

CHADS2 score of 1. Interestingly, another patient (CHADS2 score 2) of the larger cohort also developed a stroke, but without having undergone ED cardioversion.³ Weigner et al,⁵ in a similar prospective observational study of patients with recent-onset atrial fibrillation, reported 3 (0.8%) strokes within 30 days among 357 patients, 107 of whom were actively cardioverted and 250 spontaneously cardioverted. All 3 stroke patients had spontaneously cardioverted. Perhaps active cardioversion incurs no greater risk of thromboembolism than spontaneous cardioversion.

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In reply:

We thank Dr. Vinson for his interest in our article and thoughtful correspondence. He brings to our attention additional evidence in support of a management strategy of recent-onset atrial fibrillation involving emergency department (ED) cardioversion and discharge to home.

Dr. Vinson highlighted 2 articles, published subsequent to our literature review, which prospectively studied the management of recent-onset atrial fibrillation in the ED. He emphasized that the more recent studies were prospective in design and thus provide more substantial supporting evidence. However, only 1 study, that by Bellone et al,¹ was a randomized study. The authors' primary outcome was to compare electrical versus pharmacologic cardioversion success. The study suffered from a high rate of loss to follow-up, and the authors failed to

analyze their results with intention-to-treat analysis. And although they documented adverse events, they reported only those that occurred in the ED, which consequently meant fewer than 24 hours postcardioversion.

The argument can be made that ultimately a randomized controlled trial is needed comparing 30-day adverse event rates of active cardioversion in the ED and discharge to home to traditional care (admission) to change practice patterns. However, to change practice patterns we propose that not only the question of safety but also that of efficacy be addressed. Nevertheless, emergency physicians must make decisions today, with available evidence. Even if one is a skeptic, what seems clear from the available retrospective and prospective studies is that hemodynamically stable patients with recent-onset atrial fibrillation can be identified and effectively cardioverted by emergency physicians, and active cardioversion seems no more risky than spontaneous cardioversion in terms of thromboembolic risk.

The data presented by Dr. Vinson and published subsequent to the preparation of our article are in agreement with that which we presented and lend further support to our conclusion. Nevertheless, we recognize the concern of risk of an adverse outcome from such a management strategy. Dr. Vinson's thoughtful correspondence is the kind of interest and dialogue we had hoped might ensue as a result of our article because it is this kind of discussion that will potentially lead to further research with better-designed studies and practice pattern change.

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The Captain Morgan Technique for the Reduction of the Dislocated Hip

To the Editor:

We read with interest the recently published article titled "The Captain Morgan Technique for the Reduction of the Dislocated Hip" by Hendey and Avila.¹ We agree with the utility, success, and overall safety of this technique. However,

we had a complication when reducing a hip in an elderly wheelchair-bound patient and observed that the authors did not comment that in performing the reduction, care must be given to not use the “Captain’s knee” as a fulcrum to reduce the hip. Pushing down on the patient’s lower leg while having the knee fixed puts a great deal of tension on the knee and in our case created the complication of tearing the knee ligaments. We want readers to understand the potential for this complication if the technique is not followed carefully because it is common for novice users to try to create more force on the hip by pushing the leg down instead of raising the “Captain’s knee” upward.

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In reply:

I thank Drs. Almazroua and Vilke for their comments on the Captain Morgan technique for reducing a dislocated hip. They

have correctly pointed out that the knee should not be used as a fulcrum, with the main force coming from downward pressure on the patient’s ankle. Instead, the main force should be an upward or lifting force generated by one’s gastrocnemius and soleus muscles. Although I have not personally encountered a complication as described by the authors, I agree with their concern that using the knee as a fulcrum could impart a great deal of force to the patient’s knee, risking ligamentous injury. As we did describe in our article, this is one of the primary ways in which our method differs from the original report by Lefkowitz, which advocated “downward pressure applied to the patient’s ankle.”¹ Again, I thank you for emphasizing this important point, and may the Captain go with you.

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IMAGES IN EMERGENCY MEDICINE

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DIAGNOSIS:

Vaginal cuff dehiscence. Vaginal cuff dehiscence is a separation of the vaginal incision after a total hysterectomy, allowing abdominal contents to be expelled into the vaginal vault. Peritonitis, bowel injury, necrosis, and sepsis can ensue, creating a potentially life-threatening condition requiring rapid identification and swift medical and surgical intervention.

Earlier presentations are associated with premenopausal women, whereas postmenopausal women tend to present later. Dehiscence has been reported up to 15 years postoperatively, with a mean of 34 months.¹ The causes differ by menopausal state as well. There is typically an identifiable cause in premenopausal women to include trauma or rape, rough sexual intercourse, obstetric instrumentation, or insertion of foreign objects. The cause in postmenopausal women is less clear, typically occurring spontaneously or with a minor increase in intra-abdominal pressure. This is believed to be the result of a thin, scarred, foreshortened vagina. Other risk factors include a history of postoperative complications, radiation therapy, and chronic steroid use.²

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