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The authors respond: Public health intervention in the ED for hypertension

We thank Mr. Oscar M. Jolobe for the interest in our article. Exercise is certainly a highly beneficial activity, and an emergency department visit does indeed present an opportunity for promoting such prevention strategies. Emergency departments are increasingly being asked to deploy public health interventions such as HIV testing with risk reduction counseling, and mental health and substance abuse screening among others. We posit that substantial barriers remain to achieving the behavior change required to improve health outcomes through a brief intervention. There is a considerable need for research, practice, and policy change to balance the competing missions of acute care and public health, identify the resources required for emergency departments to adopt a public health mission, and promote linkage to more appropriate venues for longitudinal interventions needed to achieve sustained behavior change.

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Cranial CT of nontrauma emergency department patients

I have greatly enjoyed reading the recently published article by Covino et al. [1]. In this retrospective study, the authors evaluated 1156 patients presenting to the ED for neurological deficit, postural instability, acute headache, altered mental status, seizures, confusion, dizziness, vertigo, syncope, and pre-syncope. The authors built a score for positive cranial computed tomography prediction by using a logistic regression model on clinical factors significant at univariate analysis. I congratulate the authors for their successful article. However, I have some concerns about article. First, this study was retrospective and did not include ED patients who did not undergo cranial computed tomography. Therefore, it must be stressed that the true effect of applying these clinical predictors cannot be assessed. There is need for prospective validation of the clinical predictor variables that identified in this consecutive series of ED patients with nontraumatic neurologic symptoms who did undergo cranial computed tomography. Second, as a result of the retrospective nature of this study, patient assessment and documentation of clinical findings were not standardized. Finally, owing to the retrospective design of the study, there was no standardization of the terminology contained within the computed tomography requisitions.

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The author responds: The need for prospective studies of cranial CT for ED head trauma patients

Dear Sir,

I sincerely appreciate your interest in our work, and I thank you for the questions about our paper. In our study we retrospectively reviewed clinical data of 1156 patients presented to our ED for several clinical condition non-related to trauma, and build a score for positive cranial CT scan prediction in the ED setting. We furtherly validated our score on a prospective population of 508 patients.

Our data confirmed that risk stratification could reasonably reduce head CT utilization in the emergency department patients, keeping high standards of sensitivity.

In the first point of your letter you underline that the true effect of applying this clinical predictor could not be assessed since we did not include patients that did not undergo CT scan. However since the purpose of our work was to give a tool to emergency physicians to reduce just urgent head CT scan in the ED, we think that the design of our study is adequate to our endpoint. Furthermore it would be very difficult to design a study were every patient should undergo a urgent head CT scan regardless of clinical evaluation and physician judgement. So, in our opinion, the true incidence of any head CT rule cannot be mathematically estimated at 100% in the real world.