

RATE OF IMAGING

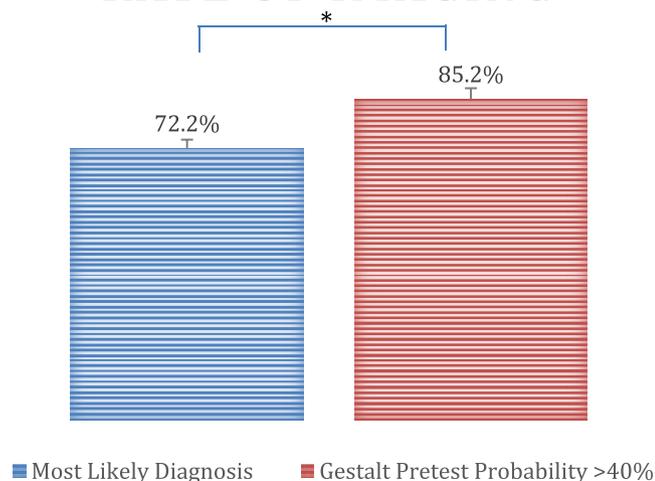


Figure. Percentage of patients with a positive subjective Wells score (ie, patients for whom pulmonary embolism was the most likely diagnosis) who underwent chest imaging compared with the percentage of patients who had gestalt pretest probability of pulmonary embolism of greater than 40% who underwent 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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<https://doi.org/10.1016/j.annemergmed.2018.12.015>

Funding and support: By *Annals* policy, all authors are required to disclose any and all commercial, financial, and other relationships in any way related to the subject of this article as per ICMJE conflict of interest guidelines (see www.icmje.org). The author has stated that no such relationships exist.

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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 formula¹) 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

conservatively (median pneumothorax size 10% [interquartile range 5% to 22%]).⁶ Seventy-seven of these patients traveled by air within 4 days after final chest radiograph, of whom 19% traveled within 24 hours. Minor complications (mild dyspnea or pain) were reported by 3 of these patients.

Considering the published reports and the physiology of gas expansion at altitude, we suggest that the waiting period before flying after complete resolution of traumatic pneumothorax might be safely reduced from 14 days to 72 hours. An observation period of 72 hours also appears to be safe for patients with a small pneumothorax who do not require a chest drain, or those with a small residual pneumothorax after chest drain removal. This interval would serve primarily to ensure that patients are clinically stable and, depending on the clinical situation, could potentially be reduced further. Insertion of a chest drain solely because a patient is traveling by air may be unnecessary in most cases, although all patients with pneumothorax still need to be individually assessed before flying.

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<https://doi.org/10.1016/j.annemergmed.2019.01.010>

Funding and support: By *Annals* policy, all authors are required to disclose any and all commercial, financial, and other relationships in any way related to the subject of this article as per ICMJE conflict of interest guidelines (see www.icmje.org). The authors have stated that no such relationships exist.

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CORRECTION NOTICE



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

[*Annals of Emergency Medicine* 72 (2018) 184–193]

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The authors regret that there is an error in Table 3. In the column labelled "Pairwise Differences (95% CI)," "1 vs 2" should be corrected to "1 vs 3."

The authors would like to apologize for any inconvenience caused.