GRADE for the development of evidence-based recommendations for immunization

Holger Schünemann, MD, PhD
Chair and Professor, Department of Clinical Epidemiology & Biostatistics
Professor of Medicine
Michael Gent Chair in Healthcare Research
McMaster University, Hamilton, Canada

STIKO, Berlin, Germany
November 22, 2010
Disclosure

• Co-chair GRADE Working Group
• Work with various guideline groups using GRADE
• No direct personal for profit payments for work related to the topic area
• American College of Physicians (ACP) Clinical Practice Guidelines Committee
• WHO: Expert Advisory Panel on Clinical Practice Guidelines and Clinical Research Methods and Ethics & chair of various guideline panels
Content

GRADE and immunizations

• Quality of evidence
• Going from evidence to recommendations
GRADE Uptake

- World Health Organization
- Allergic Rhinitis in Asthma Guidelines (ARIA)
- American Thoracic Society
- American College of Physicians (ACP)
- Canadian Task Force for the Preventive Services
- European Respiratory Society
- European Society of Thoracic Surgeons
- British Medical Journal
- Infectious Disease Society of America
- UpToDate®
- National Institutes of Health and Clinical Excellence (NICE)
- Scottish Intercollegiate Guideline Network (SIGN)
- Cochrane Collaboration
- Clinical Evidence
- Agency for Health Care Research and Quality (AHRQ)
- Partner of GIN
- Over 40 major organizations
Healthcare problem

“Healthy people”
“Herd immunity”
“Long term perspective”
“Disease perception”
“Lots of other things”

recommendation
Key issues

Guidelines for guidelines
Priority setting
Group composition and consultation process
Managing conflicts of interest
Group processes
Determining which outcomes are important
Deciding what evidence to include
Synthesis and presentation of evidence
Grading evidence and recommendations
Integrating values and priorities into the recommendations
Incorporating considerations of cost-effectiveness, affordability, and equity
Adaptation, applicability and transferability
Reporting guidelines
Disseminating and implementing guidelines
Evaluation

Guideline development Process (for WHO)

Review
Improving the use of research
Introduction
Andrew D Oxman*1, Atle Fretl

Review
Improving the use of research
1. Guidelines for guidelines
Holger J Schünemann*1, Atle Fretl

Published: 21 November 2006
This article is available from: http://www.health-policy-systems.org/content/4/1/13
Evidence based healthcare decisions

- Evidence about effects
- Population/societal values and preferences
- State and circumstances

Expertise

Haynes et al. 2002
Case scenario

A 13 year old girl who lives in rural Indonesia presented with flu symptoms and developed severe respiratory distress over the course of the last 2 days. She required intubation. The history reveals that she shares her living quarters with her parents and her three siblings. At night the family’s chicken stock shares this room too and several chicken had died unexpectedly a few days before the girl fell sick.

Potential interventions: antivirals, such as neuraminidase inhibitors oseltamivir and zanamivir
Framing a foreground question

Population: Avian Flu/influenza A (H5N1) patients

Intervention: Oseltamivir

Comparison: No pharmacological intervention

Outcomes: Mortality, hospitalizations, resource use, adverse outcomes, antimicrobial resistance

Schunemann, et al., The Lancet ID, 2007
Choosing outcomes

• Desirable outcomes
  – lower mortality
  – reduced hospital stay
  – herd immunity (new cases)
  – reduced resource expenditure

• Undesirable outcomes
  – adverse reactions
  – the development of resistance
  – costs of treatment

• Every decision comes with desirable and undesirable consequences

→ Developing recommendations must consider of desirable and undesirable outcomes
Evidence based healthcare decisions

State and circumstances

Evidence about effects

Population/societal values and preferences

Expertise

Haynes et al. 2002
GRADE: recommendations & quality of (a body of) evidence

Clear separation, but *judgments* required:

1) Recommendation: 2 grades – conditional (aka weak) or strong (for or against an action)?
   – Balance of benefits and downsides, values and preferences, resource use and quality of evidence

2) 4 categories of quality of evidence:
   + + + + (High), + + + o (Moderate), + + o o (Low), + o o o (Very low)?
   – methodological quality of evidence
   – likelihood of bias related to recommendation
   – by outcome and across outcomes

*www.GradeWorking-Group.org*
GRADE Quality of Evidence

In the context of making recommendations:
• The quality of evidence reflects the extent of our confidence that the estimates of an effect are adequate to support a particular decision or recommendation.
Figure 1. Belief and confidence: a two-dimensional weather report. (Reprinted by permission from the Wall Street Journal).
Simple hierarchies are (too) simplistic

STUDY DESIGN

- Randomized Controlled Trials
- Cohort Studies and Case Control Studies
- Case Reports and Case Series, Non-systematic observations

BIAS

Expert Opinion

Schünemann & Bone, 2003
Determinants of quality

- RCTs ⊕⊕⊕⊕
- observational studies ⊕⊕〇〇

5 factors that can lower quality
1. limitations in detailed design and execution (risk of bias criteria)
2. Inconsistency (or heterogeneity)
3. Indirectness (PICO and applicability)
4. Imprecision (number of events and confidence intervals)
5. Publication bias

3 factors can increase quality
1. large magnitude of effect
2. plausible residual bias or confounding
3. dose-response gradient
1. Design and Execution/Risk of Bias

Examples:

- Inappropriate selection of exposed and unexposed groups
- Failure to adequately measure/control for confounding
- Selective outcome reporting
- Failure to blind (e.g. outcome assessors)
- High loss to follow-up
- Lack of concealment in RCTs
- Intention to treat principle violated
Design and Execution/RoB

Regular treatment with salmeterol for chronic asthma: serious adverse events (Review)

Cates CJ, Cates MJ

Figure 4. Risk of bias summary: review authors' judgments about each risk of bias item for each included study.

From Cates, CDSR 2008
Design and Execution/RoB

Figure 3. Risk of bias graph: review authors' judgments about each risk of bias item presented as percentages across all included studies.

Overall judgment required
2. Publication Bias

- Should always be suspected
  - Only small “positive” studies
  - For profit interest
  - Various methods to evaluate – none perfect, but clearly a problem
3. Inconsistency of results (heterogeneity)

- if inconsistency, look for explanation
  - patients, intervention, comparator, outcome
- if unexplained inconsistency lower quality
Reminders for immunization uptake

Analysis 2.1. Comparison 2 letter reminders vs. control, Outcome 1 Immunized.

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Letter reminders n/N</th>
<th>Control n/N</th>
<th>Odds Ratio M-H,Random,95% CI</th>
<th>Odds Ratio M-H,Random,95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Preschool-child</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Campbell 1994T87</td>
<td>54/87</td>
<td>59/105</td>
<td></td>
<td>1.28 [0.71, 2.28]</td>
</tr>
<tr>
<td>Lieu 1997T69</td>
<td>82/153</td>
<td>47/136</td>
<td></td>
<td>2.19 [1.36, 3.52]</td>
</tr>
<tr>
<td>Lieu 1998T82</td>
<td>72/162</td>
<td>78/219</td>
<td></td>
<td>1.45 [0.95, 2.19]</td>
</tr>
<tr>
<td>Oeffinger 1992T27</td>
<td>33/116</td>
<td>31/122</td>
<td></td>
<td>1.17 [0.66, 2.07]</td>
</tr>
<tr>
<td>Young 1980T63</td>
<td>51/106</td>
<td>34/105</td>
<td></td>
<td>1.94 [1.11, 3.39]</td>
</tr>
<tr>
<td><strong>Subtotal (95% CI)</strong></td>
<td><strong>624</strong></td>
<td><strong>687</strong></td>
<td></td>
<td><strong>1.58 [1.26, 1.99]</strong></td>
</tr>
</tbody>
</table>

Total events: 292 (Letter reminders), 249 (Control)
Heterogeneity: Tau² = 0.00; Chi² = 4.08, df = 4 (P = 0.40); I² = 2%
Test for overall effect: Z = 3.92 (P = 0.000088)

Jacobson et al., CDRS 2005
## Analysis 6.1. Comparison of patient & provider reminder vs. control, Outcome 1 Immunized.

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Patient % Provider R</th>
<th>Control</th>
<th>Odds Ratio M-H, Random 95% CI</th>
<th>Weight</th>
<th>Odds Ratio M-H, Random 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rodewald 1999T95</td>
<td>616/648</td>
<td>532/719</td>
<td>-</td>
<td>30.0%</td>
<td>6.77 [ 457, 10.02 ]</td>
</tr>
<tr>
<td>Soljak 1987T35</td>
<td>539/709</td>
<td>382/613</td>
<td>-</td>
<td>31.2%</td>
<td>1.92 [ 1.51, 2.43 ]</td>
</tr>
<tr>
<td><strong>Subtotal (95% CI)</strong></td>
<td><strong>1357</strong></td>
<td><strong>1332</strong></td>
<td>-</td>
<td><strong>61.1%</strong></td>
<td><strong>3.57 [ 1.03, 12.41 ]</strong></td>
</tr>
</tbody>
</table>

Total events: 1155 (Patient % Provider R), 914 (Control)

Heterogeneity: Tau² = 0.78; Chi² = 29.55, df = 1 (P<0.00001); I² = 97%

Test for overall effect: Z = 2.00 (P = 0.046)

3. Influenza-adult

---

Jacobson et al., CDRS 2005
4. Imprecision

• Small sample size
  – small number of events

• Wide confidence intervals
  – uncertainty about magnitude of effect
**Example: Immunization in children**

**Analysis 4.3. Comparison 4 Inactivated vaccines - (cohort studies by age group), Outcome 3 Otitis media.**

Review: Vaccines for preventing influenza in healthy children

Comparison: 4 Inactivated vaccines - (cohort studies by age group)

Outcome 3 Otitis media

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Vaccine</th>
<th>Standard care</th>
<th>Risk Ratio</th>
<th>Weight</th>
<th>Risk Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive area</td>
<td>n/N</td>
<td>n/N</td>
<td>M-H,Random,95% CI</td>
<td></td>
<td>M-H,Random,95% CI</td>
</tr>
<tr>
<td>Children aged 6 months to 5 years</td>
<td>8/61</td>
<td>16/58</td>
<td>0.48 [0.22, 1.03]</td>
<td>100.0%</td>
<td>0.48 [0.22, 1.03]</td>
</tr>
<tr>
<td><strong>Total (95% CI)</strong></td>
<td><strong>61</strong></td>
<td><strong>58</strong></td>
<td>100.0%</td>
<td>0.48 [0.22, 1.03]</td>
<td></td>
</tr>
</tbody>
</table>

Total events: 8 (Vaccine), 16 (Standard care)
Heterogeneity: Not applicable
Test for overall effect: Z = 1.90 (P = 0.058)

Jefferson et al., CDRS 2008
### Analysis 6.1. Comparison 6 Inactivated vaccine versus placebo (RCTs), Outcome 1 Influenza.

Review: Vaccines for preventing influenza in healthy children

Comparison: 6 Inactivated vaccine versus placebo (RCTs)

Outcome: 1 Influenza

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Vaccine n/N</th>
<th>Control n/N</th>
<th>Risk Ratio M-H,Random,95% CI</th>
<th>Weight</th>
<th>Risk Ratio M-H,Random,95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Inactivated vaccines (one dose)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beutner 1979a</td>
<td>28/300</td>
<td>82/275</td>
<td></td>
<td>41.8%</td>
<td>0.31 [0.21, 0.47]</td>
</tr>
<tr>
<td>Clover 1991</td>
<td>9/54</td>
<td>36/82</td>
<td></td>
<td>16.6%</td>
<td>0.38 [0.20, 0.72]</td>
</tr>
<tr>
<td>Gruber 1990</td>
<td>10/54</td>
<td>37/77</td>
<td></td>
<td>18.7%</td>
<td>0.39 [0.21, 0.71]</td>
</tr>
<tr>
<td>Hoberman 2003a</td>
<td>15/273</td>
<td>22/138</td>
<td></td>
<td>17.7%</td>
<td>0.34 [0.18, 0.64]</td>
</tr>
<tr>
<td>Hoberman 2003b</td>
<td>9/252</td>
<td>4/172</td>
<td></td>
<td>5.2%</td>
<td>1.10 [0.35, 3.50]</td>
</tr>
<tr>
<td><strong>Subtotal (95% CI)</strong></td>
<td><strong>933</strong></td>
<td><strong>695</strong></td>
<td></td>
<td></td>
<td><strong>0.36 [0.28, 0.48]</strong></td>
</tr>
</tbody>
</table>

Total events: 71 (Vaccine), 181 (Control)

Heterogeneity: Tau² = 0.00; Chi² = 4.13, df = 4 (P = 0.39); I² = 5%

Test for overall effect: Z = 7.42 (p < 0.00001)

---

Favours treatment Favours control
5. Directness of Evidence
generalizability, transferability, applicability

- differences in
  - populations/patients (children – neonates, women in general – pregnant women)
  - interventions (all vaccines, new - old)
  - comparator appropriate (new policy – old or no policy)
  - outcomes (important – surrogate: cases prevented – seroconversion/immunogenicity)

- indirect comparisons
  - interested in A versus B
  - have A versus C and B versus C
  - Vaccine A versus Placebo versus Vaccine B
What can raise quality?

1. large magnitude can upgrade (RRR 50%/RR 2; RRR 80%/RR 5)
   – criteria
     • everyone used to do badly
     • almost everyone does well
   – parachutes to prevent death when jumping from airplanes
Reminders for immunization uptake

Review: Patient reminder and recall systems to improve immunization rates

Comparison: 7 Patient Reminders (summary) vs. control

Outcome: Immunized

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Patient Reminder Sum</th>
<th>Control</th>
<th>Odds Ratio</th>
<th>Weight</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n/N</td>
<td>n/N</td>
<td>M-H,Random,95% CI</td>
<td></td>
<td>M-H,Random,95% CI</td>
</tr>
<tr>
<td>4 Other-adult</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hogg1998T101</td>
<td>21/866</td>
<td>4/458</td>
<td>[2.82 [ 0.96, 8.27 ]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sansom2003T514</td>
<td>242/279</td>
<td>197/245</td>
<td>[1.59 [ 1.00, 2.55 ]</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Subtotal (95% CI)</strong></td>
<td><strong>1217</strong></td>
<td><strong>742</strong></td>
<td></td>
<td></td>
<td><strong>2.19 [ 1.21, 3.99 ]</strong></td>
</tr>
</tbody>
</table>

Total events: 283 (Patient Reminder Sum), 204 (Control)
Heterogeneity: Tau² = 0.10, Chi² = 2.93, df = 2 (P = 0.23); I² = 32%
Test for overall effect: Z = 2.57 (P = 0.010)

Citation: Jacobson Vann JC, Szilagyi P. Patient reminder and recall systems to improve immunization rates. Cochrane Database of Systematic Reviews 2005, Issue 3. Art. No.: CD003941. DOI: 10.1002/14651858.CD003941.pub2.
What can raise quality?

2. dose response relation
   - childhood lymphoblastic leukemia
     - risk for CNS malignancies 15 years after cranial irradiation
       - no radiation: 1% (95% CI 0% to 2.1%)
       - 12 Gy: 1.6% (95% CI 0% to 3.4%)
       - 18 Gy: 3.3% (95% CI 0.9% to 5.6%)

3. all plausible residual confounding may be working to reduce the demonstrated effect or increase the effect if no effect was observed
All plausible residual confounding would overestimate effect

- Hypoglycaemic drug phenformin causes lactic acidosis
- The related agent metformin is under suspicion for the same toxicity.
- Large observational studies have failed to demonstrate an association
  - Clinicians would be more alert to lactic acidosis in the presence of the agent
- Vaccine – adverse effects
<table>
<thead>
<tr>
<th>Bradford Hill criteria</th>
<th>Consideration in GRADE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strength</td>
<td>Strength of association and imprecision in effect estimate</td>
</tr>
<tr>
<td>Consistency</td>
<td>Consistency across studies, i.e., across different situations (different researchers)</td>
</tr>
<tr>
<td>Temporality</td>
<td>Study design, specific study limitations; RCTs fulfil this criterion better than observational studies, properly designed and conducted observational studies</td>
</tr>
<tr>
<td>Biological gradient</td>
<td>Dose—response gradient</td>
</tr>
<tr>
<td>Specificity</td>
<td>Indirectness</td>
</tr>
<tr>
<td>Biological plausibility</td>
<td>Indirectness</td>
</tr>
<tr>
<td>Coherence</td>
<td>Indirectness</td>
</tr>
<tr>
<td>Experiment</td>
<td>Study design, randomisation, properly designed and conducted observational studies</td>
</tr>
<tr>
<td>Analogy</td>
<td>Existing association for critical outcomes will lead to not downgrading the quality, indirectness</td>
</tr>
</tbody>
</table>
GRADE and immunizations

- Can herd immunity following immunisation and indirect effects on the co-circulation of other pathogens typically be ascertained only through the use of observational epidemiological methods?
  - Frequently yes, but innovative randomized controlled trials (RCTs) using cluster-randomization increasingly can be done.

- A 94% protective effect of a live, monovalent vaccine against measles is classified as “moderate level of scientific evidence.”
  - GRADE’s strength of association criteria maybe applied to increase the grade by 2 levels – from “low” to “high” - possible in this situation.
GRADE and immunizations

• GRADE ratings do not give credit to “gradient of effects with scale of population level impact compatible with degree of coverage.”
  – GRADE’s dose-response criterion would apply to such gradients

• May anti-vaccination lobby groups abuse the ratings
  – Abuse of any system is possible: equally likely that increased transparency provided by the GRADE framework can strengthen, rather than undermine, the trust in vaccines and other interventions
# Quality assessment criteria

<table>
<thead>
<tr>
<th>Study design</th>
<th>Initial quality of a body of evidence</th>
<th>Lower if</th>
<th>Higher if</th>
<th>Quality of a body of evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Randomised trials</td>
<td>High</td>
<td>Risk of Bias</td>
<td>Large effect</td>
<td>A/High (four plus: ✧✧✧✧)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Inconsistency</td>
<td>Dose response</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>All plausible residual confounding &amp; bias</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>-Would reduce a demonstrated effect</td>
<td>B/Moderate (three plus: ✧✧✧)</td>
</tr>
<tr>
<td>Observational</td>
<td>Low</td>
<td>Publication bias</td>
<td>-Would suggest a spurious effect if no effect was observed</td>
<td>C/Low (two plus: ✧✧✧)</td>
</tr>
<tr>
<td>studies</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>D/Very low (one plus: ✧✧✧)</td>
</tr>
</tbody>
</table>
# Pentavalent Rotavirus Vaccine: Evidence Profiles

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Design (# studies)</th>
<th>Study limitations</th>
<th>Inconsistency</th>
<th>Indirectness</th>
<th>Imprecision</th>
<th>Other considerations</th>
<th>Incidence in controls</th>
<th>Incidence in vaccinated</th>
<th>Vaccine efficacy (95% CI)</th>
<th>Absolute risk per 1000 (95% CI)</th>
<th>Number Needed to Treat (Vaccinate)</th>
<th>Evidence grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rotavirus diarrhea (RV)</td>
<td>RCT (2)</td>
<td>No serious</td>
<td>No serious</td>
<td>No serious</td>
<td>None</td>
<td></td>
<td>12.9%</td>
<td>3.5%</td>
<td>73% (66, 78)</td>
<td>-94 (-85, -100)</td>
<td>11</td>
<td>A</td>
</tr>
<tr>
<td>Severe RV diarrhea</td>
<td>RCT (2)</td>
<td>No serious</td>
<td>No serious</td>
<td>No serious</td>
<td>None</td>
<td></td>
<td>2.0%</td>
<td>0.1%</td>
<td>97% (86, 99)</td>
<td>-19 (-17, -20)</td>
<td>52</td>
<td>A</td>
</tr>
<tr>
<td>Hospitalization for RV diarrhea</td>
<td>RCT (1)</td>
<td>No serious</td>
<td>No serious</td>
<td>No serious</td>
<td>None</td>
<td></td>
<td>0.5%</td>
<td>0.02%</td>
<td>96% (91, 98)</td>
<td>-5 (-5, -5)</td>
<td>205</td>
<td>A</td>
</tr>
<tr>
<td>Intussusception</td>
<td>RCT (3)</td>
<td>No serious</td>
<td>No serious</td>
<td>No serious</td>
<td>None</td>
<td></td>
<td>1.4 per 10,000</td>
<td>1.7 per 10,000</td>
<td>1.20 (0.37–3.93)</td>
<td>0.03 (-0.1, 0.4)</td>
<td>-</td>
<td>A</td>
</tr>
<tr>
<td>Other serious adverse events</td>
<td>RCT (3)</td>
<td>No serious</td>
<td>No serious</td>
<td>No serious</td>
<td>None</td>
<td></td>
<td>2.3%</td>
<td>2.2%</td>
<td>0.96 (0.87–1.06)</td>
<td>-1 (-3, 1)</td>
<td>-</td>
<td>A</td>
</tr>
<tr>
<td>Fever</td>
<td>RCT (3)</td>
<td>No serious</td>
<td>No serious</td>
<td>No serious</td>
<td>None</td>
<td></td>
<td>38.9%</td>
<td>37.7%</td>
<td>0.97 (0.92–1.01)</td>
<td>-12 (-31, 4)</td>
<td>-</td>
<td>A</td>
</tr>
<tr>
<td>Outcome</td>
<td>Design (# studies)</td>
<td>Study limitations</td>
<td>Inconsistency</td>
<td>Indirectness</td>
<td>Imprecision</td>
<td>Other considerations</td>
<td>Evidence grade</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>--------------------</td>
<td>-------------------</td>
<td>---------------</td>
<td>--------------</td>
<td>-------------</td>
<td>----------------------</td>
<td>----------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rotavirus diarrhea (RV)</td>
<td>RCT (2)</td>
<td>No serious</td>
<td>No serious</td>
<td>No serious</td>
<td>No serious</td>
<td>None</td>
<td>A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severe RV diarrhea</td>
<td>RCT (2)</td>
<td>No serious</td>
<td>No serious</td>
<td>No serious</td>
<td>No serious</td>
<td>None</td>
<td>A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalization for RV diarrhea</td>
<td>RCT (1)</td>
<td>No serious</td>
<td>No serious</td>
<td>No serious</td>
<td>No serious</td>
<td>None</td>
<td>A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intussusception</td>
<td>RCT (3)</td>
<td>No serious</td>
<td>No serious</td>
<td>No serious</td>
<td>No serious</td>
<td>None</td>
<td>A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other serious adverse events</td>
<td>RCT (3)</td>
<td>No serious</td>
<td>No serious</td>
<td>No serious</td>
<td>No serious</td>
<td>None</td>
<td>A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fever</td>
<td>RCT (3)</td>
<td>No serious</td>
<td>No serious</td>
<td>No serious</td>
<td>No serious</td>
<td>None</td>
<td>A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Benefits: Pentavalent Rotavirus Vaccine

<table>
<thead>
<tr>
<th>Outcome</th>
<th>No. of subjects (# studies)</th>
<th>Incidence in controls</th>
<th>Incidence in vaccinated</th>
<th>Relative Risk (95% CI)</th>
<th>Absolute risk per 1000 (95% CI)</th>
<th>Number Needed to Harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intussusception</td>
<td>70,139 (3 RCTs)</td>
<td>1.4 per 10,000</td>
<td>1.7 per 10,000</td>
<td>1.20 (0.37–3.93)</td>
<td>0.03 (-0.1, 0.4)</td>
<td>-</td>
</tr>
<tr>
<td>Other serious adverse events</td>
<td>70,139 (3 RCTs)</td>
<td>2.3%</td>
<td>2.2%</td>
<td>0.96 (0.87–1.06)</td>
<td>-1 (-3, 1)</td>
<td>-</td>
</tr>
<tr>
<td>Fever</td>
<td>10,915 (3 RCTs)</td>
<td>38.9%</td>
<td>37.7%</td>
<td>0.97 (0.92–1.01)</td>
<td>-12 (-31, 4)</td>
<td>-</td>
</tr>
<tr>
<td>Outcome</td>
<td>No. of subjects (# studies)</td>
<td>Incidence in controls</td>
<td>Incidence in vaccinated</td>
<td>Relative Risk (95% CI)</td>
<td>Absolute risk per 1000 (95% CI)</td>
<td>Number Needed to Harm</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------------------------</td>
<td>-----------------------</td>
<td>------------------------</td>
<td>------------------------</td>
<td>---------------------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>Intussusception</td>
<td>70,139 (3 RCTs)</td>
<td>1.4 per 10,000</td>
<td>1.7 per 10,000</td>
<td>1.20 (0.37–3.93)</td>
<td>0.03 (-0.1, 0.4)</td>
<td>-</td>
</tr>
<tr>
<td>Other serious adverse events</td>
<td>70,139 (3 RCTs)</td>
<td>2.3%</td>
<td>2.2%</td>
<td>0.96 (0.87–1.06)</td>
<td>-1 (-3, 1)</td>
<td>-</td>
</tr>
<tr>
<td>Fever</td>
<td>10,915 (3 RCTs)</td>
<td>38.9%</td>
<td>37.7%</td>
<td>0.97 (0.92–1.01)</td>
<td>-12 (-31,4)</td>
<td>-</td>
</tr>
</tbody>
</table>
Content

- Quality of evidence
- Going from evidence to recommendations
Strength of recommendation

“The strength of a recommendation reflects the extent to which we can, across the range of patients for whom the recommendations are intended, be confident that desirable effects of a management strategy outweigh undesirable effects.”

• Strong or conditional
## Determinants of the strength of recommendation

<table>
<thead>
<tr>
<th>Factors that can strengthen a recommendation</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of the evidence</td>
<td>The higher the quality of evidence, the more likely is a strong recommendation.</td>
</tr>
<tr>
<td>Balance between desirable and undesirable effects</td>
<td>The larger the difference between the desirable and undesirable consequences, the more likely a strong recommendation warranted. The smaller the net benefit and the lower certainty for that benefit, the more likely weak recommendation warranted.</td>
</tr>
<tr>
<td>Values and preferences</td>
<td>The greater the variability in values and preferences, or uncertainty in values and preferences, the more likely weak recommendation warranted.</td>
</tr>
<tr>
<td>Costs (resource allocation)</td>
<td>The higher the costs of an intervention – that is, the more resources consumed – the less likely is a strong recommendation warranted.</td>
</tr>
</tbody>
</table>
Balancing benefits and downsides

For

- ↑ herd immunity
- ↑ QoL
- ↓ Death

Against

- ↑ Resources
- ↑ Allergic reactions
- ↑ Nausea
- ↓ Death

Conditional

Strong

- ↓ Morbidity
- ↓ Death
Balancing benefits and downsides

For
- herd immunity
- QoL
- For
- Morbidity
- Death

Against
- Resources
- Nausea
- Allergic reactions
- Local reactions

Conditional

Strong

Disclosure
Background
From quality of evidence
to recommendations
and summarizing
and conclusions
Implications of a strong recommendation

• Policy makers: The recommendation can be adapted as a policy in most situations
• Patients: Most people in this situation would want the recommended course of action and only a small proportion would not
• Clinicians: Most patients should receive the recommended course of action
Implications of a conditional recommendation

- Policy makers: There is a need for substantial debate and involvement of stakeholders.
- Patients: The majority of people in this situation would want the recommended course of action, but many would not.
- Clinicians: Be more prepared to help patients to make a decision that is consistent with their own values/decision aids and shared decision making.
Case scenario

A 13 year old girl who lives in rural Indonesia presented with flu symptoms and developed severe respiratory distress over the course of the last 2 days. She required intubation. The history reveals that she shares her living quarters with her parents and her three siblings. At night the family’s chicken stock shares this room too and several chicken had died unexpectedly a few days before the girl fell sick.
Methods – WHO Rapid Advice Guidelines for Avian Flu

- Applied findings of a recent systematic evaluation of guideline development for WHO/ACHR

- Group composition (including panel of 13 voting members):
  - clinicians who treated influenza A(H5N1) patients
  - infectious disease experts
  - basic scientists
  - public health officers
  - methodologists

- Independent scientific reviewers:
  - Identified systematic reviews, recent RCTs, case series, animal studies related to H5N1 infection
Oseltamivir for Avian Flu

Summary of findings:

• No clinical trial of oseltamivir for treatment of H5N1 patients.

• 4 systematic reviews and health technology assessments (HTA) reporting on 5 studies of oseltamivir in seasonal influenza.
  – Hospitalization: OR 0.22 (0.02 – 2.16)
  – Pneumonia: OR 0.15 (0.03 – 0.69)

• 3 published case series.

• Many in vitro and animal studies.

• No alternative that was more promising at present.

• Cost: 40$ per treatment course
## From evidence to recommendation

<table>
<thead>
<tr>
<th>Factors that can strengthen a recommendation</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of the evidence</td>
<td>Very low quality evidence</td>
</tr>
<tr>
<td>Balance between desirable and undesirable effects</td>
<td>Uncertain, but small reduction in relative risk still leads to large absolute effect</td>
</tr>
<tr>
<td>Values and preferences</td>
<td>Little variability and clear</td>
</tr>
<tr>
<td>Costs (resource allocation)</td>
<td>Low cost under non-pandemic conditions</td>
</tr>
</tbody>
</table>
**Recommendation:** In patients with HIV and drug resistant TB requiring second line drugs, the expert panel recommends/suggests to (not) administer ART (recommendation, quality evidence).

**Population:** HIV positive individuals with drug resistant TB requiring second line drugs

**Intervention:** ART use during TB treatment vs ART non-use

<table>
<thead>
<tr>
<th>Factor</th>
<th>Decision</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>High or moderate quality evidence (is there high quality evidence?) The higher the quality of evidence, the more likely is a strong recommendation.</td>
<td>Yes</td>
<td>There is limited evidence from published studies to evaluate ART use in HIV-TB coinfected patients receiving second line drugs for XDR-TB and MDR-TB. However, using IPD from longitudinal cohort studies, we found moderate quality evidence from observational studies that there</td>
</tr>
<tr>
<td>certainty about the balance of benefits versus harms and burdens (is there certainty?) The larger the difference between the desirable and undesirable consequences and the certainty around that difference, the more likely a strong recommendation. The smaller the net benefit and the lower the certainty for that benefit, the more likely is a conditional/weak recommendation.</td>
<td>No</td>
<td>Cure and survival appear to be more likely in drug resistant TB requiring second line drugs if ART is used during TB treatment.</td>
</tr>
<tr>
<td>certainty or similarity in values (is there certainty?) The smaller the variability or uncertainty around values and preferences, the more likely is a conditional or weak recommendation.</td>
<td>No</td>
<td>HR of 3.17 (1.46, 6.9) for cure and HR of 0.41 (0.26, 0.63) for death in ART vs. non ART group.</td>
</tr>
<tr>
<td>resource implications (are the resources consumed worth the expected benefit) The higher the costs of an intervention compared to the alternative that is considered and other cost related to the decision – that is, the more resources consumed – the more likely is a conditional/weak recommendation.</td>
<td>No</td>
<td>No significant change in HR for cure [HR 2.93 (0.98, 8.69)], and decreased HR for death [HR 0.23 (0.12, 0.46)] if controlling for initial CD4 count (HR 0.23)</td>
</tr>
</tbody>
</table>

**Overall strength of recommendation**

- Strong or conditional
Example: Oseltamivir for Avian Flu

Recommendation: In patients with confirmed or strongly suspected infection with avian influenza A (H5N1) virus, clinicians should administer oseltamivir treatment as soon as possible (strong recommendation, very low quality evidence).

Remarks: This recommendation places a high value on the prevention of death in an illness with a high case fatality. It places relatively low values on adverse reactions, the development of resistance and costs of treatment.

Schunemann et al. The Lancet ID, 2007
Issues in guideline development for immunization

• Causation versus effects of intervention
  – Causation not equivalent to efficacy of interventions
  – Bradford Hill
    • Nearly half a century old – tablet from the mountain?

• Harms caused by interventions
  – Assumption is that removal of vaccine (or no exposure) leads to NO adverse effects

• How confident can one be that removal of the exposure is effective in preventing disease?
  – Whether immunization or environmental factors: will depend on the intervention to remove exposure
Formulate question
Select outcomes
Rate importance
Create evidence profile with GRADEpro
Rate quality of evidence for each outcome
Randomization increases initial quality

**P**

Outcome: Critical

Outcome: Critical

Outcome: Important

Outcome: Not important

**I**

**C**

**O**

Summary of findings & estimate of effect for each outcome

Panel

**Guideline development**

**Formulate recommendations:**
- For or against (direction)
- Strong or weak/conditional (strength)

*By considering:*
- Quality of evidence
- Balance benefits/harms
- Values and preferences

Revise if necessary by considering:
- Resource use (cost)

Grade overall quality of evidence across outcomes based on lowest quality of *critical* outcomes

- “We recommend using...”
- “We suggest using...”
- “We recommend against using...”
- “We suggest against using...”
Conclusions

- Practice guidelines should be based on the **best available** evidence to be evidence based
- GRADE combines what is known in health research methodology and provides a structured approach to improve communication
- Criteria for evidence assessment across questions and outcomes
- Criteria for moving from evidence to recommendations
- Systematic
  - four categories of quality of evidence
  - two grades for strength of recommendations
- Transparency in decision making and judgments is key
Confidence in evidence

- There always is evidence
  - “When there is a question there is evidence”
- Better research $\Rightarrow$ greater confidence in the evidence and decisions
Hierarchy of evidence based on quality

**STUDY DESIGN**
- Randomized Controlled Trials
- Cohort Studies and Case Control Studies
- Case Reports and Case Series, Non-systematic observations
- Expert Opinion

**BIAS**
Explain the following?

- Confounding, effect modification & ext. validity
- Impact of loss to follow-up
- Concealment of randomization
- Blinding (who is blinded in a double blinded trial?)
- Intention to treat analysis and its correct application
Parachute use to prevent death and major trauma related to gravitational challenge: systematic review of randomised controlled trials

Gordon C S Smith, Jill P Pell
Parachute use to prevent death and major trauma related to gravitational challenge: systematic review of randomised controlled trials

Gordon C S Smith, Jill P Pell

Relative risk reduction:
....> 99.9 % (1/100,000)
U.S. Parachute Association reported 821 injuries and 18 deaths out of 2.2 million jumps in 2007
Interpretation of grades of evidence

• ⌠⌠⌠⌠/A/High: Further research is very unlikely to change confidence in the estimate of effect.

• ⌠⌠⌠⌠⌠/B/Moderate: Further research is likely to have an important impact on confidence in the estimate of effect and may change the estimate.

• ⌠⌠⌠⌠⌡/C/Low: Further research is very likely to have an important impact on confidence in the estimate of effect and is likely to change the estimate.

• ⌠⌠⌠⌠⌡⌡/D/Very low: We have very little confidence in the effect estimate: Any estimate of effect is very uncertain.