

Bond University  
Research Repository



## Cochrane acute respiratory infections group's stakeholder engagement project identified systematic review priority areas

Scott, Anna Mae; Clark, Justin; Dooley, Liz; Jones, Ann; Jones, Mark; Del Mar, Chris

*Published in:*  
Journal of Clinical Epidemiology

*DOI:*  
[10.1016/j.jclinepi.2018.05.016](https://doi.org/10.1016/j.jclinepi.2018.05.016)

*Licence:*  
CC BY-NC-ND

[Link to output in Bond University research repository.](#)

*Recommended citation(APA):*  
Scott, A. M., Clark, J., Dooley, L., Jones, A., Jones, M., & Del Mar, C. (2018). Cochrane acute respiratory infections group's stakeholder engagement project identified systematic review priority areas. *Journal of Clinical Epidemiology*, 102, 63-68. <https://doi.org/10.1016/j.jclinepi.2018.05.016>

### General rights

Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

For more information, or if you believe that this document breaches copyright, please contact the Bond University research repository coordinator.

## Title

Setting research priorities in systematic reviews: Cochrane Acute Respiratory Infections Group's Stakeholder Engagement Project

## Authors

Anna Mae Scott<sup>(1)</sup>, Justin Clark<sup>(1,2)</sup>, Liz Dooley<sup>(2)</sup>, Ann Jones<sup>(2)</sup>, Mark Jones<sup>(2,3)</sup>, Chris Del Mar<sup>(1,2)</sup>

## Affiliations

<sup>(1)</sup> Centre for Research in Evidence-Based Practice, Bond University, Gold Coast, Australia

<sup>(2)</sup> Cochrane Acute Respiratory Infections Group

<sup>(3)</sup> University of Queensland School of Public Health, Brisbane, QLD, Australia

## Corresponding author

Anna Mae Scott

Centre for Research in Evidence-Based Practice (CREBP)

Bond University

14 University Drive

Robina, QLD 4226

Australia

Email: [ascott@bond.edu.au](mailto:ascott@bond.edu.au)

Phone: +61 449 780 762

## ABSTRACT

### **Objective**

Cochrane Acute Respiratory Infections (ARI) Group conducts systematic reviews of the evidence for treatment and prevention of ARIs. We report the results of a prioritisation project, aiming to identify highest priority systematic review topics.

### **Study design/setting**

The project consisted of 2 Phases. Phase 1 analysed the gap between existing RCTs and Cochrane Systematic Reviews (reported previously). Phase 2 (reported here) consisted of a two-round survey. In round 1, respondents prioritised 68 topics and suggested up to 10 additional topics; in Round 2, respondents prioritised top 25 topics from Round 1.

### **Results**

Respondents included clinicians, researchers, systematic reviewers, allied health, patients, and carers, from 33 different countries. In Round 1, 154 respondents identified 20 priority topics, most commonly selecting topics in non-specific ARIs, influenza, and common cold. 50 respondents also collectively suggested 134 additional topics. In Round 2, 78 respondents prioritised top 25 topics, most commonly in the areas of non-specific ARIs, pneumonia and influenza.

### **Conclusion**

We generated a list of priority systematic review topics, to guide the Cochrane ARI Group's systematic review work for the next 24 months. Stakeholder involvement enhanced the transparency of the process, and will increase the usability and relevance of the Group's work to stakeholders.

### **KEYWORDS:**

Acute respiratory infections, prioritisation, systematic reviews, stakeholders, Cochrane

## HIGHLIGHTS

### **Key findings**

- We analysed Cochrane Acute Respiratory Infections Group's register of randomised controlled trials, and identified 68 systematic review topics which had adequate volume of RCT evidence to systematically review but no corresponding Cochrane Review
- We prioritised 21 of those 68 topics in a two-round online survey involving a broad range of stakeholders

### **What this adds to what is known?**

- We present a new approach to prioritisation of Cochrane systematic review topics, which involves combining of the evidence/systematic review gap analysis, with stakeholder engagement

### **What is the implication and what should change now?**

- The prioritisation project will help to enhance the transparency of systematic review topic selection in the next 24 months,
- The involvement of stakeholders in the prioritisation project will help to increase the relevance of Cochrane Acute Respiratory Infections Group's work to a wide range of stakeholders

## 1. INTRODUCTION

Cochrane is a global initiative, which produces systematic reviews in 53 healthcare subject-focused Cochrane Review Groups (CRGs). Each CRG prepares systematic reviews in teams of healthcare professionals – together with researchers, consumers and patients – on a volunteer basis. Oversight is provided by editorial teams. The Cochrane Acute Respiratory Infections (ARI) CRG focuses on diseases such as the common cold, sore throat, tonsillitis, sinusitis, influenza, and acute otitis media, but also acute respiratory infections in patients in hospital, and in intensive care. It produces about 10 Cochrane systematic reviews and 8 updates each year.

CRGs function more actively than traditional editorial groups, by providing editorial support at every stage of the systematic review process and providing feedback to ensure that reviews are of the highest quality, while traditional journals usually have a greater focus on accepting or rejecting articles. Accordingly, not all systematic reviews proposed by author teams or requested externally, can be undertaken by CRGs due to limited resources. Deciding whether to accept or reject a review proposal can be straightforward – for example, the proposed author team has insufficient expertise to conduct a Cochrane review, or the proposed topic has already been covered in a Cochrane review. However, in some instances, it is necessary to support decisions to accept or reject proposals or commissions for Cochrane reviews. Many CRGs have therefore undertaken prioritisation exercises, using a variety of methods[1], including: online surveys; Delphi panels; workshops; evidence mapping; stakeholder partnerships; consultations with partner organisations, experts and other stakeholders; scoping exercises; searches of trial registries; horizon scanning; interviews with policy- and decision-makers; and combinations of these.[2-10]

We report here the results of Cochrane Acute Respiratory Infections Group’s prioritisation project, which consisted of two phases. Phase 1 was an analysis of the gap between existing RCT evidence and existing Cochrane Systematic Reviews [11]. Phase 2 consisted of a two-round survey to identify top 20 priority topics in the area of acute respiratory infections. The aim of the project was to identify the 20 highest priority systematic review topics in the area of acute respiratory infections, to guide the Group’s work for the next two years.

## 2. MATERIAL AND METHODS

This project consisted of 2 phases.

### 2.1. Phase 1

In phase 1, we analysed the ARI CRG's register of randomised controlled trials (RCTs), and compared this against the ARI CRG's systematic review topics list. The aim of this phase was to identify those systematic review topics (health condition and intervention) for which RCTs exist, but no corresponding Cochrane Review has been conducted. To achieve this, we analysed 157 Cochrane ARI Reviews and 5,393 ARI-specific RCTs from the Cochrane ARI trials register, and found that a substantial number (2174 or 41%) of RCTs had not been systematically reviewed. The number of systematic review topics with no Cochrane Review and an available RCT was 649 out of a total of 764 (85%). Phase 1 is completed and its results have been previously reported[11]

### 2.2. Phase 2

We report here on the results of Phase 2 of the prioritisation project. Of the 649 systematic review topics which lacked a Cochrane Review but had existing RCT evidence (identified in Phase 1), we excluded those topics for which the RCT evidence was limited (4 RCTs or fewer). This left 68 systematic review topics for inclusion in Phase 2. The aim of Phase 2 was to prioritise those topics, to identify top 20 priority systematic reviews. Phase 2 consisted of a two-round survey, implemented using the surveymonkey.com platform. Ethics approval for this project was obtained from the Bond University Ethics Committee, approval number 16129 (11 Sept 2017).

#### 2.2.1 Phase 2 Round 1

Round 1 survey consisted of 5 questions: 3 demographic questions and 2 questions pertaining to topic prioritisation (see Appendix A).

Questions 1-3 queried the respondents' professional identification (one of 13 possibilities including 'other'), country of residence, and email address to enable contact for Round 2, respectively.

Question 4 listed all of the systematic review topics that were identified in Phase 1, and for which 5 or more RCTs existed, but which lacked a Cochrane Systematic Review (n=68). Each topic provided the following information: health condition, intervention, and the number of existing RCTs. The respondents were asked to tick up to 20 topics they thought should be prioritised for systematic review by the Cochrane ARI Group. Question 5 allowed respondents to suggest up to 10 additional topics that respondents thought should also be prioritised for systematic review.

The survey opened on 27 October 2017 and closed on 24 November 2017. The link to the survey was disseminated to the Cochrane ARI Group's mailing list of systematic review authors and consumers, Cochrane Comms Network Digest and Cochrane Survey Round-Up page, the Cochrane Consumer Network, and Evidence-Based Healthcare (EBHC) mailing list. To ensure broad response from consumers and patients, we also contacted several consumer health groups in Australia (Health Consumers' Alliance of South Australia and Health Consumers Queensland disseminated survey link to their members), and disseminated the request and survey link to members of the Patient and Consumer Interest Group of Health Technology Assessment international (HTAi) for assistance with further dissemination of the survey to their own networks of patient groups.

The results of Round 1 were analysed to identify the top 25 systematic review topics – those that received the highest number of identifications as “priority” by respondents in Question 4. The systematic review topics nominated by respondents in Question 5 were checked against the Cochrane Library to identify whether a systematic review on that topic currently exists. Where a systematic review topic did not exist, and was suggested with sufficiently high frequency to match that from the top 25 topics, it was advanced to Round 2.

### **2.2.2 Phase 2 Round 2**

The Round 2 survey consisted of a single question, asking respondents to choose up to 10 topics they felt should be prioritised, from a list of top 25 topics that were identified in Round 1. We contacted only those participants who provided their email in Round 1. Round 2 opened on 13 December 2017, and closed 8 January 2018. One reminder email was sent on 20 December 2017. The responses were analysed to identify top 20 systematic review topics – i.e. those 20 topics that received the highest number of identifications as a “priority” by all participants.

## **3. RESULTS**

### **3.1 Round 1**

In Round 1, we received 154 responses; 6 minutes was typically spent by each participant to complete the survey.

#### **3.1.1 Question 1: Which of these best describes you?**

Respondents were asked to tick all the categories which applied to them or had applied to them within the past 12 months. Respondents who were not captured by the provided categories were

able to tick the 'other' box and free-type a response. Because respondents were able to tick more than one box, the responses do not add up to 100%.

One hundred and fifty four respondents answered this question, with the top responses being physician (41%), researcher (37%), and systematic reviewer (29%) (Table 1). Twenty three individuals self-identified as 'other', with the highest number of those responses including members of other professional groups (e.g. teacher, librarian, etc.) (n=6) and students (n=5). No respondents self-identified as research funders.

**Table 1: Professional affiliation of the respondents**

Professional affiliation	Responses n(%)
Physician	63 (41)
Researcher	57 (37)
Systematic reviewer (Cochrane or non-Cochrane)	44 (29)
Other (please type into a box below)	23 (15)
Patient with an acute respiratory infection	22 (14)
Member of a patient organisation (e.g. patient advocacy group, disease-specific organisation, etc.)	20 (13)
Carer of a patient with an acute respiratory infection	16 (10)
Guideline developer	13 (8)
Allied health (e.g. pharmacist, dietician, physiotherapist, etc.)	11 (7)
Health policy-maker	8 (5)
Decision-maker	3 (2)
Nurse	1 (1)
Research funder	0 (0)

### 3.1.2 Question 2: Where do you presently live?

One hundred and fifty four respondents answered this question. Respondents were broadly distributed geographically, representing 33 countries. The highest numbers of responses were obtained from European (n=63), North American (n=36) and Asian (n=25) countries, driven primarily by a large number of responses from the United Kingdom (n=24), Canada (n=21) and India (n=9), respectively. Sizeable number of responses were also obtained from Australia and Oceania (n=18). Fewer than 10 responses were obtained from countries in Africa (n=4) and South America (n=5) (Table 2).



**Table 2: Location of the respondents**

Country	Number of respondents
United Kingdom	24
Canada	21
Australia	16
United States	14
India	9
Spain	8
The Netherlands	8
Italy	5
Belgium	4
Brazil	4
France	4
China	3
Denmark	3
Germany	3
Japan	3
Unclear or unstated	3
New Zealand	2
Nigeria	2
Switzerland	2
Other countries (1 respondent each): Algeria, Colombia, Indonesia, Iran, Ireland, Israel, Malaysia, Mexico, Nepal, Philippines, South Africa, Sri Lanka, Sweden, Syria, Taiwan, Thailand	16

### **3.1.3 Question 3: Please provide your email address**

So that we could contact the respondents in round 2, we requested their email addresses. One hundred and forty six usable addresses were provided; non-usable responses included: “gmail” “a@a” “a”, etc.

### **3.1.4 Question 4: Identify up to top 20 priority systematic review topics**

Respondents were provided with a list of 68 potential systematic review topics. Each topic consisted of the following information: health condition, intervention, and the volume of existing RCT evidence. In order to pre-empt the guiding of responses by the volume of RCT evidence, the topics were listed alphabetically by health condition. Respondents were asked to tick up to 20 topics they thought should be prioritised.

One hundred and thirty three individuals answered this question – i.e. 21 of the respondents who completed questions 1-3 did not answer the question. The 20 topics that garnered the highest number of responses are presented in Table 3, below; the full list of 68 topics as prioritised by respondents is presented in Appendix B.

Each of the top 20 priority topics was selected by 25% or more respondents. “Acute respiratory infection non-specific” was the most frequently selected category – 7 of the topics selected as top 20 in Round 1 pertain to this. Influenza topics were the next most common (5 in the top 20), and common cold was third most commonly selected health condition (3 in the top 20). The interventions selected by the greatest number of respondents were: vitamins and supplements (including specific type of vitamin) (n=4); Nonsteroidal anti-inflammatory drugs (NSAIDs) (n=3); vaccination (n=3) (vaccination was also included in top 20 once as a ‘health condition’ – vaccination adverse events).

### **3.1.5 Question 5: Suggest up to ten further systematic review topics not listed in Question 4**

Respondents were asked to suggest up to 10 additional systematic review topics which were not listed in Question 4, but they thought should be prioritised. Of 154 respondents, 50 suggested at least one topic, and 34 suggested 2 topics – 2 respondents suggested 10 topics.

A total of 134 individual topics were suggested. Of those, 50 suggested topics could not be searched for existing systematic reviews in the Cochrane Library due to: insufficient information about health condition (e.g. too general a statement, such as “all” or “respiratory illnesses”); insufficient information about intervention (e.g. “treatment,” “anything,” or left unstated); falling outside the remit of the Cochrane ARI Group (e.g. smoking interventions, transplantation).

Eighty four topic suggestions were sufficiently detailed to search for existing systematic reviews in the Cochrane Library. The highest number of disease areas included: pneumonia (n=14), common cold (n=10), influenza (n=9) and pharyngitis/sore throat (n=8). The most commonly suggested interventions included: honey (n=8), steroids or corticosteroids (n=8), and antimicrobials or antivirals (n=7). The full list of searchable topics is provided in Appendix C, together with titles of existing Cochrane Systematic Reviews where available.

## 3.2 Round 2

In Round 2, respondents were presented with a list of top 25 topics identified in Round 1, and asked to tick up to 10 topics they think should be prioritised for Cochrane ARI Group systematic reviews; The survey was disseminated to 146 respondents who provided usable email addresses in round 1, and received 78 responses (53% participation rate).

We list the top 21 topics identified in Round 2 of the survey (Table 3); the full list is presented in Appendix D. Twenty one, rather than 20 topics are presented, as each of these topics was selected by at least 27% of the respondents; the 22nd topic was prioritised by 24% of respondents, thus top 21 formed a natural break point.

“Acute respiratory infection – non-specific” was the most commonly selected disease category – 6 topics selected; this was followed by pneumonia (n=3) and influenza (n=3). Amongst the top 21 priority topics, the most common interventions of interest were: antivirals (n=3), vaccination as intervention (n=3) (NB: also once chosen as ‘health condition’); complementary and alternative medicine (CAM) (n=2); vitamins specific or general (n=2); NSAIDs (n=2).

**Table 3: Systematic review topics prioritised by respondents in Round 1 and Round 2 of the survey**

Systematic Review Topic	RCTs*	Round 1		Round 2	
		Responses n (%)	Rank order	Responses n (%)	Rank order
ARI nonspecific – Vaccination	18	36 (26)	14 =	40 (51)	1
ARI nonspecific – Antiviral	10	34 (26)	14 =	36 (46)	2
ARI nonspecific – NSAIDs	36	50 (38)	1 =	34 (44)	3=
ARI nonspecific - Vitamins and supplements	19	42 (32)	6	34 (44)	3=
Influenza - Infection control	5	50 (38)	1 =	32 (41)	5=
Otitis media - Antitussive / decongestant / expectorant / mucolytic	23	--	--	32 (41)	5=
Pharyngitis / sore throat – NSAIDs	31	--	--	32 (41)	5=
Sinusitis - CAM	10	36 (27)	10 =	30 (38)	8
ARI nonspecific – Corticosteroid	8	48 (36)	4	28 (36)	9
Bronchiolitis - CAM	17	38 (29)	8 =	27 (35)	10
ARI nonspecific - Vitamin C	11	49 (37)	3	26 (33)	11=
Influenza - Diagnostic test	5	36 (27)	10 =	26 (33)	11=
Pneumonia - Delivery of healthcare	12	--	--	26 (33)	11=
Common cold – Antiviral	27	--	--	25 (32)	14=
Pneumonia – Antiviral	5	--	--	25 (32)	14=
Common cold - Nasal lavage	5	35 (26)	14 =	25 (29)	16=
Pneumonia - Humidification/steam	16	--	--	23 (29)	16=
Vaccination adverse effects – Anaesthetic	5	33 (25)	18 =	23 (29)	18
Streptococcus / "strep" – Vaccination	5	38 (29)	8 =	22 (28)	19
Bronchiolitis - Saline	12	--	--	21 (27)	20=
Influenza – vaccination reminder	17	40 (30)	7	21 (27)	20=
Common cold – Vitamins and supplements	5	45 (34)	5	--	--
Pharyngitis/sore throat – NSAIDs	31	36 (27)	10 =	--	--
Influenza - Vitamins and supplements	5	34 (26)	14 =	--	--
ARI nonspecific – Paracetamol	9	33 (25)	18 =	--	--
Influenza - NSAIDs	5	33 (25)	18 =	--	--

\*The number of RCTs in CENTRAL for which no corresponding Cochrane review has been conducted.

Abbreviations: NSAIDs – nonsteroidal anti-inflammatory drugs; CAM – complementary and alternative medicine; ARI – acute respiratory infection

## 4. DISCUSSION

We report here on the results of a priority-setting project undertaken by the Cochrane ARI Group. These priorities, together with the other priority setting exercises completed and underway, should enable a more objective approach to accepting or rejecting, and also for commissioning, Cochrane reviews for the ARI CRG.

The prioritisation exercise yielded 21 high priority systematic review topics in the area of acute respiratory infections. There was a surprising change in topic priorities between the two survey rounds – only 1 topic, NSAIDs for non-specific ARIs, remained in the top 3 after the second round. Two topics that were not included among the priorities in Round 1, were included as top 5 priorities in Round 2: antitussive/decongestant/expectorant/mucolytic for otitis media, and NSAIDs for pharyngitis. Reasons for the lack of consistency between rounds may include: different respondents nominating different priorities; problems with classification (the same term might be used differently by respondents – for example, some respondents may have nominated *ARI non-specific* interchangeably with *Common cold*); some terms may have been confusing to respondents (e.g. *sinusitis* is known to be a confusing clinical term covering many conditions); and simple whimsy (which might suggest that the different preferences change readily in those with weakly held choices).

The rank order of topics was unrelated to the amount of evidence (the number of RCTs in CENTRAL available for that topic). The highest volume of evidence (36 RCTs) was for *NSAIDs for nonspecific ARI*, which ranked 3rd in Round 2. However, we might not expect this, as we were asking what questions should be asked, rather than what questions had been asked (which might be influenced by commercial interests, and many other factors other than what the community wants answers to).

The approach we adopted to identifying the priorities has several limitations. First, the respondents were drawn from a large pool, including Cochrane authors, consumers, healthcare professionals, and others. Although the respondents are therefore likely to represent many differing viewpoints, the responses may suffer from response bias, and represent the viewpoints of those with a strong prior belief. Second, to ensure a large participation by consumers and patients, we targeted dissemination of the survey to Cochrane Consumer Network, and patient and consumer groups. However, the participation of individuals who self-identified as patients, members of patient organisations, and carers was low - 14%, 13% and 10%, respectively. However, because ARIs represent a group of

diseases which everyone experiences, it may be reasonable to assume that participants might respond as patients as well as researchers, clinicians and systematic reviewers. Finally, it is not possible to estimate the response rate in Round 1. However, this is not uncommon in multi-round prioritisation projects.[7, 12] Nevertheless, the 53% response rate in round 2, is 10% lower than response rates in similar two-round survey prioritisation exercises conducted by other Cochrane groups[5, 7] and may have exaggerated the biases noted above.

This prioritisation project also has some methodological strengths. First, we sought participants from a wide range of professional backgrounds, interests and viewpoints. Second, we implemented both rounds of the survey online, in order to control for show-of-hand bias, and feelings of intimidation or suggestibility that patients and consumers may feel in an open discussion such as a face-to-face workshop or focus group.[13] Finally, our approach to prioritisation was deliberately structured to include both pre-specified topics and an option for respondents to suggest additional topics. Prioritisation projects relying solely on respondents to write-in their proposed topics have been conducted,[7] or are currently in progress,[14] however, this approach has previously been found to yield a very large number of unanswerable questions. For example, a similar exercise by the Cochrane Tobacco Addiction Group found that of the 258 questions suggested by the respondents, 183 (or 71%) were unanswerable.[7] Nevertheless, a wide variety of approaches for prioritising systematic review topics have been successful both within Cochrane and in other contexts, and no single approach is preferred.[15, 16]

## **5. CONCLUSION**

This prioritisation exercise has successfully generated a list of priority systematic review topic to guide the systematic review work in the area of acute respiratory infections. The involvement of a wide range of stakeholders in the exercise will help to enhance the transparency of topic selection in the next 24 months, and increase the relevance of the Group's work to various stakeholders. Next, the Group is planning an analysis of the TRIP database, to estimate the frequency and types of questions that clinicians ask in the area of acute respiratory infections. Together with the present results, this should yield a fuller picture of the key issues and priorities in the area of acute respiratory infections.

## **Acknowledgements and thanks**

Thanks to Muriah Umoquit, Richard Morley, Jack Nunn, Marleen Kaatee, Jo Nanson, Karen Facey, Jessica Bean, Bing Guo, Vanessa Vowles, and Suzanne Wirges for their help with distributing the survey.

## **Funding source and its role**

This work was supported by NHMRC grant for the Centre for Research Excellence in Minimising Antibiotic Resistance from Acute Respiratory Infections (CREMARA), and NHMRC's The Cochrane Collaboration Round 7 Funding Programme. The funder had no involvement in study design; collection, analysis and interpretation of data; the writing of the report; and in the decision to submit the article for publication.

## **Conflict of interest**

AMS: salary paid from an NHMRC grant for the Centre for Research Excellence in Minimising Antibiotic Resistance from Acute Respiratory Infections.

JC, LD, AJ, MJ: None to declare

CDM: Funding from the NHMRC (Australia) and from a private donor for the Cochrane Collaboration ARI Group

## REFERENCES

1. Nasser M, Welch V, Tugwell P, Ueffing E, Doyle J, Waters E: **Ensuring relevance for Cochrane reviews: evaluating processes and methods for prioritizing topics for Cochrane reviews.** *Journal of clinical epidemiology* 2013, **66**(5):474-482.
2. Buckley BS, Grant AM, Glazener CM: **Case study: a patient-clinician collaboration that identified and prioritized evidence gaps and stimulated research development.** *Journal of clinical epidemiology* 2013, **66**(5):483-489.
3. Handoll HH, Stott DJ, Elstub LJ, Elliott JC, Kavanagh AL, Madhok R: **A framework for effective collaboration between specialist and broad-spectrum groups for delivering priority Cochrane reviews.** *Journal of clinical epidemiology* 2013, **66**(5):490-495.
4. Jaramillo A, Welch VA, Ueffing E, Gruen RL, Bragge P, Lyddiatt A, Tugwell P: **Prevention and self-management interventions are top priorities for osteoarthritis systematic reviews.** *Journal of clinical epidemiology* 2013, **66**(5):503-510.e504.
5. Li T, Ervin A-M, Scherer R, Jampel H, Dickersin K: **Setting Priorities for Comparative Effectiveness Research: A Case Study Using Primary Open-Angle Glaucoma.** *Ophthalmology* 2010, **117**(10):1937-1945.
6. Li T, Vedula SS, Scherer R, Dickersin K: **What comparative effectiveness research is needed? A framework for using guidelines and systematic reviews to identify evidence gaps and research priorities.** *Annals of internal medicine* 2012, **156**(5):367-377.
7. Lindson N, Richards-Doran D, Heath L, Hartmann-Boyce J: **Setting research priorities in tobacco control: a stakeholder engagement project.** *Addiction (Abingdon, England)* 2017, **112**(12):2257-2271.
8. Thomas KS, Batchelor JM, Bath-Hextall F, Chalmers JR, Clarke T, Crowe S, Delamere FM, Eleftheriadou V, Evans N, Firkins L *et al*: **Programme Grants for Applied Research: A programme of research to set priorities and reduce uncertainties for the prevention and treatment of skin disease.** In. Southampton (UK): NIHR Journals Library; 2016.
9. Tong A, Crowe S, Chando S, Cass A, Chadban SJ, Chapman JR, Gallagher M, Hawley CM, Hill S, Howard K *et al*: **Research Priorities in CKD: Report of a National Workshop Conducted in Australia.** *American journal of kidney diseases : the official journal of the National Kidney Foundation* 2015, **66**(2):212-222.
10. Welsh E, Stovold E, Karner C, Cates C: **Cochrane Airways Group reviews were prioritized for updating using a pragmatic approach.** *Journal of clinical epidemiology* 2015, **68**(3):341-346.
11. Alloo J, Vallath S, Del Mar C, Carter M, Thorning S, Clark J: **Determining the gaps between Cochrane reviews and trials of effectiveness of interventions for acute respiratory infections: an audit.** *Systematic Reviews* 2017, **6**(1):82.
12. Wale JL, Belizan M, Nadel J, Jeffrey C, Vij SL: **The Cochrane Library review titles that are important to users of health care, a Cochrane Consumer Network project.** *Health expectations : an international journal of public participation in health care and health policy* 2013, **16**(4):e146-163.
13. Nasser M, Welch V, Ueffing E, Crowe S, Oliver S, Carlo R: **Evidence in agenda setting: new directions for the Cochrane Collaboration.** *Journal of clinical epidemiology* 2013, **66**(5):469-471.
14. Hoekstra D, Mutsch M, Kien C, Gerhardus A, Lhachimi SK: **Identifying and prioritising systematic review topics with public health stakeholders: A protocol for a modified Delphi study in Switzerland to inform future research agendas.** *BMJ open* 2017, **7**(8):e015500.
15. Bero LA, Binder L: **The Cochrane Collaboration review prioritization projects show that a variety of approaches successfully identify high-priority topics.** *Journal of clinical epidemiology* 2013, **66**(5):472-473.



16. Viergever RF, Olifson S, Ghaffar A, Terry RF: **A checklist for health research priority setting: nine common themes of good practice.** *Health Research Policy and Systems* 2010, **8**(1):36.

## APPENDIX A – Survey Round 1

### Cochrane Acute Respiratory Infections Group Systematic Review Priority Setting Project

#### ABOUT YOU

1. Which of these best describes you? (Please tick **ALL** that apply/have applied to you within the last 12 months)

- Physician
- Nurse
- Allied health (e.g. pharmacist, dietician, physiotherapist, etc.)
- Health policy-maker
- Decision-maker
- Research funder
- Guideline developer
- Systematic reviewer (Cochrane or non-Cochrane)
- Patient with acute respiratory infection
- Carer of a patient with an acute respiratory infection
- Member of a patient organisation (e.g. patient advocacy organisation, disease-specific organisation, etc.)
- Researcher
- Other (please type in below)

2. In what country do you currently live? (Please type in below)

3. So that we may contact you for the second round, please type in your email address below. (If you wish to remain anonymous, please use a generic email address – e.g. Gmail, Hotmail, etc. – rather than your workplace email).

4. Please tick up to 20 topics that you think should be prioritised for a systematic review. The topics (health condition, intervention, existing volume of randomised controlled trial evidence i.e. RCTs) are listed below, alphabetically, by health condition.

Tick box	Health condition - Intervention - Volume of existing evidence (RCTs)
	Adenovirus - Vaccination - existing evidence: 6 Randomised Controlled Trials (RCTs)
	Acute respiratory infection: nonspecific - Nonsteroidal anti - inflammatory drugs (NSAIDs) - existing evidence: 36 RCTs
	Acute respiratory infection: nonspecific - Vitamin A - existing evidence: 23 RCTs
	Acute respiratory infection: nonspecific - Vitamins and supplements - existing evidence: 19 RCTs
	Acute respiratory infection: nonspecific - Vaccination - existing evidence: 18 RCTs
	Acute respiratory infection: nonspecific - Vitamin C - existing evidence: 11 RCTs
	Acute respiratory infection: nonspecific - Antiviral - existing evidence: 10 RCTs
	Acute respiratory infection: nonspecific - Paracetamol - existing evidence: 9 RCTs
	Acute respiratory infection: nonspecific - Zinc - existing evidence: 9 RCTs
	Acute respiratory infection: nonspecific - Corticosteroid - existing evidence: 8 RCTs
	Acute respiratory infection: nonspecific - Analgesic / antipyretic - existing evidence: 7 RCTs
	Acute respiratory infection: nonspecific - Immunoglobulin - existing evidence: 7 RCTs
	Acute respiratory infection: nonspecific - Antiseptic - existing evidence: 5 RCTs
	Acute respiratory infection: nonspecific - Mast cell stabiliser - existing evidence: 5 RCTs
	Bronchiolitis - Complementary and alternative medicine (CAM) - existing evidence: 17 RCTs
	Bronchiolitis - Saline – existing evidence: 12 RCTs
	Bronchiolitis - Antitussive / decongestant / expectorant / mucolytic – existing evidence: 6 RCTs
	Bronchiolitis - Vaccination – existing evidence: 6 RCTs
	Bronchiolitis - Antiviral - existing evidence: 5 RCTs
	Bronchiolitis - Immunotherapy - existing evidence: 5 RCTs
	Bronchitis, acute - Zinc - existing evidence: 7 RCTs
	Common cold - Immunotherapy - existing evidence: 34 RCTs
	Common cold - Antiviral - existing evidence: 27 RCTs
	Common cold - Analgesic / antipyretic - existing evidence: 7 RCTs
	Common cold - Flavinoid - existing evidence: 5 RCTs
	Common cold - Nasal lavage - existing evidence: 5 RCTs
	Common cold - Vitamins and supplements - existing evidence: 5 RCTs
	Infectious mononucleosis - Antiviral - existing evidence: 10 RCTs
	Influenza - Vaccination reminder – existing evidence: 17 RCTs
	Influenza - Immunotherapy – existing evidence: 13 RCTs
	Influenza - Diagnostic test – existing evidence: 5 RCTs
	Influenza - Infection control – existing evidence: 5 RCTs
	Influenza - Nonsteroidal anti - inflammatory drugs (NSAIDs) – existing evidence: 5 RCTs
	Influenza - Vitamins and supplements – existing evidence: 5 RCTs
	Meningitis - Antifungal – existing evidence: 7 RCTs
	Otitis media - Antitussive / decongestant / expectorant / mucolytic – existing evidence: 23 RCTs

	Otitis media - Antihistamine – existing evidence: 13 RCTs
	Otitis media - Complementary and alternative medicine (CAM) – existing evidence: 10 RCTs
	Otitis media - Corticosteroid – existing evidence: 9 RCTs
	Otitis media - Nonsteroidal anti - inflammatory drugs (NSAIDs) – existing evidence: 7 RCTs
	Otitis media - Delivery of health care – existing evidence: 6 RCTs
	Otitis media - Surgery – existing evidence: 5 RCTs
	Pharyngitis / sore throat - Nonsteroidal anti - inflammatory drugs (NSAIDs) - existing evidence: 31 RCTs
	Pharyngitis / sore throat - Antiseptic - existing evidence: 7 RCTs
	Pharyngitis / sore throat - Paracetamol - existing evidence: 6 RCTs
	Pharyngitis / sore throat - Analgesic / antipyretic - existing evidence: 5 RCTs
	Pharyngitis / sore throat - Immunotherapy - existing evidence: 5 RCTs
	Pharyngitis / sore throat - Vaccination - existing evidence: 5 RCTs
	Pneumonia - Humidification / steam - existing evidence: 16 RCTs
	Pneumonia - Delivery of health care - existing evidence: 12 RCTs
	Pneumonia - Suction - existing evidence: 11 RCTs
	Pneumonia - Complementary and alternative medicine (CAM) - existing evidence: 9 RCTs
	Pneumonia - H2 Antagonist (i.e. H2 blockers) - existing evidence: 9 RCTs
	Pneumonia - Antiseptic - existing evidence: 8 RCTs
	Pneumonia - Immunoglobulin - existing evidence: 7 RCTs
	Pneumonia - Oral care - existing evidence: 7 RCTs
	Pneumonia - Ventilation - existing evidence: 7 RCTs
	Pneumonia - Enteral nutrition - existing evidence: 6 RCTs
	Pneumonia - Granulocyte - colony stimulating factor (G - CSF) - existing evidence: 6 RCTs
	Pneumonia - Antiviral - existing evidence: 5 RCTs
	Pneumonia - Sucralfate - existing evidence: 5 RCTs
	Respiratory syncytial virus - Antiviral - existing evidence: 16 RCTs
	Respiratory syncytial virus - Vaccination - existing evidence: 15 RCTs
	Respiratory syncytial virus - Corticosteroid - existing evidence: 12 RCTs
	Respiratory syncytial virus - Immunotherapy - existing evidence: 5 RCTs
	Streptococcus / "strep" - Vaccination - existing evidence: 5 RCTs
	Sinusitis - Complementary and alternative medicine (CAM) - existing evidence: 10 RCTs
	Vaccination adverse effects - Anaesthetic - existing evidence: 5 RCTs

5. **OPTIONAL:** Please suggest up to 10 systematic review topics (acute respiratory condition and therapy) that are NOT listed in the table above, but you think should also be systematically reviewed, and state why this topic is important. For example: Garlic for the common cold, because it is believed that it works and would be good to see if it's true.

Topic 1: health condition, therapy, why this topic should be prioritised.

Topic 2: health condition, therapy, why this topic should be prioritised.

Topic 3: health condition, therapy, why this topic should be prioritised.

Topic 4: health condition, therapy, why this topic should be prioritised.

Topic 5: health condition, therapy, why this topic should be prioritised.

Topic 6: health condition, therapy, why this topic should be prioritised.

Topic 7: health condition, therapy, why this topic should be prioritised.

Topic 8: health condition, therapy, why this topic should be prioritised.

Topic 9: health condition, therapy, why this topic should be prioritised.

Topic 10: health condition, therapy, why this topic should be prioritised.

## APPENDIX B – Systematic review topics prioritised in Round 1 (Question 4)

Answer Choices	Responses N(%)
Acute respiratory infection: nonspecific - Nonsteroidal anti - inflammatory drugs (NSAIDs) - existing evidence: 36 RCTs	50 (38)
Influenza - Infection control – existing evidence: 5 RCTs	50 (38)
Acute respiratory infection: nonspecific - Vitamin C - existing evidence: 11 RCTs	49 (37)
Acute respiratory infection: nonspecific - Corticosteroid - existing evidence: 8 RCTs	48 (36)
Common cold - Vitamins and supplements - existing evidence: 5 RCTs	45 (34)
Acute respiratory infection: nonspecific - Vitamins and supplements - existing evidence: 19 RCTs	42 (32)
Influenza - Vaccination reminder – existing evidence: 17 RCTs	40 (30)
Bronchiolitis - Complementary and alternative medicine (CAM) - existing evidence: 17 RCTs	38 (29)
Streptococcus / "strep" - Vaccination - existing evidence: 5 RCTs	38 (29)
Common cold - Antiviral - existing evidence: 27 RCTs	36 (27)
Influenza - Diagnostic test – existing evidence: 5 RCTs	36 (27)
Pharyngitis / sore throat - Nonsteroidal anti - inflammatory drugs (NSAIDs) - existing evidence: 31 RCTs	36 (27)
Sinusitis - Complementary and alternative medicine (CAM) - existing evidence: 10 RCTs	36 (27)
Acute respiratory infection: nonspecific - Vaccination - existing evidence: 18 RCTs	35 (26)
Common cold - Nasal lavage - existing evidence: 5 RCTs	35 (26)
Acute respiratory infection: nonspecific - Antiviral - existing evidence: 10 RCTs	34 (26)
Influenza - Vitamins and supplements – existing evidence: 5 RCTs	34 (26)
Acute respiratory infection: nonspecific - Paracetamol - existing evidence: 9 RCTs	33 (25)
Influenza - Nonsteroidal anti - inflammatory drugs (NSAIDs) – existing evidence: 5 RCTs	33 (25)
Vaccination adverse effects - Anaesthetic - existing evidence: 5 RCTs	33 (25)
Bronchiolitis - Saline – existing evidence: 12 RCTs	32 (24)
Pneumonia - Delivery of health care - existing evidence: 12 RCTs	32 (24)
Pneumonia - Humidification / steam - existing evidence: 16 RCTs	30 (23)
Pneumonia - Antiviral - existing evidence: 5 RCTs	29 (22)
Otitis media - Antitussive / decongestant / expectorant / mucolytic – existing evidence: 23 RCTs	28 (21)
Acute respiratory infection: nonspecific - Zinc - existing evidence: 9 RCTs	27 (20)
Bronchiolitis - Antitussive / decongestant / expectorant / mucolytic – existing evidence: 6 RCTs	27 (20)
Pneumonia - Complementary and alternative medicine (CAM) - existing evidence: 9 RCTs	27 (20)
Bronchiolitis - Vaccination – existing evidence: 6 RCTs	26 (20)
Common cold - Immunotherapy - existing evidence: 34 RCTs	26 (20)
Bronchiolitis - Antiviral - existing evidence: 5 RCTs	25 (19)
Otitis media - Antihistamine – existing evidence: 13 RCTs	25 (19)

Answer Choices	Responses N(%)
Common cold - Analgesic / antipyretic - existing evidence: 7 RCTs	24 (18)
Otitis media - Complementary and alternative medicine (CAM) – existing evidence: 10 RCTs	24 (18)
Otitis media - Corticosteroid – existing evidence: 9 RCTs	24 (18)
Respiratory syncytial virus - Vaccination - existing evidence: 15 RCTs	24 (18)
Respiratory syncytial virus - Corticosteroid - existing evidence: 12 RCTs	24 (18)
Acute respiratory infection: nonspecific - Analgesic / antipyretic - existing evidence: 7 RCTs	23 (17)
Pneumonia - Ventilation - existing evidence: 7 RCTs	23 (17)
Respiratory syncytial virus - Antiviral - existing evidence: 16 RCTs	23 (17)
Pharyngitis / sore throat - Paracetamol - existing evidence: 6 RCTs	22 (17)
Pharyngitis / sore throat - Analgesic / antipyretic - existing evidence: 5 RCTs	22 (17)
Infectious mononucleosis - Antiviral - existing evidence: 10 RCTs	21 (16)
Influenza - Immunotherapy – existing evidence: 13 RCTs	21 (16)
Adenovirus - Vaccination - existing evidence: 6 Randomised Controlled Trials (RCTs)	20 (15)
Meningitis - Antifungal – existing evidence: 7 RCTs	20 (15)
Otitis media - Delivery of health care – existing evidence: 6 RCTs	20 (15)
Respiratory syncytial virus - Immunotherapy - existing evidence: 5 RCTs	20 (15)
Acute respiratory infection: nonspecific - Vitamin A - existing evidence: 23 RCTs	19 (14)
Pharyngitis / sore throat - Antiseptic - existing evidence: 7 RCTs	19 (14)
Otitis media - Nonsteroidal anti - inflammatory drugs (NSAIDs) – existing evidence: 7 RCTs	18 (14)
Acute respiratory infection: nonspecific - Immunoglobulin - existing evidence: 7 RCTs	17 (13)
Pharyngitis / sore throat - Vaccination - existing evidence: 5 RCTs	17 (13)
Acute respiratory infection: nonspecific - Antiseptic - existing evidence: 5 RCTs	16 (12)
Bronchitis, acute - Zinc - existing evidence: 7 RCTs	16 (12)
Pneumonia - Oral care - existing evidence: 7 RCTs	16 (12)
Bronchiolitis - Immunotherapy - existing evidence: 5 RCTs	13 (10)
Otitis media - Surgery – existing evidence: 5 RCTs	12 (9)
Pneumonia - H2 Antagonist (i.e. H2 blockers) - existing evidence: 9 RCTs	11 (8)
Pneumonia - Immunoglobulin - existing evidence: 7 RCTs	11 (8)
Pneumonia - Antiseptic - existing evidence: 8 RCTs	10 (8)
Acute respiratory infection: nonspecific - Mast cell stabiliser - existing evidence: 5 RCTs	9 (7)
Common cold - Flavonoid - existing evidence: 5 RCTs	9 (7)
Pneumonia - Granulocyte - colony stimulating factor (G - CSF) - existing evidence: 6 RCTs	9 (7)
Pneumonia - Sucralfate - existing evidence: 5 RCTs	8 (6)
Pharyngitis / sore throat - Immunotherapy - existing evidence: 5 RCTs	7 (5)
Pneumonia - Enteral nutrition - existing evidence: 6 RCTs	7 (5)
Pneumonia - Suction - existing evidence: 11 RCTs	6 (5)

## Appendix C – Additional priority systematic review topics suggested in Round 1

Health condition	Intervention	Additional information (if provided)	Existing Cochrane review?	Cochrane Systematic Review Title
Airway oedema	Epinephrine	For minimising	No	N/A
ARI	Inhaled corticosteroids	--	Yes	Corticosteroids for the common cold
ARI	Acupuncture	--	No	N/A
ARI	Honey	--	Yes	Honey for acute cough in children
ARI	Vitamin D	In children under 5	Yes	Vitamin D supplementation for preventing infections in children under five years of age – covers pneumonia
ARI	Physical interventions for reducing	An update	Yes	Exercise versus no exercise for the occurrence, severity and duration of acute respiratory infections
ARI	Samahan (Ayurvedic medicine)	--	No	N/A
Asthma	Immunostimulants	In children, for reduction of ARIs	Yes	Immunostimulants for preventing respiratory tract infection in children – last updated 2006
Asthma (acute)	Corticosteroids	--	Yes	Early use of inhaled corticosteroids in the emergency department treatment of acute asthma
Asthma (acute)	Immunotherapy	--	No	No
Bronchiolitis	Oxygen	--	Yes	Heliox inhalation therapy for bronchiolitis in infants
Bronchiolitis	Supportive care	In children	No	No
Bronchiolitis	Beta-agonists	--	Yes	Anticholinergic drugs for wheeze in children under the age of two years
Bronchitis (acute)	NSAIDs	As alternative to antibiotics	Yes	Non-steroidal anti-inflammatory drugs for the common cold
Bronchitis (acute)	Chest physiotherapy	--	Yes	Chest physiotherapy for pneumonia in adults and children
Bronchospasm	Inhaled corticosteroids.	Population: neonatal	No	No
Common cold	Honey	--	Yes	Honey and lozenges for children with non-specific cough
Common cold	Echinacea	As a prophylactic	Yes	Echinacea for preventing and treating the common cold



Health condition	Intervention	Additional information (if provided)	Existing Cochrane review?	Cochrane Systematic Review Title
Common cold	Green tea	--	No	No
Common cold	Herbal medicines	--	Yes	Chinese medicinal herbs for the common cold
Common cold	Honey	--	Yes	Honey and lozenges for children with non-specific cough
Common cold	Nasal irrigation	As a prophylactic	Yes	Saline nasal irrigation for acute upper respiratory tract infections
Common cold	Honey and tulsi	--	No	N/A
Common cold	Lemon	What form is most effective (lemon juice, lemon bits, etc.)	No	N/A
Common cold	Vitamin c	As a prophylactic	Yes	Vitamin C for preventing and treating the common cold
Common cold	Zinc	Timing – to either prevent or shorten duration	Yes	Zinc for preventing and treating the common cold
COPD	Long-acting bronchodilators	--	Yes	Bronchodilators delivered by nebuliser versus pMDI with spacer or DPI for exacerbations of COPD
Cough	Inhaled corticosteroids.	Population: children	Yes	Inhaled corticosteroids for subacute cough in children
Cough	Inhaled bronchodilators	Population: children	Yes	Bronchodilators for bronchiolitis
Dysphagia	Prokinetic agents	For preventing bronchoaspiration	No	N/A
Endocarditis	Addition of aminoglycoside to beta-lactam	--	Yes	A comparison of different antibiotic regimens for the treatment of infective endocarditis
Influenza	Masks	As means of reducing transmission	Yes	Physical interventions to interrupt or reduce the spread of respiratory viruses
Influenza	Vaccine harms	--	Yes	Vaccines for preventing influenza in healthy adults – contains harms information
Influenza	Vaccine harms	--	Yes	Vaccines for preventing influenza in healthy adults – contains harms information
Influenza	Vaccine harms	Does vaccine cause a 'common cold' type reaction	Yes	Vaccines for preventing influenza in healthy adults – contains harms information
Influenza	Vaccine	--	Yes	Vaccines for preventing influenza in healthy adults

Health condition	Intervention	Additional information (if provided)	Existing Cochrane review?	Cochrane Systematic Review Title
Influenza	Antiviral	Prophylaxis in aged care facilities	No	N/A
Influenza	Ventilatory support	--	No	N/A
Influenza	Vaccine effectiveness.	Population: patients taking methotexate	No	N/A
Influenza	Self-management approaches	--	Yes	Saline nasal irrigation for acute upper respiratory tract infections
Influenza and URI	Vitamin C	--	No	N/A
Nasal congestion	Nasal cleaning with saline solution	--	Yes	Nasal saline irrigations for the symptoms of chronic rhinosinusitis
Nasal congestion	Saline nasal spray	--	Yes	Nasal saline irrigations for the symptoms of chronic rhinosinusitis
Otitis media	Corticosteroids	--	Yes	Systemic corticosteroids for acute otitis media in children
Otitis media	Nasal cleaning with saline solution	--	No	N/A
Otitis Media (Acute)	Antibiotics	Setting: developing countries	No	General reviews exist in this area but none are specific to developing countries
Otitis Media (Acute)	Topical decongestants	--	Yes	Decongestants and antihistamines for acute otitis media in children
Otitis Media (Acute)	Antibiotics	Population: children	Yes	Antibiotics for acute otitis media in children
Pharyngitis	Honey	Population: adults	Yes	Over-the-counter (OTC) medications for acute cough in children and adults in community settings
Pharyngitis	Honey	--	Yes	Honey for acute cough in children
Pharyngitis (sore throat)	Salt solution	To decrease the infection going down in the lungs	Yes	Saline nasal irrigation for acute upper respiratory tract infections
Pharyngitis (sore throat)	Honey	As a prophylactic	Yes	Honey for acute cough in children
Pharyngitis (sore throat)	Honey	--	Yes	Honey for acute cough in children

Health condition	Intervention	Additional information (if provided)	Existing Cochrane review?	Cochrane Systematic Review Title
Pharyngitis (sore throat) and tonsillitis	Antiseptic/analgesic gargles	--	Yes	Oral rinses, mouthwashes and sprays for improving recovery following tonsillectomy
Pneumonia	Molecular diagnostics, targeted treatment	--	No	N/A
Pneumonia	Home based newborn care programme	For minimising pneumonia	No	N/A
Pneumonia	Diet	Role in recovery	No	N/A
Pneumonia	Walking in fresh air	Role in recovery)	No	N/A
Pneumonia	Humidification	As adjuvant therapy	No	N/A
Pneumonia	Antibiotic harms	E.g. cardiotoxicity of macrolides	Yes	Protocol - Adverse events in patients taking macrolide antibiotics versus placebo for any indication
Pneumonia	RSV antiviral treatment.	Population: adults	Yes	Monoclonal antibody for reducing the risk of respiratory syncytial virus infection in children
Pneumonia	Steroids	--	Yes	Corticosteroids for pneumonia
Pneumonia	Poststenotic treatment	--	No	N/A
Pneumonia	Duration of antibiotic therapy	--	Yes	Short-course versus prolonged-course antibiotic therapy for hospital-acquired pneumonia in critically ill adults
Pneumonia	Poststenotic treatment	--	No	N/A
Pneumonia (CAP)	Anti-influenza antivirals or not	--	Yes	Amantadine and rimantadine for influenza A in children and the elderly
Pneumonia (CAP, HAP and VAP)	Duration of antibiotic therapy	--	Yes	Short-course versus prolonged-course antibiotic therapy for hospital-acquired pneumonia in critically ill adults
Pneumonia (severe, community acquired)	Macrolides vs quinolones	--	Yes	Empiric antibiotic coverage of atypical pathogens for community-acquired pneumonia in hospitalized adults
Respiratory distress syndrome (acute)	ECMO	--	Yes	Extracorporeal membrane oxygenation for critically ill adults

Health condition	Intervention	Additional information (if provided)	Existing Cochrane review?	Cochrane Systematic Review Title
Respiratory illness	Echinacea	As a prophylactic	Yes	Echinacea for preventing and treating the common cold
Respiratory virus transmission	Copper	For reducing of transmission	No	N/A
Rhinosinusitis	Criteria for clinical diagnosis	--	No	N/A
Rhinosinusitis (acute)	Herbal medicine	--	Yes	Chinese medicinal herbs for the common cold, nothing rhinosinusitis specific
Sinusitis	Netipot	--	Yes	Saline irrigation for chronic rhinosinusitis
Sinusitis	Oxymetazoline	--	Yes	Nasal decongestants in monotherapy for the common cold
Sinusitis	Inhaled nasal corticosteroids	--	Yes	corticosteroids for acute sinusitis
Sinusitis	Essential oils	--	No	N/A
Sinusitis (acute)	Nasal corticosteroids	--	Yes	Systemic corticosteroids for acute sinusitis
Sinusitis (acute)	Saline irrigation	--	Yes	Saline irrigation for chronic rhinosinusitis
Sore throat	Rapid tests	To reduce AB prescription in these patients	Yes	Rapid antigen detection test for group A streptococcus in children with pharyngitis
Sore throat	Molecular rapid tests (diagnostics)	--	Yes	Rapid antigen detection test for group A streptococcus in children with pharyngitis
URI	homeopathy	--	Yes	Homeopathic Oscilloccinum® for preventing and treating influenza and influenza-like illness
URI	UV light	For reduction of URI in triage areas	No	N/A
URTI	Antibiotics	Setting: developing countries	No	Reviews exist on this topic but none are specific to developing countries
URTI or common cold	Saline nasal drop or nasal irrigation.	Population: infants and young children	Yes	Nasal saline irrigations for the symptoms of chronic rhinosinusitis

## APPENDIX D – Systematic review topics prioritised in Round 2

Answer Choices	Responses N(%)
Acute respiratory infection: nonspecific - Antiviral - existing evidence: 10 RCTs	36 (46)
Acute respiratory infection: nonspecific - Corticosteroid - existing evidence: 8 RCTs	28 (36)
Acute respiratory infection: nonspecific - Nonsteroidal anti-inflammatory drugs (NSAIDs) - existing evidence: 36 RCTs	34 (44)
Acute respiratory infection: nonspecific - Paracetamol - existing evidence: 9 RCTs	17 (22)
Acute respiratory infection: nonspecific - Vaccination - existing evidence: 18 RCTs	40 (51)
Acute respiratory infection: nonspecific - Vitamin C - existing evidence: 11 RCTs	26 (33)
Acute respiratory infection: nonspecific - Vitamins and supplements - existing evidence: 19 RCTs	34 (44)
Bronchiolitis - Complementary and alternative medicine (CAM) - existing evidence: 17 RCTs	27 (35)
Bronchiolitis - Saline – existing evidence: 12 RCTs	21 (27)
Common cold - Antiviral - existing evidence: 27 RCTs	25 (32)
Common cold - Nasal lavage - existing evidence: 5 RCTs	23 (29)
Common cold - Vitamins and supplements - existing evidence: 5 RCTs	18 (23)
Influenza - Diagnostic test – existing evidence: 5 RCTs	26 (33)
Influenza - Infection control – existing evidence: 5 RCTs	32 (41)
Influenza - Nonsteroidal anti-inflammatory drugs (NSAIDs) – existing evidence: 5 RCTs	14 (18)
Influenza - Vaccination reminder – existing evidence: 17 RCTs	21 (27)
Influenza - Vitamins and supplements – existing evidence: 5 RCTs	19 (24)
Otitis media - Antitussive / decongestant / expectorant / mucolytic – existing evidence: 23 RCTs	32 (41)
Pharyngitis / sore throat - Nonsteroidal anti-inflammatory drugs (NSAIDs) - existing evidence: 31 RCTs	32 (41)
Pneumonia - Antiviral - existing evidence: 5 RCTs	25 (32)
Pneumonia - Delivery of healthcare - existing evidence: 12 RCTs	26 (33)
Pneumonia - Humidification/steam - existing evidence: 16 RCTs	23 (29)
Sinusitis - Complementary and alternative medicine (CAM) - existing evidence: 10 RCTs	30 (38)
Streptococcus / "strep" - Vaccination - existing evidence: 5 RCTs	22 (28)
Vaccination adverse effects - Anaesthetic - existing evidence: 5 RCTs	23 (29)