I scored the above BEEM rating because:

TXA soaked packing/merocel/etc. is common practice, and this paper suggests it may be no different in efficacy than water. There was no statistical significance in adverse reactions or secondary outcomes between the groups. The study excluded the worst bleeders (i.e. hemodynamically unstable, bleeding disorders) so maybe a difference would be found there.

The educational pearls include:

- Stepwise approach to epistaxis management
- First10EM post runs through the literature on TXA
- In the UK almost half of their epistaxis patients get admitted!

I chose the above EBM rating because:

It was a multi-center, double blinded, RCT of >400 patients. There may be some element of selection bias as a large number of patients were excluded from the study for “other” reasons.
Post: **Status underdosings**

**Author:** Adis Keric  **Reviewed by:** Melissa Seldon

<table>
<thead>
<tr>
<th>BEEM Rater Scale</th>
<th>Score - choose only 1</th>
<th>Educational Utility</th>
<th>Score - choose only 1</th>
<th>EBM</th>
<th>Score - choose only 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assuming that the results of this article are valid, how much does this article impact on EM clinical practice?</td>
<td></td>
<td>Are there useful educational pearls in this article for residents?</td>
<td></td>
<td>Is this article reflect evidence based medicine (EBM) and thus lack bias?</td>
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<tr>
<td>Useless information</td>
<td></td>
<td>Low value: No valuable pearls</td>
<td></td>
<td>Not EBM based, only expert opinion (and thus more biased)</td>
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<tr>
<td>Not really interesting, not really new, changes nothing</td>
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<tr>
<td>Interesting and new, but doesn't change practice</td>
<td></td>
<td>Yes, but there are only a few (1-2) valuable or multiple (&gt;=3) less-valuable educational pearls</td>
<td></td>
<td>Minimally EBM based</td>
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<tr>
<td>Interesting and new, has the potential to change practice</td>
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<tr>
<td>New and important: this would probably change practice for some EPs</td>
<td></td>
<td>Yes, there are several (&gt;=3) valuable educational pearls, or a few (1-2) KEY educational pearls that every resident should know before graduating</td>
<td></td>
<td>Mostly EBM based</td>
<td></td>
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<tr>
<td>New and Important: this would change practice for most EPs</td>
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<tr>
<td>This is a “must know” for EPs</td>
<td></td>
<td>Yes, there are multiple KEY educational pearls that residents should know before graduating</td>
<td></td>
<td>Yes exclusively EBM based (unbiased)</td>
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</table>

**Your Score** 3 3 5

I scored the above BEEM rating because:

I think this podcast was a great reminder of the standard of care for status epilepticus, however, these standards have been set by the Neurocritical Care Society and Epilepsy Foundation since 2012 and 2016 respectively, therefore I felt that this was not any new information. With that being said, the information discussed during the podcast should be more of a review and should not change practice unless EM providers are not already using high dose benzos as part of their standard of care for status epilepticus.

**The educational pearls include:**

- High dose benzos are standard of care for status and we should not shy away from using them even if there is concern for respiratory depression. In many cases the patient will either be intubated already or will need to be intubated regardless.
- IV access: give 0.1 mg/kg lorazepam, max dose 4 mg, repeat every 5-10 minutes.
- No IV access: 0.2 mg/kg IM midazolam, max dose 10 mg, repeat every 5-10 minutes.

I chose the above EBM rating because:

Within the podcast there were several references to RCTs that support the use of high dose benzos for status epilepticus. The author also utilized the most recent guidelines from Neurocritical Care Society (2012) and the American Epilepsy Society (2016) when discussing recommendations. The only reason I did not score this higher is that the author did discuss anecdotally that many providers are underdosing for benzos (i.e. scared of intubation) and did not have EBM to support his claim.

*Edited by Jake Binder, Andrew Hasebrook, Ryan Johnsen, Megan Elsenheimer, Dan Hogan, Alex Taylor, Jacy O’Keefe and Joe Walter*
Post: **TIA**

**Author:** Simon Carley  
**Reviewed by:** Zander Coomes

I scored the above BEEM rating because:

This appears to be a fairly well designed validation study of a more accurate and more useful risk stratification tool for patients with TIA in the ED. Discerning which of these patients should be admitted vs. discharged is not always easy and this new tool appears better able to accurately identify low risk patients compared to a previous TIA risk calculation tool (ABCD2/ABCD2i)

**The educational pearls include:**

The Canadian TIA risk score is more complicated to calculate than the ABCD2i score, but better classifies patients in the ED with TIA as low (<1%) / medium (1-5%) / high (>5%) risk of stroke or carotid endarterectomy/stenting in the next 7 days. This can be a helpful tool in determining disposition for these patients.

I chose the above EBM rating because:

This was a multicenter prospective cohort study. Exclusion criteria were reasonable for the subject being studied. Enrollment was conducted sequentially 24/7 and blinding was used when possible. The reason I did not give a higher rating is that one of the most important qualities in a validation study is that it shows validity in differing populations. I am not thoroughly convinced that the population in this new study is appreciably different from that in the original study. The original study was done in 8 large Canadian EDs. The validation study was done in 7 of those same EDs and 6 new EDs (10 academic and 3 community), all still in Canada.

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**Edited by Jake Binder, Andrew Hasebrook, Ryan Johnsen, Megan Elsenheimer, Dan Hogan, Alex Taylor, Jacy O’Keefe and Joe Walter**
I scored the above BEEM rating because:

This is the first RCT approaching the issue of acute MI (AMI) and when to transfuse in anemia, a topic with minimal data (only observational studies). Historically the level to transfuse in MI (or stroke, sepsis, or other critical clinical situation) has been left up to the provider. This new data suggesting noninferiority of transfusion for a hemoglobin level of <8 vs. <10 in AMI should prompt providers to consider a new threshold for transfusion.

The educational pearls include:

- Hemoglobin threshold of <8 for transfusion in AMI is very likely noninferior to <10.

I chose the above EBM rating because:

This is a well-designed noninferiority HCT that is honest and thoughtful about its limitations, including being open-label, having a relative risk confidence interval which has the potential to inadvertently hide clinically significant harm when utilizing a restrictive transfusion strategy, and the inclusion of patients who may be anemic from a variety of causes and at different times during hospitalization, including those who were post-cath.
Post: Vaccine acceptance

Author: Gillian SteelFischer    Reviewed by: Callie Schnitker

I scored the above BEEM rating because:

The information provided in this article is interesting and applicable, especially for those EM providers who work in rural communities in which EM physicians may be the only meaningful medical interaction some patients encounter. The article gives concise and clear statistics as well as recommendations for encouraging vaccination/overcoming barriers.

The educational pearls include:

- A large proportion in the US is still undecided about COVID vaccination.
- Physicians can play a real and meaningful role in encouraging undecided patients to get vaccinated.
- Public views of effectiveness do not always equal expert opinion.
- There is need for greater education for the general population regarding vaccine safety and reasonable outcomes (i.e. not an immediate return to normal).

I chose the above EBM rating because:

Article analyzed 39 national polls regarding COVID vaccine acceptance. Limitations inherent in randomized polls, including data and interpretations and groupings (i.e. answers including “probably get it” and “definitely get it” are grouped together as respondents who would “get the vaccine”). Overall it did well looking at the data and objectively analyzing it.

Edited by Jake Binder, Andrew Hasebrook, Ryan Johnsen, Megan Elsenheimer, Dan Hogan, Alex Taylor, Jacy O’Keefe and Joe Walter