Expanding the spectrum of European Respiratory Society official scientific documents: short documents complement clinical practice guidelines, statements and technical standards

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The European Respiratory Society now issues short official scientific documents https://bit.ly/3brN9jO

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In this issue of the *European Respiratory Journal* (*ERJ*), the European Respiratory Society (ERS) releases its first "short guideline" document, dealing with inhaled corticosteroid (ICS) withdrawal in COPD [1]. This guideline belongs to a new type of "short guidance" documents developed and published by the ERS; the main goal and characteristic is the shortened timeframe between project initiation and final output, thanks to a more restricted focus. Most importantly, these documents are not short versions of original guidelines and statements: they result from an original process.

The idea behind the decision to deliver such documents was to adapt quicker to the production of new evidence, when this evidence has the potential for being "game-changing", notably when it fills an evidence gap on a clinically crucial topic. Since their launch as an ERS activity, the usual timeframe to develop ERS official scientific documents is 2 years, which remains the standard duration. Whereas this is a generally acceptable timeframe, for crucial topics as mentioned above it might imply losing a window of opportunity for providing timely guidance for clinical practice. In addition, the society receives many more requests for guideline development than it can possibly fund. This means that choices need to be made and specific clinical problems are at risk of remaining unaddressed, as they are very specific.

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Before presenting in more detail ERS short guidance documents, it may be worth recalling that the ERS produces three types of official scientific documents (figure 1): clinical practice guidelines [2–5], statements [6–10] and technical standards [11–13]. The common feature of all these documents is that they are based on systematic literature searches. When *clinical practice guidelines* are produced, a systematic literature review is performed [2–5]. Depending on the type of question, the results of the review are either reported narratively or using full evidence grading following the GRADE (Grading of Recommendations Assessment, Development and Evaluation) approach [14–19]. In both cases, the evidence-to-decision framework is used to transparently document how recommendations and their strength were derived from the available evidence and which factors were taken into account (including patient values, feasibility, acceptability and others). Narrative reviews are particularly indicated when questions cannot be formulated using the PICO (Population Intervention Control Outcome) format, for instance questions regarding the type and frequency of disease monitoring, treatment selection in case of specific comorbidities, *etc*. The best way to explain the concept of PICO questions is to use an example; the short guidance document that is accompanied by this editorial aims to address the following clinical questions: can/should ICS be withdrawn in patients with COPD receiving ICS? If the answer is yes, when and how should this be conducted? The translation in PICO format is as follows:

- Population: patients with COPD (obviously, those receiving an ICS-containing regimen);
- Intervention: ICS withdrawal;
- Control: ICS continuation;
- Outcomes (in general, these need to be defined following advice from all relevant stakeholders, mandatorily including clinicians and patients): exacerbation frequency, respiratory hospitalisations, quality of life measures, adverse effects and pneumonia. Health care resource utilisation, all-cause hospitalisation, lung function (*e.g.* forced expiratory volume in 1 s), use of reliever medication, dyspnoea, exercise capacity and all-cause mortality.

The advantage of this format is that it forms a formalised guide for the literature search and analysis, and for formulating recommendations. Whereas systematic reviews are typically the main focus of ERS clinical practice guidelines, narrative reviews are added when necessary to guide readers on how to implement the GRADE-based recommendations in clinical practice. Altogether, the purpose of combining narrative review- and systematic review-based recommendations is to make the final guideline more complete, user-friendly and clinically applicable [14]. *Statements* describe the evidence and current practice [6–10]. Contrary to guidelines, although the literature search is centralised, formalised, structured and exhaustive, it is not followed by a full evidence synthesis and GRADE-ing of the evidence. As a result, they should not contain clinical practice recommendations. Finally, *technical standards* are meant to assess technologies

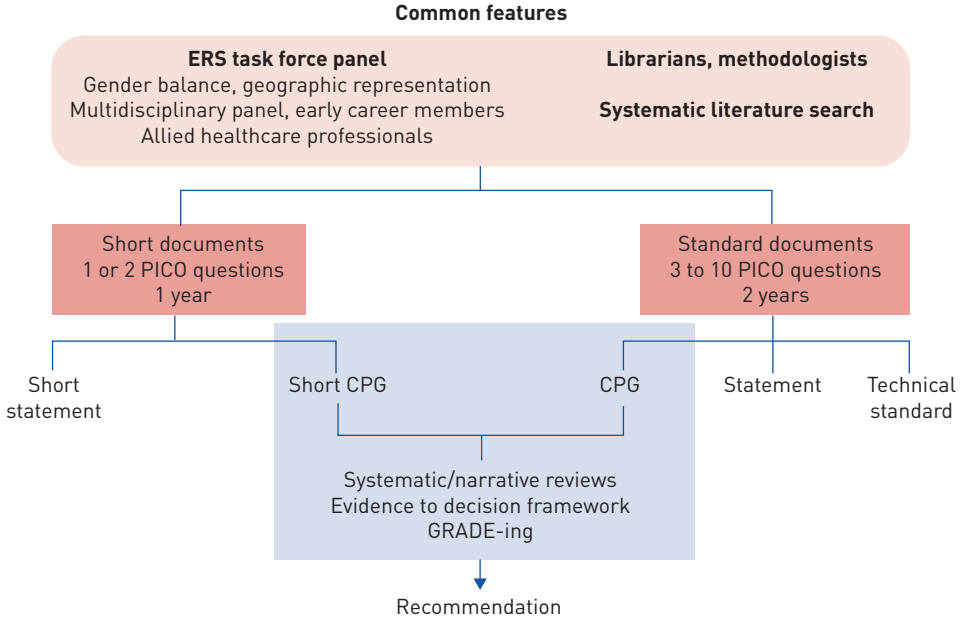

FIGURE 1 Types of European Respiratory Society (ERS) official scientific documents and their main features. CPG: clinical practice guideline.

(*e.g.* diagnostic tests or technical interventions) and/or provide guidance on how these technologies should be performed and standardised [11–13]. Importantly, the focus of these documents should not be to guide decisions on whether (and when) these technologies are to be used for clinical care, since these questions are topics for clinical practice guidelines or statements. ERS requests that representatives of patients (in conjunction with the European Lung Foundation) and early career members are involved in panels, which also need to represent the diversity of ERS community from a geographical and gender perspective.

All types of documents go through a systematic validation process before final sequential endorsement by the ERS Science Council and ERS Executive Committee. All ERS official scientific documents are published in one of the ERS journals (usually the *ERJ* but, depending on the topic, target audience and type of document, it could also be the *European Respiratory Review* or *ERJ Open Research*) and presented at the ERS international congress in dedicated high impact symposia. Publication in a non-ERS journal may occur when the task force is jointly formed with another society. Dissemination tools also include pocket guides, key-point summaries, summaries for clinicians and patients, slide kits, webinars and promotion through social networks. Finally, official ERS scientific documents are requested to highlight areas where further research is needed and to propose studies to fill evidence gaps (including type of studies and outcomes of interest).

To fit with the "short document" process, projects should deal with topics fulfilling the following requirements:

- High clinical importance, *i.e.* potentially high impact on patients' outcomes;
- And/or high public health and/or economic importance, *i.e.* potentially high impact on healthcare systems, organisations and expenses;
- Presence of controversy or uncertainty;
- Major new evidence addressing current gaps;
- Relative urgency to provide guidance to stakeholders (clinicians, patients, decision-makers, payers, *etc.*).

To address such issues, the recommended process follows the general guidance for ERS official scientific documents, with some specific aspects to facilitate a quicker development:

- A markedly smaller number of questions (formulated as PICO questions for short guidelines), *i.e.* no more than one or two questions (*versus* about eight in usual guidelines);
- a more restricted panel: maximum of 10 members including the chairs, at least one member with experience in methodology, one patient representative and one early career member; taking into account gender balance and geographical representation;
- a shorter published document (2000–3000 words *versus* 8000).

Considering the purpose of the "short guidance" process (*i.e.* to accelerate the delivery of the document), applications can be submitted throughout the year and benefit from a 3-week evaluation process before a decision is made.

Although this is only an adaptation of processes already applied by the ERS and, specifically, its Guidelines Working Group (GWG) and Science Council, it was decided to perform a pilot before generalising the process, in order to test its feasibility and utility. The topic was chosen by the ERS Science Council after appropriate consultation. The result, published in this issue of the *ERJ*, has been obtained in 10 months. One major advantage of the document is that, as all recent ERS guidelines, it clearly differentiates situations where recommendations can be provided with various strengths that are explicitly mentioned and justified, and other circumstances where the current literature is insufficient to draw evidence-based conclusions. The availability of these recommendations is of particular importance to complement other documents, such as the Global Initiative for Chronic Obstructive Lung Disease report [20], which may also provide meaningful clinical guidance but do not rely on a similarly strict evidence-based process. It is essential for clinicians to know the extent to which propositions or recommendations for clinical practice are backed by hard data.

Altogether, this experiment has been a clear success in that the short guideline document could be developed within the requested timeframe, and proposes a top quality guideline, since it has been established following the highest available methodological standards including a systematic review, GRADE-ing of the evidence and the use of a rigorous evidence-to-decision framework. This confirms the feasibility of the approach and its compatibility with ERS functioning. Thereby, it opens the way to new projects of this type. Importantly, this pilot allowed to identify the most crucial requirement to ensure success, *i.e.* defining a very limited number of highly focused PICO questions with major potential for improving clinical care and patient outcomes.

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