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, which 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 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. Four BETs are included in this issue of the journal.

### Diagnostic utility of electrocardiogram for diagnosing pulmonary embolism

**Abstract**

A shortcut review was carried out to establish the diagnostic utility of electrocardiography in patients with suspected pulmonary embolus (PE). Altogether 952 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 (table 1). It is concluded that although there are electrocardiogram (ECG) changes that are more common in PE, the ECG alone is not sufficiently sensitive or specific to rule out or rule in the diagnosis.

#### Clinical scenario

A 30 year old man presents to the emergency department with a spontaneous onset of atraumatic pleuritic chest pain. He is in a low risk group clinically. The medical registrar suggests that the fact that the ECG is normal makes the diagnosis of PE much less likely. You wonder whether his assertion that a normal ECG will help to exclude a PE is safe.

#### Three part question

In [a patient presenting with features suggestive of pulmonary embolus] what is [the diagnostic utility of ECG] in [stratifying risk of pulmonary embolus]?

### Search strategy


[(Pulmonary embolism MeSH OR thromboembolism MeSH)] AND [(electrocardiography MeSH)].

### Search outcome

Altogether 952 papers were found of which 947 were not directly relevant to the question, were of insufficient quality, or did not report enough data to assess the diagnostic utility of ECG or a scoring system in which it was included. The best papers are tabulated (table 1). It is concluded that although there are electrocardiogram (ECG) changes that are more common in PE, the ECG alone is not sufficiently sensitive or specific to rule out or rule in the diagnosis.

### Comments

Although it is clear that there are some ECG changes that occur more frequently in patients with PE, these occur infrequently. There is no evidence that an ECG alone has adequate sensitivity or specificity to rule out or in a PE. It may have utility as part of risk stratification strategies.
Differential diagnosis of narrow complex tachycardias by increasing electrocardiograph speed

Report by Joao Luis Gaspar, Medical student Search checked by Richard Body, Clinical Research Fellow
doi: 10.1136/emj.2005.029074
Table 2

<table>
<thead>
<tr>
<th>Author, country, date</th>
<th>Patient group</th>
<th>Study type</th>
<th>Outcomes</th>
<th>Key results</th>
<th>Study weaknesses</th>
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<tbody>
<tr>
<td>Accardi AJ et al, 2002 USA</td>
<td>45 patients with difficult narrow complex tachycardia (heart rate range: 150-250 beats/min)</td>
<td>Prospective comparative cohort</td>
<td>Correct ECG diagnosis</td>
<td>63% 25 mm/s standard group v 71% 50 mm/s ECG; difference in means 8.6% (95% CI 2, 15%); p = 0.002</td>
<td>Small numbers</td>
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<td>Correct ECG diagnosis of atrial flutter</td>
<td>40% 25 mm/s standard group v 52% 50 mm/s ECG; difference in means 12.5% (95% CI 1, 24%); p = 0.008</td>
<td>Definitive diagnosis was potentially inaccurate</td>
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<td></td>
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<td></td>
<td>Definitive diagnosis depended upon agreement between the ‘official’ diagnosis in the case notes and a cardiologist who reviewed each case.</td>
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<td>Correct diagnosis of atrial fibrillation</td>
<td>85% 25 mm/s standard group v 90% 50 mm/s ECG difference in means 4.5% (95% CI –5, 14%); p = 0.046</td>
<td>Review of 25 mm/sec ECGs was followed by review of 50 mm/sec ECGs two weeks later. The reviewers may have learned more about ECG diagnosis in that time, biasing the results. Intraobserver variability should have been assessed</td>
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<td></td>
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<td>Correct diagnosis of PSVT</td>
<td>73% 25 mm/s standard group v 78% 50 mm/s ECG</td>
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<td>Correct diagnosis of sinus tachycardia</td>
<td>56% 25 mm/s standard group v 81% 50 mm/s ECG</td>
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</table>

Three part question

In [adults with narrow complex tachycardia] does [increased electrocardiograph speed] improve [success in identifying the type of narrow complex tachycardia]?

Search strategy


EMBASE: [Supraventricular-tachycardia$.de. OR Tachycardia$.w..de. OR Reentry-Tachycardia$.de. OR Paroxysmal-supraventricular-tachycardia$.de. OR heart-arrhythmia$.de. OR Heart-atrium-fibrillation-tachycardia$.de. OR heart-arrhythmia$.de. OR Heart-atrium-fibrillation$.de. OR SVT.mp.] AND [Electrocardiography$.w..de. OR ECG-abnormality$.de. OR ECG.mp. OR EKG.mp. OR electrocardiography$.mp.] AND [diagnosis$.mp. OR differential$.mp.] AND [Time$.w..de. OR speed.mp. OR velocity.mp. OR 25 mm$.mp. OR 50 mm$.mp.]. LIMIT to human and English language.

CINAHL: [Tachycardia-supraventricular$.de. OR Arrhythmia$.w..de. OR Tachycardia$.w..de. OR Arrhythmia-atrial$.de. OR Tachycardia-atrial$.de. OR Atrial-fibrillation$.de. OR Atrial-flutter$.de. OR (narrow ADJ complex ADJ tachycardia).mp. OR SVT.mp.] AND [Electrocardiography$.w..de. OR ECG.mp. OR EKG.mp. OR electrocardiography$.mp.] AND [diagnosis$.mp. OR differential$.mp.] AND [speed.mp. OR velocity.mp. OR 25 mm$.mp. OR 50 mm$.mp.]. LIMIT to human and English language.

Search outcome

Using the reported searches, 116 papers were identified using OVID Medline, 216 using EMBASE, 8 using CINAHL, and 6 using Cochrane. Only one paper, which had been identified using both OVID Medline and EMBASE, was relevant to the three part question.

Comments

There is a subgroup of patients with narrow complex tachycardia who are difficult to diagnose using the initial 12-lead ECG. A trial of adenosine is often used to aid diagnosis but this often causes significant side effects to the patient and some quite literally heart stopping moments for patient and physician alike. The idea of a simple, quick, non-invasive test such as the 50 mm/s ECG to aid diagnosis is therefore attractive.

The only study to investigate the clinical utility of this strategy suggests that the addition of a 50 mm/s ECG to a standard 25 mm/s ECG improves diagnostic accuracy in narrow complex tachycardia. The study suggests that inappropriate use of adenosine may be reduced by implementing this strategy, as interpreters are more likely to correctly diagnose difficult tracings.

saturation 93% in air. A 12-lead ECG is recorded, which reveals a rapid narrow complex tachycardia. Interpretation of P wave activity is difficult because of the rapid heart rate and you cannot be entirely sure whether this is atrial flutter, junctional tachycardia, or sinus tachycardia. You wonder if increasing the ECG speed will help you to make a more accurate diagnosis.

Three part question

In [adults with narrow complex tachycardia] does [increased electrocardiograph speed] improve [success in identifying the type of narrow complex tachycardia]?
**Clinical Bottom Line**
A 50 mm/s ECG should be considered when differential diagnosis of narrow complex tachycardia is difficult.


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**Lignocaine as a pretreatment to rapid sequence intubation in patients with status asthmaticus**

Report by John Butler, Consultant

Search checked by Rupert Jackson, Consultant
doi: 10.1136/emj.2005.029058

**Abstract**
A shortcut review was carried out to establish whether pretreatment with intravenous lignocaine is of benefit in asthmatic patients undergoing rapid sequence intubation (RSI). Altogether 157 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 these best papers are tabulated (table 3). It is concluded that there is no good evidence to support the use of lignocaine in this circumstance.

**Clinical scenario**
A patient attends the emergency department in status asthmaticus. On examination they have a sinus tachycardia at a rate of 130/min, an oxygen saturation of 92% on high flow oxygen, and a pCO₂ of 7.0 kPa. Despite maximal medical treatment they are becoming exhausted. You decide that the patient needs a RSI and continuous mandatory ventilation. You wonder whether the pretreatment with lignocaine will attenuate the respiratory response (bronchospasm) to airway manipulation.

**Three part question**
In [asthmatic patients who need RSI and ventilation] does [pretreatment with intravenous lignocaine prior to RSI] reduce the incidence of [adverse airway responses]?

**Search strategy**


Altogether 157 papers were found in 2000–2005, of which 143 were unique, of which one was relevant to the question.

**Search outcome**
Altogether 157 papers were found in 2000–2005, of which 143 were unique, of which one was relevant to the question.

**Comments**
Tracheal intubation in asthmatics is linked to the risk of life threatening bronchospasm. This reflex is in part neurally mediated through the vagus nerve. Local anaesthetics have been used as a pretreatment to airway stimulation in susceptible patients in the hope of attenuating the reflex induced bronchoconstriction. The National Emergency Airway Course recommends a pretreatment dose of intravenous lignocaine (3 mg/kg) given 3 minutes prior to intubation in this patient group. There is no evidence from the above trial that this will be of value. Interestingly pretreatment with albuterol did attenuate the response.

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**Steroids in sudden sensorineural hearing loss**

Report by Angaj Ghosh, Registrar

Search checked by Rupert Jackson, Consultant
doi: 10.1136/emj.2005.029066

**Abstract**
A shortcut review was carried out to establish whether steroids are of benefit in sudden onset sensorineural deafness. Altogether 175 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 (table 4). It is concluded that there is insufficient good evidence to recommend early steroid treatment in this condition.

**Clinical scenario**

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**Table 3**

<table>
<thead>
<tr>
<th>Author, date, 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>Maslow AD et al, 2000, USA</td>
<td>60 asthmatic patients undergoing intubation</td>
<td>Prospective randomised controlled trial</td>
<td>Lower pulmonary resistance</td>
<td>8.2 ± 7.6 cm water (ns)</td>
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<tr>
<td></td>
<td>1.5 mg/kg lidocaine v saline given 3 min before tracheal intubation</td>
<td>Frequency of airway response to intubation</td>
<td>6/30 ± 5/27 (ns)</td>
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<td></td>
</tr>
</tbody>
</table>

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www.emjonline.com
Three part question
In [an adult with sudden idiopathic hearing loss] is [early steroid therapy better than no steroids] at improving [time to recovery and outcome]?

Search strategy
Medline OVID 1966 to week 4 June 2005. [(exp hearing loss, sudden/OR sudden$adj$ deaf$.mp. OR sudden adj hearing adj loss.mp.) AND (exp steroids/OR steroid$.mp. OR exp glucocortcoide/OR glucosteroid$.mp. OR exp corticosteroid$/ OR corticosteroid$.mp.)]. LIMIT to human, English language, and all adult.

Embase OVID 1980 to week 27 2005. [(exp sudden deafness/OR sudden$adj$ deaf$.mp. OR sudden adj hearing adj loss.mp.) AND (exp steroid/OR steroid$.mp. OR exp glucocortcoide/OR glucosteroid$.mp. OR exp corticosteroid$/ OR corticosteroid$.mp.)]. LIMIT to human, English language, and adult <18 to 64 years> or aged <65+ years>.


Search outcome
 Altogether 175 unique papers were found of which five directly answered the question.

Table 4

<table>
<thead>
<tr>
<th>Author, date, 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>Wilson WR and Byl FM, 1980, USA</td>
<td>Patients attending within 10 days of a 30 decibel sudden sensorineural hearing loss in at least 3 contiguous frequencies for whom no cause could be found.</td>
<td>Prospective double-blind trial, combining the results from two centres</td>
<td>Recovery of 50% of the original hearing loss</td>
<td>20/33 (61%) in steroid group and 11/34 (32%) in placebo group: significant 0.01&lt;p&lt;0.025</td>
<td>Not randomised</td>
</tr>
<tr>
<td>Moskowitz D et al, 1984, USA</td>
<td>Patients attending a private ENT clinic over a 10 year period with idiopathic sensorineural hearing loss (n = 56)</td>
<td>Prospective cohort</td>
<td>Recovery of 50% of the original hearing loss</td>
<td>24/27 (89%) with steroids and 4/9 (44%) without: statistically significant 0.005&lt;p</td>
<td>Poor design Not analysed with intention to treat Short follow up Different steroids used Not randomised</td>
</tr>
<tr>
<td>Cinamon U et al, 2001, Israel</td>
<td>41 patients with unilateral sensorineural hearing loss Randomised to prednisolone placebo tablets, carbogen inhalation or room air</td>
<td>Prospective randomised controlled trial</td>
<td>Early audiometric outcome</td>
<td>No difference</td>
<td>No power study</td>
</tr>
<tr>
<td>Kitajiri S et al, 2002, Japan</td>
<td>78 patients with sudden sensorineural hearing loss Normal treatment v normal treatment plus steroids</td>
<td>Controlled trial</td>
<td>Recovery rate</td>
<td>81% v 79%</td>
<td>Non-blinded Small numbers Non-randomised before and after design</td>
</tr>
<tr>
<td>Chen CY et al, 2003, Taiwan</td>
<td>318 patients presenting with sudden unilateral sensorineural hearing loss over 10 years Steroid treatment v none (patients who refused)</td>
<td>Observational study</td>
<td>Recovery of hearing (pure tone average) in severe cases</td>
<td>Better in those on steroids</td>
<td>Non-randomised study describing outcomes in a centre committed to steroid treatment</td>
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<td></td>
<td>Recovery of hearing (pure tone average) in milder cases</td>
<td>No difference</td>
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</table>

Comments
Idiopathic sudden sensorineural hearing loss has a high (50–70%) spontaneous partial or complete recovery rate; therefore, for a given treatment to be considered effective, a very high success rate must be demonstrated. The studies shown are all small and offer no convincing evidence of recovery rates above those expected.

► CLINICAL BOTTOM LINE
Current evidence does not support the early use of high dose steroids in idiopathic sensorineural hearing loss.