POSTERS

P002 A SUMMARY OF THE METHODS THAT THE ALEXANDRIA CENTRE FOR EVIDENCE-BASED CLINICAL PRACTICE GUIDELINES (CEBCPGs) USES TO PRODUCE CLINICAL PRACTICE GUIDELINES FOR THE HEALTHCARE QUALITY DIRECTORATE OF ALEXANDRIA UNIVERSITY HOSPITALS AND HEALTHCARE SECTORS IN ALEXANDRIA

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Background The CEBCPGs produces CPGs on high priority health topics to establish recommendations based on best evidence. The authors summarise the main methods used in adaptation and implementation of these CPGs.
Objectives The aim of this work was to promote simplicity, avoid redundancy and decrease delay in the process of CPG adaptation.
Methods Part 1) Cross-sectional/ or retrospective study and assessment of the current situation of practice in selected healthcare settings to identify/select high priority health topic(s) and to justify the need for producing a CPG for this topic(s) and expected benefit and outcome for its implementation; Part 2) consists of the Methodology for CPGs adaptation, based on an adaptation of The ADAPTE Process developed by the ADAPTE Collaboration.
Results Three main ADAPTE steps were identified as cornerstones of the process and another two steps in the assessment module were replaced by the AGREE Domains scores.
Implications for Guideline Developers/Adapters/Users 1. Health Topics for CPG Adaptation & Implementation should be selected based on Cross-sectional study/surveys for local Healthcare Professionals. 2. Adaptation of CPGs as a valid alternative to *de novo* development has many benefits for resource utilisation and unifying practice. 3. The ADAPTE process is that it is adaptable to local context and resources. 3. Successful CPGs Implementation Strategies; i)For Practitioners: Implementation tools designed to facilitate behavioural/practice changes (e.g. Posters & Brochures of Clinical algorithms & Flow charts), Educational material, Educational meetings (e.g. conferences, lectures & workshops) and Local Clinical Champions; ii) For Patients/ Carers: Education materials and meetings.

P005 INTEGRATION OF EVIDENCE ON PATIENT PREFERENCES IN HEALTH CARE DECISION-MAKING: CURRENT STATE OF PLAY

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Background Active patient participation is embedded in health care decision-making, like clinical practice guideline (CPG) development and coverage decisions. The systematic use of the available evidence on patient preferences (passive participation) is still limited.
Objectives To describe how and what type of evidence on patient preferences is considered in health care policy decisions in The Netherlands, England, Scotland, Germany and France.
Methods A document search on website and database of responsible organisations for material on current development procedures. Scoping literature search on opinion papers on the use of research on patient preferences in CPG development and coverage decisions (HTA). Selected CPG and coverage decisions were checked.
Results Procedures for coverage decisions do not mention the search for or use of research on patient preferences, nor was information found in the coverage case studies. In CPG development procedure a mandatory (Scotland) or optional (Netherlands) search for studies that reflect patients' experiences and preferences is described. The CPG case studies show various use of patient preferences in different conceptualisations.
Discussion In coverage decisions research on patient preferences has no formal role yet. In CPG this role is limited. Integration of research on patient preferences is hampered by several factors.
Implications for Guideline Developers/Users Directions for the future include: 1) conceptual work on defining and measuring patient preferences; 2) reaching consensus on the value and place of research on patient preferences for and in procedures and 3) developing a strategy for integration in procedures.

P008 WHAT TYPE OF EVIDENCE DO WE NEED TO DEVELOP GUIDELINES FOR DIAGNOSTIC IMAGING?

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Background Diagnostic imaging (DI) is used several ways in patient management, and the evidence required for each of these roles is somewhat different. This presentation will focus on the evidence needed to develop guidelines for the use of DI in primary diagnosis.
Context GRADE states that randomised control trials of patient outcomes are the highest level of evidence for assessing diagnostic tests but also that accuracy can be used as a proxy for outcomes. DI guidelines provide two basic types of information: whether DI is indicated in a particular clinical situation and what is the best DI modality to use. In choosing a modality the accuracy of different DI modalities is important. However, the question of whether DI is indicated in a given clinical situation is at least as important, and in determining this, accuracy is less important.
Best Practice The type of evidence which is needed for this question relates to whether DI will affect the management of the patient. If the information that DI provides is not relevant to the management of the patient then DI is not indicated. If the pre-test probability of the diagnosis is very low or very high then DI is also not indicated.
Lessons When developing guidelines for DI first consider whether the type of information DI can provide is important in patient management. If it is, clinical decision rules are important in assessing whether the pre-test probability justifies its use. Accuracy only becomes important in determining which imaging modality to recommend.

P012 SYSTEMATIC REVIEW OF HPV TEST [INVADER TECHNOLOGY/REAL-TIME PCR]

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