

# 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](#).

Since nests are set to Form-based Tagging mode by default, if you have configured Questions, follow [this link to learn how to use Form-based Tagging specifically](#). If not, the standard “Tagging” tab with the dropdown is still available underneath questions on the right handside. If you prefer to only see this tab and not the Questions tab, switch to Standard Tagging (Settings -> Tagging -> toggle Standard).

Regardless of Tagging mode, the below functions are both applicable. We would recommend going through this page and the above Form-based-specific page for guidance on applying tags/collecting data.

## Steps for Tagging:

### 1. Navigate to Tagging

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

The screenshot displays the Nested Knowledge application interface. On the left, a 'Nest Menu' is visible with various options. The 'Tagging' option is highlighted with a red box. The main content area shows a 'Protocol' form with the following sections:

- Objective:** Determine the added benefit of Intravenous Thrombolysis in patients undergoing Mechanical Thrombectomy for Acute Ischemic Stroke
- Scope:** Clinical trials, retrospective studies, or previous meta-analyses designed at evaluating clinical outcomes (functional and imaging) in stroke patients undergoing mechanical thrombectomy for acute ischemic stroke.
- Population:** Patients presenting with acute large artery ischemic stroke within 12 hours of symptom onset
- Primary Outcomes:**
  - Rate of TICI3 recanalization
  - First Pass Effect (Single Pass Reperfusion)
- Secondary Outcomes:**
  - Functional independence (mRS 0-2) at 90 days
  - Rate of early neurological improvement (NIHSS improvement of >8 or NIHSS 0/1 at 24 hours)
  - Ordinal mRS at 90 days
  - All-cause mortality
  - Occurrence of symptomatic ICH
  - Occurrence of distal emboli post-procedure
  - Rate of TICI 2b/3 recanalization
  - Onset-to-needle time
  - Arrival-to-needle time
  - Needle-to-puncture time
  - Needle-to-recanalization time
- Interventions and Comparators:** A table with columns for 'Interventions' and 'Comparator Arms'.

On the right, a chat window is open, showing a message from Kevin Kallmes dated 10/25/22, 6:22 PM. The message reads: '@Hassan Kobeissi You're also an admin now, crazy that you weren't yet!'.

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

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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 Churilov, Richard J Dowling, Steven J Bush, Andrew Bivand, 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 Mitroff, 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

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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

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Peter J Mitchell\*, Bernard Yan\*, Leonid Churilov, Richard J Dowling, Steven J Bush, Andrew Bivand, 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 Mitroff, 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

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Patient Characteristics

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Male Sex

Age (Mean)

Medication

Eligible for IVT

Tenecteplase (instead of alteplase)

Tags are ordered in the drop-down based on the hierarchy with the leftmost root node at the top,

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followed by its children, followed by the next root node.

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. Standard Tag Recommendations (available to all users) perform a key word search of the tag name, while Smart Tag Recommendations (only available to enterprise users) utilize OpenAI GPT 3.5/4 to perform a smart search of the tag data. Standard tags are automatic, while Smart Tags can be switched on in Settings and used to generate recommendations for Abstracts as well as Full Texts.

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 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).



Tagging: Thrombectomy alone vs. Thrombectomy plus thrombolysis

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Thrombectomy mTICI score 2b-3

12/143 (8%)

130/146 (89%)

Adjusted OR 0.84 (0.39 to 1.82)

p=0.66

NIHSS score within 72 h

4 (1-11), n=143

84/141 (60%)

4 (1-11), n=142

95/142 (67%)

Adjusted OR 0.73 (0.45 to 1.18)

p=0.20

Early neurological improvement\*

4 (1-11), n=143

84/141 (60%)

4 (1-11), n=142

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 (0.23 to 13.64)

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=0.93

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 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 64-78), 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 (60%) 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.

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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).

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Text Annotation

Primary efficacy outcome (ITT)

Functional independence mRS 0-2 or return to baseline

80/146 (55%)

89/147 (61%)

Risk difference -0.062 (-0.160 to 0.035), 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=0.25 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

3/146 (2%)

4/147 (3%)

-

-

2

30/146 (20%)

38/147 (26%)

-

-

3

25/146 (17%)

19/147 (13%)

-

-

4

12/146 (8%)

13/147 (9%)

-

-

5

4/146 (3%)

5/147 (3%)

-

-

6

2/146 (1%)

2/147 (1%)

-

-

Score on ordinal analysis

Thrombectomy mTICI score 2b-3

12/143 (8%)

130/146 (89%)

Adjusted OR 0.84 (0.39 to 1.82)

p=0.66

NIHSS score within 72 h

4 (1-11), n=143

84/141 (60%)

4 (1-11), n=142

95/142 (67%)

Adjusted OR 0.73 (0.45 to 1.18)

p=0.20

Early neurological improvement\*

4 (1-11), n=143

84/141 (60%)

4 (1-11), n=142

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 (0.23 to 13.64)

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=0.93

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 after patient crossover, 145 remained in the direct thrombectomy group and 143 in the bridging therapy

60 min in both groups (55.5 min [26.0-88.5] in the direct thrombectomy group and 44.5 min [27.0-70.0] in the

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

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

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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 -0.18 to 0.078; p=0.19). (B) Primary outcome distribution by direct thrombectomy and bridging groups in the Asian region prespecified subgroup (adjusted odds ratio 0.42; 95% CI 0.12 to 0.86; p=0.007). Horizontal stacked bar graphs show the primary outcome (mRS) distribution by direct thrombectomy and bridging therapy groups. Bars are labeled 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

DIRECTSAFE was an investigator-led clinical trial. The sponsor of the trial was the Florey 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

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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 -0.051 (-0.160 to 0.058); adjusted OR 0.75 (0.48 to 1.14)	p=0.19 for non-inferiority to 0.0523; adjusted OR 0.75 p=0.26 for superiority of bridging therapy

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:

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

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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.

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.”

The screenshot displays the Autolit Tagging interface. On the left, a sidebar contains navigation links: Nest Home, Literature Search (1/1), Screening (271/224), Tagging (3/6), Extraction (6/6), Risk of Bias (6/6), Study Inspector, and Synthesis. The main area shows a table of study outcomes for 'Thrombectomy alone vs. Thrombectomy plus thrombolysis'. The table has columns for Direct thrombectomy, Bridging therapy, Effect size (95% CI), and p-value. The right sidebar contains a 'Tagging' section with a dropdown menu showing 'mRS 0-2' and an 'Apply Tag' button. Below the tagging section are 'Tag Recommendations', 'Comments (0)', and 'History'.

	Direct thrombectomy	Bridging therapy	Effect size (95% CI)	p-value
<b>Primary efficacy outcome (ITT)</b>				
Functional independence: mRS 0-2 or return to baseline	80/145 (55%)	89/147 (61%)	Risk difference: -0.053 (-0.160 to 0.053) adjusted OR 0.75 (0.45 to 1.24)	p=0.19 for non-inferiority; p=0.26 for superiority of bridging therapy
<b>Primary efficacy outcome (PP)</b>				
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=0.15 for non-inferiority; p=0.16 for superiority of bridging therapy
<b>Secondary outcomes (ITT)</b>				
mRS 0-1 or return to baseline	62/145 (43%)	71/147 (48%)	Adjusted OR 0.76 (0.46 to 1.24)	p=0.27
Score on mRS at 90 days				
0	22/145 (15%)	30/147 (20%)	-	-
1	37/145 (26%)	40/147 (27%)	-	-
2	20/145 (14%)	19/147 (13%)	-	-
3	25/145 (17%)	19/147 (13%)	-	-
4	17/145 (12%)	13/147 (9%)	-	-
5	4/145 (3%)	5/147 (3%)	-	-
6	2/145 (1%)	2/147 (1%)	-	-
Score on ordinal analysis	7 (3-9)	7 (3-9)	Common adjusted OR 0.85 (0.56 to 1.27)	p=0.42
Thrombectomy mRS score 2b-3	122/143 (85%)	130/146 (89%)	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 0.73 (0.45 to 1.18)	p=0.20
<b>Safety outcomes</b>				
Death	22/145 (15%)	24/147 (16%)	Adjusted OR 0.92 (0.48 to 1.84)	p=0.82
Symptomatic intracerebral haemorrhage	2/145 (1%)	1/147 (1%)	Adjusted OR 1.70 (0.22 to 13.04)	p=0.62, Fisher's exact test
Any intracerebral haemorrhage	22/145 (15%)	22/147 (15%)	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; 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**

**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.

The screenshot displays the Autolit Tagging interface for a research article. The main area shows the article title 'Health complaints and use of medicines among adolescents in Malta' by Rita DARMANIN ELLUL, Maria CORDINA, Anton BUHAGIAR, Anthony FENECH, Janet MIFSUD. The abstract is visible. The right sidebar contains a 'Tagging' section with a dropdown menu showing 'Select Tag' and an 'Apply Tag' button. Below the tagging section are 'Tag Recommendations', 'Comments (0)', and '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: 16-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

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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)

Navigation

BackSkipComplete

Tagging

TagContents

Sex

Male	Female	Prefer not to say
205	333	

Apply Tag

Tag Recommendations

Comments (0)

History

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.

To alter the columns in the table for this tag, either click on the column header in the Tagging module itself, or head back to Configure Tagging. [Learn more about tag tables here.](#)

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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