

P162 RIGOR OF DEVELOPMENT OF CLINICAL PRACTICE GUIDELINES IN DENTISTRY

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Background Some reports have shown the varying quality of clinical practice guidelines (CPGs), but this aspect has not been explored in the field of dentistry. With a growing number of guidelines in dentistry being published every year, and an increase in dentist's interest to inform their practice with such documents, it is relevant to learn whether their development process has been appropriate.

Objectives To assess the rigour of development of evidence-based CPG's in dentistry.

Methods We searched Pubmed, EMBASE, and the National Guideline Clearinghouse among others. We included all evidence-based CPGs with explicit clinical recommendations, published since 2004 in English. Two independent evaluators assessed the guidelines using the "Rigour of development" domain of AGREE II.

Results A total of 73 CPGs were assessed. The mean score of the rigour of development domain across all guidelines was 34.54% (SD=19.18%). The items that scored the lowest were the description of a procedure for updating the guideline and the strengths and limitations of the evidence; whereas the items best rated were the explicit link between the evidence supporting the recommendations and the pondering of benefits, harms and risk for formulating the recommendations.

Discussion CPGs aim to support clinical decision-making, and thus they can impact the quality of health-care. Thus, the rigour in their development is a relevant aspect to consider. There is a lot of room for improvement in this regard in CPGs in dentistry.

Implications for Guideline Developers Guideline developers in dentistry should enhance the methodology when creating new guidelines or updating existing ones.

P164 THE ABYSS BETWEEN RCTS AND GUIDELINES; AND THE BRIDGING ROLE OF COCHRANE SYSTEMATIC REVIEWS

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Background Randomised trials (RCTs) and Cochrane systematic reviews (CRs) are mainstays of most clinical practice guidelines (CPGs). It is important that all relevant high level evidence is included in CPGs.

Objective To determine rates of RCT inclusion in perinatal CPGs, either directly or via CRs.

Methods We used a database of all known Australian perinatal RCTs with findings released between 1986–2010 (n = 303), compiled for a project addressing impact of evidence. International and national perinatal CPGs were manually searched for cites of any of the 303 RCTs, or perinatal CRs including the RCTs, as at January 2013.

Results 59/303 RCTs (19%) were cited in at least one perinatal CPG. Ninety per cent of the 59 RCTs (n = 53) were included in

CRs; and in 25/59 cases the RCT was only included in a CPG via the CR. All 59 included RCTs had a maternal/perinatal rather than a neonatal focus.

Discussion Over 80% of RCTs in this dataset were not included in relevant CPGs. The chance of a trial being in a CPG increased if it was included in a CR and if it had a maternal/perinatal focus. Possible ways to close the RCT-CPG abyss will be presented.

Implications for Guideline Developers/Users While translation from RCT to CR is common, we need to better understand the reasons why high level RCT and CR evidence is often missing from CPGs and what the impact is on quality of CPG recommendations.

P168 PRACTICE GUIDELINES AND PROFESSIONAL MIND-LINES. QUALITATIVE RESEARCH ON SYSADOAS FOR OSTEOARTHRITIS

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Background There is still a gap between what good quality CPGs recommend and real practice. For osteoarthritis, although best quality CPGs do not recommend SYSADOAS, a high degree of variability in prescription rates has been observed.

Objectives To explore the reasons that explains SYSADOAS prescription for osteoarthritis.

Methods A qualitative research was performed including one focus group to explore what General Practitioners (GPs) thought about this topic, and two in-depth interviews with specialised care. 8 GPs, one orthopaedic surgeon and one rheumatologist participated. Focus group and interviews, previous consent recorded, were transcribed and analysed using MAXQDA software.

Results GPs were aware of the lack of evidence about SYSADOAS efficacy, but they did not know which CPGs they should trust in. Prescription was mainly initiated by specialists, but GPs admitted that they also started it, being the respect for their colleagues and patients' pressure the main reasons. Specialists did not use CPGs on this issue, but partially admitted that SYSADOAS had no effect. For them, health care pressure, high ratio of patients and a rapid way to discharge them were the main reasons.

Discussion Clinician's knowledge about CPGs and quality standards is scarce. The lack of communication among health care levels and the inadequate management of the disease are, among others, the reasons explaining SYSADOAS prescription.

Implications for Guideline Developers/Users Provide clinicians skills and tools to empower them about which is considered good evidence and how to critically appraise CPGs, and promote the communication between levels to improve patient management.

P172 CHALLENGES OF MEASURING THE UPTAKE OF NATIONAL PUBLIC HEALTH GUIDANCE IN THE UK: A NEW METHODOLOGY

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