modified AGREE and using systematic reviews to supplement the evidence base when there is discordance among recommendations.

**Development of Multidisciplinary Symptom Management Tools Using the ADAPTE Approach**

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**Background** Evidence-based tools for symptom management were developed to assist healthcare providers in comprehensive assessment and appropriate management of symptoms. These evidence-based tools consist of comprehensive guides-to-practice, quick reference pocket guides, algorithms and smart phone apps.

**Objectives** The symptom management tools promote an interdisciplinary model of care that enables early identification and assessment of symptoms, appropriate documentation and communication regarding symptoms, optimal symptom management, and coordinated care throughout the illness trajectory. The tools are intended to be user-friendly, and are available in print, web and smartphone applications.

**Methods** The tools were developed by an interdisciplinary panel of healthcare providers using the ADAPTE guideline adaptation approach. This included a literature search for recent guidelines and systematic reviews, guideline appraisal using the AGREE tool and selection, and in some instances modification, of recommendations. Expert feedback was obtained and subsequently appropriate revisions were made.

**Results** The symptom management tools provide recommendations based on the best available evidence and expert consensus, for assessing, determining aetiology, diagnosing potential problems and for recommending non-pharmacological and pharmacological interventions.

**Implications for Guideline Developers/Users** The ADAPTE approach offers a comprehensive and rapid process of developing evidence-based tools for the cancer patient population. Following the global trend of creating user-friendly clinical guidance, the guides-to-practice, quick reference pocket guides, algorithms and smartphone apps are an innovative set of tools that are accessible to a diverse group of care providers, in a manner that would suit the individual’s clinical needs.

**Can Systems for Rating Evidence Quality and Recommendation Strength Be Harmonised?**

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**Background** In 2011 the IOM recommended that every guideline recommendation should be accompanied by an indication of Evidence Quality and Recommendation Strength and called for strategies to encourage harmonisation of development processes.

**Objectives** To characterise the differences in systems for rating Evidence Quality and Recommendation Strength as a prelude to possible standardisation.

**Methods** We examined 17 international, English-language guideline development systems to identify rating parameters and applied descriptive statistics. We also searched for conceptual linkages in the rating system descriptions and identified systems where Strength of Recommendation was stated as an Evidence Quality parameter.

**Results** Rating systems were remarkably inconsistent in their application of category indicators—using letters, Arabic and Roman numerals and combinations. The modal and median number of Evidence Quality categories was 3 (range 0 to 10) and Recommendation Strength categories was 4 (range 0 to 6). 13/17 used randomised trials as indicators of highest quality evidence. 7 systems used “expert opinion,” 6 used “case reports” or “case series,” and 4 described “reasoning from first principles” to define lowest evidence quality. Definitions of intermediate levels varied considerably. 7 systems judged benefits and harms in deriving Recommendation Strength. In 7 rating systems, Strength of Recommendation was described entirely in terms of Evidence Quality.

**Implication** There is considerable disagreement about the requisite granularity and definition of categories of Evidence Quality and Recommendation Strength. Application of the concept of Recommendation Strength consonant with the IOM standard is limited. A straightforward mapping of rating systems to one another is elusive.