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What question this study addressed: One hundred twenty-five patients with skin abscesses ranging from 0.4 to 79 cm² in diameter were randomized to incision and drainage with or without use of bedside ultrasonography. *What this study adds to our knowledge:* Rates of failure, defined as a repeated instance of incision and drainage, were 3.7% with bedside ultrasonography and 17% without it.

8 Systemic Antibiotics for the Treatment of Skin and Soft Tissue Abscesses: A Systematic Review and Meta-Analysis (Systematic Review/Meta-Analysis)

M Gottlieb, JM DeMott, M Hallock, GD Peksa

What question this study addressed: Do methicillin-resistant *Staphylococcus aureus*-active antibiotics improve clinical outcomes among patients with a drained skin abscess? *What this study adds to our knowledge:* Meta-analysis of 4 randomized placebo-controlled trials involving 2,406 participants found that methicillin-resistant *S aureus*-active antibiotics were associated with a significantly increased primary lesion cure rate (risk difference 7.4 percentage points) and reduced new lesion development rate (10.0 percentage points), with an increased rate of minor adverse events (4.4 percentage points).

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 designates Systematic Review Snapshot articles.

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What question this study addressed: Is interfacility transfer to specialized cardiac arrest receiving centers associated with reduced mortality? *What this study adds to our knowledge:* In a database analysis of 5,217 out-of-hospital cardiac arrest from all causes, treatment at a cardiac arrest receiving center was independently associated with reduced hazard of death (adjusted hazard ratio 0.84; 95% confidence interval 0.74 to 0.94) compared with treatment at a non-cardiac arrest receiving center.
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TK Trivedi, M Glenn, G Hern, DL Schriger, KA Sporer
What question this study addressed: The study examined the characteristics and safety of a program in Alameda County, CA, that allows paramedics to transport selected patients receiving involuntary psychiatric holds directly to the county psychiatric facility. *What this study adds to our knowledge:* During a 5-year period, 53,887 of 541,731 encounters (10%) were for patients receiving involuntary holds; 22,074 (41%) of held patients were transported directly to the psychiatric facility. Among them, 60 patients (0.3%) were determined to have failed diversions on the basis of a subsequent need for emergency department care within 12 hours.
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- 58 **Pneumothorax and Hemothorax in the Era of Frequent Chest Computed Tomography for the Evaluation of Adult Patients With Blunt Trauma** (Original Research)
RM Rodríguez, K Canseco, BM Baumann, WR Mower, MI Langdorf, AJ Medak, DR Anglin, GW Hendey, N Addo, D Nishijima, AS Raja
What question this study addressed: What is the incidence and clinical relevance of pneumothoraces and hemothoraces evident on computed tomography (CT) but not observed on chest radiograph? *What this study adds to our knowledge:* The authors combined 2 multicenter observational cohorts totaling 8,661 patients with both CT and chest radiographs and found that pneumothoraces and hemothoraces observed only on CT were of lesser importance.

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(Systematic Review/Meta-Analysis)

GW Fuller, R Evans, L Preston, HB Woods, S Mason

What question this study addressed: What is the risk of serious computed tomography scan findings or complications in minor head injury patients receiving direct oral anticoagulants? *What this study adds to our knowledge:* In this systematic review, 7 studies with high risk of bias included 346 patients. The pooled risk estimate for direct oral anticoagulant–treated patients who had intracranial hemorrhage, neurosurgery, or death was 4% (95% confidence interval 2% to 6%), and there were insufficient data to identify subgroups of patients with lower risk.

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What question this study addressed: This study describes immune-related adverse events resulting in an emergency department visit at a comprehensive cancer center by patients receiving immune checkpoint therapies (nivolumab, ipilimumab, or pembrolizumab). *What this study adds to our knowledge:* Among 1,026 visits, 257 were for immune-related adverse events. The most common adverse events were diarrhea, colitis, dermatitis, pneumonitis, and hypophysitis.

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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 (as for example in the EM:RAP commentaries), 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.