



Complete Summary

GUIDELINE TITLE

Screening for idiopathic scoliosis in adolescents: recommendation statement.

BIBLIOGRAPHIC SOURCE(S)

U.S. Preventive Services Task Force (USPSTF). Screening for idiopathic scoliosis in adolescents: recommendation statement. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2004 Jun. 4 p. [4 references]

GUIDELINE STATUS

This is the current release of the guideline.

This version updates a previously published guideline: U.S. Preventive Services Task Force. Guide to clinical preventive services. 2nd ed. Baltimore (MD): Williams & Wilkins; 1996. Chapter 47, Screening for adolescent idiopathic scoliosis. p. 517-29.

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SCOPE

DISEASE/CONDITION(S)

Idiopathic scoliosis

GUIDELINE CATEGORY

Prevention
Screening

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Pediatrics
Preventive Medicine

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Nurses
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

- To summarize the U.S. Preventive Services Task Force recommendations on screening for idiopathic scoliosis in adolescents and the supporting scientific evidence
- To update the 1996 recommendations contained in the *Guide to Clinical Preventive Services*, Second Edition

TARGET POPULATION

Asymptomatic adolescents seen in primary care settings

INTERVENTIONS AND PRACTICES CONSIDERED

Screening for idiopathic adolescent scoliosis using visual inspection of the spine and forward-bending test, with or without a scoliometer

MAJOR OUTCOMES CONSIDERED

This targeted review focused on the Task Force's key questions 1, 2, 3, and 5.

- **Key Question 1:** Is there new direct evidence that screening asymptomatic adolescents for idiopathic scoliosis leads to better health outcomes than not screening?
- **Key Question 2:** Is there new evidence about the rate at which minor scoliosis progresses to a clinically significant form that causes health problems later in life?
- **Key Question 3:** How valid and accurate are screening tests for adolescents with idiopathic scoliosis?
- **Key Question 5:** Is there new evidence that scoliosis treatments lead to better health outcomes if applied at an early stage?

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): A targeted evidence review was prepared by the RTI International-University of North Carolina Evidence-based Practice Center (EPC) for the Agency for Healthcare Research and Quality (AHRQ) for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Companion Documents" field).

Search Strategy

The search strategy for this brief update included MEDLINE®, Cochrane Library, and National Guideline Clearinghouse™ reviews for English-language articles published between 1994 and 2002 on new direct evidence of the benefits and harms of screening and treating adolescents for idiopathic scoliosis. The search was limited to randomized controlled trials (RCTs), meta-analyses, systematic reviews, well-designed observational studies, and editorials and commentaries concerning the critical key questions. Studies were excluded if they did not meet the specific inclusion criteria or were not relevant to a key question.

Search terms included *scoliosis, idiopathic scoliosis, mass screening, treatments, and population based*. The search terms were limited to adolescence, English language, and the years 1994 to 2002. Scoliosis and idiopathic scoliosis were Medical Subject Heading® (MeSH®) terms that were exploded by the remaining terms.

NUMBER OF SOURCE DOCUMENTS

The search yielded 120 articles related to screening for and treatment of adolescents for idiopathic scoliosis. Only 16 articles directly addressed a critical key question, and only 1 was a randomized controlled trial (RCT).

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

The U.S. Preventive Services Task Force (USPSTF) grades the **quality of the overall evidence** for a service on a 3-point scale (good, fair, poor):

Good

Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.

Fair

Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual

studies, generalizability to routine practice, or indirect nature of the evidence on health outcomes.

Poor

Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Balance Sheets
Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

When the overall quality of the evidence is judged to be good or fair, the U.S. Preventive Services Task Force (USPSTF) proceeds to consider the magnitude of net benefit to be expected from implementation of the preventive service. Determining net benefit requires assessing both the magnitude of benefits and the magnitude of harms and weighing the two.

The USPSTF classifies benefits, harms, and net benefits on a 4-point scale: "substantial," "moderate," "small," and "zero/negative."

"Outcomes tables" (similar to "balance sheets") are the USPSTF's standard resource for estimating the magnitude of benefit. These tables, prepared by the topic teams for use at USPSTF meetings, compare the condition specific outcomes expected for a hypothetical primary care population with and without use of the preventive service. These comparisons may be extended to consider only people of specified age or risk groups or other aspects of implementation. Thus, outcomes tables allow the USPSTF to examine directly how the preventive service affects benefits for various groups.

When evidence on harms is available, the topic teams assess its quality in a manner like that for benefits and include adverse events in the outcomes tables. When few harms data are available, the USPSTF does not assume that harms are small or nonexistent. It recognizes a responsibility to consider which harms are likely and judge their potential frequency and the severity that might ensue from implementing the service. It uses whatever evidence exists to construct a general

confidence interval on the 4-point scale (e.g., substantial, moderate, small, and zero/negative).

Value judgments are involved in using the information in an outcomes table to rate either benefits or harms on the USPSTF's 4-point scale. Value judgments are also needed to weigh benefits against harms to arrive a rating of net benefit.

In making its determinations of net benefit, the USPSTF strives to consider what it believes are the general values of most people. It does this with greater confidence for certain outcomes (e.g., death) about which there is little disagreement about undesirability, but it recognizes that the degree of risk people are willing to accept to avert other outcomes (e.g., cataracts) can vary considerably. When the USPSTF perceives that preferences among individuals vary greatly, and that these variations are sufficient to make trade-off of benefits and harms a "close-call," then it will often assign a C recommendation (see the "Recommendation Rating Scheme" field). This recommendation indicates the decision is likely to be sensitive to individual patient preferences.

The USPSTF uses its assessment of the evidence and magnitude of net benefit to make recommendations. The general principles the USPSTF follows in making recommendations are outlined in Table 5 of the companion document cited below. The USPSTF liaisons on the topic team compose the first drafts of the recommendations and rationale statements, which the full panel then reviews and edits. Recommendations are based on formal voting procedures that include explicit rules for determining the views of the majority.

From: Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. *Am J Prev Med* 2001 Apr;20(3S):21-35.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

The USPSTF grades its recommendations according to one of 5 classifications (A, B, C, D, I) reflecting the strength of evidence and magnitude of net benefit (benefits minus harms):

A

The USPSTF strongly recommends that clinicians provide [the service] to eligible patients. The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.

B

The USPSTF recommends that clinicians provide [the service] to eligible patients. The USPSTF found at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms.

C

The USPSTF makes no recommendation for or against routine provision of [the service]. The USPSTF found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation.

D

The USPSTF recommends against routinely providing [the service] to asymptomatic patients. The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.

I

The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Comparison with Guidelines from Other Groups
External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Peer Review. Before the U.S. Preventive Services Task Force (USPSTF) makes its final determinations about recommendations on a given preventive service, the Evidence-based Practice Center and the Agency for Healthcare Research and Quality send a draft systematic evidence review to 4 to 6 external experts and to federal agencies and professional and disease-based health organizations with interests in the topic. They ask the experts to examine the review critically for accuracy and completeness and to respond to a series of specific questions about the document. After assembling these external review comments and documenting the proposed response to key comments, the topic team presents this information to the Task Force in memo form. In this way, the Task Force can consider these external comments and a final version of the systematic review before it votes on its recommendations about the service. Draft recommendations are then circulated for comment from reviewers representing professional societies, voluntary organizations and Federal agencies. These comments are discussed before the whole USPSTF before final recommendations are confirmed.

Recommendation of Others. Recommendations for screening for idiopathic scoliosis from the following groups were discussed: the Scoliosis Research Society and the American Academy of Orthopaedic Surgeons.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The U.S. Preventive Services Task Force (USPSTF) grades its recommendations (A, B, C, D, or I) and the quality of the overall evidence for a service (good, fair, poor). The definitions of these grades can be found at the end of the "Major Recommendations" field.

The USPSTF recommends against the routine screening of asymptomatic adolescents for idiopathic scoliosis. **D recommendation.**

The USPSTF did not find good evidence that screening asymptomatic adolescents detects idiopathic scoliosis at an earlier stage than detection without screening. The accuracy of the most common screening test—the forward bending test with or without a scoliometer—in identifying adolescents with idiopathic scoliosis is variable, and there is evidence of poor follow-up of adolescents with idiopathic scoliosis who are identified in community screening programs.

The USPSTF found fair evidence that treatment of idiopathic scoliosis during adolescence leads to health benefits (decreased pain and disability) in only a small proportion of people. Most cases detected through screening will not progress to a clinically significant form of scoliosis. Scoliosis needing aggressive treatment, such as surgery, is likely to be detected without screening.

The USPSTF found fair evidence that treatment of adolescents with idiopathic scoliosis detected through screening leads to moderate harms, including unnecessary brace wear and unnecessary referral for specialty care. As a result, the USPSTF concluded that the harms of screening adolescents for idiopathic scoliosis exceed the potential benefits.

Clinical Considerations

- Screening adolescents for idiopathic scoliosis is usually done by visual inspection of the spine to look for asymmetry of the shoulders, scapulae, and hips. A scoliometer can be used to measure the curve. If idiopathic scoliosis is suspected, radiography can be used to confirm the diagnosis and to quantify the degree of curvature.
- The health outcomes of adolescents with idiopathic scoliosis differ from those of adolescents with secondary scoliosis (i.e., congenital, neuromuscular, or early onset idiopathic scoliosis). Idiopathic scoliosis with onset in adolescence may have a milder clinical course.
- Conservative interventions to treat curves detected through screening include spinal orthoses (braces) and exercise therapy, but they may not significantly improve back pain or the quality of life for adolescents diagnosed with idiopathic scoliosis.
- The potential harms of screening and treating adolescents for idiopathic scoliosis include unnecessary follow-up visits and evaluations due to false positive test results and psychological adverse effects, especially related to brace wear. Although routine screening of adolescents for idiopathic scoliosis is not recommended, clinicians should be prepared to evaluate idiopathic

scoliosis when it is discovered incidentally or when the adolescent or parent expresses concern about scoliosis.

Cost and Research Considerations

- Although the USPSTF did not consider costs in making its recommendation and did not find high-quality studies of the cost-effectiveness of screening, the USPSTF concludes that the costs of a screening program would include the time of primary care clinicians, specialty evaluation, treatment with braces, and follow-up costs.
- Careful surveillance should accompany screening program activities to evaluate the long-term benefits and harms of treating adolescents for idiopathic scoliosis.

Definitions:

Strength of Recommendations

The USPSTF grades its recommendations according to one of 5 classifications (A, B, C, D, I) reflecting the strength of evidence and magnitude of net benefit (benefits minus harms):

A

The USPSTF strongly recommends that clinicians provide [the service] to eligible patients. The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.

B

The USPSTF recommends that clinicians provide [the service] to eligible patients. The USPSTF found at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms.

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The USPSTF makes no recommendation for or against routine provision of [the service]. The USPSTF found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation.

D

The USPSTF recommends against routinely providing [the service] to asymptomatic patients. The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.

I

The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. Evidence that [the service] is effective is

lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.

Strength of Evidence

The USPSTF grades the quality of the overall evidence for a service on a 3-point scale (good, fair, poor):

Good

Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.

Fair

Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies, generalizability to routine practice, or indirect nature of the evidence on health outcomes.

Poor

Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendations is identified in the "Major Recommendations" field.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- The U.S. Preventive Services Task Force (USPSTF) did not find good evidence that screening asymptomatic adolescents detects idiopathic scoliosis at an earlier stage than detection without screening. The accuracy of the most common screening test—the forward bending test with or without a scoliometer—in identifying adolescents with idiopathic scoliosis is variable, and there is evidence of poor follow-up of adolescents with idiopathic scoliosis who are identified in community screening programs.

- The USPSTF found fair evidence that treatment of idiopathic scoliosis during adolescence leads to health benefits (decreased pain and disability) in only a small proportion of people. Most cases detected through screening will not progress to a clinically significant form of scoliosis. Scoliosis needing aggressive treatment, such as surgery, is likely to be detected without screening.

POTENTIAL HARMS

The potential harms of screening and treating adolescents for idiopathic scoliosis include unnecessary follow-up visits and evaluations due to false positive test results and psychological adverse effects, especially related to brace wear. Although routine screening of adolescents for idiopathic scoliosis is not recommended, clinicians should be prepared to evaluate idiopathic scoliosis when it is discovered incidentally or when the adolescent or parent expresses concern about scoliosis.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

Recommendations made by the U.S. Preventive Services Task Force are independent of the U.S. Government. They should not be construed as an official position of the Agency for Healthcare Research and Quality or the U.S. Department of Health and Human Services.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The experiences of the first and second U.S. Preventive Services Task Force (USPSTF), as well as that of other evidence-based guideline efforts, have highlighted the importance of identifying effective ways to implement clinical recommendations. Practice guidelines are relatively weak tools for changing clinical practice when used in isolation. To effect change, guidelines must be coupled with strategies to improve their acceptance and feasibility. Such strategies include enlisting the support of local opinion leaders, using reminder systems for clinicians and patients, adopting standing orders, and audit and feedback of information to clinicians about their compliance with recommended practice.

In the case of preventive services guidelines, implementation needs to go beyond traditional dissemination and promotion efforts to recognize the added patient and clinician barriers that affect preventive care. These include clinicians' ambivalence about whether preventive medicine is part of their job, the psychological and practical challenges that patients face in changing behaviors, lack of access to health care or of insurance coverage for preventive services for some patients, competing pressures within the context of shorter office visits, and the lack of organized systems in most practices to ensure the delivery of recommended preventive care.

Dissemination strategies have changed dramatically in this age of electronic information. While recognizing the continuing value of journals and other print formats for dissemination, the Agency for Healthcare Research and Quality will make all U.S. Preventive Services Task Force (USPSTF) products available through its [Web site](#). The combination of electronic access and extensive material in the public domain should make it easier for a broad audience of users to access U.S. Preventive Services Task Force materials and adapt them for their local needs. Online access to U.S. Preventive Services Task Force products also opens up new possibilities for the appearance of the annual, pocket-size *Guide to Clinical Preventive Services*.

To be successful, approaches for implementing prevention have to be tailored to the local level and deal with the specific barriers at a given site, typically requiring the redesign of systems of care. Such a systems approach to prevention has had notable success in established staff-model health maintenance organizations, by addressing organization of care, emphasizing a philosophy of prevention, and altering the training and incentives for clinicians. Staff-model plans also benefit from integrated information systems that can track the use of needed services and generate automatic reminders aimed at patients and clinicians, some of the most consistently successful interventions. Information systems remain a major challenge for individual clinicians' offices, however, as well as for looser affiliations of practices in network-model managed care and independent practice associations, where data on patient visits, referrals, and test results are not always centralized.

IMPLEMENTATION TOOLS

Foreign Language Translations
Patient Resources
Pocket Guide/Reference Cards

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

U.S. Preventive Services Task Force (USPSTF). Screening for idiopathic scoliosis in adolescents: recommendation statement. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2004 Jun. 4 p. [4 references]

ADAPTATION

Not applicable: The guideline is not adapted from another source.

DATE RELEASED

1996 (revised 2004 Jun)

GUIDELINE DEVELOPER(S)

United States Preventive Services Task Force - Independent Expert Panel

GUIDELINE DEVELOPER COMMENT

The U.S. Preventive Services Task Force (USPSTF) is a federally-appointed panel of independent experts. Conclusions of the U.S. Preventive Services Task Force do not necessarily reflect policy of the U.S. Department of Health and Human Services (DHHS) or its agencies.

SOURCE(S) OF FUNDING

United States Government

GUIDELINE COMMITTEE

U.S. Preventive Services Task Force (USPSTF)

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**Member of the USPSTF at the time this recommendation was finalized. For a list of current Task Force members, go to www.ahrq.gov/clinic/uspstfab.htm.*

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

The U.S. Preventive Services Task Force has an explicit policy concerning conflict of interest. All members and evidence-based practice center (EPC) staff disclose at each meeting if they have an important financial conflict for each topic being discussed. Task Force members and EPC staff with conflicts can participate in discussions about evidence, but members abstain from voting on recommendations about the topic in question.

From: Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. *Am J Prev Med* 2001 Apr;20(3S):21-35.

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GUIDELINE AVAILABILITY

Electronic copies: Available from the [U.S. Preventive Services Task Force \(USPSTF\) Web site](http://www.ahrq.gov/clinic/uspstfab.htm).

Print copies: Available from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to <http://www.ahrq.gov/news/pubsix.htm> or call 1-800-358-9295 (U.S. only).

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

Evidence Reviews:

- Screening for idiopathic scoliosis: a brief evidence update for the U.S. Preventive Services Task Force. Rockville (MD); Agency for Healthcare Research and Quality; 2004 Jun. 7 p.

Electronic copies: Available from the [U.S. Preventive Services Task Force \(USPSTF\) Web site](#).

Background Articles:

- Woolf SH, Atkins D. The evolving role of prevention in health care: contributions of the U.S. Preventive Services Task Force. *Am J Prev Med* 2001 Apr;20(3S):13-20.
- Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. *Am J Prev Med* 2001 Apr;20(3S):21-35.
- Saha S, Hoerger TJ, Pignone MP, Teutsch SM, Helfand M, Mandelblatt JS. The art and science of incorporating cost effectiveness into evidence-based recommendations for clinical preventive services. Cost Work Group of the Third U.S. Preventive Services Task Force. *Am J Prev Med* 2001 Apr;20(3S):36-43.

Electronic copies: Available from [U.S. Preventive Services Task Force \(USPSTF\) Web site](#).

The following are also available:

- The guide to clinical preventive services, 2006. Recommendations of the U.S. Preventive Services Task Force. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2006. 228 p. Electronic copies available from the [AHRQ Web site](#).
- A step-by-step guide to delivering clinical preventive services: a systems approach. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2002 May. 189 p. Electronic copies available from the [AHRQ Web site](#). See the related QualityTool summary on the [Health Care Innovations Exchange Web site](#).

Print copies: Available from the Agency for Healthcare Research and Quality Publications Clearinghouse. For more information, go to <http://www.ahrq.gov/news/pubsix.htm> or call 1-800-358-9295 (U.S. only).

The [Electronic Preventive Services Selector \(ePSS\)](#), available as a PDA application and a web-based tool, is a quick hands-on tool designed to help primary care clinicians identify the screening, counseling, and preventive medication services that are appropriate for their patients. It is based on current recommendations of the USPSTF and can be searched by specific patient characteristics, such as age, sex, and selected behavioral risk factors.

PATIENT RESOURCES

The following is available:

- The pocket guide to good health for adults. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2003.

Electronic copies: Available from the [U.S. Preventive Services Task Force \(USPSTF\) Web site](#). Copies also available in Spanish from the [USPSTF Web site](#). See the related QualityTool summary on the [Health Care Innovations Exchange Web site](#).

Print copies: Available from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to <http://www.ahrq.gov/news/pubsix.htm> or call 1-800-358-9295 (U.S. only).

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC STATUS

This summary was completed by ECRI on June 30, 1998. The information was verified by the guideline developer on December 1, 1998. This summary was updated by ECRI on July 2, 2004. The information was verified by the guideline developer on July 9, 2004.

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