Africa and China; CHAN also seeks to build capacity and produce pragmatic solutions for the advancement of health in both regions and beyond.

Throughout the past few decades, the Chinese Government has made remarkable progress in the improvement of the country's health, especially in reproductive, maternal and child health, and infectious diseases. Innovations coming out of African health-system reforms also provide answers to some of China's health-care problems; for example, the establishment of public–private partnerships and effective insurance schemes. Current challenges of communicable and non-communicable diseases can be surmounted through collective learning and action. The value of global partnership has been shown in situations of infectious disease prevention and management. The Ebola virus outbreak in west Africa in 2014 highlights the importance of strong health systems capable of timely and integrated responses. China faced similar challenges in 2003, with the outbreak of the SARS coronavirus. Researchers at HSPH and other US institutions have shown that pandemic control, in the context of the SARS and Ebola virus outbreaks, requires comprehensive and coordinated actions—eg, reduction of transmission through public health measures to increase public awareness and identification of vaccines. The continued engagement of academia will bolster the newly established Africa Centers for Disease Control—an initiative also supported by the China Centers for Disease Control and US Centers for Disease Control.[5]

The sustainable development agenda calls for inclusive "North–South, South–South and triangular regional and international" partnerships that promote and enhance the capacity building of countries with low incomes and middle incomes.[6] CHAN is an example of the multifaceted cooperation required to push global health development forward in the 21st century.

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## PubMed should raise the bar for journal inclusion

A survey by Manca and colleagues[1,2] found that predatory journals active in neuroscience and neurology outnumber those regularly indexed in the main biomedical databases. Furthermore, this analysis of predatory publishing (as of October, 2016) showed that over 10% of predatory journals in three important subdisciplines are indexed in PubMed (12% for rehabilitation, 11·4% for neurosciences, and 20·2% for neurology).[1,2]

By April, 2017, these values increased to 23·7% for rehabilitation, 16·1% for neuroscience, and 24·7% for neurology, indicating that this practice is ceaseless and evolves rapidly. Curiously, over the same 6-month period, the number of articles retrievable in PubMed that oppose predatory publishing has grown by 46·5%, from 86 to 126, but this increase has not prevented predatory journals from continuing undisturbed.

Needless to say, PubMed is one of the world's leading medical resources; it handles millions of queries daily and is an essential tool for health researchers worldwide.[3] Since its introduction, its effect on public health has been incalculable. Therefore, it is worrisome that PubMed includes journals with seriously flawed peer review processes. This issue deserves attention as these predatory journals can benefit from PubMed's massive popularity and achieve universal exposure while their largely low-quality articles can be cited in reputable journals, thus obtaining legitimacy and polluting scientific records. This matter is particularly alarming because clinical practice heavily depends on findings generated by peer-reviewed articles.

Furthermore, although the National Library of Medicine refers to these journals under the descriptor "Not currently indexed for MEDLINE", citations for author manuscripts are labelled as "included". Thus, highly regarded databases like PubMed and PubMed Central should raise the bar for journal acceptance,[4] and join the Directory of Open Access Journals, Scopus, and MEDLINE in imposing stringent criteria for inclusion of journals and publishers.

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## The BLISTER study: possible overestimation of tetracycline efficacy

The BLISTER study, by Hywell C Williams and colleagues (March 6, p 1630),[1] indicated that a 25% decrease in the efficacy of tetracycline in the early control of blisters would be acceptable to most UK dermatologists, if accompanied by a reduction of at least 20% in long-term serious side-effects compared with prednisolone. The efficacy of the tetracycline doxycycline was acceptable according to the study's primary effectiveness measure at 6 weeks (upper limit of 90% CI of adjusted difference between treatments [UB], 26·1%, within the 37% predefined acceptable non-inferiority margin [AM]); however, we question the aspects of the study design that appear to favour doxycycline. The 37% AM (survey-specified 25%), which we believe to be overly generous, suggests the study was underpowered. The initial fixed prednisolone regimen of 0·5 mg/kg (most guidelines suggest 0·5–1·5 mg/kg)[1–3] prohibited dose adjustment for cases of more severe disease or inadequate response to treatment, or both. To us, three or fewer blisters is an incomplete response, rather than treatment success as classified by the authors, and a complete absence of blisters should be the preferred indicator of success.

The pragmatic study design, which reflected "normal clinical practice",[1] allowed treatments to be swapped before primary effectiveness was assessed. Approximately 30% of patients on doxycycline swapped, compared with none on prednisolone, and were counted as doxycycline successes if successful on prednisolone. We suggest a direct comparison is more informative, in view of the scant evidence on tetracycline efficacy. Although the study might not have been designed to detect differences without treatment swapping or for no blisters at 6 weeks, the fact that doxycycline efficacy was unacceptable in both situations (UB 41·2% and 39·1%, respectively; results outside the 37% pre specified AM) should be noted.

In summary, this study does not convince us that tetracycline satisfies the efficacy specification of the dermatologists' survey, in which case the proven enhanced safety loses relevance.

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### Authors' reply

We thank Michael J Sladden and Peter E Hutchinson for their comments, but respectfully disagree that our study design[1] favoured doxycycline. BLISTER was not an efficacy study of doxycycline versus prednisolone. We investigated whether a doxycycline-initiated pemphigoid treatment strategy could result in improved safety and acceptable effectiveness, when compared with starting with prednisolone. The doxycycline-initiated strategy was expected to be 25% less effective than prednisolone at 6 weeks. The additional 12% added to the margin (37% minus the expected 25%), dictated by the finite size of the trial, is similar to the 10% used in many non-inferiority trials where the expected difference is 0% (not 25%). Our estimate of difference in effectiveness between strategies was 18·6%, with an upper limit CI of 26·1%—ie, very close to the point estimate of 25% that dermatologists were prepared to accept.

The prednisolone dose was guided by other studies[2,3] that suggested 0·5 mg/kg per day is effective in mild and moderate disease, which was borne out by our trial results (85% success by 6 weeks for all severities).[1] The use of a higher initial dose of prednisolone or an increase in dose in prednisolone-initiated participants would have increased severe side-effects, thus favouring doxycycline-initiated treatment. Additionally, prednisolone doses were fixed for the first 6 weeks to blind outcome assessment, which is difficult to achieve in prednisolone dose-adjustment studies.[4]

We suggest that an outcome of three or fewer blisters (that can be managed topically) is good for someone who presents with many blisters. To achieve blister-free status, overtreatment with prednisolone might occur and result in increased severe side-effects, although we did present such secondary outcomes in our Article.[1] A direct comparison of the two drugs in which no change of treatment is permitted would be an efficacy trial, rather than our pragmatic strategy trial of doxycycline as a steroid-sparing agent. However, our prespecified secondary outcome showed that the proportion of participants who achieved success, but had not changed treatment before 6 weeks, was 54% in the doxycycline group and 85% in the prednisolone group, which is suggestive of a useful clinical effect even when doxycycline is used as monotherapy.

A range of views on whether the trade-off between reduced short-term


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