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June 14, 2018

Mr. Jeffery Morris
USEPA Headquarters
William Jefferson Clinton Building
1200 Pennsylvania Avenue, N. W.
Mail Code: 7401M
Washington, DC 20460

Dear Mr. Morris:

I am writing to request a correction to the May 2018 EPA document "EPA's Responses to Public Comments Received on the Scope Documents for the First Ten Chemicals for Risk Evaluation under TSCA."[1]

On pg. 15, in response 16, comments are incorrectly attributed to the UCSF Program on Reproductive Health and the Environment (PRHE). I am pasting the text from the document below and attaching the UCSF PRHE comments 0741-0057 as downloaded from the 1-Bromopropane docket.[2] UCSF PRHE's comments did not recommend or reference the "Beyond Science and Decisions" project.

> ***Other***
>
> *16. One commenters shared information on the "Beyond Science and Decisions" project, a risk methods compendium as a resource for regulators and scientists on key considerations for applying selected dose-response techniques for various problem formulations, with suggested techniques and resources (0741-0057).*
>
> *Response: Thank you for this comment and for the suggested resources.*

We did recommend that EPA use the risk assessment approaches, methods and principles in the National Academies of Sciences report "Science and Decisions: Advancing Risk Assessment" which we reference multiple times in our comments.[3]

I would appreciate if EPA could respond to this letter, correct this error immediately and issue a revised version of the "EPA's Response to Public Comments" document. Please do not hesitate to contact me with any questions.

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[1] Available: https://www.epa.gov/sites/production/files/2018-06/documents/rtc_10_pf_53118.pdf
[2] Available: https://www.regulations.gov/document?D=EPA-HQ-OPPT-2016-0741-0057
[3] National Research Council. Science and Decisions: Advancing Risk Assessment. Washington, D.C.: National Academies Press; 2009. Available: https://www.nap.edu/catalog/12209/science-and-decisions-advancing-risk-assessment

Thank you,

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Submitted to the following dockets on Regulations.gov:
EPA–HQ–OPPT–2016–0736
EPA–HQ–OPPT–2016–0741
EPA–HQ–OPPT–2016–0723
EPA–HQ–OPPT–2016–0733
EPA–HQ–OPPT–2016–0735
EPA–HQ–OPPT–2016–0742
EPA–HQ–OPPT–2016–0743
EPA–HQ–OPPT–2016–0725
EPA–HQ–OPPT–2016–0732
EPA–HQ–OPPT–2016–0737

September 19, 2017

Comments from Academics, Scientists and Clinicians on the Risk Evaluation Scoping Efforts Under TSCA for Ten Chemical Substances

Submitted online via *Regulations.gov* to dockets: EPA-HQ-OPPT-2016-0736, EPA-HQ-OPPT-2016-0741, EPA-HQ-OPPT-2016-0733, EPA-HQ-OPPT-2016-0723, EPA-HQ-OPPT-2016-0735, EPA-HQ-OPPT-2016-0742, EPA-HQ-OPPT-2016-0743, EPA-HQ-OPPT-2016-0732, EPA-HQ-OPPT-2016-0725, EPA-HQ-OPPT-2016-0737

These comments are submitted on behalf of the undersigned academic, scientists, and clinicians. We declare collectively that we have no direct or indirect financial or fiduciary interest in any chemical under consideration in these risk evaluations. The co-signers' institutional affiliations are included for identification purposes only and do not necessarily imply any institutional endorsement or support, unless indicated otherwise.

We appreciate the opportunity to provide written comments on the scope of risk evaluations for the first ten chemical substances for risk evaluations pursuant to the Toxic Substances Control Act (TSCA), as amended by the Frank R. Lautenberg Chemical Safety of the 21st Century Act (Lautenberg TSCA). Collectively, these chemicals represent an aggregate production volume of more than 1 billion pounds a year in 2015.[1] Some of these chemicals have assessments, and in some cases even restrictions, under other federal programs – but none of these other programs has the mandate given to EPA under the new TSCA: to comprehensively evaluate chemicals and ensure that they do not pose an unreasonable risk to human health and the environment, with special consideration to those most vulnerable amongst us. Therefore, the task ahead for EPA is critical.

These first ten evaluations are also consequential because they will be precedent setting for the implementation of evaluation of science under TSCA. The consequent health impacts of EPA's decisions – for better or worse – will be borne by generations of American children, workers, families, and communities. With so much at stake, we welcome EPA's engagement with the public in this process and we offer EPA concrete approaches to embed the most current scientific principles in its methods to assess the hazards and risks of environmental chemicals.

Our comments address the following main points:

1. **EPA should improve its literature search and systematic review strategies to strengthen its evaluations and increase transparency.**
2. **EPA needs to consider aggregate exposure within and across populations; otherwise it will underestimate risk. Aggregate exposure should include legacy uses, uses where a chemical is present as a contaminant or by-product, and uses already assessed by EPA.**
3. **EPA appropriately identifies factors to consider to identify populations subject to greater exposures. EPA should also address susceptible sub-populations, following recommendations**

[1] This is the aggregate production volume estimate for the 8 chemicals with production volume information available. For asbestos and pigment violet 29, manufacturers/ importers claimed production volumes as confidential business information (CBI).

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from the National Academies of Sciences (NAS) to identify susceptible sub-populations based on established extrinsic and intrinsic factors that increase vulnerability.

4. **EPA should rely on existing IRIS assessments for hazard identification. Moving forward, EPA should complete hazard identification or add additional studies only through a systematic review process, which integrates animal, human and mechanistic evidence as recommended by the recent NAS report.**
5. **For risk characterization, EPA should use defaults and methods that account for the full range of risks in the population and that will form the basis of decisions that protect the public's health.**
6. **Confidential Business Information (CBI) claims should not be used to obscure critical data and information from the public.**

We are appreciative of the opportunity to provide public input and we look forward to continuing to participate in such opportunities in the near future. Please do not hesitate to contact us with any questions regarding these comments.

Sincerely,

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DETAILED COMMENTS

1. **EPA should improve its literature search and systematic review strategies to strengthen its evaluations and increase transparency.**

Overall, we strongly commend the EPA for its efforts to utilize a systematic and transparent method of research synthesis to reach a concise, strength of evidence conclusion about the human health hazard resulting from exposures to these ten chemicals. Efforts to integrate systematic review methods, including the explicit development of search terms, strategies, and inclusion/exclusion criteria beforehand, is relatively new in EPA's chemical assessment and as such, we applaud the EPA for this and its general improvements in its hazard assessment methodology. These scoping documents generally provide an important infrastructure for outlining EPA's screening approach for identifying relevant references and to document decisions made in the process of identifying the body of scientific literature that will be evaluated in the chemical assessments.

To improve on this document and advance EPA's uptake of systematic review methods of research synthesis, we identify the following opportunities for improvement:

EPA should not exclude studies based on language. EPA's search strategy is limited to English-only studies. The exclusive reliance on English-language studies may not represent the entire body of available evidence, and studies have suggested that language bias might lead to erroneous conclusions.[2] Furthermore, when considering the inclusion or update of an existing systematic review, studies have found that language-inclusive systematic reviews (including studies in languages other than English) were of the highest quality, compared with other types of reviews.[3] Online translation tools are readily available to allow screeners to quickly evaluate study abstracts for relevance, and therefore we recommend EPA to incorporate non-English language studies in their screening and not simply exclude these potentially relevant papers.

EPA should provide exclusion reasons for off topic citations. In the Bibliography Supplemental File for the Scope Documents, EPA has provided lists of bibliographic citations that were identified and screened from the initial literature search and the initial categorization of whether citations were *on topic* or *off topic.* We recommend EPA additionally provide exclusion reasons that were used to come to the conclusion that each citation was *off topic*, as this is a standard recommendation to fulfill transparency in documenting and reporting all decisions made in the study selection process.[4] This is particularly important as EPA has proposed to do its screening in Distiller, proprietary software that presumably will

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[2] Morrison, A., Polisena, J., Husereau, D., Moulton, K., Clark, M., Fiander, M., Mierzwinski-Urban, M., Clifford, T., Hutton, B. and Rabb, D., 2012. The effect of English-language restriction on systematic review-based meta-analyses: a systematic review of empirical studies. *International journal of technology assessment in health care*, *28*(2), pp.138-144.

[3] Moher, D., Pham, B., Lawson, M.L. and Klassen, T.P., 2003. The inclusion of reports of randomised trials published in languages other than English in systematic reviews. *Health Technol Assess*, *7*(41), pp.1-90.

[4] McDonagh M et a. Methods Guide for Effectiveness and Comparative Effectiveness Reviews. Agency for Healthcare Research and Quality. 2008.

Liberati, A., Altman, D.G., Tetzlaff, J., Mulrow, C., Gøtzsche, P.C., Ioannidis, J.P., Clarke, M., Devereaux, P.J., Kleijnen, J. and Moher, D., 2009. The PRISMA statement for reporting systematic reviews and meta-analyses of studies that evaluate health care interventions: explanation and elaboration. *PLoS medicine*, *6*(7), p.e1000100.

Cochrane Handbook for Systematic Reviews of Interventions. Version 5.1.0. March 2011. Available from: http://handbook-5-1.cochrane.org/chapter_7/7_2_5_selecting_excluded_studies.htm

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not be made publicly available, raising concerns regarding the transparency and reproducibility of this screening step.

EPA should consider other tools for systematic review. EPA has also proposed to extract data results in the DRAGON software. We strongly encourage EPA to also consider other potential software tools that have been developed and actively incorporated into the process of systematic review, such as Swift Reviewer,[5] Active Screener,[6] HAWC (Health Assessment Workplace Collaborative).[7] These tools will help to ensure consistent and transparent execution and presentation of reviews and increase transparency of EPA assessment. Furthermore, we urge EPA to work with the National Toxicology Program and other organizations involved in these efforts in an ongoing basis to develop these and other open source tools to train scientists in their use. We believe that such infrastructure development will be critical to increasing the efficiency of chemical assessments and to expedite uptake of systematic reviews in environmental health.

EPA should have two independent reviewers for screening steps. EPA has outlined its process for screening title and abstracts of papers as having a single reviewer reviewing papers to determine whether the study is *on-topic* or *off-topic*. As part of this process, a senior-level technical expert in the topic area of interest reviewed the appropriateness of the assigned tags for "the first batch of studies" and provided feedback to the screener. Senior-level technicians also provided feedback and guidance on specific references to the individual screeners as needed during the screening and tagging process. From the description of this process, it does not appear that two independent reviewers screen all titles and abstracts for potential inclusion. Using two independent reviewers is a standard approach in systematic reviews and therefore we strongly recommend that EPA include a second independent reviewer within this process to ensure that **all** studies are screened by two reviewers at each step (title and abstract and full text).

EPA should clearly document decisions related to the identification and search. For example, it was unclear how many studies were included in the first batch of studies reviewed by the senior-level technician—these decisions should be clearly specified beforehand as to the number (or percent) that will be reviewed by this independent reviewer. Furthermore, it is unclear how many studies the senior-level technical experts are reviewing generally as to their additional feedback and guidance to individual screeners. This should be more clearly stated and described beforehand in these protocols.
We recommend EPA broaden the set of studies that are initially screened in the first batch to ensure consistency across reviewers and demonstrated understanding of protocol instructions by all reviewers before moving on to screening the remaining records. It is stated in the Gray Literature Search Results that individual screeners would screen and tag 10 references that would be then independently reviewed by the senior-level technical expert. However, this does not seem to be an adequate number of studies as it is a small number relative to the expected number of records that will ultimately be screened.

EPA should clarify how it will handle discrepancies in the inclusion/exclusion and tagging process. As it is stated in its current protocol, it appears that the senior-level technical expert has the final say in

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[5] Howard, B.E., Phillips, J., Miller, K., Tandon, A., Mav, D., Shah, M.R., Holmgren, S., Pelch, K.E., Walker, V., Rooney, A.A. and Macleod, M., 2016. SWIFT-Review: a text-mining workbench for systematic review. *Systematic reviews*, *5*(1), p.87.
[6] https://www.sciome.com/swift-activescreener/
[7] https://hawcproject.org/about/

determining the final inclusion/exclusion decision and tagging, for the subset of studies they evaluate. However, this should be clarified and we also highly recommend that a third party reviewer be incorporated as an arbiter for these decisions if consensus cannot be reached between the two reviewers, as is typically standard in systematic reviews.

EPA should stratify its exclusion criteria separately at the title and abstract and full-text screening steps. It is likely that title and abstracts of papers would not contain sufficient detail to evaluate all exclusion criteria—many of these would likely only be identified in the full-text of the paper. To increase the efficiency of the screening process, it would help to create a subset of exclusion criteria most relevant when screening the title and abstracts of records versus the larger set of exclusion criteria relevant to screening the full text of records.

EPA should clearly outline the process for handling anticipated overlap with literature relevant to multiple topics. EPA should describe how this will be addressed by the screeners and whether the same reviewer will be responsible for screening papers with inclusion/exclusion criteria across multiple topics or whether different reviewers are responsible only for screening studies for one particular topic. Additional details in regards to the process by which this screening will occur would be helpful. Given the breadth of each assessment (searching literature related to fate, engineering, exposure, human health, and environmental hazard) and the complexity of the screening process (tagging *on-topic* and *off-topic* literature and using additional sub-categories or sub-tags to allow for additional categorization), there appears to be the potential for individual papers to fall into different topic categories and have many different tags and sub-tags applied to indicate their relevance. However, it is unclear how this will be organized in the screening phase. Search strategies and inclusion/exclusion criteria appear to have been developed specifically for each literature topic and the potential overlap of literature relevant to multiple topics is not addressed.

EPA should explicitly include stopping rules for when the list of relevant studies will be considered final. There is no discussion of stopping dates or the process of updating the literature search to search for newer studies. Newer scientific studies will inevitably continue to appear in scientific journals and it will be impossible to continually attempt to include all these studies in a chemical assessment. To meet the deadlines as mandated by the Lautenberg Amendments, EPA should state clear stopping rules in the form of deadlines or criteria for when the body of included relevant studies will be finalized for the purposes of the chemicals assessment.

EPA should ensure gray literature search results are adequately screened. EPA's gray literature search strategy proposes to utilize Google's API to develop custom searches and return the first 100 results, sorted by predicted relevancy so that the results likely to be most relevant are screened first. It is unclear why this number is limited to only the first 100 and whether there was an empirical reason for why this particular number was selected. We recommend that EPA ensure that an adequate number of search results are screened, in particular considering that the gray literature can contribute potentially important information relevant to toxicity, mode of action, exposure, fate and transport, engineering or occupational exposure, or existence of publication bias.

EPA should consider "snowball searching," where the citations of included (i.e., *on-topic*) references are searched as well as using databases such as Web of Science to search for references that cite the included citations. EPA states that it plans on assessing the specificity and efficiency of the literature searches, through comparison of references either cited in existing problem formulation and risk assessment documents, in the public use documents and supporting life cycle diagrams, and comparison

of the references cited in review articles. Snowball searching will contribute to the evaluation of the specificity and efficiency of its literature searches, and also help to identify newer relevant studies that could potentially be included that have not yet been indexed in main databases such as PubMed.

EPA should incorporate appropriate tools for updating and evaluating systematic reviews in their chemical assessments. Garner et al., as part of efforts by a Cochrane Collaboration panel for updating guidance for systematic reviews, published guidance in 2016 for determining when it is appropriate to update a systematic review and outlining the steps for performing the update.[8] We have attached this guidance as an Appendix to these comments. EPA should evaluate the Cochrane tool's applicability to environmental chemicals given that Cochrane systematic reviews are geared towards reviews of clinical intervention evidence, so these tools may require updating and tailoring for an application to environmental health data.

A recent NAS report[9] recommends EPA should develop policies and procedures to allow the agency to identify, use and update existing systematic reviews. The committee also noted that it was important that the existing systematic review's study question directly addresses EPA's topic of interest and that the methods are critically evaluated before the systematic review is used and updated. EPA should ensure that only the highest quality systematic reviews be considered appropriate for use. It will be critical for EPA to develop tools to assist with the process of evaluating existing systematic reviews, particularly as this field continues to rapidly expand and more systematic reviews relevant to environmental health questions are published in the scientific literature, potentially of variable quality.

One tool which might be helpful for evaluating the risk of bias in systematic reviews is the ROBIS tool, which the NAS committee utilized in their report.[10] This tool was developed using rigorous methodology and can be applied for evaluating internal validity of systematic reviews in conjunction with other available tools to critically appraise and assess their quality. Of particular note is the strong emphasis on the recommendation that tools such as ROBIS should not be used to generate a composite quality score, as it has been well-documented that scoring can lead to bias in evaluation of the studies.[11] As such, the ROBIS tool presents several options for visually and graphically presenting results from risk of bias assessments based on individual domains or the overall rating, enabling reviewers to highlight particular areas of concern or reviews that are most relevant to the target question of interest.

Another tool which may be helpful in this process is the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA), used by authors of systematic reviews to improve the reporting

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[8] Garner P, Hopewell S, Chandler J, MacLehose H, Akl EA, Beyene J, Chang S, Churchill R, Dearness K, Guyatt G, Lefebvre C. When and how to update systematic reviews: consensus and checklist. bmj. 2016 Jul 20;354:i3507.

[9] The National Academies of Sciences. Application of Systematic Review Methods in an Overall Strategy for Evaluating Low-Dose Toxicity from Endocrine Active Chemicals. Washington, D.C.: National Academies Press; 2017.

[10] Id.

[11] Jüni, P., Witschi, A., Bloch, R. and Egger, M., 1999. The hazards of scoring the quality of clinical trials for meta-analysis. *Jama*, *282*(11), pp.1054-1060.

Whiting, P., Harbord, R. and Kleijnen, J., 2005. No role for quality scores in systematic reviews of diagnostic accuracy studies. *BMC Medical Research Methodology*, *5*(1), p.19.

Whiting, P., Savović, J., Higgins, J.P., Caldwell, D.M., Reeves, B.C., Shea, B., Davies, P., Kleijnen, J. and Churchill, R., 2016. ROBIS: a new tool to assess risk of bias in systematic reviews was developed. *Journal of clinical epidemiology*, *69*, pp.225-234.

of elements relevant to the systematic review and meta-analyses.[12] Increasingly, scientific journals are requiring the inclusion of checklists such as PRISMA with the submission of systematic reviews considered for publication. Although this tool is used to evaluate study reporting, and is not an assessment instrument to gauge the quality of a systematic review, it can still provide a useful framework to identify reported components of an existing systematic review in the process of evaluating quality or to identify missing components requiring follow-up with study authors to obtain additional information.

Furthermore, we strongly encourage EPA to evaluate the potential for financial conflicts of interest as an element in their study design. This is currently included as a consideration in evaluation risks of bias in some frameworks, such as the Navigation Guide,[13] and extracted for consideration as an additional domain in other frameworks, such as that developed by the National Toxicology Program's (NTP) Office of Health Assessment and Translation (OHAT).[14] The Cochrane Collaboration's risk of bias tool does not currently include a specific domain for bias related to study funding source, but this is an area of active discussion among its members.[15] The Cochrane Collaboration has recognized the importance of identifying study funding source, which has been empirically shown to be associated with biases.[16] A recent report from the NRC recommended that the U.S. EPA consider funding sources in their risk of bias assessment conducted for systematic reviews.[17]

We also strongly recommend EPA identify tools that may potentially not be appropriate for human health chemical assessments. Many tools are currently being developed for evaluating risk of bias, quality, and strength of evidence for individual studies as well as for systematic reviews. It is critical that EPA evaluate tools developed in other fields that may be relevant, such as for clinical or preclinical animal or human studies, as these tools could potentially be modified for an application to questions of environmental health relevance. However, these tools should be applied with caution—due to the

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[12] http://www.prisma-statement.org/; Moher D, Shamseer L, Clarke M, Ghersi D, Liberati A, Petticrew M, Shekelle P, Stewart LA. Preferred reporting items for systematic review and meta-analysis protocols (PRISMA-P) 2015 statement. Systematic reviews. 2015 Jan 1;4(1):1.

[13] Woodruff, T.J. and Sutton, P., 2011. An evidence-based medicine methodology to bridge the gap between clinical and environmental health sciences. *Health affairs*, *30*(5), pp.931-937.

Woodruff, T.J. and Sutton, P., 2014. The Navigation Guide systematic review methodology: a rigorous and transparent method for translating environmental health science into better health outcomes. *Environmental health perspectives*, *122*(10), p.1007.

[14] NTP OHAT Handbook for conducting a literature-based health assessment using OHAT approach for systematic review and evidence integration https://ntp.niehs.nih.gov/ntp/ohat/pubs/handbookjan2015_508.pdf

[15] Bero LA. Why the Cochrane risk of bias tool should include funding source as a standard item. *Cochrane Database Syst Rev. 2013 Dec 20; (12):ED000075.*

Sterne JA. Why the Cochrane risk of bias tool should not include funding source as a standard item. *Cochrane Database Syst Rev. 2013 Dec 20; (12):ED000076.*

[16] Krauth D, Anglemyer A, Philipps R, Bero L. Nonindustry-sponsored preclinical studies on statins yield greater efficacy estimates than industry-sponsored studies: a meta-analysis. *PLoS Biol. 2014 Jan; 12(1):e1001770*

Lundh A, Sismondo S, Lexchin J, Busuioc OA, Bero L. Industry sponsorship and research outcome. *Cochrane Database Syst Rev. 2012 Dec 12; 12():MR000033.*

[17] NRC (National Research Council). Review of EPA's Integrated Risk Information System (IRIS) Process. Washington, DC:National Academies Press. 2014.

differences in the types of evidence under evaluation a direct application to a difference evidence base than intended could lead to biased and erroneous conclusions.[18]

2. **EPA needs to consider aggregate exposure within and across populations; otherwise it will underestimate risk. Aggregate exposure should include legacy uses, uses where a chemical is present as a contaminant or by-product, and uses already assessed by EPA.**

In general, EPA is proposing to consider three populations for exposure assessment: 1) Occupational users and non-users; 2) consumers and bystanders; and 3) general population. We strongly recommend that EPA calculate the aggregate exposures within and across these populations-- risk will be underestimated if it does not include these real-world exposures. Exposures within a population should also be aggregated (rather than considered in isolation) in order to estimate the general population's actual exposure to the chemical—for example, through exposures from food, water and air.

Further, as shown in the Figure below, exposures must also be aggregated across populations. Consumers and workers are part of the general population – that is, since workers and consumers also eat food and drink water, they will have the same exposures as the general population, in addition to the anticipated exposures on-the-job or from consumer products. Some workers will also be consumer product users, so they have the potential to face general, consumer product, and on-the-job exposures. These specific exposure scenarios must be accounted for in EPA's exposure estimation to ensure that such individual exposures are adequately considered and integrated into the risk assessment.

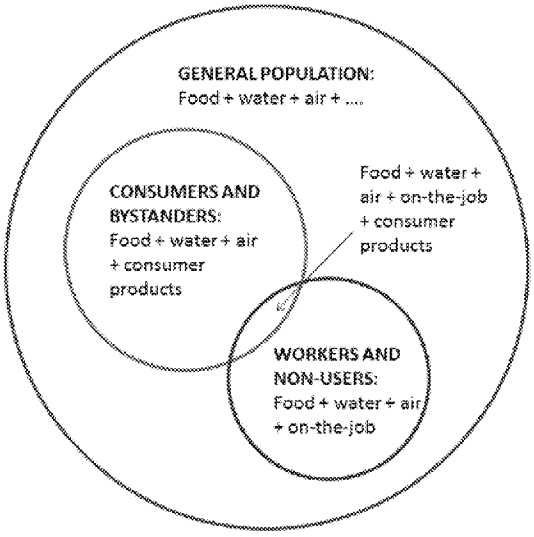

Figure: EPA must assess aggregate exposures within and across all the populations for accurate exposure assessment.

In the Introduction section of the chemical Scope documents, EPA states that it "may consider background exposures from legacy use, associated disposal, and legacy disposal as part of an assessment of aggregate exposure or as a tool to evaluate the risk of exposures resulting from non-

[18] Nachman, K.E., Lam, J., Schinasi, L.H., Smith, T.C., Feingold, B.J. and Casey, J.A., 2017. O'Connor et al. systematic review regarding animal feeding operations and public health: critical flaws may compromise conclusions. *Systematic Reviews*, *6*(1), p.179.

legacy uses."[19] This falls short of the analysis required under Lautenberg TSCA. It is critical that EPA consider ongoing exposures from legacy uses and disposal, and includes these as part of the aggregate exposure assessment. Asbestos and HBCD are two examples of this, as they have enormous volumes in place in buildings and existing infrastructure. The Healthy Building Network estimates there are 66 million- 132 million pounds (30,000-60,000 metric tons) of HBCD in insulation in existing buildings[20] — these reservoirs in-place are and will continue to be critical sources of ongoing exposures. HBCD was also used in cars and furniture, which are long-lived consumer items that will continue to contribute to ongoing exposures for years to come.

Another example is 1,4-dioxane, which was historically used as a chemical stabilizer for chlorinated solvents. Many groundwater aquifers are contaminated with 1,4-dioxane, and the extent of legacy contamination of groundwater is likely underestimated.[21] Also, 1,4-dioxane occurs in a wide variety of products including personal care products, detergents, waxes, and antifreeze, and 1,4-dioxane is a by-product in manufacturing processes involving ethylene oxide, such as the production of polyethylene terephthalate (PET), polyester, and surfactants. The use and disposal of 1,4-dioxane has led to past environmental contamination which contributes to on-going exposures.[22] The physical and chemical properties of 1,4-dioxane render it a persistent and highly mobile water contaminant: it is highly miscible in water.[23] Exposures via drinking water are documented back to the 1980s and continue today.[24] Results from EPA's Third Unregulated Contaminant Monitoring Rule (UCMR3) highlight that over 13% of 4,905 public drinking water systems serving >10,000 people had concentrations of 1,4-dioxane above the EPA Reference Concentration of 0.35 ppb 1,4-dioxane.[25] Furthermore, the UCMR3 results do not capture exposures in communities served by small public drinking water systems serving <10,000 people.[26] Approximately 27% of the US population is served by small public drinking water systems.[27] Thus, it will be critical for EPA to consider the population's current exposure to 1,4-dioxane via sources like drinking water as part of their assessment for health risks.

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[19] See, for example, US EPA (2017). Scope of the Risk Evaluation for Cyclic Aliphatic Bromides Cluster. Pg. 12

[20] Safer Chemicals, Healthy Families et al. Comments to the U.S. Environmental Protection Agency (EPA) on the Scope of its Risk Evaluation for the TSCA Work Plan Chemicals: CYCLIC ALIPHATIC BROMIDE CLUSTER or HEXABROMOCYCLODODECANE (HBCD). March 15, 2017. https://healthybuilding.net/uploads/files/saferchemicals-hbcd.pdf

[21] David T. Adamson, Shaily Mahendra, Kenneth L. Walker, Jr., Sharon R. Rauch, Shayak Sengupta, and Charles J. Newell. A Multisite Survey To Identify the Scale of the 1,4-Dioxane Problem at Contaminated Groundwater Sites. *Environmental Science & Technology Letters* 2014 1 (5), 254-258 DOI: 10.1021/ez500092u

[22] Agency for Toxic Substances and Disease Registry. TOXICOLOGICAL PROFILE FOR 1,4-DIOXANE. Atlanta, GA; 2012.

[23] U.S. Environmental Protection Agency. Integrated Risk Information System (IRIS). 1,4-Dioxane (CASRN 123-91-1). Washington, D.C.; 2013. http://www.epa.gov/iris/subst/0326.htm.

[24] Dietrich, A.M., D.S. Millington, and R.F. Christman. 1983. Specific identification of organic pollutants in Haw River water using gas chromatography/mass spectrometry. WRRI Report No. 206. North Carolina State University, Raleigh, NC.

[25] U.S. Environmental Protection Agency. Integrated Risk Information System (IRIS). 1,4-Dioxane (CASRN 123-91-1). Washington, D.C.; 2013. http://www.epa.gov/iris/subst/0326.htm.

U.S. Environmental Protection Agency. Unregulated Contaminant Monitoring Rule 74 FR 51850, EPA-HQ-OW-2007-1189 FRL-8963-6. Washington, D.C.; 2009. https://federalregister.gov/a/E9-24287.s

[26] Knappe, D.R.U., Lopez-Velandia, C., Hopkins, Z., & Sun, M. (2016). Occurrence of 1,4-Dioxane in the Cape Fear River Watershed and Effectiveness of Water Treatment Options for 1,4-Dioxane Control. NC Water Resources Research Institute.

[27] EPA. 2017. Small Drinking Water Systems Research https://www.epa.gov/water-research/small-drinking-water-systems-research-0 (accessed September 17, 2017).

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When a chemical is present in products or media as a contaminant/ by-product, EPA needs to include and assess these exposures. We strongly recommend against ignoring or discounting these potential exposures routes. For example, EPA proposes to exclude from consideration conditions of use of 1,4-dioxane when it is present as contaminant in a wide variety of items, including household detergents, cosmetics/ toiletries, and foods.[28] This exclusion is not scientifically justified. Cosmetics and personal care products have the potential to contribute significantly to exposures, since people are applying them directly to their bodies, often multiple times per day, every day.

Finally, in the exposure assessments for methylene chloride, N-methylpyrrolidone and trichloroethylene, EPA is proposing to exclude uses it already assessed.[29] We agree that EPA does not need to re-assess these uses; these evaluations have been completed and finalized. However, unless and until such uses are banned, the exposures from these uses continue. Therefore, the new risk evaluations need to consider the contributions of these uses to exposures by using the exposure values from the previous assessments.

For the occupational exposure analysis plan, EPA states it will "Consider and incorporate applicable engineering controls and/or personal protective equipment into exposure scenarios."[30] However, these are not realistic assumptions nor are they appropriate for public health protection. EPA's own research shows that the primary factors influencing whether a user understands label information are the users' literacy and numeracy, which frequently correlate with the users' education and income.[31] Therefore, people with less education, lower income, and less advanced literary skills will be the most likely to not understand label instructions. These individuals already disproportionately bear the burden of exposures to multiple environmental hazards and the resulting health impacts; thereby placing further burden on this already stressed susceptible subpopulation. Further, appropriate personal protective equipment (PPE) for workers is often not provided by employers, or may not be fitted or working properly. When evaluating occupational exposures, EPA needs to take into consideration all potential and feasible routes of exposure, and should not exclude exposure routes based on assumptions of PPE and/ or exposure controls in place. These controls are not guaranteed and may change in the future, so to assume zero exposure via these routes would be inappropriate and a failure to adequately ensure health protections, especially for susceptible sub-populations as required by the Lautenberg TSCA.

In summary, EPA needs to account for all the sources of exposure or it will underestimate risk for all 10 chemicals. When analyzing aggregate exposures, "sentinel exposure" may be considered simultaneously, where appropriate. However, these are not mutually exclusive and EPA should not incorporate sentinel to the exclusion of aggregate.

3. EPA appropriately identifies factors to consider to identify populations subject to greater exposures. EPA should also address susceptible sub-populations, following recommendations

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[28] US EPA (2017). Scope of the Risk Evaluation for 1,4-dioxane. Pg. 21

[29] US EPA (2017). Scope of the Risk Evaluation for Methylene Chloride (Dichloromethane, DCM). Pg. 30
US EPA (2017). Scope of the Risk Evaluation for N-Methylpyrrolidone. Pg. 19-20
US EPA (2017). Scope of the Risk Evaluation for Trichloroethylene. Pg. 27

[30] See, for example, US EPA (2017). Scope of the Risk Evaluation for Cyclic Aliphatic Bromides Cluster. Pg. 45

[31] US Environmental Protection Agency (EPA). 2016. "The Effectiveness of Labeling on Hazardous Chemicals and Other Products." Office of Chemical Safety and Pollution Prevention. RIN 2079-AK07.

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from the National Academies of Sciences (NAS) to identify susceptible sub-populations based on established extrinsic and intrinsic factors that increase vulnerability.

In general, EPA proposes to consider workers and occupational non-users, consumer and by-standers, and other groups within the general population in proximity to conditions of use as sub-populations who experience greater exposures. In particular, EPA has appropriately identified people who live or work near manufacturing, processing, distribution, use or disposal sites as facing greater exposures. Such communities are often low income and/ or people of color, exposed to a disproportionate share of pollution, environmental hazards, social and economic stressors. Multiple exposures to chemical and non-chemical stressors collectively increase the risk of harm, combined with synergistic effects with other health stressors in their daily lives such as limited access to quality health care.[32,33]

EPA's risk evaluation needs to fully account for the reality of cumulative exposures, as recommended by the NAS in their Phthalates and Cumulative Risk report.[34] As described below, EPA can use "default values" to account for cumulative exposures.

In regards to greater susceptibility, EPA's considerations for addressing susceptibility vary considerably across the 10 chemicals. EPA should apply a consistent approach to addressing susceptibility across the 10 chemicals. The following are well-known factors that increase biologic sensitivity or reduce resilience to exposures,[35,36] and these as well as other relevant factors should be standard considerations for all 10 chemicals to identify susceptible sub-populations:

Intrinsic/ endogenous factors

- Genetic polymorphisms/ genetics/ genetic makeup
- Health status/ nutritional status/ disease status/ pre-existing conditions
- Prenatal lifestage
- Age

Extrinsic factors

- Multiple exposures/ co-exposures
- Race/ ethnicity
- Socioeconomic status (SES)

For example, the prenatal lifestage is the most sensitive to developmental and reproductive toxicants, and women of child-bearing age should be considered as a susceptible sub-population for any chemicals with such hazards. Women of reproductive age are not specifically identified as a potential susceptible

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[32] Morello-Frosch R, Zuk M, Jerrett M, Shamasunder B, Kyle AD. Understanding the cumulative impacts of inequalities in environmental health: Implications for policy. Health Aff. 2011;30(5):879–87.

[33] Vesterinen HM, Morello-Frosch R, Sen S, Zeise L, Woodruff TJ. Cumulative effects of prenatal-exposure to exogenous chemicals and psychosocial stress on fetal growth: Systematic-review of the human and animal evidence. Meliker J, editor. PLoS One. 2017 Jul 12;12(7):e0176331.

[34] National Research Council. Committee on the Health Risks of Phthalates, Board on Environmental Studies and Toxicology, Division on Earth and Life Studies. 2008. Phthalates and cumulative risk assessment: the task ahead. Washington, D.C.: National Academies Press.

[35] Morello-Frosch R, Zuk M, Jerrett M, Shamasunder B, Kyle AD. Understanding the cumulative impacts of inequalities in environmental health: Implications for policy. Health Aff. 2011;30(5):879–87.

[36] National Research Council. Science and Decisions: Advancing Risk Assessment. Washington, D.C.: National Academies Press; 2009.

sub-population for pigment violet 29, TCE, NMP, PERC, or HBCD, even though EPA will consider reproductive and developmental toxicity hazards for these chemicals.

As discussed below, science-based defaults should be used to account for these and other susceptibilities, unless there is there is chemical-specific data available to support increasing or decreasing the default.

4. **EPA should rely on existing IRIS assessments for hazard identification. Moving forward, EPA should complete hazard identification or add additional studies only through a systematic review process, which integrates animal, human and mechanistic evidence as recommended by the recent NAS report.**

EPA cites existing IRIS assessments for five chemicals; because these are EPA's own assessments which have gone through the Agency's peer-review process, and in some cases NAS review, EPA can rely on these existing finalized, authoritative assessments for hazard identification.

Moving forward, a weight of evidence evaluation is required by law, which EPA defines as:

> "Weight of scientific evidence means a systematic review method, applied in a manner suited to the nature of the evidence or decision, that uses a pre-established protocol to comprehensively, objectively, transparently, and consistently, identify and evaluate each stream of evidence, including strengths, limitations, and relevance of each study and to integrate evidence as necessary and appropriate based upon strengths, limitations, and relevance."[37]

Therefore, EPA should use a systematic review process for evaluating scientific information for chemicals that do not have an IRIS assessment and for any additional studies that will be considered for the chemicals that have IRIS assessments.

For the scoping document, EPA should include all hazards identified in the literature, and not make decisions about their relevance to the risk evaluation until a systematic review has been completed. For a number of chemicals, EPA has inappropriately drawn conclusions about hazards prior to the completion of a systematic review. Some examples are given in the table below where EPA concludes that HBCD, NMP and pigment violet 29 are not genotoxic based on previous assessments and without conducting a systematic review.

Chemical	Example Text from EPA Scoping Document
HBCD	"Available data suggest that HBCD is not genotoxic. Existing assessments have also concluded, based on genotoxicity information and a limited lifetime study, that HBCD is not carcinogenic (NICNAS, 2012; EINECS, 2008; TemaNord, 2008; OECD, 2007). Unless new information indicates otherwise, EPA does not expect to conduct additional in-depth analysis of genotoxicity or cancer hazards in the risk evaluation of HBCD at this time."[38]
NMP	"NMP is not mutagenic, based on results from bacterial and mammalian *in vitro* tests and *in vivo* systems and is not considered to be carcinogenic (RIVM, 2013; OECD,

[37] 82 Fed. Reg. 138, 33748
[38] US EPA (2017). Scope of the Risk Evaluation for Cyclic Aliphatic Bromides Cluster. Pg.36

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	2007; WHO, 2001). Unless new information indicates otherwise, EPA does not expect to conduct additional in-depth analysis of genotoxicity and cancer hazards in the NMP risk evaluation."[39]
Pigment violet 29	"Testing for carcinogenicity of Pigment Violet 29 has not been conducted. However, negative genotoxicity results, structure-activity considerations and the expectation of negligible absorption and uptake of Pigment Violet 29 (based on very low solubility), indicate carcinogenicity of Pigment Violet 29 is unlikely. Unless new information indicates otherwise, EPA does not expect to conduct additional, in-depth analyses of genotoxicity and cancer hazards in the risk evaluation of Pigment Violet 29."[40]

The National Academies recently released a report with recommendations on implementation of systematic review for EPA's chemical evaluations (which we will refer to as the 'NAS Systematic Review report' for simplicity).[41] First, they recommend that EPA should develop policies and procedures that allow the agency to use and update existing systematic reviews, since the committee concluded that could potentially save time and resources. EPA should conduct a review to determine whether there are existing systematic reviews on the topic of interest and if there is, EPA should evaluate it to determine if it is high-quality. The NAS recommends that EPA should build on existing high-quality reviews to incorporate new studies and use the updated systematic review as a basis for its assessment. The assessments cited by EPA to support the hazard identification claims are not systematic reviews; even if they were, EPA should evaluate them for quality before relying on their conclusions.

Second, it is very likely that additional studies have been published since the assessments EPA cites were completed. EPA should develop criteria to evaluate the internal validity (risk of bias) of individual studies, utilizing existing tools that have been developed and empirically demonstrated on environmental health studies such as the Navigation Guide or the OHAT approach.[42] We also recommend that EPA not using a scoring system to evaluate study quality. Specifically, we note that empirically validated approaches in the clinical sciences such as Cochrane discourage using a numerical scale scoring approach for evaluating study quality because calculating a score requires choosing a weighting scheme for each component, which generally is nearly impossible to justify.[43] Furthermore, a study might be well designed to eliminate bias, but because the study failed to report details in the publication under review, it will receive a low score--most available scoring systems include a mix of risk of bias and reporting biases which is inappropriate. Additionally, quality scores have been shown to be invalid for assessing risk of bias in clinical research.[44] The current standard in evaluation of both clinical

[39] US EPA (2017). Scope of the Risk Evaluation for N-Methylpyrrolidone. Pg. 36

[40] US EPA (2017). Scope of the Risk Evaluation for Pigment Violet 29. Pg.29

[41] The National Academies of Sciences. Application of Systematic Review Methods in an Overall Strategy for Evaluating Low-Dose Toxicity from Endocrine Active Chemicals. Washington, D.C.: National Academies Press; 2017.

[42] Woodruff, T.J. and Sutton, P., 2011. An evidence-based medicine methodology to bridge the gap between clinical and environmental health sciences. *Health affairs*, *30*(5), pp.931-937.

Woodruff, T.J. and Sutton, P., 2014. The Navigation Guide systematic review methodology: a rigorous and transparent method for translating environmental health science into better health outcomes. *Environmental health perspectives*, *122*(10), p.1007.

NTP OHAT Handbook for conducting a literature-based health assessment using OHAT approach for systematic review and evidence integration https://ntp.niehs.nih.gov/ntp/ohat/pubs/handbookjan2015_508.pdf

[43] Juni, P., A. Witschi, R. Bloch, and M. Egger. 1999. The hazards of scoring the quality of clinical trials for meta-analysis. JAMA 282(11):1054-1060.

[44] Id.

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and environmental health research calls for reporting each component of the assessment tool separately and not calculating an overall numeric score.[45]

Data generated by alternative test methods (such as high-throughput screening methods) are not different than any other type of *in vitro* or cell-based assay data that would be considered in a systematic review. These kinds of assays provide mechanistic data, and the NAS Systematic Review report explicitly considered how mechanistic data could be utilized in a systematic review for evidence integration. The committee came to two conclusions. First, the same protocol for evaluating relevance and study quality must be used with mechanistic data as for any other study. For example, in the report's case study on phthalates, the committee was not able to integrate results from high-throughput assays because the cell lines used were of unknown relevance to the *in vivo* mechanism of phthalate toxicity.[46] Second, the foundation of the hazard classification in a systematic review is the animal and human data, with the mechanistic data playing a supporting role. If mechanistic data is relevant, it can be used to upgrade a hazard classification, or increase the confidence of a finding made based on evaluation of animal and human data. A hazard classification is never made based on high-throughput or other kinds of mechanistic data alone.[47]

5. For risk characterization, EPA should use defaults and methods that account for the full range of risks in the population and that will form the basis of decisions that protect the public's health.

Defaults

We strongly support the use of health protective defaults to incorporate factors that reflect the range of variability and susceptibility in the population to ensure risks are not underestimated. The importance of using protective science-based defaults was highlighted by the NAS in 2009.[48] The default should be used for factors that are known to influence risk unless there is chemical-specific data that support increasing or decreasing it; when there is inadequate information to quantitatively assess inter- or intra-species differences for a specific chemical, the defaults should be used. For example, EPA's defaults should include:

- Inter-human variability, general
- Inter-human susceptibility to carcinogens, adult
- Inter-human susceptibility to carcinogens, early life (including prenatal)
- Inter-human susceptibility to non-carcinogens, early life (including prenatal)
- Animal findings are relevant to humans
- Findings from one route of exposure are considered representative unless data show otherwise

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[45] Higgins, J.P.T., and S. Green, eds. 2008. Cochrane Handbook for Systematic Reviews of Interventions. Chichester, UK: John Wiley & Sons.

Whiting, P., Harbord, R. and Kleijnen, J., 2005. No role for quality scores in systematic reviews of diagnostic accuracy studies. *BMC Medical Research Methodology*, *5*(1), p.19.

Whiting, P., Savović, J., Higgins, J.P., Caldwell, D.M., Reeves, B.C., Shea, B., Davies, P., Kleijnen, J. and Churchill, R., 2016. ROBIS: a new tool to assess risk of bias in systematic reviews was developed. *Journal of clinical epidemiology*, *69*, pp.225-234.

[46] The National Academies of Sciences. Application of Systematic Review Methods in an Overall Strategy for Evaluating Low-Dose Toxicity from Endocrine Active Chemicals. Washington, D.C.: National Academies Press; 2017. Pg. 78

[47] Id. Pp. 158-9

[48] National Research Council. Science and Decisions: Advancing Risk Assessment. Washington, D.C.: National Academies Press; 2009. Ch 4-6

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EPA has relied on standard default values ("uncertainty" or "safety" factors) that have been applied across the board to various chemicals and health outcomes. But newer science demonstrates that EPA's typical safety factor of 10 is insufficient to account for variability due to life stage, genetics, underlying disease status, and external stressors that may be due to poverty or other difficult life conditions.

For cancer, the NAS recommended that EPA include a factor to account for human variability in response to carcinogens, as EPA's current approach inaccurately assumes that there is no variability in response. They found that a factor of 25- to 50- may account for the variability between the median individual and those with more extreme responses, and recommended 25 as a reasonable default value.[49]

Similarly, EPA should increase or add factors that address cancer and non-cancer susceptibility during early life stages. While EPA does account for increased susceptibility to genotoxicants, it does not include the prenatal period or chemicals that can influence cancer through other mechanisms. California EPA's guidance incorporates factors to account for increased susceptibility for exposures that occur prenatally for carcinogens, non-mutagenic carcinogenic agents and non-carcinogens. Their literature review on differential susceptibility to carcinogens and non-carcinogens based on age and life stage derived age adjustment values for carcinogens which include the prenatal period[50] and increased the default intraspecies uncertainty factors for non-carcinogens to 30 and 100 for specific endpoints such as asthma or neurotoxicity.[51] At a minimum, EPA should use Cal EPA's age adjustment values and intraspecies uncertainty factors for incorporating age/early life susceptibility.

In general, developmental life stages, including the fetus, infancy, and childhood, are more vulnerable to chemical exposure and toxicity. However, typical EPA age-dependent adjustment factors account for other life stages but NOT fetal exposures. Recent studies have demonstrated differential expression and activity of metabolic enzymes such as Cytochrome P450 in fetal versus adult tissue, indicating potential lifestage-dependent variability in metabolic capabilities and greater vulnerability during fetal development not accounted for in current risk assessment practices.[52] This is a critical point to address, as disruptions during fetal development have implications for health and disease in adulthood. EPA should evaluate this rich body of literature to identify the most up-to-date scientific knowledge regarding human variability and susceptibility and incorporate these scientifically-based default values in their assessments unless there are chemical-specific data supporting departing from the defaults. California EPA also developed child-specific risk values for chemicals (e.g., atrazine, lead, nickel, manganese, heptachlor) that specifically address routes of exposure and differences in susceptibility

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[49] Id. Pg. 168

[50] California EPA 2009. Cal EPA 2009. California Environmental Protection Agency, Office of Environmental Health Hazard Assessment. Technical Support Document for Cancer Potency Factors: Methodologies for derivation, listing of available values, and adjustments to allow for early life stage exposures. http://oehha.ca.gov/media/downloads/crnr/tsdcancerpotency.pdf

[51] Cal EPA 2008. California Environmental Protection Agency, Office of Environmental Health Hazard Assessment. Technical Support Document For the Derivation of Noncancer Reference Exposure Levels http://oehha.ca.gov/media/downloads/crnr/noncancertsdfinal.pdf

[52] Sadler, N.C., Nandhikonda, P., Webb-Robertson, B.J., Ansong, C., Anderson, L.N., Smith, J.N., Corley, R.A. and Wright, A.T., 2016. Hepatic cytochrome P450 activity, abundance, and expression throughout human development. *Drug Metabolism and Disposition*, *44*(7), pp.984-991.

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unique to children compared to adults.[53] EPA should review these evaluations and incorporate these values as appropriate. Furthermore, a default guidance principle should be that animal findings are relevant to humans unless there is sufficient and compelling information to support otherwise.

Risk estimates

EPA should not use MOE (margin of exposure) as an analysis method in the risk evaluation process moving forward. MOE is not an estimate of risk—it is a single number that is a version of the "bright line" approach like the Reference Dose (or Reference Concentration for inhalation doses). MOE is calculated by dividing the point of departure (e.g., LOAELs, NOAELs or BMDLs) by estimated exposure values, and this 'bright line' approach does not provide information about the magnitude of the risks above, at, or below this line. Further, it implies that there is a "safe" level of exposure below which no harm will occur. While this may be true for a select few chemicals, the NAS Science and Decisions report recognizes that this is not a valid assumption for all chemicals and has recommended moving away from such "bright line" approaches which do not establish risk estimates across the full range of exposures.[54] Additionally, the MOE will not provide the necessary information for future analysis of risks and benefits that will be critical for decision-making on these chemicals.[55] We recommend that EPA utilize available analytical methods such as PODs based on a BMD to develop quantified estimates of risk.

EPA appropriately states that a dose-response assessment will be conducted for all identified human health hazard endpoints. PODs should also be developed for every endpoint unless the data are insufficient to develop a model. For calculating cancer or non-cancer risks, we recommend always using a point of departure (POD) of a benchmark dose (BMD) at 1%. The POD should be based on a BMD calculation, not the NOAEL/LOAEL, unless the data are insufficient to model. EPA already recognizes the features that make BMDs superior: BMDs account for the shape of the dose–response function; are independent of study design, such as the space between dosing; and are comparable across chemicals.[56]

Historically, for carcinogens that are direct mutagens or are associated with large human body burdens, EPA has assumed there is no threshold of effect. But the NAS Science and Decisions report highlights the science indicating that this linear presumption with no threshold is appropriate for the calculation of both cancer and non-cancer risks, and regardless of whether a carcinogen is a mutagen. For example, dose-response relationships can be linear at low dose when exposures contribute to an existing disease process, add to background processes and/ or exposures, and interact with interindividual variability or susceptibility.[57] Science and Decisions recommends harmonizing cancer and non-cancer risk assessment approaches. Therefore, for calculating non-mutagen cancer or non-cancer risks based on a POD, EPA should use the same approach as for mutagens, which assumes a straight line from the POD. In fact, a

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[53] California Environmental Protection Agency. Office of Environmental Health Hazard Assessment (OEHHA). Child-Specific Reference Doses (chRDs) Finalized to Date. Available from: http://oehha.ca.gov/risk-assessment/chrd/table-all-chrds

[54] National Research Council. Science and Decisions: Advancing Risk Assessment. Washington, D.C.: National Academies Press; 2009.

[55] McGartland A, Revesz R, Axelrad DA, Dockins C, Sutton P, Woodruff TJ. Estimating the health benefits of environmental regulations. Science (80-). 2017 Aug 4;357(6350):457–8.

[56] Wignall JA, Shapiro AJ, Wright FA, Woodruff TJ, Chiu WA, Guyton KZ, Rusyn I. 2014. Standardizing benchmark dose calculations to improve science-based decisions in human health assessments. Environmental health perspectives. 122(5).

[57] National Research Council. Science and Decisions: Advancing Risk Assessment. Washington, D.C.: National Academies Press; 2009. Ch.5

linear relationship may actually underestimate risks for some chemicals where the dose-response curve is supra-linear.

6. Confidential Business Information (CBI) claims should not be used to obscure critical data and information from the public.

Production volumes for both asbestos and pigment violet 29 have been claimed as CBI. Production volume is basic information about a chemical to which the public and scientists should have access. We urge EPA to move forward with substantiating such claims under the new TSCA.

Appendix

When and how to update systematic reviews: consensus and checklist
Garner et al.
BMJ 2016;354:i3507
http://dx.doi.org/10.1136/bmj.i3507

ED_002413_00000228-00022

OPEN ACCESS

When and how to update systematic reviews: consensus and checklist

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Additional material is published online only. To view please visit the journal online.

Cite this as: *BMJ* 2016;354:i3507
http://dx.doi.org/10.1136/bmj.i3507

Accepted: 26 May 2016

Updating of systematic reviews is generally more efficient than starting all over again when new evidence emerges, but to date there has been no clear guidance on how to do this. This guidance helps authors of systematic reviews, commissioners, and editors decide when to update a systematic review, and then how to go about updating the review.

Systematic reviews synthesise relevant research around a particular question. Preparing a systematic review is time and resource consuming, and provides a snapshot of knowledge at the time of incorporation of data from studies identified during the latest search. Newly identified studies can change the conclusion of a review. If they have not been included, this threatens the validity of the review, and, at worst, means the review could mislead. For patients and other healthcare consumers, this means that care and policy development might not be fully informed by the latest research; furthermore, researchers could be misled and carry out research in areas where no further research is actually needed.[1] Thus, there are clear benefits to updating reviews, rather than duplicating the entire process as new evidence emerges or new methods develop. Indeed, there is probably added value to updating a review, because this will include taking into account comments and criticisms, and adoption of new methods in an iterative process.[2-6]

Cochrane has over 20 years of experience with preparing and updating systematic reviews, with the publication of over 6000 systematic reviews. However, Cochrane's principle of keeping all reviews up to date has not been possible, and the organisation has had to adapt: from updating when new evidence becomes available,[7] to updating every two years,[8] to updating based on need and priority.[9] This experience has shown that it is not possible, sensible, or feasible

SUMMARY POINTS

Updating systematic reviews is, in general, more efficient than starting afresh when new evidence emerges. The panel for updating guidance for systematic reviews (PUGs; comprising review authors, editors, statisticians, information specialists, related methodologists, and guideline developers) met to develop guidance for people considering updating systematic reviews. The panel proposed the following:

1. Decisions about whether and when to update a systematic review are judgments made for individual reviews at a particular time. These decisions can be made by agencies responsible for systematic review portfolios, journal editors with systematic review update services, or author teams considering embarking on an update of a review.
2. The decision needs to take into account whether the review addresses a current question, uses valid methods, and is well conducted; and whether there are new relevant methods, new studies, or new information on existing included studies. Given this information, the agency, editors, or authors need to judge whether the update will influence the review findings or credibility sufficiently to justify the effort in updating it.
3. Review authors and commissioners can use a decision framework and checklist to navigate and report these decisions with "update status" and rationale for this status. The panel noted that the incorporation of new synthesis methods (such as Grading of Recommendations Assessment, Development and Evaluation (GRADE)) is also often likely to improve the quality of the analysis and the clarity of the findings.
4. Given a decision to update, the process needs to start with an appraisal and revision of the background, question, inclusion criteria, and methods of the existing review.
5. Search strategies should be refined, taking into account changes in the question or inclusion criteria. An analysis of yield from the previous edition, in relation to databases searched, terms, and languages can make searches more specific and efficient.
6. In many instances, an update represents a new edition of the review, and authorship of the new version needs to follow criteria of the International Committee of Medical Journal Editors (ICMJE). New approaches to publishing licences could help new authors build on and re-use the previous edition while giving appropriate credit to the previous authors.

The panel also reflected on this guidance in the context of emerging technological advances in software, information retrieval, and electronic linkage and mining. With good synthesis and technology partnerships, these advances could revolutionise the efficiency of updating in the coming years.

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to continually update all reviews all the time. Other groups, including guideline developers and journal editors, adopt updating principles (as applied, for example, by the *Systematic Reviews* journal; https://systematicreviewsjournal.biomedcentral.com/).

The panel for updating guidance for systematic reviews (PUGs) group met to draw together experiences and identify a common approach. The PUGs guidance can help individuals or academic teams working outside of a commissioning agency or Cochrane, who are considering writing a systematic review for a journal or to prepare for a research project. The guidance could also help these groups decide whether their effort is worthwhile.

Panel selection and procedures

An international panel of authors, editors, clinicians, statisticians, information specialists, other methodologists, and guideline developers was invited to a two day workshop at McMaster University, Hamilton, Canada, on 26-27 June 2014, organised by Cochrane. The organising committee selected the panel (web appendix 1). The organising committee invited participants, put forward the agenda, collected background materials and literature, and drafted the structure of the report.

The purpose of the workshop was to develop a common approach to updating systematic reviews, drawing on existing strategies, research, and experience of people working in this area. The selection of participants aimed on broad representation of different groups involved in producing systematic reviews (including authors, editors, statisticians, information specialists, and other methodologists), and those using the reviews (guideline developers and clinicians). Participants within these groups were selected on their expertise and experience in updating, in previous work developing methods to assess reviews, and because some were recognised for developing approaches within organisations to manage updating strategically. We sought to identify general approaches in this area, and not be specific to Cochrane; although inevitably most of the panel were somehow engaged in Cochrane.

The workshop structure followed a series of short presentations addressing key questions on whether, when, and how to update systematic reviews. The proceedings included the management of authorship and editorial decisions, and innovative and technological approaches. A series of small group discussions followed each question, deliberating content, and forming recommendations, as well as recognising uncertainties. Large group, round table discussions deliberated further these small group developments. Recommendations were presented to an invited forum of individuals with varying levels of expertise in systematic reviews from McMaster University (of over 40 people), widely known for its contributions to the field of research evidence synthesis. Their comments helped inform the emerging guidance.

The organising committee became the writing committee after the meeting. They developed the guidance arising from the meeting, developed the checklist and diagrams, added examples, and finalised the manuscript. The guidance was circulated to the larger group three times, with the PUGs panel providing extensive feedback. This feedback was all considered and carefully addressed by the writing committee. The writing committee provided the panel with the option of expressing any additional comments from the general or specific guidance in the report, and the option for registering their own view that might differ to the guidance formed and their view would be recorded in an annex. In the event, consensus was reached, and the annex was not required.

Definition of update

The PUGs panel defined an update of a systematic review as a new edition of a published systematic review with changes that can include new data, new methods, or new analyses to the previous edition. This expands on a previous definition of a systematic review update.[10] An update asks a similar question with regard to the participants, intervention, comparisons, and outcomes (PICO) and has similar objectives; thus it has similar inclusion criteria. These inclusion criteria can be modified in the light of developments within the topic area with new interventions, new standards, and new approaches. Updates will include a new search for potentially relevant studies and incorporate any eligible studies or data; and adjust the findings and conclusions as appropriate. Box 1 provides some examples.

Which systematic reviews should be updated and when?

Any group maintaining a portfolio of systematic reviews as part of their normative work, such as guidelines panels or Cochrane review groups, will need to prioritise which reviews to update. Box 2 presents the approaches used by the Agency for HealthCare Research and Quality (AHRQ) and Cochrane to prioritise which systematic reviews to update and when. Clearly, the responsibility for deciding which systematic reviews should be updated and when they will be updated will vary: it may be centrally organised and resourced, as with the AHRQ scientific resource centre (box 2). In Cochrane, the decision making process is decentralised to the Cochrane Review Group editorial team, with different approaches applied, often informally.

Box 1: Examples of what factors might change in an updated systematic review

- A systematic review of steroid treatment in tuberculosis meningitis used GRADE methods and split the composite outcome in the original review of death plus disability into its two components. This improved the clarity of the reviews findings in relation to the effects and the importance of the effects of steroids on death and on disability.[11]
- A systematic review of dihydroartemisinin-piperaquine (DHAP) for treating malaria was updated with much more detailed analysis of the adverse effect data from the existing trials as a result of questions raised by the European Medicines Agency. Because the original review included other comparisons, the update required extracting only the DHAP comparisons from the original review, and a modification of the title and the PICO.[12]
- A systematic review of atorvastatin was updated with simple uncontrolled studies.[13] This update allowed comparisons with trials and strengthened the review findings.[14]

doi: 10.1136/bmj.i3507 | *BMJ* 2016;354:i3507 | the bmj

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The PUGs panel recommended an individualised approach to updating, which used the procedures summarised in figure 1. The figure provides a status category, and some options for classifying reviews into each of these categories, and builds on a previous decision tool and earlier work developing an updating classification system.[15 16] We provide a narrative for each step.

Step 1: assess currency

Does the published review still address a current question?

An update is only worthwhile if the question is topical for decision making for practice, policy, or research priorities (fig 1). For agencies, people responsible for managing a portfolio of systematic reviews, there is a need to use both formal and informal horizon scanning. This type of scanning helps identify questions with currency, and can help identify those reviews that should be updated. The process could include monitoring policy debates around the review, media outlets, scientific (and professional) publications, and linking with guideline developers.

Has the review had good access or use?

Metrics for citations, article access and downloads, and sharing via social or traditional media can be used as proxy or indicators for currency and relevance of the review. Reviews that are widely cited and used could be important to update should the need arise. Comparable reviews that are never cited or rarely downloaded, for example, could indicate that they are not addressing a question that is valued, and might not be worth updating.

In most cases, updated reviews are most useful to stakeholders when there is new information or methods that result in a change in findings. However, there are some circumstances in which an up to date search for information is important for retaining the credibility of the review, regardless of whether the main findings would change or not. For example, key stakeholders would dismiss a review if a study is carried out in a relevant geographical setting but is not included; if a large, high profile study that might not change the findings is not included; or if an up to date search is required for a guideline to achieve credibility. Box 3 provides such examples. If the review does not answer a current question, the intervention has been superseded, then a decision can be made not to update and no further intelligence gathering is required (fig 1).

Did the review use valid methods and was it well conducted?

If the question is current and clearly defined, the systematic review needs to have used valid methods and be well conducted. If the review has vague inclusion criteria, poorly articulated outcomes, or inappropriate methods, then updating should not proceed. If the question is current, and the review has been cited or used, then it might be appropriate to simply start with a new protocol. The appraisal should take into account the methods in use when the review was done.

Step 2: identify relevant new methods, studies, and other information

Are there any new relevant methods?

If the question is current, but the review was done some years ago, the quality of the review might not meet current day standards. Methods have advanced quickly, and data extraction and understanding of the review process have become more sophisticated. For example:

- Methods for assessing risk of bias of randomised trials,[23] diagnostic test accuracy (QUADAS-2),[24] and observational studies (ROBINS-1).[25]
- Application of summary of findings, evidence profiles, and related GRADE methods has meant the characteristics of the intervention, characteristics of the participants, and risk of bias are more thoroughly and systematically documented.[26 27]
- Integration of other study designs containing evidence, such economic evaluation and qualitative research.[28]

There are other incremental improvements in a wide range of statistical and methodological areas, for example, in describing and taking into account cluster

Box 2: Examples of how different organisations decide on updating systematic reviews

Agency for Healthcare Research and Quality (US)

The AHRQ uses a needs based approach; updating systematic reviews depends on an assessment of several criteria:

1. Stakeholder impact
   - Interest from stakeholder partners (such as consumers, funders, guideline developers, clinical societies, James Lind Alliance)
   - Use and uptake (for example, frequency of citations and downloads)
   - Citation in scientific literature including clinical practice guidelines
2. Currency and need for update
   - New research is available
   - Review conclusions are probably dated
3. Update decision
   - Based on the above criteria, the decision is made to either update, archive, or continue surveillance.

Cochrane

Of over 50 Cochrane editorial teams, most but not all have some systems for updating, although this process can be informal and loosely applied. Most editorial teams draw on some or all of the following criteria:

1. Strategic importance
   - Is the topic a priority area (for example, in current debates or considered by guidelines groups)?
   - Is there important new information available?
2. Practicalities in organising the update that many groups take into account
   - Size of the task (size and quality of the review, and how many new studies or analyses are needed)
   - Availability and willingness of the author team
3. Impact of update
   - New research impact on findings and credibility
   - Consider whether new methods will improve review quality
4. Update decision
   - Priority to update, postpone update, class review as no longer requiring an update

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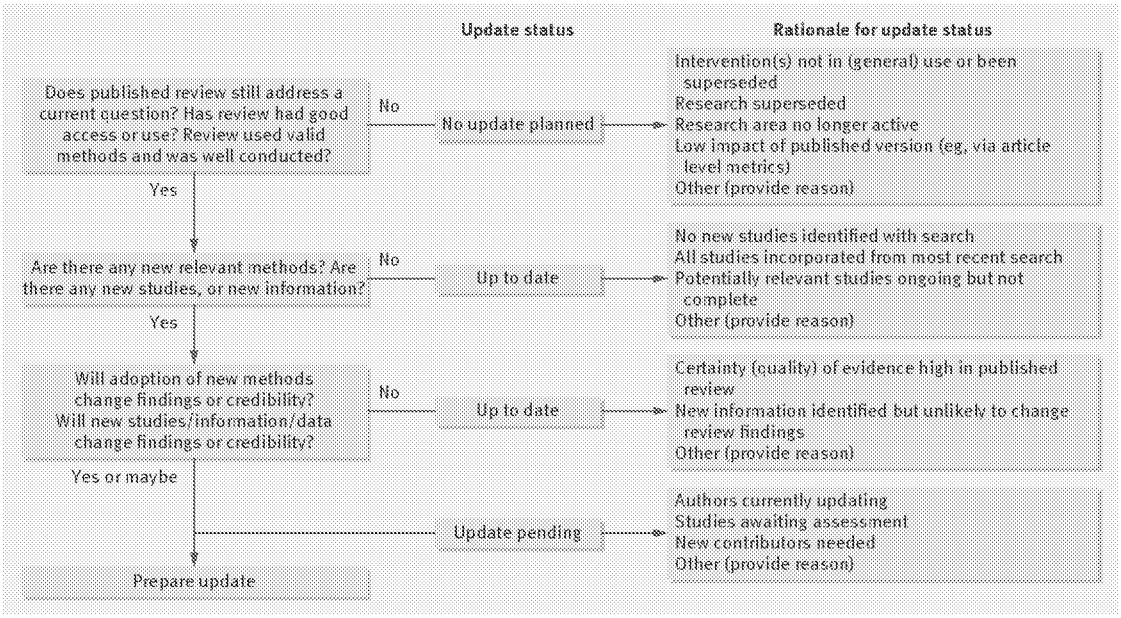

Fig 1 | Decision framework to assess systematic reviews for updating, with standard terms to report such decisions

randomised trials.[29] AMSTAR can assess the overall quality of a systematic review,[30] and the ROBIS tool can provide a more detailed assessment of the potential for bias.[31]

Are there any new studies or other information?

If an authoring or commissioning team wants to ensure that a particular review is up to date, there is a need for routine surveillance for new studies that are potentially relevant to the review, by searching and trial register inspection at regular intervals. This process has several approaches, including:

- Formal surveillance searching[32]
- Updating the full search strategies in the original review and running the searches
- Tracking studies in clinical trial and other registers
- Using literature appraisal services[33]
- Using a defined abbreviated search strategy for the update[34]
- Checking studies included in related systematic reviews.[35]

How often this surveillance is done, and which approaches to use, depend on the circumstances and the topic. Some topics move quickly, and the definition of "regular intervals" will vary according to the field and according to the state of evidence in the field. For example, early in the life of a new intervention, there might be a plethora of studies, and surveillance would be needed more frequently.

Box 3: Examples of a systematic review's currency

- The public is interested in vitamin C for preventing the common cold: the Cochrane review includes over 29 trials with either no or small effects, concluding good evidence of no important effects.[17] Assessment: still a current question for the public.
- Low osmolarity oral rehydration salt (ORS) solution versus standard solution for acute diarrhoea in children: the 2001 Cochrane review[18] led the World Health Organization to recommend ORS solution formula worldwide to follow the new ORS solution formula[19] and this has now been accepted globally. Assessment: no longer a current question.
- Routine prophylactic antibiotics with caesarean section: the Cochrane review reports clear evidence of maternal benefit from placebo controlled trials but no information on the effects on the baby.[20] Assessment: this is a current question.
- A systematic review published in the *Lancet* examined the effects of artemisinin based combination treatments compared with monotherapy for treating malaria and showed clear benefit.[21] Assessment: this established the treatment globally and is no longer a current question and no update is required.
- A Cochrane review of amalgam restorations for dental caries[22] is unlikely to be updated because the use of dental amalgam is declining, and the question is not seen as being important by many dental specialists. Assessment: no longer a current question.

Step 3: assess the effect of updating the review

Will the adoption of new methods change the findings or credibility?

Editors, referees, or experts in the topic area or methodologists can provide an informed view of whether a review can be substantially improved by application of current methodological expectations and new methods (fig 1). For example, a Cochrane review of iron supplementation in malaria concluded that there was "no significant difference between iron and placebo detected."[36] An update of the review included a GRADE assessment of the certainty of the evidence, and was able to conclude with a high degree of certainty that iron does not cause an excess of clinical malaria because the upper relative risk confidence intervals of harm was 1.0 with high certainty of evidence.[37]

Will the new studies, information, or data change the findings or credibility?

The assessment of new data contained in new studies and how these data might change the review is often used to determine whether an update should go ahead,

doi: 10.1136/bmj.i3507 | *BMJ* 2016;354:i3507 | the bmj

ED_002413_00000228-00026

Table 1 | Formal prediction tools: how potentially relevant new studies can affect review conclusions

Method	Description of approach	How it could be used	Advantages	Limitations	Validation
GRADE approach[38]	Considers whether the evidence certainty might change in the update (for example, because of lack of high certainty evidence, or because new evidence contradicts existing high certainty evidence). High certainty of evidence for critical outcomes could lower the priority for updating. Uncertainty in the review findings increases the need to include new studies[38]	Provides a benchmark by outcome to assess whether a new trial will improve the certainty of the evidence	Pragmatic. Many reviews already include GRADE	Requires GRADE to have been used in existing review or to complete an assessment according to GRADE	GRADE summary of findings tables or evidence profiles widely validated. Use of GRADE approach to prioritising updates requires further validation
Ottawa method[39-41]	A simple PubMed search (using the three largest and three most recent trials from the original review) to identify new studies. If new studies are found, then the method uses quantitative signals (eg, change in significance, effect size) to assess the likelihood that the new studies will change the review conclusion, thus triggering an update	Practical routine surveillance tool	Easy to use	Will not detect all trials; judgment only based on changing conclusion	Approach validated for consistency of predicted and actual changes to conclusions; reasonable agreement with RAND method[39 42-44]
RAND method[45]	An abbreviated search of five major journals to identify new studies, and a search of the US Food and Drug Administration website and external expert judgment to determine the currency of the report findings	Practical routine surveillance tool	Easy to use	Will not detect all trials; judgment only based on changing conclusion	Approach validated for consistency of predicted and actual changes to conclusions, and compares well with the Ottawa method[39 43 44]
Statistical prediction tool[15]	A multicomponent decision tool to assess whether there might be any new studies for the update. If new studies are identified, a statistical prediction tool estimates the probability that this will change the review conclusion	Ranks multiple systematic reviews in order of priority for updating	Uses quantitative approach	More complicated; requires commercial software	Approach validated internally[46]; requires further external validation
Value of information analysis[47 48]	Builds on the statistical prediction tool approach[15] comparing the expected health gain from new evidence with its expected cost. The gain is calculated in terms of a reduction in expected loss from reduced uncertainty and the cost is measured in days required to update the review.	Ranks selected systematic reviews in order of priority for updating	Uses quantitative approach	More complicated; requires some statistical knowledge	Approach validated internally; requires further external validation

Box 4: Examples of new information other than new trials being important

- The iconic Cochrane review of steroids in preterm labour was thought to provide evidence of benefit in infants, and this question no longer required new trials. However, a new large trial published in the *Lancet* in 2015 showed that in low and middle income countries, strategies to promote the uptake of neonatal steroids increased neonatal mortality and suspected maternal infection.[49] This information needs to somehow be incorporated into the review to maintain its credibility.
- A Cochrane review of community deworming in developing countries indicates that in recent studies, there is little or no effect.[50] The inclusion of a large trial of two million children confirmed that there was no effect on mortality. Although the incorporation of the trial in the review did not change the review's conclusions, the trial's absence would have affected the credibility of the review, so it was therefore updated.
- A new paper reporting long term follow-up data on anthracycline chemotherapy as part of cancer treatment was published. Although the effects from the outcomes remained essentially unchanged, apart from this longer follow-up, the paper also included information about the performance bias in the original trial, shifting the risk of bias for several outcomes from "unknown" to "high" in the Cochrane review.[51]

and the speed with which the update should be conducted. The appraisal of these new data can be carried out in different ways. Initially, methods focused on statistical approaches to predict an overturning of the current review findings in terms of the primary or desired outcome (table 1). Although this aspect is important, additional studies can add important information to a review, which is more than just changing the primary outcome to a more accurate and reliable estimate. Box 4 gives examples.

Reviews with a high level of certainty in the results (that is, when the GRADE assessment for the body of evidence is high) are less likely to change even with the addition of new studies, information, or data, by definition. GRADE can help guide priorities in whether to update, but it is still important to assess new studies that might meet the inclusion criteria. New studies can show unexpected effects (eg, attenuation of efficacy) or provide new information about the effects seen in different circumstances (eg, groups of patients or locations).

Other tools are specifically designed to help decision making in updating. For example, the Ottawa[39] and RAND[45] methods focus on identification of new evidence, the statistical predication tool[15] calculates the probability of new evidence changing the review conclusion, and the value of information analysis approach[52] calculates the expected health gain (table 1). As yet, there has been limited external validation of these tools to determine which approach would be most effective and when.

If potentially relevant studies are identified that have not previously been assessed for inclusion, authors or those managing the updating process need to assess whether including them might affect the conclusions of the review. They need to examine the weight and certainty of the new evidence to help determine whether an update is needed and how urgent that update is. The updating team can assess this informally by judging whether new studies or data are likely to substantively affect the review, for example, by altering the certainty in an existing comparison, or by generating new comparisons and analyses in the existing review.

New information can also include fresh follow-up data on existing included studies, or information on how the studies were carried out. These should be assessed in terms of whether they might change the review findings or improve its credibility (fig 1). Indeed, if any study has been retracted, it is important the authors assess the reasons for its retraction. In the case of data fabrication, the study needs to be removed

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from the analysis and this recorded. A decision needs to be made as to whether other studies by the same author should be removed from the review and other related reviews. An investigation should also be initiated following guidelines from the Committee on Publication Ethics (COPE). Additional published and unpublished data can become available from a wide range of sources—including study investigators, regulatory agencies and industry—and are important to consider.

Preparing for an update

Refresh background, objectives, inclusion criteria, and methods

Before including new studies in the review, authors need to revisit the background, objectives, inclusion criteria, and methods of the current review. In Cochrane, this is referred to as the protocol, and editors are part of this process. The update could range from simply endorsing the current question and inclusion criteria, through to full rewriting of the question, inclusion criteria and methods, and republishing the protocol. As a field progresses with larger and better quality trials rigorously testing the questions posed, it may be appropriate to exclude weaker study designs (such as quasi-randomised comparisons or very small trials) from the update (table 2). The PUGs panel recommended that a protocol refresh will require the authors to use the latest accepted methods of synthesis, even if this means repeating data extraction for all studies.

New authors and authorship

Updated systematic reviews are new publications with new citations. An authorship team publishing an update in a scientific or medical journal is likely to manage the new edition of a review in the same way as with any other publication, and follow the ICMJE authorship criteria.[56] If the previous author or author team steps down, then they should be acknowledged in the new version. However, some might perceive that their efforts in the first version warrant continued authorship, which may be valid. The management of authorship between versions can sometimes be complicated. At worst, it delays new authors completing an update and leads to long authorship lists of people from previous versions who probably do not meet ICMJE authorship criteria. One approach with updates including new authors is to have an opt-in policy for the existing authors: they can opt in to the new edition, provided that they make clear their contribution, and this is then agreed with the entire author team.

Although they are new publications, updates will generally include content from the published version. Changing licensing rights around systematic reviews to allow new authors of future updates to remix, tweak, or build on the contributions of the original authors of the published version (similar to the rights available via a Creative Commons licence; https://creativecommons.org) could be a more sustainable and simpler approach. This approach would allow systematic reviews to continue to evolve and build on the work of a range of authors over time, and for contributors to be given credit for contributions to this previous work.

Efficient searching

In performing an update, a search based on the search conducted for the original review is required. The updated search strategy will need to take into account changes in the review question or inclusion criteria, for example, and might be further adjusted based on knowledge of running the original search strategy. The search strategy for an update need not replicate the original search strategy, but could be refined, for example, based on an analysis of the yield of the original search. These new search approaches are currently undergoing formal empirical evaluation, but they may well provide much more efficient search strategies in the future. Some examples of these possible new methods for review updates are described in web appendix 2.

In reporting the search process for the update, investigators must ensure transparency for any previous versions and the current update, and use an adapted flow diagram based on PRISMA reporting (preferred reporting items for systematic reviews and meta-analyses).[57] The search processes and strategies for the update must be adequately reported such that they could be replicated.

Table 2 | Refresh background, objectives, inclusion criteria, and methods

Protocol section	Appraisal points
Background and research question	• Review and update background section, including supporting references to take account of any changes that may have occurred. This should include updating any new information and current policy debates on the topic. • Assess whether the current review question remains relevant to patients and practice.
Inclusion criteria	• Consider whether the existing PICO(s) remain(s) current, in the light of new knowledge. • Identify any new understanding of definition of patient populations. • Identify new interventions, or those that have been withdrawn, that are no longer in use. • Identify any changes in usual care standards. • Check for standardised core outcomes sets, such as those developed in collaboration with the core outcome measures in effectiveness trials (COMET) initiative (www.comet-initiative.org) or by guideline groups since the original review. • Check for any relevant patient reported outcomes to include subsequent to the original review. • Consider any new studies with less risk of bias that might warrant a stricter study design inclusion criteria (where the older version, when there was a dearth of evidence, included observational or quasi-randomised comparisons).
Methods	• Appraise and update the methods pending relevant methodological advancements or developments. For example, if (1) there are new tools for assessing the risk of bias of individual studies or appraising the quality of a body of evidence (eg, GRADE); or (2) new and efficient search approaches are feasible, such as a targeted approach to searching, taking into account the quality of the original search, and ensuring that the search for the update is of high quality. • Update or include a summary of findings table, which is recommended for all systematic reviews, because it improves the clarity, understanding, and interpretation of the findings of a systematic review, and rapidly reduces the amount of time readers require to find key information.[53-55]

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Peer review

Systematic reviews published for the first time in peer reviewed journals are by definition peer reviewed, but practice for updates remains variable, because an update might have few changes (such as an updated search but no new studies found and therefore included) or many changes (such as revise methods and inclusion of several new studies leading to revised conclusions). Therefore, and to use peer reviewers' time most effectively, editors need to consider when to peer review an update and the type of peer reviewer most useful for a particular update (for example, topic specialist, methodologist). The decision to use peer review, and the number and expertise of the peer reviewers could depend on the nature of the update and the extent of any changes to the systematic review as part of an editor assessment. A change in the date of the search only (where no new studies were identified) would not require peer review (except, arguably, peer review of the search), but the addition of studies that lead to a change in conclusions or significant changes to the methods would require peer review. The nature of the peer review could be described within the published article.

Reporting changes

Authors should provide a clear description of the changes in approach or methods between different editions of a review. Also, authors need to report the differences in findings between the original and updated edition to help users decide how to use the new edition. The approach or format used to present the differences in findings might vary with the target user group.[58] Publishers need to ensure that all previous versions of the review remain publically accessible.

Updates can range from small adjustments to reviews being completely rewritten, and the PUGs panel spent some time debating whether the term "new edition" would be a better description than "update." However, the word "update" is now in common parlance and changing the term, the panel judged, could cause confusion. However, the debate does illustrate that an update could represent a review that asks a similar question but has been completely revised.

Technology and innovation

The updating of systematic review is generally done manually and is time consuming. There are opportunities to make better use of technology to streamline the updating process and improve efficiency (table 3). Some of these tools already exist and are in development or in early use, and some are commercially available or freely available. The AHRQ's evidence based practice centre team has recently published tools for searching and screening, and will provide an assessment of the use, reliability, and availability of these tools.[63]

Other developments, such as targeted updates that are performed rapidly and focus on updating only key components of a review, could provide different approaches to updating in the future and are being piloted and evaluated.[64] With implementation of these various innovations, the longer term goal is for "living" systematic reviews, which identify and incorporate information rapidly as it evolves over time.[60]

Concluding remarks

Updating systematic reviews, rather than addressing the same question with a fresh protocol, is generally

Table 3 | Technological innovations to improve the efficiency of updating systematic reviews

Innovation	Description	Application	Examples of software and projects,* and current status
Integrated software	Integration of applying inclusion criteria, review management systems, statistical packages, and GRADE	To facilitate greater efficiencies in review production, including their updates	Covidence (www.covidence.org): free/pay† EPPI reviewer (http://eppi.ioe.ac.uk/cms/Default.aspx): pay DistillerSR (https://distillercer.com/products/distillersr-systematic-review-software/): pay Cochrane Review Manager (http://tech.cochrane.org/revman): free/pay† GRADEpro GDT (http://gradepro.org/): free Rayyan (http://rayyan.qcri.org/): free
Systematic review data repositories	Repositories store information from review (eg, data abstraction forms and the evidence tables)	Improve updating efficiency for new or existing teams as the data abstraction forms, evidence tables, and populating data from the original review are available	Agency of Health Care Research and Quality systematic review data repository (http://srdr.ahrq.gov): operational GRADE database of evidence profiles and evidence to decision frameworks (http://dbep.gradepro.org/): operational
Semi-automation	Machine learning techniques to use alongside human efforts	Finding studies and extracting data could benefit from semi-automation creating time efficiencies[59]	RobotReviewer (http://vortext.systems/robotreviewer): free Cochrane project transform—identification of studies (http://community.cochrane.org/tools/project-coordination-and-support/transform)
Crowdsourcing	Use of volunteers to assist systematic review authors with discrete tasks	Individuals from the "crowd" assist with tasks (identifying and screening studies, translating articles, data extraction) to help in new review production and updates[60-62]	Cochrane Project Transform—crowdsourcing (link as above)
Publication linkage	Ability to link trial registration, trial publications, and reviews citing them will help transparency	This initiative could help identify studies for systematic reviews and could also show the relation between systematic review updates	A cross publisher initiative, CrossRef, is coordinating a threaded publications/linked clinical trial reports initiative to link a clinical trial report (with a trial registration number) report and derivative publications, including reviews (www.crossref.org): operational
Data linkage	Increase links between data, existing software, and reviews	To improve identification and reuse of data for review production and dissemination	Cochrane (http://linkeddata.cochrane.org/): proof of principle example at production phase, but mostly linkage projects at exploratory phase

*Further information can be located on the SR Toolbox site (http://systematicreviewtools.com/).
†Free to Cochrane contributors; other users pay.

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more efficient and allows incremental improvement over time. Mechanical rules appear unworkable, but there is no clear unified approach on when to update, and how implement this. This PUGs panel of authors, editors, statisticians, information specialists, other methodologists, and guideline developers brought together current thinking and experience in this area to provide guidance.

Decisions about whether and when to update a systematic review are judgments made at a point in time. They depend on the currency of the question asked, the need for updating to maintain credibility, the availability of new evidence, and whether new research or new methods will affect the findings.

Whether the review uses current methodological standards is important in deciding if the update will influence the review findings, quality, reliability, or credibility sufficiently to justify the effort in updating it. Those updating systematic reviews to author clinical practice guidelines might consider the influence of new study results in potentially overturning the conclusions of an existing review. Yet, even in cases where new study findings do not change the primary outcome measure, new studies can carry important information about subgroup effects, duration of treatment effects, and other relevant clinical information, enhancing the currency and breadth of review results.

An update requires appraisal and revision of the background, question, inclusion criteria, and methods of the existing review and the existing certainty in the evidence. In particular, methods might need to be updated, and search strategies reconsidered. Authors of updates need to consider inputs to the current edition, and follow ICMJE criteria regarding authorship.[56]

The PUGs panel proposed a decision framework (fig 1), with terms and categories for reporting the decisions made for updating procedures for adoption by Cochrane and other stakeholders. This framework includes journals publishing systematic review updates and independent authors considering updates of existing published reviews. The panel developed a checklist to help judgements about when and how to update.

The current emphasis of authors, guideline developers, Cochrane, and consequently this guidance has been on effects reviews. The checklists and guidance here still applies to other types of systematic reviews, such as those on diagnostic test accuracy, and this guidance will need adapting. Accumulative experience and methods development in reviews other than those of effects are likely to help refine guidance in the future.

This guidance could help groups identify and prioritise reviews for updating and hence use their finite resources to greatest effect. Software innovation and new management systems are being developed and in early use to help streamline review updates in the coming years.

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Contributors: HJS initiated the workshop. JC, SH, PG, HM, and HJS organised the materials and the agenda. SH wrote up the proceedings. PG wrote the paper from the proceedings and coordinated the development of the final guidance; JC, SH, HM, and HJS were active in the finalising of the guidance. All PUGs authors contributed to three rounds of manuscript revision.

Funding: Attendance at this meeting, for those attendees not directly employed by Cochrane, was not funded by Cochrane beyond the reimbursement of out of pocket expenses for those attendees for whom this was appropriate. Expenses were not reimbursed for US federal government attendees, in line with US government policy. Statements in the manuscript should not be construed as endorsement by the US Agency for Healthcare Research and Quality or the US Department of Health and Human Services.

Competing interests: All participants have a direct or indirect interest in systematic reviews and updating as part of their job or academic career. Most participants contribute to Cochrane, whose mission includes a commitment to the updating of its systematic review portfolio. JC, HM, RM, CM, KS-W, and MT are, or were at that time, employed by the Cochrane Central Executive.

Provenance and peer review: Not commissioned; externally peer reviewed.

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1 Shekelle PG, Ortiz E, Rhodes S, et al. Validity of the Agency for Healthcare Research and Quality clinical practice guidelines: how quickly do guidelines become outdated?*JAMA* 2001;286:1461-7. doi:10.1001/jama.286.12.1461.
2 Claxton K, Cohen JT, Neumann PJ. When is evidence sufficient?*Health Aff (Millwood)* 2005;24:93-101. doi:10.1377/hlthaff.24.1.93.
3 Fenwick E, Claxton K, Sculpher M, et al. *Improving the efficiency and relevance of health technology assessment: the role of decision analytic modelling. Paper 179.*Centre for Health Economics, University of York, 2000.
4 Sculpher M, Claxton K. Establishing the cost-effectiveness of new pharmaceuticals under conditions of uncertainty—when is there sufficient evidence?*Value Health* 2005;8:433-46. doi:10.1111/j.1524-4733.2005.00033.x.

ED_002413_00000228-00030

5 Sculpher M, Drummond M, Buxton M. The iterative use of economic evaluation as part of the process of health technology assessment. *J Health Serv Res Policy* 1997;2:26-30.
6 Wilson E, Abrams K. From evidence based economics to economics based evidence: using systematic review to inform the design of future research. In: Shemilt I, Mugford M, Vale L, et al, eds. *Evidence based economics*.Blackwell Publishing, 2010doi:10.1002/9781444320398.ch12.
7 Chalmers I, Enkin M, Keirse MJ. Preparing and updating systematic reviews of randomized controlled trials of health care. *Milbank Q* 1993;71:411-37. doi:10.2307/3350409.
8 Higgins J, Green S, Scholten R. Chapter 3. *Maintaining reviews: updates, amendments and feedback: Version 5.1.0 (updated March 2011)*.Cochrane Collaboration, 2011.
9 Cochrane. Editorial and publishing policy resource. http://community.cochrane.org/editorial-and-publishing-policy-resource. 2016.
10 Moher D, Tsertsvadze A. Systematic reviews: when is an update an update?*Lancet* 2006;367:881-3. doi:10.1016/S0140-6736(06)68358-X.
11 Prasad K, Singh MB, Ryan H. Corticosteroids for managing tuberculous meningitis. *Cochrane Database Syst Rev* 2016;4:CD002244.
12 Zani B, Gathu M, Donegan S, Olliaro PL, Sinclair D. Dihydroartemisinin-piperaquine for treating uncomplicated *Plasmodium falciparum* malaria. *Cochrane Database Syst Rev* 2014;1:CD010927.
13 Adams SP, Tsang M, Wright JM. Lipid lowering efficacy of atorvastatin. *Cochrane Database Syst Rev* 2012;12:CD008226.
14 Higgins J. Convincing evidence from controlled and uncontrolled studies on the lipid-lowering effect of a statin. *Cochrane Database Syst Rev* 2012;12:ED000049.
15 Takwoingi Y, Hopewell S, Tovey D, Sutton AJ. A multicomponent decision tool for prioritising the updating of systematic reviews. *BMJ* 2013;347:f7191. doi:10.1136/bmj.f7191.
16 MacLehose H, Hilton J, Tovey D, et al. The Cochrane Library: revolution or evolution? Shaping the future of Cochrane content. Background paper for The Cochrane Collaboration's Strategic Session Paris, France, 18 April 2012. http://editorial-unit.cochrane.org/sites/editorial-unit.cochrane.org/files/uploads/2012-CC-strategic-session_full-report.pdf.
17 Hemilä H, Chalker E. Vitamin C for preventing and treating the common cold. *Cochrane Database Syst Rev* 2013;(1):CD000980.
18 Hahn S, Kim S, Garner P. Reduced osmolarity oral rehydration solution for treating dehydration caused by acute diarrhoea in children. *Cochrane Database Syst Rev* 2002;(1):CD002847.
19 World Health Organization (WHO). Reduced osmolarity oral rehydration salts (ORS) formulation. A report from a meeting of Experts jointly organized by UNICEF and WHO. New York: Child and Adolescent Health and Development, 18 July 2001 http://apps.who.int/iris/bitstream/10665/67322/1/WHO_FCH_CAH_01.22.pdf.
20 Smaill FM, Grivell RM. Antibiotic prophylaxis versus no prophylaxis for preventing infection after cesarean section. *Cochrane Database Syst Rev* 2014;(10):CD007482.
21 Adjuik M, Babiker A, Garner P, Olliaro P, Taylor W, White N. International Artemisinin Study Group. Artesunate combinations for treatment of malaria: meta-analysis. *Lancet* 2004;363:9-17. doi:10.1016/S0140-6736(03)15162-8.
22 Agnihotry A, Fedorowicz Z, Nasser M. Adhesively bonded versus non-bonded amalgam restorations for dental caries. *Cochrane Database Syst Rev* 2016;3:CD007517.
23 Higgins JP, Altman DG, Gøtzsche PC, et al. Cochrane Bias Methods Group Cochrane Statistical Methods Group. The Cochrane Collaboration's tool for assessing risk of bias in randomised trials. *BMJ* 2011;343:d5928. doi:10.1136/bmj.d5928.
24 Whiting PF, Rutjes AW, Westwood ME, et al. QUADAS-2 Group. QUADAS-2: a revised tool for the quality assessment of diagnostic accuracy studies. *Ann Intern Med* 2011;155:529-36. doi:10.7326/0003-4819-155-8-201110180-00009.
25 Sterne JAC, Higgins JPT, Reeves BC; on behalf of the development group for ROBINS-I. A tool for assessing risk of bias in non-randomized studies of interventions, version 7. March 2016. www.riskofbias.info.
26 Guyatt GH, Oxman AD, Vist GE, et al. GRADE Working Group. GRADE: an emerging consensus on rating quality of evidence and strength of recommendations. *BMJ* 2008;336:924-6. doi:10.1136/bmj.39489.470347.AD.
27 Schünemann HJ. Interpreting GRADE's levels of certainty or quality of the evidence: GRADE for statisticians, considering review information size or less emphasis on imprecision?*J Clin Epidemiol* 2016;75:6-15. doi:10.1016/j.jclinepi.2016.03.018.
28 Gough D. Qualitative and mixed methods in systematic reviews. *Syst Rev* 2015;4:181. doi:10.1186/s13643-015-0151-y.
29 Richardson M, Garner P, Donegan S. Cluster randomised trials in Cochrane reviews: evaluation of methodological and reporting practice. *PLoS One* 2016;11:e0151818. doi:10.1371/journal.pone.0151818.
30 Shea BJ, Grimshaw JM, Wells GA, et al. Development of AMSTAR: a measurement tool to assess the methodological quality of systematic reviews. *BMC Med Res Methodol* 2007;7:10. doi:10.1186/1471-2288-7-10.
31 Whiting P, Savović J, Higgins JP, et al. ROBIS group. ROBIS: A new tool to assess risk of bias in systematic reviews was developed. *J Clin Epidemiol* 2016;69:225-34. doi:10.1016/j.jclinepi.2015.06.005.
32 Sampson M, Shojania KG, McGowan J, et al. Surveillance search techniques identified the need to update systematic reviews. *J Clin Epidemiol* 2008;61:755-62. doi:10.1016/j.jclinepi.2007.10.003.
33 Hemens BJ, Haynes RB. McMaster Premium LiteratUre Service (PLUS) performed well for identifying new studies for updated Cochrane reviews. *J Clin Epidemiol* 2012;65:62-72.e1. doi:10.1016/j.jclinepi.2011.02.010.
34 Sagliocca L, De Masi S, Ferrigno L, Mele A, Traversa G. A pragmatic strategy for the review of clinical evidence. *J Eval Clin Pract* 2013;19:689-96. doi:10.1111/jep.12020.
35 Rada G, Peña J, Capurro D, et al. How to create a matrix of evidence in Epistemonikos. Abstracts of the 22nd Cochrane Colloquium; Evidence-informed public health: opportunities and challenges; Hyderabad, India. *Cochrane Database Syst Rev* 2014;suppl 1:132.
36 Okebe JU, Yahav D, Shbita R, Paul M. Oral iron supplements for children in malaria-endemic areas. *Cochrane Database Syst Rev* 2011;(10):CD006589.
37 Neuberger A, Okebe J, Yahav D, Paul M. Oral iron supplements for children in malaria-endemic areas. *Cochrane Database Syst Rev* 2016;2:CD006589.
38 Balshem H, Helfand M, Schünemann HJ, et al. GRADE guidelines: 3. Rating the quality of evidence. *J Clin Epidemiol* 2011;64:401-6. doi:10.1016/j.jclinepi.2010.07.015.
39 Chung M, Newberry SJ, Ansari MT, et al. Two methods provide similar signals for the need to update systematic reviews. *J Clin Epidemiol* 2012;65:660-8. doi:10.1016/j.jclinepi.2011.12.004.
40 Shojania KG, Sampson M, Ansari MT, Ji J, Doucette S, Moher D. How quickly do systematic reviews go out of date? A survival analysis. *Ann Intern Med* 2007;147:224-33. doi:10.7326/0003-4819-147-4-200708210-00179.
41 Shojania K, Sampson M, Ansari M, et al. *Updating systematic reviews; AHRQ technical reviews; report no 07-0087*.Agency for Healthcare Research and Quality, 2007.
42 Pattanittum P, Laopaiboon M, Moher D, Lumbiganon P, Ngamjarus C. A comparison of statistical methods for identifying out-of-date systematic reviews. *PLoS One* 2012;7:e48894. doi:10.1371/journal.pone.0048894.
43 Shekelle PG, Motala A, Johnsen B, Newberry SJ. Assessment of a method to detect signals for updating systematic reviews. *Syst Rev* 2014;3:13. doi:10.1186/2046-4053-3-13.
44 Shekelle PG, Newberry SJ, Wu H, et al. *Identifying signals for updating systematic reviews: a comparison of two methods; report no 11-EHC042-EF*.Agency for Healthcare Research and Quality, 2011.
45 Shekelle P, Newberry S, Maglione M, et al. *Assessment of the need to update comparative effectiveness reviews: report of an initial rapid program assessment (2005-2009)*.Agency for Healthcare Research and Quality, 2009.
46 Tovey D, Marshall R, Bazian, Hopewell S, Rader T. Fit for purpose: centralised updating support for high-priority Cochrane Reviews; National Institute for Health Research Cochrane-National Health Service Engagement Award Scheme, July 2011. https://editorial-unit.cochrane.org/sites/editorial-unit.cochrane.org/files/uploads/10_4000_01%20Fit%20for%20purpose%20-%20centralised%20updating%20support%20for%20high%20priority%20Cochrane%20Reviews%20FINAL%20REPORT.pdf.
47 Claxton K. The irrelevance of inference: a decision-making approach to the stochastic evaluation of health care technologies. *J Health Econ* 1999;18:341-64. doi:10.1016/S0167-6296(98)00039-3.
48 Wilson EC. A practical guide to value of information analysis. *Pharmacoeconomics* 2015;33:105-21. doi:10.1007/s40273-014-0219-x.
49 Althabe F, Belizán JM, McClure EM, et al. A population-based, multifaceted strategy to implement antenatal corticosteroid treatment versus standard care for the reduction of neonatal mortality due to preterm birth in low-income and middle-income countries: the ACT cluster-randomised trial. *Lancet* 2015;385:629-39. doi:10.1016/S0140-6736(14)61651-2.
50 Taylor-Robinson D, Maayan N, Soares-Weiser K, et al. Deworming drugs for soil-transmitted intestinal worms in children: effects on nutritional indicators, haemoglobin and school performance. *Cochrane Database Syst Rev* 2012;(11):CD000371.
51 van Dalen EC, van der Pal HJ, Kremer LC. Different dosage schedules for reducing cardiotoxicity in people with cancer receiving anthracycline chemotherapy. *Cochrane Database Syst Rev* 2016;3:CD005008.
52 Wilson E. on behalf of the Cochrane Priority Setting and Campbell & Cochrane Economics Methods Groups. Which study when? Proof of concept of a proposed automated tool to help decision which reviews to update first. *Cochrane Database Syst Rev* 2014;suppl 2:29-31.
53 Rosenbaum SE, Glenton C, Nylund HK, Oxman AD. User testing and stakeholder feedback contributed to the development of understandable and useful Summary of Findings tables for Cochrane reviews. *J Clin Epidemiol* 2010;63:607-19. doi:10.1016/j.jclinepi.2009.12.013.
54 Rosenbaum SE, Glenton C, Oxman AD. Summary-of-findings tables in Cochrane reviews improved understanding and rapid retrieval of key information. *J Clin Epidemiol* 2010;63:620-6. doi:10.1016/j.jclinepi.2009.12.014.

ED_002413_00000228-00031

55 Vandvik PO, Santesso N, Akl EA, et al. Formatting modifications in GRADE evidence profiles improved guideline panelists comprehension and accessibility to information. A randomized trial. *J Clin Epidemiol* 2012;65:748-55. doi:10.1016/j.jclinepi.2011.11.013.
56 International Committee of Medical Journal Editors (ICMJE). Defining the role of authors and contributors. 2016. www.icmje.org/recommendations/browse/roles-and-responsibilities/defining-the-role-of-authors-and-contributors.html.
57 Stovold E, Beecher D, Foxlee R, Noel-Storr A. Study flow diagrams in Cochrane systematic review updates: an adapted PRISMA flow diagram. *Syst Rev* 2014;3:54. doi:10.1186/2046-4053-3-54.
58 Newberry SJ, Shekelle PG, Vaiana M, et al. *Reporting the findings of updated systematic reviews of comparative effectiveness: how do users want to view new information? report no 13-EHC093-EF.* Agency for Healthcare Research and Quality, 2013.
59 Marshall IJ, Kuiper J, Wallace BC. Automating risk of bias assessment for clinical trials BCB'14. Proceedings of the 5th ACM conference on Bioinformatics, computational biology, and health informatics. 2014:88-95. http://thirdworld.nl/automating-risk-of-bias-assessment-for-clinical-trials.
60 Elliott JH, Turner T, Clavisi O, et al. Living systematic reviews: an emerging opportunity to narrow the evidence-practice gap. *PLoS Med* 2014;11:e1001603. doi:10.1371/journal.pmed.1001603.
61 Elliott J, Sim I, Thomas J, et al. #CochraneTech: technology and the future of systematic reviews. *Cochrane Database Syst Rev* 2014;(9):ED000091.
62 Cochrane. Project transform: the Cochrane Collaboration. 2016. http://community.cochrane.org/tools/project-coordination-and-support/transform.
63 Paynter R, Bañez L, Berlinerm E, et al. EPC methods: an exploration of the use of text-mining software in systematic reviews. Research white paper. AHRQ publication 16-EHC023-EF. Agency for Healthcare Research and Quality, April 2016. https://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=2214.
64 Soares-Weiser K, Marshall R, Bergman H, et al. Updating Cochrane Reviews: results of the first pilot of a focused update. *Cochrane Database Syst Rev* 2014;suppl 1:31-3.

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