

URGENT CARING
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Chris Chao, MD, President, CUCM Board of Directors



Greetings! I hope that everyone is doing well and staying healthy. This summer has been challenging for Urgent Care centers and clinicians due to continued surges in COVID-19 cases caused by variants as well a surprise influx of influenza cases. Combined with staff shortages, everyone in the industry is exhausted. Monkeypox is only adding to the challenges that we face.

The College of Urgent Care Medicine also had a busy summer. One of the many roles of CUCM is hosting the Clinical Consortium, which was held in July. Speaker Tim Uyeki, CDC Chief of Influenza Response, presented epidemiological data from Australia that showed an early influenza season with cases surpassing historical averages. He cautioned that southern hemisphere trends do not necessarily predict trends in the northern hemisphere, but clinicians should at least be alert to the possibility of an early influenza season in the United States. Concurrent cases of COVID-19 and influenza are expected, and clinicians should monitor and keep up-to-date on local and state epidemiological trends.

Moving forward, CUCM is also embarking on several projects including corticosteroid stewardship and continuing to promote antibiotic stewardship. Our Clinical Response Committee is developing educational programs to address emerging issues such as monkeypox and keeping our members informed on clinical issues. We are committed to advancing Urgent Care as a specialty, but much work still needs to be done. If you would like to help in the effort there are several volunteer opportunities.; reach out to a member of the [CUCM Board](#).

As if we don't have enough clinical challenges to deal with, please be aware of a scam targeting practitioners. Earlier this week I received a call from my state's medical board. Caller ID identified the entity placing the call as the medical board and the caller addressed me by name, knew my medical license number and other identifiers. He informed me that the medical board had received a complaint on my license about possible illegal activity out-of-state. He connected me to an investigator that identified himself as "Officer Adams" who stated he wanted to interview me about the situation.

A wave of worry and panic hit, but something seemed odd about the encounter. When I refused to answer any further questions and stated that I was going to stop this conversation and call the medical board directly, the tone of the conversation changed and threats such as "license revoked" and "possible felony charges" were used.

I promptly disconnected the call and called the medical board using the board's published number. The medical board confirmed that the call I received was a scam. **The medical board will ONLY initiate contact with a certified letter, and NEVER by a phone call.** This is also true of the DEA and the IRS. I consider myself savvy at recognizing these types of calls, but I didn't put two and two together until

about a full minute into the call. Fortunately, I did not give up any personal information or make any payments. I remember reading warnings about this in the board's newsletter and even our hospital's communication, yet I was still initially thrown off guard. **Caller ID can be spoofed, and your medical license number, NPI number and practice information are all public record.**

During challenging times remember to look out for your own mental health and physical wellbeing. Avoiding provider burnout will allow us to be prepared to serve our patients and our community. Stay well.

FROM THE EDITORS

The World Health Organization (WHO) announced the monkeypox outbreak as a global health emergency on July 23, 2022. Wow. The WHO has declared a global emergency for the second time in two years!

Monkeypox and SARS-Cov-2 are now on the Urgent Care radar in addition to the pre-pandemic common infections. We wonder how these new emerging infections might impact Urgent Care staff, including our valued clinicians. For instance, once again, we must rely on each State's Department of Health guidance to provide care for our patients. Interestingly, some UCs have access to monkeypox testing on-site, while here in Rhode Island, we must contact DOH for testing. With that said, it is not surprising to see frontline healthcare providers emotionally breaking down – mainly due to the added pressure of exposure-related occupational hazards. These stressors can push clinicians into early retirement, career changes, cuts in practice hours, and burnout.

It is critical to realize that this epidemic of "work-related fatigue" is a shared responsibility. Individuals are not going to "resilience their way" out of this without support from coworkers, colleagues, or, most importantly, medical leaders. Moreover, CUCM/UCA has added a [Monkeypox Learning Resource](#) page on our website to assist clinicians with valuable information. You can contact us or utilize the Listserv to tell us your story, how you are coping with stress, or give a shout-out to a coworker for excelling in their practice. Don't forget that your colleagues in the College are here for you.

On another topic, we are pleased to introduce the new section in Urgent Caring, "Clinical Answers in Urgent Care." You can now send us any clinical questions you might encounter during your Urgent Care shift. We will review and provide an evidence-based, peer-reviewed answer to assist you in enhancing your knowledge. Check the first publication in this issue with topics including steps to evaluate murmurs in pediatrics, wound cultures after incision and drainage, and skin testing after insect bite.

Lastly, please join us in welcoming Jerry Jones, MD FACEP FAAEM as the new EKG column Editor. Dr. Jones is ABEM board certified and Internal Medicine trained. He has provided care in UCCs, small community hospitals, and Level 1 trauma centers. He is the CEO at Medicus of Houston, an Advanced Electrocardiography instructor, and has presented on complex topics in several seminars and conferences over the years. Welcome, Dr. Jones. We look forward to your insight and contributions to Urgent Caring.

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TWO EASILY-MISSED MYOCARDIAL INFARCTIONS—AND HOW NOT TO MISS THEM

Jerry W. Jones, MD FACEP FAAEM

Section Editor, EKG

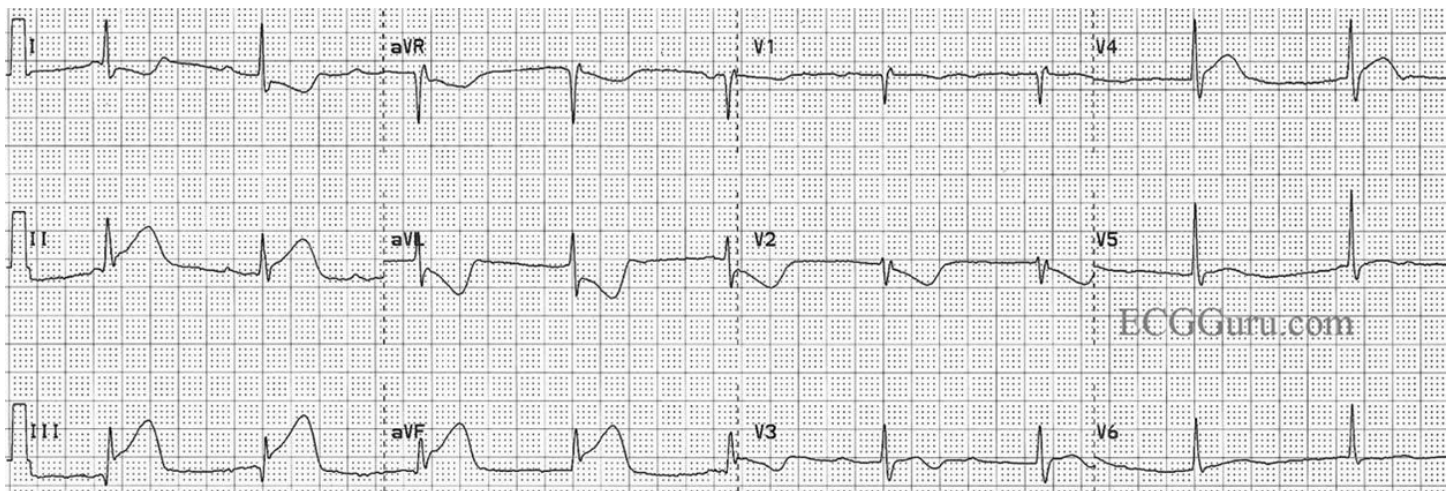


The patient is a 58-year-old male who complains of substernal chest pain and symptoms compatible with an acute coronary syndrome: pain described as “tight and squeezing,” nausea and diaphoresis. He also has Type 2 diabetes, hypercholesterolemia, and a 46 pack/year smoking history. You order a 12-lead ECG and you see an acute inferior MI with ST elevation in Leads II, III and aVF and ST depression in Leads I, aVL and V2. Do you really have a final diagnosis yet? Better think twice... or even thrice! I’m going to show you THREE diagnoses on this ECG!

When the ECG “Throws You a Bone”

“Throwing you a bone,” means the ECG distracts you by allowing you to arrive at an *obvious* diagnosis quickly and easily while possibly overlooking a *second*, and sometimes even a *third*, diagnosis that is much less obvious and more easily missed. And sometimes these other diagnoses are even more *dangerous* than the obvious one. Let’s look at this ECG...

Figure 1 (Courtesy of Dawn Altman, RN, EMT-P “ECGguru.com”)



This is an example of the ECG “throwing you a bone.” There is a very obvious acute inferior MI present (actually, an acute *epicardial ischemia*) characterized by ST elevation in Leads II, III and aVF with hyperacute T waves in the same leads. There is also marked ST depression with T wave inversion in Leads I and aVL indicating a reciprocal change to the ST elevation inferiorly. In Lead V2 we see very obvious ST depression and T wave inversion. Lead V3 has no ST depression but the T wave is still inverted. Suddenly, in Lead V4 we again find ST elevation and an upright hyperacute T wave.

Let's take a much closer look at this ECG. The ST depression in Leads I and aVL are reciprocal to the ST elevation in the inferior leads and confirms our diagnosis of *acute inferior MI*. OK... we have **one diagnosis**. Now things are going to get a bit trickier, so follow my lead...

Moving to the precordial leads, Lead V1 looks totally normal while the next three precordial leads (V2 – V4) look obviously abnormal. Leads V1 and V2 are really very close to each other and are looking at what? They're looking at adjacent areas on the *right* side of the interventricular septum. All this time you thought they were overlying the *anterior wall of the left ventricle*. And you know what? *You were right!* You just have to understand that the interventricular septum forms the anterior wall of the left ventricle. It also forms part of the posterior wall of the right ventricle. The two ventricles are really more anterior/posterior rather than right/left structures. Getting back to the ECG...

The appearance of ST depression in Leads V1 – V3 during an acute inferior MI does NOT represent anterior *subendocardial* ischemia – it represents acute *epicardial* ischemia of the lateral wall of the left ventricle. Again, the ventricles are anterior/posterior structures AND rotated to the left 50 - 60°. That places the lateral wall of the left ventricle posteriorly, underlying Leads V7 – V9, the *posterior* leads. We used to call such an infarction a *posterior* infarction, but now we now it's really an acute ischemia of the *lateral wall of the left ventricle* which happens to be rotated posteriorly.

So, now we can see that this patient not only has an *acute inferior MI*, but also an *acute lateral (formerly posterior) MI*. That's **two diagnoses** and a very large area at risk! But wait! It only gets worse!

Shouldn't Leads V1 and V3 demonstrate ST depression also, just like Lead V2? Actually... there IS ST depression in those leads! But what could prevent the ST depression from being seen? What could *counter* ST DEPRESSION in a precordial lead? Well, how about ST ELEVATION in the *same* precordial lead? In addition to acute inferior and lateral (posterior) MIs, this patient is having an *acute right ventricular MI*. That's **three diagnoses**. The amount of ST depression and ST elevation were about the same in Lead V1, so V1 comes out of this looking rather normal. The ST depression was obviously far greater than the ST elevation in Lead V2, so Lead V2 continues to record marked ST depression (ST depression during a posterolateral MI is usually greatest in Lead V2). Again, in Lead V3 the ST depression and ST elevation cancel each other almost equally (there is still some residual T wave inversion). There was never any ST depression in Lead V4 (though there sometimes can be), so we see the pure ST elevation of right ventricular infarction. It goes no further than Lead V4. Posterior leads (V7 – V9) and right-sided leads (especially Lead V4R) would be very useful as confirmation of these areas at risk.

Right ventricular infarctions may occur in up to 50% of right coronary artery occlusions. We used to think it involved fewer occlusions, but recent studies have shown that we were mistaken. About 30% of these RV infarctions will result in profound hemodynamic disturbances accompanied by a high in-hospital mortality. So what started out as an inferior wall myocardial infarction has turned out to be a massive area at risk involving the inferior and posterolateral walls of the left ventricle and the right ventricle. This is an extremely dangerous and lethal situation for this patient!

Well, I promised you three diagnoses and I delivered. But there's just one problem: I lied. There are really **FOUR diagnoses!**

Did you notice the AV dissociation? This is likely due to a temporary 3rd degree AV block caused by a loss of circulation to the AV node. This is not a Mobitz I AV block because there is no dropped QRS. Such a

block, added to the hemodynamic instability of an acute right ventricular infarction could be devastating, even though it will likely disappear when circulation is restored. It *could* be AV dissociation due to increased automaticity (AV dissociation by usurpation), but with this amount of ischemia, it is more likely to be a block in the AV node. There is no rhythm strip on this 3-channel, 12-lead ECG, but each channel is continuously recorded, even though the leads change three times. It does not pause between leads. You can still use it to evaluate the relationship of the P waves to the QRS complexes, though the P waves may be harder to see in some leads.

Here's what you can do to avoid missing these acute coronary occlusions:

1. Never diagnose a chest pain patient based on just one ECG, on just 12 leads or on just one cardiac troponin drawn less than 4 hours after the pain onset unless the initial results are clearly diagnostic.
2. In the presence of an inferior MI, a normal Lead V1 with ST depression in Lead V2 is always an ominous sign. Look for an acute right ventricular infarction accompanying a left lateral wall (posterior) MI. Do right-sided leads for *every* inferior MI. If present and *noted*, mortality will be high! If present and *missed*, mortality will be even higher! Be prepared for a profound cardiovascular collapse and be certain that you have excellent large-bore IV access before giving NTG or morphine.
3. The ST depression of a reciprocal change to an acute coronary occlusion may appear BEFORE the ST elevation. Remember **Jones's Rule**: ST depression on the 12-lead ECG of a patient having chest pain compatible with an acute coronary syndrome should be considered a reciprocal change until proved otherwise.
4. If an inferior MI is occurring, ST depression in Leads V1 – V3 does NOT represent anterior subendocardial ischemia. It represents the reciprocal changes to an acute epicardial ischemia of the lateral wall of the left ventricle.
5. If you have an acute inferior MI, **always** look for three other diagnoses:
 - a. Acute left lateral wall (posterior) MI
 - b. Acute right ventricular MI
 - c. AV block
6. **BONUS PEARL: Right coronary artery and left circumflex occlusions may result in AV block while left anterior descending artery occlusions may result in bundle branch block (especially cRBBB).**

Recommended Reading:

Marti, D. et al. *Usefulness of Reciprocal Changes in the Diagnosis of Myocardial Infarction With Minimal ST-segment Elevation*. Scientific letters / Rev Esp Cardiol. 2016;69(7):706.

Miranda MD, D. et al. *New Insights Into the Use of the 12-Lead Electrocardiogram for Diagnosing Acute Myocardial Infarction in the Emergency Department*. Canadian Journal of Cardiology 34 (2018) 132e145.

Radhakrishnan MD, N. and Glancy D. MD. *ECG Discrimination Between Right and Left Circumflex Coronary Arterial Occlusion in Patients With Acute Inferior Myocardial Infarction*. CHEST 2002; 122:134–139

van Gorselen, E.O.F. et al. *Posterior myocardial infarction: the dark side of the moon*. Netherlands Heart Journal, Volume 15, Number 1, January 2007.

ANTIBIOTIC STEWARDSHIP—FOCUS ON OTITIS MEDIA



Joseph Toscano, MD, FCUCM

Section Editor, Antibiotic Stewardship

Otitis media (OM) is one of the most common reasons that antibiotics are prescribed for children in Urgent Care. Over time, expert guidelines have informed and reformed us about the appropriate antibiotics to use, how to dose them, and the duration of therapy. The most recent comprehensive expert guidelines¹ for children 6 months to 12 years of age were published close to a decade ago by the American Academy of Pediatrics (AAP). Fueled by newer high-quality data on the results of placebo or no treatment for OM, those guidelines emphasized a “watch and wait” approach (vs immediate antibiotic prescription) for some children with non-severe otitis media, which was first proposed in the 2004 guidelines from the AAP and the American Academy of Family Practice. Non-severe OM is defined by no worse than mild pain, for less than 48 hours and temperature < 39°C (102.2°F). Surveys showed that physicians were very slow to adopt the watch and wait approach after the 2004 guidelines. Whether that has changed is uncertain, though there is still plenty of evidence that antibiotics are overprescribed, in Urgent Care, as well as the emergency department and primary care offices.

In February of this year, *JAMA Pediatrics* published an interesting Viewpoint by Frost and Hersh². The authors used epidemiological microbiologic data to project the percentage of patients with otitis media who would improve with no antimicrobial treatment (over 55%), plain amoxicillin (almost 35%) or amoxicillin-clavulanate (under 15%). While it’s true that none of us can tell whether a case of OM is caused by a virus or *Moraxella catarrhalis* by history or exam, and the days of tympanocentesis are no longer (thankfully!), this viewpoint reinforces an approach of:

- Advise parents of the **option to treat the pain of OM but forgo immediate antibiotics (do offer easy follow-up or a delayed prescription) when otitis is non-severe and unilateral in children 6 months to 2 years old; or even bilateral, but non-severe in children 2 years and older.**
- When you do prescribe antibiotics for otitis media, **consider plain amoxicillin as first line, unless a child is allergic or has clinical indicators of the need for broader spectrum coverage.** The clinical indicators for the need for broader spectrum coverage are:
 - the child has received amoxicillin in the past 30 days, or
 - the child has concurrent purulent conjunctivitis (this syndrome is more likely to be caused by nontypeable *Haemophilus influenzae*), or
 - the child has had a history of OM that failed amoxicillin treatment in the past

- **Do not prescribe antibiotics for a longer duration than recommended:**
 - Children 6 years of age and older with mild to moderate symptoms need only 5-7 days of antibiotics
 - Children 2-5 years of age with mild to moderate symptoms need only 7 days of antibiotics
 - Reserve 10-day courses of antibiotics for children under age 2, particularly if it's severe and children (of any age) with tympanic membrane perforation or history of recurrent OM.

[The 2013 guidelines](#) and the [Viewpoint by Frost and Hersh](#) are available for free and I'd urge all Urgent Care clinicians to take a look!

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1. Lieberthal AS, et al. The diagnosis and management of acute otitis media. *Pediatrics*. 2013;131(3):e964-e999. doi:10.1542/peds.2012-3488
2. Frost HM, et al. Rethinking our management of acute otitis media. *AMA Pediatr*. 2022;176(5):439-440. doi:10.1001/jamapediatrics.2021.6575
3. Pelton S, Tahtinen P. Acute otitis media in children: Treatment. . UpToDate. https://www.uptodate.com/contents/acute-otitis-media-in-children-treatment?search=otitis+media&source=search_result&selectedTitle=2~150&usage_type=default&display_rank=2. Accessed August 28, 2022.

URGENT CARE CASE STUDY

MEDIAL KNEE PAIN IN A RUNNER

TRACEY QUAIL DAVIDOFF, MD, FCUCM

A 55-year-old female presents with left medial knee pain for 2 weeks. She has no history of previous knee pain or injury. She is an avid runner and states that 2 weeks ago she was doing a half marathon when she



developed pain in her medial knee about halfway through. She did not fall, twist her knee, or have any specific injury that she can recall. She did not complete the race due to pain. She had trained for the marathon without difficulty. Over the following 2 weeks she rested, iced, elevated, and did not do any running. She states the pain is worse at the end of the day. Going up and down stairs is particularly challenging. She can use the exercise bike with no problem but cannot walk on the treadmill for more than a few minutes due to pain. She notes swelling on left medial knee with point tenderness over the proximal tibia. She does recall a remote history of knee injury but did not recall what was injured. There was no surgical intervention at the time.

Exam findings note vague swelling over the proximal medial tibia. There is no redness or warmth. There is point tenderness over the flat portion of the proximal tibia (see arrow) which exactly reproduced her pain. There is no joint or pre-patellar effusion. Range of motion is preserved and without significant pain. Provocative testing of the meniscus, cruciate, and collateral ligaments are normal and without pain. The hip and ankle exams are normal. The remainder of the history and physical are normal.

Diagnosis: Pes Anserine Pain Syndrome

Pes anserine pain syndrome (PAPS) is a common condition causing pain and tenderness on the medial knee over the flat portion of the proximal tibia where the conjoined tendons of the sartorius, gracilis, and semitendinosus meet. This insertion resembles the footprint of a goose, “anser” in Latin and old Spanish. Previously called pes anserine bursitis, only a tiny fraction of these patients will have a true bursitis. PAPS is more common in females than males, patients with osteoarthritis, and obesity. Diabetes may also be a risk factor, as is malalignment of the knee. The pathogenesis of PAPS is unclear. Previous injury to the medial knee may be a contributing factor.

There are no established diagnostic criteria for PAPS. Patients with the above risk factors who have unilateral pain with medial knee pain, tenderness over the upper medial tibia between the pes anserinus and the tibial joint line, and the absence of significant local swelling or induration should be suspected to have PAPS. Furthermore, it should be suspected in patients who have one of the following: medial knee

pain with rising from a chair, ascending or descending stairs, inability to side sleep due to pain, rapidly developing medial knee pain in a patient with known OA, or change in character of previous OA pain to night pain, as opposed to morning pain with initiation of activity.

The physical exam is rarely dramatic. On inspection, varus or valgus deformity may be present. There is little to no swelling over the flat portion of the proximal tibia, with no redness or warmth. This area will have point tenderness. There may be associated medial meniscus or medial collateral ligament signs.

The differential diagnosis of medial knee pain includes true anserine bursitis, proliferative disorders such as giant cell tumors, snapping pes anserinus, medial meniscal tear, medial collateral ligament sprain, tibial stress fracture, osteonecrosis, osteomyelitis, and fibromyalgia,

Imaging is not necessary, but it may be worth performing conventional radiographs to establish a diagnosis of OA. Ultrasound may be used to exclude other rare disorders and to guide therapeutic injections. MRI may also be useful if US reveals a solid lesion in the area.

This condition may be difficult to treat. Short term NSAIDs should be used for pain control, as well as a soft knee brace, physical therapy with quadriceps strengthening, and weight reduction should be recommended. This will be successful in only 30% of patients. In those that fail conservative treatment steroid injections may be beneficial.

References:

1. Canoso JJ, Katz, JN. Knee bursitis. UpToDate. https://www.uptodate.com/contents/knee-bursitis?search=pes+anserinus+pain+syndrome&ionRank=1&usage_type=default&anchor=H217809402&source=machineLearning&selectedTitle=1~14&display_rank=1#references. Accessed July 20, 2022.
2. Mohseni M, Graham C. Pes Anserine Bursitis. [Updated 2022 Jul 10]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2022 Jan-. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK532941/>
3. Alvarez-Nemegyei J. Risk factors for pes anserinus tendinitis/bursitis syndrome: a case control study. *J Clin Rheumatol* 2007; 13:63.

DOT EXAMS: DETERMINATION PENDING VERSUS SHORT TERM CERTIFICATION

Max Lebow, MD, MPH, FACEP, FACPM

Section Editor, Occupational Medicine



A common decision for the Medical Examiner during a DOT FMCSA Commercial Driver exam is in what circumstances to use Determination Pending (DP) versus Short-Term Certificate (STC) when additional information is needed to make a definitive certification decision. This article will help the ME determine which is best option, depending on the driver's individual circumstances.

Before deciding between Determination Pending and Short-Term Certification, the medical examiner should be comfortable that the driver is safe to drive a Commercial Motor Vehicle/CMV. Otherwise, the correct decision is that the examinee should be disqualified.

- Use Determination Pending – when additional **information** is required to make a certification decision, but the driver remains safe to drive on an existing certification if it has not expired.
- Use Short-Term Certification – when additional **treatment** is required, but the driver is qualified today.
- The Medical Examiner should use neither Determination Pending nor Short-Term Certification to temporize or compromise when a driver is unsafe to drive a Commercial Motor Vehicle. The driver should be disqualified.

Determination Pending

Determination Pending, first appearing as an option on form Medical Examination Report Form 5875 in 2016, serves three purposes. First, it replaced the temporary certifications used for poorly controlled hypertension. DP also is meant to prevent incomplete examination forms from being held in informal limbo without final action. Finally, Determination Pending charts are submitted to FMCSA, making them aware when a CMV driver has been examined, and alerting FMCSA when multiple exams are being performed, as in doctor shopping.

At its most basic, Determination Pending is a delay in the certification decision, allowing the exam to remain open for up to 45 days without a decision. Determination Pending's most common features include:

- **DP is not a temporary certification - it is No Decision** - A driver may **not** operate a CMV during the 45 days DT period **unless** the driver has an existing valid certificate.
- **A new physical exam is not required when the patient returns within the DP period**- The initial physical exam is still valid because the case is still open. However, a new physical exam may be performed at the discretion of the Medical Examiner.

- **DP may not be used to extend the driver's existing CMV certificate past the expiration date** - If the driver's current certificate expires during the 45-day Determination Pending, the driver must stop driving.
- **DP must be amended (updated) on or before the 45-day expiration date** - At the expiration of the 45 days, the open exam becomes invalid. Therefore, a new exam must be performed if the driver returns past the 45-day window.
- **If certification is granted, its expiration date is the date of Determination** - Not the original exam date.
- **No more than one DP per physical exam is permitted** – Each new 45-day DP requires a new physical examination, and a new Form 5875 must be initiated. However, there is no prohibition of a new exam resulting in another DP.

Example:

Determination Pending can be used to await documentation of compliance with a medical treatment from a personal physician, such as documentation that the patient with a pacemaker is getting regular pacemaker checks (at least every 6 months - these checks can be done remotely). Another example is when a driver with Diabetes Type II is positive for urine glucose or has a moderately elevated blood sugar. The Medical Examiner may wish the driver to return with a hemoglobin A1C to assure patient compliance.

It should be stressed that in both these examples the driver remains qualified to operate a commercial vehicle if the driver's current certification has not expired. If this certification expires during the determination pending, the driver cannot continue to operate a commercial vehicle during the DP period.

Short-Term Certification

There are some situations when a Short-Term Certification/STC may be more appropriate than Determination Pending.

Some features of STC:

- **STC invalidates all previous certifications and expiration dates** – The most recent certification decision always takes precedence over any prior decision. If a new STC expires in 30 days, that is the new termination date, regardless of previous certifications expiring after that time.
- **DMV Certification length is up to the discretion of the Medical Examiner** - While the checkbox options are defined lengths of time, the ME is free to choose any certification length, theoretically down to one day.
- **STC is used only when a driver is fully medically qualified to operate a CMV** - but has a medical condition that, if left unaddressed, may result in the driver becoming disqualified. For example, poorly controlled hypertension that is not disqualifying.
- **STC allows the driver to continue driving with the new expiration date**
- **Multiple STCs may be used consecutively** – However, the ME should examine the underlying condition that would require such an approach to determine if the driver is genuinely safe to operate a Commercial Motor Vehicle. It's

Example:

An example of Short-Term Certification might be a driver who recently changed hypertensive medications and presents with elevated blood pressure between 140/90 to 180/110. Based on the Medical Examiner's

judgment of the driver's history and physical, level of hypertension, and history of compliance, the ME may use STC while the driver's private provider pursues additional treatment. This new certification becomes the new expiration date, superseding any previous certification expiration.

As the Medical Examiner completes Form 5875, several options exist. The most fundamental decision: Is the driver qualified to operate a CMV safely? If the driver is qualified, then Determination Pending and Short-Term Certification offer additional choices to allow drivers to safely meet the FMCSA standards for the operation of Commercial Motor Vehicles.

I welcome your questions or comments. Please feel free to contact me at the email below.

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WOUND MANAGEMENT

TAKING THE MYSTERY OUT OF MATTRESS SUTURES

Patrick O'Malley, MD

Section Editor, Wound Management



If you are new to suturing, you may have heard the term “mattress suture” before and wonder what this is and when to utilize them. I have looked high and low for the origin of this without much luck, but for some reason have a recollection of someone telling me it was taken from the technique of sewing buttons onto mattresses. The long needle goes all the way through the mattress and is reintroduced and exits on the same side as it first entered. This allows the thread to be pulled, tethering the button, and allowing for application of tension.

The concept in suturing is the same; we want to have a way to close wounds that are gaping open or may be under a larger degree of tension. Enter the mattress suture. The horizontal mattress suture (see image) consists of two interrupted sutures side by side without the thread being cut in between. The thread that is visible above the skin acts to pull the tissue edges together by distributing tension across this tissue. It gives more strength and reduces the tension within the wound. I use the horizontal mattress suture very often. There are some advanced modified techniques of the horizontal mattress suture that can be used with more complex wounds.

You can also combine these with steri-strips for extra strength (see image). There is a time saving element; the horizontal mattress suture allows you to place two sutures with only one tied knot.

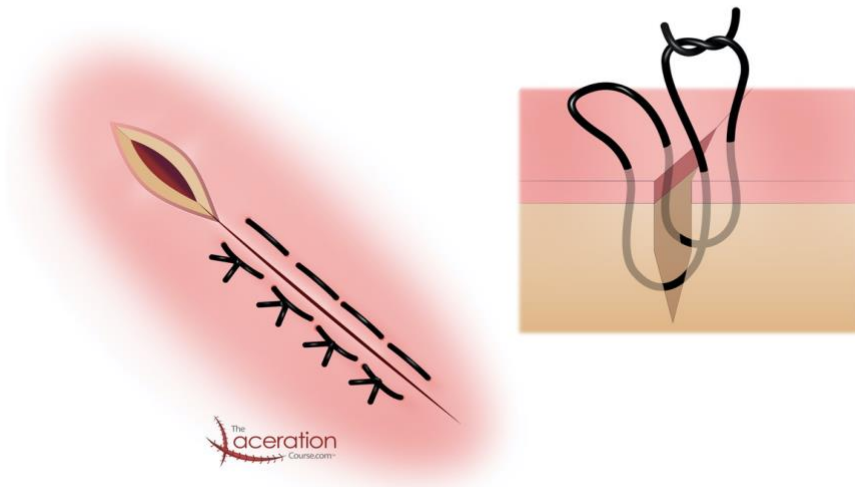
The same goes for the vertical mattress suture (see image). In this case 2 sutures are placed on top of each other in the same plane, just at different depths and widths from the wound edges. This suture is sometimes referred to as the far-far, near-near stitch. You enter and exit the skin far away, maybe 1 cm from the wound edge with a deep bite into the tissue. The second component is the near/shallower

suture, roughly 5 mm from the wound edges. The ends are then tied off on the same side as you first entered the skin. I like using these over joints, such as the elbow and knee.

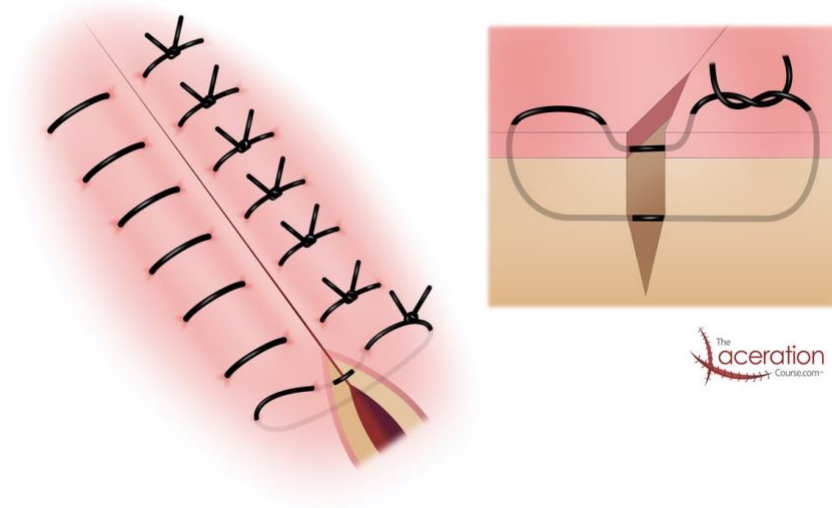
As with all things, don't be afraid to try a new technique that you are not familiar with. If you are uncomfortable trying it on a patient, try it out on a pig's foot or with a practice suture kit. Remember, if it is not perfect the first time, you can remove the suture and do it again.

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Horizontal Mattress



Vertical Mattress





CHEMICAL BURNS



EYE IRRIGATION SETUP

Cesar Mora Jaramillo, MD, FAAFP, FCUCM

Chemical burns (acids or alkalis) involving the eyes require immediate treatment to prevent damage and permanent vision loss. Regardless of the chemical involved, essential steps include removing the offending agent, promoting ocular surface healing, eliminating inflammation, preventing infection, and controlling Intraocular pressure (IOP).¹

Immediate copious-high volume irrigation of the eyes is crucial to wash out chemicals and is considered the single most important therapy for treating chemical injuries. Irrigation should begin at the site of contamination and the eyes and face if they are involved or adjacent to the exposed area.² Furthermore, the eyes should be anesthetized (if available) before irrigation with saline solution or Ringer's lactate solution.¹

Morgan lenses are widely used to irrigate eyes in the United States and other countries. In fact, over 90% of hospitals use lens for irrigation.³ Eye irrigation should be continued until the pH of the eye is neutralized to a range of 7.0-7.2, usually requiring 1-2 liters of fluid (for alkalis, generally takes two to three hours and at least 20 to 30 minutes for acids).^{2,3} PH should be reassessed at 15- to 20-minute intervals after stabilization to ensure that no further particles are present to continue changing the pH.² If a Morgan lens is unavailable, it is important to keep the eyelids retracted for maximal exposure of the conjunctiva and cornea. If a concomitant globe rupture or penetrating injury is suspected or confirmed, a Morgan lens should not be used, and only careful, gentle irrigation is advised to avoid exacerbating the injury.²



Urgent Care management can be challenging if no appropriate tools are available. Hence a nasal cannula can be used for irrigation and could help clinicians provide high-volume eye irrigation. Attach the nasal cannula to an oxygen port, then attach it to the end of IV tubing. Set up a piggyback line to the IV connection so more than one bolus can run at a time, and you can alternate without stopping. Affix the nasal cannula over the nasal bridge, and you can start irrigation. Remember that you will need a method to avoid the patient getting soaked wet or making a mess in the room. Use a basin and a suction to collect the irrigation fluid or place towels and absorbent padding around the patient's head.⁵

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EXPERT INSIGHTS

PATIENT LABELING IN THE MEDICAL RECORD: THE IMPACT OF STIGMATIZING LANGUAGE ON PATIENT CARE

Victoria Pittman, MPAP, PA-C

Imagine that you've just arrived at work, and the first patient of the day checks in with "nasal congestion." You review their medical record and click on a note from 6 months ago with the following:

This is a 35 y/o obese female with uncontrolled DM due to medication non-compliance who presents with nasal congestion that began today. No fevers. Exam is unremarkable. Presentation is consistent with a viral URI. After discussing the likelihood of a viral cause of her symptoms, the patient demands she be prescribed an antibiotic, stating, "But I always get a Z-pack." After discussing supportive care for a viral URI, the patient insists that, "Decongestants never work, and I'll just be back here in a few days for an antibiotic if you don't give me one today."

What feelings do you have towards this patient after reading this? There is a high likelihood that you've labeled her as "difficult" and "demanding" even before walking into the room.

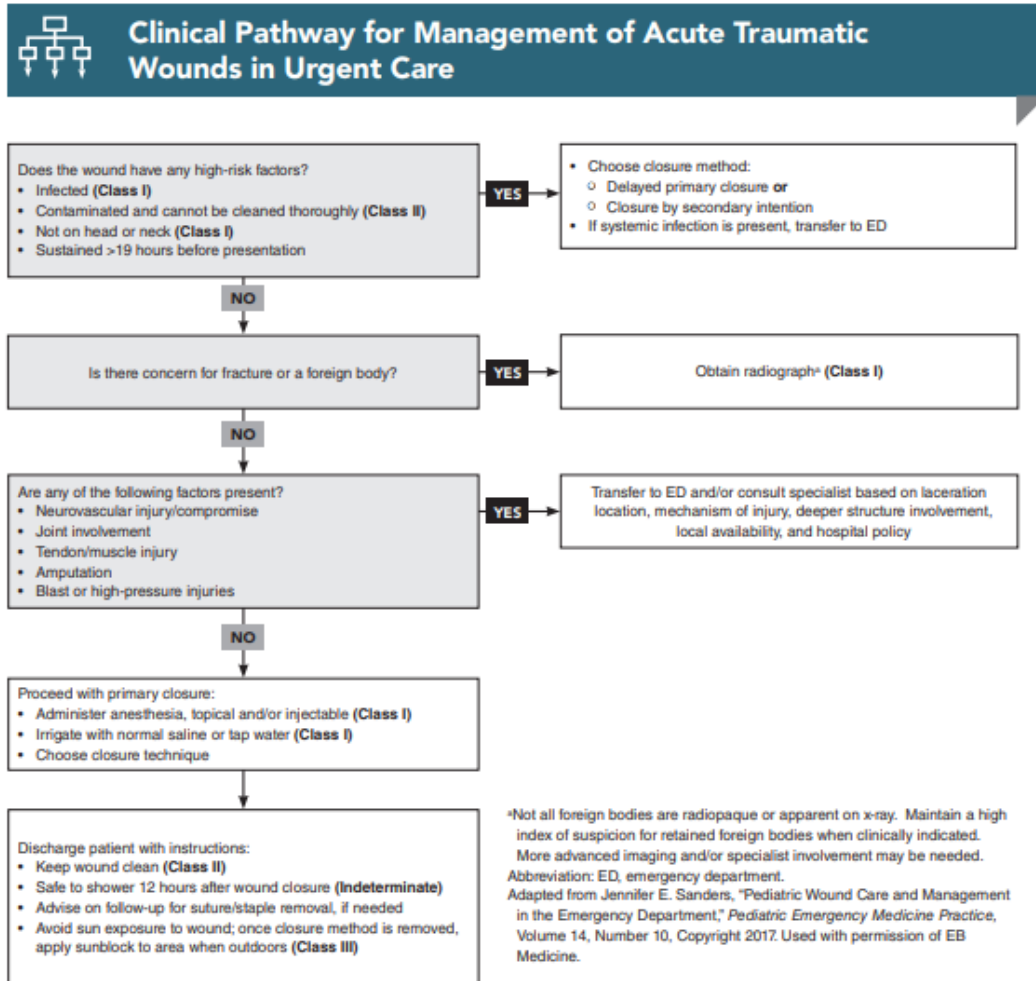
Patient labels are a form of stigmatizing language, which is language used in medical records that can elicit a negative bias toward the patient when another clinician reads the chart. A [2021 JAMA Network study by Park et al.](#) investigated the types of stigmatizing language written by physicians in the medical record. The authors categorized both positive and negative language. Common negative language categories include:

- 1) **Labeling by disease rather than a patient with a condition** (e.g. "An obese woman" vs. "A women with obesity")
- 2) **Questioning credibility** (Use of doubt markers; e.g. "supposedly," "claims," or "insists")

- 3) **Disapproval** (Use of language that implies poor patient reasoning and self care; e.g. “The patient has not taken her BP meds”)
- 4) **Stereotyping** (Quoting incorrect grammar or unsophisticated language; e.g. “sugar pills” to describe diabetes medication)
- 5) **Difficult patient** (Portraying patients as ignorant or difficult; e.g. “Poor historian”)
- 6) **Unilateral decisions** (Conveying a paternalistic tone; e.g. “I have instructed her”)

The use of stigmatizing language in the medical record can propagate clinician bias, perpetuate healthcare disparities, and influence the quality-of-care patients receive. A study by [Goddu et al.](#) evaluated the impact of stigmatizing language in the medical record on clinician decision-making around pain management for individuals with sickle cell disease. The authors found that reading a note with stigmatizing language was associated with less aggressive management of the patient's pain compared to a note using neutral language.

Management of Acute Traumatic Wounds and Thermal Burns in Urgent Care



Class of Evidence Definitions

Each action in the clinical pathways section of *Evidence-Based Urgent Care* receives a score based on the following definitions.

Class I

- Always acceptable, safe
- Definitely useful
- Proven in both efficacy and effectiveness

Level of Evidence:

- One or more large prospective studies are present (with rare exceptions)
- High-quality meta-analyses
- Study results consistently positive and compelling

Class II

- Safe, acceptable
- Probably useful

Level of Evidence:

- Generally higher levels of evidence
- Nonrandomized or retrospective studies: historic, cohort, or case control studies
- Less robust randomized controlled trials
- Results consistently positive

Class III

- May be acceptable
- Possibly useful
- Considered optional or alternative treatments

Level of Evidence:

- Generally lower or intermediate levels of evidence
- Case series, animal studies, consensus panels
- Occasionally positive results

Indeterminate

- Continuing area of research
- No recommendations until further research

Level of Evidence:

- Evidence not available
- Higher studies in progress
- Results inconsistent, contradictory
- Results not compelling

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient's individual needs. Failure to comply with this pathway does not represent a breach of the standard of care. Copyright © 2022 EB Medicine. www.ebmedicine.net. No part of this publication may be reproduced in any format without written consent of EB Medicine.

KidBits: Non-accidental Burn Injuries in Pediatric Patients

Intentional injury must be considered in the evaluation of all pediatric burns, as well as in burned adults who are at risk for abuse due to functional limitations or disabilities. Assessing for abuse can be challenging, as scald burns are the most common type of both accidental and non-accidental pediatric thermal burns. A systematic review of 26 retrospective studies found that symmetric appearance to wounds, clear upper wound margins, and the presence of old or apparently unrelated injuries were associated with intentional scald injuries.¹ Non-accidental burns tended to involve immersion of the extremities, buttocks, or perineum, whereas accidental burns were more likely to involve the upper body. Time-to-presentation was not examined by enough high-quality studies to determine with a high degree of confidence that delayed presentation is associated with abuse; however, a 2014 single-center prospective observational study described an association between delayed presentation and nonaccidental injury.²

1. Maguire S, Moynihan S, Mann M, et al. A systematic review of the features that indicate intentional scalds in children. *Burns*. 2008;34(8):1072-1081. **(Systematic review; 26 studies)**
2. Wibbenmeyer L, Liao J, Heard J, et al. Factors related to child maltreatment in children presenting with burn injuries. *J Burn Care Res*. 2014;35(5):374-381. **(Prospective observational study; 68 patients)**

Excerpted from Pochick K. Urgent Care management of patients with thermal burns. *Evidence-Based Urgent Care*. 2022 July 1;1(4). Reprinted with permission of EB Medicine.

Risk Management Pitfalls in Wound Management

1. “My patient said he still felt a foreign body near his wound, but I didn’t see anything, so I proceeded with the laceration repair.” There should be a high index of suspicion for a retained foreign body in a wound if the mechanism of injury supports it, and especially when the patient reports a foreign body sensation in the wound. X-rays should be used, with the understanding that not all foreign bodies are radiopaque.

2. “My patient has diabetes but the laceration on her hand looked fine after I sutured it. I advised her to have the sutures removed in 7 to 10 days.” There is a higher risk of wound infection associated with diabetes, advanced age, larger wound size, contamination, and a location not on the head or neck. Other conditions that impair wound healing include renal failure, obesity, malnutrition, and immunocompromised status. Prophylactic antibiotics should be considered for patients with these risk factors.

3. “The patient was in too much pain to move her finger so I could examine it, so I just sutured the laceration and told her to follow up with her primary care provider.” Assessment for fractures, neurovascular compromise, and injury to tendons and other adjacent structures is an important component of wound evaluation. Pain control and administration of an anesthetic may be required before a patient can cooperate fully with the examination.

4. “The laceration looked really dirty, so I decided to clean and irrigate it with iodine.” There is no significant difference in rates of infections with the use of antiseptics for irrigation versus NS or tap water. Antiseptics may impede wound healing due to cytotoxic effects.

5. “My patient was anxious to be discharged quickly, so I repaired his deep, complicated cheek laceration myself.” Specialist consultation and/or ED transfer should be considered for lacerations that

violate the eyelid margin, the lacrimal duct, or the tarsal plate, or for injuries that result in ptosis. Deep lacerations near the parotid gland, parotid duct, or facial nerve should raise strong suspicion for injuries to these structures.

6. “It was a busy shift and the laceration looked typical to me. I didn’t ask in detail how the patient came to be injured.” Certain mechanisms of injury, such as high-pressure injuries, require surgical consultation for potential operative debridement. The extent of tissue damage may not be readily apparent on initial visual inspection.

7. “The laceration appears to be under some tension, but this adhesive should work just fine.” Tissue adhesive should be limited to use in low-tension, linear wounds. Wounds under high tension or with jagged edges will likely respond poorly to repair with adhesives.

8. “The wound looks okay, but I’ll give the patient some antibiotics just in case.” Prophylactic antibiotics are not recommended for routine use in wound care.⁸⁸ Antibiotics have a role in management of wounds that are at high risk for infection.

Excerpted from Pochick K. Acute traumatic wounds: evaluation, cleansing, and repair in Urgent Care. *Evidence-Based Urgent Care*. 2022 August 1;1(5). Reprinted with permission of EB Medicine. Learn more about *Evidence-Based Urgent Care* and get a free sample issue at <https://www.ebmedicine.net/urgent-care-info>

BEST PRACTICE SUMMARY FROM THE COLLEGE OF URGENT CARE MEDICINE
DIAGNOSIS AND TREATMENT OF COMMUNITY ACQUIRED PNEUMONIA IN ADULTS

Date Reviewed	8/23/22
Evidence based guideline with strength of evidence	Diagnosis and Treatment of Adults with Community-acquired Pneumonia. An Official Clinical Practice Guideline of the American Thoracic Society and Infectious Diseases Society of America Am J Respir Crit Care Med. 2019 Oct 1;200(7):e45-e67.
Patient Population	Adult patients > 18 years who do not have an immunocompromising condition
Rationale	Pneumonia is a frequently diagnosed illness in Urgent Care. Arriving at the correct diagnosis and providing the appropriate treatment is key to improving patient outcomes, lowering cost of treatment, and decreasing antibiotic driven complications and resistance.
Introduction	Symptoms of pneumonia are seen daily in Urgent Care. This guideline was developed using studies that focus on patients with radiographic evidence of pneumonia; clinical signs and symptoms alone for CAP diagnosis are not considered accurate. It is focused on patients in the US who have not had recent foreign travel, especially to areas with emerging respiratory pathogens. Also excluded are adults with an

	<p>immunocompromising condition (inherited immunodeficiency, AIDS, chemotherapy, other neutropenic disorders.)</p> <p><i>Streptococcus pneumoniae</i> has traditionally been the most common pathogen seen in this disease, but recently the widespread use of pneumococcal vaccines has been changing the profile of microbial etiology in pneumonia. Treatment with antibiotics should be aimed at the most common pathogens, which include the following: <i>Streptococcus pneumoniae</i>, <i>Haemophilus influenzae</i>, <i>Mycoplasma pneumoniae</i>, <i>Staphylococcus aureus</i>, <i>Legionella</i> species, <i>Chlamydia pneumoniae</i>, and <i>Moraxella catarrhalis</i>. There has also been an increase in viral pathogens with and without bacterial co-infections. COVID-19, Influenza, and RSV are the most commonly encountered.</p>
<p>Key Points for Urgent Care</p>	<p>Diagnosis: Currently there is no diagnostic test proven accurate enough to be of any diagnostic use in determining the pathogen responsible for pneumonia in vivo. Rapid PCR tests are an emerging technology that may change this in the future, but currently not in widespread use.</p> <ul style="list-style-type: none"> ● Positive PCR tests for viruses do not exclude coinfection with bacteria. For this reason, it is recommended patients with positive radiographic findings of pneumonia should be assumed to have a bacterial pathogen and treated empirically with antibiotics. ● Patients managed as outpatients do not require sputum or blood cultures (strong recommendation, very low quality of evidence) ● When influenza viruses are circulating in the community, a molecular test (NAAT, PCR) should also be performed (strong recommendation, very low quality of evidence), which is preferred over a rapid influenza diagnostic test (i.e., antigen test) (strong recommendation, moderate quality of evidence). Note: if there is a high probability that the patient has influenza due to local prevalence, known exposure, etc., and PCR is not available, assume influenza is present even if antigen testing is negative. ● Routine testing for urine pneumococcal antigen or <i>Legionella</i> antigen should not be performed except where indicated by epidemiologic factors. (Conditional recommendation, low quality of evidence) ● Serum procalcitonin levels should not be used to make a decision to withhold antibiotic therapy in suspected and radiographically confirmed evidence of CAP. (strong recommendation, moderate quality of evidence)

- The use of a validated clinical prediction rule for prognosis, preferably Pneumonia Severity Index (PSI) should be used to determine the need for hospitalization in adults diagnosed with community acquired pneumonia (strong recommendation, moderate quality of evidence) (See Figure 1). Recognizing that Urgent Care centers may not have the resources required to use the PSI, clinicians should use the prognostic tools available to them e.g., CURB-65 or SOAR are other clinically validated tools that may be useful in Urgent Care practice. See Figure 2 and 3.

Treatment: See Figure 4.

In addition:

- Patients who have had recent (3 months) exposure to one class of antibiotics should be treated with an antibiotic from another class due to the increased risk of bacterial resistance.
- Corticosteroids are NOT recommended in adults with non-severe CAP (strong recommendation, high quality of evidence) as there is no evidence it improves mortality, reduces risk of organ failure, or improves outcome. The exception is when the patient has a pre-existing diagnosis such as COPD, asthma, or autoimmune disorder where steroids are supported as a component of treatment.
- Anti-influenza treatment should be provided in those patients with CAP who test positive for influenza or those patients with a high clinical suspicion of influenza INDEPENDENT of their duration of illness before diagnosis (conditional recommendation, low quality of evidence).
- Standard antibacterial treatment should also be prescribed if there is clinical or radiographic evidence of pneumonia either in outpatient or inpatient setting (strong recommendation, low quality of evidence). Bacterial co-infections are a common and serious complication of influenza, especially in high-risk patients.
- Duration of antibiotics should be guided by a measure of clinical stability (improved vital signs, mentation, ability to eat, global improvement), and should be continued for no less than 5 days (strong recommendation, moderate quality of evidence). Failure to achieve clinical stability within 5 days is associated with a higher mortality and worse clinical outcome. Patients at this point should be assessed for resistant pathogens or complications such as empyema, lung abscess, or an alternative source of infection.
- Routine follow up chest x-rays after resolution of illness are no longer recommended if the patient's symptoms resolve in 5-7 days. In patients

	with significant smoking history, consider a future cancer-screening CT scan.
Summary	<ul style="list-style-type: none"> ● The diagnosis of CAP should be made based on clinical and radiographic findings of pneumonia. Diagnostic testing such as sputum and blood cultures and PCR testing should not be performed or relied upon for diagnosis. The diagnosis of a viral infections such as influenza does not rule-out co-infection with a bacterial pathogen, and patients who test positive for influenza should be treated with antivirals AND antibiotics, regardless of their time since onset of disease. ● A severity index score should be used to determine which patients may be treated as outpatients and which should be referred to the hospital for further evaluation. ● First line outpatient treatment for pneumonia in previously healthy adults should include high dose amoxicillin (strong recommendation, moderate quality of evidence) or doxycycline (conditional recommendation, low quality of evidence). ● Macrolides alone should only be used in areas where the resistance of pneumococcus to macrolides is < 25%. (Note that most localities in the USA have macrolide resistance approaching or greater than 25%) ● Adults with significant comorbidities should be treated with amoxicillin/clavulanate or a second or third generation cephalosporin, AND a macrolide or doxycycline. Another option is a respiratory fluoroquinolone. The choice between these options requires a risk–benefit assessment for each individual patient, weighing local epidemiological data against specific risk factors that increase the risk of individual choices, such as documented β-lactam or macrolide allergy, cardiac arrhythmia (macrolides), vascular disease (fluoroquinolones), and history of infection with <i>Clostridium difficile</i>. ● Steroids are NOT recommended for the outpatient treatment of CAP except in patients with COPD, asthma, or autoimmune disorder. ● Patients with recent exposure to one class of the antibiotics above receive treatment with antibiotics from a different class, given the increased risk for bacterial resistance to the initial treatment regimen. ● Although patients with significant risk factors for CAP due to MRSA or <i>P. aeruginosa</i> are not commonly managed in the outpatient setting, these patients may require antibiotics that include coverage for these pathogens.

	<ul style="list-style-type: none"> ● Antibiotics should be continued for a minimum of 5 days. Duration should be guided by clinical improvement. ● Patients who do not show improvement in 5 days should be re-evaluated for other pathogens or sources of infection. ● Follow-up CXR's are not required in all uncomplicated cases (conditional recommendation, low quality of evidence). In patients with significant smoking history, consider a future cancer-screening CT scan.
Reviewers	Tracey Q. Davidoff, MD FCUCM, Chyrsa Charno, PA-C, MBA, FCUCM, Joseph Toscano, MD, FCUCM
Attachments	See below

Figure 1: IDSA/ATS Criteria for Defining Severe CAP

Validated definition includes either one major criteria or three or more minor criteria

Minor criteria

- Respiratory rate ≥ 30 breaths/min
- PaO₂/FiO₂ ratio ≤ 250
- Multi-lobar infiltrates
- Confusion or disorientation
- Uremia (BUN >20 mg/dl)
- Leukopenia (WBC < 4,000 cells/ μ l)
- Thrombocytopenia (platelet count < 100,000/ μ l)
- Hypothermia (core temp < 36°C)
- Hypotension requiring aggressive fluid resuscitation

Major criteria

- Septic shock with need for vasopressors
- Respiratory failure requiring mechanical ventilation

(Table 1. 2007 Infectious Diseases Society of America/American Thoracic Society Criteria for Defining Severe Community-acquired Pneumonia) Diagnosis and Treatment of Adults with Community-acquired Pneumonia. An Official Clinical Practice Guideline of the American Thoracic Society and Infectious Diseases Society of America (Am J Respir Crit Care Med. 2019 Oct 1;200(7):e45-e67.)

Figure 2: CURB-65 Pneumonia Severity Score

1. Confusion
2. Blood Urea Nitrogen > 19 mg/dl (>7mmol/L)
3. Respiratory rate \geq 30 per minute
4. Systolic blood pressure < 90 mmHg
5. Age > 65

Each of the five items in the score is awarded 1 point if present during the evaluation, therefore the total result varies from 0 (low risk pneumonia) to 5 (highly severe pneumonia)

Score	Mortality Risk	Interpretation	Recommendations
0	0.60%	Low risk pneumonia	Outpatient treatment
1	2.70%	Low risk pneumonia	Outpatient treatment, less likely inpatient
2	6.80%	Moderate risk pneumonia	Short inpatient stay or supervised outpatient treatment
3	14%	Severe risk pneumonia	Hospitalization
4 or 5	27.80%	Severe risk pneumonia	Hospitalization, possibly ICU

Figure 3: SOAR Severity Score for Community Acquired Pneumonia

Assign 1 point for each of the following:

- A. Systolic blood pressure < 90 mmHg
- B. Partial arterial oxygen pressure to FIO₂ ratio < 250*
- C. Age 65 or older
- D. Respiratory rate \geq 30 breaths per minute

Interpretation:

- Score 0-1: Outpatient management (30-day mortality < 8%)
- Score 2-4: Inpatient management (30-day mortality 33%)

*For Urgent Care purposes this can grossly be extrapolated to an SpO₂ of < 90-92%

Figure 4: Outpatient treatment of community acquired pneumonia in adults

Healthy outpatient adults WITHOUT comorbidities or risk factors for resistant pathogens: (MRSA, pseudomonas)

- Amoxicillin 1 gm three times daily (strong recommendation, moderate quality of evidence)
OR
- Doxycycline 100 mg twice daily (conditional recommendation, low quality of evidence)
OR

A macrolide such as azithromycin (standard dosing) or clarithromycin 500 mg twice daily. **ONLY IN AREAS WHERE PNEUMOCOCCAL RESISTANCE TO MACROLIDES IS < 25%**

(n.b. The rate of macrolide resistance among *S. pneumoniae* isolates in the US is approaching 25-30%.)

Outpatient adults WITH comorbidities such as chronic heart, lung, liver, or renal disease, DM, alcoholism, malignancy, or asplenia:

- Amoxicillin/clavulanate 500/125 mg three times daily or 875/125 mg twice daily or 2,000/125 mg twice daily or a cephalosporin such as cefpodoxime or cefuroxime
AND
- Macrolide (azithromycin or clarithromycin) OR doxycycline 100 mg twice daily.
OR
- Monotherapy with a respiratory fluoroquinolone, moxifloxacin or levofloxacin or Gemifloxacin (strong recommendation, moderate quality of evidence)

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CUCM POSITION STATEMENTS

POSITION STATEMENT #1: CORTICOSTEROID STEWARDSHIP IN URGENT CARE MEDICINE

Subject	Corticosteroid (CS) Stewardship Best Practices
Patient Population	Adults and children
Rationale	<p>Steroid stewardship is needed in all clinical settings, including Urgent Care. It is acknowledged that corticosteroids can be a critical tool in the management of both acute and chronic conditions. The focus of this stewardship statement is to create awareness amongst clinicians regarding CS usage, encourage a stewardship approach, and to educate patients on the risks and benefits of their use and overuse.</p>
Introduction	<p>Steroid stewardship is the systematic effort to administer or prescribe glucocorticoids in a rational, evidence-based manner, balancing any benefits and the potential risks. There is evidence that even a short course of CS increases the risk of fracture, blood clots, GI bleeding, mood changes, sleep disturbances, heart failure, and sepsis. Long term or repeated use of CS can result in adrenal insufficiency and/or adrenal crisis. These risks may be present with a lifetime cumulative dose of steroids with a lower threshold than might be expected.</p> <p>Significant drug interactions exist that impact how steroids and medications are metabolized, either increasing or decreasing the effect of CS and/or medications. CS are frequently involved in malpractice claims which can lead to costly payments and may result in a report to the National Practitioners Data Bank (NPDB).</p>
Discussion	<p>There is evidence that patients benefit from the proper utilization of CS and that they can potentially suffer serious consequences for using CS even when indicated.</p> <p>Corticosteroid stewardship recognizes physicians' and advanced practice providers' responsibility to practice evidence-based medicine. Clinicians must assess the need for systemic CS in each individual patient, balancing benefit versus risk of harm. Clinicians have the responsibility to educate patients on the risk and benefits of CS based on the patient's condition and individual health status including adverse drug reactions and drug interactions.</p> <p>Major drivers for the inappropriate use of CS include clinicians' lack of understanding of the risks of even short-course steroids, the appropriate and inappropriate indications for systemic CS, and patient expectations.</p> <p>Strategies to assist clinicians with steroid stewardship:</p> <ul style="list-style-type: none">• Healthcare organizations should develop their own CS stewardship statement and/or policies and procedures

- Each organization and clinician should strive to use the lowest effective dose for the shortest effective duration to manage the acute medical problem
- To support the CS statement, organizations should develop a system to monitor CS utilization among clinicians and then to provide coaching as necessary to comply with the CS stewardship statement and evidence-based medicine
- Clinicians should be encouraged to provide information to patients on the risks and benefits of steroid use and to document that discussion in the medical record
- Some healthcare organizations may even consider requiring clinicians to have patients sign an informed consent, as is customary with steroid epidural or joint injections
- Clinicians are asked to consider CS sparing treatment options when CS use is not supported by guidelines

Summary

Just as antibiotic stewardship is a clinician’s responsibility, so is CS stewardship. A change in CS prescribing practices will require ongoing education and involve extra effort and time spent with patients. Clinicians are encouraged to stay current on the appropriate use of CS and the potential risks of overuse and misuse. Medical providers should have a conversation with each patient to explain the decision to recommend CS for a specific diagnosis. Clinicians should include documentation in the medical record of the discussion with the patient on the risks and benefits of corticosteroids.

Proven Benefit to Balance Any Harm	May be beneficial depending on clinical situation	Potential Harm > Benefits
<ul style="list-style-type: none"> • Bell’s Palsy, including Ramsay-Hunt Syndrome • Flares of diagnosed rheumatologic conditions • Asthma exacerbations • Significant COPD exacerbations • Croup • Presumptive diagnosis of polymyalgia rheumatica, pending confirmation • Presumptive diagnosis of temporal arteritis, pending confirmation 	<ul style="list-style-type: none"> • Severe or significant contact dermatitis where topical steroids may be insufficient or contraindicated* • Pericarditis • Gout • Pharyngitis with severe pain, swelling • Urticaria/angioedema • Anaphylaxis 	<ul style="list-style-type: none"> • Symptom relief in URI, RTI, cough • Pneumonia • “Pick me up” • Allergic or other rhinitis • Sinusitis • Otitis media • Varicella zoster (shingles), except Ramsay-Hunt • Mild to moderate severity strep/viral pharyngitis • Acute musculoskeletal injuries including back and neck pain • Acute radiculopathy • Osteoarthritis • Tendonitis • Non-rheumatologic arthralgia • Aphthous stomatitis (consider topical)

*Consider systemic steroids if rash involves > 20% of the body, or on areas sensitive to more than low-potency steroids, such as genital area or face

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Corticosteroid Stewardship – Specific Medical Conditions

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Steroid Statements

12. Joint Oral Corticosteroid Stewardship Statement

<https://www.aafa.org/media/2244/oral-corticosteroid-stewardship-statement-november-2018.pdf>

13. Breathe California: Oral Corticosteroid Stewardship Statement

<https://www.lungsrus.org/oral-corticosteroid-stewardship-statement/>

14. Oral corticosteroids stewardship for asthma in adults and adolescents: A position paper from the Thoracic Society of Australia and New Zealand

<https://onlinelibrary.wiley.com/doi/full/10.1111/resp.14147>

Medicolegal Considerations

15. Informed consent and its documentation: Implications for medical malpractice liability

<https://bcmj.org/articles/informed-consent-and-its-documentation-implications-medical-malpractice-liability>

16. Corticosteroids: Side Effects, Legal Considerations and Legal Adventures

<https://www.hmpgloballearningnetwork.com/site/thederm/site/cathlab/event/corticosteroids-side-effects-legal-considerations-and-legal-adventures>

17. Medicolegal Considerations Regarding Steroid Use in Otolaryngology: A Review of the Literature

<https://pubmed.ncbi.nlm.nih.gov/34151596/>

POSITION STATEMENT #2: CHAPERONES IN URGENT CARE ENVIRONMENT OF CARE

The College of Urgent Care Medicine recommends that Urgent Care organizations establish clear policies on the use of chaperones in their center(s) as a best practice. Clear policies protect the patient, the provider, and the organization. The organization might consider the following when creating its policy.

- Chaperones should be offered for any sensitive examination to include:
 - Any rectal, genital or breast examination
 - When the patient requests a chaperone
 - When the provider recommends a chaperone.
- Individuals who can serve as a chaperone should be defined (e.g., any licensed or unlicensed member of the healthcare team who has also agreed to serve as a chaperone such as medical assistants, nurses, and technicians). Chaperones are expected to uphold professional standards for patient privacy and confidentiality.
- Chaperone discussions are best conducted in the back office during triage if a sensitive exam is anticipated or between the provider and the patient.
- If a patient declines a chaperone, the provider bears ultimate responsibility to determine whether to:
 - Provide the examination without the chaperone based on urgency and/ or clinical judgment; or,
 - Suggest the patient return another day based on staffing; or,

- Suggest the patient seek care at another location where a more gender appropriate provider is available.
- Electronic health record (EHR) documentation should include the presence and identification of the chaperone involved in the examination. If the patient declined a chaperone, document the details of the declination (discussion/ decision for ongoing care).
- The policy is to be consistently applied irrespective of the gender of the provider and patient.

NOTE: Some states require medical chaperones during certain examinations. Organizations should verify if their state has regulations on chaperones.

URGENT UPDATES: SEPTEMBER 2022

NIRMATRELVIR USE AND SEVERE COVID-19 OUTCOMES DURING THE OMICRON SURGE

According to this study published in NJEM, the antiviral drug Paxlovid appears to reduce the risk of dying from COVID-19 by 79% and decrease hospitalizations by 73% in at-risk patients who are ages 65 and older. Among patients 65 years of age or older, the rates of hospitalization and death due to Covid-19 were significantly lower among those who received nirmatrelvir than among those who did not. No evidence of benefit was found in younger adults. **Full Access:** [NJEM](#)

CHARACTERISTICS OF ELECTRIC SCOOTER AND BICYCLE INJURIES AFTER INTRODUCTION OF ELECTRIC SCOOTER RENTALS IN OSLO, NORWAY

In this cohort study of 3191 patients with e-scooter or bicycle injuries, e-scooter injuries commonly occurred at nighttime and involved young adults who were not helmeted and most often intoxicated. In contrast, most bicycle injuries were sustained during commuting hours and involved riders of a wider age range who were often helmeted and less likely to be riding while intoxicated. The rate of intoxication in e-scooter riders injured at nighttime was high. **Full Access:** [JAMA](#)

ASTHMA AND THE RISK OF SARS-COV-2 INFECTION AMONG CHILDREN AND ADOLESCENTS

Over 6 million pediatric severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infections have occurred in the United States. A retrospective cohort study of 46 900 children, 6324 (13.5%) met criteria for asthma. Children with asthma were more likely to be tested for SARS-CoV-2 infection than children without asthma (33.0% vs 20.9%, $P < .0001$). There was no evidence of effect modification of this association by inhaled corticosteroid prescription, history of severe exacerbation, or comorbid atopic diseases. Researcher found that children with asthma have a similar SARS-CoV-2 infection risk as children without asthma. **Full Access:** [AAP](#)

RACIAL AND SEX DISPARITIES IN GOUT PREVALENCE AMONG US ADULTS

In this cross-sectional study of 18 693 participants, gout was 1.8 times more prevalent among Black women than White women and 1.3 times more prevalent among Black men than White men. These associations attenuated most after adjusting for poverty, diet, body mass index, and chronic kidney disease (CKD) among women and for diet and CKD among men. These findings suggest that racial disparities in gout may be explained by diet, social determinants of health, and CKD, which could help identify interventions to reduce these disparities. **Full Access:** [JAMA](#)

MINOR CONSENT LAWS FOR SEXUALLY TRANSMITTED INFECTION AND HIV SERVICES.

Adolescents in the US have reported that a significant barrier to seeking sexually transmitted infection (STI) and HIV services is concern that a guardian will find out. To address this barrier, states have enacted

statutes granting minors legal capacity to consent to STI/HIV services without their guardians' involvement. Although reviews of STI/HIV minor consent laws exist,²⁻⁴ many are dated, have unclear methodology, provide conflicting information, or lack details needed to serve adolescents, researchers, and clinicians. **Full Access:** [JAMA](#)

EVUSHELD TREATMENT TIMING SET

People eligible for COVID-19 preexposure prophylaxis (PrEP) with the monoclonal antibody combination of tixagevimab and cilgavimab (Evusheld) should be treated every 6 months to maintain protection against infection, according to the recently revised Fact Sheet for Healthcare Providers. **Full access:** [JAMA](#)

OVER HALF OF KNOWN HUMAN PATHOGENIC DISEASES CAN BE AGGRAVATED BY CLIMATE CHANGE

Climate change can affect human pathogenic diseases; however, the full extent of this risk remains poorly quantified. Researchers carried out a systematic search for empirical examples about the impacts of ten climatic hazards sensitive to greenhouse gas (GHG) emissions on each known human pathogenic disease. They found that 58% (that is, 218 out of 375) of infectious diseases confronted by humanity worldwide have been at some point aggravated by climatic hazards. **Full Access:** [Nature](#)

WHEN TO USE ANTIBIOTICS IN COVID-19: A PROPOSAL BASED ON QUESTIONS

Safe antimicrobial stewardship strategies aim to limit indiscriminate use to decrease antimicrobial resistance. The use of antibiotics in COVID-19 is not yet standardized, and there is no evidence for their routine use. There is no evidence to justify the systematic use of antimicrobials in COVID-19. The COVID-19 treatment recommendations seek to provide knowledge regarding treatment; standardizing a management algorithm requires validation in clinical trials and studies of greater methodological rigor. **Full Access:** [Cureus](#)

ASSESSMENT OF CHANGES IN VISITS AND ANTIBIOTIC PRESCRIBING DURING THE AGENCY FOR HEALTHCARE - Research and Quality Safety Program for Improving Antibiotic Use and the COVID-19 Pandemic.

In this cohort study comprising members of 389 US ambulatory practices, the Agency for Healthcare Research and Quality Safety Program for Improving Antibiotic Use Program addressed attitudes and culture that challenge judicious antibiotic prescribing and incorporated best practices for the management of common infections. Between September 2019 and November 2020, antibiotic prescribing at clinic visits decreased from 18% to 9%, and antibiotic prescribing at acute respiratory infection visits decreased from 39% to 25%. **Full Access:** [JAMA](#)

THE FREQUENCY AND CHARACTERISTICS OF EPINEPHRINE USE DURING IN-FLIGHT ALLERGIC EVENTS

Allergic reactions account for 2-4% of medical events in-flight and 5.5% of all medical events in passengers 18 years and under. A retrospective study of the GBMS showed that epinephrine administration was recommended in 398 passengers. Of those, 328 (82.4%) ultimately received at least one dose of epinephrine. Passengers older than 12 years of age were at a statistically higher risk for epinephrine administration. **Full Access:** [Annal of Allergy, Asthma & Immunology](#)

NEW SECTION!

URGENT CARE CLINICAL ANSWERS

Are wound cultures needed after incision and drainage of abscesses?

Avoid wound cultures in patients with uncomplicated skin and soft tissue abscesses after successful incision and drainage and with adequate medical follow-up.

Skin and soft tissue infections are a frequent reason for visiting an Urgent Care center. Opening and draining an abscess is the appropriate treatment. Culture of the drainage is not normally needed as the result will not routinely change treatment.

Source: [choosing wisely](#)

What are the appropriate steps when evaluating a heart murmur in a pediatric patient?

Many children have heart murmurs, but most do not have heart disease. A detailed history and physical examination can assist clinicians identifying children at increased risk for significant heart disease. When a pathologic murmur is suspected (a sound level of grade 3 or louder, a diastolic murmur or an increase in intensity when the patient is standing, family history of Marfan syndrome or sudden death in young family members, malformation syndrome, increased precordial activity, decreased femoral pulses, abnormal second heart sound, clicks), patient must be referred to a pediatric cardiologist. Echocardiography is not always needed to diagnose pediatric murmurs. One study showed that direct referral for echocardiography was an expensive way to evaluate children with heart murmurs.

Source: [AAFP](#)

What is the evidence-based recommendation for referral to allergist for skin testing after an insect sting?

Patients with a history of a systemic reaction to an insect sting should be evaluated with skin testing and, if positive, treated with venom immunotherapy to decrease risk of recurrent reaction. Evidence A (good-quality patient-oriented evidence, meta-analysis of randomized controlled trials).

Source: [AAFP](#)

EMAIL your clinical questions to the Editors: Tracey Davidoff, MD, FCUCM tdavidoff@coucm.org OR Cesar Mora Jaramillo, MD, FAAFP,FCUCM cmjaramillo@coucm.org

Disclaimer: This material is for educational purposes only. Medical practice and knowledge are 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.

CAUSE FOR APPLAUSE



In this issue of Cause for Applause we wish to recognize the rapidly growing number of Fellows of the College of Urgent Care Medicine. These fellows represent the best of us who work every day to provide the highest quality of medicine and advance the specialty of Urgent Care Medicine. They should be honored for their dedication and contributions.

Do you want to be recognized? Fellows include currently practicing physicians, PA's, and NP's who have a solid foundation in Urgent Care and who are active members of CUCM for at least 1 year. Further requirements can be found here:

<https://www.ucaoa.org/About-UCA/Strategic-Affiliates/College-of-Urgent-Care-Medicine>

Those who achieve fellowship status will be entitled to use the initials FCUCM - Fellow of the College of Urgent Care Medicine®

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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 3 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 learning@ucaoa.org with questions.

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Disclaimer

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