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.

Five of the BETs published below were first reported at the Critical Appraisal Journal Club at the Manchester Royal Infirmary. Guest BETs submitted from around the world are also shown. 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

**Guest BETs**
- The Ottawa ankle rules in children
- Belching as a symptom of myocardial ischaemia
- Skull fracture and intracranial injury in children
- Indication for head CT in children with mild head injury

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**Negative urine analysis to exclude urinary tract infection**

Report by Bruce Martin, Specialist Registrar in Emergency Medicine

Checked by Angaj Ghosh, Senior Clinical Fellow

Clinical scenario
A very anxious mother brings her 4 year old daughter to the emergency department concerned about her persistent fever. Examination reveals that she does indeed have a temperature of 37.6°C. She has no obvious signs of localised infection, so you decide that you need to test her urine to see whether she has got a urinary tract infection (UTI). After much coaxing she provides you with a sample but you now wonder if dipstick analysis is sufficient for diagnosis, or whether you ought to arrange for urgent microscopy.

Three part question
In [children with pyrexia with suspected UTI] is [dipstick urine analysis as sensitive as microscopy] in [ruling out infection]?

Search strategy
Medline 1966–08/01 using the OVID interface. (exp adolescence/ OR exp child/ or exp child of impaired parents/ or exp child, abandoned/ or exp child, exceptional/ or exp child, hospitalized/ or exp child, institutionalized/ or exp child, preschool/ or exp child, unwanted/ or exp disabled children/ or exp homeless youth/ or exp infant/ or exp only child/ OR child$.mp) AND (exp Indicators/ and reagents/ OR exp Reagent strips/ OR exp Urinalysis/ OR dipstick.mp) AND (exp Urinary tract infections/ OR urinary tract infection.mp) AND (exp "sensitivity and specificity"/ or "sensitivity and specificity".mp OR diagno$.mp OR exp Diagnosis/) LIMIT to human AND english.

Search outcome
Altogether 156 papers found. Of these, one was a recent meta-analysis that included all those papers identified as answering the three part question (table 1)
Clinical bottom line
Children who present with fever and who have positive dipstick testing for leucocyte esterase and nitrite should be given antibiotics and referred for further investigation. Dipstick testing would appear to have the sensitivity for children with negative testing to be discharged, with the urine being sent for Gram stain and culture the following day rather than arranging urgent microscopy.

Intramuscular piroxicam or intramuscular diclofenac for renal colic
Report by Russell Boyd, Consultant in Emergency Medicine
Checked by Polly Terry, Specialist Registrar in Emergency Medicine

Clinical scenario
A 35 year old man presents to the emergency department with acute renal colic proven on urine dipstick analysis and urgent IVU. His pain is severe and you would like to give him IM diclofenac as he is vomiting and it is your current practice. He tells you he developed a sterile abscess last time he was given IM diclofenac. You wonder if an alternative NSAID, piroxicam, given by the IM route would be as effective as the diclofenac you are reluctant to give.

Three part question
[In renal colic] is [IM piroxicam or IM diclofenac] better [at reducing pain]?

Search strategy
Medline 1966–08/01 using the OVID interface. [exp piroxicam/ OR piroxicam.mp OR nefeldene.mp] AND [exp diclofenac/ OR diclofenac.mp OR voltarol.mp] AND [exp kidney calculi/ OR exp Ureteral calculi/ OR renal colic.mp]

Search outcome
Two papers were identified of which one was relevant (table 2).

Comment(s)
Both forms of IM NSAID work well with some small advantage in favour of piroxicam in terms of pain relief at 30 minutes. IM voltarol has several notable administration problems that piroxicam does not.

Clinical bottom line
IM piroxicam appears to perform better than IM diclofenac for renal colic pain relief. Given it has fewer injection site side effects IM piroxicam should replace IM diclofenac for renal colic.


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>Al-Waili NS and Saloom KY, 1999, Germany</td>
<td>64 patients with proven diagnosis of renal colic on IVU, USS and clinical examination</td>
<td>Double blind randomised controlled study</td>
<td>Change in mean pain scores at 30 and 60 minutes post administration of 75 mg IM diclofenac or 40 mg IM piroxicam as measured on a Visual Analogue 10 cm line</td>
<td>Both treatments dramatically decreased pain scores by 30 minutes. Diclofenac pre-treatment score 7.83 and 30 minutes post treatment 1.47; piroxicam pre-treatment score 7.41 with 30 minutes post treatment score 0.84. There was a significant improvement in favour of piroxicam for pain relief at 30 minutes (t test of means p&lt;0.05)</td>
<td>The blinding mechanism is not given Uncertain of sampling method</td>
</tr>
</tbody>
</table>

Oral (fast dissolving) piroxicam or intramuscular diclofenac for renal colic
Report by Russell Boyd, Consultant in Emergency Medicine
Checked by Polly Terry, Specialist Registrar in Emergency Medicine

Clinical scenario
You have just seen a patient with presumed renal colic. You have prescribed a dose of IM diclofenac as per departmental policy but wonder if a newer fast dissolving oral piroxicam agent would be as effective as the usual parenteral diclofenac agent.
### 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>Supervia A et al, Spain, 1998</td>
<td>80 sequential patients with a clinical diagnosis of renal colic confirmed by either urine analysis or ultrasound.</td>
<td>Double blind randomised controlled trial</td>
<td>Pain as measured by visual analogue score at 30 minutes</td>
<td>Both treatments significantly reduced pain scores at 30 minutes post administration. No significant difference evident between treatments in terms of efficacy of pain relief.</td>
<td>Relatively small numbers with no power study so possible type II error.</td>
</tr>
<tr>
<td>Sharon A et al, 2000, Israel</td>
<td>40 patients with ACPO NIPPV + CPAP</td>
<td>Prospective randomised controlled trial</td>
<td>Clinical variables</td>
<td>BP and PaCO2 lower in NIPPV group (p&lt;0.05) 10/14 in NIPPV group v 4/13 with CPAP (p=0.05)</td>
<td>No power study so possible type II error.</td>
</tr>
<tr>
<td>Mehta S et al, 1997, USA</td>
<td>27 patients with ACPO NIPPV + CPAP</td>
<td>Prospective randomised controlled trial</td>
<td>Incidence of myocardial infarction</td>
<td>N/S differences between groups</td>
<td>Relatively small numbers with no power calculation</td>
</tr>
<tr>
<td>Supervia A et al, Spain, 1998</td>
<td>40 patients with ACPO NIPPV and low dose nitrates v high dose nitrates alone</td>
<td>Prospective randomised controlled trial</td>
<td>Incidence of myocardial infarction</td>
<td>11/20 in NIPPV group v 2/20 (p=0.0006) 16/20 in NIPPV group v 2/20 (p=0.0004)</td>
<td>Relatively small numbers with underpowered study</td>
</tr>
<tr>
<td>Masip J et al, 2000, Spain</td>
<td>40 patients with ACPO NIPPV + O2</td>
<td>PRCT</td>
<td>Intubation</td>
<td>Improvement significantly slower with NIPPV Control 2/18 Intervention 0/18 (p=0.04)</td>
<td>Not analysed on basis of intention to treat</td>
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<tr>
<td>Park M et al, 2001, Brazil</td>
<td>26 patients with ACPO O2 v BiPAP v CPAP</td>
<td>PRCT</td>
<td>Intubation</td>
<td>No significant difference between groups</td>
<td>Small numbers with no power calculation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Hospital stay</td>
<td>No difference at 60 mins</td>
<td>No clear randomisation</td>
</tr>
</tbody>
</table>

### NIPPV for acute cardiogenic pulmonary oedema

**Report by Rupert Jackson, Specialist Registrar in Emergency Medicine**

Checked by Steve Jones, Specialist Registrar in Emergency Medicine

**Clinical scenario**

A 76 year old man is brought in to the emergency department in a collapsed state. He has a history of ischaemic heart disease. He is agitated, tachypnoeic and sweating profusely. His neck veins are distended and there are widespread coarse crepitations in his chest. He has a diminished oxygen saturation. You make a clinical diagnosis of acute cardiogenic pulmonary oedema. In addition to vasodilator treatment and opioids, you wonder whether you should administer non-invasive positive pressure ventilation (NIPPV).

**Three part question**

In [patients with acute LVF] is [NIPPV better than alternative treatment strategies] at [avoiding intubation and improving mortality]?

**Search strategy**

Medline 1966–08/01 using the OVID interface. [exp Diclofenac/ OR exp diclofenac sodium/ OR diclofenac.mp OR voltarol.mp] AND [exp piroxicam/ OR piroxicam.mp OR feldene.mp] AND [renal colic.mp OR exp ureteral calculi/ OR exp renal calculi]

**Clinical bottom line**

There is reasonable evidence to suggest the use of oral fast dissolving piroxicam is as effective as IM diclofenac.

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### Table 4

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<tr>
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<td>Prospective randomised controlled trial</td>
<td>Clinical variables</td>
<td>BP and PaCO2 lower in NIPPV group (p&lt;0.05) 10/14 in NIPPV group v 4/13 with CPAP (p=0.05)</td>
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<tr>
<td>Park M et al, 2001, Brazil</td>
<td>26 patients with ACPO O2 v BiPAP v CPAP</td>
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<td>Intubation</td>
<td>No significant difference between groups</td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Hospital stay</td>
<td>No difference at 60 mins</td>
<td>No clear randomisation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Clinical variables (for example, RR, HR, etc)</td>
<td>O2—4/10 CPAP—3/9 BiPAP—07</td>
<td>Small numbers with no power calculation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Intubation</td>
<td>O2—0 CPAP—1 (day 3) BiPAP—0</td>
<td>No clear randomisation</td>
</tr>
</tbody>
</table>
Corticosteroids in the management of near-drowning

Report by Bernard A Foex, Specialist Registrar
Checked by Russell Boyd, Consultant (Adelaide, Australia)

Clinical scenario
A 15 year old boy was playing in the local canal. He jumped off a small bridge and got his foot caught in an old shopping trolley on the bottom. He was pulled out but he was unconscious and apnoeic. He was given BLS by the paramedics so that when he arrived in accident and emergency he was conscious, tachypnoeic, and centrally cyanosed. He had ronchi and coarse crepitations in both lung fields. You wonder whether he would benefit from intravenous corticosteroids.

Three part question
In a case of [near-drowning], does the [use of corticosteroids] affect [outcome in terms of survival or pulmonary complications]?
Table 6

<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>Chande VT, 1995, USA</td>
<td>68 patients aged 2–18 years</td>
<td>Prospective. Diagnostic</td>
<td>Ankle fractures</td>
<td>Sensitivity 100% (95% CI. 77% to 100%). Specificity 32% (95% CI. 21% to 43%)</td>
<td>Small sample size. Only 54% of patients were aged 12 or below. \nInter-rater reliability was not assessed.</td>
</tr>
<tr>
<td>McBride KL, 1997, Canada</td>
<td>318 adults and children (37 children) presenting with ankle injury to a community ED</td>
<td>Validation Cohort</td>
<td>Sensitivity of rules in age &lt;16 potential reduction in radiographs if rules had been applied</td>
<td>100% sensitivity</td>
<td>22%</td>
</tr>
<tr>
<td>Plint AC et al, 1999, Canada</td>
<td>670 patients aged 2–16 years</td>
<td>Prospective. Diagnostic</td>
<td>Ankle and midfoot fractures</td>
<td>For ankle fractures - Sensitivity 100% (95% CI. 95% to 100%). Specificity 24% (95% CI. 20% to 28%). For midfoot fractures - Sensitivity 100% (95% CI. 82% to 100%). Specificity 36% (95% CI. 29% to 43%)</td>
<td>Not every patient was radiographed. 305 eligible patients were not included. Only 25% of patients were aged 9.7 or below. \nInter-rater reliability was not assessed.</td>
</tr>
<tr>
<td>Libetta C et al, 1999, UK</td>
<td>761 patients aged 1–15 years</td>
<td>Prospective. Diagnostic</td>
<td>Ankle and midfoot fractures</td>
<td>Sensitivity 98.3% (95% CI not given). Specificity 94.6% (95% CI not given). (Combined analysis for ankle and foot fractures)</td>
<td>Not every patient was radiographed. \nInter-rater reliability was not assessed.</td>
</tr>
</tbody>
</table>

The Ottawa ankle rules in children
Report by Man-Cheuk Yuen, Senior Medical Officer
Checked by Fiona Saunders, Specialist Registrar

Clinical scenario
A 5 year old boy attends the emergency department after sustaining a twisting injury to his left ankle. On examination there is swelling and tenderness over the lateral malleolus. You know that the Ottawa ankle rules are applicable in adult patients and you wonder whether they are applicable in children too.

Three part question
In [paediatric patients with blunt ankle injuries] are [the Ottawa ankle rules] sensitive in [detecting fractures]?

Search strategy
Medline 1966–08/01 using the OVID interface. [exp ankle/ or ankle.mp. or exp ankle injuries/ or exp ankle joint/ or exp lateral ligament, ankle/] AND [clinical decision.mp. or exp Decision Support Systems, Clinical/ or exp Decision Support Techniques/ or ottawa.mp.] AND [pediat$.mp. or paed$.mp. or exp Age Factors/ or age factors.mp. or Child/] LIMIT to human and english

Clinical bottom line
There is very little evidence on the value of giving intravenous corticosteroids in cases of near-drowning.

Comment(s)
All the case reports suggested that corticosteroids are of benefit in near-drowning. The only prospective study included 10 patients. However, all seven of those given methylprednisolone (5mg/kg/24 hours IV divided into six equal doses) survived. All the other studies were retrospective analyses of case notes. None showed any benefit from corticosteroids, but they did not provide enough data about the corticosteroids used, the doses used, or specific outcomes to provide reliable evidence.

Case reports, which may be inherently biased, show some benefit, but there is no good evidence that the routine use of intravenous corticosteroids improves the outcome in cases of near-drowning. There may be a case for conducting a properly controlled trial to settle the issue.

Reference
the Ottawa ankle rules in small children is not yet answered.

**Clinical bottom line**

More work is required to determine if the Ottawa rules are applicable in children. Early results suggest that they will.

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**Belching as a symptom of myocardial ischaemia**

Report by Jason Smith, Specialist Registrar in Emergency Medicine

Checked by Simon Carley, Specialist Registrar in Emergency Medicine

**Clinical scenario**

A 60 year old man attends the emergency department with chest pain. He also gives a history of belching since the onset of the pain. His initial ECG is normal. You wonder if the symptom of belching has any prognostic value in the diagnosis of cardiac chest pain, or is more suggestive of a gastrointestinal cause.

**Three part question**

In [patients with chest pain] is [belching a useful discriminatory symptom] of [myocardial ischaemia]?

**Search strategy**

Medline 1966 to 08/01 using the OVID interface. [(exp myocardial infarction OR myocardial infarction.mp. OR ML.mp OR exp myocardial ischemia OR myocardial ischemia.mp OR myocardial ischaemia.mp OR myocardial ischaemia.mp OR angina pectoris) AND (exp eructation OR eructation.mp OR belching.mp OR eructonesius.mp)] LIMIT to human and english.

**Search outcome**

Seven articles were found of which five were irrelevant or of insufficient quality. The two remaining papers are shown in the table.

**Comment(s)**

There are no randomised trials that answer the question. The best evidence would appear to come from two questionnaire studies, which show that belching is a symptom of myocardial ischaemia or infarction in a significant number of patients. It should not be assumed, therefore, that patients who have both chest pain and belching are more likely to be suffering from a non-cardiac cause.

**Clinical bottom line**

Belching is a recognised symptom of myocardial ischaemia or infarction.

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**Table 7**

<table>
<thead>
<tr>
<th>Author, date and country</th>
<th>Patient group</th>
<th>Study type (level of evidence)</th>
<th>Outcomes</th>
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<th>Study weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Darsee JR, 1978, USA</td>
<td>108 consecutive patients presenting to CCU</td>
<td>Questionnaire</td>
<td>Belching as a symptom in patients with confirmed inferior myocardial infarction</td>
<td>Sensitivity 69%, specificity 84% (no p value given)</td>
<td>Possible bias from direct questioning.</td>
</tr>
<tr>
<td>Logan RL, et al, 1986, NZ</td>
<td>227 consecutive patients presenting to CCU</td>
<td>Questionnaire</td>
<td>Belching as a symptom in patients with confirmed cardiac ischaemia</td>
<td>Positive predictive value of 72% (no p value given)</td>
<td>Possible bias from population chosen, that is, CCU admissions.</td>
</tr>
</tbody>
</table>

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**Skull fracture and intracranial injury in children**

Report by Andrew Munro, Specialist Registrar in Emergency Medicine

Checked by Ian Maconochie, Paediatric Consultant in Emergency Medicine

**Clinical scenario**

Different emergency departments have different protocols/preferences in the way children with mild or minor head injury are investigated. Some prefer observation plus or minus plain skull radiographs, others use head scan as the first choice modality. The department you are currently working in uses plain radiology. You are concerned that in children with mild head injury with no abnormal neurology and no fracture seen on plain skull films there is a tendency to be falsely reassured that intracranial injury (ICI) is unlikely.

**Three part question**

In [children with minor head injury] does [absence of skull fracture] predict [absence of ICI]?

**Search strategy**

Medline 1985–08/01 using the OVID interface. ((exp brain injuries/ or exp craniocerebral trauma/ or exp head injuries, closed/ or head trauma.mp or head injur$.mp or exp skull fractures/ or skull fracture8.mp) AND (exp child/ or exp adolescence/ or exp child, abandoned/ or exp child, exceptional/ or exp child, hospitalized/ or exp child, institutionalized/ or exp child of impaired

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Table 8

<table>
<thead>
<tr>
<th>Author, date and country</th>
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<th>Key results</th>
<th>Study weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chan KH et al, 1990; Hong Kong</td>
<td>118 adolescents (11–15 y)</td>
<td>Prospective</td>
<td>Fracture on plain skull radiograph with ICI</td>
<td>13 of 26 with skull fracture developed ICI</td>
<td>Not restricted to mild head trauma</td>
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<td>ICI without fracture</td>
<td>10 of those had admission GCS of 15</td>
<td>CTs done selectively</td>
</tr>
<tr>
<td>Levi DA et al, 1991; Israel</td>
<td>Sub group of 384 (GCS 13–15) from 653 children = 14 years old analysed from paper. Mean age 7.1 yrs, 62% male.</td>
<td>Prospective</td>
<td>Skull fracture and ICI</td>
<td>Of 97 children, 22% had ICI</td>
<td>Results shown are secondary outcomes of the study.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>No skull fracture and ICI</td>
<td>Of 287 children 15% had ICI</td>
<td>Not clear if truly prospective</td>
</tr>
<tr>
<td>Dietrich AM et al, 1993; USA</td>
<td>Sub-group of 233 children with minor head injury and GCS 15, all were head scanned.</td>
<td>Prospective. Cohort</td>
<td>CT results</td>
<td>11% had isolated skull fracture</td>
<td>The incidence of skull fracture with ICI was not given.</td>
</tr>
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<td>Plain skull radiographs</td>
<td>5% had ICI ± fractured skull, none of whom had abnormal neurology</td>
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<td>64% of isolated skull fractures were seen on plain skull radiograph</td>
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<tr>
<td>Quayle KS et al, 1997; USA</td>
<td>Data collected in 322 ‘non-trivial’ head injuries.</td>
<td>Prospective cohort</td>
<td>Skull radiograph and head CT Surgical follow up</td>
<td>8.4% had ICI</td>
<td>Selective and incomplete data collection on subgroup.</td>
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<td>59% (16) of those with ICI had GCS 15 and no focal neurology, 1 of whom required neurosurgery.</td>
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<td>6 of these asymptomatic children were &lt;1 year (5% had scalp hematoma).</td>
<td>No restricted to mild trauma</td>
</tr>
<tr>
<td>Lloyd DA et al, 1997; UK</td>
<td>883 head injured children</td>
<td>Prospective data over 2 years</td>
<td>Skull # on radiograph and CT</td>
<td>66% of 162 with skull fracture were CTed of which 13% had ICI</td>
<td>Not restricted to mild trauma</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>No skull # and CT</td>
<td>Only 6% of 708 CTed of which 9% had ICI</td>
<td>Only 18% had head CT</td>
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<td>Remainder went to CT (4 out of 5 who were CTed had ICI with no fracture) or observed only.</td>
<td>Not clearly prospective</td>
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<td>15.9% of those scanned had ICI - 77% of whom had skull fracture. 27.5% of those imaged had skull fracture diagnosed - 26.1% of whom had ICI. 2.1% of those who were CT scanned had evacuation of haematoma.</td>
<td>Up to 23% of skull fractures not seen by ED staff</td>
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<td>Only 31% had head CT, with a further 20% having skull radiograph only.</td>
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<td>GCS not formally used.</td>
</tr>
<tr>
<td>Greens SA and Schutzman SA, 1999; USA</td>
<td>608 infants &lt;2 years. (11.2 ± 6.8 months, 57% male)</td>
<td>Prospective (selected CT scan).</td>
<td>Imaging</td>
<td></td>
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<td></td>
<td>27.4% had abnormal CT. 19.1% with intra-cranial haemorrhage - 53% of whom had no fracture. 18.5% had skull fractures - 48% of whom had intra-cranial haematoma.</td>
<td>Data not available for 52 additional patients who fitted inclusion criteria but were not transported to the trauma center.</td>
</tr>
<tr>
<td></td>
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<td>3.2% had evacuation of intra-cranial haematomas.</td>
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</tr>
<tr>
<td>Wang MY et al, 2000; USA</td>
<td>157 children less than 15 years old with field/paramedic GCS (or infant CS) of 13–14 transported by ambulance to a trauma center over twelve month period.</td>
<td>Prospective, multicenter</td>
<td>Disposition</td>
<td>27.4% had abnormal CT. 19.1% with intra-cranial haemorrhage - 53% of whom had no fracture. 18.5% had skull fractures - 48% of whom had intra-cranial haematoma. 3.2% had evacuation of intra-cranial haematomas.</td>
<td>No deaths</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Head CT results</td>
<td>No deaths</td>
<td>No plain radiology.</td>
</tr>
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</table>

Search outcome
Altogether 194 papers were found, of which 187 were irrelevant or of insufficient quality to include. The remaining seven papers are shown in the table.

Comment(s)
Seven prospective papers were found. No consistent evidence exists to show that the presence or absence of skull fracture reliably predicts ICI. There is a suggestion that older children with skull fracture may have higher risk for ICI. Computed tomography was used to show isolated ICI (that is, no fracture seen), in 4%–15% of children with mild head injury (GSC=13). The significance of ICI in this group remains unclear, 1%–3% have neurosurgery implying that missed ICI from mild head injury can occasionally have severe consequences.

Clinical bottom line
The absence of skull fracture does not predict absence of ICI as seen on computed tomography. Computed tomography is therefore the imaging modality of choice if ICI is to be excluded in children with mild head injury.


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Indication for head CT in children with mild head injury

Report by Andrew Munro, Specialist Registrar in Emergency Medicine
Checked by Ian Maconochie, Paediatric Consultant in Emergency Medicine

Clinical scenario
It is 9 pm on a Saturday, a 5 year old boy is brought to the emergency department by his mother after an unobserved fall on a trampoline. The mechanism is unclear but he was playing with an older boy. He was not thought to have cried immediately. He has a moderate sized contusion to his occiput but no focal neurology. He has a GCS of 14, opening his eyes to voice only. No skull fracture is identified on plain films. You consider it appropriate to use computed tomography on the basis of his GCS, scalp haematoma and the possibility of loss of consciousness. The on call radiologist thinks it more appropriate to admit for neurological observation. You are concerned that there is an incidence of intracranial injury (ICI) in this group, but have no data to support an argument for early head scanning.

Three part question
In [children who have sustained a mild or minor head injury with a GCS=13–15] do [clinical findings] predict [intracranial injury on computed tomography]?

Search strategy
Medline 1985–08/01 using the OVID interface. [(exp brain injuries OR exp craniocebral trauma OR exp head injuries, closed) OR (head trauma.mp) OR (head injur$.mp)] AND [(exp adolescence OR exp child OR exp child of impaired parents OR exp child, abandoned OR exp child, exceptional OR exp child, hospitalized OR exp child, institutionalized, OR exp child, preschool OR exp child, unwanted OR exp disabled children OR exp homeless youth OR exp infant OR exp only child OR child$) OR (exp pediatrics OR pediatric$ OR paediatric$)]] AND (exp tomography scanners, x-ray computed OR exp tomography, x-ray computed OR exp tomography.mp OR CT scan$) AND (exp prospective studies OR prospective.mp OR prospectively$) LIMIT to (human AND english language AND yr=1985–2001).

Search outcome
Altogether 194 papers were found of which five were considered relevant and of sufficient quality to include (see table 9).

Table 9

<table>
<thead>
<tr>
<th>Author, date and location</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>Teasdale GM et al, 1990, Glasgow</td>
<td>Sub group in paper of 99 head injured children requiring neurosurgery</td>
<td>Multicentred prospective comparative</td>
<td>Fully conscious and no skull fracture</td>
<td>16% of those with ICI</td>
<td>Incomplete data</td>
</tr>
<tr>
<td>Dietrich AN et al, 1993, USA</td>
<td>All head trauma children scanned in 12 month period n=322, mean age of 7.1 years, 20% &lt;2 years old, 62% male</td>
<td>Prospective cohort</td>
<td>Impaired consciousness and no skull fracture</td>
<td>0.5% of all attendees with head injury in this category</td>
<td>Not restricted to mild trauma</td>
</tr>
<tr>
<td>Quayle KS et al, 1997, USA</td>
<td>322 ‘non-trivial’ head injuries</td>
<td>Prospective cohort</td>
<td>CT results</td>
<td>7.6% of all attendees in this category</td>
<td>Not restricted to mild trauma</td>
</tr>
<tr>
<td>Greener DS and Schutzman SA, 1999, USA</td>
<td>608 infants &lt;2 years old (11.2 +/− 6.8 months, 57% male) with head trauma</td>
<td>Prospective cohort (selected CT scan)</td>
<td>Clinical factors</td>
<td>12% with ICI</td>
<td>Not clear if mild trauma</td>
</tr>
<tr>
<td>Wang MY et al, 2000, USA</td>
<td>157 of 209 children with GCS of 13–14 as assessed by paramedic at scene transported to trauma centre and were CT scanned</td>
<td>Prospective multicentre</td>
<td>CT result</td>
<td>5% of those with ICI had evacuation of haematoma. 13% died</td>
<td>No clear if all head trauma seen was scanned</td>
</tr>
</tbody>
</table>

M & M highlighted the importance of a normal CT in the prediction of ICI. Half of those with ICI had no symptoms. Significantly more ICI in infants <3 months old. 93% of infants who were asymptomatic with ICI had scalp haematoma (77% of those with ICI overall) and 13% of infants with ICI had evacuation of haematoma.

Scalp haematoma 13% of infants with ICI had evacuation of haematoma.

M & M 3.2% had haematoma evacuation, one of whom required long term rehabilitation. All lived.

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While no paper directly answered the question, five prospective studies clearly demonstrate ICI occurring in the absence of altered GCS and/or focal neurology. It is also clear that ICI occurs in children whose GCS has improved.

There seems to be no consistent linear relation between other clinical factors and predictability of ICI. Two papers showed that in infants who have no focal signs and no altered mental state the presence of significant scalp haematoma was an indication of increased risk of ICI. The full significance of ICI in asymptomatic head injured children is not clear however as many as one in six asymptomatic infants with ICI may be given neurosurgery.

**Clinical bottom line**

All head injured children who have a GCS of < 15 should undergo cranial CT. Asymptomatic infants who have head injury and a scalp haematoma should also undergo cranial CT.