January 2014 Pulmonary Journal Club: Interventional Guidelines

Feuerstein JD, Akbari M, Gifford AE, Hurley CM, Leffler DA, Sheth SG, Cheifetz AS. Systematic analysis underlying the quality of the scientific evidence and conflicts of interest in interventional medicine subspecialty guidelines. Mayo Clin Proc. 2014;89(1):16-24. [CrossRef] [PubMed] (For editorial comment click here)

A few years ago a colleague and I were discussing the shape of healthcare in the USA. One of the comments that was made was "that despite the high costs within our system, that at least there was some standardization in the treatment of certain diseases, for example, receiving Aspirin for an acute myocardial infarction". Guidelines exist to ensure that for certain conditions a standard of care is practiced. When guidelines start to become a measuring stick for what is now considered best practice…..then it our responsibility to ensure that guidelines are rooted on high quality evidence. This paper reviewed the validity of guidelines published and practiced by several of the interventional medical societies including the American Association for Bronchology and Interventional Pulmonology (AABIP), American Society of Diagnostic and Interventional Nephrology (ASDIN), American Society For Gastrointestinal Endoscopy (ASGE) and the Society for Cardiovascular Angiography and Interventions (SCAI).

A total of 153 interventional guidelines were evaluated between November 2012 and January 2013. Each guideline was reviewed to determine the level of evidence and convicts of interest. The large majority of the guidelines reviewed were from the ASGE (67) and SCAI (80). The results showed that out of the 153 guidelines reviewed that only 69 (46%) had a grades of evidence associated with them. The levels of evidence for most guidelines were grade B or C (expert Opinion). Nearly 50% of recommendations were based on expert opinion whereas Only 11% of the recommendations were validated by Grade A evidence. When looking at conflict of interest only 57 of the guidelines revealed a conflict of interest out of which 52 (91%) revealed that a conflict of interest existed. Most of the guidelines (62%) failed to report on whether any conflict of interest existed.

Practice guidelines should exist to improve the standard of care wince they have been based on repeated validation and held to the highest level of evidence. We are now to often seeing guidelines set forth based on weak evidence and then tied into best practice measures. It is our duty as clinicians, scientists, and educators, to ensure that practice models are based on the best interest of the patient which can any be met by rigorous and repeated testing and the highest grade of evidence. Setting forth guidelines and recommendations based on expert opinion may be of benefit when no other studies exist but the level of evidence on these practices should be made clear and conflicts of interest be reported. In our haste to standardize healthcare practices we have become lax to include recommendations that are more in the interest of the institutions rather that for the patient.

Manoj Mathew MD FCCP MCCM