Methods and organization

C. Vayssière a,b,*, H. Grandjeanb

*Service de gynécologie-obstétrique, Hôpital Paule-de-Viguier, CHU Toulouse, 31059 Toulouse cedex 9, France
bUMR U558, INSERM, Université Paul-Sabatier, 31073 Toulouse cedex 7, France

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Abstract
Reminder of the aim of clinical practice recommendations (CPR).

The ever more rapid development of new techniques and the diffusion of large amounts of information in the medical literature make it difficult for clinicians to assimilate and synthesize everything, giving rise to major variations in practices that are sometimes inappropriate or even unnecessary. This situation has led several countries to establish recommendations for treatment, diagnosis, prevention methods and disease care. These recommendations aim to help clinicians in decision-making by offering a synthesis with a certain level of scientific proof or professional consensus.

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1. Methods

The French Health Authority (HAS) has defined a certain number of objective methodological principles that we have adopted to establish these CPR. This methodological approach is constraining, but necessary in order to clearly define health interventions that are appropriate, those that are not and those for which there is ambiguity in the level of scientific proof (LP) and/or in professional consensuses (Table 1).
Table 1
Level of proof and recommendation grades according to the French HAS.

<table>
<thead>
<tr>
<th>Level of scientific proof in the literature (therapeutic studies)</th>
<th>Recommendation grades</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td></td>
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<tr>
<td>High quality randomized comparative trials</td>
<td>A</td>
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<tr>
<td>Meta-analysis of randomized comparative trials</td>
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<tr>
<td>Decision analysis based on well run studies</td>
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<tr>
<td>Level 2</td>
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<tr>
<td>Low quality randomized comparative trials</td>
<td>B</td>
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<tr>
<td>Well run non randomized comparative studies</td>
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<tr>
<td>Cohort studies</td>
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<tr>
<td>Level 3</td>
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<tr>
<td>Case-control studies</td>
<td>C</td>
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<tr>
<td>Level 4</td>
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<td>Comparative studies with major biases</td>
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<tr>
<td>Retrospective studies</td>
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<td>Case series</td>
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</table>

2. The five steps that helped the work group establish the CPR

1. Designation by the promotor (the National College of French Gynaecologists and Obstetricians (CNGOF)), a co-ordinator and a president as members of the organization committee.

2. Elaboration of precise questions and designation by experts in the organizing committee to answer these questions.

3. Analysis of the literature by experts and drafting of provisory conclusions by assigning a level of proof for each important assertion.

4. Conclusions and texts are addressed to a large number of expert reviewers on the subject at hand or practitioners from the public or private sectors. Reviewers receive texts that have been rendered anonymous.

5. Drafting of graded recommendations after considering the reviewers’ critiques.

In 1996 the CNGOF and the French-language Association studying diabetes and metabolic diseases recommended universal screening of GDM based on a two-step strategy [1]; in 2005 the French Health Authority (Haute Autorité de santé) could not come to a conclusion on the best screening and diagnostic strategies for GDM [2]. The US Preventive Services Task Force also agreed that there was an absence of a sufficient level of proof to give recommendations on universal screening for gestational diabetes [3].

Since 2005, two intervention studies [4, 5] and one observational study [6] gave new elements that led to international recommendations for diagnosing and classifying hyperglycaemia during pregnancy in favour of universal screening in 2010 [7].

However, several questions should be asked:

- Can the results obtained be generalized for low risk populations or using different glycaemic criteria?
- For the way how to results were used to obtain a consensus in the observational study [6]:
  - Were the complications retained to establish the thresholds pertinent?
  - Are the arguments to define the recommended thresholds sufficient?
  - Is it acceptable to switch overnight, because of a change in definition, the prevalence of GDM from 4 to 18%, which affects 140,000 women per year?

3. The following subjects were discussed by the group

1/ Definitions, epidemiology, risk factors.
2/ Maternal complications.
3/ Fetal and neonatal complications.
4/ Interest of screening and comparison of universal and selective methods.
5/ When to screen.
6/ Screening and diagnostic methods between 24 and 28 WG.
7/ Diagnostic criteria.
8/ Treatment.
9/ Obstetric and prenatal care and specifics of treating risk of preterm labour.
10/ Birth (term, route, glycaemic balance during labour) adapted to gestational diabetes.
11/ Specificities of neonatal care of newborns with mothers with gestational diabetes, paediatric atmosphere.
12/ Post-partum and contraception in women who had gestational diabetes.
13/ Maternal outcome after gestational diabetes. Screening and prevention of type 2 diabetes.
14/ Long-term consequences of fetal exposition to gestational diabetes.

4. Conflicts of interest

No conflict of interest related to the article.

References

[1] Collège national des gynécologues et obstétriciens français. Recom-


