COCHRANE RENAL GROUP
A REVIEW GROUP OF THE COCHRANE COLLABORATION

Newsletter - October 2012

Cochrane Renal Group — New reviews, protocols and titles

New and updated reviews

In Issues 4-9, 2012 we published nine new and updated reviews:

New

- Antibiotics for treating lower urinary tract infection in children
- High-flux versus low-flux membranes for end-stage kidney disease
- Rheum officinale (a traditional Chinese medicine) for chronic kidney disease
- Sodium bicarbonate supplements for treating acute kidney injury
- Tidal versus other forms of peritoneal dialysis for acute kidney injury

Updated

- Extracorporeal shock wave lithotripsy (ESWL) versus ureteroscopic management for ureteric calculi
- Nutritional support for acute kidney injury
- Water for preventing urinary stones

Conclusions changed

- Interventions for preventing infection in nephrotic syndrome

New protocols

In Issues 4-9, 2012 we published 12 new protocols:

- Altered dietary salt intake for chronic kidney disease
- Analgesia for patients undergoing shockwave lithotripsy for urinary stones
- Antibiotic prophylaxis for transurethral urological procedures
- Citrate salts for preventing and treating kidney stones
- Continuous erythropoiesis receptor activator (CERA) for the anaemia of chronic kidney disease
- Fenoldopam for preventing and treating acute kidney injury
- Glucose lowering therapies for chronic kidney disease and kidney transplantation
- Haemodialysis duration, frequency and intensity for end-stage kidney disease
- Interventions for post-transplant anaemia in kidney transplant recipients
- Parathyroidectomy for chronic kidney disease-mineral and bone disorder (CKD-MBD)
- Pharmacological interventions for preventing recurrent urinary stones in adults and children
- Screening with urinary dipsticks for reducing morbidity and mortality

New titles

- Advanced care planning for haemodialysis patients
- Antihypertensive agents for children with chronic kidney disease
- Interventions for infected cysts in patients with polycystic kidney disease
- Interventions for preventing haemolytic uraemic syndrome/thrombotic thrombocytopenic purpura
- Interventions for preventing the progression of autosomal dominant polycystic kidney disease
- Normal saline versus low-chloride solutions for kidney transplantation
- Pharmacological interventions for reducing serum potassium
- Self-rating scales versus clinical interview for the diagnosis of depression in people with chronic kidney disease
- Urinary alkalisation for uncomplicated urinary tract infection

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Renal group news

CRG Editorial Meeting May 2012 - *L to R: Ionut Nistor (Visiting ERBP Fellow (Romania)), Angela Webster, Jonathan Craig, Narelle Willis, Ruth Mitchell, Ann Jones, Davide Bolignano (Visiting ERBP Fellow (Italy))*

Visitors to the Cochrane Renal Group

Nuria Montero Perez—Visiting Nephrology Fellow

In June 2012 Nuria Montero Perez joined the Cochrane Renal Group (CRG) for three months.

Nuria has a Nephrology Fellowship at the Hospital del Mar, Barcelona, Spain and is a Resident with the Nephrology Department and Kidney Transplantation Program at Hospital del Mar.

Nuria spent time with the CRG to improve her knowledge in systematic reviews, meta-analysis and literature searching. While with the CRG she completed the review "Steroid avoidance or withdrawal for pancreas and pancreas with kidney transplant recipients", registered a new review "Interventions for infected cysts in patients with polycystic kidney disease", and assisted in the update of "Target of rapamycin inhibitors (TOR-I; sirolimus and everolimus) for primary immunosuppression in kidney transplant recipients".

Maria Haller—Visiting ERBP Fellow

In October 2012 Maria Haller joined the Cochrane Renal Group (CRG) for six months.

Maria has a European Renal Best Practice (ERBP) Fellowship provided by the ERA-EDTA. She is a Resident for internal medicine at the Department of Nephrology, Rheumatology, Hypertension and Transplantation, Hospital Elisabethinen, Linz, Austria.

The aim of Maria's training with CRG is for her to become responsible for a selection of reviews related to the ERBP guidelines. To do this she will learn to use RevMan and the central information management system, Archie. She will also be responsible for finding and appraising the potential studies to be included in these reviews and learning how to design and run search strategies for the major medical databases (MEDLINE, EMBASE, CINAHL and CENTRAL).

Maria was able to attend the 20th Cochrane Colloquium held in Auckland—a good introduction for anyone to The Cochrane Collaboration.

Evi Nagler— Visiting ERBP Fellow

Evi Nagler is returning to the CRG in October 2012 for a further six months. She is a Specialist Registrar in Nephrology at Ghent University Hospital in Belgium and is an ERBP Fellow responsible for Development of the ERBP Guidelines on the management and evaluation of the kidney donor and recipient, and diagnosis and treatment of hyponatraemia.

Evi previously visited us in 2010 for nine months. This time she will be visiting in summer—something she is looking forward to!

Renal group news (Cont'd)

Changes in policy regarding acceptance of title registrations, and deadlines for protocol and review submissions

In our role of supporting review authors through the review process, we are constantly looking at ways to ensure the best use of our limited resources. To this end we have decided to place a strong focus on the registration of priority titles only. All potential titles will be compared to a priority list that has been put together with input from our editors and Advisory Board members. The list was created by asking "what are your top 5 review questions that need answering". The questions must be topical; relevant to patients, health care providers and policy makers and have some evidence in the form of RCTs.

In addition we will be more strictly adhering to our pre-specified timelines for the various stages of the review process. These include:

- From title registration to submission of draft protocol: **6 months.**
- From publication of a protocol to submission of draft review: **12 months**
- From publication of a review to submission of draft review update: **2 years**

Naturally reminders will be sent out to the contact/corresponding author to let them know that submission deadlines are approaching. Requests for extensions will be considered but cannot be guaranteed.

We also understand that the refereeing process can take some time—as with most journals some topic areas are harder to identify referees than others. Factoring in the complexity and size of Cochrane systematic reviews, there can at times be extensive delays. To help speed up the internal checks needed when a draft protocol or review is submitted, a pre-submission checklist will be required to be submitted by the author team. This lists the majority of checks we have to undertake before submitting for editorial approval for refereeing.

If your have a draft submission that is currently overdue, please email us (contact details) to discuss any assistance we may be able to offer.

Cochrane Commentaries

A new partnership with our colleagues at the journal *Nephrology*, means our reviews can reach a wider audience.

Cochrane commentaries are short synopses of recent Cochrane reviews or review updates, each chosen because it is likely to be of interest to the *Nephrology* journal's readership and relevant to clinical practice.

With Angela Webster working with our review authors to write each commentary, we hope to see a Cochrane Commentary in each issue of the journal *Nephrology* (6 per year). We are working with our publisher Wiley to build similar partnerships with other journals, where our reviews are relevant.

Our first commentary was published in July this year. Cardiac testing for coronary artery disease in potential kidney transplant recipients. DOI: 10.1111/j.1440-1797.2012.01624.x

We are now on Twitter!

We have now have a Twitter account and hope to keep you up-to-date with news and events relating to our group, The Cochrane Collaboration and kidney disease.

Follow us now **@CochraneRenal**

Recent abstracts

Antibiotics for treating lower urinary tract infection in children

Anita Fitzgerald, Rintaro Mori, Monica Lakhanpaul, Kjell Tullus

Background
Urinary tract infection (UTI) is one of the most common bacterial infections in infants and children. Lower UTI is the most commonly presenting and in the majority of cases can be easily treated with a course of antibiotic therapy with no further complications. A number of antimicrobials have been used to treat children with lower UTIs; however is it unclear what are the specific benefits and harms of such treatments.

Objectives
This review aims to summarise the benefits and harms of antibiotics for treating lower UTI in children.

Search methods
We searched the Renal Group's Specialised Register (April 2012), CENTRAL (The Cochrane Library 2012, Issue 5), MEDLINE OVID SP (from 1966), and EMBASE OVID SP (from 1988) without language restriction.
Date of last search: May 2012.

Selection criteria
Randomised controlled trials (RCTs) and quasi-RCTs in which antibiotic therapy was used to treat bacteriologically proven, symptomatic, lower UTI in children aged zero to 18 years in primary and community healthcare settings were included.

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 expressed as risk ratios (RR) with 95% confidence intervals (CI).

Main results
Sixteen RCTs, analysing 1,116 children were included. Conventional 10-day antibiotic treatment significantly increased the number of children free of persistent bacteriuria compared to single-dose therapy (6 studies, 228 children: RR 2.01, 95%CI 1.06 to 3.80). No heterogeneity was observed. Persistent bacteriuria at the end of treatment was reported in 24% of children receiving single-dose therapy compared to 10% of children who were randomised to 10-day therapy. There were no significant differences between groups for persistent symptoms, recurrence following treatment, or re-infection following treatment. There was insufficient data to analyse the effect of antibiotics on renal parenchymal damage, compliance, development of resistant organisms or adverse events. Despite the inclusion of 16 RCTs, methodological weakness and small sample sizes made it difficult to conclude if any of the included antibiotics or regimens were superior to another.

Authors' conclusions
Although antibiotic treatment is effective for children with UTI, there are insufficient data to answer the question of which type of antibiotic or which duration is most effective to treat symptomatic lower UTI. This review found that 10-day antibiotic treatment is more likely to eliminate bacteria from the urine than single-dose treatments. No differences were observed for persistent bacteriuria, recurrence or re-infection between short and long-course antibiotics where the antibiotic differed between groups. This data adds to an existing Cochrane review comparing short and long-course treatment of the same antibiotic who also reported no evidence of difference between short and long-course antibiotics.

High-flux versus low-flux membranes for end-stage kidney disease

Suetonia C Palmer, Kannaiyan S Rabindranath, Jonathan C Craig, Carmen Bonifati, Conal Daly, Alison M MacLeod, Paul J Roderick, Francesco Locatelli, Giovanni FM Strippoli

Background
Clinical practice guidelines regarding the use of high-flux haemodialysis membranes vary widely.

Objectives
We aimed to analyse the current evidence reported for the benefits and harms of high-flux and low-flux haemodialysis.

Search methods
We searched Cochrane Renal Group's specialised register (March 2011), the Cochrane Central Register of Controlled Trials (CENTRAL), MEDLINE (1948 to March 2011), and EMBASE (1947 to March 2011) without language restriction.

Selection criteria
We included randomised controlled trials (RCTs) that compared high-flux haemodialysis with low-flux haemodialysis in people with end-stage kidney disease (ESKD) who required long-term haemodialysis.

Data collection and analysis
Data were extracted independently by two authors for study characteristics (participants and interventions), risks of bias, and outcomes (all-cause mortality and cause-specific mortality, hospitalisation, health-related quality of life, carpal tunnel syndrome, dialysisrelated arthropathy, kidney function, and symptoms) among people on haemodialysis.

Treatment effects were expressed as a relative risk (RR) or mean difference (MD), with 95% confidence intervals (CI) using the random-effects model.

Main results
We included 33 studies that involved 3820 participants with ESKD. High-flux membranes reduced cardiovascular mortality (5 studies, 430 events/2612 participants: RR 0.83, 95% CI 0.70 to 0.99) but not all-cause mortality (10 studies, 1071 events/2915 participants: RR 0.95, 95% CI 0.87 to 1.04). In absolute terms, high -flux membranes may prevent three cardiovascular deaths in 100 people treated with haemodialysis for two years. While high—flux membranes reduced predialysis beta-2 microglobulin levels (MD -12.17 mg/L, 95% CI—15.83 to -8.51 mg/L), insufficient data were available to reliably estimate the effects of membrane flux on infection-related mortality, hospitalisation, carpal tunnel syndrome, or amyloid-related

Recent abstracts (Cont'd)

arthropathy. Evidence for effects of high-flux membranes was limited by selective reporting in few studies. An insufficient number of studies limited our ability to conduct subgroup analyses for membrane type, biocompatibility, or reuse. In general, the risk of bias was either high or unclear in the majority of studies.

Authors' conclusions

High-flux haemodialysis may reduce cardiovascular mortality in people requiring haemodialysis by about 15%. A large well-designed RCT is now required to confirm this.

Rheum officinale (a traditional Chinese medicine) for chronic kidney disease

Han Wang, Hongxian Song, Jirong Yue, Jun Li, Yan Bin Hou, Jue Lin Deng

Background

Chronic kidney disease (CKD) is a major public health issue worldwide. Standard therapies to delay CKD progression include dietary protein restriction and administration of angiotensin-converting enzyme inhibitors (ACEi) and angiotensin receptor blockers (ARB) to help control blood pressure and confer additional renoprotective effects. Despite such interventions, CKD incidence and mortality rates continue to increase. Rheum officinale (Da Huang) a medicinal herb used widely in China to treat CKD has been reported to offer a range of pharmacological properties that may delay disease progression.

Objectives

To assess the benefits and harms of Rheum officinale for preventing the progression of CKD.

Search methods

We searched the Cochrane Renal Group's Specialised Register and CENTRAL (Issue 4, 2011), MEDLINE, EMBASE, the Chinese Biomedicine Database (CBM), China National Knowledge Infrastructure (CNKI), VIP (Chongqing VIP Chinese Science and Technology Periodical Database), and Wanfang Data. We also handsearched reference lists of articles. We applied no restrictions on language of publication.

Selection criteria

We included randomised controlled trials (RCTs) and quasi-RCTs that assessed the benefits and harms of Rheum officinale for preventing the progression of CKD regardless of dosage, type, maturity, mode of administration, duration of treatment, or storage time before use.

Data collection and analysis

Two authors independently screened titles and abstracts for eligibility, assessed study quality, and extracted data. We expressed results for dichotomous outcomes (need for renal replacement therapy, all-cause mortality, quality of life) as risk ratios (RR) with 95% confidence intervals (CI). Continuous outcomes (glomerular filtration rate (GFR), serum creatinine (SCr), creatinine clearance (CrCl), blood urea nitrogen (BUN)) were expressed as mean differences (MD) with 95% CIs.

Main results

We identified nine studies that enrolled 682 participants. None of the studies reported blinding or group allocation methods. Seven studies were judged to be at low risk of incomplete outcome reporting; three studies were judged to be a low risk of selective reporting (protocols were available and/or all outcomes relevant to the this review were reported); and two studies were judged free of other potential biases.
Seven studies compared Rheum officinale with no treatment and two made comparisons with captopril, an angiotensin-converting enzyme inhibitor (ACEi). Compared with no treatment, Rheum officinale had a positive effect on SCr (MD -87.49 µmol/L, 95% CI -139.25 to -35.72) and BUN (MD -10.61 mmol/L, 95% CI -19.45 to -2.21). Compared with captopril, a statistically significant difference was not demonstrated in relation to Rheum officinale for any outcome (BUN, CrCl, or patients' capacity to undertake work). No data were available on all-cause mortality or cost of treatment. Only minor adverse events were reported in association with Rheum officinale.

Recent abstracts (Cont'd)

Authors' conclusions
Currently available evidence concerning the efficacy of Rheum officinale to improve SCr and BUN levels in patients with CKD is both scant and low quality. Although Rheum officinale does not appear to be associated with serious adverse events among patients with CKD, there is no current evidence to support any recommendation for its use.

Sodium bicarbonate supplements for treating acute kidney injury

Jonathan Hewitt, Mark Uniacke, Navjyot K Hansi, Gopalakrishnan Venkat-Raman, Kathryn McCarthy

Background
Acute kidney injury (AKI) is a common, serious, but potentially treatable condition. Because AKI is often associated with acidosis, it has become common practice to recommend administration of sodium bicarbonate to correct acid imbalance.

Objectives
To assess the benefits and harms of the use of sodium bicarbonate for people with AKI. The primary outcome measure was all-cause mortality, and secondary outcome measures were patients' need for renal replacement therapy; return to baseline kidney function; and overall survival.

Search methods
In November 2011 we searched the Cochrane Renal Group's Specialised Register using keywords relevant to this review. The register is populated using searches of Ovid MEDLINE, the Cochrane Central Register of Controlled Trials, EMBASE and handsearching records from renal-related journals and conference proceedings.

Selection criteria
All randomised controlled trials (RCTs) that investigated the use of sodium bicarbonate supplements, administered by any route, for the treatment of adults with AKI were to be included. The search strategy did not restrict inclusion based on an upper age limit or publication language. We did not consider inclusion of studies that investigated use of sodium bicarbonate for AKI prevention.

Data collection and analysis
All authors planned to independently assess and extracted information. Information was to be collected on methods, participants, interventions and outcomes. Results were to be expressed as risk ratios (RR) for dichotomous outcomes or as mean differences (MD) for continuous data with 95% confidence intervals (CI).

Main results
Although our literature search identified four studies, none of these met our predetermined selection criteria. Hence, no suitable studies were identified for inclusion in this review.

Authors' conclusions
We found no RCT evidence - supportive or otherwise - for the use of sodium bicarbonate for people with AKI. We concluded that there is an urgent need for well conducted RCTs in this area.

Tidal versus other forms of peritoneal dialysis for acute kidney injury

Lei Jiang, Rong Zeng, KeHu Yang, Deng Hai Mi, Jin Hui Tian, Bin Ma, Yali Liu

Background
Acute kidney injury (AKI) is associated with substantial morbidity and mortality. Recent studies have shown that dialysis dose was a major factor associated with patient survival. Unresolved questions persist about which mode of peritoneal dialysis (PD) should be used for most patients with AKI.

Objectives
To assess the benefits and harms of tidal PD (TPD) versus other forms of PD on outcomes for patients with AKI.

Search methods
In February 2012 we searched the Cochrane Renal Group's specialised register, CENTRAL (in The Cochrane Library), MEDLINE (from 1966) and EMBASE (from 1980). We also searched reference lists of included studies, review articles and nephrology text books, and contacted local and international experts.

Selection criteria
All randomised controlled trials (RCTs) and quasi-RCTs (RCTs in which allocation to treatment was obtained by alternation, use of alternate medical records, date of birth or other predictable methods) of TPD versus other forms of PD for AKI.

Data collection and analysis
Two authors independently reviewed search results, extracted data and assessed risk of bias. Results were expressed as risk ratios (RR) with 95% confidence intervals (CI) for dichotomous outcomes and mean difference (MD) for continuous outcomes using a random-effects model.

Main results
We included one randomised cross-over study, enrolling 87 participants, which compared TPD with continuous equilibrating PD (CEPD) for patients with AKI. Sequence generation was adequate while allocation concealment was not reported. Our primary outcomes of mortality and recovery of renal function (complete or partial) were not reported (high risk of selective reporting bias). The results from this one study showed TPD resulted in higher creatinine clearance (CrCl) (MD 1.88 mL/min, 95% CI 0.91 to 2.85) and blood urea nitrogen (BUN) clearance (MD 14.71 mL/min, 95% CI 8.24 to 21.18) than CEPD; was superior to CEPD in the removal of potassium, phosphates and in generating ultrafiltrate; was better tolerated; consumed less time and was less expensive than CEPD. There was greater protein loss with TPD. No adverse events were reported.

Authors' conclusions
At present, there is insufficient RCT evidence to enable evaluation of the effect of TPD in patients with AKI. Well-designed and larger RCTs are required to better understand the risks and benefits of TPD for AKI.

Upcoming workshops 2012

Australasian Cochrane Centre/
Cochrane Renal Group*

12-16 November	Review completion workshop Melbourne
5-7 December	Introduction to writing a Cochrane review Sydney*
13 December	12:00pm AEST Cochrane Live! Webinar: Risk of bias assessments: putting them into practice

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

Workshop "Cochrane Systematic Reviews of Diagnostic Test Accuracy"

10-11 December, 2012 in Amsterdam

For the sixth time, we will run our popular two-day workshop "Cochrane Systematic Reviews of Diagnostic Test Accuracy" for Cochrane review authors. The workshop will be held in Amsterdam, The Netherlands and run by members of the Cochrane Diagnostic Test Accuracy Working Group.

This workshop is targeted at review authors who are planning to do a Cochrane diagnostic test accuracy review (SRDTA). The objective of the workshop is to inform the participants about the peculiarities around SRDTAs and to train them to prepare and conduct an SRDTA. The workshop will focus mainly on methodological challenges around SRDTAs. We will also address basic statistical methods for meta-analysis and the logistics for processing SRDTAs within The Cochrane Collaboration.

For more information and a registration form, please visit http://srdta.cochrane.org/workshops-and-events
Rob Scholten

Evidence-based Guidelines Affecting Policy, Practice and Stakeholders—Conference

Date: 10 - 11 December 2012, New York City

Details: G-I-N North America will co-sponsor with the New York Academy of Medicine a two-day conference on Evidence-based Guidelines Affecting Policy, Practice and Stakeholders.

The mission of the conference is:
1. To provide a platform for constructive dialogue and collaboration between otherwise disparate perspectives that affect development of evidence based guidelines, their translation to clinical practice, and their value and impact on health care and patient outcomes.

2. To illuminate the perspectives, processes, values, principles, and circumstances that collectively impact health care policy and its relationship to scientific evidence and clinical practice guidelines.

3. To highlight best practices for guideline development, dissemination, and implementation for producing clear, actionable, scientifically sound, and trustworthy guidance that can improve quality of care, reduce unexplained variations, and avoid inappropriate or potentially harmful interventions.

Register now using the below link:
http://support.nyam.org/site/Calendar?id=102741&view=Detail
Contact: Dr. Rich Rosenfeld
Website: http://nyam.org/egapps2012

Aubrey Sheiham Public Health and Primary Care Scholarship—applications invited

Applications are invited for The Cochrane Collaboration Aubrey Sheiham Public Health and Primary Care Scholarship from health workers, consumers and researchers living in low-or middle-income countries.

This is not a call for new reviews but rather for those who've already registered a title with the relevant Cochrane Review Group.

This is a Scholarship of up to 3-months to develop skills in preparing systematic reviews of health care interventions within the Cochrane Collaboration. Applicants must have agreed to a review topic before 1st September 2012 with the relevant Cochrane Review Group.

Cochrane Collaboration news (Cont'd)

Application deadline: 31st October 2012. For more information and requirements: www.cochrane.org/docs/Fellowshipsandscholarships.htm#ASPHPCS

Send applications to: Carly Mole, Programme Support Officer, Summertown Pavilion, Middle Way, Oxford OX2 7LG, Fax: +44 (0) 1865 516311
Email: cmole@cochrane.ac.uk

Epistemonikos database released in 9 languages

Epistemonikos (www.epistemonikos.org) is a multilingual (English, Spanish, Portuguese, French, Italian, German, Dutch, Arabic and Chinese), collaborative and free database of health evidence.

Through advanced software, it provides a user-friendly, multilingual search interface. Epistemonikos run searches in multiple databases and a network of collaborators process the information, in order to connect different types of evidence, check accuracy (e.g. if a review is 'systematic'), extract additional information, and translate titles and abstracts. It now includes over 20.000 systematic reviews, and more than 100.000 records (many of them not indexed in PubMed). New records are added every day.

Information in the database is interconnected following the principles of Evidence-Based Health Care, which allows users to navigate through different types of evidence (e.g. from a primary study to a systematic review), or to user-friendly structured summaries. There is detailed information in the website at:
About Epistemonikos (www.epistemonikos.org/en/about_us/)
and at How it works (www.epistemonikos.org/en/how_it_works/)

A workshop (http://colloquium.cochrane.org/workshops/epistemonikos-comprehensive-systematic-collaborative-and-multilingual-database-evidence-ba) targeted to review authors, researchers, and entity and Centre staff will be held at the Colloquium.

Contact: For more information about Epistemonikos project, please email Gabriel Rada, Chilean Cochrane Centre radagabriel@epistemonikos.org

Child Health Field is recruiting commentary authors for Evidence-Based Child Health

As you may be aware, the Cochrane Child Health Field publishes a bimonthly journal, Evidence-Based Child Health: A Cochrane Review Journal. In each issue, we reprint several Cochrane reviews, selected from all areas of child health. For each review, we commission one or two short commentaries highlighting the relevance of the findings for child health practice and/or policy. The commentaries are about 500 words long. They are written by people with expertise in the area covered by the review, and experience in preparing systematic reviews and interpreting their findings. The general timeframe for writing the commentary is four to six weeks.

We are currently building a database of potential commentary authors. I would like to invite you to contribute your name to this database. You would be contacted when we are looking for a commentary in an area that matches your area(s) of interest. Of course, if you are not able to write one at the time we contact you, that's fine and we would keep your name in the database until you ask to be removed.

Of note, our publisher, Wiley Blackwell, will provide the author of each published commentary with a complimentary one-year individual subscription to The Cochrane Library.

If you are interested, please send me the following information:
- Your name
- Profession (nurse, physician, pharmacist, social worker, consumer, etc.)
- Area(s) of specialty (emergency, trauma, respiratory, infectious diseases, public health, etc.)
- Topic(s) on which you would be interested in commenting (specific conditions e.g. diabetes, bronchiolitis, or broader areas - it's up to you).
- E-mail address

I would be happy to answer any questions you may have; you may contact me at dthomson@ualberta.ca.

Announcement of the new CEO of The Cochrane Collaboration

On behalf of the Steering Group, we are delighted to announce the appointment of Mark Wilson as the new Chief Executive Officer of The Cochrane Collaboration.

Mark joins the Collaboration with extensive leadership experience at the highest levels in international humanitarian and development organisations, including the International Federation of the Red Cross and Red Crescent Societies, where he became Chef de Cabinet and the organisation's Head of Planning. Previously he

Cochrane Collaboration news (Cont'd)

had been Head of Delegation in Mozambique, and managed the Federation's humanitarian operations in the Balkans during the Kosovo War, from 1998-9.

Mark is currently Executive Director of Panos London, part of a global network of institutes that aims to ensure information is effectively used to foster public debate, pluralism and democracy, focussing particularly on development of the media and information and communication technologies in lower income countries. He is a member of the Royal Institute of International Affairs and the International Institute for Strategic Studies. He holds Masters degrees in International Politics, Soviet and East European Studies, Management, and Journalism. As a former journalist in London and Hong Kong, and Communications Director of the Swiss-based Business Council for Sustainable Development, he is an experienced commentator on economics, business and politics.

Mark is a highly skilled and experienced manager of complex organisations and international operations involving multi-cultural teams, strategic thinking and policy-making, organisational planning and implementation. As his background indicates, he shares the ethos and values of the Collaboration, and we look forward to his leadership of our organisation.
Of his appointment, Mark says, "The Cochrane Collaboration is a recognised leader in its field with a global reputation for the quality and integrity of its work in promoting evidence-based health care. I am thrilled to be given this opportunity to lead the Collaboration and to work with staff and volunteers around the world in building on the organisation's dynamic growth over nearly two decades, and expanding its influence and impact in future."

Mark will be based at the Cochrane Operations Unit in the UK and will start in post on 12th November 2012. He will also be attending the Auckland Colloquium.

We would like to thank the CEO selection panel (Jonathan Craig, Nicky Cullum, Marina Davoli, Kay Dickersin, Jeremy Grimshaw, Zulma Ortiz and David Tovey) for their contribution to the appointment process, and to our previous CEO, Nick Royle, for providing a strong foundation on which Mark will have the opportunity to build.

Jonathan Craig & Jeremy Grimshaw,
Co-Chairs of The Cochrane Collaboration Steering Group

Conferences

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

November 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/

January 23-25, 2013
15th International Conference On Dialysis ADVANCES IN CKD 2013, Rio Grande, Puerto Rico
www.renalresearch.com/RRI/Conference/index.htm

March 9 - 12, 2013
33rd Annual Dialysis Conference
19th International Symposium on Hemodialysis
24th Annual Symposium on Pediatric Dialysis
Seattle, Washington, USA
http://som.missouri.edu/Dialysis/

March 23 – 27, 2013
TSANZ Annual Scientific Meeting, Darwin, NT, Australia
www.fcconventions.com.au/TSANZ2013/

April 2—6, 2013
NKF 2013 Spring Clinical Meetings, Orlando, FL, USA
www.kidney.org/news/meetings/clinical/index.cfm

April 13—16, 2013
66th USANZ Annual Society Meeting (ASM), Melbourne, Australia
www.usanz2013.com

May 4 – 7, 2013
Pediatric Academic Societies, Washington, DC, USA
www.pas-meeting.org/2013DC/Alliance/alliance_organizations.asp

May 18 – 21, 2013
ERA-EDTA 50th Congress, Istanbul, Turkey
www.era-edta2013.org/

May 18 – 22, 2013
American Transplant Congress 2013, Seattle, WA, USA
http://2012.atcmeeting.org/future-atc-meeting-dates

May 31 – June 4, 2013
ISN World Congress of Nephrology 2013, Hong Kong
www.wcn2013.org/

August 31 – September 4, 2013
The Sixteenth Congress of the IPNA, Shanghai, China
www.ipna2013.org/ipna/

September 8-10, 2013
The Seventh International Congress on Peer Review and Biomedical Publication, Chicago, IL, USA
www.ama-assn.org/public/peer/peerhome.htm

September 8-11, 2013
ESOT 2013: 16th Congress of the European Society for Organ Transplantation, Vienna, Austria
http://vienna.esot.org/

September 18-23, 2013
Cochrane Colloquium 2013, Quebec City, Canada

November 5 – 10, 2013
ASN Kidney Week 2013, Atlanta, GA, USA
www.asn-online.org/education_and_meetings/

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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