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## PEDIATRICS

- FREE**  **429 A Cost-Effectiveness Analysis Comparing Clinical Decision Rules PECARN, CATCH, and CHALICE With Usual Care for the Management of Pediatric Head Injury** (Original Research)  
K Dalziel, JA Cheek, L Fanning, ML Borland, N Phillips, A Kochar, S Dalton, J Furyk, J Neutze, SR Dalziel, MD Lyttle, S Bressan, S Donath, C Molesworth, SJC Hearps, E Oakley, FE Babl, for the Pediatric Research in Emergency Departments International Collaborative (PREDICT)

*What question this study addressed:* Are any of these clinical decision rules more cost-effective than unstructured clinical judgment? *What this study adds to our knowledge:* In this Australian and New Zealand decision analysis model based on 18,913 injured children, the cost-effectiveness was similar between the 3 clinical decision rules and unstructured clinical judgment.

- FREE**  **440 Implementation of a Clinical Decision Support System for Children With Minor Blunt Head Trauma Who Are at Nonnegligible Risk for Traumatic Brain Injuries** (Original Research)  
DW Ballard, N Kuppermann, DR Vinson, E Tham, JM Hoffman, M Swietlik, SJ Deakne Davies, EA Alessandrini, L Tzimenatos, L Bajaj, DG Mark, SR Offerman, UK Chettipally, MD Paterno, MH Schaeffer, R Richards, TC Casper, HS Goldberg, RW Grundmeier, PS Dayan, for the Pediatric Emergency Care Applied Research Network (PECARN), Clinical Research on Emergency Services and Treatment (CREST) Network, and Partners HealthCare

*What question this study addressed:* What is the effect of providing risk estimates of clinically important traumatic brain injury and recommendations using computerized clinical decision support on computed tomography (CT) scan use for children with isolated risk factors? *What this study adds to our knowledge:* This secondary analysis of a nonrandomized clinical trial with concurrent controls showed a decrease in CT use from 24.2% to 21.6% in children with one isolated PECARN risk factor after implementation of decision support.

**SRS** designates Systematic Review Snapshot articles.

**FREE** designates free full-text access for nonsubscribers at [www.annemergmed.com](http://www.annemergmed.com).

**CME** designates that Continuing Medical Education exam for this article is available at <http://www.acep.org/ACEPeCME/>.

 indicates a podcast is available at [www.annemergmed.com](http://www.annemergmed.com).

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 designates content is only available at [www.annemergmed.com](http://www.annemergmed.com).

 indicates related video files are available at [www.annemergmed.com](http://www.annemergmed.com).



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## PAIN MANAGEMENT AND SEDATION

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- (R) 462 Premedication With Midazolam or Haloperidol to Prevent Recovery Agitation in Adults Undergoing Procedural Sedation With Ketamine: A Randomized Double-Blind Clinical Trial**  
 (Original Research)  
*N Akhlaghi, P Payandemehr, M Yaseri, AA Akhlaghi, A Abdolrazaghnejad*  
*What question this study addressed:* Does premedication with midazolam or haloperidol decrease recovery agitation after adult ketamine sedation? *What this study adds to our knowledge:* In this 3-arm randomized controlled trial of 185 subjects, prophylactic midazolam and haloperidol were associated with significantly lower recovery agitation scores and a decreased frequency of clinically important recovery agitation. Recovery times were also longer with these adjuncts (median 17 and 32 additional minutes, respectively).
- (R) 470 Clinical Practice Guideline for Emergency Department Procedural Sedation With Propofol: 2018 Update** (Concepts)  
*KA Miller, G Andolfatto, JR Miner, JH Burton, BS Krauss*  
 We update an evidence-based clinical practice guideline for the administration of propofol for emergency department procedural sedation. Both the unique considerations of using this drug in the pediatric population and the substantial new research warrant revision of the 2007 advisory. We discuss the indications, contraindications, personnel requirements, monitoring, dosing, coadministered medications, and adverse events for propofol sedation.
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## CARDIOLOGY

 **491 A Rule-Out Strategy Based on High-Sensitivity Troponin and HEART Score Reduces Hospital Admissions** (Original Research)

*L Ljung, B Lindahl, KM Eggers, M Frick, R Linder, HB Löfmark, A Martinsson, D Melki, N Sarkar, P Svensson, T Jernberg*

*What question this study addressed:* This before-after study of the Swedish Fast Assessment of Thoracic Pain in the Emergency Department Using High-Sensitive Troponins and a Simple Risk Score study assessed the actual influence of using the History, ECG, Age, Risk Factors, and Troponin score along with baseline and 1-hour high-sensitivity troponins on admission rates of 1,233 patients. *What this study adds to our knowledge:* Adherence to the protocol was high, and admission rates decreased from 59% to 33%. Adjusted odds of admission were 0.33 (95% confidence interval 0.25 to 0.42).

 **500 Prevalence of Pulmonary Embolism Among Emergency Department Patients With Syncope: A Multicenter Prospective Cohort Study** (Original Research)

*V Thiruganasambandamoorthy, MLA Sivilotti, BH Rowe, AD McRae, M Mukarram, S Malveau, AN Yagapen, BC Sun, for the North American Syncope Consortium*

*What question this study addressed:* The proportion of pulmonary embolus diagnoses in greater than 9,000 emergency department syncope patients enrolled at 17 North American sites was investigated. Both admitted and discharged patients were included and assessed at 30 days. *What this study adds to our knowledge:* Prevalence of pulmonary embolism was 0.6% (95% confidence interval 0.5% to 0.8%). Although evaluation for pulmonary embolism was performed at the discretion of the managing physician, even with a worst-case scenario analysis the prevalence was much lower than in the 2016 study.

 **511 What Is the Diagnostic Accuracy of Cardiac Biomarkers for the Prediction of Adverse Cardiac Events in Patients Presenting With Acute Syncope?** (Systematic Review Snapshot)

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*B Long, MD April*

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*LS Nelson, SM Keim, MS Beeson, CR Chudnofsky, M Gausche-Hill, DL Gorgas, DG Goyal, T Kowalenko, RL Muelleman, From the Research Committee, American Board of Emergency Medicine, KB Joldersma, MM Johnston, American Board of Emergency Medicine*

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Aromatherapy Versus Oral Ondansetron for Antiemetic Therapy Among Adult Emergency Department Patients: A Randomized Controlled Trial. *Annals of Emergency Medicine* 2018;72:184–193

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### **The Peer Review Process at *Annals of Emergency Medicine***

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.

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.

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.