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UCA URGENT CARE
ASSOCIATION

 COLLEGE OF
URGENT CARE
MEDICINE

 URGENT CARE
COLLEGE OF
PHYSICIANS

CASE REPORT

cme

Identifying the Hallmarks of Ramsay Hunt Syndrome in Urgent Care

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New Diagnostic Approaches May
Decrease Congenital Syphilis Rates
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The Connection Among Dehydration,
Electrolytes, and Atrial Fibrillation
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Clinical Management Challenges
in Accidental Jewelry Ingestion



31 **Practice Management**
How Clinician Decisions
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CASE REPORT

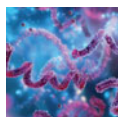
11 Ramsay Hunt Syndrome—Early Recognition of Herpes Zoster Oticus in Urgent Care: A Case Report

If not recognized early, herpes zoster oticus may progress to Ramsay Hunt syndrome with facial nerve paralysis. Recognition can be challenging because vesicular lesions may be sparse at first. Early antiviral therapy should be initiated, ideally within 72 hours of rash onset, to optimize outcomes.

Vishal Prajapati, MBBS

CLINICAL TOPIC REVIEW

15 Addressing Congenital Syphilis With Point-of-Care Testing in Urgent Care

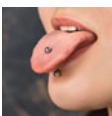


Urgent care centers can help prevent congenital syphilis by screening pregnant patients, confirming reactive test results, and administering penicillin when follow-up is uncertain.

Amir Reza Tehrani, BS; Glenn E. Harnett, MD; Jeffrey D. Klausner, MD, MPH

CASE REPORT

26 Accidental Tongue Ring Ingestion: Balancing Caution and Conservative Management in Urgent Care



Most ingested foreign objects pass spontaneously with little risk. However, in patients with persistent symptoms, emergency department evaluation may be appropriate.

Naun Gutierrez Jr., MSN, FNP-C; Christina Gardner, DHSc, MBA, PA-C

CASE REPORT

20 New-Onset Atrial Fibrillation Triggered by Diarrhea-Induced Dehydration: A Case Report



Dehydration and its associated electrolyte disturbances can precipitate new-onset atrial fibrillation. Recognition of an irregular cardiac rhythm should prompt electrocardiographic evaluation and/or a higher level of care.

Morgan Cianciolo, FNP-C; Christina Gardner, DHSc, MBA, PA-C, CAQ-EM

PRACTICE MANAGEMENT

31 Urgent Care Practice Varies More by Provider on Duty Than by Center, Payer, or Patient



Urgent care operators may find practice variation among clinicians in the same clinic. The reason comes down to the decision making of the clinician rather than infrastructure, payer, or population.

Alan A. Ayers, MBA, MAcc

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A Historic Milestone for Urgent Care Nurse Practitioners: The Journey to Specialty Certification Begins

■ Lisa H. Bishop, DNP, MSN, MHA, FNP-BC, CDEO, FCUCM

After years of persistence, collaboration, and advocacy, we have reached a historic milestone for the nurse practitioner profession and the specialty of urgent care. The American Academy of Nurse Practitioners Certification Board (AANPCB) has officially confirmed our petition to begin development of the first Urgent Care Nurse Practitioner Certification.

This announcement represents far more than the creation of a new credential. It is the beginning of a movement to formally recognize the unique body of knowledge, clinical expertise, and decision-making required to practice in today's urgent care environment.

Foundational Work

In September, our inaugural panel of selected urgent care nurse practitioner clinicians and leaders met in Las Vegas to begin the foundational work of defining the certification. Together, we worked to identify the knowledge domains, establish practice standards, and begin outlining the blueprint for what will ultimately become the certification examination.

Next, the panel will reconvene virtually in November to continue refining the examination framework and competency expectations. While certification development is a rigorous, evidence-based process that requires multiple phases of review and validation, our goal is to have the first Urgent Care Nurse Practitioner Certification available in 2027.

Developing a national certification is an extensive undertaking. It begins with defining the scope of practice

“Perhaps most importantly, this certification represents another significant step toward achieving broader recognition of urgent care as a true medical specialty.”

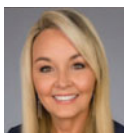
through a comprehensive job task analysis, followed by identifying the competencies that distinguish expert urgent care clinicians. Examination content must be carefully developed, peer-reviewed, and tested to ensure it accurately measures the knowledge and clinical judgment required for safe and effective practice. Every step is designed so the ultimate credential created is meaningful to clinicians, employers, and patients alike.

What This Means for Urgent Care Nurse Practitioners

Urgent care has become one of the fastest-growing and most complex areas of healthcare. Today's clinicians manage everything from acute illnesses and injuries to emergency stabilization, occupational medicine, point-of-care diagnostics, procedures, and increasingly complex medical decision-making in a fast paced environment. Yet despite this specialized practice, no nationally recognized certification exists to acknowledge expertise in urgent care.

That is about to change.

This certification will enable nurse practitioners to demonstrate advanced knowledge and competence in urgent care medicine. It will serve as a nationally recognized designation that distinguishes clinicians who have dedicated themselves to mastering this specialty.



Lisa H. Bishop, DNP, MSN, MHA, FNP-BC, CDEO, FCUCM, is the Vice President of the College of Urgent Care Medicine.

For nurse practitioners as individuals, certification will provide them recognition as experts in urgent care medicine. It will also validate their specialized knowledge beyond primary care preparation and demonstrate their increased professional credibility with employers, colleagues, and patients.

For employers, specialty certification provides an objective measure of clinician expertise that can support hiring, onboarding, professional development, and quality initiatives. For patients, it reinforces confidence that they are receiving care from clinicians whose knowledge has been validated in the unique practice of urgent care.

Advancing Urgent Care as a Specialty

Perhaps most importantly, this certification represents another significant step toward achieving broader recognition of urgent care as a true medical specialty. Specialty certification helps define standards of practice, establishes professional identity, and elevates expectations for education and competency. It demonstrates that urgent care requires a unique combination of knowledge and skills that extend beyond traditional primary

care or emergency medicine training.

My hope is that this effort will encourage other disciplines practicing within urgent care to pursue specialty certification as well. As our profession continues to mature, standardized specialty credentials will further establish urgent care as an essential component of the healthcare system.

Looking Ahead

While there is still considerable work ahead, this milestone is worth celebrating. The journey from concept to certification requires collaboration, scientific rigor, and unwavering commitment from dedicated clinicians across the country. I am honored to be part of this historic effort and grateful to the many colleagues who have helped make this possible.

The work began in September, continues through the fall, and, if all proceeds as planned, culminates in the launch of the first Urgent Care Nurse Practitioner Certification in 2027. This is only the beginning, and I could not be more excited about what lies ahead for our profession and for the future of urgent care medicine. ■



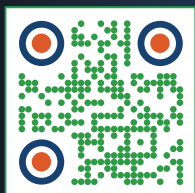
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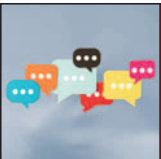
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URGENT INTERACTIONS



"If a female patient has pelvic complaints, a self-swab for infections is insufficient. Do the pelvic exam. You wouldn't ignore the cardiac exam and only do an ECG in a patient complaining of chest pain."

— **Lindsey E. Fish, MD, FCUCM**
JUCM Editor-in-Chief



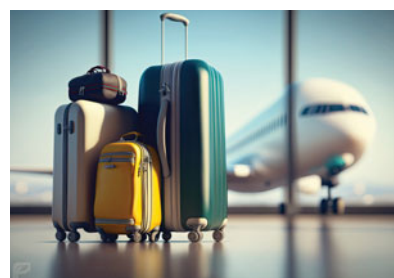
"It is important that the clinician document and communicate to the patient when there is diagnostic uncertainty at discharge."

— **Michael Weinstock, MD**
JUCM Senior Clinical Editor



"Fellowship in the College of Urgent Care Medicine represents my dedication to elevating urgent care through leadership, collaboration, and innovation, while honoring the clinicians who inspire me and advancing high-quality, evidence-based care that expands access for our communities."

— **Michelle Kerr, DMS, PA-C, DFAAPA, FCUCM**
Director, Advocate Health/Atrium Health Southern Region Urgent Cares and Levine Children's Urgent Cares; Chief Advanced Practice Provider, Advocate Health/Atrium Health Urgent Care Division; Co-chair, Atrium Health Medical Group Ambulatory Peer Review Committee



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www.urgentcaremeeting.com/

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February 8-9, 2027
Grand Hyatt Nashville
Nashville, Tennessee
www.experityhealth.com/events/urgent-care-connect/

Society for Pediatric Urgent Care 13th Annual Conference

March 10-12, 2027
Nationwide Children's Hospital
Columbus, Ohio
<https://urgentcarepeds.org/>

UCA Urgent Care Conference

May 1-4, 2027
West Palm Beach, Florida
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Beyond Convenience: Becoming a Healthcare Partner

■ Steve Sellars

For much of Urgent Care's history, convenience was our calling card. Walk-in access, extended hours, 7-day availability, and locations close to where people live and work changed what patients expected from healthcare. Convenience helped build this field, but it won't be the only thing defining our future.

Last month, I wrote about the forces reshaping healthcare: growing challenges with primary care access, rising costs, pressure on emergency departments, and employers searching for better ways to connect their workforce with affordable care. Those challenges create an enormous opportunity for Urgent Care, but they also ask more of us.

The Next Evolution

What Urgent Care needs to focus on now is becoming an even stronger healthcare partner. That starts with recognizing what we do, and what we don't do. Urgent Care isn't a replacement for primary care. Patients need longitudinal relationships with primary care clinicians, particularly for chronic disease management and preventive care. Hospitals and emergency departments remain essential for patients requiring higher-acuity services. But between those settings is an enormous and growing need for timely, high-quality, affordable, everyday healthcare. That's where Urgent Care excels.

Approximately half a million patients walk through our doors each day. Our clinicians evaluate illnesses and injuries, perform diagnostic testing, provide occupational health services, identify conditions requiring higher levels of care, and help patients determine what should happen next. That last part is increasingly important.

Being the front door to everyday healthcare isn't simply about treating the patient in front of us. It's about helping that patient move appropriately through a very complicated

healthcare system.

Imagine the opportunity when an Urgent Care visit more seamlessly connects a patient back to primary care, helps a health system avoid unnecessary emergency department utilization, gives an employer's workforce faster access to appropriate care, or identifies a patient who needs more specialized treatment. In that model, our value extends beyond the individual visit.

For clinicians, this evolution reinforces the importance of clinical excellence, appropriate referrals, care coordination, and practicing at the top of our capabilities.

For operators, it creates opportunities to build stronger relationships with health systems, employers, payers, and other healthcare partners.

This evolution also requires us to demonstrate our value. Access matters, but increasingly, our partners will expect evidence of quality, outcomes, appropriate utilization, patient experience, and cost. That's why the Urgent Care Association's work around advocacy, benchmarking, quality standards, industry data, and initiatives like the "Bring Congress to Urgent Care" campaign is so important. Through that campaign, we're helping policymakers see firsthand the impact Urgent Care has on patients, communities, and the broader healthcare system.

Together, these efforts help build the credibility required for Urgent Care to assume a larger role in healthcare delivery. That credibility—and the relationships that support it—will be increasingly important moving forward. The organizations that thrive won't simply be those that see the most patients or operate the most centers. They will be those that understand how Urgent Care fits into the larger healthcare ecosystem while building relationships that make the entire system work better.

We should be proud that convenience helped establish Urgent Care. Now we have an opportunity to build on it. Our next chapter is about becoming more connected, more measurable, and more valuable to the patients, employers, payers, and healthcare partners who increasingly depend on us. That's how we move from being a convenient place to receive care to an indispensable partner in delivering it. ■



Steve Sellars is Chief Executive Officer of the Urgent Care Association.



CONTINUING MEDICAL EDUCATION

Release Date: October 1, 2026
Expiration Date: September 30, 2028

Target Audience

This continuing medical education (CME) program is intended for urgent care physicians, primary care physicians, resident physicians, nurse practitioners, and physician assistants currently practicing, or seeking proficiency in, urgent care medicine.

Learning Objectives

Upon completion of this educational activity, the learner will be able to:

1. Provide best practice recommendations for the diagnosis and treatment of common conditions seen in urgent care
2. Review clinical guidelines wherever applicable and discuss their relevance and utility in the urgent care setting
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Ramsay Hunt Syndrome—Early Recognition of Herpes Zoster Oticus in Urgent Care: A Case Report (page 11)

- 1. Herpes zoster oticus results from the reactivation of which latent virus?**
 - a. Varicella-zoster virus
 - b. SARS-CoV-2
 - c. Human papillomavirus
 - d. All of the above
- 2. Which finding most strongly supports a diagnosis of early herpes zoster oticus rather than uncomplicated otitis externa?**
 - a. Severe burning otalgia with auricular vesicles
 - b. Reduced bilateral hearing
 - c. Low fever
 - d. Purulent nasal drainage
- 3. What clinical development distinguishes Ramsay Hunt syndrome from herpes zoster oticus as defined in the article?**
 - a. Development of facial nerve paralysis
 - b. Development of ear pain
 - c. Appearance of auricular erythema
 - d. Development of ear drainage

New-Onset Atrial Fibrillation Triggered by Diarrhea-Induced Dehydration: A Case Report (page 20)

- 1. What actions might a clinician take to help identify possible new-onset atrial fibrillation in urgent care?**
 - a. Cardiac auscultation
 - b. Electrocardiogram
 - c. Collect patient history
 - d. All of the above
- 2. Which of these may contribute to new-onset atrial fibrillation?**
 - a. Probiotics
 - b. Lack of physical activity
 - c. Dehydration and electrolyte imbalance
 - d. Adherence to a BRAT diet (banana, rice, applesauce, toast)

3. In this case, what clinical evidence supported the diagnosis of new-onset atrial fibrillation?

- a. Electrocardiogram
- b. Distended abdomen with focal tenderness
- c. Hyperactive bowel sounds
- d. Stool culture

Accidental Tongue Ring Ingestion: Balancing Caution and Conservative Management in Urgent Care (page 26)

- 1. What percentage of ingested foreign bodies resolve spontaneously?**
 - a. 8–9%
 - b. 20–25%
 - c. 50–65%
 - d. 80–90%
- 2. When might computed tomography be considered for a suspected ingested foreign body?**
 - a. With concern for gastrointestinal perforation
 - b. After the foreign body has passed
 - c. For all patients
 - d. Never
- 3. In the case presented, what was the primary reason the urgent care team referred this patient to the emergency department despite the foreign body's low-risk characteristics?**
 - a. Evidence of severe bleeding
 - b. Inability to tolerate oral intake
 - c. Persistent abdominal tenderness
 - d. Previously diagnosed eosinophilic esophagitis



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Ramsay Hunt Syndrome—Early Recognition of Herpes Zoster Oticus in Urgent Care: A Case Report

Urgent Message: If not recognized early, herpes zoster oticus may progress to Ramsay Hunt syndrome with facial nerve paralysis. Early antiviral therapy should be initiated, ideally within 72 hours of rash onset, to optimize outcomes.

Vishal Prajapati, MBBS

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Keywords: herpes zoster oticus; Ramsay Hunt syndrome; peripheral facial palsy; varicella-zoster virus; otalgia; facial paralysis; antiviral therapy

Abstract

Introduction: Herpes zoster oticus results from reactivation of varicella-zoster virus within the geniculate ganglion of the facial nerve. When facial nerve paralysis develops, the condition progresses to Ramsay Hunt syndrome. Early presentations of herpes zoster oticus frequently mimic benign otologic conditions such as otitis externa, creating significant diagnostic challenges in first-contact medical settings. Because vesicular lesions may be sparse at initial presentation, the diagnosis may be easily missed. Prompt recognition and antiviral therapy within 72 hours of rash onset are critical to reducing neural injury.

Presentation: A previously healthy 27-year-old man presented with a 3-day history of severe right-sided burning otalgia, dermatomal hypersensitivity of the auricle and lateral face, and mild serous ear drainage, which disrupted sleep. He denied fever, vertigo, or hearing loss.



Physical Exam: Inspection of the right auricle revealed translucent vesicles along the conchal bowl and cartilaginous canal with areas of crusting and erythema from ruptured lesions. Mild ear canal edema was present; the tympanic membrane was intact without middle ear effusion. Cranial nerve examination demonstrated normal facial symmetry with full eyelid closure and preserved hearing on bedside testing.

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Figure 1. Crusted Vesicular Lesions Associated With Early Herpes Zoster Oticus



Ruptured vesicles with honey-colored crusting are visible along the cartilaginous canal and conchal surface, characteristic of varicella-zoster virus reactivation in the distribution of the geniculate ganglion.

Diagnosis: Early herpes zoster oticus was suspected based on the dermatomal pain pattern and vesicular eruption. Antiviral therapy with valacyclovir was initiated; corticosteroids were deferred given intact facial nerve function. The patient returned 48 hours later with acute lower motor neuron facial palsy (incomplete eyelid closure and drooping of the oral commissure), consistent with a diagnosis of Ramsay Hunt syndrome. Corticosteroid therapy was added, ocular protection measures initiated, and urgent otolaryngology and neurology referrals arranged.

Conclusion: This case highlights that normal cranial nerve findings at initial presentation do not exclude impending facial nerve involvement in herpes zoster oticus. Structured short-interval follow-up within 24–48 hours is recommended to detect potential neurologic progression and initiate timely corticosteroid therapy before permanent facial nerve injury occurs.

Introduction

Acute otalgia is often benign, but a small subset of cases may include early manifestations of neurologic disease requiring prompt recognition and treatment. Herpes zoster oticus results from reactivation of latent varicella-zoster virus (VZV) within the geniculate ganglion of the facial nerve, and viral replication produces inflammation affecting both sensory and motor fibers of the facial nerve.¹ For purposes of this case report, herpes zoster oticus refers to VZV reactivation involving the ear without facial paralysis; when facial nerve paralysis develops in association with auricular vesicles, the condition is referred to as Ramsay Hunt syndrome (RHS).²

Patients often present with severe unilateral otalgia, dermatomal hypersensitivity, and subtle vesicular lesions involving the auricle or external auditory canal.³ Because early dermatologic findings may be sparse or overlooked, herpes zoster oticus may be misdiagnosed as otitis externa, dermatitis, or nonspecific ear pain.³ Early antiviral therapy is most effective when initiated within the first 72 hours of rash onset and may reduce the severity of neurologic complications.⁴

Case Presentation

A 27-year-old previously healthy man presented to a community urgent care clinic with a 3-day history of progressively worsening right-sided ear pain. He described the pain as sharp and burning, radiating across the auricle and lateral face. The discomfort had intensified overnight and was severe enough to disrupt his sleep. The patient reported marked hypersensitivity over the ear and adjacent facial skin.

He denied fever, vertigo, hearing loss, or upper respiratory symptoms. Over the preceding 24 hours, he had noted mild serous drainage from the right ear.

On examination, the patient appeared uncomfortable but was afebrile with normal vital signs. Inspection of the right auricle and external auditory canal revealed several small translucent vesicles along the conchal bowl and cartilaginous canal. Some lesions had ruptured, leaving areas of crusting and erythema (**Figure 1**). Mild canal edema was present; however, the tympanic membrane appeared intact and without middle ear effusion.

Cranial nerve examination demonstrated normal facial symmetry. The patient could elevate both eyebrows, close both eyes fully, and produce a symmetric smile. His hearing appeared intact on bedside testing.

Medical Decision Making

The primary diagnostic challenge was distinguishing

early herpes zoster oticus from uncomplicated otitis externa. The severe neuropathic character of the patient's pain combined with vesicular lesions suggested viral neuritis rather than simple bacterial infection.

Given the dermatomal pain pattern and vesicular eruption, a clinical diagnosis of early herpes zoster oticus was suspected. Antiviral therapy with valacyclovir 1,000 mg orally 3 times daily for 7 days was initiated. As portions of the canal demonstrated crusting suggestive of secondary bacterial infection, treatment for possible otitis externa was also prescribed.

Early antiviral therapy was initiated to suppress VZV replication and limit inflammatory injury to the facial nerve. As the patient initially had normal facial nerve function, corticosteroids were deferred at the index visit. Instead, the patient was provided explicit counseling regarding symptoms of facial nerve dysfunction and instructed to return promptly if such symptoms occurred.

Differential Diagnosis and Final Diagnosis

Differential diagnoses considered during the initial evaluation included:

- **Otitis externa**—Common cause of otalgia with canal erythema and discharge.
- **Acute otitis media**—Less likely given absence of middle-ear findings.
- **Auricular dermatitis or eczema**—Can produce crusting but usually lacks severe neuropathic pain.
- **Herpes zoster oticus**—Supported by vesicular lesions and dermatomal neuralgia.

Follow-up and Disposition

The patient returned 2 days later reporting new right-sided facial weakness. The examination revealed diminished right forehead movement, incomplete right eyelid closure (lagophthalmos), and drooping of the right oral commissure. These findings were consistent with Ramsay Hunt syndrome. Notably, the vestibulocochlear nerve was not clinically involved at the second visit. Audiometric testing and vestibular assessment were arranged at the otolaryngology referral to evaluate for eighth cranial nerve complications including sensorineural hearing loss and vertigo, which occur in a subset of patients with RHS.⁵

Systemic corticosteroid therapy was initiated with prednisone 60 mg orally daily for 7 days, followed by a 7-day taper, in combination with continued antiviral therapy.⁶ Ocular protection measures were implemented, including lubricating eye drops and nighttime eyelid taping to prevent corneal exposure injury. The

patient was referred urgently to otolaryngology and neurology for audiometric testing and further evaluation.

For immunocompetent outpatient presentations such as this case, oral combination therapy is appropriate. Urgent referral to the emergency department for intravenous antiviral therapy (acyclovir 10 mg/kg every 8 hours) should be considered for immunocompromised patients, evidence of disseminated zoster, or an inability to tolerate oral medications.⁷

“Severe burning ear pain disproportionate to otoscopic findings should raise suspicion for viral neuritis.”

Discussion

Herpes zoster oticus represents a clinically important cause of acute otalgia in urgent care practice. Reactivation involving the geniculate ganglion may initially present with subtle dermatologic findings and disproportionately severe neuropathic pain.² Importantly, an atypical variant known as zoster sine herpete—in which VZV reactivation occurs without visible vesicular eruption—has been reported in 8%–25% of patients with acute peripheral facial palsy, reinforcing the need for a high index of suspicion even when skin findings are absent.⁸

The pathophysiology of RHS reflects VZV reactivation producing inflammation and neural edema within the narrow fallopian canal of the temporal bone. Viral spread may involve not only the facial nerve but also the adjacent vestibulocochlear nerve, resulting in sensorineural hearing loss, tinnitus, and vertigo in a significant proportion of patients.⁵ These eighth cranial nerve complications should be specifically assessed at follow-up and at specialty evaluation. Without treatment, full facial nerve recovery occurs in as few as 20% of patients; this rate improves substantially with combined antiviral and corticosteroid therapy if initiated within 72 hours of onset.⁶

Corticosteroid dosing for RHS may follow these protocols: prednisone 60 mg orally daily (or 1 mg/kg/day up to 60 mg) for 7–14 days, followed by a gradual taper over an additional 7 days, administered in combination with a 7–10-day course of oral antiviral therapy.⁶ Corti-

costeroids may be introduced once facial paralysis becomes apparent to reduce inflammatory edema, and combined therapy may be superior to antivirals alone.⁶ For immunocompromised patients or those with severe, rapidly progressive palsy, referral for intravenous acyclovir (10 mg/kg every 8 hours for 7 days) is recommended.⁷

For urgent care clinicians, several diagnostic principles emerge from this case. Severe burning ear pain disproportionate to otoscopic findings should raise suspicion for viral neuritis. A normal cranial nerve examination at the initial visit does not exclude impending facial nerve involvement. Structured short-interval follow-up within 24–48 hours is essential to detect neurological progression and initiate corticosteroid therapy promptly.² A key clinical pitfall is assuming that severe unilateral otalgia with minimal otoscopic findings represents benign otitis externa; delayed recognition can allow progression to permanent facial nerve injury.

Patients with suspected herpes zoster oticus should receive explicit counseling regarding early symptoms of facial nerve dysfunction, including difficulty closing the eye, asymmetric smiling, or fluid leakage from the mouth, and should be instructed to return immediately if these develop. Because these symptoms often emerge outside the clinical environment, structured follow-up within 24–48 hours may facilitate early recognition of neurological progression and allow timely initiation of corticosteroid therapy.

Clinical Red Flags for Herpes Zoster Oticus in Urgent Care

- Severe unilateral otalgia disproportionate to exam findings
- Burning or neuropathic quality of pain
- Dermatomal hypersensitivity of the auricle or lateral face
- Vesicular lesions within the conchal bowl or external auditory canal
- Hyperacusis (sensitivity to sound) or altered taste
- Early facial heaviness, asymmetry, or difficulty closing the eye
- New vertigo or unilateral hearing loss (may suggest eighth cranial nerve involvement)

Ethics Statement

The patient provided written consent for publication of this case report, including the clinical image.

Takeaway Points

- Severe unilateral otalgia with neuropathic features is a hallmark of early herpes zoster oticus and should prompt examination for vesicles and cranial nerve involvement.²
- Early antiviral therapy should be initiated, ideally within 72 hours of rash onset, to optimize outcomes.⁴
- Antivirals are started at onset of vesicles and corticosteroids (prednisone 60 mg/day for 7–14 days, then tapered) may be added if facial palsy develops.⁶
- Immunocompromised patients and patients with disseminated zoster warrant emergency referral for intravenous antiviral therapy.⁷
- Sensorineural hearing loss and vertigo may accompany facial palsy in RHS and require audiometric and vestibular assessment.⁵
- Follow-up within 24–48 hours is recommended to detect potential progression from herpes zoster oticus to Ramsay Hunt syndrome in order to initiate timely corticosteroid therapy.² ■

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Addressing Congenital Syphilis With Point-of-Care Testing in Urgent Care

Urgent Message: Urgent care centers can help prevent congenital syphilis by screening pregnant patients lacking prenatal records, confirming reactive point-of-care results, and administering penicillin when follow-up is uncertain.

Amir Reza Tehrani, BS; Glenn E. Harnett, MD; Jeffrey D. Klausner, MD, MPH

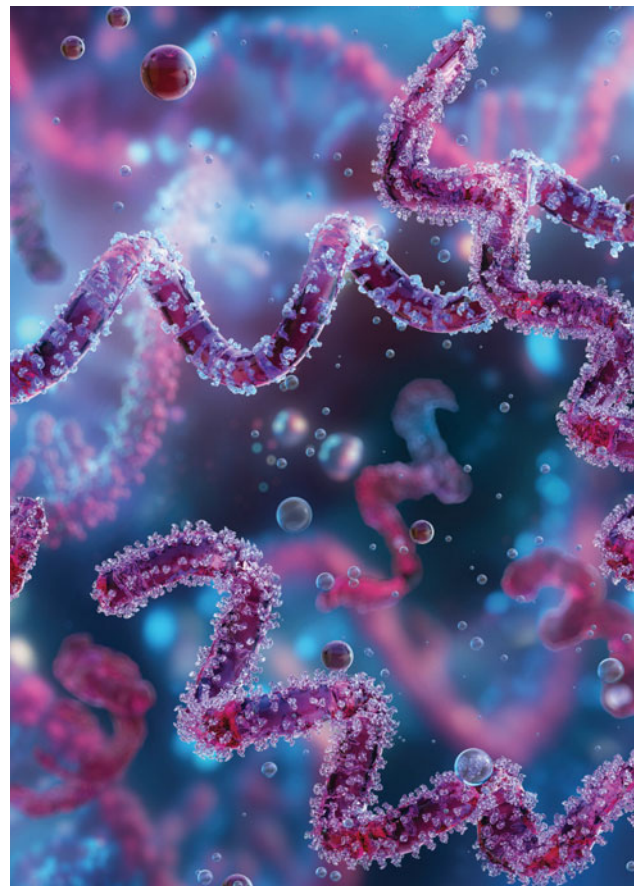
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Keywords: syphilis screening; congenital syphilis; point-of-care testing; sexually transmitted infections; pregnant patients; urgent care; rapid diagnostics

Abstract

Purpose: The purpose of this review is to use clinical, operational, and economic evidence to support integrating rapid point-of-care syphilis testing in U.S. urgent care centers. Urgent care centers, despite becoming a de facto frontline for sexually transmitted infection (STI) care in key populations, have limited adoption of point-of-care syphilis testing.

Recent Findings: Epidemiological data reveals that, although primary and secondary syphilis rates are falling, congenital syphilis rates are climbing. Clinical data from emergency department settings show that opt-out point-of-care testing models increase screening rates as much as 28-fold (from 2% to 56%), enabling single-visit testing and treatment. Adoption of the models, however, may be hindered due to perceived increased costs and staff time and lack of adequate models demonstrating workflow and clinical outcomes.



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Summary: To navigate limitations of current tests, we propose a “test-and-treat” algorithm. A longer-term solution requires a multifaceted approach: changes to point-of-care testing reimbursement; creating or strengthening partnerships between urgent care centers and public health departments for reporting and follow-up; and accelerated Food and Drug Administration approval of additional point-of-care tests targeting multiple STIs.

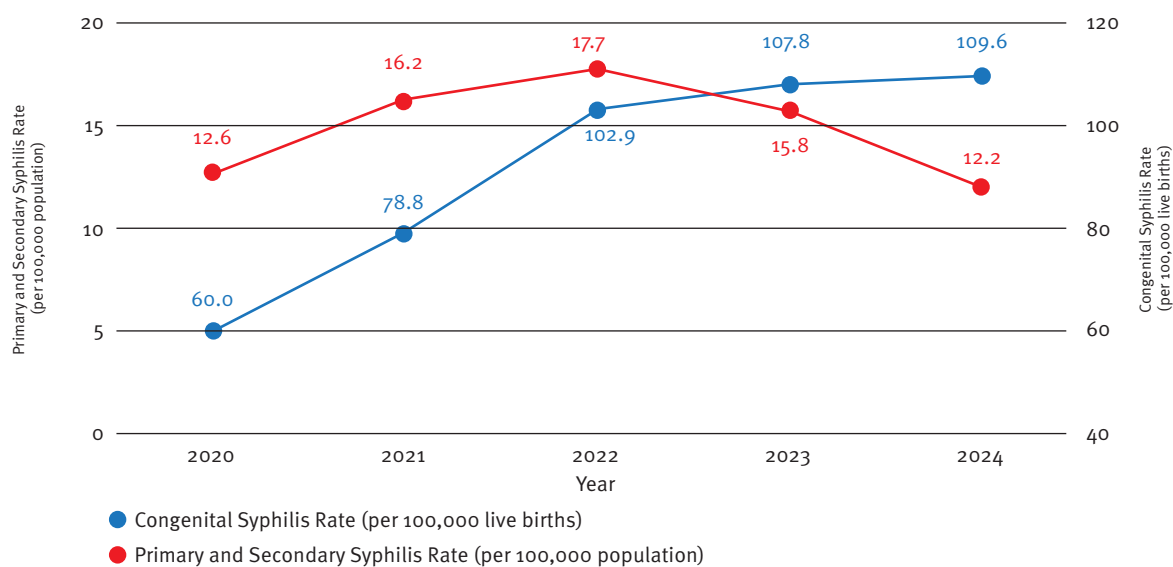
Introduction

Congenital syphilis—a preventable outcome of maternal *Treponema pallidum* infection—is surging in the United States primarily due to 3 factors: missed or delayed prenatal care; missed or delayed screening; and missed or delayed stage-appropriate treatment.¹ Congenital syphilis is often preventable when maternal infection is diagnosed and treated with stage-appropriate penicillin. Despite effective treatment, congenital syphilis cases continue to rise. Patients increasingly rely on urgent and on-demand care settings for care, where the lack of rapid point-of-care testing may represent a missed opportunity for same-day syphilis screening, staging, and treatment.^{2,3} Paradoxically, even as rates of primary and secondary syphilis in the general population have begun to decline, congenital cases have continued to rise (**Figure 1**). As publicly funded sexually transmitted infection (STI)

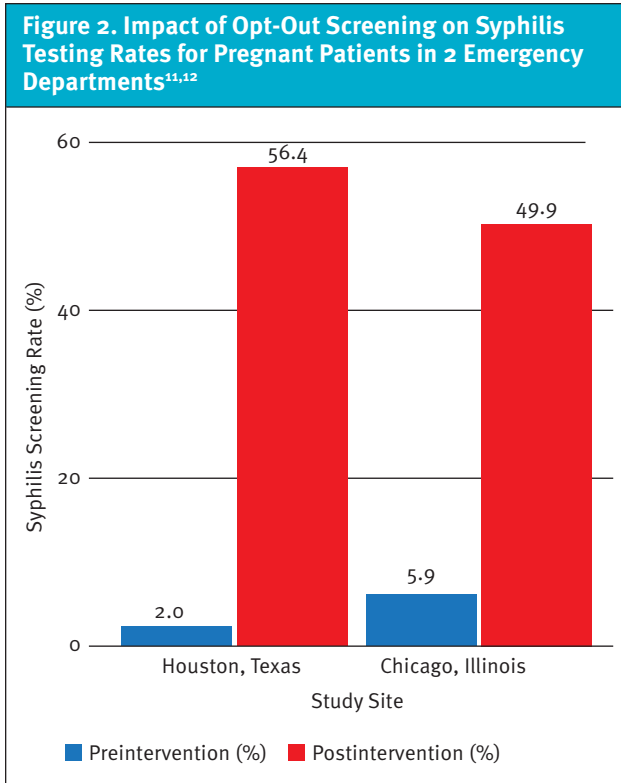
clinics reduce services—such as STI screening and treatment, partner notification, and follow-up care—the care burden shifts onto the most accessible on-demand providers.⁴ Consequently, the confluence of reduced public services and primary care access as well as patient preference for convenience has positioned urgent care centers as a point of access for rapid STI diagnosis and treatment.^{4,5}

A 2017 analysis quantified the trend of urgent care centers being transformed into the main point of access for STI care, showing that urgent care centers saw a ~2-fold increase in the number of visits (for chlamydia and gonorrhea testing) and a >3-fold increase in visits by persons with diagnosed STIs.⁶ More recent data demonstrates that the top 1% of urgent care centers in the United States by STI volume attribute 6% of their total visits to STI testing.⁴ Leading this increasing patient volume in urgent care is patient avoidance of the traditional primary care system; the 2025 Health of U.S. Primary Care Scorecard found that more than 30% of U.S. adults lacked a usual source of care in 2022, the highest level in a decade.⁷ Additionally, an urban urgent care study of men aged 20–55 years found that 92% of visits (10,144/10,983 total visits across 6,946 unique patients) had no documented syphilis testing in the previous year, regardless of HIV status; 44% of the study population was uninsured.⁸

Figure 1. Syphilis Control in the United States, 2020–2024 (Provisional)⁹



Congenital syphilis rate (blue line, right Y-axis) increased 83% from 2020–2024. Conversely, the primary and secondary syphilis rate (red line, left axis) peaked at 17.7 in 2022 before falling to 12.2 by 2024 (a 31% decrease).



Adapting the ‘Test-and-Treat’ Model

The “test-and-treat” model, where diagnosis and treatment occur in a single visit, can directly address some of the issues associated with untreated maternal syphilis. Some states have specific policies aimed at improving identification and treatment of maternal syphilis. For example, Colorado codified statewide requirements mandating healthcare settings—including urgent care clinics—to offer syphilis screening to pregnant patients.¹⁰ Emergency department studies support the clinical principle that point-of-care testing and immediate treatment improve screening and treatment completion rates (**Figure 2**). An opt-out rapid point-of-care syphilis testing program in a Houston, Texas, emergency department resulted in a 28-fold increase in syphilis testing. The program raised the syphilis screening rate for pregnant individuals from 2% during the preimplementation phase (where laboratory-based testing was only performed when clinically indicated) to 56% in the postimplementation phase (which included opt-out rapid point-of-care and laboratory-based testing for pregnant patients without documented syphilis testing results).¹¹ The intervention in Houston detected a 3.5% prevalence of active syphilis (4 positive cases out of 114 tested) and all 4 (100%)

patients who tested positive were treated in the emergency department before discharge. The study reported that approximately 80% of pregnant patients found syphilis testing acceptable, with 100% of them demonstrating a willingness to accept the rapid Syphilis Health Check (Diagnostics Direct, LLC, Stone Harbor, New Jersey) test at the point of care.¹¹ A similar program in Chicago, Illinois, yielded an approximately 8.5-fold increase in screening among pregnant women, from 5.9% of encounters (272 of 4,579) preintervention to 49.9% (2,061 of 4,129) postintervention.¹²

“Some states have specific policies aimed at improving identification and treatment of maternal syphilis.”

The Economic and Operational Case for Adoption

There are several hurdles to the adoption of point-of-care testing for sexually transmitted infections, such as unfavorable or nonexistent reimbursement for rapid testing and the operational costs required to conduct testing. Some urgent care centers with payer contracts using Healthcare Common Procedure Coding System (HCPCS) Level II code S9083 may be financially discouraged from pursuing point-of-care testing because of the contractual flat fees or global payments, whereby the insurer pays a bundled rate for the entire visit regardless of the clinic’s treatment expenses.¹³ Reimbursement for a rapid test with separate payment, depending on the payment model, may not account for test acquisition, staff time, quality control, and follow-up. Similarly, some urgent care centers may be discouraged by capitation models, in which the clinic receives a fixed monthly payment per patient per month.^{4,14-16} Under those payment models, urgent care centers may be financially disincentivized from performing screening tests, as they must purchase, conduct, and document the tests—and provide treatment when necessary—without receiving any additional reimbursement. Even urgent care centers that have fee-for-service payer contracts may find it difficult to economically justify rapid syphilis testing. Overall, reimbursement differs based on the insurer, area of service, and provider-insurer contractual agreement.

Table 1. Analysis of U.S. Payment Models and Their Impact on Point-of-Care Test Adoption for Sexually Transmitted Infections¹³⁻¹⁸

Payment Model	Mechanism	Resulting Clinic Incentive	Impact on Point-of-Care Adoption
Flat Fee or Global Payments	Insurer pays a fixed sum for the visit.	Choose the test with the lowest cost to minimize impact on profit margins.	Financial impact depends on terms of contract and related costs; using point-of-care testing may not create separate payment, reducing clinic's profitability.
Fee-for-Service	Clinic receives payments based on each service performed, including point-of-care testing.	If the difference between the test cost and test reimbursement is favorable, the clinic may make a variable profit performing the test.	Net effect depends on payment, test costs, staffing, quality checks, confirmatory testing, and follow-up costs; total costs may exceed payment.
Potential Solution	Point-of-care tests reimbursed as an extra service separate from the flat fee or global visit fee. Ensure the entire cost of the test is covered by reimbursement for all payer contracting models.	Change focus from cost reduction to prompt and accurate diagnosis.	Facilitates widespread adoption, allowing clinics to choose the best test for each patient, promoting public health initiatives.

By way of example, a rapid syphilis test waived under the Clinical Laboratory Improvement Amendments (CLIA), reported with Current Procedural Terminology (CPT) code 86780, might cost approximately \$10.50. The 2026 Medicare Clinical Laboratory Fee Schedule—basing payment amounts on the weighted median of reported private-payer rates—averages only \$13.24.^{17,18} This \$2.74 difference may fall short of covering the total cost of providing point-of-care syphilis testing after staff time, quality control, documentation, and other costs are considered (Table 1).

Despite clear benefits to early detection and treatment, current payment models continue to hinder implementation of these evidence-based public health interventions. Molecular point of care diagnostic tests for STI screening may soon be widely available, but the potential for their adoption across urgent care centers is uncertain.

Improving Outcomes

For clinicians, implementing point-of-care syphilis testing could lead to improvements in treating cases of syphilis, treating cases of maternal syphilis, and decreasing adverse outcomes. Newborns with congenital syphilis have hospital stays 3.53 times longer (95% confidence interval [CI], 3.38–3.68) and hospital expenses 4.93 times higher (95% CI, 4.57–5.32) than newborns without congenital syphilis.² In a separate 2019 nationwide analysis, mean hospitalization charges for infants with congenital syphilis were \$58,502 vs. \$12,592 for unaffected infants.^{19,20}

Existing CLIA-waived point-of-care testing represents a reasonably accurate and actionable initial screening test in persons without prior history of syphilis.^{3,11} Since reactive treponemal assays cannot distinguish treated infection from active infection, the National Syphilis and Congenital Syphilis Syndemic Federal Task Force recommends combining point-of-care screening with confirmatory nontreponemal laboratory testing and clinical staging. For patients with a reactive point-of-care test who lack documented treatment history, including pregnant patients for whom follow-up is uncertain, same-visit treatment may be appropriate based on clinical judgment (such as an initial dose of benzathine penicillin G) while confirmatory testing is pending, with subsequent treatment based on clinical staging.^{1,3,11} Stocking benzathine penicillin G may pose a financial challenge, however, due to several factors including cost and low-volume use.

Recommendations

To reduce incidence of congenital syphilis, stakeholders may consider the following strategies:

- Clinicians
 - Consider adopting a rapid “test-and-treat” workflow as described above, prioritizing pregnant patients—especially those presenting without documented prenatal screening—as well as those presenting with signs, symptoms, or high-risk exposures for sexually transmitted infections
- Urgent Care Administrators

“A test-and-treat model for syphilis—and potentially other STIs—may improve access to same-visit screening and treatment if leaders from urgent care, policymakers, public health authorities, and payers are encouraged to collaborate on solutions.”

- Consider establishing standing-order protocols defining patient eligibility, same-visit confirmatory lab collection, access to benzathine penicillin G, responsibilities for reviewing pending results and contacting patients, prenatal and referral pathways, and reporting
- Policymakers
 - Consider separate reimbursement for point-of-care syphilis screening (CPT code 86780) when testing is not included in a payment; set reimbursement to reflect operational costs and test acquisition costs
 - Review payment bundling of tests recommended by the Centers for Disease Control and Prevention, the U.S. Preventive Services Task Force, and the American College of Obstetricians and Gynecologists for all STIs that may financially discourage suggested tests
- Test Developers, Food and Drug Administration
 - Expedite the regulatory CLIA-waiver process for diagnostic tests capable of differentiating active from previously treated infection

Conclusion

A test-and-treat model for syphilis—and potentially other STIs—may improve access to same-visit screening and treatment if leaders from urgent care, policymakers, public health authorities, and payers are encouraged to collaborate on solutions.

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New-Onset Atrial Fibrillation Triggered by Diarrhea-Induced Dehydration: A Case Report

Urgent Message: Dehydration and its associated electrolyte disturbances can precipitate new-onset atrial fibrillation. Recognition of an irregular cardiac rhythm should prompt electrocardiographic evaluation and/or referral to a higher level of care.

Morgan Cianciolo, FNP-C, Christina Gardner, DHSc, MBA, PA-C, CAQ-EM

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Keywords: new-onset atrial fibrillation; dehydration; volume depletion; diarrhea; electrolyte imbalance; urgent care

Abstract

Introduction: Atrial fibrillation is the most common sustained arrhythmia in adults and is frequently associated with precipitating factors, including systemic illness, metabolic derangements, and physiologic stressors. Although dehydration and hypovolemia are reversible, recognized contributors, they may be overlooked in older adults presenting with prolonged gastrointestinal illness.

Clinical Presentation: A 75-year-old female presented to urgent care with a 2-month history of persistent diarrhea, worsening thirst, dry mouth, orthostatic lightheadedness, and recent heat exposure while working outdoors.

Physical Examination: Physical examination demonstrated dry mucous membranes and an irregularly irregular cardiac rhythm.

Diagnosis: Electrocardiography confirmed new-onset



atrial fibrillation with a controlled ventricular response.

Resolution: The patient was referred to the emergency department for further evaluation. Laboratory studies demonstrated low-normal potassium (3.6 mmol/L) and mild hypomagnesemia (1.8 mg/dL) in the setting of ongoing gastrointestinal fluid loss and volume depletion. Treatment included electrolyte replacement,

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telemetry monitoring, anticoagulation with apixaban, and further cardiac evaluation.

Conclusion: This case highlights prolonged gastrointestinal fluid loss resulting in dehydration and borderline electrolyte abnormalities as potentially reversible contributors to new-onset atrial fibrillation in older adults.

Introduction

Atrial fibrillation (AF) is the most common sustained arrhythmia in adults and is associated with an increased risk of stroke, heart failure, and mortality.¹ Additionally, AF is frequently associated with underlying cardiovascular disease as well as acute precipitating factors including systemic illness, metabolic disturbances, and physiologic stressors.¹ While structural heart disease and acute systemic stressors—including infection, hypoxia, and metabolic disturbances—are well-recognized contributors to AF, volume depletion and electrolyte abnormalities may also contribute to arrhythmia development, particularly in older adults.¹ Patients with new-onset AF may initially present with nonspecific symptoms or incidental examination findings.¹

In the urgent care setting, the relationship between volume depletion, electrolyte abnormalities, and cardiac conduction disturbances may be easily overlooked, potentially delaying diagnosis of underlying arrhythmia. Careful cardiac auscultation remains essential, as identification of an irregularly irregular rhythm should prompt further evaluation with electrocardiography, consistent with current guideline recommendations.¹

This case highlights the development of new-onset atrial fibrillation in an older adult with prolonged diarrhea, dehydration, and borderline electrolyte abnormalities. Although dehydration and electrolyte disturbances are well-recognized reversible precipitants of atrial fibrillation, this case illustrates the importance of recognizing these factors during an urgent care evaluation, particularly when relatively mild electrolyte abnormalities accompany prolonged gastrointestinal fluid loss.¹

Clinical Presentation

A 75-year-old female presented to urgent care with a 2-month history of persistent watery diarrhea that began following a 10-day course of amoxicillin prescribed for a sinus infection. She reported previous self-limited episodes of post-antibiotic diarrhea; however, this episode

was notably more severe and prolonged, with peak frequency reaching 10–20 episodes of diarrhea per day.

She described the stools as watery, yellowish-brown, non-bloody, and odorless without associated mucus. Accompanying symptoms included diffuse lower abdominal cramping, which had since improved, with a sensation of generalized abdominal pressure. Over the past few weeks, the patient initiated self-directed management with loperamide, probiotics (*Saccharomyces boulardii*), oral rehydration therapy (powdered electrolyte drink), and adherence to a BRAT diet (banana, rice, applesauce, toast), resulting in partial symptom improvement. At the time of visit, her stool frequency had decreased to approximately 3 episodes per day.

Despite this improvement, she reported persistent signs of dehydration, including dry mouth, increased thirst, and orthostatic lightheadedness. She also noted an unintentional weight loss of approximately 5 lbs over the past month. She denied fever, nausea, vomiting, chest pain, or shortness of breath. She had not undergone a recent colonoscopy and declined further gastrointestinal workup due to emotional distress about the experience. She reported no known history of cardiac disease or other chronic medical conditions.

Physical Exam

The patient was alert, comfortable, and non-toxic. Vital signs were notable for a heart rate of 93 beats per minute, a respiratory rate of 20 breaths per minute, a blood pressure of 139/87 mmHg, and an oxygen saturation of 96% on room air. She was afebrile. Her mucous membranes were noted to be dry. Abdominal examination revealed a soft and nondistended abdomen without focal tenderness, and she had hyperactive bowel sounds.

Cardiac auscultation revealed an irregularly irregular rhythm with variable heart sound intensity and no discernible cadence. No murmurs, rubs, or gallops were appreciated. Given the abnormal rhythm on examination, an electrocardiogram (ECG) was performed, demonstrating findings consistent with AF, including irregular R–R intervals and the absence of distinct P waves. The rate remained controlled at 82 beats per minute. All other systems were unremarkable on physical exam.

Given the persistence of symptoms and recent antibiotic exposure, outpatient stool testing—including *Clostridioides difficile* (*C. difficile*), stool culture, and ova and parasite evaluation—was initially planned as the patient was unable to provide a specimen in the clinic. However, the patient's disposition changed following electrocardiographic confirmation of new-onset AF. Im-

mediate emergency department (ED) referral became the priority for further evaluation and management. As a result, the planned outpatient stool studies were not completed through the urgent care.

Differential Diagnosis and Medical Decision Making

The patient's initial presentation of persistent watery diarrhea raised several diagnostic considerations. Given the temporal association with a recent course of amoxicillin, *C. difficile* infection was high on the differential.² Although the patient described the stools as watery, non-bloody, and odorless, *C. difficile* infection remained an important consideration given the persistent symptoms following recent antibiotic exposure, and testing was warranted.² Other potential etiologies included viral gastroenteritis and antibiotic-associated, noninfectious diarrhea. The absence of fever and systemic signs of infection made other invasive bacterial enteric infections less likely, though they could not be definitively excluded.

Given the duration and severity of diarrhea, volume depletion and electrolyte imbalance were significant concerns.^{1,3} The patient exhibited clinical signs of fluid loss and was at risk for hypovolemia, particularly in the setting of advanced age. Her volume depletion and electrolyte abnormalities could also contribute to an increased susceptibility to arrhythmias.^{1,3} Cardiac auscultation revealed an irregularly irregular rhythm, prompting ECG evaluation. Because the patient remained hemodynamically stable following identification of new-onset atrial fibrillation, evaluation focused on identifying reversible precipitating factors, including suspected volume depletion and electrolyte abnormalities, while arranging transfer to the ED for further evaluation and management.¹

Final Diagnosis

The patient was diagnosed with new-onset AF in the setting of volume depletion and mild electrolyte abnormalities associated with prolonged diarrhea. The diagnosis was supported by electrocardiographic confirmation of AF in a patient without a prior history of arrhythmia. Clinical evidence of dehydration, prolonged gastrointestinal fluid loss, and low-normal potassium and hypomagnesemia suggested these reversible metabolic disturbances were likely precipitating factors contributing to the patient's cardiac presentation.

Emergency Department Course, Disposition

In the ED, laboratory evaluation revealed a potassium

level of 3.6 mmol/L and a magnesium level of 1.8 mg/dL. All the other laboratory results were unremarkable.

In the ED:

- Electrolyte repletion was initiated.
- The CHA₂DS₂-VASc score—a validated clinical tool used to estimate thromboembolic risk in patients with AF and guide anticoagulation decisions—was calculated by ED clinicians.¹
- Anticoagulation with apixaban was initiated.
- A transthoracic echocardiogram was ordered to assess for underlying structural heart disease.

Discussion

Dehydration and electrolyte imbalance may contribute to the development of AF, particularly in older adults who are more susceptible to volume depletion, as seen in this case, which was due to gastrointestinal losses and environmental heat exposure. The 2023 American College of Cardiology, American Heart Association/American College of Chest Physicians, and Heart Rhythm Society guideline for the diagnosis and management of AF recognizes that it is frequently associated with acute precipitating factors, including metabolic disturbances and physiologic stressors.¹

The ECG in this case demonstrated AF with a controlled ventricular response, characterized by an irregularly irregular rhythm, absence of discrete P waves, and variable R-R intervals. Recognition of these characteristic ECG findings is essential in the urgent care setting, as prompt diagnosis facilitates evaluation for reversible precipitating factors and timely referral for definitive management.¹

Potassium plays a central role in maintaining cardiac electrophysiologic stability by regulating resting membrane potential and repolarization. Hypokalemia can delay repolarization, increase myocardial excitability, and promote ectopic atrial activity, creating a pro-arrhythmic state.³ While more pronounced potassium abnormalities are well-established contributors to arrhythmogenesis, milder reductions may contribute to electrical instability in susceptible individuals, particularly in the presence of concurrent physiologic stressors such as dehydration.^{3,4}

Mild hypokalemia is generally defined as a serum potassium concentration between 3.0–3.5 mmol/L. Although this patient's potassium level remained within the low-normal range at 3.6 mmol/L, prior studies suggest that potassium concentrations near the lower limit of normal may still increase susceptibility to arrhythmogenesis in predisposed individuals, particularly in

older adults with concurrent physiologic stressors. In this case, ongoing gastrointestinal fluid losses and dehydration may have contributed to increased susceptibility to atrial fibrillation.^{3,4}

Potassium depletion secondary to diarrhea or profuse sweating is common in older adults. With aging, total body water decreases, and renal mechanisms for fluid and electrolyte conservation become less efficient.⁴ Gastrointestinal potassium losses may further contribute to potassium depletion.⁴ Importantly, serum potassium may not fully reflect total body stores, as intracellular depletion can persist despite normalization of serum values, potentially contributing to ongoing electrical instability. These considerations underscore the importance of appropriate monitoring and repletion in patients with suspected electrolyte imbalance.⁴

Magnesium deficiency may contribute to arrhythmic risk by impairing the sodium-potassium ATPase pump, promoting intracellular potassium loss and disrupting normal cardiac ion homeostasis.⁵ In this case, mild hypomagnesemia (1.8 mg/dL), in combination with volume depletion and low-normal potassium levels (3.6 mmol/L), may have contributed to electrical instability.

Volume depletion may contribute to the development of AF by exacerbating metabolic and electrolyte disturbances that promote electrical instability, particularly in susceptible older adults.^{1,3} Dehydration may also worsen underlying electrolyte abnormalities, further increasing susceptibility to arrhythmia.^{1,3}

Persistent diarrhea following recent antibiotic exposure should prompt consideration of *C. difficile* infection. Current Infectious Diseases Society of America guidelines recommend considering *C. difficile* testing in patients with diarrhea following antimicrobial use or persistent diarrhea without another clear etiology.² The patient's atrial fibrillation in this case was likely precipitated by dehydration and electrolyte abnormalities; however, evaluation for the underlying etiology of her diarrhea was also important to ensure appropriate treatment.

This case highlights the importance of recognizing dehydration and electrolyte abnormalities as potential contributors to new-onset AF, particularly in older adults presenting with gastrointestinal illness. In the urgent care setting, careful physical examination and identification of abnormal cardiac rhythms should prompt further evaluation with electrocardiography. Early recognition and treatment of contributing factors may help reduce complications and improve patient outcomes.

Ethics Statement

The patient was unable to be contacted; therefore, certain demographics and details of the case have been changed to protect patient anonymity and confidentiality.

Takeaway Points

- In patients with suspected volume depletion, evaluation of volume status and electrolyte abnormalities should be prioritized.
- Dehydration and electrolyte imbalance may contribute to new-onset AF, particularly in older adults.
- Identification of an irregularly irregular cardiac rhythm on examination should prompt further evaluation with electrocardiography.
- Urgent care clinicians play an important role in early recognition, evaluation, and appropriate triage of patients with newly identified arrhythmias. ■

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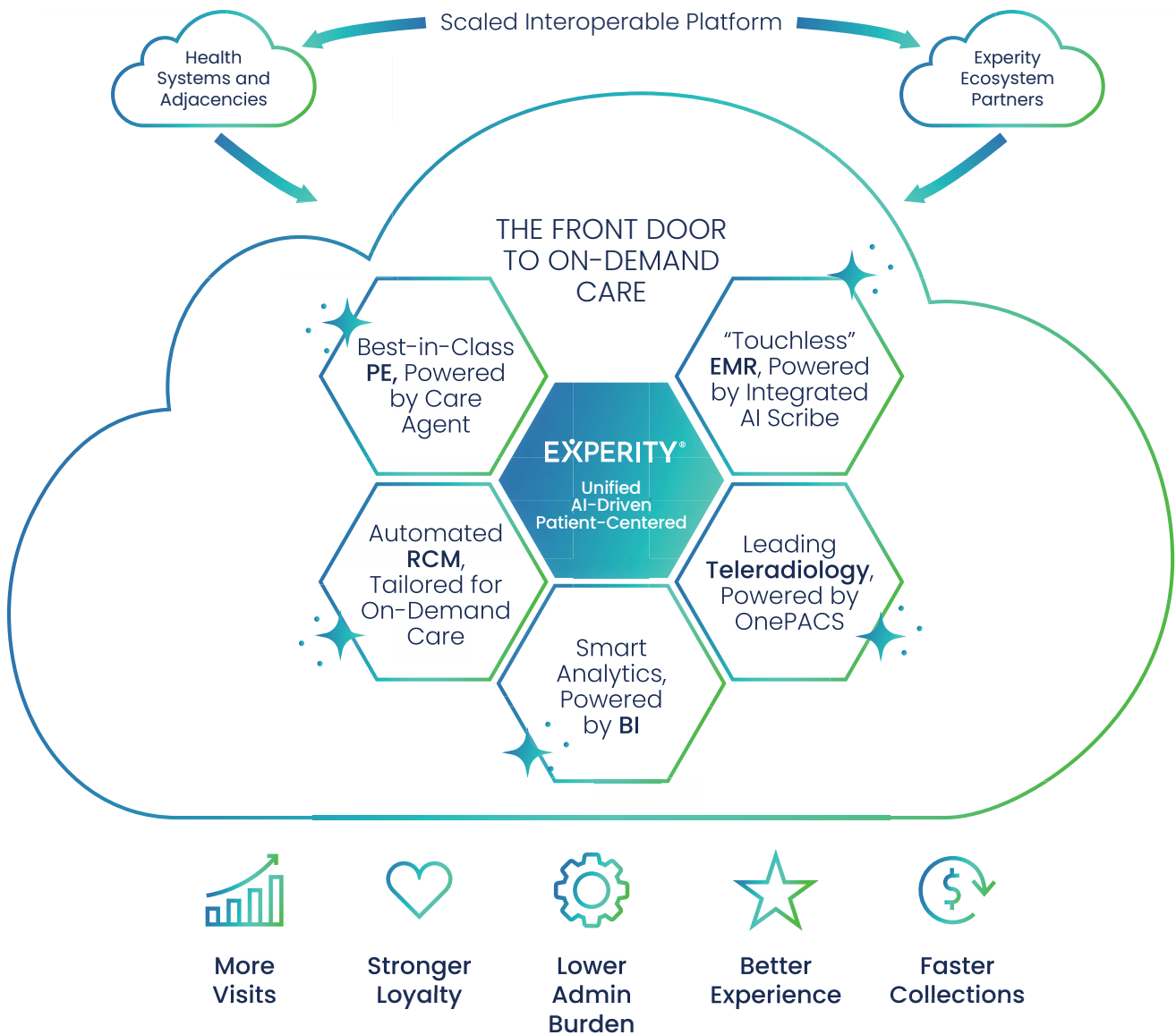
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Accidental Tongue Ring Ingestion: Balancing Caution and Conservative Management in Urgent Care

Urgent Message: Most ingested foreign objects pass spontaneously with little risk of complications in adults. However, in cases where patients experience persistent symptoms, escalation to emergency department evaluation may be appropriate.

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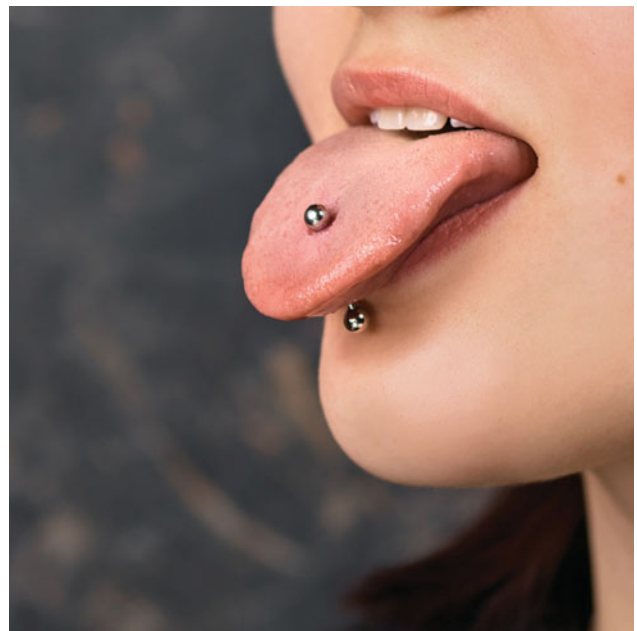
Keywords: foreign body ingestion; gastrointestinal foreign body; tongue ring ingestion; radiography; conservative management; urgent care

Abstract

Introduction: Foreign body ingestion is a clinically important presentation in urgent care, with management guided by object characteristics, location in the gastrointestinal tract, and patient symptoms.

Presentation: A 21-year-old woman presented to urgent care 2 days after accidentally swallowing a tongue ring. She was tolerating oral intake without difficulty but reported mild persistent lower abdominal pain. She denied nausea, vomiting, hematemesis, melena, dysphagia, or bowel habit changes.

Physical Exam: Vital signs were within normal limits. She was well appearing and in no acute distress. Abdominal examination demonstrated mild tenderness to palpation in the lower quadrants without guarding or rebound. Cardiopulmonary and oropharyngeal examinations were unremarkable.



Diagnostic Evaluation and Diagnosis: Abdominal radiography demonstrated a linear-appearing metallic foreign body within the cecum measuring approximately 21 × 1 mm, without evidence of obstruction or perforation, consistent with ingested jewelry.

Management and Outcome: Given persistent abdominal tenderness in the setting of a distal gastrointestinal

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foreign body, the patient was referred to the emergency department (ED) for further evaluation. No additional diagnostic testing was required in the ED. She remained clinically stable during observation and was discharged home with return precautions.

Conclusion: This case highlights risk stratification and clinical decision-making in urgent care for distal gastrointestinal foreign bodies, emphasizing the role of symptom assessment, imaging, and determination of escalation of care.

Introduction

Foreign body ingestion occurs in both pediatric and adult populations.^{1,2} In adults, ingestion is most often accidental and commonly involves objects such as dental hardware, jewelry, or food-related materials.^{1,2} Most ingested foreign bodies pass through the gastrointestinal tract without intervention, with approximately 80–90% resolving spontaneously.^{3,4} However, clinical risk is highly dependent on object characteristics. Sharp objects, magnets, and button batteries are among those associated with increased risk of obstruction, perforation, or tissue injury, requiring urgent evaluation.^{5,6,7} Initial evaluation includes symptom assessment and imaging to characterize the ingested object and guide clinical decision-making.^{4,5}

Case Presentation

A 21-year-old woman with no significant medical history presented to an urgent care clinic 48 hours after accidentally swallowing her tongue ring. She did not seek immediate care, anticipating spontaneous passage of the object. She complained of mild but persistent lower abdominal pain that started the morning of presentation. She continued to eat and drink normally and denied nausea, vomiting, melena, hematochezia, hematemesis, swallowing difficulties, or any other bowel habit changes. She had no prior gastrointestinal disease or abdominal surgeries.

On examination, the patient's vital signs were as follows: blood pressure of 123/78 mmHg; heart rate of 78 beats per minute; a respiratory rate of 17 breaths per minute; temperature of 37.1°C (98.9°F); oxygen saturation of 98% on room air; and a pain score of 2/10. She appeared well, alert, and in no acute distress. General examination was normal. Oral examination revealed moist mucous membranes without lesions, swelling, or visible foreign body. Oropharyngeal examination was otherwise normal. Cardiovascular examination demonstrated a regular rate and rhythm without murmurs, rubs, or gallops. Pulmonary examination revealed clear

breath sounds bilaterally with no wheezes, rales, or rhonchi and no signs of respiratory distress. Abdominal examination revealed mild tenderness to palpation in the right and left lower quadrants without rebound tenderness, guarding, or rigidity.

Abdominal radiographs showed a linear-appearing metallic object in the cecum measuring approximately 21 × 1 mm. There was no evidence of obstruction, free air, or other acute findings. The radiologist recommended conservative outpatient management, expecting spontaneous passage within 48 hours. Despite the object's low-risk characteristics and distal progression, the urgent care team elected to refer the patient to the emergency department (ED) because of persistent abdominal tenderness and the inability to provide prolonged observation within the urgent care setting.

In the ED, the patient underwent further clinical evaluation, during which she remained hemodynamically stable with no progression of symptoms. Urgent care radiographs, reviewed through the shared institutional imaging system, confirmed the location of the tongue ring in the cecum without evidence of obstruction, perforation, or other acute complication. Given the reassuring clinical presentation and imaging findings, no additional diagnostic testing was pursued. Her abdominal discomfort improved with conservative management during observation, and she continued to tolerate oral intake without difficulty. The patient was subsequently discharged home in stable condition with return precautions. She was scheduled for a follow-up appointment with her primary care provider the next day.

Differential Diagnosis and Medical Decision-Making

The differential diagnosis included gastrointestinal perforation, bowel obstruction, mucosal injury, and localized bowel irritation secondary to foreign body ingestion. Although imaging demonstrated the tongue ring within the cecum without evidence of obstruction or perforation, the patient's persistent lower abdominal pain raised concern for possible early mucosal irritation or evolving complication. Stable vital signs and reassuring imaging findings reduced the likelihood of acute surgical pathology but did not fully exclude early complications.

Key factors guiding management included the object's size, smooth contour, and distal cecal location. The tongue ring measured less than 6 cm in length and 2.5 cm in width, classifying it as low risk and likely to pass spontaneously.⁵ However, given the presence of persistent abdominal pain and the limitations of urgent care monitoring, the decision was made to refer the patient to the emergency department for further evaluation and obser-

Table 1. Urgent Care Management Algorithm for Foreign Body Ingestion ⁵		
Step	Action	Notes
1	Assess patient symptoms	Assess for pain, vomiting, bleeding, obstruction signs
2	Obtain radiographs	Determine size, shape, and location of object
3	Categorize object risk	Categorize low risk vs. high risk
4	Decide management	Consider observation vs. referral
5	Patient education	For observation patients, educate about symptoms and follow-up instructions
6	Follow-up	For observation patients, ensure passage; repeat imaging if necessary
Adapted by authors.		

Table 2. Select Foreign Body Risk Levels			
Object Type	Risk Level	Management	Notes
Small, smooth metal (<6 cm long, <2.5 cm wide)	Low	Typically outpatient observation; follow-up imaging if needed	Usually passes spontaneously
Sharp metal	High	Emergent/urgent endoscopic removal if in stomach/esophagus; monitor distal if clinically appropriate	Risk of mucosal injury or perforation
Multiple magnets	High	Urgent gastrointestinal/surgical consult	Risk of fistula or necrosis
Button battery	Very High	Emergency management often required, depending on location, symptoms, battery characteristics, etc.	Risk of chemical or electrical injury
Adapted by authors.			

vation. This decision reflected a cautious, patient-centered approach that balanced low-risk object characteristics with clinical symptoms, incorporating inter-provider collaboration and adherence to evidence-based guidelines.⁴ After observation in the ED, repeat assessment showed no progression or peritoneal signs.

Final Diagnosis

The final diagnosis was accidental ingestion of a tongue ring, located in the cecum, without complications.

Patient Perspective

The patient appreciated the detailed explanation and rationale for the referral to the ED. She understood the conservative approach and felt reassured by clear ED discharge instructions for home monitoring and follow-up. She reported confidence in safely tracking the object's passage.

Discussion

National data estimate there were more than 900,000 foreign body ingestion cases during 2014–2023 in the

United States, with increasing incidence among adults.⁸ Approximately 90% of patients are discharged after evaluation without requiring admission or procedural intervention.^{1,3,4} However, adult cases are more frequently associated with hospitalization and higher-risk ingestion patterns, particularly in populations with underlying comorbidities or intentional ingestion.⁹

Clinical presentation depends on object type, size, and anatomic location. Many patients with uncomplicated foreign body passage to the distal gastrointestinal tract remain asymptomatic; however, symptoms such as abdominal pain, vomiting, drooling, chest discomfort, or signs of peritonitis may indicate complications and warrant further evaluation.³ In this case, the patient's persistent abdominal pain raised concern for possible localized irritation or early complication, prompting closer clinical assessment. Although the tongue ring had progressed to the cecum and possessed low-risk characteristics (small size, blunt contour, and distal location), the presence of persistent abdominal pain complicated an otherwise straightforward conservative management pathway.

Current guidelines generally support outpatient observation for asymptomatic patients with blunt foreign bodies that have passed beyond the stomach (Tables 1–2).⁴ However, persistent abdominal symptoms warrant careful reassessment because early perforation, localized inflammation, or evolving obstruction may initially present with subtle findings despite reassuring imaging.³ In this case, escalation to the ED was primarily driven by persistent abdominal pain despite distal progression of the object. The referral reflected a cautious approach intended to facilitate further monitoring and rapid access to advanced imaging or specialty consultation if symptoms progressed.⁴

Diagnostic evaluation begins with a focused history and physical exam. Plain radiography is typically recommended for suspected radiopaque objects to determine the presence, size, number, and location of the foreign body.^{4,5} Computed tomography should be considered when there is concern for perforation or other complications.⁴ In this case, imaging confirmed the object's location within the cecum and supported risk stratification.

Management is time-sensitive and depends on the object's characteristics, location, and the patient's clinical status. Emergent endoscopy (preferably within 2 hours and no later than 6 hours) is indicated for complete esophageal obstruction and for sharp-pointed objects or batteries in the esophagus. Other high-risk objects, including magnets, may require urgent intervention depending on their number and location.^{4,7} Urgent or nonurgent endoscopy may be appropriate for other retained objects depending on size and progression. Objects that are long (greater than 5–6 cm) or wide (greater than 2–2.5 cm) are less likely to pass spontaneously and may require intervention.^{4,10} In contrast, asymptomatic patients with small, blunt objects that have progressed beyond the stomach can often be managed conservatively with observation alone.

Special scenarios require additional consideration. Button battery ingestion requires prompt evaluation and management based on the battery's location and clinical circumstances, and ingestion of multiple magnets poses a risk of bowel necrosis from pressure effects. Concealed packets of drugs that have been swallowed ("body packing") are typically managed with close observation rather than endoscopic retrieval. Surgical intervention is reserved for suspected obstruction or packet rupture.⁴ Food bolus impaction may require endoscopic management and further evaluation for underlying esophageal pathology, such as eosinophilic esophagitis.¹¹

Ethics Statement

Patient consent for publication was obtained in accordance with institutional guidelines. No identifiable patient information is included in this case report.

Takeaway Points

- Foreign body ingestion in adults is most often low risk, as most objects without high-risk features pass spontaneously once beyond the stomach.
- Clinical decision-making in urgent care relies on integrating symptom assessment, imaging findings, and object characteristics to appropriately stratify risk.
- Persistent abdominal symptoms despite distal progression of a foreign body warrant careful reassessment and may justify escalation of care.
- High-risk ingestions, including button batteries, sharp objects, and magnets, require prompt recognition due to increased risk of severe complications.
- Patient education, return precautions, and inter-provider communication are essential components of safe, evidence-based management of foreign body ingestion. ■

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Urgent Care Practice Varies More by Provider on Duty Than by Center, Payer, or Patient

Urgent Message: Urgent care operators may find practice variation in testing, imaging, referral, and coding among clinicians working in the same clinic. According to this data analysis, the reason for variation ultimately comes down to the decision making of the individual clinician rather than infrastructure, payer, or patient population.

Alan A. Ayers, MBA, MAcc

Citation: Ayers AA. Urgent Care Practice Varies More by Provider on Duty Than by Center, Payer, or Patient. *J Urgent Care Med.* 2026;21(1):31-34

Keywords: urgent care practice variation; provider variation; clinical practice patterns; diagnostic testing; referral patterns; evaluation and management coding; clinician performance

Walk into any 2 urgent care centers operating under the same banner, and you would expect 2 patients with the same complaint to receive the same care. Yet, they often do not. One gets a strep test, and the other doesn't. One visit is billed for an evaluation and management (E/M) level 3, but the other a level 4. Two decades of effort have gone into standardizing the patient experience across urgent care, from workflows to staff training to software, but the question of why similar patients still get different workups remains.

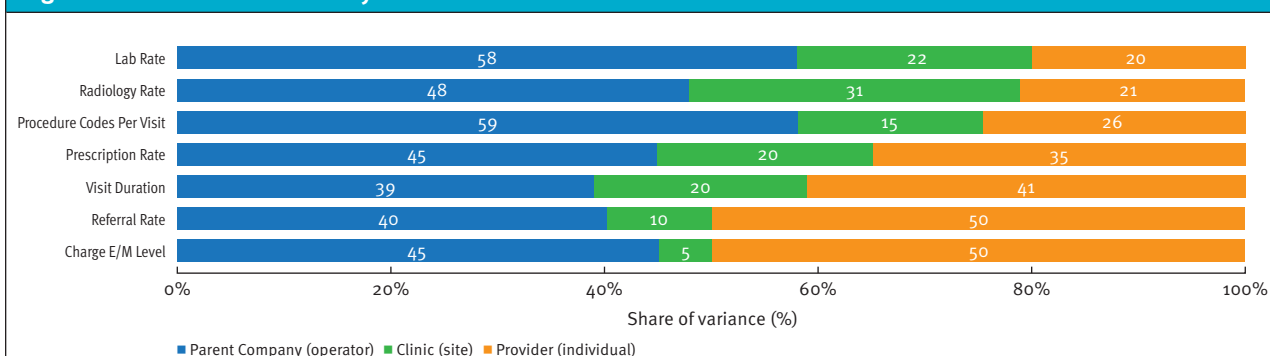
When comparing practice variation between urgent care visits, there are several variables to consider, such as:

- Characteristics of the patient population
- Capabilities of the specific clinic
- Policies and infrastructure of the parent company
- Decision making of the individual provider

For example, an older or sicker population legitimately requires a more time-consuming workup. A clinic without an x-ray machine must refer patients



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Figure 1. Sources of Variation By Practice Indicator

Mixed effects models are limited to providers with substantial volume at clinics with 3 or more providers within organizations operating 3 or more clinics. The E/M estimate uses the continuous CPT code distribution. To read Figure 1, consider that providers across the network differ widely in how they practice. Some order labs on most visits, others on few; some code most visits level 4, others level 3. Each bar takes the total spread in one indicator and asks where it comes from: the parent company a provider works for (blue), the specific clinic within that company (green), or the individual provider (gold). In reading the “Lab Rate” row, for example, of all the differences in lab testing rates across the network, 58% of them trace to the company a provider works for, 22% to which clinic, and 20% to the individual. Therefore, company policy largely decides lab testing rates. In reading the “Charge E/M Level” row, the pattern reverses, and half of all variation traces to the individual provider. The takeaway from Figure 1 is that the indicators near the top reflect decisions companies make; the indicators near the bottom reflect decisions individuals make.

elsewhere for imaging. Or an individual provider may require a certain test before prescribing a certain medication while another provider treats presumptively.

Analyzing Sources Of Variation

In July 2026, Urgent Care Consultants analyzed 13.4 million urgent care visits from the Experity network, which processes roughly 3 in 10 urgent care visits nationally. The extract covered January–June 2026 across nearly 3,000 clinics, more than 7,500 providers, and 17 payer classes, generating 13.7 million E/M codes. Test and training accounts, inactive sites, and low volume providers were excluded. Mixed-effects models then partitioned the differences in 7 practice indicators across 3 levels: the company; the individual clinic; and the individual provider. Payer type, patient age, sex, and race were examined separately.

Based on the analysis, the largest practice differences were observed between individual providers working in the same clinic. Brand, payer, and patient demographics accounted for very little of the practice variation in the indicators that depend on clinical judgment. Decision making of the individual provider was a more telling variable.

Testing Capability Is a Corporate Decision

Some practice indicators depend mostly on what a clinic is equipped to do. Whether a patient can get an x-ray or a definitive strep test, for example, comes down to equipment, laboratory certification, and support staffing. And these are corporate decisions, not bedside ones.

The data shows company and site together account for roughly 80% of the differences in lab testing and radiology rates and about three-quarters of the differences in procedure codes per visit (Figure 1).

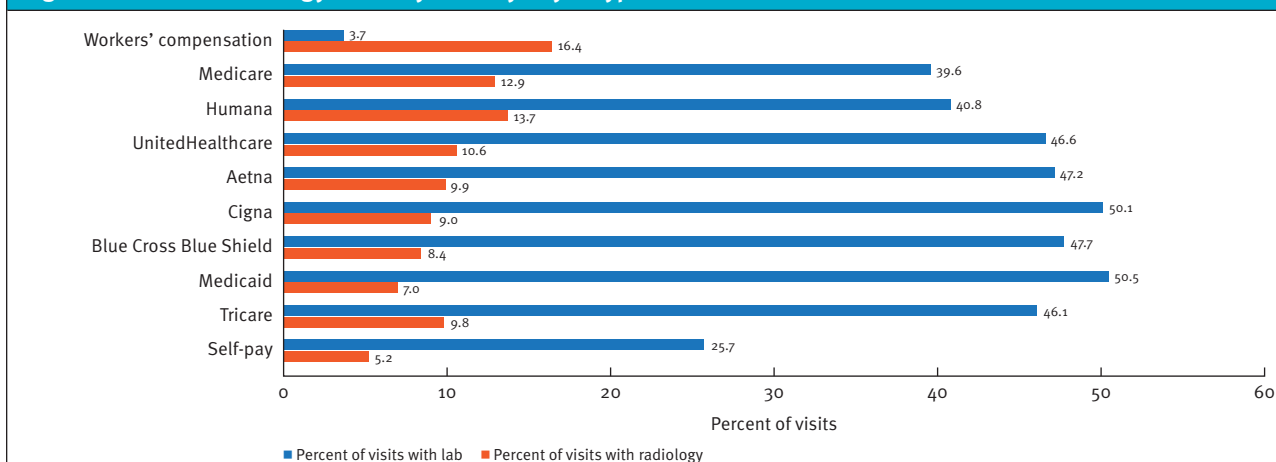
One exception stands out. Inside urgent care networks where most locations have a regular flow of imaging volume, a few individual clinics logged no radiology at all. This pattern is unlikely to reflect clinical judgment. Instead, a more probable explanation is an out-of-service machine or an unfilled radiologic technologist position. X-ray availability is the only finding in this dataset attributable primarily to the individual site.

Ordering Behavior Resolves To Individual Provider

In analyzing decisions made inside the exam room, half of the variation in E/M coding intensity is attributable to the individual provider; the same is true of referral rates. Meanwhile, more than 40% of visit duration variation can be traced to the provider as well.

The absolute gaps are large. At a typical clinic staffed by 5 or more providers, those providers coding at the highest level and those coding at the lowest level are 33 percentage points apart when examining the share of E/M visits billed at level 4 or 5. The clinician with the highest imaging rate orders x-rays at nearly 3 times the rate of the provider with the lowest imaging rate, while drawing from the same population. Lab testing rates differ by 18 percentage points between colleagues in the same building.

Provider credentials (physician, nurse practitioner, physician assistant/associate) explain little of this practice

Figure 2. Lab and Radiology Rates by Primary Payer Type

Data is limited to clinic-payer combinations with 100 or more visits. The major commercial carriers (Aetna, Blue Cross Blue Shield, Cigna, UnitedHealthcare) cluster within a narrow band on both measures. Workers' compensation and self-pay stand apart because they represent different visit types and price signals, not different practice patterns.

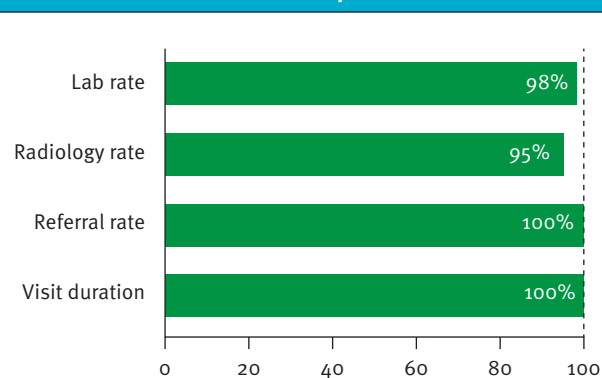
variation. Once the analysis accounts for work location, physicians and advanced practice providers order, refer, and code at nearly identical rates. The differences occur between individual clinicians, not between clinician types.

Individual ordering patterns of clinicians also appear stable across their different patient types. A provider's testing rate with male patients closely matches that same provider's rate with female patients. Providers who spend more time with a particular age group tend to spend more time with all of their patients. In other words, ordering intensity appears to function more as an individual characteristic than as a response to the presenting patient.

Payer Type Explains Little

Many operators assume that insurance type drives coding or testing, but the data does not support this. Among conventional insurance types, the patient's health plan accounts for less than 1% of the variation in coding. Medicare visits show coding patterns similar to commercial visits within the same clinics. When analyzing lab and radiology orders, Aetna, Blue Cross Blue Shield, Cigna, and UnitedHealthcare patients cluster together tightly enough that the differences among them carry no operational consequence (Figure 2).

Where payer type does appear to matter, visit composition rather than the payer itself is the more likely driver. For example, workers' compensation involves more injury care, heavy on imaging and light on labs. And occupational medicine is largely composed of physicals and drug screens. These differences appear to reflect

Figure 3. Persistence of Provider Differences After Standardization Of Patient Population

Share of provider-to-provider variance remaining after every provider is standardized to the same patient mix (%).

the different composition of needs rather than different practice patterns.

Self-pay is another exception. Within the same clinics, cash-paying patients received roughly half as many labs and 40% less imaging. Their visits were also coded about a third of a level lower. This variation can be found even among established patients. This may indicate that cash patients arrive with simpler complaints, or providers may purposefully order less when the patient is paying out of pocket.

Patient Mix Does Not Account For Gaps

The obvious alternative explanation to such practice

variation is case mix. Yet patient age, sex, and race combined account for less than 3% of the visit-level variation in any indicator.

Age by itself does produce clinical variation. For example, the analysis found that imaging rates climb roughly fivefold from toddlers to seniors, and lab testing peaks in the school-age years (when streptococcal pharyngitis is most common).

To account for these differences in case mix, direct standardization can provide a sharper test of provider variation. In a detailed analysis among 4,095 providers, each provider's rates (ie, labs, radiology, referral, and visit duration) were recalculated as though every provider treated an identical patient population, with the comparison populations matched on age and sex. The result: 95%–100% of the provider-to-provider variation persisted even after the standardization adjustment (Figure 3).

Implications For Operators

These findings suggest that operational standardization may be largely succeeding, so an operator seeking to improve practice variation metrics might look to focus on provider behavior. This analysis establishes that practice differences exist; it cannot establish which part of the range represents better medicine.

The various indicators each call for a different response:

- **Standardize.** For situations in which there is 1 defensible standard—such as coding accuracy, documentation, and charge capture—standardize outright. A 33-point coding spread within a single clinic is a training and compliance problem more than it is anything else, and it represents both an operational improvement opportunity and potential audit exposure that could result in denied claims and lost revenue.
- **Manage the extremes.** Where genuine clinical judgment is involved, manage the extremes rather than the average. Consider showing every provider case-mix-adjusted numbers alongside those of their clinic colleagues and ask outliers at both ends to share their reasoning for why they do or do not order labs or imaging, for example. The 2025 Cochrane review of audit and feedback found larger effects when data was used to measure the individual clinician rather than the team or organization and when performance was benchmarked against top peers.¹ In a randomized trial across 47 primary care practices, monthly emails that shared data comparing individual clinicians to top performers reduced inappropriate antibiotic prescribing.²

“Clinic-level dashboards and provider-level dashboards should be evaluated because a site’s average may conceal precisely the variation that needs to be visible in order to improve operations.”

- **Leave the middle alone.** Moving a provider from the 55th percentile to the 60th percentile accomplishes little and uses resources better reserved for the genuine outliers.

Clinic-level dashboards and provider-level dashboards should be evaluated because a site's average may conceal precisely the variation that needs to be visible in order to improve operations. New hires should be measured within their first 90 days, since practice patterns have more to do with the provider than the job. And credentials should not be used as a proxy for practice pattern.

For individual providers, the implication of practice pattern analysis and/or comparison may be uncomfortable, especially when variation appears to be largely a personal pattern and neither the insurer nor the patient population is driving it. Providers who want to improve should ask for their own practice pattern numbers. A clinician who is ordering imaging at 3 times a colleague's rate in the same clinic should be able to say why, and an inability to answer is often a conversation worth having.

While the urgent care industry has spent 2 decades successfully standardizing the physical clinic, the next frontier of quality, compliance, and margin improvement largely depend on measuring and managing individual provider behavior. ■

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ABSTRACTS IN URGENT CARE

Guideline for Recurrent Urinary Tract Infections in Women

Take Home Point: This guideline recommends that urinalysis with symptoms should be used to diagnose recurrent urinary tract infection (rUTI) and emphasizes culture-guided antibiotic therapy, supportive care, and preventative measures to reduce antimicrobial resistance and overtreatment.

Citation: Ackerman A, Bradley M, D'Anci K, et al. Updates to recurrent uncomplicated urinary tract infections in women: AUA/CUA/SUFU guideline (2025). *J Urol.* 2026; 215(1):3–12.

Relevance: Understanding of female rUTI has evolved with new insights into its pathophysiology. This updated guideline provides recommendations for the evaluation and management of women with rUTI.

Study Summary: This updated guideline was produced by the American Urological Association, the Canadian Urological Association, and the Society of Urodynamics, Female Pelvic Medicine & Urogenital Reconstruction. The update reflects the evolving understanding of rUTI.

Recommendations include obtaining urinalysis, urine culture, and sensitivity testing with each symptomatic episode of acute cystitis before initiating treatment in patients with rUTI. To establish a diagnosis of rUTI, clinicians should document evidence of inflammation (pyuria) and uropathogenic bacteria in association with symptomatic episodes. For symptomatic UTIs in women, clinicians should use first-line therapy with nitrofurantoin, trimethoprim-sulfamethoxazole (TMP-SMX), or fosfomycin based on the local antibiogram. Clinicians should not treat asymptomatic bacteriuria. Cranberry may be offered as an option for prophylaxis in women with rUTI.

Editor's Comments: This guideline is directly relevant to urgent care, in which recurrent urinary symptoms are common and antibiotic decisions are often made quickly. Be-

sides appropriate diagnosis and treatment, discussion of nonantibiotic prevention, such as cranberry products or increased fluid intake when appropriate, can reduce unnecessary antibiotic exposure. ■

Nasal Sprays, Behavioral Intervention for Respiratory Tract Infections

Take Home Point: In this study, nasal sprays reduced illness days and symptom severity in patients with respiratory tract infections (RTIs), while a behavioral intervention promoting physical activity and stress management was associated with fewer infections.

Citation: Little P, Vennik J, Rumsby K, et al. Nasal sprays and a behavioural intervention for respiratory tract infections in primary care: 12-month follow-up of a randomised open-label trial. *Br J Gen Pract.* 2026;76(768):e572-e582. doi:10.3399/BJGP.2025.0269.

Relevance: RTIs are a common presentation to urgent care centers (UCCs), with most cases caused from a viral etiology. Antimicrobials are not helpful for viral RTIs, creating a need for evidence-based alternatives that clinicians can offer to patients for symptom relief. Evidence supporting interventions for symptomatic relief of viral RTIs is limited.

Study Summary: This was a 4-arm randomized controlled trial of patients recruited from participating general practitioner practices in the United Kingdom. Participants were aged ≥ 18 years and had ≥ 1 comorbidity or risk factor, such as heart disease, asthma or lung disease, or diabetes, and/or ≥ 3 RTIs in a typical year. Participants were randomly assigned to usual care, Vicks First Defence nasal spray (VFD), isotonic buffered saline nasal spray, or a behavioral website promoting physical activity and stress management. Outcomes were assessed with questionnaires every 28 days for 12 months and at 6 and 12 months to recall infections since the start of the trial.

The authors recruited 13,799 participants over 3 successive winter seasons. Participants receiving usual care ($n=3,052$) had a mean of 21.8 illness days in a 12-month period (standard deviation [SD] 35.2), compared with 17.8 days (SD 27.9) with VFD ($n=3,076$; adjusted incidence rate ratio [IRR] 0.84; 99% CI, 0.79–0.90; $p<0.0001$) and 17.7



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days (SD 21.1) with saline (n=3,142; IRR 0.83; 99% CI, 0.78–0.89; $p<0.0001$). Illness days were not significantly reduced with the behavioral website (n=2,811; 19.5 days [SD 31.2]; IRR 0.94; 99% CI, 0.88–1.01; $p=0.03$).

The occurrence of infections was lower in the behavioral website group (adjusted risk ratio [RR] 0.96; 95% CI 0.93–0.99; $p=0.006$) but not in the nasal spray groups. Moderately severe symptoms and workdays lost were significantly reduced in all intervention groups. Participants in both nasal spray groups were less likely to intend to seek care for subsequent infections and had significantly lower scores for perceived stress and depression. Anxiety scores were significantly lower in the behavioral website group compared with the usual care group.

Editor's Comments: This study offers findings that may be useful to urgent care clinicians when discussing supportive treatment for RTIs. The benefits of nasal sprays may have been underestimated because participants had to request additional sprays, and adherence may have been limited. The association between the behavioral intervention and reduced occurrence of RTIs may be useful when counseling patients about preventive measures. ■

Physical Examination Reliability in Diagnosing Kids' Pneumonia

Take Home Point: This study suggests that individual auscultation findings, including rhonchi, crackles, and decreased breath sounds, did not demonstrate sufficient interrater reliability between emergency medicine clinicians to be used independently when assessing children for the diagnosis of pneumonia.

Citation: Hooli S, Reeder R, Cutler L, et al; Pediatric Emergency Care Applied Research Network (PECARN) PedCAPS Investigators. Reliability of physical examination findings in youths diagnosed with pneumonia. *JAMA Netw Open*. 2026;9(8):e2630074. doi:10.1001/jamanetworkopen.2026.30074.

Relevance: Respiratory illness commonly brings children to urgent care centers and emergency departments, where caregivers and clinicians are often concerned with identifying and treating community-acquired pneumonia (CAP) while minimizing radiation exposure.

Study Summary: This cohort study evaluated the interrater

reliability (IRR) of physical examination findings using data from an ongoing prospective, multicenter cohort study designed to derive and validate a pediatric CAP severity (PedCAPS) clinical prediction rule within the Pediatric Emergency Care Applied Research Network (PECARN). Children aged 3 months through 17 years who were diagnosed with CAP at 7 academic pediatric emergency departments (EDs) in the United States were recruited. ED clinicians, including attending physicians, advanced practice clinicians, and pediatric emergency medicine fellows, completed a standardized case report form (CRF) detailing each patient's symptoms, comorbidities, and physical examination findings. A second ED clinician independently examined the patient and completed an identical CRF within 60 minutes of the first examination, with no interventions provided between examinations.

A total of 252 children were enrolled in the IRR component of the PedCAPS study, with 249 (98.8%) having both clinical and radiographic diagnoses of pneumonia. No physical examination finding demonstrated substantial IRR (defined as $\kappa>0.7$). The highest IRR was observed for wheezing ($\kappa=0.50$; 95% CI, 0.39–0.62) and retractions ($\kappa=0.49$; 95% CI, 0.37–0.60). There were no significant differences in the IRR of physical examination findings between the 124 patients discharged from the ED and the 128 patients who were admitted.

Editor's Comments: Because the raters did not receive standardized prestudy training on the terminology used, some variation in IRR scores might be expected. However, the study demonstrates meaningful variability among clinicians in assessing physical examination findings. This is particularly relevant in urgent care settings, where CAP diagnoses are often based primarily on clinical assessment. ■

Antimicrobial Stewardship Programs in Urgent Care

Take Home Point: The results of this systematic review suggest that antimicrobial stewardship programs (ASPs) can improve the quality and appropriateness of antimicrobial prescribing while maintaining favorable clinical outcomes in urgent care settings.

Citation: Amjad M, Morley J, Fiaz R. Antimicrobial stewardship in urgent care settings: a systematic review of prescribing, clinical, and microbiological outcomes. *Cureus*. 2026;18(8):e114916. doi:10.7759/cureus.114916.

Relevance: Antimicrobial resistance is an increasing global concern. Urgent care occupies a unique position to implement antimicrobial stewardship because of its high volume of patients with acute infectious conditions, both bacterial and viral.

Study Summary: This systematic review was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines using 4 major electronic databases: MEDLINE (PubMed), Embase, Web of Science, and Scopus. Included studies evaluated implementation of or clinician adherence to an ASP in an urgent care setting caring for adult or pediatric patients.

The authors identified 12 studies for review. Education- and guideline-based approaches produced some of the largest reductions in prescribing, including an 80% reduction in broad-spectrum antibiotic use for pharyngitis and reductions of 29.5%–55.2% for acute otitis media. Audit-and-feedback and decision-support approaches generally produced smaller reductions, although the changes were still often statistically significant. Importantly, the authors noted that antimicrobial stewardship in urgent care did not always mean reducing antibiotic use; in some cases, it meant using antibiotics in a more appropriately targeted manner.

Editor's Comments: As urgent care research is still developing, most of the included studies were conducted at

single centers and used quasiexperimental or before-and-after designs without concurrent control groups. This increases their susceptibility to confounding and temporal bias and limits generalizability. However, this is one of the few reviews specifically focused on available evidence for ASPs in urgent care settings. It therefore provides a useful foundation for organizations seeking to improve antimicrobial stewardship and prescribing practices by identifying the most impactful pieces of an ASP. ■

Point-of-Care High-Sensitivity Troponin I for Rapid ACS Assessment

Take Home Point: The results of this study suggest that the i-STAT point-of-care (POC) high-sensitivity cardiac troponin I (hs-cTnI) o/2-hour algorithm had high efficacy and negative predictive value (NPV) for myocardial infarction (MI) among ED patients with symptoms of possible acute coronary syndrome (ACS).

Citation: Mahler S, Ashburn N, Villenthi A, et al. Validation of a o/2-Hour Point-Of-Care High Sensitivity Troponin Algorithm: A Multisite US Study. *Acad Emerg Med.* 2026;33(7):e70379. doi: 10.1111/acem.70379.

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Relevance: Rapid POC high-sensitivity troponin testing may be relevant to urgent care settings evaluating patients with possible acute coronary syndrome.

Study Summary: This was a prospective, multisite, observational cohort study of adult ED patients with symptoms suggestive of possible ACS at 3 EDs in North Carolina. The authors sought to validate a 0/2-hour algorithm for the i-STAT POC hs-cTnI assay that had previously been derived in Australia. Participants underwent standard-of-care evaluation for possible ACS, including central laboratory hs-cTnI testing. Blood samples collected simultaneously were also tested by research personnel using the i-STAT POC hs-cTnI assay. Clinicians were blinded to the POC hs-cTnI results, which were not used to guide patient care. The primary outcome was MI during the index visit. Secondary outcomes included cardiac death or MI at 30 days and major adverse cardiovascular events (MACE).

The authors analyzed data from 578 patients, of which 48% (279/578) were female and 40% (233/578) were non-White. The original Australian derived 0/2-hour algorithm had an efficacy of 54.8% (317/578), with 36.3% (210/578) classified to the observation zone and 8.8% (51/578) to the rule-in zone. Among the 317 patients classified to the rule-out zone, 0.6% (2/317) had an index MI, yielding a negative predictive value (NPV) for index MI of 99.4% (95% CI: 97.7%–99.9%). The single sample rule-out (0-hour hs-cTn <5 ng/L) criteria were met by 48.4% (280/578) and demonstrated a NPV of 99.6% (95% CI: 98.0%–100.0%) for index MI. The optimized 0/2-hour algorithm increased efficacy to 60.0% (347/578) and had an NPV of 99.4% (95% CI 97.9%–99.9%).

Editor's Comments: High-sensitivity cardiac troponin testing has traditionally relied on central laboratory platforms, whereas these newer POC hs-cTnI assays can provide rapid testing at the bedside. The efficacy and NPV for this POC test could significantly impact patient care in urgent care settings. However, this was an observational study conducted in EDs. Therefore, further research is needed to ensure patient safety. ■

Evaluating Thoracolumbar Spinal Injury

Take Home Point: The results of this study suggest that the combination of a normal physical examination (PE) and normal spine radiographs can reliably exclude pediatric thoracolumbar spinal injuries (TLSIs) requiring intervention.

Citation: Prabhala T, Herzog A, Scheub R, et al. Evaluation of thoracolumbar spine injury utilizing plain film and phys-

ical exam in the pediatric population: a multicenter study. *J Trauma Acute Care Surg.* 2026;100(6):915-921. doi:10.1097/TA.0000000000004941.

Relevance: Pediatric TLSIs are relatively uncommon, and the need for intervention is low. However, evaluation of suspected injuries may involve cross-sectional imaging (computed tomography or magnetic resonance imaging) and associated radiation exposure. Identifying patients who can be adequately evaluated with physical examination and plain radiographs alone could help reduce unnecessary imaging.

Study Summary: This was a retrospective observational study of pediatric patients (ages 1–18 years) presenting to 5 U.S. Level I pediatric trauma centers who were identified through local trauma registries. Patient age, race, weight, body mass index, injury mechanism, comorbidities, and associated PE findings, including tenderness, gross deformity, and neurologic deficit, were recorded. Cross-sectional imaging reports were reviewed to identify fracture location as thoracic, lumbar, or both. All included patients had undergone plain radiography as part of their evaluation. The deidentified radiographs were subsequently reviewed by blinded radiologists to determine whether spinal injury was visible.

Of 17,093 patients seen at the 5 centers during the study period, 232 had complete data available for analysis. Among these patients, 109 (47%) sustained isolated thoracic injuries, 81 (35%) sustained isolated lumbar injuries, and 42 (18%) sustained both thoracic and lumbar injuries. Radiographs were 82.7% sensitive for injury and 100% sensitive for injury requiring surgery. In the study, 164 (70%) had PE findings suggestive of TLSI. In the 133 patients with thoracic spine radiographs, the combination of a normal thoracic spine PE and normal radiographs excluded >99% of injuries and 100% of injuries requiring intervention. No patients with a normal lumbar spine radiograph required intervention.

Editor's Comments: The retrospective design may have introduced selection bias, particularly in decisions regarding imaging and intervention. The study setting may also limit generalizability to urgent care, where patients are often lower acuity and mechanisms of injury may be less severe. However, the finding that a normal physical examination combined with normal radiographs identified patients who did not require intervention may be useful to urgent care clinicians when seeing a pediatric patient with possible TLSIs. ■



CLINICAL IMAGE CHALLENGE

X-RAY

Editor's Note: While the images presented here are authentic, the patient cases are hypothetical.

68-Year-Old Female With Swollen, Painful Hand



Figure 1: Initial X-rays

A 68-year-old woman presents to urgent care with her husband after tripping on a rug at home the previous day and falling onto her left hand. She has experienced persistent pain and swelling in the hand since the fall. Ibuprofen provided modest pain relief. Physical examination reveals normal vital signs with focal edema and tenderness over the dorsal surface of the 4th and 5th metacarpals. Decreased range of motion and knuckle contour at the 5th metacarpophalangeal (MCP) joint are noted, and ecchymosis is seen on the palmar surface of the 5th metacarpal area. Sensation is intact to the 4th and 5th digits, interphalangeal joints are mobile, and capillary refill is brisk.

phalangeal (MCP) joint are noted, and ecchymosis is seen on the palmar surface of the 5th metacarpal area. Sensation is intact to the 4th and 5th digits, interphalangeal joints are mobile, and capillary refill is brisk.

View the image taken and consider what your diagnosis and next steps would be. Resolution of the case is described on the following page.

Acknowledgment: Images and case provided by Experity Teleradiology (www.experityhealth.com/teleradiology).



Differential Diagnosis

- Contusion
- Metacarpophalangeal dislocation
- Fifth metacarpal neck fracture
- Intra-articular fifth metacarpal head fracture

Diagnosis

Plain radiographs show an acute, mildly displaced 5th metacarpal neck fracture. Soft tissue swelling, severe osteoarthritis, and mild osteoporosis are also noted in the images. Fifth metacarpal neck fractures, commonly known as boxer's fractures, are among the most common hand injuries, accounting for 30% to 40% of all hand fractures. Fractures to the neck of the metacarpal are usually due to direct trauma to a clenched fist or direct blunt force trauma to the dorsum of the hand, often seen in falls among older populations. They most often involve the fifth and occasionally the fourth metacarpal neck.

What to Look For

- Thorough examination of the hand for signs of fracture angulation and rotational malalignment, impaired extensor function of the fingers, neurovascular compromise and loss of skin integrity should be performed.
- Plain radiographs including 3 views of the hand (anteroposterior, lateral, and oblique) adequately display metacarpal neck fractures; measurements of angulation should be performed on the lateral view.

- Ultrasound may also be used in evaluating fractures in the metacarpal bones; evidence suggests high sensitivity and specificity in diagnosing metacarpal fractures.

Pearls For Urgent Care Management

- Acute fracture reduction is indicated if there is hyperextension at the MCP joint and flexion at the proximal interphalangeal (PIP) joint with attempted extension of the finger. Reduction is also needed for significantly angulated 4th or 5th metacarpal fractures. If performed in the urgent care setting, post-reduction immobilization and repeat radiographs are recommended to ensure adequate reduction and alignment.
- An ulnar gutter splint may be used to immobilize fractures of the 4th and 5th metacarpal necks; however, growing evidence supports more minimalist interventions for uncomplicated 5th metacarpal neck fractures. Off-the-shelf Galveston splints allow for use of fingers while maintaining fracture position, which may be beneficial for older patients, and buddy taping and soft wrapping may also be appropriate.
- Complex metacarpal neck fractures that are severely comminuted, angulated > 30 degrees or have any rotational malalignment should be referred to a hand surgeon.
- Return to work should be expected when the patient's metacarpal joint is pain-free, non-tender, and has functional range of motion. Return to contact sports or heavy labor prior to 6 weeks post fracture requires orthotic protection. ■



CLINICAL IMAGE CHALLENGE

DERMATOLOGY

52-Year-Old Female With Extremely Itchy Dark-Ringed Bumps on Skin of Back



A 52-year-old woman visits the urgent care clinic for itchy bumps that have been present on her back for the past 3 months. The lesions are very itchy, and it is difficult for the patient to stop scratching. She has not tried any treatments for her symptoms since onset. On dermatological examination, pink scaly papules with dark exterior rims are seen on

her back, some of which appear excoriated. Laboratory results for complete blood count, comprehensive metabolic panel, and thyroid function tests are all within normal limits.

View the image taken and consider what your diagnosis and next steps would be. Resolution of the case is described on the following page.

Acknowledgment: Image and case presented by VisualDx (www.VisualDx.com/jucm).

**Differential Diagnosis**

- Lichen planus
- Nummular dermatitis
- Prurigo nodularis
- Pemphigoid nodularis
- Seborrheic dermatitis
- Nodular scabies
- Hypertrophic lichen planus
- Epidermolysis bullosa pruriginosa

Diagnosis

The correct diagnosis is prurigo nodularis (PN). PN is an uncommon, chronic skin disorder affecting primarily older adults. PN is characterized by symmetrically distributed, multiple, firm, pruritic nodules, typically localized to the extensor surface of extremities and trunk. PN is frequently associated with a history of atopic dermatitis and seems to be more common among African Americans than in other ethnic groups. Systemic diseases and psychiatric disorders have also been reported with high frequency in patients with PN.

The diagnosis of PN is clinical. The diagnosis is based upon a history of chronic, severe pruritus and the clinical finding of the characteristic excoriated, nodular lesions which are often symmetrically distributed. A skin biopsy is not routinely required to confirm the diagnosis. PN is a chronic and often intractable disease that may last for years, with a profound impact on the patient's quality of life. Complete resolution of lesions is rare, even after the itch-scratch cycle has been successfully interrupted. Recurrence is common.

What To Look For

- Exam reveals firm, dome-shaped, itchy nodules ranging in size from a few millimeters to several centimeters. The

nodules can be flesh-colored, erythematous, or brown/black and range in number from a few to hundreds.

- The extensor surfaces of the extremities are characteristically involved, but the upper back, abdomen, and sacrum may also be involved. The palms, soles, face, and flexural areas are rarely involved.
- Pruritus is always severe and distressing. It can be paroxysmal, sporadic, or continuous and is worsened by heat, sweating, or irritation from clothing.

Pearls for Urgent Care Management

- Symptomatic treatment of pruritus: recommend mild cleansers for bathing or showering and applying emollients multiple times per day; may try lotions that provide a cooling sensation on the skin, such as calamine lotion or lotions containing menthol and camphor. Keep nails short and recommend wearing gloves at night.
- Topical and intralesional corticosteroids: superpotent topical corticosteroids as first-line therapy—clobetasol dipropionate 0.05% ointment applied under occlusion with plastic wrap once at nighttime for at least 2-4 weeks. Topical corticosteroids can be tapered to once or twice weekly and continued as a long-term maintenance regimen.
- Treat the itch: first-generation antihistamines such as hydroxyzine or diphenhydramine administered at bedtime may help control nocturnal pruritus. Other topical treatments could be considered including capsaicin, calcineurin inhibitors or topical vitamin D analogues.
- Widespread or recalcitrant disease: Refer to primary care and/or dermatology as they may benefit from ultraviolet phototherapy, intralesional injection of corticosteroids, or tricyclic antidepressants to control pruritus. ■



CLINICAL IMAGE CHALLENGE

ECG

62-Year-Old With Acute Dyspnea

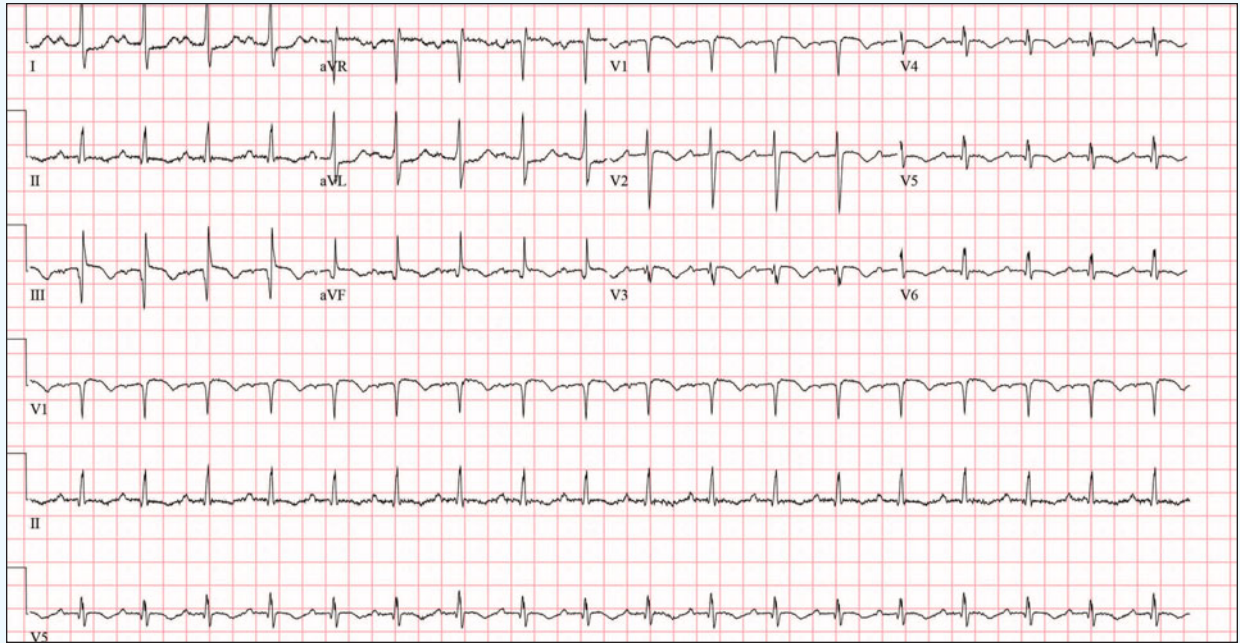


Figure 1: Initial ECG

A 62-year-old female presents to urgent care with acute dyspnea that worsened significantly 2 hours prior to arrival. She has noted progressive shortness of breath over the past week but now feels severely winded. She denies chest pain, cough, fever, leg swelling, or history of deep vein thrombosis.

On evaluation, the patient is tachycardic and tachypneic with a heart rate of 110 beats per minute and an oxygen saturation of 91% on room air. She is alert and speaking in short sentences. An electrocardiogram (ECG) is obtained.

View the ECG and consider what your diagnosis and next steps would be. Resolution of the case is described on the next page.

Case presented by Jonathan Giordano, DO, MEd, Vagelos College of Physicians and Surgeons, Columbia University Irving Medical Center. Case courtesy of ECG Stampede (www.ecgstampede.com).

ECG  STAMPEDE



Differential Diagnosis

- Hyperkalemia
- Non-ST-segment elevation myocardial infarction (NSTEMI)
- Wellens syndrome
- Pulmonary embolism with acute right ventricular strain
- Hypertrophic cardiomyopathy

Diagnosis

The diagnosis in this case is pulmonary embolism with acute right ventricular strain. The ECG demonstrates sinus tachycardia at approximately 110 beats per minute with a normal axis and normal intervals. There is ST-segment elevation of approximately 1 millimeter in leads III and aVF with reciprocal ST-segment depression in lead aVL—a pattern consistent with inferior ST-segment elevation myocardial infarction (STEMI). In addition, there are T wave inversions in the right precordial leads V1 through V3, with deep T wave inversions visible throughout the V1 rhythm strip, as well as an S1Q3T3 pattern, all consistent with acute right ventricular strain.

Discussion

This case demonstrates an interesting phenomenon: a pulmonary embolism with right ventricular strain masquerading as an inferior STEMI. The ST-segment elevation in leads III and aVF with reciprocal ST-segment depression in lead aVL should prompt activation of the cardiac catheterization laboratory and/or immediate transfer to a cath-capable facility; however, there are additional clues that point to an alternative diagnosis.

While T wave inversions are often cited as a finding in acute coronary syndrome, alternative causes also exist. Electrocardiographic findings that support the diagnosis of pulmonary embolism over acute coronary syndrome include T wave inversions in leads V1 through V3, inferior T wave inversions, and an S wave in lead I. One study

suggests the pattern of simultaneous T wave inversions in lead III and V1 yields a specificity of 99% for pulmonary embolism.¹ This ECG not only suggests pulmonary embolism but identifies this patient as high risk.^{2,3} Additionally, the presenting symptom (acute dyspnea and hypoxia rather than chest pain) points to acute pulmonary embolism rather than acute coronary syndrome.

A large pulmonary embolism can mimic a STEMI by increasing right ventricular wall tension and oxygen demand. Because the right coronary artery supplies the inferior wall of the left ventricle in most patients (right-dominant circulation), right coronary artery hypoperfusion in pulmonary embolism can produce inferior ECG changes that range from T wave inversion to ST-segment depression to frank ST-segment elevation, as in this case.⁴ Regardless, immediate transfer to a cardiac care center is warranted.

Wellens syndrome refers to deeply inverted or biphasic T waves in leads V2 and V3 in a patient who is pain-free at the time of the ECG and reflects critical left anterior descending artery stenosis. This patient's presentation of acute dyspnea, tachycardia, and hypoxia does not fit. Hypertrophic cardiomyopathy produces deep asymmetric T wave inversions typically in the lateral leads often with voltage criteria for left ventricular hypertrophy. Neither is present on this ECG, and hypertrophic cardiomyopathy does not present acutely over hours. Findings of hyperkalemia—peaked T waves, bradycardia, junctional rhythm, widened QRS complex—are not visualized on this ECG.

Urgent care management of a suspected pulmonary embolism is focused on hemodynamic stabilization and immediate transfer. A thorough history should screen for symptoms of hypoperfusion, such as syncope or altered mental status, and risk factors (such as recent surgery, malignancy, or prolonged immobilization). Initial steps include establishing intravenous access, placing the patient on continuous cardiac monitoring, and ad-

ministering supplemental oxygen if hypoxic. Hemodynamically unstable patients (ie, presenting with hypotension or shock) require immediate resuscitation and transfer via advanced life support to the nearest emergency department.⁵

What To Look For

- Pulmonary embolism can produce inferior ST-segment elevation that mimics STEMI.
- Simultaneous T wave inversions in the inferior (II, III, aVF) and right-precordial leads (V1–V3) strongly favor pulmonary embolism over acute coronary syndrome.
- Sinus tachycardia is the most common ECG abnormality in pulmonary embolism.
- The classic S1Q3T3 pattern is specific but has low sensitivity (<20%) for pulmonary embolism and represents acute right ventricular strain.

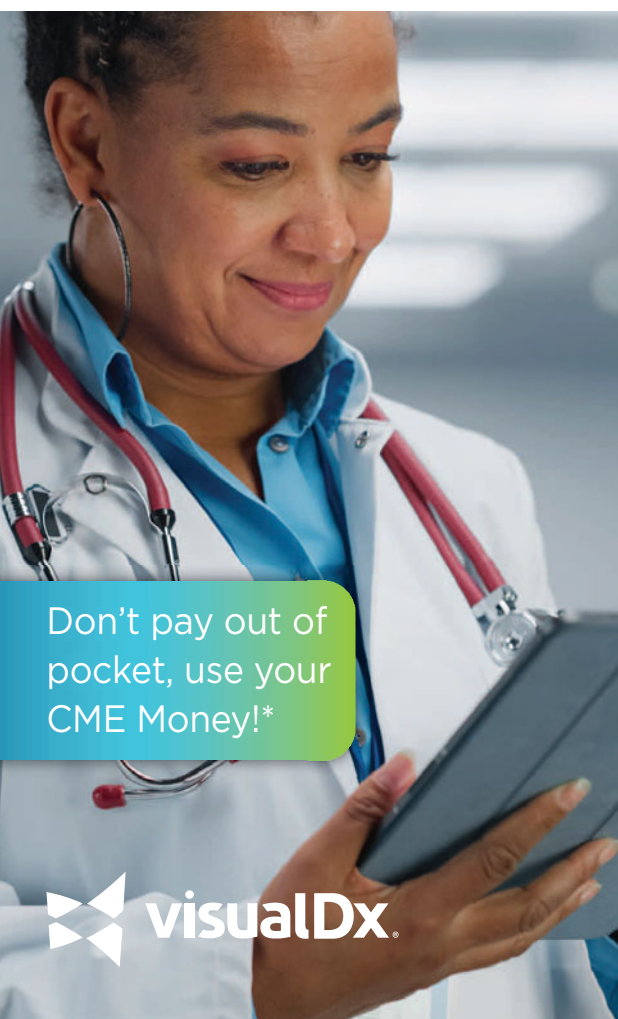
Pearls For Initial Management, Considerations For Transfer

- Establish intravenous access, initiate continuous cardiac monitoring, and administer supplemental oxygen immediately if the patient is hypoxic.

- Perform a rapid screening history for risk factors of deep vein thrombosis and pulmonary embolism, such as recent surgery or immobilization.
- Transfer the patient immediately via advanced life support to the nearest emergency department if the patient is hemodynamically unstable or if there is high clinical suspicion for pulmonary embolism.
- Do not delay transfer to obtain outpatient imaging or blood work when a massive pulmonary embolism is clinically suspected. ■

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Are You Documenting For Comprehensive Care?

■ Brad Laymon, PA-C, CPC, CEMC

Is there an opportunity to optimize for accurate billing when more comprehensive care is delivered? Clinicians ask me this question more often than almost any other, thinking they might be leaving money on the table. The honest answer is usually yes, but not the way most people expect. The opportunity rarely sits in doing more procedures. It sits in documentation that reflects the comprehensive care that was delivered during the visit.

Most encounters involve more thinking than the note shows. A patient comes in for a sprained ankle, for example. Along the way, you notice they are on anticoagulation medication, so you factor that into your management decision and adjust your return precautions accordingly. That second problem, addressed in real time, often never makes it onto the page. The visit was comprehensive. The chart was not.

This gap matters because medical decision making is built on 3 elements: problems addressed; complexity of data reviewed; and risks associated with the management chosen.¹ When a visit genuinely touches all 3 at a meaningful level, the code should reflect that. But coding only credits what gets written down. A comorbidity that shaped your risk assessment counts only if you say so. A lab reviewed from 6 months ago that changed your differential counts only if you connect it to your decision. An independent historian who gave you history that a confused or very young patient could not provide counts only if the chart says where that information came from.

Compare 2 versions of the same encounter. The first reads, “Ankle pain, x-ray negative, splint applied, follow up as needed.” The second reads, “Ankle pain following

inversion injury, x-ray negative for fracture. Patient on warfarin for atrial fibrillation, which raised concern for occult soft tissue bleeding and informed the decision to splint rather than wrap. Discussed signs of compartment syndrome given anticoagulation status. Follow up in 1 week or sooner if swelling worsens.” Both clinicians likely thought through the same risk. Only 1 chart shows it, and only 1 supports the level of care actually delivered.

None of this is about padding a note or inflating a level. It is about closing the distance between the comprehensive thinking that already happened in the room and the comprehensive documentation meant to represent it. Clinicians who chronically undercode are likely not doing so to protect themselves from malpractice risk or audits. They are likely describing their work as simpler than it was, visit after visit, and absorbing the financial cost without realizing it.

The fix is small and specific rather than sweeping. For every secondary problem managed alongside the chief complaint, write a sentence showing you evaluated it and made a decision. For every piece of outside data reviewed, tie it directly to how it changed or confirmed your plan. For every comorbidity that raises risk, name the risk in a single line. For every follow-up plan, give it a timeframe and a reason rather than the reflexive “follow up as needed.”

These additions take seconds, not minutes, and they do not change a single decision you already made at the bedside. What they do is let the level of service finally match the level of care, which is the entire point of the coding system. The hidden value of excellent documentation is mitigation of malpractice risk. The opportunity to bill for more comprehensive care is not an opportunity to bill for more. It is an opportunity to bill accurately for what you already provide. ■



Brad Laymon, PA-C, CPC, CEMC, is a Physician Associate with 27 years of continuous urgent care clinical experience and dual certification in medical coding—Certified Professional Coder (CPC) and Certified Evaluation and Management Coder (CEMC). He is also the founder of Coding Excellence, a national consulting and education practice serving healthcare organizations across multiple specialties, and Laymon Medical Expert Consulting.

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How Often Do Urgent Cares Close Unexpectedly?

■ Alan A. Ayers, MBA, MAcc

URGENT CARE CENTER UNEXPECTED CLOSURES BY OPERATOR SIZE

Operator Size	Operator Closure Rate Unexpected Days Closed per 1,000 Operating Days	Closure Rate per Center Unexpected Days Closed per Center per Year
Single Center	15.2	4.6
2 to 5 centers	10.3	3.1
6 to 20 centers	8.4	2.5
21 to 75 centers	7.3	2.2
76 or more centers	5.7	1.7

The average urgent care center goes unexpectedly “dark” 2.3 days a year—which means it closed on a day it otherwise should have been open (eg, staff illness, building repair, power outage, etc.). And the range in unexpected closure days is wide. Centers run by operators that have only a single location experience unexpected closures 4.6 days a year. Centers with 76 or more locations have 1.7 days of unexpected closures per center per year.

The lower number of closure days among large groups may reflect their ability to borrow staff from nearby sites as well as more efficient, centralized scheduling.

A parallel analysis looking at days of the week reveals Saturday and Sunday are the most common days to go

dark—about 10 closures per 1,000 operating days, compared with 6 closures per 1,000 operating days on Tuesday, Wednesday, and Thursday. Together, Friday through Monday disproportionately account for two-thirds of all unexpected closures while making up just 56% of total operating days.

These findings were drawn from a center-by-day analysis of 4,416 Experity-platform urgent care centers, covering 93 million visits during January 2024–August 2026.

In the analysis, a closed day was an operating day with no visits posted in the EMR. Each center’s schedule was inferred from a rolling 13-week window of the same weekday, so for example, a center that never opens Sundays was not included in unexpected closures for Sundays. Also excluded were new location ramp-ups, permanent closures, and relocations. Holidays and days with regional weather events were excluded as well. ■



Alan A. Ayers, MBA, MAcc is President of Urgent Care Consultants and Senior Editor of *The Journal of Urgent Care Medicine*.

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