endpoints, “An important reason for using a composite endpoint is that the incidence rate of each of the events may be too low to allow a study of reasonable size to have adequate power; the composite endpoint can provide a substantially higher overall event rate that allows a study with a reasonable sample size and duration to have adequate power.” We adhered to recommendations for reporting of composite endpoints (“only combine components of similar clinical importance, take care to define them consistently, analyze the pre-specified composite, and list results for all components (not just first occurring events) in a table with confidence intervals”). We reported each of the specific morbidity endpoints in our results (Table 2).

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Breaking Down Silos: The Joint Statement About the Clinical Use of Resuscitative Endovascular Balloon Occlusion of the Aorta (REBOA) Warrants Revision

To the Editor:
Brenner et al1 recently published a joint statement between the American College of Surgeons Committee on Trauma and the American College of Emergency Physicians on the clinical use of resuscitative endovascular balloon occlusion of the aorta (REBOA). The statement created concern in both civilian and military communities by its—in our opinion—overly restrictive message and notable omissions.

Major resuscitations are team-based endeavors. The entire team should understand REBOA’s use and limitations. Excluding appropriately trained emergency physicians without an additional critical care medicine fellowship from using REBOA is incongruent with the observed strong foundation emergency medicine training creates to teach safe use. This has been demonstrated in international systems in which emergency physicians without critical care medicine training use REBOA.2 Citing only one proprietary training course (Basic Endovascular Skills for Trauma [BEST]) that does not currently accept civilian emergency physicians negates the role of other appropriately designed, inclusive military and civilian courses.

The joint statement did not adequately take into account the US military’s experience with REBOA; its comprehensive, evidence-based clinical practice guideline; or its pragmatic approach to skills development.3 The US Air Force’s Special Operations Surgical Team’s recent multidisciplinary experience with REBOA as an option in mass casualty incidents is relevant to civilian practice.4,5 Any guidance proposed in civilian health systems should not inadvertently restrict the practice of military emergency physicians and surgeons using REBOA to save lives while overseas, or to maintain their skills and train civilian counterparts after returning or after separation from the armed forces.

The joint statement also seemingly overlooks the capability of some out-of-hospital systems already involved in advanced interfacility transfers such as extracorporeal membrane oxygenation. Given the burden of preventable out-of-hospital death from torso hemorrhage, the challenge of managing these cases in smaller centers within a trauma network, and the anticipated evolution of REBOA.
procedural technique (eg, partial REBOA), we recommend a collaborative dialogue between the American College of Surgeons Committee on Trauma, the American College of Emergency Physicians, and the National Association of EMS Physicians. Optimum use in transfer and primary scene response situations should be reviewed, with particular attention on ensuring adequate system support.²

This statement risks becoming standard of care at individual institutions, limiting REBOA use within appropriate systems and stunting growth in those wanting to progress. Future revisions should include input from military and civilian experts with practical REBOA experience to provide perspective on the unique challenges and opportunities.

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Is Procalcitonin-Guided Antibiotic Therapy Working in Emergency Department Outpatients?

To the Editor:

We thank Drs. Tupchong and Chien for their summary comment¹ in regard to our recent metanalysis.²,³

In their discussion, the authors mention the limitation that not many patients are treated as emergency department (ED) outpatients. We agree that a large proportion of patients included in the individual randomized controlled trials that recruited patients through the ED were admitted to the hospital and not treated as outpatients. We also did not examine the subgroup of outpatients versus inpatients in our initial review. In response to their comment, we conducted a secondary analysis including all ED trials and stratified results according to whether patients were discharged from the ED or treated as inpatients.¹

First, we again examined inclusion and exclusion criteria of trials. As shown in Table 1, none of the 11 ED trials excluded outpatients explicitly according to the protocols. Out of 3,253 individual ED patients with confirmed respiratory infections who were included in these trials, 495 (15%) were discharged home from the ED and treated as outpatients. Most of the ED trials were conducted in Europe, where low-risk patients are often treated by their primary care physician, and patients going to the ED are referred for inhospital treatment.

Furthermore, when comparing effects of procalcitonin treatment on antibiotic use and clinical outcomes between inpatients and outpatients, we found similar effects in regard to duration of antibiotic treatment, total exposure of antibiotics, 30-day mortality, and treatment failure (Table 2).

Although we agree that future research is needed to examine ED patients treated as outpatients, particularly in the US setting, the current data set based on 11