

Urgent Caring

First Quarter, 2022

Volume 6 Issue 8

FROM THE COLLEGE OF URGENT CARE MEDICINE (CUCM®)

LOW(ER) PATIENT VOLUME—CHALLENGES AND OPPORTUNITIES



Jasmeet Bhogal, MD, President, CUCM Board of Directors

Many of us have experienced some very drastic swings in patient volumes for some time now. There was a time just a few months/weeks back when we were in full pandemic mode with extreme surge in volumes leading to long lines at our front doors, extremely long wait times, extreme staff shortages, staff burn out and an overall negative patient experience. With COVID-19 patient numbers dropping, the volumes at most urgent care centers have seen a double-digit percentage drop as compared to the last few months, and in many cases, even to the same time last year. This drop comes with its own unique challenges. There are, however, some opportunities that we need to realize and focus on during this time.

Challenges:

1. Staffing: With the drop in patient numbers, staffing needs have to be adjusted accordingly. Many centers are finding themselves to be overstaffed and have needed to readjust their schedules to balance the staffing needs to the patient volumes. The unpredictability of staffing needs has led to constant reshuffling of staff schedules. Earlier, everyone was being requested to work more, now, they are asked to reduce their shifts.

2. Affecting the bottom line: The decrease in volume also affects the bottom line of a clinical practice. Many clinics are seeing numbers that are lower than what they were seeing during this time of the year in pre-COVID days.

It is not tough to imagine how the effects on the bottom-line and staffing changes are related as well.

Opportunities:

1. A renewed focus on higher acuity patients: Urgent care providers have the opportunity to focus again on patients who come to us to be seen for acute illnesses that are beyond just COVID testing. This allows us to return to what we do best, help patients with their acute needs, avoid unnecessary emergency room visits, and support patients in navigating the complex health care model by arranging appropriate follow-ups with their primary care providers and/or specialists as needed.

2. Focus on chronic conditions: For patients presenting with elevated blood pressure and elevated blood sugars as unrelated issues, it is a good time to discuss these concerns with patients and advise appropriate follow-ups. Medication refills to make sure that continuity of care is maintained is important as well.

3. Patient experience: The current lower patient volume provides an opportunity for us to understand aspects of our practice that work well for patient experience and make them a part of our organization's DNA. At the same time, we should focus on our blind spots and get our teams to work on these. Many of us are now afforded the luxury of digging into satisfaction data, recognizing trends over the last few months, and subsequently developing performance improvement action plans.

Now is the time for us to refocus on certain aspects of urgent care that will help build stronger and more robust clinical teams and clinical practices. Urgent care has evolved during this pandemic and continues to do so. We improve with every iteration, which is mind blowing in itself. Thank you for all you do. Stay safe.

FROM THE EDITORS—URGENT CARING WHAT TO EXPECT AND HOW TO BE A PART OF THIS CHANGE!

We are happy to announce new changes and improvements to the newsletter. Urgent Caring is now available quarterly to our members. This change will allow us to provide a diverse set of articles and expand content to improve the reader's experience. We welcome your suggestions, comments and ideas on what you find helpful and how we might improve.

We also encourage clinicians to write clinical articles, submit challenging cases, educational discussions, pediatric reviews, orthopedics reviews, best practices, image challenges - including EKG, x-rays, and rashes, occupational medicine topics, editorials relevant to urgent care or anything you think our readers would find valuable and interesting. You don't have to be a member to publish in the newsletter so ask your colleagues to participate as well. Furthermore, when you are published, you earn points towards the criteria for attainment of Fellowship Recognition - FCUCM!

And one more addition, we are pleased to announce Urgent Caring's new "**Cause for Applause**" recognition. Peer-to-peer recognition matters! Fellow clinicians can nominate individuals or an entire Center to be recognized for excelling in the Urgent Care field. This quarter, and in recognition of National Physicians' Week, we applaud all of the deserving physicians working in urgent care medicine.

It has been quite a challenge for the Urgent Care industry over the past two years. We have been through FOUR waves of covid-19 infections, the emotions in frontline staff when rapid testing was available in our centers, centers adjusting to provide

Monoclonal Antibody (mAb) infusions, and now oral therapies are available. Ugh... that is a lot for this short period. And we wonder why burnout rates are so high in healthcare.

With that said, let's dive into this newsletter content. In our first of many articles, Dr. Chris Chao takes an interesting perspective regarding covid-19 testing and clinical diagnosis and asks if clinicians are fading away from using clinical judgment and relying too much on testing? We can argue both sides as testing has been an important part of medicine, especially in certain situations when tests assist clinicians to make medical decisions. Many epidemiologists and virologists have stated that Covid-19 is here to stay and will become an endemic disease eventually. When can we treat Covid-19 like Influenza?

Thanks for reading!

Tracey Davidoff, MD, FCUCM
tdavidoff@coucm.org

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

ARE WE OVERTESTING FOR COVID-19?

CHRIS CHAO, MD, Board of Directors, CUCM



The bulk of the workflow issues and volume in the past week in our urgent care centers has been the result of patients requesting COVID-19 testing. We have seen our volumes surge significantly, especially as community testing sites are unable to keep up with demand.

Our urgent care centers already restrict testing to symptomatic patients and do not offer asymptomatic exposure testing or testing for travel documentation. Even so, we are seeing several dozens of patients come in every day requesting testing. We have even experienced patients who have learned to falsify and make up symptoms to qualify for testing.

I teach APP and medical students that a medical test should only be ordered if the test result will assist in making a diagnosis or will change management. The majority of COVID-19 testing performed in Urgent Care centers does neither.

If influenza is a clinical diagnosis, then why isn't COVID-19 a clinical diagnosis?

Influenza testing is not necessary to make the diagnosis of influenza or initiate the treatment of antivirals in patients who are suspected to have influenza. When prevalence of disease is high, the pre-test probability of disease in a patient that shows symptoms is high. The negative predictive value of the test is low and false

negatives increase. The decision to start antiviral medications for influenza is based on the *clinical* diagnosis, and the CDC warns providers that a negative influenza test does not exclude the diagnosis of flu.

So why are we doing things differently with COVID-19? If the community test rate is > 20% (at the time I write this it is > 50% in our clinical practice), the patient likely has COVID-19. Unless a positive test result is REQUIRED for EUA eligibility for treatment, the outpatient management of COVID-19 is supportive care and isolation. Since CDC has shortened the stay-at-home isolation duration to 5 days, it would be more prudent for patients with suspected COVID-19 infection to isolate in accordance to the latest CDC guidelines. Even more concerning, patients may have a false negative result and not isolate, which accelerates the spread of infection.

With oral antiviral (i.e., nirmatrelvir/ritonavir aka Paxlovid and molnupiravir) availability starting in January 2022 and sotrovimab being distributed, high risk patients who are eligible for outpatient antiviral treatments would need COVID-19 testing as a positive test result is required to meet the EUA. But, low risk patients, especially patients who have symptoms > 5 days would not need COVID-19 testing and would simply be advised to isolate or wear a mask for the appropriate time frame.

Granted, patients want what they want. Patients seek care in urgent care and expect a test. The risk of implementing change may decrease patient satisfaction. There are also situations where a school system or employer may *require* a COVID-19 test; however, when volumes of patients are unsustainable, and provider and staff are burning out, any action to decrease the insanity may help.

Has anyone started restricting COVID-19 testing in your urgent care centers and excluding low risk symptomatic patients? What has been the patient response, and has it helped with patient flow? You can respond using the COVID-19 Listserv for our members. I hope to hear from you.

URGENT CARE CASE STUDIES

CASE STUDY #1: DERMADILEMMA—RASH AFTER EYEBROW TINTING Tracey Davidoff, MD, FCUCM



A 28-year-old female presents to urgent care 48 hours after having her eyebrows tinted. Initial symptoms the following day included redness and itching. She washed off any remaining tint, but the following morning awoke with severe redness, swelling, blistering, and edema of the eyelids shown above. Oral diphenhydramine provided mild relief.

Which of the following is the most likely diagnosis?

- A. Impetigo
- B. Allergic contact dermatitis
- C. Herpes simplex
- D. Chemical burn

Diagnosis: Allergic contact dermatitis.

Allergic contact dermatitis is common following contact with dyes used for beauty purposes such as hair, eyebrow, and eyelash dye. These items contain many chemicals that patients can have sensitivity. Shortly after exposure, red, scaly, indurated plaques will develop. Vesicles and bullae may appear in severe cases. Areas with thin skin, such as eyelids may develop significant edema. Satellite lesions, as seen in this case between the heads of the eyebrows may be seen. Initial treatment is focused on removing as much of the allergen as possible. Gentle cleaning with mild soap and cool cloths is most tolerable to the inflamed skin. Areas of thicker skin such as trunk or extremities may be treated with a medium to medium-high potency steroid cream. Areas of the face should be treated with a low to medium potency steroid cream. Severe cases that are highly symptomatic, consume a large surface area, are on the face, or are associated with edema, such as in this case, may be treated with oral steroids. A burst of 7 days or tapering over 10-14 days is recommended.



CASE STUDY #2: MYOPERICARDITIS AFTER STREPTOCOCCAL PHARYNGITIS

Cesar Mora Jaramillo MD, FAAFP, FCUCM

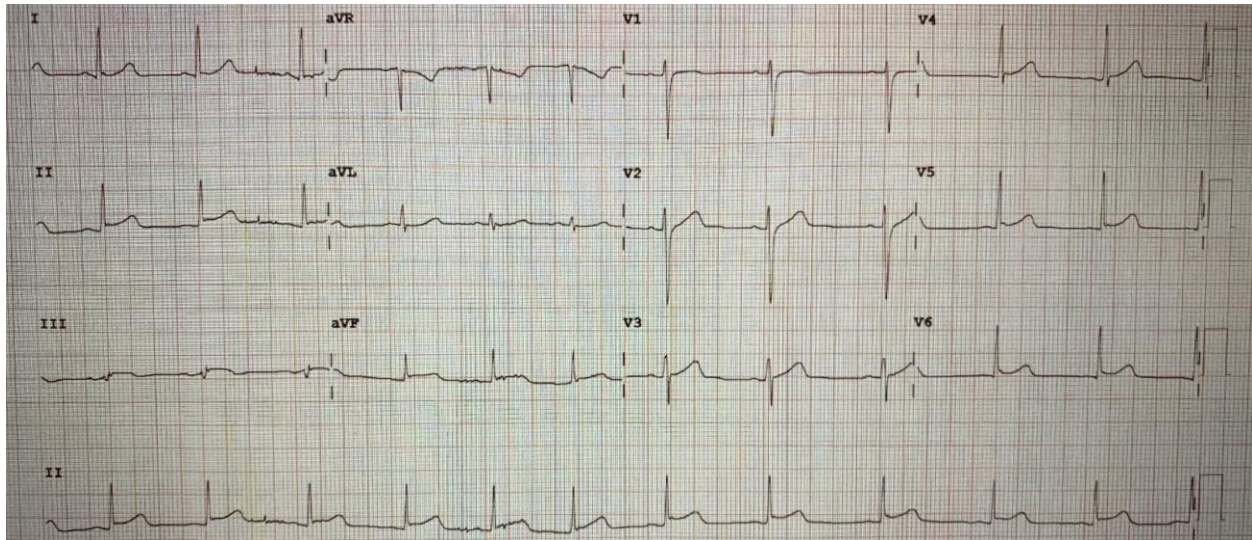


A 30-year-old Male with past medical history of hypertension, childhood asthma, anxiety who presented to the Emergency Department with 30 mins of sudden mid-chest substernal chest pain. Pain is described as pressure, non-radiating, 7/10 and without respirophasic or positional changes. Patient reports dizziness associated with pain. He denied diaphoresis, shortness of breath, nausea, or palpitations. Patient recently completed antibiotic treatment with amoxicillin for streptococcal pharyngitis prescribed in Urgent Care.

Physical Exam

Upon arrival, his vital signs were as follows: heart rate 76 beats/min; respiratory rate, 18 breaths/min; oxygen saturation in the 100%; blood pressure, 107/64 mm Hg; and temperature 36.9°C. No acute distress. Alert and oriented. Cardiovascular regular rate and rhythm, no murmurs, no rubs. Lungs: clear to auscultation bilaterally.

Diagnostic tests. Stat electrocardiography (ECG) revealed diffuse ST segment elevation leads II, III and AVF < 1mm, minimal ST elevation in V4-6, no clear reciprocal changes and no convincing PR depression (Figure 1). Results of a basic metabolic panel were normal. Results of a complete blood cell count were remarkable for an elevated white blood cell of $12.9 \times 10^9/L$. Results of a cardiac enzyme panel showed an elevated troponin I level of 35 ng/mL. C Reactive Protein 76mg/L and Sedimentation rate 45mm/hour. Lipid panel showed LDL 150mg/dl, cholesterol 214mg/dl, triglycerides 168mg/dl and HDL 30mg/dl. Chest radiographs showed clear lungs and normal heart size. Transthoracic echocardiography results showed Left ventricle and Right ventricle normal size, normal valves. No wall motion abnormalities. No pericardial effusion. Ejection fraction was 55%. Cardiac catheterization revealed normal coronary arteries.



Outcome of the case. The patient was admitted to the intensive care unit for treatment of myopericarditis and to rule out acute coronary syndrome. Therapy included ticagrelor, aspirin, heparin drip, colchicine, and ibuprofen. After cardiac catheterization, only colchicine and ibuprofen were continued. He rapidly improved and was discharged on hospital day 3.

Discussion. Myopericarditis is an acute inflammation of the pericardium and myocardium resulting in myocellular damage.¹ Awareness of myopericarditis is imperative as symptoms can mimic acute myocardial infarction (MI). Both syndromes may present with acute-onset chest pain, ECG abnormalities (ST elevation), and cardiac enzyme elevation. In certain cases, diagnosis might be difficult especially when the ECG changes are focal instead of diffuse and elevation of troponins is associated.¹

Acute pericarditis is a clinical diagnosis supported by EKG and echocardiogram. At least two of the following four criteria must be present for the diagnosis: pleuritic chest pain, pericardial rub, diffuse ST-segment elevation on EKG, and pericardial effusion. The echocardiogram frequently is normal but could show an effusion in 60%, and tamponade in 5%, of cases.^{2,3}

Pericarditis and myocarditis can coexist frequently, most common etiology is viral (coxsackie B, cytomegalovirus, parvovirus B 19, Epstein barr virus, rubella, influenza A virus, adenovirus and during hepatitis A and C virus infection). Some bacterial association has been reported including streptococcal tonsillitis.¹

Thrombolytic therapy can be detrimental in acute pericarditis, due to risk of cardiac tamponade. Echocardiogram is an important diagnostic tool in acute pericarditis.^{1,6} The outcome of myopericarditis is good. Troponin elevation is not a negative prognostic marker in this setting.^{3,4} Due to risk of developing heart failure or subclinical left ventricular dysfunction, the patient should be followed for several weeks.¹

The initial treatment of myopericarditis is a nonsteroidal anti-inflammatory drug for 10 to 14 days. Colchicine for 3 to 6 months can be administered to prevent recurrence. Corticosteroids should be used only in systemic autoimmune diseases as increases the risk for recurrences. ⁶

References

1. Omar HR, Fathy A, Rashad R, Elghonemy M. Acute perimyocarditis mimicking transmural myocardial infarction. *Int Arch Med*. 2009;2(1):37. Published 2009 Dec 9. doi:10.1186/1755-7682-2-37
2. Korcak AJ. How is acute pericarditis diagnosed and treated? - page 2 of 4. *The Hospitalist*. <https://www.the-hospitalist.org/hospitalist/article/125026/how-acute-pericarditis-diagnosed-and-treated/2/>. Published December 19, 2021. Accessed February 26, 2022.
3. LESLIE E. TINGLE, MD; DANIEL MOLINA, MD; and CHARLES W. CALVERT, DO, Acute Pericarditis. *Am Fam Physician*. 2007 Nov 15;76(10):1509-1514.
4. Massimo Imazio, Antonio Brucato, Andrea Barbieri, Francesca Ferroni, Federica Bonomi, Francesca Mantovani, Alessandra Chinaglia, Paola DiCorato, Roberta Lugli, Paola Valenti, Giovanni Della Casa, Riccardo Belli. Outcome Of Myopericarditis And Perimyocarditis: Results From A Multicenter Prospective Cohort Study. *Journal of the American College of Cardiology* Mar 2013, 61 (10 Supplement) E1279; DOI: 10.1016/S0735-1097(13)61279-6
5. M Imazio, A Brucato, A Barbieri, F Ferroni, S Maestroni, G Ligabue, A Chinaglia, D Cumetti, G Della Casa, F Bonomi, F Mantovani, P Di Corato, R Lugli, R Faletti, S Leuzzi, R Bonamini, MG Modena, R Belli. Good Prognosis for Pericarditis With and Without Myocardial Involvement: Results From a Multicenter Prospective Cohort Study. *Circulation* 2013 May 24, From MEDLINE®/PubMed®, a database of the U.S. National Library of Medicine.
6. M Seferović, Petar & D Ristić, Arsen & Maksimović, Ružica & S Simeunović, Dejan & Milinković, Ivan & Seferovic, Jelena & Kanjuh, Vladimir & Pankuweit, Sabine & Maisch, Bernhard. (2012). Pericardial syndromes: An update after the ESC guidelines 2004. *Heart failure reviews*. 18. 10.1007/s10741-012-9335-x.

EXPERT INSIGHTS

URGENT CARE APPROACH TO THE SYNCOPAL PATIENT

Points

- Syncope is a transient loss of consciousness, typically with associated loss of postural tone, followed by complete, spontaneous recovery.
- Syncope results from global cerebral hypoperfusion from decreased peripheral vascular resistance, decreased cardiac output, or both.

- There are 3 classifications of syncope: (1) neurally mediated (reflex) syncope (the most common): (2) orthostatic hypotension (second most common), and (3) cardiac syncope (the least common, but with highest morbidity).
- An ECG should be obtained for all patients who present with syncope.
- Consider a family history of sudden cardiac death, and a death perceived to be from drowning or motor vehicle crash that may have actually been from unrecognized syncope.
- For elderly patients, consider falls without clear mechanism as possible syncope; 25% to 50% may be related to syncope.¹⁻³
- In elderly patients, the presence of orthostatic hypotension does not exclude more serious causes of syncope.^{4,5}
- Assess the events before and after the syncopal episode, using witnesses if possible. Specifically seek details of the patient's position, prodrome, exertion, and duration of event. Note any symptoms such as palpitations, chest pain, shortness of breath, headache, or neurological deficit.
- Laboratory testing is of low yield unless the history and physical examination indicate a serious underlying disease process.
- Many clinical risk-stratification tools have commonalities, but at this time, none of them perform better than clinical judgment in predicting adverse events.
- Approximately 9% of patients may have recurrence of a syncopal episode within 6 months;⁶ consult local laws regarding release for driving or return-to-work restrictions.

Pearls

- Any patient with neurologic deficit, headache, chest pain, abdominal pain, or persistent abnormal vital signs should not be diagnosed with benign, low-risk syncope unless all more serious diagnoses are excluded. Many of these patients will require evaluation in the ED.
- The most helpful feature indicating seizure is disorientation lasting more than a few seconds or age <45 years.^{7,8} If a reliable estimate of the number of jerks is available, <10 may indicate syncope; >20 may indicate seizure.
- If there is no apparent immediate threat to life, attempt to identify the type and etiology of the syncope; if that cannot be determined, attempt to risk-stratify the patient for high-risk or low-risk features.

KidBits: The Syncopal Pediatric Patient

The approach to syncope in children mirrors that of adults. The history, physical examination, and ECG are the most useful components of a syncope evaluation in children, and the vast majority of children have a benign etiology for syncope. One study found that neurally mediated syncope accounted for 80% of cases of children with syncope who underwent ED evaluation, and the majority of cases of cardiac syncope may be diagnosed by history, physical examination, and ECG.⁹ Family history, exertional syncope, syncope without prodrome, and syncope while supine may suggest a cardiac cause, and syncope associated with a loud noise (sudden adrenergic surge) should prompt evaluation for long QT syndrome.¹⁰ Pediatric patients with syncope often receive extensive evaluation, including head CT (58%, in one study) and laboratory testing, with very low yield, and 10% are admitted, with very few ultimately receiving a diagnosis of cardiac syncope.¹¹

References

- 1Anpalahan M, Gibson S. The prevalence of neurally mediated syncope in older patients presenting with unexplained falls. *Eur J Intern Med.* 2012;23(2):e48-52. (Prospective; 200 patients)
 - 2Bhangu J, Hall P, Devaney N, et al. The prevalence of unexplained falls and syncope in older adults presenting to an Irish urban emergency department. *Eur J Emerg Med.* 2019;26(2):100-104. (Prospective observational; 561 patients)
 - 3Ungar A, Mussi C, Ceccofiglio A, et al. Etiology of syncope and unexplained falls in elderly adults with dementia: Syncope and Dementia (SYD) Study. *J Am Geriatr Soc.* 2016;64(8):1567-1573. (Prospective observational; 357 patients)
 - 4Mussi C, Ungar A, Salvioli G, et al. Orthostatic hypotension as cause of syncope in patients older than 65 years admitted to emergency departments for transient loss of consciousness. *J Gerontol A Biol Sci Med Sci.* 2009;64(7):801-806.(Prospective; 259 patients)
 - 5Schaffer JT, Keim SM, Hunter BR, et al. Do orthostatic vital signs have utility in the evaluation of syncope? *J Emerg Med.* 2018;55(6):780-787. (Review article)
 - 6Barbic F, Dipaola F, Casazza G, et al. Syncope in a working-age population: recurrence risk and related risk factors. *J Clin Med.* 2019;8(2). (Prospective observational; 348 patients)
 - 7Hoefnagels WA, Padberg GW, Overweg J, et al. Transient loss of consciousness: the value of the history for distinguishing seizure from syncope. *J Neurol.* 1991;238(1):39-43. (Prospective observational; 94 patients)
 - 8Shmueli S, Bauer PR, van Zwet EW, et al. Differentiating motor phenomena in tilt-induced syncope and convulsive seizures. *Neurology.* 2018;90(15):e1339-e1346. (Prospective observational; 115 patients)
 - 9Massin MM, Bourguignon A, Coremans C, et al. Syncope in pediatric patients presenting to an emergency department. *J Pediatr.* 2004;145(2):223-228. (Prospective observational; 226 patients)
 - 10Sanatani S, Chau V, Fournier A, et al. Canadian Cardiovascular Society and Canadian Pediatric Cardiology Association position statement on the approach to syncope in the pediatric patient. *Can J Cardiol.* 2017;33(2):189-198. (Review article)
 - 11Goble MM, Benitez C, Baumgardner M, et al. ED management of pediatric syncope: searching for a rationale. *Am J Emerg Med.* 2008;26(1):66-70. (Retrospective; 140 patients)
- Excerpted from Pochick K, Morris J. Urgent care approach to the syncopal patient. *Evidence-Based Urgent Care.* 2022 Apr 1;1(1). 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**

Title: Cerumen Impaction

Date Reviewed	6 December 2021
Subject	Diagnosis and Management of Cerumen Impaction
Patient Population	Adults and children over 6 months of age
Rationale	Cerumen impaction is a common disorder seen in urgent care in both children and adults. Patients may present with symptomatic cerumen impaction as a chief complaint, or cerumen may prevent adequate assessment of the ear and require removal.
Introduction	Accumulation of cerumen is generally caused by failure of the routine cleaning mechanism of the ear. Patients with decreased ability to communicate such as patients with dementia, the very young, and those with developmental delay are likely underdiagnosed and undertreated.
Evidence based guideline with strength of evidence	Schwartz SR, Magit AE, Rosenfeld RM, et. al. Clinical Practice Guideline (Update): Earwax (Cerumen Impaction). Otolaryngol Head Neck Surg. 2017 Jan;156(1_suppl):S1-S29. https://doi.org/10.1177%2F0194599816671491
Discussion	Clinicians should diagnose cerumen impaction when the accumulation of cerumen in the ear canal causes symptoms or prevents adequate assessment of the ear or both. Clinicians should ask about factors that may modify management including anticoagulant therapy, immunocompromised state, diabetes mellitus, prior radiation to the head and neck, ear canal stenosis, exostoses, and non-intact tympanic membrane. Patients with hearing aids should be assessed more frequently as they are at increased risk for accumulation of cerumen. Patients who are asymptomatic without hearing aids, developmental delay, dementia,

	<p>or are very young should not be treated for cerumen accumulation if found incidentally. If treated, each of the following alone or in combination are effective therapies: cerumenolytics, irrigation with water or saline, or manual removal using instrumentation. Otoscopy after treatment should be performed to confirm resolution. If not resolved, the patient should be referred to a higher level of care such as an otolaryngologist. Clinicians should recommend against ear candling, use of cotton swabs, bobby pins, and other small objects to clean ears.</p>
Summary	<p>Cerumen impaction should only be diagnosed and treated if it is symptomatic or necessary for exam. Combination of cerumenolytics, irrigation, or manual removal is acceptable. The ear should be re-examined at the conclusion of treatment. Providers should educate patients on proper ear cleaning and advise against potentially dangerous practices.</p>
References	<p>Schwartz SR, Magit AE, Rosenfeld RM, et. al. Clinical Practice Guideline (Update): Earwax (Cerumen Impaction). Otolaryngol Head Neck Surg. 2017 Jan;156(1_suppl):S1-S29. https://doi.org/10.1177%2F0194599816671491</p> <p>Roland, PS, Smith, TL, Schwartz, SR. Clinical practice guideline: cerumen impaction. Otolaryngol Head Neck Surg. 2008;139:S1-S21.</p>
Reviewers	Tracey Q, Davidoff, MD, FCUCM
Attachments (flow charts, graphics, tables, etc.)	

OCCUPATIONAL MEDICINE SECTION

THE OCCUPATIONAL MEDICAL HISTORY—ARE THERE DIFFERENCES FROM THE URGENT CARE HISTORY?

Max Lebow, MD, MPH, FACEP, FACOEM



Welcome to the Occupational Medicine Section of Urgent Caring new quarterly format. The purpose of this section will be to discuss Occupational Medicine (OM) subjects of interest to urgent care providers that see an occasional workplace injury, to those in which Occupational Medicine is a significant percentage of their patient flow and income.

For the initial article, we start with a review of the basics of Occupational Medicine, which will serve as a foundation from which we will explore OM subjects such as repetitive strain injuries, how to use ACOEM and other guidelines, and what to do with the "difficult to discharge" patient. Like any patient, a good history is key to diagnostic and treatment decisions.

The Occupational Medicine/OM History

What differentiates the workup of an injured worker versus the patient with a similar injury that occurred at home? The history distinguishes OM most distinctly from an urgent care workup. In outline form, the elements of an occupational medicine history appear below. It may seem like a lot of information to gather and document, but at the end, we illustrate how an OM history can be documented in a concise and time-efficient way.

- Confirm the Exact Date of Injury/DOI – Determining the exact date of injury is essential for workers who sustain an injury or illness as part of their work-related duties. The reason is that OSHA, case managers, and insurance carriers use DOI as a key identifier of the employee's Worker's Compensation case. Submitting bills or requests for authorization of physical therapy or diagnostic tests with the incorrect DOI, off even one day, will result in denial of payment and essential services for the injured worker.
- Employee Work History/WH – Several elements make up a work history. This information is essential if you place the patient on modified duty and help determine future diagnostic and treatment options.
 - Job Title and/or Job Duties – Some job titles describe the job duties, such as short-order cook. Documenting the amount and frequency of weight lifted if

part of the job, or number of hours walking versus sitting for examples of essential job functions

- Length of Employment/LOE - An important metric predictive of outcome.
- Full or Part-Time
- Right or Left-handedness

- Mechanism of Injury/MOI - MOI should answer two questions.

- First, MOI must establish that the patient's illness or injury is more likely than not caused or directly contributed by employment activities.
- Second, the MOI must be consistent with the patient's complaints – the MOI should account for each patient's complaints. Differentiation between a contusion and a strain should be evident in the MOI.

- The Patient's Complaints – Patients with work-related injuries often have complaints in multiple body areas. It is essential to capture all but trivial complaints of injury. The reason is that, like the DOI, Worker's Compensation cases are also identified by body part. An incomplete history that does not mention a significant injury will make it difficult for the patient to get treatment or access to diagnostic testing for an injury not documented on the initial visit.

- Organizing Multiple Complaints – One of the best ways to manage the patient's complaints is to list areas from most to least painful. Assigning an individual pain scale number to each body part is sometimes done.
- Document Loss of Functionality – Occupational medicine is about loss and regaining functionality. Because of its subjective nature, pain complaints play a secondary role. A description such as "unable to stand for longer than 10 minutes without pain" or a more general "unable to perform usual duties" will justify placing the patient on limited or modified duty.
- End with "No Other Complaints" – This should appear near the end of the OM history to avoid a claim that part of the injury was not documented.
- Documenting Discrepancy between Subjective Complaints and Objective Findings – Differences between subjective and objective findings are unusual in urgent care. However, such outcomes occur more than occasionally in the OM environment. Documenting them early will get the case off to a good start.

- Past Medical History

- Besides the standard PMH, inquiring about previous injuries is part of the OM history.
- PMH of Work-Related Injuries or Surgery – If the patient lists previous injuries, ask if any were work-related.
- Any Current Work Injuries or Work Limitations – Inquiring if the patient has any current work injuries can sometimes show that the patient has one or several injuries being treated simultaneously.

- Social History – in addition to the usual general medical social history, asking about higher risk hobbies or other activities that may play an important role. Any injury reported on Monday morning with a questionable mechanism of injury difficult to explain based on the patient's job duties may represent an accident away from the workplace

The history described above may seem like a lot of information. As the provider becomes more comfortable and efficient with the occupational medicine history, it will flow naturally as any standard urgent care history. It also does not require much more documentation than any urgent care patient. An example of a brief occupational medicine history that includes most of the elements listed above appears below.

DOI 7/1/21
LOE: 16 months Warehouse stocker, lifts to 50 lb.; FT – RHD

Patient fell 2 days ago. Was walking in kitchen, slipped on wet floor. Fell onto R Knee and Twisted R ankle, also with strain of back. Now finding it difficult to walk normally, and pain on lifting more than 10 pounds.
C/O pain in R ant knee most, then lateral ankle, lower back pain.
No previous injuries, work or otherwise.
No other complaints

WOUND CARE SECTION

EPINEPHRINE IN LOCAL ANESTHESIA: MYTHBUSTING 101
Patrick O'Malley, MD



Myths abound in the practice of medicine. We tend to practice based on what we learned in training. Some of these lessons we take as gospel and never challenge them. It is important to keep an open mind and be receptive to ideas and practice patterns that are contradictory to previous held beliefs. Just because you have been doing something the same way for 20 years doesn't mean it is right! Over time in this section of Urgent Caring I would like to review some common myths in medicine. These will be countered with solid, evidenced based recommendations. Please send me any long-held myths that you think need to be busted! Email to: omalleypat@mac.com

Myth – Epinephrine is NOT Safe to Use in Fingers:

Remember the old mantra of "fingers, toes, penis, nose"? These are the anatomic locations where you are not supposed to use epinephrine. Did you know there is actually no literature to support this? (1) One of these studies, involving over 4000 patients undergoing hand surgery utilizing local anesthesia with epinephrine, which was published in Orthopedics in 2020, shows no adverse effects from the use of epinephrine. (2) It is interesting to note that a survey sent out to members of the American Society of Plastic Surgeons found that 37% of respondents still believed that this practice was not safe (3). Sure, if the patient has known, severe PAD or Reynaud's, maybe don't use it, but otherwise it is safe to use.

Using lidocaine with epinephrine for a digital block is safe as well. It helps maintain anesthesia longer. It can also help control bleeding through the vasoconstrictive action of the epinephrine in the block by constricting the blood vessels of the finger. It can also be applied directly to the wound itself if needed, for example avulsions. Think how much easier that finger repair would be with less bleeding.

It is always fun to find the origin of medical myths. This one arose many years ago with case reports of digital necrosis came to the forefront following hand surgeries utilizing procaine and epinephrine. When examined more closely, it was discovered that it was actually the pH of the procaine that caused the problem, NOT the epinephrine. (4)

As far as the other components of that mantra, the nose, penis, and toes, the same applies. You can safely use epinephrine containing anesthetic agents in these locations as well.

1. <http://www.emdocs.net/wp-content/uploads/2014/10/LidowithEpiDigits-Moleno-.pdf>
2. <https://pubmed.ncbi.nlm.nih.gov/32882049/>
3. <https://link.springer.com/article/10.1007/s00238-013-0925-1>
4. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5582825/>

CAUSE FOR APPLAUSE #1 RECOGNIZING URGENT CARE MEDICINE PHYSICIANS

This quarter in honor of National Physicians' week (March 25-31, 2022) Urgent Caring would like to applaud all Urgent Care Physicians who have worked so hard over the last two years! You have been through multiple surges, staffing highs and lows, angry patients, acutely ill patients and, for many, even COVID-19 itself. You have risen to the challenge and survived. You served your colleagues, communities, and the industry admirably. For this, the College of Urgent Care Medicine applauds you as our inaugural recognition recipients in "Cause for Applause"!

URGENT UPDATES—MARCH 2022

ORALLY DISSOLVING BUPRENORPHINE TIED TO SEVERE TOOTH DECAY, FDA WARNS

Orally dissolving medications containing buprenorphine are linked to severe dental problems, including total tooth loss, the US Food and Drug Administration (FDA) warns. The oral side effects of these medications, which are used to treat opioid use disorder (OUD) and pain, include cavities/tooth decay, including rampant caries; dental abscesses/infection; tooth erosion; fillings falling out; and, in some cases, total tooth loss. **Full Access:** [Medscape](#)

INTRANASAL OXYTOCIN SHOWS EARLY PROMISE FOR COCAINE DEPENDENCE

A small 6-week randomized, placebo-controlled trial in patients with cocaine use disorder showed a high level of abstinence in those who received Intranasal oxytocin (INOT) beginning 2 weeks after treatment initiation. Researchers conclude that INOT is showing early promise as a treatment for cocaine dependence. **Full Access:** [Medscape](#)

FDA CONSIDERS SECOND COVID-19 BOOSTER SHOT

The FDA has begun reviewing data to potentially authorize a fourth dose of the Pfizer and Moderna COVID-19 vaccines for the fall. The authorization would depend on ongoing studies, which must show that a fourth dose would increase waning immunity and reduce the risk of severe disease. FDA is considering whether the vaccine should target the Omicron variant or have a different formula. Health experts are also investigating whether a fourth shot could begin an annual COVID-19 vaccination program. **Full Access:** [Medscape](#)

REMOTE SIX-MINUTE WALK TESTING IN PATIENTS WITH PULMONARY HYPERTENSION: A PILOT STUDY

In this two-center observational pilot study published in American Journal of Respiratory and Critical Care Medicine, researchers observed no systematic differences in average 6-minute walk distance between in-clinic and remote settings, across sites or between in-clinic and remote testing by site. Remote 6-minute walk testing was consistent with standardized clinic walks and may be valid in pulmonary testing. **Full Access:** [American Journal of Respiratory and Critical Care Medicine](#)

RESULTS FROM A TEST-TO-RELEASE FROM ISOLATION STRATEGY AMONG FULLY VACCINATED NATIONAL FOOTBALL LEAGUE PLAYERS AND STAFF MEMBERS WITH COVID-19 — UNITED STATES, DECEMBER 14–19, 2021

On December 16, 2021, the NFL updated its test-to-release from COVID-19 isolation protocols in response to increasing SARS-CoV-2 cases and predominance of Omicron variant. Among 173 vaccinated adults with COVID-19 undergoing RT-PCR testing, 46% received a negative on or before day 6 postdiagnosis. These data indicate that

persons with COVID-19 should continue to take precautions, including correct and consistent mask use, for a full 10 days after symptom onset or after initial positive test results if they are asymptomatic. **Full Access:** [CDC](#)

FDA PERMITS MARKETING OF FIRST CONDOM SPECIFICALLY INDICATED FOR ANAL INTERCOURSE

On February 23, 2022, the U.S. Food and Drug Administration authorized the marketing of the first condoms specifically indicated to help reduce transmission of sexually transmitted infections (STIs) during anal intercourse. The condoms, which will be marketed as the One Male Condom, are also indicated as a contraceptive to help reduce the risk of pregnancy and the transmission of STIs during vaginal intercourse. This authorization helps the priority of advancing health equity through the development of safe and effective products that meet the needs of diverse populations. **Full Access:** [FDA](#)

DIVERTICULITIS IN THE ELDERLY CLINICAL PRACTICE GUIDELINES (2022, WSES/SICG/ACOI/SICUT/ACEMC/SIFIPAC)

Clinical practice guidelines on the diagnosis and treatment of diverticulitis in the were published in January 2022. Some of the recommendations include Computed tomography (CT) with intravenous contrast is suggested for elderly patients with suspected acute left colonic diverticulitis, who present with abdominal guarding or pain in the lower left abdomen; conservative treatment without antibiotics is the suggested approach for immunocompetent elderly patients who have uncomplicated left colonic diverticulitis; antibiotic therapy is appropriate for elderly patients who have localized complicated left colonic diverticulitis with pericolic air bubbles or a small amount of pericolic fluid without abscess. **Full Access:** [Medscape](#)

IDENTIFYING HIGHER-VOLUME ANTIBIOTIC OUTPATIENT PRESCRIBERS USING PUBLICLY AVAILABLE MEDICARE PART D DATA – UNITED STATES, 2019

Antibiotic prescribing can lead to adverse drug events and antibiotic resistance, which pose ongoing urgent public health threats. The highest 10% of antibiotic prescribers prescribed 41% of total antibiotic prescriptions for Medicare Part D beneficiaries in 2019. The antibiotic prescribing rate of these higher-volume prescribers was 60% higher than that of lower-volume prescribers. These public data can be used by organizations and health care systems to guide antibiotic stewardship interventions and optimize antibiotic prescribing to limit the emergence of antibiotic resistance and improve patient outcomes. **Full Access:** [CDC](#)

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

Chris Chao, MD

Reports no financial interest relevant to this newsletter

Cesar Mora Jaramillo, MD

Reports no financial interest relevant to this newsletter

Max Lebow, MD

Reports no financial interest relevant to this newsletter

Patrick O'Malley, MD

Reports no financial interest relevant to this newsletter

Keith Pochick, MD

Reports no financial interest relevant to this newsletter

Disclaimer

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

URGENT CARING STAFF MEMBERS

Urgent Caring Editors-in-Chief

Tracey Q. Davidoff, MD, FCUCM

Cesar Mora Jaramillo, MD, FAAFP, FCUCM

Occupational Medicine Section

Max Lebow, MD, MPH

Advancing the Specialty/Antibiotic Stewardship Section

Joseph Toscano, MD, FCUCM

Wound Management Section

Patrick O'Malley, MD

Administrator

Laurel Stoimenoff, PT, CHC

Publisher

Urgent Care Association

CUCM Board of Directors: Executive Committee

- Jasmeet Bhogal, MD, President

- Tracey Q. Davidoff, MD, FCUCM, Vice-President

- Chris Chao, MD, Treasurer

- Chrysa Charno, RPA-C, MBA, FCUCM, Secretary