**[Review Group]**

# Cochrane Upper Gastrointestinal and Pancreatic Diseases Group

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## What's new

***New protocols***

Imatinib mesylate for gastrointestinal stromal tumours (GISTs), Prof Humberto Saconato, Brazil

Red cell transfusion for the management of upper gastrointestinal haemorrhage, Dr Sarah Hearnshaw, UK

Tranexamic acid for upper gastrointestinal bleeding, Dr Lise Lotte Gluud, M.D., Denmark

This takes our total to 63 published reviews and protocols (38 reviews and 25 protocols)

***Corrections***

We have corrected an error in the Additional Tables of "Neoadjuvant chemotherapy versus none for resectable gastric cancer", Evan Wu et al. Table entries relating to Cunningham 2005, which is an excluded study, were removed from the Additional Tables in this version of the review published in this edition of The Cochrane Library. This review is being revised and an updated version will appear in a future edition of The Cochrane Library.

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Please note that due to staff changes and organisation of the editorial base, the office at the University of Leeds is no longer staffed on a full time basis. For enquiries, please use the email address above. Email is accessed once a week and our response to your enquiry may take several days.



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The Meta Analysis Group of the MRC Trials Office, Cambridge UK converted an individual patient data review of pre-operative radiotherapy in operable cancer of the oesophagus (on behalf of the Oesophageal Cancer Collaborative Group).

## Consumer involvement

Consumer representative: Mr David Kirby (Oesophageal Patients Association, UK)
Any relevant involvement by consumers (people with the relevant health care condition, their carers, policy makers, health professional, and others who may make use of the reviews prepared by the CRG) is welcomed by the UGPD Group. At present, consumers act as peer referees for protocols and reviews which have been prepared by the UGPD Group. However, we intend to expand the role of consumers, possibly to include production of patient support and information leaflets, and welcome enquiries from interested parties.

## Involvement of other users

## Conflict of interest

No conflicts of interest are known

## Background

Discussions concerning the formation of an Upper Gastrointestinal (GI) Cochrane Review Group (CRG) began in 1993, when a number of meetings were held to develop the work of the Cochrane Collaboration in GI disease in general. These led to the formation of the Inflammatory Bowel Disease (IBD) CRG and the Hepatobiliary CRG. It was clear that there was also a need for a CRG in upper GI disease, not least because of the enormous health service costs involved in the clinical management of dyspepsia, and the burgeoning number of clinical trials of variable quality.
Professor David Forman, now Co-ordinating Editor of the UGPD Group, has a long established research interest in the clinical impact of Helicobacter pylori infection. This seemed to be a subject that demanded methodologically robust review if it was to lead to meaningful and practical conclusions for doctors and their patients.
A "Dyspepsia CRG" exploratory meeting took place on 16th October 1996 in Copenhagen. All those who had contacted the Cochrane Collaboration with an interest in this area of medicine were invited. Also present were people known to have an interest in reviews of dyspepsia, representatives of the IBD and Hepatobiliary CRGs, the Cochrane Cancer Network, and the two pharmaceutical companies (Glaxo-Wellcome and Astra Hassle), who had agreed to support the event. The meeting was chaired by Andy Oxman on behalf of the Collaboration.
There was unanimous and enthusiastic support at the meeting in favour of establishing a CRG, although it was felt that the scope of the Group should also include all diseases of the oesophagus, stomach and duodenum (including malignancies). To reflect this widened scope, a provisional title of "Oesophageal, Gastric and Duodenal Diseases CRG" was adopted. It was agreed that Leeds should be the editorial base for the Group and that Professor Forman should be the prospective Co-ordinating Editor.
Work commenced on obtaining the commitment of editors, reviewers and other contributors. The name changed again in February 1998 to Upper Gastrointestinal and Pancreatic Diseases Group (UGPD), to reflect the integration of pancreatic diseases into the scope of the Group.
Formal registration of the UGPD Group took place on 1 June 1998.
Funding to support the core activities for the Group is now in place until March 2009.

Cochrane UGPD Group Editors' Meetings
1. 16th November 1999, at the Osservatorio Epidemiologico Regionale, Rome.
2. 27th November 2000, UEGW Meeting, in Brussels, Belguim.
3. 21st May 2001, DDW Meeting, Atlanta, US.
4. 20th May 2002, DDW Meeting, San Francisco, US.
5. 20th May 2003, DDW Meeting, Orlando, US.
6. 16th May 2005, DDW Meeting, Chicago, US.

## Scope

"To use evidence from randomised controlled trials to answer practical questions of the prevention, treatment and rehabilitation of benign and malignant disorders of the oesophagus, stomach, duodenum and pancreas. Systematic reviews of other types of trials will be used where necessary."
No orphan review topics are covered by the UGPD Group.
There are possible areas of mutual interest with other Cochrane Gastrointestinal Groups, i.e. Hepatobiliary, Inflammatory Bowel and Colorectal Cancer CRGs. Other CRGs which share a potential common interest include those which address interventions which may have an effect on the upper gastrointestinal system (for example, NSAIDs in musculoskeletal problems). Every attempt will be made to ensure that duplication of work does not occur and that support is given to other CRGs who wish to take responsibility for review topics where there is mutual interest. In particular, we would aim to support CRGs by suggesting peer referees and by searching our specialised register for appropriate trials. All interventions (surgical, pharmacological, educational, psychological etc.) for prevention, treatment (acute and maintenance) and rehabilitation will be covered.
The CRG's policy on outcome variables is under development. Many reviews will include death, recurrence of illness, improvement of symptoms or eradication of Helicobacter pylori as an outcome.

## Glossary

This glossary is under development and suggestions for improvement should be sent to the review group co-ordinator.

Achalasia (treatment)
A condition in which the ring of muscle around the junction of the oesophagus and stomach (the gastro-oesophageal sphincter) fails to relax normally on swallowing, thus allowing food to be retained in the lower part of the oesophagus.

Adenoid Cystic Carcinoma of Oesophagus

A type of tumour also called cylindroma, adenoid basal cell carcinoma or x carcinoma. Occurs more often in the salivary gland, rarely in the oesophagus Cystic structures are seen microscopically, lined by flattened cells with mucoid substance in the cystic spaces.

Adjuvant Chemotherapy
Use of an agent (drug) in addition to the principal drug directed against a disease (see Chemotherapy), which increases the effectiveness of such a drug.

Alginates
These act only as a physical barrier and have no known pharmacological action. They are polyuronic acids obtained from seaweed. They are available in combination with antacids or cimetidine. Alginates form a floating raft of high pH on the surface of the gastric contents and reduce gastric reflux into the oesophagus. They also protect oesophageal mucosa from the stomach contents e.g. acid and pepsin.

Antacids
Substances that neutralise gastric acid in the stomach. They are systemic when they alter the acid-base balance of the body (e.g. sodium bicarbonate) and nonsystemic when they do not (e.g. magnesium trisilicate).

Antacids or bicarbonate with pancreatic enzymes
Given for the same reasons as above i.e. to restore normal duodenal pH and allow enzymes to operate.

Anticholinergic drug
A drug that inhibits transmission at synapses mediated by acetylcholine. Selective drugs can either act at nicotinic cholinoreceptors or muscarinic cholinoreceptors. The term "anticholinergic" is imprecise and the type of receptor affected should be described (e.g. antimuscarinic).

Anti-H pylori therapy
Use of substances that are administered to inhibit or destroy the micro-organism Helicobacter pylori.

Anti-oxidants
Molecular scavengers of reactive oxygen species (OH, O2-) and other oxidising compounds e.g. haem compounds with high-valence iron. Examples are vitamins C and E.

Antrectomy
Surgical resection of the stomach distally often combined with section of the truncal vagus nerves at the oesophageal hiatus (vagotomy).

Aprofinin
An inhibitor of bovine pancreatic proteinase.

Autoimmune gastritis
Cell damage in the GI tract caused by an attack from the host's own immune system.

Bacterial Infections of the Oesophagus
Usually rare compared with diseases of viral and fungal origin. Tuberculosis of the oesophagus is very rare, and scarlet fever and diphtheria are now also uncommon. Occasionally in meningococemia, there may be a fibrous stricture of the oesophagus as a sequel.

Balloon Dilatation (Tamponade)
Use of an inflated (in situ) balloon to control variceal bleeding or recurrent haemorrhage in the upper gastrointestinal tract.

Barrett's Oesophagus
Intestinal metaplasia proximal to the gastro-oesophageal junction. The lower portion of the oesophagus is lined with columnar rather than squamous epithelium.

Benign Duodenal Tumours
Tumours with no ability to metastasise. May be polypoid, plaque like or annular and vary greatly in size. Most are mesodermal or nonepithelial in origin. Carcinoid polyps also occur. Neurogenic tumours come from the nerve sheath (neurofibromas) or the sympathetic and chromatin systems (ganglioneuromas). Inflammatory pseudo tumours with fibrous and granulation tissue, are polypoid in nature.

Bezoar
A concretion (solid mass) made of hair or other material found in the stomach or intestines. In man, this refers to a hair-ball found in the stomach consisting either of hair (trichobezoar) or of vegetable or fruit fibre (phytobezoar).

Bile Reflux
Passage of bile salts (bile) into the stomach (e.g. after gastric surgery or due to obstruction of normal bile passage in the ducts).

Billroth I and II
Surgical procedures carried out to reconnect the stomach and distal parts of the intestine after gastronomy. In Billroth I, the stomach and duodenum are rejoined, whereas in Billroth II the stomach and jejunum are joined, leaving a closed duodenal stump.

Bismuth Salts
A class of compounds used in the treatment of diarrhoea, gastro-intestinal inflammation and peptic ulceration.

Botulinum toxin (use of)
A bacterial toxin used in intrasphincteric injections, to paralyse the hypertensive sphincter in the gastroesophageal tract to relieve dysphagia (difficulty in swallowing).

Brachytherapy
Treatment applied by means of a sealed radioactive source in direct contact with body tissues.

Calcitonin
A natural hormone that regulates calcium metabolism. It is a polypeptide produced by the parafollincular cells of the thyroid glands.

Calcium channel blocker (calcium antagonists)
A drug that prevents the passage of calcium ions through calcium channels in the cell membrane.

Camostat (Mesilate)
An inhibitor of pancreatic energies given by mouth in the treatment of pancreatitis.

Carbenoxolone
A drug used in the treatment of peptic ulcer. The precise mode of action is uncertain.

Celestin Dilatation
Dilatation of oesophageal strictures using a guide wire upon which is threaded a dilator consisting of a tube with several "steps" of increasing external diameter.

Celiac Plexus Block
Ablation of the celiac plexus during pancreatic duodenectomy or palliative surgery by neurolysis or chemical splanch-nicectomy to relieve abdominal pain.

Chemical, physical and drug-induced oesophagitis
Inflammation of the oesophagus carried by an exogenous chemical or physical insult or drugs.

Chemotherapy

Use of drugs to injure or destroy either invading organisms or cancers without (unacceptable) injury to the host.

Chemotherapy oesophagitis
As above, but caused as a secondary effect of chemotherapeutic drug administration.

Coeliac Disease
A syndrome associated with the malabsorption of foodstuffs and may be due to abnormal sensitivity of the intestinal mucosa to dietary gluten.

Congenital abnormalities of the duodenum
These include varying degrees of stenosis in the infant, ranging from complete absence of a lumen with two separated blind ends, or two separated segments connected by a fibrous cord or membrane, or merely a web or narrowed area impeding intestinal flow. In the adult, abnormal shape or rotation can adversely affect intestinal flow. Dilation is also encountered (mega-duodenum).

Congenital gastric disorders
Malfunction of the stomach linked to genetic factors.

Congenital oesophageal disorders
Disorders such as "rings" and "webs" (see above) emanating from congenital failure of correct oesophageal development in the embryo.

Coring out of Head of Pancreas
Used as a surgical procedure in the management of chronic pancreatitis. In the Beger operation the pancreatic head is first cored out and then the cored out head is drained with a Roux-en-Y (see above) limb, and the body and tail of the pancreas are drained into the jejunum with an end-to-end anastomosis.

Corticosteroids
A group of natural hormones (or chemical modifications of same) used in an anti-inflammatory or immune-suppressive role-as a mineralocurticoid.

Dumping Syndrome
There are two stages. The first stage arises by vagal stimulation caused by food dropping rapidly into the jejunum and overdistending it. A feeling of fullness, cramps, nausea, diarrhoea, palpitations, cold sweats and fainting occurs. The (rarer) late stage involves overproduction of insulin giving rise to hypoglycaemia.

Duodenal Carcinoma
Primary malignant cancers of the duodenum. These are rare. Typical endoscopic appearance is of an exophytic mass. Lymphoma accounts for about 20% of duodenal malignancies, mostly associated with gastric lymphoma. Most cancers arise from another primary site. Many occur as an extension into the duodenum from contiguous carcinoma of the head of the pancreas. Other cancers include primary carcinoma of the ampulla.

Duodenal Ischaemia
Effects caused by disorders of intestinal blood flow and diseases of vascular impairment.

Duodenum-preserving resection of the head of the pancreas.
Surgical procedure that spares the duodenum whilst removing the pancreatic head.

Eder-Puestow Dilatation
If an oesophageal stricture is too fibrous or too narrow, dilation can be performed using guided, woven dilators (bongies) passed over a string or wire. Filiform bougies (olives) are passed over the thread/were and guided through the stricture.

Embolisation of Splenic Artery
Artificial blockage of the artery carried out pre-operatively in an operation for e.g. pseudocyst in chronic pancreatitis, to minimise blood loss during the operation. This could be carried out by surgical ligature.

Empirical Acid Suppression
Use of substances that inhibit gastric acid secretion to treat patients without knowledge of underlying pathology.

Empirical Anti H-pylori therapy
Use of above substances to treat patients without knowledge of underlying pathology.

Endoscope
An instrument comprising a flexible tube with a light source attachment, which can be passed into a patient for visual internal examination. Various therapies can be administered though the tube during internal examination whilst the area of interest is continuously monitored.
Endoscopic Balloon Dilation
Use of an endoscope (see above) to introduce a balloon which may be inflated to remove blockage of flow in the intestine.

Endoscopic dilation/drainage of bile duct
Procedure using endoscope (see above) to open up blockages of the bile duct to allow drainage of bile to occur.

Endoscopic Drainage
Drainage of pancreatic fluids by endoscope (see above).

Endoscopic Sphincterectomy
An endoscopic technique to cut the bile duct widening its diameter to allow the removal of gallstones from the bile duct.

Endoscopic Stenting
Use of an endoscope to place stents (see above) so as to maintain potency of ducts and thus fluid flow.

Endosocopic Mucosal Resection
Removal of flat gastrointestinal lesions using endoscopic techniques.

Enteral nutrition
Nutrition by the alimentary tract.

Enteric-coated preparations
Tablets etc coated with a substance resistant to gastric secretion (e.g. varnish as in enteric-coated aspirin) so that the coating is dissolved and the drug released only after they reach the small intestine.

Eosinophilic gastro enteritis
A disorder in which eosinophils infiltrate into the stomach, either as a localised inflammatory polyp (granuloma or hemangiopericytoma) or a diffuse modular infiltration (gastro-enteritis). Often accompanied by evidence of food allergy, but not always so.

Foreign Body Impaction
Objects swallowed by subjects which stick, most commonly just below the cricopharyngeus or just above the cardio-oesophageal junction, occasionally for several months. Strictures promote such capture and sticking.

Fundoplication
A surgical procedure often involving various degrees of wrapping the stomach around the lower end of the oesophagus, to aid in the treatment of hiatus hernia or reflux oesophagitis.

Fungal and Bacterial Lipase
Often contained in during preparation used to combat steatorrhea caused by pancreatic insufficiency and failure to produce endogenous lipase activity.

Fungal Infections of the Oesophagus organism
Can occur as monilial oesphagitis (an ulcerative pseudomembranous inflammation of the oesophagus) by Candida albicans or Torulopsis glabrata. Ordinarily found in patients whose resistance is lowered by disease or drugs e.g. those with lymphoma

or leukaemia on irradiation or anti-tumour therapy, those on antibiotic or steroid therapy, some patients with diabetes mellitus or aplastic anemia. Actinomycosis and histoplasmosis are also reported.

Gabexate Mesilate
A drug acting as an inhibitor of protein-degrading enzymes in pancreatitis and also used as an anticoagulant in haemodialysis.

Gastrectomy (total/subtotal)
Surgical excision of the stomach (in whole/ or in part.)

Gastric Acid Secretion Inhibitors with pancreatic enzymes.
In untreated pancreatic insufficiency there can be a significant reduction in formation of micelles of bile acids and lipid, causing lipid malabsorption. This is due to a lowered pH in the duodenum, which can be modulated to higher values by giving are inhibitor of gastric acid secretion such as cimetidine.

Gastric Atrophy (atrophic gastritis)
A condition where blood vessels can be seen branching through the gastric mucosa and which can exist throughout the body and fundus of the stomach.

Gastric Carcinoids
Small tumours recognised as malignant though allowing long survival. They are a heterogeneous collection of growths occurring anywhere in the gut except the oesophagus. Usually well-demarcated, small, plaque-like tumours appearing yellow in cut section.

Gastric Erosions
Damage to the mucus lining of the stomach by acid permitting potential injury to the gastric mucosa. Can occur by drugs (e.g. aspirin) or by infection by Helicobacter pylori.

Gastric Feeding
Feeding of patient directly into the stomach by tube.

Gastric hamartomas
An abnormal mixture of tissue indigenous to the organ involved. In the stomach they usually come from connective tissue, showing smooth muscle, nerves and epithelial elements.

Gastric Ischaemia
Insufficiency of blood supply to the stomach causing pain, vomiting and distension.

Gastric leiyomyoma and liposarcoma
A connective tissue tumour found in the stomach (see gastric polyps gastric stromal tumours).

Gastric polyps
Any circumscribed discrete tumour of the stomach, with varying histological characteristics (lipoma, adenoma or other small tumour).#

Gastric Stromal Tumours
Slow-growing tumours found deep in the stroma and submucosa of the stomach. Small tumours are asymptomatic but larger ones may ulcerate and bleed. Malignant tumours are those with local invasion or distant metastasis. Previously known as smooth muscle tumours (histologically spindle cell tumours of mesenchaymal origin).

Gastric Surgery for Obesity
Surgery involving reduction of the effective stomach volume available to food (e.g. gastric stapling).

Gastroenterostomy
A surgically created anastomosis (an opening between, or joining of, two or more channels, vessels, organs or spaces) between the stomach and small intestine.

Glucagon
A natural hormone that is an antagonist to insulin.

H pylori gastritis
Gastric inflammation caused by infection of the stomach by Helicobacter pylori.

Heparin
A naturally occurring substance (sulphated complex polysaccharide) especially in the liver, lung and in most cells. Used as an anti-coagulant by injection.

Hiatus hernia
An abnormal protrusion of part of the stomach through the oesophageal hiatus of the diaphragm into the thorax. Often associated with reflux of acid gastric contents into the lower part of the oesophagus.

Histamine H2- receptor therapy
Use of such substances to control gastric acid secretion.

Histamine H2-receptor antagonists (H2RA)
Substances that antagonise (inhibit) the promotion by histamine of increased heart rate and contractility and gastric acid secretion.

Intestinal metaplasia
Replacement of cells normal to the gastric epithelium with cells identical to those of the normal small intestine. A disorder causing gastritis, increasing in frequency with age and with increased levels of gastric atrophy (see).

Intra-operative and post-operative radiotherapy
Attempts to locally control unresectable pancreatic tumours by use of radiotherapy using electron team therapy during operation (intra-operative) or after (post-operative). Radiation during surgery permits higher doses to be delivered to the tumour, sparing other neighbouring structures such as kidney and duodenum. External radiotherapy is more likely to damage such structures unnecessarily.

Isovolaemic haemodilation
Intravenous replacement of fluid to retain adequate intravascular volume. Albumin may be also needed to sustain optimum viscosity and blood physical properties to maintain fluidity of red blood cells in the pancreatic circulation.

Lactose intolerance
The inability by some subjects to utilise the natural milk sugar lactose owing to the lack of the enzyme lactose.

Laparoscopy (peritoneoscopy)
Involves inflating the abdomen with carbon dioxide and passing a rigid peritoneoscope (apparatus for direct visualisation) into the peritoneal cavity through a small sub-umbilical incision.

Laser therapy
Use of an endoscope (see above) to introduce a laser beam directed at a target in the GI tract to destroy unwanted tissues.

Lexipafant
An antagonist of platelet-activating factor in the treatment of acute pancreatitis.

Lithotripsy
A technique for the destruction of gallstones in situ (extra-corporal shock wave therapy ESWL).

Longitudinal Pancreatico-jejunostomy
Surgery on the jejunum adjacent to the pancreas lengthways to open up the pancreatic duct after obstruction.

Lymphocyte gastro enteritis
Invasion of lymphocytes into the gastrointestinal tract under the influence of unknown primary inciting factors, and the resulting cytotoxicity causing injury to cells in the GI tract.

Maldigestion over to pancreatic disorders
This is usually due to a lack of the appropriate pancreatic secretions that contain important enzymes such as amylase for digestion of food.
Mallory-Weiss Tear

A mucosal tear at the oesophago-gastric junction due to forceful vomiting causing bleeding.

Ménétrièr Disease
A giant growth in size of the mucosal folds of the gastric mucosa associated with protein loss from the stomach and thus hypoproteinaemia.

Micronutrient Supplementation Treatment
Addition to the diet of vitamins, trace elements and other minerals to allay nutrient deficiency.

Multimodality Therapy
Use of a multi modal approach to patients with pancreatic cancer. Choice of procedures are related to the individual needs of the patient rather than being applied indiscriminately.

Nasogastric Aspiration
Removal of gastric juice and air from the stomach by a nasogastric tube (see above).

Naso-gastric feeding

Feeding of subject by tube through the nose to the stomach.

Necrosectomy
Surgical removal of necrotic tissue in the pancreas during acute pancreatitis.

Nitrates
A class of compounds used as coronary vaso-dilators.

Non steroidal anti-inflammatory drugs (NSAIDS)
Drugs (not adrenocortical steroids,) that relieve inflammation, by inhibition of prostaglandin synthesis (e.g. aspirin, ibuprofen and indomethacin).

Non-enteric coated preparations
Tablets etc not coated to resist gastric secretions.

Nutrition
Administrative of suitable food or other life-sustaining material to the subject.

Octroetide
A drug similar to the natural hormone somatostatin. It suppresses secretion of serotonin and gastrointestinal peptides and pancreatic polypeptides. It stimulates fluid and electrolyte absorption from the gastrointestinal tract. Inhibits severe diarrhoea.

Oesophageal Dilatation
Opening of the oesophageal tube by physical intervention (see various dilatation techniques).

Oesophageal Disease caused by systemic disease
Any disorder of the oesophagus caused indirectly by other diseases with primary effects elsewhere.

Oesophageal Diverticulae and Pseudodiverticulae
Pharygngeal pouches present with intermittent dysphagia and regurgitation in the elderly.

Oesophageal intramural haematoma
Bleeding into the oesophageal wall following a) a Mallory-Weiss tear (see above), at the distal end of the oesophagus or (b) haematologic disorders or impaired haemostasis from anticoagulants (occurring anywhere in the oesophagus).

Oesophageal perforation
This term is reserved for perforation of the oesophagus, usually in the cervical region during endoscopy (see above). Spontaneous perforation is caused by a sudden increase in oesophageal pressure, tearing through all layers of the left lateral wall of the oesophagus just above the diaphragm (Boerhaave's syndrome).

Oesophageal rings
Circumferential fibrous contraction in the middle or lower third of the oesophagus (usually diagnosed radiologically) e.g. Schatzki's ring.

Oesophageal Small cell carcinoma
A cancer of the mucosa where the cells poorly differentiated, small, round or spindle-shaped and certain little cytoplasm. Often seen in erosive early oesophageal carcinoma.

Oesophageal webs
Constrictions of the oesophagus by "web like" fibrous tissue causing dysphagia. Apparently of congenital origin from mis-development of the embryonic oesophagus (see also oesophageal rings).

Oesophagogastrectomy
Resection of the oesophagus (and stomach).

Open Fundoplication
Performance of fundoplication (see above) by open surgery as opposed to laparoscopic (see above) methodology.

Opioid Analgesic
Any substance that relieves pain by effects mediated through the same class of receptors as are acted upon by morphine.

Palliation
Treatment undertaken with the objective of relieving symptoms, particularly when these are painful and distressing, in the knowledge that it will not affect the outcome of the disease.

Pancreatic duodenectomy
A surgical division of the stomach between the antrum and body followed by trancal vagotomy (see above). Used in chronic pancreatitis where the principal locus of disease is the head of the pancreas with a small pancreatic duct in the gland.

Pancreatic Enzymes Inhibitors
Substances used to inhibit the action of enzymes released by the pancreas that cause inflammation. These include raw soybean meal, field beans and eggs to inhibit protease, (-glucosidase inhibitors to inhibit (-amylase and tetrahydrolipstatin (THL) to inhibit lipase (pancreatic and gastric).

Pancreatic Fistula
Abnormal connections between the pancreatic duct and epithelium. They can be caused by pancreatic trauma, external drainage of pseudocysts or operation on the pancreas. Traumatic fistulas often result from pancreatic injury over looked at initial operation.

Pancreatic Pseudocyst

Localised collections of pancreatic secretions that occur as a result of pancreatic inflammation. They are located in either the pancreatic parenchyma or one of the potential spaces separating the gland from the adjacent abdominal viscera.

Pancreatic Rests
In the stomach, the rest is usually submucosal, lying within 5 cm of the pyloric sphincter. Usually a sessile nodule 1-2 cm diameter with a centre or pit into which small ducts empty. They are benign lesions merely requiring excision.

Paracetamol (acetaminophen)
An important non-narcotic analgesic (pain-relieving). Less irritating to the stomach than aspirin but with no significant anti-inflammatory action.

Parenteral nutrition
Nutrition supplied by a route other than the alimentary tract.

Percutaneous Drainage
Use of aspiration via a fine needle surgically inserted through the abdomen for the drainage of e.g. pseudocysts or abscesses in the pancreas that may cause acute inflammation.

Percutaneous Endoscopic Gastrostomy
The placement of a tube for feeding a patient, made by penetration of the abdominal wall into the stomach, using an endoscope (see above). Often used in patients with chromic neurological disorders (e.g. stroke) who cannot swallow.

Peritoneal Lavage
A method of "washing out" ascitic fluid from the peritoneal cavity to remove activated pancreatic enzymes and toxins before they can be harmfully re-absorbed into the circulation. Used for acute pancreatitis.

Photodynamic Therapy
Intravenous administration of haematoporphyrin derivatives or dihaemato-porphyrin ether which selectively accumulates in tumour cells and, when actuated by a low-power laser results in fluorescence, cytotoxicity and tumour necrosis.

Platelet Aggregation Inhibitors
Substances that prevent aggregation of platelets and this tendency to form blood clots, and impedance of blood flop include aspirin, dipyrimadole, sulphinpyrazone and ticlopidine hydrochloride.

Pre-operative Radiotherapy for Pancreatic Cancer
Use of radiotherapy to limit growth of tumours before surgical operations are undertaken.

Primary oesophageal lymphoma
A neoplasia primarily affecting oesophageal lymph nodes.

Prokinetics
Enhancement of movement, contraction or emptying, especially applied to the stomach.

Protease Inhibitors
Substance (see above) that inhibit the action of protease enzyme.

Proton-pump inhibitor
An agent that inhibits the enzyme H+/K+-adenosine triphosphatase (proton pump) of the gastric parietal cell, providing dose-related inhibition of gastric acid secretion.

Pseudoaneurysm
An expansion in size of the Splenic artery associated with splenic vein thrombosis and caused by the blockage of blood flow resulting from the thrombolic event.

Psychotropics

Drugs affecting mental function.

Pyloroplasty
The surgical reformation of the pylorus, the narrow muscular tube connecting the stomach to the duodenum.

Pylorus-preserving pancreatic duodenectomy
As for standard pancreatic duodenectomy except that the pylorus of the stomach is not removed.

R2 Gastrectomy
Now known as D2. Less radical than RI (Dr), and involves the resection of nodal groups around the stomach, grouped in concentric rings, designated N1 and N2 by Japanese practice.

Radiation oesophagitis
As above, but caused as a secondary effect of radiation therapy.

Radiological Percutaneous Gastrostomy
Placement of tube for feeding a patient, made by penetration of the abdominal wall into the stomach, using radiological guidance.
Radiotherapy
The application of ionising radiation in the treatment of disease (almost entirely for the treatment of cancer).

Regional Pancreatectomy
This surgical operation for pancreatic cancer involves a total pancreatectomy (see) plus removal of portions of the portal vein and in some cases, of parts of the hepatic or superior mesenteric arteries.

Resection
The removal of all or part of an organ by surgery.

RI Gastrectomy

Now known as D1. Radical but not total, gastrectomy, normally applied for removal of a gastric cancer and lymph nodes within the surrounding 5 cm. Generally performed by Western, as opposed to Japanese surgeons.

Roux-en-Y
Surgical procedure designed to reduced possibility of bile reflux.

Roux-en-Y gastrojejunostomy
A surgical technique to permit drainage of the jejunum otherwise blocked by obstruction.

Sphincterotomy
Removal of gallstones impacted in the pancreatic ducts.

Splenectomy
Surgical removal of spleen in splenic vein thrombosis, especially where there is also left-sided portal hypertension and bleeding gastric varies.

Splenic Vein Thrombosis
A vascular anomaly in the splenic vein occurring in up to 60% of patients with chronic pancreatitis undergoing surgery. Can be suspected in all patients with pseudocysts in the body or tail of the pancreas.

Stent
A device for maintaining patency of tubes in the gastrointestinal tract.

Stent
A device inserted into the pancreatic duct to relieve obstruction caused by stones. A drain is also used to remove excess fluids.

Steroid(s)
Derivative(s) of perhydrocyclo-pentranophenanthrene: a more oxygenated product of cholesterol. Many such substances are natural hormones e.g. cortisone, aldosterone, oestradiol. Included in this group are chemically modified derivatives which may also process hormonal activity and are used therapeutically.

Stromal Cell Tumour
A tumour (benign or malignant) of neuro-ectodemal origin.

Subtotal Pancreatic Resection
Partial surgical removal of some of the pancreatic gland in cases of pancreatic cancer, where total removal is not required.

Sucralfate (Cerafate, sulcrate)
The aluminium salt of a sulphurated disaccharide. It is thought to form an adherent complex with albumin and fibrinogen at the site of an ulcer, protecting if from further damage by gastric acid. It also can from a viscous adhesive barrier on the surface of the gastric mucosa and duodenum.

Surgical Biliary Drainage, Percutaneous Transhepatic Biliary Drainage
Surgical or radiological intervention to release obstruction of bile ducts by placing a tube from the bile duct to the stein.

Surgical Drainage
Direct surgical intervention to promote drainage of above.

Surgical gastrostomy
Any procedure whereby the stomach is entered by surgery.

Surgical Myotomy
Enlargement of stricture e.g. in oropharyngeal dysphasia by surgical division of musculature.

Sympathetic Blockade
Use of drugs to inhibit the sympathetic nervous system in the pancreas.

Total Pancreatectomy
Surgical removal of the entire pancreas in cases of pancreatic cancer.

Tranexamic Acid
A drug inhibiting the actuation of plasminogen (this decreasing the conversion of plasminogen to plasmin (the enzyme that breaks down fibrin clots.) Used to inhibit haemorrhage.

Tropical Sprue
A syndrome similar to coeliac disease (see above) but occurring in tropical regions and is not caused by gluten and responds to vitamins and antibiotics.

Tumour Resection
Removal of tumours by surgery.
Vagotomy
The surgical division of one or both vagus (tenth cranial) nerves.

Viral Infections of the Oesophagus
In viral (herpetic) oesophagitis there is inflammation of the oesophagus associated with superficial ulceration, as a result of viral infection of the squamous cells of the oesophagus, particularly by herpes simplex virus.

Whipple's Disease
A chronic inflammatory disease of the bowel.

## Specialised register

**Inclusion criteria**
The specialised register for the group will include reports of trials in any language, in the prevention, treatment and rehabilitation of benign and malignant diseases of the upper gastrointestinal tract including disorders of the oesophagus, stomach, duodenum and pancreas.
Gastrointestinal adverse effects of certain treatments, for example NSAIDs, are also included in the register of clinical trials. Oesophageal and gastric varices are included by the Hepatobiliary group, pancreatic complications of cystic fibrosis are covered by the Cystic Fibrosis Group and these are therefore not included in the UGPD register. A full list of the subjects that are covered by the group's specialised register is given in the Topics list.

**Search strategies for the identification of studies**
***Electronic searches***
The UGPD Group searches The Cochrane Controlled Trials Register to identify controlled clinical trials for inclusion in the specialised register. Handsearching of specialist journals and conference proceedings are being carried out to uncover further studies. Relevant unpublished studies will be included where available.
The UGPD Group Search Strategy for The Cochrane Controlled Trials Register has been derived from MeSH subject headings of digestive system diseases and surgical procedures, which are relevant to the scope of the Group. Appropriate free text terms have been used in conjunction with the MeSH headings to identify reports of randomised and controlled clinical trials. This strategy is under development and further search terms will be added to ensure that all trials relevant to the scope of the UGPD Group are retrieved.
In particular, further work is required to ensure that treatments and all surgical interventions for the upper gastrointestinal tract and the pancreas are adequately covered by the search terms.
The Cochrane Controlled Trials Register is searched quarterly, after each new issue of the
Cochrane Library, using the following strategy.

1 ESOPHAGEAL-MOTILITY-DISORDERS*:ME
2 GERD OR GORD
3(GASTRO-OESOPHAGEAL OR GASTRO-ESOPHAGEAL OR GASTROESOPHAGEAL) NEAR
REFLUX
4 ESOPHAGITIS*:ME
5 (OESOPHAGITIS or ESOPHAGITIS)
6 #1 OR #2 OR #3 OR #4 OR #5
7 ESOPHAGEAL-NEOPLASMS:ME
8 OESOPHAG* OR ESOPHAG*
9 NEOPLASM* OR CANCER* OR CARCIN* OR MALIGNAN* OR TUMOUR* OR LYMPHOMA
10 #7 OR (#8 AND #9)
11 (STRICTURE OR NARROW*)
12 #11 AND #8
13 ACHALASIA
14 SPHINCTER NEXT PRESSURE
15 #13 OR (#14 AND #8)
16 DYSMOTILITY OR MOTILITY
17 #16 AND #8
18 ESOPHAGEAL-DIVERTICULUM:ME
19 DIVERTIC*
20 #18 OR (#19 AND #8)
21 RING* AND WEB*
22 (FUNGAL OR VIRAL OR BACTERIAL OR PARASITIC) AND (INFECTION OR INFECTIONS)
23 (#21 OR #22) AND #8
24 #6 OR #10 OR #12 OR #15 OR #17 OR #20 OR #23
25 ESOPHAGEAL-PERFORATION*:ME
26 PERFORAT* OR RUPTURE*
27 MALLORY NEXT WEISS
28 #27 OR #25 OR (#8 AND #26)
29 HEMATOMA:ME
30 HAEMATOMA OR HEMATOMA
31 (#29 OR #30) AND #8
32 ESOPHAGEAL-ATRESIA:ME
33 HERNIA-HIATAL:ME
34 HERNIA AND HIAT*
35 #32 OR #33 OR #34
36 ESOPHAGEAL-STENOSIS:ME

37 ESOPHAGEAL-FISTULA:ME
38 #36 OR #37
39 FISTUL*
40 OBSTRUCTION
41 FOREIGN-BODIES*:ME
42 #8 AND (#39 OR #40 OR #41)
43 #28 OR #31 OR #35 OR #38 OR #42
44 #24 OR #43
45 HELICOBACTER-PYLORI:ME
46 PYLORI
47 #45 OR #46
48 PEPTIC-ULCER*:ME
49 STOMACH OR GASTR* OR PEPTIC OR DUODEN*
50 ULCER*
51 ZOLLINGER-ELLISON
52 #48 OR #51 OR (#49 AND #50)
53 STOMACH-NEOPLASMS:ME
54 #53 OR (#9 AND #49)
55 STOMACH-DISEASES*:ME
56 GASTRITIS OR MENETRIER*
57 INTESTINAL AND METAPLASIA
58 #55 OR #56 OR #57
59 ATROPHY OR POLYP*
60 HAMARTOMAS OR ISCHEMIA OR LIPOMA OR LIPOSARCOMA
61 #49 AND (#59 OR #60 OR #22)
62 POSTGASTRECTOMY-SYNDROMES*:ME
63 DUMPING NEAR SYNDROME
64 #58 OR #61 OR #62 OR #63
65 CELIAC-DISEASE:ME
66 WHIPPLES-DISEASE:ME
67 SPRUE-TROPICAL:ME
68 LACTOSE-INTOLERANCE:ME
69 CELIAC OR WHIPPLE* OR (TROPICAL AND SPRUE) OR (LACTOSE AND INTOLER*)
70 #65 OR #66 OR #67 OR #68 OR #69
71 GASTROINTESTINAL-HEMORRHAGE*:ME
72 HEMORRHAGE OR HAEMORRHAGE OR BLEED* OR REBLEED*
73 PERFORAT* OR RUPTURE*
74 #71 OR ((#72 OR #73) AND #49)
75 DUODENAL-DISEASES:ME
76 AFFERENT-LOOP-SYNDROME:ME
77 #75 OR #76
78 DYSPEPSIA:ME
79 GASTROPARESIS
80 REFLUX OR EROSION
81 #80 AND #49
82 #78 OR #79 OR #81
83 #44 OR #47 OR #52 OR #54 OR #64 OR #70 OR #74 OR #77 OR #82
84 ENDOSCOPY-DIGESTIVE-SYSTEM:ME
85 DUODENOSCOPY:ME
86 GASTROSCOPY:ME
87 ESOPHAGOSCOPY:ME
88 CHOLANGIOPANCREATOGRAPHY-ENDOSCOPIC-RETROGRADE:ME
89 ERCP OR (ENDOSCOPIC AND RETROGRADE AND CHOLANGIOPANCREATOGRAPHY)
90 ENDOSCOP* OR DUODENOSCOP* OR GASTROSCOP*
91 #84 OR #85 OR #86 OR #87 OR #88 OR #89 OR #90
92 FUNDOPLICATION:ME
93 FUNDOPLICATION
94 #92 OR #93
95 DILATATION:ME
96 BALLOON-DILATATION*:ME
97 (((EDER-PEUSTOW or CELESTIN) or BALLOON) AND DILATATION)
98 #8 AND (#95 OR #96 OR #97)
99 DUODENOSTOMY:ME
100 ESOPHAGECTOMY:ME
101 ESOPHAGOPLASTY:ME
102 ESOPHAGOSTOMY:ME

103 ESOPHAGOGASTRECTOMY OR OESOPHOGASTRECTOMY
104 GASTRECTOMY:ME
105 ENDOSCOPIC AND MUCOSAL AND RESECTION
106 #99 OR #100 OR #101 OR #102 OR #103 OR #104 OR #105
107 BILROTH OR ROUX-EN-Y
108 ANASTOMOSIS-ROUX-EN-Y:ME
109 VAGOTOMY*:ME
110 VAGOTOMY AND (GASTROENTEROSTOMY OR PYLOROPLASTY)
111 GASTROENTEROSTOMY*:ME
112 #107 OR #108 OR #109 OR #110 OR #111
113 GASTROPLASTY:ME
114 GASTROSTOMY:ME
115 JEJUNOSTOMY:ME
116 GASTROJEJUNOSTOMY OR JEJUNOSTOMY
117 #113 OR #114 OR #115 OR #116
118 #106 OR #112 OR #117
119 #83 OR #91 OR #98 OR #118
120 ANTI-ULCER-AGENTS:ME
121 ANTIULCER NEXT AGENT*
122 ANTI-ULCER NEXT AGENT*
123 #120 OR #121 OR #122
124 HISTAMINE-H2-ANTAGONISTS:ME
125 HISTAMINE NEAR ANTAGONIST*
126 RECEPTOR* NEAR ANTAGONIST*
127 CIMETIDINE:ME
128 FAMOTIDINE:ME
129 NIZATIDINE:ME
130 RANITIDINE:ME
131 CIMETIDINE OR FAMOTIDINE OR NIZATIDINE OR RANITIDINE
132 #124 OR #125 OR #126 OR #127 OR #128 OR #129 OR #130 OR #131
133 OMEPRAZOLE:ME
134 (PROTON NEXT PUMP) NEAR INHIBITOR*
135 (PROTON NEXT PUMP) NEAR BLOCKER*
136 OMEPRAZOLE OR LANSOPRAZOLE OR PANTOPRAZOLE OR RABEPRAZOLE
137 #133 OR #134 OR #135 OR #136
138 PROKINETIC NEAR AGENT*
139 ERYTHROMYCIN OR DOMPERIDONE OR METOCLOPRAMIDE OR CISAPRIDE
140 ERYTHROMYCIN:ME
141 DOMPERIDONE:ME
142 METOCLOPRAMIDE:ME
143 #138 OR #139 OR #140 OR #141 OR #142
144 ALGINATES:ME
145 ALUMINUM-HYDROXIDE:ME
146 ALGICON OR ALGINATE*
147 CALCIUM-CARBONATE:ME
148 MAGNESIUM-HYDROXIDE:ME
149 MAGNESIUM-OXIDE:ME
150 SODIUM-BICARBONATE:ME
151 #144 OR #145 OR #146 OR #147 OR #148 OR #149 OR #150
152 ALTACITE* OR ASILONE*
153 GASTROCOTE* OR GAVISCON*
154 HYDROTALCITE* OR MAALOX*
155 MUCAINE
156 #152 OR #153 OR #154 OR #155
157 ALUMIN* NEXT HYDROXIDE*
158 CALCIUM NEXT CARBONATE*
159 MAGNESIUM NEXT HYDROXIDE*
160 MAGNESIUM NEXT OXIDE*
161 MAGNESIUM NEXT TRISILICATE*
162 SODIUM NEAR BICARBONATE*
163 SODIUM NEAR CARBONATE*
164 #157 OR #158 OR #159 OR #159 OR #160 OR #161 OR #162 OR #163
165 CARBENOXOLONE:ME
166 MISOPROSTOL:ME
167 SUCRALFATE:ME
168 MUCOSAL AND PROTECTING AND AGENT*

169 CARBENOXOLONE OR MISOPROSTOL OR SUCRALFATE
170 #165 OR #166 OR #167 OR #168 OR #169
171 MUSCARINIC-ANTAGONISTS:ME
172 DICYCLOMINE:ME
173 PIRENZEPINE:ME
174 PROPANTHELINE:ME
175 ANTIMUSCARINIC*
176 MUSCARINIC NEAR ANTAGONIST*
177 DICYCLOMINE OR METHANTHELINE OR PIRENZEPINE
178 PROPANTHELINE
179 #171 OR #172 OR #173 OR #174 OR #175 OR #176 OR #177 OR #178
180 #123 OR #132 OR #137 OR #143 OR #151 OR #156 OR #164 OR #170 OR #179
181 #119 or (#180 and (#49 or #8))

***Hand searching***

The UGPD has registered with the New England Cochrane Centre their intention to handsearch the following specialist journals:
Journals:
Acta Medica Austriaca 1990-
Cancer Research, 1980-
Alimentary Pharmacology and Therapeutics, 1987-
Canadian Journal of Gastroenterology. 1987-
Digestive Endoscopy. 1989-
European Journal of Gastroenterology & Hepatology. (1989-1994)
Helicobacter. 1996-
International Journal of Pancreatology. 1986-
Pancreas. 1986-
Conference Proceeding:
Digestive Disease Week. 1997 May 11-14; Washington DC.

Journals being handsearched by the Biomed project for the UGPD Group
The Biomed handsearching project is a three year project in which seven European Cochrane Centres collaborate to handsearch western European specialized health care journals. The Biomed project has undertaken to handsearch the following journals on behalf of the UGPD group:
Acta Endoscopia.
Acta Gastro-enterologica Belgica.
Annales de Gastroenterologie et d'Hepatologie.
Chirurgia Gastroenterologica.
Chirurgische Gastroenterologie
Endoskopie Heute.
Gastrum Patologia del Aparato Digestva.
Gastro-Enterologie Clinique et Biologie.
Gastro-Enterologia y Hepatologia.
Gastroenterologisches Journal.
Italian Journal of Gastroenterology and Hepatology.
Revisiones en Gastroenterologia.
Revista Andaluza de Patologia Digestiva.
Revista de la Asociacion Castellana del Aparato Digestivo.
Revista Espanola de Enfermedades Digestivas.
Revue Francaise de Gastro-enterologie.
Sociedad Valenciana de Patologia Digestiva

***Other strategies***

For each review a search strategy is produced based on relevant clinical terms agreed by the reviewer and the Trials Search Co-ordinator. The search strategy is constructed using a combination of Mesh terms and free text terms. All reports of randomised controlled trials identified whilst searching will be added to the Group's Specialised Register. Where applicable, the following information sources are searched using an individual search strategy developed for each review:
*The Cochrane Library*
Medline
Embase
Cinahl
Cancerlit
Web of Science
LILACS
PDQ
PsychINFO
AHMED

Current Contents
SIGLE

The following information sources are searched for all reviews:
National Research Register
Medical Research Council (MRC)
Center Watch.
Clinicaltrials.gov
Current Controlled Trials
TrialsCentral

The UGPD Group has been fortunate to receive bibliographies from Adam Harris (UK), Richard Hunt (Canada) and Jean Paul Galmiche (France), which have been searched and the relevant trials added to our specialised register.

***Planned searching activities***
We have identified several non-English language journals and conference proceedings which we feel may contain reports of trials relevant to our Group. These include Japanese Journal of Gastroenterology, Gastroenterological Society of Taiwan Journal, Endoskopie Heute, and many others. However, at present we are unable to identify handsearchers for these, accordingly we have not registered them on the Cochrane Handsearching Masterlist. If you are able to help us with searching non-English language journals, please contact our Trials Search Co-ordinator.

## Methods used in reviews

**Search strategies**
***Access to specialised register by reviewers***
The specialised register is available for all reviewers to consult through the Cochrane Library. However, to avoid duplication of searching activities and to provide reviewers with a comprehensive search of the database, the Trials Search Co-ordinator will liaise with reviewers to construct and develop search strategies for each review, to be carried out at the editorial base. Searches for updating reviews will be carried out at the editorial base by the Trials Search Co-ordinator on an annual basis.

***Additional search strategies***
The Trials Search Co-ordinator will work with the reviewer to create a specific search strategy for each reviewer, which will then be run in EMBASE, CINAHL, and BIDS ISI, in addition to the Cochrane Library. The UGPD Group also liaises with the Cancer Network when searching for reviewers with cancer related topics. In order to identify unpublished trials, experts in the field and pharmaceutical companies will be contacted for information, and, where applicable, the Internet will also be searched. Reports of trials found by these methods will be added to the UGPD register of trials. Reviewers should search citations in each trial report for additional trials.

**Study selection**
The UGPD Group recommends that the trials included are randomised, pseudorandomised or controlled clinical trials which compare the test intervention with placebo or standard treatment.
Other types of trials can be used where necessary
Selection of studies for inclusion in a review should be performed independently by more than one reviewer. The editorial base will assist with this if an independent reviewer cannot be found.
The editor assigned to the review will work to resolve differences in study selection between reviewers.

**Assessment of methodological quality**
Procedures for the assessment of methodological quality are under development.

Advice on standard criteria for assessing quality will be given by the editorial team. Examples of quality assessment checklists are available. Methods are described in the Cochrane Reviewers Handbook which is available from the editorial team, on the Cochrane library and via the Cochrane Web sites.
In general:
An accepted method of quality assessment should be used.
Quality should be independently assessed by more than one reviewer and the level of agreement should be reported in the review.
The editor responsible for the development of the review will resolve difference in quality assessment between reviewers.
Quality assessment will be reported in the methods and results sections of the review.

**Data collection**
The UGPD group recommends that the extraction of data is done independently by more than one reviewer. The editor responsible for the development of the review will resolve difference in data interpretation between reviewers. Data verification with the person responsible for the study will not normally be required other than where the data is unpublished or confirmation of results are required.
Data from RCTs that have not been published will be eligible for use in systematic reviews prepared by the UGPD group, subject to verification of data by the primary investigator. The UGPD Group will not routinely collect and analyse data on rare adverse events collected from non-RCTS.

**Analysis**
Statistical guidance is available from the editorial base (Statistical Editor: Liz Gardener).
Data entry to RevMan should be done using the double data entry facility which allows more than one reviewer to independently enter data. Where this cannot be done (e.g. single author review) the editorial base will work with the reviewer to ensure that data entry is accurate.
Policies on statistical methods are under development.
These will incorporate guidance derived from Section 8.5 of the Reviewers Handbook on Standard statistical methods and the use of confidence intervals.
Heterogeneity of trials and issues such as crossover trials will be addressed.

**Reporting of reviews**
Discussion and conclusions section
The strength of the evidence should be categorised using the hierarchy of evidence scale detailed in CRD report 4, available from the editorial base.

The applicability of the results should be commented on taking into account the applicability of the trials to use of the intervention in standard practice for treatment of the disorder. Cost benefit analysis will not be routinely performed.

The use of non-RCT derived data when discussing results and drawing conclusions should be commented on in this section. Where applicable, other reviews will be cross-referenced in this section.

Tables and figures
Information in the excluded and excluded trials tables should brief and structured to include the Study Identifier, Methods of the Trial, Participants, Interventions, Outcomes, and further Notes.

Studies in the excluded trials table should consist of those trials which were initially selected for assessment, but which later proved to be non-RCTs or ineligible for other reasons. Advice is available from the editorial team on the validity of trials for inclusion into the review.

Table of comparisons
Policies for the structure or order of outcomes are under development and depend to some extent on the outcomes we select as 'default' for this group.

The order of trials in the tables will be alphabetical, then by date. Trials will be named preferably by author surname (e.g. Smith 1998) or, where this is not possible, by trial group identifiers (e.g. Oesophageal Cancer Trials Collaborators Group OCTCG 1997).

There may be multiple publications from one trial. Such reports should be cross referenced to the original study, for example, a publication by Jones et al reporting data from the Oesophageal Trials Collaborators Group study of 1997, should be reported as Jones 1999 (OCTCG 1997).

Any factors which could be perceived as conflict of interest should be stated.

## Editorial process

**Titles**
Review authors are invited to submit tiles at any time. In order to reduce the risk of wasted effort, a title should always be registered with the Editorial Base before the review author starts work.

The preferred format is

[Intervention] in [disorder], and may specify in which population e.g. older people.

Newly registered titles will be publicised throughout the Cochrane Collaboration with the aim of increasing awareness of areas of potential common interest.

Protocols are normally expected within 6 months of acceptance of a title.

If more than one person proposes doing the same review then the UGPD Group will invite both persons to co-operate in the preparation of the review, either by working together, or by independently analysing data and comparing the results. The Co-ordinating Editor will work with the authors to resolve disagreements about authorship of a review.

Each review title will be assigned to a contact editor who will oversee the editorial process, supported by the editorial base in administrative matters, methodological issues and trials search and retrieval.

**Protocols**
The UGPD Group editorial team supports reviewers in the preparation of protocols by providing methodological advice, formulation and execution of search strategies, provision of RevMan software and other Cochrane Collaboration materials such as the handbook for reviewers and training and support as required on an ad hoc basis. Informal advice is available

through the Review Group Co-ordinator.

At least three referees are asked to provide comments on each protocol. In general these will be: a person with experience of Cochrane methodology, a clinical expert and a consumer. These referees are usually from outside the editorial team, but editors may be asked to provide referee comments for protocols other than those for which they have editorial responsibility. In the case of methodological difficult or clinically contentious issues, comments may be sought from additional peer referees.

Each review protocol will be assigned to a contact editor who will oversee the editorial process, supported by the editorial base in administrative matters, methodological issues and trials search and retrieval.

After comments from referees have been returned to the reviewer, the reviewer is asked to modify the protocol as appropriate and return this to the Review Group Co-ordinator with a commentary of the changes made and how these address the referees' comments.

Once approved by the contact editor, the editorial team will check and approve the protocol. Final approval for publication will be given by the Co-ordinating Editor. Copy editing will not be done routinely by the UGPD Group.

The UGPD Group's policy for resolving disagreements between the editorial team and reviewers or between the reviewers themselves about the content of the protocol will attempt to resolve such issues by informal discussion between all those involved in production of the protocol, including the editor assigned to the protocol. In the event of an unresolvable issue, the advice of the director of the UK Cochrane Centre will be sought.

Time between submission of protocol and receipt of the completed review should normally be two years or less. After this time, protocols will be judged to have 'expired' and will be removed from the Cochrane Library with a note to that effect in the What's New section.

Referees will be sent copies of the other referees' comments and the reviewer's response, once the protocol is approved for publication.

**Reviews**
The UGPD Group editorial team supports reviewers in the preparation of reviews by providing methodological advice, formulation and execution of search strategies, provision of RevMan software and other Cochrane Collaboration materials such as the handbook for reviewers and training and support as required on an ad hoc basis. Informal advice is available through the Review Group Co-ordinator.

At least three referees are asked to provide comments on each review, in general these will be: a person with experience of Cochrane methodology, a clinical expert and a consumer. These referees are usually from outside the editorial team, but editors may be asked to provide referee comments for reviews other than those for which they have editorial responsibility. In the case of methodological difficult or clinically contentious issues, comments may be sought from additional peer referees. Where possible comments will be sought from the same peer referees who commented on the protocol.

Each review will be assigned to a contact editor who will oversee the editorial process, supported by the editorial base in administrative matters, methodological issues and trials search and retrieval.

After comments from referees have been returned to the reviewer the reviewer is asked to modify the review as appropriate and return this to the contact editor with a commentary of the changes made and how these address the referees' comments.

Once approved by the contact editor, the editorial team will check and approve the review. Final approval for publication will be given by the Co-ordinating Editor. Copy editing will not be done routinely by the UGPD Group.

The UGPD Group's policy for resolving disagreements between the editorial team and reviewers or between the reviewers themselves about the content of the review will attempt to resolve such issues by informal discussion between all those involved in production of the review, including the editor assigned to the review. In the event of an unresolvable issue, the advice of the director of the UK Cochrane Centre will be sought.

Referees will be sent copies of the other referees' comments and the reviewer's response, once the review is approved for publication.

**Updating**
Review authors will obtain newly identified information which may be relevant to their review from the specialised register on an annual basis.

Reviews will be updated whenever new studies are identified. If no new trials are found at the annual update search, a note will be made on the published review to this effect.

Updates of reviews will not normally be subject to the peer referee process as described for reviews unless the conclusions of the review are substantially altered by the addition of new data.

Feedback

Brendan Delaney is the Feedback Editor appointed by the UGPD, and will oversee the process of dealing with comments and criticisms.

Out of date reviews
Policy to be developed.

Disagreements about updates
The UGPD Group's policy for resolving disagreements between the editorial team and review authors or between the review authors themselves about the updating of reviews will attempt to resolve such issues by informal discussion between all those involved in preparation of the review, including the editor assigned to the review. In the event of an unresolvable issue, the advice of the Director of the UK Cochrane Centre will be sought.

## Publications

Publications of Cochrane UGPD Reviews

Journal Articles/Book Chapters

Arnott S. et al. Preoperative radiotherapy in esophageal carcinoma: a meta-analysis using individual patient data. Int. J. Radiation Oncology Biol. Phys., 41 (3)579- 583. Also published as: Preoperative radiotherapy for esophageal carcinoma Tierney J. et al. *The Cochrane Library*.

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Delaney B. on behalf of the Dyspepsia Review Group. Increasing the impact of meta-analyses on decision-makers: adding cost information to a systematic review of the effectiveness of Helicobacter pylori eradication for non-ulcer dyspepsia. 3rd. Symposium on systematic reviews, Oxford July 4-6 2000.

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Wong K.S.R. Meta-analysis of Combined Chemotherapy and Radiotherapy for Esophageal Cancer. ASTRO, American Society of Therapeutic Radiation Oncology. San Antonio, TX. September 1999.

Plenaries and Workshops
Briggs A, Delaney BC; Schulpher M, Claxton K. Stochastic cost-effectiveness modelling. Society for Medical Decision Making. Chicago, Illinois, USA. October 21st 2003. (invited postgraduate course)

Delaney B.C. The role of quality of life measurement in the clinical assessment of GERD. Symptom assessment in reflux

disease. Marrakech, Morocco, 7-8th September 2002.

Delaney B.C. Test and treat strategies for H.pylori in the management of dyspepsia. Chris Silagy memorial lecture: The impact of systematic reviews on primary care. Kellog College, Oxford. 26th Sept 2002.

Delaney B.C. 'Pragmatic' RCTs : planning, conduct and analysis of RCTs with cost-effectiveness as the primary outcome. Epidemiology Grand Round, McGill University Health Centre, Montreal Canada, October 8th 2002.

Delaney B.C. A Bayesian approach to dyspepsia: working with uncertainty at the interface between research and practice. Invited lecture, Montreal, Canada 8th October 2002.

Delaney B.C. The Cochrane Collaboration and the evidence-base for managing dyspepsia. Gastroenterology Grand Round, Montreal General Hospital, Montreal, Canada. 9th October 2002.

Delaney B. Effectiveness of empirical treatments for undiagnosed dyspepsia. Primary Care Society for Gastroenterology Symposium at The British Society of Gastroenterology ASM, Birmingham, March 21-23, 2000.

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Delaney BC. Managing dyspepsia in primary care. XVIth International Workshop Gastrointestinal Pathology and Helicobacter. Stockholm 4-6 September 2003.

Delaney BC. Prevalence and epidemiology of GERD. Europe-Japan Joint Expert meeting, London, 22nd Sept 2003.

Delaney BC. Managing dyspepsia in Primary Care A new Cochrane individual patient data meta-analysis. (AGA Special Symposium) Digestive Disease week, New Orleans, USA 19th May 2004.

Delaney BC. Management of Dyspepsia. (invited talk) WONCA-Europe, Amsterdam 3 June 12004.

Delaney BC. Dyspepsia management: H pylori and beyond (invited talk). United European Gastroenterology week, Prague 27th Sept 2004.

Delaney BC. Approach to the patient with dyspepsia (lunch session). United European Gastroenterology week, Prague 28th Sept 2004.

Delaney BC. Dyspepsia: Test and treat. Takeda Satellite symposium:United European Gastroenterology week, Prague 28th Sept 2004

Delaney BC. Acute management of the patient with Gastroesophageal reflux disease: Workshop on Gastrointestinal Disease, Paris 21st Oct 2004

Incorporation of reviews into guidelines/discussion of reviews at meetings (e.g. consensus conferences)

NHS Executive Evidence Review: "Improving Outcomes in Upper GI Cancers". This evidence review has been published and used by the NHS Centre for Research and Development in the development of their manual: "Guidance on Commissioning Cancer Services: Upper GI Cancer". The Manual will, in turn, be used by Health Authorities to provide guidance in the commissioning of relevant services.

The review "Short-term treatment with proton pump inhibitors, H2-receptor antagonists and prokinetics for gastro-oesophageal reflux disease-like symptoms and endoscopy negative reflux disease" will be included in primary care guidelines by the European Society for Primary Care Gastroenterology.

The HTA Report: "Managing the Dyspeptic Patient" will be used as the evidence base for the production of guidelines by the British Society of Gastroenterology.

Dr R. Malthaner (UGPD editor and reviewer) and Dr Wong (UGPD reviewer) are contributing reviews of chemo- or radiotherapy as adjuvant or neoadjuvant therapy for oesophageal resectable cancer and took the lead in drafting and revising the Cancer Care Ontario Practice Guidelines Initiative, recently submitted to "Cancer Practice and Control".

Tierney, J The results of the pre-op RT in oesophageal cancer are included in the British Columbia Cancer Agency Cancer Management Guidelines for Gastrointestinal Cancer.
http://www.bccancer.bc.ca/HPI/CancerManagementGuidelines/Gastrointestinal/01.EsophagusAndCardia/Management/Localize

## References

## Additional information