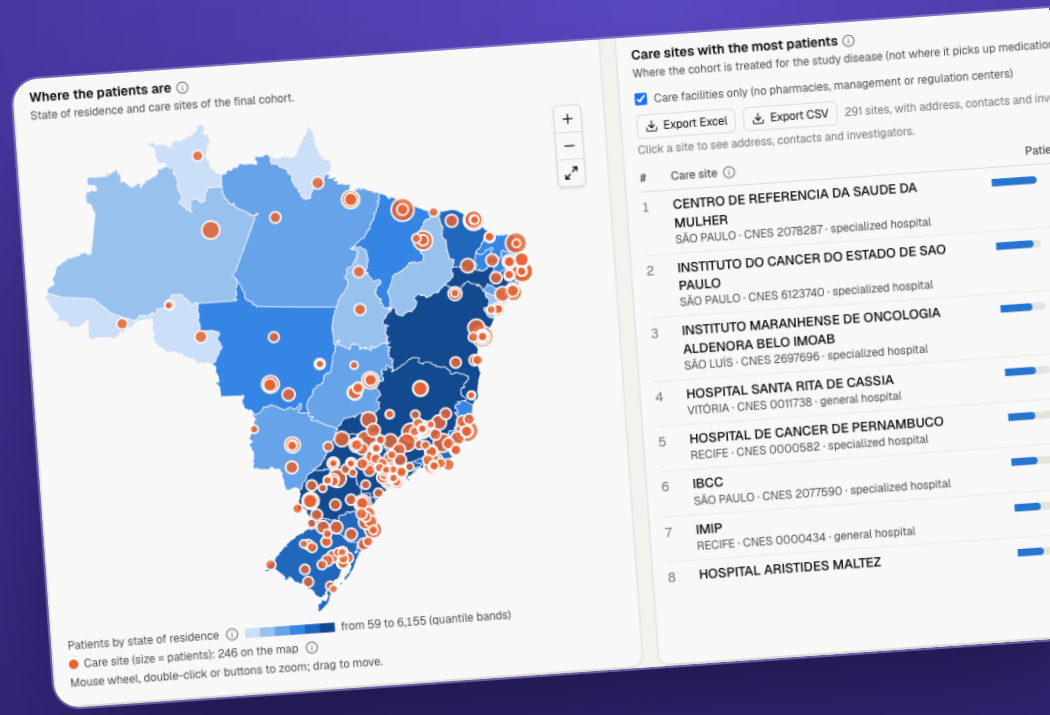
Genius Cohort

How many patients in Brazil fit your protocol, and where they are.

Clinical trial feasibility, site selection, recruitment planning and study budgeting built on real-world data from Brazil's national health records — in minutes, not weeks.



Corporate presentation · October 2026 · geniuscohort.ttrials.com

TECHTRIALS

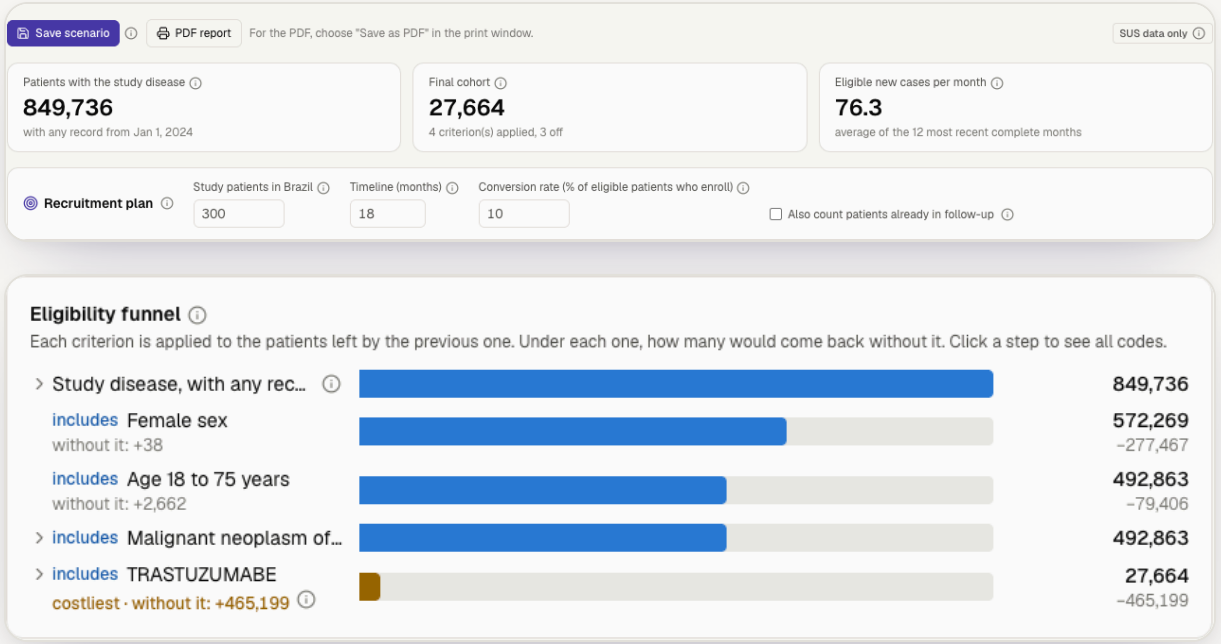
EXECUTIVE SUMMARY

Feasibility answered with data, not with questionnaires.

Genius Cohort applies a study's eligibility criteria directly to the real records of Brazil's public health system and shows, for that exact protocol, how many patients qualify, where they live, which hospitals treat them, how fast new eligible cases arrive and how long recruitment will take.

It serves the three parties of every clinical study — **sponsors**, **CROs** and **research sites** — each with a screen arranged around the decision they have to make. An AI layer reads protocols, proposes criteria, suggests protocol adjustments, ranks sites and writes a meeting-ready report, while every number on screen is computed from the data.

- **Protocol to cohort in minutes:** upload the protocol or paste the criteria; the AI maps each one to official health codes.
- **Where to open sites:** public hospitals with patient volume and research centers with track record, scored together.
- **How long it will take:** recruitment time and curve against the target and timeline.
- **What it will cost:** site and country budget from the protocol's schedule of assessments.



A real search on the platform: HER2-positive breast cancer protocol, target of 300 patients in 18 months. Final cohort, eligible new cases per month and the criterion-by-criterion funnel.

THE CHALLENGE

Most recruitment problems are visible before the first site opens — if you can see the patients.

Feasibility by estimate

Site questionnaires, investigator recall and literature prevalence are still the usual basis for deciding whether a protocol can be recruited in a country. They rarely reflect the exact combination of criteria in the protocol, and they cannot show which single criterion is shrinking the population.

Sites chosen by habit

The same well-known centers are invited study after study, while high-volume public hospitals that treat the patients go unseen — and experienced centers end up competing with each other for the same patient in the same disease.

Timelines discovered too late

When the arrival rate of eligible new cases is lower than the pace the target requires, the gap shows up months into enrollment, as amendments, rescue sites and extended timelines — the most expensive moment to find out.

Brazil has one of the largest public health systems in the world, with administrative records for diagnoses, procedures, chemotherapy, medications and hospital stays.

Those records already describe the patients a protocol is looking for: their diagnoses, the treatments they received, where they live and where they are treated. Genius Cohort turns that national record base into a feasibility instrument — aggregated, anonymized and organized around the protocol, so the decision about a country, a site list or a protocol amendment is made with evidence before recruitment starts.

ONE PLATFORM, THREE QUESTIONS

Each party of a clinical study gets the screen for its own decision.

PHARMACEUTICAL INDUSTRY

Is this protocol feasible in Brazil? Which criterion blocks recruitment?

Criterion-by-criterion eligibility funnel, how many patients each criterion costs, a simulator that tests alternative criteria with real searches, nationwide recruitment time, site analysis and the country budget.

CROS

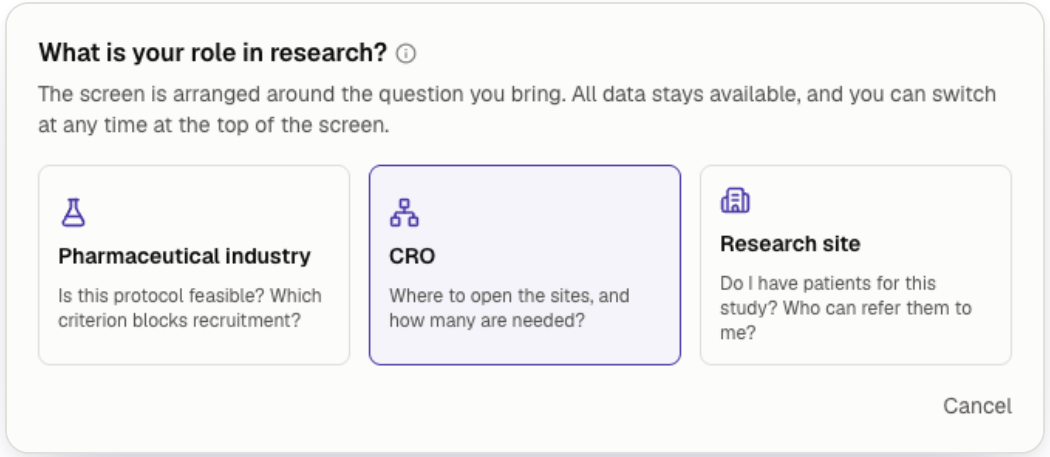
Where should we open sites, and how many do we need?

Candidate sites from public hospitals and from ClinicalTrials.gov, research experience and competing studies, AI-suggested roles for each site, the simulated capacity of the selection, site sheets with contacts and investigators, and Excel exports.

RESEARCH SITES

Do we have patients for this study? Who can refer them to us?

Patients the site already treats, where they come from, nearby facilities treating the same cohort, the site's recruitment curve, a medical-record pre-screening checklist, a monthly radar of opportunities and a feasibility letter for the sponsor.



Profile selection. The profile is defined by TechTrials for each client account: it decides which views and exports are available, so a research site never sees national lists meant for sponsors.

Bilingual by design. The whole platform — screens, AI reports, PDF and Word exports — runs in English and Portuguese, with the same login used across TechTrials products.

DATA FOUNDATION

Three national sources, linked and refreshed on a schedule.

PATIENT RECORDS

Brazilian public health system (SUS / DataSUS)

Diagnoses (ICD-10), outpatient procedures, chemotherapy and radiotherapy authorizations, specialized-component medication dispensing and hospital admissions, linked by patient, with history since 2008. Rebuilt every month when new national files are released.

FACILITIES

National Registry of Health Facilities (CNES)

Address, type, beds, service accreditations and equipment of every health facility in the country, used to tell a hospital that can host a study from an emergency unit that can refer patients.

CLINICAL RESEARCH

ClinicalTrials.gov

More than 11,000 studies with sites in Brazil, with phases, sponsors, enrollment, recruitment status and site contacts, refreshed weekly and linked to the facility registry so research experience and patient volume sit on the same row.

What the search confirms

- Diagnosis codes, with time windows and minimum months of treatment
- Procedures, medications and chemotherapy regimens from the official procedure table (SIGTAP)
- Hospitalization, age, sex, recent contact with the system and recorded death
- 103 selected tests (genetic testing, viral load, PSA, echocardiography and others) as a record that they were performed

What it does not show — and how the platform handles it

- Test results, biomarkers, clinical scales and performance status are not in administrative data: they go to a **pre-screening checklist** and, optionally, to an **AI estimate kept apart** from the real counts
- Patients treated only by private insurance do not appear: counts are a floor for the whole country
- The most recent months of outpatient data arrive late, so monthly rates use complete months only

HOW IT WORKS

From protocol to site plan in one session.

01

Read the protocol

Upload Word or PDF, or paste the criteria. The AI splits each criterion and classifies it as assessable, approximated or not assessable in the data.

02

Build the cohort

Criteria become official codes (ICD-10, procedures, medications, regimens) combined with AND/OR, time windows and treatment duration.

03

Run the funnel

One criterion at a time, with how many patients each one costs. The costliest criterion is flagged.

04

Test adjustments

The AI proposes alternative criteria; each proposal is measured with a real search before anyone decides.

05

Locate the patients

State of residence, facilities that treat the cohort, diversity by race/skin color, sex and region.

06

Plan recruitment

Arrival of eligible new cases versus the pace the target requires; recruitment time and curve with an uncertainty band.

07

Select and budget sites

Candidate sites scored by patients, research experience and competition; site and country budget from the schedule of assessments.

08

Report

A structured AI report for the meeting, exportable to Word, PDF and a presentation; scenarios saved and compared side by side.

THE RULE BEHIND EVERY SCREEN

The AI interprets and writes. The numbers come from the search.

Counts, rates, times and capacities are computed by the search engine over the records. When the AI writes a report, it can only cite numbers that the search produced; sentences that cite anything else are discarded before the report is shown. Where the AI does estimate — for criteria the records cannot measure — the estimate is labeled, kept in a separate layer and never mixed with the real counts.

A real search, end to end.

The following pages follow one illustrative protocol through the platform: an adjuvant phase 3 study in HER2-positive early breast cancer, women aged 18 to 75 treated with trastuzumab, with a target of 300 patients in 18 months at a 10% conversion rate. Every number shown was computed live on the platform on 16 October 2026.

STEP 1 · PROTOCOL ASSISTANT

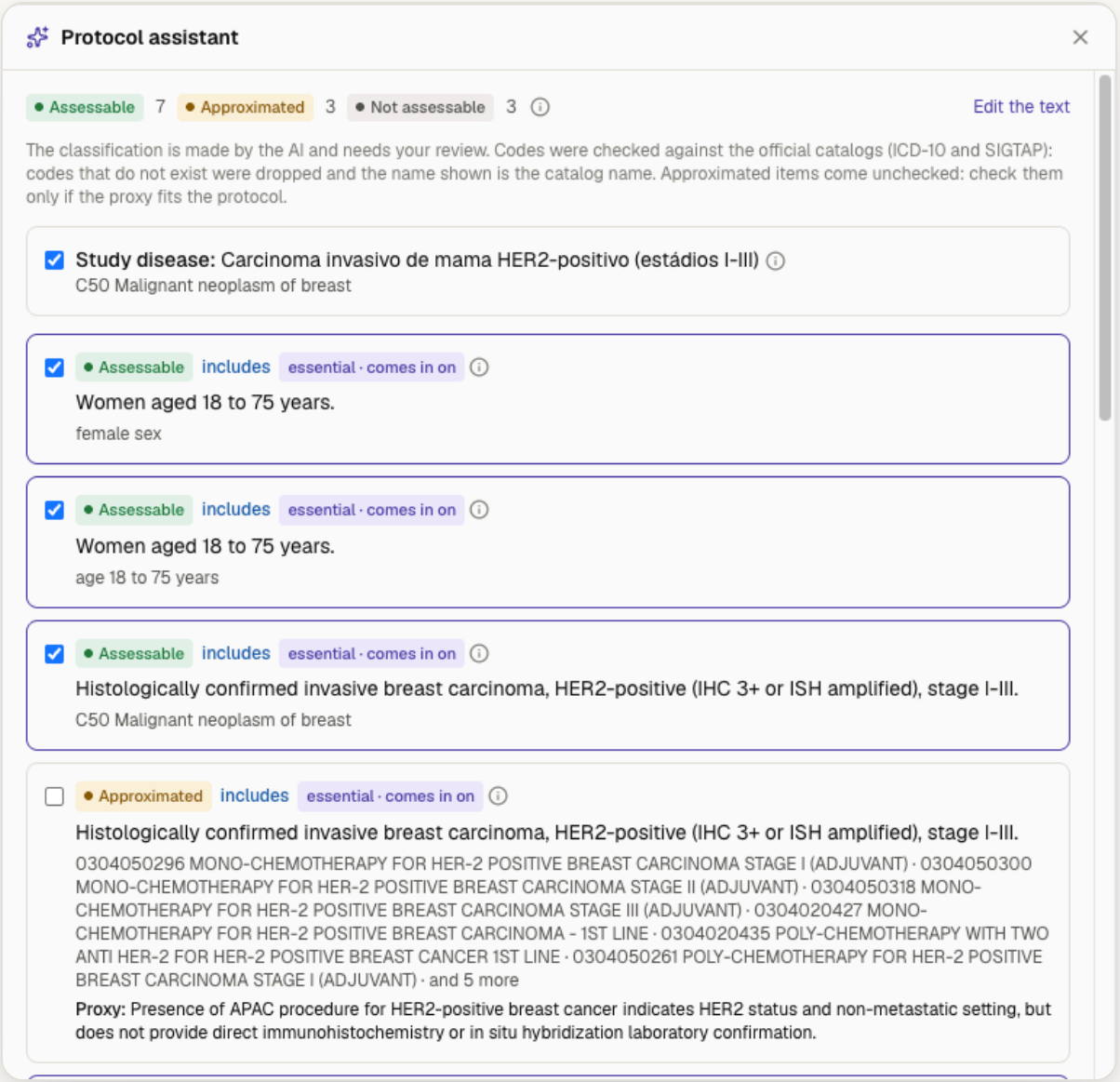
The AI reads the protocol and proposes each criterion with official codes.

The user uploads the full protocol (Word or PDF) or pastes the eligibility section. The assistant splits the text into criteria and classifies each one:

- **Assessable** — measured directly in the records (diagnosis, age, sex, treatment, procedure, hospitalization).
- **Approximated** — measured through a proxy, which comes unchecked so the user decides whether it fits.
- **Not assessable** — such as ECOG or ejection fraction; sent to the pre-screening checklist.

Every code is checked against the official ICD-10 and procedure catalogs; codes that do not exist are dropped. In this protocol the assistant found 7 assessable, 3 approximated and 3 non-assessable items.

Confidentiality. The protocol is processed in memory and discarded when the analysis ends. It is not stored and is not used to train AI models.



STEP 2 · ELIGIBILITY

See which criterion costs the most patients.

The funnel applies one criterion at a time to the patients left by the previous one. Under each step it shows how many patients would come back without it, and the costliest criterion is highlighted.

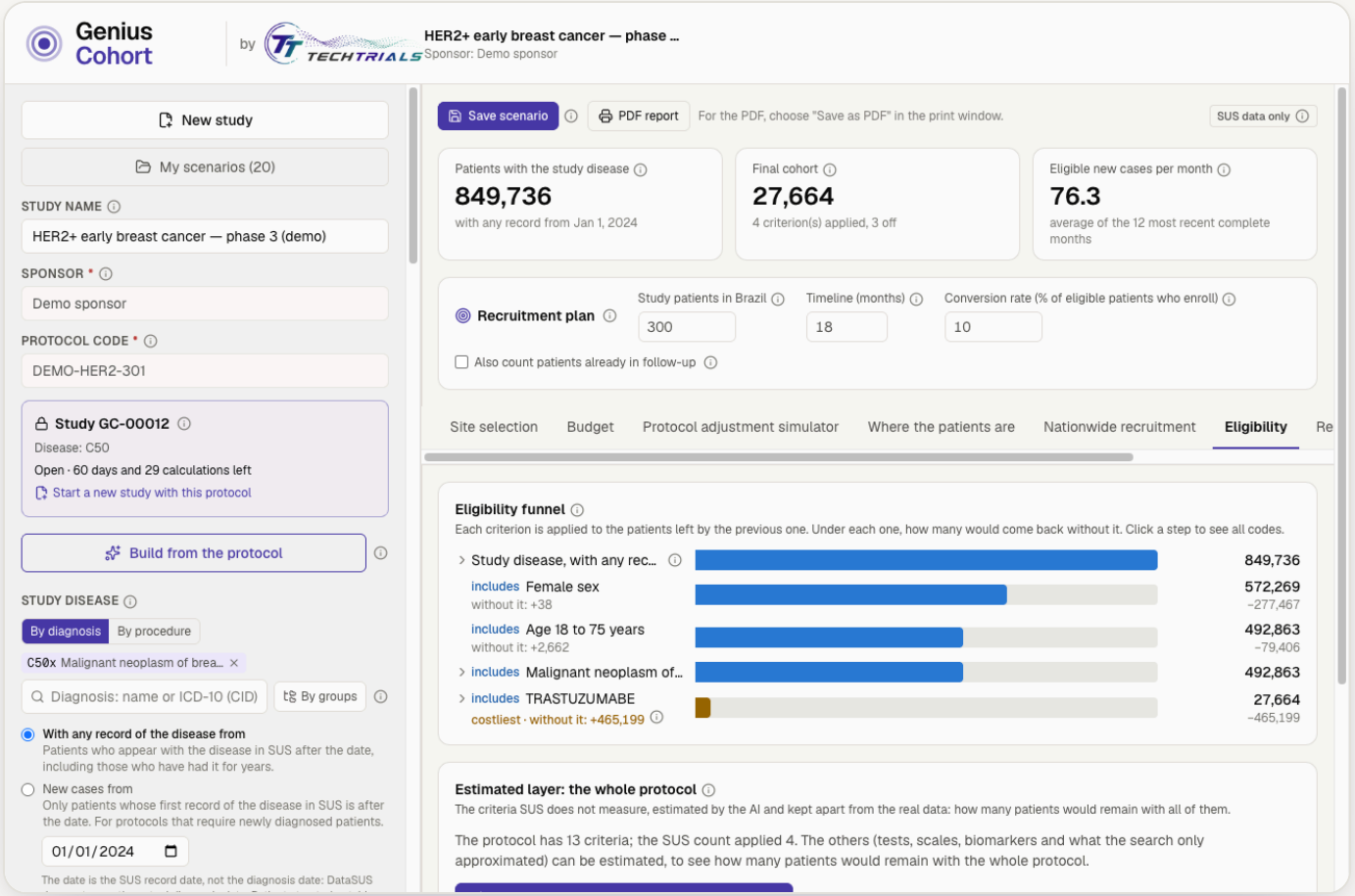
849,736
patients with breast cancer and any record since January 2024

27,664
final cohort after the protocol's assessable criteria

76.3
eligible new cases per month, average of the 12 latest complete months

−465k
patients removed by the trastuzumab criterion, the costliest step

Clicking any step opens the full list of codes used. The same screen keeps the recruitment plan — target, timeline and conversion rate — that drives every downstream calculation.



STEP 2 · WHAT THE RECORDS CANNOT MEASURE

Two honest answers for the criteria outside administrative data.

PRE-SCREENING CHECKLIST

What the site must confirm in the medical record

Every criterion the search could not apply becomes a line in a pre-screening checklist, grouped into three blocks: not assessable in the data, approximated in the search (confirm the actual criterion) and applied exclusions (confirm the absence, because an exclusion only removes what was coded). Sites use it as the screening log for the study.

Criterion in this protocol	How it is treated
Women aged 18–75, invasive breast carcinoma	**Assessable** — applied in the search
Trastuzumab-based therapy in the last 12 months	**Assessable** — applied in the search
HER2-positive by IHC 3+ or ISH	**Approximated** — HER2-specific chemotherapy codes as a proxy
ECOG 0–1; LVEF ≥ 55%	**Not assessable** — checklist

ESTIMATED LAYER

How many would remain with the whole protocol

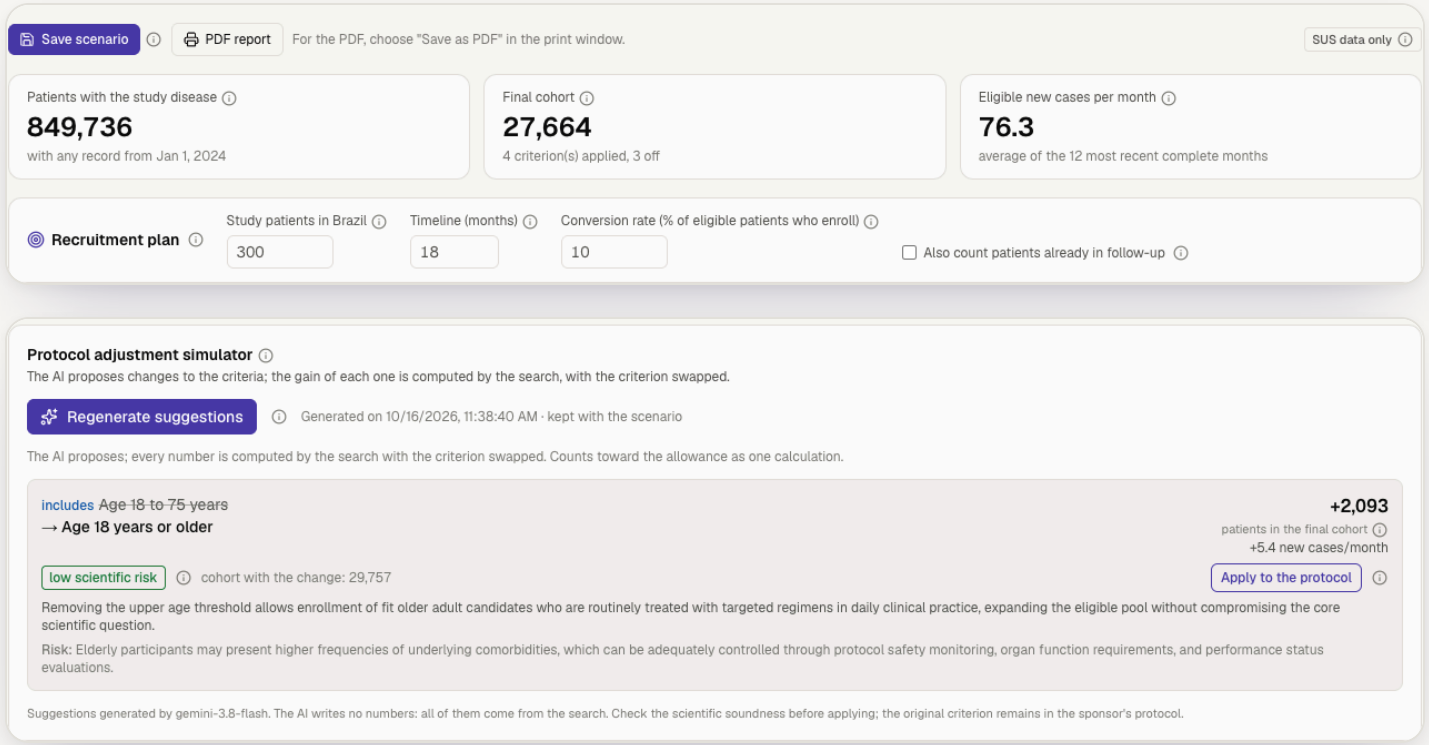
Optionally, the AI estimates the share of the cohort that would pass the criteria the records cannot see — biomarkers, scales, test results — and shows the estimated cohort beside the real one, never merged with it.

- Each estimate is read **three times** and the median is used, with the range shown.
- Supporting literature is checked against PubMed: **author, year and journal must match**, and the abstract must support the claim. References that fail are removed.
- Scenarios that include an estimate carry a visible “SUS data + AI estimate” label, in the screen and in every export.

Regional registries with clinical detail, such as hormone receptor status, are shown as reference only and are never added to the national count.

STEP 3 · PROTOCOL ADJUSTMENT SIMULATOR

Negotiate amendments with numbers, before the protocol is final.



The AI proposed removing the upper age limit. The search measured the gain: +2,093 patients in the final cohort and +5.4 eligible new cases per month, classified as low scientific risk.

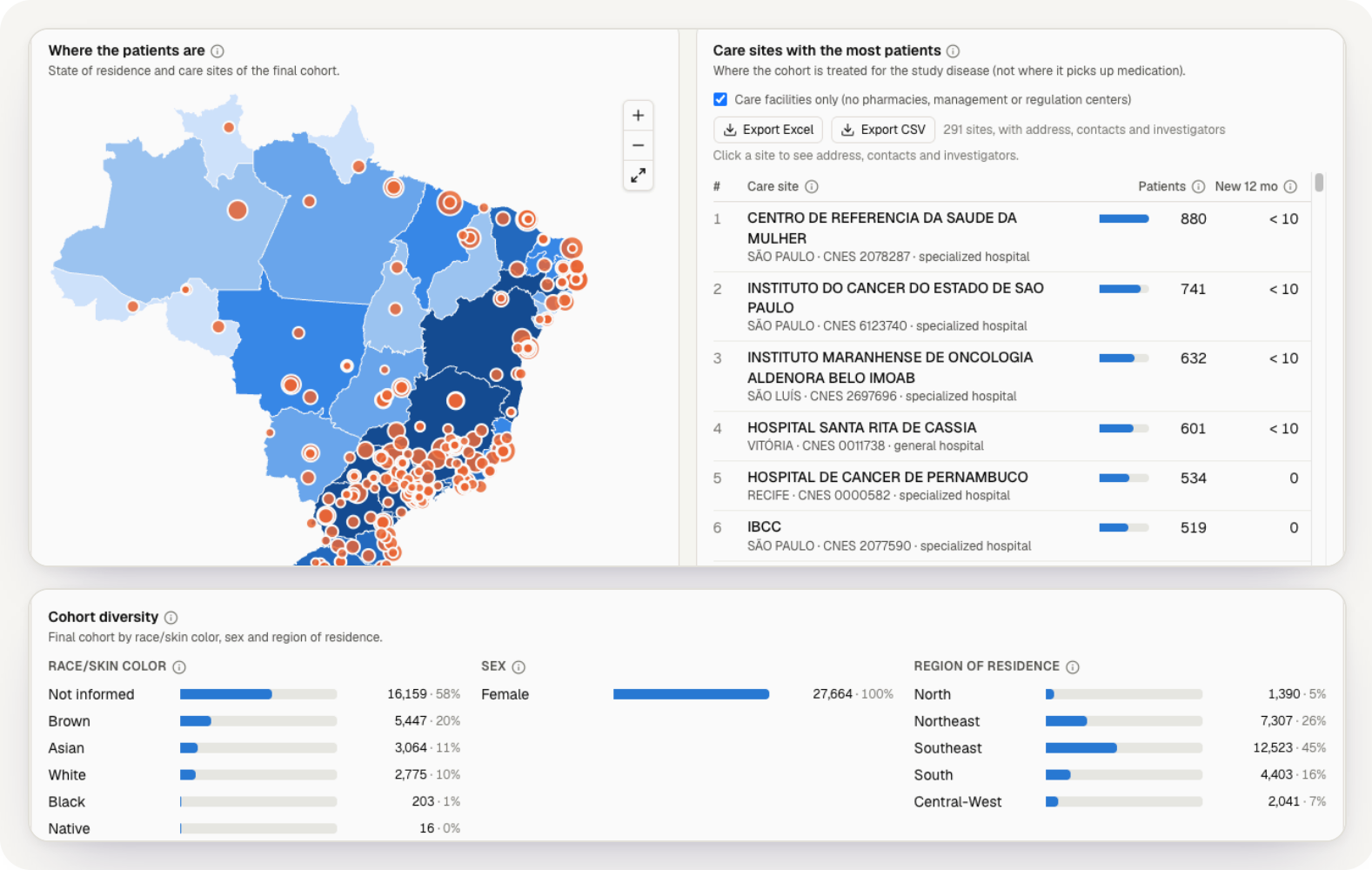
When the cohort falls short of the target, the simulator asks the AI for alternative versions of the criteria — a wider age range, a shorter washout, a time limit on a past condition — and runs each alternative as a real search with that criterion swapped.

- **Gain measured, not guessed:** patients added to the final cohort and to the monthly arrival of new cases.
- **Scientific risk graded** (low, medium, high) with the rationale and the residual risk spelled out.
- **One click to apply** the change to the working protocol; the sponsor's original criterion remains on record.

Sponsors use it to stress-test eligibility before submission; CROs use it to bring evidence-based amendment proposals to the sponsor.

STEP 4 · WHERE THE PATIENTS ARE

The geography of the cohort, down to each facility that treats it.



States are shaded by where the final cohort lives; each point is a facility that treats it, sized by patients. The ranking beside the map lists the facilities with the most patients and new cases in the last 12 months — 291 in this example — exportable to Excel with address, contacts and investigators.

Each patient counts at the facility where they are most often treated for the study disease, not where they pick up medication, so pharmacies and regulation centers do not distort the list.

Cohort diversity

Aggregate composition by race/skin color, sex and region of residence, to plan representativeness early — with explicit warnings where the administrative field is often missing or known to be inflated.

STEP 5 · RECRUITMENT TIME

Know whether the pace covers the target before the first patient is screened.

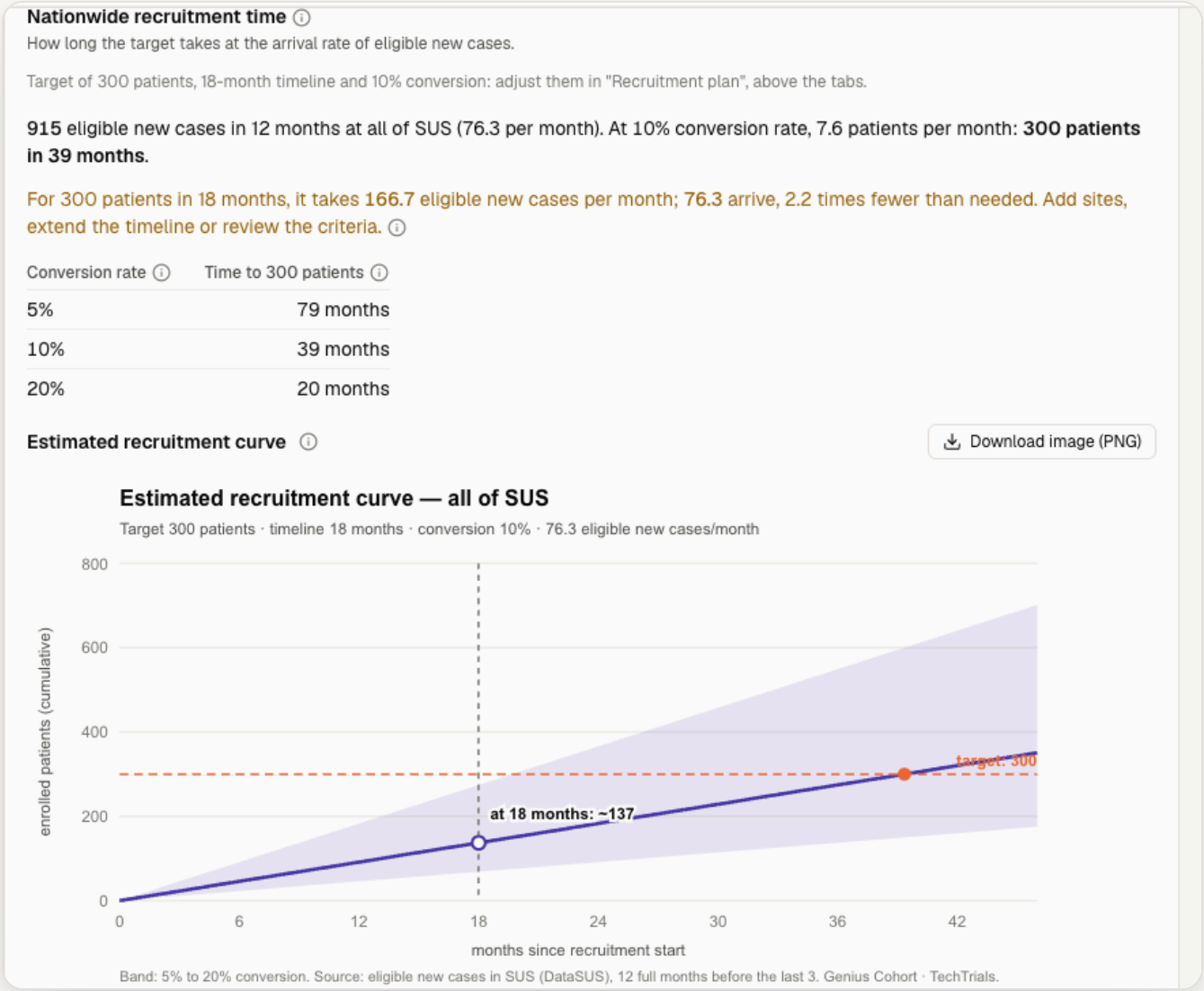
With the target, timeline and conversion rate, the platform compares the arrival of eligible new cases with the pace the target requires and estimates the time to reach it at 5%, 10% and 20% conversion.

166.7
eligible new cases per month needed for 300 patients in 18 months

39 months
to reach 300 nationwide at 10% conversion — 2.2× slower than planned

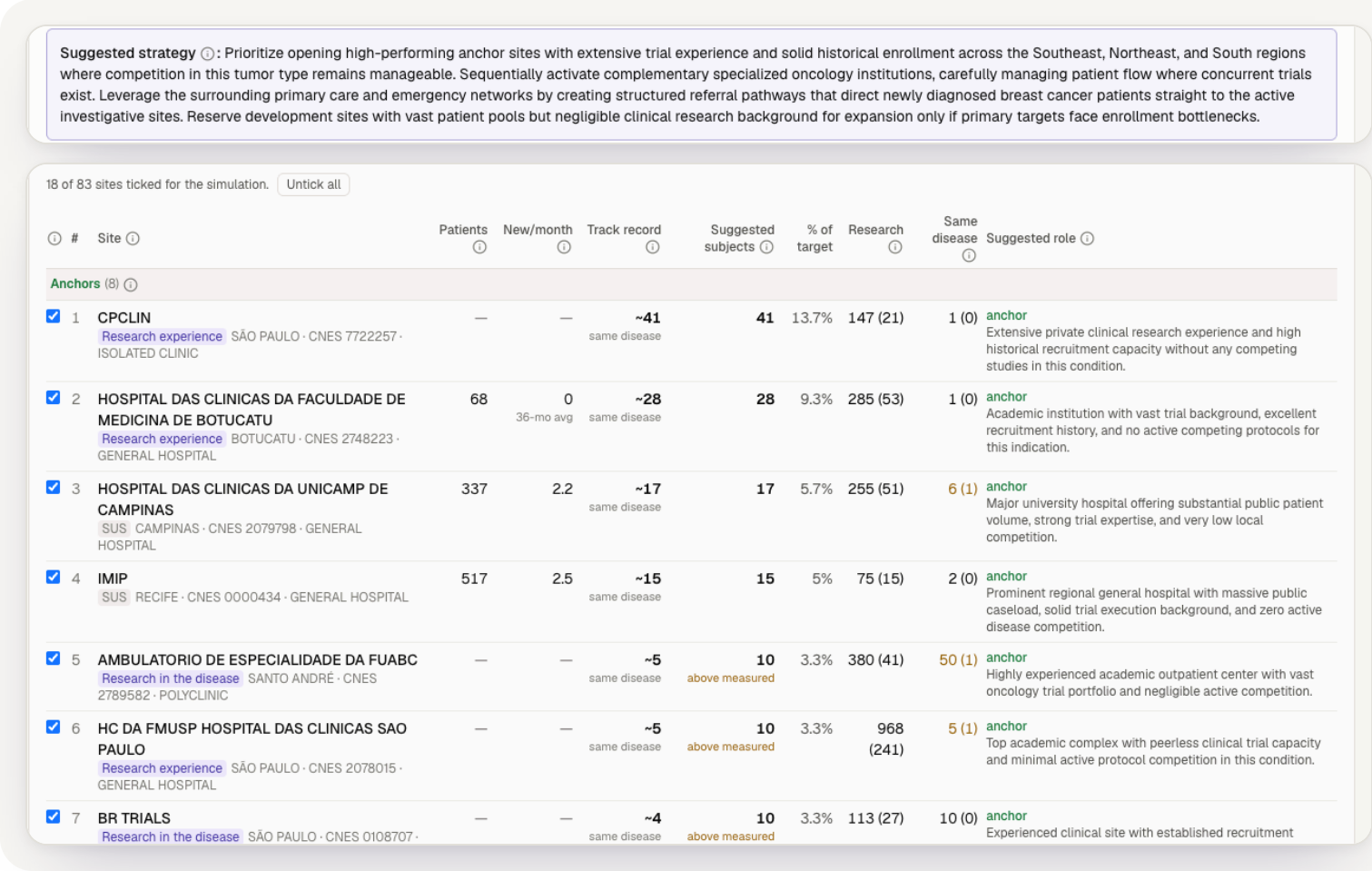
The recruitment curve shows patients enrolled month by month with an uncertainty band for conversion. It can be downloaded as an image and goes into the PDF report. New cases are also charted over the last 36 months against the required pace, so seasonality and trends are visible.

> In this example the answer is clear on day one: national incident cases alone cannot meet the plan, so the study needs a site network with research capacity and a protocol adjustment — which is exactly what the next steps address.



STEP 6 · SITE SELECTION

Public hospitals with patients and research centers with track record, on the same list.



Suggested strategy ⓘ: Prioritize opening high-performing anchor sites with extensive trial experience and solid historical enrollment across the Southeast, Northeast, and South regions where competition in this tumor type remains manageable. Sequentially activate complementary specialized oncology institutions, carefully managing patient flow where concurrent trials exist. Leverage the surrounding primary care and emergency networks by creating structured referral pathways that direct newly diagnosed breast cancer patients straight to the active investigative sites. Reserve development sites with vast patient pools but negligible clinical research background for expansion only if primary targets face enrollment bottlenecks.

18 of 83 sites ticked for the simulation. Untick all

#	Site	Patients	New/month	Track record	Suggested subjects	% of target	Research	Same disease	Suggested role
Anchors (8)									
☑ 1	**CPCLIN** Research experience · SÃO PAULO · CNES 7722257 · ISOLATED CLINIC	—	—	~41 same disease	41	13.7%	147 (21)	1 (0)	anchor Extensive private clinical research experience and high historical recruitment capacity without any competing studies in this condition.
☑ 2	**HOSPITAL DAS CLINICAS DA FACULDADE DE MEDICINA DE BOTUCATU** Research experience · BOTUCATU · CNES 2748223 · GENERAL HOSPITAL	68	0 36-mo avg	~28 same disease	28	9.3%	285 (53)	1 (0)	anchor Academic institution with vast trial background, excellent recruitment history, and no active competing protocols for this indication.
☑ 3	**HOSPITAL DAS CLINICAS DA UNICAMP DE CAMPINAS** SUS · CAMPINAS · CNES 2079798 · GENERAL HOSPITAL	337	2.2	~17 same disease	17	5.7%	255 (51)	6 (1)	anchor Major university hospital offering substantial public patient volume, strong trial expertise, and very low local competition.
☑ 4	**IMIP** SUS · RECIFE · CNES 0000434 · GENERAL HOSPITAL	517	2.5	~15 same disease	15	5%	75 (15)	2 (0)	anchor Prominent regional general hospital with massive public caseload, solid trial execution background, and zero active disease competition.
☑ 5	**AMBULATORIO DE ESPECIALIDADE DA FUABC** Research in the disease · SANTO ANDRÉ · CNES 2789582 · POLYCLINIC	—	—	~5 same disease	10 above measured	3.3%	380 (41)	50 (1)	anchor Highly experienced academic outpatient center with vast oncology trial portfolio and negligible active competition.
☑ 6	**HC DA FMUSP HOSPITAL DAS CLINICAS SAO PAULO** Research experience · SÃO PAULO · CNES 2078015 · GENERAL HOSPITAL	—	—	~5 same disease	10 above measured	3.3%	968 (241)	5 (1)	anchor Top academic complex with peerless clinical trial capacity and minimal active protocol competition in this condition.
☑ 7	**BR TRIALS** Research in the disease · SÃO PAULO · CNES 0108707 ·	—	—	~4 same disease	10 above measured	3.3%	113 (27)	10 (0)	anchor Experienced clinical site with established recruitment

83 candidates in this example: 40 from the public system — hospitals, polyclinics and specialty centers with the most eligible new cases and patients in follow-up — and 43 research sites from ClinicalTrials.gov with studies in the disease or strong industry experience, 27 of them with no cohort patients in public records.

For each site: patients, eligible new cases per month, enrollment track record, suggested subjects, share of the target, research experience and studies in the same disease (competition). Emergency and primary care units are not candidates; they become each site's referral network within 30 km.

The AI groups the sites by role — **anchor, complementary, to develop, avoid** — explains each choice and writes an activation strategy. The system then simulates how many of the selected sites meet the target on time.

SITE SELECTION · METHODOLOGY

A transparent rule for choosing candidates and sizing capacity.

Component	Rule
Who can host a study	Facility type in the national registry: general and specialized hospitals, day hospitals, polyclinics and specialty centers. Other units host studies only when they already appear in ClinicalTrials.gov.
Candidates from patient records	The 30 facilities with the most eligible new cases per month and the 10 with the most patients in follow-up — chronic-disease studies recruit mostly patients already in treatment.
Candidates from research	Every Brazilian site with a study in the same disease (up to 40) and the 15 with the most industry studies in the last 10 years, even without patients in public records.
Referral network	Emergency, primary care and similar units count toward the nearest candidate within 30 km, each unit to one site only; added to capacity only on request.
Capacity by track record	For each past study at the site: participants ÷ number of sites worldwide. The site's estimate is the median, from studies in the same disease or, failing that, industry studies.

Why it matters

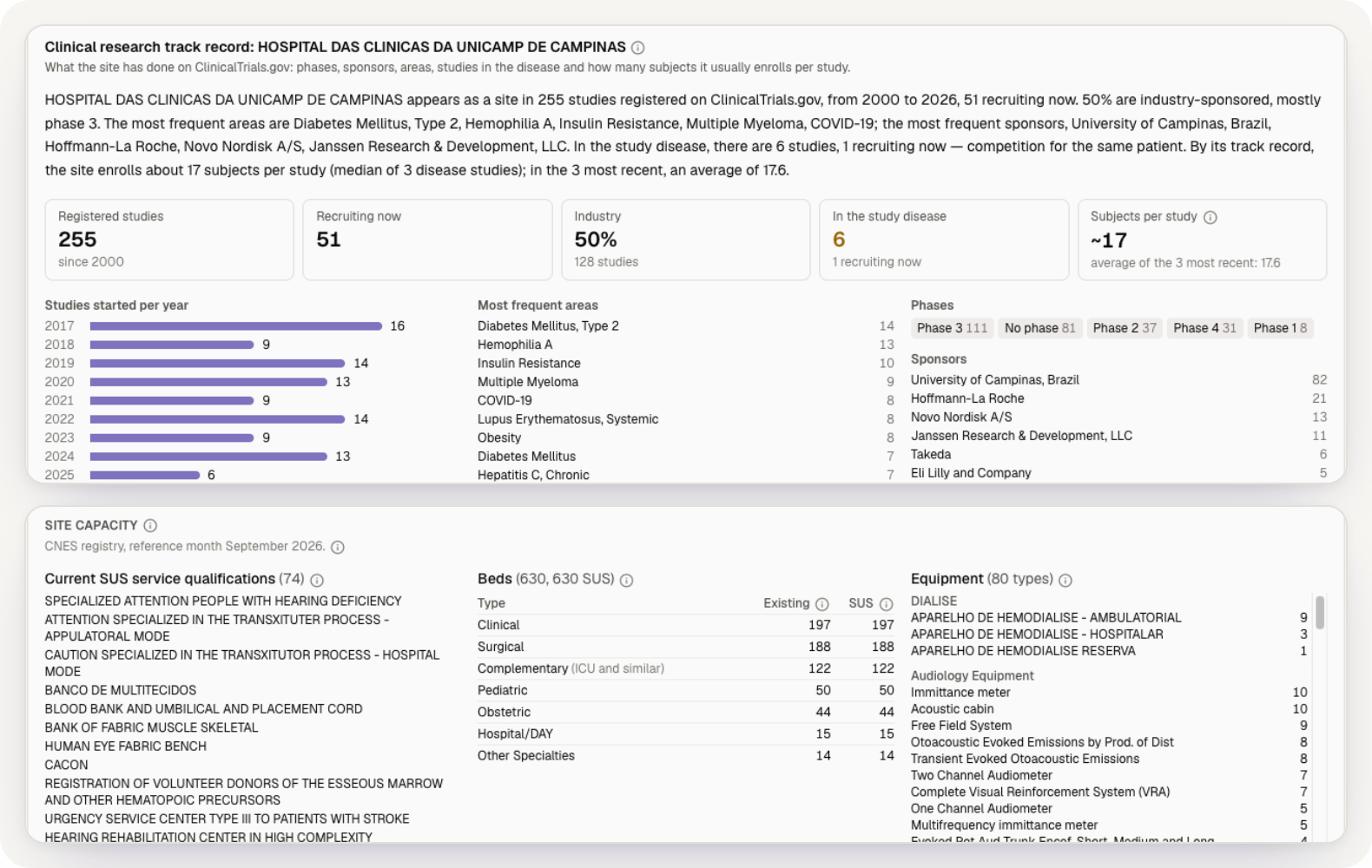
Ranking sites only by new cases favors emergency units: an acute flare is coded where the patient seeks urgent care. In an atopic dermatitis test, 13 of the top 30 facilities by new cases were emergency units, and a leading academic center with nine studies in the disease ranked 72nd. The rule above brings research-ready centers back into view without hiding the public hospitals that hold the patients.

What CROs export

- Excel and CSV of all candidates with address, contacts and investigators
- Site sheet with the investigators and the diseases of their studies
- Verified-site badge for centers whose profile was confirmed by TechTrials
- Minimum subjects per site configurable for consolidation

STEP 7 · RESEARCH SITE ANALYSIS

Due diligence on any site, in one screen.



Clinical research track record

From ClinicalTrials.gov: studies per year, phases, therapeutic areas, sponsors, studies in the disease and the typical number of subjects the site enrolls per study. In the example, the analyzed university hospital appears in 255 registered studies, 51 recruiting now, 50% industry-sponsored, enrolling about 17 subjects per study in the disease.

Site capacity

From the national facility registry: service accreditations, beds and equipment.

Clinical research in the region

Competitors recruiting the same disease within the radius, and potential collaborators with studies in the disease.

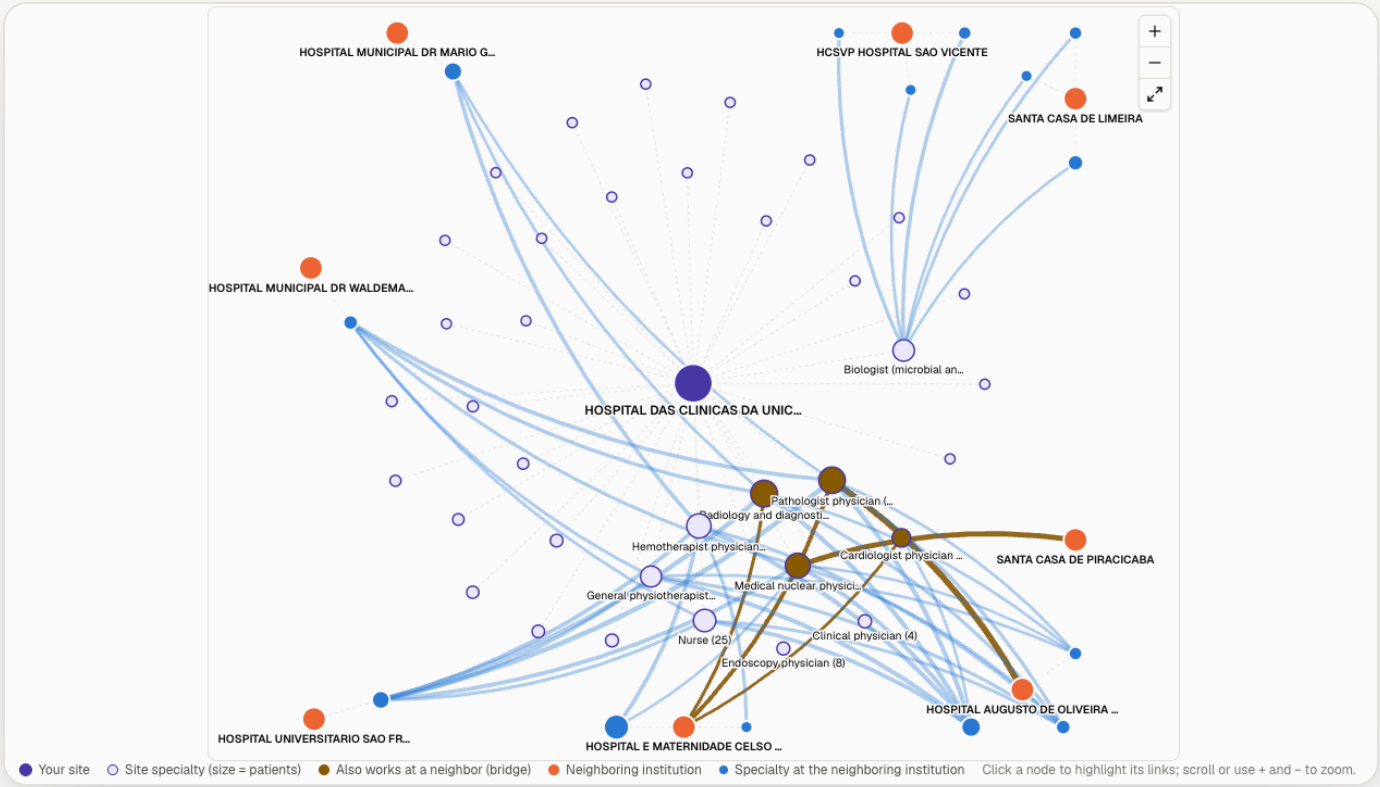
> Any site in Brazil can be analyzed by registry code, name or postal code, within a radius of up to 500 km.

STEP 7 · REFERRAL PATHS

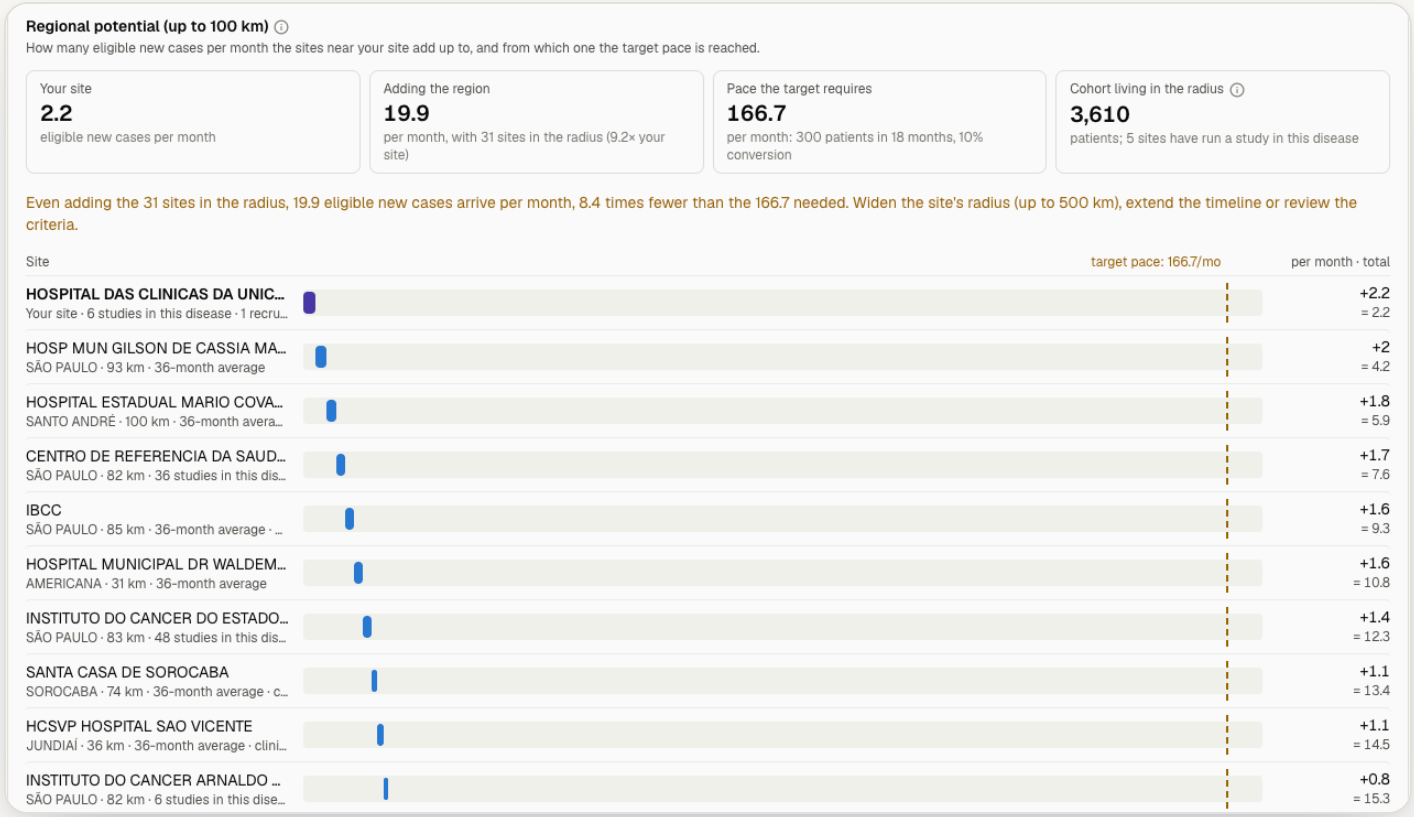
See the paths patients already take between institutions.

The relationship network maps how the cohort moves between the analyzed site and the institutions within the radius. Blue lines are cohort patients seen on both sides — the path patients already take. Gold nodes are **bridge specialties**: professionals who treat the cohort at the site and also at a neighboring institution, the people who can help refer.

Line thickness is the number of shared patients; links with fewer than 5 patients are not shown.



Privacy by profile. Sponsors and CROs see professionals by specialty only, never by name. A research site sees names only for its own team, and only after TechTrials has verified the person's link to that site.



STEP 7 · REGIONAL POTENTIAL

How far a site plus its region can go.

Regional potential adds, site by site, the eligible new cases per month of the facilities around the analyzed site and shows from which point the target pace is reached.

2.2
eligible new cases per month at the analyzed site

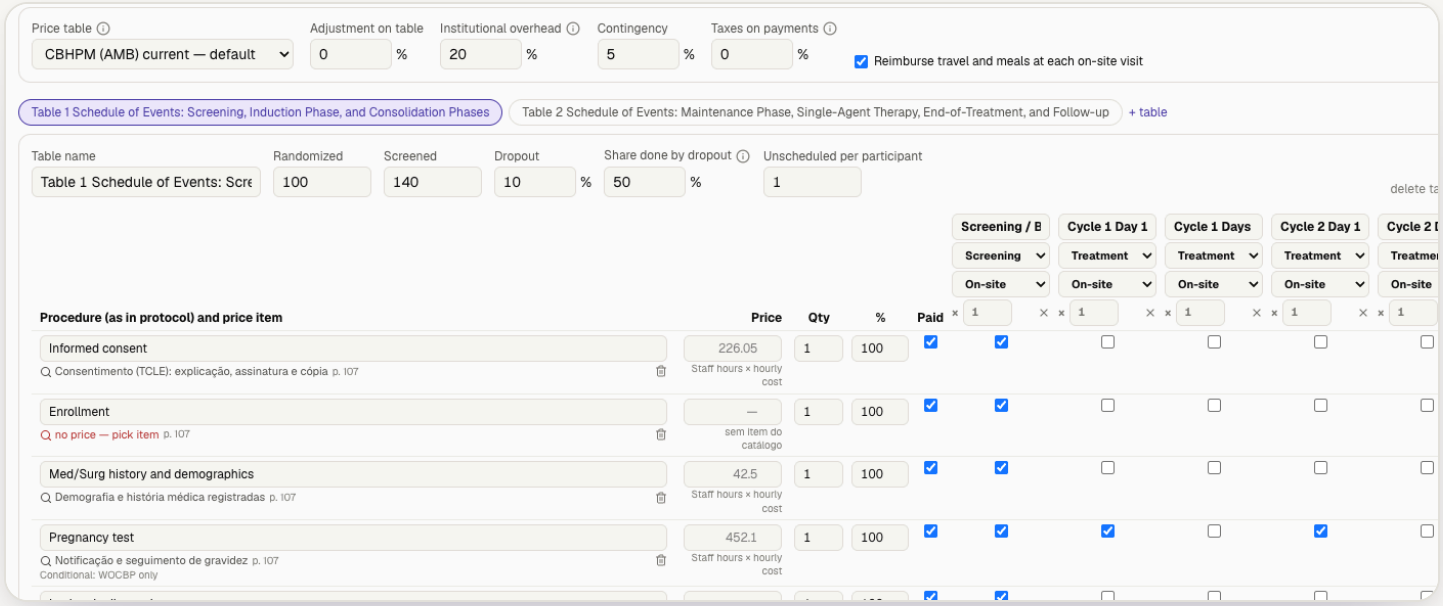
19.9
adding the 31 facilities within 100 km — still 8.4× short of the pace

The conclusion is stated in plain words with the next move: widen the radius (up to 500 km), extend the timeline or review the criteria. It is the quantitative version of the conversation every sponsor has with a site before activation.

For rare diseases, facilities with fewer than 10 new cases use an average of up to 36 months, and small values are sealed and only added up in rounded totals.

STEP 8 · STUDY BUDGET

From the schedule of assessments to the site and country budget.



Budget built from a phase 3 protocol: the AI read the schedule-of-events tables and their footnotes and proposed a price item for each procedure, citing the protocol page.

The user uploads the protocol; the AI finds the schedule-of-assessments tables, reads visits, procedures and footnotes, and the system suggests each line's price from a reference catalog. Nothing is final until the user reviews it, and every line cites the protocol page it came from.

- **Reference prices** from the Brazilian medical procedure fee schedule (CBHPM, 4,266 codes), editable, with adjustment, institutional overhead, contingency and taxes.
- **Per-visit grid** with screened, randomized and dropout assumptions and unscheduled visits.
- **Site Excel and Brazil Excel**: the national view assembles every selected site from the same model.
- **Two-way check:** the engine's totals are compared with the exported spreadsheet recalculated by its own formulas.

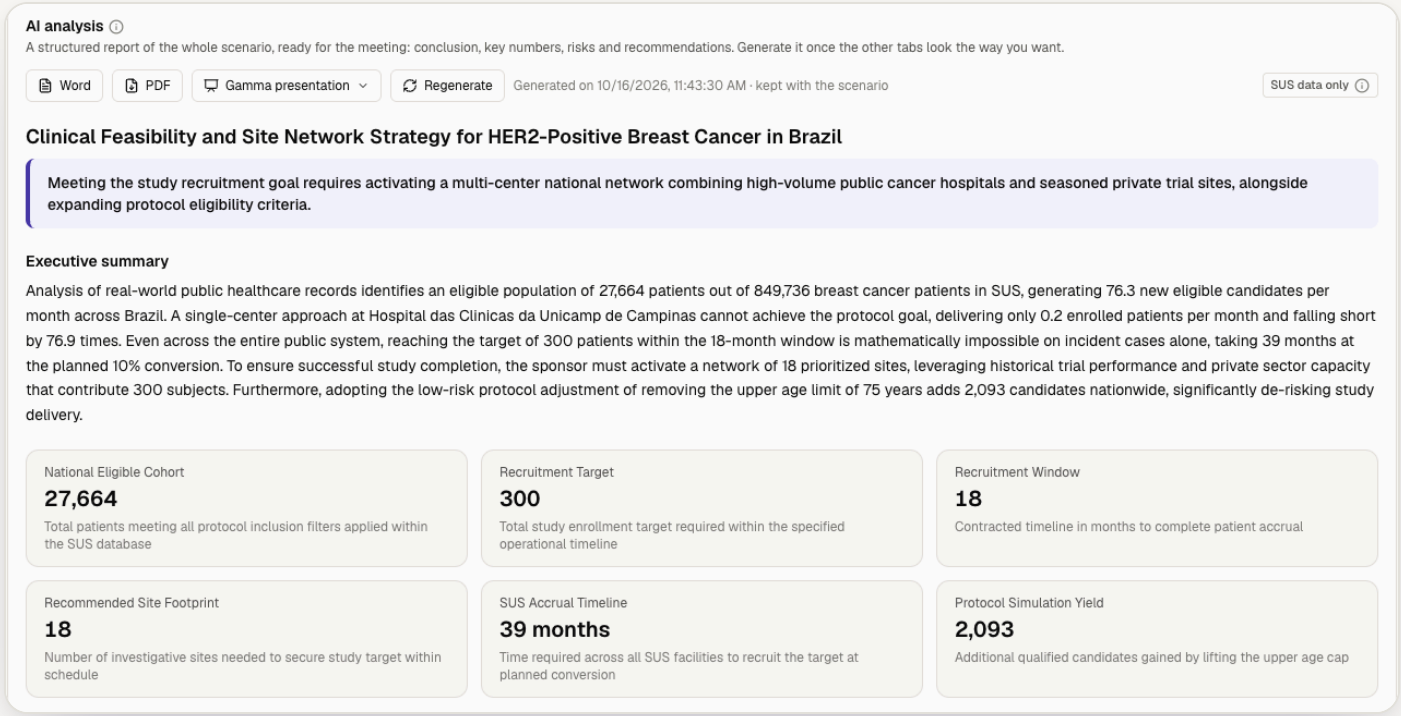
Available in Brazilian reais and US dollars.

STEP 9 · AI ANALYSIS

A meeting-ready report, written from the scenario's own numbers.

Once the tabs look the way the team wants, one click produces a structured report of the whole scenario: headline conclusion, executive summary, key numbers, cohort, site selection, recruitment schedule, competition, protocol adjustments to negotiate, the analyzed site and its region, pre-screening, alerts, recommendations, next steps and limitations.

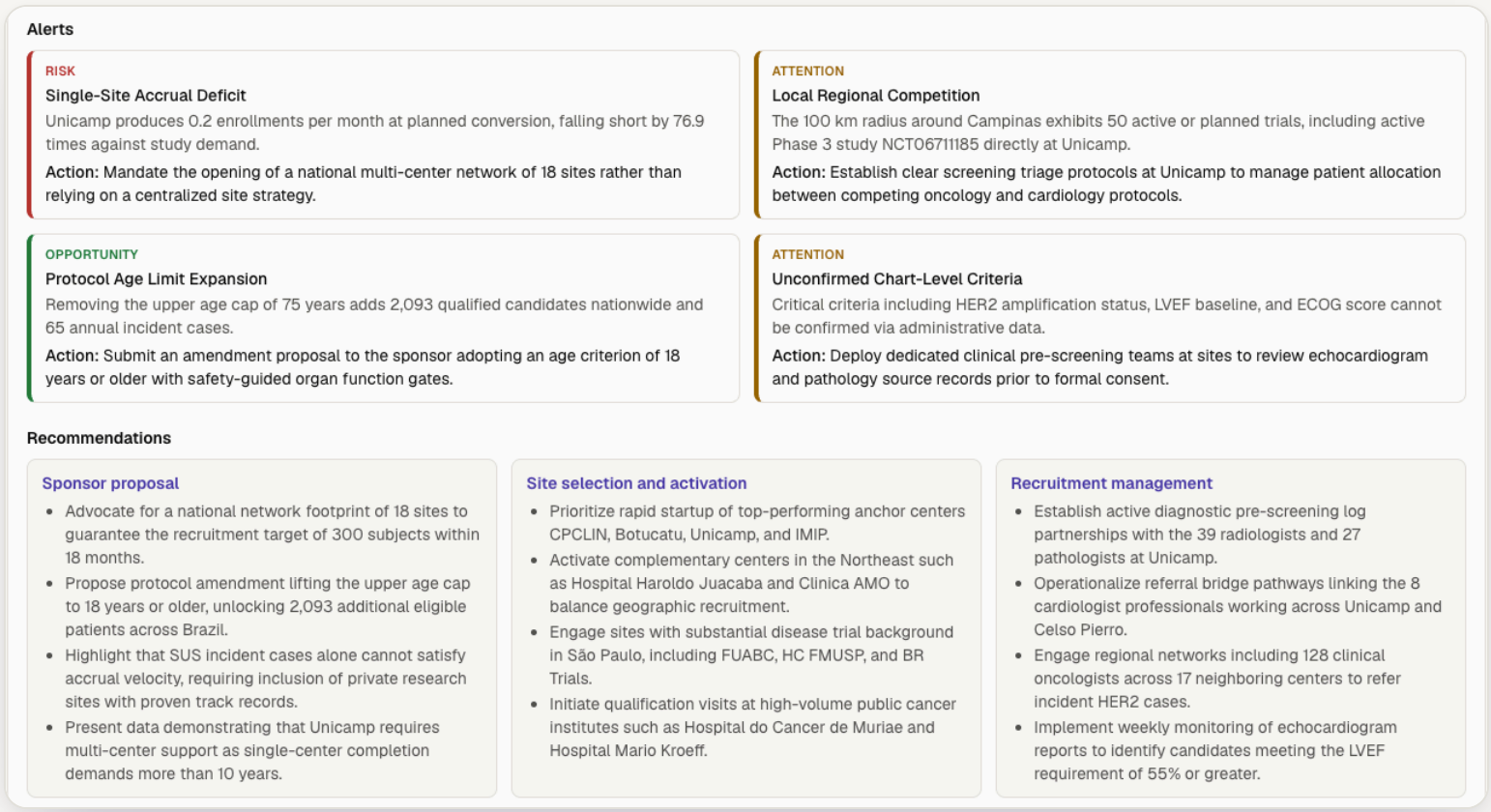
The report is written for the profile that generates it — sponsor, CRO or research site — and exported to **Word, PDF** or a **presentation**.



Numbers are verified, not trusted. Every figure in the text must match a number the search produced; sentences citing anything else are removed before display. In internal tests, reports cited 86 to 93 numbers with no sentence discarded.

STEP 9 · AI ANALYSIS

Risks, opportunities and recommendations, each with an action.



Alerts

RISK

Single-Site Accrual Deficit

Unicamp produces 0.2 enrollments per month at planned conversion, falling short by 76.9 times against study demand.

Action: Mandate the opening of a national multi-center network of 18 sites rather than relying on a centralized site strategy.

ATTENTION

Local Regional Competition

The 100 km radius around Campinas exhibits 50 active or planned trials, including active Phase 3 study NCT06711185 directly at Unicamp.

Action: Establish clear screening triage protocols at Unicamp to manage patient allocation between competing oncology and cardiology protocols.

OPPORTUNITY

Protocol Age Limit Expansion

Removing the upper age cap of 75 years adds 2,093 qualified candidates nationwide and 65 annual incident cases.

Action: Submit an amendment proposal to the sponsor adopting an age criterion of 18 years or older with safety-guided organ function gates.

ATTENTION

Unconfirmed Chart-Level Criteria

Critical criteria including HER2 amplification status, LVEF baseline, and ECOG score cannot be confirmed via administrative data.

Action: Deploy dedicated clinical pre-screening teams at sites to review echocardiogram and pathology source records prior to formal consent.

Recommendations

Sponsor proposal

- Advocate for a national network footprint of 18 sites to guarantee the recruitment target of 300 subjects within 18 months.
- Propose protocol amendment lifting the upper age cap to 18 years or older, unlocking 2,093 additional eligible patients across Brazil.
- Highlight that SUS incident cases alone cannot satisfy accrual velocity, requiring inclusion of private research sites with proven track records.
- Present data demonstrating that Unicamp requires multi-center support as single-center completion demands more than 10 years.

Site selection and activation

- Prioritize rapid startup of top-performing anchor centers CPCLIN, Botucatu, Unicamp, and IMIP.
- Activate complementary centers in the Northeast such as Hospital Haroldo Juacaba and Clinica AMO to balance geographic recruitment.
- Engage sites with substantial disease trial background in São Paulo, including FUABC, HC FMUSP, and BR Trials.
- Initiate qualification visits at high-volume public cancer institutes such as Hospital do Cancer de Muriae and Hospital Mario Kroeff.

Recruitment management

- Establish active diagnostic pre-screening log partnerships with the 39 radiologists and 27 pathologists at Unicamp.
- Operationalize referral bridge pathways linking the 8 cardiologist professionals working across Unicamp and Celso Pierro.
- Engage regional networks including 128 clinical oncologists across 17 neighboring centers to refer incident HER2 cases.
- Implement weekly monitoring of echocardiogram reports to identify candidates meeting the LVEF requirement of 55% or greater.

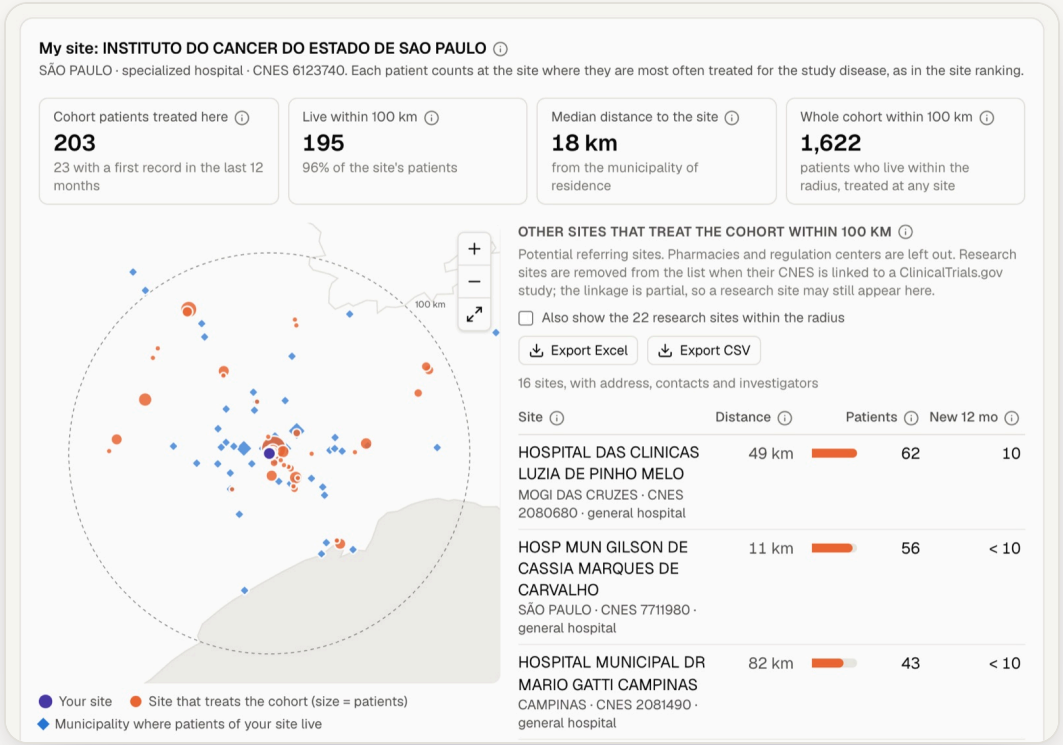
Alerts are classified as **risk**, **attention** or **opportunity**, and every alert ends with a concrete action. Recommendations are split by audience — sponsor proposal, site selection and activation, recruitment management.

In the example, the report concluded that a single-site strategy cannot meet the goal, that an 18-site network combining public cancer hospitals and experienced private research sites is required, and that lifting the upper age limit adds 2,093 patients nationwide at low scientific risk.

It also flags what administrative data cannot confirm — HER2 amplification, ejection fraction, performance status — and turns it into a pre-screening action for the sites.

FOR RESEARCH SITES

The site’s own patients, its referral network and a monthly radar.



My site

How many cohort patients the site already treats, how many had a first record in the last 12 months, the median distance from where they live, the whole cohort within the radius and the facilities nearby that treat the same patients — potential referrers.

Feasibility letter for the sponsor

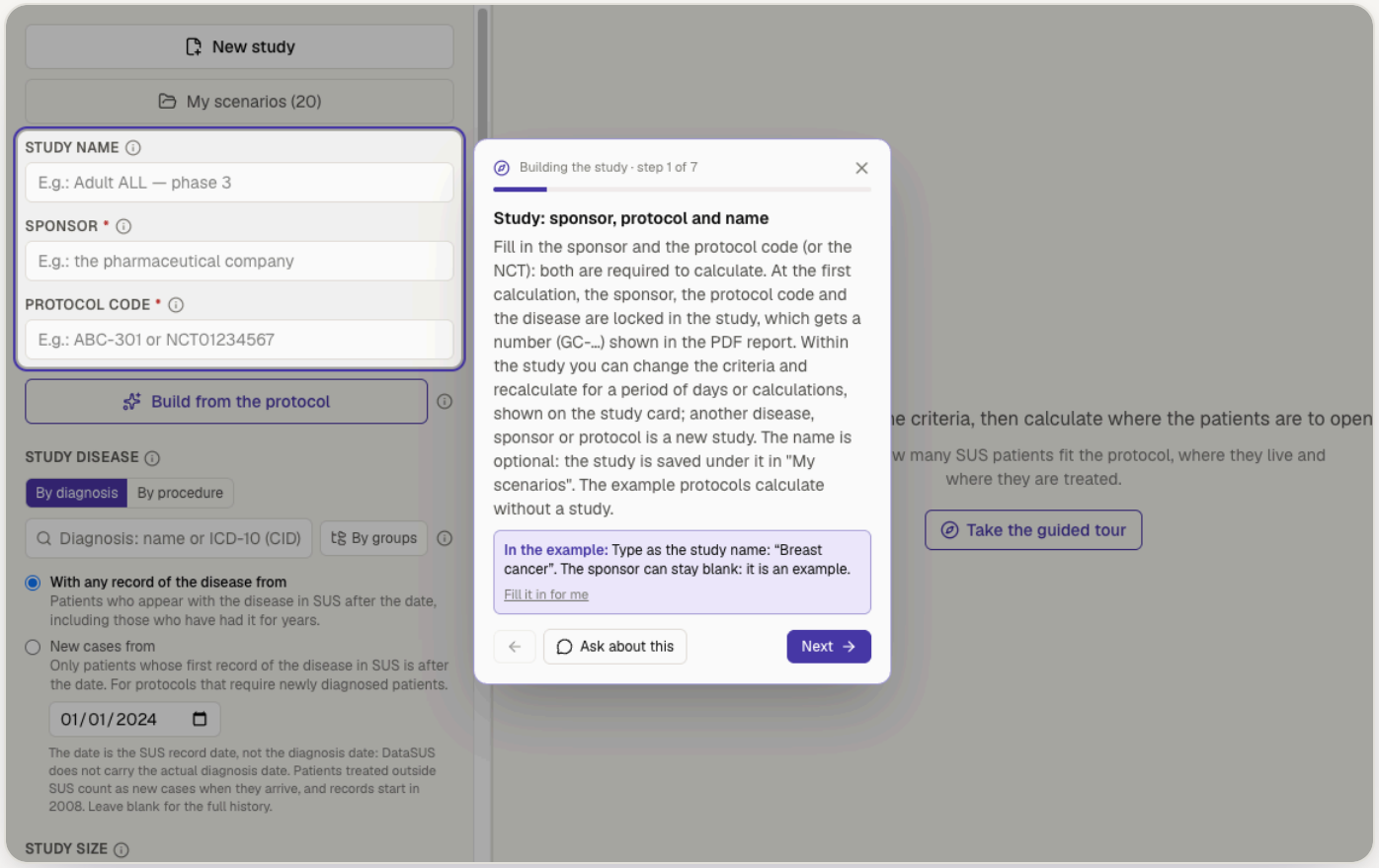
A PDF in the site’s name with its own indicators, infrastructure from the national registry and the recruitment curve, ready to answer a sponsor’s feasibility questionnaire.

Monthly radar and verified profile

Every month, by e-mail: the site’s patients in the diseases it researches and the studies recruiting in Brazil that it is not yet part of. The verified profile — diseases, phases, team, infrastructure, contact — is what sponsors and CROs see when they choose sites.

Exact numbers for verified teams

Once TechTrials verifies the user’s link to the site, the site sees its own exact counts and its professionals by name.



EASE OF USE

A guide that waits for the user to act.

Cohort Companion builds a study together with the user, step by step: it shows where each field is, the user fills it in, and then they read each result tab together. A full study takes about ten minutes, with the option to start from a real project or from a ready example.

At any step the user can ask the AI a question about what is on screen; the guide and the AI answer from the same script, so the explanation in the tour and the explanation in the chat never diverge.

- Six sample protocols across oncology, endocrinology, cardiology and rheumatology
- Contextual help on every number (“ⓘ”), in plain language
- Scenarios saved to the account and compared side by side
- PDF report stamped with sponsor, protocol and study number

TRUST, PRIVACY AND SCIENTIFIC RIGOR

Built to stand up in front of a sponsor, an auditor and an ethics committee.

No patient is identified

Only aggregate counts leave the database. Any number below 10 is shown as “< 10”; small values are sealed and only enter rounded sums. Data handling follows the LGPD, Brazil’s data protection law.

Protocols stay confidential

Uploaded protocols are processed in memory and discarded; they are not stored and are not used to train AI. The AI runs on a paid plan whose terms exclude training on submitted content.

Access by profile

The client profile is set by TechTrials and enforced on the server. Health professionals appear by specialty to sponsors and CROs; names only for the verified site’s own team.

Numbers come from the search

The AI never types a count, rate or time. Reports are checked number by number against the search; estimates are labeled and kept apart from real data.

Official catalogs only

Every code proposed by the AI is checked against the official ICD-10 and procedure catalogs; invalid codes are dropped. Literature references must match PubMed by author, year and journal.

Limitations stated on screen

Every result screen explains what the counts mean: patients treated only by private insurance are not included, comorbidity exclusions give a ceiling and inclusions a floor, and late-arriving months are left out of rates.

VALUE

What changes for each team.

Decision	Pharmaceutical industry	CROs	Research sites
Country feasibility	Eligible cohort and monthly arrival for the exact protocol, in minutes, before committing a country allocation.	Evidence to support or challenge the sponsor's allocation for Brazil.	A clear yes or no on whether the site has the patients, before signing a feasibility questionnaire.
Protocol design	The costliest criterion and the measured gain of each alternative, to adjust eligibility before submission.	Quantified amendment proposals to bring to the sponsor.	Which criteria must be confirmed in the medical record — the pre-screening checklist.
Site network	Public hospitals with volume and experienced research centers, with competition in the same disease.	Candidate list with roles, capacity, contacts and investigators; simulated capacity against the target.	Who treats the same patients nearby and the paths patients already take — the referral network.
Timeline	Recruitment time at 5%, 10% and 20% conversion and the curve against the target.	Activation plan sized to the pace the target requires.	The site's own recruitment curve, to commit to a realistic number.
Budget	Country budget assembled from every selected site.	Site and country budget from the schedule of assessments.	Site budget with reference prices and overhead.
Communication	AI report for governance meetings, in Word, PDF or presentation.	Sponsor-ready report and Excel exports.	Feasibility letter in the site's name; verified profile seen by sponsors.

GETTING STARTED

Start with a free trial and a protocol of your own.

RESEARCH SITES

Trial period for the site

Sign up at geniuscohort.ttrials.com with the site's national registry code (CNES). TechTrials checks the site and sends the access by e-mail, starting with a trial period. The site's team can run studies, receive the monthly radar and publish its verified profile.

SPONSORS AND CROS

Trial period for the company

Request access with a corporate e-mail. TechTrials enables the company's account with the profile that fits its role — pharmaceutical industry or CRO — and a trial period to evaluate the platform on real protocols.

ENGAGEMENT

Per study or by agreement

Each study is tied to a disease, a sponsor and a protocol code, with criteria open for adjustment over a defined period. Companies can contract per study or through an agreement covering a period and a number of studies.

Bring a protocol. In one session you will see the cohort, the costliest criterion, where the patients are, which sites to open and how long recruitment will take.

Platform: geniuscohort.ttrials.com (English: /en)

Product page: ttrials.com/genius-cohort

Contact: ttrials@ttrials.com

Languages: English and Portuguese · browser-based, nothing to install

AI, real-world evidence and health data science for pharma, hospitals and government.

TechTrials builds analytical platforms on Brazilian health data, combining data engineering at national scale, epidemiological method and applied AI. Genius Cohort brings that experience to the point where a clinical study is decided: the protocol, the country, the sites and the timeline.