

Editorial Comment

Best practice in oral care for children and young people being treated for cancer: can we achieve consensus?

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Received 19 January 2004; accepted 18 February 2004

The administration of many chemotherapy regimens may be complicated by toxicities that limit clinicians' abilities to deliver the most effective dose. One such clinically important acute side-effect is oral mucositis, a common, debilitating complication of cancer chemotherapy and radiotherapy, which can cause considerable discomfort and pain. It can also limit adequate nutritional intake, leading to delays in drug administration, increased hospital stay and, in some patients, life-threatening infection. These factors can severely affect the quality of life of children and their families.

Oral complications remain one of the most challenging cancer-related symptoms to manage. They have been examined extensively in medical, nursing and dental publications. Numerous articles describe the oral-care protocols used in various institutions [1]. One consistent finding when the various protocols are reviewed is that they are inconsistent about what constitutes appropriate oral care. No one strategy or approach has been found reliable in terms of clinical outcomes. What exists is a variety of interventions used for both the prevention and treatment of oral complications, only some of which have been shown to be effective [2,3]. This has resulted in uncertainty for nurses about which oral-care regimens they should follow, and to the conclusion that such regimens are often based on tradition, anecdote and subjective evaluation [4,5]. Nurses must, however, be accountable for the care they give, and, whenever possible, scientific-based evidence should inform decision-making and underpin the rationale for care given. Children and young people undergoing treatment for cancer experience many invasive procedures and therefore each and every procedure must be justified.

One method of reducing confusion and conflict is through the development and use of evidence-based guidelines. Guidelines that link recommendations to

research are one tool for bringing evidence of effective practice to the attention of practitioners. At present there are no such guidelines for practice in the management of oral care. In their absence, many centres in Europe have introduced guidance/guidelines based on a consensus of local expert opinion. This is considered the weakest form of evidence [6] but relevant where high-quality research evidence is unavailable [7]. Where local guidance/guidelines are in place, it may be possible to reduce the problem of inappropriate variation in clinical practice, but how far such guidance/guidelines make evidence-based recommendations (as opposed to recommendations from local practice or local views) available to health-care professionals may be less certain.

The potential benefits of evidence-based guidelines are, in outline [8], that they:

- Reduce unacceptable or undesirable variations in clinical practice
- Highlight available research findings
- Offer a way of implementing research findings
- Provide a focus for discussion among both health professionals and their patients/families
- Help professionals from different disciplines to come to an agreement about treatment
- Provide a quality framework against which to measure practice
- Give managers useful data for assessing treatment costs.

I am in no doubt that evidence-based guidelines will reduce the inconsistencies that currently surround oral care. To that end, a group of health-care professionals under the auspices of the United Kingdom Cancer in Childhood Study Group and The Paediatric Oncology Nurses Forum of The Royal College of Nursing is in the process of developing evidence-based guidelines using The Scottish Intercollegiate Guidelines Network (SIGN) framework (www.sign.ac.uk). How far this will

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represent a consensus on best practice across Europe I am less confident, for two reasons: the nature of the evidence and subjectivity in the process.

Current methods of evidence assessment have random controlled trials (RCTs) as their starting point. However, the assessment of trial evidence is not yet seamless, and the means of assessing non-trial evidence have only just begun to be addressed. In health care there are many other forms of evidence than RCTs; hence the opportunities for subjectivity to intrude into a seemingly objective process of guideline development are present from the start. Added to this, there may be a lack of evidence specific to the clinical questions asked by the guideline group. In this situation, consensus-building methods will be required to support recommendations. There may also be contradictory evidence; here again clinical expertise will be utilised in deciding what is recommended. Finally, patient choice? The accepted definition of evidence is the combination of research, clinical expertise and patient choice [9]. Yet patient involvement, which includes children, young people and families, remains a more recent addition in guideline development. It is not without its problems and would benefit from being evaluated in order to guarantee that patient involvement remains integral to the process. The accessibility of guidelines, their format and content, all influence the extent to which guidelines can assist decision-making with our client group. Decisions about clinical practice will always be a mixture of evidence-based and opinion-led actions [10]. Which leads me to conclude that our guidelines will go some way to achieving consensus in oral care through a development process that is well-structured and transparent, makes clear where recommendations are based on evidence and consensus, includes and values consultation (practitioners and patients) and peer review, allows sufficient time for presentation, dissemination and widespread implementation, and encompasses audit and review in a cyclical process.

But, one final word on the nature of the evidence. If we are to examine effectiveness of practice through the singular use of RCTs, then clinical questions, which are concerned with the meaning of events for practitioners

and patients, are more likely to be overlooked. Effective quality care in the management of oral care would benefit from research that embraces a range of methodologies to generate new knowledge. The notion of best practice must never be static; the guidelines that result from our activity in the UK are just the starting point. The success of these guidelines will be measured by the number of centres across Europe that adapt them for use locally. One further and exciting outcome I hope for is that the audit and review process of the guidelines will lead to large-scale, multicentred, national and international collaborative research. Only then can we be confident that consensus on best practice in oral care has been achieved.

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