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Guidelines and systematic reviews

Thank you for the article by van Driel and Spurling (*AFP* June 2017),¹ which stresses the need to apply as much caution to assessing a guideline as is applied to a clinical paper. The article stresses the risks of selection biases:

- Publication bias – were only the good results published?
- Eligibility bias – were only people with one condition, one sex or one age group selected?
- Population bias – were the people selected only from hospital or specialist practices?

I also liked the emphasis on ensuring that the populations studied were relevant to general practice. There are countless guidelines on individual illnesses and conditions, a few guidelines for people with dual comorbidities and almost none for triple comorbidities. It is not unusual in aged care to see people with up to five comorbidities.

However, the authors missed one point. Formulating guidelines is an iterative process that relies heavily on feedback and, hopefully, formal data-gathering by the end users – clinicians – especially GPs. I have been involved in writing guidelines for several conditions and we rely heavily on credible feedback. Also, guidelines have a limited lifetime and are regularly reviewed for three reasons: first, diagnostic methods and criteria improve; second, treatment options improve; and third, but rarely, the diseases can change. GPs should be more than the passive recipients of guidelines. We should be active critics who gather data to improve their relevance for the most essential of people – our patients.

Associate Professor Chris D Hogan
Department of General Practice
University of Melbourne

Reference

1. van Driel ML, Spurling G. Guidelines and systematic reviews: Sizing up the guidelines in general practice. *Aust Fam Physician* 2017;46(6):438–40.

Reply

We would like to thank Associate Professor Chris Hogan for his letter supporting many of the points made in our article published in *Australian Family Physician* (*AFP* June 2017),¹ which explores ways in which general practitioners (GPs) can assess guidelines that inform their practice. We underline the importance of stakeholder involvement and the role of clinicians, including GPs, in providing feedback to guideline developers. This is essential for guideline relevance, usability and uptake in clinical practice. While not all GPs will be in a position to collect data that can inform guidelines, we fully agree with Dr Hogan that GPs should be encouraged to contribute to guideline production, and look for evidence of stakeholder engagement when they evaluate guidelines they are using. For example, the development and updating of the Australian *Therapeutic Guidelines* relies on end-user input, coordinated by a specific evaluation unit that actively solicits feedback from GPs, junior doctors and students.²

Keeping guidelines up to date is indeed a universal challenge. Current processes for updating guidelines are slow as it takes time to rigorously assess and weigh all relevant evidence. Publishing guidelines online will reduce the delay of printed publication, but other initiatives are needed. A new initiative by the *BMJ* aims to overcome this delay by publishing rapid guidance on new evidence that has the potential to change practice.³ In the 'rapid recs', new findings are assessed in the context of existing evidence and a multidisciplinary panel, including

patients, then formulates practice recommendations. Input from practising clinicians and their patients is essential in this process.

Professor Mieke van Driel
Dr Geoffrey Spurling

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Bariatric-metabolic surgery: A guide for the primary care physician

We would like to make the following comments based on the recent article by Lee and Dixon (*AFP* July 2017).¹ While guidelines on managing patients before and after bariatric surgery are welcome, there is a lack of guidelines and programs that general practitioners (GPs) can use for patients who are on the waiting list to attend an obesity service. This is an important area of need in which GPs can play an important part, as waiting times to access obesity clinics via the public sector can take years.² Furthermore, prolonged obesity clinic waiting lists have negative effects on patients' health and quality of life.³

Improving obesity management during the obesity clinic waiting period could also lead to better outcomes. A US study on weight change patterns in patients awaiting a behavioural obesity treatment program showed that weight remained unchanged for most patients

(61%).⁴ Nonetheless, those who lost weight during the waiting period went on to lose more weight post-treatment, compared with those who gained or maintained their weight.⁴ In 2008, the Weight Wise Clinical Module (WWCM) program was developed to support patients on the obesity clinic waiting list in Canada.⁵ It was evidence-based and delivered by a multidisciplinary team at community health centres.⁵ Although it was estimated that over 50% of patients participated, most of them were lost to follow-up.⁵

There are currently no Australian data on obesity management during the obesity clinic waiting period. Moreover, the aforementioned studies⁴⁻⁵ are quantitative in nature. There are no qualitative studies to explain how and why some patients changed or maintained their weight while being on the obesity clinic waiting list. Of note, the WWCM program has not been evaluated since its introduction in 2008.⁵

In summary, obesity management during the obesity clinic waiting period is currently a missed opportunity for improving outcomes for patients with obesity. More research, including rigorous evaluations of existing programs, is essential for developing effective and patient-centred programs that can be implemented at a primary care level to improve obesity management while awaiting obesity clinic reviews.

Dr Sze Mei Yong, MBBS (Hons), Final-year Advanced Trainee in General and Acute Care Medicine, Alfred Health; Master of Public Health student, University of Melbourne

Associate Professor John Furler, MBBS, FRACGP, PhD, Senior Research Fellow, Department of General Practice, University of Melbourne

Dr Sharon Marks, MBBS, FRACP, PhD, Head of Clinical Nutrition and Metabolism Unit, Monash Health

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Reply

We would like to thank Dr Yong and colleagues for their comments. As pointed out, access to appropriate obesity care is an issue in many parts of the world, including Australia. Given the rise in prevalence of obesity, particularly clinically severe obesity, prioritisation of those with clinically severe obesity who may benefit more from expedited assessment and surgery is important. Comprehensive clinical pathways that involve internal medicine/primary care physicians as part of a multidisciplinary team to treat clinically severe obesity have also been proposed.¹

However, long waiting lists for bariatric care should not be an excuse for clinical inertia concerning treatment of obesity. While waiting for bariatric surgery, a range of other options are available to the primary care physician for the treatment of obesity. Similarly, these options are needed in patients who are not suitable or not willing to have surgery. In Australia, comprehensive National Health and Medical Research Council guidelines provide guidance on effective and well-researched treatment options for obesity.² Ongoing engagement in lifestyle modification is needed, and dietary interventions, such as very low energy diets, can be successful.³ In recent years,

several new weight-loss medications have been approved in the US for long-term use, and we have written a separate review article in *Australian Family Physician* on the use of some of these medications to treat obesity.⁴ A recent obesity management algorithm proposed by the Australian Diabetes Society, the Australian and New Zealand Obesity Society and the Obesity Surgery Society of Australia and New Zealand also offers practical clinical tools to assist GPs in the treatment of obesity.⁵

Dr Phong Ching Lee, MBChB, MRCP (UK), FRCP (Edin)
Consultant Endocrinologist
Singapore General Hospital

Professor John Dixon, MBBS, PhD, FRACGP, FRCP (Edin)
Head of Clinical Obesity Research,
Baker Heart and Diabetes Institute;
Adjunct Professor, Primary Care Research Unit, Monash University

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Letters to the editor

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