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Update of the guidelines for laparoscopic treatment of ventral and incisional abdominal wall hernias by the International Endohernia Society: Why we rely on OCEBM rather than GRADE in the current guideline process?

Dear Editor,

The ongoing update of the International Endohernia Society (IEHS) guidelines for laparoscopic treatment of ventral and incisional abdominal wall hernias represents an unprecedented international effort. A total of 112 experts on hernia surgery from 22 countries and regions (Argentina, Austria, Belgium, Brazil, Canada, China, Colombia, Denmark, Germany, Great Britain, Hong Kong, Indonesia, India, Japan, Nepal, the Netherlands, Singapore, Spain, Switzerland, Thailand, the USA, and Vietnam) are contributing to this work. This diversity ensures that the recommendations will reflect not only the best available evidence but also a truly global consensus. Currently, Part A of the guideline update is about 60% complete. The collaborative process is progressing well, and the final document is scheduled for submission by the end of 2025, prior to the Delphi consensus.^[1]

The main reason for the letter to the editor at hand is that there is an ongoing discussion regarding evidence grading systems in surgical guideline development. In the current update of the IEHS guidelines for laparoscopic treatment of ventral and incisional hernias, the Oxford Levels of Evidence (OCEBM) were applied instead of the Grading Quality of Evidence and Strength of Recommendations (GRADE) approach. We would like to briefly comment on this decision.

OCEBM^[2] and GRADE^[3] represent two distinct philosophies of evidence-based

medicine: Oxford offers a simple hierarchical scheme primarily based on the study design, while GRADE provides a multilayered framework that incorporates study quality, patient values, feasibility, and resource considerations. Comparative methodological analyses have demonstrated that no single system fully meets all requirements across specialties.^[4] Moreover, applying GRADE requires specific training of all contributors in order to ensure consistent use of its domains and criteria—a process that is both time-consuming and resource-intensive, typically demanding dedicated workshops or methodological courses over several days.

OCEBM provides rapid and transparent orientation, which is particularly helpful in surgical fields where evidence often consists of mixed study designs, registries, and expert consensus. In the IEHS project, as mentioned, 112 experts from 22 countries are contributing to the guideline process, making a straightforward and universally understood grading system a pragmatic choice. Coordinating such a large and diverse group is already a considerable challenge; requiring all contributors to undergo additional training in the application of a more complex methodology would hardly be feasible and could seriously jeopardize the progress of the project. By contrast, the HerniaSurge guideline for groin hernia management, developed by a considerably smaller panel of around 30 international experts, explicitly applied the GRADE methodology.^[5] This underlines that the

choice of the grading system also depends on the size and complexity of the project. Recent analyses also support a pragmatic, situational approach: in areas with limited randomized data (e.g., palliative care), hybrid or alternative grading systems may better reflect the available evidence and remain more intuitive for clinicians.^{16]}

We propose that the choice of the grading system should be guided by the clinical question and the evidence landscape, in order to achieve recommendations that are both scientifically robust and practical in daily use. We therefore consider the use of the OCEBM in the current IEHS guideline update as a justified, context-driven decision, while acknowledging that GRADE remains the gold standard in many disciplines.

Ethical policy and Institutional Review Board statement

Not applicable.

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Conflicts of interest

There are no conflicts of interest.

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