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**Congruency of Disposition After Emergency Department Intubation in a Regional Database**

*To the Editor:*

The National Hospital Ambulatory Medical Care Survey (NHAMCS) is the largest national emergency department (ED) database, used by many groups to better understand practice patterns and trends in emergency medicine. A number of recent studies have raised questions about the data quality and reliability of the NHAMCS database, most recently one by Green. One of the concerns raised in regard to NHAMCS was abstractor training. Is database reliability an endemic issue or simply, as suggested by Green and others, related to abstractor training?

To address this question, we performed an institutional review board–approved analysis of the Illinois Department of Public Health Trauma Registry. The department requires that all trauma centers submit data for patients who sustain traumatic injuries that require treatment at a trauma center and are subsequently admitted to a trauma center, are transferred to a trauma center, or are dead on arrival or die in the ED. Each institution has designated, trained personnel who enter these data into the Illinois Department of Public Health database.

We reviewed data for all trauma patients requiring intubation in the ED between 2004 and 2012 at our institution. We analyzed time of presentation, length of stay, discharge time, discharge destination, and total days requiring mechanical ventilation. Disposition of each patient was determined according to the discharge disposition recorded for each patient on completion of his or her medical treatment. We considered all patients with a length of stay less than 24 hours with a disposition recorded as discharged home or self-care as having a disposition potentially incompatible with intubation. Charts of all patients flagged in this category underwent a complete review by study investigators to determine whether the disposition was compatible with the patients’ having been intubated.

A total of 2,384 trauma patients were intubated during the study period. Twelve patients (0.5%; 95% confidence interval [CI] 0.29% to 0.87%) had dispositions potentially incompatible with intubation. Further review of these charts revealed that 9 patients had been intubated in the ED, had negative evaluation results, and were subsequently extubated and discharged home within 24 hours. Two patients were intubated for surgical procedures performed in the operating room, extubated postoperatively, and discharged home within 24 hours. Only 1 patient’s data (0.04%; 95% CI 0.01% to 0.2%) were entered incorrectly (Table).

Table. Disposition of intubated patients in the Illinois Department of Public Health Trauma Registry, 2004 to 2012 (n=2,384).

<table>
<thead>
<tr>
<th>Disposition</th>
<th>Subtotal (%)</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disposition compatible with intubation</td>
<td>2,372 (99.5)</td>
<td></td>
</tr>
<tr>
<td>Disposition incompatible with intubation</td>
<td>12 (0.5)</td>
<td></td>
</tr>
<tr>
<td>Negative evaluation result, extubation and discharge within 24 h</td>
<td>9 (0.38)</td>
<td></td>
</tr>
<tr>
<td>Intubation for surgical procedure, extubation postoperatively and discharge within 24 h</td>
<td>2 (0.08)</td>
<td></td>
</tr>
<tr>
<td>Erroneous entry</td>
<td>1 (0.04)</td>
<td></td>
</tr>
</tbody>
</table>

Although this analysis is not sufficient to preclude other inaccuracies or flaws in this state-run database, our results lend support to the suggestion that abstractor training and experience may be crucial for database accuracy. As stated earlier, a primary concern raised in recent analyses and descriptions of NHAMCS...
The Elbow Extension Test Remains a Useful Adjunct to Clinical Judgment in Elbow Trauma

To the Editor:

I read with interest the article by Jie et al1 on the elbow extension test. I disagree with the authors’ conclusion that their data contradict those of previous studies.

First, using a radiograph as a criterion standard for elbow fracture is problematic because its own performance has never been formally established. Indeed, sensitivities as low as 21% have been reported in an adult model.2 It seems reasonable to expect even worse performance in children.

Second, the reported sensitivity of 94% (95% confidence interval 89% to 96%) for the extension test in adults is in line with that of previous studies.3 Could the authors comment on the proportion of adults with a normal extension test result who required surgery according to the radiographic findings?

Thus, although the elbow extension test cannot be used single-handedly as a clinical decision rule to exclude elbow fracture in all populations, it remains a very useful adjunct to clinical judgment in adult trauma and may inform the decision to forgo imaging.

The conclusion by Appelboam et al3 still fully applies: “The elbow extension test can be used in routine practice to inform clinical decision making. Patients who cannot fully extend their elbow after injury should be referred for radiography, as they have a nearly 50% chance of fracture. For those able to fully extend their elbow, radiography can be deferred if the practitioner is confident that an olecranon fracture is not present. Patients who do not undergo radiography should return if symptoms have not resolved within 7-10 days.”

Ivan Pavlov, MD
Hôpital de Verdun
Montreal, Quebec, Canada

In reply:

We thank Dr. Pavlov for his interest in our study. In response to his comments, we agree that a radiograph may not be the perfect criterion standard for elbow fracture. However, our study goal was not to test radiograph performance, but to find a practical clinical decision rule. Because radiograph is widely accepted and clinically used as diagnostic tool, it would be illogical to choose otherwise.

Dr. Pavlov disagrees that elbow extension test performance in adults of our study contradicts that in the study by Appelboam et al.3 We oppose his remark because sensitivity


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