Fontes de informação secundária para apoio à decisão clínica: selecção e usos

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Esquema da introdução

1. Perspectiva clínica de apoio à decisão
2. Contextos em que é necessária informação científica
3. As necessidades em informação para uma prática clínica baseada na evidência
4. Temos problemas de translação do conhecimento?
5. O que é um recurso de “melhor evidência disponível”?
6. Onde se encontra a melhor evidência disponível?
7. Conclusões.

Contextos em que é necessária informação científica

- Ensino (pré, pós-graduado e continuado)
- Investigação clínica
- Actualização dos conhecimentos médicos
- *Assistência directa aos doentes.*

As necessidades em informação na prática clínica

- Tratamento e prevenção
- Diagnóstico
- Prognóstico e predição clínica
- Causalidade/etiologia
- Melhoria da qualidade
- Custo-efectividade
- HOR, HSR
- ….

Tipos de questões clínicas

Evolução clínica →

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Brian Haynes
McMaster University
Canada

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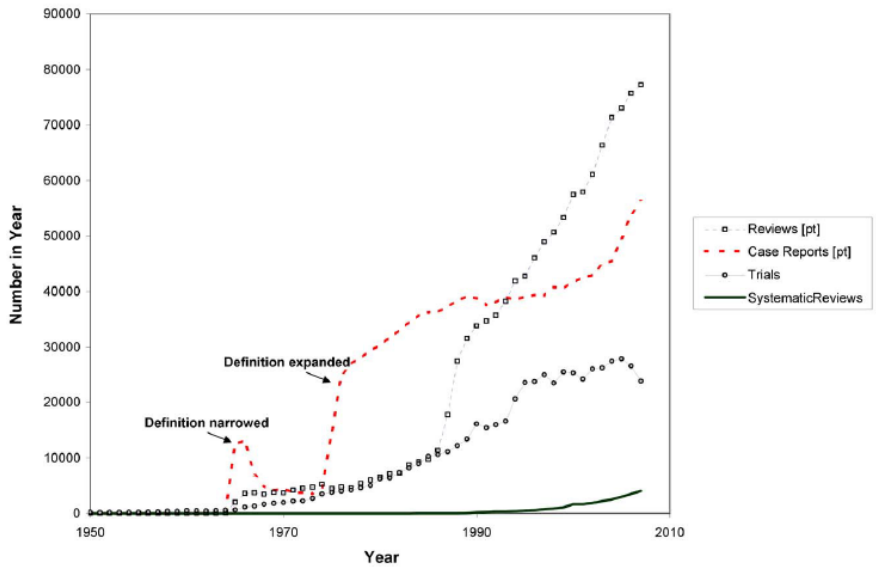
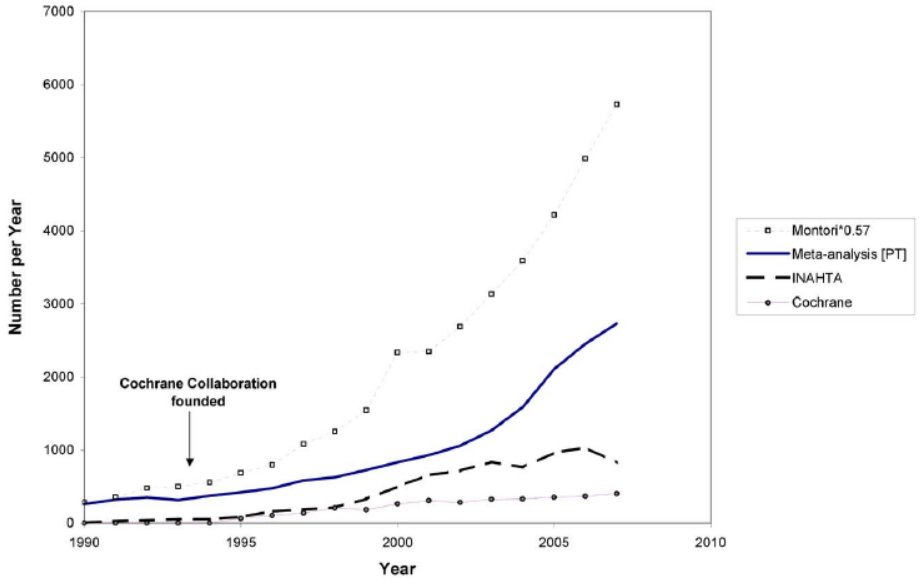
Seventy-Five Trials and Eleven Systematic Reviews a Day: How Will We Ever Keep Up?

Hilda Bastian[1]*, Paul Glasziou[2], Iain Chalmers[3]

1 German Institute for Quality and Efficiency in Health Care (IQWiG), Cologne, Germany, **2** Centre for Research in Evidence-Based Practice, Faculty of Health Sciences, Bond University, Gold Coast, Australia, **3** James Lind Library, James Lind Initiative, Oxford, United Kingdom



The rise in non-systematic reviews, case reports, trials, and systematic reviews, 1950 to 2007



The number of systematic reviews in health care, 1990 to 2007

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The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Selective Publication of Antidepressant Trials and Its Influence on Apparent Efficacy

Erick H. Turner, M.D., Annette M. Matthews, M.D., Eftihia Linardatos, B.S., Robert A. Tell, L.C.S.W., and Robert Rosenthal, Ph.D.

DOI: 10.1377/hlthaff.2011.0172
HEALTH AFFAIRS 30,
NO. 12 (2011): 2338–2345

PHARMACEUTICALS

By Michael R. Law, Yuko Kawasumi, and Steven G. Morgan

Despite Law, Fewer Than One In Eight Completed Studies Of Drugs And Biologics Are Reported On Time On ClinicalTrials.gov

ORIGINAL INVESTIGATION

Adverse Effects of Inhaled Corticosteroids in Funded and Nonfunded Studies

Antonio Nieto, MD, PhD; Angel Mazon, MD, PhD; Rafael Pamies, MD; Juan J. Linana, MD; Amparo Lanuza, MD, PhD; Fernando Oliver Jiménez, MD; Alejandra Medina-Hernandez, MD; F. Javier Nieto, MD, PhD

Systematic Review of the Empirical Evidence of Study Publication Bias and Outcome Reporting Bias

Kerry Dwan[1]*, Douglas G. Altman[2], Juan A. Arnaiz[3], Jill Bloom[4], An-Wen Chan[5], Eugenia Cronin[6], Evelyne Decullier[7], Philippa J. Easterbrook[8], Erik Von Elm[9,10], Carrol Gamble[1], Davina Ghersi[11], John P. A. Ioannidis[12,13], John Simes[14], Paula R. Williamson[1]

Journals: redundant publications are bad news

Publishing the same work twice is unethical and casts doubt on the integrity of research.

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Avoidable waste in the production and reporting of research evidence

Lancet 2009; 374: 86–89

Iain Chalmers, Paul Glasziou

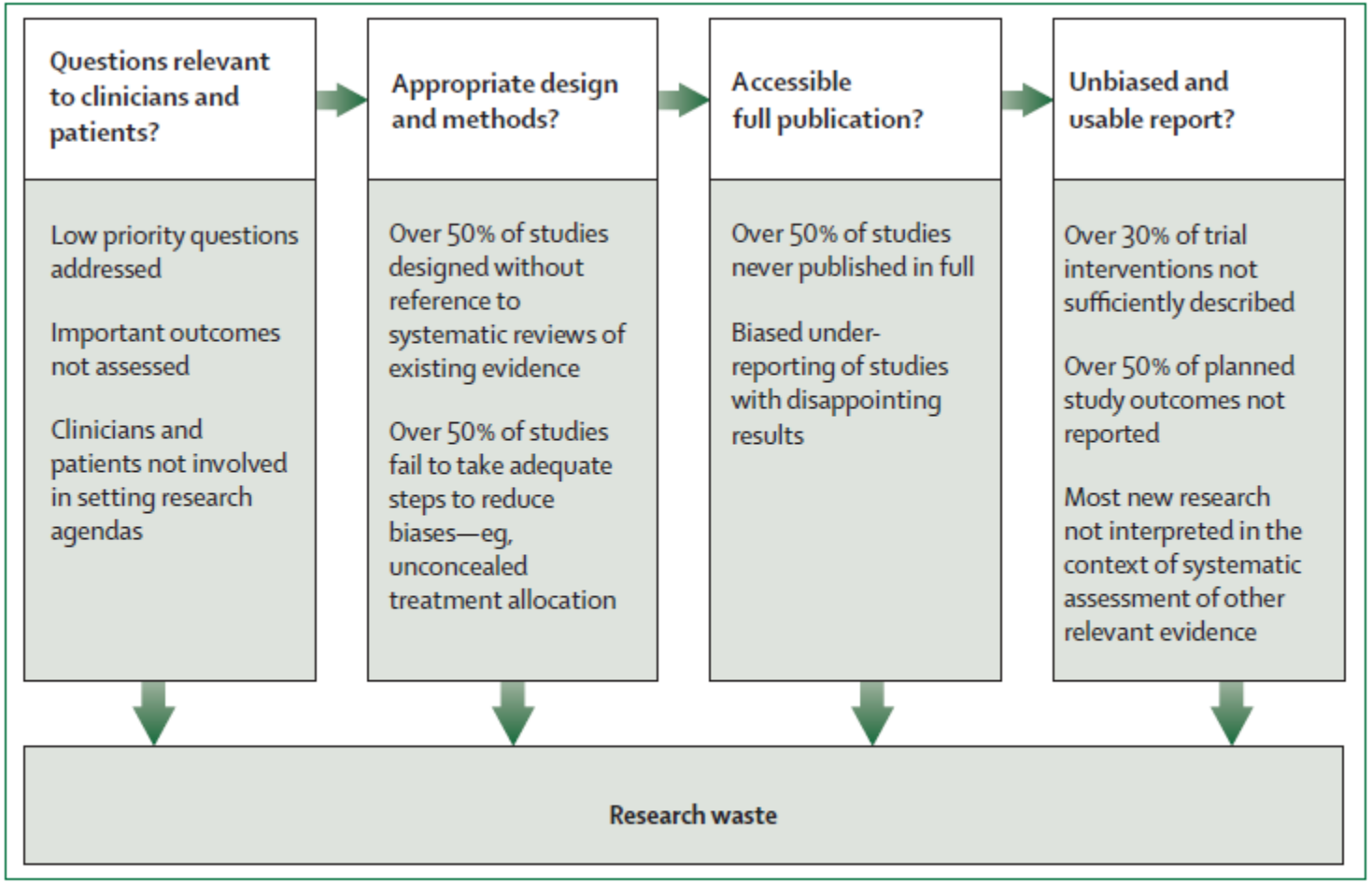

Figure: Stages of waste in the production and reporting of research evidence relevant to clinicians and patients

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Temos problemas de translação do conhecimento para uma prática baseada na evidência?

- A translação do conhecimento define-se como a organização, selecção, refinamento, disseminação e utilização de informação médica produzida pela investigação clínica de alta qualidade, para uma prática clínica baseada na evidência
- A prática clínica baseada na evidência é um conjunto de procedimentos, recursos pré-avaliados e tecnologias de informação que ajudam os médicos a aplicar os dados científicos aos cuidados dos doentes individuais.

Temos problemas de translação do conhecimento?

- Apenas 12-15% dos doentes hipertensivos têm a sua tensão arterial controlada
- A grande maioria dos doentes geriátricos não se tratam para a depressão em ambulatório
- Só uma percentagem menor de doentes com ICC fazem beta-bloqueantes
- Os diabéticos têm a TA mal controlada e a glicémia também.

O que é um recurso de "melhor evidência disponível"?

- É uma fonte de informação que selecciona e sintetiza a melhor evidência científica clínica publicada
- Tem metodologia própria para a selecção da evidência
- Tem regras explícitas para a avaliação da qualidade intrínseca da evidência
- E a sua síntese apoia, em maior ou menor grau, a decisão clínica imediata.

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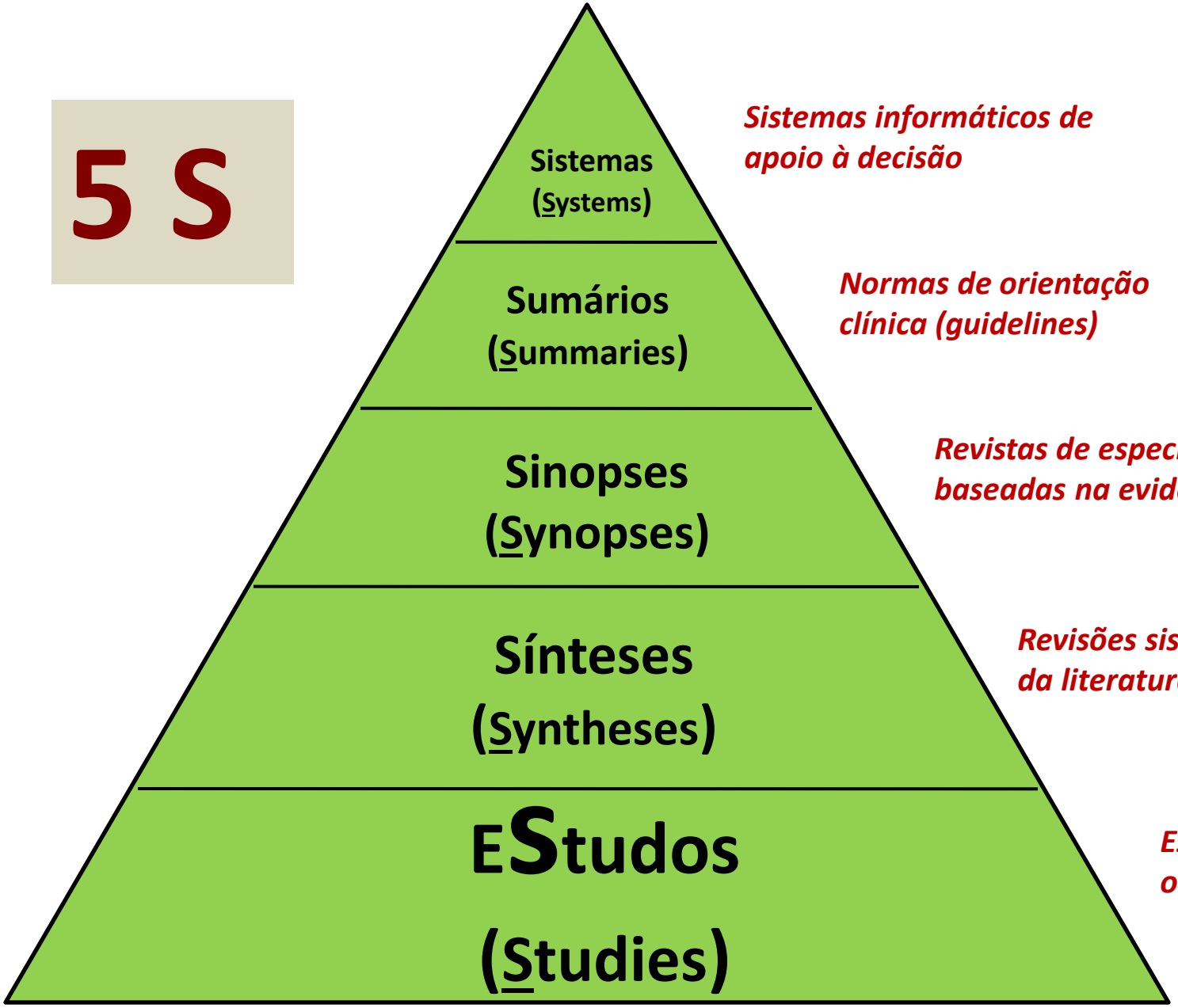

Sistemas informáticos de apoio à decisão

Normas de orientação clínica (guidelines)

Revistas de especialidade baseadas na evidência

Revisões sistemáticas da literatura

Estudos originais

Adaptado de Haynes RB, ACP Nov-Dec 2006, 145:A8-A9

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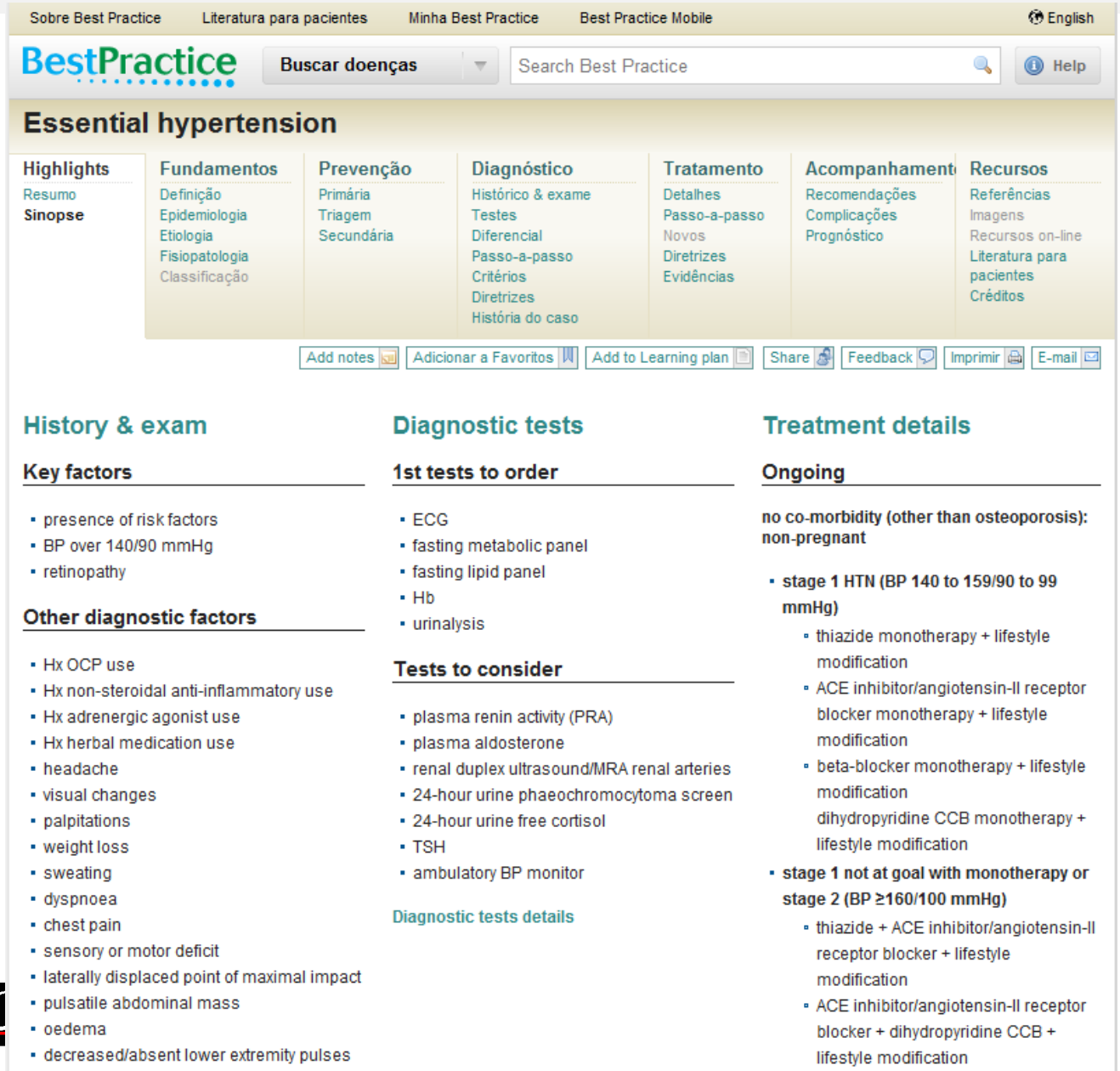
Categorias das fontes de informação clínica

Categoria	Descrição	Grau de processamento da evidência	Quantos existem?	Facilidade de utilização
Sistemas	Recursos informáticos (ou não), integrando informação variada para apoio directo à prática clínica	Elevado: integra a evidência com a prática	Escassos	Muito fácil
Sumários	Normas de Orientação Clínica baseadas na evidência	Apresentação e contextualização da evidência dos estudos primários	Menos de 50.000	Fácil
Sinopses	Resumos de estudos, com conselhos de aplicação prática por peritos	Avaliação crítica da evidência, informando sobre a robustez e fraquezas de cada estudo	Milhares	Moderada
Sínteses	Revisões sistemáticas da literatura	Sumarização e apresentação dos estudos primários	Milhares	Moderada
Estudos	Estudos individuais na Medline, EMBASE, etc.	Nenhum	Milhões	Uso difícil, pesquisa por experts

Onde se encontra a melhor evidência disponível ("puxar")?

- **UpToDate** (http://www.uptodate.com)
- **DynaMed** (https://dynamed.ebscohost.com/)
- **Best Practice** (http://bestpractice.bmj.com)
- **eMedicine** (emedicine.medscape.com/)

Só 12-15% dos doentes hipertensivos têm a sua tensão arterial controlada



Sobre Best Practice | Literatura para pacientes | Minha Best Practice | Best Practice Mobile | English

BestPractice | Buscar doenças | Search Best Practice | Help

Essential hypertension

Highlights
Resumo
Sinopse

Fundamentos
Definição
Epidemiologia
Etiologia
Fisiopatologia
Classificação

Prevenção
Primária
Triagem
Secundária

Diagnóstico
Histórico & exame
Testes
Diferencial
Passo-a-passo
Critérios
Diretrizes
História do caso

Tratamento
Detalhes
Passo-a-passo
Novos
Diretrizes
Evidências

Acompanhament
Recomendações
Complicações
Prognóstico

Recursos
Referências
Imagens
Recursos on-line
Literatura para pacientes
Créditos

Add notes | Adicionar a Favoritos | Add to Learning plan | Share | Feedback | Imprimir | E-mail

History & exam

Key factors

- presence of risk factors
- BP over 140/90 mmHg
- retinopathy

Other diagnostic factors

- Hx OCP use
- Hx non-steroidal anti-inflammatory use
- Hx adrenergic agonist use
- Hx herbal medication use
- headache
- visual changes
- palpitations
- weight loss
- sweating
- dyspnoea
- chest pain
- sensory or motor deficit
- laterally displaced point of maximal impact
- pulsatile abdominal mass
- oedema
- decreased/absent lower extremity pulses

Diagnostic tests

1st tests to order

- ECG
- fasting metabolic panel
- fasting lipid panel
- Hb
- urinalysis

Tests to consider

- plasma renin activity (PRA)
- plasma aldosterone
- renal duplex ultrasound/MRA renal arteries
- 24-hour urine phaeochromocytoma screen
- 24-hour urine free cortisol
- TSH
- ambulatory BP monitor

Diagnostic tests details

Treatment details

Ongoing

no co-morbidity (other than osteoporosis): non-pregnant

- **stage 1 HTN (BP 140 to 159/90 to 99 mmHg)**
  - thiazide monotherapy + lifestyle modification
  - ACE inhibitor/angiotensin-II receptor blocker monotherapy + lifestyle modification
  - beta-blocker monotherapy + lifestyle modification
    dihydropyridine CCB monotherapy + lifestyle modification
- **stage 1 not at goal with monotherapy or stage 2 (BP ≥160/100 mmHg)**
  - thiazide + ACE inhibitor/angiotensin-II receptor blocker + lifestyle modification
  - ACE inhibitor/angiotensin-II receptor blocker + dihydropyridine CCB + lifestyle modification

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A grande maioria dos doentes geriátricos não se tratam para a depressão em ambulatório

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Diagnosis and management of late-life depression

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TOPIC OUTLINE

SUMMARY & RECOMMENDATIONS

Diagnosis and management of late-life depression

Authors
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Section Editors
Peter P Roy-Byrne, MD
Kenneth E Schmader, MD

Deputy Editor
David Solomon, MD

Disclosures

All topics are updated as new evidence becomes available and our peer review process is complete.
Literature review current through: Dec 2012. | **This topic last updated:** Nov 2, 2012.

INTRODUCTION — The term late-life depression includes both aging patients whose mood disorder presented in earlier life, and patients whose mood disorder presents for the first time in later life. Depressive illness in the older population is a serious health concern leading to unnecessary suffering, impaired functional status, increased mortality, and excessive use of health care resources.

Late-life depression remains underdiagnosed and inadequately treated [1-4]. In the United States, older men and older African Americans and Hispanics are at even greater risk of unrecognized depression [5-7]. The public health consequences of inadequately treated depression in late life will increase over time as the population continues to age.

Over 80 percent of mental health treatment for depressed older adults is delivered in the primary care setting. Depression often goes undiagnosed in primary care [8], and is often left untreated, even when diagnosed [9]. Recognition and management of late-life depression is an important responsibility for the primary care clinician.

This topic will review the epidemiology of late-life depression, diagnostic strategies, and options for treatment in the older adult. The diagnosis, management and prognosis of depression in the general population are discussed separately. (See "Clinical manifestations and diagnosis of depression" and "Initial treatment of depression in adults" and "Serotonin-norepinephrine reuptake inhibitors (SNRIs) and other antidepressants for treating depressed adults" and "Monoamine oxidase inhibitors (MAOIs) for treating depressed adults" and "Unipolar depression in adults and tricyclic and tetracyclic drugs: Pharmacology, administration, and side effects" and "Antidepressant medication in adults: Switching and discontinuing medication" and "Unipolar depression in adults: Prognosis and course of illness".)

EPIDEMIOLOGY — Depression is not a normal consequence of aging [10,11]. Sadness and grief are normal responses to life events that occur with aging such as bereavement; adjustment to changes in social status with retirement and loss of income; transition from independent living to assisted or residential care; and loss of physical, social, or cognitive function from illness. (See "Grief and bereavement".) Despite these losses, healthy independent community-dwelling elderly in the United States have a lower prevalence rate of clinical depression than the general adult population (figure 1) [12].

Rates of depression for community-dwelling older adults range from 2 percent (for patients in community settings who meet strict diagnostic interview criteria) to about 10 percent for patients with minor depression [13]. Cultural factors [14] as well as variations in methods of assessment lead to significant variations in reported prevalence. Rates of depression are higher for older adults with comorbid medical illness and in general medical settings. Hospitalized geriatric populations have prevalence rates of depression over 30 percent, and patients with stroke, myocardial infarction (MI), or cancer have rates over 40 percent (figure 1) [15-17].

Although prevalence of depression in the older healthy population is lower than in comparable younger groups, incidence rates may not differ. A cohort study of 5600 community dwelling persons in the Netherlands, aged 56 or older (mean age 70 years at baseline) and followed for eight years, found the incidence of depressive syndromes (major depression and dysthymia) to be 7 per 1,000 person years [18]. Most depressive episodes occurred in persons with a prior history of depression, with a recurrence rate of 25.5 per 1,000 person years. Clinically significant but subthreshold depressive symptoms occurred at twice the rate of depressive syndromes.

The true incidence of depressive disorders in the oldest-old (>85 years old) may be underestimated. This group may have an increased prevalence of depressive symptoms, although few epidemiologic studies have included participants of these ages [19,20].

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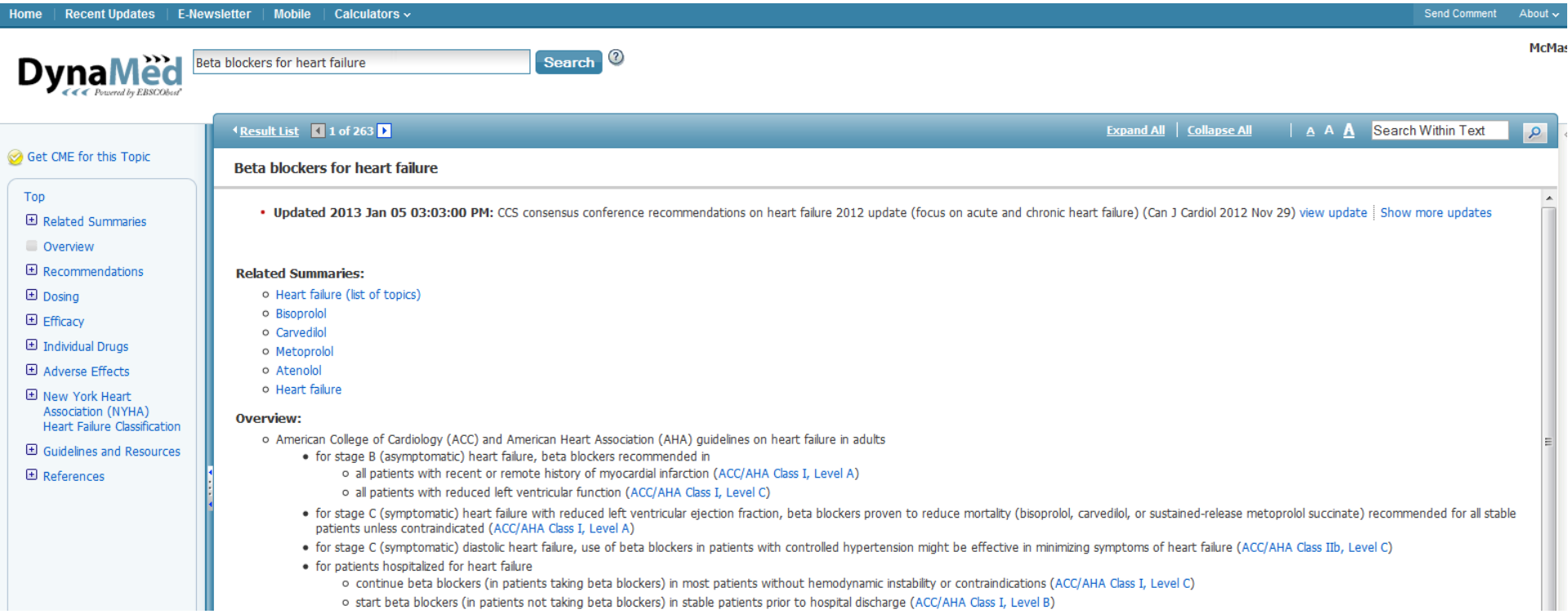
Só uma percentagem menor de doentes com ICC fazem beta-bloqueantes



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DynaMed Powered by EBSCOhost — Beta blockers for heart failure — Search

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- Overview
- Recommendations
- Dosing
- Efficacy
- Individual Drugs
- Adverse Effects
- New York Heart Association (NYHA) Heart Failure Classification
- Guidelines and Resources
- References

Beta blockers for heart failure

- **Updated 2013 Jan 05 03:03:00 PM:** CCS consensus conference recommendations on heart failure 2012 update (focus on acute and chronic heart failure) (Can J Cardiol 2012 Nov 29) view update | Show more updates

Related Summaries:
- Heart failure (list of topics)
- Bisoprolol
- Carvedilol
- Metoprolol
- Atenolol
- Heart failure

Overview:
- American College of Cardiology (ACC) and American Heart Association (AHA) guidelines on heart failure in adults
  - for stage B (asymptomatic) heart failure, beta blockers recommended in
    - all patients with recent or remote history of myocardial infarction (ACC/AHA Class I, Level A)
    - all patients with reduced left ventricular function (ACC/AHA Class I, Level C)
  - for stage C (symptomatic) heart failure with reduced left ventricular ejection fraction, beta blockers proven to reduce mortality (bisoprolol, carvedilol, or sustained-release metoprolol succinate) recommended for all stable patients unless contraindicated (ACC/AHA Class I, Level A)
  - for stage C (symptomatic) diastolic heart failure, use of beta blockers in patients with controlled hypertension might be effective in minimizing symptoms of heart failure (ACC/AHA Class IIb, Level C)
  - for patients hospitalized for heart failure
    - continue beta blockers (in patients taking beta blockers) in most patients without hemodynamic instability or contraindications (ACC/AHA Class I, Level C)
    - start beta blockers (in patients not taking beta blockers) in stable patients prior to hospital discharge (ACC/AHA Class I, Level B)

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Os diabéticos têm a TA mal controlada e a glicémia também

Type 2 Diabetes Mellitus Treatment & Management

Print

Author: Romesh Khardori, MD, PhD, FACP; Chief Editor: George T Griffing, MD more...

Management of Hypertension

Blood pressure goals

The role of hypertension in increasing microvascular and macrovascular risk in patients with diabetes mellitus has been confirmed in the UKPDS and Hypertension Optimal Treatment (HOT) trials.[189, 190] The ADA suggests that the blood pressure goal be below 130/80 mm Hg.

In patients with greater than 1 g/day proteinuria and renal insufficiency, a more aggressive therapeutic goal (ie, 125/75 mm Hg) is advocated. According to the Veterans Affairs Diabetes Trial, however, a diastolic blood pressure of less than 70 mm Hg increases the risk of cardiovascular disease in patients with diabetes, even when systolic blood pressure is within the current guidelines (recommended range, < 140 mm Hg).[191]

Pharmacologic therapy

While angiotensin-converting enzyme (ACE) inhibitors, angiotensin receptor blockers (ARB), diuretics, beta blockers, and calcium channel blockers are all considered acceptable initial therapy, the author prefers inhibitors of the renin-angiotensin system (ie, ACE inhibitors, ARBs) because of their proven renal protection effects in patients with diabetes. Many patients require multiple agents. Diuretics or calcium channel blockers frequently are useful as second and third agents.

The ALTITUDE Trial investigating the impact of direct renin inhibitor with aliskiren

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Tipos de aplicabilidade

Software	Natureza do conteúdo	Aplicação prática na assistência clínica
UpToDate	Informação em bruto, muito detalhada, em texto corrido Ex.: síndromes coronários agudos = 101 caps.	moderada
DynaMed	Estratificada em "bullets", fornecendo a evidência de base muito detalhada	pobre
BMJ Best Practice	"Livro de cozinha" muito completo, com evidência de base seleccionada	alta
eMedicine	Livro de texto clássico	moderada

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