ARISTOTLE
UNIVERSITY OF
THESSALONIKI

Interreg
Greece-Bulgaria
The Healthy Municipality
European Regional Development Fund

**"Policies for Enhancing Access to Health Services in
Deprived Areas: The Healthy Municipality"**

**co-funded by INTERREG V-A Cooperation Programme Greece -
Bulgaria 2014 – 2020**

Deliverable 4.2.1

**Setting up examination protocols in partner areas upon
most frequent diseases**

Protocols Template

Thessaloniki, May 2020

Interreg
Greece-Bulgaria
European Regional Development Fund
EUROPEAN UNION

Template for setting up examination protocol for a disease

The following template was used for setting up the examination protocols of each one of the seven most prevalent diseases, based on the guidelines proposed for the management of the most frequent diseases in Primary Health Care of the Greek Ministry of Health.

Health problem: Name of the disease (e.g. Diabetes Mellitus)

1. Introduction

An introductory section presents the impact of the disease at an international and national level according to bibliographic evidence.

2. Definition of the disease

A definition of the disease is presented based on previous literature.

3. Clinical questions

The questions about examinations concerning early diagnosis, prevention and follow up- where applicable- that would be answered by the recommendations that follow in the next section are presented. (e.g. Which are the exams with high predictive value for the diagnosis of DM in primary health care?)

4. Final recommendations, level of evidence and level of recommendation

Recommendations are numbered according to their order of presentation. Each one is follow by its level of evidence and level of recommendation, while the evidence that support it are also presented with the appropriate references. The hierarchy of evidence (level I-IV) used to build the recommendations is based on the rigor of the research methods of the studies

used, according to the National Health and Medical Research Council of Australia (NHMRC), as presented in Table 1. Finally, taking into consideration the level of evidence, the clinical impact, the ability to generate and apply, each recommendation was categorized from A to D (A= strong recommendation supported by high to moderate-quality evidence suggested for clinical practice), B= strong recommendation supported by high to moderate-quality evidence suggested for the majority of the cases in clinical practice), C= weak recommendation supported partly by any quality evidence that it should be followed with caution, D= weak recommendation supported low quality evidence suggesting that it should be followed with caution).

e.g.

Recommendation 1:

It is recommended for primary care physicians to diagnose diabetes based on one of the following three methods of blood glucose measurement: a) a fasting blood glucose level of 126 mg per dL (7.0 mmol per L) or greater on two separate occasions. b) a serum blood glucose level of greater than 199 mg per dL (11.0 mmol per L) in the oral glucose tolerance test, or c) a random blood glucose level of 200 mg per dL (11.1 mmol per L) or greater and classic symptoms of diabetes (e.g., polyuria, polydipsia, weight loss, blurred vision, fatigue) are present.

Level of Evidence: I   Level of recommendation A

Evidence on which the recommendation is based: relevant text with appropriate references.

5. References

All the references that are mentioned throughout all the text are presented numbered at this section

Table 1. *The hierarchy of evidence by the Australian National Health and Medical Research Council (NHMRC).*

Level of evidence	
Level I	Evidence obtained from a systematic review of all relevant randomised controlled trials.
Level II	Evidence obtained from at least one properly designed randomised controlled trial.
Level III-1	Evidence obtained from well-designed pseudo-randomised controlled trials (alternate allocation or some other method).
Level III-2	Evidence obtained from comparative studies with concurrent controls and allocation not randomised (cohort studies), case control studies, or interrupted time series with a control group.
Level III-3	Evidence obtained from comparative studies with historical control, two or more single-arm studies, or interrupted time series without a parallel control group.
Level IV	Evidence obtained from case series, either post-test or pre-test and post-test.