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CHBG NEWSLETTER

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427. Extracorporeal shock wave lithotripsy for bile stones. Veedfald S, Penninga L, Gluud C, Wettergren A.
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PAST EVENTS

THE 19TH COCHRANE COLLOQUIUM

The 2011 19th Cochrane Colloquium was held in Madrid, Spain from 19 to 22 of October. The theme was 'Scientific evidence for healthcare quality and patient safety'. There were a number of workshops and sessions on diagnostic test accuracy reviews.

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

The 29th bi-annual CHBG meeting was run November 7, 2011 from 12:30 to 14:00 at Room Nob Hill CD, at Marriott Marquis Hotel, San Francisco, California, USA. We thank the presenters for very interesting presentations. We wished that more people had found the meeting room!

The CHBG exhibition stand during the AASLD meeting was well attended.

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

A representative from four of the seven Cochrane Groups dealing with gastroeneterology issues presented at the Cochrane session.

The session outlined the strengths and limitations of systematic reviews and how Cochrane reviews could help resolve controversies in existing gastroenterology guidelines.

Christian Gluud (DK) presented "Can you really believe systematic reviews?" and stressed that it is due to often very sparse data, and repetitive testing on cumulative data was necessary to address the risks of random errors much more stringently than hitherto conducted in systematic reviews. He suggested that all meta-analyses should be subjected to trial sequential analysis. The software and a Handbook are available at: www.ctu.dk/tsa.

For information about future congresses, visit http://uegw11.uegf.org.

FUTURE EVENTS

EVIDENCE-BASED MEDICINE PRACTICE COURSE AND WORKSHOP, RIJEKA, CROATIA. MARCH 2 TO 4, 2012.

Evidence based medicine practice course and workshop will be held from 2 to 4 of March, 2012 in Rijeka, Croatia. The Cochrane Hepato-Biliary Group, Copenhagen, Denmark; the School of Medicine, University of Rijeka, and the Croatian Society for Quality Improvement in Health Care are its organisers. Tutors are CHBG members from Croatia, Denmark and Serbia.

THE 30TH BI-ANNUAL CHBG MEETING, APRIL 18, AND EXHIBITION STAND DURING THE 47TH ANNUAL MEETING OF THE EUROPEAN ASSOCIATION FOR THE STUDY OF THE LIVER (EASL), BARCELONA, SPAIN, APRIL 18 TO APRIL 22, 2012

The CHBG meeting will be run on 18 of April from 6:00 pm to 7:30 pm, room number 124, at the Centre Convencions Internacional (CCIB). Attendance is free of charge.

The CHBG booth number is 37. We will be most happy to see you also at the exhibition stand.

VISITS 2011 – 2012

Mieke Lamers, The Netherlands, worked at The CHBG Editorial Team Office from 11 December to February 29, 2011. The aim of Mieke's visit was to be trained in preparation of Cochrane systematic reviews based on meta-analyses of randomised clinical trials and on trial sequential analysis (http://ctu.dk/tsa). During Mieke's stay, Mieke worked on two CHBG reviews, i.e., 'Aminoadamantanes for chronic hepatitis C' and 'Aminoadamantanes versus other antiviral drugs for chronic hepatitis C'. It is nice to note that Mike finalised the two protocols and managed to also finalise one of the reviews with more than 40 trials included.

Jelena Rudic, Serbia, worked at The CHBG Editorial Team Office from January 18 to February 7, 2012. Jelena worked on one systematic review, ie, 'Ursodeoxycholic acid for primary biliary cirrhosis'. Jelena left with a finalised review.

We thank all our visitors for their dedication and commitment to CHBG work.

NEWS OF IMPORTANCE TO AUTHORS

STANDARDISING OUTCOME MEASURES IN CHBG REVIEW PROTOCOLS

Following a CHBG Editors' telephone conference on February 14, the CHBG continues its efforts in standardising outcome measures in review protocols. Please read current recommendations.

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 5.1.0 March 2011. The Cochrane Collaboration, 2009. Available from www.cochrane-handbook.org.

See the following section in the Handbook:

"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, in general, be the first primary outcome.

4. Morbidity from the disease should, in general, 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, e.g., 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.

Should you wish to share your opinion or comment on outcomes defined in published protocols after April 2011, please do not hesitate to contact staff at The CHBG Editorial Team Office.

AUDIT OF THE ABSTRACT, PLAIN LANGUAGE SUMMARY, AND SUMMARY OF FINDINGS TABLES IN PUBLISHED COCHRANE REVIEWS
The Cochrane Editorial Unit in Oxford, UK, based on the audit on abstracts of new Cochrane reviews, have prepared recommendations on how the abstract of an intervention review should be reported. Below are the recommendations which

CHBG authors should follow and incorporate in their reviews.

1. The word limit of abstracts is now increased from 400 to an absolute limit of 1000 words; however, authors are, in general, encouraged to make abstracts no longer than 700 words.

2. There should be:
- Clear description of the question addressed by the review.
- Explicit description of the intervention(s) and comparisons.
- Inclusion of the date(s) and scope of search(es).
- Comment on the risk of bias of included trials.
- Description of the number of trials and participants in the review.
- Clear and consistent description of results for important outcomes, including a comment if no studies measured them.
- Absolute effects should be reported alongside relative effects in the abstract.

E.g., "Meta-analysis of five trials comparing interferon alpha with no-treatment control group included 169 participants. There were seven drop-outs in the treatment group and nine in the control group. One patient out of 92 (1.1%) died in the interferon alpha group compared with zero out of 77 (0.0%) in the no-intervention control group (risk ratio (RR)) 3.00; 95% confidence interval (CI) 0.14 to 66.5). Interferon alpha led to failure of end of treatment virological response in 62/92 (67.4%) of the patients compared with 71/77 (92.2%) in the untreated controls (RR 0.76, 95% CI 0.66 to 0.87, P = 0.0001 by fixed-effect model and RR 0.71, 95% CI 0.43 to 1.16, P = 0.17 by random-effects model). Failure of normalisation of alanine aminotransferase (ALT) at the end of treatment was seen in 60/92 (65.2%) patients treated with interferon alpha versus 76/77 (98.7%) in the control group (RR 0.69, 95% CI 0.59 to 0.80, P < 0.00001). Sustained virological response was not achieved in 76/92 (82.6%) of patients on interferon compared with 73/77 (94.8%) of controls (RR 0.89, 95% CI 0.80 to 0.98, P = 0.02). Serum alanine amino-transferase was abnormal in 81/92 (88.0%) treated with interferon alpha patients at six months post-treatment follow-up compared with 76/77 (98.7%) in controls (RR 0.92, 95% CI 0.84 to 0.99, P = 0.04). There was no significant histological improvement in 67/92 (72.8%) patients treated with interferon alpha compared with 65/77 (84.4%) in controls (RR 0.86, 95% CI 0.74 to 1.00, P = 0.06)."

From: Abbas Z, Khan MA, Salih M, Jafri W. Interferon alpha for chronic hepatitis D. Cochrane Database of Systematic Reviews 2011, Issue 12. Art. No.: CD006002. DOI: 10.1002/14651858.CD006002.pub2.

E.g., We included two trials with 493 randomised participants with various Child-Pugh scores. The trials had a low risk of bias. The rHuFVIIa administration did not reduce the risk of mortality within five days (21/288 (7.3%) versus 15/205 (7.3%); risk ratio (RR) 0.88, 95% confidence interval (CI) 0.48 to 1.64, $I^2$49%) and within 42 days (5/286 (1.7%) versus 36/205 (17.6%); RR 1.01, 95% CI 0.55 to 1.87, $I^2$55%) when compared with placebo. Trial sequential analysis demonstrated that there is sufficient evidence to exclude that rHuFVIIa decreases mortality by 80%, but there is insufficient evidence to exclude smaller effects. The rHuFVIIa did not increase the risk of adverse events by number of patients (218/297 (74%) and 164/210 (78%); RR 0.94, 95% CI 0.84 to 1.04, $I^2$1%), serious adverse events by adverse events reported (164/590 (28%) versus 123/443 (28%); RR 0.91, 95% CI 0.75 to 1.11, I^2 0%), and thromboembolic adverse events (16/297 (5.4%) versus 14/210 (6.7%); RR 0.80, 95% CI 0.40 to 1.60, $I^2$0%) when compared with placebo."

From: Martí-Carvajal AJ, Karakitsiou D-E, Salanti G. Human recombinant activated factor VII for upper gastrointestinal bleeding in patients with liver diseases. Cochrane Database of Systematic Reviews 2012, Issue 3 . Art. No.: CD004887. DOI:10.1002/14651858.CD004887. pub3 .

- Full and consistent reporting of benefits and harms and overall conclusions across the abstract, plain language summaries and summary of findings tables.

As the abstract, plain language summaries and summary of findings tables contain the key information in Cochrane Reviews, it is expected

that the above set of criteria will contribute to reporting guidelines for abstracts of systematic reviews being developed by Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) (http://www.prisma-statement.org).

ABSTRACT CHECKLIST BASED ON CRITERIA PROVIDED IN THE COCHRANE HANDBOOK (CHAPTER 11)

Before submitting a review for editorial approval, authors must check the abstract of the review against the following checklist:

1. In the background section, does the abstract explain the context or elaborate on the purpose and rationale of the review?
2. In the objectives section, does the abstract include the following information: intervention or comparison, type of people, disease or problem, and setting (if specified)?'
3. In the search methods section, does the abstract list the sources and the dates of the last search for each source?
4. In the selection criteria section, does the abstract include the following: type of study, intervention or comparison, and type of people, disease or problem?
5. In the data collection and analysis section, does the abstract include details of how many people extracted data?
6. In the main results section, does the abstract list the total number of studies included in the review?
7. In the main results section, does the abstract list the total number of participants included in the review?
8. In the main results section, does the abstract include brief details of the comparability of the studies, if applicable?
9. In the main results section, does the abstract include brief details of the risk of bias of the studies, if applicable?
10. In the main results section, does the abstract include the results of the primary outcome and no more than five other results?
11. In the main results section, does the abstract include whether or not adverse effects were identified, and if so, the findings?
12. In the main results section, is there an explanation of the size and direction of effect to accompany the numerical results?
13. In the main results section, are the summary statistics presented in a standard way? See already given examples as well as the following example:

"Bezafibrate compared with no intervention significantly decreased plasma immunoglobulin M (MD -164.00 mg/dl, 95% CI -259.47 to -68.53; 3 trials with 50 patients; I^2 = 46%) and serum bilirubin concentration (MD -0.19 mg/dl, 95% CI -0.38 to -0.00; 2 trials with 34 patients; I^2 0%). However, the latter two results were not supported by trial sequential analyses".

From: Rudic JS, Poropat G, Krstic MN, Bjelakovic G, Gluud C. Bezafibrate for primary biliary cirrhosis. Cochrane Database of Systematic Reviews 2012, Issue 1. Art. No.: CD009145. DOI: 10.1002/14651858.CD009145.pub2.

Consider carefully when to present data with the risk ratio and when with the odds ratio, and should you compare them by providing the risk difference (i.e., their difference in risk), see relevant chapters in the Handbook (www.cochrane-handbook.org) (e.g., 9.2.2.1 Risk and odds).
14. In the main results section, are risks of events (percentage) or averages (for continuous data) reported for both comparison groups?
15. Is the information in the main results and conclusions sections consistent with each other?
16. Does the abstract avoid making recommendations?
17. Is there a summary of findings table(s)?
18. Is the summary of findings table(s) in the appropriate format?
19. Is the plain language summaries title a clear re-statement of the title and not a conclusion?
20. Are the findings reported in the plain language summaries consistent with those of the abstract?

PLAIN LANGUAGE SUMMARIES

The Cochrane Collaboration now recommends that the titles of plain language summaries shall contain an absolute maximum of 150 characters (approximately 25 words) and that longer titles should be amended.

The rationale for requesting these changes now includes the extremely sub-optimal way that these summary titles will appear when presented on PubMed Health, a service from the US National Library of Medicine (NLM) aimed at the public, but the same holds true for the presentation on The Cochrane Library and also for the proposed new consumer portal on the Collaboration's own site.

Authors of plain language summaries shall avoid declarative titles as these are contrary to Handbook guidance.

Though the current guidance on overall word count for plain language summaries is limited to 400 words, authors of plain language summaries may write the summary longer than that, as feedback from readers read that they would also like to find some background information on the question that is being addressed by the review, in addition to a description of the methods and results. Therefore, feedback is now to be taken into consideration and for longer summaries authors are strongly encouraged to break up the text into digestible sections by paragraph breaks and headings as appropriate.

Authors of plain language summaries shall ensure that the text is entirely consistent with the findings of the rest of the review.

THE COCHRANE CO-PUBLICATION POLICY

The Cochrane Policy Manual (http://www.cochrane.org/policy-manual/welcome) outlines the principles and processes for co-publishing Cochrane Reviews outside The Cochrane Library. The section of the manual that has been revised is 2.2.5 (http://www.cochrane.org/policy-manual/225-publication-versions-cochrane-reviews-print-journals). Appendix 2 contains the form to request co-publication.

The table listing the existing agreements with journals for co-publishing Cochrane Reviews is populated over time.

COPY-EDITING POLICY

The Cochrane Editorial Unit, Oxford, UK, now requires that all Cochrane protocols and reviews should be sent by the Cochrane Collaborative Group to the Copy-editing Support Team. However, this does not mean that authors should submit their protocols or reviews for editorial consideration without following the Cochrane Collaboration Style Guidelines that you will find at http://www.cochrane.org/training/authors-mes/cochrane-style-resource or through RevMan help.

COCHRANE ONLINE LEARNING

All authors of intervention reviews may register and receive training online. To do this, visit the webpage - http://training.cochrane.org.

The Diagnostic Test Accuracy Working Group lists training events for authors of diagnostic reviews on their website http://srdta.cochrane.org/workshops-and-events.

RISKS OF RANDOM ERRORS

When few and small trials are combined in meta-analyses, the risk of introducing random errors increase due to sparse data and due to multiplicity when conducting cumulative meta-analyses.[1,2] The CHBG, therefore, urge review authors to consider employing trial sequential analyses of their meta-analyses.[1-5] During an Editorial Group meeting in Copenhagen in April 2009, the Editors decided to advise to use trial sequential analysis for every important analysis in CHBG reviews in order to test for robustness.

An example of a text in a protocol can be:

Trial sequential analysis

Trial sequential analysis will be applied because cumulative meta-analyses are at risk of producing random errors due to sparse data and repetitive testing of the accumulating data.[1] To minimise random errors, we will calculate the required information size (i.e., the number of participants needed in a meta-analysis to detect or reject a certain intervention effect).[1] The required information size calculation should also account for the heterogeneity or diversity present in the meta-analysis.[1,5] In our meta-analysis, the required information size will be based on the

event proportion in the control group; assumption of a plausible RR reduction of 20%, or on the RR reduction observed in the included trials with low risk of bias; a risk of type I error of 5%; a risk of type II error of 20%; and the assumed heterogeneity or diversity of the meta-analysis.[1,5,6,7]

The underlying assumption of trial sequential analysis is that testing for significance may be performed each time a new trial is added to the meta-analysis. We will add the trials according to the year of publication, and if more than one trial has been published in a year, trials will be added alphabetically according to the last name of the first author. On the basis of the required information size, trial sequential monitoring boundaries will be constructed.[1,6,7] These boundaries will determine the statistical inference one may draw regarding the cumulative meta-analysis that has not reached the required information size; if the trial sequential monitoring boundary is crossed before the required information size is reached, firm evidence may perhaps be established and further trials may turn out to be superfluous. On the other hand, if the boundary is not surpassed, it is most probably necessary to continue doing trials in order to detect or reject a certain intervention effect.

One may access the Trial Sequential Analysis software at www.ctu.dk/tsa.

References:

1. Wetterslev J, Thorlund K, Brok J, Gluud C. Trial sequential analysis may establish when firm evidence is reached in cumulative meta-analysis. Journal of Clinical Epidemiology 2008;61:64-75.
2. Brok J, Thorlund K, Gluud C, Wetterslev J. Trial sequential analysis reveals insufficient information size and potentially false positive results in many meta-analyses. Journal of Clinical Epidemiology. 2008. DOI:10.1016/j.jclinepi.2007.10.007.
3. Brok J, Thorlund K, Wetterslev J, Gluud C. Apparently conclusive meta-analyses may be inconclusive - Trial sequential analysis adjustment of random error risk due to repetitive testing of accumulating data in apparently conclusive neonatal meta-analyses. International Journal of Epidemiology. 2009;38(1):287-98.
4. Thorlund K, Devereaux PJ, Wetterslev J, Guyatt G, Ioannidis JP, Thabane L, Gluud LL, Als-Nielsen B, Gluud C. Can trial sequential monitoring boundaries reduce spurious inferences from meta-analyses? International Journal of Epidemiology. 2009;38(1):276-86.
5. Wetterslev J, Thorlund K, Brok J, Gluud C. Estimating required information size by quantifying diversity in random-effects model meta-analyses. BMC Medical Research Methodology 2009;9:86.
6. Thorlund K, Engstrøm J, Wetterslev J, Brok J, Imberger G, Gluud C. User manual for trial sequential analysis (TSA). Copenhagen Trial Unit, Centre for Clinical Intervention Research, Copenhagen, Denmark. 2011. p. 1-115. Available from www.ctu.dk/tsa
7. TSA – Trial Sequential Analysis. http://ctu.dk/tsa.

VACANCIES

The CHBG is accepting applications for Editors' positions from all-over the world

The Cochrane Hepato-Biliary Group (CHBG), part of The Cochrane Collaboration (www.cochrane.org), has ten available positions for editors. The main products of The CHBG are systematic reviews of interventions based on available evidence from randomised clinical trials as well as systematic reviews of diagnostic test accuracy based on available evidence from studies of various designs. The CHBG peer reviewed protocols and reviews are published in The Cochrane Library (http://www.thecochranelibrary.com). The CHBG has open peer reviewed process, i.e., names of peer reviewers as well as editors are public when the respective protocol or review is published.

The ideal candidates are expected to do extensive work in order to ensure that the content of the CHBG protocols and reviews is up to date and free of errors.

Core duties and responsibilities of the Editors:

- Review the content of the submitted protocols and reviews for publication. Work closely with the Managing Editor and the whole CHBG Editorial Team to ensure that each protocol and review complies with the guidelines provided in The Cochrane Handbook for Systematic Reviews of Interventions and The CHBG Module.
- Check thoroughly facts, data, methodology, and statistic analyses, and based on that to prepare comments for the authors before and after peer reviewers' comments.
- Verify that the submitted material is

scientifically accurate and supported by references.
- Participate in telephone conferences or face-to-face meetings organised by the CHBG Editorial Team office when needed.
- Participate in Cochrane colloquia and workshops.
- Be active and work to improve CHBG working policies.

We expect candidates to:
- be medical doctors/surgeons with specialty in hepatology/gastroenterology having additional knowledge in methodology and statistics;
- possess communication skills and have eye for detail, including command of the English language and its nuances;
- have published evidence-based systematic reviews;
- commit to a 3- to 5-year term, during which time to expect to be able to meet 12 deadlines a year and be good at communicating with editorial team staff, the other CHBG editors, and can handle timeline pressure;
- use computer and Internet;
- be willing to learn how to use and work with Cochrane software;
- follow strictly WAME's research and publications ethics.

The editor's work is voluntary; it may take up to 6 hours a week.

The Cochrane Collaboration is a not-for-profit organisation, free of industry support and so is The CHBG.

Please send a cover letter, curriculum vitae, and a publication list with five most important publications by your choice by May 1 2012, to dnikolov@ctu.rh.dk. On the subject line, write “Application for a CHBG Editor position”.

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)

30th CHBG Systematic Review Meeting for Practitioners

Wednesday, April 18, 2012

Time: 18:00 to 19:30.
Location: Meeting room 124. Centre Convencions Internacional (CCIB), Barcelona, Spain.

Chair: Christian Gluud, DK.

18:00 - 18:05.	Welcome and presentation of the programme.	Christian Gluud (DK).
18:05- 18:25.	Interleukin-2 receptor antagonists for solid organ transplant recipients. A Cochrane Hepato-Biliary Group systematic review.	Luit Penninga (DK), André Wettergren (DK), Daniel A. Steinbrüchel (DK), Christian Gluud (DK).
18:25 - 18:45.	Ursodeoxycholic acid for primary biliary cirrhosis. A Cochrane Hepato-Biliary Group updated systematic review.	Jelena Rudic (SER), Goran Poropat (CRO), Miodrag Krstic (SER), Goran Bjelakovic (SER), Erik Christensen (DK), Christian Gluud (DK).
18:45 - 19:05.	Aminoadamantanes for chronic hepatitis C. A Cochrane Hepato-Biliary Group systematic review.	Mieke Lamers (The NL), Mark Broekman (The NL), Joost PH Drenth (The NL), Christian Gluud (DK).
19:05 - 19:25.	Interferon for interferon nonresponding and relapsing patients with chronic hepatitis C. A Cochrane Hepato-Biliary Group systematic review.	Ronald L. Koretz (USA), Maria Pleguezuelo (ES), Vasiliki Arvaniti (GR), Pilar Barrera Baena (ES), Ruben Ciria (ES), Kurinchi S. Gurusamy (UK), Brian R. Davidson (UK), Andrew K. Burroughs (UK).
19:25 - 19:30.	Closing remarks and discussion.	All attendants.

The Cochrane Collaboration is an international, independent, not-for-profit organization of over 28,000 contributors from more than 100 countries, dedicated to making up-to-date, accurate information about the effects of health care readily available worldwide.

The Editorial Team Office of The CHBG is in Copenhagen, Denmark. For information visit www.cochrane.org.