

USING THE EVIDENCE WE HAVE TO INFORM BEST PRACTICE

Peter J Franks

Management of disease must be undertaken using the best available evidence. The development of clinical guidelines is seen as a major contribution to improving care, though how evidence is selected and used has in the past often been on an ad hoc basis. The ideal guideline should be based on systematic reviews (SRs), which examine the evidence in detail before making recommendations on treatment.

The most high profile SRs have been undertaken within the auspices of the Cochrane collaboration (www.cochrane.org). There have been three notable SRs in the management of lymphoedema undertaken by Dr Caroline Badger and colleagues at St George's Medical School in London (Badger et al, 2004a; 2004b; 2004c). The only acceptable evidence in a Cochrane review is that derived from randomised controlled trials.

The results of these SRs were disappointing, with few trials and designs that did not lend themselves to aggregation of data. The only positive comment was that penicillin appeared to reduce the incidence of cellulitis when combined with appropriate foot care.

While randomised controlled trials (RCTs) are considered as central to the development of practice, not all questions about treatment and management are answerable using a RCT methodology (West and Newton, 1997). Equally, not all aspects of care and management will have been the subject of research and, where this is the case, ways must be found to make use of other sources of evidence,

Peter J Franks is Professor of Health Sciences, Centre for Research & Implementation of Clinical Practice, Faculty of Health & Human Sciences, Thames Valley University, London

such as professional and patient expert opinion (Rycroft-Malone, 2001).

The Lymphoedema Framework Project (LFP) wished to develop a Best Practice document (BPD) to guide practitioners in the appropriate management of patients suffering from all causes of lymphoedema. Without RCT evidence, alternative methods had to be used.

Based on guidance from the Health Technology Assessment Programme (Murphy et al, 1998), a modified nominal group technique was adopted. This allowed for mailed questionnaires to elicit private decisions and opinions.

While the consensus methodology used in the BPD offers a reasonable method to develop a guideline, there are still opportunities to examine in detail particular aspects of care that might fall between the Cochrane reviews and this consensus approach. The Joanna Briggs Institute (www.joannabriggs.edu.au) uses information other than (but including) that from RCTs to make recommendations on practice. In particular, it uses information from RCTs, non-RCT quantitative, qualitative and narrative data. The LFP is currently developing a protocol within the JBI to evaluate the potential benefit of massage on improving outcomes for individuals with lymphoedema/chronic oedema. This will explore massage in its totality, not just that advocated by the western schools of lymphoedema management. Information from these sources will be supplemented by studies from China and India where practice in massage is very different.

The SR has four main research themes:

- ▶▶ Patient-centred and economic effects of massage, and its role in prevention in 'at-risk' groups
- ▶▶ Physiological effects of massage and how results from these studies have influenced the use and development of clinical techniques used in practice
- ▶▶ The historical, philosophical and cultural context of manual lymphatic drainage (MLD) and other massage techniques
- ▶▶ The psychological and social effects of all forms of massage carried out in primary and secondary care settings by healthcare professionals, patients and carers.

This will provide a much more rounded review of the literature, while trying to understand how techniques have developed, their physiological basis and the evidence in terms of effectiveness in reducing and preventing lymphoedema development. **JL**

References

- Badger C, Preston N, Seers K, Mortimer P (2004a) Benzo-pyrones for reducing and controlling lymphoedema of the limbs. *Cochrane Database of Systematic Reviews* 2003, Issue 4
- Badger C, Preston N, Seers K, Mortimer P (2004b) Physical therapies for reducing and controlling lymphoedema of the limbs. *Cochrane Database of Systematic Reviews* 2004, Issue 4
- Badger C, Seers K, Preston N, Mortimer P (2004c) Antibiotics/anti-inflammatories for reducing acute inflammatory episodes in lymphoedema of the limbs. *Cochrane Database of Systematic Reviews* 2004, Issue 2
- Lymphoedema Framework (2006) *Best Practice for the Management of Lymphoedema*. International Consensus. London: MEP Ltd, 2006
- Murphy MK, Black NA, Lamping DL, McKee CM, Sanderson CFB, Askham J, Marteau T (1998) Consensus development methods, and their use in clinical guideline development. *Health Technology Assessment* 2(3)
- Rycroft-Malone J (2001) Formal consensus: the development of a national clinical guideline. *Qual Health Care* 10: 238-44
- West E, Newton J (1997) Clinical guidelines. An ambitious national strategy. *Br Med J* 315: 324