

**Urgent Caring  
August 2021  
Volume 5 Issue 4**

**FROM THE COLLEGE OF URGENT CARE MEDICINE (CUCM®)**

**PRESIDENT OF THE CUCM BOARD OF DIRECTORS—JASMEET BHOGAL, MD**



**Stay Strong**

There is a palpable stress amongst healthcare personnel. Summertime, which is typically a time of recovery and lower patient volumes for urgent care centers, has been that of high volumes for 2020 and 2021. After the wave that started to show some retraction a few months back, we are now seeing a resurgence that took many of us by surprise as the vaccine became more readily available. Healthcare personnel were just starting to feel some relief but it was short-lived. Over the last couple of weeks, I have seen many urgent care providers post messages on social media that are reflective of signs of burnout and morale injury. Many urgent care providers are either decreasing their clinical hours or completely leaving clinical care because of burnout.

The issue of staff morale is further compounded by the shortages we are all experiencing with our non-provider staff. In recent discussions with some of our colleagues from urgent care centers from different parts of the country, all have expressed concerns regarding shortage of medical assistants and radiology technicians. Call outs from symptomatic staff workers is also something that might further stretch our teams.

Coverage of this year's Olympics included substantial discussion on the importance of protecting and preserving one's mental health. The athletes are under tremendous pressure—and so are we. Our teams are working diligently to provide the best possible care to our patients when they themselves are tired and burnt out. Many of us are going through this personally as well. Please take time to talk to your team members individually to ask them how they are doing. Simply listening to their concerns might go a long way in helping them understand that we are all there for them in these tough times. Sometimes, listening and acknowledging the concerns of our team members is the most important step we can take to help with their overall morale and mental health. Stay strong.

**EDITOR'S CORNER: SEAN MCNEELEY, MD, FCUCM**

## **AFTER A BRIEF HIATUS WE ARE BACK**



Well, we are back. After a short delay Urgent Caring is back and even better than before. We are now featuring a new format allowing us to reach more providers and an updated look and feel. Thanks to Laurel Stoimenoff and the rest of our CUCM team for the upgrade. While we have been busy fighting the delta variant the team took the time to prepare this upgrade. Tell us what you think. Let us know how we can upgrade and we will give it a try. Don't forget to get your free CME.

All of us within the College are saddened by the cancellation of our 2021 Convention but we are appreciative to the boards for making the tough decision to wait until spring. We will definitely miss seeing all of you until then. Stay safe and we will be back next month.

Contact Dr. McNeeley at [sean.mcneeley@uhhospitals.org](mailto:sean.mcneeley@uhhospitals.org)

## **THE COLLEGE AT WORK: CUCM FORMS A TASK FORCE TO FOCUS ON ADVANCING THE SPECIALTY OF URGENT CARE MEDICINE**

### **JOE TOSCANO, MD, FCUCM, UC SPECIALTY TASK FORCE CHAIR**



Long discussed has been the issue of whether Urgent Care will ever be a "true specialty" in the house of medicine. Training programs have evolved and changed, but none have been ACCME-approved. Board exams exist, one within ABPS but none within ABMS. In spite of this, UC is firmly entrenched in the healthcare landscape, delivering care for countless millions of patients for many years, and now crucial care during the ongoing pandemic. There is, however, a rising concern among clinicians and operators in the urgent care community. That concern revolves around the gradual decrease in the scope of services offered in many urgent care centers. Flat-rate reimbursement favors quicker, less complicated visits. The increased demand for clinicians leads to the necessary hiring of those less trained or experienced with procedures or evaluating patients with chest pain or head injury, for example. Whether these trends will continue and where they might lead is uncertain, but there is now a call to explore the situation, understand the forces at work, and develop a strategy to preserve and advance the practice of urgent care medicine. UCA and CUCM have formed a Task Force for this express purpose.

Look for updates from the Task Force as things develop. We will need EVERYONE'S help. Advocate for the recognition of the importance of your and your colleagues' practice. Participate in ongoing education to hone and advance your knowledge and skills. Practice evidence-based urgent care medicine. Treat patients as if you are a specialist, because you are.

If you have suggestions, please email Laurel Stoimenoff at [lstoimenoff@ucaoa.org](mailto:lstoimenoff@ucaoa.org)

## CLINICAL CONSIDERATIONS

### PAROTITIS AS A PRESENTING SYMPTOM OF COVID-19 INFECTION

#### TRACEY QUAIL DAVIDOFF, MD, FCUCM



A 66-year-old female presented to urgent care with her spouse requesting testing for COVID-19 infection. The patient had been exposed to a co-worker 3-4 days earlier who had been diagnosed with the infection. Although previously vaccinated for COVID-19, the patient had awoken that morning with mild sore throat and nasal congestion and wanted to be sure she had not developed infection. She was informed at the front desk that due to the recent surge in infections there would be a three to four hours wait to be seen. She was put on the waiting list and was told to wait in her car until she was called in to be seen. While she was waiting, she and her spouse became hungry, and went to a nearby restaurant for food. While eating, she developed painful swelling of the right cheek, just in front of the ear and over the angle of the mandible.

Upon arrival to the urgent care, the patient was afebrile, and had normal vitals including oxygen saturation. She was non-ill appearing and without dyspnea. She had no other COVID-19 related symptoms except sore throat and nasal congestion. She had obvious swelling to the right side of her face. There was no redness or warmth to the touch. Tenderness was minimal. The swelling was well demarcated with no fluctuance or palpable mass. The external ear, ear canal, and tympanic membrane were normal on the affected side. The oral cavity and pharynx were normal. Stenson's duct was not palpable, and there was no stone appreciated. There was no submandibular swelling and no anterior or posterior cervical lymphadenopathy. Her lungs were clear. The remainder of the physical exam was normal. She had no significant past medical history. The patient had reported that she had received all of her childhood immunizations, as far as she knew.

A rapid COVID-19 antigen test was positive for COVID-19 infection. The patient was diagnosed with parotitis due to COVID-19. She was told to apply warm compresses and take ibuprofen as needed for pain. She was to isolate for 10 days. She was to return or contact an otolaryngologist if she developed redness, worsening swelling or pain, or if symptoms had not begun to improve in a few days. Due to her age, she was referred for monoclonal antibody treatment but refused for unknown reasons.

Sialadenitis is the swelling of salivary glands. It can be single or multiple, acute or chronic. The parotid gland is one of many salivary glands. Swelling of this gland is

more specifically called parotitis. Acute parotitis is defined as the sudden enlargement of the parotid gland which may be due to obstructive, infectious, or inflammatory disorders.

The most classic cause of infectious parotitis is mumps. Prior to the development of vaccination, it was also the most common. Other viruses may also cause acute parotitis, most notably EBV, parvovirus B19, HIV, lymphocytic choriomeningitis virus, and an emerging pathogen, COVID-19. Viral infiltration causes enlargement of the gland which blocks Stenson's duct. This causes saliva retention and inflammation of the gland. Sjogren's syndrome and sarcoidosis may also cause acute parotid swelling. Bacterial infections may cause suppurative sialadenitis with pus exuding from Stenson's duct. Salivary duct stones may be palpable inside the mouth along the duct or at the opening. Other differential diagnoses include facial cellulitis and tumor.

Most cases of parotitis may be diagnosed clinically. If the diagnosis is in questions an ultrasound, CT, or MRI may be performed. Viral infectious agents may be diagnosed by RT-PCR, but this is rarely necessary.

Treatment of presumed viral parotitis is mainly supportive including analgesia, warm compresses, and treatment of the underlying infection, if indicated. Isolation for contagious infections is also recommended.

Parotitis due to COVID-19 has been described in several articles in the literature with about 25 reported cases. Patients present with unilateral swelling of a parotid gland in association with typical COVID-19 symptoms. Patients vary between male and female and vary in ages from 13-73. Parotid swelling occurs most commonly on day 1 of symptomatic COVID-19 infection but may occur several days after symptom onset. Parotid swelling may last 1-6 days. In all cases the parotid swelling resolved spontaneously without complications.

In the face of a COVID-19 pandemic, providers need to recognize that parotitis may be a presenting symptom of COVID-19, and test, treat, and isolate accordingly.

#### References:

Walls RM, Hockberger RS, et. al. Rosen's Emergency Medicine, 9th ed. Elsevier 2018, pp. 828, 1598.

Lechien JR, Chetrit A, et. al. Parotitis-like symptoms associated with COVID-19 France, March-April 2020. Emer Infect Dis. 2020 Sept; 26(9): 2270-71.

Riad A, Kasseem I, et. al. Acute Parotitis as presentation of COVID-19. Oral Dis. Published online 25 July 2020. <https://doi.org/10.1111/odi.13571>.

Fischer J, Motette D, et. al. COVID-19 associated parotitis. Am Jour Emer Med. 39: Jan 2021; 254.

[https://www.uptodate.com/contents/salivary-gland-swelling-evaluation-and-diagnostic-approach?search=viral%20parotitis&source=search\\_result&selectedTitle=1~150&usage\\_type=default&display\\_rank=1](https://www.uptodate.com/contents/salivary-gland-swelling-evaluation-and-diagnostic-approach?search=viral%20parotitis&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1)

## **PEARLS FROM A PRACTICING PEDIATRICIAN—“SPORTS PHYSICALS IN THE ERA OF COVID-19—WHAT YOU NEED TO KNOW”**

**THOMAS W. TRYON, MD, MBA, FAAP; FCUCM**  
**UCA Pediatric Section Chair, Secretary of the Board of Directors**

School is starting, fall sports are back in action, and on top of everything else in the business of urgent care with increased volumes of sick patients, COVID testing, COVID vaccinations and the potential for new COVID therapies on the horizon, this is also a time when many urgent care centers are deluged with sports physicals for school-aged athletes. Parents, coaches and athletes will all have a lot of questions about COVID and the impact of this disease on their participation.



Fortunately, there are a number of really good references available to provide information and guidance for providers, parents, coaches and students. First, the American Academy of Pediatrics (AAP) on August 2, 2021 released a new resource titled “COVID-19 Interim Guidance – Return to Sports and Physical Activity”<sup>1</sup>. According to the AAP: “Approximately 35 to 45 million youth 6 to 18 years of age participate in some form of athletics. The COVID-19 pandemic has affected many aspects of the lives of children and families, including youth sport activity. As children present for health supervision visits and preparticipation physical evaluations, parents and athletes likely will ask questions about how best to ensure safety when considering a return to sports participation and physical activity. This guidance is intended for pediatricians to inform families on how to mitigate risk and prevent the spread of severe acute respiratory syndrome-coronavirus 2 (SARS-CoV-2), the virus that causes COVID-19, to others within sports and other physical activities.” The AAP also recommends that all healthcare providers be aware of local and state regulations in each individual area.

During the pre-participation physical all providers are encouraged to inquire about any known COVID-19 infections both past and present as well as the vaccination status of eligible adolescent patients. The AAP recommends that all people who are eligible should receive the COVID-19 vaccine. All of this should be documented in the patient’s chart. If the athlete is fully vaccinated, they should still continue to follow CDC transmission mitigation advice.

What about transmissibility or infectivity of children and adolescents ill with COVID-19? According to the AAP: “The preponderance of evidence indicates that children and adolescents are less likely than adults to be symptomatic or have severe disease resulting from SARS-CoV-2 infection. It appears that children younger than 10 years are less likely to become infected and less likely to spread infection to others, although further studies are needed. Data suggest adolescents may spread SARS-CoV-2 as efficiently as adults.”

Of interest, the sports that seem to be the highest risk for transmission among adolescents are indoor sports and include basketball, ice hockey and wrestling. For outdoor activities such as football or rugby, most transmission occurs away from the field of practice or play and is around team meals, transportation, or other indoor close quarters exposures. However, the AAP currently does not recommend testing of all athletes before participation in sports and instead recommends testing for any symptomatic athlete or any athlete in close contact with a known current or recently infected individual.

The Interim Guidance also provides advice on when face masks should be worn, how families can mitigate risks if they are traveling to away games with their child, and modifications and strategies to reduce risk for the participating athletes.

What should a family do if a family member or athlete develops signs of symptoms of COVID-19? According to the AAP "All parents/guardians need to report if the athlete or any household contact is exhibiting any signs or symptoms of COVID-19 or tests positive for SARS-CoV-2, even if asymptomatic. These athletes should be held out of ALL practices and games until the CDC-recommended isolation or quarantine period has expired. If the test result for SARS-CoV-2 is positive, team officials and the health department should be notified so contact tracing and appropriate quarantining can be performed. The local health department can assist in determining when it is safe for athletes and exposed contacts to return to practice, and guidelines from the CDC should be followed to determine clearance."

Additionally, the AAP recommends that all children under 12 years of age can return to play based on their individual exercise tolerance level. However, for children 12 years of age and older, they recommend a seven-day graduated return to play guideline with consideration being given to extending that seven-day period for athletes who had a moderate illness (defined as four days or longer of a fever of 100.4 or greater, one week or more of myalgias, chills, or lethargy or a non-ICU hospital stay with no concerns for the MIS-C complication seen in children and adolescents).

What about cardiac concerns for children and adolescents who have had or currently have a COVID-19 infection? Fortunately, the latest evidence is that the incidence of myocarditis in children and adolescents is less than previously though with the risk between 0.5% and 3%. However, of concern is that the majority of children with myocarditis initially presented either asymptomatic or mildly symptomatic with COVID symptoms. Thus, screening for any history of syncope, chest pain, respiratory symptoms out of proportion to a typical URI should result in additional screening and examination, including consideration of obtaining an ECG.

The American Academy of Cardiology has also provided updated and revised recommendations as of March, 2021. According to the article on "COVID-19 and the Athlete" published in the Journal of the American Academy of Cardiology "Major updates to the first algorithm were: 1) Return to play (RTP) recommendations for high school aged athletes; 2) RTP recommendations for master-level (i.e., post-collegiate) athletes; 3) suggested reduction of self-isolation period from 14 to 10 days, in

keeping with updated Center for Disease Control (CDC) guidelines; 4) discussion of pitfalls of over-interpretation of myocardial injury and myocarditis by cardiac magnetic resonance imaging (CMR) in athletes; and 5) deemphasis of cardiovascular testing in those with mild or no symptoms. As cardiovascular screening protocols are focused on asymptomatic, mildly asymptomatic, and less commonly, moderately symptomatic competitive athletes seeking to RTP, an adapted algorithm from the most recent recommendations was provided.”<sup>2</sup>

As you provide sports physicals for athletes participating in organized sports this fall, the Centers for Disease Control and local health department officials can also be a great resource to you in your practice. Information from the Centers for Disease Control that is specific to athletes can be obtained at: <https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/youth-sports.html>.

1 <https://www.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/clinical-guidance/covid-19-interim-guidance-return-to-sports/>

2 <https://www.jacc.org/doi/pdf/10.1016/j.jacc.2021.02.002>



SARAH KIDD, MD

## **ACUTE FLACCID MYELITIS: TIPS FOR RECOGNIZING THE SIGNS AND SYMPTOMS IN THE URGENT CARE SETTING**

**Sarah Kidd MD (1), Alexandra Hess PhD (1,2), Janell Routh MD (1)**

Author affiliation: **(1)** Division of Viral Diseases, National Center for Immunization and Respiratory Diseases, Centers for Disease Control and Prevention; **(2)** Webber Shandwick

Acute flaccid myelitis (AFM) is an uncommon but serious neurologic condition that can cause limb weakness and paralysis. Multiple viruses, such as West Nile virus, adenovirus, and certain enteroviruses, are known to cause AFM in a small percentage of persons who are infected. Specific pathogens are rarely identified in the cerebrospinal fluid (CSF) of AFM patients, but recent research suggests that enterovirus D68 (EV-D68) is likely a primary driver of the recent increases in cases reported in the United States (US). Since first reported in 2014, US AFM cases have peaked during the late summer and early fall in a biennial pattern (in 2014, 2016, and 2018), with fewer cases reported during 2015, 2017, and 2019. Based on this pattern, another increase in AFM was expected in 2020. However, cases remained low in 2020, and it is uncertain when the next increase in AFM should be expected.

AFM is characterized by the sudden onset of flaccid limb weakness resulting from lesions in the gray matter of the spinal cord that can be identified on magnetic resonance imaging (MRI). Weakness can progress rapidly within hours to a few days and lead to the life-threatening complication of respiratory failure. It is important to recognize the signs and symptoms of AFM and immediately admit patients with suspected AFM to the hospital for monitoring, further evaluation, and consultation with neurology and infectious disease specialists.

Most AFM cases occur in previously healthy children, with a median age of 5–9 years depending on the year (patients tend to be younger during peak years than in non-peak years). Many AFM patients have a preceding viral illness during the 1–2 weeks before the onset of limb weakness; fever and respiratory symptoms are most common, but gastrointestinal symptoms or rash may also precede weakness. Many patients also report stiff neck, headache, neck or back pain, or pain in the affected limb(s) along with weakness or just prior to the onset of weakness. The weakness associated with AFM can be in one or more limbs, can be asymmetric, and often affects the larger, proximal muscle groups more than the smaller, distal muscles. Typically, the weakness is accompanied by decreased muscle tone and decreased reflexes in the affected limb(s). Although less common, cranial nerve abnormalities and sensory deficits may also be present.

A careful history and neurologic exam are critical for the evaluation of flaccid limb weakness. In addition to gathering information about the current signs and symptoms, also ask about any history of symptoms of viral illness in the past 4 weeks. When limb weakness is suspected, it is important to examine and document strength in both proximal muscle groups and distal muscles (typically assessed on a 5-point scale with 5 = full strength; 4 = decreased strength but can move against gravity and some resistance; 3 = can move against gravity, but not against additional resistance; 2 = can move if gravity is eliminated; 1 = trace movement; or 0 = no movement at all). Muscle tone (low, normal, or increased) and reflexes (normal, increased/hyperactive, decreased/hypoactive, or absent) should also be examined and documented. Cranial nerve and sensory exams should also be performed but are often normal in patients with AFM.

Young children may not present with a chief complaint of limb weakness. Instead, parents may describe refusal to use a limb or apparent limb pain. Parents may notice that a child is not using one or more limbs or not able to do things that he/she was previously able to do (put on/take off a T-shirt, get in and out of bathtub unassisted, roll over or sit up in bed). When evaluating young children with limb complaints, it can be helpful to ask parents if the child is using one limb less than usual, or if they are falling down or tripping more than usual. To evaluate proximal strength in the neck and shoulder girdle, ask the child to tilt their head side to side, lift both arms above the head, and do a strong high-five with each arm. To evaluate hip and trunk strength, observe how the child walks. Are they limping or dragging one leg? Can they squat down and stand back up? Can they bend over at the waist to touch their toes? Any new difficulty performing these activities should be investigated further.

Clinicians should suspect AFM in any child with limb weakness, especially during the late summer or early fall, and especially in patients with a recent viral illness. Patients with suspected AFM should immediately be referred to the emergency room and admitted to the hospital for further evaluation and monitoring for signs of respiratory compromise.

References and resources

- AFM Clinical Presentation for Clinicians | CDC
- Initial Evaluation and Diagnostic Studies for AFM | CDC
- Head Shoulders Knees & Toes (cdc.gov)
- AFM Cases and Outbreaks | CDC

**BEST PRACTICES**

**Management of Asymptomatic Elevated Blood Pressure**

Date Reviewed	7/31/2021
Subject	Management of Asymptomatic High Blood pressure readings
Patient Population	Pregnant patients of any age and Adults ( $\geq 18$ years old)
Rationale	The disease of hypertension (HTN) is diagnosed by sustained elevated blood pressure and results in significant morbidity and mortality long-term. HTN is common and important to recognize and treat. Not all elevated blood pressure readings, however, indicate the disease of HTN and, in the overwhelming majority of cases, acute treatment or emergency department (ED) referral is not required. Most patients can be followed up over time in a nonacute setting, to confirm the diagnosis and start treatment if needed. Appropriate urgent care clinician interpretation and response to elevated blood pressure readings will lead to increased recognition of the disease of HTN, while decreasing unnecessary ED referrals.
Introduction	<p>Blood pressure elevated above normal levels is commonly seen in urgent care, in patients with known HTN and those without the diagnosis. A reliable and accurate diagnosis of HTN requires elevated blood pressure readings on several occasions, in most cases over several days, and incorporating blood pressure readings when patients are outside of medical settings is now emphasized.</p> <p>Expert guidelines outline an approach to patients with high blood pressure readings that is safe and improves the accuracy of diagnosis of the disease of HTN. Such</p>

	<p>an approach is suitable to urgent care medicine situations.</p>
<p>Evidence-based guideline with strength of evidence</p>	<p>Patient with elevated blood pressure and symptoms that could represent an acute end-organ effect (acute coronary syndrome, acute congestive heart failure, vascular dissection, acute stroke syndrome, pre-eclampsia/eclampsia, etc.) should be promptly and safely transferred to a medical setting where this can be evaluated and treated. Many times, these symptoms of end-organ changes should prompt similar transfer, regardless of blood pressure readings at the time. Front office and all clinical staff should be educated about early recognition of such symptoms.</p> <p>Staff who are responsible for taking patient vital signs should be educated regarding the appropriate technique for acquiring blood pressure readings.<sup>2</sup></p> <p>Initially elevated readings may be repeated once or twice, again emphasizing proper technique.</p> <p><b>For pregnant patients of any age</b>, a BP <math>\geq</math> 160 systolic OR <math>\geq</math> 110 diastolic on one occasion or BP <math>\geq</math> 140 systolic OR <math>\geq</math> 90 diastolic on 2 occasions at least 4 hours apart in a woman after 20 weeks EGA should raise suspicion and trigger testing for preeclampsia (or referral for same), even in an asymptomatic patient.</p> <p><b>For nonpregnant adults (age 18 years and older)</b>, the following strategies are recommended for blood pressures in specific ranges:</p> <p>&lt;130/85 (i.e., "normal"). Remeasure within 3 years (1 year in those with other cardiac risk factors).</p> <p>130–159/85–99. Refer for primary care follow-up within a few weeks. If possible, obtain and record several out-of-office (e.g., pharmacy or home monitor) blood pressure measurements during that time.</p> <p>&gt;160/100. Refer for primary care follow-up within a few days to a week. If possible, obtain and record several out-of-office (e.g., pharmacy or home monitor) blood pressure measurements during that time.</p> <p><math>\geq</math>180/110. It is reasonable to make a diagnosis of HTN in a single visit if there is evidence of cardiovascular disease (asymptomatic) already apparent and begin</p>

	<p>treatment or the patient may be referred to primary care promptly. Consideration may be given to checking serum creatinine.</p> <p>Practices which and clinicians who are interested in diagnosing and treating HTN should be familiar with resources and guidelines and consider a standardized protocol.<sup>1, 2, 5</sup></p>
Discussion	<p>When elevated blood pressure readings are found in nonpregnant patients in urgent care, the patient should be risk-stratified based on the level of blood pressure elevation and accordingly referred for follow-up. Immediate referral is not necessary unless symptoms of acute end-organ effects (as above) are present. In most cases, such symptoms require prompt treatment and referral regardless of blood pressure. Pregnant patients require different decision-making. Determining next steps for all other patients is non-emergent. Confirmation of elevated readings is typically sought prior to beginning medications. Healthy lifestyle measures may be recommended for all patients.</p>
Summary	<p>Guidelines from several organizations endorse a measured approach to diagnosing and treating HTN. Elevated blood pressure readings once or even multiple times in one day, in nonpregnant patients, does not require immediate intervention in asymptomatic patients. Such elevations should, however, generate recommendations for repeating measurements outside of medical settings and reviewing values with a primary care or other clinician with expertise in treating HTN. The timing of such follow-up should be based on the initial level of blood pressure elevation.</p>
References	<ol style="list-style-type: none"> <li>1. USPSTF. Screening for Hypertension in Adults. US Preventive Services Task For Reaffirmation Recommendation Statement. <i>JAMA</i>. 2021;325(16):1650-1656. doi:10.1001/jama.2021.4987.</li> <li>2. Unger T, et al. 2020 International Society of Hypertension Global Hypertension Practice Guidelines. <i>Hypertension</i>. 2020;75:1334-1357. doi:10.1161/hypertensionAHA.120.15026</li> <li>3. Gestational Hypertension and Preeclampsia. ACOG Practice Bulletin, Number 222 Obstet Gynecol. 2020 Jun;135(6):e237-e260. DOI: 10.1097/AOG.0000000000003891</li> </ol>

	<p>4. Wolf SJ, et al. Clinical Policy: Critical Issues in the Evaluation and Management of Adult Patients in the Emergency Department With Asymptomatic Elevated Blood Pressure. <i>Ann Emerg Med.</i> 2013;62:59-68. <a href="http://dx.doi.org/10.1016/j.annemergmed.2013.05.012">http://dx.doi.org/10.1016/j.annemergmed.2013.05.012</a></p> <p>5. Iacovo JM, Cohen B, Butler JM. Implementing clinical practice guidelines in adults with hypertension: an effective practice change in urgent care. <i>J Urgent Care Med.</i> 2021;15(6);25-32.</p>
Reviewers	Tracey Davidoff, MD, FCUCM
Attachments (flow charts, graphics, tables, etc.)	NA

## URGENT UPDATES [U<sup>2</sup> LOGO HERE]

### **RANDOMIZED TRIAL OF IV METOCLOPRAMIDE VS IV KETOROLAC IN TREATMENT OF ACUTE PRIMARY HEADACHES**

A large variety of treatment options are available for acute primary headaches. This double-blind, randomized clinical trial study, we demonstrated that IV metoclopramide provided more headache relief but not statistically significant than IV ketorolac in adults patients presented to an ED with acute primary headache. **Full Access:** [Journal of Emergency Medicine](#)

### **USE OF INVOLUNTARY EMERGENCY TREATMENT BY PHYSICIANS AND LAW ENFORCEMENT FOR PERSONS WITH HIGH-RISK DRUG USE OR ALCOHOL DEPENDENCE**

In this cohort study, we compared the number of public court records of 213 that underwent temporary involuntary commitment secondary to substance use under Section 35 of the Massachusetts General Law. The high proportion of individuals with comorbid mental health diagnoses seen in this cohort suggests that optimal treatment should involve immersive, dual-diagnosis treatment. The findings suggest the need to further explore a multidisciplinary approach to caring for individuals with substance use disorders. Full Access: [JAMA](#)

### **CONVALESCENT PLASMA DIDN'T HELP HIGH-RISK COVID PATIENTS: NIH**

NIH new release that a clinical showed convalescent plasma did not stop the progression of COVID-19 in high-risk patients when given during the first few weeks of their symptoms. Of the 511 people in the study, the disease progressed in 77 (30%) in the COVID-19 plasma group compared with 81 patients (31.9%) in the placebo group. This finding suggests that more effective treatments against this devastating disease should be explored. **Full Access:** [Medscape](#)

## **HOW TO PICK THE BEST FACE MASKS FOR KIDS, ACCORDING TO THE EXPERTS**

The Centers for Disease Control and Prevention (CDC) and the American Academy of Pediatrics recommend masks for kids going back to school. This article provides guidance on selecting masks for kids including 1) N95s are not made to fit kids. They do not come in kid sizes 2) Any masks that gapes around the edges isn't going to work well, no matter how well it filters. Parents need to consider the attributes masks in this order of priority: Comfort: "If your kid won't wear it, it's not helping at all". Fit: "Leaks around the sides are like having a hole in your mask and aerosols carrying the virus can get right through". Filtration: How well the mask blocks small particles. KF94 or KN95 masks, which are being manufactured in China and Korea, are good choices. They offer nearly the same degree of filtration as an N95, and they fit closely to the face, to minimize leaks. **Full Access:** [Medscape](#)

## **JOINT STATEMENT FROM HHS PUBLIC HEALTH AND MEDICAL EXPERTS ON COVID-19 BOOSTER SHOTS**

Based on latest assessments, the current protection against severe disease, hospitalization, and death could diminish in the months ahead, especially among those who are at higher risk or were vaccinated during the earlier phases of the vaccination rollout. For that reason, experts suggest that a booster shot will be needed for American people to maximize vaccine-induced protection and prolong its durability. **Full Access:** [CDC](#)

## **ANNOUNCEMENTS**

### **FROM THE CDC: CAN WE GET A FOLLOW? CDC ADDS NEW TWITTER ANTIMICROBIAL RESISTANCE HANDLE**

CDC's Antibiotic Resistance Coordination and Strategy Unit (ARX) just launched a new Twitter handle, @CDC\_AR, to engage partners, policymakers, and the public on antibiotic resistance in the United States and around the world.

Follow us today to stay up to date on what CDC's doing to combat antibiotic resistance—including new resources, publications, and activities. Please share or like our content, tag @CDC\_AR, and be sure to tell your friends. We look forward to seeing you there!

## **Quiz Questions—Test Your Knowledge**

**Quiz questions no longer need to be submitted to attain CME (instructions provided below on how to do so).**

**Answers will be provided in next month's Urgent Caring.**

1. Regarding COVID-19 and pre-participation physicals (sports physicals) for adolescent athletes, the American Academy of Pediatrics recommends each of the following EXCEPT:
  - a. Asking about either past or present COVID-19 infection
  - b. Asking about COVID-19 vaccination status
  - c. Encouraging COVID-19 vaccination IF the patient has not been vaccinated and qualifies for vaccination
  - d. Recommending that athletes no longer follow CDC transmission mitigation advice once fully vaccinated
  
2. The most common cause of parotitis is?
  - a. Stone formation
  - b. Mumps
  - c. Bacterial infection
  - d. Gum chewing
  
3. When evaluating young children for possible AFM, which of the following are important?
  - a. Proximal limb strength evaluation
  - b. Muscle tone and reflexes evaluation and documentation
  - c. Detailed history, including illness in the past 4 weeks, noting fever, respiratory, rash, or gastrointestinal symptoms
  - d. All of the above

### **CME Answers from the Prior Edition of Urgent Caring**

1. Where is masking still considered unnecessary for fully vaccinated individuals:
  - a. **Restaurants on the inside**
  - b. Were required by federal law
  - c. Where required by tribal law
  - d. Where ill patients are present
  
2. Select the correct statement:
  - a. Resistance is not a side effect of prolonged antibiotic use.
  - b. Antibiotic-inappropriate prescribing for respiratory diagnoses was lowest in urgent care centers in comparison to other ambulatory settings.
  - c. Clinicians should prescribe antibiotics for a minimum of 10 days for Community Acquired Pneumonia.

d. For non-purulent cellulitis, clinicians should prescribe a 5- to 6-day course for patients able to self-monitor and who have close follow-up with primary care

3. How did last year's influenza season compare to previous

a. Very similar to the last three years

b. Much worse in morbidity and mortality from influenza

c. Very light compared to last 10 years

d. Influenza tracking was not performed due to the pandemic

4. Red flag vital signs are important because:

a. Insurance expects us to define them

b. Providers should be made aware of their presence immediately.

c. Medicare defines them for their patient population

d. There is no such term in the sample policy

## **CONTINUING MEDICAL EDUCATION (CME)**

### **Target Audience**

This CME activity is intended for medical professionals who practice medicine in the on-demand space including urgent care, retail medicine and other similar venues. These providers may include physicians, nurse practitioners, and physician assistants.

### **Designation Statement**

The Urgent Care Association (UCA) designates this enduring material activity for a maximum of 1 AMA PRA Category 1 Credit(s)™. Physicians should claim credits only commensurate with the extent of their participation in the activity. Credits may be claimed for one year from the date of release of this issue.

### **CME Objectives**

1. Provide updates on the diagnosis and treatment of clinical conditions commonly managed by on-demand providers

2. Alert on-demand providers to potential unusual cases that may present to them

3. Utilize tips and tricks to improve patient care in the on-demand space

### **Accreditation Statement**

This activity has been planned and implemented in accordance with the accreditation requirement and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the Urgent Care Association and the College of Urgent Care Medicine. UCA is accredited by the ACCME to provide continuing medical education for physicians.

### **CME Credit Instructions**

Once you have read the article, please log into your UCA profile. Once you are logged in go to Learn-> CME->Request CME. Complete the survey with the requested information for Urgent Caring. Your certificate will then be emailed to you within 3-5 business days. Please email [education@ucaoa.org](mailto:education@ucaoa.org) with questions.

### **CUCM CME Planning Committee**

Jasmeet Bhogal, MD

Reports no financial interest relevant to this newsletter

Tracey Davidoff, MD, FCUCM

Reports no financial interest relevant to this newsletter

Sean M. McNeeley, MD, FCUCM

Reports no financial interest relevant to this newsletter

Joseph Toscano, MD

Reports no financial interest relevant to this newsletter

Authors

Jasmeet Bhogal, MD

Reports no financial interest relevant to this newsletter

Tracey Davidoff, MD, FCUCM

Reports no financial interest relevant to this newsletter

Cesar Mora Jaramillo, MD

Reports no financial interest relevant to this newsletter

Sean M. McNeeley, MD, FCUCM

Reports no financial interest relevant to this newsletter

### **Disclaimer**

Medical practice and knowledge is constantly evolving and changing. This information is peer-reviewed but should not be your only source. Providers of care should use discretion when applying knowledge to any individual patient.