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>
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<tr>
<td>Class I</td>
<td>Meta-analysis, technology assessment, or systematic review</td>
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<td>Class II</td>
<td>Randomized controlled trial</td>
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<td>Class III</td>
<td>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

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. Text book 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.


BHIVA, British HIV Association guidelines for the management of HIV infection in pregnant women 2012 (2014 interim review). 2014 (IV)


Bojahr et al. Malignancy rate of 10,731 uteri morcellated during laparoscopic supracervical hysterectomy (LASH). Arch Gynecol Obstet 2015. (III)


Bugg et al. Oxytocin versus no treatment or delayed treatment for slow progress in the first stage of spontaneous labour. Cochrane Database Syst Rev 2013. 6:CD007123. (I)


Daniels et al. Laparoscopic uterosacral nerve ablation for alleviating chronic pelvic pain: a randomized controlled trial. JAMA 2009. 302(9):955-961. (II)


Fergusson et al. Endometrial resection and ablation versus hysterectomy for heavy menstrual bleeding. The Cochrane database of systematic reviews 2013. 11:CD000329. (I CER)


Hendrickson and Delaney. Hemolytic Disease of the Fetus and Newborn: Modern Practice and Future Investigations. Transfus Med Rev 2016. 30(4):159-64. (V)


Koopmans et al. Induction of labour versus expectant monitoring for gestational hypertension or mild pre-eclampsia after 36 weeks' gestation (HYPITAT): a multicentre, open-label randomised controlled trial. Lancet 2009. 374(9694):979-88. (II)


Lee et al. The feasibility and safety of same-day discharge after robotic-assisted hysterectomy alone or with other procedures for benign and malignant indications. Gynecologic oncology 2014. 133(3):552-5. (V)

Lethaby et al. Endometrial resection and ablation techniques for heavy menstrual bleeding. The Cochrane database of systematic reviews 2013. 8:CD001501. (I)


Lourenco et al. Ovarian and tubal torsion: imaging findings on US, CT, and MRI. Emerg Radiol 2013 Sep 28 (V)

Maher et al. Surgical management of pelvic organ prolapse in women. Cochrane Database Syst Rev 2013. 4:CD004014. (I)

Mahnert et al. Unexpected gynecologic malignancy diagnosed after hysterectomy performed for benign indications. Obstetrics and gynecology 2015. 125(2):397-405. (III)


Mousa et al. Treatment for primary postpartum haemorrhage. The Cochrane database of systematic reviews 2014. 2:CD003249. (I)


National Cancer Institute. Endometrial Cancer; 2013. (IV)


Sesti et al. Randomized comparison of total laparoscopic, laparoscopically assisted vaginal and vaginal hysterectomies for myomatous uteri. Archives of gynecology and obstetrics 2014. 290(3):485-91. (II CER)


Tita et al. What we have learned about scheduling elective repeat cesarean delivery at term. Semin Perinatol 2016. 40(5):287-90. (V)


Transmission. Recommendations for use of antiretroviral drugs in pregnant HIV-1-infected women for maternal health and interventions to reduce perinatal HIV transmission in the United States. Bethesda; 2012. (IV)


Trimble et al. Management of endometrial precancers. Obstetrics and gynecology 2012. 120(5):1160-75. (V)


Wood et al. Does induction of labour increase the risk of caesarean section? A systematic review and meta-analysis of trials in women with intact membranes. BJOG 2014. 121(6):674-85; discussion 85. (I)

Wright et al. Robotically assisted vs laparoscopic hysterectomy among women with benign gynecologic disease. JAMA 2013. 309(7):689-98. (III)

Wright et al. Uterine pathology in women undergoing minimally invasive hysterectomy using morcellation. JAMA 2014. 312(12):1253-5. (III)


