International collaboration in guideline development - Experiences in the Netherlands

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GIN Conference Berlin, August 2012

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NEDERLANDSE VERENIGING VOOR PSYCHIATRIE

Background

Every country individually develops guidelines and every country

reviews the international literature

General goal of collaboration:

join forces!

- Develop guideline with broader scope
- Save time / money

Content

1. Background
2. Collaboration partners
3. Specific goals
4. How did we proceed?
5. Applying UK methods
   A. Project management methods
   B. Literature review methods
6. Practical challenges
7. Conclusion
8. Lessons learned

Collaboration between:

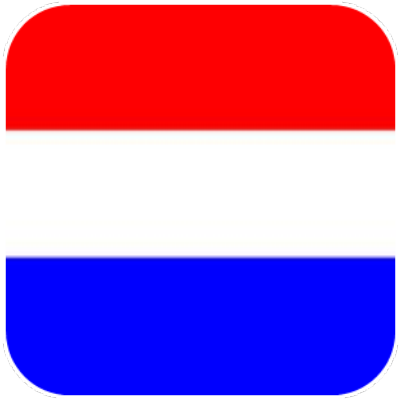
- **the United Kingdom**
- **the Netherlands**

2. collaboration partners

NL:

The Netherlands Institute of Mental Health and Addiction (Trimbos Institute)

The NL guideline was commissioned by the Netherlands Psychiatric Association (NVvP)



UK:

National collaborating Centre for Mental Health (NCCMH)

The UK Guideline was commissioned by NICE

3. Specific goals

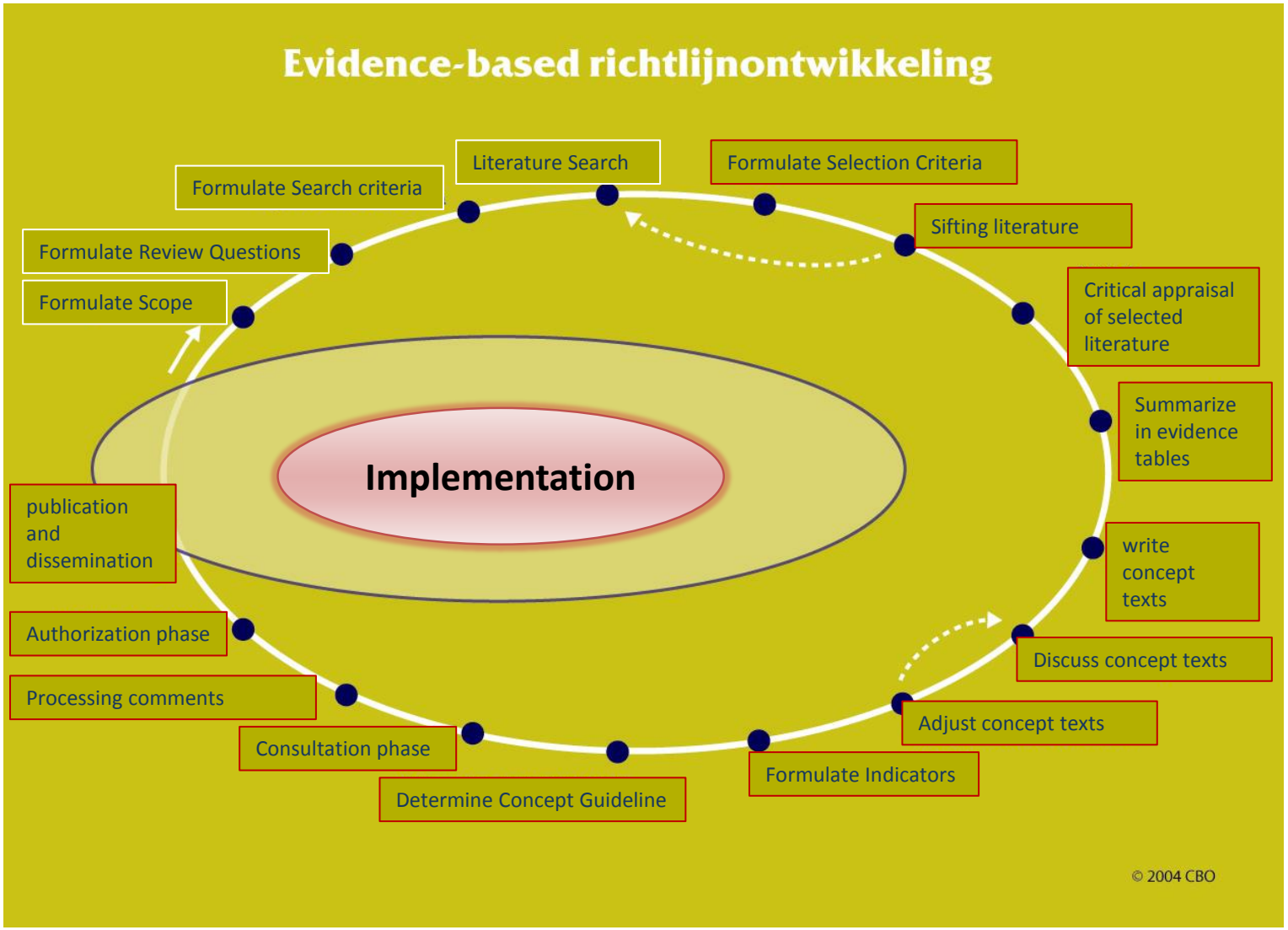
- Make 2 guidelines on *Autism Spectrum Disorder in adults* (UK & NL)
- Increase our quality of guideline development by applying UK methods
- Explore the options for further international collaboration

GDG chairs meet in London

January 14th 2011

Chair of UK GDG (Simon Baron Cohen) meets chair of NL GDG (Cees Kan)

EB Guideline Development



4. How did we proceed?

- Seperate GDG's, technical teams, projectmanager, project plannings
- NL GDG used UK scope & clinical questions
- NL followed the time line of UK: worked parallel
- NL applied project management methods of UK
- NL applied literature review methods of UK
- Clinical questions were divided (NL less, UK more)
- Regular communication between UK-NL projectmanagers and UK-NL technical teams
- Presenting same reviews in two GDG's
- One UK reviewer worked in NL during development

Collaborate – Adopt / Adapt

ADOPT/ADAPT	
Literature search	
Selection criteria	
Review of literature	
Conclusion	
Recommendation	
Context UK	Context NL
Adjustment in wording because of context?	

COLLABORATE	
Literature search	
Selection criteria (interactive)	
Review of literature (interactive)	
Interpretation UK	Interpretation NL
Conclusion UK	Conclusion NL
Context UK	Context NL
Recommendation UK	Recommendation NL

5. Applying UK methods

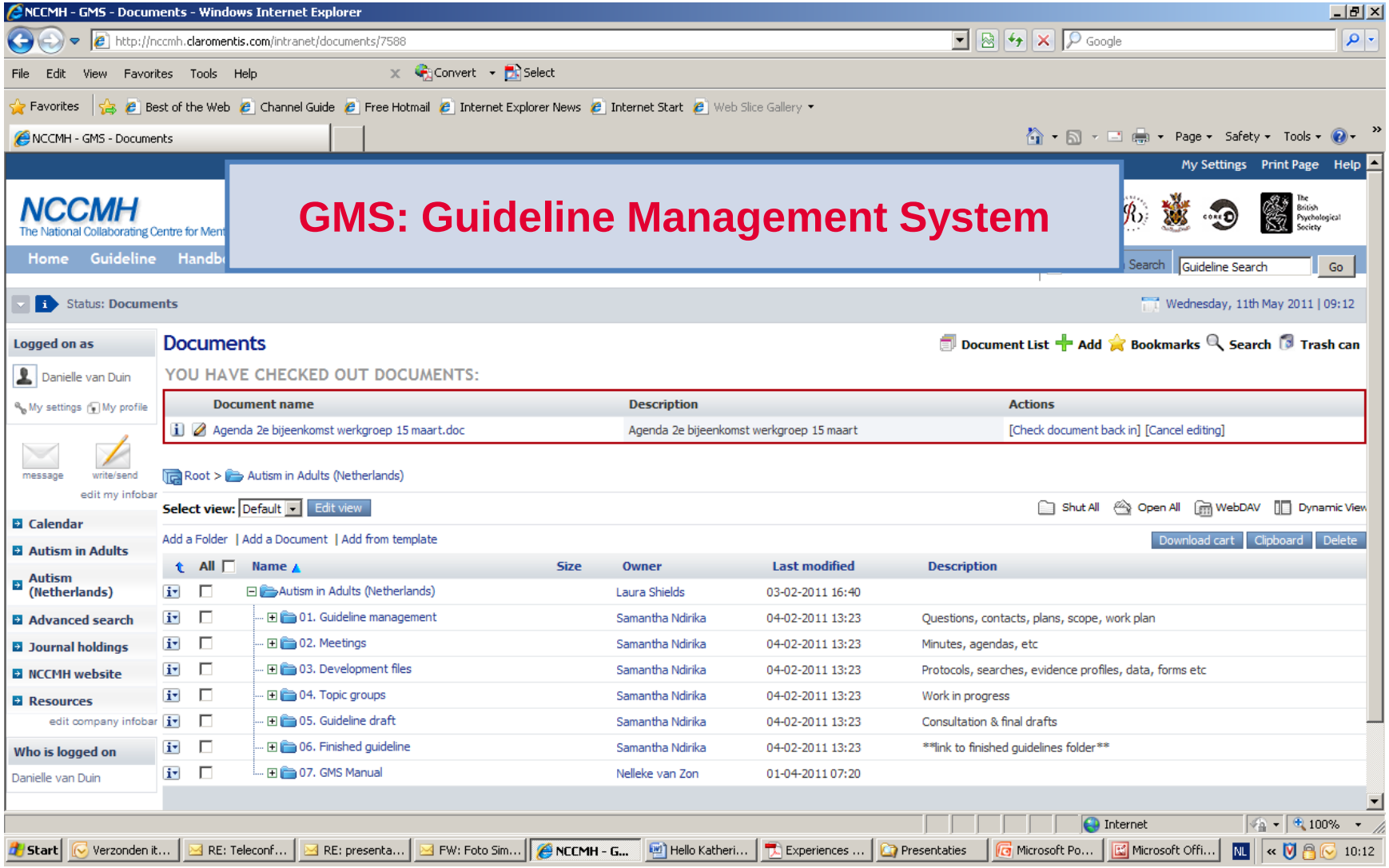
A. Project management methods

B. Technical literature review methods

A. Project management processes

- Involvement of professionals
  - Communication with colleague professionals
  - Authorizaton
- Planning tools
  - Overall guideline planning
  - Workplan GDG meetings
  - Review protocol + Writing plan
- GDG meetings
  - Meetings of whole day i.s.o. 2 hours
  - Concept versions of literature
  - Reviews presented by reviewers in both countries
- Digital environment

Digital environment



B. Technical literature review

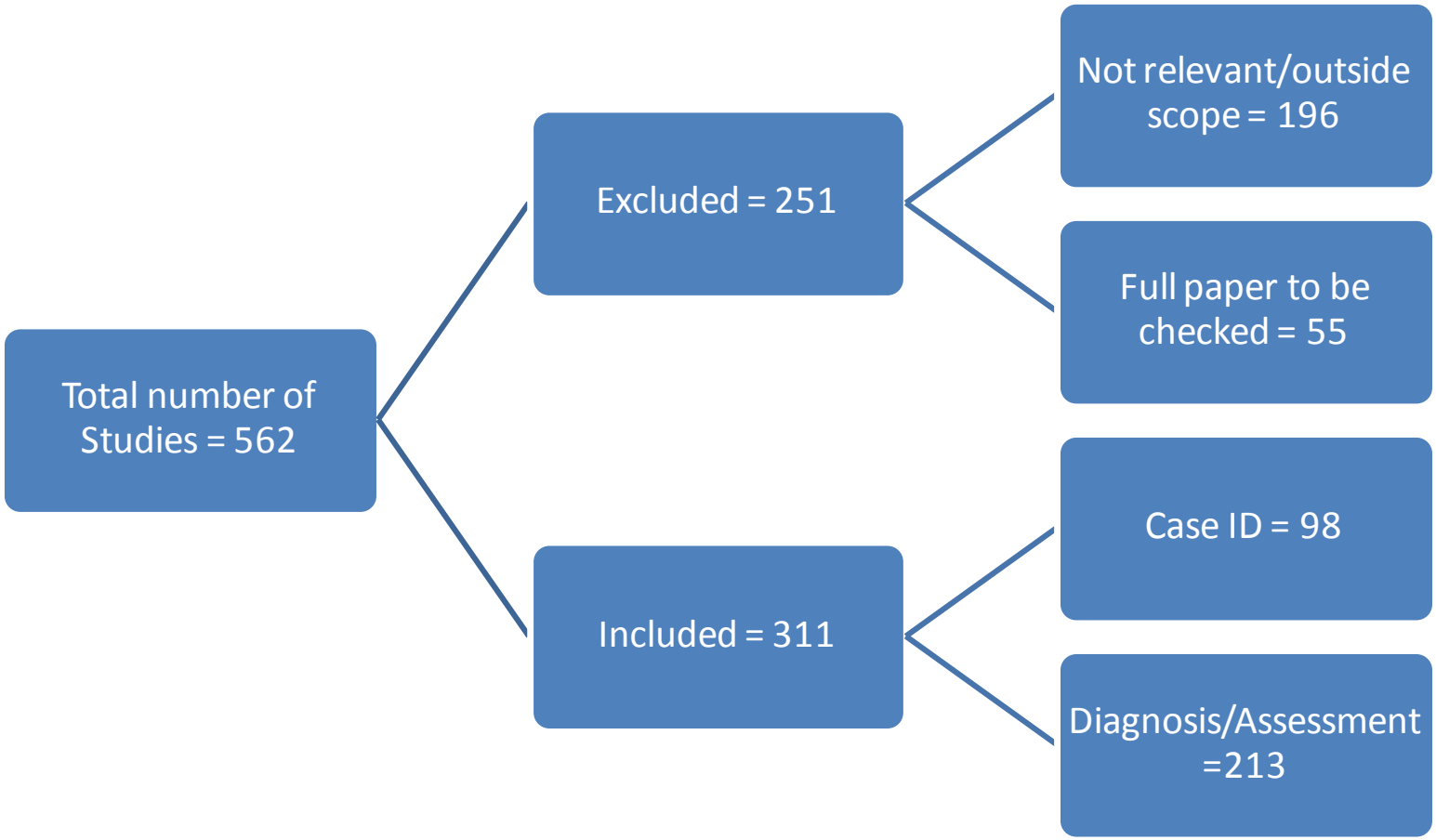
What:

- Sifting procedure
- Meta-analysis
- GRADE
- Health Technology Assessment (HTA)
- Extrapolating from other study populations

How:

- One former UK-reviewer worked in NL Technical Team ('liaison officer')
- Training of technical team in meta-analysis, GRADE and Health economics
- Regular contact between Technical Teams

Sifting Procedure



Meta-analysis

Similar:

- Evidence tables (or study characteristics tables)
- Quality assessments (templates for different study design)
- Narrative review of the literature

Additional:

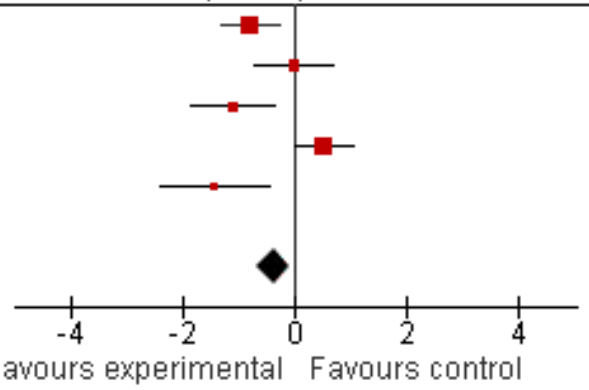
- Only primary studies, no systematic reviews
- Meta-analysis in review manager, resulting in forest plots

Meta-analysis: Forest Plot

Forest Plots: give a graphic representation of a meta-analysis

Study or Subgroup	Std. Mean Difference	SE	Weight	Std. Mean Difference IV, Fixed, 95% CI
AMORE2011	-0.78877	0.263692	31.0%	-0.79 [-1.31, -0.27]
HELLINGS2005	-0.01852	0.36597	16.1%	-0.02 [-0.74, 0.70]
MCDOUGLE1998	-1.10875	0.392202	14.0%	-1.11 [-1.88, -0.34]
TYRER2008	0.504129	0.266752	30.3%	0.50 [-0.02, 1.03]
VANHEMERT1975	-1.42955	0.501089	8.6%	-1.43 [-2.41, -0.45]
Total (95% CI)			**100.0%**	**-0.37 [-0.66, -0.09]**

Heterogeneity: Chi² = 22.20, df = 4 (P = 0.0002); I² = 82%
Test for overall effect: Z = 2.54 (P = 0.01)



Each study is represented by a block at the point estimate of the intervention effect (as measured by standard mean difference here)

The area of the block corresponds to the weight allocated to that study in the meta-analysis

The horizontal line depicts the confidence interval (95% CI). Larger weight is usually given to studies with smaller confidence intervals

The diamond represents the overall effect and the significance of the overall effect is given at the bottom of the plot

GRADE

Author(s): Elie Akl & Holger Schunemann **Date:** 2008-09-11
Question: Should parenteral anticoagulation be used in prolonging survival of patients with cancer? **Settings:** Outpatient
Bibliography: EA Akl, FF van Doormaal, M Barba, G Kamath, SY Kim, S Kuipers, S Middeldorp, V Yosuico, H Dickinson, HJ Schünemann. Parenteral anticoagulation for prolonging survival in patients with cancer who have no other indication for anticoagulation. CDSR Reviews. 2007 Issue 3

Quality assessment							Summary of findings					
							No of patients		Effect		Quality	Importance
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	anticoagulation	control	Relative (95% CI)	Absolute		
Survival at 12 months (study follow up)												
5	randomised trials	no serious limitations[1]	no serious inconsistency	no serious indirectness[2]	no serious imprecision	none	339/586 (57.8%)	390/588 (60%)	RR 0.87 (0.8 to 0.95)	78 fewer per 1000 (from 30 to 120 fewer)	⊕⊕⊕⊕ HIGH	CRITICAL
Survival (overall - study follow up at 24 to 84 months)												
5	randomised trials	no serious limitations[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	477/586 (81.4%)	520/588 (85%)	HR 0.77 (0.65 to 0.91)	82 fewer per 1000 (from 28 to 141 fewer)	⊕⊕⊕⊕ HIGH	CRITICAL
DVT												
2	randomised trials	no serious limitations[1]	no serious inconsistency	no serious indirectness	very serious[3]	reporting bias[4]	1/232 (0.4%)	2/226 (4%)	RR 0.61 (0.08 to 4.91)	16 fewer per 1000 (from 37 fewer to 156 more)	⊕OOO VERY LOW	CRITICAL
Major bleeding												
3	randomised trials	no serious limitations[1]	no serious inconsistency	no serious indirectness	serious[3]	reporting bias[5]	8/406 (2%)	6/408 (1.5%)	RR 1.50 (0.26 to 8.8)	7 more per 1000 (from 11 fewer to 117 more)	⊕⊕OO LOW	CRITICAL
Minor bleeding												
3	randomised trials	no serious limitations[1]	no serious inconsistency	no serious indirectness	serious[3]	reporting bias[5]	14/380 (3.7%)	5/380 (1.3%)	RR 2.07 (0.78 to 5.51)	14 more per 1000 (from 3 fewer to 59 more)	⊕⊕OO LOW	IMPORTANT

[1] Unclear concealment in one of the five trials did not lead to downgrading the quality of evidence.
[2] The studies used different LMWHs but indirectness is not likely given the similiarity in results across studies.
[3] The 95% CI includes both negligible effect and appreciable benefit or appreciable harm
[4] Out of 5 included studies, only 2 reported DVT. We assumed that this was based on selective reporting of outcomes. The authors of the study did not provide further information.
[5] Out of 5 included studies, only 3 reported major bleeding. We assumed that this was based on selective reporting of outcomes. The authors of the study did not provide further information.

6. Practical challenges

- Little literature available on topic
  - ✓need for extrapolating and less training in MA
- Training of new methods needs investment
  - ✓often learning by doing works best
- Work together in the same timeline
- Understand rationale behind choices
  - ✓subtle differences in health system UK-NL
- Communicate all details on content and reviewing of literature
  - ✓communication reviewers UK/NL to other GDG

7. Conclusions

- A broader scope and more clinical questions were handled in the same amount of time
- Qualilty improvement: several UK methods will be adapted in regular NL guideline development
- Working on international collaboration is: working on international trust
  1. Transparancy in guideline texts
  2. Apply equal review methods
  3. Share evidence tables + literature reviews

8. Lessons learned

- Search for similarity:
  - Use the same methods and formats
  - Make the same choices (PICO's and inclusion criteria)
- Implementation of new skills takes time
- Communication is essential due to differences in work methods, cultural aspects and geographical distance. So:
  - Form one technical team, with regular international meetings
  - Use one overall planning, with the same time line
  - Plan regular international consultation between GDG's
- Sequel:
  collaboration on Bipolar Disorder guideline

Thanks!

Thanks for your attention!

Questions?

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GRADE

Outcome	Challenging behaviour – Irritability (continuous data)	Challenging behaviour – Irritability (dichotomous data)	Challenging behaviour - Aggression	Symptom severity / improvement	Side effects
Study ID	HELLINGS2005 HOLLANDER 2010	HOLLANDER 2010	HELLINGS2005	HELLINGS2005	HELLINGS2005
Effect size	SMD = -0.05 (-0.58, 0.48)	RR = 6.87 (1.02, 46.28)	MD = 0.14 (-2.93, 3.21)	MD = -0.37 (-0.97, 0.23)	RR = 1.19 (0.88, 1.61)
Quality of evidence (GRADE)	Very low[1,2,3]	Low[2,3]	Low[2,3]	Low[2,3]	Low[2,3]
Number of studies /participants	(K=2; N=57)	(K=1; N=27)	(K=1; N=30)	(K=1; N=30)	(K=1; N=30)
Forest plot	Biomedical #	Biomedical #	Biomedical #	Biomedical #	Biomedical #

[1]Downgraded for inconsistency: HELLINGS2005 and HOLANDER2010
[2]Downgraded for indirectness as extrapolating from children with autism
[3]Downgraded for imprecision as the sample size is small