

Applying Tags

Tags reflect the qualitative content of underlying studies and provide method for attaching text or images from these studies. After tags have been [configured](#), and so long as at least one study has been included, you can begin applying tags. Once a tag is applied, it is immediately viewable on [Qualitative Synthesis](#).

Steps for Tagging:

1. Navigate to Tagging

Click the “Tagging” button on the left-hand side, in the Nest Menu.

The screenshot displays the Nest Knowledge interface for a protocol titled "Home: Thrombectomy alone vs. Thrombectomy plus thrombolysis". On the left, the "Nest Home" menu is visible, with the "Tagging" button highlighted in red. The main content area shows the "Protocol" view with sections for Objective, Scope, Population, Primary Outcomes, Secondary Outcomes, and Interventions and Comparators. The "Interventions and Comparators" section is partially visible at the bottom. On the right, a sidebar shows a notification from Kevin Kallmes and a comment input field.

This will enable you to apply tags to records sequentially. If you would prefer to search and find records to tag, or to view records that have already been tagged, use [Study Inspector](#).

2. View the Full Text

Click on the “Full Text” toggle in the upper left to view the full-text PDF.

Tagging: Thrombectomy alone vs. Thrombectomy plus thrombolysis

Nest Home

Dashboard

Settings

Literature Search

1 / 1

Other Sources

Duplicate Review

Search Exploration

Query Builder

Screening

271 / 274

Configure Screening

Tagging

3 / 6

Configure Tagging

Extraction

6 / 6

Configure Extraction

Risk of Bias

6 / 6

Study Inspector

Synthesis

Manuscript Editor

Abstract Editor

Export

Abstract

Full Text

Supplements

Related Reports

10

0

0

4

0

0

PubMed

3 / 6

Navigation

Back

Skip

Complete

Tagging

Select Tag

Enter Text

Apply Tag

Tag Recommendations

Comments (0)

History

Articles

Endovascular thrombectomy versus standard bridging thrombolytic with endovascular thrombectomy within 4-5 h of stroke onset: an open-label, blinded-endpoint, randomised non-inferiority trial

Peter J Mitchell*, Bernard Yan*, Leonid Churlov, Richard J Dowling, Steven J Bush, Andrew Bivard, Xiao Chuan Huo, Guoqing Wang, Shi Yong Zhang, Mai Duy Ton, Dennis J Cordato, Timothy J Kleinig, Henry Ma, Ronil V Chandra, Helen Brown, Bruce CV Campbell, Andrew K Cheung, Brendan Steinfart, Rebecca Scroop, Kendal Redmond, Ferdinand Miteff, Yan Liu, Dang Phuc Duc, Hal Rice, Mark W Parsons, Teddy Y Wu, Huy-Thang Nguyen, Geoffrey A Donnan†, Zhong Rong Miao†, Stephen M Davis†, on behalf of the DIRECT-SAFE Investigators†

Summary

Background The benefit of combined treatment with intravenous thrombolysis before endovascular thrombectomy in patients with acute ischaemic stroke caused by large vessel occlusion remains unclear. We hypothesised that the clinical outcomes of patients with stroke with large vessel occlusion treated with direct endovascular thrombectomy within 4-5 h would be non-inferior compared with the outcomes of those treated with standard bridging therapy (intravenous thrombolysis before endovascular thrombectomy).

Methods DIRECT-SAFE was an international, multicentre, prospective, randomised, open-label, blinded-endpoint trial. Adult patients with stroke and large vessel occlusion in the intracranial internal carotid artery, middle cerebral artery (M1 or M2), or basilar artery, confirmed by non-contrast CT and vascular imaging, and who presented within 4-5 h of stroke onset were recruited from 25 acute-care hospitals in Australia, New Zealand, China, and Vietnam. Eligible patients were randomly assigned (1:1) via a web-based, computer-generated randomisation procedure stratified by site of baseline arterial occlusion and by geographic region to direct endovascular thrombectomy or bridging therapy. Patients assigned to bridging therapy received intravenous thrombolytic (alteplase or tenecteplase) as per standard care at each site; endovascular thrombectomy was also per standard of care, using the Trevo device (Stryker Neurovascular, Fremont, CA, USA) as first-line intervention. Personnel assessing outcomes were masked to group allocation; patients and treating physicians were not. The primary efficacy endpoint was functional independence defined as modified Rankin Scale score 0-2 or return to baseline at 90 days, with a non-inferiority margin of -0.1, analysed by intention to treat (including all randomly assigned and consenting patients) and per protocol. The intention-to-treat population was included in the safety analyses. The trial is registered with ClinicalTrials.gov, NCT03494920, and is closed to new participants.

Findings Between June 2, 2018, and July 8, 2021, 295 patients were randomly assigned to direct endovascular

If no full text has yet been imported, learn how to upload it [here](#).

3. Find the Relevant Tag

As you read through the article and find the relevant tags in the text, tables, or figures, search/select the relevant tag in the drop-down:

Tagging: Thrombectomy alone vs. Thrombectomy plus thrombolysis

Nest Home

Dashboard

Settings

Literature Search

1 / 1

Other Sources

Duplicate Review

Search Exploration

Query Builder

Screening

271 / 274

Configure Screening

Tagging

3 / 6

Configure Tagging

Extraction

6 / 6

Configure Extraction

Risk of Bias

6 / 6

Study Inspector

Synthesis

Manuscript Editor

Abstract Editor

Export

Abstract

Full Text

Supplements

Related Reports

10

0

0

4

0

0

PubMed

3 / 6

Navigation

Back

Skip

Complete

Tagging

Tag

Text

Study Design

Secondary Research

Meta-analysis

Systematic Review

Original Research

Case Series

Retrospective Cohort Study

Prospective Cohort Study

Randomized Controlled Trial

Patient Characteristics

Demographics

Age (Median)

Male Sex

Age (Mean)

Medication

Eligible for IVT

Tenecteplase (instead of alteplase)

Articles

Endovascular thrombectomy versus standard bridging thrombolytic with endovascular thrombectomy within 4-5 h of stroke onset: an open-label, blinded-endpoint, randomised non-inferiority trial

Peter J Mitchell*, Bernard Yan*, Leonid Churlov, Richard J Dowling, Steven J Bush, Andrew Bivard, Xiao Chuan Huo, Guoqing Wang, Shi Yong Zhang, Mai Duy Ton, Dennis J Cordato, Timothy J Kleinig, Henry Ma, Ronil V Chandra, Helen Brown, Bruce CV Campbell, Andrew K Cheung, Brendan Steinfart, Rebecca Scroop, Kendal Redmond, Ferdinand Miteff, Yan Liu, Dang Phuc Duc, Hal Rice, Mark W Parsons, Teddy Y Wu, Huy-Thang Nguyen, Geoffrey A Donnan†, Zhong Rong Miao†, Stephen M Davis†, on behalf of the DIRECT-SAFE Investigators†

Summary

Background The benefit of combined treatment with intravenous thrombolysis before endovascular thrombectomy in patients with acute ischaemic stroke caused by large vessel occlusion remains unclear. We hypothesised that the clinical outcomes of patients with stroke with large vessel occlusion treated with direct endovascular thrombectomy within 4-5 h would be non-inferior compared with the outcomes of those treated with standard bridging therapy (intravenous thrombolysis before endovascular thrombectomy).

Methods DIRECT-SAFE was an international, multicentre, prospective, randomised, open-label, blinded-endpoint trial. Adult patients with stroke and large vessel occlusion in the intracranial internal carotid artery, middle cerebral artery (M1 or M2), or basilar artery, confirmed by non-contrast CT and vascular imaging, and who presented within 4-5 h of stroke onset were recruited from 25 acute-care hospitals in Australia, New Zealand, China, and Vietnam. Eligible patients were randomly assigned (1:1) via a web-based, computer-generated randomisation procedure stratified by site of baseline arterial occlusion and by geographic region to direct endovascular thrombectomy or bridging therapy. Patients assigned to bridging therapy received intravenous thrombolytic (alteplase or tenecteplase) as per standard care at each site; endovascular thrombectomy was also per standard of care, using the Trevo device (Stryker Neurovascular, Fremont, CA, USA) as first-line intervention. Personnel assessing outcomes were masked to group allocation; patients and treating physicians were not. The primary efficacy endpoint was functional independence defined as modified Rankin Scale score 0-2 or return to baseline at 90 days, with a non-inferiority margin of -0.1, analysed by intention to treat (including all randomly assigned and consenting patients) and per protocol. The intention-to-treat population was included in the safety analyses. The trial is registered with ClinicalTrials.gov, NCT03494920, and is closed to new participants.

Findings Between June 2, 2018, and July 8, 2021, 295 patients were randomly assigned to direct endovascular

Tags are ordered in the dropdown based on the hierarchy with the leftmost root node at the top, followed by its children, followed by the next root node.

https://wiki.nested-knowledge.com/

Printed on 2024/05/31 23:37

3a. Tag Details

If you need further details on the tags in order to determine applicability, and if the Tag Description was filled in for the tag in question, you can view it next to the Tag drop-down. An “i” icon will appear next to the Tag if a Description exists, and you can view it upon hovering:



3b. Tag Recommendations

Regardless of your Tagging mode, there will be a right-hand menu tab titled “Tag Recommendations” beneath either “Tagging” (in Standard mode) or “Questions” (in Form-based mode). Tag Recommendations searches the study full text, highlighting specific text that may be applicable to the tags in your hierarchy. Learn more about how to use [Tag Recommendations](#).

4. Add an Annotation

To associate text content with a tag, identify this text either before or after selecting the tag from the drop-down. You have three options for how to identify the text excerpt that will be associated with that tag:

- **Highlighting (Text Annotation):** A traceable, exact quote from the text of the article.
- **Selection (Area Annotation):** A traceable, exact image extraction from a table, figure, or other area of the article.
- **Manual entry (No Annotation):** A non-traceable excerpt (that is, an excerpt that is not connected to a specific part of the article) that you type into the Tag Text box.

You can annotate either before or after selecting the tag of interest in the drop-down (red circle below).

4a. Use the Highlighting Tool:

The screenshot shows the 'Tagging' interface for a medical article. The main text area displays the article title and abstract. A red arrow points to the 'Highlighting' icon in the top toolbar. On the right, the 'Tagging' sidebar shows the 'Onset-to-needle' tag selected, with a red outline around the 'Enter Text' field.

The default Tag Text method is Highlighting. You can also manually select the Highlighting icon (see red arrow above), if you need to toggle back to this option.

Click and drag over the text you would like to Highlight. Highlighting will extract an exact text excerpt that is shown in light blue (see red arrow below), and the text will be automatically populated to the Tag Text box (red outline below).

The screenshot shows the 'Tagging' interface for a medical article. The main text area displays a table of outcomes. A red arrow points to the 'Select' icon in the top toolbar. On the right, the 'Tagging' sidebar shows the 'mRS 0-2' tag selected, with a red outline around the 'Enter Text' field.

	Thrombectomy mRS score 0-3	12/143 (8%)	13/1046 (8%)	Adjusted OR 0.84 (0.59 to 1.82)	p=0.66
NIHSS score within 72 h	4 (3-11), n=143	4 (3-11), n=143	4 (3-11), n=143	-	-
Early neurological improvement*	84/143 (59%)	95/142 (67%)	95/142 (67%)	Adjusted OR 0.73 (0.45 to 1.18)	p=0.20
Safety outcomes					
Death	22/146 (15%)	24/147 (16%)	Adjusted OR 0.92 (0.46 to 1.84)	p=0.82	
Symptomatic intracerebral haemorrhage	2/146 (1%)	3/147 (2%)	Adjusted OR 1.70 (0.22 to 13.04)	p=0.62	Fisher's exact test
Any intracerebral haemorrhage	3/146 (2%)	3/147 (2%)	Adjusted OR 0.97 (0.56 to 1.70)	p=0.92	

Data are n/N (%) or median (IQR). ITT-intention to treat. mRS-modified Rankin Scale. PP-per protocol. OR-odds ratio. NIHSS-National Institutes of Health Stroke Scale. mRS=modified Rankin Scale. *NIHSS reduction of 8 points or more, or reaching 0-1 at 3 days, adjusted for baseline NIHSS and age.

Table 3: Study outcomes

patients lost to follow-up. In the per-protocol analysis after patient crossover, 145 remained in the direct thrombectomy group and 143 in the bridging therapy group (figure 1). In the direct thrombectomy group, ten patients did not have endovascular thrombectomy as there was no retrievable thrombus, whereas in the bridging therapy group, no retrievable thrombus was found in 15 patients who hence had no thrombectomy (figure 1).

Baseline characteristics were similar in the two groups (table 1). Overall, the median age of the patients was 68 years (IQR 61-78), and 166 (57%) of 293 were men. The median NIHSS score was 15 in both groups, and the median time from hospital admission to thrombolysis in the bridging therapy group was 64 min (IQR 47-87). The median time from randomisation to arterial puncture was 29 min (19-47) in the direct thrombectomy group and 42 min (29-59) in the bridging therapy group. Median times from arterial puncture to reperfusion were below 60 min in both groups (55-5 min [26-0-88-5] in the direct thrombectomy group and 44-5 min [27-0-70-0] in the bridging group; table 1). Table 2 shows procedural characteristics and complications.

Favourable outcome (mRS 0-2 or return to baseline) occurred in 80 (55%) of 146 patients in the direct thrombectomy group and 89 (61%) of 147 patients in the bridging therapy group (intention-to-treat risk difference -0.051, two-sided 95% CI -0.160 to 0.059), with the lower end of the confidence interval below the predefined non-inferiority margin of -0.1. The per-protocol analysis showed a favourable outcome in 79 (54%) of 145 patients in the direct thrombectomy group and 88 (62%) of 143 patients in the bridging therapy group (risk difference -0.062, two-sided 95% CI -0.173 to 0.049; figure 2). Hence, non-inferiority was not shown.

4b. Use the Select Tool:

To switch from the default Highlighting tool to the Select tool, click the middle icon above the full text

(see red arrow in the top menu below).

Tagging: Thrombectomy alone vs. Thrombectomy plus thrombolysis

Nest Home

Dashboard

Settings

Literature Search

1 / 1

Other Sources

Duplicate Review

Search Exploration

Query Builder

Screening

271 / 224

Configure Screening

Tagging

3 / 6

Configure Tagging

Extraction

6 / 6

Configure Extraction

Risk of Bias

6 / 6

Study Inspector

Synthesis

Manuscript Editor

Abstract Editor

Export

Abstract

Full Text

Supplements

Related Reports

Text Annotation

10

0

0

4

0

0

PubMed

3 / 6

?

	Direct thrombectomy	Bridging therapy	Effect size (95% CI)	p-value
Primary efficacy outcome (ITT)				
Functional independence: mRS 0-2 or return to baseline	80/146 (55%)	89/147 (61%)	Risk difference -0.051 (-0.160 to 0.058), adjusted OR 0.75 (0.45 to 1.24)	p=0.19 for non-inferiority; p=0.26 for superiority of bridging therapy
Primary efficacy outcome (PP)				
Functional independence: mRS 0-2 or return to baseline	79/145 (54%)	88/143 (62%)	Risk difference -0.062 (-0.173 to 0.049), adjusted OR 0.69 (0.41 to 1.13)	p=0.35 for non-inferiority; p=0.16 for superiority of bridging therapy
Secondary outcomes (ITT)				
mRS 0-1 or return to baseline	62/146 (42%)	71/147 (48%)	Adjusted OR 0.76 (0.46 to 1.24)	p=0.27
Score on mRS at 90 days				
0	22/146 (15%)	30/147 (20%)	-	-
1	32/146 (22%)	40/147 (27%)	-	-
2	30/146 (21%)	38/147 (26%)	-	-
3	25/146 (17%)	30/147 (21%)	-	-
4	17/146 (12%)	13/147 (9%)	-	-
5	4/146 (3%)	5/147 (3%)	-	-
6	2/146 (1%)	2/147 (1%)	-	-
Score on ordinal analysis	2/146 (1%)	2/147 (1%)	Common adjusted OR 0.85 (0.56 to 1.27)	p=0.42
Thrombectomy mTICI score ≥3	127/143 (89%)	130/146 (89%)	Adjusted OR 0.84 (0.30 to 1.82)	p=0.66
NIHSS score within 72 h	4 (1-11), n=141	4 (1-11), n=142	-	-
Early neurological improvement*	84/141 (60%)	95/142 (67%)	Adjusted OR 0.73 (0.45 to 1.19)	p=0.20
Safety outcomes				
Death	22/146 (15%)	24/147 (16%)	Adjusted OR 0.92 (0.46 to 1.84)	p=0.82
Symptomatic intracerebral haemorrhage	2/146 (1%)	1/147 (1%)	Adjusted OR 1.70 (0.22 to 13.04)	p=0.61, Fisher's exact test
Any intracerebral haemorrhage	32/146 (22%)	32/147 (22%)	Adjusted OR 0.97 (0.56 to 1.70)	p=0.93

Data are n/N (%) or median (IQR). ITT=Intention to treat; mRS=modified Rankin Scale; PP=per protocol; OR=odds ratio; NIHSS=National Institutes of Health Stroke Scale; mTICI=modified Treatment in Cerebral Ischemia; *NIHSS reduction of 8 points or more, or reaching 0-1 at 3 days, adjusted for baseline NIHSS and age.

Table 3: Study outcomes

patients lost to follow-up. In the per-protocol analysis times from arterial puncture to reperfusion were below after patient crossover, 145 remained in the direct thrombectomy group and 143 in the bridging therapy 60 min in both groups (55-5 min [26-64] vs 55-5 min [26-64] in the direct thrombectomy group and 44-5 min [27-60-70-0] in the

Navigation

Back

Skip

Complete

Tagging

Tag

Text

mRS 0-2

[Selection]

Apply Tag

Tag Recommendations

Comments (0)

History

Create a box across the area you'd like to select for the tag (red arrow in the text section). Click in the left-hand corner of your area of interest and drag across the text or table. This selection will be automatically saved in the tag text box.

Selection / Area Annotation is best used on tables, figures, and images that are not amenable to exact text quotation.

4c. Manually type out in Tag text box:

If you prefer to manually type the information from the text, you can do this by clicking your cursor in the tag text box and type what you'd like.

Tagging: Thrombectomy alone vs. Thrombectomy plus thrombolysis

Nest Home

Dashboard

Settings

Literature Search

1 / 1

Other Sources

Duplicate Review

Search Exploration

Query Builder

Screening

271 / 224

Configure Screening

Tagging

3 / 6

Configure Tagging

Extraction

6 / 6

Configure Extraction

Risk of Bias

6 / 6

Study Inspector

Synthesis

Manuscript Editor

Abstract Editor

Export

Abstract

Full Text

Supplements

Related Reports

Text Annotation

10

0

0

4

0

0

PubMed

3 / 6

?

Figure 2: Primary outcome overall and in prespecified Asian region subgroup
(A) Primary outcome by overall distribution by direct thrombectomy and bridging therapy (risk difference -0.051, 95% CI -0.16 to 0.058, p=0.19). (B) Primary outcome distribution by direct thrombectomy and bridging groups in the Asian region prespecified subgroup (adjusted odds ratio 0.45, 95% CI 0.11 to 1.08, p=0.07). Horizontal stacked bar graphs show the primary outcome (mRS) distribution by direct thrombectomy and bridging therapy groups. Bars are labelled with proportions. mRS=modified Rankin Scale.

generating stratum-specific risk differences with corresponding 95% CIs for each of the four strata (age <60 years vs 60 years or older by baseline NIHSS 0-15 or 16 and above) with subsequent pooling across strata using the Mantel-Haenszel method.

The proportions of mRS 0-2 or no change from baseline and death due to any cause were compared between the direct thrombectomy group and the standard bridging therapy group, adjusted for geographical region, age, and baseline NIHSS score using a logistic regression model. The proportions of participants with good angiographic reperfusion

Role of the funding source
DIRECT-SAFE was an investigator-led clinical trial. The sponsor of the trial was the Flinders Institute. The trial was supported by a grant from the Australian National Health and Medical Research Council programme, and Stryker USA. The trial was managed by Neuroscience Trials Australia. Database management and central data monitoring and verification was performed by Neuroscience Trials Australia and independent statistical analysis done by the Methods and Implementation Support for Clinical and Health Research Hub at the University of Melbourne, VIC, Australia. The regulatory sponsor and funding agents did not participate in the study design.

Results
Between June 2, 2018, and July 8, 2021, 295 patients were randomly assigned to direct thrombectomy (n=148) or bridging therapy (n=147). After two patients withdrew consent, 146 patients remained in the direct thrombectomy group and 147 patients in the bridging therapy group for intention-to-treat analysis, with no

Navigation

Back

Skip

Complete

Tagging

Tag

Text

Select Tag

Between June 2, 2018, and July 8, 2021, 295 patients were randomly assigned to direct thrombectomy (n=148) or bridging therapy (n=147).

Apply Tag

Tag Recommendations

Comments (0)

History

Manual text entry should be used whenever you want to associate customized text rather than quotation from the underlying article. **Warning:** manual entry will not maintain an exact location in the full text, so it may be difficult to find the exact contents of the article that support manually entered text excerpts.

Clear Annotations

If you need to redo your tag text annotation, you can either simply redo the action (Highlighting, Selecting, or Manually typing), or select "Clear Annotation" from the top of the Full Text:

The screenshot displays the Wiki.Nested-Knowledge interface for a clinical trial titled "Thrombectomy alone vs. Thrombectomy plus thrombolysis". The interface includes a sidebar with navigation options like "Nest Home", "Literature Search", "Screening", "Tagging", "Extraction", "Risk of Bias", "Study Inspector", and "Synthesis". The main content area shows the "Full Text" of the article, which includes a bar chart (Figure 2) and a table of results. A tag annotation is visible in the text, and a red box highlights the "Clear Annotation" button in the top right corner of the text area. The right sidebar contains a "Navigation" panel with options like "Skip", "Complete", "Tagging", "Tag Recommendations", "Comments (0)", and "History".

This will remove all tag text; next, choose the tag text type you would like to use, and redo the relevant Highlight, Selection, or Manual text entry.

Q: Why not leave the annotation / tag text blank?



A: It is possible to apply tags without filling in the tag text. However, doing so will mean that the only evidence that the tag is applicable to that specific study will be the fact that it was applied, and those who view your Qualitative Synthesis will have no context. If you fill in text content, you provide specific evidence of that tag's applicability as well as presenting the specific information from that study to viewers of Qualitative Synthesis.

5. Click "Apply Tag"

Once you have the content of interest into the tag text box, make sure that you have selected the

relevant tag from the drop-down menu (red box). Once you have confirmed that both the Tag and the Tag Text Content are correct, click “Apply Tag.”

Tagging: Thrombectomy alone vs. Thrombectomy plus thrombolysis

Nest Home

Literature Search

Screening

Tagging

Extraction

Risk of Bias

Study Inspector

Synthesis

Abstract

Full Text

Supplements

Related Reports

Articles

	Direct thrombectomy	Bridging therapy	Effect size (95% CI)	p value
Primary efficacy outcome (ITT)				
Functional independence: mRS 0-2 or return to baseline	80/146 (55%)	89/147 (61%)	Risk difference -0.052 (-0.160 to 0.055); adjusted OR 0.75 (0.45 to 1.24)	p=0.19 for non-inferiority; p=0.25 for superiority of bridging therapy
Primary efficacy outcome (PP)				
Functional independence: mRS 0-2 or return to baseline	79/145 (54%)	88/143 (62%)	Risk difference -0.062 (-0.173 to 0.049); adjusted OR 0.69 (0.41 to 1.15)	p=0.25 for non-inferiority; p=0.16 for superiority of bridging therapy
Secondary outcomes (ITT)				
mRS 0-1 or return to baseline	62/146 (43%)	71/147 (48%)	Adjusted OR 0.76 (0.48 to 1.21)	p=0.27
Score on mRS at 90 days				
0	22/146 (15%)	30/147 (20%)	--	--
1	20/146 (14%)	40/147 (27%)	--	--
2	20/146 (14%)	18/147 (12%)	--	--
3	25/146 (17%)	19/147 (13%)	--	--
4	17/146 (12%)	11/147 (7%)	--	--
5	4/146 (3%)	5/147 (3%)	--	--
6	2/146 (1%)	24/147 (16%)	--	--
Score on ordinal analysis	7 (1-4)	7 (1-4)	Common adjusted OR 0.85 (0.56 to 1.27)	p=0.42
Thrombectomy mRS score 2b-3	12/143 (8%)	13/146 (9%)	Adjusted OR 0.84 (0.39 to 1.82)	p=0.66
NIHSS score within 72 h	4 (1-11), n=141	4 (1-11), n=142	--	--
Early neurological improvement*	84/141 (60%)	95/142 (67%)	Adjusted OR 0.72 (0.45 to 1.18)	p=0.20
Safety outcomes				
Death	22/146 (15%)	24/147 (16%)	Adjusted OR 0.92 (0.46 to 1.84)	p=0.82
Symptomatic intracerebral haemorrhage	2/146 (1%)	1/147 (1%)	Adjusted OR 1.70 (0.22 to 13.61)	p=0.61; Fisher's exact test p=0.62
Any intracerebral haemorrhage	11/146 (8%)	11/147 (8%)	Adjusted OR 0.97 (0.56 to 1.70)	p=0.92

Data are n/N (%) or median (IQR). ITT: intention to treat; mRS: modified Rankin Scale; PP: per protocol; OR: odds ratio; NIHSS: National Institutes of Health Stroke Scale; mRS: modified Rankin Scale; mRS: modified Rankin Scale; mRS: modified Rankin Scale.

Table 3: Study outcomes

Navigation

Tagging

Tag Recommendations

Comments (0)

History

Note: Anytime there is a module box with the adjustable icon, you can drag to adjust the width of the box depending on your preference.

Abstract

Full Text

Supplements

Related Reports

PMC

Navigation

Tagging

Tag Recommendations

Comments (0)

History

Original Research

Health complaints and use of medicines among adolescents in Malta

Rita DARMANIN ELLUL, Maria CORDINA, Anton BUHAGIAR, Anthony FENECH, Janet MIFSUD.

Received (first version): 17-Mar-2008 Accepted: 18-Aug-2008

ABSTRACT

Objective: To investigate self-reported health complaints and the use of medicines among adolescents in Malta.

Methods: A self-administered questionnaire was used to survey self-reported health complaints, the

adolescents that will integrate information about the proper use of medicines.

Keywords: Adolescent. Drug Utilization. Malta.

Tags with Table Contents

Similarly to tags with text contents, you select the dropdown to find the tag of choice. When selected, the table you created will be shown and you can input text into any of the rows. When you are satisfied, click “Apply Tag.”

Tagging: Thrombectomy alone vs. Thrombectomy plus thrombolysis

3 / 6

Nest Home

Dashboard

Settings

Literature Search

1 / 1

Other Sources

Duplicate Review

Search Exploration

Screening

271 / 293

Configure Screening

Tagging

3 / 6

Configure Tagging

Extraction

6 / 6

Configure Extraction

Risk of Bias

6 / 6

Study Inspector

Synthesis

Manuscript Editor

Abstract Editor

Export

Abstract

Full Text

Supplements

Related Reports

135

4

148

4

PubMed

Navigation

Back

Skip

Complete

Tagging

Tag

Contents

Sex

Male

Female

Prefer not to say

205

333

Apply Tag

Tag Recommendations

Comments (0)

History

Table 1. Demographic and Clinical Characteristics of the Patients at Baseline.*

Characteristic	EVT Alone (N=273)	Alteplase Followed by EVT (N=266)
Median age (IQR) — yr	72 (62–80)	69 (61–77)
Male sex — no. (%)	161 (59.0)	144 (54.1)
Median NIHSS score (IQR) †	16 (10–20)	16 (10–20)
Medical history		
Ischemic stroke — no. (%)	47 (17.2)	44 (16.5)
Atrial fibrillation — no. (%)	86 (31.5)	63 (23.7)
Diabetes mellitus — no. (%)	40 (14.7)	50 (18.8)
Hypertension — no./total no. (%)	121/273 (44.3)	139/265 (52.5)
Prestroke score on the modified Rankin scale — no./total no. (%) ‡		
0	189/272 (69.5)	185/266 (69.5)
1	51/272 (18.8)	49/266 (18.4)
2	24/272 (8.8)	25/266 (9.4)
≥3	8/272 (2.9)	7/266 (2.6)
Median systolic blood pressure (IQR) — mm Hg §	150 (135–167)	150 (130–169)
Median glucose level (IQR) — mmol/liter ¶	6.6 (5.8–7.6)	6.8 (5.9–8.5)
Median ASPECTS (IQR)	9 (8–10)	9 (8–10)
Location of intracranial occlusion — no./total no. (%) **		
Intracranial ICA	4/272 (1.5)	0/266
Terminal ICA	64/272 (23.5)	50/266 (18.8)
M1	156/272 (57.4)	174/266 (65.4)

Highlighting pdfs does not automatically input the text into the box unlike tags with text contents only. However, it will remember any text highlighted or selected in the pdf and auto-scroll to it when the tag is selected again.

Note: If you are entering numerical data into tables, no automated statistics are generated. This is only done in the Meta-Analytical Extraction module.

Add New Tags on the Fly

When you find a term that you want to add to the Tag Hierarchy, you can either add it on the Configure Tagging page, or add it 'on the fly' without leaving the page.

To add a tag on the fly, type the title of your new tag into the “Select Tag” box, and click “Add Option” that appears at the top of the drop-down list of tags.

NEW TAG NAME

0

Add Option: NEW TAG NAME

Patient Characteristics

Rescue therapy applied?

Aspiration

IVT

Inclusion Criteria for Occlusion Location

Posterior Cerebral Artery (PCA)

Anterior Cerebral Artery (ACA)

Middle Cerebral Artery

Basilar artery

Internal carotid artery (ICA)

Parent Artery Location

Last Known Well

Presentation

NIHSS (mean) Baseline

ASPECTS

NIHSS (median) Baseline

In the modal that appears, confirm the tag name, add a description (optional), and as relevant, identify the new tag's Parent Tag. Once created, you will now be able to find the new Tag on the drop-

down list.

Note: Only tags with text contents can be created on the fly. To toggle on table contents, edit the tag in Configure Tagging.

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