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EDITORIAL

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The tools at our hand to ensure the highest quality, systematicity, transparency and trustworthiness of clinical practice guidelines

The current issue of the United European Gastroenterology Journal builds on its previous dedication to guidelines and guideline methods by introducing the AGREE-S methodological guide, an AGREE II extension for surgical interventions.[1] The AGREE-S methodological guide is further enhanced by a reporting checklist and appraisal tool available at https://agree-s.org/.[1] The AGREE-S focuses on ensuring the quality of guidelines that specifically target surgical interventions with their characteristic challenges. Mainly to be used to aid with the completeness of reporting and transparency in de novo development of recommendations, it is also highly valuable in adoption, adaptation or adolopment of existing guidelines.

Clinical practice guidelines provide evidence-based guidance coupled with expert input and patient perspectives to assist policymakers, clinicians, and patients in making decisions and improving clinical outcomes. Guideline panels often need to formulate recommendations when evidence is not optimal or is completely lacking. Responding to this issue by developing guidelines solely based on consensus without any attempt at systematic searching of the available literature is unsatisfactory and often leads to low uptake. Guideline methodologists, including the Grading of Recommendations Assessment, Development and Evaluation (GRADE) experts, have addressed the issue and solutions and good practice examples are available.[2,3] To increase impact, guidelines need to be trustworthy[4] and the United European Gastroenterology (as well as many other organisations) is dedicated to ensuring the highest standard with its relatively recently published guideline framework.[5]

One of the central principles underlying trustworthiness is transparency. In other words, the methods used to develop guidelines as well as all the steps surrounding its conception, draughting, review and publication are publicly available and fully reported. Such high level of transparency is also needed to assess when changes in policy should be made, to understand the rationale for such changes, and for the process of adapting guidelines to local contexts. There are many methods and tools designed to support the development, reporting and assessment of *trustworthy and transparent* guidelines.[6]

Among them is the Appraisal of Guidelines for Research & Evaluation (AGREE II) Instrument, an established tool that, although widely used, validated, and respected, may not necessarily, due to its general nature and focus on the clinical setting, address the specifics of certain fields, including surgery.[7] Some of the issues pertaining to surgical guidelines are the need to rely on low-quality scientific evidence or solely expert evidence, the lack of standardisation among surgeons, the large impact of the level of surgical expertise and skills on the outcomes, and the differences in access to equipment, supplies and infrastructure, among others.[8] This was apparent in the 2019 guidelines on the surgical management of the Crohn's Disease,[9] where the developers felt that using the GRADE methodology (as was done for the medical management part of the same guideline) in the context of low-quality observational surgical evidence would hamper, if not prevent completely, formulating recommendations, possibly sacrificing guideline quality.

Recent research has shown that 40% of surgical guidelines may not be suitable for clinical use with the median overall quality score of 4 out of 7.[8] This research has also indicated that having dedicated guideline committees, issuing guidelines regularly (to accumulate experience) and using GRADE were associated with the highest quality in surgical guidelines. These findings are in line with other guideline quality assessment studies.[10] In light of such evidence, it seems desirable to accelerate the implementation of the GRADE approach. To increase the number of available GRADE methodologists the Guidelines International Network (GIN) has recently initiated a comprehensive training program.

The AGREE-S methodological guide, developed through a systematic, structured, evidence-based and stakeholder-informed consensus, responds to these challenges by proposing to develop a guideline protocol, to use a guideline development committee with a guideline methodologist, and to give special considerations to surgical expertise, among others.[1] We can underpin these points by our experience with a recently developed (not yet published) surgical guideline, where the panel prioritised the setting of a minimum surgical expertise and other necessary standards for certain considered procedures as one of the guideline key questions.

Moreover, tools such as AGREE-S can be used for the adoption, adaptation and adolopment of high-quality existing guidelines,

methods that increase efficiency and avoid duplication of effort and are, therefore, preferrable to de novo development, whenever possible.[11] Although coming with its own set of challenges, the basis is to search and appraise existing guidelines and contextualise the recommendations using standardised validated tools.[5,12] A dedicated GIN Adaptation group is ready to assist in this area.

KEYWORDS

AGREE-II, AGREE-S, clinical practice guidelines, methodological quality, quality assessment, surgery

CONFLICT OF INTEREST

The authors have a potential intellectual conflict of interest in their involvement with guideline methods groups including the GIN Adaptation Group and the GRADE Working Group. There are no financial conflicts of interest.

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DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analysed in this study.

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