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19th Cochrane Colloquium: *Scientific evidence for healthcare quality and patient safety, in conjunction with VI International Conference on Patient Safety.* Madrid, 19–22 October 2011



L to R (back): Evi Nagler, Narelle Willis, Yizhi Chen, Gail Higgins
L to R (front): Ruth Mitchell, Ann Jones

“I am Don Quixote, and my profession is Knight-Errantry. My laws—to unblind the blind, spread goodness and avoid evil. I flee from the easy life, ambition and hypocrisy and look for the narrowest and most difficult path towards my own glory. Is that silly or unrealistic?” Miguel de Cervantes

Cervantes’ words, chosen by the organising committee, not only showcase one of Spain’s most revered authors but also served to remind Colloquium participants about the role of the Cochrane family and allied collaborators in global health. As a first time participant, my experience was captured by another Don Quixote-ism: “No man (or woman) is born wise”. The program provided learning opportunities from sun up¹ to sun down and beyond².

Cochrane Colloquia “are designed to bring people together in one place to discuss, develop and promote our work and to shape

the organisation’s future direction”³. The program offered joint plenary and oral presentations (many with simultaneous Spanish-English translation); meetings, workshops, and 393 poster presentations.

The program challenged participants to consider issues such as: are we sufficiently patient-centred in presentation of research findings? How can economic perspectives be better incorporated into findings? Are our present quality standards sufficiently robust? Are there better, more effective means to present evidence? How can non-randomised studies be incorporated into reviews? Are our editorial and publication standards sufficient? Are authors whose first language is not English disadvantaged in registering titles for review? How well do we prioritise publication? Will faster publication of reviews improve health standards and outcomes?

Hands-on workshops were also a feature. Participants were able to learn and re-visit concepts in topics such as statistical and meta-analytical techniques; editorial practice; economic data interpretation; qualitative evidence synthesis; and information management issues from search strategies to investigating advanced techniques in text analysis tools and more.

I’m looking forward to exploring new concepts, and being challenged to adopt, apply and critique innovations with the aim of helping to create reliable, high quality evidence that can enhance health outcomes.

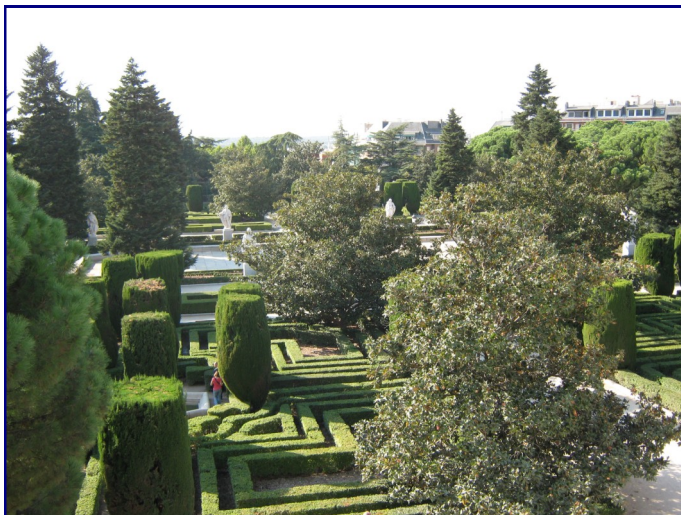
Ann Jones
Assistant Managing Editor, Cochrane Renal Group

¹Literally. Daylight saving in Spain meant that in October, daybreak was around 8 am

²It’s debatable that there were a lot of educational activities in the social activities, but they were a great way to meet international colleagues

³<http://www.cochrane.org/features/annual-colloquium-0>

Renal group news



Royal Palace Gardens, Madrid

19th Cochrane Colloquium—workshops

The Renal Group trials search coordinators were involved, with other Cochrane colleagues, in the development and facilitation of four workshops during the Colloquium.

Developing search strategies for systematic reviews of diagnostic test accuracy was an advanced workshop in the computer lab attended by 18 information specialists. Through worked examples, it emphasised the need to consider more complex search structures where there are known anomalies in author reporting and database indexing of tests.

Peer reviewing the search strategy for a Cochrane review of diagnostic test accuracy was attended by nine trials search co-ordinators, and aimed to assist those who lacked experience of peer reviewing. It generated much useful discussion about both the management of the peer review process and how best to provide helpful and encouraging recommendations to review authors.

Searching for diagnostic test accuracy studies: review authors and information specialists working in partnership may have suffered from being in the last session before the Colloquium Closing Session, as none of the registered authors turned up! However the TSCs who came voted to stay, and the remaining time proved a useful opportunity to trial some of the materials being developed for a new online training resource on searching for DTA studies. *Information Management System workshop for Cochrane trials search co-ordinators* provided the 16 TSCs present in the computer lab with the latest updates to the Cochrane Information Management System, including workflows and

RevMan5.1. Useful discussion was had also around how these new features can support TSC-specific activities and improve their input to editorial processes.

Ruth Mitchell and Gail Higgins,
Trials Search Co-ordinators, Cochrane Renal Group

Peer reviewing resources

Peer reviewing is an activity that many of the Renal Group members will have undertaken, including for our protocols and reviews. For those of you who would like to learn more about the whys and hows of peer reviewing, some resources are provided below: -

Translating Critical Appraisal of a Manuscript into Meaningful Peer Review is a free-of-charge online course developed by the US Cochrane Center. It consists of two didactic modules of lectures with slides, the first being a two lecture introduction to peer review, and the second consisting of 10 lectures covering topics such as the study question, study design, measures of disease frequency and association, and critical appraisal and peer review of a variety of question types. It is accessible at <http://us.cochrane.org> (currently on the home page), or at <http://eyes.cochrane.org> under workshops and courses. You can contact uscevg@jhsph.edu for more information.

The BMJ provides resources about peer review at <http://resources.bmj.com/bmj/reviewers>. They include general guidelines, chapters from several books, and access to the pdf of the book by Wager E, Godlee F, Jefferson T. *How to survive peer review*. BMJ Books; London; 2002. (Chapter 3 is the most relevant for those undertaking a peer review).

Ware M & Monkman M. *Peer Review in Scholarly Journals - perspective of the scholarly community: an international study*. <http://www.publishingresearch.net/PeerReview.htm>

Pain, E. Learning the ropes http://sciencecareers.sciencemag.org/career_magazine/previous_issues/articles/2008_08_15/caredit.a0800122 This website provides an overview, and links to more resources, including the two directly above.

Hames, I. *Peer review and manuscript management in scientific journals: guidelines for good practice*. Blackwell Publishing Ltd; Malden, MA; 2007. pp78-82

Ruth Mitchell
Trials Search Coordinator, Cochrane Renal Group

Renal group news (cont'd)

Visiting Nephrology resident— Ionut Nistor

This month Ionut Nistor joined the Cochrane Renal Group for six months. He is part of a research project for the European Renal Best Practice (ERBP), the leading body in renal recommendation development. Ionut will be trained in the skills of guideline-related literature searching and evidence grading to assist guideline authors in preparation and updating of the ERBP guidelines.



Ionut is a Nephrology Resident with the Parhon University, Iasi, Romania. He studied medicine at the University of Medicine “Gr. T. Popa” Iasi, graduating in 2004. He started a PhD in 2011 on the evidence for treatment of diabetics with developed CKD 3b/4/5. His research interests also include cardiovascular complication in CKD patients, dialysis and transplant patients.

Committee on Publication Ethics (COPE) –November 14, 2011

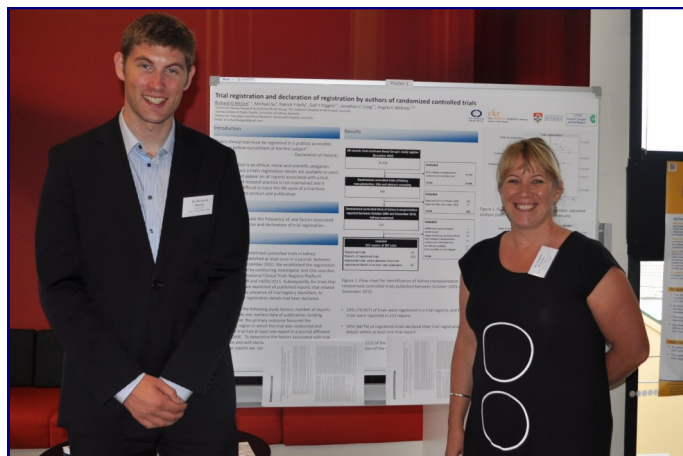
Recently members of the Cochrane Renal Group attended the very first Committee on Publication Ethics (COPE) Asia Pacific seminar and forum in Melbourne, Australia. COPE are an international organisation composed primarily of journal editors whose aim is to promote integrity in research publication. COPE achieves this by providing advice to editors and publishers on all aspects of publication ethics and, in particular, how to handle cases of research and publication misconduct. The Cochrane Collaboration review groups are all members.

The theme of the day was “Publication ethics at the four points of the journal editing compass”, and aimed to discuss how publication ethics are similar across all disciplines, and journal editors, researchers and journal authors face very similar challenges, whether based in

physical sciences, life sciences, social sciences or health sciences. The seminar opened with a hypothetical ethics case, acted out by various members of the COPE committee, who posed as a journal editor, a research scientist, the head of a research lab, the employer of the research lab staff and a reviewer. The case related to a case of data manipulation by authors, who manipulated images in their paper to suit their preferred findings, and showed how this might come to light, and the possible actions that could be taken by each party involved. This was followed by subsequent talks from a variety of disciplines, including an excellent presentation on real world examples of image manipulation from Professor David Vaux of the Walter and Eliza Hall Institute of Medical Research.

During the day Richard McGee, a Cochrane Renal Group author, and Angela Webster, the Deputy Co-ordinating Editor, presented a poster on the importance of trial registration, which has subsequently been published (<http://www.ncbi.nlm.nih.gov/pubmed/21978995>).

Finally, although the resources of COPE are primarily designed for journal editors, they are freely available for all to view and use (<http://publicationethics.org/resources>). The COPE website includes flowcharts on suggested response to any suspected research misconduct, including potential plagiarism, data fabrication or manipulation, duplicate publication, conflicts of interest and managing errors. There is also a large bank of real life cases and responses from COPE forums from around the globe. We encourage interested researchers, authors and others to access these fantastic resources.



Richard McGee and Angela Webster

Cochrane Renal Group – New reviews, protocols and titles

New and updated reviews

In Issues 7-11, 2011 we published four new reviews:

New

- Angiotensin-converting enzyme inhibitors and angiotensin receptor blockers for adults with early (stage 1 to 3) non-diabetic chronic kidney disease
- Exercise training for adults with chronic kidney disease
- Laparoscopic versus open nephrectomy for live kidney donors
- Ultrasound use for the placement of haemodialysis catheters

New protocols

In Issues 7-11, 2011 we published six new protocols:

New

- Acupuncture and related interventions for the symptoms of chronic kidney disease
- Darbepoetin for the anaemia of chronic kidney disease
- Sodium bicarbonate supplements for treating acute kidney injury
- Uric acid lowering therapies for preventing or delaying the progression of chronic kidney disease
- Vascular access type for patients on chronic haemodialysis
- Vitamin B and/or its derivatives for diabetic kidney disease

New titles

- Analgesia for patients undergoing shockwave lithotripsy for urinary stones
- Antimicrobial lock solutions for preventing catheter-related infections in haemodialysis
- Belatacept for preventing rejection in kidney transplantation
- Dimercaptosuccinic acid renal scan versus voiding cystourethrogram for the diagnosis of vesicoureteral reflux in children (DTA)
- Erythropoiesis stimulating agents for anaemia: a multiple treatments meta-analysis
- Intensity of continuous renal replacement therapy for acute kidney injury
- Interventions for post-transplant anaemia in kidney transplant recipients
- Pharmacological interventions for preventing recurrent urinary stones in adults and children
- Pre-emptive correction for hemodialysis AV access stenosis
- Surgery versus conservative management of unilateral ureteric-pelvic junction obstruction in children
- Timing of continuous renal replacement therapy initiation for acute kidney injury
- Vitamin B and/or its derivatives for chronic kidney disease

Recent abstracts

[Angiotensin-converting enzyme inhibitors and angiotensin receptor blockers for adults with early \(stage 1 to 3\) non-diabetic chronic kidney disease.](#)

Pawana Sharma, Rachel C Blackburn, Claire L Parke, Keith McCullough, Angharad Marks, Corri Black

Background

Chronic kidney disease (CKD) is a long term condition that occurs as a result of damage to the kidneys. Early recognition of CKD is becoming increasingly common due to widespread laboratory estimated glomerular filtration rate (eGFR) reporting, raised clinical awareness, and international adoption of Kidney Disease Outcomes Quality Initiative (K/DOQI) classification. Early recognition and management of CKD affords the opportunity not only to prepare for progressive kidney impairment and impending renal replacement therapy, but also for intervening to reduce the risk of progression and cardiovascular disease. Angiotensin-converting enzyme inhibitors (ACEi) and angiotensin receptor blockers (ARB) are two classes of antihypertensive drugs that act on the renin-angiotensin-aldosterone system. Beneficial effects of ACEi and ARB on renal outcomes and survival in people with a wide range of severity of renal impairment have been reported; however, their effectiveness in the subgroup of people with early CKD (stage 1 to 3) is less certain.

Objectives

This review aimed to evaluate the benefits and harms of ACEi and ARB or both in the management of people with early (stage 1 to 3) CKD who do not have diabetes mellitus.

Search strategy

In March 2010 we searched *The Cochrane Library*, including The Cochrane Renal Group's specialised register and The Cochrane Central Register of Controlled Trials (CENTRAL), MEDLINE and EMBASE.

Reference lists of review articles and relevant studies were also checked. The search was conducted using the optimally sensitive strategy developed by the Cochrane Collaboration for the identification of randomised controlled trials (RCTs) with input from an expert in trial search strategy.

Selection criteria

All RCTs reporting the effect of ACEi or ARB in people with early (stage 1 to 3) CKD who did not have diabetes mellitus were selected for inclusion. Only studies of at least four weeks duration were selected. Authors, working in teams of two, independently assessed the retrieved titles and abstracts, and whenever necessary the full text of these studies were screened to determine which studies satisfied the inclusion criteria.

Data collection and analysis

Data extraction was carried out by two authors, independently, using a standard data extraction form and cross checked by two other authors. Methodological quality of included studies was assessed using the Cochrane risk of bias tool. Data entry was carried out by one author and cross checked by another author. When more than one study reported similar outcomes, data were pooled using the random-effects model, but a fixed-effect model was also analysed to ensure the robustness of the model chosen and to check susceptibility to outliers. Heterogeneity was analysed using a Chi² test on N-1 degrees of freedom, with an alpha of 0.05 used for statistical significance and with the I² test. Where data permitted, subgroup analysis was used to explore possible sources of heterogeneity. The quality of the evidence was analysed.

Main results

Four RCTs enrolling 2177 participants met our inclusion criteria. Of these, three compared ACEi with placebo and one compared ACEi with ARB. Two studies had an overall low risk of bias, and the other two were considered to be at moderate to high risk of bias. Low to moderate quality of evidence (from two studies representing 1906 patients) suggested that ACEi had no impact on all-cause mortality (RR 1.80, 95% CI 0.17 to 19.27, P = 0.63) or cardiovascular events (RR 0.87, 95% CI 0.66 to 1.14, P = 0.31) in people with stage 3 CKD. For all-cause mortality, there was substantial heterogeneity in the results.

Recent abstracts (Cont'd)

One study (quality assessment: low risk of bias) reported no difference in the risk of end-stage kidney disease in those with an eGFR > 45 mL/min/1.74 m² treated with ACEi versus placebo (RR 1.00, 95% CI 0.09 to 1.11, P = 0.99). The (high risk of bias) study that compared ACEi with ARB reported little difference in effect between the treatments when urinary protein, blood pressure or creatinine clearance were compared. No published studies comparing ARB with placebo or ACEi and ARB with placebo were identified.

Authors' conclusions

Our review demonstrated that there is currently insufficient evidence to determine the effectiveness of ACEi or ARB in patients with stage 1 to 3 CKD who do not have diabetes mellitus. We have identified an area of significant uncertainty for a group of patients who account for most of those labelled as having CKD.

[Exercise training for adults with chronic kidney disease.](#)

Susanne Heiwe, Stefan H Jacobson

Background

Chronic kidney disease (CKD) is a worldwide public health problem. In the National Kidney Foundation Disease Outcomes Quality Initiative guidelines it is stressed that lifestyle issues such as physical activity should be seen as cornerstones of the therapy. The physical fitness in adults with CKD is so reduced that it impinges on ability and capacity to perform activities in everyday life and occupational tasks. An increasing number of studies have been published regarding health effects of various regular exercise programmes in adults with CKD and in renal transplant patients.

Objectives

We aimed to: 1) assess the effects of regular exercise in adults with CKD and kidney transplant patients; and 2) determine how the exercise programme should be designed (e.g. type, duration, intensity, frequency of exercise) to be able to affect physical fitness and functioning, level of physical

activity, cardiovascular dimensions, nutrition, lipids, glucose metabolism, systemic inflammation, muscle morphology and morphometrics, dropout rates, compliance, adverse events and mortality.

Search strategy

We searched the Cochrane Renal Group's specialised register, CENTRAL, MEDLINE, EMBASE, CINAHL, Web of Science, Biosis, Pedro, Amed, AgeLine, PsycINFO and KoreaMed. We also handsearched reference lists of review articles and included studies, conference proceeding's abstracts. There were no language restrictions. Date of last search: May 2010.

Selection criteria

We included any randomised controlled trial (RCT) enrolling adults with CKD or kidney transplant recipients undergoing any type of physical exercise intervention undertaken for eight weeks or more. Studies using less than eight weeks exercise, those only recommending an increase in physical activity, and studies in which co-interventions are not applied or given to both groups were excluded.

Data collection and analysis

Data extraction and assessment of study and data quality were performed independently by the two authors. Continuous outcome data are presented as standardised mean difference (SMD) or mean difference (MD) with 95% confidence intervals (CI).

Main results

Forty-five studies, randomising 1863 participants were included in this review. Thirty two studies presented data that could be meta-analysed. Types of exercise training included cardiovascular training, mixed cardiovascular and resistance training, resistance-only training and yoga. Some studies used supervised exercise interventions and others used unsupervised interventions. Exercise intensity was classed as 'high' or 'low', duration of individual exercise sessions ranged from 20 minutes/session to 110 minutes/session, and study duration was from two to 18 months. Seventeen per cent of studies were classed as having an overall low risk of bias, 33% as moderate, and 49% as having a high risk of bias.

Recent abstracts (Cont'd)

The results shows that regular exercise significantly improved: 1) physical fitness (aerobic capacity, 24 studies, 847 participants: SMD -0.56, 95% CI -0.70 to -0.42; walking capacity, 7 studies, 191 participants: SMD -0.36, 95% CI -0.65 to -0.06); 2) cardiovascular dimensions (resting diastolic blood pressure, 11 studies, 419 participants: MD 2.32 mm Hg, 95% CI 0.59 to 4.05; resting systolic blood pressure, 9 studies, 347 participants: MD 6.08 mm Hg, 95% CI 2.15 to 10.12; heart rate, 11 studies, 229 participants: MD 6 bpm, 95% CI 10 to 2); 3) some nutritional parameters (albumin, 3 studies, 111 participants: MD -2.28 g/L, 95% CI -4.25 to -0.32; pre-albumin, 3 studies, 111 participants: MD -44.02 mg/L, 95% CI -71.52 to -16.53; energy intake, 4 studies, 97 participants: SMD -0.47, 95% CI -0.88 to -0.05); and 4) health-related quality of life. Results also showed how exercise should be designed in order to optimise the effect. Other outcomes had insufficient evidence.

Authors' conclusions

There is evidence for significant beneficial effects of regular exercise on physical fitness, walking capacity, cardiovascular dimensions (e.g. blood pressure and heart rate), health-related quality of life and some nutritional parameters in adults with CKD. Other outcomes had insufficient evidence due to the lack of data from RCTs. The design of the exercise intervention causes difference in effect size and should be considered when prescribing exercise with the aim of affecting a certain outcome. Future RCTs should focus more on the effects of resistance training interventions or mixed cardiovascular- and resistance training as these exercise types have not been studied as much as cardiovascular exercise.

[Laparoscopic versus open nephrectomy for live kidney donors](#)

Colin H Wilson, Aliu Sanni, David A Rix, Naeem A Soomro

Background

Waiting lists for kidney transplantation continue to

grow and live organ donation has become more important as the number of brain stem dead cadaveric organ donors continues to fall. The major disincentive to potential kidney donors is the pain and morbidity associated with open surgery.

Objectives

To identify the benefits and harms of using laparoscopic compared to open nephrectomy techniques to recover kidneys from live organ donors.

Search methods

We searched the online databases CENTRAL (in The Cochrane Library 2010, Issue 2), MEDLINE (January 1966 to January 2010) and EMBASE (January 1980 to January 2010) and handsearched textbooks and reference lists.

Selection criteria

Randomised controlled trials comparing laparoscopic donor nephrectomy (LDN) with open donor nephrectomy (ODN).

Data collection and analysis

Two review authors independently screened titles and abstracts for eligibility, assessed study quality, and extracted data. We contacted study authors for additional information where necessary.

Main results

Six studies were identified that randomised 596 live kidney donors to either LDN or ODN arms. All studies were assessed as having low or unclear risk of bias for selection bias, allocation bias, incomplete outcome data and selective reporting bias. Four of six studies had high risk of bias for blinding. Various different combinations of techniques were used in each study, resulting in heterogeneity in the results. The conversion rate from LDN to ODN ranged from 1% to 1.8%. LDN was generally found to be associated with reduced analgesia use, shorter hospital stay, and faster return to normal physical functioning. The extracted kidney was exposed to longer warm ischaemia periods (2 to 17 minutes) with no associated short-term consequences. ODN was associated with shorter duration of procedure. For those outcomes that could be meta-analysed there were no significant differences between LDN or ODN

Recent abstracts (Cont'd)

for perioperative complications (RR 0.87, 95% CI 0.47 to 4.59), reoperations (RR 0.57, 95% CI 0.09 to 3.64), early graft loss (RR 0.31, 95% CI 0.06 to 1.48), delayed graft function (RR 1.09, 95% CI 0.52 to 2.30), acute rejection (RR 1.41, 95% CI 0.87 to 2.27), ureteric complications (RR 1.51, 95% CI 0.69 to 3.31), kidney function at one year (SMD 0.15, 95% CI -0.11 to 0.41) or graft loss at one year (RR 0.76, 95% CI 0.15 to 3.85).

Authors' conclusions

LDN is associated with less pain compared with open surgery; however, there are equivalent numbers of complications and occurrences of perioperative events that require further intervention. Kidneys obtained using LDN procedures were exposed to longer warm ischaemia periods than ODN-acquired grafts, although this has not been reported as being associated with short-term consequences.

[Ultrasound use for the placement of haemodialysis catheters](#)

Kannaiyan S Rabindranath, Emil Kumar, Ranjit Shail, Emma C Vaux

Background

A significant proportion of patients starting dialysis do so with a temporary or tunnelled haemodialysis catheter. Insertion of these catheters can be achieved either by using the anatomical landmarks for the veins into which they are inserted or using ultrasound guidance. It has been suggested that the use of ultrasound guidance reduces the immediate complications of haemodialysis catheter insertions such as pneumothorax or arterial puncture.

Objectives

The aim of the review was to compare the use of real-time 2-dimensional (2-D) Doppler ultrasound venous imaging in the insertion of percutaneous central venous catheters for dialysis versus the traditional "blind" landmark method.

Search methods

We searched the Cochrane Renal Group's

Specialised Register, MEDLINE, EMBASE, Cochrane Central Register of Controlled Trials (CENTRAL). Reference lists of identified studies and relevant narrative reviews were also screened. Search date: January 2011.

Selection criteria

All randomised controlled trials (RCTs) and quasi-RCTs evaluating ultrasound guidance in the percutaneous insertion of central venous catheters for dialysis (both cuffed and uncuffed) against the traditional blind landmark method.

Data collection and analysis

Two authors assessed risk of bias and extracted data. Statistical analyses were performed using the random effects model and the results expressed as risk ratios (RR) for dichotomous outcomes or mean difference (MD) for continuous data with 95% confidence intervals (CI).

Main results

We identified seven studies enrolling 767 patients and with 830 catheter insertions. Three of seven studies described the method of random sequence generation, none described allocation concealment, and blinding of participants and personnel was not possible. Real-time ultrasound guidance was found to significantly reduce the risk of catheter placement failure on the first attempt (5 studies, 595 catheters): RR 0.40, 95% CI 0.30 to 0.52), significantly reduce the risk of arterial puncture (6 studies, 535 catheters: RR 0.13, 95% CI 0.04 to 0.37) and haematomas (4 studies, 323 catheters: RR 0.22, 95% CI 0.06 to 0.81) when compared to the landmark method. The time taken for successful cannulation was significantly lower with the use of real-time ultrasound guidance (1 study, 73 catheters: MD -1.40 min, 95% CI -2.17 to -0.63) and there were less attempts/catheter insertion (1 study, 110 catheters: -0.35, 95% CI -0.54 to -0.16).

Authors' conclusions

Use of real-time 2-D Doppler ultrasound guidance has significant benefits with respect to the number of catheters successfully inserted on the first attempt, reduction in the risk of arterial puncture and haematomas and the time taken for successful vein puncture.

Cochrane Collaboration news

Launch of eLENA, the WHO electronic Library of Evidence for Nutrition Actions

Details: The WHO Department of Nutrition for Health and Development has announced the launch of the WHO electronic Library of Evidence for Nutrition Actions (eLENA) (www.who.int/elena), an online catalogue of interventions addressing different forms of malnutrition. Aimed at community leaders, policy-makers, specialists and advocates in health, nutrition, food and agriculture, eLENA provides a single point of reference for WHO guidance on effective nutrition interventions, as well as the most up-to-date scientific evidence underlying it, in order to help prioritise and design country policies and programmes. eLENA contains a link to Cochrane Systematic Reviews on the issues, as well as a link to the international clinical trial register.

Contact: Dr Hannah Neufeld, Department for Nutrition for Health and Development, Non-Communicable Diseases and Mental Health, World Health Organization
Email: neufeldh@who.int

The Cochrane Collaboration is in Official Relations with the World Health Organization. Read about other joint projects between the Collaboration and the WHO, here: [http://www.cochrane.org/about-us/relations-world-health-organization-influencing-world-health-organization-policy](http://www.cochrane.org/about-us/relations-world-health-organization/influencing-world-health-organization-policy)

Introducing the Evidence Aid Knowledge Manager - Claire Allen

Claire Allen from the Collaboration's Secretariat will be taking on the part-time role of Evidence Aid Knowledge Manager, funded by the Evidence Aid project. Evidence Aid was established by The Cochrane Collaboration after the Indian Ocean tsunami in 2004 and, working with the Cochrane Editorial Unit, has recently prepared special collections of knowledge from Cochrane Reviews of relevance to the natural disasters in Haiti, Pakistan and Japan. Evidence Aid aims to provide reliable, up-to-date evidence on interventions that might be considered in the context of natural disasters and other humanitarian emergencies, and is now expanding to include information from other systematic reviews, including those of relevance from outside health care.

One of Claire's principal tasks will be to identify the systematic reviews for Evidence Aid, which will involve close liaison with Cochrane Review Groups. She will

also work with the Wiley-Blackwell web team, the Collaboration's web team, the Cochrane Editorial Unit and others to promote the accessibility of the systematic reviews of relevance to Evidence Aid, and the associated commentaries and contextual information.

Claire will join the Evidence Aid Co-ordinator, Bonnix Kayabu (based in the Centre for Global Health in Trinity College Dublin), and Mike Clarke (based in Queen's University Belfast), on the Evidence Aid team. She will continue as Deputy Administrator at the Collaboration's Secretariat, splitting her time equally between both roles. Kiley Richmond and the Secretariat's new administrative assistant, Rachel Sayers, will ensure the Secretariat's administrative capacity is maintained.

Claire can be contacted for Evidence Aid enquiries at callen@evidenceaid.org, and for Secretariat enquiries at callen@cochrane.org. Secretariat administrative enquiries should be directed to krichmond@cochrane.org or rsayers@cochrane.org.

New postings and comments on the Consumer Blog

Does Cochrane have a plan for consumer participation? As part of its funding for a consumer co-ordinator, The Cochrane Collaboration requested that the CCNet design a plan for consumer participation in Cochrane Reviews. The Collaboration and CCNet hired consultants who interviewed consumers, editors and authors to identify any gaps in the current process and to determine the best solutions to support consumers within Cochrane. The Consumers' Executive has been working with the Consumer Co-ordinator, the CCNet Geographical Advisory Group, and members of CCNet and Cochrane to develop these solutions into a new support structure that will improve consumer integration within The Collaboration. All consumers and Cochrane Collaboration members are invited to comment. Read comments and the original posting at: <http://consumers.cochrane.org/blog/does-cochrane-have-plan-consumer-participation>

What if there is no clear evidence one way or the other of the intervention under review?

I would like to run past Consumers a problem I have had with comments that have turned up on the Internet that have been taken out of context. I personally have never put anything on the net. Also I have never seen the following subject raised in discussion in Consumer circles when review results are not clear-cut. ... Read comments & the original posting at:

Cochrane Collaboration news (Cont'd)

<http://consumers.cochrane.org/blog/what-if-there-no-clear-evidence-one-way-or-other-intervention-under-review>

New Comments posted on the Consumer Blog

How Well Do Meta-Analyses Disclose Conflicts of Interests in Underlying Research Studies—A recent study published in JAMA reviewed 29 meta-analyses from high impact journals and found that conflicts of interests in the studies underlying the meta-analyses were rarely disclosed. The 29 meta-analyses included 11 from general medicine journals; 15 from specialty medicine journals, and... Read comments & the original posting at:

<http://consumers.cochrane.org/blog/how-well-do-meta-analyses-disclose-conflicts-interests-underlying-research-studies-0>

What about the outcomes? A consumer point of view I have to admit that I have always had problems with outcomes. Death is sometimes listed as a primary outcome, sometimes a secondary outcome; quality of life wanders likewise between the two, as does pain & days in hospital. ... Read comments & the original posting at:

<http://consumers.cochrane.org/blog/what-about-outcomes-consumer-point-view>

Subscribe to the Consumer Blog online at <http://consumers.cochrane.org/blog>

Web Team updates - The Intranet on cochrane.org has a new look and a new name!

Dear Cochrane Contributors,
The Intranet area of cochrane.org has a new name and a new face! Over the last few months, The Cochrane Collaboration Web Team has, in consultation with various individuals and groups within The Collaboration, worked to redesign the homepage and navigation of the internal, Archie-authenticated area of cochrane.org, now renamed the "Community" area. We did this in order to improve navigation and accessibility of the resources and tools available there, such as discussion forums, presentation tools, organizational documents, meeting minutes, etc.

We are delighted to announce that these changes are now live. Please navigate to <http://cochrane.org/login> (or simply to cochrane.org and click on the "Community" tab on the far right) and click the "Login" button where you

are directed to/from Archie for authentication. Use the left-hand navigation ("Community") to navigate resources and information within the Community platform. In the main area of the page, you'll find the latest discussion forum topics, social networking links, news and blog feeds and other information. And coming soon, you'll be able to upload photos or stories about your work. Under "Here you can:" in the middle of the new homepage, you can "Watch a video about this site" to help you become acquainted with the new design.

The Community area of cochrane.org is designed to give Collaboration Contributors a central place to access the information, resources and tools they need to work together more effectively. Feedback is always welcome - please login to the Community platform and leave a comment in this forum topic <http://www.cochrane.org/forum/website-and-intranet/new-cochrane-intranet-now-community-platform-leave-feedback-here> in the "Website and community area" forum. Alternatively, you can always email us at web@cochrane.org <<mailto:web@cochrane.org>>.

While we have your attention, just a reminder to everyone that you can contribute news, events, jobs or

Upcoming workshops 2011

Australasian Cochrane Centre/
Cochrane Renal Group*

Penang, Malaysia

Nov 29 How to use Cochrane Systematic Reviews

Nov 30-Dec 1 Developing a Protocol for a Cochrane Review

Dec 2 GRADE workshop

Sydney, Australia*

Dec 1 & 2 Introduction to Writing a Cochrane Review

For further information on Australasian workshops please go to:

<http://acc.cochrane.org/timetable-registration>

Cochrane Collaboration news (Cont'd)

other items to cochrane.org. Look for the "Contribute news, events, jobs" large, green button on all News and Events pages or via the new Community homepage under "Here you can:".

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We want to hear from you! Want to be a content contributor to cochrane.org? Have an idea for a blog post or a homepage feature? Have suggestions for new features to either the public site or the Community area? The Cochrane Collaboration Web Team always welcomes feedback and comments for improvement to our websites and services. Login to the Community area (<http://cochrane.org/login>) and click on "Discussion Forums" (<http://cochrane.org/forum>) and post your comments in the "Website and community area" forum or email us directly at web@cochrane.org.

With best regards,
Chris Mavergames, on behalf of your Cochrane Collaboration Web Team

Systematic Review of Complex Interventions workshop in Oxford, UK

Event: Conducting Systematic Review of Complex Interventions using experimental treatments & quasi experimental designs

Date: Friday 25 November 2011

Location: UK Cochrane Centre, Oxford, UK

Details: This one day workshop is aimed at Cochrane Review Authors based in the UK but from any CRG who are undertaking reviews of complex interventions using experimental treatments and quasi experimental designs including cluster randomised, controlled before and after studies and interrupted time series. Further information can be obtained from Nicola McDowell.



Conferences



2011-2012

December 1-4, 2011

The 4th International Conference on Treatment of Hypertension, Dyslipidemia and Diabetes Mellitus, Paris, France.

www.fixedcombination.com/2011

February 26-28, 2012

32nd Annual Dialysis Conference, San Antonio, Texas - USA

<http://som.missouri.edu/Dialysis/>

May 9-13, 2012

8th International Congress on Autoimmunity, Granada, Spain

www2.kenes.com/autoimmunity/pages/home.aspx

May 24-27, 2012

49th ERA-EDTA Congress, Paris, France.

www.eraedta2012.org

September 9– 12, 2012

14th Congress of the International Society of Peritoneal Dialysis, Kuala Lumpur, Malaysia.

www.ispd2012.org.my

October 30, 2012 to November 4, 2012

ASN Renal Week, San Diego, California, USA.

www.asn-online.org



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

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