

TABLE OF CONTENTS

Annals of Emergency Medicine

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13A GLOBAL RESEARCH HIGHLIGHTS

PHYSICIAN WELLNESS

-   **325 Use of Pharmacologic Sleep Aids and Stimulants Among Emergency Medicine Staff Physicians in a Canadian Tertiary Care Setting: A Web-Based Survey** (Brief Research Report)
MN Francis, IM Wishart, T Williamson, R Iverach

What question this study addressed: To what extent do emergency physicians use pharmacologic sleep aids and what are their patterns of use? *What this study adds to our knowledge:* In this survey of 198 emergency physicians in the Calgary, Canada, region, 67% had used pharmacologic sleep aids and 56% were currently using them. Non-benzodiazepine hypnotics predominated.

-  **330 It's Time to Wake Up to the Use of Pharmacologic Sleep Aids by Emergency Physicians** (Editorial)
SR Votey

INFECTIOUS DISEASE

-  **334 Development and Evaluation of a Machine Learning Model for the Early Identification of Patients at Risk for Sepsis** (Original Research)

RJ Delahanty, J Alvarez, LM Flynn, RL Sherwin, SS Jones

What question this study addressed: Whether the use of machine learning on a large population (>2 million) could develop a risk score for sepsis identification that outperformed existing screening tools. *What this study adds to our knowledge:* The Risk of Sepsis score, which uses commonly available clinical data such as lactate level, neutrophil levels, and shock index, performed superiorly to the Sequential Organ Failure Assessment, the quick Sequential [Sepsis-related] Organ Failure Assessment, and other recommended methods across all points up to 24 hours.

-  **345 Emergency Department Crowding Is Associated With Delayed Antibiotics for Sepsis** (Original Research)

ID Peltan, JR Bledsoe, TA Oniki, J Sorensen, AR Jephson, TL Allen, MH Samore, CL Hough, SM Brown

What question this study addressed: Is increased emergency department (ED) crowding associated with delayed administration of antibiotics in sepsis? *What this study adds to our knowledge:* In this analysis of 3,572 ED sepsis patients presenting to 1 of 4 hospitals, each 10% increase in ED occupancy was associated with a 4-minute delay in antibiotic administration. ED crowding was associated with slower initial patient assessment but not other ED antibiotic time subsegments.

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- 🔗 **356 The 2018 Surviving Sepsis Campaign's Treatment Bundle: When Guidelines Outpace the Evidence Supporting Their Use** (Editorial)

R Spiegel, JD Farkas, P Rola, J-E Kenny, S Olusanya, PE Marik, SD Weingart

- 🔗 **359 Challenging the One-Hour Bundle Goal for Sepsis Antibiotics** (Editorial)

DA Talan, DM Yealy

- 🔗 **SRS** **363 Does the Severe Sepsis and Septic Shock Early Management Bundle (SEP-1) Improve Survival in Septic Adults?** (Systematic Review Snapshot)

S Sanghvi, M Podlog, RD Aycock

- 🔗 **CME** **366 Identification of Clinical Characteristics Associated With High-Level Care Among Patients With Skin and Soft Tissue Infections** (Original Research)

WR Mower, SP Kadera, AD Rodriguez, V Vanderkraan, PK Krishna, E Chiu, MJ Wilson, M Gupta, A Krishnadasan, GJ Moran, DA Talan

What question this study addressed: What are the features of emergency department patients with these infections that are associated with death, surgical intervention, or ICU care? *What this study adds to our knowledge:* In analysis of 2,923 patient records from 3 California hospitals, patients with abnormal imaging results, evidence of a systemic inflammatory response, a history of diabetes, or previous infection at the same site; those who were older than 65 years; and those who had hand involvement were at higher risk for the composite outcome.

- 🔗 **375 Stewardship of Patient Outcomes Based on Evidence not Expert Opinion**

(Clinical Controversies)

P DeBlieux

- 🔗 **377 Antibiotics Should Not Be Routinely Prescribed After Incision and Drainage of Uncomplicated Abscesses** (Clinical Controversies)

M Pulia, B Fox

- 379 Increase in Acute Flaccid Myelitis—United States, 2018** (CDC Update)

AA Rouhani, S Lai

- 380 Commentary** (CDC Update)

CARDIOLOGY

- 🔗 **382 The Canadian Community Utilization of Stroke Prevention Study in Atrial Fibrillation in the Emergency Department (C-CUSP ED)** (Original Research)

R Parkash, K Magee, M McMullen, M Clory, M D'Astous, M Robichaud, G Andolfatto, B Read, J Wang, L Thabane, C Atzema, P Dorian, J Kaczorowski, D Banner, R Nieuwlaat, N Ivers, T Huynh, J Curran, I Graham, S Connolly, J Healey

What question this study addressed: The authors measured the rate of new oral anticoagulation prescriptions by emergency physicians for eligible atrial fibrillation patients before and after exposure to educational and atrial fibrillation specialty-clinic follow-up interventions during a 24-month period in 5 emergency departments in Canada. *What this study adds to our knowledge:* New oral anticoagulation prescriptions increased from 15.8% to 54.1% after the educational tool was implemented. Additional telephone and atrial fibrillation clinic follow-ups did not improve oral anticoagulation prescribing (47.2%).

393 Survival After Cardiac Arrest With Instantaneous Rigorlike Stiffness: A Case Report

(Case Report)

Y Okada, H Narumiya, N Kobayashi, H Nishimura, H Kotani, K Koike, T Iwami, R Iiduka

397 Understanding Right Atrial Collapse: Timing Is Everything (Brief Commentary)

E Argulian, R Ramirez

SRS 400 What Signs Increase the Likelihood of Acute Aortic Dissection? (Systematic Review Snapshot)

N Chien, PE Casey, M Gottlieb

SRS 403 In Patients With Acute Myocardial Infarction and No Hypoxemia, Does Oxygen Therapy Improve Outcomes Compared With No Supplemental Oxygen? (Systematic Review Snapshot)

B Long, MD April

ECG OF THE MONTH

406 An Ominous ECG Pattern

RB Witkov, BL Cooper

409 A Single Lead of Concordant ST Deviation in Left Bundle Branch Block

BW Lin, A Mattu, W Brady, J Tabas

413 Sudden Cardiac Death in a Hyperthyroid Adult Female

KK Gudivada

IMAGES IN EMERGENCY MEDICINE

333 Man With Erythematous Rash and Muscle Weakness

F Bernardes Filho, DP Brito, RM Queiroz, DFRE Mello, MVN Valentin

415 Young Male With Epigastric Pain

DM Patel, AQ Yaffee

 **e39 Woman With Abdominal Pain**

C-W Hong, C-J Yang, S-H Tsai

 **e41 Neonate With Abdominal Distention**

AQ Lynn, MS Toce, JT Neal

 **e43 Young Male With Low Back Pain**

Y-C An, C-J Yang, K-H Chang, K-M Yeh, S-H Tsai

 **e45 Child With Unilateral Temporal Swelling**

E Conversano, C Udina, G Cozzi, SD Bo, F Marchetti, E Barbi

CHANGE OF SHIFT

416 In My Element

S Benjamin

417 Dignity and Safety

Anonymous

ANNALS OF EMERGENCY MEDICINE JOURNAL CLUB

JC **419 Stop the Clot: Should Emergency Clinicians Champion Stroke Prevention and Prescribe Anticoagulation for Patients With Atrial Fibrillation?**

CL Freeman, TW Barrett

CORRESPONDENCE

422 Intramuscular Midazolam, Olanzapine, Ziprasidone, or Haloperidol for Treating Acute Agitation

S Zeller, M Wilson, K Nordstrom/LR Klein, BE Driver, ML Martel, JR Miner, JB Cole

424 Why a Pelvic Exam is Needed to Diagnose Cervicitis and Pelvic Inflammatory Disease

K Mealey, PK Braverman, LMP Koenigs/C Tejani, A Sivitz, S Farrukh, K Patel

426 Should There Now Be a Geriatric BRUE?

A Sacchetti, C Carpenter, A Husain

READER SERVICES

18A Information for Readers

27A Calendar for Continuing Education

40A Classified Advertising Rates & Data

41A Classified Advertising

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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.

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The vast majority of scientific content that we publish is critically reviewed first by members of our editorial board with specific expertise, and then gets additional scrutiny from our expert reviewers. Our most stringent level of review is reserved for original research, which will form the basis of the scientific record in the future. These submissions are reviewed by at least two of our expert reviewers who are blinded to the identity of the authors. Quite a few papers are reviewed more than once, and sometimes in particularly complex cases 5 or 6 reviewers and editors may be involved, including deputy editors. During this process there is much consultation and discussion between editors, reviewers, and authors and recommendations are made to the authors. Sometimes that discussion exceeds the length of the original paper itself, and it certainly is a laborious and time-consuming process. Editors and reviewers must disclose potential conflicts of interest which are managed as per a rigorous policy (<http://www.annemergmed.com/content/policies-coi>). Virtually no original research is accepted with no revisions whatsoever, and our authors strongly agree that in general the process improves the quality of the final manuscript. Once it has been discussed, revised, and received the final stamp of approval from the supervising editor (whose name is always published with the manuscript for transparency), all original science content in the journal undergoes a final review by the editor in chief before acceptance.

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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.