Abstract

A short cut review was carried out to establish whether incision and drainage or antibiotics was best for acute paronychia. No relevant papers were found using the reported search. There is currently no evidence that oral antibiotics are any better or worse than incision and drainage for acute paronychiae.

Three part question

In [a patient with an acute paronychial nail infection] is [incision and drainage superior to oral antibiotics] in [setting infection]?

Clinical scenario

A healthy 22 year old lady attends the emergency department complaining of a painful, red finger, which she says has come on over a couple of days. Examination reveals erythema to the side of her fingernail with a suggestion of a slight yellow centre. You diagnose an acute paronychia, but wonder whether to prescribe her a course of oral antibiotics or formally incise and drain the suspected collection.

Search strategy


Search outcome


Relevant paper(s)

There were no relevant papers.

Comment(s)

It seems to be generally accepted practice in emergency medicine that any paronychial infection with an apparent area of pus requires incision and drainage, which is painful for the patient and time consuming for the clinician. In contrast, we regularly see patients who have failed treatment with antibiotics prescribed by other departments or primary care. There is currently no evidence that surgical management confers any advantage over oral antibiotics for the treatment of paronychiae. A well-designed comparative trial may help to elucidate whether the traditional surgical
approach actually leads to superior outcome. Currently our practice is to incise and drain if pus is present.

**CLINICAL BOTTOM LINE**

There is currently no evidence that oral antibiotics are any better or worse than incision and drainage for acute paronychiae.

No evidence found that a femoral nerve block in cases of femoral shaft fractures can delay the diagnosis of compartment syndrome of the thigh

**Report by George Karagiannis, Medical student**

**Checked by Richard Hardern, Consultant**

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**Abstract**

A short cut review was carried out to establish whether a femoral nerve block may mask the signs and symptoms of thigh compartment syndrome. No relevant papers were found using the reported search. There is no evidence to associate a femoral nerve block with a delayed or missed diagnosis of compartment syndrome.

**Three part question**

In [adults with suspected femoral shaft fracture] is there an association between [pain relief with femoral nerve block] and [delayed or missed diagnosis of compartment syndrome]? 

**Clinical scenario**

A 30 year old man is brought into accident and emergency who has sustained multiple fractures following a road traffic accident. The orthopaedic registrar complains that a femoral block could potentially mask the symptoms of a compartment syndrome. You are wondering if there is any evidence to support this.

**Search strategy**

Medline(R) 1966 to July 2005 using the OVID interface: [{(exp Nerve Block/or exp Anesthesia, Local/or exp Anesthetics, Local/or exp BUPIVACAINE/or exp LIDOCAINE/or exp PRILOCAINE/or (nerves and block$).mp. or (an?esthes$ and local).mp. or (an?esthes$ and block$).mp. or BUPIVACAIN$.mp. or (LIDOCAIN$. or LIGNOCAIN$).mp. or PRILOCAINS.mp. or (regional and an?esthes$).mp. or (regional and block$).mp. or (regional and analgesia).mp. or (local and analgesia).mp.) AND (exp Femoral Fractures/or (exp thigh/and exp fracture/) or (fem$ and fracture$).mp. or (thigh and fracture$).mp.) AND (exp Compartment Syndrome/or (compartment$ and syndrome$).mp. or (volkmann$ and contracture$).mp.)}] LIMIT to human AND English. All EBM Reviews (Cochrane DSR, ACP Journal Club, DARE, and CCTR) using the OVID interface: [{((nerve$ and block$) or (an?esthesia and local) or (an?esthesia and block$) or BUPIVACAIN$. or (LIDOCAIN$. or LIGNOCAIN$). or PRILOCAINS or (regional and an?esthesia) or (regional and block$) or (regional and analgesia) or (local and analgesia)).mp.) AND (((fem$ and fracture$) or (thigh and fracture$)).mp.) AND (((compartment$ and syndrome$) or (volkmann$ and contracture$)).mp.)}] LIMIT to human AND English.

**Search outcome**

Altogether three papers were found in Medline, six in Embase and one in all EBM, of which none were relevant.

**Relevant paper(s)**

No relevant papers were found.

**Comment(s)**

No reliable evidence or any official guidance has been found to contraindicate the administration of a femoral block. In theory, pain disproportionate to the injury is thought to be the most important indicator of acute compartment syndrome in awake patients. However the diagnostic value of this sign is doubtful since the fracture as such can cause intolerable pain. Strong analgesia at this point will allow for a relatively painless application of a splint which in turn will provide adequate immobilisation of the limb. With the splint in place it is easier and less painful to transfer and position the patient in the x ray department. Plus it is thought to reduce haematoma formation.

**CLINICAL BOTTOM LINE**

There is no evidence of an association between a femoral nerve block with a delayed or missed diagnosis of compartment syndrome.

**Acknowledgement**

The authors would like to thank Mr Chris Phillips, Consultant, for his guidance in preparing this BET.


**How to immobilise after shoulder dislocation?**

**Report by Lennard Funk, Consultant**

**Checked by Martin Smith, Consultant**

doi: 10.1136/emj.2005.030197

**Abstract**

A short cut review was carried out to establish the best way to immobilise dislocated shoulders after reduction. A total of 47 papers were identified using the reported search, of which four represent 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. For patients with a first anterior shoulder dislocation immobilisation in external rotation may be of more benefit than immobilisation in internal rotation.

Three part question

[In patients with primary anterior shoulder dislocation] is [immobilisation in internal or external rotation] better at [reducing redislocation rates]?

Clinical scenario

A 25 year old man presents to the emergency department with a first left anterior shoulder dislocation. This is reduced satisfactorily under sedation. You decide to put the patient in a collar and cuff in internal rotation (as you have always done). However, your emergency department physiotherapist suggests that it should be placed in external rotation. You wonder why?

Search strategy

Medline 1966 to June 2005 using the OVID interface; Embase 1996 to week 31, 2005: [shoulder dislocation.mp. or exp Shoulder Dislocation/] and [exp Immobilization/or immobilisation.mp. or exp Casts, Surgical/] and [external.af.]. Cochrane 2005, Issue 3: “shoulder dislocation external”.

Search outcome

Medline: 15 papers found of which four were relevant (table 1). Embase: nine papers found, no new references found. Cochrane: 23 citations, no new references found.

Comment(s)

Standard teaching has been to immobilise patients with anterior shoulder dislocations in internal rotation, typically using a collar and cuff system. These interesting studies question this perceived wisdom and suggest that external rotation may be a better position. There is only one clinical study here that suggests good results, though the follow up for the clinical study was short and the position of external rotation immobilisation may not achieve such good compliance in clinical practice.

CLINICAL BOTTOM LINE

For patients with a first anterior shoulder dislocation immobilisation in external rotation may be of more benefit than immobilisation in internal rotation.


Cricoid pressure in emergency rapid sequence induction

Report by John Butler, Consultant

Checked by Ayan Sen, Clinical Fellow
doi: 10.1136/emj.2005.030205

A short cut review was carried out to establish cricoid pressure reduced aspiration during rapid sequence induction (RSI) of anaesthesia. A total of 241 papers were identified using the reported search, of which three represented 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. There is little evidence to support the widely held belief that the application of cricoid pressure reduces the incidence of aspiration during a rapid sequence intubation.

Table 1

<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>
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</thead>
<tbody>
<tr>
<td>Itoi E et al, 1999, Japan</td>
<td>Cadaveric study. Ten thawed fresh-frozen cadaveric shoulders with all of the muscles removed. A simulated Bankart lesion was created. Linear transducers attached to the anteroinferior and inferior portions of the Bankart lesion, the opening and closing of the lesion were recorded with the arm in 0, 30, 45, and 60 degrees of elevation in the coronal and sagittal planes as well as with the arm in rotation from full internal to full external rotation in 10 degree increments</td>
<td>Laboratory trial</td>
<td>Position of Bankart lesion to glenoid</td>
<td>The best coapted positions were: (1) adduction plus full internal rotation to 30 degrees of external rotation; and (2) 30 degrees of flexion or abduction, neutral, and internal rotation</td>
<td>Cadaveric. Theoretical rather than actual clinical outcome</td>
</tr>
<tr>
<td>Itoi E et al, 2001, Japan</td>
<td>19 patients with shoulder dislocations. Magnetic resonance imaging, with the arm held at the side of the trunk and positioned first in internal rotation (mean, 29 degrees) and then in external rotation (mean, 35 degrees), in 19 shoulders</td>
<td>Prospective study</td>
<td>Position of Bankart lesion to glenoid</td>
<td>Separation and displacement of the labrum were both significantly less (p = 0.0047 and p = 0.0017, respectively) when the arm was in external rotation than when it was in internal rotation</td>
<td>13 shoulders were recurrent dislocations and 6 acute, thus not same</td>
</tr>
<tr>
<td>Itoi E et al, 2003, Japan</td>
<td>40 patients with initial shoulder dislocations. Randomised into internal rotation (IR) immobilisation and external rotation (ER) immobilisation</td>
<td>Prospective, randomised study</td>
<td>Recurrent dislocation rate</td>
<td>The recurrence rate was 30% in the ER group and 0% in the IR group at a mean 15.5 months</td>
<td>Early results. Immobilisation position may achieve less compliance in clinical practice</td>
</tr>
<tr>
<td>Miller BS et al, 2005, Australia</td>
<td>10 cadaveric shoulder girdles stripped of major muscles (but rotator cuff intact) and a surgical Bankart lesion fashioned. Contact force was measured between glenoid and humerus in a variety of positions</td>
<td>Laboratory trial</td>
<td>Contact forces in different positions</td>
<td>No contact force in internal rotation. Maximum contact force when arm at 45 degrees of external rotation</td>
<td>Cadaveric. Does not take account of other damage that may occur following a dislocation. Theoretical rather than clinical outcome</td>
</tr>
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Three part question
In [patients undergoing emergency RSI] does [cricoid pressure] reduce the [incidence of aspiration of gastric contents/ morbidity/mortality]?

Clinical scenario
You are about to perform an RSI in a 26 year old man with a severe head injury. You have been told that the gentleman has consumed a significant amount of alcohol in the last three hours. The nurse asks you whether application of cricoid pressure will stop him aspirating.

Search strategy
Medline 1950 to July 2005 via OVID; Embase 1988 to July 2005 via OVID: [(Sellick’s manoeuvre.mp) OR (Cricoid pressure.mp) OR/cricoid pressure] LIMIT to HUMAN and ENGLISH and ABSTRACTS. Cochrane Database of Systematic Reviews 2005.

Search outcome
Medline: 241 papers in total of which 3 papers were relevant to the question (table 2). Embase: 119 citations, no new references found. Cochrane: No new papers found.

Comment(s)
Cricoid pressure has been described as the “linchpin of rapid sequence induction” and has become widely accepted as the standard of practice during anaesthesia in the UK and USA. However, it is not widely used in some continental countries. Although it is a simple manoeuvre there have been concerns about its safety and efficacy. Opinion on its use varies widely from those who believe it should remain the standard of care to those who urge for re-evaluation of the technique. Concern has been expressed that cricoid pressure may interfere with airway management, obscuring the laryngeal view and creating difficulties in passing the endotracheal tube. This may lead to a failure of airway techniques and subsequent morbidity and mortality. The evidence presented in this review suggests that none of the papers confirm the perceived clinical benefit of cricoid pressure in reducing the incidence of aspiration during an emergency RSI.

It will be interesting to see whether a technique that is now so widely engrained in anaesthetic practice will ever be submitted to a more rigorous evaluation.

► CLINICAL BOTTOM LINE
There is little evidence to support the widely held belief that the application of cricoid pressure reduces the incidence of aspiration during a rapid sequence intubation.


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<th>Table 2</th>
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<tr>
<td><strong>Author, date, and country</strong></td>
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<tr>
<td>Sellick BA, 1961, UK</td>
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<td>Briscoe JR and Berry AM, 1997, Canada</td>
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<tr>
<td>Airway patency</td>
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<td>Upper oesophageal sphincter pressure</td>
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<td>Gastric insufflation with BVM</td>
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<td>Airway/soft tissue injury</td>
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<td>Smith KJ et al, 2003, Canada</td>
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