Outcomes of Cochrane Skin Group Prioritisation Exercise 2017

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# METHODOLOGY

A comprehensive exercise in setting priorities for undertaking new Cochrane Skin Group (CSG) reviews was undertaken in the Spring of 2017. We used mixed methods to develop a prioritisation list. First we contacted professional societies, guideline development groups, healthcare commissioners, the CSG membership and patient representatives to ask for title suggestions. We then reviewed prioritisation exercises undertaken by the James Lind Alliance (JLA) and others and suggestions for further research made by national and international guideline groups. A list of the organisations contacted is shown in the Appendix, together with the questions asked.

In this summary document all suggestions received are summarised, grouped by skin disorder(s). First those disorders identified as carrying a significant global burden in the Global Burden of Disease (GBD) project (summary Figure below); and then ‘other’ skin disorders. GBD estimated the global burden of disease attributable to different categories of skin disease in 187 countries between 1990 and 2010 {Hay, 2014 #1293}. It should be noted that melanoma was not included in the GBD skin report.

In 2014 an assessment was made of how well the skin conditions highlighted in the GBD report are represented in CSG coverage {Karimkhani, 2014 #1294}. In our report we divide conditions into those which were found to be under-represented in CSG reviews, and those which were not thought to be under-represented.

Each skin condition or group of conditions is listed together with a summary of all suggestions received in the prioritisation exercise, and their attribution, followed where available by a summary of any Priority Setting Partnerships in relation to each disease, and research priorities identified by the UK National Institute for Health and Care Excellence (NICE). Existing CSG reviews relevant to the priority areas are included in the document, to help identify gaps. To make evaluation of this document easier, we have summarised areas which have been suggested as priorities and are not currently well covered by CSG reviews, in a brief paragraph at the end of the text for each skin condition.

## Global Burden of Skin Disease, measured as years lost to disability, per region



# SKIN DISORDERS ON THE GLOBAL BURDEN OF DISEASE ‘TOP 15’ LIST

## Acne (under-represented in CSG, in relation to GBD, in 2014 review)

### Cochrane Skin Group Prioritisation Exercise (2017) Questions:

* What is the most appropriate dose and duration of therapy for isotretinoin in treating acne? (BAD)

*Oral isotretinoin for acne #33 (review stage - post peer review)*

* What is the effect of isotretinoin on mood? (BAD)

*Oral isotretinoin for acne #33 (review stage - post peer review)*

* Oral interventions for acne vulgaris (Jelena Barbaric)

[*Minocycline for acne vulgaris: efficacy and safety*](http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD002086.pub2/abstract) *#05 2012*

* Topical interventions for acne vulgaris (Jelena Barbaric)

*Topical benzoyl peroxide for acne #149 (protocol published 2014)*

*Topical antibiotics for acne #152 (protocol published 2016)*

*Topical azelaic acid, salicylic acid, nicotinamide, sulphur, zinc and fruit acid for acne #155 (protocol published 2014)*

* Alternative and complementary medicine interventions for acne vulgaris (Jelena Barbaric)

[*Complementary therapies for acne vulgaris*](http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD009436.pub2/abstract) *#110 2015*

* What is the most cost-effective treatment for different grades of acne (Sue Jessop)

### James Lind Alliance Priority Setting Partnership identified 10 key research priorities in acne:

1. What management strategy should be adopted for the treatment of acne in order to optimise short and long-term outcomes?

2. What is the correct way to use antibiotics in acne to achieve the best outcomes with least risk?

3. What is the best treatment for acne scars?

[*Interventions for acne scars*](http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD011946.pub2/abstract) *#14 2016*

4. What is the best way of preventing acne?

5. What is the correct way to use oral isotretinoin (Roaccutane) in acne in order to achieve the best outcomes with least risk of potentially serious adverse effects?

6. Which lifestyle factors affect acne susceptibility or acne severity the most and could diet be one of them?

7. What is the best way of managing acne in mature women who may/may not have underlying hormonal abnormalities?

8. What is the best topical product for treating acne?

9. Which physical therapies, including lasers and other light based treatments, are safe and effective in treating acne?

[*Light therapies for acne*](http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007917.pub2/abstract) *#122 2016*

10. How long do acne treatments take to work and which ones are fastest acting?

### ACNE SUMMARY:

Several questions about acne treatment have been raised, which might be addressed through targeted updates of existing acne treatment reviews.

JLA priorities which are not currently covered include acne prevention, and the role of diet/lifestyle factors in prevention/management.

## Alopecia (under-represented in CSG, in relation to GBD, in 2014 review)

### Cochrane Skin Group Prioritisation Exercise (2017) Questions:

* Comparative efficacy of treatments for alopecia areata (AAD)
* Interventions for alopecia areata (PhD student, IMIBIC)

*Interventions for alopecia areata #30 2008 - being updated currently*

* Interventions for scarring alopecia (Sue Jessop)

### James Lind Alliance Priority Setting Partnership identified 10 key research priorities in alopecia areata:

1.What are the causes of alopecia areata? For example - medications, medical problems, lifestyle, vaccinations.

2.Are immunosuppressant therapies (for example- methotrexate, mycophenolate mofetil) better than placebo in the treatment of alopecia areata?

3.In alopecia areata, are biological therapies (including JAK inhibitors and anti-cytokine therapies) more effective than placebo in causing hair re-growth?

4.Are psychological interventions helpful in alopecia areata?

5.Can progression of alopecia areata be prevented by early diagnosis and treatment?

6.Do certain foods, vitamins or nutritional supplements improve hair re-growth in alopecia areata?

7.What can be learnt about alopecia areata from other autoimmune conditions?

8.In whom does alopecia areata hair loss progress and why?

9.Do any treatments have a long-term benefit in alopecia areata?

10.How effective are alternative therapies in alopecia areata?

### James Lind Alliance Priority Setting Partnership identified 10 research priorities for other hair loss disorders:

1.What is the most effective treatment for frontal fibrosing alopecia?

2.What are the causes of frontal fibrosing alopecia?- for example- dietary, genetic, autoimmune, skin care products, medications, hormonal, environmental, vaccination, infection.

3.What are the causes of female pattern hair loss?- for example- genetic, hormonal and childbirth, autoimmune, dietary, other medical conditions, environmental factors.

4.In all types of hair loss, are psychological therapies effective in improving patient outcomes?

5.In all types of hair loss, what outcome measures should be used to assess severity of hair loss, progression and impact on the individual?

6.Is spironolactone helpful in managing female pattern hair loss?

7.In all types of hair loss, does raising ferritin levels/replacing iron improve hair growth? And what is the optimal level of ferritin?

8.What is the most effective treatment for Lichen planopilaris?

9.In all types of hair loss, do certain diets or nutritional supplements (for example vitamin D) prevent or improve hair loss?

10.In female pattern hair loss, does hormone replacement therapy (HRT) halt progression of the hair loss compared to placebo?

[*Interventions for female pattern hair loss*](http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007628.pub4/abstract) *#123 2016*

*Non-surgical interventions for androgenic alopecia in men #48 (never published)*

### ALOPECIA SUMMARY:

Several questions about alopecia areata treatment have been raised, which might be addressed through targeted updates of the overarching review #30 which is currently being updated. Or review #30 could be split if it becomes unwieldy. AAD question suggests that a network meta-analysis may be useful.

JLA priorities which are not currently covered include treatment of other forms of alopecia including frontal fibrosing alopecia and lichen planopilaris, psychological, nutritional and alternative therapies for alopecia.

## Bacterial Infection (including impetigo) (under-represented in CSG, in relation to GBD, in 2014 review)

### Cochrane Skin Group Prioritisation Exercise (2017) Questions:

* Management of MRSA infection and MRSA colonization (hospital and community acquired) (AAD)

*Except for an unused title ‘Linezolid versus vancomycin for the treatment of complicated MRSA skin and soft tissue infections’, all MRSA titles are with Wounds Group*

* Interventions for the prevention of recurrent erysipelas and cellulitis (Natasha Rogers)

*Interventions for the prevention of recurrent erysipelas and cellulitis #136 (ready for copy-edit)*

* How should we treat extensive folliculitis (Sue Jessop)

*Unused title ‘Interventions for pseudofolliculitis, acne keloidalis, folliculitis decalvans and dissecting cellulitis’ #75*

### James Lind Alliance priority setting partnership for cellulitis identified the following key research priorities:

1. What are the best diagnostic criteria for cellulitis, and are they different for different patient groups (e.g. people with lymphoedema)?

2. How can healthcare professionals be best supported to accurately diagnose and manage cellulitis and to advise their patients in how to prevent relapses?\* (\* This topic includes the development of tests or tools to assist with the diagnosis and management of cellulitis)

3. What are the early signs and symptoms of cellulitis that can help to ensure speedy treatment?

4. When treating cellulitis, could a higher initial dose and / or longer course of antibiotics result in a quicker recovery and / or fewer relapses?

*Interventions for the treatment of cellulitis and erysipelas #56 (stalled)*

5. Is the duration, dose and method of administration of antibiotics needed to treat cellulitis related to patient characteristics (e.g. patients with diabetes, who are overweight or have swelling of the limb may require a higher dose/duration)?

6. Does rest / elevation during an episode of cellulitis help to speed up recovery and improve symptoms, compared to exercise/movement of the affected limb?

7. Is there a role for the use of compression garments / bandages on the affected limb during an episode (when tolerable), or immediately following an episode of cellulitis, to speed recovery and reduce complications and recurrence?

8. What is the best NON-antibiotic intervention for the prevention of cellulitis (e.g. skin care, foot care, moisturisers, antiseptics, life-style changes such as weight-loss and exercise, compression garments, treating athlete’s foot, complementary and alternative therapy)?

9. What type of patients are most likely to benefit from low-dose antibiotics to prevent repeated episodes of cellulitis?

10. How safe are long-term antibiotics for the prevention of recurrent cellulitis?

### BACTERIAL INFECTION AND SKIN INFESTATION SUMMARY:

Several questions about cellulitis treatment have been raised, especially non-antibiotic treatment strategies, which might be addressed through completion of #56 +/- targeted updates of #56.

JLA priorities which are not currently covered include diagnosis of cellulitis. Other areas not covered by current CSG reviews include treatment of folliculitis and non-surgical approaches to boils (abscesses).

## Leprosy (under-represented in CSG, in relation to GBD, in 2014 review)

No titles suggested in Cochrane Skin Group Prioritisation Exercise (2017).

### LEPROSY SUMMARY:

No titles suggested, and no PSP or other research priorities identified. Currently most leprosy reviews are undertaken within the Cochrane Infectious Diseases group. Existing Cochrane Skin Group titles areL

#60 Interventions for skin changes caused by nerve damage in leprosy

#100 Interventions for erythema nodosum leprosum

## Pruritus (under-represented in CSG, in relation to GBD, in 2014 review)

Cochrane Skin Group Prioritisation Exercise (2017) Questions*:*

* What is the role of antidepressants in treatment of pruritus (BAD)
* What is the role of phototherapy in treatment of pruritus (particularly PUO) (BAD)
* Efficacy and safety anti-pruritic agents in dermatology for generalized or localized pruritus (AAD)
* Safety of topical and systemic medications in elderly population (AAD)

### PRURITUS SUMMARY:

We have previously viewed pruritus as a symptom rather than a disease. Do we need to reconsider this, given BAD and AAD priorities and the place of Pruritus in the Global Burden of Disease?

## Urticaria (under-represented in CSG, in relation to GBD, in 2014 review)

### Cochrane Skin Group Prioritisation Exercise (2017) Questions:

* Non-antihistamine interventions for urticarial (BAD)

*Interventions for chronic spontaneous urticaria excluding antihistamines #143 (protocol published 2014)*

* Updates of H1-antihistamines for chronic spontaneous urticaria (2014) and Histamine-blocking (H2) drugs for hives (2012) (BAD)

*H1-antihistamines for chronic spontaneous urticaria #97 2014 (update underway?)* [*Histamine H2-receptor antagonists for urticarial*](http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD008596.pub2/abstract) *#45 2012*

### URTICARIA SUMMARY:

The suggested research questions are already covered.

## Atopic Dermatitis

### Cochrane Skin Group Prioritisation Exercise (2017) Questions:

* Efficacy and safety of topical and physical modalities (e.g. NBUVB) for atopic dermatitis (AAD)

*#29 Interventions for hand eczema (protocol 2003, making MECIR compliant…)*

*#148 Complementary and alternative medicine treatments for atopic eczema (protocol 2014)*

* Efficacy and safety of systemic therapies in atopic dermatitis (AAD) Effects of systemic immunosuppressive therapies for moderate-to-severe eczema in children and adults (Natasha Rogers)

*#154 Systemic immunosuppressive therapies for moderate-to-severe atopic eczema (protocol 2015, review submitted)*

* Food, environmental allergies and atopic dermatitis (AAD)

*#130 House dust mite reduction and avoidance measures for treating eczema (2015)*

*#128 Specific allergen immunotherapy for treatment of atopic eczema (2016)*

*#31 Dietary exclusions for established atopic eczema (2008)*

* Update of Dietary exclusions for improving established atopic eczema in adults and children (2008) (BAD; PhD student, IMIBIC)

*#31 Dietary exclusions for established atopic eczema (2008)*

* Research needs identified in guideline (see below) (NICE)
* Biological treatments for eczema (Jonathan Batchelor)

*Unused title Omalizumab (IgE blocking agent) for atopic eczema*

* Update of Oral evening primrose oil and borage oil for eczema (2013) (BAD)

*#53 Oral evening primrose oil and borage oil for atopic eczema (2013, stable)*

* Update of Dietary supplements for established atopic eczema in adults and children (2012) (BAD; PhD student, IMIBIC)

*#91 Dietary supplements for established atopic eczema (2012)*

* Update of Probiotics for treating eczema (2008) (BAD; PhD student, IMIBIC)

*#102 Probiotics for treating eczema (protocol 2008, review submitted)*

* Oral H1 antihistamines as ‘add-on’ therapy to topical treatment for eczema (Natasha Rogers)

*#115 Oral H1 antihistamines as monotherapy for eczema (was H1 Antihistamines for eczema) (2013, stable)*

*#145 Oral H1 antihistamines as ‘add-on’ therapy to topical treatment for eczema (protocol 2016, review submitted)*

* Different strategies for using topical corticosteroids for established eczema (Natasha Rogers)

*#141 Different strategies for using topical corticosteroids for established eczema (protocol 2012)*

* Interventions for prurigo nodularis (PhD student, IMIBIC)
* Endolysins for eczema (Amanda Roberts)
* Topical probiotics for eczema (Amanda Roberts)

*#102 Probiotics for treating eczema (protocol 2008, review submitted)*

### James Lind Alliance Priority Setting Partnership identified 4 key shared priorities:

1. What is the best and safest way of using topical steroids for eczema?

*#141 Different strategies for using topical corticosteroids for established eczema (protocol 2012)*

2. What is the long-term safety of applying steroids to the skin for eczema?

*#141 Different strategies for using topical corticosteroids for established eczema (protocol 2012)*

3. What role might food allergy tests play in treating eczema?

*#31 Dietary exclusions for established atopic eczema (2008)*

4. Which emollient is the most effective and safe in treating eczema?

*#124 Emollients for eczema (2017)*

### And 10 other research priorities:

1. What is the best psychological treatment for itching ⁄ scratching in eczema?

*#44 Psychological and educational interventions for atopic eczema in children (2014)*

*#167 Psychological and educational interventions for atopic eczema in adults (protocol submitted)*

2. What is the best way for people with eczema to wash: frequency of washing, water temperature, bath vs. shower?

3. What are the best and safest natural products to apply to the skin for eczema?

4. How much does avoidance of irritants and allergens help people with eczema?

*#130 House dust mite reduction and avoidance measures for treating eczema (2015)*

5. What is the role of diet in treating eczema: exclusion diets and nutritional supplements?

*#31 Dietary exclusions for established atopic eczema (2008)*

*#91 Dietary supplements for established atopic eczema (2012)*

*#102 Probiotics for treating eczema (protocol 2008, review submitted)*

*#53 Oral evening primrose oil and borage oil for atopic eczema (2013, stable)*

*#17 Chinese herbal medicine for atopic eczema (2013, stable)*

6. Which is most effective in the management of eczema: education programmes, GP care, nurse-led care, dermatologist-led care or multidisciplinary care?

*#44 Psychological and educational interventions for atopic eczema in children (2014)*

*#167 Psychological and educational interventions for atopic eczema in adults (protocol submitted)*

7. Which is safer and more effective for treating eczema: steroids or calcineurin inhibitors?

*#141 Different strategies for using topical corticosteroids for established eczema (protocol 2012)*

*#69 Topical tacrolimus for atopic dermatitis (2015)*

*#82 Topical pimecrolimus for eczema (2007)*

8. How effective are interventions to reduce skin infections in the management of eczema?

*#43 Interventions to reduce Staphylococcus aureus in the management of atopic eczema (2008 update underway)*

9. Which should be applied first when treating eczema, emollients or topical steroids?

*#141 Different strategies for using topical corticosteroids for established eczema (protocol 2012)*

*#124 Emollients for eczema (2017)*

10. What is the best and safest way of using drugs that suppress the immune system when treating eczema

*#154 Systemic immunosuppressive therapies for moderate-to-severe atopic eczema (protocol 2015, review submitted)*

*#146 Leukotriene receptor antagonists for atopic eczema (protocol 2014, post peer review)*

### NICE research uncertainties for eczema identified in 2007 were:

1. What is the optimal feeding regimen in the first year of life for children with established atopic eczema?

*#31 Dietary exclusions for established atopic eczema (2008)*

*#91 Dietary supplements for established atopic eczema (2012)*

2. Which are the best, most cost-effective treatment strategies for managing and preventing flares in children with atopic eczema?

*#141 Different strategies for using topical corticosteroids for established eczema (protocol 2012)*

*#69 Topical tacrolimus for atopic dermatitis (2015)*

*#82 Topical pimecrolimus for eczema (2007)*

*#124 Emollients for eczema (2017)*

3. What effect does improving the control of atopic eczema in the first year of life have on the long-term control and severity of atopic eczema and the subsequent development and severity of food allergy, asthma and allergic rhinitis?

*#172 Prospectively planned meta-analysis of skin barrier studies for the prevention of eczema and associated health conditions*

*#141 Different strategies for using topical corticosteroids for established eczema (protocol 2012)*

*#69 Topical tacrolimus for atopic dermatitis (2015)*

*#82 Topical pimecrolimus for eczema (2007)*

*#124 Emollients for eczema (2017)*

4. What are the long-term effects (when used for between 1 and 3 years) of typical use of topical corticosteroids in children with atopic eczema?

*#141 Different strategies for using topical corticosteroids for established eczema (protocol 2012)*

5. How effective and cost effective are different models of educational programmes in the early management of atopic eczema in children, in terms of improving adherence to therapy and patient outcomes such as disease severity and quality of life?

*#44 Psychological and educational interventions for atopic eczema in children (2014)*

*#167 Psychological and educational interventions for atopic eczema in adults (protocol submitted)*

### ECZEMA SUMMARY:

Some questions about eczema treatment have been raised which might be addressed through targeted updates of the reviews i.e. #31, #91, #102, #130, #141.

However despite the large number of Cochrane Reviews covering Eczema, there are a number of identified priorities which are not currently well covered:

Suggested questions from the prioritisation exercise which are currently poorly covered are: biologics for eczema treatment (the unused omalizumab title could be modified to cover this), physical modalities for eczema treatment (AAD; e.g. NBUVB), interventions for prurigo nodularis, and endolysins for eczema.

JLA priorities which are not currently covered include: the best way for people with eczema to wash, the best natural products to apply to the skin for eczema, relative safety and efficacy of topical corticosteroids and calcineurin inhibitors, most effective way of delivering eczema management.

NICE priorities which are not currently covered include comparative studies of different eczema treatments, different models of education programmes including cost effectiveness, and long term effects of eczema treatment during childhood especially with topical corticosteroids.

## Fungal infections of skin, nails and scalp

### Cochrane Skin Group Prioritisation Exercise (2017) Questions:

* Onychomycosis - efficacy of pulse regimens vs daily (AAD)

*Oral antifungal medication for toenail onychomycosis #67 (protocol 2012, review ready for copy-edit)*

* What are the most appropriate interventions for fungal infections of the scalp and nail (BAD)? With reference to existing reviews:

*Systemic antifungal therapy for tinea capitis in children #49 2016*

*Topical treatments for fungal infections of the skin and nails of the foot #04 2007 (being updated as two titles: #04 Topical and device-based treatments for fungal infections of the toenails (protocol published 2016) & #147 Topical treatments for athlete's foot (protocol published 2013)*

*Oral treatments for fungal infections of the skin of the foot #01 2012 (update underway)*

*Topical antifungal treatments for tinea cruris and tinea corporis (#140 review published 2014)*

*Oral potassium iodide for the treatment of sporotrichosis (#71 review published 2009; targeted update Interventions for cutaneous sporotrichosis will be published 2017)*

### FUNGAL INFECTIONS SUMMARY:

The questions raised are mostly covered, but fungal infections of fingernails or areas of skin other than the foot and scalp are not covered.

## Psoriasis

### Cochrane Skin Group Prioritisation Exercise (2017) Questions:

* Topical treatments for psoriasis (targeted update of Anne Mason’s 2013 review) (NICE; PhD student, IMIBIC)

*Topical treatments for chronic plaque psoriasis #66 2013*

* Combined betamethasone/calcipotriol foam for psoriasis (targeted update) (NICE)

*Topical treatments for chronic plaque psoriasis #66 2013*

* Biologics for psoriasis (network meta-analysis) (NICE; Jonathan Batchelor)

*Systemic pharmacological treatments for chronic plaque psoriasis: network meta-analysis #156 (protocol published 2015, review submitted)*

* Anti-TNF agents for paediatric psoriasis (PhD student, IMIBIC)

*Anti-TNF agents for paediatric psoriasis #137 2015*

* Preventive measures and stress reduction programmes for psoriasis (Carlos Monson)

*Complementary therapies for chronic plaque psoriasis #138 (protocol published 2014, review submitted); Lifestyle changes for treating psoriasis #161 (protocol published 2015)*

### NICE research uncertainties for psoriasis identified in 2012 were:

1. What is the impact of methotrexate compared with other approaches to care (for example other systemic non-biological or biological treatments) on risk of significant liver disease in people with psoriasis

*Systemic pharmacological treatments for chronic plaque psoriasis: network meta-analysis #156 (protocol published 2015, review submitted)*

*Oral fumaric acid esters for psoriasis #90 (2015)*

*Oral retinoids for psoriasis #93 (protocol underway)*

2. In people with psoriasis, does early intervention with systemic treatments improve the long-term prognosis of psoriasis severity, comorbidities (including psoriatic arthritis), or treatment-related adverse effects

*Methotrexate for psoriasis #83 (protocol published 2013)*

3. Do structured psoriasis-focused self-management programmes improve patient confidence, wellbeing and disease control compared with standard care

4. How should topical therapies be used to maintain disease control

*Topical treatments for chronic plaque psoriasis #66 2013*

### Other psoriasis reviews already published or in progress, but not suggested as priorities:

* *Interventions for guttate psoriasis #02 2000 (update by way of a new protocol published 2015*
* *Antistreptococcal interventions for guttate and chronic plaque psoriasis #16 2000 (update by way of a new protocol published 2015*
* *Narrow-band ultraviolet B phototherapy versus broad-band ultraviolet B or psoralen-ultraviolet A photochemotherapy for psoriasis #76 2013*
* *Balneophototherapy for chronic plaque type psoriasis #117 (protocol 2015, review submitted)*

Note that a Prioritisation Setting Partnership is ongoing for chronic plaque psoriasis, led by a team in Manchester. We plan to review priority titles for chronic plaque psoriasis when the PSP is completed.

### PSORIASIS SUMMARY:

The questions raised are mostly covered, or could be covered by targeted updates. As with eczema, there was a suggestion to evaluate the effects of early intervention (here with systemic treatments) on longer term outcomes including complications of disease and treatment.

## Skin Cancer – both Melanoma and Non-Melanoma

### Cochrane Skin Group Prioritisation Exercise (2017) Questions:

* Diagnostic accuracy of reflectance confocal microscopy for skin cancer (AAD)

*Reflectance confocal microscopy for the diagnosis of cutaneous melanoma in adults #164b; Reflectance confocal microscopy for the diagnosis of keratinocyte skin cancers in adults #165b (both to be published 2017)*

* Diagnostic accuracy of optical coherence tomography for skin cancer (AAD)

*Optical coherence tomography for the diagnosis of keratinocyte skin cancer in adults #165f (to be published 2017)*

* Treatment and chemoprevention of NMSC among high risk patients (e.g. patients post-transplantation, on chronic immunosuppression, or with history of severe sun damage) (AAD)

*Interventions for preventing non-melanoma skin cancers in high-risk groups #39 2007*

* Photoprotection and full body skin check for the general public: frequency, sunscreen safety, vitamin D, full body skin exam (AAD)

*Sun protection for preventing basal cell and squamous cell skin cancers #157 2016*

* Research needs identified in guideline (NICE; see below)
* Comparison of surgery versus radiotherapy for basal cell carcinoma (Barry Powell). *Interventions for basal cell carcinoma of the skin #26 2007 (update underway)*
* What are the most effective surgical margins for primary melanoma (Update of 2009 review).

*Surgical excision margins for primary cutaneous melanoma #35 2009 (update underway)*

* Efficacy of different surgical options (excision, amputation, Mohs) for nail tumors (AAD)
* Cutaneous Non HIV Kaposi (French Satellite)
* Screening for reducing morbidity and mortality in malignant melanoma (Jelena Barbaric)

*Screening for reducing morbidity and mortality in malignant melanoma #166 review submitted)*

* Educational programmes for primary prevention of skin cancer in developing country settings (Jelena Barbaric)

*#52 Educational programmes for primary prevention of skin cancer – review in progress but may require extra support*

* Interventions for cutaneous squamous cell carcinoma (Jonathan Kantor)

### NICE research uncertainties for skin cancer identified in 2015 were:

1. In people with reported atypical spitzoid lesions, how effective are fluorescence in‑situ hybridization (FISH), comparative genomic hybridization (CGH) and tests to detect driver mutations compared with histopathological examination alone in predicting disease‑specific survival

2. For people with lentigo maligna (stage 0 in sun‑damaged skin, usually on the face) how effective is Mohs micrographic surgery, compared with excision with a 0.5 cm clinical margin, in preventing biopsy‑proven local recurrence at 5 years

*Interventions for melanoma in situ, including lentigo maligna #86 2014*

3. In people treated for high‑risk stage II and III melanoma, does regular surveillance imaging improve melanoma‑specific survival compared with routine clinical follow‑up alone?

4. In people with stage I–III melanoma does vitamin D supplementation improve overall survival?

5. In people diagnosed with melanoma what is the effect of drug therapy to treat concurrent conditions on disease‑specific survival?

*Systemic treatments for metastatic cutaneous melanoma #03 2000 (being updated – submitted)*

*Sentinel lymph node biopsy followed by lymph node dissection for localised primary cutaneous melanoma #126 2015*

### SKIN CANCER SUMMARY:

Several of the questions raised are covered by the recent diagnostic accuracy reviews. Educational programmes for primary prevention of skin cancer in developing country settings (Jelena Barbaric) is partially covered by an ongoing review, but may need to be prioritised for support in order to deliver.

Areas not yet covered, which could be prioritised, include updating ‘#39 Interventions for preventing non-melanoma skin cancers in high-risk groups‘ (AAD); efficacy of different surgical options (excision, amputation, Mohs) for nail tumors (AAD); interventions for cutaneous non-HIV Kaposi (French Satellite) or cutaneous squamous cell carcinoma (Jonathan Kantor); regular surveillance imaging for high-risk stage II or III melanoma (NICE); vitamin D supplementation for stage I-III melanoma (NICE); interventions for treating concurrent conditions in people with melanoma (NICE); prognostic reviews on FISH versus CGH for atypical spitzoid lesions (NICE) and defining populations at high risk for melanoma (AAD).

## Viral infections of the skin (including molluscum contagiosum)

### Cochrane Skin Group Prioritisation Exercise (2017) Questions:

* Interventions for plantar wart (Jian Wang, Dermatologist, China)

*Topical treatments for cutaneous warts #12 2012 includes plantar*

Other areas already covered or in progress include:

*#58 Interventions for cutaneous molluscum contagiosum (update published 2017)*

*#12 Topical treatments for cutaneous warts (update published 2012)*

*#40 Interventions for treatment of herpes simplex labialis (cold sores on the lips) (protocol published 2011, team revived with new lead author 2016)*

*#92 Interventions for prevention of herpes simplex labialis (cold sores on the lips) (review published 2015)*

There is also one unused title in CSG ‘Systemic treatments (including homeopathy) for children with warts’

### VIRAL INFECTIONS SUMMARY:

The sole suggested research question is already covered.

# SKIN DISORDERS NOT ON THE GLOBAL BURDEN OF DISEASE ‘TOP 15’ LIST

## Please note that there is a summary of key proposed priorities which are not well covered in the current CSG review portfolio, for all diseases outside the GBD top 15, on page 22.

## Hidradenitis Suppurativa

James Lind Alliance Priority Setting Partnership identified these areas as key priorities for research:

1. What is the most effective and safe group of oral treatments in treating HS (e.g. antibiotics, hormonal treatments, retinoids, immunosuppressants, metformin, steroids)?

2. What is the best management of an acute flare?

3. What is the impact of HS and its treatment on people with HS (physical, psychological, financial, social, quality of life)?

4. How effective are biologics (etanercept, adalimumab, infliximab, ustekinumab) in treating HS?

5. Does early diagnosis and aggressive treatment influence the course of HS?

6. What is the best surgical procedure to perform in treating HS, e.g. incision and drainage, local excision, wide excision?

7. Which factors are useful in determining the prognosis (disease progression) of HS?

8. What is the best method of wound care after surgery or for active disease (e.g. skin grafts, secondary intention, dressings)?

9. To what extent is HS caused by genetic factors?

10. What is the best management of pain associated with HS?

*Interventions for hidradenitis suppurativa #81 2015*

### HIDRADENITIS SUPPURATIVA SUMMARY:

We could consider a prognosis review, and targeted updated of #81, to address the priorities rasied in the JLA PSP.

## Vitiligo

Cochrane Skin Group Prioritisation Exercise (2017) Questions:

* Interventions for vitiligo (PhD student, IMIBIC)

*Interventions for vitiligo #24 2015*

### James Lind Alliance Priority Setting Partnership identified key shared priorities:

1. How effective are systemic immunosuppressants in treating vitiligo?

2. How much do psychological interventions help people with vitiligo?

3. Which treatment is more effective for vitiligo: light therapy or calcineurin inhibitors?

4. How effective is ultraviolet B therapy when combined with creams or ointments in treating vitiligo?

5. What role might gene therapy play in the treatment of vitiligo?

6. How effective are hormones or hormone-related substances that stimulate pigment cells (melanocyte-stimulating hormone analogues, afamelanotide) in treating vitiligo?

7. Which treatment is more effective for vitiligo: calcineurin inhibitors or steroid creams⁄ ointments?

8. Which treatment is more effective for vitiligo: steroid creams ⁄ointments or light therapy?

9. How effective is the addition of psychological interventions to patients using cosmetic camouflage for improving their quality of life?

10. How effective is pseudocatalase cream (combined with brief exposure to ultraviolet B) in treating vitiligo?

### VITILIGO SUMMARY:

We could consider targeted updates of #24 to address the JLA PSP priorities.

## Dystrophic Epidermolysis Bullosa

Spanish Priority Setting Partnership identified these shared priorities (most important at the top):

* 1. Wound care for people with DEB.
* 2. Interventions for itch.
* 3. Interventions for reducing pain during procedures such as bathing.
* 4. Detection and treatment of neoplasms, especially squamous cell carcinoma.

*Interventions for preventing non-melanoma skin cancers in high-risk groups #39 2007*

* 5. Prevention or treatment of syndactyly.

*Interventions for inherited forms of epidermolysis bullosa #168 (protocol submitted)*

## Actinic Keratosis

Cochrane Skin Group Prioritisation Exercise (2017) Questions:

* Efficacy of PDT and other light-based devices for the treatment of actinic keratosis (AAD)
* Efficacy of topical medications in the treatment of actinic keratosis (AAD)
* Comparison of field therapy (eg 5-fu vs imiquimod vs PDT); efficacy for number of treatments, length of treatment, frequency of treatments (AAD)

*Interventions for actinic keratoses #34 2012 (update by way of a new protocol ‘Topical treatments for actinic keratosis of the head and neck’)*

## Ageing

Cochrane Skin Group Prioritisation Exercise (2017) Questions:

* Laser, light treatment and related modalities for skin ageing and photodamage (Miny Samuels and Khimara Naidoo)

*#11 Creams, lotions and chemical peels for skin photodamaging and ageing (protocol submitted 2017)*

*#150 Botulinum toxin for facial wrinkles (review submitted 2016)*

## Dermatomyositis

Cochrane Skin Group Prioritisation Exercise (2017) Questions:

* Intervention for cutaneous involvement in dermatomyositis erythema multiforme (acute and chronic form): (French satellite – already doing and could become a CSG review)

## Diagnostic methods

Cochrane Skin Group Prioritisation Exercise (2017) Questions

* Dermatoscopy for non neoplastic diseases and histology for inflammatory diseases (French satellite)

## Drug reactions

Cochrane Skin Group Prioritisation Exercise (2017) Questions:

* Interventions for DRESS (Drug Reaction with Eosinophilia and Systemic Symptoms) (French Satellite)
* What is the best treatment for severe drug reactions – may need to include observational studies (Sue Jessop)

*#07 Interventions for treatment of Stevens-Johnson Syndrome (SJS), Toxic Epidermal Necrolysis (TEN) and SJS/TEN overlap syndrome (protocol just submitted; previous version published 2002)*

*Unused title ‘Interventions for skin reactions associated with targeted anticancer treatments’ #134*

## Dysplastic Nevi

Cochrane Skin Group Prioritisation Exercise (2017) Questions:

* Management of dysplastic nevi (AAD)

## Genital dermatoses

Cochrane Skin Group Prioritisation Exercise (2017) Questions:

* Interventions for encouraging healthcare seeking behaviour in people with genital dermatoses (Gudula Kirtschig)

## Lichen Sclerosus

Cochrane Skin Group Prioritisation Exercise (2017) Questions:

* Interventions for lichen sclerosus, via update and extension of review on topical interventions for genitcal lichen sclerosus (Natasha Rogers; Gudula Kirtschig)

*Topical interventions for genital lichen sclerosus #108 2011; Gudula planning extended update which would need new protocol)*

## Ochre dermatitis

* Intense pulsed light for ochre dermatitis (Title suggestion from Professor Luis Nakano and a Brazilian team with experience in the Vascular group)

## Palmoplantar pustulosis

Cochrane Skin Group Prioritisation Exercise (2017) Questions:

* Interventions for palmoplantar pustulosis (BAD)

*Interventions for chronic palmoplantar pustulosis #06 2006 (update underway by way of new protocol published 2015)*

## Pemphigus/ Pemphigoid

Cochrane Skin Group Prioritisation Exercise (2017) Questions:

* Update of 2009 review on interventions for pemphigus (BAD)

*Interventions for pemphigus vulgaris and pemphigus foliaceus #106 2009 (update underway)*

* Update of review on interventions for bullous pemphigoid (Gudula Kirtschig)

*Interventions for bullous pemphigoid #18 2010 (Gudula plans to start update later this year)*

## Skin surgery

Cochrane Skin Group Prioritisation Exercise (2017) Questions:

* Surgical reconstruction after Mohs micrographic surgery (Jonathan Kantor)
* Suturing techniques for skin and soft tissue reconstruction (Jonathan Kantor)

## Vascular malformations

Cochrane Skin Group Prioritisation Exercise (2017) Questions:

* Interventions for vascular malformations of face (Dr via Cochrane Oral Health)
* Propranalol for infantile haemangiomas (Lisette WA van Suijlekom-Smit) –

*Interventions for infantile haemangiomas (strawberry birthmarks) of the skin #112 2011 (update submitted); Targeted update produced 2016*

### SUMMARY OF OTHER DISEASES OUTSIDE THE ‘TOP 15’:

We could consider:

* targeted updates of #34 to address the AAD actinic keratosis priorities i.e. comparisons of PDT, topical therapies
* a new review to address AAD priority ‘management of dysplastic nevi’
* French Satellite suggestions for dermatoymyositis, diagnostic methods and DRESS reviews
* prioritising #168 to address Spanish PSP priorities for dystrophic EB
* Gudula’s suggestion for promotion of healthcare seeking behaviour in people with genital dermatoses
* Jonathan Kantor’s surgery suggestions - surgical reconstruction after Mohs micrographic surgery, and suturing techniques for skin and soft tissue reconstruction
* Cochrane Oral Health’s suggestion interventions for vascular malformations of the face
* Khimara Naidoo’s suggestion laser, light treatment and related modalities for skin ageing and photodamage
* New title application intense pulsed light for ochre dermatitis

Other suggestions are generally covered by reviews or updates in progress.

## Suggestions received during prioritisation which are not within CSG scope

* What is the efficacy of PPP in preventing pregnancy during isotretinoin treatment (BAD).

*This systematic review of contraception is not within Cochrane Skin Group scope*

* Defining populations at high risk for melanoma (AAD)

*This systematic review of observational studies is not within Cochrane Skin Group scope*

# APPENDIX

i. Stakeholders contacted as part of prioritisation exercise:

World Health Organization

National Institute for Health and Care Excellence

American Academy of Dermatology, European Academy of Dermatology and Venereology,

European Dermatology Foundation, British Skin Foundation

National Eczema Society, L’Association Française de l’Eczéma, National Eczema Association (US and Australia), Nottingham support group for carers of children with eczema

Acción Psoriasis, Psoriasis International Network, Psoriasis Association, Psoriasis and psoriatic arthritis

Vitiligo Society, Hidradenitis Suppuritiva Trust, Alopecia UK

Skin cancer awareness

Cochrane child health field, Cochrane nursing field

UK Dermatology Clinical Trials mailing list, Cochrane Skin Group mailing list

ii. Prioritisation email sent to stakeholders:

‘We are writing to you as one of Cochrane Skin's key stakeholders. We would like to ask you if you would think about **what reviews or updates you would like us to prioritise over the next three years**. We are writing to a wide range of stakeholders, and we will gather your views together and then make a final shortlist with our international editors and feedback to you at that stage. We are open to suggestions of new review questions that are not already on our [existing list of reviews and protocols](http://cochrane.us12.list-manage.com/track/click?u=8fc937d46bf829bdead1e0f52&id=e9af3d9a6b&e=02b840d147) (click on 'Full list'). New reviews should be concerned with healthcare interventions. Now that we have good methodologists in our team, we are also interested in doing more methodologically challenging systematic reviews that involve techniques such as network meta-analysis, individual patient meta-analysis and diagnostic test accuracy reviews.

The Cochrane Skin Group has now been running for 20 years, and we are proud of the 100+ high quality systematic reviews that have been produced over that period. It is difficult to keep expanding on new and updated reviews year on year, as we only have so much capacity at the editorial base to manage the review process and ensure quality and relevance to a wide range of stakeholders. That means we will have to prioritise reviews much more in the future. Perhaps that will mean ending up doing less reviews, so we want to ensure that they are the reviews most needed by our stakeholders. We are particularly interested in reviews that are key to informing guidelines or policy, or that our funded by our stakeholders. We are also open to reviews that deal with the big problems in low to middle income countries, if we have not covered them already.

So for now, please let us know what you regard as **the most important topics** for us to prioritise as Cochrane Skin reviews in the next three years, listing a maximum of 5 specific questions listed in rank order (with 1 being most important and 5 being least important to you). Just send us back your suggestions via email and we will take it from there.’