

FROM THE COLLEGE OF URGENT CARE MEDICINE (CUCM®)

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



Are You Vaccinated Against COVID-19? A Tough Conversation

Talking to patients and our staff regarding the importance of vaccination and addressing their concerns and fears has never been more important than the current times. Yet, it is somehow one of the toughest conversations to have today. With the amount of misinformation and incorrect messaging that is currently being circulated, it is no wonder that only 54.1% of our population has been fully vaccinated as of August 13, 2021 (CDC data). Our clinicians are experiencing challenges to these conversations and often, our emotions are getting the best of us and making us say and do things that can derail our ultimate efforts of getting more people vaccinated.

As clinicians we know that immunity against viruses such as COVID can be achieved via natural means, aka, getting infected, and, by getting the vaccine. The natural method does confer immunity, however, if left by itself, this alone leads to significant suffering and, worst case, death. We are all aware of the flu pandemic of 1918. Yes, we got over that pandemic, however, the cost was 50 million lives worldwide, a staggering one third of the world population at the time, with 675,000 of them in the U.S. With vaccines coming into the picture, immunity against such viruses, including COVID-19, can be achieved while reducing the death and suffering associated with attaining natural immunity. No one *wants* to have a severe illness which can potentially lead to death. With the availability of vaccines, no one should have to make that choice, and this message needs to be delivered clearly to everyone.

In order to deliver this message, we as clinicians have to make sure that prior to having these discussions with staff and patients, we are building trust and creating an environment which is conducive to have such discussions. Shaming the unvaccinated and pointing fingers at them will not help us increase our vaccination rates. Especially, shaming someone who now has COVID and did not get the vaccine is not going to solve any purpose. We have to proactively ask if someone has any questions regarding the vaccine and also acknowledge the fact that it is okay to have/ask questions. Our job as clinicians is to answer those questions using scientific knowledge and evidence-based data. Bringing political issues into our discussions with patients will not help our cause.

It is completely understandable that when seeing so much suffering around us, being overworked, fatigued, and burnt out, it is sometimes tough to have empathy or even sympathy for people who find themselves inflicted with COVID when they've chose not to, or delayed, a decision to receive the vaccine. Trying to have this conversation with a healthy person who refuses to get vaccinated can be even tougher. These are times when our leadership skills are truly being tested. The only way we will be able to a meaningful impact with the vaccination rates is by building trust with our patients and our teams. There is power in how we care for every single patient. Trying to have these conversations regarding the importance of vaccination will help us move the needle one patient at a time. If each of the urgent care professionals in the country can move the needle by even a couple of patients a day, the national impact will undoubtedly be significant.

EDITOR'S CORNER: SEAN MCNEELEY, MD, FCUCM

WHY WE DO IT



Welcome to our second updated version of Urgent Caring.

As we fight through this second wave of the coronavirus pandemic, we need something to focus on to help us stay on track and get up each morning. For me it's not complicated. Every year we have had a flu season and I find I need to focus on why we see patients to help me survive the long days and fatigue brought on by increased volumes and patient anxiety. I do it because medicine is the one field where we make a difference in the most important aspect of our lives. Without our health we don't have much left. We forget this often as we are busy with life but once illness strikes, we are painfully aware of it. What we do is important to our patients and their families. We must never forget that as every new patient is another opportunity and we cannot let a single one down.

Contact Dr. McNeeley at sean.mcneeley@uhhospitals.org

BEST PRACTICES

THE TETANUS VACCINATION IN URGENT CARE

Date Reviewed	September 20, 2021
Subject	Tetanus Immunization in Urgent Care Practice
Patient Population	Adolescents and adults
Rationale	Tetanus is a disease caused by <i>Clostridium tetani</i> when spores enter the body through a breach in the skin. As wounds are commonly seen in urgent care, it is essential that the UC provider address vaccination

	status for tetanus when patients present with wounds.
Introduction	<i>C. tetani</i> spores are found in dirt worldwide. They may enter the body through wounds where the spores germinate. The bacteria produce toxins which disseminate through the body entering the nervous system. These toxins block neurotransmitters leading to unopposed muscle contractions and spasms. Seizures may also occur. Those at risk are patients who have either never received a tetanus vaccine series or did not stay up to date with the recommended 10-year booster shots. Improper wound care also increases the risk. As morbidity and mortality from this disease is high, prevention with vaccination is highly recommended.
Evidence based guideline with strength of evidence	https://www.cdc.gov/vaccines/vpd/dtap-tdap-td/hcp/recommendations.html
Discussion	<p>Infants and children should receive 5 doses of DTaP at ages 2 months, 4 months, 6 months, 15-18 months, and 4-6 years. Tdap should be administered at age 11-12. Booster immunizations should be provided with either Td or Tdap every 10 years thereafter. At least one vaccine in adulthood should be Tdap. This can be given at any time regardless of previous Td vaccination. Recent information endorsed by the CDC and ACIP indicates that for adults, routine or episodic tetanus prophylaxis may be provided with Td or Tdap interchangeably, provided the patient has had at least 1 Tdap as an adult. The difference between the two vaccines, other than containing pertussis, is cost. Tdap is more expensive than Td which may be an issue for some urgent cares.</p> <p>A tetanus toxoid-containing vaccine is indicated for wound management when >5 years has passed since the last dose, regardless of type of wound. If the patient is \geq 11 years, Tdap is preferred unless it has been previously administered, in which case Td is sufficient.</p> <p>Patients who have not completed a primary vaccination series for tetanus or if it cannot be determined if they completed a primary vaccination series, should receive tetanus immune globulin following a suspected contaminated wound. Immunosuppressed patients with contaminated wounds should receive tetanus immune globulin regardless of vaccinated status.</p>

Summary	Updating tetanus vaccination status is a common procedure in urgent care following traumatic wounds. The urgent care provider needs to assess the patient's previous tetanus history. Patients who have a traumatic wound who have not received a tetanus booster within 5 years should receive either Td or Tdap. Adult patients should receive at least 1 Tdap in their lifetime, however future updates may be either Td or Tdap. Patients who have not received a primary series, it cannot be determined if they received a primary series, or if they are immunosuppressed should receive tetanus immune globulin.
References	<p>Use of Tetanus Toxoid, Reduced Diphtheria Toxoid, and Acellular Pertussis Vaccines: Updated Recommendations of the Advisory Committee on Immunization Practices — United States, 2019 <i>MMWR</i>, January 24, 2020, Vol 69(3);77-83</p> <p>https://www.cdc.gov/vaccines/vpd/dtap-tdap/hcp/recommendations.html</p> <p>https://www.cdc.gov/tetanus/clinicians.html</p> <p>https://www.cdc.gov/mmwr/volumes/67/rr/rr6702a1.html</p>
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Attachments (flow charts, graphics, tables, etc.)	N/A

URGENT UPDATES [U² LOGO HERE]

ANTIVAXXERS GARGLING WITH THE ANTISEPTIC BETADINE

The idea that gargling with the common antiseptic Betadine will prevent COVID-19 is finding a home in corners of social media, but there's no evidence it works. Immediate side effects of ingesting any povidone-iodine antiseptic include nausea, vomiting, general weakness, and diarrhea. In severe cases, people can suffer acute renal failure, cardiovascular collapse, liver function impairment, shortness of breath, low blood pressure, and even death. **Full Access:** [Medscape](#)

CUBA STARTS VACCINATING KIDS AS YOUNG AS 2

Cuba has begun vaccinating children as young as 2 against COVID-19 because of a sharp increase in pediatric infections and deaths caused by the virus. Cuba's regulating agency gave an emergency use authorization last week for kids 2 to 18 years old to be given two doses of the Soberana 2 vaccine followed by one dose of Soberana Plus booster. **Full Access:** [Medscape](#)

ANTIBIOTIC USE AND COLON CANCER: MORE EVIDENCE OF LINK

The latest data come from a Swedish population study shows an association between antibiotic use and an increased risk for colon cancer. They found that moderate use of antibiotics increased the risk for proximal colon cancer by 9% and that very high antibiotic use increased the risk by 17%. **Full Access:** [Medscape](#)

HALLUCINOGENIC MUSHROOM TOXICITY

Hallucinogenic mushroom toxicity is not a new phenomenon. Consumption of hallucinogenic mushrooms continues to be popular today in some settings. Use of hallucinogenic mushrooms rarely results in life-threatening symptoms and symptoms typically are mild to moderate in severity and self-limited. Symptoms of poisoning typically begin 30 minutes to 1 hour after ingestion. Hallucinations may be accompanied by dysarthria, ataxia, and muscle cramps and may persist for as long as 8 hours. Benzodiazepines may be used for sedation and treatment of panic attacks, hallucinations, and seizures. **Full Access:** [Medscape](#)

ANNOUNCEMENTS

FROM THE FEDERAL COVID RESPONSE TEAM—CHANGES IN THE DISTRIBUTION AND ADMINISTRATION OF MONOCLONAL ANTIBODY THERAPEUTICS

Thank you for the important role you play in the distribution and administration of COVID-19 monoclonal antibody (mAb) therapeutics. We know this is a very challenging time, and we appreciate your continued partnership.

We recently informed you that the increased incidence of the Delta variant of SARS-CoV-2 caused a substantial surge in the utilization of monoclonal antibody drugs, particularly in areas of the country with low vaccination rates. We are committed to helping ensure consistent availability of these critical drugs for current and future patients in all geographic areas of the country. As such, we have updated the distribution process for mAbs.

As of Monday, September 13, HHS transitioned from the direct ordering process to a state/territory-coordinated distribution system, similar to that used from November 2020 – February 2021. We fully recognize that state/territorial health departments know best where product is needed in their areas. Transitioning to a state/territory-coordinated distribution system will give health departments maximum flexibility to get these critical drugs where they are needed most.

The federal government will determine the weekly amount of mAb products each state and territory receives based on COVID-19 case burden and mAb utilization. State and territorial health departments subsequently identify which sites in their respective jurisdictions receive product as well as the amount each site receives.

As of Monday, September 13, 2021:

- Administration sites no longer order directly from AmerisourceBergen.
- Weekly distribution amounts for each state/territory will be determined by HHS based on weekly reports of new COVID-19 cases and hospitalizations in addition to data on inventories and use submitted in HHSProtect.
- State/Territorial Health Departments will determine where product goes in their jurisdictions.

We will continue to monitor product utilization rates, COVID-19 case burden, and overall availability of mAbs to determine when a shift back to the normal direct ordering process may be possible. In the meantime, your cooperation in this effort will help ensure that, to the extent feasible, current and future patients receive monoclonal antibodies as needed.

We encourage you to join this week's stakeholder call and the office hour sessions to learn more about the state/territory-coordinated distribution system. Should you have questions regarding this update or need instructions for dialing into the calls/sessions please email the Federal COVID-19 Response Team at COVID19therapeutics@hhs.gov.

CME Answers from the Prior Edition of 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. 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
- 3. The most common cause of parotitis is?
 - a. Stone formation
 - b. Mumps
 - c. Bacterial infection
 - d. Gum chewing

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.

CUCM CME Planning Committee

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