It’s almost the end of another year! With your help we have managed to publish 16 new reviews, 20 updates and 23 protocols in 2012! And there are already reviews and protocols on the books for early 2013.

Each year the editorial board meets and we discuss issues and new methods arising over the year and think about how we can improve our Cochrane Airways reviews going forward. This year we met at the European Respiratory Society meeting in Vienna. This bulletin updates you on some of those things along with several developments in the Cochrane Collaboration.
Bye to Charlotta, Hello Kayleigh!

Our research assistant, Charlotta Karner—pictured below, has joined BMJ evidence HTA team. Charlotta worked with several review teams and with Chris on a number of reviews for our NIHR program grant. We are fortunate to have found a fabulous replacement in the form of Kayleigh Kew. Kayleigh is working together with teams in Sweden, Russia, USA and Australia to complete our suite of reviews on inhaled therapies.

Reporting absolute and relative effects in abstracts.

Cochrane reviews usually have the treatment effect and 95% confidence interval reported in the review text and in the abstract in the form (MD 0.03 L; 95% CI -0.01 to 0.07). We encourage you to report absolute differences alongside the relative effect taken from meta-analysis. The summary of findings table calculates the natural frequencies for you and you can then quote these in the abstract.

The following passage from a recent review illustrates what we mean:

There was low quality evidence that exacerbation rates in people using LABA/ICS inhalers were lower in comparison to those with LABA alone, from nine studies which randomised 9921 participants (rate ratio 0.76; 95% CI 0.68 to 0.84). This corresponds to one exacerbation per person per year on LABA and 0.76 exacerbations per person per year on ICS/LABA. Our confidence in this effect was limited by statistical heterogeneity between the results of the studies (I² = 68%) and a risk of bias from the high withdrawal rates across the studies. When analysed as the number of people experiencing one or more exacerbations over the course of the study, FPS lowered the odds of an exacerbation with an odds ratio (OR) of 0.83 (95% CI 0.70 to 0.98, 6 studies, 3357 participants). With a risk of an exacerbation of 47% in the LABA group over one year, 42% of people treated with LABA/ICS would be expected to experience an exacerbation. Concerns over the effect of reporting biases led us to downgrade the quality of evidence for this effect from high to moderate.

Other biases
Sometimes people ask: what are other biases?
Well, a recent trial reported free gym membership! Another trial reported that the active treatment group for a trial on an exercise intervention in asthma took more steroids – this confounds the results.

Top tips
We have started a FAQs page. I know you probably have plenty to read already, but we have several idiots’ guides to practical things you need to know about RevMan and Archie such as

- How do I change my affiliation/contact details?
- Creating tracked change versions of reviews (basically how to check on changes made by co-authors and editors since you last saw the review)
- Guide to using menus in RevMan
- How do I import references into Endnote?
- How do I export references from Endnote into RevMan format?
- How do I import references into RevMan?

http://airways.cochrane.org/faqs-top-tips

Visitors
We have had several local reviewers visit us for hands on help with their reviews. We have found it is possible to enter all the data into a review, to have a tour of how to use RevMan and to ask any questions about statistics or how to write up your results and discussion. We encourage authors visiting London to drop by to meet us – we can make a laptop available to you to work on your review and meeting face-to-face can really help speed things along. If you can’t call by but would like a guided tour of RevMan over the Skype, email me to arrange a time – I can share my screen with you using Skype and help you start entering data if you are stuck or have questions you don’t feel comfortable putting in an email.

What are the minimum standards expected in Cochrane Reviews
The collaboration has now defined a set of minimum standards for Cochrane Reviews. These are based on methods in the Cochrane Handbook and the CAG will be working with authors to get all our new reviews up to this standard. The standards are called “Methodological Expectations of Cochrane Intervention Reviews” or MECIR for short. You can read more about them here (http://www.editorial-unit.cochrane.org/mecir) including downloading a pdf for reference.

The Airways Group are implementing the standards in two ways. The first is that standard text will be entered into all new RevMan protocols when a title is registered. As an author, you will then be able to write the background and add any additional methods that you need for your specific review. We anticipate that this will not only save authors’ time, but save editorial time too. The second way is that during editing if I, or one of the editors, notice that something in
your review does not meet the MECIR standards, you will be asked to update your draft to comply with the standard.

The **good news** is that at the CAG we feel most of our reviews meet most of the standards. However there are several areas that we will be focussing on in the coming months for NEW reviews including:

1. Justifying choice of study design (apart from RCTs)
2. We must now routinely search trial registries e.g. ClinicalTrials.gov (the Cochrane Register of Studies (CRS) and Liz can help with this)
3. Retractions and amendments of included studies should be searched for and included
4. PRISMA diagrams to record the flow of studies in the review are mandatory
5. Separate out blinding of patients/personnel (performance bias) and data collectors (detection bias)
6. Summary of findings table – highly desirable. They are basically mandatory within the CAG unless it’s meaningless to include one.

Contact me if you need help!

**Get involved in translations**

Cochrane reviews would ideally be available worldwide in many languages. If you want to get involved in translating Cochrane reviews, please get in touch with Juliane Ried who will be able to help you [juliane.ried@cochrane.org](mailto:juliane.ried@cochrane.org)

**Review Group Activities 2012**

The Group’s main task is to coordinate the preparation and publication of systematic reviews. Details of our recent work in this area are given below. Completed reviews and protocols are published on The Cochrane Library which can be accessed at [www.thecochranelibrary.com](http://www.thecochranelibrary.com)

**New reviews**

**Weight loss interventions for chronic asthma** *(Adeniyi FB, Young T)*

Asthma is a disease affecting people of all races ages and gender. People with asthma experience recurrent episodes of cough, chest tightness or shortness of breath, which may limit daily activities. In the past few decades, research has shown that people who are overweight or obese
are more likely to have asthma as well as have severe symptoms. This review sought to find out if weight loss interventions in overweight or obese patients with asthma, improve asthma control, as well as achieved weight loss.

We included four studies made up of a total of 197 participants from four countries (Brazil, Finland, Mexico and Australia) in the review. Interventions included low energy diets, anti-obesity drugs and physical activity, either singly or in combination. Studies had a high risk of bias and results show that weight loss interventions produced weight loss in treatment compared to control groups. Weight loss was also associated with improvement in symptoms, reduction in need for reliever medication in the short term and some improvement in lung function. There was inadequate data to comment on the effect of the intervention on quality of life, health care utilization and adverse effects.

Better designed and reported studies are needed, especially in children and in resource constrained countries such as Africa, where the pre-packaged, low energy diets, as well as structured physical activity-based interventions utilized in these included studies, may not be feasible or applicable.

**Tiotropium versus placebo for chronic obstructive pulmonary disease (Charlotta Karner, Jimmy Chong, Phillippa Poole)**

Chronic obstructive pulmonary disease (COPD) is a lung disease which includes the conditions, chronic bronchitis and emphysema. It is caused by smoking or inhaled dust, which leads to blockage or narrowing of the airways. The symptoms include breathlessness and a chronic cough. Tiotropium is an inhaled medication that helps widen the airways (bronchodilator) for up to 24 hours, and is used to manage persistent symptoms of COPD.

We found 22 studies including 23,309 participants, comparing the long-term effectiveness and side effects of tiotropium and placebo. Compared with placebo, tiotropium treatment led to an improvement in quality of life, fewer people had an exacerbation (worsening of COPD symptoms), or exacerbations leading to hospital admissions. The number of people that needed to be treated for a year, for one person to avoid one additional exacerbation was 16 (95% confidence interval (CI) 10 to 36). We found no statistically significant difference between the tiotropium and placebo groups in terms of the number of hospital admissions for any cause, serious adverse events or deaths during the studies. However, when we divided the data depending on whether a dry powder inhaler or a soft mist inhaler was used in the studies, these two subgroups were significantly different. With the dry powder inhaler there were fewer deaths in the tiotropium group than in the placebo group, whereas with the soft mist inhaler there were significantly more deaths in the tiotropium group than in the placebo group. Also, there was a larger number of participants that stopped study medication early in the placebo group than in the tiotropium group.

This review shows that treatment with tiotropium improves patients' quality of life, and reduces the risk of exacerbations, including exacerbations leading to hospitalisation. But tiotropium does not reduce hospitalisations for all causes or the number of deaths. Based on the evidence in this review, tiotropium appears to be a reasonable treatment choice for patients with stable COPD. However, the review also shows that tiotropium delivered via the Respimat soft mist inhaler is associated with an increased risk of death, which calls for both caution and further investigation.

**Tiotropium versus long-acting beta-agonists for stable chronic obstructive pulmonary disease (Chong J, Karner C, Poole P)**
Tiotropium is an inhaled medication that helps open the airways (bronchodilator) and is used to manage persistent symptoms of COPD. We found seven studies including 12,223 participants that compared tiotropium with long-acting beta$_2$-agonists (LABAs), which are another type of bronchodilator. This systematic review found that currently there is insufficient evidence to suggest which of these treatments provides greater long-term benefit in quality of life. Furthermore, both treatments had similar effects on symptoms, lung function and death rates.

Tiotropium appears better than LABAs in preventing COPD exacerbations (worsening of COPD symptoms) and reducing the number of COPD-related hospitalisations. Furthermore, there were fewer participants during the study period with serious adverse events or who withdrew early from the studies with tiotropium compared with LABA treatment. However, there was no difference in the total number of people who were hospitalised.

We found six economic evaluations looking at the cost and effectiveness of tiotropium and the LABA salmeterol that were conducted in the UK, Greece, Netherlands, Spain, or USA. All the studies estimated tiotropium to be better than salmeterol based on medical outcomes (exacerbations or quality of life) and/or lower total costs, including respiratory medications and hospitalisations. However, these results were very uncertain.

**Breathing exercises for chronic obstructive pulmonary disease** (Holland A, Hill CJ, Jones AY, McDonald CF)

People with chronic obstructive pulmonary disease (COPD) often have an altered breathing pattern and experience shortness of breath, particularly when they exercise. This review aimed to determine whether breathing exercises that are designed to retrain the breathing pattern could reduce breathlessness, increase exercise capacity and improve well-being for people with COPD.

Sixteen trials with 1233 participants were included, most of whom had severe COPD. The breathing techniques studied included pursed lip breathing (breathing out slowly with the lips in a whistling position), diaphragmatic breathing (deep breathing focusing on the abdomen), pranayam yoga breathing (timed breathing with a focus on exhalation), changing the breathing pattern using computerised feedback to slow the respiratory rate and increase exhalation time, or combinations of these techniques. The study quality was generally low. Breathing exercises appeared to be safe for people with COPD. Yoga breathing, pursed lip breathing and diaphragmatic breathing improved the distance walked in six minutes by an average of 35 to 50 metres in four studies. Effects of breathing exercises on shortness of breath and well-being were variable. When added to whole body exercise training, breathing exercises did not appear to have any additional benefit.

**Safety of regular formoterol or salmeterol in children with asthma: an overview of Cochrane reviews** (Cates CJ, Oleszczuk M, Stovold E, Wieland LS)

Asthma is a common condition that affects the airways, the small tubes that carry air in and out of the lungs. People can have underlying inflammation in their lungs and sticky mucus or phlegm may build up, which can narrow the airways. When a person with asthma comes into contact with an irritant (an asthma trigger), the muscles around the walls of the airways tighten, the airways become narrower, and the lining of the airways becomes inflamed and starts to swell. This leads to the symptoms of asthma, which are wheezing, coughing and difficulty in breathing. There is no cure for asthma; however, there are medications that allow most people to control...
their asthma so they can get on with daily life. People with asthma are generally advised to take inhaled corticosteroids to combat the underlying inflammation in their lungs. If asthma is still not controlled, current clinical guidelines recommend the introduction of an additional medication to help. One type of additional medication is the long-acting beta_2-agonists, such as formoterol and salmeterol, which work by reversing the narrowing of the airways that occurs during an asthma attack. These drugs, taken by inhaler, are known to improve lung function, symptoms, quality of life and to reduce the number of asthma attacks. However, the evidence for the usefulness of long-acting beta_2-agonists is more limited in children than adults, and there are concerns about the safety of these drugs in both adults and children. We did this overview to take a closer look at the safety of formoterol or salmeterol, either alone or given in combination with corticosteroid therapy, in children with asthma.

We looked at previous Cochrane reviews on long-acting beta_2-agonists and also searched for additional trials on long-acting beta_2-agonists in children. We found a total of 21 trials involving 7318 children that provided information on the safety of formoterol or salmeterol given alone or combined with corticosteroids. We also found one trial on 156 children which directly compared formoterol to salmeterol.

There were more non-fatal serious adverse events in children taking formoterol or salmeterol compared to those on placebo; for every 1000 children treated with formoterol or salmeterol over six months, 21 extra children suffered a non-fatal event in comparison with placebo. There was a smaller and non-significant increase in serious adverse events in children on formoterol or salmeterol and corticosteroids compared to corticosteroids alone: for every 1000 children treated with combination therapy over three months, three extra children suffered a non-fatal event in comparison with corticosteroids alone. This number illustrates the average difference between combination therapy and corticosteroids. Our analyses showed that in fact the true answer could be between 1 fewer and 12 more children who would experience a non-fatal event.

We did not have enough numbers from the small trial comparing formoterol to salmeterol, or from information in the other trials, to tell whether one long-acting beta_2-agonist treatment is safer than the other. There was only one death across all the trials, so we did not have enough information to tell whether formoterol or salmeterol increases the risk of death.

**Ketamine for management of acute exacerbations of asthma in children (Jat KR, Chalwa D)**

Children frequently visit the emergency department for acute exacerbation of asthma. Some of these children fail to respond to standard treatment (corticosteroids and bronchodilators) with increased morbidity. Ketamine has bronchodilatory properties and may be useful for acute exacerbation of asthma. We evaluated the efficacy of ketamine for management of severe acute asthma in children who had not responded to standard therapy. We found, through systematic search, only one study where investigators assessed the usefulness of ketamine for management of severe acute asthma in children. While this single study suggested that there is a lack of evidence for usefulness of ketamine in acute exacerbation of asthma in children, more trials are needed regarding the use of ketamine in acute asthma before more specific recommendations can be made.

**Addition of intravenous beta2-agonists to inhaled beta2-agonists for acute asthma (Travers AH, Milan SJ, Jones AP, Camargo Jr CA, Rowe BH)**

Beta_2-agonist drugs are used for the treatment of asthma and work by opening the airways to help
people breathe more easily. Beta₂-agonists can be given to people in two different ways – intravenously (directly thorough a vein) and via an inhaler. Inhalers are one of the most important treatments for people with acute severe asthma. The question this review considered was whether treatment would offer additional benefit if patients received these drugs both ways (by breathing them via an inhaler and receiving them directly through a vein) than by just inhaling them alone. This review examined all the randomised controlled trials on the use of intravenous beta₂-agonists in addition to inhaled beta₂-agonists with existing standard care (such as steroids either taken as tablets or by injection) in severe acute asthma.

We found three trials involving 104 people (75 children and 29 adults) with acute asthma. There was no significant difference in adults receiving intravenous beta-agonists as well as standard care in the one small trial considering this comparison. We also looked at length of stay in the emergency department. Two reported shorter recovery time or quicker discharge from the emergency department in patients also receiving intravenous beta-agonists. One trial reported that more children experienced tremor if they had received injected beta-agonists whereas another trial, with adults, reported no significant difference in adverse effects. As there are so few trials and so few included patients we cannot be sure about the reliability of these findings.

This review found that until more, larger, high quality clinical trials in this area are conducted it is not possible to judge whether there is any enhanced benefit using additional intravenous beta₂-agonists in children or adults with severe acute asthma compared with inhaled beta₂-agonists alone.

**Antibiotics for exacerbations of chronic obstructive pulmonary disease (Vollenweider DJ, Jarrett H, Steurer-Stey CA, Garcia-Aymerich J, Puhan MA)**

Chronic obstructive pulmonary disease (COPD) is a chronic condition, often caused by smoking, which affects the passage of air in and out of the lungs. Exacerbations of COPD are defined as a sustained worsening of the patient’s symptoms from their usual stable state and commonly reported symptoms are worsening breathlessness, cough, increased sputum production and change in sputum colour. Antibiotics are frequently prescribed for exacerbations in patients with COPD although the cause of exacerbations is often difficult to determine (viral, bacterial, environmental). We did this systematic review to find out if there is good evidence for using antibiotics for exacerbations of COPD and if benefits of taking antibiotics in individuals outweigh potential harms for individual patients and the risks of multi-resistant bacteria to the population.

We found 16 randomised studies compared antibiotics with placebo in a total of 2068 COPD patients who presented with a wide range of severities of exacerbations. Analyses showed that antibiotics reduce treatment failures (no improvement) compared with placebo in hospitalised patients with severe exacerbations. In outpatients with mild to moderate exacerbations, the evidence is more unclear because analyses showed a reduction of treatment failure when all studies and antibiotics were considered, but analyses did not suggest such an effect when they were restricted to antibiotics in current use. Length of hospital stay and mortality were not reduced by antibiotics in hospitalised patients except for those who needed treatment on the intensive care unit. Patients treated with antibiotics experienced diarrhoea twice as often as patients receiving placebo. Severity of underlying COPD could not be compared across trials because lung function and
other parameters were reported inconsistently between trials.

Current evidence shows that antibiotics reduce treatment failures in patients who are hospitalised for the treatment of a COPD exacerbation, and to a lesser extent in outpatients. Mortality is only reduced by antibiotics in patients with very severe exacerbations who need treatment in the intensive care unit. The rather small and inconsistent effects of antibiotics on treatment failure suggest that antibiotics are effective in some patients but not in all inpatients and outpatients. Future high-quality studies should explore how antibiotic therapy may be targeted towards patients who benefit by using clinical signs (e.g. purulent sputum) or biomarkers at the time when patients present to the primary care doctor or emergency department.

**Antibiotics for persistent cough or wheeze following acute bronchiolitis in children**

(McCallum GB, Morris PS, Chang AB)

Bronchiolitis is a common lung infection, affecting children across the world. It is usually caused by a virus called RSV (respiratory syncytial virus) but other viruses can cause this too. Young children with bronchiolitis normally have a cough, fast and difficult breathing, and poor feeding. Antibiotics are not normally prescribed to children with bronchiolitis unless there is concern of a secondary bacterial infection. However, some children continue to have ongoing problems (i.e. wheeze, cough) after the acute viral infection (> 14 days); increasing the risk of burden of disease and cost to the health system. These children often re-present for further medical care in the community (general practitioners and health providers) or in hospital (emergency departments). Antibiotics may help treat these ongoing symptoms and get rid of the bacteria in the lungs.

This review found only one eligible study looking at antibiotics compared to placebo for children in the post-acute bronchiolitis phase. This randomised controlled trial was from Turkey and enrolled 30 infants aged seven months or younger. There is currently not enough evidence to inform whether antibiotics should be used to treat or prevent persistent respiratory symptoms in the post-acute bronchiolitis phase. Randomised controlled trials that evaluate the efficacy of antibiotics to reduce persistent respiratory symptoms are needed, especially in countries where the morbidity of acute bronchiolitis is high such as in Indigenous populations.

**Intermittent versus daily inhaled corticosteroids for persistent asthma in children and adults**

(Chauhan BF, Chartrand C, Ducharme FM)

Chronic asthma is a disease caused by underlying inflammation in the airways (the small tubes in the lungs) and asthma attacks occur when the airways contract making it difficult for the person to breath. In people with mild asthma, inhaled corticosteroids are often recommended to be taken every day to control the underlying inflammation. However, many people with asthma take inhaled corticosteroids only when symptoms appear. We wanted to look for the available evidence from randomised controlled trials comparing the use of inhaled corticosteroids everyday with use of these drugs only at the time of worsening of symptoms in children and adults with persistent asthma (six trials representing 1211 patients).

This review of randomised controlled trials found no significant difference in the number of asthma attacks of moderate severity between people taking inhaled corticosteroids every day and those taking them ‘as needed’. However, there was not enough information to conclude to that the two approaches were equivalent. However, we found that people taking inhaled corticosteroids everyday had slightly better asthma control with
better lung function, less use of reliever medication and more symptom-free days than those taking inhaled corticosteroids intermittently. We also observed that compared to intermittent inhaled corticosteroids, children grew slightly less with daily inhaled budesonide and beclomethasone (inhaled corticosteroids are known to affect growth), underlying the importance of using the safest and lowest effective dose of inhaled corticosteroids. We did not observe any significant group difference in the rate of withdrawals or adverse effects. These results do not provide firm conclusions, although the improvement in asthma control, lung function and airway inflammation would provide slightly greater support for the use of inhaled corticosteroids every day as compared to taking them only when symptoms get worse. Physicians and patients are advised to weigh the risks and benefits of each treatment option carefully and monitor the response of individual patients to adjust therapy as needed.

**Intravenous beta2-agonists versus intravenous aminophylline for acute asthma** (Travers AH, Jones AP, Camargo Jr CA, Milan SJ, Rowe BH)

Beta2-agonist and aminophylline drugs are used for the treatment of asthma and work by opening the airways to help people breathe more easily. Both drugs can be given intravenously (IV) (directly through a vein). The question this review considered was whether there was any important difference between these drugs for patients with acute asthma. This review examined all the randomised controlled trials comparing IV beta2-agonists to aminophylline.

We found 11 studies involving 350 patients (157 children and 193 adults) with acute asthma. No consistent evidence favouring either IV beta2-agonists or IV aminophylline was found from randomised trials of patients with acute asthma. It is recommended that these results should be viewed carefully alongside the conclusions from separate Cochrane reviews comparing IV beta2-agonists plus inhaled beta2-agonists versus inhaled beta2-agonists alone and IV aminophylline plus inhaled beta2-agonists versus inhaled beta2-agonists alone.

**Updated reviews**

**Inhaled corticosteroids for stable chronic obstructive pulmonary disease** (Yang IA, Clarke MS, Sim EHA, Fong KM)

**Mucolytic agents for chronic bronchitis or chronic obstructive pulmonary disease** (Poole P, Black PN, Cates CJ)

**Alexander technique for chronic asthma** (Dennis JA, Cates CJ)

**Ionisers for chronic asthma** (Blackhall K, Appleton S, Cates CJ)

**Restriction of oral intake of water for aspiration lung disease in children** (Weir K, McMahon S, Chang AB)

**Combined corticosteroid and long-acting beta2-agonist in one inhaler versus long-acting beta2-agonists for chronic obstructive pulmonary disease** (Nannini LJ, Lasserson TJ, Poole P)

**Interventions for primary (intrinsic) tracheomalacia in children** (Goyal V, Masters IBrent, Chang AB)

**Early use of inhaled corticosteroids in the emergency department treatment of acute asthma** (Edmonds ML, Milan SJ, Camargo Jr CA, Pollack CV, Rowe BH)

**Inhaled magnesium sulfate in the treatment of acute asthma** (Powell C, Dwan K, Milan SJ, Beasley R, Hughes R, Knopp-Sihota JA, Rowe BH)

**Non-invasive positive pressure ventilation for treatment of respiratory failure due to severe acute exacerbations of asthma** (Lim WJ,
Mohammed Akram R, Carson KV, Mysore S, Labiszewski NA, Wedzicha JA, Rowe BH, Smith BJ

Nutritional supplementation for stable chronic obstructive pulmonary disease (Ferreira IM, Brooks D, White J, Goldstein R)

Protocols
Smartphone and tablet self-management apps for asthma (Marcano Belisario JS, Greenfield G, Huckvale K, Gunn LH, Car J)

Bronchial thermoplasty for moderate or severe persistent asthma in adults (Yepes-Nuñez JJ, Torrego A, Solà I, Alonso-Coello P, Plaza V, Roqué i Figuls M)

Safety of regular formoterol or salmeterol in children with asthma: an overview of Cochrane reviews (Cates CJ, Oleszczuk M, Stovold E, Wieland LS)

Tai Chi for chronic obstructive pulmonary disease (COPD) (Ngai SPC, Jones AY, Tam W)

Calcium channel blockers for pulmonary arterial hypertension (Chen Y, Fan Z, Liu H)

Inhaled steroids and risk of pneumonia for chronic obstructive pulmonary disease (Karner C, Seniukovich A)

Indacaterol, a once-daily beta2-agonist, versus twice-daily beta-agonists or placebo for chronic obstructive pulmonary disease (Geake JB, Dabscheck EJ, Wood-Baker R)

Inhaled corticosteroids in children with persistent asthma: effects of different drugs and delivery devices on growth (Axelsson I, Prietsch SOM, Zhang L)

Long-acting beta2-agonists for chronic obstructive pulmonary disease (Karner C, Stovold E)

Long-acting therapy for chronic obstructive pulmonary disease: an overview (Karner C, Li T, Kew KM)

Addition of inhaled anticholinergics to beta2-agonists for children with acute asthma in hospital (Vézina K, Chauhan BF, Ducharme FM)

Weight loss intervention through lifestyle modification or pharmacotherapy for obstructive sleep apnoea in adults (Hosseini Araghi M, Chen Y-F, Jagielski A, Mannan Choudhury S, Banerjee D, Thomas GN, Taheri S)

Hot tips for review authors
Working on a protocol or review? Here are a few important things to bear in mind:

- Don’t leave the protocol or review ‘checked out’ when you’re not working on it. Check it back into Archie after every session.
- Extracted data but not sure how to present it? Talk to the Managing Editor before entering data to RevMan.
- If you are planning to use GIV data, please get in touch when you enter the data – we have found it can go badly wrong and it’s better to get the data entered correctly from the outset than have to rewrite the review during the editorial process.
- In your review, follow the methods you had set out in your protocol. If there’s a good reason for taking a different course, make this plain in the review.
- Be prepared for multiple iterations of your protocol or review after the first submission. Work is rarely accepted for publication immediately after it has been resubmitted following editorial or peer review.
- Make sure that everyone on your team has activated their Archie accounts otherwise the publication process can be severely delayed.
- Outcomes should not be changed between protocol and review. If you want to do this please speak to the managing editor.
Merry Christmas and best wishes for a Happy New Year from all of us!

Chris, Emma J, Liz, Kayleigh, Emma W, Steve