

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



ARE OUR PATIENTS DONE WITH COVID-19? ARE WE GOING BACK TO, "I NEED MY Z-PAK!"

During my recent conversations with some urgent care providers, the topic of antibiotic stewardship took center stage. This was a change from the usual COVID discussions that seem to be the start and the end of all conversations these days. With COVID being the priority for a long time, the biggest questions that patients had was whether they have COVID or not. Almost two years into this pandemic, the conversation about antibiotics seem to be resurfacing again during the provider interactions with patients. Many providers feel that the "I need my Z-Pak for this sinus infection" statement is slowly but surely making its way back into their conversations with patients. Antibiotic stewardship still continues to be an important goal that we in urgent care need to work on.

According to the 2020 CDC report titled "Antibiotic Use in the United States - Progress and Opportunities, 2020 Update"¹, in more than one million urgent care encounters, antibiotics were prescribed during more than one third of encounters. Clinician prescribing for respiratory encounters varied dramatically, ranging from 3% to 94%. Furthermore, when antibiotic selection was compared for pharyngitis, sinusitis and acute otitis media in retail clinics, urgent care centers, emergency departments and offices, first-line antibiotics were prescribed in only 50% of patient visits for these conditions. This data shows the need for our continued focus on antibiotic stewardship, specifically directed towards urgent care.

We need to do a better job of leading the national effort on antibiotic stewardship. The true effort lies in striking a balance between patient expectations and the practice of evidence-based medicine. We need to work together as an urgent care specialty and provide a united front to address this issue. Working in isolation without having a national approach will not help us improve the quality and safety of care for our

¹ <https://www.cdc.gov/antibiotic-use/stewardship-report/current.html>

patients. Developing our own national urgent care database of antibiotic prescribing practices is the first step towards understanding the magnitude of this issue. This is no longer an issue that affects a few practices, it is a national issue, and the approach has to be on the national level as well. Thoughts are welcome.

URGENT CARE CASE STUDY

CASE OF PENILE MASS IN URGENT CARE; WHAT IS THE NEXT STEP?

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Case Presentation

Patient is a 29-year-old Male, who presents to Urgent Care with several months of penile shaft “lump”. He describes the lump as firm cord that might be increasing in size over the past one month. He denies pain but reports mild discomfort. Additionally, patient denies penile discharge or genital lesions. No past medical history of Sexual transmitted diseases and he denies any high-risk sexual behavior.

On physical exam: patient is in no acute distress; vital signs are normal. Abdomen is not distended, non-tender and bowel sounds are present. Penis is circumcised, a small firm – mobile cord is palpated on the midshaft dorsum of the penis. Non tender, no edema, no erythema. No groin lymphadenopathy. No penile discharge or lesions. Testicular exam was normal.

Differential diagnosis

Peyronie’s Disease
Sclerosing lymphangitis
Mondor’s Disease
Penile Carcinoma

Diagnosis

Mondor’s Disease is a rare and self-limiting, benign process. The chest, abdominal wall, penis, upper arm and other parts of the body may also be involved by the disease.

Penile Mondor’s Disease is thrombophlebitis of the superficial dorsal vein of the penis. Although some findings suggest that it might be of lymphatic origin, it may be associated with psychological distress and sexual incompatibility. Early and accurate diagnosis increases efficiency of the medical treatment.

The patient was referred for ultrasound that showed multiple dilated superficial veins along the right side of the penile shaft consistent with superficial varicosities. Several

are incompressible and contains echogenic material consistent with superficial thrombophlebitis.

Pearls for Urgent Care Management

- Patients usually present with the feeling of a hard rope/thick cord.
- Affects sexually active men of any age.
- Causes of the disease include frequent, severe and prolonged sexual intercourse, penile trauma, prolonged abstinence, local (syphilis, candida) or distant infections, sexual transmitted diseases, thrombophilia, among other conditions.
- Sudden and painful or painless cord induration is the commonest presentation.
- Doppler ultrasound is important for diagnosis.
- Laboratory tests are often not necessary.
- Patients usually recover within 4-6 weeks without any treatment.
- Sexual activity should be restricted in addition to the use of anticoagulant agents.
- Anti-inflammatory drugs are commonly prescribed for this condition.
- Referral to urology should be considered for medical treatment that includes creams containing heparin or surgery for refractory cases.
- Prognosis is good. There are no reports of erectile dysfunction or penile deformity after treatment.

References:

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INSIGHTS FROM THE FIELD

Recognizing and De-Escalating Potential Violence in the Urgent Care Center



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Healthcare workplace violence is nothing new. According to the Bureau of Labor Statistics (BLS), from 2011 to 2018, there has been a 64% increase in reported violent episodes in healthcare settings.² Violence against healthcare workers has been recognized nationally, as the Workplace Violence Prevention for Health Care and Social Service Workers Act of 2021 recently passed the U.S. House of Representatives and is now in the Senate³.

Reports of physical violence against healthcare workers in our urgent care centers have increased recently. Whether from the stress of Covid-19, long waits due to healthcare staffing shortages, or a general reduction in respect and authority of our institutions in general, violent incidents have been escalating. This report aims to increase awareness and generate a conversation amongst urgent care leadership and staff on recognizing, preparing, and addressing potential violent episodes from our patients.

Recognizing the Signs of Potential Violence

As leaders in urgent care medicine, our primary responsibility is to keep patients and our staff safe. Giving them tools to recognize potential violence in our patients is an essential tool to achieve this goal. One tool to help healthcare workers recognize potentially dangerous situations developed by The Joint Commission has the acronym STAMP. The risk signs include **S**taring, **T**one and volume of voice, **A**nxiety, **M**umbling, and **P**acing.

Tools such as STAMP can help or staff be prepared and differentiate upset patients from those who pose a risk. Early intervention can bend the arc of violence and result in a safe outcome for both staff and the patient.

Mitigation of Risk from Potential Violence

Patients get angry for any number of reasons. The urgent care staff must be prepared for patients who represent a physical danger. There are steps that urgent care centers can take to help prevent violence before it occurs or mitigate its effects if it does.

² U.S. Bureau of Labor Statistics, Fact Sheet: Workplace Violence in Healthcare, 2018

³ 117th United States Congress. Workplace Violence Prevention for Health Care and Social Service Workers Act (<https://www.congress.gov/bill/117th-congress/house-bill/1195/text?r=1&s=1>). HR 1195. April 19, 2021.

- The exam room documentation area should be close to the door. Review each exam room set up to ensure that the examiner is between the patient and the door, not the other way around.
- If a patient is angry, enter the exam room accompanied by another staff member. Extra staff may be excused once the situation is de-escalated.
- Encourage staff who feel uneasy or frightened to leave the room promptly. The team needs to know that urgent care leadership encourages staff to use their best judgment. A polite excuse such as, "I'll be right back," or "I need to check your chart" if you have time, but if not, just leave.
- Consider a medical cause – Is the patient angry, or is there an underlying medical condition such as alcohol withdrawal, or delirium from medication?⁴
- Never hesitate to call for help – from security or even 911. Unlike an emergency department, most urgent care centers do not have access to chemical or physical restraints for the strength of numbers. Get help when needed.

De-Escalation

Verbal de-escalation of angry or potentially violent patients is a process. While several steps are listed, the literature suggests that the process of de-escalation can be completed in less than five minutes.⁵

- Apologize for the Wait - Delays before seeing the provider often make patients angry, a precursor to violent outbursts. The introduction is the first and best opportunity to connect with the patient. "I'm sorry it took so long, but I'm here for you now," shows empathy and breaks barriers to begin your relationship.
- Stay Calm - Do not take it Personally - Patient outbursts often are directed toward caregivers. These can include insults, racial and ethnic slurs, and ridicule of medical skills. Providers must anticipate behavior and manage it with the same professionalism used to approach any patient with an unexpected medical condition.
- Direct conversation to Feelings - for example, the response to, "I could've died waiting for you," is not to tell the patient they're not dying, but rather a response such as, "I understand, but I'm here now to help. Tell me what's going on".
- Establish a dialogue – de-escalation frequently takes the form of a verbal loop in which the clinician listens to the patient, finds a way to respond that agrees with or validates the patient's position, and then states what he wants the patient to do, e.g., sit down, lower his voice. The loop repeats as a clinician listens to the patient's response.⁶

⁴ Meehan, T., McIntosh, W. & Bergen, H. (2006). Aggressive behavior in the high secure forensic setting: The perceptions of patients. *Journal of Psychiatric and Mental Health Nursing*, 13, 19–25.

⁵ Verbal De-Escalation of the Agitated Patient: consensus statement from the American Association for Emergency Psychiatry De-Escalation Workgroup (http://escholarship.org/uc/uciem_westjem) DOI: 10.5811/westjem.2011.9.6864; 19

⁶ Verbal De-Escalation of the Agitated Patient: consensus statement from the American Association for Emergency Psychiatry De-Escalation Workgroup (http://escholarship.org/uc/uciem_westjem) DOI: 10.5811/westjem.2011.9.6864; p 21

- Begin setting clear limits - this process may seem like a negotiation, but in reality, this conversation reintroduces rules of conduct that will allow the urgent care visit to proceed.

Healthcare workplace violence is a fact. Preparing providers and all clinic employees to recognize the signs of impending violence and decrease risk is the best way to keep our patients and staff safe.

URGENT UPDATES

POTENTIALLY INAPPROPRIATE MEDICATION PRESCRIBING BY NURSE PRACTITIONERS AND PHYSICIANS

Potentially inappropriate medication (PIM) use is a risk factor for hospitalization and mortality. The rate of visits with a PIM prescription from the same provider was measured, the association of an NP provider with lower odds of receiving a PIM refill was more pronounced in older patients and in those with more comorbidities. NPs prescribed fewer initial PIMs and were less likely to refill a PIM after an outpatient visit than physicians. **Full Access:** [Medscape](#)

THE IMPACT OF COMMUNITY MASKING ON COVID-19: A CLUSTER-RANDOMIZED TRIAL IN BANGLADESH

Scientific evidence suggests that face masks can protect against COVID-19. In Bangladesh, researchers and IPA found that a four-part intervention (the "NORM model") tripled mask usage (a 29- percentage-point increase), and increased physical distancing by 5 percentage points. Further, this increase in mask-wearing reduced symptomatic SARS-CoV-2 infections. This was the first large-scale randomized evaluation to demonstrate the effectiveness of masks in a real-world setting. **Full Access:** [IPA](#)

NEW SAFETY DATA REGARDING COVID VACCINES

Parsonage-Turner syndrome has been highlighted as a potential adverse effect of mRNA COVID vaccines in a recent pharmacovigilance monitoring reports from the French National Agency for the Safety of Medicines and Health Products (ANSM). The rare condition is characterized by the sudden onset of severe pain in the shoulder, followed by arm paralysis. Its etiopathogenesis is not well understood, but vaccines, in particular the flu vaccine, have been implicated in some cases. **Full Access:** [Medscape](#)

FDA CLEARS FIRST MOBILE RAPID TEST FOR CONCUSSION

The US Food and Drug Administration (FDA) has cleared SyncThink's Eye-Sync technology to aid in the diagnosis of mild traumatic brain injury. Eye-Sync is a virtual reality eye-tracking platform that provides objective measurements to aid in the assessment of concussion. The technology uses a series of 60-second eye tracking assessments, neurocognitive batteries, symptom inventories, and standardized

patient inventories to identify the type and severity of impairment after concussion. The data study showed that Eye-Sync had sensitivity greater than 82% and specificity greater than 93%. **Full Access:** [Medscape](#)

INFECTIONS AND ANTIBIOTICS DURING FETAL LIFE AND CHILDHOOD AND THEIR RELATIONSHIP TO JUVENILE IDIOPATHIC ARTHRITIS: A PROSPECTIVE COHORT STUDY

It has been shown that use of antibiotics is associated with Juvenile Idiopathic Arthritis (JIA) and Rheumatic Arthritis. Exposure to antibiotics during the periods 1–12 months, 1–3 years and 5–8 years was significantly associated with increased risk for JIA. The odds of developing JIA were three times higher in those exposed to antibiotics during the first 3 years of life compared with those not exposed. The cumulative number of courses of antibiotics was significantly higher during childhood for the individuals who developed JIA. **Full Access:** [Pediatric Rheumatology](#)

ANTIBIOTIC RESISTANCE COSTLY, DEADLY FOR OLDER AMERICANS

In 2017, multidrug-resistant infections led to \$1.9 billion in healthcare costs, 448,224 days in the hospital and 11,852 deaths among older adults in the United States. The greatest burden was associated with infections caused by methicillin-resistant *Staphylococcus aureus* (MRSA), carbapenem-resistant Enterobacteriaceae (CRE) and extended-spectrum beta-lactamase (ESBL)-producing Enterobacteriaceae. Important steps to fight this overwhelming threat includes antibiotic stewardship, antibiotic innovation, surveillance, research, diagnostics, infection prevention, the infectious diseases workforce and global coordination. **Full Access:** [Medscape](#)

EFFECT OF ANTITHROMBOTIC THERAPY ON CLINICAL OUTCOMES IN OUTPATIENTS WITH CLINICALLY STABLE SYMPTOMATIC COVID-19 - THE ACTIV-4B RANDOMIZED CLINICAL TRIAL

This randomized trial of 657 symptomatic outpatients with COVID-19 conducted in the US, showed low event rate among participants. Participants who initiated trial treatment with aspirin (81 mg once daily), apixaban (2.5 mg twice daily), apixaban (5.0 mg twice daily), or placebo, the rates of an adjudicated composite outcome (all-cause mortality, symptomatic venous or arterial thromboembolism, myocardial infarction, stroke, or hospitalization for cardiovascular or pulmonary cause) after 45 days were 0.0%, 0.7%, 1.4%, and 0.0%, respectively; there were no significant differences between the active groups and the placebo group. These data do not support the use of aspirin or apixaban in the outpatient setting to reduce the major adverse cardiovascular or pulmonary consequences associated with symptomatic but clinically stable SARS-CoV-2 infection. Full Access: [JAMA](#)

EMERGENCY DEPARTMENT VISITS FOR BICYCLE-RELATED TRAUMATIC BRAIN INJURIES AMONG CHILDREN AND ADULTS — UNITED STATES, 2009–2018

During 2009-2018, an estimated 596,972 ED visits for bicycle-related TBIs occurred in the US. The rate of ED visits for bicycle related TBIs decreased by approximately one half a month children and adolescents ages <17 years and by 5.5 % among adults during this time. Rates were the highest among adult males and children and adolescents aged 10-14 years. Expanded implementation of comprehensive bicycling safety interventions (e.g., improving compliance with traffic laws, helmet use, and bicycle infrastructure) and targeted interventions might be beneficial. **Full Access:** [CDC](#)

CDC: CHILDREN JUST AS VULNERABLE TO COVID AS ADULTS

Schools without mask requirements were three-and-a-half times more likely to have COVID-19 outbreaks than those enforcing mask mandates, according to new CDC research. The study, which focused on 1,000 schools in Arizona’s Maricopa and Pima counties, found that there were 113 COVID-19 outbreaks in schools without mask requirements in the first month of in-person learning. There were 16 outbreaks in schools with mask requirements. A CDC study published last week found that children had similar infection rates, compared with adults, confirming there is risk to people of all ages. **Full Access:** [WebMD](#)

SAMPLE POLICY—FROM THE CLINICAL RESPONSE TASK FORCE

Red Flags Identification and Intervention Policy for Urgent Care Centers

Policy:

Patients presenting to urgent care with severe illness or injury should be recognized immediately and appropriate intervention should be initiated.

Purpose:

The purpose of this policy is to establish guidelines for the recognition of patients presenting with serious illness or injury that may need immediate medical attention. This policy is to be used in conjunction with the [Abnormal Vital Signs Policy](#).

Scope:

Applicable to all staff members at urgent care centers.

Definitions:

N/A

Responsibilities:

It is the responsibility of the site supervisor as well as the Medical Director to ensure the implementation of this policy at all urgent care sites. The staff responsible for patient intake as well as anyone charged with triaging the patients should be able to recognize the red flags and initiate appropriate steps as outlined below. The provider caring for the patient, in conjunction with the provider's clinical support staff, is responsible for addressing these concerns immediately so that there is no delay in care for such patients.

Exceptions:

None.

Procedure:

1. When reasonable to do so, one room at each urgent care location shall be dedicated to, and kept ready for, emergencies. If this room is already occupied, patients should be taken immediately to another available exam room.
2. Staff members doing the registration/ intake inquire as to the reason for the visit. If the reason for seeking care is any of the following red flag signs or symptoms, the staff member will take the patient back to one of the exam rooms as stated above.
 - a. Patient in obvious distress
 - b. Chest Pain
 - c. Shortness of Breath
 - d. Major trauma
 - e. Active bleeding
 - f. Loss of consciousness, change in speech, altered mental status (in children this may be a change from baseline activity), confusion with or without history of recent head injury
 - g. Trouble breathing, throat closing sensation, severe allergic reaction
 - h. Head injury with patient currently on blood thinners
 - i. New localized weakness
 - j. Severe pain, including severe abdominal pain
 - k. Chemical exposure to the eye
 - l. Toxic ingestion/ potential overdose
 - m. Severe testicular pain or trauma
 - n. Seizure
 - o. Vital signs are outside the following parameters are considered Red Flags:

[NOTE: the parameters below are guidelines. We encourage medical leadership to review and customize to your own setting, as appropriate)

 - i. For Adults:

Temperature	102 degrees F or greater
Respiratory Rate	Greater than 22 per minute or difficulty breathing/distress
Pulse	Less than 50 per minute or greater than 110 per minute
Pulse Oximetry	Less than 94% on room air
Blood Pressure	<p>Systolic less than 90mmHg or greater than 180mmHg, Diastolic less than 60mmHg or greater than 120mmHg, with symptoms of headache, dizziness, lightheadedness, chest pain, shortness of breath, slurred speech, loss of balance, weakness on one side of the body.</p> <p>Pregnancy: Systolic Blood Pressure less than 90mmHg or \geq 140mmHg and/or Diastolic Blood Pressure less than 60mmHg or \geq 90mmHg.</p>

*Reminder: Normal blood pressure for adults is Systolic < 120mmHg and Diastolic <80mmHg.

ii. For Children:

- a) Pulse ox less than 94% room air
 - b) Patient less than 2 months of age with a rectal temperature 100.4 degrees Fahrenheit or greater (temperature can be taken at the urgent care center or the symptom of fever as stated by the care giver)
3. The staff will immediately notify the onsite provider regarding the patient.
 4. The provider will promptly examine the patient and provide care as appropriate.
 5. Documentation:
 - a. Front desk staff will prioritize the registration of such patients and will register and generate a chart for these patients in the EMR. If possible, the Site Manager and the Medical Director will work with the EMR team to develop a process for quickly registering such patients.
 - b. Providers will document their note for this visit.

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 with questions.

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