Towards evidence based emergency medicine: best BETs from the Manchester Royal Infirmary

Edited by K Mackway-Jones

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.

The BETs published below were first reported at the Critical Appraisal Journal Club at the Manchester Royal Infirmary.

1 Each BET has been constructed in the four stages that have been described elsewhere.

2 The four topics covered in this issue of the journal are:

- Radiological diagnosis of mandibular fracture
- Management of undisplaced Bennett’s fracture
- Diagnostic imaging of the hip in the limping child
- Immediate anticoagulant management of unstable angina

Radiological diagnosis of mandibular fracture

Report by Piraya Begum, Medical Student

Search checked by Steve Jones, Research Fellow

Clinical scenario

A 24 year old man presents to the emergency department on Saturday night with injuries to his lower jaw. He has been involved in a fight. On examination there is extensive bruising to the left side of the face and chin. The patient is unable to open his mouth or talk due to pain and trismus. You suspect a mandibular fracture and decide to x-ray the mandible. You wonder whether a standard mandibular series or a panoramic view is the best technique for accurately detecting any fracture.

Three part question

In [adult patients with mandibular trauma] are [panoramic radiographs better than the standard mandibular series] at [accurately diagnosing fractures]?

Search strategy

Medline 1966 to 10/99 using the OVID interface. [(exp fractures OR fracture$.mp] AND [exp mandible OR mandible$.mp or mandibular.mp}) OR exp mandibular fractures] AND [exp radiography OR x-ray$.mp OR roentgen$.mp] AND [exp radiography, panoramic

<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>Johnston and Doris, 1980, USA¹</td>
<td>17 patients with 24 mandibular fractures Standard series v OPG</td>
<td>Survey v Radiography</td>
<td>x Ray diagnosis v OPG</td>
<td>8 (47%) fractures seen more easily on OPG v OPG more easily interpreted</td>
<td>Patients with fractures only</td>
</tr>
<tr>
<td>Moilanen, 1982, Finland²</td>
<td>272 mandibular fractures Standard series v OPG</td>
<td>Retrospective diagnostic</td>
<td>x Ray diagnosis</td>
<td>33% fractures seen more easily on OPG v OPG</td>
<td>Gold standard not stated Patients with fractures only</td>
</tr>
<tr>
<td>Chayra et al, 1986, USA³</td>
<td>50 patients with 88 mandibular fractures Standard series v OPG</td>
<td>Retrospective diagnostic</td>
<td>x Ray diagnosis</td>
<td>27% fractures seen more easily on OPG v OPG</td>
<td>Gold standard not stated Patients with fractures only</td>
</tr>
<tr>
<td>Markowitz et al, 1999, USA⁴</td>
<td>21 patients with 33 fractures Standard series v OPG v CT scan</td>
<td>Prospective diagnostic</td>
<td>x Ray diagnosis</td>
<td>Sensitivities 91% (standard series) v 88% (OPG) v 90% (CT scan)</td>
<td>Gold standard not stated Patients with fractures only</td>
</tr>
</tbody>
</table>

OPG = orthopantomography.

Table 1


Management of undisplaced Bennett's fracture

Report by Bruce Martin, Clinical Fellow

Search checked by Martin Smith, Specialist Registrar

Clinical scenario

A 32 year old man presents to the emergency department following a fight. He complains of pain around the base of the right thumb metacarpal. Radiography reveals an undisplaced Bennett's fracture. You wonder whether he should be treated conservatively or surgically.

Three part question

In [an adult patients with an undisplaced Bennett's fracture] is [conservative management better than surgical management] at [minimising time to recovery and final disability]?

Search strategy

Medline 1966 to 10/99 using the OVID interface. [{exp fractures OR exp fractures, closed OR fracture$.mp} AND [{exp thumb OR thumb.mp OR first.mp} AND {exp metacarpus OR metacarp$.mp}) OR Bennett$] AND {exp emergency treatment OR exp treatment outcome OR treatment$.mp OR treat$.mp}]} LIMIT to human AND english.

Search outcome

Ninety eight papers were found of which 92 were irrelevant or of insufficient quality for inclusion. The remaining six papers are shown in table 2.

Comment

The evidence in this area is extremely poor. All studies are small and retrospective. A well designed prospective randomised controlled trial is needed.

Clinical bottom line

Good initial reduction probably reduces the incidence of later arthritis of the base of the thumb metacarpal. There is no evidence to help decide whether a conservative or a surgical approach is preferable.

Table 2

<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>van Niekerk and Ouwens, 1989, Netherlands</td>
<td>12 of 23 patients with fractures at the base of the thumb metacarpal treated surgically</td>
<td>Retrospective survey</td>
<td>Limitation of activities of daily living</td>
<td>No limitations</td>
<td>Small numbers Uncontrolled</td>
</tr>
<tr>
<td>Kjaer-Petersen et al, 1990, Denmark</td>
<td>41 patients with Bennett's fracture treated variously (9 closed reduction, 6 percutaneous K wires, 26 open reduction) Followed up at a median of 7.3 years</td>
<td>Retrospective survey</td>
<td>Residual symptoms</td>
<td>No symptoms in 15 of 18 with good reductions compared with 6 of 13 with residual displacement</td>
<td></td>
</tr>
<tr>
<td>Livesey, 1990, UK</td>
<td>17 patients with Bennett's fracture treated conservatively Followed up at a mean of 26 years</td>
<td>Retrospective survey</td>
<td>Residual symptoms Range of movement and grip strength</td>
<td>Reduced in all patients</td>
<td>Small numbers Uncontrolled</td>
</tr>
<tr>
<td>Thurston and Dempsey, 1993, New Zealand</td>
<td>21 of 76 patients with Bennett's fracture Followed up at a mean of 7 years 7 months</td>
<td>Retrospective survey</td>
<td>Residual symptoms Less if residual fracture displacement less than 1mm Method of reduction immaterial</td>
<td>Small numbers</td>
<td></td>
</tr>
<tr>
<td>Timmenja et al, 1994, Netherlands</td>
<td>18 patients with Bennett's fracture. Closed reduction with K wire fixation (7) v open reduction and bone graft (11) Followed up at a mean of 10.7 years</td>
<td>Retrospective survey</td>
<td>Thumb mobility Grip strength Osteoarthritis</td>
<td>Full in all cases Reduced in all cases Degree correlated with the residual displacement</td>
<td>Small numbers</td>
</tr>
<tr>
<td>Oosterbos and de Boer, 1995, Netherlands</td>
<td>20 of 22 patients with Bennett's fracture treated by closed reduction and plaster immobilisation</td>
<td>Retrospective survey</td>
<td>Subjective outcome Development of arthritis</td>
<td>Satisfactory in 18 of 20 7 of 20. In 6 of these original reduction had been nonanatomic</td>
<td>Small numbers Uncontrolled</td>
</tr>
</tbody>
</table>

OR orthopantomogram.mp OR OPG.mp LIMIT to human AND english.

Search strategy

SnOut. Further well designed diagnostic studies in the correct spectrum of patients are needed.

Clinical bottom line

Adult patients with suspected mandibular fractures should have OPG as a screening radiograph. If no fracture is seen but clinical suspicion remains high then further views should be obtained.
Diagnostic imaging of the hip in the limping child

Report by Nicola Wright, Medical Student
Search checked by Vince Choudhery, Specialist Registrar

Clinical scenario
A 3 year old child presents to the emergency department with recent onset of left sided limp and no history of trauma. He is apyrexial, systemically well with a normal white cell count and erythrocyte sedimentation rate. You diagnose irritable hip and wonder whether x ray or ultrasoundography is better at detecting a joint effusion.

Three part question
In [a child with an irritable hip] is [x ray better than ultrasoundography] at [detecting a hip effusion]?

Search strategy
Medline 1966 to 10/99 using the OVID interface. [{exp ultrasonography OR ultrasound$.mp} AND {exp pain OR pain$.mp OR irritable$.mp OR limp$.mp OR exp synovitis OR synovitis.mp}) AND {exp pediatric OR pediatric$.mp OR paediatric.mp OR child$}] AND {exp ultrasonography OR ultrasound$.mp}] LIMIT to human AND english.

Search outcome
Fifty two papers were found of which 46 were irrelevant or of insufficient quality for inclusion. The six remaining papers are shown in table 3.

Comment
In all the studies found, ultrasonography was its own gold standard for the detection of hip effusions. Therefore no comment about the sensitivity or specificity of ultrasonography itself can be made. Radiography is, however, clearly less sensitive than ultrasonography at detecting hip effusions. The role of x ray in detecting Perthes’ disease should not be forgotten.

Clinical bottom line
Ultrasound is more sensitive than plain x ray at detecting hip effusions in children. It should be the first imaging investigation of the irritable hip.

Table 3

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<tbody>
<tr>
<td>Adam et al, 1986, UK</td>
<td>87 children with irritable hip</td>
<td>Diagnostic</td>
<td>Detection of effusions</td>
<td>28 of 47 children with an effusion on ultrasound had x ray abnormalities</td>
<td>No universal gold standard</td>
</tr>
<tr>
<td>Rosenborg and Mortensson, 1986, Sweden</td>
<td>58 examinations of 47 children, of whom had acute unilateral transient synovitis of the hip</td>
<td>Diagnostic</td>
<td>Detection of effusions</td>
<td>43% of 23 children with an effusion on ultrasound had diaphyseal fatty layer sign on plain x ray, while 52% had abnormal capsular fat pad sign</td>
<td>No universal gold standard</td>
</tr>
<tr>
<td>Zieger et al, 1987, Germany</td>
<td>123 consecutive patients with suspected joint effusions</td>
<td>Diagnostic</td>
<td>Detection of effusions</td>
<td>USS 100% sensitive x Ray 27.8% sensitive</td>
<td>No universal gold standard</td>
</tr>
<tr>
<td>Miralles et al, 1989, Spain</td>
<td>500 children with a painful hip or a limp</td>
<td>Diagnostic</td>
<td>Detection of effusions</td>
<td>58 of 235 patients with ultrasound had abnormal x rays. 4 patients with normal ultrasounds had abnormal x rays</td>
<td>No universal gold standard</td>
</tr>
<tr>
<td>Bickerstaff et al, 1990, UK</td>
<td>111 children with acute hip pain</td>
<td>Diagnostic</td>
<td>Change in clinical care</td>
<td>USS detection of effusion changed clinical care in only 6 cases</td>
<td>No universal gold standard</td>
</tr>
<tr>
<td>Terjesen and Osthus, 1991, Norway</td>
<td>59 children with acute synovitis of the hip</td>
<td>Diagnostic</td>
<td>Detection of effusions</td>
<td>Effusion detected in 71% by USS but only in 15% by x ray. x Ray changed clinical care in only 2 cases (children with Perthes’ disease)</td>
<td>No universal gold standard</td>
</tr>
</tbody>
</table>

USS = ultrasonography.
Immediate anticoagulant management of unstable angina
Report by Katrina Richell-Herren, Research Fellow
Search checked by Kevin Mackway-Jones, Consultant

Clinical scenario
A 45 year old man attends the emergency department with 30 minutes of chest pain. An ECG shows ST segment depression in the inferior leads. You wonder whether he should be treated with low molecular weight heparin (LMWH) or a glycoprotein IIb/IIIa complex inhibitor.

Three part question
In [a patients with acute myocardial ischaemia] is [a low molecular weight heparin better than a platelet glycoprotein IIb/IIIa complex inhibitor] at [reducing morbidity and mortality]?

Search strategy
Medline 1966 to 10/99 using the OVID interface. [{exp angina, unstable OR unstable angina.mp} OR exp myocardial ischaemia OR myocardial ischemia].mp OR myocardial ischaemia.mp] AND [{exp heparin OR exp heparin, low-molecular-weight OR heparin$.mp OR LMWH$.mp} AND {exp platelet aggregation inhibitors OR exp platelet glycoprotein gpiib-iiiia complex OR tirofiban$.mp}] AND maximally sensitive RCT filter LIMIT to human AND english.

Search outcome
Altogether 324 papers were found of which 318 were irrelevant or of insufficient quality for inclusion. The six remaining papers, which refer to five studies, are shown in table 4.

<table>
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<tr>
<td>Gurfinkel et al, 1996, Argentina</td>
<td>219 patients with unstable angina, Aspirin alone v aspirin and heparin v aspirin and LMWH</td>
<td>Double blind PRCT</td>
<td>Major end points (recurrent angina, myocardial infarction, urgent revascularisation, major bleeding, death) Minor end points (silent myocardial ischaemia, minor bleeding)</td>
<td>Recurrent angina, myocardial infarction, and urgent revascularisation were significantly less frequent in the LMWH group. Major bleeding only occurred in the unfractionated heparin group. Silent myocardial ischaemia was significantly less frequent in the LMWH group. Minor bleeding was significantly more frequent in the unfractionated heparin group</td>
<td></td>
</tr>
<tr>
<td>Cohen et al, 1997 and 1998, USA</td>
<td>3171 patients with angina at rest or non-Q wave myocardial infarction, Enoxaparin v unfractionated heparin</td>
<td>Double blind PRCT</td>
<td>Composite end point (recurrent angina, myocardial infarction, death)</td>
<td>No difference at 48 h. Significantly better (16.6% v 19.8%) in enoxaparin group at 14 days. Difference continues at 30 days</td>
<td></td>
</tr>
<tr>
<td>PRISM Study Investigators, 1998, Multinational</td>
<td>3232 with unstable angina, myocardial ischaemia, raised CK-MB or history of significant IHD. All on aspirin, Unfractionated heparin or tirofiban</td>
<td>Double blind PRCT</td>
<td>Composite end point (refractory ischaemia, myocardial infarction, death)</td>
<td>Significantly better (2.3% v 3.6%) in tirofiban group at 48h. No difference at 14 and 30 days, although mortality was lower in tirofiban group at this time. No difference in mortality at 6 months</td>
<td></td>
</tr>
<tr>
<td>PRISM-PLUS Study Investigators, 1998, Multinational</td>
<td>1915 patients with unstable angina, myocardial ischaemia or raised CK-MB. All on aspirin, Unfractionated heparin or tirofiban or unfractionated heparin and tirofiban</td>
<td>Double blind PRCT</td>
<td>Composite end point (refractory ischaemia, myocardial infarction, death)</td>
<td>Significantly worse mortality in tirofiban alone group at 7 days (4.6% v 1.1% for heparin alone) Significantly lower composite end point occurrence in tirofiban plus heparin group at 7 (12.9% v 17.9%) and 30 days</td>
<td>Tirofiban alone group stopped prematurely</td>
</tr>
<tr>
<td>The PARAGON Investigators, 1998, Multinational</td>
<td>2282 patients with non-ST elevation acute coronary syndromes. All on aspirin, High or low dose tirofiban with or without unfractionated heparin v heparin alone</td>
<td>Double blind PRCT</td>
<td>Composite end point (non-lethal myocardial infarction or death)</td>
<td>No differences at 30 days. Significantly lower composite end point occurrence at 6 months for low dose lamifiban and heparin</td>
<td></td>
</tr>
</tbody>
</table>

CK-MB = creatine kinase MB fraction; IHD = ischaemic heart disease; LMWH = low molecular weight heparin; PRCT = prospective randomised controlled trial.

Comment
There is no trial that directly compares LMWHs with platelet glycoprotein IIb/IIIa complex inhibitors. Both treatments appear to be better than no treatment. The evidence that enoxaparin is better than unfractionated heparin is compelling (for unstable angina odds ratios 0.81, 95% confidence interval 0.68 to 0.96), while that for tirofiban is less so. Even more work is required in this area.

Clinical bottom line
All patients with unstable angina should receive LMWHs in preference to unfractionated heparin. The case for the use of platelet glycoprotein IIb/IIIa complex inhibitors in preference to LMWHs has not been established.

The BMA library supplied the papers.