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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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<tbody>
<tr>
<td>Class I</td>
<td>Meta-analysis or systematic review</td>
</tr>
<tr>
<td>Class II</td>
<td>Well-designed controlled clinical trial or experimental study</td>
</tr>
<tr>
<td>Class III</td>
<td>Well-designed observational or epidemiologic study</td>
</tr>
<tr>
<td>Class IV</td>
<td>Evidence-based guideline</td>
</tr>
<tr>
<td>Class V</td>
<td>Expert opinion, panel consensus, literature review, text or reference book, descriptive study, case report, or case series</td>
</tr>
</tbody>
</table>

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.

InterQual® Imaging Criteria: PEDIATRIC


Barkhof et al. Comparison of MRI criteria at first presentation to predict conversion to clinically definite multiple sclerosis. Brain 1997. 120 ( Pt 11):2059-2069. (III)
InterQual® Imaging Criteria: PEDIATRIC


Cincinnati Children's Hospital Medical Center. Evidence-based care guideline for medical management of first urinary tract infection in children 12 years of age or less. Cincinnati (OH): Cincinnati Children's Hospital Medical Center; 2006. (IV)


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Friedman and Grosberg. Diagnosis and management of the primary headache disorders in the emergency department setting. Emerg Med Clin North Am 2009. 27(1):71-87, viii. (V)


InterQual® Imaging Criteria: PEDIATRIC


InterQual® Imaging Criteria: PEDIATRIC


InterQual® Imaging Criteria: PEDIATRIC


Musunuru et al. Computed Tomography in the Diagnosis of Acute Appendicitis: Definitive or Detrimental? J Gastrointest Surg 2007 (III)


Nichols. Rogers textbook of pediatric intensive care, 4th ed. Lippincott Williams & Wilkins; 2008. (V)


Perry et al. Is the combination of negative computed tomography result and negative lumbar puncture result sufficient to rule out subarachnoid hemorrhage? Ann Emerg Med 2008. 51(6):707-713. (III)


Podoloff et al. NCCN task force report: positron emission tomography (PET)/computed tomography (CT) scanning in cancer. J Natl Compr Canc Netw 2007. 5 Suppl 1:S1-S22; quiz S23-22. (IV)

Portis and Sundaram. Diagnosis and initial management of kidney stones. Am Fam Physician 2001. 63(7):1329-1338. (V)


InterQual® Imaging Criteria: PEDIATRIC

Shneker and Fountain. Epilepsy. Dis Mon 2003. 49(7):426-478. (V)
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Temiz et al. The efficacy of Tc99m dimercaptosuccinic acid (Tc-DMSA) scintigraphy and ultrasonography in detecting renal scars in children with primary vesicoureteral reflux (VUR). Int Urol Nephrol 2006. 38(1):149-152. (III)
InterQual® Imaging Criteria: PEDIATRIC
