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Editorial

Clinical practice guidelines. Let's identify them

Las guias de practica clinica. Identifiquemoslas

At many conferences, we attend round tables or other types of surgical pedagogical activities where Clinical Practice Guidelines (CPG) are debated. The discussion is sometimes intense, with arguments that question the usefulness of CPG, to say the least. The controversy is only heightened by the discrepancies in the recommendations of different CPG published by different groups on the same topic, the possible influence of conflicts of interest or methodological inconsistencies in their preparation, and the lack of compliance with CPG of the medical professionals for whom they have been written.

As a user and coordinator of CPG, active surgeon, and member of the Editorial Board of our *CIRUGÍA ESPAÑOLA* journal, which receives manuscripts labeled as CPG, I thought it would be interesting to reflect on how to correctly identify a CPG.

CPG are essential tools for the practice of evidence-based surgery and have proliferated over the last decade. "Standard" requirements for CPG have been perfectly established.[1,2] Despite this, numerous factors have been identified where CPG can fail,[2–5] although it is not our intention to mention all of them here. However, we would like to briefly highlight the characteristics that CPG must have in order to provide the highest-quality recommendations.[2–5] Thus, CPG must be based on: (a) a systematic review of the literature with meta-analysis, if applicable; (b) a direct connection (not indirect or extrapolated) between the evidence of the recommendations and their strength; (c) the recommendations must be aimed at directly improving patient benefits and not the disease (biochemical markers, risk factors, etc); (d) the preparation of CPG must be a transparent process, with no conflicts of interest; (e) ideally, CPG should present prospective validation demonstrating how the recommendations improve patient outcomes.

Related to the above, certain easy-to-use tools can help us identify whether a CPG is really a CPG, and whether it is useful. Among these tools is the G-TRUST instrument.[6] G-TRUST is categorical and suggests some key items which we can use to evaluate whether a document presented to us is not a CPG, subsequently identifying it as not useful, namely: (a) recommendations must be based on demonstrated direct benefits; (b) recommendations for each CPG question should be based on a systematic review of the literature with meta-analysis, if applicable; and (c) recommendations should be based on the stratification and analysis of the quality of the evidence and an assessment of the strength of that recommendation, using methodologies such as GRADE.[7]

Unfortunately, surgery has often been an "opaque" world when it comes to information and its dissemination. Historically, the privilege of knowing and disseminating — in short, being informed — depended on the "generosity" of a few who "guided" the rest. Evidence-based surgery seemed like it would "free" us from that kind of "surgical shamanism." Furthermore, access to information as well as the advances made in the methods of access that have occurred from the end of the 20th century until now (including social networks) should have represented a step up to another level. Tools like CPG, which theoretically should synthesize the best information, were supposed to be reliable tools for the homogenization and optimization of patient care. However, this does not seem to have become the case across the board, and sometimes CPG construct recommendations in an inverse manner based on unverified results. Other CPG may be influenced by the conflicts of interest of their authors. But perhaps on most occasions, the resulting low-quality CPG merely respond to a lack of methodological knowledge when creating them.

Karl Popper (one of the most important philosophers of science of the 20th century) wrote: "Evidence (data) is information that is used to get closer to the truth..."[8] The "truth" (understood as the evidence that the data gives us), in medicine in general and in surgery in particular, is not always easily grasped; it is elusive and changing. Popper wrote that we would "approach" it.[8] Unfortunately, it is obvious that CPG do not "contain" the entire "truth", nor are they a cookbook. Nevertheless, in an attempt at putting an end to the controversy and skepticism that seem to exist around CPG, perhaps the initial step — and one of the most important — is for us to know how to identify them clearly, as follows:

1 As surgeons, it is our obligation to know the basic fundamentals in order to identify a CPG as a truly useful guideline. That is, we must understand enough about methodology in order to be able to recognize what is and what is not a CPG as well as how to use evaluation tools, such as G-TRUST.[6]

2 If a CPG is not based on a systematic review of the literature with meta-analysis (if necessary) of all the questions it raises, the recommendations are not based on proven direct benefits for patients, and there is no clearly established methodology behind it like GRADE,[7] we simply cannot identify those types of documents as CPG.

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Manuel López Cano*
Abdominal Wall Surgery Unit, General Surgery Department, Hospital Universitario Vall d'Hebrón, Universidad Autónoma de Barcelona, Barcelona, Spain

**Corresponding author.* mlpezcano@gmail.com

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