INTERQUAL® IMAGING CRITERIA
BIBLIOGRAPHY: CHEST & HEART
McKesson Clinical Evidence Classification

References cited in the clinical content are classified according to the type of evidence presented. Classification ratings of I through V are used. Ratings are applied as clinical content is updated; therefore, a rating may not appear after each reference. Classification ratings appear in parentheses at the end of a reference.

<table>
<thead>
<tr>
<th>Classification</th>
<th>Type of Evidence</th>
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<tr>
<td>Class I</td>
<td>Meta-analysis or systematic review</td>
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<td>Class II</td>
<td>Well-designed controlled clinical trial or experimental study</td>
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<td>Class III</td>
<td>Well-designed observational or epidemiologic study</td>
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<td>Class IV</td>
<td>Evidence-based guideline</td>
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<td>Class V</td>
<td>Expert opinion, panel consensus, literature review, text or reference book, descriptive study, case report, or case series</td>
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**Class I**
A meta-analysis is an analysis of data pooled from multiple trials. A systematic review is a qualitative means of summarizing multiple trials on the same intervention. Class I studies can show a statistically significant difference in support of an intervention when smaller studies could not. A meta-analysis or systematic review that finds insufficient evidence to support or refute an intervention (due to a lack of properly designed trials) is inconclusive. A potential weakness of Class I studies is that they may only assess published studies. Since studies demonstrating significant differences are more likely to be published than those that do not, publication bias is of concern.

**Class II**
A randomized controlled trial (RCT) is an experimental study design in which subjects are randomly assigned to an intervention or a control group. A RCT is the gold standard for testing cause and effect relationships. Intention-to-treat analysis should be performed to account for missing data points.

**Class III**
Observational or epidemiologic studies can suggest an association between events or findings. These associations cannot be used to establish causality. Cross-sectional, cohort, and case-control studies are all used to identify possible risk factors. Cross-sectional studies are also used to determine the prevalence of a condition. Cohort studies are used to study incidence, the natural history of a condition, prognosis after a specific exposure, and associated harms.

**Class IV**
Evidence-based guidelines are systematically developed recommendations for clinical practice. Evidence-based guidelines identify the methodology used to gather the evidence on which the recommendations are based. Usually, a grading system for both the quality of the evidence and the strength of the recommendations is provided. Guidelines that are evidence-based may also contain consensus recommendations in areas where evidence is lacking, but these recommendations are clearly identified and appropriately graded.

**Class V**
Class V references may be the best information in the absence of other evidence. Expert opinion, panel consensus, literature reviews, and descriptive studies (case reports or case series) are subject to significant bias. A case series with comparison to historical controls can be plagued with missing data, and data extraction inconsistencies are common. The use of historical controls does not address how the diagnosis of disease or its treatment has evolved over time with newer technologies or medication. Text book information may be out of date by the time the book is published.
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Anand et al. Does this patient have deep vein thrombosis? JAMA 1998. 279(14):1094-1099. (V)
Bonello et al. Non-invasive coronary angiography for patients with acute atypical chest pain discharged after negative screening including maximal negative treadmill stress test. A prospective study. Int J Cardiol 2008 (III)
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Budoff et al. Assessment of coronary artery disease by cardiac computed tomography: a scientific statement from the American Heart Association Committee on Cardiovascular Imaging and Intervention, Council on Cardiovascular Radiology and Intervention, and Committee on Cardiac Imaging, Council on Clinical Cardiology. Circulation 2006. 114(16):1761-1791. (IV)


Dalen JE. Pulmonary embolism: what have we learned since Virchow? Natural history, pathophysiology, and diagnosis. Chest 2002; 122(4):1440-1456. (V)

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Hillner et al. Impact of positron emission tomography/computed tomography and positron emission tomography (PET) alone on expected management of patients with cancer: initial results from the National Oncologic PET Registry. J Clin Oncol 2008. 26(13):2155-2161. (III)


Knuuti et al. The need for standardisation of cardiac FDG PET imaging in the evaluation of myocardial viability in patients with chronic ischaemic left ventricular dysfunction. Eur J Nucl Med Mol Imaging 2002. 29(9):1257-1266. (V)


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Marcu et al. Clinical applications of cardiovascular magnetic resonance imaging. CMAJ 2006. 175(8):911-917. (V)


Pfisterer et al. Outcome of elderly patients with chronic symptomatic coronary artery disease with an invasive vs optimized medical treatment strategy: one-year results of the randomized TIME trial. JAMA 2003. 289(9):1117-1123. (II)


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Schroeder et al. Cardiac computed tomography: indications, applications, limitations, and training requirements: report of a Writing Group deployed by the Working Group Nuclear Cardiology and Cardiac CT of the European Society of Cardiology and the European Council of Nuclear Cardiology. Eur Heart J 2008. 29(4):531-556. (IV)


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