Attribute	TQIP	BTF	LABIC	Concussion	Ontario
Clinical population	In-hospital management Severe TBI	All adult & paediatric TBI Three separate guidelines - Prehospital severe TBI - Adult in-hospital severe - Paed in-hospital severe - (*Surgical guidelines*)		Sports-related concussion All ages	Paediatric (5-18 years) Concussion (all causes) mTBI (18+ years) all causes
Guideline process	Expert consensus following evaluation of literature Bibliography, rather than referenced statements	IOM Template Independent sys review Methodology support Clinical involvement and signoff		Delphi for questions 12 SRs (PRISMA) 202 abstracts 2 day open meeting + - One day: Closed panel - Half day: New metrics	ADAPTE cycle Systematic review (independent) Team meeting AGREE for approval
Target audience	Hospital physicians	Hospital Clinicians EMS Director/Practitioner QI personnel		Summary of evidence Physicians/health care professionals	Primary care providers Schools and coaches Parents
Updates		Historically 5-10 yearly Shift to living guidelines		4 yearly	4 Yearly
Access	Access at TQIP site: https://www.facs.org/quality-programs/trauma/tqip/best-practice	BTF Website (+ AHRQ) https://www.braintrauma.org/coma/guidelines		Special edition of BJSM Free access- summary: http://dx.doi.org/10.1136/bjsports-2017-097699	http://onf.org/documents/guidelines-diagnosing-and-managing-pediatric-concussion http://onf.org/documents/guidelines-for-concussion-mtbi-persistent-symptoms-second-edition

Guideline development: Integrating EBM & MBE - 1

- Evidence when we have it
  - Must be current = LSR
  - Rigorously compiled and evaluated
  - Minimise duplication of effort and publication overload
    - POSPERO registers systematic review protocols
    - However, no registry of completed SRs (Cochrane Collaboration registers Cochrane SRs only)
    - No Journal requirement to quote past SRs on same topic
    - Need SR registry in TBI: support Journals/Reviewers in evaluating manuscripts
    - Any substantive new SR should cite last SR on same/related topic at submission
    - And specify what's new: *evidence gathering, integration, conceptual synthesis, clinical inference*

Guideline development: Integrating EBM & MBE - 2

- Best judgment from experience when we don't have evidence
  - Must integrate wide expertise
    - *nemo solus satis sapit* (EBIC credo: no one knows enough alone)
  - Must take account of context
    - LMIC *vs.* HIC (or better: resource rich *vs.* resource limited)
  - So, unlike evidence synthesis:
    - May require duplication to allow diversity between settings
    - Can vary in detail (sometimes substantially)
    - Can be based on rational physiology

Guideline development: Integrating EBM & MBE - 3

Common Guideline Elements (CGE) as a concept

- Must support non-expert clinical practice – even if evidence incomplete
- Must incorporate **current** evidence and experience: **Living guidelines**
- However, must clearly differentiate
  - Evidence based guidelines (Evidence Based Medicine)
  - Expert recommendations (Medicine Based Evidence)

Continue to seek objective evidence (RCT, CER)

Recommendations

- Maintain a Registry of SRs (with a 10 year [?] lifetime)
- Set up and maintain an LSR process **WHO?**
- Maintain a Registry of Guidelines
- Recognise the reality of context/resource limitation
- Implementation using frameworks (publication alone is not enough)
- Cost benefit ratio
- Feasibility
- Patient centeredness
- Personnel resource?