For 3 decades, the American College of Cardiology (ACC) and the American Heart Association (AHA) have jointly developed clinical practice guidelines in an effort to align patient care with scientific evidence (1). The “2015 ACC/AHA/HRS Guideline on the Management of Patients With Supraventricular Tachycardia” (2) introduces the latest recommendation classification system (Table 1), which has continued to evolve. The present brief commentary summarizes and explains the changes incorporated in the current scheme. More detailed reviews of the evolution of ACC/AHA guideline methodology have been published (1,3–5).

Guideline recommendations are categorized by the Class of Recommendation (COR) and Level of Evidence (LOE). The COR reflects the magnitude of benefit over risk and corresponds to the strength of the recommendation. Class I recommendations are strong and indicate that the treatment, procedure, or intervention is useful and effective and should be performed or administered for most patients under most circumstances. Class II recommendations are weaker, denoting a lower degree of benefit over risk and corresponding to less certainty. Class IIa recommendations are of intermediate strength and represent a reasonable alternative to other therapies. Class IIb recommendations are of lower strength and represent a less common or controversial approach. Class III recommendations indicate that the treatment, procedure, or intervention is not useful and effective and should not be performed or administered for most patients under most circumstances. Class IV recommendations indicate that the treatment, procedure, or intervention is contraindicated and should never be performed or administered. Class V recommendations are not applicable because no data are available to support the recommendation.
of benefit in proportion to risk. Benefit is generally greater for Class Ila (moderate) recommendations and smaller for Class Iib (weak) recommendations, for which benefit only marginally exceeds risk. A COR of Iib suggests that implementation should be selective and based on careful consideration of individual patient factors and, for invasive procedures, available expertise. Class III is assigned when actions are specifically not recommended, either because studies have found no evidence of benefit or because the intervention causes harm.

The LOE denotes the confidence in or certainty of the evidence supporting the recommendation, based on the type, size, quality, and consistency of pertinent research findings. In general, for pharmacological treatments or therapeutic procedures, data from randomized controlled trials provide a higher LOE than do observational or retrospective studies, but other considerations apply to recommendations involving diagnostic testing, population-based interventions, or lifestyle modifications. High-quality, concordant evidence from more than 1 adequately powered
randomized controlled trial, meta-analyses of high-quality trials, or randomized controlled trial data corroborated by high-quality registry or practice-based studies qualifies as LOE A. Moderate-quality or less convincing evidence based on 1 or more trials, meta-analyses of moderate-quality studies, or data derived exclusively from registries or other sources that have not been externally validated are assigned LOE B and are now further delineated according to whether the evidence derives from randomized (B-R) or nonrandomized studies (B-NR). When firm scientific support for a recommendation is not available, the evidence is designated as LOE C. There is now a new subcategorization of lower-quality evidence, assigned either because data are limited (C-LD) (i.e., based on physiological preclinical studies, case reports, or studies with methodological deficiencies in design or execution) or because the recommendation is based on clinical experience and a consensus of expert opinion (C-EO).

The COR and LOE are assessed independently. When a recommendation is designated as LOE C, that does not imply that the recommendation is weak. In some cases, clinical benefit is self-evident, and the intervention is unlikely to undergo randomized study. Where available data are weak, conflicting, or absent, recommendations based on this relatively low level of evidence may provide guidance for patient care when clinicians need it most (3). Nevertheless, because in the past a relatively high proportion of recommendations were based on LOE C and a modest percentage were based on LOE A (6), greater emphasis is now placed on formulating recommendations supported by higher-quality evidence and limiting those based on lower-quality evidence.

**References**


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