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MAIG 2013

V Jornada d'Atenció
Compartida en
Pneumologia AIS-BE

hp
Hospital Plató

Àrea Integral
de Salut
Barcelona Esquerra

Institut Català de la Salut
Àmbit d'Atenció Primària
Barcelona Ciutat

C S B Consorci Sanitari de Barcelona
Ens públic de la Generalitat de Catalunya
i l'Ajuntament de Barcelona

CLÍNIC
Corporació Sanitària

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eixample

cap
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Sant Gervasi
Les Planes

Capio Hospital Universitari Sagrat Cor

Conseil Català
de Formació Contínua
Professions Sanitàries

**Normativas, guías clínicas y
recomendaciones, evidencia
científica o tratamiento
individualizado?**

Néstor Soler

*Servei de Pneumologia. Institut del Tòrax
Hospital Clínic-Universitat de Barcelona*

Consideraciones previas

- No se hace un análisis crítico de la evidencia científica
- No se habla de Medicina personalizada (4P)
- No se comparan diferentes normativas en términos de calidad ni adecuación terapéutica
- No es una revisión bibliográfica exhaustiva del tema



- **ATS Documents: Statements, Guidelines & Reports**

Clinical Guideline stable COPD: clinical practice guideline update. *Ann Intern Med* 2011

- **COPD-NICE Guidance 2013**

guidance.nice.org.uk

- **GOLD-COPD. Updated 2013**

www.goldcopd.org

- **COPD-Canadian Respiratory Guidelines 2012**

www.respiratoryguidelines.ca

- **Guía EPOC SEPAR-ALAT 2009**

www.separ.es

- **GesEPOC-Guía española de la EPOC 2012**

www.gesepoc.com

- **Guía EPOC SemFYC-SEPAR 2010**

Guía de Práctica Clínica Atención Integral al Paciente con EPOC

Otras recomendaciones:

- ✓ **Estrategia EPOC del Sistema Nacional de Salud (SNC)**
- ✓ **Guía MPOC (ICS)**
- ✓ **Documentos de consenso: Sociedad Madrileña, Sociedad Andaluza, etc**
- ✓ **Además:**
 - Guía utilización de inhaladores
 - Guía VMNI
 - Guía rehabilitación pulmonar
 - Tratamiento de la EPOC avanzada



Assessment of COPD scale
GOLD mobile app launched! GOLD's mobile app for physicians is now available in the iTunes App Store.



Características de las guías de práctica clínica (GPC)

- ✓ Proporcionan recomendaciones basadas en la evidencia científica
- ✓ A partir de grandes estudios aleatorizados (ensayos clínicos controlados doble ciego)
- ✓ Siguen una metodología rigurosa
- ✓ Se apoyan en la opinión consensuada de expertos
- ✓ Su implementación:
 - **reduce la variabilidad de la práctica clínica**
 - **disminuye la mortalidad y las hospitalizaciones**

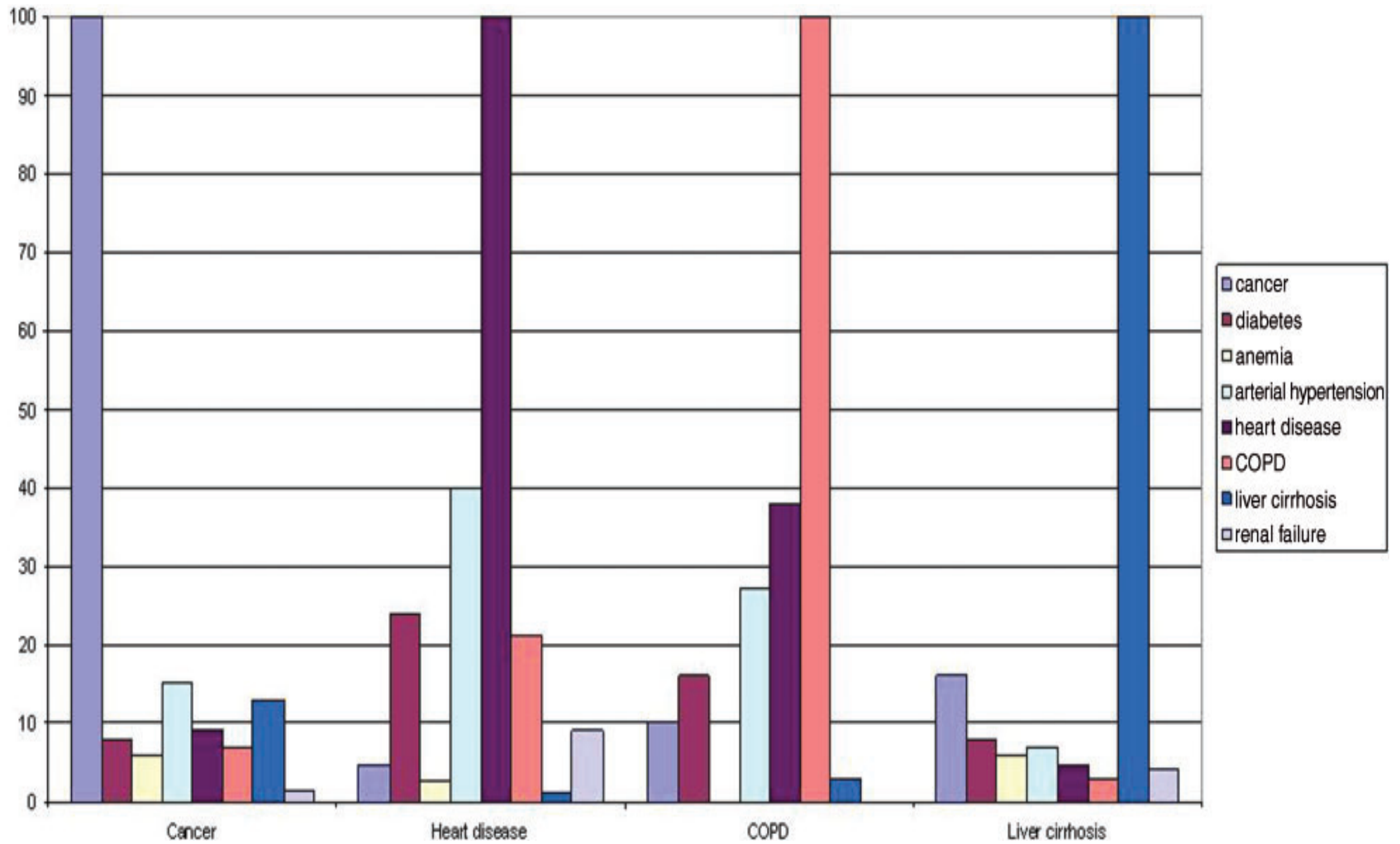
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- ✓ A partir de grandes estudios aleatorizados (ensayos clínicos controlados doble ciego)
- ✓ Siguen un proceso sistemático
- ✓ Se centran en la enfermedad y menos en el paciente
- ✓ Sus objetivos son:
 - reducir la morbilidad y la mortalidad
 - disminuir la mortalidad y las hospitalizaciones

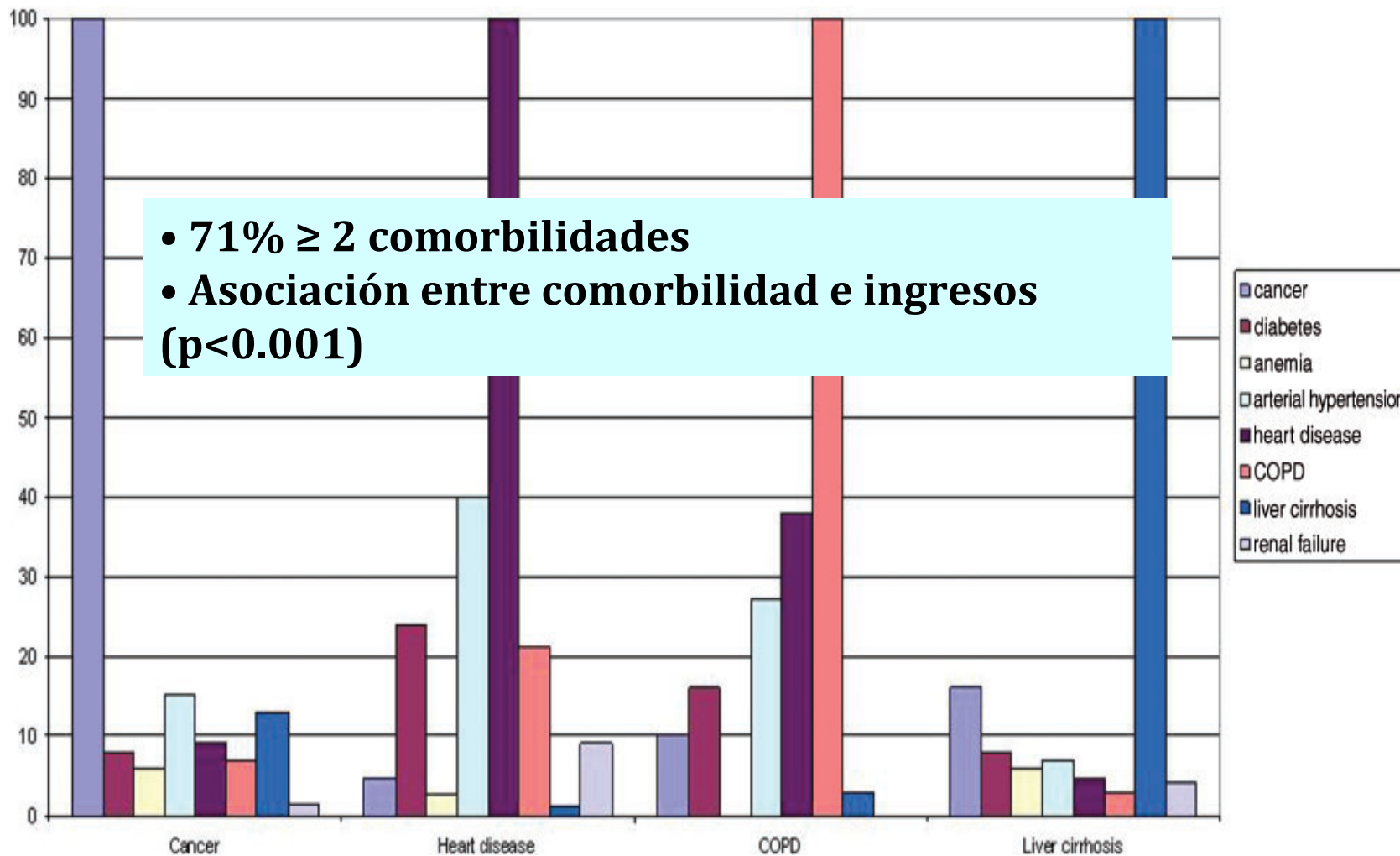
Algunas condiciones que limitan su aplicabilidad

- **Multi-comorbilidad**
- **Edad avanzada**
- **Adherencia al tratamiento**
- **Opinión del paciente**





Impacto de la comorbilidad



Guidelines for people not for diseases: the challenges of applying UK clinical guidelines to people with multimorbidity

LLOYD D. HUGHES, MARION E. T. MCMURDO, BRUCE GUTHRIE

Age and Ageing 2013; 42: 62–69

	<i>Depression</i>	<i>Type 2 diabetes</i>	<i>Heart disease</i>	<i>COPD</i>	<i>Osteoarthritis</i>
Does guideline address treatment in over 75s?	Minimal	Minimal	Moderate	Moderate across multiple areas	Moderate across several areas
Does guideline address comorbidity?	Extensive consideration	Moderate discussion	Extensive discussion	Moderate discussion Cross-referenced to depression	Extensive discussion
Does guideline explicitly discuss patient choice and preferences?	Generic introduction	Generic introduction	Generic introduction only	Generic introduction only	Generic introduction
Does guideline explicitly discuss potential challenges to patient adherence?	Moderate discussion	None	Moderate discussion	Moderate discussion	Minimal discussion

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Current Guidelines Have Limited Applicability to Patients with Comorbid Conditions: A Systematic Analysis of Evidence-Based Guidelines

Marjolein Lugtenberg^{1,2*}, Jako S. Burgers^{2,3}, Carolyn Clancy⁴, Gert P. Westert^{1,2}, Eric C. Schneider^{5,6,7}

Table 2. Characteristics of guidelines in terms of addressing comorbidity (N = 20).

Guidelines	COPD (N = 6)		DEP (N = 4)		DM II (N = 7)		OA (N = 3)		TOTAL (N = 20)	
	N	%	N	%	N	%	N	%	N	%
<i>Issue of comorbidity addressed</i>	5	83	4	100	7	100	1	33	17	85
Provision of comorbidity prevalence data	3	50	2	50	2	29	1	33	8	40
Screening/diagnosing for comorbidity	5	83	3	75	7	100	1	33	16	80
Considering comorbidity in treatment	5	83	4	100	7	100	1	33	17	85
Inclusion of patient centered aspects	4	67	3	75	4	57	1	33	12	60
<i>Includes specific comorbidity-related treatment recommendation(s)</i>	3	50	4	100	6	86	1	33	14	70
Mean number of recommendations per guideline (range)	0.7	(0–2)	2.3	(1–4)	6.3	(0–26)	0.7	(0–2)	3.0	(0–26)

COPD = Chronic Obstructive Pulmonary Disease; DEP = Major depressive disorder; DM II = Diabetes Mellitus type 2; OA = Osteoarthritis.
doi:10.1371/journal.pone.0025987.t002

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Inclusion of patient centered aspects	3	50	4	57	4	57	1	33	12	60
Includes specific comorbidity-related treatment recommendation(s)	4	67	6	86	6	86	1	33	14	70
Mean number of recommendations	1.5 (0–2)		2.3 (1–4)		6.3 (0–26)		0.7 (0–2)		3.0 (0–26)	

COPD = Chronic Obstructive Pulmonary Disease; DEP = Major depressive disorder; DM II = Diabetes Mellitus type 2; OA = Osteoarthritis.
doi:10.1371/journal.pone.0025987.t002

Evidencia moderada en 25% y baja en 37%

Tratamiento de las comorbilidades

Lugtemberg et al. PlosOne 2011

Table 3. Characteristics of comorbidity-related treatment recommendations (N = 59).

Comorbidity-related treatment recommendations	COPD (N = 4)	DEP (N = 9)	DM II (N = 44)	OA (N = 2)	TOTAL (N = 59)	
	N	N	N	N	N	%
<i>Type of comorbidity addressed</i>						
concordant comorbidity	3	5	38	0	46	78
discordant comorbidity	1	3	4	0	8	14
not specified	0	1	2	2	5	8
<i>Nr of comorbid conditions addressed</i>						
one comorbid condition	4	8	42	0	54	92
multiple comorbidities	0	0	0	0	0	0
not specified	0	1	2	2	5	8
<i>Type of recommendation</i>						
general treatment	0	3	1	0	4	7
drug therapy	1	4	27	0	32	54
life-style advice	0	0	1	1	2	3
surgery	0	0	5	1	6	10
other*	3	2	10	0	15	25
Includes patient centered aspects	0	3	4	0	7	12

COPD = Chronic Obstructive Pulmonary Disease; DEP = Major depressive disorder; DM II = Diabetes Mellitus type 2; OA = Osteoarthritis.

*The category 'other' includes: psychological interventions, oxygen therapy, referral, assessment before flying, target levels, risk stratification.

doi:10.1371/journal.pone.0025987.t003

La importancia de la adherencia al tratamiento

- **Aplicar un modelo de atención integrada al paciente crónico**
Adams SG. Arch Intern Med 2007
- **Desarrollo de programas asistenciales coste/efectivos en la EPOC**
Steuten LM. Int J Chronc Obstruct Pulmon Dis 2009
- **Relación entre la habilidad de autocuidado y el bienestar del paciente con EPOC**
Cramm J. Int J Chronc Obstruct Pulmon Dis 2013

Ejemplo: Paciente 1 (i)

- **Mujer de 78 años, fumadora 40p/año, BMI 29**
- **Antecedentes de:**
 - **HTA**
 - **IAM hace 2 años**
 - **DM tipo II**
 - **Dolor crónico por artrosis,**
 - **EPOC GOLD III (mMRC grado 3)**
 - **Depresión moderada**

Ejemplo: Paciente 1 (ii)

- **Recomendaciones**
 - **Fármacos:** omeprazol, metformina, citalopram, salmeterol inhalado, tiotropio inhalado, AAS, lisinopril, sinvastatina, bisoprolol, paracetamol, ibuprofeno y fentanilo parches
 - **Tratamiento no farmacológico:** deshabituación tabaquismo, higiene del sueño, ejercicio aeróbico (60 min./día), dieta hiposódica, monitorización de la glucosa plasmática (programa educativo)
 - **Seguimiento:** control anual diabetes, control anual EPOC, fondo de ojo anual, control HbA1c (3-6 meses), control PA (4-6 semanas), vacunación anual gripe, programa tabaquismo, rehabilitación pulmonar

Ejemplo: Paciente 2 (i)

- **Varón de 75 años, ex-fumador 80p/año, BMI 33**
- **Antecedentes de:**
 - **HTA**
 - **DM tipo II**
 - **Cardiopatía hipertensiva**
 - **FA crónica**
 - **EPOC GOLD II (B)**
 - **SAHS desde hace 5 años**
 - **Enfermedad vascular arterial periférica**

Ejemplo: Paciente 2 (ii)

- *Recomendaciones*

- **Fármacos:** omeprazol, metformina, formoterol inhalado, tiotropio inhalado, AAS, losartan, finasteride, atorvastatina, furosemida, acenocumarol

- **Tratamiento no farmacológico:** CPAP nocturna, higiene del sueño, dieta hipocalórica, monitorización de la glucosa plasmática y peso (programa educativo)

- **Seguimiento:** control INR (3 semanas) control anual DM II, control 6 meses EPOC, control HbA1c (6 meses), control PA (2 meses), control anual HBP, vacunación anual gripe, programa tabaquismo

Evaluación global del paciente (i)

- **Paciente 1**

- Escaso conocimiento de sus enfermedades
- Cuidadora de su esposo con demencia
- Renta baja
- Hijos sin recursos económicos

2 ingresos hospitalarios/año

3 consultas urgencias

- **Paciente 2**

- Vive solo
- Parcialmente dependiente
- Ayuda 3h/día
- Equipo de primaria sin atención domiciliaria

3 ingresos hospitalarios/año

Ingreso en centro de convalecencia (2 meses)

Evaluación global del paciente (ii)

- **Paciente 1**

- Escaso conocimiento de sus enfermedades
- Cuidadora de su esposo con demencia
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- Hijos sin recursos económicos

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- **Paciente 2**

- Vive solo
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3 ingresos hospitalarios/año

Ingreso en centro sociosanitario

Medicina basada en la evidencia en pacientes ancianos: Limitaciones y soluciones potenciales

Decision Steps After Diagnosis	Barriers	Potential Solutions
What are the relative benefits and harms of potential treatments as assessed in clinical trials?	<ul style="list-style-type: none"> Underrepresentation of older patients in trials Explanatory study designs limiting generalizability of results Surrogate or invalidated symptom-based outcome measures Loss to follow-up Underreporting of adverse effects 	<ul style="list-style-type: none"> Note trials that exclusively or predominantly enroll older patients. Identify older patient subgroup analyses in trials/reviews. Assume that relative effects are the same and consider older patients' increase in baseline risk. Be aware that characteristics of patients entered into trials may be substantially different from those in clinical practice. Do not trust surrogate outcomes. Be wary of trials in which validity, responsiveness, and interpretability of measures of change in health status have not been established. Consider the vulnerability of trials to show outcomes different from those reported in patients lost to follow-up. Scrutinize trials for their rigor in reporting adverse outcomes. Note population-based, longitudinal studies with adverse event monitoring as the main objective.
What are the absolute levels of benefit and harm in my individual patient?	<ul style="list-style-type: none"> Underreporting of absolute risk (vs relative risk) Unstudied factors that modify treatment effects: <ul style="list-style-type: none"> -Competing disease risks -Time-dependent changes in risk -Variation in risk-treatment thresholds 	<ul style="list-style-type: none"> Use validated risk prediction rules or scores, and calculate absolute risk reduction. Assess trials for use of expected event-free, quality-adjusted life gain methods in quantifying treatment benefits.
What are the values and preferences of my patient?	<ul style="list-style-type: none"> Limited health literacy and avoidance of decision participation Opinions of surrogate decision makers may not reflect those of patients 	<ul style="list-style-type: none"> Use validated decision aids to aid understanding of risk and benefit. Retrieve population-based studies of elderly health values wherever possible. Critically appraise the validity of surrogate opinions. Adopt consensus approaches that are more likely to give stable, consistent views of patient preferences.
What are the treatments that should take priority over others?	<ul style="list-style-type: none"> Disease-specific clinical practice guidelines may exacerbate the problem of polypharmacy and drug-related adverse events 	<ul style="list-style-type: none"> Retrieve guidelines that focus on older populations and ensure that treatment burden and inconvenience receive adequate consideration in decision making.
Will my patient be capable of adhering to treatment?	<ul style="list-style-type: none"> Uncertainty regarding enablers and barriers to adherence 	<ul style="list-style-type: none"> Use validated adherence-enhancing strategies.

Medicina basada en la evidencia en pacientes ancianos: Limitaciones y soluciones potenciales

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Qué estrategias se pueden seguir para mejorar la aplicación de la Medicina basada en la evidencia?

Table 4. Strategies for Improving the Evidence Base for Older Patient Care

Strategy

More meta-analyses of age-stratified individual patient data obtained from randomized trials that include sizable numbers of older patients

More clinical trials (preferably randomized megatrials) specific to older patient populations in which:

- Trial populations are representative of community populations
- Age-based exclusions and other exclusions that disproportionately reduce enrollment of older patients are eliminated where possible
- Nonpharmacologic treatments are given equal weighting to pharmacologic treatments
- Multidrug regimens are compared directly with simpler regimens
- Assessment of physical, psychological, cognitive, and other outcomes is routinely performed using validated, standardized measurement tools
- Benefits and harms are rigorously evaluated and reported in absolute and relative terms
- Sample size calculations ensure adequate power for age-stratified analyses
- Minimal important difference has been prespecified for trials evaluating treatment effects on patient-reported outcomes
- Prespecified subgroup analyses are performed to assess primary outcomes according to age (65-74, 75-84, and ≥ 85 y), treatment intensity or duration of follow-up, and selected comorbidities or levels of premorbid function

More observational studies and clinical registries specific to older patients in which:

- Outcome measures are standardized and regularly include measures of physical, psychological, and cognitive function
- Subgroup analyses are performed if possible as described previously herein
- Multivariate regression models are applied to whole cohorts and subgroups in identifying patient types who are more likely to benefit (or be harmed) by treatments in question

More clinical practice guidelines that, regarding older patients:

- Use the GRADE system or a similar approach that makes explicit recommendations for which there is compelling evidence of benefits substantially outweighing harm under most circumstances
- Consider the limitations of applying multiple treatments to patients with multiple chronic diseases

Qué estrategias se pueden seguir para mejorar la aplicación de la Medicina basada en la evidencia?

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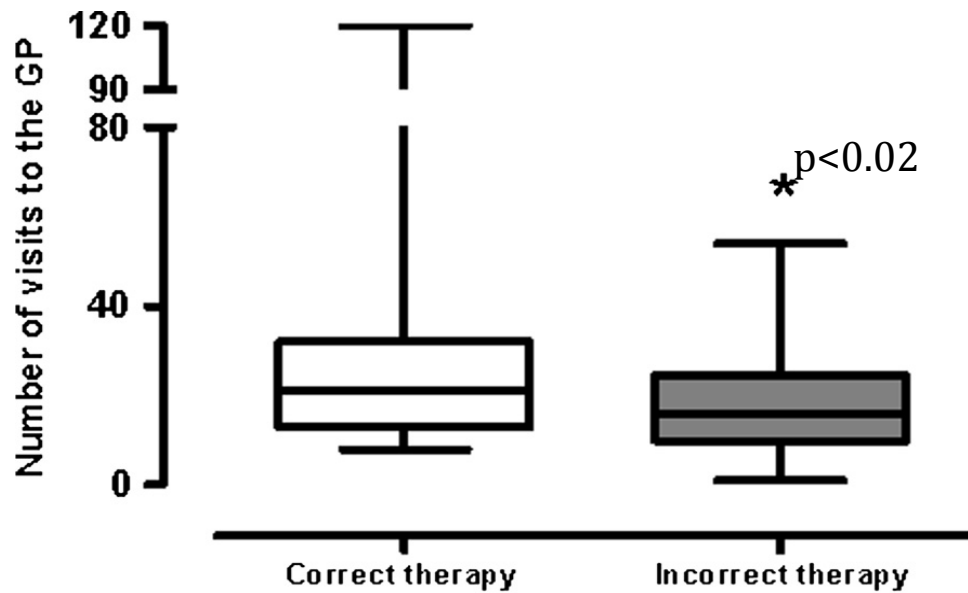
- Más ensayos clínicos dirigidos a población anciana
- Evaluación de tratamientos no farmacológicos
- Grupos específicos de análisis (65-74, 75-84, >85 años)
- Limitación de aplicar múltiples tratamientos en pacientes con enfermedades crónicas

and cognitive function

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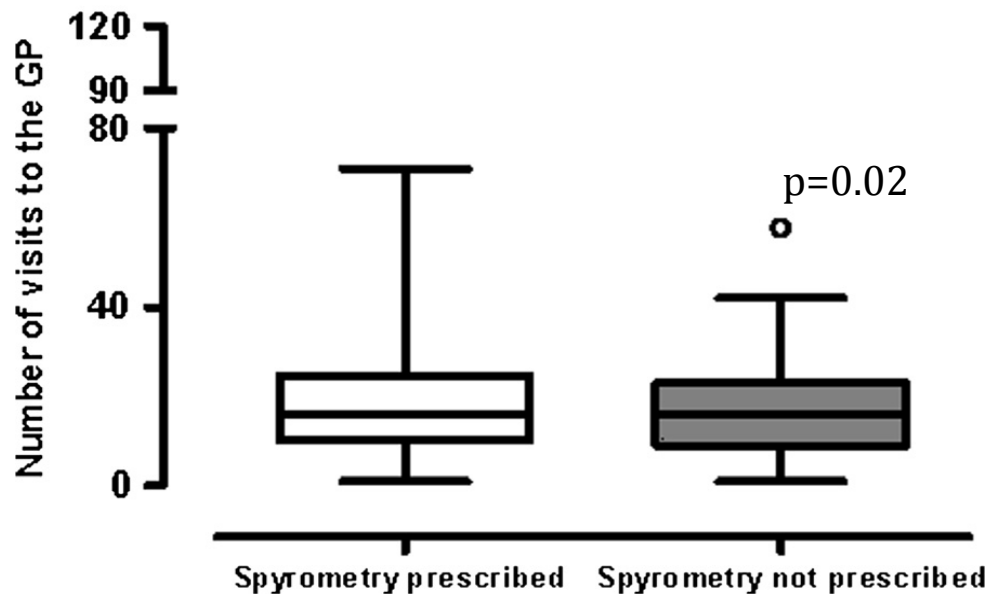
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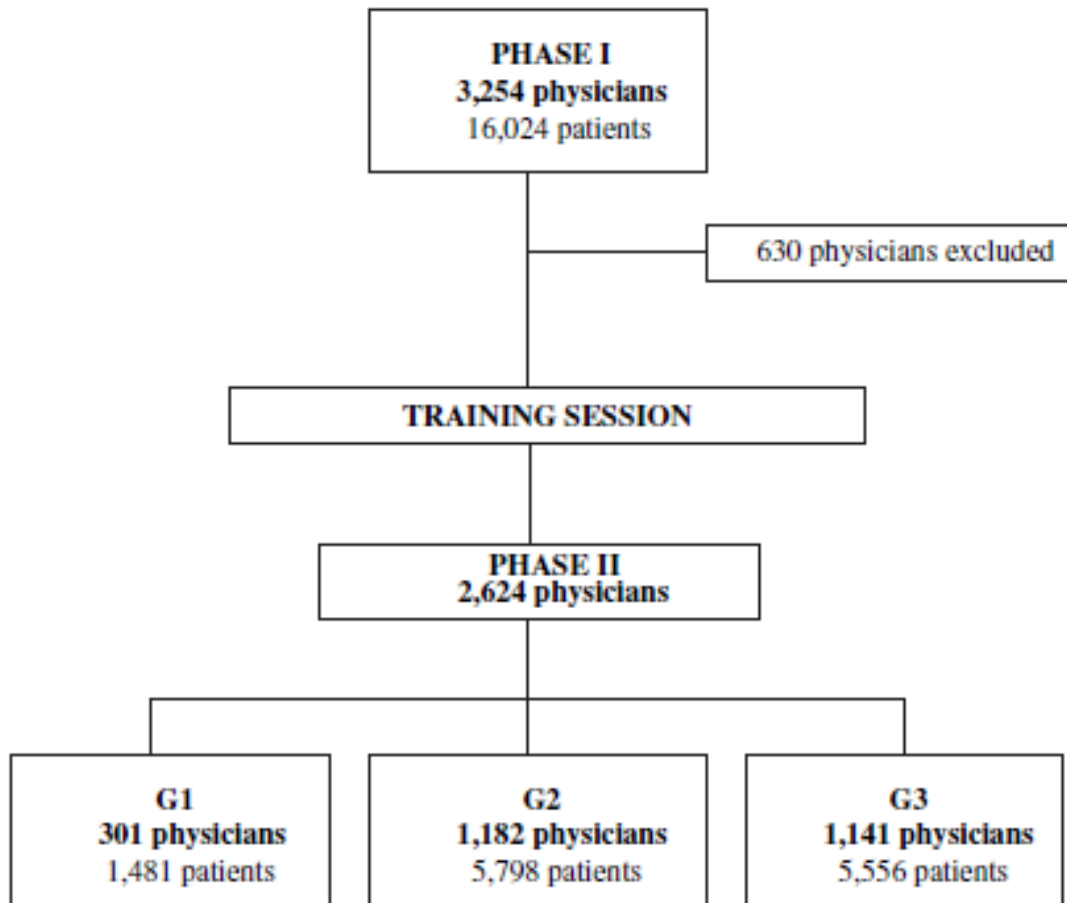


Impacto de un programa de formación en MG

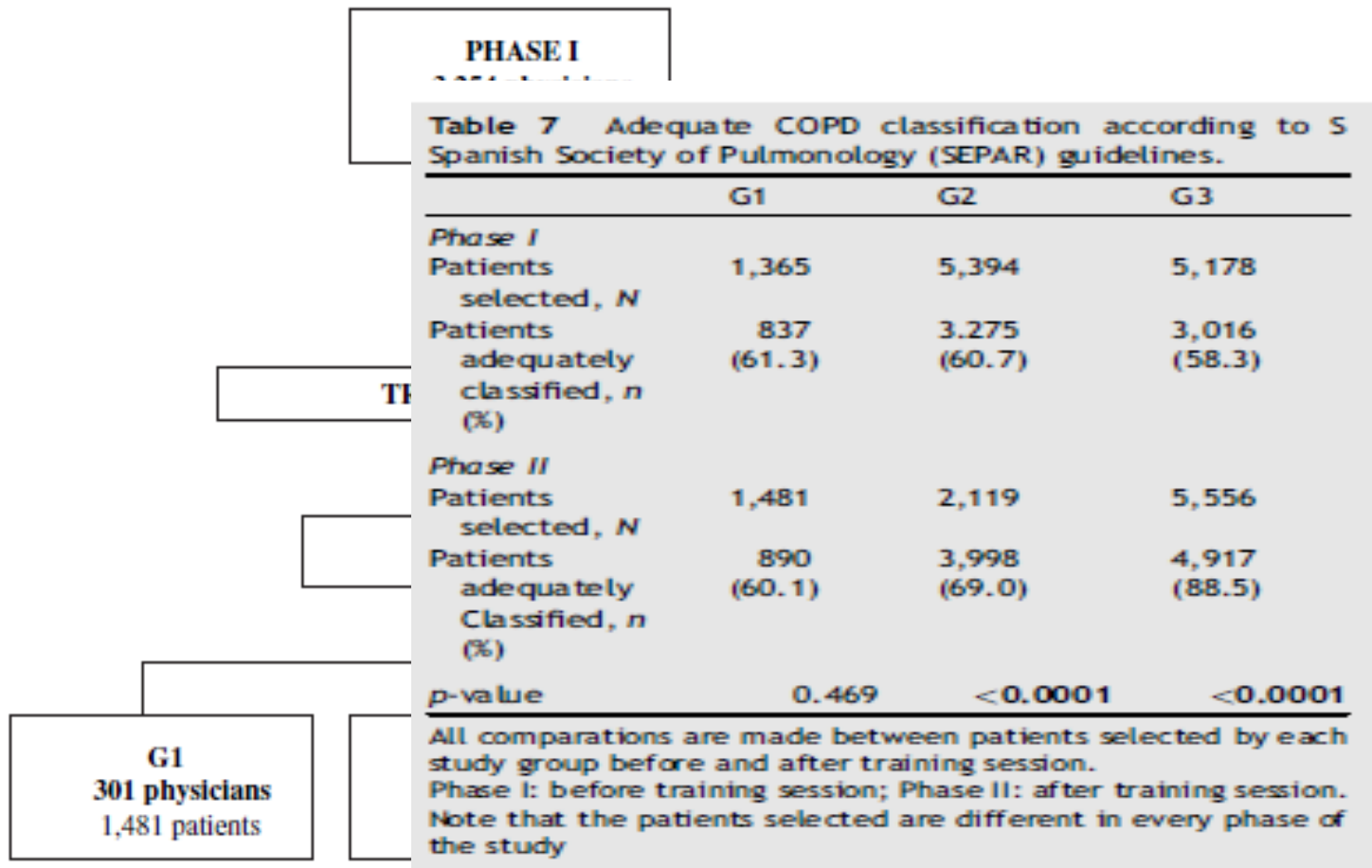
- Mejoría en el tratamiento prescrito
- Número de espirometrías solicitadas



EMMPOC *flow-chart*



EMMPOC flow-chart



EMMPOC flow-chart

PHASE I

Table 7 Adequate COPD classification according to S Spanish Society of Pulmonology (SEPAR) guidelines.

	G1	G2	G3
<i>Phase I</i>			
Patients selected, N	1,365	5,394	5,178
Patients adequately classified, n (%)	837 (61.3)	3,275 (60.7)	3,016 (58.3)
<i>Phase II</i>			
Patients selected, N	1,481	2,119	5,556
Patients adequately classified, n (%)	890 (60.1)	3,998 (69.0)	4,917 (88.5)
p-value	0.469	<0.0001	<0.0001

All comparisons are made between patients selected by each study group before and after training session. Phase I: before training session; Phase II: after training session. Note that the patients selected are different in every phase of the study

G1
301 physicians
1,481 patients

REVIEW

Primary care spirometry

E. Derom, C. van Weel, G. Liistro, J. Buffels, T. Schermer, E. Lammerse, E. Wouters and M. Decramer

Eur Respir J 2008; 31: 197–203

*“Softening the stringent ATS/ERS criteria could enhance the acceptability rates of spirometry when used in a general practice. However, the implications of potential simplifications on the quality of the data and clinical decision making remain to be investigated. **Hand-held office spirometers have been developed in recent years, with a global quality and user-friendliness that makes them acceptable for use in general practices.**”*



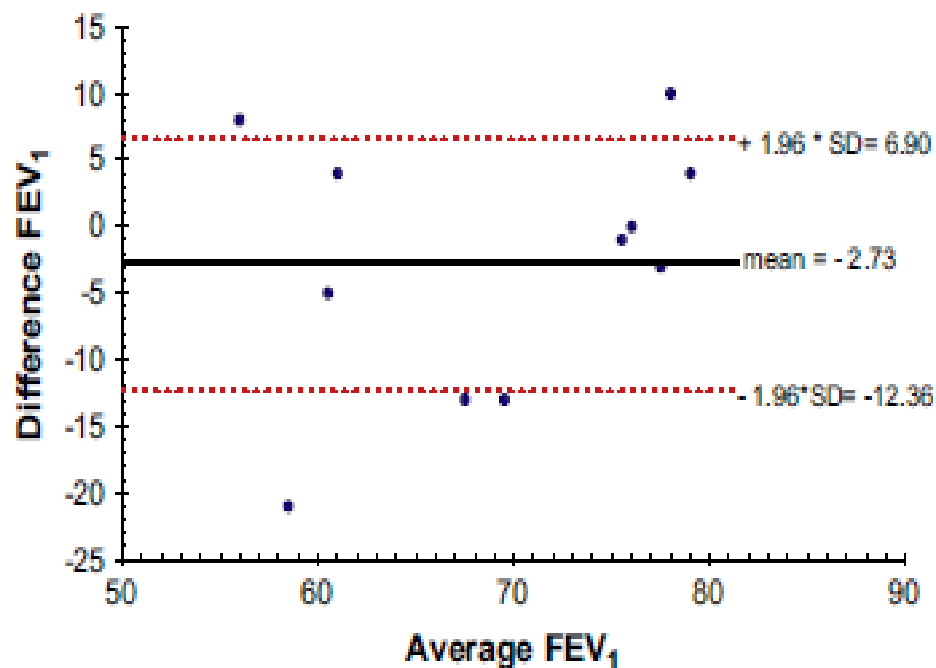
ELSEVIER

available at www.sciencedirect.com

journal homepage: www.elsevier.com/locate/rmed

COPD case finding by spirometry in high-risk customers of urban community pharmacies: A pilot study

D. Castillo ^{a,f,*}, R. Guayta ^b, J. Giner ^c, F. Burgos ^{d,f}, C. Capdevila ^b,
J.B. Soriano ^{e,f}, M. Barau ^b, P. Casan ^c on behalf of the FARMAEPOC group

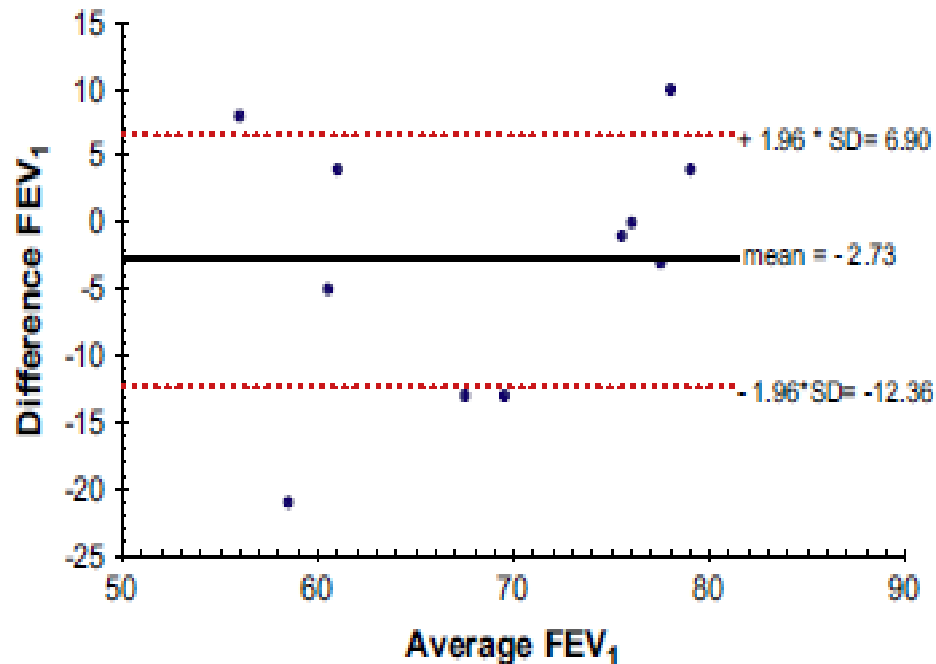


Concordancia entre los FEV₁% obtenidos (farmacia-hospital)



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- 70% calidad grados A y B
- 73% aceptable por expertos en función pulmonar

Concordancia entre los FEV₁% obtenidos (farmacia-hospital)

Uso de GPC: Puntos clave

- La aplicación de las GPC se basa en pruebas sobre grupos de población y están limitadas en su enfoque individual
- Las GPC deben ser más aplicables a los pacientes con comorbilidad y mayor riesgo de reacciones adversas a medicamentos
- Deben tener en cuenta el impacto de la edad avanzada y la clase funcional
- Las GPC deberían centrarse en la atención individual e integrar las directrices para procesos de enfermedad similares

Recomendaciones para mejorar las GPC

- ✓ Proporcionar información resumida y comparable sobre beneficios/riesgos de los tratamientos recomendados
- ✓ Las directrices deben conllevar una referencia cruzada cuando las recomendaciones son sinérgicas o contradictorias
- ✓ Deben identificar el riesgo de interacciones entre medicamentos
- ✓ Incluir algunos consejos específicos para los médicos en el tratamiento de pacientes de edad avanzada