



Correspondence

Observations regarding battlefield acupuncture to treat low back pain in the emergency department?


Dear Editor,

We read with great interest a recent publication on the use of battlefield acupuncture (BFA) to treat low back pain (LBP) in the emergency department [1]. This is a pilot interventional study illustrating the feasibility of using ear acupuncture as a modality to alleviate symptoms of LBP. We would like to highlight a few observations. Although the study has shown a statistically significant difference in the post-intervention numerical rating scale (NRS) for low back pain between the control group and BFA group, it was unclear what were the pre-intervention NRS in these 2 groups and the changes in the pre-and-post intervention NRS between the 2 groups. A statistically significant NRS between the two groups post intervention does not equate a statistically significant reduction in NRS within the group pre-and-post treatment. As a result, it was impossible to comment on the clinical significance between the pre-and-post intervention NRS. A previous study conducted in an emergency department setting involving patients presenting with pain had determined the minimum clinically significant difference for the 11 point NRS to be 1.39 ± 1.05 (95% confidence interval, 1.27–1.51) [2]. Hence knowing the magnitude of change in NRS may help to place the significance of the intervention in context.

It is also interesting to note that an equal number of patients in both groups had opioid medications administered in the emergency department. Hence battlefield acupuncture did not reduce the number of patients who required opioids, however it was unclear regarding the timing of opioid administration relative to the application of battlefield acupuncture. Although the number of patients requiring opioids did not change, it may be worthwhile looking at the total dosage of opioids required to ascertain if there might be a difference between the two groups.

A systematic review and meta-analysis by Jan et al. specifically examined the role of auriculoacupuncture for pain relief in the emergency setting had shown significantly reduced pain scores but acknowledged that the overall number of patients included were small [3]. We do not dispute the potential efficacy of acupuncture for pain management in general but the fact remains that evidence of auriculoacupuncture is less robust than conventional acupuncture.

In addition to the problem with opioid use, we understand that it is difficult to manage acute low back pain with non-pharmacological techniques in the environment of the emergency department. Hence any novel techniques including battlefield acupuncture will be welcomed.

We would like to end by congratulating the authors on completing this study within the complexities of an emergency department.

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Resuscitation group should be a part of all pulmonary thromboembolism risk stratifications


To the Editor,

Pulmonary thromboembolism (PTE) is manifested in numerous ways, from asymptomatic and/or incidentaloma to being fatal. Because the symptoms and signs are not specific, PTE has been named as “the chameleon”. Together with this, the prevalent co-morbidities cause a delay in the correct diagnosis thereby postponing the necessary timely treatment (that can be life-saving) [1]. From the number of patients who die because of PTE, the majority do so prior to reaching the hospital [2]. Therefore, a significant proportion of patients with cardiac arrest is because of PTE: 2–13% of arrests occur out of the hospital and 5–6% of those occurring in the hospital [3–5]. No less than 30% of such patients had been misdiagnosed [5,6]. The pulseless electrical activity (PEA) had been found in 63% of PTE patients with cardiac arrest, asystole in 32% and ventricular fibrillation in 5% [5,6]. This group of resuscitated PTE patients has a bleak prognosis [5]. The question of fibrinolytic effect in PTE patients with cardiac arrest has been an important topic and a challenging task for years [7].

Although thrombolysis can save patients who either suffer coronary or pulmonary artery thrombosis, the systemic fibrinolytic administration to all patients with cardiac arrest, does not appear to be appropriate. Both, the unique Thrombolysis in Cardiac Arrest (TROICA) trial and a meta-analysis confirm this [5]. Even though the quality of the evidence for fibrinolysis is considered weak, all the guidelines recommend that