What is already known on this subject

Chest pain observation units have the potential to improve care for patients presenting with acute, undifferentiated chest pain and reduce costs to the health service.

Care in the chest pain observation unit is safe and practical, but reliable evidence of effectiveness and cost effectiveness is lacking.

What this study adds

Care in the chest pain observation unit reduces hospital admissions without increasing inappropriate discharges with an acute coronary syndrome.

Health utility is improved while costs to the health service are reduced.

Care in the chest pain observation unit is therefore more effective and more cost effective than routine care.

Limitations

Since randomisation takes place before recruitment and consent to participate, it is possible for selection bias to influence results. We attempted to reduce this possibility by rigorous recording of selection criteria and by adjusting for known confounders in secondary analyses. This cannot, however, completely rule out the potential influence of selection bias. Secondly, since it is impossible to blind participants to the fact that they are receiving care in the chest pain observation unit or routine care, it is possible that a measure reported by patients, such as the EQ-5D, may be influenced by the patients' awareness that they are receiving "new" or routine care. Finally, further research is required before we can generalise the results from the Northern General chest pain observation unit to other hospitals.

Acknowledgments: We thank the staff of the Northern General Hospital departments of emergency medicine, acute medicine, and cardiology for their help with this project. We thank Brian Morris for support with chemical pathology services and Stephen Walters for additional statistical advice.

Contributors: See bmj.com.

Funding: The Northern General Hospital received a grant of £94 000 from the Department of Health to establish the chest pain observation unit. The study was supported by a £30 000 grant from a NHS Trent Health Services research fellowship. Unit costs of health and social care were funded by a NHS Trent Health Services research fellowship.

Competing interests: SG, FM, Percy, RF, Raftery, J, A, J, M, P, and F have no competing interests to declare. JN, SD, EC, SJC, and DQ have no competing interests to declare.

Competing interests: SG, FM, Percy, RF, Raftery, J, A, J, M, P, and F have no competing interests to declare. JN, SD, EC, SJC, and DQ have no competing interests to declare.

Conclusion

Chest pain observation units have the potential to improve care for patients presenting with acute, undifferentiated chest pain and reduce costs to the health service.

References


(Accepted 13 November 2003)

doi 10.1136/bmj.37956.6642536.EE

Corrections and clarifications

Three journals raise doubts on validity of Canadian studies

Three errors crept into this news article by Carolyn White (10 January, p 67). In the sixth paragraph we inadvertently referred to datasets in two papers being the same, instead of two sets of patients being the same. In the following paragraph, we referred to the number of digits remembered by patients as part of a memory test. The numbers given in the submitted paper refer to scores, however, so cannot be reliably converted into digits. The relevant sentence should therefore read: “One was the implausibly high score relating to the number of digits remembered by the participants.” Lastly, Dr Jack Strawbridge is director of faculty relations (not labour relations) at Memorial University.

Clinical arithmetic

A missing “t” in the author’s email address may have prevented you from writing to Colin Currie about his editorial in the Christmas issue (BMJ 2003;327:1418-9; doi:10.1136/bmj.327.7429.1418). We slipped up here, although we can’t work out what went wrong in our process, as we did mean to add the “t”. The correct email address is drcollincurrie@hotmail.com.

Strudlebrugs, sugar, and gatekeepers: a tale of our times

A crucial word change phoned to us by the author somehow did not end up on the diabetes wards after someone notices their blood sugar is high [not “low”] and all other specialists have lost interest.”