

The form may be saved to your computer and completed electronically in Word or printed and completed by hand.

Practice/Group Meeting Date No. Attendees

A Your Question/Topic

Reason for choosing topic?

B Evidence You Used

Type of evidence Guideline Study Other
Study type Systematic Review RCT Qualitative Other

Appraising the evidence

Nationally recognised **guidelines** e.g. NICE are assumed to be based on high quality evidence and do not need to be appraised. For all **study types**, following steps (1), (2) and (3) will help you to make sense of the evidence.

(1) What question did the study ask? What is the ...

Population/clinical problem?

Intervention/therapy?

Control/comparison?

Outcome?

Is the study question the same as yours? Yes No

(2) How well was the study done? Below are some questions to help you make sense of a RCT (See supplementary sheet for other study types)

Recruitment? Subjects representative of target population

Allocation? Randomised & concealed Comparable groups at start of trial

Maintenance? Equal co-interventions for each group Adequate follow-up; losses <20%

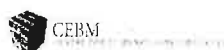
Measurement of outcomes? Blinded subjects and assessors Objective outcomes

(3) What do the results mean? Some tips for interpreting statistics in a RCT study

P-Value - $p < 0.05$ is often accepted as "statistically significant" i.e. there is a less than 1 in 20 (or 5 in 100) chance that the difference seen in the study would have arisen by chance.

NNT (Number Needed to Treat) is used to help assess clinical significance, for example, if $NNT=5$ then treating 5 patients with the new treatment will prevent 1 adverse event occurring.

95% CI (Confidence Interval) - If the CI does NOT cross 1 (for a ratio) or 0 (for a mean) - it is statistically significant. There is evidence of an effect and it may be clinically significant.



C Discussion Points

Consider, for example, whether this is new evidence (or old evidence not yet acted upon) - could it have an impact on patient care? Are the results credible and clinically significant? Is there a large variation in current practice? What barriers exist to its implementation?

1. Hypertension is a common co-morbidity in hypertensive patients (75%) – therefore clinicians need to consider the diagnosis of gout in HTN patients presenting with a monoarthritis and review their medication as well as doing further investigations and treatment.
2. Patients with HTN and gout should be on losartan or a calcium channel Blocker first line and other antihypertensive STOPPED or reduced if possible.
3. Guidance on acute and chronic Gout is currently different from what Parkside clinicians are doing therefore: Parkside Gout protocol to be established and we need to review our patients with Gout.

Does the evidence confirm or change current practice? Confirm Change Not relevant

What action(s) are you going to take?

For example, do you need to find more evidence / have training/ undertake an audit / take advice from specialists / spread to other practices / change your practice management / follow-up with health:mk?

		Who by?	Date by?
Action 1	Search on patient with diagnosis of Gout for GP to review current management.	TN then all clinicians	04/05/12
Action 2	Parkside GOUT protocol to be established and shown at the clinical meeting.	TN	30/04/12

Summary drafted by	Dr T Nguyen	Date	23/04/12
Verified / transcribed by	Dr N Smith	Date	23/04/12

Please take a copy for your records and e-mail the original to Linda.potter@mkhospital.nhs.uk or send in the internal mail to MKH Library, Postgrad Centre, Standing Way, Eaglestone, Milton Keynes MK6 5LD. Use your copy to record outcomes of actions.

Reviewing your agreed action(s)

Please use the space below on your copy to record benefits and/or outcomes of action(s) taken; it is recommended that agreed action(s) are reviewed 3 months after your IMPACTE meeting discussion. (On review, please send a copy to Linda.potter@mkhospital.nhs.uk)

		Date
Action 1		
Action 2		

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