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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Objective HPV Test [Invader Technology/Real-Time PCR] is a molecular genetic test performed for confirming the presence of infection by detecting 14 types of HPV and additionally, for classifying types 16 and 18 genotypes.
Methods It was assessed using 8 domestic databases including Korea Med and Ovid-MEDLINE, Ovid-EMBASE. 1,214 works were identified. Of them, animal experimental or studies not published in Korean or English were excluded. Total of 23 literatures composed of 8 literatures for Invader Technology and 15 literatures on Real-Time PCR were included in the final assessment. Two reviewers screened all references independently, for assessing included articles quality and extracted data.
Results Index tests were assessed to be a safe test, since it does not impart direct harm to the patients as it is conducted outside the patients body by collecting uterus cervical cells. Effectiveness was assessed by diagnostic accuracy, concordance rate, detection rate. Diagnostic accuracy of Invader Technology with sequencing was high (sensitivity=0.89, specificity=0.92). As the result of comparison between Invader Technology and Hybrid Capture 2 (HC2), the false positive rate of index test (5.8%) was lower than HC2 (5.5–21.9%). The concordance rate was 83.1%-94.0%. Diagnostic accuracy of Real-Time PCR with DNA chip was high level (sensitivity=0.96, specificity=1.00). Rate of concordance between Real-Time PCR and HC2 was in the range of 82.6–98.3%, with DNA chip was in the range of 66.7–98.3%.
Conclusion These tests are safety. Also, there are the effectiveness of additional diagnosis for genotypes 16 and 18, high level of concordance with the existing tests and high level of detection of HPV genotypes 16 and 18 in high risk group.

P013 A PRELIMINARY ANALYSIS OF THE CLINICAL PATHWAYS IN CHINA

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Background Clinical pathway (CP) is an application of rational process and time management for specific disease and surgery in practice. The CP was firstly introduced into China in 1990s.

Objective To find the current status of clinical pathways in China.
Methods We used word clinical pathway in title by searching the web of clinical pathway (www.ch-cp.org.cn), CNKI, etc. and collected CP on title, date, specialties and main contents, etc. Search date till July 30, 2012.
Results 1) 331 CPs were issued in 2009-2011, 25,503 departments from 3,467 hospitals conducted CP and public hospital accounted for 46.9% by 2011 in China. 2) The CPs was pilot implemented in 110 selected hospitals from 23 provinces on 22 specialties, such as general surgery, cardiovascular, orthopaedics, etc. 3) The contents of CP mainly include: disease and target population, diagnosis, treatment option, standard length of stay in hospital, criteria for CP entrance, preoperative evaluation, time and choice for use of prophylactic antibiotics, operation day, postoperative hospital stay recovery, discharge standard, variance and reason analysis, etc. Few CP described the sources of funding, composition of group that authored the CP and financial disclosures. 4) The major influential factors of CP implementation include: the participation of doctors and patients, explanation of the various process and documents, payment problems, hospital management, appropriate incentive mechanisms, information systems and other support policies, etc.
Conclusions Clinical pathway may a tool for hospital quality management and assessment criteria of disease effectiveness-costs. More communications with doctors and patients and innovative payment methods would be better for CP implementation.

P016 A GUIDELINE ON UNDESCENDED TESTIS: MORE TRANSPARENCY BY A DECISION ANALYSIS

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Background Undescended testis (UDT) is the most common genital anomaly seen in boys and can be treated surgically by orchiopexy. The age at which orchiopexy should be performed is controversial for both congenital and acquired UDT.
Objectives Performing a decision analysis in order to develop a guideline on UDT.
Methods A decision analysis was performed in which all available knowledge is combined to assess the outcomes of orchiopexy at different ages, expressed in quality adjusted life years (QALY). Furthermore a sensitivity analysis was performed to assess whether the determined optimal age of orchiopexy is influenced by gaps in current knowledge.
Results Surgery at the earliest age (at detection of UDT) will lead to the lowest loss in QALY for UDT compared to no surgery. For bilateral UDT (both congenital and acquired) this was caused by increased paternity and for unilateral UDT by cosmetic aspects. Sensitivity analyses did not change the preferences for strategies. However, given the modest differences in outcomes, there is room for patient preference with respect to performance and timing of surgery in case of unilateral UDT.
Discussion The choice for no surgery in case of unilateral UDT was not acceptable for the expert group. Therefore, a consensus based guideline was developed in which surgery was recommended also for unilateral UDT. More clinical evidence on issues related to timing may in the future modify these results and hence this advice.
Implications for Guideline Developers/Users A decision analyses provides a clear insight in the data available and argumentations made.

P022 GINSENG FOR HEALTH CARE: A SYSTEMATIC REVIEW OF RANDOMISED CONTROLLED TRIALS IN KOREAN LITERATURE

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