Where Are We Headed: The Value of Updating Guidelines

Several years ago Shekelle et al. subtitled their report examining the AHRQ guidelines, “How quickly do guidelines become outdated?” This review asked the developers of 17 guidelines whether those that had been available for several years and not updated were still valid. The findings were somewhat startling: 7 required major update and 6 needed minor revision. Only 3 were considered still valid as written. Half the guidelines were invalid at 5.6 years, and the authors recommended that clinical practice guidelines undergo review at least every 3 years.

The NCCN guidelines are updated annually. Of course, no one is surprised that the tremendous advances in oncology drug development lead to major new recommendations in the management of many cancers each year. Thanks to the dedication of the NCCN panels, major new advances may be inserted into the guidelines almost immediately. The goal is ensuring that new interventions that benefit patients, especially those that impact survival, are incorporated into the corpus of oncologic knowledge with no delay. The rapid revision of the breast cancer guidelines to incorporate trastuzumab after the ASCO presentations is a prime example of this nimbleness.

The myelodysplastic syndromes (MDS) guidelines in this issue illustrate an even more profound example of the need to update guidelines regularly and frequently. As stated in the manuscript, MDS represent “myeloid clonal hemopathies with relative heterogeneous spectrums of [clinical] presentation.” Several years ago, as this guideline was being developed, the heterogeneity represented by the FAB variants was categorized into groups according to the International Prognostic Scoring System. This grouping still included substantial clinical variability, so the spectrum of treatment recommendations for each group remained broad and depended on individual case assessment, with recommendations ranging from watchful waiting to high-dose chemotherapy.

This year’s MDS guideline shows the impact of incremental knowledge changing the basic approach to the disease. Although individual management and multiple options still exist, there appears to be a more systematic approach to management. The CALGB randomized study of 5-azacytidine has established this as a modality appropriate for several of the clinical manifestations of the syndrome. The clinician using the guideline now is directed to a specific recommendation rather than to a list of options.

Where are we headed? An inspection of this new algorithm shows that it is starting to comprise refined pathways based on new translational research findings. As a prime example, a special pathway now singles out anemic patients with erythropoietin levels greater than 500 mU/mL. 5-Azacytidine is recommended for those who are HLADR-15 negative, and antithymocyte globulin or cyclosporine is recommended for those who are HLADR-15 positive. This undoubtedly reflects the MDS guidelines of the future: laboratory assessments at the genetic level will identify clinically discreet groups for whom specialized interventions are appropriate. Rather than having to rely solely on clinical judgment, oncologists will make more scientific decisions based on re-conceptualization of the disease, which is then built into the guideline. Persistent and committed updating of clinical practice guidelines is a sine qua non for applying sound science to the complex problems our patients present.

References