



Cochrane Renal Group Newsletter

May 2009

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New reviews, protocols

New and updated reviews

In Issues 1 & 2, 2009 we published five new reviews and one 'conclusions changed' review:

New

- HMG CoA reductase inhibitors (statins) for kidney transplant recipients
- HMG CoA reductase inhibitors (statins) for people with chronic kidney disease not requiring dialysis
- Interventions for haemolytic uraemic syndrome and thrombotic thrombocytopenic purpura
- Pharmacological interventions for preventing complications in idiopathic hypercalcaemia
- Steroid avoidance or withdrawal for kidney transplant recipients

Conclusions changed

- HMG CoA reductase inhibitors (statins) for dialysis patients

New and major change protocols

In Issues 1 & 2, 2009 we published seven new protocols and three 'major change' protocols:

New

- Angiotensin converting enzyme inhibitors and angiotensin receptor blockers for adults with early (stage 1-3) non-diabetic chronic kidney disease
- Antihypertensive agents for dialysis patients
- Biocompatible dialysis fluids for peritoneal dialysis
- Hydroxyethyl starch (HES) versus other fluid therapies: effects on kidney function
- Interventions for treating sexual dysfunction in patients with chronic kidney disease
- Mycophenolic acid versus azathioprine as primary immunosuppression for kidney transplant recipients

- Steroid avoidance or withdrawal for pancreas and kidney transplant recipients

Major change

- HMG CoA reductase inhibitors (statins) for kidney transplant recipients
- Interventions for lowering plasma homocysteine levels in dialysis patients
- Ultrasound use for the placement of haemodialysis catheters

New titles

- Dialysate temperature control for haemodialysis
- Loop diuretics for acute kidney injury in adults and children
- Low molecular weight heparin (LMWH) versus unfractionated heparin (UFH) for haemodialysis anticoagulation
- Percussion, diuresis and inversion therapy for the passage of lower pole kidney stones after shock wave lithotripsy
- Single dose antibiotics for treating uncomplicated urinary tract infection in women
- Single versus simultaneous-double pediatric donor organs for adult kidney transplant recipients
- Tubeless versus standard percutaneous nephrolithotomy for treating kidney stones

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



New Collaboration Co-Chair—Jonathan Craig

The announcement below was made following the recent Cochrane Collaboration Steering Group mid year meeting:

“One of our important tasks was the selection of a new Co-Chair to replace Adrian Grant when his term expires this October. I am very pleased to announce that the Steering Group has selected Jonathan Craig for this role. Jonathan is well known to many of you. He has been a member of The Cochrane Collaboration since 1998 when he began work on his first Cochrane review. He is now a co-author on 49 reviews and as the Co-ordinating Editor of the Cochrane Renal Group has contributed to the production and updating of all of that Group’s 68 reviews. Jonathan brings a wealth of relevant experience and international recognition as a clinician, researcher, policy maker, journal editor, guideline developer and consumer advocate. Within the Collaboration, he has a leadership role in the Diagnostic Test Accuracy Methods Working Group, the Co-ordinating Editors’ Executive and the Co-Eds Methods Working Group, in addition to serving on the Steering Group and several of its advisory groups.

Jonathan will be inducted as a Co-Chair during the Singapore Colloquium and all of us on the Steering Group are looking forward to working with him in this new role.

*Best wishes,
Lorne Becker and Adrian Grant
Co-Chairs, The Cochrane Collaboration Steering Group “*

New Editors

In December 2008 we welcomed two new Editors to the Cochrane Renal Group Editorial team – Vivekanand Jha and Marcello Tonelli (see below).

We also thanked our retiring Editorial Board members - Cecile Couchoud, Denis Fouque, Alison MacLeod, Giuseppe Remuzzi, Teut Risler and Paul Roderick - for their involvement and substantial contribution over many years.



Vivekanand Jha graduated from Patna Medical College, did his postgraduate training in Medicine and Nephrology from the Postgraduate Institute of Medical Education and Research (PGI), Chandigarh, India and a basic research Fellowship at the Beth Israel Deaconess Medical Center, Boston.

He has been on the faculty of Nephrology at the PGI since 1992 and currently is the Additional Professor of Nephrology and Co-ordinator of Stem Cell Research. His research interests have encompassed all fields of nephrology and transplantation, including clinical research in tropical acute and chronic kidney diseases, post-transplant infections, and pharmacogenetics of immunosuppressive drug therapy. He is currently investigating the role of genetic polymorphisms in kidney diseases, and is working on developing a facility for translational research in regenerative medicine.

He is the Deputy Editor of the Indian Journal of Nephrology, and works with NGOs to provide preventive healthcare to populations living in remote areas.



Dr Marcello Tonelli received an MD from the University of Western Ontario, specialist certification in nephrology (FRCPC) at Dalhousie University, and an SM in epidemiology from Harvard University. He is currently a nephrologist and Associate Professor at the University of Alberta. He serves as Associate Editor of American Journal of Kidney Diseases, the Cochrane Renal Group and the Journal of Nephrology, and is a

member of the Editorial Board for JASN. He is the chair of the Canadian Society of Nephrology Clinical Practice Guidelines committee and the President-Elect of the Canadian Society of Nephrology and a member of the Minister’s Expert Committee for Drug Evaluation for the Province of Alberta.

Dr Tonelli received a Health Scholar award from the Alberta Heritage Foundation for Medical Research (AHFMR). He is a founding member of the Alberta Kidney Disease Network and co-leader of the Interdisciplinary

Renal group news (Cont'd)

Chronic Disease Collaboration (ICDC) research team. Since 2005, Dr Tonelli has been the co-leader of a joint initiative between the University of Alberta and the Hospital Civil de Guadalajara, aimed at prevention of kidney failure among the poor of Jalisco, Mexico.

Dr Tonelli's research is aimed at improving the care of people with chronic kidney disease and its major causes (hypertension, diabetes mellitus, and atherosclerosis). Specific areas of focus within these clinical populations include: identification and management of novel risk factors; designing new strategies to improve the efficiency of healthcare delivery; and determinants of access to high quality care. A unique aspect of Dr Tonelli's research program includes partnering with regional, provincial, and national decision-makers to ensure that the findings will be used to produce rational health policy.

Cochrane Register of Controlled Studies

Gail Higgins, TSC with the Cochrane Renal Group, was invited to be part of the consultation process for a new Cochrane Register of Controlled Studies. In March this year she attended the UK and Ireland Contributors' Meeting in Edinburgh, where details of the proposed register were presented for feedback before the Request for Proposal is released for tender.

Diagnostic Test Accuracy Reviews

A workshop on Cochrane Diagnostic Test Accuracy Reviews was held recently by the Australasian Cochrane Centre, in collaboration with the Cochrane DTA Working Group, in Melbourne on the 23rd – 24th March. Jon Deeks (University of Birmingham), Patrick Bossuyt (University of Amsterdam), Petra Macaskill (University of Sydney) and Ruth Mitchell (Cochrane Renal Group) gave presentations on the science and methods of undertaking diagnostic test accuracy reviews, including question formulation, study design, study quality, locating studies, meta-analysis and interpretation & presentation of results.

The workshop was held to assist editorial teams and authors of Australasian-based Cochrane Review Groups to undertake DTA reviews, and also included information on how Cochrane DTA reviews should be structured, and the editorial processes involved.

Cochrane Collaboration news

Results of the Cochrane Strategic Review

The Cochrane Collaboration has been in existence since 1993 – just over 16 years. During that time it has grown organically and now involves over 22,000 people world-

wide. Some elements of its structure were planned, while others were the result of a specific event, need or interest at a given time.

It is a good idea, from time to time, to review an organisation's purposes, activities, structures and governance. The Cochrane Collaboration has reviewed some parts of its organisation (e.g. periodic reviews of its governance) but never the organisation as a whole. The Cochrane Collaboration Steering Group decided that it was time to conduct the first ever formal review of the organisation with each of its elements considered in context. The Strategic Review of The Cochrane Collaboration was approved and then initiated in 2008.

The Strategic Review has been carried out in keeping with, and consistent to, the ten principles of The Cochrane Collaboration. It was conducted by Cochrane members (Jeremy Grimshaw, Mary Ellen Schaafsma, Lisa McGovern and Lucie Jones), with the guidance of a consulting firm that specialises in strategy engagement (Ashridge Consulting). It was constructed as a deliberate conversation with the Collaboration's members, contributors, partners and funders, and carried out in a series of surveys and interviews, probing questions on the topics of:

- Purpose;
- Brand and glue (external and internal coherence);
- Competition (external environment);
- Financial viability;
- Accountability and decisionmaking;
- Structures and processes; and,
- Communication, advocacy and engagement with external stakeholders.

The goal was to engage as many people as possible – both within and external to the Collaboration – in conversations on these topics to build a better understanding from our important stakeholders of how The Collaboration is perceived, how it functions, and what may affect its success into the future.

Over the life of the Strategic Review we, the Review Team, interviewed 75 Collaboration members and external stakeholders, 185 people completed on-line surveys, an average of 850 unique visitors went to our website each month from July 2008 to January 2009, and many people engaged in the process at the Freiburg Colloquium in October 2008 (for example, we gave out 450 badges saying "I am a face of The Cochrane Collaboration" that people wore proudly during the Colloquium).

As we considered what emerged from each Dialogue, we identified five cross-cutting themes and twenty six recommendations that we believe will strengthen The Cochrane Collaboration as it goes forward, ensuring its ongoing success.

The full report gives details about the process of the Review. It outlines what we asked, what you told us and how

Cochrane Collaboration news (Cont'd)

we reflected on what we heard in order to arrive at these recommendations. Additional information for each Dialogue and the full Strategic Review Recommendations Report are available from the Review website: <http://ccreview.wikispaces.com/Final+Report+and+Background+Documents>.

We heard from you that The Cochrane Collaboration needs:

Clarity of purpose, and should:

- Reaffirm our primary purpose to be the production of systematic reviews
- Formalise additional purposes including training, methods development and advocacy for evidence-based decision-making and identify responsibilities of entities for these purposes
- Identify principles for developing new products or lines of activity

Engagement of partners for mutual benefits, and should:

- Develop a Marketing and Communications Strategy to promote external and internal awareness of the value arguments for and achievements of The Cochrane Collaboration
- Improve the usability of *The Cochrane Library* and other products for diverse stakeholders
- Develop a partnership strategy to engage other systematic review producers and knowledge packagers
- Establish formal membership for its contributors
- Establish an External Advisory Board

New resource options for supporting strategic objectives, and should:

- Invest in a development function for new products or lines of activities
- Investigate the development of a broad-based educational program ('*Cochrane Education*')
- Investigate the development of a responsive review program ('*Cochrane Response*')
- Acknowledge the reality of our current infrastructure funding model and work to maintain it
- Explore and pursue new funding opportunities

Management, accountability and effective leadership, and should:

- Clarify the roles and responsibilities of its scientific/professional, managerial and editorial leadership
- Develop and implement a formal succession planning mechanism for entity leadership

- Develop and implement performance appraisal mechanisms for entity leaders
- Enhance accountability mechanisms of entities to ensure core functions are met and Collaboration policies are implemented
- Develop and implement policy for minimal competencies for review author teams
- Develop and implement central decision-making processes that clearly identify communication, implementation and monitoring plans
- Review the membership of the Cochrane Collaboration Steering Group (CCSG) and its alignment with the purposes of the Collaboration
- Define required competencies for CCSG membership and induction and ongoing training for CCSG members
- Review terms of reference and membership of CCSG Sub-Groups and Advisory Groups

'Strategic Thinking' embedded at all levels, and at all times, in the Collaboration, and should:

- Undertake a formal environmental scan every two to three years
- Use uncommitted income strategically to develop new products/lines of activity
- Review terms of reference, and number and geographic spread of Cochrane entities to ensure efficient alignment with the purposes of the Collaboration
- Develop an ongoing and participatory approach to strategy formation

*Jeremy Grimshaw
Strategic Review Team*

Are you listening? Podcasts from *The Cochrane Library*

Podcasts from *The Cochrane Library* began as a pilot project after approval from the Collaboration Publishing Policy Group (PPG) in November 2007. Thirteen months, lots of positive feedback and 56 podcasts later, Cochrane podcasts are included for every issue and are now a regular and popular feature of *The Cochrane Library*.

The idea to include podcasts in *The Cochrane Library* came after the success of the Dublin and São Paulo Colloquia's video and audio podcasts of the plenary sessions. The thinking was - if our plenaries were popular, imagine the impact of our Cochrane reviews. The preparations were made for Issue 1, 2008 to host the first collection of podcasts: Mike Clarke (UK Cochrane Centre) accepted the role

Cochrane Collaboration news (Cont'd)

of Podcast Editor providing support and guidance to authors; technical support was led by Chris Mavergames (German Cochrane Centre) and co-ordination and support were provided by Wiley-Blackwell, publishers of *The Cochrane Library*.

The reviews for podcasting are selected from each issue's press release list. The authors of these selected reviews are invited to record a podcast. The instructions provided include editorial information on preparing the summary of the review, some technical information and a stipulation to contact the Podcast Editor before recording their podcast. On average, in 2008, 60% of invited authors accepted to record and publish a podcast, summarising their review's findings.

The whole process is completed within four weeks, with some authors providing their podcasts within two weeks of being invited. Ivo Tremont-Lukats, podcast author from Issue 2 had this to say, "I can tell you, my experience was a breeze. I received excellent coaching from Mike, who was very receptive and helpful. I felt proud of myself after I made my first podcast ever! Finally, Chris' assistance was superb. We should podcast all reviews from now on."

Recording a podcast is very simple, and requires some software (freely available) to generate the mp3. The recording should take place in a quiet room, using a headset microphone. If any problems arise from the test file, there are opportunities to correct these or use another format, i.e. Skype. More information at:

<http://www.cochrane.org/resources/podcasting-guide.htm>. "Hearing authors tell the story of their Cochrane review is a great way to improve access to their findings," said Mike Clarke.

Once the podcasts are available online, visitors can do three things: 1) Listen to the podcast (i.e. download or play now); 2) Read the review (i.e. go straight to the reviews in *The Cochrane Library*); 3) Freely subscribe to receive the podcast collection and future postings (i.e. subscribe using iTunes). In 2008, for the 56 podcasts published, 44,072 hits to the *Listen now* and *Read review* pages were recorded. On average, this translates to approximately 120 people per day accessing the podcasts from February to December, 2008.

Mike Clarke and David Tovey, Editor in Chief of *The Cochrane Library*, will be working together to further expand the dissemination of Cochrane Reviews in podcast format. "We aim to build on the success of this pilot project, with podcasts reflecting the needs of our international audience, extending further the diversity of involvement and the range of topic coverage," said David.

Laura Sampson
Wiley-Blackwell and Sons

Cochrane Diagnostic Test Accuracy Reviews profiled in Annals of Internal Medicine

The co-convenors of the Cochrane Diagnostic Test Accuracy Working Group have co-authored an article summarizing the Cochrane approach to systematically reviewing diagnostic test accuracy, which was published in *Annals of Internal Medicine*, in December 2008. The article summarizes the key methodological developments in defining the objectives for the review, identification and selection of studies, assessment of methodological quality, analysing data and presenting and interpreting results. Greater detail will be available in the forthcoming Handbook chapters. (Reference Leeftang MMG, Deeks JJ, Gatsonis C, Bossuyt PMM. Systematic reviews of diagnostic test accuracy. *Annals of Internal Medicine* 2008; 149 (12): 889-897). The same issue of *Annals* included an editorial concerning test evaluation, profiling the Collaboration's decision to include test accuracy reviews.

PDFs on www.annals.org are freely available after six months, but available only to subscribers initially. If your institute subscribes you can access the article at: <http://www.annals.org/cgi/content/abstract/149/12/889>

Editorial available at: <http://www.annals.org/cgi/content/full/149/12/904>

James Lind Library Newsletters

Many thousands of people worldwide already appreciate free access to the material about the evolution of fair tests of treatments that is contained in the James Lind Library. Thanks to PAHO and WHO, the James Lind Library explanatory essays are now available in seven languages, and the 100-page book 'Testing Treatments' is downloadable free in English, Arabic, Spanish and Chinese.

James Lind Library Newsletters are issued twice a year. If you would like to receive future issues, please email: feedback@jameslindlibrary.org. You will not be sent any further unsolicited information.
Website: www.jameslindlibrary.org

Cochrane review rated most interesting of 2008 by BMJ's Evidence Updates

The Cochrane review 'St John's wort for major depression' (Linde K, Berner MM, Kriston L. *Cochrane Database of Systematic Reviews* 2008, Issue 4. Art. No.: CD000448. DOI: 10.1002/14651858.CD000448.pub3) has been rated the most interesting article of 2008 on Evidence Updates, sponsored by the BMJ Group. Cochrane reviews made up four of the top 25 for 2008, second only to the *New England Journal of Medicine*.

Evidence Updates is a searchable database of citations and

Cochrane Collaboration news (Cont'd)

abstracts from over 150 clinical journals, pre-rated for quality by research staff, then rated for clinical relevance and interest by at least three members of a worldwide panel of practising physicians. How 'interesting' an article is considered to be is measured by the frequency with which subscribers to Evidence Updates view it in full through the website. Website: <http://plus.mcmaster.ca/EvidenceUpdates>

Nursing Care Network now registered

The Nursing Care Network was officially registered with The Collaboration on 25 February, 2009. Please pass on this information to interested members of your entity. The Network Co-ordinator/Convenor is Professor Alan Pearson, operating from the School of Population Health and Clinical Practice, The University of Adelaide South Australia 5005.

Tel: +61 8 8303 6157

Fax: +61 8 8303 8280

E-mail: alan.pearson@adelaide.edu.au

Launch of Centre for Health Communication and Participation

We are pleased to announce the launch of our new Centre for Health Communication and Participation at La Trobe University. The Centre's mission is to improve communication with, and participation by, consumers and carers through evidence-informed policy and decision-making. It springs from the work of the Cochrane Consumers and Communication Review Group, which is one of the three 'arms' of the new Centre.

Contact: Megan Pictor

Email: M.Pictor@latrobe.edu.au

Website: <http://www.latrobe.edu.au/chcp/>

10th Nordic Workshop

Event: The 10th Nordic Workshop on How to Practice Evidence-Based Health Care

Host: The Norwegian Knowledge Centre for the Health Services

Location: Holmsbu, Norway

Date: 8-12 June, 2009

Details: This five-day workshop (Monday 2 p.m. - Friday 2 p.m.) will focus on teaching the basics of, and developing further insights into, the conscientious use of current best evidence in making decisions about the care of individual patients or the delivery of health services.

Contact: Kari Haavelsrud

Email: kari.haavelsrud@nokc.no

Website: <http://www.kunnskapscenteret.no/binary/4351/file>



Conferences



May 22-26, 2009 World Congress of Nephrology. Milan, Italy. www.wcn2009.org

May 30-June 3, 2009 American Transplant Congress. Boston, USA. www.atcmeeting.org/

June 17-20, 2009 Transplantation Society of Australia and New Zealand Annual Scientific Meeting, Canberra, Australia. www.tsanz.com.au

June 23-26, 2009 18th International Vicenza Course on Peritoneal Dialysis, Vicenza, Italy. www.nefrologiavicenza.it

August 28-30, 2009 2nd Congress of the International Society of Hemodialysis, Hong Kong. www.ishd2009.org

September 2-5, 2009 42nd Annual Scientific Meeting of the European Society for Paediatric Nephrology. Birmingham, England. www.espn2009.co.uk

September 5-9, 2009 Australian and New Zealand Society of Nephrology's 2009 Annual Scientific Meeting, Hobart, Tasmania. www.nephrology.edu.au

September 10-12, 2009 The Sixth International Congress on Peer Review and Biomedical Publication, Vancouver, Canada. www.ama-assn.org

October 27-November 1, 2009 American Society of Nephrology Renal Week. California, USA. www.asn-online.org

November 1-4, 2009 6th Guidelines International Network (G-I-N) Conference 2009, Lisbon, Portugal. www.g-i-n.net

Cochrane Collaboration news (Cont'd)

Cochrane Diagnostic Test Accuracy Review workshop

Event: Cochrane Diagnostic Test Accuracy Review workshop
Host: Continental Europe Support Unit (CESU) and UK Support Unit (UKSU)

Date: 19 - 20 June, 2009

Application deadline:

Location: Academic Medical Center, Amsterdam, The Netherlands

Details: This workshop is targeted at review authors who are planning to do a Cochrane Systematic Review of Diagnostic Test Accuracy (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.

Email: CESU@amc.uva.nl

Website: <http://srda.cochrane.org/en/events.html>

Two evidence-based workshops - USA

Event: 11th Rocky Mountain Workshop on How to Practice Evidence-based Health Care (EBHC Workshop)

Host: University of Colorado Denver

Date: 4-5 June, 2009

Location: Baltimore, Maryland (USA)

Details: Join with other leading evidence-based clinical guideline producers for a summit to address the use of quality systematic reviews to inform evidence-based guidelines. Hear from experts on the latest methods and practices for systematic review and guideline development. Share successes, pitfalls, current challenges and future opportunities for evidence-based guidelines. Consider the role of clinical guidelines in the shifting federal debate about quality health care and comparative effectiveness. Engage with guideline developers from multiple disciplines to consider:

Contact: Janie Gordon

Telephone: 410-502-4641

Email: jlordon@jhsp.edu

Website: [http://apps1.jhsp.edu/cochrane/](http://apps1.jhsp.edu/cochrane/NSconferencesandevents.htm)

NSconferencesandevents.htm

Date: 26-30 July, 2009

Location: Vail Cascade Club & Resort; Vail, Colorado (USA)

Details: This five-day, hands-on workshop is held annually in the summer at one of the beautiful resorts in the Rocky Mountains. Directed by Andy Oxman, Senior Researcher from the Norwegian Knowledge Centre for the Health Services, and Judith Baxter, from the Colorado School of Public Health at the University of Colorado Denver, this workshop features a cadre of world-renowned teachers, practitioners and researchers from the arena of evidence-based health care.

Upcoming workshops 2009

Australasian Cochrane Centre/ Cochrane Renal Group

25 May	Brisbane	Developing a Protocol for a Systematic Review Workshop Closing Date: 11 May
26 May	Brisbane	Introduction to Analysis Workshop Closing Date: 11 May
27-29 May	Brisbane	Cochrane Review Completion and Update Program Closing Date: 13 May
25 June	Sydney	Developing a Protocol for a Systematic Review Workshop Closing Date: 11 June
26 June	Sydney	Introduction to Analysis Workshop Closing Date: 11 June
20 July	Perth	Developing a Protocol for a Systematic Review Workshop Closing Date: 6 July
21 July	Perth	Introduction to Analysis Workshop Closing Date: 6 July
22-24 July	Perth	Cochrane Review Completion and Update Program Closing Date: 2 July
25 Aug	Adelaide	Developing a Protocol for a Systematic Review Workshop Closing Date: 11 Aug
26 Aug	Adelaide	Introduction to Analysis Workshop Closing Date: 11 Aug
27 Aug	Adelaide	Cochrane Review Completion and Update Program Closing Date: 13 Aug
3 Dec	Sydney	Developing a Protocol for a Systematic Review Workshop Closing Date: 19 November
4 Dec	Sydney	Introduction to Analysis Workshop Closing Date: 19 November

For further information on Australasian workshops please go to:
www.cochrane.org.au/training/timetable.php

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

Cochrane Collaboration news (Cont'd)

Contact: Jen Stachelski
Telephone: 303-724-7550
Email: Jennifer.mcintyre@ucdenver.edu
Website: <http://ebhc.uchsc.edu>

Event: Stakeholder Summit on Using Quality Systematic Reviews to Inform Evidence-based Guidelines
Host: US Cochrane Center

University of McGill summer course

Topic: EPIB-672 Systematic reviews and data analysis
Location: University of McGill, Montreal, Quebec (Canada)
Date: 8-19 June 2009; 1:30 - 4 p.m.

Details: This course will provide a detailed description of the systematic review process, discuss the strengths and limitations of the method, and provide step-by-step guidance on how to actually perform a systematic review.

Contact: Dr Madhukar Pai, MD, PhD
(madhukar.pai@mcgill.ca)
Website: <http://www.mcgill.ca/epi-biostat-occh/summer/>

EQUATOR Network Workshop and 2nd Annual Lecture

Event: Workshop - Key guidelines for reporting health re-

search studies
Host: EQUATOR Network
Location: Vancouver, British Columbia (Canada)
Date and time: 9 September 2009, 14:00-17:30
Details: Editors and peer reviewers of medical research journals are encouraged to attend. Workshop facilitators are Doug Altman, David Moher, Kenneth F. Schulz, and John Hoey. Registration fees are as follows: early bird (by 31 May 2009): £ 85; late registration (after 31 May 2009): £ 100. Places are limited to 40 participants, so please book soon to avoid disappointment
Contact: Tracy Edwards
Email: tracy.edwards@csm.ox.ac.uk
Website: www.equator-network.org

Event: 2nd EQUATOR Annual Lecture
Lecturer: Dr Richard Horton, Editor-in Chief of The Lancet
Location: Vancouver, British Columbia (Canada)
Date and time: 9 September 2009, 18:00-19:00
Details: The talk will focus on important issues relating to the research reporting in the context of global health issues. Lecture is free, everyone is welcome.
Contact: Iveta Simera
Email: Iveta.Simera@csm.ox.ac.uk
Website: www.equator-network.org



The Merlion is Singapore's most recognisable national symbol. Its lion head and fish body recalls the legend of an 11th century prince who spotted a lion when coming ashore after being shipwrecked. He named the island Singapura - lion (singa) city (pura) in Sanskrit. Today, Singapore's unique fusion of east and west draws visitors from around the world and the Singapore Branch is proud to host Asia's first Cochrane Colloquium.

Welcome to Singapore! www.colloquium.info/2009



Recent synopses and abstracts

HMG CoA reductase inhibitors (statins) for kidney transplant recipients Navaneethan SD, Perkovic V, Johnson DW, Nigwekar SU, Craig JC, Strippoli GFM

Background

Cardiovascular deaths account for the majority of deaths in kidney transplant recipients and dyslipidaemia contributes significantly to their cardiovascular disease. Statins are widely used in kidney transplant patients given their established benefits in the general population, however evidence favouring their use is lacking.

Objectives

To assess the benefits and harms of statin therapy on mortality and renal outcomes in kidney transplant recipients.

Search strategy

We searched MEDLINE, EMBASE, the Cochrane Central Register of Controlled Trials (CENTRAL), and hand searched reference lists of articles and scientific proceedings.

Selection criteria

Randomised controlled trials (RCTs) and quasi-RCTs comparing statins with placebo, no treatment or other statins in kidney transplant recipients.

Data collection and analysis

Two authors independently assessed study quality and extracted data. Statistical analyses were performed using the random effects model after testing for heterogeneity. Results were expressed as mean difference (MD) for continuous outcomes (lipid parameters) and risk ratio (RR) for dichotomous outcomes (mortality, allograft rejection, liver enzymes, occurrence of rhabdomyolysis and study withdrawal) with 95% confidence intervals (CI).

Main results

Sixteen studies (3229 patients) comparing statins versus placebo (15) or another statin (1) were included. Compared to placebo, statins did not decrease all-cause mortality (14 studies: RR 1.30, 95% CI 0.54 to 3.12). Point estimates favoured statins in terms of cardiovascular mortality (13 studies: RR 0.68, 95% CI 0.46 to 1.03) and non-fatal cardiovascular events (1 study: RR 0.70, 95% CI 0.48 to 1.01), however the results were not statistically significant. Compared to placebo, the use of statins was associated with a significantly lower end of treatment average total cholesterol (10 studies: MD -42.33 mg/dL (1.26 mmol/L), 95% CI -53.02 to -31.64), LDL cholesterol (10 studies: MD -46.15 mg/dL (1.19 mmol/L), 95% CI -55.97 to -36.33) and triglycerides (10 studies: MD -25.46 mg/dL (0.26 mmol/L), 95% CI -33.95 to 16.9). There was no sig-

nificant difference in the risk of acute rejection (5 studies: RR 0.61; 95% C.I.0.32 to 1.16.) No data on chronic rejection was available and no major toxicity was noted.

Authors' conclusions

Statins significantly reduced hyperlipidaemia and tended to reduce cardiovascular events in kidney transplant recipients, but no effect has yet been demonstrated for mortality outcomes. Most of the data was derived from one large long-term study. Considering the significant impact of statins on all-cause and cardiovascular mortality in the general and predialysis populations, more studies are needed in kidney transplant patients.

HMG CoA reductase inhibitors (statins) for people with chronic kidney disease not requiring dialysis Navaneethan SD, Pansini F, Perkovic V, Manno C, Pellegrini F, Johnson DW, Craig JC, Strippoli GFM

Background

Dyslipidaemia occurs frequently in chronic kidney disease (CKD) patients and contributes both to cardiovascular disease and worsening renal function. Statins are widely used in non-dialysis dependent CKD patients (pre-dialysis) even though evidence favouring their use is lacking.

Objectives

To evaluate the benefits and harms of statins in CKD patients who were not receiving renal replacement therapy.

Search strategy

We searched MEDLINE, EMBASE, CENTRAL (in The Cochrane Library), and hand-searched reference lists of textbooks, articles and scientific proceedings.

Selection criteria

Randomised controlled trials (RCTs) and quasi-RCTs comparing statins with placebo, no treatment or other statins in adult pre-dialysis CKD patients.

Data collection and analysis

Two authors independently assessed study quality and extracted data. Results were expressed as mean difference (MD) for continuous outcomes (lipids, creatinine clearance and proteinuria) and risk ratio (RR) for dichotomous outcomes (all-cause mortality, cardiovascular mortality, fatal and non-fatal cardiovascular events, elevated liver enzymes, rhabdomyolysis and withdrawal rates) with 95% confidence intervals (CI).

Main results

Twenty six studies (25,017 participants) comparing statins with placebo were identified. Total cholesterol decreased

Recent synopses and abstracts (Cont'd)

significantly with statins (18 studies, 1677 patients: MD -41.48 mg/dL, 95% CI -49.97 to -33.99). Similarly, LDL cholesterol decreased significantly with statins (16 studies, 1605 patients: MD -42.38 mg/dL, 95% CI -50.71 to -34.05). Statins decreased both the risk of all-cause (21 RCTs, 18,781 patients, RR 0.81, 95% CI 0.74, 0.89) and cardiovascular deaths (20 studies, 18,746 patients: RR 0.80, 95% CI 0.70 to 0.90). Statins decreased 24-hour urinary protein excretion (6 studies, 311 patients: MD -0.73 g/24 h, 95% CI -0.95 to -0.52), but there was no significant improvement in creatinine clearance - a surrogate marker of renal function (11 studies, 548 patients: MD 1.48 mL/min, 95% CI -2.32 to 5.28). The incidence of rhabdomyolysis, elevated liver enzymes and withdrawal rates due to adverse events (well known complications of statins use), were not significantly different between patients receiving statins and placebo.

Authors' conclusions

Statins significantly reduced the risk of all-cause and cardiovascular mortality in CKD patients who are not receiving renal replacement therapy. They do not impact on the decline in renal function as measured by creatinine clearance, but may reduce protein excretion in urine. Statins appear to be safe in this population. Guidelines recommendations on hyperlipidaemia management in CKD patients could therefore be followed targeting higher proportions of patients receiving a statin, with appropriate monitoring of adverse events.

Interventions for haemolytic uraemic syndrome and thrombotic thrombocytopenic purpura Michael M, Elliott EJ, Ridley GF, Hodson EM, Craig JC

Background

Haemolytic uraemic syndrome (HUS) and thrombotic thrombocytopenic purpura (TTP) are related conditions with similar clinical features of variable severity. Survival of patients with HUS and TTP has improved greatly over the past two decades with improved supportive care for patients with HUS and by the use of plasma exchange (PE) with fresh frozen plasma (FFP) for patients with TTP.

Separate pathogenesis of these two disorders has become more evident, but management overlaps.

Objectives

To evaluate the benefits and harms of different interventions for HUS and TTP separately, in patients of all ages. Search strategy

We searched MEDLINE, EMBASE, the Cochrane Central Register of Controlled Trials (CENTRAL), conference proceed-

ings, reference lists of articles and text books and contact with investigators were used to identify relevant studies.

Selection criteria

Randomised controlled trials (RCTs) evaluating any interventions for HUS or TTP in patients of all ages.

Data collection and analysis

Three authors independently extracted data and evaluated study reporting quality using standard Cochrane criteria. Analysis was undertaken using a random effects model and results expressed as risk ratio (RR) and 95% confidence intervals (CI).

Main results

For TTP, we found six RCTs (331 participants) evaluating PE with FFP as the control. Interventions tested included antiplatelet therapy (APT) plus PE with FFP, FFP transfusion and PE with cryosupernatant plasma (CSP). Two studies compared plasma infusion (PI) to PE with FFP and showed a significant increase in failure of remission at two weeks (RR 1.48, 95% 1.12 to 1.96) and all-cause mortality (RR 1.91, 95% 1.09 to 3.33) in the PI group. Seven RCTs were undertaken in children with HUS. None of the assessed interventions used (FFP transfusion, heparin with or without urokinase or dipyridamole, shiga toxin binding protein and steroids) were superior to supportive therapy alone, for all-cause mortality, neurological/extrarenal events, renal biopsy changes, proteinuria or hypertension at the last follow-up visit. Bleeding was significantly higher in those receiving anticoagulation therapy compared to supportive therapy alone (RR 25.89, 95% CI 3.67 to 182.83).

Authors' conclusions

PE with FFP is still the most effective treatment available for TTP. For patients with HUS, supportive therapy including dialysis is still the most effective treatment. All studies in HUS have been conducted in the diarrhoeal form of the disease. There were no RCTs evaluating the effectiveness of any interventions on patients with atypical HUS who have a more chronic and relapsing course.

Pharmacological interventions for preventing complications in idiopathic hypercalcaemia Escribano J, Balaguer A, Pagone F, Feliu A, Roqué i Figuls M

Background

Idiopathic hypercalcaemia is an inherited metabolic abnormality characterised by excessive amounts of calcium excreted into the urine in patients with normal serum levels of calcium. The morbidity of hypercalcaemia is related to

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kidney stone disease and bone demineralization.

In children, hypercalciuria can cause recurrent haematuria, frequency-dysuria syndrome, urinary tract infection and abdominal and lumbar pain. Several pharmacological treatments have been described that can decrease the levels of urinary calcium or its index of urinary crystallization.

Objectives

To assess the benefits and harms of pharmacological interventions for preventing complications and decreasing urological symptoms in patients with idiopathic hypercalciuria.

Search strategy

We searched MEDLINE, EMBASE, the Cochrane Renal Group's specialised register, the Cochrane Central Register of Controlled Trials (CENTRAL, The Cochrane Library), hand-searched relevant conference proceedings and reference lists of articles.

Selection criteria

All randomised controlled trials (RCTs) and quasi-RCTs that compared any pharmacological intervention for preventing complications in idiopathic hypercalciuria, with placebo, other pharmacological intervention or a different administration mode or dose of the same treatment given for a minimum duration of four months and had a follow-up period of at least six months.

Data collection and analysis

Four authors assessed the studies for inclusion and extracted the data. Disagreements were resolved through discussion. Results were expressed as risk ratios (RR) with 95% confidence intervals (CI) or mean difference (MD).

Main results

Five studies (316 adult patients) were included. Four compared thiazides with standard treatment (periodic clinical follow-up and increased water intake) or specific dietary recommendations and one analysed the effect of thiazide plus a neutral potassium salt. There was a significant decrease in the number of new stone recurrences in those treated with thiazides (RR 1.61, 95% CI 1.33 to 1.96), although the follow-up periods varied. The stone formation rate also showed a statistically significant decrease in the patients treated with diuretics (MD -0.18, 95%CI -0.30 to -0.06). Thiazides plus potassium salts significantly decreased calciuria and vitamin D levels.

Authors' conclusions

There is some evidence that in patients with idiopathic hy-

percalciuria and recurrent stones, the addition of thiazides to a normal or modified diet for short to long periods (five months to three years) reduced the number of stone recurrences and decreased the stone formation rate. Thiazides and neutral potassium phosphate decreased calciuria in symptomatic patients with idiopathic hypercalciuria. There were no studies investigating the effect of pharmacological treatment on other clinical complications or asymptomatic idiopathic hypercalciuria.

Steroid avoidance or withdrawal for kidney transplant recipients Pascual J, Zamora J, Galeano C, Royuela A, Quereda C

Background

Steroid-sparing strategies have been attempted during the last two decades in order to avoid morbidity in kidney transplant recipients. Previous systematic reviews of steroid withdrawal after kidney transplantation have shown significant increases in acute rejection and an increase in graft failure rates. Steroid avoidance in kidney transplantation is increasingly attempted and the possible benefits or harms have never been a subject of a systematic review.

Objectives

To assess the safety and efficacy of steroid withdrawal or avoidance in patients receiving a kidney transplant.

Search strategy

We searched CENTRAL, MEDLINE and EMBASE, references lists and abstracts from international transplantation society scientific meetings.

Selection criteria

Randomised controlled studies (RCTs) of steroid avoidance or withdrawal were included providing that one treatment arm consisted in steroid avoidance or withdrawal and intention-to-treat rates of acute rejection and graft failure were clearly established after steroid avoidance or use or withdrawal or continuation. Observational studies were tabulated.

Data collection and analysis

Two authors independently assessed trial quality and extracted data. Statistical analyses were performed using the random effects model and results expressed as risk ratio (RR) or mean difference (MD) with 95% confidence intervals (CI).

Main results

We included 30 RCTs (5949 participants). Steroid-sparing strategies showed no effect on mortality or graft loss including death. Patients on any steroid-sparing strategy showed

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a higher risk of graft loss excluding death than those with conventional steroid use (RR 1.23, 95% CI 1.00 to 1.52), especially in those not receiving MMF/Myf or everolimus (RR 1.70, 95% CI 1.00 to 2.90). Acute rejection was more frequent with a steroid-sparing strategy (RR 1.27, 95% CI 1.14 to 1.40) and more frequent after steroid withdrawal or avoidance when compared with standard steroid treatment when cyclosporin (CsA) was used. Steroid-sparing and withdrawal strategies showed benefits in reducing antihypertensive drug need, serum cholesterol, antihyperlipidaemic drug need, new-onset diabetes after transplantation (NODAT) requiring any treatment and cataracts. Steroid avoidance did not alter serum cholesterol, but was associated with less frequent NODAT requiring any treatment. Cardiovascular events were reduced with steroid avoidance. Reduced antihypertensive drug need and serum cholesterol were similar with CsA or tacrolimus (TAC). Reduced antihyperlipidaemic drug need was only evident with TAC, whereas the reduction in NODAT requiring any treatment was only evident with CsA. Infection was lower in steroid-sparing patients using CsA (RR 0.88, 95% CI 0.78 to 1.00). NODAT requiring any treatment was less frequent with steroid avoidance than with steroid withdrawal.

Authors' conclusions

This review confirms that steroid avoidance and steroid withdrawal strategies in kidney transplantation are not associated with increased mortality or graft loss despite an increase in acute rejection. These immunosuppression strategies may allow safe steroid avoidance or elimination a few days after kidney transplantation if antibody induction treatment is prescribed or after three to six months if such induction is not used.

HMG CoA reductase inhibitors (statins) for dialysis patients Navaneethan SD, Nigwekar SU, Perkovic V, Johnson DW, Craig JC, Strippoli GFM

Background

Cardiovascular disease accounts for more than half the number of deaths among dialysis patients. The role of HMG CoA reductase inhibitors (statins) in the treatment of dyslipidaemia in dialysis patients is unclear and their safety has not been established.

Objectives

To assess the benefits and harms of statins in peritoneal dialysis (PD) and haemodialysis patients (HD).

Search strategy

We searched MEDLINE, EMBASE, the Cochrane Central Register of Controlled trials (CENTRAL, in The Cochrane Library), the Cochrane Renal Group's specialised register and hand-searched reference lists of textbooks, articles and scientific proceedings.

Selection criteria

Randomised controlled trials (RCTs) and quasi-RCTs comparing statins with placebo, no treatment or other hypolipidaemic agents in dialysis patients.

Data collection and analysis

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

Main results

Fourteen studies (2086 patients) compared statins versus placebo or other lipid lowering agents. Compared to placebo, statins did not decrease all-cause mortality (10 studies, 1884 patients; RR 0.95, 95% CI 0.86 to 1.06) or cardiovascular mortality (9 studies, 1839 patients: RR 0.96, 95% CI 0.65 to 1.40). There was a lower incidence of nonfatal cardiovascular events with statins compared to placebo in haemodialysis patients (1 study, 1255 patients; RR 0.86, 95% CI 0.74 to 0.99). Compared with placebo, statin use was associated with a significantly lower end of treatment average total cholesterol (14 studies, 1823 patients; MD -42.61 mg/dL, 95% CI -53.38 to -31.84), LDL cholesterol (13 studies, 1801 patients; MD -43.06 mg/dL, 95% CI -53.78 to -32.35) and triglycerides (14 studies, 1823 patients; MD -24.01 mg/dL, 95% CI -47.29 to -0.72). There was similar occurrence of rhabdomyolysis and elevated liver function tests with statins in comparison to placebo.

Authors' conclusions

Statins decreased cholesterol levels in dialysis patients similar to that of the general population. With the exception of one study, studies were of short duration and therefore the efficacy of statins in decreasing the mortality rate is still unclear. Statins appear to be safe in this high-risk population. Ongoing studies should provide more insight about the efficacy of statins in reducing mortality rates in dialysis patients.

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