

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



Coordinating Editor
Jonathan Craig

Coordinator
Narelle Willis

Trials Coordinators
Sandrine Dury
Gail Higgins
Ruth Mitchell

Editors
Cecile Couchoud
Denis Fouque
Elisabeth Hodson
Alison MacLeod
Giuseppe Remuzzi
Teut Risler
Paul Roderick

Criticisms Editor
Bertram Kasiske

Statistical Advisor
Ian Marschner

Business Advisor
John Knight

Cochrane Renal Group
Centre for Kidney Research
The Children's Hospital at
Westmead
Locked Bag 4001
Westmead, NSW 2145
Australia

crg@chw.edu.au
www.cochrane-renal.org

The Cochrane Renal Group Newsletter

Tuesday 16 October at Marriott Hotel, Yerba Buena Salon room 11-12.

Renal group news

Website

Our website should be up and running by the time you receive this newsletter. The site is

www.cochrane-renal.org



Workshops

We have recently assisted with a workshop held in Darwin preceding the Australian and New Zealand Society of Nephrology (ANZSN) annual conference. We shall also be holding a protocol and RevMan workshop in Sydney on the 15-16 November. If you would like to attend please contact Narelle.

Funding

We have received infrastructure funding from the Commonwealth Department of Health & Aged Care for the next two years.

Meeting in Lyon

We will be holding an afternoon meeting in Lyon on Friday 12 October from 16:00 - 17:00 in the Forum. Hope to see you there!

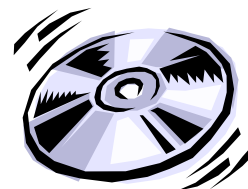
Meeting at ISN/ASN

At the upcoming ISN/ASN meeting in San Francisco we will be holding a lunchtime meeting (12:00-13:00) on

Bibliography of RCTs in kidney disease

We have recently compiled 2000 RCTs in Kidney Disease for distribution via CD-ROM. This CD will be available from the ISN booth at the ISN/ASN meeting in San Francisco. This project was supported by an unrestricted educational grant from Amgen. With this funding we have been able to employ Gail Higgins to assist Ruth in the preparation of this CD. Our next aim is to provide abstracted data of these RCTs.

If you would like a copy of this CD please contact the editorial base (crg@chw.edu.au).



In this issue

Reviews and protocols	2
Our scope	3
Priority areas	3
Reviewer support	4
Trials Register	4
Collaboration news	6
Synopses and abstracts	10
Nephrology conferences	17
Cochrane workshops	18

Membership

The number of active members has increased from 111 at the last issue to 156. This includes 13 consumers. We have members from 22 countries, including Russia and China.

Gail Higgins

Gail completed a Bachelor of Arts and a Graduate Diploma in Education from the University of Sydney in 1972. In 1981 she completed a Graduate Diploma in Library Science from Kuringai College of Advanced Education. Following a number of years as a Teacher Librarian, she changed tack in 1989 and spent 3 years with the NSW TAFE Information Systems Division, a position which stimulated an interest in information technology. In 1994 she joined the University of Sydney Library as Pharmacy Librarian. Since then she has had a number of positions within the University Library which have allowed her to combine her interest in information technology and information management. These positions included Coordinator, Access to Networked Information Resources and Internet Training Librarian.

We would like to welcome Gail to our team.

Advisory Board

Representatives of our supporters and users met for the first time at the end of April. Members are David Harris (ANZSN), Bob Atkins (AKF & ISN), Stephen Leeder (Dean of the Faculty of Medicine, University of Sydney), Kim Oates (CEO, The Children's Hospital at Westmead), Jim Dellit (Consumer), Chris Silagy (Australasian Cochrane Centre), David Henderson-Smart (Health Advisory Committee, NHMRC), John Knight, Narelle Willis and myself (Cochrane Renal Group). The purpose of the board is multiple but includes strategic planning, oversight, resource planning and advocacy. A major function is to encourage clarity of communication between the editorial base of the group and the group's supporters.

Priority reviews

One of the outcomes of the Advisory Board meeting was to highlight the need for the right mix between reviews done by enthusiasts from around the world and reviews which may be of less interest to nephrologists but which the editorial group need to support as part of our "good citizenship" mandate. In addition the Review Group should encourage a few important reviews. Some of the suggestions for important reviews to

come out of the Advisory Board meeting were diabetic nephropathy and transplantation reviews. We are exploring novel sources of funding for these reviews over and above what is required to support the editorial base.

The Advisory Board shall next meet on Wednesday 14 November 2001.

Jonathan Craig

Reviews and protocols

Since Issue 2 2001 we have published 5 new reviews and 8 new protocols. This brings our total to 12 reviews and 17 protocols.

Our most recent reviews are:

- **Comparison of cellulose, modified cellulose and synthetic membranes in the haemodialysis of patients with end-stage renal disease.** Alison MacLeod et al., UK.
- **Growth hormone for children with chronic renal failure.** Dushyanthi Vimalachandra et al., Australia.
- **Long-term antibiotics for preventing recurrent urinary tract infections in children.** Gabrielle Williams et al., Australia
- **Non-corticosteroid treatment for nephrotic syndrome in children.** Ann Durkan et al., Australia.
- **Recombinant human erythropoietin for chronic renal failure anaemia in pre-dialysis patients.** June Cody et al., UK.

The titles of our most recent protocols are:

- **Duration of antibacterial treatment for uncomplicated urinary tract infection in women.** Gai Milo et al., Israel.
- **Emergency management of hyperkalaemia.** Catherine Clase et al., Canada.
- **Exercise training for uraemic patients.** Susanne Hiewe et al., Sweden.
- **Immunosuppressive treatment for idiopathic focal and segmental glomerulosclerosis in adults.** Norbert Braun et al., Germany.
- **Methenamine salts for preventing urinary tract infections.** Bonne Lee et al., Australia.
- **Oral versus intravenous antibiotic therapy for symptomatic urinary tract infections.** Annette Pohl et al., Germany.
- **Therapeutic interventions for membranoproliferative glomerulonephritis.** Ping Fu et al., China.

- **Treatment for renal vasculitis and Goodpasture's disease in adults.** Giles Walters et al., Australia.

Other published reviews

Corticosteroid therapy for nephrotic syndrome in children. Elisabeth Hodson et al., Australia.



Cranberries for preventing urinary tract infections. Ruth Jepson et al., UK.

Cranberries for treating urinary tract infections. Ruth Jepson et al., UK.

Cytomegalovirus prophylaxis with antiviral agents for solid organ transplantation. Cecile Couchoud, France.

Double bag or Y-set versus standard transfer systems for continuous ambulatory peritoneal dialysis in end-stage renal disease. Conal Daly et al., UK.

Effects of non steroidal anti-inflammatory drugs on post-operative renal function in normal adults. Anna Lee et al., Hong Kong.

Other published protocols

Antibiotic duration for treating uncomplicated, symptomatic lower urinary tract infections in elderly women. Monica Lutters et al., Switzerland.

Antihypertensive treatment for non diabetic kidney disease. Ettore Guidi et al., Italy.

Antihypertensive treatment for protecting kidney function in hypertensive adults. Maurice Laville et al., France.

Correction of chronic metabolic acidosis in pre end stage chronic renal failure. Paul Roderick et al., UK.

Cyclosporin A for steroid-resistant nephrotic syndrome in adults and children. Paulo Koch Nogueira et al., Brazil.

Interventions for preventing recurrent urinary tract infection in women. Inmaculado Pereiro et al., Spain.

Interventions for primary vesicoureteric reflux. Danielle Wheeler et al., Australia.

Short versus standard duration therapy for acute urinary tract infection in children. Vir-

ginia Moyer et al., USA.

Treatment for lupus nephritis. Steven Chadban et al., Australia.

New titles

Continuous replacement renal therapy for the critically ill without acute renal failure. Bruce Powell et al., UK.

Dialysis and transplantation for end-stage renal disease. Giorgina Piccoli et al., Italy.

Interventions for preventing contrast-induced nephropathy. Rakesh Gulati et al., USA.

Interventions for preventing haemolytic uraemic syndrome. Elizabeth Elliott et al., Australia.

Our Scope

- Acute renal failure
- Chronic renal failure
- Renal transplantation
- Renovascular hypertension
- Glomerular diseases
- Urinary tract infections
- Nephrolithiasis



Priority areas

We are looking for people to undertake the following reviews:

- Renal transplantation
 - Tacrolimus for renal transplant recipients
 - Antilymphocyte preparations for renal transplant recipients
 - IL-2 receptor blockers for renal transplant recipients
 - Sirolimus for renal transplant recipients
 - Steroid withdrawal for renal transplant recipients.
 - Steroid tapering for renal transplant recipients.

➤ **Dialysis**

- Interventions to prevent peritonitis and exit site infections in peritoneal dialysis
- Treatment for dialysis-related hypotension
- Kt/v and creatinine clearance targets for dialysis
- Interventions for preventing cramps during dialysis

➤ **Urinary tract infection**

- Antiseptic impregnated urethral catheters for the prevention of urinary tract infections

➤ **General nephrology**

- Corticosteroids in minimal change nephropathy in adults
- Interventions to reduce infection risk in nephrotic syndrome
- Interventions to reduce thrombosis risk in nephrotic syndrome

Reviewer support

Further information booklet

- For those who would like to know more about the Renal Group and the Cochrane Collaboration.

New Members booklet

- General information about the review process, how new members may contribute and how the Editorial Team can help them.

How to write a protocol

- Step by step manual including where to download all the relevant software, the Renal Group guidelines for completing a protocol, which sections of RevMan needs to be completed, a data extraction form and a submission checklist.
- This booklet is sent to reviewers on registration of a title.

Referees guide for protocols

- A checklist and guide for referees to help them assess protocols.

Referees guide for reviews

- A checklist and guide for referees to help them assess reviews.

If you would like a copy of any of these booklets, contact Narelle at narellw2@chw.edu.au

A further 2 booklets are planned:

How to write a review

- Step by step guide with examples, synopsis writing guidelines and reviewer checklist.
- Sent to reviewers on completion of protocol.

How to update a review

- How to update your review, how often it needs to be done and how we can help.

Synopses - what are they?

Synopses are short, plain language summaries of a Cochrane review and its subject. They are included on the Cochrane Consumer website and are written for consumers. These synopses should aim to:

- Be short, accurate and easy to read
- Encompass the basic requirements for informed consumer decision making in health (explanation of the intervention, alternatives, positive and adverse effects)
- Inform people of the evidence only, and not offer advice or tell people what to do

The synopsis has a short 'headline' encapsulating the findings of the review (up to 25 words) and then a fuller piece of text based on the content guidelines (up to 100 words).

At the moment the Australasian Cochrane Centre (ACC) is happy to prepare the synopses for you. On submission of your review to editorial base, it is forwarded to the ACC and a synopsis is written. This is then modified in negotiation with both the reviewers and the editorial team. It is then included with the review and is also posted on the consumer website.

Trials register

One of our projects is to collect as much information as possible about ongoing trials in kidney disease, using a variety of websites and other resources. Three of the main websites are:

- Current Controlled Trials (www.controlled-trials.com). It has a meta register of ongoing randomised controlled trials sourced from a large number of organisations. Its strength lies in the level of information it requires before a trial can be included, making it easy to

fill in all the detail required to use MeerKat to its best advantage.

- **ClinicalTrials.Gov (www.clinicaltrials.gov)**
This is the National Institutes of Health register of clinical trials, maintained by the National Library of Medicine. It mainly features trials occurring in the US and Canada, and its strength is in the clear, consumer-oriented synopses of these trials.
- **CentreWatch (www.centrewatch.com)**. Contains a list of industry-sponsored clinical trials, already sorted by broad clinical areas e.g. nephrology/urology. It has no minimum requirements for information about each trial, but often provides links that enable the user to go directly to a trial website.

We also use the UK-based National Research Register, sent out to us on CD ROM via the Collaboration. It is also included in the Current Controlled Trials meta register, but has a more sophisticated search facility, enabling more specific searches to be made.

Gail Higgins

Handsearching

We are pleased to have gained three experienced handsearchers for our group, due to the move of the Acute Respiratory Infections Group from Canberra to Brisbane. Many thanks to Ron D'Souza, former RGC for the group, for thinking of us, and ensuring that these valuable people were not lost to the Collaboration. I will be meeting with them for the first time post-Colloquium.

Ruth Mitchell

New RCT/systematic review research

Triallists often pay more attention to the benefits of interventions than the harms. A group from Boston (*Ioannidis J, Lau J. Completeness of safety reporting in randomised trials. JAMA 2001;285: 437-443*) examined the quality and quantity of reporting of harm data from 192 drug trials from 7 medical areas. They found that the severity of clinical adverse effects and laboratory-determined toxicity was adequately defined in only 39% and 29% of trial reports, respectively. Only 46% of trials stated the frequency of specific reasons for discontinuation of study treatment due to toxicity. Overall, the median space allocated to safety results was 0.3 page. A similar amount of space was devoted to

contributor names and affiliations ($P = 0.16$)! On average, the percentage of space devoted to safety in the results section was 9.3% larger in trials involving dose comparisons than in those that did not ($P < 0.001$) and 3.8% smaller in trials reporting statistically significant results for efficacy outcomes ($P = 0.047$). **Bottom line: for readers of trials, read the fine-print harm data, for doers of trials, give more harm detail. Clinicians and patients need both.**

New trials

Coadministration of losartan and enalapril exerts additive antiproteinuric effect in IgA nephropathy. Russo D et al. *Am J Kidney Dis* 2001 38(1):18-25

A randomized trial of high-dose compared with low-dose omega-3 fatty acids in severe IgA nephropathy. Donadio JV Jr et al. *J Am Soc Nephrol* 2001 12(4) 791-799

Randomized trial of tacrolimus plus mycophenolate mofetil or azathioprine versus cyclosporine oral solution (modified) plus mycophenolate mofetil after cadaveric kidney transplantation: results at 2 years. Ahsan N et al. *Transplantation* 2001 72(2):245-250

Effect of ibandronate on bone loss and renal function after kidney transplantation. Grotz W et al. *J Am Soc Nephrol* 2001 12(7):1530-1537

Multicenter trial of one HLA-DR-matched or mismatched blood transfusion prior to cadaveric renal transplantation. Hiesse C et al. *Kidney Int* 2001 60(1):341-349

Lead chelation therapy and urate excretion in patients with chronic renal diseases and gout. Lin JL et al. *Kidney Int* 2001 60(1):266-271

Enzyme replacement therapy in Fabry disease: a randomized controlled trial Schiffmann R et al. *JAMA* 2001 285(21):2743-2749

Effect of ramipril vs amlodipine on renal outcomes in hypertensive nephrosclerosis: a randomized controlled trial. African American Study of Kidney Disease and Hypertension Study Group. *JAMA* 2001 285(21):2719-2728

Effect of lovastatin, an HMG CoA reductase inhibitor, on acute renal allograft rejection. Sahu K et al. *Clin Transplant* 2001 15(3):173-175

Medical versus surgical treatment in children with severe bilateral vesicoureteric reflux and bilateral nephropathy: a randomised trial. Smellie JM et al. *Lancet* 2001 357(9265):1329-1333

An economic and quality-of-life assessment of basiliximab vs antithymocyte globulin immunoprophylaxis in renal transplantation. Polsky D et al. *Nephrol Dial Transplant* 2001 16(5):1028-1033

Renal insufficiency as a predictor of cardiovascular outcomes and the impact of ramipril: the HOPE randomized trial. Mann JF et al. *Ann Intern Med* 2001 134(8):629-636

Prospective randomized study of various techniques of percutaneous nephrolithotomy. Feng MI et al. *Urology* 2001 58(3):345-350

Uricosuric effect of losartan in patients with renal transplants. Kamper AL et al. *Transplantation* 2001 72(4):671-674

A randomized clinical trial of continuous versus intermittent dialysis for acute renal failure. Mehta RL et al. *Kidney Int* 2001 60(3):1154-1163

Effects of a long-acting formulation of octreotide on renal function and renal sodium handling in cirrhotic patients with portal hypertension: A randomized, double-blind, controlled trial. Ottesen LH et al. *Hepatology* 2001 34(3):471-477

Effect of acetate-free biofiltration on the anaemia of haemodialysis patients: a prospective cross-over study. Basile C et al. *Nephrol Dial Transplant* 2001 16(9):1914-1919

A controlled trial comparing two doses of cyclosporine in conjunction with mycophenolate mofetil and corticosteroids. Sevaux RG et al. *J Am Soc Nephrol* 2001 12(8):1750-1757

A prospective crossover trial comparing intermittent intravenous and continuous oral iron supplements in peritoneal dialysis patients. Johnson DW et al. *Nephrol Dial Transplant* 2001 16(9):1879-1884

Oral supplementation of branched-chain amino acid improves nutritional status in elderly patients on chronic haemodialysis. Hiroshige K et al. *Nephrol Dial Transplant* 2001 16(9):1856-1862

Combination therapy with pulse cyclophosphamide plus pulse methylprednisolone improves long-term renal outcome without adding toxicity in patients with lupus nephritis. Illei GG et al. *Ann Intern Med* 2001 135(4):248-257

Randomized controlled trial of hand-assisted laparoscopic versus open surgical live donor nephrectomy. Wolf JS Jr et al. *Transplantation* 2001 72(2):284-290

A randomized, double-blind, placebo-controlled trial of supplementary vitamins E, C and their combination for treatment of haemodialysis

cramps. Khajehdehi P et al. *Nephrol Dial Transplant* 2001 16(7):1448-1451

A randomized, controlled parallel-group trial on efficacy and safety of iron sucrose (Venofer) vs iron gluconate (Ferrlecit) in haemodialysis patients treated with rHuEpo. Kosch M et al. *Nephrol Dial Transplant* 2001 16(6):1239-1244

A randomized trial of minidose warfarin for the prevention of late malfunction in tunneled, cuffed hemodialysis catheters. Mokrzycki MH et al. *Kidney Int* 2001 59(5):1935-1942

Randomized, controlled trial comparing once daily and three times daily gentamicin in children with urinary tract infections. Carapetis JR et al. *Pediatr Infect Dis J* 2001 20(3):240-246

Low-dose dopamine in patients with early renal dysfunction: a placebo-controlled randomised trial. Australian and New Zealand Intensive Care Society (ANZICS) Clinical Trials Group. *Lancet* 2000;356:2139-43.

Collaboration news

Cochrane Colloquium dates

9th Annual International Cochrane Colloquium
Lyon, France, 9 - 13 October 2001

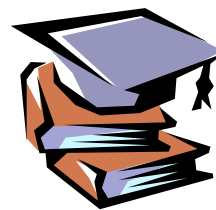
10th Annual International Cochrane Colloquium
Stavanger, Norway, 31 July - 3 August 2002

11th Annual International Cochrane Colloquium
Barcelona, Spain, 25 October - 1 November 2003

12th Annual International Cochrane Colloquium
Ottawa, Canada, 2 - 6 October 2004

CME points

The UK Cochrane Centre in May received confirmation from the Royal College of Physicians of London that the one day workshop 'Developing a protocol for a review' has been allocated 6 CME credits for the full attendance. This is recognised by all other UK Medical Royal Colleges for CME. The centre is currently looking into gaining accreditation from other professional institutions. Attendance certificates and other workshop literature will now reflect this.



Nicola Thornton

Change of name

The Software Development Group has changed its name to the **Information Management System Group (IMSG)**. The IMSG is an advisory group to the Cochrane Collaboration Steering Group. The IMSG will now be responsible for overseeing the development of any software developed in-house which is to be used Collaboration-wide e.g. RevMan.

Methods Group newsletter now online

The Cochrane Methods Groups Newsletter for June 2001 is now available on the Collaboration website at:

<http://www.cochrane.de/newslett/mgnews5.pdf>

For the first time previous issues of the Newsletter are now also available at:

www.cochrane.de/newslett/newslet.htm

Sally Hopewell

The Hypertension Group

The Hypertension Group, whose reviews were being looked after temporarily by the Heart Group, has established its editorial base in Vancouver, Canada. Professor James Wright is now the Coordinating Editor and Ciprian Jauca is the Review Group Coordinator. The Contact details for the editorial base are as follows:

Mr Ciprian Jauca
Review Group Coordinator
Cochrane Hypertension Group
2176 Health Science Mall
Vancouver, BC V6T 1Z3
Canada
Tel: +1 604 822 0700
Fax: +1 604 822 0701
email: jauca@ti.ubc.ca

New Methods Group

The Health-Related Quality of Life Methods Group was registered with the Cochrane Collaboration effective 8 May 2001. Contact details are:

Juliette Longin
MAPI Research Institute
27, Rue de la Villette
69003 Lyon
France
Tel: +04 72 13 66 67
Fax: +04 72 13 66 82
email: jlongin@mapi.fr

Centre news

The Brazilian Cochrane Centre has a new URL:
<http://www.centrocochranedobrasil.org>

The Cochrane Library



1000 reviews!!!

In Issue 2 2001 this mythical barrier was broken - and in Issue 3 2001 the number of reviews has now reached 1147. This is a fantastic achievement considering The Collaboration is only 8 years old!!

Free access to the Cochrane Library

Scrip World Pharmaceutical News (Issue no 2637, April 25 2001, page 7) has reported that the Scottish Executive is making The Cochrane Library freely available to health professionals through their intranet to ensure that they will have access to world class evidence of best practice.

The Cochrane Methodology Register

If you want to find articles about publication bias, double data entry, citation errors, collecting data for systematic reviews, the first place to look is the Cochrane Methodology Register on the Cochrane Library. The Register now contains 3,500 records.

The audio Companion to the Cochrane Library

Some of you may have seen promotional material for a new product named The Audio Companion to The Cochrane Library. This product is produced by a company named Oakstone Publishing in association with Johns Hopkins University. The Audio Companion to The Cochrane Library consists of discussions of selected Cochrane Reviews recorded on cassette tapes. The April 2001 issue, for example, focuses on Peripheral Vascular Disease, and includes discussions of 8 reviews on medical, surgical, and nonpharmacologic treatment for claudication, and 5 reviews on treatment of venous leg ulcers. The intended audience is internists and family practice physicians interested in evidence-based medicine. The Audio Companion is distributed on a subscription basis, and subscribers to the Audio Companion are eligible for CME Credits through a program administered by the Johns Hopkins University School of Medicine. While this product is based on Cochrane Reviews, and Cochrane reviewers are involved in its production, it is neither a Cochrane Collaboration nor an Update Software product. That said, Oakstone have been very good about telling us what they are doing and about trying to involve individ-



ual contributors to the Collaboration. The best source of information on the Audio Companion is the Oakstone Web site:

www.oakstonemedical.com. I am certain the people at Oakstone would welcome your comments.

Mark Star, *Update Software*

MEDLINE 1998 & 1999 search complete

The electronic search of MEDLINE, using Phases 1 and 2 of the Cochrane highly sensitive search strategy, to identify MEDLINE records not currently identified as RANDOMIZED CONTROLLED TRIAL (publication type) [RCT] or CONTROLLED CLINICAL TRIAL (publication type) [CCT] has been completed for the years 1998 and 1999. The results have been submitted to the National Library of Medicine during 2000 for the 2001 update of MEDLINE, and to Update Software for inclusion of the identified records in CENTRAL, Issue 2 2001, The Cochrane Library.

Eric Manheimer

Gold Nuggets

Now in its second edition, Gold Nuggets is a printed journal which is produced on a quarterly basis along side each new issue of The Cochrane Library. This invaluable reference tool contains the abstracts of all the new Cochrane Reviews in the current issue of The Library as well as a full listing of all those reviews which have been substantially updated for the current release. The paper format of this quarterly journal makes vital new Cochrane Reviews accessible to the reader wherever they are and enables them to see at a glance what new information may be of interest to them. Subscription forms for Gold Nuggets can be found on Update Software's web site www.update-software.com You can either order your copy of the publication online or if you would prefer you can download a PDF copy of the order form which can then be faxed or posted back to us. If you would like more information about Gold Nuggets please send your questions to info@update.co.uk

Niki Rainbow, *Update Software*

Faster Access to The Cochrane Library Online

For those of you who normally access The Cochrane Library online via the UK server you may be interested to know that there might be a quicker way to get in to The Library. The German (Freiburg) Server is a quicker server with a faster connection speed and depending on your lo-

cation it may allow you better access to The Cochrane Library. The German server can be accessed via the following site <http://cochrane.redi-fr.belwue.de> Once on the site simply enter your usual username and password in the spaces provided and you are away. Alternatively if you are not sure which site would give you the fastest access simply connect to The Library via the following page www.update-software.com/clibhome/clibdetect.htm Depending on your location and how busy each of the two servers are at that moment in time this link will automatically connect you to the fastest site.

Niki Rainbow, *Update Software*

CDSR on DataStar

Update Software are proud to announce their latest publishing venture with their new publishing partners The Dialog Corporation. As from the 5th of September 2001 The Cochrane Database of Systematic Reviews (CDSR) can now be found online on DataStar, Dialog's global online resource for reliable, up-to-date information. The site provides comprehensive European coverage and is a primary resource for biomedical, pharmaceutical and healthcare information. They describe DataStar as "the ultimate research tool" and are keen to work in partnership with Update Software in making further resources available to their customers. For more information about Dialog and the services they provide why not visit their web site www.dialog.com

Niki Rainbow, *Update Software*

Endorsement for Cochrane Reviews

The following is taken from the notes the BMJ sends to people who are asked to prepare editorials for them:

"We would like you to mention whether or not there is a Cochrane review if you are writing on a clinical issue."

It is the only reference to a particular type of publication in these notes to editorial writers.

Mike Clark

Lancet-Cochrane collaborate on systematic reviews

The Lancet now encourages Cochrane reviewers to submit versions for their reviews to the journal for consideration for publication, in accordance with their guidance published at the beginning of each month, "Writing for The Lancet". This advice

applies even if an earlier version of the review has already appeared in The Cochrane Library. Typically, it is expected that the reviews submitted to The Lancet will have been updated in light of comments received and new information added. Their criteria of topicality, originality, validity, and appropriateness for their readership will still apply. In this way it is hoped that the readers of The Lancet will benefit from up-to-date high-quality systematic reviews of topics of interest to them.

Mike Clarke, *UK Cochrane Centre*

Richard Horton, *The Lancet*

The full editorial appeared in *Lancet* vol 357 June 2, 2001 p 1728.

Quality Improvement Manager

Nancy Owens, former Review Coordinator Group for the Schizophrenia Group, has been appointed Quality Improvement Manager for The Collaboration. Nancy will be working with the Steering Group, Quality Advisory Group and others to map out the processes we currently use to produce reviews and to identify priorities for improving our procedures in the future. Congratulations Nancy.

Results of the Steering Group elections

The following people have been elected to the Steering Group for a 3 year period:

- David Henderson-Smart* (CRG representative)
- Silvana Simi (Consumer Network representative)
- Kathie Clark (Centre representative)

And welcome back to:

- Mike Clark (Methods Working Group representative)
- Gerd Antes (Centre representative)

(*David's main role is regional Coordinator for the Neonatal Group and he is also part of the Renal Group's Advisory Board)

Users' guides to the medical literature

- User's Guides to the Medical Literature. A Manual for Evidence-Based Clinical Practice.
- Users' Guide to the Medical Literature. Essentials of Evidence-Based Clinical Practice.

The Evidence-based Medicine Working Group, including 50 clinical epidemiologists, biostatisticians, and health service researchers from around the world, has produced the definitive text on using the medical literature to solve patient prob-

lems. Based on the 25-part Users' Guide to the Medical Literature published between 1993 and 2000 in JAMA, "The Users' Guide to the Medical Literature: A manual for evidence-based clinical practice" reviews the core concepts of how to search the medical literature, and assess the validity, results and applicability of studies of therapy, diagnosis, harm and prognosis. In addition, the book expands on all key concepts, and will thus be of great use to experts, and teachers. For instance, it deals extensively with the methodology of systematic reviews, including chapters on fixed versus random effects models, publication bias, dealing with heterogeneity of results, and interpreting sub-group analyses. The book comes with a sophisticated CD-ROM version, and allows access to a web-based version with additional features, including interactive programs. The book represents a "must have" for clinicians interested in evidence-based medicine. Order from Online BMJ Bookshop: www.bmjbookshop.com

Publishers to provide low-cost access to medical journals in poor countries

Six large publishing concerns, including Elsevier, Harcourt General, Springer-Verlag, and John Wiley & Sons, have announced plans to provide free or discounted access to approximately 1,000 medical journals to medical schools, research laboratories, and government health departments in poor countries, the New York Times reports. Led by the World Health Organization (<http://www.who.int/>), the initiative will benefit some 600 institutions, primarily in Africa.

Subscriptions to the average specialty medical publication average roughly \$1,500 a year, with libraries and research institutions often paying higher prices than individuals. According to the initiative's guidelines, institutions in poor countries where the per capita gross national product is less than \$1,000 a year will get the journals free, while institutions in countries where the per capita GNP is \$1,000 to \$3,000 will receive journals at a sharply reduced cost. The journals will be made available through a Web portal the World Health Organization is creating as part of its Health InterNetwork, a program that works to make statistical data, peer-reviewed scientific publications, clinical guidelines, software, and online training available electronically in poor countries.

In related news, the New York City-based Open Society Institute, which in recent years has pro-

vided electronic journal access to 2,100 institutions in 39 countries, most of them states of the former Soviet Union, has announced that it will make its network of contacts available to WHO, which hopes to have the program up and running by January 2002.

Petersen, Melody. "Medical Journals to Offer Lower Rates in Poor Nations." New York Times 07/09/01.

Brown, David. "Free Access to Medical Journals to Be Given to Poor Countries." Washington Post 07/09/01.

Dr Anthony Petrosino

Carola Warburg Rothschild Award

Congratulations to Drs. Iain Chalmers, Murray Enkin, and Marc Keirse!

The Carola Warburg Rothschild Award is for 'outstanding contributions to the health and well-being of women and their families'. It was presented on May 4, 2001 to Iain Chalmers, Murray Enkin, and Marc Keirse "For refining the scientific synthesis of research evidence and leading a dedicated team in the application of these systematic review methods to the entire field of maternal and newborn care; for disseminating their findings in a series of landmark publications; for helping to ensure that women, clinicians, and policy makers can make decisions about maternity care that are informed by the best available research; and for their continuing efforts to determine the safety and effectiveness of maternity care for mothers and babies".

Officer of the Order of Canada

Dave Sackett has been named an Officer of the Order of Canada! The Officer award is the second of three levels of the Order of Canada, and is about as high as anyone is appointed in the first instance. Most appointments are at the third level, "Member". These awards are most truly merited when the individual so honoured has substantially and unselfishly benefited others. Dave Sackett certainly meets this criterion. His own brilliantly creative methodologic work in health research would be enough to merit such recognition, but the mark of the man is that he has made so many of us successful through his endlessly enthusiastic pedagogy, stewardship, and friendship. David Sackett was the first Chair of the Cochrane Collaboration.

Brian Haynes

Synopses & abstracts

Below are the synopses and abstracts of our most recent reviews.

Comparison of cellulose, modified cellulose and synthetic membranes in the haemodialysis of patients with end-stage renal disease. Alison MacLeod et al., UK.

Not enough evidence to show the effect of synthetic membranes when compared with cellulose membranes for haemodialysis

When the kidney fails the blood cannot be filtered properly. Protein breakdown and water need to be removed by haemodialysis, a mechanical process that passes blood over a special filtering membrane. Natural membranes such as cellulose are used. The more expensive synthetic types are considered more compatible as they cause less of an immune response but it is not clear how real clinical outcomes are affected. The review compared synthetic membranes with cellulose/modified cellulose membranes. Not enough evidence was found to show a beneficial effect for synthetic membranes although some improvements were noted. More research is needed.

Background

When the kidney fails the blood borne metabolites of protein breakdown and water cannot be excreted. The principle of haemodialysis is that such substances can be removed when blood is passed over a semipermeable membrane. Natural membrane materials can be used including cellulose or modified cellulose, more recently various synthetic membranes have been developed. Synthetic membranes are regarded as being more "biocompatible" in that they incite less of an immune response than cellulose-based membranes.

Objectives

To assess the effects of different haemodialysis membrane material in patients with end-stage renal disease (ESRD).

Search strategy

We searched Medline (1966 to December 2000), Embase (1981 to November 2000), PreMedline (29 November 2000), HealthStar (1975 to December 2000), Cinahl (1982 to October 2000), The Cochrane Controlled Trials Register (Issue 1, 1996), Biosis (1989 to June 1995), Sigle (1980 to

June 1996), Crib (10th edition, 1995), UK National Research Register (September 1996), and reference lists of relevant articles. We contacted biomedical companies, investigators and we hand searched Kidney International (1980 to 1997). Date of the most recent searches: November 2000.

Selection criteria

All randomised or quasi-randomised clinical trials comparing different haemodialysis membrane material in patients with ESRD.

Data collection & analysis

Two reviewers independently assessed the methodological quality of studies. Data was abstracted from included studies onto a standard form by one reviewer and checked by another.

Main results

Twenty seven studies met our inclusion criteria and where possible data from these were summarised by meta-analyses (Peto's odds ratio (OR) and weighted mean difference (WMD) with 95% confidence intervals (CI)). Twenty two outcome measures were sought in 10 broad areas. For two (number of episodes of significant infection per year and quality of life) no data were available. For the comparison of cellulose with synthetic membranes, data for 12/20 outcome measures were available in only a single trial. For modified cellulose and synthetic membranes, data for three outcome measures were available in one trial only and for 12 of the outcomes no data were found, crossover studies were analysed separately and studies which randomised by patient yet analysed by dialysis sessions adjusted for clustering.

Pre-dialysis beta2 microglobulin concentrations were significantly lower at the end of the studies in patients treated with synthetic membranes (WMD - 14.5; 95% CI -17.4 to -11.6). One crossover study showed a lowering of beta2 microglobulin when low flux synthetic membranes were used. When analysed for a change in beta2 microglobulin across a trial a fall was only noted when high flux membranes were used. In one very small study the incidence of amyloid was less in patients who were dialysed for six years with high flux synthetic membranes (OR 0.05; 95% CI 0.01 to 0.18). In the single study which measured triglyceride values there was a significant difference in favour of the synthetic (high flux) membrane (WMD -0.66; 95% CI -1.18 to -0.14). Serum albumin was higher in patients treated

with synthetic membranes (both low and high flux) although this just bordered statistical significance (WMD -0.09; 95% CI -0.18 to 0.00). Dialysis adequacy measured by Kt/V was marginally higher when cellulose membranes were used (WMD 0.10; 95% CI 0.04 to 0.16). There was no significant difference between these membranes for any of the other clinical outcomes measures but confidence intervals were generally wide. No differences were found between modified cellulose and synthetic membranes although many fewer trials were carried out for this comparison.

Reviewers' conclusions

For clinical practice

This systematic literature review has generated no evidence of benefit when synthetic membranes were used compared with cellulose/modified cellulose membranes in terms of reduced mortality nor reduction in dialysis related adverse symptoms. Despite the relatively large number of RCTs undertaken in this area none of the included studies reported any measures of quality of life. End-of-study beta2 microglobulin values, and possibly the development of amyloid disease, were less in patients treated with synthetic membranes compared with cellulose membranes. Plasma triglyceride values were also lower with synthetic membranes in the single study that measured this outcome. Differences in these outcomes may have reflected the high flux of the synthetic membrane. Serum albumin was higher when synthetic membranes of both high and low flux were used. Kt/V and urea reduction ratio were higher when cellulose or modified cellulose membranes were used in the few studies that measured these outcomes. We are hesitant to recommend the universal use of synthetic membranes for haemodialysis in patients with ESRD because of; the small number of trials (particularly for modified cellulose membranes, most with low patient numbers), the heterogeneity of many of the trials compared, the variations in membrane flux, the differences in exclusion criteria, particularly relating to comorbidity and the relative lack of patient-centred outcomes studied. Such evidence as we have favours synthetic membranes but even if we assume extra benefit it may be at considerable cost, particularly if high flux synthetic membranes were to be used.

For further research

A further systematic review of RCTs comparing high and low flux haemodialysis membranes, subgrouped according to membrane composition

(cellulose, modified cellulose, synthetic) and reporting clinical outcomes of major importance to patients needs to be undertaken. Further pragmatic RCTs are required to compare the different dialysis membranes available. We recommend that they:

- Take into account other properties including flux as well as the material from which the membrane is made and test modified cellulose membranes as well as standard ones.
- Record an agreed minimum dataset on primary outcomes of major importance to patients.
- Explicitly record whether symptoms are patient- or staff-reported recognising that generally patient reporting will be more appropriate for evaluating effectiveness but staff reported data may be necessary for calculating the cost of treating complications.
- Be multi-centre (and possibly multinational) to have sufficient patients to complete the study to allow for a considerable number of withdrawals and dropouts.
- Have sufficient length of follow up to draw conclusions for important clinical outcome measures and continue to follow patients who have renal transplants.
- Include older patients and those with comorbid illnesses and take into account age and comorbidity when assessing outcomes (possibly by stratification at trial entry).
- Carry out, in parallel, an economic evaluation of the different policies being compared in the trial.

Growth hormone for children with chronic renal failure. Dushyanthi Vimalachandra et al., Australia.

Some evidence that human growth hormone may help reduce growth problems in children with chronic renal failure

The kidneys filter blood. People with chronic renal failure (CRF) need their blood filtered by machine (dialysis) or need a kidney transplant. CRF can stunt growth in children. Growth hormone (recombinant hGH) has been used to help children grow to a more average height for their age but hGH may have adverse effects including added risk of transplant rejection and high pressure in the brain. The review of trials found that hGH increased height in children with CRF by about 4-6 cm with 1-2 years of treatment and that adverse effects are very rare.

Background

Over the past 10 years, recombinant human Growth Hormone (hGH) treatment has been used to help short children with CRF attain a height more in keeping with their age group. However, there are concerns that hGH may have an adverse effect on the preservation of native renal function, predispose to acute rejection in renal transplant recipients, and cause benign intracranial hypertension and slipped capital femoral epiphysis. Although many trials of hGH treatment in children with CRF have been undertaken, uncertainty exists on the magnitude of benefits and side effects of the treatment. A systematic review of hGH treatment was undertaken to evaluate growth outcomes to establish the effect of treatment over time. We sought to establish if the growth outcomes remained linear over time or if there was a waning effect of the treatment. Secondly, we examined the effect of varying doses of the treatment. Thirdly, we explored the effect of the following factors on treatment: age, sex, pubertal status and the stage of CRF (pre-dialysis, on dialysis, post-transplant). Finally, the study evaluated potential side effects of hGH treatment.

Objectives

To evaluate the benefits and harms of recombinant human growth hormone (hGH) treatment in children with chronic renal failure (CRF).

Search strategy

Published and unpublished randomised controlled trials (RCTs) were identified from the Cochrane Controlled Trials Register, Medline, Embase, article reference lists and through contact with local and international experts in the field.

Selection criteria

Randomised controlled trials (RCTs) were included if they were carried out in children aged 0-18 years, diagnosed with CRF who are pre-dialysis, on dialysis or post-transplant; if they compared hGH treatment with placebo/no treatment or two doses of hGH treatments; and if they included height outcomes.

Data collection & analysis

Two reviewers independently assessed studies for methodological quality and extracted data from eligible trials. The primary outcome measure was difference in mean change in height standard deviation score (SDS). Secondary outcome measures included change in height SDS from treatment onset to completion, change in height SDS during puberty, change in height velocity, final height, qual-

ity of life and adverse effects. To estimate summary treatment effects, data was pooled using a random effects model with calculation of weighted mean difference (WMD) for continuous outcomes and relative risk for categorical outcomes.

Main results

Ten RCTs involving 481 children were identified. Treatment with hGH (28 IU/m²/wk) resulted in a significant increase in height standard deviation score (SDS) at one year (four trials, WMD 0.77, 95% confidence limits (CI) 0.51 to 1.04), and a significant increase in height velocity at six months (two trials, WMD 5.7 cm/yr, 95%CI 4.4 to 7.0) and one year (two trials, WMD 4.1 cm/yr, 95%CI 2.6 to 5.6), but there was no further increase in height indices during the second year of administration. Compared to the 14 IU/m²/wk group, there was a 1.4 cm/yr (0.6 to 2.2) increase in height velocity in the 28 IU/m²/wk group. The frequency of reported side effects of hGH were similar to that of the control group.

Reviewers' conclusions

On average, one year of 28 IU/m²/wk hGH in children with CRF results in a 4 cm/yr increase in height velocity above that of untreated controls, however, it is not certain if this will result in an increase in final adult height. Benefits of longer courses or higher doses of treatment warrants further study.

Long-term antibiotics for preventing recurrent urinary tract infections in children. Gabrielle Williams et al., Australia

Long term antibiotic use for children to try and prevent urinary tract infections may cause more problems than they prevent.

Bladder and kidney infections (urinary tract infection - UTI) are common in children, especially girls. They cause vomiting, fever and tiredness, and occasionally lead to kidney damage. Some children keep getting repeat bouts, and the risk of kidney damage increases. Sometimes, children take antibiotics long-term to try and prevent infections returning, but this can cause a lot of adverse effects (including vomiting). The review of trials found some evidence that the antibiotics did prevent some infections, but more with too many adverse effects to be worthwhile. Nitrofurantoin was more effective than trimethoprim but had more adverse effects.

Background

Acute urinary tract infection (UTI) is common in children. By the age of seven years, 8.4% of girls and 1.7% of boys will have suffered at least one episode. Symptoms are systemic rather than localised in early childhood and consist of fever, lethargy, anorexia, and vomiting. UTI is caused by *E. coli* in over 80% of cases and treatment consists of a course of antibiotics. Due to the unpleasant acute illness caused by UTI and the risk of pyelonephritis-induced permanent kidney damage, many children are given long-term antibiotics aimed at preventing recurrence. However these medications may cause side effects and promote the development of resistant bacteria.

Objectives

To determine the efficacy and side effects of long-term antibiotics given to prevent recurrent UTI in children.

Search strategy

A search of MEDLINE (1966 to Jan 2001), EMBASE (1988 to Jan 2001) and the Cochrane Controlled Trials Register for relevant randomised controlled trials without language restriction; reference lists of review articles; contact with content experts.

Selection criteria

Randomised comparisons of two or more antibiotics and placebo with one or more antibiotics to prevent recurrent UTI.

Data collection & analysis

Two reviewers independently assessed and extracted information. For each trial, information was collected on the methods of the trial, participants, interventions and outcomes. A random-effects model was used to estimate a summary relative risk (RR) and a summary risk difference (RD) for recurrent UTI. Heterogeneity tests and subgroup analyses were carried out based on a priori hypothesis of plausible effect modification.

Main results

There were three trials (n = 151) comparing antibiotics with placebo/no treatment. The duration of antibiotic prophylaxis treatment varied among the studies (10 weeks to 12 months). The method of allocation concealment in the three trials was inadequate, unclear and adequate. The overall rate of recurrent UTI in the placebo/no treatment group was 63% (48/76). Compared to placebo/no treatment, antibiotics reduced the risk of recurrent UTI (RR 0.36, 95% CI 0.16 to 0.77; RD -46%, 95% CI -59% to -33%). No side effects were described

in any of these three trials.

There was one double-blinded trial (n = 120) with unclear allocation concealment that compared two different types of antibiotics to prevent recurrent UTI. Nitrofurantoin was more effective than trimethoprim in preventing recurrent UTI over a six month period (RR 0.48, 95% CI 0.25 to 0.92; RD -18%, 95% CI -34% to -3%). However, patients receiving nitrofurantoin were more likely to discontinue the antibiotic due to side effects (mainly gastrointestinal) than patients receiving trimethoprim (RR 3.17, 95% CI 1.36 to 7.37; RD 22%, 95% CI 8% to 36%).

Reviewers' conclusions

Most published studies to date have been poorly designed with biases known to overestimate the true treatment effect. Large, properly randomised, double blinded trials are needed to determine the efficacy of long-term antibiotics for the prevention of UTI in susceptible children.

Non-corticosteroid treatment for nephrotic syndrome in children. Ann Durkan et al, Australia.

Loss of protein in children with nephrotic syndrome can be reduced with non-corticosteroid drugs

Children with nephrotic syndrome lose excessive amounts of protein from their blood stream into their urine. This loss of protein causes tissue swelling, especially in the face, stomach and legs. The risk of infection also increases because important proteins used by their immune system have been lost. Corticosteroids such as prednisone can stop the protein leak but also have adverse effects of poor growth, cataracts, osteoporosis and high blood pressure. The review of trials compared several drugs and found cyclophosphamide, chlorambucil and levamisole are more effective than prednisone alone in preventing leaks reoccurring. More research is needed.

Background

Eighty to ninety per cent children with steroid sensitive nephrotic syndrome (SSNS) have one or more relapses. About half of these children relapse frequently and are at risk of the adverse effects of corticosteroids. Non-corticosteroid immunosuppressive agents are used to prolong periods of remission in children, who relapse frequently. However these non-corticosteroid agents also have significant potential adverse effects.

Currently there is no consensus as to the most appropriate second line agent in children who are steroid sensitive, but who continue to relapse. In this systematic review of randomised controlled trials (RCTs), the benefits and harms of these immunosuppressive agents are evaluated.

Objectives

To evaluate the benefits and harms of non-corticosteroid immunosuppressive agents in relapsing SSNS in children.

Search strategy

Published and unpublished randomised controlled trials were identified from the Cochrane Controlled Trials Register, MEDLINE, EMBASE, reference lists of articles, abstracts from proceedings and contact with known investigators in the area.

Selection criteria

Randomised or quasi-randomised trials were included if they were carried out in children (aged three months to 18 years) with relapsing SSNS, if they compared non-corticosteroid agents with placebo, prednisone or no treatment, different doses and/ or durations of the same non-corticosteroid agent, different non-corticosteroid agents and if they had outcome data at six months or more.

Data collection & analysis

Two reviewers independently reviewed all eligible studies for inclusion, assessed study quality and extracted data. The principle outcome measure was the number of children with and without relapse after six and 12 to 24 months. Secondary outcomes sought were the mean time to next relapse, the mean number of relapses per year and adverse events. A random effects model was used to estimate summary effect measures after testing for heterogeneity. Examination of possible between-study differences due to study quality, different interventions and different populations was attempted by subgroup analysis.

Main results

Eighteen trials involving 828 children were identified. Cyclophosphamide (three trials; relative risk (RR) 0.44; 95% confidence intervals (95% CI) 0.26 to 0.73) and chlorambucil (two trials; RR 0.13; 95% CI 0.03 to 0.57) significantly reduced the relapse risk at six to twelve months compared with prednisone alone. In the single chlorambucil versus cyclophosphamide trial, there was no observed difference in relapse risk at two years (RR 1.31; 95% CI 0.80 to 2.13). Cyclosporin was as effective as

cyclophosphamide (one trial, RR 1.07; 95% CI 0.48 to 2.35) and chlorambucil (one trial, RR 0.82; 95% CI 0.44 to 1.53) but the effect was not sustained when cyclosporin was ceased. During treatment levamisole (three trials, RR 0.60; 95% CI 0.45 to 0.79) was more effective than steroids alone but the effect was not sustained. Mizoribine (one trial) and azathioprine (two trials) were no more effective than placebo or prednisone alone in maintaining remission.

Reviewers' conclusions

Eight weeks courses of cyclophosphamide or chlorambucil and prolonged courses of cyclosporin and levamisole reduce the risk of relapse in children with relapsing SSNS compared with corticosteroids alone. Clinically important differences in efficacy among these agents are possible and further comparative trials are still needed. Meanwhile choice between these agents depends on physician and patient preferences related to therapy duration and the type and frequency of complications.

Recombinant human erythropoietin for chronic renal failure anaemia in pre-dialysis patients.
June Cody et al., UK.

Erythropoietin may help people with kidney failure and symptoms from anaemia who are not yet on dialysis.

Anaemia (low red blood cells) is a common complication of kidney failure. Anaemia causes some of the tiredness and problems associated with kidney failure. Manufactured erythropoietin (a hormone that increases red blood cell production) improves this, and is used by people on dialysis (treatment from an artificial kidney machine). The review of trials found it can also reduce anaemia for people with kidney failure who are not yet on dialysis. There may be increases in blood pressure. It is not known if erythropoietin use can delay the need for dialysis.

Background

Treatment with recombinant human erythropoietin (rHu EPO) in dialysis patients has been shown to be highly effective in terms of correcting anaemia and improving quality of life. There is debate concerning the benefits of rHu EPO use in pre-dialysis patients. There is a concern that rHu EPO may accelerate the deterioration in renal function, however the opposing view is that if rHu EPO is as effective in pre-dialysis patients that

by improving the patients sense of well-being the onset of dialysis could be delayed.

Objectives

To assess the effects of rHu EPO use in pre-dialysis patients with renal anaemia.

Search strategy

We searched MEDLINE (1980 to May Week 3 2001), EMBASE (1984 to Week 24 2001), BIOSIS (1985 to January 1997), CINAHL (1982 to October 1997), The Cochrane Library (Issue 1, 1997), CHEMABS (1984 to November 1996), SIGLE (1980 to June 1996), CRIB (10th edition, 1995), UK NRR (14TH consolidation, September 1996), RSC (1980 to February 1997), HealthSTAR (1995 to October 1997), IBSS (1984 to July 1997), NEED (July 1997) and reference lists of relevant articles. We contacted biomedical companies and investigators in the field and we hand searched *Kidney International* (including all supplements but excluding all conference proceedings except for 1994) July 1983 to May 1997 inclusive. The internet was also searched on: August 1997. We had also identified some studies from a previous broad search for all randomised controlled trials (RCTs) relevant to the management of end-stage renal disease. Date of the most recent search: June 2001.

Selection criteria

RCTs or quasi-RCTs comparing the use of rHu EPO with no rHu EPO or placebo in pre-dialysis patients.

Data collection & analysis

Only published data were used. Data were abstracted by a single investigator onto a standard form. A sample of the data abstracted was double-checked by another reviewer. The data abstracted were relevant to the predetermined outcome measures. Some authors were contacted to clarify how patients were allocated to groups. All authors from included studies were contacted for missing information.

Main results

Twelve studies with a total of 232 participants met the inclusion criteria and where possible data from these were summated by meta-analyses (Peto's Odds Ratio (OR) and Weighted Mean Difference (WMD)). The majority of the trials included small numbers and were of short duration (8-10 weeks) with the exception of three trials. There was a marked improvement in haemoglobin (mean difference 2.3g/dL, 95% CI 1.37 to 3.23) and haematocrit (WMD 9.92%, 95% CI 8.78 to 11.05) with the treatment and a decrease in the number of patients requiring blood transfusion (OR

0.25, 95% CI 0.09 to 0.69). The data from all studies which reported quality of life or exercise capacity demonstrated an improvement in the rHu EPO group. None of the measures of progression of renal disease (when a summary statistic was calculated) demonstrated a statistically significant difference. Though the requirement for antihypertensive treatment appears to be increased by rHu EPO (OR 1.84, 95% CI 1.02 to 3.32), there was no other statistically significant increase in adverse events.

Based on the limited current evidence, decisions therefore have to be made on whether the putative benefits in terms of quality of life identified in the review are worth the extra costs of pre-dialysis rHu EPO.

Reviewers' conclusions

This review has shown that treatment with rHu EPO in pre-dialysis patients corrects anaemia and avoids the requirement for blood transfusions.

There are also improvements in quality of life and exercise capacity. There may be increased hypertension. Most of the trials were not of sufficient duration to assess the effects of rHu EPO on progression of renal disease. In the long term, questions still remain about whether pre-dialysis rHu EPO either speeds up or delays the onset of dialysis. Thus there is insufficient evidence on the total costs and benefits of treating pre-dialysis patients with rHu EPO.

Next Issue...

The review process from title registration to publication.

Your comments on this newsletter are greatly appreciated. Please let us know if it is too long or too short, should come out more/less often (twice yearly at the moment) and what sort of things you would like to see included. If we have left out meetings or if you know dates for upcoming meetings please contact us.



Nephrology conferences



American Society of Nephrology/International Society of Nephrology World Congress of Nephrology October 13-17, 2001, San Francisco, California

2nd Symposium of the International Federation of Kidney Foundations. 18-19 October 2001, Los Angeles, USA (www.nephrology.rei.edu/IFKF.htm)

Renal disease in racial and ethnic minority groups. 19-20 Oct, 2001. Eldorado Hotel, Santa Fe, New Mexico. (david.pugsley@nwahs.sa.gov.au)

9th International Symposium on IgA Nephropathy. 1-2 Nov 2001. Kyongju, Korea (www.igan.net/Korea/Korea.htm)

IVth Bolivian Congress of Transplantation & VIth Bolivian Meeting of Nephrology 22-24 Nov 2001, Cochabamba, Bolivia.

Continance Foundation of Australia 23-25 Nov 2001 Hobart, Tasmania (eventsol@tpgi.com.au)

The 2nd International Congress On Immunosuppression 6-8 Dec 2001, San Diego, USA.

European Society of Pediatric Nephrology, Modern concepts and management of Paediatric Nephrolithiasis 17 Dec 2001 Institute of Child Health, London

International Conference on Dialysis IV Advances in ESRD 2002, January 23-25, 2002 Pointe Hilton - Tapatio Cliffs Resort, Phoenix, AZ (www.renalresearch.com/Events.htm)

Pediatric Nephrology Seminar XXIX 1-5 Mar 2002, Fontainebleau Hilton Hotel, Miami Beach, Florida.

11th International Congress on Nutrition & Metabolism in Renal Disease 29-31 Mar, 2002 Nagoya, JAPAN (www.med.nagoya-u.ac.jp/yoboiryo/icnrmrd/)

The British Renal Association 9-10 Apr 2002, The College of Ripon and York St John, York

Twentieth Annual Scientific Meeting of the Transplantation Society of Australia and New Zealand 10-12 Apr 2002 The Australian Academy of Science Canberra, Australia (www.racp.edu.au/tsanz/asm.htm)

European Society of Pediatric Urology 13th Annual Meeting 11-13 Apr 2002 Budapest, Hungary (convention.budapest@mail.datanet.hu; www.convention.hu)

Second International Conference on Pediatric Renal Replacement Therapy, 20-22 Jun 2002 Disney's Coronado Springs Resort and Conference Center, Orlando, Florida

European Renal Association & European Dialysis and Transplantation Association (ERA-EDTA), 14-17 Jul 2002, Copenhagen, Denmark (www.unipr.it/~eraedta)

ANZSN 38th Annual Scientific Meeting, Sep 2002, Sydney, Australia.

European Society of Pediatric Nephrology 2002, 20-23 Sep 2002, Bilbao, Spain

Chilean Society of Nephrology Meeting 3-5 Oct 2002, Chile.

9th Asian Pacific Congress of Nephrology 16-20 Feb 2003, Pattaya, Thailand.

Upcoming Cochrane workshops 2001/2002

Australasian Cochrane Centre/Cochrane Renal Group*

8-9 November 2001	Melbourne	Developing a protocol/using RevMan
15-16 November 2001	Sydney*	Developing a protocol/using RevMan
18-19 April 2002	Perth	Developing a protocol/using RevMan

Brazilian Cochrane Centre

30 October 2001	Sao Paulo	Developing a protocol/using RevMan
27 November 2001	Sao Paulo	Developing a protocol/using RevMan

Canadian Cochrane Centre

22-23 November 2001	Edmonton	Developing a protocol, completing a review
22-24 November 2001	Edmonton	Canadian Cochrane Centre Symposium "Marketing the Evidence" http://www.ualberta.ca/CCNC/symposium2001

Dutch Cochrane Centre

29 November 2001	Amsterdam	Developing a Systematic Review
------------------	-----------	--------------------------------

French Cochrane Centre

9-13 October 2001	Lyon	9 th International Cochrane Colloquium
-------------------	------	---

German Cochrane Centre

7-8 December 2001	Freiburg	Developing a protocol, using RevMan
-------------------	----------	-------------------------------------

Iberoamerican Cochrane Centre

8-9 November 2001	Barcelona	Developing a protocol, using RevMan
-------------------	-----------	-------------------------------------

UK Cochrane Centre

25-26 October 2001	Oxford	Preparing a protocol, using RevMan
5 November 2001	Liverpool	Preparing a protocol
12-13 November 2001	Edinburgh	Preparing a protocol, using RevMan
3 December 2001	Liverpool	Using RevMan
13-14 December 2001	London	Preparing a protocol, using RevMan

2nd International Symposium on Health Economics - Brazil

<http://www.economiadasaude.com.br/cursos.shtml>

20-21 November 2001	São Paulo	Health Technology Assessment
---------------------	-----------	------------------------------

Do we have your correct details?



**The Cochrane
Renal Group**

Please return if:

- Your contact details have changed
- You would like to be included on our mailing list
- You would like more information about becoming a member
- You would like to be removed from the mailing list

Name:

Title/position:

Interests:
.....

Address:
.....
.....
.....
.....

Phone:

Fax:

email:

Please fax to: +61 2 9845 3038
or post: The Cochrane Renal Group
Centre for Kidney Research
The Children's Hospital at Westmead
Locked Bag 4001
Westmead, NSW 2145
Australia

**The Cochrane Renal Group
Centre for Kidney Research
The Children's Hospital at Westmead
Locked Bag 4001
Westmead, NSW 2145
Australia**



Coordinator

Narelle Willis Tel: +61 2 9845 1292
 Fax: +61 2 9845 3038
 email: narellw2@chw.edu.au

Trials Search Coordinators

Ruth Mitchell Tel: +61 2 9845 3049
 Fax: +61 2 9845 3038
 email: ruthm4@chw.edu.au

Sandrine Dury email: sdury@free.fr
Gail Higgins Tel: +61 2 9845 3125
 Fax: +61 2 9845 3038
 email: gailh2@chw.edu.au

Supported by...



Commonwealth Department of
**Health and
Aged Care**



Based at:
**the
children's
hospital** at Westmead

Amgen

Aventis Pharma

Janssen-Cilag

Servier
