

2002 CPR-ECC Criteria

Table 1: Evaluation of the strength of literature

Level of Evidence	Definition
1: Positive RCTs p<0.05)	Prospective randomized controlled trials with conclusion that new intervention is significantly better or worse than control
2: Neutral RCTs (NS)	Randomized controlled trials with conclusions that neither therapy is better than the other
3: Prospective, nonrandom	Nonrandomized, prospective observational study with treatment and control groups
4: Retrospective, nonrandom	Nonrandomized, retrospective observational study with treatment and control groups
5: Case series	Series of patients received new intervention in past or will in future. Watch to see effect without control group
6: Animal Studies	Studies using animals or mechanical models
7: Extrapolations	Reasonable extrapolations from existing data or data collected for other purposes; quasi-experimental designs
8: Rational conjecture Common sense	Fits with common sense, has face validity, applies to many non-evidence-based guidelines that "made sense", No evidence of harm

Table 2: Classification of recommendations

Evidence	Class	Interpretation
Minimum evidence required: - Level 1 evidence - Critical assessment: excellent - Homogenous, consistently positive, robust results	Class I: Excellent ■ Definitely recommended ■ Support: excellent evidence ■ Proven efficacy and effectiveness	Always safe, proven safe and definitely useful
Minimum evidence required: - Higher level of evidence - Multiple studies, mostly positive - Critical assessment: good-very good - Weight of evidence/expert opinion and magnitude of benefit more strongly in favor of intervention than IIb - More long-term outcomes than IIb	Class IIa: Good to Very Good ■ Acceptable and useful ■ Supported by good-very good evidence <i>**Contextual factors may influence classification (cost, magnitude of benefit, logistical problems, etc.)**</i>	Acceptable, safe and useful ■ Considered standard of care reasonably prudent physicians can choose ■ Considered intervention of choice by experts ■ Often receive AHA support in training materials, etc.
Minimum evidence required: - Level of evidence low-intermediate - Few studies, generally positive - Fair to poor studies - Weight of expert opinion/evidence less in favor of usefulness/efficacy - Immediate, intermediate, surrogate outcomes	Class IIb: Fair to Good ■ Acceptable and useful ■ Fair to good evidence supporting use <i>**Contextual factors should not be used to avoid adopting new but clinically beneficial treatments**</i>	Acceptable, safe and useful ■ Considered within standard of care reasonably prudent physicians can choose ■ Considered optional or alternative treatment by most experts
Evidence found but available studies have shortcomings - Promising but low level - Fail to address relevant clinical outcomes - Inconsistent, non-compelling or contradictory results - May be high level but with conflicting results	Class Indeterminate ■ Preliminary research stage ■ Insufficient evidence for class ■ Promising but needs additional confirmation ■ No harm but no benefit ■ No recommendation until further evidence	- May still be recommended but acknowledging weaknesses of supporting evidence - Do not use to resolve debates among experts, esp. with evidence interpreted differently - Limited to promising interventions
Positive evidence completely absent or Evidence strongly suggests or confirms harm	Class III Unacceptable, Not useful, May be harmful	Evidence of benefit is completely lacking or studies suggest or confirm harm