Levels of evidence: How they help in applying study findings to clinical practice

Levels of evidence can make it easier for busy physicians to apply the results of clinical research to their practice and to incorporate evidence-based medicine into patient care.

Levels of evidence are assigned to studies based on the quality of their design, validity, and applicability to patient care. The Agency for Health Care Quality and Research (AHRQ) has proposed that any system assigning levels of evidence should incorporate quality, quantity, and consistency of the evidence. Leading family medicine journals have adopted a uniform grading system known as the Strength of Recommendation Taxonomy (SORT), which includes these key elements and 3 levels of evidence. SORT is one among several different methods of grading levels of evidence that make use of similar principles. SORT’s primary advantage is its simplicity.

The randomized controlled trial (RCT) is the most rigorous study design. According to SORT, RCTs that deal with patient-oriented outcomes and include concealment, double-blinding, intention-to-treat analysis, and complete follow-up (and meta-analyses or systematic reviews of such randomized trials) provide a level of evidence (LOE) of 1. Observational studies, such as cohort and case-control studies (and systematic reviews that include them), are less rigorous in their design, and they are given an LOE of 2. Level 3 evidence, the lowest level, is assigned to consensus guidelines, expert opinion, usual practice, etc, or to studies that look at intermediate or disease-oriented outcomes.

Although the Nurses Health Study, a large cohort trial involving nearly 88,000 women, and other observational studies (LOE: 2) suggested a cardiovascular benefit from vitamin E, the Finnish Alpha-Tocopherol, Beta-Carotene Cancer Prevention study, a well-designed RCT (LOE: 1) proved the opposite. A recently published Italian study provided Level 3 evidence, demonstrating that vitamin E prevented an oxidation-induced reduction in coronary blood flow. Therefore, based on the highest level of evidence available, vitamin E to prevent cardiovascular disease is not recommended.

REFERENCES