# Annotation guidelines for annotation of temporal information related to medications in CRIS notes

Part of CRIS approved project 18-067 and 19-070

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#### Annotation task:

- 1. Determine time references and attributes for medications in CRIS documents
- 2. Please annotate all mentions of a medication (even if there are multiple references in the same document)

### **Medication attributes**

Information for attributes will be derived from the sentence or span in question, not from the rest of the document.

For each annotated medication, please add the following prescription attributes:

- Drug: the name of the drug in the prescription
- Frequency: represents the number of times the dose is taken in the dose interval (2 in "twice a day")
- Interval: is the time interval to which the dose frequency applies (1 in "twice a day")

{Additional examples for Frequency and Interval: Once a day – Frequency is 1, Interval is 1; 3 times a day – Frequency is 3, interval is 1; Once every 4 days – Frequency is 1, interval is 4.}

Dose value: 200 in "200mg"Dose unit: mg in "200mg"

Note: In instances of dose changes such as "patient on clozapine 250mg to be increased to 500mg..." – this should incorporate two annotation spans. The first span will include "clozapine 250mg" and the second span will include "clozapine 250mg to be increased to 500mg" i.e. the entire span including the previous one.

• Route: oral, IV...

• When: at night, morning...

For each medication annotation, we also consider the following temporal attributes:

- 1. Initiation:
  - Possible values: Current, past or future

- Did the patient start this medication in the past, or does the medication start now (or even in the future)?
- 2. Initiation time: the specific time
  - Possible values: exact date, vague date in any given time granularity
  - Default: unknown
  - Date formats:

Full date: DD/MM/YYYY Ex: 25/02/2015 Partial date: Mon YYYY Ex: Feb 2016

Year: YYYY Ex: 2014

Ranges: Mon YYYY – Mon YYYY Ex: Jun 2009 – Sep 2010

#### 3. Cessation:

- Possible values: Current, past or future
- Did the medication stop in the past, is it stopping now, or will it stop in the future?
- 4. Cessation time: the specific time
  - Possible values: exact date, vague date in any given time granularity
  - Default: unknown
  - Date formats:

Full date: DD/MM/YYYY Ex: 25/02/2015 Partial date: Mon YYYY Ex: Feb 2016

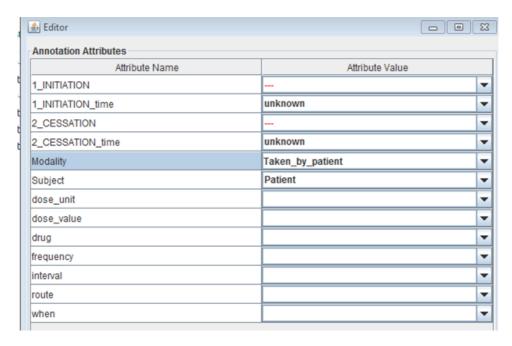
Year: YYYY Ex: 2014

Ranges: Mon YYYY – Mon YYYY Ex: Jun 2009 – Sep 2010

## 5. Subject:

- Possible values:
  - o Patient when the medication refers to the patient;
  - Other when the medication refers to a relative/parent etc.
- Default: patient
- 6. Modality
  - Possible values:
    - o taken\_by\_patient when the medication is being taken by the patient, including overdose and side-effects, with clear indication that the patient has taken the medication;
    - o not\_taken\_by\_patient refers to allergy information/ hypothetical discussions of medications/ anything else that suggests that the patient did not take the medication
  - Default: taken by patient

Below you can find a screenshot with all possible attributes for each annotated medication.



Situation	Initiation	Cessation
Patient was on a medication	Past	Past
in the past and is not on it		
anymore		
Patient was started on a	Past	-
medication in the past and is		
still on it		
Patient was started on a	Past	Current
medication in the past and it		
is being stopped now	_	_
Patient was started on a	Past	Future
medication in the past and it		
is planned to be stopped in		
x months or after a fixed		
duration		
Patient is being prescribed a	Current	-
medication indefinitely		
Patient is being prescribed a	Current	Current
medication one time only		
(For example, they were		
given something to calm		
them down at that time)		
Patient is being prescribed a	Current	Future
medication and it is planned		
to be stopped in x months or		
after a fixed duration		
Plan made to start patient	Future	-
on a medication in the future		

Plan made to prescribe	Future	Future
patient on a medication for a		
fixed duration in the future		

# Important: if you have any doubt please add a comment

## **Frequently Asked Questions**

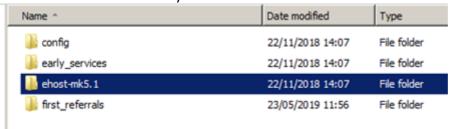
- 1. Should the following be annotated?
  - a. Mentions of recreational drugs such as weed etc. No
  - b. Mentions of alcohol use No
  - c. Mentions of the word "medication" or "drug" No
  - d. Generic mentions such as "painkillers", "laxatives", "IV fluids", "antipsychotics", "antidepressants" Yes. Comment as "Generic mention" if possible.
  - e. Vaccinations No
  - f. Mentions of overdose Yes. Comment as "overdose" if possible.
- 2. In a situation where a blood test was done to check levels of a particular medication, should the medication be annotated? Yes, probably with a comment about it being regarding blood test levels of the drug. Comment as "Blood test mention" if possible.

#### **Annotation tool**

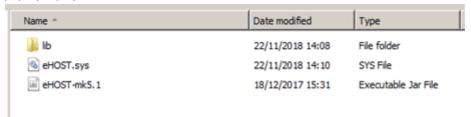
To run the annotation tool, go to the folder:

T:\Natalia Viani\annotation\_prescription

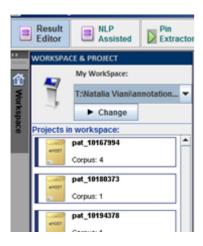
Then select the folder with your name and move to the ehost-mk5.1 folder.



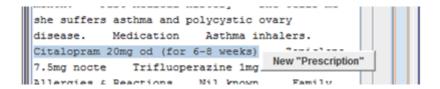
Here you will find an Executable file called ehost-mk5.1. You can run the tool with a double-click on this.



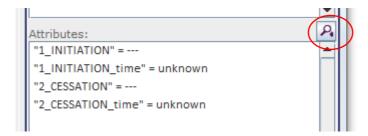
You will find the list of patients that has been assigned to you on the left (this is the first batch of patients).



When you select one patient (double-click on the folder name), the list of documents associated to him/her is displayed. Once a document is selected (double-click on the document name), you can mark the PRESCRIPTION by selecting the text you would like to annotate:



Finally, you can change the value of the different attributes by clicking on the symbol in the "Attributes" window (bottom-right).



# **Contact information:**

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