Towards evidence based emergency medicine: best BETs from the Manchester Royal Infirmary

Edited by S D Carley

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 practicing 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 Infirmary1 or placed on the BestBETs website. Each BET has been constructed in the four stages that have been described elsewhere.2 The BETs shown here together with those published previously and those currently under construction can be seen at http://www.bestbets.org.3 Four BETs are included in this issue of the journal. Details on how to do a BET are available online at http://www.bestbets.org/home/participation.html.

Do non-steroidal anti-inflammatory drugs cause a delay in fracture healing?

Report by Simon Clarke, Consultant
Checked by Fiona Lecky, Consultant
doi: 10.1136/emj.2005.028647

Abstract
A short cut review was carried out to establish whether there is any evidence that non-steroidal anti-inflammatory drugs (NSAIDs) might delay fracture healing. A total of 514 papers were found using the reported search, of which three 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. At present, although there are theoretical concerns about the adverse effects of NSAIDs on fracture healing, there is not enough clinical evidence to deny patients with simple fractures their analgesic benefits.

Clinical scenario
A 21 year old man attends the emergency department having sustained an undisplaced, closed fracture of his distal radius. You wonder whether giving the patient a course of NSAIDs will delay fracture healing.

Three part question
In [patients with simple fractures] do [NSAIDs compared with conventional analgesia] delay [fracture healing]?

Search strategy
Medline 1966–04/05 using the OVID interface. [(exp fractures OR fracture$.mp OR fracture healing.mp) AND (exp anti-inflammation$.mp OR non-steroidal$ OR nsaid$.mp OR anti-inflammatory$.mp OR anti-inflammatory$.mp) LIMIT to human. References of papers and suitable review articles were scrutinised for further possible articles.

Search outcome
A total of 514 papers were found of which three were relevant to the three part question. No further articles were discovered by the reference review.

Comment(s)
Inflammatory processes are integral to the early stages of fracture healing and there is theoretical concern that this may be inhibited by NSAIDs leading to delayed or even non-union. This worry seems to have been backed up by animal experimentation (primarily on rats); the two small randomised controlled trials did not give any clear evidence to suggest that this is translated into significant clinically adverse effects in humans. The case control study has raised a concern about the relation of NSAIDs to non-union that needs further evaluation. NSAIDs are effective analgesics for musculoskeletal trauma, so until more solid evidence becomes available, their use should not be discouraged.

CLINICAL BOTTOM LINE
At present, although there are theoretical concerns about the adverse effects of NSAIDs on fracture healing, there is not enough clinical evidence to deny patients with simple fractures their analgesic benefits.


Rectal or intravenous non-steroidal anti-inflammatory drugs in acute renal colic

Report by Caroline Lee, Specialist Registrar
Checked by Dhurga Gnanasegaram and Margaret Maloba, Specialist Registrars
doi: 10.1136/emj.2005.028654

Abstract

A short cut review was carried out to establish whether rectal non-steroidal anti-inflammatory drugs (NSAIDs) are as effective as IV NSAIDs in the management of acute renal colic. Altogether 179 papers were found using the reported search, of which two 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. Rectal NSAIDs are an effective form of analgesia for patients with acute renal colic and have fewer side effects compared with intravenous NSAIDs.

Three part question

In [patients with a clinical diagnosis of renal colic] is [PR NSAIDs better than IM NSAIDs] at [reducing pain (length and speed of analgesia)]?

Clinical scenario

A 21 year old male presents to the emergency department with sudden onset of left lumbar pain radiating to the groin. A clinical diagnosis of renal colic is made. You wonder whether rectal NSAIDs would be more effective than IV or IM NSAIDs?

Search strategy


Search outcome

A total of 179 papers were found of which two were relevant to the question. No additionally relevant citations were found in The Cochrane Library.

<table>
<thead>
<tr>
<th>Table 1</th>
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<tbody>
<tr>
<td>Author, date, and country</td>
<td>Patient group</td>
<td>Study type</td>
<td>Outcomes</td>
</tr>
<tr>
<td>Davis, 1988, UK</td>
<td>100 patients &gt;40 years with a first Colles’ fracture given别名</td>
<td>RCT</td>
<td>Functional recovery</td>
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<tr>
<td>Adolphson, 1993, Sweden</td>
<td>42 post menopausal women with first Colles’ fracture given piroxicam 20 mg once daily or placebo for 8/52</td>
<td>RCT</td>
<td>Radiological and functional recovery</td>
</tr>
<tr>
<td>Giannoudis, 2000, UK</td>
<td>99 patients who had undergone intramedullary nailing of femoral shaft fractures over a 6 year period. 32 patients had suffered from a non-union while 67 had successful bone healing</td>
<td>Case control study</td>
<td>The patients were telephoned with a questionnaire about a number of factors which included NSAID use. Their notes were scrutinised for the type of operative procedure and device used (which was the primary variable under investigation).</td>
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<th>Table 2</th>
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<tr>
<td>Author, date, and country</td>
<td>Patient group</td>
<td>Study type</td>
<td>Outcomes</td>
</tr>
<tr>
<td>Nelson CE et al, 1988, Sweden</td>
<td>84 patients from two emergency departments with a preliminary diagnosis of acute renal colic who later had diagnosis confirmed by IVU or urine sediment. Patients received one rectal and one IV injection Randomised to receive 100 mg indomethacin PR plus placebo IV injection (riboflavin coloured saline) in 37 patients OR placebo PR plus 50 mg indomethacin intramuscularly in 47 patients</td>
<td>Double blind RCT</td>
<td>Pain severity score (visual analogue scale 0–100) at 0, 10, 20, and 30 minutes after treatment Side effects Need for supplementary analgesia</td>
</tr>
<tr>
<td>Nissen I et al 1990, Denmark</td>
<td>116 patients from 10 departments of surgery/urology with clinical symptoms of ureteric colic who were later proven to have a stone on IVU or an passage of stones. Randomised to receive 100 mg indomethacin PR or 50 mg indomethacin IV</td>
<td>Double blind RCT</td>
<td>Intensity of pain (visual analogue score 0–100) at 0, 10, 20, and 30 minutes after treatment Adverse events at time of treatment Need for supplementary analgesia</td>
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</table>
Comment(s)
There are many studies in the literature which compare intravenous with intramuscular NSAID use in acute renal colic. Unfortunately no studies were found comparing intramuscular NSAIDs with rectal NSAIDs, which are commonly used in our emergency departments. Rectal NSAIDs have advantages in busy departments by providing urgent analgesia when there are delays in staff available to cannulate the patient and the patient is vomiting.

> CLINICAL BOTTOM LINE
Rectal NSAIDs are an effective form of analgesia for patients with acute renal colic and have fewer side effects compared with intravenous NSAIDs.


Are antibiotics indicated following human bites?

Report by Dr Alma-Victoria Rittner and Dr Kevin Fitzpatrick, Senior House Officers
Checked by Dr Alasdair Corfield, Registrar
doi: 10.1136/emj.2005.028662

Abstract
A short cut review was carried out to establish whether antibiotics are indicated for human bites. Eighty nine papers were found using the reported search, of which two 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. Prophylactic antibiotics should be given to all patients with human bites to the hands, feet, and skin overlying joints or cartilaginous structures. It may be that antibiotic treatment of the low risk bites described is unnecessary. Until further studies show no reduction in infection rates for human bites, antibiotics should be given to all patients except those presenting with superficial bites outwith the areas described above. No prospective randomised controlled trials have investigated which particular antibiotics should be prescribed, and therefore antibiotic choice should follow local guidelines until studies have shown a particular antibiotic to be the most effective.

> CLINICAL BOTTOM LINE
Prophylactic antibiotics should be given to all patients with human bites to the hands, feet, and skin overlying joints or cartilaginous structures, and to all patients with bites that penetrate deeper than the epidermal layer.


Nebulised furosemide in acute adult asthma

Report by Zui-Shen Yen, Emergency Physician
Checked by Shyr-Chyr Chen, Emergency Physician
doi: 10.1136/emj.2005.028670

Abstract
A short cut review was carried out to establish whether the addition of nebulised furosemide to beta-agonist therapy improves outcomes in acute asthma. Altogether 87 papers were defined as those bites that penetrated only the epidermis and did not involve the hands, feet, or skin overlying joints or cartilaginous structures. It may be that antibiotic treatment of the low risk bites described is unnecessary. Until further studies show no reduction in infection rates for human bites, antibiotics should be given to all patients except those presenting with superficial bites outwith the areas described above. No prospective randomised controlled trials have investigated which particular antibiotics should be prescribed, and therefore antibiotic choice should follow local guidelines until studies have shown a particular antibiotic to be the most effective.

> CLINICAL BOTTOM LINE
Prophylactic antibiotics should be given to all patients with human bites to the hands, feet, and skin overlying joints or cartilaginous structures, and to all patients with bites that penetrate deeper than the epidermal layer.

were found using the reported search, of which two presented the best evidence to answer the clinical question. A further relevant paper was found on scanning the references of these papers. The author, date and country of origin, patient group studied, study type, relevant outcome, results, and study weaknesses of the best papers are tabulated. There is currently insufficient evidence to support the routine addition of nebulised furosemide to standard beta agonist therapy in acute asthma in adults

**Three part question**

In [an adult with asthma] is [nebulised beta agonist with nebulised furosemide better than nebulised beta agonist alone] at [improving airflow and reducing morbidity]?

**Clinical scenario**

A known asthmatic adult patient is brought into the emergency department with signs consistent with acute asthma. Little improvement is noted with nebulised beta agonist therapy. You wonder if adjunctive nebulised furosemide would provide any benefit.

**Search strategy**

Medline 1966–12/04 and Embase: Drugs & Pharmacology 1980–01/03 using the OVID interface, The Cochrane Library, Issue 2, 2005. Medline: [(exp furosemide OR furosemi$$.mp OR lasix$$.mp) AND (nebuli$$.mp OR vapor$$.mp OR inhal$$.mp OR aerosol$$.mp) AND (exp asthma OR exp asthma, exercise-induced OR asthma$$.mp OR exp bronchial spasm OR bronchial spasmi$$$.mp OR bronchospasm$$.mp)] LIMIT to human AND English language. Embase: [(exp furosemide OR furosemi$$.mp OR lasix$$.mp) AND (nebuli$$.mp OR vapor$$.mp OR inhal$$.mp OR aerosol$$.mp) AND (exp asthma OR exp exercised induced asthma OR exp allergic asthma OR exp occupational asthma OR exp bronchospasm OR bronchial spasmi$$$.mp OR bronchospasm$$.mp)] LIMIT to human AND English language. Cochrane Library: “furosemide”.

**Search outcome**

Altogether 87 papers from Medline and 156 from Embase were found of which two were considered to be original research of high quality (randomised controlled trials) and relevant to the topic of interest. A further reference was found after scanning of paper references. These three papers are summarised in table 1. Thirty four papers were found in the Cochrane Library, none of which were relevant to the three part question.

**Comment(s)**

A number of mechanisms have been postulated to explain the bronchodilating effect of nebulised furosemide, including: (1) induction of relaxant prostaglandins; (2) blockade of mediator production from inflammatory cells; (3) regulation of ion exchange in the airway epithelium. Of the few randomised controlled studies that relate to the efficacy of nebulised furosemide in the treatment of acute adult asthma, samples remain small and conflicting results persist. More large scale studies are needed to determine whether nebulised furosemide has any therapeutic benefit in acute adult asthma.

**CLINICAL BOTTOM LINE**

There is currently insufficient evidence to support the routine addition of nebulised furosemide to standard beta agonist therapy in acute asthma in adults.

<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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<tbody>
<tr>
<td>Nannini LJ, et al 1992, Canada</td>
<td>20 patients with acute asthma randomised to inhaled salbutamol/furosemide (age 31 [SD 11]) or inhaled salbutamol/noral saline (age 41 [SD 12])</td>
<td>PRCT</td>
<td>PEFR (percentage increase)</td>
<td>Salbutamol/furosemide 83 (SD 61) % v salbutamol/noral saline 35 (SD 24) % at 30 minutes, p = 0.05</td>
<td>Small sample Unclear randomisation and blinding procedure Unknown exclusion and inclusion criteria Poor comparability of baseline data between two groups</td>
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<td>Karpel JP, et al. 1994, USA</td>
<td>24 patients [age 18–45] with acute asthma randomised to nebulised furosemide or nebulised metaproterenol or nebulised metaproterenol/furosemide</td>
<td>PRCT</td>
<td>FEV1</td>
<td>No statistical difference between the metaproterenol group and the metaproterenol/furosemide group</td>
<td>Small sample Unclear randomisation and blinding procedure Past hoc analysis of patients with short duration of exacerbations</td>
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<tr>
<td>Pendino JC, et al. 1998, Canada</td>
<td>42 patients [age 18–45] with acute asthma randomised to nebulised salbutamol/furosemide or salbutamol/noral saline</td>
<td>PRCT</td>
<td>PEFR (percentage increase) in all patients PEFR (percentage increase) in patients with short duration of exacerbations (&lt;8 hours)</td>
<td>No significant difference in PEFR between both groups at 15 minutes and 30 minutes. Salbutamol/furosemide 82 (SD 48) % and 113 (SD 49) % v salbutamol/noral saline 35 (SD 40) % and 61 (SD 35) %, at 15 minutes (p = 0.03) and 30 minutes (p = 0.014) respectively</td>
<td>Small sample Unclear randomisation and blinding procedure Past hoc analysis of patients with short duration of exacerbations</td>
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