



South Asian Cochrane Network News

SACN News

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2007

Investing in evidence: dividends start pouring in

The South Asian Cochrane Network's efforts, to improve the amount, quality and relevance of reliable evidence used in healthcare decision making, require investments of various sorts: time, passion, ideas and hard work from contributors who undertake systematic reviews, training, mentoring and dissemination activities; as well as investments from other sources.

Earlier this year, the efforts of the SACN in increasing the accessibility of the Cochrane Library to users in India were met by an enthusiastic response from the Indian Council of Medical Research (ICMR) that purchased a national subscription for all residents in India to *The Cochrane Library* (SACN News, 2007 Vol. 1; issue 1). This issue of SACN News carries a report of the usage statistics of The Cochrane Li-

brary from India following the national provision and documents the tremendous increase in usage. The ICMR's far-sighted decision and, not insubstantial investment in the face of competing priorities, appear to have started paying dividends, alleviating concerns that few would use this valuable resource.

Using the Cochrane Library is one dividend but do Cochrane Reviews affect policy and practice? Issue 1, 2007 of the SACN News had reported a test case of a systematic review from the region on evaluating national policies in India and Sri Lanka on primaquine regimens for radical cure of *P. vivax* malaria. This issue reports success in changing the national policies of both countries since publication of the review in Issue 1, 2007 of *The Cochrane Library*. Divi-

dends again for the review authors, the Cochrane Infectious Diseases Group that mentored, supported and edited the review, and for millions of people with *P. vivax* malaria in the region and elsewhere who will benefit from evidence based policy.

As in other walks of life, investing in people usually brings the most enduring dividends. The SACN held its first workshop in Dhaka, Bangladesh this year and the annual protocol development workshop at Vellore midyear. Two workshops on advanced statistics are expected in Karachi and Chandigarh later this year.

The Clinical Trials Register - India (www.ctri.in) has started prospectively registering clinical trials from India and the region and this initiative, supported by the SACN, will also aid

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identification of relevant research to include in synthesis of evidence.

An exciting half-year so far!!

Happy reading!

Prathap Tharyan
(Coordinator, SACN)



Usage statistics for India

The Indian Council of Medical Research (ICMR) purchased a national provision to *The Cochrane Library* in late January 2007 and news of this valuable evidence resource was disseminated to the nation by February.

One of the concerns expressed at the time was uncertainty whether this resource would be used by people in India. However, statistics on usage kindly provided by John Wiley & Sons, the publishers of *The Cochrane Library* reveal no cause for such concern. The number of people accessing the web-pages of The Cochrane Library (number of hits) grew from 21678 during the last seven months of 2006 to 61713 for the first six months of 2007.

However, such statistics can be misleading as they do not necessarily reflect serious users of this resource. A more revealing statistic would be the number of full text articles downloaded (pdf and HTML). During June to December 2006, a total of 3999 full text articles were downloaded, averaging around a little over 500 per month, and access was denied in a further 2848 instances due to lack of personal subscriptions. During January to June 2007 the number of full text articles downloaded grew by 350% to 24090, with a surge in usage after the national provision became available and a steady growth in usage ever since. The paucity of instances where access was denied since the national provision is also revealing of the need for this provision. The South Asian Cochrane Network salutes the ICMR on behalf of the nation, for this valuable gift.

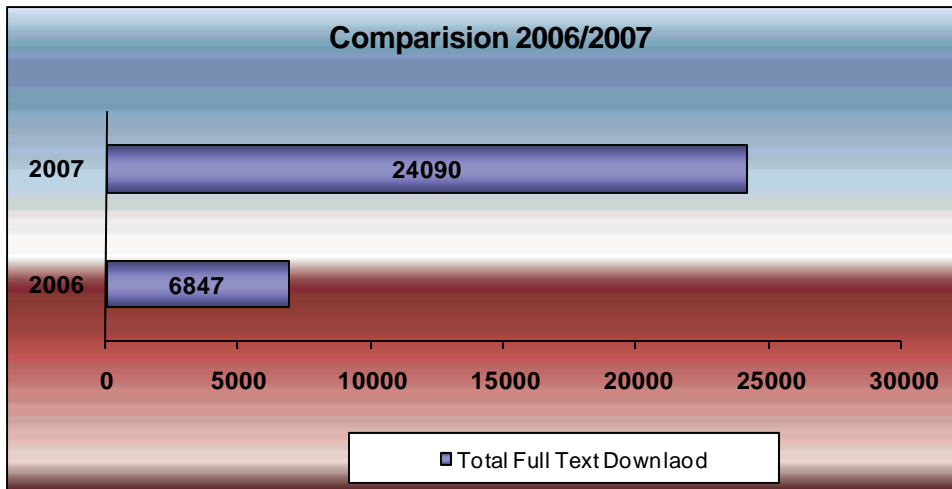
Full Text Usage from India: June to December 2006 compared with January to June 2007

Activity 2006	June	July	August	September	October	November	December	Total for 7 months
Full Text (Total)	22	546	800	878	655	564	534	3999
Access Denied*	50	455	444	373	471	531	524	2848
Activity 2007	Jan	Feb	March	April	May	June	July	Total for 6 months
Full Text (Total)	1365	4096	4760	5208	3572	5089	Not available	24090

*There was no Access Denied in 2007 since the National Provision



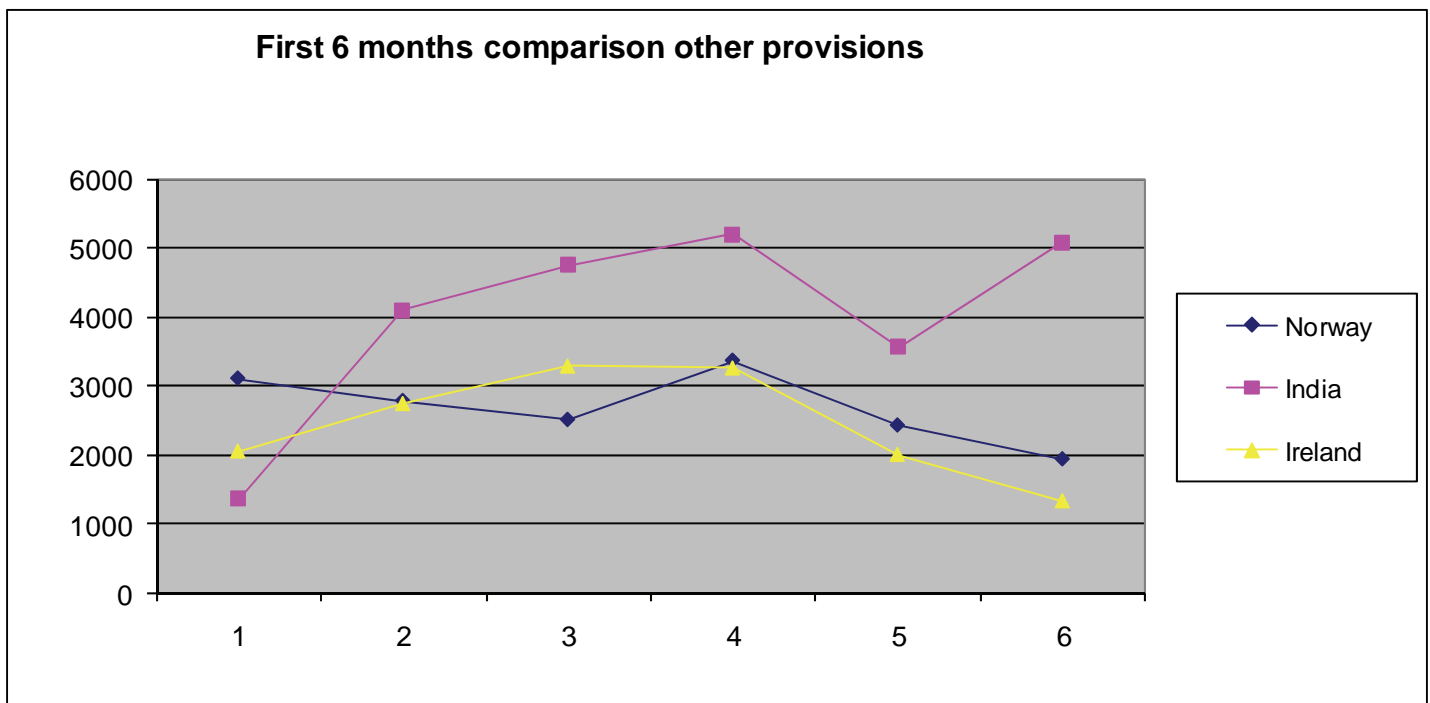
Comparison of usage with other countries with national provisions



Usage for 2007 of *The Cochrane Library* in India grew by 350% to over 24,000 full-text downloads in 6 months (January to June) compared with the last 7 months in 2006 (June-December). This strong growth is comparable to many of *The Cochrane Library* national provisions.

The growth in usage of *The Cochrane Library* is comparable with that in other countries like Norway and Ireland countries where a national provision has been in place for several years (see below), . India has a much larger population than these countries but the proportion of people with access to the internet is considerably smaller. Methods need to be found whereby evidence from *The Cochrane Library* may be disseminated to those without such access in ways that are meaningful to them.

The SACN is grateful to John Wiley & Sons for data on usage of *The Cochrane Library* from India.



What articles from the Cochrane Library do people in India read?

Top Cochrane reviews accessed in India in 2006 and their overall ranking (Data from John Wiley & Sons)

Article Author - Title	Rank in World (full text accesses)	Rank in India (accesses + access denied)
TSA Fidelix, BGDO Soares, M Trevisani VF - Diacerein for osteoarthritis	896	1
J Volmink, P Garner - Directly observed therapy for treating tuberculosis	180	2
P Tharyan, CE Adams - Electroconvulsive therapy for schizophrenia	243	3
DE Thomas, EJ Elliott, GA Naughton - Exercise for type 2 diabetes mellitus	13	4
DE Thomas, EJ Elliott, L Baur - Low glycaemic index, or low glycaemic load, diets for overweight and obesity	1134	4
DG Hermans, U Hla Htay - Non-pharmacological interventions to prevent wandering in the domestic setting	2926	4
DG Altman - Cochrane Statistical Methods Group	3570	4
DF) Dengfeng Wang (Wang, LN) Lina Hu (Hu, GJ) Gu - Traditional Chinese medicines for ectopic pregnancy	4527	4
FA Laar, PLBJ Lucassen, RP Akkermans, EH Lisdonk - Alpha-glucosidase inhibitors for type 2 diabetes mellitus	382	5
C Curioni, C Andre; - Rimonabant for overweight or obesity	50	6
C Curioni, C Andre, R Veras - Weight reduction for primary prevention of stroke in adults with over-	1447	6
C Daly, M Campbell, JD Cody, C Donaldson, A Gran - Double bag or Y-set versus standard transfer systems for continuous ambulatory peritoneal dialysis in end-stage renal disease	3722	6
S Jayaraman, PHD Colquhoun, RA Malthaner - Stapled versus conventional surgery for hemorrhoids	873	7
NL Siegfried, PJU Deventer, FA Mahomed, GW Ruthe - Stavudine, lamivudine and nevirapine combination therapy for treatment of HIV infection and AIDS in adults	1861	7
SJ Allen, B Okoko, E Martinez, G Gregorio, LF Da - Probiotics for treating infectious diarrhoea	228	9
S Sauerland, R Lefering, EAM Neugebauer - Laparoscopic versus open surgery for suspected appendicitis	159	10
TM Kay, A Gross, C Goldsmith, PL Santaguida, J H - Exercises for mechanical neck disorders	18	11
PC Gotzsche, M Nielsen - Screening for breast cancer with mammography	3	12
A Pollock, G Baer, V Pomeroy, P Langhore - Physiotherapy treatment approaches for the recovery of postural control and lower limb function following stroke	29	13
HV Worthington, JE Clarkson, OB Eden - Interventions for preventing oral mucositis for patients with cancer receiving treatment	38	13
KJ Jorgensen, PC Gotzsche, HK Joha - Voriconazole versus amphotericin B in cancer patients with neutropenia	361	13
SK Kabra, R Lodha, RM Pandey - Antibiotics for community acquired pneumonia in children	651	13
M Esposito, MG Grusovin, P Coulthard, HV Worthin - Enamel matrix derivative (Emdogain) for periodontal tissue regeneration in intrabony defects	981	13
KJ Price, TM Elliott - Stimulant laxatives for constipation and soiling in children	1676	13
SK Kakkos, G Geroulakos, J Caprini, AN Nicolaide - Combined intermittent pneumatic leg compression and pharmacological prophylaxis for prevention of venous thrombosis	1690	13
KJ McLaughlin, AF Brindley, CA Crowther - Informational video for potential participants of clinical studies used in the process of seeking informed consent	2866	13
KJ Wiggins, JC Craig, D Johnson, GF Strippoli - Treatment for peritoneal dialysis-associated peritonitis	3052	13
KJ McLaughlin, CP Barnett, CA Crowther - Ethanol in threatened preterm labour for preventing preterm birth	4421	13
KV Trinh, N Graham, AR Gross, CH Goldsmith, E Wa - Acupuncture for neck disorders	83	18
K H O Deane, D Jones, C Ellis-Hill, C E Clarke, - Physiotherapy for Parkinson's disease: a comparison of techniques	146	18
RL Manser, LB Irving, C Stone, G Byrnes, M Abram - Screening for lung cancer	615	18
RL Hayes, JJ McGrath - Cognitive rehabilitation for people with schizophrenia and related conditions	668	18

Do Cochrane reviews affect health policy in South Asia?

Malaria is a major public health problem in many parts of the world, including South Asia. Infection with *Plasmodium vivax* causes a relapsing type of malaria since, in addition to the pre-erythrocytic and erythrocytic stages found in *P. falciparum* and *P. malariae*, there is a stage in the liver called the hypnozoite. These dormant forms can be activated weeks to years after the initial infection and cause relapses of the infection. A combination of chloroquine and primaquine is used to treat *P. vivax* malaria. Chloroquine acts on the blood stages of the parasite and primaquine eliminates the liver forms.

For many years, there had been a discrepancy in the treatment guidelines for radical cure of *P. vivax* malaria between those issued by the National Malaria Control Programmes in the region, such as in India and Sri Lanka that recommend 5 days of primaquine following chloroquine, and those from the World Health Organization that recommends a 14-day course of primaquine as the standard treatment for preventing relapses.

Gawrie Galappaththy, from the Anti-malaria campaign, Ministry of Health, Sri Lanka, and others published a Cochrane Review in issue 1, 2007 of *The Cochrane Library* that included 9 randomized controlled trials of over 3400 people from the region. The review showed that giving 5 days of primaquine (15 mg/kg) after chloroquine is no better in preventing relapses than using chloroquine alone. Primaquine (15 mg/kg/day) for 14 days plus chloroquine was more effective in preventing relapses of *P. vivax* malaria than chloroquine alone or primaquine for 5 days plus chloroquine.

Within 6 months of publication of this review, the Revised Malaria Treatment Guidelines issued by the National Vector Borne Diseases Control Programme, Ministry of Health and Family Welfare, Government of India, and the 2007 guidelines of the National Anti Malaria campaign Directorate, Ministry of Health in Sri Lanka had both changed recommendations for the use of primaquine for preventing relapses in *P. vivax* malaria from 5 days to the WHO recommended 14 days treatment regimen.

For this evidence based policy recommendation to affect practice, attention now needs to be given to improving compliance with the longer primaquine regimen. Primaquine resistance is also increasing in the region and higher doses of primaquine (30 mg/kg) for 14 days and other drugs that eliminate the liver forms of *P. Vivax* need to be evaluated in systematic reviews.

Investing time and effort in undertaking systematic review can pay dividends that affect the lives of many; kudos to the Cochrane Infectious Diseases group for the effort that resulted in this important review for reliable evidence in South Asia.

National policies in Sri Lanka and India have incorporated evidence from a Cochrane review on primaquine treatment regimens for preventing relapses in *P. vivax* malaria.

Clinical Trials Registry– India is now open for prospectively registering trials

The Clinical Trials Registry – India (www.ctri.in) accepts prospective registration of all clinical trials in humans conducted in India and the region. Registration is voluntary but some items are mandatory for complete registration. Registration and full disclosure must take place before enrolment of the first participant. The CTRI is one of the primary registers in the WHO ICTRP network of registers and will provide data to the WHO ICTRP Search Portal (www.who.int/trialsearch)

The Clinical trials Registry– India (CTRI), an on-line (www.ctri.in) register of prospective clinical trials in humans, was launched by Prof. Nirmal Ganguly, Director General of the Indian Council of Medical Research (ICMR) in New Delhi on June 20, 2007. This register is fully compliant with the requirements of the WHO– International Clinical Trials Registry Platform (WHO ICTRP) and will form one of five Primary Registers currently within WHO Register Network and will contribute trials via the WHO ICTRP Search Portal (<http://www.who.int/trialsearch/>). Primary Registers accept direct registration of trials or from partner registers (pharmaceutical company clinical trials registers, university registers etc) and provide access to the WHO 20-item data set from these trials to the ICTRP database and the

International Search Portal.

The CTRI is an online register of clinical trials being conducted in India and the region. Any researcher who plans to conduct a trial involving human participants, of any intervention (drug, surgical procedure, preventive measures, lifestyle modifications, devices, educational or behavioral treatment, rehabilitation strategies and complementary therapies) are expected to register the trial in CTRI *before enrolment of the first participant*. Registration is voluntary but some fields are mandatory for registration to proceed. All 20 items of the WHO data set also need to be filled if the trial is to receive a registration number and fulfill WHO/ICMJE requirements. Incomplete entries will be given a provisional registration number that will not suffice for purposes of publication in journals that endorse the ICMJE recommendations for trial registration. Registration of trials in the CTRI is free. All registered trials will be made publicly available. The CTRI will be searchable by anyone free of charge.

It is hoped that every clinical trial conducted in India and the region will be prospectively registered with full disclosure of the 20-item WHO ICTRP dataset, as well as the additional 10 items of the CTRI dataset, in order to 1) improve transparency and accountability, 2) improve the internal validity (details of the methods of the trial that produce reliable results) of trials right from the design, through conduct and reporting, 3) conform to accepted ethical standards and 4) lead to reporting of all relevant results of all clinical trials in India and the region.

“The registration of all interventional trials is a scientific, ethical and moral responsibility”.
WHO

The CTRI is maintained by the National Institute of Medical Statistics (ICMR) with funding from the Department of Science and Technology, the WHO-India country office and the ICMR.

NEWS FROM THE SOUTH ASIAN REGION

First Cochrane Workshop in Bangladesh



Left: Prof. Omar Rahman addressing participants at the Independent University, Dhaka, Bangladesh; Above: Dr. Andy Oxman, EPOC Group, Oslo



Sir Iain Chalmers



Participants at the workshop

The SACN held its first systematic review workshop at SACN Bangladesh site at the Independent University, Dhaka, Bangladesh (Centre for Health, Population and Development) on May 4, 2007. Prof. Omar Rahman, Pro-Vice Chancellor and coordinator of the SACN site, and his team efficiently organized this event that was attended by participants from the Independent University, the International Centre for Diarrheal Diseases Research, Bangladesh (ICDDR,B) and other centres in Dhaka. Sir Iain Chalmers, Dr. Andy Oxman and Dr. Prathap Tharyan led participants through the work of the Cochrane collaboration, the SACN, and on conducting systematic reviews in health systems and clinical interventions. The first titles and protocols from Bangladesh are expected shortly.

Protocol development workshop: CMC Vellore, India



The 4th annual Cochrane Systematic Review Protocol Development Workshop was held at the Lecture Theatre of the Community Health Training Centre from June 25-27, 2007. The workshop was organized and hosted by the Prof. BV Moses Centre for Research and Training in Evidence Based Health Care, the coordinating site of the South Asian Cochrane Network (SACN). This hands-on workshop was funded by the Indian Council of Medical Research (ICMR), with additional sponsorship by the Cochrane Schizophrenia Group (CSG), the Cochrane Infectious Diseases Group (CIDG), and the Department for International Development (DFID)-UK. Prof. Clive Adams, coordinating editor of the CSG, University of Leeds; Ms. Judy Wright, Trials Search Coordinator of the CSG; Ms. Katherine Abba, Lecturer in Research Synthesis, CIDG, Liverpool School of Tropical Medicine; Prof. Thambu David; and Prof. Prathap Tharyan of the SACN, were resource persons.

The 41 participants included 22 senior members from the ICMR headquarters and ICMR supported institutions, 6 participants from other institutions in India and 13 CMC faculty. Between them, the participants worked on developing 22 potential protocols for systematic reviews of interventions in various aspects of health care relevant to the region.



Effective Health Care Research Programme Consortium

The purpose of the *Effective Health Care Research Programme Consortium* (www.liv.ac.uk/evidence/index.htm) is to increase decisions relating to the health sector based on best available evidence in middle-income and low-income countries. The consortium focuses on:

1. Preparing and updating Cochrane Reviews about the effects of health care (malaria and tuberculosis, child health, maternal health, and health systems) relevant to low-income and middle-income countries and identifying approaches to ensure dissemination;
2. Using the results of systematic reviews in decision making, through effective dialogue between research, policy, and practice communities in the public and private sectors in low and middle-income countries.

The Programme is supported by funds from the Department for International Development (DFID) UK and is directed by *Professor Paul Garner* at the Liverpool School of Tropical Medicine, affiliated to the University of Liverpool.

The Consortium partners include *Martin Meremikwu*, University of Calabar, College of Medical Sciences, NIGERIA (Nigeria Effective Health Care Alliance; www.ehcapnigeria.org/); *Jimmy Volmink and Taryn Young*, Medical Research Council, Cape Town, SOUTH AFRICA (South African Cochrane Centre; www.mrc.ac.za/cochrane/cochrane.htm); *Prathap Tharyan*, Christian Medical College, Vellore, INDIA (South Asian Cochrane Network; www.cochrane-sacn.org) and *Wang Yang*, School of Public Health, Chongqing University of Medical Science, CHINA (China Effective Health Care Network; www.chinaehcrpc.cn). Other partners include *Lilia Ziganshina*, Kazan State Medical Academy; RUSSIA (www.evidence-update.ru); *Mary Anne Lansang*, University of the Philippines; and *Ratana Panpanich*, Chiang Mai University, THAILAND (Thai Cochrane Network; www.tn.cochrane.org/en/index.html).

The SACN input to the EHCRCPC: The national provision for The Cochrane Library was helped by to a consortium funded workshop for the ICMR held at New Delhi in October 2006; attempts to influence health policy continued with the protocol development workshop at Vellore in June 2007 that was partly funded by the EHCRCPC. The Cochrane review on [Primaquine for preventing relapses in *P. vivax* malaria](#) was an EHCRCPC effort, as was another review by *Srividya Adinarayan* from the Vector Control and Research Center, Pondicherry, and colleagues on '[Diethylcarbamazine \(DEC\)- medicated salt for community-based control of lymphatic filariasis](#)' (CDSR, Issue 1, 2007) that concluded that low dose DEC-medicated salt is an effective intervention when maintained at 90% coverage for at least 6 months.

Forthcoming EHCRCPC sponsored reviews with authors from the SACN include: Antibiotics for Shigella dysentery; Effectiveness of home visits on reducing neonatal mortality; Single dose treatment for treating lymphatic filariasis; Diethylcarbamazine regimens for controlling lymphatic filariasis; [Anthelmintics for people with neurocysticercosis](#); [Nutritional supplements for people being treated for active tuberculosis](#); [Pyronridine for treating uncomplicated malaria](#). Review updates expected include: Steroids for treating tuberculous meningitis; [Corticosteroids for treating cerebral malaria](#) and [Fluoroquinolones for treating typhoid and paratyphoid fever \(enteric fever\)](#).

We also disseminate Cochrane evidence through [Evidence Update](#). These are two page summaries of Cochrane systematic reviews of health care interventions relevant to low and middle-income countries and have been disseminated to over 400 primary care physicians across India and to medical colleges in the country.

ICMR Advanced Centre for Evidence Based Health Care

The Indian Council of Medical Research (ICMR) is continuing efforts to invest in evidence for healthcare by awarding the SACN coordinating site at the Prof. BV Moses Centre for Research and Training Evidence Based Health Care, CMC Vellore, India, the status of an ICMR Centre for Advanced Research in Evidence Based Health Care. Funding for the activities under this grant will commence in August 2007 and will continue for the next five years.

The overall objectives of this proposal are to:

A. To improve the quality of health care and health policy in India through: the increased capacity among health professionals to understand and to conduct systematic reviews; the increased dissemination of the results of systematic reviews of interventions in health care and evaluation of their usefulness to clinicians and people with health care needs and identification of gaps in evidence requiring systematic reviews or interventional trials; and improving the design, conduct and reporting of clinical trials conducted in India.

B. To partner the International Cochrane Collaboration in its activities of preparing, maintaining and disseminating systematic reviews of interventions through: supporting network sites of the South Asian Cochrane Network (SACN) and improving capacity in fulfilling their designated roles; establishing an independent South Asian Cochrane Centre and Network (SACCN) with the coordinating centre at CMC Vellore in India; maintaining a register of controlled clinical trials in the region and contributing to the Cochrane Central Register of Controlled Clinical Trials (CENTRAL).

The SACN is grateful to the ICMR for their continued support and will work towards ensuring that this investment reaps rich dividends.

Growth of the SACN

Issue 3, 2007 of the Cochrane Library lists 175 people contributing to the work of 30 Cochrane Review Groups of the Cochrane Collaboration from countries represented in the SACN. Of these, 136 are review authors or co-authors, four are editors of review groups, one is an assistant trials search coordinator and the rest are peer reviewers, hand-searchers or consumer referees. The Cochrane Information Management System (Archie) lists over 300 people from countries in the region involved with the work of the Collaboration.

The steady growth of the SACN is encouraging and contrasts with around 30 people from the region that were involved with the Collaboration in 2003 prior to the formation of the SACN. New titles and protocols continue to be registered at a steady rate and we invite more participation from people in the region.

ACTREC joins the SACN

The Advanced Centre for Treatment, Research and Education in Cancer ([ACTREC](#)) at Mumbai, a state of the art, national, cancer research and treatment centre, and a satellite of the Tata Memorial Centre and [Tata Memorial Hospital](#), the largest cancer hospital in Asia, is now an SACN site.



Prof. Rajiv Sarin, Director of ACTREC, takes over from Prof. Purvish Parikh, the previous coordinator of this site. Prof Sarin and his team at ACTREC have a number of systematic reviews in international journals on cancer and are involved in developing evidence based guidelines for interventions in cancer relevant to the region. ACTREC hopes to link its work with the Cochrane Cancer Network and Prof Sarin has been in touch with Mark Lodge of the CCN in this regard. ACTREC recently signed a memorandum of understanding with the SACN.

We welcome Prof Sarin and his team and recognize the enormous potential of this valuable resource. The SACN thanks Prof Parikh for his valuable contributions and will continue to support him as he undertakes systematic reviews in oncology.

Cochrane Schizophrenia Group Satellite

The Cochrane Schizophrenia Group's (CSG) Specialist Register contains over 10,000 reports arranged into around 7000 indexed studies. The SACN coordinating centre at CMC Vellore has, since October 2005, served as a satellite for the CSG and Julie Monalisa joined us in April 2007. as Assistant Trials Search Coordinator (TSC) for the CSG. Over the past year, Julie has, working with Judy Wright and Drew Davey at the CSG editorial base in Leeds, UK, coded



Julie Monalisa: Assistant Trials Search Coordinator; Cochrane Schizophrenia Group

over 1400 records of trials, and formatted them for entry into Procite and Meerkat, the proprietary software of the Collaboration that the CSG uses for its register. Julie also searches for trials from the region and helps maintain the quality of the CSG register. Clive Adams, Coordinating Editor of the CSG, and Judy Wright helped in her training and she is supervised and supported by Zenobia Kanagaraj, administrator at the SACN coordinating centre.

The SACN thanks and bids farewell to Judy Wright and Tessa Grant (CSG Review Group Coordinator) who leave the CSG as the editorial base shifts to Nottingham.

New Reviews from the SACN in 2007

Adinarayanan S, Critchley J, Das PK, Gelband H.

Diethylcarbamazine (DEC)-medicated salt for community-based control of lymphatic filariasis.

Cochrane Database of Systematic Reviews: 2007 Issue 1; CD006709

BACKGROUND: Mass treatment with diethylcarbamazine (DEC)-medicated salt has been used in a number of places as a control measure for lymphatic filariasis. We sought reliable evidence about its effect on lymphatic filariasis transmission.

OBJECTIVES: To evaluate the effects of DEC-medicated salt on infection with lymphatic nematodes in studies of individuals and communities.

SEARCH STRATEGY: In August 2006, we searched the Cochrane Infectious Disease Group Specialized Register, CENTRAL (The Cochrane Library 2006, Issue 3), MEDLINE, EMBASE, and LILACS. We also checked reference lists.

SELECTION CRITERIA: Studies of DEC-medicated salt in endemic populations or microfilaraemic individuals that reported on some measure of human infection before and after the intervention.

DATA COLLECTION AND ANALYSIS: Two authors assessed study eligibility and methodological quality. We calculated the percentage change in microfilariae prevalence and density, adult worm prevalence, disease rates, and vector infection and infectivity. We carried out meta-regression to explore the variability in percentage reduction in microfilariae prevalence between studies.

MAIN RESULTS: Twenty-one studies were included; two compared DEC-medicated salt with other forms of DEC, five had some control group, and 14 were before-and-after studies. Five were efficacy and safety studies of individuals who were all microfilaraemic at baseline; the rest studied endemic communities. Percentage reductions in microfilariae prevalence were large (43% to 100%) and consistent in most studies with high levels of coverage. Large reductions in microfilariae density were also observed, though most studies reported changes in microfilariae density only for people with microfilaraemia at baseline. Vector infection and infectivity also declined, but the samples were usually small. Changes in disease prevalence were inconclusive as most studies were not powered for this outcome. Adverse events seemed mild. Only two studies compared DEC-medicated salt with other forms of DEC (such as annual or standard 12-day dose), but in both performance of DEC-medicated salt was better. A few studies included longer term follow up (two to 19 years). Reductions in microfilariae prevalence, density, and vector infectivity were maintained over time. The DEC concentration in the salt and the duration of intervention were significant factors influencing the percentage reduction in microfilariae prevalence in these studies.

AUTHORS' CONCLUSIONS: DEC-medicated salt is an effective intervention when maintained with levels of coverage of at least 90% for at least six months. Further studies are required to assess the effects of continuous low-dose, DEC-medicated salt on adult worms, disease prevalence, and development of drug resistance.

PLAIN LANGUAGE SUMMARY: High population coverage of DEC-medicated salt maintained over at least six months in a community is effective at reducing transmission of lymphatic filariasis and can, if maintained over a long enough period, completely interrupt transmission. Filariasis is a parasite infection of threadlike worms, affecting about 120 million people in more than 83 countries. The infection is transmitted by mosquitoes. Larval forms take up to a year to develop into adult worms, which mate and release thousands of microfilariae (mf) into the blood over the course of their lives. Mf are ingested by mosquitoes from the blood of an infected individual, completing the cycle. This infection may lead to severe disability in the form of lymphoedema and eventually elephantiasis of limbs, and hydrocoele. Though most infected people remain asymptomatic, the lymph vessels are often damaged. A drug, diethylcarbamazine (DEC) has been shown to kill mf, but repeated doses are needed before adult worms are killed or sterilized. This review looked at the effectiveness of giving entire communities DEC-medicated salt. The review of studies found evidence that DEC when given

in a low dose over a period of months or years is effective in reducing the prevalence of filariasis in communities, with no recognized adverse events.

Galappaththy GNL, Omari AAA, Tharyan P.

[Primaquine for preventing relapses in people with Plasmodium vivax malaria.](#)

Cochrane Database of Systematic Reviews: 2007 Issue 1; CD004389

BACKGROUND: Plasmodium vivax infections contribute to a significant proportion of the malaria infections in many countries. Primaquine is the most widely used drug for treating the dormant liver stage. Different primaquine dosing regimens are in use.

OBJECTIVES: To compare primaquine regimens for preventing relapses in people with P. vivax malaria.

SEARCH STRATEGY: In 2006, we searched the Cochrane Infectious Diseases Group's Specialized Register (January), CENTRAL (The Cochrane Library 2006, Issue 3), MEDLINE (October), EMBASE (January), LILACS (January). We also checked conference proceedings and reference lists, and contacted researchers, the World Health Organization (WHO), malaria mailing lists, and pharmaceutical companies.

SELECTION CRITERIA: Randomized and quasi-randomized controlled trials comparing primaquine plus chloroquine with chloroquine alone, and the standard primaquine regimen (15 mg/day for 14 days) with other primaquine-containing regimens in people with vivax malaria.

DATA COLLECTION AND ANALYSIS: All authors independently assessed trial eligibility and quality, and extracted data. We calculated odds ratios (OR) with 95% confidence intervals (CI) for dichotomous data, and used the random-effects model if there was significant heterogeneity.

MAIN RESULTS: Nine trials (3423 participants) met the inclusion criteria. Compared with chloroquine alone, five-day primaquine plus chloroquine was no better at preventing relapses (OR 1.04, 95% CI 0.64 to 1.69, random-effects model; 2104 participants; 3 trials), while 14-day primaquine plus chloroquine was significantly better (OR 0.24, 95% CI 0.12 to 0.45, random-effects model; 1071 participants, 6 trials). Limited data suggest the advantage for the 14-day primaquine regimen persisted for over six months (OR 0.41, 95% CI 0.29 to 0.60; 585 participants, 2 trials). Direct comparisons of the 14-day and five-day primaquine plus chloroquine regimens also confirm the superiority of the longer course (OR 13.33, 95% CI 3.45 to 51.44; 186 participants, 2 trials). Adverse effects were poorly reported, with three trials reporting skin rash, vertigo, headache, abdominal pain and/or nausea, and two trials reporting that primaquine was well tolerated.

AUTHORS' CONCLUSIONS: Primaquine (15 mg/kg/day for 14 days) plus chloroquine is more effective than chloroquine alone or primaquine (15 mg/kg for 5 days) plus chloroquine in preventing relapses of vivax malaria. Primaquine (five days) plus chloroquine appears no better than chloroquine. Countries should follow the WHO's recommendation for 14-day primaquine plus chloroquine regimen. Alternative regimens need to be evaluated in randomized controlled trials, which should also consider variations in regional P. vivax strains and the possibility of primaquine resistance, reinfection, and adherence in those who relapse.

PLAIN LANGUAGE SUMMARY: Primaquine for preventing relapses in people with Plasmodium vivax malaria. P. vivax infections contribute to a significant proportion of the malaria infections in many Asian-Pacific and South American countries. Primaquine is the most frequently used drug for treating the dormant liver stage of the infection and is given in combination with chloroquine. Different primaquine dosing regimens are used to prevent relapses of the disease. The review included nine randomized controlled trials, comparing either primaquine plus chloroquine with chloroquine or the 14-day primaquine plus chloroquine regimen with a 5-day primaquine plus chloroquine regimen. Compared with chloroquine alone, primaquine (for five days) plus chloroquine was no better in preventing relapses of P. vivax infection, while primaquine (for 14 days) plus chloroquine resulted in significantly fewer relapses. The 14-day primaquine regimen was also significantly

better than the five-day primaquine regimen at preventing relapses. Adverse effects were poorly reported; three trials reported skin rash, vertigo, headache, abdominal pain and/or nausea in some participants, and two trials reported that primaquine was well tolerated. Since the five-day primaquine plus chloroquine does not prevent relapses, countries should follow the World Health Organization's recommendation of the 14-day primaquine plus chloroquine regimen.

Elias A, Kumar A.

Testosterone for schizophrenia.

Cochrane Database of Systematic Reviews: 2007 Issue 3; CD006197

BACKGROUND: Recently, sex hormones such as estrogens and testosterone or its derivatives have been the focus of interest for treatment of persistent symptoms associated with schizophrenia.

OBJECTIVES: To review the effects of dehydroepiandrosterone (DHEA)/testosterone as adjunctive therapy to standard antipsychotic drugs.

SEARCH STRATEGY: We searched the Cochrane Schizophrenia Group Trials Register (January 2007).

SELECTION CRITERIA: We included all clinical randomised trials comparing DHEA/testosterone plus standard antipsychotic treatment with standard treatment alone.

DATA COLLECTION AND ANALYSIS: We independently selected studies and extracted data. For dichotomous data we calculated the relative risk (RR) and its 95% confidence interval (CI) on an intention to treat basis, using a fixed effects model. We presented continuous data using the weighted mean difference statistic, with a 95% confidence interval using a fixed effects model.

MAIN RESULTS: We found three relevant small, short trials (total n=126). Clinical Global Impression data were equivocal (n=27, 1 RCT, WMD -0.43 CI -0.9 to 0.1). Average total PANSS scores were not significantly different between the DHEA plus antipsychotic group and those given antipsychotic drugs and placebo (n=82, 2 RCTs, WMD -4.16 CI -13.8 to 5.5). PANSS positive scores were equivocal (n=55, 1 RCT, WMD -1.00 CI -3.8 to 1.8). For negative symptoms binary SANS scale data favoured the DHEA plus antipsychotic group (n=30, 1 RCT, RR 0.23 CI 0.1 to 0.6, NNT 2 CI 2 to 3) but PANSS negative scores were not significantly different between comparison groups (n=55, 1 RCT, WMD -2.30 CI -6.4 to 1.8). About 17% of people left both groups early (n=64, 2 RCTs, RR 0.80 CI 0.3 to 2.4). St Hans Rating Scale data for extrapyramidal symptoms favoured the DHEA plus antipsychotic group (n=30, 1 RCT, WMD -5.00 CI -8.8 to -1.2) but akathisia ratings were equivocal (n=34, 1 RCT, RR 2.67 CI 0.3 to 23.1). Ratings of parkinsonian movement disorder differed within the same trial depending of the outcome scale used. Quality of life seemed unaffected by use of DHEA (n=55, 1 RCT, WMD 6.20 CI -1.4 to 13.8).

AUTHORS' CONCLUSIONS: Results are inconclusive with most outcomes being either non-significant or producing contradictory findings. Currently, adjunctive DHEA should remain an experimental treatment for people with schizophrenia.

PLAIN LANGUAGE SUMMARY: About 1% of people suffer from schizophrenia, a serious mental illness found in all societies and cultures. Many treatments options are available to reduce the dramatic symptoms of this illness such as the false beliefs (delusions) and false or distorted perceptions (hallucinations). Other symptoms, such as emotional withdrawal and apathy are also often seen with schizophrenia and seem less responsive to treatment with antipsychotic drugs. In addition, some people continue to experience delusions and hallucinations despite adequate use of antipsychotic drugs and often supplementary treatments are used. These supplementary treatments include sex hormones such as estrogen and testosterone. We reviewed the effects of dehydroepiandrosterone (DHEA)/testosterone as an adjunctive therapy to standard antipsychotic drugs for people with schizophrenia and found three relevant small, short studies. All trials compared antipsychotic drugs plus DHEA with antipsychotic drugs and placebo. Results are inconclusive, with most outcomes being either non-significant or contradictory and a much larger, conclusive study should be undertaken. Currently however,

people with schizophrenia should only agree to take this experimental treatment within the context of a well designed experimental study. We found nothing in these studies to suggest that it should be used in routine care.

Vemgal P, Ohlsson A.

Interventions for non-oliguric hyperkalaemia in preterm neonates.

Cochrane Database of Systematic Reviews: 2007 Issue 1; CD005257

BACKGROUND: Non-oliguric hyperkalaemia of the newborn is defined as a plasma potassium level > 6.5 mmol/L in the absence of acute renal failure. Hyperkalaemia is a common complication in the first 48 hours of life in very low birth weight (birth weight < 1500 g) and/or very preterm newborns (< 32 weeks gestational age).

OBJECTIVES: To determine the effectiveness and safety of interventions for non-oliguric hyperkalaemia [for the purpose of this review defined as serum potassium > 6.0 mmol/L (the clinical setting in which interventions would likely be introduced prior to reaching a grossly abnormal level) and a urine output > 0.5 ml/kg/hour] in preterm or very low birth weight (VLBW) infants during their first 72 hours of life.

SEARCH STRATEGY: The Cochrane Central Register of Controlled Trials (CENTRAL, The Cochrane Library, Issue 2, 2006) was searched to identify relevant randomised and quasi-randomised controlled trials. The following data bases were searched in June 2006; MEDLINE from 1966, EMBASE from 1980, CINAHL from 1982.

SELECTION CRITERIA: Randomised or quasi-randomised controlled trials conducted in preterm and/or VLBW neonates with a diagnosis of non-oliguric hyperkalaemia. The interventions included were those aimed at redistributing serum potassium (sodium bicarbonate or insulin and glucose) or increasing the elimination of potassium from the body [diuretics (any type) or ion exchange resins (any type), or exchange transfusion, or peritoneal dialysis, or salbutamol, or albuterol] or counteracting potential arrhythmias from hyperkalaemia (calcium) vs. placebo or no intervention; or comparing any two of these interventions. The primary outcome measure was 'All cause mortality during initial hospital stay'. Secondary outcomes included common adverse outcomes seen in infants born preterm.

DATA COLLECTION AND ANALYSIS: The standard review methods of the Cochrane Neonatal Review Group were used. All studies identified as potentially relevant by the literature search were assessed for inclusion in the review by the two authors. The statistical methods included relative risk (RR), risk difference (RD), number needed to treat to benefit (NNTB) or number needed to treat to harm (NNTH) for dichotomous and weighed mean difference (WMD) for continuous outcomes reported with 95% confidence intervals (CI). A fixed effects model was used for meta-analysis. Heterogeneity was assessed using the I squared (I²) statistic.

MAIN RESULTS: Three randomized trials, enrolling 74 preterm infants (outcome data available on 71 infants) evaluated interventions for hyperkalemia. Urine output was ascertained only in one study (Hu 1999). In none of the trials could we ascertain that allocation to the comparison groups was concealed. The sample sizes of the three trials were very small with 12 (Malone 1991), 19 (Singh 2002) and 40 infants enrolled (Hu 1999). The intervention and the outcomes assessments could not be blinded to the clinical staff in two trials (Hu 1999; Malone 1991). In one study (Malone 1991), glucose and insulin, compared to cation-exchange resin, caused a reduction in all cause mortality that was of borderline statistical significance: RR 0.18 (95% CI 0.03, 1.15); RD -0.66 (95% CI -1.09, -0.22); NNTB 2 (95% CI 1, 5)]. In the study of Hu (Hu 1999), the incidence of intraventricular haemorrhage > grade 2 was significantly reduced [RR 0.30 (95% CI; 0.10, 0.93); RD -0.35 (95% CI; -0.62, -0.08); NNTB 3 (95% CI; 2, 13)]. Albuterol inhalation vs. saline inhalation changed serum K⁺ from baseline at 4 hours [WMD -0.69 mmol/L (95% CI; -0.87, -0.51)] and at 8 hours [WMD -0.59 mmol/L (95% CI; -0.78, -0.40)] after initiation of treatment. No differences were noted in mortality or other clinical outcomes (Singh 2002). No serious side effects were noted with either the combination of insulin and glucose or albuterol inhalation. Other interventions that we listed in our objectives have not been studied to date.

AUTHORS' CONCLUSIONS: In view of the limited information from small studies of uncertain quality, no firm recommendations for clinical practice can be made. It appears that the combination of insulin and glucose is preferred over treatment with rectal cation-resin for hyperkalaemia in preterm infants. Both the combination of insulin and glucose and albuterol inhalation deserve further study. The two interventions could possibly be tested against each other. The effectiveness of other potentially effective interventions for non-oliguric hyperkalaemia (diuretics, exchange transfusion, peritoneal dialysis and calcium) have not been tested in randomized controlled trials.

PLAIN LANGUAGE SUMMARY: Elevated levels of potassium (an important salt for normal body functions) are common in infants born very preterm or with birth weight less than 1500 g. High potassium levels in the blood may lead to irregular or rapid heart rate that may result in bleedings in the brain and/or sudden death. The objective of this review was to determine the effectiveness and safety of interventions for this serious condition. Two studies enrolling 52 infants that assessed the use of a combination of insulin and sugar to reduce the blood levels of potassium were identified. This combination reduced the duration of high blood levels of potassium and the risk for bleeds in the brains of the infants. One study that enrolled 19 patients reported on the use of Albuterol (a medication that helps to move potassium from the blood to the body cells). Albuterol lowered the blood levels of potassium both at 4 and at 8 hours after the treatment had started. Because of the few infants enrolled in the studies to date, no firm recommendations for the treatment of too high blood levels of potassium in neonates can be made. Further research is needed.

Mumtaz K, Hamid S, Jafri W.

[Endoscopic retrograde cholangiopancreatography with or without stenting in patients with pancreaticobiliary malignancy, prior to surgery.](#)

Cochrane Database of Systematic Reviews: 2007 Issue 3: CD006001

BACKGROUND: Postoperative morbidity and mortality are high in patients undergoing pancreaticoduodenectomy for malignant pancreatico-biliary stricture. Different approaches have been tried to improve the outcomes, including pre-surgical biliary stenting with endoscopic retrograde cholangiopancreatography (ERCP).

OBJECTIVES: To assess the beneficial and harmful effects of biliary stenting via ERCP for pancreatico-biliary stricture confirmed or suspected to be malignant, prior to surgery.

SEARCH STRATEGY: We identified trials through The Cochrane Hepato-Biliary Group Controlled Trials Register (October 2006), the Cochrane Central Register of Controlled Trials (CENTRAL) in The Cochrane Library (Issue 2, 2006), MEDLINE (1950 to October 2006), EMBASE (1980 to October 2006), and Science Citation Index Expanded (1945 to October 2006). We also searched the references in the published papers and wrote to stent producers.

SELECTION CRITERIA: Randomised trials comparing ERCP with biliary stenting versus ERCP without biliary stenting for pancreatico-biliary malignancy prior to surgery.

DATA COLLECTION AND ANALYSIS: Two authors independently selected trials for inclusion and extracted data. The primary pre-surgical, post-surgical, and final outcome measures were mortality. The secondary outcomes were complications such as cholangitis, pancreatitis, bleeding, pancreatic fistula, intra-abdominal abscess, improvement in bilirubin, and quality of life. Dichotomous outcomes were reported as odds ratio (OR) with 95% confidence interval (CI) based on fixed- and random-effect models.

MAIN RESULTS: We identified two randomised trials with 125 patients undergoing pancreaticoduodenectomy; 62 patients underwent ERCP with biliary stenting and 63 had ERCP without biliary stenting prior to surgery. Pre-surgical mortality was not significantly affected by stenting (OR 3.14, 95% CI 0.12 to 79.26), while there were significantly more complications in the stented group (OR 43.75, 95% CI 2.51 to 761.8). Stenting had no significant effect on the post-surgical mortality (OR 0.75, 95% CI 0.25 to 2.24). However, post-surgical complications were significantly less in the stented group (OR 0.45, 95% CI 0.22 to 0.91).

Overall mortality (OR 0.81, 95% CI 0.17 to 3.89) and complications (OR 0.50, 95% CI 0.01 to 23.68) were not significantly different in the two groups.

AUTHORS' CONCLUSIONS: We could not find convincing evidence to support or refute endoscopic biliary stenting on the mortality in patients with pancreatico-biliary malignancy. Large randomised trials are needed to settle the question of pre-surgical biliary stenting.

PLAIN LANGUAGE SUMMARY: No evidence to support or refute endoscopic retrograde cholangiopancreatography (ERCP) with stenting in patients with malignant pancreaticobiliary diseases, awaiting surgery. Pancreatico-biliary malignancy includes cancers of pancreas, ampulla, duodenum, and cholangiocarcinoma. There is significant morbidity and mortality related to surgery in these patients. Studies have claimed the beneficial role of biliary decompression, which can be performed via endoscopic retrograde cholangiopancreatography (ERCP) with stent insertion pre-surgically. The review found that pre-surgical biliary stenting via ERCP did not improve the morbidity and mortality in patients with pancreatico-biliary malignancy. Further evidence about its efficiency is needed.

Mahomed K, Bhutta Z, Middleton P

Zinc supplementation for improving pregnancy and infant outcomes.

Cochrane Database of Systematic Reviews: 2007 Issue 2; CD000230

BACKGROUND: It has been suggested that low serum zinc levels may be associated with suboptimal outcomes of pregnancy such as prolonged labour, atonic postpartum haemorrhage, pregnancy-induced hypertension, preterm labour and post-term pregnancies, although many of these associations have not yet been established.

OBJECTIVES: To assess the effects of zinc supplementation in pregnancy on maternal, fetal, neonatal and infant outcomes.

SEARCH STRATEGY: We searched the Cochrane Pregnancy and Childbirth Group's Trials Register (February 2007).

SELECTION CRITERIA: Randomised or quasi-randomised trials of zinc supplementation in pregnancy.

DATA COLLECTION AND ANALYSIS: Two review authors applied the study selection criteria, assessed trial quality and extracted data. When necessary, study authors were contacted for additional information.

MAIN RESULTS: We included 17 randomised controlled trials (RCTs) involving over 9000 women and their babies. Zinc supplementation resulted in a small but significant reduction in preterm birth (relative risk (RR) 0.86, 95% confidence interval (CI) 0.76 to 0.98 in 13 RCTs; 6854 women). This was not accompanied by a similar reduction in numbers of babies with low birthweight (RR 1.05 95% CI 0.94 to 1.17; 11 studies of 4941 women). No significant differences were seen between the zinc and no zinc groups for any of the other primary maternal or neonatal outcomes, except for a small effect favouring zinc for caesarean section (four trials with high heterogeneity) and for induction of labour in a single trial. No differing patterns were evident in the subgroups of women with low versus normal zinc and nutrition levels or in women who complied with their treatment versus those who did not.

AUTHORS' CONCLUSIONS: The 14% relative reduction in preterm birth for zinc compared with placebo was primarily in the group of studies involving women of low income and this has some relevance in areas of high perinatal mortality. There was no convincing evidence that zinc supplementation during pregnancy results in other useful and important benefits. Since the preterm association could well reflect poor nutrition, studies to address ways of improving the overall nutritional status of populations in impoverished areas, rather than focusing on micronutrient and or zinc supplementation in isolation, should be an urgent priority.

PLAIN LANGUAGE SUMMARY: Taking zinc during pregnancy helps to slightly reduce preterm births, but does not help prevent other problems such as low birthweight babies. Many women of childbearing age may have mild to moderate zinc deficiency. Low zinc levels may cause preterm birth or they may prolong labour. It

is also possible that zinc deficiency may affect infant growth as well. The review of 17 trials, involving over 9000 women and their babies, found that although zinc supplementation has a small effect on reducing preterm births, it does not help to prevent low birthweight babies. Finding ways to improve women's overall nutritional status, particularly in low-income areas, will do more to improve the health of mothers and babies than supplementing pregnant women with zinc.

New Protocols from the SACN in 2007

Jacob TJ, Keighley MRB, Perakath B.

[Surgical intervention for chronic anorectal fistula.](#)

Cochrane Database of Systematic Reviews: Protocols 2007 Issue 1; CD006319

Malhotra S, Bhasin DK, Kumar R, Pandhi P, Rana S, Shafiq N.

[Pancreatic enzymes for chronic pancreatitis.](#)

Cochrane Database of Systematic Reviews: Protocols 2007 Issue 1; CD006302

Mathew JL, Lasserson TJ, Mathew PJ.

[Pressurised-metered dose inhalers versus other hand-held inhalation devices for the delivery of inhaled corticosteroid therapy in children with non-acute asthma.](#)

Cochrane Database of Systematic Reviews: Protocols 2007 Issue 1; CD006339

Mumtaz K, Hamid S, Brok J, Jafri W.

[Pegylated interferon for chronic hepatitis B.](#)

Cochrane Database of Systematic Reviews: Protocols 2007 Issue 1; CD006303

Shankar PK, Devi V, Bairy KL, Nair S.

[Antibiotics for Staphylococcus aureus pneumonia in adults.](#)

Cochrane Database of Systematic Reviews: Protocols 2007 Issue 1; CD006337

Thomas J, Philipraj J, Annamma K.

[Pharmacological interventions for preventing recurrent urinary stones in adults and children.](#)

Cochrane Database of Systematic Reviews: Protocols 2007 Issue 1; CD006361

Unnikrishnan B, Fahad S, Joy S.

[Measles/MMR vaccine for infants born to HIV-positive mothers.](#)

Cochrane Database of Systematic Reviews: Protocols 2007 Issue 1; CD006416

Unnikrishnan B, Nair S, Rajeev A.

[Pyronaridine for treating uncomplicated malaria.](#)

Cochrane Database of Systematic Reviews: Protocols 2007 Issue 1; CD006404

Mathew JL, El Dib R, Mathew PJM, Boxall EH, Brok J.

[Hepatitis B immunization in persons not previously exposed to hepatitis B or with unknown exposure status.](#)

Cochrane Database of Systematic Reviews: Protocols 2007 Issue 2; CD006481

Sharma BC, Glud LL, Sarin SK.

[Beta-blockers alone or with endoscopic therapy for prevention of variceal rebleeding in portal hypertension.](#)

Cochrane Database of Systematic Reviews: Protocols 2007 Issue 2; CD006426

Adhikary SD, Babu SK, Tharyan P, Venkatesan T.

[The effects of general anaesthetic agents on cortical mapping during neurosurgical procedures involving eloquent areas of the brain.](#)

Cochrane Database of Systematic Reviews: Protocols 2007 Issue 3; CD006679

George R, Jeba J, Leng M, Chacko AG, Tharyan P.

[Interventions for the treatment of metastatic extradural spinal cord compression.](#)

Cochrane Database of Systematic Reviews: Protocols 2007 Issue 3; CD006716

Mumtaz K, Subhan A, Hamid S, Jafri W.

[Lamivudine for chronic hepatitis B in adults.](#)

Cochrane Database of Systematic Reviews: Protocols 2007 Issue 2; CD006547

Sharma BC, Glud LL, Sarin SK.

[Beta-blocker plus nitrates for secondary prevention of variceal bleeding.](#)

Cochrane Database of Systematic Reviews: Protocols 2007 Issue 3; CD006709

Vidanapathirana J, Randeniya M, Operario D.

[Interventions for reduction of stigma in people with HIV/AIDS.](#)

Cochrane Database of Systematic Reviews: Protocols 2007 Issue 3; CD006735

New Review Titles from the SACN in 2007

1. Anterior temporal lobectomy versus selective amygdalohippocampectomy for medically refractory temporal lobe epilepsy (Roy Daniel)
2. Antibiotics for Shigella dysentery (Prince Christopher)
3. Cognitive rehabilitation for Occupational Outcomes after Traumatic brain Injury (Suresh Kumar K)
4. Diethylcarbamazine regimens for controlling lymphatic filariasis (Srividya Adinarayan)
5. Early amino acids for parenterally fed neonates (Nirmala Thomas)
6. Early versus late removal of laryngeal mask airway (LMA) for general anaesthesia (Preethy Mathew)
7. Educational interventions for improving psychosocial outcomes in primary caregivers and their children with intellectual disability (Sushila Russell)
8. Gabapentin monotherapy for epilepsy (Elangovan Subramaniam)
9. General anaesthetic agents for evoked potential monitoring during surgery on and around the spinal cord (Parthiban Velayutham)
10. Human chorionic gonadotrophin as an ovulation trigger for anovulatory women receiving either anti-estrogens or aromatase inhibitors (Korula George)
11. Intervention for dialysis patients with Hepatitis-C (Ravindra Prabhu)

Forthcoming Events

First South Asian Regional Symposium on Evidence Based Health Care

The first South Asian Regional Symposium on Evidence Based Health Care will be held on Friday August 24, 2007 at the Post Graduate Institute of Medicine, Colombo. The objectives are to raise awareness on the practice and teaching of Evidence Based Health Care among clinicians and health care managers in the region in general and Sri Lanka in particular. This is the first of a series of annual South Asian Regional symposia that will be held around the region.

The resource persons for this symposium include Steve Mc Donald, Co-Director of the Australasian Cochrane Centre; Chrisantha Abeysena, Coordinator, SACN, Sri Lanka site; Prathap Tharyan, Coordinator, SACN; Rajiv Sarin, Director, ACTREC, Mumbai; Meenu Singh, Editor, Cochrane Acute Respiratory Infections review group; Chandigarh; Battool Rehan, Aga Khan University, Karachi, Omar Rahman, Pro-Vice Chancellor; Independent University, Dhaka; Sreekumaran Nair, Cochrane ARI and HIV/AIDS Groups Manipal; Gawrie Galapaththy, Anti-Malaria Campaign and Cochrane Infectious Diseases Group, Sri Lanka, Janaki Vidanapitarana, Cochrane HIV/AIDS review Group, Sri Lanka; and Thambu David; Cochrane Infectious Diseases and ARI Groups, Vellore.

The First South Asian Regional Symposium on Evidence-Based Health Care will be held at the Post Graduate Institute, Colombo on Friday August 24, 2007

For enquiries, please contact: Chrisantha Abeysena, (chrishantha-abeyesena@mfac.kln.ac.lk).

Statistical Methods in Systematic Reviews workshops

Georgia Salanti, Cochrane Statistical Methods Group is back in the region for the second consecutive year and will take the following workshops:


Aga Khan University, Karachi, Pakistan: *August 10, 2007*– Introduction to Cochrane Reviews and Meta-analysis; *August 11-14, 2007*– Advanced Statistical methods in Cochrane Reviews

Contact: Dr. Anita Zaidi; email: anita.zaidi@aku.edu

Post graduate Institute for Medical Education & Research , Chandigarh, India: *August 17-19, 2007*– Workshop on methodologies for Cochrane Systematic Reviews

Contact: Dr. Meenu Singh; email: meenusingh4@rediffmail.com;

Dr. Josph Mathew: email: jlmathew@rediffmail.com

SACN News	Other Events
<p>South Asian Cochrane Network Coordinating Centre Prof. BV Moses Centre for Research and Training In Evidence Based Health Care Christian Medical College Vellore 632002 Tamil Nadu, INDIA</p> <p>Tel: +91 416 2284499/ 2284505 Fax: +91 416 2260085 E-mail: cochrane@cmcvellore.ac.in Mailing list: south-asian-subscribers@cochrane.de</p>  <p>SOUTH ASIAN COCHRANE NETWORK</p> <p>www.cochrane-sacn.org</p>	<p>XV Cochrane Colloquium; Sao Paulo, Brazil. 23-27, 2007: Early registration closes August 15th, 2007</p> <p>The SACN Annual Indian Network Site Representatives Meeting; 24, August, 2007: at Ramaratnam Epilepsy Research Foundation, T. Nagar, Chennai</p> <p>SACN Steering Group Meeting; 25th August, 2007: at the Galle Face Hotel, Colombo, Sri Lanka.</p> <p>Workshop on Design and Analysis of Randomised Controlled Trials; 27 August, 2007: at the Sri Lanka Medical Association Auditorium, Colombo, Sri Lanka.</p> <p>Effective Health Care Research Programme Consortium Regional Meeting; 2-4, November, 2007: at Chonqing University, China.</p> <p>Cochrane Review Completion Workshop; 12-14 November, 2007: at Christian Medical College, Vellore, India</p> <p>Second South Asian Regional Symposium on Evidence Based Health Care; April 9, 2008: Christian Medical College, Vellore, India</p>

South Asian Cochrane Network Sites and Steering Group

Bangladesh:

Centre for Health, Population and Development, Independent University, Dhaka

Coordinator: Prof. Omar Rahman

India:

Christian Medical College, Vellore

SACN Coordinator: Prof. Prathap Tharyan

SACN Administrator: Ms. Zenobia M.E. Kanagaraj

Advanced Centre for Treatment, Research & Education in Cancer, Mumbai:

Coordinator: Prof. Rajiv Sarin

All India Institute of Medical Sciences, New Delhi:

Coordinator: Prof. Kameshwar Prasad

Manipal Academy of Higher Education, Manipal:

Coordinator: Prof Sreekumaran Nair

Post Graduate Institute for Medical Education

& Research, Chandigarh:

Coordinator: Prof. Meenu Singh

The Nerve Centre, Ramaratnam Epilepsy Research Foundation, Chennai:

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Pakistan:

Aga Khan University, Karachi:

Coordinators: Prof. Anita Zaidi & Dr. Batool Haider Rehan

Post Graduate Institute, Lady reading Hospital, Peshawar:

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