

# JUCM™

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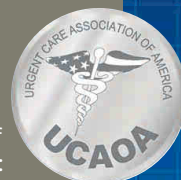
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## Pitfalls in Assessing and Managing Common Pediatric Injuries

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## LETTER FROM THE EDITOR-IN-CHIEF

# A Crisis in Quality? Lessons from History



If history repeats itself, then we just may be in big trouble. Many of us remember the doc-in-the-box days of the early 80s, when the first urgent care boom occurred. There was a wild proliferation of urgent care centers, driven mostly by physician entrepreneurs looking to make a quick buck. By 1985, in excess of 3,000 centers dotted the country. The following decade brought significant contraction within the industry, before the rebound we are now witnessing that began in the late 90s.

So, what's different now? How do we avoid the landmines associated with the decline of the 80s and 90s?

I believe that there were two factors contributing to lean years in the industry.

First, was managed care. Urgent care centers did not fit into the managed care model very well, and despite the lower cost of care vs. the emergency department, declining reimbursement and capitated payment methods made it very difficult for urgent cares to generate enough revenue. With high site development and labor costs, a number of centers went bankrupt or sold out to large healthcare organizations. While, perhaps, no one predicts a complete return to the managed care days, hints of the same (e.g. "Accountable Care Organizations") are beginning to re-surface.

Less discussed, but no less important, was a failure of quality control. With a limited physician workforce amid efforts to staff the centers for extended hours, urgent care centers were increasingly turning to less skilled physicians and residents. Moonlighters from numerous specialties, from orthopedics to urology, and residents of all levels were staffing the urgent cares and delivering sub-par care outside of their expertise. Quality control and standards of care were disregarded in favor of fast money and convenient staffing.

A crisis in quality was quickly followed by a crisis in confidence, and the once promising industry went into a tailspin.

Urgent care was then, and remains now, attractive to independent-minded physicians looking to apply standard business practice to a healthcare delivery model. Exceptional customer service, strong financial management, cost control, marketing, and retail conveniences are often applied.

I have no issue with applying a "retail" standard to urgent care, but consider this: If urgent care is a retail business, then what is our product? And how do we ensure that product is of high quality, and delivered in a consistent manner? If Starbucks served bad coffee, it really wouldn't matter much that they pick the best real estate or have the friendliest baristas; they would fail.

Urgent care is no different. The urgent care "product" is the provider-patient encounter. It is a clinical product dependent on the knowledge and expertise of the provider across the core competencies of the discipline.

It is worth noting here that urgent care providers do not receive consistent training across the spectrum of urgent care core competencies. There are only a handful of formal clinical fellowships, ultimately representing a tiny fraction of the urgent care workforce. Urgent care centers are staffed with physicians from multiple specialties along with physician assistants and nurse practitioners, all with variable expertise and all with variable gaps in competency. And yet, only a small number of urgent care practices make much of an effort to thoroughly assess competency and offer focused training and education opportunities to fill gaps.

This represents the perfect storm for a crisis in quality. The success of the urgent care model cannot be predicated on access, convenience, and customer service alone.

Our "customer" is not ignorant. As were the ghosts of urgent care past, we too shall be judged on the quality of our product. And if we fail to consistently deliver a quality clinical product, our industry will fail, regardless of how we pick real estate or how friendly our baristas are. ■

Lee A. Resnick, MD  
Editor-in-Chief  
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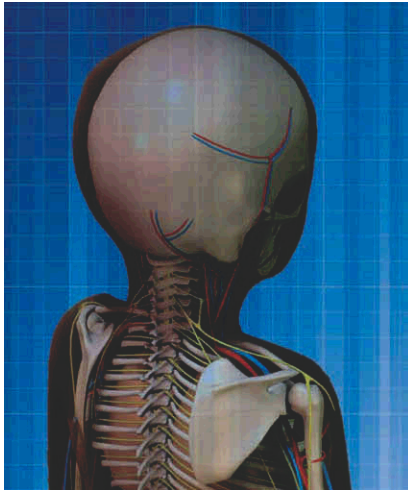
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## February 2011

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### CLINICAL

## 9 Pitfalls in Assessing and Managing Common Pediatric Injuries

Fractures are common among pediatric patients. Familiarity with the growth process and the unique properties of the immature skeleton—as well as immediate identification of conditions requiring emergent referral—are necessary for appropriate care and avoidance of long-term sequelae. The first of two parts.

By Justin Kunes, MD, Shane R. Hanzlik, MD, and Allison Gilmore, MD

### CASE REPORT

## 16 Hearing the Hoof Beats of Zebras! Facial Nerve Palsy: A Case Report

There is no diagnosis so “common” that it cannot be missed or mistaken for something else. A systematic approach to the history and examination are crucial to reaching the right conclusion and positive outcomes.

By Lee A. Resnick, MD



### WEB EXCLUSIVE

A 73-year-old male tells you it feels like his heart is “missing beats.” He’s concerned that his pacemaker might not be working properly. Is it just his imagination? Must he be transported immediately to the ED? Or should he simply be referred to his cardiologist for follow-up? A new case report, available exclusively at [www.jucm.com](http://www.jucm.com).

By John F. O’Brien, MD, FACEP

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### IN THE NEXT ISSUE OF JUCM

In part 2 of our overview of pediatric orthopedic injuries, the authors will focus on particular fracture types, from assessment to management with consideration of presenting symptoms, diagnostics, mechanism of injury, and splinting. In addition, we will also present a new article in the Bouncebacks! series.

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**JUCM** The Journal of Urgent Care Medicine supports the evolution of urgent care medicine by creating content that addresses both the clinical practice of urgent care medicine and the practice management challenges of keeping pace with an ever-changing healthcare marketplace. As the Official Publication of the Urgent Care Association of America, **JUCM** seeks to provide a forum for the exchange of ideas and to expand on the core competencies of urgent care medicine as they apply to physicians, physician assistants, and nurse practitioners.

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The most common adverse reactions reported in 1-2% of patients were eye irritation, pyrexia, and conjunctivitis.

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1. MOXEZA<sup>TM</sup> Solution package insert.

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## JUCM CONTRIBUTORS

**B**roken bones may be “just part of growing up” for a lot of children, but for others the long-term sequelae can be severe. A lot rests on the correct initial assessment and subsequent management.

In Pitfalls in Assessing and Managing Common Pediatric Injuries (page 9), authors **Justin Kunes, MD**, **Shane R. Hanzlik, MD**, and **Allison Gilmore, MD** review essential facts about the growth process and the unique properties of the immature skeleton, certain conditions that require emergent referral, and more. This is the first of a two-part series.

Drs. Kunes, Hanzlik, and Gilmore are all affiliated with the Department of Pediatric Orthopaedics at Case Medical Center, Rainbow Babies & Children's Hospital in Cleveland, OH.

Of course, there is no diagnosis so common that it can't be missed or mis-identified. That's one lesson of Hearing the Hoof Beats of Zebras! Facial Nerve Palsy: A Case Report (page 16) by **Lee A. Resnick, MD**.

Astute (or even casual) readers will recognize Dr. Resnick as the editor-in-chief of this publication. He's also the immediate past-president of the Urgent Care Association of America, a clinical instructor at Case Western Reserve University, and a principal of the Institute of Urgent Care Medicine.

Finally, in an article you can find only at [www.jucm.com](http://www.jucm.com), **John F. O'Brien, MD, FACEP** recounts a visit from a 73-year-old man with a pacemaker and concerns that his heart is “missing beats.”

Dr. O'Brien is the associate residency director of the Department of Emergency Medicine at Orlando Regional Medical Center in Orlando, FL. He is also an associate professor at the University of Central Florida School of Medicine and Florida State University School of Medicine.

## Also in this issue:

**Nahum Kovalski, BSc, MDCM** reviews new abstracts on current literature germane to the urgent care clinician.

**David Stern, MD, CPC** responds to queries about coding for intravenous infusion, fees for S9083, and other vexing coding questions.

**John Shufeldt, MD, JD, MBA, FACEP** rhapsodizes on the importance of efficient and appropriate non-verbal, written, and oral communication.

**Frank Leone, MBA, MPH** explains the advantages of bidding adieu to printed marketing materials.

We would like to ensure that the content we publish is, to paraphrase Abraham Lincoln, for, by, and of the urgent care community. If you have an idea for an article, please describe it in an email to Dr. Resnick at [editor@jucm.com](mailto:editor@jucm.com). ■





## FROM THE EXECUTIVE DIRECTOR

# Stepping Up

■ LOU ELLEN HORWITZ, MA

Doing the right thing is often so much harder than doing the wrong thing—or doing nothing at all. It's called "the easy way out" for a reason: it's easier! It's easier to sit back and let the status quo continue, to let others do the heavy lifting, to leave "well enough" alone.

I have four discussion areas this month that relate to this theme.

1. The first is the announcement of the opening of the *nomination* period for candidates for the UCAOA Board of Directors. If you are interested in "stepping up" in this way and working closely with other leaders to help direct the future of your association, you should consider running for the Board of Directors. Nomination forms are on the website now ([www.ucaoa.org](http://www.ucaoa.org)) in the Membership section, and require nomination support from 10 other UCAOA members.

The official nomination period closes on March 14, 2011.

2. The second is about the *election* itself. The election happens live via secret ballot at the annual UCAOA Members Meeting in Chicago on May 12, 2011, during the Spring Convention. If you are going to the Convention, you can vote onsite during that meeting.

If you are not, don't let your opportunity to vote go to waste; "step up" and designate a proxy so that your voice can be heard. Proxy forms are available now on the website in the Membership section, and are due to us by May 6.

The business of setting the future direction of UCAOA and the oversight of our success or failure is not something to be taken lightly. We hope that our programs and resources are benefitting you, your clinics, and the

*The new patient/public website  
([www.urgentcarecenter.org](http://www.urgentcarecenter.org))  
is our way of stepping up.*

industry as a whole. But none of that happens in a vacuum; we very much need input, guidance, opinions and leadership from our members via elected leaders if we are going to continue to be able to meet your needs and exceed your expectations in the future.

3. The third is about *benchmarking* data. The 2010 Benchmarking Survey Results are ready to be published, and we hope that you are both informed and impressed with the new information we are able to present to the industry.

And can anyone guess how all that was possible? Of course, it's by centers just like yours "stepping up" when we asked for participation in the survey. On behalf of all of us, an enormous "Thank you!" to those centers. You are a model for the industry.

4. The last is about the new patient/public website ([www.urgentcarecenter.org](http://www.urgentcarecenter.org)) that we debuted to the industry in late January—and will be launching to the general public this month.

This website is our way of "stepping up" our responsibility for advocating on your behalf.

Over the years, we have launched smaller initiatives, such as an annual Urgent Care Awareness Week in November, but it was time to have a place that both you and we could send patients, the media, and other stakeholders that would be just for them, and that could showcase the benefits of urgent care from the public's point of view. We look forward to hearing about the positive impact this will have on all of your centers as it continues to raise awareness of our industry.

It's just one more "step" we are taking toward achieving UCAOA's vision of being "the catalyst for the recognition of urgent care as an essential part of the healthcare system." ■



**Lou Ellen Horwitz** is executive director of the Urgent Care Association of America. She may be contacted at [lhhorwitz@ucaoa.org](mailto:lhhorwitz@ucaoa.org).

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## The Bottom Line

- ✓ Respiratory infections have similar symptoms
- ✓ Differential diagnosis leads to proper treatment and reduces healthcare costs
- ✓ Rapid tests provide tremendous value at the point-of-care

SYMPTOMS OF FIVE COMMON INFECTIONS/ RESPIRATORY ILLNESSES**	Influenza	Strep A	Meningitis	Whooping Cough	Pneumonia
Runny Nose / Sneezing / Congestion	✓			✓	
Fever	✓	✓	✓	✓	✓
Headache	✓	✓	✓		
Aches / Stiff Neck	✓	✓	✓		
Sore Throat / Cough	✓	✓		✓	✓
Fatigue	✓	✓	✓	✓	✓
Nausea / Vomiting		✓	✓	✓	✓

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\* Theocharis, George. Vouloumanou, Evridiki et al. "Evaluation of a direct test for seasonal influenza in outpatients", *European Journal of Internal Medicine*, Vol.21 (2010) 434-438

\*\* CDC Disease Listing, <http://www.cdc.gov/ncidod/dbmd/diseaseinfo/default.htm>

## Pitfalls in Assessing and Managing Common Pediatric Injuries

**Urgent message:** Fractures are common among pediatric patients. Familiarity with the growth process and the unique properties of the immature skeleton—as well as immediate identification of conditions requiring emergent referral—are necessary for appropriate care and avoidance of long-term sequelae. The first of two parts.

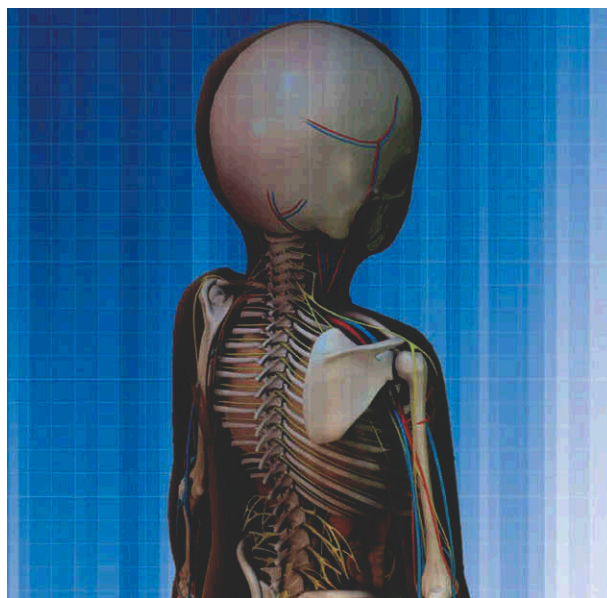
Justin Kunes, MD, Shane R. Hanzlik, MD, Allison Gilmore, MD

### Epidemiology

Injuries that ultimately prove to be fractures are a common cause of visits to the emergency room and urgent care among pediatric patients. Approximately 20% of children who seek attention for an injury will have a fracture.<sup>1</sup> From birth to age 16, the chance of sustaining a fracture is 42% in boys and 27% in girls, with the most common sites being, in order, the distal radius, clavicle, hand, elbow, and tibia.<sup>2</sup>

### Anatomy

Growing bones (**Figure 1**) differ from skeletally mature bones in that their inherent nature allows for increasing length and diameter.



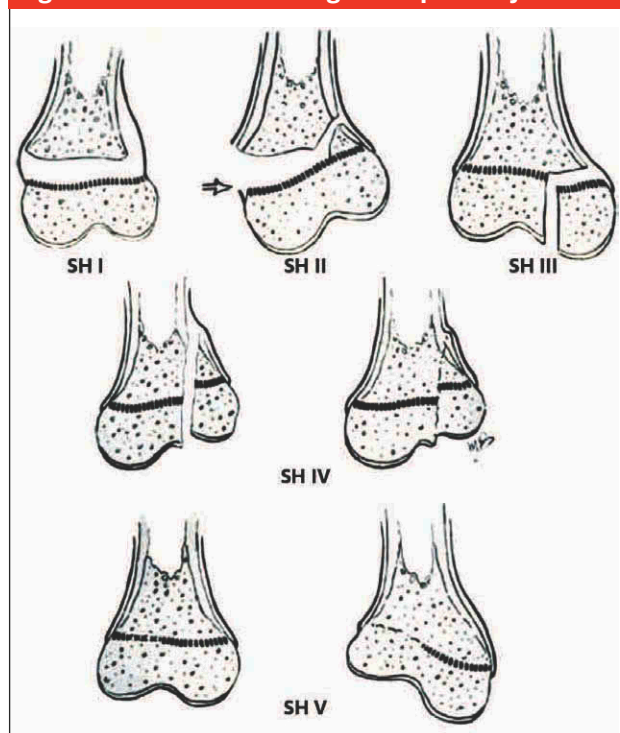
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Such “growing bones” includes the epiphysis, physis, metaphysis, diaphysis, and the periosteum.

### *The importance of the physis*

As children’s bones are different from adult bones, care of their fractures also differs. Where adult fractures must be aligned perfectly, many children’s fractures can be left angulated. This is because the growing child’s bone, when fractured at or near the growth plate, can remodel even severe deformities.<sup>3-5</sup>

However, fractures that do occur at the growth plate may cause a physeal arrest with subsequent growth disturbance. The physis is injured in as many as 27% of

**Figure 1. Growing anatomy.****Figure 2. Classification of growth plate injuries.**

Source: Salter RB, Harris WR. Injuries involving the epiphyseal plate. *J Bone Joint Surg Am*. 1963;4(3):587-622.

all fractures in children.<sup>6</sup>

The most prevalent classification system for growth plate injuries is the Salter-Harris classification system (**Figure 2**), which divides the injury anatomically by describing which direction the fracture line propagates.<sup>7</sup>

The fact that immature bone is more resilient to stressful conditions (and therefore more likely to “bounce back” to its original shape) is evident in the following injury patterns in growing bones:

- **Plastic deformation.** Immature bones break differently than adult bones. In fact, they actually bend more than they break; when a bone is bent but no fracture line is evident, this is referred to as “plastic deformation.” The deformity can be straightforward (**Figure 3**) and can be gently manipulated into anatomic alignment with the child medically sedated.

This injury may also be more complex, such as when plastic deformations of the ulna shaft in the forearm causes a radial head dislocation. Therefore, when plastic deformation is noted, it is important to look at the joint above and below the injury. If the ulna is bowed and the radial head is not aligned with the capitellum, then a Monteggia variant is suspected; if this is confirmed, it must be reduced immediately.<sup>8</sup>

- **Torus fracture.** Torus (buckle) fractures are among the most common types of fractures in children (**Figure 4**). These fractures are quite stable, result from a compressive force to the bone, and usually heal uneventfully. However, they still require immobilization in a splint, followed by a cast.

Repeat x-rays in a few weeks will show callus formation, indicating the body’s healing response by forming new bone.

- **Greenstick fracture.** Greenstick fractures (**Figure 5**) occur when the causative force results in a break in one side of the bone while the opposite side just bends. This is due to the thick, flexible nature of immature bone.

### Unique Properties of the Immature Skeleton

Fractures in children tend to heal faster than those in adults. This presents a distinct advantage in the form of shorter periods of immobilization.

The *disadvantage* is that misaligned fragments become “solid” sooner. Mild angular deformities remodel themselves if a child has more than two years of growth remaining.



**Figure 3. Plastic deformation of the radius (left). Post closed manipulation of the radius (right)**

Rotational deformities require reduction and do not remodel in children or adults.

Fractures in children may stimulate longitudinal growth, and sometimes the injured extremity becomes

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**Figure 4. Torus (buckle) fracture.**

longer than the unaffected limb.

Often, children do not become as stiff as adults after immobilization and may return to sports and activities of daily living at earlier rates.

### Upper Extremity Physical Examination

The upper extremity exam in a child with a suspected fracture may be somewhat difficult (especially in the very young), if for no other reason than the child will be in pain and may be too frightened to help with localizing the injury.

After an appropriate history, begin the exam by looking at the position of the extremity.

If there is an unstable fracture, usually the child will not move the involved extremity.

If a child is actively using the extremity, it is unlikely (though not impossible) that the injury is actually a fracture.

Note swelling, redness, open wounds, and/or deformity.

If the child can localize the area of pain, then start the exam away from the noted area of pain.

Even if you are fairly certain the child has a wrist injury, make sure to gently squeeze the forearm, elbow,

and shoulder since multiple fractures at varying locations are often missed. Palpate the area that hurts gently. Check to see if the range of motion is decreased, compared with the opposite side.

### Vascular assessment

Vascular assessment includes checking for palpable pulses (radial and ulnar arteries) and making sure the fingers are warm and pink.

Check capillary refill at the tips of the fingers.

If there is no pulse, do a Doppler exam. If there is still no pulse, then immediate transfer to the emergency room is needed so an orthopedic surgeon and vascular surgeon can get the patient to the operating room.

Begin the sensory exam by assessing light touch sensation over the dorsal aspect of the thumb (radial nerve), tips of the fingers (median nerve), and ulnar side of the ring finger and radial and ulnar side of the little finger (ulnar nerve).

Begin the motor exam by observing active wrist and finger flexion (median nerve) and extension (radial nerve).

Have the patient make an “O sign” with the index finger and thumb (anterior interosseous branch of the median nerve).

Have the child abduct and adduct his or her fingers (ulnar nerve).

Perform all of these assessments prior to infiltration with local anesthetics, as both neurologic and vascular examinations will be affected.

Do not use epinephrine in a digit, due to the theoretical risk of distal ischemia.

As touched on previously, it is important to also assess the elbow joint with a wrist injury (and vice versa). The forearm is an interlinked structure that can be thought of as two main parts interconnected to and by multiple structures. Injuries include dislocation and supracondylar, lateral, and medial condyle fractures.

The carpal bones should also be assessed. An easily overlooked, common site for fractures is the scaphoid (the radial-most proximal row carpal bone). Left untreated, such a fracture can result in significant disability with early-onset arthritis.

If a patient is tender in the “anatomic snuffbox” (formed at the base of the thumb metacarpal between the extensor pollicis longus and abductor pollicis longus and extensor pollicis brevis tendons), wrist radiographs should be obtained; obtain four views, including a specialized PA view with the wrist ulnarly deviated.

The thumb should be included in the immobilization,

even if this fracture is not clearly visualized until the patient can be reassessed by an orthopedist and their radiographs reviewed.

**Special Complication:  
Compartment Syndrome**

Compartment syndrome is defined by increased tissue pressure within the non-distensible fascial compartments of a limb (forearm, arm, leg, thigh), resulting in ischemia to the tissues and, ultimately, muscle death.

If children have significant pain that is not improving following reduction and splinting, they must be monitored clinically with serial hourly physical examinations.

In adults, pain with passive extension of the fingers or toes is the most reliable early symptom of compartment syndrome in adults. However, this is often unreliable in children, and the only indicator may be increasing narcotic requirements. Splints must be removed and the site examined for tight compartments.

Neurologic and vascular examination should be compared with those obtained prior to intervention.

Suspected compartment syndrome warrants immediate surgical evaluation by any available surgical consultant.

*It is important to note that transfer time to a tertiary care center is a critical factor; the more time that elapses, the more significant the risk that the child will suffer ischemic insult. Once this occurs, permanent injury happens in a matter of hours.*

If a compartment syndrome is suspected, the child must be taken to the operating room and fasciotomies performed; this can be limb-saving.

Compartment pressures in awake children are not always indicated, and physical exam alone may be enough.

**Conclusion**

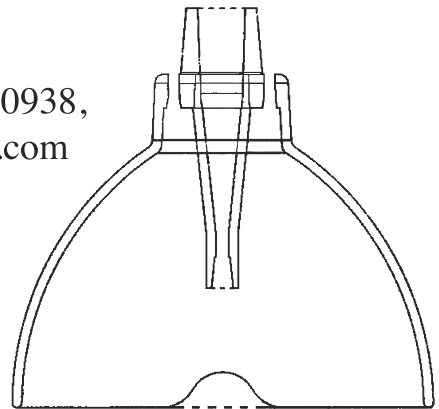
Nearly 20% of children coming to the urgent care center with an injury will have a fracture. It is important to re-

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**Figure 5. Greenstick fracture.**

member that physeal injuries are very common and may present with no radiographic findings.

Occult injuries are also possible in the shaft of the bone in kids.

Even if you are in doubt as to the correct diagnosis, it is advisable to splint a suspected fracture in a child. If a fracture displaces, a physeal arrest may occur.

A thorough history and exam, adequate radiographs, and a good splint with care to avoid pressure over bony prominences will help patients and their families get through the healing process with as little discomfort as possible.

With appropriate and efficiently administered care, children heal more quickly than adults and, barring complications, usually return to full pre-injury activity level. ■

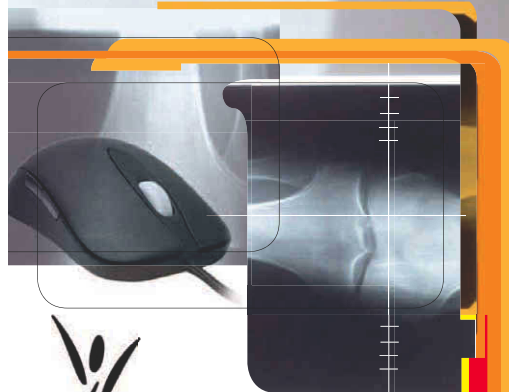
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*Editor's note: In the second part of this article, to be published in the March issue of JUCM, the authors will address the diagnoses and management of fractures common among pediatric patients.*

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# Case Report

## Hearing the Hoof Beats of Zebras! Facial Nerve Palsy: A Case Report

**Urgent message:** There is no diagnosis so “common” that it cannot be missed or mistaken for something else. A systematic approach to the history and examination are crucial to reaching the right conclusion and positive outcomes.

Lee A. Resnick, MD

### Introduction

Every now and then, medical school pearls are wrong. You remember: “When hearing hoof beats in Central Park, don’t go looking for zebras.” It may be true that zebras are infrequent visitors to New York City parks, but there *are* zebras in the Central Park Zoo, so theoretically you could see one.

By and large, the commonalities in medicine prevail, but no one wants to miss the zebra.

A systematic approach is critical to the care of the urgent care patient. Applying this approach, even for the most common presentations, can help identify the needle in the haystack, and prevent unnecessary harm to our patients.



The following case report exemplifies the importance of this concept.

### Case Presentation

ML is a 51-year-old male with no past medical history who presents to the urgent care center with 36 hours of intense, sharp, right-sided ear and temporal pain; onset was followed by 24 hours of dramatic right facial droop.

Pain and droop persisted throughout the day. ML cannot close the right eye. He denies weakness or numbness of the extremities, slurred speech, dysar-

thria, confusion, or memory loss. He also denies rash, fever, vision impairment, or photophobia, as well as trauma, neck pain, and stiffness.

Figure 1.

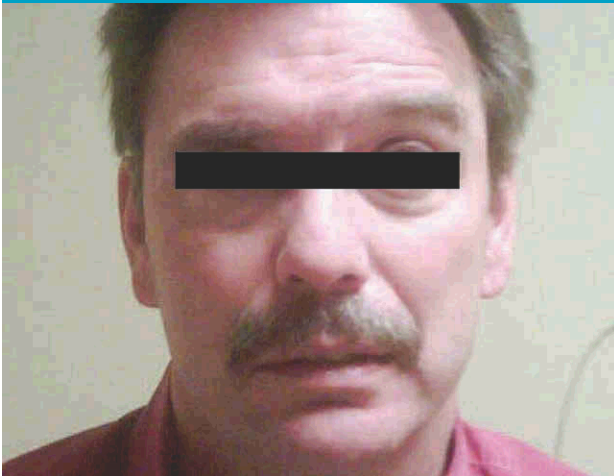
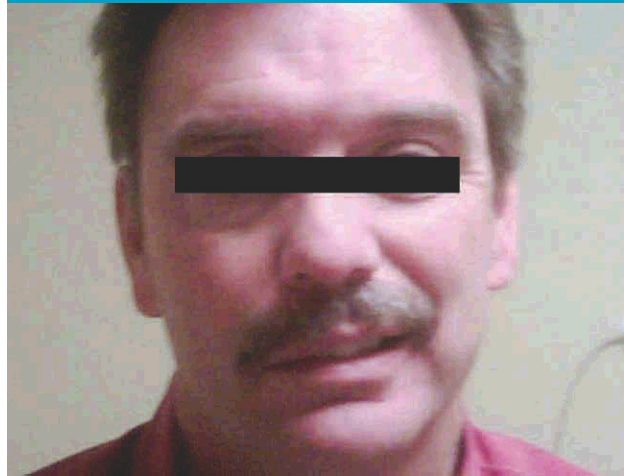


Figure 2.



Past medical history is negative for migraine, CVA, MI, and aneurysm. He has no history of diabetes or hypertension.

On exam, he has a grossly apparent right-sided facial

droop. Other findings:

- BP: 130/90
- HR: 83
- Temp: 97°F



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**Figure 3.**

ML was alert and cooperative. He had a loss of brow furrowing on the right, and complete paralysis of the facial nerve. There were no skin lesions present. The tympanic membranes were clear, as were the canals. There was no mastoid tenderness. He had mild tenderness of the temporal artery on the right.

Examination of the right eye revealed inability to close that eye. PERRL, EOMI, and the fundoscopic exam were normal. There were no corneal infiltrates or ulcers.

The tongue extended midline. Examination of the oropharynx reveals a distinct cluster of erythematous vesicles on the right side of the soft palate.

These lesions do not extend past midline. No other mouth ulcers were seen. There was no neck stiffness or carotid bruits.

CV exam was unremarkable.

The neuron exam was otherwise unremarkable, except for slightly decreased grip strength on the right.

A head CT was obtained secondary to the unexpected finding of decreased right grip strength. This was negative.

CBC w diff was unremarkable, and sed rate was 5.

### Diagnosis

This is a classic presentation of Ramsay-Hunt syndrome, a constellation of facial nerve palsy in association with herpes zoster reactivation (shingles) along the facial nerve.

In this case, the patient had the most unusual pres-

entation of unilateral palatal vesicular lesions; lesions are most frequently discovered pre-auricular, on the TM itself or, less frequently, on the soft palate.

Such patients are often misdiagnosed with Bell's palsy, due to the inconspicuous locations for the characteristic lesions, and the oft-delayed onset of rash. Missed or delayed diagnosis leads to unnecessary morbidity.

Hearing loss, chronic pain, and persistent facial droop are common complications

### Keys to the differential

- Bell's palsy: Diagnosis of exclusion. Other causes must be ruled out first. Both the upper face and lower face are affected. Pain is usually mild to moderate
- Cortical stroke/other central lesions: Due to duplicative central innervation, the upper part of the face (brow) is spared. This remains the hallmark distinction between central and peripheral causes of facial droop.
- Ramsay-Hunt syndrome: Facial paralysis with characteristic zoster lesions. Look carefully in the ears and mouth, as lesions may be difficult to appreciate in these locations. Pain is often severe compared with Bell's palsy.

### Management

Patients should be started immediately on systemic steroids: prednisone 40 mg/day to 80 mg/day for seven days, with or without a taper. Antivirals (valacyclovir/famciclovir) are usually prescribed, though their benefit in addition to corticosteroids is uncertain.

This case of Ramsay-Hunt syndrome is an important reminder that even routine presentations mandate a complete and systematic approach. You never know when one of those zebras will break out of the zoo and stomp through Central Park. ■

### Resources

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## ABSTRACTS IN URGENT CARE

# On Missed Fractures, Head Lice, Echinacea and the Common Cold, Children's Nighttime Coughing, and Cryotherapy vs. Salicylic Acid for Common Warts

■ NAHUM KOVALSKI, BSc, MDCM

Each month, Dr. Nahum Kovalski reviews a handful of abstracts from, or relevant to, urgent care practices and practitioners. For the full reports, go to the source cited under each title.

### Most Frequently Missed Fractures in the Pediatric Emergency Department

**Key point:** The most commonly missed fractures were phalanges of the hand and metatarsal fractures.

**Citation:** Mounts J, Clinenpeel J, McGuire E, et al. Most frequently missed fractures in the emergency department. *Clin Pediatr (Phila)*. 2010 Dec 2. [Epub ahead of print.]

This study quantified the types of extremity fractures most commonly missed on plain radiographs by pediatric emergency medicine specialists after an initial emergency department encounter.

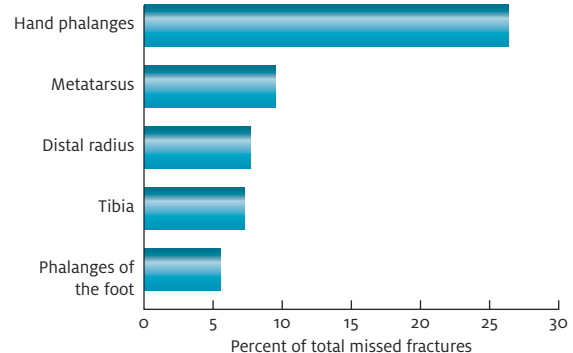
From February 2006 to June 2009, extremity radiographs obtained in a pediatric ED in which a radiologist categorized the ED attendings' read of "normal" as incorrect were tabulated. The authors also counted the total number of each type of radiograph completed when radiologists were unavailable. The percentage of each type of fracture missed was calculated based on the total number of missed fractures.

It was found that a total of 220 fractures were missed during ED encounters in the study period. The most frequently missed fractures were of the hand phalanges (26.4%) followed by metatarsus (9.5%), distal radius (7.7%), tibia (7.3%), and phalanges of the foot (5.5%).



Nahum Kovalski is an urgent care practitioner and assistant medical director/CIO at Terem Emergency Medical Centers in Jerusalem, Israel. He also sits on the JUCM Editorial Board.

Most Common Missed Fractures in the ED



Emergency and urgent care physicians alike should be aware that the most commonly missed fractures in the ED were phalanges of the hand and metatarsal fractures. ■

### Oral Ivermectin: A Good Option for Treatment of Head Lice

**Key point:** Ivermectin is effective for treating body lice and scabies, but few studies have evaluated the oral preparation for head lice in children.

**Citation:** Ameen M, Arenas R, Villanueva-Reyes J, et al. Oral ivermectin for treatment of pediculosis capitis. *Pediatr Infect Dis J*. 2010;29(11):991-993.

Pediculosis capitis (head lice) can lead to school absenteeism and, often, to parental anxiety. Treatment usually involves topical therapy that can be time consuming and

painful if excoriations are present.

In addition, pediculicide resistance is increasing and can lead to treatment failure. Ivermectin is effective for treatment of body lice and scabies, but few studies have evaluated the oral preparation for head lice in children.

In an open-label study, investigators recruited 44 children (age range: 6 to 15 years) living in an indigenous community in Mexico with confirmed head lice and treated them with a single dose of oral ivermectin (200 µg/kg). No nit removal was included in the protocol.

One week after treatment, no children had adult live lice. Although 90% of children still had nits, most were nonviable. The 18 children with moderate-to-abundant nits received an additional dose of ivermectin; one week later, no viable nits were present. No adverse events were reported.

Ivermectin is not familiar to most pediatricians, but has been used successfully and safely for treatment of several helminthes.

Although this was a small, open-label trial, the results indicate that ivermectin is a safe and effective pediculicide in children older than 5 years.

Currently, resistance to ivermectin is not a concern, making the drug a good addition to the treatment options outlined in the American Academy of Pediatrics revised clinical report on the management of head lice (*JW Pediatr Adolesc Med*, August 25, 2010).

Parents might prefer ivermectin because it is easy to use.

[Published in *J Watch Pediatr Adolesc Med*, December 15, 2010—Peggy Sue Weinrub, MD.] ■

## Echinacea for Treating the Common Cold: A Randomized Trial

**Key point:** Echinacea does not significantly reduce cold severity or duration.

**Citation:** Barrett B, Brown R, Rakel D, et al. *Ann Intern Med*. 2010;153:769-777.

Some 700 patients aged 12 to 80 with new-onset colds were randomized to receive open-label echinacea, blinded echinacea, placebo, or no pills for five days. Overall, self-reported cold duration was slightly improved—by about half a day—with echinacea compared with placebo or no pills, but this difference did not achieve statistical significance.

In addition, cold severity was slightly, but not significantly, improved with active treatment.

The researchers concluded that “the pharmacologic activity of echinacea probably has only a small beneficial effect in persons with the common cold....Individual choices about whether to use echinacea...should be guided by personal

health values and preferences, as well as by the limited evidence available.” ■

## Vapor Rub for Children with Nocturnal Cough and Cold Symptoms

**Key point:** In a single-night study, vapor rub improved cough and congestion symptoms in children.

**Citation:** Paul IM, Beiler JS, King TS, et al. Vapor rub, petrolatum, and no treatment for children with nocturnal cough and cold symptoms. *Pediatrics*. 2010;126(6):1092-1099.

Many of us can recall the use of Vicks VapoRub during childhood. In a manufacturer-sponsored study, 138 children (age range, 2–11 years) seen at a single pediatric center in Pennsylvania for colds characterized by cough, rhinorrhea, and congestion for at least one week were randomized to receive vapor rub, petrolatum, or no treatment for one night. In an attempt at blinding, parents in the vapor rub and petrolatum groups placed Vicks VapoRub under their own noses prior to applying treatment to their child’s upper chest and neck area before sleep.

Parents completed a six-item symptom survey at enrollment to assess symptoms on the night before treatment and the morning after.

Symptoms improved in all groups on the night after treatment. However, child and parent sleep and combined symptom scores improved significantly more in the vapor rub group than in the petrolatum and no-treatment groups.

In addition, vapor rub significantly reduced frequency of cough and severity of cough and congestion compared with no treatment; improvement approached statistical significance compared with petrolatum.

Almost half of the vapor rub group reported minor, adverse side effects, such as a burning sensation on the skin. Most parents knew the group that their child had been assigned to (no treatment, 100%; vapor rub, 86%; petrolatum, 89%).

The obvious limitation of this study is the lack of successful blinding. However, because sleep is such an important commodity, recommending vapor rub for children seems reasonable.

[Published in *J Watch Pediatr and Adolesc Med*, November 24, 2010—Howard Bauchner, MD.] ■

## Cryotherapy is More Effective than Salicylic Acid for Common Warts

**Key point:** No clinically significant difference between treatments for plantar warts was seen, but there are clear benefits for warts on hands.

*Continued on page 28*

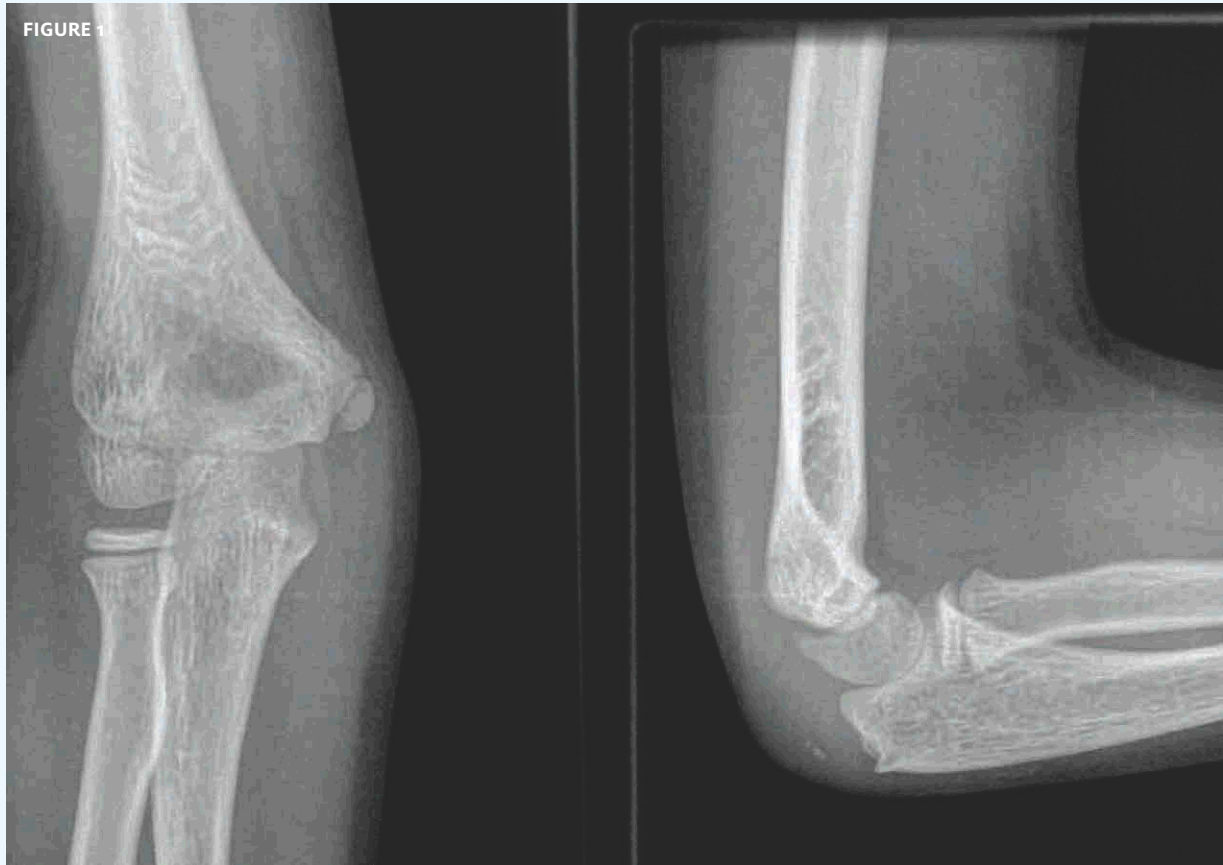


## INSIGHTS IN IMAGE

# CLINICAL CHALLENGE

In each issue, *JUCM* will challenge your diagnostic acumen with a glimpse of x-rays, electrocardiograms, and photographs of dermatologic conditions that real urgent care patients have presented with.

If you would like to submit a case for consideration, please email the relevant materials and presenting information to [editor@jucm.com](mailto:editor@jucm.com).

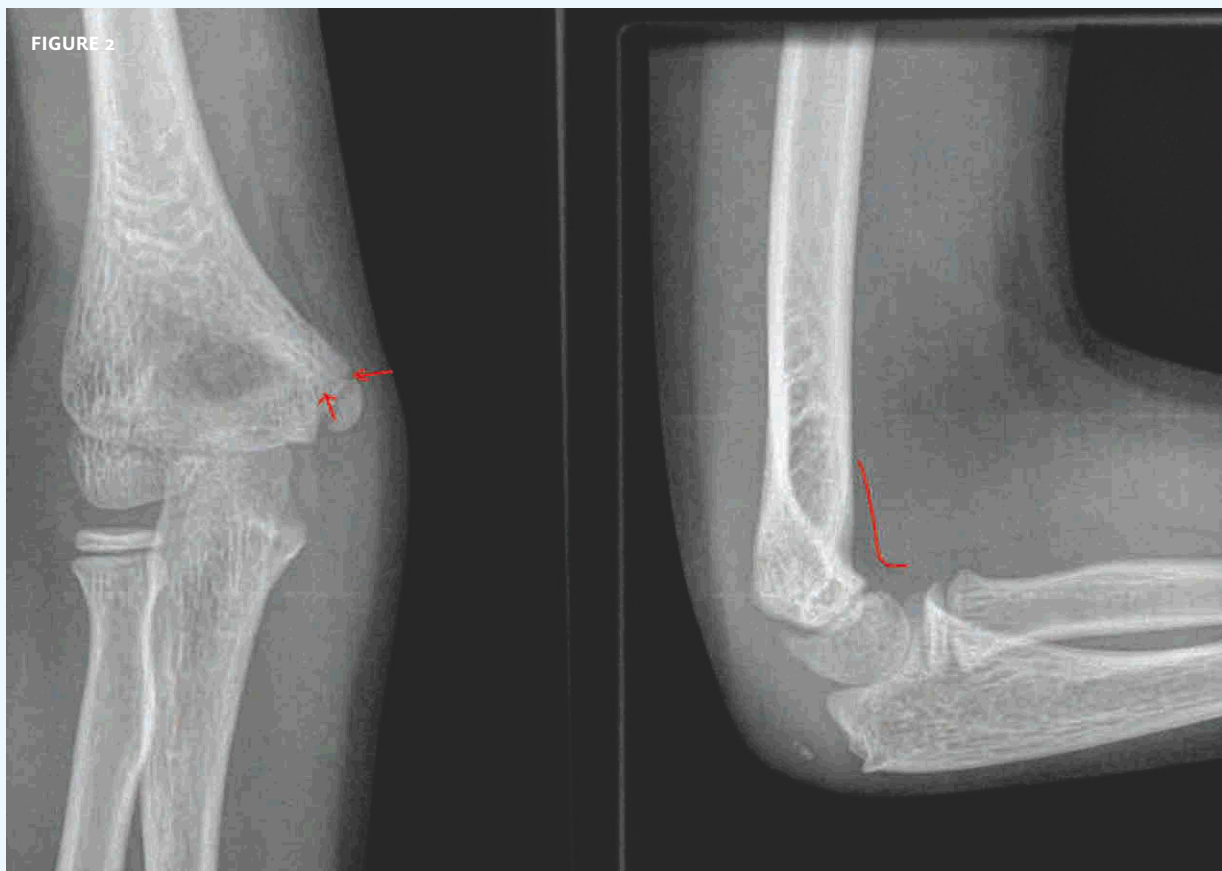


The patient is a 10-year-old who presents after experiencing a blow to the right elbow, with resultant pain on extension of the arm.

View the image taken (**Figure 1**) and consider what your diagnosis and next steps would be.

Resolution of the case is described on the next page.

## THE RESOLUTION



There is a suspicious line on the front view; the angle of the distal humerus (on lateral) is also suspicious.

As initially suspected, this child sustained a supracondylar fracture of the distal humerus and was placed in a cast splint at 90° at the elbow.

It should be noted that such fractures are ripe for complication, due in part to the fact that they can be easy to miss. Vigilance based on mechanism of injury is advised.

*Acknowledgment: Case presented by Nahum Kovalski, BSc, MDCM, Terem Emergency Medical Centers, Jerusalem, Israel.*

*These cases are among hundreds that can be found in Terem's online X-ray Teaching File, with more being added daily. Free access to the file is available at <https://www2.teremi.com/xrayteach/>. A no-cost, brief registration is required.*



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# Coding for Intravenous Infusion, Fees for S9083, Morgan Lens Irrigation, and UB-04 Revenue Codes for Urgent Care

■ DAVID STERN, MD, CPC

**Q.** I had a patient come in who needed IV fluids and monitoring for five hours. We found the CPT codes 96360 (intravenous infusion, hydration; initial 31 minutes to 1 hour) and 96361 (each additional hour...) to use for the IV hydration therapy. However, my doctor cannot believe how low these codes are reimbursed by his health insurance. We did bill an office visit in addition to the IV. Is this all we can bill?

- Nicole, Fresno, CA

**A.** I believe that you are using the correct codes. In addition to the correct codes, many physicians want to add codes for IV fluids, tubing, and a code for venipuncture. However, according to CPT, the following are bundled into (i.e., included in) the IV hydration codes:

- Use of local anesthesia
- IV start
- Access to indwelling IV, subcutaneous catheter, or port
- Flush at conclusion of infusion
- Standard tubing, syringes, and supplies

Don't forget to list the 96361 multiple times, when appropriate. For this visit, for example, you might code an E/M code (e.g., 99203-25), 96360 (first hour IV hydration), and 96361 (each additional hour) x 4.

**Q.** Our urgent care clinic is trying to set up a contract, but the insurance company wants us to use the code S9083 (global fee urgent care centers). Is there a minimum or maximum amount we are allowed to charge? I have

looked through several locations, and nothing is actually telling me the amounts. Can you please assist me?

- Pamela Seekford, Austin, TX

**A.** The contracted rate the payor will reimburse for this code should be noted in your contract with the payor; many times it is possible to negotiate a higher rate. There is no specific dollar amount that is standard for S9083. As you add payors, you should make sure your fee for S9083 is higher than the highest reimbursement level from any payor for the S9083.

Most software solutions will require you to manually enter the code. For efficiency and error prevention, you might want to look for software that is set up to automatically bill the S9083 (i.e., override other CPT and HCPCS codes) for specific payors that only pay on S9083.

**Q.** When a patient has chemical conjunctivitis and needs irrigation of the eye with a Morgan lens hooked up to a bag of fluids, how is this coded? What is the code for a Morgan lens?

- Maureen McRae, MD, Victor, NY

**A.** Some coders include the procedure in the E/M code. This is not intuitive; nor is it necessary, as the procedure adds significant expenses for supplies, staff time, additional risk, and facility usage. There is no specific code for Morgan lens irrigation. You might consider using the following codes:

■ **Eye Irrigation Procedure (possible codes):**

- **92499**—Unlisted ophthalmological service or procedure; or
- **65205**—Removal of foreign body (external) from eye but non-surgical. (Note: 65205 is the code recommended by the manufacturer. It is not a perfect code, as the physician is usually trying to flush out a foreign liquid (which is not exactly a "foreign body."); or

Continued on page 26



**David E. Stern, MD, CPC** is a certified professional coder. He is a partner in Physicians Immediate Care, operating 12 urgent care centers in Oklahoma and Illinois. Dr. Stern speaks frequently at urgent care conferences. He is CEO of Practice Velocity ([www.practicevelocity.com](http://www.practicevelocity.com)), providing urgent care software solutions to more than 500 urgent care centers. He welcomes your questions about coding in urgent care.



## Like Super Good Written, Verbal and Non-verbal Communication and Stuff

■ JOHN SHUFELDT, MD, JD, MBA, FACEP

Who could forget this memorable exchange in the movie *The Sure Thing*? Gib, (John Cusack) is discussing his chances for dating a fellow classmate:

**Gib's friend:** Forget her; I hear she only likes intellectuals.

**Gib:** So? I'm intellectual and stuff.

**Gib's friend:** You're flunking English. That's your mother tongue, and stuff.

I will begin this short essay by admitting that I am not always the best or most appropriate in terms of my style or manner of communication, which is no news to my two relatives who make up half the readership of these articles.

I have also learned over the years to take most things with a grain of salt (particularly if it is followed by a shot of tequila and a slice of lime), so I don't get too worked up over much of anything that is directed my way.

That said, I have learned a thing or two about how not to communicate and what not to say or write, mostly from experience.

What follows are styles of communication which, at best, do little to further the intended discourse or outcome. At worst, they convey the wrong message entirely, insult the other party, or reflect poorly on you.

### Non-verbal Communication

- Standing up while taking a history from a patient (conveys dominance which is not reassuring when you are sick).
- Talking with your arms folded across your chest or with your

fists clenched at your side (conveys aggressiveness).

- Blowing your nose or wiping your mouth and then shaking someone's hand (I am not sure what this conveys, but it is disgusting).
- Rolling your eyes when someone is speaking to you. (My children will tell you that this is a sure way for me to tell them, "The last thing I want to do is hurt you, but it's still on the list.")
- Talking over your shoulder while walking out of a room or away.
- Crossing your legs and folding your arms while sitting (conveys that you are hiding something, or that you are cold).
- Snapping gum or chewing with your mouth open (conveys that your parents were first cousins).
- Shifting eyes or shifting back and forth while standing (conveys that you are being deceitful or have to urinate).
- Working, reading, texting, writing, or watching TV while someone is trying to have a conversation with you.
- Not making eye contact while speaking directly to someone or shaking their hand and not looking at them.

### Written Communication

- Frequently misspelling words or writing in different tenses.
- Spelling someone's name incorrectly despite it being part of the correct email address that you just spelled correctly. (This one always amazes me; example: "Dear Mr. Schoefelt" sent to [jshufeldt@shufeldtconsulting.com](mailto:jshufeldt@shufeldtconsulting.com).)
- Using excessive legalese in a document (heretofore, etc.).
- Using email or written communication to convey important information that should be communicated in person (for example, telling a close friend, not-for-profit, or long-time business partner that you will be dissolving your relationship).
- CAPITALIZING EVERY WORD IN AN EMAIL OR TEXT MESSAGE.
- Using multiple exclamation points or adding extra letters to a word. ("I was sooooo drunk last night!!!!!!")



**John Shufeldt** is principal of Shufeldt Consulting and sits on the Editorial Board of JUCM. He may be contacted at [JohnShufeldt@shufeldtconsulting.com](mailto:JohnShufeldt@shufeldtconsulting.com).

- Using shortened, text message versions of words or phrases in a business email (e.g., prolly, lol, ur, OMG, IDK, lol, lmaorotf, eieio...).
- Multiple smiley faces, frowns, or any other kind of word art in a business email. ☺
- Creatively interchanging to, too, and two; your and you're; its and it's; and their, there, and they're.
- Excessively long sentences without any punctuation really drive me crazy almost more so than anything else even chewing gum with an open mouth or swearing in a meeting or one time at band camp this guy like really thought he was cool and then started drinking OMG he was so drunk that his parents were called and then he like vomited twice right before he passed out in front of I
- Using "I" and "me" interchangeably. ("Him and me went to the tractor pull and drank some beers.")

### Oral Communication

- Like saying "like" like every few words. (I for one don't like it.)
- Using threats; "If you don't do XXX, then I will do YYY!" (The conversation can only go in one direction from here and it is rarely positive since you leave the recipient no out.)
- Speaking in the third person about yourself or the person you're speaking to (although this is really fun, me saying "John's getting angry!" is like super annoying).
- Mumbling, low-talking, or talking into the hand. (Sadly, I used to silently mouth words to my grandmother to see if I could make her tap her hearing aid. I'm sick, I know).
- Saying "Whatever!" whenever something is annoying.
- When someone asks a legitimate question, responding with, "I can't believe you didn't know that!" (Conveys that you believe that they are stupid.)
- Saying "Trust me" and then proceeding to say something completely untrue.
- Trailing off in mid-sentence and waiting for someone else to finish your sentence. ("In 1930, the Republican-controlled House of Representatives, in an effort to alleviate the effects of the...anyone, anyone? Great Depression. Passed the...anyone, anyone? The tariff bill? The Hawley Smoot tariff act? Which? Anyone, anyone? Raised or lowered...? Anyone, anyone?" ("Bueller? Bueller?"))
- Interrupting while the other person is still speaking.

For the vast majority of individuals, none of the above is rocket science. However, for an infuriating few, these tidbits may be the difference between a successful career and a continuing march toward abject mediocrity.

All joking aside, effective communication is an art which must be practiced and I, like many others, must continue to train. Ancaro imparo; "I am still learning." ■

- **V2799**—Vision service, miscellaneous.
- **Morgan Lens: V2797**—Vision supply, accessory, and/or service component of another HCPCS vision code.
- **Fluid: J7120**—Ringers lactate infusion, up to 1000 cc (code once per liter or part of liter used).
- **IV Tubing: S1015**—IV tubing extension set (not for Medicare).

It should be noted that, if you are coding for a hospital, many hospitals use Morgan lens irrigation as a criteria for a level 5 E/M code on the facility billing UB-04. If you are not billing on the UB-04, you should ignore this comment. Morgan lens irrigation does not affect the physician E/M that is billed on the CMS-1500.

**Q. Our hospital has an off-site urgent care office that uses the same tax ID number as the affiliated hospital. We are having problems getting our facility fee reimbursed. We are currently filing the claim on a UB-04 with revenue code 456 and CPT 99202. Do you see any issues with this billing method? Should this be filed on a HCFA 1500 instead?**

– Jessica Easterwood

**A.** If you performed separate contracting for the urgent care, you may have contracted as a physician office, in which case the payors will not reimburse on the UB-04.

Many payors will reimburse hospitals (even for off-site urgent care centers) for the facility fee on the UB-04. You might find that the payor is expecting a different revenue code. Although some make more sense than others, possible revenue codes might include:

- 0456 Urgent Care
- 0516 Urgent Care Clinic
- 0519 Other Clinic
- 0520 Free-Standing Clinic
- 0523 Family Practice Clinic
- 0526 Urgent Care Clinic
- 0500 Outpatient Services.

I would recommend that you contact each payor to see what they expect. Don't be surprised, however, if the rep you call is unable to help you, as many times the payor is not sure itself what codes are expected in the edits of their software. ■

*Note: CPT codes, descriptions, and other data only are copyright 2011, American Medical Association. All Rights Reserved (or such other date of publication of CPT). CPT is a trademark of the American Medical Association (AMA).*

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# Say 'Arrivederci' to Printed Materials

■ FRANK H. LEONE, MBA, MPH

An interesting title for a book addressing the impact of the electronic information age might be *The End of Paper*. Look around. Daily newspapers are dramatically down in circulation and shutting down at a rapid rate.

That 20-volume encyclopedia that used to sit on your parents bookshelf? No mas.

Those written assignments at every school level? A thing of the past.

Seems like a no brainer. Out with the paper and in with the electronic medium. Yet when it comes to the marketing materials most urgent care clinics use, the paper trail has far from disappeared.

This month's column will propose numerous areas in which your clinic might transition from paper to electronic media in order to more effectively get your message across in a less costly manner.

### Collaterals

In many respects, old-fashioned collateral materials are counterproductive. People do not have time to read much of anything these days. Consequently, a big folder of collaterals will almost certainly never be read and most likely be quickly discarded.

A waste of your clinic's money and a squandered opportunity to place information before your clients and prospects.

I believe the origins lay in the recent evolution (or lack thereof) of healthcare marketing. The 1980s were the hey-day of healthcare marketing; healthcare organizations were throwing money into marketing, marketing officers and staff was being hired at a dizzying rate, and radio, television,

print ads, and billboards proliferated.

Then the new electronic age (email, attachments, and websites) kicked in and the old guard didn't quite know what to do. Thus, a continued reliance on printed matter from Marketing Central.

### What to Do?

- Consider eliminating *all* paper collaterals. Use your cost savings to upgrade your website, enhance your salesperson's incentive compensation, and/or pay for a spiffy open house.

If you must commit something to paper, make it a simple one-page flier replete with photos, phone numbers, and third-party testimonials.

- Create an electronic library. Send clients or prospects exactly what *they* need and nothing more. There are numerous advantages to this approach compared with traditional hard materials:

- You are giving them something that is customized, and customization is invariably a leading reason why employers select a provider ("Urgent Care Plus considers the nuances of *our* workplace!").
- You are not handing off a generic "one size fits all" packet of information.
- You seize an opportunity to show client/prospects how quickly you can react. For example, if your clinic can email appropriate information sheets within a few hours of a sales call, you invariably create a halo effect of responsiveness that reflects favorably on your clinic.
- You can customize within your customized forms. That is, you can not only pick and choose the information you wish to send on, but you can customize that information to reflect the prospect's special needs and utilize buzz words appropriate to a particular company.
- You can update information at any moment. Your clinic cannot make such changes in written materials, which are often obsolete the moment they arrive from the



**Frank Leone** is president and CEO of RYAN Associates and executive director of the National Association of Occupational Health Professionals. Mr. Leone is the author of numerous sales and marketing texts and periodicals, and has considerable experience training medical professionals on sales and marketing techniques. E-mail him at [fleone@naohp.com](mailto:fleone@naohp.com).



printer. An electronic library renders material (including staff and staff bios) suitable for immediate updating.

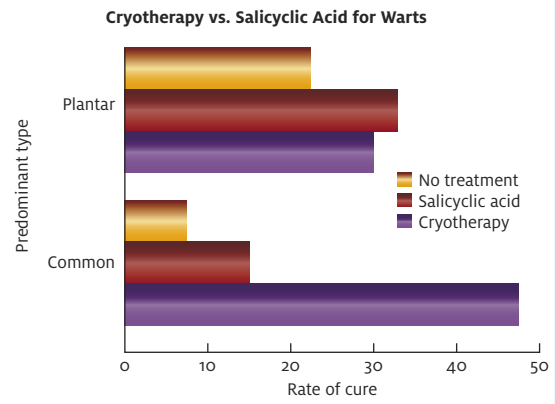
- Develop multiple opportunities to distribute selected materials. In the old paper days, material had to be either mailed or hand-delivered. The electronic age opens up new opportunities:
  - Through your website. You can add many of these materials directly to your website or link readers to a printable version of various documents. Product descriptions, legal explanations, staff biographies, clinic registration materials, and seminar registrations are but a few of the materials or links that could be made available on your website.
  - As email attachments. You can and should load up your professional email correspondences with direct links to various information sheets and forms as appropriate.
  - Mass email blasts. Do you need to introduce a new or revitalized service, a new staff member, or a new policy? An email blast with a proper link or attachment is a quick and costless way of getting such information out.

### Don't Stop There

While you're at it, consider looking at other areas of your operation with this same mindset. The use of almost any paper can and should be minimized.

- Work toward a paperless office. Backing up computer files has become so sophisticated that we have little to worry about. Paperless is not perfect, but paperless perfection is getting closer all of the time.
- Minimize direct mail. This includes most letters that can be sent via email for immediate delivery to (gulp) the bulk mailing of promotional materials supporting your program. Remember, *bulk* mail is *junk* mail and is seldom, if ever, read by the recipient.
- Collect survey data electronically. Regardless of purpose or length, it is wiser and more effective to gather survey data (e.g., annual employer survey) via an email attachment or link. This brings in some responses which makes life less difficult—and less expensive—on the back end.

The rule of the road is clear: Time-strapped people have little time to read, review, and absorb. You have to hedge your bets by providing clients and prospects with only the information that they absolutely need. Such targeted information, expense, and time and is likely to resonate more clearly with the recipient. ■



**Citation:** Bruggink SC, Gussekloo J, Berger MY, et al. Cryotherapy with liquid nitrogen versus topical salicylic acid application for cutaneous warts in primary care: Randomized controlled trial. *CMAJ*. 2010;182(15):1624-1630.

Cutaneous warts are seen often in primary care, particularly among children, but a recent Cochrane review was inconclusive on the relative merits of the two most common treatments, salicylic acid and cryotherapy.

Dutch researchers randomized 250 patients (43% younger than 12 years) who were recruited from 30 primary care practices with one or more new cutaneous warts (<1 cm diameter) to receive cryotherapy with liquid nitrogen every two weeks, daily self-applications of 40% salicylic acid gel, or no treatment for 13 weeks.

Half the patients had predominantly common warts (mainly on the hands), and half had predominantly plantar warts. Among patients with predominantly common warts, warts were significantly more likely to resolve completely with cryotherapy than with salicylic acid or no treatment (49% vs. 15% and 8%, respectively).

Patients with predominantly plantar warts had similar cure rates regardless of treatment (30%, 33%, and 23%, respectively) and were more likely to be completely cured if they were younger than 12 years (50% vs. 3%) or if their warts had been present for <6 months (46% vs. 10%).

Cryotherapy caused more local side effects than salicylic acid did, but more patients who received cryotherapy were satisfied with their treatment.

This pragmatic primary care-based trial suggests that cryotherapy is the preferred treatment for common warts. Persistent plantar warts in adolescents and adults are unlikely to respond to brief therapy with either cryotherapy or salicylic acid.

[Published in *J Watch Gen Med*, November 30, 2010—Bruce Soloway, MD.] ■

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Benjamin Franklin (1706-1790), American author, diplomat, inventor, printer, scientist, and Founding Father

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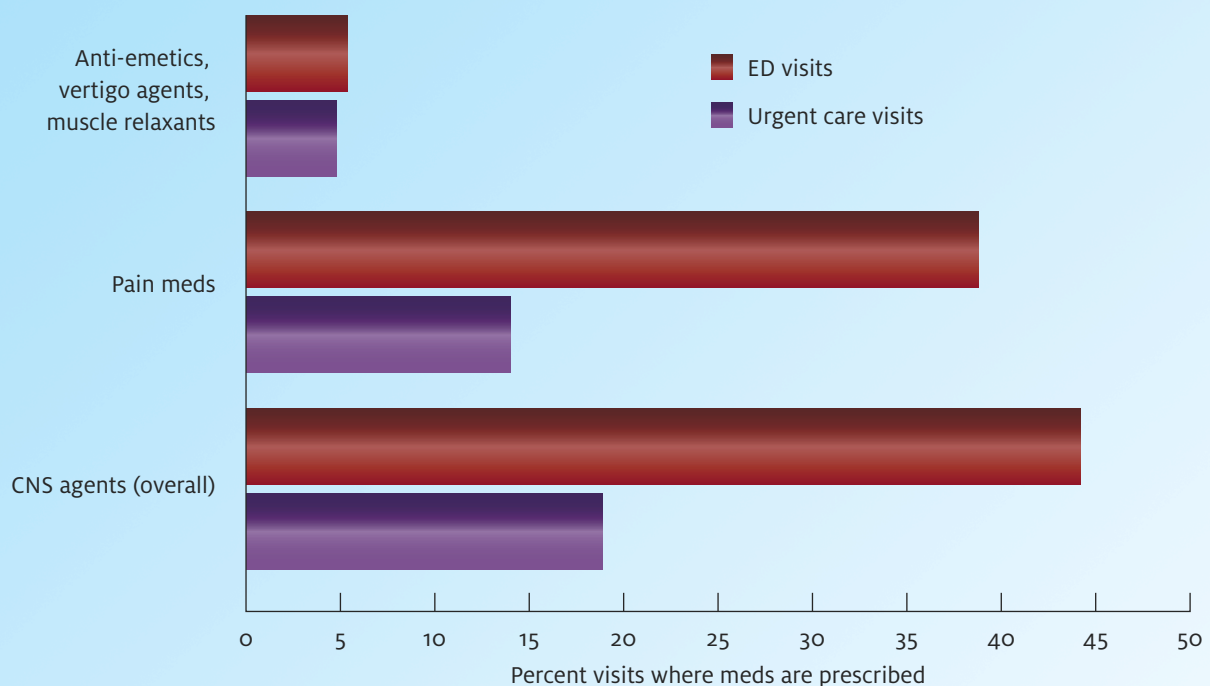


## DEVELOPING DATA

In each issue on this page, we report on research from or relevant to the emerging urgent care marketplace. This month, we continue looking into data brought to light in *Many Emergency Department Visits Could Be Managed at Urgent Care Centers and Retail Clinics*,<sup>1</sup> an article that (as the title implies) compared the capabilities and usage of urgent care centers vs. other immediate-care options the U.S. It may be most valuable to the urgent care practitioner as a barometer of patient preferences when choosing which site best suits their needs.

Last month, we shared data on antibiotics prescribed at urgent care centers and EDs. Here, we offer a comparison of how central nervous system (CNS) agents are prescribed.

### CNS AGENT PRESCRIBING



#### Reference

1. Weinick RM, Burns RM, Mehrotra A. *Health Affairs*. 2010;29(9):1630-1636.

Do the data reflect your own experiences? Whether they do or not, they offer valuable insight into how patients in your area decide who can help them when they need it most. Make sure you're arming them with the information they need to make informed decisions.

In future issues, we will look at other therapeutic classes, as well as data on diagnoses treated at the urgent care, ED, and retail clinic levels.

If you are aware of new data that you've found useful in your practice, let us know via e-mail to [editor@jucm.com](mailto:editor@jucm.com). We'll share your discovery with your colleagues in an upcoming issue of *JUCM*.

SPRING 2011

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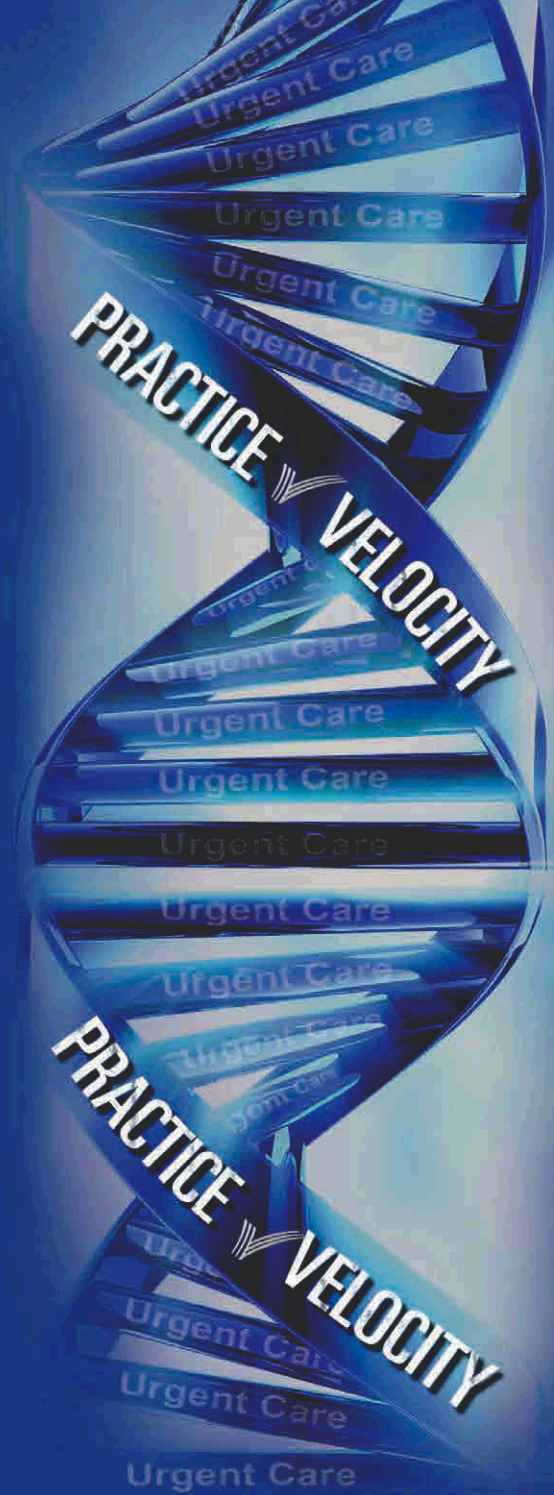
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