

# **Lipids and dementia: An investigation of their relationship**

Luke A McGuinness

University of Bristol

*A thesis submitted for the degree of  
Doctor of Philosophy in Population Health Sciences*

TBC

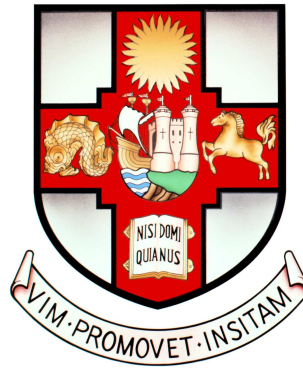
## **Abstract**

### **Background**

In the UK, an estimated 800000 people are currently living with dementia and this number is expected to double by 2040. Despite the number of dementia cases and decades of research, there remains much unknown about the pathogenesis and progression of the disease, and, at present, no effective treatment exists to arrest or reverse the cognitive decline associated with the condition. In this context, identification of causal relationships between modifiable targets and dementia risk is central to the development of evidence-based prevention strategies and will be critically important in maintaining the long-term health of the ageing public. Blood lipid levels have been implicated in the aetiology of dementia by genetic linkage and functional cell biology studies, but current epidemiological evidence has yet to reach a consensus on their role in dementia risk.



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For Brendan McHugh





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Thanks to the creator of the oxforddown which was used

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robvis contributors

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All authors who volunteered time and effort

Canynge Hall, Bristol

1 December 2021



## Author's declaration

I declare that the work in this dissertation was carried out in accordance with the requirements of the University's Regulations and Code of Practice for Research Degree Programmes and that it has not been submitted for any other academic award. Except where indicated by specific reference in the text, the work is the candidate's own work. Work done in collaboration with, or with the assistance of, others, is indicated as such. Any views expressed in the dissertation are those of the author.

SIGNED: ..... DATE: .....



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# List of Abbreviations

<b>API</b>	. . . . .	Application programming interface
<b>AzD</b>	. . . . .	Alzheimer's disease
<b>CIND</b>	. . . . .	Cognitive impairment not dementia
<b>CPRD</b>	. . . . .	Clinical Practice Research Datalink
<b>CRAN</b>	. . . . .	Comprehensive R Archive Network
<b>DOI</b>	. . . . .	Digital object identifier
<b>HDL</b>	. . . . .	High density lipoprotein
<b>IPD</b>	. . . . .	Individual participant data
<b>LDL</b>	. . . . .	Low density lipoprotein
<b>MCI</b>	. . . . .	Mild cognitive impairment
<b>MMSE</b>	. . . . .	Mini Mental State Exam
<b>MoCA</b>	. . . . .	Montreal Cognitive Assessment
<b>MR</b>	. . . . .	Mendelian randomization
<b>NOS</b>	. . . . .	Newcastle-Ottawa Scale
<b>PDF</b>	. . . . .	Portable document format
<b>RCT</b>	. . . . .	Randomised controlled trial
<b>TG</b>	. . . . .	Triglycerides
<b>VaD</b>	. . . . .	Vascular dementia



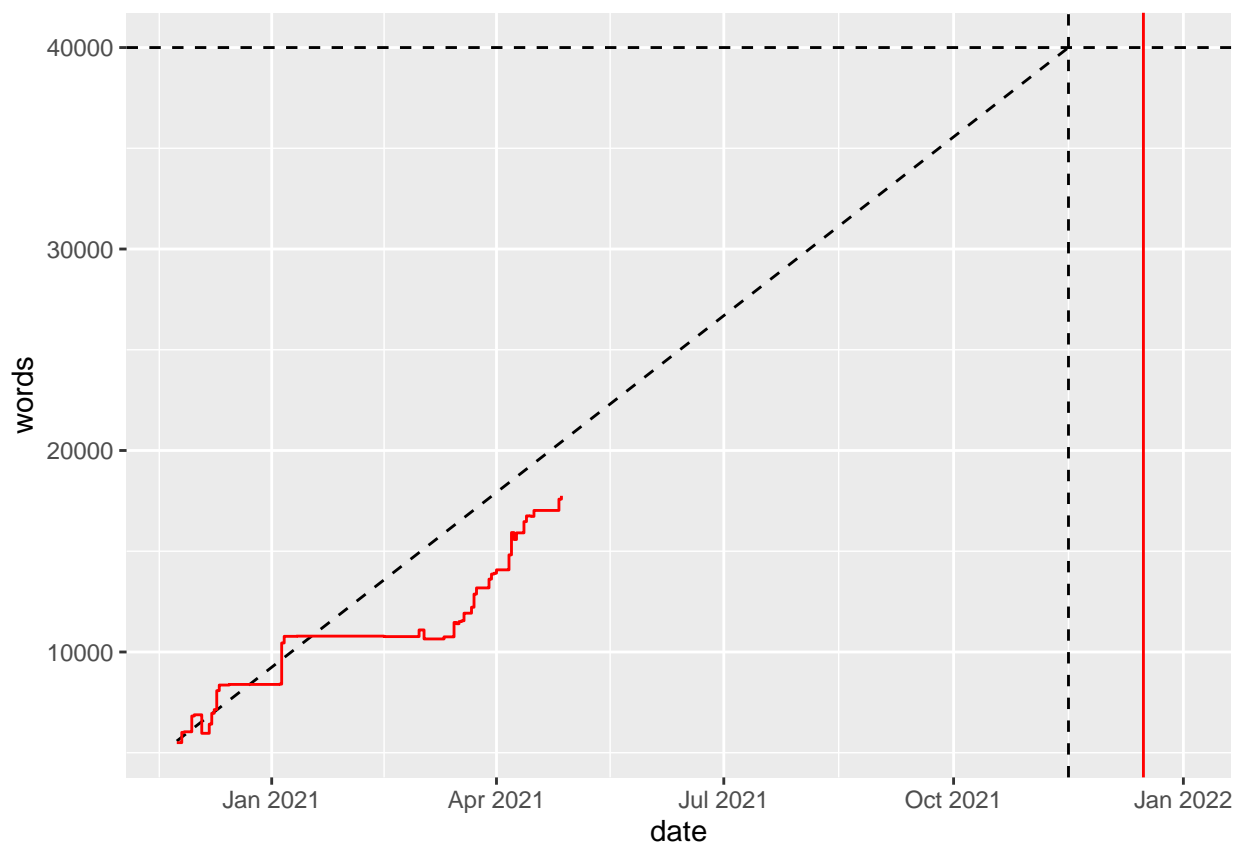
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# 1

## Introduction

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## 1.1 Additional ideas

### 1.1.1 General

- Explore difference/similarities between the published and unpublished literature, potentially formally, using funnel plots and also by following up preprints to see if they are eventually published. Limit to the date we ran the original search and see if any study included in the study had not been published by the time the review was finished.
- Compare and contrast the codes used to find the AzD cases in the previous study and in this study, potentially with a view to contrasting misclassification between the two.
-

**1.1.2 Background**

**1.1.3 medrxivr**

**1.1.4**

# 2

## Background, Theoretical framework, Aims & Objectives

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### 2.1 Lay summary

[Note: see Section 2.7.3 for details on the layout of each chapter.]

Around 850,000 people in the UK live with dementia, and by 2040, nearly twice as many will have the condition. Despite many promising candidates, no cure for dementia currently exists, meaning the focus is on finding ways to prevent the

condition. The best way to do this is to find risk factors (characteristics that influence a person's chance of developing a disease) for dementia that we can easily change. Avoiding a risk factor does not guarantee that a person will not develop dementia but makes it less likely. A key risk factor for dementia may be the levels of lipids (fatty substances such as cholesterol) in a person's blood, though not all existing research agrees. The aim of this thesis is to use all available evidence to assess whether blood lipids levels are in fact a risk factor for dementia.

This introductory chapter provides background information on both dementia and blood lipids, and on the potential link between them. It introduces the theory used to frame the research presented here, and then maps the formal aims and objectives of the research project to the relevant chapters of this thesis. Finally, it summarises the outputs (journal articles, presentations and software) that were created as part of this thesis.

## **2.2 Introduction**

This chapter provides an overview of the broad context of this thesis, introducing the core concepts used throughout and providing some background on each. It briefly discusses the underlying pathologies and diagnosis of dementia, its public health importance, and the current state of treatment and prevention research. It then provides background on blood lipids and lipid-modifying treatments, and summarises the existing evidence on the effect of these exposures on dementia outcomes.

The chapter introduces evidence synthesis as the key framework used to guide the research presented in the remaining chapters. Finally, it outlines the aims, objectives and structure of this thesis, and briefly summarises the contributions to the scientific literature that arose from this research.



## 2.3 Dementia

### 2.3.1 Definition and underlying pathologies

Defined by the Diagnostic and Statistical Manual of Mental Disorders as a “major neurocognitive disorder”, dementia is a progressive disease which impairs cognitive functions including speech, memory and executive reasoning.<sup>1</sup> At advanced stage, the condition causes severe behavioral and personality changes,<sup>2</sup> cumulating in reduced motor control that affects patients ability to swallow or breathe.<sup>3</sup> The condition has several distinct underlying causes, including Alzheimer’s disease and vascular dementia.<sup>4</sup>

Alzheimer’s disease is the most common cause of dementia, accounting for approximately 60-80% of cases. Characterised by substantial cognitive impairment and difficulty with high level executive function to the extent that it interferes with, it is an insidious disease, within initial onset thought to occur up to 15 years prior to symptomatic presentation.<sup>5</sup> Much remains unknown about Alzheimer’s pathogenesis, despite research implicating the “amyloid hypothesis”,<sup>5</sup> as a potential mechanism of disease. Under this hypothesis, the build-up of amyloid plaques (composed mainly of amyloid- $\beta$  peptide) and neurofibrillary tangles (composed mainly of tau protein) triggers a range of physiological changes, including inflammation and cell death, that result in cognitive impairment.<sup>5</sup>

Vascular dementia (VaD) is the second largest underlying pathology of dementia, accounting for ~10% of cases. Vascular dementia is caused by a range of cerebrovascular disorders, and as a result, presentation of symptoms can vary widely.<sup>6</sup> Similarly, due to the varied underlying pathophysiology, vascular dementia can either onset quite rapidly following a cerebrovascular event such as a stroke or over a long time-frame due to a series of small infarcts.<sup>7</sup> Vascular dementia regularly co-occurs in patients with Alzheimer’s disease.<sup>6</sup> This presentation is described as “mixed” dementia,<sup>8</sup> and occurs in approximately 25% of cases.<sup>4</sup>

The remaining 10-30% of cases are caused other dementia subtypes (e.g. Lewy Body dementia, frontotemporal dementia) or by progression of other neurological diseases (e.g. Parkinson's disease).<sup>4</sup>

### **2.3.2 Diagnostic criteria**

Dementia is difficult to diagnose, primarily due to its slow onset, in addition to the confusion of initial symptoms with normal ageing.<sup>5</sup> Dementia is diagnosed on the basis of behavioral and cognitive changes as assessed by an experienced clinician, using one of several diagnostic criteria.

**Table 2.1:** Overview of the DSM-5 criteria for dementia and vascular dementia.<sup>1</sup>

Criterion	Major neurocognitive event (previously dementia)
<b>A</b>	Evidence of significant cognitive decline from a previous level of performance in one or more cognitive domains:.* - Learning and memory - Language - Executive function - Complex attention - Perceptual-motor - Social cognition
<b>B</b>	The cognitive deficits interfere with independence in everyday activities. At a minimum, assistance should be required with complex instrumental activities of daily living, such as paying bills or managing medications.
<b>C</b>	The cognitive deficits do not occur exclusively in the context of a delirium.
<b>D</b>	The cognitive deficits are not better explained by another mental disorder (eg, major depressive disorder, schizophrenia).

\* From DSM: Evidence of decline is based on concern of the individual, a knowledgeable informant, or the clinician that there has been a significant decline in cognitive function and a substantial impairment in cognitive performance, preferably documented by standardized neuropsychological testing or, in its absence, another quantified clinical assessment.

One of the most commonly used criteria are those found in the Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria (Table 2.1).<sup>1</sup> These criteria are outlined in Table 2.1, and form the broad definition of a dementia diagnoses, supported by a detailed patient history, evidence from carers and family members, and objective assessments of cognitive ability using neurocognitive tests.

Many cognitive assessment tools exist for the purpose of informing a diagnoses of dementia,<sup>9</sup> with two of the best known of these being the Mini Mental State Exam (MMSE) and Montreal Cognitive Assessment (MoCA) scale. The distinction

between these memory scales and diagnostic criteria presented above should be noted. For example, the MMSE is used to provide evidence for part A of the criteria presented in 2.1. Taken alone, it does not indicate the absence or presence of dementia, instead merely indicating cognitive impairment which could be due to another cause (for example, temporary delirium as a result of an infection or surgery).

Differentiating between the underlying causes of a dementia diagnosis is challenging but necessary, as whether the patient has Alzheimer's disease or vascular dementia will affect expected progression and potential treatment options available (see Section 2.3.4). Cause-specific criteria exist for the diagnosis of dementia sub-types. For example, the NINCDS-ADRDA criteria are commonly used to assess patients for Alzheimer's disease,<sup>10</sup> while vascular dementia is diagnosed using the NINCDS-AIREN criteria.<sup>11</sup>

### **2.3.3 Public health importance**

Dementia is quickly becoming a critically important public health issue. Despite the age-specific incidence and prevalence of dementia remaining relatively constant over time,<sup>12</sup> an ageing population is set to create a dementia epidemic, particularly in Westernised countries.<sup>13</sup> While approximately 525,000 patients have received a dementia diagnosis, the true number of people currently living with dementia in the UK is thought to be closer to 850,000, with this figure expected to double by 2040.<sup>14</sup> Globally, the prevalence of dementia is expected to reach 75 million by 2030.<sup>12</sup> Dementia is the leading cause of death in the UK, and the only one without a proven treatment.

Dementia also has a substantial economic impact. In 2015, the estimated total cost of dementia in England was £24.2 billion. Health care costs alone were £3.8 billion,<sup>15</sup> Globally, the cost of dementia care is expected to rise to \$1tr by 2030.<sup>16</sup>

As such, the urgent need to reduce the burden of dementia, both at the personal and system level, is clear.

### 2.3.4 Treatments

Developing treatments for dementia is regularly deemed to be one of the hardest markets in the pharmaceutical world, with trials of seemingly promising therapeutics being regularly abandoned due to futility.<sup>17</sup> At present, there are no known curative treatments for dementia, regardless of the underlying cause, though several available therapeutics can help alleviate the symptoms of Alzheimer's disease.

The most common of these are acetylcholinesterase (ACE) inhibitors, which inhibit the degradation of the neurotransmitter acetylcholine by competitively binding the ACE enzyme. Acetylcholine plays a key role in controlling the cholinergic synapses, which are highly concentrated in regions of the brain (such as the neocortex) that control higher level brain functions such as memory and attention.<sup>18</sup> Commonly prescribed ACE inhibitors include donepezil and galantamine.<sup>19</sup> ACE inhibitors increase the availability of the neurotransmitter, and has shown clinical effect is easing the behavioural and memory-related symptoms of Alzheimer's disease.<sup>20</sup> ACE inhibitors represent only a stop-gap treatment, treating the symptoms rather than the underlying pathology which may continue to progress.<sup>21</sup>

### 2.3.5 Risk factors

Given the substantial burden that dementia represents and the absence of any curative therapies, as detailed in the above sections, the assessment of easily modifiable targets for their utility in the prevention of dementia should be prioritized.<sup>22</sup> To date, a substantial amount of research has been produced examining putative risk factors for dementia.<sup>23-25</sup>

The benefits of a prevention-based approach based on addressing these risk factors are well-studied. Reducing the prevalence of the seven most important risk factors for dementia (obesity, hypertension,<sup>26</sup> diabetes, smoking, physical inactivity, and low educational attainment) by 10-20% per decade is estimated to result in a reduction in dementia prevalence of 8-15% by 2050.<sup>27</sup>

In this context, lipid levels represent a promising target for preventative treatment, due to the ready availability of lipid-modifying treatments which could be repurposed.<sup>28</sup> Determining whether variations in lipid levels are causative for dementia may prove critical in reducing the future burden of the condition.

This thesis will focus on blood lipids as the primary risk factor of interest. The next section provides an overview of blood lipid fractions and therapeutic interventions that modify them, while Section 2.5 provides an overview of the existing evidence for an association between lipids and dementia outcomes.

## 2.4 Serum lipids

### 2.4.1 Lipid fractions

The blood lipid profile contains a range of component parts, or fractions. However, this thesis will only consider the two most important fractions, triglycerides (TG) and cholesterol, which are either absorbed from food (exogenous lipids) or produced internally (endogenous lipids).<sup>23</sup>

Triglycerides are the simplest and most common type of lipids found across the body. They are used to store unused calories from food, and to move energy around the body.<sup>29</sup> In contrast, cholesterol is primarily used to create cell walls and certain sex hormones.<sup>30</sup> As lipids are not water soluble, within the blood stream, cholesterol is transported in lipoprotein structures of varying densities. Low-Density-Lipoprotein-cholesterol (LDL-c), commonly known as the “bad” cholesterol, transports fat to cells, acting as an energy conveyor. In contrast, High Density-Lipoprotein-cholesterol (HDL-c), transports cholesterol to the liver to be broken down and excreted.<sup>23</sup>

In addition to the individual fractions, total serum cholesterol (TC) is a commonly-used summary measure to estimate the total amount of lipid present in the blood. The measure is derived from measurements of the individual HDL-c, LDL-c and TG levels using the Friedwald formula.<sup>31</sup>

$$TC \approx LDLc - HDLc - kTG$$

where  $k$  is 0.20 if measurements are in milligrams per decilitre ( $mg/dl$ ) and 0.45 if measured in millimole per litre ( $mmol/l$ ).

Widely-used ranges for the acceptable levels of different types of lipids are based on the National Cholesterol Education Program (NCEP)<sup>32</sup>, and are outlined in Table 2.2.

**Table 2.2:** Classification of blood lipid levels according to the National Cholesterol Education Program guidelines.<sup>32</sup>

Fraction	Measure (mg/dL)	Classification
LDL Cholesterol	<100	Optimal
	100-129	Near/above optimal
	130-159	Borderline high
	160-189	High
	>190	Very high
HDL Cholesterol	<40	Low
	>60	High
Triglycerides	<150	Normal
	150-199	Borderline high
	200-499	High
	>500	Very high
Total Cholesterol	<200	Desirable
	200-239	Borderline high
	>240	High

Elevated LDL-c in the bloodstream, a condition also known as hypercholesterolaemia or hyperlipidaemia,<sup>33</sup> can lead to atherosclerosis,<sup>34</sup> the build-up of fatty deposits in the blood vessels. These deposits constrict blood flow and can lead to vascular

complications. Alternatively, part of the deposit can detach from the artery walls, forming a clot that can lead to a heart attack or stroke.<sup>34</sup> Globally, the prevalence of elevated cholesterol was estimated by the World Health Organisation to be approximately 40%.

### 2.4.2 Statins

Statins are a commonly prescribed method of lipid regulation.<sup>35</sup> Statins inhibit the conversion of 3-Hydroxy-3-Methylglutaryl-Coenzyme-A (HMG-CoA) into mevalonic acid, by competitively binding with HMG-CoA Reductase (HMG-CoA-R). This conversion limits the rate at which cholesterol can be produced, enabling statins to effectively reduce the production of LDL cholesterol.

### 2.4.3 Other lipid regulating agents (LRA)

There are a range of other interventions that can be used to modify a persons lipid profile, which each acting in slightly different ways (Table ??). However, in general, these treatments are either used as adjunct (additional) treatments with statins therapy or are used in situations where statins are contra-indicated or not tolerated.

The most commonly used non-statin therapeutic is ezetimibe,<sup>36</sup> which prevents intestinal absorption of cholesterol. However, when used alone, it has a limited LDL-c lowering effect, leading to the creation of combined statin/ezetimibe therapies (both compounds contained in a single pill, as opposed to complimentary treatments).<sup>37</sup>

A second example are fibrates, used to treat hypertriglyceridaemia by reducing production of triglyceride carrying compounds in the liver. They are commonly used in patients with mixed hyperlipidaemia if treatment with statins has failed to sufficiently control cholesterol levels.

Finally, PCSK9 inhibitors (or PCSK9i) are a relatively new treatment with strong lipid lowering effects, lauded as a potential alternative to statins.<sup>38</sup> Their mechanism



of action is to bind to and inhibit PCSK9, which breaks down LDL-c receptors on the surface of the liver, thus allowing more LDL-c to be internalised and broken down.

Other therapies targeting triglycerides exist, including nicotinic acids<sup>39</sup> and omega-3-fatty acids,<sup>40</sup> but they are far less effective in LDL-c lowering than the therapies described above.

**Table 2.3:** Summary of available treatments for hyperlipidaemia.

<b>Treatment</b>	<b>Effect</b>	<b>Mechanism of action</b>	<b>Examples</b>
<b>HMG CoA reductase inhibitors (statins)</b>	Lowers LDL-c & TG Raises HDL-c	Inhibits cholesterol biosynthesis pathway in the liver	Atorvastatin, Simvastatin, Pravastatin
<b>Ezetimibe</b>	Lowers LDL-c	Prevents absorption of cholesterol from diet	
<b>Bile acid sequestrants</b>	Lowers LDL-c	Prevent bile acid reabsorption in the gastro-intestinal tract, increasing conversion of cholesterol to bile acids	Colestipol
<b>Proprotein convertase subtilisin kexin 9 (PCSK9) inhibitors</b>	Lowers LDL-c	Bind to PCSK9 protein, preventing it from breaking down LDL receptors on hepatic cells, increasing cholesterol uptake	Evolocumab, Alirocumab

## **2.5 Evidence for the association between blood lipids and dementia**

This section provides an overview of the varying sources of evidence on the relationship between blood lipid levels and dementia risk.

### **2.5.1 Basic science**

A role for lipids in the aetiology of the dementia is supported by both genetic linkage studies and functional cell biology studies. The generation of the amyloid plaques found in the brains of Alzheimer's patients is cholesterol dependent,<sup>41,42</sup> while the most established genetic risk factor for late-onset dementia, apolipoprotein E (ApoE), is involved in cerebral cholesterol transport. Several other genes involved in cholesterol transport have also been found to be associated with increased AD susceptibility.<sup>43-45</sup>

Despite these results, evidence from the diverse range of epidemiological studies on this topic has been inconclusive.

### **2.5.2 Observational studies**

By far the largest source of evidence on the relationship between comes from observational designs. Several studies have examined the relationships between concentrations of serum lipids (total cholesterol (TC), low density lipoprotein cholesterol (LDL-c), high density lipoprotein cholesterol (HDL-c) and triglycerides) and both Alzheimer's disease and vascular dementia and reported extremely varied results. In some studies, a high serum cholesterol concentration has been found to be associated with an increase in susceptibility to AD,<sup>46-50</sup> however others have shown no association,<sup>51-54</sup> or a reduced susceptibility.<sup>55,56</sup> With regards vascular dementia, decreased levels of HDL-c appear to be associated with increased risk,<sup>56</sup> while for LDL-c, studies have reported both positive and negative associations.<sup>56,57</sup>

## *2.5 - Evidence for the association between blood lipids and dementia*

Several previous systematic review of observational studies examining the effect of lipids<sup>58</sup> and lipid-regulating agents<sup>59,60</sup> on dementia outcomes have been performed. However, these reviews have several limitations. Many did not consider grey literature sources (see Section 2.6.1). Additionally, many of the reviews of observational studies did not perform any risk-of-bias assessment<sup>59</sup> or used an outdated assessment tool.<sup>58,60</sup>

### **2.5.3 Randomised controlled trials**

In terms of the central research of this thesis, RCTs of statin therapy can be used to provide indirect evidence for the effect of reducing blood LDL-c levels on dementia risk.

However, RCTs may be infeasible if the outcome of interest is one with a long prodromal period, such as dementia (see Section 2.3.1), as they would require extremely long and costly follow-up.<sup>61</sup> It is no surprise then that the two previous trials providing evidence on the effect of statins on dementia risk, identified by a recent Cochrane review,<sup>62</sup> are in fact trials of statins for the prevention of coronary related outcomes.

While being widely cited, these studies have major limitations that reduce their utility as a source of evidence on the effect of statin treatment on in assessing the impact of lipid-lowering treatment on dementia risk. Firstly, there was no clinical cognitive evaluation of patients to determine a dementia outcome. One of the trials, the Prospective Study of Pravastatin in the Elderly (PROSPER) trial,<sup>63</sup> reported not on dementia outcomes but on the change in cognitive scores over a mean of 3.2 years. As highlighted in Section 2.3.2, a “change in score” alone is insufficient to diagnose a dementia outcome. The second trial, the Medical Research Council/British Health Foundation Protection Study,<sup>64</sup> found no effect of simvastatin on dementia (OR: 1.00, 95% CI: 0.61-1.65), but did not report how the outcome was assessed/recorded within the trial.

## *2.5 - Evidence for the association between blood lipids and dementia*

Additionally, the two trials did not make any effort to assign an underlying pathology to each case, instead reporting an all-cause dementia outcome. As discussed in Section 2.3.1, the different underlying pathology of dementia have different mechanisms of action, and so it is not guaranteed that the effect of statins would be consistent across them.

Both trials were also limited by the relatively short follow-up period examined, expected when the primary outcome of the trials were coronary related conditions rather than dementia.<sup>63,64</sup> The PROSPER trial had a mean follow-up of 3.2 years, while the MRC/BHF Protection Study estimated risk at 5 years of follow-up. Given the long lag time between non-symptomatic onset of dementia and clinical presentation, it is likely that these durations are insufficient to fully capture the onset of dementia. Finally, as they included only patients at high vascular risk, their generalisability to other settings is limited.<sup>65</sup>

### **2.5.4 Mendelian randomisation**

Newer methodological approaches, such as Mendelian randomisation (MR),<sup>66</sup> have also been used to examine the effect of varying lipid levels on dementia risk in an effort to combat the risk of reverse causation and residual confounding inherent to observational studies.<sup>67</sup> In brief, MR uses genetic variants that are both strongly associated with the exposure of interest and are independent from potential confounders to strengthen causal inference.<sup>66</sup> The analytic method relies on several assumptions about the instrumental variable (IV),<sup>68</sup> namely that:

1. the IV is associated with the exposure of interest (the relevance assumption);
2. the IV and outcome do not share a common cause (the independence assumption); and
3. the IV does not affect the outcome other than via the exposure (the exclusion restriction assumption).

## 2.6 - Theoretical framework: Evidence synthesis

Recent MR studies indicated that genetically determined low levels of LDL-c may cause a reduction in AD risk.<sup>69,70</sup> However, the effect was attenuated in sensitivity analysis that exclude the region surrounding the ApoE gene, the strongest known risk factor for Alzheimer's disease.<sup>71</sup> Inclusion of ApoE4 variants invalidates the exclusion restriction criteria (Assumption 3, above), as the risk reduction observed may be driven by variants in this region via a pathway independent of lipid levels. This was supported by further MR studies where *ApoE4* variants were intentionally excluded.<sup>72</sup>

Despite the increasing number of MR studies examining this topic, no systematic review of this study design as a source of evidence has been performed.

In summary, multiple sources of evidence exist on the relationship between statins and dementia. In the next section, I introduce the synthesis of diverse sources of evidence as the theoretical framework used in this thesis.

Multiples forms of evidenc

## 2.6 Theoretical framework: Evidence synthesis

Evidence synthesis is the process of finding and integrating information from several sources to examine a research question.<sup>73</sup> A common tyoe of evidence synthesis is a systematic review, either with or without a meta-analysis.<sup>74</sup>

The results of an evidence synthesis exercise can be used to provide a more definitive answer to that question or, failing that, to highlight gaps in the existing evidence base. The ability to identify these gaps is particularly useful in guiding future research to address questions that have yet to be answered, or to provide an additional source of evidence for an existing question.

This thesis seeks to use an evidence synthesis framework to assess the effect of lipids, and treatments that influence lipid levels, on dementia outcomes. Specifically, this thesis considers three methodologies within the umbrella term of evidence synthesis:

- Inclusion of grey literature
- Triangulation across evidence sources
- Individual patient data meta-analysis

These three elements are expanded on below and are used to frame the research presented in the subsequent Chapters.

### 2.6.1 Inclusion of grey literature

The importance of including grey (or gray) literature in systematic reviews is widely acknowledged. Meta-research studies have demonstrated that systematic reviews excluding grey literature sources overestimate the effect of interventions.<sup>75–77</sup> Common, well-accepted forms of grey literature include conference abstracts and theses.<sup>78</sup>

A important developing source of grey literature are preprints. Defined by the Committee on Publication Ethics (COPE) as ‘scholarly manuscript[s] posted by the author(s) in an openly accessible platform, usually before or in parallel with the peer review process’<sup>79</sup>, preprints serve several purposes. They are used to establish primacy when submitting to a journal where the peer-review process may take several months,<sup>80</sup> to rapidly disseminate research findings, as occurred during the COVID-19 pandemic,<sup>81</sup> and to make available publications that may not have been accepted elsewhere in an attempt to combat publication bias or the “file-drawer” effect.<sup>82</sup>

One of the major criticisms of using preprints as an evidence source is that they have not yet undergone formal peer review.<sup>83,84</sup> However, this approach assigns substantial weight to peer-review as a indicator of “quality”, and is at odds with the acceptance of non-reviewed conference proceedings as an evidence source.<sup>78,85</sup> The argument for including preprints as an evidence source is further strengthened by results that demonstrate preprinted studies seldom change following peer review. Meta-studies of the concordance between preprinted and published studies showed that results were broadly comparable between the two, indicating that while the numerical results may change, the overall interpretation of the results were consistent

in the majority of cases.<sup>86–88</sup> This indicates that preprints should be considered a reliable reflection of a given study.

In this thesis, preprints are considered an important source of evidence, in contrast to previous reviews on this topic. However, as with many sources of grey literature,<sup>85</sup> there are several logistical issues with carrying out systematic searches in preprint repositories. As such, to enable the inclusion of preprints in the systematic review described in Chapter 4, a new tool addressing these issues is presented in Chapter ??.

## 2.6.2 Triangulating across study designs

As illustrated in Section 2.5, several diverse epidemiological methods have been used to examine the effect of varying blood lipid levels on dementia risk. However, each method is limited by its own unique biases. Aetiological triangulation is a developing evidence synthesis method that seeks to exploit these inherent differences in study design, and as a result, in biases.<sup>89</sup> If several sources of evidence are available and point towards identical conclusions about a exposure-outcome relationship, and these sources are at risk of unrelated biases, this strengthens our confidence in the result. The ideal scenario is where predicted sources of bias are likely to be in competing directions, one expected to increased the effect of the exposure and the other to attenuate it.<sup>89</sup> As such, triangulating these results can provides us a middle-ground between the competing directions of bias. A triangulation approach can also prove useful in a prospective manner, helping to design new studies that are at risk of different sources of bias to that already available from the published literature. This thesis seeks to apply a triangulation approach to provide the best available evidence on the effect of lipids, and lipid regulating agents, on dementia outcomes. All existing evidence, regardless of study design, is first identified by the by the systematic review presented in Chapter 4. Risk-of-bias assessment using a domain-based tool is already a recommended part of the systematic review process, but is particularly important to a triangulation exercise.<sup>90–92</sup> As such, a core component

of the review is a comprehensive domain-based risk-of-bias assessment for all included studies.

Finally all evidence, both pre-existing and produced as part of this thesis (Chapter 5 and ??), are triangulated in Chapter ??.

### 2.6.3 Individual patient data meta-analysis

Individual patient data meta-analyses are commonly held to represent the gold standard in evidence synthesis methodology.<sup>93,94</sup> IPD methods seek to obtain the raw data from each study identified in a systematic review, rather than basing the meta-analysis on summary results extracted from the literature.<sup>93</sup>

In the context of this thesis, if lipids are found to have a causal role in development of dementia, evidence-based preventative strategies would be best informed by identifying the types of individuals who are most likely to receive benefit from treatment with lipid-modifying agents.<sup>95-97</sup> However, if primary studies do not presenting results stratified by covariates of interests, meta-analyses of summary-level data on this topic often have limited ability to examine research questions related to exposure-covariate interactions.<sup>93</sup> In terms of this thesis, patient sex is considered to be of particular interest.<sup>95,98</sup>

An IPD meta-analysis of lipid levels on dementia outcomes would overcome this limitation of summary-level data, as access to the raw data allows for an analysis that investigates these interactions.<sup>99</sup> This approach has the added benefit of allowing a common set of inclusion criteria and statistical model to be applied across all dataset, potentially eliminating some important sources of heterogeneity.<sup>100</sup>

Despite their advantages, IPD meta-analysis are rarely performed.<sup>101</sup> Factors limiting their uptake include the increased time and effort they require when compared to a summary-level analysis, and the low success rate associated with obtaining the raw data.<sup>102,103</sup> The data underlying primary studies is frequently not publicly available,<sup>104,105</sup> and the availability of data “available on request from authors” declines rapidly over time.<sup>106</sup> Several systematic barriers to open data sharing have



been identified<sup>107</sup>. Of particular concern for biomedical IPD analyses are legal issues surrounding the sharing of medical data, motivated by concerns around patient privacy.<sup>108</sup>

In response to these limitations, new collaborative initiatives have developed to enable rapid access to relevant data in a secure supported workshop. The most import in relation to this thesis is the Dementia Platform UK (DPUK),<sup>109</sup> which aims to provide access to several dementia-related datasets via a single simplified application process.

This thesis will attempt to obtain the raw data from relevant primary studies identified by the systematic review in Chapter 4. Any data obtained will be combined with that available from the DPUK portal as part of an individual participant data meta-analysis in Chapter ??, enabling the assessment of the effect of lipids on dementia stratified by key variables such as sex.

## **2.7 Thesis overview**

### **2.7.1 Hypothesis**

Circulating blood lipid levels, and by extension treatments that modify blood lipid levels such as statins, affect the subsequent risk of dementia and related outcomes.

### **2.7.2 Aims and objectives**

The specific research objectives that this thesis seeks to address are:

- To create a tool that allows for the inclusion of health related preprints in evidence syntheses in a systematic and reproducible manner
- To review all available evidence across multiple diverse study designs to assess the effect of lipids and lipid regulating agents on dementia risk

- To examine whether there is evidence for an effect of lipid-regulating agents on dementia and related outcomes in a large scale population-based cohort, the Clinical Practice Research Datalink (CPRD)
- To meta-analyse raw dementia-related datasets as part of a individual participant data (IPD meta-analysis) to produce evidence on exposure-covariate interactions

### 2.7.3 Structure

Chapters are self-contained, presenting the methods and results of that specific research project. They are bookended by introductory and discussion sections which place the methods and results in context. Each chapter is prefaced by a “Lay” or plain English summary, developed with input from the Patient and Public Advisory Group (see Section 7.8 for a discussion of the group’s involvement and Appendix A.1.2 for more detail on the group).

- **Chapter 2:** Background information on dementia and blood lipid levels. This chapter provides an introduction to the topics covered in this thesis to non-subject area experts, and discusses the motivation for the remainder of the thesis.
- **Chapter 3:** This Chapter introduces a new tool, `medrxivr`, which was used to developed to allow for systematic searches of the health-related preprint repositories.
- **Chapter 4:** This Chapter describes a comprehensive systematic review and meta-analysis of all available evidence on the effect of blood lipids, and interventions that modified blood lipids, on dementia outcomes.
- **Chapter 5:** This Chapter examines the relationship between lipid-regulating agent use and dementia outcomes in the Clinical Practice Research Datalink, a large primary care electronic health record database.

- **Chapter 6:** This Chapter describes an individual patient data analysis of several longitudinal cohort studies to describe the relationship between blood serum lipids and dementia outcomes, stratified by important covariates such as sex.
- **Chapter 7:** This Chapter integrates the diverse evidence identified by, and produced as part of, this thesis. The overall strengths and weaknesses of this project are discussed in detail, and further avenues of research are suggested.

An overview of how all research studies in this thesis can be found in Table 2.4

**Table 2.4:** Summary of studies included in this thesis, and used as evidence sources in the triangulation exercise performed in Chapter 7. Note, Chapter 3 is intentionally not included in this table, as it describes a tool rather than a research study.

Chapter	Research Question	Exposure/ Intervention	Outcome	Contribution to evidence synthesis framework
Chapter 3	Based on the available evidence; (i) are lipid fractions associated with subsequent dementia risk, stratified by subtype? (ii) Are lipid regulating agents associated with subsequent dementia risk, stratified by subtype?	Lipids (HDL-c, LDL-c, TC, TG),  Lipid regulating agents (statins, ezetimibe, fibrates, etc.)	Dementia, stratified by subtype	Provides overview of existing evidence
Chapter 4	Are lipid regulating agents associated with dementia risk in a large scale electronic health record database?	Seven classes of lipid regulating agents	Dementia, stratified by subtype	Provides additional observational data on vascular dementia (under-represented in the literature)  Provides a source of observational evidence created using a method with distinct sources of bias to those identified by the systematic review
Chapter 5	Are lipid levels associated with dementia risk in an individual participant data meta-analysis?	Lipids (HDL-c, LDL-c, TC, TG)	Dementia, stratified by subtype	Provides additional evidence from unanalysed datasets  Allows for stratification of effect by variables of interest (e.g. sex)

## 2.8 Outputs from this thesis

The outputs of this thesis are detailed below, and include peer-reviewed papers, presentations, and open-source evidence synthesis tools.

### 2.8.1 Contributions to the scientific literature

During the course of this thesis, I have made several contributions to the scientific literature. Those arising from or directly related to the contents of this submission are presented below.

**McGuinness, L. A., and L Schmidt.** (2020) *medrxivr: Accessing and searching medRxiv and bioRxiv preprint data in R.* *Journal of Open Source Software* 5.54 2651. DOI: 10.21105/joss.02651

A paper introducing the open-source preprint search tool described in Chapter 3. As is common for journal articles describing software, the paper is intentionally short providing only a broad overview of the tool while extensive documentation is available from the project website (see 3.2 for more details).

*Hennessey, E. A., Acabchuk, R., Arnold, P. A., Dunn, A. G., Foo, Y. Z., Johnson, B. T., Geange, S. R., Haddaway, N. R., Nakagawa, S., Mapanga, W., Mengersen, K., Page, M., Sánchez-Tójar, A. Welch, V., **McGuinness L. A.** (2020). *Ensuring Prevention Science Research is Synthesis-Ready for Immediate and Lasting Scientific Impact.* *MetaArXiv*. DOI: 10.31222/osf.io/ptg9j*

The experience of extracting data for the systematic review in Chapter 4 inspired a practical guide for researchers. This piece was co-written with Dr. Emily Hennessey (see Author Declarations in the front materials). [Under 2nd round of review at Prevention Science]

**McGuinness, L. A., and Higgins J. P. T. (2020)** “Risk-of-bias VISualization (robvis): An R package and Shiny web app for visualizing risk-of-bias assessments.” *Research Synthesis Method*. DOI: 10.1002/jrsm.1411

The tool used to visualise the risk-of-bias assessments in Chapter 4 has been published in Research Synthesis Methods. See Appendix B.2 for more details on this tool.

**McGuinness, L. A., and Sheppard A. L. 2020.** “A Descriptive Analysis of the Data Availability Statements Accompanying Medrxiv Preprints and a Comparison with Their Published Counterparts.” *MetaArXiv*. DOI: 10.31222/osf.io/p75xe

Using the tool described in Chapter ??, I lead a “research-on-research” study to assess the concordance between the data availability statements accompanying a sample of medRxiv preprints and their published counterparts. [Accepted to PLOS One - need to update the citation]

For information on additional contributions to the scientific literature not directly related to this thesis, see Appendix A.1.1.

## 2.8.2 Presentations/Talks

“Identifying and triangulating all available evidence on the effect of blood lipids and statins on dementia outcomes”: Accepted poster abstract, Alzheimer’s Association International Conference 2021.

“medrxivr: A new tool for searching for and retrieving records and PDFs from the medRxiv preprint repository”: Accepted oral presentation abstract, Cochrane Colloquium 2020 (note: event was cancelled due to the COVID-19 pandemic)

*“On the shoulders of giants”: advantages and challenges to building on established evidence synthesis packages, using the {robvis} package as a case study”*: Oral presentation, Evidence Synthesis and Meta-Analysis in R Conference (ESMARConf) 2021.

*“RoB 2.0: A revised tool to assess risk of bias in randomized trials”*: Webinar, co-presented with Dr. Theresa Moore as part of the Evidence Synthesis Ireland Methods Series.

### 2.8.3 Software

#### **medrxvir**

An R package that allows users to easily search and retrieve bibliographic data from the medRxiv<sup>110</sup> and bioRxiv<sup>111</sup> preprint repositories. See Chapter 3 for more details. Install a stable version of the package from the Comprehensive R Archive Network (CRAN), or alternatively install the development version from GitHub, using:

```
# CRAN version
install.packages("medrxivr")

# Development version
devtools::install_github("ropensci/medrxivr")
```

#### **robvis**

An R package and associated shiny web application that allows users to easily visualize the results of the risk-of-bias assessments performed as part of a systematic review. See Appendix B.2 for more details. Install a stable version of the package from CRAN, or alternatively install the development version from GitHub, using:

```
# CRAN version
install.packages("robvis")
```

```
# Development version  
devtools::install_github("mcguinlu/robvis")
```

## 2.9 Summary

This Chapter has provided background information on the core elements of the central research question, framed the research presented in this thesis in the context of an evidence synthesis framework, and described the contributions of this thesis to the scientific literature.



## **2.10   References**



# 3

## medrxivr: an R package for systematically searching biomedical preprints

### Contents

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### 3.1 Lay summary

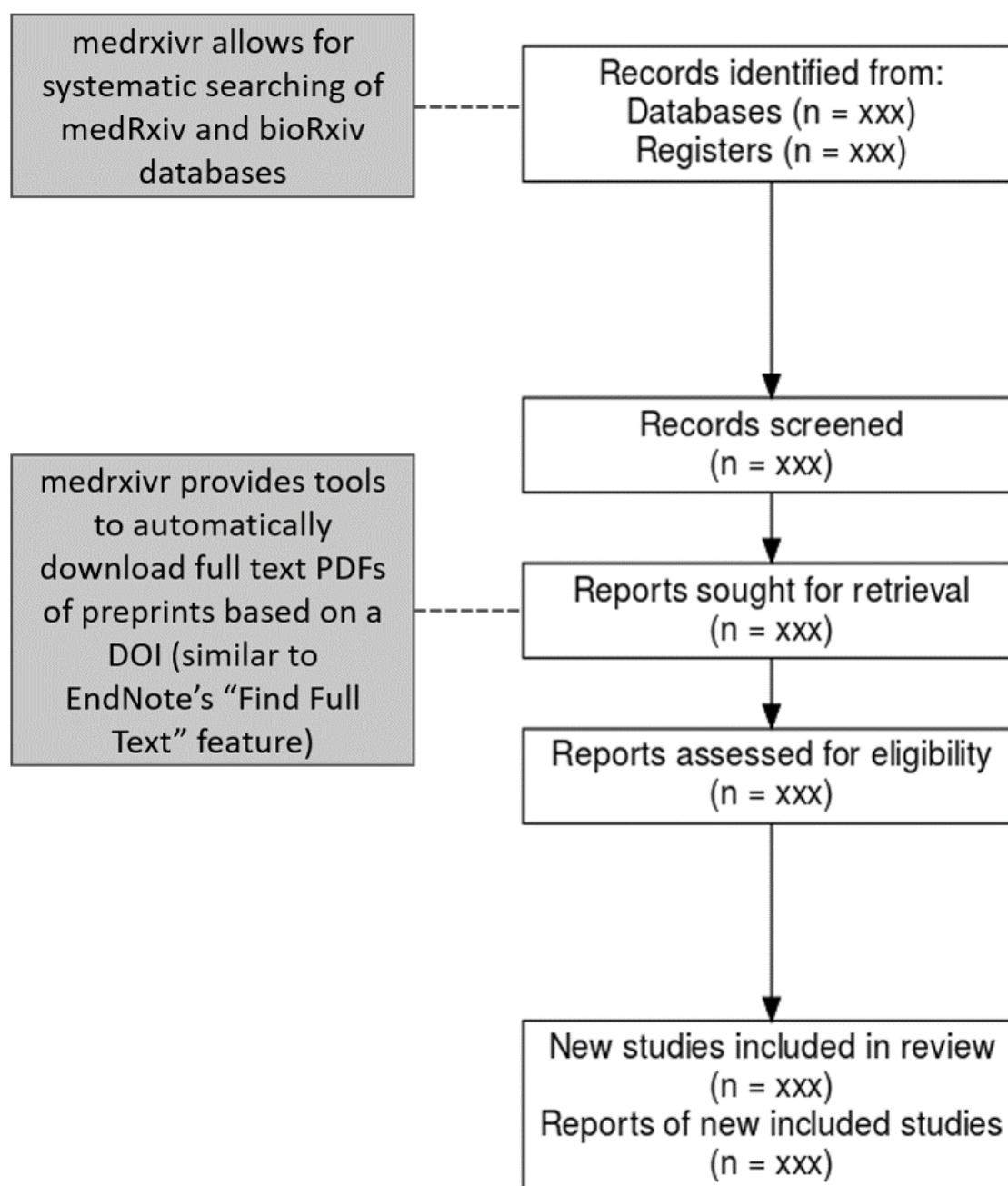
Preprints are copies of academic manuscripts that are posted online in advance of being formally published by an academic journal. They represent an important source of scientific literature. A new software program called **medrxivr** was created to allow researchers to find preprints related to their research in a transparent and reproducible way. Development of this tool was an essential part of this thesis, as preprints represent a key source of information needed for the research reported in future chapters.

## 3.2 Introduction

Preprints represent an increasingly important source of scientific information (see Section 2.6.1). As a result, repositories of preprinted articles should be considered a distinct but complementary information source when reviewing the evidence base as part of a systematic review. The two key repositories in the health science are bioRxiv, established in 2013,<sup>111</sup> and medRxiv, which evolved to replace the “Epidemiology” and “Clinical Trial” categories of bioRxiv, which launched in 2019.<sup>110</sup>

Searching these preprints as part of the systematic review described in Chapter 4 was a necessity, as many of the existing reviews on the topic of lipids and dementia have not considered this important source of grey literature. At the time of writing, however, the bioRxiv and medRxiv websites allow only simple search queries as opposed to the often complex Boolean logic (AND/OR/NOT) that information specialists use to query other major databases.<sup>113,114</sup> Additionally, the best available extraction mechanism for obtaining references for all records returned by a search were to go through each record, one-by-one, downloading individual citations. As the scale of these preprint databases increase, particularly in light of the massive expansion of the medRxiv repository as a result of COVID, this already time-consuming and error-prone method is no longer feasible.

This chapter outlines the development and key functionality of `medrxivr` (version 0.0.5), a tool created to facilitate the searching of medRxiv and bioRxiv preprints. The factors that necessitated the development of this tool in the context of this thesis are outlined, and the use of `medrxivr` in external projects and by other researchers is discussed. As the majority of work on this aspect of this thesis is represented by lines of code (available at <https://github.com/ropensci/medrxivr>) this Chapter is an intentionally short, high-level summary of the work done on this project. The GitHub repository for the `medrxivr` contains a complete record of the development of this tool, including discussion with other members of the systematic review community.



**Figure 3.1: Role of medrxivr in a systematic review workflow:** medrxivr allows for systematic searching of biomedical preprints as part of the initial literature searching. Following title and abstract screening, reviewers can then programmatically retrieve a copy of the PDF of included records to facilitate the full-text screening stage (similar to Endnote's "Find Full Text" feature).

## 3.3 Development

### 3.3.1 Success criteria

The tool was developed to meet three success criteria,<sup>115</sup> influenced both by the functionality required to perform systematic searches as part of the review in Chapter 4, discussion with information specialist colleagues, and an informal survey of the evidence synthesis and health librarian communities on Twitter. The criteria were as follows:

1. reliable, reproducible and transparent search functionality, allowing for Boolean (AND/OR/NOT) operator logic;
2. support for bulk export of references returned by the search to a file type that can be readily imported into a reference manager (e.g., *.bib* or *.ris*); and
3. automated retrieval of the full-text PDFs of relevant records, similar to the Find Full Text feature offered by EndNote.

### 3.3.2 Alternative medRxiv/bioRxiv interfaces

Prior development of this tool, an audit of existing tools for accessing medRxiv and bioRxiv metadata was conducted. While none address the success criteria described above, two of these tools are useful to consider to highlight the additional functionality that `medrxivr` contributes.

The first, a platform called Rxivist,<sup>116</sup> allows users to search preprints using keywords. However, the core functionality of the Rxivist platform is focused around exploring the number of times a preprint has been downloaded and/or shared on Twitter, to allow researchers to find the most popular papers related to their topic. The search

interface<sup>1</sup> does not allow for complex search strategies using Boolean operators and there is no option to batch-export the results of a search.

The second tool, **search.bioPreprint**, allows users to search for terms across a range of preprint servers, including medRxiv and bioRxiv, but also journals which use a post-publication peer-review process such as F1000Research.<sup>117</sup> However, similar to the Rxivist platform, this tool is designed for researchers aiming to keep up to date with recent developments in their fields rather than systematically assess the entirety of the available literature. As such, the platform only returns the most recent 1,000 records by publication date.

Finally, neither tool provides an easy way to programmatically download a copy of the PDF of relevant preprints as part of the preparation for the full-text screening stage of a systematic review.

### 3.3.3 Early versions

Work on the **medrxivr** tool began in Summer 2019, and initially consisted of a development of set of R scripts to allow for searching medRxiv and bioRxiv as part of the systematic search outlined in Chapter 4. Following interest from other researchers in using the *ad-hoc* web-scraping scripts, additional development work took place in 2019/2020, allowing for improved searching and exporting functionality and the initial version of the **medrxivr** R package was released in February 2020.

Early versions of the tool had a reliance on scraping data directly from the repository website. Web-scraping is a fragile mechanism for extracting data, as it is entirely dependent on consistent website design and underlying code structure remaining unchanged.<sup>118,119</sup> In the case of **medrxivr**, constant maintenance work was required to ensure the web-scraping script performed as expected, as the repository website was regularly updated.

---

<sup>1</sup>Available at <https://rxivist.org/>

However, an Application Programming Interface (API) for the medRxiv and bioRxiv repositories was made public in early 2020 by the institution responsible for managing these preprint repositories, the Cold Springs Harbor Laboratory. This allowed for newer versions of the `medrxivr` package to engage in active “fault prevention” and provide a more robust interface to the data by removing the reliance of web-scraping.<sup>119</sup>

### 3.3.4 Package infrastructure

The `medrxivr` package was written in R using RStudio,<sup>120</sup> and followed development best-practice, including detailed documentation, a robust unit testing framework (99% of all code lines within the package are formally tested across multiple platforms including Windows, MacOS, and Linux), and in-depth code review by two experienced, independent reviewers.

## 3.4 Usage

The `medrxivr` R package is split into two component parts:

- an interface to the Cold Springs Harbor Laboratory API, which imports medRxiv and bioRxiv metadata into R; and
- a collection of functions for working with the imported metadata, with an explicit focus on searching this data as part of a systematic review or evidence synthesis project.

The standard workflow is to download a copy of all metadata contained in the repository, and then to perform searches on this local copy. This is a workaround as the Cold Springs Harbor Laboratory API does not provide any functionality to search the database.



While the package allows for users to search both medRxiv and bioRxiv, as the process is identical for both, the examples in the sections are limited to the medRxiv repository.

### 3.4.1 Installation

`medrxivr` has been released to the Comprehensive R Archive Network (CRAN), and can be installed with the following code:

```
install.packages("medrxivr")
```

Alternatively, the development version of the package can be installed from GitHub:

```
# install.packages("devtools")  
devtools::install_github("ropensci/medrxivr")
```

### 3.4.2 Importing preprint metadata

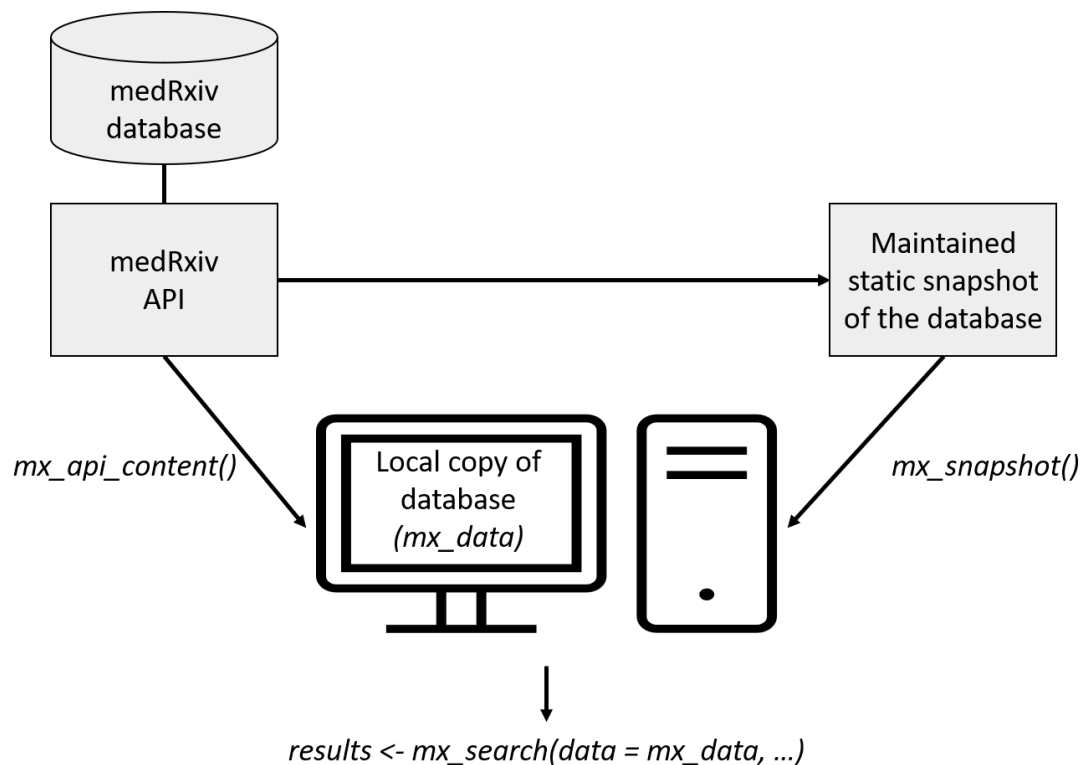
`medrxivr` provides two ways to access medRxiv data, as shown in Figure 3.2. The first, via the `mx_api_content()` function, creates a local copy of all data available from the medRxiv API at the time the function is run.

```
# Get a copy of the database from the live medRxiv API endpoint  
mx_data <- mx_api_content()
```

The second, via the `mx_snapshot()` function, provides access to a maintained static snapshot of the database, created each morning at 6am using `mx_api_content()`.

```
# Import a copy of the medRxiv data from the snapshot
mx_data <- mx_snapshot()
```

Allowing users of `medrxivr` to access a maintained snapshot removes any dependency on the API, which can become unavailable during peak usage times. The relationship between the two methods for accessing the data contained in the medRxiv database is summarized in Figure 3.2.



**Figure 3.2: Overview of medrxivr data sources:** Users can either access the API directly via `mx_api_content()`, or can import a maintained snapshot of the database, taken each morning at 6am, via the `mx_snapshot()` function. Note: due to the size of bioRxiv, only a maintained snapshot of the medRxiv repository is available via `mx_snapshot()`.

### 3.4.3 Performing a search

Once a local copy of the metadata is created, the first step in searching it is to create a search strategy. Search terms to be combined with the OR operator are contained in vectors (`c(...)`), while topics to be combined with the AND operator are contained in lists (`list(...)`).

```
# Create the search query
topic1 <- c("dementia","alzheimer's") # Combined with OR
topic2 <- c("lipids","statins")         # Combined with OR

myquery <- list(topic1, topic2)          # Combined with AND
```

For example, when written in standard syntax, the search contained in the `myquery` object above would be: “((dementia **OR** alzheimer’s) **AND** (lipids **OR** statins))”. There is no limit to the number of search terms that can be included in each topic, nor in the number of topics that can be search for. Search terms can also contain common syntax used by systematic reviewers and health librarians, including the use of NEAR statements which allows for identification of co-localised terms, and wild-cards, which allow for alternate spellings, e.g. “randomisation” vs “randomization”. Once a strategy has been defined, it is passed along with the local copy of the database to the `mx_search()` function.

```
# Run the search
results <- mx_search(mx_data,
                     myquery)
```

### 3.4.4 Refining your search

An important argument of the `mx_search()` is `report`, which outputs a structured table with each search strategy presented on an individual line and the number of records associated with this strategy. [CITATION NEEDED - PRISMA-S]

```
results <- mx_search(mx_data,
                     myquery, # Combined with OR
                     report = TRUE)
```

```
## Found 1 record(s) matching your search.
##
## Total topic 1 records: 224
## dementia: 224
## alzheimer's: 0
##
## Total topic 2 records: 119
## lipids: 90
## statins: 33
```

This allows users to discover which terms in their search are contributing most to the total number of results returned. This is important as part of developing a search strategy,<sup>121</sup> as it allows for the key terms related to each topic to be discovered. It also aids in identifying misspelled or case-sensitive search terms, which will frequently return no results. As an example, in the search presented above, the term “alzheimer’s” returns no records. This is expected, as “Alzheimer” is a proper noun and so should be capitalised, but serves to illustrate the usefulness of the reporting function.

### 3.4.5 Exporting to a bibliography file

In line with the second success criteria (Section 3.3.1), one of the key features of the `medrxivr` is the ability for users to easily export the results of their systematic search to a reference manager. While it is a seemingly simple request, this is one of the key ways in which `medrxivr` is set apart from other preprint search tools, including the native medRxiv/bioRxiv website search functionality.

For example, the results of our simple search above can be exported to the "medrxivr\_export.bib" file using the following code:

```
mx_export(results,
          file = "medrxivr_export.bib",
          report = TRUE)
```

### 3.4.6 Downloading the PDFs of relevant records

`medrxivr` also allows users to download the full text papers for records that are deemed eligible for full-text screening (see Figure 3.1). `mx_download()` takes the list of included records and saves the PDF for each to a folder specified by the user. This functionality is similar to the “Find Full Text” feature offered by EndNote.

```
mx_download(results, # Search results, less excluded records
            "pdf/")  # Directory to save PDFs to
```

## 3.5 Discussion

### 3.5.1 Reception and future plans

The tool has been well received by the community (as of December 2021, `medrxivr` has been downloaded more than 3100 times), and several use cases have been

reported. It has been used to investigate the role of preprints in the response to the 2019 coronavirus outbreak,<sup>122</sup> perform searches of preprints as part of a systematic review,<sup>123,124</sup> and examine how data-sharing behaviour is affected by journal policies (see 2.8).<sup>125</sup>

The package was been onboarded into the rOpenSci suite of packages, a collection of “carefully vetted, staff- and community-contributed R software tools that lower barriers to working with scientific data sources on the web”.<sup>126</sup> As part of this process, following rigorous peer-review, an associated article introducing the tool was published by the Journal of Open Source Software.<sup>127</sup> The entire review discussion is publicly available and can be viewed online.<sup>2</sup> The tool has also been well received by the open-source community, demonstrated by the engagement of other developers in contributing to important new functionality and suggesting bug-fixes.

Lobbying of the Cold Springs Harbor Laboratory to develop the API to allow for direct searching of the database has been ongoing. This would negate the current need to download a local copy of the relevant preprint database before searching it, which is currently the rate limiting step for performing searches. For example, as of January 2021, downloading a copy of the bioRxiv database takes approximately an hour.

### 3.5.2 Limitations of medrxivr

While searching of the medRxiv and bioRxiv databases was crucial for the systematic review element of this thesis presented in Chapter 4, there are some important limitations to note here. A key example is that the tool only searches the available metadata of preprint records (the title, abstract and keywords), rather than the full text of preprints, meaning some relevant records might be missed. However, this approach echoes that used by other search platforms such as OvidSP, and while some relevant records may be missed (reduced sensitivity), limiting the search to the

---

<sup>2</sup><https://github.com/ropensci/software-review/issues/380>

metadata fields prevents non-relevant records from being returned (high specificity). A key example of the reduced specificity when searching the full text, identified during development of `medrxivr`, is that a search for “dementia” would return a record where the only occurrence of this term is in the title of one of the references.<sup>128</sup>

There is also the potential that the cross-section of literature posted on medrxiv/bioRxiv is substantially different from the true grey literature (studies or analyses that are not published for a range of reasons including results that are not deemed “novel” or are not statistically significant).<sup>129</sup> This is because simply lowering the barriers to publication may well encourage authors to published “null” results, but due to the effort involved in writing up a distributable manuscript, it is unlikely to completely address the “file drawer” effect.<sup>82</sup> It is likely too early (and likely too methodologically difficult) to tell whether the increased popularity and acceptance of preprint repositories will have any effect of the availability of research that was not considered “publishable” at other venues.

### 3.5.3 Role of open source tools in evidence synthesis

Part of the motivation for creating the `medrxivr` tool was a belief that the development and distribution of open source scripts and tools should be a fundamental part of evidence synthesis research.<sup>130,131</sup> In the case of `medrxivr`, it is likely that several other evidence synthesists had written personal scripts that have a similar, or related, functionality - in fact, following development of the tool, I identified one other researcher that has done so (Nicholas Fraser, author of the `rbiorxiv` package, which allows for importing medRxiv metadata into R but does not provide search functionality).<sup>132</sup> If these scripts continue to be developed in private and are never shared or publicised, this will inevitably harm to the evidence synthesis community, not only in terms of duplication of time and effort but also due to lost opportunities for collaboration.<sup>131</sup> Creating and sharing well-documented packages, the recognised standard for sharing code in R, represents one way to reduce this inefficiency.<sup>133</sup>

## 3.6 Summary

- In this Chapter, I have introduced a new tool, **medrxivr**, for performing complex systematic searches of the medRxiv and bioRxiv preprint repositories.
- I have outlined the motivation for developing this tool in relation to this thesis - more specifically, that it was used to perform systematic and reproducible searches of a key literature sources used in the comprehensive systematic review described in Chapter 4.
- I have contrasted **medrxivr** with other available interfaces to medRxiv/bioRxiv data to highlight the added functionality it offers. I have also discussed the tools reception to date, its limitations, and the important role of open-source tools like **medrxivr** in evidence synthesis.



## **3.7 References**



*“It is surely a great criticism of our profession that we have not organised a critical summary by speciality or sub-speciality, up-dated periodically, of all relevant RCTS.”*

— Archie Cochrane, 2000<sup>134</sup>

# 4

## Systematic review of all available evidence

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### 4.1 To Do

- Examine how many times a primary study was included in a review
- Look at whether searching preprints made any difference to my results
- Could apply ROBIS to previous reviews to see how they stack-up?

## 4.2 Extra studies to include:

- Smeet et al. reference in the CPRD analysis
- Larsson - 10.1136/bmj.j5375<sup>135</sup>

## 4.3 Lay summary

## 4.4 Additional ideas

- Evidence map - show the distribution of the different studies population across the world.
- Living systematic review approach - update weekly based on medRxiv

## 4.5 Aims

The aim of this chapter is to systematically review all available literature on the association between blood levels of total cholesterol and it's constituent parts (HDL-c, LDL-c and triglycerides) on the subsequent risk of dementia.

Based on the review of prev, no previous

Literature con

## 4.6 Methods

### 4.6.1 Search strategy

We will systematically search electronic bibliographic databases to identify potentially relevant records. The search strategy used in each database will be developed in an iterative manner using a combination of free text and controlled vocabulary (MeSH/EMTREE) terms to identify studies which have examined the relationship between blood lipids levels and dementia, incorporating input from an information specialist. The strategy will include terms related to lipids, lipid

modifying treatments, and dementia and its sub-types, and will be designed for MEDLINE before being adapted for use in the other bibliography databases listed. An outline of the general strategy is presented in the Table 3.2 below and the full draft search strategies for each database are attached to this protocol. To ensure that the study design filters are not excluding potentially relevant records, a random sample of 500 records identified by the main search but excluded by the filters (defined as Line 7 NOT Line 13 in Table 3.2) will be screened. If any potentially relevant studies are identified, their titles and abstracts will be searched for key terms that can be incorporated into the filters to improve search sensitivity.

The following databases will be searched from inception onwards: Medline, EMBASE, Psycinfo, Cochrane Central Register of Controlled Trials (CENTRAL), and Web of Science Core Collection. We will also search clinical trial registries, for example ClinicalTrials.gov, to identify relevant randomized controlled trials.

The abstracts list of relevant conferences (e.g. the proceedings of the Alzheimer's Association International Conference, published in the journal *Alzheimer's & Dementia*) will be searched. Grey literature will also be searched via ProQuest, OpenGrey and Web of Science Conference Proceedings Citation Index, while theses will be accessed using the Open Access Theses and Dissertations portal. We will also search bioRxiv and medRxiv, preprint repositories using a tool built as part of this thesis, to identify potentially relevant studies. Finally, the reference lists of included studies will be searched by hand while studies citing included studies will be examined using Google Scholar (forward and reverse citation searching).

The full search strategy for the Medline search, which was designed first and subsequently translated into the syntax for other databases is presented in Appendix A.2.1.

### 4.6.2 Study selection

Records will be imported into Endnote and deduplicated using the method outlined in Bramer et al. (2016).<sup>136</sup> Screening (both title/abstract and full-text) will be performed using a combination of Endnote and Rayyan, a web based screening

application.<sup>137</sup> Title and abstract screening to remove obviously irrelevant records will be performed by the primary author, with a random selection of excluded records being screened in duplicate to ensure consistency with the inclusion criteria. If this demonstrates a significant level of erroneous exclusion by the primary author a larger proportion will be dual-screened. Full-text screening will also be completed in full by the primary author. A second reviewer will screen a random sample of included and excluded records, in addition to any records identified by the first reviewer as being difficult to assess against the inclusion criteria. Reasons for exclusion at this stage will be recorded. Disagreements occurring during either stage of the screening process will be resolved through discussion with a senior colleague. A PRIMSA flow diagram will be produced to document how records moved through the review.<sup>138</sup>

### **Inclusion criteria**

We will seek studies that examine the relationship between blood lipid levels (or any specific lipid fraction, including total cholesterol, HDL, LDL, and triglycerides) and risk of incident dementia/MCI. Eligible study designs include randomized controlled trials and non-randomized observational studies of lipid modifying treatments, longitudinal studies examining the effect of increased/decreased blood lipid levels, and genetic instrumental variable (Mendelian randomization) studies examining the effect of genetically increased/decreased blood lipid levels.

Participants will be free (or assumed to be free) of dementia/MCI at baseline. Studies of any duration will be included to allow for exploration of the effect of length of follow-up on the effect estimate using meta-regression. No limits will be placed on the sample size of included studies.

Eligible studies will define dementia according to recognised criteria, for example the National Institute of Neurological Disorders and Stroke Association-Internationale pour la Recherche en l'Enseignement en Neurosciences (NINDS-AIREN), International Classification of Diseases (ICD), or Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria. For MCI, eligible studies are those that

attempted state a definition for diagnoses of MCI (e.g. an adapted version of the Petersen criteria)<sup>139</sup> and create ordinal groups of patients (e.g. no dementia or dementia/MCI/dementia) based on this definition.

No limitations will be imposed on publication status, publication date, venue or language, although we will require sufficiently detailed reports of the studies to be able to examine their methods. Preprints and unpublished reports will be eligible for inclusion if relevant. Multiple publications resulting from the analysis of the same data will be included and grouped.

### **Exclusion criteria**

Case-control studies, cross-sectional studies, qualitative studies, case reports/series and narrative reviews will be excluded. Studies which present no evidence of attempting to exclude prevalent cases from their analyses will also be excluded. Studies that measure change in continuous cognitive measures (e.g. MoCA score) without attempt to map these scores to ordinal groups (e.g. no dementia/MCI/dementia) will be excluded. Conference abstracts with no corresponding full-text publication will be examined, and we will contact authors to obtain information on the study's status. Studies that are reported in insufficient detail (e.g. only in conference abstracts, new, letters, editorials and opinion) will be excluded. Previous systematic reviews will not be eligible, but their reference lists will be screened to identify any potentially relevant articles. Studies with outcomes not directly related to the clinical syndrome of dementia (e.g., neuroimaging), studies implementing a “multi-domain intervention” where the lipid-regulating agent is included in each arms (e.g. for example, a study examining exercise + statins vs statins alone, but a study examining exercise + statins vs exercise alone would be included), and studies where there was no screening for dementia at baseline except if the sample was initially assessed in mid-life (i.e. below the age of 50) will be excluded.

Excluded studies performing autopsy unless it was done under accepted criteria  
Exclude studies using a dietary intervention, for example omega-3 fatty acid enriched

diet, as it hard to disentangle the effect of other elements contained within te diet, vs simple tablet based supplements of

### 4.6.3 Data extraction

Harmonization of cholesterol measures across studies was performed, as different studies used different methods to quantify exposure, including comparing differing risks in the highest vs lowest quartiles of a lipid, using a binary classification of patients into a hypercholesterolaemia or not, categorizing lipid levels into high, middle, and low groups according to study-defined criteria, and simply treating the exposure as a continuous variable.

### 4.6.4 Risk of bias assessment

Risk of bias assessment was performed using the domain-based risk-of-bias assessment tool appropriate to the study design. Randomized controlled trials were assessed using the RoB2 tool,<sup>140</sup> non-randomized studies of interventions were assessed using the ROBINS-I tool,<sup>141</sup> and non-randomized studies of exposures were assessed using the ROBINS-E tool.[CITE]

I opted to use the ROBINS-E tool, despite it still being in development,<sup>142</sup> in place of other existing published tools such as the Newcastle-Ottawa scale (NOS).<sup>143</sup> There are two primary reasons for this: firstly, current thinking in assessing internal validity has moved away from scales.

Secondly, using a domain based to assess the risk of bias in studies of exposure allowed for better comparison and consistency across the tool used for different study designs, as they are all domain based.

At present, no risk of bias assessment tool for Mendelian randomization studies is available. Bias in these studies was assessed with the help of an expert panel drawn from my supervisors and other external invited researchers.[CITE] The risk of bias in Mendelian randomisation studies was informed by the approach used in a



previous systematic review of Mendelian randomisation, as identified by a review of risk of bias assessments in systematic reviews of MR studies.<sup>144</sup> A copy of the is available in Appendix A.2.3. Advance results from this review of bias assessment in MR studies were obtained from contact with the authors.

Results from the risk-of-bias assessment will be visualized using a paired forest/risk-of-bias blobbogram, created using the `robvis` tool. This tool was developed as an adjunct to this thesis to aid in creating standard risk-of-bias figures.<sup>145</sup> A summary of the tool is provided in Appendix B.2.

Many reviews use reporting guidelines instead - this is bad!<sup>146</sup>

#### 4.6.5 Patient and public involvement

### 4.7 Results

#### 4.7.1 Previous reviews

**Will need to include something in the methods section on this**

As part of this analysis, we examined the overlap between different published reviews on this topic.

Several primary studies were captured in multiple systematic reviews. However, some studies were not captured by any previous review,

Put upSet plot here.

An upset plot shows the total size of each set (in this case, the set of included studies in each review) in the bottom left hand bar plot. For example, the XXXX review includes XXXX studies.

Where a line joins two points in the matrix, the main barchart shows the number of records shared by these reviews. So for example, XXXX records were captured both by the XXXX review and the XXXX review.

Where the matrix has just a single point highlighted, this shows the records unique to that review.

The reviews are ordered by date, to attempt to show the increasing overlap and total number of studies

Our review is presented as the last point on this plot, and captured XXXX records

The alternative is to have a barplot showing the total cumulative number of records over the years, using our set as the master, with the bars coloured by the number of records included in 1/2/3/4 reviews. The information below the bar axis could then show the number of reviews published in that year, or alternative, you could have an upsidedown bar to show cumulative number of reviews on this topic.

Of note, this review did not include the commonly cited PROSPER study, which examined the effect of pravastatin on CVD risk and putatively provides no evidence for an effect of the statin on dementia outcomes. While widely cited and included in the Cochrane review on this topic, it has not been included here, for the reason that it only reported the change from cognitive score (as measured using the [CHECK] scale) over a mean follow-up. While this is a useful indicator of general cognitive decline, it is not equivalent to a dementia outcome, as cognitive scales should feed into a broader diagnostic pathway - See section 2.3.2

This does introduce some conflicts with other studies where a change score has been dichotomised in order to have a binary dementia or not dementia outcome.

Does it also cause issues in terms of self-report?

## 4.7.2 Screening results

Following screening, XXX studies were included.

The distribution of included studies over time demonstrates that despite the conduct of several previous reviews of different types of literature surrounding this question, primary studies continue to be published as these reviews have yet to provide a definite answer.

Table ?? shows the characteristics [Include column here that says whether it was included in a systematic review - see below]

As part of our forward snowballing exercise (where articles citing an included study are cited), we recorded whether a study included in our review had been included in any previous evidence synthesis attempt in an attempt to qualify the added value of this analysis. Additionally, if an included article was subsequently cited by a review, all studies in that review were screened for inclusion for the sake of completeness. This analysis was performed by extracting the citing articles from Google Scholar on [DATE] and screening them manually. The DOI of articles extracted from this analysis are included in the appendix, as the Google Scholar search functionality is not readily reproducible.\*

As a summary of the duplication of work in this area, we looked at how many reviews a single included study had previously been included in.

Inter- and intra-rater reliability was assessed for a 10% sub-sample of records at the title and abstract screening stage. Intra-rater reliability involved a single reviewer applying the inclusion criteria to the same set of records while blinded to their previous decisions, while inter-rater reliability involved two reviewers independently screening the same set of records.

Rater reliability was assessed using Gwet's agreement coefficient (AC1).<sup>147</sup> This measure of inter-rater reliability was chosen over other methods of assessing inter-rater reliability such as percent agreement (number of agreements divided by total number of assessments) as it accounts for chance agreement between reviewers but does not suffer from severely imbalanced marginal totals in the same way that Cohen's kappa value does.<sup>147</sup>

How to interpret agreement co-efficients is widely debated. Here we use guidelines based on a stricter interpretation of the Cohen's Kappa coefficient,<sup>150</sup> presented in Table 4.1.

**Table 4.1:** Agreement for kappa

Kappa	Interpretation
0 – 0.20	None
0.21 – 0.39	Minimal
0.40 – 0.59	Weak
0.60 – 0.79	Moderate
0.80 – 0.90	Strong
> 0.90	Almost perfect

In a two-by-two table with cells A, B, C and D, Gwet's AC1 is calculated using the following:

$$AC1 = \frac{\frac{A+D}{N} - e(\gamma)}{1 - e(\gamma)}$$

where  $e(\gamma)$  is the chance agreement between raters, given as  $2q(1 - q)$ , where

$$q = \frac{(A + C) + (A + B)}{2N}$$

-> Insert formula here. Need to be sure of how to calculate.<sup>147,151</sup>

For the inter-rater reliability, percentage agreement was 97.3% (AC1 = XXXX, Table ??), while for the intra-rater reliability, agreement was 98.6% (AC1 = XXXX, Table ??).

The discrepancy between the percent agreement and the associated value of AC is expected, due to the heavy imbalance in this sample towards exclusion.<sup>152</sup>

Those records which were excluded in the initial screening, but were included either by the same reviewer on their second viewing (n=4), or by the second reviewer (n=29), were investigated. This discrepancy between the two reviewers was explained in all cases by differing interpretations of the inclusion criteria, specifically around the definition of cognitive decline versus mild cognitive impairment, and the definition of eligible lipids fractions.

**Figure 4.1: PRISMA Flowchart:** Overview of how records moved through the systematic review process

#####

Following de-duplication, the titles and abstracts of 16109 records were assessed for eligibility. 387 were deemed potentially eligible and the full text records for these were requested and screened. 4.1

### 4.7.3 Characteristics of included studies

XXXX studies met the criteria for inclusion in the review.

Include here:

- PRISMA Flowchart (use PRISMA2020 from GitHub - depending on level of involvement, could refer to the Appendix here too.)
- Summary of types of study
- Summary of locations
- Summary of diagnostic criteria used
- Summary of risk of bias
- Long table, horizontally. Newer version of flextable (GH) allows for PDF output

A common theme across the studies was a lack of data on vascular dementia. This is particularly interesting as lipids and statins are primarily a vascular disease. There is the potential that they studies encountered similar difficulties in address the unexpected results observed in the CPRD analysis in Chapter 5. For vascular dementia, few studies examined this outcome, primarily because of the absence (until recently) of

One item of particular interest in the absence of studies examining Mendelian randomisation studies is the absence of any effect following the adjustment for ApoE4. As covered in the discussion, ApoE4 genotype is the major risk factor for Alzheimer's disease.

In addition, there was quite a spread in terms of the effect estimates used to the. Previous systematic review

#### 4.7.4 Converting risk ratios to odds ratios

Include formulae and informed assumptions

### 4.7.5 Hazard ratios vs risk/odds ratios

Not interchangeable in the context of systematic review. If outcome is rare, odds and risk ratios approximate each other, but the hazard ratio is measuring something completely different, by taking into account time-to-event in each treatment group.

Several existing reviews do not distinguish between the two types of effect measures and include all existing studies in a single meta-analysis to produce an overall effect.

The likely effect of this is that the overall effect measures are biased towards . . . ?

Can you predict the direction of effect from a

Best practice methods for dealing with disparate effect measures in included studies is to not perform a meta-analysis

Some evidence of manipulation of effect estimates in previous reviews, (e.g. Chou, Sci Reports - at least one study disagrees with) but not documented in review text.

### 4.7.6 Risk of bias

### 4.7.7 Sources of heterogeneity

Detail that some of these are exploratory, in particular the effect of different scales on the association between the groups. [CROSS]

### 4.7.8 Publication bias

- Check if there are protocols available for any of the published reports (unlikely for non-randomised controlled trials), and whether there were
- Vascular dementia has substantially less published reports. Many (reference Smeeth et al 2010 here) simply group into AD and non-AD making comparison between published studies difficult

One particularly interesting meta-bias potentially applicable in this review is the definition

### 4.7.9 Triangulation across evidence sources

One key question for which multiple distinct sources of evidence were available were those looking at Laz

A key limitation for other types of dementia, in particularly vascular, is that there has yet to be a GWAS identifying relevant SNPS that could then be used in a MR study with SNPS for lipids to estimates the causal effect of lipids on vascular dementia [Is this true?] This rules out the use. In addition, there was limited literature available - as discussed in CHapter ??

Consideration of the potential impact of the magnitude and direct of residual confounders/bias is not a major stretch from what is already happening in the assessment of the quality of evidence (GRADE) framework. Within GRADE, the overall quality of evidence can be upgraded when there is deemed to be unmeasured or residual confounding variables which reduce the. For example, if the propensity to treatment is related to comorbidity burden, but those on treatment still have better outcomes then those on control, it is likely that the true effect of the intervention is being underestimated.<sup>153</sup>

Without our framework and as part of the risk of bias assessments reported in 4.7.6, we test test

### 4.7.10 Added evidential value of including preprints

There were several relevant preprints captured by the search run using the tool presented in Chapter 3 (see Appendix A.2.2). While many of the preprints included were subsequently published by the time of submission of this thesis, at the time of the search they were only available

Of interest,

This likely reflects a bias in the type of study that is submitted, but indicates the additional evidential value of include preprints in the search strategy. It also means that searches are current - if the aim of systematic reviews is to



While the total number of relevant studies found using this method was

On further investigation, the argument that .

It is not so much that they provide a source of unpublished grey-literature, more so that they provide a “future” look at .

However, if the aim is to find the current state of the art in the topic area at the time of searching, inclusion of preprints is a requirement.

While concerns have been raised that

Previous meta-studies have found high concordance between the main interpretations and other study design details in preprint-journal article pairs,<sup>154</sup> though quality of reporting was slightly better in formally published articles.<sup>155</sup>

A common criticism of preprinted articles is that they have not formally been peer-reviewed. [CITATION NEEDED] However, I believe this criticism is less warranted in the context of inclusion of preprints in a systematic review, given a formal assessment of risk of bias, which provides a structured approach to assessing the internal validity of a study.

Anyone who can't assess a study to the level of peer review shouldn't do a systematic review

References included in the review were also searched for on PubPeer, a platform which enables post-publication peer review of published journal articles.<sup>156</sup>

The added value of peer-review to papers that is questionable and difficult to quantify for a number of reasons, including the fact that most peer reviews are closed

While [some] preprint have subsequently been published, this does not cause any major issues.

## 4.8 Discussion

Major limitation is that several included studies used data from electronic health databases, which come with serious concerns regarding validity<sup>157</sup> [**ALSO CITE WILKINSON AND MCGUINNESS HERE**].

In addition, the a

### 4.8.1 Searching for/including Mendelian randomisation studies

As a form of analysis that lends itself to multiple comparison, there is a strong

Through snowballing and other measures, we identified at least one Mendelian randomisation study<sup>135</sup>

Is it a big issue that the studies have the same underlying datasets?

### 4.8.2 Comments on the process

Systematic reviews should not be performed as part of a thesis, without suitable support and resourcing guaranteed. Assumption that everyone does a systematic review (without risk of bias assessments, inclusion of all literature, searching for other reviews) is foolish.

Great learning experience in terms of managing a team, but due to a rotating schedule of people, much harder to do that expected.

A final point on the progress of the review is that, due to the need for dual screening and data extraction, a number of external researchers became involved in this review. I found the people-management aspect particularly challenging and could definitely have improved the process through better communication of deadlines, but it has provided good experience of leading a review team.

### 4.8.3 Inclusion of preprints

As highlighted in Section 2.6.1, this thesis sought to synthesize evidence across different publication statuses, predominantly preprinted. Using the tool described in Chapter @ref(), two preprint servers related to health and biomedical sciences were searched as part of this review.

The added evidential value of including these preprints was highlighted in Section . On further investigation, X of these preprints were subsequently published since the search was performed in 2019. While this provides some additional evidence that the quality of the research described by included preprints was sufficiently high to pass peer-review, it does not invalidate the approach, as the future publication status was unavailable at the time the search was conducted.

### 4.8.4 Open data sharing

### 4.8.5 Original contribution to research

I believe there are three aspects where this review is distinct from those reviews already available in the published literature (as identified by [CITATION NEEDED]):

- *Comprehensiveness*: While several reviews of this research topic exist,<sup>59,158–160</sup> the overlap between the list of studies included in each is not 100%. As part of this review, I have not only performed a original search of primary literature databases, but have also screened the reference lists of comparable reviews to ensure no study has been omitted.
- *Structured risk of bias assessment*: The majority of the highly cited reviews on this topic either do not formally consider the risk of bias in the observational studies they include or do not use an appropriate domain-based assessment tool (e.g. ROBINS-I/E). This is important area in which this thesis can add value, as based on the risk-of-bias assessments I have performed to date,

several primary studies are at high risk of bias and this should be reflected in the findings of any review on this topic.

- *Inclusion of preprints:* Unlike other available reviews and enabled by the tool described in Chapter 3, this review systematically searched preprinted health-related manuscripts as a source of grey literature. As part of this chapter, I plan to examine the extent of the additional information provided to the review by the inclusion of preprints.

### 4.8.6 Comparison with other reviews

Of note, as part of the review, we identified several previous systematic reviews of this topic.[CITE] However, this review is the first to use established domain based assessments tools (for example, the RoB 2 tool for randomized controlled trials)<sup>140</sup> to assess the risk of bias in included studies, and explore the heterogeneity of results across different levels of risk of bias levels.

Some previous reviews did assess risk of bias, but used non-domain based assessment tools. Newcastle-Ottawa scale,

**The duplication of work across reviews (including, ironically, by this review) is substantial. In Section XXXX, I demonstrated that the each primary study included in this review was also included in other review so this topic, but that not all studies were included in all reviews. However, by creating a comprehensive review that attempted to draw together all available evidence from across the full range of study types.**

**Exclusion of the PROSPER trial** Will need to have a good bit here on the exclusion of this RCT, particularly as it is included in the Cochrane review on the topic. Cross-reference with the meta-bias section in the early section, on the impact of only included studies that sought to make a definitive diagnosis, rather than using change in cognitive assessment scales.

### 4.8.7 Reviewing Mendelian randomisations studies

While

This may be because Mendelian randomisation studies have yet to reach a critical mass in terms of requiring a systematic review.

Recent updates, such as a guide to reading and interpreting. However, this guide includes reporting items in their quality checklist - reporting quality while important, is unrelated to internal validity.

Problems with overlapping samples in reviews of Mendelian randomisation studies in that we may be double counting participants - for

Methods for reviews of Mendelian randomisation studies are not well developed to account for the consideration above.

### 4.8.8 Strenghts and limitations

Potentially missing other Mendelian randomisation studies, as we identified some through our snowball searching that were not captured by the search strategy. An example is Larsson et al. 2017<sup>161</sup>, where the study examined the association between lipid fractions

Comment on the fact that several of the studies identified through the search of preprints, were subsequently published, but much later than the

Test

## 4.9 Conclusion

Test



# 5

## Primary analysis of lipid regulating agents and dementia

### Contents

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### 5.1 Additional ideas

One of the problems I'll point out with the trials in the systematic review chapter (Chapter 4) is that they only included people with a high cardiovascular risk - we are kind of doing the same by using elevated test cholesterol results as the index event.

Might be able to get around this by pointing out that you need some index event to be able to do this analysis (?)

**Things we tried**

- Conditioning entry to the cohort on QRISK score (as defined by codes) rather than by . Need to be able to demonstrate here that not many meeting our original entry criteria actually go on to have a statin quickly. Need total number of those starting and average time to start.
- Positive controls. Need to be able to explain why these controls have such wildly increased results. Cross-reference these results with the Hernan paper.
- Competing risk analysis, with death as a competing risk. Need numbers of deaths in each group, and preliminary results
- Allowing for time-varying confounders for binary covariates.

### Things we could try

- Work through data using positive control to see if the way it is being added is what is causing the issues.
- Examine Cramer et al. thesis and see what they did
- Marginal structural models approach (a la J. Sterne)

## 5.2 Lay summary

Large scale database such as this are often called population level, and studies that make use of them have a number of advantages.

This analysis uses one of these databases, the Clinical Practice Research Datalink (CPRD), which contains the electronic medical records of XXXXXX people from YYYYYY general practices across England.

Using this data, I have analysed the ...

## 5.3 Introduction

Lack of evidence for the association of statins on vascular dementia risk

Large scale databases advantages over other means



Cross reference here aswell re: the lack of information on Vascular dementia and the need for analyses at different sources of bias.

## 5.4 Methods

### 5.4.1 Data source

The Clinical Practice Research Datalink (CPRD) is a large, population-based, electronic health record database.<sup>163</sup> It contains the primary care records for

Originally termed the General Practice Research Database,

The

Data completeness and collection of certain disease are heavily influenced by exercises that reward doctors for capturing certain diagnoses, such as the Quality and Outcomes Framework. However, these drives can often have unintended consequences<sup>164</sup>

The CPRD uses a coding system called Read code

### 5.4.2 Study design and protocol

We performed a prospective cohort study using data from the CPRD. Our initial sample included all participants registered at a participating practice between 1 January 1995 and 29 February 2016 who had a flag for “research quality” data. All events of interest were identified using predetermined code lists, which are available for inspection (see Data/code availability).

An *a priori* protocol for this study was published,<sup>165</sup> and amendments to this are recorded in Supplementary Materials 1. This study was reported in line with the STROBE Cohort guidelines (Supplementary Table 3).<sup>166</sup>

### 5.4.3 Study cohort

Participants were included in our study cohort if their record contained any of the following index events: a Read code for a diagnosis of hypercholesterolemia or related condition; a Read code for prescription of a lipid-regulating agent (such as statins); a total cholesterol test result of  $>4$  mmol/L; or an LDL-c test result of  $>2$  mmol/L.

These index events allowed us to define a population of participants who were either at risk of hypercholesterolemia, as indicated by the elevated total or LDL cholesterol test results, or had already been diagnosed with it, as indicated by a diagnostic code/related prescription. This approach was employed in an attempt to reduce confounding by indication that we would expect to observe in the full cohort, because individuals not prescribed lipid-regulating agents likely be less healthy across a range of variables than those prescribed lipid-regulating agents, leading to a biased association between lipid-regulating agent use and dementia. Conditioning entry into the study on being either “at-risk” or already diagnosed with hypercholesterolemia attempts to mitigate this bias.

The index date for a participant was defined as the date where the first relevant code or test result was recorded on their clinical record, and participants were followed up until the earliest of: an outcome of interest; death; end of follow-up (29 February 2016); or last registration date with their GP practice. Participants were removed from our sample if they were less than 40 years of age, had less than 12 months of “research quality” data, were simultaneously prescribed more than one lipid-regulating agent (due to the difficulty of assigning these to a single exposure group), or were diagnosed with dementia before or on the date of the index event.

### 5.4.4 Exposures

We considered seven lipid-regulating drug classes based on groupings in the British National Formulary (BNF)<sup>167</sup>, namely: statins, fibrates, bile acid sequestrants,

ezetimibe, nicotinic acid groups, ezetimibe and statin (representing one treatment containing both drugs, rather than the two classes being prescribed concurrently), and omega-3 fatty acid groups.

A participant's drug class was assigned based on their first recorded prescription, and any drug switching was ignored in an effort to mimic an intention-to-treat approach. We did however examine how often the initial drug class was stopped (defined as last prescription of the primary class being followed by at least six months of observation), added to (defined as a second drug class being prescribed before the last prescription of the initial class), or switched (defined as a second drug class being prescribed after the last prescription of the initial class).

### 5.4.5 Outcomes

We considered five outcomes as part of this analysis: probable Alzheimer's disease, possible Alzheimer's disease, vascular dementia, other dementia, and a composite all-cause dementia outcome (Supplementary Figure 1). When two or more outcomes were coded in a participant's clinical record, a decision tree was used to differentiate between them (Supplementary Figure 1). The diagnosis date of the outcome was determined by the first record of a relevant code.

Participants were followed up, and were censored at the earliest of date of diagnosis, death, date of transfer out of the study cohort or end of follow-up ( )

*As a positive control outcome, we included coronary artery disease. Statins have a known effect on this outcome on the basis of randomised controlled trials.*

We also used a negative control of backpain to investigate the potential for residual confounding.

### 5.4.6 Covariates

A range of additional variables were included in the analysis, intended to address differential distributions of potential confounding variables between those who had a

The analysis was adjusted for a range of baseline covariates including sex,

grouped year of entry into the cohort (<2000, 2000-2004, 2005-2009, >2010),

Charlson co-morbidity index,

Index of Multiple Deprivation (IMD),

consultation rate,

alcohol (current, former, never),

smoking (current, former, never),

BMI,

baseline total cholesterol,

and history of cardiovascular disease, coronary bypass surgery, coronary artery disease, peripheral arterial disease, hypertension, chronic kidney disease, and Type 1 and Type 2 diabetes.

All covariates were determined at index and definitions for each can be found in the archived data repository reflecting this study

### 5.4.7 Missing data

Missing data was handled using a multiple imputation approach. Variables with missing observations were identified, and

In the case of missing data, we used multiple imputation by chained equations (MICE) in STATA to create 20 imputed datasets. All covariates included in the analytic model were also included in the imputation model.

### 5.4.8 Time axis

To address the potential for immortal time bias, we employed a time-varying indicator of treatment status to correctly allocate time-at-risk to the exposed and unexposed groups.<sup>168</sup> We ran two models, one unadjusted except for age, which was captured by using the participant's age as the time axis for the model,<sup>169-171</sup> and a second adjusted for the additional covariates described above. Additional analyses stratified by outcome and drug class were also performed.

### 5.4.9 Estimation methods

Potential biases included time varying confounding, selection bias due to censoring on death and We use a Cox proportional hazards model with a time-varying treatment indicator.

Expand on post estimation analyses, which showed that nothing except age had an effect.

$$h(t) = h_o(t) \times \exp(b_1x_1 + b_2x_2 + \dots + b_px_p)$$

where:

- $t$  is the survival time;
- $h(t)$  is the hazard function; and
- $x_1, x_2, \dots, x_p$  are the covariates which determine the hazard function, while  $b_1, b_2, \dots, b_p$  are the coefficients for each covariate.
- $h_o(t)$  is the baseline hazard - when all  $x_i$  are zero, the  $\exp()$  function resolves to 1.

As the values of  $b_i$  increases, value of  $\exp(b_i)$  (i.e. the hazard ratio) increases in tandem, thus reducing the survival time,  $t$ .

### **Bit on why Cox models are slightly different from others, due to proportional hazards assumptions**

Hazard ratios are

Test for non-proportionality are therefore very important, as models which fail

Problems with testing for non-proportional hazards when

#### **5.4.10 Immortal time bias and time-varying treatment indicators**

Immortal time bias is a type of misclassification bias. It occurs when

One potential way to address this is the use of a time-varying treatment indicator, a factor which modi

In the case of this analysis, this treatment indicator is statin use. Using codes for statins (see Appendix @ref())

#### **5.4.11 Estimating the value of the time-varying confounders**

Mean time from index event to first prescription of statins was 2.4 years. This negates the promised benefit of ruling out confounding by indication (where the test result leads to the prescription of the treatment and also increases the risk of the outcome, distorting the relationship between the two), as there is no relationship between index TC/LDL-c and eventual LRA prescription.

Additionally, the time between index event and prescription does lead to a problem in terms of time varying confounding, as an average time of 2.4 years between current measurement of the covariates and treatment switching means there is plenty of time for the value of the covariate to change. This is problematic when the decision to change treatments (in this case to move from no LRA use to LRA use)

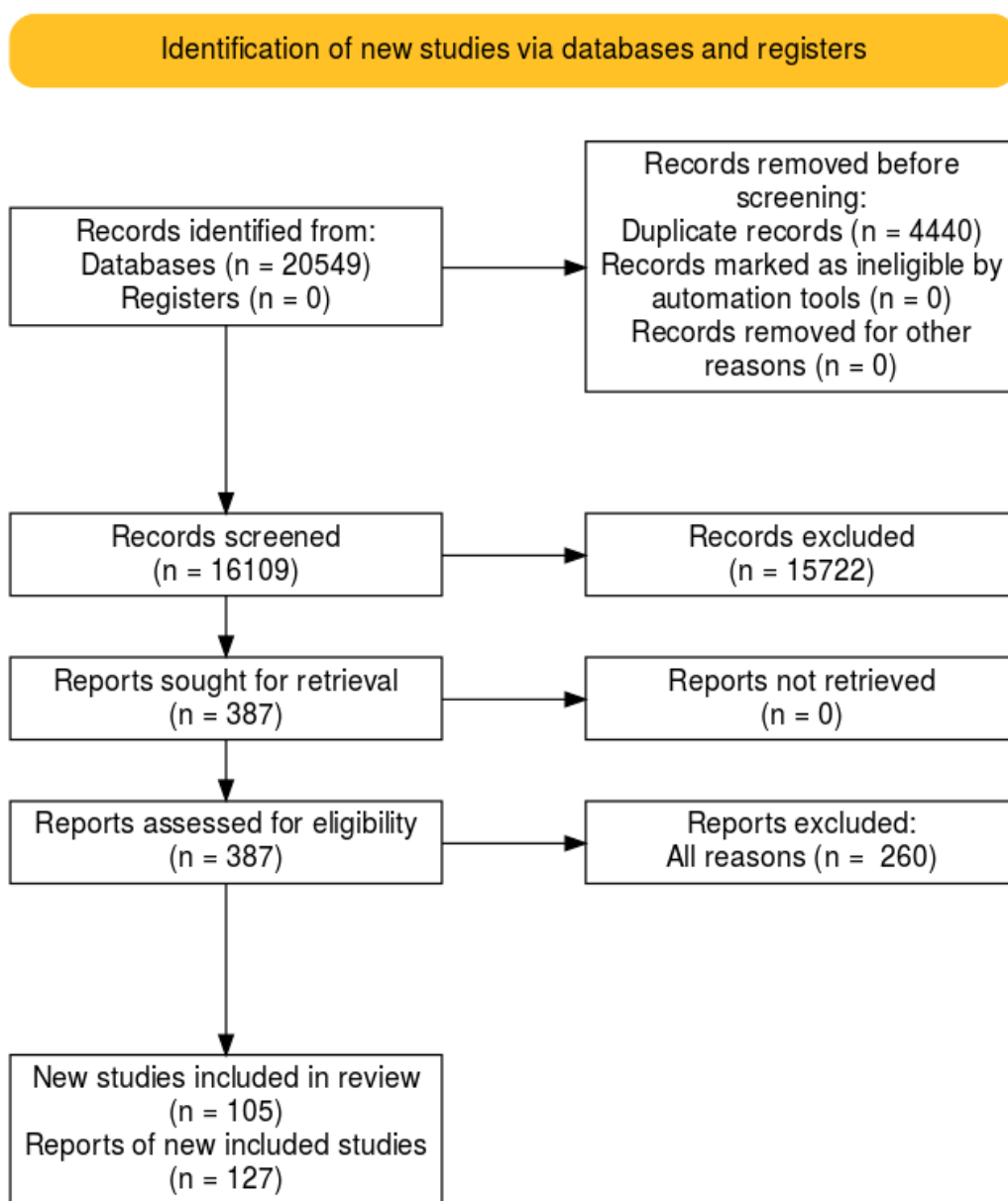


Figure 5.1: Directed acyclic graph showing assumed relationship between exposure and covariate:

is influenced by a set of prognostic factors that in turn may have been influenced by the initial treatment decision, as is likely to be the case for a range of covariates included in the model. For example:

`_No CVD (t=0) -> No LRA (t=0) -> CVD (t=1) -> LRA (t=1) -> Dementia (t=2)_`

In this case, the decision to move to LRA use is influenced by CVD status at *Time 1*, which will not be captured by adjusting only for CVD status at *Time 0*.

In practice, this means that the value of the prognostic factor should be regularly captured

However, in electronic health records, a change in the value of the prognostic factors is only important if it is recorded in a patient's record, as for it to have an impact on treatment decisions, it must be recorded.

This means we can find the most recent value of the covariate before the switch and apply a marginal structural model approach, filling all values for that variable before the most recent measure with the baseline measurement, and all after the most recent measure with the value of the most recent measure (on the basis that you won't go from having CVD back to not having CVD).

i.e.

Timepoint 12345678

CVD 00001111

Treatment 00000111

Split into 3 month blocks since index event and use the same approach as above to work out the values of each covariate at each time point.

Note: this will be harder for things that are not dichotomous and can go up as well as down. Examples include total cholesterol and BMI, which can go up as well as down.



### 5.4.12 The effect of total cholesterol or LDL-cholesterol on LRA prescription

It would be fair to assume that the baseline total cholesterol/LDL-cholesterol would at least in part predict the likelihood of someone being prescribed a statin.

However, this is not the case. Baseline cholesterol level are predicted to be a poorer instrument for than QRISK2 score,<sup>172</sup> which estimates a patients' 10-year risk of a cardiovascular event. Current NICE guidelines state that those with a QRISK score of 10% or higher, and in whom lifestyle modification is ineffective/inappropriate, should received a lipid regulation agent. However, this analysis could not find any effect of QRISK2 scores on statins prescription levels at 6 months.

As expected, in a confirmatory analysis using lipid levels, there was no association between *the most recent total cholesterol or LDL-cholesterol reading in the CPRD and the treatment, indicating that adjusting for this variable was not required.*

### 5.4.13 Replicating other analytical strategies

**Comparing and contrasting between different studies is particularly difficult** because of the impact that the use of different code list can have on the analysis<sup>173,174</sup> This highlights a particular challenge in comparing research across different time-periods and coding systems. Previous work has demonstrated that electronic health records have variable positive and negative predictive values, based substantially on the exact code-lists used to define each outcome.

In order to

As part of my exploration of the unexpected results, I attempted to replicate the analyses of another paper that used a different approach to

Having contacted the authors to address these concerns, it was noted that

Propensity scores are based on a range of baseline variables, and provide an estimates of the

They used propensity scores to attempt to match patients equally likely to receive the vaccine

In addition, the need to contact the authors for their code-lists reinforces the points raised in Section 4.8.4 - that all relevant material should be readily shared. Fortunately, the authors kindly shared their

However, there was a large difference in the case mix of dementia diagnoses between the two analyses.

However, as shown in Table 5.1, there is substantial divergence between the two sets of code-lists.

The reason for the discrepancy in terms of the number of Alzheimer cases as a percentage of total dementia cases between our study and the Smeeth 2010 paper is due to two things: • While all of the codes used to define Alzheimer’s in the Smeeth paper are included in our “Probable Alzheimer’s” code-list, we also have several additional codes used to define this outcome (including, for example, “Eu00013: [X]Alzheimer’s disease type 2”). • Several of the codes in our “Possible Alzheimer’s” code list are included in the “Other dementia” code list used by Smeeth.

Using the Smeeth code-list, we get a similar breakdown of cases to that paper, with Alzheimer’s disease being a lot less frequent than when using our code-lists (which is not surprising based on the points above).

Replicating a matched analysis a la Smeeth et al 2010 - though questions were raised as to how they had actually done the analysis (they did not match on propensity score, they simply adjusted for it - find paper that explores 4 ways of accounting for PS and shows this is the worst), they adjusted for things likely to be on the causal pathway, and they saw a huge change in direction for MI pre- vs post- adjustment.

**Table 5.1:** Comparison of code lists used in this analysis and in Smeeth et al.

	<b>mpg</b>	<b>cyl</b>	<b>disp</b>
Mazda RX4	21.0	6	160
Mazda RX4 Wag	21.0	6	160
Datsun 710	22.8	4	108
Hornet 4 Drive	21.4	6	258

## 5.5 Results

### 5.5.1 Patient characteristics

### 5.5.2 Missing data

### 5.5.3 Primary analysis

### 5.5.4 Sensitivity analyses

By pregnancy

By age-at-entry

By statin type (lipo vs hydrophilic)

### 5.5.5 Controls

Backpain

Coronary artery disease

## 5.6 Discussion

### 5.6.1 Main findings

Lipid-regulating agents had no effect on probable and possible Alzheimer's when compared with no treatment, but were associated with increased risk of an all-cause dementia, vascular dementia and other dementia diagnosis. The effect observed in each case was driven by the statin subgroup, which included a substantial majority of participants. For the other drug classes, no association was found with any outcome, with two exceptions being that ezetimibe was associated with increased risk of vascular and other dementia, while fibrates were associated with increase risk of all-cause dementia and probable Alzheimer's disease.

### 5.6.2 Comparison to other literature

Much of the existing literature focuses on the association of statins alone with neurodegenerative outcomes, with other lipid-regulating agents being grouped as “non-statin cholesterol-lowering drugs”.<sup>175</sup> This echoes the distribution of participants among subgroups in our analysis, with the statin subgroup including almost all participants.

#### Statins and all-cause dementia

A recent Cochrane Review identified two randomized trials comparing treatment with statins versus non-treatment for the prevention of dementia, only one of which presented information on the incidence of dementia.<sup>62</sup> This study (Heart Protection Study) showed no effect of treatment with simvastatin on all-cause dementia risk (OR: 1.00, 95%CI:0.61-1.65),<sup>176</sup> but concerns were raised over the diagnostic criteria used. A meta-analysis of 30 observational studies found a reduced risk of all-cause dementia was associated with statin treatment (RR 0.83, 95%CI: 0.79–0.87).<sup>177</sup>

These sources of evidence conflict with the findings of our analysis, where statin use was associated with an increased risk of all-cause dementia. However, some of the included studies in the meta-analysis specifically exclude vascular dementia from the definition of all-cause dementia,<sup>178</sup> which may lead to a artificial protective effect of statins on all-cause dementia

### **Statins and Alzheimer's disease**

Our results are broadly in line with the findings of two distinct approaches examining the effect of statin treatment on subsequent Alzheimer's disease. No randomized trials of statins for the prevention of Alzheimer's disease have been reported, but a recent meta-analysis of 20 observational studies found statins were associated with a reduced risk of Alzheimer's disease (RR 0.69, 95% CI 0.60–0.80), though the reduction was more extreme than observed in our analysis.<sup>177</sup> In addition, a recent Mendelian randomization study examining the effect of genetic inhibition of HMGCR on Alzheimer's disease found a small reduction in risk of Alzheimer's disease, comparable in magnitude to our findings, but could not rule out no effect (OR: 0.91, 95%CI: 0.63-1.31).<sup>179</sup>

An additional analysis found no difference in effect between lipophilic and hydrophilic statins for the prevention of Alzheimer's disease, consistent with a recent meta-analysis.<sup>180</sup>

### **Statins and non-Alzheimer's disease dementia**

Much less literature is available on the association between lipid-regulating agents and vascular dementia or other dementia. A recent review found four observational studies examining the association of statins and vascular dementia found no effect (RR:0.93, 95% CI 0.74–1.16).<sup>177</sup> This contrasts with the increased effect found in our analysis. An additional analysis found that lipophilic statins were more

harmful than hydrophilic statins in vascular dementia, potentially due to their ability to cross the blood brain barrier.

### Other drug classes

Apart from statins, few studies examining a lipid-regulating agent have been reported. One of the few classes for which data was available were fibrates, which were shown to have no effect on all-cause dementia,<sup>175</sup> inconsistent with our finding of a small increase in all-cause dementia risk in those prescribed a fibrate.

To our knowledge, there is no previous study of the effect of preventative treatment with ezetimibe on any dementia outcome, and so we cannot compare our unexpected finding that treatment with the drug associated with an increased risk of the vascular and other dementia outcomes.

### 5.6.3 Original contribution to research

There are two primary ways in which this research adds to the topic:

- *Size of the CPRD and length of follow-up:* Having reviewed the other studies identified by the systematic review in Chapter 4, this analysis of 1.7 million participants is one of the largest studies of this research question.
- *Addressing the limitations of other observational analyses:* Analyzing this data has provided the opportunity to use a separate analytical technique to many of the studies identified in the systematic review, As an example, the Hipsley-Cox BMJ paper examining the effect of statins, which makes use of the THIN EHR database, likely suffers from immortal time bias as exposed and unexposed participants are not followed up from a common time point.<sup>181</sup> As touched on in the section above, this provides an additional evidence point with a different source and direction of bias, which is useful for the triangulation aspect of the thesis.

### 5.6.4 Coding quality in the CPRD

Lots of things influence prevalence: historic trends, availability of good codes

There is some encouraging evidence that a dedicated coding exercise increases the identification of dementia case in primary care database, and does not add a substantial administrative burden.<sup>182</sup>

### 5.6.5 Strengths and Limitations

A major strength of our analysis is the size of the included cohort and the length of follow-up that the use of electronic health records allowed. In addition, we followed users and non-users from a common index date, using a time-updating treatment indicator to correctly assign time-at-risk to the exposed and unexposed groups.

However, the findings of our analysis are subject to several limitations. There is a strong possibility of differential misclassification of dementia-related condition based on the exposure, as those with memory complaints are more likely to be classified as vascular dementia than Alzheimer’s disease if their medical records contains prescriptions for lipid-regulating agents. Further, there is a potential for non-differential misclassification of the outcome based on the use of electronic health records to identify dementia cases.<sup>183,184</sup>

Our study may be subject to confounding by indication, which occurs when factors that affect whether a participant is exposed also affect their outcome. We attempted to address this by limiting inclusion to those either prescribed or “at risk” of being prescribed, which was determined using an elevated test result. We also adjusted for several additional potential confounding variables. However, the negative control analysis of back pain demonstrated a harmful association with lipid-regulating agent use, indicting that our findings may be biased by residual confounding. Important confounding variables for which we have not adjusted could include genetic factors. A recent preprint of a study in the UK Biobank demonstrated that an Alzheimer’s disease polygenic risk score was associated with an increased risk of

unspecified Alzheimer’s and vascular dementia, and also with an increased frequency of self-reported raised cholesterol levels, a diagnosis of hypercholesterolaemia, and a history of taking lipid-regulating agents such as statins or ezetimibe.<sup>185</sup> This finding, combined with the potential for differential misclassification between Alzheimer’s disease and vascular dementia, could explain part of the observed association between lipid-regulating agents and vascular dementia.

A further limitation is the possibility of time-varying confounding

Finally, there is also the potential for reverse causation in this analysis. Dementia and associated conditions have a long prodromal period, during which preclinical disease could cause indications for the prescription of a lipid-regulating agent.

### 5.6.6 Enabling easy synthesis

In light of my own experiences in attempting to extract information for papers assessing preventive measures, I attempted to document

This study was reported in line with the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) reporting guidelines<sup>186</sup> (see Appendix @ref() for the STROBE checklist)

Reporting guidelines do not always work, but help to guide

All code and summary statistics (i.e. the tables presented in this chapter, plus summary tables of effect estimates) are readily available in machine readable formats, without any formatting (i.e. as comma separated values, or CSV, files) from the Github repository for this project.

### 5.6.7 Conclusions

We have provided new evidence on the potential repurposing of lipid-regulating agents for the prevention of all-cause dementia, Alzheimer’s disease, vascular



dementia, and other dementia. We found use of lipid-regulating agents not associated with probable or possible Alzheimer's disease, but were associated with an increased risk of all-cause, vascular and other dementias. In all cases, the estimated associations were driven by those observed in the statin subgroup, which comprised the majority of participants in our cohort.

We have attempted to account for important sources of bias in our analysis and provide a comparison with other available literature. However, there is a strong potential for unmeasured confounding, misclassification and reverse causation, which raises questions about our findings, in particular the unexpected increase in risk of vascular dementia associated with statin use. Future research should aim to address these potential biases and, while it may be costly in terms of time and resources, a large scale, long-term randomized controlled trial would provide useful additional information on the effect of lipid-regulating agents on the risk of dementia and related outcomes.

## **5.7 References**

# 6

## Individual participant data meta-analysis

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## 6.1 Methods

### 6.1.1 Data sources

Several cohort studies were approach

As part of this Chapter, I will use individual patient data from a range of sources. These sources are described here in detail for reference.

Should also include a list of reasons why specific additional cohorts were not included - some like the EHR might be too big to get

Each should have:

- Description (including observation period, numbers, numbers with outcome, etc)
- Whether they are a known genetically at-risk cohort
- 

### 6.1.2 Epic Norfolk

The European Prospective Investigation of Cancer - Norfolk is a<sup>187,188</sup>

Different approaches to combining subgroups.<sup>189</sup>

## 6.2 Risk of bias assessment

Risk of bias assessment was performed for each of the included cohorts using the relevant tool described in Section 4.6.4.

## 6.3 Data cleaning

## 6.4 Discussion

Letters sent to all cohorts identified through the systematic review - will need quite a bit here on the numbers approached and how they responded if at all. Will also need to comment on the additional tactics used.

This is likely due to my junior position as a early a

Range of reasons why data is not readily available.

Unfortunately,

As part of this, an analysis of

## 6.5 Discussion

Describe your experience of trying to access the DPUK - while a great resources, furstrating at times.



# 7

## Discussion

### **7.1 Triangulation across existing evidence and evidence produced in this thesis**

Using the review of the literature as a guide to identify useful further studies that could be performed, I then performed .

Summary table of different studies and results

### **7.2 Discussion of E-values**

How strong unmeasured confounding would have to be in order to explain the observed effect.

Heavily criticised in a range of papers.

## **7.3 Use of consensus panel to bring everything together**

## **7.4 Additional topics for the discussion**

There are several addition topics I would like to cover:

- The difference between the peer review of the software vs. the peer review of papers. A conversation until everything is fixed/clear reporting guidelines/checklists, with acceptance dependent on them being implemented /built-in version control, and cross linking discussion points to changes through the linking of commits and comments. Essentially, a more transparent and open

## **7.5 Summary of findings (and implications for policy makers)**

## **7.6 Strengths and Limitations**

There are several strengths and limitations to the work presented in this thesis. One particularly strength is the lengths gone to find all available published and unpublished evidence around the question, and to integrate this evidence in a coherent framework, taking into account the limitations of ach source and how these limitations may be used to provide

Need for large simple trials for common disease where small treatment effect can have large effect <sup>-190</sup>

## **7.7 Reproducible research**

Reproducible and science has been a key theme running through this thesis, as reflected by the development of an open source tool to help search medRxiv and



bioRxiv preprint metadata. In line with this, an open source copy of the code used to produce this thesis is available on GitHub, as is the code used to perform the analysis contained within it.

Containerisation was used to ensure that the code is reproducible, in line with best practices

Commentary on the fact that the best you can do is replicate vs reproducible (due to the closed nature of the data).

One is the ability to recreate the results given the same data and code, the other is the ability to recreate the results given the same code but a different dataset. In theory it is possible to gain access to the dataset given the information presented in Chapter 4 (ref:cprd-analysis-heading). However, access is dependent on an ISAC application to the managing body of the CPRD.

## **7.8 Public involvement and engagement**

Involving and engaging the public and patients has been a central theme to this thesis.

Public engagement activities included

Public involvement also steered the creation of the topic

P

## **7.9 Future work**

## **7.10 Overall conclusions**



*Lasciate ogni speranza, voi ch'intrate. . .*

# 8

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# Appendices





## By Chapter

### **A.1 Chapter 1**

#### **A.1.1 Publications beyond the scope of this thesis**

##### **Peer reviewed**

- McGuinness & Sheppard. Comparison of pairwise
- PRISMA main paper
- PRISMA E&E
- PRISMA 2020 software
- COVID Suicide Living Review
- Data extraction tools systematic review

##### **Under review/Preprints**

- MSc Paper on systematic reviews of this thesis topic
-

### A.1.2 Involvement of patients and the public

Patients were involved at several stages of this research. when designing the PhD programme of work, a Patient and Public Advisory Group (PPAG) provided feedback on the relevance of the question.

Additionally,

Lay summaries appear at the beginning of each chapter, reviewed by the Patient and Public Involvement panel. They provide a plain language summary

## A.2 Chapter 3

### A.2.1 Search strategy

### A.2.2 Code to search preprints

```
library(medrxivr)

mx_data <- mx_api_content(to_date = "2019-09-01")

bx_data <- mx_api_content(server = "biorxiv",
                          to_date = "2019-09-01")

topic1 <- c("statin",
            mx_caps("ldl"),
            mx_caps("hdl"),
            mx_caps("TG"),
            paste0("\\b",mx_caps("TC"),"\\b"),
            "ezetim",
            "lipoprotein",
            "lipid",
            "cholesterol")
```

```
topic2 <- c(mx_caps("dementia"),
            mx_caps("alzheim"),
            mx_caps("MCI"),
            mx_caps("mild cognitive"))

query <- list(
  topic1,
  topic2
)

test <- mx_search(bx_data, query)

test2 <- mx_search(mx_data, query)
```

Note

### A.2.3 MR risk of bias tool

## A.3 Chapter 4

## A.4 Chapter 5

### A.4.1 Code lists





# B

## Other Appendix

### B.1 Software used to create this thesis

This thesis was written in RMarkdown. Several R packages were used as part of this project.<sup>132,191–207</sup>

All projects in these thesis attempt to conform to minimal best practices for research computing.<sup>208,209</sup>

### B.2 Producing risk-of-bias visualisations with robvis

#### B.2.1 Introduction

Risk of bias assessment - evaluation of the internal validity of studies included in a systematic review - often forms a key part of the evidence synthesis process, particularly in the health sciences.<sup>210</sup> A well-developed family of tools is widely used, which have in common the characteristic that they evaluate specific domains of bias rather being constructed as a checklist or a quantitative score.<sup>210</sup> These tools include the RoB 2 tool for randomized trials,<sup>211</sup> the ROBINS-I tool for non-randomized studies of interventions,<sup>212</sup> the QUADAS 2 tool for test accuracy and

## *B.2 - Producing risk-of-bias visualisations with **robvis***

the ROBIS tool for systematic reviews.<sup>213</sup> Within each bias domains a judgement is reached about the strength of the study in that regard: for example, the first domain in the Cochrane RoB 2 tool deals with bias arising from the randomization process.<sup>211</sup> Accessible graphics summarizing the results of these domain-based risk-of-bias assessments are included in reports of systematic reviews. A convenient plot in many reviews is a “traffic light” plot, which tabulates the judgement for each study in each domain. For larger numbers of studies, when such a table become unmanageable, a popular alternative is a weighted bar plot, which show the proportion of information with each judgement for each domain.<sup>214</sup>

Researchers can face a number of barriers in creating these plots. While some evidence synthesis platforms, such as Cochrane’s Review Manager,<sup>215</sup> are able to produce these visualizations, not all researchers use these systems to conduct their systematic reviews, and copying the risk-of-bias data into these systems simply to produce the plots is inefficient and error prone. Likewise, creating the figures by hand, through software such as MS PowerPoint or Adobe Illustrator, may lead to unintentional errors and require the plots to be redrawn during an update to the review. Additionally, while the field of evidence synthesis software has grown rapidly in recent years,<sup>216</sup> this growth has not been equally distributed across the different aspects of the systematic review process. For example, a recent review found several software offerings aimed specifically at the abstract screening stage of the review process,<sup>217</sup> but no similar time- and error-reducing tool has been proposed for visualizing the results of risk-of-bias assessments.

Fortunately, tools such as R, RStudio and **Shiny** (an R package for building interactive web apps) have made it easier than ever to produce such a tool.<sup>218–220</sup> Here, we present **robvis** (Risk Of Bias VISualiation),<sup>221</sup> an R package and **Shiny** web-app that allows users to create publication-ready risk-of-bias plots quickly and easily. Originally created for use with the major risk-of-bias assessment tools used in health research, the tool allows users to visualize the results from any domain-based risk-of-bias assessment or quality appraisal tool.

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The tool is open-source and available to use free of charge. Users can download a stable version of the R package from CRAN (<https://cran.r-project.org/package=robvis>); or access and contribute to the development version via GitHub (<https://github.com/mcguinlu/robvis>).

### **B.2.2 Development**

Development of **robvis** began in April 2019 at the Evidence Synthesis Hackathon (ESH), an event which brings together interested researchers, practitioners and coders to discuss and develop new open-source evidence synthesis technologies. Test versions of both the R package and the web app were made available in early June 2019, with attendees of the ESH and members of the Bristol Appraisal and Review of Research (BARR) group at the University of Bristol being invited to test the tool and provide feedback. This feedback, along with other feature suggestions from the wider evidence synthesis community captured via GitHub issues, was incorporated and the first release version of the package was uploaded to CRAN in November 2019. The tool has been well received and is beginning to be cited in the evidence synthesis literature.<sup>222–226</sup>

### **B.2.3 Installation**

A stable version of **robvis** is hosted on the Comprehensive R Archive Network (CRAN) and can be installed using:

```
install.packages("robvis")
```

As development of **robvis** is ongoing, new features are often available in the development version some time before they appear in the stable CRAN version. The most recent development version can be install from GitHub using:

```
devtools::install_github("mcguinlu/robvis")
```

### B.2.4 Usage

*robvis* contains two main functions. The first, `rob_traffic_light()`, creates a traffic light plot by tabulating each study by each domain, providing a more detailed view of the results of the risk-of-bias assessment. The second, `rob_summary()`, creates a weighted bar plot showing the proportion of information with each judgement for each domain in the assessment tool specified.

A worked example using these functions is outlined below, showing the ease with which risk-of-bias plots can be created using *robvis*. A detailed description of the additional options that can be used with each function is presented in Table B.1

Using the example data set (`data_rob2`) which is built into the package and is presented in Table ?? for reference, the traffic light plot shown in Figure B.1 is created using:

**NEED TO ADD DATA HERE!**

```
rob_traffic_light(data = data_rob2,
                  tool = "ROB2",
                  psize = 15)
```

Similary, using the same data set, the summary barplot shown in Figure B.2 is created using:

```
rob_summary(data = data_rob2,
            tool = "ROB2",
            overall = TRUE)
```

A list of arguments available to the two functions in *robvis* are shown in Table B.1

**Table B.1:** Description of the arguments available in the two main ‘*robvis*’ functions. ‘X’ indicates that the option is available for the respective function.

Argument	<code>rob_traffic_light()</code>	<code>rob_summary()</code>	Description
<code>data</code>	X	X	Defines the dataframe containing the summary (domain) level risk-of-bias assessments. See the text and Table 1 for the format expected by ‘ <i>robvis</i> ’

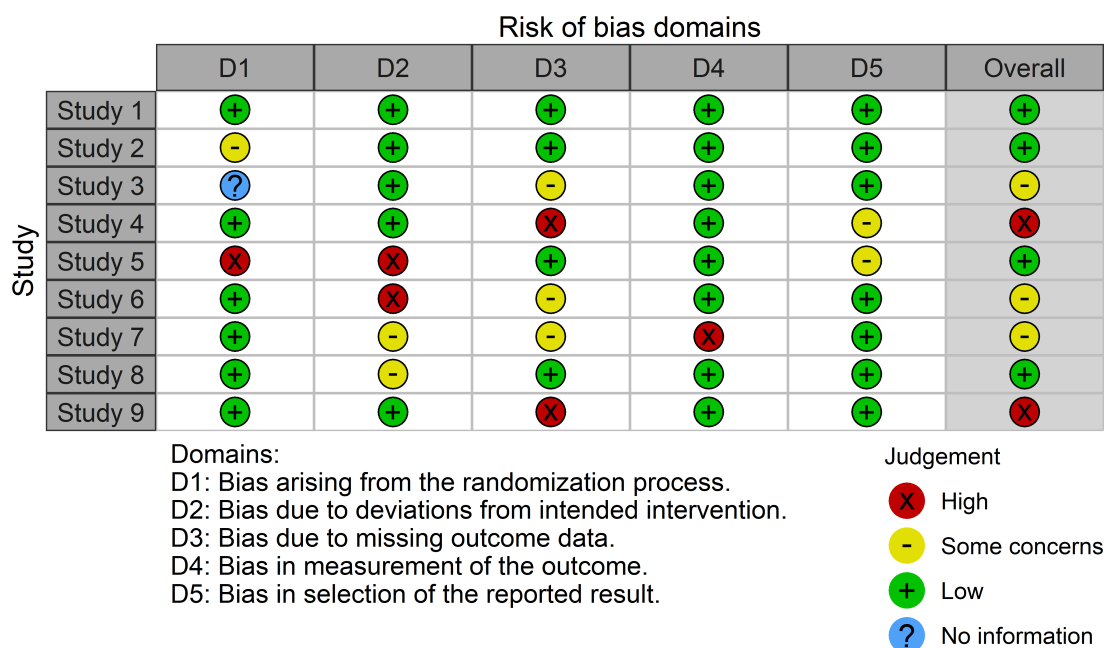
**Table B.1:** Description of the arguments available in the two main ‘robvis’ functions. ‘X’ indicates that the option is available for the respective function. (*continued*)

Argument	rob_traffic_light()	rob_summary()	Description
tool	X	X	Defines the risk of bias assessment tool used. The RoB2 ( <code>‘tool="ROB2"‘</code> ), ROBINS-I ( <code>‘tool="ROBINS-I"‘</code> ), and QUADAS-2 ( <code>‘tool="QUADAS-2"‘</code> ) assessments tools are currently supported. Other tools can be visualised using the generic template ( <code>‘tool = "Generic"‘</code> )
colour	X	X	Defines the colour scheme for the plot. The default is <code>‘colour = "cochrane"‘</code> which uses the "Cochrane" (red, yellow, green) colours, while a preset option for a colour-blind friendly palette is also available ( <code>‘colour = "colourblind"‘</code> ). Alternatively, users can specify their own colour scheme e.g. <code>‘colour = c("#f442c8", "#bef441", "#000000")‘</code>
overall		X	Defines whether to include an additional bar showing the distribution of overall risk of bias judgements in the summary barplot figure. Default is <code>‘overall = FALSE‘</code> .
weighted		X	Defines whether weights should be used to produce the summary barplot figure. Default is <code>‘weighted = TRUE‘</code> , in line with current Cochrane Collaboration guidance.
psize	X		Defines the size of the points in the traffic light plot. Default is <code>‘psize = 20‘</code> .

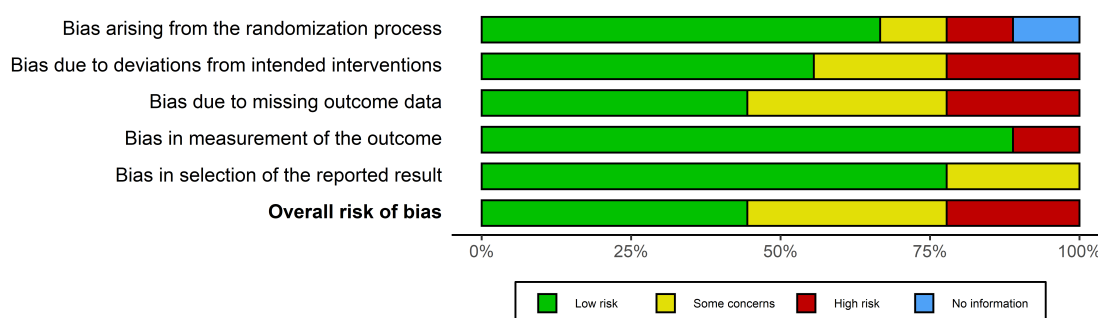
### B.2.5 Reception and Future Plans

As of December 2021, *robvis* has been downloaded more than 11600 times. It has been well received but the systematic review community, and has been cited frequently in the published literature. A paper describing the tool was published in a special issue of Research Synthesis Methods focusing on data visualisation methods. A chapter on the tool has been incorporated in to the “Doing Meta-Analysis in R” online textbook.<sup>227</sup>

While *robvis* is a stable package, a range of additional functionality could be



**Figure B.1:** Example risk of bias traffic light plot created using ‘robvis’



**Figure B.2:** Example risk of bias summary plot created using ‘robvis’ and the example ROB2 dataset

added. At present, the number of tools with a specific template included in *robvis* is limited - adding additional templates is a priority. For example, a template for ROBIS, a tool for assessing risk of bias in systematic reviews, is in development.<sup>228</sup> Additionally, the tool does not yet allow for the production of paired forest plots, where the risk-of-bias judgement is presented alongside each specific result included in the meta-analysis.<sup>210</sup> This was initially considered to be beyond the scope of the tool, as it involves the visualization of something other than risk-of-bias assessments. However, following user-driven demand, this functionality

## *B.2 - Producing risk-of-bias visualisations with **robvis***

is in development and will be available in the near future. Finally, we would like to add similar functionality to that provided by the `metafor::reporter()` function, which generates a brief paragraph of text describing the results of a meta-analysis. The future `robvis::reporter()` function would provide a boilerplate description of the assessment tool used and the key domains at risk of bias.