Cochrane Renal Group Newsletter

April 2012

Cochrane Renal Group — New reviews, protocols and titles

New and updated reviews

In Issue 12, 2011 and Issues 1-3, 2012 we published four new, and two updated reviews:

New

- Cardiac testing for coronary artery disease in potential kidney transplant recipients *(Diagnostic)*
- Interventions for covert bacteriuria in children
- Parenteral versus oral iron therapy for adults and children with chronic kidney disease
- Pentoxifylline for diabetic kidney disease

Updated

- Fluids and diuretics for acute ureteric colic
- Growth hormone for children with chronic kidney disease

New protocols

In Issue 12, 2011 and Issues 1-3, 2012 we published 11 new protocols:

New

- Acupuncture for renal colic
- Antibiotics for asymptomatic bacteriuria
- Anticoagulants and antiplatelet agents for preventing central venous haemodialysis catheter malfunction in patients with end-stage kidney disease
- Aspiration and sclerotherapy versus hydrocoelectomy for treating hydrocoeles
- Clinical and physical signs for identification of impending and current water-loss dehydration in older people *(Diagnostic)*
- Cordyceps sinensis (a traditional Chinese medicine) for kidney transplant recipients
- Home versus in-centre haemodialysis for end-stage kidney disease
- Human albumin infusion for

Inside this issue:

New Protocols (Cont'd)

treating oedema in people with nephrotic syndrome

- Interventions for preventing intradialytic hypotension in haemodialysis patients
- Single dose antibiotics for treating urinary tract infection in children
- Target of rapamycin inhibitors (TORi) as maintenance immunosuppression for kidney transplant recipients

New titles

- Cardiac testing for coronary artery disease in patients with chronic kidney disease (CKD) stages 4 to 5D
- Chinese herbal medicine for treating recurrent urinary tract infections (RUTIs) in women
- Direct renin inhibitors for preventing the progression of diabetic kidney disease
- Fibrates for people with chronic kidney disease
- Interventions for promoting adherence to fluid intake and dietary salt restriction in patients with end-stage kidney disease
- Interventions for treating urinary stones in children
- Interventions for undescended testes in children
- Ischemic preconditioning for the reduction of renal ischemia/reperfusion injury
- Laparoendoscopic single site nephrectomy versus standard laparoscopic nephrectomy
- Magnesium-based interventions for people with chronic kidney disease
- Revascularisation for patients with end-stage kidney disease stages 4 to 5D

Renal group news

The Cochrane Renal Group team at the Centre for Kidney Research Annual Planning Day 2012
L to R (Back): Jonathan Craig, Ionut Nistor (ERBP), Giovanni Strippoli, Davide Bolignano (ERBP), Ann Jones
L to R (Front): Angela Webster, Narelle Willis, Leslee Edwards, Ruth Mitchell, Gail Higgins

Cochrane Renal Group Advisory Board

The Cochrane Renal Group's Advisory Board meet twice a year to discuss strategic planning and policy development for the Renal Group.

We would like to welcome **Dr Michael Webster** who recently joined the Board as a consumer representative.

Visitors to the Cochrane Renal Group

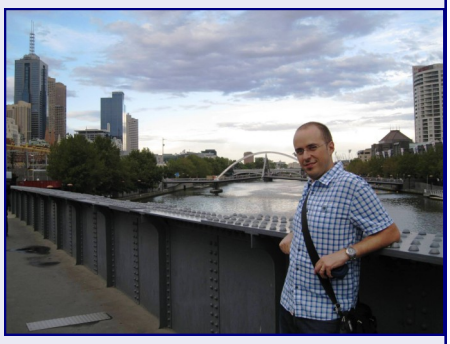
Nephrologist — Davide Bolignano

In February 2012 Davide Bolignano joined the Cochrane Renal Group for four months. Davide is currently involved in the diabetes guidelines project of the European Renal Best Practice group (ERBP), the leading body in renal recommendation. He is visiting the Cochrane Renal Group to improve his knowledge in systematic reviews, meta-analysis and

Renal Group News (Cont'd)

literature searching.

Davide is a young Italian nephrologist working as clinical researcher at the Institute of Biomedicine and Molecular Immunology of the Italian National Research Council (CNR) in Reggio Calabria, Italy. His fields of interest and research are the epidemiology, physiology and pathophysiology of kidney diseases.



Davide Bolignano (Melbourne)

Visiting Nephrology fellow— Michelle Wong

Michelle Wong is a visiting Nephrology fellow from the University of British Columbia, Canada. She has an interest in hypertension and is also a reviewer for the Cochrane Hypertension Group. During her two month research elective with the Cochrane Renal Group, she has been working on a systematic review of interventions to improve adherence to fluid and salt restriction in end-stage renal disease, as well as a review assessing the prognostic significance of interdialytic weight gain.

She completed her medical degree at the University of British Columbia and her internal medicine training at the University of Alberta. Her other research interests include management of hypertension in the dialysis population and systematic review methodology.

Michelle Wong (Randwick Racecourse, Sydney)

Recent abstracts

Cardiac testing for coronary artery disease in potential kidney transplant recipients

Louis W Wang, Magid A Fahim, Andrew Hayen, Ruth L Mitchell, Laura Baines, Stephen Lord, Jonathan C Craig, Angela C Webster

Background
Patients with chronic kidney disease (CKD) are at increased risk of coronary artery disease (CAD) and adverse cardiac events. Screening for CAD is therefore an important part of preoperative evaluation for kidney transplant candidates. There is significant interest in the role of non-invasive cardiac investigations and their ability to identify patients at high risk of CAD.

Objectives
We investigated the accuracy of non-invasive cardiac screening tests compared with coronary angiography to detect CAD in patients who are potential kidney transplant recipients.

Search methods
MEDLINE and EMBASE searches (inception to November 2010) were performed to identify studies that assessed the diagnostic accuracy of non-invasive screening tests, using coronary angiography as the reference standard. We also conducted citation tracking via Web of Science and handsearched reference lists of identified primary studies and review articles.
Selection criteria
We included in this review all diagnostic cross sectional, cohort and randomised studies of test accuracy that compared the results of any cardiac test with coronary angiography (the reference standard) relating to patients considered as potential candidates for kidney transplantation or kidney-pancreas transplantation at the time diagnostic tests were performed.

Data collection and analysis
We used a hierarchical modelling strategy to produce summary receiver operating characteristic (SROC) curves, and pooled estimates of sensitivity and specificity. Sensitivity analyses to determine test accuracy were performed if only studies that had full verification or applied a threshold of ≥ 70% stenosis on coronary angiography for the diagnosis of significant CAD were included.

Main results
The following screening investigations included in the meta-

Recent abstracts (Cont'd)

analysis were: dobutamine stress echocardiography (DSE) (13 studies), myocardial perfusion scintigraphy (MPS) (nine studies), echocardiography (three studies), exercise stress electrocardiography (two studies), resting electrocardiography (three studies), and one study each of electron beam computed tomography (EBCT), exercise ventriculography, carotid intimal media thickness (CIMT) and digital subtraction fluorography (DSF). Sufficient studies were present to allow hierarchical summary receiver operating characteristic (HSROC) analysis for DSE and MPS. When including all available studies, both DSE and MPS had moderate sensitivity and specificity in detecting coronary artery stenosis in patients who are kidney transplant candidates [DSE (13 studies) - pooled sensitivity 0.79 (95% CI 0.67 to 0.88), pooled specificity 0.89 (95% CI 0.81 to 0.94); MPS (nine studies) - pooled sensitivity 0.74 (95% CI 0.54 to 0.87), pooled specificity 0.70 (95% CI 0.51 to 0.84)]. When limiting to studies which defined coronary artery stenosis using a reference threshold of ≥ 70% stenosis on coronary angiography, there was little change in these pooled estimates of accuracy [DSE (9 studies) - pooled sensitivity 0.76 (95% CI 0.60 to 0.87), specificity 0.88 (95% CI 0.78 to 0.94); MPS (7 studies) - pooled sensitivity 0.67 (95% CI 0.48 to 0.82), pooled specificity 0.77 (95% CI 0.61 to 0.88)]. There was evidence that DSE had improved accuracy over MPS (P = 0.02) when all studies were included in the analysis, but this was not significant when we excluded studies which did not avoid partial verification or use a reference standard threshold of ≥70% stenosis (P = 0.09).

Authors' conclusions
DSE may perform better than MPS but additional studies directly comparing these cardiac screening tests are needed. Absence of significant CAD may not necessarily correlate with cardiac-event free survival following transplantation. Further research should focus on assessing the ability of functional tests to predict postoperative outcome

Interventions for covert bacteriuria in children

Anita Fitzgerald, Rintaro Mori, Monica Lakhanpaul

Background
Many studies investigating covert bacteriuria in children were conducted in the 1970s, but uncertainty remains about whether treatment is beneficial, because results are mixed in terms of treatment effectiveness. It is important to establish the effectiveness of antibiotics and other treatments to eliminate infection, reduce recurrence, and prevent long-term kidney damage. It is essential that treatment benefit to individual children outweigh any harm.

Objectives
This review aims to evaluate the benefits and harms of treating covert bacteriuria in children.

Search methods
We searched the Cochrane Central Register of Controlled Trials (CENTRAL in The Cochrane Library), MEDLINE (from 1966) and EMBASE (from 1988) without language restriction.
Date of last search: 28 December 2011

Selection criteria
We included randomised and quasi-randomised controlled trials that investigated any intervention for covert bacteriuria in children aged up to 18 years with culture-proven urinary tract infection (UTI) and no known urinary symptoms at the time of diagnosis.

Data collection and analysis
Two authors independently assessed study quality and extracted data. Statistical analyses were performed using the random-effects model and the results were expressed as risk ratios (RR) with 95% confidence intervals (95% CI) for dichotomous outcomes and mean difference (MD) for continuous outcomes.

Main results
This review included three randomised controlled trials (RCTs) that involved 460 children (all girls). Overall, the studies were not methodologically strong. Gaps in reporting among the included studies made assessment of methodological quality challenging. One study reported that the number of children with bacteriuria was significantly reduced at follow-up six months after antibiotic treatment (RR 0.33; 95% CI 0.13 to 0.83). At follow-up two years after treatment, two studies reported that there was no evidence of a reduction in persistent bacteriuria (RR 0.32; 95% CI 0.03 to 3.44). At follow-up four to five years after initial treatment, all included studies reported that antibiotic treatment was effective in reducing the number of children with bacteriuria (RR 0.54; 95% CI 0.42 to 0.70). There were no differences in kidney growth between treated and untreated groups (MD 0.62; 95% CI -0.43 to 1.68).
None of the included studies reported data on compliance or adverse effects.

Authors' conclusions
The included studies do not provide sufficient detail about the harms and benefits of treating covert bacteriuria to enable formation of reliable conclusions. It appears that antibiotic treatment for covert bacteriuria is unlikely to benefit children in the long term.

Recent abstracts (Cont'd)

Parenteral versus oral iron therapy for adults and children with chronic kidney disease

Jumana Albaramki, Elisabeth M Hodson, Jonathan C Craig, Angela C Webster

Background
The anaemia seen in chronic kidney disease (CKD) may be exacerbated by iron deficiency. Iron can be provided through different routes, with advantages and drawbacks of each route. It remains unclear whether the potential harms and additional costs of intravenous (IV) compared with oral iron are justified.

Objectives
To determine the benefits and harms of IV iron supplementation compared with oral iron for anaemia in adults and children with CKD.

Search methods
In March 2010 we searched the Cochrane Renal Group's specialised register, the Cochrane Central Register of Controlled Trials (CENTRAL) in The Cochrane Library, MEDLINE and EMBASE without language restriction.

Selection criteria
We included randomised controlled trials (RCTs) and quasi-RCTs in which oral and IV routes of iron administration were compared in adults and children with CKD.

Data collection and analysis
Two authors independently assessed study eligibility, risk of bias, and extracted data. Results were reported as risk ratios (RR) or risk differences (RD) with 95% confidence intervals (CI) for dichotomous outcomes and for continuous outcomes the mean difference (MD) was used or standardised mean difference (SMD) if different scales had been used. Statistical analyses were performed using the random-effects model. Subgroup analysis and univariate meta-regression were performed to investigate between study differences.

Main results
Twenty eight studies (2098 participants) were included. Risk of bias attributes were poorly performed and/or reported with low risk of bias reported in 12 (43%) studies for sequence generation, incomplete outcome reporting and selective outcome reporting and in 6 (16%) studies for allocation concealment. No study was blinded for participants, investigators and outcome assessors but all were considered at low risk of bias because the primary outcome of haemoglobin was a laboratory outcome and unlikely to be influenced by lack of blinding. Haemoglobin (22 studies, 1862 patients: MD 0.90 g/dL, 95% CI 0.44 to 1.37); ferritin (24 studies, 1751 patients: MD 243.25 µg/L, 95% CI 188.74 to 297.75); and transferrin saturation (18 studies, 1457 patients: MD 10.20%, 95% CI 5.56 to 14.83) were significantly increased by IV iron compared with oral iron. There was a significant reduction in erythropoiesis-stimulating agent (ESA) dose in patients receiving dialysis who were treated with IV iron (9 studies, 487 patients: SMD -0.76, 95% CI -1.22 to -0.30). There was a high level of heterogeneity in all analyses. Mortality and cardiovascular morbidity did not differ significantly, but were reported in few studies. Gastrointestinal side effects were more common with oral iron, but hypotensive and allergic reactions were more common with IV iron.

Authors' conclusions
The included studies provide strong evidence for increased ferritin and transferrin saturation levels, together with a small increase in haemoglobin, in patients with CKD who were treated with IV iron compared with oral iron. From a limited body of evidence, we identified a significant reduction in ESA requirements in patients treated with IV iron, and found no significant difference in mortality. Adverse effects were reported in only 50% of included studies. We therefore suggest that further studies that focus on patient-centred outcomes are needed to determine if the use of IV iron is justified on the basis of reductions in ESA dose and cost, improvements in patient quality of life, and with few serious adverse effects.

Recent abstracts (Cont'd)

Pentoxifylline for diabetic kidney disease

Dan Shan, Hong Mei Wu, Qi Yuan Yuan, Jun Li, Rong Le Zhou, Guan J Liu

Background
Diabetic kidney disease (DKD) is associated with increased morbidity and mortality, mostly relating to cardiovascular complications. The relevance of inflammation in the pathogenesis of DKD has been investigated in recent years, and it has been shown that inflammatory markers are higher in people with DKD compared with the wider population. Pentoxifylline is a methylxanthine phosphodiesterase inhibitor with favourable anti-inflammatory effects and immunoregulatory properties. The anti-inflammatory effects conferred by pentoxifylline may be beneficial in the management of DKD.

Objectives
To assess the benefits and harms of pentoxifylline for treating people with DKD.
Search methods
We searched the Cochrane Renal Group's specialised register (January 2012), CENTRAL (Issue 12, 2011), MEDLINE, EMBASE and four Chinese biomedical literature databases (CBM-disc, 1979 to July 2009), Chinese Science and Technique Journals Database (VIP, until July 2009), China National Knowledge Infrastructure (CNKI, until July 2009) and WanFang database (until July 2009).

Selection criteria
All randomised controlled trials (RCTs) and quasi-RCTs studying the benefits and harms of pentoxifylline for DKD.

Data collection and analysis
Data were extracted independently by two authors. Meta -analyses were performed when more than one study provided data on a comparable outcome in sufficiently similar patients. Results of dichotomous outcomes were expressed as risk ratios (RR) with 95% confidence intervals (CI). Mean differences (MD) were calculated to assess the effects of treatment where outcomes were expressed on continuous scales, and standardised mean differences (SMD) calculated where different scales were used. Data was pooled using the random effects model. Adverse effects were assessed using descriptive techniques and where possible, risk differences (RD) with 95% CI.

Main results
We identified 17 studies that included a total of 991 participants with DKD which met our inclusion criteria. Overall, the methodological quality of included studies was low: 4/17 reported the method of randomisation, 13/17 did not; no study described the method of random allocation; 4/17 studies were considered to be at high risk of bias and 13/17 were considered to have unclear risk for incomplete outcome data reporting; 9/17 studies were at low risk bias and in 8/17 the risk of bias was unclear for selective outcome reporting.

Compared with placebo, pentoxifylline significantly reduced serum creatinine (SCr) (MD -0.10 mg/dL, 95% CI -0.17 to -0.03), albuminuria (SMD -2.28, 95% CI -3.85 to -0.70) and overt proteinuria (MD -428.58 µg/min, 95% CI -661.65 to -195.50), but there was no difference in creatinine clearance (CrCl) (MD -5.18 mL/min, 95% CI -15.55 to 5.19). When compared with routine treatment alone, pentoxifylline did not significantly reduce SCr (MD 0.00 mg/dL, 95% CI -0.06 to 0.07) or blood pressure (systolic (SBP): MD -0.28 mm Hg, 95% CI -2.20 to 1.63; diastolic (DBP): MD -0.15 mm Hg, 95% CI -1.44 to 1.14), but did significantly reduce albuminuria (SMD 0.62, 95% CI 0.18 to 1.07) and proteinuria (MD 0.46 g/24 h, 95% CI 0.17 to 0.74). There was no significant difference in SCr (MD 0.00 mg/dL, 95% CI -0.08 to 0.07), albuminuria (MD -8.79 µg/min, 95% CI -27.18 to 9.59), proteinuria (MD -0.01 g/24 h, 95% CI -0.03 to 0.01) or blood pressure (SBP: MD 1.46 mm Hg, 95% CI -0.57 to 3.50; DBP: MD 1.37 mm Hg, 95% CI -0.23 to 2.98) between pentoxifylline and the active comparator (captopril or clonidine/methyldopa) for patients with type 1 and type 2 DKD. CrCl was significantly increased when pentoxifylline was compared to clonidine/methyldopa (MD 10.90 mL/ min, 95% CI -1.40 to 20.40) but not with captopril (MD 3.26 mL/min, 95% CI -1.05 to 7.59). No data were available on the incidence of end-stage kidney disease (ESKD), time to ESKD, quality of life, or all-cause mortality. The adverse events of pentoxifylline were mild; no serious adverse events were reported in any of the included studies.

Authors' conclusions
From the available evidence, pentoxifylline seems to offer some beneficial effects in renal function improvement and reduction in albuminuria and proteinuria, with no obvious serious adverse effects for patients with DKD. However, most studies were poorly reported, small, and methodologically flawed. Evidence to support the use of pentoxifylline for DKD was insufficient to develop recommendations for its use in this patient population. Rigorously designed, randomised, multicentre, large scale studies of pentoxifylline for DKD are needed to further assess its therapeutic effects.

Upcoming workshops 2012

Australasian Cochrane Centre/ Cochrane Renal Group*

9-10 May (closes 20 April)	Cochrane systematic reviews of complex interventions *Melbourne*
14-18 May (closes 30 April)	Review completion workshop *Melbourne*
13-15 June (closes 30 May)	Introduction to writing a Cochrane review *Brisbane*
26-28 June (closes 12 June)	Introduction to writing a Cochrane review *Adelaide*
4-6 July (closes 20 June)	Introduction to writing a Cochrane review* *Sydney*
9-13 July	Developing protocol for Cochrane systematic review *Kuala Lumpur Malaysia*
20-21 August	Introduction to systematic reviews of interventions (Note: this workshop is part of the Monash University Short Course program, and is open to non-Cochrane authors. Fees apply to all participants.) *Melbourne*
12-16 November (closes 29 Oct)	Review completion workshop *Melbourne*
5-7 December (closes 21 Nov)	Introduction to writing a Cochrane review* *Sydney*

For further information on Australasian workshops please go to: http://acc.cochrane.org/timetable-registration

For Review workshops offered by other Cochrane Centres please go to: www.cochrane.org/training

Cochrane Collaboration news

Health Systems Evidence launch

The next generation of Health Systems Evidence www.healthsystemsevidence.org - the world's most comprehensive, free access point for high-quality evidence on health systems - has been launched by the McMaster Health Forum. Health Systems Evidence is a valuable resource for policymakers, stakeholders and researchers seeking to address today's most pressing health challenges. It provides answers on questions about how to strengthen or reform health systems, or how to get cost-effective programs, services and drugs to those who need them.

The redeveloped website offers numerous enhancements, including new open search and advanced search functionalities, and is available in seven languages: Arabic, Chinese, English, French, Portuguese, Russian and Spanish. A video tutorial www.youtube.com/user/mcmasterhealthforum on how to make the best use of the site is provided, which will assist users to rapidly identify syntheses of the best available research on a particular health system topic, as well as evidence on economic evaluations, and descriptions of health systems and health systems reforms.

Health Systems Evidence is also now providing the option for users to subscribe to a customizable evidence service that will provide monthly email alerts identifying new documents available in the database specific to someone's individual interests. Visit the site at www.healthsystemsevidence.org to register and explore its many features.

Newly published, descriptive analysis of Cochrane reviews

A new descriptive analysis of more than 22,000 meta-analyses within Cochrane Reviews has just been published in an open access article in BMC Medical Research Methodology: www.biomedcentral.com/1471-2288/11/160

Every meta-analysis in the 2321 full reviews in the January 2008 issue of the Cochrane Database of Systematic Reviews was classified according to the healthcare specialty, the types of interventions being compared and the type of outcome. The report includes descriptive statistics for numbers of meta-analyses, numbers of component studies and sample sizes of component studies, broken down by these categories. We hope these results will be of interest and provide a useful resource to people throughout The Cochrane Collaboration.

Cochrane Collaboration news (Cont'd)

Cochrane Canada Symposium

Find out all about the 10th Annual Cochrane Canada Symposium to be held 9-10 May 2012 in Winnipeg, Manitoba at the website:
http://ccc-symposium.cochrane.org/

New Methods Book on Qualitative Evidence Synthesis

"Qualitative Evidence Synthesis: choosing the right approach", a new methods book published by Wiley-Blackwell, is now available. In this book, authors Karin Hannes and Craig Lockwood discuss the options available to researchers, including approaches that have not had a substantial uptake among researchers. It provides arguments for when and why researchers should opt for a certain approach to synthesis, the challenges they might face in doing so and the potential strengths and weaknesses of each approach.
More information is available at:
http://217.171.192.157:8080/r.html?uid=1.15.cr.9g.pc3c7uiecj

EQUATOR Scientific Symposium 2012: ACT now: Accuracy, Completeness, and Transparency in health research reporting

Date: 11 - 12 October 2012
Location: Freiburg, Germany
Details: Scientific symposium and 4th EQUATOR Annual Lecture organised by the EQUATOR Network and the German Cochrane Centre. We invite you to present research, debate current practice with many international experts, and discuss steps needed for more efficient publication of health research studies. For more information please visit: www.equator-network.org/
Target audience: Health research scientists and clinicians, journal editors and peer reviewers, reporting guideline developers, publishers, research funders and other professionals involved in research education, research governance and the publication of medical research.

Global Symposium on Health Systems Research

We are pleased to officially announce that the Second Global Symposium on Health Systems Research call for abstracts is now open!

The Symposium will take place from 31 October - 3 November 2012 in Beijing, People's Republic of China.

For more information go to:
www.hsr-symposium.org

Themes
The Symposium will focus on the science to accelerate universal health coverage around the world. It will cover three main themes:
- Knowledge Translation
- State-of-the-Art Health Systems Research
- Health Systems Research Methodologies

There will also be three cross-cutting themes:
- Innovations in Health Systems Research
- Neglected Priorities or Populations in Health Systems Research
- Financing and Capacity Building for Health Systems Research

Call for Session Proposals & Individual Abstracts You are invited to submit an abstract for an oral presentation, a poster or a film! For more information go to:
http://hsr2012.abstractsubmit.org/

Featured Consumer Stories on CCNet's Blog

To mark the end of Wise Consumer Health Month, look back at the articles posted recently on the Consumer Blog at http://consumers.cochrane.org/blog.

Campaigning for Evidence: Sara Yaron - a patient's story
I met The Cochrane Collaboration the first time, at an international conference regarding breast cancer, in the late 90's in Europe. There, I read a brochure, published by CCNet, and fell in love with the idea. At that time, I was a very young woman diagnosed with breast cancer (grade 3) and a mother of three little children, with one very ill daughter, so I was "thirsty" for any certified, objective written medical information regarding my family's diseases...

Maryann Napoli - Informing Consumers, Negotiating Change
Thanks to a consumer stipend, I had the good fortune to attend my first Colloquium in 2001 in Lyons, France. There was so much new information to absorb, not the least of which was how the Collaboration worked and how to understand Cochranespeak. I happened into an ongoing workshop in time to hear something shocking

Cochrane Collaboration news (Cont'd)

and entirely new to me. The speaker was reporting his review of drug trials and how common it is for the serious adverse events (SAE) data to be withheld. ...

How to get involved: Heather Goodare - a patient's story
How do patients get involved in medical research? First of all, in my own case, to try to set the record straight where they think it is faulty. When I was prescribed tamoxifen for breast cancer in 1987 no oestrogen receptor test was done: tamoxifen was given to everyone regardless. The main side effect that gave me grief was the loss of my singing voice, which went croaky and dropped an octave. I contacted the drug company concerned, thinking that they would be at least interested to know, but they tried to stop the news getting out ...

Consumer stories: Gill Gyte - Consumer Editor, Activist
I joined The Cochrane Collaboration in 1997, when the Pregnancy and Childbirth Group (PCG) invited me to help them involve consumers in their work. At the time, I was an antenatal teacher with the UK National Childbirth Trust (NCT) and I was on the NCT Research and Information Group because I had a scientific background. I was interested in PCG because Iain Chalmers had made a distinct impression on me when he spoke at an NCT conference a few years earlier...

Visit http://consumers.cochrane.org/blog to read these consumer stories and more. To find out about Wise Consumer Health Month, visit CCNet News at http://consumers.cochrane.org/news.

The Knowledgeable Patient: Communication and Participation in Health

Part of the Cochrane Book Series, *The Knowledgeable Patient* is an essential guide to a new era of complex healthcare. Integrating consumer stories and evidence from systematic reviews, it examines key communication and participation issues in a range of contexts, including surgery, safe medicine use, chronic disease self management and notification of rare disease risk.

The book is edited by Sophie Hill, head of the Centre for Health Communication and Participation and coordinating editor of the Cochrane Consumers and Communication Review Group.

Conferences

May 9-13, 2012
8th International Congress on Autoimmunity, Granada, Spain
www2.kenes.com/autoimmunity/pages/home.aspx

May 24-27, 2012
49th ERA-EDTA Congress, Paris, France.
www.eraedta2012.org

June 2-6, 2012
American Transplant Congress, Boston, MA, USA
http://2012.atcmeeting.org/

June 26-30, 2012
XVI International Congress on Nutrition and Metabolism in Renal Disease (ICNMRD), Honolulu, Hawaii
www.RenalNutritionWeek.com

July 15– 19, 2012
24TH International Congress of the Transplantation Society, Berlin
www.transplantation2012.org/

Aug 22-25, 2012
G-I-N (Guidelines International Network) - Global Evidence - International Diversity 2012 Conference, Berlin, Germany
www.g-i-n.net/events/9th-conference

Aug 27 -29, 2012
ANZSN 48th Annual Scientific Meeting, Auckland, NZ
www.conference.co.nz/nephrology12

Sept 9—12, 2012
14th Congress of the International Society of Peritoneal Dialysis
Kuala Lumpur, Malaysia
www.ispd2012.org.my

Sept 29 - Oct 4, 2012
24th Meeting of the International Society of Hypertension (ISH) combining with the 9th Congress of the Asian Pacific Society of Hypertension (APSH) and the 34th Annual Scientific meeting of the High Blood Pressure Research Council of Australia (HBPRCA) at "Hypertension Sydney 2012", Sydney, NSW
www.ish2012.org

Sept 30 - Oct 3, 2012
20th Cochrane Colloquium 2012, Auckland, NZ
www.cochrane.org/news/tags/authors/cochrane-colloquium-2012-auckland-new-zealand

Oct 5 – 7, 2012
2012 European Organ Donation Congress, 24th ETCO-EDC (European Society of Organ Transplantation ESOT), Dubrovnik, Croatia
www.esot.org/Meetings/PublicPlatform/MeetingPlatform.aspx?MeetingPlatformUI=17

Oct 30 - Nov 4, 2012
ASN Kidney Week, San Diego, California, USA
www.asn-online.org

Nov 15-18, 2012
5th World Congress on Controversies in Urology (CURy), Barcelona, Spain
www.researchgate.net/conference/The_5th_World_Congress_on_Controversies_in_Urology_CURy/

THE COCHRANE COLLABORATION®

The Cochrane Collaboration

preparing, maintaining and promoting the accessibility of systematic reviews of the effects of health care interventions

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