



COLLEGE OF
URGENT CARE
MEDICINE

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FROM THE COLLEGE OF URGENT CARE MEDICINE (CUCM®)

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

HERE WE GO AGAIN!



The flu season is upon us. This is supposed to be the busy season for us in urgent care and most agree that this is going to be a unique season as it shapes up to be a combined flu-COVID season. With this surge in COVID cases that we are currently experiencing, there is anticipation that urgent care volumes could reach their highest levels. Here are some things that we will need to be aware of that may impact our clinical practices and our providers:

1. **Staffing shortages:** This is probably the most important concern facing many of our clinical practices and these shortages are not limited to just the providers. Many practices are struggling with medical assistant and radiology technician staffing as well. Actively recruiting and developing unique ways to retain staff is a challenge that we will need to take up this season.
2. **Supplies shortages:** Supply chain issues continue to plague many industries and healthcare is not immune to it. COVID and other testing supply shortages can seriously impact our clinic operations. We will need to be extra vigilant and judicious in using our supplies, while also maintaining close connections with our suppliers to maintain sufficient inventory.
3. **Triage and stopping walk-ins:** Extremely high patient volume can lead to certain centers making decisions to close their site to new patients who are walking in to be seen. This frankly is a slippery slope. Often, we do not know what concerns bring patients in. Decisions to stop walk-ins prior to the official closing times can lead to missing serious pathologies in need of emergent care. It is essential that clinical leadership develops and trains personnel in good triage policies. The College's Clinical Response Taskforce has developed a [Red Flags Triage Policy](#) that can help guide triage decisions.
4. **Patient Experience issues:** High patient volume often leads to increased wait times. They can also lead to increased clinical errors as providers are trying to see more patients in the same allotted time. These issues impact the patient experience. Many practices are already struggling with declining patient experience scores. Our teams should be aware of these issues and proactively work towards mitigating negative patient experiences.

Unlike last year, people are now getting a chance to gather during the holidays. This is great progress; however, shared experiences lead to shared viruses. Preparing accordingly to meet this surge is our latest challenge.

Urgent care as a specialty has proven its vital role in this pandemic. Consumers valued the ready access to patient-centric quality care offered by centers across the country. Focusing on the patient as our customer is what launched a new industry decades ago. We cannot lose sight of that differentiator despite our many challenges. Anticipating where breakdowns might occur now and addressing those areas will not only manifest in a better patient experience, but also reduce staff and provider stress.

Thank you for everything that you all are doing to help your communities. You are all awesome. Keep up the great work and Happy Holidays!

Jaz

FROM THE EDITORS—CHANGING OF THE GUARD

We are sad to announce that Sean McNeeley, MD, founder, and editor of the premier newsletter for CUCM members has resigned from his UCA and CUCM activities. We would like to introduce ourselves as the new editors-in-chief of Urgent Caring, Tracey Davidoff, MD and Cesar Jaramillo, MD. As members of the committee and frequent contributors to the newsletter, we are happy to take on this role together.

Dr. McNeeley has served the urgent care industry and the specialty of urgent care medicine for many years. He has been the President of the Urgent Care Association and the College of Urgent Care Medicine. He has chaired countless committees and has made a real difference in future of urgent care medicine. His energy and passion for urgent care seemed endless. He has been a mentor to many of us, inspiring and fostering the ideals of volunteerism, passion for urgent care medicine, and life-long learning. He will be deeply missed.

Urgent Caring was Dr. McNeeley's vision of a digital platform to share information among members of CUCM with case presentations, relevant articles on topics trending in the industry, images, editorials, and later CME. His goal was for the newsletter to be a true value to our members.

Although we cannot hope to fill his shoes, we can be true to his vision, and aspire to continue making Urgent Caring a value to CUCM members. We hope you continue to enjoy reading Urgent Caring as much as we enjoy producing it. As always, if you have topics you would like to see addressed, would like to contribute an article, or have any comments you want to share, please reach out. Anyone can submit an article, member or not, provider, nurse, or manager, as long as the subject is current and relevant to Urgent Care.

Thanks for reading!

Tracey Davidoff, MD, FCUCM
tdavidoff@coucm.org

Cesar Mora Jaramillo, MD, FCUCM
cmjaramillo@coucm.org

FROM THE CHAIR OF THE URGENT CARE PEDIATRICS SECTION

Pearls from a Practicing Pediatrician – “Finding joy in what we do – look to the children”

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



I am unabashedly a pediatrician by training (though I have spent a third of my career taking care of adults, too) and am a full time pediatric urgent care physician now. Like each of you, I have been submerged in the COVID pandemic and have been a front-line care provider. While we had a bit of a lull in patient volumes in 2019, that has rebounded. For over a year our volumes are crazy busy, we are understaffed and overworked, and it is a struggle at times to know where the energy will come for another shift of PPE, long lines, long wait times, and incredible stress. In my career, I have never seen the level of discouragement, burnout, fatigue and almost a sense of hopelessness as we look toward the future with no end in sight. These are difficult times for front line urgent care providers as well as for others in healthcare. It is very hard to find joy in what we do.

Yet, I believe that is exactly what we each need to do. For a model of how to find joy all we need to do is look to the children. This time of year has to be one of the most exciting and joyful for all children, regardless of their personal situation. Children simply love the holidays. They love holiday lights, decorations, the possibility of receiving gifts, and the possibility of being around people that they love and that love them.

Without a doubt, there are children who are living in challenging situations. According to the American Academy of Pediatrics, one in six children in this country are living with food insecurity. School breakfast and lunch programs are geared to help children with this concern. Homelessness is being markedly impacted by the COVID pandemic. A recent article by the American Academy of Pediatrics reports that 59% of people who experience homelessness are children under 18 years of age who are either unaccompanied by an adult or are homeless as part of a family unit. It is estimated that on any given night, around 58,000 families (including 100,000 children) experience homelessness. Further, many children are being orphaned by

losing one or more parents to the COVID pandemic. For sure, it is challenging time for many children.

However, regardless of their situation, children do not allow it to take away their joy; their joy of the holidays, their joy of the decorations and lights, the joy of getting presents or gifts and the joy of being around people who care for them and love them.

I believe each of us can model a child-like perspective and can find joy in what we are doing. What we are doing is making a difference. We all went into medicine to help people. To bring a healing touch, a kind word, a caring bedside manner, and to even in small ways to work to improve the lives of the patients we touch on a daily basis. For many, we are the only access point for patients who are sick, worried, stressed, and need our touch. Please never forget the importance of what each of you is doing, one patient at a time. In many ways, you are bringing joy and peace to your patients with each interaction. I hope and trust this will give you a sense of joy and peace as well as we enter the holiday season. **Best wishes!**

URGENT CARE CASE STUDY

ANTERIOR AND POSTERIOR FAT PAD SIGNS

Cesar Mora Jaramillo, MD, FAAFP, FCUCM



Reading x-rays in Urgent Care can be challenging, especially when fractures are not easily identified. This article discusses the use of two important radiographic signs that are indirect indicators of occult fracture when present.

Displacement of fat pads on radiographs can be suggestive of hemorrhage or an elbow joint effusion; but in the setting of known trauma or suspected injury, these two signs are considered a marker of an occult nondisplaced fracture.¹ In adults, this is usually a radial head fracture, whereas in children a supracondylar fracture.²



An anterior fat pad can be considered a normal variant when it appears as a narrow radiolucent strip superior to the radial head and anterior to the distal humerus. A wide anterior fat pad, also known as "sail" sign, has a sensitivity of 96% and a positive predictive value (PPV) of 64%.¹

A posterior fat pad is not normally visible, but when

noted in x-rays it appears as a radiolucency posterior to the distal humerus and adjacent to the olecranon fossa in children with a distal humeral fracture. The sensitivity varies significantly in the literature with the largest study suggesting a sensitivity of approximately 88 percent and a PPV of 79%.¹

Case:

A 2 year 10 months old Male presents to Urgent Care with foster mom for evaluation of right arm pain and edema after jumping of the couch. Pt experienced R elbow trauma against a table. After the incident patient has limited the use of this extremity. No LOC or head injury. No other injury reported.

Exam: Patient is clearly uncomfortable. He can flex and extend fingers and grip without difficulty. Left elbow moderate edema is observed and patient is uncomfortable with diffuse palpation of the elbow. Limited range of motion of the elbow as patient cries. Radial pulse is normal, skin is intact. He walks with steady gait.

Imaging: x-rays showed abnormal anterior humeral line with positive sail signs concerning for supracondylar fracture.

He was treated with a sugar tong splint and sling in addition to NSAIDS and referral to orthopedics.



References

1. Ryan LM. Elbow anatomy and radiographic diagnosis of elbow fracture in children. UpToDate. <https://www.uptodate.com/contents/elbow-anatomy->

and-radiographic-diagnosis-of-elbow-fracture-in-children?search=fat+pad+sign&ionRank=1&usage_type=default&anchor=H13&source=machineLearning&selectedTitle=1~150&display_rank=1#H13. Accessed December 5, 2021.

2. Gaillard F. Sail Sign (elbow): Radiology reference article: Radiopaedia.org. Radiopaedia. <https://prod-assets-static.radiopaedia.org/articles/sail-sign-elbow-1?lang=us>. Accessed December 5, 2021.

EXPERT INSIGHTS

COVID VACCINATIONS FOR KIDS 5-11 YEARS OF AGE

Victoria Pittman, PA-C

The Pfizer BioNTech COVID-19 vaccine was granted emergency use authorization by the FDA for children ages 5 to 11 years in late October 2021. To date, there have been over 1.9 million cases¹, 8,300 hospital admissions², and around 100 deaths in this age group³. In August 2021, due to the circulating Delta variant, new cases of COVID-19 in children exceeded the number of new cases in adults for the first time in the pandemic. The impact of COVID-19 extends into many areas of health and well-being for children and their families. Data from the vaccine trial has shown this to be an effective and safe vaccine for this age group. The vaccine was found to be 90.7% effective in preventing COVID-19 and no serious side effects were detected in the study participants.⁴

¹ <https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2021-11-2-3/03-COVID-Jefferson-508.pdf>

² <https://www.fda.gov/news-events/press-announcements/fda-authorizes-pfizer-biontech-covid-19-vaccine-emergency-use-children-5-through-11-years-age>

³ <https://www.fda.gov/media/153447/download>

⁴ <https://www.fda.gov/media/153447/download>

- The dose is one-third of the dose (10 µg) than that for those ≥12 years of age (30 µg).
 - The dose is not weight-based.
 - The vial for this age group (5-11 years) has a distinctive orange top.
 - You cannot take one-third of the dose of the 30-µg vial because it is mixed in a different buffer than the one used for the 10-µg dose.
 - Can be co-administered with other vaccines, preferably at separate sites.
- Talking to parents and patients about the risks and benefits of the COVID vaccine
 - Side effect profile is similar to what is seen in adults.
 - Injection-site pain, fever, headache, and body aches that are self-resolving within a few days.
 - Myocarditis: For individuals over 11 years of age, the risk of myocarditis from the COVID vaccine is much less than the risk from COVID-19 infection. In older children (>12 years old), the severity of vaccine-associated myocarditis is significantly less than that from naturally acquired infection. No cases of myocarditis were seen in the vaccine trial for children ages 5-11 years, but safety monitoring is ongoing.

For the urgent care physicians who are board certified in pediatrics, Hippo Education has created a resource to help you confidently answer your American Board of Pediatrics MOCA-Peds questions. The MOCA-Peds 2021 eBook is a downloadable PDF that is easily searchable. Each chapter details one of the 45 ABP learning objectives, with a key-takeaway “Pearls” section at the top and a deeper dive into the topic below. And the best part...it’s free!

[\[CLICK TO DOWNLOAD\]](#)

Not taking MOCA-Peds? This resource is a great refresher on common pediatric topics for all clinicians.

**BEST PRACTICE SUMMARY FROM THE COLLEGE OF URGENT CARE
MEDICINE**

Group A Streptococcal Pharyngitis Diagnosis and Treatment

Date Reviewed	12/06/2021
Subject	Group A Streptococcal Pharyngitis Diagnosis and Treatment
Patient Population	Children and Adults
Rationale	<p>Pharyngitis is one of the most common conditions encountered by clinicians in the Urgent Care setting.</p> <p>Identifying patients that meet criteria for testing and benefit from antibiotic treatment is paramount to avoid misdiagnosis and unnecessary antibiotic treatment. Hence, accurate diagnosing streptococcal pharyngitis will reduce sequelae and curb antibiotic overuse in non-streptococcal pharyngitis.</p>
Introduction	<p>Pharyngitis is diagnosed in eleven (11) million patients in the outpatient setting each year in the United States. Although most episodes are caused by viruses, group A beta-hemolytic streptococcal (GABHS) infection accounts for approximately 15% to 30% of sore throats in children and 5% to 15% in adults and is more common in the spring and late winter.</p> <p>Infection is self-limited and resolves within a few days, even without treatment.</p> <p>Although complications are rare in the United States, they can be prevented if antibiotics are started within the first nine days of infection.</p>
Evidence based guideline with strength of evidence	<p>A combination of clinical decision and selective use of testing / results is crucial to avoid unwarranted antibiotic prescriptions and reduce the cost of unnecessary testing.</p> <p>The strongest independent predictors are patient age of five to 15 years, absence of cough, tender anterior cervical adenopathy, tonsillar exudates, and fever (see Table 1).</p> <p>Patients with clear viral symptoms do not need testing or antibiotic treatment (see Table 1).</p> <p>A rapid antigen detection test (RADT) should be ordered in patients with a modified Centor or FeverPAIN score of 2 or 3 (see Flowchart). ACP suggests testing with a modified Centor score of 1 to 3.</p> <p>Positive RADTs are highly specific and do not necessitate a back-up culture.</p>

	<p>AAP recommends a back-up culture after a negative RADT result because of higher risk for complications in children (peritonsillar abscess, mastoiditis, retropharyngeal abscess, cervical lymphadenitis, acute rheumatic fever, post-streptococcal glomerulonephritis). ++ Routine use of back-up throat cultures for a negative RADT is not recommended for adults.</p> <p>Testing is not routinely indicated for children younger than 3 years of age, unless risk factors are identified: such as an older sibling with GABHS infection.</p> <p>Follow-up posttreatment testing, testing or empiric antibiotic treatment of asymptomatic household contacts of patients with GABHS pharyngitis is not routinely recommended.</p> <p>Empiric antibiotics are recommended for modified Centor score of 4. Patients diagnosed with GABHS pharyngitis may return to work or school 24 hours after starting antibiotics and when afebrile.</p>
<p>Discussion</p>	<p>Diagnosis:</p> <ul style="list-style-type: none"> • It is not recommended to order any blood work for diagnosis of acute uncomplicated GABHS pharyngitis. • Streptococcal antibody titers are not routinely recommended. <p>Imaging:</p> <ul style="list-style-type: none"> • It is not recommended in the evaluation of acute uncomplicated GAS pharyngitis. <p>Antibiotic Treatment:</p> <ul style="list-style-type: none"> • Antibiotic of choice include oral penicillin V; intramuscular penicillin G benzathine and amoxicillin (See table 2). • First-generation cephalosporins are used for patients with type IV hypersensitivity to penicillin. • Clindamycin, clarithromycin*, or azithromycin * should be considered for patients with type I hypersensitivity to penicillin. <p>Length of treatment:</p> <ul style="list-style-type: none"> • The recommended duration of therapy is 10 days except when IM Penicillin is used (single dose). <p>Symptomatic therapy:</p>

	<ul style="list-style-type: none"> • Nonsteroidal anti-inflammatory drugs (NSAIDs) are beneficial in relieving symptoms. • Adjunctive therapy with a corticosteroid is not recommended. • Throat lozenges and topical anesthetics may alleviate pain but must be used frequently. • Chinese herbal therapies are not effective in the symptomatic treatment. • Topical anesthetics containing benzocaine can be used in adults but should be avoided in children due to risk of methemoglobinemia. <p>Referral to a Specialist:</p> <ul style="list-style-type: none"> • The American Academy of Otolaryngology–Head and Neck Surgery recommends tonsillectomy for patients with recurrent streptococcal pharyngitis (seven or more throat infections -viral or bacterial- in one year, five or more infections per year for the past two years, or three or more infections per year for the past three years). • Patients with allergic reactions to multiple antibiotic treatments, or a history of peritonsillar abscess. • Patients that are seriously ill, continue to deteriorate clinically or present with clinical complications, might be referred to higher level of care.
Summary	<p>Streptococcal pharyngitis is a very common diagnosis in Urgent Care. Clinicians must be recognizant of the implications related to inappropriate testing or unnecessary antibiotic treatment when addressing patients with symptoms of pharyngitis.</p> <p>A combined approach using clinical decision rules and selective use of testing / results is the best method to diagnose and select patients that benefit from antibiotic treatment.</p> <p>The appropriate use of antibiotic regimen shortens the duration of symptoms, reduces the likelihood of transmission to close contacts, and prevents the development of complications.</p> <p>Referral to Specialist should be considered under certain circumstances.</p>

References	<p>Norton LE, Lee BR, Harte L, et al. Improving guideline-based streptococcal pharyngitis testing: A quality improvement initiative. American Academy of Pediatrics. https://pediatrics.aappublications.org/content/142/1/e20172033. Published July 1, 2018. Accessed August 3, 2021.</p> <p>Pharyngitis (STREP Throat): Information for clinicians. Centers for Disease Control and Prevention. https://www.cdc.gov/groupastrep/diseases-hcp/strep-throat.html. Published November 1, 2018. Accessed August 3, 2021.</p> <p>Choby BA. Diagnosis and treatment of streptococcal pharyngitis. American Family Physician. https://www.aafp.org/afp/2009/0301/p383.html. Published March 1, 2009. Accessed August 4, 2021.</p> <p>Kalra MG, Higgins KE, Perez ED. Common questions about streptococcal pharyngitis. American Family Physician. https://www.aafp.org/afp/2016/0701/p24.html. Published July 1, 2016. Accessed August 4, 2021.</p> <p>Randel A. Idsa updates guideline for managing group a streptococcal pharyngitis. American Family Physician. https://www.aafp.org/afp/2013/0901/p338.html. Published September 1, 2013. Accessed August 4, 2021.</p> <p>Shulman ST, Bisno AL, Clegg HW, et al. Clinical practice guideline for the diagnosis and management of Group a STREPTOCOCCAL Pharyngitis: 2012 update by the infectious Diseases Society of America. OUP Academic. https://academic.oup.com/cid/article/55/10/e86/321183. Published September 9, 2012. Accessed August 4, 2021.</p>
Reviewers	<p>Author: Cesar Mora Jaramillo, MD, FAAFP Reviewer: Tracey Davidoff, MD, FACP, FCUCM</p>
Attachments (flow charts, graphics, tables, etc.)	<p>Table 1 (Features Suggestive of Group A Streptococcal and Viral Pharyngitis) Table 2 (First - line Treatments) Flow Chart (Clinical Decision Rule for Diagnosis GABHS Pharyngitis – Modified Centor Criteria)</p>

++When using one of the newer highly sensitive optical immunoassay or molecular tests, a backup culture is of little value, even in children, and may be omitted. Clinicians should be aware of the type of RADT used in their clinical setting.

**Resistance of group A strep to these agents is well-known and varies geographically and temporally.*

Table 1 (Features Suggestive of Group A Streptococcal and Viral Pharyngitis)

Group A Streptococcal Infection

- Sudden onset of sore throat
- Age 5 to 15 years
- Fever
- Headache
- Nausea, vomiting, abdominal pain
- Tonsillopharyngeal inflammation
- Patchy tonsillopharyngeal exudates
- Palatal petechiae
- Anterior cervical adenitis (tender nodes)
- Presentation in winter or early spring
- History of Exposure to Streptococcal pharyngitis
- Scarletiform rash

Viral Infection

- Conjunctivitis
- Coryza
- Cough
- Diarrhea
- Hoarseness
- Discrete Ulcerative stomatitis
- Viral exanthem

From: <https://academic.oup.com/cid/article/55/10/e86/321183>

Table 2 (First-line treatments for GABHS Pharyngitis)

Amoxicillin is as effective as penicillin and has better palatability in children.

- Children: 50mg /kg/day orally (maximum 1,000mg per day)
- Alternative: 25 mg per kg twice daily (maximum= 500 mg)
- Adults with mild to moderate GABHS pharyngitis: 500mg orally two times per day
- Adults with severe GABHS pharyngitis: 875mg orally two time per day

Penicillin G Benzathine

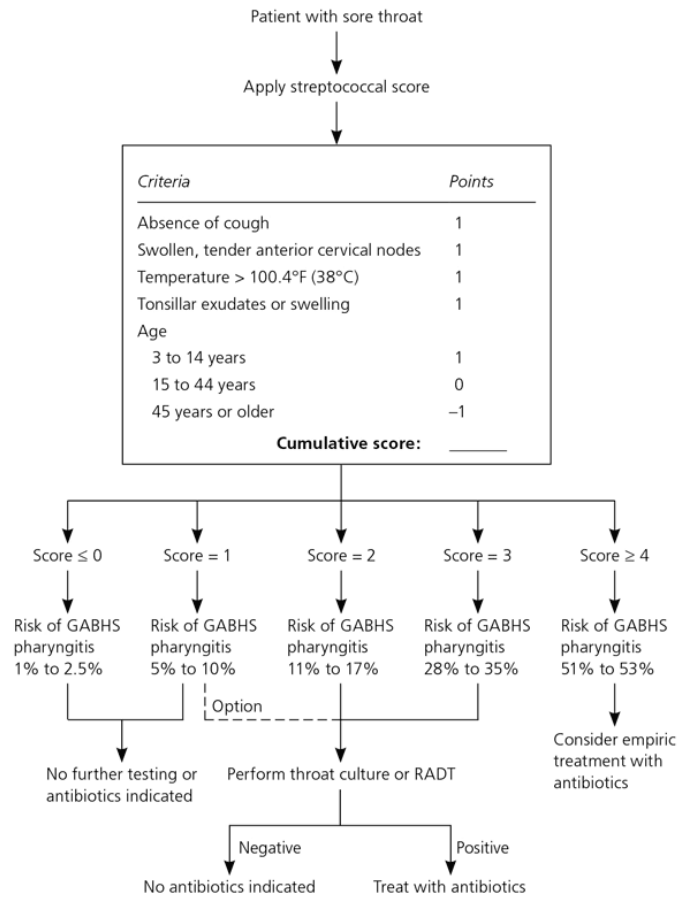
- Children < 60 lb. (27 kg): 600,000 U intramuscularly single dose
- Children ≥ 60 lb. and adults: 1,200,000 U intramuscularly single dose

Penicillin V

- Children with mild to moderate GABHS pharyngitis: 25 mg per kg per day orally, in two divided doses (maximum: 1,000 mg per day)
- Children with severe GABHS pharyngitis: 50 mg per kg per day orally, in two divided doses (maximum: 1,000 mg per day)
- Adults: 500 mg orally two times per day

From: <https://www.aafp.org/afp/2016/0701/p24.html>

Flow Chart - Clinical Decision Rule for Diagnosis GABHS Pharyngitis – Modified Centor Criteria



GABHS = group A beta-hemolytic streptococcal; RADT = rapid antigen detection testing

From: <https://www.aafp.org/afp/2016/0701/p24.html>

URGENT UPDATES—DECEMBER 2021

NEW COVID VARIANT OF CONCERN DRIVES US TRAVEL BANS

The World Health Organization (WHO) on Friday classified a new COVID-19 variant (B.1.1.529/Omicron) from South Africa as a variant of concern, which means it could be more contagious, cause more severe disease, and reduce the efficacy of vaccines and treatments. This variant has a large number of mutations, and some of these mutations have some worrying characteristics. Preliminary evidence suggests an increased risk of reinfection with this variant. **Full Access:** [Medscape](#)

DRUG OVERDOSE DEATHS IN THE U.S. TOP 100,000 ANNUALLY FOR IMMEDIATE RELEASE: NOVEMBER 17, 2021

Provisional data from CDC's National Center for Health Statistics indicate that there were an estimated 100,306 drug overdose deaths in the United States during 12-month period ending in April 2021, an increase of 28.5% from the 78,056 deaths during the same period the year before.

Overdose deaths from synthetic opioids (primarily fentanyl) and psychostimulants such as methamphetamine also increased in the 12-month period ending in April 2021. Cocaine deaths also increased, as did deaths from natural and semi-synthetic opioids (such as prescription pain medication). **Full Access:** [CDC](#)

COVID CASES HIT RECORDS IN EUROPE, PROMPTING BOOSTER SHOT RETHINK

Coronavirus infections broke records this past week in parts of Europe, once again the epicenter of a pandemic which has prompted new curbs on movement. The European Centre for Disease Prevention and Control (ECDC), the EU public health agency, recommended vaccine boosters for all adults, with priority for those over 40, in a major shift of policy. Available evidence emerging from Israel and the UK shows a significant increase in protection against infection and severe disease following a booster dose in all age groups in the short term. **Full Access:** [Medscape](#)

EXPERIMENTAL CHEWING GUM COULD REDUCE CORONAVIRUS SPREAD

A new experimental chewing gum could reduce the amount of coronavirus particles in saliva and help slow transmission, according to a recent study published in the journal *Molecular Therapy*.

The gum contains copies of the ACE2 protein on cell surfaces, which is the "spike" protein that the coronavirus uses to break into cells and infect them. Hence, it could limit the spread of virus-laden droplets when infected people are talking, breathing, or coughing. **Full Access:** [Medscape](#)

COVID ANTIVIRAL PILLS: WHAT SCIENTISTS STILL WANT TO KNOW

Two antiviral drugs have been found to cut COVID-19 hospitalizations and deaths in clinical trials of people treated soon after their initial infection. On 4 November, the

United Kingdom became the first country to approve Molnupiravir. Researchers are also keen for any clue — including from further clinical trials — as to whether the drugs affect transmission of the coronavirus or prevent illness in people who have been exposed to it. Molnupiravir acts by introducing mutations into the viral genome during viral replication. Human cells have a DNA, rather than an RNA, genome, but some laboratory experiments have suggested that Molnupiravir could cause mutations in human DNA as well. Full Access: [Nature](#)

EVALUATION OF PHARMACOLOGIC TREATMENTS FOR H₁ ANTIHISTAMINE-REFRACTORY CHRONIC SPONTANEOUS URTICARIA: A SYSTEMATIC REVIEW AND NETWORK META-ANALYSIS

In this network meta-analysis of 23 randomized clinical trials including 2480 participants, the biologic agents ligelizumab, 72 or 240 mg (large beneficial effect), and omalizumab, 300 or 600 mg (moderate beneficial effect), appeared to be effective treatments for H₁ antihistamine-refractory chronic spontaneous urticaria. With respect to the magnitude of effect size and evidence certainty, dapson; hydroxychloroquine; cyclosporine; ligelizumab, 24 mg; omalizumab, 150 mg; and zafirlukast seem to have a small beneficial effect. Full Access: [JAMA](#)

AAP UPDATES COVID-19 GUIDANCE FOR TESTING, FACE MASKS, MIS-C

This guidance is intended to assist pediatricians in understanding indications for SARS-CoV-2 testing as well as test selection and interpretation. The document also provides algorithms for common testing scenarios and information about practical considerations for in-office testing for SARS-CoV-2. Some of the recommendations include that patient treated for MIS-C wait at least 90 days after the diagnosis to receive a COVID-19 vaccine. Full Access: [AAP](#)

ACG CLINICAL GUIDELINE FOR THE DIAGNOSIS AND MANAGEMENT OF GASTROESOPHAGEAL REFLUX DISEASE

ACG updates guidelines for GERD diagnosis, pharmacologic, lifestyle, surgical and endoscopic management. Some of the recommendations include: for patients with classic GERD symptoms of heartburn and regurgitation who have no alarm symptoms, we recommend an 8-wk trial of empiric PPIs once daily before a meal; we recommend attempting to discontinue the PPIs in patients whose classic GERD symptoms respond to an 8-wk empiric trial of PPIs; we recommend PPI administration 30–60 min before a meal rather than at bedtime for GERD symptom control; we do not recommend sucralfate for GERD therapy except during pregnancy. Full Access: [The American Journal of Gastroenterology](#)

NON-SURGICAL TREATMENT OF LATERAL EPICONDYLITIS: A SYSTEMATIC REVIEW OF RANDOMIZED CONTROLLED TRIALS

There are multiple randomized controlled trials for non-surgical management of lateral epicondylitis, but the existing literature does not provide conclusive evidence

that there is one preferred method of non-surgical treatment for this condition. Lateral epicondylitis is a condition that is usually self-limited, resolving over a 12- to 18-month period without treatment.

A 2014 systematic review of RCTs of nonsurgical treatments for lateral epicondylitis identified 4 studies comparing corticosteroid injections to saline or anesthetic injections. Neither corticosteroid, platelet-rich plasma, botulinum toxin, prolotherapy, hyaluronic acid, or autologous blood injections have proven superior to saline or anesthetic injections. However, all injections that contained “placebo” significantly improved lateral epicondylitis. **Full Access:** [Pubmed](#)

SUCCESS OF COVID ANTIVIRAL PILLS HINGES ON SPEEDY, ACCURATE TESTS

U.S. could have access to a new antiviral pill from Merck expected to alter the deadly trajectory of the covid-19 pandemic — with a second option from Pfizer to follow shortly after. In clinical trials, Molnupiravir was given to non-hospitalized, unvaccinated, high-risk adult patients within five days of their first covid symptoms. Pfizer's product, Paxlovid, was tested in similar patients as early as three days — just 72 hours — after symptoms emerged. Results from the Merck trial showed the drug reduced the risk of hospitalizations by about 50% and prevented deaths entirely. Full Access: [Medscape](#)

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

Tracey Davidoff, MD, FCUCM

Reports no financial interest relevant to this newsletter

Authors

Jasmeet Bhogal, MD

Reports no financial interest relevant to this newsletter

Cesar Mora Jaramillo, MD

Reports no financial interest relevant to this newsletter

Victoria Pittman, PA-C

Reports no financial interest relevant to this newsletter

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