ADAPTING GUIDELINES TO PRACTICE

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INTRODUCTION

Developing a clinical practice guideline takes time and resources. A special committee comprising representatives across all disciplines get together to prepare a set of practice guidelines. Opinions from members of the committee are taken into account during the formation of the guideline.

It may take a year or two from inception to the production form in the doctor's office. An extensive literature search is first conducted on the topic to be reviewed; next, these are graded and a level of evidence are assigned to each of them. Evidence based statements, derived from these literature search, form the background of the recommendations on the guideline to be produced. Recommendations on evaluation and treatment are also derived from this evidence.

How useful will this set of guideline be at the point of care in the busy Family Physician's office? It depends. Most guidelines deal with the biomedical aspects of the disease. Yet today we all know that the psychosocial and environment play very important role in the formation and management of the disease. These aspects are often deficient in many of today's clinical practice guidelines. Hopefully, with involvement of family physicians (FP) in the practice guideline committees, the deficient aspects will be addressed.

ADAPTING GUIDELINES AT POINT OF CARE

In practice, there is a need to adapt guidelines at the point of care. Thus, the Global Initiative for Chronic Obstructive Lung Disease (GOLD)[1] based treatment of the disease on the severity of the disease. In the latest version in 2005, severity is graded from stage I to stage IV. These stages are based on spirometry readings with arbitrary cut points of FEV_1.

The Family Physician (FP) sees a patient at various snapshots of the natural history of the disease. The available COPD guidelines provide evidence-based guide for the general management of the disease. It is for the FP to adapt the guidelines into the care of the patient who may present at various stages of the disease[2].

Let us illustrate this adaptation with a typical COPD patient. We know that COPD is a progressive disease. The strategy is to slow down the speed of progression.

During the first 20 years of the disease, productive cough is likely the only symptom. The patient will be in his early 40s or late 30s. He may have been smoking some 10- 20 sticks of cigarettes per day in all these years.

He will be seeing the primary care physician sporadically for the occasional respiratory tract symptoms. He is likely to have normal spirometry readings and will not have the breathlessness of established COPD at all. At this stage of his life, it is important for the primary care physician to focus on prevention. Every encounter should be concentrated on removing the causative agents, which usually include smoking. The patient should be encouraged to quit smoking and adopt a healthy lifestyle.

For the next twenty years, if the patient continues to smoke, he will see his primary care physician for frequent exacerbations and chronic cough, and towards the end of that time, dyspnoea begins to set in. At this stage, the primary care physician will have to treat patient symptomatically as these symptoms have become troublesome. Treatment and care will have to be continuing and not sporadic. Besides smoking cessation, the FP will now need to look at preventing acute exacerbation and also treating these symptoms early and effectively[3]. The patient may reach a stage where he needs regular medications such as a beta-agonist and an anticholinergic via metered dose inhalations. At this stage, the patient will benefit from annual influenza vaccination and pneumoccocal vaccination.

At a later stage, the patient will need pulmonary rehabilitation. He may lose weight and skeletal mass through poor nutrition, inactivity and hypoxia from respiratory failure. This is also the stage of frequent hospitalisations for acute exacerbations. Home oxygen therapy may need to be considered if hypoxia becomes a problem. The primary care physician looking after the patient at this stage will need to look at pulmonary rehabilitation through a series of graded exercises, and some resistance training may be included as tasks of daily living. Eventually, death occurs through respiratory failure, cancer, pneumonia or pulmonary embolism, and the natural history of COPD reaches its conclusion. The FP would have seen a lot of him in his struggles.

CONCLUSIONS

Primary care physicians looking after patients with chronic respiratory problems, such as asthma and COPD, need to be aware that continuing care is needed. Care cannot be sporadic. It has to be as continuous as any other chronic disease care, such as diabetes and hypertension. The clinical practice guidelines are merely guides, thus the FP has to fill in the tasks in between what is stated in the guidelines. Above all, there is a need to treat the patient holistically. Adapt the guidelines to suit the patient's needs and stage of disease.

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