

agreement test for different raters in systematic reviews 3. How to from evidence to recommendations in guidelines 4. Exploration of the application of GRADE in clinical stage (e.g. whether the guideline covers prevention, screening, assessment, treatment, rehabilitation or monitoring); Exploration of the application of GRADE in different areas such as public health, health policy and system. 5. The establishment and development of GRADE centre such as the Chinese GRADE centre and Spanish GRADE centre and how to promote the implementation of GRADE.

Conclusion As a new paradigm, the GRADE approach provides a comprehensive, explicit, and transparent methodology for grading the quality of evidence and strength of recommendations about the management of patients, however, GRADE is not a perfect system and still need to develop itself and been disseminated widely.

P044 QUALITY ASSESSMENT OF TRADITIONAL CHINESE CLINICAL GUIDELINES: 2003–2012

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Background Little is known about quality and quantity of traditional Chinese clinical guidelines. We aim to systematically review all of traditional Chinese clinical guidelines.

Methods We searched CNKI (China National Knowledge Infrastructure/Chinese Academic Journals full text Database), VIP (a fulltext database of China), WANFANG (a fulltext database of China) and CBM (China Biomedicine Database Disc). Two groups of review authors independently applied inclusion criteria, assessed trial quality, and extracted data.

Results We identified 75 traditional Chinese clinical guidelines from 2003 to 2012, and only 11(15%) were claimed that an evidence based approached were used in the process of development. From the assessment with the Appraisal of Guidelines for Research and Evaluation II (AGREE II), the mean scores were low for the domains ‘clarity of presentation’ (28%), ‘scope and purpose’ (15%) and ‘editorial independence’ 12%; and very low for the other domains (‘stakeholder involvement’ 8%, ‘rigour of development’ 5% and ‘applicability’ 3%). AGREE II mean scores of traditional Chinese clinical guidelines lower than Chinese clinical practice guidelines and the world average.

Conclusions Traditional Chinese clinical guidelines received lower scores, which indicate a relatively poor quality of the guidelines. However, there was some increase over time. Meanwhile, given the characteristics of Traditional Chinese medicine, CONSORT group has been developing CONSORT for TCM and for Acupuncture, we plan to develop AGREE TCM to be used to inform the development, appraisal and reporting of evidence-informed traditional Chinese clinical guidelines.

P049 EVIDENCE DISTRIBUTION OF A COMPREHENSIVE MUSCULO-SKELETAL GUIDELINE

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Background Occupational Medicine focuses on return to functionality and work, however the overwhelming majority of injuries are musculoskeletal and require very specific clinical situation evidence review. Body part areas addressed include spine, shoulder, elbow, hand/wrist/forearm, hip/groin, knee and ankle/foot. Interventions assessed include diagnostic, therapeutic and medical therapies.

Objectives To assess the theoretical evidence distribution of a comprehensive musculoskeletal guideline and its potential application in practice. **Methods:** Evidence ratings (A,B,C) were determined by expert data extraction from over 5,000 randomised controlled trials (RCT), non-RCT evidence was designated as insufficient (I). RCT evidence ratings were quantified on an 11 point scale that assessed appropriateness, biases and effectiveness. High quality evidence was defined as 8.0–11 points, moderate 4.0–7.5, and low < 4.0 points. A level evidence (Strong) was defined as 2 or more high-quality RCTs, B (Moderate) 1 high-quality or multiple moderate-quality, C (Limited) at least one study of moderate-quality. Low quality, observational or conflicting evidence was designated as Insufficient (I). A similar profile was used for diagnostic evidence recommendations. Evidence ratings were verified by independent writing panels.

Results Only 0% of 2500 recommendations were supported by a Limited (C) or better evidence base. When adjusting for frequency of occurrence from a claims data base, and cost was estimated in only 14% of costs were associated with quality RCT studies.

Conclusions These data suggest that the majority of musculoskeletal clinical decisions do not have a sufficient evidence base for rules-based decision making.

P050 ‘FOOD AND EATING BEHAVIOUR’ – DEVELOPMENT OF A GUIDELINE FOR DUTCH PREVENTIVE CHILD HEALTH CARE

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Background Many parents worry that their child is eating either too much or too little. In The Netherlands, Preventive Child Health Care (PCHC) is the main source of advice and information on food and eating behaviour. Yet, evidence on the subject is sparse and scattered. The Dutch Ministry of Health Welfare and Sports, therefore, requested a guideline; the PCHC-guideline should fit together with a guideline for paediatricians on the same subject, which was developed concurrently.

Objectives To develop a national guideline for PCHC-professionals on the subject to enhance uniform, evidence-based practice.

Methods A working group of guideline developers, epidemiologists, and dieticians, together with professionals in PCHC, child-psychology and -pedagogs, and a pre-speech therapist developed the guideline, according to the principles of evidence-based medicine. Close collaboration took place with a group of paediatricians developing the new guideline ‘Signalling somatic causes of abnormal nutritional behaviour in children’. Questions were formulated by the working group and evidence was extracted from literature, supplemented by practice-based consensus. The guideline was piloted in several PCHC settings.

Results Together with a group of child psychologists and psychiatrists, referral criteria for eating disorders were agreed on. Paediatricians formulated ‘Somatic alarm symptoms’. Discussion Working with a large, interdisciplinary group of guideline