



# Plenary 1

## **Evidence-Based Child Health: A Cochrane Review Journal – why and how?**

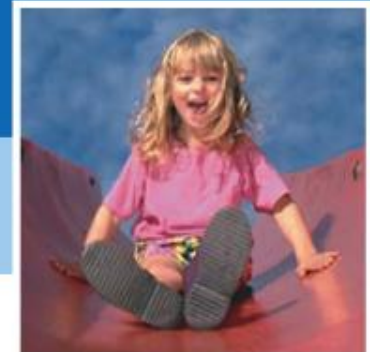
**Martin Offringa  
and Terry Klassen**  
*Pembroke*

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# **Evidence-Based Child Health**

**A Cochrane Review Journal**

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# Evidence-Based Child Health

A Cochrane Review Journal

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# Why and How?

Martin Offringa, MD, PhD  
Co-Editor-in-Chief

# Why?

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- ❑ To make child health evidence easier to find, interpret and use
- ❑ To “add value” to current Cochrane reviews
- ❑ To increase impact of Cochrane evidence for children

# How?

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- Online journal
- Published quarterly by Wiley
- Editorial process coordinated by Canadian and Dutch editorial offices

# Editorial Board

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- Virginia Moyer, Texas, USA
- Leontien Kremer, Amsterdam, NL
- Joan Robinson, Edmonton, Canada
- Jonathan Craig, Sydney, Australia
- Kent Stobart, Edmonton, Canada
- Lorne Becker, New York, USA
- Michael Smith, Craigavon, Northern Ireland
  
- Terry Klassen, Edmonton, Canada
- Martin Offringa, Amsterdam, NL

# Two who make it really happen

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- Denise Thomson, Edmonton, Canada
- Elvira van Dalen, Amsterdam, NL



# How? (cont...)

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## □ Each issue:

- 4-6 Cochrane reviews, reprinted in full
  - Expert commentary
  - Table of key findings
  - Summary
- Umbrella Review
- Tips and Tricks
- Editors' Introduction



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# The Cochrane Collaboration

The reliable source of evidence in health care



## Evidence-based Child Health - Issue 2 now available

In the latest issue of Evidence-Based Child Health: A Cochrane Review Journal, an Umbrella Review looks into nephrotic syndrome....

In the 1950s, approximately two-thirds of children with nephrotic syndrome died. Despite effective treatment with corticosteroids, nephrotic syndrome still has a significant morbidity and mortality rate. The Umbrella Review concludes that, although corticosteroids are very effective, there is a need to search for alternative treatment options for children who relapse.

Other reviews in the second issue of Evidence-Based Child Health: A Cochrane Review Journal include:

- Vaccines for preventing influenza in healthy children
- Antibiotics for acute pyelonephritis in children
- Interventions for promoting the initiation of breastfeeding
- Interventions to improve antibiotic prescribing practices in ambulatory care

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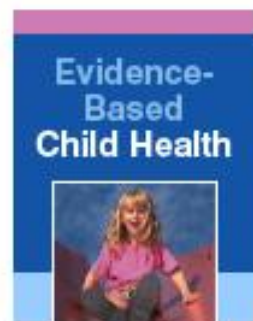
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### Evidence-Based Child Health: A Cochrane Review Journal

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## CURRENT ISSUE

[< Previous Issue](#) | [Next Issue >](#)

**Volume 1, Issue 3 (September 2006)**

Articles in the Current Issue:

### Editorial

**Editors' introduction and letter to the editors (p 734-735)**

## Measles

### Cochrane review: Vitamin A for treating measles in children (p 743-766)

Y Huiming, W Chaomin, M Meng

Published Online: 29 Sep 2006

DOI: 10.1002/ebch.47

[Abstract](#) | [References](#) | Full Text: [HTML](#), [PDF](#) (Size: 370K)

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**Review reprinted in full**

### Summary of 'Vitamin A for treating measles in children' (p 767-768)

Andrea Milne

Published Online: 29 Sep 2006

DOI: 10.1002/ebch.55

[Abstract](#) | [References](#) | Full Text: [HTML](#), [PDF](#) (Size: 53K)

● [Save Article](#)

**Summary**

### Commentary on 'Vitamin A for treating measles in children' (p 769-770)

Stanley Zlotkin

Published Online: 29 Sep 2006

DOI: 10.1002/ebch.58

[Abstract](#) | [References](#) | Full Text: [HTML](#), [PDF](#) (Size: 63K)

● [Save Article](#)

**Expert commentary**

### Characteristics and key findings for 'Vitamin A for treating measles in children' (p 771-772)

Elvira van Dalen, Martin Offringa, Leontien Kremer

Published Online: 29 Sep 2006

DOI: 10.1002/ebch.60

[Abstract](#) | Full Text: [HTML](#), [PDF](#) (Size: 53K)

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**Table of key findings**

# Cochrane review

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- Reprinted in full so that readers have the original source to which they can refer
  - HTML and PDF version
- Selected in an editorial process
  - Relevance
  - Quality
  - Timeliness
  - Fit



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## GLOBAL THEME ISSUE

PRINT VERSION

### Global Theme Issue

#### Call for Participation

#### Global Theme Issue on Poverty and Human Development Planned for October 2007

The Council of Science Editors is organizing a Global Theme Issue on Poverty and Human Development in October 2007. Science journals throughout the world will simultaneously publish papers on this topic of worldwide interest - to raise awareness, stimulate interest, and stimulate research into poverty and human development. This is an international collaboration with journals from developed and developing countries.

Thus far, 33 journals have agreed to participate (see list below). The journals plan to publish new original research, review articles, editorials, perspectives, news stories, and other types of articles on the subject of poverty and human development with a common publication or release date of Monday, October 22, 2007.

Some journals will dedicate an entire issue to this subject, others will publish a few papers, and still others plan to publish an editorial. Some journals with less frequent publication schedules plan to release these articles early online to coincide with the common release date.

All science journals are invited to participate in the Global Theme Issue. Representatives of interested journals should send an e-mail to the attention of Annette Flanagan at [jeni.reiling@jama-archives.org](mailto:jeni.reiling@jama-archives.org). Please direct any questions or requests for additional information to this e-mail address as well.

Two previous global theme issues have been published successfully by biomedical journals. In January 1996, more than 200 articles on Emerging and Reemerging Global Microbial Threats were published by 36 journals from 21 countries, and in



## Journals Participating in the CSE Global Theme Issue on Poverty and Human Development as of September 2006

Annals of African Medicine	Nature Cell Biology
ATVB (Arteriosclerosis, Thrombosis, and Vascular Biology)	Nature Genetics
BMJ	Nature Immunology
Brazilian Journal of Medical and Biological Research	Nature Materials
Breast Diseases: A Year Book Quarterly	Nature Medicine
Canadian Pharmacists Journal	Nature Methods
Circulation	Nature Nanotechnology
Circulation Research	Nature Physics
Clinics	PLoS Biology
East African Medical Journal	PLoS Clinical Trials
Environmental Health Perspectives	PLoS Medicine
<b>Evidence Based Child Health *</b>	PNAS
Ghana Medical Journal	Reviews of Modern Physics
Hypertension	Science
JAMA	Stroke
Journal of Public Health Policy	The Lancet
Mountain Research and Development	
Nature	

# EBCH Summary

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- Aimed at health professionals and consumers who wish a quick overview of the review's content
- Written by a writer at the *Child Health Field*
- Peer reviewed by EB member
  
- *example*

## EBCH Summary

# Summary of ‘Vitamin A for treating measles in children’

Andrea Milne\*

*Alberta Research Centre for Child Health Evidence, University of Alberta, Edmonton, Alberta, Canada*

This is a summary of a Cochrane review, published in this issue of EBCH, first published as: Huiming Y, Chaomin W, Meng M. Vitamin A for treating measles in children. *Cochrane Database of Systematic Reviews* 2005, Issue 4. Art. No.: CD001479. DOI: 10.1002/14651858.CD001479.pub3.

Further information for this Cochrane review is available in this issue of EBCH in the accompanying Expert Commentary and Characteristics and Key Findings Tables articles.

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### **Is Vitamin A therapy beneficial in preventing mortality, pneumonia and other complications in children with measles?**

To answer this question, researchers from the Acute Respiratory Infections Group reviewed eight studies including 2574 children, and commented on data from a non-randomized 1932 (1) study of 600 children. Children were under the age of 15 years and diagnosed with measles. Oral vitamin A or a placebo was given

despite a 96 per cent immunization rate in children over 14 months of age.

In 1932, Ellison (1) was the first to document the protective effect of vitamin A on measles mortality. In 1987, a study by Barclay (2) drew attention to the results of this earlier work by Ellison. It led the World Health Organization (WHO) and United Nations International Children’s Fund (UNICEF) to make a joint recommendation. They advised that a single oral dose of vitamin A should be administered

# EBCH Table of Key Findings

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- Presents key outcomes of the review
- Decisions on relevant outcomes
- Statement on inference
  - Building on work done by the CCA&RM Group, GRADE, etc.
  
- *example*





**Table II.** Key findings based on selection of clinical relevant outcomes

Comparison 01. Vitamin A versus placebo						
Outcome	N Studies	N Children	Method	Result	Inference	I <sup>2</sup>
Mortality	7	1974	Relative Risk (Random) 95% CI	0.83 [0.51, 1.34]	No evidence of effect	30.0%
Development of pneumonia	2	219	Relative Risk (Random) 95% CI	subtotals		
Duration of pneumonia (days)	2	249	Weighted Mean Difference (Random) 95% CI	-3.69 [-7.53, 0.16]	Unclear <sup>1</sup>	90.3%

<sup>1</sup> substantial heterogeneity (Higgins JPT, Green S, editors. *Cochrane Handbook for Systematic Reviews of Interventions* 4.2.5 [updated May 2005]. In: *The Cochrane Library*, issue 2, 2006. Chichester, UK: John Wiley & Sons, Ltd.)

# Challenge: What to translate?

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- 'Demographics'
  - Nr of RCTs, patients, contrasts?
  - Quality SR?
  - Quality RCTs?
- Contrasts, Outcomes, and Subgroups
  - Doses, routes, duration, delivered by whom?
  - Clinical relevant, ELISAs, pain indexes?
  - HQ-LQ trials?
- 'Statistics'
  - Patients 'randomized', or 'analyzed'?
  - Pooling heterogeneous material?
  - Non pooled results?

# Expert commentary

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- To provide context for the application of the evidence presented by the review

- *example*

## Expert Commentary

# Commentary on ‘Vitamin A for treating measles in children’

Stanley Zlotkin\*

*Departments of Paediatrics (Primary), Nutritional Sciences and Public Health Sciences, and Research Fellow, Centre for International Health, University of Toronto, Toronto, Canada; Program in Metabolism, Research Institute, Director, Sprinkles Global Health Initiative, and Head, Division of Gastroenterology, Hepatology and Nutrition, Hospital for Sick Children, Toronto, Canada*

This is a commentary on a Cochrane review, published in this issue of EBCH, first published as: Huiming Y, Chaomin W, Meng M. Vitamin A for treating measles in children. *Cochrane Database of Systematic Reviews* 2005, Issue 4. Art. No.: CD001479. DOI: 10.1002/14651858.CD001479.pub3.

Further information for this Cochrane review is available in this issue of EBCH in the accompanying EBCH Summary and Characteristics and Key Findings Tables articles.

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While measles is now rare in many industrialized countries, it remains a common illness in many developing countries. More than 30 million people are affected each year by measles. Not only is it a common illness, but it remains a leading cause of death among young children, despite the availability of a safe and effective vaccine for the past 40 years.

the vitamin A supplemented group in children under 2 years of age. These results contrast quite clearly to the two community-based studies of ‘not-so-sick’ patients (non-hospitalized), with a case-fatality rate <6 per cent, where there was no difference in risk of mortality between vitamin A supplementation and controls (5, 6).

death among young children, despite the availability of a safe and effective vaccine for the past 40 years. According to World Health Organization statistics, an estimated 454,000 people, the majority of them children, died from measles in 2004 (the last year for which figures are available). The key findings in this review are thus very important in terms of their support of current public health guidelines for the treatment of measles. The key findings were the reduced mortality in hospitalized young children (under 2 years of age) who were given two doses of vitamin A and in areas where the case fatality was greater than 10 per cent. This finding supports the latest WHO and UNICEF recommendation that '200,000 IU of vitamin A be given twice to children with measles who are over the age of one year and live in populations where vitamin A deficiency may be present (1).

The magnitude and precision of the treatment effect was quite robust in the sickest and youngest patients (2,3,4). For overall mortality, in the sickest patients (hospitalized patients in a region where the case fatality rate was >10 per cent), the use of at least two doses of vitamin A was associated with a statistically significant 64 per cent reduction in risk of mortality (RR 0.36, CI 0.13–0.82). In the same at risk population, there was an 83 per cent reduction in risk of mortality (RR 0.17; 95% C.I. 0.03–0.61) in

\*Correspondence to: Dr Stanley Zlotkin, Hospital for Sick Children,

tality between vitamin A supplementation and controls (5, 6).

It is of relevance that all the six studies from the developing world which were included in the review were from Africa (the seventh study was from Japan and the eighth from England). Yet of those children who died from the complications of measles in 2004, slightly fewer than 50 per cent were from Africa (see Table I) (7). Thus this reviewer is left wondering if the results from this review, (which could almost be renamed 'Vitamin A for treating measles in *African* children') can be extrapolated to young children of non-African origin living in South Asia, South-east Asia, etc.

The authors correctly point out that the review included a relatively small number of studies and sample sizes which made it difficult to stratify for subgroup analysis. They also highlight that only two studies (4,6) reported on the immunization status of

**Table I.** Estimated measles deaths, with uncertainty bounds\*, by World Bank geographical region (2004)

Sub-Saharan Africa	216,000	[216,000–279,000]
South Asia	202,000	[145,000–264,000]
East Asia & Pacific	32,000	[21,000–47,000]
Middle East & North Africa	4000	[2000–5000]
Europe & Central Asia	<1000	[-]
Latin America & Caribbean	<1000	[-]
High Income Countries	<000	[-]
TOTAL	454,000	[329,000–596,000]

# Umbrella Review

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- Prepared according to the format of the *Cochrane Umbrella Reviews Working Group*
- Written on invitation
  
- *example*

## Umbrella Review

# ***The Cochrane Library and chronic cough in children: an umbrella review***

Liza Bialy,<sup>1\*</sup> Frank J. Domino,<sup>2</sup> Anne B. Chang,<sup>3</sup> Denise Thomson<sup>4</sup> and Lorne Becker<sup>5</sup>

<sup>1</sup>Alberta Research Centre for Child Health Evidence, University of Alberta, Edmonton, Alberta, Canada

<sup>2</sup>University of Massachusetts Medical School, Worcester, Massachusetts, USA

<sup>3</sup>Department of Respiratory Medicine, Royal Children's Hospital, Herston, Queensland, Australia

<sup>4</sup>Cochrane Child Health Field, Department of Pediatrics, University of Alberta, Edmonton, Alberta, Canada

<sup>5</sup>Cochrane Umbrella Reviews Working Group and Department of Family Medicine, SUNY Upstate Medical University, Syracuse, New York, USA

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*Editors' note: Umbrella reviews, compiling evidence from multiple Cochrane reviews into one accessible and usable document, will be a regular feature of this*

secretions are minimal or non-existent and hence this type of cough is classified as 'dry' (4). The aetiology of persistent non-specific cough is not known,

maximum score being 4 was given to each study using the Jadad scale. One study had a score of 2 and all others a score of 3. All four studies adequately described withdrawals from the trial with three blinding participants and investigators. Allocation concealment was clearly inadequate in two of studies, adequate in one, and unclear in the final study.

## Results

Ten systematic reviews examining interventions for chronic cough in children were located within *The Cochrane Library*. Reviewers were unable to identify any trials of anticholinergics, cromones, methylxanthines, or indoor air modification for children with persistent cough that fulfilled their eligibility criteria. Results from four non-randomized studies suggested the possibility of an effect with methylxanthines. The search for indoor air quality interventions yielded five potential studies with none related to cough specific outcomes. Two additional reviews (leukotrienes and antihistamines) identified relevant studies, but were unable to combine data for meta-analysis because of study limitations. Only one study on the use of leukotrienes in children was identified. Cough specific data could not be extracted, and it was not possible to separate the subset of children with non-specific cough. Three studies were identified on the use of antihistamines for prolonged non-specific cough in children. Two larger studies found no significant difference between treatment and placebo arms but the smaller study found a significant difference between

or substantially improved at follow-up using short term antibiotic therapy versus placebo. These studies included children under the age of 18 with prolonged moist cough (>10 days). For the 'intention to treat' population, treatment with antibiotics reduced the proportion of children with wet cough that were not cured at follow-up in both studies (a wet cough is described as producing sputum and phlegmy sound). In an analysis excluding children with proven *Bordetella pertussis* infection did not significantly change the risk ratio. This suggests that one of every three children treated with antibiotics will be cured.

One review reported the Chang 1998 study (21) as finding no difference in the treatment success or failure between beclomethasone and placebo. A side effect rate of 2 per cent was reported in the erythromycin group of one study with amoxicillin/clavulanic acid and placebo groups both reporting 12 per cent. Three reviews identified studies reporting clinical failure (antihistamines, gastro-oesophageal reflux treatment, and leukotrienes) but were unable to combine data for meta-analysis. Four additional reviews reporting the same outcome (anticholinergics, cromones, methylxanthines, and indoor air modification) were unable to identify studies satisfying the eligibility criteria.

Improvement in cough frequency (Table II): One study reported outcomes relating to 75 per cent or more improvement in cough frequency, classed as a substantial improvement, using very high dose inhaled corticosteroids consisting of 2 mg of fluticasone propionate per day for 3 days (off-license dose that is 10 times the usual dose for most children with asthma).

Table 1. Clinical failure: children not cured or substantially improved at follow-up

Outcome comparison	Number of subjects (studies)	Average control group failure rate <sup>1</sup>	Relative risk of failure (95% CI) <sup>2</sup>	Grade of evidence (28)	General comments
<b>Treatments for prolonged moist cough</b>					
Antibiotics versus placebo (intention to treat) (18)	140 (2)	72.6%	0.46 [0.32, 0.65]	Moderate	Erythromycin ethylsuccinate and amoxicillin/clavulanic acid.
Antibiotics versus placebo (excluding those with B.Pertussis) (18)	128 (2)	70.1%	0.39 [0.25, 0.59]	Moderate	Included if prolonged moist cough (> 10 days). Sixteen patients withdrew or were lost to follow-up
<b>Treatments for persistent non-specific cough</b>					
Antihistamines (14)	182 (3)	—	—	Low	Clinical heterogeneity evident and limited data prevented combining for meta-analysis. Parents reported good/very good efficacy was 29/52 in the ketotifen versus 26/50 in placebo arm
Leukotrienes (15)	256 (1)	—	—	Low	Asthma symptoms including cough was used as criteria for inclusion; it is likely that a number of children would not have fulfilled review criteria
Gastro-oesophageal reflux treatment (16)	198 (3)	—	—	Low	Insufficient data for infants and children. One larger study described decrease in percentage of feeds associated with cough/gag/choke episodes in infants given pre-thickened milk
Methylxanthines (11)	—	—	—	Low	No RCTs located that examined the efficacy of methylxanthines. Four non randomized trials were identified; all reported a rapid response, mostly within 2–5 days
Cromones (12)	—	—	—	—	No eligible trials identified
Indoor air modification (17)	—	—	—	—	No eligible trials identified
Anticholinergics (13)	—	—	—	—	No eligible trials identified

<sup>1</sup> Average control group rate: baseline risk of failure<sup>2</sup> Relative risk: likelihood of failure in the intervention group relative to those not receiving treatment or receiving placebo

— Data not available

# Tips and Tricks

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- Help readers interpret the evidence, and use it correctly
- Written by EB members and lead Cochrane 'methodologist'

## Tips and Tricks

# Tips and tricks for understanding and using SR results – no. 3: meta-analysis and heterogeneity

Leontien C. M. Kremer,<sup>1\*</sup> Elvira C. van Dalen<sup>2</sup> and Ben Vandermeer<sup>3</sup>

<sup>1</sup>Department of Paediatrics, Emma Children's Hospital/Academic Medical Center, University of Amsterdam, the Netherlands

<sup>2</sup>Department of Paediatric Oncology, Emma Children's Hospital/Academic Medical Center, University of Amsterdam, the Netherlands

<sup>3</sup>Department of Paediatrics, Alberta Research Centre for Child Health Evidence (ARCHE), University of Alberta, Canada

This third article for 'Tips and tricks for understanding and using SR results' in *Evidence-Based Child Health* is, like the previous articles, aimed at helping to understand the results of systematic reviews and to use the results in clinical practice. This time, we focus on the concepts of meta-analysis and heterogeneity. The information in this article is based on earlier papers, the *Cochrane Handbook*, and the collective experience of the authors in teaching evidence-based medicine (1–5).

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## Understanding SR results

### Meta-analysis

A meta-analysis can be one of the components of a systematic review. In a meta-analysis the results of several individual studies are combined. A meta-analysis can only be performed if the study design, participants, interventions, and outcomes in the individual studies are similar. The overall effect estimate will be calculated as a weighted average of the treatment effects estimated in the individual studies. The weighted average is based on the treatment effect and the standard error of the results; larger and/or more precise studies have more influence than the smaller ones. By combining the results of several individual

overall effect estimate (and corresponding confidence interval) calculated by the fixed and random effects models will be seen only if studies are markedly heterogeneous.

### What is heterogeneity?

Inevitably, studies brought together in systematic reviews will differ. Variability among the individual studies is called heterogeneity. There are different types of heterogeneity (1): *clinical heterogeneity* may be caused by variability in the participants, interventions and outcomes studied, and *methodological heterogeneity* may be caused by variability in study design and quality.

A consequence of clinical and/or methodological

# Editors' Introduction

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- Highlighting new developments
  - in Child Health
  - in Evidence Based Practice

## Editorial

### Editors' introduction and letter to the editors

Martin Offringa<sup>1\*</sup> and Terry Klassen<sup>2†</sup>

<sup>1</sup>Department of Paediatrics, Emma Children's Hospital/Academic Medical Center, University of Amsterdam, The Netherlands

<sup>2</sup>Department of Pediatrics, University of Alberta, Stollery Children's Hospital, Edmonton, Canada

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#### Retirement of experts or a clarification of their role?

In 1982, Dr David Sackett wrote a paper in which he called for the compulsory retirement of experts in the health sciences (1). He based his recommendation on two types of harm such experts could cause. One is that their observations may be afforded a weight or prestige disproportionate to the scientific evidence. Second, experts may be greatly tempted to accept or reject new evidence, not on the basis of its scientific merit, but rather according to the extent to which it agrees with their prior beliefs or own body of research, thus demonstrating a bias to new ideas. In 2000 Sackett noted that there were '... still far more experts around than is healthy for the advancement of science' (2).

Oxman and colleagues, tongue in cheek, developed 'A field guide to experts' (3). Several statements they used to describe experts were 'An expert is a man who has stopped thinking – he knows!'. Or 'An expert is somebody who is more than 50 miles from home, has no responsibility for implementing the advice he gives, and shows slides'. Another was 'An expert is a man who has made all the mistakes which can be made in a very narrow field'.

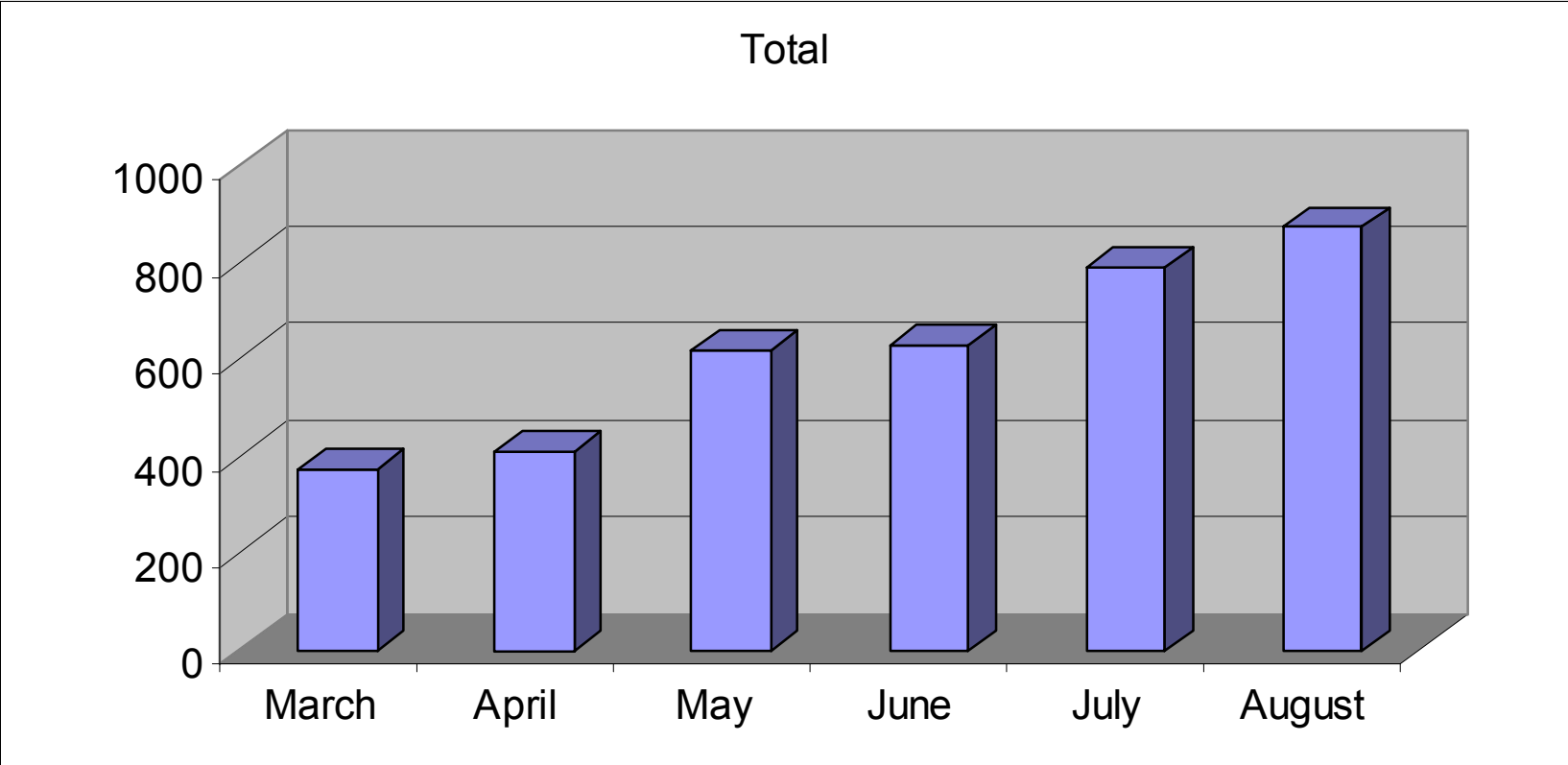
clinicians acquire through clinical experience and clinical practice' (7). And so, evidence-based medicine does include clinical experience.

Recently, the Canadian Health Services Research Foundation issued a report entitled 'Conceptualizing and Combining Evidence for Health System Guidance'. This is a systematic review examining how the concept of evidence is treated by those who produce scientific evidence, by those who formulate guidance and by those who make decisions (8). One view of evidence is that it is a context-free universal truth; the report authors suggested this view is particularly prevalent in evidence-based medicine circles. Others, however, recognize that evidence has little meaning or importance for decision making unless it is adapted to the particulars of the circumstances in which it is being applied. With this approach, scientific evidence on effectiveness is combined with scientific evidence of context.

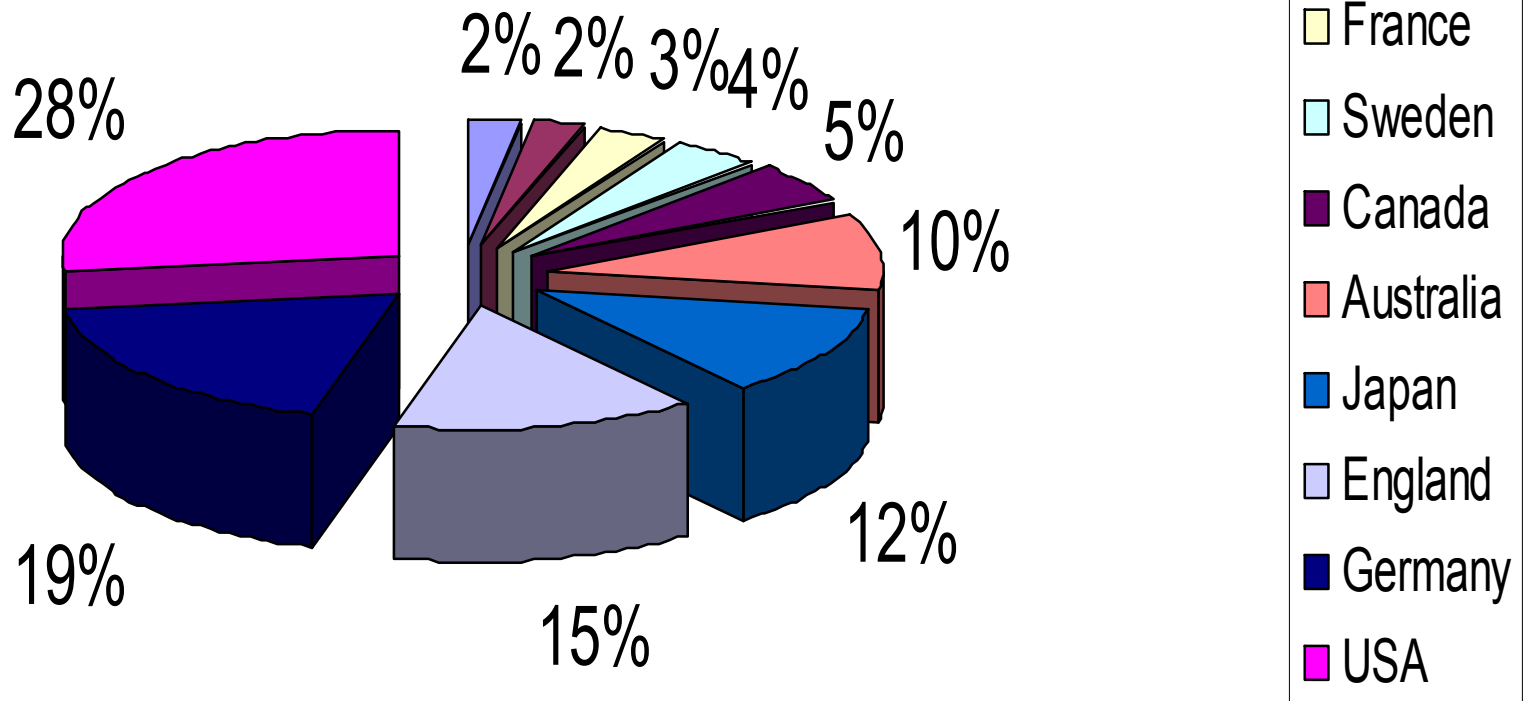
We believe the role of experts is to provide context for the application of the evidence generated by the systematic reviews that we select for each issue of EBCH. Now, as always, it is reader beware. We have attempted to keep close watch on the nature

# Libraries EBCH-opt-in

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# Geo split





ONLINE

## Evidence-Based Child Health

A Cochrane Review Journal

[www.evidence-basedchildhealth.com](http://www.evidence-basedchildhealth.com)



# Acute Complications and Eventual Remedies

Terry Klassen, MD, MSc  
Co-Editor-in-Chief

# The birth of a new journal

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- A number of challenges
  - Organizational
  - Editorial
  - Content-related
  - Relational

# Organizational challenges

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- ❑ Two-site model: Canada & The Netherlands
- ❑ Allocation of responsibilities
- ❑ Tight time frame for the first year

# Editorial challenges

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- Creating an editorial board
- What is the role of an editor?

# Content challenges

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- Expert commentaries
  - Guidelines for experts
  - Role of experts in a EB journal?
- Umbrella reviews and summaries
  - Evolving format
  - Implement and test Cochrane developments
- Tables of key findings
  - Pooling of heterogenous data
  - Selecting relevant outcomes

# Processes - Commentary

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- 'Experts' are invited to write commentaries based on **clinical expertise** and **experience in evidence-based medicine**

# Processes – author/CRG

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- The lead author of each review, along with the CRG, are offered the opportunity to review and comment on the **summary**, **tables** and **commentary** prior to publication
- Review authors' **responses will be published** in EBCH, if desired

# Processes – umbrella reviews

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- Umbrella reviews are **peer reviewed** prior to publication by EB members and by external reviewers

# Relational challenges

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- Review authors
  - Duplicate publication?
  - Can authors veto inclusion of their review?
- Cochrane Review Groups
  - Extra work – for what reward?
  - Conflict with module submission deadlines
- The Cochrane Collaboration
  - Who owns Cochrane reviews?

# Resolving these issues always comes down to...

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- The purpose of the journal – making child health evidence easier to *find, interpret* and *use*
- Make Cochrane reviews accessible and comprehensible

# Central question

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- What value does EBCH add to CLIB?
  - Builds on work of the Collaboration by making child health evidence easier to *find, interpret and use*
  - *Translational* steps involved
- We will ask our readership
  - Is this the helpful **format**?

# For more information

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- Child Health Field meeting
- Wednesday October 25,  
12:30-13:15 (tomorrow)

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# Evidence-Based Child Health

A Cochrane Review Journal

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Thanks!



# Plenary 1

## **Evidence-Based Child Health: A Cochrane Review Journal – why and how?**

**Martin Offringa  
and Terry Klassen**  
*Pembroke*