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Treatment Guidelines: The Ongoing Pursuit of Excellence

You are listening to ReachMD, The Channel for Medical Professionals. Welcome to Heart Matters where leading cardiology experts explore the latest trends, technologies, and clinical developments in cardiology practice. Your host for Heart Matters is Dr. Jack Lewin, Chief Executive Officer of the American College of Cardiology.

New treatment guidelines regularly make headlines in medicine. Recommending advances in our approach to care. In recent years, we have accelerated the speed with which we can update our guidelines and we have welcomed more global input into the process. Will these trends continue and where else can we improve our process for authoring treatment guidelines.

Our guest today is Dr. Elliott Antman. Dr. Antman is Professor of Medicine at Harvard Medical School is the Director of the Samuel A. Levine Cardiac Unit at Brigham and Women's Hospital in Boston. He is the past chairman of the American College of Cardiology and the American Heart Association's task force on practice guidelines and currently directs the ACC-AHA Committee to revise guidelines for management of ST-elevation myocardial infarction.

DR. JACK LEWIN:

Welcome Dr. Antman.

DR. ELLIOTT ANTMAN:

Thank you very much; it's a pleasure to be here.

DR. JACK LEWIN:

At what point did treatment guidelines become standard operating procedure for cardiology and you know for medicine, more generally?

DR. ELLIOTT ANTMAN:

It's a very good question. You know, we ought to step back for a moment and actually ask why did we actually produce guidelines in the first place and many individuals may not be aware of how the whole guideline story got started. It actually began in the (**01:30**) early 1980s as a request from the Federal Government when there was rather frequent use of pacemakers and there was a serious question as to whether or not the pacemakers were always being inserted for appropriate indications. So actually the very first guideline that was produced by the ACC and AHA was designed to organize our thinking about permanent pacemaker implantation and as an outgrowth of that, we now have approximately 17 guidelines that are in play at any one moment in time. These are all evidence based and we hope

that by providing recommendations to clinicians, we can codify best practices. Based upon the evidence we have actually gotten a lot of high marks and credit from other specialties in medicine who look to us for the leadership role in producing these kinds of guidelines. So I would say that this is perhaps one of the most important efforts of the American College of Cardiology and the American Heart Association as a joint effort of two professional societies trying to put together best practices so that we can actually treat our patients most appropriately.

DR. JACK LEWIN:

Oh, it is impressive. There is a lot of excitement about how these guidelines could be used. How are the topics chosen?

DR. ELLIOTT ANTMAN:

The topics originally were chosen based upon where there was a perceived need and very often those were procedure based guidelines. For example, we had guidelines as I mentioned about pacemaker implantation and then there were others on echocardiography (**03:00**) and radionuclide imaging. We have decided that it is much more useful for our practicing clinicians to have disease management guidelines. So we have undertaken a switch over the last decade or so to disease management topics such as the management of patients with unstable angina, non-ST elevation myocardial infarction, ST-elevation myocardial infarction, congestive heart failure. We have an arrhythmia triad that we have done jointly with the European Society of Cardiology, paroxysmal supraventricular tachyarrhythmia, atrial fibrillation, and ventricular arrhythmias, and sudden cardiac death. So these are very common cardiac problems that our colleagues are seeing everyday in their practice and we try and hit those topics that we think will be most helpful to them and also we do identify topics where we have a good evidence base so that we can actually codify the recommendations as best we can.

DR. JACK LEWIN:

And in terms of assembling the experts that we need. How do the committee members come together, are they volunteers, who selects them, what's the process for choosing these important people to make these decisions?

DR. ELLIOTT ANTMAN:

The task force on practice guidelines is the oversight body that determines when a guideline needs to be written or updated and that same task force identifies the writing committee chair and that task force also identifies writing committee members and the membership (**04:30**) on the writing committee is purposefully chosen so that it has broad representation. So there are individuals who have an academic background, clinical investigation background. There are individuals who have extensive clinical practice, expertise. We have individuals who may have nursing expertise that is extremely important. We generally have approximately 12 to 15 members of the writing committee who get together with face-to-face meetings and multiple conference calls to try and put the document together.

DR. JACK LEWIN:

And each topic area has got a different group of experts based on what we are focusing on?

DR. ELLIOTT ANTMAN:

Absolute. For example, my particular area of interest and expertise is in management of patients with acute coronary syndrome, so I have been heavily involved in the ACS guidelines with STEMI and the UA, NSTEMI guidelines. Other individuals have particular expertise in heart failure. So, for example, Dr. K. Nanette and Dr. Sharon Hunt have been very heavily involved in the heart failure guideline.

DR. JACK LEWIN:

You know one of the most controversial areas about guidelines, science, anything that it comes out to recommend how to treat patients out there these days relates to conflicts with industry and in fact the relationships of people engaged in producing scientific documents or recommendations with industry. So how does the ACC-AHA and this whole process protect against relationships with industry that could influence (**06:00**) or bias the guideline?

DR. ELLIOTT ANTMAN:

That's a very important point that you are raising. The task force on practice guidelines is well aware of this issue. So when the writing committee chair is selected and when the members of the writing committee are selected, all individuals are asked to submit documents that indicate their relationships with industry. We are trying as much as possible to avoid having individuals who have significant relationships with industry serving as the writing committee chair. Sometimes we have a situation where there is such expertise that we really need to rely on an individual to be the writing committee chair or a member of the writing committee, but we ask them to refuse themselves from voting on recommendations where they have a relationship with industry or even a perceived relationship with industry where there are particular orientation andvote could be questioned by some individuals. So the readers of these documents can find at the back of the document tables that list the relationship with industry. Incidentally, not only for the members of the writing committee, but also for the reviewers. So, for example, when we worked on the ST-elevation MI guideline which was produced in 2004, we sent that document around the world for peer review. By the time we were finished with peer review and then the review by both the board of trustees (**07:30**) for the American College of Cardiology and SACH for the American Heart Association. We probably had about 93 individuals who had actually read that document and each of those individuals we need to know what their relationship with industry is. So we have the writing committee members, their reviewers, all listed at the back of the document in a table so that it's as transparent as we can make it to the readers of the document.

DR. JACK LEWIN:

That's very impressive.

DR. JACK LEWIN:

Now, if you are just joining us, you are listening to Heart Matters on ReachMD, The Channel for Medical Professionals. I am your host, Dr. Jack Lewin. Our guest is Dr. Elliott Antman, Professor of Medicine at Harvard Medical School and Director of the Samuel A. Levine Cardiac Unit at Brigham and Women's Hospital in Boston. We are discussing how we develop improved treatment guidelines.

Dr. Antman, there is a lot of compromise, obviously involved in writing of the guidelines. How do the writers strike the appropriate balance between content, experts, and practice clinicians, academia, non-academia, variations based on regional practice, and so forth?

DR. ELLIOTT ANTMAN:

This is an important issue as well. The task force on practice guidelines reviews the potential list of writing committee members and really works very hard at getting a good distribution of the membership so that we might have individuals who have been involved in clinical trials. Other individuals who have large clinical practices, and we need all that expertise sitting around the table together to formulate the recommendations (**09:00**). Now the recommendations are put forward in a very strict fashion and each of our guidelines has a table that identifies the class of the recommendation and we divide our recommendations into class I, IIA, IIB, and III, and each of these recommendations is also associated with a level of evidence; level of evidence A, B, and C. The highest recommendation that we can give to clinicians would be a class I recommendation leveled evidence A and that would be a statement where the writing committee feels that a procedure or treatment should be performed or particular therapy should be administered because there is extensive evidence usually with multiple randomized clinical trials, multiple population strata that are represented in these trials. Now, unfortunately because of the way evidence is accumulated these days, it is actually the minority of our recommendations that truly are associated with level of evidence A and two-thirds of our recommendations are level of evidence C, which is expert consensus opinion, so we have individuals who are experts who are members of the writing committee and put forward a recommendation which they believe is based upon best practice that we experienced to date and we do gain the information from individuals who are peer reviewers who may have some varying opinion about a recommendation and that's where modifications in the document might be made. So this level of evidence C is not just the individuals(**10:30**) sitting around the table who are members of the writing committee, but it's the peer reviewers as well and the formal review processes for both the American College of Cardiology and the American Heart Association. That's important to recognize when one is looking at one of these documents.

DR. JACK LEWIN:

Well, so Elliott, let's say that we have got this expert consensus, we have gone through this process and then there is you know a new study that comes out and it's kind of earth shattering, a late breaking clinical trial, hits the books, and everybody sees it at the papers, pick it up, does a singular study cause the committee to come back together and revise a guideline, what kind of additional evidence provokes a revision of a guideline?

DR. ELLIOTT ANTMAN:

It is an important question. We are fortunate in cardiology that we do have a lot of evidence. It is a monumental task for us in the guidelines effort because it is a fast moving evidence base. We now are in the midst of an effort to turbo charge our guidelines with what we refer to as focused updates. There are 3 major cardiology meetings that take place throughout the course of the year. That would be the ACC meeting, the AHA meeting, and the ESC meeting; it would be the European Society of Cardiology, so our members of the writing committee are polled after each of these major meetings with respect to the late breaking clinical trials that have been presented at those meetings. More and more of those trials are actually published simultaneously in peer reviewed literature and we ask the writing committee members if they believe that the late breaking trial that has just hit the press is of sufficient importance (**12:00**) to actually change a guideline and very often we find one or two trials at each of these meetings that really does warrant a closer look at the evidence and may be a modification of the recommendation, and we are now trying to put out focussed updates which are much shorter documents and just identify those areas that need to be changed. There are three that have been done that were put out last year, for example, the percutaneous coronary intervention or PCI. STEMI underwent a focussed update as well. So clinicians should be looking for these focussed updates and we are hard at work trying to really speed the process along in response to what you have mentioned.

DR. JACK LEWIN:

I like it that way; I like the turbo charge idea there. You know what about the average practicing cardiologist out there or internist is there any wiki process where people can tell you that they are having trouble and they want to update the guideline or there is a feedback loop that's provided for just the average clinician?

DR. ELLIOTT ANTMAN:

We do have processes where clinicians can actually pose questions and in fact very often you probably know that we have received a phone call at the college with a question about the guideline or a suggestion or recommendation and in essence it's an open-door policy and there can be requests, comments, questions that are posed to the task force on practice guidelines. These are reviewed regularly. There is a monthly call by the task force and there are face-to-face meetings that take place several times a year for the task force and all these kinds of questions are put forward and it's often these kinds of questions (**13:30**) that come in from our clinicians in practice who really drive or stimulate us to update a guideline when we hear that there are a lot of questions out there.

DR. JACK LEWIN:

It's an important thing for the listeners out there, just to realize that we'd like to hear from them when they feel like there is a need for a revision or an update of a guideline.

DR. ELLIOTT ANTMAN:

Yes, that's very important for our listeners to be aware of. it is also important that they should realize that these are large documents and sometimes individuals find them almost too imposing, but we are trying to deal with that by providing an executive summary which is a shorter version of the key recommendations and the College has actually put forward pocket guidelines that literally can fit in a white coat and they have the key tables, figures, and recommendations for management of patients. I happen to be holding the one on management of patients with atrial fibrillation which was put out in July 2007 and this is really quite a useful format. This is a derivative product that comes from the guidelines and these are very helpful to clinicians as well.

DR. JACK LEWIN:

That is exciting.

We have been talking about the process through which we update treatment guidelines with Dr. Elliott Antman.

Dr. Antman, thank you for being our guest.

DR. ELLIOTT ANTMAN:

My pleasure. Thank you very muc

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