Best evidence topic reports (BETs) summarise the evidence pertaining to particular clinical questions. They are not systematic reviews, but rather contain the best (highest level) evidence that can be practically obtained by busy practising clinicians. The search strategies used to find the best evidence are reported in detail in order to allow clinicians to update searches whenever necessary. Each BET is based on a clinical scenario and ends with a clinical bottom line that indicates, in the light of the evidence found, what the reporting clinician would do if faced with the same scenario again.

Altogether 95 papers were found using the reported search, of which two presented the best evidence to answer the clinical question. The BETs published below were first reported at the Critical Appraisal Journal Club at the Manchester Royal Infirmary or placed on the BestBETs web site. Each BET has been constructed in the four stages that have been described elsewhere. The BETs shown here together with those published previously and those currently under construction can be seen at http://www.bestbets.org. Four BETs are included in this issue of the journal.

**Endotracheal intubation in γ-hydroxybutyric acid intoxication and overdose**

Report by Helen Michael, Medical Student Checked by Magnus Harrison, Clinical Research Fellow

doi: 10.1136/emj.2004.021154

**Abstract**

A short cut review was carried out to establish whether intubation is always required in patients presenting with a decreased conscious level after γ-hydroxybutyric acid ingestion. Altogether 95 papers were found using the reported search, of which two presented the best evidence to answer the clinical question. The author, date and country of publication, patient group studied, study type, relevant outcomes, results and study weaknesses of these best papers are tabulated. A clinical bottom line is stated.

**Clinical scenario**

A comatose 20 year old man is brought to the emergency department with a GCS of 3/15 and in respiratory arrest. Acute overdose with γ-hydroxybutyric acid is suspected. Ventilation is initially assisted with a bag and mask. Your anaesthetic colleagues are very reluctant to intubate the patient as they state that the patient will wake up soon and there are no beds in the intensive care unit.

**Three part question**

In [patients with presumed GHB intoxication and respiratory depression] is [endotracheal intubation more effective than non-invasive airway management] at [reducing the complications of an unprotected airway]?

**Search strategy**

Medline 1966–09/04 using the OVID interface. [exp Hydroxybutyrates OR gamma hydroxybutyric acid.mp. OR GHB.mp] AND [exp Poisoning OR intoxication.mp OR exp Overdose OR overdose.mp] LIMIT to English language.

**Search outcome**

Altogether 95 papers were found. Two papers were relevant to the three part question (see table 1).

**Comment(s)**

The evidence for and against endotracheal intubation is scanty. These reports show no evidence for aspiration but the numbers involved (of non-intubated patients) are small. There is insufficient evidence here to change the standard approach to airway management in the unconscious patient. The reduced GCS is an indicator for airway protection that would normally be achieved using a rapid sequence induction of anaesthesia.

**CLINICAL BOTTOM LINE**

In patients with suspected GHB toxicity, reduced GCS and a threatened airway, rapid sequence induction and intubation should be performed.


Abstract
A short cut review was carried out to establish the published evidence for gastric lavage in lithium overdose. Altogether 20 papers were found using the reported search, of which none presented the best evidence to answer the clinical question. A clinical bottom line is stated.

Three part question
In [overdose of lithium salts] is [gastric lavage better than charcoal or nothing] at [reducing toxicity]?

Clinical scenario
A 25 year old television producer with bipolar disorder attends the emergency department after taking his months supply of lithium carbonate over the past two hours. They are not sustained release tablets. You wonder whether gastric lavage would be of benefit.

Search strategy
Medline 1966–09/04 using the OVID interface. [(exp gastric lavage OR exp gastric emptying OR exp irrigation OR lavage.af OR empt$.af OR irrigat$.af OR washout.af OR wash-out.af) AND (exp poisoning OR exp overdose OR exp suicide OR exp poisoning OR exp self-injurious behavior OR pois$.af OR overdos$.af OR suicid$.af OR (deliberate adj5 self adj5 harm).af OR dsh.af) AND (exp lithium OR exp lithium compounds OR exp lithium carbonate OR exp lithium chloride OR lithium.af OR Li+.af OR camcolit.af OR priadel.af OR liskonum.af OR li-liquid.af)] LIMIT to English language.

Search outcome
Altogether 20 papers were found all of which failed to answer the three part question.

Comment(s)
There is no currently available clinical evidence to support the use of gastric lavage in lithium overdose. UK Poisons Centre advice (http://www.spib.axl.co.uk/) suggests that gastric lavage should be considered for non-sustained release preparations if more than 4 g has been ingested by an adult within one hour, or definite ingestion of a significant amount by a child. Lavage is thought to be of limited use in sustained release preparations as they do not disintegrate in the stomach and therefore are unlikely to be retrieved.

► CLINICAL BOTTOM LINE
As there is no evidence from clinical trials national guidelines should be followed (http://www.spib.axl.co.uk/).

Table 1

<table>
<thead>
<tr>
<th>Author, date and country</th>
<th>Study type (level of evidence)</th>
<th>Patient group</th>
<th>Outcomes</th>
<th>Key results</th>
<th>Study weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Li J et al, 1998, USA</td>
<td>7 patients with GHB ingestion, identified by urine spectrometry</td>
<td>Case report</td>
<td>Prehospital GCS</td>
<td>6 had GCS &lt;9, 1 had GCS &gt;9</td>
<td>Case report</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Intubation</td>
<td>4 intubated</td>
<td>Small number of patients</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Time to extubation</td>
<td>Time to extubation 6, 4, 2, and 2 hours. 1 patient required sedation</td>
<td>No record of any adverse events</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Attempted intubation</td>
<td>2 failed intubations, patients observed thereafter</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>No intubation</td>
<td>1 patient not intubated</td>
<td></td>
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<tr>
<td>Chin RL et al, 1998, USA</td>
<td>88 patients with GHB ingestion, 1993–1996. Single ED in San Francisco. 11 of 88 patients were intubated.</td>
<td>Retrospective note review over a three year period</td>
<td>Aspiration</td>
<td>No record of aspiration in any patient</td>
<td>Retrospective analysis. GHB ingestion confirmed from case notes, not toxicological testing.</td>
</tr>
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<td></td>
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<td>Time to regaining consciousness</td>
<td>Intubation related to recovery time: mean time to recovery among non-intubated = 146 mins (16–389). Mean time to recovery among intubated = 274 mins (161–439)</td>
<td>Clinical picture of GHB intoxication often complicated by other substances.</td>
</tr>
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<td>GCS</td>
<td>28% (25) GCS = 3, 32% (28) GCS = 4–8, 40% (35) GCS = 9–15</td>
<td>Differences in recovery time may reflect use of sedative agents during intubation, or the initial severity of presentation among intubated group.</td>
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<td></td>
<td>Co-ingestion of other drugs</td>
<td>Co-ingestion: 39% (34) alcohol, 28% (25) other drugs 13% (11) intubated. 73% (8) of those intubated had GCS 3, 27% (3) had GCS 4–7. 73% also had bradycardia. Mean duration of intubation = 179 min. 9 of these were admitted for 24 hours. 2 were discharged directly.</td>
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<td></td>
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</table>

Paddle position in emergency cardioversion of atrial fibrillation
Report by Katherine Potier de la Morandiere, Specialist Registrar
Checked by Henry Morriss, Specialist Registrar
doi: 10.1136/emj.2004.021170
Clinical scenario
A 60 year old man presents to the emergency department with a history of sudden onset palpitations. This is associated with some mild chest discomfort and breathlessness. On examination he is in atrial fibrillation at a rate of 180, and has a blood pressure of 95/60. He looks pale and sweaty. You feel he needs urgent electrical cardioversion and wonder whether the paddle position used will affect your success rate.

Abstract
A short cut review was carried out to establish whether the antero-lateral or antero-posterior paddle position is best at reverting acute atrial fibrillation to sinus rhythm. Altogether 954 papers were found using the reported search, of which five presented the best evidence to answer the clinical question. The author, date and country of publication, patient group studied, study type, relevant outcomes, results and study weaknesses of these best papers are tabulated. A clinical bottom line is stated.

Clinical bottom line is stated.

Search strategy

Search outcome
Altogether 954 papers were found in Medline of which five were relevant to the question (see table 2). No additional papers were found in the Cochrane library.

Comment(s)
AF is a common problem encountered in the emergency department. These papers shows that some good quality

### Table 2

<table>
<thead>
<tr>
<th>Author, date and country</th>
<th>Patient group</th>
<th>Study type (level of evidence)</th>
<th>Outcomes</th>
<th>Key results</th>
<th>Study weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mathew TP et al, 1999, UK</td>
<td>90 patients</td>
<td>Elective</td>
<td>Cardioversion success rate</td>
<td>38/45 success for AL v 33/45 for AP p = 0.42</td>
<td>No power</td>
</tr>
<tr>
<td></td>
<td>Antero-lateral (AL) v Antero-posterior (AP) 100J then 200J, 300J, 360J</td>
<td>Prospective, randomised</td>
<td>Mean (SD) energy used</td>
<td>223 (96.1) J for AL v 222 (110) J for AP</td>
<td>Randomisation method not explicit</td>
</tr>
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<td>Mean (SD) thoracic impedance on first shock</td>
<td>77.5 (18.4) Ohms AL v 73.7 (18.7) Ohms AP p = 0.34</td>
<td>Elective patients</td>
</tr>
<tr>
<td>Botto GL et al, 1999, Italy</td>
<td>301 patients with stable AF</td>
<td>Prospective randomised controlled trial</td>
<td>Cardioversion success rate at initial 3J/kg shock</td>
<td>87/151 success for AL v 100/150 for AP</td>
<td>No power calculation</td>
</tr>
<tr>
<td></td>
<td>AL v AP</td>
<td></td>
<td>Cumulative success rate after first 4J/kg shock</td>
<td>114/151 for AL v 131/150 for AP (p = 0.013)</td>
<td>Randomisation method not explicit</td>
</tr>
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<td></td>
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<td></td>
<td>With first 360J AL more successful</td>
<td>8/19 for AP (p = 0.048)</td>
<td>All elective with chronic AF</td>
</tr>
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<td></td>
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<td>DC shock</td>
<td>4/19 for AL v 5/12 for AP p = 0.22</td>
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<td>Cardioversion second 360J shock</td>
<td>50/52 for AP v 44/56 for AL p = 0.009, 8/12 cardioverted when crossed from AL to AP. No success in those AP to AL (2 patients)</td>
<td>Elective patients with persistent AF</td>
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<tr>
<td></td>
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<td></td>
<td>Patients with persistent AF</td>
<td>No randomisation details</td>
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<td></td>
<td></td>
<td>Elective cardioversion (50–360J) AP v AL</td>
<td>Small numbers</td>
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<td></td>
<td>RCT cross-over</td>
<td>Small, low powered study</td>
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<td></td>
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<td></td>
<td>Cardioversion success rate in initial paddle position failed</td>
<td>50/52 for AP v 44/56 for AL p = 0.009, 8/12 cardioverted when crossed from AL to AP. No success in those AP to AL (2 patients)</td>
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<td>RCT cross-over</td>
<td>Elective patients with persistent AF</td>
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</table>

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research has been done on cardioversion but not in the emergency setting. The five best papers show conflicting results regarding the positioning of paddles in elective cardioversion, the most recent showing no difference between the two positions. In our clinical scenario the AP position may be difficult to achieve in such an unwell, shocked patient.

▶ CLINICAL BOTTOM LINE
There is little evidence to suggest that paddle position significantly influences the success of cardioversion emergency department patients with AF.


Table 3

<table>
<thead>
<tr>
<th>Author, date and country</th>
<th>Patient group</th>
<th>Study type (level of evidence)</th>
<th>Outcomes</th>
<th>Key results</th>
<th>Study weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strupp M, et al, 1998, Germany</td>
<td>600 neurology patients undergoing diagnostic LP randomly assigned (patient blinded) 300 to stylet replacement before needle removal, other 300 not reinserted. Similar sex and age. Used 21 gauge atraumatic needle</td>
<td>Prospective randomised controlled trial</td>
<td>Post-lumbar puncture syndrome (headache, tinnitus, dizziness) reproducible by position and improved laying down, over seven days</td>
<td>Not reinserted 49/300 (16%) post-lumbar puncture syndrome v 15/300 (5%) when stylet reinserted. Post-lumbar puncture syndrome was also less severe (2.8 v 4.5 scale of 10) if stylet reinserted</td>
<td>Excluded patients with headache before LP Post-lumbar puncture syndrome intensity scale not clearly defined Follow up not clearly described</td>
</tr>
</tbody>
</table>

Three part question

In [patients undergoing diagnostic lumbar puncture] does [reinsertion of the stylet prior to needle removal] reduce [the incidence of post-lumbar puncture headache]?

Search strategy


Search outcome

Altogether 235 papers were found, two of which addressed the three part question (same article published as correspondence then full study) (table 3). No additional references were found in the Cochrane database.

Comment(s)

The theory is when CSF is removed, strands of arachnoid enter the needle. When the needle is removed, the strand may then be threaded back through the dural defect and produce prolonged CSF leakage resulting in the post-lumbar puncture syndrome. This was postulated on the finding that the post-lumbar puncture syndrome is much lower after spinal anaesthesia than after diagnostic lumbar puncture. Replacing the stylet would then push out or cut off any strand of arachnoid. The authors also rotated the needle 90 degrees before removal (see Evans). This is the only study performed looking at replacing the stylet. Some aspects of the study are not clearly described—randomisation, intensity scale, follow up. Nevertheless, there seems to be minimal risk and likely benefit in replacing the stylet prior to removing the needle.

▶ CLINICAL BOTTOM LINE
Replacing the stylet before removal of the spinal needle may help decrease the incidence of post-lumbar puncture headaches.


Reinsertion of the stylet before needle removal in diagnostic lumbar puncture

Report by Matthew Deibel, Senior Resident

Checked by Jeffrey Jones, Michael Brown, Research Director and Director of the Emergency Medicine Residency programme respectively

doi: 10.1136/emj.2004.021188

Abstract

A short cut review was carried out to establish whether reinsertion of the stylet before needle removal changed the incidence of post-lumbar puncture syndrome and headache. Altogether 235 papers were found using the reported search, of which two presented the best evidence to answer the clinical question. The author, date and country of publication, patient group studied, study type, relevant outcomes, results and study weaknesses of these best papers are tabulated. A clinical bottom line is stated.

Clinical scenario

A 31 year old woman presents to the emergency department with a sudden onset severe headache. After a normal head computed tomogram, you prepare for lumbar puncture with a small gauge non-traumatic needle. You remember a colleague telling you it is also important to replace the stylet before

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S D Carley

doi: 10.1136/emj.2004.021147

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