Cochrane Renal Group Newsletter

October 2010

Inside this issue:

New reviews, protocols and titles

New and updated reviews

In Issues 5-10, 2010 we published five new reviews :

New

- Antimicrobial agents for treating uncomplicated urinary tract infection in women
- Bicarbonate versus lactate solutions for acute peritoneal dialysis
- Heparin and related substances for preventing diabetic kidney disease
- Prostaglandin E1 for preventing the progression of diabetic kidney disease
- Teicoplanin versus vancomycin for proven or suspected infection

New protocols

In Issues 5-10, 2010 we published nine new protocols:

New

- Alpha-blockers as medical-expulsive therapy for ureteral stones
- Antibiotic prophylaxis for preventing post solid organ transplant tuberculosis
- Cardiac testing for coronary artery disease in potential kidney transplant recipients *(Diagnostic Test Accuracy Protocol)*
- Continuous renal replacement therapy (CRRT) for rhabdomyolysis
- Diuretics for treating oedema in nephrotic syndrome
- Percussion, diuresis and inversion therapy for the passage of lower pole kidney stones after shock wave lithotripsy
- Probiotics for preventing urinary tract infections in adults and children
- Tripterygium wilfordii Hook F (a traditional Chinese medicine) for primary nephrotic syndrome
- Upper limb exercise for haemodialysis fistula surgery

New titles

- Antibiotics for asymptomatic bacteriuria
- Aspiration and sclerotherapy versus hydrocelectomy for hydroceles
- Conventional dissection versus plastic device circumcision for treating phimosis in pediatric patients
- Cordyceps sinensis (a traditional Chinese medicine) for kidney transplant recipients
- Cyclosporin target values in the immediate post-operative period for kidney transplant recipients
- Dialyser reuse for people on haemodialysis
- Parathyroidectomy for chronic kidney disease-mineral and bone disorder (CKD-MBD)
- Vassopressin receptor antagonists for hyponatraemia

Potential titles

Our potential titles list is constantly being updated. If you would like a copy please email us at crg@chw.edu.au.

If you have a proposal for a review that is not on the list, please check our list of current reviews to make sure you are not proposing a review that has been completed or is currently being written: (www.cochrane.org/reviews/en/topics/89.html)

Renal group news

L to R: Gail Higgins, Jim Dellit, Elisabeth Hodson

Cochrane Renal Group's 10th Anniversary Celebration

In May 2010, the Cochrane Renal Group celebrated 10 years at its editorial base in the Centre for Kidney Research at The Children's Hospital at Westmead, Sydney, Australia.

One of the guest speakers at the cocktail party was Jim Dellit. Jim was a consumer representative on the Renal Group Advisory Board from 2001 to 2007 and has participated in reviews for the Cochrane Renal and Skin Groups. Jim's speech from the night provided an insightful and thoughtful perspective on the Cochrane Collaboration, the Renal Group & 'medical consumers'. It is reproduced below.

Thank you for inviting me and making it possible for me to be here.

The Cochrane Collaboration, and in this instance, the Renal Cochrane Group, have changed the ways that many renal treatments are conceived and undertaken and our understanding of renal diseases has changed and grown as a direct consequence of the research and reviews undertaken by the Renal Cochrane Group. Whilst metadata research and carefully refereed reviews might seem arcane, the outcomes for patients have been practical and utilitarian. The change in cranberry consumption can be directly linked to the Renal Cochrane Group!

I will leave it to others to document these important outcomes because what I want to briefly focus on are the processes that the Cochrane Collaboration as a whole, as well as this Renal entity, have developed and employ because they provide, in my opinion, models for research, treatment, program and policy development and consumer engagement that should inform future medical developments. Obviously, the greatest contribution the Cochrane has made so far is to promote evidence-based medicine and demonstrate ways of 'creating' evidence, evaluating it and acting on it. Evidence-based medicine is now institutionalized into the rhetoric, and occasionally action, of health departments around Australia and the world and has spilled over into other areas like education and social welfare.

My perspective is that of 'the consumer' and I would like to start by expressing my admiration for the work of the Cochrane Renal Group and its staff and its Advisory Board. I was one of two consumer representatives on the Advisory Board for about five years at the start of this century, and have participated in reviews for the Renal and Skin Groups.

I dislike the term 'consumer' with its input/output, supply/demand connotations and overtones of passivity mixed with rapaciousness but it is a commonly used term, it is part of the lexicon of the Cochrane Collaboration and I'll continue to use it. Like most 'medical consumers', my participation in the medical system and my subsequent activism emerged from a diseased background – renal failure, dialysis, transplants. It is important from a consumer perspective that consumers are seen to have more than their medical experience to offer the partnership with the medical world in which they are forced to enact their part as participants or patients (I am not too fond of that latter word either with its overtones of 'quiescent suffering').

I have participated in many medical forums as a consumer and in many, consumers are invited as "the right thing to do", or because it is a requirement, often seen by professionals on committees or working groups as an impost. Such groups do not really know how to make good use of the consumer experience and advice. Consumers in such groups feel patronized: an adornment rather than a useful appendage. Many consumers use such relationships to vent their anger and frustration at what they see as an inhospitable medical world.

The great thing about the Cochrane Collaboration as a whole, and the Renal Group in particular, is that its structure has roles and responsibilities for consumers that are clearly described and it is very clear about the purposes for including consumers as participants and outcomes that can be expected from consumer participation. Consumer engagement in the evaluation and reviewing processes is different from, and additional to, the work of medical clinicians, researchers and writers. Consumer input is seen to ground the research in experience, and value-adds:

> *The aim of any medical care is to benefit patients. Ultimately, the best person to judge whether any healthcare intervention has been beneficial is the patient.*
> (from the Cochrane Collaboration website http://consumers.cochrane.org/cochrane-groups)

It is a partnership that makes productive use of the specialized experience of the consumer as a particular ingredient in the mix, not as a patronizing feel-good thing to do. The Cochrane Collaboration believes that its information products based on evidence in relation to practice, cannot be achieved without this. Consumer engagement in the reviewing process also ensures that products are achieved that consumers can understand and act on.

As an educator I am aware of the changes required in curriculum and teaching methodologies as the social learning capital increases. We have the most educated parent cohort currently that we have ever had. Not only do educators need to be aware of this group's changed expectations of learning for their children, but we also need to take account of, and use, this enhanced capacity to access knowledge and learning in the home. Changes in the ways that information can be accessed through technologies are also significant in my industry. The medical world is coming to understand that patients and their families are more educated, have a greater capacity to analyze information

Renal group news (Cont'd)

and have uninhibited access to information and a significant capacity to reach conclusions, make judgments and create knowledge for themselves .

The Cochrane Groups understand this and produce information, based on reviews and analysis that engage patients as sentient beings. These analyses are published on-line and in newsletters. They put information about evidence based medicine into the hands of patients as well as doctors: they help put the 'informed' into 'informed consent'. Cochrane assists in creating partnerships among doctors, patients and researchers through the creation of knowledge. The Cochrane Collaboration has been significant in creating this useful, defined partnership role for consumers and it has provided a model for other groups that engage with consumers.

Governments are also looking for such partnerships as part of new forms of governance. Terry Moran the head of the Prime Minister's Department has shifted Health governance directly to the Council of Australian Governments (COAG) in a further step removed from traditional health policy decision-makers:

> *I think the current COAG process has now reached a point where it is apparent that the total body of reform possibilities is broader and more substantial than all of the national competition policy reforms of the 1990s.*
>
> *We need a bold approach to reform. And to achieve such reform, we need a new way of governing—in particular, increased cooperation between federal, state and local governments, businesses and community organisations.*
>
> *A renewed belief in the possibility of reform was apparent at the 3 July 2008 COAG meeting. Leaders reaffirmed their commitment to the goals of the COAG reform agenda to address the challenges of:*
> *• boosting productivity*
> *• increasing workforce participation and mobility*
> *• delivering better services for the community.*
> *Reforms in these areas will in turn contribute to achieving broader goals of social inclusion, closing the gap on Indigenous disadvantage and environmental sustainability. An overriding principle is that the key to building a strong economy is long-term productivity growth and participation in the workforce.* (Moran, Terry, Splicing the perspectives of the Commonwealth and states into a workable federation, keynote address at the ANZSOG Annual Conference on 12 September 2008, reprinted as Chapter4 in *Critical Reflections on Australian Public Policy*, ANU Press 2009)

I trust that the Australian government, and governments elsewhere, will extend their recognition that the Cochrane Collaboration, through its focus on evidence based medicine and its structures that include consumers as partners, has an important role in creating new medical paradigms for developing policies and programs in healthcare.

Not only has the Cochrane Collaboration played an important role in making consumers useful, it has demonstrated a further capacity to link consumers as well as doctors and medical researchers across the world. It is both an international organization and a global one: 'international' in the sense that it connects 'nations' and their nationals and shapes healthcare delivery in particular countries in particular ways; 'global' in the sense that it connects

L to R: Ruth Mitchell, Jonathan Craig, Gail Higgins, Angela Webster, Richard McGee, Narelle Willis, Elisabeth Hodson, Leslee Edwards

individuals as well as groups across boundaries and borders, and recognizes and assists patients and doctors to recognize the 'globality' of their diseases and treatments. Moreover, and necessarily, it relies on changing global communication systems and technologies to do so in ways that provide models for others. It has divided up responsibilities in a useful management model, eg the Cochrane Renal Group is located in Australia for resource, logistical and expertise reasons, but the approach and connectivity is always global. Patients as consumers are connected in a global partnership. The value of this as a model and its importance of taking patients beyond the narrow worlds of their clinics and their waiting rooms cannot be over-estimated. Cochrane has a global framework at the same time the Australian government is struggling to create a national one.

The Cochrane Collaboration is no doubt considering the benefits and risks of cloud computing 'a billowing virtual infrastructure for services – and savings' (CoSN EdTechNext Winter 2009/10 Cloud Computing). As more patients use public clouds in their day-to-day lives, they will expect that their health services will be provided without either obvious gateways or impermeable membranes. From an individual perspective the service, product or infrastructure should be available as and when they need it via the media or devices of their choice. Collective cloud computing might enable more efficient and cost effective services, especially where support and maintenance must be provided to small, geographically distributed sites, often in locations, including homes, without technical expertise. Public cloud computing opportunities raise questions about the efficacy of jurisdictional boundaries in health service provision because they become unnecessary. The Cochrane Collaboration with its global frameworks is well placed to comprehend and act on these information and communication technological shifts.

I have lost the purpose of this commentary and have finished up in the clouds. I apologize. Happy anniversary to the Cochrane Renal Group: it's a great achievement given the vagaries of funding and shifting priorities. Your ten years as a productive and highly valued group is a testament to the drive of the individuals involved and to their dedication and professionalism. And ***that*** is what we consumers are celebrating.

Jim DELLIT

Renal group news (Cont'd)

Visitors to the Cochrane Renal Group (CRG)

At the end of August 2010 the Cochrane Renal Group welcomed two visiting graduate medical students, Anouk Bakens and Mariska van der Veldt, from the Radboud University of Nijmegen in Holland. Anouk and Mariska will work with us at the Centre for Kidney Research until November 2010.

Anouk is contributing to a systematic review on probiotics for hepatic encephalopathy, searching for studies for inclusion in the review, and then appraising and abstracting data from included studies, and contributing to data analysis, and presentation of data in figures and tables. Mariska is involved in a project about surgical RCTs, helping to develop and run the search strategies, creating databases and generating figures and tables, and appraising the methodology of a subset of RCTs.

An article on a Renal Group impact review, recently featured on the Cochrane Collaboration's website, is reproduced below.

Drug for treating kidney transplant rejection to be discontinued following publication of a Cochrane Review

The pharmaceutical company Janssen-Cilag is to discontinue manufacturing its monoclonal antibody muromonab-CD3 (Orthoclone®; OKT3), a decision which was announced following the publication of a Cochrane Review (Webster 2006) evaluating antibodies for acute kidney transplant rejection. Muromonab-CD3 is an immunosuppressant drug that targets the CD3 receptor, and was the first monoclonal antibody to be approved for clinical use in 1986. It is indicated for treating acute, glucocorticoid-resistant rejection of allogeneic renal, heart and liver transplants.

The Cochrane Review compared the effects of monoclonal and polyclonal antibodies with other treatments for reversing acute renal transplant rejection. The review found that although muromonab-CD3 significantly reduced acute rejection compared with steroids in people with a first rejection, there were no significant differences between groups in recurrent rejection, graft loss, or death, and significantly more people had malaise, chills and fever with muromonab-CD3. For people with steroid-resistant rejection, there were no significant differences in reversal of acute rejection, graft loss, or death between muromonab-CD3 and other antibodies (antilymphocyte globulin or antithymocyte globulin), or between muromonab-CD3 and intravenous immunoglobulin. Again, more people had malaise, chills and fever with muromonab-CD3 than with either other antibodies or intravenous immunoglobulin. These results indicate that there may be little or no benefit of muromonab-CD3 over other treatments for acute kidney transplant rejection, and that muromonab-CD3 may result in an increased incidence of specific adverse effects compared with other treatments. The review notes, however, that none of the studies used contemporary baseline immunosuppression, and that there were issues with quantity and quality of existing published trials.

In a press release from Jansen-Cilag (2010), which cites the findings of this Cochrane Review, the company reveals that the sales of muromonab-CD3 are low and declining, and that muromonab-CD3 is considered to be the third-line treatment for acute renal allograft rejection (after equine antithymocyte immunoglobulin and rabbit anti-human thymocyte immunoglobulin). The press release states that "The reason for discontinuing OKT3 is that there are newer biological medicines currently available with similar efficacy but fewer side effects than OKT3". Muromonab-CD3 is currently licensed for use in 27 countries, including Australia, European Union member states, New Zealand and the United States of America, but it is no longer being actively marketed in 10 of these countries (Medicines Complete 2009).

Jonathan Craig, Co-ordinating Editor of the Cochrane Renal Group, said "It is very pleasing to see that our work is more than just a theoretical exercise and does impact upon policy and practice. Ultimately it is about better informing decision making, improving the care of people and improving health outcomes".

[1]Rachel Marshall

[1]Rachel Marshall (rmarshall@cochrane.org), Editor, Cochrane Editorial Unit, 29 Queen Elizabeth Street, London SE1 2LP, UK

References

Janssen-Cilag. Orthoclone®OKT3 muromonab-CD3 – Worldwide discontinuation [press release] 4 January 2010.

MedicinesComplete © Pharmaceutical Press 2009 http://www.medicinescomplete.com/mc/martindale/current/3278-f.htm (Accessed 23 September 2010)

Webster AC, Pankhurst T, Rinaldi F, Chapman JR, Craig JC. Polyclonal and monoclonal antibodies for treating acute rejection episodes in kidney transplant recipients. Cochrane Database of Systematic Reviews 2006, Issue 2. Art. No.: CD004756. DOI: 10.1002/14651858.CD004756.pub3.

Competing interests: The author has completed the Unified Competing Interest form at www.icmje.org/coi_disclosure.pdf (available upon request) and declares (1) no receipt of payment or support in kind for any aspect of the article; (2) no financial relationships with any entities that have an interest related to the submitted work; (3) that R Marshall is employed as an Editor at the Cochrane Editorial Unit and otherwise the authors/spouse/partner/children have no financial relationships with entities that have an interest in the content of the article; and (4) that there are no other relationships or activities that could be perceived as having influenced, or giving the appearance of potentially influencing, what was written in the submitted work.

Renal group news (Cont'd)

The Cochrane Library and Renal Group Impact Factor 2009

The Cochrane Database of Systematic Reviews has an IMPACT FACTOR OF 5.653 and is ranked 11th out of 132 in the ISI category Medicine, General & Internal. The impact factor (IF) describes the ratio of the number of reviews published during 2007 and 2008 (1163) to the number of citations these reviews received in 2009 (6574).

The 2008 IF was 5.182 and the ranking was 12th out of 107 journals. The 2007 IF was 4.654 and the ranking was 14th out of 100.

How the *Renal Group* contributes to Cochrane Database of Systematic Reviews
The 2009 impact factor for the Renal Group is 4.269 (26 publications cited 111 times).

A review published by the Renal Group in 2007 or 2008 was cited, on average, 4.269 times in 2009.

Policy Implications of Renal Reviews

Cochrane Renal reviews have been used and cited in clinical practice guidelines, been instrumental in changing national policy, contributed to successful funding achievement, and been cited as supportive evidence for drug withdrawal.

Cranberries for preventing urinary tract infections
- Cited in 2009 International Clinical Practice Guidelines from the Infectious Diseases Society of America

Polyclonal and monoclonal antibodies for treating acute rejection episodes in kidney transplant recipients
- Cited as supportive evidence for the worldwide withdrawal of the drug OKT3 (see article P 4)

Interleukin 2 receptor antagonists for kidney transplant recipients
- Successful funding achieved for IL2 receptor antagonists in Canada and New Zealand.

Corticosteroid therapy for nephrotic syndrome in children
- Management of steroid sensitive nephrotic syndrome: Revised Guidelines. Indian Pediatric Nephrology Group, Indian Academy of Pediatrics. *Indian Pediatrics*. 45:203-214, March 17, 2008)

Cochrane Register of Diagnostic Test Accuracy Studies

There are almost 5,000 studies in the Register, thanks to the efforts of Tom Rogerson, who is now employed as a part-time research assistant.

I attended the "Methods for Evaluating Medical Tests and Biomarkers" symposium at the University of Birmingham, UK on the 1st and 2nd July. Many interesting papers and posters were presented on a wide variety of topics, including the development of clinical prediction models, how to measure the cost effectiveness of diagnostic testing, and developing clinical guidelines for diagnostic testing. Following this I helped facilitate a two-day intensive workshop at the University for Trials Search Coordinators, aimed at increasing their skills in understanding diagnostic test accuracy studies and in developing sensitive, well-structured search strategies to retrieve them from electronic databases. Fellow presenters were Anne Eisinga, Information Specialist for the UK Support Unit for DTA reviews, and Julie Glanville, Project Director - Information Services for the York Health Economics Consortium Ltd at the University of York, UK. Fourteen TSCs from the UK and Europe attended the workshop, which was a mix of presentations and practical exercises.

The Italian Connection

Giovanni Strippoli, one of our editors, invited us to provide on-site training for his team in developing search strategies. I was lucky enough to travel to Italy to the Consorzio Mario Negri Sud, situated near Lanciano in Abruzzo. Over two weeks I provided a series of morning workshops about the major medical electronic databases, search strategy development, reference management software, the structure of Cochrane systematic reviews, and new features on the Cochrane Library, such as Journal Club. In the afternoons I worked with people on their individual projects, including Suetonia Palmer, one of the Renal Group's authors, who attended for the first week. This intensive work was largely ameliorated by the wonderful hospitality of Giovanni and his team, who showed me around this beautiful region of Italy, and introduced me to its delicious food and wine, and gorgeous scenery.

Ruth Mitchell
Trials Search Coordinator

Cochrane Collaboration news

Cochrane Collaboration 2009/10 Annual Report now available

The Collaboration's latest annual report is available on their website at: www.cochrane.org

New Cochrane Centre in France

The Collaboration is delighted to announce that it now has a Cochrane Centre in Paris, France.

The overall mission of the French Cochrane Centre (Centre Cochrane Français) will be to foster evidence-based healthcare decision-making by promoting the awareness, appreciation, distribution and use of Cochrane Reviews; and by identifying and supporting individuals in France and in French-speaking countries who wish to be involved in The Cochrane Collaboration.

The Centre will be directed by Professor Philippe Ravaud and Dr Pierre Durieux, from University Paris Descartes. Both have been active contributors to the Collaboration for some time, Philippe as a member of the Patient-Reported Outcomes Methods Group, and Pierre as an author for the Effective Practice and Organisation of Care Review Group.

The French Centre will be jointly funded by the L'Ecole des Hautes Etudes en Santé Publique, La Haute Autorité de Santé, L'Assistance Publique - Hôpitaux de Paris, and L'Institut National de la Santé et de la Recherche Médicale.

A website for the French Cochrane Centre is currently under development.

Introducing a new way for people in the USA to donate to the Collaboration

If 501(c)(3) matters to you, then read on. . .

The Cochrane Collaboration is deeply indebted to its funders, and knowing how you want us to use every cent wisely, we work hard to keep our administrative costs down. But the downside of this is that we don't have registered offices around the world*. This presents challenges when donors wish to make their donations tax efficient**.

Recognising this, we've linked up with the New York-based BSUF [www.bsuf.org/], to provide a route to allow our US donors to make tax-efficient donations to the Collaboration. All donations made through this route will be used to further our objectives in capacity building globally through education, training and mentoring. To date (June 2010), over $40,000 has been donated through BSUF.

Donating through BSUF is easy - just fill in their Donor Transmittal Form:

www.bsuf.org/BSUF%20Donor%20Transmittal%20Form.doc

and send it to BSUF with your check (payable to BSUF), or use their online system: www.bsuf.org/donorinfo.htm.

Make sure you fill in 'The Cochrane Collaboration' as the designated institution you want to support.

Read more about why you should, and how you can, donate to the Collaboration on our website:

Conferences 2010 – 2011

October 18-22, 2010 Joint Colloquium of the Cochrane and Campbell Collaborations, Keystone, Colorado, USA. www.regonline.com/colloquium2010

November 16 – 21, 2010 ASN Renal Week 2010 - Colorado Convention Center, Denver, CO, USA
www.asn-online.org

February 21-24 , 2011
Urological Society of Australia and New Zealand
64th Annual Scientific Meeting www.urologymeeting.com.au/

April 8 - April 12, 2011
World Congress of Nephrology, Vancouver, Canada
Website: www.isn-online.org

April 30 – May 4, 2011
American Transplant Congress, Philadelphia
www.atcmeeting.org/2011/index.cfm

April 30 – May 3, 2011
American Society of Pediatric Nephrology 2011 Annual Meeting, Denver, Colorado
www.ipna-online.org/2010/07/american-society-of-pediatric-nephrology-2011-annual-meeting/

June 23-26, 2011
XLVIII ERA-EDTA Congress, Prague, Czech Republic
www.eraedta2011.org

June 29 - July 1, 2011
2011 TSANZ Annual Scientific Meeting
Manning Clark Centre on the ANU Campus, Canberra, ACT.
www.tsanz.com.au/meetings/index.asp

August 28-31, 2011
8th G-I-N conference,
Seoul, Korea - Inchon Memorial Hall, Korea University
www.g-i-n.net/events/8th-conference

October 19-21, 2011
19th Annual Cochrane Colloquium 2011
Location: Madrid, Spain
www.cochrane.org/events/cochrane-collaboration-calendar/19th-annual-cochrane-colloquium-2011-madrid-spain

November 8— 13, 2011
ASN Renal Week
Pennsylvania Convention Center, Philadelphia, Pennsylvania, USA
Website: www.asn-online.org

Cochrane Collaboration news (cont'd)

www.cochrane.org/about-us/support-us.

Thanks again for your support - together we are changing the health care for the better.

Julian Higgins awarded the Campbell Collaboration's Frederick Mosteller Award

Julian Higgins, Methods Group representative on The Cochrane Collaboration's Steering Group and Senior Statistician at the MRC Biostatistics Unit in Cambridge, UK, has been awarded the Campbell Collaboration's Frederick Mosteller Award for Distinctive Contributions to Systematic Reviewing. For more information, follow the link below: www.campbellcollaboration.org/c2_awards/frederick_mosteller_award.php

Julian is an active contributor to both Campbell and Cochrane Collaborations, and is co-editor of the Cochrane Handbook for Systematic Reviews of Interventions: www.cochrane.org/training/cochrane-handbook

The Handbook is the official document that describes in detail the process of preparing and maintaining Cochrane systematic reviews on the effects of healthcare interventions. About the accolade, Julian says, "I am surprised, flattered and delighted to have been chosen for this award. Fred Mosteller was a great statistician, and to have my name associated with him in this way is a huge honour".

Julian will be presented with his award at the first joint Colloquium of the Campbell and Cochrane Collaborations, in Keystone USA, in October. Arild Bjørndal, Co-chair of Campbell Collaboration's Steering Group, says, "it is very appropriate that the Campbell Collaboration will honour Julian Higgins at the first Colloquium to be co-hosted with The Cochrane Collaboration. Julian has worked - both theoretically and practically - to improve the methodological quality of systematic reviews. In that work the boundaries between the two Collaborations are insignificant; Campbell has learned a tremendous lot from Julian and the Cochrane effort".

PAHO Partners with EQUATOR

I am pleased to inform you that PAHO partnered with the EQUATOR Network to enhance access to research reporting guidelines, especially in the Americas.

The first phase of this collaboration will make the EQUATOR Network contents available in Spanish but the work plan expands to cover other languages and aspects relevant to the objectives of PAHO's Policy on Research for Health now available in official and abridged colloquial language version: www.paho.org/researchportal/policy

Press release PAHO-EQUATOR Network
http://new.paho.org/hq/index.php?option=com_content&task=view&id=3200&Itemid=1926

Request for Proposal

As per the recommendations put forward by the Strategic Review and the direction and approval of the Cochrane Collaboration Steering Group, the Marketing and Communications Working Group has recently developed a Request for Proposal to be distributed to key international marketing and communications firms.

The goal is to identify a professional firm with which to move forward and build on our current communications efforts such as the newly revamped cochrane.org. We acknowledge that in order to strengthen the Collaboration's brand, and in turn impact, we must engage the skills of a specialized firm that can complement the skill sets we offer within the Collaboration. The Request for Proposal is available on the news section of cochrane.org.

Mary Ellen Schaafsma
Chair, Marketing and Communications Working Group

NIHR Annual Report highlights the work of The Cochrane Collaboration

Among the many funders of The Cochrane Collaboration around the world, the National Institute for Health Research (NIHR) in the UK makes the largest contribution to the Collaboration's infrastructure costs. Its continuing support is a key element in the sustainability of our work. It is good to see, therefore, that the NIHR Annual Report, which has just been published, draws attention to the value and importance of the work of The Cochrane Collaboration, including a special feature on the Cochrane Schizophrenia Group. The NIHR provides support for the costs of the editorial bases of 20 Cochrane Reviews Groups and the UK Cochrane Centre, as well as providing the funds for a series of Programme Grants, the NHS-Cochrane Engagement Awards and the Cochrane Reviews Incentive Scheme. This funding comes through the NIHR's Systematic Reviews Infrastructure (SRI) programme and the foreword to the report by Earl Howe (Parliamentary Under Secretary of State for Quality) highlights specifically the importance of this, noting how the NIHR SRI helps to generate the knowledge and evidence on which continually improving health outcomes depend.

The report is available at www.nihr.ac.uk/files/pdfs/400891_NIHR_AnnualReport2010_acc3.pdf.

Cochrane Collaboration news (cont'd)

Complementary Medicine Field Bursary Scheme (2010) - Call for Applications

The Cochrane Collaboration Complementary Medicine Field is pleased to announce our 2010 bursary scheme made possible through funds from the US National Institutes of Health, National Center for Complementary and Alternative Medicine. The purpose of this bursary scheme is to ensure that reviews relevant to complementary and alternative medicine (CAM) are completed and published in The Cochrane Library.

Funding offered:
* 2 review proposals in the amount of $5,000 USD each will be funded. The funding must be paid directly to the individual bursary recipient; it cannot be paid to the recipient's institution.

Eligibility requirements:
* Review must be registered with a Cochrane Collaborative Review Group, and the relevant protocol/review must already be published in The Cochrane Library;
* The topic of the review must relate to CAM (see scope in Call for Applications); and
* Bursaries will be targeted to reviews for which substantial progress has already been made and whose completion has been stalled due to a lack of funding.

Timeline:
Completed application forms should be e-mailed to Eric Manheimer (emanheimer@compmed.umm.edu) by 29 October 2010. Forms sent by postal delivery or fax will not be accepted. Successful candidates will be notified by 19 November 2010. Funds will be distributed to successful applicants in a single installment, after the award notification. Funds must be paid to the individual recipients of the bursary, and not to their institutions.

For more information (e.g. the assessment criteria, additional details about eligibility and application procedures), please see the full Call for Applications and Application Form (available at: www.compmed.umm.edu/integrative/cochrane_bursary.asp).

Congratulations to the recipients of the 2009 CAM Field bursary scheme awards:
* Gabriele Dennert, for the Cochrane Gynaecological Cancer Group Review 'Selenium for preventing cancer'
* Kalpana Sridharan, for the Cochrane Metabolic and Endocrine Disorders Group Review 'Ayurvedic treatments for diabetes mellitus'

Best wishes,
Eric Manheimer, on behalf of the Cochrane Collaboration Complementary Medicine Field

New Korean Branch of the Australasian Cochrane Centre

We are delighted to announce the Monitoring and Registration Committee's approval of the Korean Branch of the Australasian Cochrane Centre. Congratulations to Hyeong Sik Ahn, the Branch Director, who has led this initiative.

An informal network has been in place since 2007 and provided a focus for Cochrane activities, including several Cochrane review workshops. There are now about 30 authors in Korea contributing to 20 titles, protocols and reviews. We look forward to further involvement from Korean authors, and the increased profile the Collaboration will have in Korea.

Further information on the ACC website (http://acc.cochrane.org/korea).

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 developing 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 3-month Scholarship 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 August 2010 with the relevant Cochrane Review Group.

Application deadline: 31 October 2010
For more information and requirements:
www.cochrane.org/docs/Fellowshipsandscholarships.htm#ASPHPCS

Cochrane Canada Live

Event: Cochrane Canada Live: Late 2010 Series
Date: September through December on select dates
Location: We broadcast the web seminars (webinars) from Ottawa, Canada. Participants join via computer and Internet access, subject to convenience for time zones.
Details: Join us for our next webinar series! New to the series is a methodology clinic specifically for Cochrane authors - apply to receive methods consultation for your review. Please visit our website for more details (address shown below). We look forward to your participation!
Contact: The Canadian Cochrane Centre
Email: ccnc-iph@uottawa.ca
Website: http://ccnc.cochrane.org/cochrane-canada-live-webinars

Cochrane Collaboration news (cont'd)

New Entity - Justice Health Field

I am delighted to announce that the Cochrane Justice Health Field became a registered entity within The Cochrane Collaboration on 7 September 2010.

Contact details for the Justice Health Field are as follows:
Dr Catherine Gallagher
Convenor, Cochrane Justice Health Field
Justice, Law and Crime Policy Program
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Catherine is co-ordinating the Field alongside Stuart Kinner (kinner@burnet.edu.au) from the Burnet Institute in Melbourne, Australia, and they are both being ably assisted by Adam Dobrin who can be contacted at adobrin@fau.edu.

Wishing the members of the Cochrane Justice Health Field a very warm welcome to the Collaboration.

Society for Clinical Trials - Trial of the Year

Each year the Society for Clinical Trials and Project ImpACT presents an award to the randomized clinical trial published (electronically or on paper) in the previous year that best fulfills the following standards:

* It improves the lot of mankind.
* It provides the basis for a substantial, beneficial change in health care.
* It reflects expertise in subject matter, excellence in methodology, and concern for study participants.
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We are now accepting nominations for the outstanding Trial of the Year published (electronically or on paper) in 2010. The deadline for nominations is January 31, 2011, and the award will be presented at our annual meeting in Vancouver.
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Workshops

Systematic Review Completion & Review Update Workshop 8 - Friday 12 November 2010
Location: Christian Medical College, Vellore- 632002, Tamil Nadu, India.
Website: www.cochrane-sacn.org

Workshop on creating Summary of Findings using GRADE-Pro
12 November 2010
Location: Christian Medical College, Vellore- 632002, Tamil Nadu, India
Website: www.cochrane-sacn.org

Developing a Cochrane Systematic Review workshop
12 - 14 January 2011
Location: Baltimore, Maryland (USA)
Website: http://eyes.cochrane.org/workshop-developing-systematic-review

The Nottingham Systematic Review Course 2011
7-10 June 2011
Location: The University of Nottingham, UK
Website: http://szg.cochrane.org/en/events.html

For Review workshops offered by other Cochrane Centres please go to: www.cochrane.org/events/w-shops/all

Upcoming workshops 2010

Australasian Cochrane Centre/
Cochrane Renal Group

DECEMBER—Sydney

1 December	Cochrane Review Completion and Update Program
2 December	Developing a Protocol for a Systematic Review
3 December	Introduction to Analysis

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

Recent abstracts

Antimicrobial agents for treating uncomplicated urinary tract infection in women. Anca Zalmanovici Trestioreanu, Hefziba Green, Mical Paul, John Yaphe, Leonard Leibovici

Background
Acute uncomplicated lower urinary tract infection (UTI) is one of the most common problems for which young women seek medical attention.

Objectives
To compare the efficacy, resistance development and safety of different antimicrobial treatments for acute uncomplicated lower UTI.

Search strategy
We searched the Cochrane Central Register of Controlled Trials (CENTRAL), the Cochrane Renal Group's Specialised Register, MEDLINE, EMBASE and bibliographies of included studies.

Selection criteria
Randomised controlled trials (RCTs) comparing different classes of antimicrobials for acute uncomplicated UTI in women were included.The outcomes of interestwere symptomatic and bacteriological cure at short and long-termfollow-up, resistance development, number of days to symptom resolution, days of work loss, adverse events and complications.

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

Main results
Trimethoprim-sulfamethoxazole (TMP-SMX) was as effective as fluoroquinolones in achieving short-term (RR 1.00, 95% CI 0.97 to 1.03) and long-term (RR 0.99, 95% CI 0.94 to 1.05) symptomatic cure. Beta-lactam drugs were as effective as TMP-SMX for short-term (RR 0.95' 95% CI 0.81 to 1.12) and long-term (RR 1.06' 95% CI 0.93 to 1.21) symptomatic cure. Short-term cure for nitrofurantoin was similar to that of TMP-SMX (RR 0.99' 95% CI 0.95 to 1.04) as was long-term symptomatic cure (RR 1.01' 95% CI 0.94 to 1.09).

Fluoroquinolones were more effective than beta-lactams (RR 1.22, 95% CI 1.13 to 1.31) for short-term bacteriological cure. Rashes were more frequent in patients treated with TMP-SMX than with nitrofurantoin or fluoroquinolones and in patients treated with beta-lactam drugs compared to fluoroquinolones. Minimal data were available on the emergence of resistant strains during or after antimicrobial treatment.

Authors' conclusions
No differences were observed between the classes of antimicrobials included in this review for the symptomatic cure of acute uncomplicated UTI. Fluoroquinolones proved more effective than beta-lactams for the short-term bacteriological outcome, probably with little clinical significance. Individualised treatment should take into consideration the predictable susceptibility of urinary pathogens
in local areas, possible adverse events and resistance development, and patient preference.

Bicarbonate versus lactate solutions for acute peritoneal dialysis. Zheng Gang Bai, KeHu Yang, Jinhui Tian, Bin Ma, Yali Liu, Lei Jiang, Jiying Tan, Tian Xi Liu, Iris Chi

Background
The high mortality rate among critically ill patients with acute kidney injury (AKI) remains an unsolved problem in intensive care medicine, despite the use of renal replacement therapy (RRT). Increasing evidence from clinical studies in adults and children suggests that the new peritoneal dialysis (PD) fluids may allow for better long-term preservation of peritoneal morphology and function. Formation of glucose degradation products (GDPs) can be reduced and even avoided with the use of newer "biocompatible" solutions. However, it is still unclear if there are any differences in using conventional (lactate) solutions compared with low GDP (bicarbonate) solutions for acute PD.

Objectives
To look at the benefits and harms of bicarbonate versus lactate solutions in acute PD.

Search strategy
We searched the Cochrane Central Register of Controlled Trials (CENTRAL), MEDLINE (from 1966), EMBASE (from 1980), Latin American and Caribbean Health Sciences Literature Database LILACS (from 1982), and reference lists of articles.

Selection criteria
Randomised controlled trials (RCTs) comparing bicarbonate to lactate solution for acute PD.

Data collection and analysis
Two authors independently assess the methodological quality of studies. One author abstracted data onto a standard form, and a second author checked data extraction. We used the random-effects model and expressed the results as relative risk (RR) for dichotomous outcomes and mean difference (MD) for continuous outcomes with 95% confidence intervals (CI).

Main results
We included one study (20 patients) in this review. In shock patients, bicarbonate did not differ from lactate with respect to mortality (RR 0.50, 95% CI 0.06 to 3.91); however there

Recent abstracts (cont'd)

were significant differences in blood lactate (MD -1.60 mmol/L, 95% CI -2.04 to -1.16), serum bicarbonate (MD 5.00 mmol/L, 95% CI 3.26 to 6.74) and blood pH (MD 0.12, 95% CI 0.06 to 0.18). In non-shock patients there was a significance difference in blood lactate (MD -0.60 mmol/L, 95% CI -0.85 to -0.35) but not in serum bicarbonate (MD 1.10 mmol/L, 95% CI -0.27 to 2.47) or blood pH (MD -0.02, 95% CI -0.02 to -0.06). Other outcomes could not be analysed because of the limited data available.

Authors' conclusions
There is no strong evidence that any clinical advantage for patients requiring acute PD for AKI when comparing conventional (lactate) with low GDP dialysis solutions (bicarbonate).

Heparin and related substances for preventing diabetic kidney disease. Jun Li, Hong Mei Wu, Ling Zhang, Bin Zhu, Bi Rong Dong

Background
Diabetic kidney disease (DKD, also called diabetic nephropathy, DN) is the major cause of end-stage kidney disease (ESKD) in many countries and is associated with increased morbidity and mortality as compared to other causes of kidney disease. One of the pathological changes of DKD is the thickening of the glomerular basement membrane, mesangial expansion and proliferation. The presence of the glycosaminoglycan side chains of heparan sulfate proteoglycan, an important constituent of the glomerular basement membrane, is decreased in DKD proportionally to the increasing degree of proteinuria. Research on animals has suggested that heparin and related substances may prevent glomerular membrane thickening. However, it is not known whether heparin and related substances can prevent the onset of DKD and, therefore, be recommended for primary prevention of this condition.

Objectives
To assess the benefits and harms of heparin and related substances for preventing the onset of DKD.

Search strategy
We searched the Cochrane Renal Group's Specialised Register and the Cochrane Central Register of Controlled Trials (CENTRAL) in The Cochrane Library (Issue 2, 2009). We also searched MEDLINE (1966 to June 2009), EMBASE (1980 to June 2009), China Biological Medicine (CBM; 1979 to June 2009), VIP Chinese Science and Technique Journals Database (until June 2009), China National Infrastructure (CNKI) (until June 2009) and Wanfang database (until June 2009). Reference lists of nephrology textbooks, review articles and relevant studies were also searched.

Selection criteria
All relevant randomised controlled trials (RCTs) and quasi-RCTs looking at the benefits and harms of heparin and related substances for preventing the onset of DKD were eligible.

Data collection and analysis
We planned for two authors to extract data independently using a self-developed data extraction form and enter them into RevMan 5 software; for meta-analyses to be performed when more than one study provided data on a comparable outcome on sufficiently similar patients; for random-effects analyses to be performed whenever heterogeneity between results appeared to be present; and for standardised differences in mean outcome measures to be used due to the use of different scales and periods of treatment.

Main results
No studies met our inclusion criteria.

Authors' conclusions
Rigorously well-designed, randomised, multi-centre, large-sample studies of heparin and related substances for preventing the onset of DKD are needed.

Prostaglandin E1 for preventing the progression of diabetic kidney disease. Han Wang, Jue Lin Deng, Jirong Yue, Jun Li, Yan Bin Hou

Background
Diabetic kidney disease (DKD) is one of the major chronic microvascular complications in diabetes mellitus, and may progress to end-stage kidney disease (ESKD). There are no definitely effective approaches for preventing, delaying or treating DKD. Small studies have shown that Prostaglandin E1 (PGE1) can improve renal blood circulation and decrease proteinuria and albuminuria.

Objectives
To assess the benefits and harms of PGE1 for preventing the progression of DKD.

Search strategy
We searched the Cochrane Central Register of Controlled Trials (CENTRAL), MEDLINE, EMBASE, Chinese Biomedicine Database (CBM) and reference lists of articles with no language restriction.

Selection criteria
All randomised controlled trials (RCTs) or quasi-RCTs comparing any PGE1 agent used for preventing the progression of DKD, regardless of dosage, mode of administra-

Recent abstracts (Cont'd)

tion, addition of cointerventions or duration of treatment.

Data collection and analysis
Two authors independently assessed study quality and extracted data. For dichotomous outcomes (all-cause mortality, ESKD), results were expressed as relative risk (RR) with 95% confidence intervals (CI). Continuous outcomes (microalbuminuria, proteinuria, albuminuria, doubling of serum creatinine, serum creatinine) were expressed as mean difference (MD) with 95% CI.

Main results
Six studies (271 patients) were included. Five studies investigated PGE1 with or without fosinopril/losartan versus fosinopril/losartan or no treatment and one compared PGE1 versus Xueshuantong (a Chinese medicinal herb). There was a significant decrease in urinary albumin excretion rate (UAER) in patients treated with PGE1 (MD -48.28 µg/min, 95% CI -75.29 to -21.28), other outcomes also showed a significant decrease in the patients with PGE1 (albuminuria: MD -143.66 mg/24 h, 95% CI -221.48 to -65.84; proteinuria: MD -300 g/24 h, 95% CI -518.34 to -81.66). PGE1 had a positive effect on albuminuria (MD -660 mg/24 h, 95% CI -867.07 to -452.93) in clinical DKD (CDN, III stage of DN) compared with Xueshuantong. No data on incidence of ESKD, all-cause mortality or quality of life were available.

Authors' conclusions
PGE1 may have positive effects on DKD by reducing UAER, decreasing albuminuria and lessening proteinuria, with no obvious serious adverse events. However, limited by the poor methodological quality of the included studies and the small number of participants, there is currently insufficient evidence for determining if PGE1 could be used for preventing the progression of DKD. Large, properly randomised, placebo-controlled, double-blind studies are urgently needed.

Teicoplanin versus vancomycin for proven or suspected Infection. Alexandre B Cavalcanti, Anderson R Goncalves, Claudia S Almeida, Diogo DG Bugano, Eliezer Silva

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Background
Vancomycin and teicoplanin are commonly used to treat gram-positive infections, particularly those caused by methicillin-resistant Staphylococcus aureus (MRSA). There is uncertainty regarding the effects of teicoplanin compared to vancomycin on kidney function with some previous studies suggesting teicoplanin is less nephrotoxic than vancomycin.

Objectives
To investigate the efficacy and safety of vancomycin versus teicoplanin in patients with proven or suspected infection.

Search strategy
We searched the Cochrane Renal Group's Specialised Register, CENTRAL, MEDLINE, EMBASE, reference lists of nephrology textbooks, review articles with relevant studies and sent letters seeking information about unpublished or incomplete studies to investigators involved in previous studies.

Selection criteria
We searched for randomised controlled trials (RCTs) in any language comparing teicoplanin to vancomycin for patients with proven or suspected infection.

Data collection and analysis
Two authors independently evaluated methodological quality and extracted data using standardised data extraction forms. Study investigators were contacted for information not available in the original manuscripts. Random effects model was used to estimate the pooled risk ratio (RR) with 95% confidence interval (CI).

Main results
We included 24 studies (2,610 patients) in this review. Teicoplanin reduced the risk of nephrotoxicity compared to vancomycin (RR 0.66, 95% CI 0.48 to 0.90).The effects of teicoplanin or vancomycin were similar for clinical cure (RR 1.03, 95% CI 0.98 to 1.08), microbiological cure (RR 0.98, 95% CI 0.93 to 1.03) and mortality (RR 1.02, 95% CI 0.79 to1.30). Six studies reported no cases of acute kidney injury (AKI) needing dialysis. Adverse events were less frequent with teicoplanin including cutaneous rash (RR 0.57, 95% CI 0.35 to 0.92), red man syndrome (RR 0.21, 95% CI 0.08 to 0.59) and total adverse events (RR 0.73, 95% CI 0.53 to 1.00). A lower risk of nephrotoxicity with teicoplanin was observed in patients either with (RR 0.51, 95% CI 0.30 to 0.88) or without aminoglycosides (RR 0.31, 95% 0.07 to 1.50), and also when vancomycin dosing was guided by serum levels (RR 0.22, 95% CI 0.10 to 0.52).

Authors' conclusions
Teicoplanin and vancomycin are both effective in treating those with proven or suspected infection; however the incidence of adverse effects including nephrotoxicity was lower with teicoplanin. There were no cases of AKI needing dialysis. It remains unclear whether the differential effect on kidney function should influence which antibiotic be prescribed, although it may be reasonable to consider teicoplanin for patients at higher risk for AKI needing dialysis.

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