regression model, there is no statistically significant difference between the level of BNP and the severity of CHF in non-obese patient group (p>0.05). However, in obese CHF patients, when divided into 3 subgroups according to the level of BNP (higher BNP group with level ≥1000pg/ml, mid-level group with level between 500 to 1000pg/ml and lower BNP group with level ≤500pg/ml), BUN in higher BNP group was 42.2±26.7mg/dl and low BNP group was 21.0±13.5mg/dl (p=0.03). Creatinine level in higher BNP group was 2.5±1.6mg/dl and 1.25±0.5mg/dl in lower BNP group (<0.05). The length of hospitalization in higher BNP group was 5.2±2.3 days and lower BNP group was 3.9±1.6 days (p=0.045).

Conclusion: Higher BMI is associated with relatively lower level of BNP and the level of BNP is also inversely proportional to the severity of obesity in CHF patients. However, only in obese CHF patients, higher BNP is associated with worsening renal function and longer hospitalization stay.

184 Quantitative Meaning of Common Terms Like “Very Low Risk” and “Low Risk” for Chest Pain Patients
Menchine M, Wiechmann W/University of California, Irvine, Irvine, CA

Study Objectives: Although emergency physicians often use the terms low risk or high risk to describe chest pain patients, little is known about their quantitative meaning. We sought to assign a quantitative meaning for these common qualitative terms with respect to acute coronary syndrome and serious outcomes in chest pain patients. We also sought to identify the risk threshold at which emergency physicians admit or discharge these patients.

Methods: We conducted a web-based survey of emergency medicine residents at 11 academic medical centers. Participants were given 5 case scenarios of common ED presentations for chest pain. The scenarios were designed to encompass a broad range of risk, although none had frank ST-elevation myocardial infarction. All participants received the same clinical scenarios - half were asked to qualitatively assess the risk of ACS and half were asked to assess the risk of serious complications (death, dysrhythmia, or congestive heart failure). For each scenario, participants were asked to evaluate the patient’s risk as Very Low, Low, Moderate, High, or Very High. Once this determination was made, subjects were asked to quantify the exact risk the patient had and choose an appropriate disposition for the patient. Responses were grouped according to the qualitative risk categorization and the mean quantitative response was tabulated for each of the 5 categories. The admission rate for each risk category was also evaluated. Descriptive statistics are presented.

Results: 217 physicians (90.6% residents) completed the questionnaire. For cases that were categorically coded as Very Low Risk of ACS, the median quantitative risk was 0.088% [IQR 0.009 – 0.20%] with an associated admission rate of 7.14% [CI 0 – 15.2%]. Those coded as Low, Moderate, High, and Very High Risk had values of 0.45% [IQR 0.1 – 1.0%], 1.05% [IQR 1.0 – 2.29%], 3.53% [IQR 1.6 – 10%], and 10% [IQR 2.94 – 20%], respectively, with admission rates of 31.6% [CI 23.1 – 40.1%], 93.8% [CI 90.1 – 97.3%], 100% [CI 97.1 – 100%], and 100% [CI 93.7 – 100%] respectively. Cases coded as Very Low Risk for serious complications had a median quantitative risk of 0.015% [IQR 0.009 – 0.1%] with an associated admission rate of 1.89% [CI 0 – 5.7%]. Those coded as Low, Moderate, High, and Very High Risk had values of 0.25% [IQR 0.09 – 1.0%], 1% [IQR 0.49 – 2%], 1.68% [IQR 1 – 4%], and 5% [IQR 1.0 – 10%] respectively, with admission rates of 42.3% [CI 33.7 – 50.9%), 92.4% [CI 88.4 – 96.4%], 99.3% [CI 98.1 – 100%], and 100% [CI 92.1 – 100%] respectively.

Conclusion: This is the first study to determine the quantitative meaning of the common terms Very Low, Low, Moderate, High, and Very High Risk with respect to chest pain scenarios. High rates of admission are seen for patients assessed as Moderate, High, and Very High risk. Quantitative risk assessments were similar when physicians were asked to assess the risk of ACS or assess the risk of serious complications despite epidemiologic evidence that these should markedly differ. This finding merits further study.

185 Asymptomatic Bacteriuria: Is the Presence of Microscopic Bacteriuria Without Pyuria in Asymptomatic Pregnant Females Associated With Positive Urine Culture? A Retrospective Cross-Sectional Study
Hite D, Cashin B, Crouch R, Strode C/Madigan Army Medical Center, Tacoma, WA

Study Objectives: Urine samples are frequently collected from pregnant females in the acute care setting during triage, or as part of initial workup, regardless of the presence of symptoms consistent with urinary tract infection. Asymptomatic culture-proven bacteriuria in pregnant females is typically treated with antibiotics due to concern for risks to the pregnancy and the development of pyelonephritis. In the acute care setting, it is common practice to treat patients with abnormal urinalysis results, as patient follow-up for culture results may be problematic. While the sensitivity and specificity of the various components of microscopic urinalysis have been well described, there is a paucity of literature comparing culture results of abnormal urinalyses to normal urinalyses in asymptomatic pregnant females. Our objective was to determine if there is a significant difference in positive culture results in pregnant patients whose urinalysis is positive only for microscopic bacteria, as compared to those with normal urinalysis.

Methods: A retrospective cross-sectional study was performed on pregnant females who presented as outpatients to a military treatment facility (MTF), and had both a urinalysis and urine culture performed. Pregnant females aged 18–50 were included who denied symptoms of urinary tract infection. Exclusion criteria included symptoms of urinary tract infection, urinalysis positive for markers other than bacteria, or incomplete information regarding symptoms, urinalysis or culture results. The study variables included positive or negative microscopic bacteria on urinalysis, and positive or negative urine culture. The data was summarized by comparing proportions with 95% confidence interval for positive culture results in both groups.

Results: All pregnant females who presented to an MTF in 2008–February 2009, and had a urinalysis and urine culture performed, were identified via computer data extraction. A total of 3547 charts were reviewed. 2552 charts were excluded due to incomplete data or exclusion criteria. 995 patients were included; 473 with urinalysis abnormal only for presence of bacteria, and 522 with normal urinalysis. Nine patients with bacteria noted on urinalysis had positive urine cultures; 1.9% (95% confidence interval, .95% to 3.6%). Twelve patients with normal urinalysis had positive urine cultures. 2.2% (95% confidence interval, 1.3% to 4.0%).

Conclusion: There was no significant difference between proportions of positive culture results in the groups evaluated in our study. In this study population, pregnant women without symptoms of urinary tract infection whose urinalysis is positive only for bacteria do not have a significantly greater incidence of bacteriuria as defined by culture results, compared to those with completely negative urinalyses. It may be reasonable to withhold antibiotics from asymptomatic pregnant females whose microscopic urinalysis demonstrates presence of bacteria without other indicators of infection.

186 Tamsulosin Does Not Increase One-Week Rate of Passage of Ureteral Stones in Emergency Department Patients
Lipe KM, Ziadeh J, Bu D, Swor R, Jackson R, Ross M/William Beaumont Hospital, Royal Oak, MI

Study Objective: Our objective was to determine if tamsulosin monotherapy improves rates of ureteral stone passage at one week or time to pain resolution, compared to placebo.

Methods: We conducted a prospective, double-blind, randomized, trial of Tamsulosin compared to placebo in the treatment of ureterolithiasis, with a primary outcome of proportion of stones passed at 7 days. Emergency department (ED) patients who presented with documented kidney stone by Helical CT between April 2007 and February 2009 were considered for inclusion. Patients received standard analgesia and either tamsulosin or placebo for a total of 10 days. A structured telephone survey was conducted at days 2, 3, 5, 7, and 10 to assess for stone passage and pain scores. Exclusion criteria included stone > 8mm, patients who required immediate surgical intervention, concurrent infection, and presence of ureteral stent. Our power analysis, based on previous reports, assumed a one-week passage rate with tamsulosin of 85% and placebo of 60%. Based on an alpha error of 0.05 and power of 80%, we needed 57 subjects per group. Chi square and Fisher’s exact test were used for analysis.

Results: 127 patients were enrolled over a 22-month period; 15 were lost to follow-up and 12 required a surgical intervention before 7 days, leaving 100 patients for analysis. Of these, 47 received placebo and 53 received tamsulosin. Groups were similar for age, sex, initial serum creatinine, initial pain score on ED presentation, location of stone, proportion of stone < 6 mm, history of prior stone or stent, and degree of hydronephrosis. There was no difference in pain medication usage between the two groups at days 2, 3, and 7. The percentage of patients who had stone passage