Ad-o-lopment of guidelines: a way forward for Croatia

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Deputy Director, Cochrane Germany
Director, GRADE Center Freiburg

Trusted evidence.
Informed decisions.
Better health.
Special thanks to:

Holger Schünemann
Elie Akl
Jan Brozek
Members of the KSA Team
Members of the GRADE Working Group
<table>
<thead>
<tr>
<th>Phase</th>
<th>Modules</th>
<th>Steps</th>
</tr>
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<tr>
<td>I. Setup</td>
<td>Preparation</td>
<td>• Establish an organizing committee</td>
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<tr>
<td></td>
<td></td>
<td>• Select a guideline topic</td>
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<tr>
<td></td>
<td></td>
<td>• Check whether adaptation is feasible</td>
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<td></td>
<td></td>
<td>• Identify necessary resources and skills</td>
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<td></td>
<td></td>
<td>• Complete tasks for the set-up phase</td>
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<td></td>
<td></td>
<td>• Write adaptation plan</td>
</tr>
<tr>
<td>II. Adaptation</td>
<td>Scope and purpose</td>
<td>• Determine the health questions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Search for guidelines and other relevant documents</td>
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<tr>
<td></td>
<td></td>
<td>• Screen retrieved guidelines</td>
</tr>
<tr>
<td></td>
<td>Search and screen</td>
<td>• Reduce a large number of retrieved guidelines</td>
</tr>
<tr>
<td></td>
<td>Assessment</td>
<td>• Assess guideline quality</td>
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<td></td>
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<td>• Assess guideline currency</td>
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<td>• Assess guideline content</td>
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<td></td>
<td>• Assess guideline consistency</td>
</tr>
<tr>
<td></td>
<td>Decision and selection</td>
<td>• Assess acceptability/applicability of the recommendations</td>
</tr>
<tr>
<td>III. Finalization</td>
<td>External review and acknowledgment</td>
<td>• Review assessments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Select between guidelines and recommendations to create an adapted</td>
</tr>
<tr>
<td></td>
<td></td>
<td>guideline</td>
</tr>
<tr>
<td></td>
<td>Customization</td>
<td>• Prepare draft adapted guideline</td>
</tr>
<tr>
<td></td>
<td>Aftercare planning</td>
<td>• External review by target users</td>
</tr>
<tr>
<td></td>
<td>Final production</td>
<td>• Consult with relevant endorsement bodies</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Consult with developers of source guidelines</td>
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<tr>
<td></td>
<td></td>
<td>• Acknowledge source documents</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Plan scheduled review and update of adapted guideline</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Produce final guidance document</td>
</tr>
</tbody>
</table>
Decide if adaptation required

<table>
<thead>
<tr>
<th>Factors influencing the applicability or transferability of guidelines across different settings</th>
<th>Response (positive answers increase the likelihood that recommendations should be flagged as requiring adaptation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is there important variation in need (prevalence, baseline risk or health status) that might lead to different decisions?</td>
<td>□ Yes □ Unclear □ No</td>
</tr>
<tr>
<td>2. Is there important variation in the availability of resources that might lead to different decisions?</td>
<td>□ Yes □ Unclear □ No</td>
</tr>
<tr>
<td>3. Is there important variation in costs (e.g. of drugs or human resources) that might lead to different decisions?</td>
<td>□ Yes □ Unclear □ No</td>
</tr>
<tr>
<td>4. Is there important variation in the presence of factors that could modify the expected effects (e.g. resistance patterns of microbiological pathogens), which might lead to different decisions?</td>
<td>□ Yes □ Unclear □ No</td>
</tr>
<tr>
<td>5. Is there important variation in the relative values of the main benefits and downsides that might lead to different decisions?</td>
<td>□ Yes □ Unclear □ No</td>
</tr>
</tbody>
</table>

Variation in:
- Baseline risk
- Availability of resources
- Costs
- Effect modifiers
- Values & preferences
Guideline ‘Ad-o-lopment’

- Ad-o-lopment = Adaptation + Adoption + Development
- Approach to the “adolopment” of guidelines through
  1. Identification of existing evidence syntheses (systematic reviews, HTAs, and evidence reports), which address specific clinical questions (and may have been produced to support previous guidelines)
  2. Updating the evidence syntheses
  3. Development of guideline recommendations in structured and transparent way specific to a healthcare setting (EtDs).
- Often not simply adopting recommendations given in previous guidelines.
Selection of Guidelines

- Use transparent grading and recommendation methodology
- Use transparent criteria for moving from evidence to recommendations
- Provide evidence summaries that are transparent (to allow production of GRADE evidence tables)
- Recently published
Credibility of the Systematic Review Process (e.g. AMSTAR)

- Did the review explicitly address a sensible clinical question?
- Was the search for relevant studies exhaustive?
- Was the risk of bias of the primary studies assessed?
- Were selection and assessments of studies reproducible?
- Did the review address possible explanations of between-study differences in results (heterogeneity)?
- Did the review present results that are ready for clinical application?
- Did the review address confidence in effect estimates (i.e., quality of evidence)?
SAUDI ARABIAN MOH GUIDELINES – PHASE II
Project Overview

- **Objective**: To develop health care guidelines on 12 clinical topics.

- **Timeline**: June 2014 through January 2015

- **Focus** in this project is on *‘ad-o-lopment’* of guidelines, rather than *de novo* development of guidelines.

- Collaboration between Ministry of Health of Kingdom of Saudi Arabia (MoH KSA) and McMaster University, Department of Clinical Epidemiology and Biostatistics (and partners in Freiburg und Beirut)
Selection of guideline topics

List of approximately 50 eligible existing guidelines or high priority topics

Definition of selection criteria and assessment of the potential topics according to the criteria.

- Published recently (i.e. 3-4 year max) in English language
- Risk of bias assessment for the evidence
- Existing, or accessible or reproducible, evidence tables or summaries,
- Transparent grading methodology of the quality of the evidence (ideally)
- Published (or otherwise accessible) search strategies with inclusion and exclusion criteria, for updating

Reasonably good scoring on credibility assessment tools (well done evidence review)
Topics

1. Prevention of venous thromboembolism (VTE) in nonsurgical patients
2. Prevention of VTE in surgical patients
3. Management of pre-eclampsia
4. Management of eclampsia
5. Screening for hypertension
6. Management of ST-elevation myocardial infarction
7. Screening for colon cancer
8. Management of obesity/overweight in adults
9. Management of breast lump
10. Migraine diagnosis and treatment
11. Management of thalassemia – treatment of iron overload and supplementation
12. Management of sickle cell anemia – acute and chronic
Groups and Roles

McMaster Guideline Working Group:

- Methodological support and training
- Evidence synthesis and updating
- Preparing evidence summaries for panels
- SRs on values and economic data
- Preparing guideline reports

Saudi Centre for EBHC

Saudi Expert Guideline Panels
Groups and Roles

McMaster Guideline Working Group

Saudi Centre for EBHC:
- Project coordination
- Recruiting panel members
- Facilitating communication with panels
- Dissemination of guidelines

Saudi Expert Guideline Panels
Groups and Roles

McMaster Guideline Working Group

Saudi Centre for EBHC

Saudi Expert Guideline Panels:

• Prioritization of questions for guidelines
• Suggesting local evidence and input on local data and contextual factors
• Reviewing evidence summaries
• Making judgements and formulating recommendations in final panel meeting
• Dissemination of guidelines
Selection of a topic / guideline for adaptation ➔ EBHC, McMaster group

Selection of the recommendations/clinical questions for adaptation ➔ McMaster group, KSA panel members

Update of the evidence (SRs), including local evidence ➔ McMaster group, KSA panel members

Develop KSA-specific EtD tables ➔ McMaster group, KSA panel members

Adaptation of the recommendations ➔ KSA panel members, McMaster group

Draft of the guideline ➔ McMaster group, EBHC, KSA panel members

Feedback on draft guideline from panel members and EBHC

Feedback on draft guideline from external peer-reviewers ➔ KSA panel members
The Question

Key questions

1. Should home treatment vs. hospital treatment be used for patients with acute DVT of the leg?
2. Should early discharge vs. standard discharge be used for patients with acute PE?
3. Should heparin vs no heparin be used in outpatients with cancer who have no other therapeutic or prophylactic indication for anticoagulation?
4. Should oral anticoagulation vs no oral anticoagulation be used in outpatients with cancer who have no other therapeutic or prophylactic indication for anticoagulation?
5. Should parenteral anticoagulation vs no anticoagulation be used in patients with cancer and central venous catheters?
6. Should oral anticoagulation vs no anticoagulation be used in patients with cancer and central venous catheters?
### The GRADE SoF table

**Home treatment compared to hospital treatment for patients with DVT**

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Assumed risk</th>
<th>Corresponding risk</th>
<th>Relative effect (95% CI)</th>
<th>No of Participants (studies)</th>
<th>Quality of the evidence (GRADE)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality</td>
<td>43 per 1000</td>
<td>33 per 1000</td>
<td>RR 0.72 (0.45 to 1.15)</td>
<td>1708 (8 studies)</td>
<td>low</td>
<td></td>
</tr>
<tr>
<td>Recurrent VTE</td>
<td>78 per 1000</td>
<td>48 per 1000</td>
<td>RR 0.65 (0.44 to 0.94)</td>
<td>1709 (7 studies)</td>
<td>moderate</td>
<td></td>
</tr>
<tr>
<td>Major bleeding</td>
<td>21 per 1000</td>
<td>14 per 1000</td>
<td>RR 0.67 (0.33 to 1.30)</td>
<td>1708 (8 studies)</td>
<td>low</td>
<td></td>
</tr>
<tr>
<td>Quality of life</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post thrombotic syndrome - not reported</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).*

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**Cochrane Working Group grades of evidence**

High quality: Further research is very unlikely to change our confidence in the estimate of effect.

Moderate quality: Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate.

Low quality: Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate.

Very low quality: We are very uncertain about the estimate.

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1. RCTs included recruited patients whose home circumstances were adequate
2. RCTs included patients with leg DVT. They excluded those with PE and pregnant women
3. 4 RCTs had partial hospital treatment for some participants in the home group: Levine 1996 (mean hospital stay 2.1 vs. 6.5 days in home and hospital arms respectively), Koopman 1996 (2.7 vs. 8.1 days), Boccalon 2000 (1 vs. 9.8 days), and Ramacciotti 2004 (3 vs. 7 days). Chong 2005 and Daskalopoulos 2005 did not report mean duration of hospital stay.
4. One RCT (Bacclon 2000) used LMWH in both treatment groups. Remaining studies used LMWH in the outpatient group and UFH in the inpatient group.
5. Of 7 RCTs, allocation was clearly concealed in 3 (unclear in 4), outcome adjudicators were clearly blinded in the 2 largest RCTs (unclear in remaining 5), missing data was significant in one small RCT, and analysis was ITT in 4 (unclear in remaining 3). These limitations did not warrant downgrading of quality of evidence, particularly because it had already been downgraded by at least one level for other reasons.
6. CI includes values suggesting benefit and values suggesting harm
7. Backman 2004, using EQ 5D, found no differences in mean QoL scores or in proportion of participants showing improvement in self-rated health state. Koopman 1996, using the Medical Outcome Study Short Form-20 and an adapted version of the Rotterdam Symptom Checklist, found that changes over time were similar in both arms (exception: had better scores for physical activity (P=0.002) and social functioning (P=0.001)) in those receiving LMWH at the end of the initial treatment. O'Brien 1999, using SF-36 in 300 participants from Levine 1996, found no significant differ-
The GRADE/DECIDE EtD Framework

Key questions

1. Should home treatment vs. hospital treatment be used for patients with acute DVT of the leg?
2. Should early discharge vs. standard discharge be used for patients with acute PE?
3. Should heparin vs. no heparin be used in outpatients with cancer who have no other therapeutic or prophylactic indication for anticoagulation?
4. Should oral anticoagulation vs. no oral anticoagulation be used in outpatients with cancer who have no other therapeutic or prophylactic indication for anticoagulation?
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6. Should oral anticoagulation vs. no anticoagulation be used in patients with cancer and central venous catheters?
DECADE

Developing and Evaluating Communication Strategies to Support Informed Decisions and Practice Based on Evidence

Welcome

DECADE is a 5-year project (running from January 2011 to 2015) co-funded by the European Commission under the Seventh Framework Programme.

Project Objective

"To improve the dissemination of evidence-based recommendations by building on the work of the GRADE Working Group to develop and evaluate methods that address the targeted dissemination of guidelines."

Background

Healthcare decision makers face challenges in understanding guidelines, including the quality of the evidence upon which recommendations are made, which often is not clear. Guidelines are also typically developed as a one-size-fits-all package. By developing and evaluating targeted dissemination strategies, DECADE aims to increase the use of evidence-based interventions in a sustainable way and to reduce the use of interventions where benefits are uncertain.

Methods

GRADE is a systematic approach towards assessing and communicating the quality of evidence and the strength of recommendations. It has been developed to address the weaknesses of other grading systems and is now widely used internationally. The DECADE consortium, which is composed of members of the GRADE Working Group, will further develop this approach to ensure effective dissemination of evidence-based recommendations targeted at the key stakeholders (healthcare professionals; policymakers and managers; patients and the general public) who determine what happens in clinical practice. We will collect stakeholder input from advisory groups, consultations and user testing. This will be done across a wide range of health systems in Europe. The targeted dissemination strategies that are developed will be evaluated in randomized trials, refined and used and evaluated with real guidelines developed by the DECADE partners and other guideline developers that we support.

Expected results

Dissemination strategies for recommendations that have been rigorously evaluated in diverse settings, support the transfer of research into practice, and are adapted to real-world healthcare systems.
### Question/Problem

- Benefits and harms
- Quality of evidence
- Values
- Resources
- Equity
- Acceptability
- Feasibility
- Recommendation
GRADE Evidence to Decision Frameworks

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>JUDGEMENTS</th>
<th>RESEARCH EVIDENCE</th>
<th>ADDITIONAL CONSIDERATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there a problem priority?</td>
<td>Yes</td>
<td>Critical</td>
<td></td>
</tr>
<tr>
<td>What is the overall certainty of this evidence?</td>
<td>High</td>
<td>Low</td>
<td></td>
</tr>
<tr>
<td>Is there important uncertainty about how much people value the main outcomes?</td>
<td>Yes</td>
<td>Low</td>
<td></td>
</tr>
</tbody>
</table>

The relative importance or values of the main outcomes of interest:

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Relative Importance</th>
<th>Certainty of the evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer Mortality for Screening Intervals ≥ 24 Months for All Ages</td>
<td>Critical</td>
<td>Low</td>
</tr>
<tr>
<td>Breast Cancer Mortality for Screening Intervals ≥ 24 Months for Ages 70-74</td>
<td>Critical</td>
<td>Low</td>
</tr>
<tr>
<td>Breast Cancer Mortality for Screening Intervals &lt; 24 Months for All Ages</td>
<td>Critical</td>
<td>High</td>
</tr>
<tr>
<td>Breast Cancer Mortality for Screening Intervals ≥ 24 Months for Ages 50-69</td>
<td>Critical</td>
<td>Moderate</td>
</tr>
<tr>
<td>Breast Cancer Mortality for Screening Intervals &lt; 24 Months for Ages 50-69</td>
<td>Critical</td>
<td>High</td>
</tr>
<tr>
<td>Breast Cancer Mortality for Screening Intervals &lt; 24 Months for Ages 39-49</td>
<td>Critical</td>
<td>High</td>
</tr>
</tbody>
</table>

Summary of Findings: Control

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Without Screening</th>
<th>With Screening</th>
<th>Difference (95% CI)</th>
<th>Relative effect (RR, 95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer Mortality for Screening Intervals ≥ 24 Months for All Ages</td>
<td>4 per 1000 (3 to 5)</td>
<td>3 per 1000</td>
<td>1018 fewer per 1000 (from 1886 fewer to 145 more)</td>
<td>RR 0.7715 (0.5765 to 1.0326)</td>
</tr>
</tbody>
</table>
The Final Product

Key questions

1. Should home treatment vs. hospital treatment be used for patients with acute DVT of the leg?
2. Should early discharge vs. standard discharge be used for patients with acute PE?
3. Should heparin vs no heparin be used in outpatients with cancer who have no other therapeutic or prophylactic indication for anticoagulation?
4. Should oral anticoagulation vs no oral anticoagulation be used in outpatients with cancer who have no other therapeutic or prophylactic indication for anticoagulation?
5. Should parenteral anticoagulation vs no anticoagulation be used in patients with cancer and central venous catheters?
6. Should oral anticoagulation vs no anticoagulation be used in patients with cancer and central venous catheters?

Recommendation 1:

For patients with simple acute DVT of the leg, the Saudi Expert Panel suggests home treatment over hospital treatment (conditional recommendation; moderate quality evidence)

Remarks:
- Ensure that patients have support from family, access to a phone, access to a physician, and the ability to get to a hospital in a reasonable time if needed
- Consider patient level of education, knowledge about the disease, and likelihood of compliance
- Consider hospital treatment for patients with severe acute DVT of the leg and patients who are apprehensive
- This recommendation applies to anticoagulation treatment with LMWH but not NOACs
Breast cancer screening

Recommendations on screening for breast cancer in average-risk women aged 40–74 years

The Canadian Task Force on Preventive Health Care


Women aged 40–49 years

For women 40–49 years of age, we recommend not routinely screening for breast cancer with mammography. (Weak recommendation; moderate-quality evidence.)
Recommendations

Recommendation 1:
The Saudi Expert Panel suggests screening with mammography in women aged 40–49 years every 1 to 2 years. (Conditional recommendation; low-quality evidence)

Clinical Practice Guideline on the Use of Screening Strategies for the Detection of Breast Cancer
Remarks:

Based on local cancer registry data, the incidence of breast cancer in the KSA seems to be higher than in the other countries in which studies were conducted. This fact may indicate that higher benefit on breast cancer mortality justifies a recommendation in favor of implementing breast cancer screening using mammography in this age group. Since the guideline panel determined that there is a close balance between desirable and undesirable consequences, they also suggest implementing shared-decision making strategies as a way to incorporate actively patients' perspective into the decision.
Reason

Different baseline risk in Saudi Arabia
Multi vessel vs single vessel intervention for myocardial infarction (not recommended)

National Clinical Guideline Centre

1.5 Culprit versus complete revascularisation

1.5.1 Culprit-only PPCI versus immediate multivessel PCI

Figure 180: RCTs: all-cause mortality (≤ 30 days)
Mortality-long term

Reinfarction
**Recommendation:**
Two small trials vs four trials
~200 vs 1000 patients

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**Evidence Profile:** Multi-vessel PPCI compared to culprit only PPCI in patients with STEMI and multi-vessel coronary artery disease undergoing PPCI

**Author(s):** Veena Manja & Wojtek Wiercioch

**Date:** 2014-12-15

<table>
<thead>
<tr>
<th>Nr of studies</th>
<th>Study design</th>
<th>Risk of bias</th>
<th>Inconsistency</th>
<th>Indirectness</th>
<th>Imprecision</th>
<th>Other considerations</th>
<th>Nr of patients</th>
<th>Effect</th>
<th>Quality</th>
<th>Importance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>multi-vessel PPCI</td>
<td>Relative (95% CI)</td>
<td>Absolute (95% CI)</td>
<td></td>
</tr>
<tr>
<td>Mortality - long term</td>
<td>4</td>
<td>randomised trials</td>
<td>serious ¹</td>
<td>not serious</td>
<td>not serious</td>
<td>serious ²</td>
<td>none</td>
<td>21/501 (4.2%)</td>
<td>35/478 (7.3%)</td>
<td>RR 0.63 (0.37 to 1.05)</td>
</tr>
<tr>
<td>Reinfarction</td>
<td>4</td>
<td>randomised trials</td>
<td>serious ¹</td>
<td>not serious</td>
<td>not serious</td>
<td>not serious</td>
<td>none</td>
<td>12/501 (2.4%)</td>
<td>32/478 (6.7%)</td>
<td>RR 0.37 (0.19 to 0.71)</td>
</tr>
<tr>
<td>Revascularization</td>
<td>4</td>
<td>randomised trials</td>
<td>serious ¹</td>
<td>not serious</td>
<td>not serious</td>
<td>not serious</td>
<td>none</td>
<td>38/501 (7.6%)</td>
<td>92/478 (19.2%)</td>
<td>RR 0.37 (0.26 to 0.53)</td>
</tr>
</tbody>
</table>
Reason

Saudi Arabian panel more certain in decision/recommendation

• NEW EVIDENCE IDENTIFIED during our effort
**Summary: Adolopment**

**Advantages**
- Methodological team required
- Faster
- Less resources required
- Transparent consideration of factors beyond QoE (EtDs) with focus on local/regional setting
- Greater buy-in / better implementation
- Builds capacity
- Good fun

**Challenges**
- Methodological team required
- Solid guideline/SRs required as starting point
- Challenging if no comprehensive guideline available
- Challenging if existing SR restricted inclusion to RCTs or highly selected outcomes
- Panels need to commit to follow rigorous methodological approach and stick to timelines
Thank you:

Questions?

Discussion?

“A world without bias is too hard. Would you settle for world peace?”
EtD Purpose

To help guideline panels (and decision makers) move from evidence to a recommendation or decision by:

• Inform judgements about the pros and cons of each option (intervention) that is considered

• Ensure that important factors that determine a decision (criteria) are considered

• Provide a concise summary of the best available research evidence to inform judgements about each criterion

• Help structure discussion and identify reasons for disagreements

• Make the basis for decisions transparent to target audiences
Criteria on which a recommendation is based
Judgements that must be made in relation to each criterion
Research evidence to inform each judgement
Additional considerations that inform or explain each judgement
Guidelines 2.0: systematic development of a comprehensive checklist for a successful guideline enterprise

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ABSTRACT

Background: Although several tools to evaluate the credibility of health care guidelines exist, guidance on practical steps for developing guidelines is lacking. We systematically compiled a comprehensive checklist of items linked to relevant resources and tools that guideline developers could consider, without the expectation that every guideline would address each item.

Methods: We searched data sources, including manuals of international guideline developers, literature on guidelines for guidelines (with a focus on methodology reports from international and national agencies, and professional societies) and recent articles providing systematic guidance. We reviewed these sources in duplicate, extracted items for the checklist using a sensitive approach and developed overarching topics relevant to guidelines. In an iterative process, omissions and involved experts in guideline development for revisions and suggestions for items to be added.

Results: We developed a checklist with 18 topics and 146 items and a webpage to facilitate its use by guideline developers. The topics and included items cover all stages of the guideline enterprise, from the planning and formulation of guidelines, to their implementation and evaluation. The final checklist includes links to training materials as well as resources with suggested methodology for applying the items.

Interpretation: The checklist will serve as a resource for guideline developers. Consideration of items on the checklist will support the development, implementation and evaluation of guidelines. We will use crowdsourcing to

Competing interests: None declared. Authors of this manuscript have been involved in the development of various guideline manuals which are referenced in this article.

This article has been peer reviewed.

Correspondence to: Holger Schünemann, schuneh@mcmaster.ca

Main limitation

Time

• May through December 2014

Focus this project on **updating** existing, highly credible systematic reviews and provide other information, rather than completely **de novo** development of guidelines
A new version of GRADEpro proudly engineered by Evidence Prime

The official tool of GRADE and DECIDE

A new quality in guideline development
Brought to you by the creators of GRADEpro

Guideline Development Tool is an easy to use all-in-one web solution for summarizing and presenting information for healthcare decision making. It supports creating concise summary tables for systematic reviews and health technology assessments as well as facilitates development

Best for both worlds
Guideline developers and authors of systematic reviews

Anyone preparing a systematic review will benefit from a simple online solution that assists creating summaries of evidence. Anyone developing clinical guidelines or other recommendations in healthcare will also benefit from a tool that smoothens the way of following a systematic and