## Glossary.

**Blinding (masking)**: in an experimental study, refers to whether patients, clinicians providing an intervention, people assessing outcomes, and/or data analysts were aware or unaware of the group to which patients were assigned. In the design section of *Evidence-Based Nursing* abstracts of treatment studies, the study is identified as *blinded*, with specification of who was blinded; *unblinded*, if all parties were aware of patients' group assignments; or *blinded (unclear)* if the authors did not report or provide us with an indication of who was aware or unaware of patients' group assignments.

Concealment of randomisation: concealment of randomisation is specified in the design section of Evidence-Based Nursing abstracts of treatment studies as follows: allocation concealed (deemed to have taken adequate measures to conceal allocation to study group assignments from those responsible for assessing patients for entry in the trial [ie, central randomisation; sequentially numbered, opaque, sealed envelopes; sealed envelopes from a closed bag; numbered or coded bottles or containers; drugs prepared by the pharmacy; or other descriptions that contain elements convincing of concealment]); allocation not concealed (deemed to have not taken adequate measures to conceal allocation to study group assignments from those responsible for assessing patients for entry in the trial [ie, no concealment procedure was undertaken, sealed envelopes that were not opaque or were not sequentially numbered, or other descriptions that contained elements not convincing of concealment]); unclear allocation concealment (the authors did not report or provide a description of an allocation concealment approach that allowed for the classification as concealed or not concealed). Confidence interval (CI): quantifies the uncertainty in measurement; usually reported as 95% CI, which is the range of values within which we can be 95% sure that the true value for the whole population lies.

**Diagnostic (gold or criterion) standard:** the current best available measure of an outcome; used for assessing properties of a new diagnostic or screening test. The results from a new test are compared with the results from the diagnostic standard to assess the usefulness of the new test (ie, its sensitivity, specificity, and likelihood ratios).

**Fixed effects model**<sup>1</sup>: gives a summary estimate of the magnitude of effect in meta-analysis. It takes into account within-study variation but not between-study variation and hence is usually not used if there is significant heterogeneity. **Intention to treat analysis (ITT)**: all patients are analysed in the groups to which they were randomised, even if they failed to complete the intervention or received the wrong intervention.

**Likelihood ratio (for positive and negative results)**<sup>2</sup>: a way of summarising the findings of a study of a diagnostic test for use in clinical situations where there may be differences in the prevalence of the disease. The likelihood ratio for a positive test is the likelihood that a positive test result comes from a person that really does have the disorder rather than one that does not have the disorder [sensitivity/(1–specificity)]. The likelihood ratio for a negative test is the likelihood that a negative test result comes from a person with the disorder rather than one without the disorder [(1–sensitivity)/specificity].

**Number needed to harm (NNH)**<sup>3</sup>: number of patients who, if they received the experimental treatment, would lead to 1 additional person being harmed compared with patients who receive the control treatment; this is calculated as 1/ absolute risk increase (rounded to the next whole number), accompanied by the 95% confidence interval.

**Number needed to treat (NNT)**: number of patients who need to be treated to prevent 1 additional negative event (or to promote 1 additional positive event); this is calculated as 1/ absolute risk reduction (rounded to the next whole number), accompanied by the 95% confidence interval.

**Odds ratio (OR)**: describes the odds of a patient in the experimental group having an event divided by the odds of a patient in the control group having the event *or* the odds that a patient was exposed to a given risk factor divided by the odds that a control patient was exposed to the risk factor.

**Random effects model**¹: gives a summary estimate of the magnitude of effect in meta-analysis. It takes into account both within-study and between-study variance and gives a wider confidence interval to the estimate than a fixed effects model if there is significant between-study variation.

**Relative benefit increase (RBI)**: the proportional increase in the rates of good events between experimental and control participants; it is reported as a percentage (%).

**Relative risk (risk ratio or RR)**: proportion of patients experiencing an outcome in the treated (or exposed) group divided by the proportion experiencing the outcome in the control (or unexposed) group.

**Relative risk increase (RRI)**: the proportional increase in bad outcomes between experimental and control participants; it is reported as a percentage (%).

**Relative risk reduction (RRR)**: the proportional reduction in bad outcomes between experimental and control participants; it is reported as a percentage (%).

**Sensitivity**<sup>3</sup>: a measure of a diagnostic test's ability to correctly detect a disorder when it is present in a sample of people.

**Specificity**<sup>3</sup>: a measure of a diagnostic test's ability to correctly identify the absence of a disorder in a sample of people who do not have the disorder.

**Standardised mean difference**<sup>1</sup>: in a systematic review, a way of combining the results of studies that may have measured the outcome (eg, pain) in different ways, using different scales; effects are expressed as a standard value, with no units (difference between 2 means / estimate of within-group standard deviation).

**Weighted mean difference**<sup>1</sup>: in a meta-analysis, used to combine outcomes measured on continuous scales (eg, height), assuming that all trials measured the outcome on the same scale; the mean, standard deviation, and sample size of each group are known, and weight given to each trial is determined by the precision of its estimate of effect.

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Updated quarterly.

Streiner D, Geddes J. Some useful concepts and terms used in articles about diagnosis [editorial]. Evid Based Ment Health 1998;1:6–7.

<sup>3</sup> Sackett DL, Haynes RB, Guyatt GH, et al. Clinical epidemiology: basic science for clinical medicine, Second edition. Boston: Little, Brown and Company, 1991.