MEN®; site of administration VISNee® (vision), OPTIclear®, Phot-oDERM®; dosage form as Enemacort® (ENEMA CORTisone), Follicap® (FOLlic acid CAPsules); dose regimen and duration Cefobid® (CEPHalosporin BID-twice daily), Lasix® it's effectLAST for SIX hours, Slow K it is a SLOW release potassium(K), Novorapid® reflects short and Rapid acting insulin; drug history or story Nystatin® was named after the New York(NY) STATE, while warfarin® is an acronym for Wisconsin Alumni Research Foundation(W.A.R.F). Trade names affected by brand name as Glimaryl®, affected by Amaryl® while Marisvani® affected by Marivan®.

Conclusions The research highlights 12 observed patterns used in pharmaceutical trade naming. Implementation of these methods will help the students, pharmacists and health care providers to become more aware of the message that the drug trade name delivers.

55 HOW MUCH DO GENERAL PRACTITIONERS KNOW ABOUT THE ABSOLUTE VALUE AND POSSIBLE HARM OF TREATMENTS FOR COMMON LONG-TERM CONDITIONS? A QUESTIONNAIRE SURVEY


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Objectives In Britain, GPs are responsible for prescribing multiple long-term treatments to their patients. To support shared clinical decision making, understanding of the absolute benefits and harms of individual treatments is needed. International evidence shows that doctors’ knowledge of absolute treatment effects is poor, but this has not been researched among British GPs.

Aim To assess and describe the level and range of the quantitative understanding of the benefits and harms of treatments for common long-term conditions among British GPs.

Method An online survey distributed to GPs in Britain over two months in 2018. Participants were asked to estimate the percentage absolute risk reduction or risk increase conferred by 13 interventions across 10 long term conditions on 17 important outcomes. Responses were collated and presented graphically for each clinical question and analyses performed to estimate the proportion of correct responses.

Results 443 respondents, broadly representative of the British GP population, were included in the analysis. The majority of respondents demonstrated poor knowledge of the absolute benefits and harms of treatments with inaccuracies common and wide ranging. Per question, only 3.2 - 28.4% of responses were correct allowing for +/- 1% margin in ARR estimates and 10.4 - 55.6% allowing a +/- 3% margin. 65% of GPs self-reported low to very low confidence in their knowledge.

Conclusions GPs’ knowledge of the absolute benefits and harms of treatments is poor, with inaccuracies of a magnitude likely to significantly affect clinical decision making and impede meaningful conversations with patients regarding treatment choices.

This represents a barrier to the practice of EBM as it is intended. The causes are complex and lie within the system of evidence dissemination, implementation and performance management of practitioners. These will be discussed along with potential solutions.
A dedicated website to clearly explain biases that systematic reviews are prone to
Guidelines to help peer-reviewers, journal editors and the public understand appropriate systematic review team composition and assess potential for bias or poor conduct.

**REFERENCE**

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**ESTIMATING THE EVIDENCE GAP IN NETWORK META-ANALYSIS**

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Objectives Network meta-analysis (NMA) provides plots of interventions networks per outcome. Such plots also demonstrate all possible pairwise comparisons in a network. This paper discusses the gap between evidence expected from a given network and observed evidence from trials by use of a simple formula.

Method Published network meta-analyses in BMJ, JAMA, Lancet and New England Journal of Medicine were collected (2003-2019). The potential number of comparisons per network plot was calculated using \( \frac{n(n-1)}{2} \) and the number of direct comparisons from trials was deducted to obtain the ‘evidence gap’ per network plot. We also compared evidence gap in the networks with low or high number of intervention nodes. All steps were conducted by GA, repeated by FS and supervised by CEA.

Results We excluded four NMAs because of mixing study designs but were able to include 41 NMAs of randomised controlled trials (RCTs). We identified 77 network plots from NMAs. The plots consisted of between 2 and 31 intervention nodes. Only four plots were complete and based on only direct comparisons. The evidence gap was between 0.06 and 0.88 for the remainder - between 10% and 90% of the comparisons in the network have not yet been reported in RCTs. There is a positive and strong correlation between the number of interventions and the number of indirect comparisons in RCTs. \( R^2 = 0.894 \) highlighting the considerable gap in the certainty of body of evidence as presented in NMAs. The evidence gap is filled statistically without real-world evidence from trials and the results of NMA are particularly problematic when there are many interventions in the plot.

Conclusions Researchers who undertake NMAs should report network plots and a list of missing comparisons from the trials. They should also report the evidence gap to emphasise the proportion of the NMA which is based on data derived from real world experiments and the proportion from statistic-based inference. The findings of our research call for an update of the PRISMA for Network Meta-Analyses reporting guideline.

**REFERENCE**


Our doctors need help! – ‘EVIDENCE BASED MEDICINE DOCTORS INFORMATION CENTERS’ COULD BE THE KEY TO FACILITATE DAILY PRACTICE

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Our doctors need help! – ‘Evidence Based Medicine Doctors Information Centers’ could be the key to facilitate daily practice

Every month 150,000 articles are published in 20,000 different medical journals. In order to stay up-to-date with constantly increasing research one needs to read 500 Studies each week. That is 1,5m of paper every week. As a comparison: in 1980 it was merely 1 study per week one had to read. As medical professional it can thus be very challenging and time consuming to find good and solid evidence in a myriad of research of today’s society that is pressured to constantly publish new data and information. Even guidelines can be written incomprehensibly or might even be contradicting themselves. In order to critically question studies, some practice and additional training are needed, which are often neglected in medical education. Many doctors thus lack essential skills to select, understand and critically appraise information that is being presented to them. We need more tools for clinical practice that facilitate decision making in evidence-based medicine. The ‘evidence-based medicine information center for doctors’ is a great example of how this can be achieved. It is a project, originally initiated by the Cochrane Collaboration Austria, that answers clinical questions from everyday hospital life in the form of rapid reviews. The great thing about rapid reviews is that evidence is synthesized more quickly than in a systematic review, since certain methodological aspects are abbreviated, and all the important knowledge is compressed in a short and understandable matter. For each question the first step is a systematic literature search in several databases. Two research assistants then examine a large number of international studies to see whether they fit the question. After abstract screening all articles that are shortlisted are examined again and the entire study is checked for its quality, i.e. whether the methodological implementation meets internationally recognized standards. Finally, an assessment of how much confidence the Information Centre has in the results of the selected studies is included in each Rapid Review, which gives the doctors an explanation of how strong and trustworthy this evidence is. This tool, specifically designed for doctors, gives guidance in clinical decision making and answers, ‘real life’ and relevant questions that arise when good evidence cannot be found, is not understood or guidelines are simply unclear. Of course, one could argue that training could be a more efficient way to equip doctors with the skills necessary to assess evidence. But let’s be realistic – who has the time? This tool should be implemented in every country to give our doctors the possibility to come into contact with those that have been trained to synthesize and assess evidence effectively. The clinical decisions our doctors make directly affect the health of our patients, so it should be our main priority to find and implement a solution that supports our medical professionals to make an informed and fair decision. If it works in Austria, why wouldn’t it in other countries?