reason

Not an RCT

Duplication

new ex

Does not report therapies of interest

Does not report patient outcomes

Published Before 2010-01-01

Not Published in English

Advance:

Advance

This study is associated with (0) screening decisions.

Comments (6)

History

Even in Abstract Screening, you may want to view the full text, to do so go to the Full Text tab. In Dual Screening types, the status of whether the full text has been uploaded or not is hidden. This is to avoid bias as the knowledge that the other user has uploaded the record's full text may influence your screening decision. You still have the option to show the full text upload status as well as the full text regardless by clicking "Show Anyways." This action does not affect your screening decisions and is not shown in the Full Text Screening module since all full texts will be uploaded.

The screenshot shows the Autolit interface. On the left is a sidebar with navigation links: Nest Home, Literature Search, Abstract Screening (13/16), Full Text Screening (4/5), Tagging (3/4), Extraction (1/4), Study Inspector, and Synthesis. The main area displays a 'Full Text Blinded' warning: 'The full text may or may not be uploaded. Knowing this information may bias your screening decision, by revealing the actions of another reviewer.' Below the warning is a 'Show Anyways' button. On the right is a 'Navigation' sidebar with links: Back, Skip, Abstract Screening, Full Text Review, Upload Full Text, Exclude (Search Reasons), Select Reason, Advance, Tagging, Comments (6), and History.

2. Adjudicate decision for abstracts

There is an option to [auto-adjudicate](#). For any study that is not Auto-Adjudicated, an Admin will need to manually adjudicate in order to provide a final screening decision on the abstracts. The Admin should choose between selecting the decision of Screener 1 or Screener 2, or if both are incorrect, provide a different option. Once adjudicated, the studies will either be excluded or advanced and sent forward to Full Text Screening.

The screenshot shows the 'Adjudicate Abstract Screening' screen. The main area displays the abstract text for a study titled 'Immediate and Long-Term Outcomes of Reperfusion Therapy in Patients With Cancer'. The abstract text is highlighted in yellow. On the left is a sidebar with navigation links: Nest Home, Literature Search (1/1), Abstract Screening (250/270), Full Text Screening (185/186), Tagging (4/4), Extraction (4/4), Study Inspector, and Synthesis. On the right is a 'Navigation' sidebar with links: Back, Skip, Abstract Screenings, Screening 1, Screening 2, Exclude (Does not report patient outcomes), Advance, Select Different Option, Full Text Review, Upload Full Text, Exclude (Search Reasons), Select Reason, Advance, Tagging, Comments (0), and History.

4. Screen the full-text of each study.

Two independent reviewers will need to review the full-text of every study and [screen](#) the abstracts using the same approach as Standard Screening Mode. AutoLit automatically queues the full-texts to all users until two screening decisions are made; then, the articles are sent forward for adjudication.

Nest Home

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Configure Extraction

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Export

Abstract

Full Text

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Related Reports

University of Groningen

Safety and efficacy of aspirin, unfractionated heparin, both, or neither during endovascular stroke treatment (MR CLEAN-MED)

MR CLEAN-MED investigators: van der Steen, Wouter; van de Graaf, Rob A; Chalos, Vicky; Lingsma, Hester F; van Doormaal, Pieter Jan; Coutinho, Jonathan M; Emmer, Bart J; de Ridder, Inger; van Zwam, Wim

Published in: The Lancet

DOI: 10.1016/S0140-6736(22)00014-9

IMPORTANT NOTE: You are advised to consult the publisher's version (publisher's PDF) if you wish to cite from it. Please check the document version below.

Document Version

Publisher's PDF, also known as Version of record

Publication date: 2022

Link to publication in University of Groningen/UMCG research database

Navigation

Full Text Screening

Full Text Review

Train Inclusion Mode

Full Text Uploaded!

Exclude:

Search Reasons

Select Reason

Does not compare MT alone to MT plus thrombolysis

Does not relate to AIS

Published Before 2010-01-01

Does not report patient outcomes

Not Published in English

Not an RCT

Does not differentiate IVT eligibility

Include:

Include

Tagging

Comments (0)

History

5. Adjudicate decisions for full-texts

There is an option to **auto-adjudicate**. For any study that is not Auto-Adjudicated, an Admin will need to manually adjudicate in order to provide a final screening decision on the full-texts. The Admin should choose between selecting the decision of Screener 1 or Screener 2, or if both are incorrect, provide a different option. Once adjudicated, the studies will either be excluded or included.

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Configure Tagging

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Configure Extraction

Study Inspector

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Manuscript Editor

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Export

Abstract

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BMJ Open

Cost-effective analysis of mechanical thrombectomy alone in the treatment of acute ischaemic stroke: a Markov modelling study

Mingyang Han,¹ Yongkai Qin,¹ Xin Tong,^{2,3} Linjin Ji,⁴ Songfeng Zhao,¹ Lang Liu,¹ Jigang Chen,^{2,3} Aihua Liu,^{2,3}

ABSTRACT

Objective Recently, a randomised controlled trial (DIRECT-MT) demonstrated that mechanical thrombectomy (MT) was non-inferior to MT with intravenous alteplase as to the functional outcomes. This study aims to investigate whether MT alone is cost-effective compared with MT with alteplase in China.

Methods A Markov decision analytic model was built from the Chinese healthcare perspective using a lifetime horizon. Probabilities, costs and outcomes data were obtained from the DIRECT-MT trial and other most recent/comprehensive literature. Base case calculation was conducted to compare the costs and effectiveness between MT alone and MT with alteplase. One-way and probabilistic sensitivity analyses were performed to evaluate the robustness of the results.

Results MT alone had a lower cost and higher effectiveness compared with MT with alteplase. The probabilistic sensitivity analysis demonstrated that, over a lifetime horizon, MT alone had a 99.5% probability of being cost-effective under the willingness-to-pay threshold of 1× gross domestic product per capita in China based on data obtained from the DIRECT-MT trial. These results remained robust under one-way sensitivity analysis.

Conclusions MT alone was cost-effective compared with MT with alteplase in China. However, cautions are needed

Strengths and limitations of this study

The cost-effectiveness of mechanical thrombectomy (MT) alone versus MT with alteplase has been evaluated for the first time from the perspective of Chinese healthcare

A decision analytic model was developed to compare the costs and effectiveness between MT alone and MT with alteplase.

The complications of different treatment strategies such as bleeding or operation failure were not considered in the study.

We assumed the patients with different levels of disability had the same rate of a recurrent stroke, which might not be true.

The indirect costs such as lost work productivity were not included in this analysis.

Check for updates

Agreements

Auto Adjudicate 1 Study

Navigation

Full Text Screenings

Screening 1:

Screening 2:

Include (Full Text Review)

Include (Full Text Review)

Select Different Option

Full Text Review

Train Inclusion Mode

Full Text Uploaded!

Exclude:

Search Reasons

Select Reason

Does not compare MT alone to MT plus thrombolysis

Does not relate to AIS

Published Before 2010-01-01

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Not an RCT

Does not differentiate IVT eligibility

Include:

Include

Tagging

Comments (0)

History

Kappa Statistics for Interrater Reliability

After you finish Dual Screening, you can view the **Kappa statistics** in **Activity**.

Nested Knowledge - <https://wiki.nested-knowledge.com/>

Guidance on Dual Screening Best Practices

For guidance on best practices in Dual Screening, click [here](#).



From:
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Permanent link:
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