INTERQUAL® CARE PLANNING CRITERIA

BIBLIOGRAPHY: Procedures- Orthopedic – Lower Extremity 2017
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>
</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>
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</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. 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.

Bibliography

Aynardi et al. Outpatient surgery as a means of cost reduction in total hip arthroplasty: a case-control study. HSS J 2014. 10(3):252-5. (III)


Bisicchia et al. Osteochondral allograft of the talus. The Iowa orthopaedic journal 2014. 34:30-7. (V)


Clohisy et al. Surgical procedure profile in a comprehensive hip surgery program. Iowa Orthop J 2006. 26:63-68. (III)


INTERQUAL® CARE PLANNING CRITERIA Bibliography: Procedures- Orthopedic – Lower Extremity 2017


Demetracopoulos et al. Total ankle arthroplasty in end-stage ankle arthritis. Current reviews in musculoskeletal medicine 2013. 6(4):279-84. (V)


Donken et al. Surgical versus conservative interventions for treating ankle fractures in adults. The Cochrane database of systematic reviews 2012. 8:CD008470. (I CER)


Goh et al. Outcomes are favorable after arthroscopic treatment of osteochondritis dissecans of the talus. The Journal of foot and ankle surgery : official publication of the American College of Foot and Ankle Surgeons 2015. 54(1):57-60. (III)


Hepple and Guha. The role of ankle arthroscopy in acute ankle injuries of the athlete. Foot and ankle clinics 2013. 18(2):185-94. (V)
Hernandez-Vaquero et al. Total knee arthroplasties performed with a mini-incision or a standard incision. Similar results at six months follow-up. BMC Musculoskeletal Disorders 2010. 11:27. (II CER)


Lombardi et al. Outpatient Arthroplasty is Here Now. Instr Course Lect 2016. 65:531-46. (V)


Lumsden et al. Medical and endovascular management of critical limb ischemia. J Endovasc Ther 2009. 16(2 Suppl 2):I131-62. (V)


Morelli and Braxton. Meniscal, plica, patellar, and patellofemoral injuries of the knee: updates, controversies and advancements. Prim Care 2013. 40(2):357-82. (V)


Rodrigues-Pinto et al. Total ankle replacement in patients under the age of 50. Should the indications be revised? Foot and ankle surgery : official journal of the European Society of Foot and Ankle Surgeons 2013. 19(4):229-33. (III)


Rubin et al. SSR Practice Parameter for the Performance and Interpretation of Magnetic Resonance Imaging (MRI) or the Ankle and Hindfoot. Journal of the American College of Radiology : JACR 2014:16. (IV)


Scottish Intercollegiate Guidelines Network (SIGN), Management of early rheumatoid arthritis. SIGN publication no. 123. Edinburgh: SIGN; 2011 (IV)


Taljanovic et al. ACR Appropriateness Criteria on Chronic Hip Pain; 2011. (IV)


Wallace et al. The effect of body mass index on the risk of post-operative complications during the 6 months following total hip replacement or total knee replacement surgery. Osteoarthritis Cartilage 2014. 22(7):918-27. (III)


Werner et al. Obesity Is Associated With Increased Complications After Operative Management of End-Stage Ankle Arthritis. Foot & ankle international 2015. (III)

Wiewiorski et al. Chondral and osteochondral reconstruction of local ankle degeneration. Foot and ankle clinics 2013. 18(3):543-54. (V)


Zmistowski et al. Diagnosis of periprosthetic joint infection. The Journal of arthroplasty 2014. 29(2 Suppl):77-83. (V)