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Reply to the comment: With regard to the implementation of the AGREE instrument in Atrial Fibrillation Clinical Guidelines

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Dear Editor:

We appreciate the comments of Dr. Morales Salinas et al [1] in the publication mentioned [2], and offer some details that allow a better understanding of the assessment process and critical appraisal of clinical practice guidelines in general and atrial fibrillation guidelines in particular.

We agree that "clinical practice guidelines and the quality of clinical evidence and medical advice should be reviewed and carefully analyzed", without making only a limited assessment to clinical trials supported by its extensive internal validity but low external validity [3], bypassing observational studies that can provide relevant information; a fact that was already mentioned in a previous article [4].

We believe the recommendations of experts can be useful, due to their extensive experience in the subject, the daily patient care and the diversity of research carried out. However, we believe that the recommendation of a guideline should be done through a proper process of critical appraisal, an impartial evaluation and use of validated instruments widely used in various parts of the world. It's time to nurture medical thinking with critical reading tools [5] as STROBE, CONSORT, AGREE, etcetera, available on the web platform (www.equator-network.org); always with the aim of achieving an evidence based medical practice beyond the views of some experts on any subject.

The AGREE instrument allows a methodological evaluation of the quality of clinical practice guidelines [6],[7]. Domain 3 (Rigor in development) evaluates the process of developing a clinical practice guideline [8]; the relevance of this domain [9] compared with domain 4 (Clarity of Presentation), is reflected when making the decision to recommend a guideline to adapt it or to adopt it [6]. This last aspect is relevant in Latin American countries given the economic and expertise limitations in the development of a novo guideline. Therefore, if a guideline does not have adequate rigor of development (domain 3), there may be large biases in its recommendations.

We agree that a guideline should be evaluated by a multidisciplinary team that includes specialists in the area, primary care physicians and trained methodologists in the AGREE methodology, as it was the case of the evaluating team of the article afore mentioned. We encourage primary care physicians to use the AGREE as an instrument of evaluation of clinical practice guidelines, particularly in Latin American countries where we have few de novo guidelines [9].

It should be clarified that examiners conducted an assessment independently, but it was useful to discuss the differences on the issues covered by each of the items of the AGREE and know whether they were included or not in the guidelines evaluated, considering the previous studies in order to raise a consensus on how to assess each guideline.

It is important that the appraisal of clinical practice guidelines "should include consultation of supplemental materials and in the case of an update the prior guideline should be consulted "; however, in the supplement of the Canadian guideline evaluated [10] as in the previous one [11], no details of the process of guideline drafting were included. We consider important both in its first edition and updates to include the details of the guideline development process to show rigor in its preparation, as was done by the Canadian guideline of hypertension in its two versions [12],[13].

We agree that the recommendations and levels of evidence are not comparable, and therefore Table 3 presents a "summary of the levels of evidence of the recommendations" and not a comparison of them.

The absence of a link between the grades of recommendation and levels of evidence in the NICE guideline generates a constraint to be considered, but not consider a "cardinal sin" given the quality of development of the NICE [14] guidelines. This limitation is evident in the scores obtained in the domain 5 (applicability of the recommendations).

Similarly domain 4 assesses the clarity of presentation, which may occur independently of the quality of the process developed by the guideline authors. In this respect, the guideline should be clear in presenting the recommendations, although readers may not know how the process of evaluation of the evidence took place, or optionally there was no evidence-based recommendations, or a group of experts carried out through a process loosely.

We believe that the most important issue is not "the degree of patient adherence to a selected guide" as Morales *et al.* pointed out [1]; but the attachment of health personnel (medical specialists, primary care physicians, nurses, etcetera) and patient adherence to treatment provided by the health professional based on a clinical practice adopted or adapted.

The evaluation of clinical practice guidelines is a long thorough process, which involves reviewing each of the evaluated guides, supplements, web pages and available resources, and analyze them according to criteria set by the instrument used (AGREE II); ending with the overall evaluation of the guide supported in all aspects previously evaluated as was done in the study mentioned.

Critical appraisal of clinical practice guidelines in cardiology (hypertension and atrial fibrillation) is of great importance for making decisions about health; a more obvious situation for clinical practice guidelines of atrial fibrillation compared with hypertension guidelines where such assessments are common [15],[16],[17],[18].

Finally, comments and opinions made by Morales Salinas *et al.* [1] have been very helpful in allowing us to explain some important details of the critical appraisal of clinical practice guidelines in general.

Notes

From the editor
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Conflicts of interest
The authors declare that there are no conflicts of interest

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