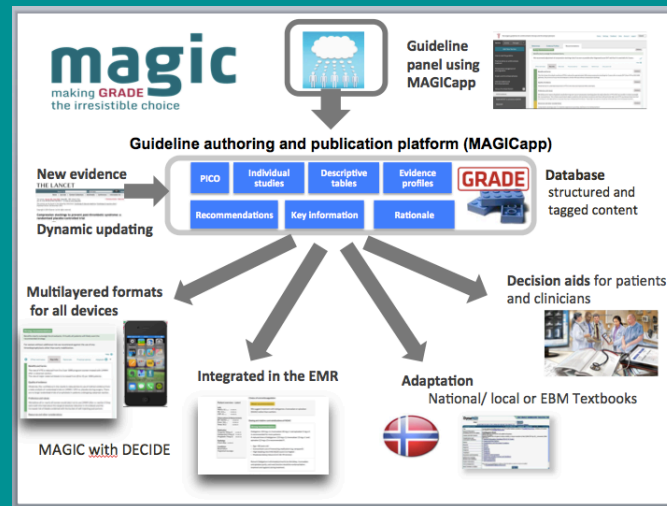


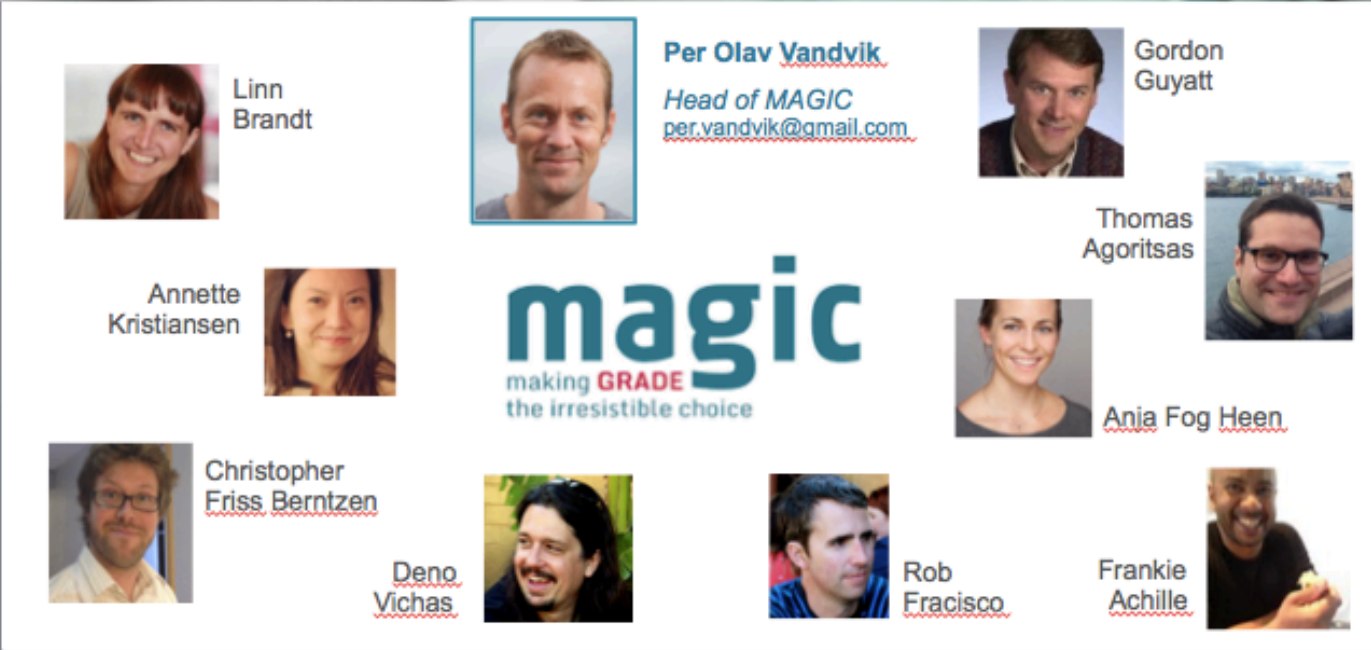
# How to develop and publish a trustworthy evidence summary and recommendation through the MAGIC authoring and publication platform



# Declaration of interests and who we are

Improving patient care through guidelines, evidence summaries and decision aids that we can all trust, use and share

A non-profit authoring and publication platform helping you put best current evidence into practice



**Linn Brandt**

**Per Olav Vandvik**  
*Head of MAGIC*  
[per.vandvik@gmail.com](mailto:per.vandvik@gmail.com)

**Gordon Guyatt**

**Annette Kristiansen**

**Thomas Agoritsas**

**Ania Fog Heen**

**Christopher Friss Berntzen**

**Deno Vichas**

**Rob Fracisco**

**Frankie Achille**

# Objectives

- To be introduced to the process of developing a trustworthy recommendation with the GRADE system and the MAGICapp ([www.magicapp.org](http://www.magicapp.org))
- To get hands-on experience with use of the MAGICapp in the creation of an evidence summary and treatment recommendation.

# Corticosteroids for community-acquired pneumonia

March 2015

Table

Bottom line

Plain language statements

Absolute effect

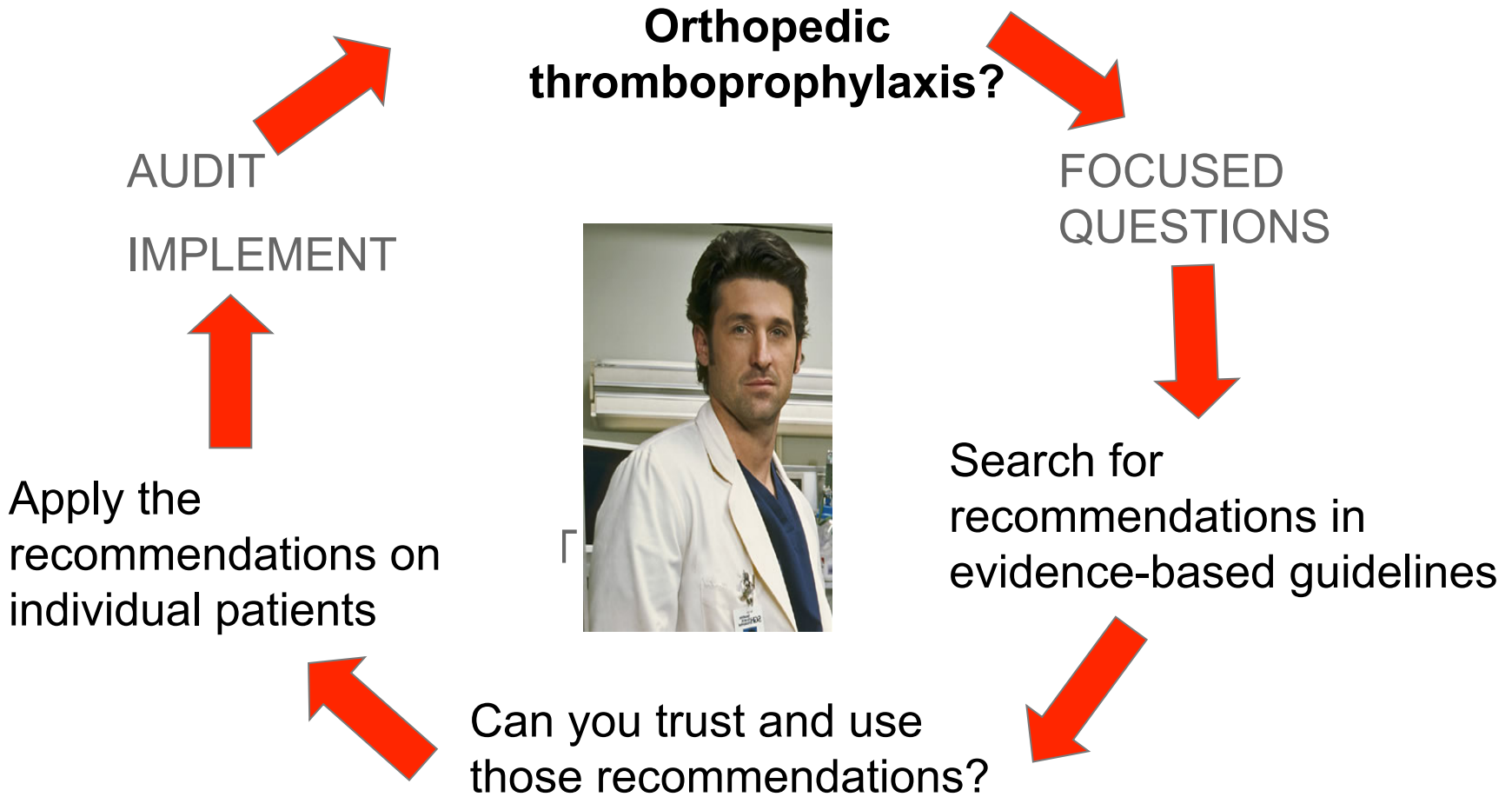
Relative effect

Visual overview

Outcomes	Plain language statements	Absolute Effect		Relative effect (95% CI) N° of participants & studies	Certainty of the evidence GRADE
		Without Corticosteroids	With Corticosteroids		
<b>All-cause mortality</b> Follow-up: In-hospital	<i>Corticosteroids are likely to result in a small reduction in the risk of dying.</i>	85 per 1000	57 per 1000  Difference: 28 less per 1000 patients (95% CI: 47 less to 1 more per 1000 patients)	RR 0.67 (0.45 to 1.01)  Based on data from 1974 patients in 12 studies	⊕⊕⊕⊖ Moderate <sup>1</sup>
<b>Need of mechanical ventilation</b> <sup>1</sup> Follow-up: In-hospital		50 less per 1000			⊕⊕⊕⊖ Moderate <sup>1</sup>
<b>Admission to intensive care unit</b> <sup>1</sup> Follow-up: 30 days		42 less per 1000			⊕⊕⊕⊖ Moderate <sup>1</sup>
<b>Acute respiratory distress syndrome</b> <sup>1</sup> Follow-up: 30 days		50 less per 1000			⊕⊕⊕⊖ Moderate <sup>1</sup>
<b>Duration of hospitalization.</b> <sup>1</sup> Follow-up: In-hospital		Reduced by 1 day			⊕⊕⊕⊕ High
<b>Time to clinical stability.</b> <sup>1</sup> Follow-up: In-hospital		Reduced by 1 day			⊕⊕⊕⊕ High
<b>Readmission to hospital</b> <sup>1</sup> Follow-up: 30 days		Likely no difference			⊕⊕⊕⊖ Moderate <sup>1</sup>
<b>Hyperglycemia</b> <sup>1</sup> Follow-up: 30 days		35 more per 1000			⊕⊕⊕⊕ High
<b>Gastrointestinal hemorrhage</b> Follow-up: In-hospital		Likely no difference			⊕⊕⊕⊖ Moderate <sup>1</sup>
<b>Severe neuropsychiatric complications</b> <sup>1</sup> Follow-up: 30 days		11 more per 1000			⊕⊕⊕⊖ Moderate <sup>1</sup>



# Finding trustworthy answers to clinical questions



# Evidence-based medicine: Great advances



3rd EDITION

## Users' Guides to the Medical Literature

A MANUAL FOR EVIDENCE-BASED CLINICAL PRACTICE

Gordon Guyatt, MD  
Drummond Rennie, MD  
Maureen O. Meade, MD  
Deborah J. Cook, MD

Mc  
Graw  
Hill  
Education

JAMAevidence®

Copyrighted Material

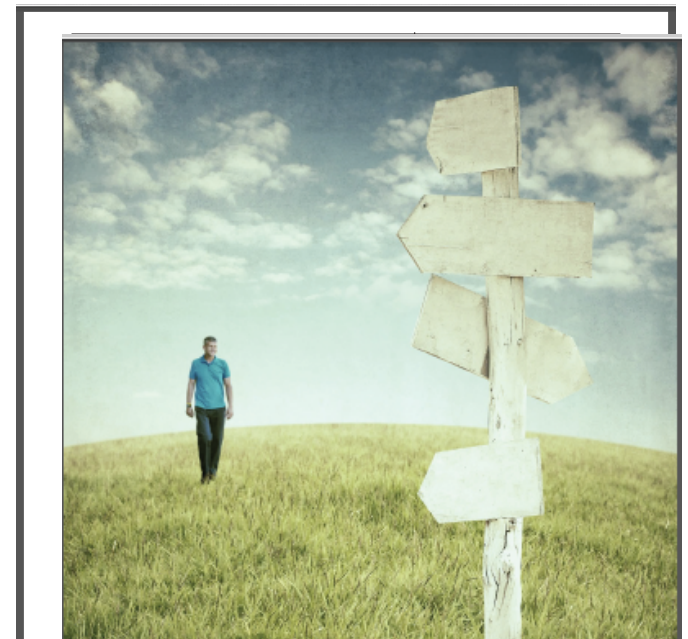
Front Cover

# We need to create trustworthy evidence summaries and guidelines according to new definition and standards

## New definition

*“Clinical Practice Guidelines are statements that include recommendations intended to optimize patient care. They are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options”*

## New standards



**GRADE**

Formulate question

Select outcomes

Rate importance

Outcomes across studies

Create evidence profile with GRADEpro

Rate quality of evidence for each outcome

P  
I  
C  
O

Outcome Critical

Outcome Critical

Outcome Important

Outcome Not important



TABLE 2A  
Question: Should Low molecular Weight Heparin (LMWH) rather than Vitamin K Antagonists (VKA) be used for long-term treatment of Venous Thromboembolism (VTE)?  
Background: Low molecular weight heparin compared with vitamin K antagonists for the long-term treatment of venous thromboembolism: a systematic review. Dink Padman (Lipidolab)

Quality assessment	Risk of bias					Overall quality of evidence	Recurrence of bleeding at 12 months	
	Participants (Study) Follow-up	Inconsistency	Indirectness	Imprecision	Publication bias		RR (95% CI)	RR (95% CI)
Overall mortality (CRITICAL OUTCOME)	LOW	LOW	LOW	LOW	LOW	0.82 (0.67 to 1.02)	14 deaths per 1000 (over 21 years)	3 more deaths per 1000 (over 21 years)
Recurrent symptomatic VTE (CRITICAL OUTCOME): Deep venous thrombosis and pulmonary embolism	LOW	LOW	LOW	LOW	LOW	0.80 (0.65 to 0.98)	11 more VTE per 1000 (over 21 years)	10 fewer VTE per 1000 (over 21 years)
	LOW	LOW	LOW	LOW	LOW	0.81 (0.66 to 0.99)	11 more VTE per 1000 (over 21 years)	10 fewer VTE per 1000 (over 21 years)
	LOW	LOW	LOW	LOW	LOW	0.81 (0.66 to 0.99)	11 more VTE per 1000 (over 21 years)	10 fewer VTE per 1000 (over 21 years)
	LOW	LOW	LOW	LOW	LOW	0.81 (0.66 to 0.99)	11 more VTE per 1000 (over 21 years)	10 fewer VTE per 1000 (over 21 years)

High  
Moderate  
Low  
Very low

Summary of findings & estimate of effect for each outcome

Systematic review

Guideline development

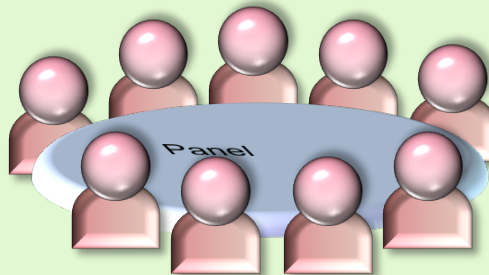
Formulate recommendations:  
•For or against (direction)  
•Strong or weak/conditional (strength)



considering:

- Quality of evidence
- Balance benefits/harms
- Values and preferences

Revise if necessary by considering:  
 Resource use (cost)



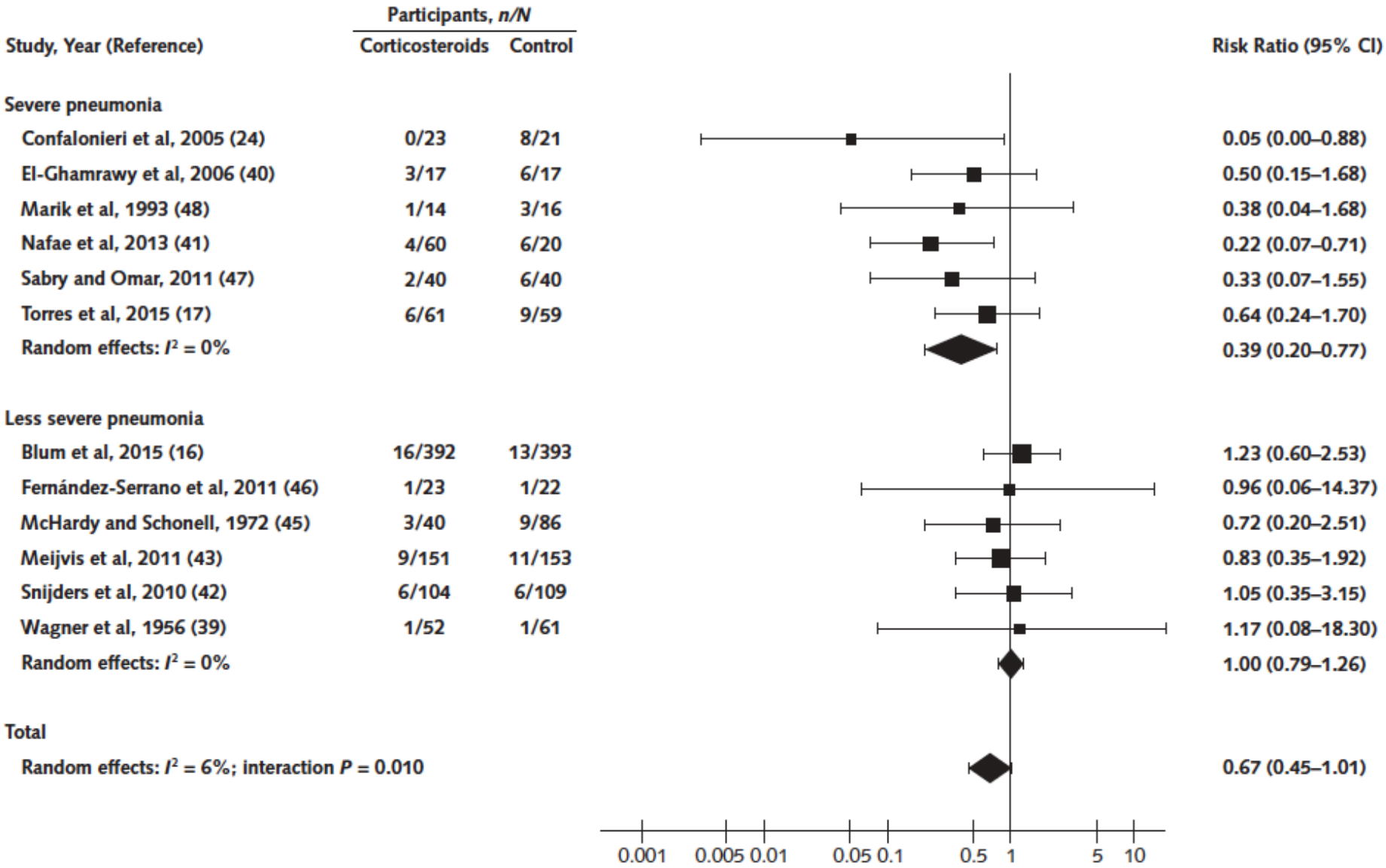
Grade overall quality of evidence across outcomes



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

Illustration from Holger Schunemann and Yngve Falck Ytter


**Figure 1.** Effect of corticosteroids on all-cause mortality in patients hospitalized with community-acquired pneumonia, by severity of pneumonia.





# Imagine you found a trustworthy guideline

- Huge duplication, lots of work
- Are these guidelines
- ✓ Available, useful and understandable for clinicians?
- ✓ Suited for integration into EMRs, EBM textbooks and adaptation?
- ✓ Sufficiently up to date?
- ✓ Facilitating shared decisions?
- 2010: No available tools
- We need



CHEST

Commentary

## Creating Clinical Practice Guidelines We Can Trust, Use, and Share

### A New Era Is Imminent

*Per Olav Vandvik, MD, PhD; Linn Brandt, MD; Pablo Alonso-Coello, MD, PhD; Shaun Treweek, PhD; Elie A. Akl, MD, MPH, PhD; Annette Kristiansen, MD; Anja Fog-Heen, MD; Thomas Agoritsas, MD; Victor M. Montori, MD; and Gordon Guyatt, MD, FCCP*

Standards and guidance for developing trustworthy clinical practice guidelines are now available, and a number of leading guidelines adhere to the key standards. Even current trustworthy guidelines, however, generally suffer from a cumbersome development process, suboptimal presentation formats, inefficient dissemination to clinicians at the point of care, high risk of becoming quickly outdated, and suboptimal facilitation of shared decision-making with patients. To address these limitations, we have—in our innovative research program and nonprofit organization, MAGIC (Making GRADE the Irresistible Choice)—constructed a conceptual framework and tools to facilitate the creation, dissemination, and dynamic updating of trustworthy guidelines. We have developed an online application that constitutes an authoring and publication platform that allows guideline content to be written and structured in a database, published directly on our web platform or exported in a computer-interpretable language (eg, XML) enabling dissemination through a wide range of outputs that include electronic medical record systems, web portals, and applications for smartphones/tablets. Modifications in guidelines, such as recommendation updates, will lead to automatic alterations in these outputs with minimal additional labor for guideline authors and publishers, greatly facilitating dynamic updating of guidelines. Semiautomated creation of a new generation of decision aids linked to guideline recommendations should facilitate face-to-face shared decision-making in the clinical encounter. We invite guideline organizations to partner with us ([www.magicproject.org](http://www.magicproject.org)) to apply and further improve the tools for their purposes. This work will result in clinical practice guidelines that we cannot only trust, but also easily share and use.

*CHEST 2013; 144(2):381–389*

**Abbreviations:** ACCP = American College of Chest Physicians; ATB = Antithrombotic Therapy and the Prevention of Thrombosis, 9th Edition; American College of Chest Physicians Evidence-Based Guidelines; CDSS = clinical decision support system; DA = decision aid; DECIDE = Developing and Evaluating Communication Strategies to Support Informed Decisions and Practice Based on Evidence; EMR = electronic medical record; GRADE = Grading of Recommendations Assessment, Development and Evaluation; MAGIC = Making GRADE the Irresistible Choice; PICO = population, intervention, comparator, outcomes; SoF = summary of findings

To succeed in evidence-based diagnosis and treatment at the point of care, health-care personnel need access to trustworthy clinical practice guidelines.<sup>1</sup> The last decade has seen major advances in the science of creating clinical practice guidelines, including rigorous standards for development and tools to assess their methodologic rigor and transparency.<sup>1,2</sup> Advances in approaches to summarize evidence, rate its quality, and move in a transparent manner from

of Recommendations Assessment, Development and Evaluation (GRADE) system.<sup>4,5</sup> GRADE has become an international standard, adopted by > 70 organizations worldwide, providing a framework and detailed guidance for producing trustworthy guidelines.<sup>6</sup> Despite this progress, challenges remain (Table 1).

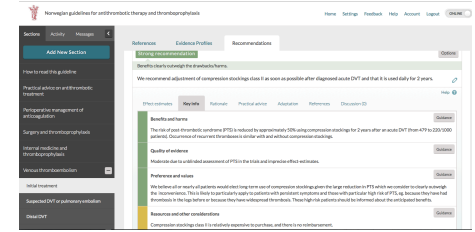
**For editorial comment see page 365**

# magic

making **GRADE**  
the irresistible choice



Guideline panel using  
MAGICapp



## Guideline authoring and publication platform (MAGICapp)

New evidence  
THE LANCET



Dynamic updating



**GRADE**

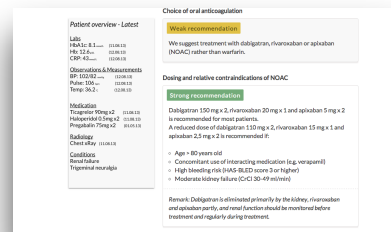


Database  
structured and  
tagged content

Multilayered formats  
for all devices



Integrated in the EMR



Adaptation

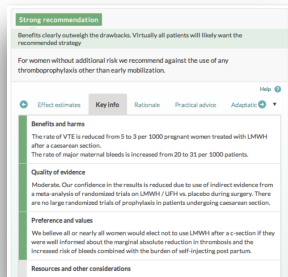
National/ local or EBM Textbooks



Decision aids for patients  
and clinicians



MAGIC with DECIDE





Let us check it out:  
[www.magicapp.org](http://www.magicapp.org)



# Prevention of VTE in Orthopedic Surgery Patients: A Norwegian adaptation of the 9th ed. of the ACCP Antithrombotic Therapy and Prevention of Thrombosis Evidence-based Clinical Practice Guidelines

Sections

Orthopedic surgery and prevention of venous thromboembolism

Patients at moderate to high risk of thrombosis: All surgery of the lower extremities

Major hip and knee surgery

Other interventions and screening

## 2 Patients at moderate to high risk of thrombosis: All surgery of the lower extremities

**Strong recommendation**

Benefits clearly outweigh the drawbacks. Virtually all patients will likely want the recommended strategy

We recommend thromboprophylaxis with low molecular weight heparin, low-dose direct factor Xa inhibitor (apixaban, rivaroxaban) or dabigatran for the first 10 postoperative days.

*High risk: previous symptomatic VTE.*

*Moderate risk: age > 80 years or multiple comorbidities.*

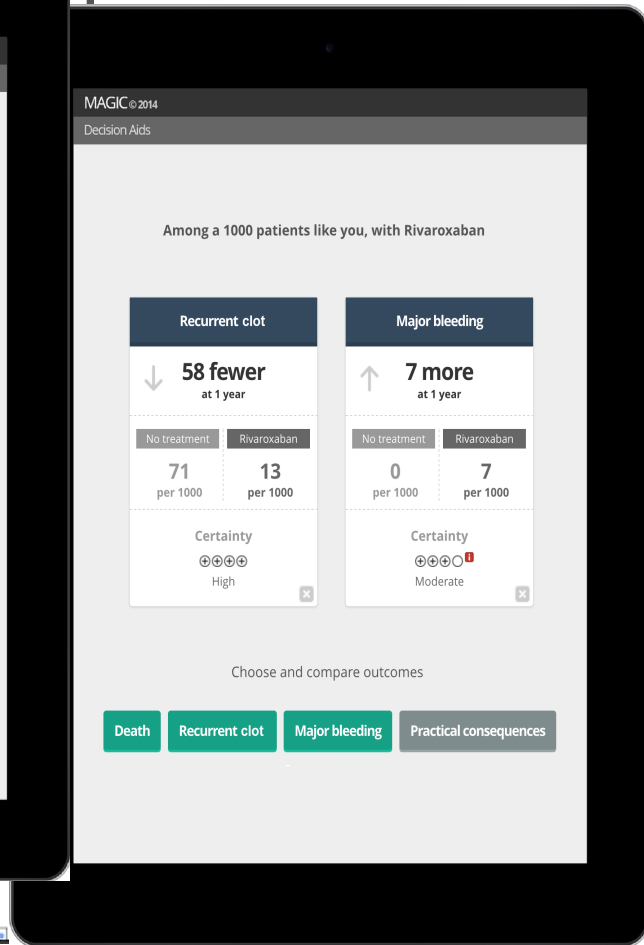
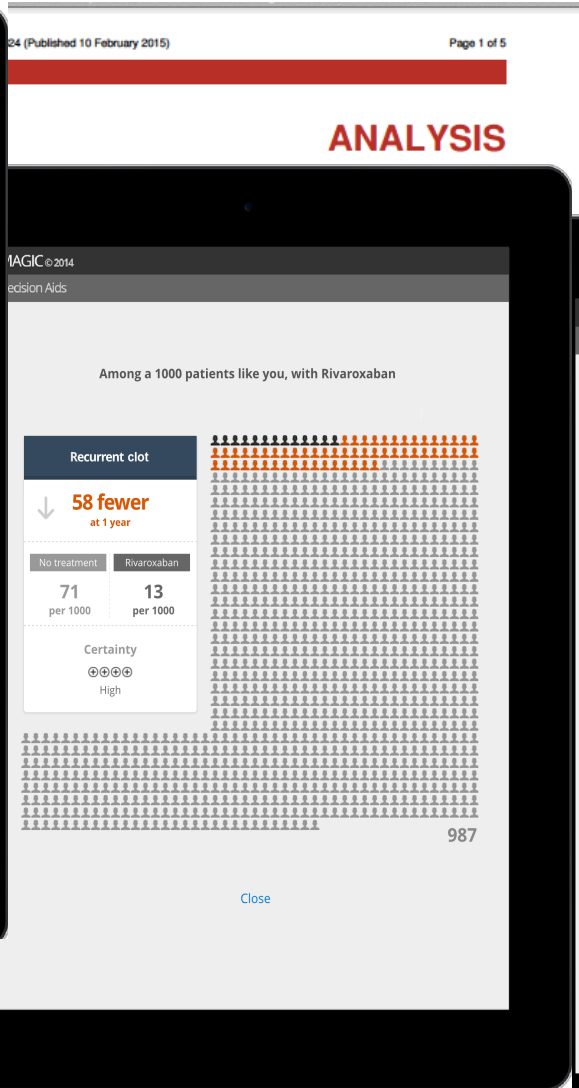
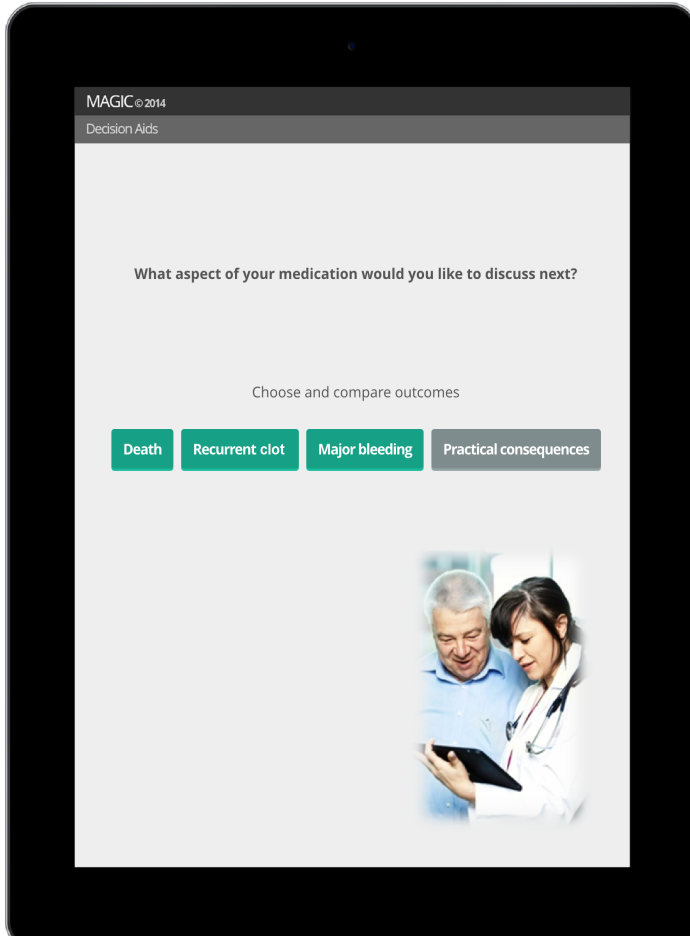
*Patient risk can be assessed using the Charlson Comorbidity index or ASA classification. Please see under "practical information".*

[View More Details](#)

Effect estimates **Key info** Rationale Practical advice Adaptation **References** Discussion (0)

Title	Pubmed Link	Journal Link
Falck-Ytter et al. Prevention of VTE in Orthopedic Surgery Patients. Chest 2012;141:e2785-e325S	22315265	10.1378/chest.11-2404
Collins et al. Reduction in fatal pulmonary embolism and venous thrombosis by perioperative administration of subcutaneous heparin. N Engl J Med. 1988;318(18):1162-1173.	3283548	10.1056/NEJM1988050531818
Lederle et al. Venous Thromboembolism Prophylaxis in Hospitalized Medical Patients and Those With Stroke: A Background Review for an American College of Physicians Clinical Practice Guideline. Annals of Internal Medicine. 2011;155:602-615.	22041949	10.7326/0003-4819-155-9-201111010-00008

# SHARE IT: Creating discussions in consultations



and summaries of evidence to address the educational needs of clinicians in a format that supports their needs. Meanwhile, struggle to integrate versions of evidence, although previous versions of guidelines have been developed. In this article we highlight the use of decision aids and discuss how they can be used to support decision making in consultations.

Correspondence to: T Agoritsas, thomas.agoritsas@gmail.com

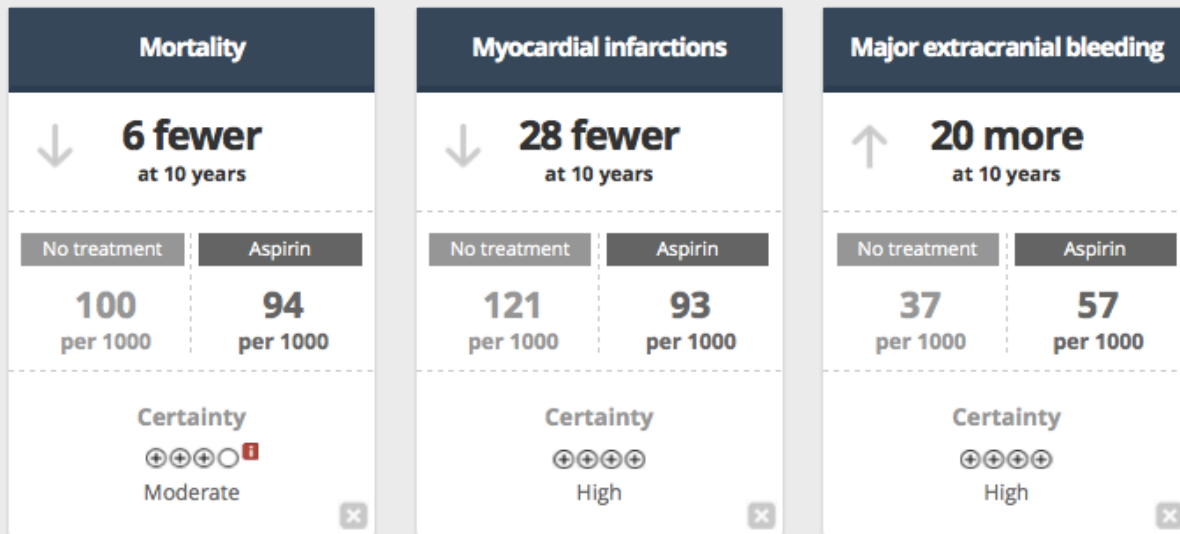
For personal use only. See rights and reprints <http://www.bmj.com/permissions>

Subscribe <http://www.bmj.com/subscribe>



Low dose aspirin vs. no treatment for primary prevention ▼

Among a 1000 patients like you, with aspirin



Choose and compare outcomes

- Mortality
- Myocardial infarctions
- Non-fatal stroke
- Major extracranial bleeding
- Practical consequences

# Integrating recommendations in the EMR, linked to patient specific data

RANESTAD, Kristin  
100480\*09896 - 34 år - Kvinne

Clinical Decision Support

Excerpt from Norwegian guidelines for antithrombotic therapy and thromboprophylaxis

### 1 Venous thromboembolism

Selection of drug for long term treatment

**Weak recommendation**

It is less clear whether the benefits outweigh the drawbacks/harms.

For patients without malignancy we suggest warfarin or rivaroxaban for long-term treatment rather than LMWH.

Remark: Dabigatran and apixaban are not registered for use on this indication in Norway at the time of writing (november 2013).

View less details

Effect estimates | Key info | Rationale | Practical advice | Adaptation | References

**Benefits and harms**

Long-term treatment with LMWH instead of warfarin in patients with cancer reduces the number of recurrent thromboses from 30 till 19/1000 patients with no significant differences in major bleeding or deaths.

- Rivaroxaban versus LMWH / warfarin: No significant difference for any outcome.
- Dabigatran versus warfarin: No significant difference for any outcome.
- Apixaban versus warfarin: No significant difference for recurrent thrombosis or death after 6 months, but significantly fewer major bleeds with apixaban.

**Quality of evidence**

For LMWH versus warfarin considered here: Moderate due to low precision and possible risk of bias.

For NOAC versus warfarin: Moderate due to imprecise effect-estimates for mortality and recurrent venous thrombosis.

**Preference and values**

We believe that most patients will want long term oral treatment instead of LMWH given the burden of self-injections. Patients who place a high value on avoiding INR monitoring and diet restrictions are likely to prefer rivaroxaban rather than warfarin.

**Resources and other considerations**

Warfarin, LMWH and rivaroxaban reimbursed. Three months' supply of warfarin (3 tbl daily): € 43,-, rivaroxaban 20 mg x 1: NOK 225,-, LMWH 10000 IU x 1: NOK 740,-, (POR 08/01/12).

### EMR Data

Found 16 emr codes for current Recommendation.

Neoplasm	SNOMED: 108369006
Liver disease	SNOMED: 235856003
Renal failure	SNOMED: 236423003
Temperature	37,7 °C SNOMED: 246508008   I går, kl 23:14
Body weight	60 kg SNOMED: 27113001   16-Aug kl 08:37
Pulse Rate	89 /min SNOMED: 78564009   16-Aug kl 08:38
Antithrombotics	ATC: B01A
Creatinin	78 mmol/l LOINC: LP14355-9   I går, kl 08:19
Hemoglobin	11,2 gm/l LOINC: LP14449-0   I går, kl 07:56
Platelets	256 10 <sup>9</sup> /l LOINC: LP14597-6   I går, kl 07:56
Potassium	3,7 mmol/l LOINC: LP15098-4   I går, kl 08:16
Sodium	LOINC: LP15099-2
INR	LOINC: LP20762-8
Blood pressure	110 / 72 mm[Hg] LOINC: LP40259-1   16-Aug kl 09:15
C reactive protein	18 mg/l LOINC: LP41279-8   16-Aug kl 13:03
Alanine aminotransferase	LOINC: LP44699-4   I går, kl 07:51

Pasienter

Arbeidsflate

Attuell kontakt | Dokumenter

DIPS Classic | Oppgaver

Pasientliste

Arctype Admin | Pasientlisteadmin

# MAGIC collaborates with DECIDE +++



[Home](#)

## DECIDE

*Developing and Evaluating Communication Strategies to Support Informed Decisions and Practice Based on Evidence*



GDT - Guideline Development Tool

GDT

**A new quality in guideline development**  
Brought to you by the creators of GRADEpro (GRADE Working Group)

Contact support

**GRADE** Selective serotonin re-uptake inhibitors (SSRIs) for preventing migraine and tension-type headaches

▼ Should chronic daily headache - SSRIs vs placebo be used for preventing migraine and tension-type headaches?

Quality assessment						Summary of findings					
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	№ of patients	Effect	Quality	Importance	
							Chronic daily headache - SSRIs	placebo	Relative (95% CI)	Absolute (95% CI)	
Drop out due to any reasons											
1	observational studies	serious	very serious	serious	serious	very strong association	4/22 (20.0%)	4/19 (21.6%)	not pooled	not pooled	HIGH IMPORTANCE
Drop out due to side effects											
Short name: <input type="text"/> Assessed/measured with: <input type="text"/>											
Type: <input checked="" type="checkbox"/> dichotomous <input type="checkbox"/> continuous											
Length of follow-up: <input type="text"/> days <input type="text"/> weeks <input type="text"/> months <input type="text"/> years											
Length of follow-up: <input type="text"/> mean <input type="text"/> range											
1	observational studies	serious		not serious		publication bias strongly suspected	2/22 (9.09%)	0/19 (0.0%)	OR ranged from 0.24 to 137.26		CRITICAL
Number of patients with minor side effects											
1	observational studies	very serious	very serious	very serious			11/22 (50.0%)	11/19 (57.9%)	not pooled	not pooled	IMPORTANT
Add outcome											

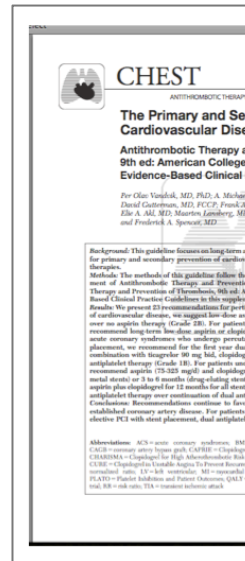
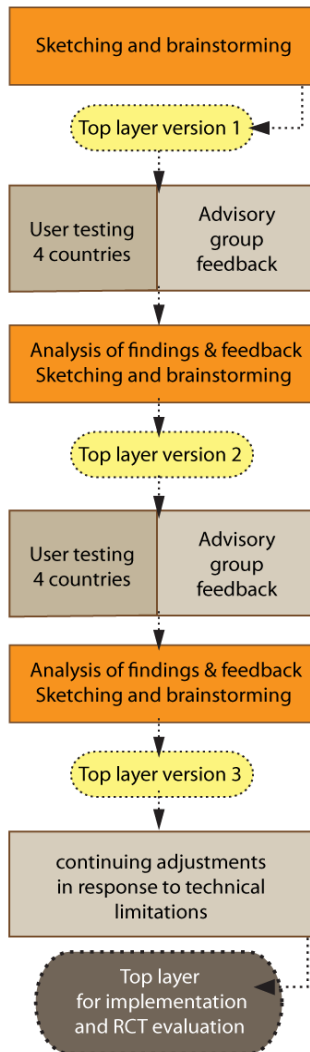
Login

Create bookmark  
to launch offline

it's **FREE**



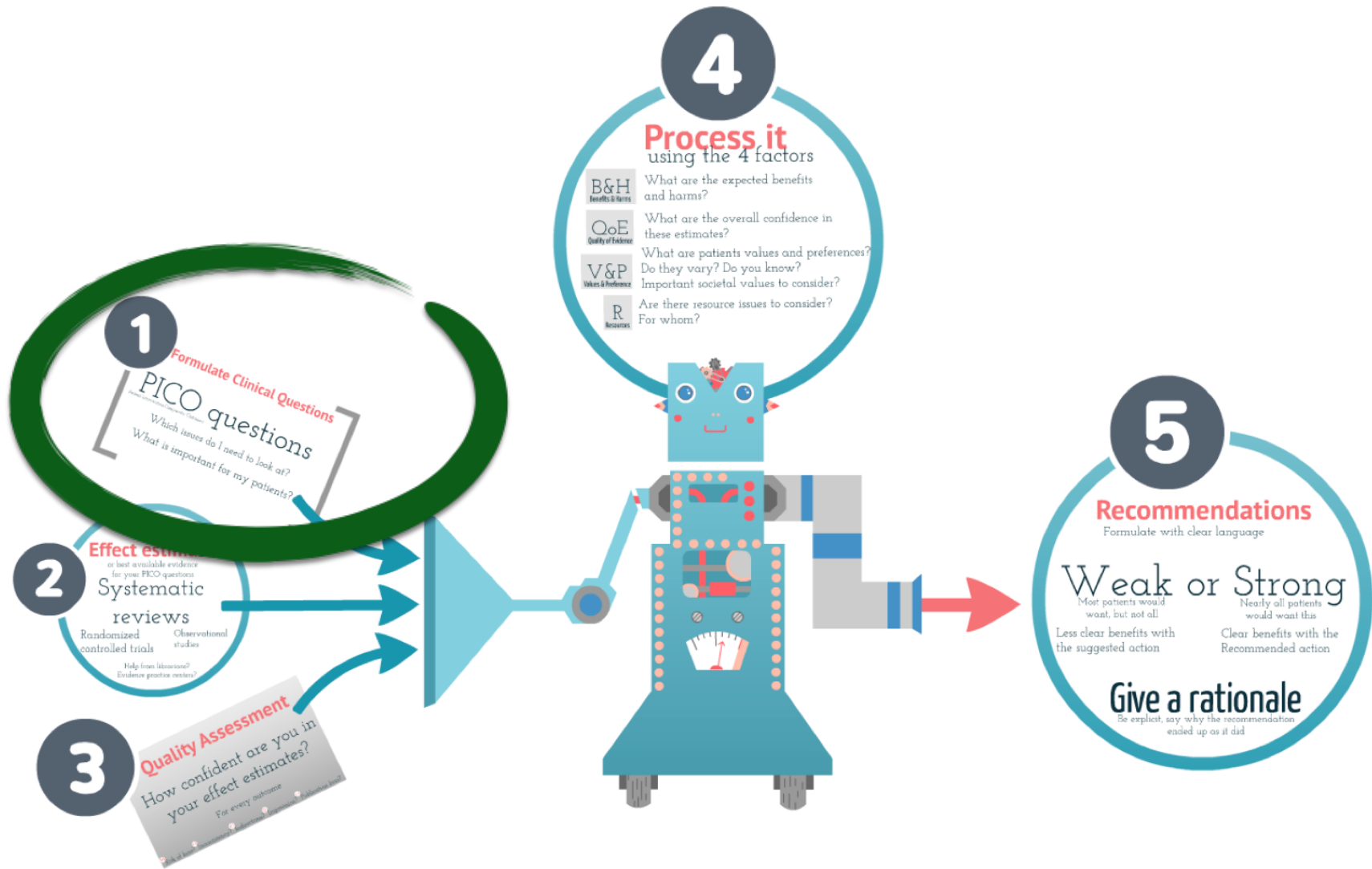
# Research in DECIDE (e.g. Multilayered guideline formats)



*Number of iterations may be more or less than 3, depending on nature of findings and feedback*

**Insight from user-testing:**  
Insufficient conceptual understanding of guideline methodology (e.g. strength of recommendations and quality of evidence) may hamper application of trustworthy guidelines in practice





# BASICs of making **GRADE** guidelines

# Authoring in MAGICapp: PICO and evidence profiles



Prevention of VTE in Orthopedic Surgery Patients: A Norwegian adaptation of the 9th ed. of the ACCP Antithrombotic Therapy and Prevention of Thrombosis

Evidence-based Clinical Practice Guidelines

References Evidence Profiles Recommendations

Sections Activity Messages

Add New Section

Orthopedic surgery and prevention of venous thromboembolism

Patients at moderate to high risk of thrombosis: All surgery of the lower extremities

Major orthopedic surgery: patients at low risk of thrombosis

Other interventions and screening

## 2 Patients at moderate to high risk of thrombosis: All surgery of the lower extremities

Background Text Add PICO

2.1

Population

Thromboprophylaxis in patients at moderate risk of VTE

Add Outcome

Intervention

Heparin

Comparator

No prophylaxis

Outcome

DVT, non-fatal pulmonary embolism

Evidence profile Summary References Codes Matrix Evidence feed Search strategy

Outcomes	Confidence In Effect Estimates	Relative Effect	No Prophylaxis	Heparin	Absolute Difference	Participants (Studies), Follow-Up	
DVT (5 weeks)	Moderate <i>Risk of bias and indirectness of borderline importance.</i>	RR 0.44 <i>(CI 0.31 - 0.63)</i>	45 <i>per 1000</i>	20 <i>per 1000</i>	25 fewer <i>per 1000</i> <i>(CI 31 fewer - 17 fewer)</i>	12.698 (22)	Remove
Non-fatal pulmonary embolism (5 weeks)	Moderate <i>Risk of bias and indirectness of borderline importance.</i>	RR 0.44 <i>(CI 0.31 - 0.63)</i>	22 <i>per 1000</i>	10 <i>per 1000</i>	12 fewer <i>per 1000</i> <i>(CI 15 fewer - 8 fewer)</i>	12.698 (22)	Remove

# Authoring in MAGICapp: PICO and evidence profiles

Norsk Selskap for Trombose og Hemostase

Home Settings Feedback Help Account Logout ONLINE

## Outcome (Dichotomous)

Outcome [↗](#) MeSH Term [↗](#) Code

DVT (5 weeks) MeSH Term Code

### Effect estimates (results) [↗](#)

Estimates from	Estimates from	Relative effect	Confidence interval	Participants (studies), Follow-up
Select a Reference	Select a Reference	Relative risk	( 0.31 - 0.63 )	12.698 (22)
No prophylaxis 45 per 1000		0.44		
Heparin 20 per 1000	Absolute difference	25 fewer per 1000	Confidence interval ( 31 fewer - 17 fewer )	

Timeframe  Auto-calculated

e.g over 1 year, until discharge, during 6 weeks...

### Your confidence in the effect estimates (Quality Assessment)

Study Type <a href="#">↗</a>	Risk of bias <a href="#">↗</a>	Imprecision <a href="#">↗</a>
Select	Select	Select
Randomized trials with no serious limitations		

Comment... Comment...

importance.

Recommendations

Background Text Add PICO

Add Outcome

Participants (studies), Follow-Up

698 (22) Remove

698 (22) Remove

# Going from evidence to recommendation: Linking to PICO and its evidence profile

Strong recommendation

Options

Benefits clearly outweigh the drawbacks. Virtually all patients will likely want the recommended strategy

We recommend surgical treatment over conservative treatment of unstable distal radial fractures in adults with normal functional requirements.

Effect estimates

Key info

Rationale

Practical advice

Adaptation

References

Discussion (0)

Show Selected

Show Section

Show All

Selected	Patient	Intervention	Control	Outcome
<input checked="" type="checkbox"/>	Patients with unstable distal radial fractures <a href="#">View</a>	Percutaneous pinning	Conservative treatment	Pain, Function, Anatomical position, Complications

Evidence profile

Summary

References

Evidence feed

Outcomes	Confidence In Effect Estimates	Relative Effect	Conservative Treatment	Percutaneous Pinning	Difference With Intervention	Participants (Studies), Follow-Up
Requiring re-dislocation	Moderate <i>due to the risk of bias (systematic error) and imprecise effect estimates</i>	RR 0.09 (CI 0.02 - 0.37)	143 per 1000	13 per 1000	130 fewer per 1000 (CI 140 fewer - 90 fewer)	269 (4 RCT)
Carpal tunnel syndrome (compression of	Low	RR 0.53			25 fewer	

# Going from evidence to recommendation: Multilayered formats as developed in DECIDE



## Prevention of VTE in Orthopedic Surgery Patients: A Norwegian adaptation of the 9th ed. of the ACCP Antithrombotic Therapy and Prevention of Thrombosis

### Evidence-based Clinical Practice Guidelines

Sections Activity Messages

Add New Section

Orthopedic surgery and prevention of venous thromboembolism

Patients at moderate to high risk of thrombosis: All surgery of the lower extremities

Major orthopedic surgery: patients at low risk of thrombosis

Other interventions and screening

References Evidence Profiles Recommendations

### 2 Patients at moderate to high risk of thrombosis: All surgery of the lower extremities

Background Text

Add Recommendation

Strong recommendation

Options

Benefits clearly outweigh the drawbacks. Virtually all patients will likely want the recommended strategy

We recommend thromboprophylaxis with low molecular weight heparin, low-dose direct factor Xa inhibitor (apixaban, rivaroxaban) or dabigatran for the first 10 postoperative days.

*High risk: previous symptomatic VTE.*

*Moderate risk: age > 80 years or multiple comorbidities.*

*Patient risk can be assessed using the Charlson Comorbidity index or ASA classification. Please see under "practical information".*

Effect estimates

Key info

Rationale

Practical advice

Adaptation

References

Discussion (0)

Benefits and harms

Help decide

Rich text editor toolbar with icons for undo, redo, bold, italic, underline, strikethrough, bulleted list, numbered list, link, unlink, indent, and outdent.

Patients with one or more patient-specific risk factors for thrombosis have an up to 6-fold increased risk of venous thromboembolism.

# www.magicapp.org/public


www.magicapp.org/app#/guidelines

Apper Logg Save to Mendeley WebVPN - UIO Wolfram|Alpha MAGIC user voice MAGICapp checklist Google Oversetter OFU Innlandet MEDLINE TREND Multiple-treatments

Feedback Help Log in EN ONLINE

Public Evidence summaries

Filter by owner Title contains Sort by Reset


 **Treatment of distal radius fractures in adults**  
Norwegian Orthopaedic Association - The Norwegian Medical Association - Main editor- and author: Hebe Désirée Kvernmo;  
Co-authors: Leiv M. Hove, Katrine Bjørnebek Frønsdal, Ingrid Harboe, Adalsteinn Odinson, Yngvar Krukhaug

16 Recommendations  
15 Clinical questions/ PICOs

CURRENT PUBLISHED VERSION: v0.1 - 4/17/15 [View](#)

DOWNLOADS: [PDF](#) [Export](#)

OFFLINE: Turn on to enable offline access


 **National klinisk retningslinje for analinkontinens hos voksne – konservativ behandling og udredning af nyopstået fækalinkontinens efter fødsel**  
Sundhedsstyrelsen - NKR sekretariatet, Sundhedsstyrelsen

11 Recommendations  
12 Clinical questions/ PICOs

CURRENT PUBLISHED VERSION: v0.1 - 4/17/15 [View](#)

DOWNLOADS: [PDF](#) [Export](#)

OFFLINE: Turn on to enable offline access

 **DEMO: Scandinavian clinical practice guideline on choice of fluid in resuscitation of critically ill patients with acute circulatory failure**  
The Scandinavian Society of Anaesthesiology and Intensive Care Medicine (SSAI) - Morten Hylander Møller

8 Recommendations  
12 Clinical questions/ PICOs

# Log in as workshop-test www.magicapp.org

## Group 1:

user: workshop1@magicapp.org  
Pass: workshop1

## Group 2:

user: workshop2@magicapp.org  
Pass: workshop2


## Group 3:

user: workshop3@magicapp.org  
Pass: workshop3

## Group 4:

user: workshop4@magicapp.org

**Welcome Back**  
Login with however you originally signed up.

 Sign in with Google


- Or enter your credentials below -


**Email Address**  
workshop1@magicapp.org

**Password**  
.....

[Forgot Password?](#)

Author 🇬🇧 ⓘ 📄 ⚙️

	<b>Adjunctive corticosteroid therapy for adults hospitalized with community-acquired pneumonia - 1</b> PERSONAL - Sicily workshop group 1	<b>1</b> Recommendations
		<b>1</b> Clinical questions/ PICOs

<b>LATEST DRAFT (NOT PUBLISHED)</b> 10/29/15 <span style="float: right;">Edit</span>	<b>DOWNLOADS</b>  7/10/15 Update now <span style="float: right;">Export</span>	<b>OFFLINE</b> Turn on to enable offline access <span style="float: right;">🔴 X</span>
---	---	---



# Changing practice requires more than EBM

Orthopedic  
thromboprophylaxis?



Quality improvement  
Measure practice

IN Apply the  
E: recommendation on  
P: individual patients

FOCUSED  
QUESTIONS

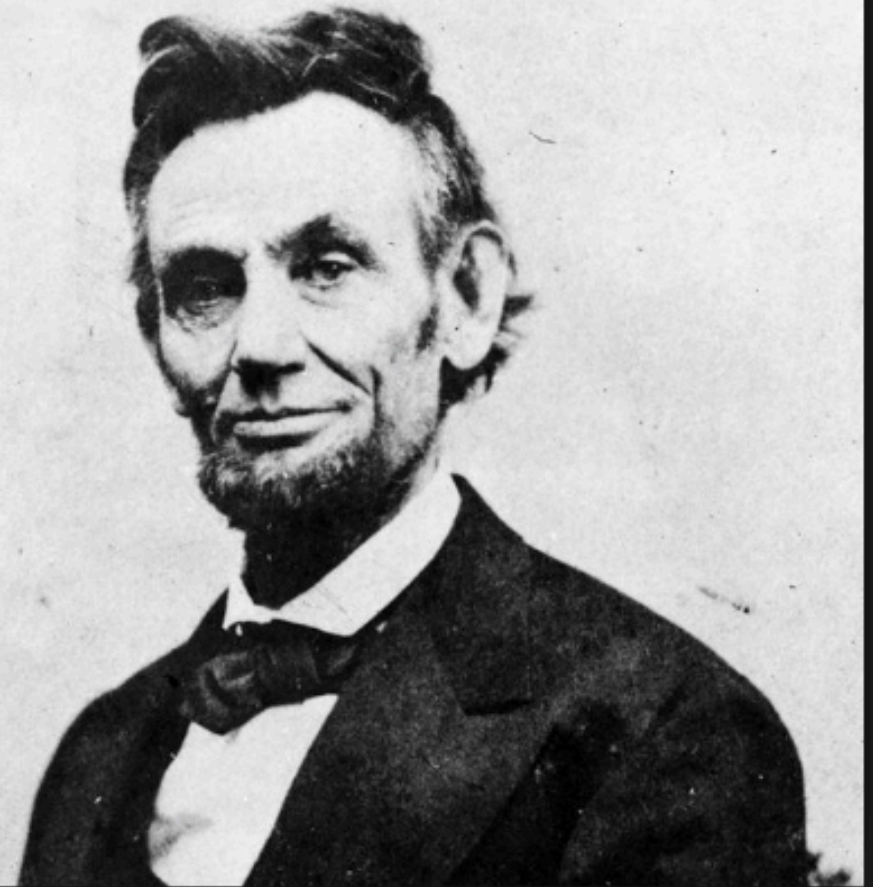
Search for  
recommendations in  
evidence-based guidelines

Weak recommendation  
for long term prophylaxis

# Health care and society face major challenges

**“The best way  
to predict  
the future  
is to  
create it.”**

Abraham Lincoln



# Steroids in pneumonia: WikiRecs as alternative approach

Annals of Internal Medicine  
**Corticosteroid Therapy for Patients Hospitalized With Community-Acquired Pneumonia**  
 A Systematic Review and Meta-analysis  
 David C. Hennekens, MD, Robert D. Murray, MD, Peter Avner-Cook, MD, PhD, Matthew H. Wu, MD, Michael S. Glick, MD, Joseph A. Sparano, MD, PhD, Thomas P. Althoff, MD, PhD, Paul T. Pinsky, MD, PhD, and Robert M. Serlin, MD, PhD  
 BACKGROUND: Community-acquired pneumonia (CAP) is a common cause of death. To assess the effect of adjunctive corticosteroid therapy on mortality and clinical outcomes in hospitalized adults with CAP.  
 DESIGN: Randomized, controlled, and comparative studies published between 1966 and 2014.  
 SETTING: Hospitalized adults with CAP.  
 PATIENTS: Hospitalized adults with CAP.  
 MAIN RESULTS: Corticosteroid therapy was associated with a lower risk of death (OR, 0.82; 95% CI, 0.67 to 1.01) and a lower risk of clinical failure (OR, 0.82; 95% CI, 0.67 to 1.01) compared with no corticosteroid therapy. The absolute risk reduction for death was 1.2% (95% CI, 0.5% to 2.0%) and for clinical failure was 1.2% (95% CI, 0.5% to 2.0%).  
 CONCLUSIONS: Corticosteroid therapy is associated with a lower risk of death and clinical failure in hospitalized adults with CAP.  
 KEY WORDS: corticosteroids, pneumonia, mortality, clinical failure.  
 DOI: 10.1093/ajph.2014.104.1911

Adjunctive corticosteroid therapy for adults hospitalized with community-acquired pneumonia  
 V1.1 | published on 8/10/15

1 Corticosteroids for community-acquired pneumonia

Adults hospitalized with community-acquired pneumonia

**Weak recommendation**

It is less clear whether the benefits outweigh the drawbacks/harms.

We suggest a short course of adjunctive corticosteroids rather than no corticosteroids

Most trials used approximately 0.5-1.0 mg/kg per day of prednisone-equivalent for 7-10 days

Effect estimates | Key info | Rationale | Practical advice | Adaptation | References

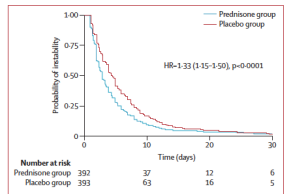
T2

Day 30: Systematic review submitted to journal

11 August 2015: Systematic review and WikiRecs published

Recommendation can be integrated in the EMR...?

19 January 2015: RCT in Lancet



**magic**  
 making GRADE the irresistible choice  
 Enhancing the Evidence Ecosystem

We can do shared decision-making...



T1

Basic research  
 E.g. pharmacogenomics drug development...

Document change in practice, in the EMR, in registries...  
 What are we waiting for?

T3

Increasing value?  
 If implemented March 2015?  
 300 lives saved in Norway