an intubation would be unreliable. Intubation encounters with earlier or more complete relaxation based on paralytic agent used might translate to differences in adverse events or first-pass success. In response to the particular situation brought up by the authors, an intubation undertaken after challenging or incomplete preoxygenation would possibly result in a higher rate of desaturation and multiple attempts in patients experiencing a slower onset of acceptable intubating conditions. The fact that we observed no such differences leads us to believe that most ED clinicians are facile with these medications or the differences in onset are clinically insignificant.

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Framing and Anchoring—In Journals and in Medicine

To the Editor:

It was a pleasure to read the piece by Callaham et al[1] on how reviewer scores affect editor decisions. We know from their previous work that there is incongruity in how editors rate reviewers and how much they ultimately agree with them on article decisions.[2] In this new study, the authors attempt to objectify how much of a change in score is needed to change the ultimate decision to accept or reject an article.

As the authors mention, negativity bias seems to play a role, leading to a tighter threshold for rejection compared with acceptance. They mention the importance of how to frame a question; indeed, Tversky and Kahneman[3] performed groundbreaking work on the psychology of decisionmaking and showed with multiple elegant experiments that simply how a question is framed can significantly alter responses. With that in mind, it may not be just negativity bias playing a role but also the actual structure of the numbers themselves. For example, consider the inverse rubric in which 1 is a really strong score and 5 a really poor score (ie, going from a 4 to a 3.8 would make an editor more likely to accept and vice versa more likely to reject). It is possible that in this case, there would be a *positivity* bias; namely, it may be that the psychology of seeing the number 3 itself in almost all scenarios (3.2, 3.4, etc) plays a significant role and that the number 4 is another "threshold" just by virtue of being a different character. Indeed, when it comes to the importance of seeing a number, the aforementioned Nobel Prize–winning economists have shown that people assign very different values when they are asked to estimate a median value compared to when they are asked to estimate a 90% interval *around* a value—all due to the framing of the question and anchoring on the first number seen.[4]

We see this with medical decisionmaking as well. In our recent article, we showed that *how* a gestalt estimate of probability of pulmonary embolism is framed to the provider significantly affects the provider's response.[5] In theory, a patient who is assigned a gestalt pretest probability of greater than 40% for pulmonary embolism should usually be assigned a positive subjective Wells score (pulmonary embolism as or most likely) *and* vice versa. Yet we found that patients assigned a pretest probability of greater than 40% were significantly more likely to also have a positive subjective Wells score than those with a positive

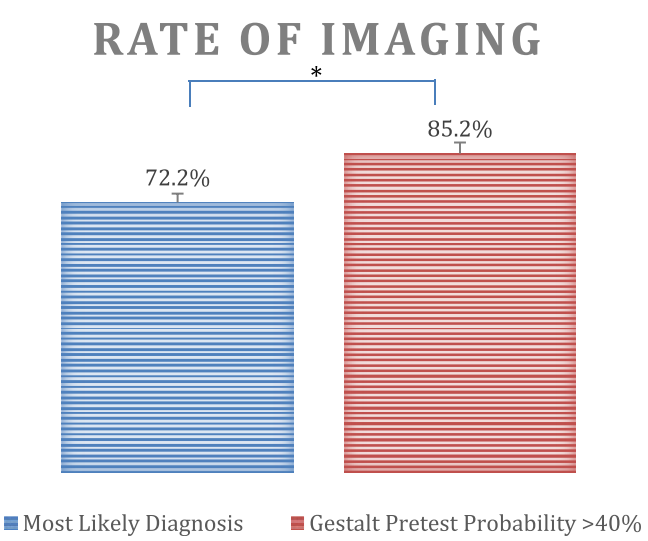

Figure. Percentage of patients with a positive subjective Wells score (ie, patients for whom pulmonary embolism was the most likely diagnosis) who underwent chest imaging compared with the percentage of patients who had gestalt pretest probability of pulmonary embolism of greater than 40% who underwent chest imaging ($P<.001$).

subjective Wells score were to also have a pretest gestalt probability of pulmonary embolism of greater than 40% ($P<.001$) or even greater than or equal to 15% ($P=.002$). This is yet more proof of how framing the question affects responses—and even medical evaluations (Figure).

In that sense, further research is needed not just for how articles are evaluated by journal editors but also for how any scoring system (Likert or otherwise) affects our everyday decisions as medical providers.

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Pneumothorax, Chest Drain, and Commercial Air Travel

To the Editor:

We report a case of a previously healthy 54-year-old patient who sustained a small traumatic hemopneumothorax (10% by the Collins formula[1]) and multiple rib fractures after a biking accident while on vacation. The patient was initially treated conservatively and then had a chest drain with Heimlich valve inserted a week later to allow him to fly home unaccompanied on a long-distance commercial flight. No complications were reported. We discuss the need for chest drain with Heimlich valve in such cases.

A pneumothorax is considered an absolute contraindication for commercial flights.[2] According to Boyle's law and a previous study of helicopter transport, a pneumothorax is expected to expand by 25% at an altitude of 8,000 ft (2.48 km) (the highest pressurization altitude on commercial flights).[3] For our patient, this implied a hypothetical expansion of the pneumothorax from 10% to 12.5%, which would likely not have been of clinical significance. For patients with traumatic pneumothorax, the International Air Transport Association recommends a waiting period of 14 days after full resolution of the pneumothorax before flying. This recommendation is based on a single publication from 1999 that reported on 12 patients who flew after traumatic pneumothorax. None of the 10 who flew after at least 14 days experienced complications.[4] Of the 2 patients who flew earlier than 14 days, only 1 experienced respiratory distress during the flight (the other one remained asymptomatic), but symptoms resolved spontaneously. Because imaging was not performed on this patient, the cause of the symptoms was not definitively established.

A retrospective series from Alaska reported on 80 patients who flew after traumatic pneumothorax was identified, of whom 75 required a chest drain.[5] The median interval between the flight and removal of the chest drain was 6 days (interquartile range 3 to 9 days), and there were no complications during the flight or after the patients' return home. Ten patients with a small residual pneumothorax flew without any complications, and 5 patients who did not require a chest drain (ie, occult pneumothorax on computed tomography scan) also had no complications during the flight.

In a prospective study of patients who had undergone transthoracic biopsy (n=183), 65 patients had a pneumothorax; 15 needed a chest drain and 50 were treated