INTERQUAL® SPECIALTY REFERRAL CRITERIA
BIBLIOGRAPHY: DERMATOLOGIC DISORDERS
McKesson 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>
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<tbody>
<tr>
<td>Class I</td>
<td>Meta-analysis or systematic review</td>
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<tr>
<td>Class II</td>
<td>Well-designed controlled clinical trial or experimental study</td>
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<tr>
<td>Class III</td>
<td>Well-designed observational or epidemiologic study</td>
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<tr>
<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 the results 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. 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. Text book information may be out of date by the time the book is published.
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Comparative Effectiveness Research (CER)
"Comparative effectiveness research is the conduct and synthesis of research comparing the benefits and harms of different interventions and strategies to prevent, diagnose, treat and monitor health conditions in 'real world' settings." (U.S. Department of Health and Human Services, Report to the President and the Congress on Comparative Effectiveness Research; 2009. Available from: http://www.hhs.gov/recovery/programs/cer/execsummary.html [cited Apr 20 2010])

Bibliography

Alomar et al. Vehicle-controlled, randomized, double-blind study to assess safety and efficacy of imiquimod 5% cream applied once daily 3 days per week in one or two courses of treatment of actinic keratoses on the head. Br J Dermatol 2007. 157(1):133-141. (II)
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Kreuter et al. 1% pimecrolimus, 0.005% calcipotriol, and 0.1% betamethasone in the treatment of intertriginous psoriasis: a double-blind, randomized controlled study. Arch Dermatol 2006. 142(9):1138-1143. (II)
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Ozolins et al. Randomised controlled multiple treatment comparison to provide a cost-effectiveness rationale for the selection of antimicrobial therapy in acne. Health Technol Assess 2005. 9(1):iii-212. (II)
Primary Care Dermatology Society & British Association of Dermatologists. Guidelines for the management of atopic eczema. London: British Association of Dermatologists; February 2006. (V)
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