
La documentazione scientifica nella pratica clinica Il significato e il valore della ricerca di letteratura per le professioni biomediche

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ASO Santa Croce e Carle - Cuneo

Torino, 28 febbraio 2014

Metodi di apprendimento

- *Induttivo*: apprendere sulla base della propria esperienza
 - *Abdicativo*: affidarsi al giudizio di un esperto
 - *Deduttivo*: farsi una propria opinione di prima mano
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EDITORIAL

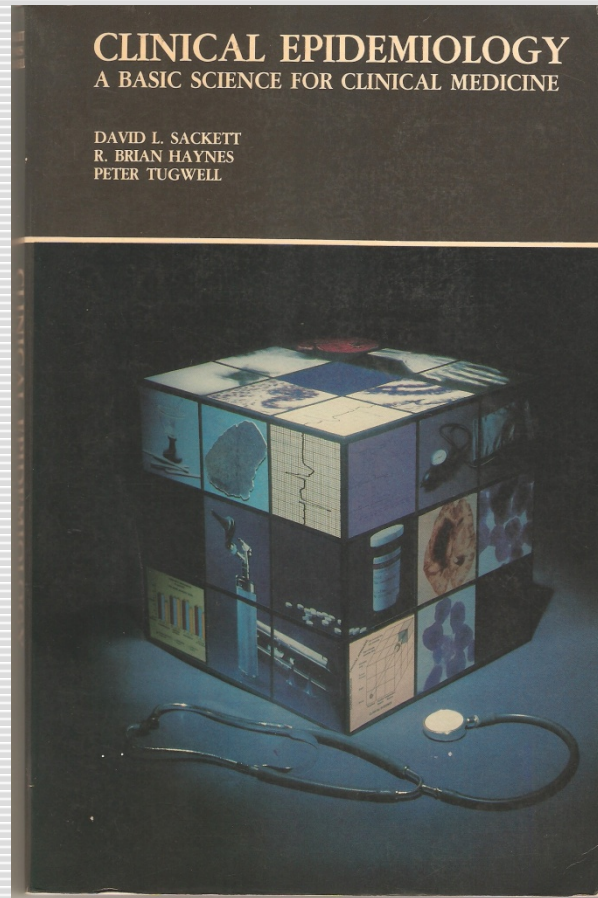
On the Training of Cardiologists*

J. WILLIS HURST, MD, FACC

Atlanta, Georgia

Oltre a conoscere la fisiopatologia, in modo da usarla per risolvere i problemi clinici, e a conoscere il valore prognostico dei test, in modo da applicarli correttamente nella prescrizione di indagini strumentali, *il buon medico* deve anche saper leggere e interpretare la letteratura, in modo da sistemare le nuove informazioni in processi logici e utilizzare al momento opportuno le più recenti acquisizioni.

1985

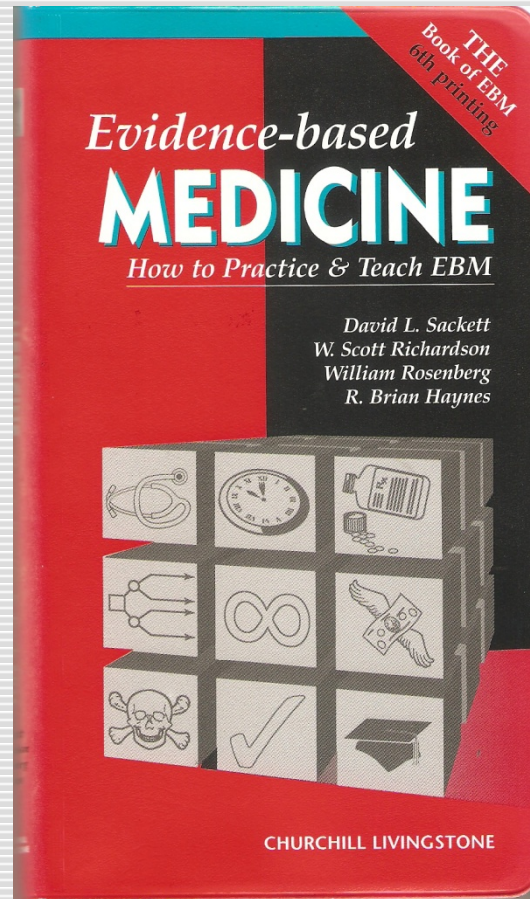


**THE
LITERATURE
OF
MEDICINE**

**How to Keep Up with the Medical Literature: IV. Using the Literature to Solve
Clinical Problems**

R. BRIAN HAYNES, M.D., Ph.D.; K. ANN McKIBBON, M.L.S.; DOROTHY FITZGERALD, M.L.S.; GORDON
H. GUYATT, M.D., M.Sc.; CYNTHIA J. WALKER, M.L.S.; and DAVID L. SACKETT, M.D., M.Sc.Epid.;
Hamilton, Ontario, Canada

1997



1. convert these information needs into answerable questions;
2. track down, with maximum efficiency, the best evidence with which to answer them (whether from the clinical examination, the diagnostic laboratory, from research evidence or other sources);
3. critically appraise that evidence for its validity (closeness to the truth) and usefulness (clinical applicability);
4. apply the results of this appraisal in our clinical practice; and
5. evaluate our performance.

2 Searching for the best evidence

Orientarsi tra le risorse di informazioni evidence-based

- Bruciare i libri
- Investire in data-base
- Permutare gli abbonamenti delle riviste
- Investire in riviste evidence based e servizi online

The logo consists of the lowercase letters 'bvs-p' in a bold, sans-serif font. The 'b' and 's' are dark grey, while the 'v' is a reddish-brown color. A horizontal line is positioned below the logo.

bvs-p

ANMCO - FIRENZE 1998

Guideline-mania

Già pubblicate più di 1.000
linee guida sui più disparati
aspetti della medicina e della
prevenzione

Ma servono?

A chi le scrive
o a chi le legge?

Clinical Practice Guidelines and Quality of Care for Older Patients With Multiple Comorbid Diseases

Implications for Pay for Performance

Cynthia M. Boyd, MD, MPH

Jonathan Darer, MD, MPH

Chad Boulton, MD, MPH, MBA

Linda P. Fried, MD, MPH

Lisa Boulton, MD, MPH, MA

Albert W. Wu, MD, MPH

Table 3. Treatment Regimen Based on Clinical Practice Guidelines for a Hypothetical 79-Year-Old Woman With Hypertension, Diabetes Mellitus, Osteoporosis, Osteoarthritis, and COPD*

Time	Medications†	Other
7:00 AM	Ipratropium metered dose inhaler 70 mg/wk of alendronate	Check feet Sit upright for 30 min on day when alendronate is taken Check blood sugar
8:00 AM	500 mg of calcium and 200 IU of vitamin D 12.5 mg of hydrochlorothiazide 40 mg of lisinopril 10 mg of glyburide 81 mg of aspirin 850 mg of metformin 250 mg of naproxen 20 mg of omeprazole	Eat breakfast 2.4 g/d of sodium 90 mmol/d of potassium Low intake of dietary saturated fat and cholesterol Adequate intake of magnesium and calcium Medical nutrition therapy for diabetes‡ DASH‡
12:00 PM		Eat lunch 2.4 g/d of sodium 90 mmol/d of potassium Low intake of dietary saturated fat and cholesterol Adequate intake of magnesium and calcium Medical nutrition therapy for diabetes‡ DASH‡
1:00 PM	Ipratropium metered dose inhaler 500 mg of calcium and 200 IU of vitamin D	
7:00 PM	Ipratropium metered dose inhaler 850 mg of metformin 500 mg of calcium and 200 IU of vitamin D 40 mg of lovastatin 250 mg of naproxen	Eat dinner 2.4 g/d of sodium 90 mmol/d of potassium Low intake of dietary saturated fat and cholesterol Adequate intake of magnesium and calcium Medical nutrition therapy for diabetes‡ DASH‡
11:00 PM	Ipratropium metered dose inhaler	
As needed	Albuterol metered dose inhaler	

Box. Recommendations Based on Clinical Practice Guidelines for a Hypothetical 79-Year-Old Woman With Hypertension, Diabetes Mellitus, Osteoarthritis, Osteoporosis, and COPD*

Patient Tasks

Joint protection

Energy conservation

Exercise

- Non-weight-bearing if severe foot disease present or weight-bearing for osteoporosis

- Aerobic exercise for 30 min on most days

- Muscle strengthening

- Range of motion

Avoid environmental exposures that might exacerbate chronic obstructive pulmonary disease (COPD)

Wear appropriate footwear

Limit intake of alcohol

Maintain normal body weight (body mass index of between 18.5 and 24.9)

Clinician Tasks

Administer vaccine

- Pneumonia

- Influenza annually

Check blood pressure at all clinician visits and sometimes at home†

Evaluate self-monitoring of blood glucose

Foot examination at all clinician visits if neuropathy present; otherwise check feet for protective sensation, structure, biomechanics, vascular status, and skin integrity annually

Laboratory tests

- Microalbuminuria annually if not already present

- Creatinine level and electrolytes at least 1 to 2 times per year

- Cholesterol levels annually

- Liver function biannually

- Glycosylated hemoglobin level biannually to quarterly, depending on level of control

Referrals

- Physical therapy

- Ophthalmologic examination

- Pulmonary rehabilitation

- Dual-energy x-ray absorptiometry scan every other year

Patient education

- High-risk foot conditions, foot care, and foot wear

- Osteoarthritis

- COPD medication and delivery system training

- Diabetes mellitus

*See asterisk footnote in Table 3 for a list of the clinical practice guidelines used.

†Ambulatory blood pressure monitoring is helpful if “white coat hypertension” is suspected and no target organ damage, apparent drug resistance, hypotensive symptoms with antihypertensive medication, or episodic hypertension.

Scientific Evidence Underlying the ACC/AHA Clinical Practice Guidelines

Pierluigi Tricoci, MD, MHS, PhD

Joseph M. Allen, MA

Judith M. Kramer, MD, MS

Robert M. Califf, MD

Sidney C. Smith Jr, MD

Context The joint cardiovascular practice guidelines of the American College of Cardiology (ACC) and the American Heart Association (AHA) have become important documents for guiding cardiology practice and establishing benchmarks for quality of care.

Objective To describe the evolution of recommendations in ACC/AHA cardiovascular guidelines and the distribution of recommendations across classes of recommendations and levels of evidence.

Riviste le linee guida dell'American College of Cardiology e dell'American Heart Association (ACC/AHA) pubblicate dal 1984 al 2008

Pubblicate 53 linee guida su 22 argomenti

JAMA. 2009;301(8):831-841

Scientific Evidence Underlying the ACC/AHA Clinical Practice Guidelines

Tricoci et al. JAMA 2009;301(8):831-841

Risultati e conclusioni

- Aumenta il numero di raccomandazioni ma si riduce il livello di evidenza su cui sono costruite
 - **Stabili** le raccomandazioni di **classe I** e **aumento** di quelle di **classe II**
 - La maggior parte delle raccomandazioni di **classe I** sono basate su livelli di **evidenza minore o sull'opinione degli esperti**
 - Necessario concentrare l'attività di ricerca sulle aree carenti di evidenze ed **espandere i finanziamenti** della ricerca clinica
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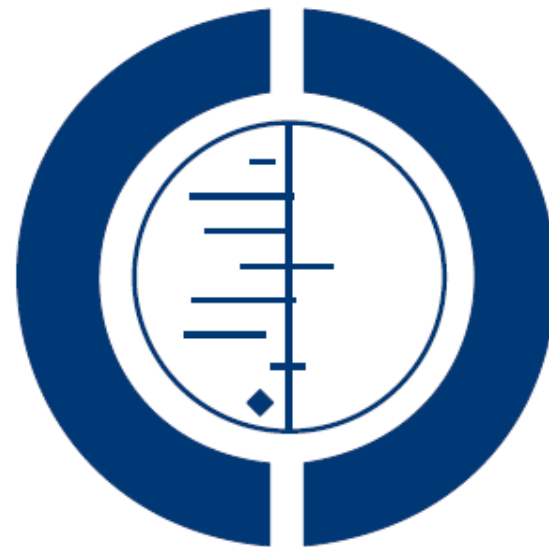
Scientific Evidence Underlying the ACC/AHA Clinical Practice Guidelines

Tricoci et al. JAMA 2009;301(8):831-841

Implications for Research

The findings of this analysis indicate that the current system generating research is inadequate to satisfy the information needs of caregivers and patients in determining benefits and risks of drugs, devices, and procedures. The

Revisioni sistematiche



**THE COCHRANE
COLLABORATION®**

Review article

Why are Cochrane hepato-biliary reviews undervalued by physicians as an aid for clinical decision-making?

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^a University of Palermo, Italy

^b Clinical Epidemiology, National Cancer Research Institute, Genoa, Italy

^c Division of Cardiology, Ospedale Santa Croce e Carle, Cuneo, Italy

Results: Six empty reviews found no eligible randomised trials and six found one trial, precluding a systematic review; some empty reviews investigated irrelevant topics. Twenty-one reviews investigated outdated interventions, and thirteen of them were posted ten or more years after the publication of the most recent trial included. Most reviews were too lengthy (median: 40 pages) and their consultation was time-consuming with respect to clinical content. They generally compared two treatments, disregarding other options, and usually did not report any non-randomised (although convincing) evidence of potential use in clinical decision-making.

Risorse secondarie



Speed of updating online evidence based point of care summaries: prospective cohort analysis

Rita Banzi,^{1,2} Michela Cinquini,² Alessandro Liberati,^{1,3} Ivan Moschetti,¹ Valentina Pecoraro,¹ Ludovica Tagliabue,^{1,4} Lorenzo Moja^{1,4}

STUDY QUESTION

What is the updating speed of authoritative point of care summaries—that is, the time between a relevant paper's publication and its citation?

Main results and the role of chance

Dynamed has an updating process that markedly leads the others. For instance, the hazard ratios of citation of EBM Guidelines and Clinical Evidence compared with the top performer were 0.22 (95% confidence interval 0.17 to 0.29) and 0.03 (0.01 to 0.05), respectively. The median citation was around two months for Dynamed and around 10 months for EBM Guidelines but close to the limit of our follow-up (nine months). UpToDate, eMedicine, and Clinical Evidence were so slow that they exceeded the follow-up period so the median could not be computed. Overall, Dynamed cited 87% of the sampled systematic reviews and the others less than 50%.

Ahmadi N et al. *Evidence-Based Reviews in Surgery Steering Group. Teaching evidence based medicine to surgery residents-is journal club the best format? A systematic review of the literature.* J Surg Educ 2012 Jan-Feb;69(1):91-100.

Conclusions: There is some evidence that courses with or without the addition of journal clubs lead to improved knowledge of the EBM process although the impact on patient care is unknown.

Journal clubs seem to be the preferred way of teaching critical appraisal skills but while some components of journal clubs are favored by participants, it remains unclear which elements are most important for resident learning.

Learning in practice

What is the evidence that postgraduate teaching in evidence based medicine changes anything? A systematic review

Arri Coomarasamy, Khalid S Khan

Conclusion Teaching of evidence based medicine should be moved from classrooms to clinical practice to achieve improvements in substantial outcomes.

REVIEW

How to run an effective journal club: a systematic review

Y. Deenadayalan BPT IMMP BEHM (MBA),¹ K. Grimmer-Somers PhD MMedSci BPhy,²
M. Prior BPhy (Hons)¹ and S. Kumar PhD MPT BPT³

Conclusion Characteristics of successful journal clubs included regular and anticipated meetings, mandatory attendance, clear long- and short-term purpose, appropriate meeting timing and incentives, a trained journal club leader to choose papers and lead discussion, circulating papers prior to the meeting, using the internet for wider dissemination and data storage, using established critical appraisal processes and summarizing journal club findings.
