InterQual® Procedures Criteria: General Surgery

Bibliography

Change Healthcare Clinical Evidence Classification

References cited in the clinical content are classified according to the type of evidence presented. The class ratings, I through V, are intended to provide a classification of the evidence but are not necessarily hierarchical. Classifications appear in parentheses at the end of each reference. References followed by an (NC) are not classified; examples include pre-published research or information from government, manufacturer, laboratory, or patient education websites.

<table>
<thead>
<tr>
<th>Classification</th>
<th>Type of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class I</td>
<td>Meta-analysis, technology assessment, or systematic review</td>
</tr>
<tr>
<td>Class II</td>
<td>Randomized controlled trial</td>
</tr>
<tr>
<td>Class III</td>
<td>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

Class I sources synthesize the results of multiple studies. When quantitative synthesis is possible, meta-analyses can provide a more accurate estimate of the effect or association size than individual smaller studies can. A Class I study that finds insufficient evidence to support or refute an intervention (due to a lack of appropriate primary research) is inconclusive. A potential weakness of Class I studies is that they may only assess published research, potentially leaving their findings vulnerable to publication bias.
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. An 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. Nonrandomized controlled trials are sometimes used when randomization is impossible or unethical.

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. Textbook information may be out of date by the time the book is published.

Comparative Effectiveness Research (CER)

Citations are designated with the CER label as part of the evidence classification if the article cited is one of the following:

1. A clinical trial or other clinical study that directly compares two or more health care interventions for the same clinical scenario.
2. A systematic review that compares two or more health care interventions by synthesizing the research from previous clinical studies.
Bibliography


Aguilar-Olivas et al. The role of bariatric surgery in the management of nonalcoholic fatty liver disease and metabolic syndrome. Metabolism 2016. 65(8):1196-207. (V)


American College of Radiology. ACR appropriateness criteria: incidentally discovered adrenal mass. Reston, VA: American College of Radiology; 2012. (IV)


American College of Radiology (ACR). ACR appropriateness criteria: Vomiting in Infants Up to 3 Months of Age. Reston (VA): American College of Radiology; 2014. (IV)


American Society of Metabolic and Bariatric Surgery. The role of endoscopy in the bariatric surgery patient; 2015. (IV)


Bahn Chair et al. Hyperthyroidism and other causes of thyrotoxicosis: management guidelines of the American Thyroid Association and American Association of Clinical Endocrinologists. Thyroid 2011. 21(6):593-646. (IV)


Bays et al. Lipids and bariatric procedures Part 2 of 2: scientific statement from the American Society for Metabolic and Bariatric Surgery (ASMBS), the National Lipid Association (NLA), and Obesity Medicine Association (OMA). Surg Obes Relat Dis 2016. 12(3):468-95. (V)


Bibliography

Benotti et al. Gastric Bypass Surgery Produces a Durable Reduction in Cardiovascular Disease Risk Factors and Reduces the Long-Term Risks of Congestive Heart Failure. J Am Heart Assoc 2017. 6(5). (III)


Breuer et al. Pediatric thyroid disease: when is surgery necessary, and who should be operating on our children? J Clin Res Pediatr Endocrinol 2013. 5 Suppl 1:79-85. (IV)

Byrne et al. The fate of patients who undergo “preoperative” ERCP to clear known or suspected bile duct stones. Surg Endosc 2009. 23(1):74-79. (III)


Courcoulas et al. Three-Year Outcomes of Bariatric Surgery vs Lifestyle Intervention for Type 2 Diabetes Mellitus Treatment: A Randomized Clinical Trial. JAMA Surg 2015. 150(10):931-40. (II CER)


Csendes et al. Late follow-up of polypoid lesions of the gallbladder smaller than 10 mm. Ann Surg 2001. 234(5):657-60. (III)


Frazee et al. Outpatient laparoscopic appendectomy should be the standard of care for uncomplicated appendicitis. J Trauma Acute Care Surg 2014. 76(1):79-82; discussion -3. (III)


Giuliano et al. Axillary dissection vs no axillary dissection in women with invasive breast cancer and sentinel node metastasis: a randomized clinical trial. JAMA 2011. 305(6):569-75. (II CER)


Golden et al. Prospective evaluation of the ability of clinical scoring systems and physician-determined likelihood of appendicitis to obviate the need for CT. Emerg Med J 2016. (III)


Ibrahim et al. Reoperation and Medicare Expenditures After Laparoscopic Gastric Band Surgery. JAMA Surg 2017. (III)


Kang et al. Laparoscopic cholecystectomy only could be an appropriate treatment for selected clinical R0 gallbladder carcinoma. Surg Endosc 2007. 21(9):1582-7. (III)


Kokotovic et al. Watchful waiting as a treatment strategy for patients with a ventral hernia appears to be safe. Hernia 2016. 20(2):281-7. (III)

Konrad et al. MRI: first-line imaging modality for pregnant patients with suspected appendicitis. Abdom Imaging 2015. 40(8):3359-64. (III)


Krag et al. Sentinel-lymph-node resection compared with conventional axillary-lymph-node dissection in clinically node-negative patients with breast cancer: overall survival findings from the NSABP B-32 randomised phase 3 trial. Lancet Oncol 2010. 11(10):927-33. (II CER)


Lahaye et al. Mandatory imaging cuts costs and reduces the rate of unnecessary surgeries in the diagnostic work-up of patients suspected of having appendicitis. Eur Radiol 2015. 25(5):1464-70. (III)


Lohsiriwat. Hemorrhoids: from basic pathophysiology to clinical management. World J Gastroenterol 2012. 18(17):2009-17. (V)


Newell et al. ACR Appropriateness Criteria(R) on nonpalpable mammographic findings (excluding calcifications). J Am Coll Radiol 2010. 7(12):920-30. (IV)


Park et al. Is cholecystectomy a reasonable treatment option for simple gallbladder polyps larger than 10 mm? World J Gastroenterol 2015. 21(14):4248-54. (III)


Piepoli et al. 2016 European Guidelines on cardiovascular disease prevention in clinical practice: The Sixth Joint Task Force of the European Society of Cardiology and Other Societies on Cardiovascular Disease Prevention in Clinical Practice (constituted by representatives of 10
societies and by invited experts) Developed with the special contribution of the European Association for Cardiovascular Prevention & Rehabilitation (EACPR). Eur Heart J 2016. 37(29):2315-81. (IV)


Rebecchi et al. Gastroesophageal reflux disease and morbid obesity: To sleeve or not to sleeve? World J Gastroenterol 2017. 23(13):2269-75. (V)


Sebastian et al. Managing incidental findings on abdominal and pelvic CT and MRI, Part 4: white paper of the ACR Incidental Findings Committee II on gallbladder and biliary findings. J Am Coll Radiol 2013. 10(12):953-6. (V)


Smith et al. ACR Appropriateness Criteria(R) Right Lower Quadrant Pain--Suspected Appendicitis. Ultrasound Q 2015. 31(2):85-91. (IV)


Ukai et al. Evidence of surgical outcomes fluctuates over time: results from a cumulative meta-analysis of laparoscopic versus open appendectomy for acute appendicitis. BMC Gastroenterol 2016. 16:37. (I CER)


Ward et al. Laparoscopic appendectomy is safer than open appendectomy in an elderly population. JSLS 2014. 18(3). (III)


Zoarets et al. Does selective use of computed tomography scan reduce the rate of "white" (negative) appendectomy? Isr Med Assoc J 2014. 16(6):335-7. (III)