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The ILCOR process for developing guidelines

Publication on 18th October of the 2010 International Consensus on Cardiopulmonary Resuscitation (CPR) and Emergency Cardiovascular Care (ECC) Science with Treatment Recommendations was the culmination of at least 3 years of work co-ordinated by the International Liaison Committee on Resuscitation (ILCOR) [1, 2]. Established in 1993, ILCOR currently includes representatives from the American Heart Association (AHA), the European Resuscitation Council (ERC), the Heart and Stroke Foundation of Canada (HSFC), the Australian and New Zealand Committee on Resuscitation (ANZCOR), Resuscitation Council of Southern Africa (RCSA), the InterAmerican Heart Foundation (IAHF), and the Resuscitation Council of Asia (RCA) [3].

Since 2000 [4], ILCOR has facilitated 5-yearly comprehensive reviews of resuscitation science. The conclusions and recommendations of the 2005 International Consensus Conference on CPR were published at the end of 2005 [5, 6]. The most recent International Consensus Conference was held in Dallas in February 2010 and the consensus science statements and treatment recommendations were published in Resuscitation and Circulation [1, 2].

The 2010 science review process was thorough: worksheet (review) topics were selected by each of six ILCOR task forces, comprising basic life support (BLS); advanced life support (ALS); acute coronary syndromes (ACS); paediatric life support; neonatal life support; and education, implementation and teams (EIT). A total of 277 resuscitation topics were placed in standard PICO (Population, Intervention, Comparison Outcome) format. International experts, ideally two per topic, were invited to undertake reviews. They were given explicit instructions on undertaking the search for relevant studies, determining the level of evidence for each study, summarising the evidence and drafting treatment recommendations [7]. To ensure a consistent and thorough approach, a worksheet template was created to ensure that the review methodology was standardised. Evidence evaluation experts reviewed all worksheets and assisted the worksheet reviewers to ensure consistency and quality of the evidence evaluation. Many of these reviews were presented and discussed at task force webinars that were held as often as twice a month for about 2 years leading up to the 2010 International Consensus Conference. From October 2009 the evidence reviews were posted on the ILCOR internet site (www.ilcor.org). More than 300 experts from 30 countries participated in the 2010 International Consensus Conference. Most of the science statements and treatment recommendations were completed during the conference but the final wording was completed after further review by ILCOR member organisations and the editorial board.

A very robust conflict of interest (COI) policy was created for the 2005 International Consensus Conference [8] and this was updated for the 2010 process [9]. Representatives of manufacturers and industry did not participate in either of the 2005 and the 2010 conferences.

As in 2005, the 2010 Consensus on CPR Science publication summarises the science of resuscitation and provides broad treatment recommendations where these could be agreed. More detailed guidelines have been published, or will be published, by the ILCOR member organisations and, although consistent with the science in the consensus document, they take into account geographic, economic, and system differences [10, 11]. There remain some differences between the ERC and the AHA guidelines (e.g. use of vasopressin) but these are generally minor and certainly less than the differences that existed between the two organisations in 2005. In particular, the AHA has adopted the CAB (compressions–airway–breathing) approach that had been implemented by the ERC in 2005. Minor international differences in CPR practice are inevitable and the reasons for these have been elucidated in the 2010 consensus document [3].

What is the future for the international consensus on CPR science? The 2010 process was time-consuming and relatively expensive. In my opinion, the end product was of high quality and of considerable value in providing the evidence supporting resuscitation practice. Some have advocated more frequent, smaller updates in guidelines but this would not make it easy to keep training materials up to date. The 2015 debate has already started!

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