COCHRANE
PRIMARY HEALTH
CARE FIELD

October 2012

News

Correction on Impact Factor for the Cochrane Database of Systematic Reviews (CDSR)
Our colleagues at Wiley-Blackwell have issued the Impact Factor reports for 2009, 2010 and 2011. They had a follow up on an error made by Thomson ISI in the initial impact factor calculation that has now been formally corrected.

Some highlights from this year's Impact Factor release are stated below:

- **The 2011 Impact Factor** for the Cochrane Database of Systematic Reviews (CDSR) is **5.912**.
- The CDSR is ranked in the top 10 (of 155) in the Medicine, General & Internal category.
- The number of citations received by the CDSR in the Impact Factor year increased by 10.6% from 6978 to 7721.

Attached a link to the Impact Factor reports for 2009, 2010 and 2011 (http://www.editorial-unit.cochrane.org/impact-factor-reports).

Events

Cochrane Author Training workshop
This two-day workshop is targeted at review authors who are planning to do a Cochrane diagnostic test accuracy review. The objective of the workshop is to inform participants about the methodology particular to SRDTAs and to train them to prepare and conduct an SRDTA.

10 - 11 December 2012 at Academic Medical Center, Amsterdam, the Netherlands
For information and conditions for registration, click http://srdta.cochrane.org/workshops-and-events
For more information contact Rob Scholten at cochrane@amc.uva.nl

Peer Review Congress: Call for abstracts
JAMA and the BMJ invite abstracts for the Seventh International Congress on Peer Review and Biomedical Publication. The congress will provide a forum for the presentation and discussion of new research on peer review and scientific publication. Abstracts that report new research and findings will be given priority. Abstracts can be submitted between 1 January and 1 March, 2013.
Suggested research topics, instructions for preparing and submitting abstracts, programs and abstracts from previous congresses, and information about the meeting hotel, and other information are available on the Peer Review Congress website at www.peerreviewcongress.org.

8-10 September 2013, in Chicago, Illinois

International Summer School: Prognosis Research: Concepts, Methods and Clinical Application
The course consists of a mixture of seminars and guest lectures from international experts in the field, including Prof Carl Moons (University Medical Centre Utrecht, Netherlands) and Prof Douglas Altman (University of Oxford); group work and case studies.

26-28 June 2013 at Keele University, Keele, Staffordshire, United Kingdom

Contact: Sue Weir or Danielle van der Windt
Email: S.Weir@keele.ac.uk or D.van.der.Windt@keele.ac.uk
Website: www.progress-partnership.org/training.html

Interesting new reviews

The following recently published Cochrane reviews have been selected for your interest.

Exercise interventions on health-related quality of life for cancer survivors

Interventions for preventing falls in older people living in the community

Combined pharmacotherapy and behavioural interventions for smoking cessation

Interesting new titles

The following titles have been registered with the Cochrane Collaboration. This means that at this moment the protocol is being written. If you feel that this topic is of special importance and that you want to be of assistance in some way (e.g., peer review protocol, give advice etc.) please contact us at info@cochraneprimarycare.org

- **Surgical versus non-surgical interventions in patients with adolescent idiopathic scoliosis**
- **Optimum antibiotic doses for Helicobacter pylori eradication**
- **Immunotherapy (oral and sublingual) for food allergy to fruits**

P.E.A.R.L.S.

practical evidence about real life situations

The New Zealand Guideline Group fund the Cochrane Primary Care Field to produce the P.E.A.R.L.S. (click here for the websitelink)

Access http://www.cochraneprimarycare.org/ to view the PEARLS online.

Structured telephone support or telemonitoring effective for chronic heart failure

Clinical question	How effective is structured telephone support or telemonitoring for patients with chronic heart failure (HF)?
Bottom line	Compared with standard practice, structured telephone support and telemonitoring programmes for patients with chronic HF living in the community reduced the risk of all-cause mortality by 12% and more than one-third respectively, reduced the risk of chronic HF hospitalisation by more than one-fifth and may have reduced all-cause hospitalisations by 8% to 9%. For both interventions, there was improved quality of life and reduced healthcare costs, and the technology was acceptable to patients. There were also improvements in prescribing, patient knowledge and self-care, and New York Heart Association functional class.
Caveat	Although a reduction in the proportion of participants with an all-cause or chronic HF-related hospitalisation was observed, the review did not identify a consistent impact of structured telephone support or telemonitoring on length of stay for such admissions. Length of stay was inconsistently reported, thus preventing metaanalysis of this outcome.
Context	In the context of limited health funding, and a rapidly expanding population of older patients with chronic HF, it is increasingly difficult for healthcare systems to provide high-quality care to patients with chronic HF. Multidisciplinary specialist HF clinics are available only to a minority of patients and do not have the capacity for frequent patient review. Patients may be unwilling or unable to attend frequent clinic appointments due to disability or financial and transport constraints. Structured telephone support and telemonitoring can provide specialised HF care to a large number of patients with limited access to healthcare services.
Cochrane Systematic Review	Inglis SC et al. Structured telephone support or telemonitoring programmes for patients with chronic heart failure. Cochrane Reviews, 2010, Issue 8. Article No. CD007228. DOI: 10.1002/14651858.CD007228. pub2. This review contains 25 studies and 5 published abstracts involving 9603 participants.
Pearls No. 284 October 2010, written by Brian R McAvoy	

Paracetamol effective for perineal pain in the early postpartum period

Clinical question	How effective is a single administration of paracetamol for the relief of acute postpartum perineal pain?
Bottom line	More women experienced pain relief with paracetamol compared with placebo (most pain was caused by episiotomies). In addition, there were significantly fewer women having additional pain relief with paracetamol compared with placebo. Both the 500mg to 650mg and 1000mg doses were effective in providing more pain relief than placebo. The studies did not look closely at potential adverse effects but generally paracetamol at these doses caused few problems. There were also generally no identified problems for breastfed babies when mothers took paracetamol, but these outcomes were not specifically assessed in any of the included studies
Caveat	The studies were quite old (mainly 1970s and 1980s) and not of high

	quality. There were no empirical data to evaluate the effect of paracetamol versus placebo on outcomes which might affect a mother's ability to care for her baby (maternal sedation, psychological impact, prolonged hospitalisation, breastfeeding, postpartum depression) or neonatal outcomes.
Context	Perineal pain is a common but poorly studied adverse outcome following childbirth. Pain may result from perineal trauma due to bruising, spontaneous tears, episiotomies, or in association with ventouse or forceps assisted births.
Cochrane Systematic Review	Chou D et al. Paracetamol/acetaminophen (single administration) for perineal pain in the early postpartum period. Cochrane Reviews, 2010, Issue 3. Article No. CD008407. DOI: 10.1002/14651858.CD008407. This review contains 10 studies involving 2307 participants.
Pearls No. 285, October 2010, written by Brian R McAvoy	

Some evidence that interventions can increase uptake and adherence in cardiac rehabilitation

Clinical question	How effective are interventions to increase patient uptake of, and adherence to, cardiac rehabilitation?
Bottom line	A small body of evidence suggests interventions involving motivational communications delivered through letters, telephone calls and home visits may be effective in increasing uptake of cardiac rehabilitation, as may the use of liaison nurses to support coordination of care. Two of 7 studies intended to increase adherence to exercise as part of cardiac rehabilitation had a significant effect (although 1 of these studies was of poor quality). Coping strategies targeting barriers to adherence may be helpful in improving adherence. Barriers to uptake and adherence in cardiac rehabilitation are many and varied, and reasons for non-participation may vary between individuals. Individually tailored approaches may increase the likelihood of success.
Caveat	The quality of studies was generally low. Only 1 study reported the non-significant effects of the intervention on cardiovascular risk factors. No studies reported data on mortality, morbidity, costs or healthcare resource utilisation. Meta-analysis was not possible due to multiple sources of heterogeneity
Context	Cardiac rehabilitation is an important component of recovery from coronary events but uptake and adherence to such programmes are below the recommended levels. Cardiac rehabilitation programmes vary, but usually include one or more of the following: exercise, education and psychological counselling/support.
Cochrane Systematic Review	Davies P et al. Promoting patient uptake and adherence in cardiac rehabilitation. Cochrane Reviews, 2010, Issue 7. Article No. CD007131. DOI: 10.1002/14651858.CD007131.pub2. This review contains 10 studies involving 1361 participants.
Pearls No. 286, November 2010, written by Brian R McAvoy	

Limited evidence for effectiveness of influenza vaccine in healthy adults

Clinical question	How effective are vaccines in preventing influenza in healthy adults

	(aged between 16 and 65 years)?
Bottom line	Inactivated influenza vaccines decreased the risk of symptoms of influenza and time off work, but their effects were minimal. In the relatively uncommon circumstance of the vaccine matching the viral circulating strain and high circulation, the NNT* to avoid influenza symptoms was 33. In average conditions (partially matching vaccine) the NNT was 100. There was no evidence vaccines affected hospital admissions, complication rates or transmission. Inactivated vaccines caused local harms (local erythema, tenderness and soreness), and an estimated 1.6 additional cases of Guillain-BarrŽ syndrome per million vaccinations. * NNT= number needed to treat to benefit 1 individual.
Caveat	These results may be an optimistic estimate because company-sponsored influenza vaccines trials tend to produce results favourable to their products, and some of the evidence came from trials carried out in ideal viral circulation and matching conditions; also because the harms evidence base was limited. Fifteen of the 36 trials in the review were funded by vaccine companies and 4 had no funding declaration.
Context	Over 200 viruses cause influenza and influenza-like illness (which produces the same symptoms). At best, vaccines might be effective against only influenza A and B, which represent about 10% of all circulating viruses. Healthy adults are presently targeted for influenza vaccination mainly in North America.
Cochrane Systematic Review	Jefferson T et al. Vaccines for preventing influenza in healthy adults. *Cochrane Reviews*, 2010, Issue 7. Article No. CD001269. DOI: 10.1002/14651858.CD001269.pub4. This review contains 50 studies involving over 80,000 participants.
Pearls No. 287, November 2010, written by Brian R McAvoy	

Insufficient evidence to support bedrest for preventing miscarriage

Clinical question	How effective is bedrest for risk of miscarriage?
Bottom line	There is insufficient evidence bedrest in hospital or at home prevents miscarriage in women with confirmed foetal viability and vaginal bleeding in the first half of pregnancy. In 1 trial there was a higher risk of miscarriage in those women in the bedrest group than in those in a human chorionic gonadotrophin therapy group with no bedrest.
Caveat	The small number of participants in the studies reviewed is a major factor contributing to the inconclusive findings. There is currently no evidence to provide reassurance about recommending bedrest for preventing miscarriage since none of the studies assessed potential side effects of bedrest (thromboembolic events, maternal stress, depression and costs).
Context	Miscarriage happens in 10Ð15% of pregnancies depending on maternal age and parity. It is associated with chromosomal defects in about half or two-thirds of cases. Many interventions have been used to prevent miscarriage but bedrest is probably the most commonly prescribed in cases of threatened miscarriage and for those with a history of previous miscarriage.
Cochrane Systematic Review	Aleman A et al. Bed rest during pregnancy for preventing miscarriage. Cochrane Reviews, 2010, Issue 10. Article No. CD003576. DOI: 10.1002/14651858.CD003576.pub2. This review contains 2 studies involving 84 participants.

Pearls No. 288, November 2010, written by Brian R McAvoy.

Acamprosate effective in supporting alcohol abstinence

Clinical question	How effective is acamprosate in supporting continuous abstinence after detoxification from alcohol?
Bottom line	Compared to placebo, acamprosate added to psychosocial treatment strategies was shown to significantly reduce the risk of any drinking (NNT* 9) and to significantly increase the cumulative abstinence duration, while secondary outcomes (gammaglutamyltransferase, heavy drinking) did not reach statistical significance. Diarrhoea was the most frequently reported side effect with acamprosate. Overall, side effects did not cause more participants to stop treatment when taking acamprosate compared to placebo. Even though the sizes of treatment effects appear to be moderate, they should be valued against the background of the relapsing nature of alcoholism and the limited therapeutic options currently available for its treatment. The effects of acamprosate did not differ in industry-sponsored and non-profit funded trials. Three trials compared acamprosate and naltrexone, and did not indicate a superiority of one or the other drug in effect on return to any drinking, return to heavy drinking and cumulative abstinence duration. *NNT = number needed to treat to benefit 1 individual.
Caveat	Effect sizes reflected the additional benefit of adding acamprosate to psychosocial treatments rather than its benefit compared to placebo Ð a fact which often remained unconsidered in the interpretation of treatment effects. Treatment duration varied from 8 weeks to 1 year, with 6 months treatment being most common.
Context	Alcohol dependence is among the leading health risk factors in most developed and developing countries. In the year 2004, 3.8% of all global deaths and 4.6% of global disability-adjusted life-years were attributable to alcohol.1 The therapeutic success of psychosocial programmes for relapse prevention is moderate but could potentially be increased by an adjuvant treatment with the glutamate antagonist acamprosate.
Cochrane Systematic Review	Rosner S et al. Acamprosate for alcohol dependence. Cochrane Reviews, 2010, Issue 9. Article No. CD004332. DOI: 10.1002/14651858.CD004332.pub2. This review contains 24 studies involving 6915 participants.
Pearls No. 289 November 2010, written by Brian R McAvoy.	

1. Rehm J et al. Lancet 2009;373:2223Ð33

Some evidence that interventions can increase uptake and adherence in cardiac rehabilitation

Clinical question	How effective are interventions to increase patient uptake of, and adherence to, cardiac rehabilitation?
Bottom line	A small body of evidence suggests interventions involving motivational communication delivered through letters, telephone calls and home visits may be effective in increasing uptake of cardiac rehabilitation, as may the use of liaison nurses to support coordination of care. Two of 7 studies intended to increase adherence to exercise as part of cardiac rehabilitation had a significant effect (although 1 of these studies was of poor quality).

	Coping strategies targeting barriers to adherence may be helpful in improving adherence. Barriers to uptake and adherence in cardiac rehabilitation are many and varied, and reasons for non-participation may vary between individuals. Individually tailored approaches may increase the likelihood of success.
Caveat	The quality of studies was generally low. Only 1 study reported the non-significant effects of the intervention on cardiovascular risk factors. No studies reported data on mortality, morbidity, costs or healthcare resource utilisation. Meta-analysis was not possible due to multiple sources of heterogeneity.
Context	Cardiac rehabilitation is an important component of recovery from coronary events, but uptake, and adherence, to such programmes is below the recommended levels. Cardiac rehabilitation programmes vary, but usually include 1 or more of the following: exercise, education, and psychological counselling/support
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Pearls No. 290, November 2010, written by Brian R McAvoy	

Abstracts

The actual Cochrane abstracts for the P.E.A.R.L.S are at

No. 284 Structured telephone support or telemonitoring effective for chronic heart failure

No. 285 Paracetamol effective for perineal pain in the early postpartum period

No. 286 Some evidence that interventions can increase uptake and adherence in cardiac rehabilitation

No. 287 Limited evidence for effectiveness of influenza vaccine in healthy adults

No. 288 Insufficient evidence to support bedrest for preventing miscarriage

No. 289 Acamprosate effective in supporting alcohol abstinence

No. 290 Some evidence that interventions can increase uptake and adherence in cardiac rehabilitation

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