Record #1 of 45 

ID: CD006104

AU: Birks Jacqueline

AU: Flicker Leon

TI: Donepezil for mild cognitive impairment

SO: Cochrane Database of Systematic Reviews

YR: 2006

NO: 3

PB: John Wiley & Sons, Ltd

KY: Indans [adverse effects] [therapeutic use];Memory Disorders [drug therapy];Nootropic Agents [therapeutic use];Piperidines [adverse effects] [therapeutic use];Randomized Controlled Trials as Topic;Humans[checkword]

CC: DEMENTIA

DOI: 10.1002/14651858.CD006104

AB: Background: Problems with memory which do not meet the diagnostic criteria for dementia, usually called mild cognitive impairment (MCI), can be the first sign of an impending dementia, particularly Alzheimer's disease (AD). There is no consensus on a definition or diagnostic criteria for MCI, and MCI remains a vague term and those so described are a heterogeneous population, consisting of people who may rapidly progress to dementia but also of people with stable cognitive deficits and some who may actually improve.Treatment in the very earliest stages of AD may delay progression to AD. Donepezil (Aricept, E2020), a cholinesterase inhibitor, has been shown to benefit all severities of AD including mild and it would be reasonable to investigate its efficacy for those with MCI.Objectives: To assess the effects of donepezil in people with mild cognitive impairment but no diagnosis of dementia.Search methods: We searched ALOIS - the Cochrane Dementia and Cognitive Improvement Group?s Specialized Register on 20 May 2010 using the term: donepezil and in combination with those studies in which the participants had mild cognitive impairment.Selection criteria: All double blind, randomized trials in which treatment with donepezil was compared with placebo for patients with mild cognitive impairment.Data collection and analysis: Data were extracted from the published reports of the included studies, pooled where appropriate and the treatment effects or the risks and benefits estimated.Main results: The three included studies, with a total of 782 patients, all with a MMSE greater than 23 points, identified similar patients for inclusion, but were quite different with respect to design and objective. Pooling results in a meta-analysis was not possible. In the first study the 13-item ADAS-Cog showed benefit associated with 10 mg/day donepezil compared with placebo at 24 weeks (MD 1.90, 95% CI 0.51 to 3.29, p=0.007), but four other measures of cognitive function did not. The analysis of withdrawals before the end of

treatment at 24 weeks, withdrawals due to an adverse event, and numbers experiencing an adverse event, showed a significant difference between the donepezil group and the placebo group in favour of placebo, (43/133 donepezil 23/137 placebo, OR 2.37, 95% CI 1.33 to 4.22, p=0.003), (29/133 donepezil 10/137 placebo, OR 3.54, 95% CI 1.65 to 7.60, p=0.001), (116/133 donepezil, 100/137 placebo, OR 2.52 95% CI 1.34 to 4.76, p=0.004). Various adverse effects were recorded, and several types of event, diarrhoea, nausea, vomiting, leg cramps and abnormal dreams, were reported more frequently in the donepezil group compared with the placebo.In the second study there was a significant difference between the number of patients diagnosed with AD or another dementia between the donepezil group and the placebo group in favour of donepezil after one year of treatment (16/253 donepezil 38/259 placebo) (OR 0.39, 95% CI 0.21 to 0.72, p=0.003), but no difference after 3 years of treatment (63/253 donepezil 73/259 placebo) (OR 0.84, 95% CI 0.57 to 1.25, p=0.4).The third study assessed cognitive function but did not report the results.Authors' conclusions: There are two included studies which reported results for cognitive function. One study demonstrated a modest treatment effect in cognitive function as assessed by ADAS-Cog13 but not for other outcomes assessing different domains of cognitive function. Donepezil was associated with significantly more adverse effects compared with placebo, mostly gastrointestinal. From the second study, there is no evidence that donepezil delays the onset of AD. There is no evidence to support the use of donepezil for patients with MCI. The putative benefits are minor, short lived and associated with significant side effects.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006104/abstract

Record #2 of 45

ID: CD006504

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TI: Cholinesterase inhibitors for dementia with Lewy bodies, Parkinson's disease dementia and cognitive impairment in Parkinson's disease

SO: Cochrane Database of Systematic Reviews

YR: 2012

NO: 3

PB: John Wiley & Sons, Ltd

KY: Cholinesterase Inhibitors [adverse effects] [therapeutic use];Cognition Disorders [drug therapy] [etiology];Dementia [drug therapy] [etiology];Indans [adverse effects] [therapeutic use];Lewy Body Disease [drug therapy];Neuroprotective Agents [adverse effects] [therapeutic use];Parkinson Disease [complications];Phenylcarbamates [adverse effects] [therapeutic use];Piperidines [adverse effects] [therapeutic use];Randomized Controlled Trials as Topic;Humans[checkword]

CC: DEMENTIA

DOI: 10.1002/14651858.CD006504.pub2

AB: Background: Previous Cochrane reviews have considered the use of cholinesterase inhibitors in both Parkinson's disease with dementia (PDD) and dementia with Lewy bodies (DLB). The clinical features of DLB and PDD have much in common and are distinguished primarily on the basis of whether or not parkinsonism precedes dementia by more than a year. Patients with both conditions have particularly severe deficits in cortical levels of the neurotransmitter acetylcholine. Therefore, blocking its breakdown using cholinesterase inhibitors may lead to clinical improvement.Objectives: To assess the efficacy, safety and tolerability of cholinesterase inhibitors in dementia with Lewy bodies (DLB), Parkinson?s disease with dementia (PDD), and cognitive impairment in Parkinson?s disease falling short of dementia (CIND-PD) (considered as separate phenomena and also grouped together as Lewy body disease).Search methods: The trials were identified from a search of ALOIS, the Specialised Register of the Cochrane Dementia and Cognitive Improvement Group (on 30 August 2011) using the search terms Lewy, Parkinson, PDD, DLB, LBD. This register consists of records from major healthcare databases (MEDLINE, EMBASE, PsycINFO, CINAHL) and many ongoing trial databases and is updated regularly.Reference lists of relevant studies were searched for additional trials.Selection criteria: Randomised, double-blind, placebo-controlled trials assessing the efficacy of treatment with cholinesterase inhibitors in DLB, PDD and cognitive impairment in Parkinson?s disease (CIND-PD).Data collection and analysis: Data were extracted from published reports by one review author (MR). The data for each 'condition' (that is DLB, PDD or CIND-PD) were considered separately and, where possible, also pooled together. Statistical analysis was conducted using Review Manager version 5.0.Main results: Six trials met the inclusion criteria for this review, in which a total of 1236 participants were randomised. Four of the trials were of a parallel group design and two cross-over trials were included. Four of the trials included participants with a diagnosis of Parkinson's disease with dementia (Aarsland 2002a; Dubois 2007; Emre 2004; Ravina 2005), of which Dubois 2007 remains unpublished. Leroi 2004 included patients with cognitive impairment and Parkinson's disease (both with and without dementia). Patients with dementia with Lewy bodies (DLB) were included in only one of the trials (McKeith 2000).For global assessment, three trials comparing cholinesterase inhibitor treatment to placebo in PDD (Aarsland 2002a; Emre 2004; Ravina 2005) reported a difference in the Alzheimer's Disease Cooperative Study-Clinical Global Impression of Change (ADCS-CGIC) score of -0.38, favouring the cholinesterase inhibitors (95% CI -0.56 to -0.24, P < 0.0001).For cognitive function, a pooled estimate of the effect of cholinesterase inhibitors on cognitive function measures was consistent with the presence of a therapeutic benefit (standardised mean difference (SMD) -0.34, 95% CI -0.46 to -0.23, P < 0.00001). There was evidence of a positive effect of cholinesterase inhibitors on the

Mini-Mental State Examination (MMSE) in patients with PDD (WMD 1.09, 95% CI 0.45 to 1.73, P = 0.0008) and in the single PDD and CIND-PD trial (WMD 1.05, 95% CI 0.42 to 1.68, P = 0.01) but not in the single DLB trial.For behavioural disturbance, analysis of the pooled continuous data relating to behavioural disturbance rating scales favoured treatment with cholinesterase inhibitors (SMD -0.20, 95% CI -0.36 to -0.04, P = 0.01).For activities of daily living, combined data for the ADCS and the Unified Parkinson's Disease Rating Scale (UPDRS) activities of daily living rating scales favoured treatment with cholinesterase inhibitors (SMD -0.20, 95% CI -0.38 to -0.02, P = 0.03).For safety and tolerability, those taking a cholinesterase inhibitor were more likely to experience an adverse event (318/452 versus 668/842; odds ratio (OR) 1.64, 95% CI 1.26 to 2.15, P = 0.0003) and to drop out (128/465 versus 45/279; OR 1.94, 95% CI 1.33 to 2.84, P = 0.0006). Adverse events were more common amongst those taking rivastigmine (357/421 versus 173/240; OR 2.28, 95% CI 1.53 to 3.38, P < 0.0001) but not those taking donepezil (311/421 versus 145/212; OR 1.24, 95% CI 0.86 to 1.80, P = 0.25). Parkinsonian symptoms in particular tremor (64/739 versus 12/352; OR 2.71, 95% CI 1.44 to 5.09, P = 0.002), but not falls (P = 0.39), were reported more commonly in the treatment group but this did not have a significant impact on the UPDRS (total and motor) scores (P = 0.71). Fewer deaths occurred in the treatment group than in the placebo group (4/465 versus 9/279; OR 0.28, 95% CI 0.09 to 0.84, P = 0.03).Authors' conclusions: The currently available evidence supports the use of cholinesterase inhibitors in patients with PDD, with a positive impact on global assessment, cognitive function, behavioural disturbance and activities of daily living rating scales. The effect in DLB remains unclear. There is no current disaggregated evidence to support their use in CIND-PD.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006504.pub2/abstract

Record #3 of 45

ID: CD006531

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AU: Trespidi Carlotta

AU: Magni Laura R

AU: Rizzo Carla

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AU: Watanabe Norio

AU: Cipriani Andrea

AU: Barbui Corrado

TI: Paroxetine versus other anti-depressive agents for depression

SO: Cochrane Database of Systematic Reviews

YR: 2014

NO: 4

PB: John Wiley & Sons, Ltd

CC: DEPRESSN

DOI: 10.1002/14651858.CD006531.pub2

AB: Background: Paroxetine is the most potent inhibitor of the reuptake of serotonin of all selective serotonin reuptake inhibitors (SSRIs) and has been studied in many randomised controlled trials (RCTs). However, these comparative studies provided contrasting findings and systematic reviews of RCTs have always considered the SSRIs as a group, and evidence applicable to this group of drugs might not be applicable to paroxetine alone. The present systematic review assessed the efficacy and tolerability profile of paroxetine in comparison with tricyclics (TCAs), SSRIs and newer or non-conventional agents.Objectives: 1. To determine the efficacy of paroxetine in comparison with other anti-depressive agents in alleviating the acute symptoms of Major Depressive Disorder.2. To review acceptability of treatment with paroxetine in comparison with other anti-depressive agents.3. To investigate the adverse effects of paroxetine in comparison with other anti-depressive agents.Search methods: We searched the Cochrane Depression, Anxiety and Neurosis Review Group's Specialized Register (CCDANCTR, to 30 September 2012), which includes relevant randomised controlled trials from the following bibliographic databases: The Cochrane Library (all years), EMBASE (1974 to date), MEDLINE (1950 to date) and PsycINFO (1967 to date). Reference lists of relevant papers and previous systematic reviews were handsearched. Pharmaceutical companies marketing paroxetine and experts in this field were contacted for supplemental data.Selection criteria: All randomised controlled trials allocating participants with major depression to paroxetine versus any other antidepressants (ADs), both conventional (such as TCAs, SSRIs) and newer or non-conventional (such as hypericum). For trials which had a cross-over design, only results from the first randomisation period were considered.Data collection and analysis: Two review authors independently checked eligibility and extracted data using a standard form. Data were then entered in RevMan 5.2 with a double-entry procedure. Information extracted included study and participant characteristics, intervention details, settings and efficacy, acceptability and tolerability measures.Main results: A total of 115 randomised controlled trials (26,134 participants) were included. In 54 studies paroxetine was compared with older ADs, in 21 studies with another SSRI, and in 40 studies with a newer or non-conventional antidepressant other than SSRIs. For the primary outcome (patients who responded to treatment), paroxetine was more effective than reboxetine at increasing patients who responded early to treatment (Odds Ratio (OR): 0.66, 95% Confidence Interval (CI) 0.50 to 0.87, number needed to treat to provide benefit (NNTb) = 16, 95% CI 10 to 50, at one to four weeks, 3 RCTs, 1375 participants, moderate quality of evidence), and less effective than mirtazapine (OR: 2.39, 95% CI 1.42 to

4.02, NNTb = 8, 95% CI 5 to 14, at one to four weeks, 3 RCTs, 726 participants, moderate quality of evidence). Paroxetine was less effective than citalopram in improving response to treatment (OR: 1.54, 95% CI 1.04 to 2.28, NNTb = 9, 95% CI 5 to 102, at six to 12 weeks, 1 RCT, 406 participants, moderate quality of evidence). We found no clear evidence that paroxetine was more or less effective compared with other antidepressants at increasing response to treatment at acute (six to 12 weeks), early (one to four weeks), or longer term follow-up (four to six months). Paroxetine was associated with a lower rate of adverse events than amitriptyline, imipramine and older ADs as a class, but was less well tolerated than agomelatine and hypericum. Included studies were generally at unclear or high risk of bias due to poor reporting of allocation concealment and blinding of outcome assessment, and incomplete reporting of outcomes.Authors' conclusions: Some possibly clinically meaningful differences between paroxetine and other ADs exist, but no definitive conclusions can be drawn from these findings. In terms of response, there was a moderate quality of evidence that citalopram was better than paroxetine in the acute phase (six to 12 weeks), although only one study contributed data. In terms of early response to treatment (one to four weeks) there was moderate quality of evidence that mirtazapine was better than paroxetine and that paroxetine was better than reboxetine. However there was no clear evidence that paroxetine was better or worse compared with other antidepressants at increasing response to treatment at any time point. Even if some differences were identified, the findings from this review are better thought as hypothesis forming rather than hypothesis testing and it would be reassuring to see the conclusions replicated in future trials. Finally, most of included studies were at unclear or high risk of bias, and were sponsored by the drug industry. The potential for overestimation of treatment effect due to sponsorship bias should be borne in mind.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006531.pub2/abstract

Record #4 of 45

ID: CD001860

AU: Evans Jennifer R

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TI: Antibiotics for trachoma

SO: Cochrane Database of Systematic Reviews

YR: 2011

NO: 3

PB: John Wiley & Sons, Ltd

KY: Chlamydia trachomatis;Administration, Oral;Administration, Topical;Anti-Bacterial Agents [administration & dosage] [therapeutic use];Azithromycin [administration &

dosage];Randomized Controlled Trials as Topic;Tetracycline [administration & dosage];Trachoma [drug therapy];Humans[checkword]

CC: EYES

DOI: 10.1002/14651858.CD001860.pub3

AB: Background: Trachoma is the world's leading infectious cause of blindness. In 1997 the World Health Organization (WHO) launched an Alliance for the Global Elimination of Trachoma by the year 2020, based on the 'SAFE' strategy (surgery, antibiotics, facial cleanliness and environmental improvement).Objectives: To assess the evidence supporting the antibiotic arm of the SAFE strategy by assessing the effects of antibiotics on both active trachoma (primary objective) and on Chlamydia trachomatis (C. trachomatis) infection of the conjunctiva (secondary objective).Search methods: We searched CENTRAL (which contains the Cochrane Eyes and Vision Group Trials Register) (The Cochrane Library 2010, Issue 11), MEDLINE (January 1950 to December 2010), EMBASE (January 1980 to December 2010), the metaRegister of Controlled Trials (mRCT) (www.controlled-trials.com) (December 2010) and ClinicalTrials.gov (www.clinicaltrials.gov) (December 2010). We used the Science Citation Index to look for articles that cited the included studies. We searched the reference lists of identified articles and we contacted authors and experts for details of further relevant studies. There were no language or date restrictions in the search for trials. The electronic databases were last searched on 12 December 2010.Selection criteria: We included randomised trials that satisfied either of two criteria: (a) trials in which topical or oral administration of an antibiotic was compared to placebo or no treatment in people or communities with trachoma, (b) trials in which a topical antibiotic was compared with an oral antibiotic in people or communities with trachoma. A subdivision of particular interest was trials in which topical tetracycline or chlortetracycline and oral azithromycin were compared with each other, or in which one of these treatments was compared with placebo or no treatment, as these are the two WHO recommended antibiotics. We considered individually randomised and cluster-randomised trials separately.Data collection and analysis: Two authors independently assessed trial quality and extracted data. We contacted investigators for missing data. Where appropriate, the effect estimates from the individual studies (risk ratios) were pooled using a random-effects model.Main results: A total of 14 trials randomised individuals with trachoma to oral antibiotic, topical antibiotic, both, or control (no treatment or placebo) and were eligible for inclusion in this review (n = 3587). Overall, the quality of the evidence provided from these trials was low. Nine of the trials compared antibiotic treatment to control. Most of the studies found a beneficial effect of treatment on active trachoma and ocular chlamydial infection at three and 12 months follow up. There was considerable clinical and statistical heterogeneity between trials, which meant that it was difficult to reliably estimate the size of the treatment effect. It is likely to be in the region of a 20% relative risk reduction. Seven of the 14 trials compared the effectiveness of oral and topical antibiotics. There was no consistent evidence as to whether oral or topical antibiotics were more effective, although one trial suggested that a single dose of oral azithromycin was significantly more effective than unsupervised use of topical tetracyclineA further eight trials assessed the effectiveness of community-based treatment. In five trials antibiotic treatment was compared to no (or delayed) treatment (57 communities), and in three trials oral antibiotic was compared to topical treatment (12 communities). The

quality of the evidence provided by these trials was variable but at least one trial was considered to provide high quality evidence. There was evidence that community-based antibiotic treatment reduced the prevalence of active trachoma and ocular infection 12 months after single-dose treatment. There was some evidence that oral azithromycin was more effective than topical tetracycline as a community treatment. Data on adverse effects were not consistently reported however there were no reported serious adverse events associated with treatment with oral azithromycin or topical tetracycline; in one sample survey of 671 people treated with azithromycin between 10% and 15% experienced gastrointestinal adverse effects (nausea or vomiting, or both).Authors' conclusions: Antibiotic treatment reduces the risk of active trachoma and ocular chlamydial infection in people infected with C. trachomatis, but we do not know for certain the size of the treatment effect in individuals. Mass antibiotic treatment with single-dose oral azithromycin reduces the prevalence of active trachoma and ocular infection in communities.

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Record #5 of 45

ID: CD004916

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AU: Cotter Susan A

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AU: Twelker J. Daniel

TI: Interventions to slow progression of myopia in children

SO: Cochrane Database of Systematic Reviews

YR: 2011

NO: 12

PB: John Wiley & Sons, Ltd

KY: Contact Lenses;Eyeglasses;Atropine [therapeutic use];Cyclopentolate [therapeutic use];Disease Progression;Muscarinic Antagonists [therapeutic use];Myopia [prevention & control];Ophthalmic Solutions [therapeutic use];Pirenzepine [therapeutic use];Randomized Controlled Trials as Topic;Child[checkword];Humans[checkword]

CC: EYES

DOI: 10.1002/14651858.CD004916.pub3

AB: Background: Nearsightedness (myopia) causes blurry vision when looking at distant objects. Highly nearsighted people are at greater risk of several vision-threatening problems such as retinal detachments, choroidal atrophy, cataracts and glaucoma. Interventions that have been explored to slow the progression of myopia include bifocal spectacles, cycloplegic drops, intraocular pressure-lowering drugs, muscarinic receptor antagonists and contact lenses. The purpose of this review was to systematically assess the effectiveness of strategies to control progression of myopia in children.Objectives: To assess the effects of several types of interventions, including eye drops, undercorrection of nearsightedness, multifocal spectacles and contact lenses, on the progression of nearsightedness in myopic children younger than 18 years. We compared the interventions of interest with each other, to single vision lenses (SVLs) (spectacles), placebo or no treatment.Search methods: We searched CENTRAL (which contains the Cochrane Eyes and Vision Group Trials Register) (The Cochrane Library 2011, Issue 10), MEDLINE (January 1950 to October 2011), EMBASE (January 1980 to October 2011), Latin American and Caribbean Literature on Health Sciences (LILACS) (January 1982 to October 2011), the metaRegister of Controlled Trials (mRCT) (www.controlled-trials.com) and ClinicalTrials.gov (http://clinicaltrials.gov). There were no date or language restrictions in the electronic searches for trials. The electronic databases were last searched on 11 October 2011. We also searched the reference lists and Science Citation Index for additional, potentially relevant studies.Selection criteria: We included randomized controlled trials (RCTs) in which participants were treated with spectacles, contact lenses or pharmaceutical agents for the purpose of controlling progression of myopia. We excluded trials where participants were older than 18 years at baseline or participants had less than -0.25 diopters (D) spherical equivalent myopia.Data collection and analysis: Two review authors independently extracted data and assessed the risk of bias for each included study. When possible, we analyzed data with the inverse variance method using a fixed-effect or random-effects model, depending on the number of studies and amount of heterogeneity detected.Main results: We included 23 studies (4696 total participants) in this review, with 17 of these studies included in quantitative analysis. Since we only included RCTs in the review, the studies were generally at low risk of bias for selection bias. Undercorrection of myopia was found to increase myopia progression slightly in two studies; children who were undercorrected progressed on average 0.15 D (95% confidence interval (CI) -0.29 to 0.00) more than the fully corrected SVLs wearers at one year. Rigid gas permeable contact lenses (RGPCLs) were found to have no evidence of effect on myopic eye growth in two studies (no meta-analysis due to heterogeneity between studies). Progressive addition lenses (PALs), reported in four studies, and bifocal spectacles, reported in four studies, were found to yield a small slowing of myopia progression. For seven studies with quantitative data at one year, children wearing multifocal lenses, either PALs or bifocals, progressed on average 0.16 D (95% CI 0.07 to 0.25) less than children wearing SVLs. The largest positive effects for slowing myopia progression were exhibited by anti-muscarinic medications. At one year, children receiving pirenzepine gel (two studies), cyclopentolate eye drops (one study), or atropine eye drops (two studies) showed significantly less myopic progression compared with children receiving placebo (mean differences (MD) 0.31 (95% CI 0.17 to 0.44), 0.34 (95% CI 0.08 to 0.60), and

0.80 (95% CI 0.70 to 0.90), respectively).Authors' conclusions: The most likely effective treatment to slow myopia progression thus far is anti-muscarinic topical medication. However, side effects of these medications include light sensitivity and near blur. Also, they are not yet commercially available, so their use is limited and not practical. Further information is required for other methods of myopia control, such as the use of corneal reshaping contact lenses or bifocal soft contact lenses (BSCLs) with a distance center are promising, but currently no published randomized clinical trials exist.

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Record #6 of 45

ID: CD007176

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AU: Gluud Lise Lotte

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AU: Gluud Christian

TI: Antioxidant supplements for prevention of mortality in healthy participants and patients with various diseases

SO: Cochrane Database of Systematic Reviews

YR: 2012

NO: 3

PB: John Wiley & Sons, Ltd

KY: Mortality;Antioxidants [administration & dosage] [adverse effects];Ascorbic Acid [administration & dosage] [adverse effects];Health Status;Primary Prevention [methods];Randomized Controlled Trials as Topic;Secondary Prevention [methods];Selenium [administration & dosage] [adverse effects];Vitamin A [administration & dosage] [adverse effects];Vitamin E [administration & dosage] [adverse effects];beta Carotene [administration & dosage] [adverse effects];Female[checkword];Humans[checkword];Male[checkword]

CC: LIVER

DOI: 10.1002/14651858.CD007176.pub2

AB: Background: Our systematic review has demonstrated that antioxidant supplements may increase mortality. We have now updated this review.Objectives: To assess the beneficial and

harmful effects of antioxidant supplements for prevention of mortality in adults.Search methods: We searched The Cochrane Library, MEDLINE, EMBASE, LILACS, the Science Citation Index Expanded, and Conference Proceedings Citation Index-Science to February 2011. We scanned bibliographies of relevant publications and asked pharmaceutical companies for additional trials.Selection criteria: We included all primary and secondary prevention randomised clinical trials on antioxidant supplements (beta-carotene, vitamin A, vitamin C, vitamin E, and selenium) versus placebo or no intervention.Data collection and analysis: Three authors extracted data. Random-effects and fixed-effect model meta-analyses were conducted. Risk of bias was considered in order to minimise the risk of systematic errors. Trial sequential analyses were conducted to minimise the risk of random errors. Random-effects model meta-regression analyses were performed to assess sources of intertrial heterogeneity.Main results: Seventy-eight randomised trials with 296,707 participants were included. Fifty-six trials including 244,056 participants had low risk of bias. Twenty-six trials included 215,900 healthy participants. Fifty-two trials included 80,807 participants with various diseases in a stable phase. The mean age was 63 years (range 18 to 103 years). The mean proportion of women was 46%. Of the 78 trials, 46 used the parallel-group design, 30 the factorial design, and 2 the cross-over design. All antioxidants were administered orally, either alone or in combination with vitamins, minerals, or other interventions. The duration of supplementation varied from 28 days to 12 years (mean duration 3 years; median duration 2 years). Overall, the antioxidant supplements had no significant effect on mortality in a random-effects model meta-analysis (21,484 dead/183,749 (11.7%) versus 11,479 dead/112,958 (10.2%); 78 trials, relative risk (RR) 1.02, 95% confidence interval (CI) 0.98 to 1.05) but significantly increased mortality in a fixed-effect model (RR 1.03, 95% CI 1.01 to 1.05). Heterogeneity was low with an I2- of 12%. In meta-regression analysis, the risk of bias and type of antioxidant supplement were the only significant predictors of intertrial heterogeneity. Meta-regression analysis did not find a significant difference in the estimated intervention effect in the primary prevention and the secondary prevention trials. In the 56 trials with a low risk of bias, the antioxidant supplements significantly increased mortality (18,833 dead/146,320 (12.9%) versus 10,320 dead/97,736 (10.6%); RR 1.04, 95% CI 1.01 to 1.07). This effect was confirmed by trial sequential analysis. Excluding factorial trials with potential confounding showed that 38 trials with low risk of bias demonstrated a significant increase in mortality (2822 dead/26,903 (10.5%) versus 2473 dead/26,052 (9.5%); RR 1.10, 95% CI 1.05 to 1.15). In trials with low risk of bias, beta-carotene (13,202 dead/96,003 (13.8%) versus 8556 dead/77,003 (11.1%); 26 trials, RR 1.05, 95% CI 1.01 to 1.09) and vitamin E (11,689 dead/97,523 (12.0%) versus 7561 dead/73,721 (10.3%); 46 trials, RR 1.03, 95% CI 1.00 to 1.05) significantly increased mortality, whereas vitamin A (3444 dead/24,596 (14.0%) versus 2249 dead/16,548 (13.6%); 12 trials, RR 1.07, 95% CI 0.97 to 1.18), vitamin C (3637 dead/36,659 (9.9%) versus 2717 dead/29,283 (9.3%); 29 trials, RR 1.02, 95% CI 0.98 to 1.07), and selenium (2670 dead/39,779 (6.7%) versus 1468 dead/22,961 (6.4%); 17 trials, RR 0.97, 95% CI 0.91 to 1.03) did not significantly affect mortality. In univariate meta-regression analysis, the dose of vitamin A was significantly associated with increased mortality (RR 1.0006, 95% CI 1.0002 to 1.001, P = 0.002).Authors' conclusions: We found no evidence to support antioxidant supplements for primary or secondary prevention. Beta-carotene and vitamin E seem to increase mortality, and so may higher doses of vitamin A. Antioxidant supplements need to be considered as medicinal products and should undergo sufficient evaluation before marketing.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007176.pub2/abstract

Record #7 of 45

ID: CD005562

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AU: Spector Aimee E

AU: Orrell Martin

TI: Cognitive stimulation to improve cognitive functioning in people with dementia

SO: Cochrane Database of Systematic Reviews

YR: 2012

NO: 2

PB: John Wiley & Sons, Ltd

KY: Cognition [physiology];Dementia [therapy];Memory [physiology];Orientation [physiology];Psychotherapy [methods];Randomized Controlled Trials as Topic;Aged[checkword];Humans[checkword]

CC: HM-DEMENTIA

DOI: 10.1002/14651858.CD005562.pub2

AB: Background: Cognitive stimulation is an intervention for people with dementia which offers a range of enjoyable activities providing general stimulation for thinking, concentration and memory usually in a social setting, such as a small group. Its roots can be traced back to Reality Orientation (RO), which was developed in the late 1950s as a response to confusion and disorientation in older patients in hospital units in the USA. RO emphasised the engagement of nursing assistants in a hopeful, therapeutic process but became associated with a rigid, confrontational approach to people with dementia, leading to its use becoming less and less common.Cognitive stimulation is often discussed in normal ageing as well as in dementia. This reflects a general view that lack of cognitive activity hastens cognitive decline. With people with dementia, cognitive stimulation attempts to make use of the positive aspects of RO whilst ensuring that the stimulation is implemented in a sensitive, respectful and person-centred manner.There is often little consistency in the application and availability of psychological therapies in dementia services, so a systematic review of the available evidence regarding cognitive stimulation is important in order to identify its effectiveness and to place practice recommendations on a sound evidence base.Objectives: To evaluate the effectiveness

and impact of cognitive stimulation interventions aimed at improving cognition for people with dementia, including any negative effects.Search methods: The trials were identified from a search of the Cochrane Dementia and Cognitive Improvement Group Specialized Register, called ALOIS (updated 6 December 2011). The search termsused were: cognitive stimulation, reality orientation, memory therapy, memory groups, memory support, memory stimulation, global stimulation, cognitive psychostimulation. Supplementary searches were performed in a number of major healthcare databases and trial registers to ensure that the search was up to date and comprehensive.Selection criteria: All randomised controlled trials (RCTs) of cognitive stimulation for dementia which incorporated a measure of cognitive change were included.Data collection and analysis: Data were extracted independently by two review authors using a previously tested data extraction form. Study authors were contacted for data not provided in the papers. Two review authors conducted independent assessments of the risk of bias in included studies.Main results: Fifteen RCTs were included in the review. Six of these had been included in the previous review of RO. The studies included participants from a variety of settings, interventions that were of varying duration and intensity, and were from several different countries. The quality of the studies was generally low by current standards but most had taken steps to ensure assessors were blind to treatment allocation. Data were entered in the meta-analyses for 718 participants (407 receiving cognitive stimulation, 311 in control groups). The primary analysis was on changes that were evident immediately at the end of the treatment period. A few studies provided data allowing evaluation of whether any effects were subsequently maintained. A clear, consistent benefit on cognitive function was associated with cognitive stimulation (standardised mean difference (SMD) 0.41, 95% CI 0.25 to 0.57). This remained evident at follow-up one to three months after the end of treatment. In secondary analyses with smaller total sample sizes, benefits were also noted on self-reported quality of life and well-being (standardised mean difference: 0.38 [95% CI: 0.11, 0.65]); and on staff ratings of communication and social interaction (SMD 0.44, 95% CI 0.17 to 0.71). No differences in relation to mood (self-report or staff-rated), activities of daily living, general behavioural function or problem behaviour were noted. In the few studies reporting family caregiver outcomes, no differences were noted. Importantly, there was no indication of increased strain on family caregivers in the one study where they were trained to deliver the intervention.Authors' conclusions: There was consistent evidence from multiple trials that cognitive stimulation programmes benefit cognition in people with mild to moderate dementia over and above any medication effects. However, the trials were of variable quality with small sample sizes and only limited details of the randomisation method were apparent in a number of the trials. Other outcomes need more exploration but improvements in self-reported quality of life and well-being were promising. Further research should look into the potential benefits of longer term cognitive stimulation programmes and their clinical significance.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD005562.pub2/abstract

Record #8 of 45

ID: CD004816

AU: Taylor Fiona

AU: Huffman Mark D

AU: Macedo Ana Filipa

AU: Moore Theresa HM

AU: Burke Margaret

AU: Davey Smith George

AU: Ward Kirsten

AU: Ebrahim Shah

TI: Statins for the primary prevention of cardiovascular disease

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 1

PB: John Wiley & Sons, Ltd

KY: Cardiovascular Diseases [blood] [mortality] [prevention & control];Cause of Death;Cholesterol, HDL [blood];Cholesterol, LDL [blood];Hydroxymethylglutaryl-CoA Reductase Inhibitors [adverse effects] [therapeutic use];Myocardial Revascularization [methods];Primary Prevention;Randomized Controlled Trials as Topic;Stroke [prevention & control];Adult[checkword];Humans[checkword]

CC: VASC

DOI: 10.1002/14651858.CD004816.pub5

AB: Background: Reducing high blood cholesterol, a risk factor for cardiovascular disease (CVD) events in people with and without a past history of CVD is an important goal of pharmacotherapy. Statins are the first-choice agents. Previous reviews of the effects of statins have highlighted their benefits in people with CVD. The case for primary prevention was uncertain when the last version of this review was published (2011) and in light of new data an update of this review is required.Objectives: To assess the effects, both harms and benefits, of statins in people with no history of CVD.Search methods: To avoid duplication of effort, we checked reference lists of previous systematic reviews. The searches conducted in 2007 were updated in January 2012. We searched the Cochrane Central Register of Controlled Trials (CENTRAL) in The Cochrane Library (2022, Issue 4), MEDLINE OVID (1950 to December Week 4 2011) and EMBASE OVID (1980 to 2012 Week 1).There were no language restrictions.Selection criteria: We included randomised controlled trials of statins versus placebo or usual care control with minimum treatment duration of one year and follow-up of six months, in adults with no restrictions on total, low density lipoprotein (LDL) or high density lipoprotein (HDL) cholesterol levels, and where 10% or less had a history of CVD.Data collection and analysis:

Two review authors independently selected studies for inclusion and extracted data. Outcomes included all-cause mortality, fatal and non-fatal CHD, CVD and stroke events, combined endpoints (fatal and non-fatal CHD, CVD and stroke events), revascularisation, change in total and LDL cholesterol concentrations, adverse events, quality of life and costs. Odds ratios (OR) and risk ratios (RR) were calculated for dichotomous data, and for continuous data, pooled mean differences (MD) (with 95% confidence intervals (CI)) were calculated. We contacted trial authors to obtain missing data.Main results: The latest search found four new trials and updated follow-up data on three trials included in the original review. Eighteen randomised control trials (19 trial arms; 56,934 participants) were included. Fourteen trials recruited patients with specific conditions (raised lipids, diabetes, hypertension, microalbuminuria). All-cause mortality was reduced by statins (OR 0.86, 95% CI 0.79 to 0.94); as was combined fatal and non-fatal CVD RR 0.75 (95% CI 0.70 to 0.81), combined fatal and non-fatal CHD events RR 0.73 (95% CI 0.67 to 0.80) and combined fatal and non-fatal stroke (RR 0.78, 95% CI 0.68 to 0.89). Reduction of revascularisation rates (RR 0.62, 95% CI 0.54 to 0.72) was also seen. Total cholesterol and LDL cholesterol were reduced in all trials but there was evidence of heterogeneity of effects. There was no evidence of any serious harm caused by statin prescription. Evidence available to date showed that primary prevention with statins is likely to be cost-effective and may improve patient quality of life. Recent findings from the Cholesterol Treatment Trialists study using individual patient data meta-analysis indicate that these benefits are similar in people at lower (< 1% per year) risk of a major cardiovascular event.Authors' conclusions: Reductions in all-cause mortality, major vascular events and revascularisations were found with no excess of adverse events among people without evidence of CVD treated with statins.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004816.pub5/abstract

Record #9 of 45

ID: CD004567

AU: Mathew Milan C

AU: Ervin Ann-Margret

AU: Tao Jeremiah

AU: Davis Richard M

TI: Antioxidant vitamin supplementation for preventing and slowing the progression of age-related cataract

SO: Cochrane Database of Systematic Reviews

YR: 2012

NO: 6

PB: John Wiley & Sons, Ltd

KY: Antioxidants [administration & dosage] [therapeutic use];Ascorbic Acid [administration & dosage] [therapeutic use];Cataract [drug therapy] [prevention & control];Disease Progression;Vitamin E [administration & dosage] [therapeutic use];Vitamins [administration & dosage] [therapeutic use];beta Carotene [administration & dosage] [therapeutic use];Adult[checkword];Aged[checkword];Humans[checkword];Middle Aged[checkword]

CC: HM-EYES

DOI: 10.1002/14651858.CD004567.pub2

AB: Background: Age-related cataract is a major cause of visual impairment in the elderly. Oxidative stress has been implicated in its formation and progression. Antioxidant vitamin supplementation has been investigated in this context.Objectives: To assess the effectiveness of antioxidant vitamin supplementation in preventing and slowing the progression of age-related cataract.Search methods: We searched CENTRAL (which contains the Cochrane Eyes and Vision Group Trials Register) (The Cochrane Library 2012, Issue 2), MEDLINE (January 1950 to March 2012), EMBASE (January 1980 to March 2012), Latin American and Caribbean Literature on Health Sciences (LILACS) (January 1982 to March 2012), Open Grey (System for Information on Grey Literature in Europe) (www.opengrey.eu/), the metaRegister of Controlled Trials (mRCT) (www.controlled-trials.com), ClinicalTrials.gov (www.clinicaltrials.gov) and the WHO International Clinical Trials Registry Platform (ICTRP) (www.who.int/ictrp/search/en). There were no date or language restrictions in the electronic searches for trials. The electronic databases were last searched on 2 March 2012. We also checked the reference lists of included studies and ongoing trials and contacted investigators to identify eligible randomized trials.Selection criteria: We included only randomized controlled trials in which supplementation with one or more antioxidant vitamins (beta-carotene, vitamin C and vitamin E) in any form, dosage or combination for at least one year was compared to another antioxidant vitamin or to placebo.Data collection and analysis: Two authors extracted data and assessed trial quality independently. We pooled results for the primary outcomes, i.e., incidence of cataract and incidence of cataract extraction. We did not pool results of the secondary outcomes - progression of cataract and loss of visual acuity, because of differences in definitions of outcomes and data presentation. We pooled results by type of cataract when data were available. We did not perform a sensitivity analysis.Main results: Nine trials involving 117,272 individuals of age 35 years or older are included in this review. The trials were conducted in Australia, Finland, India, Italy, the United Kingdom and the United States, with duration of follow-up ranging from 2.1 to 12 years. The doses of antioxidant vitamins were higher than the recommended daily allowance. There was no evidence of effect of antioxidant vitamin supplementation in reducing the risk of cataract, cataract extraction, progression of cataract or in slowing the loss of visual acuity. In the pooled analyses, there was no evidence of effect of beta-carotene supplementation in reducing the risk of cataract (two trials) (relative risk (RR) 0.99, 95% confidence interval (CI) 0.91 to 1.08; n = 57,703) or in reducing the risk of cataract extraction (three trials) (RR 1.00, 95% CI 0.91 to 1.10; n = 86,836) or of vitamin E supplementation in reducing the risk of cataract (three trials) (RR 0.97, 95% CI 0.91 to 1.04; n = 50,059) or of cataract extraction (five trials) (RR 0.98, 95% CI 0.91

to 1.05; n = 83,956). The proportion of participants developing hypercarotenodermia (yellowing of skin) while on beta-carotene ranged from 7.4% to 15.8%.Authors' conclusions: There is no evidence from RCTs that supplementation with antioxidant vitamins (beta-carotene, vitamin C or vitamin E) prevents or slows the progression of age-related cataract. We do not recommend any further studies to examine the role of antioxidant vitamins beta-carotene, vitamin C and vitamin E in preventing or slowing the progression of age-related cataract. Costs and adverse effects should be weighed carefully with unproven benefits before recommending their intake above recommended daily allowances.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004567.pub2/abstract

Record #10 of 45

ID: CD003380

AU: Merry Sally N

AU: Hetrick Sarah E

AU: Cox Georgina R

AU: Brudevold-Iversen Tessa

AU: Bir Julliet J

AU: McDowell Heather

TI: Psychological and educational interventions for preventing depression in children and adolescents

SO: Cochrane Database of Systematic Reviews

YR: 2011

NO: 12

PB: John Wiley & Sons, Ltd

KY: Depression [diagnosis] [prevention & control];Depressive Disorder [diagnosis] [prevention & control];Program Evaluation;Psychotherapy [methods];Randomized Controlled Trials as Topic;Adolescent[checkword];Child[checkword];Child, Preschool[checkword];Female[checkword];Humans[checkword];Male[checkword];Young Adult[checkword]

CC: HM-DEPRESSN

DOI: 10.1002/14651858.CD003380.pub3

AB: Background: Depression is common in young people, has a marked negative impact and is associated with self-harm and suicide. Preventing its onset would be an important advance in public health. Objectives: To determine whether psychological or educational interventions, or both, are effective in preventing the onset of depressive disorder in children and adolescents.Search methods: The Cochrane Depression, Anxiety and Neurosis Review Group's trials registers (CCDANCTR) were searched at the editorial base in July 2010. Update searches of MEDLINE, EMBASE, PsycINFO and ERIC were conducted by the authors in September 2009. Conference abstracts, reference lists of included studies and reviews were searched and experts in the field contacted.Selection criteria: Randomised controlled trials of psychological or educational prevention programmes, or both, compared with placebo, any comparison intervention, or no intervention for young people aged 5 to 19 years-old, who did not currently meet diagnostic criteria for depression or who were below the clinical range on standardised, validated, and reliable rating scales of depression, or both, were included.Data collection and analysis: Two authors independently assessed studies for inclusion and rated their quality. Sample sizes were adjusted to take account of cluster designs and multiple comparisons. We contacted study authors for additional information where needed. Main results: Fifty-three studies including 14,406 participants were included in the analysis. There were only six studies with clear allocation concealment, participants and assessors were mostly not blind to the intervention or blinding was unclear so that the overall risk of bias was moderately high. Sixteen studies including 3240 participants reported outcomes on depressive diagnosis. The risk of having a depressive disorder post-intervention was reduced immediately compared with no intervention (15 studies; 3115 participants risk difference (RD) -0.09; 95% confidence interval (CI) -0.14 to -0.05; P<0.0003), at three to nine months (14 studies; 1842 participants; RD -0.11; 95% CI -0.16 to -0.06) and at 12 months (10 studies; 1750 participants; RD -0.06; 95% CI -0.11 to -0.01). There was no evidence for continued efficacy at 24 months (eight studies; 2084 participant; RD -0.01; 95% CI -0.04 to 0.03) but limited evidence of efficacy at 36 months (two studies; 464 participants; RD -0.10; 95% CI -0.19 to -0.02). There was significant heterogeneity in all these findings. There was no evidence of efficacy in the few studies that compared intervention with placebo or attention controls.Authors' conclusions: There is some evidence from this review that targeted and universal depression prevention programmes may prevent the onset of depressive disorders compared with no intervention. However, allocation concealment is unclear in most studies, and there is heterogeneity in the findings. The persistence of findings suggests that this is real and not a placebo effect.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003380.pub3/abstract

Record #11 of 45

ID: CD002854

AU: Farina Nicolas

AU: Isaac Mokhtar Gad El Kareem Nasr

AU: Clark Annalie R

AU: Rusted Jennifer

AU: Tabet Naji

TI: Vitamin E for Alzheimer's dementia and mild cognitive impairment

SO: Cochrane Database of Systematic Reviews

YR: 2012

NO: 11

PB: John Wiley & Sons, Ltd

KY: Alzheimer Disease [drug therapy];Antioxidants [therapeutic use];Disease Progression;Mild Cognitive Impairment [drug therapy];Outcome Assessment (Health Care);Randomized Controlled Trials as Topic;Vitamin E [therapeutic use];Humans[checkword]

CC: DEMENTIA

DOI: 10.1002/14651858.CD002854.pub3

AB: Background: Vitamin E is a dietary compound that functions as an antioxidant scavenging toxic free radicals. Evidence that free radicals may contribute to the pathological processes of cognitive impairment including Alzheimer's disease has led to interest in the use of vitamin E in the treatment of mild cognitive impairment (MCI) and Alzheimer's dementia (AD).Objectives: To assess the efficacy of vitamin E in the treatment of AD and prevention of progression of MCI to dementia.Search methods: The Specialized Register of the Cochrane Dementia and Cognitive Improvement Group (ALOIS), The Cochrane Library, MEDLINE, EMBASE, PsycINFO, CINAHL, LILACS as well as many trials databases and grey literature sources were searched on 25 June 2012 using the terms: "Vitamin E", vitamin-E, alpha-tocopherol.Selection criteria: All unconfounded, double-blind, randomised trials in which treatment with vitamin E at any dose was compared with placebo for patients with AD and MCI.Data collection and analysis: Two review authors independently applied the selection criteria and assessed study quality and extracted and analysed the data. For each outcome measure data were sought on every patient randomised. Where such data were not available an analysis of patients who completed treatment was conducted. It was not possible to pool data between studies owing to a lack of comparable outcome measure.Main results: Only three studies met the inclusion criteria: two in an AD population and one in an MCI population. In the first of the AD studies (Sano 1996) the authors reported some benefit from vitamin E (2000 IU/day) with fewer participants reaching an end point of death, institutionalisation, change to a Clinical Dementia Rating (CDR) of three, or loss of two basic activities of daily living within two years. Of patients completing treatment, 58% (45/77) on vitamin E compared with 74% (58/78) on placebo reached one of the end points (odds ratio (OR) 0.49; 95% confidence interval (CI) 0.25 to 0.96). The second AD treatment study (Lloret 2009) explored the effects of vitamin E (800 IU/day) on cognitive progression in relation to oxidative stress levels. Patients whose oxidative stress markers were lowered by vitamin E showed no significant difference in the percentage change

in Mini-Mental State Examination (MMSE) score, between baseline and six months, compared to the placebo group. The primary aim of the MCI study (Petersen 2005) was to investigate the effect of vitamin E (2000 IU/day) on the time to progression from MCI to possible or probable AD. A total of 214 of the 769 participants progressed to dementia, with 212 being classified as having possible or probable AD. There was no significant difference in the probability of progression from MCI to AD between the vitamin E group and the placebo group (hazard ratio 1.02; 95% CI 0.74 to 1.41; P = 0.91).Authors' conclusions: No convincing evidence that vitamin E is of benefit in the treatment of AD or MCI. Future trials assessing vitamin E treatment in AD should not be restricted to alpha-tocopherol.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD002854.pub3/abstract

Record #12 of 45

ID: CD001191

AU: Birks Jacqueline

AU: Grimley Evans John

AU: Iakovidou Vasso

AU: Tsolaki Magda

TI: Rivastigmine for Alzheimer's disease

SO: Cochrane Database of Systematic Reviews

YR: 2009

NO: 2

PB: John Wiley & Sons, Ltd

KY: Alzheimer Disease [drug therapy];Cholinesterase Inhibitors [administration & dosage] [adverse effects] [therapeutic use];Cognition Disorders [drug therapy];Phenylcarbamates [administration & dosage] [adverse effects] [therapeutic use];Randomized Controlled Trials as Topic;Severity of Illness Index;Humans[checkword]

CC: DEMENTIA

DOI: 10.1002/14651858.CD001191.pub2

AB: Background: Alzheimer's disease (AD) is the commonest cause of dementia affecting older people. One of the therapeutic strategies aimed at ameliorating the clinical manifestations of Alzheimer's disease is to enhance cholinergic neurotransmission in relevant parts of the brain by the use of cholinesterase inhibitors to delay the breakdown of acetylcholine released into

synaptic clefts. Tacrine, the first of the cholinesterase inhibitors to undergo extensive trials for this purpose, was associated with significant adverse effects including hepatotoxicity. Other cholinesterase inhibitors, including rivastigmine, with superior properties in terms of specificity of action and low risk of adverse effects, have now been introduced. Rivastigmine has received approval for use in 60 countries including all member states of the European Union and the USA.Objectives: To determine the clinical efficacy and safety of rivastigmine for patients with dementia of Alzheimer's type.Search methods: The Specialized Register of the Cochrane Dementia and Cognitive Improvement Group (CDCIG), The Cochrane Library, MEDLINE, EMBASE, PsycINFO, CINAHL and LILACS were searched on 27 March 2008 using the terms: Rivastigmine OR exelon OR ENA OR "SDZ ENA 713" . The CDCIG Specialized Register contains records from all major health care databases (The Cochrane Library, MEDLINE, EMBASE, PsycINFO, CINAHL, LILACS) as well as from many clinical trials registries and grey literature sources.Selection criteria: All unconfounded, double-blind, randomized trials in which treatment with rivastigmine was administered to patients with dementia of the Alzheimer's type for more than two weeks and its effects compared with those of placebo in a parallel group of patients.Data collection and analysis: One reviewer (JSB) applied study selection criteria, assessed the quality of studies and extracted data.Main results: Nine trials, involving 4775 participants, were included in the analyses. Use of rivastigmine in high doses was associated with statistically significant benefits on several measures. High-dose rivastigmine (6 to 12 mg daily) was associated with a two-point improvement in cognitive function on the ADAS-Cog score compared with placebo (weighted mean difference -1.99, 95% confidence interval -2.49 to -1.50, on an intention-to-treat basis) and a 2.2 point improvement in activities of daily living assessed on the Progressive Deterioration Scale (weighted mean difference -2.15, 95% confidence interval -3.16 to -1.13, on an intention-to-treat basis) at 26 weeks. At lower doses (4 mg daily or lower) differences were in the same direction but were statistically significant only for cognitive function. There were statistically significantly higher numbers of events of nausea, vomiting, diarrhoea, anorexia, headache, syncope, abdominal pain and dizziness among patients taking high-dose rivastigmine than among those taking placebo. There was some evidence that adverse events might be less common with more frequent, smaller doses of rivastigmine. The 2008 update includes a new study testing two types of rivastigmine transdermal patch, one delivering a higher dose than previously tested (17.4 mg/day) and a smaller patch delivering 9.6 mg/day. The efficacy of the smaller patch was not significantly different compared with the capsules of similar daily dose, but was associated with significantly fewer adverse events of nausea, vomiting, dizziness and asthenia. The efficacy of the larger patch was not significantly different compared with the smaller patch, but the smaller patch was associated with significantly fewer adverse events of nausea, vomiting, weight loss and dizziness. There appears to be advantages associated with the smaller patch compared with both the higher dose patch and the 6-12 mg/day capsules.Authors' conclusions: Rivastigmine appears to be beneficial for people with mild to moderate Alzheimer's disease. In comparisons with placebo, improvements were seen in the rate of decline of cognitive function, activities of daily living, and severity of dementia with daily doses of 6 to 12 mg. Adverse events were consistent with the cholinergic actions of the drug. A transdermal patch has been tested in one trial, and there is evidence that the lower dose smaller patch is associated with fewer side effects than the capsules or the higher dose

larger patch and has comparable efficacy to both. This review has not examined economic data.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD001191.pub2/abstract

Record #13 of 45

ID: CD001478

AU: Zhang Linjie

AU: Prietsch Sílvio OM

AU: Axelsson Inge

AU: Halperin Scott A

TI: Acellular vaccines for preventing whooping cough in children

SO: Cochrane Database of Systematic Reviews

YR: 2012

NO: 3

PB: John Wiley & Sons, Ltd

KY: Age Factors;Diphtheria-Tetanus-Pertussis Vaccine [adverse effects] [therapeutic use];Diphtheria-Tetanus-acellular Pertussis Vaccines [adverse effects] [therapeutic use];Pertussis Vaccine [therapeutic use];Randomized Controlled Trials as Topic;Whooping Cough [prevention & control];Child[checkword];Humans[checkword]

CC: HM-ARI

DOI: 10.1002/14651858.CD001478.pub5

AB: Background: Routine use of whole-cell pertussis (wP) vaccines was suspended in some countries in the 1970s and 1980s because of concerns about adverse effects. Following such action, there was a resurgence of whooping cough. Acellular pertussis (aP) vaccines, containing purified or recombinant Bordetella pertussis (B. pertussis) antigens, were developed in the hope that they would be as effective, but less reactogenic than the whole-cell vaccines.Objectives: To assess the efficacy and safety of acellular pertussis vaccines in children.Search methods: We searched the Cochrane Register of Controlled Trials (CENTRAL) (The Cochrane Library 2011, Issue 4) which contains the Cochrane Acute Respiratory Infections Group's Specialised Register, MEDLINE (1950 to December week 4, 2011), EMBASE (1974 to January 2012), Biosis Previews (2009 to January 2012), and CINAHL (2009 to January 2012).Selection criteria: We selected double-blind randomised efficacy and safety trials of aP

vaccines in children up to six years old, with active follow-up of participants and laboratory verification of pertussis cases.Data collection and analysis: Two review authors independently extracted data and assessed the risk of bias in the studies. Differences in trial design precluded a meta-analysis of the efficacy data. We pooled the safety data from individual trials using a random-effects meta-analysis model.Main results: We included six efficacy trials with a total of 46,283 participants and 52 safety trials with a total of 136,541 participants. Most of the safety trials did not report the methods for random sequence generation, allocation concealment and blinding, which made it difficult to assess the risk of bias in the studies. The efficacy of multi-component (? three) vaccines varied from 84% to 85% in preventing typical whooping cough (characterised by 21 or more consecutive days of paroxysmal cough with confirmation of B. pertussis infection by culture, appropriate serology or contact with a household member who has culture-confirmed pertussis), and from 71% to 78% in preventing mild pertussis disease (characterised by seven or more consecutive days of cough with confirmation of B. pertussis infection by culture or appropriate serology). In contrast, the efficacy of one- and two-component vaccines varied from 59% to 75% against typical whooping cough and from 13% to 54% against mild pertussis disease. Multi-component acellular vaccines are more effective than low-efficacy whole-cell vaccines, but may be less effective than the highest-efficacy whole-cell vaccines. Most systemic and local adverse events were significantly less common with aP vaccines than with wP vaccines for the primary series as well as for the booster dose.Authors' conclusions: Multi-component (? three) aP vaccines are effective and show less adverse effects than wP vaccines for the primary series as well as for booster doses.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD001478.pub5/abstract

Record #14 of 45

ID: CD009138

AU: Leucht Claudia

AU: Huhn Maximilian

AU: Leucht Stefan

TI: Amitriptyline versus placebo for major depressive disorder

SO: Cochrane Database of Systematic Reviews

YR: 2012

NO: 12

PB: John Wiley & Sons, Ltd

KY: Amitriptyline [therapeutic use];Antidepressive Agents, Tricyclic [therapeutic use];Depressive Disorder, Major [drug therapy];Placebo Effect;Randomized Controlled Trials as Topic;Adult[checkword];Humans[checkword]

CC: DEPRESSN

DOI: 10.1002/14651858.CD009138.pub2

AB: Background: Amitriptyline is a tricyclic antidepressant that was synthesised in 1960 and introduced as early as 1961 in the USA, but is still regularly used. It has also been frequently used as an active comparator in trials on newer antidepressants and can therefore be called a 'benchmark' antidepressant. However, its efficacy and safety compared to placebo in the treatment of major depression has not been assessed in a systematic review and meta-analysis.Objectives: To assess the effects of amitriptyline compared to placebo or no treatment for major depressive disorder in adults.Search methods: We searched the Cochrane Depression, Anxiety and Neurosis Group's Specialised Register (CCDANCTR-Studies and CCDANCTR-References) to August 2012. This register contains relevant randomised controlled trials from: The Cochrane Library (all years), EMBASE (1974 to date), MEDLINE (1950 to date) and PsycINFO (1967 to date). The reference lists of reports of all included studies were screened and manufacturers of amitriptyline contacted for details of additional studies.Selection criteria: All randomised controlled trials (RCTs) comparing amitriptyline with placebo or no treatment in patients with major depressive disorder as diagnosed by operationalised criteria.Data collection and analysis: Two review authors independently extracted data. For dichotomous data, we calculated the odds ratio (OR) with 95% confidence intervals (CI). We analysed continuous data using standardised mean differences (with 95% CI). We used a random-effects model throughout.Main results: The review includes 39 trials with a total of 3509 participants. Study duration ranged between three and 12 weeks. Amitriptyline was significantly more effective than placebo in achieving acute response (18 RCTs, n = 1987, OR 2.67, 95% CI 2.21 to 3.23). Significantly fewer participants allocated to amitriptyline than to placebo withdrew from trials due to inefficacy of treatment (19 RCTs, n = 2017, OR 0.20, 95% CI 0.14 to 0.28), but more amitriptyline-treated participants withdrew due to side effects (19 RCTs, n = 2174, OR 4.15, 95% CI 2.71 to 6.35). Amitriptyline also caused more anticholinergic side effects, tachycardia, dizziness, nervousness, sedation, tremor, dyspepsia, sedation, sexual dysfunction and weight gain. In subgroup and meta-regression analyses the results of the primary outcome were robust towards publication year (1971 to 1997), mean participant age at baseline, mean amitriptyline dose, study duration in weeks, pharmaceutical sponsor, inpatient versus outpatient setting and two-arm versus three-arm design. However, higher severity at baseline was associated with higher superiority of amitriptyline (P = 0.02), while higher responder rates in the placebo groups were associated with lower superiority of amitriptyline (P = 0.05). The results of the primary outcome were rather homogeneous, reflecting comparability of the trials. However, methods of randomisation, allocation concealment and blinding were usually poorly reported. Not all studies used intention-to-treat analyses and in many of them standard deviations were not reported and often had to be imputed. Funnel plots suggested a possible publication bias, but the trim and fill method did not change the overall effect size much (seven adjusted studies, OR 2.64, 95% CI 2.24 to 3.10).Authors' conclusions: Amitriptyline is an efficacious antidepressant drug. It is, however,

also associated with a number of side effects. Degree of placebo response and severity of depression at baseline may moderate drug-placebo efficacy differences.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD009138.pub2/abstract

Record #15 of 45

ID: CD009228

AU: Galvagno Jr Samuel M

AU: Thomas Stephen

AU: Stephens Christopher

AU: Haut Elliott R

AU: Hirshon Jon M

AU: Floccare Douglas

AU: Pronovost Peter

TI: Helicopter emergency medical services for adults with major trauma

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 3

PB: John Wiley & Sons, Ltd

KY: Air Ambulances;Disability Evaluation;Injury Severity Score;Quality-Adjusted Life Years;Regression Analysis;Survival Analysis;Wounds and Injuries [complications] [mortality];Adult[checkword];Humans[checkword]

CC: INJ

DOI: 10.1002/14651858.CD009228.pub2

AB: Background: Although helicopters are presently an integral part of trauma systems in most developed nations, previous reviews and studies to date have raised questions about which groups of traumatically injured patients derive the greatest benefit.Objectives: The purpose of this review is to determine if helicopter emergency medical services transport (HEMS) is associated with improved morbidity and mortality, compared to ground emergency medical services transport (GEMS), for adults with major trauma. The primary outcome was survival to hospital discharge. Secondary outcomes were quality-adjusted life years (QALYs) and disability-

adjusted life years (DALYs).Search methods: Searches were run in CENTRAL, MEDLINE, EMBASE, CINAHL (EBSCOhost), SCI-EXPANDED, CPCI-S, and ZETOC in January 2012. Relevant websites were also searched, including controlled trials registers, HSRProj, the World Health Organization (WHO) ICTRP, and OpenSIGLE. Searches were not restricted by date, language, or publication status. Attempts were made to contact authors in the case of missing data.Selection criteria: Eligible trials included randomised controlled trials (RCTs) and non-randomised intervention studies. Non-randomised studies (NRS), including controlled trials and cohort studies, were also evaluated. Each study was required to have a GEMS comparison group. An injury severity score (ISS) > 15 or an equivalent marker for injury severity was required. Only adults aged 16 years or older were included.Data collection and analysis: Three review authors independently extracted data and assessed the risk of bias of included studies. The Downs and Black quality assessment tool was applied for NRS. The results were analysed in a narrative review, and with studies grouped by methodology and injury type. A predefined subgroup was comprised of four additional studies that examined the role of HEMS versus GEMS for inter-facility transfer. Summary of findings tables were constructed in accordance with the GRADE Working Group criteria.Main results: Twenty-five studies met the entry criteria for this review. Four additional studies met the criteria for a separate, predefined subgroup analysis of patients transferred to trauma centres by HEMS or GEMS. All studies were non-randomised studies; no RCTs were found. Survival at hospital discharge was the primary outcome. Data from 163,748 people from 21 of the 25 studies included in the primary analysis were available to calculate unadjusted mortality. Overall, considerable heterogeneity was observed and an accurate estimate of overall effect could not be determined. Based on the unadjusted mortality data from five trials that focused on traumatic brain injury, there was no decreased risk of death with HEMS (relative risk (RR) 1.02; 95% CI 0.85 to 1.23). Nine studies used multivariate regression to adjust for confounding, the five largest indicated a statistically significant increased odds of survival associated with HEMS. All Trauma-Related Injury Severity Score (TRISS)-based studies indicated improved survival in the HEMS group as compared to the Major Trauma Outcomes Study (MTOS) cohort; some studies showed survival benefits in both the HEMS and GEMS groups as compared to MTOS. No studies were found to evaluate the secondary outcome of morbidity as assessed by QALYs and DALYs. All four studies suggested a positive benefit when HEMS was used to transfer patients to higher level trauma centres. Overall, the quality of the included studies was very low as assessed by the GRADE Working Group criteria.Authors' conclusions: Due to the methodological weakness of the available literature, and the considerable heterogeneity of effects and study methodologies, an accurate composite estimate of the benefit of HEMS could not be determined. Although five of the nine multivariate regression studies indicated improved survival associated with HEMS, the remainder did not. All were subject to a low quality of evidence as assessed by the GRADE Working Group criteria due to their non-randomised design. Similarly, TRISS-based studies, which all demonstrated improved survival, cannot be considered strong evidence because of their methodology, which did not randomize the use of HEMS. The question of which elements of HEMS may be beneficial for patients has not been fully answered. The results from this review provide motivation for future work in this area. This includes an ongoing need for diligent reporting of research methods, which is imperative for transparency and to maximise the potential utility of results. Large, multicentre studies are warranted as these will help produce more robust estimates of treatment effects. Future work in this area

should also examine the costs and safety of HEMS, since multiple contextual determinants must be considered when evaluating the effects of HEMS for adults with major trauma.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD009228.pub2/abstract

Record #16 of 45

ID: CD006757

AU: Casparis Heather

AU: Lindsley Kristina

AU: Kuo Irene C

AU: Sikder Shameema

AU: Bressler Neil M

TI: Surgery for cataracts in people with age-related macular degeneration

SO: Cochrane Database of Systematic Reviews

YR: 2012

NO: 6

PB: John Wiley & Sons, Ltd

KY: Cataract [complications];Cataract Extraction [adverse effects];Disease Progression;Macular Degeneration [complications] [pathology];Randomized Controlled Trials as Topic;Humans[checkword];Middle Aged[checkword]

CC: EYES

DOI: 10.1002/14651858.CD006757.pub3

AB: Background: Cataract and age-related macular degeneration (AMD) are common causes of decreased vision that often occur simultaneously in people over age 50. Although cataract surgery is an effective treatment for cataract-induced visual loss, some clinicians suspect that such an intervention may increase the risk of worsening of underlying AMD and thus have deleterious effects on vision.Objectives: The objective of this review was to evaluate the effectiveness and safety of cataract surgery in eyes with AMD.Search methods: We searched CENTRAL (which contains the Cochrane Eyes and Vision Group Trials Register) (The Cochrane Library 2012, Issue 4), MEDLINE (January 1950 to April 2012), EMBASE (January 1980 to April 2012), Latin American and Caribbean Literature on Health Sciences (LILACS) (January 1982 to April 2012), the metaRegister of Controlled Trials (mRCT) (www.controlled-trials.com), ClinicalTrials.gov (www.clinicaltrials.gov) and the WHO International Clinical Trials Registry

Platform (ICTRP) (www.who.int/ictrp/search/en). There were no date or language restrictions in the electronic searches for trials. The electronic databases were last searched on 16 April 2012.Selection criteria: We included randomized controlled trials (RCTs) and quasi-randomized trials of eyes affected by both cataract and AMD in which cataract surgery would be compared to no surgery.Data collection and analysis: Two authors independently evaluated the search results against the inclusion and exclusion criteria. Two authors independently extracted data and assessed risk of bias for included studies. We resolved discrepancies by discussion.Main results: One RCT with 60 participants with visually significant cataract and AMD was included in this review. Participants were randomized to immediate cataract surgery (within two weeks of enrollment) (n = 29) or delayed cataract surgery (six months after enrollment) (n = 31). At six months, four participants were lost to follow-up; two participants from each group. The immediate surgery group showed mean improvement in best-corrected visual acuity (BCVA) compared with the delayed surgery group at six months (mean difference (MD) 0.15 LogMAR, 95% confidence interval (CI) 0.28 to 0.02). There was no significant difference in the development of choroidal neovascularization between groups (1/27 eyes in the immediate surgery group versus 0/29 eyes in the delayed surgery group). Results from Impact of Vision Impairment (IVI) questionnaires suggested that the immediate surgery group faired better with quality of life outcomes than the delayed surgery group (MD in IVI logit scores 1.60, 95% CI 0.61 to 2.59). No postoperative complication was reported. We identified a second potentially relevant study of immediate versus delayed cataract surgery in 54 people with AMD. Results for the study are not yet available, but may be eligible for future updates of this review.Authors' conclusions: At this time, it is not possible to draw reliable conclusions from the available data to determine whether cataract surgery is beneficial or harmful in people with AMD. Physicians will have to make practice decisions based on best clinical judgment until controlled trials are conducted and their findings published.It would be valuable for future research to investigate prospective RCTs comparing cataract surgery to no surgery in patients with AMD to better evaluate whether cataract surgery is beneficial or harmful in this group. However ethical considerations need to be addressed when delaying a potentially beneficial treatment and it may not be feasible to conduct a long-term study where surgery is withheld from the control group. Utilization of pre-existing, standardized systems for grading cataract and AMD and measuring outcomes (visual acuity, change in visual acuity, worsening of AMD and quality of life measures) should be encouraged.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006757.pub3/abstract

Record #17 of 45

ID: CD007868

AU: Walsh Tanya

AU: Worthington Helen V

AU: Glenny Anne-Marie

AU: Appelbe Priscilla

AU: Marinho Valeria CC

AU: Shi Xin

TI: Fluoride toothpastes of different concentrations for preventing dental caries in children and adolescents

SO: Cochrane Database of Systematic Reviews

YR: 2010

NO: 1

PB: John Wiley & Sons, Ltd

KY: Cariostatic Agents [administration & dosage] [therapeutic use];Dental Caries [prevention & control];Fluorides [administration & dosage] [therapeutic use];Randomized Controlled Trials as Topic;Toothpastes [chemistry] [therapeutic use];Adolescent[checkword];Child[checkword];Humans[checkword]

CC: HM-ORAL

DOI: 10.1002/14651858.CD007868.pub2

AB: Background: Caries (dental decay) is a disease of the hard tissues of the teeth caused by an imbalance, over time, in the interactions between cariogenic bacteria in dental plaque and fermentable carbohydrates (mainly sugars). The use of fluoride toothpaste is the primary intervention for the prevention of caries.Objectives: To determine the relative effectiveness of fluoride toothpastes of different concentrations in preventing dental caries in children and adolescents, and to examine the potentially modifying effects of baseline caries level and supervised toothbrushing.Search methods: A search was undertaken on Cochrane Oral Health Group's Trials Register, CENTRAL, MEDLINE and several other databases. Reference lists of articles were also searched. Date of the most recent searches: 8 June 2009.Selection criteria: Randomised controlled trials and cluster-randomised controlled trials comparing fluoride toothpaste with placebo or fluoride toothpaste of a different concentration in children up to 16 years of age with a follow-up period of at least 1 year. The primary outcome was caries increment in the permanent or deciduous dentition as measured by the change in decayed, (missing), filled tooth surfaces (D(M)FS/d(m)fs) from baseline.Data collection and analysis: Inclusion of studies, data extraction and quality assessment were undertaken independently and in duplicate by two members of the review team. Disagreements were resolved by discussion and consensus or by a third party. The primary effect measure was the prevented fraction (PF), the caries increment of the control group minus the caries increment of the treatment group, expressed as a proportion of the caries increment in the control group. Where it was appropriate to pool data, network meta-analysis, network meta-regression or meta-analysis models were used. Potential sources of heterogeneity were specified a priori and examined through random-effects meta-regression analysis where appropriate.Main results: 75 studies were included, of which 71 studies comprising 79 trials contributed data to

the network meta-analysis, network meta-regression or meta-analysis.For the 66 studies (74 trials) that contributed to the network meta-analysis of D(M)FS in the mixed or permanent dentition, the caries preventive effect of fluoride toothpaste increased significantly with higher fluoride concentrations (D(M)FS PF compared to placebo was 23% (95% credible interval (CrI) 19% to 27%) for 1000/1055/1100/1250 parts per million (ppm) concentrations rising to 36% (95% CrI 27% to 44%) for toothpastes with a concentration of 2400/2500/2800 ppm), but concentrations of 440/500/550 ppm and below showed no statistically significant effect when compared to placebo. There is some evidence of a dose response relationship in that the PF increased as the fluoride concentration increased from the baseline although this was not always statistically significant. The effect of fluoride toothpaste also increased with baseline level of D(M)FS and supervised brushing, though this did not reach statistical significance. Six studies assessed the effects of fluoride concentrations on the deciduous dentition with equivocal results dependent upon the fluoride concentrations compared and the outcome measure. Compliance with treatment regimen and unwanted effects was assessed in only a minority of studies. When reported, no differential compliance was observed and unwanted effects such as soft tissue damage and tooth staining were minimal.Authors' conclusions: This review confirms the benefits of using fluoride toothpaste in preventing caries in children and adolescents when compared to placebo, but only significantly for fluoride concentrations of 1000 ppm and above. The relative caries preventive effects of fluoride toothpastes of different concentrations increase with higher fluoride concentration. The decision of what fluoride levels to use for children under 6 years should be balanced with the risk of fluorosis.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007868.pub2/abstract

Record #18 of 45

ID: CD003260

AU: Bahar-Fuchs Alex

AU: Clare Linda

AU: Woods Bob

TI: Cognitive training and cognitive rehabilitation for mild to moderate Alzheimer's disease and vascular dementia

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 6

PB: John Wiley & Sons, Ltd

KY: Alzheimer Disease [rehabilitation];Cognitive Therapy [methods];Dementia, Vascular [rehabilitation];Randomized Controlled Trials as Topic;Humans[checkword]

CC: DEMENTIA

DOI: 10.1002/14651858.CD003260.pub2

AB: Background: Cognitive impairments, particularly memory problems, are a defining feature of the early stages of Alzheimer's disease (AD) and vascular dementia. Cognitive training and cognitive rehabilitation are specific interventional approaches designed to address difficulties with memory and other aspects of cognitive functioning. The present review is an update of previous versions of this review.Objectives: The main aim of the current review was to evaluate the effectiveness and impact of cognitive training and cognitive rehabilitation for people with mild Alzheimer's disease or vascular dementia in relation to important cognitive and non-cognitive outcomes for the person with dementia and the primary caregiver in the short, medium and long term.Search methods: The CDCIG Specialized Register, ALOIS, which contains records from MEDLINE, EMBASE, CINAHL, PsycINFO, LILACS and many other clinical trial databases and grey literature sources, was most recently searched on 2 November 2012.Selection criteria: Randomised controlled trials (RCTs), published in English, comparing cognitive rehabilitation or cognitive training interventions with control conditions, and reporting relevant outcomes for the person with dementia and/or the family caregiver, were considered for inclusion.Data collection and analysis: Eleven RCTs reporting cognitive training interventions were included in the review. A large number of measures were used in the different studies, and meta-analysis could be conducted for 11 of the primary and secondary outcomes of interest. Several outcomes were not measured in any of the studies. The unit of analysis in the meta-analysis was the change from baseline score. Overall estimates of treatment effect were calculated using a fixed-effect model, and statistical heterogeneity was measured using a standard Chi2 statistic. One RCT of cognitive rehabilitation was identified, allowing examination of effect sizes, but no meta-analysis could be conducted.Main results: Cognitive training was not associated with positive or negative effects in relation to any reported outcomes. The overall quality of the trials was low to moderate. The single RCT of cognitive rehabilitation found promising results in relation to a number of participant and caregiver outcomes, and was generally of high quality.Authors' conclusions: Available evidence regarding cognitive training remains limited, and the quality of the evidence needs to improve. However, there is still no indication of any significant benefit derived from cognitive training. Trial reports indicate that some gains resulting from intervention may not be captured adequately by available standardised outcome measures. The results of the single RCT of cognitive rehabilitation show promise but are preliminary in nature. Further, well-designed studies of cognitive training and cognitive rehabilitation are required to obtain more definitive evidence. Researchers should describe and classify their interventions appropriately using available terminology.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003260.pub2/abstract

Record #19 of 45

ID: CD008191

AU: Seitz Dallas P

AU: Adunuri Nikesh

AU: Gill Sudeep S.

AU: Gruneir Andrea

AU: Herrmann Nathan

AU: Rochon Paula

TI: Antidepressants for agitation and psychosis in dementia

SO: Cochrane Database of Systematic Reviews

YR: 2011

NO: 2

PB: John Wiley & Sons, Ltd

KY: Antidepressive Agents [therapeutic use];Citalopram [therapeutic use];Dementia [psychology];Psychomotor Agitation [drug therapy];Psychotic Disorders [drug therapy];Randomized Controlled Trials as Topic;Risperidone [therapeutic use];Serotonin Uptake Inhibitors [therapeutic use];Trazodone [therapeutic use];Adult[checkword];Humans[checkword]

CC: DEMENTIA

DOI: 10.1002/14651858.CD008191.pub2

AB: Background: Agitation and psychosis are common among older adults with dementia and are challenging to manage. At the present time, little is known about the efficacy and safety of antidepressant medications when used to treat these symptoms.Objectives: To assess the safety and efficacy of antidepressants in treating psychosis and agitation in older adults with Alzheimer's disease, vascular, or mixed dementia.Search methods: We searched the Cochrane Dementia and Cognitive Improvement Group?s Specialized Register which included Cochrane Central Register of Controlled Trials (The Cochrane Library 2009, Issue 3), MEDLINE (January 1950 to October 2009), EMBASE (1980 - October 2009), CINAHL (all dates - October 2009) and PsycINFO (1806 to October 2009).Selection criteria: Randomized, controlled trials of antidepressants (selective serotonin reuptake inhibitors (SSRIs), tricyclic antidepressants, trazodone, and other antidepressants), compared to either placebo or comparator medications (typical or atypical antipsychotics, anticonvulsants, benzodiazepines, cholinesterase inhibitors, memantine or other medications) for treatment of agitation or psychosis in older adults with dementia.Data collection and analysis: Two authors independently assessed trial quality and extracted trial data. We collected information on

efficacy as measured by dementia neuropsychiatric symptom rating scales and adverse effects. Study authors were contacted for additional information.Main results: Nine trials including a total of 692 individuals were included in the review. Five studies compared SSRIs to placebo and two studies were combined in a meta-analysis for the outcome of change in Cohen-Mansfield Agitation Inventory (CMAI) scores. There was a significant difference between antidepressants and placebo on measures of agitation as reported on the change in CMAI total score (mean difference (MD), -0.89, 95% CI, -1.22 to -0.57) although the results were heavily weighted by one large study. There were no significant differences in change in behavioral symptoms of dementia for SSRIs compared to placebo in the one study that reported on changes in the Neuropsychiatric Inventory and Behavioral Pathology in Dementia scales. One study comparing citalopram to placebo found a significant difference in NPS as measured on the Neurobehavioral Rating Scale (NBRS) after controlling for baseline severity NBRS score although the unadjusted mean difference was not statistically significant (MD - 7.70, 95% CI: -16.57 to 1.17). There was no difference in the rates of trial withdrawals due to adverse events for SSRIs compared to placebo for four studies reporting this outcome (relative risk (RR), 1.07, 95% CI: 0.55 to 2.11) or in the number of trial withdrawals due to any cause in the three studies reporting this outcome (RR, 0.91, 95% CI, 0.65 to 1.26). One study compared the SSRI citalopram to the atypical antipsychotic risperidone and found no difference in NBRS scores, trial withdrawals due to any cause or trial withdrawals due to adverse events although the rates of adverse events as measured on the UKU side effect scale total score were lower for citalopram (MD -2.82, 95% CI: -4.94 to -0.70). Three studies compared SSRIs to typical antipsychotics. In meta-analysis of two studies there was no statistically significant differences in changes in CMAI total scores (MD, 4.66, 95% CI: -3.58 to 12.90). There was also no difference in trial withdrawals due to any cause or due to adverse events for SSRIs compared to typical antipsychotics. One study of trazodone compared to placebo did not find any significant difference in change in CMAI total scores (MD, 5.18, 95% CI, -2.86 to 13.22) or trial withdrawals due to any cause (RR, 1.06, 95% CI, 0.54 to 2.09). Two studies comparing trazodone to haloperidol also failed to detect any difference in change in CMAI total scores (MD, 3.28, 95% CI, -3.28 to 9.85) or trial withdrawals due to any cause (RR, 0.79, 95% CI, 0.43 to 1.46).Authors' conclusions: Currently there are relatively few studies of antidepressants for the treatment of agitation and psychosis in dementia. The SSRIs sertraline and citalopram were associated with a reduction in symptoms of agitation when compared to placebo in two studies. Both SSRIs and trazodone appear to be tolerated reasonably well when compared to placebo, typical antipsychotics and atypical antipsychotics. Future studies involving more subjects are required to determine if SSRIs, trazodone, or other antidepressants are safe and effective treatments for agitation and psychosis in dementia.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD008191.pub2/abstract

Record #20 of 45

ID: CD009425

AU: Xiao Yousheng

AU: Wang Jin

AU: Jiang Shan

AU: Luo Hongye

TI: Hyperbaric oxygen therapy for vascular dementia

SO: Cochrane Database of Systematic Reviews

YR: 2012

NO: 7

PB: John Wiley & Sons, Ltd

KY: Cognition [drug effects];Combined Modality Therapy [methods];Dementia, Vascular [therapy];Hyperbaric Oxygenation [methods];Indans [therapeutic use];Nootropic Agents [therapeutic use];Piperidines [therapeutic use];Randomized Controlled Trials as Topic;Humans[checkword]

CC: DEMENTIA

DOI: 10.1002/14651858.CD009425.pub2

AB: Background: Hyperbaric oxygen therapy (HBOT) has been used to treat a variety of conditions and has shown possible efficacy for treating vascular dementia (VaD) in experimental and preliminary clinical studies.Objectives: To assess the efficacy and safety of HBOT for VaD, used alone or as an adjuvant treatment.Search methods: We searched ALOIS: the Cochrane Dementia and Cognitive Improvement Group Specialised Register on 20 December 2011 using the terms: hyperbaric OR oxygen OR HBO OR HBOT. ALOIS contains records of clinical trials identified from monthly searches of a number of major healthcare databases, numerous trial registries and grey literature sources. We also searched the Chinese Biomedical Database (CBM), the Chinese National Knowledge Infrastructure (CNKI) and the VIP Chinese Science and Technique Journals Database on 10 November 2011 using the terms 'gaoyayang', 'xueguanxingchidai' and 'chidai'. In addition, we contacted authors of included studies for additional information.Selection criteria: Trials were eligible for inclusion if they were randomised controlled trials comparing HBOT to no intervention or to sham HBOT, or comparing HBOT plus another treatment to the same other treatment in patients with VaD.Data collection and analysis: Two review authors independently assessed trial quality and extracted data.Main results: One study involving 64 patients was included. It compared HBOT as an adjuvant to donepezil with donepezil alone. This one included study was judged to be of poor methodological quality. Patients receiving HBOT plus donepezil had significantly better cognitive function than the donepezil only group after 12 weeks of treatment, measured by the Mini-Mental State Examination (MMSE) (WMD 3.50; 95% CI 0.91 to 6.09) or by Hasegawa's Dementia Rating Scale (HDS) (WMD 3.10; 95% CI 1.16 to 5.04). There were no deaths or withdrawals, and the study did not mention safety assessment at all. Global function,

behavioral disturbance and activities of daily living were not investigated in the study.Authors' conclusions: There is insufficient evidence to support HBOT as an effective treatment for patients with VaD. Future trials should be randomised, double-blind comparisons of HBOT to sham HBOT.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD009425.pub2/abstract

Record #21 of 45

ID: CD008811

AU: Ang Marcus

AU: Evans Jennifer R

AU: Mehta Jod S

TI: Manual small incision cataract surgery (MSICS) with posterior chamber intraocular lens versus extracapsular cataract extraction (ECCE) with posterior chamber intraocular lens for age-related cataract

SO: Cochrane Database of Systematic Reviews

YR: 2012

NO: 4

PB: John Wiley & Sons, Ltd

KY: Lenses, Intraocular;Age Factors;Cataract Extraction [adverse effects] [methods];India;Lens Implantation, Intraocular [methods];Nepal;Posterior Eye Segment;Randomized Controlled Trials as Topic;Adult[checkword];Aged[checkword];Aged, 80 and over[checkword];Humans[checkword];Middle Aged[checkword]

CC: HM-EYES

DOI: 10.1002/14651858.CD008811.pub2

AB: Background: Age-related cataract is the opacification of the lens, which occurs as a result of denaturation of lens proteins. Age-related cataract remains the leading cause of blindness globally, except in the most developed countries. A key question is what is the best way of removing the lens, especially in lower income settings.Objectives: To compare two different techniques of lens removal in cataract surgery: manual small incision surgery (MSICS) and extracapsular cataract extraction (ECCE).Search methods: We searched CENTRAL (which contains the Cochrane Eyes and Vision Group Trials Register) (The Cochrane Library 2012, Issue 1), MEDLINE (January 1950 to February 2012), EMBASE (January 1980 to February 2012), Latin American and Caribbean Literature on Health Sciences (LILACS) (January 1982 to February

2012), Web of Science Conference Proceedings Citation Index- Science (CPCI-S), the metaRegister of Controlled Trials (mRCT) (www.controlled-trials.com), ClinicalTrials.gov (www.clinicaltrials.gov) and the WHO International Clinical Trials Registry Platform (ICTRP) (www.who.int/ictrp/search/en). There were no date or language restrictions in the electronic searches for trials. The electronic databases were last searched on 14 February 2012.Selection criteria: We included randomised controlled trials (RCTs) only. Participants in the trials were people with age-related cataract. We included trials where MSICS with a posterior chamber intraocular lens (IOL) implant was compared to ECCE with a posterior chamber IOL implant.Data collection and analysis: Data were collected independently by two authors. We aimed to collect data on presenting visual acuity 6/12 or better and best-corrected visual acuity of less than 6/60 at three months and one year after surgery. Other outcomes included intraoperative complications, long-term complications (one year or more after surgery), quality of life, and cost-effectiveness. There were not enough data available from the included trials to perform a meta-analysis.Main results: Three trials randomly allocating people with age-related cataract to MSICS or ECCE were included in this review (n = 953 participants). Two trials were conducted in India and one in Nepal. Trial methods, such as random allocation and allocation concealment, were not clearly described; in only one trial was an effort made to mask outcome assessors. The three studies reported follow-up six to eight weeks after surgery. In two studies, more participants in the MSICS groups achieved unaided visual acuity of 6/12 or 6/18 or better compared to the ECCE group, but overall not more than 50% of people achieved good functional vision in the two studies. 10/806 (1.2%) of people enrolled in two trials had a poor outcome after surgery (best-corrected vision less than 6/60) with no evidence of difference in risk between the two techniques (risk ratio (RR) 1.58, 95% confidence interval (CI) 0.45 to 5.55). Surgically induced astigmatism was more common with the ECCE procedure than MSICS in the two trials that reported this outcome. In one study there were more intra- and postoperative complications in the MSICS group. One study reported that the costs of the two procedures were similar.Authors' conclusions: There are no other studies from other countries other than India and Nepal and there are insufficient data on cost-effectiveness of each procedure. Better evidence is needed before any change may be implemented. Future studies need to have longer-term follow-up and be conducted to minimize biases revealed in this review with a larger sample size to allow examination of adverse events.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD008811.pub2/abstract

Record #22 of 45

ID: CD005285

AU: Brady Marian C

AU: Kinn Sue

AU: Ness Valerie

AU: O'Rourke Keith

AU: Randhawa Navdeep

AU: Stuart Pauline

TI: Preoperative fasting for preventing perioperative complications in children

SO: Cochrane Database of Systematic Reviews

YR: 2009

NO: 4

PB: John Wiley & Sons, Ltd

KY: Drinking;Fasting;Intraoperative Complications [prevention & control];Laryngopharyngeal Reflux [prevention & control];Pneumonia, Aspiration [prevention & control];Practice Guidelines as Topic;Preoperative Care [methods];Randomized Controlled Trials as Topic;Thirst;Time Factors;Adolescent[checkword];Child[checkword];Humans[checkword]

CC: WOUNDS

DOI: 10.1002/14651858.CD005285.pub2

AB: Background: Children, like adults, are required to fast before general anaesthesia with the aim of reducing the volume and acidity of their stomach contents. It is thought that fasting reduces the risk of regurgitation and aspiration of gastric contents during surgery. Recent developments have encouraged a shift from the standard 'nil-by-mouth-from-midnight' fasting policy to more relaxed regimens. Practice has been slow to change due to questions relating to the duration of a total fast, the type and amount of intake permitted.Objectives: To systematically assess the effects of different fasting regimens (duration, type and volume of permitted intake) and the impact on perioperative complications and patient well being (aspiration, regurgitation, related morbidity, thirst, hunger, pain, comfort, behaviour, nausea and vomiting) in children.Search methods: We searched Cochrane Wounds Group Specialised Register (searched 25/6/09), the Cochrane Central Register of Controlled Trials (The Cochrane Library, Issue 2 2009), Ovid MEDLINE (1950 to June Week 2 2009), Ovid EMBASE (1980 to 2009 Week 25), EBSCO CINAHL (1982 to June Week 3 2009), the National Research Register, relevant conference proceedings and article reference lists and contacted experts.Selection criteria: Randomised and quasi randomised controlled trials of preoperative fasting regimens for children were identified.Data collection and analysis: Data extraction and trial quality assessment was conducted independently by three authors. Trial authors were contacted for additional information including adverse events.Main results: This first update of the review identified two additional eligible studies, bringing the total number of included studies to 25 (forty seven randomised controlled comparisons involving 2543 children considered to be at normal risk of regurgitation or aspiration during anaesthesia). Only one incidence of aspiration and regurgitation was reported.Children permitted fluids up to 120 minutes preoperatively were not found to experience higher gastric volumes or lower gastric pH values than those who fasted. The children permitted fluids were less thirsty and hungry, better behaved and

more comfortable than those who fasted.Clear fluids preoperatively did not result in a clinically important difference in children's gastric volume or pH. Evidence relating to the preoperative intake of milk was sparse. The volume of fluid permitted during the preoperative period did not appear to impact on children's intraoperative gastric volume or pH contents.Authors' conclusions: There is no evidence that children who are denied oral fluids for more than six hours preoperatively benefit in terms of intraoperative gastric volume and pH compared with children permitted unlimited fluids up to two hours preoperatively. Children permitted fluids have a more comfortable preoperative experience in terms of thirst and hunger. This evidence applies only to children who are considered to be at normal risk of aspiration/regurgitation during anaesthesia.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD005285.pub2/abstract

Record #23 of 45

ID: CD006539

AU: Sena Dayse F

AU: Lindsley Kristina

TI: Neuroprotection for treatment of glaucoma in adults

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 2

PB: John Wiley & Sons, Ltd

KY: Antihypertensive Agents [therapeutic use];Disease Progression;Glaucoma, Open-Angle [drug therapy];Neuroprotective Agents [administration & dosage];Optic Nerve;Optic Nerve Diseases [etiology] [prevention & control];Quinoxalines [therapeutic use];Randomized Controlled Trials as Topic;Retinal Ganglion Cells [physiology];Timolol [therapeutic use];Adult[checkword];Humans[checkword]

CC: EYES

DOI: 10.1002/14651858.CD006539.pub3

AB: Background: Glaucoma is a heterogeneous group of conditions involving progressive damage to the optic nerve, deterioration of retinal ganglion cells and ultimately visual field loss. It is a leading cause of blindness worldwide. Open angle glaucoma (OAG), the commonest form of glaucoma, is a chronic condition that may or may not present with increased intraocular pressure (IOP). Neuroprotection for glaucoma refers to any intervention intended to prevent optic nerve damage or cell death.Objectives: The objective of this review was to

systematically examine the evidence regarding the effectiveness of neuroprotective agents for slowing the progression of OAG in adults.Search methods: We searched CENTRAL (which contains the Cochrane Eyes and Vision Group Trials Register) (The Cochrane Library 2012, Issue 9), Ovid MEDLINE, Ovid MEDLINE In-Process and Other Non-Indexed Citations, Ovid MEDLINE Daily, Ovid OLDMEDLINE, (January 1950 to October 2012), EMBASE (January 1980 to October 2012), Latin American and Caribbean Literature on Health Sciences (LILACS) (January 1982 to October 2012), the metaRegister of Controlled Trials (mRCT) (www.controlled-trials.com), ClinicalTrials.gov (www.clinicaltrials.gov) and the WHO International Clinical Trials Registry Platform (ICTRP) (www.who.int/ictrp/search/en). We did not use any date or language restrictions in the electronic searches for trials. The electronic databases were last searched on 16 October 2012.Selection criteria: We included randomized controlled trials (RCTs) in which topical or oral treatments were used for neuroprotection in adults with OAG. Minimum follow up time was four years.Data collection and analysis: Two review authors independently reviewed titles and abstracts from the literature searches. Full-text copies of potentially relevant studies were obtained and re-evaluated for inclusion. Two review authors independently extracted data related study characteristics, risk of bias, and outcome data. One trial was identified for this review, thus we performed no meta-analysis. Two studies comparing memantine to placebo are currently awaiting classification until additional study details are provided. We documented reasons for excluding studies from the review.Main results: We included one multi-center RCT of adults with low-pressure glaucoma (Low-pressure Glaucoma Treatment Study, LoGTS) conducted in the USA. The primary outcome was visual field progression after four years of treatment with either brimonidine or timolol. Of the 190 adults enrolled in the study, 12 (6.3%) were excluded after randomization and 77 (40.5%) did not complete four years of follow up. The rate of attrition was unbalanced between groups with more participants dropping out of the brimonidine group (55%) than the timolol group (29%). Of those remaining in the study at four years, participants assigned to brimonidine showed less visual field progression than participants assigned to timolol (5/45 participants in the brimonidine group compared with 18/56 participants in the timolol group). Since no information was available for the 12 participants excluded from the study, or the 77 participants who dropped out of the study, we cannot draw any conclusions from these results as the participants for whom data are missing may or may not have progressed. The mean IOP was similar in both groups at the four-year follow up among those for whom data were available: 14.2 mmHg (standard deviation (SD) = 1.9) among the 43 participants in the brimonidine group and 14.0 mmHg (SD = 2.6) among the 48 participants in the timolol group. Among the participants who developed progressive visual field loss, IOP reduction of 20% or greater was not significantly different between groups: 4/9 participants in the brimonidine group and 12/31 participants in the timolol group. The study authors did not report data for visual acuity or vertical cup-disc ratio. The most frequent adverse event was ocular allergy to study drug, which occurred more frequently in the brimonidine group (20/99 participants) than the timolol group (3/79 participants).Authors' conclusions: Although neuroprotective agents are intended to act as pharmacological antagonists to prevent cell death, this trial did not provide evidence that they are effective in preventing retinal ganglion cell death, and thus preserving vision in people with OAG. Further clinical research is needed to determine whether neuroprotective agents may be beneficial for individuals with OAG. Such research should focus outcomes important to patients, such as preservation of vision, and how these outcomes

relate to cell death and optic nerve damage. Since OAG is a chronic, progressive disease with variability in symptoms, RCTs designed to measure the effectiveness of neuroprotective agents would require long-term follow up (more than four years) in order to detect clinically meaningful effects.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006539.pub3/abstract

Record #24 of 45

ID: CD005240

AU: Kardamanidis Katina

AU: Martiniuk Alexandra

AU: Ivers Rebecca Q

AU: Stevenson Mark R

AU: Thistlethwaite Katrina

TI: Motorcycle rider training for the prevention of road traffic crashes

SO: Cochrane Database of Systematic Reviews

YR: 2010

NO: 10

PB: John Wiley & Sons, Ltd

KY: Motorcycles;Accident Prevention [methods];Accidents, Traffic [prevention & control];Licensure;Program Evaluation;Wounds and Injuries [mortality] [prevention & control];Humans[checkword]

CC: INJ

DOI: 10.1002/14651858.CD005240.pub2

AB: Background: Riding a motorcycle (a two-wheeled vehicle that is powered by a motor and has no pedals) is associated with a high risk of fatal crashes, particularly in new riders. Motorcycle rider training has therefore been suggested as an important means of reducing the number of crashes, and the severity of injuries.Objectives: To quantify the effectiveness of pre- and post-licence motorcycle rider training on the reduction of traffic offences, traffic crash involvement, injuries and deaths of motorcycle riders.Search methods: We searched the Cochrane Injuries Group Specialised Register, CENTRAL (The Cochrane Library 2008, Issue 3), TRANSPORT, MEDLINE, EMBASE, CINAHL, WHOLIS (World Health Organization Library Information System), PsycInfo, LILACS (Latin American and Caribbean Health Sciences), ISI Web

of Science: Social Sciences Citation Index (SSCI), ERIC, ZETOC and SIGLE. Database searches covered all available dates up to October 2008. We also checked reference lists of relevant papers and contacted study authors in an effort to identify published, unpublished and ongoing trials related to motorcycle rider training.Selection criteria: We included all relevant intervention studies such as randomised and non-randomised controlled trials, interrupted time-series and observational studies such as cohort and case-control studies.Data collection and analysis: Two review authors independently analysed data about the study population, study design and methods, interventions and outcome measures as well as data quality from each included study, and compared the findings. We resolved differences by discussion with a third review author.Main results: We reviewed 23 studies: three randomised trials, two non-randomised trials, 14 cohort studies and four case-control studies. Five examined mandatory pre-licence training, 14 assessed non-mandatory training, three of the case-control studies assessed ?any? type of rider training, and one case-control study assessed mandatory pre-licence training and non-mandatory training. The types of assessed rider training varied in duration and content.Most studies suffered from serious methodological weaknesses. Most studies were non-randomised and controlled poorly for confounders. Most studies also suffered from detection bias due to the poor use of outcome measurement tools such as the sole reliance upon police records or self-reported data. Small sample sizes and short follow-up time after training were also common.Authors' conclusions: Due to the poor quality of studies identified, we were unable to draw any conclusions about the effectiveness of rider training on crash, injury, or offence rates. The findings suggest that mandatory pre-licence training may be an impediment to completing a motorcycle licensing process, possibly indirectly reducing crashes through a reduction in exposure. It is not clear if training (or what type) reduces the risk of crashes, injuries or offences in motorcyclists, and a best rider training practice can therefore not be recommended. As some type of rider training is likely to be necessary to teach motorcyclists to ride a motorcycle safely, rigorous research is needed.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD005240.pub2/abstract

Record #25 of 45

ID: CD006727

AU: Wilkinson Philip

AU: Izmeth Zehanah

TI: Continuation and maintenance treatments for depression in older people

SO: Cochrane Database of Systematic Reviews

YR: 2012

NO: 11

PB: John Wiley & Sons, Ltd

KY: Antidepressive Agents [therapeutic use];Combined Modality Therapy [methods];Depression [therapy];Maintenance Chemotherapy [methods];Psychotherapy [methods];Randomized Controlled Trials as Topic;Recurrence [prevention & control];Aged[checkword];Female[checkword];Humans[checkword];Male[checkword];Middle Aged[checkword]

CC: DEPRESSN

DOI: 10.1002/14651858.CD006727.pub2

AB: Background: Depressive illness in older people causes significant suffering and health service utilisation. Relapse and recurrence rates are high.Objectives: To examine the efficacy of antidepressants and psychological therapies in preventing the relapse and recurrence of depression in older people.Search methods: Search of the Cochrane Depression, Anxiety and Neurosis Review Group's specialized register (the CCDANCTR) up to 22 June 2012. The CCDANCTR includes relevant randomised controlled trials from the following bibliographic databases: The Cochrane Library (all years), EMBASE, (1974 to date) MEDLINE (1950 to date) and PsycINFO (1967 to date). We handsearched relevant journals, contacted experts in the field and examined reference lists, conference proceedings and bibliographies.Selection criteria: Both review authors independently selected studies. We included randomised controlled trials (RCTs) involving people aged 60 and over successfully treated for an episode of depression and randomised to receive continuation and maintenance treatment with antidepressants, psychological therapies, or combination.Data collection and analysis: Data were extracted independently by the two authors.The primary outcome was relapse/recurrence rate of depression (reaching a cut-off on any depression rating scale) at six-monthly intervals. Secondary outcomes included global impression of change, social functioning, and deaths. Meta-analysis was performed using risk ratio for dichotomous outcomes and mean differences (MD) for continuous outcomes, with 95% confidence intervals.Main results: Seven studies met the inclusion criteria (803 participants). Six compared antidepressant medication with placebo; two involved psychological therapies. There was marked heterogeneity between the studies.Comparing antidepressants with placebo, at six months follow-up there was no significant difference. At 12 months follow-up there was a statistically significant difference favouring antidepressants in reducing recurrence compared with placebo (three RCTs, N = 247, RR = 0.67, 95% CI 0.55 to 0.82; NNTB = five). At 24 months there was no significant difference for antidepressants overall, however, for the subgroup of tricyclic antidepressants there was significant benefit (three RCTs, N = 169, RR = 0.70, 95% CI 0.50 to 0.99; NNTB = five). At 36 months there was no significant difference for antidepressants overall. There was no difference in treatment acceptability or death rates between antidepressant and placebo.There was no significant difference between psychological treatment and antidepressant in recurrence rates at 12, 24, and 36 months (one RCT, N = 53) or between combination and antidepressant alone.Overall, the included studies were at low risk of bias.Authors' conclusions: The long-term benefits of continuing antidepressant medication in the prevention of recurrence of depression in older people are not clear and no firm treatment recommendations can be made on the basis of this review.

Continuing antidepressant medication for 12 months appears to be helpful but this is based on only three small studies with relatively few participants using differing classes of antidepressants in clinically heterogeneous populations. Comparisons at other time points did not reach statistical significance. Data on psychological therapies and combined treatments are too limited to draw any conclusions.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006727.pub2/abstract

Record #26 of 45

ID: CD006897

AU: Walters Julia AE

AU: Wang Wendy

AU: Morley Carla

AU: Soltani Amir

AU: Wood-Baker Richard

TI: Different durations of corticosteroid therapy for exacerbations of chronic obstructive pulmonary disease

SO: Cochrane Database of Systematic Reviews

YR: 2011

NO: 10

PB: John Wiley & Sons, Ltd

KY: Adrenal Cortex Hormones [administration & dosage];Disease Progression;Drug Administration Schedule;Glucocorticoids [administration & dosage];Methylprednisolone [administration & dosage];Prednisolone [administration & dosage];Pulmonary Disease, Chronic Obstructive;Randomized Controlled Trials as Topic;Aged[checkword];Humans[checkword];Middle Aged[checkword]

CC: AIRWAYS

DOI: 10.1002/14651858.CD006897.pub2

AB: Background: Current guidelines recommend that acute exacerbations of chronic obstructive pulmonary disease (COPD) be treated with systemic corticosteroids (SCs) for seven to 14 days. Intermittent SC use is cumulatively associated with adverse effects such as osteoporosis, hyperglycaemia and muscle weakness. Shorter treatment could therefore reduce the risk of adverse effects.Objectives: To compare the efficacy of short-duration (seven days or

fewer) and longer-duration (more than seven days) SC treatment of acute COPD exacerbations in adults.Search methods: We searched the Cochrane Airways Group Register of Trials (to April 2011) Cochrane Central Register of Controlled Trials (to April 2011), MEDLINE (from 1950 to October 2010), EMBASE (from 1980 to October 2010) and the reference lists of articles.Selection criteria: Randomised controlled trials comparing different durations of SC (seven days or fewer or more than seven days). Other interventions, e.g. bronchodilators and antibiotics, were standardised; studies in other lung diseases were excluded, unless data on participants with COPD were available.Data collection and analysis: Two review authors independently extracted data that were pooled them using Review Manager 5. We sought missing data from authors of studies published as abstracts only.Main results: We identified seven studies including 288 participants; two studies were fully published and five were published as abstracts. We obtained data for two studies published as abstracts from authors; these two abstracts and the two full papers contributed to meta-analysis. No study specified COPD diagnostic criteria and only one specified exacerbation criteria. Short course treatment varied between three and seven days and longer duration 10 to 15 days, at equivalent daily doses of corticosteroids; five studies used oral prednisolone (dose 30 mg, four studies, one tapered dose) and two studies used intravenous corticosteroid treatment. Mean ages of participants ranged from 64 to 73 years. We assessed the risk of allocation and blinding bias as low for these studies. Primary outcomes: risk of treatment failure did not differ significantly by treatment duration, but the confidence interval (CI) was too wide to conclude equivalence (Peto odds ratio (OR) 0.82; 95% CI 0.24 to 2.79) (three studies, n = 146). Forced expiratory volume in 1 second (FEV1) did not differ significantly when measured up to seven days (mean difference (MD) -0.07 L; 95% CI -0.19 to 0.05) or after seven days (MD -0.02 L; 95% CI -0.10 to 0.06) in four studies (n = 187). The likelihood of an adverse event (four studies, n = 192) did not differ significantly by treatment duration, but again the CI was wide (OR 0.58, 95% CI 0.14 to 2.40).Authors' conclusions: We based assessment of the efficacy of short (seven days or less) compared to longer duration (more than seven days) systemic corticosteroid therapy for acute exacerbations of COPD in this review on four of the seven included studies for which data were available. Two studies were fully published and two were published as conference abstracts but trialists were able to supply data requested for the review.The finding in this review that there is no significant increase in treatment failure with shorter systemic corticosteroid treatment for seven days or less for acute exacerbations of COPD, does not give conclusive evidence to recommend change in clinical practice due to a wide confidence interval around the estimate of effect. The four studies which contributed to the meta-analysis were of relatively low quality and five of the seven studies were not published as full articles. Thus there are insufficient data to allow firm conclusions concerning the optimal duration of corticosteroid therapy of acute exacerbations of COPD to be drawn.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006897.pub2/abstract

Record #27 of 45

ID: CD007365

AU: Hao Zilong

AU: Liu Ming

AU: Liu Zhiqin

AU: Lu DongHao

TI: Huperzine A for vascular dementia

SO: Cochrane Database of Systematic Reviews

YR: 2009

NO: 2

PB: John Wiley & Sons, Ltd

KY: Alkaloids;Dementia, Vascular [drug therapy];Drugs, Chinese Herbal [therapeutic use];Neuroprotective Agents [therapeutic use];Sesquiterpenes [therapeutic use];Humans[checkword]

CC: DEMENTIA

DOI: 10.1002/14651858.CD007365.pub2

AB: Background: Huperzine A, a form of herbal medicine, has been considered as an alternative treatment for vascular dementia (VaD) in China.Objectives: To assess the efficacy and safety of Huperzine A in patients with vascular dementia.Search methods: We searched ALOIS: the Cochrane Dementia and Cognitive Improvement Group?s Specialized Register on 10 February 2011 using the terms: chinese, plants, huperzine, HUP, ayapin, scoparon. ALOIS contains records of clinical trials identified from monthly searches of a number of major healthcare databases (The Cochrane Library, MEDLINE, EMBASE, PsycINFO, CINAHL, LILACS), numerous trial registries and grey literature sources. We also searched the following databases in March 2011 using the terms 'Huperzine A', 'Shishanjianjia', 'Haboyin' and 'Shuangyiping': The Chinese Biomedical Database (CBM) (1977 to March 2011); Chinese Science and Technique Journals Database (VIP) (1989 to March 2011); China National Knowledge Infrastructure (CNKI) (1979 to March 2011); Google (March 2011). In addition, we searched relevant reference lists. We also contacted researchers to request additional information where necessary.Selection criteria: We considered randomized controlled trials comparing Huperzine A with placebo in people with vascular dementia eligible for inclusion.Data collection and analysis: Two review authors independently applied the inclusion criteria, assessed trial quality and extracted the data. We resolved any disagreement by discussion.Main results: We included only one small trial, involving 14 participants with vascular dementia. No significant effect of Huperzine A on cognitive function measured by MMSE (WMD 2.40; 95% CI -4.78 to 9.58) was observed. There was a significant beneficial effect of Huperzine A on performance of activities of daily living (WMD -13.00; 95% CI -23.24 to -2.76) after six months of treatment. No deaths from any cause at the end of treatment were reported. Behaviour, quality of life and caregiver burden were not assessed in the included trial.Authors' conclusions: There is currently no high quality

evidence to support the use of Huperzine A for the treatment of vascular dementia. Further randomized placebo controlled trials are needed to determine whether there is worthwhile benefit.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007365.pub2/abstract

Record #28 of 45

ID: CD006378

AU: Jaturapatporn Darin

AU: Isaac Mokhtar Gad El Kareem Nasr

AU: McCleery Jenny

AU: Tabet Naji

TI: Aspirin, steroidal and non-steroidal anti-inflammatory drugs for the treatment of Alzheimer's disease

SO: Cochrane Database of Systematic Reviews

YR: 2012

NO: 2

PB: John Wiley & Sons, Ltd

KY: Alzheimer Disease [drug therapy] [etiology];Anti-Inflammatory Agents [adverse effects] [therapeutic use];Anti-Inflammatory Agents, Non-Steroidal [adverse effects] [therapeutic use];Aspirin [adverse effects] [therapeutic use];Cyclooxygenase 2 Inhibitors [adverse effects] [therapeutic use];Glucocorticoids [adverse effects] [therapeutic use];Inflammation [complications] [drug therapy];Randomized Controlled Trials as Topic;Treatment Outcome;Aged[checkword];Aged, 80 and over[checkword];Humans[checkword]

CC: DEMENTIA

DOI: 10.1002/14651858.CD006378.pub2

AB: Background: Alzheimer?s disease (AD) is the most common form of dementia. The incidence of AD rises exponentially with age and its prevalence will increase significantly worldwide in the next few decades. Inflammatory processes have been suspected in the pathogenesis of the disease.Objectives: To review the efficacy and side effects of aspirin, steroidal and non-steroidal anti-inflammatory drugs (NSAIDs) in the treatment of AD, compared to placebo.Search methods: We searched ALOIS: the Cochrane Dementia and Cognitive Improvement Group?s Specialized Register on 12 April 2011 using the terms: aspirin

OR "cyclooxygenase 2 inhibitor" OR aceclofenac OR acemetacin OR betamethasone OR celecoxib OR cortisone OR deflazacort OR dexamethasone OR dexibruprofen OR dexketoprofen OR diclofenac sodium OR diflunisal OR diflusinal OR etodolac OR etoricoxib OR fenbufen OR fenoprofen OR flurbiprofen OR hydrocortisone OR ibuprofen OR indometacin OR indomethacin OR ketoprofen OR lumiracoxib OR mefenamic OR meloxicam OR methylprednisolone OR nabumetone OR naproxen OR nimesulide OR "anti-inflammatory" OR prednisone OR piroxicam OR sulindac OR tenoxicam OR tiaprofenic acid OR triamcinolone OR NSAIDS OR NSAID. ALOIS contains records of clinical trials identified from monthly searches of a number of major healthcare databases (including MEDLINE, EMBASE, PsycINFO, CINAHL, LILACS), numerous trial registries (including national, international and pharmacuetical registries) and grey literature sources.Selection criteria: All randomised controlled trials assessing the efficacy of aspirin, steroidal and non-steroidal anti-inflammatory drugs in AD.Data collection and analysis: One author assessed risk of bias of each study and extracted data. A second author verified data selection.Main results: Our search identified 604 potentially relevant studies. Of these, 14 studies (15 interventions) were RCTs and met our inclusion criteria. The numbers of participants were 352, 138 and 1745 for aspirin, steroid and NSAIDs groups, respectively. One selected study comprised two separate interventions. Interventions assessed in these studies were grouped into four categories: aspirin (three interventions), steroids (one intervention), traditional NSAIDs (six interventions), and selective cyclooxygenase-2 (COX-2) inhibitors (five interventions). All studies were evaluated for internal validity using a risk of bias assessment tool. The risk of bias was low for five studies, high for seven studies, and unclear for two studies.There was no significant improvement in cognitive decline for aspirin, steroid, traditional NSAIDs and selective COX-2 inhibitors. Compared to controls, patients receiving aspirin experienced more bleeding while patients receiving steroid experienced more hyperglycaemia, abnormal lab results and face edema. Patients receiving NSAIDs experienced nausea, vomiting, elevated creatinine, elevated LFT and hypertension. A trend towards higher death rates was observed among patients treated with NSAIDS compared with placebo and this was somewhat higher for selective COX-2 inhibitors than for traditional NSAIDs.Authors' conclusions: Based on the studies carried out so far, the efficacy of aspirin, steroid and NSAIDs (traditional NSAIDs and COX-2 inhibitors) is not proven. Therefore, these drugs cannot be recommended for the treatment of AD.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006378.pub2/abstract

Record #29 of 45

ID: CD003150

AU: Forrester Lene Thorgrimsen

AU: Maayan Nicola

AU: Orrell Martin

AU: Spector Aimee E

AU: Buchan Louise D

AU: Soares-Weiser Karla

TI: Aromatherapy for dementia

SO: Cochrane Database of Systematic Reviews

YR: 2014

NO: 2

PB: John Wiley & Sons, Ltd

KY: Aromatherapy;Dementia [therapy];Randomized Controlled Trials as Topic;Humans[checkword]

CC: DEMENTIA

DOI: 10.1002/14651858.CD003150.pub2

AB: Background: Complementary therapy has received great interest within the field of dementia treatment and the use of aromatherapy and essential oils is increasing. In a growing population where the majority of patients are treated by US Food and Drug Administration (FDA)-approved drugs, the efficacy of treatment is short term and accompanied by negative side effects. Utilisation of complimentary therapies in dementia care settings presents as one of few options that are attractive to practitioners and families as patients often have reduced insight and ability to verbally communicate adverse reactions. Amongst the most distressing features of dementia are the behavioural and psychological symptoms. Addressing this facet has received particular interest in aromatherapy trials, with a shift in focus from reducing cognitive dysfunction to the reduction of behavioural and psychological symptoms in dementia.Objectives: To assess the efficacy of aromatherapy as an intervention for people with dementia.Search methods: ALOIS, the Cochrane Dementia and Cognitive Improvement Group Specialized Register, was searched on 26 November 2012 and 20 January 2013 using the terms: aromatherapy, lemon, lavender, rose, aroma, alternative therapies, complementary therapies, essential oils.Selection criteria: All relevant randomised controlled trials were considered. A minimum length of a trial and requirements for follow-up were not included, and participants in included studies had a diagnosis of dementia of any type and severity. The review considered all trials using fragrance from plants defined as aromatherapy as an intervention with people with dementia and all relevant outcomes were considered.Data collection and analysis: Titles and abstracts extracted by the searches were screened for their eligibility for potential inclusion in the review. For Burns 2011, continuous outcomes were estimated as the mean difference between groups and its 95% confidence interval using a fixed-effect model. For Ballard 2002, analysis of co-variance was used for all outcomes, with the nursing home being treated as a random effect.Main results: Seven studies with 428 participants were included in this review; only two of these had published usable results. Individual patient data were obtained from one trial (Ballard 2002) and additional analyses

performed. The additional analyses conducted using individual patient data from Ballard 2002 revealed a statistically significant treatment effect in favour of the aromatherapy intervention on measures of agitation (n = 71, MD -11.1, 95% CI -19.9 to -2.2) and behavioural symptoms (n = 71, MD -15.8, 95% CI -24.4 to -7.2). Burns 2011, however, found no difference in agitation (n = 63, MD 0.00, 95% CI -1.36 to 1.36), behavioural symptoms (n = 63, MD 2.80, 95% CI -5.84 to 11.44), activities of daily living (n = 63, MD -0.50, 95% CI -1.79 to 0.79) and quality of life (n = 63, MD 19.00, 95% CI -23.12 to 61.12). Burns 2011 and Fu 2013 found no difference in adverse effects (n = 124, RR 0.97, 95% CI 0.15 to 6.46) when aromatherapy was compared to placebo.Authors' conclusions: The benefits of aromatherapy for people with dementia are equivocal from the seven trials included in this review. It is important to note there were several methodological difficulties with the included studies. More well-designed, large-scale randomised controlled trials are needed before clear conclusions can be drawn regarding the effectiveness of aromatherapy for dementia. Additionally, several issues need to be addressed, such as whether different aromatherapy interventions are comparable and the possibility that outcomes may vary for different types of dementia.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003150.pub2/abstract

Record #30 of 45

ID: CD004242

AU: Fedorowicz Zbys

AU: Lawrence David

AU: Gutierrez Peter

AU: van Zuuren Esther J

TI: Day care versus in-patient surgery for age-related cataract

SO: Cochrane Database of Systematic Reviews

YR: 2011

NO: 7

PB: John Wiley & Sons, Ltd

KY: Ambulatory Surgical Procedures [economics];Cataract Extraction [economics];Hospitalization [economics];Feasibility Studies;Randomized Controlled Trials as Topic;Humans[checkword]

CC: EYES

DOI: 10.1002/14651858.CD004242.pub4

AB: Background: Age-related cataract accounts for more than 40% of cases of blindness in the world with the majority of people who are blind from cataract found in the developing world. With the increased number of people with cataract there is an urgent need for cataract surgery to be made available as a day care procedure.Objectives: To provide reliable evidence for the safety, feasibility, effectiveness and cost-effectiveness of cataract extraction performed as day care versus in-patient procedure.Search methods: We searched CENTRAL (which contains the Cochrane Eyes and Vision Group Trials Register) (The Cochrane Library 2011, Issue 5), MEDLINE (January 1950 to May 2011), EMBASE (January 1980 to May 2011), Latin American and Caribbean Health Sciences Literature Database (LILACS) (January 1982 to May 2011), the metaRegister of Controlled Trials (mRCT) (www.controlled-trials.com) and ClinicalTrials.gov (www.clinicaltrials.gov). There were no date or language restrictions in the electronic searches for trials. The electronic databases were last searched on 23 May 2011.Selection criteria: We included randomised controlled trials comparing day care and in-patient surgery for age-related cataract. The primary outcome was the achievement of a satisfactory visual acuity six weeks after the operation.Data collection and analysis: Two authors independently assessed trial quality and extracted data. We contacted study authors for additional information. Adverse effects information was collected from the trials.Main results: We included two trials (conducted in Spain and USA), involving 1284 people. One trial reported statistically significant differences in early postoperative complication rates in the day care group, with an increased risk of increased intraocular pressure, which had no clinical relevance to visual outcomes four months postoperatively. The mean change in visual acuity (Snellen lines) of the operated eye four months postoperatively was 4.1 (standard deviation (SD) 2.3) for the day care group and 4.1 (SD 2.2) for the in-patient group and not statistically significant. The four-month postoperative mean change in quality of life score measured using the VF14 showed minimal differences between the two groups. Costs were 20% more for the in-patient group and this was attributed to higher costs for overnight stay. One study only reported hotel costs for the non-hospitalised participants making aggregation of data on costs impossible.Authors' conclusions: This review provides some evidence that there is a cost saving but no significant difference in outcome or risk of postoperative complications between day care and in-patient cataract surgery. This is based on one detailed and methodologically sound trial conducted in the developed world. The success, safety and cost-effectiveness of cataract surgery as a day care procedure appear to be acceptable. Future research may well focus on evidence provided by high quality clinical databases and registers which would enable clinicians and healthcare planners to agree clinical and social indications for in-patient care and so make better use of resources, by selecting day case surgery unless these criteria are met.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004242.pub4/abstract

Record #31 of 45

ID: CD005244

AU: Ker Katharine

AU: Chinnock Paul

TI: Interventions in the alcohol server setting for preventing injuries

SO: Cochrane Database of Systematic Reviews

YR: 2008

NO: 3

PB: John Wiley & Sons, Ltd

KY: Alcohol Drinking [adverse effects];Accident Prevention [methods];Accidents, Traffic [prevention & control];Alcoholic Beverages [supply & distribution];Automobile Driving;Health Promotion;Randomized Controlled Trials as Topic;Wounds and Injuries [prevention & control];Humans[checkword]

CC: INJ

DOI: 10.1002/14651858.CD005244.pub3

AB: Background: Injuries are a significant public health burden and alcohol intoxication is recognised as a risk factor for injuries. Increasing attention is being paid to supply-side interventions that aim to modify the environment and context within which alcohol is supplied and consumed.Objectives: To quantify the effectiveness of interventions implemented in the server setting for reducing injuries.Search methods: We searched the following electronic databases to November 2008; Cochrane Injuries Group's Specialised Register, CENTRAL, MEDLINE, EMBASE, PsycINFO, PsycEXTRA, ISI Web of Science, Conference Proceedings Citation Index - Science, TRANSPORT and ETOH. We also searched reference lists of articles and contacted experts in the field.Selection criteria: Randomised controlled trials (RCTs), non-randomised controlled trials (NRTs) and controlled before and after studies (CBAs) of the effects of interventions administered in the server setting that attempted to modify the conditions under which alcohol is served and consumed, to facilitate sensible alcohol consumption and reduce the occurrence of alcohol-related harm.Data collection and analysis: Two authors independently screened search results and assessed the full texts of potentially relevant studies for inclusion. Data were extracted and methodological quality was examined. Due to variability in the types of interventions investigated, a pooled analysis was not appropriate.Main results: Twenty-three studies met the inclusion criteria. Overall methodological quality was poor. Five studies used an injury outcome measure; one of these studies was randomised, the remaining four where CBA studies.The RCT targeting the alcohol server setting environment with an injury outcome compared the introduction of toughened glassware (experimental) to annealed glassware (control) on the number of bar staff injuries; a greater number of injuries were detected in the experimental group (relative risk 1.72, 95% CI 1.15 to 2.59).One CBA study investigated server training and estimated a reduction of 23% in single-vehicle, night-time crashes in the experimental area (controlled for crashes in the control area). Another CBA study examined the impact of a drink driving service, and reported a reduction in injury road crashes of 15% in the experimental area, with no change in the control; no difference was found for fatal crashes. In a CBA study investigating the impact of an

intervention aiming to reduce crime in drinking premises, the study authors found a lower rate of all crime in the experimental premises (rate ratio 4.6, 95% CI 1.7 to 12, P = 0.01); no difference was found for injury (rate ratio 1.1 95% CI 0.1 to 10, P = 0.093). A CBA study investigating the impact of a policy intervention reported that pre-intervention the serious assault rate in the experimental area was 52% higher than the rate in the control area. After intervention, the serious assault rate in the experimental area was 37% lower than in the control area.The effects of such interventions on patron alcohol consumption is inconclusive. One randomised trial found a statistically significant reduction in observed severe aggression exhibited by patrons. There is some indication of improved server behaviour but it is difficult to predict what effect this might have on injury risk.Authors' conclusions: There is insufficient evidence from randomised controlled trials and well conducted controlled before and after studies to determine the effect of interventions administered in the alcohol server setting on injuries. Compliance with interventions appears to be a problem; hence mandated interventions may be more likely to show an effect. Randomised controlled trials, with adequate allocation concealment and blinding are required to improve the evidence base. Further well-conducted, non-randomised trials are also needed when random allocation is not feasible.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD005244.pub3/abstract

Record #32 of 45

ID: CD004744

AU: Birks Jacqueline

AU: McGuinness Bernadette

AU: Craig David

TI: Rivastigmine for vascular cognitive impairment

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 5

PB: John Wiley & Sons, Ltd

KY: Cholinesterase Inhibitors [therapeutic use];Dementia, Vascular [drug therapy];Nootropic Agents [therapeutic use];Phenylcarbamates [therapeutic use];Adult[checkword];Aged[checkword];Aged, 80 and over[checkword];Humans[checkword];Middle Aged[checkword]

CC: DEMENTIA

DOI: 10.1002/14651858.CD004744.pub3

AB: Background: Vascular dementia represents the second most common type of dementia after Alzheimer's disease. In older patients, in particular, the combination of vascular dementia and Alzheimer's disease is common, and is referred to as mixed dementia. The classification of vascular dementia broadly follows three clinico-pathological processes: multi-infarct dementia, single strategic infarct dementia and subcortical dementia. Not all victims fulfil strict criteria for dementia and may be significantly cognitively impaired without memory loss, when the term vascular cognitive impairment (VCI) is more useful. Currently, no established standard treatment for VCI exists. Reductions in acetylcholine and acetyltransferase activity are common to both Alzheimer's disease and VCI, raising the possibility that cholinesterase inhibitors - such as rivastigmine - which are beneficial in Alzheimer's disease, may also be beneficial for VCI.Objectives: To assess the efficacy of rivastigmine compared with placebo in the treatment of people with vascular cognitive impairment (VCI), vascular dementia or mixed dementia.Search methods: We searched ALOIS (the Cochrane Dementia and Cognitive Improvement Group?s Specialized Register) on 12 February 2013 using the terms: rivastigmine, exelon, "SDZ ENA 713". ALOIS contains records of clinical trials identified from monthly searches of a number of major healthcare databases (The Cochrane Library, MEDLINE, EMBASE, CINAHL, PsycINFO, LILACS), numerous trial registries and grey literature sources.Selection criteria: All unconfounded randomized double-blind trials comparing rivastigmine with placebo in the treatment of people with VCI, vascular dementia or mixed dementia were eligible for inclusion.Data collection and analysis: Two reviewers extracted and assessed data independently, and agreement was reached after discussion. They noted results concerning adverse effects.Main results: Three trials, with a total of 800 participants, were identified for inclusion. The participants in one trial did not have dementia, while the other two studies included participants with dementia of different severities. The dose of rivastigmine was different in each study. No pooling of study results was attempted because of these differences between the studies.One trial included 40 participants with subcortical vascular dementia (age range 40 to 90 years) with a mean mini-mental state examination (MMSE) score of 13.0 and 13.4 in the rivastigmine and placebo arms, respectively. Treatment over 26 weeks was limited to 3 mg rivastigmine twice daily, or placebo. No significant difference was found on any outcome measure relevant to cognition, neuropsychiatric symptoms, function or global rating, or in the number of withdrawals before the end of treatment.Another trial included 710 participants with vascular dementia, including subcortical and cortical forms (age range 50 to 85 years). Over 24 weeks, a mean dose of rivastigmine of 9.4 mg/day was achieved versus placebo. Baseline MMSE was identical for both groups, at 19.1. Statistically significant advantage in cognitive response (but not with global impression of change or non-cognitive measures) was seen with rivastigmine treatment at 24 weeks (MMSE change from baseline MD 0.6, 95% CI 0.11 to 1.09, P value 0.02; Vascular Dementia Assessment Scale (VaDAS) change from baseline MD -1.3, 95% CI-2.62 to 0.02, P value 0.05). Significantly higher rates of vomiting, nausea, diarrhoea and anorexia and withdrawals from treatment were noted in the participants randomized to rivastigmine compared with placebo (withdrawals rivastigmine 90/365, placebo 48/345, OR 2.02, 95% CI 1.38 to 2.98) (withdrawals due to an adverse event rivastigmine 49/365, placebo 19/345, OR 2.66, 95% CI 1.53 to 4.62, P value 0.0005).The third study included 50 participants (age range 48 to 84 years) with mean

MMSE scores of 23.7 and 23.9 in the rivastigmine and placebo arms, respectively. Over a 24-week period, participants labelled as having cognitive impairment but no dementia (CIND) following ischaemic stroke were given up to 4.5 mg rivastigmine twice daily, or placebo. Primary and secondary outcome measures showed no statistically significant difference when considering neurocognitive abilities, function, neuropsychiatric symptoms and global performance. One participant in the rivastigmine group and two in the placebo group discontinued their medication because of an adverse effect.Authors' conclusions: There is some evidence of benefit of rivastigmine in VCI from trial data from three studies. However, this conclusion is based on one large study. Rivastigmine is capable of inducing side effects that lead to withdrawal in a significant proportion of patients.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004744.pub3/abstract

Record #33 of 45

ID: CD004549

AU: Gates Simon

AU: Anderson Elizabeth R

TI: Wound drainage for caesarean section

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 12

PB: John Wiley & Sons, Ltd

KY: Cesarean Section [adverse effects];Randomized Controlled Trials as Topic;Suction [methods];Female[checkword];Humans[checkword];Pregnancy[checkword]

CC: WOUNDS

DOI: 10.1002/14651858.CD004549.pub3

AB: Background: Subcutaneous and sub rectus sheath wound drains are sometimes used in women who have undergone caesarean section. The indications for using drains vary by clinician.Objectives: To compare the effects of using a wound drain with not using a wound drain at caesarean section, and of different types of drain, on maternal health and healthcare resource use.Search methods: In November 2013, for this second update, we searched the Cochrane Wounds Group Specialised Register; The Cochrane Central Register of Controlled Trials (CENTRAL) (The Cochrane Library); Ovid Medline; Ovid Medline - In-Process & Other Non-Indexed Citations; Ovid Embase; and EBSCO CINAHL. No date, language or publication status limits were appliedSelection criteria: Studies were included if they allocated women to

groups at random and they compared any type of wound drain with no wound drainage, or with any other type of drain, in women undergoing caesarean section.Data collection and analysis: Trials were evaluated for appropriateness for inclusion and methodological quality without consideration of their results. This was done by two reviewers according to pre-stated eligibility criteria.Main results: Ten trials that recruited 5248 women were included in the review. Meta-analysis found no evidence of a difference in the risk of wound infection, other wound complications, febrile morbidity or pain in women who had wound drains compared with those who did not. There was some evidence from one trial that a subcutaneous drain may increase wound infection compared to a sub-sheath drain (RR 5.42, 95% CI 1.28 to 22.98). No differences in outcomes were found between subcutaneous drainage and subcutaneous suturing in the three trials that made this comparison.Authors' conclusions: Existing evidence suggests that the routine use of wound drains at caesarean section does not confer any substantial benefit to the women involved. However, neither moderate benefit nor harm are excluded.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004549.pub3/abstract

Record #34 of 45

ID: CD007220

AU: Ooi Cheow Peng

AU: Loke Seng Cheong

AU: Yassin Zaitun

AU: Hamid Tengku-Aizan

TI: Carbohydrates for improving the cognitive performance of independent-living older adults with normal cognition or mild cognitive impairment

SO: Cochrane Database of Systematic Reviews

YR: 2011

NO: 4

PB: John Wiley & Sons, Ltd

KY: Cognition;Cognition Disorders [drug therapy];Dietary Carbohydrates [therapeutic use];Independent Living;Aged[checkword];Humans[checkword]

CC: DEMENTIA

DOI: 10.1002/14651858.CD007220.pub2

AB: Background: Mild cognitive impairment (MCI) is an intermediate state between normal cognition and dementia in which daily function is largely intact. This condition may present an opportunity for research into the prevention of dementia. Carbohydrate is an essential and easily accessible macronutrient which influences cognitive performance. A better understanding of carbohydrate-driven cognitive changes in normal cognition and mild cognitive impairment may suggest ways to prevent or reduce cognitive decline.Objectives: To assess the effectiveness of carbohydrates in improving cognitive function in older adults with normal cognition or mild cognitive impairment.Search methods: We searched ALOIS, the Cochrane Dementia and Cognitive Improvement Group Specialized Register, on 6 April 2012 using the terms: carbohydrates OR carbohydrate OR monosaccharides OR disaccharides OR oligosaccharides OR polysaccharides OR CARBS. ALOIS contains records from all major healthcare databases (The Cochrane Library, MEDLINE, EMBASE, PsycINFO, CINAHL, LILACS) as well as from many trial databases and grey literature sources.Selection criteria: All randomised controlled trials (RCT) examining the effect of any form of carbohydrates on the cognition or daily functioning of adults aged 55 years or over with normal cognition or MCI.Data collection and analysis: One review author selected and retrieved relevant articles for further assessment. The remaining authors independently assessed whether any of the retrieved trials should be included. Disagreements were resolved by discussion. Main results: One study was included. It involved 44 adults aged 60 to 80 years and compared a glucose drink with a saccharin drink, given on only a single occasion. Those receiving the glucose drink were significantly faster in completing the switching condition of the modified Stroop test ($F\ 1, 41 = 10.47$; $P < 0.01$) compared to those receiving the saccharin drink. Participants in the glucose group also showed a significantly smaller dual-task cost in a computerised test of divided attention compared to the placebo group ($F\ 1, 38 = 8.49$; $P < 0.01$, ?2 = 0.18). As a glucose drink was administered only once, safety, global function, behaviour disturbance, and activities of daily living were not investigated in the study.Authors' conclusions: With only one RCT included, there is insufficient evidence to base any recommendations about the use of any form of carbohydrate for enhancing cognitive performance in older adults with normal cognition or mild cognitive impairment. More studies of many different carbohydrates are needed to tease out complex nutritional issues and to further evaluate memory improvement.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007220.pub2/abstract

Record #35 of 45

ID: CD003082

AU: Adams Clive E

AU: Bergman Hanna

AU: Irving Claire B

AU: Lawrie Stephen

TI: Haloperidol versus placebo for schizophrenia

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 11

PB: John Wiley & Sons, Ltd

KY: Antipsychotic Agents [therapeutic use];Haloperidol [therapeutic use];Placebo Effect;Randomized Controlled Trials as Topic;Schizophrenia [drug therapy];Humans[checkword]

CC: SCHIZ

DOI: 10.1002/14651858.CD003082.pub3

AB: Background: Haloperidol was developed in the late 1950s for use in the field of anaesthesia. Research subsequently demonstrated effects on hallucinations, delusions, aggressiveness, impulsiveness and states of excitement and led to the introduction of haloperidol as an antipsychotic.Objectives: To evaluate the clinical effects of haloperidol for the management of schizophrenia and other similar serious mental illnesses compared with placebo.Search methods: Initially, we electronically searched the databases of Biological Abstracts (1985-1998), CINAHL (1982-1998), The Cochrane Library (1998, Issue 4), The Cochrane Schizophrenia Group's Register (December 1998), EMBASE (1980-1998), MEDLINE (1966-1998), PsycLIT (1974-1998), and SCISEARCH. We also checked references of all identified studies for further trial citations and contacted the authors of trials and pharmaceutical companies for further information and archive material.For the 2012 update, on 15 May 2012, we searched the Cochrane Schizophrenia Group?s Trials Register.Selection criteria: We included all relevant randomised controlled trials comparing the use of haloperidol (any oral dose) with placebo for those with schizophrenia or other similar serious, non-affective psychotic illnesses (however diagnosed). Our main outcomes of interest were death, loss to follow-up, clinical and social response, relapse and severity of adverse effects.Data collection and analysis: We evaluated data independently and extracted, re-inspected and quality assessed the data. We analysed dichotomous data using risk ratio (RR) and calculated their 95% confidence intervals (CI). For continuous data, we calculated mean differences (MD). We excluded continuous data if loss to follow-up was greater than 50% and inspected data for heterogeneity. We used a fixed-effect model for all analyses. For the 2012 update, we assessed risk of bias of included studies and used the GRADE approach to create a 'Summary of findings' table.Main results: Twenty-five trials randomising 4651 people are now included in this review. We chose seven main outcomes of interest for the 'Summary of findings' table. More people allocated haloperidol improved in the first six weeks of treatment than those given placebo (4 RCTs n = 472, RR 0.67 CI 0.56 to 0.80, moderate quality evidence). A further eight trials also found a difference favouring haloperidol across the six weeks to six months period (8 RCTs n = 307 RR 0.67 CI 0.58 to 0.78, moderate quality evidence). Relapse data from two trials favoured haloperidol at < 52 weeks but the evidence was very low quality (2 RCTs n = 70, RR 0.69 CI 0.55 to 0.86). Moderate quality evidence showed about half of those entering studies failed to

complete the short trials (six weeks to six months), although, at up to six weeks, 16 studies found a difference that marginally favoured haloperidol (n = 1812, RR 0.87 CI 0.80 to 0.95). Adverse effect data does, nevertheless, support clinical impression that haloperidol is a potent cause of movement disorders, at least in the short term. Moderate quality evidence indicates that haloperidol caused parkinsonism (5 RCTs n = 485, RR 5.48 CI 2.68 to 11.22), akathisia (6 RCTs n = 695, RR 3.66 CI 2.24 to 5.97, and acute dystonia (5 RCTs n = 471, RR 11.49 CI 3.23 to 10.85). Discharge from hospital was equivocal between groups (1 RCT n = 33, RR 0.85 CI 0.47 to 1.52, very low quality evidence). Data were not reported for death and patient satisfaction.Authors' conclusions: Haloperidol is a potent antipsychotic drug but has a high propensity to cause adverse effects. Where there is no treatment option, use of haloperidol to counter the damaging and potentially dangerous consequences of untreated schizophrenia is justified. However, where a choice of drug is available, people with schizophrenia and clinicians may wish to prescribe an alternative antipsychotic with less likelihood of adverse effects such as parkinsonism, akathisia and acute dystonias. Haloperidol should be less favoured as a control drug for randomised trials of new antipsychotics.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003082.pub3/abstract

Record #36 of 45

ID: CD006252

AU: Desapriya Ediriweera

AU: Harjee Rahana

AU: Brubacher Jeffrey

AU: Chan Herbert

AU: Hewapathirane D Sesath

AU: Subzwari Sayed

AU: Pike Ian

TI: Vision screening of older drivers for preventing road traffic injuries and fatalities

SO: Cochrane Database of Systematic Reviews

YR: 2014

NO: 2

PB: John Wiley & Sons, Ltd

KY: Automobile Driving;Vision Screening;Accidents, Traffic [prevention & control];Aged[checkword];Humans[checkword]

CC: INJ

DOI: 10.1002/14651858.CD006252.pub4

AB: Background: Demographic data in North America, Europe, Asia, Australia and New Zealand suggest a rapid growth in the number of persons over the age of 65 years as the baby boomer generation passes retirement age. As older adults make up an increasing proportion of the population, they are an important consideration when designing future evidence-based traffic safety policies, particularly those that lead to restrictions or cessation of driving. Research has shown that cessation of driving among older drivers can lead to negative emotional consequences such as depression and loss of independence. Older adults who continue to drive tend to do so less frequently than other demographic groups and are more likely to be involved in a road traffic crash, possibly due to what is termed the "low mileage bias". Available research suggests that older driver crash risk estimates based on traditional exposure measures are prone to bias. When annual driving distances are taken in to consideration, older drivers with low driving distances have an increased crash risk, while those with average or high driving distances tend to be safer drivers when compared to other age groups. In addition, older drivers with lower distance driving tend to drive in urban areas which, due to more complex and demanding traffic patterns, tend to be more accident-prone. Failure to control for actual annual driving distances and driving locations among older drivers is referred to as "low mileage bias" in older driver mobility research. It is also important to note that older drivers are more vulnerable to serious injury and death in the event of a traffic crash due to changes in physiology associated with normal ageing. Vision, cognition, and motor functions or skills (e.g., strength, co-ordination, and flexibility) are three key domains required for safe driving. To drive safely, an individual needs to be able to see road signs, road side objects, traffic lights, roadway markings, other vulnerable road users, and other vehicles on the road, among many other cues-all while moving, and under varying light and weather conditions. It is equally important that drivers must have appropriate peripheral vision to monitor objects and movement to identify possible threats in the driving environment. It is, therefore, not surprising that there is agreement among researchers that vision plays a significant role in driving performance. Several age-related processes/conditions impair vision, thus it follows that vision testing of older drivers is an important road safety issue. The components of visual function essential for driving are acuity, static acuity, dynamic acuity, visual fields, visual attention, depth perception, and contrast sensitivity. These indices are typically not fully assessed by licensing agencies. Also, current vision screening regulations and cut-off values required to pass a licensing test vary from country to country. Although there is a clear need to develop evidence-based and validated tools for vision screening for driving, the effectiveness of existing vision screening tools remains unclear. This represents an important and highly warranted initiative to increase road safety worldwide.Objectives: To assess the effects of vision screening interventions for older drivers to prevent road traffic injuries and fatalities.Search methods: For the update of this review we searched the Cochrane Injuries Group's Specialised Register, the Cochrane Central Register of Controlled Trials (CENTRAL) (The Cochrane Library), MEDLINE (OvidSP), Embase (OvidSP), PsycINFO (OvidSP) and ISI Web of

Science: (CPCI-S & SSCI). The searches were conducted up to 26 September 2013.Selection criteria: Randomised controlled trials (RCTs) and controlled before and after studies comparing vision screening to non-screening of drivers aged 55 years and older, and which assessed the effect on road traffic crashes, injuries, fatalities and any involvement in traffic law violations.Data collection and analysis: Two review authors independently screened the reference lists for eligible articles and independently assessed the articles for inclusion against the criteria. If suitable trials had been available, two review authors would have independently extracted data using a standardised extraction form.Main results: No studies were found that met the inclusion criteria for this review.Authors' conclusions: Most countries require a vision screening test for the renewal of an individual's driver's licence. There is, however, lack of methodologically sound studies to assess the effects of vision screening tests on subsequent motor vehicle crash reduction. There is a need to develop valid and reliable tools of vision screening that can predict driving performance.

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Record #37 of 45

ID: CD008827

AU: Yue Jirong

AU: Dong Bi Rong

AU: Lin Xiufang

AU: Yang Ming

AU: Wu Hong Mei

AU: Wu Taixiang

TI: Huperzine A for mild cognitive impairment

SO: Cochrane Database of Systematic Reviews

YR: 2012

NO: 12

PB: John Wiley & Sons, Ltd

KY: Alkaloids [therapeutic use];Cholinesterase Inhibitors [therapeutic use];Mild Cognitive Impairment [drug therapy];Neuroprotective Agents [therapeutic use];Sesquiterpenes [therapeutic use];Humans[checkword]

CC: DEMENTIA

DOI: 10.1002/14651858.CD008827.pub2

AB: Background: Mild cognitive impairment (MCI) has been proposed as a condition of intermediate symptomatology between the cognitive changes of ageing and fully developed symptoms of dementia. Treatment in the stages of MCI may delay the deterioration of cognitive impairment and delay the progression to dementia. Currently, the treatments for Alzheimer's disease have been focused on increasing acetylcholine levels in the brain. However, these drugs have not been proven to be effective for MCI and have numerous side effects. Huperzine A may have some beneficial effects in MCI.Objectives: To assess the clinical efficacy and safety of huperzine A for the treatment of patients with MCI.Search methods: We searched ALOIS: the Cochrane Dementia and Cognitive Improvement Group's Specialized Register on 23 May 2011 using the terms: huperzine, ayapin, scoparon. ALOIS contains records of clinical trials identified from monthly searches of a number of major healthcare databases, numerous trial registries and grey literature sources. Additional searches were also performed separately in MEDLINE, EMBASE, PsycINFO, LILACS, clinicalTrials.gov, the ICTRP (WHO portal), CENTRAL (The Cochrane Library) and Web of Science with Conference Proceedings.The following Chinese databases were searched: The Chinese Biomedical Database, VIP Chinese Science and Technique Journals Database, China National Knowledge Infrastructure and The Chinese Clinical Trials Register. In addition, we handsearched 20 Chinese traditional medicine journals from between 1970 and 1989.Selection criteria: Randomised, parallel-group, placebo-controlled trials comparing huperzine A with placebo in patients with MCI were eligible for inclusion.Data collection and analysis: Two review authors independently assessed studies for their eligibility for inclusion.Main results: No eligible trials were identified. In the absence of any suitable randomised placebo-controlled trials in this area, we were unable to perform a meta-analysis.Authors' conclusions: The currently available evidence is insufficient to assess the potential for huperzine A in the treatment of MCI. Randomised double-blind placebo-controlled trials are needed.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD008827.pub2/abstract

Record #38 of 45

ID: CD003719

AU: Youssef Mohamed AFM

AU: Al-Inany Hesham G

AU: Aboulghar Mohamed

AU: Mansour Ragaa

AU: Abou-Setta Ahmed M

TI: Recombinant versus urinary human chorionic gonadotrophin for final oocyte maturation triggering in IVF and ICSI cycles

SO: Cochrane Database of Systematic Reviews

YR: 2011

NO: 4

PB: John Wiley & Sons, Ltd

KY: Chorionic Gonadotropin [therapeutic use];Fertilization in Vitro;Gonadotropin-Releasing Hormone [agonists];Luteinizing Hormone [therapeutic use];Ovulation Induction [methods];Randomized Controlled Trials as Topic;Recombinant Proteins [therapeutic use];Sperm Injections, Intracytoplasmic;Female[checkword];Humans[checkword]

CC: MENSTR

DOI: 10.1002/14651858.CD003719.pub3

AB: Background: For the last few decades urinary human chorionic gonadotrophin (hCG) has been used to induce final oocyte maturation triggering in in vitro fertilization (IVF) and intra-cytoplasmic sperm injection (ICSI) cycles. Recombinant technology has allowed the production of two drugs that can be used for the same purpose, to mimic the endogenous luteinizing hormone (LH) surge. This allows commercial production to be adjusted according to market requirements; the removal of all urinary contaminants; and the safe subcutaneous administration of a compound with less batch-to-batch variation. However, prior to a change in practice the effectiveness of the recombinant drugs should be known compared to the currently used urinary human chorionic gonadotrophin (uhCG).Objectives: To assess the efficacy and safety of subcutaneous recombinant hCG (rhCG) and high dose recombinant LH (rLH) compared with intramuscular uhCG for inducing final oocyte maturation triggering in IVF and ICSI cycles.Search methods: We searched the Cochrane Menstrual Disorders and Subfertility Group Trials Register (January 2010), the Cochrane Central Register of Controlled Trials (CENTRAL) (The Cochrane Library 2010), MEDLINE (1966 to January 2010) and EMBASE (1980 to January 2010).Selection criteria: Two review authors independently scanned titles and abstracts and selected those that appeared relevant for collection of the full paper. Only truly randomised controlled trials comparing rhCG and rLH with urinary hCG for final oocyte maturation triggering in IVF and ICSI cycles for treatment of infertility in normo-gonadotropic women were included.Data collection and analysis: Assessment for inclusion or exclusion, quality assessment and data extraction were performed independently by two authors. Discrepancies were discussed in the presence of a third author and consensus reached. Quality assessment included method of randomisation, allocation concealment, blinding of participants and assessors, reporting of a power calculation and intention-to-treat analysis.Main results: Fourteen RCTs (n = 2306) were identified; 11 compared rhCG with uhCG and three compared rhLH with uhCG. There was no evidence of a statistically significant difference between rhCG and uhCG regarding the ongoing pregnancy or live birth rate (6 RCTs: OR 1.04, 95% CI 0.79 to 1.37; P = 0.83, I2 = 0%). There was no significant difference in the incidence of ovarian hyperstimulation syndrome (OHSS) between rhCG and uhCG (3 RCTs: OR

1.5, 95% CI 0.37 to 4.1; P = 0.37, I2 = 0%). There was no evidence of statistically significant difference between rhLH and uhCG regarding the ongoing pregnancy or live birth rate (OR 0.94, 95% CI 0.50 to 1.76) and incidence of OHSS (OR 0.82, 95% CI 0.39 to 1.69). These results leave open the possibility of strong differences in favour of either treatment for both ongoing pregnancy and OHSS.Authors' conclusions: We conclude that there is no evidence of difference between rhCG or rhLH and uhCG in achieving final follicular maturation in IVF, with equivalent pregnancy rates and OHSS incidence. According to these findings uHCG is still the best choice for final oocyte maturation triggering in IVF and ICSI treatment cycles.

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Record #39 of 45

ID: CD005151

AU: Wakai Abel

AU: McCabe Aileen

AU: Kidney Rachel

AU: Brooks Steven C

AU: Seupaul Rawle A

AU: Diercks Deborah B

AU: Salter Nigel

AU: Fermann Gregory J

AU: Pospisil Caroline

TI: Nitrates for acute heart failure syndromes

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 8

PB: John Wiley & Sons, Ltd

KY: Acute Disease;Heart Failure [drug therapy];Isosorbide Dinitrate [therapeutic use];Nitrates [therapeutic use];Nitroglycerin [therapeutic use];Randomized Controlled Trials as Topic;Syndrome;Vasodilator Agents [therapeutic use];Adult[checkword];Humans[checkword]

CC: VASC

DOI: 10.1002/14651858.CD005151.pub2

AB: Background: Current drug therapy for acute heart failure syndromes (AHFS) consists mainly of diuretics supplemented by vasodilators or inotropes. Nitrates have been used as vasodilators in AHFS for many years and have been shown to improve some aspects of AHFS in some small studies. The aim of this review was to determine the clinical efficacy and safety of nitrate vasodilators in AHFS.Objectives: To quantify the effect of different nitrate preparations (isosorbide dinitrate and nitroglycerin) and the effect of route of administration of nitrates on clinical outcome, and to evaluate the safety and tolerability of nitrates in the management of AHFS.Search methods: We searched the Cochrane Central Register of Controlled Trials (CENTRAL) (The Cochrane Library 2011, Issue 3), MEDLINE (1950 to July week 2 2011) and EMBASE (1980 to week 28 2011). We searched the Current Controlled Trials MetaRegister of Clinical Trials (compiled by Current Science) (July 2011). We checked the reference lists of trials and contacted trial authors. We imposed no language restriction.Selection criteria: Randomised controlled trials comparing nitrates (isosorbide dinitrate and nitroglycerin) with alternative interventions (frusemide and morphine, frusemide alone, hydralazine, prenalterol, intravenous nesiritide and placebo) in the management of AHFS in adults aged 18 and over.Data collection and analysis: Two authors independently performed data extraction. Two authors performed trial quality assessment. We used mean difference (MD), odds ratio (OR) and 95% confidence intervals (CI) to measure effect sizes. Two authors independently assessed and rated the methodological quality of each trial using the Cochrane Collaboration tool for assessing risk of bias.Main results: Four studies (634 participants) met the inclusion criteria. Two of the included studies included only patients with AHFS following acute myocardial infarction (AMI); one study excluded patients with overt AMI; and one study included participants with AHFS with and without acute coronary syndromes.Based on a single study, there was no significant difference in the rapidity of symptom relief between intravenous nitroglycerin/N-acetylcysteine and intravenous frusemide/morphine after 30 minutes (fixed-effect MD -0.30, 95% CI -0.65 to 0.05), 60 minutes (fixed-effect MD -0.20, 95% CI -0.65 to 0.25), three hours (fixed-effect MD 0.20, 95% CI -0.27 to 0.67) and 24 hours (fixed-effect MD 0.00, 95% CI -0.31 to 0.31). There is no evidence to support a difference in AHFS patients receiving intravenous nitrate vasodilator therapy or alternative interventions with regard to the following outcome measures: requirement for mechanical ventilation, systolic blood pressure (SBP) change after three hours and 24 hours, diastolic blood pressure (DBP) change after 30, 60 and 90 minutes, heart rate change at 30 minutes, 60 minutes, three hours and 24 hours, pulmonary artery occlusion pressure (PAOP) change after three hours and 18 hours, cardiac output (CO) change at 90 minutes and three hours and progression to myocardial infarction. There is a significantly higher incidence of adverse events after three hours with nitroglycerin compared with placebo (odds ratio 2.29, 95% CI 1.26 to 4.16) based on a single study. There was no consistent evidence to support a difference in AHFS patients receiving intravenous nitrate vasodilator therapy or alternative interventions with regard to the following secondary outcome measures: SBP change after 30 and 60 minutes, heart rate change after 90 minutes, and PAOP change after 90 minutes. None of the included studies reported healthcare costs as an outcome measure. There were no data reported by any of the studies relating to the acceptability of the treatment to the patients (patient satisfaction scores).Overall there was a paucity of relevant quality data in the included studies. Assessment of overall risk of bias in

these studies was limited as three of the studies did not give sufficient detail to allow assessment of potential risk of bias.Authors' conclusions: There appears to be no significant difference between nitrate vasodilator therapy and alternative interventions in the treatment of AHFS, with regard to symptom relief and haemodynamic variables. Nitrates may be associated with a lower incidence of adverse effects after three hours compared with placebo. However, there is a lack of data to draw any firm conclusions concerning the use of nitrates in AHFS because current evidence is based on few low-quality studies.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD005151.pub2/abstract

Record #40 of 45

ID: CD010561

AU: Athale Abha H

AU: Marcucci Maura

AU: Iorio Alfonso

TI: Immune tolerance induction for treating inhibitors in people with congenital haemophilia A or B

SO: Cochrane Database of Systematic Reviews

YR: 2014

NO: 4

PB: John Wiley & Sons, Ltd

CC: CF

DOI: 10.1002/14651858.CD010561.pub2

AB: Background: The occurrence of factor inhibitory antibodies, or inhibitors, is a significant complication in the care of individuals with congenital haemophilia A or B. Currently, immune tolerance induction is the only known intervention to successfully eradicate inhibitors. However, ideal dosing regimens, and the comparative safety and efficacy of different immune tolerance induction regimens have not yet been established.Objectives: The objective of this review was to assess the effects of immune tolerance induction (different protocols of this therapy versus each other, or versus only bypassing agents) for treating inhibitors in people with congenital haemophilia A or B.Search methods: We searched the Cochrane Cystic Fibrosis and Genetic Disorders Group's Coagulopathies Trials Register, compiled from electronic database searches and handsearching of journals and conference abstract books. We also searched: MEDLINE (from 1946 to 15 July 2013); Embase (from 1980 to 15 July 2013) via the OVID platform; CINAHL (from conception to 15 July 2013); and ClinicalTrials.gov (most recent

search: 15 July 2013). We also searched the reference lists of relevant articles and reviews.Selection criteria: Randomised controlled trials comparing either different immune tolerance induction regimens or immune tolerance induction versus only bypassing therapy for the eradication of factor inhibitory antibodies in patients with congenital haemophilia A or B.Data collection and analysis: Two review authors independently completed data collection, extraction and assessment of the risk of bias of trials.Main results: One methodologically sound randomised controlled trial met the inclusion criteria and was included in the review. One further randomised controlled trial has been recently stopped, but it has not yet been reported.The included multinational trial randomised 115 paediatric participants with severe haemophilia A and high-responding inhibitors, for whom this was the first attempt at immune tolerance induction, to receive either a low dose (50 IU/kg of factor VIII concentrate three times per week) or a high dose (200 IU/kg of factor VIII daily). Although, there was no statistically significant difference in the success of immune tolerance induction between treatment arms, the confidence intervals were too wide to infer no effect: 24 out of 58 participants (46.6%) in the low-dose group and 22 out of 57 (38.6%) in the high-dose group experiencing full tolerance, risk ratio 1.07 (95% CI 0.68 to 1.68) (moderate quality evidence). The rate of infection was not statistically different between groups, but again confidence intervals were too wide. Of those patients who had a central venous catheter device, 19 out of 47 participants (40.4%) in the low-dose arm had 69 infections, and 22 out of 52 participants (42.3%) in the high-dose arm had 55 infections, risk ratio 0.96 (95% CI 0.60 to 1.53) (moderate quality evidence). However, participants in the low-dose immune tolerance induction group experienced significantly more bleeding episodes (50 out of 58 participants (86.2%) experienced one or more bleeding events) than those in the high-dose group (36 out of 57 participants (63.1%) experienced one or more bleeding events), risk ratio 1.36 (95% CI 1.09 to 1.71) (low quality evidence). One factor VIII reaction, one incidence of trauma and 13 incidences of needing to insert or remove the catheter were reported as trial-related serious adverse events; however, the treatment group where these events occurred was not specified. No incidence of nephrotic syndrome was reported.Authors' conclusions: We did not find any randomised controlled trial-based comparison of immune tolerance induction with alternate treatment schemes (i.e. bypassing agents for bleeding only). In a single randomised trial, there were no significant differences in the immune tolerance induction success rate between different dosing regimens, which may have been due to imprecision of the estimate. There is low-quality evidence to suggest that high-dose immune tolerance induction may induce tolerance more quickly which is associated with fewer bleeding complications. The choice of immune tolerance induction regimen should be considered individually for each case, until further research provides additional evidence.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010561.pub2/abstract

Record #41 of 45

ID: CD010034

AU: Grewal Rumant S

AU: Kazeem Ayodele

AU: Pappas Yannis

AU: Car Josip

AU: Majeed Azeem

TI: Training interventions for improving telephone consultation skills in clinicians

SO: Cochrane Database of Systematic Reviews

YR: 2012

NO: 8

PB: John Wiley & Sons, Ltd

CC: HM-EPOC

DOI: 10.1002/14651858.CD010034

AB: This is the protocol for a review and there is no abstract. The objectives are as follows:To assess the effectiveness of training interventions on clinician telephone skills.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010034/abstract

Record #42 of 45 

ID: CD004746

AU: Birks Jacqueline

AU: Craig David

TI: Galantamine for vascular cognitive impairment

SO: Cochrane Database of Systematic Reviews

YR: 2006

NO: 1

PB: John Wiley & Sons, Ltd

KY: Alzheimer Disease [complications] [drug therapy];Cholinesterase Inhibitors [therapeutic use];Cognition Disorders [drug therapy] [etiology];Dementia, Vascular [drug

therapy];Galantamine [adverse effects] [therapeutic use];Nootropic Agents [adverse effects] [therapeutic use];Randomized Controlled Trials as Topic;Humans[checkword]

CC: DEMENTIA

DOI: 10.1002/14651858.CD004746.pub2

AB: Background: Vascular dementia represents the second most common type of dementia after that caused by Alzheimer's disease. Particularly in older patients, the combination of vascular dementia and Alzheimer's disease is common and is referred to as mixed dementia. The classification of vascular dementia broadly follows three clinico-pathological processes: multi-infarct dementia, single strategic infarct dementia and subcortical dementia. Not all patients fulfil strict criteria for dementia and may be significantly cognitively impaired without memory loss and the term vascular cognitive impairment is more useful. Currently, no established standard treatment for vascular cognitive impairment exists. Reductions in acetylcholine and acetyltransferase activity are common to both Alzheimer's disease and vascular cognitive impairment raising the possibility that cholinesterase inhibitors such as galantamine may be beneficial for the latter.Objectives: To assess the efficacy of galantamine in the treatment of people with vascular cognitive impairment or vascular dementia or mixed dementia.Search methods: The trials were identified from a search of ALOIS: the Cochrane Dementia and Cognitive Improvement Group?s Specialized Register on 12 January 2013. The register contains information on trials identified from frequent searches of a number of major healthcare and medical databases (MEDLINE, EMBASE, PsycINFO, CINAHL and LILACS) as well as from a number of international and national trial registries and grey literature sources. The terms used were: galantamine, galanthamine, Reminyl, Razadyne, Nivalin.Selection criteria: All unconfounded randomised double-blind trials comparing galantamine with placebo were eligible for inclusion.Data collection and analysis: Two review authors independently extracted the data from included studies.Main results: Two trials, 1378 participants, employing randomised, double-blind, parallel-group methodology were included. Both trials were of six months duration and were testing a galantamine dose of 16-24 mg/day in two divided doses. Both trials had an overall low risk of bias.The GAL-INT-6 trial included 592 patients with vascular dementia diagnosed according to recognised criteria and patients with Alzheimer's disease and coincidental radiographic findings of cerebrovascular disease. Limited outcome data were reported for the subgroup data with vascular dementia. In the whole trial population, statistically significant treatment effects in favour of galantamine compared with placebo in cognition (ADAS-cog, mean difference (MD) -2.29, 95% confidence interval (CI) -3.46 to -1.12, P = 0.0001), activities of daily living (DAD, MD 4.10, 95% CI 1.25 to 6.95, P = 0.005) and behaviour (NPI, MD -2.06, 95% CI -4.09 to -0.03, P = 0.05) were noted. Significantly higher numbers of patients dropped out, (102/396 galantamine, 33/196 placebo odds ratio (OR) 1.71, 95% CL 1.11 to 2.65, P = 0.02) and withdrew due to an adverse event from the group treated with galantamine compared with the placebo group (79/396 galantamine, 16/196 placebo, OR 2.80, 95% CI 1.59 to 4.95, P =0.0004).Data were also included from a second larger trial (GAL-INT-26) involving 788 patients with vascular dementia diagnosed using standard criteria. Statistically significant benefits favouring galantamine over placebo in assessments of cognition (ADAS-cog, MD -1.50, 95% CI -2.39 to -0.61, P = 0.0009), and favouring placebo compared with galantamine for behaviour (NPI, MD 1.80, 95% CI 0.29 to 3.31, P = 0.02) are

recorded. Significantly higher numbers of patients dropped out from the group treated with galantamine compared with the placebo group (50/396 galantamine, 25/390 placebo OR 2.11, 95% CL 1.28 to 3.49, P = 0.004).Authors' conclusions: Limited data were available when considering the impact of galantamine on vascular dementia or vascular cognitive impairment. The data available suggest some advantage over placebo in the areas of cognition and global clinical state. In both included trials galantamine produced higher rates of gastrointestinal side-effects. More studies are needed before firm conclusions can be drawn.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004746.pub2/abstract

Record #43 of 45

ID: CD007804

AU: Forsman Anna

AU: Jane-Llopis Eva

AU: Schierenbeck Isabell

AU: Wahlbeck Kristian

TI: Psychosocial interventions for prevention of depression in older people

SO: Cochrane Database of Systematic Reviews

YR: 2009

NO: 2

PB: John Wiley & Sons, Ltd

CC: HM-DEPRESSN

DOI: 10.1002/14651858.CD007804

AB: This is the protocol for a review and there is no abstract. The objectives are as follows:1. To assess the effectiveness of psychosocial interventions in primary prevention of depressive symptoms and unipolar depressive disorders in people over the age of 65.2. The secondary objective is to separately assess the effectiveness of different forms of preventive interventions that have an impact on the social capital (i.e. social network, social support, trust, social participation) of participants.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007804/abstract

Record #44 of 45

ID: CD008118

AU: Usinger Lotte

AU: Reimer Christina

AU: Ibsen Hans

TI: Fermented milk for hypertension

SO: Cochrane Database of Systematic Reviews

YR: 2012

NO: 4

PB: John Wiley & Sons, Ltd

KY: Cultured Milk Products [chemistry];Freeze Drying;Hypertension [diet therapy];Milk Proteins [therapeutic use];Humans[checkword]

CC: HM-HTN

DOI: 10.1002/14651858.CD008118.pub2

AB: Background: Fermented milk has been suggested to have a blood pressure lowering effect through increased content of proteins and peptides produced during the bacterial fermentation. Hypertension is one of the major risk factors for cardiovascular disease world wide and new blood pressure reducing lifestyle interventions, such as fermented milk, would be of great importance.Objectives: To investigate whether fermented milk or similar products produced by lactobacilli fermentation of milk proteins has any blood pressure lowering effect in humans when compared to no treatment or placebo.Search methods: The Cochrane Central Register of Controlled Trials (CENTRAL), English language databases, including MEDLINE (1966-2011), EMBASE (1974-2011), Cochrane Complementary Medicine Trials Register, Allied and Complementary Medicine (AMED) (1985-2011), Food science and technology abstracts (1969-2011).Selection criteria: Randomised controlled trials; cross over and parallel studies evaluating the effect on blood pressure of fermented milk in humans with an intervention period of 4 weeks or longer.Data collection and analysis: Data was extracted individually by two authors, afterwards agreement had to be obtained before imputation in the review.Main results: A modest overall effect of fermented milk on SBP was found (MD -2.45; 95% CI -4.30 to -0.60), no effect was evident on DBP (MD -0.67; 95% CI -1.48, 0.14).Authors' conclusions: The review does not support an effect of fermented milk on blood pressure. Despite the positive effect on SBP the authors conclude, for several reasons, that fermented milk has no effect on blood pressure. The effect found was very modest and only on SBP, the included studies were very heterogeneous and several with weak methodology. Finally, sensitivity and subgroup analyses could not reproduce the antihypertensive effect. The results do not give notion to the use of fermented milk as treatment for hypertension or as a lifestyle intervention for pre-hypertension nor would it influence population blood pressure.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD008118.pub2/abstract

Record #45 of 45

ID: CD006932

AU: Rooney Alasdair

AU: Grant Robin

TI: Pharmacological treatment of depression in patients with a primary brain tumour

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 5

PB: John Wiley & Sons, Ltd

KY: Antidepressive Agents [adverse effects] [therapeutic use];Brain Neoplasms [psychology];Depression [drug therapy] [etiology];Humans[checkword]

CC: GYNAECA

DOI: 10.1002/14651858.CD006932.pub3

AB: Background: This is an updated version of the original Cochrane review published in Issue 3, 2010.Patients with a primary brain tumour often experience depression, for which drug treatment may be prescribed. However, these patients are also at high risk of epileptic seizures, cognitive impairment and fatigue, all of which are potential side effects of antidepressants. The benefit, or harm, of pharmacological treatment of depression in brain tumour patients is unclear.Objectives: To assess the benefits and harms of pharmacological treatment of depression in patients with a primary brain tumour.Search methods: We updated the search to include the Cochrane Central Register of Controlled Trials (CENTRAL) (The Cochrane Library 2012, Issue 10), MEDLINE to October 2012, EMBASE to October 2012 and PsycINFO to October 2012. We searched the British Nursing Index, LILACS, PSYNDEX, the NHS National Research Register, the NHS Centre for Reviews and Dissemination's Database of Abstracts of Reviews of Effectiveness (DARE) and Web of Knowledge (covering Science Scisearch, Social Sciences Citation Index and Biological Abstracts) for the original review (to July 2009). In the original review we also handsearched Neuro-oncology, the Journal of Neuro-oncology, the Journal of Neurology, Neurosurgery and Psychiatry and the Journal of Clinical Oncology (July 1999 to June 2009) and wrote to all the pharmaceutical companies manufacturing antidepressants for use in the UK.Selection criteria: We searched for all randomised controlled trials (RCTs), controlled clinical trials, cohort studies and case-control studies of any pharmacological treatment of depression in patients with a histologically

diagnosed primary brain tumour.Data collection and analysis: No studies met the inclusion criteria.Main results: We found no eligible studies evaluating the benefits of any pharmacological treatment of depression in brain tumour patients.Authors' conclusions: No high-quality studies have examined the value of pharmacological treatment of depression in patients with a primary brain tumour. RCTs and detailed prospective studies are required to inform the effective pharmacological treatment of this common and important complication of brain tumours. Since the last version of this review none of the new relevant studies have provided additional information to change these conclusions.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006932.pub3/abstract