

# Décision médicale partagée nouveaux défis & nouvelles approches



Reproduced from cover page of JAMA, Users' Guide to the Medical Literature, 3<sup>rd</sup> ed.

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 [@ThomasAgoritsas](https://twitter.com/ThomasAgoritsas)

# Conflits d'intérêts potentiels

- **FINANCIERS: Aucun financement pharmas ou devices**
- **INTELLECTUELS: membre de plusieurs groupes EBM et guidelines**
  - Membre de GRADE  
<http://www.gradeworkinggroup.org>
  - Deputy CEO of the MAGIC Evidence Ecosystem Foundation  
<http://magicevidence.org>  
Organisation à but non-lucratif pour l'amélioration de la création, dissémination, et mise à jour des guidelines, résumés d'évidences et aides décisionnelles.
  - Co-fondateur BMJ Rapid Recommendations  
<http://www.bmj.com/rapid-recommendations>
  - Editeur de ACP journal club / Evidence Alerts  
<https://plus.mcmaster.ca/evidencealerts>

Soins centrés patient



Médecine personnalisée

Décision partagée



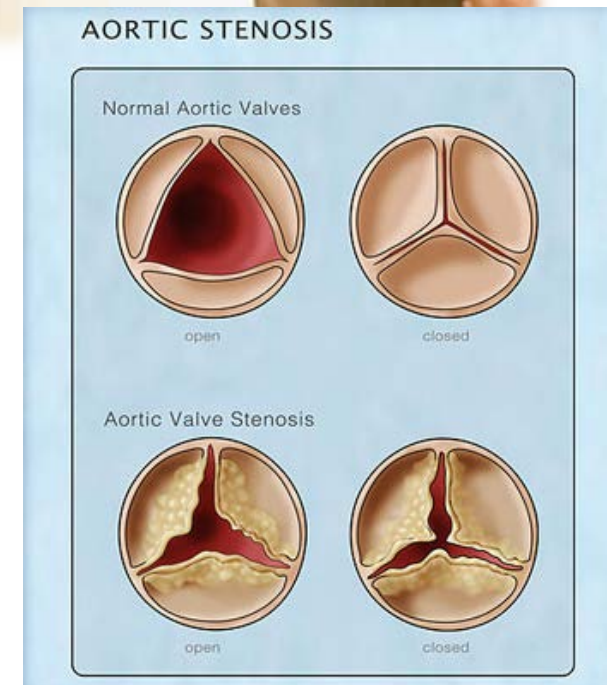
Barry et al. Shared decision making - pinnacle of patient-centered care. *NEJM* 2012;366:780-1.

Stigglebout et al. Shared decision making: really putting patients at the centre of healthcare. *BMJ* 2012;344:e256.

Djulgovic B et al. Evidence-based practice is not synonymous with delivery of uniform health care. *JAMA* 2014;312:1293-4.

# Daniel, 66 ans

- Récemment retraité
- Essoufflement à l'effort
- Très limitant au quotidien
- A perdu connaissance
  
- Souffle à l'auscultation
- Echographie du coeur:
- **Sténose aortique sévère**



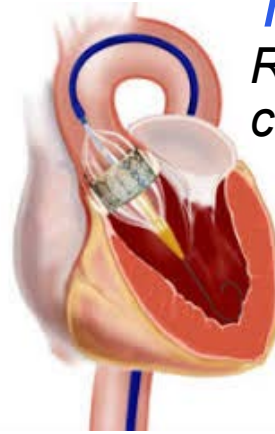
Selon vous, quels sont les ingrédients à la décision dont Daniel et ses médecins ont besoin?



# Les ingrédients utiles à la décision?

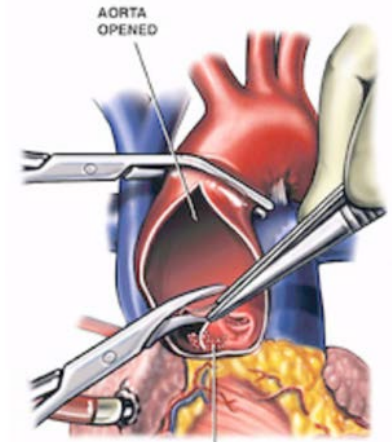
Quels options?

Le menu



*TAVI*

*Remplacement par cathétérisme*



*SAVR*

*Remplacement par chirurgie*

Bénéfices & Risques

La pesée



Certitude

« L'indice de confiance »

Aspects pratiques



# La pratique clinique = myriade de décisions

Besoin de SDM

- Quand devrais-je consulter [Patient]
- Quand devrais-je hospitaliser [Médecine]
- Quand devrais-je appeler le médecin? [Infirmier.e]
  
- Quel test diagnostique effectuer/proposer?
- Que devrions-nous dépister et quand?
  
- **Quels sont les options thérapeutiques raisonnables?**
- Quel type et fréquence de suivi?
- Quels sont les aspects pratiques à mettre en œuvre?

+ nombreuses interactions thérapeutiques non décisionnelles

→ Champ de connaissances



**La décision partagée** est un processus par lequel

un **patient** et un **clinicien**

travaillent ensemble,

ont une **conversation**,

entrent en partenariat

afin d'identifier **la meilleure approche**,


le meilleur traitement ou test

dans une situation donnée.

C'est un **partage de ce qui compte**

Les cliniciens partagent l'information sur les alternatives disponibles, les risques, bénéfices, implications pratiques.

Les patients partagent les expériences, attentes, valeurs, préférences



**Pas que  
des  
nombres!**





## MEDECINE PERSONALISEE

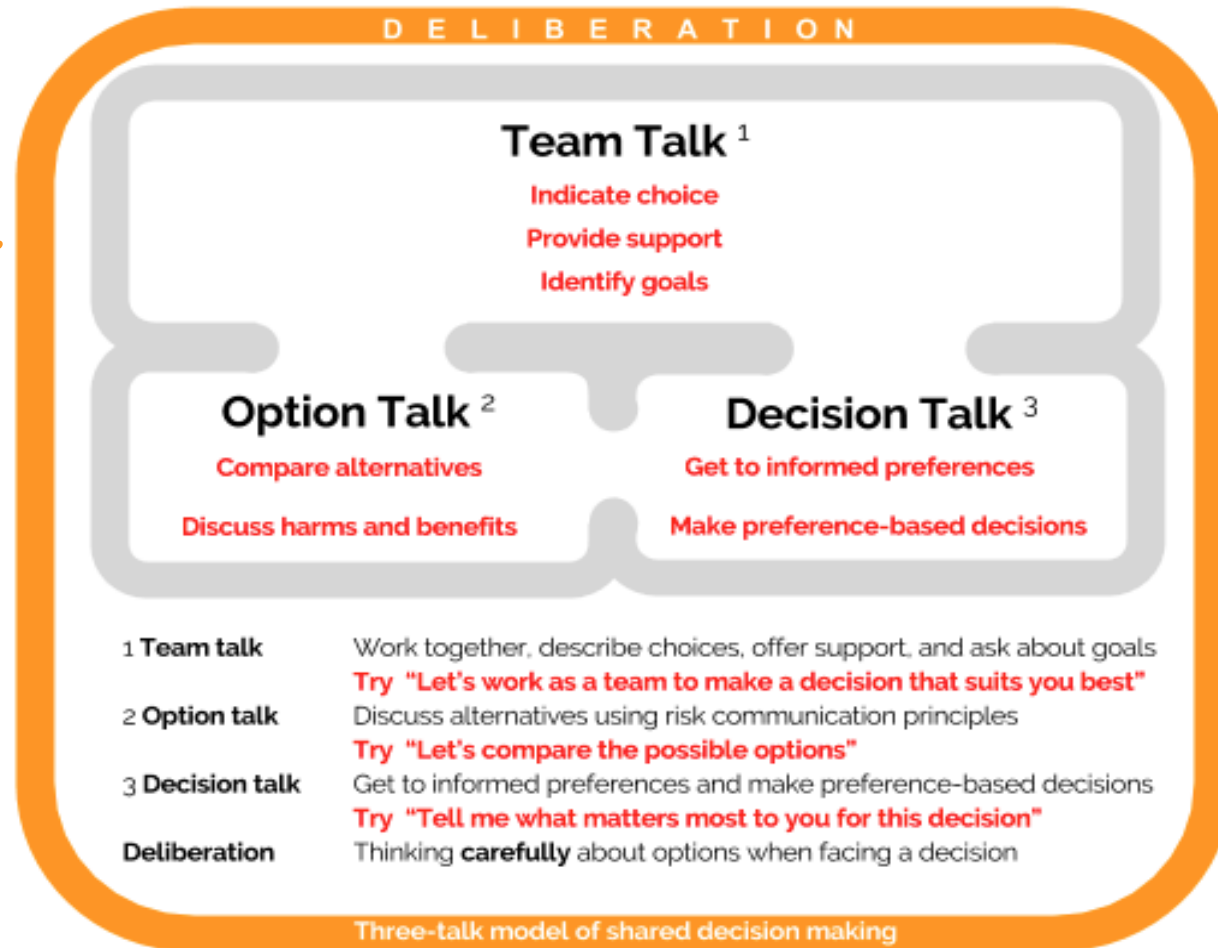
RISQUE INDIVIDUEL

VALEURS & PREFERENCES

DECISION PARTAGEE



*Une danse  
en 3 temps...*



*Elwyn G et al. Shared decision making: a model for clinical practice.  
J Gen Intern Med. 2012 Oct;27(10):1361-7.*

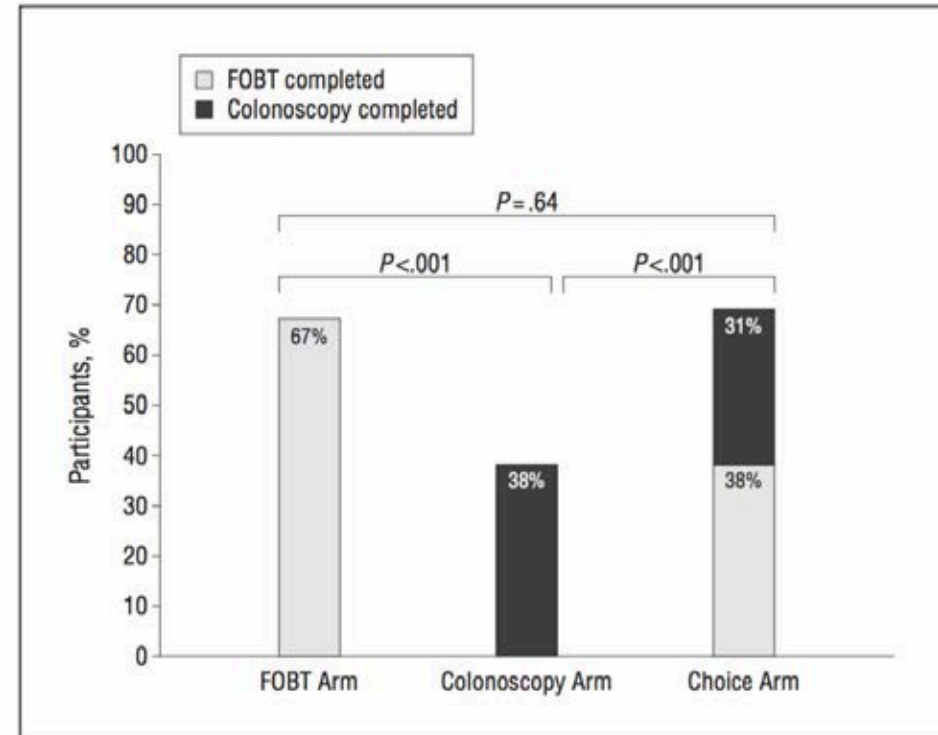
# Décision partagée: croyances et objections

- **Consultation plus longues?**
  - Pas de rallongement systématique (3 revues systématiques)
- **Les patients ne désirent pas partager la décision?**
  - 70-90% préfèrent SDM (enquête européenne >8000 pat)
  - Time trend (50% avant les années 2000)
  - >50% insatisfaits (quantité d'info et implication)
- **Les patients n'en sont pas capables?**
  - Faux, y compris les populations vulnérables / illettrées
- **Mais on le fait déjà!**
  - Pas assez... "perception-reality gap »
  - Moyenne 23/100 sur OPTION scale (33 études internationales)

# Adh rence, libre choix et d cision partag e

Exemple d'un essai cluster aux USA

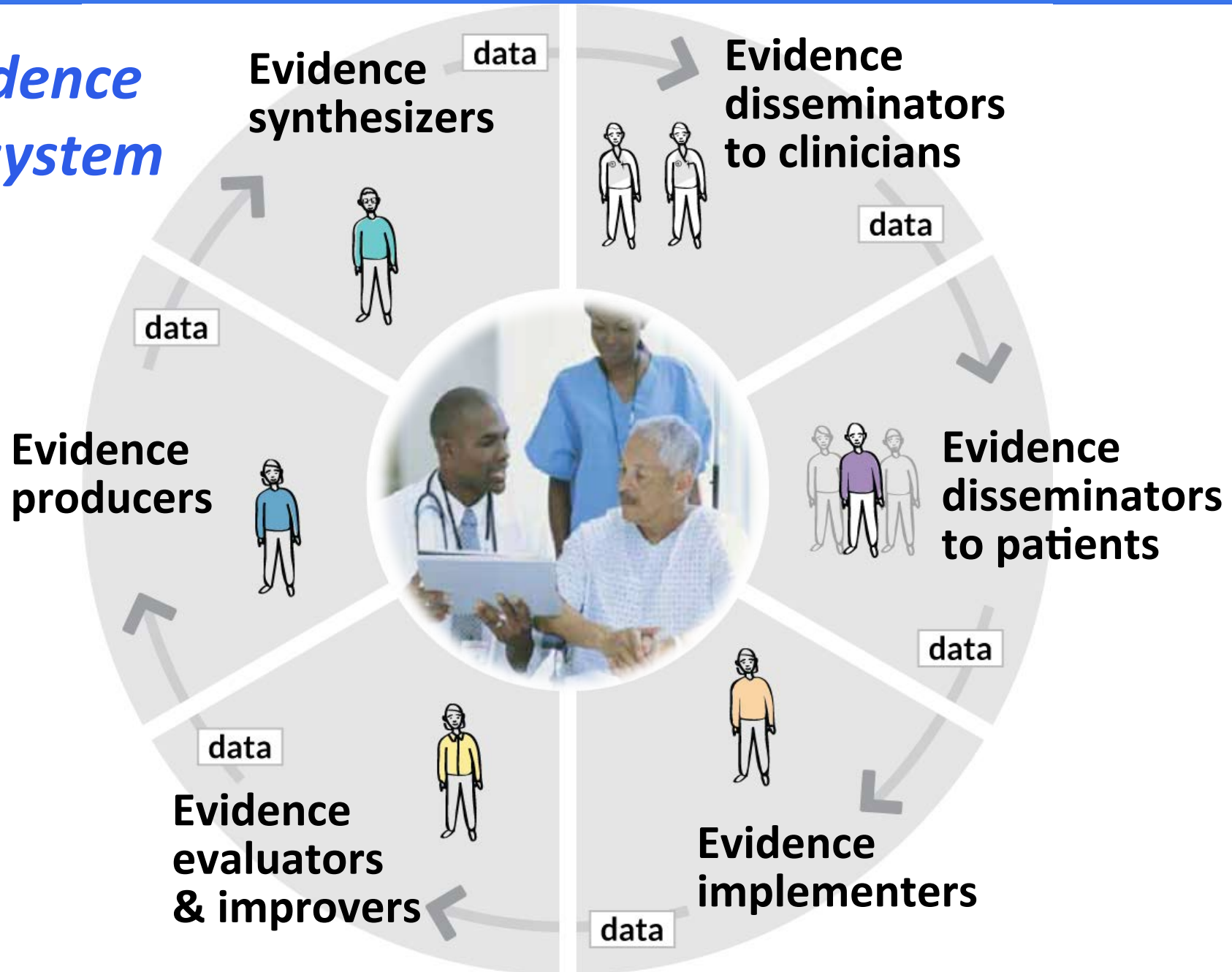
- Taux sup rieurs avec le test f cal, quelque soit le contexte socio-culturel.
- Le libre choix colonoscopie vs test f cal augmente l'adh rence au d pistage
- B n fice de la d cision partag e et du « **Choice awareness** »



**Figure 2.** Completion rates by study arm. Participants recommended colonoscopy completed screening at a significantly lower rate than participants recommended fecal occult blood testing (FOBT) or a choice between colonoscopy or FOBT. The level of statistical significance was reduced to .01 to adjust for multiple comparisons.

# Où trouver les ingrédients à la décision partagée?

## *Evidence Ecosystem*



# Volume de l'evidence QUOTIDIENNE

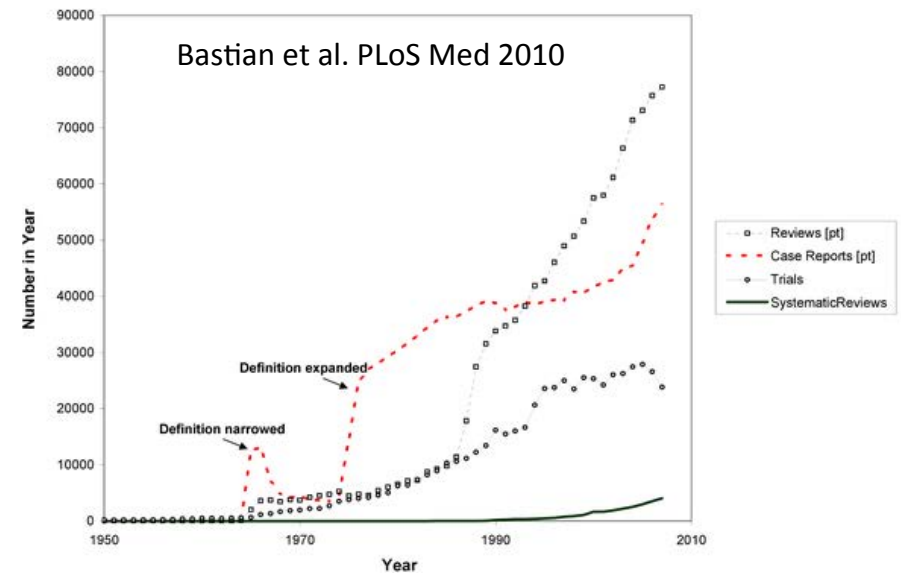
## ➤ 3000-4000 publications

- 100 Essais randomisés
- 20 Méta-analyses

Chercher une réponse  
Signal vs. Bruit?



Rester à jour



- **Agoritsas** et al. Increasing the quantity and quality of searching for current best evidence to answer clinical questions. *Implement Sci* 2014;9:125.
- **Agoritsas** et al. Sensitivity and predictive value of 15 PubMed search strategies to answer clinical questions rated against full systematic reviews. *J Med Internet Res* 2012;14:e85.
- **Agoritsas** et al. Finding Current Best Evidence, in *JAMA Users' Guides to the Medical Literature*. McGraw-Hill Medical, 2015.



The BMJ Practice: [Transcatheter versus surgical aortic valve replacement in symptomatic, aortic stenosis at low and intermediate risk](#)

The BMJ Research: [Transcatheter versus surgical aortic valve replacement in symptomatic aortic stenosis at low and intermediate risk: systematic review and meta-analysis](#)

The BMJ Research: [Prognosis after surgical replacement of the aortic valve in symptomatic aortic stenosis](#)

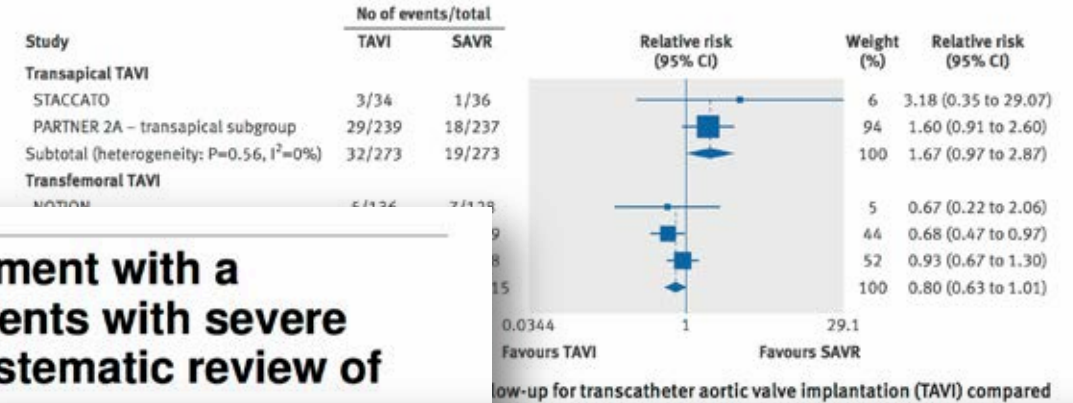
BMJ Open research: [Patient values and preferences for aortic stenosis](#)

## Transcatheter versus surgical aortic valve replacement in patients with severe aortic stenosis at low and intermediate risk: systematic review and meta-analysis

Reed A Siemieniuk,<sup>1,2</sup> Thomas Agoritsas,<sup>1,3</sup> Veena Manja,<sup>1,4,5</sup> Tahira Devji,<sup>1</sup> Yaping Chang,<sup>1</sup> Malgorzata M Bala,<sup>6</sup> Lehana Thabane,<sup>1</sup> Gordon H Guyatt<sup>1</sup>

### ABSTRACT OBJECTIVE

To examine the relative risk of mortality and morbidity associated with transcatheter aortic valve implantation (TAVI) compared with surgical aortic valve replacement (SAVR) in patients with severe aortic stenosis at low and intermediate risk.



## Prognosis after surgical replacement with a bioprosthetic aortic valve in patients with severe symptomatic aortic stenosis: systematic review of observational studies

OPEN ACCESS

Farid Foroutan *master student*<sup>1,2</sup>, Gordon H Guyatt *disruptive undergraduate student*<sup>2</sup>, Eva Bain *undergraduate student*<sup>2</sup>, Sai Bhagra *physician*<sup>2</sup>, Daegan Sit *medical student*<sup>1</sup>, R Yaping Chang *PhD student*<sup>1</sup>, Tahira Devji *PhD student physician*<sup>1,3,4</sup>, Toni Schofield *physician*<sup>2</sup>, Reed A Siemieniuk *professor*<sup>1,6</sup>, Rodrigo Bagur *assistant professor*<sup>7</sup>, Catharina Munch *associate professor*<sup>9,10</sup>

<sup>1</sup>Department of Clinical Epidemiology and Biostatistics, McMaster University, 1280 Main Street West, Toronto, Ontario, Canada; <sup>2</sup>Department of Cardiology, University Health Network, Toronto General Hospital, Toronto, Ontario, Canada; <sup>3</sup>Department of Cardiology, State University of New York at Buffalo, Buffalo, USA; <sup>4</sup>VA WNY Health Care System, Buffalo, USA; <sup>5</sup>Department of Cardiology, University of Toronto, Toronto, Ontario, Canada; <sup>6</sup>Division of General Internal Medicine, University of Toronto, Toronto, Ontario, Canada; <sup>7</sup>Division of General Internal Medicine, University of Geneva, Geneva, Switzerland; <sup>8</sup>Division of Cardiology, London Health Sciences Centre, London, Ontario, Canada N6A 5W9; <sup>9</sup>Division of Cardiology, University of Washington, Seattle, WA, USA; <sup>10</sup>Department of Internal Medicine, Inland Hospital, Faculty of Medicine, University of Oslo, Norway

Open Access

Research

## BMJ Open Patient values and preferences on transcatheter or surgical aortic valve replacement therapy for aortic stenosis: a systematic review

Lyubov Lytvyn,<sup>1</sup> Gordon H Guyatt,<sup>2</sup> Veena Manja,<sup>2,3,4</sup> Reed A Siemieniuk,<sup>2,5</sup> Yuan Zhang,<sup>2</sup> Thomas Agoritsas,<sup>2,6</sup> Per O Vandvik<sup>7,8</sup>

**To cite:** Lytvyn L, Guyatt GH, Manja V, et al. Patient values and preferences on transcatheter or surgical aortic valve replacement therapy for aortic stenosis: a systematic review. *BMJ Open* 2018;12:e002020. doi:10.1136/bmjopen-2017-002020

### ABSTRACT

**Objective:** To investigate patients' values and preferences regarding aortic valve replacement therapy for aortic stenosis.

**Setting:** Studies published after transcatheter aortic valve insertion (TAVI) became available (2002).

### Strengths and limitations of this study

- This is the first systematic review of patient values and preferences regarding aortic stenosis valve replacement therapy.
- Our results informed the *BMJ-RapidRecs* guideline.

# Les failles de nombreux guidelines



## ORIGINAL INVESTIGATION

ONLINE FIRST | HEALTH CARE REFORM

### Failure of Clinical Practice Guidelines to Meet Institute of Medicine Standards

Two More Decades

Justin Kung, MD; Ram

**Background:** In March 2001, the Institute of Medicine (IOM) issued a new set of standards for clinical practice guidelines intended to improve the quality of care being produced. To our knowledge, no large-scale study of adherence to these standards has been taken since one published in 1999.

**Methods:** Two review articles and 114 guidelines selected at random from the National Guideline Clearinghouse (NCG) were analyzed against 18 of 25 IOM standards.

**Results:** The overall mean adherence to IOM standards satisfied (our

ONLINE FIRST

### In Guidelines We Cannot Trust

The Institute of Medicine (IOM) has set its standards for guideline development. Trustworthiness connotes integrity, reliability. Unfortunately, in guidelines we cannot trust. In the late 1990s, 2 colleagues and I praised a broad set of published guidelines. Unfortunately, a rate similar to that found in 1999 (43.1%). While we found some

## INVITED COMMENTARY



BMJ 2016;353:i3200 doi: 10.1136/bmj.i3200 (Published 27 June 2016)



### Clinical encounters in the post-guidelines era

Glyn Elwyn and colleagues highlight the potential benefits of fast and frugal knowledge tools

Glyn Elwyn professor<sup>1</sup>, Siestse Wieringa research fellow<sup>2</sup>, Trisha Greenhalgh professor<sup>3</sup>

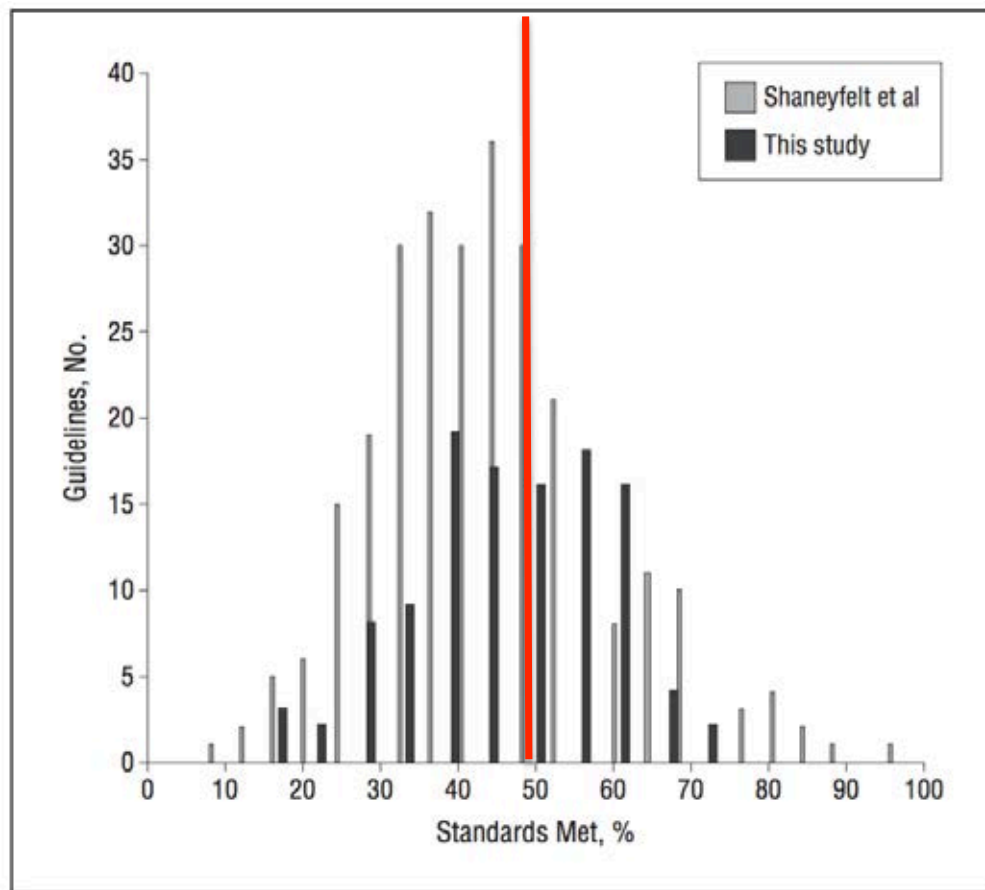
<sup>1</sup>Dartmouth Institute for Health Policy and Clinical Practice, Hanover, New Hampshire 03755, USA; <sup>2</sup>Institute of Health and Society, University of Oslo, Oslo, Norway; <sup>3</sup>Nuffield Department of Primary Care Health Sciences, University of Oxford, Oxford, UK



# Failure of Clinical Practice Guidelines to Meet Institute of Medicine Standards

Kung et al. Arch Intern Med. 2012

\* Evaluation on 18 criteria (from 25) – N=130 guidelines



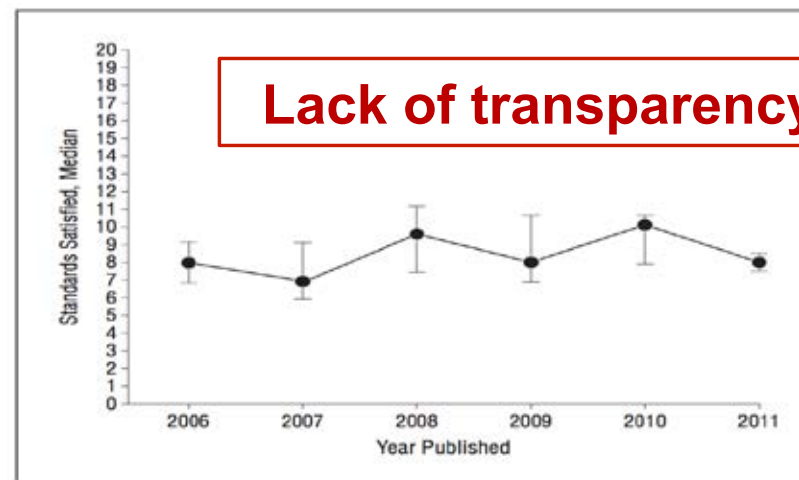
**Table 1. Frequency of Adherence to Institute of Medicine Standards by Organization Type and Subspecialty Area**

Organization Type (No. of Guidelines)	Standards Met, Median	Guidelines Meeting >50% of Standards, No. (%)
All (114)	8 (44.0)	56 (49.1)
United States (68)	8 (44.0)	34 (50.0)
Non-US (46)	9 (50.0)	22 (47.8)
US government agency (15)	9 (50.0)	10 (66.7)
Subspecialty societies (41)	8 (44.0) <sup>a</sup>	16 (39.0) <sup>b</sup>
Subspecialty area		
Infectious diseases (21)	9 (50.0)	11 (52.4)
Oncology (17)	9.5 (52.8)	9 (52.9)
OB/GYN (12)	8 (44.0)	3 (25.0)
All other (64)	8 (44.0)	36 (56.2) <sup>c</sup>

## Financial COI

- 71% of guideline chairs
- 91% of co-chairs

Patients included – 15%





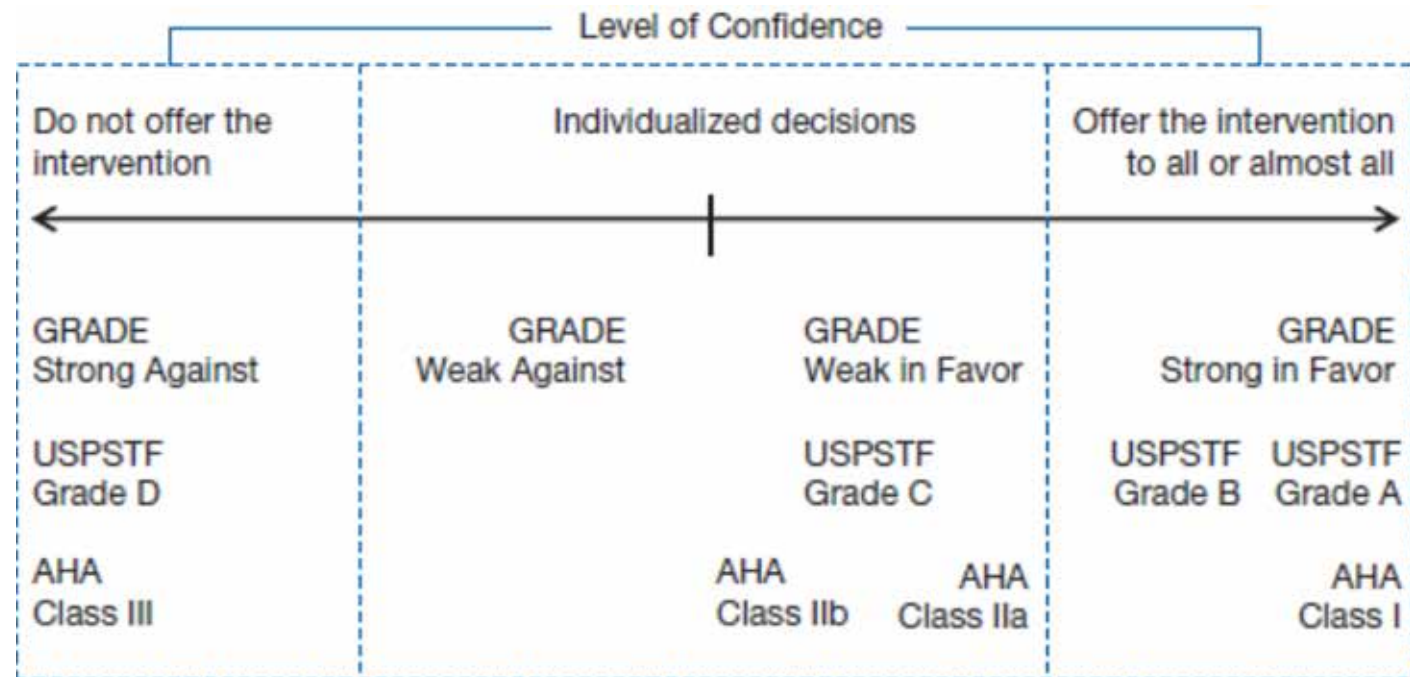
# Niveau d'évidence & recommandations???

From: How to Use a Patient Management Recommendation: Clinical Practice Guidelines and Decision Analyses  
Users' Guides to the Medical Literature, 2014

**Class Ia?**

**Grade A**

**Class IIIb?**



**Legend:**

Direction and Strength of Recommendations in Different Grading Systems

Abbreviations: AHA, American Heart Association; GRADE, Grading of Recommendations Assessment, Development and Evaluation; USPSTF, US Preventive Services Task Force.

**ANALYSIS**

**GRADE**

**RATING QUALITY OF EVIDENCE AND STRENGTH OF RECOMMENDATIONS**

# GRADE: an emerging consensus on rating quality of evidence and strength of recommendations

Guidelines are inconsistent in how they rate the quality of evidence and the strength of recommendations. This article explores the advantages of the GRADE system, which is increasingly being adopted by organisations worldwide

Guideline developers around the world are inconsistent in how they rate quality of evidence and grade strength of recommendations. As a result, guideline users face challenges in understanding the messages that grading systems try to communicate. Since 2006 the *BMJ* has requested in its “Instructions for Authors” on *bmj.com* that authors should use the Grading of Recommendations Assessment and Evaluation (GRADE) system when submitting a clinical guidelines article. What was behind this decision?

Gordon H Guyatt professor,  
Department of Clinical  
Epidemiology and Biostatistics,  
McMaster University, Hamilton,  
ON, Canada L8N 3Z5  
Andrew D Oxman researcher,

advantages and disadvantages but also by their confidence in these estimates. The cartoon depicting the weather forecaster’s uncertainty captures the difference between an assessment of the likelihood of an outcome and the confidence in that assessment (figure). The use of intervention that estimate. As offering recommendations have often erred as a result of not taking sufficient account of the quality of evidence.<sup>2</sup> For a decade, organisations recommended


→ BMJ 2004, BMJ 2008, JCE 2010-present  
→ continued evolution


Norwegian Knowledge Centre for  
the Health Services, PO Box 7004,  
St Olavs Plass, 0130 Oslo, Norway

# Lien avec l'évidence?

**GRADE**

## Recommandations forte


1. Balance claire 
  - Bénéfices >> Risques/charge
  - Risques/charge >> Bénéfices

2. Certitude de l'effet suffisante (haute-moy) 

3. Valeurs & Préférences
  - Tous le **même** choix



## Recommandations faible

1. Balance étroite 
  - Faible différence absolue
  - Dans un sens ou l'autre

2. Incertitude de l'effet 

3. Valeurs & Préférences
  - Variables (ou incertaines)

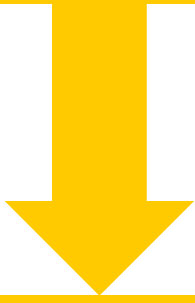


*Lien avec l'évidence?*

**GRADE**

*Recommandations forte*

*Recommandations faible*



*Just do it*

*Décision Médicale Partagée*



# Most important decisions in health care are not clear cut

## Strength of recommendations in UpToDate (n=9451)

	<b>All Recommendations</b>
	<b>N (%)</b>
<b>Low confidence</b>	4701 (49.7%)
<b>Moderate confidence</b>	3759 (39.8%)
<b>High confidence</b>	991 (10.5%)
<b>Total</b>	<b>9451 (100%)</b>


# Most important decisions in health care are not clear cut

## Strength of recommendations in UpToDate (n=9451)



	<b>Weak Recommendations</b>	<b>Strong Recommendations</b>	<b>All Recommendations</b>
	<b>N (%)</b>	<b>N (%)</b>	<b>N (%)</b>
<b>Low confidence</b>	4335 (66.7%)	366 (12.4%)	4701 (49.7%)
<b>Moderate confidence</b>	2019 (31.1%)	1740 (59.0%)	3759 (39.8%)
<b>High confidence</b>	147 (2.3%)	844 (28.6%)	991 (10.5%)
<b>Total</b>	<b>6501</b> (68.8% of all rec)	<b>2950</b> (31.2% of all rec)	<b>9451</b> (100%)

# Most important decisions in health care are not clear cut

## Strength of recommendations in UpToDate (n=9451)



	Weak Recommendations	Strong Recommendations	All Recommendations
	N (%)	N (%)	N (%)
	4335 (66.7%)	366 (12.4%)	4701 (49.7%)
	2019 (31.1%)	1740 (59.0%)	3759 (39.8%)
	147 (2.3%)	844 (28.6%)	991 (10.5%)
	<b>6501</b>	<b>2950</b>	<b>9451</b>
	<b>(68.8% of all rec)</b>	<b>(31.2% of all rec)</b>	<b>(100%)</b>

# « BMJ Rapid Recommendations » : vers un nouveau modèle de recommandations pour la pratique clinique

Dr THOMAS AGORITSAS<sup>a</sup>, Dr PAULINE DARBELLAY FARHOUMAND<sup>a</sup>, Dr REED SIEMIENIUK<sup>b</sup>, Dr ANJA FOG HEEN<sup>c</sup>,  
LYUBOV LYTVYN<sup>b</sup>, Dr HELEN MACDONALD<sup>d</sup>, Dr WILL STAHL-TIMMINS<sup>d</sup>, Prs GORDON GUYATT<sup>b</sup> et PER OLAV VANDVIK<sup>e</sup>

*Rev Med Suisse 2019; 15: 149-55*

Les guidelines ont une place centrale dans notre pratique clinique, mais leur développement manque souvent de rigueur et de transparence, rendant leurs recommandations vulnérables aux conflits d'intérêts. S'y ajoutent les problèmes de mise à jour insuffisante, et des formats qui ne facilitent pas leur adaptation locale ou la décision médicale partagée. En réponse à ces problèmes, nous avons conçu les RapidRecs en collaboration avec le *British Medical Journal*. Cette approche innovante consiste à: a) identifier des nouvelles études pouvant changer la pratique; b) les incorporer dans des revues systématiques en environ 45 jours; c) rassembler un panel international indépendant, sans conflit d'intérêts et incluant des patients et d) émettre des recommandations selon GRADE en environ 90 jours, avec des outils didactiques facilitant la décision médicale partagée.

**The BMJ Rapid Recommendations: towards  
a new model for the production of clinical  
practice guidelines**

## GUIDELINES POUR LA PRATIQUE CLINIQUE: POUR LE MEILLEUR ET POUR LE PIRE?

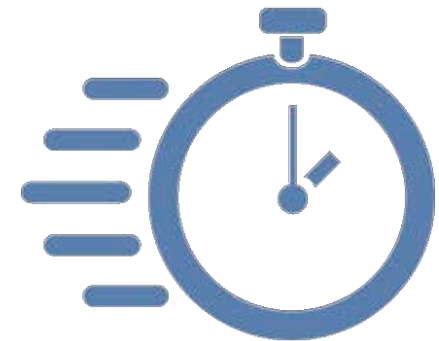
L'avènement de l'Evidence Based Medicine (EBM) dans les années 90 a été accompagné d'une explosion du nombre de publications. Actuellement, environ 3000 à 4000 citations sont ajoutées à PubMed tous les jours, dont une centaine d'essais randomisés et une vingtaine de revues systématiques.<sup>1</sup> Face à ce volume de nouvelles connaissances, les cliniciens s'appuient de plus en plus sur des guidelines pour la pratique clinique,<sup>2</sup> soit sous la forme de publications de sociétés savantes, soit dans des ressources en ligne telles que UpToDate ou Dynamed.<sup>3</sup>

Toutefois, trois types de guidelines restent potentiellement problématiques, voire peuvent induire en erreur pour les raisons suivantes: a) les guidelines ne respectent pas les critères de fiabilité et de crédibilité, et sont donc vulnérables à des conflits d'intérêts; b) les guidelines emploient une méthodologie fiable et crédible, mais ne sont plus à jour et c) les



# thebmj Rapid Recommendations (Rapid Recs)

[www.bmj.com/rapid-recommendations](http://www.bmj.com/rapid-recommendations)



WARNING!



CLINICAL PRACTICE  
GUIDELINES  
WE CAN TRUST

TRUSTED BY MEDICAL  
PROFESSIONS



**GRADE**

Patient partners



**M** Authoring &  
Publication  
Platform

Infographics

Colorectal cancer screening

Prostate cancer screening

Screening

[www.bmj.com/rapid-recommendations](http://www.bmj.com/rapid-recommendations)

8 guidelines in 3 years

>30 recs

22 meta-analyses

Corticosteroids for treatment of sore throat

Primary Care

Antibiotics for uncomplicated skin abscesses

Antiretroviral therapy in pregnant women living with HIV

Dual vs single antiplatelet therapy

Drugs  
Acute care

Gastrointestinal bleeding prophylaxis

Corticosteroid therapy for sepsis

Altmetric\*



Thyroid hormones treatment for subclinical hypothyroidism

Oxygen therapy for acutely ill medical patients

Low intensity pulsed ultrasound (LIPUS) for bone healing

Subacromial decompression surgery for adults with shoulder pain

Arthroscopic surgery for degenerative knee arthritis and meniscal tears \*

Strong Recs Against

**smartermedicine**

Choosing Wisely Switzerland

De-implementation

Atraumatic (pencil-point) versus conventional needles for lumbar puncture

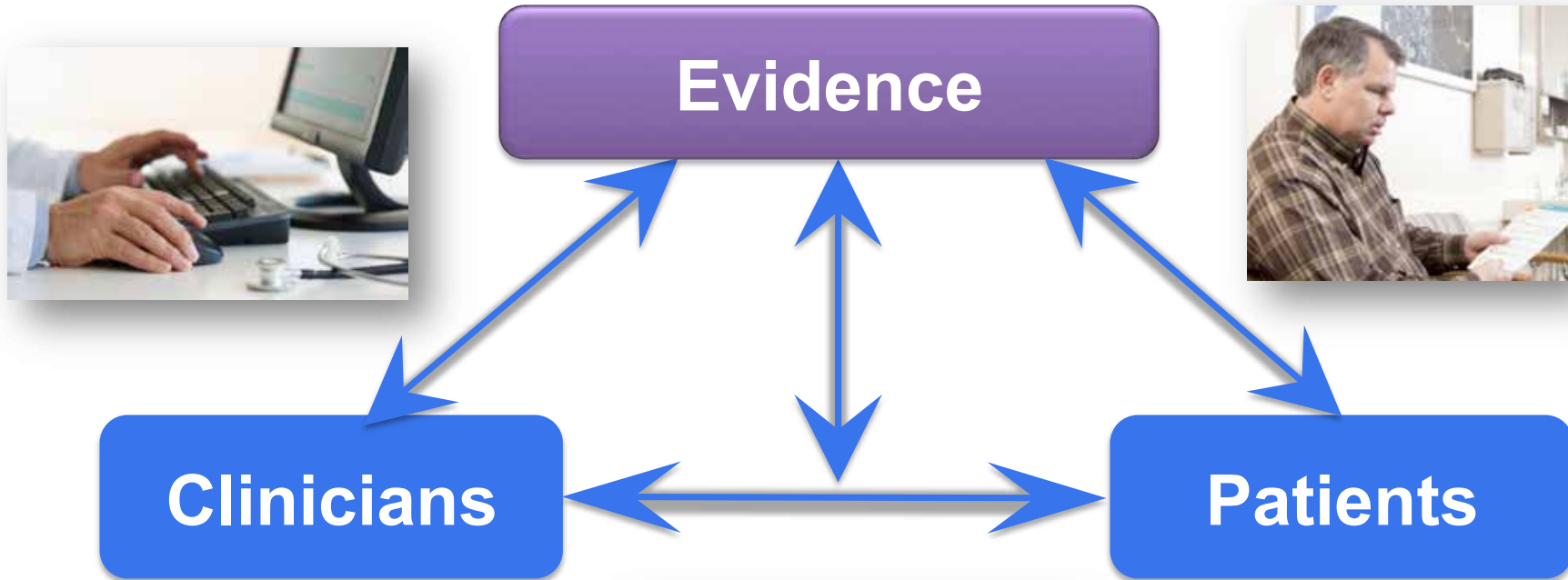
Devices

Transcatheter versus surgical aortic valve replacement

Patent foramen ovale closure or drug therapy for management of cryptogenic stroke

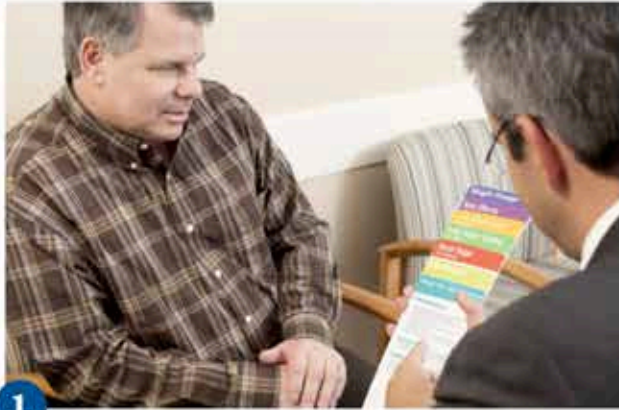
# AIDES DECISIONNELLES: *une aide?*

Patient Decision Aids



Consultation Decision Aids

# Consultation Decision Aids



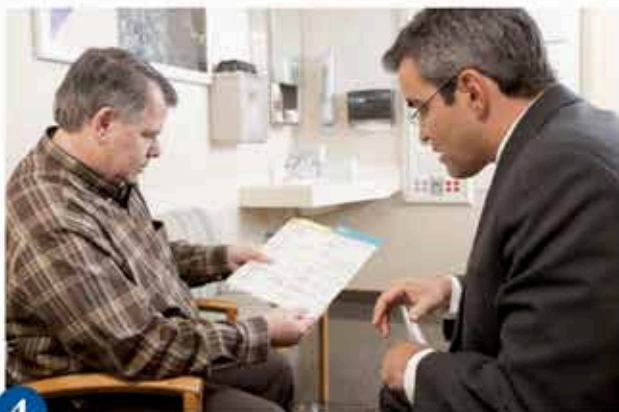
1 Clinician and patient discuss the "What You Should Know" card.



2 Clinician asks, "What issues concerning a medication to treat depression symptoms would you like to discuss first?" Patient selects first card.



3 Patient and clinician review this card.



4 Patient selects a second card and compares the two.



5 Medication options are discussed.



6 Medication choice is made— brochure given to patient to take home.

Blood Sugar

Daily Routine

Daily Sugar Testing

Low Blood Sugar

Weight Change

Side Effects

Costs

**Blood Sugar**

**Metformin** 1 - 2%

**Insulin** Unlimited %

**Pioglitazone** 1%

**Liraglutide/  
Exenatide** 0.5% - 1%

**Sulfonylureas** 1 - 2%

**Gliptins** 0.5 - 1%

**Daily Routine**

**Metformin**



**Insulin**



**Pioglitazone**



**Liraglutide / Exenatide**



Take in the hour before meals.

**Sulfonylureas**

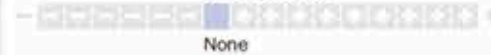


**Gliptins**



**Weight Change**

**Metformin**



None

**Insulin**



4 to 6 lb. gain

**Pioglitazone**



More than 2 to 6 lb. gain

**Liraglutide/Exenatide**



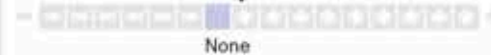
3 to 6 lb. loss

**Sulfonylureas**



2 to 3 lb. gain

**Gliptins**



None

January 9, 2017

# Clinicians' Expectations of the Benefits and Harms of Treatments, Screening, and Tests

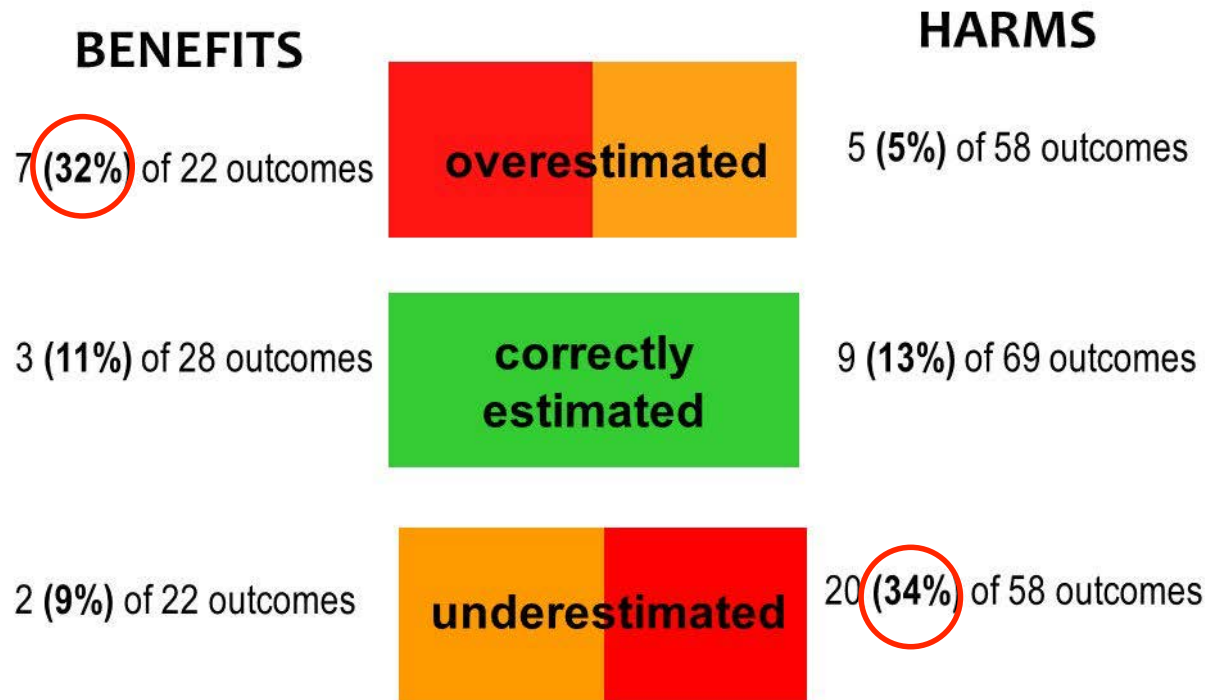
## A Systematic Review

Tammy C. Hoffmann, PhD<sup>1</sup>; Chris Del Mar, MD, FRACGP<sup>1</sup>

» [Author Affiliations](#)

*JAMA Intern Med.* Published online January 9, 2017. doi:10.1001/jamainternmed.2016.8254

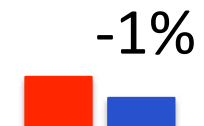
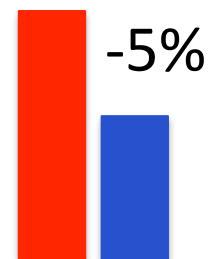
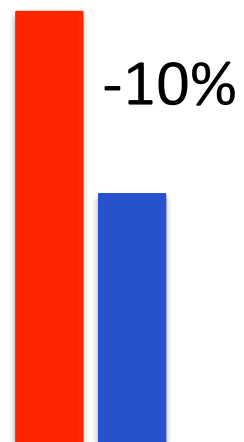
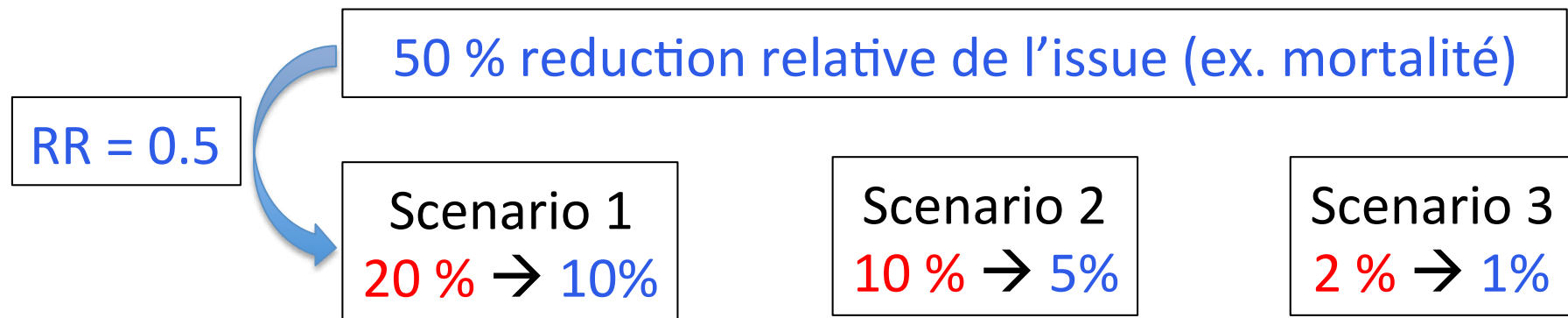
In this systematic review,  $\geq 50\%$  of clinicians...



Hoffmann TC, Del Mar CB. Clinicians' expectations of the benefits and harms of treatments, screening, and tests: a systematic review. *JAMA Int Med.* doi:10.1001/jamainternmed.2016.8254

# Absolute differences = NOT a subgroup effect

Traitement vs. Placebo



# Différence risque risque & possible effet de sous-groupe

RR = 0.14



RR = 0.5

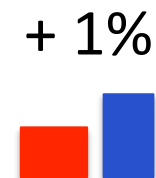
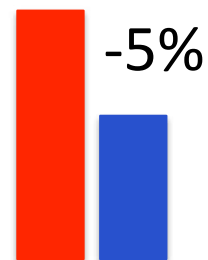
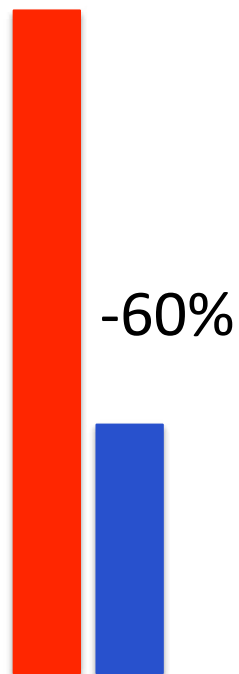


RR = 1.5

Scenario 1  
70 % → 10%

Scenario 2  
10 % → 5%

Scenario 3  
2 % → 3%





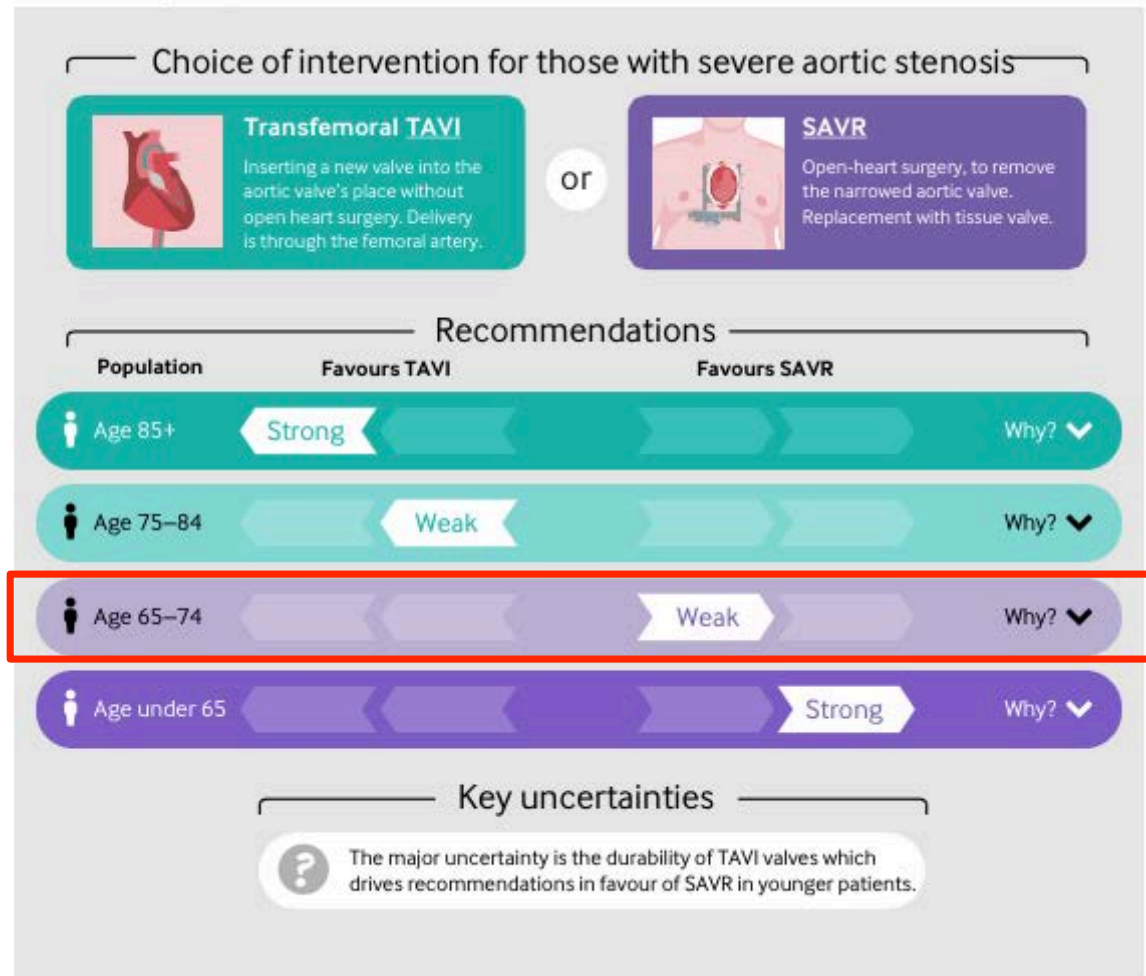
Practice

Rapid Recommendations

Transcatheter or surgical aortic valve replacement for patients with severe, symptomatic, aortic stenosis at low to intermediate surgical risk: a clinical practice guideline

BMJ 2016 ; 354 doi: <http://dx.doi.org/10.1136/bmj.i5085> (Published 28 September 2016)

Cite this as: *BMJ* 2016;354:i5085



## Patient and trial characteristics



**Is the evidence applicable to our patient?**





Age 65–74

Weak

Why?

### Comparison of benefits and harms

Favours transfemoral TAVI

Favours SAVR

Events per 1000 people– within 2 years

Quality of evidence

Deaths	73	19 fewer	92	★★★★	Moderate
Strokes	56	14 fewer	70	★★★★	Moderate
Aortic valve reinterventions	10	7 fewer	3	★★★★	Moderate
Pacemaker insertions	226	134 fewer	92	★★★★	Moderate
Life-threatening bleeds	161	252 fewer	413	★★★★★	High
New onset atrial fibrillation	134	178 fewer	312	★★★★★	High
Moderate / severe heart failure	87	18 fewer	69	★★★★	Moderate

Events per 1000 people– within 10 years

Aortic valve reinterventions	198	137 fewer	61	★★★★	Very low
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Length of hospital stay

Median days in hospital	8	4 fewer	12	★★★★	High
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See all 14 outcomes **MAGIC** app

#### Preferences and values

People who wish to avoid open-heart surgery are likely to favour TAVI. People who place more value on avoiding a second aortic valve placement are likely to choose surgery.

#### Resourcing

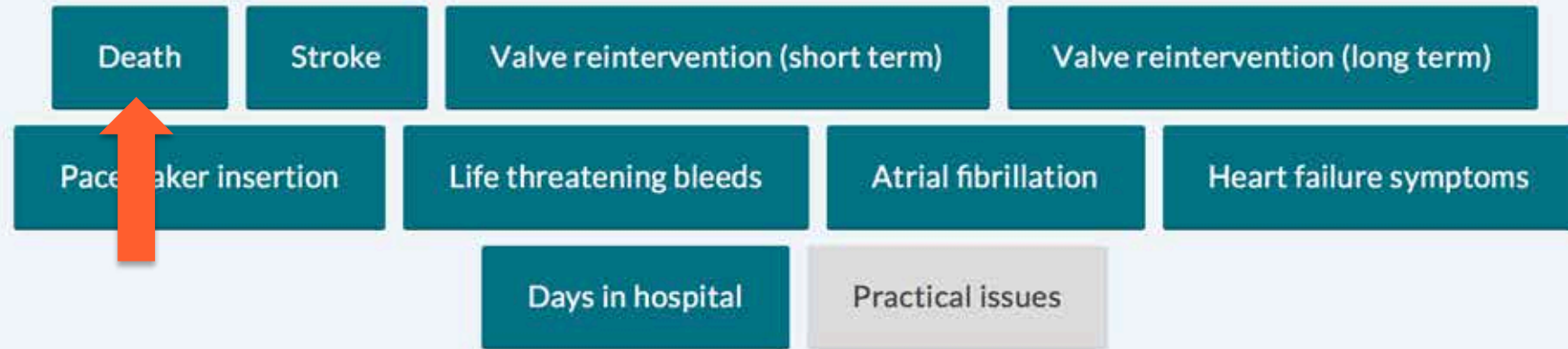
TAVI is likely to be a cost-effective alternative to SAVR for patients at low to moderate perioperative risk, but we have not identified any cost-effectiveness analyses to support this.

#### Other

Only centres with sufficient expertise and an established TAVI team with experienced general and interventional cardiologists and cardiac surgeons should offer TAVI.

# SHARE-IT Decision Aids

What aspect of your treatment would you like to discuss next?



# Death



Among a 1000 patients like you, with Transfemoral TAVI



**19 fewer**

2 years

SAVR

Transfemoral TAVI

**92**

per 1000

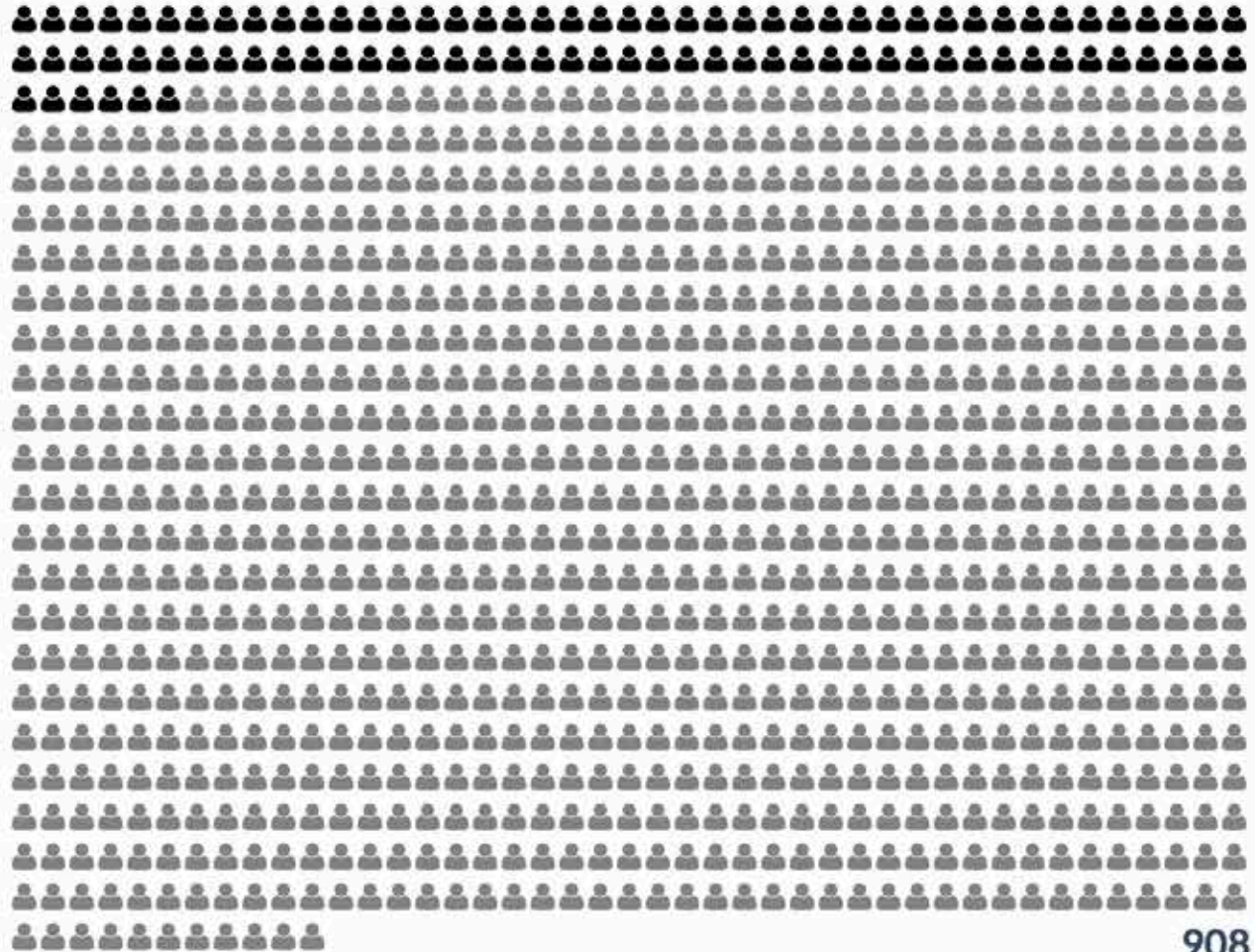
**73**

per 1000

Certainty



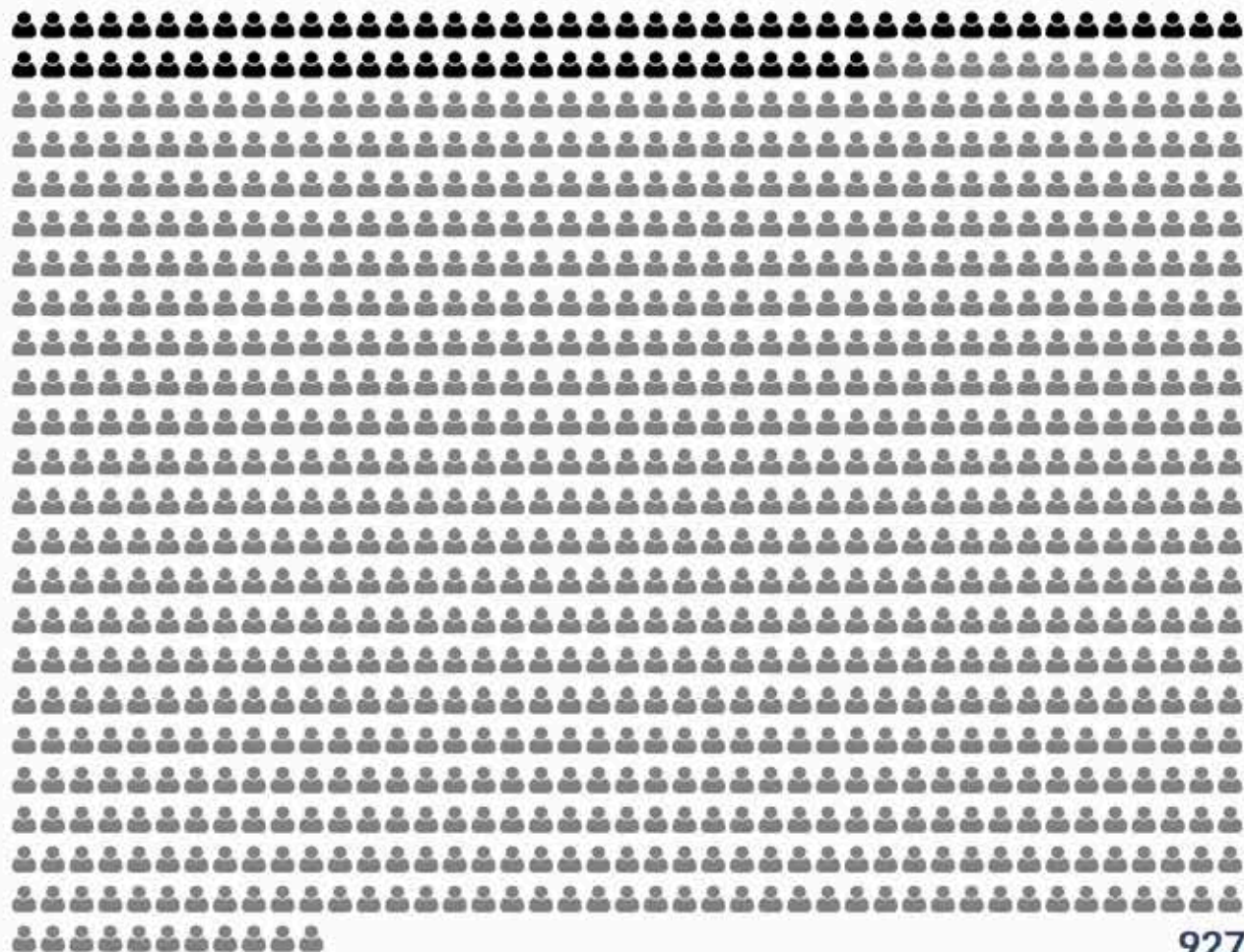
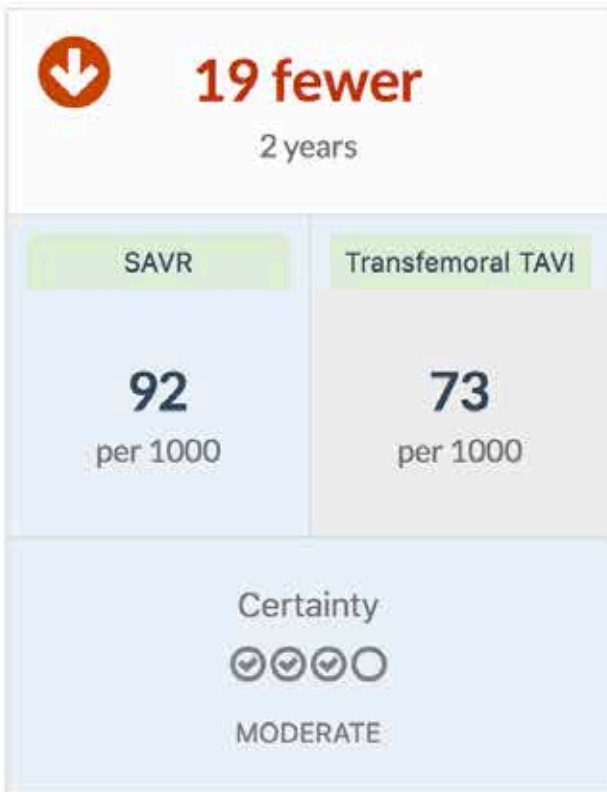
MODERATE



# Death



Among a 1000 patients like you, with Transfemoral TAVI



# Death

Among a 1000 patients like you, with Transfemoral TAVI



**19 fewer**

2 years

SAVR

Transfemoral TAVI

**92**

per 1000

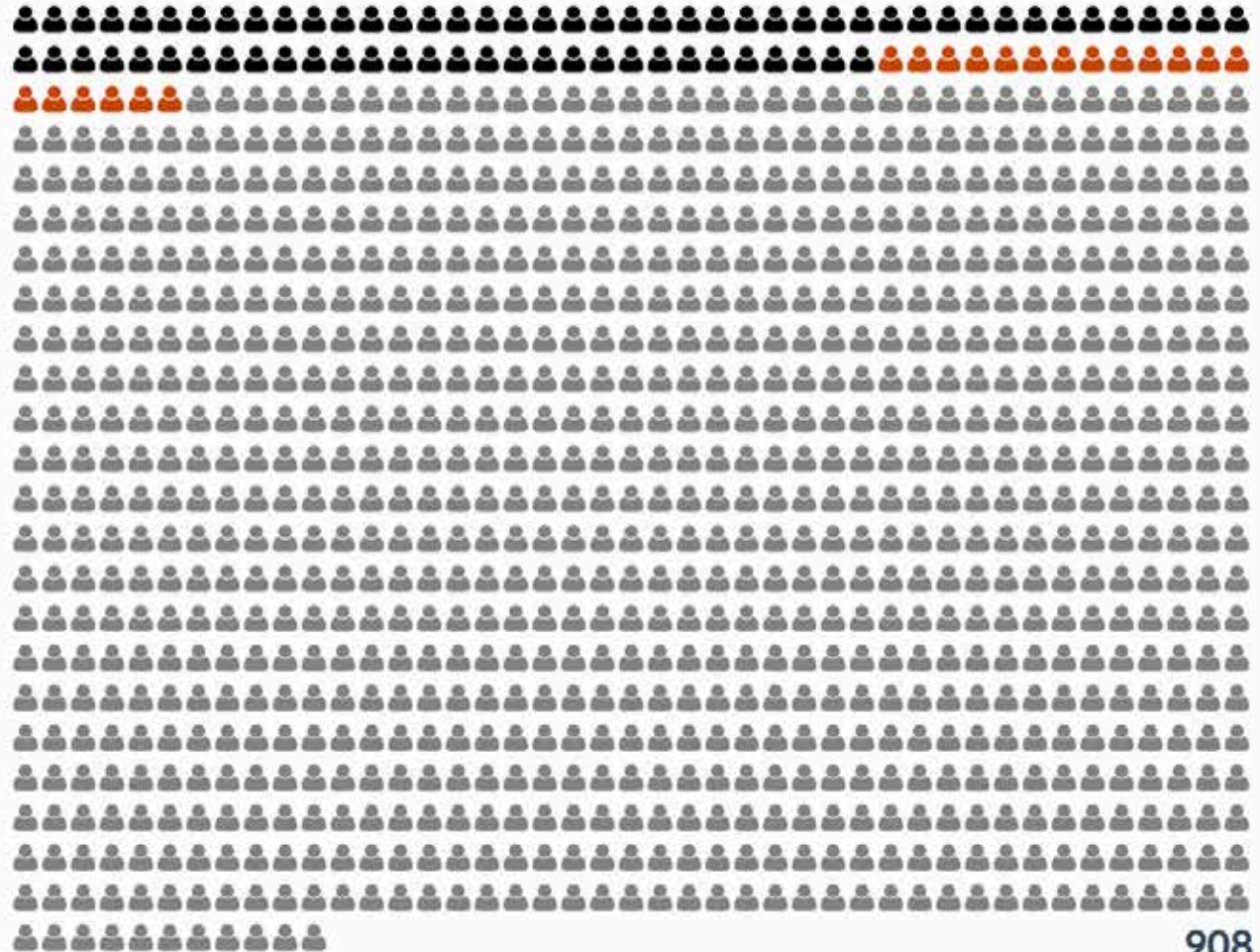
**73**

per 1000

Certainty

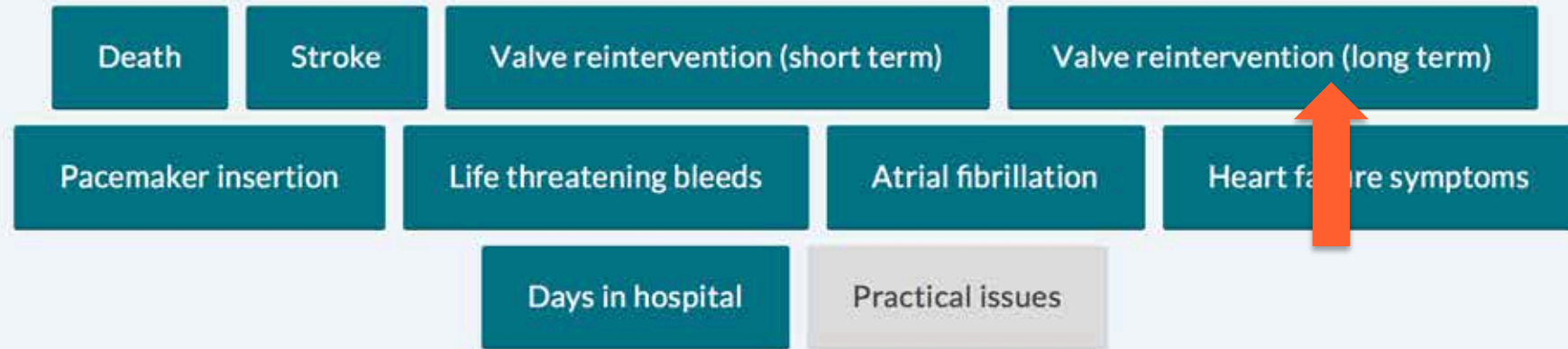


MODERATE



# SHARE-IT Decision Aids

What aspect of your treatment would you like to discuss next?





# Valve reintervention (long term)

Among a 1000 patients like you, with Transfemoral TAVI



**137 more**

10 years

SAVR

Transfemoral TAVI

**61**

per 1000

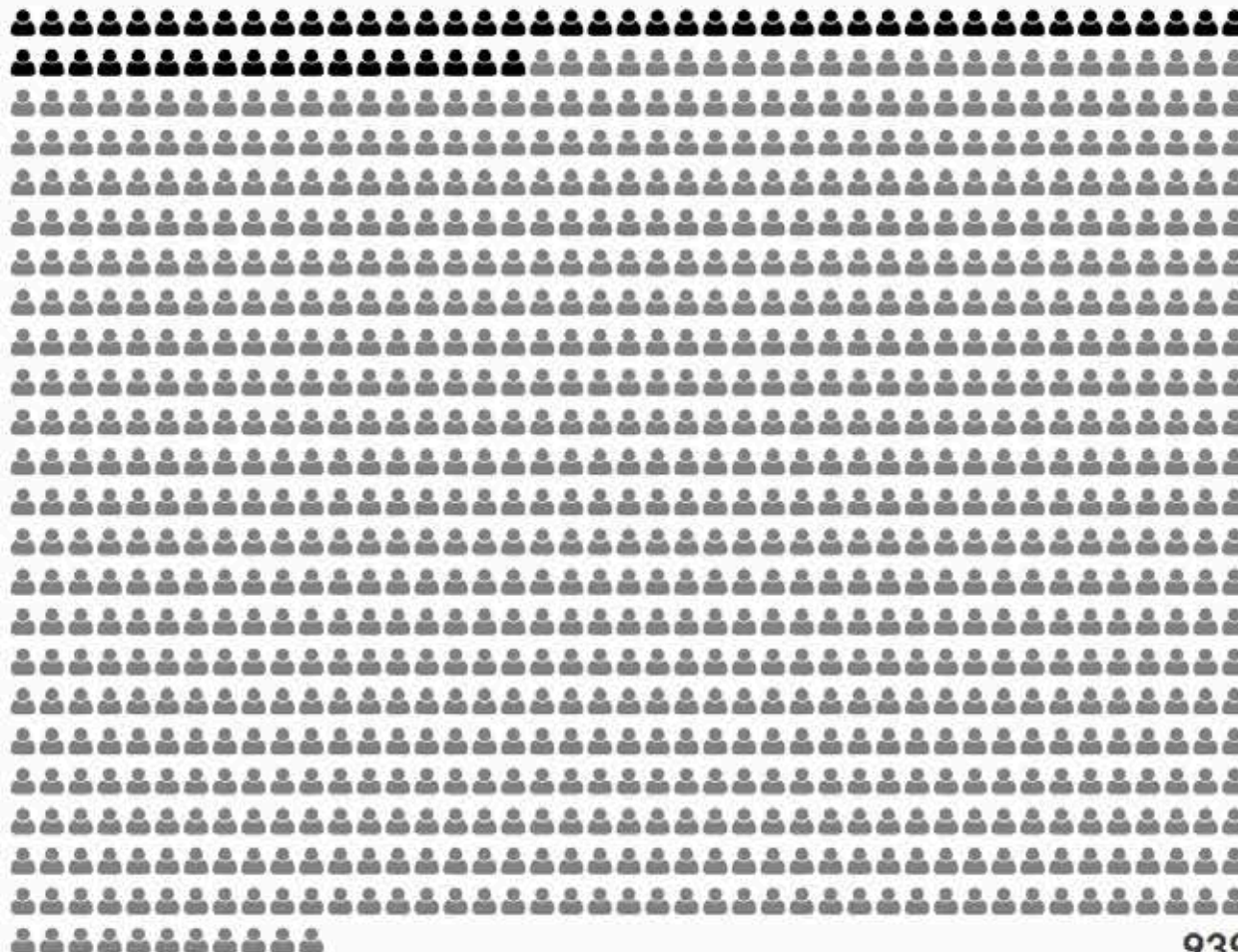
**198**

per 1000

Certainty



VERY LOW




939

# Valve reintervention (long term)

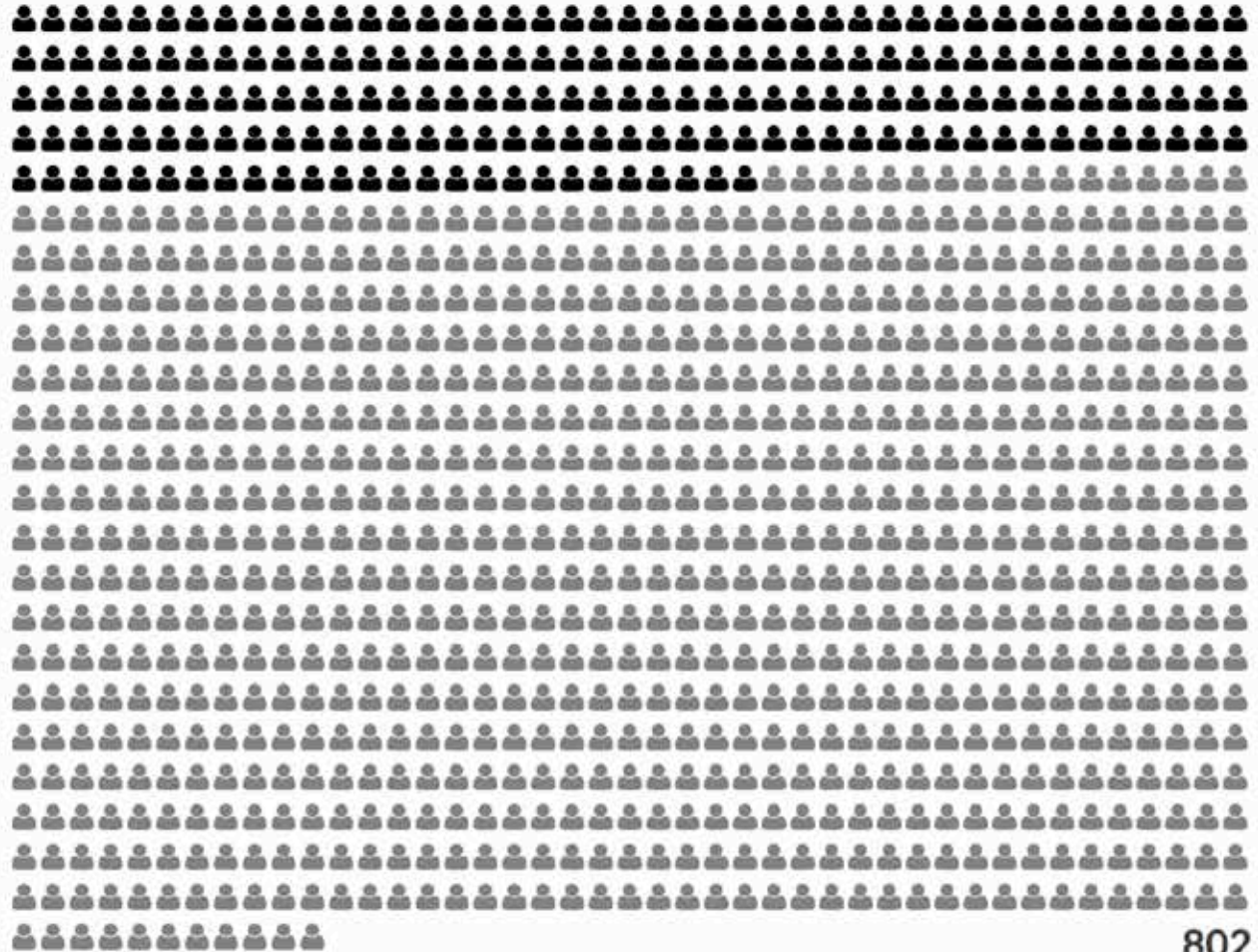


Among a 1000 patients like you, with Transfemoral TAVI

 **137 more**  
10 years

SAVR	Transfemoral TAVI
<b>61</b> per 1000	<b>198</b> per 1000


Certainty  
👍👎👎👎  
VERY LOW



# Valve reintervention (long term)



Among a 1000 patients like you, with Transfemoral TAVI

 **137 more**  
10 years

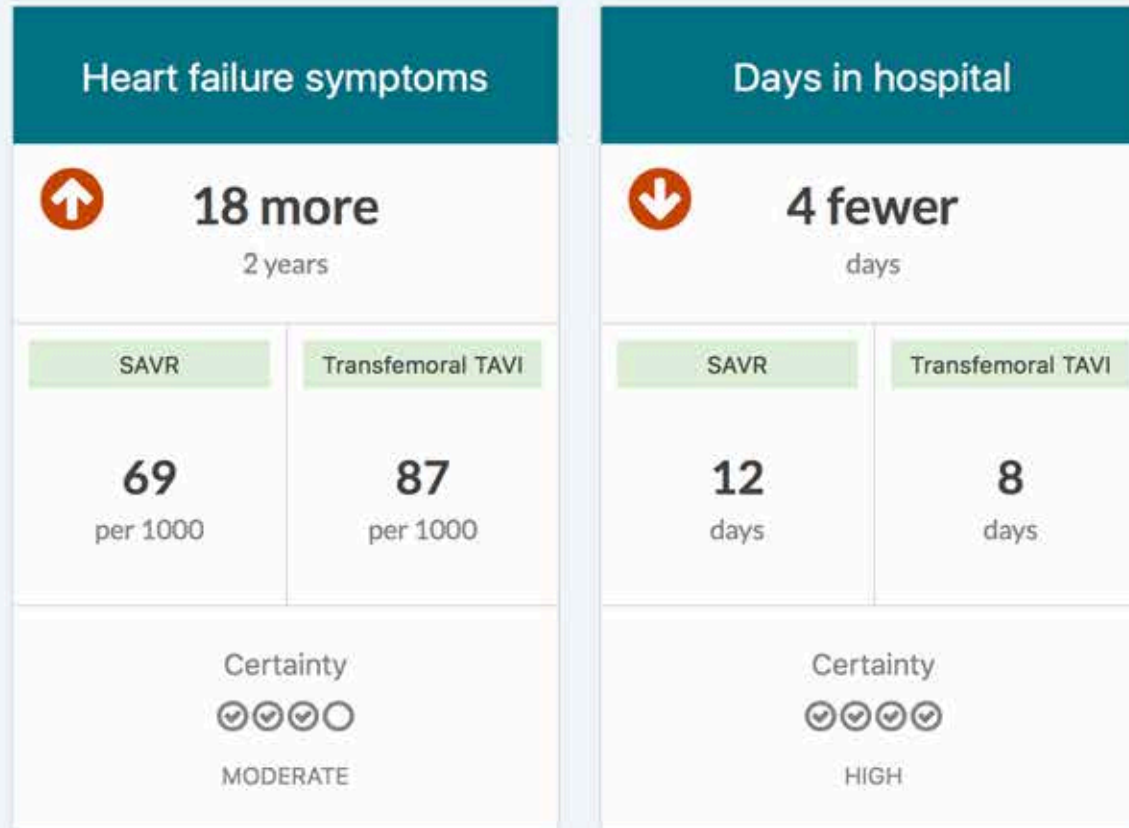
SAVR	Transfemoral TAVI
<b>61</b> per 1000	<b>198</b> per 1000

Certainty  
👍👎👎👎  
VERY LOW



802

Among a 1000 patients like you, on average with Transfemoral TAVI



- Death
- Stroke
- Valve reintervention (short term)
- Valve reintervention (long term)
- Pacemaker insertion
- Life threatening bleeds
- Atrial fibrillation
- Practical issues

# SHARE-IT Decision Aids

## Practical issues



Medication routine



Tests and visits



Procedure and device



Recovery and  
adaptation



Coordination of care



Adverse effects,  
interactions and  
antidote



Physical well-being



Emotional well-being



Pregnancy and  
nursing



Costs and access



Food and drinks



Exercise and  
activities



Social life and  
relationships



Work and education



Travel and driving

# SHARE-IT Decision Aids

The image shows a screenshot of the SHARE-IT Decision Aids interface. It features a grid of 15 categories, each with an icon and a text label. A modal window is open over the 'Work and education' category, providing detailed information about return-to-work timelines for different procedures.

**Work and education**

- with Transfemoral TAVI**  
-May be 2-6 weeks
- with SAVR**  
-May be 6-8 weeks
- with Both**  
-Time until return to work depends on speed of recovery

The grid of categories includes:

- Medication routine (syringe icon)
- Coordination of care (handshake icon)
- Adverse effects, interactions and antidote (pill icon)
- Physical well-being (Vital Signs icon)
- Emotional well-being (smiley face icon)
- Pregnancy and nursing (pregnant woman icon)
- Costs and access (stack of money icon)
- Food and drinks (fork and plate icon)
- Exercise and activities (person on bicycle icon)
- Social life and relationships (couple icon)
- Work and education (person with cart icon)
- Travel and driving (airplane icon)

# Questions posées par le panel des RapidRec

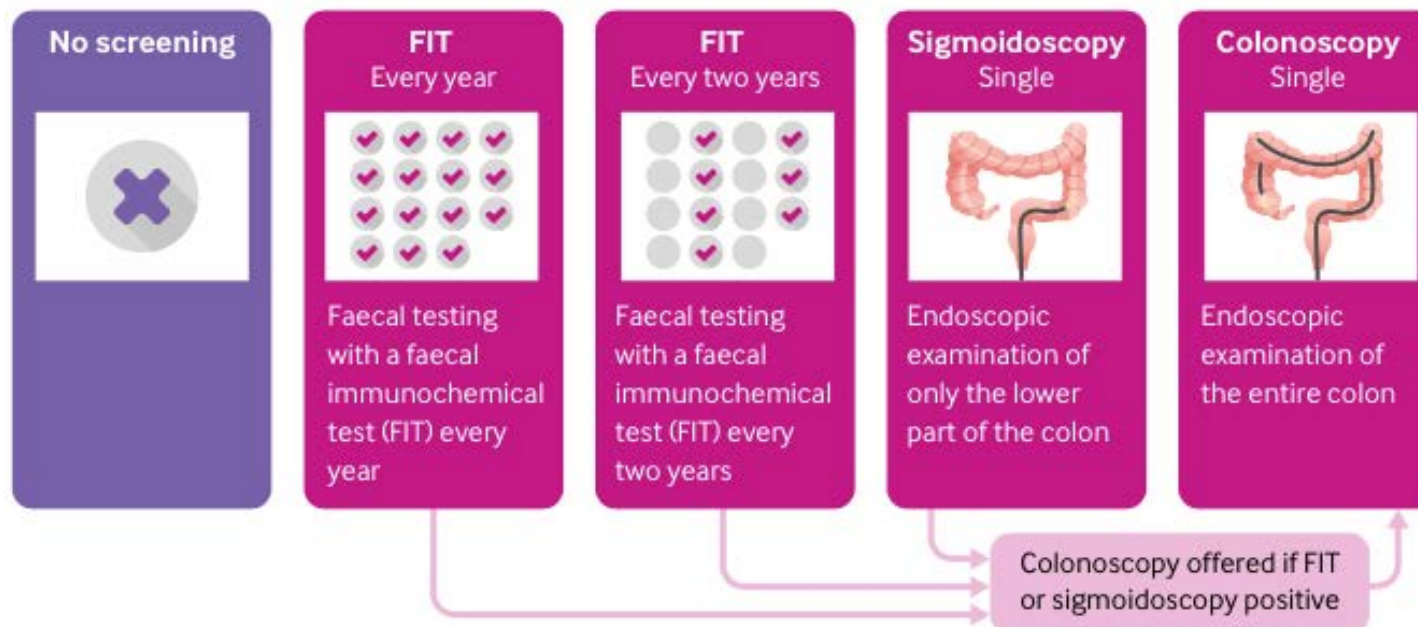
## ➤ Population d'intérêt

- Adultes en bonne santé
- Agés de 50 à 79 ans

## Exclusion:

- Déjà dépistés
- ATCD personnels de cancer ou de polypes
- ATCD familiaux de de cancer colorectal ou d'adénome
- Syndromes héréditaires (Syndrome de Lynch, Polypose Adénomateuse Familiale)
- MICI (Crohn, RCUH)
- Maladie intercurrente grave

## ➤ Interventions comparées



# Outcomes

Colorectal cancer incidence

Colorectal cancer mortality

Procedure related mortality

Gastrointestinal perforation or bleeding

Other gastrointestinal adverse events

Cardiovascular adverse events

Screening tests needed

One or more

Two or more colonoscopies

## Practical issues



Medical routine



Tests and visits



Procedure and device



Recovery and adaptation



Coordination of care



Adverse effects, interactions and antidote



Physical well-being



Emotional well-being



Pregnancy and nursing



Costs and access



Food and drinks



Exercise and activities



Social life and relationships



Work and education



Travel and driving

- Incidence cancer
- Mortalité
- Complications

## Considérations pratiques:

- Nb tests
- Anxiété
- Inconfort
- Absence travail
- ...



# Résumés d'évidence et aides décisionnelles

Stratifiés pour le risque individuel de cancer colorectal

## ✓ Screening options



Screening options should be chosen in shared decision making, based on a person's individual risk of cancer

Visit the MAGICapp multiple comparison tool to compare and choose options



### Evidence summaries

For a person with a 2% risk of colorectal cancer within 15 years



For a person with a 3% risk of colorectal cancer within 15 years



For a person with a 4% risk of colorectal cancer within 15 years



What aspect of screening would you like to explore next?

Colorectal cancer  
incidence

Colorectal cancer  
mortality

Procedure related  
mortality

Gastrointestinal  
perforation or bleeding

Other gastrointestinal  
adverse events

Cardiovascular adverse  
events

Screening tests needed

One or more  
colonoscopies needed

Two or more colonoscopies  
needed

Practical issues

Among a 1000 people

	No screening	FIT every two years	FIT every year	Sigmoidoscopy	Colonoscopy
Colorectal cancer incidence 15 years	30 per 1000	<b>1 fewer</b>	<b>4 fewer</b>	<b>8 fewer</b>	<b>10 fewer</b>
	certainty →	⊙⊙⊙⊙	⊙⊙⊙⊙	⊙⊙⊙⊙	⊙⊙⊙⊙
Colorectal cancer mortality 15 years	9 per 1000	<b>5 fewer</b>	<b>6 fewer</b>	<b>5 fewer</b>	<b>6 fewer</b>
	certainty →	⊙⊙⊙⊙	⊙⊙⊙⊙	⊙⊙⊙⊙	⊙⊙⊙⊙

How to use the multiple comparisons table



Among a 1000 people

	No screening	FIT every two years	FIT every year	Sigmoidoscopy	Colonoscopy
Colorectal cancer incidence 15 years	30 per 1000	<b>1 fewer</b>	<b>4 fewer</b>	<b>8 fewer</b>	<b>10 fewer</b>
	certainty →	☑☑○○	☑☑○○	☑☑○○	☑☑○○
Colorectal cancer mortality 15 years	9 per 1000	<b>5 fewer</b>	<b>6 fewer</b>	<b>5 fewer</b>	<b>6 fewer</b>
	certainty →	☑☑○○	☑☑○○	☑☑○○	☑☑○○
One or more colonoscopies needed 15 years	0 per 1000	<b>246 more</b>	<b>347 more</b>	<b>237 more</b>	<b>1000 more</b>
	certainty →	☑☑○○	☑☑○○	☑☑○○	☑☑☑☑
Two or more colonoscopies needed 15 years	0 per 1000	<b>83 more</b>	<b>101 more</b>	<b>86 more</b>	<b>105 more</b>
	certainty →	☑☑○○	☑☑○○	☑☑○○	☑☑○○

How to use the multiple comparisons table



Among a 1000 people

	No screening	FIT every two years	FIT every year	Sigmoidoscopy	Colonoscopy
Gastrointestinal perforation or bleeding 15 years	0 per 1000 certainty →	<b>1 more</b> ☑○○○	<b>1 more</b> ☑○○○	<b>1 more</b> ☑○○○	<b>2 more</b> ☑☑○○
Other gastrointestinal adverse events 15 years	0 per 1000 certainty →	<b>1 more</b> ☑○○○	<b>1 more</b> ☑○○○	<b>1 more</b> ☑○○○	<b>2 more</b> ☑☑○○
Procedure related mortality 15 years	0 per 1000 certainty →	No apparent difference ☑○○○	No apparent difference ☑○○○	No apparent difference ☑○○○	No apparent difference ☑☑○○
Cardiovascular adverse events 15 years	0 per 1000 certainty →	<b>1 more</b> ☑○○○	<b>1 more</b> ☑○○○	<b>1 more</b> ☑○○○	<b>1 more</b> ☑☑○○

How to use the multiple comparisons table



Among a 1000 people

Sigmoidoscopy  
FIT every year

	No screening	FIT every two years	Colonoscopy
Colorectal cancer incidence 15 years	30 per 1000 certainty →	<b>1 fewer</b> ⊙⊙○○	<b>10 fewer</b> ⊙⊙○○
Colorectal cancer mortality 15 years	9 per 1000 certainty →	<b>5 fewer</b> ⊙⊙○○	<b>6 fewer</b> ⊙⊙○○
One or more colonoscopies needed 15 years	0 per 1000 certainty →	<b>246 more</b> ⊙⊙○○	<b>1000 more</b> ⊙⊙⊙⊙
Two or more colonoscopies needed 15 years	0 per 1000 certainty →	<b>83 more</b> ⊙⊙○○	<b>105 more</b> ⊙⊙○○

How to use the multiple comparisons table

Procedure related mortality

Gastrointestinal perforation or bleeding

Other gastrointestinal adverse events

Cardiovascular adverse events

Screening tests needed

Practical issues

## Population



### Estimating risk

Understanding a person's risk of cancer can help to determine the benefits and harms of different screening tests for their individual situation.

We suggest using a tool such as the QCancer® calculator to estimate the risk of colorectal cancer for each person in the next 15 years. This calculates risk, based on:

Age Sex Ethnicity BMI

Smoking status Medical and family history



Link to QCancer® calculator

[qcancer.org/15yr/colorectal/](https://qcancer.org/15yr/colorectal/)

## Recommendations

Favours no screening

Strong <sup>i</sup>

Weak <sup>i</sup>

Weak <sup>i</sup>

Strong <sup>i</sup>

Favours screening



People with an estimated 15 year risk of colorectal cancer **below** 3%

We suggest no screening

Favours no screening

Strong <sup>i</sup>

Weak <sup>i</sup>

Weak <sup>i</sup>

Strong <sup>i</sup>

Favours screening



People with an estimated 15 year risk of colorectal cancer **above** 3%

We suggest screening with one of the four screening options

# Individualiser le risque ?

Risque à 15 ans

2%

3%

4%

	FIT every two years	Colonoscopy		FIT every two years	Colonoscopy		FIT every two years	Colonoscopy
Colorectal cancer incidence 15 years	19 per 1000	<b>6 fewer</b>		29 per 1000	<b>9 fewer</b>		38 per 1000	<b>12 fewer</b>
	certainty →	☺☺☺☺		certainty →	☺☺☺☺		certainty →	☺☺☺☺
Colorectal cancer mortality 15 years	3 per 1000	<b>1 fewer</b>		4 per 1000	<b>1 fewer</b>		7 per 1000	<b>2 fewer</b>
	certainty →	☺☺☺☺		certainty →	☺☺☺☺		certainty →	☺☺☺☺
One or more colonoscopies needed 15 years	203 per 1000	<b>797 more</b>		246 per 1000	<b>754 more</b>		288 per 1000	<b>712 more</b>
	certainty →	☺☺☺☺		certainty →	☺☺☺☺		certainty →	☺☺☺☺
Two or more colonoscopies needed 15 years	54 per 1000	<b>14 more</b>		83 per 1000	<b>22 more</b>		112 per 1000	<b>32 more</b>
	certainty →	☺☺☺☺		certainty →	☺☺☺☺		certainty →	☺☺☺☺

- ✓ Quel bénéfice requis pour souhaiter le dépistage? 3% ?
- ✓ FIT aussi raisonnable qu'une colonoscopie
- ✓ Décision probablement dominée par des considérations pratiques

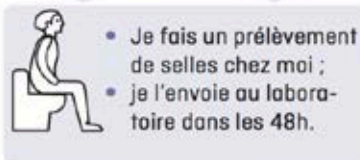


# Aspects pratiques dominant la décision

## J'ai choisi le test de recherche de sang occulte dans les selles (FIT)



+ Dexterité



Je reçois le résultat par la poste.

**Absence de sang dans les selles**  
**Résultat négatif**  
(93 cas sur 100)

- Je reçois automatiquement, deux ans plus tard, un bon pour obtenir le test directement dans une pharmacie participante ;
- entre deux dépistages, je consulte mon médecin en cas de symptômes.

**Présence de sang dans les selles**  
**Résultat positif**  
(7 cas sur 100)

- Je dois retourner chez mon médecin de famille\* : qui me prescrit une coloscopie pour déterminer l'origine du saignement ;
- si cette coloscopie est négative, je suis réinvité dix ans plus tard.

## J'ai choisi la coloscopie



+ Sédation?

+ Congé?

**Coloscopie normale**  
(70 cas sur 100)

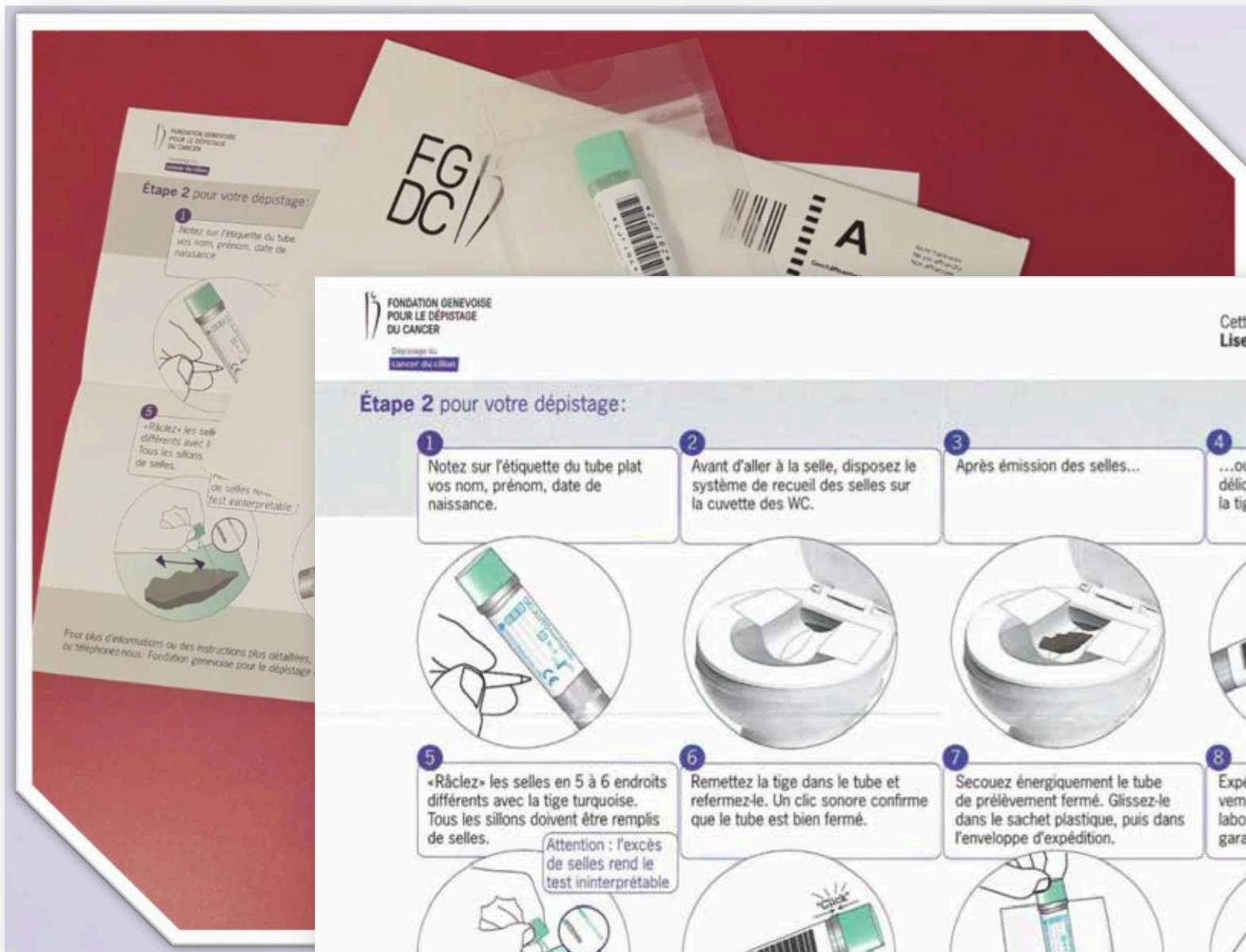
- Je suis réinvité automatiquement dix ans plus tard pour réaliser une nouvelle coloscopie ;
- entre deux dépistages, je consulte mon médecin en cas de symptômes.

**Coloscopie avec présence de polype ou cancer**  
(30 cas sur 100)

- Élimination des polypes ou mise en route d'un traitement si un cancer est confirmé ;
- je détermine les modalités de surveillance avec mon gastroentérologue.

Remboursement avec exemption de franchise:  
quote-part 4 CHF


Remboursement avec exemption de franchise:  
quote-part 80-120 CHF





Cette notice explique comment utiliser le test.  
**Lisez-la soigneusement !**


**Étape 2 pour votre dépistage:**


- 1** Notez sur l'étiquette du tube plat vos nom, prénom, date de naissance.


- 2** Avant d'aller à la selle, disposez le système de recueil des selles sur la cuvette des WC.



- 3** Après émission des selles...



- 4** ...ouvrez le tube plat en dévissant délicatement le bouchon turquoise; la tige de prélèvement apparaît.



- 5** «Râclez» les selles en 5 à 6 endroits différents avec la tige turquoise. Tous les sillons doivent être remplis de selles.  
*de selles non-test ininterprétable*



Attention : l'excès de selles rend le test ininterprétable
- 6** Remettez la tige dans le tube et refermez-le. Un clic sonore confirme que le tube est bien fermé.


- 7** Secouez énergiquement le tube de prélèvement fermé. Glissez-le dans le sachet plastique, puis dans l'enveloppe d'expédition.


- 8** Expédiez au plus vite le tube de prélèvement **ainsi que le formulaire** au laboratoire d'analyses. Un envoi rapide garantit la fiabilité du test.



Pour plus d'informations ou des instructions plus détaillées, veuillez contacter votre pharmacien, votre médecin, ou téléphonez-nous: Fondation genevoise pour le dépistage du cancer - 022 320 28 28

**Le résultat vous parviendra, ainsi qu'à votre médecin traitant, dans un délai de 8 jours.**

# 40%

Des patients rapportent des **contraintes**  
importantes ou insurmontables  
**liées au traitement**

NOVEMBER 2014 check re sec ip

SUNDAY MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY SATURDAY

2 30w, then Hospital higher ground 4 TBI CCC 5 Salvation Army started

Get rept of sent unan from cilia started  
 DAYLIGHT SAVING TIME ENDS  
 9 call  
 6:15 at G.A. / about Rent  
 10 6 day (com) Marlieser 8:30a  
 11 HCMC  
 9 AM Rheumatology  
 9 AM Marcel Emerge  
 10 6 day (com) Marlieser 8:30a  
 11 HCMC  
 9 AM Rheumatology  
 9 AM Marcel Emerge  
 16 17 HCMC DT-1PM  
 SLP-KRC-10A  
 speech therapy  
 18 HOME CEC  
 2 PM Mobic 7.5  
 pr. increasing with today  
 23 10-24 → 24 10-24 → 25 60 do 26 09  
 off CCG 8PM  
 30 work  
 2 AM Chang  
 5 AM Purple  
 8 AM CCG  
 10 AM CCG  
 Pen-A  
 10 AM tom

call & confirm Dr. Scheufler appointment tomorrow the 25th

8 PM NA @ Sid. Army  
 60 Emerge  
 612-321-3429

OCTOBER 2014

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

NOVEMBER 2014

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

DECEMBER 2014

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

JANUARY 2015

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

FEBRUARY 2015

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

call Aaron & to 60 Emerge  
 8 AM Dr. Cui & Salvation start add & depart

Pick-up of Tramadol Park CVJ

13 8:30 AM Disinfect  
 1 PM Emerge  
 Marcel  
 10 AM Jarke  
 20 House Authority

14 HCMC  
 1 PM Dr. bench  
 Purple Buildy  
 Susannah 10 AM

21 House  
 21 Charity  
 22 off  
 22 off

27 07 28 29

worked worked

THANKSGIVING DAY (US)  
 sen Don't call relay just say I am done

# TRAVAIL additionnel

Préparer la consultation

Voir les vidéos éducationnelles

Amener ces questions, être prêt à des nouvelles

Enregistrer l'entrevue ou prendre des notes

Revoir son dossier médical

Transmettre données via le portail internet

Self-measure, self-monitor, self-manage

Gérer les rendez-vous, ordonnances, factures

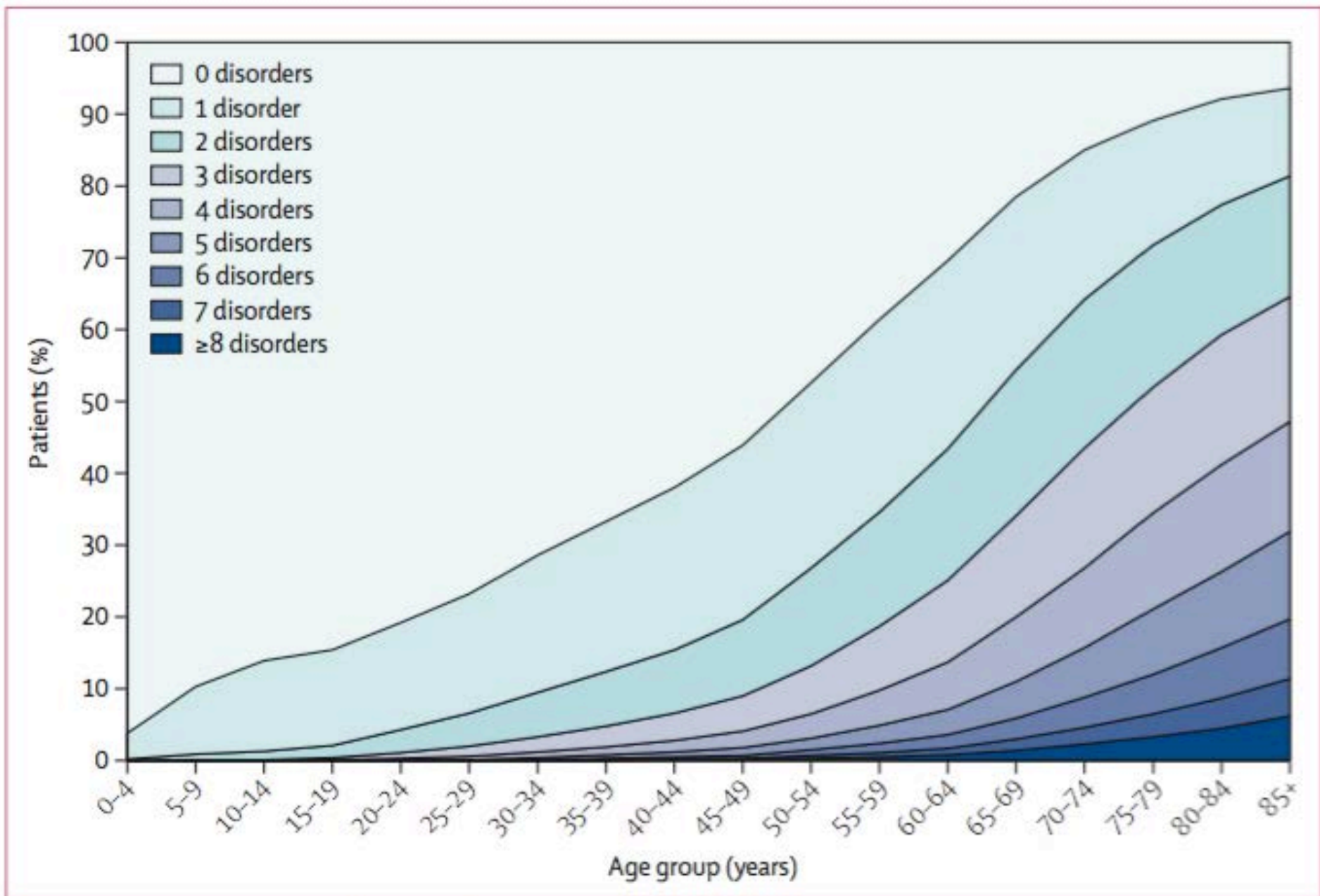
Garder ses proches informés

Ménager, prendre soins de ses proches

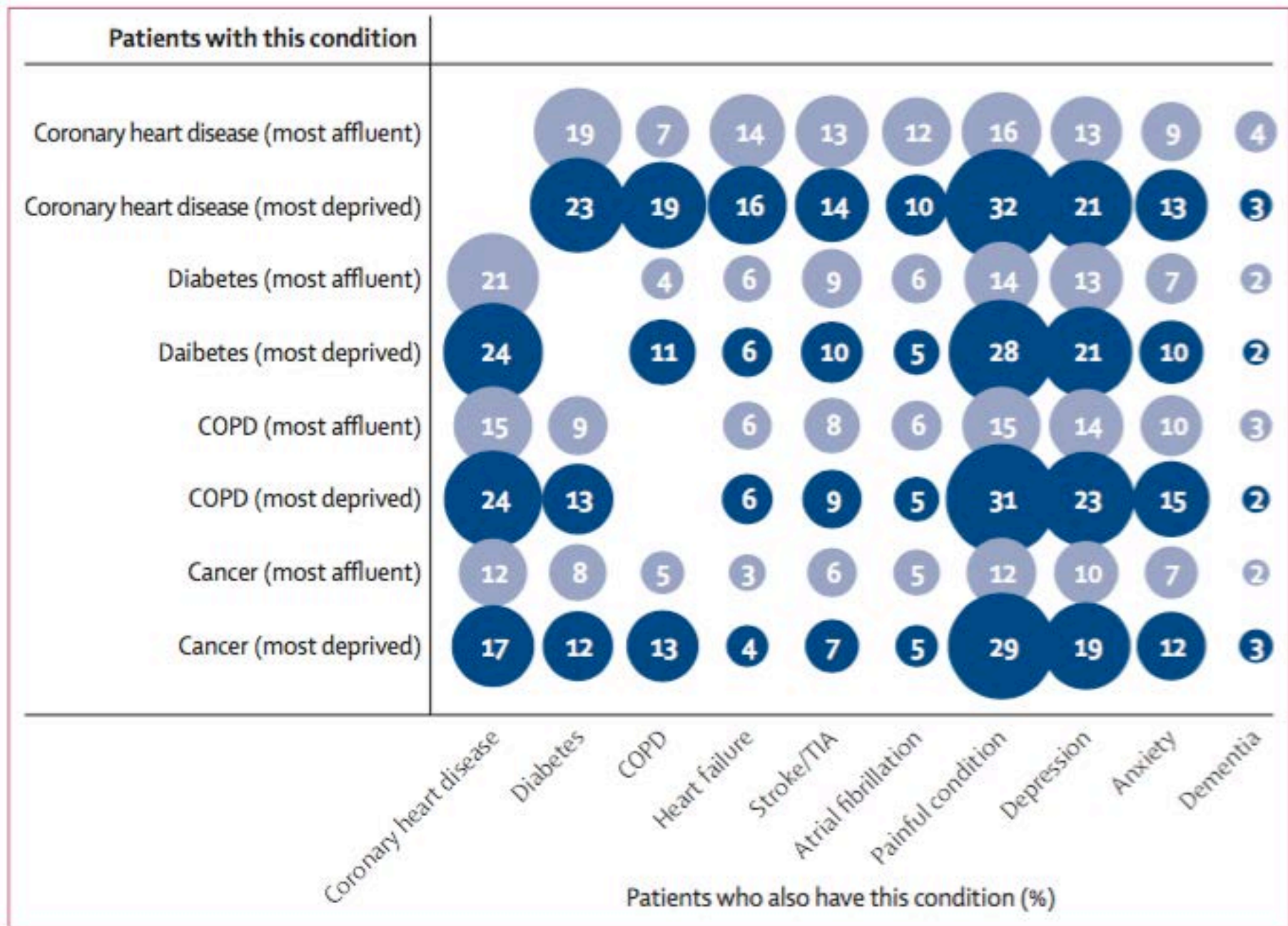
Partenariat patients, activisme

# NONCOMPLIANCE





**Figure 1: Number of chronic disorders by age-group**



**Figure 4: Selected comorbidities in people with four common, important disorders in the most affluent and most deprived deciles**

COPD=chronic obstructive pulmonary disease. TIA=transient ischaemic attack.



# Le travail de patient

## Charge

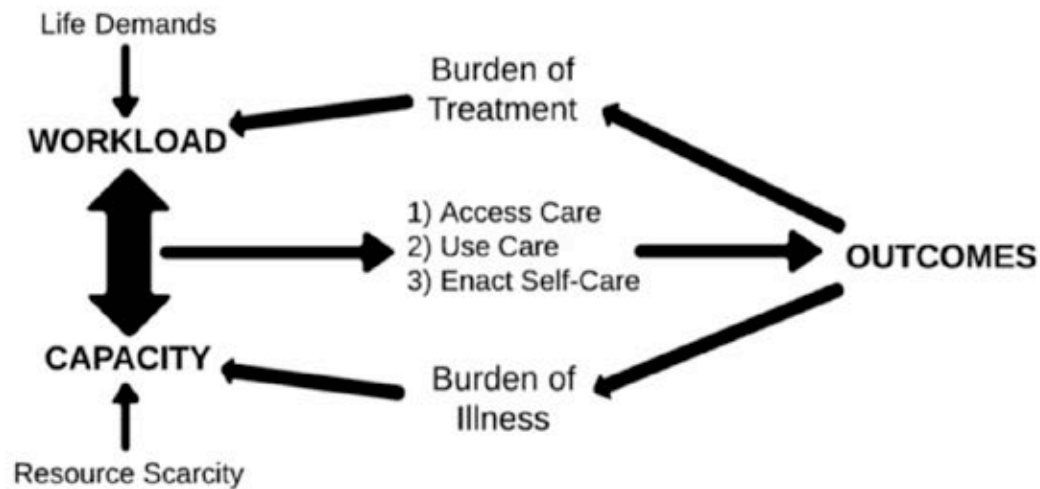


Figure 1. The cumulative complexity model.

## Capacité



Soins < Besoins



Besoins > Soins



Sous-utilisation

Sur-utilisation

**Strong  
Recommendations**

Soins appropriés

Soins < Souhaitis  
←

Soins > Souhaitis  
→

Sous-traitement

Sur-traitement

**Weak  
Recmendations**

Desirable  
care

# Evidence-Based Medicine

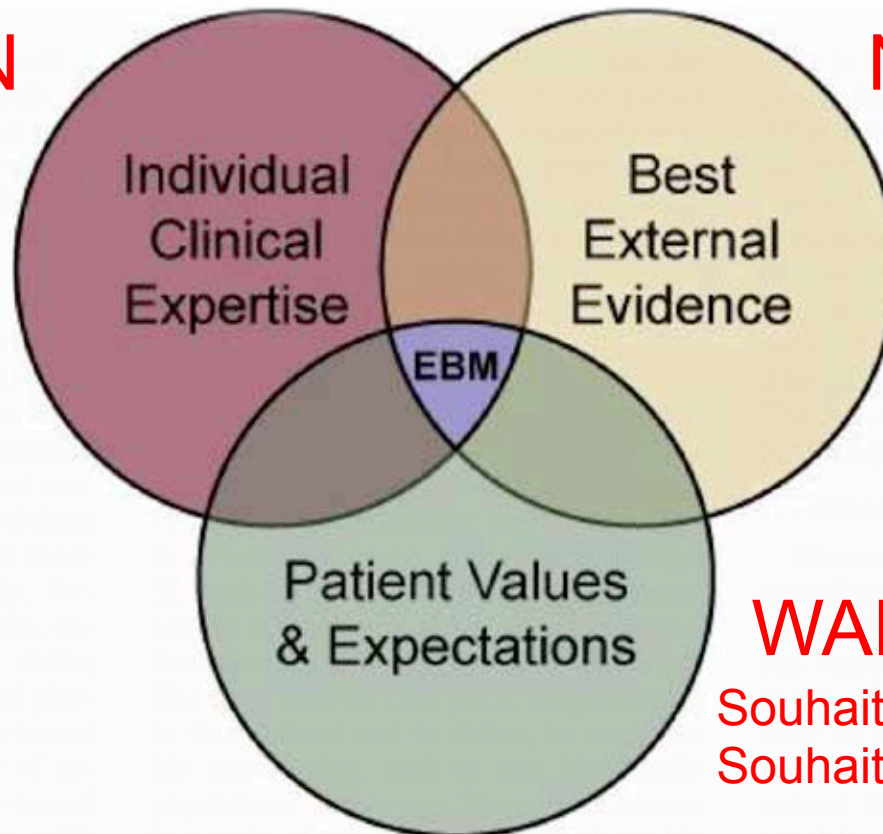
## A New Approach to Teaching the Practice of Medicine

Evidence-Based Medicine Working Group

A NEW paradigm is emerging in medicine, one that de-emphasizes rote clinical expertise in favor of a more rational, evidence-based approach to clinical decision-making. This new paradigm is based on the systematic examination of the medical literature to find the best evidence to guide clinical practice. It requires new teaching methods, including effective use of the applied evidence evaluation.

An important component of this paradigm is the identification of problems in the practice of medicine. Struc- tural academic programs have voted to recruit more physicians with evidence-based medicine; and providing faculty with feedback on their performance as role models and teachers of evidence-based medicine. The influence of evidence-based medicine on clinical practice and medical education is increasing.

**CAN**  
Faisable?



**NEED**  
Approprié?

**WANT**  
Souhaitable?  
Souhaité?

In a state of vague trepidation about his risk of subsequent seizure.

### The Way of the Future

The resident asks herself whether she knows the prognosis of a first seizure

tenable, the paradigm is challenged and replaced by a new way of looking at the world. Medical practice is changing, and the change, which involves using the medical literature more effectively in guiding medical practice, is profound.

, and at 3 and 60%. 18 months likely be this infor- with a rec- is medica- larly, and medication 18 months. ar idea of

scientific ng at the oblems that d and the that may defects in late to the no longer