URGENT CARING

A PEER-REVIEWED PUBLICATION

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URGENT CARING
CME ELIGIBLE
2024

COLLEGE OF URGENT CARE MEDICINE

URGENT CARE COLLEGE OF PHYSICIANS

A publication of the Urgent Care College of Physicians in collaboration with the College of Urgent Care Medicine.

Table of Contents

A Message from CUCM President, Cesar Mora Jaramillo, MD, FAAFP, FCUCM 2

Year-End Updates – 'Tis the Season for Viruses and Exciting News for UCCOP 2

From the Editor 4

Bounce-Back Patients in Urgent Care: A Clinical Perspective on Serious Conditions 6

Use of GLP-1 Agonists, an Obesity Specialist's Perspective 10

Case Study: 46-Year-Old Taking Tirzepatide, Presenting with Abdominal Pain 14

Images in Urgent Care 17

DOT Exam Column 18

Images in Urgent Care Continued 19

Tricks of the Trade: Achieving a Bloodless Field in Finger Injuries—MacGyver in Medicine 21

Coding and Documentation Corner: Ear Irrigation/Lavage 25

Insights: Organizations Driving Innovation in Urgent Care Education 27

The First 5 Minutes of Managing Hydrofluoric Acid Burns in Urgent Care 27

Diagnosis and Management of Acute Gastroenteritis in Adults in the Urgent Care Setting 29

Management of Epistaxis in the Urgent Care Setting 31

Influenza in Urgent Care: 2024-2025 Season Update 33

Urgent Updates 35

Urgent Updates in Pediatric Research Briefs 37

Cause for Applause Q4 2024 40

Advertising in Urgent Caring 43

A Message from CUCM President, Cesar Mora Jaramillo, MD, FAAFP, FCUCM

Year-End Updates – 'Tis the Season for Viruses and Exciting News for UCCOP

Dear Urgentologist,

It is hard to believe it's already December! I hope you're taking some time off during the holiday season and recharging your batteries as the Centers for Disease Control and Prevention (CDC) expects a 2024/2025 winter peak higher than the 2024 summer peak, similar to COVID-19 trends over the last four years.

During that time, RSV activity started to increase in the early fall and peaked in mid-December, but the timing and severity of the RSV season in a given community can vary from year to year. Interestingly, the activity of the big three viruses (COVID-19, flu and RSV) has remained low this fall, which means it is likely returning to pre-pandemic patterns.

Furthermore, the CDC expects the fall and winter virus season will likely have a similar or lower peak number of combined hospitalizations from COVID-19, influenza and RSV compared to last year. However, peak hospitalizations from all respiratory viruses remain likely to be substantially higher than they were before the emergence of COVID-19.

Since the respiratory season "officially" began a couple of weeks ago, it will soon cross the epidemic threshold.

We must get ready for the "holiday" effect and the expected increase in patient volume coming to Urgent Care centers. We are all in this together.

What Is Happening with the Increase in Cases of Walking Pneumonia?

As many of you might have already seen, there's been an uptick of "walking pneumonia" infections since this past August. It is surprising that the group getting respiratory mycoplasma infections is the pediatric population, ages 2-5. With that said, we should not forget that this infection can also affect the adult population. So, having walking pneumonia on your differential diagnosis is important.

The U.S. usually sees a surge every 3-7 years, and thus far, cases have reached a level 10 times higher this year than last year. Cases are typically mild (which can be mistaken for other respiratory illnesses), and while it is usually less severe than traditional pneumonia, the infection can still take a toll on children's overall well-being, particularly if left untreated.

Urgent Care clinicians should be able to diagnose atypical pneumonias, and we should use our clinical judgment when it comes to testing (swabs versus chest X-rays).

Prompt and accurate diagnosis prevents complications, reduces the risk of transmission and ensures appropriate use of antibiotics, improving patient outcomes and public health safety.

The Urgent Care College of Physicians Accepted as a Member of the AMA Specialty and Service Society

In another exciting development, I am thrilled to share that a longstanding goal to become a member of the American Medical Association's Specialty and Service Society (SSS) has been rewarded. UCCOP received notification of acceptance in late November following the AMA's Interim Meeting in Orlando, Fla. This is a landmark achievement for the field of Urgent Care, underscoring the growing recognition of Urgent Care as a critical component in the healthcare ecosystem. Additionally, it reflects the hard work, dedication and expertise of each one of you.

This recognition not only affirms the critical importance of our field but also opens doors for future advancements and growth—not to mention an opportunity to have a voice representing Urgent Care medicine. And this designation is a testament to the high level of care and expertise that Urgent Care clinicians offer, and it reflects the evolving role of Urgent Care centers in addressing both urgent and non-emergency healthcare needs.

Our priority is to advance the specialty of Urgent Care medicine, and we are proud to be part of this evolving healthcare milestone.

As exciting as this moment is, our journey is far from over. It's crucial that we continue our efforts strategically so we can ensure our priorities are well-represented, and our specialty's influence continues to grow.

I look forward to working with all of you as we continue to elevate our specialty and make a lasting impact. I cannot wait to see what we accomplish next!

Sincerely,

Cesar Mora Jaramillo, MD, FAAFP, FCUCM

From the Editor

This November, the CDC held U.S. Antibiotic Awareness Week (USAAW), which was supported by UCA, CUCM and UCCOP. This got me thinking about stewardship in general. We talk about antibiotic stewardship, steroid stewardship, and even X-ray and laboratory stewardships. But what does this really mean, and how does it apply to Urgent Care clinicians or any clinician for that matter? Why should we care?

Miriam-Webster defines stewardship as, "the careful and responsible management of something entrusted to one's care." It can apply to literally anything: environmental resources, such as water or endangered species; financial resources, such as trusts or other investments; cultural resources, such as historical places, artifacts or traditions, or in our case, the responsible use of healthcare resources, including patient care, medical supplies and public health resources.

In patient care, this boils down to providing the most appropriate, evidence-based care to patients with the resources available. In times of crisis, this may include rationing services, such as providing care only to those patients likely to survive. But in everyday practice, this comes down to two basic principles: Do only what is necessary and do no harm. We are entrusted by our patients to do this.

No one wants testing and treatment that is unnecessary and may cost them excessive amounts of healthcare dollars with little chance of meaningful results. An example of this would be ordering CT scans on everyone with abdominal pain. If the patient has no positive physical findings and no index of suspicion for a significant abdominal process, the test would be of extremely low yield. You would have to scan hundreds if not thousands of patients to get one positive result. This has now cost the patient and their insurance company unnecessary dollars, has exposed the patient to unnecessary radiation and may have delayed services for someone who truly needed the test. Add to that the chance of a nonspecific finding that may need further evaluation, which will now require even more unnecessary testing. That secondary testing will likely be painful and expensive and unfruitful. We have all chased after that unexpected X-ray finding when the radiologist recommends "further study to exclude XYZ."

Secondly, do no harm. Patients trust us not to order any tests or treatments that may hurt them unless it is necessary. Take antibiotics and steroids, for instance. You may think you are doing the right thing prescribing antibiotics "just in case" or those steroids just to decrease inflammation. But can an unnecessary antibiotic or steroid prescription do harm? Yes. Unnecessary antibiotics can cause allergic reactions, renal or hepatic damage, drug interactions, Stevens-Johnson syndrome, secondary fungal and GI infections, such as *Candida* and *C. difficile*, alter the normal microbiome and cause antibiotic resistance in future infections. Antibiotics are lifesaving when necessary but can be life-threatening as well. Patients may think they need antibiotics, but it is up to us to decide when they are necessary. If patients could tell when they needed antibiotics, they would be over the counter next to the acetaminophen and cold medication. A prescription would not be required. Patients may not realize it, but they trust us to determine when these drugs are indicated and are more likely to do harm.

There are very few acute illnesses presenting in the outpatient setting that have evidence supporting the use of steroids. In common use in Urgent Care, corticosteroids may temporarily improve symptoms, which is appealing to our type of practice, but in many cases, corticosteroids are not proven *necessary* to alter the

course of disease. Examples of this include non-specific back pain, pneumonia, bronchitis, non-specific viral upper respiratory infections, otitis media and allergies. The literature is clear on this: there is more risk of doing harm with corticosteroids, including elevated blood sugar, which is worse in diabetics, gastric bleeding and irritation, cataracts, muscle atrophy, osteoporosis and more. We don't always appreciate this on a daily basis because most of these risks occur over time and after multiple uses. Don't believe me? Look it up!

So where do we go from here? Let's go back to doing only what is necessary and do no harm. This is good advice for everything we face in medicine. As clinicians, we are the stewards of healthcare. We oversee ordering tests and prescriptions, and we are trained to know what patients need, what they do not and what can hurt them. These recommendations tend to change with time, and it is important to keep up to date on what the evidence says are the best tests and treatments. Do not be complacent that your knowledge from training will carry you through your career. Take a class, read a journal, go to a conference, (read Urgent Caring!) and keep up to date.

And what if patients question your recommendations? A little patient education about the pros and cons of whatever tests or treatment they are requesting goes a long way. Sometimes all they really want is reassurance and information. Letting them know you are doing what evidence says is best and reminding them that modern medicine may be helpful but potentially hurtful is all that is needed. It's all a matter of risk versus benefit. Don't forget, the first tenet in medicine is "do no harm."

Want to know more? Check out the following links:

https://urgentcareassociation.org/about/strategic-initiatives/antibiotic-stewardship/
https://urgentcareassociation.org/learning-center/trending-topics/corticosteroid-stewardship/

Tracey Quail Davidoff, MD, FCUCM

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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 Urgent Care Association and the College of Urgent Care Medicine. UCA is accredited by the ACCME to provide continuing medical education for physicians.

Financial Disclosures
All planners: Cesar Mora Jaramillo, MD, FAAFP, FCUCM; Tracey Davidoff, MD, FCUCM; Laurel Stoimenoff, PT; Melodie Turk, MHA; and Marley Haus have no ineligible relationships to disclose.

All other authors of CME eligible content have no relevant financial relationships to disclose.

Bounce-Back Patients in Urgent Care: A Clinical Perspective on Serious Conditions

Cesar Mora Jaramillo, MD, FAAFP, FCUCM

As Urgent Care clinicians, we pride ourselves on delivering efficient, high-quality care. Yet, one of the most pressing challenges in our field is the phenomenon of bounce-back patients.

In the fast-paced Urgent Care environment, bounce-back patients pose a unique challenge. While many revisit for benign or self-limiting conditions, lingering symptoms or dissatisfaction with initial treatment, these cases can sometimes signify a more serious issue that can be overlooked with potentially dire consequences.

The expeditious nature of Urgent Care encounters, characterized by high patient volumes and time constraints, increases the likelihood of diagnostic uncertainty. Recognizing patterns and risk factors in bounce-back cases is essential to improve clinical outcomes and patient safety.

Consequently, understanding and addressing bounce-back cases is critical to maintaining high patient care and safety standards.

Clinical Case

The patient is a 2-month-old infant. No known allergies or contact allergy history. No past medical history. Pregnancy history is unremarkable. Birth history: Spontaneous vaginal delivery at full term with no complications. No NICU.

First Urgent Care visit: Mom brings the infant due to a neck rash for a couple of days. The rash is localized on the neck and is described as erythematous patches on the neck folds. The patient is diagnosed with Candida intertrigo infection. The clinician prescribes a topical antifungal medication with instructions to follow up if symptoms worsen or do not improve.

Second Urgent Care visit (10 days later): Mom returns with the patient as the rash is not improving and is slightly progressing. Mom reports that the topical antifungal caused some initial improvement in the rash, but the rash has progressed the last few days. The rash is localized on the neck, the lower abdomen and the pelvis, and it is described as erythematous patches with no vesicles, blisters, oozing, pustules or papules. The patient is now diagnosed with eczema, and the clinician prescribes Aquaphor, provides educational material about avoiding certain situations that might exacerbate eczema and instructs Mom to return with the patient if symptoms do not improve or worsen.

Third Urgent Care visit (4 days later): Mom reports that the rash is worsening (spreading) to the entire body and now has a "fishy odor." The rash is now localized on the neck, abdomen, back, perineum, arms, hands

and legs and is described as dry/scaly erythematous patches with minimal desquamation. The infant is diagnosed with atopic dermatitis and treated with topical nystatin, and a referral to dermatology is placed.

ER visit (2 days later): Mom decides to take the patient to the ER as the rash is rapidly progressing and spreading. In addition, the mother noted oozing from the rash, and the patient has a mild decrease in appetite. The infant gets admitted to the hospital with the diagnosis of Staphylococcal Scalded Skin Syndrome (SSSS).

Important information: During all Urgent Care visits, the patient did not have a fever (at home or in the center), decreased PO intake or decreased urine output, and no weight loss was noted. The infant did not have any GI or URI symptoms. There were no known sick contacts. Vital signs were normal. Cardiovascular and neurological exams were unremarkable. The mucosal areas were spared.

Case Resolution:
The infant was admitted with the diagnosis of SSSS and was treated with IV fluids, IV cefazolin and Aquaphor. After one day of improvement, he was transitioned to PO cephalexin. His blood cultures showed no growth. The wound culture and gram stain showed many gram-positive cocci and moderate gram-positive cocci, and the wound culture grew oxacillin susceptible to *Staph aureus*. He was sent home to complete a 10-day total course of antibiotics. This child's recovery was uneventful.

Discussion
SSSS, also known as Ritter disease, is a condition that predominantly affects the pediatric population and causes a spectrum of skin lesions. It is a systemic cutaneous infection caused by toxin-producing staphylococcal species. It is seen chiefly in neonates of 3–15 days of age, children less than 5 years and adults with various comorbidities.[1,2,3] SSSS can present as early as 48 hours after birth and becomes less frequent in children older than 6. [1]

Outbreaks of SSSS among neonates are usually linked to close contact with caregivers who are carriers of these strains[3]. The condition commonly presents with desquamation of the skin and superficial skin erythema, which is initially accentuated in skin folds and periorificial areas. SSSS subsequently progresses quickly to blistering and denudation.[1,3]

Superficial desquamation occurs, leaving extensive areas of denuded skin with a scalded appearance. Progressive desquamation and healing without scarring occur over the next two weeks.

Nikolsky sign is positive (elicited by applying gentle pressure on the skin, resulting in the extension of blisters and separation of the epidermis of the adjacent skin). Other symptoms might include pain, malaise, irritability, poor feeding and fever.[3]

Infants and immunocompromised adults or adults with renal disease show a higher incidence of SSSS due to their undeveloped immune systems' inability to produce antibodies against the exfoliative toxins (ETs) and their inadequate renal capacity to excrete the pathogenic toxins.[2]

SSSS is a clinical diagnosis, but the diagnostic evaluation might include identifying possible bacteremia and distinguishing it from similar conditions like bullous impetigo, toxic epidermal necrolysis (TEN), toxic shock syndrome (TSS), Kawasaki disease, Stevens-Johnson syndrome (SJS) and pemphigus. [1,2,3,4,5]

As with other systemic illnesses, clinicians may perform routine blood tests, including a complete blood count, urinalysis, comprehensive metabolic profile and blood cultures.[1]

Affected areas can be treated with emollients and non-adherent dressings to promote healing, moisturize the skin and reduce heat loss. Corticosteroids are contraindicated as they worsen the disease.

Management typically requires inpatient admission with fluid resuscitation, intravenous antibiotics and monitoring for possible sequelae, including hypothermia or hemodynamic instability. Antibiotic therapy includes coverage against MSSA, such as cefazolin, nafcillin or oxacillin and should be administered promptly.

Pediatric patients generally do well with minimal to no scarring. Healing typically occurs within two weeks. The mortality rate in children is less than 5%. In contrast, adults with SSSS have a much higher mortality risk, as high as 60%.[1,2]

SSSS is a dermatologic emergency that requires prompt clinical recognition and intervention. Understanding its pathogenesis, differentiating it from other conditions and implementing timely management are essential to prevent complications and improve outcomes.

Conclusion

Bounce-back cases in Urgent Care represent a pivotal opportunity for clinicians to reassess initial evaluations and safeguard against potentially life-threatening conditions. Recognizing the significance of a patient returning with unresolved or worsening symptoms should prompt clinicians to expand their differential diagnoses and consider serious conditions that may have been initially overlooked. Clinician

awareness and vigilance are paramount in managing bounce-back cases. Expanding the differential diagnosis during revisits ensures that atypical presentations of critical conditions are not missed. Additionally, reevaluating the clinical trajectory with a fresh perspective helps identify subtle clues that might have been overshadowed during the initial visit.

Recognizing the significance of bounce-back visits is essential, as these revisits often signal unresolved symptoms, progression of an underlying condition or a missed diagnosis during the initial visit. To address these challenges, Urgent Care teams should adopt a proactive and systematic approach, emphasizing thorough evaluations and effective follow-up mechanisms.

Effective communication and patient education also play a pivotal role in mitigating bounce-back cases. Discharge instructions should clearly outline red-flag symptoms and guide patients to seek further medical attention. Moreover, establishing a follow-up system for high-risk patients can help identify complications early, preventing unnecessary revisits and potential adverse outcomes. Identifying trends in bounce-back cases can inform quality improvement initiatives, such as adjusting diagnostic thresholds or refining patient triage protocols.

Take home points:

- Urgent Care centers can reduce bounce-back cases and improve patient outcomes by implementing strong follow-up protocols and leveraging data information.
- Clinicians must ensure clear discharge instructions are discussed, including red flag symptoms that warrant immediate attention, and patients should receive written instructions to help them better understand their care plan.
- Follow-up calls or messages within 24-48 hours can catch unresolved or worsening issues early. Organizations can implement the usage of telemedicine for cases that need close follow-up, and access to primary care might be limited.
- Collaboration with primary care clinicians and specialists is also critical, as it ensures continuity of care for complex cases.
- Utilize electronic health record (EHR) to flag bounce-back cases or chief complaints to alert clinicians or staff.
- Staff education to recognize subtle signs of worsening conditions, including abnormal vital signs, clear communication with the team and refining triage protocols can further minimize preventable return visits.

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Use of GLP-1 Agonists, an Obesity Specialist's Perspective

Erin Loo, PA-C

Urgent message: Because of the popularity and widespread usage of GLP-1 drugs, Urgent Care clinicians must be prepared to recognize and treat side effects and potential severe complications of these drugs.

It is hard to remember the time before GLP-1 receptor agonists had their meteoric rise in medicine and became embedded in our collective consciousness. Words such as "semaglutide" and "tirzepatide" are now part of our medical jargon for all GLP-1 medications. And if the hype is to be believed, these medicines are the holy grail, with results including turning everyone into a size four to curing gambling. While the truth is likely nowhere this extreme, it cannot be disputed that these drugs have been a game changer for some. Their impact is not only felt in the realm of medical weight loss, but in cardiac, renal and neurologic benefits as well. Considering 1 in 8 adults in the U.S. has tried a GLP-1 drug and around 6% are currently on one, it is important as Urgent Care clinicians to educate ourselves on this drug class and its side effects (1). New indications are also on the horizon which will likely increase the number of patients using these medications as well. Complications from GLP-1s should be on the differential when seeing these patients in the Urgent Care setting, and a few can't miss differentials exist for this drug class.

I sat down with Linda Meade, MD, an internal medicine physician, who is board certified in obesity medicine, to discuss her experience with GLP-1s and how we as Urgent Care clinicians can be better prepared to take care of this patient population. Meade owns Brazos Weight & Wellness Medicine in College Station, Texas. The conversation has been edited and condensed for space and clarity. In addition, she was not involved in the care or management of the patient in the case.

Q&A with Linda Meade, MD

Owner of Brazos Weight & Wellness Medicine

Do you mind telling me more about your background?

I trained in internal medicine and worked for close to 25 years as an internist, but I was always interested in preventative medicine and nutrition. When you practice internal medicine, you see a lot of chronic disease, such as diabetes, hypertension and heart issues, and I really felt like lifestyle changes could help, but it's hard for anyone to lose weight or change their lifestyle. Now that I'm also board certified in obesity medicine, I'm transitioning to taking care of patients while also treating the underlying causes of their chronic diseases. In medical school, you don't get a lot of training in nutrition at all. I really try to focus on being very evidence-based about recommendations, and, of course, we use medications, but I spend a lot of time on lifestyle, too. That's why I call my practice a wellness practice.

How long have you been prescribing GLP-1s?

I started prescribing GLP-1s for diabetes in my internal medicine practice, so it's not a new treatment for me, but just in the last few years, their use has expanded with new weight loss indications. I was somewhat familiar with liraglutide and exenatide, but we see the weight loss that we do now with these newer medications like semaglutide and tirzepatide. Now there's much more information, and the studies are very different in terms of weight loss and additional benefits besides just weight loss.

How do you determine if a GLP-1 is appropriate for your patient? How do you counsel them when you start them on the medicine?

A lot of times, because of the publicity of these drugs, I have patients that have already decided they want a GLP-1. When I do an intake with the new patient, it's an hour-long visit. We talk about all aspects of lifestyle, including mood, physical activity, what their daily schedule is like, their nutrition and their sleep. I spend a lot of time on the nutrition aspect, and then just a small part on the medication. We really focus on building other lifestyle changes and behaviors before we talk about medication. I explain to them that this is not a short-term medication, that you have to commit to this for a year, two years, maybe even longer. The other starting point is that I explain to patients that obesity is a chronic condition. It's a chronic medical illness. They have a stigma with it sometimes, or they have been made to feel guilty about it, or they just are eating the wrong things, or they're being lazy. It's not that; it's a medical condition. So, sometimes medication is required for treatment.

We will talk about options. We go over, “what is a GLP-1?” We go over other medication choices, some of the side effects and contraindications. I think when they understand what they're getting into and the cost of it, they realize these medications may not be the best fit for them. We talk about how when you use these injectable medications, if you are not active physically, you're going be at risk for losing muscle. We discuss if they are willing to commit to long-term use of these medications. It's not magic. It's not something that you can do three months or four months to get a jump start on things, and then you just stop because you're going to regain the weight again as soon as you discontinue the GLP-1.

How do most of your patients do on these medications?

Most of my patients tolerate them fairly well. If they do OK with the first dose, then they tend to do OK with the high doses. If they're very sensitive with the low doses, they may have more problems with titrating. In general, most tolerate them because I explain to them what to look for, to be preventative with constipation, which is a big side effect. I advise them to drink enough water, get enough fiber, but there are some that just can't tolerate it, and some that have more unusual side effects. You hear about the GI side effects, but I have several patients who have extreme fatigue with it also. They feel like they just don't have the energy to do things. And it’s not the decreased caloric intake, it’s a medication side effect.

For those of us who practice in Urgent Care, we see some of these patients come into our practice if their doctor isn't available, or maybe they're getting the medication from an online pharmacy. How do you suggest that we approach patients?

Well, I have a very low tolerance for any side effects from medications. If there's any changes in terms of how they feel, and the only new thing is these medications, it may be worthwhile to think about, “Is that related to that medication?” Nausea, vomiting, constipation, indigestion and stomach cramping are common side effects, but I have had a patient develop full-blown pancreatitis. You need to use more caution in people who have diabetes because of gastroparesis. They already are prone to that, so that is a more likely side

effect. Depending on the symptoms, patients may need to hold their medication, and you may need to do lab testing for renal function and to rule out pancreatitis.

You mentioned fatigue. What are some other uncommon side effects to be aware of?

I have had patients develop tachycardia with the GLP-1s. You need to be careful in patients with atrial fibrillation or other underlying tachycardia because these medications can exacerbate that. In patients with diabetes, semaglutide and tirzepatide have been linked with retinopathy, so any sort of visual changes with these medications would be something to take seriously. They should be having regular eye exams anyway, but I always advise patients to pay attention to their vision on these medications. You also have to be really careful in patients with diabetes because if they're already on other diabetic medications, they could drop their blood sugar and become hypoglycemic.

Have you seen anyone have any psych issues with GLP-1s?

Primarily, fatigue. It makes them feel like they don't want to do anything, but not depression or anxiety. I haven't really seen that.

So, fatigue, tachycardia, retinopathy and pancreatitis are some of the more unusual side effects that you've seen. Are there any red flags if someone came into an Urgent Care center that we should be really concerned about?

I have had some patients who are really sensitive and experience a lot of vomiting. That's a concern, especially when they first start: intractable nausea and vomiting. I have referred patients to go to Urgent Care or the ER because they can get dehydrated.

The patient comes in with vomiting that they can't control. How do you suggest treating that? What are you using for other GI side effects?

Mainly, ondansetron, and I also proactively give it to them when I start them on a prescription. If they have some nausea, I tell them to preventatively use ondansetron the day or two after they do their injection, especially every time they increase the dose. Ondansetron, metoclopramide and promethazine all work pretty well.

The other side effect that people underestimate is how severe constipation can be. I've had people who stopped the treatment because the constipation was so bad. Patients need to make sure they are paying attention to their bowel movements, drinking enough water, eating enough fiber and taking a stool softener as well. And I am also careful with patients who have indigestion because I have found the GLP-1s can actually make that worse. PPIs are OK for that. Once they get up to a maintenance dose, the side effects tend to settle out.

Have you had any patients who have injection-site reactions? How do you manage those?

Yes. I do have a couple of patients who get a little rash right at the injection site but nothing more serious in terms of other systemic reactions. I have them apply topical hydrocortisone at the injection site and take cetirizine or another antihistamine a day or two around the time they do their injection. Moving the injection site around also helps.

Are there any suggestions to adjust other medications like NSAIDs or antibiotics because of changes in gut motility?

I don't think there's any evidence that any adjustments are necessary.

Any other unusual concerns to be aware of?

From a surgery clearance standpoint, the anesthesiologists are asking patients to hold their GLP-1s sometimes for up to two weeks because the half-life of the medication is so long, you don't want to go into major surgery with the patient's stomach not empty. Consider this especially in diabetics already at risk for gastroparesis. And if a patient comes into an Urgent Care center following surgery, be sure to consider that they are at higher risk of aspiration pneumonia.

Do you have any opinion on compounding pharmacies?

Compounding pharmacies are really popular, and there's so many of them. The FDA has issued warnings about compounding pharmacies in terms of adverse events that they get reports on, so I generally don't use them. If patients want to use one of these pharmacies, that's up to them, and they have to evaluate the risk associated with that. I've read where they've gone in and analyzed the actual medication in these compounded injections, and it's just not what you would expect. I have a lot of patients who come to my practice on compounded GLP-1s, and they have a lot of side effects. So, be aware of where they are getting their prescriptions from.

Do you consider GLP-1s to be a health disparity issue?

It is a health disparity issue because if you have insurance that is not going to cover it, you're not going to get access to these medications. I don't know of a solution because it's so expensive to use these medications. I think that there has to be some types of structural changes and big policy changes to improve patient access. I'm hoping that in the future there will be some generic options that will make it a little bit easier.

If patients have to stop them because of insurance issues, how do you advise them?

I tell them they need to plan for that. "Do you have a good exercise routine and good meal plan in place? If you don't, you're going to regain the weight again, and that's just really hard on your body when you go up and down in weight all the time." They forget how hard it is to not eat the things they would normally eat because the medicine blunts that hunger and all of their cravings. I tell patients, if they've been on it at long-term maintenance, to stretch out the dose from seven days to 10 days to start to remember how it feels to be hungry when you don't have the medicine to rely on.

Dr. Meade, thank you so much for your time and insights.

Case Study: 46-Year-Old Taking Tirzepatide, Presenting with Abdominal Pain

Erin Loo, PA-C

Gender: Male

Age: 46

PMHx: obesity; GERD, melanoma; basal cell carcinoma (BCC); anxiety disorder; binge eating disorder

PSHx: BCC removal: 2016; melanoma resection: 2020

Social Hx: smoking: never; drug use: never; ETOH: 1-2 drinks a month

Chronic medications: tirzepatide; omeprazole

HPI: Patient presents to Urgent Care with two days of severe abdominal pain and bloating, worse with eating and improved by leaning forward. He denies fever, nausea, vomiting, bloody stool and black tarry stool.

Vitals: pulse: 90; BP: 142/90; O2 sat: 98%; RR: 16; BMI: 34

Exam:

General: A&O x 3; patient in mild distress

HEENT: unremarkable

Cardiac: RRR

Pulmonary: lungs CTA: bilaterally

GI: Diffuse tenderness on exam with no rebound or guarding. Negative Murphy's sign.

Extremities: no rashes; normal capillary refill

Diagnosis: diverticulitis

Plan: ciprofloxacin: 500mg BID x 10 days; metronidazole: 500mg BID x 10 days; ER precautions; follow-up with PCP

The patient's abdominal pain did not improve with antibiotics. The patient was seen in the ER twice following the Urgent Care visit, had a negative cardiac workup, a normal CMP, a negative lipase and a negative abdominal CT. On the follow-up visit with the PCP, he was given a referral to GI. The patient self-discontinued his tirzepatide after reading about side effects online, and his abdominal pain slowly improved. A follow-up visit with GI approximately two months following the initial episode, the GI physician diagnosed the patient

with gastroparesis caused by tirzepatide and exacerbated by omeprazole. The patient was started on metoclopramide for gastric motility with some improvement.

The patient's use of a GLP-1 receptor agonist should have been considered earlier in the progression of his illness. GLP-1 use is associated with gastroparesis which is an uncommon but serious side effect (2). A high index of suspicion needs to be maintained in these patients. It is important to discontinue the medication when this adverse event is identified.

Takeaway Points:

- GLP-1 agonist medications, including semaglutide and tirzepatide, are used for the management of diabetes and obesity. They work by stimulating insulin secretion, slowing gastric emptying, inhibiting glucagon production and increasing satiety (3).
- Patients should be counseled before starting these medications on appropriate fluid intake, using stool softeners, eating slowly and following a low-fat diet. These lifestyle considerations help to minimize adverse events (4).
- Most common side effects are nausea, vomiting, diarrhea, GERD, constipation and injection-site reactions. Side effects are most common when initiating medication or when increasing the dose, however, adverse events can happen at any time while using GLP-1s (4).
- Uncommon adverse events include pancreatitis, biliary dysfunction, gastroparesis, retinopathy, hypoglycemia and atrial fibrillation. Remember that gastroparesis and retinopathy are more common in patients with diabetes who are using GLP-1 (2,5). Hypoglycemia is also more common in patients with diabetes, especially with concomitant use of sulfonylureas and insulin (5).
- Treatment of symptoms in the Urgent Care setting includes ondansetron, promethazine, metoclopramide and fluid resuscitation for severe nausea and vomiting. There is no way to reverse effects of medication, so patients should be counseled that because of the long half-life of injectable medication, side effects may take 1-8 days to resolve. Encourage patients to monitor for sufficient fluid intake and return to the Urgent Care center or ER for signs and symptoms of dehydration (4). Consider checking renal function in patients with prolonged nausea and vomiting. Minor injection site reactions can be managed with antihistamines, however, anaphylaxis has been reported and GLP-1 medication should be discontinued if no other causative agent is identified (5).
- Consider where patients are obtaining their medications. Because of the high cost of GLP-1s, many patients will turn to compounding pharmacies. Side effects may be more common with this source of medication due to fewer regulations (3,5).
- Clinicians providing preoperative screening should counsel patients that GLP-1s should be held for 1-2 weeks prior to procedures requiring anesthesia because of risk of aspiration due to incomplete gastric emptying (3).
- New indications are on the horizon for GLP-1s which will likely increase the number of patients using these medications. Non-alcoholic fatty liver disease, PCOS and neurodegenerative diseases, including Parkinson's and Dementia, IBS and cardiovascular protection are all possible future uses (6,7,8,9).

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Images in Urgent Care

Tracey Q. Davidoff, MD, FCUCM

A 72-year-old woman presents with a rash on the left lower leg for three weeks. She lives in the Southeastern U.S. and is an avid gardener, frequently wearing shorts and working barefoot. It is moderately itchy. As the days pass, the lesion appears to get longer and more tortuous at the proximal end. There was no improvement with over-the-counter hydrocortisone cream. She is very healthy and has not had this in the past.

View the image below and consider your diagnosis and next steps. Resolution of the case is described on page 19.

DOT Exam Column

Rick Nunez, MD

Must a Driver Be Fluent in English in Order to Pass the DOT Physical Exam?

It is not the role of the medical examiner to establish if a driver is fluent in English. Federal regulations state that a commercial motor vehicle driver must be able to "read and speak the English language sufficiently to converse with the general public, to understand highway traffic signs and signals in the English language, to respond to official inquiries and to make entries on reports and records." However, it is the responsibility of the motor carrier, not the medical examiner (ME), to ensure proficiency in English.

You know the medical examination report form? The form that you use every day to complete DOT exams? The instructions on page 7 state, "***When determining a driver's physical qualification, please note that English language proficiency is not factored into that determination.***"[1]

As currently stated on the FMCSA website[2]:

MEs (medical examiners) are not required to certify the extent to which an individual understands English. However, MEs should only conduct examinations when they are confident that they can communicate with individuals to the level that allows for a thorough examination to be conducted. As the signature authority on the medical examiner's certificate, form MCSA-5876, MEs can turn the individual away if the level of English is not proficient enough to conduct the examination. Therefore, if the certifying ME cannot obtain a complete medical history to appropriately proceed with conducting a physical qualification examination with or without an interpreter, the ME should not conduct the examination.

What about the use of an interpreter? Is this permitted?

Per the FMCSA, there is no explicit prohibition against the use of an interpreter. Certainly, if you, as the medical examiner, do not feel confident that you can communicate with the driver to obtain a thorough exam, you have every right to refuse to conduct the exam. However, if in your judgment, an interpreter allows for such communication, there is no specific rule, policy or regulation against use of an interpreter. In sum, then, there is no regulation against the use of an interpreter when such use will allow for an accurate DOT evaluation and will allow for the driver's understanding of the attestation on the medical examination report form that the information is complete and accurate.

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[1] *FMCSA. Medical Examination Report (MER) Form, MCSA-5875. Page 7.*

[2] FMCSA. *Medical Examiner's Handbook*. 2024: Pg. 102

If you have any questions regarding the DOT exam or obtaining NRCME certification, feel free to email at mail@EMedHome.com.

Rick Nunez, MD, is medical editor for easyDOTexam.com and the NRCME training at EMedHome.com.

Images in Urgent Care Continued

The following resolution is to the image and introduction provided on page 17.

Differential Diagnosis:

- Tinea pedis
- Scabies
- Cutaneous larva-migrans
- Contact Dermatitis
- Erythema chronicum migrans (ECM) (Lyme disease)

Diagnosis:

This patient has hookworm-related cutaneous larva migrans, (HrCLM), also called, "creeping eruption." It is an accidental infection in humans from hookworm eggs passed from the stool of infected dogs and cats who are the usual hosts[3]. Although hookworms can be found worldwide, there is a geographic preference for the warmer tropical and subtropical climates such as the Caribbean, Southeast Asia, Northern Africa, South America and the southeastern parts of the U.S. Patients at risk include travelers, children, swimmers, laborers and anyone subject to contact with sand or sandy soil, especially in subtropical and tropical regions[4].

HrCLM most commonly affects the lower legs but can occur anywhere skin may come into contact with infected sand or soil[5]. Patients initially present with an erythematous papule at the inoculation site followed by a pruritic, elevated, serpiginous track days to weeks later. It may lengthen by millimeters to centimeters in length per day. The larva is usually 1-2 cm ahead of the lesion[6]. Although most cases are self-limited and resolve spontaneously in 2-8 weeks, rarely cases persist for as long as two years. Lesions can be distressing due to itch and disrupt sleep, cosmetically disturbing or may develop complications such as vesiculation,

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crusting and secondary infection. Rare cases, especially in frail or immunocompromised patients, may disseminate hematogenously to the lungs.

The diagnosis is usually made clinically based on history and appearance of the lesions. Testing is generally not required.
Other less common parasitic infections, such as strongyloidiasis and Loiasis, may cause similar rashes but vary in geographic location, severity of itching (or absence of symptoms) and speed of migration[7]. Non-parasitic causes and non-migratory skin lesions that may be mistaken for HrCLM include tinea, contact dermatitis, scabies, impetigo and ECM.

Treatment options for HrCLM include the anthelmintics ivermectin or albendazole orally for 1-3 days[8] Antihistamines may be useful to control itch and help sleep.

Pearls for Urgent Care management:

- Infection occurs in tropical and subtropical regions after contact with sandy soil, most commonly after gardening or beach-going. Think of HrCLM in a returning traveler or immigrant from these regions.
- The history of travel and contact with sandy soil coupled with the characteristic migratory rash is generally diagnostic, and no further evaluation is required.
- The differential diagnosis may include strongyloidiasis and loa loa ("worm worm") if there is a history of travel or the more common entities: tinea, scabies, impetigo, folliculitis and contact dermatitis.
- Although most cases are self-limited and resolve spontaneously, patients may be treated with a short course of oral ivermectin or albendazole.
- Complications may include vesicular lesions, crusting or superimposed bacterial infection.

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Tricks of the Trade: Achieving a Bloodless Field in Finger Injuries—MacGyver in Medicine

Tracey Quail Davidoff, MD, FCUCM

Suturing a bleeding finger laceration can be challenging due to the vascular nature of the hand. Although bleeding is usually controlled by direct pressure, manipulation of the wound for inspection and cleaning often disrupts hemostasis, causing recurrent bleeding[9]. This often prevents adequate evaluation and makes repair difficult.

Placing a tourniquet at the base of the finger can control bleeding, making evaluation and repair quicker and easier. This technique is commonly used by hand surgeons in the operating room and can also be implemented by the Urgent Care clinician. Traditionally a common tourniquet used for phlebotomy or a Penrose drain is used with a Kelly clamp to secure it. A limitation of this method is that the tourniquet or drain may be too large for smaller fingers and may also exert uneven or excessive pressure if applied incorrectly or too tightly. Commercial finger tourniquets solve this problem and are available but may be cost prohibitive or unavailable in some centers. A nitrile glove is always accessible and can easily be used for this purpose[10].

Theoretically, a tourniquet of the finger would need to exert pressure greater than the patient's blood pressure but low enough to prevent damage to vascular and soft tissues. An emergency medicine study found that Penrose drains exert a pressure of 727 mmHg, the glove tourniquet 267 mmHg and commercial tourniquets <240 mmHg[11]. This would indicate that the commercial tourniquets would be the best option; the glove tourniquet may be the next best option.

To create a glove tourniquet, a finger is cut from a glove at the base and the very tip. It is applied to the injured finger and worked down to the base exsanguinating the blood from the finger, working carefully around the injury.

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If a digital block is required, it should be performed before the application of the tourniquet. The tourniquet may be safely left in place for 30 to 45 minutes but should be removed as soon as possible. (9)

There are cases in the literature reporting tourniquets inadvertently left on fingers and toes after procedures, prompting some authors to discourage their use.[12] [13] Prolonged application may result in necrosis of the finger and in severe cases, amputation. The commercial finger tourniquets have addressed this problem by being brightly colored, large or with tags to make it nearly impossible to accidentally leave them in place. Using blue nitrile gloves, attaching a clamp to the tourniquet or setting a timer are ways to prevent this when using a glove. It is always prudent to double check before discharging the patient.

Figure 1. How to make a glove tourniquet.

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Figure 2. Glove tourniquet in place with an exsanguinated finger.

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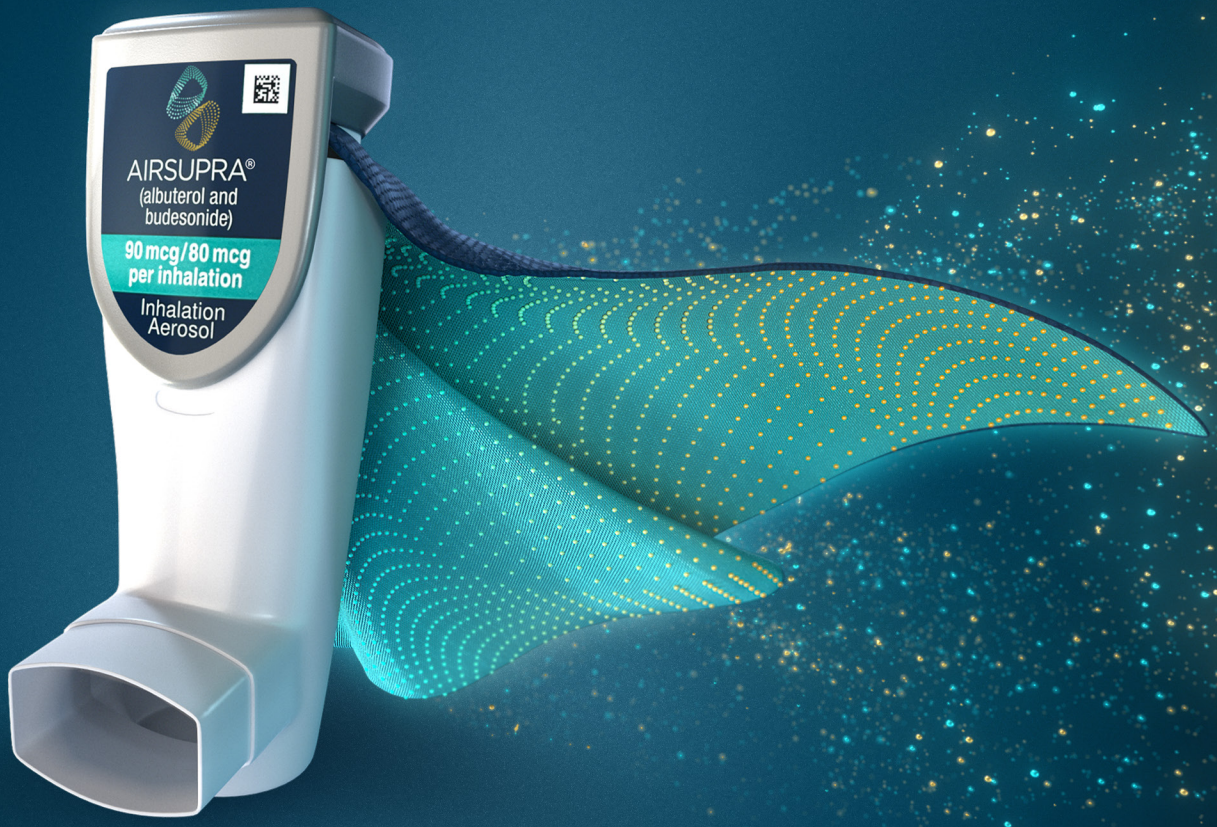

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Coding and Documentation Corner: Ear Irrigation/Lavage

Brad Laymon, RPA-C, CPC, CEMC

Precise coding and documentation for ear irrigation are vital for achieving proper reimbursement and maintaining clinical accuracy. Thorough documentation not only substantiates the procedure for billing purposes but also creates a reliable record of patient care. Accurately capturing the details of ear irrigation—whether performed with instrumentation or simple irrigation/lavage and whether by a qualified healthcare team member or a clinician—ensures compliance with coding guidelines and reduces the likelihood of denied claims. This attention to detail in coding underscores the value of the care provided and supports data integrity for quality assessments.

Let's run through different patient scenarios Urgent Care centers will see. Remember, a procedure note is necessary, with "impaction" as the required diagnosis.

- Lavage only with removal of impaction **by clinician** - E/M (99202-99215) code only.
- Lavage only with removal of impaction **by non-clinician-** 69209 only.
- Lavage with removal of impaction **and treatment of underlying infection with prescription or OTC medications**- E/M level, modifier 25 and CPT code 69209.
- Cerumen removal **with instrumentation only by clinician** - example curette or spoon- 69210 only.
- Cerumen removal **with instrumentation by clinician and treatment of underlying infection with prescription or OTC medication** - E/M level, modifier 25, and CPT code 69210.

Here are the definitions from the 2024 CPT Professional Edition:

69209- *Removal impacted cerumen using irrigation/lavage, unilateral*

69210- *Removal impacted cerumen requiring instrumentation, unilateral*

CMS limits payment for CPT code 69210 to earwax removal during visits that meet all the following criteria:

- Cerumen removal is the only reason for the visit.
- Cerumen removal is performed personally by a physician or advanced practice clinician.
- The patient is symptomatic (has pain, pressure and poor hearing, etc.) from excessive cerumen.
- Cerumen removal requires more than drops, cotton swabs and a cerumen spoon.
- Documentation in the patient record shows that the procedure required significant time and effort.

Check payer contracts to understand the reimbursement rules for these services. Most payers follow CMS requirements for reimbursement.

In summary, accurate coding and documentation for ear irrigation are essential to support reimbursement, uphold clinical standards and ensure comprehensive patient records. By following clear guidelines and thoroughly documenting the procedure, healthcare clinicians can help ensure accurate billing and contribute to high-quality patient care.

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2. Definitions from CPT: 2024 CPT Professional Edition Page 522

The First 5 Minutes of Managing Hydrofluoric Acid Burns in Urgent Care

Kelly Heidepriem, MD
Hippo Education

Hydrofluoric acid (HF) is a silent threat, seemingly harmless at first glance but with the potential to cause severe, life-threatening harm. It's one of those rare exposures that many medical professionals may never encounter, but when it does happen, prompt and precise action is crucial. In this post, we'll break down the crucial first five minutes after identifying an HF burn and the vital steps that Urgent Care clinicians should take before transporting the patient to the emergency room.

It Doesn't Look That Bad... Understanding the Dangers of Hydrofluoric Acid

HF is dangerously deceptive. Unlike many chemical burns, the initial injury from HF might not appear severe but don't be fooled. The real danger lies in the chemical properties of hydrofluoric acid.

When HF contacts the skin, it dissociates into hydrogen and fluoride ions. The hydrogen ions cause tissue damage through coagulative and liquefactive necrosis, while the fluoride ions penetrate deeply into the tissue, binding to calcium and magnesium ions in the body. This binding leads to systemic toxicity, including hypocalcemia, hypomagnesemia and hyperkalemia, which can cause life-threatening cardiac arrhythmias, such as prolonged QT intervals and torsades de pointes.

The First Five Minutes: Urgent Care Protocol

Given the seriousness of HF exposure, your initial response in Urgent Care is crucial. Here's what you need to do within the first five minutes of a patient presenting with a potential HF burn injury:

1. **History and identification**: Start with a detailed history. Ask the patient about the specific substance they were using. Many people don't realize they're handling hydrofluoric acid. Common sources include glass etching products, rust removers and metal cleaners. If the patient doesn't know the exact concentration, you may be able to estimate the concentration based on the timing of the onset of pain. Immediate pain suggests a more concentrated solution, while delayed pain might indicate a more diluted solution.

2. **Initial assessment**: Examine the wound. While HF burns might not look severe, the pain is often out of proportion to the appearance. Even small burns can be dangerous, and systemic toxicity can occur even with minimal surface area involvement, especially with concentrated solutions.
3. **Decision to transport**: Given the potential for systemic toxicity, most HF exposures should be managed in an ED. Initiate transport must be carried out immediately. The mode of transport, ambulance versus private vehicle, depends on the severity of symptoms, the concentration of the acid and the extent of the burn. Any patient with suspected systemic involvement should be transported by ambulance.
4. **Decontamination**: While waiting for transport, initiate decontamination by removing any contaminated clothing and washing the affected area with copious amounts of water. This step is vital to minimize further absorption of the acid. Ensure medical staff are wearing protective gear to avoid exposure.
5. **Calcium treatment**: If available, administer a calcium-based treatment to the burn area. Calcium binds to the fluoride ions, reducing pain and preventing further systemic toxicity. A practical and effective method in Urgent Care is the use of a calcium slurry, made by crushing calcium gluconate tablets (or Tums) and mixing them with a water-based lubricant like KY Jelly. Apply this mixture to the affected area, and if the burn is on the hand, place it inside a surgical glove to keep the slurry in contact with the skin.
6. **Monitoring**: Place the patient on a cardiac monitor while awaiting transport, as HF exposure can lead to serious cardiac arrhythmias. If time allows, perform an EKG, looking for signs of QT prolongation or other electrolyte disturbances.

What Happens in the Emergency Room?

Once the patient arrives at the hospital, the focus shifts to further decontamination, aggressive electrolyte management as needed and close cardiac monitoring. The emergency team will likely consult poison control and may administer additional calcium and magnesium, along with other interventions to address systemic toxicity.

Top Take-Home Points

- **Recognize**: HF burns can be deceptive in appearance, but pain is often a key indicator of the severity.
- **Decontaminate and irrigate**: Immediate and thorough washing of the affected area is critical.
- **Calcium treatment**: Apply a calcium-based slurry to neutralize the fluoride ions and reduce systemic toxicity.

This case underscores the importance of preparation and quick action in Urgent Care settings, where having the right knowledge and tools can make all the difference in outcomes.

Diagnosis and Management of Acute Gastroenteritis in Adults in the Urgent Care Setting

Excerpted from: **Chien C, Block PD**. Diagnosis and management of acute gastroenteritis in adults in the Urgent Care setting. *Evidence-Based Urgent Care*. 2024 October;3(10):1-27. Reprinted with permission of EB Medicine.

Acute gastroenteritis is a common condition frequently encountered in the Urgent Care setting. Although most cases are mild and self-limited, an important subgroup of patients will manifest severe disease that necessitates comprehensive diagnostic testing, empiric therapy and escalation of care.

Key Points

- The hallmark symptom of acute gastroenteritis is acute onset of diarrhea, with or without nausea and vomiting.
- The most common cause of acute gastroenteritis is norovirus.[1,2] Food-borne bacterial pathogens, certain types of medication and certain conditions can also present as new-onset diarrhea.
- The differential diagnosis for acute diarrheal illness is complicated by its similarity to other common noninfectious diagnoses, such as intestinal ischemia, medication-induced diarrhea, inflammatory bowel disease or diverticulitis.
- A detailed history and targeted questions about key environmental exposures can narrow down the differential diagnosis.
- Molecular stool pathogen panels should be obtained if there are worrisome symptoms, such as bloody or mucoid stools, abdominal pain, signs of sepsis or concern for community outbreak. Blood tests, endoscopy and imaging have limited utility in diagnosing acute gastroenteritis.
- Supportive care that includes rehydration and antiemetic therapy, without the need for empiric therapy or comprehensive testing, is the mainstay approach to treatment.[3-10] Empiric antimicrobials, bismuth subsalicyates[11,12] and certain antimotility agents should be used cautiously.[13-21]
- Older patients, immunocompromised patients, pregnant patients and patients with inflammatory bowel disease or travelers' diarrhea warrant careful management and a low threshold to refer to specialty care, as these populations are more likely to experience severe or prolonged acute gastroenteritis.

Clinical Pearls

- Characterizing the duration, frequency, volume and quality of stools is helpful in assessing disease severity and guiding treatment.
- Key environmental factors relevant to determining the cause of acute gastroenteritis include recent food intake, antibiotic exposure, travel history, work at a daycare and sexual encounters.
- Rehydration is the most important step of treatment. Depending on the severity of symptoms, this can be oral rehydration solutions or intravenous fluids.[13,14,23]

- Red flag symptoms, such as hematochezia, signs of sepsis or dehydration or peritonitis, require more in-depth diagnostic testing, escalation of supportive care and referral to the ED.

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Management of Epistaxis in the Urgent Care Setting

Excerpted from: **Yuan J.,** Management of epistaxis in the Urgent Care setting. *Evidence-Based Urgent Care*. 2024 November;3(11):1-21. Reprinted with permission of EB Medicine.

Epistaxis, or bleeding from the nose, is a common presentation in the Urgent Care setting, and it can be distressing for patients. Although most cases resolve without complicated intervention, patients may seek medical care if bleeding is severe, refractory or recurrent. Unusual conditions that present with epistaxis can be serious, therefore, the Urgent Care clinician should be familiar with the wide differential diagnosis to aid in distinguishing between the benign causes of epistaxis and those that require referral to the ED.

Key Points

- Epistaxis is more commonly seen in patients aged <10 years or >70 years old.[1]
- The etiology and differential diagnosis of epistaxis are very broad. Kiesselbach plexus is a common source of anterior bleeds.[2] Trauma, digital manipulation and foreign bodies are common causes of epistaxis.
- Initial evaluation begins by assessing airway compromise, hemodynamic instability or respiratory distress, followed by determining volume of blood loss.
- The use of personal protective equipment, such as gloves, face mask and eye protection, is recommended when evaluating patients with epistaxis. A nasal speculum and headlamp are often helpful during physical examination.
- Since clots perpetuate local bleeding via fibrinolysis, have the patient blow their nose and then apply firm compression with bidigital pressure distal to the nasal bones for 15 uninterrupted minutes.[3,4] The patient should be leaning forward to avoid swallowing blood.
- Intranasal vasoconstrictors (e.g., phenylephrine 0.25% or oxymetazoline 0.05%) or topical nasal decongestants can be used to control active bleeding that does not resolve with sustained pressure.[5]
- Most epistaxis cases will resolve with conservative treatment.
- Anterior septal bleeds that can be visualized but do not respond to compression or nasal decongestants can be effectively treated with chemical or electrical cautery.[5,6]
- Certain situations may predispose a patient to epistaxis: pregnancy, von Willebrand disease, hereditary hemorrhagic telangiectasias, medical anticoagulation, injury and presence of a foreign body. Many of these cases will require advanced interventions with higher level care or management by an otolaryngology specialist.
- Only clinicians experienced with posterior nasal packing experience should attempt this procedure, as complications of nasal packing can be serious.
- An ED referral should be initiated if bleeding cannot be controlled in the Urgent Care setting[6] or if the patient has unstable vital signs, significant head or facial trauma, concern for posterior epistaxis or social and safety concerns of abuse.

Clinical Pearls

- Urgent Care management of epistaxis begins with conservative measures and then progresses to more invasive treatments: compression, topical decongestant, chemical or electrical cautery, nasal packing (with training) and then referral to the emergency department.
- For patients with first-time nosebleeds or bleeding that resolves with pressure, there is very low utility in performing diagnostic or laboratory studies.
- Observation of patients for at least 30 minutes after initial treatment is crucial due to the risk of rebleeding.[7]
- Viscous mucosal moisturizing agents, such as saline gel and petroleum jelly, are more effective than aerosolized sprays in creating a barrier for inflamed mucosal tissue to prevent further episodes of epistaxis.[8]
- Prophylactic antibiotics are unnecessary after nasal packing placement.[9,10]

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Influenza in Urgent Care: 2024-2025 Season Update

Excerpted from: Influenza in Urgent Care: 2024-2025 season update. *Evidence-Based Urgent Care*. 2024 December;3(12):1-32. Reprinted with permission of EB Medicine.

Seasonal influenza results in substantial medical costs and lost wages in the U.S., and it remains a major cause of mortality, partly related to the aging of the population. Urgent Care clinicians should be aware of the most current diagnostic and therapeutic recommendations for influenza and the resources available for guiding management.

Key Points

- The CDC defines influenza-like illness (ILI) as a temperature >37.8°C (100°F), with either cough or sore throat, in the absence of a known cause other than influenza.[1]
- Since the emergence of COVID-19, tracking of ILI has become significantly more complicated as healthcare-seeking behavior for ILI symptoms has markedly changed.
- The most common symptoms of influenza in adults are cough, fatigue, nasal congestion and fever.[1]
- Sneezing is a negative predictor of influenza in adults.[2]
- In children, the most common presenting symptoms are fever, cough and rhinitis. Vomiting and diarrhea are more common in children than adults.[3]
- When influenza is suspected, patients and clinicians should wear face masks to avoid spreading the virus.
- Isolation and droplet precautions should be maintained in the Urgent Care setting for suspected or confirmed infections.[4]
- Though influenza vaccine effectiveness is typically only 50%,[5] this still translates to a significant decrease in influenza-related morbidity and mortality.[6,7]
- For mild-to-moderate disease and no underlying high-risk conditions, supportive therapy is usually sufficient.
- For more-ill patients or those at substantial risk for complications, consider antiviral treatment.
- Neuraminidase inhibitors (oseltamivir, zanamivir, peramivir) are associated with decreased duration of symptoms and complications, especially if started within two days of symptom onset.[8]
- Oseltamivir is approved for patients of all ages, and it reduces the duration of symptoms by one day if given within 48 hours of onset of symptoms.[9]
- Chemoprophylaxis with oseltamivir or zanamivir should be considered in patients who are immunocompromised or at elevated risk for complications and cannot receive the vaccination.[10]
- Consider oseltamivir for post-exposure prophylaxis in pregnant women, as they are at high risk for complications from influenza.[11]
- During influenza season, monitor the CDC website, https://www.cdc.gov/flu/professionals/index.htm, frequently for current information on prevalence, circulating strains and recommended treatments.

- For patients who can be safely discharged from Urgent Care, clinicians should engage with the patient in shared decision-making regarding the risks and benefits of available treatments and review return precautions and reasons to seek care in the ED.

Clinical Pearls

- During peak influenza season, clinical judgement may be as good as rapid testing, making rapid testing less necessary.[12,13]
- Rapid testing may be more beneficial in times of lower disease prevalence.
- Empiric treatment of patients who are at high risk for complications of influenza and a more severe disease course should be considered even if rapid testing is negative.

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Urgent Updates

2024 International Consensus on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science with Treatment Recommendations
This latest summary addresses the most recent published resuscitation evidence reviewed by the International Liaison Committee on Resuscitation task force science experts. In addition, the task forces list priority knowledge gaps for further research. **Full Access:** AHA

Wound Characteristics Among Patients Exposed to Xylazine
In this case series of patients with confirmed xylazine exposure, wounds were commonly located on extensor surfaces of the extremities, frequently had devitalized wound beds and were more likely to have larger and necrotic wound beds the longer wounds had persisted. **Full Access:** JAMA

Cephalosporins for Outpatient Pyelonephritis in the Emergency Department: COPY-ED Study
This was a multicenter, retrospective, observational cohort study of 11 geographically diverse U.S. Emergency Departments. Researchers found that oral cephalosporins were associated with similar treatment failure rates compared with Infectious Diseases Society of America guideline-endorsed treatments for the treatment of pyelonephritis in ED patients discharged home. **Full Access:** Annals of Emergency Medicine

Comparative Effects of Drug Interventions for the Acute Management of Migraine Episodes in Adults: Systematic Review and Network Meta-Analysis In these randomized controlled trials, eletriptan, rizatriptan, sumatriptan and zolmitriptan had the best profiles, and they were more efficacious than the recently marketed drugs lasmiditan, rimegepant and ubrogepant. Although cost effectiveness analyses are warranted, and careful consideration should be given to patients with a high-risk cardiovascular profile, the most effective triptans should be considered as preferred acute treatment for migraine and included in the WHO List of Essential Medicines to promote global accessibility and uniform standards of care. **Full Access:** BMJ

Primary Care Physicians Underutilize Nonantibiotic Prophylaxis for Recurrent UTIs
Researchers surveyed 40 primary care physicians at one academic medical center and found that 96% of primary care physicians prescribe vaginal estrogen therapy for recurrent UTI prevention. Estrogen deficiency and urinary retention are strong contributors to infection. However, 78% of physicians surveyed said they had never prescribed methenamine hippurate, and 85% said they had never prescribed D-mannose. **Full Access:** Medscape

Any Combination of Hypertension Drugs Can Work in Underserved Groups
In TOPSPIN, almost 2,000 adults were randomly assigned to one of three treatment groups. All three combinations had a good safety profile; less than 3% of study participants ended treatment because of adverse effects related to the medications. The message from this trial is that physicians can use any

combination of these medications to treat hypertension in patients and can choose whichever is most appropriate based on availability and cost. **Full Access:** Medscape

COVID-19 Deaths Drop, but Mortality Data Shows Room for Prevention While SARS-CoV-2 infections continue to influence trends in U.S. death rates, COVID-19 is no longer among the nation's top three killers. The tragic trio are heart disease, cancer and unintentional injury, showing substantial room for America's physicians to play a role in preventing disease and saving lives. **Full Access:** AMA

Severe and Fatal Rocky Mountain Spotted Fever After Exposure in Tecate, Mexico — California, July 2023–January 2024
During July 2023–January 2024, six cases of RMSF in persons with exposure were reported to the California Department of Public Health; three patients died. This outbreak highlights a newly recognized location in Baja California with high RMSF risk. Increased awareness of RMSF among healthcare clinicians on both sides of the border between the U.S. and Mexico would facilitate prompt treatment and help prevent fatalities. **Full Access:** CDC

Urgent Updates in Pediatric Research Briefs

Ivan Koay, MBChB, MRCS, FRNZCUC, MD
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Atopic Dermatitis (Eczema) Guidelines

AAAAI/ACAAI JTF Atopic Dermatitis Guideline Panel; Chu D, Schneider L, Asiniwasis R, et. al. Atopic dermatitis (eczema) guidelines: 2023 American Academy of Allergy, Asthma and Immunology/American College of Allergy, Asthma and Immunology Joint Task Force on Practice Parameters GRADE- and Institute of Medicine-based recommendations. Ann Allergy Asthma Immunol. 2024 Mar;132(3):274-312. doi: 10.1016/j.anai.2023.11.009

This was a practical guideline produced to provide evidence-based recommendations about optimal management of atopic dermatitis (AD; [atopic] eczema) in amongst others, children and adolescents. The good practice statement at the outset encourages clinicians to perform the following:

- Ensure the correct diagnosis and identify complicating diagnoses.
- Provide education and, for instance, an information guide about the disease and an action plan.
- Address trigger avoidance.
- Ensure proper medication use and adherence.
- Encourage application of a bland moisturizer titrated to symptomatic benefit (at least once, often multiple times, per day).

Other recommendations include:

- Use a standard, bland (free of fragrance and other potential contact allergens) over-the-counter moisturizer over a prescription moisturizer.
- In patients with uncontrolled AD refractory to moisturization alone, the panel recommends addition of a topical corticosteroid.
- In patients with mild AD, the JTF panel suggests against adding dilute bleach baths to topical therapy regime.

The authors noted that AD lacks robust evidence for safety of medication during pregnancy and breastfeeding. Additionally, they did not review other non-traditional therapies which include complementary medicine.

Practice Pointers for Assessing and Managing Self-Harm and Suicide Risk in Young People

Mughal F, Ougrin D, Stephens L, et. al. PRACTICE POINTER: Assessment and management of self-harm and suicide risk in young people. BMJ 2024;386: e073515 http://dx.doi.org/10.1136/bmj-2022-073515

This was an educational publication looking at practical scenarios on the assessment and management of self-harm and suicide risk in young people. Suicide and self-harm are an increasing and serious public health concern. The authors' approach was informed by the National Institute of Health Excellence (NICE) guidelines published in 2022. They note that factors which increase the risk of self-harm and suicide in young people include current mental illness and distress, a history of self-harm, the use of alcohol or illicit drugs, parental separation, death or mental illness, history of abuse, chronic physical health conditions, family history of suicide and identifying as LGBTQ+.

Tips for assessment of young people include listening attentively and in a non-judgmental way, building a rapport, demonstrating acceptance of the patient and asking regarding sharing of information to the person's family early on. Assessment of the patient includes observing facial expressions, eye contact and rate, volume and tone of speech and with self-harm, the thoughts, intent and plans.

Present evidence supports cognitive behavioral therapy-type psychological interventions, dialectical behavior therapy for adolescents and mentalization-based therapy, which lead to reductions in self-harm repetition and frequency.

Editor's comments: This is an area of increasing common prevalence, where presentations to Urgent Care may be for wound care from self-harm. As clinicians, we should be vigilant and, where appropriate, then be able to assess the patients to ensure that they will be safe for discharge home or requiring further investigation and intervention.

Opioid Prescribing in Children for Acute Pain

Hadland SE, Agarwal R, Raman SR, et al. Opioid Prescribing for Acute Pain Management in Children and Adolescents in Outpatient Settings: Clinical Practice Guideline. Pediatrics. 2024;154(5): e2024068752

Pain is a common symptom that results in visits for medical attention by parents/caregivers. The authors of this guideline outline practical measures for clinicians prescribing opioids in an outpatient setting, which does include Urgent Care centers.

The recommendations include:

- Clinicians treating pain with a multimodal approach, which includes non-pharmacological therapies, non-opioid medication and, in certain relevant circumstances, opioid medication.
- Clinicians are advised NOT to prescribe opioids as monotherapy for children and adolescents with acute pain.
- When prescribing opioids for acute pain in children and adolescents, clinicians should provide immediate-release opioid formulations.
    - Start with the lowest age- and weight-appropriate doses.
    - Provide an initial supply of <5 days (unless the pain is related to trauma or surgery with an expected duration of pain of >5 days).
- When treating acute pain in children and adolescents <12 years, clinicians should NOT prescribe codeine or tramadol.

- When prescribing opioids, clinicians should provide naloxone and counsel patients and families on the signs of opioid overdose and on how to respond to an overdose.

Editor's comments: This is a very relevant guide to practical prescribing of opioids. The consensus remains to try and avoid opioid prescribing where possible due to the high potential for misuse and addiction. It would be very rare for an Urgent Care clinician to need to prescribe opioids, and institutional guidance would also help with these situations and cases.

Cause for Applause Q4 2024

Welcome CUCM's Newest Fellows

DeVon Dahlke M.P.A.S., PA-C, FCUCM is an Urgent Care clinician, manager and clinical operations manager for Sterling Urgent Care in Logan, UT. He is an active clinician providing Urgent Care services, occupational health and DOT physicals, while also serving as a managing partner of Sterling Provider Group. As the clinical operations manager, he oversees clinical practice and processes for the multi-site, multi-state Sterling Clinics organization. DeVon received his bachelor of science degree and his master's degree in physician studies from Idaho State University.

Ahmed Elbedewy, MD, MBA, CPE, DNBPAS, CHCQM, FAAP, FCUCM is the newest physician to become a Fellow in the College of Urgent Care Medicine distinction. He has 10-plus years of experience as a pediatrician and has also attained an MBA in health informatics. Originally, medically trained at Cairo University, Egypt, Dr. Elbedewy completed his residency training at Nassau University Medical Center in New York. He also obtained a fellowship in pediatric Urgent Care medicine. He is a diplomate of the American Board of Pediatrics and the American Board of Quality Assurance and Utilization Review Physicians and is a Certified Physician Executive. Dr. Elbedewy has served in various roles which include executive medical leader, medical director and physician reviewer.

Stephanie Mercer, PA-C, FCUCM is a physician assistant with GoHealth Urgent Care in New York and serves as GoHealth's national chair of coding and documentation. As such, Stephanie is involved in education on coding and documentation related issues, as well as making changes to the EHR templates to address the evolving state of documentation and coding. She received her bachelor of science and her master's degree in physician assistant studies from Kings College in Wilkes-Barre, PA.

Amelia N. Nadler, DNP, FNP-C, FCUCM has held multiple leadership positions since joining PhysicianOne Urgent Care in 2019, most recently as medical director/director of training and compliance. She has experience in Urgent Care, as well as emergency and disaster medicine. Amelia received her nursing degree from George Mason University where she was a member of the Division I women's rowing team. She subsequently went on to graduate from Beth Israel Deaconess Medical Center with a fellowship in disaster medicine and achieve both her FNP-C and DNP from the University of Massachusetts Medical School.

Congratulations to all!

Becoming a Fellow is open to physicians and APCs in Urgent Care medicine. Click here to learn more about becoming a Fellow or to view the growing list of your colleagues who have achieved the status.

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