shared decisionmaking are needed for this population because it could help reduce inappropriate use of head CT in patients with either minimal or minor head injury.[5]

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The content of the submitted letter is solely the responsibility of the authors and does not reflect the official views of any aforementioned establishments.

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In reply:

We appreciate the letter by Tran et al[1] and essentially agree with their comments. Their first concern is the use of a decision rule validated in one population of subjects but applied to a population with potentially different characteristics. Although a derivation-validation study conducted with a population with minimal head injury would have been ideal, we neither had the resources to perform such a study nor believed such an effort was necessary. Risk factors for consequential head injury have been explored in many patient populations and clinical settings already[2-4] and finding additional factors seemed unlikely. We also believe the medical community does not need another head computed tomography (CT) rule at this juncture, nor would they necessarily want to adopt one.

We agree that referral bias likely existed in our study subjects, such that our inclusion criteria selected for the more severely injured of the minimal head injury group. We doubt (though without any evidence) that there would have been a sufficient number of false-negative results to significantly affect the sensitivity of the Canadian CT Head Rule in our study. Ideally, we would have included all

patients with minimal head injury (including those who did not receive a head CT); however, our study was designed in this manner because this was not a population that we were able to screen for effectively in our emergency department. We also wanted to include physician judgment as a factor in our study design and were concerned about biasing providers toward ordering CTs (and were concerned about the unnecessary radiation exposure for patients), which may have been triggered by a study based on chief complaint rather than the clinical judgment of the provider.

Our goals for this study were 2-fold: trying to ascertain the rate of injury in this population, and identifying whether the Canadian CT Head Rule could safely obviate obtaining a CT in this group and therefore decrease CT use in what is considered to be a very low-risk group. There is a steady increase in the use of CT imaging,[5] and this study suggests that providers should have a higher threshold for ordering a head CT in this population. We regret that we did not more carefully define what shared decisionmaking meant in our study. The study form had a box for the provider to check (yes/no) if they used shared decisionmaking when determining whether a head CT would be performed. In our study, 51% of physicians reported using shared decisionmaking when ordering a head CT. We did not provide a script or suggest any language for these conversations, and the specifics of the discussion were left to the discretion of the individual provider. We suspect that greater use of shared decisionmaking could also reduce the use of imaging in this low-risk population.

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Safety of a Brief Emergency Department Observation Protocol for Patients With Presumed Fentanyl Overdose

To the Editor:

We read with interest the article by Scheuermeyer et al.[1] Although the study sought to fulfill a needed gap in regard to the management of patients with fentanyl overdose, we have questions about certain aspects of it.

The authors presumed that the majority of study patients were exposed to fentanyl, according to city public health surveillance data demonstrating that 86% of tested heroin samples contained fentanyl. However, because only the heroin samples in the city were tested, and not the patients, it is unclear what opioid was used by any individual patient. Perhaps more information about the source and character of the public health surveillance data would have alleviated some of this concern. We do not know the number of tested samples, nor how representative the selection. For example, if the heroin samples were obtained through arrests at select points of sale, how likely is it that they reflect the larger drug environment in the region under study?

Most important, we would like to better understand the decision to lengthen the observation time for patients with presumed fentanyl exposures compared with the authors' heroin observation protocol. The rationale was that fentanyl has a longer half-life than heroin. Although this may be true when terminal elimination is compared