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CHBG NEWSLETTER

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The numbering is a continuation from Vol. 14, Issue 2, 2010

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127. Three dimensional versus two dimensional imaging for laparoscopic cholecystectomy. Gurusamy KS, Sahay S, Davidson BR.
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267. Methods of intra-peritoneal local anaesthetic instillation for laparoscopic cholecystectomy. Gurusamy Ks, Guerrini GP, Zinnuroglu M, Davidson BR.
268. Methods to decrease blood loss and transfusion requirements for liver transplantation. Gurusamy KS, Davidson BR.
269. Postexposure vaccines for hepatitis A. Irving GJ, Holden J, Pope D.
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271. Adefovir dipivoxil for chronic hepatitis B. Njet B, Kongnyuy EJ, Kibot L.
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374. Endoscopic injection of cyanoacrylate versus other endoscopic procedures for acute bleeding gastric varices in cirrhotic patients. Rios E, Seron P, Bonfill Cosp X.
375. Non-pharmacological and pharmacological interventions for primary prevention of gallbladder stones. Stokes C, Lammert F.
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377. Pentoxifylline versus corticosteroids for alcoholic hepatitis. Thiele M, Gluud LL, Krag A.
378. Chinese herbal medicines for adverse effects of chemotherapy in patients with primary liver cancer. Li X, Zhou Q, Liu JP, Tao K, Chen H, Ling C.
379. Chinese herbal medicine for liver fibrosis and/or cirrhosis. Tao K-M, Liu JP, Chen H-Y, Han M.
380. Magnetic resonance imaging versus liver biopsy for the diagnosis of patients with hepatic iron overload disorders. Finkenstedt A, Zoller H, Auer T.
381. ACE inhibitors for prevention of liver fibrosis progression in patients with chronic hepatitis C. Boleto GMG, Correia R.
382. Bisphosphonates for osteoporosis in primary biliary cirrhosis. Rudic JS, Giljaca V, Krstic MN, Bjelakovic G, Gluud C.
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384. Vitamin D supplementation for chronic liver diseases. Bjelakovic G, Gluud LL, Nikolova D,

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387. Hormone replacement for osteoporosis in women with primary biliary cirrhosis. Rudic JS, Poropat G, Krstic MN, Bjelakovic G, Gluud C.
388. Glycyrrhizin versus antiviral drugs for chronic hepatitis B virus infection. Xia Y, Liu JP, Gluud C.
389. Preexposure vaccines for hepatitis A. Irving GJ, Holden J, Pope D.
390. Nitazoxanide for chronic hepatitis C. Nikolova K, Awad T, Gluud C
391. Somatostatin analogues for polycystic liver disease in adults. Chavez-Tapia NC, Alfaro-Lara R, Barrientos-Gutierrez T, Roman-Sandoval JdJ, Mendez-Sanchez N, Tellez-Avila FI, Penninga L, Uribe M.
392. Serological laboratory tests for diagnosis of human leptospirosis in patients presenting with clinical symptoms. Goris MG A, Strijker M, BK Rachel, Hartskeerl R, Lucas C, Leeflang MM.
393. Postexposure vaccines for hepatitis A. Irving GJ, Holden J, Pope D.
394. Beta-blockers for secondary prevention in patients with oesophageal varices. Gluud LL, Krag A.
395. Medical interventions and banding ligation alone or combined for primary prevention in patients with oesophageal varices. Gluud LL, Krag A.
396. Medical interventions and banding ligation versus banding ligation for secondary prevention in patients with oesophageal varices. Gluud LL, Krag A.
397. Medical interventions and banding ligation versus medical interventions for secondary prevention in patients with oesophageal varices. Gluud LL, Krag A.
398. Beta-blockers for primary prevention in patients with oesophageal varices. Gluud LL, Krag A.

PAST EVENTS

JOINT COLLOQUIUM OF THE COCHRANE & CAMPBELL COLLABORATIONS. OCTOBER 18 TO 22, 2010

The Joint Colloquium of the Cochrane and Campbell Collaborations was held at the Keystone Resort in Colorado, USA. This was the first time for the two organisations to hold a combined colloquium.

Abstracts from colloquia are to be found at http://cochrane.org/colloquia/abstracts/.

The scientific programme was excellent, the nature fantastic, but air was thin and sparse.

For authors of Cochrane reviews!

During the 2010 Cochrane Colloquium in Keystone, it was decided that the domains 'baseline imbalance' and 'early stopping of trials' shall not be routinely judged when assessing the risk of bias in an included trial of a systematic review.

The argumentation for not considering baseline imbalance is that this imbalance may occur due to random error ('play of chance') and that such random error is likely to be levelled out by conducting a meta-analysis of several trials.

The argumentation for not considering early stopping is that such trials - although they may overestimate intervention effects - is likely counterbalanced by trials finding no significant difference. By solely excluding trials that are stopped early one would bias the meta-analysis towards a neutral effect.

The bias risks of the randomised trials included in the reviews is assessed separately and independently by authors of the review using the assessment criteria defined in the protocol. This should follow the Handbook.[1] Eventual differences in the bias risk of trials are resolved by discussion in order to reach consensus.

Methodological studies indicate that trials with unclear or inadequate methodological quality may be associated with risk of bias.[1-11] Such bias may lead to overestimation of intervention benefits. This is the case because the bias of the investigators is toward the benefit of the intervention.

Trials with adequate randomisation (both sequence generation and allocation concealment), blinding, and follow-up generate the most valid results. Unfortunately, such trials are often not available for meta-analyses. Of 370 drug trials, 28% reported adequate generation of the allocation sequence, 22% reported adequate allocation concealment, and 63% were double blind.[7] Accordingly, only 4% were adequate regarding all components. Subgroup analyses and meta-regression analyses are, therefore, important to evaluate the influence of risk of bias on the results.

Based on the recommendations in the Cochrane Reviewers' Handbook[1] and methodological studies[2-4;6], we suggest that authors of systematic reviews use the following definitions in the assessment of bias risk. Please note that specific circumstances may sometimes necessitate changes in the definitions or the use of additional risk of bias domains.

The following text is from The CHBG Module in The CLib, Issue 3, 2011:

Allocation sequence generation
- Low risk of bias: sequence generation was achieved using computer random number generation or a random number table. Drawing lots, tossing a coin, shuffling cards and throwing dice are adequate if performed by an independent adjudicator.
- Uncertain risk of bias: the trial is described as randomised, but the method of sequence generation was not specified.
- High risk of bias: the sequence generation method is not, or may not be, random. Quasi-randomised studies, those using dates, names, or admittance numbers in order to allocate patients are inadequate and will be excluded for the assessment of benefits but not for harms.

Allocation concealment
- Low risk of bias: allocation was controlled by a central and independent randomisation unit, sequentially numbered, opaque and sealed envelopes or similar, so that intervention allocations could not have been foreseen in advance of, or during, enrolment.
- Uncertain risk of bias: the trial was described as randomised but the method used to conceal the allocation was not described, so that intervention allocations may have been foreseen in advance of, or during, enrolment.
- High risk of bias: if the allocation sequence was known to the investigators who assigned participants or if the study was quasi-randomised. Quasi-randomised studies will be excluded for the assessment of benefits but not for harms.

Blinding
- Low risk of bias: the trial was described as blinded, the parties that were blinded, and the method of blinding was described, so that knowledge of allocation was adequately prevented during the trial.
- Uncertain risk of bias: the trial was described as blind, but the method of blinding was not described, so that knowledge of allocation was possible during the trial.
- High risk of bias, the trial was not blinded, so that the allocation was known during the trial.

Incomplete outcome data
- Low risk of bias: the numbers and reasons for dropouts and withdrawals in all intervention groups were described or if it was specified that there were no dropouts or withdrawals.
- Uncertain risk of bias: the report gave the impression that there had been no dropouts or withdrawals, but this was not specifically stated.
- High risk of bias: the number or reasons for dropouts and withdrawals were not described.

Selective outcome reporting
- Low risk of bias: pre-defined, or clinically relevant and reasonably expected outcomes are reported on.
- Uncertain risk of bias: not all pre-defined, or clinically relevant and reasonably expected outcomes are reported on or are not reported fully, or it is unclear whether data on these

outcomes were recorded or not.
- High risk of bias: one or more clinically relevant and reasonably expected outcomes were not reported on; data on these outcomes were likely to have been recorded.

To report on other bias in addition to the above mentioned (eg, industry bias, academic bias, etc), one should continue using the following pattern:

Other bias
- Low risk of bias: the trial appears to be free of other components that could put it at risk of bias.
- Uncertain risk of bias: the trial may or may not be free of other components that could put it at risk of bias.
- High risk of bias: there are other factors in the trial that could put it at risk of bias, eg, for-profit involvement, authors have conducted trials on the same topic etc.

One should also consider the administration of inappropriate treatment being given to the controls, such as suboptimal dosage of medication or a supraoptimal dosage of medication.

Trials assessed as having 'low risk of bias' in all of the specified in the review individual domains shall usually be considered 'trials with low risk of bias'. Trials assessed as having 'uncertain risk of bias' or 'high risk of bias' in one or more of the specified in the review individual domains shall be considered trials with 'high risk of bias'.

In a large number of reviews, such optimal division of trials may not be possible, simply due to the fact that there are no or there are very few trials with low risk of bias. If review authors have a suspicion that this may be so, they should try to formulate alternative ways of defining low-bias risk trials based on fewer components. Such definitions should preferably be considered at the protocol stage, well before embarking on data extraction and analyses. When drawing conclusions, however, it has to be remembered that no or only few trials with low risk of bias existed. Hence, the chance to know the 'true' intervention effect is low.

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COCHRANE CLINICAL SYMPOSIUM DURING THE UEGW MEETING IN BARCELONA, SPAIN. OCTOBER 23 TO 27, 2010

The Upper Gastrointestinal and Pancreatic Diseases Group and its Satellite Centre, the Cochrane Colorectal Cancer Group, and the Inflammatory Bowel Disease and Functional Bowel Disorders Group ran a symposium entitled: ‘Can evidence-based medicine help reduce cancer burden in gastroenterology?’ The symposium was Monday, 25 of October, from 2 pm to 3:30 pm.

THE 26TH BI-ANNUAL CHBG MEETING, NOVEMBER 1, AND EXHIBITION STAND DURING THE 61ST ANNUAL AASLD MEETING BOSTON, USA, OCTOBER 29 TO NOVEMBER 2, 2010

The Cochrane Hepato-Biliary Group and The American Association for the Study of Liver Diseases Joint Systematic Review Meeting for Practitioners was held on November 1 from 6:30 pm to 8:30 pm. For the first time since The CHBG started having meetings, the CHBG program was on the AASLD website, in the AASLD itinerary planner, and in the AASLD program book. We thank AASLD for this progress.

The meeting was a success. More than 200 people came to listen to the presentations.

Wiley also promoted our meeting at their new gastroenterology subject page - http://onlinelibrary.wiley.com/subject/code/000059.

The CHBG had a well visited stand during the AASLD meeting.

FUTURE EVENTS

THE 28TH BI-ANNUAL CHBG MEETING, APRIL 1, AND EXHIBITION STAND DURING THE 46TH ANNUAL MEETING OF THE EUROPEAN ASSOCIATION FOR THE STUDY OF THE LIVER (EASL), BERLIN, GERMANY, MARCH 30 TO APRIL 3, 2011

The CHBG meeting session will be held in Hall 7 at the ICC Berlin (the EASL venue), on April 1, 2011 from 6:15pm to 8:15pm. The room is for 240 people. The CHBG session programme is enclosed.

You are most welcome to bring colleagues and friends. The session is free of charge. Questions on how to contribute to the work of The CHBG can be asked at the end of the presentations or at The CHBG stand.

The CHBG is also going to have a stand during the EASL exhibition. You are most welcome to see us at booth #1706 in Hall 17.

We thank Professor Heiner Wedemeyer, EASL Secretary General, and the EASL Governing Board for providing The CHBG a free meeting room and a complimentary booth in the exhibition hall.

COCHRANE SYMPOSIUM DURING DDW 2011, MAY 7 TO 10, CHICAGO, USA

The Cochrane symposium 'Controversies and consensus: how Cochrane reviews guide therapy in inflammatory bowel disease' will be run on Monday May 9, 2011 at 4:00pm to 5:30pm. Its moderator is Brian Feagan, The Co-ordinating Editor of the Inflammatory Bowel Disease and Functional Bowel Disorders Group. The American Gastroenterological Association booked a 2000 seat venue for the symposium.

The programme of the DDW 2011 Cochrane Symposium is as follows:

1. John WD McDonald, Canada. *Induction of remission in Crohn's disease: a synthesis of data from Cochrane reviews.*
2. Tony Akobeng, UK. *Maintenance of remission in Crohn's disease: a synthesis of data from Cochrane reviews.*
3. Nilesh Chande, Canada. *An evidence-based treatment algorithm for Crohn's disease.*
4. John Marshall, Canada. *Induction of remission in ulcerative colitis: a synthesis of data from Cochrane reviews.*
5. Antje Timmer, Germany. *Maintenance of remission in ulcerative colitis: a synthesis of data from Cochrane reviews.*
6. Corey Siegel, USA. *An evidence-based treatment algorithm for ulcerative colitis.*

There will be a full page advertisement in the 2nd of March issue of *Alimentary Pharmacology* & *Therapeutics* and in the April issue of *Inflammatory Bowel Disease* journal.

The Cochrane Colorectal Cancer Group will have a stand during the exhibition. Meet them at booth # 2154.

For current information, check the web site http://www.ddw.org/wmspage.cfm?parm1=822

ILCA 2011 ANNUAL CONFERENCE, HONG KONG, SEPTEMBER 2 TO 4, 2011

The latest information on the program can be

found on the official website of the conference www.ilca2011.org.

Christian Gluud is among the presenters. Christian's presentation, entitled 'Levels of evidence: from case series to systematic reviews' is on September 3, 2011 at 1:30pm to 3:00 pm.

UPCOMING COCHRANE COLLOQUIUM

The upcoming 2011 Cochrane Colloquium will be held in Madrid, Spain from 19 to 22 of October.

For current information, check the web site (http://colloquium.cochrane.org/).

COCHRANE SYMPOSIUM DURING THE UNITED EUROPEAN GASTROENTEROLOGY WEEK (UEGW), STOCKHOLM, SWEDEN, OCTOBER 22ND TO 26TH, 2011

A representative from each of the four Cochrane Gastroenterology Groups will present at the Cochrane session.

The session will outline the strengths and limitations of systematic reviews and how Cochrane reviews can help resolve controversies in existing gastroenterology guidelines.

Peer Wille-Jørgensen, Co-ordinating Editor of The Colorectal Cancer Group and Christian Gluud from The CHBG will chair the session.

The program is:

Christian Gluud (DK). *Can you really believe systematic reviews?*

Brian Feagan, Co-ordinating Editor of the Inflammatory Bowel Disease and Functional Bowel Disorders Group (CA). *Crohn's disease guidelines: Europe versus the North America*.

Grigoris Leontiadis, Deputy Co-ordinating Editor of the Upper Gastrointestinal and Pancreatic Diseases Cochrane Group (CA). *Gastrointestinal bleeding guidelines.*

Richard L Nelson, Deputy Co-ordinating Editor of The Colorectal Cancer Group. *Clostridium difficile treatment guidelines.*

For current information, check the http://uegw11.uegf.org/.

THE 62ND ANNUAL AASLD MEETING NOVEMBER 4 TO 8, 2011, SAN FRANCISCO, CA, USA

Information on The 28th bi-annual CHBG meeting and exhibition stand during the AASLD meeting will be given after the summer as well as in the next Issue 2 of 2011 CHBG Newsletter.

VISITS 2011

Yun Xia, China, arrived on 16 of September, and by now she managed to prepare three systematic reviews in which the Chinese medicinal herbs, phyllanthus and glycyrrhizin are studied in patients with chronic hepatitis B virus infection. Yun Xia is a ph.d. student. Yun's stay is funded by The Chinese Government.

Goran Bjelakovic, Serbia, arrived on 16 of January and will stay until 15 of March. Goran managed to complete one new review with a title 'Vitamin D supplementation for prevention of mortality in adults', updated the 'Antioxidant supplements for prevention of mortality in healthy participants and patients with various diseases' review, and conduct one new protocol 'Vitamin D supplementation for chronic liver diseases'.

Jelena Rudic, Serbia, arrived on 16 of January and will stay until 17 of April. Jelena is working on three new reviews on medical interventions for primary biliary cirrhosis. She is also updating presently published reviews on primary biliary cirrhosis. The reviews are part of Jelena's ph.d. thesis in Serbia. Jelena obtained support for her accommodation from The Serbian Medical Society.

Chavdar Pavlov is the first author from Russia who visited The CHBG Editorial Team Office to work on three diagnostic test accuracy reviews. Chavdar arrived on February 1 and left February 25. Chavdar managed to draft three diagnostic test accuracy protocols with the titles: 'Transient elastography versus liver morphology for diagnosis of fibrosis in patients with alcoholic liver disease', 'Ultrasonography versus liver

morphology for diagnosis of fibrosis or steatosis in patients with alcoholic liver disease', and 'FibroTest alone versus FibroTest plus transient elastography for diagnosis of fibrosis in adult patients with chronic hepatitis C'.

HOW TO WRITE RESPONSES TO COMMENTS FROM PEER REVIEWERS

We felt that the following text should be republished as there is still more to be desired from CHBG authors sending replies to comments, be it from peer reviewers or editors.

Authors of reviews and protocols are asked to submit a cover letter with point-to-point replies to the raised comments by the peer reviewers, contact editor, or editors, alongside with the revised version of the protocol or review. While the protocol or review is uploaded on Archie, the cover letter is usually sent by e-mail to the Managing Editor but addressed to the Contact Editor. The cover letter is a different document than the protocol or review checklists.

When you start preparing your cover letter, start with the title of the review and the names of the authors. Address the cover letter to the Contact Editor, writing also his or her name. Copy or retype the comments of all peer reviewers.

You shall start providing answers under each of the raised items by the peer reviewers. When you have made a change based on a comment or a suggestion, write for example: Thank you for the good comments. We have now written; or the sentence now reads, etc (and then you shall cite exactly the way the text reads in this new version of the protocol or review). When you decide to not make a suggested change, you shall justify why you think the change you are requested/suggested to make would not be appropriate. Continue in the same way. Be sure that you do not omit any raised point.

Usually, changing sentences and their structure, adding text, etc requires another global polishing of the whole review text, tables, figures, references, etc. Be sure that your text is grammatically sound. Print out and check before you submit. Please manually check for spelling errors and typos.

It could be that the Contact Editor has also made comments. You shall address these comments in the same cover letter. Finish your cover letter with your full name plus the names of the review authors who have contributed to the revision. Do not forget to write the place and the date when you have written the letter.

You may also upload the cover letter on Archie within the Notes section of the protocol or review document. However, please do not forget to share it with the authors and the editorial team. Otherwise we cannot read it. The help function in Archie will guide you how to work with 'Notes'.

Do not forget to mark the protocol or review for 'Editorial Write Phase' when you check it back on Archie. This will create an automated e-mail to the Managing Editor.

The protocol or review checklists can be downloaded from The CHBG website (http://ctu.rh.dk/chbg) under Newsletters and Letters.

We, of course, assume that the revision of the protocol or review is performed with the common efforts of the authors and that all review authors have approved of the revised version.

NEWS OF IMPORTANCE TO AUTHORS

RevMan 5.1

RevMan 5.1 is ready to be released to authors. The release date for RevMan 5.1 will be 22 March 2011 in order to give editorial teams and authors time to be trained and become familiar with the new content options before editorial teams and authors start to use it.

RevMan 5.1 is not a major structural change, but there are several improvements that you need to be aware of, in particular the changes to the Cochrane 'Risk of bias' tool.

Arrangements are already well underway for other support materials, including a document

outlining the new features and the implications for existing reviews as well as new and updated reviews. An update to The Cochrane Handbook to reflect the changes to the 'Risk of bias' tool will also be released. The Collaboration will also send all authors an e-mail letter to inform authors of the release of RevMan 5.1 and the implications for them.

For more information about RevMan 5.1, see http://ims.cochrane.org/revman/revman5.1.

ELECTRONIC 'LICENCE FOR PUBLICATION' FORMS

Dear Cochrane author,

The Cochrane Collaboration has now introduced electronic Licence for Publication forms for reviews. Previously, you had to either sign a paper copy of the form or sign it electronically and fax, post, or email it to your Managing Editor. With the introduction of the new electronic system, the process should be simpler.

Your Managing Editor will send you an email with a link to an online Licence for Publication form whenever a form is required for your review. The link in the email will lead you through the Archie login page (after entering your Archie username and password for authentication) to your individual Licence for Publication web form. Here all you need to do is to read and accept the licence, type in your name, and click a button. (Please note that if you do not have an Archie account already, you do not have to do anything now. Your Managing Editor will organise an account for you when it is required.) The email you receive through the new system will also have, as an attachment, a PDF of the proof of your review. You will also be able to read the final version of your review within the Licence for Publication form before accepting the Licence. Although the proof should be the final version for publication, in exceptional circumstances, minor changes may be made to your review just before publication. In the event of such changes to your review, if you choose to receive notification of changes, you will be sent a new PDF file and a link that allows you to quickly identify the changes. If necessary, you will also be able to retract a submitted form up until the deadline for the next submission of reviews for publication in the Cochrane Database of Systematic Reviews (CDSR).

It is important to note that the system will not release the review to our publishers for publication until all authors have accepted the licence and submitted their forms. In other words, if one author does not sign the form by the submission deadline, it will not be published in the next issue of the CDSR; the review will not be published until the Licence has been accepted by all the authors named on the byline.

If you experience technical problems or there are other reasons that prevent you from accessing the electronic Licence for Publication form, it is important that you contact your Managing Editor. You will still be able to use the old methods of sending your signed form to your Managing Editor.

If you want to know more about the new forms, please consult the online documentation in Archie. If you have any further questions, please contact your Managing Editor.

Best wishes,
David Tovey, Editor in Chief, The Cochrane Library.
Rasmus Moustgaard, Cochrane IMS Team.

STANDARDISING OUTCOME MEASURES IN CHBG REVIEW PROTOCOLS

On a CHBG Editors' telephone conference on February 14, we discussed what the outcome measures in CHBG review protocols shall be and whether we shall standardise outcome measures in CHBG review protocols, still keeping in mind the review topic. We would like to direct the attention of especially new authors on this very important issue within Cochrane CHBG review protocols.

1. In general, selection of review protocol outcome measures and their listing shall follow the Guidelines in Higgins JPT, Green S (editors). Higgins JPT, Green S (editors). *Cochrane Handbook for Systematic Reviews of Interventions* Version 5.0.2 [updated September 2009]. The Cochrane Collaboration, 2009. Available from www.cochrane-handbook.org.

In the Handbook on p.88 to p.90 you will read:

"5.4.2 Prioritizing outcomes: main, primary and secondary outcomes

Main outcomes
Once a full list of relevant outcomes has been compiled for the review, authors should prioritize the outcomes and select the main outcomes of relevance to the review question. The main outcomes are the essential outcomes for decision-making, and are those that would form the basis of a 'Summary of findings' table. 'Summary of findings' tables provide key information about the amount of evidence for important comparisons and outcomes, the quality of the evidence and the magnitude of effect (see Chapter 11, Section 11.5). There should be no more than seven main outcomes, which should generally not include surrogate or interim outcomes. They should not be chosen on the basis of any anticipated or observed magnitude of effect, or because they are likely to have been addressed in the studies to be reviewed.

Primary outcomes
Primary outcomes for the review should be identified from among the main outcomes. Primary outcomes are the outcomes that would be expected to be analysed should the review identify relevant studies, and conclusions about the effects of the interventions under review will be based largely on these outcomes. There should in general be no more than three primary outcomes and they should include at least one desirable and at least one undesirable outcome (to assess beneficial and adverse effects respectively).

Secondary outcomes
Main outcomes not selected as primary outcomes would be expected to be listed as secondary outcomes. In addition, secondary outcomes may include a limited number of additional outcomes the review intends to address. These may be specific to only some comparisons in the review.

For example, laboratory tests and other surrogate measures may not be considered as main outcomes as they are less important than clinical endpoints in informing decisions, but they may be helpful in explaining effect or determining intervention integrity (see Chapter 7, Section 7.3.4).

Box 5.4.a summarizes the principal factors to consider when developing criteria for the 'Types of outcomes'." (*end of citation*)

2. Review protocol outcome measures should include clinical outcome measures no matter the clinical outcome measures reported in the trials one is going to include in the review. Trial culture shall never be the culture of systematic reviews, as most trialists, for example, select ten to fifteen outcomes but report only on a selected few.

3. Mortality should stand alone, and it should be the first primary outcome.

4. Morbidity from the disease should be the second primary outcome.

5. Adverse events should be included as a primary outcome unless the review topic or title formulation precludes the occurrence of an adverse event.

6. Quality of life, even that it is seldom reported, should be included as a primary outcome or as one of the secondary outcomes.

7. Surrogate outcomes (especially non-validated ones) should be included only as secondary outcomes.

8. Health economics. This outcome should preferably be the subject of a separate review, see Chapter 15 in the Handbook.

9. Composite outcomes. If trial authors have failed in reporting the separate components of composite outcomes in separate, it is up to the judgement of the review authors to meta-analyse them together or not.

We should continue to work on defining fixed outcomes depending on the review topic, eg, interventions for chronic hepatitis B, or chronic hepatitis C. This will help authors, consumers, and policy makers in preparing or using also overview of reviews, as well as preparation of 'Summary of findings' tables and their understanding, respectively.

THE COCHRANE COLLABORATION AS A NON-GOVERNMENTAL ORGANIZATION IN OFFICIAL RELATIONS WITH THE WORLD HEALTH ORGANIZATION

The following text is with abbreviations:

"The Cochrane Collaboration has been accepted as a non-governmental organization in official relations with the World Health Organization (WHO) at the WHO's Executive Board meeting in Geneva, Switzerland. In formalizing Cochrane relationship with the WHO, The Cochrane Collaboration has been awarded a seat at the World Health Assembly, allowing the Collaboration to provide input on WHO health resolutions.

"*Formulating an official partnership with an influential institute such as the World Health Organization is an honour. This speaks volumes about the work of Cochrane in evidence-based health care,*" says Jeremy Grimshaw, Co-Chair of the Steering Group.

"*The Cochrane Collaboration provides an international benchmark for the independent assessment and assimilation of scientific evidence. It is a leading producer of high quality systematic reviews in health care*," adds Marie-Paule Kieny, Assistant Director General, Innovation Information Evidence and Research at the World Health Organization. "

You can read more in the official press release announcing this story on www.cochrane.org.

The Cochrane Hepato-Biliary Group (The CHBG) Newsletter is written, edited, and published in electronic and paper format by staff at The CHBG Editorial Base in Copenhagen, Denmark. It is issued twice a year and distributed for free in paper and electronic formats world-wide to all people on The CHBG members' list who have contributed, are contributing, or have shown interest in the work of The CHBG. The purpose with The CHBG Newsletter is to inform its readers about activities within The CHBG.

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The Cochrane Hepato-Biliary Group (THE CHBG)

PROGRAMME
of
The 28TH Cochrane Hepato-Biliary Group Meeting

Date: April 1, 2011.
Time: 6:15 pm to 8:15 pm.
Place: Hall 7 at Messe Berlin, Messedamm 22, 14055 Berlin, Germany.

Moderator: Christian Gluud, DK.

6:15pm – 6:35pm	Wound infiltration with local anaesthetic agents for laparoscopic cholecystectomy. A Cochrane Hepato-Biliary Group systematic review.	Kurinchi Gurusamy (UK), Yogesh Kumar (UK), Brian Davidson (UK).
6:35pm – 6:55pm	Antibody induction therapy for liver transplant recipients. A Cochrane Hepato-Biliary Group systematic review.	Luit Penninga (DK), Andre Wettergren (DK), Daniel A Steinbrüchel (DK), Christian Gluud (DK).
6:55pm – 7:15pm	Phyllanthus species versus placebo, no intervention, or versus other antiviral drugs for chronic hepatitis B virus infection. Two Cochrane Hepato-Biliary Group systematic reviews.	Yun Xia (CHI), Hui Luo (CHI), JianPing Liu (CHI), Christian Gluud (DK).
7:15pm – 7:35pm	Bezafibrate for primary biliary cirrhosis. A Cochrane Hepato-Biliary Group systematic review.	Jelena Rudic (SER), Goran Poropat (CRO), Miodrag Krstic (SER), Goran Bjelakovic (SER), Christian Gluud (DK).
7:35pm – 7:55pm	Bisphosphonates for osteoporosis in primary biliary cirrhosis. A Cochrane Hepato-Biliary Group systematic review.	Jelena Rudic (SER), Vanja Giljaca (CRO), Miodrag Krstic (SER), Goran Bjelakovic (SER), Christian Gluud (DK).
7:55pm – 8:13pm	Branched-chain amino acids for hepatic encephalopathy. A Cochrane Hepato-Biliary Group systematic review.	Lise Lotte Gluud (DK), Christian Gluud C (DK), Niels Risum (DK), Hans Timm (DK), Bodil Als-Nielsen B (DK).
8:13pm – 8:15pm	Closing remarks.	Christian Gluud (DK).