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The ISN Clinical Practice Guidelines Committee

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The recognition that the outcomes of patients with kidney disease vary widely between regions and countries and that treatments should be based on the best evidence available, has led to an outpouring of clinical practice guidelines. In response, the International Society of Nephrology (ISN) established the Clinical Practice Guidelines Committee (CPGC) in 2005. The Committee has global representation, but does not produce its own guidelines; instead, members of the Committee review and assist in the development of guidelines formulated by other bodies. Since its inception, the CPGC has reviewed the European Best Practice Guidelines for Peritoneal Dialysis (Abboud O *et al*. [2007] *Nat Clin Pract Nephrol* 3: 6–7) and has consulted on the European Best Practice Guidelines on Haemodialysis and the upcoming Kidney Disease: Improving Global Outcomes (KDIGO) Guidelines on Bone and Mineral Metabolism.

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When reviewing clinical practice guidelines, the CPGC focuses on methodology and applicability. The methods used to evaluate evidence and express recommendations are considered. We realize that such evidence can be sparse. Randomized controlled trials are the preferred type of evidence on which to base practice; however, nephrology is remarkable for its lack of such trials. The 'parachute' phenomenon (Smith GC and Pell JP [2003] *BMJ* 327: 1459–1461), whereby expectation or experience of changes in mortality ethically and practically prevent the undertaking of a randomized controlled trial, is often encountered. However, many practices that are carried out simply because they are 'what we've always done' should be tested in randomized controlled trials. In the meantime, if the evidence for an intervention is weak, guidelines should reflect the paucity of data rather than impose rules with little evidence base. Accordingly, the European Best Practice Guidelines group has announced that it will publish European Renal Best Practice advice documents, rather than guidelines, when high levels of evidence are lacking (Zoccali C *et al*. [2008] *Nephrol Dial Transplant* 23: 2162–2166), and the recent KDIGO Hepatitis C guidelines use three statements to reflect differing levels of evidence (KDIGO committee [2008] *Kidney Int* 73 [Suppl 109]: S1–S99).

The CPGC evaluates the applicability of published guidelines in a global context. Inherent in evidence-based clinical practice guidelines is the recommendation of practices based on the best available evidence, irrespective of cost or other regional considerations. This aspirational approach might not be the pragmatic solution in areas where resources are limited. Introducing an expensive therapy with a proven but clinically marginal advantage could deprive patients of other more helpful therapies, or deprive others of any therapy at all. The CPGC will highlight regional influences that could modify the implementation of specific guidelines.

The Committee, in its second role of assisting in the development of clinical practice guidelines, aims to promote collaboration and consistency by liaising with major guideline-producing bodies and the renal community worldwide. Overall, we hope to add value to clinical practice guidelines by giving the global community an international perspective on the nuances of the application of such guidelines in the face of the growing epidemic of chronic kidney disease.

Supplementary information in the form of an unabridged version of this article is available on the *Nature Clinical Practice Nephrology* website.

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Competing interests
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