Table II. Strength of recommendation and certainty of evidence

Strength of recommendation	Wording	Implication[5-7]
Strong recommendation *for* the use of an intervention	"We recommend…"	Benefits clearly outweigh risk and burdens; recommendation applies to most patients in most circumstances.
Strong recommendation *against* the use of an intervention	"We recommend against…"	Risk and burden clearly outweigh benefits; recommendation applies to most patients in most circumstances.
Good practice statement	"We recommend…"	Guidance was viewed by the Work Group as imperative to clinical practice and developed when the supporting evidence was considerable but indirect, and the certainty surrounding an intervention's impact was high with the benefits clearly outweighing the harms (or vice versa). Good Practice Statements are strong recommendations as the certainty surrounding the impact of the recommended intervention is high. Implementation of these strong recommendations is considered to clearly result in beneficial outcomes.[7]
Conditional recommendation *for* the use of an intervention	"We conditionally recommend…"	Benefits are closely balanced with risks and burden; recommendation applies to most patients, but the most appropriate action may differ depending on the patient or other stakeholder values.
Conditional recommendation *against* the use of an intervention	"We conditionally recommend against…"	Risks and burden closely balanced with benefits; recommendation applies to most patients, but the most appropriate action may differ depending on the patient or other stakeholder values
Certainty of evidence	**Wording**	**Implication[5,6]**
High	"high certainty evidence"	Very confident that the true effect lies close to that of the estimate of the effect.
Moderate	"moderate certainty evidence"	Moderately confident in the effect estimate; the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.
Low	"low certainty evidence"	Confidence in the effect estimate is limited; the true effect may be substantially different from the estimate of the effect
Very low	"very low certainty evidence"	The estimate of effect is very uncertain; the true effect may be substantially different from the estimate of effect

While some *C. acnes* species have developed resistance to antibiotics[46,47] and certain strains are more strongly associated with acne, routine microbiologic and/or antibiotic susceptibility testing is not indicated for patients with acne since it does not affect management. Patients presenting with eruptive uniform pustules to nodules in periorificial areas, particularly in settings of prolonged tetracycline treatment, may benefit from lesion culture to diagnose Gram-negative folliculitis. Treatment with isotretinoin or another antibiotic may be required. Microbiologic testing may also be considered for patients presenting with monomorphic truncal papules and pustules to diagnose pityrosporum folliculitis.

Androgens, such as testosterone and dehydroepiandrosterone sulfate, have central roles in the pathogenesis of acne. The association between acne severity and androgen levels remains unclear, with some studies showing positive associations while others showed no associations.[48,49]

Routine endocrinologic testing is not indicated for most patients with acne. Patients who present with acne and clinical signs or symptoms of hyperandrogenism, such as hirsutism, oligomenorrhea or amenorrhea, androgenic alopecia, infertility, polycystic ovaries, clitoromegaly, and truncal obesity may warrant further endocrine testing for hyperandrogenism. Polycystic ovarian syndrome is a common cause of hyperandrogenism, characterized by ovulatory dysfunction or polycystic ovaries on ultrasonography. Tests for serum total and/or free testosterone, dehydroepiandrosterone sulfate, androstenedione, luteinizing hormone, follicle-stimulating hormone may be considered.[50-54] For women with hyperandrogenism, screening for