CEBM
Global evidence-based projects

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Primary Care for the Developing World

Our research rethinks the way healthcare is delivered to people, helping them to manage their own health and reduce the numbers that need to be admitted to hospital.

This improves patient's independence and well-being as well as dramatically reducing the cost to the NHS.

Groups within this theme

Primary Care for the Developing World

WHO Collaborating Centre for Self-Care

OUR RESEARCH THEMES

Behavioural Medicine
Cancer
Cardiovascular & Metabolic Disease
Centre for Evidence-Based Medicine
Clinical Trials
Infection & Childhood Disease
WHO Collaborating Centre for Self-Care

The Nuffield Department of Primary Care Health Sciences has been designated a World Health Organization (WHO) Collaborating Centre for Self-Care in recognition of its international reputation in patient self-monitoring and self-management of cancer, cardiovascular disease and other non-communicable disease (NCDs).

The research, training and education undertaken in collaboration with the WHO aims to embed primary care practice to support NCD patient self-care in:

- Under WHO's coordination set up a network of research centres in Low and Middle Income Countries to promote implementation research, guided by the WHO's prioritised NCD research agenda recommendations.
- Assist WHO in the development and update of guidelines for self-care in NCDs.
- To contribute to the work related to the development of the second Global Status Report of NCDs as requested by WHO.
The World Health Organization position paper on mammography screening was produced under the overall direction of Dr Oleg Chestnov, Assistant Director-General, Noncommunicable Diseases and Mental Health, and Dr Shanthi Mendis, Director a. i., Management of Noncommunicable Diseases.

Dr Cecilia Sepúlveda, Senior Advisor, Cancer Control WHO, coordinated the overall publication and provided editorial input.

Professor Hassan Murad, Knowledge and Evaluation Unit of the Center for the Science of Healthcare Delivery and the Center for Translational Services Science Activities, Mayo Clinic, USA, conducted the systematic review.

Professor Carl Heneghan of the Centre for Evidence-Based Medicine, Nuffield Department of Primary Care Health Sciences, University of Oxford, United Kingdom was co-chair of the Guideline Development Group meeting on recommendations.

Dr Gerald Gartlehner, GRADE Methodologist and Head of Department for Evidence-based Medicine and Clinical Epidemiology at the Danube University, Krems, Austria, was co-chair of the Guideline Development Group meeting on recommendations. He also provided assistance with the GRADE methodology and evidence during the recommendations process.

David Bramley was rapporteur and writer of these guidelines.
WHO guidelines on Cardiovascular risk

The WHO Global NCD Action Plan 2013-2020 provides a road map to attain nine voluntary global targets, including that of a 25% relative reduction in premature mortality from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases by 2025. Over the last 4.5 years, staff at the CEBM have been working towards the actualisation of the WHO Global NCD Action Plan.

The last WHO working meeting on the development of screening guidelines for cardiovascular disease (CVD) risk took place on November 6-7, 2013 at Geneva. Carl Heneghan chaired the meeting, which included participants from across the globe. Igbo Onakpoya presented the synthesized evidence on the benefits and harms of CVD risk screening. Using the GRADE methodology, the evidence presented was used to develop a set of recommendations on screening for CVD risk including diabetes.

A provisional draft based on the recommendations developed at the meeting has been written by Igbo Onakpoya, Alison Ward and Carl Heneghan, and is presently under consideration. The CVD risk screening guideline should be available in 2014.

Image - A snapshot of participants at the WHO meeting on guidelines development for CVD risk screening (including diabetes) held at Geneva, Switzerland, November 6-7, 2013.
Prevention and control of NCDs

Oxford, WHO workshop on the prevention and control of NonCommunicable Diseases

In May 2013, the World Health Assembly endorsed the WHO Action Plan for the Prevention and Control of NonCommunicable Diseases (NCDs). The purpose of the workshop, held jointly with the WHO and the University of Oxford's, Centre for Evidence-Based Medicine and Department of Primary Care, aimed to strengthen the capacity for health systems research.

Why are NCDs important to the WHO? It is a simple answer, an estimated 36 million deaths, or 63% of the 57 million deaths in 2008, were due to NCDs.

In terms of the WHO Global strategy; the first initiative relating to NCDs, was set in 2000, at the World Health Assembly. This led initially to the Global Strategy on Diet Activity and Health, followed by the Action Plan for the Prevention and Control of NCDs. In 2013, the WHO Global Action plan was directly aimed at the prevention and control of NCDs, setting six objectives alongside a number of targets. These targets include a 25% reduction in premature mortality from NCDs, as well as 80% coverage for essential medicines and technologies, with no increase in obesity and diabetes and a 30% reduction in tobacco use. These are stiff targets and are all to be delivered by 2015.

The global action plan offers a paradigm shift by providing a road map and a menu of policy options for Member States, WHO, other UN organizations and intergovernmental organizations, NGOs and the private sector which, when implemented collectively between 2013 and 2020, will attain 9 voluntary global targets, including that of a 25% relative reduction in premature mortality from NCDs by 2025.
1. To raise the priority accorded to the prevention and control of noncommunicable diseases in global, regional and national agendas and internationally agreed development goals, through strengthened international cooperation and advocacy.

2. To strengthen national capacity, leadership, governance, multisectoral action and partnerships to accelerate country response for the prevention and control of noncommunicable diseases.

3. To reduce modifiable risk factors for noncommunicable diseases and underlying social determinants through creation of health-promoting environments.

4. To strengthen and orient health systems to address the prevention and control of noncommunicable diseases and the underlying social determinants through people-centred primary health care and universal health coverage.

5. To promote and support national capacity for high-quality research and development for the prevention and control of noncommunicable diseases.

6. To monitor the trends and determinants of noncommunicable diseases and evaluate progress in their prevention and control.

Halt the rise in diabetes and obesity.

At least 50% of eligible people receive drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes.

An 80% availability of the affordable basic technologies and essential medicines, including generics, required to treat major noncommunicable diseases in both public and private facilities.
Evidence for non-communicable diseases: analysis of Cochrane reviews and randomised trials by World Bank classification

C Heneghan, C Blacklock, R Perera, R Davis, A Banerjee, P Gill, S Liew, L Chamas, J Hernandez, K Mahtani, G Hayward, S Harrison, D Lasserson, S Mickan, C Sellers, D Carnes, K Homer, L Steed, J Ross, N Denny, C Goyder, M Thompson, A Ward


ABSTRACT

Introduction: Prevalence of non-communicable diseases (NCDs) is increasing globally, with the greatest projected increases in low-income and middle-income countries. The evidence base for NCD prevention is strong; however, many developing countries lack the capacity to use this evidence to inform health policy and practice.

ARTICLE SUMMARY

Article focus
- Non-communicable diseases (NCDs) such as cardiovascular disease, diabetes, and cancer account for a growing proportion of global disease burden.
- Many developing countries lack the capacity to use evidence to inform health policy and practice.
- This study aims to provide an evidence-based assessment of NCD prevention interventions in low- and middle-income countries.
Trials and number of participants from 626 Cochrane non-communicable disease reviews, by Gross National Income (GNI).

The growing problem of Overdiagnosis

When I first heard the concept of overdiagnosis my initial thoughts were that surely such a concept couldn’t exist: either the diagnosis is correct or it’s incorrect. The second overdiagnosis conference, organized by CEBM in Sep 2014, and held in Oxford, offered insight into the range of diagnosis and diseases affected by overdiagnosis and the extent of the problem.

In terms of cancer, there seems to be issues in all of the major diseases: ovarian, cervical, breast, prostate and thyroid all formed part of the presentations and discussions. Some of these issues, such as overdiagnosis in breast screening are more prominent and have led to significant policy changes. In 2009, the US Preventive Services Task Force created controversy by suggesting that fewer screening tests be done and in the UK, policy now requires women to be given more information about the potential harm of being tested.

Some areas, such as overdiagnosis in thyroid cancer were new to me. A 2012 BMJ paper on how to stop harming the healthy provides a useful visual understanding: whilst the incidence of thyroid cancer continues to rise no benefits are observed in terms of the hard outcome – death.

Additionally, I now have a grasp of a new term that underpins a lot of the growth in overdiagnosis found by of imaging – I had to look it up check the spelling – the Incidentaloma: a tumour detected incidentally without symptoms or suspicion. Although articles go as far back as 1990, describing the phenomenon, it is the recent rise in super sensitive scanners and the increasing number of scans driving the increase. As an example, at autopsy, an adrenal mass occurs in 3% of over 50s, but only about 1 in 4000 is malignant.
Drugs for pre-osteoporosis: prevention or disease mongering?

After looking at data used to support treatment of women with slightly lowered bone mineral density, Pablo Alonso-Coello and colleagues argue that proponents have overstated the benefits and underplayed the harms.

Influenza: marketing vaccine by marketing disease

The CDC pledges “To base all public health decisions on the highest quality scientific data, openly and objectively derived.” But Peter Doshi argues that in the case of influenza vaccinations and their marketing, this is not so.

Screening for breast cancer—balancing the debate

Polarised arguments about the benefits and harms of breast screening are not helping women to make an informed decision. Klim McPherson looks at the evidence and calls for dispassionate analysis of all available data.

When a test is too good: how CT pulmonary angiograms find pulmonary emboli that do not need to be found

The introduction of CT pulmonary angiography has been associated with an 80% rise in the detection of pulmonary emboli in the US, but with little change in death rates. Renda Soylemez Wiener and colleagues argue this is evidence of overdiagnosis. They say some patients are helped, but many are harmed by the adverse effects of unnecessary treatment.

Stop the medicalisation of old age

The “egregious marketing” of therapies for everyday ailments in older people, along with disease mongering and overtreatment, help no one. But which interventions lack proved benefit? Graham Mulley found answers in this iconoclastic book.
As Margaret McCartney, one of the keynote speakers and a GP stated: 'we can do better'

- professional - high quality decision making takes time
- compassionate - stop systematically promoting things that don't benefit patients and distract professionals from what patients need and want. Whose 'rules'
- evidence based - we need quick access to relevant information wanted by patients and HCP on the ground

OxPrimaryCareSci
@OxPrimaryCare
GPs can do better @mgtmccartney: "I want to be professional, compassionate + evidence-based" #PODC2014 #primarycare
10:52 AM - 17 Sep 2014
Connecting with Saudi Arabia

In June, Drs. Zulfia Al Rayess and Amena Munshi spent a week at Oxford University while attending the Evidence-based health practice: knowledge into action course. Dr. Zulfia is a Family Medicine consultant and the Head of the Saudi Centre For Evidence-Based Health Care (EBHC). Dr. Amena, a community physician, is also a project manager at the Saudi Centre for EBHC.

Sharon Mckean had the opportunity to meet with them while they were in Oxford studying for the Knowledge into Action module in June, and learn about the Centre and their clinical practice guidelines development program.

When did you establish the Saudi Centre for EBHC?

The Saudi Centre was officially established at the Ministry of Health (MoH) in December 2012. Since then, our mission evolved from delivering training on evidence-based medicine to the development of clinical practice guidelines (CPGs) covering the most critical and prevalent diseases in the country. We seek to adapt the best available international CPGs for prevention, diagnosis and treatment, and to establish rules and regulations for their implementation. We provide guidance to specialists and practitioners and support them to provide the best health care in Saudi Arabia. The Center also seeks to raise awareness of evidence-based medicine and support its practice across the Kingdom.
CEBM holds follow up outreach workshop in Lithuania

Members of the CEBM faculty have held a second workshop in the city of Kaunas, Lithuania. This followed on from last year’s inaugural one in Vilnius, Lithuania. The aim was to build on and support a movement in the country to foster more evidence based medicine in clinical practice and teaching.

The CEBM team members supporting the movement this year were Dr Kamal R. Mahtani and Dr David Nunan. The all day workshop took place on the opening day of a 3-day conference on improving EBM in the country www.medvidence.eu at the Lithuanian University of Health Sciences. Dr Mahtani and Dr Nunan gave the opening plenaries to the conference on the topics of Applying evidence to patient care and Study designs respectively. The conference was the largest EBM conference held in the country and the morning session alone was delivered to over 300 clinicians, academics and medical students.

During the afternoon session Dr Mahtani and Dr Nunan coordinated a more interactive session on applying EBM though formulating clinical questions, searching for evidence and appraising the evidence.

The delegates were asked to provide feedback on the opening day of the conference with Dr Mahtani scoring 4.69 out of 5, and Dr. Nunan 4.59 out of 5. The highest positive feedback was for the afternoon session which was rated at 4.71 out of 5. When the delegates were asked “How likely are you to apply skills acquired in the workshop to your daily practice?” the average score was 8.68 out of 10. When asked to “Rate the need for formal EBM teaching in Lithuanian medical schools” the delegates mean score was 9.49 out of 10.
Projects

Reduced dietary salt intake in heart failure patients

eat less

Clinical Prediction Rules

Background One way of implementing Evidence-Based Medicine for diagnosis and prognosis in clinical practice is to use appropriately validated and tested clinical prediction rules (CPRs). There are many that have Read More

Real v Rubbish EBM

Evidence-based medicine: where it came from, what it isn’t and what it could be. Led by Trish Greenhalgh, Professor of Primary Health Care and Dean for Research impact. This is Read More
Roche agrees to release all trial data on Tamiflu drug

The drug company Roche, which makes Tamiflu, has announced it will give researchers access to all its trial data for the influenza drug, the BBC reports.

Roche had previously been criticised for failing to grant access to the results of all its Tivares trials.

In an email it said it would provide the information over the next few months.

Campaigners say Roche should not have delayed access to the data.

It is estimated that half of all clinical trials have never been published and positive trial results are twice as likely to be published as negative findings.

The AllTrials campaign wants the pharmaceutical industry to publish all trials, and is supported by the Melbourne Trust, the British Medical Journal and MRC.

In December 2008, Roche gave the Cochrane group – an internationally renowned human health care and policy research body – access to its

Medical-device recalls in the UK and the device-regulation process: retrospective review of safety notices and alerts

C Heneghan,1 M Thompson,1,2 M Billingsley,3 D Cohen4

ABSTRACT: Medical devices are used safely for virtually every disease and condition. Although devices are subject to regulation, the number of recalls, the clinical data requirements for regulation and the impact on patient safety are poorly understood.

Methods: The authors defined a device using European directives and used publicly available information on the Medicines and Health Regulatory Authority website to determine the number of devices recalled from January 2006 to December 2010. Two reviewers independently assessed Field Safety Notices and Medical Device Alerts. The authors wrote to manufacturers to obtain further information and clinical data, and summarized data by year. Conformity European classification, indication, and Food and Drug Administration recall system of severity.

Results: In total, 2144 field safety notices were issued over the 5-year period, an increase of 123% in 2010 to 2011. 474 devices were recalled in the UK from 2006, 157 of which were food and drug administration recall system of severity.
Contributing to EBM

1. Contribute to the development of the evidence-base
2. Contribute to the methods of EBM
3. Contribute to the teaching, dissemination and communication of EBM
You can help shape a new global statement on clinical trial reporting. Write to the WHO before 15 November.

It's time all clinical trial results are reported.

Patients, researchers, pharmacists, doctors and regulators everywhere will benefit from publication of clinical trial results. Wherever you are in the world please sign the petition:

Thousands of clinical trials have not reported their results; some have not even been registered.

Information on what was done and what was found in these trials could be lost forever to doctors and researchers, leading to bad treatment decisions, missed opportunities for good medicine, and trials being repeated.

All trials past and present should be registered, and the full methods and the results reported.

We call on governments, regulators and research bodies to implement measures to achieve this.

Once you've signed the petition, make sure you get involved in the campaign.

If you would like to sign the petition on behalf of an organisation, email your organisation's logo and a short statement to alltrials@senseaboutscience.org.

Petition data will be held by Sense About Science. Read our privacy policy here.

Scroll down for petition translations.
THANK YOU