ISSN 1901-6301

# CHBG NEWSLETTER

## The Cochrane Hepato-Biliary Group (THE CHBG)

October 2012

Volume 16, Issue 2

IN THIS ISSUE



*The numbering is a continuation from Vol. 16, Issue 1, 2012, in which some numbering errors occurred.*

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146 Nutritional support for liver disease. Koretz RL, Avenell A, Lipman TO.

147 Hepatitis A immunisation in persons not previously exposed to hepatitis A. Irving GJ, Holden J, Yang R, Pope D.

148 Banding ligation versus beta-blockers for primary prevention in oesophageal varices in adults. Gluud LL, Krag A.

149 Nutritional interventions for liver-transplanted patients. Langer G, Großmann K, Fleischer S, Berg A, Grothues D, Wienke A, Behrens J, Fink A.

150 Chlorambucil for patients with primary biliary cirrhosis. Li WX, Yan X, Shi CR, Zhang AP.

151 Extended peginterferon plus ribavirin treatment for 72 weeks versus standard peginterferon plus ribavirin treatment for 48 weeks in chronic hepatitis C genotype 1 infected slow-responder adult patients. Katz LH, Goldvaser H, Gafter-Gvili A, Tur-Kaspa R.

152 Transarterial (chemo)embolisation versus no intervention or placebo intervention for liver metastases. Riemsma RP, Bala MM, Wolff R, Kleijnen J.

#### UPDATED REVIEWS

47. Cardiopulmonary interventions to decrease blood loss and blood transfusion requirements for

liver resection. Gurusamy KS, Li J, Vaughan J, Sharma D, Davidson BR.
48. Alpha-foetoprotein and/or liver ultrasonography for screening of hepatocellular carcinoma in patients with chronic hepatitis B. Aghoram R, Cai P, Dickinson JA.
49. Antifibrinolytic amino acids for upper gastrointestinal bleeding in patients with acute or chronic liver disease. Martí-Carvajal AJ, Solà I, Martí-Carvajal PI.
50. Robot assistant versus human or another robot assistant in patients undergoing laparoscopic cholecystectomy. Gurusamy KS, Samraj K, Fusai G, Davidson BR.
51. Terlipressin for hepatorenal syndrome. Gluud LL, Christensen K, Christensen E, Krag A.
52. Vitamin K for upper gastrointestinal bleeding in patients with acute or chronic liver diseases. Martí-Carvajal AJ, Solà I.
53. Abdominal lift for laparoscopic cholecystectomy. Gurusamy KS, Koti R, Samraj K, Davidson BR.
54. Pre-operative biliary drainage for obstructive jaundice. Fang Y, Gurusamy KS, Wang Q, Davidson BR, Lin H, Xie X, Wang C.

**NEW AND UPDATED PROTOCOLS**

247. Education of patients about to undergo laparoscopic cholecystectomy. Gurusamy KS, Davidson BR.
248. Non-pharmacological and pharmacological interventions for primary prevention of gallbladder stones in adults. Stokes C, Lammert F.
249. Aminoadamantanes for chronic hepatitis C. Lamers MH, Broekman M, Drenth J, Gluud C.
Chinese herbal medicines for adverse events of transarterial chemoembolization in patients with primary liver cancer. Li X-Q, Zhou Q, Liu JP, Tao K-M, Chen H, Ling C.
250. Preoperative physical exercise training for patients scheduled for major abdominal surgery. van Heusden-Scholtalbers LAG, ter Voert JM, Staal JB, Bonenkamp HJ, Nijhuis-van der Sanden MWG, van Goor H.
251. Antibody induction versus placebo, no induction, or another type of antibody induction for liver transplant recipients. Penninga L, Wettergren A, Wilson CH, Chan A-W, Steinbrüchel DA, Gluud C.
252. Antibody induction versus corticosteroid induction for liver transplant recipients. Penninga L, Wettergren A, Wilson CH, Chan A-W, Steinbrüchel DA, Gluud C.

**NEW REGISTERED TITLES**

430 Banding ligation versus placebo or no intervention for primary prophylaxis of esophageal varices in children. Gana JC.
431 Banding ligation versus beta-blockers for primary prophylaxis of esophageal varices in children. Gana JC.
432 Sclerotheraphy versus placebo or no intervention for primary prophylaxis of esophageal varices in children. Gana JC.
433 Sclerotheraphy versus beta-blockers for primary prophylaxis of esophageal varices in children. Gana JC.
434 Beta-blockers versus placebo or no intervention for primary prophylaxis of esophageal varices in children. Gana JC.
435 Banding ligation versus sclerotheraphy for primary prophylaxis of esophageal varices in children. Gana JC.
436 Octreotide for hepatocellular carcinoma. Chandok N, Aggarwal R, Uhanova J.
437 Tyrosine kinase inhibitors for unresectable hepatocellular carcinoma. Giacomin E, Cannizzaro R, Baldo P, Chan ALF.
438 Modified dietary fat intake for gallstone disease. Madden A, Murray SM.
439 Antibody induction versus corticosteroid induction for liver transplant recipients. Penninga L, Wettergren A, Wilson CH, Steinbrüchel DA, Gluud C.
440 Antibody induction versus no induction, placebo, or another type of antibody induction for liver transplant recipients. Penninga L, Wettergren A; Wilson CH, Steinbrüchel DA, Gluud C.
441 Abdominal ultrasonography, hepatobiliary scintigraphy, and magnetic resonance cholangiopancreatography for the diagnosis of biliary atresia in newborns and infants with cholestatic jaundice. Gaitán HG, Guzmán Arias E.

## THE CHBG AND IMPACT FACTOR

### HOW THE CHBG CONTRIBUTES TO THE COCHRANE DATABASE OF SYSTEMATIC REVIEWS (CDSR)

Each year in June, Thomson Reuters publish the impact factors of all journals indexed in the ISI Journal Citation Report.

The 2011 impact factor for CDSR is 5.912, which describes the ratio of the number of 2011 citations of reviews published during 2009 and 2010 (7721 citations) to the number of reviews published during 2009 and 2010 (1306).

The 2011 CRG impact factor for The CHBG is 3.000 (132 citations of 44 reviews).

A review published by The CHBG in 2009 or 2010 was cited, on average, 3.000 times in 2011.

The top ten most cited reviews from The CHBG contributing to the 2011 impact factor are:

1. Techniques for liver parenchymal transaction in liver resection.
2. Virtual reality training for surgical trainees in laparoscopic surgery.
3. Antibiotic prophylaxis for cirrhotic patients with upper gastrointestinal bleeding.
4. Neoadjuvant and adjuvant therapy for surgical resection of hepatocellular carcinoma.
5. Emergency sclerotherapy versus vasoactive drugs for bleeding oesophageal varices in cirrhotic patients.
6. Liver resection versus other treatments for neuroendocrine tumours in patients with resectable liver metastases.
7. Bariatric surgery for non-alcoholic steatohepatitis in obese patients.
8. Antibiotic prophylaxis for spontaneous bacterial peritonitis in cirrhotic patients with ascites, without gastro-intestinal bleeding.
9. Methods of vascular occlusion for elective liver resections.
10. Antiviral therapy for recurrent liver graft infection with hepatitis C virus.

### HOW THE CHBG IMPACT FACTOR COMPARES TO THAT OF JOURNALS PUBLISHING IN THE SAME SUBJECT

| The CHBG | Median impact factor for gastro-enterology and hepatology – the journal "Gastroentero-logy and Hepatology" | Gastroente-rology | Hepatology |
|---|---|---|---|
| 3.000 | 2.379 | 11.675 | 11.665 |

Reviews published by The CHBG were accessed in full-text format on average 264.07 times during 2011 (153 articles accessed 40,403 times).

The top ten most accessed reviews from The CHBG are:

1. Antioxidant supplements for prevention of mortality in healthy participants and patients with various diseases.
2. Early versus delayed laparoscopic cholecystectomy for acute cholecystitis.
3. Antibiotic prophylaxis for cirrhotic patients with upper gastrointestinal bleeding.
4. Transarterial (chemo)embolisation for unresectable hepatocellular carcinoma.
5. Interventions for paracetamol (acetaminophen) overdose.
6. Interferon for acute hepatitis C.
7. Pentoxifylline for alcoholic hepatitis.
8. Surgical versus endoscopic treatment of bile duct stones.
9. Antibiotic prophylaxis for spontaneous bacterial peritonitis in cirrhotic patients with ascites, without gastro-intestinal bleeding.
10. Antioxidant supplements for liver diseases.

These data have been compiled by Wiley, the publisher of The Cochrane Library.

## PAST EVENTS

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

Evidence-based medicine practice course and workshop was held from 2 to 4 of March, 2012 in Rijeka, Croatia. It was organised and conducted by the School of Medicine, University of Rijeka, the Croatian Society for Quality Improvement in Health Care; and The CHBG, Copenhagen, Denmark. Tutors were CHBG members from

Croatia, Denmark, and Serbia. The workshop was well attended; there were about 45 participants from the Balkans, Turkey, and Egypt. New people joined our work as authors of systematic reviews.

#### THE 30TH BI-ANNUAL CHBG MEETING, APRIL 18, 2012 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 meeting was small, but discussions were relevant and interesting. We thank Luit Penning from Denmark, Jelena Rudic from Serbia, Mieke Lamers from the Netherlands, and Ronald L. Koretz from USA for their presentations. We also thank the attendants for good discussions.

The CHBG exhibition stand during the EASL exhibition was well attended. New people joined the work of the group.

#### THE ARCHITECTURE OF CLINICAL REASONING, GARGNANO, ITALY. SEPTEMBER 12 TO 15, 2012

An advanced residential course was held in September at Palazzo Feltrinelli Gargnano, Lago di Garda, Italy. It was organised by Centro Interuniversitario "Thomas C. Chalmers", Italy; Università degli Studi di Milano, Facoltà di Medicina e Chirurgia, Cattedra di Gastroenterologia, Milano, Italy; Fondazione IRCCS "Ca' Granda -Ospedale Maggiore Policlinico" U.O.C. di Gastroenterologia 2, The Cochrane Multiple Sclerosis Group, Fondazione Istituto Nazionale Neurologico Besta, Milano, Italy; and The CHBG, The Copenhagen Trial Unit (CTU), Centre for Clinical Intervention Research, Rigshospitalet, Copenhagen, Denmark.

Two earlier courses conducted in 2009 and 2010 helped the participants to expand further their knowledge of diagnostic study architecture. The presentations encompassed the clinical phases in diagnostic study research as well as the respective study designs and sample size calculations. The need of prognostic studies, the link between prognosis and diagnosis, bias in clinical studies and systematic reviews, statistical issues related to diagnostic research, critical appraisal of diagnostic studies, and how to read, understand, and use their results in practice were also on the program. The need of Cochrane systematic reviews of diagnostic test accuracy based on observational studies and randomised clinical trials was also stressed. All theoretical presentations were linked with group work and common discussions.

Roberto D'Amico, the new Director of the Italian Cochrane Centre, paid tribute to the memory of Alessandro Liberati by giving a talk "Uncertainty in medicine", inspired by Alessandro Liberati's publication in 2004 in the *British Medical Journal*, "An unfinished trip through uncertainties". In this article, Alessandro Liberati wrote about his own life-threatening illness and how agonising it is to know that there is no sound research on which to base treatment decisions.

As a number of CHBG editors were present in Gargnano, we also used the opportunity to discuss editorial issues.

A CHBG author, Augusto José Cavalcanti Neto from Brazil, working on the 'Magnetic resonance cholangiopancreatography adding conventional magnetic resonance imaging for the diagnosis of bile duct stenosis' review attended the course.

#### THE 20TH COCHRANE COLLOQUIUM, AUCKLAND, NEW ZEALAND. SEPTEMBER 30 TO OCTOBER 3

The theme of this year's Colloquium was 'Evidence around the globe'. There were four days of meetings and workshops, along with a full program of scientific sessions on topics such as 'Rational thinking about health care', 'It's about connections', and 'Better global health'.

Plenaries from this colloquium are available for viewing at the following location http://webcast.gigtv.com.au/Mediasite/Catalog/catalogs/colloquium

Posters can also be viewed at http://colloquium.cochrane.org/posters

For other information, visit http://colloquium.cochrane.org/

## FUTURE EVENTS

#### THE 63RD ANNUAL AASLD MEETING NOVEMBER 9 TO 13, 2012, BOSTON, MASSACHUSETTS, USA. THE CHBG EXHIBITION STAND

The CHBG has decided not to run a meeting this year due to limited attendance during earlier

AASLD meetings. We recon this is greatly due to the fact that the CHBG meeting program has not been visible in the AASLD information material, including the AASLD official program book or online. The time slot we are usually given also coincides with major industry symposia. This is why The CHBG will attempt to present systematic reviews at the exhibition stand. We have planned three presentations; please see last page for details.

We will be happy to see you at booth No 13.

## FOR AUTHORS

**BIAS RISK**

In the CHBG Module within The Cochrane Library, we recommend six bias risk domains to be assessed in CHBG reviews. As we have slightly improved the wording of the definitions, we kindly ask CHBG authors to use the below text. We suggest overall assessment of the bias risk of trials irrespective of outcome as well as according to outcome. The latter can be displayed in Summary of Findings tables.

### Domains for bias risk assessment

*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 research assistant not otherwise involved in the trial.
- Uncertain risk of bias: the method of sequence generation was not specified.
- High risk of bias: the sequence generation method was not random.

*Allocation concealment*

- Low risk of bias: the participant allocations could not have been foreseen in advance of, or during, enrolment. Allocation was controlled by a central and independent randomisation unit. The allocation sequence was unknown to the investigators (for example, if the allocation sequence was hidden in sequentially numbered, opaque, and sealed envelopes).
- Uncertain risk of bias: 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: the allocation sequence was likely to be known to the investigators who assigned the participants.

*Blinding of participants, personnel, and outcome assessors*

- Low risk of bias: blinding was performed adequately, or the assessment of outcomes was not likely to be influenced by lack of blinding.
- Uncertain risk of bias: there was insufficient information to assess whether blinding was likely to induce bias on the results.
- High risk of bias: no blinding or incomplete blinding, and the assessment of outcomes were likely to be influenced by lack of blinding.

*Incomplete outcome data*

- Low risk of bias: missing data were unlikely to make treatment effects depart from plausible values. Sufficient methods, such as multiple imputation, have been employed to handle missing data.
- Uncertain risk of bias: there was insufficient information to assess whether missing data in combination with the method used to handle missing data were likely to induce bias on the results.
- High risk of bias: the results were likely to be biased due to missing data.

*Selective outcome reporting*

- Low risk of bias: all outcomes were pre-defined (for example, in a published protocol) and reported, or all clinically relevant and reasonably expected outcomes were reported.
- Uncertain risk of bias: it is unclear whether all pre-defined and clinically relevant and reasonably expected outcomes were reported.
- High risk of bias: one or more clinically relevant and reasonably expected outcomes were not reported, and data on these outcomes were likely to have been recorded.

*Other bias**
To report on other bias in addition to the above mentioned domains (for example, industry bias, academic bias, etc) one should continue using the following pattern, specifying the risk of bias chosen as most important for one's specific review.
- Low risk of bias: the trial appears to be free of other components (should be listed, for example, industry bias, academic bias, etc) 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 (for example, for-profit involvement, authors have conducted trials on the same topic, etc).

*Please think of one or more risks of bias that are most relevant for your review.

We can also recommend you to read the paper "Influence of reported study design characteristics on intervention effect estimates from randomized, controlled trials" by Savović J, Jones HE, Altman DG, Harris RJ, Jüni P, Pildal J, Als-Nielsen B, Balk EM, Gluud C, Gluud LL, A Ioannidis JP, Schulz KF, Beynon R, Welton NJ, Wood L, Moher D, Deeks JJ, Sterne JA, published in full in Health Technol Assess. 2012 Sep;16(35):1-82; and abridged in Annals of Internal Medicine. 2012;157(6):429-38.

**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 employ 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. With trial sequential analysis you are able to obtain important pieces of information. First, you obtain a required information size of your meta-analysis (equal to a sample size in a single trial). Second, you can see if your meta-analysis has accrued fewer or more patients than the required information size. In case of fewer patients (the typical scenario), there are three typical directions of the cumulative Z-score in the trial sequential analysis and lessons to be learned. For cumulative meta-analysis in which the Z-score crosses one of the trial sequential alpha-spending monitoring boundaries you are able to exclude type I random error (and either declare benefit or harm provided you can exclude systematic errors).

For cumulative meta-analyses in which the Z-score crosses the trial sequential beta-spending monitoring boundaries, you are able to exclude type II random error (and declare futility provided you can exclude systematic errors).

For cumulative meta-analyses in which the Z-score does not cross any of the monitoring boundaries, you are likely to request more randomised trials to sufficiently assess the outcome in question.

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 alpha spending 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 if the trial sequential beta-spending monitoring boundaries are not crossed. If the latter is the case, futility may be declared.

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 Programme. 2011. Version 0.9 beta. http://ctu.dk/tsa.

**STANDARDS FOR REPORTING OF COCHRANE INTERVENTION REVIEWS**

A letter by David Tovey,
Editor in Chief of *The Cochrane Library*

Dear Colleagues,

The Methodological Expectations of Cochrane Intervention Reviews (MECIR) project team have finalized standards for the reporting of Cochrane Intervention Reviews. They are available from the CEU website: http://www.editorial-unit.cochrane.org/mecir. These have been developed in consultation with people from inside and outside The Cochrane Collaboration.

The reporting standards complement work that has already identified standards for the conduct of our reviews. They are not intended to apply to protocols or updated reviews at this point, and we intend to address these in further work. As with the standards for conduct we have designated each reporting item to be either mandatory or highly desirable. We have also provided a rationale for each standard and indicated any relevant conduct standards/locations in the Cochrane Handbook. There is also a separate project ongoing aimed at clarifying expectations for plain language summaries (PLEACS: http://consumers.cochrane.org/PLEACS).

The Cochrane Collaboration has adopted recommendations provided in the PRISMA statement www.prisma-statement.org. We believe the reporting standards will ensure compliance with these recommendations. Extensions to the PRISMA statement may also be relevant to particular reviews, such as reviews addressing equity issues http://equity.cochrane.org/equity-extension-prisma.

Further details of the MECIR project can be found at our website: http://www.editorial-unit.cochrane.org/mecir .

## VISITS 2012

Arturo Marti Carvajal, Venezuela, worked at The CHBG Editorial Team Office from June 15 to July 15, 2012. The aim of Arturo's visit was to be trained in using trial sequential analysis (http://ctu.dk/tsa) in systematic reviews. During his stay, Arturo updated two of his reviews, i.e., 'Antifibrinolytic amino acids for upper gastrointestinal bleeding in patients with acute or chronic liver disease' and 'Vitamin K for upper gastrointestinal bleeding in patients with acute or chronic liver diseases'. Arturo also started work on other reviews falling within the scope of the Cochrane Collaboration.

Goran Hauser, Croatia, worked at The CHBG Editorial Team Office from June 4 to June 18, 2012. The aim of Goran's visit was to be trained in using trial sequential analysis (http://ctu.dk/tsa) in systematic reviews as well as review conductance. During his stay, Goran worked on two reviews, i.e., 'Peginterferon alpha-2a versus peginterferon alpha-2b for chronic hepatitis C' and 'Peginterferon plus ribavirin versus interferon plus ribavirin for chronic hepatitis C'. The reviews are expected to be finalised and published by the early spring.

Rosa Simonetti, Italy, paid us a one-day visit on 16 of July. Rosa did some editorial work.

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

## COCHRANE ONLINE LEARNING

Authors of intervention reviews may register and receive training online – see 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.

## WORKSHOPS

Presently, workshops being offered are:

**Systematic Review of Diagnostic Test Accuracy. December 10 and 11, 2012, Academic Medical Center, Amsterdam, The Netherlands.**

This workshop is targeted at review authors who are planning to do a Cochrane diagnostic test accuracy review. The objective of the workshop is to inform participants about the methodology particular to systematic reviews of diagnostic test accuracy (SRDTAs) and to train authors to prepare and conduct an SRDTA.

The workshop will focus mainly on methodological challenges around SRDTAs. Basic statistical methods for meta-analysis and the logistics of processing SRDTAs within The Cochrane Collaboration will also be addressed.

See the webpage for more information and registration.

**UK Support Unit Cochrane Diagnostic Test Accuracy author training modules: University of Birmingham, UK.**

November 29th 2012. Progressing your review - Module 3.

Forms for registration are to be found on the website.

Module 4 training in Statistical Analysis is run in Birmingham for individual author teams or groups of authors working on reviews with similar issues. Authors should arrange a date for this with course tutors when they attend Module 3.

**Please note: there are strict entry requirements for the offered modules.**

Course materials
Presentations from previous training can be found on the webpage.

## CALL FOR APPLICATIONS

### COMPLIMENTARY MEDICINE FIELD BURSARY SCHEME 2012

The Cochrane Collaboration Complementary Medicine Field announces a 2012 bursary scheme made possible through funds from the US

National Institutes of Health, National Center for Complementary and Alternative Medicine. The purpose of this bursary scheme is to ensure that reviews relevant to complementary and alternative medicine (CAM) are completed and published in *The Cochrane Library*.

Application deadline: 3 December 2012.

Completed application forms should be sent to Eric Manheimer (emanheimer@compmed.umm.edu).

External link for more information: www.cochrane.org/news/tags/authors/call-applications-complementary-medicine-field-bursary-scheme-12.

#### AUBREY SHEIHAM PUBLIC HEALTH AND PRIMARY CARE SCHOLARSHIP 2012

Applications are invited for The Cochrane Collaboration Aubrey Sheiham Public Health and Primary Care Scholarship from health workers, consumers and researchers living in low-or middle-income countries.

This is not a call for new reviews but rather for those who have already registered a title with the relevant Cochrane Review Group.

This is a scholarship of up to three months to develop skills in preparing systematic reviews of healthcare interventions within The Cochrane Collaboration. Applicants must have agreed to a review topic before 1 September 2012 with the relevant Cochrane Review Group.

Application deadline: 31 October 2012. For more information and requirements: www.cochrane.org/docs/Fellowshipsandscholarships.htm#ASPHPCS.

Completed application forms should be sent to Carly Mole (cmole@cochrane.ac.uk).

External link for more information: http://www.cochrane.org/docs/Fellowshipsandscholarships

#### CHBG CONSUMERS

The CHBG is in need of consumers. Do you wish to be involved as a consumer peer reviewer of our reviews or perhaps you know someone who might be interested in obtaining this role? If so, please contact us or the Cochrane Consumer Network (http://consumers.cochrane.org) who coordinates the involvement of consumers within the Collaboration. The network also provides training – see http://consumers.cochrane.org/refereetraining.

Besides commenting on the reviews, consumers are also expected to prepare plain language summaries.

#### THE CHBG EDITORIAL TEAM

In the February 2012 Issue of The CHBG Newsletter we announced a call for editors. At a telephone conference on 7 of June 2012 as well as email correspondence with editors who could not attend the conference, six new editors were nominated for the position. We are very happy to welcome Goran Bjelakovic, Serbia; Vanja Giljaka, Croatia; Norberto C. Chavez-Tapia, Mexico; Luit Penninga, Denmark; Davor Stimac, Croatia; and Giovanni Gasazza, Italy as new editors of The CHBG. The primary responsibility of the first five editors is to provide support to authors of intervention reviews, and the main responsibility of Giovanni Gasazza is to provide statistical support to authors of diagnostic test accuracy reviews. We wish to welcome our new editors once again.

Nicholas Alexakis, Greece, Robert Sutton, UK, and Luigi Pagliaro have stepped down as CHBG editors due to other obligations. We thank them kindly for their support during the past years.

#### ADDRESS CHANGE

The CHBG has moved to another building, also this time in close proximity to the main building of the Rigshospital. This caused some undesirable interruption of our work. We also had to establish a new IT network infrastructure. During the process, some mails could have been lost. If you have not received a reply to your mail, please kindly resend it to us. We apologize for the inconveniences.

# COCHRANE HEPATO-BILIARY GROUP PRESENTATIONS

**Dates and event:** November 10 to 13. The 2012 AASLD exhibition.
**Place and location:** Booth No. 13 in the exhibition hall of the Hynes Convention Center. Boston, MA.

| Title of the presentation | Authors | Time |
|---|---|---|
| Antibody induction for liver transplant recipients: A Cochrane systematic review. | Penninga L, Wettergren A, Wilson CH, Chan AW, Steinbrüchel DA, Gluud C. | Saturday, November 10. From 6:00 pm to 6:20 pm.<br>Sunday, November 11. From 10:00 am to 10:20 am.<br>Monday, November 12. From 12:00 pm to12:20 pm. |
| Antibody induction for solid organ transplant recipients: A Cochrane systematic review. | Penninga L, Møller CH, Wettergren A, Steinbrüchel DA, Gluud C. | Saturday, November 10. From 6:30 pm to 6:50 pm.<br>Sunday, November 11. From 12:00 pm to 12:20 pm.<br>Monday, November 12. From 10:00 pm to 10:20 pm. |
| The effect of vitamin D supplementation on mortality: updated Cochrane systematic review with meta-analysis and trial sequential analysis of randomised clinical trials. | Bjelakovic G, Gluud LL, Nikolova D, Whitfield K, Wetterslev J, Simonetti RG, Bjelakovic M, Gluud C. | Sunday, November 11. From 12:30 pm to 12:50 pm. |

All are invited and encouraged to discuss the presentations with the presenters.

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 is 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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