Why we changed to a focused format?

Trusted evidence.
Informed decisions.
Better health.
Aims of changing review (and data) formats

1. Streamline the development and publication of Cochrane reviews
2. Improve author, editor and user experience
3. Innovate in how we share and use our content
Clear distinction between main article and supplementary materials

Consolidated author guidance and review templates pre-populated in RevMan

Moved to publishing standard reporting guidelines

New subheadings to improve consistency between Reviews and showcase integrity

New included studies and analyses table
# Summary of changes for 2023

## Study centric data
- Improved data management
- Import extracted data
- Data package export
- Data re-use

## Focused review format
- Subheadings
- PRISMA & templates
- Supplementary materials
- Included studies and analyses table

**Recommended but optional**

**All submissions to use from 1 April 2024**
Focus on fewer comparisons
A focused review involves

Technology

Processes

People
Innovate in how we share and use our content

Living reviews

Evidence surveillance

Enhanced CDSR content

Improved protocols

Enhanced CENTRAL

Focused review format

Study centric data (improved data management)
What it means for authors

- Work smarter in RevMan
- Simplified reporting and faster review development
- Greater impact of published Reviews
- Better showcase of the integrity of Cochrane evidence
- Faster editorial processing
- Faster production processing
Want to find out more?

Study centric data (improved data management)

Focused review format
Moving to publishing standard reporting guidelines
Benefits

1. It's simpler
2. It's more efficient
Cochrane's reporting template

Methods

Cochrane conduct standards: Setting eligibility criteria for inclusion studies in the review.
See 'Chapter 11', Section 11.2.4, of the Cochrane Handbook for Systematic Reviews of Interventions.

PREMB-20 (guidance 2.14): Describe and explain any amendments to information provided at registration in the protocol or the last update. Note (at the amendment start) all 3: the reason for the amendment. This includes adding new decisions about eligibility criteria or the addition of subgroup analyses. Report aspects of the protocol that were not implemented (e.g., because studies were not found).

State which randomisation and reporting guidelines were adhered to, for example:
We followed the Methodological Expectations for Cochrane Intervention Reviews when conducting the review and the Preferred Reporting Items of Systematic Reviews and Meta-Analyses (PRISMA) 2020 for the reporting. (As this is a protocol, in both, we followed the guidance until the end of the methods sections).

Criteria for considering studies for this review

Cochrane conduct standards: Setting eligibility criteria for inclusion studies in the review.
See 'Chapter 11', Section 11.2.4, of the Cochrane Handbook for Systematic Reviews of Interventions.

PREMB-20 (guidance 2.15): Specify the inclusion and exclusion criteria for the review and how studies were grouped for the systems, for types of studies participants, interventions and outcome measures, using the following subsections.

Types of studies

Specify all characteristics related to the types of studies used to decide whether a study was eligible for inclusion or exclusion in the review, which should focus on study design(s) features, region, as well as other characteristics, such as settings. Also specify report characteristics eligible for inclusion or exclusion in the review, such as year of dissemination, Language, and report status (for example, whether reports such as unpublished manuscripts and conference abstracts were eligible or not).

Provide rationale for any notable restrictions to study eligibility. For example, authors might explain that the review was restricted to...
Why use this template?

Submissions that follow this template will have a better chance of being accepted for publication. Please also refer to Cochrane's author guidelines.

This template will help you focus your review and report your findings concisely. Cochrane recommends you follow this general guidance:

- **Focus on a manageable scope.** Decide how to address the review objectives as early in the process as possible. Your findings should be easy for you to summarise and easy for users of Cochrane evidence to read. If you need to include multiple interventions or comparators outside a network meta-analysis in a series of pairwise meta-analyses, please consider whether you should split this review into more than one review.
- **Include the smallest number of comparisons** that address the main objectives (most often this is one, but can be more than one).
- **Include up to seven outcomes** within each comparison (these are your outcomes that are critical or important to users of the review).
- For reviews based on pairwise meta-analyses, there should be one summary of findings table for each relevant comparison that includes your (up to) seven critical and important outcomes for that comparison. Reviews which include a network meta-analysis may need to include one summary of findings table for each outcome.
- **Focus on comparisons and outcomes that users will find most useful in decision-making.** You must be able to summarise all of the comparisons in the Abstract (approx. 700 words).
How to use the reporting template
Does each section of my work follow the template?

Included studies

The new study added to this review update included 254 participants (Jackson 2018), meaning a total of nine studies met the eligibility criteria with a total of 1013 participants. Of all randomised participants, 50.4% had an exacerbation that led to use of the study inhaler.

Table 1 is a summary of included studies and synthesises key study characteristics important for interpreting the synthesises and full included studies details are available in Supplementary material 3.

Characteristics of studies

Studies conducted in Europe, North America, and Australia and published between 1996 and 2016. Five studies evaluated adult populations (1247 participants; 15 years), and four studies evaluated child or adolescent populations (776 participants; 15 years). Approximately 50% of randomised participants initiated the study inhaler (range 23% to 100%). The included studies reported treatment failure in a variety of ways, meaning we needed to make assumptions to allow us to combine data. All studies were published as full-text papers except for Weinheit 2009, for which study details and results were provided by the lead investigator.

Characteristics of participants

Details about the age range, gender, smoking status and asthma severity in participants in each study are shown in Supplementary material 4.

For the purpose of the subgroup analysis by age (children < 15 years versus adults ≥ 15 years), we classified four studies as having child populations (Lombardi 1998; Jackson 2018; Martinez 2011; Weinheit 2009) and five studies as having adult populations (FitzGerald 2004; Farquharson 2003; Harrison 2004; Offen 2005; Rice 2005). FitzGerald 2004 had a lower age limit of 13 years and we included it in the adult subgroup because the age range was more consistent with the adult studies and the mean age of participants was 32 years. Similarly, Martinez 2011 included adolescents up to 15 years and we classified it as a child population because the age range was more consistent with the other child studies and the mean age was 11.5 years. Mean participant age in the five adult studies ranged from 42 to 56 (median 46.5) years and mean participant range from the four paediatric studies ranged from 4 to 12 (median 6.1) years (we calculated a rough mean age of 7.6 from age group categories reported for Weinheit 2009). Inclusion criteria for each study are in Supplementary material 4.