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, the last two of which are negative.

► Abdominal radiography in “body packers”
► Use of heliox for acute asthma in the emergency department
► Cardiopulmonary bypass and the survival of patients in cardiac arrest
► Oral or intravenous thiamine in the emergency department
► Antibiotic prophylaxis for pretilial haematomas in the elderly population
► Prophylactic antibiotics for subungual hematomas

K Mackway-Jones, Department of Emergency Medicine, Manchester Royal Infirmary, Oxford Road, Manchester M13 9WL, UK; kevin.mackway-jones@man.ac.uk
3 Mackway-Jones K, Carley SD. bestbets.org: Odds on favourite for evidence to the topic of interest (table 1).

Altogether 12 papers were found of which two were relevant to the topic of interest (table 1).

Comment(s)
The possibility of internal carriage of drugs is an increasingly frequent presentation to urban emergency departments. A diagnostic dilemma is usual because of the credibility of the presentation. It is important, therefore, that clinicians understand the utility of any investigations used. In particular the failure to appreciate the possibility of a false negative result might prove fatal.

► CLINICAL BOTTOM LINE
A single abdominal radiograph is insufficiently sensitive to rule out abdominal drug carriage. However, specificity is high and a positive finding is diagnostic.


Abstract
A short cut review was carried out to establish whether heliox is of benefit in patients with an exacerbation of asthma
resistant to standard treatments. Eighteen 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.

**Clinical scenario**

A 20 year old man attends the emergency department with a moderate to severe exacerbation of his asthma. He does not improve after repeated doses of nebulised salbutamol and atrovent. You have a feeling that heliox might be beneficial in just this sort of situation but wonder whether this is based on evidence or marketing hype.

**Three part question**

In [patients with an acute exacerbation of asthma] is [heliox] beneficial in [reducing the severity of the exacerbation]?

**Search strategy**


Medline: [(asthma.mp OR exp asthma OR exp asthma, exercise-induced OR exp bronchial spasm OR broncospasm$.mp OR wheeze$.mp OR exp bronchial hyperreactivity OR exp respiratory hypersensitivity OR Status asthmaticus$.mp OR exp status asthmaticus OR acute asthma$.mp) AND (exp helium OR helium$.mp OR heliox$.mp OR (helium AND oxygen).mp)] LIMIT to human AND English language.

Cochrane: ‘heliox’

**Search outcome**

Altogether 207 papers were found, of which six were considered to be original research of high quality (randomised controlled trials) suitable for inclusion. Secondary citations from these papers were also scanned. These six papers have since been subject to meta-analysis by the Cochrane Review Group. The review was first published in 2000 with the most recent substantive amendment made in November 2002 (see table 2).

**Comment(s)**

The individual trials examined in the Cochrane review vary widely in the type of patients recruited (age, severity of asthma), delivery of heliox and outcome measures.

Outcomes vary between heliox having a beneficial effect and having no effect. There are very few side effects of heliox reported.

**Clinical bottom line**

At the moment the evidence does not support the use of heliox in the emergency department treatment of acute asthma exacerbations.

<table>
<thead>
<tr>
<th>Author, date and country</th>
<th>Patient group</th>
<th>Study type</th>
<th>Outcomes</th>
<th>Key results</th>
<th>Study weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tisherman SA et al, 1990, USA</td>
<td>28 year old woman brought to the emergency department with recurrent VF CPS instituted after 46 min of CPR</td>
<td>Case report</td>
<td>CPB duration</td>
<td>Outcome</td>
<td>15 hours</td>
</tr>
<tr>
<td>Rees MR et al, 1992, UK</td>
<td>Percutaneous cardiopulmonary support (CPS) started in four patients in cardiogenic shock, four patients in asystole, and one patient in resistant VF</td>
<td>Case series</td>
<td>Survival in arrest group</td>
<td>All five patients reverted to sinus rhythm after angioplasty on CPS, and three survived to discharge</td>
<td>One death due to aortic root rupture and one due to bronchopneumonia after 2 months 60% survival</td>
</tr>
<tr>
<td>Martin GB et al, 1998, USA</td>
<td>10 patients attending the ED with out of hospital cardiac arrest unresponsive to conventional methods, placed on Fem fem CPB</td>
<td>Case series</td>
<td>Long term survivors</td>
<td>Weaning from CPB</td>
<td>7 successfully weaned from CPB with spontaneous circulation</td>
</tr>
<tr>
<td>Karmy-Jones R et al, 1999</td>
<td>29 year old woman whom, while undergoing an elective gynaecological procedure, acutely arrested. ACLS ineffective. CPS was started</td>
<td>Case report</td>
<td>Cardiac arrest to CPB</td>
<td>Outcome</td>
<td>Mean time 32 min</td>
</tr>
<tr>
<td>Jaski BE et al, 1999, USA</td>
<td>10 patients who had an out of hospital acute myocardial infarction and cardiac arrest were placed on percutaneous CPB</td>
<td>Case series</td>
<td>Long term survival</td>
<td>Cause of death</td>
<td>Neurological insufficiency in two, ineffective CPB in two, recurrent collapse after weaning in two</td>
</tr>
<tr>
<td>Nagao K et al, 2000, Japan</td>
<td>36 patients arriving in the ED after out of hospital arrest, if return of spontaneous circulation could not be achieved in patients with VF after unsynchronized electric shocks, with the second administration of epinephrine, or in patients without VF after the second administration of epinephrine, emergency CPB and intra-aortic balloon pumping (IABP) were immediately performed in the emergency room.</td>
<td>Prospective cohort study</td>
<td>Return of spontaneous circulation</td>
<td>Mean CPR time prior to CPB</td>
<td>17 min in survivors and 54 min for non-survivors</td>
</tr>
<tr>
<td>Fujimoto K et al, 2001</td>
<td>Nine patients suffering circulatory collapse after AMI refractory to ACLS resuscitation put on CPS</td>
<td>Case series</td>
<td>Long term survival</td>
<td>4 survivors although one had a poor neurological outcome</td>
<td>All patients required a surgical procedure, including VSD repair in 4 and free wall rupture in 2</td>
</tr>
<tr>
<td>Kuruz M et al, 2002, USA</td>
<td>Review of clinical reports of CPB in cardiac arrest or cardiogenic shock</td>
<td>Review</td>
<td>Survival after cardiac arrest</td>
<td>88 of 407 reported in the literature (21%)</td>
<td>Not systematic, search strategies not reported</td>
</tr>
<tr>
<td></td>
<td>13 papers found reporting CPB after cardiac arrest and 17 papers reporting CPB after cardiogenic shock</td>
<td></td>
<td>Survival after cardiogenic shock</td>
<td>137 of 335 (41%)</td>
<td>Some papers missed</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Poor survival</td>
<td>Patients with unwitnessed cardiac arrest or CPR over 30 min</td>
<td></td>
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</tbody>
</table>
shocks. A single additional DC shock at 360 J restores sinus rhythm with an output.

Your ICU colleague informs you four days later that this patient has severe anoxic brain damage and is unlikely to be discharged from hospital. You feel that failure has been snatched from the jaws of success and wonder whether some other intervention, such as cardiopulmonary bypass support, might have improved his chances of functional survival.

Three part question
In [patients with cardiac arrest refractory to ACLS intervention] is [institution of cardiopulmonary bypass] of any benefit in [improving survival and neurological function]?

Search strategy
Medline 1966-03/04 using the OVID interface. [exp Heart Arrest/OR exp life support care/OR cardiac arrest.mp OR cardiac massage.mp OR CPR.mp] AND [exp Cardiopulmonary Bypass/OR Cardiopulmonary Bypass.mp OR cardiopulmonary support.mp] LIMIT to human AND English language.

Search outcome
Alltogether 387 papers were found one of which was a review summarising 35 papers. Eight papers not included in this review were also found. Thus nine relevant papers are summarised in the table 3.

Comment(s)
There is a large variability in the reported papers. The prior clinical status of the patient is one very important factor in determining survival, as a patient with known coronary arterial disease arresting in the catheter lab will clearly have a superior survival to an out of hospital arrest with unknown pathology. However, some studies relied only on cardiopulmonary bypass and gradually weaned the patient after a number of hours, whereas other investigators immediately took the patient to the catheter lab to establish a diagnosis or to theatre for a definitive procedure. In addition there were differences in technique in the method of cardiopulmonary bypass. One important difference is whether the venous return adequately drains the right atrium, as failure to do this will cause the heart to distend and cause pulmonary oedema.

► CLINICAL BOTTOM LINE
Around 15%–25% of selected patients who suffer witnessed cardiac arrest and who are not responsive to ACLS resuscitation may be successfully resuscitated with the assistance of cardiopulmonary bypass.


Oral or intravenous thiamine in the emergency department

Report by Rupert Jackson, Consultant
Checked by Stewart Teece, Clinical Research Fellow
doi: 10.1136/emj.2004.016550

Abstract
A short cut review was carried out to establish whether parenteral thiamine was more effective than an oral preparation at replacing thiamine in alcoholics without encephalopathy. Twenty five 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 56 year old man attends the emergency department with cellulitis in his left leg. He is unkempt and drinks heavily. The cellulitis can be treated as an outpatient with oral antibiotics, but you suspect he is thiamine deficient as a result of long term alcohol misuse. You are therefore about to prescribe an intravenous infusion of thiamine as you have always given it this way. This will commit you to an inpatient admission and beds are at a premium. You wonder whether there is any basis for your prescribing practice—perhaps oral thiamine would be just as effective.
Three part question
In [thiamine deficient patients without Wernicke's encephalopathy] is [parenteral delivery of thiamine better than the oral route] at [achieving bioavailability without side effects]?

Search strategy
Medline 1966-03/04 using the OVID interface. [(exp thiamine OR thiamine.af OR (vitamin adj5 b1).af) AND (exp infusions, intravenous/OR exp injections, intravenous OR intravenous.af OR exp infusions, parenteral OR parenteral.af) AND (exp administration, oral OR oral.af OR exp tablets OR tablet.af OR po.af)] LIMIT to human AND English Language.

Search outcome
Altogether 25 papers were found of which two were relevant to the three part question (table 4).

Comment(s)
Clearly concordance with treatment also has to be considered. This has not been considered at all in the papers found.

▶ CLINICAL BOTTOM LINE
Oral thiamine administration is as effective as parenteral administration after five days. In compliant alcoholics without encephalopathy oral administration is the route of choice.

<table>
<thead>
<tr>
<th>Table 4</th>
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</thead>
<tbody>
<tr>
<td>Author, date and country</td>
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<tr>
<td>Tallaksen CME et al, 1993, Norway</td>
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<td></td>
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<td>Baines M et al, 1988, UK</td>
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</table>

Antibiotic prophylaxis for pretibial haematomas in the elderly population

Report by Stewart Teece, Clinical Research Fellow
Checked by Ian Crawford, Clinical Research Fellow
doi: 10.1136/emj.2004.016568

Abstract
A short cut review was carried out to establish whether prophylactic antibiotics reduce infections and other complications in elderly patients with pretibial haematomas.

Altogether 65 papers were found using the reported search, of which none presented any evidence to answer the clinical question. It is concluded that there is no evidence available to answer this question. Further research is needed.

Clinical scenario
A 95 year old woman attends the emergency department having slipped against her zimmer frame, hitting her right shin. Examination shows a 10 cm haematoma with no break to the skin. Given the size and site of the haematoma you feel there is a risk of infection developing in the haematoma before it resolves. You therefore arrange clinic follow up and give her prophylactic flucloxacillin. On discussing the case the next day it becomes apparent that a number of colleagues would not have bothered with the antibiotics. You decide to check the literature to see who is right.

Three part question
In [elderly patients with a large pretibial haematoma] does [the prophylactic use of antibiotics] give [a reduction in infective complications]?

Search strategy
Medline 1966-03/04 and CINAHL 1980-03/04 using the OVID interface. Medline: [(exp Hematoma OR haematoma.af OR hematoma.af OR exp CONTUSIONS OR contusion.af) AND (exp Antibiotic Agents OR antibiotic.af. OR anti-biotic.af. OR infection.af)] LIMIT to English language.

Search outcome
Altogether 65 papers found on Medline, 30 on CINAHL none of which answered the three part question.

Comment
There are no trials of any kind looking at the use of prophylactic antibiotics on the incidence of infections or complications in patients with pretibial haematomas.

▶ CLINICAL BOTTOM LINE
There is no evidence to confirm/refute the use of antibiotics in pretibial haematoma, local guidelines should be followed.
Prophylactic antibiotics for subungual haematoma

Report by Jonathan Costello, Specialist Registrar
Checked by Marten Howes, Specialist Registrar
doi: 10.1136/emj.2004.016576

Abstract
A short cut review was carried out to establish whether antibiotic prophylaxis is indicated after trephining of a subungual haematoma. Two papers were found using the reported search, of which neither presented any evidence to answer the clinical question. It is concluded that there is no evidence available to answer this question. Further research is needed.

Clinical scenario
A 25 year old labourer presents to the emergency department with a subungual haematoma of acute onset. After trephination, the patient requests antibiotics. You wonder if such prophylaxis is indicated.

Three part question
In [the management of subungual haematoma] are [prophylactic antibiotics] indicated to [improve outcome]?

Search strategy
Medline 1966-03/04 using the OVID interface. (Exp antibiotics OR antibiotic$.mp OR exp antibiotic prophylaxis OR antibiotic prophylaxis.mp OR prophylactic antibiotics.mp) AND (exp hematoma OR hematoma.mp OR haematoma.mp OR clot.mp) AND (exp nails OR exp Nail Diseases OR nail$.mp OR ungual$.mp OR subungual$.mp)

Search outcome
Two papers were found neither of which were relevant.

Comment(s)
There are no trials of any kind looking at the use of antibiotics on the incidence of infections or complications after subungual trephination.

† CLINICAL BOTTOM LINE
There is no evidence for antibiotic prophylaxis in the management of uncomplicated subungual haematoma.

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