

TABLE OF CONTENTS

Annals of Emergency Medicine

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12A GLOBAL RESEARCH HIGHLIGHTS

NEUROLOGY

FREE **CME**  **105 Fast Protocol for Treating Acute Ischemic Stroke by Emergency Physicians**

(Original Research)

I Heikkilä, H Kuusisto, M Holmberg, A Palomäki

What question this study addressed: What was the effect of a reorganization of the acute stroke process to focus on emergency physicians guiding acute stroke care? *What this study adds to our knowledge:* Stroke patients were treated faster after the reorganization. Although complications were similar before and after the change, the study was not powered to confirm their equivalency.

 **113 Fast Protocol for Treating Acute Ischemic Stroke by Emergency Physicians: What Took So Long?** (Editorial)

EC Jauch, CA Holmstedt

 **118 Treatment Delays for Patients With Acute Ischemic Stroke in an Iranian Emergency Department: A Retrospective Chart Review** (Original Research)

H Hassankhani, A Soheili, SS Vahdati, FA Mozaffari, JF Fraser, N Gilani

What question this study addressed: In an Iranian hospital with an acute stroke team, what are the barriers to acute stroke treatment? *What this study adds to our knowledge:* Only 5.3% of 394 acute ischemic stroke patients received thrombolytic drugs. Most patients (72%) present outside the window for receiving intravenous thrombolysis. When a stroke code was activated, median treatment intervals (69 minutes) only slightly exceeded recommended guidelines.

130 Subarachnoid Mirage: A Case of Pseudosubarachnoid Hemorrhage (Case Report)

MA Camacho, J Druck, M Musi

PAIN MANAGEMENT AND SEDATION

FREE  **133 Randomized Controlled Trial of Intravenous Acetaminophen Versus Intravenous Hydromorphone for the Treatment of Acute Pain in the Emergency Department** (Original Research)

DP Barnaby, AE Chertoff, AJ Restivo, CM Campbell, S Pearlman, D White, PE Bijur, EJ Gallagher

What question this study addressed: How does intravenous acetaminophen at 1 g compare with intravenous hydromorphone at 1 mg for treating acute pain? *What this study adds to our knowledge:* In this randomized, double-blind trial of 220 emergency department adults, hydromorphone resulted in a significantly greater and clinically important reduction in pain scores relative to acetaminophen.

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- 📄 **141 A Randomized Trial of a Long-Acting Depot Corticosteroid Versus Dexamethasone to Prevent Headache Recurrence Among Patients With Acute Migraine Who Are Discharged From an Emergency Department** (Original Research)
A Latev, BW Friedman, E Irizarry, C Solorzano, A Restivo, A Chertoff, E Zias, EJ Gallagher
What question this study addressed: The authors investigated the effectiveness of a longer-acting steroid in decreasing the number of days with headache during the week after emergency department (ED) discharge. *What this study adds to our knowledge:* In this 207-patient randomized trial of intramuscular metoclopramide plus either dexamethasone or methylprednisolone acetate, there was little difference in days with headache during the first week after ED discharge.
- 📄 **150 Intravenous Fluid for the Treatment of Emergency Department Patients With Migraine Headache: A Randomized Controlled Trial** (Original Research)
CW Jones, LB Remboski, B Freeze, VA Braz, JP Gaughan, SA McLean
What question this study addressed: Is a blinded, randomized controlled trial of intravenous fluids for emergency department migraine treatment feasible? *What this study adds to our knowledge:* Blinding, enrollment, and intervention delivery were feasible. The reduction in pain from intravenous fluids in this 49-patient study was likely to be smaller than the minimally clinically significant difference established in previous drug trials.
- 📄 **157 Are Topical Nonsteroidal Anti-Inflammatory Drugs Useful for Analgesia in Patients With Traumatic Corneal Abrasions?** (Systematic Review Snapshot)
JR West

GENERAL MEDICINE

- 📄 **160 Normal Saline Solution and Lactated Ringer's Solution Have a Similar Effect on Quality of Recovery: A Randomized Controlled Trial** (Original Research)
A Friederich, N Martin, MB Swanson, BA Faine, NM Mohr
What question this study addressed: In similar emergency department (ED) patients randomized to normal saline solution or lactated Ringer's solution, are there differences in patient-reported symptoms and other measures of recovery 24 hours after ED discharge? *What this study adds to our knowledge:* Follow-up in 94 patients treated with either fluid found no differences in Quality of Recovery–40 score or (for 78 patients) measures of further health care use.
- 📄 **170 Is Normal Saline Solution an Acceptable Choice of Fluid for Stable Patients?** (Editorial)
DT Huang, R Murugan
- 📄 **172 Expanding Health Information Exchange Improves Identification of Frequent Emergency Department Users** (Original Research)
X Han, TY Lowry, GT Loo, EJ Rabin, ZM Grinspan, LM Kern, GJ Kuperman, JS Shapiro
What question this study addressed: The authors compared the identification rate of frequent emergency department (ED) users when the health information exchange increased from 10 to 31 participating hospitals in a high-density metropolitan area. *What this study adds to our knowledge:* Tripling the number of hospitals participating in the health information exchange resulted in an approximately 8% absolute increase in the identification rate of frequent ED users.
- 📄 **180 Is the Liberal Use of Oxygen Associated With Worse Outcomes Among Critically Ill Patients?** (Systematic Review Snapshot)
M Gottlieb, C Goldstein, EJ Ward

INJURY PREVENTION

183 Physical Restraint Use in Adult Patients Presenting to a General Emergency Department

(Original Research)

AH Wong, RA Taylor, JM Ray, SL Bernstein

What question this study addressed: The authors quantified the use of restraints in a large regional health system, identifying specific patient populations for whom they were most used. *What this study adds to our knowledge:* Most but not all restraints were used for psychiatric patients. Younger patients had an alcohol or drug history, whereas older patients were more likely to have an underlying medical cause for agitation.

193 Trauma-Informed Care for Violently Injured Patients in the Emergency Department

(Review Article)

KR Fischer, KM Bakes, TJ Corbin, JA Fein, EJ Harris, TL James, MD Melzer-Lange

Violent traumatic injury remains a common condition treated by emergency physicians. The medical management of these patients is well described and remains an area of focus for providers. However, violently injured patients disproportionately carry a history of physical and psychological trauma that frequently affects clinical care in the emergency department. The alteration of our clinical approach, taking into consideration how a patient's previous experiences influence how he or she may perceive and react to medical care, is a concept referred to as *trauma-informed care*. We provide practical considerations for emergency physicians in the delivery of trauma-informed care for violently injured patients.

IMAGES IN EMERGENCY MEDICINE



116 Man With Abdominal Pain

D Barbic, J Boyd, FX Scheuermeyer

117 Man With Accidentally Swallowed Dental C+ File

J Zhou, Y Yu, K Li

203 Woman With Hip Pain

EL Calder, AT Smith

e9 Man With Persistent Rash

R Ibrahim, G Armoni, V Molho-Pessach, Y Ramot

e11 Young Girl With Torticollis

R Klinger, G Altberg, J Greenstein, J Hwang, S Serras, B Hahn

e13 Young Woman With Unilateral Vision Loss

HI Kuttab, M Chottiner, A Movahedan, NM Hafez, J Purakal

CHANGE OF SHIFT

204 My Job: A Courtroom Victim Impact Statement

AD Costigan

ANNALS OF EMERGENCY MEDICINE JOURNAL CLUB



206 Epinephrine in Out-of-Hospital Cardiac Arrest: Saving Lives or Prolonging Death?

R Spiegel, R Radecki

CORRESPONDENCE

208 Aromatherapy Versus Oral Ondansetron for Antiemetic Therapy Among Adult Emergency Department Patients: A Randomized Controlled Trial

SB Freedman, S Ali, Y Finkelstein/MD April, JJ Oliver, WT Davis, D Ong, EM Simon, PC Ng, CJ Hunter

210 Emergency Physicians and Firearms: Effects of Hands-on Training

ME Betz, VS Bebarata, W DeWispelaere, W Barrett, M Victoroff, K Williamson, D Abbott

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Most readers highly value the fact that articles in a journal like ours have undergone formal peer review. Many readers also have a relatively simple understanding of that term as describing a single well-defined process of review by expert reviewers, but it is a lot more complicated and nuanced than that. We therefore provide a very brief summary of our procedures to provide appropriate levels of review for most (but not entirely all) the journal content.

Although we try to be a model among journals for the rigor of our peer review process, like most of them (including the most prestigious) this does not mean that all content is peer reviewed in the same way. All original content (particularly research content) in the journal is peer reviewed by one of the many experts on our editorial board, but additional peer review of every submission by members of our reviewer panel is not always necessary or appropriate. Many submissions are not appropriate for the journal for one fairly obvious reason or another (eg, target audience), so like most other journals we reject many manuscripts after review by an editor. For those which are not obviously inappropriate, however, we receive far more submissions than we can publish, so our further process seeks to identify the best of the best.

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None of this means the final article is irrefutable truth; such a thing does not exist in science where our state of knowledge is (we hope) constantly evolving and no study should be judged in isolation. But it does mean that we've asked all the appropriate questions we could think of, made suggestions, and required revisions to make the paper as complete and transparent to replication as possible.

This process for original research is the most rigorous and is probably what most readers think of as "formal peer review," but the journal contains much other content of a factual and scientific nature which does not lend itself to this approach. For example, we have a number of regular journal features (like News & Perspective, CDC Update, NHTSA Notes, etc) that are updates written by selected topic experts on a routine basis. These are also reviewed by an editor but not sent out for additional review. A very few items, such as ACEP Clinical Policies, are published verbatim from the experts that develop them and are not revised (for obvious reasons); this fact is published along with each.

There are always some exceptions to the above processes as we develop new types of content or relatively unique contributions occur. We try to describe the particular variants of peer review that were used for each of these, or if there was none, that is made clear as well. Our goal is to provide as much oversight as is needed and logistically practical, and to enable readers to determine what that level of oversight was as conveniently as possible.