

Editorial

From Canadian Living Guidelines to Global Living Guidelines: A Post Pandemic Effort



Ines Colmegna¹  and Michael E. Weinblatt² 

Since the coronavirus disease 2019 (COVID-19) pandemic, “living” practice guidelines are increasingly being used to ensure that recommendations are responsive to rapidly emerging evidence. In this issue of *The Journal of Rheumatology*, Hazlewood et al provide living recommendations on the issue of biologic (b-) and targeting synthetic (ts-) disease-modifying antirheumatic drug (DMARD) de-escalation in adults with rheumatoid arthritis (RA).¹ The panel recommends that patients with RA in sustained remission or low disease activity for at least 6 months and ideally 12 months, upon glucocorticoid discontinuation, are offered a trial of stepwise tapering (ie, extension of interval between doses or dose reduction) but no discontinuation of bDMARD (ie, originator and biosimilars) and tsDMARD therapy. This is a conditional recommendation, meaning that “the majority of people with RA in this situation would want the suggested course of action, but many would not.”¹ This recommendation is meant to be based on a shared decision including the discussion of a flare management plan and only in patients who have rapid access to rheumatology care in case of flare. If access to care is limited, the panel conditionally recommended against tapering.¹ This is the first report of an ongoing effort endorsed by the Canadian Rheumatology Association (CRA) to conduct living guidelines on the pharmacological management of people living with RA.

Why living guidelines?

Living guidelines are an optimization of the guideline development process that allows updating individual recommen-

dations as soon as new relevant evidence becomes available.^{2,3} Living guidelines are particularly useful in clinical areas in which research and practice are rapidly developing or evolving (eg, COVID-19, non-small cell lung cancer).⁴ In fact, certain aspects determine when a living guideline is appropriate for a particular clinical topic. Those include when the topic is a priority for health decision making (eg, large numbers of people affected, effect on health outcomes, known variation in practice), when there is uncertainty in the existing evidence, and when it is likely to be emerging evidence that will affect the conclusions of the evidence synthesis and potentially lead to changes in recommendations.⁵

How living guidelines?

Three key aspects are involved in the development of living guidelines.⁶ First, core skills in evidence synthesis and the use of an appropriate framework (ie, GRADE [Grading of Recommendations Assessment, Development and Evaluation approach]) are required determinants of success to ensure that living guidelines provide up-to-date evidence-based guidance. The recommendation by Hazlewood et al¹ used as a “backbone” the evidence search and grading that led to the Australian Living Guideline for the Pharmacological Management of Inflammatory Arthritis,⁷ which was developed following high-quality standards. Hazlewood and colleagues applied similar standards and counted on methodological support provided by Cochrane Musculoskeletal for evidence synthesis. Second, guideline development requires the integration of evidence, consumer and clinical expertise, and the ability to engage expert input that promotes guidelines uptake. This aspect was also part of the process reported by Hazlewood et al, illustrated by the inclusion of consumers, expert clinicians, and researchers as members of the guideline panel; the endorsement of this work by the CRA; and the generation of a patient decision aid. The latter has simplified language and content to improve information processing and retention, and it is short and easy to use to facilitate guideline implementation and promote shared decision

¹I. Colmegna, MD, Associate Professor, Division of Rheumatology, Department of Medicine, McGill University Health Centre, Montreal, Quebec, Canada; ²M.E. Weinblatt, MD, John R. and Eileen K. Riedman Professor of Medicine, Division of Rheumatology, Inflammation and Immunity, Brigham and Women's Hospital, Boston, Massachusetts, USA. The authors declare no conflicts of interest relevant to this article.

Address correspondence to Dr. I. Colmegna, The Research Institute of the McGill University Health Centre, 1001 Decarie Blvd, Office # EM2-3238, Montreal, QC H4A 3J1, Canada. Email: ines.colmegna@mcgill.ca.

See CRA RA guideline, page 1092

making. Third, a priori decisions about thresholds for inclusion of new evidence should be made based on whether the new evidence is likely to change the direction, clinical importance, or certainty of the effect.⁸ This point was implied in the work of Hazlewood et al as the recommendation will change over time as new evidence emerges, but no specifications or timeframes were mentioned. A challenge of living guidelines is the need for a living evidence synthesis process.³ The frequency of literature searches depends on the available resources to conduct the work, assess the relevance of new studies, and incorporate new evidence.⁵

What living guidelines?

The evidence used by Hazlewood et al¹ was that of the Australian living guidelines and that data was contextualized to the Canadian Health System with emphasis on health equity. In this process, the recommendation implications for populations at risk for inequities (ie, rural and remote residents, Indigenous peoples, elderly persons with frailty, minority populations of first-generation immigrants and refugees, persons with low socioeconomic status or who are vulnerably housed, and sex and gender populations) were considered. Similarly, equity was an important aspect for the Australian panel that considered “factors that influence individual patient’s health opportunities and outcomes” including poor health literacy; residence in rural, remote, or relatively underserved locations; primary language other than English; low educational attainment; the presence of disability; or adverse socioeconomic or social circumstances.⁷ Australia and Canada have structural similarities (eg, large geographical area with low population density, Indigenous populations) and provide universal health care. The work done by Hazlewood and the expert team he assembled confirm that rheumatology societies of developed countries share an interest in the rapid and equitable implementation of emerging evidence in RA. One of the many lessons of the COVID-19 pandemic

was that global collaborations led to fast and more impactful results. Isn’t now the time to apply this lesson to RA? Could this type of coordinated effort lead to better global patient outcomes, less societal costs, faster assessment of difficulties in implementation of recommendations, and optimized approaches to help our most vulnerable patients?

REFERENCES

1. Hazlewood GS, Pardo JP, Barnabe C, et al. Canadian Rheumatology Association living guidelines for the pharmacological management of rheumatoid arthritis with disease-modifying antirheumatic drugs. *J Rheumatol* 2022;49:1092-9.
2. Akl EA, Meerpohl JJ, Elliott J, Kahale LA, Schunemann HJ, Living Systematic Review Network. Living systematic reviews: 4. Living guideline recommendations. *J Clin Epidemiol* 2017;91:47-53.
3. El Mikati IK, Khabsa J, Harb T, et al; Living Guidelines Group. A framework for the development of living practice guidelines in health care. *Ann Intern Med* 2022 Jul 5 (Epub ahead of print).
4. Alonso-Coello P, Schunemann HJ, Moher J, et al. GRADE Evidence to Decision (EtD) frameworks: a systematic and transparent approach to making well informed healthcare choices. 1: Introduction. *BMJ* 2016;353:i2016.
5. Turner T, McDonald S, Wiles L, English C, Hill K. How frequently should “living” guidelines be updated? Insights from the Australian Living Stroke Guidelines. *Health Res Policy Syst* 2022;20:73.
6. Turner T, Elliott J, Tendal B, et al; National COVID-19 Clinical Evidence Taskforce. The Australian living guidelines for the clinical care of people with COVID-19: what worked, what didn’t and why, a mixed methods process evaluation. *PLoS One* 2022;17:e0261479.
7. ANZMUSC. An Australian Living Guideline for the Pharmacological management of Inflammatory Arthritis. 2020 [version 0.3]. Available from: https://files.magicapp.org/guideline/8402cb01-551d-415b-9995-f5363df28622/published_guideline_6576-2_0.pdf
8. Elliott JH, Synnot A, Turner T, et al; Living Systematic Review Network. Living systematic review: 1. Introduction-the why, what, when, and how. *J Clin Epidemiol* 2017;91:23-30.