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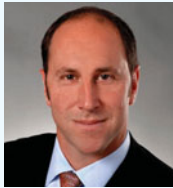


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LETTER FROM THE EDITOR-IN-CHIEF

The 'Control' Paradox



Influenza is off to a fast start this year and volumes are ballooning. 'Tis the season to be swamped in urgent care, and without a good approach, urgent care clinicians can quickly become overwhelmed, burned out, and irritable. Pile

on the stress of the holidays and the demands of family and loved ones and you've got a recipe for disaster. Work-life balance is important for all of us, yet feels almost out of reach in a profession increasingly squeezed in a vice-grip of revenue and productivity demands. If we don't find a pressure release valve, we risk an explosion of negative coping and behavior.

The impact of these compounding stressors is dramatic:

1. Suicide rates for physicians are more than *double* that for the general population.
2. Female physicians have a rate *quadruple* the general population.
3. Substance abuse, depression, and divorce rates are all higher for physicians.

Experts have identified several traits of physicians that seem to set the stage for negative coping, including the very bravado and invincibility that seems necessary in order to become a physician in the first place. Female physicians are even more vulnerable, as they endure a "double whammy" of expectations about their roles at home and at work. Caring for patients all day can cause a sort of "care fatigue" that can be especially problematic for physician moms who are supposed to be "on" when their male counterparts are generally allowed to be "off."

Perhaps, then, it is not surprising that a "sense of control over one's life" has been identified as one of the most important feelings associated with self-reported "well-being." It is also not surprising that physicians have unrealistic expectations internally and externally about being "in control." Nothing is more burdensome than this responsibility and it permeates the life of a physician "on and off the court." Control, therefore, is a double-edged sword for physicians, and without perspective, can slice deeply into positive coping and a rewarding life and career.

I would propose that the vast majority of a physician's work-life, on an encounter to encounter basis, is out of our control. The health care economy is such that individual physicians have little to no control, and the regulatory and liability environment isn't exactly physician-friendly either. Pile on unrealistic patient expectations and a 5-minute encounter and any naive effort to wrest back control is something between an "utter waste of time" and "playing with fire." You see, we are setting ourselves up for failure if we hang on to our dreams of control, and our continued pursuit makes us angry, bitter, and embroiled in negative relationships. No one is impervious to the aftershocks and consequences and many will bring it home, turn to substances, or worse.

It may just be that the only healthy way to regain control is to give away a good chunk of it....for free. Control what you *can* easily control but donate the rest. For example, it can be terrifically liberating to share control with patients, engaging them in decision-making and parsing out some risk. It is even more of a relief to give yourself permission to actually, heaven forbid, let some chips fall where they may. You simply can't account for every eventuality in this business, so why insist on trying? This is not to say that we should care less or avoid more, but without a realistic, more balanced approach, it's a zero sum game anyway. And when you break out of the self-imposed confinement of control, the whole world opens up to you, the sun shines more brightly, and the anger recedes. You will quickly enlarge your capacity to forgive those who have wronged you and, perhaps, even yourself. Your patients, family, and friends will notice and you may just rediscover the joyfulness of a career in medicine. ■

Lee A. Resnick, MD, FAAFP
Editor-in-Chief, JUCM, *The Journal of Urgent Care Medicine*



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Evaluation and treatment of injuries of the cheek, ear, nose, lips and tongue are explored to help urgent care clinicians more confidently manage these presentations.

Toyin Fapohunda-Adekola, MD, MBA

PRACTICE MANAGEMENT



17 The Sword and the Shield: Best Hiring Practices for Urgent Care Facilities

It is imperative that urgent care centers utilize the various tools at their disposal to recruit the best candidates, while implementing best practices that mitigate the potential for lawsuits.

Damaris L. Medina, Esq.

CASE REPORT

21 Periostitis in secondary syphilis

Be on the lookout for periostitis in patients with syphilis who present with extremity pain.

May Mohty, MD, FAAP, FAAUCM, and Casey Philipsborn, MSIV



IN THE NEXT ISSUE OF JUCM

According to a recent CDC report, almost 40% of older Americans use five or more prescription medications in a given month. Polypharmacy is independently associated with increased risk of an adverse drug event, irrespective of age. Next month's cover story looks at the challenges to urgent care physicians of managing a patient's acute condition appropriately while balancing acute needs related to use of multiple medications. Included is information on methods of screening for inappropriate medication use in older adults, dose-related adverse events, drug-drug interactions, and allergies and pseudoallergic reactions.

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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 and the Urgent Care College of Physicians, *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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JUCM CONTRIBUTORS

Our two-part series on scalp and face lacerations, by Toyin Fapohunda-Adekola, MD, concludes this month with concise information on management of lacerations of the cheek, ear, nose, lips, and tongue. The review reminds urgent care providers about when and when not to perform a surgical closure for these wounds, “red flags” to look for that signal a need to rule out serious or potentially fatal injuries, appropriate options for anesthesia for laceration repair, and special considerations related to lacerations of the lips and tongue.

Toyin Fapohunda-Adekola, MD, is a 2014 graduate of the Urgent Care Fellowship at the University Hospital of Cleveland, Department of Family Medicine, Case Western Reserve, Cleveland, Ohio.



This month’s case report profiles a patient with a 2-month history of progressively worsening fatigue and dizziness, plus severe diarrhea and dehydration. Physical exam of the 62-year-old white male, who stated that he was HIV-negative, was positive for ulceration of the buccal mucosa and an extensive maculopapular rash. The diagnosis: Periostitis in secondary syphilis. As authors May Mohty, MD, FAAP, FAAUCM, and Casey Philipsborn, MSIV, note, this case underscores the need to recognize the various signs and symptoms of syphilis in the outpatient setting.

May Mohty, MD, FAAP, FAAUCM, is a clinical assistant professor at the University of Arizona College of Medicine and Urgent Care Physician at CIGNA Healthcare of Arizona. Casey Philipsborn is a fourth-year medical student and Osteopathic

Manipulative Medicine Scholar at Arizona College of Osteopathic Medicine.

Hiring and retaining good employees is important to the success of an urgent care center, and a thorough hiring process is the subject of this month’s practice management article, by Damaris L. Medina, Esq. Included in the article are guidelines on use of job applications and background checks, employment testing, interview questions, and checks of social media and references.



Damaris L. Medina, Esq., is an experienced business and litigation attorney in the Healthcare Department of Michelman & Robinson, LLP, a law firm representing health care providers all over the nation.

Also in this issue:

In Health Law this month, **John Shufeldt, MD, JD, MBA, FACEP**, discusses ways that providers end up in front of their respective medical boards.

Sean M. McNeeley, MD, and **The Urgent Care College of Physicians** review new abstracts on topics in the literature germane to the urgent care clinician, including clarithromycin and risk of cardiac death, new vs old treatments for VTE, and fluid intake and recurrent nephrolithiasis.

In Coding Q&A, **David Stern, MD, CPC**, discusses coding for fractures, strapping and splint application and the S9088 code.

Our Developing Data end piece this month looks at lack of access to primary care as a driver of urgent care industry growth. ■

To Submit an Article to JUCM

JUCM, *The Journal of Urgent Care Medicine* encourages you to submit articles in support of our goal to provide practical, up-to-date clinical and practice management information to our readers—the nation’s urgent care clinicians. Articles submitted for publication in **JUCM** should provide practical advice, dealing with clinical and practice management problems commonly encountered in day-to-day practice.

Manuscripts on clinical or practice management topics should be 2,600–3,200 words in length, plus tables, figures, pictures, and references. Articles that are longer than this will, in most cases, need to be cut during editing. The information you provide should be of practical use to our readers, who have come to practice in an urgent care setting from a variety of clinical backgrounds. Your article should take their perspective into account by considering several key issues, such as: What immediate management is indicated? What labs or diagnostics are required?

What are the next steps; with whom should the patient follow up? Who should be admitted or referred to the emergency room? Imagine yourself in the reader’s shoes and ensure your article includes the answers to questions you’d be asking.

We prefer submissions by e-mail, sent as Word file attachments (with tables created in Word, in multicolumn format) to editor@jucm.com. The first page should include the title of the article, author names in the order they are to appear, and the name, address, and contact information (mailing address, phone, fax, e-mail) for each author.

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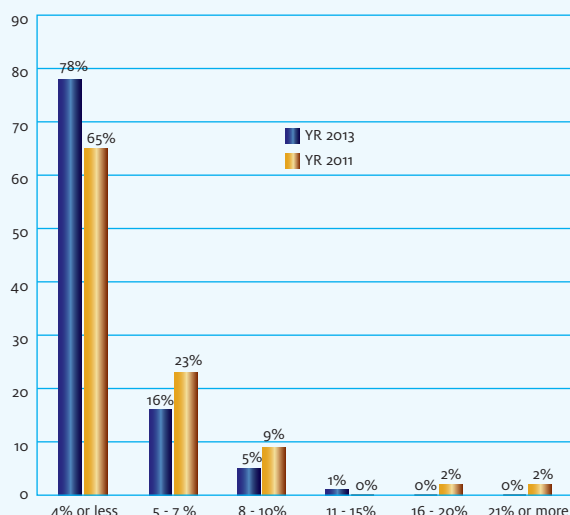
bench•mark – measurement of an organization's policies, products, programs, strategies, time, financial performance, and productivity (to name a few) with standard measurements of peers. (1) to determine what and where improvements are called for; (2) to analyze how other organizations achieve their high performance levels; and, (3) to use this information to improve performance.

A critical part of analyzing your urgent care center's and your providers' and operational team's performance is regularly conducting periodic benchmarking. Partnering with UCAOA, you can track your progress and keep your finger on the pulse of the industry. You can assess and compare more than 200 performance metrics, such as compensation, productivity, number of patients seen, staffing, revenue, operating expense, and accounts receivable, to industry standards. This process is one of the best ways to identify problems and opportunities for improvement and to celebrate your success.

These benchmarks cannot and should not stand alone. Comparing one's practice to "like" urgent care centers in similar demographic settings, for instance, is now a benefit of purchasing access to the interactive UCAOA Benchmarking Platform. This is helpful to both centers that participated in the survey and those that did not. Participants will be able to see their center's results compared to the aggregate responses from hundreds of other centers. In future years, participants will be able to look at year-over-year data for their own centers as well as the aggregate. Centers that did not participate will still be able to filter against many metrics but will have access to only the aggregate data.

Similarly, interpreting the data without considering it in

Percentage of patients transferred/directed to ER



the proper context could lead to poor assumptions. Thus, UCAOA is offering a document that includes expert-driven commentary which places further explanation and context around the data points as well as comparisons to previous study data.

Additional context can be placed around the benchmarking study results through UCAOA resources ranging from expert presentations highlighting best practices for incorporating the results into your practice, (to be offered at the National Urgent Care Convention [April 27-30 in Chicago]); to the 2015 Policies & Procedures Online Manual, which provides customizable templates for hundreds of forms and policies; the Accreditation Standards Manual; and participation in the certification (scope) and accreditation (scope, quality and safety) evaluation and recognition process.

To learn more about and to purchase access to the interactive UCAOA Benchmarking Platform and/or the results summary, please go to <http://www.ucaoa.org/?2014Benchmarking> or call the UCAOA office at 877-698-2262. ■



P. Joanne Ray is chief executive officer of the Urgent Care Association of America. She may be contacted at jray@ucaoa.org.

Repair of Lacerations of the Face and Scalp: Part 2

Urgent message: Evaluation and treatment of injuries of the cheek, ear, nose, lips and tongue are explored to help urgent care clinicians more confidently manage these presentations.

TOYIN FAPOHUNDA-ADEKOLA MD, MBA

Introduction

In Part 1 of this series, we covered the evaluation and management of scalp, brow, and eyelid lacerations. In Part 2, we will explore injuries of the cheek, ear, nose, lips and tongue. As previously discussed, careful evaluation of neurovascular function and appreciation of techniques that contribute to adequate cosmesis is necessary for ensuring the best results. Basic wound repair skills and application of standard anatomic rule-sets is all that's required for most facial lacerations. The urgent care clinician should be able to manage the vast majority of these presentations with only occasional referral. However, clinical judgment, patient or parental anxiety, and an assessment of risk or liability are always required and should prompt referral to a higher level of care whenever necessary.

In this article, the second of a two-part series, we will examine the approach to lacerations of the cheek, ear, nose, lips, and tongue.

Cheek Laceration

Patients with lacerations of the cheek are quite commonly seen in the urgent care setting and their injuries usually are associated with animal bites and contact sports. Radiographs are recommended to search for foreign bodies such as tooth fragments and to evaluate for

Toyin Fapohunda-Adekola, MD, is a 2014 graduate of the Urgent Care Fellowship at the University Hospital of Cleveland, Department of Family Medicine, Case Western Reserve, Cleveland, Ohio.



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associated zygomatic or orbital fractures.¹ Careful examination and testing for injury to the facial nerve and its branches also is necessary. The simple act of elevating the eyebrows can be used to test for the temporalis branch of the facial nerve whereas asking the patient to sniff tests the zygomatic branch. Asking the patient to smile and frown tests the buccal and mandibular branches of the facial nerve and shrugging tests the



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Figure 1. Regional anesthesia for the ear

functioning of the cervical branch.

Wound closure preparation and technique. Anesthesia for small cheek lacerations can be done through direct infusion whereas regional blocks may be necessary for larger wounds. Infra-orbital blocks provide coverage of the superior and medial cheek and are preferable for through-and-through lacerations of the cheek that require closure layer by layer, from the intra-oral mucosa toward the skin. In such situations, a regional block prevents distortion of the tissue and, in multilayer lacerations, provides the longer-acting anesthesia necessary to allow a physician the time to suture each layer.

Mucosal lacerations of less than 3 to 5 cm do not require closure, as they will heal by themselves.² For larger wounds, closure of the oral mucosa should be done with monofilament 5-0 absorbable suture, which should be followed by copious irrigation of the external wound to remove debris and bacteria that otherwise

would contaminate the wound. The external cheek can then be closed with 6-0 monofilament sutures. Large external lacerations, complex bite wounds, or lacerations running perpendicular to the lines of tension should be considered for referral. Care for bite wounds to the cheek follows the same principle as for cheek lacerations of any etiology in regard to irrigation and prep for closure. Although prospective data are lacking, general consensus suggests that bite wounds to the cheek are appropriately managed with primary closure within 24 hours of injury, provided there are no signs of acute infection. As discussed previously, empiric antibiotics are generally not necessary but should be considered for deep tissue injuries, bites from cats and dogs or potentially rabid vermin, or for patients who are immunocompromised.

After care and follow up. Patients with cheek lacerations should be instructed to cleanse their wounds daily with soap and water. In most cases, prophylactic antibiotics are not necessary, but if required, coverage should be based on the type of bacteria that are most common in each situation (e.g., *Pasteurella multocida* in dog/cat bites; *Staphylococcus aureus* in human bites).

Ear Laceration

Ear lacerations usually are a result of blunt trauma to the head. Therefore, the most important initial consideration is assessment of potential for serious brain injury by checking the patient for altered level of consciousness, impaired breathing, or signs of basilar skull fractures. Deficits in cranial nerves VI, VII, and VIII in the setting of blunt head trauma are red flags for basilar skull fracture and should be referred urgently. Once these signs have been ruled out, specific evaluation begins with a focus on the location of the laceration, amount of cartilage involved, and depth of injury. Basilar and middle ear trauma should also be assessed via otoscope and considered in patients who exhibit nystagmus, retro-auricular bruising or hematoma (Battle sign), hemotympanum, otorrhea (both clear or bloody) or ataxia.

Contraindications to ear laceration repairs include evidence of basilar skull fractures, infection, total auricular avulsion, extension of a laceration into the auditory canal or hearing loss caused by the injury. In these situations, the patient should be immediately referred to an otolaryngologist, surgeon, or to the emergency department if basilar fractures are suspected.

Wound closure preparation and technique. For ear lacerations, the preferred anesthesia is local infiltration of lidocaine without epinephrine because epinephrine can cause vasoconstriction and disruption of the blood sup-

Celebrate the Urgent Care Industry

The Urgent Care Association of America (UCAOA) invites you to recognize achievements and contributions made to urgent care! Nominate yourself or a colleague for the UCAOA Awards to be presented at the Members' Breakfast during the **2015 Spring Convention, April 27-30**.

Awards Categories

- **Outstanding Achievement Award:** The highest honor given by UCAOA, this award recognizes significant achievements in the field of urgent care medicine.
- **Lifetime Membership Award:** Recognizes an individual member's significant contributions to the Urgent Care Association of America.
- **Advocacy Award:** Honors individuals, organizations or companies for impactful advocacy efforts benefitting patients or the industry on a state or national level.
- **Community Service:** Recognizes an individual or organization for significant volunteer initiatives that result in a positive impact on community health.
- **Humanitarian:** Recognizes an individual or organization for substantial medical-related volunteer outreach on a national or international level.

Submit your nominations at ucaoa.org/AwardNominations by 5pm Central on February 16, 2015.

If you have questions about the submission process please contact **Ross Reed**, Marketing Communications Specialist, at rreed@ucaoa.org or call **331-472-3746**.



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Figure 2. Auricular hematoma

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ply can damage the cartilage. A regional block is preferable for extensive lacerations.

To administer a regional block, enter at a point just below the ear. Move posteriorly and inject 5 mL of lidocaine (0.7 mL/kg) as the needle is being withdrawn. Without removing the needle, redirect the needle anteriorly (in a vertical V shape) and inject another 5 mL. Next, insert the needle at a point just above the ear and repeat the previous steps to anesthetize an area in an inverted V shape (**Figure 1**).

Wound closure preparation and technique. Once anesthesia for an ear laceration has been achieved, irrigate the wound with normal saline without unintentionally debriding tissue needed to close the laceration. Suture choice should be dependent on the tissue being closed. For skin closure, 5-0 or 6-0 non-absorbable sutures should be used in single interrupted fashion. Split earlobes, one of the most common ear lacerations seen in the urgent care setting, require both subcutaneous closure with absorbable suture and skin closure with non-absorbable single interrupted sutures.

Complex lacerations, which expose or extend through the cartilage, should be carefully repaired with attention paid to properly approximating the cartilage and ensuring that the cartilage is covered by skin to prevent deformities. Because the skin overlying the cartilage is thin, the sutures should incorporate the two layers. Sutures should never be buried in the cartilage. All subcutaneous stitches should be buried in the perichondrium using 5-0 absorbable suture and with special care to gently approximate the cartilage without damaging or tearing this fragile tissue.

Debridement of cartilage is also not recommended unless the laceration involves infection or the edges are severely deformed or jagged. In those situations, debridement should be kept to a minimum to prevent notching and preserve cosmesis.

After care and follow up. Tetanus prophylaxis should be provided as indicated.

Antibiotics are not required for most ear lacerations. The exceptions are for lacerations caused by a human or animal bite, those in which contamination is obvious or suspected, or lacerations in patients who are immunodeficient or who have poor vascularity. Patients treated for ear lacerations should be counseled on signs of infection and told to gently clean their wounds once a day but with strict water precautions. They should be instructed to return for re-evaluation in 24 to 48 hours and non-absorbable sutures should be removed in 7 to 10 days.

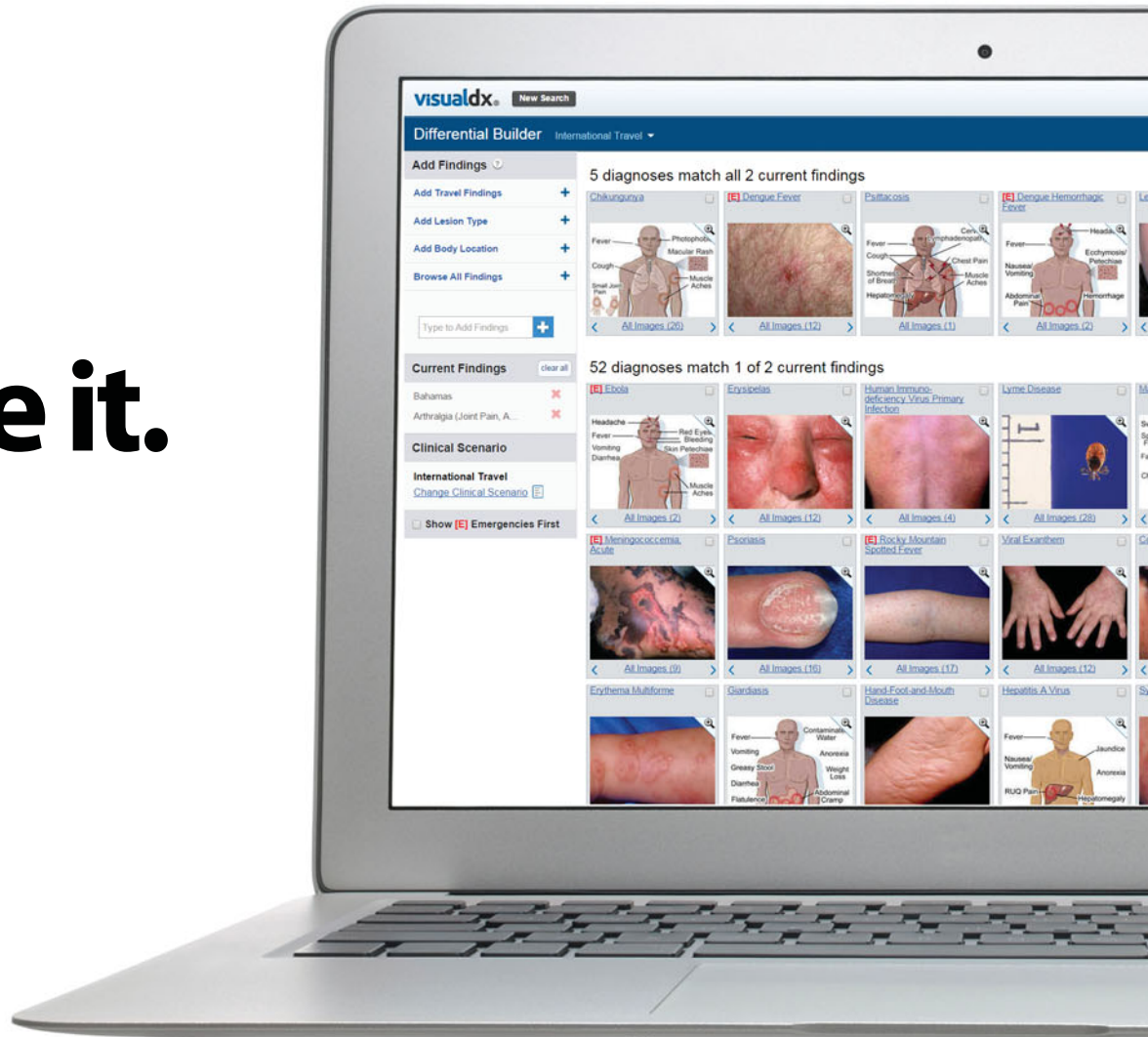
Prevention and management of auricular hematoma. Auricular hematomas tend to occur from blunt force trauma and are usually seen in athletes such as wrestlers and football players who present for urgent care with injuries sustained during a match (**Figure 2**).

With auricular hematomas, pressure caused by accumulation of blood within the space between the cartilage and perichondrium deprives the cartilage of its blood supply, leading to necrosis. If the blood is not properly drained, the consequence is deformity of the cartilage, otherwise known as cauliflower ear.

Depending on an urgent care provider's comfort level, needle aspiration can be used to drain auricular hematomas less than 2 cm that have been present less than 48 hours. However, patients who present with hematomas that occurred more than 7 days previously should be referred to an otolaryngologist for treatment.²

Pressure dressings tend to be the most effective way to prevent auricular hematomas in patients with ear lacerations. To apply a pressure dressing, first provide support for the ear by creating a "bed" from 4x4 sponges cut in the contoured shape of the ear. Then fill the space

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Figure 3. Septal hematoma

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within the helix with petrolatum gauze and mold it over the antitragus, antihelix, and external canal. Place gauze sponges over the whole ear, followed by a 3- or 4-inch gauze bandage wrapped around the head for compression. This can be further tightened by applying gauze tie anterior to the ear.³

Management of perichondritis and chondritis. Infection and inflammation of the perichondrium (perichondritis) and auricular cartilage (chondritis), respectively, are other complications of ear laceration. These conditions are easily diagnosed based on symptoms including redness, warmth, and fluctuance. Prompt drainage is required for treatment of perichondritis and chondritis to prevent permanent deformity of the cartilage and, subsequently, the ear. In most of the cases, the bacteria responsible is *pseudomonas* and antibiotic treatment with fluoroquinolones or penicillin is required.

Nose Laceration

The nose is composed of both bony and cartilaginous components and injuries to it are common and often seen as a result of physical assaults and unintentional sports-related traumas. Taking a proper patient history is important in patients with nose lacerations because the mode of injury is a vital detail suggestive of other systems that should be assessed. For example, significant blunt force trauma, as with an assault by a baseball bat, require an extensive ocular, neurologic, and dental examination, along with evaluation for more significant facial bone injuries.

Examination of the patient with a nose laceration should include both internal and external inspection, with concentration on possible obstruction and breath-

ing difficulties. Signs of basilar fracture, which requires immediate neurosurgical consultation, include the emission of clear fluid from the nares, hemotympanum, "raccoon eyes" sign, or "Battle's sign" (ecchymosis around mastoid). Delayed closure and prompt consultation are required for displaced fractures of the nasal bone associated with laceration (open fracture).

Management of septal hematomas. As with auricular hematomas, septal hematomas can occur in patients with nasal lacerations. Appearing as a dark blue or purple tender mass at the septum, a septal hematoma increases the risk of cartilage damage and subsequent deformity and it may signal the presence of a basilar fracture (**Figure 3**). The appropriate treatment is drainage and examination of fluid, followed by pressure packing with a nasal tampon. Keep in mind that because all tampon insertions increase the risk of toxic shock syndrome, empirical antibiotics (preferably amoxicillin/clavulanic acid) should be given. For small hematomas, drainage and close monitoring may be sufficient.

Wound closure preparation and technique. When anesthetizing the nose, direct infiltration with lidocaine without epinephrine is usually sufficient. If a nasal block is even a consideration, the appropriateness of the case for urgent care should be re-evaluated.

After proper anesthesia is achieved, irrigation should be done with normal saline with or without povidone-iodine. Debridement should be kept to the utmost minimum, as nasal tissue is not elastic and heals poorly from any deformation. Skin tags or flaps can be tacked down with interrupted sutures or steri-strips.² Non-absorbable 6-0 sutures should be used, taken in small shallow bites, as nasal tissue tends to invert and cannot hold tension. Sutures with high tension should be removed and replaced with deep absorbable 5-0/6-0 sutures first before superficial ones are placed. Nasal lacerations usually involve multiple layers (i.e., skin, mucosa, and cartilage). Closing the skin and mucosa with the closest approximation as possible is important to prevent notching and deformity. Suturing cartilage is unnecessary because its coverage by skin and mucosa ensures healing.² However, if the cartilage cannot be completely covered, the risk of chondritis and deformity is increased and referral to an otolaryngologist or to a plastic surgeon is recommended.

After care and follow up. Patients with nasal lacerations may be self-conscious about the appearance of their wound but dressings generally are not required. For superficial wounds, empirical antibiotics are usually unnecessary because the nose's high vascularity protects against infections.

Lip Laceration

Etiologies of lip laceration are many, ranging from assault to falls. Because the lip is rich in vascularity, lacerations tend to bleed profusely and they are a very common presentation in the urgent care setting.

Indications for repair of lip laceration include a wound larger than 0.25 cm and/or one that gapes at rest.⁴ Macerated wounds, associated facial bone fracture, suspected injury to the orbicularis muscle, large areas of missing lip tissue or wounds left unrepaired for more than 12 hours all necessitate management by a plastic surgeon.⁴

In patients whose lacerations can be repaired, perform a complete exploration for foreign bodies and a dental check for missing or broken teeth. If there are any teeth missing, a facial x-ray should be considered to rule out embedment.

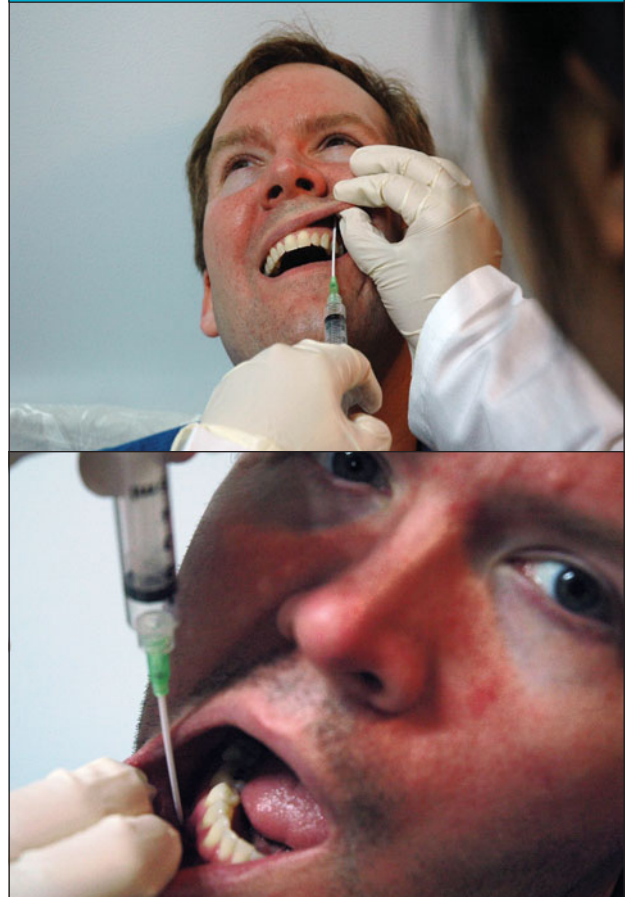
Wound closure, preparation and technique. Because direct infiltration of anesthetics into the lip can distort the tissue, regional blocks should be used for anesthesia in lip laceration (**Figure 4**). An infraorbital block (deposition of anesthesia into the anterior margin of the maxillary canine) can be used for lacerations that involve the upper lip. For injury of the lower lip, a mental block (with lower lip retraction, inject inferior to the second bicuspid in the gingival-buccal margin) can be used. The anesthetic of choice is plain lidocaine but for external lacerations with profuse bleeding, epinephrine can be added to gain hemodynamic control. Once complete anesthesia is achieved, irrigation with saline should follow.

If there are skin flaps present, care should be taken not to mistakenly debride tissue. For the repair, non-absorbable sutures (preferably 4-0 or 5-0) generally can be used. However, for a lacerations that extend to deep muscle, closure of each layer individually is required and buried absorbable sutures should be used for the muscle and inner mucosa (**Figure 5**).

Special considerations: Frenulum, Vermillion borders, philtrum. The vermillion border is an important anatomical structure and a distortion in it of as little as 1 mm can create a “step off” that is visible to the naked eye.² Because of this, the vermillion border should be approximated first and repaired before any other part of the lip is closed. Suturing of the vermillion border should be done with 6-0 non-absorbable materials and, if the laceration extends into the oral mucosa, 5-0 absorbable sutures can be used. Not all lip and oral lacerations need repair; lacerations and avulsions of the frenulum, for example, tend to heal on their own and need no further management.

The philtrum is another location of anatomic importance. This cosmetically sensitive area represents the

Figure 4. Regional anesthesia for the lip



Photos courtesy of Michael Jaskewicz

vertical cleft between the nose and upper lip. Patients who have lacerations in this area should be referred to a plastic surgeon because any distortion in the tissue can cause significant cosmetic disproportion.

After care and follow up. Oral antibiotics (usually penicillins) are required following closure of a lip laceration that extends into the deep mucosa. Patients who have superficial lacerations should be counseled to follow a regular cleansing protocol and advised on warning signs of infection. A follow-up visit should be scheduled in 24 to 48 hours.

Tongue Laceration

The tongue is important to both digestion and speech. Proper repair of a tongue laceration is imperative to preserve speech, ensure the function of swallowing, and prevent infection. Many tongue lacerations do not require repair but it is important to recognize those that

“Repair of tongue lacerations should be performed with absorbable sutures. Chromic gut 4-0 or 5-0 is preferable because it is less sharp than other materials, such as nylon.”

do. Indications for repair of tongue laceration include large (>1 cm) gaping wounds with edges that don't approximate when at rest, involvement of muscle, uncontrolled profuse bleeding, or “through and through” injuries.

Wound closure preparation and repair technique. Patients with tongue lacerations should be examined for debris and tooth fragments, especially if they have broken or missing teeth. Following examination, irrigation with normal saline should be done, with debridement of any noticeable necrotic tissue.

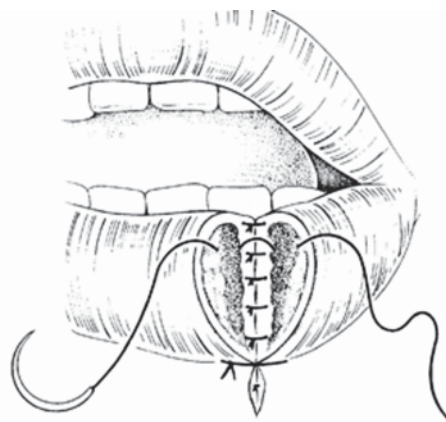
Lidocaine is the anesthetic of choice for tongue repair. Topical application of a gauze soaked with lidocaine 4% is appropriate, as is local infiltration with lidocaine 1% with or without epinephrine. For larger lacerations, a lingual block may be necessary.

Suturing of the tongue or any part of the oral cavity can be quite difficult, requiring a patient's mouth to be held in an unnatural and, therefore, uncomfortable position. To facilitate optimal positioning and ease for both patient and physician, mouth gags and bite blocks can be used to keep the mouth open. To keep the tongue protruding, gauze sponges can be used. With the tongue fully anesthetized, a single suture also can be passed through the tongue and held in extension.

Repair of tongue lacerations should be performed with absorbable sutures. Chromic gut 4-0 or 5-0 is preferable because it is less sharp than other materials, such as nylon. To prevent the knots from being untied by the natural movements of the tongue, sutures should be placed in square knot “bites” that are wide and deep enough to close all layers with a single stitch.

Antibiotics are indicated for patients with heavily contaminated tongue lacerations for which debridement is suboptimal, when debridement is delayed for more than 24 hours, for wounds associated with jaw fractures and that require open reduction, in immunocompromised patients, and for wounds caused by human or animal bites.⁵ Clindamycin or penicillin is an optimal antibiotic because it covers both the anaerobic

Figure 5. Repair of lip laceration



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and Gram-positive bacteria of the oral cavity.

After care and follow up. On discharge, patients with tongue lacerations should be instructed to gently swish and spit with mouthwash and avoid eating or drinking until anesthesia has worn off and their sensation has returned. They should be counseled to eat a soft diet to ensure healing and to suck on ice chips or apply anything cold to help prevent swelling.

Conclusion

Facial lacerations can create a significant amount of anxiety for patients and clinicians alike. Good cosmesis and healing depend on an understanding of facial anatomy and the principles of repair. The evaluation and treatment of these injuries in the urgent care setting is appropriate in most circumstances, and the techniques used for repair are not new to the urgent care clinician. This two-part series explored the indications and procedures for urgent care management as well as reasons for referral to specialty care. With this clinical review, the clinician should be able to more confidently evaluate facial injuries and better determine the optimal clinical management and disposition. ■

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Practice Management

The Sword and the Shield: Best Hiring Practices for Urgent Care Facilities

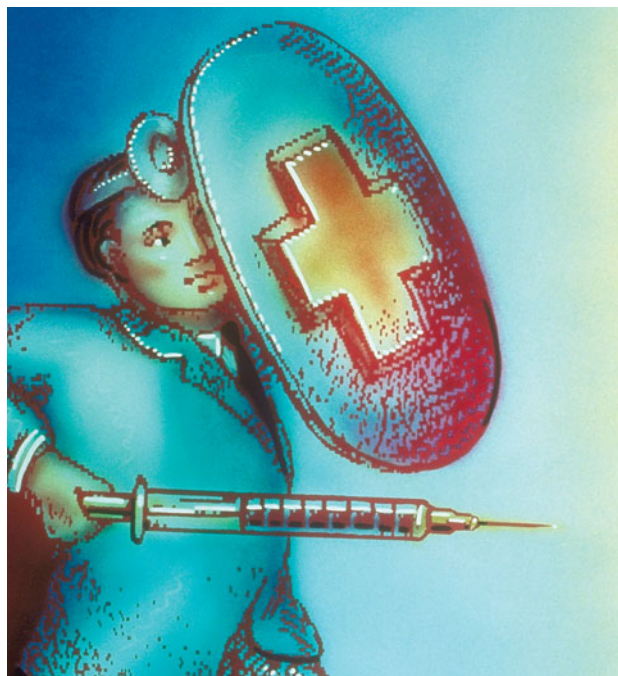
Urgent message: It is imperative that urgent care centers utilize the various tools at their disposal to recruit the best candidates, while implementing best practices that mitigate the potential for lawsuits.

DAMARIS L. MEDINA, ESQ.

Urgent care is one of the fastest growing segments of American health care. Historically, many urgent care facilities were considered small businesses because they employed fewer than 15 people, making them exempt from certain hiring discrimination claims under The Federal Civil Rights Act of 1964 (usually referred to as Title VII) because compliance with these laws was thought to be too burdensome. However, the need for immediate access to medical care has fueled growth, prompting many urgent care centers to outgrow their small business, “mom and pop” status. As a result, they must take into account a whole host of factors when making their hiring decisions.

Many urgent care centers, for instance, have developed a thorough application process to ensure the hiring of good employees, not realizing that as they grow beyond a staff of 15, there are legal restrictions on the types of information they can request. Employment lawsuits based on discriminatory hiring, therefore, have been on the rise. It is important for urgent care centers to understand the potential risks, the relevant law, and to adapt their hiring practices to avoid what could be construed by a job candidate as discrimination.

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Title VII

Title VII prohibits discrimination in the workplace. Under Title VII, an employer is prohibited from intentionally using race, color, gender, religion or national origin as a basis for its hiring decisions. A myriad of federal anti-discrimination laws have subsequently been

enacted to include additional protected classes of people, including:

- Age (Age Discrimination Act of 1967)
- Sex (Equal Pay Act of 1963)
- Pregnancy (Pregnancy Discrimination Act)
- Citizenship (Immigration Reform and Control Act)
- Familial Status (Title VIII of the Civil Rights Act of 1968)
- Disability Status (Vocational Rehabilitation and Other Rehabilitation Services of 1973 and Americans with Disabilities Act of 1990)
- Veteran Status (Vietnam Era Veterans' Readjustment Assistance Act of 1974 and Uniformed Services Employment and Reemployment Rights Act)
- Genetic Information (Genetic Information Nondiscrimination Act)

Many states have enacted laws that increase the scope for discrimination lawsuits. For example, in California, it is illegal to discriminate against a potential hire based on sexual orientation. Other states are quickly following suit.

Growing urgent care centers need to make optimum hiring decisions that will help their practice run smoothly and avoid potential issues with "problem employees." It may sound obvious, but the best way to deal with problem employees is to ensure that you steer clear of them when hiring. The following are some best practices that urgent care facilities can implement to ensure hiring compliance while avoiding hiring mistakes.

- **Use Job Applications and Background Checks.** Job applications are typically an employer's first significant written communication from a prospective employee. Effective applications ask for detailed job and education history, references, and the employee's written promise that everything in the application is accurate. Employers can use this information to look for gaps in work history, evaluate questionable career moves, and contact former employers. When used in conjunction with a background check, discrepancies between the check and the application, such as residential addresses compared to job locations, may surface. In addition, if the employee later sues, the employer can use application fraud as an argument to reduce damages. Employers must ensure that all applications and background checks comply with applicable federal and state law.
- **Establish At-Will Employment.** Employees often attempt to claim that their termination was without "good cause," and therefore, the employer is liable

for breach of contract. Employees will sometimes try to create contracts for good cause termination by pointing to promises of continued employment, progressive discipline policies, or historical treatment of employees at the company. Employers can counter such claims by having employees acknowledge, in writing, that their employment is "at will": that the employer or the employee can terminate the employment relationship at any time or for any (lawful) reason. While it is always good for employers to document performance problems and reasons for termination, at-will employment status makes terminations easier to justify, by eliminating any "good cause" requirement.

- **Screen with Confidence.** Urgent care centers can quickly eliminate unqualified candidates by using employment tests. Personality exams, credit checks, background checks, drug tests, and medical examinations are all popular modes of screening a potential hire. Employees will frequently allege that the tests are inherently discriminatory, and have a disproportionate impact on a protected class. In order to counter these allegations, an employer must be able to demonstrate that the test is job-related and consistent with business necessity. However, an employee can prevail by showing that a less discriminatory alternative is available. These standards make it difficult for employers to strike a balance between administering effective tests and being sued for discrimination.

EEOC Guidelines for Employment Testing

The Equal Employment Opportunity Commission (EEOC) has established its own set of guidelines regarding employment tests, and urgent care centers would be wise to review them.¹ They are as follows:

- Administer tests without regard to protected characteristics, to make sure they are anti-discriminatory in nature.
- The tests must be properly validated for the positions and the purposes for which they are used, i.e., job-related.
- Consider alternatives if the test results have a propensity to detrimentally impact a protected group.
- Train managers to fully understand the testing and the proper way to administer the tests.
- Technology is constantly evolving and changing the way jobs are performed, so keep tests current in order to keep up with job requirements.

- Tests should be specifically tailored to the skill set for a particular position.
- Employers should conduct an independent review when purchasing pre-made tests, in order to ensure that they are free of bias.
- Track the effects of tests on particular applicant groups, and even consider hiring consultants to have selection procedures professionally validated.
- At least annually, review the tests to determine whether they are achieving their stated purpose, and make the necessary adjustments.

Understanding and Conveying the Position

It is fundamental that urgent care facilities have a firm grasp of the positions for which they are hiring, and detail responsibilities in an extensive written job description complete with a requirements section and additional information (travel, work hours). This will go a long way in providing prospective candidates with helpful criteria, and weeding out unqualified candidates. Look closely at cover letters and resumes, examining all information including substantive work experience, writing style, spelling and grammar. Does the candidate pay close attention to detail? Poor appearance, vague phrasing, and typographical errors will quite often provide tremendous insight into the approach the person will take toward his or her work. Also, use a critical eye when examining gaps in work history and make sure that listed jobs follow a logical career trajectory. However, do not discount people with varied backgrounds and experiences. Many people take time off to raise families, travel, and follow their passions. Therefore, being too formal and rigid on this issue can be a mistake.

Applications

When using applications, urgent care centers should ask questions designed to elicit skills and qualifications that will pertain to the position. Use closed questions—concise requests for specific information that begin the conversation and summarize progress. Open-ended questions, on the other hand, are better suited for the interview process because they tend to draw out opinions and feelings that hand control of the conversation over to the applicant.

Always ask specific questions regarding mandatory job criteria, in order to knock candidates lacking in experience or skills out of the running. However, make sure to ask questions that do not violate the law. It is a best practice to include a statement that the application

should in no way be construed as an employment contract and to list that you are an Equal Opportunity Employer. In addition, avoid phrasing that could lead to discrimination allegations, such as “looking for a young and energetic team member.” Both young and energetic could possibly be construed as ageist and may therefore lead to a lawsuit.

The Interview Process

An initial phone interview is a great screening tool urgent care facilities can utilize when considering potential hires. Further, as the candidate gets a better sense of the position, he or she might decide the job is no longer a good fit. Once you decide to bring the person onsite, do your homework to adequately prepare. It is important to remember that eliciting specific information is imperative so you can review it later when stacking up your top picks.

Never ask a question about a particular characteristic that the law does not allow you to consider when evaluating a candidate. If an interviewee opens the door to national origin or disability, you will want to tread lightly and try to steer the conversation in a different direction. In addition, always respect the candidate's privacy and never ask about sensitive topics like religion or sex.

The following are topics to keep *off* applications and avoid in interviews to ward off potential discrimination lawsuits:

- How old are you? (However, it is permissible to ask if the potential hire is 18 or older.)
- What is your race?
- What is your gender?
- What is your sexual orientation?
- What religion do you belong to?
- What country are you from? (You *are* permitted to ask if someone is legally authorized to work in the United States.)
- Are you married? (If you know the person is married, it is fine to inquire about the candidate's spouse's job, but do not pry.)
- Are you disabled? (It is okay to ask if someone is able to perform the job functions, as clearly defined in the job description. However, inquiring about medical/psychiatric problems is prohibited behavior under the law.)
- Excessive assurance about job security.

Social Media

In these days of cyberspace, it is not uncommon for employers to do some investigative work on potential hires

by perusing Facebook, LinkedIn or Twitter. However, requiring that someone provide you with his or her password(s) to these websites has been a hot topic lately, and generally viewed as a violation of a candidate's privacy rights. Maryland, California, Illinois, and Michigan have all passed laws banning this behavior. Further, the federal government is looking into whether these practices violate federal discrimination and privacy laws.

Candidate Investigations

As already touched upon with screening tests and social media, it is important to look into the pasts of your top candidates. This is critical from a legal perspective and can save you from litigation down the road. A perfect example would be an urgent care center hiring an employee who had a violent criminal history. If this individual winds up attacking a co-worker, inflicting serious injuries, the injured employee may have recourse to sue for negligent hiring. In addition, if a current employee exhibits problematic behavior at the facility, you may be sued for negligent retention and face serious liability if you act carelessly in your treatment of the matter.

References and Background Checks

References are a great way to get more information about a candidate, and it is a good idea to have potential hires sign a release that gives former employers permission to talk to you. Keep questions relevant to the job, and the same rules apply regarding questions that violate the law.

Again, you will want to have candidate consent in writing to do a background check. Explain the kind of information you are hoping to acquire—this will allow people to take themselves out of the running if they believe the background check will reveal problematic findings. Under the Fair Credit Reporting Act (FCRA), it is mandatory for employers to obtain written consent before pulling and reviewing a person's credit report, and some states have additional laws surrounding these reports as well. If you decide not to hire someone based on information in the report, you are required to provide the candidate a copy of the report and explain to them that they have the right to challenge the report under the FCRA. However, it is illegal to take someone's bankruptcy history into account when making hiring decisions. If you use a third party to conduct your background check, as is often the case, you must first obtain consent from the applicant. Lastly, be aware that it is illegal to refuse to hire someone for having collected unemployment or Workers' Compensation in the past.

Criminal Background Checks

In 2013, the Equal Employment Opportunity Commission (EEOC) issued an updated enforcement guidance regarding employers' ability to consider criminal records when making hiring decisions. The EEOC's previous guidance was issued over two decades ago, when conducting criminal background checks was more difficult. The new guidance, according to the EEOC, is necessary for the electronic age.

According to the EEOC, a company that rejects all candidates with criminal records could be discriminating against certain minority groups, as some statistics suggest that these minority groups are convicted of some crimes at a rate higher than their percentage of the overall population. The EEOC believes that such a blanket ban could result in unlawful discrimination under the "disparate impact" theory of discrimination recognized by courts under federal and state anti-discrimination law.

Best practices for conducting criminal background checks include:

- Eliminate policies or practices that exclude people from employment based on any criminal record;
- Develop a narrowly-tailored written policy and procedure for screening applicants and employees for criminal conduct;
- Determine the specific offenses that may demonstrate unfitness for performing such jobs;
- Identify the criminal offenses based on all available evidence;
- Determine the duration of exclusions for criminal conduct based on all available evidence;
- Include an individualized assessment;
- Record the justification for the policy and procedures;
- Note and keep a record of consultations and research considered in crafting the policy and procedures; and
- Train managers, hiring officials, and decision makers on how to implement the policy and procedures consistent with anti-discrimination law.

When asking questions about criminal records, limit inquiries to records for which exclusion would be job related for the position in question and consistent with business necessity and keep information about applicants' and employees' criminal records confidential. Only use it for the purpose for which it was intended. ■

Reference

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Case Report

Periostitis in secondary syphilis

Urgent message: Be on the lookout for periostitis in patients with syphilis who present with extremity pain.

MAY MOHTY, MD, FAAP, FAAUCM, and CASEY PHILIPSBORN, MSIV

Introduction

Syphilis (from the Greek word Syphlos, meaning crippled) is an infectious disease caused by the spirochete species *Treponema pallidum*. Patients can present with manifestations of any of the three stages of syphilis, ranging from a painless ulcer to an asymptomatic rash, to general paresis and dementia, among a myriad of other clinical findings. Secondary syphilis can present with a diverse range of symptoms including fever, malaise, headache, and rash. Uveitis, periostitis and osteomyelitis are less common.

Although syphilis was a rare finding at the turn of the 21st century, in the past 8 years, syphilis rates have almost doubled in the United States, particularly in men.¹ This highlights the need for physicians to recognize the variety of signs and symptoms of syphilis in the outpatient setting so that it can be diagnosed and treated in a timely manner. This case emphasizes the importance of a thorough history and physical as well as the pursuit of additional laboratory and imaging studies.

Case Presentation

A 62-year-old white male was referred to an urgent care center by his primary care physician for “fatigue and dizziness.” The patient noted these symptoms had been progressively worsening for 2 months, during which time he said he had been hospitalized twice for “severe diarrhea and dehydration.” The patient reported weight



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loss of 60 lb over the preceding 6 months. Review of systems was positive for shortness of breath on exertion, a rash and significant pain in his shins and ankles. At that time, the patient was on furosemide, spironolactone, sildenafil, carvedilol, aspirin, clopidogrel, and simvastatin. He reported no history of smoking, admitted to drinking socially, and denied illicit drug use. The patient is in a homosexual relationship and stated that he was tested for sexually transmitted diseases, including HIV, and all results were negative.

Physical Exam

On initial presentation, vital signs were:

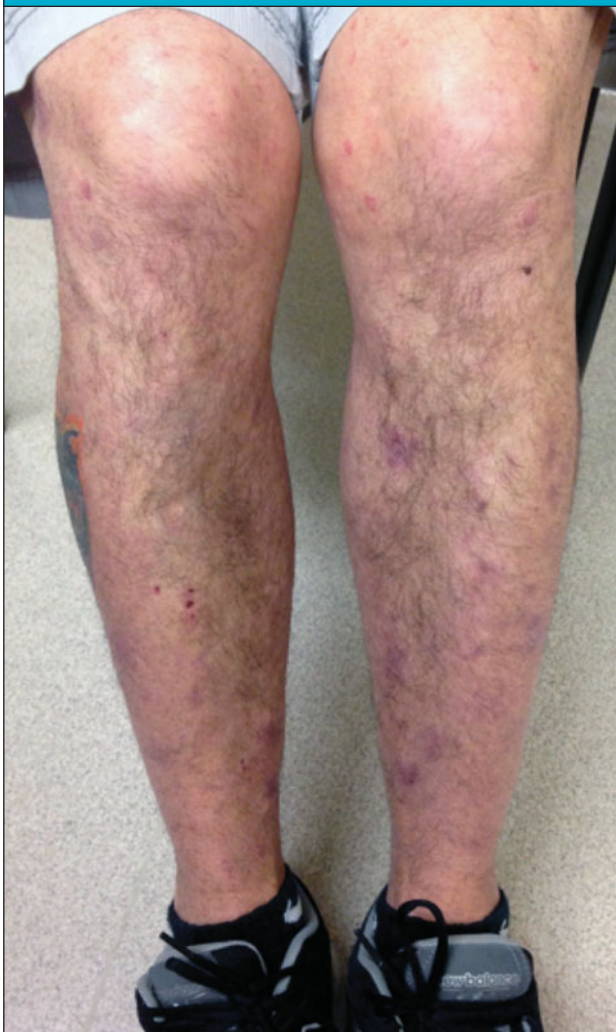
- BP: 105/73

May Mohty, MD, FAAP, FAAUCM, is a clinical assistant professor at University of Arizona College of Medicine and Urgent Care physician at CIGNA Healthcare of Arizona. Casey Philipsborn is a fourth year medical student and Osteopathic Manipulative Medicine Scholar at Arizona College of Osteopathic Medicine.

Figure 1. Maculopapular rash involving palm of hand.

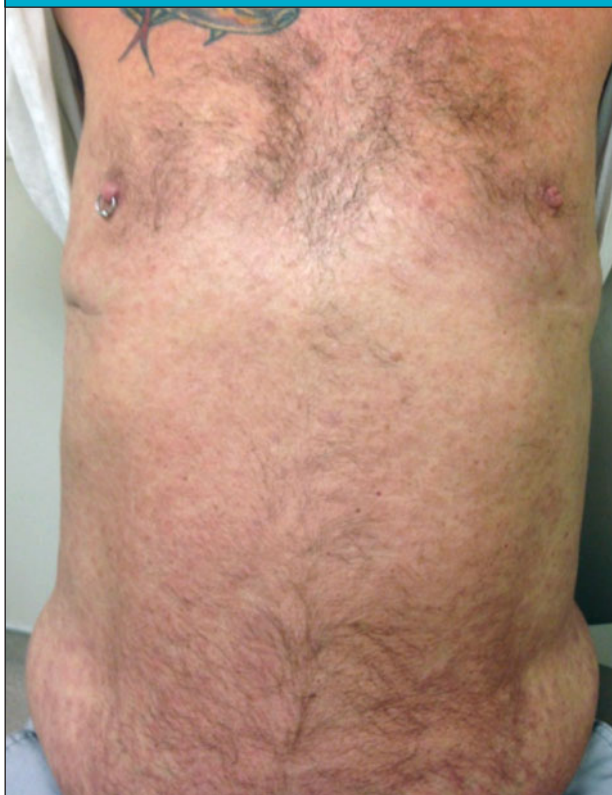


Figure 2. Rash involving shins bilaterally



- Pulse: 91
- Respiratory Rate: 20

Figure 3. Diffuse maculopapular rash over entire trunk



- Temperature: 97.9°F
- SpO₂: 98%

The patient's physical exam was significant for a single non-bleeding ulceration of the lower left buccal mucosa and an extensive maculopapular rash over the entirety of his trunk, back, arms, legs, and palms bilaterally (**Figures 1-3**). There was significant tenderness to light palpation of bilateral shins and ankles. Orthostatic vitals were negative and there were no cardiopulmonary findings on examination. The rash, particularly being present on the palms of the hands, and significant bone pain warranted further investigation.

Labs/Imaging

- CBC
- BMP
- RPR
- IgM and IgG Coccidioides antibodies
- EKG
- Right and left tibia-fibula x-rays

“With the reemergence of syphilis over the past decade, it is critical that health care providers are cognizant of the invariable versatile symptomatology and presentation of syphilis and its various stages.”

The patient's chief complaint of dizziness in light of a cardiac history warranted an electrocardiogram, which was read as sinus rhythm. The CBC and BMP, reported in **Table 1**, did not demonstrate significant aberrancies, except for slightly low sodium at 132. Both lower-extremity x-rays were read by the radiologist as normal, with no abnormalities in the bony structures, soft tissues, or articulations. At this point in time, the patient was discharged home on lower doses of antihypertensive medications. Spironolactone was discontinued. The patient was informed that results of send-out tests would be reported to him via phone and was instructed to follow up within the week with his primary care physician.

The laboratory results of coccidioides antibodies were negative. RPR titer resulted positive (1:1024) and FTA-Abs were positive as well. The patient was notified of the results and instructed to return to the urgent care center for treatment with penicillin G benzathine. Given continued, severe shin pain, the patient was also sent for a bone scan to rule out spirochete bone involvement.

The decision was made to treat the patient with a daily dose of penicillin G benzathine, 2.4 million units, until bone scan results returned. Seven days after initial presentation and 3 days after diagnosis, a three-phase bone scan was performed after intravenous administration of Tc-99mMDP. The bone scan results were significant for mild, diffuse increase in tracer activity involving the lower extremities from the knees to the feet, indicative of mild periostitis (**Figure 4**).

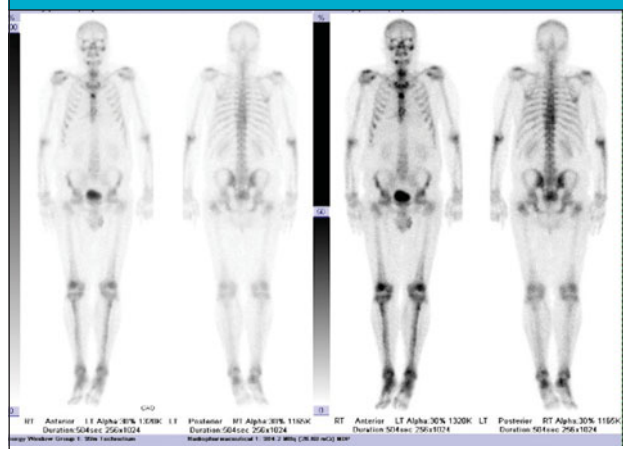
The patient continued treatment with daily penicillin G benzathine for a total of 10 doses. By day 5 of treatment, the pain in the patient's legs began to improve and, by day 10 of treatment, the pain was minimal.

It should be noted that in a subsequent visit with his primary care physician, the patient discussed a recent potential exposure to syphilis. HIV tests were repeated and found to be reactive both with ELISA screening and Western Blot results. The patient was referred to an

Table 1. Laboratory Test Results

Item Name	Value
Sodium	132
Potassium	4.3
Chloride	98
CO ₂	25
BUN	23
Creatinine	1.0
Glucose	89

Figure 4. Increased tracer uptake seen in the lower extremity



infectious disease specialist for treatment of HIV.

Diagnosis

Secondary syphilis with bilateral tibial periostitis.

Discussion

With the reemergence of syphilis over the past decade, it is critical that health care providers are cognizant of the invariable versatile symptomatology and presentation of syphilis and its various stages. Diagnosis of early syphilis, including primary, secondary, and early latent syphilis, is key so that treatment can be initiated, thereby preventing further progression to tertiary syphilis and neurologic involvement of the disease. Furthermore, because syphilis facilitates the transmission of HIV, it is very important to diagnose and treat it in a timely manner to decrease HIV transmission.

Epidemiology

The number of syphilis cases peaked in the United States

in the late 1980s and early 1990s. Following that, the nation reached an all-time low number of cases, prompting the Centers for Disease Control and Prevention (CDC) to discuss eradicating the disease, ultimately having fewer than 1,000 cases of the disease in the country by 2005.² Unfortunately, since that time, the number of cases per 100,000 has significantly increased, particularly in men. The majority of cases in the United States occur in men who have sex with men (MSM) and these account for 65% of the cases. Up to 60% of such patients are also coinfecting with HIV.³ That said, in the 21st century, the number of cases of syphilis in heterosexual patients has also risen.⁴ There is a recent increase in this diagnosis among women and infants. From ages 20 to 24, incidence of syphilis infection is much higher in black men, followed by Hispanic men, in comparison to white males of the same age group.^{1,3} Across the United States, the western regions have the highest rate of syphilis, totaling 6.5 cases/100,000 in 2013.¹

Clinical Presentation

Syphilis is classically referred to as the “great imitator” of diseases.³ Infection with *T pallidum* is a multi-phasic disease, occurring in progressive stages if left untreated. Transmission of the spirochete infection occurs via direct contact with active lesions, often during intercourse. The initial stage of infection often presents within 3 weeks of exposure as a painless ulcer at the site of inoculation, usually on the genitalia or other mucosal surface. If left untreated, 4 to 8 weeks after initial infection, the disease will progress into secondary syphilis, which can present in a protean fashion.⁵ Patients may present with systemic complaints of fatigue, malaise, fever or weight loss. They may also experience pruritus, sore throats or headaches.⁶ On physical exam, nearly all patients with secondary syphilis will have dermatologic findings, although up to 25% may be unaware of any rash (source). The morphologic features of cutaneous lesions of secondary syphilis also greatly vary. They are often symmetric, macular, papular, follicular, or pustular, covering large portions of the trunk and extremities, including the palms and soles.⁷ Mucosal ulcerations are often common, and can be present in both primary and secondary syphilis, with overlap occurring more often in HIV-infected patients.⁸ Bone

“From ages 20 to 24, incidence of syphilis infection is much higher in black men, followed by Hispanic men, in comparison to white males of the same age group.”

and joint pain is a recognized finding in congenital syphilis (known as saber shins), but it is a far less common finding in acquired disease.⁹ Bone involvement often occurs in the long bones and can also be found in the skull.⁹ Patients present with pain over the bony regions. Plain radiographs are often found to be

negative, but bone scintigraphy demonstrates increased uptake in areas of disease involvement.⁹

Treatment

The standard treatment for primary syphilis is well documented, studied, and clinically proven to be a single intramuscular dose of penicillin G benzathine, 2.4 million units given intramuscularly. While there are case studies that suggest treatment should be extended (ranging from 2 to 10 days) for bone involvement, there are no extended studies validating these efforts.^{3,5-8} The CDC recommendation for treatment of tertiary syphilis is daily doses of penicillin G benzathine for 3 weeks.¹⁰ Patients coinfecting with HIV should be treated according to staging of syphilis and given a one-time dose for early stages and 3 weeks of treatment for later stages of disease.¹⁰ Improvement in bone pain has been reported within weeks and resolution of bone scan abnormalities is achieved within 3 to 4 months.^{3,11} In this case, the patient reported improvement in bone pain after 1 week of daily treatment. Follow-up repeat bone scan has not been done yet and will be left to the discretion of the patient's primary care physician and infectious disease specialist. ■

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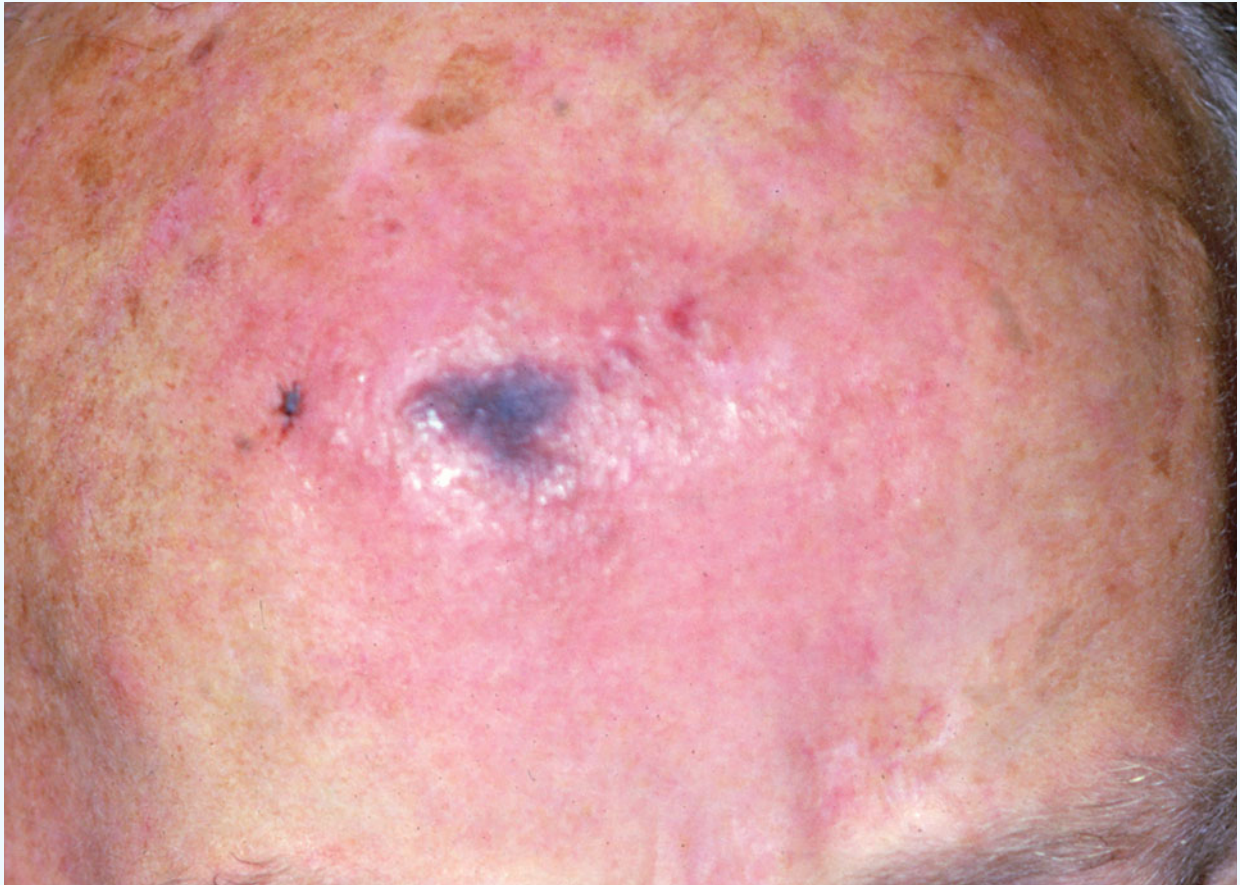


INSIGHTS IN IMAGES

CLINICAL CHALLENGE

This feature will challenge your diagnostic acumen with a glimpse of x-rays, electrocardiograms, and photographs of conditions that real urgent care patients have presented with.

If you would like to submit a case for consideration, please e-mail the relevant materials and presenting information to editor@jucm.com.



Man with forehead erythema

Case

An 80-year-old man woke up with a localized area of erythema on his forehead. He didn't think much of it, until the lesion slowly became white and then started turning blue over a few hours. He says that the lesion is painful and is getting larger and darker. He denies the presence of headaches, muscle pain, abdominal pain, sweating, and tremors.

THE RESOLUTION

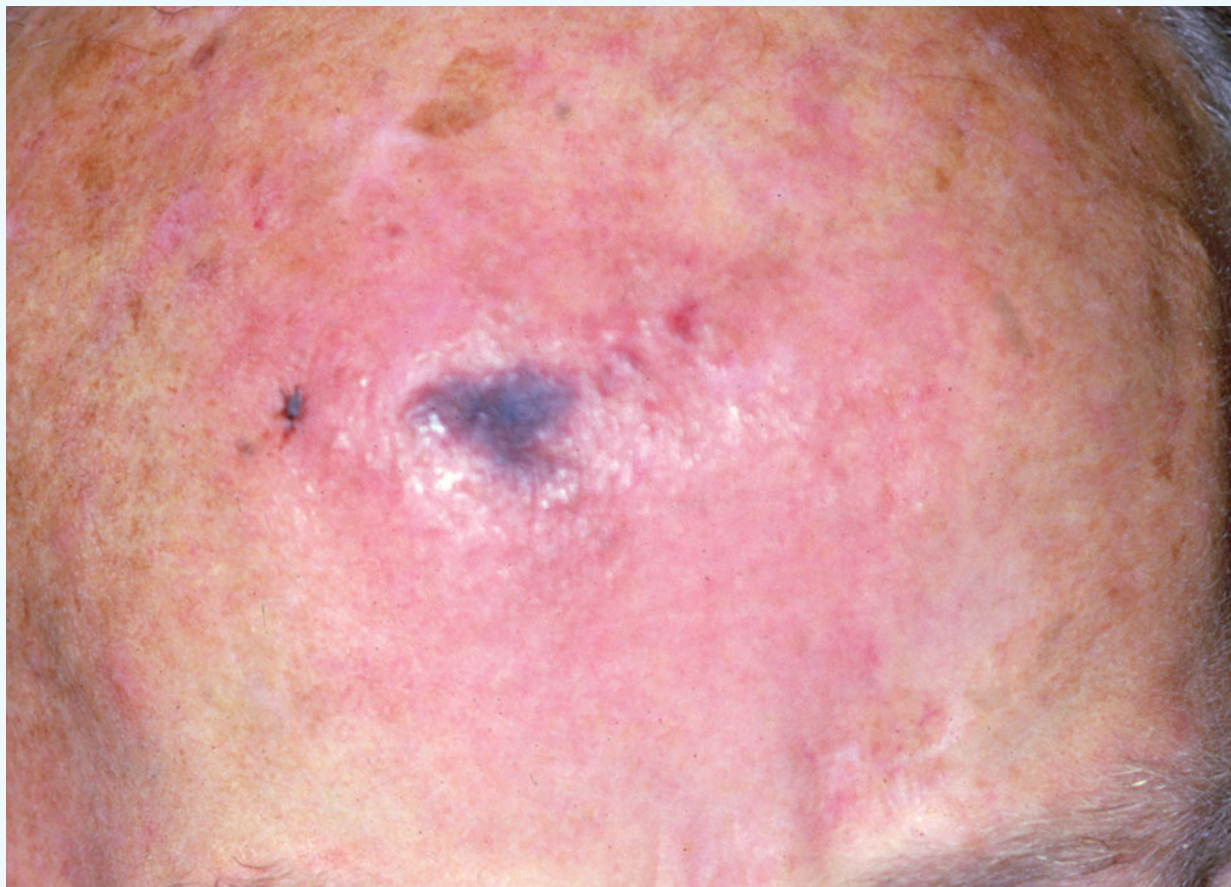


Image courtesy of Logical Images, Inc. www.VisualDx.com/JUCM

DDx

Community-acquired methicillin-resistant *Staphylococcus aureus* (MRSA) infection
 Caterpillar envenomation
 Contact dermatitis
 Ecthyma
 Solar purpura

Learnings

Common spider bites usually present with erythema and edema. A necrotic or dusky center within a red, inflammatory plaque is characteristic.

In brown recluse spider bites, vesicles and bullae can present early. Between 12 and 24 hours after envenomation, a large plaque consisting of erythema, ischemia, and necrosis ("red, white, and blue" sign) develops. Later, these lesions can progress into painful, full-thickness necrotic plaques.

Patients with black widow bites have local sweating, piloerection, redness, and mild edema. The systemic symptoms of muscle pain, cramps, abdominal pain, salivation, lacrimation, sweating, and tremors are more prominent than the skin findings.

If the victim brings in the spider, seek out a trained arachnologist or entomologist for accurate identification.

Diagnostic Pearls

Look closely for 2 small puncta, the fang marks of the spider.

Most suspected spider bites seen in the United States turn out to be the result of other causes, most commonly cellulitis or furunculosis caused by MRSA. Unless the spider has specifically been identified as the etiology of the symptoms, be cautious about narrowing your differential diagnosis and consider culturing for MRSA.



INSIGHTS IN IMAGES

CLINICAL CHALLENGE



Man with unilateral decreased vision

Case

A 68-year-old man with a long history of uncontrolled hypertension and hyperlipidemia presented with unilateral decreased vision for the last 3 weeks. On exam, you saw a fundus with diffuse retinal hemorrhages and swelling.

THE RESOLUTION



Image courtesy of Logical Images, Inc. www.VisualDx.com/JUCM

DDx

Diabetic retinopathy
Ocular ischemic syndrome
Hyperviscosity retinopathy
Papilledema with hemorrhage

Learnings

Central retinal vein occlusion (CRVO) is a potentially blinding sub-acute vascular occlusion of the eye. The prevalence of CRVO is between 0.1% and 0.4% in individuals who are aged 40 or older. Most patients have associated local or systemic disease, with systemic hypertension, diabetes mellitus, and open-angle glaucoma being the most common.

The central retinal artery and vein share a common adventitial sheath as they exit the optic nerve head and pass through the lamina cribrosa. Often in CRVO, a rigid atherosclerotic artery impinges on the nearby vein, causing turbulence and predisposing to thrombus formation. With increased resistance of venous flow, the retina becomes ischemic and fluid leaks out of the vessels. Increased intraocular pressure can also cause turbulence of the central retinal vein and lead to thrombus formation and obstruction.

The occluded central vein can lead to intraretinal hemorrhage, exudation of fluid, varying levels of ischemia, and neovascular complications such as neovascular glaucoma. CRVO is commonly classified by severity into two forms: the nonischemic form of CRVO, which is milder and more common, and the ischemic form, which results in more severe retinal damage and vision loss. In ischemic CRVO, more than 90% of patients have vision of 20/400 or worse. One-third of patients with the nonischemic type progress to the ischemic type.

Iris neovascularization, which is associated with neovascular glaucoma, occurs in up to 60% of patients with the ischemic form, usually 3 to 5 months following the obstruction. The main risk factors for development of neovascular glaucoma after a CRVO are the extent of capillary nonperfusion, poor visual acuity, severe venous tortuosity, and retinal hemorrhage.

What to look for

The presenting visual acuity at the time of diagnosis of CRVO is the best predictor of visual prognosis. In a patient with CRVO, there is a 10% risk of developing a CRVO in the fellow eye, especially when there is an underlying systemic abnormality.



Medical Boards: Part 1

■ JOHN SHUFELDT, MD, JD, MBA, FACEP

I have been practicing medicine for nearly 30 years. I have received countless letters from law firms for records requests and notifying our group or me of an impending issue. I'm kind of numb to it. Conversely, anytime I get a letter from the medical board, I go into SVT. I am sure it is the same way with the physician assistant and nursing boards. You just start thinking, "What good can come of this?"

Fortunately, but for the grace of God, I have not had to personally respond to accusations in front of the medical board – the day is still young. However, in my law practice, I have represented a few providers who, for some obvious and some not so obvious reasons, have found themselves on the wrong side of the table.

In Part 1 of this two-part series, using the Arizona Revised Statutes¹ as an example, we will look at ways providers end up in front of their respective medical boards. In Part 2 we will discuss what to do if you receive a summons or if your presence is "requested."

Before we get started, I advise you to go to your state's respective medical, nursing (if you are a nurse practitioner) or physician assistant (often part of the physician medical board) board website and review the rules and statutes. You may be surprised. Things that you thought were benign may in fact be problematic.

According to the Federation of State Medical Boards, fewer than 1% of physicians are sanctioned in any given year. A sanction can range from a nondisciplinary letter of concern to revocation of your license. Check with your board to review the various levels of action the board may take.

Generally speaking, being a "negligent provider" gets you into trouble far less often than issues revolving around "unprofessional conduct." Acts of unprofessional conduct are, at least in Arizona, listed under Definitions in the Statutes and Rules Section of the Arizona Revised Statutes for Medical Doctors.



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"I advise you to go to your state's respective medical, nursing or physician assistant board website and review the rules and statutes. You may be surprised. Things that you thought were benign may in fact be problematic."

Unprofessional Conduct, at least in my state, is a catchall for a wide variety of conduct. Below is a partially redacted list of areas upon which the medical board takes issue, along with some comments in bold. Note the bold underlined area "in this state or others." This means exactly what it says. If you receive a DUI while on vacation in Ireland, you will likely be sanctioned by your state's Medical Board

27. "Unprofessional conduct" includes the following, whether occurring **in this state or elsewhere**:

(c) False, fraudulent, deceptive or misleading advertising by a doctor of medicine or the doctor's staff, employer or representative. **"At XYZ Urgent Care you will be seen in 15 minutes or less" could be construed as deceptive or misleading if you miss the advertised time.**

(d) Committing a felony, whether or not involving moral turpitude, or a misdemeanor involving moral turpitude. In either case, conviction by any court of competent jurisdiction or a plea of no contest is conclusive evidence of the commission. **One of my favorites. You are on a hike and urinate in the woods or while walking down an alley at 3 am because your car was towed. If are cited, it will likely be for indecent exposure. You see where I'm going with this? Pun intended!**

(e) Failing or refusing to maintain adequate records on a patient. **You get behind, you forget, you're sloppy, and you violate the Statute. I've seen this one often when a Board**

requests records and an office produces less than adequate charting. Or worse, charting that is completed after the Board's request.

(f) Habitual intemperance in the use of alcohol or habitual substance abuse.

(g) Using controlled substances except if prescribed by another physician for use during a prescribed course of treatment. **Here is the latest one I've seen. A physician on a remote locums assignment broke his ribs mountain biking. He went to the ED he was staffing and received appropriate treatment, including a script for narcotics. He was discharged at 1 am Sunday morning. All the pharmacies were closed, so a nurse said, "Here are five Percocets that I did not use which were given to me after surgery. Take them and write me a script for five so that in case I need them I am not out." The physician saw the logic in that and did exactly as the Good Samaritan nurse suggested. What had he done? He had used narcotics meant for someone else, prescribed by a provider with whom he had no relationship, and he had written narcotics for someone who was not his patient on whom he had not performed an exam. That ridiculously benign transgression has followed him from state to state.**

(h) Prescribing or dispensing controlled substances to members of the physician's immediate family. **Your significant other breaks a bone and is in pain. You are traveling home from skiing and call in a script so that your spouse doesn't suffer needlessly during the 3-hour drive.**

(j) Prescribing, dispensing or administering any controlled substance or prescription-only drug for other than accepted therapeutic purposes. **Giving your body-building friend a script for Lasix so that he or she "looks more cut" for the competition.**

(k) Signing a blank, undated or predated prescription form. **You go to lunch and sign a few scripts for your physician assistant who does not yet have a DEA number to use in case a patient presents.**

(l) Conduct that the board determines is gross malpractice, repeated malpractice or any malpractice resulting in the death of a patient. **If you are unlucky enough to have a couple of events or one event with a very bad outcome, after the trial or settlement, you will have to answer again to the Board.**

(o) Action that is taken against a doctor of medicine by another licensing or regulatory jurisdiction due to that doctor's mental or physical inability to engage safely in the practice of medicine or the doctor's medical incompetence or for unprofessional conduct as defined by that jurisdiction and that corresponds directly or indirectly to an act of unprofessional conduct prescribed by this paragraph. **Sanctioning in one state means that you will likely be sanctioned in all states and**

"If you are unlucky enough to have a couple of events or one event with a very bad outcome, after the trial or settlement, you will have to answer again to the Board."

have to go through the process repeatedly. Double jeopardy does not apply. Also, if one jurisdiction has some weird provision like, "It is unprofessional conduct to give your pet a medication prescribed for a human," and your state does not have a similar provision, you could still be sanctioned.

(p) Sanctions imposed by an agency of the federal government, including restricting, suspending, limiting or removing a person from the practice of medicine or restricting that person's ability to obtain financial remuneration. **If CMS bans you from Medicare and Medicaid remuneration, you will be sanctioned in AZ.**

(q) Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public. **The major catchall. "Any conduct that might be harmful..." So, even if your conduct was not actually harmful, the fact that it could have been can get you sanctioned.**

(t) Knowingly making any false or fraudulent statement, written or oral, in connection with the practice of medicine or if applying for privileges or renewing an application for privileges at a health care institution. **"Knowingly" is the key. If you honestly forget to include something, you are arguably safe. If you purposely forget to put down that you received a DUI, not so much.**

(z) Engaging in sexual conduct with a current patient or with a former patient within 6 months after the last medical consultation unless the patient was the licensee's spouse at the time of the contact or, immediately preceding the physician-patient relationship, was in a dating or engagement relationship with the licensee. **Check your statutes. States view this differently and Arizona changed this. Here is what often happens. Your girlfriend with whom you are sexually active has a UTI and you write a script for Macrobid. You don't have a medical record. In some states, you just had sex with your patient and, as bad, your medical records are inadequate.**

(dd) Failing to furnish information in a timely manner to the board or the board's investigators or representatives if legally requested by the board. **More on this in the next issue. Bottom line: Don't delay but get a lawyer before complying.**

(ee) Failing to allow properly authorized board personnel on demand to examine and have access to documents, reports and records maintained by the physician that relate to the physician's medical practice or medically related activities.

(ff) Knowingly failing to disclose to a patient on a form that is prescribed by the board and that is dated and signed by the patient or guardian acknowledging that the patient or guardian has read and understands that the doctor has a direct financial interest in a separate diagnostic or treatment agency or in non-routine goods or services that the patient is being prescribed and if the prescribed treatment, goods or services are available on a competitive basis. **This one is tough. If you have a primary care practice and a separate urgent care practice, if your primary care practice refers to the urgent care after hours and the patients are not informed, you have violated the statute.**

(i) Adequate informed patient consent. **Another catchall. If something goes wrong, the argument is that the consent was "not informed." "I wouldn't have allowed this if I had known THIS was going to happen!"**

(ii) Lack of or inappropriate direction, collaboration, or direct supervision of a medical assistant or a licensed, certified, or registered health care provider employed by, supervised by or assigned to the physician. **Yikes. If you supervise mid-levels or other licensed providers and don't provide adequate supervision, you have committed unprofessional conduct.**

(jj) Knowingly making a false or misleading statement to the board or on a form required by the board or in a written correspondence, including attachments, with the board. **If you lie during the investigation or interview you are guilty of unprofessional conduct. Get an attorney, answer questions honestly and don't purposely mislead the investigators.**

(ll) Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient. **If you are unlucky enough to have a couple of events or one event with a very bad outcome, after the trial or settlement, you will have to answer again to the Board. Even if you are successfully sued, the Board still can sanction you.**

(nn) Refusing to submit to a body fluid examination or any other examination known to detect the presence of alcohol or other drugs as required by the board pursuant to section 32-1452 or pursuant to a board investigation into a doctor of medicine's alleged substance abuse. **Over the years, I have collected a lot of amazing anecdotes on this issue, however, cathing yourself and injecting your dog's urine into your bladder may top the list. Take home point – NO ILLICIT SUBSTANCES should be in your urine, blood or hair. And, if you find yourself attempting to catch your dog's urine, you have bigger problems than substance abuse!**

(oo) Failing to report in writing to the Arizona medical

"Sanctioning in one state means that you will likely be sanctioned in all states and have to go through the process repeatedly. Double jeopardy does not apply."

board or the Arizona regulatory board of physician assistants any evidence that a doctor of medicine or a physician assistant is or may be medically incompetent, guilty of unprofessional conduct or mentally or physically unable to safely practice medicine or to perform as a physician assistant. **This is a tough one. If your colleague tells you about a grievous error or action are you required to report them if they "may be" below the standard of care or "may be" guilty of unprofessional conduct.**

(pp) The failure of a physician who is the chief executive officer, the medical director or the medical chief of staff of a **health care institution** to report in writing to the board that the hospital privileges of a doctor of medicine have been denied, revoked, suspended, supervised or limited because of actions by the doctor that **appear to show** that the doctor is or **may be medically incompetent**, is or may be guilty of unprofessional conduct or is or may be unable to engage safely in the practice of medicine. Danger Will Robinson! If you are a medical director and you terminate the relationship with a provider because you believe his or her care or interpersonal skills are below the standard, are you guilty of unprofessional conduct if you don't report that person? Even if the provider only "may be" guilty, you are still on the hook. It may come back to bite you when your previously terminated provider screws up again and the Board comes back to ask you why the relationship was terminated. When you say, "I fired the provider because of incompetence," be prepared for the fall out.

(ss) Prescribing, dispensing or furnishing a prescription medication or a prescription-only device as defined in section 32-1901 to a person unless the licensee first conducts a physical or mental health status examination of that person or has previously established a doctor-patient relationship. The physical or mental health status examination may be conducted during a real-time telemedicine encounter with audio and video capability.

Now that you have a sense of the boundaries, in the next issue, I will discuss what to do if you are accused of crossing one of them! ■

Reference

1. <http://www.azleg.state.az.us/FormatDocument.asp?inDoc=/ars/32/01401.htm&Title=32&DocType=ARS>



ABSTRACTS IN URGENT CARE

- Fatigue and inappropriate antibiotic prescription
- Clarithromycin and risk of cardiac death
- Isolated loss of consciousness and TBI
- New vs old treatments for VTE
- Antibiotics for pediatric pharyngitis
- Antibiotics and childhood obesity
- TMP/SMX in the elderly
- AAP guidelines for treatment of bronchiolitis
- Fluid intake and recurrent nephrolithiasis
- Treatment options for gonorrhea
- High Alvarado score and need for CT scan
- Influenza in vaccinated patients

■ SEAN M. MCNEELEY, MD

Each month the Urgent Care College of Physicians (UCCOP) provides a handful of abstracts from or related to urgent care practices or practitioners. Sean McNeeley, MD, leads this effort.

Fatigue and inappropriate antibiotic prescription

Key point: *As the day goes on, resistance to prescribe potentially inappropriate antibiotics seems to fade.*

Citation: Linder JA, Doctor JN, Friedberg MW, et al. Time of day and the decision to prescribe antibiotics. *JAMA Intern Med.* 2014 Oct 6; doi: 10.1001/jamainternmed.2014.5225. [Epub ahead of print]

Previous research has shown that resistance to making the easier choice tends to fade as fatigue increases. Physicians make many difficult decisions during the day and the authors of this study hypothesized that resistance to prescribing antibiotics for potentially inappropriate patients would decrease as the day progressed. Whether the pressure was perceived or related to actual patient demand, a desire to do something or excessive concerns about complications, physicians potentially face these pressures every day and decision fatigue might increase the likelihood of inappropriate antibiotic prescription.

The authors of this study attempted to prove their theory by reviewing prescription writing for diagnoses that are considered

inappropriate. This study was a retrospective review of billing and electronic medical record data compared with time of prescription in a 4-hour patient care session. Over 20,000 adult patients at 23 centers met inclusion criteria. Odds ratios increased from the first hour to 1.01 in the second hour, 1.14 in the third hour, and 1.26 in the final hour. Diagnoses for which antibiotics are never indicated included bronchitis, nonspecific respiratory tract infection, influenza and non-streptococcal pharyngitis. Diagnoses for which antibiotics are sometimes appropriate included otitis media, sinusitis, pneumonia, and strep. Making assumptions about the appropriateness of antibiotics based solely on diagnosis codes and prescribing data is far from a perfect method. If patient records were reviewed the number of inappropriate prescriptions may be less than what was used in the study. However, the authors' theory remains interesting. Unfortunately they do not provide a method for reducing the effect of decision fatigue.

Acute care providers should at least keep the premise of this study in mind when deciding to prescribe antibiotics as the day wears on. ■

Clarithromycin and risk of cardiac death

Key point: *Clarithromycin may increase risk of cardiac death although the risk is small.*

Citation: Svanström H, Pasternak B, Hviid A. Use of clarithromycin and roxithromycin and risk of cardiac death: Cohort study. *BMJ.* 2014;349:g4930. doi: 10.1136/bmj.g4930.

Recent studies have pointed to increased cardiac death from erythromycin and azithromycin. The current theory is that



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macrolides prolong the Q-T interval, leading to torsades de point and eventually death from arrhythmia. Danish investigators attempted to see if there was an increased risk of cardiac death from clarithromycin and roxithromycin (the two macrolides available in their country) compared with penicillin V.

In this prospective cohort study, use of antibiotics and cardiac causes of death in patients ages 40 to 74 were reviewed. More than 3 million patients qualified and 160,297 courses of clarithromycin and almost 4.4 million courses of Penicillin V were given. The cardiac death rates were 2.5/1000 patient years for penicillin compared with 5.3 for clarithromycin. The ratio was 1.79 for all clarithromycin patients, but 2.83 for women. Overall, the use of clarithromycin would account for 37 deaths per 1 million courses.

From an urgent care provider perspective, although the absolute number is very small, this information should be added to the risk:benefit balance when prescribing clarithromycin, particularly in women or patients who have any other reason for prolonged QT interval. ■

Isolated loss of consciousness and TBI

Key point: *Isolated loss of consciousness is a poor predictor of clinically important traumatic brain injury (ciTBI)*

Citation: Lee LK, Monroe D, Bachman MC, et al. Isolated loss of consciousness in children with minor blunt head trauma. *JAMA Pediatr.* 2014;168(9):837-843.

This article takes another look at the 2008 PECARN study data to assess the risk of ciTBI in patients with loss of consciousness. The original prospective multicenter cohort study enrolled more than 42,000 children. Of them, 15% were noted to have loss of consciousness (LOC). The prevalence of ciTBI was 2.5% with LOC and 0.5% without. Isolated LOC had a prevalence of 0.5% ciTBI.

From an urgent care perspective, this review of the data should reinforce the low risk of ciTBI in isolated LOC. It should also help reduce the number of CT scans of the head ordered in these children. For those of us without CT scanners, it should help to reduce the need to transfer patients as well. ■

New vs old treatments for VTE

Key point: *New treatments for VTE may be as good as or even better than the old.*

Citation: Castellucci LA, Cameron C, Le Gal G, et al. Clinical and safety outcomes associated with treatment of acute venous thromboembolism: A systematic review and meta-analysis. *JAMA.* 2014;312(11):1122-1135.

For many years, heparin and then vitamin K antagonist was the treatment of choice for venous thromboembolus. Recently seven other methods have been proposed and evaluated. These include low-molecular-weight heparin (LMWH), or fonda-

parinux in combination with vitamin K antagonists; LMWH with dabigatran or edoxaban; rivaroxaban; apixaban; and LMWH alone. In this systematic review and meta-analysis, the authors reviewed 1197 trials and selected 45 trials with almost 45,000 patients. Included studies were chosen based on rates of recurrent thromboembolus and inclusion of major bleeding.

The authors of this study concluded that there were no statistically significant differences for the efficacy and safety of the new methods compared to LMH and vitamin K antagonist. Of interest, unfractionated heparin (UFH) plus vitamin K therapy antagonist was the least effective therapy and rivaroxaban and apixaban appeared to be associated with the lowest risk of bleeding.

For the urgent care provider considering which method to use, the old way (UFH then vitamin K therapy antagonist) may not be the best way and consideration of this meta-analysis may help guide these decisions. ■

Antibiotics for pediatric pharyngitis

Key point: *Gaps between recommended prescription practice and actual data may be large.*

Citation: Dooling KL, Shapiro DJ, Van Beneden C, et al. Over-prescribing and inappropriate antibiotic selection for children with pharyngitis in the United States, 1997–2010. *JAMA Pediatr.* 2014 Sep 29 doi: 10.1001/jamapediatrics.2014.1582. [Epub ahead of print]

In this pediatric pharyngitis-focused study, the authors attempted to look at both the amount and type of antibiotics used to treat pharyngitis. National data were extrapolated from two surveys (National Ambulatory Medical Care Survey and the National Hospital Ambulatory Medical Care Survey) for pediatric patients with pharyngitis and their treatment. Almost 12 million visits per year were noted with prescription of antibiotics to 60% of the patients. Other studies have shown a strep rate closer to 37%. Of those prescriptions, almost 40% were drug other than narrow-spectrum antibiotics such as penicillin and amoxicillin, which have been determined to be almost universally effective.

Although the authors attempted to eliminate other reasons for use or alternative type of antibiotics, even allergy status was not part of this analysis. This study may be a good reminder that narrow-spectrum antibiotics are best for strep throat, however, the final data are questionable because their methods of deciding what was inappropriate were not based on chart data but billing data. This study may be a better example of trend than of degree of antibiotic overuse and potentially inappropriate choice. ■

Antibiotics and childhood obesity

Key point: *Rethink the antibiotic and reduce the spectrum to potentially decrease childhood obesity.*

Citation: Bailey LC, Forrest CB, Zhang P, et al. Association of antibiotics in infancy with early childhood obesity. *JAMA Pediatr.* 2014;168(11):1063-1069.

Childhood obesity has been in the news recently. This study, which looked at antibiotic use before age 2 and obesity from ages 2 to 5, presents a potential cause as well as a modifiable risk factor. The cohort study was conducted using electronic medical records from 2001 to 2013. A total of 64,580 children were included. Sixty-nine percent of the children were exposed to antibiotics before age 2. Antibiotics such as penicillin and amoxicillin, which are recommended in guidelines for first-line treatment, were labeled as narrow-spectrum antibiotics. All others were considered broad spectrum. Both exposed and unexposed children had the same pre-antibiotic weight to height Z scores.

Increased obesity in children was associated with treatment with broad-spectrum antibiotics but not with treatment with narrow-spectrum antibiotics—relative risk 1.16. The effect was greater with more exposures, particularly in children with more than 4 exposures. The proposed mechanism is changes in the gut flora during an important developmental period. This study is far from proving cause but it does provide at least a reason for thought. From an acute care perspective, it offers another reason to avoid broad-spectrum antibiotics, if possible. It also might be helpful in convincing parents about the dangers of antibiotics. ■

TMP/SMX in the elderly

Key point: Reconsider trimethoprim/sulfamethoxazole in elderly patients taking ACE inhibitors and blockers.

Citation: Fralick M, Macdonald EM, Gomes T, et al. Co-trimoxazole and sudden death in patients receiving inhibitors of renin-angiotensin system: population based study. *BMJ.* 2014;349:g6196 doi: 10.1136/bmj.g6196 (Published 30 October 2014)

This large study reviewed sudden deaths in patients aged 66 years or older treated with an angiotensin-converting enzyme inhibitor or angiotensin receptor blocker and antibiotics. The antibiotics included co-trimoxazole, amoxicillin, ciprofloxacin, norfloxacin, and nitrofurantoin. Almost 40,000 patients were identified and 1,027 deaths occurred. Elevated potassium levels were felt to be the causative agent in these deaths. Limitations of this study included data not being directly from patient charts. Blood values and the diseases treated also may have affected the results. The authors found a significant increased risk of death in patients treated with co-trimoxazole compared to amoxicillin—odds ratio 1.83. Ciprofloxacin also was associated with a small increase in risk of sudden death.

From an acute care perspective, these results should give

providers pause in prescribing cotrimoxazole and perhaps even ciprofloxacin to the aforementioned patients. ■

AAP guidelines for treatment of bronchiolitis

Key point: AAP guidelines on the treatment of bronchiolitis offer few surprises.

Citation: <http://pediatrics.aappublications.org/content/early/2014/10/21/peds.2014-2742>

Bronchiolitis continues to be an illness frequently seen in urgent care centers. The American Academy of Pediatrics has issued new guidelines for the treatment of bronchiolitis in children younger than age 2 years. As expected, the guideline is well done and the recommendations are graded by level of evidence. As with other guidelines, I will review some of the recommendations most applicable to urgent care. Recommendation 1c: When clinicians diagnose bronchiolitis on the basis of history and physical examination, radiographic or laboratory studies should not be obtained routinely (Evidence Quality: B; Recommendation Strength: Moderate Recommendation). Recommendation 2: Clinicians should not administer albuterol (or salbutamol) to infants and children with a diagnosis of bronchiolitis (Evidence Quality: B; Recommendation Strength: Strong Recommendation). Recommendation 5: Clinicians should not administer systemic corticosteroids to infants with a diagnosis of bronchiolitis in any setting (Evidence Quality: A; Recommendation Strength: Strong Recommendation). Recommendation 8: Clinicians should not administer antibacterial medications to infants and children with a diagnosis of bronchiolitis unless there is a concomitant bacterial infection, or a strong suspicion of one (Evidence Quality: B; Recommendation strength: Strong Recommendation). From an acute care perspective, these guidelines will likely confirm current practice. ■

Fluid intake and recurrent nephrolithiasis

Key point: Consider recommending to patients at risk of recurrent nephrolithiasis intake of more fluids to produce 2 L of urine per day.

Citation: Qaseem A, Dallas P, Forciea MA, Starkey M, Denberg TD, for the Clinical Guidelines Committee of the American College of Physicians. Dietary and Pharmacologic Management to Prevent Recurrent Nephrolithiasis in Adults: A Clinical Practice Guideline From the American College of Physicians. *Ann Intern Med.* 2014;161:659-667.

This article, which was written by the American College of Physicians (ACP), is intended as a guideline to help prevent recurrent nephrolithiasis and was created through a synthesis of the medical literature. Grading was done by ACP's clinical practice guideline grading system, including strength of recommen-

“The American Academy of Pediatrics has issued new guidelines for the treatment of bronchiolitis in children younger than age 2 years.”

dation and quality of evidence. Dietary and pharmacological interventions were both reviewed. The literature analysis resulted in two recommendations. The first was to increase fluid intake throughout the day to produce 2 L of urine daily (weak recommendation, low quality evidence). The second recommendation was to add treatment with a thiazide diuretic, citrate, or allopurinol if increased fluid intake failed (weak recommendation, moderate quality evidence).

For acute care providers, it makes sense to consider recommending increased fluid intake in patients who are unlikely to be harmed by this intervention. Consideration the risks associated with the medications, prescription of them may be better left to specialists. ■

Treatment options for gonorrhea

Key point: Options may exist if ceftriaxone is not the best choice for treatment of gonorrhea.

Citation: Kirkcaldy RD, Weinstock HS, Moore PC, et al. The efficacy and safety of gentamicin plus azithromycin and gemifloxacin plus azithromycin as treatment of uncomplicated gonorrhea. *Clin Infect Dis*. 2014;59(8):1083-1091.

As the authors state, intramuscular ceftriaxone injection is the foundation of treatment for gonorrhea. Other options may soon become necessary because of increasing resistance or in patients who are allergic to ceftriaxone. The authors designed a randomized, multisite, open-label, noninferiority trial in five outpatient sexually transmitted disease clinics in the United States. Patients with uncomplicated urogenital gonorrhea were randomly assigned to either gentamicin 240 mg intramuscularly plus azithromycin 2 g orally, or gemifloxacin 320 mg orally plus azithromycin 2 g orally. Of 202 patients treated with gentamicin and azithromycin who were able to be evaluated, 100% were cured. The primary outcome was microbiological cure defined by a negative repeat culture. For 199 patients treated with gemifloxacin and azithromycin, the cure rate was 99.5%. Both groups had significant side effects.

From an urgent care perspective, this is a small study but

might provide some direction if the traditional treatment with ceftriaxone is ineffective or contraindicated. ■

High Alvarado score and need for CT scan

Key point: High Alvarado score may reduce the need for CT scan
Citation: Tan WJ, Acharyya S, Goh YC et al. Prospective comparison of the Alvarado Score and CT scan in the evaluation of suspected appendicitis: A proposed algorithm to guide CT use. *J Am Coll Surg*. 2014 Oct 25; [e-pub ahead of print].

The balance between unnecessary surgery and missing appendicitis has been made easier by the computed tomography (CT) scan. However, radiation exposure concerns have called into question the number of scans performed. The authors of this prospective trial once again looked to see if the Alvarado appendicitis score had utility in determining the need for CT. A total of 350 consecutive patients scanned for appendicitis were assigned an Alvarado score and final pathology was used. The authors concluded that an Alvarado score of 7 and above in males and 9 and above in females should be used to decide whether to go straight to surgery rather than CT scan. The authors did note that their score cut off development was prospective but the trial itself was done to create the rule rather than to evaluate it. Therefore these values need prospective review before they can be validated.

From an acute care perspective, the Alvarado score is less helpful because the consulting surgeon may not accept these data. A number below which a CT scan should not be obtained might be more helpful. ■

Influenza in vaccinated patients

Key point: It could still be influenza if the patient was immunized.
Citation: Aquino TL, Brice GT, Hayes S, et al. Influenza outbreak in a vaccinated population — USS Ardent, February 2014. *MMWR Morb Mortal Wkly Rep*. 2014 Oct 24;63(42):947-949.

In February 2014, an outbreak of influenza among young adults with prior influenza vaccine was noted on a naval vessel. Over a 3-day period, 25 of 102 crew members sought care for flu-like symptoms. Of those patients, 20 were found to have Influenza A and 18 of those cases were H3N2. The influenza vaccine was though appropriate for the strain identified. The outbreak was on the USS Ardent, an Avenger-class minesweeper, one of the smallest ships in the U.S. Navy, and it was tracked to a patient who roomed with a member of the crew who likely had influenza 11 days earlier.. Although influenza vaccination continues to be the best way to prevent the illness, it still can occur in a significant percentage of young, healthy adults.

For acute care providers, this article reminds us to consider influenza even in vaccinated populations. ■



Fracture Codes, Strapping and Splint Application Codes, S9088 Code

■ DAVID STERN, MD, CPC

Q. When is it appropriate to use fracture codes without manipulation? If a patient comes in with pain in a finger after a fall and an evaluation and management is performed, x-rays are taken to confirm a fracture, the finger is splinted, and the patient is referred to an orthopedist, would that treatment constitute billing for fracture care? If not, what must we do to be able to bill these?

A. CPT suggests that only the physician who provides the “restorative treatment” should code and bill for the fracture care. CPT further states that “if cast application or strapping is provided as an initial service (e.g., casting of a sprained ankle or knee) in which no other procedure or treatment (e.g., surgical repair, reduction of a fracture, or joint dislocation) is performed or is expected to be performed by a physician rendering the initial care only, use the casting, strapping and/or supply code [99070] in addition to an evaluation and management (E/M) code as appropriate.”

In your example, billing the E/M (if appropriate) with modifier -25 (with a separate and identifiable procedure note), splint application (CPT 29130), x-ray, and supplies (HCPCS Q4049) used to make the splint would be appropriate because you do not plan any further treatment of the fracture.

However, if you splinted the fracture (i.e., provided “restorative treatment”) and scheduled follow up at your facility, then it would be appropriate to code 26720, “Closed treatment of phalangeal shaft fracture, proximal or middle phalanx, finger

“You can find splint and cast supply codes in HCPCS under code range Q4001-Q4051. If you use supplies to make your splints and casts, refer to these codes for billing.”

or thumb; without manipulation, each” or 26725, “...with manipulation, with or without skin or skeletal traction, each” along with the E/M (if appropriate), with modifier -57. ■

Q. We had a patient who came in with a wrist injury. The final diagnosis was a sprained wrist. We applied a cock-up splint (HCPCS code L3908) with an Ace bandage. Can we bill out a strapping code and a splint application code together? Can we bill for both the splint and the Ace bandage?

A. You would not bill splint or cast application codes with strapping codes for the same procedure. Billing for the splint application depends on whether the splint applied was prefabricated or was constructed in the clinic. The American Medical Association (AMA) stated in *CPT Assistant* (May 09:8) that “splint application requires creation of the splint.”

According to HCPCS, L3908 is defined as “Wrist-hand orthotic (WHO), wrist extension control cock-up, nonmolded, prefabricated, includes fitting and adjustment.” Therefore, billing a splint application code along with this code would not be appropriate because the fitting and adjustment is included with the code. If an elastic bandage was used to secure the splint, you would bill a HCPCS code from range A6448-A6450, depending on the size of the bandage.



David E. Stern, MD is a certified professional coder and board certified in Internal Medicine. He was a Director on the founding Board of UCAOA and has received the organization's Lifetime Membership Award. He is CEO of Practice Velocity, LLC (www.practicevelocity.com), PV Billing and NMN Consulting, providers of software, billing and urgent care consulting services. Dr. Stern welcomes your questions about urgent care in general and about coding issues in particular.

“Medicare does not recognize either S9088 or 99051 so do not use either code for claims submitted to Medicare.”

You can find splint and cast supply codes in HCPCS under code range Q4001-Q4051. If you use supplies to make your splints and casts, refer to these codes for billing. There are separate codes for different anatomy, plaster, fiberglass, and age.

For example, if a short arm splint was made in the clinic from fiberglass materials for an 8-year-old, you would use HCPCS code Q4024, “Cast supplies, short arm splint, pediatric (0-10 years), fiberglass.” If the same splint was made for a 25-year-old, you would use code Q4022, “Cast supplies, short arm splint, adult (11 years +), fiberglass.”

In both cases, you would also assign CPT code 29125, “Application of short arm splint (forearm to hand); static” because the codes for application and strapping are not age-dependent. ■

Q. Can we bill both the S9088 and 99051 on the same visit for our urgent care visits?

A. Yes, you can bill both codes for the same visit along with the E/M code. HCPCS code S9088, “Services provided in an urgent care center (list in addition to code for service),” is specifically for use in an urgent care center.

CPT code 99051, “Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service” is another code that could be billed to insurance plans, with the exception of Medicare. Evening hours are generally considered to start at 5 p.m. This code was designed to compensate your practice for the additional costs of being open for extended hours. This code is typically billed to patients seen after 5 p.m. Monday through Friday and all day on Saturday, Sunday, and federal holidays.

Medicare does not recognize either code so do not use either code for claims submitted to Medicare.

Check the policies of each payor for both of these codes to see if the payor views either code as a covered service. If not, you can consider requesting reimbursement for these codes when negotiating contracts. ■

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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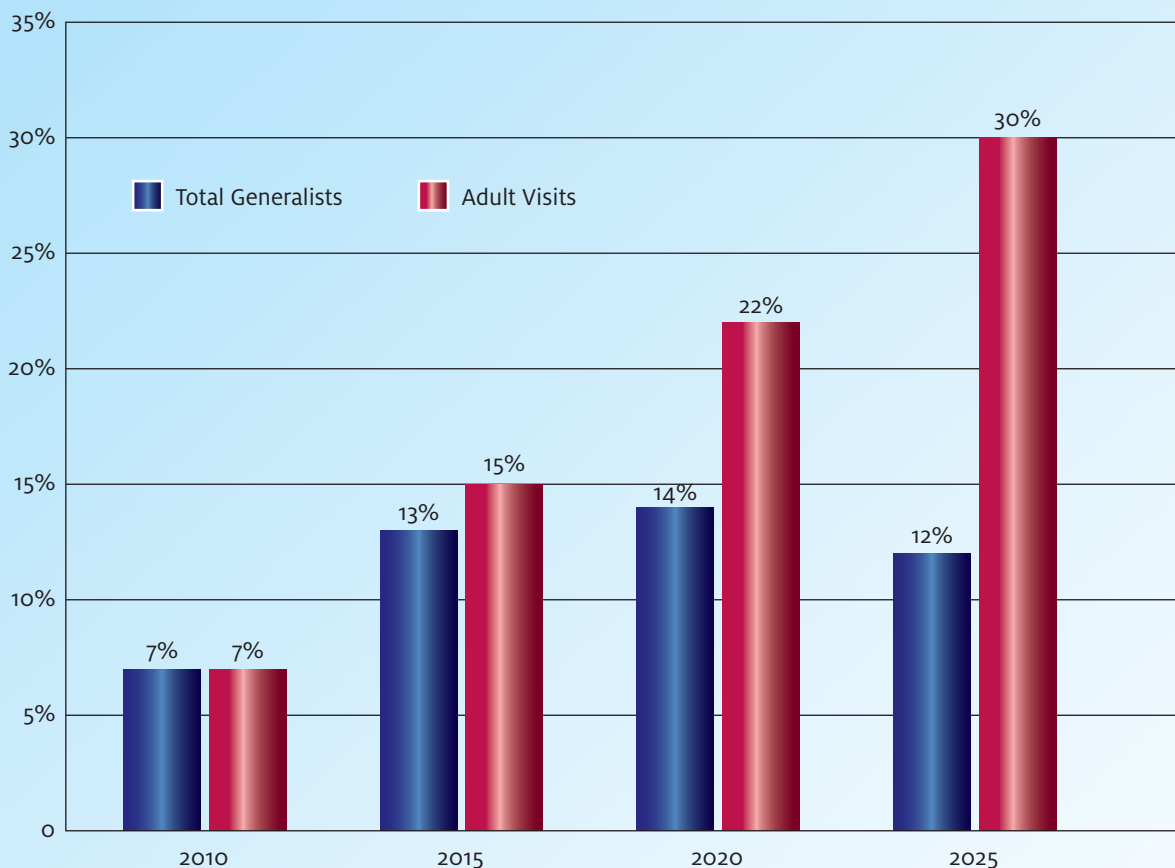
DEVELOPING DATA

Data from the Bureau of Health Professionals show that lack of access to primary care in the United States is driving the heightened demand for urgent care utilization. As of 2013, approximately 60 million individuals in the United States lacked access to primary care, an increase from 56 million in 2007. The lack of access is driven by a number of factors, including inconvenient hours, stringent scheduling requirements, and overcapacity at primary care physician offices.

In this issue: Lack of Access to Primary Care as a Driver of Urgent Care Industry Growth

CHANGE IN GENERAL PHYSICIANS VS. ADULT PATIENT POPULATION

For the Years Ending December 31, 2005-2025
(% change relative to 2005; numbers for 2015 and beyond are projections)



Patient visits are projected to grow 30% by 2025, while the supply of generalist physicians will only grow 12%.

Source: Healthcare @ Life Sciences (HCLS) Group at Harris Williams @ Co.



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