Editorial

Publication of national dermatology guidelines as a Research letter in the BJD: can less ever be enough?

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In this issue of the *BJD* we introduce publication of the summary of a national dermatology guideline as a Research Letter, the Dutch clinical practice guideline (CPG) for rosacea.[1] With this editorial we would like to familiarize clinicians, authors and peer reviewers with the new concept of summarizing a guideline in such a succinct way.

High-quality CPGs can improve patient outcomes as well as quality of care and minimise inappropriate treatments.[2,3] As a global journal,[4] the *BJD* aims to provide dermatologists with high-quality, trustworthy guidelines relevant to their practice and location.[5] Although traditionally most CPGs published in the *BJD* were produced by the British Association of Dermatologists (BAD) CPG group, we are pleased to see an increasing number of submissions of CPGs from other countries, extending the geographical reach of the journal.

Whilst there is room for publication in the *BJD* of guidelines that are merely consensus-based due to lack of randomised controlled trial evidence, some important aspects need to be addressed for *all* guidelines submitted to the *BJD*: detailed and transparent reporting of methodology, including the methods applied to move from evidence to recommendations (ideally with GRADE), minimization of authors' conflicts of interest and clear statements of funding sources.

Where sufficient evidence exists, CPGs are ideally underpinned by one or more systematic reviews. Conducting a high-quality systematic review is labour intensive, time consuming and costly. We recently discussed in the *BJD* common methodological pitfalls and new developments in systematic review meta-analysis.[6] It takes a comprehensive team to conduct a high-quality systematic review with input needed from clinicians, methodologists, statisticians, information specialists and patients to address all stages of the guideline development process adequately. Before the underpinning systematic review can start, registration or publication of a protocol is required.[6] Despite incorporating the global body of available evidence it is typically utilised for just one national or regional CPG.

Based on the systematic review, the certainty of evidence and the confidence in the effect estimates can be used by guideline developers to make formal recommendations. Importantly, values and preferences of patients need to be taken into account and frequently vary between countries, influencing how patients weigh the potential benefits, harms, costs, limitations, and inconvenience of the different treatment options in relation to one another.[7,8] Availability of medication, access to

physicians or hospitals/clinics and affordability (costs of healthcare and health insurance) can all further influence the recommendations made.[9]

In a recent *BJD* commentary, Gregor Jemec pointed out that efforts of CPG development teams are frequently repeated by several teams at more or less the same time, in several countries or regions.[10] The duplication of effort often leads to similar findings, resulting in research waste.

Another issue affecting both CPGs and systematic reviews is that they are updated infrequently. For some disease areas this might have no practical consequences, but in other areas there may be rapid developments, with a swift accumulation of new evidence likely to alter clinical practice. For instance, there might be new treatment effectiveness or safety data. This delay in translating evidence into guideline recommendations is of serious concern to patients who could miss out on guidance that may optimise their treatment.

The *BJD* now offers the opportunity to use the format of a Research Letter, accompanied by a treatment algorithm, to make the international dermatology community aware of local and national guidelines if they have been published elsewhere, even if such a publication is not in English. The Research Letter should demonstrate that the CPG adhered to the BAD standards for guideline development and is based on one or more recently published systematic reviews. This will help to avoid research waste and create opportunities for guideline developers to publish their main findings and recommendations in a new and succinct way. These concise guidelines will also benefit from a BJD plain language summary, made freely available, to ensure that patients can access them easily.

We hope that this new format for guideline publication will be a success with clinicians and patients alike, proving the point that less can indeed be enough.

References

1. van Zuuren EJ, van der Linden MMD, Arents BWM. Rosacea treatment guideline for The Netherlands. *Br J Dermatol* 2020; **x**:y-z.
2. Lugtenberg M, Burgers JS, Westert GP. Effects of evidence-based clinical practice guidelines on quality of care: a systematic review. *Qual Saf Health Care* 2009; **18**:385-92.
3. Institute of Medicine (US) Committee on Standards for Developing Trustworthy Clinical Practice Guidelines; Graham R, Mancher M, Miller Wolman D, et al., editors. Clinical Practice Guidelines We Can Trust. Washington (DC): National Academies Press (US); 2011. Available from: https://www.ncbi.nlm.nih.gov/books/NBK209539/
4. Linos E, Rajan N, Ingram JR. BJD: A global dermatology journal serving the needs of its readers worldwide. *Br J Dermatol* 2019; **181**:3-4.
5. Ingram JR, Anstey A. The evolution of clinical guidelines for dermatologists: GRADE, AGREE, and occasionally consensus by experts. *Br J Dermatol* 2017; **176**:3-4.
6. Leonardi-Bee J, Flohr C, van Zuuren EJ *et al*. Common methodological pitfalls and new developments in systematic review meta-analysis. *Br J Dermatol* 2019; **181**:649-51.
7. Montori V. The optimal practice of evidence-based medicine: incorporating patient preferences in practice guidelines. *JAMA* 2013; **18**:2503-4.
8. Andrews J, Guyatt G, Oxman AD *et al*. GRADE guidelines: 14. Going from evidence to recommendations: the significance and presentation of recommendations. *J Clin Epidemiol* 2013; **66**:719-25.
9. Brunetti M, Shemilt I, Pregno S *et al*. GRADE guidelines:10. Considering resource use and rating the quality of economic evidence. *J Clin Epidemiol* 2013; **66**:140-50.
10. Jemec GBE. Evidence-based hidradenitis suppurativa guidelines – and now all together. *Br J Dermatol* 2019; **180**:975.