

ACİL TIP TA EN ÇOK ATIF ALAN 10 MAKALE

Uz. Dr. Mustafa Ekici
Aydın Atatürk Devlet Hastanesi

ATIF

- **ATIF NEDİR ?** Bilimsel makalelerin bazıları, daha iyi yöntemlerle, daha özenle yapılmış, daha nitelikli bilimsel çalışmalardır. Bu çalışmalar bilim camiasının daha çok ilgisini çeker. Bir bilimsel makale, diğer bir bilimsel makaleyi kaynak olarak gösterince, o makaleye atıf yaptı diyoruz.
- **ATIFLAR NEDEN VERİLİR ?** Çünkü bilimsel makalelerde eğer bir bilgi için bizzat deneysel, gözlemsel kanıt göstermiyorsanız güvenilir bir kaynağı dayanak göstermeniz gerekir; atıflar da bunu sağlar
- **ATIF NE İŞE YARAR ?** Hangi makalenin daha çok ilgi çektiğini öğrenmek için, o makalenin “atıf” sayısına bakılır. Bilimsel dergiler de yayınladıkları makalelerin atıf sayısına dayanan bir ölçek olan “etki değeri”ne göre değerlendirilirler.

Bibliyometrik analiz nedir?

- Belirli bir alanda belirli bir dönemde ve belirli bir bölgede kişiler ya da kurumlar tarafından üretilmiş yayınların ve bu yayınlar arasındaki ilişkilerin sayısal olarak analizidir.



- Peki bir makaleye atıf yapmış diğer makaleleri nasıl bulabiliriz? Bunun için bilimsel atıf dizinleri kullanılır. Bunlar arasında en çok kullanılan *Bilim Atıf Dizini* ve *Toplumsal Bilimler Atıf Dizini* adlı iki dizin, **Thomson Reuters** adlı şirketin ürünleridir ve erişebilmek için şirketin hizmetlerine abone bir akademik kütüphaneye başvurmak gerekir. Son yıllarda **Scopus** ve **Google Scholar** dizinleri bu şirketin ürünleriyle rekabete katılmıştır.

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OVERCROWDING / REVIEW

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Chart Reviews In Emergency Medicine Research: Where Are The Methods?

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Study objective: Medical chart reviews are often used in emergency medicine research. However, the reliability of data abstracted by chart reviews is seldom examined critically. The objective of this investigation was to determine the proportion of emergency medicine research articles that use data from chart reviews and the proportions that report methods of case selection, abstractor training, monitoring and blinding, and interrater agreement.

Methods: Research articles published in three emergency medicine journals from January 1989 through December 1993 were identified. The articles that used chart reviews were analyzed.

Results: Of 986 original research articles that were identified, 244 (25%; 95% confidence interval [CI], 22% to 28%) relied on chart reviews. Inclusion criteria were described in 98% (95% CI, 96% to 99%), and 73% (95% CI, 67% to 79%) defined the variables being analyzed. Other methods were seldom mentioned: abstractor training, 18% (95% CI, 13% to 23%); standardized abstraction forms, 11% (95% CI, 7% to 15%); periodic abstractor monitoring, 4% (95% CI, 2% to 7%); and abstractor blinding to study hypotheses, 3% (95% CI, 1% to 6%). Interrater reliability was mentioned in 5% (95% CI, 3% to 9%) and tested statistically in .4% (95% CI, 0% to 2%). A 15% random sample of articles was reassessed by a second investigator; interrater agreement was high for all eight criteria.

Conclusion: Chart review is a common method of data collection in emergency medicine research. Yet, information about the quality of the data is usually lacking. Chart reviews should be held to higher methodologic standards, or the conclusions of these studies may be in error.

[Gilbert EH, Lowenstein SR, Koziol-McLain J, Barta DC, Steiner J: Chart reviews in emergency medicine research: Where are the methods? *Ann Emerg Med* March 1996;27:305-308.]

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Resuscitation 81 (2010) 1219–1276



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European Resuscitation Council Guidelines for Resuscitation 2010

Section 1. Executive summary

Jerry P. Nolan^{a,*}, Jasmeet Soar^b, David A. Zideman^c, Dominique Biarent^d, Leo L. Bossaert^e, Charles Deakin^f, Rudolph W. Koster^g, Jonathan Wyllie^h, Bernd Böttigerⁱ,
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Section 4. Adult advanced life support

Charles D. Deakin^{a,1}, Jerry P. Nolan^{b,*,1}, Jasmeet Soar^c, Kjetil Sunde^d, Rudolph W. Koster^e, Gary B. Smith^f, Gavin D. Perkins^f

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Clinical Significance of Reported Changes in Pain Severity

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Joseph P Funk, MD
Robert Bonacci, PA

Study objective: To determine the amount of change in pain severity, as measured by a visual analog scale, that constitutes a minimum clinically significant difference.

Methods: Patients 18 years of age or older who presented with acute pain resulting from trauma were enrolled in this prospective, descriptive study. The setting was an urban county hospital emergency department with a Level I trauma center. In the course of a brief interview, patients were asked to indicate their current pain severity with a single mark through a standard 100-mm visual analog scale. At intervals of 20 minutes for the next 2 hours, patients were asked to repeat this measurement and, in addition, to contrast their present pain severity with that at the time of the previous measurement. They were to indicate whether they had "much less," "a little less," "about the same," "a little more," or "much more" pain. All contrasts were made without reference to prior visual analog scale measurements. A maximum of six measurements of pain change were recorded per patient. Measurements ended when the patient left the ED or when the patient reported a pain score of zero.

The minimum clinically significant change in visual analog scale pain score was defined as the mean difference between current and preceding visual analog scale scores when the subject noted a little less or a little more pain.

Results: Forty-eight subjects were enrolled, and 248 pain contrasts were recorded. Of these contrasts, 41 were rated as a little less and 39 as a little more pain. The mean difference between current and preceding visual analog scale scores in these 80 contrasts was 13 mm (95% confidence interval, 10 to 17 mm).

Conclusion: The minimum clinically significant change in patient pain severity measured with a 100-mm visual analog scale was 13 mm. Studies of pain experience that report less than a 13-mm change in pain severity, although statistically significant, may have no clinical importance.



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Clinical paper

Global incidences of out-of-hospital cardiac arrest and survival rates: Systematic review of 67 prospective studies^{☆,☆☆}

Jocelyn Berdowski^{a,*}, Robert A. Berg^b, Jan G.P. Tijssen^a, Rudolph W. Koster^a^a Department of Cardiology, Academic Medical Centre – University of Amsterdam, Amsterdam, The Netherlands^b Department of Anaesthesiology and Critical Care, The Children's Hospital of Philadelphia and Centre for Resuscitation Science at The University of Pennsylvania, Philadelphia, PA, USA

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ABSTRACT

Aim: The aim of this investigation was to estimate and contrast the global incidence and outcome of out-of-hospital cardiac arrest (OHCA) to provide a better understanding of the variability in risk and survival of OHCA.

Methods: We conducted a review of published English-language articles about incidence of OHCA, available through MEDLINE and EmBase. For studies including adult patients and both adult and paediatric patients, we used Utstein data reporting guidelines to calculate, summarize and compare incidences per 100,000 person-years of attended OHCAs, treated OHCAs, treated OHCAs with a cardiac cause, treated OHCA with ventricular fibrillation (VF), and survival-to-hospital discharge rates following OHCA.

Results: Sixty-seven studies from Europe, North America, Asia or Australia met inclusion criteria. The weighted incidence estimate was significantly higher in studies including adults than in those including adults and paediatrics for treated OHCAs (62.3 vs 34.7; $P < 0.001$); and for treated OHCAs with a cardiac cause (54.6 vs 40.8; $P = 0.004$). Neither survival to discharge rates nor VF survival to discharge rates differed statistically significant among studies. The incidence of treated OHCAs was higher in North America (54.6) than in Europe (35.0), Asia (28.3), and Australia (44.0) ($P < 0.001$). In Asia, the percentage of VF and survival to discharge rates were lower (11% and 2%, respectively) than those in Europe (35% and 9%, respectively), North America (28% and 6%, respectively), or Australia (40% and 11%, respectively) ($P < 0.001$, $P < 0.001$).

Conclusions: OHCA incidence and outcome varies greatly around the globe. A better understanding of the variability is fundamental to improving OHCA prevention and resuscitation.

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EDUCATIONAL ADVANCES

Reliability of the Visual Analog Scale for
Measurement of Acute Pain

POLLY E. BIJUR, PHD, WENDY SILVER, MA, E. JOHN GALLAGHER, MD

Abstract. **Objective:** Reliable and valid measures of pain are needed to advance research initiatives on appropriate and effective use of analgesia in the emergency department (ED). The reliability of visual analog scale (VAS) scores has not been demonstrated in the acute setting where pain fluctuation might be greater than for chronic pain. The objective of the study was to assess the reliability of the VAS for measurement of acute pain. **Methods:** This was a prospective convenience sample of adults with acute pain presenting to two EDs. Intraclass correlation coefficients (ICCs) with 95% confidence intervals (95% CIs) and a Bland-Altman analysis were used to assess reliability of paired VAS measurements obtained 1 minute apart every 30 minutes over two hours. **Results:**

The summary ICC for all paired VAS scores was 0.97 [95% CI = 0.96 to 0.98]. The Bland-Altman analysis showed that 50% of the paired measurements were within 2 mm of one another, 90% were within 9 mm, and 95% were within 16 mm. The paired measurements were more reproducible at the extremes of pain intensity than at moderate levels of pain. **Conclusions:** Reliability of the VAS for acute pain measurement as assessed by the ICC appears to be high. Ninety percent of the pain ratings were reproducible within 9 mm. These data suggest that the VAS is sufficiently reliable to be used to assess acute pain. **Key words:** pain; pain measurement; reproducibility of results. ACADEMIC EMERGENCY MEDICINE 2001; 8:1153–1157



Predicting Survival From Out-of-Hospital Cardiac Arrest: A Graphic Model

From the Center for Evaluation of Emergency Medical Services, Emergency Medical Services Division, Seattle, King County Department of Public Health;* and Department of Medicine and Biostatistics, University of Washington,† Seattle.

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Alfred P Hallstrom, PhD†

Study objective: To develop a graphic model that describes survival from sudden out-of-hospital cardiac arrest as a function of time intervals to critical prehospital interventions.

Participants: From a cardiac arrest surveillance system in place since 1976 in King County, Washington, we selected 1,667 cardiac arrest patients with a high likelihood of survival: they had underlying heart disease, were in ventricular fibrillation, and had arrested before arrival of emergency medical services (EMS) personnel.

Methods: For each patient, we obtained the time intervals from collapse to CPR, to first defibrillatory shock, and to initiation of advanced cardiac life support (ACLS).

Results: A multiple linear regression model fitting the data gave the following equation: survival rate = $67\% - 2.3\%$ per minute to CPR – 1.1% per minute to defibrillation – 2.1% per minute to ACLS, which was significant at $P < .001$. The first term, 67%, represents the survival rate if all three interventions were to occur immediately on collapse. Without treatment (CPR, defibrillatory shock, or definitive care), the decline in survival rate is the sum of the three coefficients, or 5.5% per minute. Survival rates predicted by the model for given EMS response times approximated published observed rates for EMS systems in which paramedics respond with or without emergency medical technicians.

Conclusion: The model is useful in planning community EMS programs, comparing EMS systems, and showing how different arrival times within a system affect survival rate.

[Larsen MP, Eisenberg MS, Cummins RO, Hallstrom AP: Predicting survival from out-of-hospital cardiac arrest: A graphic model. *Ann Emerg Med* November 1993;22:1652-1658.]

8

A Practical Score for the Early Diagnosis of Acute Appendicitis

*We conducted a retrospective study of 305 patients hospitalized with abdominal pain suggestive of acute appendicitis. Signs, symptoms, and laboratory findings were analyzed for specificity, sensitivity, predictive value, and joint probability. The total joint probability, the sum of a true-positive and a true-negative result, was chosen as a diagnostic weight indicative of the accuracy of the test. Eight predictive factors were found to be useful in making the diagnosis of acute appendicitis. Their importance, according to their diagnostic weight, was determined as follows: localized tenderness in the right lower quadrant, leukocytosis, migration of pain, shift to the left, temperature elevation, nausea-vomiting, anorexia-acetone, and direct rebound pain. Based on this weight, we devised a practical diagnostic score that may help in interpreting the confusing picture of acute appendicitis. [Alvarado A: A practical score for the early diagnosis of acute appendicitis. *Ann Emerg Med* May 1986;15:557-564.]*

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INTRODUCTION

Acute appendicitis is a common cause of abdominal pain in all ages. However, it is often a perplexing diagnostic problem during the early stages of the disease. In many cases, usually during the prodromal phase, its clinical manifestations may be vague and uncertain. Failure to make an early diagnosis is a primary reason for the persistent rate of morbidity and mortality.¹⁻³ Perforation rates range from 4%⁴ to 45%,⁵ and death rates range from 0.17%⁶ to 7.5%.⁷ Mortality in children less than 2 years old is surprisingly high (20%).⁵

The number of unnecessary laparotomies, particularly in women, may be as high as 45%.¹ The overall "negative" appendectomy rate ranges from 14%^{2,8} to 75%.⁹

Our goal is to be able to reduce the negative appendectomy rate without increasing the risk of perforation. This might be accomplished by sharpening our diagnostic acumen, especially during the early stages of the disease, because most of the perforations occur outside the hospital.^{2,3} A careful evaluation of each patient may reduce the number of "healthy" appendices removed.^{4,6,8}

MATERIALS AND METHODS

The records of 305 patients who were hospitalized from January 1975 to December 1976 at Nazareth Hospital in Philadelphia, Pennsylvania, with abdominal pain (epigastric, periumbilical, diffuse, or in the right lower quadrant) suggestive of acute appendicitis were reviewed. Data, including age, sex, duration of pain, symptoms, physical signs, and such laboratory findings as white blood count (WBC), differential count, urinalysis, and pathology report, were tabulated from existing clinical records.

RESULTS

Of 305 patients hospitalized, 51 (17%) were kept for observation and treated nonoperatively. They were discharged from the hospital with the diagnosis of possible acute mesenteric adenitis (29 patients, 57%) or nonspecific gastroenteritis (22 patients, 43%).

Of the 305 patients, 254 (83%) had an appendectomy. Of these, 27 (11%) did not have acute appendicitis. The remaining 227 (89%) did have acute appendicitis at varying pathological stages (Table 1).



Systematic Review of Emergency Department Crowding: Causes, Effects, and Solutions

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Emergency department (ED) crowding represents an international crisis that may affect the quality and access of health care. We conducted a comprehensive PubMed search to identify articles that (1) studied causes, effects, or solutions of ED crowding; (2) described data collection and analysis methodology; (3) occurred in a general ED setting; and (4) focused on everyday crowding. Two independent reviewers identified the relevant articles by consensus. We applied a 5-level quality assessment tool to grade the methodology of each study. From 4,271 abstracts and 188 full-text articles, the reviewers identified 93 articles meeting the inclusion criteria. A total of 33 articles studied causes, 27 articles studied effects, and 40 articles studied solutions of ED crowding. Commonly studied causes of crowding included nonurgent visits, "frequent-flyer" patients, influenza season, inadequate staffing, inpatient boarding, and hospital bed shortages. Commonly studied effects of crowding included patient mortality, transport delays, treatment delays, ambulance diversion, patient elopement, and financial effect. Commonly studied solutions of crowding included additional personnel, observation units, hospital bed access, nonurgent referrals, ambulance diversion, destination control, crowding measures, and queuing theory. The results illustrated the complex, multifaceted characteristics of the ED crowding problem. Additional high-quality studies may provide valuable contributions toward better understanding and alleviating the daily crisis. This structured overview of the literature may help to identify future directions for the crowding research agenda. [Ann Emerg Med. 2008;52:126-136.]

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Overcrowding in the Nation's Emergency Departments: Complex Causes and Disturbing Effects

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See editorial, p. 83.

Ten years ago, serious overcrowding in emergency departments became a national issue. Although temporary improvement of the problem occurred, the issue of ED overcrowding has now resurfaced and threatens to become worse. Overcrowding is caused by a complex web of interrelated issues described in this article. ED overcrowding has multiple effects, including placing the patient at risk for poor outcome, prolonged pain and suffering of some patients, long patient waits, patient dissatisfaction, ambulance diversions in some cities, decreased physician productivity, increased frustration among medical staff, and violence. Solving the problem of overcrowding will not only require a major financial commitment from the federal government and local hospitals, but will also require a cooperation from managed care. Unless the problem is solved in the near future, the general public may no longer be able to rely on EDs for quality and timely emergency care, placing the people of this country at risk.

[Derlet RW, Richards JR. Overcrowding in the nation's emergency departments: complex causes and disturbing effects. *Ann Emerg Med*. January 2000;35:63-68.]

50 Other Biomedical Journal Articles Ranked by Citation

Rank	Author	Title	Year	Journal	Citation Count	Altmetric Score	Altmetric Rank	Topic	Type of Study
1	Baker	Injury Severity Score - Method for describing patients with multiple injuries and evaluating emergency care.	1974	<i>J Trauma</i>	4,020	3	36*	Trauma	Prospective cohort
2	Kessler	Post traumatic stress disorder in the national comorbidity survey.	1995	<i>Arch Gen Psych</i>	3,701	56	5	Psychiatry	Cross-sectional
3	Bone	Definitions for sepsis and organ failure and guidelines for the use of innovative therapies in sepsis.	1992	<i>Chest</i>	3,578	12	19*	Sepsis	Guideline statement
4	Rivers	Early goal directed therapy in the treatment of severe sepsis and septic shock.	2001	<i>NEJM</i>	3,441	176	1	Sepsis	Randomized controlled trial
5	Bernard	Efficacy and safety of recombinant human activated protein C for severe sepsis.	2001	<i>NEJM</i>	3,283	35	10	Sepsis	Randomized controlled trial
6	Yusuf	Effects of clopidogrel in addition to aspirin in patients with acute coronary syndromes without ST-segment elevation.	2001	<i>NEJM</i>	3,061	19	15	Cardiology	Randomized controlled trial
7	Angus	Epidemiology of severe sepsis in the United States: Analysis of incidence, outcomes, and associated costs of care.	2001	<i>Crit Care Med</i>	2,993	0	42*	Sepsis	Retrospective cohort
8	Gent	A randomised, blinded trial of clopidogrel versus aspirin in patients at risk of ischemic events (CAPRIE).	1996	<i>Lancet</i>	2,784	1	41	Cardiology	Randomized controlled trial
9	Bone	Definitions for sepsis and organ failure and guidelines for the use of innovative therapies in sepsis.	1992	<i>Chest</i>	2,784	12	19*	Sepsis	Guideline statement
10	Le Gall	A new simplified acute physiology score (SAPS-II) based on a European North American multicenter study.	1993	<i>JAMA</i>	2,758	3	36*	Critical Care	Prospective cohort

Top 50 EM Articles From All Journals Ranked by Altmetric Score

Rank	Altmetric Score	Author	Title	Year	Journal	Citation Count	Topic	Type of Study
1	176	Rivers	Early goal directed therapy in the treatment of severe sepsis and septic shock.	2001	<i>NEJM</i> †	3,441	Sepsis	Randomized controlled trial
2	173	Brenner	Current concepts - Computed tomography - An increasing source of radiation exposure.	2007	<i>NEJM</i> †	2,358	Radiology	Descriptive review
3	160	Boden	Optimal medical therapy with or without PCI for stable coronary disease.	2007	<i>NEJM</i> †	1,288	Cardiology	Randomized controlled trial
4	70	Finfer	Intensive versus conventional glucose control in critically ill patients.	2009	<i>NEJM</i> †	1,309	Critical care	Randomized controlled trial
5	56	Kessler	Post traumatic stress disorder in the national comorbidity survey.	1995	<i>Arch Gen Psych</i> †	3,701	Psychiatry	Cross sectional
6	49	Cannon	Intensive versus moderate lipid lowering with statins after acute coronary syndromes.	2004	<i>NEJM</i> †	2,141	Cardiology	Randomized controlled trial
7*	47	Bernard	Treatment of comatose survivors of out-of-hospital cardiac arrest with induced hypothermia.	2002	<i>NEJM</i> †	1,944	Cardiac arrest	Randomized controlled trial
7*	47	Hacke	Thrombolysis with alteplase 3 to 4.5 hours after acute ischemic stroke.	2008	<i>NEJM</i> †	1,542	Stroke	Randomized controlled trial
9	39	Wiviott	Prasugrel versus clopidogrel in patients with acute coronary syndrome.	2007	<i>NEJM</i> †	1,853	Cardiology	Randomized controlled trial
10	35	Bernard	Efficacy and safety of recombinant human activated	2001	<i>NEJM</i> †	3,283	Sepsis	Randomized controlled

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