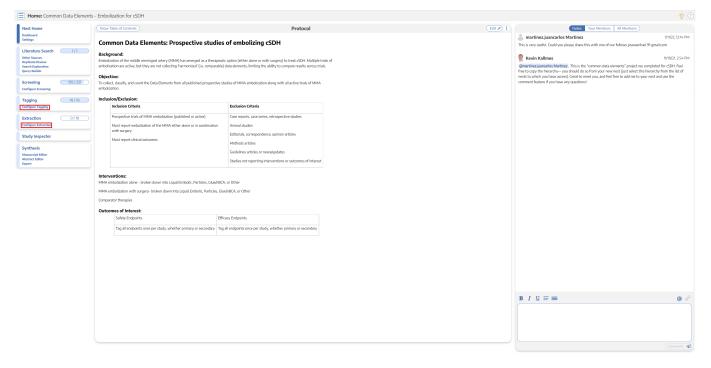
1/10

In order to Extract, you first need to Configure Interventions and Data Elements, which you do from the Configure Study Tags page in order to reuse the structure you built during the Tagging stage.

Interventions correspond to the types of therapies/treatments/medications etc. that were compared across the articles and appear as purple in the Tagging Hierarchy. **Data Elements** refer to all other relevant data from the article that will be extracted and appear as gold in the Tagging Hierarchy.

Note: Only one hierarchy can be designated as your Intervention hierarchy, but any node in your hierarchy can be configured as a Data Element. There is no requirement, however, that every tag be configured as a data element!

Where does Extraction Configuration take place?

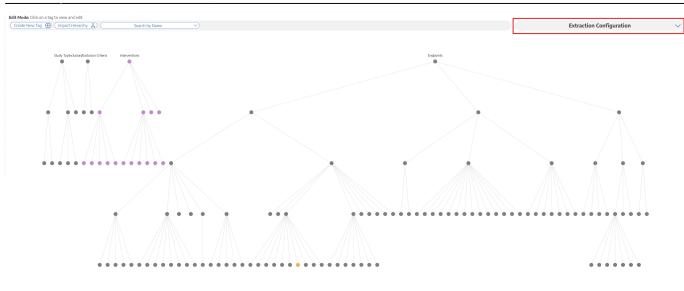


Extraction can be configured in two places: in the same location that Tags are configured or under "Configure Extraction" in the Extraction module. Extraction configuration is integrated into tagging configuration in order to use your existing hierarchy to structure your Interventions and Data Elements.

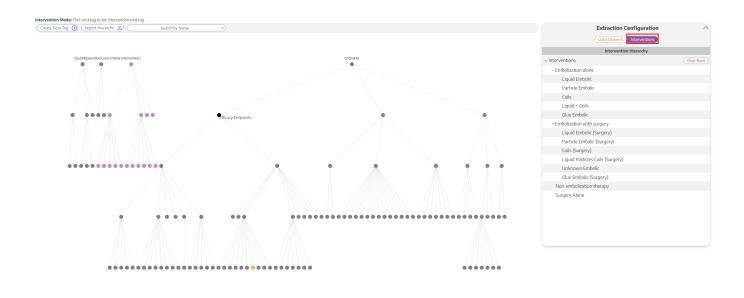
Configuring Interventions

1. Open the Extraction Configuration panel

Expand the "Extraction Configuration" dropdown button on the right.

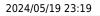


2. Toggle to Interventions

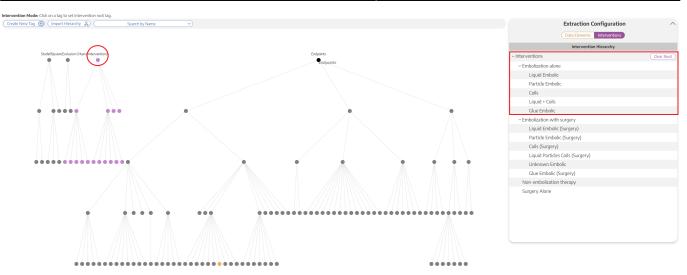


3. Click on the "Interventions" Root Tag

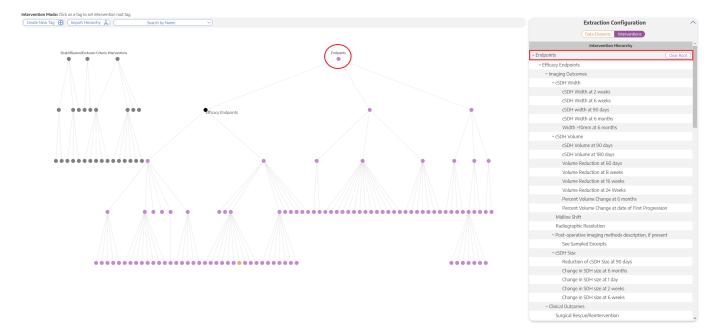
The Intervention list on the right corresponds to all of the tags underneath the "Intervention" root tag



3/10



Intervention tags can easily be changed. For example, by simply opening the Interventions tab and clicking "Endpoints", all tags under "Endpoints" are now Interventions for your Extraction.



This is important to note because if you accidentally leave the incorrect hierarchy as the Interventions and then you go to extract, these incorrect Interventions options (for instance, "Endpoints" tags in the example above) will appear under the Intervention dropdown menu instead of the "Interventions" tags

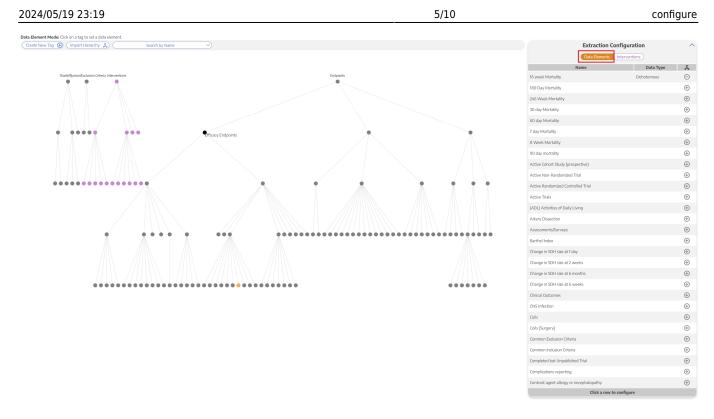
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er Sources				Arms	Intervention	Arm Size	
licate Review ch Exploration		RESEARCH—HUMAN—CLINICAL STUDIES		~	No Selection		
ery Builder				(ADL) Activities of Daily Living	×		
	Peter Ken, MD, MPH, FRCS ¹			16 week Mortality			
reening 195/237	Georgios A. Maragkos, MD ^b	•	0	2 180 Day Mortality 246 Week Mortality			
figure Screening	Aditya Srivatsan, MS 😒 Visish Srivivasan, MD	Middle Meningeal Artery Embolization for Chronic	Quest	30 day Mortality			
gging (18/18	Jeremieh Johnson, MD* Jan-Karl Durkhardt, MD*	Subdural Hematoma: A Multi-Center Experience of	oode	1 60 day Mortality			
1figure Tagging	Timothy M. Robinson, MD ⁴ Mohamed M. Selem, MD ⁴	154 Consecutive Embolizations	1 for	7 day Mortality		15 Days	
	Stephen Chen, MD ⁴ Howard A, Rina, MD ⁴	191 Consecutive Embonizations	- 5	S Week Mortality 90 day mortality Ø		Total	
traction 0/18	Omar Tarrweer, MD	BACKGROUND: Middle meningeal artery (MMA) embolization has emerged as a	No.	90 day mortality @ Artary Dissection		2	
nfigure Extraction	Elad I. Levy, MD* Alejandro M. Spiotta, MD*	promising treatment for chronic subdural hematoma (cSDH). OBJECTIVE: To determine the safety and efficacy of MMA embolization.	Cieda	Assessments/Surveys			
udy Inspector	Sami Al Kasab, MD** Jonathan Lena, MD**	METHODS: Consecutive patients who underwent MMA embolization.	The second se	Barthelindex			
udy inspector	Bradley A. Gross, MD ⁴⁴ Jecob Cherian, MD ⁶⁴⁴	treatment or recurrence after conventional surgery) at 15 centers were included. Clinical	o dre	Change in SDH size at 1 day			
nthesis	C. Michael Cawley, MD ⁴⁹ Brian M. Howard, MD ⁴⁹	details and follow-up were collected prospectively. Primary clinical and radiographic outcomes were the proportion of patients requiring additional surgical treatment within	OT IN	Change in SDH size at 2 weeks Change in SDH size at 6 months			
nuscript Editor	Alexander A. Khalessi, MD ⁴⁰ Aditya S. Pandey, MD ⁶⁰	90 d after index treatment and proportion with > 50% cSDH thickness reduction on follow-	8	Change in SDH size at 6 weeks			
stract Editor	Adrya S. Pandey, MD 94 Andrew J. Ringer, MD ⁴⁴ Bicardo Hanel, MD, PhD ⁴⁴	up computed tomography imaging within 90 d. National Institute of Health Stroke Scale and modified Bankin Scale were also clinical outcomes.	uge	Clinical Outcomes			
1107	Rafael A. Ortiz, MD***	RESULTS: A total of 138 patients were included (mean age: 69.8, 29% female). A total of	rjiba	CNS infection			
	David Langer, MD*** Cory M. Kelly, MS***	15 patients underwent bilateral interventions for 154 total embolizations (66.7% primary treatment). At presentation. 30.4% and 23.9% of patients were on antiplatelet and antico-	Nano	Complications reporting Contrast agent allergy or encephalopathy			
	Brian T. Jankowitz, MD ⁸⁸⁸ Christopher S. Ogilyy, MD ⁶	agulation therapy, respectively. Median admission cSDH thickness was 14 mm. A total of	8	contrast agent avergy or encephalopathy cSDH Size			
	Justin M. Meore, MD, PhD ³ Michael R. Levitt, MD ³⁹	46.1% of embolizations were performed under general anesthesia, and 97.4% of proce- dures were successfully completed. A total of 70.2% of embolizations used particles, and	lote to	100000	*		
	Mandy Elening, MD Ramesh Grandhi, MD, MS	25.3% used liquid embolics with no significant outcome difference between embolization	0,10				
	Farban Siddig, MD**** Ajth J. Thomas, MD*	materials (P > .05). On last follow-up (mean 94.9 d), median cSDH thickness was 4 mm (71% median thickness reduction). A total of 70.8% of patients had > 50% improvement on	100				
		imaging (31.9% improved clinically), and 9 patients (6.5%) required further cSDH treatment.	10 mar				
	*Department of Neurosunger College of Medicine, Housto	n Text: There is completenents with 5 (00%) because of continued nentational expansion.	roste				
	¹ Neurosurgical Service, Bet Deaccews Medical Center,	Narvad lying comorbidities.					
	Medical School, Boston, Massac (Continued on n	alternative to conventional surgical techniques.	1735916				
	*Peter Kan and Georgies A. Mas contributed equally to this work This work has been previously p	embolization, Refractory subdural hematoma, Refractory subdural hemorrhage	961 by (
	as an oral presentation at the 20 Congress of Neurological Surge Survise Session, on October 21, 2	015, 2019, in					
	San Diego, California.	hronic subdural hematoma (cSDH) is one of the most common neurosurgical hole irrigation or craniotomy and drainage a					
	Correspondence: Peter Kars, MD, MPH, FRCS,	diseases. Its incidence is rising from considered the pold standard for symptomat	k e				
	Department of Neurosungery, Baylor College of Medicine,	population aging and increasing antiplatelet and anticoagulant use. ¹⁻⁶ Spontaneous resolution of operative cases are associated with hematon					
	7200 Cambridge St, Suite SA, Houston, TX 77000, USA. Email: ptkangutmbadu	cSDH is rare, reported mainly for patients with recurrence. ⁴⁻¹³ Symptomatic recurrence	ik see				
	Received, December 19, 2019. Accepted, June 27, 2020.	ABBREVIATIONS: CMO, comfort measures only: CSDH, chronic subdural hematoma; CT, computed temographig IOR, intergrantile range; MLS, milline shift; MMA, middle meningeal artery; mRS, modified flankin Scale; NIHSS,	08 Octo				
	Copyright © 2020 by the Congress of Neurological Surge	National institute of Health Stroke Scale; RCT, randomized controlled trial; SDH, subdural hematoma	ber 2				
	Congress of Neurological Surge	Supplemental digital content is available for this article at www.neurosurgery-online.com.	8				

Luckily, this is easily fixed: just navigate back to the Data Elements Menu within the Tagging Hierarchy, click on the "Interventions" root tag, and viola, your Interventions are Interventions once again!

Configuring Data Elements

1. View the Data Elements Menu

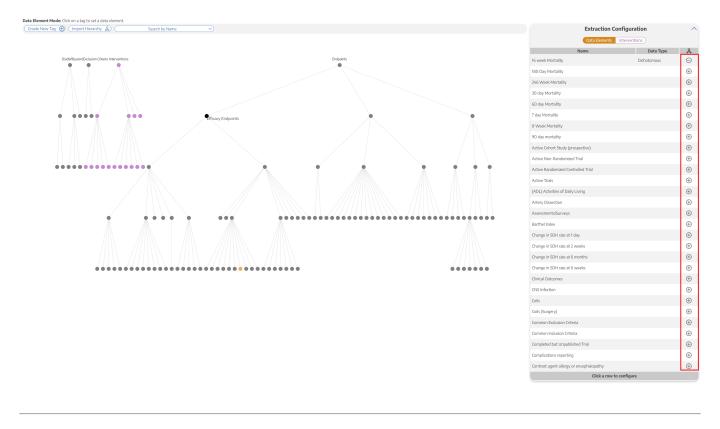
Navigate to the Data Elements Menu and click "Data Elements"



The data elements tab will show you a list of all tags, which you can select either in the list or by clicking on the tag node.

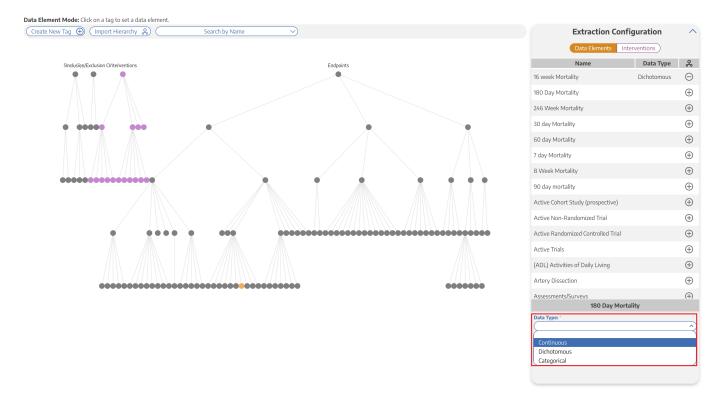
2. Turn tag into Data Element

Click the plus sign next to a tag to turn the tag into a Data Element



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3. Select the Data Type

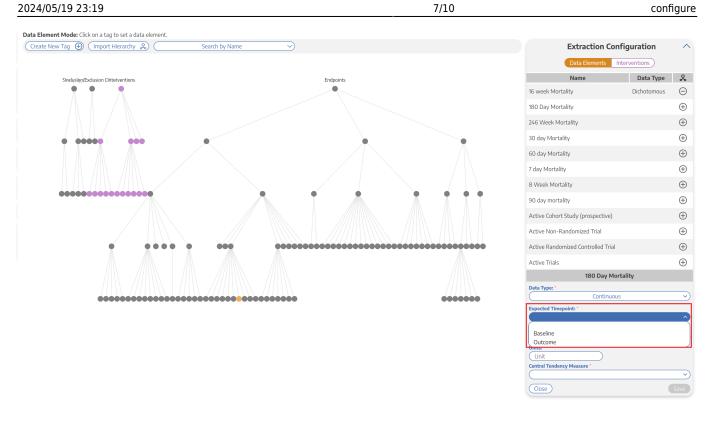


Continuous, Dichotomous, or Categorical (Mandatory)

Depending on the data type, different inputs will populate. For example, if a data element is categorical, you will be able to specify the different categories.

4. Select the Expected Timepoint

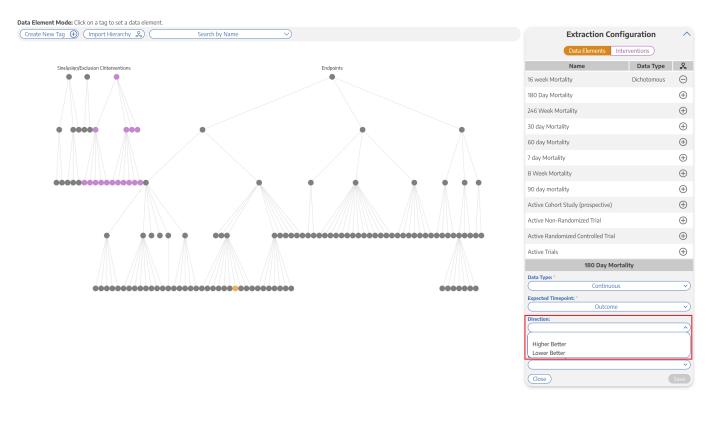
Baseline or Outcome - Choose the Expected Timepoint based on whether the data was collected at Baseline or as an Outcome (Mandatory)



If the data element can be both a Baseline and an Outcome, choose Baseline.

5. Select the Direction

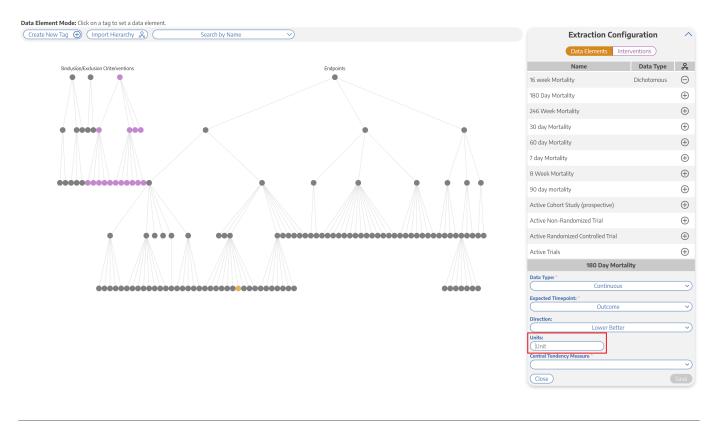
Higher Better or Lower Better (if applicable) - For example, the Data Element is "Mortality", Lower Better would most likely be appropriate



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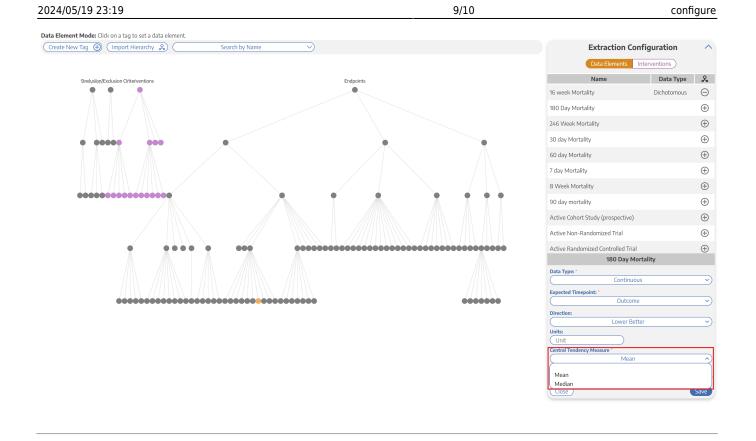
6. Add the Measurement Units

Example: Mintues, mL, kg (if applicable)



7. Add the Central Tendency Measurement

Mean or Median (Mandatory for continuous variables) - After choosing Mean or Median, it will also ask you about "Dispersion Measure" (SD for Mean; IQR or Range for Median)



8. Click Save

Confirm that the configuration worked based on whether the node turned gold, and move on to configure any other Data Elements of interest

How many Data Elements should you create?

When configuring your Data Elements, it is vital to recognize that **every Data Element you configure must be**:

- 1. collected as a metric across all studies, adding time to your project, and
- 2. presented on Synthesis, potentially confusing readers as to which Data Elements are vital to your review/meta-analysis.

It is also important to understand that, unlike with primary studies, multivariate comparisons are limited in meta-analytical research by the aggregated nature of the data. Thus, all Data Elements should be of direct interest to compare among Interventions of interest.

There is no exactly 'correct' number of Data Elements. However, remember that: the minimum # of metrics collected = # of study arms * # of Data Elements configured, and this can increase if multiple timepoints are collected.

Therefore, the following **suggested guidelines** may help estimate the appropriate number of Data Elements and project timelines:

• **1-3 Data Elements:** <5 min per study, highly focused Synthesis. May provide too little context for key outcomes.

- **4-7 Data Elements:** 5-10 min per study, focused Synthesis. Likely represents the primary & secondary outcomes of interest, as well as high-value background data.
- 8-10 Data Elements: 10-20 min per study, detailed Synthesis. Likely represents all primary & secondary outcomes of interest, subsidiary endpoints, and any background data of interest. Data sparsity may be a problem. Recommended that you keep your review to this size or smaller!
- **10-20 Data Elements:** Up to an hour per study, intensively detailed Synthesis. Likely represents most data elements reported in underlying studies; may represent an unfocused research question. Should be reserved only for extensive reviews where the endpoints of interest are undefined, or review types that require going beyond conventional methods.
- 20+ Data Elements: Several hours per study, potentially overwhelming Synthesis. Can introduce not only data sparsity but collection quality concerns. May reflect an unfocused research question or unconventional review type. Recommended that such reviews be split into smaller pieces if they must be undertaken.

These are suggestions only, but can have major impact on the quality, focus, and timeliness of projects. If you have any questions on this guidance, feel free to Contact Support!

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