Best evidence topic reports (BETs) summarise the evidence pertaining to particular clinical questions. They are not systematic reviews, but rather contain the best (highest level) evidence that can be practically obtained by busy practising clinicians. The search strategies used to find the best evidence are reported in detail in order to allow clinicians to update searches whenever necessary. Each BET is based on a clinical scenario and ends with a clinical bottom line that indicates, in the light of the evidence found, what the reporting clinician would do if faced with the same scenario again. The BETs published below were first reported at the Critical Appraisal Journal Club at the Manchester Royal Infirmary or placed on the BestBETs web site. Each BET has been constructed in the four stages that have been described elsewhere. The BETs shown here together with those published previously and those currently under construction can be seen at http://www.bestbets.org. Four BETs are included in this issue of the journal.

Endotracheal intubation in γ-hydroxybutyric acid intoxication and overdose

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

doi: 10.1136/emj.2004.021154

Abstract

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

Clinical scenario

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

Three part question

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

Search strategy

Medline 1966–09/04 using the OVID interface. [exp Hydroxybutyrates OR gamma hydroxybutyric acid.mp. OR GHB.mp] AND [exp Poisoning OR intoxication.mp OR exp Endotracheal intubation more effective than exp Non-invasive airway management.mp] LIMIT to English language.

Search outcome

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

Comment(s)

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

Clinical bottom line

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

No clinical evidence for gastric lavage in lithium overdose

Report by Stewart Teece, Clinical Research Fellow Checked by Ian Crawford, Clinical Research Fellow

doi: 10.1136/emj.2004.021162
**Abstract**
A short cut review was carried out to establish the published evidence for gastric lavage in lithium overdose. Altogether 20 papers were found using the reported search, of which none presented the best evidence to answer the clinical question. A clinical bottom line is stated.

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

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

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

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

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

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

# Table 1

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

---

**Paddle position in emergency cardioversion of atrial fibrillation**

Report by Katherine Potier de la Morandiere, Specialist Registrar
Checked by Henry Morriss, Specialist Registrar
doi: 10.1136/emj.2004.021170
Abstract
A short cut review was carried out to establish whether the antero-lateral or antero-posterior paddle position is best at reverting acute atrial fibrillation to sinus rhythm. Altogether 954 papers were found using the reported search, of which five presented the best evidence to answer the clinical question. The author, date and country of publication, patient group studied, study type, relevant outcomes, results and study weaknesses of these best papers are tabulated. A clinical bottom line is stated.

Clinical scenario
A 60 year old man presents to the emergency department with a history of sudden onset palpitations. This is associated with some mild chest discomfort and breathlessness. On examination he is in atrial fibrillation at a rate of 180, and has a blood pressure of 95/60. He looks pale and sweaty. You feel he needs urgent electrical cardioversion and wonder whether the paddle position used will affect your success rate.

Table 2

<table>
<thead>
<tr>
<th>Author, date and country</th>
<th>Patient group</th>
<th>Study type (level of evidence)</th>
<th>Outcomes</th>
<th>Key results</th>
<th>Study weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mathew TP et al, 1999, UK</td>
<td>90 patients Elective</td>
<td>Antero-lateral (AL) v Antero-posterior (AP) 100J then 200J, 300J, 360J</td>
<td>Cardioversion success rate Mean (SD) energy used Mean (SD) thoracic impedance on first shock</td>
<td>38/45 success for AL v 33/45 for AP p = 0.42 223 (96.1) J for AL v 232 (110) J for AP 77.5 (18.4) Ohms AL v 73.7 (18.7) Ohms AP p = 0.34</td>
<td>No power</td>
</tr>
<tr>
<td>Botto GL et al, 1999, Italy</td>
<td>301 patients with stable AF AL v AP 3J/kg then 4J/kg then 5J/kg in alternative position</td>
<td>Prospective randomised controlled trial</td>
<td>Success rate at initial shock Cumulative success rate after first 4J/kg shock Cumulative success after second 4J/kg shock</td>
<td>87/151 success for AL v 100/150 for AP. 114/151 for AL v 131/150 for AP (p = 0.013) 140/150 for AL v 140/150 for AP p = NS</td>
<td>No power calculation</td>
</tr>
<tr>
<td>Kirchhof P et al, 2002, Germany</td>
<td>108 patients with persistent AF Elective cardioversion (50–360J) AP v AL</td>
<td>RCT cross-over</td>
<td>Cardioversion success rate on initial 360J DC shock Cardioversion second 360J shock</td>
<td>With first 360J AL more successful 18/30 v10/29 for AP (p = 0.048). 4/19 for AL v 5/12 for AP p = 0.22</td>
<td>Small numbers</td>
</tr>
<tr>
<td>Chen CJ and Guo GB, 2003, Japan</td>
<td>70 patients with persistent AF (≤ 1 month). AL (31 patients) v AP (39 patients)</td>
<td>Randomised controlled trial</td>
<td>Cardioversion success at 100J Cumulative cardioversion success at 150J</td>
<td>AP v AL 23% v19.4% p = NS AP v AL 41% v 45.2% p = NS</td>
<td>Small, low powered study</td>
</tr>
<tr>
<td></td>
<td>Step up protocol 100, 150, 200, 300, 360 joules</td>
<td>Cumulative cardioversion success at 200J Cumulative cardioversion success at 300J</td>
<td>AP v AL 66.7% v 74.2% p = NS AP v AL 79.5% v 77.4% p = NS AP v AL 84.6% v 83.9% p = NS</td>
<td>No randomisation details</td>
<td>Only looks at those with persistent AF in an elective setting (excluded those with new onset AF, one month)</td>
</tr>
</tbody>
</table>

Three part question
In [a patient with new onset AF who needs urgent electrical cardioversion] is [antero-posterior better than antero-lateral paddle position] at [reverting the patient to sinus rhythm]?

Search strategy

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

Comment(s)
AF is a common problem encountered in the emergency department. These papers shows that some good quality
research has been done on cardioversion but not in the
emergency setting. The five best papers show conflicting
results regarding the positioning of paddles in elective
cardiocversion, the most recent showing no difference
between the two positions. In our clinical scenario the AP
position may be difficult to achieve in such an unwell,
shocked patient.

► CLINICAL BOTTOM LINE
There is little evidence to suggest that paddle position
significantly influences the success of cardioversion emer-
gency department patients with AF.

Matthew TP, Moore A, McIntyre M, et al. Randomised comparison of electrode

Botto GI, Politis A, Bonini W, et al. External cardioversion of atrial fibrillation: role
of paddle position on technical efficacy and energy requirements. Heart

antero-posterior paddle positions for DC cardioversion of persistent atrial

electrode positions for external cardioversion of atrial fibrillation: a randomised

Chen CJ, Guo GB. External cardioversion in patients with persistent atrial

Reinsertion of the stylet before
needle removal in diagnostic lumbar puncture

Report by Matthew Deibel, Senior Resident
Checked by Jeffrey Jones, Michael Brown,
Research Director and Director of the Emergency
Medicine Residency programme respectively
doi: 10.1136/emj.2004.021188

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

Clinical scenario
A 31 year old woman presents to the emergency department
with a sudden onset severe headache. After a normal head
computed tomogram, you prepare for lumbar puncture with a
small gauge non-traumatic needle. You remember a collea-
gue telling you it is also important to replace the stylet before
removing the needle to prevent a post-lumbar puncture headache. You wonder what is found in the literature.

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

Search strategy
Medline 1966-09/04 using the OVID interface and Cochrane
database 2004 Edition 3 via NeLIH. Medline: [exp spinal
puncture OR (spinal adj5 tap).af OR (spinal adj5 puncture).af
OR (spinal adj5 injection).af OR (lumbar adj5 tap).af OR
(lumbar adj5 puncture).af OR (lumbar adj5 injection).af OR
(lumbar adj5 puncture).af OR (lumbar adj5 injection).af] AND [exp headache OR exp headache
disorders OR headache.af OR post-lumbar puncture syndrome.
mp OR PDHF.mp OR PLPS.mp] AND [needle.mp OR exp

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

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

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

<table>
<thead>
<tr>
<th>Author, date and country</th>
<th>Patient group</th>
<th>Study type (level of evidence)</th>
<th>Outcomes</th>
<th>Key results</th>
<th>Study weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strupp M, Brandt T</td>
<td>600 neurology patients undergoing diagnostic LP randomly assigned (patient blinded) 300 to stylet replacement before needle removal, other 300 not reinserted. Similar sex and age. Used 21 gauge atraumatic needle</td>
<td>Prospective randomised controlled trial</td>
<td>Post-lumbar puncture syndrome (headache, tinnitus, dizziness) reproducible by position and improved laying down, over seven days</td>
<td>Not reinserted 49/300 (16%) post-lumbar puncture syndrome v 15/300 (5%) when stylet reinserted. Post-lumbar puncture syndrome was also less severe (2.8 v 4.3 scale of 10) if stylet reinserted</td>
<td>Excluded patients with headache before LP. Post-lumbar puncture syndrome intensity scale not clearly defined. Follow up not clearly described.</td>
</tr>
</tbody>
</table>