Record #1 of 175

ID: CD011137

AU: Bansal Dipika

AU: Gudala Kapil

AU: Undela Krishna

TI: Statins for preventing colorectal adenoma and carcinoma

SO: Cochrane Database of Systematic Reviews

YR: 2014

NO: 5

PB: John Wiley & Sons, Ltd

CC: COLOCA

DOI: 10.1002/14651858.CD011137

AB: This is the protocol for a review and there is no abstract. The objectives are as follows:The primary objectives are to assess the effect of statins on the incidence of colorectal adenomatous polyps and on the incidence of CRC compared with placebo. A secondary objective is to evaluate the incidence of adverse effects resulting from this intervention.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD011137/abstract

Record #2 of 175

ID: CD010870

AU: Kokka Fani

AU: Bryant Andrew

AU: Brockbank Elly

AU: Jeyarajah Arjun

TI: Surgical treatment of stage IA2 cervical cancer

SO: Cochrane Database of Systematic Reviews

YR: 2014

NO: 5

PB: John Wiley & Sons, Ltd

CC: GYNAECA

DOI: 10.1002/14651858.CD010870.pub2

AB: Background: Cervical cancer is the second most common cancer among women up to 65 years of age and is the most frequent cause of death from gynaecological cancers worldwide. Women with International Federation of Gynecology and Obstetrics (FIGO) stage IA2 cervical cancer have measured stromal invasion (when the cancer breaks through the basement membrane of the epithelium) of greater than 3 mm and no greater than 5 mm in depth with a horizontal surface extension of no more than 7 mm. For stage IA2 disease, radical hysterectomy with pelvic lymphadenectomy or radiotherapy is the standard treatment. In order to avoid complications of more radical surgical methods, less invasive options, such as simple hysterectomy, simple trachelectomy or conisation, with or without pelvic lymphadenectomy, may be feasible for stage IA2 disease, considering the relative low risk of local or distant metastatic disease. The evidence for less radical tumour excision and for the role of systematic lymphadenectomy in stage IA2 cervical cancer is not clear.Objectives: To evaluate the effectiveness and safety of less radical surgery in stage IA2 cervical cancer.Search methods: We searched the Cochrane Gynaecological Cancer Group trials register, Cochrane Central Register of Controlled Trials (CENTRAL), MEDLINE and EMBASE up to September 2013. We also searched registers of clinical trials and abstracts of scientific meetings.Selection criteria: We searched for randomised controlled trials (RCTs) that compared surgical techniques in women with stage IA2 cervical cancer.Data collection and analysis: Two review authors independently assessed whether potentially relevant studies met the inclusion criteria. We found no trials and, therefore, no data were analysed.Main results: The search strategy identified 982 unique references, which were all excluded on the basis of title and abstract because it was clear that they did not meet the inclusion criteria. We identified one relevant large ongoing trial, so it is anticipated that we will be able to add this evidence to this review in the future.Authors' conclusions: We found no evidence to inform decisions about different surgical techniques in women with stage IA2 cervical cancer. In the future, the results of one large ongoing RCT should allow comparison of different types of surgery.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010870.pub2/abstract

Record #3 of 175

ID: CD009108

AU: Derry Christopher J

AU: Derry Sheena

AU: Moore R Andrew

TI: Sumatriptan (all routes of administration) for acute migraine attacks in adults - overview of Cochrane reviews

SO: Cochrane Database of Systematic Reviews

YR: 2014

NO: 5

PB: John Wiley & Sons, Ltd

CC: SYMPT

DOI: 10.1002/14651858.CD009108.pub2

AB: Background: Migraine is a highly disabling condition for the individual and also has wide-reaching implications for society, healthcare services, and the economy. Sumatriptan is an abortive medication for migraine attacks, belonging to the triptan family. It is available for administration by four different routes: oral, subcutaneous, intranasal, and rectal.Objectives: To summarise evidence from four Cochrane intervention reviews on the efficacy and tolerability of sumatriptan in the treatment of acute migraine attacks in adults by four routes of administration (oral, subcutaneous, intranasal, and rectal) compared with both placebo and active comparators.Methods: The included reviews were written by the authors of this overview; no additional searching was carried out. All included reviews were conducted according to a standard protocol and reported a standard set of outcomes. From each individual review we extracted results for pain relief at different levels, and adverse events. No additional statistical comparison was undertaken as part of the overview. We focused on the most important findings for doses and routes licensed in North America or Europe (oral 25 mg, 50 mg, 100 mg; subcutaneous 4 mg, 6 mg; intranasal 5 mg, 10 mg, 20 mg; rectal 25 mg).Main results: Included reviews provided data for 18 different dose and route of administration combinations in 52,236 participants. Data for the primary outcomes sought were generally well reported, and involved adequate numbers of participants to give confidence in the results, except for the rectal route of administration, where numbers were low.Subcutaneous administration was the most effective, with pain reduced from moderate or severe to none by two hours in almost 6 in 10 people (59%) taking 6 mg sumatriptan, compared with approximately 1 in 7 (15%) taking placebo; the number needed to treat (NNT) was 2.3 (95% confidence interval 2.1 to 2.4) with 2522 participants in the analysis. The most commonly used doses of oral, rectal, and intranasal sumatriptan also provided clinically useful pain relief, with the oral 50 mg dose providing complete relief of pain in almost 3 in 10 people (28%) compared with about 1 in 10 (11%) after placebo (NNT 6.1 (5.5 to 6.9) in 6447 participants). Subcutaneous administration provided more rapid pain relief than the other routes. Taking medication early, when pain was mild, was more effective than waiting until the pain was moderate or severe.The most effective dose of sumatriptan for each route of administration for the outcome of headache relief (pain reduced from moderate or severe to none or mild) at two hours was oral 100 mg (NNT 3.5 (3.2 to 3.7) in 7811 participants), subcutaneous 6 mg (NNT 2.1 (2.0 to 2.2) in 2738 participants), intranasal 20 mg (NNT 3.5 (3.1 to 4.1) in 2020 participants), and rectal 25 mg (NNT 2.4 (1.9 to 3.4) in 240 participants).Adverse events were

generally of mild or moderate severity, of short duration, and more common with subcutaneously administered sumatriptan and higher doses of oral and intranasal sumatriptan than with other dose and route combinations.Authors' conclusions: Sumatriptan is an effective abortive treatment for acute migraine attacks, but is associated with increased adverse events relative to placebo. The route of administration influences efficacy, particularly within the first hour after administration. Subcutaneous sumatriptan shows the greatest efficacy in terms of pain relief, but at the expense of relatively high levels of adverse events, and with a high financial cost compared with other routes. Information about the relative efficacy of the different routes of administration for different outcomes should help to inform decisions about the suitability of sumatriptan as a migraine treatment, as well as about the most appropriate way to administer the treatment for individual patients.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD009108.pub2/abstract

Record #4 of 175

ID: CD008671

AU: Hirunyachote Phenpan

AU: Zhang Mingjuan Lisa

AU: Jampel Henry

TI: Combined surgery versus cataract surgery alone for eyes with cataract and glaucoma

SO: Cochrane Database of Systematic Reviews

YR: 2014

NO: 5

PB: John Wiley & Sons, Ltd

CC: EYES

DOI: 10.1002/14651858.CD008671.pub2

AB: This is the protocol for a review and there is no abstract. The objectives are as follows:To assess the effectiveness and safety of combined surgery versus cataract surgery (phacoemulsification) alone for co-existing cataract and glaucoma. The secondary objectives include cost analyses for different surgical techniques for co-existing cataract and glaucoma.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD008671.pub2/abstract

Record #5 of 175

ID: CD010125

AU: Lamers Mieke H

AU: Broekman Mark

AU: Drenth Joost PH

AU: Gluud Christian

TI: Aminoadamantanes for chronic hepatitis C

SO: Cochrane Database of Systematic Reviews

YR: 2014

NO: 5

PB: John Wiley & Sons, Ltd

CC: LIVER

DOI: 10.1002/14651858.CD010125.pub2

AB: Background: Around 3% of the world's population (approximately 160 million people) are chronically infected with hepatitis C virus. The proportion of infected people who develop clinical symptoms varies between 5% and 40%. Combination therapy with pegylated interferon-alpha plus ribavirin eradicates the virus from the blood six months after treatment (sustained virological response) in approximately 40% to 80% of infected patients, depending on the viral genotype. New antiviral agents, such as boceprevir and telaprevir, in combination with standard therapy, can increase sustained virological response in genotype 1 infected patients to at least 70%. There is therefore an unmet need for drugs that can achieve a higher proportion of sustained virological response. Aminoadamantanes are antiviral drugs used for treatment of patients with chronic hepatitis C.Objectives: To assess the beneficial and harmful effects of aminoadamantanes for patients with chronic hepatitis C infection by conducting a systematic review with meta-analyses of randomised clinical trials, as well as trial sequential analyses.Search methods: We conducted electronic searches of the Cochrane Hepato-Biliary Group Controlled Trials Register (1996 to December 2013), the Cochrane Central Register of Controlled Trials (CENTRAL) 2013, Issue 11 of 12 (1995 to December 2013), MEDLINE (1946 to December 2013), EMBASE (1974 to December 2013), Science Citation Index EXPANDED (1900 to December 2013), the WHO International Clinical Trials Registry Platform (www.who.int/ictrp), Google Scholar, and Eudrapharm up to December 2013 and checked the reference lists of identified publications.Selection criteria: Randomised clinical trials assessing aminoadamantanes in patients with chronic hepatitis C infection.Data collection and analysis: Two authors independently extracted data. We assessed for risks of systematic errors ('bias') using the 'Risk of bias' tool. We analysed dichotomous data with risk ratio (RR) and continuous data with mean difference (MD) or standardised mean difference (SMD), both with 95% confidence intervals (CI). We used trial sequential analysis to assess the risk of random errors

('play of chance'). We assessed quality using the GRADE system.Main results: We included 41 randomised clinical trials with 6193 patients with chronic hepatitis C. All trials had high risk of bias. All included trials compared amantadine versus placebo or no intervention. Standard antiviral therapy was administered equally to the intervention and the control groups in 40 trials. The standard antiviral therapy, which was administered to both intervention groups, was interferon-alpha, interferon-alpha plus ribavirin, and peg interferon-alpha plus ribavirin, depending on the time when the trial was conducted.When we meta-analysed all trials together, the overall results demonstrated no significant effects of amantadine, when compared with placebo or no intervention, on our all-cause mortality or liver-related morbidity composite outcome (5/2353 (0.2%) versus 6/2264 (0.3%); RR 0.90, 95% CI 0.38 to 2.17; I^2 = 0%; 32 trials; very low quality). There was also no significant effect on adverse events (288/2869 (10%) versus 293/2777 (11%); RR 0.98, 95% CI 0.84 to 1.14; I^2 = 0%; 35 trials; moderate quality). We used both fixed-effect and random-effects meta-analyses. Amantadine, when compared with placebo or no intervention, did not significantly influence the number of patients who failed to achieve a sustained virological response (1821/2861 (64%) versus 1737/2721 (64%); RR 0.98, 95% CI 0.95 to 1.02; I^2 = 35%; 35 trials; moderate quality). However, in the subgroup using interferon plus ribavirin, amantadine decreased the number of patients who failed to achieve a sustained virological response (422/666 (63%) versus 447/628 (71%); RR 0.89, 95% CI 0.83 to 0.96; I^2 = 41%; 11 trials; low quality). Similar results were found for failure to achieve an end of treatment virological response. Amantadine, when compared with placebo or no intervention, significantly decreased the number of patients without normalisation of alanine aminotransferase (ALT) serum levels at the end of treatment (671/1141 (59%) versus 732/1100 (67%); RR 0.88, 95% CI 0.83 to 0.94; I^2 = 47%; 19 trials; low quality). Amantadine, when compared with placebo or no intervention, did not significantly influence the end of follow-up biochemical response (1133/1896 (60%) versus 1151/1848 (62%); RR 0.95, 95% CI 0.91 to 1.00; I^2 = 49%; 21 trials; low quality).The observed beneficial effects could be true effects but could also be due to both systematic errors (bias) and random errors (play of chance). The latter is due to the fact that trial sequential analyses could not confirm or refute our findings. We were not able to perform meta-analyses for failure of histological improvement or quality of life due to a lack of valid data.Authors' conclusions: This systematic review does not demonstrate any significant effects of amantadine on all-cause mortality or liver-related morbidity composite outcome and on adverse events in patients with hepatitis C; however, the median trial duration was 12 months, with a median follow-up of six months, which is not long enough to assess the composite outcome sufficiently. Overall, we did not see an effect of amantadine on failure to achieve a sustained virological response. Subgroup analyses demonstrated that the combination of amantadine plus interferon-alpha and ribavirin seems to increase the number of patients achieving a sustained virological response. This finding may be caused by both systematic errors (bias) and risks of random errors (play of chance), but it could also be real. Based on the results of the overall evidence, it appears less likely that future trials assessing amantadine for patients with chronic hepatitis C will show strong benefits. Therefore, it is probably advisable to wait for the results of trials assessing other direct-acting antiviral drugs. In the absence of convincing evidence of benefit, the use of amantadine is justified in the context of randomised clinical trials assessing the effects of combination therapy. We found a lack of evidence on other aminoadamantanes than amantadine.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010125.pub2/abstract 

Record #6 of 175

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 #7 of 175

ID: CD006531

AU: Purgato Marianna

AU: Papola Davide

AU: Gastaldon Chiara

AU: Trespidi Carlotta

AU: Magni Laura R

AU: Rizzo Carla

AU: Furukawa Toshi A

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 #8 of 175

ID: CD002990

AU: Zwerink Marlies

AU: Brusse-Keizer Marjolein

AU: van der Valk Paul DLPM

AU: Zielhuis Gerhard A

AU: Monninkhof Evelyn M

AU: van der Palen Job

AU: Frith Peter A

AU: Effing Tanja

TI: Self management for patients with chronic obstructive pulmonary disease

SO: Cochrane Database of Systematic Reviews

YR: 2014

NO: 3

PB: John Wiley & Sons, Ltd

KY: Patient Education as Topic;Self Care;Outcome Assessment (Health Care);Patient Compliance;Program Evaluation;Pulmonary Disease, Chronic Obstructive [therapy];Quality of Life;Randomized Controlled Trials as Topic;Humans[checkword]

CC: AIRWAYS

DOI: 10.1002/14651858.CD002990.pub3

AB: Background: Self management interventions help patients with chronic obstructive pulmonary disease (COPD) acquire and practise the skills they need to carry out disease-specific medical regimens, guide changes in health behaviour and provide emotional support to enable patients to control their disease. Since the first update of this review in 2007, several studies have been published. The results of the second update are reported here.Objectives: 1. To evaluate whether self management interventions in COPD lead to improved health outcomes.2. To evaluate whether self management interventions in COPD lead to reduced healthcare utilisation.Search methods: We searched the Cochrane Airways Group Specialised Register of trials (current to August 2011).Selection criteria: Controlled trials (randomised and non-randomised) published after 1994, assessing the efficacy of self management interventions for individuals with COPD, were included. Interventions with fewer than two contact moments between study participants and healthcare providers were excluded.Data collection and analysis: Two review authors independently assessed trial quality and extracted data. Investigators were contacted to ask for additional information. When appropriate, study results were pooled using a random-effects model. The primary outcomes of the review were health-related quality of life (HRQoL) and number of hospital admissions.Main results: Twenty-nine studies were included. Twenty-three studies on 3189 participants compared self management versus usual care; six studies on 499 participants compared different components of self management on a head-to-head basis. Although we included non-randomised controlled clinical trials as well as RCTs in this review, we restricted the primary analysis to RCTs only and reported these trials in the abstract.In the 23 studies with a usual care control group, follow-up time ranged from two to 24 months. The content of the

interventions was diverse. A statistically relevant effect of self management on HRQoL was found (St George's Respiratory Questionnaire (SGRQ) total score, mean difference (MD) -3.51, 95% confidence interval (CI) -5.37 to -1.65, 10 studies, 1413 participants, moderate-quality evidence). Self management also led to a lower probability of respiratory-related hospitalisation (odds ratio (OR) 0.57, 95% CI 0.43 to 0.75, nine studies, 1749 participants, moderate-quality evidence). Over one year of follow-up, eight (95% CI 5 to 14) participants with a high baseline risk of respiratory-related hospital admission needed to be treated to prevent one participant with at least one hospital admission, and 20 (95% CI 15 to 35) participants with a low baseline risk of hospitalisation needed to be treated to prevent one participant with at least one respiratory-related hospital admission.No statistically significant effect of self management on all-cause hospitalisation (OR 0.77, 95% CI 0.45 to 1.30, 6 studies, 1365 participants, low-quality evidence) or mortality (OR 0.79, 95% CI 0.58 to 1.07, 8 studies, 2134 participants, very low-quality evidence) was detected. Also, dyspnoea measured by the (modified) Medical Research Council Scale ((m)MRC) was reduced in individuals who participated in self management (MD -0.83, 95% CI -1.36 to -0.30, 3 studies, 119 participants, low-quality evidence). The difference in exercise capacity as measured by the six-minute walking test was not statistically significant (MD 33.69 m, 95% CI -9.12 to 76.50, 6 studies, 570 participants, very low-quality evidence). Subgroup analyses depending on the use of an exercise programme as part of the intervention revealed no statistically significant differences between studies with and without exercise programmes in our primary outcomes of HRQoL and respiratory-related hospital admissions.We were unable to pool head-to-head trials because of heterogeneity among interventions and controls; thus results are presented narratively within the review.Authors' conclusions: Self management interventions in patients with COPD are associated with improved health-related quality of life as measured by the SGRQ, a reduction in respiratory-related hospital admissions, and improvement in dyspnoea as measured by the (m)MRC. No statistically significant differences were found in other outcome parameters. However, heterogeneity among interventions, study populations, follow-up time and outcome measures makes it difficult to formulate clear recommendations regarding the most effective form and content of self management in COPD.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD002990.pub3/abstract

Record #9 of 175

ID: CD007337

AU: Gurusamy Kurinchi Selvan

AU: Nagendran Myura

AU: Guerrini Gian Piero

AU: Toon Clare D

AU: Zinnuroglu Murat

AU: Davidson Brian R

TI: Intraperitoneal local anaesthetic instillation versus no intraperitoneal local anaesthetic instillation for laparoscopic cholecystectomy

SO: Cochrane Database of Systematic Reviews

YR: 2014

NO: 3

PB: John Wiley & Sons, Ltd

CC: LIVER

DOI: 10.1002/14651858.CD007337.pub3

AB: Background: While laparoscopic cholecystectomy is generally considered less painful than open surgery, pain is one of the important reasons for delayed discharge after day surgery and overnight stay laparoscopic cholecystectomy. The safety and effectiveness of intraperitoneal local anaesthetic instillation in people undergoing laparoscopic cholecystectomy is unknown.Objectives: To assess the benefits and harms of intraperitoneal instillation of local anaesthetic agents in people undergoing laparoscopic cholecystectomy.Search methods: We searched the Cochrane Central Register of Controlled Trials (CENTRAL), MEDLINE, EMBASE, and Science Citation Index Expanded to March 2013 to identify randomised clinical trials of relevance to this review.Selection criteria: We considered only randomised clinical trials (irrespective of language, blinding, or publication status) comparing local anaesthetic intraperitoneal instillation versus placebo, no intervention, or inactive control during laparoscopic cholecystectomy for the review with regards to benefits while we considered quasi-randomised studies and non-randomised studies for treatment-related harms.Data collection and analysis: Two review authors collected the data independently. We analysed the data with both fixed-effect and random-effects models using Review Manager 5 analysis. For each outcome, we calculated the risk ratio (RR) or mean difference (MD) with 95% confidence intervals (CI).Main results: We included 58 trials, of which 48 trials with 2849 participants randomised to intraperitoneal local anaesthetic instillation (1558 participants) versus control (1291 participants) contributed data to one or more of the outcomes. All the trials except one trial with 30 participants were at high risk of bias. Most trials included only low anaesthetic risk people undergoing elective laparoscopic cholecystectomy. Various intraperitoneal local anaesthetic agents were used but bupivacaine in the liquid form was the most common local anaesthetic used. There were considerable differences in the methods of local anaesthetic instillation including the location (subdiaphragmatic, gallbladder bed, or both locations) and timing (before or after the removal of gallbladder) between the trials. There was no mortality in either group in the eight trials that reported mortality (0/236 (0%) in local anaesthetic instillation versus 0/210 (0%) in control group; very low quality evidence). One participant experienced the outcome of serious morbidity (eight trials; 446 participants; 1/236 (0.4%) in local anaesthetic instillation group versus 0/210 (0%) in the control group; RR 3.00; 95% CI 0.13

to 67.06; very low quality evidence). Although the remaining trials did not report the overall morbidity, three trials (190 participants) reported that there were no intra-operative complications. Twenty trials reported that there were no serious adverse events in any of the 715 participants who received local anaesthetic instillation. None of the trials reported participant quality of life, return to normal activity, or return to work.The effect of local anaesthetic instillation on the proportion of participants discharged as day surgery between the two groups was imprecise and compatible with benefit and no difference of intervention (three trials; 242 participants; 89/160 (adjusted proportion 61.0%) in local anaesthetic instillation group versus 40/82 (48.8%) in control group; RR 1.25; 95% CI 0.99 to 1.58; very low quality evidence). The MD in length of hospital stay was 0.04 days (95% CI -0.23 to 0.32; five trials; 335 participants; low quality evidence). The pain scores as measured by the visual analogue scale (VAS) were significantly lower in the local anaesthetic instillation group than the control group at four to eight hours (32 trials; 2020 participants; MD -0.99 cm; 95% CI -1.10 to -0.88 on a VAS scale of 0 to 10 cm; very low quality evidence) and at nine to 24 hours (29 trials; 1787 participants; MD -0.53 cm; 95% CI -0.62 to -0.44; very low quality evidence). Various subgroup analyses and meta-regressions to investigate the influence of the different local anaesthetic agents, different methods of local anaesthetic instillation, and different controls on the effectiveness of local anaesthetic intraperitoneal instillation were inconsistent.Authors' conclusions: Serious adverse events were rare in studies evaluating local anaesthetic intraperitoneal instillation (very low quality evidence). There is very low quality evidence that it reduces pain in low anaesthetic risk people undergoing elective laparoscopic cholecystectomy. However, the clinical importance of this reduction in pain is unknown and likely to be small. Further randomised clinical trials of low risk of systematic and random errors are necessary. Such trials should include important clinical outcomes such as quality of life and time to return to work in their assessment.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007337.pub3/abstract

Record #10 of 175

ID: CD002245

AU: Kwan Irene

AU: Bunn Frances

AU: Chinnock Paul

AU: Roberts Ian

TI: Timing and volume of fluid administration for patients with bleeding

SO: Cochrane Database of Systematic Reviews

YR: 2014

NO: 3

PB: John Wiley & Sons, Ltd

KY: Hemorrhage [therapy];Infusions, Intravenous;Plasma Substitutes [administration & dosage];Randomized Controlled Trials as Topic;Time Factors;Wounds and Injuries [blood] [complications];Humans[checkword]

CC: INJ

DOI: 10.1002/14651858.CD002245.pub2

AB: Background: Treatment of haemorrhagic shock involves maintaining blood pressure and tissue perfusion until bleeding is controlled. Different resuscitation strategies have been used to maintain the blood pressure in trauma patients until bleeding is controlled. However, while maintaining blood pressure may prevent shock, it may worsen bleeding.Objectives: To examine the effect on mortality and coagulation times of two intravenous fluid administration strategies in the management of haemorrhagic hypovolaemia, early compared to delayed administration and larger compared to smaller volume of fluid administered.Search methods: We searched the Cochrane Injuries Group Specialised Register, Cochrane Central Register of Controlled Trials (CENTRAL) in The Cochrane Library, Ovid MEDLINE(R), Ovid MEDLINE(R) In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily and Ovid OLDMEDLINE(R), Embase Classic + Embase (OvidSP), ISI Web of Science (SCI-Expanded and CPCI-S) and clinical trials registries. We checked reference lists of identified articles and contacted authors and experts in the field. The most recent search was run on 5 February 2014.Selection criteria: Randomised trials of the timing and volume of intravenous fluid administration in trauma patients with bleeding. Trials in which different types of intravenous fluid were compared were excluded.Data collection and analysis: Two authors independently extracted data and assessed trial quality.Main results: Six trials involving a total of 2128 people were included in this review. We did not combine the results quantitatively because the interventions and patient populations were so diverse. Early versus delayed fluid administration Three trials reported mortality and two reported coagulation data.In the first trial (n = 598) the relative risk (RR) for death with early fluid administration was 1.26 (95% confidence interval (CI) 1.00 to 1.58). The weighted mean differences (WMD) for prothrombin time and partial thromboplastin time were 2.7 (95% CI 0.9 to 4.5) and 4.3 (95% CI 1.74 to 6.9) seconds, respectively. In the second trial (n = 50) the RR for death with early blood transfusion was 5.4 (95% CI 0.3 to 107.1). The WMD for partial thromboplastin time was 7.0 (95% CI 6.0 to 8.0) seconds. In the third trial (n = 1309) the RR for death with early fluid administration was 1.06 (95% CI 0.77 to 1.47). Larger versus smaller volume of fluid administration Three trials reported mortality and one reported coagulation data.In the first trial (n = 36) the RR for death with a larger volume of fluid resuscitation was 0.80 (95% CI 0.28 to 22.29). Prothrombin time and partial thromboplastin time were 14.8 and 47.3 seconds in those who received a larger volume of fluid, as compared to 13.9 and 35.1 seconds in the comparison group. In the second trial (n = 110) the RR for death with a high systolic blood pressure resuscitation target (100 mm Hg) maintained with a larger volume of fluid as compared to a low systolic blood pressure resuscitation target (70 mm Hg) maintained with a smaller volume of fluid was 1.00 (95% CI 0.26 to 3.81). In the third trial (n = 25) there were no deaths.Authors' conclusions: We found no evidence from

randomised controlled trials for or against early or larger volume of intravenous fluid administration in uncontrolled haemorrhage. There is continuing uncertainty about the best fluid administration strategy in bleeding trauma patients. Further randomised controlled trials are needed to establish the most effective fluid resuscitation strategy.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD002245.pub2/abstract

Record #11 of 175

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 #12 of 175

ID: CD005560

AU: Christmas David MB

AU: Crombie Ian

AU: Eljamel Sam

AU: Fineberg Naomi

AU: MacVicar Bob

AU: Matthews Keith

AU: Ruck Christian

AU: Stark Cameron

TI: Neurosurgery for obsessive-compulsive disorder, other anxiety disorders and depressive disorders

SO: Cochrane Database of Systematic Reviews

YR: 2014

NO: 2

PB: John Wiley & Sons, Ltd

CC: DEPRESSN

DOI: 10.1002/14651858.CD005560.pub2

AB: This is the protocol for a review and there is no abstract. The objectives are as follows:(1) Primary objectives:1.1 To determine the efficacy and adverse outcomes of neurosurgical interventions for: (a) Obsessive-compulsive disorder (OCD) (b) Major Depressive Disorder (c) Other Anxiety disorders (Generalised Anxiety Disorder, Panic Disorder and/ or Agoraphobia, Social Phobia/ Social Anxiety Disorder)Each condition will be considered separately. Treatment comparisons will consist of each neurosurgical intervention versus control. The control group is expected to be either waiting list or treatment as usual for ablative neurosurgery, and 'no stimulation' for VNS and DBS. (2) Secondary objectives:2.1 To establish the relative efficacy of different neurosurgical procedures, attempting to compare directly where possible. Comparisons will not be performed if the data are not sufficient to permit this. 2.2 To determine whether different neurosurgical procedures confer differential risks of side effects and adverse outcomes.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD005560.pub2/abstract

Record #13 of 175

ID: CD007317

AU: Dong Bi Rong

AU: He Ping

AU: Lu Zhenchan

AU: Wu Taixiang

AU: Liu Guan J

AU: Huang Chang Quan

TI: Exercise for older depressed people

SO: Cochrane Database of Systematic Reviews

YR: 2014

NO: 2

PB: John Wiley & Sons, Ltd

CC: DEPRESSN

DOI: 10.1002/14651858.CD007317.pub2

AB: This is the protocol for a review and there is no abstract. The objectives are as follows:The objectives are as follows: 1. To examine the efficacy of exercise therapy in reducing the symptoms of clinical depression (as defined by the authors) in older people compared with standard care 2. To compare the efficacy of exercise therapy in reducing the symptoms of clinical depression in older people compared with other therapies 3. To compare the efficacy of different forms of exercise therapy in reducing the symptoms of clinical depression in older people

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007317.pub2/abstract

Record #14 of 175

ID: CD010962

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AU: Chandra Shivika

AU: Perez Fernandez Guillermo Alberto

AU: Michalsen Andreas

TI: Leeches (Hirudinea) for osteoarthritis

SO: Cochrane Database of Systematic Reviews

YR: 2014

NO: 2

PB: John Wiley & Sons, Ltd

CC: MUSKEL

DOI: 10.1002/14651858.CD010962

AB: This is the protocol for a review and there is no abstract. The objectives are as follows:To assess the benefits and harms of leeches compared with placebo, no intervention or any other active treatment in people with osteoarthritis.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010962/abstract

Record #15 of 175

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.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006252.pub4/abstract

Record #16 of 175

ID: CD005380

AU: Sampson Elizabeth L

AU: Jenagaratnam Lydia

AU: McShane Rupert

TI: Metal protein attenuating compounds for the treatment of Alzheimer's dementia

SO: Cochrane Database of Systematic Reviews

YR: 2014

NO: 2

PB: John Wiley & Sons, Ltd

KY: Alzheimer Disease [drug therapy];Chelating Agents [adverse effects] [therapeutic use];Clioquinol [adverse effects] [analogs & derivatives] [therapeutic use];Randomized Controlled Trials as Topic;Aged[checkword];Humans[checkword]

CC: DEMENTIA

DOI: 10.1002/14651858.CD005380.pub5

AB: Background: Alzheimer's dementia (AD) may be caused by the formation of extracellular senile plaques comprised of beta-amyloid (Aß). In vitro and mouse model studies have demonstrated that metal protein attenuating compounds (MPACs) promote the solubilisation and clearance of Aß.Objectives: To evaluate the efficacy of metal protein attenuating compounds (MPACs) for the treatment of cognitive impairment due to Alzheimer's dementia.Search methods: We searched ALOIS, the Cochrane Dementia and Cognitive Improvement Group Specialized Register, on 29 July 2010 using the terms: Clioquinol OR PBT1 OR PBT2 OR "metal protein" OR MPACS OR MPAC.Selection criteria: Randomised double-blind trials in which treatment with an MPAC was administered to participants with Alzheimer's

dementia in a parallel group comparison with placebo were included.Data collection and analysis: Three review authors (RM, LJ, ELS) independently assessed the quality of trials according to the Cochrane Handbook for Systematic Reviews of Interventions.The primary outcome measure of interest was cognitive function (as measured by psychometric tests). The secondary outcome measures of interest were in the following areas: quality of life, functional performance, effect on carer, biomarkers, safety and adverse effects, and death.Main results: Two MPAC trials were identified. One trial compared clioquinol (PBT1) with placebo in 36 patients and 32 had sufficient data for per protocol analysis. There was no statistically significant difference in cognition (as measured on the Alzheimer's Disease Assessment Scale - Cognition (ADAS-Cog)) between the active treatment and placebo groups at 36 weeks. The difference in mean change from baseline ADAS-Cog score in the clioquinol arm compared with the placebo arm at weeks 24 and 36 was a difference of 7.37 (95% confidence interval (CI) 1.51 to 13.24) and 6.36 (95% CI -0.50 to 13.23), respectively.There was no significant impact on non-cognitive symptoms or clinical global impression. One participant in the active treatment group developed neurological symptoms (impaired visual acuity and colour vision) which resolved on cessation of treatment and were possibly attributable to the drug.In the second trial a successor compound, PBT2, was compared with placebo in 78 participants with mild Alzheimer's dementia; all were included in the intention-to-treat analysis. There was no significant difference in the Neuropsychological Test Battery (NTB) composite or memory between placebo and PBT2 in the least squares mean change from baseline at week 12. However, two executive function component tests of the NTB showed significant improvement over placebo in the PBT2 250 mg group from baseline to week 12: category fluency test (2.8 words, 95% CI 0.1 to 5.4; P = 0.041) and trail making part B (-48.0 s, 95% CI -83.0 to -13.0; P = 0.009). In the executive factor Z score, the difference in least squares mean change from baseline at week 12 for PBT2 250 mg compared with placebo was 0·27 (0·01 to 0·53; p=0·042).There was no significant effect on cognition on Mini-Mental State Examination (MMSE) or ADAS-Cog scales. PBT2 had a favourable safety profile.Authors' conclusions: There is an absence of evidence as to whether clioquinol (PBT1) has any positive clinical benefit for patients with AD, or whether the drug is safe. We have some concerns about the quality of the study methodology; there was an imbalance in treatment and control groups after randomisation (participants in the active treatment group had a higher mean pre-morbid IQ) and the secondary analyses of results stratified by baseline dementia severity. The planned phase III trial of PBT1 has been abandoned and this compound has been withdrawn from development. The second trial of PBT2 was more rigorously conducted and showed that after 12 weeks this compound appeared to be safe and well tolerated in people with mild Alzheimer's dementia. Larger trials are now required to demonstrate cognitive efficacy.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD005380.pub5/abstract

Record #17 of 175

ID: CD010271

AU: Masterson Liam

AU: Moualed Daniel

AU: Masood Ajmal

AU: Dwivedi Raghav C

AU: Benson Richard

AU: Sterling Jane C

AU: Rhodes Kirsty M

AU: Sudhoff Holger

AU: Jani Piyush

AU: Goon Peter

TI: De-escalation treatment protocols for human papillomavirus-associated oropharyngeal squamous cell carcinoma

SO: Cochrane Database of Systematic Reviews

YR: 2014

NO: 2

PB: John Wiley & Sons, Ltd

CC: ENT

DOI: 10.1002/14651858.CD010271.pub2

AB: Background: Human papillomavirus-associated oropharyngeal squamous cell carcinomas are a distinct subgroup of tumours that may have a better prognosis than traditional tobacco/alcohol-related disease. Iatrogenic complications, associated with conventional practice, are estimated to cause mortality of approximately 2% and high morbidity. As a result, clinicians are actively investigating the de-escalation of treatment protocols for disease with a proven viral aetiology.Objectives: To summarise the available evidence regarding de-escalation treatment protocols for human papillomavirus-associated, locally advanced oropharyngeal squamous cell carcinoma.Search methods: We searched the Cochrane Ear, Nose and Throat Disorders Group Trials Register; the Cochrane Central Register of Controlled Trials; PubMed; EMBASE; CINAHL; Web of Science; Cambridge Scientific Abstracts; ICTRP and additional sources for published and unpublished trials. The date of the most recent search was 25 June 2013.Selection criteria: Randomised controlled trials investigating de-escalation treatment protocols for human papillomavirus-associated, locally advanced oropharyngeal carcinoma. Specific de-escalation categories were: 1) bioradiotherapy (experimental) versus chemoradiotherapy (control); 2) radiotherapy (experimental) versus chemoradiotherapy (control); and 3) low-dose (experimental) versus standard-dose radiotherapy (control). The

outcomes of interest were overall and disease-specific survival, treatment-related morbidity, quality of life and cost.Data collection and analysis: Three authors independently selected studies from the search results and extracted data. We planned to use the Cochrane 'Risk of bias' tool to assess study quality.Main results: We did not identify any completed randomised controlled trials that could be included in the current version of this systematic review. We did, however, identify seven ongoing trials that will meet our inclusion criteria. These studies will report from 2014 onwards. We excluded 30 studies on methodological grounds (seven randomised trials with post hoc analysis by human papillomavirus status, 11 prospective trials and 12 ongoing studies).Authors' conclusions: There is currently insufficient high-quality evidence for, or against, de-escalation of treatment for human papillomavirus-associated oropharyngeal carcinoma. Future trials should be multicentre to ensure adequate power. Adverse events, morbidity associated with treatment, quality of life outcomes and cost analyses should be reported in a standard format to facilitate comparison with other studies.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010271.pub2/abstract

Record #18 of 175

ID: CD007059

AU: Eldaly Mohamed A

AU: Bunce Catey

AU: ElSheikha Ola Z

AU: Wormald Richard

TI: Non-penetrating filtration surgery versus trabeculectomy for open-angle glaucoma

SO: Cochrane Database of Systematic Reviews

YR: 2014

NO: 2

PB: John Wiley & Sons, Ltd

CC: EYES

DOI: 10.1002/14651858.CD007059.pub2

AB: Background: Glaucoma is the second commonest cause of blindness worldwide. Non-penetrating glaucoma surgeries have been developed as a safer and more acceptable surgical intervention to patients compared to conventional procedures.Objectives: To compare the effectiveness of non-penetrating trabecular surgery compared with conventional trabeculectomy in people with glaucoma.Search methods: We searched CENTRAL (which

contains the Cochrane Eyes and Vision Group Trials Register) (The Cochrane Library 2013, Issue 8), Ovid MEDLINE, Ovid MEDLINE In-Process and Other Non-Indexed Citations, Ovid MEDLINE Daily, Ovid OLDMEDLINE (January 1946 to September 2013), EMBASE (January 1980 to September 2013), Latin American and Caribbean Literature on Health Sciences (LILACS) (January 1982 to September 2013), 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. We last searched the electronic databases on 27 September 2013.Selection criteria: This review included relevant randomised controlled trials (RCTs) and quasi-RCTs on participants undergoing standard trabeculectomy for open-angle glaucoma compared to non-penetrating surgery, specifically viscocanalostomy or deep sclerectomy, with or without adjunctive measures.Data collection and analysis: Two review authors independently reviewed the titles and abstracts of the search results. We obtained full copies of all potentially eligible studies and assessed each one according to the definitions in the 'Criteria for considering studies' section of this review. We used standard methodological procedures expected by The Cochrane Collaboration.Main results: We included five studies with a total of 311 eyes (247 participants) of which 133 eyes (participants) were quasi-randomised. One hundred and sixty eyes which had trabeculectomy were compared to 151 eyes that had non-penetrating glaucoma surgery (of which 101 eyes had deep sclerectomy and 50 eyes had viscocanalostomy). The confidence interval (CI) for the odds ratio (OR) of success (defined as achieving target eye pressure without eye drops) does not exclude a beneficial effect of either deep sclerectomy or trabeculectomy (OR 0.98, 95% CI 0.51 to 1.88). The odds of success in viscocanalostomy participants was lower than in trabeculectomy participants (OR 0.33, 95% CI 0.13 to 0.81). We did not combine the different types of non-penetrating surgery because there was evidence of a subgroup difference when examining total success. The odds ratio for achieving target eye pressure with or without eye drops was imprecise and was compatible with a beneficial effect of either trabeculectomy or non-penetrating filtration surgery (NPFS) (OR 0.79, 95% CI 0.35 to 1.79). Operative adjuvants were used in both treatment groups; more commonly in the NPFS group compared to the trabeculectomy group but no clear effect of their use could be determined. Although the studies were too small to provide definitive evidence regarding the relative safety of the surgical procedures we noted that there were relatively fewer complications with non-filtering surgery compared to trabeculectomy (17% and 65% respectively). Cataract was more commonly reported in the trabeculectomy studies. None of the five trials used quality of life measure questionnaires. The methodological quality of the studies was not good. Most studies were at high risk of bias in at least one domain and for many, there was lack of certainty due to incomplete reporting. Adequate sequence generation was noted only in one study. Similarly, only two studies avoided detection bias. We detected incomplete outcome data in three of the included studies.Authors' conclusions: This review provides some limited evidence that control of IOP is better with trabeculectomy than viscocanalostomy. For deep sclerectomy, we cannot draw any useful conclusions. This may reflect surgical difficulties in performing non-penetrating procedures and the need for surgical experience. This review has highlighted the lack of use of quality of life outcomes and the need for higher methodological quality RCTs to address these issues. Since it is unlikely that better IOP control will be offered by NPFS, but

that these techniques offer potential gains for patients in terms of quality of life, we feel that such a trial is likely to be of a non-inferiority design with quality of life measures.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007059.pub2/abstract

Record #19 of 175

ID: CD003137

AU: Chauhan Bhupendrasinh F

AU: Ducharme Francine M

TI: Addition to inhaled corticosteroids of long-acting beta2-agonists versus anti-leukotrienes for chronic asthma

SO: Cochrane Database of Systematic Reviews

YR: 2014

NO: 1

PB: John Wiley & Sons, Ltd

KY: Adrenal Cortex Hormones [therapeutic use];Adrenergic beta-2 Receptor Agonists [therapeutic use];Anti-Asthmatic Agents [therapeutic use];Asthma [drug therapy];Chronic Disease;Drug Therapy, Combination;Leukotriene Antagonists [therapeutic use];Randomized Controlled Trials as Topic;Adolescent[checkword];Adult[checkword];Child[checkword];Humans[checkword]

CC: AIRWAYS

DOI: 10.1002/14651858.CD003137.pub5

AB: Background: Asthma patients who continue to experience symptoms despite taking regular inhaled corticosteroids (ICS) represent a management challenge. Long-acting beta2-agonists (LABA) and anti-leukotrienes (LTRA) are two treatment options that could be considered as add-on therapy to ICS.Objectives: To compare the safety and efficacy of adding LABA versus LTRA to the treatment regimen for children and adults with asthma who remain symptomatic in spite of regular treatment with ICS. We specifically wished to examine the relative impact of the two agents on asthma exacerbations, lung function, symptoms, quality of life, adverse health events and withdrawals.Search methods: We searched the Cochrane Airways Group Specialised Register until December 2012. We consulted reference lists of all included studies and contacted pharmaceutical manufacturers to ask about other published or unpublished studies.Selection criteria: We included randomised controlled trials (RCTs) conducted in adults or children with recurrent asthma that was treated with ICS along with a fixed dose of a LABA or an LTRA for a minimum of four weeks.Data collection and analysis: Two

review authors independently assessed the risk of bias of included studies and extracted data. We sought unpublished data and further details of study design when necessary.Main results: We included 18 RCTs (7208 participants), of which 16 recruited adults and adolescents (6872) and two recruited children six to 17 years of age (336) with asthma and significant reversibility to bronchodilator at baseline. Fourteen (79%) trials were of high methodological quality.The risk of exacerbations requiring systemic corticosteroids (primary outcome of the review) was significantly lower with the combination of LABA + ICS compared with LTRA + ICS-from 13% to 11% (eight studies, 5923 adults and 334 children; risk ratio (RR) 0.87, 95% confidence interval (CI) 0.76 to 0.99; high-quality evidence). The number needed to treat for an additional beneficial outcome (NNTB) with LABA compared with LTRA to prevent one additional exacerbation over four to 102 weeks was 62 (95% CI 34 to 794). The choice of LTRA, the dose of ICS and the participants' age group did not significantly influence the magnitude of effect. Although results were inconclusive, the effect appeared stronger in trials that used a single device rather than two devices to administer ICS and LABA and in trials of less than 12 weeks' duration.The addition of LABA to ICS was associated with a statistically greater improvement from baseline in lung function, as well as in symptoms, rescue medication use and quality of life, although the latter effects were modest. LTRA was superior in the prevention of exercise-induced bronchospasm. More participants were satisfied with the combination of LABA + ICS than LTRA + ICS (three studies, 1625 adults; RR 1.12, 95% CI 1.04 to 1.20; moderate-quality evidence). The overall risk of withdrawal was significantly lower with LABA + ICS than with LTRA + ICS (13 studies, 6652 adults and 308 children; RR 0.84, 95% CI 0.74 to 0.96; moderate-quality evidence). Although the risk of overall adverse events was equivalent between the two groups, the risk of serious adverse events (SAE) approached statistical significance in disfavour of LABA compared with LTRA (nine studies, 5658 adults and 630 children; RR 1.33, 95% CI 0.99 to 1.79; P value 0.06; moderate-quality evidence), with no apparent impact of participants' age group.The following adverse events were reported, but no significant differences were demonstrated between groups: headache (11 studies, N = 6538); cardiovascular events (five studies, N = 5163), osteopenia and osteoporosis (two studies, N = 2963), adverse events (10 studies, N = 5977 adults and 300 children). A significant difference in the risk of oral moniliasis was noted, but this represents a low occurrence rate.Authors' conclusions: In adults with asthma that is inadequately controlled by predominantly low-dose ICS with significant bronchodilator reversibility, the addition of LABA to ICS is modestly superior to the addition of LTRA in reducing oral corticosteroid?treated exacerbations, with an absolute reduction of two percentage points. Differences favouring LABA over LTRA as adjunct therapy were observed in lung function and, to a lesser extend, in rescue medication use, symptoms and quality of life. The lower overall withdrawal rate and the higher proportion of participants satisfied with their therapy indirectly favour the combination of LABA + ICS over LTRA + ICS. Evidence showed a slightly increased risk of SAE with LABA compared with LTRA, with an absolute increase of one percentage point. Our findings modestly support the use of a single inhaler for the delivery of both LABA and low- or medium-dose ICS. Because of the paucity of paediatric trials, we are unable to draw firm conclusions about the best adjunct therapy in children.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003137.pub5/abstract

Record #20 of 175

ID: CD010936

AU: Faddy Steven C

AU: McMullen Michael A

TI: Bypass for primary percutaneous intervention or thrombolysis at the nearest hospital for patients suffering ST-elevation myocardial infarction

SO: Cochrane Database of Systematic Reviews

YR: 2014

NO: 1

PB: John Wiley & Sons, Ltd

CC: VASC

DOI: 10.1002/14651858.CD010936

AB: This is the protocol for a review and there is no abstract. The objectives are as follows:This review will compare the efficacy of transporting people with ST-elevation myocardial infarction (STEMI) to a percutaneous coronary intervention (PCI) centre for primary PCI (PPCI) compared to thrombolysis at the nearest hospital. The review will evaluate whether there is a limit to transport time where PPCI becomes less efficacious than thrombolysis. If possible, the review will compare the effect of concomitant antiplatelet and anticoagulant therapies administered alongside thrombolytic drugs.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010936/abstract

Record #21 of 175

ID: CD007719

AU: Bello Segun

AU: Meremikwu Martin M

AU: Ejemot-Nwadiaro Regina I

AU: Oduwole Olabisi

TI: Routine vitamin A supplementation for the prevention of blindness due to measles infection in children

SO: Cochrane Database of Systematic Reviews

YR: 2014

NO: 1

PB: John Wiley & Sons, Ltd

KY: Blindness [etiology] [prevention & control];Measles [complications];Randomized Controlled Trials as Topic;Vitamin A [administration & dosage];Vitamins [administration & dosage];Adolescent[checkword];Child[checkword];Child, Preschool[checkword];Humans[checkword];Infant[checkword]

CC: ARI

DOI: 10.1002/14651858.CD007719.pub3

AB: Background: Reduced vitamin A concentration increases the risk of blindness in children infected with the measles virus. Promoting vitamin A supplementation in children with measles contributes to the control of blindness in children, which is a high priority within the World Health Organization (WHO) VISION 2020 The Right to Sight Program.Objectives: To assess the efficacy of vitamin A in preventing blindness in children with measles without prior clinical features of vitamin A deficiency.Search methods: We searched CENTRAL 2013, Issue 2, MEDLINE (1950 to November week 2, 2013), EMBASE (1974 to November 2013) and LILACS (1985 to November 2013).Selection criteria: Randomised controlled trials (RCTs) assessing the efficacy of vitamin A in preventing blindness in well-nourished children diagnosed with measles but with no prior clinical features of vitamin A deficiency.Data collection and analysis: For the original review, two review authors independently assessed studies for eligibility and extracted data on reported outcomes. We contacted trial authors of the included studies for additional information on unpublished data. We included two RCTs which were clinically heterogenous. We presented the continuous outcomes reported as the mean difference (MD) with 95% confidence interval (CI). Due to marked clinical heterogeneity we considered it inappropriate to perform a meta-analysis.Main results: For the first publication of this review, two RCTs involving 260 children with measles which compared vitamin A with placebo met the inclusion criteria. Neither study reported blindness or other ocular morbidities as end points. One trial of moderate quality suggested evidence of a significant increase in serum retinol levels in the vitamin A group one week after two doses of vitamin A (MD 9.45 µG/dL, 95% CI 2.19 to 16.71; 17 participants) but not six weeks after three doses of vitamin A (MD 2.56 µG/dL, 95% CI -5.28 to 10.40; 39 participants). There was no significant difference in weight gain six weeks (MD 0.39 kg, -0.04 to 0.82; 48 participants) and six months (MD 0.52 kg, 95% CI -0.08 to 1.12; 36 participants) after three doses of vitamin A. The second trial found no significant difference in serum retinol levels two weeks after a single dose of vitamin A (MD 2.67 µG/dL, 95% CI -0.29 to 5.63; 155 participants). No adverse event was reported in either study. We did not find any new randomised controlled trials for this update.Authors' conclusions: We did not find any trials assessing whether or not vitamin A supplementation in children with measles prevents blindness, as neither study reported blindness or other ocular

morbidities as end points. However, vitamin A use in children should be encouraged for its proven clinical benefits.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007719.pub3/abstract

Record #22 of 175

ID: CD008963

AU: Kroon Féline PB

AU: van der Burg Lennart RA

AU: Buchbinder Rachelle

AU: Osborne Richard H

AU: Johnston Renea V

AU: Pitt Veronica

TI: Self-management education programmes for osteoarthritis

SO: Cochrane Database of Systematic Reviews

YR: 2014

NO: 1

PB: John Wiley & Sons, Ltd

CC: MUSKEL

DOI: 10.1002/14651858.CD008963.pub2

AB: Background: Self-management education programmes are complex interventions specifically targeted at patient education and behaviour modification. They are designed to encourage people with chronic disease to take an active self-management role to supplement medical care and improve outcomes.Objectives: To assess the effectiveness of self-management education programmes for people with osteoarthritis.Search methods: The Cochrane Central Register of Controlled Trials (CENTRAL), MEDLINE, EMBASE, PyscINFO, SCOPUS and the World Health Organization (WHO) International Clinical Trial Registry Platform were searched, without language restriction, on 17 January 2013. We checked references of reviews and included trials to identify additional studies.Selection criteria: Randomised controlled trials of self-management education programmes in people with osteoarthritis were included. Studies with participants receiving passive recipients of care and studies comparing one type of programme versus another were excluded.Data collection and analysis: In addition to standard methods we extracted components of the self-management interventions using

the eight domains of the Health Education Impact Questionnaire (heiQ), and contextual and participant characteristics using PROGRESS-Plus and the Health Literacy Questionnaire (HLQ). Outcomes included self-management of osteoarthritis, participant's positive and active engagement in life, pain, global symptom score, self-reported function, quality of life and withdrawals (including dropouts and those lost to follow-up). We assessed the quality of the body of evidence for these outcomes using the GRADE approach.Main results: We included twenty-nine studies (6,753 participants) that compared self-management education programmes to attention control (five studies), usual care (17 studies), information alone (four studies) or another intervention (seven studies). Although heterogeneous, most interventions included elements of skill and technique acquisition (94%), health-directed activity (85%) and self-monitoring and insight (79%); social integration and support were addressed in only 12%. Most studies did not provide enough information to assess all PROGRESS-Plus items. Eight studies included predominantly Caucasian, educated female participants, and only four provided any information on participants' health literacy. All studies were at high risk of performance and detection bias for self-reported outcomes; 20 studies were at high risk of selection bias, 16 were at high risk of attrition bias, two were at high risk of reporting bias and 12 were at risk of other biases. We deemed attention control as the most appropriate and thus the main comparator.Compared with attention control, self-management programmes may not result in significant benefits at 12 months. Low-quality evidence from one study (344 people) indicates that self-management skills were similar in active and control groups: 5.8 points on a 10-point self-efficacy scale in the control group, and the mean difference (MD) between groups was 0.4 points (95% confidence interval (CI) -0.39 to 1.19). Low-quality evidence from four studies (575 people) indicates that self-management programmes may lead to a small but clinically unimportant reduction in pain: the standardised mean difference (SMD) between groups was -0.26 (95% CI -0.44 to -0.09); pain was 6 points on a 0 to 10 visual analogue scale (VAS) in the control group, treatment resulted in a mean reduction of 0.8 points (95% CI -0.14 to -0.3) on a 10-point scale, with number needed to treat for an additional beneficial outcome (NNTB) of 8 (95% CI 5 to 23). Low-quality evidence from one study (251 people) indicates that the mean global osteoarthritis score was 4.2 on a 0 to 10-point symptom scale (lower better) in the control group, and treatment reduced symptoms by a mean of 0.14 points (95% CI -0.54 to 0.26). This result does not exclude the possibility of a clinically important benefit in some people (0.5 point reduction included in 95% CI). Low-quality evidence from three studies (574 people) showed no signficant difference in function between groups (SMD -0.19, 95% CI -0.5 to 0.11); mean function was 1.29 points on a 0 to 3-point scale in the control group, and treatment resulted in a mean improvement of 0.04 points with self-management (95% CI -0.10 to 0.02). Low-quality evidence from one study (165 people) showed no between-group difference in quality of life (MD -0.01, 95% CI -0.03 to 0.01) from a control group mean of 0.57 units on 0 to 1 well-being scale. Moderate-quality evidence from five studies (937 people) shows similar withdrawal rates between self-management (13%) and control groups (12%): RR 1.11 (95% CI 0.78 to 1.57). Positive and active engagement in life was not measured.Compared with usual care, moderate-quality evidence from 11 studies (up to 1,706 participants) indicates that self-management programmes probably provide small benefits up to 21 months, in terms of self-management skills, pain, osteoarthritis symptoms and function, although these are of doubtful clinical importance, and no improvement in positive and active engagement in life or quality of life. Withdrawal rates were

similar. Low to moderate quality evidence indicates no important differences in self-management , pain, symptoms, function, quality of life or withdrawal rates between self-management programmes and information alone or other interventions (exercise, physiotherapy, social support or acupuncture).Authors' conclusions: Low to moderate quality evidence indicates that self-management education programmes result in no or small benefits in people with osteoarthritis but are unlikely to cause harm.Compared with attention control, these programmes probably do not improve self-management skills, pain, osteoarthritis symptoms, function or quality of life, and have unknown effects on positive and active engagement in life. Compared with usual care, they may slightly improve self-management skills, pain, function and symptoms, although these benefits are of unlikely clinical importance.Further studies investigating the effects of self-management education programmes, as delivered in the trials in this review, are unlikely to change our conclusions substantially, as confounding from biases across studies would have likely favoured self-management. However, trials assessing other models of self-management education programme delivery may be warranted. These should adequately describe the intervention they deliver and consider the expanded PROGRESS-Plus framework and health literacy, to explore issues of health equity for recipients.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD008963.pub2/abstract

Record #23 of 175

ID: CD007115

AU: Lunn Michael PT

AU: Hughes Richard AC

AU: Wiffen Philip J

TI: Duloxetine for treating painful neuropathy, chronic pain or fibromyalgia

SO: Cochrane Database of Systematic Reviews

YR: 2014

NO: 1

PB: John Wiley & Sons, Ltd

KY: Analgesics [administration & dosage] [adverse effects];Chronic Disease;Diabetic Neuropathies [drug therapy];Fibromyalgia [drug therapy];Randomized Controlled Trials as Topic;Thiophenes [administration & dosage] [adverse effects];Humans[checkword]

CC: NEUROMUSC

DOI: 10.1002/14651858.CD007115.pub3

AB: Background: Duloxetine is a balanced serotonin and noradrenaline reuptake inhibitor licensed for the treatment of major depressive disorders, urinary stress incontinence and the management of neuropathic pain associated with diabetic peripheral neuropathy. A number of trials have been conducted to investigate the use of duloxetine in neuropathic and nociceptive painful conditions. This is the first update of a review first published in 2010.Objectives: To assess the benefits and harms of duloxetine for treating painful neuropathy and different types of chronic pain.Search methods: On 19th November 2013, we searched The Cochrane Neuromuscular Group Specialized Register, CENTRAL, DARE, HTA, NHSEED, MEDLINE, and EMBASE. We searched ClinicalTrials.gov for ongoing trials in April 2013. We also searched the reference lists of identified publications for trials of duloxetine for the treatment of painful peripheral neuropathy or chronic pain.Selection criteria: We selected all randomised or quasi-randomised trials of any formulation of duloxetine, used for the treatment of painful peripheral neuropathy or chronic pain in adults.Data collection and analysis: We used standard methodological procedures expected by The Cochrane Collaboration.Main results: We identified 18 trials, which included 6407 participants. We found 12 of these studies in the literature search for this update. Eight studies included a total of 2728 participants with painful diabetic neuropathy and six studies involved 2249 participants with fibromyalgia. Three studies included participants with depression and painful physical symptoms and one included participants with central neuropathic pain. Studies were mostly at low risk of bias, although significant drop outs, imputation methods and almost every study being performed or sponsored by the drug manufacturer add to the risk of bias in some domains. Duloxetine at 60 mg daily is effective in treating painful diabetic peripheral neuropathy in the short term, with a risk ratio (RR) for ? 50% pain reduction at 12 weeks of 1.73 (95% CI 1.44 to 2.08). The related NNTB is 5 (95% CI 4 to 7). Duloxetine at 60 mg daily is also effective for fibromyalgia over 12 weeks (RR for ? 50% reduction in pain 1.57, 95% CI 1.20 to 2.06; NNTB 8, 95% CI 4 to 21) and over 28 weeks (RR 1.58, 95% CI 1.10 to 2.27) as well as for painful physical symptoms in depression (RR 1.37, 95% CI 1.19 to 1.59; NNTB 8, 95% CI 5 to 14). There was no effect on central neuropathic pain in a single, small, high quality trial. In all conditions, adverse events were common in both treatment and placebo arms but more common in the treatment arm, with a dose-dependent effect. Most adverse effects were minor, but 12.6% of participants stopped the drug due to adverse effects. Serious adverse events were rare.Authors' conclusions: There is adequate amounts of moderate quality evidence from eight studies performed by the manufacturers of duloxetine that doses of 60 mg and 120 mg daily are efficacious for treating pain in diabetic peripheral neuropathy but lower daily doses are not. Further trials are not required. In fibromyalgia, there is lower quality evidence that duloxetine is effective at similar doses to those used in diabetic peripheral neuropathy and with a similar magnitude of effect. The effect in fibromyalgia may be achieved through a greater improvement in mental symptoms than in somatic physical pain. There is low to moderate quality evidence that pain relief is also achieved in pain associated with depressive symptoms, but the NNTB of 8 in fibromyalgia and depression is not an indication of substantial efficacy. More trials (preferably independent investigator led studies) in these indications are required to reach an optimal information size to make convincing determinations of efficacy.Minor side effects are common and more common with duloxetine 60 mg and particularly with 120 mg daily, than 20 mg daily, but serious side effects are rare.Improved direct comparisons of duloxetine with other antidepressants and with other drugs, such as pregabalin, that have

already been shown to be efficacious in neuropathic pain would be appropriate. Unbiased economic comparisons would further help decision making, but no high quality study includes economic data.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007115.pub3/abstract

Record #24 of 175

ID: CD008876

AU: He Dian

AU: Zhang Yun

AU: Dong Shuai

AU: Wang Dongfeng

AU: Gao Xiangdong

AU: Zhou Hongyu

TI: Pharmacological treatment for memory disorder in multiple sclerosis

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 12

PB: John Wiley & Sons, Ltd

KY: Ginkgo biloba;Indans [therapeutic use];Memantine [therapeutic use];Memory Disorders [drug therapy] [etiology];Multiple Sclerosis [complications];Neuroprotective Agents [therapeutic use];Nootropic Agents [therapeutic use];Phenylcarbamates [therapeutic use];Phytotherapy [methods];Piperidines [therapeutic use];Randomized Controlled Trials as Topic;Adult[checkword];Humans[checkword];Middle Aged[checkword]

CC: MS

DOI: 10.1002/14651858.CD008876.pub3

AB: Background: This is an update of the Cochrane review "Pharmacologic treatment for memory disorder in multiple sclerosis" (first published in The Cochrane Library 2011, Issue 10).Multiple sclerosis (MS) is a chronic immune-mediated, inflammatory, demyelinating, neurodegenerative disorder of the central nervous system (CNS) and can cause both neurological and neuropsychological disability. Both demyelination and axonal and neuronal loss are believed to contribute to MS-related cognitive impairment. Memory disorder is one of

the most frequent cognitive dysfunctions and presents a considerable burden to people with MS and to society due to the negative impact on function. A number of pharmacological agents have been evaluated in many existing randomised controlled trials for their efficacy on memory disorder in people with MS but the results were not consistent.Objectives: To assess the absolute and comparative efficacy, tolerability and safety of pharmacological treatments for memory disorder in adults with MS.Search methods: We searched the Cochrane Multiple Sclerosis and Rare Diseases of the Central Nervous System Group Trials Register (24 July 2013), PsycINFO (January 1980 to 26 June 2013) and CBMdisc (1978 to 24 June 2013), and checked reference lists of identified articles, searched some relevant journals manually, registers of clinical trials and published abstracts of conference proceedings.Selection criteria: All double-blind, randomised controlled parallel trials on pharmacological treatment versus placebo or one or more pharmacological treatments in adults with MS who had at least mild memory impairment (at 0.5 standard deviations below age- and sex-based normative data on a validated memory scale). We placed no restrictions regarding dose, route of administration and frequency; however, we only included trials with an administration duration of 12 weeks or greater.Data collection and analysis: Two review authors independently assessed trial quality and extracted data. We discussed disagreements and resolved them by consensus among review authors. We contacted principal investigators of included studies for additional data or confirmation.Main results: We included seven randomised controlled trials (RCTs) involving 625 people mostly with relapsing-remitting, secondary-progressive and primary-progressive MS, evaluating the absolute efficacy of donepezil, ginkgo biloba, memantine and rivastigmine versus placebo in improving memory performance with diverse assessment scales. Overall, clinical and methodological heterogeneities existed across these studies. Moreover, most of them had methodological limitations on non-specific selections of targeted sample, non-matched variables at baseline or incomplete outcome data (high attrition bias). Only the two studies on donepezil had clinical and methodological homogeneity and relatively low risks for bias. One RCT evaluating estriol versus placebo is currently ongoing.We could not carry out a meta-analysis due to the heterogeneities across studies and the high attrition bias. A subgroup analysis for donepezil versus placebo showed no treatment effects on total recall on the Selective Reminding Test (mean difference (MD) 1.68; 95% confidence interval (CI) -2.21 to 5.58), total correct scores on the 10/36 Spatial Recall Test (MD -0.93; 95% CI -3.18 to 1.32), the Symbol Digit Modalities Test (MD -1.27; 95% CI -3.15 to 0.61) and the Paced Auditory Serial Addition Test (2+3 sec) (MD 2.23; 95% CI -1.87 to 6.33). Concerning safety, the main adverse events were: diarrhoea (risk ratio (RR) 3.88; 95% CI 1.66 to 9.05), nausea (RR 1.71; 95% CI 0.93 to 3.18) and abnormal dreams (RR 2.91; 95% CI 1.38 to 6.14). However, the results in both studies were subjected to a serious imprecision resulting from the small sample sizes and the low power of test (lower than 80%), which contributed to a moderate quality of the evidence. No serious adverse events were attributed to the treatments in all experimental groups.Authors' conclusions: We found no convincing evidence to support the efficacy of pharmacological symptomatic treatment for MS-associated memory disorder because most of available RCTs had a limited quality. Whether pharmacological treatment is effective for memory disorder in patients with MS remains inconclusive. However, there is moderate-quality evidence that donepezil 10 mg daily was not effective in improving memory in MS patients with mild memory impairment, but had a good tolerability. Adverse events such as nausea, diarrhoea and abnormal dreams were not frequent but were associated with

treatment. Ginkgo biloba, memantine and rivastigmine were safe and well tolerated and no serious adverse effects were reported. Future large-scale RCTs with higher methodological quality are needed.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD008876.pub3/abstract

Record #25 of 175

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 #26 of 175

ID: CD009596

AU: Schmidt-Hansen Mia

AU: Bromham Nathan

AU: Taubert Mark

AU: Arnold Stephanie

TI: Buprenorphine for treating cancer pain

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 12

PB: John Wiley & Sons, Ltd

CC: SYMPT

DOI: 10.1002/14651858.CD009596.pub3

AB: This is the protocol for a review and there is no abstract. The objectives are as follows:To assess the effectiveness and tolerability of buprenorphine for pain in adults and children with cancer.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD009596.pub3/abstract

Record #27 of 175

ID: CD006272

AU: Billio Atto

AU: Morello Enrico

AU: Clarke Mike J

TI: Serotonin receptor antagonists for highly emetogenic chemotherapy in adults

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 12

PB: John Wiley & Sons, Ltd

KY: Serotonin 5-HT3 Receptor Antagonists;Dexamethasone [adverse effects] [therapeutic use];Granisetron [adverse effects] [therapeutic use];Isoquinolines [adverse effects] [therapeutic use];Nausea [chemically induced] [drug therapy];Ondansetron [adverse effects] [therapeutic use];Quinuclidines [adverse effects] [therapeutic use];Randomized Controlled Trials as Topic;Vomiting [chemically induced] [drug therapy];Adult[checkword];Humans[checkword]

CC: SYMPT

DOI: 10.1002/14651858.CD006272.pub3

AB: Background: Serotonin receptor antagonists (5-HT3 RAs) are used to control chemotherapy-induced emesis. Although they have the same general mechanism of action (blockade of serotonin receptors), they have different chemical structures and may have different effects.Objectives: To compare efficacy of different serotonin receptor antagonists (5-HT3 RAs) in the control of acute and delayed emesis induced by highly emetogenic chemotherapy.Search methods: We searched CENTRAL, the Specialised Register of the Cochrane PaPaS Group, PubMed, EMBASE, and LILACS databases. Our most recent search was in March 2009.Selection criteria: Randomised trials comparing 5-HT3 RAs in an adult cancer population.Data collection and analysis: We extracted information from the included studies on the control of acute and delayed nausea and vomiting, either as a single or a combined outcome. Where appropriate, we combined the results of similar trials. We carried out sensitivity and subgroup analyses to test the robustness of our findings.Main results: We included 16 randomised trials (7808 participants). Nine of the trials compared granisetron versus ondansetron. No other drug comparison was studied in more than one trial. The meta-analyses of the granisetron versus ondansetron trials found similar results for the two drugs on acute vomiting (eight trials, 4256 participants, odds ratio (OR) 0.89; 95% CI 0.78 to 1.02), acute nausea (seven trials, 4160 participants, OR 0.97; 95% CI 0.85 to 1.10), delayed vomiting (three trials, 1119 participants, OR 1.00; 95% CI 0.74 to 1.34) and delayed nausea (two trials, 1024 participants, OR 0.96; 95% CI 0.75 to 1.24). Granisetron and ondansetron showed similar effects on headache and diarrhoea, with the possible exception of less constipation associated with ondansetron.One study of 1114 participants comparing palonosetron plus dexamethasone versus granisetron plus dexamethasone showed superiority of palonosetron in

controlling delayed vomiting (OR 1.45; 95% CI 1.14 to 1.85) and delayed nausea (OR 1.63; 95% CI 1.27 to 2.10). Complete response for delayed nausea and vomiting was also in favour of the combination palonosetron and dexamethasone (OR 1.63; 95% CI 1.29 to 2.07).Authors' conclusions: Ondansetron and granisetron appear to be equivalent drugs for the prevention of acute and delayed emesis following the use of highly emetogenic chemotherapy.According to one single trial the combination of palonosetron and dexamethasone was superior to granisetron and dexamethasone in controlling delayed emesis. However, more evidence is needed before palonosetron could become the candidate 5-HT3 RA for the control of delayed emesis induced by highly emetogenic chemotherapy.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006272.pub3/abstract

Record #28 of 175

ID: CD010842

AU: Hurley Michael

AU: Dickson Kelly

AU: Walsh Nicola

AU: Hauari Hanan

AU: Grant Robert

AU: Cumming Jo

AU: Oliver Sandy

TI: Exercise interventions and patient beliefs for people with chronic hip and knee pain: a mixed methods review

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 12

PB: John Wiley & Sons, Ltd

CC: MUSKEL

DOI: 10.1002/14651858.CD010842

AB: : This is the protocol for a review and there is no abstract. The objectives are as follows:Overarching objective: To improve our understanding of the complex inter-relationship between pain, psychosocial effects, physical function and exercise.Specific aims and

objectives:: To systematically review the evidence on the impact of physical exercise on patients' pain, physical and psychosocial functioning including: identifying the most effective formats for delivering exercise advice; explaining why some exercise interventions may be more effective than others; recommending exercise formats and content by constructing a "toolbox" which describes the most effective exercise interventions for healthcare providers and patients to use. These will be achieved by conducting: a synthesis of quantitative data on the benefits and harm of exercise interventions for improving pain, physical and psychosocial functioning; a synthesis of qualitative data on participant's experiences, opinions and preferences of physical exercise; a cross-studies synthesis of the quantitative and qualitative data to assess the extent to which existing evaluated interventions address the needs and concerns of people living with osteoarthritis

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010842/abstract

Record #29 of 175

ID: CD010851

AU: Xu Hua

AU: He Mao Lin

AU: Xiao Zeng Ming

AU: Cao Yunfei

TI: Hip resurfacing versus traditional total hip arthroplasty for osteoarthritis and other non-traumatic diseases of the hip

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 12

PB: John Wiley & Sons, Ltd

CC: MUSKEL

DOI: 10.1002/14651858.CD010851

AB: This is the protocol for a review and there is no abstract. The objectives are as follows:To assess the effects of total hip resurfacing versus traditional total hip arthroplasty (THA) for osteoarthritis and other non-traumatic diseases of the hip.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010851/abstract

Record #30 of 175

ID: CD010821

AU: Hill Kylie

AU: Mathur Sunita

AU: Roig Marc

AU: Janaudis-Ferreira Tania

AU: Robles Priscila

AU: Dolmage Thomas E

AU: Goldstein Roger

TI: Neuromuscular electrostimulation for chronic obstructive pulmonary disease

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 11

PB: John Wiley & Sons, Ltd

CC: AIRWAYS

DOI: 10.1002/14651858.CD010821

AB: This is the protocol for a review and there is no abstract. The objectives are as follows:To determine the effects of NMES, applied in isolation or as an adjunct to whole-body exercise training, on muscle function (i.e. force-generating capacity and endurance), muscle size, exercise capacity, functional performance, symptoms, HRQoL and adverse events in people with COPD.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010821/abstract

Record #31 of 175

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 #32 of 175

ID: CD008143

AU: Hemmingsen Bianca

AU: Lund Søren S

AU: Gluud Christian

AU: Vaag Allan

AU: Almdal Thomas P

AU: Hemmingsen Christina

AU: Wetterslev Jørn

TI: Targeting intensive glycaemic control versus targeting conventional glycaemic control for type 2 diabetes mellitus

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 11

PB: John Wiley & Sons, Ltd

KY: Blood Glucose [analysis];Cardiovascular Diseases [mortality];Cause of Death;Diabetes Mellitus, Type 2 [blood] [drug therapy] [mortality];Hyperglycemia [complications] [drug therapy] [mortality];Hypoglycemia [chemically induced] [mortality];Hypoglycemic Agents [therapeutic use];Randomized Controlled Trials as Topic;Adult[checkword];Humans[checkword];Middle Aged[checkword]

CC: ENDOC

DOI: 10.1002/14651858.CD008143.pub3

AB: Background: Patients with type 2 diabetes mellitus (T2D) have an increased risk of cardiovascular disease and mortality compared to the background population. Observational studies report an association between reduced blood glucose and reduced risk of both micro- and macrovascular complications in patients with T2D. Our previous systematic review of intensive glycaemic control versus conventional glycaemic control was based on 20 randomised clinical trials that randomised 29?,986 participants with T2D. We now report our updated review.Objectives: To assess the effects of targeted intensive glycaemic control compared with conventional glycaemic control in patients with T2D.Search methods: Trials were obtained from searches of The Cochrane Library, MEDLINE, EMBASE, Science Citation Index Expanded, LILACS, and CINAHL (all until December 2012).Selection criteria: We included randomised clinical trials that prespecified targets of intensive glycaemic control versus conventional glycaemic control targets in adults with T2D.Data collection and analysis: Two authors independently assessed the risk of bias and extracted data. Dichotomous outcomes were assessed by risk ratios (RR) and 95% confidence intervals (CI). Health-related quality of life and costs of intervention were assessed with standardized mean differences (SMD) and 95% Cl.Main results: Twenty-eight trials with 34,912 T2D participants randomised 18,717 participants to intensive glycaemic control versus 16,195 participants to conventional glycaemic control. Only two trials had low risk of bias on all risk of bias domains assessed. The duration of the intervention ranged from three days to 12.5 years. The number of participants in the included trials ranged from 20 to 11,140. There were no statistically significant differences between targeting intensive versus conventional glycaemic control for all-cause mortality (RR 1.00, 95% CI 0.92 to 1.08; 34,325 participants, 24 trials) or cardiovascular mortality (RR 1.06, 95% CI 0.94 to 1.21; 34,177 participants, 22 trials). Trial sequential analysis showed that a 10% relative risk reduction could be refuted for all-cause mortality. Targeting intensive glycaemic control did not show a statistically significant effect on the risks of macrovascular complications as a composite outcome in the random-effects model, but decreased the risks in the fixed-effect model (random RR 0.91, 95% CI 0.82 to 1.02; and fixed RR 0.93, 95% CI 0.87 to 0.99; P = 0.02; 32,846 participants, 14 trials). Targeting intensive versus conventional glycaemic control seemed to reduce the risks of non-fatal myocardial infarction (RR 0.87, 95% CI 0.77 to 0.98; P = 0.02; 30,417 participants, 14 trials), amputation of a lower extremity (RR 0.65, 95% CI 0.45 to 0.94; P = 0.02; 11,200 participants, 11 trials), as well as the risk of developing a composite outcome of microvascular diseases (RR 0.88, 95% CI 0.82 to 0.95; P = 0.0008; 25,927 participants, 6 trials), nephropathy (RR 0.75, 95% CI 0.59 to 0.95; P =

0.02; 28,096 participants, 11 trials), retinopathy (RR 0.79, 95% CI 0.68 to 0.92; P = 0.002; 10,300 participants, 9 trials), and the risk of retinal photocoagulation (RR 0.77, 95% CI 0.61 to 0.97; P = 0.03; 11,212 participants, 8 trials). No statistically significant effect of targeting intensive glucose control could be shown on non-fatal stroke, cardiac revascularization, or peripheral revascularization. Trial sequential analyses did not confirm a reduction of the risk of non-fatal myocardial infarction but confirmed a 10% relative risk reduction in favour of intensive glycaemic control on the composite outcome of microvascular diseases. For the remaining microvascular outcomes, trial sequential analyses could not establish firm evidence for a 10% relative risk reduction. Targeting intensive glycaemic control significantly increased the risk of mild hypoglycaemia, but substantial heterogeneity was present; severe hypoglycaemia (RR 2.18, 95% CI 1.53 to 3.11; 28,794 participants, 12 trials); and serious adverse events (RR 1.06, 95% CI 1.02 to 1.10; P = 0.007; 24,280 participants, 11 trials). Trial sequential analysis for a 10% relative risk increase showed firm evidence for mild hypoglycaemia and serious adverse events and a 30% relative risk increase for severe hypoglycaemia when targeting intensive versus conventional glycaemic control. Overall health-related quality of life, as well as the mental and the physical components of health-related quality of life did not show any statistical significant differences.Authors' conclusions: Although we have been able to expand the number of participants by 16% in this update, we still find paucity of data on outcomes and the bias risk of the trials was mostly considered high. Targeting intensive glycaemic control compared with conventional glycaemic control did not show significant differences for all-cause mortality and cardiovascular mortality. Targeting intensive glycaemic control seemed to reduce the risk of microvascular complications, if we disregard the risks of bias, but increases the risk of hypoglycaemia and serious adverse events.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD008143.pub3/abstract

Record #33 of 175

ID: CD003111

AU: Kusec Vesna

AU: Adachi Jonathan

AU: Tugwell Peter

AU: Wells George A

AU: Marusic Ana

AU: Jeroncic Ana

TI: Human parathyroid hormone for the treatment of osteoporosis in post-menopausal women

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 11

PB: John Wiley & Sons, Ltd

CC: MUSKEL

DOI: 10.1002/14651858.CD003111.pub2

AB: This is the protocol for a review and there is no abstract. The objectives are as follows:To determine the benefit and harm of hPTH in the treatment of postmenopausal osteoporosis.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003111.pub2/abstract

Record #34 of 175

ID: CD003794

AU: Nannini Luis Javier

AU: Poole Phillippa

AU: Milan Stephen J

AU: Holmes Rebecca

AU: Normansell Rebecca

TI: Combined corticosteroid and long-acting beta2-agonist in one inhaler versus placebo for chronic obstructive pulmonary disease

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 11

PB: John Wiley & Sons, Ltd

KY: Adrenergic beta-Agonists [therapeutic use];Bronchodilator Agents [therapeutic use];Drug Combinations;Nebulizers and Vaporizers;Pulmonary Disease, Chronic Obstructive [drug therapy];Randomized Controlled Trials as Topic;Humans[checkword]

CC: AIRWAYS

DOI: 10.1002/14651858.CD003794.pub4

AB: Background: Both long-acting beta2-agonists (LABA) and inhaled corticosteroids (ICS) have been recommended in guidelines for the treatment of chronic obstructive pulmonary disease (COPD). Their coadministration in a combination inhaler may facilitate adherence to medication regimens and improve efficacy.Objectives: To determine the efficacy and safety of combined ICS and LABA for stable COPD in comparison with placebo.Search methods: We searched the Cochrane Airways Group Specialised Register of trials, reference lists of included studies and manufacturers' trial registries. The date of the most recent search was June 2013.Selection criteria: We included randomised and double-blind studies of at least four weeks' duration. Eligible studies compared combined ICS and LABA preparations with placebo.Data collection and analysis: Two review authors independently assessed study risk of bias and extracted data. Dichotomous data were analysed as fixed-effect odds ratios (OR) or rate ratios (RR) with 95% confidence intervals (95% CI), and continuous data as mean differences with 95% confidence intervals.Main results: Nineteen studies met the inclusion criteria (with 10,400 participants randomly assigned, lasting between 4 and 156 weeks, mean 42 weeks). Studies used three different combined preparations (fluticasone/salmeterol, budesonide/formoterol or mometasone/formoterol). The studies were generally at low risk of bias for blinding but at unclear or high risk for attrition bias because of participant dropouts. Compared with placebo, both fluticasone/salmeterol and budesonide/formoterol reduced the rate of exacerbations. Mometasone/formoterol reduced the number of participants experiencing one or more exacerbation. Pooled analysis of the combined therapies indicated that exacerbations were less frequent when compared with placebo (Rate Ratio 0.73; 95% CI 0.69 to 0.78, 7 studies, 7495 participants); the quality of this evidence when GRADE criteria were applied was rated as moderate. Participants included in these trials had on average one or two exacerbations per year, which means that treatment with combined therapy would lead to a reduction of one exacerbation every two to four years in these individuals. An overall reduction in mortality was seen, but this outcome was dominated by the results of one study (TORCH) of fluticasone/salmeterol. Generally, deaths in the smaller, shorter studies were too few to contribute to the overall estimate. Further longer studies on budesonide/formoterol and mometasone/formoterol are required to clarify whether this is seen more widely. When a baseline risk of death of 15.2% from the placebo arm of TORCH was used, the three-year number needed to treat for an additional beneficial outcome (NNTB) with fluticasone/salmeterol to prevent one extra death was 42 (95% CI 24 to 775). All three combined treatments led to statistically significant improvement in health status measurements, although the mean differences observed are relatively small in relation to the minimum clinically important difference. Furthermore, symptoms and lung function assessments favoured combined treatments. An increase in the risk of pneumonia was noted with combined inhalers compared with placebo treatment (OR 1.62, 95% CI 1.36 to 1.94), and the quality of this evidence was rated as moderate, but no dose effect was seen. The three-year NNTH for one extra case of pneumonia was 17, based on a 12.3% risk of pneumonia in the placebo arm of TORCH. Fewer participants withdrew from the combined treatment arms for adverse events or lack of efficacy.Authors' conclusions: Combined inhaler therapy led to around a quarter fewer COPD exacerbations than were seen with placebo. A significant reduction in all-cause mortality was noted, but this outcome was dominated by one trial (TORCH), emphasising the need for further trials of longer duration. Increased risk of pneumonia is a concern; however, this did not translate into increased exacerbations,

hospitalisations or deaths. Current evidence does not suggest any major differences between inhalers in terms of effects, but nor is the evidence strong enough to demonstrate that all are equivalent. To permit firmer conclusions about the effects of combined therapy, more data are needed, particularly in relation to the profile of adverse events and benefits in relation to different formulations and doses of inhaled ICS. Head-to-head comparisons are necessary to determine whether one combined inhaler is better than the others.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003794.pub4/abstract

Record #35 of 175

ID: CD010805

AU: Yang Wei

AU: Zhuo Qi

AU: Chai Wei

AU: Chen Jiying

AU: Sun Cheng

AU: Wang Yan

TI: Bisphosphonates for osteoarthritis

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 11

PB: John Wiley & Sons, Ltd

CC: MUSKEL

DOI: 10.1002/14651858.CD010805

AB: This is the protocol for a review and there is no abstract. The objectives are as follows:To assess the benefits and harms of bisphosphonates for the pharmacological treatment of the hip, knee and hand OA. Both symptomatic and structural outcomes will be evaluated.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010805/abstract

Record #36 of 175

ID: CD007468

AU: McAllister Kerrie

AU: Walker David

AU: Donnan Peter T

AU: Swan Iain

TI: Surgical interventions for the early management of Bell's palsy

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 10

PB: John Wiley & Sons, Ltd

KY: Bell Palsy [surgery];Decompression, Surgical [methods];Facial Nerve [surgery];Randomized Controlled Trials as Topic;Humans[checkword]

CC: NEUROMUSC

DOI: 10.1002/14651858.CD007468.pub3

AB: Background: Bell's palsy is an acute paralysis of one side of the face of unknown aetiology. Bell's palsy should only be used as a diagnosis in the absence of all other pathology. As the proposed pathophysiology is swelling and entrapment of the nerve, some surgeons suggest surgical decompression of the nerve as a possible management option. This is an update of a review first published in 2011.Objectives: To assess the effects of surgery in the management of Bell's palsy.Search methods: On 29 October 2012, we searched the Cochrane Neuromuscular Disease Group Specialized Register, CENTRAL (2012, Issue 10), MEDLINE (January 1966 to October 2012) and EMBASE (January 1980 to October 2012). We also handsearched selected conference abstracts for the original version of the review.Selection criteria: We included all randomised or quasi-randomised controlled trials involving any surgical intervention for Bell's palsy. We compared surgical interventions to no treatment, sham treatment, other surgical treatments or medical treatment.Data collection and analysis: Two review authors independently assessed whether trials identified from the searches were eligible for inclusion. Two review authors independently assessed the risk of bias and extracted data.Main results: Two trials with a total of 69 participants met the inclusion criteria. The first study considered the treatment of 403 people but only included 44 participants in the surgical trial, who were randomised into surgical and non-surgical groups. However, the report did not provide information on the method of randomisation. The second study randomly allocated 25 participants into surgical or control groups using statistical charts. There was no attempt in either study to conceal allocation. Neither participants nor outcome assessors were blind to the interventions, in either study. The first study lost seven participants to follow-up and there

were no losses to follow-up in the second study.Surgeons in both studies decompressed the nerves of all the surgical group participants using a retroauricular approach. The primary outcome was recovery of facial palsy at 12 months. The first study showed that the operated group and the non-operated group (who received oral prednisolone) had comparable facial nerve recovery at nine months. This study did not statistically compare the groups but the scores and size of the groups suggested that statistically significant differences are unlikely. The second study reported no statistically significant differences between the operated and control (no treatment) groups. One operated participant in the first study had 20 dB sensorineural hearing loss and persistent vertigo. We identified no new studies when we updated the searches in October 2012.Authors' conclusions: There is only very low quality evidence from randomised controlled trials and this is insufficient to decide whether surgical intervention is beneficial or harmful in the management of Bell's palsy.Further research into the role of surgical intervention is unlikely to be performed because spontaneous recovery occurs in most cases.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007468.pub3/abstract

Record #37 of 175

ID: CD009437

AU: Kruis Annemarije L

AU: Smidt Nynke

AU: Assendelft Willem JJ

AU: Gussekloo Jacobijn

AU: Boland Melinde RS

AU: Rutten-van Mölken Maureen

AU: Chavannes Niels H

TI: Integrated disease management interventions for patients with chronic obstructive pulmonary disease

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 10

PB: John Wiley & Sons, Ltd

CC: AIRWAYS

DOI: 10.1002/14651858.CD009437.pub2

AB: Background: In people with chronic obstructive pulmonary disease (COPD) there is considerable variation in symptoms, limitations and well-being, which often complicates medical care. To improve quality of life (QoL) and exercise tolerance, while reducing the number of exacerbations, a multidisciplinary program including different elements of care is needed.Objectives: To evaluate the effects of integrated disease management (IDM) programs or interventions in people with COPD on health-related QoL, exercise tolerance and number of exacerbations.Search methods: We searched the Cochrane Airways Group Register of trials, CENTRAL, MEDLINE, EMBASE and CINAHL for potentially eligible studies (last searched 12 April 2012).Selection criteria: Randomized controlled trials evaluating IDM programs for COPD compared with controls were included. Included interventions consisted of multidisciplinary (two or more health care providers) and multi-treatment (two or more components) IDM programs with a duration of at least three months.Data collection and analysis: Two review authors independently assessed trial quality and extracted data; if required, we contacted authors for additional data. We performed meta-analyses using random-effects modeling. We carried out sensitivity analysis for allocation concealment, blinding of outcome assessment, study design and intention-to-treat analysis.Main results: A total of 26 trials involving 2997 people were included, with a follow-up ranging from 3 to 24 months. Studies were conducted in 11 different countries. The mean age of the included participants was 68 years, 68% were male and the mean forced expiratory volume in one second (FEV1)% predicted value was 44.3% (range 28% to 66%). Participants were treated in all types of healthcare settings: primary (n = 8), secondary (n = 12), tertiary care (n = 1), and in both primary and secondary care (n = 5). Overall, the studies were of high to moderate methodological quality.Compared with controls, IDM showed a statistically and clinically significant improvement in disease-specific QoL on all domains of the Chronic Respiratory Questionnaire after 12 months: dyspnea (mean difference (MD) 1.02; 95% confidence interval (CI) 0.67 to 1.36); fatigue (MD 0.82; 95% CI 0.46 to 1.17); emotional (MD 0.61; 95% CI 0.26 to 0.95) and mastery (MD 0.75; 95% CI 0.38 to 1.12). The St. George's Respiratory Questionnaire (SGRQ) for QoL reached the clinically relevant difference of four units only for the impact domain (MD -4.04; 95% CI -5.96 to -2.11, P < 0.0001). IDM showed a significantly improved disease-specific QoL on the activity domain of the SGRQ: MD -2.70 (95% CI -4.84 to -0.55, P = 0.01). There was no significant difference on the symptom domain of the SGRQ: MD -2.39 (95% CI -5.31 to 0.53, P = 0.11). According to the GRADE approach, quality of evidence on the SGRQ was scored as high quality, and on the CRQ as moderate quality evidence. Participants treated with an IDM program had a clinically relevant improvement in six-minute walking distance of 43.86 meters compared with controls after 12 months (95% CI 21.83 to 65.89; P < 0.001, moderate quality). There was a reduction in the number of participants with one or more hospital admissions over three to 12 months from 27 per 100 participants in the control group to 20 (95% CI 15 to 27) per 100 participants in the IDM group (OR 0.68; 95% CI 0.47 to 0.99, P = 0.04; number needed to treat = 15). Hospitalization days were significantly lower in the IDM group compared with controls after 12 months (MD -3.78 days; 95% CI -5.90 to -1.67, P < 0.001). Admissions and hospital days were graded as high quality evidence. No adverse effects were reported in the intervention group. No difference between groups was found on mortality (OR 0.96; 95%CI 0.52 to 1.74). There was insufficient evidence to refute or confirm the long term effectiveness of IDM.Authors'

conclusions: In these COPD participants, IDM not only improved disease-specific QoL and exercise capacity, but also reduced hospital admissions and hospital days per person.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD009437.pub2/abstract

Record #38 of 175

ID: CD010744

AU: van Eerd Eva

AU: van der Meer Regina M

AU: Reda Ayalu A

AU: van Schayck Constant Paul

AU: Kotz Daniel

TI: Smoking cessation in smokers with chronic obstructive pulmonary disease

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 9

PB: John Wiley & Sons, Ltd

CC: AIRWAYS

DOI: 10.1002/14651858.CD010744

AB: This is the protocol for a review and there is no abstract. The objectives are as follows:To evaluate the effectiveness of behavioural and/or pharmacological smoking cessation interventions in smokers with COPD.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010744/abstract

Record #39 of 175

ID: CD006826

AU: Nannini Luis Javier

AU: Poole Phillippa

AU: Milan Stephen J

AU: Kesterton Annabel

TI: Combined corticosteroid and long-acting beta2-agonist in one inhaler versus inhaled corticosteroids alone for chronic obstructive pulmonary disease

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 8

PB: John Wiley & Sons, Ltd

KY: Adrenal Cortex Hormones [administration & dosage] [adverse effects];Adrenergic beta-2 Receptor Agonists [administration & dosage] [adverse effects];Albuterol [administration & dosage] [adverse effects] [analogs & derivatives];Androstadienes [administration & dosage] [adverse effects];Bronchodilator Agents [administration & dosage] [adverse effects];Budesonide [administration & dosage] [adverse effects];Drug Combinations;Drug Therapy, Combination [adverse effects] [methods];Ethanolamines [administration & dosage] [adverse effects];Nebulizers and Vaporizers;Pneumonia [chemically induced];Pulmonary Disease, Chronic Obstructive [drug therapy] [mortality];Randomized Controlled Trials as Topic;Steroids [administration & dosage] [adverse effects];Humans[checkword]

CC: AIRWAYS

DOI: 10.1002/14651858.CD006826.pub2

AB: Background: Both long-acting beta2-agonists and inhaled corticosteroids have been recommended in guidelines for the treatment of chronic obstructive pulmonary disease (COPD). Their co-administration in a combined inhaler is intended to facilitate adherence to medication regimens and to improve efficacy. Three preparations are currently available: fluticasone propionate/salmeterol (FPS). budesonide/formoterol (BDF) and mometasone furoate/formoterol (MF/F).Objectives: To assess the efficacy and safety of combined long-acting beta2-agonist and inhaled corticosteroid (LABA/ICS) preparations, as measured by clinical endpoints and pulmonary function testing, compared with inhaled corticosteroids (ICS) alone, in the treatment of adults with chronic obstructive pulmonary disease (COPD).Search methods: We searched the Cochrane Airways Group Specialised Register of trials, which is compiled from systematic searches of multiple literature databases. The search was conducted in June 2013. In addition, we checked the reference lists of included studies and contacted the relevant manufacturers.Selection criteria: Studies were included if they were randomised and double-blind. Compared studies combined LABA/ICS with the ICS component.Data collection and analysis: Two review authors independently assessed trial quality and extracted data. The primary outcomes were exacerbations, mortality and pneumonia. Health-related quality of life (as measured by validated scales), lung function and side effects were secondary outcomes. Dichotomous data were analysed as fixed-effect odds ratios with 95% confidence intervals (CIs), and continuous data as mean differences or rate ratios and 95% CIs.Main results: A total

of 15 studies of good methodological quality met the inclusion criteria by randomly assigning 7814 participants with predominantly poorly reversible, severe COPD. Data were most plentiful for the FPS combination. Exacerbation rates were significantly reduced with combination therapies (rate ratio 0.87, 95% CI 0.80 to 0.94, 6 studies, N = 5601) compared with ICS alone. The mean exacerbation rate in the control (ICS) arms of the six included studies was 1.21 exacerbations per participant per year (range 0.88 to 1.60), and we would expect this to be reduced to a rate of 1.05 (95% CI 0.97 to 1.14) among those given combination therapy. Mortality was also lower with the combination (odds ratio (OR) 0.78, 95% CI 0.64 to 0.94, 12 studies, N = 7518) than with ICS alone, but this was heavily weighted by a three-year study of FPS. When this study was removed, no significant mortality difference was noted. The reduction in exacerbations did not translate into significantly reduced rates of hospitalisation due to COPD exacerbation (OR 0.93, 95% CI 0.80 to 1.07, 10 studies, N = 7060). Lung function data favoured combination treatment in the FPS, BDF and MF/F trials, but the improvement was small. Small improvements in health-related quality of life were measured on the St George's Respiratory Questionnaire (SGRQ) with FPS or BDF compared with ICS, but this was well below the minimum clinically important difference. Adverse event profiles were similar between the two treatments arms, and rates of pneumonia when it was diagnosed by chest x-ray (CXR) were lower than those reported in earlier trials.Authors' conclusions: Combination ICS and LABA offer some clinical benefits in COPD compared with ICS alone, especially for reduction in exacerbations. This review does not support the use of ICS alone when LABAs are available. Adverse events were not significantly different between treatments. Further long-term assessments using practical outcomes of current and new 24-hour LABAs will help determine their efficacy and safety. For robust comparisons as to their relative effects, long-term head-to-head comparisons are needed.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006826.pub2/abstract

Record #40 of 175

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 #41 of 175

ID: CD010665

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AU: Mauricio Didac

AU: Bonfill Cosp Xavier

TI: Interventions for treating overweight or obesity in adults: an overview of systematic reviews

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 8

PB: John Wiley & Sons, Ltd

CC: ENDOC

DOI: 10.1002/14651858.CD010665

AB: This is the protocol for a review and there is no abstract. The objectives are as follows:Our overall aim is to provide an overview of the efficacy of interventions for obesity or overweight in adults by summarising the evidence from multiple systematic reviews.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010665/abstract

Record #42 of 175

ID: CD009444

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AU: Dong Bi Rong

TI: Cholinesterase inhibitors for neurological conditions associated with rarer dementias

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 7

PB: John Wiley & Sons, Ltd

CC: DEMENTIA

DOI: 10.1002/14651858.CD009444.pub2

AB: This is the protocol for a review and there is no abstract. The objectives are as follows:The objectives of this review are to evaluate: The efficacy of cholinesterase inhibitors for the treatment of cognitive impairment or dementia in neurological conditions associated with rarer dementias; The adverse effects of cholinesterase inhibitors in these conditions.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD009444.pub2/abstract

Record #43 of 175

ID: CD008955

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AU: Chiarion Sileni Vanna

TI: Interferon alpha for the adjuvant treatment of cutaneous melanoma

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 6

PB: John Wiley & Sons, Ltd

KY: Antineoplastic Agents [therapeutic use];Chemotherapy, Adjuvant [methods] [mortality];Disease-Free Survival;Interferon-alpha [therapeutic use];Melanoma [drug therapy] [mortality] [surgery];Randomized Controlled Trials as Topic;Skin Neoplasms [drug therapy] [mortality] [surgery];Humans[checkword]

CC: SKIN

DOI: 10.1002/14651858.CD008955.pub2

AB: Background: Interferon alpha is the only agent approved for the postoperative adjuvant treatment of high-risk cutaneous melanoma. However, the survival advantage associated with this treatment is unclear, especially in terms of overall survival. Thus, adjuvant interferon is not universally considered a gold standard treatment by all oncologists.Objectives: To assess the disease-free survival and overall survival effects of interferon alpha as adjuvant treatment for people with high-risk cutaneous melanoma.Search methods: We searched the following databases up to August 2012: the Cochrane Skin Group Specialised Register, CENTRAL in The Cochrane Library (2012, issue 8), MEDLINE (from 2005), EMBASE (from 2010), AMED (from 1985), and LILACS (from 1982). We also searched trials databases in 2011, and proceedings of the ASCO annual meeting from 2000 to 2011. We checked the reference lists of selected articles for further references to relevant trials.Selection criteria: We included only randomised controlled trials (RCTs) comparing interferon alpha to observation (or any other treatment) for the postoperative (adjuvant) treatment of patients with high-risk skin melanoma, that is, people with regional lymph node metastasis (American Joint Committee on Cancer (AJCC) TNM

(tumour, lymph node, metastasis) stage III) undergoing radical lymph node dissection, or people without nodal disease but with primary tumour thickness greater than 1 mm (AJCC TNM stage II).Data collection and analysis: Two authors extracted data, and a third author independently verified the extracted data. The main outcome measure was the hazard ratio (HR), which is the ratio of the risk of the event occurring in the treatment arm (adjuvant interferon) compared to the control arm (no adjuvant interferon). The survival data were either entered directly into Review Manager (RevMan) or extrapolated from Kaplan-Meier plots and then entered into RevMan. Based on the presence of between-study heterogeneity, we applied a fixed-effect or random-effects model for calculating the pooled estimates of treatment efficacy.Main results: Eighteen RCTs enrolling a total of 10,499 participants were eligible for the review. The results from 17 of 18 of these RCTs, published between 1995 and 2011, were suitable for meta-analysis and allowed us to quantify the therapeutic efficacy of interferon in terms of disease-free survival (17 trials) and overall survival (15 trials). Adjuvant interferon was associated with significantly improved disease-free survival (HR (hazard ratio) = 0.83; 95% CI (confidence interval) 0.78 to 0.87, P value < 0.00001) and overall survival (HR = 0.91; 95% CI 0.85 to 0.97; P value = 0.003). We detected no significant between-study heterogeneity (disease-free survival: I^2 statistic = 16%, Q-test P value = 0.27; overall survival: I^2 statistic = 6%; Q-test P value = 0.38).Considering that the 5-year overall survival rate for TNM stage II?III cutaneous melanoma is 60%, the number needed to treat (NNT) is 35 participants (95% CI = 21 to 108 participants) in order to prevent 1 death. The results of subgroup analysis failed to answer the question of whether some treatment features (i.e. dosage, duration) might have an impact on interferon efficacy or whether some participant subgroups (i.e. with or without lymph node positivity) might benefit differently from interferon adjuvant treatment.Grade 3 and 4 toxicity was observed in a minority of participants: In some trials, no-one had fever or fatigue of Grade 3 severity, but in other trials, up to 8% had fever and up to 23% had fatigue of Grade 3 severity. Less than 1% of participants had fever and fatigue of Grade 4 severity. Although it impaired quality of life, toxicity disappeared after treatment discontinuation.Authors' conclusions: The results of this meta-analysis support the therapeutic efficacy of adjuvant interferon alpha for the treatment of people with high-risk (AJCC TNM stage II-III) cutaneous melanoma in terms of both disease-free survival and, though to a lower extent, overall survival. Interferon is also valid as a reference treatment in RCTs investigating new therapeutic agents for the adjuvant treatment of this participant population. Further investigation is required to select people who are most likely to benefit from this treatment.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD008955.pub2/abstract

Record #44 of 175

ID: CD004704

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TI: Mass media interventions for smoking cessation in adults

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 6

PB: John Wiley & Sons, Ltd

KY: Mass Media;Health Behavior;Health Promotion [methods];Smoking [prevention & control];Smoking Cessation [methods];Adult[checkword];Humans[checkword]

CC: TOBACCO

DOI: 10.1002/14651858.CD004704.pub3

AB: Background: Mass media tobacco control campaigns can reach large numbers of people. Much of the literature is focused on the effects of tobacco control advertising on young people, but there are also a number of evaluations of campaigns targeting adult smokers, which show mixed results. Campaigns may be local, regional or national, and may be combined with other components of a comprehensive tobacco control policy.Objectives: To assess the effectiveness of mass media interventions in reducing smoking among adults.Search methods: The Cochrane Tobacco Addiction Group search strategy was combined with additional searches for any studies that referred to tobacco/smoking cessation, mass media and adults. We also searched the Cochrane Register of Controlled Trials (CENTRAL) and a number of electronic databases. The last search was carried out in February 2013.Selection criteria: Controlled trials allocating communities, regions or states to intervention or control conditions; interrupted time series. Adults, 25 years or older, who regularly smoke cigarettes. Studies which cover all adults as defined in studies were included. Mass media are defined here as channels of communication such as television, radio, newspapers, billboards, posters, leaflets or booklets intended to reach large numbers of people, and which are not dependent on person-to-person contact. The purpose of the mass media campaign must be primarily to encourage smokers to quit. They could be carried out alone or in conjunction with tobacco control programmes. The primary outcome was change in smoking behaviour. This could be reported as changes in prevalence, changes in cigarette consumption, quit rates, odds of being a smoker.Data collection and analysis: Two authors independently assessed all studies for inclusion criteria and for study quality (MB, LS, RTM). One author (MB) extracted data, and a second author (LS) checked them. Results were not pooled due to heterogeneity of the included studies and are presented narratively and in table form.Main results: Eleven campaigns met the inclusion criteria for this review. Studies differed in design, settings, duration, content and intensity of intervention, length of follow-up, methods of evaluation and also in definitions and measures of smoking behaviour used. Among nine campaigns reporting smoking prevalence, significant decreases were observed in the California and Massachusetts

statewide tobacco control campaigns compared with the rest of the USA. Some positive effects on prevalence in the whole population or in the subgroups were observed in three of the remaining seven studies. Three large-scale campaigns of the seven presenting results for tobacco consumption found statistically significant decreases. Among the seven studies presenting abstinence or quit rates, four showed some positive effect, although in one of them the effect was measured for quitting and cutting down combined. Among the three that did not show significant decreases, one demonstrated a significant intervention effect on smokers and ex-smokers combined.Authors' conclusions: There is evidence that comprehensive tobacco control programmes which include mass media campaigns can be effective in changing smoking behaviour in adults, but the evidence comes from a heterogeneous group of studies of variable methodological quality. One state-wide tobacco control programme (Massachusetts) showed positive results up to eight years after the campaign. Another (California) showed positive results during the period of adequate funding and implementation and in final evaluation since the beginning of the programme. Six of nine studies carried out in communities or regions showed some positive effects on smoking behaviour and at least one significant change in smoking prevalence (Sydney). The intensity and duration of mass media campaigns may influence effectiveness, but length of follow-up and concurrent secular trends and events can make this difficult to quantify. No consistent relationship was observed between campaign effectiveness and age, education, ethnicity or gender.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004704.pub3/abstract

Record #45 of 175

ID: CD008933

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AU: Di Pietrantonj Carlo

AU: Beecher Deirdre

AU: Salanti Georgia

TI: Immunomodulators and immunosuppressants for multiple sclerosis: a network meta-analysis

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 6

PB: John Wiley & Sons, Ltd

KY: Antibodies, Monoclonal, Humanized [therapeutic use];Immunologic Factors [therapeutic use];Immunosuppressive Agents [therapeutic use];Interferon-beta [therapeutic use];Mitoxantrone [therapeutic use];Multiple Sclerosis, Chronic Progressive [drug therapy];Multiple Sclerosis, Relapsing-Remitting [drug therapy];Peptides [therapeutic use];Randomized Controlled Trials as Topic;Humans[checkword]

CC: MS

DOI: 10.1002/14651858.CD008933.pub2

AB: Background: Different therapeutic strategies are available for treatment of multiple sclerosis (MS) including immunosuppressants, immunomodulators, and monoclonal antibodies. Their relative effectiveness in the prevention of relapse or disability progression is unclear due to the limited number of direct comparison trials. A summary of the results, including both direct and indirect comparisons of treatment effects, may help to clarify the above uncertainty.Objectives: To estimate the relative efficacy and acceptability of interferon ß-1b (IFNß-1b) (Betaseron), interferon ß-1a (IFNß-1a) (Rebif and Avonex), glatiramer acetate, natalizumab, mitoxantrone, methotrexate, cyclophosphamide, azathioprine, intravenous immunoglobulins, and long-term corticosteroids versus placebo or another active agent in participants with MS and to provide a ranking of the treatments according to their effectiveness and risk-benefit balance.Search methods: We searched the Cochrane Database of Systematic Reviews, the Cochrane MS Group Trials Register, and the Food and Drug Administration (FDA) reports. The most recent search was run in February 2012.Selection criteria: Randomized controlled trials (RCTs) that studied one of the 11 treatments for use in adults with MS and that reported our pre-speci?ed efficacy outcomes were considered for inclusion.Data collection and analysis: Identifying search results and data extraction were performed independently by two authors. Data synthesis was performed by pairwise meta-analysis and network meta-analysis that was performed within a Bayesian framework. The body of evidence for outcomes within the pairwise meta-analysis was assessed according to GRADE, as very low, low, moderate, or high quality.Main results: Forty-four trials were included in this review, in which 17,401 participants had been randomised. Twenty-three trials included relapsing-remitting MS (RRMS) (9096 participants, 52%), 18 trials included progressive MS (7726, 44%), and three trials included both RRMS and progressive MS (579, 3%). The majority of the included trials were short-term studies, with the median duration being 24 months. The results originated mostly from 33 trials on IFNß, glatiramer acetate, and natalizumab that overall contributed outcome data for 9881 participants (66%).From the pairwise meta-analysis, there was high quality evidence that natalizumab and IFNß-1a (Rebif) were effective against recurrence of relapses in RRMS during the first 24 months of treatment compared to placebo (odds ratio (OR) 0.32, 95% confidence interval (CI) 0.24 to 0.43; OR 0.45, 95% CI 0.28 to 0.71, respectively); they were more effective than IFNß-1a (Avonex) (OR 0.28, 95% CI 0.22 to 0.36; OR 0.19, 95% CI 0.06 to 0.60, respectively). IFNß-1b (Betaseron) and mitoxantrone probably decreased the odds of the participants with RRMS having clinical relapses compared to placebo (OR 0.55, 95% CI 0.31 to 0.99; OR 0.15, 95% CI 0.04 to 0.54,

respectively) but the quality of evidence for these treatments was graded as moderate. From the network meta-analysis, the most effective drug appeared to be natalizumab (median OR versus placebo 0.29, 95% credible intervals (CrI) 0.17 to 0.51), followed by IFNß-1a (Rebif) (median OR versus placebo 0.44, 95% CrI 0.24 to 0.70), mitoxantrone (median OR versus placebo 0.43, 95% CrI 0.20 to 0.87), glatiramer acetate (median OR versus placebo 0.48, 95% CrI 0.38 to 0.75), IFNß-1b (Betaseron) (median OR versus placebo 0.48, 95% CrI 0.29 to 0.78). However, our confidence was moderate for direct comparison of mitoxantrone and IFNB-1b vs placebo and very low for direct comparison of glatiramer vs placebo. The relapse outcome for RRMS at three years? follow-up was not reported by any of the included trials.Disability progression was based on surrogate markers in the majority of included studies and was unavailable for RRMS beyond two to three years. The pairwise meta-analysis suggested, with moderate quality evidence, that natalizumab and IFNß-1a (Rebif) probably decreased the odds of the participants with RRMS having disability progression at two years' follow-up, with an absolute reduction of 14% and 10%, respectively, compared to placebo. Natalizumab and IFNß-1b (Betaseron) were significantly more effective (OR 0.62, 95% CI 0.49 to 0.78; OR 0.35, 95% CI 0.17 to 0.70, respectively) than IFNß-1a (Avonex) in reducing the number of the participants with RRMS who had progression at two years' follow-up, and confidence in this result was graded as moderate. From the network meta-analyses, mitoxantrone appeared to be the most effective agent in decreasing the odds of the participants with RRMS having progression at two years' follow-up, but our confidence was very low for direct comparison of mitoxantrone vs placebo. Both pairwise and network meta-analysis revealed that none of the individual agents included in this review were effective in preventing disability progression over two or three years in patients with progressive MS.There was not a dose-effect relationship for any of the included treatments with the exception of mitoxantrone.Authors' conclusions: Our review should provide some guidance to clinicians and patients. On the basis of high quality evidence, natalizumab and IFNß-1a (Rebif) are superior to all other treatments for preventing clinical relapses in RRMS in the short-term (24 months) compared to placebo. Moderate quality evidence supports a protective effect of natalizumab and IFNß-1a (Rebif) against disability progression in RRMS in the short-term compared to placebo. These treatments are associated with long-term serious adverse events and their benefit-risk balance might be unfavourable. IFNß-1b (Betaseron) and mitoxantrone probably decreased the odds of the participants with RRMS having relapses, compared with placebo (moderate quality of evidence). The benefit-risk balance with azathioprine is uncertain, however this agent might be effective in decreasing the odds of the participants with RRMS having relapses and disability progression over 24 to 36 months, compared with placebo. The lack of convincing efficacy data shows that IFNß-1a (Avonex), intravenous immunoglobulins, cyclophosphamide and long-term steroids have an unfavourable benefit-risk balance in RRMS. None of the included treatments are effective in decreasing disability progression in patients with progressive MS. It is important to consider that the clinical effects of all these treatments beyond two years are uncertain, a relevant point for a disease of 30 to 40 years duration. Direct head-to-head comparison(s) between natalizumab and IFNß-1a (Rebif) or between azathioprine and IFNß-1a (Rebif) should be top priority on the research agenda and follow-up of the trial cohorts should be mandatory.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD008933.pub2/abstract

Record #46 of 175

ID: CD010580

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AU: Car Josip

TI: Educational interventions for improving the skills of medical practitioners to detect, diagnose, and manage people with cognitive impairment and dementia

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 6

PB: John Wiley & Sons, Ltd

CC: DEMENTIA

DOI: 10.1002/14651858.CD010580

AB: This is the protocol for a review and there is no abstract. The objectives are as follows:To assess and compare the effectiveness of different educational interventions that are aimed at improving the skills of primary care and secondary care clinicians to detect, diagnose, and manage people with cognitive impairment and dementia.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010580/abstract

Record #47 of 175

ID: CD003260

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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 #48 of 175

ID: CD003002

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AU: Smith Ian

TI: Drug therapy for obstructive sleep apnoea in adults

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 5

PB: John Wiley & Sons, Ltd

KY: Randomized Controlled Trials as Topic;Sleep Apnea, Obstructive [drug therapy];Adult[checkword];Humans[checkword]

CC: AIRWAYS

DOI: 10.1002/14651858.CD003002.pub3

AB: Background: The treatment of choice for moderate to severe obstructive sleep apnoea (OSA) is continuous positive airways pressure (CPAP) applied via a mask during sleep. However, this is not tolerated by all individuals and its role in mild OSA is not proven. Drug therapy has been proposed as an alternative to CPAP in some patients with mild to moderate sleep apnoea and could be of value in patients intolerant of CPAP. A number of mechanisms have been proposed by which drugs could reduce the severity of OSA. These include an increase in tone in the upper airway dilator muscles, an increase in ventilatory drive, a reduction in the proportion of rapid eye movement (REM) sleep, an increase in cholinergic tone during sleep, an increase in arousal threshold, a reduction in airway resistance and a reduction in surface tension in the upper airway.Objectives: To determine the efficacy of drug therapies in the specific treatment of sleep apnoea.Search methods: We searched the Cochrane Airways Group Specialised Register of trials. Searches were current as of July 2012.Selection criteria: Randomised, placebo controlled trials involving adult patients with

confirmed OSA. We excluded trials if continuous positive airways pressure, mandibular devices or oxygen therapy were used. We excluded studies investigating treatment of associated conditions such as excessive sleepiness, hypertension, gastro-oesophageal reflux disease and obesity.Data collection and analysis: We used standard methodological procedures recommended by The Cochrane Collaboration.Main results: Thirty trials of 25 drugs, involving 516 participants, contributed data to the review. Drugs had several different proposed modes of action and the results were grouped accordingly in the review. Each of the studies stated that the participants had OSA but diagnostic criteria were not always explicit and it was possible that some patients with central apnoeas may have been recruited.Acetazolamide, eszopiclone, naltrexone, nasal lubricant (phosphocholinamine) and physiostigmine were administered for one to two nights only. Donepezil in patients with and without Alzheimer's disease, fluticasone in patients with allergic rhinitis, combinations of ondansetrone and fluoxetine and paroxetine were trials of one to three months duration, however most of the studies were small and had methodological limitations. The overall quality of the available evidence was low.The primary outcomes for the systematic review were the apnoea hypopnoea index (AHI) and the level of sleepiness associated with OSA, estimated by the Epworth Sleepiness Scale (ESS). AHI was reported in 25 studies and of these 10 showed statistically significant reductions in AHI.Fluticasone in patients with allergic rhinitis was well tolerated and reduced the severity of sleep apnoea compared with placebo (AHI 23.3 versus 30.3; P < 0.05) and improved subjective daytime alertness. Excessive sleepiness was reported to be altered in four studies, however the only clinically and statistically significant change in ESS of -2.9 (SD 2.9; P = 0.04) along with a small but statistically significant reduction in AHI of -9.4 (SD 17.2; P = 0.03) was seen in patients without Alzheimer's disease receiving donepezil for one month. In 23 patients with mild to moderate Alzheimer's disease donepezil led to a significant reduction in AHI (donepezil 20 (SD 15) to 9.9 (SD 11.5) versus placebo 23.2 (SD 26.4) to 22.9 (SD 28.8); P = 0.035) after three months of treatment but no reduction in sleepiness was reported. High dose combined treatment with ondansetron 24 mg and fluoxetine 10 mg showed a 40.5% decrease in AHI from the baseline at treatment day 28. Paroxetine was shown to reduce AHI compared to placebo (-6.10 events/hour; 95% CI -11.00 to -1.20) but failed to improve daytime symptoms.Promising results from the preliminary mirtazapine study failed to be reproduced in the two more recent multicentre trials and, moreover, the use of mirtazapine was associated with significant weight gain and sleepiness. Few data were presented on the long-term tolerability of any of the compounds used.Authors' conclusions: There is insufficient evidence to recommend the use of drug therapy in the treatment of OSA. Small studies have reported positive effects of certain agents on short-term outcomes. Certain agents have been shown to reduce the AHI in largely unselected populations with OSA by between 24% and 45%. For donepezil and fluticasone, studies of longer duration with a larger population and better matching of groups are required to establish whether the change in AHI and impact on daytime symptoms are reproducible. Individual patients had more complete responses to particular drugs. It is possible that better matching of drugs to patients according to the dominant mechanism of their OSA will lead to better results and this also needs further study.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003002.pub3/abstract

Record #49 of 175

ID: CD010520

AU: Xu Li

AU: Wang Xuemei

AU: Wu Meijing

TI: Topical medication instillation techniques for glaucoma

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 5

PB: John Wiley & Sons, Ltd

CC: EYES

DOI: 10.1002/14651858.CD010520

AB: This is the protocol for a review and there is no abstract. The objectives are as follows:To investigate the effectiveness of topical medication instillation techniques in the management of glaucoma, including primary open-angle glaucoma (POAG), primary angle-closure glaucoma (PACG), and secondary glaucomas.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010520/abstract

Record #50 of 175

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 #51 of 175

ID: CD010521

AU: Kavirajan Harish C

AU: Lueck Kristin

AU: Chuang Kenneth

TI: Alternating current cranial electrotherapy stimulation (CES) for depression

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 5

PB: John Wiley & Sons, Ltd

CC: DEPRESSN

DOI: 10.1002/14651858.CD010521

AB: This is the protocol for a review and there is no abstract. The objectives are as follows:To assess the effectiveness and safety of alternating current cranial electrotherapy stimulation (CES) compared with sham CES for acute depression.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010521/abstract

Record #52 of 175

ID: CD010516

AU: Gonzales John A

AU: Gritz David C

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AU: Kim Alisa

AU: Chuck Roy S

TI: Non-steroidal anti-inflammatory drugs versus corticosteroids for controlling inflammation after uncomplicated cataract surgery

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 5

PB: John Wiley & Sons, Ltd

CC: EYES

DOI: 10.1002/14651858.CD010516

AB: : This is the protocol for a review and there is no abstract. The objectives are as follows:Primary objectives: To evaluate the effectiveness of topical NSAIDs (alone or in combination with topical corticosteroids) versus topical corticosteroids in controlling intraocular inflammation after uncomplicated cataract surgery and answer the question: is there sufficient evidence for the utilization of NSAIDs alone or in combination with corticosteroids to control postoperative inflammation after cataract surgery?This review will address the comparative effectiveness of these drugs in controlling inflammation in patients who underwent phacoemulsification for cataract extraction.Secondary objectives: To assess postoperative best-corrected visual acuity (BCVA) as well as patient-reported discomfort, symptoms, or complications (such as elevation of IOP) with the use of postoperative NSAIDs or

corticosteroids. We also will evaluate the cost-effectiveness of using topical NSAIDs alone or in combination with topical corticosteroids.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010516/abstract

Record #53 of 175

ID: CD002127

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AU: Capra Ruggero

AU: Comi Giancarlo

TI: Mitoxantrone for multiple sclerosis

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 5

PB: John Wiley & Sons, Ltd

KY: Disease Progression;Immunosuppressive Agents [adverse effects] [therapeutic use];Mitoxantrone [adverse effects] [therapeutic use];Multiple Sclerosis [drug therapy];Multiple Sclerosis, Chronic Progressive [drug therapy];Multiple Sclerosis, Relapsing-Remitting [drug therapy];Randomized Controlled Trials as Topic;Humans[checkword]

CC: MS

DOI: 10.1002/14651858.CD002127.pub3

AB: Background: Mitoxantrone (MX) has been shown to be moderately effective in reducing the clinical outcome measures of disease activity in multiple sclerosis (MS) patients.This is an update of the Cochrane review "Mitoxantrone for multiple sclerosis" (published on Cochrane Database of Systematic Reviews 2013, Issue 5).Objectives: The main objective was to assess the efficacy and safety of MX compared to a control group in relapsing-remitting (RRMS), progressive relapsing (PRMS) and secondary progressive (SPMS) MS participants.Search methods: We searched the Cochrane Multiple Sclerosis and Rare Diseases of the Central Nervous System Group Specialised Register (23 May 2013). We also undertook handsearching and contacted trialists and pharmaceutical companies.Selection criteria: Randomised, double-blinded, controlled trials (RCTs) comparing the administration of MX versus placebo or MX plus

steroids treatment versus placebo plus steroids treatment were included.Data collection and analysis: The review authors independently selected articles for inclusion. They independently extracted clinical, safety and magnetic resonance imaging (MRI) data, resolving disagreements by discussion. Risk of bias was evaluated to assess the quality of the studies. Treatment effect was measured using odds ratios (OR) with 95% confidence intervals (CI) for the binary outcomes and mean differences (MD) with 95% CI for the continuous outcomes. If heterogeneity was absent, a fixed-effect model was used.Main results: Three trials were selected and 221 participants were included in the analyses. MX reduced the progression of disability at two years follow-up (proportion of participants with six months confirmed progression of disability (OR 0.30, 95% CI 0.09 to 0.99 and MD -0.36, 95% CI- 0.70 to -0.02; P = 0.04). Significant results were found regarding the reduction in annualised relapse rate (MD -0.85, 95% CI -1.47 to -0.23; P = 0.007), the proportion of patients free from relapses at one year (OR 7.13, 95% CI 2.06 to 24.61; P = 0.002) and two years (OR 2.82, 95% CI 1.54 to 5.19; P = 0.0008), and the number of patients with active MRI lesions at six months or one year only (OR 0.24, 95% CI 0.10 to 0.57; P = 0.001).Side effects reported in the trials (amenorrhoea, nausea and vomiting, alopecia and urinary tract infections) were more frequent in treated patients than in controls, while no major adverse events have been reported. These results should be considered with caution because of the limited number of included subjects the heterogeneous characteristics of included trials in term of drug dosage, inclusion criteria and quality of included trials. Moreover, it was not possible to estimate the long-term efficacy and safety of MX.Authors' conclusions: MX shows a significant but partial efficacy in reducing the risk of MS progression and the frequency of relapses in patients affected by worsening RRMS, PRMS and SPMS in the short-term follow-up (two years). No major neoplastic events or symptomatic cardiotoxicity related to MX have been reported; however studies with longer follow-up (not included in this review) have raised concerns about the risk of systolic disfunction and therapy-related acute leukaemias, occurring in about 12% and 0.8% of MX-treated patients respectively.MX should be limited to treating patients with worsening RRMS and SPMS and with evidence of persistent inflammatory activity after a careful assessment of the individual patients? risk and benefit profiles. Assessment should also consider the present availability of alternative therapies with less severe adverse events.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD002127.pub3/abstract

Record #54 of 175

ID: CD007890

AU: De Lima Luiz Gustavo

AU: Soares Bernardo GO

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AU: Atallah Álvaro N

AU: da Silva Edina MK

TI: Beta-blockers for preventing stroke recurrence

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 5

PB: John Wiley & Sons, Ltd

KY: Adrenergic beta-1 Receptor Antagonists [therapeutic use];Atenolol [therapeutic use];Cause of Death;Ischemic Attack, Transient [complications];Myocardial Infarction [mortality];Recurrence [prevention & control];Secondary Prevention [methods];Stroke [prevention & control];Humans[checkword]

CC: STROKE

DOI: 10.1002/14651858.CD007890.pub2

AB: Background: Stroke affects 15 million people per year worldwide. Despite recent developments in acute stroke treatment, prevention remains very important. Stroke has a high rate of recurrence; therefore secondary prevention is also important. Many clinical approaches to control risk factors have been proposed. One of these approaches is the prescription of beta-blockers that have effects beyond the reduction of blood pressure, which can reduce the recurrence of stroke.Objectives: To evaluate the efficacy of beta-blockers for preventing stroke recurrence and for reducing death and major vascular events in people with a previous stroke or transient ischaemic attack (TIA), and to determine their safety, particularly with regard to the development of diabetes mellitus.Search methods: We searched the Cochrane Stroke Group Trials Register (December 2011), the Cochrane Central Register of Controlled Trials (CENTRAL) and the Cochrane Database of Systematic Reviews (CDSR) (The Cochrane Library 2011, Issue 12), the Database of Abstracts of Reviews of Effects (DARE) (December 2011), MEDLINE (1966 to December 2011), EMBASE (1980 to December 2011), and Latin American and Caribbean Health Sciences Literature (LILACS) (1982 to December 2011). We also searched ongoing trials registers and reference lists.Selection criteria: Randomised controlled trials (RCTs) that included participants with previous stroke or TIA due to arterial thrombosis or embolism.The intervention was any beta-blocker versus control, or beta-blocker plus other treatment versus other treatment.Data collection and analysis: Two review authors independently screened the trials identified, appraised quality, and extracted data.Main results: We included two RCTs involving 2193 participants in the review. Both studies randomised participants to either beta-blocker (atenolol 5 mg) or placebo. No statistical differences were noted among the groups in risks of fatal and non-fatal stroke (risk ratio (RR) 0.94, 95% confidence interval (CI) 0.75 to 1.17). For all other outcomes analysed (death from all causes, cardiac death, non-fatal myocardial infarction, major vascular events), we observed no significant differences between the groups.Authors' conclusions: To date, no available evidence supports the routine use of beta-blockers for secondary prevention after stroke or TIA. More studies with larger samples are needed.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007890.pub2/abstract

Record #55 of 175

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

Record #56 of 175

ID: CD001293

AU: Thomas Roger E

AU: McLellan Julie

AU: Perera Rafael

TI: School-based programmes for preventing smoking

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 4

PB: John Wiley & Sons, Ltd

KY: Program Evaluation;Health Promotion;Randomized Controlled Trials as Topic;School Health Services [standards];Schools;Smoking [prevention & control];Adolescent[checkword];Child[checkword];Child, Preschool[checkword];Humans[checkword]

CC: TOBACCO

DOI: 10.1002/14651858.CD001293.pub3

AB: Background: Helping young people to avoid starting smoking is a widely endorsed public health goal, and schools provide a route to communicate with nearly all young people. School-based interventions have been delivered for close to 40 years.Objectives: The primary aim of this review was to determine whether school smoking interventions prevent youth from starting smoking. Our secondary objective was to determine which interventions were most effective. This included evaluating the effects of theoretical approaches; additional booster sessions; programme deliverers; gender effects; and multifocal interventions versus those

focused solely on smoking.Search methods: We searched the Cochrane Central Register of Controlled Trials (CENTRAL), the Cochrane Tobacco Addiction Group's Specialised Register, MEDLINE, EMBASE, PsyclNFO, ERIC, CINAHL, Health Star, and Dissertation Abstracts for terms relating to school-based smoking cessation programmes. In addition, we screened the bibliographies of articles and ran individual MEDLINE searches for 133 authors who had undertaken randomised controlled trials in this area. The most recent searches were conducted in October 2012.Selection criteria: We selected randomised controlled trials (RCTs) where students, classes, schools, or school districts were randomised to intervention arm(s) versus a control group, and followed for at least six months. Participants had to be youth (aged 5 to 18). Interventions could be any curricula used in a school setting to deter tobacco use, and outcome measures could be never smoking, frequency of smoking, number of cigarettes smoked, or smoking indices.Data collection and analysis: Two reviewers independently assessed studies for inclusion, extracted data and assessed risk of bias. Based on the type of outcome, we placed studies into three groups for analysis: Pure Prevention cohorts (Group 1), Change in Smoking Behaviour over time (Group 2) and Point Prevalence of Smoking (Group 3).Main results: One hundred and thirty-four studies involving 428,293 participants met the inclusion criteria. Some studies provided data for more than one group.Pure Prevention cohorts (Group 1) included 49 studies (N = 142,447). Pooled results at follow-up at one year or less found no overall effect of intervention curricula versus control (odds ratio (OR) 0.94, 95% confidence interval (CI) 0.85 to 1.05). In a subgroup analysis, the combined social competence and social influences curricula (six RCTs) showed a statistically significant effect in preventing the onset of smoking (OR 0.49, 95% CI 0.28 to 0.87; seven arms); whereas significant effects were not detected in programmes involving information only (OR 0.12, 95% CI 0.00 to 14.87; one study), social influences only (OR 1.00, 95% CI 0.88 to 1.13; 25 studies), or multimodal interventions (OR 0.89, 95% CI 0.73 to 1.08; five studies). In contrast, pooled results at longest follow-up showed an overall significant effect favouring the intervention (OR 0.88, 95% CI 0.82 to 0.96). Subgroup analyses detected significant effects in programmes with social competence curricula (OR 0.52, 95% CI 0.30 to 0.88), and the combined social competence and social influences curricula (OR 0.50, 95% CI 0.28 to 0.87), but not in those programmes with information only, social influence only, and multimodal programmes.Change in Smoking Behaviour over time (Group 2) included 15 studies (N = 45,555). At one year or less there was a small but statistically significant effect favouring controls (standardised mean difference (SMD) 0.04, 95% CI 0.02 to 0.06). For follow-up longer than one year there was a statistically nonsignificant effect (SMD 0.02, 95% CI -0.00 to 0.02).Twenty-five studies reported data on the Point Prevalence of Smoking (Group 3), though heterogeneity in this group was too high for data to be pooled.We were unable to analyse data for 49 studies (N = 152,544).Subgroup analyses (Pure Prevention cohorts only) demonstrated that at longest follow-up for all curricula combined, there was a significant effect favouring adult presenters (OR 0.88, 95% CI 0.81 to 0.96). There were no differences between tobacco-only and multifocal interventions. For curricula with booster sessions there was a significant effect only for combined social competence and social influences interventions with follow-up of one year or less (OR 0.50, 95% CI 0.26 to 0.96) and at longest follow-up (OR 0.51, 95% CI 0.27 to 0.96). Limited data on gender differences suggested no overall effect, although one study found an effect of multimodal intervention at one year for male students. Sensitivity analyses for Pure Prevention cohorts and Change in Smoking Behaviour over time outcomes suggested that neither

selection nor attrition bias affected the results.Authors' conclusions: Pure Prevention cohorts showed a significant effect at longest follow-up, with an average 12% reduction in starting smoking compared to the control groups. However, no overall effect was detected at one year or less. The combined social competence and social influences interventions showed a significant effect at one year and at longest follow-up. Studies that deployed a social influences programme showed no overall effect at any time point; multimodal interventions and those with an information-only approach were similarly ineffective.Studies reporting Change in Smoking Behaviour over time did not show an overall effect, but at an intervention level there were positive findings for social competence and combined social competence and social influences interventions.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD001293.pub3/abstract

Record #57 of 175

ID: CD006132

AU: Waterman Heather

AU: Evans Jennifer R

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AU: Henson David

AU: Harper Robert

TI: Interventions for improving adherence to ocular hypotensive therapy

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 4

PB: John Wiley & Sons, Ltd

KY: Medication Adherence;Ocular Hypertension [drug therapy];Ophthalmic Solutions [administration & dosage];Patient Education as Topic;Randomized Controlled Trials as Topic;Reminder Systems [instrumentation];Humans[checkword]

CC: EYES

DOI: 10.1002/14651858.CD006132.pub3

AB: Background: Poor adherence to therapy is a significant healthcare issue, particularly in patients with chronic disease such as open-angle glaucoma. Treatment failure may necessitate unwarranted changes of medications, increased healthcare expenditure and risk to the patient

if surgical intervention is required. Simplifying eye drop regimes, providing adequate information, teaching drop instillation technique and ongoing support according to the patient need may have a positive effect on improving adherence.Objectives: To summarise the effects of interventions for improving adherence to ocular hypotensive therapy in people with ocular hypertension (OHT) or glaucoma.Search methods: We searched CENTRAL (which contains the Cochrane Eyes and Vision Group Trials Register) (The Cochrane Library 2012, Issue 6), MEDLINE (June 1946 to June 2012), EMBASE (June 1980 to June 2012), Cumulative Index to Nursing and Allied Health Literature (CINAHL) (June 1937 to June 2012), PsycINFO (1806 to June 2012), PsycEXTRA (1908 to June 2012), Web of Science (1970 to June 2012), ZETOC (1993 to June 2012), OpenGrey (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). We did not use any date or language restrictions in the electronic searches for trials. The electronic databases were last searched on 26 June 2012. We did not search the National Research Register (NNR) as this resource has now been now archived. We contacted pharmaceutical manufacturers to request unpublished data and searched conference proceedings for the Association for Research in Vision and Ophthalmology (ARVO), and the Annual Congress for the Royal College of Ophthalmologists (RCO).Selection criteria: We included randomised controlled trials (RCTs) and quasi-RCTs that compared interventions to improve adherence to ocular hypotensive therapy for patients with OHT or glaucoma.Data collection and analysis: At least two authors independently assessed the search results for eligibility and extracted data for included trials onto specifically designed forms. We did not pool data due to clinical and methodological heterogeneity.Main results: Sixteen trials (1565 participants) met the inclusion criteria. Seven studies investigated some form of patient education. In six of these studies this education was combined with other behavioural change interventions including tailoring daily routines to promote adherence to eye drops. Eight studies compared different drug regimens (one of these trials also compared open and masked monitoring) and one study investigated a reminder device. The studies were of variable quality and some were at considerable risk of bias; in general, the length of follow-up was short at less than six months with only two studies following up to 12 months. Different interventions and outcomes were reported and so it was not possible to produce an overall estimate of effect. There was some evidence from three studies that education combined with personalised interventions, that is, more complex interventions, improved adherence to ocular hypotensive therapy. There was less information on other outcomes such as persistence and intraocular pressure, and no information on visual field defects, quality of life and cost. There was weak evidence as to whether people on simpler drug regimens were more likely to adhere and persist with their ocular hypotensive therapy. A particular problem was the interpretation of cross-over studies, which in general were not reported correctly. One study investigated a reminder device and monitoring but the study was small and inconclusive.Authors' conclusions: Although complex interventions consisting of patient education combined with personalised behavioural change interventions, including tailoring daily routines to promote adherence to eye drops, may improve adherence to glaucoma medication, overall there is insufficient evidence to recommend a particular intervention. The interventions varied between studies and none of the included studies reported on the cost of the intervention. Simplified drug regimens also could be of benefit but again the current

published studies do not provide conclusive evidence. Future studies should follow up for at least one year, and could benefit from standardised outcomes.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006132.pub3/abstract

Record #58 of 175

ID: CD010472

AU: Wang Xue

AU: Wang Ruidi

AU: Coleman Anne

TI: Device modified trabeculectomy for glaucoma

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 4

PB: John Wiley & Sons, Ltd

CC: EYES

DOI: 10.1002/14651858.CD010472

AB: This is the protocol for a review and there is no abstract. The objectives are as follows:The primary objective of this systematic review of modified trabeculectomy for glaucoma is to assess the effectiveness of the use of different devices with standard trabeculectomy on IOP control in patients with glaucoma. We will also assess the safety of the interventions by a review of all adverse events occurring during and after the intervention.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010472/abstract

Record #59 of 175

ID: CD010418

AU: Ryan Cristin

AU: McCullough Amanda

AU: Elborn Stuart

AU: Hughes Carmel

TI: Pharmacist-led interventions for adults with asthma or COPD

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 4

PB: John Wiley & Sons, Ltd

CC: AIRWAYS

DOI: 10.1002/14651858.CD010418

AB: This is the protocol for a review and there is no abstract. The objectives are as follows:To review the evidence base for pharmacist-led interventions to improve the management of adults with asthma and COPD.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010418/abstract

Record #60 of 175

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 #61 of 175

ID: CD010419

AU: Vattakatuchery Joe

AU: Lathif Nismen

AU: Joy Jaya

AU: Cavanna Andrea

AU: Rickards Hugh E

TI: Pharmacological interventions for depression in people with traumatic brain injury

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 3

PB: John Wiley & Sons, Ltd

CC: INJ

DOI: 10.1002/14651858.CD010419

AB: This is the protocol for a review and there is no abstract. The objectives are as follows:To assess the effects of pharmacological interventions for depressive disorder in people with traumatic brain injury.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010419/abstract

Record #62 of 175

ID: CD000020

AU: Crowther Caroline A

AU: Middleton Philippa

AU: McBain Rosemary D

TI: Anti-D administration in pregnancy for preventing Rhesus alloimmunisation

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 2

PB: John Wiley & Sons, Ltd

KY: Immunologic Factors [therapeutic use];Pregnancy Trimester, Third;Randomized Controlled Trials as Topic;Rh Isoimmunization [prevention & control];Rho(D) Immune Globulin [therapeutic use];Female[checkword];Humans[checkword];Pregnancy[checkword]

CC: PREG

DOI: 10.1002/14651858.CD000020.pub2

AB: Background: During pregnancy, a Rhesus negative (Rh-negative) woman may develop antibodies when her fetus is Rhesus positive (Rh-positive). These antibodies may harm Rh-positive babies.Objectives: To assess the effects of antenatal anti-D immunoglobulin on the incidence of Rhesus D alloimmunisation when given to Rh-negative women without anti-D antibodies.Search methods: We searched the Cochrane Pregnancy and Childbirth Group's Trials Register (30 September 2012).Selection criteria: Randomised trials in Rh-negative women without anti-D antibodies given anti-D after 28 weeks of pregnancy, compared with no treatment, placebo or a different regimen of anti-D.Data collection and analysis: Two review authors independently assessed trial eligibility and risk of bias and extracted the data.Main results: Two trials with moderate to high risk of bias, involving over 4500 women, compared anti-D prophylaxis with no anti-D during pregnancy. When women received anti-D at 28 and 34

weeks' gestation, risks of immunisation were not significantly different than for women not given antenatal anti-D: risk ratio (RR) of immunisation during pregnancy was 0.42 (95% confidence interval (CI) 0.15 to 1.17); after the birth of a Rh-positive infant the RR was 0.42 (95% CI 0.15 to 1.17); and within 12 months after birth of a Rh-positive infant the RR was 0.39 (95% CI 0.10 to 1.62).However, women receiving anti-D during pregnancy were significantly less likely to register a positive Kleihauer test (which detects fetal cells in maternal blood) in pregnancy (RR 0.60, 95% CI 0.41 to 0.88) and at the birth of a Rh-positive infant (RR 0.60, 95% CI 0.46 to 0.79). No data were available for the risk of Rhesus D alloimmunisation in a subsequent pregnancy. No significant differences were seen for neonatal jaundice, and no adverse effects were reported in either trial.Authors' conclusions: The risk of Rhesus D alloimmunisation during or immediately after a first pregnancy is about 1%. Administration of 100 µg (500 IU) anti-D to women in their first pregnancy can reduce this risk to about 0.2% without, to date, any adverse effects. Although unlikely to confer benefit in the current pregnancy, fewer women may have Rhesus D antibodies in any subsequent pregnancy, but the effects of this needs to be tested in studies of robust design.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD000020.pub2/abstract

Record #63 of 175

ID: CD001134

AU: Dennis Cindy-Lee

AU: Dowswell Therese

TI: Psychosocial and psychological interventions for preventing postpartum depression

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 2

PB: John Wiley & Sons, Ltd

KY: Depression, Postpartum [prevention & control];Family Health;House Calls;Peer Group;Psychotherapy [methods];Randomized Controlled Trials as Topic;Social Support;Female[checkword];Humans[checkword]

CC: PREG

DOI: 10.1002/14651858.CD001134.pub3

AB: Background: Epidemiological studies and meta-analyses of predictive studies have consistently demonstrated the importance of psychosocial and psychological variables as postpartum depression risk factors. While interventions based on these variables may be

effective treatment strategies, theoretically they may also be used in pregnancy and the early postpartum period to prevent postpartum depression.Objectives: Primary: to assess the effect of diverse psychosocial and psychological interventions compared with usual antepartum, intrapartum, or postpartum care to reduce the risk of developing postpartum depression. Secondary: to examine (1) the effectiveness of specific types of psychosocial and psychological interventions, (2) the effectiveness of professionally-based versus lay-based interventions, (3) the effectiveness of individually-based versus group-based interventions, (4) the effects of intervention onset and duration, and (5) whether interventions are more effective in women selected with specific risk factors.Search methods: We searched the Cochrane Pregnancy and Childbirth Group's Trials Register (30 November 2011), scanned secondary references and contacted experts in the field. We updated the search on 31 December 2012 and added the results to the awaiting classification section of the review for assessment at the next update.Selection criteria: All published and unpublished randomised controlled trials of acceptable quality comparing a psychosocial or psychological intervention with usual antenatal, intrapartum, or postpartum care.Data collection and analysis: Review authors and a research co-ordinator with Cochrane review experience participated in the evaluation of methodological quality and data extraction. Additional information was sought from several trial researchers. Results are presented using risk ratio (RR) for categorical data and mean difference (MD) for continuous data.Main results: Twenty-eight trials, involving almost 17,000 women, contributed data to the review. Overall, women who received a psychosocial or psychological intervention were significantly less likely to develop postpartum depression compared with those receiving standard care (average RR 0.78, 95% confidence interval (CI) 0.66 to 0.93; 20 trials, 14,727 women). Several promising interventions include: (1) the provision of intensive, individualised postpartum home visits provided by public health nurses or midwives (RR 0.56, 95% CI 0.43 to 0.73; two trials, 1262 women); (2) lay (peer)-based telephone support (RR 0.54, 95% CI 0.38 to 0.77; one trial, 612 women); and (3) interpersonal psychotherapy (standardised mean difference -0.27, 95% CI -0.52 to -0.01; five trials, 366 women). Professional- and lay-based interventions were both effective in reducing the risk to develop depressive symptomatology. Individually-based interventions reduced depressive symptomatology at final assessment (RR 0.75, 95% CI 0.61 to 0.92; 14 trials, 12,914 women) as did multiple-contact interventions (RR 0.78, 95% CI 0.66 to 0.93; 16 trials, 11,850 women). Interventions that were initiated in the postpartum period also significantly reduced the risk to develop depressive symptomatology (RR 0.73, 95% CI 0.59 to 0.90; 12 trials, 12,786 women). Identifying mothers 'at-risk' assisted the prevention of postpartum depression (RR 0.66, 95% CI 0.50 to 0.88; eight trials, 1853 women).Authors' conclusions: Overall, psychosocial and psychological interventions significantly reduce the number of women who develop postpartum depression. Promising interventions include the provision of intensive, professionally-based postpartum home visits, telephone-based peer support, and interpersonal psychotherapy.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD001134.pub3/abstract

Record #64 of 175

ID: CD010351

AU: Husk Kerryn

AU: Lovell Rebecca

AU: Cooper Chris

AU: Garside Ruth

TI: Participation in environmental enhancement and conservation activities for health and well-being in adults

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 2

PB: John Wiley & Sons, Ltd

CC: PUBHLTH

DOI: 10.1002/14651858.CD010351

AB: This is the protocol for a review and there is no abstract. The objectives are as follows:To assess the health and well-being impacts on adults following participation in environmental enhancement and conservation activities.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010351/abstract

Record #65 of 175

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 #66 of 175

ID: CD010067

AU: Turley Ruth

AU: Saith Ruhi

AU: Bhan Nandita

AU: Rehfuess Eva

AU: Carter Ben

TI: Slum upgrading strategies involving physical environment and infrastructure interventions and their effects on health and socio-economic outcomes

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 1

PB: John Wiley & Sons, Ltd

KY: Health Status;Poverty Areas;Socioeconomic Factors;Communicable Disease Control;Developing Countries;Diarrhea [prevention & control];Quality of Life [psychology];Urban Renewal [methods];Humans[checkword]

CC: PUBHLTH

DOI: 10.1002/14651858.CD010067.pub2

AB: Background: Slums are densely populated, neglected parts of cities where housing and living conditions are exceptionally poor. In situ slum upgrading, at its basic level, involves improving the physical environment of the existing area, such as improving and installing basic infrastructure like water, sanitation, solid waste collection, electricity, storm water drainage, access roads and footpaths, and street lighting, as well as home improvements and securing land tenure.Objectives: To explore the effects of slum upgrading strategies involving physical environment and infrastructure interventions on the health, quality of life and socio-economic wellbeing of urban slum dwellers in low and middle income countries (LMIC). Where reported, data were collected on the perspectives of slum dwellers regarding their needs, preferences for and satisfaction with interventions received.Search methods: We searched for published and unpublished studies in 28 bibliographic databases including multidisciplinary (for example Scopus) and specialist databases covering health, social science, urban planning, environment and LMIC topics. Snowballing techniques included searching websites, journal handsearching, contacting authors and reference list checking. Searches were not restricted by language or publication date.Selection criteria: We included studies examining the impact of slum upgrading strategies involving physical environment or infrastructure improvements (with or without additional co-interventions) on the health, quality of life and socio-economic wellbeing of LMIC urban slum dwellers. Randomised controlled trials (RCTs), controlled before and after studies (CBAs) and interrupted time series (ITS) were eligible for the main analysis. Controlled studies with only post-intervention data (CPI) and uncontrolled before and after (UBA) studies were included in a separate narrative to examine consistency of results and to supplement evidence gaps in the main analysis.Data collection and analysis: Two authors independently extracted data and assessed risk of bias for each study. Differences between the included study interventions and outcomes precluded meta-analysis so the results were presented in a narrative summary with illustrative harvest plots. The body of evidence for outcomes within the main analysis was assessed according to GRADE as very low, low, moderate or high quality.Main results: We identified 10,488 unique records, with 323 screened as full text. Five studies were included for the main analysis: one RCT with a low risk, two CBAs with a moderate risk and two CBAs with a high risk of bias. Three CBAs evaluated multicomponent slum upgrading strategies. Road paving only was evaluated in one RCT and water supply in one CBA. A total of 3453 households or observations were included within the four studies reporting sample sizes.Most health outcomes in the main studies related to communicable diseases, for which the body of evidence was judged to be low quality. One CBA with a moderate risk of bias found that diarrhoeal incidence was reduced in households which received water connections from a private water company (risk ratio (RR) 0.53; 95% confidence interval (CI) 0.27 to 1.04) and the severity of diarrhoeal episodes (RR 0.48; 95% CI 0.19 to 1.22). There was no effect for duration of diarrhoea. Road paving did not result in changes in parasitic infections or sickness in one RCT. After multicomponent slum upgrading,

claims for a waterborne disease as opposed to a non-waterborne disease reduced (RR 0.64; 95% CI 0.27 to 0.98) in one CBA with a high risk of bias but there was no change in sanitation-related mortality in a CBA with a moderate risk of bias.The majority of socio-economic outcomes reported within the main studies related to financial poverty, for which the body of evidence was of very low quality. Results were mixed amongst the main studies; one RCT and two CBAs reported no effect on the income of slum dwellers following slum upgrading. One further CBA found significant reduction in monthly water expenditure (mean difference (MD) -17.11 pesos; 95% CI -32.6 to -1.62). One RCT also showed mixed results for employment variables, finding no effect on unemployment levels but increased weekly worked hours (MD 4.68; 95% CI -0.46 to 9.82) and lower risk of residents intending to migrate for work (RR 0.78; 95% CI 0.60 to 1.01).There was no evidence available to assess the impact of slum upgrading on non-communicable diseases or social capital. Maternal and perinatal conditions, infant mortality, nutritional deficiencies, injuries, self-reported quality of life, education and crime were evaluated in one study each.Nine supporting studies were included that measured varying outcomes (6794 households or observations within eight studies reporting sample sizes). One CPI evaluated cement flooring only while three UBAs and five CPIs evaluated multicomponent slum upgrading strategies. All studies but one had a high risk of bias.The studies reinforced main study findings for diarrhoea incidence and water-related expenditure. Findings for parasitic infections and financial poverty were inconsistent with the main studies. In addition, supporting studies reported a number of disparate outcomes that were not evaluated in the main studies.Five supporting studies included some limited information on slum dweller perspectives. They indicated the importance of appropriate siting of facilities, preference for private facilities, delivering synergistic interventions together, and ensuring that infrastructure was fit for purpose and systems were provided for cleaning, maintenance and repair.Authors' conclusions: A high risk of bias within the included studies, heterogeneity and evidence gaps prevent firm conclusions on the effect of slum upgrading strategies on health and socio-economic wellbeing. The most common health and socio-economic outcomes reported were communicable diseases and indicators of financial poverty. There was a limited but consistent body of evidence to suggest that slum upgrading may reduce the incidence of diarrhoeal diseases and water-related expenditure. The information available on slum dwellers? perspectives provided some insight to barriers and facilitators for successful implementation and maintenance of interventions.The availability and use of reliable, comparable outcome measures to determine the effect of slum upgrading on health, quality of life and socio-economic wellbeing would make a useful contribution to new research in this important area. Given the complexity in delivering slum upgrading, evaluations should look to incorporate process and qualitative information alongside quantitative effectiveness data to determine which particular interventions work (or don?t work) and for whom.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010067.pub2/abstract

Record #67 of 175

ID: CD008628

AU: Bruce Julie

AU: Sutherland Alasdair

TI: Surgical versus conservative interventions for displaced intra-articular calcaneal fractures

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 1

PB: John Wiley & Sons, Ltd

KY: Calcaneus [injuries];Fracture Fixation [methods];Intra-Articular Fractures [therapy];Pain Measurement;Quality of Life;Randomized Controlled Trials as Topic;Recovery of Function;Return to Work;Shoes;Walking;Humans[checkword]

CC: MUSKINJ

DOI: 10.1002/14651858.CD008628.pub2

AB: Background: Fractures of the calcaneus (heel bone) comprise up to 2% of all fractures. These fractures are mostly caused by a fall from a height, and are common in younger adults. Treatment can be surgical or non-surgical; however, there is clinical uncertainty over optimal management.Objectives: To assess the effects of surgical compared with conservative treatment of displaced intra-articular calcaneal fractures in adults.Search methods: We searched the Cochrane Bone, Joint and Muscle Trauma Group Specialised Register (to July 2011), the Cochrane Central Register of Controlled Trials (The Cochrane Library, 2011 Issue 3), MEDLINE (1948 to July 2011), EMBASE (1980 to 2011 Week 27), the WHO International Clinical Trials Registry Platform, Current Controlled Trials, and Orthopaedic Trauma Association annual meeting archives (1996 to 2011). Reference lists of retrieved articles were checked. No language restrictions were applied.Selection criteria: Randomised and quasi-randomised controlled clinical studies comparing surgical versus conservative management for displaced intra-articular calcaneal fractures.Data collection and analysis: Two review authors independently screened search results, selected studies, extracted data and assessed risk of bias. Primary outcomes were function (e.g. walking ability) and chronic pain. Risk ratios were calculated for dichotomous outcomes and mean differences for continuous outcomes. Missing standard deviations were calculated from P values.Main results: Four trials were included (602 participants). Three trials were small single-centre trials, and the fourth a large multi-centre trial including 424 participants. All trials had methodological flaws, usually failure to conceal allocation and incomplete follow-up data, which put them at high risk of bias. Follow-up ranged from 1 to 15 years after treatment.Data for functional outcomes, including walking ability, from three trials could not be pooled. The strongest evidence was from the multi-centre trial. This showed no statistically or clinically significant differences between the surgical and conservatively treated groups at three years follow-up in the ''validated disease-specific" score (0 to 100: perfect result; 424 participants; mean difference (MD) 4.30, 95% confidence interval (CI) -1.11 to 9.71; P = 0.12). There was no significant difference between

the two groups in the risk of chronic pain at follow-up (19/40 versus 24/42; risk ratio (RR) 0.79, 95% CI 0.53 to 1.18; 2 trials). The multi-centre trial found no statistically or clinically significant difference between the two groups in health-related quality of life at three years follow-up (SF-36 (0 to 100: best outcome): MD 4.00, 95% CI -1.16 to 9.16; P = 0.13).Two small trials provided some limited evidence of a tendency for a higher return to previous employment after surgery (27/34 versus 15/27; RR 1.45, 95% CI 0.75 to 2.81; I^2 = 55%; 2 trials). One small trial found no difference between the two groups in the ability to wear normal shoes, whereas another small trial found that surgery resulted in more people who were able to wear all shoes comfortably. There was a higher rate of major complications, such as surgical site infection, after surgery compared with conservative treatment (57/206 versus 42/218; RR 1.44, 95% CI 1.01 to 2.04; 1 trial). Conversely, significantly fewer surgical participants had subtalar arthrodeses due to the development of subtalar arthritis (7/206 versus 37/218; RR 0.20, 95% CI 0.09 to 0.44; 1 trial). There were no significant differences between the two groups in range of movement outcomes or radiological measurements (e.g. Bohler's angle).Authors' conclusions: The bulk of the evidence in this review derives from one large multi-centre but inadequately reported trial conducted over 15 years ago. This found no significant differences between surgical or conservative treatment in functional ability and health related quality of life at three years after displaced intra-articular calcaneal fracture. Though it reported a greater risk of major complications after surgery, subtalar arthrodeses for the development of subtalar arthritis was significantly greater after conservative treatment.Overall, there is insufficient high quality evidence relating to current practice to establish whether surgical or conservative treatment is better for adults with displaced intra-articular calcaneal fracture. Evidence from adequately powered randomised, multi-centre controlled trials, assessing patient-centred and clinically relevant outcomes is required. However, it would be prudent to reassess this need after an update of the review that incorporates new evidence from a currently ongoing multi-centre trial.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD008628.pub2/abstract

Record #68 of 175

ID: CD010295

AU: Mortimer Duncan

AU: Ghijben Peter

AU: Harris Anthony

AU: Hollingsworth Bruce

TI: Incentive-based and non-incentive-based interventions for increasing blood donation

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 1

PB: John Wiley & Sons, Ltd

CC: COMMUN

DOI: 10.1002/14651858.CD010295

AB: This is the protocol for a review and there is no abstract. The objectives are as follows:To assess the safety, effectiveness and cost of incentive-based and non-incentive-based interventions for increasing blood donation.We are particularly interested in the following comparisons: Monetary versus non-monetary incentives. Monetary incentives versus non-incentive based interventions. Monetary incentives, non-monetary incentives and non-incentive-based interventions versus current practice.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010295/abstract

Record #69 of 175

ID: CD008075

AU: Borthwick Emma MJ

AU: Hill Christopher J

AU: Rabindranath Kannaiyan S

AU: Maxwell Alexander P

AU: McAuley Danny F

AU: Blackwood Bronagh

TI: High-volume haemofiltration for sepsis

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 1

PB: John Wiley & Sons, Ltd

KY: Critical Illness [mortality];Hemodiafiltration [methods];Hemofiltration [methods] [mortality];Intensive Care Units;Randomized Controlled Trials as Topic;Sepsis [mortality] [therapy];Shock, Septic [mortality] [therapy];Adult[checkword];Humans[checkword]

CC: ANAESTH

DOI: 10.1002/14651858.CD008075.pub2

AB: Background: Severe sepsis and septic shock are leading causes of death in the intensive care unit (ICU). This is despite advances in the management of patients with severe sepsis and septic shock including early recognition, source control, timely and appropriate administration of antimicrobial agents, and goal directed haemodynamic, ventilatory and metabolic therapies. High-volume haemofiltration (HVHF) is a blood purification technique which may improve outcomes in critically ill patients with severe sepsis or septic shock. The technique of HVHF has evolved from renal replacement therapies used to treat acute kidney injury (AKI) in critically ill patients in the ICU.Objectives: This review assessed whether HVHF improves clinical outcome in adult critically ill patients with sepsis in an ICU setting.Search methods: We searched the Cochrane Central Register of Controlled Trials (CENTRAL) (The Cochrane Library, 2011, Issue 7); MEDLINE (1990 to August 2011), EMBASE (1990 to August 2011); LILACS (1982 to August 2011), Web of Science (1990 to August 2011), CINAHL (1982 to August 2011) and specific websites.Selection criteria: We included randomized controlled trials (RCTs) and quasi-randomized trials comparing HVHF or high-volume haemodiafiltration to standard or usual dialysis therapy; and RCTs and quasi-randomized trials comparing HVHF or high-volume haemodiafiltration to no similar dialysis therapy. The studies involved adults in critical care units.Data collection and analysis: Three review authors independently extracted data and assessed trial quality. We sought additional information as required from trialists.Main results: We included three randomized trials involving 64 participants. Due to the small number of studies and participants, it was not possible to combine data or perform sub-group analyses. One trial reported ICU and 28-day mortality, one trial reported hospital mortality and in the third, the number of deaths stated did not match the quoted mortality rates. No trials reported length of stay in ICU or hospital and one reported organ dysfunction. No adverse events were reported. Overall, the included studies had a low risk of bias.Authors' conclusions: There were no adverse effects of HVHF reported.There is insufficient evidence to recommend the use of HVHF in critically ill patients with severe sepsis and or septic shock except as interventions being investigated in the setting of a randomized clinical trial. These trials should be large, multi-centred and have clinically relevant outcome measures. Financial implications should also be assessed.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD008075.pub2/abstract

Record #70 of 175

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 #71 of 175

ID: CD010284

AU: Chan Edwin SY

AU: Bautista Dianne

AU: You Yong

AU: Long Jian Ting

AU: Ling Lu

AU: Li Wenyun

AU: Chen Christopher

TI: Traditional Chinese herbal medicine for vascular dementia

SO: Cochrane Database of Systematic Reviews

YR: 2013

NO: 1

PB: John Wiley & Sons, Ltd

CC: DEMENTIA

DOI: 10.1002/14651858.CD010284

AB: This is the protocol for a review and there is no abstract. The objectives are as follows: To evaluate the efficacy and safety of traditional Chinese herbal medicines (TCHMs) used in treating vascular dementia. To identify promising TCHM formulas for further clinical research.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010284/abstract

Record #72 of 175

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 #73 of 175

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 #74 of 175

ID: CD005465

AU: Cameron Ian D

AU: Gillespie Lesley D

AU: Robertson M Clare

AU: Murray Geoff R

AU: Hill Keith D

AU: Cumming Robert G

AU: Kerse Ngaire

TI: Interventions for preventing falls in older people in care facilities and hospitals

SO: Cochrane Database of Systematic Reviews

YR: 2012

NO: 12

PB: John Wiley & Sons, Ltd

KY: Hospitals [statistics & numerical data];Nursing Homes [statistics & numerical data];Accidental Falls [prevention & control] [statistics & numerical data];Calcium, Dietary [administration & dosage];Exercise;Randomized Controlled Trials as Topic;Safety Management;Vitamin D [administration & dosage];Vitamins [administration & dosage];Aged[checkword];Aged, 80 and over[checkword];Female[checkword];Humans[checkword];Male[checkword]

CC: MUSKINJ

DOI: 10.1002/14651858.CD005465.pub3

AB: Background: Falls in care facilities and hospitals are common events that cause considerable morbidity and mortality for older people. This is an update of a review first

published in 2010.Objectives: To assess the effectiveness of interventions designed to reduce falls by older people in care facilities and hospitals.Search methods: We searched the Cochrane Bone, Joint and Muscle Trauma Group Specialised Register (March 2012); The Cochrane Library 2012, Issue 3; MEDLINE, EMBASE, and CINAHL (all to March 2012); ongoing trial registers (to August 2012), and reference lists of articles.Selection criteria: Randomised controlled trials of interventions to reduce falls in older people in residential or nursing care facilities or hospitals.Data collection and analysis: Two review authors independently assessed risk of bias and extracted data. We used a rate ratio (RaR) and 95% confidence interval (CI) to compare the rate of falls (e.g. falls per person year) between intervention and control groups. For risk of falling we used a risk ratio (RR) and 95% CI based on the number of people falling (fallers) in each group. We pooled results where appropriate.Main results: We included 60 trials (60,345 participants), 43 trials (30,373 participants) in care facilities, and 17 (29,972 participants) in hospitals.Results from 13 trials testing exercise interventions in care facilities were inconsistent. Overall, there was no difference between intervention and control groups in rate of falls (RaR 1.03, 95% CI 0.81 to 1.31; 8 trials, 1844 participants) or risk of falling (RR 1.07, 95% CI 0.94 to 1.23; 8 trials, 1887 participants). Post hoc subgroup analysis by level of care suggested that exercise might reduce falls in people in intermediate level facilities, and increase falls in facilities providing high levels of nursing care.In care facilities, vitamin D supplementation reduced the rate of falls (RaR 0.63, 95% CI 0.46 to 0.86; 5 trials, 4603 participants), but not risk of falling (RR 0.99, 95% CI 0.90 to 1.08; 6 trials, 5186 participants).For multifactorial interventions in care facilities, the rate of falls (RaR 0.78, 95% CI 0.59 to 1.04; 7 trials, 2876 participants) and risk of falling (RR 0.89, 95% CI 0.77 to 1.02; 7 trials, 2632 participants) suggested possible benefits, but this evidence was not conclusive.In subacute wards in hospital, additional physiotherapy (supervised exercises) did not significantly reduce rate of falls (RaR 0.54, 95% CI 0.16 to 1.81; 1 trial, 54 participants) but achieved a significant reduction in risk of falling (RR 0.36, 95% CI 0.14 to 0.93; 2 trials, 83 participants).In one trial in a subacute ward (54 participants), carpet flooring significantly increased the rate of falls compared with vinyl flooring (RaR 14.73, 95% CI 1.88 to 115.35) and potentially increased the risk of falling (RR 8.33, 95% CI 0.95 to 73.37).One trial (1822 participants) testing an educational session by a trained research nurse targeting individual fall risk factors in patients at high risk of falling in acute medical wards achieved a significant reduction in risk of falling (RR 0.29, 95% CI 0.11 to 0.74).Overall, multifactorial interventions in hospitals reduced the rate of falls (RaR 0.69, 95% CI 0.49 to 0.96; 4 trials, 6478 participants) and risk of falling (RR 0.71, 95% CI 0.46 to 1.09; 3 trials, 4824 participants), although the evidence for risk of falling was inconclusive. Of these, one trial in a subacute setting reported the effect was not apparent until after 45 days in hospital. Multidisciplinary care in a geriatric ward after hip fracture surgery compared with usual care in an orthopaedic ward significantly reduced rate of falls (RaR 0.38, 95% CI 0.19 to 0.74; 1 trial, 199 participants) and risk of falling (RR 0.41, 95% CI 0.20 to 0.83). More trials are needed to confirm the effectiveness of multifactorial interventions in acute and subacute hospital settings.Authors' conclusions: In care facilities, vitamin D supplementation is effective in reducing the rate of falls. Exercise in subacute hospital settings appears effective but its effectiveness in care facilities remains uncertain due to conflicting results, possibly associated with differences in interventions and levels of dependency. There is evidence that multifactorial interventions reduce falls in hospitals but the evidence for risk of

falling was inconclusive. Evidence for multifactorial interventions in care facilities suggests possible benefits, but this was inconclusive.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD005465.pub3/abstract

Record #75 of 175

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 #76 of 175

ID: CD008413

AU: Tiamklang Thavatchai

AU: Sumanont Sermsak

AU: Foocharoen Thanit

AU: Laopaiboon Malinee

TI: Double-bundle versus single-bundle reconstruction for anterior cruciate ligament rupture in adults

SO: Cochrane Database of Systematic Reviews

YR: 2012

NO: 11

PB: John Wiley & Sons, Ltd

KY: Anterior Cruciate Ligament [injuries] [surgery];Anterior Cruciate Ligament Reconstruction [methods];Knee Joint;Pain, Postoperative [etiology];Randomized Controlled Trials as Topic;Rupture [surgery];Adult[checkword];Humans[checkword]

CC: MUSKINJ

DOI: 10.1002/14651858.CD008413.pub2

AB: Background: Arthroscopic reconstruction for anterior cruciate ligament rupture is a common orthopaedic procedure. One area of controversy is whether the method of double-bundle reconstruction, which represents the 'more anatomical' approach, gives improved outcomes compared with the more traditional single-bundle reconstruction.Objectives: To assess the effects of double-bundle versus single-bundle for anterior cruciate ligament reconstruction in adults with anterior cruciate ligament deficiency.Search methods: We searched the Cochrane Bone, Joint and Muscle Trauma Group Specialised Register (to February 2012), the Cochrane Central Register of Controlled Trials (CENTRAL) (The Cochrane Library 2012, Issue 2), MEDLINE (1966 to February week 3 2012) and EMBASE (1980 to 2012 Week 8). We also searched trial registers, conference proceedings, and contacted authors where necessary.Selection criteria: Randomised and quasi-randomised controlled clinical trials comparing double-bundle versus single-bundle reconstruction for anterior cruciate ligament (ACL) rupture in adults.Data collection and analysis: Two review authors independently selected articles, assessed risk of bias and extracted data. We contacted investigators to obtain missing information. Where appropriate, results of comparable studies were pooled.Main results: Seventeen trials were included. These involved 1433 people, mostly young physically active adults. All included trials had methodological weaknesses and were at risk of bias, notably selection bias from inadequate or lack of allocation concealment. Data for pooling individual outcomes were available for a maximum of nine trials and 54% of participants.There were no statistically or clinically significant differences between double-bundle and single-bundle reconstruction in the subjective functional knee scores (subjective IKDC score, Tegner activity score, Lysholm score) in the intermediate (six months up to two years since surgery) or long term (two to five years from surgery). For example, the long term results for the Lysholm score (0 to 100: best score) were: mean difference (MD) 0.12, 95% confidence interval (CI) -1.50 to 1.75; 5 trials, 263 participants). The only trial reporting on long term knee pain found no statistically significant differences between the two groups. There were no significant differences between the two groups in adverse effects and complications (e.g. infection reported by nine trials (7/285 versus 7/393; risk ratio (RR) 1.14, 95% CI 0.46 to 2.81); graft failure reported by six trials (1/169 versus 4/185; RR 0.45; 95% CI 0.07 to 2.90).Limited data from five trials found a better return to pre-injury level of activity after double-bundle reconstruction (147/162 versus 208/255; RR 1.15, 95% CI 1.07 to 1.25). At long term follow-up, there were statistically significant differences in favour of double-bundle reconstruction for IKDC knee examination (normal or nearly normal categories: 325/344 versus 386/429; RR 1.05, 95% CI 1.01 to 1.08; 9 trials), knee stability measured with KT-1000 arthrometer (MD -0.74 mm, 95% CI -1.10 to -0.37; 5 trials, 363 participants) and rotational knee stability tested by the pivot-shift test (normal or nearly normal categories: 293/298 versus 382/415; RR 1.06, 95% CI

1.02 to 1.09; 9 trials). There were also statistically significant differences in favour of double-bundle reconstruction for newly occurring meniscal injury (9/240 versus 24/358; RR 0.46, 95% CI 0.23 to 0.92; 6 trials) and traumatic ACL rupture (1/120 versus 8/149; RR 0.17, 95% CI 0.03 to 0.96; 3 trials). There were no statistically significant differences found between the two groups in range of motion (flexion and extension) deficits.Authors' conclusions: There is insufficient evidence to determine the relative effectiveness of double-bundle and single-bundle reconstruction for anterior cruciate ligament rupture in adults, although there is limited evidence that double-bundle ACL reconstruction has some superior results in objective measurements of knee stability and protection against repeat ACL rupture or a new meniscal injury. High quality, large and appropriately reported randomised controlled trials of double-bundle versus single-bundle reconstruction for anterior cruciate ligament rupture in adults appear justified.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD008413.pub2/abstract

Record #77 of 175

ID: CD010195

AU: Farzi Sylvia

AU: Mahla Elisabeth

AU: Metzler Helfried

AU: Berghold Andrea

TI: The effect of preoperative treatment of P2Y12 receptor antagonists on perioperative bleeding and mortality in patients treated with coronary artery bypass grafting (CABG)

SO: Cochrane Database of Systematic Reviews

YR: 2012

NO: 11

PB: John Wiley & Sons, Ltd

CC: HM-ANAESTH

DOI: 10.1002/14651858.CD010195

AB: This is the protocol for a review and there is no abstract. The objectives are as follows:The primary objective of this review is to assess the effect of P2Y12 receptor inhibitor therapy, administered within the recommended specific preoperative withdrawal period (five days for clopidogrel and ticagrelor, seven days for prasugrel) on in-hospital and 30-day all-cause mortality and perioperative bleeding in CABG patients.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010195/abstract

Record #78 of 175

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 #79 of 175

ID: CD004770

AU: Candy Bridget

AU: Jackson Kenneth C

AU: Jones Louise

AU: Leurent Baptiste

AU: Tookman Adrian

AU: King Michael

TI: Drug therapy for delirium in terminally ill adult patients

SO: Cochrane Database of Systematic Reviews

YR: 2012

NO: 11

PB: John Wiley & Sons, Ltd

KY: Antipsychotic Agents [therapeutic use];Chlorpromazine [therapeutic use];Delirium [drug therapy] [etiology];Haloperidol [therapeutic use];Lorazepam [therapeutic use];Randomized Controlled Trials as Topic;Terminally Ill [psychology];Adult[checkword];Humans[checkword]

CC: SYMPT

DOI: 10.1002/14651858.CD004770.pub2

AB: Background: Delirium is a syndrome characterised by a disturbance of consciousness (often fluctuating), cognition and perception. In terminally ill patients it is one of the most common causes of admission to clinical care. Delirium may arise from any number of causes and treatment should be directed at addressing these causes rather than the symptom cluster. In cases where this is not possible, or treatment does not prove successful, the use of drug therapy to manage the symptoms may become necessary. This is an update of the review published on 'Drug therapy for delirium in terminally ill adult patients' in The Cochrane Library 2004, Issue 2 (Jackson 2004).Objectives: To evaluate the effectiveness of drug therapies to treat delirium in adult patients in the terminal phase of a disease.Search methods: We searched the following sources: CENTRAL (The Cochrane Library 2012, Issue 7), MEDLINE (1966 to 2012), EMBASE (1980 to 2012), CINAHL (1982 to 2012) and PSYCINFO (1990 to 2012).Selection criteria: Prospective trials with or without randomisation or blinding involving the use of drug therapies for the treatment of delirium in adult patients in the terminal phase of a disease.Data collection and analysis: Two authors independently assessed trial quality using standardised methods and extracted trial data. We collected outcomes related to efficacy and adverse effects.Main results: One trial met the criteria for inclusion. In the 2012 update search we retrieved 3066 citations but identified no new trials. The included trial evaluated 30 hospitalised AIDS patients receiving one of three agents: chlorpromazine, haloperidol and lorazepam. The trial under-reported key methodological features. It found overall that patients in the chlorpromazine group and those in the haloperidol group had fewer symptoms of delirium at follow-up (to below the diagnostic threshold using the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) and that both were equally effective (at two days mean difference (MD) 0.37; 95% confidence interval (CI) -4.58 to 5.32; between two and six days MD -0.21; 95% CI -5.35 to 4.93). Chlorpromazine and haloperidol were found to be no different in improving cognitive status in the short term (at 48 hours) but at subsequent follow-up cognitive status was reduced in those taking chlorpromazine. Improvements from baseline to day two for patients randomised to lorazepam were not apparent. All patients on lorazepam (n = 6) developed adverse effects, including oversedation and increased confusion, leading to trial drug discontinuation.Authors' conclusions: There remains insufficient evidence to draw conclusions about the role of drug therapy in the treatment of delirium in terminally ill patients. Thus, practitioners should continue to follow current clinical guidelines. Further research is essential.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004770.pub2/abstract

Record #80 of 175

ID: CD010166

AU: McLaren Lindsay

AU: Sumar Nureen

AU: Lorenzetti Diane L

AU: Campbell Norman RC

AU: McIntyre Lynn

AU: Tarasuk Valerie

TI: Population-level interventions in government jurisdictions for dietary sodium reduction

SO: Cochrane Database of Systematic Reviews

YR: 2012

NO: 10

PB: John Wiley & Sons, Ltd

CC: PUBHLTH

DOI: 10.1002/14651858.CD010166

AB: This is the protocol for a review and there is no abstract. The objectives are as follows:To assess the impact of population-level interventions for dietary sodium reduction in government jurisdictions worldwide (including high-, middle-, and low-income countries), as well as the differential impact, by social and economic indicators, of these interventions.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010166/abstract

Record #81 of 175

ID: CD009132

AU: Russ Tom C

AU: Morling Joanne R

TI: Cholinesterase inhibitors for mild cognitive impairment

SO: Cochrane Database of Systematic Reviews

YR: 2012

NO: 9

PB: John Wiley & Sons, Ltd

KY: Cholinesterase Inhibitors [adverse effects] [therapeutic use];Dementia [etiology];Diarrhea [chemically induced];Disease Progression;Mild Cognitive Impairment [drug therapy];Nausea [chemically induced];Randomized Controlled Trials as Topic;Vomiting [chemically induced];Humans[checkword]

CC: HM-DEMENTIA

DOI: 10.1002/14651858.CD009132.pub2

AB: Background: Mild cognitive impairment is hypothesised to represent a pre-clinical stage of dementia but forms a heterogeneous group with variable prognosis.Objectives: To assess the safety and efficacy of cholinesterase inhibitors in people with mild cognitive impairment.Search methods: Trials were identified from the Cochrane Dementia and Cognitive Improvement Group's Specialised Register, which is frequently updated from the major healthcare databases (MEDLINE, EMBASE, CINAHL, PsycINFO and Lilacs) as well as trial registers and grey literature.Selection criteria: Double-blind, placebo-controlled randomised trials of any cholinesterase inhibitor in people with mild cognitive impairment.Data collection and analysis: Data were extracted from the published reports of the included studies, combined by meta-analysis where appropriate, and treatment efficacy and risk of adverse events were estimated.Main results: Nine studies (from eight published reports) of 5149 individuals with mild cognitive impairment (however defined) were included in the review. Limited pooling of results was possible owing to different lengths of trials. Meta-analysis of the three studies reporting conversion to dementia gives no strong evidence of a beneficial effect of cholinesterase inhibitors on the progression to dementia at one, two or three years. The risk ratio (RR) for conversion at two years was significantly different from unity (0.67; 95% confidence interval (CI) 0.55 to 0.83), but this is based on only two studies reported in the same article. There was essentially no effect of cholinesterase inhibitors on cognitive test scores.Based on the results from 4207 individuals, there were significantly more adverse events in the cholinesterase inhibitor groups (RR 1.09; 95% CI 1.02 to 1.16), but no more serious adverse events or deaths. Gastrointestinal side effects were much more common (diarrhoea: RR 2.10; 95% CI 1.30 to 3.39; nausea: RR 2.97; 95% CI 2.57 to 3.42; vomiting: RR 4.42; 95% CI 3.23 to 6.05). Cardiac problems were no more likely in either group (RR 0.71; 95% CI 0.25 to 2.02). Other side effects reported significantly more often in the cholinesterase inhibitor group were muscle spasms/leg cramps (RR 7.52; 95% CI 4.34 to 13.02), headache (RR 1.34; 95% CI 1.05 to 1.71), syncope or dizziness (RR 1.62; 95% CI 1.36 to 1.93), insomnia (RR 1.66; 95% CI 1.36 to 2.02) and abnormal dreams (RR 4.25; 95% CI 2.57 to 7.04).Authors' conclusions: There is very little evidence that cholinesterase inhibitors affect progression to dementia or cognitive test scores in mild cognitive impairment. This weak evidence is

overwhelmed by the increased risk of adverse events, particularly gastrointestinal. Cholinesterase inhibitors should not be recommended for mild cognitive impairment.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD009132.pub2/abstract

Record #82 of 175

ID: CD007146

AU: Gillespie Lesley D

AU: Robertson M Clare

AU: Gillespie William J

AU: Sherrington Catherine

AU: Gates Simon

AU: Clemson Lindy M

AU: Lamb Sarah E

TI: Interventions for preventing falls in older people living in the community

SO: Cochrane Database of Systematic Reviews

YR: 2012

NO: 9

PB: John Wiley & Sons, Ltd

KY: Accidental Falls [prevention & control];Accidents, Home [prevention & control];Bone Density Conservation Agents [administration & dosage];Environment Design;Exercise;Independent Living [injuries];Patient Education as Topic;Randomized Controlled Trials as Topic;Tai Ji;Vitamin D [administration & dosage];Aged[checkword];Female[checkword];Humans[checkword];Male[checkword]

CC: MUSKINJ

DOI: 10.1002/14651858.CD007146.pub3

AB: Background: Approximately 30% of people over 65 years of age living in the community fall each year. This is an update of a Cochrane review first published in 2009.Objectives: To assess the effects of interventions designed to reduce the incidence of falls in older people living in the community.Search methods: We searched the Cochrane Bone, Joint and Muscle Trauma Group Specialised Register (February 2012), CENTRAL (The Cochrane Library 2012, Issue 3),

MEDLINE (1946 to March 2012), EMBASE (1947 to March 2012), CINAHL (1982 to February 2012), and online trial registers.Selection criteria: Randomised trials of interventions to reduce falls in community-dwelling older people.Data collection and analysis: Two review authors independently assessed risk of bias and extracted data. We used a rate ratio (RaR) and 95% confidence interval (CI) to compare the rate of falls (e.g. falls per person year) between intervention and control groups. For risk of falling, we used a risk ratio (RR) and 95% CI based on the number of people falling (fallers) in each group. We pooled data where appropriate.Main results: We included 159 trials with 79,193 participants. Most trials compared a fall prevention intervention with no intervention or an intervention not expected to reduce falls. The most common interventions tested were exercise as a single intervention (59 trials) and multifactorial programmes (40 trials). Sixty-two per cent (99/159) of trials were at low risk of bias for sequence generation, 60% for attrition bias for falls (66/110), 73% for attrition bias for fallers (96/131), and only 38% (60/159) for allocation concealment.Multiple-component group exercise significantly reduced rate of falls (RaR 0.71, 95% CI 0.63 to 0.82; 16 trials; 3622 participants) and risk of falling (RR 0.85, 95% CI 0.76 to 0.96; 22 trials; 5333 participants), as did multiple-component home-based exercise (RaR 0.68, 95% CI 0.58 to 0.80; 7 trials; 951 participants and RR 0.78, 95% CI 0.64 to 0.94; 6 trials; 714 participants). For Tai Chi, the reduction in rate of falls bordered on statistical significance (RaR 0.72, 95% CI 0.52 to 1.00; 5 trials; 1563 participants) but Tai Chi did significantly reduce risk of falling (RR 0.71, 95% CI 0.57 to 0.87; 6 trials; 1625 participants). Overall, exercise interventions significantly reduced the risk of sustaining a fall-related fracture (RR 0.34, 95% CI 0.18 to 0.63; 6 trials; 810 participants).Multifactorial interventions, which include individual risk assessment, reduced rate of falls (RaR 0.76, 95% CI 0.67 to 0.86; 19 trials; 9503 participants), but not risk of falling (RR 0.93, 95% CI 0.86 to 1.02; 34 trials; 13,617 participants).Overall, vitamin D did not reduce rate of falls (RaR 1.00, 95% CI 0.90 to 1.11; 7 trials; 9324 participants) or risk of falling (RR 0.96, 95% CI 0.89 to 1.03; 13 trials; 26,747 participants), but may do so in people with lower vitamin D levels before treatment.Home safety assessment and modification interventions were effective in reducing rate of falls (RaR 0.81, 95% CI 0.68 to 0.97; 6 trials; 4208 participants) and risk of falling (RR 0.88, 95% CI 0.80 to 0.96; 7 trials; 4051 participants). These interventions were more effective in people at higher risk of falling, including those with severe visual impairment. Home safety interventions appear to be more effective when delivered by an occupational therapist.An intervention to treat vision problems (616 participants) resulted in a significant increase in the rate of falls (RaR 1.57, 95% CI 1.19 to 2.06) and risk of falling (RR 1.54, 95% CI 1.24 to 1.91). When regular wearers of multifocal glasses (597 participants) were given single lens glasses, all falls and outside falls were significantly reduced in the subgroup that regularly took part in outside activities. Conversely, there was a significant increase in outside falls in intervention group participants who took part in little outside activity.Pacemakers reduced rate of falls in people with carotid sinus hypersensitivity (RaR 0.73, 95% CI 0.57 to 0.93; 3 trials; 349 participants) but not risk of falling. First eye cataract surgery in women reduced rate of falls (RaR 0.66, 95% CI 0.45 to 0.95; 1 trial; 306 participants), but second eye cataract surgery did not.Gradual withdrawal of psychotropic medication reduced rate of falls (RaR 0.34, 95% CI 0.16 to 0.73; 1 trial; 93 participants), but not risk of falling. A prescribing modification programme for primary care physicians significantly reduced risk of falling (RR 0.61, 95% CI 0.41 to 0.91; 1 trial; 659 participants).An anti-slip shoe device reduced rate of falls in icy conditions (RaR 0.42, 95% CI 0.22 to 0.78; 1 trial; 109 participants).

One trial (305 participants) comparing multifaceted podiatry including foot and ankle exercises with standard podiatry in people with disabling foot pain significantly reduced the rate of falls (RaR 0.64, 95% CI 0.45 to 0.91) but not the risk of falling.There is no evidence of effect for cognitive behavioural interventions on rate of falls (RaR 1.00, 95% CI 0.37 to 2.72; 1 trial; 120 participants) or risk of falling (RR 1.11, 95% CI 0.80 to 1.54; 2 trials; 350 participants).Trials testing interventions to increase knowledge/educate about fall prevention alone did not significantly reduce the rate of falls (RaR 0.33, 95% CI 0.09 to 1.20; 1 trial; 45 participants) or risk of falling (RR 0.88, 95% CI 0.75 to 1.03; 4 trials; 2555 participants).Thirteen trials provided a comprehensive economic evaluation. Three of these indicated cost savings for their interventions during the trial period: home-based exercise in over 80-year-olds, home safety assessment and modification in those with a previous fall, and one multifactorial programme targeting eight specific risk factors.Authors' conclusions: Group and home-based exercise programmes, and home safety interventions reduce rate of falls and risk of falling.Multifactorial assessment and intervention programmes reduce rate of falls but not risk of falling; Tai Chi reduces risk of falling.Overall, vitamin D supplementation does not appear to reduce falls but may be effective in people who have lower vitamin D levels before treatment.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007146.pub3/abstract

Record #83 of 175

ID: CD010123

AU: Gera Tarun

AU: Shah Dheeraj

AU: Garner Paul

AU: Sachdev Harshpal S

TI: Integrated Management of Childhood Illness (IMCI) Strategy for children under five: effects on death, service utilisation and illness

SO: Cochrane Database of Systematic Reviews

YR: 2012

NO: 9

PB: John Wiley & Sons, Ltd

CC: HM-EPOC

DOI: 10.1002/14651858.CD010123

AB: This is the protocol for a review and there is no abstract. The objectives are as follows:To evaluate the effects of programmes that implement the Integrated Management of Childhood Illnesses (IMCI) strategy on death, service utilisation, quality of case management, and illness in children below the age of five years.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010123/abstract

Record #84 of 175

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 #85 of 175

ID: CD010006

AU: Papageorgiou Alexia

AU: Loke Yoon

AU: Deane Katherine HO

AU: Fromage Michelle

TI: Communication skills training for mental health professionals working with people with severe mental illness

SO: Cochrane Database of Systematic Reviews

YR: 2012

NO: 8

PB: John Wiley & Sons, Ltd

CC: HM-SCHIZ

DOI: 10.1002/14651858.CD010006

AB: This is the protocol for a review and there is no abstract. The objectives are as follows:To review the effectiveness of communication skills training for mental health professionals who work with people with severe mental illness.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010006/abstract

Record #86 of 175

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 #87 of 175

ID: CD008000

AU: Wang Han

AU: Song Hongxian

AU: Yue Jirong

AU: Li Jun

AU: Hou Yan Bin

AU: Deng Jue Lin

TI: Rheum officinale (a traditional Chinese medicine) for chronic kidney disease

SO: Cochrane Database of Systematic Reviews

YR: 2012

NO: 7

PB: John Wiley & Sons, Ltd

KY: Angiotensin-Converting Enzyme Inhibitors [therapeutic use];Captopril [therapeutic use];Disease Progression;Kidney Failure, Chronic [drug therapy];Medicine, Chinese Traditional;Phytotherapy [adverse effects] [methods];Rheum [adverse effects] [chemistry];Humans[checkword]

CC: RENAL

DOI: 10.1002/14651858.CD008000.pub2

AB: Background: Chronic kidney disease (CKD) is a major public health issue worldwide. Standard therapies to delay CKD progression include dietary protein restriction and administration of angiotensin-converting enzyme inhibitors (ACEi) and angiotensin receptor blockers (ARB) to help control blood pressure and confer additional renoprotective effects. Despite such interventions, CKD incidence and mortality rates continue to increase. Rheum officinale (Da Huang) a medicinal herb used widely in China to treat CKD has been reported to offer a range of pharmacological properties that may delay disease progression.Objectives: To assess the benefits and harms of Rheum officinale for preventing the progression of CKD.Search methods: We searched the Cochrane Renal Group's Specialised Register and CENTRAL (Issue 4, 2011), MEDLINE, EMBASE, the Chinese Biomedicine Database (CBM), China National Knowledge Infrastructure (CNKI), VIP (Chongqing VIP Chinese Science and Technology Periodical Database), and Wanfang Data. We also handsearched reference lists of articles. We applied no restrictions on language of publication.Selection criteria: We included randomised controlled trials (RCTs) and quasi-RCTs that assessed the benefits and harms of Rheum officinale for preventing the progression of CKD regardless of dosage, type, maturity, mode of administration, duration of treatment, or storage time before use.Data collection and analysis: Two authors independently screened titles and abstracts for eligibility, assessed study quality, and extracted data. We expressed results for dichotomous outcomes (need for renal replacement therapy, all-cause mortality, quality of life) as risk ratios (RR) with 95% confidence intervals (CI). Continuous outcomes (glomerular filtration rate (GFR), serum creatinine (SCr), creatinine clearance (CrCl), blood urea nitrogen (BUN)) were expressed as mean differences

(MD) with 95% CIs.Main results: We identified nine studies that enrolled 682 participants. None of the studies reported blinding or group allocation methods. Seven studies were judged to be at low risk of incomplete outcome reporting; three studies were judged to be a low risk of selective reporting (protocols were available and/or all outcomes relevant to the this review were reported); and two studies were judged free of other potential biases.Seven studies compared Rheum officinale with no treatment and two made comparisons with captopril, an angiotensin-converting enzyme inhibitor (ACEi). Compared with no treatment, Rheum officinale had a positive effect on SCr (MD -87.49 µmol/L, 95% CI -139.25 to -35.72) and BUN (MD -10.61 mmol/L, 95% CI -19.45 to -2.21). Compared with captopril, a statistically significant difference was not demonstrated in relation to Rheum officinale for any outcome (BUN, CrCl, or patients' capacity to undertake work). No data were available on all-cause mortality or cost of treatment. Only minor adverse events were reported in association with Rheum officinale.Authors' conclusions: Currently available evidence concerning the efficacy of Rheum officinale to improve SCr and BUN levels in patients with CKD is both scant and low quality. Although Rheum officinale does not appear to be associated with serious adverse events among patients with CKD, there is no current evidence to support any recommendation for its use.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD008000.pub2/abstract

Record #88 of 175

ID: CD009986

AU: Alarcon Jose D

AU: Rubiano Andres M

AU: Okonkwo David O

AU: Urrútia Gerard

AU: Bonfill Cosp Xavier

TI: Elevation of the head during intensive care management in patients with severe traumatic brain injury

SO: Cochrane Database of Systematic Reviews

YR: 2012

NO: 7

PB: John Wiley & Sons, Ltd

CC: HM-INJ

DOI: 10.1002/14651858.CD009986

AB: This is the protocol for a review and there is no abstract. The objectives are as follows:To assess the clinical effects of head elevation during intensive care management in patients with severe traumatic brain injury.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD009986/abstract

Record #89 of 175

ID: CD004143

AU: Marjoribanks Jane

AU: Farquhar Cindy

AU: Roberts Helen

AU: Lethaby Anne

TI: Long term hormone therapy for perimenopausal and postmenopausal women

SO: Cochrane Database of Systematic Reviews

YR: 2012

NO: 7

PB: John Wiley & Sons, Ltd

KY: Perimenopause;Postmenopause;Cardiovascular Diseases [chemically induced] [mortality];Estrogen Replacement Therapy [adverse effects] [methods];Estrogens [adverse effects] [therapeutic use];Hot Flashes [drug therapy];Neoplasms [chemically induced] [mortality];Progesterone [adverse effects] [therapeutic use];Randomized Controlled Trials as Topic;Venous Thromboembolism [chemically induced];Adult[checkword];Aged[checkword];Female[checkword];Humans[checkword];Middle Aged[checkword]

CC: MENSTR

DOI: 10.1002/14651858.CD004143.pub4

AB: Background: Hormone therapy (HT) is widely used for controlling menopausal symptoms and has also been used for the management and prevention of cardiovascular disease, osteoporosis and dementia in older women. This is an updated version of a Cochrane review first published in 2005.Objectives: To assess the effects of long term HT on mortality, cardiovascular outcomes, cancer, gallbladder disease, fractures, cognition and quality of life in perimenopausal and postmenopausal women, both during HT use and after cessation of HT

use.Search methods: We searched the following databases to February 2012: Cochrane Menstrual Disorders and Subfertility Group Trials Register, Cochrane Central Register of Controlled Trials (CENTRAL), MEDLINE, EMBASE, PsycINFO.Selection criteria: We included randomised double-blind studies of HT versus placebo, taken for at least one year by perimenopausal or postmenopausal women. HT included oestrogens, with or without progestogens, via oral, transdermal, subcutaneous or intranasal routes.Data collection and analysis: Two authors independently assessed study quality and extracted data. We calculated risk ratios (RRS) for dichotomous data and mean differences (MDs) for continuous data, with 95% confidence intervals (CIs). Where findings were statistically significant, we calculated the absolute risk (AR) in the intervention group (the overall risk of an event in women taking HT).Main results: Twenty-three studies involving 42,830 women were included. Seventy per cent of the data were derived from two studies (WHI 1998 and HERS 1998). Most participants were postmenopausal American women with at least some degree of co-morbidity, and the mean participant age in most studies was over 60 years. None of the studies focused on perimenopausal women. In relatively healthy postmenopausal women (that is generally fit, without overt disease) combined continuous HT significantly increased the risk of a coronary event (after one year's use: AR 4 per 1000, 95% CI 3 to 7), venous thrombo-embolism (after one year's use: AR 7 per 1000, 95% CI 4 to 11), stroke (after three years' use: AR 18 per 1000, 95% CI 14 to 23), breast cancer (after 5.6 years' use: AR 23 per 1000, 95% CI 19 to 29), gallbladder disease (after 5.6 years' use: AR 27 per 1000, 95% CI 21 to 34) and death from lung cancer (after 5.6 years' use plus 2.4 years' additional follow-up: AR 9 per 1000, 95% CI 6 to 13). Oestrogen-only HT significantly increased the risk of venous thrombo-embolism (after one to two years' use: AR 5 per 1000, 95% CI 2 to 10; after 7 years' use: AR 21 per 1000, 95% CI 16 to 28), stroke (after 7 years' use: AR 32 per 1000, 95% CI 25 to 40) and gallbladder disease (after seven years' use: AR 45 per 1000, 95% CI 36 to 57) but did not significantly increase the risk of breast cancer. Among women aged over 65 years who were relatively healthy and taking continuous combined HT, there was a statistically significant increase in the incidence of dementia (after 4 years' use: AR 18 per 1000, 95% CI 11 to 30). Among women with cardiovascular disease, long term use of combined continuous HT significantly increased the risk of venous thrombo-embolism (at one year: AR 9 per 1000, 95% CI 3 to 29). Women taking HT had a significantly decreased incidence of fractures with long term use (after 5.6 years of combined HT: AR 86 per 1000, 95% CI 79 to 84; after 7.1 years' use of oestrogen-only HT: AR 102 per 1000, 95% CI 91 to 112). Risk of fracture was the only outcome for which there was strong evidence of clinical benefit from HT. There was no strong evidence that HT has a clinically meaningful impact on the incidence of colorectal cancer.One trial analysed subgroups of 2839 relatively healthy 50 to 59 year old women taking combined continuous HT and 1637 taking oestrogen-only HT versus similar-sized placebo groups. The only significantly increased risk reported was for venous thrombo-embolism in women taking combined continuous HT: their absolute risk remained low, at less than 1/500. However, other differences in risk cannot be excluded as this study was not designed to have the power to detect differences between groups of women within 10 years of the menopause.Authors' conclusions: HT is not indicated for primary or secondary prevention of cardiovascular disease or dementia, nor for preventing deterioration of cognitive function in postmenopausal women. Although HT is considered effective for the prevention of postmenopausal osteoporosis, it is generally recommended as an option only for women at significant risk, for whom non-oestrogen therapies are unsuitable.

There are insufficient data to assess the risk of long term HT use in perimenopausal women or postmenopausal women younger than 50 years of age.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004143.pub4/abstract

Record #90 of 175

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 #91 of 175

ID: CD007731

AU: Jin Xingzhong

AU: Ruiz Beguerie Julieta

AU: Sze Daniel Man-yeun

AU: Chan Godfrey CF

TI: Ganoderma lucidum (Reishi mushroom) for cancer treatment

SO: Cochrane Database of Systematic Reviews

YR: 2012

NO: 6

PB: John Wiley & Sons, Ltd

KY: Antineoplastic Agents [immunology] [therapeutic use];Immunity, Cellular [immunology];Neoplasms [drug therapy] [immunology] [therapy];Randomized Controlled Trials as Topic;Reishi [chemistry];Humans[checkword]

CC: GYNAECA

DOI: 10.1002/14651858.CD007731.pub2

AB: Background: Ganoderma lucidum is a natural medicine that is widely used and recommended by Asian physicians and naturopaths for its supporting effects on immune system. Laboratory research and a handful of preclinical trials have suggested that G. lucidum carries promising anticancer and immunomodulatory properties. The popularity of taking G. lucidum as an alternative medicine has been increasing in cancer patients. However, there is no systematic review that has been conducted to evaluate the actual benefits of G. lucidum in cancer treatment.Objectives: To evaluate the clinical effects of G. lucidum on long-term survival, tumour response, host immune functions and quality of life in cancer patients, as well as adverse events associated with its use.Search methods: The authors ran an extensive set of databases including the Cochrane Central Register of Controlled Trials (CENTRAL), MEDLINE, EMBASE, NIH, AMED, CBM, CNKI, CMCC and VIP Information/Chinese Scientific Journals Database was searched for randomised controlled trials (RCTs) in October 2011. Other strategies used were scanning the references of articles retrieved, handsearching of the International Journal of Medicinal Mushrooms and contact with herbal medicine experts and manufacturers of G. lucidum.Selection criteria: To be eligible for being included in this review, studies had to be RCTs comparing the efficacy of G. lucidum medications to active or placebo control in patients with cancer that had been diagnosed by pathology. All types and stages of cancer were eligible for inclusion. Trials were not restricted on the basis of language.Data collection and analysis: Five RCTs met the inclusion criteria and were included in this review. Two independent review authors were assigned to assess the methodological quality of individual trials. Common primary outcomes were tumour response evaluated according to the World Health Organization (WHO) criteria, immune function parameters such as natural killer (NK)-cell activity and T-lymphocyte co-receptor subsets, and quality of life measured by the Karnofsky scale score. No trial had recorded long-term survival rates. Associated adverse events were reported in one study. A meta-analysis was performed to pool available data from the primary trials. Results were gauged using relative risks (RR) and standard mean differences

(SMD) for dichotomous and continuous data respectively, with a 95% confidence interval (CI).Main results: The methodological quality of primary studies was generally unsatisfying and the results were reported inadequately in many aspects. Additional information was not available from primary trialists. The meta-analysis results showed that patients who had been given G. lucidum alongside with chemo/radiotherapy were more likely to respond positively compared to chemo/radiotherapy alone (RR 1.50; 95% CI 0.90 to 2.51, P = 0.02). G. lucidum treatment alone did not demonstrate the same regression rate as that seen in combined therapy. The results for host immune function indicators suggested that G. lucidum simultaneously increases the percentage of CD3, CD4 and CD8 by 3.91% (95% CI 1.92% to 5.90%, P < 0.01), 3.05% (95% CI 1.00% to 5.11%, P < 0.01) and 2.02% (95% CI 0.21% to 3.84%, P = 0.03), respectively. In addition, leukocyte, NK-cell activity and CD4/CD8 ratio were marginally elevated. Four studies showed that patients in the G. lucidum group had relatively improved quality of life in comparison to controls. One study recorded minimal side effects, including nausea and insomnia. No significant haematological or hepatological toxicity was reported.Authors' conclusions: Our review did not find sufficient evidence to justify the use of G. lucidum as a first-line treatment for cancer. It remains uncertain whether G. lucidum helps prolong long-term cancer survival. However, G. lucidum could be administered as an alternative adjunct to conventional treatment in consideration of its potential of enhancing tumour response and stimulating host immunity. G. lucidum was generally well tolerated by most participants with only a scattered number of minor adverse events. No major toxicity was observed across the studies. Although there were few reports of harmful effect of G. lucidum, the use of its extract should be judicious, especially after thorough consideration of cost-benefit and patient preference. Future studies should put emphasis on the improvement in methodological quality and further clinical research on the effect of G. lucidum on cancer long-term survival are needed. An update to this review will be performed every two years.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007731.pub2/abstract

Record #92 of 175

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 #93 of 175

ID: CD005005

AU: Bennett Michael H

AU: Feldmeier John

AU: Hampson Neil

AU: Smee Robert

AU: Milross Christopher

TI: Hyperbaric oxygen therapy for late radiation tissue injury

SO: Cochrane Database of Systematic Reviews

YR: 2012

NO: 5

PB: John Wiley & Sons, Ltd

KY: Anus Neoplasms [radiotherapy];Head and Neck Neoplasms [radiotherapy];Hyperbaric Oxygenation [methods];Neoplasms [radiotherapy];Osteoradionecrosis [prevention & control];Radiation Injuries [prevention & control] [therapy];Randomized Controlled Trials as Topic;Rectal Neoplasms [radiotherapy];Humans[checkword]

CC: HM-GYNAECA

DOI: 10.1002/14651858.CD005005.pub3

AB: Background: Cancer is a significant global health problem. Radiotherapy is a treatment for many cancers and about 50% of patients having radiotherapy with be long-term survivors.

Some will experience late radiation tissue injury (LRTI) developing months or years later. Hyperbaric oxygen therapy (HBOT) has been suggested as a treatment for LRTI based upon the ability to improve the blood supply to these tissues. It is postulated that HBOT may result in both healing of tissues and the prevention of problems following surgery.Objectives: To assess the benefits and harms of HBOT for treating or preventing LRTI.Search methods: In March 2011 we updated the searches of the Cochrane Central Register of Controlled Trials (CENTRAL), (The Cochrane Library, Issue 1), MEDLINE, EMBASE, DORCTIHM and reference lists of articles.Selection criteria: Randomised controlled trials (RCTs) comparing the effect of HBOT versus no HBOT on LRTI prevention or healing.Data collection and analysis: Three review authors independently evaluated the quality of the relevant trials using the guidelines of the Cochrane Handbook for Systematic Reviews of Interventions and extracted the data from the included trials.Main results: Eleven trials contributed to this review (669 participants). For pooled analyses, investigation of heterogeneity suggested important variability between trials but there was some evidence that HBOT is more likely to achieve mucosal coverage with osteoradionecrosis (ORN) (risk ratio (RR) 1.3; 95% confidence interval (CI) 1.1 to 1.6, P = 0.003, number needed to treat for an additional beneficial outcome (NNTB) 5). From single studies there was a significantly increased chance of improvement or cure following HBOT for radiation proctitis (RR 1.72; 95% CI 1.0 to 2.9, P = 0.04, NNTB 5), and following both surgical flaps (RR 8.7; 95% CI 2.7 to 27.5, P = 0.0002, NNTB = 4) and hemimandibulectomy (RR 1.4; 95% CI 1.1 to 1.8, P = 0.001, NNTB 5). There was also a significantly improved probability of healing irradiated tooth sockets following dental extraction (RR 1.4; 95% CI 1.1 to 1.7, P = 0.009, NNTB 4).There was no evidence of benefit in clinical outcomes with established radiation injury to neural tissue, and no data reported on the use of HBOT to treat other manifestations of LRTI. These trials did not report adverse effects.Authors' conclusions: These small trials suggest that for people with LRTI affecting tissues of the head, neck, anus and rectum, HBOT is associated with improved outcome. HBOT also appears to reduce the chance of ORN following tooth extraction in an irradiated field. There was no such evidence of any important clinical effect on neurological tissues. The application of HBOT to selected patients and tissues may be justified. Further research is required to establish the optimum patient selection and timing of any therapy. An economic evaluation should be undertaken.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD005005.pub3/abstract

Record #94 of 175

ID: CD009486

AU: Corrigan Ruth

AU: Derry Sheena

AU: Wiffen Philip J

AU: Moore R Andrew

TI: Clonazepam for neuropathic pain and fibromyalgia in adults

SO: Cochrane Database of Systematic Reviews

YR: 2012

NO: 5

PB: John Wiley & Sons, Ltd

KY: Analgesics [therapeutic use];Anticonvulsants [therapeutic use];Clonazepam [therapeutic use];Fibromyalgia [drug therapy];Neuralgia [drug therapy];Pain Management [methods];Adult[checkword];Humans[checkword]

CC: SYMPT

DOI: 10.1002/14651858.CD009486.pub2

AB: Background: Antiepileptic drugs have been used in pain management since the 1960s; some have shown efficacy in treating different neuropathic pain conditions. Clonazepam, a benzodiazepine, is an established antiepileptic drug, but its place in the treatment of neuropathic pain is unclear.Objectives: To assess the analgesic efficacy and adverse effects of the antiepileptic drug clonazepam in neuropathic pain and fibromyalgia.Search methods: We searched the Cochrane Central Register of Controlled Trials (CENTRAL) (The Cochrane Library 2012, Issue 2). MEDLINE, and EMBASE to 28 February 2012, together with reference lists of retrieved papers and reviews, and ClinicalTrials.gov.Selection criteria: We planned to include randomised, double-blind studies of eight weeks duration or longer, comparing clonazepam with placebo or another active treatment in chronic neuropathic pain or fibromyalgia.Data collection and analysis: Two review authors would independently extract data for efficacy and adverse events, and examine issues of study quality.Main results: We did not identify any studies that satisfied the inclusion criteria.Authors' conclusions: This review uncovered no evidence of sufficient quality to support the use of clonazepam in chronic neuropathic pain or fibromyalgia.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD009486.pub2/abstract

Record #95 of 175

ID: CD009485

AU: Birse Fraser

AU: Derry Sheena

AU: Moore R Andrew

TI: Phenytoin for neuropathic pain and fibromyalgia in adults

SO: Cochrane Database of Systematic Reviews

YR: 2012

NO: 5

PB: John Wiley & Sons, Ltd

KY: Analgesics [therapeutic use];Anticonvulsants [therapeutic use];Fibromyalgia [drug therapy];Neuralgia [drug therapy];Pain Management [methods];Phenytoin [therapeutic use];Adult[checkword];Humans[checkword]

CC: SYMPT

DOI: 10.1002/14651858.CD009485.pub2

AB: Background: Antiepileptic drugs have been used in pain management since the 1960s; some have shown efficacy in treating different neuropathic pain conditions. Phenytoin is an established antiepileptic drug that has been used occasionally to treat intractable trigeminal neuralgia.Objectives: To assess the analgesic efficacy and adverse effects of the antiepileptic drug phenytoin in neuropathic pain and fibromyalgia.Search methods: We searched the Cochrane Central Register of Controlled Trials (CENTRAL) (The Cochrane Library 2012, Issue 2), MEDLINE, and EMBASE to 28 February 2012, together with reference lists of retrieved papers and reviews, and ClinicalTrials.gov.Selection criteria: We planned to include randomised, double-blind studies of eight weeks duration or longer, comparing phenytoin with placebo or another active treatment in chronic neuropathic pain or fibromyalgia.Data collection and analysis: Two review authors would independently extract data for efficacy and adverse events, and examine issues of study quality.Main results: We did not identify any studies that satisfied the inclusion criteria.Authors' conclusions: This review uncovered no evidence of sufficient quality to support the use of phenytoin in chronic neuropathic pain or fibromyalgia.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD009485.pub2/abstract

Record #96 of 175

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 #97 of 175

ID: CD005007

AU: Bennett Michael H

AU: Feldmeier John

AU: Smee Robert

AU: Milross Christopher

TI: Hyperbaric oxygenation for tumour sensitisation to radiotherapy

SO: Cochrane Database of Systematic Reviews

YR: 2012

NO: 4

PB: John Wiley & Sons, Ltd

KY: Radiation Tolerance;Bronchial Neoplasms [mortality] [radiotherapy];Combined Modality Therapy [methods];Esophageal Neoplasms [mortality] [radiotherapy];Head and Neck Neoplasms [mortality] [radiotherapy];Hyperbaric Oxygenation [adverse effects] [methods];Neoplasm Recurrence, Local [epidemiology];Neoplasms [mortality] [radiotherapy];Randomized Controlled Trials as Topic;Rectal Neoplasms [mortality] [radiotherapy];Time Factors;Urinary Bladder Neoplasms [mortality] [radiotherapy];Uterine Cervical Neoplasms [mortality] [radiotherapy];Female[checkword];Humans[checkword];Male[checkword]

CC: GYNAECA

DOI: 10.1002/14651858.CD005007.pub3

AB: Background: Cancer is a common disease and radiotherapy is one well-established treatment for some solid tumours. Hyperbaric oxygenation therapy (HBOT) may improve the ability of radiotherapy to kill hypoxic cancer cells, so the administration of radiotherapy while breathing hyperbaric oxygen may result in a reduction in mortality and recurrence.Objectives: To assess the benefits and harms of radiotherapy while breathing HBO.Search methods: In March 2011 we searched The Cochrane Central Register of Controlled Trials (CENTRAL), (The Cochrane Library, Issue 3), MEDLINE, EMBASE, DORCTHIM and reference lists of articles.Selection criteria: Randomised and quasi-randomised studies comparing the outcome of malignant tumours following radiation therapy while breathing HBO versus air.Data collection and analysis: Three review authors independently evaluated the quality of the relevant trials and extracted the data from the included trials.Main results: Nineteen trials contributed to this review (2286 patients: 1103 allocated to HBOT and 1153 to control). With HBOT, there was a reduction in mortality for head and neck cancers at both one year and five years after therapy (risk ratio (RR) 0.83, P = 0.03, number needed to treat (NNT) = 11; and RR 0.82, P = 0.03, NNT = 5 respectively), as well as improved local tumour control at three months (RR with HBOT 0.58, P = 0.006, NNT = 7). The effect of HBOT varied with different fractionation schemes. Local tumour recurrence was less likely with HBOT at one year (head and neck: RR 0.66, P < 0.0001, NNT = 5), two years (uterine cervix: RR 0.60, P = 0.04, NNT = 5) and five years (head and neck: (RR 0.77, P = 0.01, NNT = 6). Any advantage is achieved at the cost of some adverse effects. There was a significant increase in the rate of both severe radiation tissue injury (RR 2.35, P < 0.0001, (number needed to harm (NNH) = 8) and the chance of seizures during therapy (RR 6.76, P = 0.03, NNH = 22) with HBOT.Authors' conclusions: There is some evidence that HBOT improves local tumour control and mortality for cancers of the head and neck, and local tumour recurrence in cancers of the head and neck, and uterine cervix. These benefits may only occur with unusual fractionation schemes. HBOT is associated with significant adverse effects including oxygen toxic seizures and severe tissue radiation injury. The methodological and reporting inadequacies of the studies included demand a cautious interpretation. More research is needed for head and neck cancer, but is probably not justified for bladder cancer. There is little evidence available concerning malignancies at other anatomical sites on which to base a recommendation.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD005007.pub3/abstract

Record #98 of 175

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 #99 of 175

ID: CD006504

AU: Rolinski Michal

AU: Fox Chris

AU: Maidment Ian

AU: McShane Rupert

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 #100 of 175

ID: CD007176

AU: Bjelakovic Goran

AU: Nikolova Dimitrinka

AU: Gluud Lise Lotte

AU: Simonetti Rosa G

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 #101 of 175

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 #102 of 175

ID: CD005562

AU: Woods Bob

AU: Aguirre Elisa

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 #103 of 175

ID: CD009663

AU: Derry Christopher J

AU: Derry Sheena

AU: Moore R Andrew

TI: Sumatriptan (intranasal route of administration) for acute migraine attacks in adults

SO: Cochrane Database of Systematic Reviews

YR: 2012

NO: 2

PB: John Wiley & Sons, Ltd

KY: Acute Disease;Administration, Intranasal;Dihydroergotamine [administration & dosage];Migraine Disorders [drug therapy];Pain Management [methods];Randomized Controlled Trials as Topic;Serotonin 5-HT1 Receptor Agonists [administration & dosage];Sumatriptan [administration & dosage];Triazoles [administration & dosage];Tryptamines [administration & dosage];Adult[checkword];Female[checkword];Humans[checkword];Male[checkword]

CC: HM-SYMPT

DOI: 10.1002/14651858.CD009663

AB: Background: Migraine is a highly disabling condition for the individual and also has wide-reaching implications for society, healthcare services, and the economy. Sumatriptan is an abortive medication for migraine attacks, belonging to the triptan family. Intranasal administration may be preferable to oral for individuals experiencing nausea and/or vomiting, although it is primarily absorbed in the gut, not the nasal mucosa.Objectives: To determine the efficacy and tolerability of intranasal sumatriptan compared to placebo and other active interventions in the treatment of acute migraine attacks in adults.Search methods: We searched Cochrane Central Register of Controlled Trials (CENTRAL), MEDLINE, EMBASE, online databases, and reference lists for studies through 13 October 2011.Selection criteria: We included randomised, double-blind, placebo- and/or active-controlled studies using intranasal sumatriptan to treat a migraine headache episode, with at least 10 participants per treatment arm.Data collection and analysis: Two review authors independently assessed trial quality and extracted data. We used numbers of participants achieving each outcome to calculate relative risk (or 'risk ratio') and numbers needed to treat to benefit (NNT) or harm (NNH) compared to placebo or a different active treatment.Main results: Twelve studies (4755 participants) compared intranasal sumatriptan with placebo or an active comparator. Most of the data were for the 10 mg and 20 mg doses. Sumatriptan surpassed placebo for all efficacy outcomes. For

sumatriptan 10 mg versus placebo the NNTs were 7.3, 7.4, and 5.5 for pain-free at two hours, and headache relief at one and two hours, respectively. For sumatriptan 20 mg versus placebo the NNTs were 4.7, 4.9, and 3.5, respectively, for the same outcomes. The 20 mg dose was significantly better than the 10 mg dose for each of these three primary efficacy outcomes.Relief of headache-associated symptoms, including nausea, photophobia, and phonophobia, was greater with sumatriptan than with placebo, and use of rescue medication was lower with sumatriptan than placebo. For the most part, adverse events were transient and mild and were more common with sumatriptan than placebo.Direct comparison of sumatriptan with active treatments was limited to two studies, one comparing sumatriptan 20 mg and dihydroergotamine (DHE) 1 mg, and one comparing sumatriptan 20 mg with rizatriptan 10 mg.Authors' conclusions: Intranasal sumatriptan is effective as an abortive treatment for acute migraine attacks, relieving pain, nausea, photophobia, phonophobia, and functional disability, but is associated with increased adverse events compared with placebo.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD009663/abstract

Record #104 of 175

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 #105 of 175

ID: CD004162

AU: Essali Adib

AU: Ali Ghassan

TI: Antipsychotic drug treatment for elderly people with late-onset schizophrenia

SO: Cochrane Database of Systematic Reviews

YR: 2012

NO: 2

PB: John Wiley & Sons, Ltd

KY: Age of Onset;Antipsychotic Agents [therapeutic use];Benzodiazepines [therapeutic use];Randomized Controlled Trials as Topic;Risperidone [therapeutic use];Schizophrenia [drug therapy];Aged[checkword];Female[checkword];Humans[checkword];Male[checkword];Middle Aged[checkword]

CC: SCHIZ

DOI: 10.1002/14651858.CD004162.pub2

AB: Background: Schizophrenia is usually considered an illness of young adulthood. However, onset after the age of 40 years is reported in 23% of patients hospitalised with schizophrenia. At least 0.1% of the world's elderly population have a diagnosis of late-onset schizophrenia which seems to differ from earlier onset schizophrenia on a variety of counts including response to antipsychotic drugs.Objectives: To assess the effects of antipsychotic drugs for elderly people with late-onset schizophrenia.Search methods: We searched the Cochrane Schizophrenia Group Trials Register (January 2010) which is based on regular searches of CINAHL, EMBASE, MEDLINE and PsycINFO. We inspected references of all identified studies for further trials. We contacted relevant authors of trials for additional information.We updated this search Janurary 2013 and added 48 new trials to the awaiting classification section.Selection criteria: All relevant randomised controlled trials that compared antipsychotic drugs with other treatments for elderly people (at least 80% older than 65 years) with a recent (within five years) diagnosis of schizophrenia or schizophrenia like illnesses.Data collection and analysis: For the 2010 search, two new review authors (AE, AG) inspected all citations to ensure reliable selection. We assessed methodological quality of trials using the criteria recommended in the Cochrane Handbook for Systematic Reviews of Interventions. AE and AG also independently extracted data. For homogenous dichotomous data, we planned to calculate the relative risk (RR) and 95% confidence interval (CI).Main results: There were no included studies in the original version of this review (2002 search). The 2010 search for the current update produced 211 references, among which we identified 88 studies. Only one study met the inclusion criteria and was of acceptable quality. This was an eight-week randomised trial of risperidone and olanzapine in 44 inpatients with late-onset schizophrenia.

All participants completed the eight-week trial, indicating that both drugs were well tolerated. Unfortunately, this study provided little usable data. We excluded a total of 81 studies, 77 studies because they either studied interventions other than antipsychotic medication or because they involved elderly people with chronic - not late-onset - schizophrenia. We excluded a further four trials of antipsychotics in late-onset schizophrenia because of flawed design. Five studies are still awaiting classification, and one is on-going.Authors' conclusions: There is no trial-based evidence upon which to base guidelines for the treatment of late-onset schizophrenia. There is a need for good quality-controlled clinical trials into the effects of antipsychotics for this group. Such trials are possible. Until they are undertaken, people with late-onset schizophrenia will be treated by doctors using clinical judgement and habit to guide prescribing.Note: the 48 citations in the awaiting classification section of the review may alter the conclusions of the review once assessed.

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Record #106 of 175

ID: CD007967

AU: Singh Jasvinder

AU: Kour Kamalpreet

AU: Jayaram Mahesh B

TI: Acetylcholinesterase inhibitors for schizophrenia

SO: Cochrane Database of Systematic Reviews

YR: 2012

NO: 1

PB: John Wiley & Sons, Ltd

KY: Antipsychotic Agents [therapeutic use];Cholinesterase Inhibitors [therapeutic use];Galantamine [therapeutic use];Indans [therapeutic use];Phenylcarbamates [therapeutic use];Piperidines [therapeutic use];Psychotic Disorders [drug therapy];Randomized Controlled Trials as Topic;Schizophrenia [drug therapy];Schizophrenic Psychology;Humans[checkword]

CC: SCHIZ

DOI: 10.1002/14651858.CD007967.pub2

AB: Background: Antipsychotic medication remains the mainstay of treatment for schizophrenia and has been in use for a long time. As evidenced by ongoing research and partial effectiveness of the antipsychotics on cognitive and negative symptoms, the search is

on for drugs that may improve these domains of functioning for someone suffering from schizophrenia. Acetylcholinesterase inhibitors have long been in use for treating cognitive symptoms of dementia.Objectives: The aim of the review was to evaluate the clinical effects, safety and cost effectiveness of acetylcholinesterase inhibitors for treating people with schizophreniaSearch methods: We searched the Cochrane Schizophrenia Group's Register (February 2009), and inspected the references of all identified studies for further trials.Selection criteria: We included all clinical randomised trials comparing acetylcholinesterase inhibitors with antipsychotics or placebo either alone, or in combination, for schizophrenia and schizophrenia-like psychoses.Data collection and analysis: We extracted data independently. For dichotomous data, we calculated risk ratios (RR) and their 95% confidence intervals (CI) on an intention-to-treat (ITT) basis based on a random-effects model. For continuous data, we calculated mean differences (MD), again based on a random-effects model.Main results: The acetylcholinesterase inhibitor plus antipsychotic showed benefit over antipsychotic and placebo in the following outcomes.1. Mental state - PANSS negative symptoms average end point score (2 RCTs, n = 31, MD -1.69 95% CI -2.80 to -0.57), PANSS General Psychopathology average end point score (2 RCTs, n = 31, MD -3.86 95% CI -5.40 to -2.32), and improvement in depressive symptoms showed at least by one short-term study as measured by CDSS scale (data skewed).2. Cognitive domains - attention, (1 RCT, n = 73, MD 1.20 95% CI 0.14 to 2.26), visual memory (2 RCTs, n = 48 , MD 1.90 95% CI 0.52 to 3.28), verbal memory and language (3 RCTs, n = 42, MD 3.46 95% CI 0.67 to 6.26) and executive functioning (1 RCT, n = 24, MD 17.10 95% CI 0.70 to 33.50).3. Tolerability - EPSE: AIMS, (1 RCT, n = 35, MD 1.50 95% CI 1.04 to 1.96).No difference was noted between the two arms in other outcomes. The overall rate of participants leaving studies early was low (13.6 %) and showed no clear difference between the two groups.Authors' conclusions: The results seem to favour the use of acetylcholinesterase inhibitors in combination with antipsychotics on a few domains of mental state and cognition, but because of the various limitations in the studies as mentioned in the main text, the evidence is weak. This review highlights the need for large, independent, well designed, conducted and reported pragmatic randomised studies.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007967.pub2/abstract

Record #107 of 175

ID: CD008207

AU: He Mao Lin

AU: Xiao Zeng Ming

AU: Lei Ming

AU: Li Ting Song

AU: Wu Hao

AU: Liao Jun

TI: Continuous passive motion for preventing venous thromboembolism after total knee arthroplasty

SO: Cochrane Database of Systematic Reviews

YR: 2012

NO: 1

PB: John Wiley & Sons, Ltd

KY: Arthroplasty, Replacement, Knee [adverse effects];Motion Therapy, Continuous Passive [methods];Pulmonary Embolism [prevention & control];Venous Thromboembolism [prevention & control];Venous Thrombosis [prevention & control];Humans[checkword]

CC: HM-PVD

DOI: 10.1002/14651858.CD008207.pub2

AB: Background: Total knee arthroplasty (TKA) is a common form of orthopedic surgery. Venous thromboembolism (VTE), which consists of deep venous thrombosis (DVT) and pulmonary embolism (PE), is a major and potentially fatal complication after TKA. The incidence of DVT after TKA is 40% to 80% and the incidence of PE is approximately 2%. It is generally agreed that thromboprophylaxis should be used in patients who undergo TKA. Both pharmacological and mechanical methods are used in the prevention of DVT. Pharmacological methods alter the blood coagulation profile and may increase the risk of bleeding complications. When pharmacological methods cannot be used, the mechanical methods become crucial for VTE prophylaxis. Continuous passive motion (CPM) is through an external motorised device which enables a joint to move passively throughout a preset arc of motion. Despite the theoretical effectiveness and widespread use of CPM, there are still differing views on the effectiveness of CPM as prophylaxis against thrombosis after TKA.Objectives: The aim of this review is to determine the effectiveness of continuous passive motion therapy for preventing thrombosis in patients after total knee arthroplasty (TKA).Search methods: The Cochrane Peripheral Vascular Diseases Group searched their Specialised Register (last searched January 2011), CENTRAL (2011, Issue 1), MEDLINE (1948 to Week 2 January 2011) and EMBASE (1980 to Week 3 January 2011). In addition, the authors searched the reference lists of identified trials.Selection criteria: Randomised controlled trials (RCTs) comparing the use of CPM with control in preventing DVT or PE after TKA. People aged 18 years and older who have undergone TKA were included in this review. We excluded studies of patients who presented with DVT at baseline. Both the experimental and control groups received similar postoperative care and therapy other than the CPM.Data collection and analysis: Two review authors independently assessed the citations retrieved by the search strategies for reports of relevant RCTs. They independently selected trials that satisfied the inclusion criteria, extracted data and undertook quality assessment. Effects were estimated as risk ratios (RRs) or mean differences or standardised mean differences with 95% confidence intervals (CI). Meta-analyses were performed using a fixed-effect model for continuous variables. Where

heterogeneity existed (determined by the I2 statistic), a random-effects model was used.Main results: Ten randomised controlled trials involving 764 participants met the inclusion criteria. Four studies with a total of 361 patients reported the incidence of DVT. In the CPM group (182 patients) 36 developed DVT (20%) compared to 28 (16%) the control group of 179 patients. The meta-analysis result showed no evidence that CPM had any effect on preventing VTE after TKA (RR 1.27, 95% CI 0.87 to 1.86). One trial (150 participants) did not find PE in any of the patients during hospitalisation or in the subsequent three months. None of the trials reported any deaths of the included participants.Authors' conclusions: There is not enough evidence from the available RCTs to conclude that CPM reduces VTE after TKA. We cannot assess the effect of CPM on death because no such events occurred amongst the participants of these trials.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD008207.pub2/abstract

Record #108 of 175

ID: CD005181

AU: La Mantia Loredana

AU: Vacchi Laura

AU: Di Pietrantonj Carlo

AU: Ebers George

AU: Rovaris Marco

AU: Fredrikson Sten

AU: Filippini Graziella

TI: Interferon beta for secondary progressive multiple sclerosis

SO: Cochrane Database of Systematic Reviews

YR: 2012

NO: 1

PB: John Wiley & Sons, Ltd

KY: Adjuvants, Immunologic [therapeutic use];Interferon-beta [therapeutic use];Multiple Sclerosis, Chronic Progressive [drug therapy];Randomized Controlled Trials as Topic;Humans[checkword]

CC: MS

DOI: 10.1002/14651858.CD005181.pub3

AB: Background: Therapy with either recombinant beta-1a or beta-1b interferons (IFNs) is worldwide approved for Relapsing Remitting Multiple Sclerosis (RRMS). A major unanswered question is whether this treatment is able to safely reverse or retard the progressive phase of the disease.Objectives: The main objective was to verify whether IFNs treatment in Secondary Progressive Multiple Sclerosis (SPMS) is more effective than placebo in reducing the number of patients who experience disability progression.Search methods: We searched the Cochrane Multiple Sclerosis Group's Trials Register (1995 to 15 February 2011), the reference lists of relevant articles and conference proceedings. Regulatory agencies were used as additional sources of information.Selection criteria: We included all randomised, double or single blind, placebo-controlled trials (RCTs) evaluating the efficacy of IFNs versus placebo in SPMS patients.Data collection and analysis: Two review authors independently assessed all reports retrieved from the search. They independently extracted clinical, safety and MRI data, using a predefined data extraction form, resolving disagreements after discussion with a third reviewer. Risk of bias was evaluated to assess the quality of the studies. Treatment effect was measured using Risk Ratio (RR) with 95% confidence intervals (CI) for the binary outcomes and Standard Mean Difference with 95% CI for the continuous outcomes.Main results: Five RCTs met the inclusion criteria, from which 3122 (1829 IFN and 1293 placebo) treated patients contributed to the analysis. Included population was heterogeneous in terms of baseline clinical characteristics of the disease, in particular the percentage of patients affected by secondary progression with superimposed relapse ranging from 72% to 44%. IFN beta 1a and 1b did not decrease the risk of progression sustained at 6 months (RR, 95% CI: 0.98, [0.82-1.16]) after three years of treatment. A significant decrease of the risk of progression sustained at 3 months (RR, 95% CI: 0.88 [0.80, 0.97]) and of the risk of developing new relapses at three years (RR 0.91, [0.84-0.97]) were found. The risk of developing new active brain lesions decreased over time but this data was obtained from single studies on Magnetic Resonance Imaging (MRI), performed in subgroups of patients; in spite of no effect on progression, the radiological data supported an effect on MRI parameters. The safety profile reflects what is commonly reported in MS IFN-treated patients.Authors' conclusions: Well designed RCTs, evaluating a high number of patients were included in the review. Recombinant IFN beta does not prevent the development of permanent physical disability in SPMS. We were unable to verify the effect on cognitive function for the lack of comparable data. This treatment significantly reduces the risk of relapse and of short -term relapse-related disability.Overall, these results show that IFNs' anti-inflammatory effect is unable to retard progression, when established. In the future, no new RCTs for IFNs versus placebo in SPMS will probably be undertaken, because research is now focusing on innovative drugs. We believe that this review gives conclusive evidence on the clinical efficacy of IFNs versus placebo in SPMS.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD005181.pub3/abstract

ID: CD004916

AU: Walline Jeffrey J

AU: Lindsley Kristina

AU: Vedula Satyanarayana S

AU: Cotter Susan A

AU: Mutti Donald O

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.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004916.pub3/abstract

Record #110 of 175

ID: CD008273

AU: Chan Raymond J

AU: Webster Joan

AU: Marquart Louise

TI: Information interventions for orienting patients and their carers to cancer care facilities

SO: Cochrane Database of Systematic Reviews

YR: 2011

NO: 12

PB: John Wiley & Sons, Ltd

KY: Cancer Care Facilities;Caregivers;Patient Admission;Anxiety [prevention & control];Neoplasms [psychology];Patient Education as Topic [methods];Randomized Controlled Trials as Topic;Stress, Psychological [prevention & control];Humans[checkword]

CC: COMMUN

DOI: 10.1002/14651858.CD008273.pub2

AB: Background: Cancer patients experience distress and anxiety related to their diagnosis, treatment and the unfamiliar cancer centre. Strategies with the aim of orienting patients to a cancer care facility may improve patient outcomes. Although meeting patients' information needs at different stages is important, there is little agreement about the type of information and the timing for information to be given. Orientation interventions aim to address information needs at the start of a person's experience with a cancer care facility. The extent of any benefit of these interventions is unknown.Objectives: To assess the effects of information interventions which orient patients and their carers/family to a cancer care facility, and to the services available in the facility.Search methods: We searched the Cochrane Central Register of Controlled Trials (CENTRAL) (The Cochrane Library 2011, Issue 2); MEDLINE (OvidSP) (1966 to Jun 2011), EMBASE (Ovid SP) (1966 to Jun 2011), CINAHL (EBSCO) (1982 to Jun 2011), PsycINFO (OvidSP) (1966 to Jun 2011), review articles and reference lists of relevant articles. We contacted principal investigators and experts in the field.Selection criteria: Randomised controlled trials (RCTs), cluster RCTs and quasi-RCTs evaluating the effects of information interventions that orient patients and their carers/family to a cancer care facility.Data collection and analysis: Results of searches were reviewed against the pre-determined criteria for inclusion by two review authors. The primary outcomes were knowledge and understanding; health status and wellbeing, evaluation of care, and harms. Secondary outcomes were communication, skills acquisition, behavioural outcomes, service delivery, and health professional outcomes. We pooled results of RCTs using mean differences (MD) and 95% confidence intervals (CI).Main results: We included four RCTs involving 610 participants. All four trials aimed to investigate the effects of orientation programs for cancer patients to a cancer facility. There was high risk of bias across studies. Findings from two of the RCTs demonstrated significant benefits of the orientation intervention in relation to levels of distress (mean difference (MD) -8.96 (95% confidence interval (CI) -11.79 to -6.13), but non-significant benefits in relation to state anxiety levels (MD -9.77 (95% CI -24.96 to 5.41). Other outcomes for participants were generally positive (e.g. more knowledgeable about the cancer centre and cancer therapy, better coping abilities). No harms or adverse effects were measured or reported by any of the included studies. There were insufficient data on the other outcomes of interest.Authors' conclusions: This review has demonstrated the feasibility and

some potential benefits of orientation interventions. Orientation interventions may reduce distress in patients, but the quality of the evidence is low. However, most of the other outcomes remain inconclusive (patient knowledge recall/ satisfaction). The majority of studies were subject to high risk of bias, and were likely to be insufficiently powered. Further well conducted and powered RCTs are required to provide evidence for determining the most appropriate intensity, nature, mode and resources for such interventions. Patient and carer-focused outcomes should be included.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD008273.pub2/abstract

Record #111 of 175

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 #112 of 175

ID: CD002950

AU: Pani Pier Paolo

AU: Trogu Emanuela

AU: Vecchi Simona

AU: Amato Laura

TI: Antidepressants for cocaine dependence and problematic cocaine use

SO: Cochrane Database of Systematic Reviews

YR: 2011

NO: 12

PB: John Wiley & Sons, Ltd

KY: Antidepressive Agents [adverse effects] [therapeutic use];Behavior, Addictive [therapy];Cocaine-Related Disorders [drug therapy] [rehabilitation];Opioid-Related Disorders [rehabilitation];Patient Dropouts [psychology];Psychotherapy [methods];Randomized Controlled Trials as Topic;Humans[checkword]

CC: HM-ADDICTN

DOI: 10.1002/14651858.CD002950.pub3

AB: Background: Cocaine dependence is a disorder for which no pharmacological treatment of proven efficacy exists, advances in the neurobiology could guide future medication development.Objectives: To investigate the efficacy and acceptability of antidepressants alone or in combination with any psychosocial intervention for the treatment of cocaine dependence and problematic cocaine use.Search methods: We searched the Cochrane Central Register of Controlled Trials (CENTRAL), PubMed, EMBASE and CINAHL in July 2011 and researchers for unpublished trials.Selection criteria: Randomised clinical trials comparing antidepressants alone or associated with psychosocial intervention with placebo, no treatment, other pharmacological or psychosocial interventions.Data collection and analysis: Two authors independently assessed trial quality and extracted data.Main results: 37 studies were included in the review (3551 participants).Antidepressants versus placebo: results for dropouts did not show evidence of difference, 31 studies, 2819 participants, RR 1.03 (Cl 95% 0.93 to 1.14). Looking at Abstinence from cocaine use, even though not statistically significant, the difference shown by the analysis in the three-weeks abstinence rate was in favour of antidepressants (eight studies, 942 participants, RR 1.22 (Cl 95% 0.99 to 1.51)). Considering only studies involving tricyclics, five studies, 367 participants, or only desipramine, four studies, 254 participants, the evidence was in favour of antidepressants. However, selecting only studies with operationally defined diagnostic criteria, statistical significance favouring antidepressants, as well as the trend for significance shown by the full sample, disappeared. Looking at safety issues, the results did not show evidence of differences (number of patients withdrawn for medical reasons, thirteen studies, 1396 participants, RR 1.39 (Cl 95% 0.91 to 2.12)). Subgroup analysis considering length of the trial, associated opioid dependence or associated psychosocial interventions as confounding factors, failed in showing consistent and statistically significant differences in favour of antidepressants.Antidepressants versus other drugs: Comparing antidepressants with dopamine agonists or with anticonvulsants, no

evidence of differences was shown on dropouts and on other outcomes (abstinence from cocaine use, adverse events).Authors' conclusions: At the current stage of evidence data do not support the efficacy of antidepressants in the treatment of cocaine abuse/dependence. Partially positive results obtained on secondary outcome measures, such as depression severity, do not seem to be associated with an effect on direct indicators of cocaine abuse/dependence. Antidepressants cannot be considered a mainstay of treatment for unselected cocaine abusers/dependents.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD002950.pub3/abstract

Record #113 of 175

ID: CD009524

AU: Herrmann Nathan

AU: Chau Sarah

AU: Hussman Julia M

AU: Lanctôt Krista L

TI: Dimebon for Alzheimer's disease

SO: Cochrane Database of Systematic Reviews

YR: 2011

NO: 12

PB: John Wiley & Sons, Ltd

CC: HM-DEMENTIA

DOI: 10.1002/14651858.CD009524

AB: This is the protocol for a review and there is no abstract. The objectives are as follows:To evaluate the efficacy and safety of latrepirdine for the treatment of AD.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD009524/abstract

Record #114 of 175

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 #115 of 175

ID: CD009183

AU: Gill Dipender

AU: Derry Sheena

AU: Wiffen Philip J

AU: Moore R Andrew

TI: Valproic acid and sodium valproate for neuropathic pain and fibromyalgia in adults

SO: Cochrane Database of Systematic Reviews

YR: 2011

NO: 10

PB: John Wiley & Sons, Ltd

KY: Analgesics [therapeutic use];Diabetic Neuropathies [drug therapy];Fibromyalgia [drug therapy];Neuralgia, Postherpetic [drug therapy];Randomized Controlled Trials as Topic;Valproic Acid [adverse effects] [therapeutic use];Adult[checkword];Humans[checkword]

CC: SYMPT

DOI: 10.1002/14651858.CD009183.pub2

AB: Background: Valproic acid and its sodium salt (sodium valproate) are antiepileptic drugs that are sometimes used to treat chronic neuropathic pain and fibromyalgia, although they are not licensed for this use.Objectives: To evaluate the analgesic efficacy and adverse effects of valproic acid and sodium valproate in the management of chronic neuropathic pain and fibromyalgia.Search methods: We identified randomised controlled trials (RCTs) of valproic acid and sodium valproate in acute, and chronic pain by searching MEDLINE, EMBASE and Cochrane CENTRAL to June 2011, together with reference lists of retrieved papers and reviews.Selection criteria: RCTs that were double blind and of eight-weeks duration or longer, reporting on analgesic effects and adverse events with valproic acid and sodium valproate in the treatment of chronic neuropathic pain and fibromyalgia.Data collection and analysis: Two review authors independently extracted results and scored for quality. We extracted efficacy and adverse event data, and examined issues of study quality.Main results: We included three studies, two in diabetic neuropathy (42 participants treated with valproate, 42 with placebo), and one in post-herpetic neuralgia (23 treated with divalproex sodium, 22 with placebo). Study duration was eight or 12 weeks. No studies were found in fibromyalgia.Only one study reported one of our primary outcomes (? 50% pain relief), while all three reported group means for pain reduction from baseline to endpoint. In all three studies; efficacy results were given only for participants who completed the study. One study in diabetic neuropathy and the study in post-herpetic neuralgia reported significant differences between active and placebo groups, but there were insufficient data for reliable pooled analysis.More adverse events were reported with active treatment than placebo, and included nausea, drowsiness and abnormal liver function tests. One participant taking sodium valproate withdrew due to serious derangement of liver enzymes.Authors' conclusions: These three studies no more than hint that sodium valproate may reduce pain in diabetic neuropathy, and divalproex sodium in post-herpetic neuralgia, but the use of 'completer' analysis may overestimate efficacy, and there were too few data for pooled analysis of efficacy or harm, or to have confidence in the results of the individual studies. There is insufficient evidence to support the use of valproic acid or sodium valproate as a first-line treatment for neuropathic pain. There is more robust evidence of greater efficacy for a small number of other drugs.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD009183.pub2/abstract

Record #116 of 175

ID: CD009221

AU: Poole Norman

AU: Dougall Dominic

AU: Agrawal Niruj

TI: Pharmacotherapy for chronic cognitive impairment in traumatic brain injury

SO: Cochrane Database of Systematic Reviews

YR: 2011

NO: 7

PB: John Wiley & Sons, Ltd

CC: HM-DEMENTIA

DOI: 10.1002/14651858.CD009221

AB: This is the protocol for a review and there is no abstract. The objectives are as follows:The authors aim to perform a systematic review and meta-analysis of all published randomised controlled trials and first phase of all cross-over studies that study the role of pharmacological agents in cognitive impairment subsequent to traumatic brain injury in adult humans.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD009221/abstract

Record #117 of 175

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 #118 of 175

ID: CD009081

AU: Parsons Carole

AU: Hughes Carmel

AU: McGuinness Bernadette

AU: Passmore Peter

TI: Withdrawal or continuation of cholinesterase inhibitors and/or memantine in patients with dementia.

SO: Cochrane Database of Systematic Reviews

YR: 2011

NO: 4

PB: John Wiley & Sons, Ltd

CC: HM-DEMENTIA

DOI: 10.1002/14651858.CD009081

AB: This is the protocol for a review and there is no abstract. The objectives are as follows:To evaluate the effects of withdrawal or continuation of cholinesterase inhibitors and/or memantine in patients with dementia on: cognitive, neuropsychiatric and functional outcomes, rates of institutionalisation, quality of life and carer-related outcomes, safety issues such as mortality, adverse effects or withdrawal symptoms.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD009081/abstract

Record #119 of 175

ID: CD009074

AU: Udell Julie E

AU: Drahota Amy

AU: Dean Taraneh P

AU: Sander Ruth

AU: Mackenzie Heather

TI: Interventions for preventing falls in older people: an overview of Cochrane Reviews

SO: Cochrane Database of Systematic Reviews

YR: 2011

NO: 4

PB: John Wiley & Sons, Ltd

CC: HM-MUSKINJ

DOI: 10.1002/14651858.CD009074

AB: This is the protocol for a review and there is no abstract. The objectives are as follows:Our overall aim is to provide an overview of interventions for preventing falls in older people by summarising the evidence from multiple Cochrane intervention reviews that evaluate the effects (primarily, rate of falls and number of fallers) of these interventions in different populations of older people, such as those defined by setting or by specific medical conditions.Fall prevention interventions will include those in the following categories: supervised or unsupervised exercises; medication; surgery; management of urinary incontinence; fluid or nutrition therapy; psychological; environment and assistive technologies; social environment; knowledge/education interventions and any other interventions that do not fall into one of these categories (Lamb 2007). Interventions tested may belong to one category ('single' intervention), or more than one category ('multiple' and 'multifactorial' interventions).

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD009074/abstract

Record #120 of 175

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.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003719.pub3/abstract

Record #121 of 175

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 #122 of 175

ID: CD008068

AU: Yang Weimin

AU: Liu Ming

AU: Teng Junfang

AU: Hao Zilong

AU: Wu Bo

AU: Wu Taixiang

AU: Liu Guan J

TI: Almitrine-Raubasine combination for dementia

SO: Cochrane Database of Systematic Reviews

YR: 2011

NO: 3

PB: John Wiley & Sons, Ltd

KY: Almitrine [therapeutic use];Dementia [drug therapy];Drug Combinations;Neuroprotective Agents [therapeutic use];Yohimbine [therapeutic use];Aged[checkword];Humans[checkword];Middle Aged[checkword]

CC: DEMENTIA

DOI: 10.1002/14651858.CD008068.pub2

AB: Background: Almitrine-raubasine combination (brand name Duxil), has been considered as an alternative treatment for dementia.Objectives: To determine the clinical efficacy and safety of Duxil in the treatment of patients with dementia.Search methods: We searched the Cochrane Dementia and Cognitive Improvement Group Specialised Register (now known as ALOIS) (September 2009), the China Biological Medicine Database (CBM-disc 1979 to December 2009), the Chinese National Knowledge Infrastructure (www.cnki.net 1979 to December 2009), the Stroke Trials Registry at www.strokecentre.org/trials/index.aspx. We searched identified citations for additional trials, contacted the first author of identified trials for additional references and unpublished data. We also contacted the pharmaceutical company manufacturing Duxil (Servier Pharmaceutical Co Ltd) for additional unpublished data.Selection criteria: Randomised controlled trials studying the efficacy and safety of Duxil for dementia were included, irrespective of blinding, publication status, or language. If the trial was cross-over in nature, only data from the first period were included.Data collection and analysis: Two review authors independently selected trials for inclusion, assessed trial quality and extracted the data.Main results: Three trials involving a total of 206 participants were included, all patients with vascular dementia. All three included studies were assessed as being at high risk of bias. When analysing these trials together, there was significant beneficial effect of Duxil on the improvement of cognitive function measured by MMSE (WMD 2.04, 95% CI 1.43 to 2.66). No data on behaviour and death at the end of treatment and follow-up were available from the included trials. Two trials failed to show an improvement of functional performance measured by ADL (WMD -1.68; 95% CI -3.70 to 0.35). Of the three included trials, all described the adverse events in detail, there were no statistically significant differences across the trials (OR 4.84, 95%CI 0.55 to 42.67). Behaviour disturbance, quality of life, caregiver burden were not undertaken in the included trials.Authors' conclusions: Due to the low methodological quality of included trials, small number of trials and probable publication bias, this review did not provide sufficient evidence to support the routine use of Duxil for the treatment of patients with dementia. High-quality and large-scale randomised controlled trials are needed to confirm or refute these results.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD008068.pub2/abstract

Record #123 of 175

ID: CD001860

AU: Evans Jennifer R

AU: Solomon Anthony W

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.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD001860.pub3/abstract

Record #124 of 175

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 #125 of 175

ID: CD008985

AU: Rustamov Oybek

AU: Alfirevic Zarko

AU: Arora Rohit

AU: Siddiqui Iram

AU: Mitchell Alana L

TI: Imaging techniques for antenatal detection of morbidly adherent placenta

SO: Cochrane Database of Systematic Reviews

YR: 2011

NO: 2

PB: John Wiley & Sons, Ltd

CC: HM-PREG

DOI: 10.1002/14651858.CD008985

AB: This is the protocol for a review and there is no abstract. The objectives are as follows:To evaluate the impact of ultrasound and MRI imaging on the outcome of pregnancy for women at risk of morbidly adherent placenta.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD008985/abstract

Record #126 of 175

ID: CD008121

AU: Komossa Katja

AU: Depping Anna M

AU: Gaudchau Andrea

AU: Kissling Werner

AU: Leucht Stefan

TI: Second-generation antipsychotics for major depressive disorder and dysthymia

SO: Cochrane Database of Systematic Reviews

YR: 2010

NO: 12

PB: John Wiley & Sons, Ltd

KY: Antidepressive Agents [therapeutic use];Antipsychotic Agents [therapeutic use];Benzodiazepines [therapeutic use];Depressive Disorder, Major [drug therapy];Dibenzothiazepines [therapeutic use];Dysthymic Disorder [drug therapy];Piperazines [therapeutic use];Quinolones [therapeutic use];Randomized Controlled Trials as Topic;Risperidone [therapeutic use];Sulpiride [analogs & derivatives] [therapeutic use];Humans[checkword]

CC: DEPRESSN

DOI: 10.1002/14651858.CD008121.pub2

AB: Background: Major depressive disorder (MDD) is a common condition with a lifetime prevalence of 15% to 18%, which leads to considerable suffering and disability. Some antipsychotics have been reported to induce remission in major depression, when added to an antidepressant.Objectives: To evaluate the effects of second-generation antipsychotic (SGA) drugs (alone or augmentation) compared with placebo or antidepressants for people with MDD or dysthymia.Search methods: The Cochrane Depression, Anxiety and Neurosis Group's controlled trial registers (CCDANCTR-Studies and CCDANCTR-References) were searched up to 21 July 2010. The author team ran complementary searches on clinicaltrials.gov and contacted key authors and drug companies.Selection criteria: We included all randomised, double-blind trials comparing oral SGA treatment (alone or augmentation) with other forms of pharmaceutical treatment or placebo in people with MDD or dysthymia.Data collection and analysis: We extracted data independently. For dichotomous data we calculated the odds ratio (OR) and 95% confidence interval (CI) on an intention-to-treat basis, and for continuous data the mean difference (MD), based on a random-effects model. We presented each comparison separately; we did not perform a pooled data analysis.Main results: We included 28 trials with 8487 participants on five SGAs: amisulpride, aripiprazole, olanzapine, quetiapine and risperidone.Three studies (1092 participants) provided data on aripiprazole augmentation in MDD. All efficacy data (response n = 1092, three RCTs, OR 0.48; 95% CI 0.37 to 0.63), (MADRS n = 1077, three RCTs, MD -3.04; 95% CI -4.09 to -2) indicated a benefit for aripiprazole but more side effects (weight gain, EPS) .Seven trials (1754 participants) reported data on olanzapine. Compared to placebo fewer people discontinued treatment due to inefficacy; compared to antidepressants there were no efficacy differences, olanzapine augmentation showed symptom reduction (MADRS n = 808, five RCTs, MD -2.84; 95% CI -5.48 to -0.20), but also more weight or prolactin increase.Quetiapine data are based on seven trials (3414 participants). Compared to placebo, quetiapine monotherapy (response n = 1342, three RCTs, OR 0.52; 95% CI 0.41 to 0.66) and quetiapine augmentation (response n = 937, two RCTs, OR 0.68; 95% CI 0.52 to 0.90) showed symptom reduction, but quetiapine induced more sedation.Four trials (637 participants) presented data on risperidone augmentation, response data were better for risperidone (n = 371, two RCTs, OR 0.57; 95% CI 0.36 to 0.89) but augmentation showed more prolactin increase and weight gain.Five studies (1313 participants) presented data on amisulpride treatment for dysthymia. There were some beneficial effects compared to placebo or antidepressants but tolerability was worse.Authors' conclusions: Quetiapine was more effective than placebo treatment. Aripiprazole and quetiapine and partly also olanzapine and risperidone augmentation showed beneficial effects compared to placebo. Some evidence indicated beneficial effects of low-dose amisulpride for dysthymic people. Most SGAs showed worse tolerability.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD008121.pub2/abstract

Record #127 of 175

ID: CD004607

AU: Wilson Cecilia

AU: Willis Charlene

AU: Hendrikz Joan K

AU: Le Brocque Robyne

AU: Bellamy Nicholas

TI: Speed cameras for the prevention of road traffic injuries and deaths

SO: Cochrane Database of Systematic Reviews

YR: 2010

NO: 11

PB: John Wiley & Sons, Ltd

KY: Accident Prevention [instrumentation] [methods];Accidents, Traffic [mortality] [prevention & control] [statistics & numerical data];Controlled Clinical Trials as Topic;Photography [instrumentation];Radar [instrumentation];Safety;Humans[checkword]

CC: INJ

DOI: 10.1002/14651858.CD004607.pub4

AB: Background: It is estimated that by 2020, road traffic crashes will have moved from ninth to third in the world ranking of burden of disease, as measured in disability adjusted life years. The prevention of road traffic injuries is of global public health importance. Measures aimed at reducing traffic speed are considered essential to preventing road injuries; the use of speed cameras is one such measure.Objectives: To assess whether the use of speed cameras reduces the incidence of speeding, road traffic crashes, injuries and deaths.Search methods: We searched the following electronic databases covering all available years up to May 2010: the Cochrane Library, MEDLINE (WebSPIRS), EMBASE (WebSPIRS), TRANSPORT, IRRD (International Road Research Documentation), TRANSDOC (European Conference of Ministers of Transport databases), Web of Science (Science and Social Science Citation Index), PsycINFO, CINAHL, EconLit, WHO database, Sociological Abstracts, Dissertation Abstracts, Index to Theses.Selection criteria: Randomised controlled trials, interrupted time series and controlled before-after studies that assessed the impact of speed cameras on speeding, road crashes, crashes causing injury and fatalities were eligible for inclusion.Data collection and analysis: We independently screened studies for inclusion, extracted data, assessed methodological quality, reported study authors' outcomes and where possible, calculated standardised results based on the information available in each study. Due to considerable heterogeneity between and within included studies, a meta-analysis was not appropriate.Main results: Thirty five studies

met the inclusion criteria. Compared with controls, the relative reduction in average speed ranged from 1% to 15% and the reduction in proportion of vehicles speeding ranged from 14% to 65%. In the vicinity of camera sites, the pre/post reductions ranged from 8% to 49% for all crashes and 11% to 44% for fatal and serious injury crashes. Compared with controls, the relative improvement in pre/post injury crash proportions ranged from 8% to 50%.Authors' conclusions: Despite the methodological limitations and the variability in degree of signal to noise effect, the consistency of reported reductions in speed and crash outcomes across all studies show that speed cameras are a worthwhile intervention for reducing the number of road traffic injuries and deaths. However, whilst the the evidence base clearly demonstrates a positive direction in the effect, an overall magnitude of this effect is currently not deducible due to heterogeneity and lack of methodological rigour. More studies of a scientifically rigorous and homogenous nature are necessary, to provide the answer to the magnitude of effect.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004607.pub4/abstract

Record #128 of 175

ID: CD006788

AU: Peuckmann-Post Vera

AU: Elsner Frank

AU: Krumm Norbert

AU: Trottenberg Peter

AU: Radbruch Lukas

TI: Pharmacological treatments for fatigue associated with palliative care

SO: Cochrane Database of Systematic Reviews

YR: 2010

NO: 11

PB: John Wiley & Sons, Ltd

KY: Palliative Care;Amantadine [therapeutic use];Benzhydryl Compounds [therapeutic use];Central Nervous System Stimulants [therapeutic use];Fatigue [drug therapy] [etiology];Kidney Failure, Chronic [complications];Methylphenidate [therapeutic use];Multiple Sclerosis [complications];Neoplasms [complications];Pemoline [therapeutic use];Randomized Controlled Trials as Topic;Adult[checkword];Humans[checkword]

CC: HM-SYMPT

DOI: 10.1002/14651858.CD006788.pub2

AB: Background: In healthy individuals, fatigue is a protective response to physical or mental stress, often relieved by rest. By contrast, in palliative care patients fatigue can be severely debilitating, thereby impacting daily activity and quality of life, often with rest not counteracting fatigue. Fatigue frequently occurs in patients with advanced disease and modalities treating cancer often contribute or cause fatigue. Further complicating issues are its multidimensionality, subjective nature, and lack of a consensus definition of fatigue. Pathophysiology is not fully understood and evidence-based treatment approaches are needed.Objectives: The objective was to determine efficacy of pharmacological treatments on non-specific fatigue in palliative care. The focus was on patients at an advanced stage of disease, including cancer and other chronic diseases associated with fatigue, aiming to relieve fatigue. Studies aiming at curative treatment (e.g. surgical intervention for early breast cancer) were not included.Search methods: We searched EMBASE; Psych Lit, CENTRAL and MEDLINE to June 2009.Selection criteria: We considered randomised controlled trials (RCTs) concerning adult palliative care with focus on pharmacological treatment of fatigue. The primary outcome had to be non-specific fatigue (or related terms such as asthenia).Data collection and analysis: Results were screened and included if they met the selection criteria. If two or more studies were identified that investigated a specific drug in a population with the same disease, meta-analysis was conducted. In addition, comparison of type of drug investigated in a specific population as well as comparison of frequent adverse effects of fatigue treatment was done by creating overview tables.Main results: More than 2000 publications were screened, and 22 met inclusion criteria. In total, data from 11 drugs and 1632 participants were analysed. Studies investigating amantadine, pemoline, and modafinil in participants with Multiple Sclerosis (MS)-associated fatigue and methylphenidate in patients suffering from advanced cancer and fatigue could be used for meta-analysis. Amantadine in MS and methylphenidate in cancer patients showed a superior effect. Most studies had low participant numbers and were heterogenous.Authors' conclusions: Based on limited evidence, we cannot recommend a specific drug for treatment of fatigue in palliative care patients. Surprisingly, corticosteroids have not been a research focus for fatigue treatment, although these drugs are frequently used. Recent fatigue research seems to focus on modafinil, which may be beneficial although there is no evidence currently. Amantadine and methylphenidate should be further examined. Consensus regarding fatigue assessment in advanced disease is needed.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006788.pub2/abstract

Record #129 of 175

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 #130 of 175

ID: CD007906

AU: Dieterich Marina

AU: Irving Claire B

AU: Park Bert

AU: Marshall Max

TI: Intensive case management for severe mental illness

SO: Cochrane Database of Systematic Reviews

YR: 2010

NO: 10

PB: John Wiley & Sons, Ltd

KY: Case Management;Community Mental Health Services [methods];Hospitalization [statistics & numerical data];Mental Disorders [therapy];Outcome and Process Assessment (Health Care) [methods];Randomized Controlled Trials as Topic;Humans[checkword]

CC: SCHIZ

DOI: 10.1002/14651858.CD007906.pub2

AB: Background: Intensive Case Management (ICM) is a community based package of care, aiming to provide long term care for severely mentally ill people who do not require immediate admission. ICM evolved from two original community models of care, Assertive Community Treatment (ACT) and Case Management (CM), where ICM emphasises the

importance of small caseload (less than 20) and high intensity input.Objectives: To assess the effects of Intensive Case Management (caseload <20) in comparison with non-Intensive Case Management (caseload > 20) and with standard community care in people with severe mental illness. To evaluate whether the effect of ICM on hospitalisation depends on its fidelity to the ACT model and on the setting.Search methods: For the current update of this review we searched the Cochrane Schizophrenia Group Trials Register (February 2009), which is compiled by systematic searches of major databases, hand searches and conference proceedings.Selection criteria: All relevant randomised clinical trials focusing on people with severe mental illness, aged 18 to 65 years and treated in the community-care setting, where Intensive Case Management, non-Intensive Case Management or standard care were compared. Outcomes such as service use, adverse effects, global state, social functioning, mental state, behaviour, quality of life, satisfaction and costs were sought.Data collection and analysis: We extracted data independently. For binary outcomes we calculated relative risk (RR) and its 95% confidence interval (CI), on an intention-to-treat basis. For continuous data we estimated mean difference (MD) between groups and its 95% confidence interval (CI). We employed a random-effects model for analyses.We performed a random-effects meta-regression analysis to examine the association of the intervention's fidelity to the ACT model and the rate of hospital use in the setting where the trial was conducted with the treatment effect.Main results: We included 38 trials (7328 participants) in this review. The trials provided data for two comparisons: 1. ICM versus standard care, 2. ICM versus non-ICM.1. ICM versus standard care Twenty-four trials provided data on length of hospitalisation, and results favoured Intensive Case Management (n=3595, 24 RCTs, MD -0.86 CI -1.37 to -0.34). There was a high level of heterogeneity, but this significance still remained when the outlier studies were excluded from the analysis (n=3143, 20 RCTs, MD -0.62 CI -1.00 to -0.23). Nine studies found participants in the ICM group were less likely to be lost to psychiatric services (n=1633, 9 RCTs, RR 0.43 CI 0.30 to 0.61, I^2=49%, p=0.05).One global state scale did show an Improvement in global state for those receiving ICM, the GAF scale (n=818, 5 RCTs, MD 3.41 CI 1.66 to 5.16). Results for mental state as measured through various rating scales, however, were equivocal, with no compelling evidence that ICM was really any better than standard care in improving mental state. No differences in mortality between ICM and standard care groups occurred, either due to 'all causes' (n=1456, 9 RCTs, RR 0.84 CI 0.48 to 1.47) or to 'suicide' (n=1456, 9 RCTs, RR 0.68 CI 0.31 to 1.51).Social functioning results varied, no differences were found in terms of contact with the legal system and with employment status, whereas significant improvement in accommodation status was found, as was the incidence of not living independently, which was lower in the ICM group (n=1185, 4 RCTs, RR 0.65 CI 0.49 to 0.88).Quality of life data found no significant difference between groups, but data were weak. CSQ scores showed a greater participant satisfaction in the ICM group (n=423, 2 RCTs, MD 3.23 CI 2.31 to 4.14).2. ICM versus non-ICM The included studies failed to show a significant advantage of ICM in reducing the average length of hospitalisation (n=2220, 21 RCTs, MD -0.08 CI -0.37 to 0.21). They did find ICM to be more advantageous than non-ICM in reducing rate of lost to follow-up (n=2195, 9 RCTs, RR 0.72 CI 0.52 to 0.99), although data showed a substantial level of heterogeneity (I^2=59%, p=0.01). Overall, no significant differences were found in the effects of ICM compared to non-ICM for broad outcomes such as service use, mortality, social functioning, mental state, behaviour, quality of life, satisfaction and costs.3. Fidelity to ACT Within the meta-regression we found that i. the more ICM is adherent to the ACT model, the

better it is at decreasing time in hospital ('organisation fidelity' variable coefficient -0.36 CI -0.66 to -0.07); and ii. the higher the baseline hospital use in the population, the better ICM is at decreasing time in hospital ('baseline hospital use' variable coefficient -0.20 CI -0.32 to -0.10). Combining both these variables within the model, 'organisation fidelity' is no longer significant, but 'baseline hospital use' result is still significantly influencing time in hospital (regression coefficient -0.18 CI -0.29 to -0.07, p=0.0027).Authors' conclusions: ICM was found effective in ameliorating many outcomes relevant to people with severe mental illnesses. Compared to standard care ICM was shown to reduce hospitalisation and increase retention in care. It also globally improved social functioning, although ICM's effect on mental state and quality of life remains unclear. ICM is of value at least to people with severe mental illnesses who are in the sub-group of those with a high level of hospitalisation (about 4 days/month in past 2 years) and the intervention should be performed close to the original model.It is not clear, however, what gain ICM provides on top of a less formal non-ICM approach.We do not think that more trials comparing current ICM with standard care or non-ICM are justified, but currently we know of no review comparing non-ICM with standard care and this should be undertaken.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007906.pub2/abstract

Record #131 of 175

ID: CD007514

AU: McGuinness Bernadette

AU: O'Hare John

AU: Craig David

AU: Bullock Roger

AU: Malouf Reem

AU: Passmore Peter

TI: Statins for the treatment of dementia

SO: Cochrane Database of Systematic Reviews

YR: 2010

NO: 8

PB: John Wiley & Sons, Ltd

KY: Alzheimer Disease [drug therapy];Dementia [drug therapy];Heptanoic Acids [therapeutic use];Hydroxymethylglutaryl-CoA Reductase Inhibitors [therapeutic use];Pyrroles [therapeutic use];Randomized Controlled Trials as Topic;Simvastatin [therapeutic use];Humans[checkword]

CC: DEMENTIA

DOI: 10.1002/14651858.CD007514.pub2

AB: Background: The use of statin therapy in established Alzheimer's disease (AD) or vascular dementia (VaD) is a relatively unexplored area. In AD ß-amyloid protein (Aß) is deposited in the form of extracellular plaques and previous studies have determined Aß generation is cholesterol dependent. Hypercholesterolaemia has also been implicated in the pathogenesis of VaD. Due to the role of statins in cholesterol reduction it is biologically plausible they may be efficacious in the treatment of AD and dementia.Objectives: To assess the clinical efficacy and tolerability of statins in the treatment of dementia.Search methods: We searched the Specialized Register of the Cochrane Dementia and Cognitive Improvement Group, The Cochrane Library, MEDLINE, EMBASE, PsycINFO, CINAHL and LILACS, as well as many trials registries and grey literature sources (27 October 2008).Selection criteria: Double-blind, randomized controlled trials of statins given for at least six months in people with a diagnosis of dementia.Data collection and analysis: Two independent authors extracted and assessed data independently against the inclusion criteria. Data were pooled where appropriate and entered into a meta-analysis.Main results: Three studies were identified (748 participants, age range 50-90 years). All patients had a diagnosis of probable or possible AD according to standard criteria and most patients were established on a cholinesterase inhibitor. Treatment in ADCLT 2005 consisted of 80mg atorvastatin compared to placebo for 52 weeks, serum low density lipoprotein (LDL) cholesterol was reduced by 54% in the atorvastatin group. Treatment in Simons 2002 consisted of 40mg simvastatin compared to placebo for 26 weeks, serum LDL cholesterol was reduced by 52% in the simvastatin group. Treatment in LEADe 2010 consisted of 80mg atorvastatin compared to placebo for 72 weeks, LDL cholesterol was reduced by 50.2% by month 3 and remained constant through month 18. Change in Alzheimer's Disease Assessment Scale- cognitive subscale (ADAS-Cog) from baseline was a primary outcome in 3 studies; when data were pooled there was considerable heterogeneity so the random effects model was used, statins did not provide any beneficial effect in this cognitive measure [mean difference -1.12, 95% CI -3.99, 1.75, p = 0.44]. All studies provided change in Mini Mental State Examination (MMSE) from baseline; again random effects model was used due to considerable heterogeneity: there was no significant benefit from statins in this cognitive measure when the data were pooled [mean difference -1.53, 95% CI -3.28, 0.21, p = 0.08]. There was some evidence that patients on statins in ADCLT 2005 maintained better cognitive function if serum cholesterol was high at baseline, MMSE was higher at baseline or if they had an apolipoprotein E4 allele present. This would need to be confirmed in larger studies however. Treatment related adverse effects were available from two studies, LEADe 2010 and Simons 2002; when data were pooled there was no significant difference between statins and placebo [odds ratio 2.45, 95% CI 0.69, 8.62, p = 0.16]. There was no significant difference in global function, behaviour or activities of daily living in the statin and placebo groups. One large randomised controlled trial (RCT) (CLASP 2008) has not yet published its results. There were no studies identified assessing role of statins in treatment of VaD. There was no evidence that statins

were detrimental to cognition.Authors' conclusions: There is insufficient evidence to recommend statins for the treatment of dementia. Analysis from the studies available, including one large RCT, indicate statins have no benefit on the outcome measures ADAS-Cog or MMSE. We need to await full results from CLASP 2008 before we can be certain. This Cochrane review will be updated as these results become available.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007514.pub2/abstract

Record #132 of 175

ID: CD006704

AU: Minton Ollie

AU: Richardson Alison

AU: Sharpe Michael

AU: Hotopf Matthew

AU: Stone Patrick

TI: Drug therapy for the management of cancer-related fatigue

SO: Cochrane Database of Systematic Reviews

YR: 2010

NO: 7

PB: John Wiley & Sons, Ltd

KY: Antidepressive Agents [therapeutic use];Central Nervous System Stimulants [therapeutic use];Erythropoietin [adverse effects] [analogs & derivatives] [therapeutic use];Fatigue [drug therapy] [etiology];Hematinics [adverse effects] [therapeutic use];Methylphenidate [therapeutic use];Neoplasms [complications];Progestins [therapeutic use];Randomized Controlled Trials as Topic;Adult[checkword];Humans[checkword]

CC: SYMPT

DOI: 10.1002/14651858.CD006704.pub3

AB: Background: This review is an update of a previously published review in The Cochrane Database of Systematic Reviews (Issue 1 2008). Cancer-related fatigue (CRF) is common, under-recognised and difficult to treat. There have been studies looking at drug interventions to improve CRF but results have been conflicting depending on the population studied and outcome measures used. No previous reviews of this topic have been exhaustive or have synthesised all available data.Objectives: To assess the efficacy of drugs for the management

of CRF.Search methods: We searched the Cochrane Central Register of Controlled Trials (from Issue 2 2007) MEDLINE and EMBASE from January 2007 to October 2009 and a selection of cancer journals. We searched references of identified articles and contacted authors to obtain unreported data.Selection criteria: Studies were included in the review if they 1) assessed drug therapy for the management of CRF compared to placebo, usual care or a non-pharmacological intervention in 2) randomised controlled trials (RCT) of 3) adult patients with a clinical diagnosis of cancer.Data collection and analysis: Two review authors independently assessed trial quality and extracted data. Meta-analyses were performed on different drug classes using continuous variable data.Main results: Fifty studies met the inclusion criteria. Six additional studies were identified since the original review. Only 31 of these studies involving 7104 participants were judged to have used a sufficiently robust measure of fatigue and thus were deemed suitable for detailed analysis. The drugs were still analysed by class (psychostimulants; haemopoietic growth factors; antidepressants and progestational steroids). Methylphenidate showed a small but significant improvement in fatigue over placebo (Z = 2.83; P = 0.005). Since the publication of the original review increased safety concerns have been raised regarding erythropoietin and this cannot now be recommended in practice.There was a very high degree of statistical and clinical heterogeneity in the trials and the reasons for this are discussed.Authors' conclusions: There is increasing evidence that psychostimulant trials provide evidence for improvement in CRF at a clinically meaningful level. There is still a requirement for a large scale RCT of methylphenidate to confirm the preliminary results from this review. There is new safety data which indicates that the haemopoietic growth factors are associated with increased adverse outcomes. These drugs can no longer be recommended in the treatment of CRF. Readers of the first review should re-read the document in full.

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Record #133 of 175

ID: CD005074

AU: Walters Julia AE

AU: Turnock Allison C

AU: Walters E. Haydn

AU: Wood-Baker Richard

TI: Action plans with limited patient education only for exacerbations of chronic obstructive pulmonary disease

SO: Cochrane Database of Systematic Reviews

YR: 2010

NO: 5

PB: John Wiley & Sons, Ltd

KY: Patient Education as Topic;Self Care;Behavior Therapy;Health Promotion;Health Services Needs and Demand [statistics & numerical data];Patient Care Planning [organization & administration];Pulmonary Disease, Chronic Obstructive [diagnosis] [therapy];Quality of Life;Randomized Controlled Trials as Topic;Recurrence;Humans[checkword]

CC: AIRWAYS

DOI: 10.1002/14651858.CD005074.pub3

AB: Background: Chronic obstructive pulmonary disease (COPD) is a progressive disease characterised by exacerbations, usually infective in origin, which affect symptoms and quality of life. Action plans may help individuals recognise a deterioration in their symptoms and initiate changes to treatment early, thereby reducing the impact of the exacerbation.Objectives: To assess the efficacy of action plans in the management of COPD.Search methods: We searched the Cochrane Airways Group Specialised Register (7 July 2009), CENTRAL, MEDLINE , CINAHL and ongoing trials registers (last searched July 2009).Selection criteria: Randomised controlled trials of an individual action plan with minimal or no self management education, compared to control in patients with COPD were included. Studies in asthma and in multi-faceted interventions in which an action plan was combined with other elements such as education programme, exercise programme or outreach visits were excluded.Data collection and analysis: Two reviewers independently assessed trial quality and extracted data. We contacted investigators for additional information when necessary.Main results: Five studies enrolling 574 participants with moderate or severe COPD, with follow-up from six to twelve months, were included. There was no evidence that action plans reduced health care utilisation; assessed by hospital admission (mean difference (MD) 0.23; 95% CI -0.03 to 0.49), emergency department visits (MD 0.37; 95% CI -0.50 to 1.24) or GP visits (MD 0.53; -0.45, 1.50). Use of action plans was associated with increased initiation of treatment for acute exacerbations. Oral corticosteroid use was increased over 12 months (MD 0.74; 95% CI 0.14 to 1.35) with a significant increase in odds of being treated with antibiotics over 12 months (odds ratio 1.65; 95% CI 1.01 to 2.69). Self management knowledge and intention to initiate appropriate actions were improved in one study; recognition of a severe exacerbation (MD 2.50; 95% CI 1.04 to 3.96) and self initiating action in a severe exacerbation (MD 1.50; 95% CI 0.62 to 2.38). Health-related quality of life data were limited.Authors' conclusions: There is evidence that action plans with limited COPD education aid recognition of, and response to, an exacerbation with initiation of antibiotics and corticosteroids. Only one study measured patients' self health appropriate behaviour (decision making and taking action). There is no evidence of reduced healthcare resources utilisation or improved health-related quality of life.The practice of giving patients an action plan and limited self-management education for the management of COPD exacerbations, without a multi-faceted self-management program or ongoing case management cannot be recommended as the standard of care in COPD.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD005074.pub3/abstract

Record #134 of 175

ID: CD002094

AU: Leontiadis Grigorios I

AU: Sharma Virender Kumar

AU: Howden Colin W

TI: Proton pump inhibitor treatment for acute peptic ulcer bleeding

SO: Cochrane Database of Systematic Reviews

YR: 2010

NO: 5

PB: John Wiley & Sons, Ltd

KY: Proton Pump Inhibitors;Acute Disease;Anti-Ulcer Agents [therapeutic use];Cause of Death;Histamine H2 Antagonists [therapeutic use];Peptic Ulcer Hemorrhage [drug therapy] [mortality];Randomized Controlled Trials as Topic;Recurrence;Humans[checkword]

CC: UPPERGI

DOI: 10.1002/14651858.CD002094.pub4

AB: Background: Randomised controlled trials (RCTs) evaluating the clinical effect of proton pump inhibitors (PPIs) in peptic ulcer (PU) bleeding yield conflicting results.Objectives: To evaluate the efficacy of PPIs in acute bleeding from PU using evidence from RCTs.Search methods: We searched CENTRAL, The Cochrane Library (Issue 4, 2004), MEDLINE (1966 to November 2004), EMBASE (1980 to November 2004), proceedings of major meetings to November 2004, and reference lists of articles. We contacted pharmaceutical companies and experts in the field.Selection criteria: RCTs of PPI treatment (oral or intravenous) compared with placebo or H2-receptor antagonist (H2RA) in acute bleeding from PU.Data collection and analysis: Two reviewers extracted data independently, assessed study validity, summarised studies and undertook meta-analysis. The influence of study characteristics on the outcomes was examined by subgroup analyses and meta-regression.Main results: Twenty-four RCTs comprising 4373 participants in total were included. Statistical heterogeneity was found among trials for rebleeding (P = 0.04), but not for all-cause mortality (P = 0.24) or surgery (P = 0.45). There was no significant difference in all-cause mortality rates between PPI and control treatment; pooled rates were 3.9% on PPI versus 3.8% on control (odds ratio (OR) 1.01; 95% CI 0.74 to 1.40). PPIs significantly reduced rebleeding compared to control; pooled rates were 10.6% with PPI versus 17.3% with control treatment (OR 0.49; 95% CI 0.37 to 0.65). PPI treatment significantly reduced surgery compared with control; pooled rates were 6.1% on PPI versus 9.3% on control (OR 0.61; 95% CI 0.48 to 0.78). There was no evidence to suggest that results on mortality and rebleeding were dependent on study quality, route of PPI

administration, type of control treatment or application of initial endoscopic haemostatic treatment. PPIs significantly reduced surgery compared with placebo but not when compared with H2RA. There was no evidence to suggest that study quality, route of PPI administration or application of initial endoscopic haemostatic treatment influenced results on surgery. PPI treatment appeared more efficacious in studies conducted in Asia compared to studies conducted elsewhere. All-cause mortality was reduced only in Asian studies; reductions in rebleeding and surgery were quantitatively greater in Asian studies. Among patients with active bleeding or non-bleeding visible vessel, PPI treatment reduced mortality (OR 0.53; 95% CI 0.31 to 0.91), rebleeding and surgery.Authors' conclusions: PPI treatment in PU bleeding reduces rebleeding and surgery compared with placebo or H2RA, but there is no evidence of an overall effect on all-cause mortality.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD002094.pub4/abstract

Record #135 of 175

ID: CD008525

AU: Lewis Ian S.

AU: Joska John A.

AU: Siegfried Nandi

TI: Antidepressants for depression in adults with HIV infection

SO: Cochrane Database of Systematic Reviews

YR: 2010

NO: 5

PB: John Wiley & Sons, Ltd

CC: HM-HIV

DOI: 10.1002/14651858.CD008525

AB: This is the protocol for a review and there is no abstract. The objectives are as follows:To determine whether antidepressants are clinically effective in the treatment of depression in adults infected with HIV

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD008525/abstract

Record #136 of 175

ID: CD003243

AU: Wileman Samantha M

AU: McCann Sharon

AU: Grant Adrian M

AU: Krukowski Zygmunt H

AU: Bruce Julie

TI: Medical versus surgical management for gastro-oesophageal reflux disease (GORD) in adults

SO: Cochrane Database of Systematic Reviews

YR: 2010

NO: 3

PB: John Wiley & Sons, Ltd

KY: Fundoplication [methods];Gastroesophageal Reflux [surgery] [therapy];Health Status;Quality of Life;Randomized Controlled Trials as Topic;Adult[checkword];Humans[checkword]

CC: HM-UPPERGI

DOI: 10.1002/14651858.CD003243.pub2

AB: Background: Gastro-oesophageal reflux disease (GORD) is a common condition with up to 20% of patients from Westernised countries experiencing heartburn, reflux or both intermittently. It is unclear whether medical or surgical (laparoscopic fundoplication) management is the most clinically and cost-effective treatment for controlling GORD.Objectives: To compare the effects of medical management versus laparoscopic fundoplication surgery on health-related and GORD-specific quality of life (QOL) in adults with GORD.Search methods: We searched CENTRAL (Issue 2, 2009), MEDLINE (1966 to May 2009) and EMBASE (1980 to May 2009). We handsearched conference abstracts and reference lists from published trials to identify further trials. We contacted experts in the field for relevant unpublished material.Selection criteria: All randomised or quasi-randomised controlled trials comparing medical management with laparoscopic fundoplication surgery.Data collection and analysis: Two authors independently extracted data from articles identified for inclusion and assessed the methodological quality of eligible trials. Primary outcomes were: health-related and GORD-specific QOL, heartburn, regurgitation and dysphagia.Main results: Four trials were included with a total of 1232 randomised participants. Health-related QOL was reported by four studies although data were combined using fixed-effect models for two studies (Anvari 2006; REFLUX Trial 2008). There were statistically significant improvements in health-related

QOL at three months and one year after surgery compared to medical therapy (mean difference (MD) SF36 general health score -5.23, 95% CI -6.83 to -3.62; I2 = 0%). All four studies reported significant improvements in GORD-specific QOL after surgery compared to medical therapy although data were not combined. There is evidence to suggest that symptoms of heartburn, reflux and bloating are improved after surgery compared to medical therapy, but a small proportion of participants have persistent postoperative dysphagia. Overall rates of postoperative complications were low but surgery is not without risk and postoperative adverse events occurred although they were uncommon. The costs of surgery are considerably higher than the cost of medical management although data are based on the first year of treatment therefore the cost and side effects associated with long-term treatment of chronic GORD need to be considered.Authors' conclusions: There is evidence that laparoscopic fundoplication surgery is more effective than medical management for the treatment of GORD at least in the short to medium term. Surgery does carry some risk and whether the benefits of surgery are sustained in the long term remains uncertain. Treatment decisions for GORD should be based on patient and surgeon preference.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003243.pub2/abstract

Record #137 of 175

ID: CD007868

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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 #138 of 175

ID: CD005103

AU: Misso Marie L

AU: Egberts Kristine J

AU: Page Matthew

AU: O'Connor Denise

AU: Shaw Jonathan

TI: Continuous subcutaneous insulin infusion (CSII) versus multiple insulin injections for type 1 diabetes mellitus

SO: Cochrane Database of Systematic Reviews

YR: 2010

NO: 1

PB: John Wiley & Sons, Ltd

KY: Diabetes Mellitus, Type 1 [drug therapy];Hypoglycemic Agents [administration & dosage];Infusions, Subcutaneous;Insulin [administration & dosage];Randomized Controlled Trials as Topic;Adolescent[checkword];Adult[checkword];Child[checkword];Humans[checkword]

CC: ENDOC

DOI: 10.1002/14651858.CD005103.pub2

AB: Background: Type 1 diabetes is a metabolic disorder resulting from a defect in insulin secretion. Onset of type 1 diabetes mellitus may occur at any age and it is one of the most common chronic diseases of childhood and adolescence. Since there are no interventions known to prevent onset, it is vital that effective treatment regimes are available. Glycaemic control is maintained by replacement of insulin and may be in the form of 'conventional' insulin therapy (multiple injections per day) or continuous subcutaneous insulin infusion

(CSII).Objectives: To assess the effects of CSII compared to multiple insulin injections (MI) in people with type 1 diabetes mellitus.Search methods: Studies were obtained from electronic searches of The Cochrane Library, MEDLINE, EMBASE and CINAHL.Selection criteria: Studies were included if they were randomised controlled trials comparing CSII with three or more insulin injections per day (MI) in people with type 1 diabetes mellitus.Data collection and analysis: Two authors independently assessed risk of bias and extracted characteristics of included studies. Authors contacted study investigators to obtain missing information. Generic inverse variance meta-analyses using a random-effects model were performed.Main results: Twenty three studies randomised 976 participants with type 1 diabetes to either intervention. There was a statistically significant difference in glycosylated haemoglobin A1c (HbA1c) favouring CSII (weighted mean difference -0.3% (95% confidence interval -0.1 to -0.4). There were no obvious differences between the interventions for non-severe hypoglycaemia, but severe hypoglycaemia appeared to be reduced in those using CSII. Quality of life measures suggest that CSII is preferred over MI. No significant difference was found for weight. Adverse events were not well reported, no information is available on mortality, morbidity and costs.Authors' conclusions: There is some evidence to suggest that CSII may be better than MI for glycaemic control in people with type 1 diabetes. Non-severe hypoglycaemic events do not appear to be reduced with CSII. There is insufficient evidence regarding adverse events, mortality, morbidity and costs.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD005103.pub2/abstract

Record #139 of 175

ID: CD008275

AU: Almoammar Ibtesam A

AU: Al-Mansoof Afaf Saleh

AU: Alamri Nadrah Z

TI: Taping for knee osteoarthritis

SO: Cochrane Database of Systematic Reviews

YR: 2010

NO: 1

PB: John Wiley & Sons, Ltd

CC: HM-MUSKEL

DOI: 10.1002/14651858.CD008275

AB: This is the protocol for a review and there is no abstract. The objectives are as follows: To determine the effect of taping on pain and function in adults with knee osteoarthritis compared with other interventions. To explore whether potential variation between trials can be explained by differences in taping method or by biases affecting individual trials.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD008275/abstract

Record #140 of 175

ID: CD006743

AU: Perez Marco I

AU: Musini Vijaya M

AU: Wright James M

TI: Effect of early treatment with anti-hypertensive drugs on short and long-term mortality in patients with an acute cardiovascular event

SO: Cochrane Database of Systematic Reviews

YR: 2009

NO: 4

PB: John Wiley & Sons, Ltd

KY: Adrenergic beta-Antagonists [therapeutic use];Angiotensin-Converting Enzyme Inhibitors [therapeutic use];Antihypertensive Agents [adverse effects] [therapeutic use];Calcium Channel Blockers [therapeutic use];Cardiovascular Diseases [drug therapy] [mortality];Cause of Death;Drug Administration Schedule;Hypertension [drug therapy];Nitrates [therapeutic use];Randomized Controlled Trials as Topic;Humans[checkword]

CC: HM-HTN

DOI: 10.1002/14651858.CD006743.pub2

AB: Background: Acute cardiovascular events represent a therapeutic challenge. Blood pressure lowering drugs are commonly used and recommended in the early phase of these settings. This review analyses randomized controlled trial (RCT) evidence for this approach.Objectives: To determine the effect of immediate and short-term administration of anti-hypertensive drugs on all-cause mortality, total non-fatal serious adverse events (SAE) and blood pressure, in patients with an acute cardiovascular event, regardless of blood pressure at the time of enrollment.Search methods: MEDLINE, EMBASE, and Cochrane clinical trial register from Jan 1966 to February 2009 were searched. Reference lists of articles were also browsed. In case of missing information from retrieved articles, authors were contacted.Selection

criteria: Randomized controlled trials (RCTs) comparing anti-hypertensive drug with placebo or no treatment administered to patients within 24 hours of the onset of an acute cardiovascular event.Data collection and analysis: Two reviewers independently extracted data and assessed risk of bias. Fixed effects model with 95% confidence intervals (CI) were used. Sensitivity analyses were also conducted.Main results: Sixty-five RCTs (N=166,206) were included, evaluating four classes of anti-hypertensive drugs: ACE inhibitors (12 trials), beta-blockers (20), calcium channel blockers (18) and nitrates (18). Acute stroke was studied in 6 trials (all involving CCBs). Acute myocardial infarction was studied in 59 trials. In the latter setting immediate nitrate treatment (within 24 hours) reduced all-cause mortality during the first 2 days (RR 0.81, 95%CI [0.74,0.89], p<0.0001). No further benefit was observed with nitrate therapy beyond this point. ACE inhibitors did not reduce mortality at 2 days (RR 0.91,95%CI [0.82, 1.00]), but did after 10 days (RR 0.93, 95%CI [0.87,0.98] p=0.01). No other blood pressure lowering drug administered as an immediate treatment or short-term treatment produced a statistical significant mortality reduction at 2, 10 or ?30 days. There was not enough data studying acute stroke, and there were no RCTs evaluating other acute cardiovascular events.Authors' conclusions: Nitrates reduce mortality (4-8 deaths prevented per 1000) at 2 days when administered within 24 hours of symptom onset of an acute myocardial infarction. No mortality benefit was seen when treatment continued beyond 48 hours. Mortality benefit of immediate treatment with ACE inhibitors post MI at 2 days did not reach statistical significance but the effect was significant at 10 days (3-5 deaths prevented per 1000). There is good evidence for lack of a mortality benefit with immediate or short-term treatment with beta-blockers and calcium channel blockers for acute myocardial infarction.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006743.pub2/abstract

Record #141 of 175

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 #142 of 175

ID: CD003240

AU: Shek Elena

AU: Stein Airton T

AU: Shansis Flavio M

AU: Marshall Max

AU: Crowther Ruth

AU: Tyrer Peter

TI: Day hospital versus outpatient care for people with schizophrenia

SO: Cochrane Database of Systematic Reviews

YR: 2009

NO: 4

PB: John Wiley & Sons, Ltd

KY: Aftercare;Ambulatory Care [standards];Day Care [economics] [standards];Hospitals, Psychiatric;Mental Disorders [therapy];Program Evaluation;Randomized Controlled Trials as Topic;Schizophrenia [therapy];Humans[checkword]

CC: SCHIZ

DOI: 10.1002/14651858.CD003240.pub2

AB: Background: This review considers the use of day hospitals as an alternative to outpatient care. Two types of day hospital are covered by the review: 'day treatment programmes' and 'transitional' day hospitals. Day treatment programmes offer more intense treatment for people who have failed to respond to outpatient care. Transitional day hospitals offer time-limited care to people who have just been discharged from inpatient care.Objectives: To assess effects of day hospital care as an alternative to continuing outpatient care for people with schizophrenia and and other similar severe mental illness.Search methods: We searched the Cochrane Schizophrenia Group Trials Register (May 2009) and references of all identified studies for further citations. If necessary, we also contacted authors of trials for further information.Selection criteria: Randomised controlled trials comparing day hospital care with outpatient care for those with schizophrenia and other similar severe mental illness.Data collection and analysis: We extracted and cross-checked data independently. We analysed

dichotomous data using fixed-effect relative risk (RR) and estimated the 95% confidence interval (CI). If continuous data were included, we analysed this data using the random-effects weighted mean difference (MD) with a 95% confidence interval.Main results: We identified four relevant trials all dating from before 1986 (total n=309 participants); all but one of which (n=37) evaluated day treatment centres. Across time less people allocated to day hospital care tend to be admitted to hospital (beyond one year: n=242, 2 RCTs, RR 0.71 CI 0.56 to 0.89 day treatment centres) but data are heterogeneous (I2 =74% P=0.05) and should not be taken into account. Data on time spent as an inpatient seem to support this finding but are poorly reported. We found no clear difference between day hospital and outpatient care for the outcome of ?lost to follow up? (at six months: n=147, 3 RCTs, RR 0.97 CI 0.48 to 1.95; at 12 months: n=117, 2 RCTs, RR 0.97 CI 0.48 to 1.95 day treatment centres / transitional day hospital). Scale derived findings on social functioning are equivocal (SAS: n=37, 1 RCT, MD 0.36 CI -0.07 to 0.79 transitional day hospital) but there was some suggestion from small studies that day hospital care may decrease the risk of unemployment (at 12 months: n=80, 1 RCT, RR 0.86 CI 0.69 to 1.06 day treatment centre). Different measures of mental state showed no convincing effect (Symptom Check List: n=30, 1 RCT, MD -90 0.31 CI -0.20 to 0.82 day treatment centre). Poorly reported economic data from decades ago suggested that day hospitals were more costly to establish and run than outpatient care but took no account of other costs such as inpatient stay.Authors' conclusions: Evidence is limited and dated. Day hospital care may help avoid inpatient care but data are lacking on missing on a raft of outcomes that are now considered important, such as quality of life, satisfaction, healthy days, and cost.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003240.pub2/abstract

Record #143 of 175

ID: CD004433

AU: Sirtori Valeria

AU: Corbetta Davide

AU: Moja Lorenzo

AU: Gatti Roberto

TI: Constraint-induced movement therapy for upper extremities in stroke patients

SO: Cochrane Database of Systematic Reviews

YR: 2009

NO: 4

PB: John Wiley & Sons, Ltd

KY: Upper Extremity;Exercise Movement Techniques [methods];Immobilization [methods];Paresis [etiology] [rehabilitation];Randomized Controlled Trials as Topic;Stroke [complications] [rehabilitation];Time Factors;Humans[checkword]

CC: HM-STROKE

DOI: 10.1002/14651858.CD004433.pub2

AB: Background: In stroke patients, upper limb paresis affects many activities of daily life. Reducing disability is therefore a major aim of rehabilitation programmes for hemiparetic patients. Constraint-induced movement therapy (CIMT) is a current approach to stroke rehabilitation that implies the forced use and the massed practice of the affected arm by restraining the unaffected arm.Objectives: To assess the efficacy of CIMT, modified CIMT (mCIMT), or forced use (FU) for arm management in hemiparetic patients.Search methods: We searched the Cochrane Stroke Group trials register (last searched June 2008), the Cochrane Central Register of Controlled Trials (CENTRAL) (The Cochrane Library Issue 1, 2008), MEDLINE (1966 to June 2008), EMBASE (1980 to June 2008), CINAHL (1982 to June 2008), and the Physiotherapy Evidence Database (PEDro) (June 2008).Selection criteria: Randomised control trials (RCTs) and quasi-RCTs (qRCTs) comparing CIMT, mCIMT or FU with other rehabilitative techniques, or none.Data collection and analysis: Two review authors independently classified the identified trials according to the inclusion and exclusion criteria, assessed methodological quality and extracted data. The primary outcome was disability.Main results: We included 19 studies involving 619 participants. The trials included participants who had some residual motor power of the paretic arm, the potential for further motor recovery and with limited pain or spasticity, but tended to use the limb little if at all. Only five studies had adequate allocation concealment. The majority of studies were underpowered (median number of included patients was 15) and we cannot rule out small-trial bias. Six trials (184 patients) assessed disability immediately after the intervention, indicating a significant standard mean difference (SMD) of 0.36, 95% confidence interval (CI) 0.06 to 0.65. For the most frequently reported outcome, arm motor function (11 studies involving 373 patients), the SMD was 0.72 (95% CI 0.32 to 1.12). There were only two studies that explored disability improvement after a few months of follow up and found no significant difference, SMD -0.07 (95% CI -0.53 to 0.40).Authors' conclusions: CIMT is a multifaceted intervention: the restriction to the normal limb is accompanied by a certain amount of exercise of the appropriate quality. It is associated with a moderate reduction in disability assessed at the end of the treatment period. However, for disability measured some months after the end of treatment, there was no evidence of persisting benefit. Further randomised trials, with larger sample sizes and longer follow up, are justified.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004433.pub2/abstract

Record #144 of 175

ID: CD007303

AU: Bohlius Julia

AU: Schmidlin Kurt

AU: Brillant Corinne

AU: Schwarzer Guido

AU: Trelle Sven

AU: Seidenfeld Jerome

AU: Zwahlen Marcel

AU: Clarke Mike J

AU: Weingart Olaf

AU: Kluge Sabine

AU: Piper Margaret

AU: Napoli Maryann

AU: Rades Dirk

AU: Steensma David

AU: Djulbegovic Benjamin

AU: Fey Martin F

AU: Ray-Coquard Isabelle

AU: Moebus Volker

AU: Thomas Gillian

AU: Untch Michael

AU: Schumacher Martin

AU: Egger Matthias

AU: Engert Andreas

TI: Erythropoietin or Darbepoetin for patients with cancer - meta-analysis based on individual patient data

SO: Cochrane Database of Systematic Reviews

YR: 2009

NO: 3

PB: John Wiley & Sons, Ltd

KY: Erythrocyte Transfusion;Anemia [complications] [mortality] [therapy];Disease-Free Survival;Erythropoietin [adverse effects] [analogs & derivatives];Hematinics [adverse effects];Neoplasms [complications] [mortality] [therapy];Randomized Controlled Trials as Topic;Recombinant Proteins;Adult[checkword];Child[checkword];Female[checkword];Humans[checkword];Male[checkword]

CC: HAEMATOL

DOI: 10.1002/14651858.CD007303.pub2

AB: Background: Erythropoiesis-stimulating agents (ESAs) reduce anemia in cancer patients and may improve quality of life, but there are concerns that ESAs might increase mortality.Objectives: Our objectives were to examine the effect of ESAs and identify factors that modify the effects of ESAs on overall survival, progression free survival, thromboembolic and cardiovascular events as well as need for transfusions and other important safety and efficacy outcomes in cancer patients.Search methods: We searched the Cochrane Library, Medline, Embase and conference proceedings for eligible trials. Manufacturers of ESAs were contacted to identify additional trials.Selection criteria: We included randomized controlled trials comparing epoetin or darbepoetin plus red blood cell transfusions (as necessary) versus red blood cell transfusions (as necessary) alone, to prevent or treat anemia in adult or pediatric cancer patients with or without concurrent antineoplastic therapy.Data collection and analysis: We performed a meta-analysis of randomized controlled trials comparing epoetin alpha, epoetin beta or darbepoetin alpha plus red blood cell transfusions versus transfusion alone, for prophylaxis or therapy of anemia while or after receiving anti-cancer treatment. Patient-level data were obtained and analyzed by independent statisticians at two academic departments, using fixed-effects and random-effects meta-analysis. Analyses were according to the intention-to-treat principle. Primary endpoints were on study mortality and overall survival during the longest available follow-up, regardless of anticancer treatment, and in patients receiving chemotherapy. Tests for interactions were used to identify differences in effects of ESAs on mortality across pre-specified subgroups. The present review reports only the results for the primary endpoint.Main results: A total of 13933 cancer patients from 53 trials were analyzed, 1530 patients died on-study and 4993 overall. ESAs increased on study mortality (combined hazard ratio [cHR] 1.17; 95% CI 1.06-1.30) and worsened overall survival (cHR 1.06; 95% CI 1.00-1.12), with little heterogeneity between trials (I2 0%, p=0.87 and I2 7.1%, p=0.33, respectively). Thirty-eight trials enrolled 10441 patients receiving chemotherapy. The cHR for on study mortality was 1.10 (95% CI 0.98-1.24) and 1.04; 95% CI 0.97-1.11) for overall survival. There was little evidence for a difference between trials of patients receiving different cancer treatments (P for interaction=0.42).Authors' conclusions: ESA treatment in cancer patients increased on study mortality and worsened overall survival. For patients undergoing chemotherapy the increase was less pronounced, but an adverse effect could not be excluded.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007303.pub2/abstract

Record #145 of 175

ID: CD006456

AU: Mestre Tiago

AU: Ferreira Joaquim

AU: Coelho Miguel M

AU: Rosa Mário

AU: Sampaio Cristina

TI: Therapeutic interventions for symptomatic treatment in Huntington's disease

SO: Cochrane Database of Systematic Reviews

YR: 2009

NO: 3

PB: John Wiley & Sons, Ltd

KY: Chorea [drug therapy];Huntington Disease [complications] [drug therapy];Randomized Controlled Trials as Topic;Humans[checkword]

CC: HM-MOVEMENT

DOI: 10.1002/14651858.CD006456.pub2

AB: Background: Huntington's disease (HD) is an orphan autosomal dominant neurodegenerative disorder caused by the amplification of a nucleic acids triplet repeat. It is characterised by core symptoms of chorea, progressive dementia and psychiatric manifestations such as depression, irritability, apathy and psychosis. In current clinical practice, drugs exist that seem to improve symptoms for HD patients. However, their effectiveness has not been fully measured.Objectives: To evaluate the effectiveness of the available interventions for the symptomatic treatment of HD.Search methods: The search strategy developed for the Movement Disorders Group was undertaken. Cochrane Controlled Trials Register, Medline, EMBASE and Clinical Trials Database of the United States National Institute of Health were thoroughly searched up until December 2007.Selection criteria: All randomised, double-blinded, placebo-controlled clinical trials conducted on any symptomatic therapy used for HD with at least ten participants were included. Participants should have HD clinical features and a confirmatory genetic diagnosis or a compatible family history. All disease variants and ages of disease onset were included. Cross-over studies were included. All pharmacological and non-pharmacological interventions aimed at the control of signs and symptoms associated with HD were to be selected.Data collection and analysis: Two reviewers

independently assessed the identified trials for eligibility. In the selected trials, the assessment of their methodological quality was done according to the Cochrane Collaboration handbook, and eligible data were registered onto standardised forms. If possible, an intention-to-treat analysis was conducted. When data were not available in the original publication, the principal investigator of the trial was contacted. A meta-analysis was conducted when possible and otherwise the descriptive summary of the results was provided. The software Revman 5.0.15 was used for statistical analysis.Main results: 22 trials (1254 participants) were included. Nine trials had a cross-over design and 13 were conducted in parallel. Study duration ranged from 2 to 80 weeks. Various pharmacological interventions were studied, mostly, they were anti-dopaminergic drugs (n = 5), glutamate receptor antagonists (n = 5) and energy metabolites (n = 5). Only tetrabenazine showed a clear efficacy for the control of chorea. The remaining pharmacological interventions revealed no clear effectiveness.Authors' conclusions: No intervention proved to have a consistent symptomatic control in HD. Tetrabenazine is the anti-choreic drug with the best quality data available. Other symptomatic areas should be explored by well-designed randomised placebo-controlled studies.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006456.pub2/abstract

Record #146 of 175

ID: CD007483

AU: Sinclair David

AU: Zani Babalwa

AU: Donegan Sarah

AU: Olliaro Piero

AU: Garner Paul

TI: Artemisinin-based combination therapy for treating uncomplicated malaria

SO: Cochrane Database of Systematic Reviews

YR: 2009

NO: 3

PB: John Wiley & Sons, Ltd

KY: Antimalarials [therapeutic use];Artemisinins [therapeutic use];Drug Combinations;Drug Therapy, Combination;Ethanolamines [therapeutic use];Fluorenes [therapeutic use];Malaria [drug therapy];Malaria, Falciparum [drug therapy];Malaria, Vivax [drug therapy];Mefloquine [therapeutic use];Parasitemia [drug therapy] [parasitology];Pyrimethamine [therapeutic

use];Quinolines [therapeutic use];Randomized Controlled Trials as Topic;Sulfadoxine [therapeutic use];Humans[checkword]

CC: HM-INFECTN

DOI: 10.1002/14651858.CD007483.pub2

AB: Background: The World Health Organization recommends uncomplicated P. falciparum malaria is treated using Artemisinin-based Combination Therapy (ACT). This review aims to assist the decision making of malaria control programmes by providing an overview of the relative benefits and harms of the available options.Objectives: To compare the effects of ACTs with other available ACT and non-ACT combinations for treating uncomplicated P. falciparum malaria.Search methods: We searched the Cochrane Infectious Diseases Group Specialized Register; the Cochrane Central Register of Controlled Trials (CENTRAL); MEDLINE; EMBASE; LILACS, and the metaRegister of Controlled Trials (mRCT) to March 2009.Selection criteria: Randomized head to head trials of ACTs in uncomplicated P. falciparum malaria.This review is limited to: dihydroartemisinin-piperaquine; artesunate plus mefloquine; artemether-lumefantrine (six doses); artesunate plus amodiaquine; artesunate plus sulfadoxine-pyrimethamine and amodiaquine plus sulfadoxine-pyrimethamine.Data collection and analysis: Two authors independently assessed trials for eligibility and risk of bias, and extracted data. We analysed primary outcomes in line with the WHO 'Protocol for assessing and monitoring antimalarial drug efficacy' and compared drugs using risk ratios (RR) and 95% confidence intervals (CI). Secondary outcomes were effects on P. vivax, gametocytes, haemoglobin, and adverse events.Main results: Fifty studies met the inclusion criteria. All five ACTs achieved PCR adjusted failure rates of < 10%, in line with WHO recommendations, at most study sites.Dihydroartemisinin-piperaquine performed well compared to the ACTs in current use (PCR adjusted treatment failure versus artesunate plus mefloquine in Asia; RR 0.39, 95% CI 0.19 to 0.79; three trials, 1062 participants; versus artemether-lumefantrine in Africa; RR 0.39, 95% CI 0.24 to 0.64; three trials, 1136 participants).ACTs were superior to amodiaquine plus sulfadoxine-pyrimethamine in East Africa (PCR adjusted treatment failure versus artemether-lumefantrine; RR 0.12, 95% CI 0.06 to 0.24; two trials, 618 participants; versus AS+AQ; RR 0.44, 95% CI 0.22 to 0.89; three trials, 1515 participants).Dihydroartemisinin-piperaquine (RR 0.32, 95% CI 0.24 to 0.43; four trials, 1442 participants) and artesunate plus mefloquine (RR 0.30, 95% CI 0.21 to 0.41; four trials, 1003 participants) were more effective than artemether-lumefantrine at reducing the incidence of P.vivax over 42 days follow up.Authors' conclusions: Dihydroartemisinin-piperaquine is another effective first-line treatment for P. falciparum malaria.The performance of the non-ACT (amodiaquine plus sulfadoxine-pyrimethamine) falls below WHO recommendations for first-line therapy in parts of Africa.In areas where primaquine is not being used for radical cure of P. vivax, ACTs with long half-lives may provide some benefit.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007483.pub2/abstract

Record #147 of 175

ID: CD006529

AU: Nakagawa Atsuo

AU: Watanabe Norio

AU: Omori Ichiro M

AU: Barbui Corrado

AU: Cipriani Andrea

AU: McGuire Hugh

AU: Churchill Rachel

AU: Furukawa Toshi A

TI: Milnacipran versus other antidepressive agents for depression

SO: Cochrane Database of Systematic Reviews

YR: 2009

NO: 3

PB: John Wiley & Sons, Ltd

KY: Antidepressive Agents [adverse effects] [therapeutic use];Cyclopropanes [adverse effects] [therapeutic use];Depressive Disorder, Major [drug therapy];Randomized Controlled Trials as Topic;Serotonin Uptake Inhibitors [adverse effects] [therapeutic use];Humans[checkword]

CC: HM-DEPRESSN

DOI: 10.1002/14651858.CD006529.pub2

AB: Background: Although pharmacological and psychological interventions are both effective for major depression, antidepressant drugs are frequently used as first-line treatment in primary and secondary care settings. Milnacipran, a dual serotonin-norepinephrine reuptake inhibitor (SNRI), is one of the antidepressant drugs that clinicians use for routine depression care.Objectives: To assess the evidence for the efficacy, acceptability and tolerability of milnacipran in comparison with tricyclic antidepressants (TCAs), heterocyclics, SSRIs and other newer antidepressive agents in the acute-phase treatment of major depression.Search methods: The Cochrane Collaboration Depression, Anxiety & Neurosis review group Controlled Trials Register (CCDANCTR-Studies and CCDANCTR-References) were electronically searched in August 2008. References of relevant trials and other reviews were also checked. Trial databases of the drug-approving agencies and ongoing clinical trial registers for all published and unpublished trials were hand-searched in 2007. All relevant authors were contacted for supplemental data. No language restriction was applied.Selection criteria: Randomised

controlled trials comparing milnacipran with any other active antidepressive agents (including non-conventional agents such as herbal products like hypericum) as monotherapy in the acute phase of major depression were selected.Data collection and analysis: Two reviewers independently checked eligibility, assessed methodological quality and extracted data from the eligible trials using a standardised data extraction form. The number of participants who responded to treatment or those who achieved remission were calculated on an intention-to-treat basis. Random-effects meta-analyses were conducted, combining data from the included trials.Main results: A total of 16 randomised controlled trials (n=2277) were included in the meta-analysis.Despite the size of this sample, the pooled 95% confidence intervals were rather wide and there were no statistically significant differences in efficacy, acceptability and tolerability when comparing milnacipran with other antidepressive agents. However, compared with TCAs, patients taking milnacipran were associated with fewer dropouts due to adverse events (OR 0.55; 95%CI 0.35 to 0.85). There was also some weak evidence to suggest that patients taking milnacipran experienced fewer adverse events of sleepiness/ drowsiness, dry mouth or constipation compared with TCAs.Authors' conclusions: Currently, there is inadequate evidence to conclude whether milnacipran is superior, inferior or the same as other antidepressive agents in terms of efficacy, acceptability and tolerability in the acute phase treatment of major depression. However, there is some evidence in favour of milnacipran over TCAs in terms of dropouts due to adverse events (acceptability) and the rates of experiencing adverse events (tolerability). Information about other clinically meaningful outcomes such as cost-effectiveness and social functioning, including the ability to return to work, is lacking. Further study is needed to answer whether milnacipran would be the better choice of antidepressant for acute major depression.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006529.pub2/abstract

Record #148 of 175

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 #149 of 175

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 #150 of 175

ID: CD000111

AU: Cluett Elizabeth R

AU: Burns Ethel

TI: Immersion in water in labour and birth

SO: Cochrane Database of Systematic Reviews

YR: 2009

NO: 2

PB: John Wiley & Sons, Ltd

KY: Immersion;Labor Stage, First;Labor Stage, Second;Water;Analgesia, Obstetrical [utilization];Natural Childbirth;Randomized Controlled Trials as Topic;Female[checkword];Humans[checkword];Pregnancy[checkword]

CC: PREG

DOI: 10.1002/14651858.CD000111.pub3

AB: Background: Enthusiasts suggest that labouring in water and waterbirth increase maternal relaxation, reduce analgesia requirements and promote a midwifery model of care. Critics cite the risk of neonatal water inhalation and maternal/neonatal infection.Objectives: To assess the evidence from randomised controlled trials about immersion in water during labour and waterbirth on maternal, fetal, neonatal and caregiver outcomes.Search methods: We searched the Cochrane Pregnancy and Childbirth Group's Trials Register (30 June 2011) and reference lists of retrieved studies.Selection criteria: Randomised controlled trials comparing immersion in any bath tub/pool with no immersion, or other non-pharmacological forms of pain management during labour and/or birth, in women during labour who were considered to be at low risk of complications, as defined by the researchers.Data collection and analysis: We assessed trial eligibility and quality and extracted data independently. One review author entered data and the other checked for accuracy.Main results: This review includes 12 trials (3243 women): eight related to just the first stage of labour: one to early versus late immersion in the first stage of labour; two to the first and second stages; and another to the second stage only. We identified no trials evaluating different baths/pools, or the management of third stage of labour.Results for the first stage of labour showed there was a significant reduction in the epidural/spinal/paracervical analgesia/anaesthesia rate amongst women allocated to water immersion compared to controls (478/1254 versus 529/1245; risk ratio (RR) 0.90; 95% confidence interval (CI) 0.82 to 0.99, six trials). There was also a reduction in duration of the first stage of labour (mean difference -32.4 minutes; 95% CI -58.7 to -6.13). There was no difference in assisted vaginal deliveries (RR 0.86; 95% CI 0.71 to 1.05, seven trials), caesarean sections (RR 1.21; 95% CI 0.87 to 1.68, eight trials), use of oxytocin infusion (RR 0.64; 95%CI 0.32 to 1.28,five trials), perineal trauma or maternal infection. There were no differences for Apgar score less than seven at five minutes (RR 1.58; 95% CI 0.63 to 3.93, five trials), neonatal unit admissions (RR 1.06; 95% CI 0.71 to 1.57, three trials), or neonatal infection rates (RR 2.00; 95% CI 0.50 to 7.94, five trials).Of the three trials that compared water immersion during the second stage with no immersion, one trial showed a significantly higher level of satisfaction with the birth experience (RR 0.24; 95% CI 0.07 to 0.80).A lack of data for some comparisons prevented robust conclusions. Further research is needed.Authors' conclusions: Evidence suggests that water immersion during the first stage of labour reduces the use of epidural/spinal analgesia and duration of the first stage of labour. There is limited information for other outcomes related to water use during the first and second stages of labour, due to intervention and outcome variability. There is no evidence of increased adverse effects to the fetus/neonate or woman from labouring in water or waterbirth. However, the studies are very variable and considerable heterogeneity was detected for some outcomes. Further research is needed.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD000111.pub3/abstract

Record #151 of 175

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 #152 of 175

ID: CD003160

AU: McGuinness Bernadette

AU: Craig David

AU: Bullock Roger

AU: Passmore Peter

TI: Statins for the prevention of dementia

SO: Cochrane Database of Systematic Reviews

YR: 2009

NO: 2

PB: John Wiley & Sons, Ltd

KY: Alzheimer Disease [prevention & control];Anticholesteremic Agents [therapeutic use];Cognition [drug effects];Dementia [prevention & control];Hydroxymethylglutaryl-CoA Reductase Inhibitors [therapeutic use];Pravastatin [therapeutic use];Randomized Controlled Trials as Topic;Simvastatin [therapeutic use];Humans[checkword]

CC: HM-DEMENTIA

DOI: 10.1002/14651858.CD003160.pub2

AB: Background: This is an update of a Cochrane review first published in 2001. At that stage there was insufficient evidence to recommend statins for the prevention of Alzheimer's disease (AD). The scope of this review has been expanded to include all forms of dementia.Objectives: To assess the effects of statins in the prevention of dementia.Search methods: The Specialized Register of the Cochrane Dementia and Cognitive Improvement Group, The Cochrane Library, MEDLINE, EMBASE, PsycINFO, CINAHL and LILACS were searched on 10 October 2007 using the terms statin*, lovastatin*, pravastatin*, simvastatin*, fluvastatin*, atorvastatin* and rosuvastatin*. The CDCIG Register contains records from many healthcare databases, SIGLE, LILACS as well as many trials databases and is updated regularly.Selection criteria: Double-blind randomized placebo-controlled trials of statins in people at risk of AD and dementia.Data collection and analysis: Two independent reviewers extracted and assessed data independently and agreement was reached after discussion. Adverse effects were noted.Main results: Two trials were identified with 26,340 participants; HPS 2002 and PROSPER 2002. Age range was 40-82 years across the two studies, PROSPER 2002 included 5804 patients aged 70-82 years and HPS included 20,536 patients with 5806 at least 70 years old at study entry. Mean total cholesterol 5.9 mmol/l, LDL cholesterol 3.4mmol/l at study entry with mean reduction in LDL cholesterol of 1.0mmol/l in simvastatin treated patients compared to placebo in HPS 2002. Mean total cholesterol 5.7mmol/l, LDL cholesterol 3.8 mmol/l at study entry with mean reduction in LDL cholesterol of 1.02 mmol/l in pravastatin treated patients compared to placebo in PROSPER 2002. Mean follow-up 3.2 years in PROSPER, 5 years in HPS 2002. Cognition was measured at different times and with different scales so could not be combined in a meta-analysis. There was no difference in incidence of dementia in HPS 2002 (31 cases in simvastatin group, 31 cases in placebo group) nor in performance on the modified Telephone Interview for Cognitive Status at final follow-up (23.7% simvastatin group cognitively impaired vs 24.2% in placebo group). There was no difference in cognition between

groups either in relation to age at study entry or previous history of cerebrovascular disease. Cognitive function declined at the same rate in both treatment groups in PROSPER 2002, there was no significant difference between pravastatin treated and placebo groups in performance on letter digit codes, picture word learning test, Stroop and Mini Mental State Examination. There was no evidence that statins were detrimental to cognition.Authors' conclusions: There is good evidence from RCTs that statins given in late life to individuals at risk of vascular disease have no effect in preventing AD or dementia. Biologically it seems feasible that statins could prevent dementia due to their role in cholesterol reduction and initial evidence from observational studies was very promising. Indication bias may have been a factor in these studies however and the evidence from subsequent RCTs has been negative.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003160.pub2/abstract

Record #153 of 175

ID: CD007204

AU: Krishnan Sarada

AU: Cairns Ruth

AU: Howard Robert

TI: Cannabinoids for the treatment of dementia

SO: Cochrane Database of Systematic Reviews

YR: 2009

NO: 2

PB: John Wiley & Sons, Ltd

KY: Alzheimer Disease [drug therapy];Cannabinoids [adverse effects] [therapeutic use];Dementia [drug therapy];Dronabinol [adverse effects] [therapeutic use];Psychotropic Drugs [adverse effects] [therapeutic use];Humans[checkword]

CC: DEMENTIA

DOI: 10.1002/14651858.CD007204.pub2

AB: Background: Following the discovery of an endogenous cannabinoid system and the identification of specific cannabinoid receptors in the central nervous system, much work has been done to investigate the main effects of these compounds. There is increasing evidence that the cannabinoid system may regulate neurodegenerative processes such as excessive glutamate production, oxidative stress and neuroinflammation. Neurodegeneration is a feature common to the various types of dementia and this has led to interest in whether

cannabinoids may be clinically useful in the treatment of people with dementia. Recent studies have also shown that cannabinoids may have more specific effects in interrupting the pathological process in Alzheimer's disease.Objectives: To determine from available research whether cannabinoids are clinically effective in the treatment of dementia.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 11 April 2008 using the terms: cannabis or cannabinoid* or endocannabinoid* or cannabidiol or THC or CBD or dronabinol or delta-9-tetrahydrocannabinol or marijuana or marihuana or hashish. 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 double-blind and single (rater)-blind randomized placebo controlled trials assessing the efficacy of cannabinoids at any dose in the treatment of people with dementia.Data collection and analysis: Two reviewers independently examined the retrieved studies for inclusion according to the selection criteria. They then independently assessed the methodological quality of selected trials and extracted data where possible.Main results: Only one study met the inclusion criteria. The data in the study report were presented in such a way that they could not be extracted for further analysis and there was insufficient quantitative data to validate the results.Authors' conclusions: This review finds no evidence that cannabinoids are effective in the improvement of disturbed behaviour in dementia or in the treatment of other symptoms of dementia. More randomized double-blind placebo controlled trials are needed to determine whether cannabinoids are clinically effective in the treatment of dementia.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007204.pub2/abstract

Record #154 of 175

ID: CD007018

AU: Pariyo George W

AU: Kiwanuka Suzanne N

AU: Rutebemberwa Elizeus

AU: Okui Olico

AU: Ssengooba Freddie

TI: Effects of changes in the pre-licensure education of health workers on health-worker supply

SO: Cochrane Database of Systematic Reviews

YR: 2009

NO: 2

PB: John Wiley & Sons, Ltd

KY: Career Choice;Health Manpower;Minority Groups;Health Personnel [education];Vocational Guidance [methods];Humans[checkword]

CC: HM-EPOC

DOI: 10.1002/14651858.CD007018.pub2

AB: Background: The current and projected crisis because of a shortage of health workers in low and middle-income countries (LMICs) requires that effective strategies for expanding the numbers of health workers are quickly identified in order to inform action by policymakers, educators, and health managers.Objectives: To assess the effect of changes in the pre-licensure education of health professionals on health-worker supply.Search methods: We searched the Cochrane Central Register of Controlled Trials (CENTRAL) (The Cochrane Library 2007, Issue 3), EMBASE, Ovid (1980 to week 3, October 2007), MEDLINE, Ovid (1950 to week 3, October 2007), CINAHL (October 2007), LILACS (week 4, November 2007), ERIC (1966 to week 3, February 2008), and Sociological Abstracts (October 2007). We searched WHO (WHOLIS) (February 2008), World Bank, Google Scholar, and human resources on health-related websites to obtain grey literature. Key experts in human resources for health were contacted to identify unpublished studies. The reference lists of included studies were searched for additional articles.Selection criteria: Randomised controlled trials, non-randomised controlled trials, controlled before and after studies, and interrupted time-series studies that measured increased numbers of health workers ultimately available for recruitment into the health workforce or improved patient to health professional ratios as their primary outcomes were considered. Although the focus of the review was on LMIC, we included studies regardless of where they were done.Data collection and analysis: Heterogeneity between the two included studies precluded meta-analysis; therefore, data were presented separately for each study.Main results: Two studies of the 7880 identified from searching the electronic databases met the inclusion criteria. Both studies were controlled before and after studies, of moderate to high risk of bias, that explored the effects of interventions to improve retention of minority groups in health professional training institutions. These studies reported that an intervention comprising of a package of student support activities including social, academic, and career guidance and mentorship resulted in an increase in the number of minority students who enrolled and graduated from health training institutions.Authors' conclusions: The evidence to estimate the likely effects of interventions in pre-licensure education to increase health-worker supply is generally insufficient or unavailable, particularly in LMICs. Promising innovations from a high-income country include providing financial support to health professional students or introducing mechanisms to identify and encourage potential students and offering support to 'at risk' students. These and other promising interventions should be evaluated in LMIC.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007018.pub2/abstract

Record #155 of 175

ID: CD007178

AU: Mohan Monica

AU: Carpenter Peter K

AU: Bennett Cathy

TI: Donepezil for dementia in people with Down syndrome

SO: Cochrane Database of Systematic Reviews

YR: 2009

NO: 1

PB: John Wiley & Sons, Ltd

KY: Alzheimer Disease [drug therapy] [etiology];Cholinesterase Inhibitors [therapeutic use];Down Syndrome [complications];Indans [therapeutic use];Piperidines [therapeutic use];Randomized Controlled Trials as Topic;Humans[checkword]

CC: HM-BEHAV

DOI: 10.1002/14651858.CD007178.pub2

AB: Background: Alzheimer's dementia (AD) is the most common form of dementia in people with Down Syndrome [DS]. Acetylcholine is a chemical found in the brain that has an important role in memory, attention, reason and language. Donepezil a reversible inhibitor of acetylcholinesterase, which is thought to maintain levels of acetylcholine, and is reported to have some benefits for people with AD in the general population. It is important to note that people with DS tend to present with AD at a much younger age than the normal population as well as having subtle differences in physiology (e.g. metabolism and heart rate) and may therefore have different requirements from the general population.Objectives: To determine the effectiveness and safety of donepezil for people with DS who develop AD.Search methods: CENTRAL, MEDLINE, EMBASE, CINAHL, PsycINFO, BIOSIS, SCI, SSCI and the NRR were searched up to October 2008. We contacted the manufacturers of donepezil as well as experts in the field, to ask about reports of unpublished or ongoing trials.Selection criteria: Randomised controlled trials of participants with DS and AD in which treatment with donepezil was administered compared with a placebo group.Data collection and analysis: Data were extracted from the published reports of the one relevant study identified.Main results: The one study included in this review is a small (n=30) randomised controlled trial lasting 24 weeks. It was followed-up by an open label study with a crossover design.No significant differences were found on any four validated outcomes including global functioning and three measures of cognitive abilities and behavioural problems. 6 out of 16 carers (37%) of participants on donepezil and 2 out of 15 (13%) on placebo reported improvement. No data were available for day to day skills, institutionalisation, reduction in carers' stress or economic outcomes. Half the intervention group and 20% of the placebo group reported adverse events; two participants

left because of adverse events.Authors' conclusions: To date there is only one small randomised controlled study on the effect of donepezil. This shows, at best, a modest, non statistically significant trend in favour of people with Down syndrome and Alzheimer's dementia who are able to tolerate donepezil (this drug is currently only dispensed in relatively large doses and is contraindicated for those with cardiac and respiratory problems).This study does not provide good evidence on which to base practice. Findings in an open-label follow up to this study suggest possible benefit in some individuals. Further, larger randomised controlled studies with longer-term follow up are required.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007178.pub2/abstract

Record #156 of 175

ID: CD007658

AU: Mohan Monica

AU: Bennett Cathy

AU: Carpenter Peter K

TI: Rivastigmine for dementia in people with Down syndrome

SO: Cochrane Database of Systematic Reviews

YR: 2009

NO: 1

PB: John Wiley & Sons, Ltd

KY: Alzheimer Disease [drug therapy] [etiology];Cholinesterase Inhibitors [therapeutic use];Down Syndrome [complications];Phenylcarbamates [therapeutic use];Humans[checkword]

CC: BEHAV

DOI: 10.1002/14651858.CD007658

AB: Background: Alzheimer's dementia (AD) is the most common form of dementia in people with Down Syndrome (DS). Acetylcholine is a chemical found in the brain that has an important role in memory, attention, reason and language. Rivastigmine is a ?pseudo-irreversible? inhibitor of acetylcholinesterase, which is thought to maintain levels of acetylcholine. Rivastigmine can improve cognitive function and slow the decline of AD in the general population over time. It is important to note that people with DS tend to present with AD at a much younger age than the normal population as well as having subtle differences in physiology (e.g. metabolism and heart rate) and may therefore have different requirements

from the general population.Objectives: To determine the effectiveness and safety of rivastigmine for people with DS who develop AD.Search methods: CENTRAL, MEDLINE, EMBASE, CINAHL, PsycINFO, BIOSIS, SCI, SSCI and the NRR were searched up to October 2008. We contacted the manufacturers of rivastigmine as well as experts in the field, to ask about reports of unpublished or ongoing trials.Selection criteria: Randomised controlled trials of participants with DS and AD in which treatment with rivastigmine was administered compared with a placebo group.Data collection and analysis: No study was identified which met inclusion criteria for this review.Main results: No study was identified which met inclusion criteria for this review.Authors' conclusions: As there are no included trials, recommendations cannot be made about rivastigmine for AD in DS. Well-designed, adequately powered studies are required.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007658/abstract

Record #157 of 175

ID: CD007657

AU: Mohan Monica

AU: Bennett Cathy

AU: Carpenter Peter K

TI: Memantine for dementia in people with Down syndrome

SO: Cochrane Database of Systematic Reviews

YR: 2009

NO: 1

PB: John Wiley & Sons, Ltd

KY: Alzheimer Disease [drug therapy] [etiology];Down Syndrome [complications];Memantine [therapeutic use];Receptors, N-Methyl-D-Aspartate [antagonists & inhibitors];Humans[checkword]

CC: HM-BEHAV

DOI: 10.1002/14651858.CD007657

AB: Background: Alzheimer's dementia (AD) is the most common form of dementia in people with Down Syndrome (DS). There is an understanding that an increase in L-glutamate contributes to the pathogenesis of cerebral ischemias and AD. Memantine acts as an antagonist of N-methyl-D-aspartate (NMDA) type receptors, which is thought to reduce abnormal activation of glutamate neurotransmission. It binds with a low affinity to the NMDA

receptor and so should not prevent learning and the formation of memory. Memantine can improve cognitive function and slow the decline of AD in the general population over time, and is the subject of this review. It is important to note that people with DS tend to present with AD at a much younger age than the normal population as well as having subtle differences in physiology (e.g. metabolism and heart rate) and may therefore have different requirements from the general population.Objectives: To determine the effectiveness and safety of memantine for people with DS who develop AD.Search methods: CENTRAL, MEDLINE, EMBASE, CINAHL, PsycINFO, BIOSIS, SCI, SSCI and the NRR were searched up to October 2008. We contacted the manufacturers of memantine, as well as experts in the field, to ask about reports of unpublished or ongoing trials.Selection criteria: Randomised controlled trials of participants with DS and AD in which treatment with memantine was administered compared with a placebo group.Data collection and analysis: No study was identified which met the inclusion criteria for this review.Main results: No study was identified which met inclusion criteria for this review, however there is an on-going randomised controlled study being conducted in the UK and data are expected in 2009.Authors' conclusions: As there are no included trials, recommendations cannot be made about memantine for AD in DS. Well-designed, adequately powered studies are required.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007657/abstract

Record #158 of 175

ID: CD007656

AU: Mohan Monica

AU: Bennett Cathy

AU: Carpenter Peter K

TI: Galantamine for dementia in people with Down syndrome

SO: Cochrane Database of Systematic Reviews

YR: 2009

NO: 1

PB: John Wiley & Sons, Ltd

KY: Alzheimer Disease [drug therapy] [etiology];Cholinesterase Inhibitors [therapeutic use];Down Syndrome [complications];Galantamine [therapeutic use];Humans[checkword]

CC: HM-BEHAV

DOI: 10.1002/14651858.CD007656

AB: Background: Alzheimer's dementia (AD) is the most common form of dementia in people with Down Syndrome (DS). Acetylcholine is a chemical found in the brain that has an important role in memory, attention, reason and language. Galantamine both inhibits the activity of acetylcholinesterase and increases the level of acetylcholine. Galantamine can improve cognitive function and slow the decline of AD in the general population over time. It is important to note that people with DS tend to present with AD at a much younger age than the normal population as well as having subtle differences in physiology (e.g. metabolism and heart rate) and may therefore have different requirements from the general population.Objectives: To determine the effectiveness and safety of galantamine for people with DS who develop AD.Search methods: CENTRAL, MEDLINE, EMBASE, CINAHL, PsycINFO, BIOSIS, SCI, SSCI and the NRR were searched up to October 2008. We contacted the manufacturers of galantamine as well as experts in the field, to ask about reports of unpublished or ongoing trials.Selection criteria: Randomised controlled trials of participants with DS and AD in which treatment with galantamine was administered compared with a placebo group.Data collection and analysis: No study was identified which met inclusion criteria for this review.Main results: No study was identified which met inclusion criteria for this review.Authors' conclusions: As there are no included trials, recommendations cannot be made about galantamine for AD in DS. Well-designed, adequately powered studies are required.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007656/abstract

Record #159 of 175

ID: CD004728

AU: Beyer Fiona R

AU: Ker Katharine

TI: Street lighting for preventing road traffic injuries

SO: Cochrane Database of Systematic Reviews

YR: 2009

NO: 1

PB: John Wiley & Sons, Ltd

KY: Accidents, Traffic [prevention & control];Lighting [methods];Wounds and Injuries [mortality] [prevention & control];Humans[checkword]

CC: INJ

DOI: 10.1002/14651858.CD004728.pub2

AB: Background: Road traffic crashes are a major cause of death and injury, especially in low and middle-income countries. It is estimated that road traffic injuries will have risen from ninth to third in world disease burden rankings by 2020, accounting for 2.3 million deaths per year globally. Street lighting has been suggested as a relatively low-cost intervention with the potential to prevent traffic crashes.Objectives: To assess the effects of street lighting on injuries caused by road traffic crashes.Search methods: We searched the Cochrane Injuries Group's Specialised Register, CENTRAL, MEDLINE, EMBASE, TRANSPORT and the Australian Transport Index. We also searched the Internet and checked reference lists of relevant papers. The search was not restricted by language or publication status. The searches were conducted to October 2008.Selection criteria: Randomised controlled trials, non-randomised controlled trials and controlled before-after studies, comparing new street lighting with unlit roads, or improved street lighting with the pre-existing lighting level.Data collection and analysis: Two authors screened search results, extracted data, assessed risk of bias and analysed the data.Main results: We found 17 controlled before-after studies of street lighting, all reporting crash data, of which 15 contributed data to the meta-analysis. Seven trials included a designated control site; the other ten collected data at one site with the day-time data being used as the control. The methodological quality of the trials was generally poor.Three trials compared street lighting with an area control on total crashes; pooled rate ratio (RR) = 0.45 (95% confidence interval (CI) 0.29 to 0.69). Two trials compared street lighting with an area control on total injury crashes (all severities); RR = 0.78 (95% CI 0.63 to 0.97). No trials compared the number of fatal crashes with an area control.Eleven trials compared street lighting with a day-time control on total crashes; pooled RR = 0.68 (95% CI 0.57 to 0.82). Six trials compared street lighting with a day-time control on total injury crashes; pooled RR = 0.68 (95% CI 0.61 to 0.77). Four trials compared street lighting with a day-time control on fatal crashes; pooled RR = 0.34 (95% CI 0.17 to 0.68).Authors' conclusions: The results from this systematic review suggest that street lighting may prevent road traffic crashes, injuries and fatalities. However, further well designed studies are needed to determine the effectiveness of street lighting, particularly in middle and low-income countries.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004728.pub2/abstract

Record #160 of 175

ID: CD005268

AU: Duke Sally-Anne S

AU: Colagiuri Stephen

AU: Colagiuri Ruth

TI: Individual patient education for people with type 2 diabetes mellitus

SO: Cochrane Database of Systematic Reviews

YR: 2009

NO: 1

PB: John Wiley & Sons, Ltd

KY: Body Mass Index;Diabetes Mellitus, Type 2 [blood] [therapy];Health Knowledge, Attitudes, Practice;Hemoglobin A, Glycosylated [metabolism];Hyperglycemia [therapy];Patient Education as Topic [methods];Randomized Controlled Trials as Topic;Humans[checkword]

CC: ENDOC

DOI: 10.1002/14651858.CD005268.pub2

AB: Background: Type 2 diabetes is a common and costly chronic disease which is associated with significant premature mortality and morbidity. Although patient education is an integral component of diabetes care, there remain uncertainties regarding the effectiveness of different methods and modes of education.Objectives: To evaluate the effectiveness of individual patient education on metabolic control, diabetes knowledge and psychosocial outcomes.Search methods: Multiple electronic bibliographic databases were searched, including The Cochrane Library, MEDLINE, Premedline, ERIC, Biosis, AMED, Psychinfo, EMBASE, CINAHL, APAIS-health, Australian Medical Index, Web of Science, dissertation abstracts and Biomed Central.Selection criteria: Randomized controlled and controlled clinical trials which evaluated individual education for adults with type 2 diabetes. The intervention was individual face-to-face patient education while control individuals received usual care, routine treatment or group education. Only studies that assessed outcome measures at least six months from baseline were included.Data collection and analysis: Information was extracted by two reviewers who summarized both study characteristics and outcome statistics. A meta-analysis using a fixed-effect model was performed if there were adequate studies with a specified outcome of sufficient homogeneity. For outcomes where there were too few studies or the assessment measurements were not standardized or variable, the results were summarised qualitatively.Main results: Nine studies involving 1359 participants met the inclusion criteria. Six studies compared individual education to usual care and three compared individual education to group education (361 participants). There were no long-term studies and overall the quality of the studies was not high. In the six studies comparing individual face-to-face education to usual care, individual education did not significantly improve glycaemic control (weighted mean difference (WMD) in HbA1c -0.1% (95% confidence interval (CI) -0.3 to 0.1, P = 0.33) over a 12 to 18 month period. However, there did appear to be a significant benefit of individual education on glycaemic control in a subgroup analysis of three studies involving participants with a higher mean baseline HbA1c greater than 8% (WMD -0.3% (95% CI -0.5 to -0.1, P = 0.007). In the two studies comparing individual to group education, there was no significant difference in glycaemic control between individual or group education at 12 to 18 months with a WMD in HbA1c of 0.03% (95% CI -0.02 to 0.1, P = 0.22). There was no significant difference in the impact of individual versus usual care or group education on body mass index systolic or diastolic blood pressure. There were too few studies to perform a meta-analysis on the effect of individual education on dietary self management, diabetes knowledge, psychosocial outcomes and smoking habits. No data were available on the other main

outcome measures of diabetes complications or health service utilization and cost analysis in these studies.Authors' conclusions: This systematic review suggests a benefit of individual education on glycaemic control when compared with usual care in a subgroup of those with a baseline HbA1c greater than 8%. However, overall there did not appear to be a significant difference between individual education and usual care. In the small number of studies comparing group and individual education, there was an equal impact on HbA1c at 12 to 18 months. Additional studies are needed to delineate these findings further.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD005268.pub2/abstract

Record #161 of 175

ID: CD003120

AU: Birks Jacqueline

AU: Grimley Evans John

TI: Ginkgo biloba for cognitive impairment and dementia

SO: Cochrane Database of Systematic Reviews

YR: 2009

NO: 1

PB: John Wiley & Sons, Ltd

KY: Ginkgo biloba;Phytotherapy;Cognition Disorders [drug therapy];Dementia [drug therapy];Plant Extracts [therapeutic use];Randomized Controlled Trials as Topic;Humans[checkword]

CC: HM-DEMENTIA

DOI: 10.1002/14651858.CD003120.pub3

AB: Background: Products of the maidenhair tree, Ginkgo biloba, have long been used in China as a traditional medicine for various disorders of health. A standardized extract is widely used in the West for the treatment of a range of conditions including memory and concentration problems, confusion, depression, anxiety, dizziness, tinnitus and headache. The mechanisms of action are thought to reflect the action of several components of the extract and include increasing blood supply by dilating blood vessels, reducing blood viscosity, modification of neurotransmitter systems, and reducing the density of oxygen free radicals.Objectives: To assess the efficacy and safety of Ginkgo biloba for dementia or cognitive decline.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 20 September 2007 using the terms: ginkgo*, tanakan, EGB-761, EGB761, "EGB

761" and gingko*. 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 trials databases and grey literature sources.Selection criteria: Randomized, double-blind studies, in which extracts of Ginkgo biloba at any strength and over any period were compared with placebo for their effects on people with acquired cognitive impairment, including dementia, of any degree of severity.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: 36 trials were included but most were small and of duration less than three months. Nine trials were of six months duration (2016 patients). These longer trials were the more recent trials and generally were of adequate size, and conducted to a reasonable standard. Most trials tested the same standardised preparation of Ginkgo biloba, EGb 761, at different doses, which are classified as high or low. The results from the more recent trials showed inconsistent results for cognition, activities of daily living, mood, depression and carer burden. Of the four most recent trials to report results three found no difference between Ginkgo biloba and placebo, and one reported very large treatment effects in favour of Ginkgo biloba.There are no significant differences between Ginkgo biloba and placebo in the proportion of participants experiencing adverse events.A subgroup analysis including only patients diagnosed with Alzhiemer's disease (925 patients from nine trials) also showed no consistent pattern of any benefit associated with Ginkgo biloba.Authors' conclusions: Ginkgo biloba appears to be safe in use with no excess side effects compared with placebo. Many of the early trials used unsatisfactory methods, were small, and publication bias cannot be excluded. The evidence that Ginkgo biloba has predictable and clinically significant benefit for people with dementia or cognitive impairment is inconsistent and unreliable.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003120.pub3/abstract

Record #162 of 175

ID: CD000059

AU: Essali Adib

AU: Al-Haj Haasan Nahla

AU: Li Chunbo

AU: Rathbone John

TI: Clozapine versus typical neuroleptic medication for schizophrenia

SO: Cochrane Database of Systematic Reviews

YR: 2009

NO: 1

PB: John Wiley & Sons, Ltd

KY: Age Factors;Antipsychotic Agents [adverse effects] [therapeutic use];Clozapine [adverse effects] [therapeutic use];Randomized Controlled Trials as Topic;Schizophrenia [drug therapy];Humans[checkword]

CC: SCHIZ

DOI: 10.1002/14651858.CD000059.pub2

AB: Background: Long-term drug treatment of schizophrenia with typical antipsychotic drugs has limitations: 25 to 33% of sufferers have illnesses that are treatment resistant. Clozapine is an antipsychotic drug, which is claimed to have superior efficacy and to cause fewer motor adverse effects than typical drugs for people with treatment-resistant illnesses. Clozapine carries a significant risk of serious blood disorders, which necessitates mandatory weekly blood monitoring at least during the first months of treatment.Objectives: To evaluate the effects of clozapine compared with typical antipsychotic drugs in people with schizophrenia.Search methods: For the current update of this review (November 2008) we searched the Cochrane Schizophrenia Group Trials Register.Selection criteria: All relevant randomised controlled trials (RCTs).Data collection and analysis: We extracted data independently. For dichotomous data we calculated relative risks (RR) and their 95% confidence intervals (CI) on an intention-to-treat basis, based on a fixed-effect model. We calculated numbers needed to treat/harm (NNT/NNH) where appropriate. For continuous data, we calculated weighted mean differences (WMD) again based on a fixed-effect model.Main results: We have included 52 trials (4746 participants) in this review. Forty-four of the included studies are less than 13 weeks in duration, and, overall, trials were at a significant risk of bias. We found no significant difference in the effects of clozapine and typical neuroleptic drugs for broad outcomes such as mortality, ability to work or suitability for discharge at the end of the study. Clinical improvements were seen more frequently in those taking clozapine (n=1119, 14 RCTs, RR 0.72 CI 0.7 to 0.8, NNT 6 CI 5 to 8). Also, participants given clozapine had fewer relapses than those on typical antipsychotic drugs (n=1303, RR 0.62 CI 0.5 to 0.8, NNT 21 CI 15 to 49). BPRS scores showed a greater reduction of symptoms in clozapine-treated participants, (n=1205, 17 RCTs, WMD -3.79 CI -4.9 to -2.7), although the data were heterogeneous (I2=69%). Short-term data from the SANS negative symptom scores favoured clozapine (n=196, 6 RCTs, WMD -7.21 CI -8.9 to -5.6). We found clozapine to be more acceptable in long-term treatment than conventional antipsychotic drugs (n=982, 6 RCTs, RR 0.60 CI 0.5 to 0.7, NNT 15 CI 12 to 20). Blood problems occurred more frequently in participants receiving clozapine (3.2%) compared with those given typical antipsychotic drugs (0%) (n=1031, 13 RCTs, RR 7.09 CI 2.0 to 25.6). Clozapine participants experienced more drowsiness, hypersalivation or temperature increase, than those given conventional neuroleptics. However, those receiving clozapine experienced fewer motor adverse effects (n=1495, 19 RCTs, RR 0.57 CI 0.5 to 0.7, NNT 5 CI 4 to 6).The clinical effects of clozapine were more pronounced in participants resistant to typical neuroleptics in terms of clinical improvement (n=370, 4 RCTs, RR 0.71 CI 0.6 to 0.8, NNT 4 CI 3 to 6) and symptom reduction. Thirty-four per cent of treatment-resistant participants had a clinical improvement with clozapine treatment.Authors' conclusions: Clozapine may be more effective in reducing symptoms of schizophrenia, producing clinically meaningful improvements and

postponing relapse, than typical antipsychotic drugs - but data are weak and prone to bias. Participants were more satisfied with clozapine treatment than with typical neuroleptic treatment. The clinical effect of clozapine, however, is, at least in the short-term, not reflected in measures of global functioning such as ability to leave the hospital and maintain an occupation. The short-term benefits of clozapine have to be weighed against the risk of adverse effects. Within the context of trials, the potentially dangerous white blood cell decline seems to be more frequent in children and adolescents and in the elderly than in young adults or people of middle age.The existing trials have largely neglected to assess the views of participants and their families on clozapine. More community-based long-term randomised trials are needed to evaluate the efficacy of clozapine on global and social functioning as trials in special groups such as people with learning disabilities.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD000059.pub2/abstract

Record #163 of 175

ID: CD003189

AU: Bohlius Julia

AU: Herbst Christine

AU: Reiser Marcel

AU: Schwarzer Guido

AU: Engert Andreas

TI: Granulopoiesis-stimulating factors to prevent adverse effects in the treatment of malignant lymphoma

SO: Cochrane Database of Systematic Reviews

YR: 2008

NO: 4

PB: John Wiley & Sons, Ltd

KY: Antineoplastic Agents [adverse effects];Fever [chemically induced] [prevention & control];Granulocyte Colony-Stimulating Factor [therapeutic use];Granulocyte-Macrophage Colony-Stimulating Factor [therapeutic use];Lymphoma [drug therapy];Neutropenia [chemically induced] [prevention & control];Randomized Controlled Trials as Topic;Humans[checkword]

CC: HM-HAEMATOL

DOI: 10.1002/14651858.CD003189.pub4

AB: Background: Granulopoiesis-stimulating factors, such as granulocyte-colony-stimulating factor (G-CSF) and granulocyte-macrophage-colony-stimulating factor (GM-CSF), are being used to prevent febrile neutropenia and infection in patients undergoing treatment for malignant lymphoma. The question of whether G-CSF and GM-CSF improve dose intensity, tumour response, and overall survival in this patient population has not been answered yet. Since the results from single studies are inconclusive, a systematic review was undertaken.Objectives: To determine the effectiveness of G-CSF and GM-CSF in patients with malignant lymphoma with respect to preventing neutropenia, febrile neutropenia and infection; improving quality of life, adherence to treatment protocol, tumour response, freedom from treatment failure (FFTF) and overall survival (OS); and adverse effects.Search methods: We searched The Cochrane Library, MEDLINE, EMBASE, CancerLit, and other relevant literature databases; Internet databases of ongoing trials; and conference proceedings of the American Society of Clinical Oncology and the American Society of Hematology (1980 - 2007). We included full-text and abstract publications as well as unpublished data.Selection criteria: Randomised controlled trials comparing prophylaxis with G-CSF or GM-CSF versus placebo/no prophylaxis in adult patients with malignant lymphoma undergoing chemotherapy were included for review. Both study arms had to receive identical chemotherapy and supportive care.Data collection and analysis: Trial eligibility and quality assessment, data extraction and analysis were done by two reviewers independently. Authors were contacted to obtain missing data.Main results: We included 13 eligible randomised controlled trials with 2607 randomised patients. Compared with no prophylaxis, both G-CSF and GM-CSF did not improve overall survival (hazard ratio 0.97; 95% CI 0.87 to 1.09) or FFTF (hazard ratio 1.11; 95% CI 0.91 to 1.35). Prophylaxis significantly reduced the relative risk (RR) for severe neutropenia (RR 0.67; 95% confidence interval (CI) 0.60 to 0.73), febrile neutropenia (RR 0.74; 95% CI 0.62 to 0.89) and infection (RR 0.74; 95% CI 0.64 to 0.85). There was no evidence that either G-CSF or GM-CSF reduced the number of patients requiring intravenous antibiotics (RR 0.82; 95%CI 0.57 to 1.18); lowered infection related mortality (RR 0.93; 95% CI 0.51 to 1.71); or improved complete tumour response (RR 1.03; 95% CI 0.95 to 1.10).One study evaluated quality of life parameters and found no differences between the treatment groups.Authors' conclusions: G-CSF and GM-CSF, when used as a prophylaxis in patients with malignant lymphoma undergoing conventional chemotherapy, reduce the risk of neutropenia, febrile neutropenia and infection. However, based on the randomised trials currently available, there is no evidence that either G-CSF or GM-CSF provide a significant advantage in terms of complete tumour response, FFTF or OS.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003189.pub4/abstract

Record #164 of 175

ID: CD004514

AU: Malouf Reem

AU: Grimley Evans John

TI: Folic acid with or without vitamin B12 for the prevention and treatment of healthy elderly and demented people

SO: Cochrane Database of Systematic Reviews

YR: 2008

NO: 4

PB: John Wiley & Sons, Ltd

KY: Dietary Supplements;Cognition [drug effects];Cognition Disorders [drug therapy] [etiology];Dementia [drug therapy] [etiology];Drug Therapy, Combination;Folic Acid [therapeutic use];Folic Acid Deficiency [complications];Randomized Controlled Trials as Topic;Vitamin B 12 [therapeutic use];Humans[checkword]

CC: HM-DEMENTIA

DOI: 10.1002/14651858.CD004514.pub2

AB: Background: Folate deficiency can result in congenital neural tube defects and megaloblastic anaemia. Low folate levels may be due to insufficient dietary intake or inefficient absorption, but impaired metabolic utilization also occurs.Because B12 deficiency can produce a similar anaemia to folate deficiency, there is a risk that folate supplementation can delay the diagnosis of B12 deficiency, which can cause irreversible neurological damage. Folic acid supplements may sometimes therefore include vitamin B12 supplements with simultaneous administration of vitamin B12.Lesser degrees of folate inadequacy are associated with high blood levels of the amino acid homocysteine which has been linked with the risk of arterial disease, dementia and Alzheimer's disease. There is therefore interest in whether dietary supplementation can improve cognitive function in the elderly.However, any apparent benefit from folic acid which was given in combination with B12 needs to be "corrected" for any effect of vitamin B12 alone. A separate Cochrane review of vitamin B12 and cognitive function has therefore been published.Objectives: To examine the effects of folic acid supplementation, with or without vitamin B12, on elderly healthy or demented people, in preventing cognitive impairment or retarding its progress.Search methods: Trials were identified from a search of the Cochrane Dementia and Cognitive Improvement Group's Specialized Register on 10 October 2007 using the terms: folic acid, folate, vitamin B9, leucovorin, methyltetrahydrofolate, vitamin B12, cobalamin and cyanocobalamin. This Register contains references from all major health care databases and many ongoing trials databases. In addition MEDLINE, EMBASE, CINAHL, PsychINFO and LILACS were searched (years 2003-2007) for additional trials of folate with or without vitamin B12 on healthy elderly people.Selection criteria: All double-blind, placebo-controlled, randomized trials, in which supplements of folic acid with or without vitamin B12 were compared with placebo for elderly healthy people or people with any type of dementia or cognitive impairment.Data collection

and analysis: The reviewers independently applied the selection criteria and assessed study quality. One reviewer extracted and analysed the data. In comparing intervention with placebo, weighted mean differences and standardized mean difference or odds ratios were estimated.Main results: Eight randomized controlled trials fulfilled the inclusion criteria for this review. Four trials enrolled healthy older people, and four recruited participants with mild to moderate cognitive impairment or dementia with or without diagnosed folate deficiency. Pooling the data was not possible owing to heterogeneity in sample selections, outcomes, trial duration, and dosage. Two studies involved a combination of folic acid and vitamin B12.There is no adequate evidence of benefit from folic acid supplemententation with or without vitamin B12 on cognitive function and mood of unselected healthy elderly people. However, in one trial enrolling a selected group of healthy elderly people with high homocysteine levels, 800 mcg/day folic acid supplementation over three years was associated with significant benefit in terms of global functioning (WMD 0.05, 95% CI 0.004 to 0.096, P = 0.033); memory storage (WMD 0.14, 95% CI 0.04 to 0.24, P = 0.006) and information-processing speed (WMD 0.09, 95% CI 0.02 to 0.16, P = 0.016).Four trials involved people with cognitive impairment. In one pilot trial enrolling people with Alzheimer's disease, the overall response to cholinesterase inhibitors significantly improved with folic acid at a dose of 1mg/day (odds ratio: 4.06, 95% CI 1.22 to 13.53; P = 0.02) and there was a significant improvement in scores on the Instrumental Activities of Daily Living and the Social Behaviour subscale of the Nurse's Observation Scale for Geriatric Patients (WMD 4.01, 95% CI 0.50 to 7.52, P = 0.02). Other trials involving people with cognitive impairment did not show any benefit in measures of cognitive function from folic acid, with or without vitamin B12.Folic acid plus vitamin B12 was effective in reducing serum homocysteine concentrations (WMD -5.90, 95% CI -8.43 to -3.37, P < 0.00001). Folic acid was well tolerated and no adverse effects were reported.Authors' conclusions: The small number of studies which have been done provide no consistent evidence either way that folic acid, with or without vitamin B12, has a beneficial effect on cognitive function of unselected healthy or cognitively impaired older people. In a preliminary study, folic acid was associated with improvement in the response of people with Alzheimer's disease to cholinesterase inhibitors. In another, long-term use appeared to improve the cognitive function of healthy older people with high homocysteine levels. More studies are needed on this important issue.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004514.pub2/abstract

Record #165 of 175

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 #166 of 175

ID: CD006237

AU: Nieuwenhuijsen Karen

AU: Bültmann Ute

AU: Neumeyer-Gromen Angela

AU: Verhoeven Arco C

AU: Verbeek Jos H

AU: Feltz-Cornelis Christina M.

TI: Interventions to improve occupational health in depressed people

SO: Cochrane Database of Systematic Reviews

YR: 2008

NO: 2

PB: John Wiley & Sons, Ltd

KY: Absenteeism;Occupational Health;Depression [therapy];Randomized Controlled Trials as Topic;Humans[checkword]

CC: HM-DEPRESSN

DOI: 10.1002/14651858.CD006237.pub2

AB: Background: Work disability such as sickness absence is common in people with depression.Objectives: To evaluate the effectiveness of interventions aimed at reducing work disability in depressed workers.Search methods: We searched the CCDANCTR-Studies and CCDANCTR-References on 2/8/2006, Cochrane Library CENTRAL register, MEDLINE, EMBASE, CINAHL, PsycINFO, OSH-ROM (Occupational Safety and Health), NHS-EED, and DARE.Selection criteria: We included randomised controlled trials (RCTs) and cluster RCTs of work-directed and worker-directed interventions for depressed people, using sickness absence as the primary outcomeData collection and analysis: Two authors independently extracted data and assessed trial quality. We used standardised mean differences (SMD) with 95% confidence intervals (CIs) to pool study results where possible.Main results: We included eleven studies, all of worker-directed interventions, involving 2556 participants. Only one study addressed work issues using adjuvant occupational therapy. Other interventions evaluated anti-depressant medication (selective serotonin reuptake inhibitors, serotonin-norepinephrine reuptake inhibitors, tricyclic antidepressants, monoamino-oxidase inhibitors), psychodynamic therapy, enhanced primary care and psychological treatmentFor medication, the combined results of three studies (n=864) showed no difference between antidepressant medication and alternative medication in their effect on days of sickness absence (SMD 0.09; 95% CI -0.05 to 0.23) In two pooled studies (n=969), the effect of enhanced primary care on days of sickness absence did not differ from usual care in the medium term (SMD -0.02; 95% CI -0.15 to 0.12)All other comparisons were based on single studies (n=6), all of which showed a lack of significant difference for sickness absence between groups, with the exception of one small study, combined psychodynamic therapy and TCAs versus TCAs alone, which favoured the combined treatment.Authors' conclusions: Based on a heterogeneous sample of studies, there is currently no evidence of an effect of medication alone, enhanced primary care, psychological interventions or the combination of those with medication on sickness absence of depressed workers. In future RCTs, interventions should specifically address work issues, and occupational outcomes should be used to measure the effect..

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006237.pub2/abstract

Record #167 of 175

ID: CD005592

AU: Li Jun

AU: Wu Hong Mei

AU: Zhou Rongle L

AU: Liu Guan Jian

AU: Dong Bi Rong

TI: Huperzine A for Alzheimer's disease

SO: Cochrane Database of Systematic Reviews

YR: 2008

NO: 2

PB: John Wiley & Sons, Ltd

KY: Alkaloids;Alzheimer Disease [drug therapy];Cholinesterase Inhibitors [therapeutic use];Randomized Controlled Trials as Topic;Sesquiterpenes [therapeutic use];Humans[checkword]

CC: HM-DEMENTIA

DOI: 10.1002/14651858.CD005592.pub2

AB: Background: Alzheimer's disease (AD) has become a major public health problem around the world due to its increasing prevalence, long duration, caregiver burden, and high financial cost of care. The degeneration of acetylcholine-containing neurons in the basal forebrain has been implicated in the symptoms of AD. Cholinesterase inhibitors may block the degradation of acetylcholine, thus increasing the efficacy of the remaining cholinergic neurons. Huperzine A is a linearly competitive, reversible inhibitor of acetyl cholinesterase that is said to have both central and peripheral activity with the ability to protect cells against hydrogen peroxide, beta-amyloid protein (or peptide), glutamate, ischemia and staurosporine-induced cytotoxicity and apoptosis. These properties might qualify Huperzine A as a promising agent for treating dementia (including AD).Objectives: To assess the efficacy and safety of Huperzine A for the treatment of patients with AD.Search methods: The Specialized Register of the Cochrane Dementia and Cognitive Improvement Group was searched on 1 February 2006 using the search term: huperzin*. The CDCIG Specialized register contains records from all major health care databases (MEDLINE, EMBASE, PsycINFO, CINAHL, SIGLE, ISTP, INSIDE, LILACS) as well as from many trials databases and grey literature sources. In addition, the CBM and AMED databases and relevant websites were searched and some journals were hand-searched. Specialists in the field were approached for unpublished material and any publications found were searched for additional references.Selection criteria: All relevant randomized controlled trials (RCTs) studying the efficacy and safety of Huperzine A for AD.Data collection and analysis: Data were extracted independently by two reviewers using a self-developed data extraction form and entered into RevMan 4.2.10 software. Meta-analyses were performed when more than one trial provided data on a comparable outcome on sufficiently similar patients. Random effects analyses were performed whenever heterogeneity between results appeared to be present. Standardized differences in mean outcome measures were used due to the use of different scales and periods of treatment.Main results: Six trials including a total of 454 patients met our inclusion criteria. The methodological quality of most included trials was not high. It was shown that compared to placebo, Huperzine A had beneficial effects on the improvement of general cognitive function measured by MMSE (WMD 2.81; 95% CI 1.87 to 3.76; P < 0.00001) and ADAS-Cog at six weeks (WMD 1.91; 95% CI 1.27 to 2.55) and at 12 weeks (WMD 2.51; 95% CI 1.74 to 3.28), global clinical assessment measured by CDR (WMD -0.80; 95% CI -0.95 to -0.65) and CIBIC-plus (OR 4.32, 95% CI 2.37 to 7.90), behavioral

disturbance measured by ADAS-non-Cog at six weeks (WMD -1.33, 95%CI -2.12 to -0.54) and at 12 weeks (WMD -1.52, 95% CI-2.39 to -0.65), and functional performance measured by ADL (WMD = -7.17; 95% CI -9.13 to -5.22; P < 0.00001). However, Huperzine A was not superior to placebo in the improvement of general cognitive function measured by Hasegawa Dementia Scale (HDS) (WMD: 2.78; 95% CI -0.17 to 5.73, P = 0.06) and specific cognitive function measured by Weshler Memory Scale (WMS) (WMD = 6.64; 95% CI -3.22 to 16.50; P = 0.19). No data were available on quality of life and caregiver burden. The adverse events of Huperzine A were mild and there were no significant differences of adverse events between Huperzine A groups and control groups.Authors' conclusions: From the available evidence, Huperzine A seems to have some beneficial effects on improvement of general cognitive function, global clinical status, behavioral disturbance and functional performance, with no obvious serious adverse events for patients with AD. However, only one study was of adequate quality and size. There is therefore inadequate evidence to make any recommendation about its use. Rigorous design, randomized, multi-centre, large-sample trials of Huperzine A for AD are needed to further assess the effects.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD005592.pub2/abstract

Record #168 of 175

ID: CD005317

AU: Overshott Ross

AU: Karim Salman

AU: Burns Alistair

TI: Cholinesterase inhibitors for delirium

SO: Cochrane Database of Systematic Reviews

YR: 2008

NO: 1

PB: John Wiley & Sons, Ltd

KY: Cholinesterase Inhibitors [therapeutic use];Delirium [drug therapy];Indans [therapeutic use];Piperidines [therapeutic use];Humans[checkword]

CC: HM-DEMENTIA

DOI: 10.1002/14651858.CD005317.pub2

AB: Background: Delirium is now the preferred term to describe acute confusional states. It is experienced by 10 to 30% of all hospital inpatients. Delirium is potentially reversible and is

related to several adverse outcomes, including increased hospital length of stay, poor functional status, persistent cognitive impairment, need for institutional care and probably mortality. Disruption of the cholinergic system has been proposed as a key mechanism of delirium. Cholinesterase inhibitors enhance the cholinergic system and there have been reports that they might be beneficial in treating delirium.Objectives: To assess the efficacy and safety of cholinesterase inhibitors in the treatment of delirium.Search methods: The Cochrane Dementia and Cognitive Improvement Group's Register of Clinical Trials (which includes records from MEDLINE, EMBASE, PsycINFO, CINAHL, CENTRAL, LILACS and other databases) was searched for relevant randomised controlled trials using the terms: donepezil or aricept, galantamine or reminyl, rivastigmine OR exelon and tacrine OR cognex on 19 April 2005. As this Specialised Register only contains trials relating to dementia and cognitive impairment, in addition all years of MEDLINE, EMBASE, PsycINFO and CINAHL were searched for trials of cholinesterase inhibitors for delirium in non-demented people.Selection criteria: Unconfounded, blinded randomised controlled trials, published or unpublished in which treatment with cholinesterase inhibitors was administered and compared with alternative interventions in patients with delirium are included.Data collection and analysis: Two reviewers (RO, SK) independently assessed the quality of the studies according to parameters such as randomisation, blinding and how dropouts were managed. Each cholinesterase inhibitor was to be examined separately and together as a group.The primary outcome measures of interest are length of delirium, severity of delirium and presence and severity of behavioural symptoms (e.g. agitation and hallucinations). Other outcomes of interest include: cognition, need for institutionalisation, length of hospital admission and adverse effects.Main results: There was one included trial of donepezil compared with placebo in 15 patients. No significant difference between the treatment and placebo groups was found in the duration of delirium. The mean duration of postoperative delirium for the donepezil group was 1.0 day (Standard Error 0.0) while for the placebo group it was 1.3 days (Standard Error 0.19). No other outcomes were measured for the patients who developed delirium.Authors' conclusions: There is currently no evidence from controlled trials that donepezil is effective in the treatment of delirium. Further trials using cholinesterase inhibitors for the treatment of delirium are needed.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD005317.pub2/abstract

Record #169 of 175

ID: CD004930

AU: Traut Ulrike

AU: Brügger Lukas

AU: Kunz Regina

AU: Pauli-Magnus Christiane

AU: Haug Klaus

AU: Bucher Heiner

AU: Koller Michael T.

TI: Systemic prokinetic pharmacologic treatment for postoperative adynamic ileus following abdominal surgery in adults

SO: Cochrane Database of Systematic Reviews

YR: 2008

NO: 1

PB: John Wiley & Sons, Ltd

KY: Abdomen [surgery];Gastrointestinal Agents [classification] [therapeutic use];Intestinal Pseudo-Obstruction [drug therapy];Peristalsis [drug effects];Postoperative Complications [drug therapy];Randomized Controlled Trials as Topic;Adult[checkword];Humans[checkword]

CC: HM-COLOCA

DOI: 10.1002/14651858.CD004930.pub3

AB: Background: Postoperative adynamic bowel atony interferes with recovery following abdominal surgery. Prokinetic pharmacologic drugs are widely used to accelerate postoperative recovery.Objectives: To evaluate the benefits and harms of systemic acting prokinetic drugs to treat postoperative adynamic ileus in patients undergoing abdominal surgery.Search methods: Trials were identified by computerised searches of the Cochrane Central Register of Controlled Trials, MEDLINE, EMBASE, and the Cochrane Colorectal Cancer Group specialised register. The reference lists of included trials and review articles were tracked and authors contacted.Selection criteria: Randomised controlled parallel-group trials (RCT) comparing the effect of systemically acting prokinetic drugs against placebo or no intervention.Data collection and analysis: Four reviewers independently extracted the data and assessed trial quality. Trial authors were contacted for additional information if needed.Main results: Thirty-nine RCTs met the inclusion criteria contributing a total of 4615 participants. Most trials enrolled a small number of patients and showed moderate to poor (reporting of) methodological quality, in particular regarding allocation concealment and intention-to-treat analysis. Fifteen systemic acting prokinetic drugs were investigated and ten comparisons could be summarized. Six RCTs support the effect of Alvimopan, a novel peripheral mu receptor antagonist. However, the trials do not meet reporting guidelines and the drug is still in an investigational stage. Erythromycin showed homogenous and consistent absence of effect across all included trials and outcomes. The evidence is insufficient to recommend the use of cholecystokinin-like drugs, cisapride, dopamine-antagonists, propranolol or vasopressin. Effects are either inconsistent across outcomes, or trials are too small and often of poor methodological quality. Cisapride has been withdrawn from the market due to adverse cardiac events in many countries. Intravenous lidocaine and neostigmine might show a potential effect, but more evidence on clinically relevant outcomes

is needed. Heterogeneity among included trials was seen in 10 comparisons. No major adverse drug effects were evident.Authors' conclusions: Alvimopan may prove to be beneficial but proper judgement needs adherence to reporting standards. Further trials are needed on intravenous lidocaine and neostigmine. The remaining drugs can not be recommended due to lack of evidence or absence of effect.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004930.pub3/abstract

Record #170 of 175

ID: CD004333

AU: Liu Bette C

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AU: Boufous Soufiane

AU: Blows Stephanie

AU: Lo Sing Kai

TI: Helmets for preventing injury in motorcycle riders

SO: Cochrane Database of Systematic Reviews

YR: 2008

NO: 1

PB: John Wiley & Sons, Ltd

KY: Accidents, Traffic [mortality];Head Protective Devices;Motorcycles;Craniocerebral Trauma [mortality] [prevention & control];Facial Injuries [prevention & control];Neck Injuries [prevention & control];Skull Fractures [prevention & control];Humans[checkword]

CC: HM-INJ

DOI: 10.1002/14651858.CD004333.pub3

AB: Background: Motorcycle crash victims form a high proportion of those killed or injured in road traffic crashes. Injuries to the head, following motorcycle crashes, are a common cause of severe morbidity and mortality. It seems intuitive that helmets should protect against head injuries but it has been argued that motorcycle helmet use decreases rider vision and increases neck injuries. This review will collate the current available evidence on helmets and their impact on mortality, and head, face and neck injuries following motorcycle crashes.Objectives:

To assess the effects of wearing a motorcycle helmet in reducing mortality and head and neck injury following motorcycle crashes.Search methods: We searched the Cochrane Injuries Group Specialised Register, Cochrane Central Register of Controlled Trials (The Cochrane Library issue 2, 2007), MEDLINE (up to April 2007), EMBASE (up to April week 16, 2007), CINAHL (January 1982 to February 2003), TRANSPORT (up to issue 12, 2006) (TRANSPORT combines the following databases: Transportation Research Information Services (TRIS) International Transport Research Documentation (ITRD) formerly International Road Research Documentation (IRRD), ATRI (Australian Transport Index) (1976 to Feb 2003), Science Citation Index were searched for relevant articles. Websites of traffic and road safety research bodies including government agencies were also searched. Reference lists from topic reviews, identified studies and bibliographies were examined for relevant articles.Selection criteria: We considered studies that investigated a population of motorcycle riders who had crashed, examining helmet use as an intervention and with outcomes that included one or more of the following: death, head, neck or facial injury. We included any studies that compared an intervention and control group. Therefore the following study designs were included: randomised controlled trials, non-randomised controlled trials, cohort, case-control and cross-sectional studies. Ecological and case series studies were excluded.Data collection and analysis: Two authors independently screened reference lists for eligible articles. Two authors independently assessed articles for inclusion criteria. Data were extracted by two independent authors using a standard extraction form.Main results: Sixty-one observational studies were selected of varying quality. Despite methodological differences there was a remarkable consistency in results, particularly for death and head injury outcomes. Motorcycle helmets were found to reduce the risk of death and head injury in motorcyclists who crashed. From four higher quality studies helmets were estimated to reduce the risk of death by 42% (OR 0.58, 95% CI 0.50 to 0.68) and from six higher quality studies helmets were estimated to reduce the risk of head injury by 69% (OR 0.31, 95% CI 0.25 to 0.38). Insufficient evidence was found to estimate the effect of motorcycle helmets compared with no helmet on facial or neck injuries. However, studies of poorer quality suggest that helmets have no effect on the risk of neck injuries and are protective for facial injury. There was insufficient evidence to demonstrate whether differences in helmet type confer more or less advantage in injury reduction.Authors' conclusions: Motorcycle helmets reduce the risk of death and head injury in motorcycle riders who crash. Further well-conducted research is required to determine the effects of helmets and different helmet types on mortality, head, neck and facial injuries. However, the findings suggest that global efforts to reduce road traffic injuries may be facilitated by increasing helmet use by motorcyclists.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004333.pub3/abstract

Record #171 of 175

ID: CD004517

AU: Maratos Anna

AU: Gold Christian

AU: Wang Xu

AU: Crawford Mike

TI: Music therapy for depression

SO: Cochrane Database of Systematic Reviews

YR: 2008

NO: 1

PB: John Wiley & Sons, Ltd

KY: Depression [therapy];Music Therapy [methods];Randomized Controlled Trials as Topic;Humans[checkword]

CC: HM-DEPRESSN

DOI: 10.1002/14651858.CD004517.pub2

AB: Background: Depression is a highly prevalent disorder associated with reduced social functioning, impaired quality of life, and increased mortality. Music therapy has been used in the treatment of a variety of mental disorders, but its impact on those with depression is unclear.Objectives: To examine the efficacy of music therapy with standard care compared to standard care alone among people with depression and to compare the effects of music therapy for people with depression against other psychological or pharmacological therapies.Search methods: CCDANCTR-Studies and CCDANCTR-References were searched on 7/11/2007, MEDLINE, PsycINFO, EMBASE, PsycLit, PSYindex, and other relevant sites were searched in November 2006. Reference lists of retrieved articles were hand searched, as well as specialist music and arts therapies journals.Selection criteria: All randomised controlled trials comparing music therapy with standard care or other interventions for depression.Data collection and analysis: Data on participants, interventions and outcomes were extracted and entered onto a database independently by two review authors. The methodological quality of each study was also assessed independently by two review authors. The primary outcome was reduction in symptoms of depression, based on a continuous scale.Main results: Five studies met the inclusion criteria of the review. Marked variations in the interventions offered and the populations studied meant that meta-analysis was not appropriate. Four of the five studies individually reported greater reduction in symptoms of depression among those randomised to music therapy than to those in standard care conditions. The fifth study, in which music therapy was used as an active control treatment, reported no significant change in mental state for music therapy compared with standard care. Dropout rates from music therapy conditions appeared to be low in all studies.Authors' conclusions: Findings from individual randomised trials suggest that music therapy is accepted by people with depression and is associated with improvements in mood. However, the small number and low methodological quality of studies mean that it is not possible to be confident about its effectiveness. High quality trials evaluating the effects of music therapy on depression are required.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004517.pub2/abstract

Record #172 of 175

ID: CD006785

AU: Wisnes Alexander R

AU: Aarskog Reidar

AU: Haugland Mildrid

AU: Jamtvedt Gro

AU: Lygren Hildegunn

AU: Nordheim Lena

TI: Traction for hip osteoarthritis

SO: Cochrane Database of Systematic Reviews

YR: 2007

NO: 4

PB: John Wiley & Sons, Ltd

CC: HM-MUSKEL

DOI: 10.1002/14651858.CD006785

AB: This is the protocol for a review and there is no abstract. The objectives are as follows:To compare the effectiveness and harms of traction interventions in patients with hip osteoarthritis to other interventions or no intervention on pain, activities of daily living, range of motion and quality of life.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006785/abstract

Record #173 of 175

ID: CD006309

AU: Dennis Cindy-Lee

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AU: Grigoriadis Sophie

TI: Psychosocial and psychological interventions for treating antenatal depression

SO: Cochrane Database of Systematic Reviews

YR: 2007

NO: 3

PB: John Wiley & Sons, Ltd

KY: Parenting;Psychotherapy;Depression [therapy];Pregnancy Complications [psychology] [therapy];Female[checkword];Humans[checkword];Pregnancy[checkword]

CC: HM-PREG

DOI: 10.1002/14651858.CD006309.pub2

AB: Background: Although pregnancy was once thought of as a time of emotional wellbeing for many women, conferring 'protection' against psychiatric disorders, a recent meta-analysis of 21 studies suggests the mean prevalence rate for depression across the antenatal period is 10.7%, ranging from 7.4% in the first trimester to a high of 12.8% in the second trimester. Due to maternal treatment preferences and potential concerns about fetal and infant health outcomes, non-pharmacological treatment options are needed.Objectives: The primary objective of this review is to assess the effects, on mothers and their families, of psychosocial and psychological interventions compared with usual antepartum care in the treatment of antenatal depression.Search methods: We searched the Cochrane Pregnancy and Childbirth Group's Trials Register (September 2006), the Cochrane Collaboration Depression Anxiety and Neurosis Group's Trials Registers (CCDANCTR-Studies and CCDANCTR-References) (July 2006), the Cochrane Central Register of Controlled Trials (The Cochrane Library 2006, Issue 3), MEDLINE (1966 to July 2006), EMBASE (1980 to July 2006) and CINAHL (1982 to July 2006). We also scanned secondary references and contacted experts in the field to identify other published or unpublished trials.We updated the search of the Cochrane Pregnancy and Childbirth Group's Trials Register on 31 March 2010 and added the results to the awaiting classification section.Selection criteria: All published, unpublished and ongoing randomised controlled trials of preventive psychosocial or psychological interventions in which the primary or secondary aim is to treat antenatal depression. We excluded quasi-randomised trials (for example, those randomised by delivery date, or odd versus even medical record numbers) from the analysis.Data collection and analysis: All review authors participated in the evaluation of methodological quality and data extraction. Results are presented using relative risk for categorical data and weighted mean difference for continuous data.Main results: One US trial was included in this review, incorporating 38 outpatient antenatal women who met Diagnostic and Statistical Manual for Mental Disorders-IV criteria for major depression. Interpersonal psychotherapy, compared to a parenting education program, was associated with a reduction in the risk of depressive symptomatology immediately post-treatment using the Clinical Global Impression Scale (one trial, n = 38; relative risk (RR) 0.46, 95% confidence interval (CI) 0.26 to 0.83) and the Hamilton Rating Scale for Depression (one trial, n = 38; RR 0.82, 95% CI 0.65 to

1.03).Authors' conclusions: The evidence is inconclusive to allow us to make any recommendations for interpersonal psychotherapy for the treatment of antenatal depression. The one trial included was too small, with a non-generalisable sample, to make any recommendations.[Note: The 12 citations in the awaiting classification section of the review may alter the conclusions of the review once assessed.]

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006309.pub2/abstract

Record #174 of 175

ID: CD005563

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TI: Interventions for preventing delirium in hospitalised patients

SO: Cochrane Database of Systematic Reviews

YR: 2007

NO: 2

PB: John Wiley & Sons, Ltd

KY: Hospitalization;Anesthesia, Epidural;Anesthetics, Inhalation;Cytidine Diphosphate Choline [administration & dosage];Delirium [prevention & control];Halothane;Indans [administration & dosage];Nootropic Agents [administration & dosage];Piperidines [administration & dosage];Humans[checkword]

CC: DEMENTIA

DOI: 10.1002/14651858.CD005563.pub2

AB: Background: Delirium is a common mental disorder with serious adverse outcomes in hospitalised patients. It is associated with increases in mortality, physical morbidity, length of hospital stay, institutionalisation and costs to healthcare providers. A range of risk factors has been implicated in its aetiology, including aspects of the routine care and environment in hospitals. Prevention of delirium is clearly desirable from patients' and carers' perspectives, and to reduce hospital costs. Yet it is currently unclear whether interventions for prevention of delirium are effective, whether they can be successfully delivered in all environments, and whether different interventions are necessary for different groups of patients.Objectives: Our

primary objective was to determine the effectiveness of interventions designed to prevent delirium in hospitalised patients. We also aimed to highlight the quality and quantity of research evidence to prevent delirium in these settings.Search methods: We searched the Specialized Register of the Cochrane Dementia and Cognitive Improvement Group on 30 September 2006. As the searches in MEDLINE, EMBASE, CINAHL and PsycINFO for the Specialized Register would not necessarily have picked up all delirium prevention trials, these databases were searched again on 28th October, 2005. We also examined reference lists of retrieved articles, reviews and books. Experts in this field were contacted and the Internet searched for further references and to locate unpublished trials.Selection criteria: Randomised controlled trials evaluating any interventions to prevent delirium in hospitalised patients.Data collection and analysis: Data collection and quality assessment were performed by three reviewers independently and agreement reached by consensus.Main results: Six studies with a total of 833 participants were identified for inclusion. All were conducted in surgical settings, five in orthopaedic surgery and one in patients undergoing resection for gastric or colon cancer.Only one study of 126 hip fracture patients comparing proactive geriatric consultation with usual care was sufficiently powered to detect a difference in the primary outcome, incident delirium. Total cumulative delirium incidence during admission was reduced in the intervention group (OR 0.48 [95% CI 0.23, 0.98]; RR 0.64 [95% CI 0.37, 0.98]), suggesting a 'number needed to treat' of 5.6 patients to prevent one case. The intervention was particularly effective in preventing severe delirium. In logistic regression analyses adjusting for pre fracture dementia and Activities of Daily Living impairment, there was no reduction in effect size, OR 0.6, but this no longer remained significant [95% CI 0.3,1.3]. There was no effect on the duration of delirium episodes, length of hospital stay, and cognitive status or institutionalisation at discharge. There was also no significant difference in cumulative delirium incidence between treatment and control groups in a sub-group of 50 patients with dementia (RR 0.9 [95% CI 0.59, 1.36]).In another trial of low dose haloperidol prophylaxis, there was no difference in delirium incidence but the severity and duration of a delirium episode, and length of hospital stay were all reduced.We identified no completed studies in hospitalised medical, care of the elderly, general surgery, cancer or intensive care patients. In outcomes, no studies examined for death, use of psychotropic medication, activities of daily living, psychological morbidity, quality of life, carers or staff psychological morbidity, cost of intervention and cost to health care services. Outcomes were only reported up to discharge, with no studies reporting medium or longer-term effects.Authors' conclusions: Research evidence on effectiveness of interventions to prevent delirium is sparse. Based on a single study, a programme of proactive geriatric consultation may reduce delirium incidence and severity in patients undergoing surgery for hip fracture. Prophylactic low dose haloperidol may reduce severity and duration of delirium episodes and shorten length of hospital admission in hip surgery. Further studies of delirium prevention are needed.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD005563.pub2/abstract

Record #175 of 175

ID: CD006448

AU: Hicks Emma

AU: Senior Hugh E

AU: Purdy Suzanne

AU: Barker-Collo Suzanne

AU: Larkins Brigette

TI: Interventions for fatigue management after traumatic brain injury

SO: Cochrane Database of Systematic Reviews

YR: 2007

NO: 2

PB: John Wiley & Sons, Ltd

CC: HM-INJ

DOI: 10.1002/14651858.CD006448

AB: This is the protocol for a review and there is no abstract. The objectives are as follows:To assess the evidence for the efficacy of methods of fatigue management in the treatment of adults with traumatic brain injury (TBI), when compared to placebo intervention, no treatment (for example, usual care) or other types of intervention.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006448/abstract