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 or placed on the BestBETs website. 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. Six BETs are included in this issue of the journal.

- Oxygen therapy in acute stroke
- CT pulmonary angiogram compared with ventilation-perfusion scan for the diagnosis of pulmonary embolism in patients with cardiorespiratory disease
- Combining clinical probability and ventilation-perfusion scan for diagnosis of pulmonary embolism
- Serum amylase and acute pancreatitis
- Ultrasonic guidance and the complications of central line placement in the emergency department
- The utility of the tongue blade test for the diagnosis of mandibular fracture

K Mackway-Jones, Department of Emergency Medicine, Manchester Royal Infirmary, Oxford Road, Manchester M13 9WL, UK; kevin.mackway-jones@man.ac.uk

Clinical scenario
A 73 year old woman presents to the emergency department with a six hour history of left sided hemiparesis. She has a past history of hypertension. On examination she is GCS 15 with a dense left hemiparesis and her basic observations are stable. You wonder whether the use of supplemental oxygen in the acute stage is needed and will have any effect on long term prognosis.

Three part question
In a patient presenting to the emergency department with a stroke who does not require resuscitative measures is [supplemental oxygen better than no oxygen] at [reducing long term disability and mortality]?

Search strategy
Medline 1966-07/03 using the OVID interface. [exp cerebrovascular accident OR cerebrovascular.mp OR stroke.mp] AND [supplemental oxygen better than no oxygen] at [reducing long term disability and mortality]?

Search outcome
Altogether 18 papers were found of which one directly addressed the three part question (table 1).

Comment(s)
This large, well conducted study shows no statistically significant difference between the two groups. It shows there is no benefit to giving oxygen routinely to stroke patients, and suggests if given to non-hypoxic patients with mild to moderate strokes may increase mortality. The results for severe stroke patients were inconclusive.

The authors hypothesise (based on a small number of animal studies) that this may be attributable to oxygen free radicals.

- CT pulmonary angiogram compared with ventilation-perfusion scan for the diagnosis of pulmonary embolism in patients with cardiorespiratory disease

Report by Katherine Potier de la Morandiere,
Specialist Registrar
Checked by Darren Walter, Consultant

Abstract
A short cut review was carried out to establish whether supplemental oxygen reduces long term disability and mortality in patients attending the emergency department with stroke who do not require resuscitation. Altogether 18 papers were found using the reported search, of which one 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 this best paper are tabulated. A clinical bottom line is stated.

Oxygen therapy in acute stroke
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>Hartmann I, et al, 2000, Netherlands</td>
<td>627 patients (91 COPD, 536 non-COPD) with suspected PE diagnosis</td>
<td>Diagnostic study</td>
<td>Proportion of diagnostic VQ scans and CT pulmonary angiograms from both groups</td>
<td>54% of VQ scans in COPD group ruled in/out PE v 79% of VQ scans in non-COPD group</td>
<td>Observational groups not evenly matched</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Sensitivity and specificity of VQ and CT in both groups</td>
<td>All CT pulmonary angiograms gave a rule in/rule out result. No statistical difference between the two groups</td>
<td>Questionable inclusion COPD criteria</td>
</tr>
</tbody>
</table>

Search outcome
Altogether 239 were papers found of which 238 did not address the exact question. One paper was of relevance (table 2).

Comment(s)
Surprisingly few comparative studies. Ultimately small number studied in the study in question. Rigid definition of study population and reporter bias pose difficulties in such a study group. Diagnostic utility of V-Q questionable because of high proportion of inconclusive results—resource and economic factors are thus of relevance.

Clinical scenario
A 70 year old known COPD patient presents to your emergency department with pleuritic chest pain and dyspnoea suggestive of pulmonary embolus. As part of your diagnostic strategy, you wonder if V-Q scintigraphy has better diagnostic utility than CT for pulmonary embolus.

Table 1

<table>
<thead>
<tr>
<th>Author, date and country</th>
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<th>Study type (level of evidence)</th>
<th>Key results</th>
<th>Outcomes</th>
<th>Study weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ronning OM and Guldhog 8, 1999, Norway</td>
<td>550 patients presenting within 24 hours after stroke onset</td>
<td>RCT (randomised on birth dates)</td>
<td>Disability at seven months (Barthel Index)</td>
<td>No difference between the two groups on disability (p = 0.07) or impairment scores (p = 0.67)</td>
<td>Quasi-randomised</td>
</tr>
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<td></td>
<td>Impairment at seven months (Scandinavian Stroke Scale) Survival at one year</td>
<td>No statistical significant difference (p = 0.3) in survival rates. One year survival greater in control group (72.9% v 68.8%)</td>
<td>Effects of being treated in a stroke unit</td>
</tr>
</tbody>
</table>

Three part question
In patients with chronic respiratory disease does V-Q scintigraphy have greater diagnostic utility than computed tomography in the investigation of pulmonary embolus?

Search strategy
Medline 1966-07/03 using the OVID interface. (exp Tomography, Spiral Computed OR exp Tomography, X-Ray Computed OR “CT”|mp AND (exp Ventilation-Perfusion Ratio OR “VQ”|mp OR “V-Q”|mp OR Ventilation Perfusion.|mp OR Ventilation-Perfusion.mp OR perfusion.mp) AND (exp pulmonary embolism OR pulmonary embolism.mp OR “PE”|mp OR Pulmonary infarct.mp OR exp thromboembolism.mp OR thromboembolism.mp) LIMIT to human AND English.

Report by Jonathan Costello, Specialist Registrar
Abstract
A short cut review was carried out to establish whether VQ scanning has better utility than CT in investigating possible pulmonary embolus in patients with chronic respiratory disease. A total of 239 papers were found using the reported search, of which one 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 this best paper are tabulated. A clinical bottom line is stated.

Three part question
In [patients with chronic respiratory disease] does V-Q scintigraphy have greater diagnostic utility than computed tomography? In the investigation of pulmonary embolus?

Combining clinical probability and ventilation-perfusion scan for diagnosis of pulmonary embolism
Kerstin Hogg, Clinical Research Fellow
Ged Brown, Specialist Registrar
Abstract
A short cut review was carried out to establish whether clinical probability estimates improve the utility of VQ scan results in patients being investigated for possible pulmonary embolus. Altogether 387 papers were found using the reported search, of which six 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 this best paper are tabulated. A clinical bottom line is stated.

Table 2

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Hartmann I, Petronella H, Melissant C, et al, 2000, Netherlands</td>
<td>637 patients (91 COPD, 536 non-COPD) with suspected PE diagnosis</td>
<td>Diagnostic study</td>
<td>Proportion of diagnostic VQ scans and CT pulmonary angiograms from both groups</td>
<td>54% of VQ scans in COPD group ruled in/out PE v 79% of VQ scans in non-COPD group</td>
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outcomes, results and study weaknesses of these best papers are tabulated. A clinical bottom line is stated.

**Clinical scenario**
A 20 year old woman presents to the emergency department with shortness of breath and chest pain. Her o-dimer level is abnormal and you have sent her for a ventilation-perfusion scan. The scan result is reported as “low probability for pulmonary embolic disease, however this does not rule out pulmonary embolism”. You have assigned her a low clinical probability of pulmonary embolism score and wonder if this helps interpret the scan.

**Three part question**
In [patients who have undergone ventilation-perfusions scans for possible pulmonary embolus] does [combining clinical probability of pulmonary embolism and ventilation-perfusion scan result] increase the [diagnostic utility]?

**Search strategy**
Medline using the OVID interface 1966-07/03. [exp pulmonary embolism/ OR pulmonary embol$.mp. OR PE.mp. OR exp thromboembolism/ OR pulmonary infarct$.mp. ] AND [exp nuclear medicine/ OR exp ventilation-perfusion ratio/ OR ventilation-perfusion.mp. OR ventilation perfusion.mp. OR

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### Table 3

<table>
<thead>
<tr>
<th>Author, date and country</th>
<th>Patient group</th>
<th>Study type (level of evidence)</th>
<th>Key results</th>
<th>Outcomes</th>
<th>Study weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PIOPED investigators, 1990, USA</strong></td>
<td>931 PE patients at six centres. All underwent clinical probability scoring, VQ scan and pulmonary angiogram. 69 patients with normal VQs and 106 others did not undergo the pulmonary angiogram. All followed up clinically for a year</td>
<td>Prospective diagnostic study</td>
<td>Accuracy of combining clinical probability with VQ scan results</td>
<td>High probability VQ scans—with high clinical probability 28 of 29 had PE—with moderate clinical probability 70 of 80 had PE Normal VQ scans— 5 of 128 PE’s regardless of clinical probability Low probability VQ scan—with low clinical probability 4 of 90 had PE. No other combination was diagnostic</td>
<td>Only 30% patients were from the emergency department</td>
</tr>
<tr>
<td><strong>Miniati M et al, 1996, Italy</strong></td>
<td>890 patients PE had a perfusion scan. 413 of 670 patients with abnormal perfusion scan had a pulmonary angiogram. All abnormal perfusion scan patients were followed up for one year</td>
<td>Prospective diagnostic study</td>
<td>Accuracy of combining clinical probability with Q scan results</td>
<td>Q scans compatible with PE—with high clinical probability 222 of 225 had PE—with moderate clinical probability 70 of 75 had PE Abnormal Q scans not compatible with PE—with low clinical probability 4 of 127 had PE. No other combination was diagnostic</td>
<td>Only 13% patients were from the emergency department</td>
</tr>
<tr>
<td><strong>Wells PS et al, 1998, Canada</strong></td>
<td>1239 patients PE underwent a clinical probability assessment, VQ scan +/− serial Doppler scans. All patients negative for PE were followed up clinically for three months</td>
<td>Management study</td>
<td>Accuracy of combining clinical probability with VQ scan results</td>
<td>Normal VQ scans— 4 of 334 had PE/DVT regardless of clinical probability Low/intermediate probability VQ scan— 13 of 454 with low clinical probability had PE/DVT No other combination was diagnostic</td>
<td>Physicians rated clinical probability of PE subjectively. Complex clinical probability scoring system</td>
</tr>
<tr>
<td><strong>Perrier A et al, 2000, Quebec and Geneva</strong></td>
<td>180 patients from two centres. Prospective management study. Intermediate probability: lung scan and low clinical probability, followed up for three months</td>
<td>Prospective diagnostic study</td>
<td>Three month outcome of patients with low clinical probability and non-diagnostic VQ scan</td>
<td>8 of 173 patients had DVT/PE diagnosed. 4.4% false negative rate False negative rate lowered to 1.7% when serial Doppler ultrasound carried out on all patients</td>
<td>Physicians rated clinical probability of PE subjectively. Patients presenting with symptoms of DVT were excluded</td>
</tr>
<tr>
<td><strong>Barghouth G et al, 2000, Switzerland</strong></td>
<td>143 consecutive PE patients in acute medical ward. Nine lost to follow up excluded. Decision algorithm used to isolate those requiring pulmonary angiogram, based on VQ scan result and clinical probability score</td>
<td>Retrospective management study</td>
<td>Number of pulmonary angiograms ordered 4 DVTs diagnosed in patients without diagnosis of PE (101 total)—7 false negatives. No further events</td>
<td>20 patients</td>
<td>Subjective clinical probability score assigned by clinicians. Decision algorithm not detailed. Eight patients were anticoagulated for reasons other than DVT/PE during follow up. Follow up not robust and carried out retrospectively</td>
</tr>
<tr>
<td><strong>Nilsson T et al, 2001, Sweden</strong></td>
<td>1707 PE patients 1991–1994. All had clinical probability score, Q or VQ scan, pulmonary angiogram, and six month follow up</td>
<td>Prospective diagnostic study</td>
<td>Accuracy of combining clinical probability with Q or VQ scan results</td>
<td>High probability VQ scans—with high clinical probability 17/17 had PE—with moderate clinical probability 10/10 had PE Normal VQ scans—0 of 27 PE’s regardless of clinical probability Low probability VQ scan—with low clinical probability 1 of 34 had PE. No other combination was diagnostic</td>
<td>Physicians used a visual analogue scale (VAS) rather than objective clinical probability score. Nuclear physicians used PIOPED criteria to report VQ scans, but then went on to give subjective VAS result as probability PE. No description of follow up methodology or completion</td>
</tr>
</tbody>
</table>
all ventilation-perfusion scans must be interpreted with an independent clinical probability score.

The Pioped Investigators. Value of the ventilation/perfusion scan in acute pulmonary embolism. JAMA 1990;263:2753–9


Clinical scenario

A 44 year old man presents to the emergency department with a four hour history of severe epigastric pain. You consider a diagnosis of pancreatitis and organise a serum amylase to be taken. You wonder whether a single normal serum amylase result is sufficiently sensitive to rule out pancreatitis in this patient.

Three part question

In [patients with abdominal pain] does [a normal serum amylase] exclude [the diagnosis of pancreatitis]?

Search strategy

Medline 1966-07/03 and Embase 1980-07/03 using the OVID interface. {[(exp Abdominal pain/ OR abdominal pain.mp) OR (exp Pancreatitis/ OR pancreatitis, acute necrotising/ OR pancreatitis, alcoholic/ OR pancreatitis.mp)) AND {exp Amylase$ OR amylase.mp}]} AND [exp Risk Assessment/ OR risk assessment.mp. OR risk stratification.mp. OR probability.mp] LIMIT to human AND English.

Search outcome

Altogether 191 papers found of which four papers were relevant to the original question (table 4).

Comment(s)

The gold standard for the diagnosis of pancreatitis is considered to be surgical examination at laparotomy or pancreatic histology. Often in practice such information is either unavailable or obtained at postmortem examination. In the absence of a readily available gold standard it becomes necessary to evaluate serum diagnostic markers against radiological methods such as CT. Only two studies used an independent “gold standard” for all patients to compare the

### Table 4

<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>Steinberg WM et al, 1985, USA</td>
<td>39 patients with pancreatitis were compared with 127 controls with abdominal pain</td>
<td>Diagnostic study</td>
<td>Sensitivity and specificity of two amylase serum assays for pancreatitis. Using upper limit of normal. Using best cut-off</td>
<td>Amylase 1 = sensitivity 94.9% specificity 88.9%. Amylase 2 = sensitivity 94.9% specificity 86.0%.</td>
<td>Various techniques used to confirm diagnosis including CT scans, laparotomy, USS scans.</td>
</tr>
<tr>
<td>Lin XZ et al, 1989, Taiwan</td>
<td>62 consecutive patients with image verified pancreatitis, and 414 patients with an acute abdomen</td>
<td>Diagnostic study</td>
<td>Sensitivity and specificity of serum amylase at selected cut-off three times above upper limit of normal</td>
<td>Sensitivity of serum amylase: 84% in image proven pancreatitis 92% in patients with or without image verified disease</td>
<td>Problems with gold standard diagnosis of pancreatitis.</td>
</tr>
<tr>
<td>Clavien PA et al, 1989, Canada</td>
<td>352 consecutive attacks of acute pancreatitis in 318 patients</td>
<td>Diagnostic study</td>
<td>Sensitivity and specificity of serum amylase (&lt;160 IU/l) compared with gold standards of CT or laparotomy</td>
<td>Sensitivity of 81% at presentation</td>
<td>Various gold standards used within the study. Chronic pancreatitis patients were excluded.</td>
</tr>
<tr>
<td>Winistel M et al, 1992, UK</td>
<td>417 patients with acute pancreatitis</td>
<td>Diagnostic study</td>
<td>Sensitivity of serum amylase (&lt;1000 IU/l) for detecting acute pancreatitis at hospital admission</td>
<td>Mild cases 96.1%. Severe cases 87.4%. Alcohol subgroup 86%</td>
<td>Variable gold standards used.</td>
</tr>
</tbody>
</table>
| | | | Sensitivity of serum amylase (<1000 IU/l) for detecting acute pancreatitis at 48 hours | Mild cases 33.3%. Severe cases 48.2%. Alcohol subgroup 76%. | Not all patients had CT.
Best evidence topic reports

Ultrasonic guidance and the complications of central line placement in the emergency department

### Table 5

<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>Randolph AG et al, 1996, USA</td>
<td>Eight randomised controlled studies identified from Medline search from 1966 to 1995 with low experience but no studies were in the emergency department</td>
<td>Meta-analysis</td>
<td>Meta-analysis of the relative risk of various clinical variables</td>
<td>Central line placement failure: 0.32 (0.18 to 0.55)</td>
<td>Medline search only, no systematic review</td>
</tr>
<tr>
<td>NICE guidelines, 2002, UK</td>
<td>Systematic review of the literature and meta analysis</td>
<td>Systematic review and meta analysis</td>
<td>Recommendations</td>
<td>Use of 2-D USS should be considered in most clinical situations where a central line is necessary electively or in an emergency</td>
<td>Grades of recommendation not provided</td>
</tr>
<tr>
<td>Only two were performed in the emergency room setting, with seven in ITU, and the remainder in elective scenarios</td>
<td></td>
<td></td>
<td>Few studies on non-anesthetist personnel in the Emergency department</td>
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<tr>
<td>Only four studies were clearly performed by non-anesthetists</td>
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<tr>
<td>Miller AH et al, 2002, USA</td>
<td>122 emergency medical patients designated as “difficult insertions” randomised to the Landmark technique (n = 71) or 2-D USS guidance technique (n = 51)</td>
<td>Cohort study</td>
<td>Time from needle touching skin to successful flashback</td>
<td>Landmark group 463 s +/- 627 s SS group 93 s +/- 176 s p &lt; 0.0001</td>
<td>The insertion time may only represent a small amount of the total time taken to set up an USS guided central line insertion</td>
</tr>
<tr>
<td>Complications</td>
<td>Landmark group 14% USS group 12% p = 0.780</td>
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</tbody>
</table>

Report by Joel Dunning, RCS Research Fellow
Checked by James Williamson, Clinical Fellow

Abstract

A short cut review was carried out to establish whether ultrasonic guidance reduces the complication rate during central line placement in the emergency department. Altogether 349 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

You are evaluating a 90 kg acutely dyspnoeic diabetic woman in the emergency department. She has a history of left ventricular failure and was an inpatient only a few weeks ago with a small myocardial infarction. Her BP is only 90/50 and you feel that she is a high risk patient with poor peripheral venous access who may need high dependency care possibly with inotropes, and you therefore decide that a central line would be of great benefit. Your department has just bought a handheld USS probe and you wonder whether it is worth having a go with this rather than your usual blind landmark technique.

diagnostic test under consideration. Despite this weakness all the above studies except one reported sensitivities below 95%, especially in alcohol related pancreatitis cases.

► CLINICAL BOTTOM LINE

In patients presenting to the emergency department with acute abdominal pain a normal serum amylase concentration is not sufficiently sensitive to rule out the diagnosis of acute pancreatitis.


2-D USS guidance technique

Landmark technique (n = 71) or

insertions’ randomised to the

patients designated as “difficult

peripheral vascular disease,

cogulopathy, obesity,

abnormal anatomy, or history of

intravenous drug misuse

Clinical bottom line

Use of 2-D USS should be considered in most clinical situations where a central line is necessary electively or in an emergency.

No. failed catheter placements RR: 0.16 (0.09 to 0.36) risk of failure RR: 0.39 (0.19 to 0.79) No. complications odds: 0.36 (0.17 to 0.36) Need for multiple catheter placement attempts 0.60 (0.45 to 0.79) Complications during catheter placement 0.22 (0.10 to 0.45)

Cost effectiveness

The extra cost is likely to be saved 90 per 1000 patients (96–63)

Number of arterial punctures saved 90 per 1000 patients The extra cost is likely to be about £10 patient, although the machines cost £7000–£15000 initially

Number of seconds saved 76 (96–63)

Number of attempts Landmark group 3.54 +/- 2.7 USS group 1.55 +/- 1.0 p < 0.0001 Complications Landmark group 14% USS group 12% p = 0.780

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Three part question
In [patients in the emergency department requiring a central line] is [USS guidance better than blind landmark techniques] at [reducing the complications of insertion]?

Search strategy
Medline 1966-07/03 using the OVID interface. [(exp Ultrasoundography/ OR ultrasound.mp) AND (exp Catheterization, Central Venous/ OR central venous catheter.mp OR central line.mp)] LIMIT to human AND English

Search outcome
Altogether 349 papers were found of which two represented the best evidence. This included a meta-analysis and an additional paper. In addition a second meta-analysis not indexed on Medline was identified by cross referencing (table 5).

Comment(s)
Two meta-analyses were identified in this area and only one additional paper could be found that neither meta-analysis included. Both meta-analyses provide strong evidence that USS guided placement significantly reduces complications during catheter placement, number of attempts at insertion and reduction in the number of attempts at insertion for both neck and femoral line insertion. In addition and the NICE meta-analysis provides evidence that insertion time is quicker although this evidence is less convincing. NICE also imply meta-analysis provides evidence that insertion time is quicker although this evidence is less convincing. NICE also imply that if used regularly the cost implication could be as little as £10 per patient although they acknowledge a projected £29 million cost for initial NHS implementation for equipment and training.

CLINICAL BOTTOM LINE
There is good evidence that USS guided placement of central lines reduces the complication rate associated with this procedure.


The utility of the tongue blade test for the diagnosis of mandibular fracture

Report by Rashmi Malhotra, Medical Student
Checked by Joel Dunning, RCS Research Fellow

Abstract
A short cut review was carried out to establish whether the tongue blade test is useful in the clinical assessment of patients with mandibular trauma. Altogether 269 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

<table>
<thead>
<tr>
<th>Table 6</th>
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</thead>
<tbody>
<tr>
<td><strong>Author, date and country</strong></td>
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<tr>
<td>Alonso LL, Thomas TB, 1995, USA</td>
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<tr>
<td>Robert A et al, 1998, USA</td>
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<tr>
<td>Exclusion criteria: patients unable to cooperate because of age, language barrier, inability to open mouth because of pain, intoxication or head injury</td>
</tr>
</tbody>
</table>

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studied, study type, relevant outcomes, results and study weaknesses of these best papers are tabulated. A clinical bottom line is stated.

**Clinical scenario**
You are evaluating a patient who has attended the emergency department having just been punched on the jaw. He is having difficulty opening his mouth and talking but you can see no step deformity or loose teeth. You recall that while you were on elective you saw the tongue blade test being used routinely in America to select patients for mandibular imaging. For this test the patient is asked to bite on the tongue blade and if the examiner can break the blade while the patient grips it, the patient does not need a mandibular radiograph. You wonder whether this is a sensitive test to use in this patient.

**Three part question**
In [patients with mandibular trauma] is [the tongue blade test] a good diagnostic test for [mandibular fracture]?

**Search strategy**
Medline 1966-7/03 using the OVID interface. [((mandibular fracture.mp.OR exp Mandibular Fractures/) OR {(exp fractures OR fracture$.mp) AND (exp mandible OR mandible$.mp or mandibular.mp)})] AND exp diagnosis OR diagnosis.mp AND maximally sensitive RCT filter LIMIT to human AND English.

**Search outcome**
Altogether 269 papers were found of which two were relevant and are listed in table 6.

**Comment(s)**
No confidence intervals were calculated by Roberts et al for the reported sensitivity of the tongue blade test so we calculated this ourselves: sensitivity 95.4% (CI 84.53% to 99.44%). The confidence intervals are comparatively wide and so the tongue blade test could not stand on its own as a single diagnostic tool in screening for mandibular fractures since missing these fractures can lead to serious long term complications.

The high sensitivities reported by both these studies do suggest, however, that the tongue blade test is a useful screening tool in evaluating patients with mandibular fracture but other clinical predictors must also be considered.

**CLINICAL BOTTOM LINE**
The tongue blade test is useful in evaluating patients with possible mandibular fracture
