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IN THIS ISSUE

Common Lacerations of the Head

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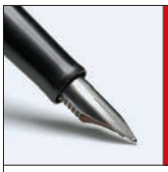

LETTER FROM THE EDITOR-IN-CHIEF

'What to Expect When You're Expecting': The Birth of a Public Health Plan

With healthcare reform imminent, the question on everyone's mind is: "How will this impact me?" While there is almost universal support for reform—what you might call the *why* of a healthcare fix—there is considerable disagreement about the *how*, *when*, *who*, and *where*.

While the details of reform may change a bit over the next several months, there are a few things we should consider invariable:

1. The Democrats' solid control of the Executive and Legislative branches of government gives them the power to push through legislation and executive initiatives with little in the way of meaningful resistance.
2. Bipartisan and medical industry input and support is sought for healthcare reform; however, it should be clear that no one has the ability to derail this train.
3. The final bill will have several components that may as well be considered "non-negotiables."
   - There *will* be a new Medicare-style public health plan. This plan will cover most of the uninsured, but it will also compete with the private insurers to cover others who determine that the public plan is a better deal.
   - This new plan *will* attempt to reign in costs in several ways. Restrictions on high-cost, low-yield procedures *will* be a cornerstone of what the government calls a "comparative effectiveness" strategy. Some of the targets: unnecessary knee arthroscopies, spine surgery, cardiac catheterizations, and "advanced imaging procedures" (MRIs, etc.).

     Increased competition in the insurance industry, it is believed, will promote a more favorable cost structure for "all things healthcare," including drugs and reimbursement for doctors and hospitals.

     Health information technology, quality-linked payment systems, and hospital readmission bundling are all likely to be implemented over the first five years of the plan.
4. Additional components on the table:
   - A tax on employer-supplied insurance benefits, lowering subsidies to hospitals for seeing the uninsured, tort reform.

So what does this mean to you?

Reimbursement under the plan will likely take the shape of a "Medicare plus." The most conservative estimate for physician services is 110% of the Medicare Fee Schedule. There is considerable support for additional, higher payments for primary care services and lower payments for specialty services.

The plan will likely cover the majority of the 45 million uninsured. In addition, some estimate that the public plan will attract up to 120 million Americans away from private health insurance.

Opportunity for Urgent Care?

This may add up to an opportunity for urgent care. Consider the following:

- Medicare is a prompt, reliable payor.
- If the public plan approaches 120% of the Medicare fee schedule for primary care-related services, urgent care stands to benefit significantly.
- The public plan will not only increase the number of insured, but it will significantly decrease the number of "underinsured."
- Access to care will increase and delayed care will decrease.
- The majority of those patients who will be newly covered on the public plan are otherwise healthy 20- to 50-year-olds—in other words, the urgent care demographic.
- The primary care shortage will not be fixed for a very long time. The rolls of the insured will increase overnight, and wait times to see primary care will increase dramatically. Urgent care is uniquely positioned to fill the access gap.

I feel a public health plan represents very little risk and a tremendous upside for urgent care.

Fear not! ■

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

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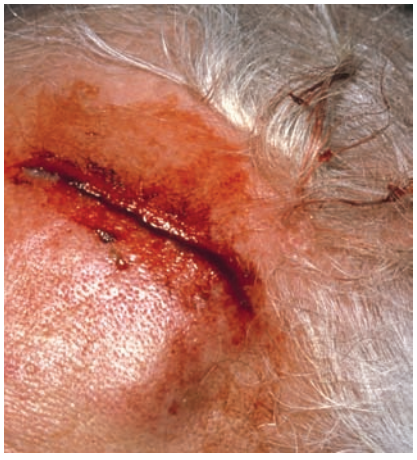

CLINICAL

11 Common Lacerations of the Head

General principles of common head laceration assessment, repair, and management start with hemorrhage control but extend to appropriate anesthesia, indications for neurologic exam, and vigilance for signs of domestic violence and non-accidental trauma.

By Clayton Josephy, MD, Samuel M. Keim, MD, MS, and Peter Rosen, MD

PRACTICE MANAGEMENT

28 Creating a Web Presence to Raise Awareness of Urgent Care

If your marketing campaign has yet to merge onto the information superhighway, it's time to get it in gear and take advantage of the abundant promotional opportunities afforded in this age of electronic media.

By Alan Ayers, MBA, MAcc

IN THE NEXT ISSUE OF *JUCM*

Most patients who opt for urgent care instead of the emergency room after a motor vehicle accident assume they've sustained only minor injuries. Prudence dictates that you not be lulled into a false sense of security by those assumptions, however.

WEB EXCLUSIVE

Galeazzi Fracture—Dislocation of the Wrist or Isolated Distal Radius Fracture?

A 14-year-old male presents with multiple facial lacerations after being struck by a car. A more serious, though relatively common, injury would become evident days later. Exclusively on *www.jucm.com.*

By Heather L. Hinshelwood, MD and David Caro, MD

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

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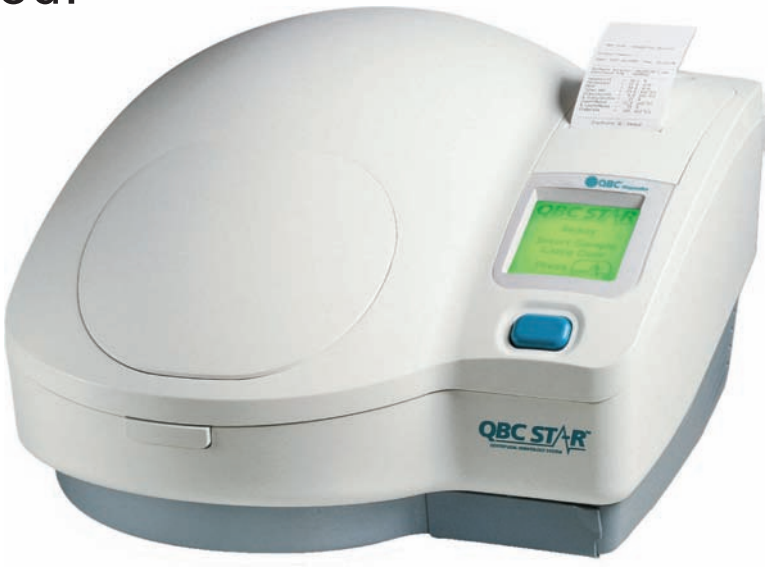

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JUCM CONTRIBUTORS

"There will be blood" is not just the title of a critically acclaimed 2007 film; it's also a guarantee when a patient with a head laceration presents to your urgent care center.

Common Lacerations of the Head (page 11) by **Clayton Josephy, MD**, **Samuel M. Keim, MD, MS**, and **Peter Rosen, MD** reviews general principles of common head laceration assessment, repair, and management relevant to the urgent care setting. In addition to the obvious need for hemorrhage control, the authors weigh in on the importance of anesthesia and situations in which a neurologic examine might be warranted, as well as tips on spotting possible domestic violence or non-accidental trauma.

Dr. Josephy is an emergency physician at the University of Arizona Medical Center in Tucson, where Dr. Keim is associate head and residency director and Dr. Rosen is a clinical professor. Dr. Rosen is also a member of the *JUCM* Advisory Board.

As that lead article points out, special considerations may be in order when the patient is a child. Certainly **Emory Petrack, MD, FAAP, FACEP** would agree. His latest, quarterly contribution to *JUCM*, Managing Summer Lacerations in Children (page 25), points out that warmer summer months and no school add up to greater potential for bruises and cuts that may lead to an urgent care visit. Being prepared to treat a bleeding, frightened child will ease the minds of worried parents and help establish you as the go-to urgent care destination for younger patients.

Dr. Petrack is president of Petrack Consulting, Inc., and medical director of the Pediatric Emergency Department at Fairview Hospital in Cleveland, OH. He also sits on the *JUCM* Advisory Board.

Word-of-mouth generated by satisfied patients (or parents) is certainly a highly credible form of publicity, but proactive operators must take advantage of all available media when trying to draw attention to their services. These days, that includes the Internet.

In Creating a Web Presence to Raise Awareness of Urgent Care (page 28) **Alan A. Ayers, MBA, MAcc** discusses consumer behavior in the age of electronic media with an eye on demographics, what to include in a web ad, and opportunities and pitfalls when designing your website.

Mr. Ayers is assistant vice president of product development for Concentra Urgent Care and content advisor for the Urgent Care Association of America.

Also in this issue:

Nahum Kovalski, BSc, **MDCM** reviews abstracts on the pandemic potential of the H1N1 flu virus, a protocol for improving survival after out-of-hospital cardiac arrest, ensuring that patients understand discharge instructions, treatment for various things that bite (i.e., lice and scorpions), and other urgent care-relevant topics.

David Stern, MD, CPC responds to questions about the proper use of code 99051 and the current status of code S9088 in Coding Q & A.

John Shufeldt, MD, JD, MBA, FACEP offers the benefit of his entrepreneurial experience—both the trials and the triumphs.

Frank Leone, MBA, MPH offers 25 Sales and Marketing Pearls designed help you realize the business potential of your urgent care occupational medicine program, covering sales skills and techniques, marketing outreach, and management.

Finally, in our monthly web-only bonus article, emergency physicians **Heather L. Hinshelwood, MD** and **David Caro, MD** offer insight into the case of a 14-year-old boy who sustained multiple lacerations to his face upon being struck by a car—specifically, the assessment and treatment of injuries that weren't apparent until days after the accident. Galeazzi Fracture—Dislocation of the Wrist or Isolated Distal Radius Fracture? is available exclusively at *www.jucm.com*.

If, while reading this page, you found yourself thinking "They need to do an article on [fill in the blank]," then we need to hear from you. Tell us how you filled in the blank in an e-mail to Editor-in-Chief **Lee A. Resnick, MD** at *editor@jucm.com*. ■

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.

Manuscripts on clinical or practice management topics should be 2,600–3,200 words in length, plus tables, figures, pictures, and references.

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.

Before submitting, we recommend reading "Instructions for Authors," available at *www.jucm.com*.

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Twenty-one Down, 8,000-plus to Go

LOU ELLEN HORWITZ, MA

In the pages of this month's *JUCM*, you will see a full-page congratulations to the first 21 urgent care centers receiving designation as a Certified Urgent Care Center.

My question to you is, why isn't yours on this list?

Your question to me may be, "Why should it be?"

The "brochure answer" looks like this:

- Gives your clinic a mark of distinction to eliminate confusion with other types of providers
- Provides a tool for negotiation as a national benchmark for discussing higher fee schedules
- Give you an edge in marketing to clearly and effectively describe your level of service

All good reasons, but let me share a possible scenario that may hit home even more.

You know (from last month's column) that UCAOA is working on ways to be more involved in the legislative and regulatory environment. Imagine this conversation as the UCAOA committee members (or even you) try to reach out to the government and payor community:

You: *Hi, Representative so and so, I'm calling you to make sure you know about urgent care and the important role it is playing in our community and even across the nation. Urgent care helps keep patients out of the emergency room and...*

Representative: *Wait, urgent care...those are those things in the drugstore, right? Yeah, those are great!*

Y: *Ah, no, urgent care is much more than that. They are usually freestanding, and provide a much broader scope of services than a drugstore clinic.*

R: *Oh, so more like a freestanding emergency room. Don't the hospital ERs have some problems with you guys stealing their patients?*

Y: *No, not like a freestanding emergency room either. We don't treat life-threatening conditions. Think of us as somewhere you go when you can't get into your primary care physician, or your injury is more serious than what your regular doctor can treat, but you don't belong in the emergency room.*

R: *You know, my primary care doc has started having evening and Saturday hours for more "urgent" care, so now I know exactly what you are talking about. Thanks for calling!*

Are you seeing a pattern? While many, many, many patients are aware of you and what you do, many of the "key people" in the government and payor communities still are not—and we, as an industry, have not done much to help them.

That is what the Certified Urgent Care Center designation is all about. It's about defining ourselves for the very powerful stakeholders that will exert tremendous influence on our industry in the coming years, either through regulatory or legislative efforts, or simply through criteria for getting on an insurance panel. The ability to say "this is what a full-fledged urgent care is" in simple, identifiable terms (one term, really) will help all of us—in ways we can't even see yet.

There's a great story that's quoted toward the end of the movie "Under the Tuscan Sun" about how the Italians built railroad tracks through the mountains before there was even a train that could make the trip. They knew that someday the train would come. The Certified Urgent Care center designation is our set of railroad tracks.

All we need, from each of you, is a tiny piece of the track. We—UCAOA—cannot build it without you. We can't staff it out, or delegate it to a committee; we don't own a single center. What we have done is to provide the roadbed (criteria). You just need to pick up a piece of track, put your name on it, and lay it down. We have 21 pieces so far—a great start, but not nearly enough to get us where we all want to be able to go.

So, if you do nothing else this month, and don't have a Certification brochure sitting buried on your desk somewhere, go to the website *www.ucaoa.org/certification* and get started on your application. The train is coming. ■

Lou Ellen Horwitz is executive director of the Urgent Care Association of America. She may be contacted at *lhorwitz@ucaoa.org*.

Call for Articles

JUCM, the Official Publication of the Urgent Care Association of America, is looking for a few good authors.

Physicians, physician assistants, and nurse practitioners, whether practicing in an urgent care, primary care, hospital, or office environment, are invited to submit a review article or original research for publication in a forthcoming issue.

Submissions on clinical or practice management topics, ranging in length from 2,500 to 3,500 words are welcome. The key requirement is that the article address a topic relevant to the real-world practice of medicine in the urgent care setting.

Please e-mail your idea to
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Lee Resnick, MD at
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He will be happy to discuss it with you.

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Clinical

Common Lacerations of the Head

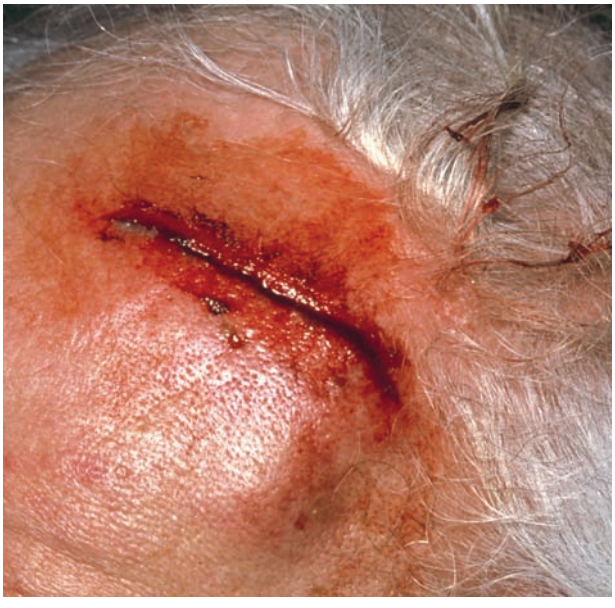
Urgent message: Effective management of head lacerations starts with hemorrhage control but also requires an understanding of appropriate use of anesthesia, the possibility of closed head or nerve injury, and vigilance for non-accidental trauma.

Clayton Josephy, MD, Samuel M. Keim, MD, MS, and Peter Rosen, MD

Introduction

Laceration repair is a common and important responsibility of physicians in the emergency and urgent care settings. A recent review of national trends in ED visits revealed that approximately 8% of presentations are for lacerations, with approximately one third of those involving structures of the head.[1]

Management and repair of soft tissue injuries to visible areas of the head tend to be especially important to the patient due to cosmetic considerations. Wounds that involve borders, margins, or multiple anatomic tissue layers have significant cosmetic and functional implications.



General Approach

As is the case with any emergent medical assessment, evaluation of a head laceration begins with the "ABCs." Lacerations of the head, especially those involving the oral or nasopharynx areas, can produce large amounts of hemorrhage, possibly resulting in airway compromise. Often, hemorrhage control (the primary focus of this article) can be achieved by direct pressure on the bleeding site. Blind clamping of vessels should be avoided, as in any other part of the body.

Following hemorrhage control, exploration of a wound is facilitated by anesthetizing the injury. In some patients, systemic analgesia will be indicated and should be administered without undue delay. Topical anesthesia is particularly helpful in children, where needle infiltration may cause significant anxiety and discomfort.[2]

With multiple or very large lacerations, it is often useful to anesthetize and repair one wound or one portion of the wound at a time. This will prevent overdose of local anesthesia, or having it wear off before the repair is carried out.

Table 1. Guidelines for Tetanus Prophylaxis in Routine Wound Management

Tetanus	Clean, minor wounds		All other wounds*	
No vaccination history	Td†	TIG	Td†	TIG
<3 doses or unknown status	Yes	No	Yes	Yes
3 or more doses: • Last dose within 5 yr • Last dose within 5-10 yr • Last dose >10 yr	 No‡ No‡ Yes	 No No No	 No Yes Yes	 No§ No§ No§

* Wounds such as, but not limited to, those contaminated with dirt, feces, soil, and saliva; puncture wounds; avulsions; and wounds resulting from missiles, crushing, burns, or frostbite.
† For children younger than 7 years, DTaP (DT, if pertussis vaccine is contraindicated) is preferred to tetanus toxoid alone. For patients 7 years or older, Td is preferred to tetanus toxoid alone.
‡ If only 3 doses of fluid toxoid have been received, then a fourth dose of toxoid, preferably an adsorbed toxoid, should be given.
§ Yes, if HIV-infected, regardless of immunization history.

Td=tetanus-diphtheria toxoids (adult type); TIG=tetanus immune globulin; DTaP=diphtheria and tetanus toxoids with acellular pertussis vaccine; DT=diphtheria and tetanus toxoids, adsorbed, pediatric strength.

Source: *Epidemiology & Prevention of Vaccine Preventable Diseases*. 8th Ed; 2004.

The maximum lidocaine infiltration without epinephrine should be 4.5 mg/kg (not to exceed 300 mg); for lidocaine with epinephrine, it should be 7 mg/kg. Toxicity thresholds, however, are variable among individuals, with some experiencing effects at relatively low doses. Vascularity of the injection site and speed of injection also play a role.[3]

Copious irrigation with sterile normal saline under pressure remains a common practice, which we recommend (although recent literature suggests that tap water is an acceptable alternative[4]).

Many repairs can be improved by careful local excision and debridement of devitalized or necrotic tissue. If the resultant wound will require moving a flap of tissue for coverage, or the placement of a skin graft, it is prudent to consult a plastic surgeon.

Generally, there is no role for prophylactic antibiotics in the management of head lacerations. The face, in particular, has a rich vascular supply and, therefore, a rate of infection lower than tissues with poorer blood supply.

On the head, wounds can safely be closed up to 12 hours after the laceration was sustained. If the wound is considerably older than 12 hours or if there is clear contamination of the wound (e.g., soil, asphalt, pus) then a delayed primary closure should be considered. This means thorough cleansing, moist dressing the wound, repeat cleaning daily, and closing the wound on day 3 or 4 when it is clear that it is not infected.

Culturing and antibiotics are indicated if the wound appears infected during this management. If the wound is infected or still contaminated after this period, it can be allowed to granulate closed without a formal repair, and then in four to six weeks, when all infection has subsided, it can be excised and closed primarily. This will of course leave a worse cosmetic scar, but it will still be superior to closing the dirty wound and having an abscess form at the site.[5]

The key to the best cosmesis of the repair is optimal approximation and timely removal of sutures. Typically, this requires a layered closure. If only the epithelial layer is closed on wounds that fully penetrate into subcutaneous tissue, and sutures removed before tissue strength regained, the final scar will resemble the width of the wound before it is closed.

The dermis should be closed with a suture material that will hold for 21 days. This can be achieved with both absorbable and non-absorbable material. For example, the dermis can be closed with monofilament nylon, but this can leave a palpable mass of suture material under the skin and possible discomfort for the patient. It can also be closed with catgut, though this material is weaker and produces an intense inflammatory reaction.[6]

Suturing needles come in different sizes and types, with the 3/8 arc, reverse-cutting needle used commonly for superficial laceration repair. In general, the needle size is chosen by considering how deep and wide (they should be roughly equal) a suturing "bite" you wish to make.

The epithelium can be closed with a paper wound closure system (e.g., Steri-strips), glue, or sutures. Most physicians prefer very small monofilament nylon for the face (5-0 and 6-0) and larger for the scalp (2-0 and 3-0). Sutures in the facial epithelium should be removed in three to five days for optimal cosmesis. The wound should be kept covered and dry for 24 hours and inspected at 48 hours for evidence of infection. Some physicians like to apply a layer of antibiotic ointment or petroleum jelly as a barrier and to keep

the scab from becoming enmeshed with the sutures. Wound infection with careful primary closure on the head should be around 1%.[6]

Cosmetic repair is less important for the scalp unless it is bald. Closure here is facilitated by shaving a small area of scalp hair, although this is not necessary for protection against infection. A single layer closure will suffice, with a running monofilament nylon suture of 2-0 or 3-0 gauge. This should be removed in seven to 10 days. Analgesia should not be delayed as part of the management of lacerations, although most wound pain will be adequately managed with an adequate instillation of local anesthesia. The circumstances of the mechanism of injury is sometimes difficult to evaluate, and non-accidental trauma should be considered.[6-10]

Tetanus status should be reviewed (and documented) as part of every wound evaluation. Tetanus immunity wanes over time at an unpredictable rate, and screening is especially important in the elderly patient.[11] Current recommendations are that anyone with uncertain tetanus status in the last five years should receive a booster, and children under 7-years-old should receive DTaP unless contraindicated (**Table 1**).[11-14]

Specific Anatomic Considerations

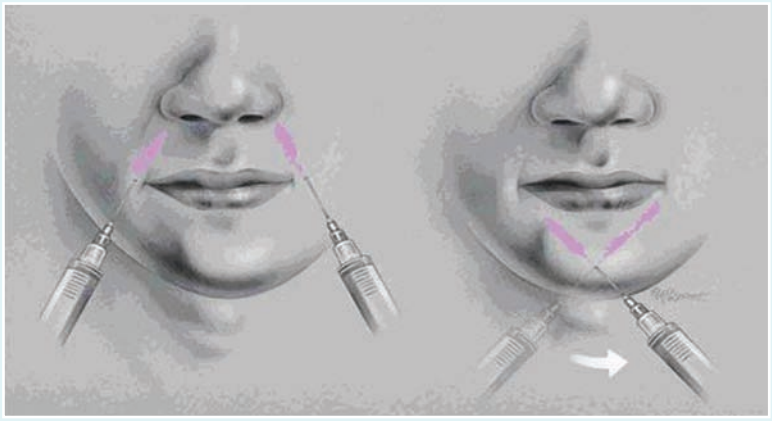
Scalp

The scalp laceration may produce enough hemorrhage to lead to hypovolemic shock. While this is more common in children, it can occur in adults, often in an alcohol-intoxicated patient who is bleeding from a scalp wound while "sleeping it off."

Scalp bleeders are hard to control, but control is useful in order to complete the rest of the evaluation. Two suggested methods are to either place a series of Raney clips that compress the bleeding vessel against the scalp or to quickly close the laceration with a running 2-0 Mersilene suture. After the evaluation of the patient is complete, either of these modalities can be removed and a more cosmetic repair achieved.

Wounds caused by significant force should promote

Figure 1.



Infraorbital and mental nerve blockade via field infiltration for upper and lower lip blocks.

Illustration courtesy Gohar Salam, MD, FACS.

concern for skull fracture or intracranial injury. This will likely require CT scan and evaluation for possible cervical spine injury.

Lips

Lip lacerations are a technical challenge, since even minute deviations from anatomical alignment can result in unsightly scar formation. The vermillion border must be meticulously repaired if involved. Some find that marking the border edges with a tuberculin-syringe injection of methylene blue aids this.

Even a malalignment of 1 mm will be apparent. If the clinician is unsure that his training and experience has prepared him for this procedure, referral is the best option.

Anesthesia can be obtained using topical lidocaine-adrenaline-tetracaine gel alone or followed by local infiltration with lidocaine. Regional anesthesia of the ipsilateral mental nerve block will cover half of the lower lip; similarly, an infraorbital nerve block will do the same for the upper lip (**Figure 1**).[15] Generally, nerve blocks are preferable to local infiltration when possible to avoid distortion of the anatomy.

Lacerations involving only the intraoral buccal mucosa frequently do not require closure unless the defect is large enough to trap food particles, due to the inherent vascularity and rapid epithelialization of mucosal tissue. Lacerations that exceed 1 cm in length should be closed using 4-0 absorbable suture with either interrupted, mattress, or running sutures.[6] Full thickness buccal lacerations require a three-layer closure to re-establish integrity of oral form and functional competency. Many ED and urgent care physicians will choose to refer these to a plastic or oral surgeon. Some oral surgeons recommend prophylactic antibiotics if the mucosa is penetrated.

Tongue

Typically, lacerations of the tongue occur from falls, penetrating trauma, or during seizures from bites. The majority of tongue lacerations need no closure. Indications for closure include persistent bleeding and major anatomic deformity (especially edges and tip). Partial amputations need referral to ENT or oral surgery.[6]

Anesthesia of the tongue is difficult to achieve due to its very vascular structure; in addition, local anesthesia wears off quickly. If the laceration involves only one side of the tongue, a lingual block may be used. A bite block is useful and prudent to maintain oral patency, and to protect the physician while repairing the tongue laceration. After adequate anesthesia is obtained, a towel clamp can be applied to the distal tip of the tongue for traction.

The wound should be approximated with widely spaced sutures using deep throws to close the entire wound in one layer. Multiple layer closure is unnecessary. Patients should be given analgesia, and instructed to swish and spit with oral antiseptic mouthwash twice a day following discharge. Depending upon the suture material chosen, the sutures can either fall out on their own or be removed within a week.

Eyelid

Simple lacerations to the eyelid can be managed in the urgent care center, provided they are superficial and do not include the lid margin (**Table 2** identifies presentations that may warrant immediate referral). A thorough examination of the globe is warranted to rule out possible injury.

Simple lacerations to the upper eyelid should be repaired using fine nonabsorbable suture material. Don't use tissue adhesive near the eye. Anesthesia

Table 2. Emergent Eyelid Referrals

- Lacerations involving the eyelid margins.
- Lacerations involving the medial eyelid; these have a high probability of involving the lacrimal system and require canaliculae microintubation to avoid epiphora or obstruction.
- Lacerations to the lateral eyelid which may involve the lacrimal gland.
- Lacerations with obvious periorbital fat expulsion likely involve the preorbital septum and require operative exploration.
- Ptosis indicates disruption of the levator palpebrae which needs to be surgically repaired.
- Any laceration involving the inner conjunctival mucosa of the eyelid, or full thickness lacerations which require layered microvascular repair of the five layers of the eyelid, including the tarsal plate.

should include careful soft tissue infiltration. The dermis is a very thin layer on the eyelid, but dermal approximation is particularly important. If the physician has no experience with the use of very fine sutures, then referral to the ophthalmologist or plastic surgeon is prudent.

If the lid margin or the under surface of the eyelid (the corneal side) is involved, the patient should be referred to the ophthalmologist. This also should be done for those lacerations near the nasal margin of the lid that might or do involve the lacrimal duct. When in doubt, assume the duct is involved and refer the patient.

Ear

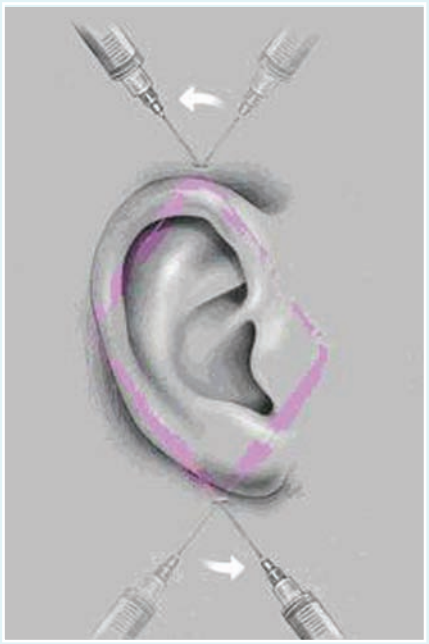
The anatomy of the ear is composed of cartilaginous framework covered by a thin layer of perichondrium and very thin layer of subcutaneous tissue and skin, making repair quite difficult. The innervation of the ear is complicated and supply is from branches of the trigeminal nerve, the facial nerve, the cervical plexus via the auricular nerve, and branches of the vagus nerve. Lacerations of the ear are often complex.

Because of the frail anatomy and tenuous vascular supply to underlying structures, the auricle (external ear or pinna) is prone to complications, including avascular necrosis of cartilage, infection, abscess, and hematoma formation. Failure to drain a pinna hematoma leads to failure of the perichondrium to adhere to the underlying cartilage. This, in turn, leads to the inflammatory fibrosis calcification known as "cauliflower ear."

Wound management of ear lacerations should include an assessment of the tympanic membrane. A hemotympanum indicates the presence of a basilar skull fracture. Otorrhea is hard to detect, and should be looked for when there is a hemotympanum.

Persistent oozing in the ear canal may, in fact, be otorrhea rather than a simple laceration of the ear canal. Application of a piece of filter paper or ordinary tissue paper may demonstrate a layering of the

Figure 2.



Field block for anesthesia of the pinna.

Illustration courtesy Gohar Salam, MD, FACS. First published in: Salam GA. Regional anesthesia for office procedures: Part I. Head and neck surgeries. *Am Fam Physician*. 2004;69(3):585-590.

fluid that represents otorrhea. If either a hemotympanum or otorrhea is found, the patient will need a head CT scan, and should have a neurosurgical consultation. Prophylactic antibiotics are not helpful, and should not be used.

Since the seventh and eighth cranial nerves run near the ear, any laceration of the ear is an indication to test the function of these two nerves. A partial 7th nerve injury may include loss of taste over the anterior 2/3 of the tongue. This will be easily missed if not explicitly tested. An alcohol swab can be used to test taste if there are no other substances conveniently available.

Obtaining anesthesia of the auricle is done by a number of methods. Local wound infiltration is best avoided due to the thin nature of the damaged tissue and potential of further dissection of the perichondrium from the cartilage.

The great auricular nerve can be blocked regionally by infiltrating along the anterior surface of the sternocleidomastoid. Alternatively, regionally blocking the inferior supply of the auricle can be done by infiltrating inferior to the auricle itself. It is important to include the pre-tragal area.

The superior innervation is supplied by the V3 block of the trigeminal nerve; a field block can be performed in this region, resulting in complete anesthesia of the external pinna (**Figure 2**).

The innervations of the meatus and external canal are supplied by the vagus nerve and are very difficult to anesthetize without infiltrating directly into the tissues of the canal. This is usually not necessary for common repairs of the pinna. Epinephrine should not be used with local anesthesia of the ear.

After anesthesia is obtained, irrigation is performed; take care not to damage tissue. Exploration will reveal foreign bodies and the extent of the injury. The layers of the ear must be carefully approximated to assure complete coverage of the cartilage and restoration of normal anatomic relationships so that vascular supply is re-established.

Repair should utilize interrupted fine nonabsorbable sutures. It may be necessary to anatomically align larger wounds with a suture through the cartilage since the perichondrium is so thin. In general, if the laceration is extensive and involves the cartilage it is only prudent to consider referral or consultation with a plastic surgeon. Exposed cartilage needs to be fully covered to avoid infection. Tissue and cartilage debridement should be avoided as much as possible (**Figure 3**).

Dressing the ear can be a bit complex. Patients will not tolerate a dressing that hyperflexes or extends the pinna. Therefore, it is necessary to protect the ear by building a layer of cotton puffs posterior to the pinna to maintain its normal position. A layer of gauze or wrap can be applied exterior to these. Many lacerations can be left open with no dressing other than a layer of antibiotic ointment or petroleum jelly. These lacerations do not require prophylactic antibiotics.

Nose

Cosmetically, the nose acts as the central point of symmetry in the face, and disfigurement can have significant cosmetic consequences. Evaluation of blunt injury to the nose includes a search for injuries to the bony and cartilaginous structures, e.g., the septum, as well as the sinuses and the facial bones.

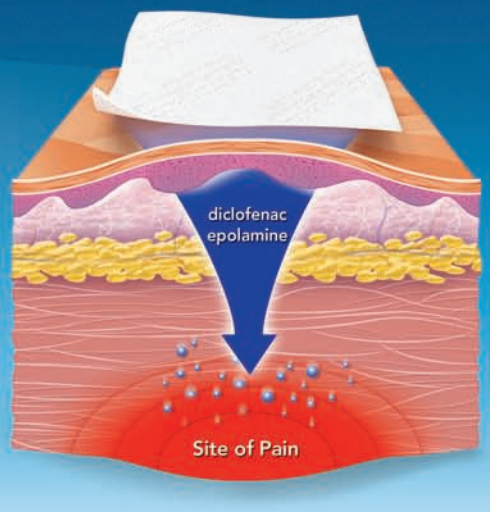
FOR THE TOPICAL TREATMENT OF ACUTE PAIN DUE TO MINOR STRAINS, SPRAINS, AND CONTUSIONS

NSAID POWER

that targets the site of acute pain

FLECTOR® Patch

- A unique way of delivering the proven efficacy of diclofenac in a patch that provides minimal systemic exposure[1,2]
- Diclofenac is a nonsteroidal anti-inflammatory drug[2]



- Dispensed in boxes of 30 patches
- 2 weeks of therapy = 1 box
- 1 month of therapy = 2 boxes

FLECTOR® Patch is indicated for the topical treatment of acute pain due to minor strains, sprains, and contusions.

Carefully consider the potential benefits and risks of FLECTOR® Patch and other treatment options before deciding to use FLECTOR® Patch. Use the lowest effective dose for the shortest duration consistent with individual patient treatment goals.

Important Safety Information

Cardiovascular (CV) risk

- **NSAIDs may cause an increased risk of serious CV thrombotic events, myocardial infarction, and stroke, which can be fatal. This risk may increase with duration of use. Patients with CV disease or risk factors for CV disease may be at greater risk**
- **FLECTOR® Patch is contraindicated for the treatment of perioperative pain in the setting of coronary artery bypass graft (CABG) surgery**

Gastrointestinal (GI) risk

- **NSAIDs cause an increased risk of serious GI adverse events at any time during use and without warning symptoms including bleeding, ulceration, and perforation of the stomach or intestines, which can be fatal. Elderly patients are at greater risk for serious GI events**

FLECTOR® Patch is contraindicated in patients with known hypersensitivity to diclofenac. FLECTOR® Patch should not be given to patients who have experienced asthma, urticaria, or allergic-type reactions after taking aspirin or other NSAIDs. Severe, rarely fatal, anaphylactic-like reactions to NSAIDs have been reported in such patients.

FLECTOR® Patch should not be applied to non-intact or damaged skin resulting from any etiology, e.g., exudative dermatitis, eczema, infected lesion, burns or wounds.

NSAIDs, including FLECTOR® Patch, can lead to new onset or worsening of hypertension, contributing to increased incidence of CV events. Fluid retention and edema have been observed in some patients taking NSAIDs. Use with caution in patients with hypertension, fluid retention or heart failure.

A patient with symptoms and/or signs of liver dysfunction, or with a history of an abnormal liver test, should be monitored for a more severe hepatic reaction and therapy stopped. Anemia is sometimes seen in patients receiving NSAIDs and platelet inhibition has been shown to prolong bleeding times.

Long-term administration of NSAIDs has resulted in renal papillary necrosis and other renal injury. Renal toxicity has also been seen in patients in whom renal prostaglandins have a compensatory role in maintaining renal perfusion. FLECTOR® Patch is not recommended in patients with advanced renal disease.

NSAIDs, including FLECTOR® Patch, can cause serious skin adverse events without warning such as exfoliative dermatitis, Stevens-Johnson Syndrome (SJS), and toxic epidermal necrolysis (TEN), which can be fatal. Patients should be informed about the signs and symptoms of serious skin manifestations and use of the drug should be discontinued at the first appearance of skin rash or any other sign of hypersensitivity.

Overall, the most common adverse events associated with FLECTOR® Patch were skin reactions (pruritus, dermatitis, burning, etc.) at the site of treatment and gastrointestinal disorders (nausea, dysgeusia, dyspepsia, etc.) and nervous system disorders (headache, paresthesia, somnolence, etc.).

In late pregnancy, as with other NSAIDs, FLECTOR® Patch should be avoided because it may cause premature closure of the ductus arteriosus. FLECTOR® Patch is in Pregnancy Category C. Safety and effectiveness in pediatric patients have not been established.

Please see Brief Summary of full Prescribing Information, including boxed warning, on adjacent page.

For more information, please visit www.FlectorPatch.com or www.KingPharm.com.

References: 1. Data on file. King Pharmaceuticals®, Inc. **2.** Flector Patch [package insert]. Piscataway, NJ: Alpharma Pharmaceuticals LLC; 2008.

King Pharmaceuticals

FLE5904 01/2009

Flector® patch
(diclofenac epolamine topical patch) 1.3%
Targeted NSAID Power

Flector® Patch (diclofenac epolamine topical patch) 1.3%

Brief Summary **Rx only**

Cardiovascular Risk: • NSAIDs may cause an increased risk of serious cardiovascular thrombotic events, myocardial infarction, and stroke, which can be fatal. This risk may increase with duration of use. Patients with cardiovascular disease or risk factors for cardiovascular disease may be at greater risk (See **WARNINGS** and Full Prescribing Information, **CLINICAL TRIALS**). • Flector® Patch is contraindicated for the treatment of peri-operative pain in the setting of coronary artery bypass graft (CABG) surgery (see **WARNINGS**).

Gastrointestinal Risk: • NSAIDs cause an increased risk of serious gastrointestinal adverse events including bleeding, ulceration, and perforation of the stomach or intestines, which can be fatal. These events can occur at any time during use and without warning symptoms. Elderly patients are at greater risk for serious gastrointestinal events (See **WARNINGS**).

INDICATION AND USAGE: Carefully consider the potential benefits and risks of Flector® Patch and other treatment options before deciding to use Flector® Patch. Use the lowest effective dose for the shortest duration consistent with individual patient treatment goals (see **WARNINGS**).

Flector® Patch is indicated for the topical treatment of acute pain due to minor strains, sprains, and contusions.

CONTRAINDICATIONS: Flector® Patch is contraindicated in patients with known hypersensitivity to diclofenac.

Flector® Patch should not be given to patients who have experienced asthma, urticaria, or allergic-type reactions after taking aspirin or other NSAIDs. Severe, rarely fatal, anaphylactic-like reactions to NSAIDs have been reported in such patients (see **WARNINGS - Anaphylactoid Reactions**, and **PRECAUTIONS - Preexisting Asthma**).

Flector® Patch is contraindicated for the treatment of peri-operative pain in the setting of coronary artery bypass graft (CABG) surgery (see **WARNINGS**).

Flector® Patch should not be applied to non-intact or damaged skin resulting from any etiology e.g. exudative dermatitis, eczema, infected lesion, burns or wounds.

WARNINGS: CARDIOVASCULAR EFFECTS: Cardiovascular Thrombotic Events: Clinical trials of several COX-2 selective and nonselective NSAIDs of up to three years duration have shown an increased risk of serious cardiovascular (CV) thrombotic events, myocardial infarction, and stroke, which can be fatal. All NSAIDs, both COX-2 selective and nonselective, may have a similar risk. Patients with known CV disease or risk factors for CV disease may be at greater risk. To minimize the potential risk for an adverse CV event in patients treated with an NSAID, the lowest effective dose should be used for the shortest duration possible. Physicians and patients should remain alert for the development of such events, even in the absence of previous CV symptoms. Patients should be informed about the signs and/or symptoms of serious CV events and the steps to take if they occur.

There is no consistent evidence that concurrent use of aspirin mitigates the increased risk of serious CV thrombotic events associated with NSAID use. The concurrent use of aspirin and an NSAID does increase the risk of serious GI events (see **GI WARNINGS**). Two large, controlled, clinical trials of a COX-2 selective NSAID for the treatment of pain in the first 10-14 days following CABG surgery found an increased incidence of myocardial infarction and stroke (see **CONTRAINDICATIONS**).

Hypertension: NSAIDs, including Flector® Patch, can lead to onset of new hypertension or worsening of preexisting hypertension, either of which may contribute to the increased incidence of CV events. Patients taking thiazides or loop diuretics may have impaired response to these therapies when taking NSAIDs. NSAIDs, including Flector® Patch, should be used with caution in patients with hypertension. Blood pressure (BP) should be monitored closely during the initiation of NSAID treatment and throughout the course of therapy.

Congestive Heart Failure and Edema: Fluid retention and edema have been observed in some patients taking NSAIDs. Flector® Patch should be used with caution in patients with fluid retention or heart failure.

Gastrointestinal Effects- Risk of Ulceration, Bleeding, and Perforation: NSAIDs, including Flector® Patch, can cause serious gastrointestinal (GI) adverse events including inflammation, bleeding, ulceration, and perforation of the stomach, small intestine, or large intestine, which can be fatal. These serious adverse events can occur at any time, with or without warning symptoms, in patients treated with NSAIDs. Only one in five patients, who develop a serious upper GI adverse event on NSAID therapy, is symptomatic. Upper GI ulcers, gross bleeding, or perforation caused by NSAIDs occur in approximately 1% of patients treated for 3-6 months, and in about 2-4% of patients treated for one year. These trends continue with longer duration of use, increasing the likelihood of developing a serious GI event at some time during the course of therapy. However, even short-term therapy is not without risk.

NSAIDs should be prescribed with extreme caution in those with a prior history of ulcer disease or gastrointestinal bleeding. Patients with a *prior history of peptic ulcer disease and/or gastrointestinal bleeding* who use NSAIDs have a greater than 10-fold increased risk for developing a GI bleed compared to patients with neither of these risk factors. Other factors that increase the risk for GI bleeding in patients treated with NSAIDs include concomitant use of oral corticosteroids or anticoagulants, longer duration of NSAID therapy, smoking, use of alcohol, older age, and poor general health status. Most spontaneous reports of fatal GI events are in elderly or debilitated patients and therefore, special care should be taken in treating this population.

To minimize the potential risk for an adverse GI event in patients treated with an NSAID, the lowest effective dose should be used for the shortest possible duration. Patients and physicians should remain alert for signs and symptoms of GI ulceration and bleeding during NSAID therapy and promptly initiate additional evaluation and treatment if a serious GI adverse event is suspected. This should include discontinuation of the NSAID until a serious GI adverse event is ruled out. For high risk patients, alternate therapies that do not involve NSAIDs should be considered.

Renal Effects: Long-term administration of NSAIDs has resulted in renal papillary necrosis and other renal injury. Renal toxicity has also been seen in patients in whom renal prostaglandins have a compensatory role in the maintenance of renal perfusion. In these patients, administration of a nonsteroidal anti-inflammatory drug may cause a dose-dependent reduction in prostaglandin formation and, secondarily, in renal blood flow, which may precipitate overt renal decompensation. Patients at greatest risk of this reaction are those with impaired renal function, heart failure, liver dysfunction, those taking diuretics and ACE inhibitors, and the elderly. Discontinuation of NSAID therapy is usually followed by recovery to the pretreatment state.

Advanced Renal Disease: No information is available from controlled clinical studies regarding the use of Flector® Patch in patients with advanced renal disease. Therefore, treatment with Flector® Patch is not recommended in these patients with advanced renal disease. If Flector® Patch therapy is initiated, close monitoring of the patient's renal function is advisable.

Anaphylactoid Reactions: As with other NSAIDs, anaphylactoid reactions may occur in patients without known prior exposure to Flector® Patch. Flector® Patch should not be given to patients with the aspirin triad. This symptom complex typically occurs in asthmatic patients who experience rhinitis with or without nasal polyps, or who exhibit severe, potentially fatal bronchospasm after taking aspirin or other NSAIDs (see **CONTRAINDICATIONS** and **PRECAUTIONS - Preexisting Asthma**). Emergency help should be sought in cases where an anaphylactoid reaction occurs.

Skin Reactions: NSAIDs, including Flector® Patch, can cause serious skin adverse events such as exfoliative dermatitis, Stevens-Johnson Syndrome (SJS), and toxic epidermal necrolysis (TEN), which can be fatal. These serious events may occur without warning. Patients should be informed about the signs and symptoms of serious skin manifestations and use of the drug should be discontinued at the first appearance of skin rash or any other sign of hypersensitivity.

Pregnancy: In late pregnancy, as with other NSAIDs, Flector® Patch should be avoided because it may cause premature closure of the ductus arteriosus.

PRECAUTIONS: General: Flector® Patch cannot be expected to substitute for corticosteroids or to treat corticosteroid insufficiency. Abrupt discontinuation of corticosteroids may lead to disease exacerbation. Patients on prolonged corticosteroid therapy should have their therapy tapered slowly if a decision is made to discontinue corticosteroids.

The pharmacological activity of Flector® Patch in reducing inflammation may diminish the utility of these diagnostic signs in detecting complications of presumed noninfectious, painful conditions.

Hepatic Effects: Borderline elevations of one or more liver tests may occur in up to 15% of patients taking NSAIDs including Flector® Patch. These laboratory abnormalities may progress, may remain unchanged, or may be transient with continuing therapy. Notable elevations of ALT or AST (approximately three or more times the upper limit of normal) have been reported in approximately 1% of patients in clinical trials with NSAIDs. In addition, rare cases of severe hepatic reactions, including jaundice and fatal fulminant hepatitis, liver necrosis and hepatic failure, some of them with fatal outcomes have been reported.

A patient with symptoms and/or signs suggesting liver dysfunction, or in whom an abnormal liver test has occurred, should be evaluated for evidence of the development of a more severe hepatic reaction while on therapy with Flector® Patch. If clinical signs and symptoms consistent with liver disease develop, or if systemic manifestations occur (e.g. eosinophilia, rash, etc.), Flector® Patch should be discontinued.

Hematological Effects: Anemia is sometimes seen in patients receiving NSAIDs. This may be due to fluid retention, occult or gross GI blood loss, or an incompletely described effect upon erythropoiesis. Patients on long-term treatment with NSAIDs, including Flector® Patch, should have their hemoglobin or hematocrit checked if they exhibit any signs or symptoms of anemia.

NSAIDs inhibit platelet aggregation and have been shown to prolong bleeding time in some patients. Unlike aspirin, their effect on platelet function is quantitatively less, of shorter duration, and reversible. Patients receiving Flector® Patch who may be adversely affected by alterations in platelet function, such as those with coagulation disorders or patients receiving anticoagulants, should be carefully monitored.

Preexisting Asthma: Patients with asthma may have aspirin-sensitive asthma. The use of aspirin in patients with aspirin-sensitive asthma has been associated with severe bronchospasm which can be fatal. Since cross reactivity, including bronchospasm, between aspirin and other nonsteroidal anti-inflammatory drugs has been reported in such aspirin-sensitive patients, Flector® Patch should not be administered to patients with this form of aspirin sensitivity and should be used with caution in patients with preexisting asthma.

Eye Exposure: Contact of Flector® Patch with eyes and mucosa, although not studied, should be avoided. If eye contact occurs, immediately wash out the eye with water or saline. Consult a physician if irritation persists for more than an hour.

Accidental Exposure in Children: Even a used Flector® Patch contains a large amount of diclofenac epolamine (as much as 170 mg). The potential therefore exists for a small child or pet to suffer serious adverse effects from chewing or ingesting a new or used Flector® Patch. It is important for patients to store and dispose of Flector® Patch out of the reach of children and pets.

Information for Patients: Patients should be informed of the following information before initiating therapy with an NSAID and periodically during the course of ongoing therapy. Patients should also be encouraged to read the NSAID Medication Guide that accompanies each prescription dispensed.

1. Flector® Patch, like other NSAIDs, may cause serious CV side effects, such as MI or stroke, which may result in hospitalization and even death. Although serious CV events can occur without warning symptoms, patients should be alert for the signs and symptoms of chest pain, shortness of breath, weakness, slurring of speech, and should ask for medical advice when observing any indicative sign or symptoms. Patients should be apprised of the importance of this follow-up (see **WARNINGS, Cardiovascular Effects**). **2.** Flector® Patch, like other NSAIDs, may cause GI discomfort and, rarely, serious GI side effects, such as ulcers and bleeding, which may result in hospitalization and even death. Although serious GI tract ulcerations and bleeding can occur without warning symptoms, patients should be alert for the signs and symptoms of ulcerations and bleeding, and should ask for medical advice when observing any indicative sign or symptoms including epigastric pain, dyspepsia, melena, and hematemesis. Patients should be apprised of the importance of this follow-up (see **WARNINGS, Gastrointestinal Effects: Risk of Ulceration, Bleeding, and Perforation**). **3.** Flector® Patch, like other NSAIDs, may cause serious skin side effects such as exfoliative dermatitis, SJS, and TEN, which may result in hospitalizations and even death. Although serious skin reactions may occur without warning, patients should be alert for the signs and symptoms of skin rash and blisters, fever, or other signs of hypersensitivity such as itching, and should ask for medical advice when observing any indicative signs or symptoms. Patients should be advised to stop the drug immediately if they develop any type of rash and contact their physicians as soon as possible. **4.** Patients should be instructed to promptly report signs or symptoms of unexplained weight gain or edema to their physicians (see **WARNINGS, Cardiovascular Effects**). **5.** Patients should be informed of the warning signs and symptoms of hepatotoxicity (e.g. nausea, fatigue, lethargy, pruritus, jaundice, right upper quadrant tenderness, and "flu-like" symptoms). If these occur, patients should be instructed to stop therapy and seek immediate medical therapy. **6.** Patients should be informed of the signs of an anaphylactoid reaction (e.g. difficulty breathing, swelling of the face or throat). If these occur, patients should be instructed to seek immediate emergency help (see **WARNINGS**). **7.** In late pregnancy, as with other NSAIDs, Flector® Patch should be avoided because it may cause premature closure of the ductus arteriosus. **8.** Patients should be advised not to use Flector® Patch if they have an aspirin-sensitive asthma. Flector® Patch, like other NSAIDs, could cause severe and even fatal bronchospasm in these patients (see **PRECAUTIONS, Preexisting asthma**). Patients should discontinue use of Flector® Patch and should immediately seek emergency help if they experience wheezing or shortness of breath. **9.** Patients should be informed that Flector® Patch should be used only on intact skin. **10.** Patients should be advised to avoid contact of Flector® Patch with eyes and mucosa. Patients should be instructed that if eye contact occurs, they should immediately wash out the eye with water or saline, and consult a physician if irritation persists for more than an hour. **11.** Patients and caregivers should be instructed to wash their hands after applying, handling or removing the patch. **12.** Patients should be informed that, if Flector® Patch begins to peel off, the edges of the patch may be taped down. **13.** Patients should be instructed not to wear Flector® Patch during bathing or showering. Bathing should take place in between scheduled patch removal and application (see Full Prescribing Information, **DOSAGE AND ADMINISTRATION**). **14.** Patients should be advised to store Flector® Patch and to discard used patches out of the reach of children and pets. If a child or pet accidentally ingests Flector® Patch, medical help should be sought immediately (see **PRECAUTIONS, Accidental Exposure in Children**).

Laboratory Tests: Because serious GI tract ulcerations and bleeding can occur without warning symptoms, physicians should monitor for signs or symptoms of GI bleeding. Patients on long-term treatment with NSAIDs, should have their CBC and a chemistry profile checked periodically. If clinical signs and symptoms consistent with liver or renal disease develop, systemic manifestations occur (e.g. eosinophilia, rash, etc.) or if abnormal liver tests persist or worsen, Flector® Patch should be discontinued.

Drug Interactions: ***ACE-inhibitors:*** Reports suggest that NSAIDs may diminish the antihypertensive effect of ACE-inhibitors. This interaction should be given consideration in patients taking NSAIDs concomitantly with ACE-inhibitors.

Aspirin: When Flector® Patch is administered with aspirin, the binding of diclofenac to protein is reduced, although the clearance of free diclofenac is not altered. The clinical significance of this interaction is not known; however, as with other NSAIDs, concomitant administration of diclofenac and aspirin is not generally recommended because of the potential of increased adverse effects.

Diuretics: Clinical studies, as well as post marketing observations, have shown that Flector® Patch may reduce the natriuretic effect-of furosemide and thiazides in some patients. This response has been attributed to inhibition of renal prostaglandin synthesis. During concomitant therapy with NSAIDs, the patient should be observed closely for signs of renal failure (see **WARNINGS, Renal Effects**), as well as to assure diuretic efficacy.

Lithium: NSAIDs have produced an elevation of plasma lithium levels and a reduction in renal lithium clearance. The mean minimum lithium concentration increased 15% and the renal clearance was decreased by approximately 20%. These effects have been attributed to inhibition of renal prostaglandin synthesis by the NSAID. Thus, when NSAIDs and lithium are administered concurrently, subjects should be observed carefully for signs of lithium toxicity.

Methotrexate: NSAIDs have been reported to competitively inhibit methotrexate accumulation in rabbit kidney slices. This may indicate that they could enhance the toxicity of methotrexate. Caution should be used when NSAIDs are administered concomitantly with methotrexate.

Warfarin: The effects of warfarin and NSAIDs on GI bleeding are synergistic, such that users of both drugs together have a risk of serious GI bleeding higher than users of either drug alone.

Carcinogenesis, Mutagenesis, Impairment of Fertility: ***Carcinogenesis:*** Long-term studies in animals have not been performed to evaluate the carcinogenic potential of either diclofenac epolamine or Flector® Patch.

Mutagenesis: Diclofenac epolamine is not mutagenic in *Salmonella Typhimurium* strains, nor does it induce an increase in metabolic aberrations in cultured human lymphocytes, or the frequency of micronucleated cells in the bone marrow micronucleus test performed in rats.

Impairment of Fertility: Male and female Sprague Dawley rats were administered 1, 3, or 6 mg/kg/day diclofenac epolamine via oral gavage (males treated for 60 days prior to conception and during mating period, females treated for 14 days prior to mating through day 19 of gestation). Diclofenac epolamine treatment with 6 mg/kg/day resulted in increased early resorptions and postimplantation losses; however, no effects on the mating and fertility indices were found. The 6 mg/kg/day dose corresponds to 3-times the maximum recommended daily exposure in humans based on a body surface area comparison.

Pregnancy: ***Teratogenic Effects. Pregnancy Category C.:*** Pregnant Sprague Dawley rats were administered 1, 3, or 6 mg/kg diclofenac epolamine via oral gavage daily from gestation days 6-15. Maternal toxicity, embryotoxicity, and increased incidence of skeletal anomalies were noted with 6 mg/kg/day diclofenac epolamine, which corresponds to 3-times the maximum recommended daily exposure in humans based on a body surface area comparison. Pregnant New Zealand White rabbits were administered 1, 3, or 6 mg/kg diclofenac epolamine via oral gavage daily from gestation days 6-18. No maternal toxicity was noted; however, embryotoxicity was evident at 6 mg/kg/day group which corresponds to 6.5-times the maximum recommended daily exposure in humans based on a body surface area comparison.

There are no adequate and well-controlled studies in pregnant women. Flector® Patch should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nonteratogenic Effects: Because of the known effects of nonsteroidal anti-inflammatory drugs on the fetal cardiovascular system (closure of ductus arteriosus), use during pregnancy (particularly late pregnancy) should be avoided.

Male rats were orally administered diclofenac epolamine (1, 3, 6 mg/kg) for 60 days prior to mating and throughout the mating period, and females were given the same doses 14 days prior to mating and through mating, gestation, and lactation. Embryotoxicity was observed at 6 mg/kg diclofenac epolamine (3-times the maximum recommended daily exposure in humans based on a body surface area comparison), and was manifested as an increase in early resorptions, post-implantation losses, and a decrease in live fetuses. The number of live born and total born were also reduced as was F1 postnatal survival, but the physical and behavioral development of surviving F1 pups in all groups was the same as the deionized water control, nor was reproductive performance adversely affected despite a slight treatment-related reduction in body weight.

Labor and Delivery: In rat studies with NSAIDs, as with other drugs known to inhibit prostaglandin synthesis, an increased incidence of dystocia, delayed parturition, and decreased pup survival occurred. The effects of Flector® Patch on labor and delivery in pregnant women are unknown.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human-milk and because of the potential for serious adverse reactions in nursing infants from Flector® Patch, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness in pediatric patients have not been established.

Geriatric Use: Clinical studies of Flector® Patch did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. Other reported clinical experience has not identified differences in responses between the elderly and younger patients.

Diclofenac, as with any NSAID, is known to be substantially excreted by the kidney, and the risk of toxic reactions to Flector® Patch may be greater in patients with impaired renal function. Because elderly patients are more likely to have decreased renal function, care should be taken when using Flector® Patch in the elderly, and it may be useful to monitor renal function.

ADVERSE REACTIONS: In controlled trials during the premarketing development of Flector® Patch, approximately 600 patients with minor sprains, strains, and contusions have been treated with Flector® Patch for up to two weeks.

Adverse Events Leading to Discontinuation of Treatment: In the controlled trials, 3% of patients in both the Flector® Patch and placebo patch groups discontinued treatment due to an adverse event. The most common adverse events leading to discontinuation were application site reactions, occurring in 2% of both the Flector® Patch and placebo patch groups. Application site reactions leading to dropout included pruritus, dermatitis, and burning.

Common Adverse Events: Localized Reactions: Overall, the most common adverse events associated with Flector® Patch treatment were skin reactions at the site of treatment.

Table 1 lists all adverse events, regardless of causality, occurring in ≥ 1% of patients in controlled trials of Flector® Patch. A majority of patients treated with Flector® Patch had adverse events with a maximum intensity of "mild" or "moderate."

Table 1. Common Adverse Events (by body system and preferred term) in ≥1% of Patients treated with Flector® Patch or Placebo Patch[1]

	Diclofenac N=572		Placebo N=564	
	N	Percent	N	Percent
Application Site Conditions	64	11	70	12
Pruritus	31	5	44	8
Dermatitis	9	2	3	<1
Burning	2	<1	8	1
Other[2]	22	4	15	3
Gastrointestinal Disorders	49	9	33	6
Nausea	17	3	11	2
Dysgeusia	10	2	3	<1
Dyspepsia	7	1	8	1
Other[3]	15	3	11	2
Nervous System Disorders	13	2	18	3
Headache	7	1	10	2
Paresthesia	6	1	8	1
Somnolence	4	1	6	1
Other[4]	4	1	3	<1

[1] The table lists adverse events occurring in placebo-treated patients because the placebo-patch was comprised of the same ingredients as Flector® Patch except for diclofenac. Adverse events in the placebo group may therefore reflect effects of the non-active ingredients. [2] Includes: application site dryness, irritation, erythema, atrophy, discoloration, hyperhidriosis, and vesicles. [3] Includes: gastritis, vomiting, diarrhea, constipation, upper abdominal pain, and dry mouth. [4] Includes: hypoaesthesia, dizziness, and hyperkinesias.

Foreign labeling describes that dermal allergic reactions may occur with Flector® Patch treatment. Additionally, the treated area may become irritated or develop itching, erythema, edema, vesicles, or abnormal sensation.

DRUG ABUSE AND DEPENDENCE: Controlled Substance Class: Flector® Patch is not a controlled substance.

Physical and Psychological Dependence: Diclofenac, the active ingredient in Flector® Patch, is an NSAID that does not lead to physical or psychological dependence.

OVERDOSAGE: There is limited experience with overdose of Flector® Patch. In clinical studies, the maximum single dose administered was one Flector® Patch containing 180 mg of diclofenac epolamine. There were no serious adverse events.

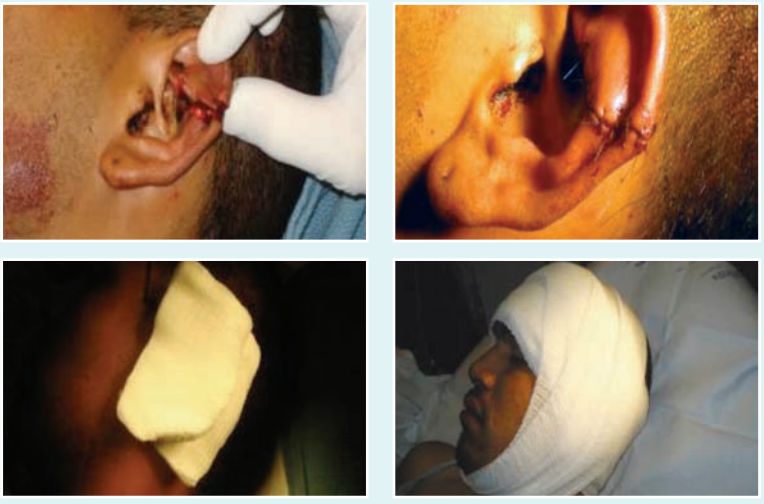
Should systemic side effects occur due to incorrect use or accidental overdose of this product, the general measures recommended for intoxication with non-steroidal anti-inflammatory drugs should be taken.

Distributed by: Alpharma Pharmaceuticals LLC
One New England Avenue, Piscataway, NJ 08854 USA
(Telephone: 1-888-840-8884) • www.FlectorPatch.com
Manufactured for: IBSA Institut Biochimique SA, CH-6903 Lugano, Switzerland
Manufactured by: Teikoku Seiyaku Co., Ltd., Sanbonmatsu, Kagawa 769-2695 Japan
Version June 2008 FI/161 1086 Ed. II/06.08

Most nasal fractures stop bleeding. A stubbornly persistent ooze may represent cerebrospinal fluid rhinorrhea from a cribiform plate fracture. This, like otorrhea, can be tested for with a piece of filter paper or tissue, looking for a layering out of the ooze. This would indicate a head CT scan, and a neurosurgical consultation. These patients do not require prophylactic antibiotics.

Anesthesia of the nose sometimes requires anesthesia of the septum, as well as the soft tissue around the laceration and the epithelium of the laceration. Regional blocks, while useful, are hard to achieve because of the diversity of the innervation of the area. You may not be able to manage complex injuries with local anesthesia. Such patients should have procedural sedation or general anesthesia and may need to be referred to the ED or operating room. These lacerations may require plastic surgery consultation. Topical anesthesia of the nasal mucosa is often adequate for nasal packing. Local anesthetic infiltration of the nose should *not* include epinephrine.

Figure 3.



Repair of full thickness ear laceration with application of pressure dressing.

Nasal lacerations either involve superficial skin only or are complex, including cartilage and bony elements of the nose. Superficial lacerations can be closed with fine non-absorbable sutures.

The physician should look for a septal hematoma, septal deviation, or nasal fracture. If present, these will need to be treated because they represent an open fracture. Many ENTs and plastic surgeons prefer to reduce septal deviations acutely. A septal hematoma needs to be drained to prevent necrosis of the septum. Needle aspiration is rarely successful since the hematoma often recurs. An incision should be made in the mucosa and the anterior chamber packed over a petroleum jelly gauze dressing.

Bilateral septal hematomas should be referred to the ENT or plastic surgeon, and not managed in the urgent care center. Through and through, lacerations of the nose are rarely isolated injuries, and are best referred and repaired by an ENT or plastic surgeon.

Summary

Common head lacerations can be managed by physicians in urgent care setting if careful attention is given to anatomical considerations. Cosmesis is a significant patient concern. ■

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The Urgent Care Association of America® congratulates the following centers who were recently presented their Certified Urgent Care designation.

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For more information on how to become a Certified Urgent Care, visit www.ucaoa.org.

Trust the Guidelines; Know Your Resistance Data

NAHUM KOVALSKI, BSC, MDCM

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

This month, we depart slightly from our typical format in order to explore one such case in greater detail.

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

Initial Presentation: Primary Care

The patient is a 45-year-old woman (herself a surgeon) who presented three weeks after first visiting her family physician with a cough, at which time the x-ray shown in **Figure 1** was taken.

She was started on erythromycin for 10 days.

After finishing that course of antibiotics with no improvement, she was started on amoxicillin-clavulanic acid.

Four days later, there was still no improvement in her status.

Second Presentation: Urgent Care

By the time the patient presented to urgent care on June 5 of this year, her complaints included back pain and weakness, in addition to the cough.

Noting that she has insulin-dependent diabetes mellitus, she also reported that her home glucose readings were "high."

Vital signs at the time of presentation to urgent care were as follows:

- Temp: 36.5°C
- Sat 94%
- Pulse 104
- BP 153/82.

Her second film (**Figure 2**), taken at the urgent care center, showed a large right-sided infiltrate/process.

Nahum Kovalski is an urgent care practitioner and assistant medical director/CIO at Terem Emergency Medical Centers in Jerusalem, Israel.

Resolution

This patient was referred to hospital, where she underwent a CT which confirmed an empyema. At the time of publication, she has a chest tube in place for drainage and is on IV antibiotics.

Teaching Points

This case serves as an important reminder that empyema is still a very real entity, even in patients who are treated early with antibiotics. Here, the failure of both a macrolide and a beta-lactam should raise suspicion of resistant pneumococcus.

The Infectious Diseases Society of America/American Thoracic Society Consensus Guidelines on the Management of Community-acquired Pneumonia in Adults note that the presence of certain comorbidities—diabetes mellitus among them—calls for aggressive, empiric treatment of community-acquired pneumonia (CAP):

- A respiratory fluoroquinolone (moxifloxacin, gemifloxacin, or levofloxacin [750 mg]) (strong recommendations; level I evidence)
- A beta-lactam *plus* a macrolide (strong recommendation; level I evidence), with high-dose amoxicillin (e.g., 1 g three times daily) or amoxicillin-clavulanate (2 g twice daily) preferred. Alternatives include:
  - ceftriaxone, cefpodoxime, and cefuroxime (500 mg twice daily)
  - doxycycline (level II evidence) in place of the macrolide

Table 1. Recommended Empirical Antibiotics for Community-acquired Pneumonia

Outpatient Treatment

1. Previously healthy and no use of antimicrobials within the previous 3 months:
   - A macrolide (strong recommendation; level I evidence)
   - Doxycyline (weak recommendation; level III evidence)
2. Presence of comorbidities such as chronic heart, lung, liver or renal disease; diabetes mellitus; alcoholism; malignancies; asplenia; immunosuppressing conditions or use of immunosuppressing drugs; or use of antimicrobials within the previous 3 months (in which case an alternative from a different class should be selected):
   - A respiratory fluoroquinolone (moxifloxacin, gemifloxacin, or levofloxacin [750 mg]) (strong recommendation; level I evidence)
   - A beta-lactam *plus* a macrolide (strong recommendation; level I evidence)
3. In regions with a high rate (>25%) of infection with high-level (MIC≥16 mg/mL) macrolide-resistant *Streptococcus pneumoniae,* consider use of alternative agents listed above in (2) for patients without comorbidities (moderate recommendation; level III evidence)

Inpatient, Non-ICU Treatment

- A respiratory fluoroquinolone (strong recommendation; level I evidence)
- A beta-lactam *plus* a macrolide (strong recommendation; level I evidence)

Inpatient, ICU Treatment

- A beta-lactam (cefotaxime, ceftriaxone, or ampicillin-sulbactam) *plus* either azithromycin (level II evidence)

or

- A respiratory fluoroquinolone (level I evidence) (strong recommendation) (for penicillin-allergic patients, a respiratory fluoroquinolone and aztreonam are recommended)

Special Concerns

If *Pseudomonas* is a consideration:

- An anti-pneumococcal, anti-pseudomonal beta-lactam (piperacillin-tazobactam, cefepime, imipenem, or meropenem) *plus* either
- ciprofloxacin or levofloxacin (750 mg)

or

- the above beta-lactam plus an aminoglycoside and azithromycin

or

- the above beta-lactam plus an aminoglycoside and an anti-pneumococcal
- fluoroquinolone (for penicillin-allergic patients, substitute aztreonam for above beta-lactam) (moderate recommendation; level III evidence)

If CA-MRSA is a consideration, add vancomycin or linezolid (moderate recommendation; level III evidence)

CA-MRSA=community-acquired methicillin-resistant *Staphylococcus aureus*
ICU=intensive care unit

Source: Mandell LA, Wunderink RG, Anzueto A, et al. Infectious Diseases Society of America/American Thoracic Society consensus guidelines on the management of community-acquired pneumonia in adults. *Clin Infect Dis.* 2007;44:S27-72.

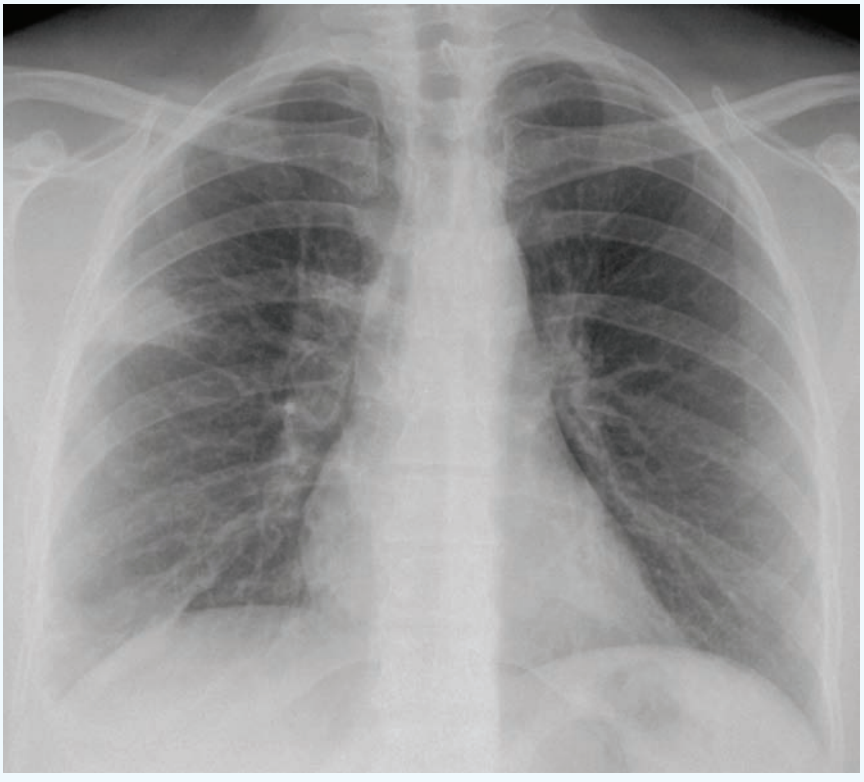

Figure 1—First presentation.

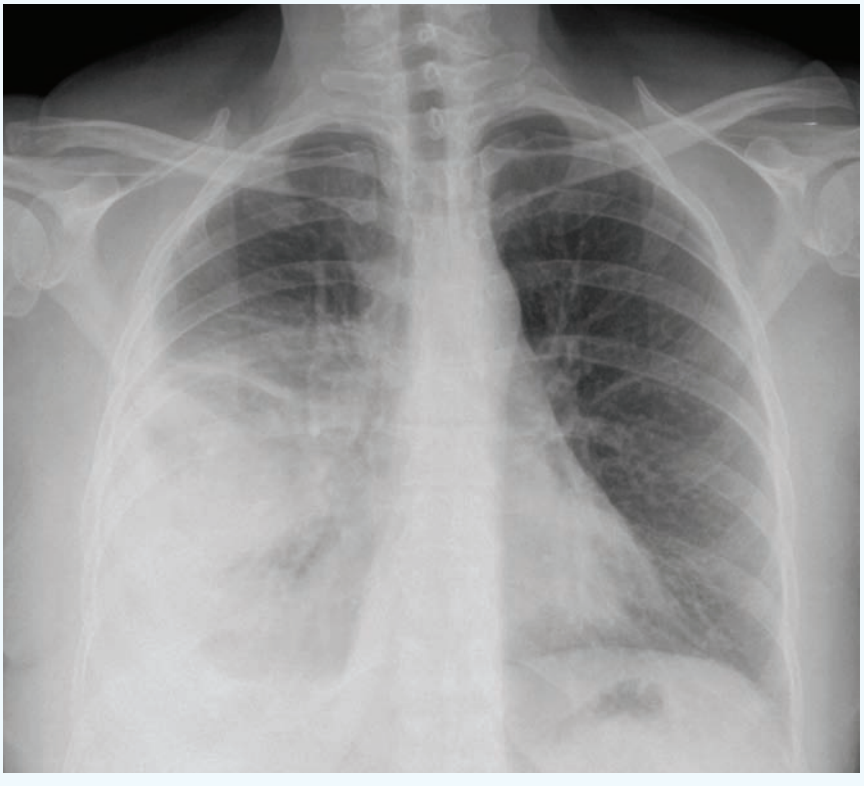

Figure 2—Three weeks later.

In regions where the rate of infection with high-level (MIC, ≥16 mcg/mL) macrolide-resistant *Streptococcus pneumoniae* exceeds 25%, the IDSA/ATS guidelines recommend that we consider using the alternative agents for any patient even in patients with no comorbidities (moderate recommendation; level III evidence).

The recommendations for empiric use of antibiotics for CAP are summarized in **Table 1**.

Pneumococcal resistance is particularly high in the U.S., but varies by region. Local health departments are an invaluable resource and should be consulted to determine pneumococcal resistance patterns in your area. ■

ABSTRACTS IN URGENT CARE

On the Pandemic Potential of H1N1, Survival After Out-of-Hospital Cardiac-Arrest, Discharge Instructions, Treatment of Head Lice, Scorpion Stings, and Rheumatic Fever

■ NAHUM KOVALSKI, BSc, MDCM

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

Early Estimate of Pandemic Potential of Influenza A H1N1 "Swine Flu"

Key point: The current virus is transmitted efficiently but probably is less lethal than past pandemic viruses.

Citation: Fraser C, DonnellyCA, Cauchemez S, et al. Pandemic potential of a strain of influenza A (H1N1): Early findings. *Science*. 2009 May 14; e-pub ahead of print.

A team of epidemiologists has analyzed the influenza A (H1N1) epidemic in Mexico. Data related to the outbreak were collected primarily in April and early May 2009. The researchers presented several tentative conclusions:

Cases outside of Mexico occurred most commonly in countries that had the highest volume of travelers from Mexico.

Attack rates of clinical disease are higher in children younger than 15 years than in adults (relative risk for children, 1.52). This finding suggests that, although the virus is novel, adults might have some protection due to cross-immunity from exposure to strains that have circulated in the past.

The virus is transmitted more efficiently from person to person than are usual seasonal flu viruses.

The estimated fatality rate is 0.4%; this virus is considerably less lethal than the virus that caused the 1918–1919 pandemic but somewhat more lethal than usual seasonal flu viruses.

Nahum Kovalski is an urgent care practitioner and assistant medical director/CIO at Terem Emergency Medical Centers in Jerusalem, Israel.

These data indicate that the current H1N1 virus is more transmissible and possibly more lethal than regular seasonal flu viruses, but it is considerably less transmissible and lethal than the catastrophic 1918–1919 pandemic virus. However, influenza viruses mutate rapidly, and this virus could change considerably in the coming months.

Published in *J Watch General Med*, May 21, 200—Anthony L. Komaroff, MD. ■

Protocol Stressing Uninterrupted Compressions Can Improve Survival After Out-of-Hospital Cardiac Arrest

Key point: Survival among adults with bystander-witnessed, out-of-hospital cardiac arrest with an initial rhythm of ventricular fibrillation (VF) improved from 22% to 44% following changes to a resuscitation protocol.

Citation: Garza AG, Gratton MC, Salomone JA, et al. Improved patient survival using a modified resuscitation protocol for out-of-hospital cardiac arrest. *Circulation*. 2009;119:2597-2605.

In this study, two protocols were compared. The historical protocol followed AHA 2000 guidelines, while the revised protocol modified this and advocated CPR before defibrillation, increased chest compressions, and decreased emphasis on ventilations and intubation in order to promote cardiac perfusion.

The study adds to the body of science demonstrating that chest compressions—and limiting interruptions to chest compressions—are one of the most important interventions that can be provided for out-of-hospital cardiac arrest

Continued on page 26

Managing Summer Lacerations in Children

Emory Petrack, MD, FAAP, FACEP

The hard play of hot summer days means those of us in the urgent care business will be seeing more children with cuts and bruises. This installment of Pediatric Urgent Care will reveal family- and child-focused ways to handle minor procedures.

Given the season, we will focus specifically on laceration repair. Many of the concepts I discuss, however, also apply to other procedures, such as blood draws, IV placement, and burn debridement.

If a cut is severe enough to require an urgent care visit, both the child and family can be quite upset. Typically, family anxiety is higher and staff anxiety begins if the child is under the age of 5. Because the family's *initial* impression of staff sets the stage for their impression of the entire experience, it is essential that the individuals on your frontline are sympathetic, attentive to pain issues, and able to address the family's concerns with compassion as the visit gets under way.

Using LET gel—lidocaine-epinephrine-tetracaine in gel form—may improve a family's laceration repair experience and help set your center apart from others. LET gel is prepared by a compounding pharmacy, and is available in most communities.

Apply LET gel to the laceration, insert a small amount of cotton into the laceration, and then soak the cotton with more LET gel. This helps absorption and results in more consistent anesthesia. After 30 minutes, test the area with a needle and inject additional lidocaine as needed.

I have found that approximately 80% of patients experience complete wound anesthesia after the initial 30 minutes. In the remaining 20%, LET gel often attenuates the pain of a subsequent lidocaine injection.

Emory Petrack is president of Petrack Consulting, Inc. (*www.petrackconsulting.com*), based in Shaker Heights, OH and medical director of the Pediatric Emergency Department at Fairview Hospital in Cleveland. He also sits on the Advisory Board of *JUCM*. Dr. Petrack may be contacted at *epetrack@petrackconsulting.com*.

Integrating Pharmacologic and Non-pharmacologic Techniques

The real power for creating a superb experience for children requiring laceration repair, however, comes from *integrating* pharmacologic and non-pharmacologic techniques. When you are almost ready to start the repair, spend just three to five minutes helping the child prepare. The child will struggle less, staff will be less anxious, and the family will leave your center more satisfied as a result.

Start while you are deciding which pharmacologic agents to use. Engage the child in conversation; connect about a vacation, TV show, school, or anything else developmentally appropriate. Bringing the parent into the conversation helps to establish trust.

Next, consider possible positions, which depend on the age of the child and the specific procedure. A great position for laceration repair in a toddler—a common and sometimes challenging procedure in the urgent care setting—is in a parent's lap. Lap position isn't appropriate for all situations, but the technique works especially well for scalp and extremity lacerations.

With position established, next communicate with the

Continued on page 27

In the updated protocol, the "electrical phase" occurs within the first five minutes after the cardiac arrest; this is when defibrillation is the optimal therapy. At five to 10 minutes after a cardiac arrest, in the "circulation phase," an optimal chest-compression strategy is needed to improve coronary perfusion pressure, to set up a successful defibrillation. Optimal treatment for the third phase, the "metabolic phase," which begins 10 minutes after cardiac arrest, is less clear.

In places such as casinos and airports, swift defibrillation upon cardiac arrest has "unquestionably" improved survival. Unfortunately, in most other scenarios, when emergency medical personnel arrive, cardiac-arrest patients are typically in the circulatory phase rather than the electrical phase, they add.

In the current study, emergency medical service providers were trained in the new resuscitation protocol, which mandated that rescue workers perform at least three rounds of 200 chest compressions before attempting intubation, maintain a 50:2 ratio of compression to ventilation, restrict aggressive ventilation, and minimize pauses for ventilation.

Overall survival increased from 7.5% to 13.9%. ■

Discharge Instructions: Understanding the Misunderstandings

Key point: Nearly 80% of patients did not understand some aspect of their ED care, usually discharge instructions, and most patients were not aware that they did not understand.

Citation: Engel KG, Heisler M, Smith DM, et al. Patient comprehension of emergency department care and instructions: Are patients aware of when they do not understand? *Ann Emerg Med* 2009;53(4):454-461.

More and more inpatient care is being shifted to the outpatient environment, and patients are increasingly being asked to assume more responsibility for their own care. Patients' ability to adhere to complex emergency department discharge instructions is directly related to how well they understand the instructions.

In a prospective study conducted at two emergency departments in Michigan, researchers interviewed 140 patients immediately after ED discharge to assess their understanding of four categories of ED care:

- Diagnosis and cause of symptoms
1. ED care received (tests and treatments)
2. Post-ED care (prescriptions, ancillary measures, follow-up)
3. Symptoms that should prompt returning to the ED
4. Patients were allowed to look at their discharge instructions during questioning.

Overall, 78% of patients demonstrated some deficiency in comprehension (less than complete concordance) in at least one category, and 51% demonstrated deficiency in two or more categories. Most deficiencies in comprehension (34%) were related to post-ED care. Only 20% of patients with comprehension deficiencies were aware that they had them.

ED staff need to be sure that patients "get it" before they leave. Asking them if they have any questions might not be enough. Perhaps we should ask patients to explain their diagnoses and treatment and follow-up plans to us in their own words.

Ironically, we probably do more to ensure understanding when patients leave against medical advice than when they are simply discharged. ■

FDA Approves Benzyl Alcohol Lotion for the Treatment of Head Lice

Key point: Three-quarters of patients in the benzyl alcohol group had no lice.

Citation: *www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm149562.htm*

The FDA has approved prescription-strength benzyl alcohol lotion (5%) to treat head lice in patients aged 6 months and older.

The approval follows two safety and efficacy studies of some 625 people with active head lice infestations. Two 10-minute treatments of benzyl alcohol lotion or topical placebo were given to patients 1 week apart. Two weeks after the last treatment, three-quarters of patients in the benzyl alcohol group had no lice.

The medication can cause skin, scalp, and eye irritations, as well as numbness at the application site. ■

Antivenom for Scorpion Stings

Key point: Children with severe reactions to stings recovered quickly after receiving antivenom.

Citation: Boyer LV, Theodorou AA, Berg RA, et al. Antivenom for critically ill children with neurotoxicity from scorpion stings. *N Engl J Med* 2009;360:2090-2098.

Stings from scorpions in the U.S. Southwest and Mexico can produce a neuromotor syndrome that, in its severe form, is characterized by uncoordinated hyperactivity with thrashing limbs, oculomotor and visual abnormalities, and respiratory compromise. Severe reactions are more common in children. An antivenom produced from various Mexican scorpion species (including some also found in the U.S.) was evaluated at two Arizona intensive care units, where 15 children (age range, 6 months to 18 years) were admitted within 5 hours of a scorpion sting with severe neuromotor syndrome; they were randomized to scorpion-specific antivenom or placebo.

Within four hours after treatment, the syndrome had resolved in all eight children who received antivenom and in only one who received placebo ($P<0.001$). Antivenom recipients also received substantially less midazolam during the first four hours. One hour after treatment, no antivenom recipients and six of seven placebo recipients had detectable plasma venom concentrations levels.

The antivenom used in this study is commercially available in

Mexico but is available only on an investigational basis in the U.S.

Published in *J Watch Pediatr Adolesc Med*—Howard Bauchner, MD. ■

Prevention of Rheumatic Fever

Key point: The American Heart Association has updated its scientific statement; as before, emphasis is on treatment and prevention of streptococcal pharyngitis.

Citation: Gerber MA, Baltimore RS, Eaton CB, et al. Prevention of rheumatic fever and diagnosis and treatment of acute streptococcal pharyngitis: *Circulation*. 2009;119:1541-1551.

This document focuses on timely diagnosis and treatment of streptococcal pharyngitis (primary prevention) and on prevention of streptococcal pharyngitis in individuals with a previous diagnosis of RF (secondary prevention).

Primary prevention requires accurate detection and proper antibiotic treatment of patients with streptococcal pharyngitis, without unnecessary treatment of those who have pharyngitis caused by other agents. Accurate detection entails using clinical judgment to evaluate signs and symptoms and confirming the diagnosis with a throat culture, a rapid antigen-detection test (RADT), or both.

This document recommends screening with RADTs and treating all patients who test positive with appropriate antibiotics. For adults who are RADT-negative, antibiotics should be withheld; for children who are RADT-negative, throat culture should be performed for confirmation, because some RADTs are more sensitive than others.

For treatment of streptococcal pharyngitis, the document recommends oral penicillin V two or three times daily for 10 days, amoxicillin once daily for 10 days, or intramuscular benzathine penicillin as a single dose. For penicillin-allergic patients, narrow-spectrum oral cephalosporins, clindamycin, or clarithromycin for 10 days—or azithromycin for five days—is suggested.

For patients with a previous diagnosis of RF, the recommended duration of prophylaxis has been unclear because guidelines from different organizations have disagreed on some of the details.

This document recommends prophylaxis for:

- 10 years or until age 40 (whichever is longer) for those with carditis and residual heart disease
- 10 years or until age 21 (whichever is longer) for those with carditis but no residual heart disease
- 5 years or until age 21 (whichever is longer) for those without carditis.

The text provides further recommendations for individualizing prophylaxis duration and suggests the possibility of lifelong prophylaxis for patients who are especially vulnerable.

Published in *J Watch Infect Dis*, March 11, 2009—Robert S. Baltimore, MD. ■

"Combining pharmacologic and non-pharmacologic techniques will create an experience that is vastly superior to what the family might have anticipated."

child about what will happen. This can range from challenging to impossible with a very young child, but you can often engage a child of 2 or 3 in some conversation and play. Let the child know what to do rather than what *not* to do. For example, say "Try to hold yourself real still" rather than saying "Don't move."

Show the child the materials you will be using. Refer to the suture material as "string Band-Aids." Let the child feel water from the irrigation syringe so she knows what to expect. Always explain that, while it should not hurt during the repair, she *will* feel some pulling and tugging, and then demonstrate that the pulling doesn't hurt. This way, the child will not be surprised at that sensation.

Finally, once the child is prepared, consider various distraction techniques to use during the laceration repair. Many books fit the bill: "I Spy" books are excellent for distracting toddlers and young school-aged children during the procedure. Or, use an inexpensive, portable CD player with music appropriate to the child's age. The child can squeeze a rubber ball, or blow bubbles during the repair. Engaging the parent in helping to distract the child is a great way to keep both the child and family less anxious as you perform the procedure.

Integrating these techniques in the following order, in my experience, ensures the most effective result in easing pain and maximizing satisfaction:

1. Decide on pharmacologic agents (in this case, LET gel and lidocaine).
2. Establish trust with the child.
3. Consider alternative positioning techniques.
4. Prepare the child using appropriate language and demonstrations.
5. Distract the child during the procedure.

By combining these pharmacologic and non-pharmacologic techniques, you will create an experience that is vastly superior to what the family might have anticipated when they arrived at your center. And this positive experience during a time of anxiety will go a long way in establishing your center as "the" place for families seeking pediatric urgent care. ■

Creating a Web Presence to Raise Awareness of Urgent Care

Urgent message: A robust—and effective—advertising campaign needs to take full advantage of all available media, with special consideration of online opportunities.

Alan A. Ayers, MBA, MAcc

In the past, advertising was a simple proposition; nearly everyone watched the same network television, read the same city newspapers, and searched for businesses in the Yellow Pages. But in recent years, such "mass marketing" has yielded to new marketing channels targeting the lifestyles and interests of narrowly defined user segments.

© iStockPhoto.com/Amanda Rohde

Today, consumers seek information on their own terms—through conventional media, on the Internet, and using handheld devices. To raise awareness and increase visits to your urgent care center, you should consider ways to integrate such "new media" with conventional advertising tactics.

Consumer Behavior in the Internet Age

According to a recent Gallup Poll, 82% of Americans are Internet users while 48% are "frequent" users—defined as spending at least an hour per day online.[1] What's significant to urgent care operators is not just that people are using the Internet, but rather, exactly *who's* online.

Consumers age 18 to 49, with a college or post-graduate education, and employed with above-average personal incomes make up the bulk of frequent Internet users. These demographics coincide with high urgent care utilization and are most likely to both search for information on the Internet and also be influenced by blogs, reviews posted by other patients, and the advice of online "friends." Web-savvy and highly focused, younger consumers tend to shut out mass media such as television, radio, and newspapers and also pay less attention to online banner and pop-up ads, which they view as "noise."

While Gallup classifies about 45% of consumers age 50 to 64 (Baby Boomers) as "frequent" Internet users—a figure slightly less than for younger generations—Baby Boomers are actually more likely to view the Internet as an information source than younger counterparts. Younger consumers spend more time online for social interaction like instant messaging, locating old friends, and sharing photographs, whereas

Table 1. Information to Include in an Urgent Care Center Website

- Center name
- Street address
- Phone number
- Map and description of location
- Operating hours (including holidays)
- Detailed list of services
- Detailed list of insurance plans accepted
- Pricing for uninsured patients and ancillary services
- Physician bios (including photographs)
- Pictures of exterior and interior of facility
- News and announcements
- Information on special promotions
- Registration forms
- HIPAA Notice of Privacy Practices
- Financial policy and billing practices
- Frequently asked questions

Baby Boomers spend more time on transactions like paying bills, trading stocks, and making travel plans. Although Baby Boomers still pay attention to conventional media, they see the Internet as a vast information repository that can answer such questions as whether an urgent care center is near an out-of-town hotel or accepts their health insurance. Thus, they are also more likely than younger generations to pay attention to online advertising.

How much to invest in an Internet strategy requires understanding an urgent care center's target market—is it younger or older?—as well as its information search habits.

Yellow Pages vs. Internet

Many urgent care operators believe a large Yellow Pages ad is the key to marketing success—and in some communities, they are correct. In resort areas with a large number of travelers and senior adults, for example, the Yellow Pages are often the first place consumers turn to find an urgent care center. But an evaluation of overall Yellow Page advertising trends indicates it's not the commonly used resource it once was.

Total Yellow Page ad spending in 2009 matched that of 1998[2] and between 2009 and 2013, ad spending in print directories is expected to decline 39%.[3] By contrast, the number of U.S. Internet users is growing at a constant rate of 7% per year, with the largest increases occurring among adults age 55 and older.[4]

As consumers switch to wireless phones and handheld devices, not only is a thick phone book not portable, but it generally covers only one metropolitan area—rendering it useless when out-of-town. In addition, the user of a city phone directory has to ascertain how close each advertiser is to his or her location. An ad won't drive business if a provider is not convenient. For a single urgent care center in a large city, it's simply an inefficient use of advertising dollars to reach consumers beyond a three- to five-mile radius of the center.

By contrast, Internet search engines can pinpoint a consumer's exact location, provide a listing of centers in order of proximity, and then deliver that information to the user's laptop or handheld device—wherever they might be.

Because Yellow Pages are updated only once per year and consumers may not always have the current edition, a start-up center depending on Yellow Page advertising might wait a year or longer before the investment drives any patient visits. Annual publication also means a center cannot add or retract outdated information such as hours or insurance plans accepted.

The "new media" equivalent of a Yellow Pages ad—and the starting place for establishing an Internet "presence"—is to have a clean and crisp website.

A Professionally Designed Website

A website serves as both a "landing page" for consumers utilizing search engines to find an urgent care center and as a point of reference for conventional and "new media" advertising.

No different than exterior signage and interior design, an urgent care center's website represents its brand. Although inexpensive software is available to build a simple website, such websites usually lack the "polish" of a professionally-designed website. Common problems of amateur websites include:

- Unattractive pages. The structure of a webpage, fonts, colors, and images should draw consumers further into the site.
- Complicated interface. When consumers land on a website, it should be clear where to click for the information they're looking for, such as operating hours or a map to the center. Consumers will navigate away from websites they can't fig-

Table 2. Ways to Increase Visibility of an Urgent Care Center Website

- Submit the website address directly to major Internet search engines like Google, Yahoo, and MSN.
- Use "metatags" to embed keywords that increase the likelihood the website will be picked by search engine "crawlers" and achieve a higher retrieval ranking in web searches.
- Ask credible websites that are already listed in search engines to include a link to your site, including those of organizations you sponsor and companies you do business with. Also consult any websites listing your competition.
- List your website address in directories consumers may consult for services—such as online Yellow Pages, chamber of commerce guides, and insurance provider listings.
- Include the website address on all printed materials, in press releases, and in conventional advertising like newspaper and radio ads.

ure out how to use.

- Simple navigation. Consumers search for information starting with major topics and then drill down into more detailed facts. Sub-menus should be limited such that important information can be found within one or two clicks of the homepage.
- Poor content. A website's content should be concise. A text-intensive page will overwhelm users; instead, write using short paragraphs and bullet points. (**Table 1** lists the types of content to include on a website.) Content should also be free of grammar and spelling errors.
- Poor function. A website should load quickly and be free of broken links and empty or "under construction" pages. All forms and search interfaces should work as intended. Avoid using animation or large image files that slow download time or hinder function on handheld devices.

A professionally designed website that considers all of these factors is not inexpensive, as local firms often charge between $1,000 and $2,000 or more, depending on the complexity of the project. But a professional web developer should also take care of many of the technical details such as securing a domain name, server hosting, and content maintenance.

Directing People to Your Website: Search Engines and Internet Directories

Once an urgent care center establishes its website, it will want to drive traffic to it. To start with, the website should be included in major search engines like Google, Yahoo, and MSN. This is accomplished in two ways—by submitting the listing directly to the search engine and by being picked up by "spiders" or "crawlers"—software search engines use to scour the Internet for new content.

Google Maps

The Internet equivalent of the Yellow Pages, Google Maps, provides consumers with business listings ranked by proximity to the geographical location they specify. To get listed is as simple as filling out an online form. Google will call or send a post card with instructions to verify the physical address. Once listed, a user can add information to their listing, including a description of services offered, photographs of the center, and even coupons.

Unlike Yellow Pages advertising, this service is free. If a search engine provides patient reviews, ask patients to submit their comments—providing positive "word of mouth" for other Internet users and additional content for search purposes.

Apart from Google Maps, submitting a web listing directly to a search engine does not guarantee a website will appear in searches, much less achieve a high search ranking. Search engines use proprietary formulas to determine listings and retrieval order that consider the page title, overall body content, the number and quality of links on a site, and how long consumers stay on a website.

Optimization

Search engine optimization is the process of developing a website such that important keywords and links are likely to be picked up by search engines and retrieved in a higher priority. A professional web developer can build "metatags"—embedded information—into a website to increase the visibility of the website to crawlers. Also linking the website to other listed websites should increase the relevance and ranking in search results. (**Table 3** lists common methods of optimization.)

Continued on page 32

CODING Q&A

Proper Use of 99051, and the Status of S9088

DAVID STERN, MD, CPC

Q. Can I bill the CPT code 99051 (*Service(s) provided in office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service*) for the purpose of getting a denial? Can I bill a Medicare patient for the 99051 code if I have an advanced beneficiary notice (ABN) completed?

– Anonymous, Texas

A. This is a very interesting question, and I am sure it will generate significant controversy.

In regard to your question about billing 99051 along with a specific ABN, it does appear to be a compliant method for billing. On first look, it does make sense for patients to pay for the increased convenience of not having to wait in a hospital emergency department or even wait until regular office hours of their primary care physicians.

Of course, Medicare patients might object to having to pay for this service, and they may complain to their carrier and/or not return to your urgent care center. The experience for most centers for privately insured patients, however, is that most patients seem to understand that this fee is reasonable for the convenience and accessibility of urgent care.

Our current practice is that we do *not* bill via this method for Medicare. If you do decide to bill this way, I would recommend that you first pursue a formal legal opinion from an attorney with significant expertise in Medicare compliance. ■

Q. I attended the UCAOA Coding Conference in Memphis last year and learned about the S9088 code. I brought the info back to my urgent care center, which is a part of a hospital system. We have been using the code and collecting. We are now being told by our billing department and contract negotiators that BCBS is no longer allowing the S9088 code, because they have "phased it out." Do you know this to be true or not?

– Anonymous, Georgia

A. This code (S9088) was requested by private payors to give them a specific method for appropriate reimbursement of urgent care centers for the increased costs (over those of primary care). Recently, a few payors have reversed their position and have been trying to cut costs by discontinuing reimbursement for S9088.

This is probably the most important (and detrimental) change in code processing for urgent care in 2009, and we did spend some time on this topic during the Coding Update session at the UCAOA National Convention in Las Vegas.

We encourage urgent care billers to appeal this decision. They should give payors the logic for reimbursing urgent care centers the additional costs (over a typical primary care practice) in wages (even when no patients walk in the door; and for staffing weekends, evenings and holidays) and equipment that an urgent care center bears.

If payors are willing to simply give you higher reimbursement, maybe this will suffice. But you will want to make sure that you find some way to get compensated for bearing these additional facility costs. ■

Q. I would be interested in attending a seminar on coding for urgent care facilities. Would there be any seminars in the New England area?

– Anonymous, Maine

A. The only urgent care-specific coding conference I am aware of is the UCAOA Fall Conference in Dallas on October 23-24, 2009. There are costs involved, but the knowledge that you gain is likely to pay for itself in increased coding compliance and/or improved revenue during the first week that you return to your center. You can get more information at *www.ucaoa.org*. Hope to see you there. ■

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In addition to offering free search, Internet search engines sell paid advertising. If a center is not achieving a high ranking through conventional search, the center can purchase "pay per click" advertising that causes banner or sidebar ads to appear on the retrieval page when consumers search for specific terms like "San Antonio" and "urgent care." The cost of this advertising is dependent on the frequency of search for the selected words and how often consumers click on an advertising link. Because this advertising is on the periphery of the webpage, it is often ignored by savvy Internet users and thus is generally less effective in capturing interest than achieving a high rank in regular searches.

Advertising banners or pop-ups may also be purchased on websites of interest to a center's community or target demographic, such as local television and newspaper websites. Sometimes this advertising is bundled into the sale of conventional advertising like radio ads or event sponsorships.

The challenge is that such ads function as "mass media"—they're delivered to all visitors of the host website without regard to need, location, or demographics. Paid banner or pop-up ads are usually most effective when announcing a new center or raising awareness of a promotion like discounted sports physicals or flu shots; when a user "clicks through" to the urgent care center's website, he or she can learn more about the offering and perhaps print a coupon or flyer.

In addition to driving consumers to a website through search engines, an urgent care center should make sure its web address is listed in all other online directories, including chamber of commerce member lists, insurance company provider listings, and government listings of specialized service providers like civil surgeon immigration physicals or FAA flight physicals.

Last, the urgent care center should include its website address on all printed marketing materials and conventional media advertisements. A website serves as a central resource for all information about an urgent care center and is easily updated when changes occur to operating hours, insurance accepted, or providers on staff.

Table 3. Elements of Search Engine Optimization

- **Descriptive title:** The title is what is displayed above the web browser's toolbar, but it also indicates the subject matter to the search engine. The title should list the center's name and describe the practice. For example, "First Urgent Care Clinic: Dallas, TX Walk-in Allergies Sprains Strains Flu" is more likely to turn up in searches than just "First Urgent Care."
- **Keyword-rich description:** The description summarizes the content on each webpage and is often indexed by search engines. The description should include keywords pertaining to the urgent care center's location, services offered, insurance accepted, and common health conditions treated.
- **Keyword-rich headlines and copy:** The website's content should be written with the search engine in mind. Arrange copy in bullet points or brief paragraphs that emphasize and repeat important search terms.
- **Real text, no flash:** Search engine crawlers can only detect text on a website. Messages that are embedded in images, saved in PDF files, or appear through Flash animation likely will not be indexed by a search engine. In addition, images on the website should be meta-tagged for detection by photo search engines.
- **Index or site map:** Having one page on the website that summarizes the content and links for all other pages provides a keyword-rich reference for search engines to appropriate classify the website.

Conclusion

Although the Internet is a global resource, it enables highly targeted and localized promotion of an urgent care center. A well-designed website acts as a centralized information repository about a center's service offering, and achieving visibility in search engines raises awareness among consumers who are specifically looking for information on urgent care services. An urgent care center's website is also a point of reference for other forms of Internet promotion, including communities of interest formed by "social media." ■

This is the first installment of a two-part series. The next article will describe ways to use "social media" to raise awareness among targeted urgent care user groups and drive additional visits to your website and center.

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Entrepreneurism—Or, How *Not* to Turn a Lot of Money into a Little

JOHN SHUFELDT, MD, JD, MBA, FACEP

Throughout history, entrepreneurs have faced harsh critics. From Shakespeare's *The Merchant of Venice* through Oliver Stone's movie *Wall Street* ("Greed is good, greed works," etc.) entrepreneurial efforts are cast in a dim light.

To paraphrase Lifebook founder Jon Butcher, though, "no other social system can compete with the free market, entrepreneurial system in terms of productivity, raising living standards, and creating prosperity....Yet, despite its overwhelming contributions, some elements of society still associate profit-making with vice."

To me, entrepreneurism is simply taking something that you are passionate about and turning it into capital so you can do more of it. Passion without monetization is called a hobby.

I am what you would call a serial entrepreneur; I have tried (and more often than not, failed) at more businesses than you can imagine. Although failing is never fun, if you keep your mind open it will teach you more than success ever will. Here, I will discuss some characteristic of successful entrepreneurs and share a story or two about those traits.

Integrity/Detail-oriented

Setting the integrity bar high is a must for the successful entrepreneur. At one point in our history, I had someone working for me who was the embodiment of hard work. She worked night and day and knew every aspect of the business. She just had two little issues.

The first was that she was like Chicken Little; the sky in her world was always falling, though she was always there to save the day. I learned over time that she devised some of these tragedies so she could come to the rescue and prove her value. This trait, annoying as it was, was tolerable, at least for the short-term.

The other trait, embezzling, was the elephant in the room. She would enter one thing in the financial software, and then manually make the check out to her husband's business. I eventually caught on. The problem was I was working day and night trying to maintain cash flow and took my eye off the books. Ergo, I was not detail-oriented. Such lack of attention, particularly during the start-up phase, can be disastrous.

"A superior operator is something all entrepreneurs have to become to achieve any lasting success."

Visionary/Risk-taking

Being visionary can be both a blessing and a curse. Decide if you are an innovator, early adopter, or superior operator.

The road to success is riddled with failed innovators. Who remembers the Altair 8800 personal computer? Or Atari, or the group (Seattle Computer Products) that sold DOS to Bill Gates for $75,000 (which, by the way, he did not have)?

Being an early adopter has some benefits. You let the innovator pave the way by educating the masses and hitting all the landmines.

At the end of the day, a "superior operator" is something all entrepreneurs have to become to achieve any lasting success.

Unfortunately, many of the business ideas I have pursued have been "innovative." For example, take the Vibrapon, which employs low-level vibrations to increase blood flow to muscle tissue, thereby relieving menstrual cramps caused by uterine contractions and lower blood flow to the uterus. I figured if a tampon could incorporate this small, non-dispos-

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able, removable component, it would be a huge hit! I even had the first commercial written. "I used to hate that time of the month until I discovered the Vibrapon. Now I almost look forward to getting my period."

Unfortunately, I learned that someone had already conceived and patented the Vibrapon, though the fact that no one has ever heard of it probably does not speak well for its success. Lesson: You have to be non-risk averse to start a business and have the vision to see it through.

This also bears out an important tip: check the U.S. Patent and Trademark Office website (*www.uspto.gov*) before spending any capital on an innovative idea.

Ambitious/Motivated

Pardon the vernacular, but if you want to be an entrepreneur you have to *get your ass out of the chair* and roll up your sleeves. Or, as I mentioned to one of our ED nurses who happened to be sitting in a chair for quite awhile while the ED sunk into chaos, "I am not sure if you have heard of Newton, but I can assure you, gravity will keep the chair from flying away if you get your rear end out of it." Anyone can talk the game. Succeeding takes someone who is motivated to not just start a business but to see it through. Remember the old adage, if this was easy, everyone would do it.

One caveat: all the ambition in the world won't save a bad idea. Or as the Successories poster says, "When you earnestly believe you can compensate for a lack of skill by doubling your efforts there's no end to what you can't do!"

A long time ago, I wanted to start a restaurant. I thought a good entry point would be to own hot dog stands. This all ended one day while working at one of the stands located in Home Depot. One of my customers said, "Don't I know you? You sewed up my foot last week in the ER and you left some glass in it!" Fortunately, I had enough sense to say, "And that's why I am selling hot dogs today."

The next day I sold the business. No matter how ambitious I was, selling hot dogs was not going to provide the returns needed to grow the business and have lasting profitability. Nor could I bear to wear that stupid apron anymore!

Optimistic/Adaptable

I am optimistic to a fault. I am sure it irritates the rest of the team. I compare everything bad to the emergency department. "If no one is dying, how bad can it be?" In my time, this attitude has driven at least one CFO to insanity (though I think she may have already been DSM3 diagnosable).

Anyway, at one point of my business life we were trying to grow the business with very little capital. In 1995 I had the brilliant (not really) idea to franchise the concept. After two years, I thought we had a pretty good operating model that could be reproducible in other markets.

"Egotism is the anesthetic that dulls the pain of stupidity."

- Frank Leahy

In essence, we adapted to our lack of capitalization by selling our platform. We learned, however, that providing healthcare is not a model which is easily franchiseable, mainly because there is no way to protect your brand. One bad apple could destroy the entire entity by providing less than acceptable service or care.

One day, while we were slugging it out trying to promote this concept, someone from the *Wall Street Journal* left a message for me to call him as soon as possible. I thought that we were finally going to get some recognition for this, at the time, ground-breaking idea. After three days of phone tag, I finally got a hold of him. "Dr. Shufeldt, it is great to finally get to speak with you. Would you like to increase your subscription from one year to two?"

Needless to say, I remain optimistic.

Sense of Humor/Humility

A sense of humor keeps an entrepreneur sane. Failing to see the humor in all the crazy things you will experience (such as a provider who locks himself in the bathroom and threatens to start drinking) will make the ride much less enjoyable.

In healthcare, a lack of sense of humor can be your undoing. I cannot tell you how many times I have looked around an exam room for the Candid Camera film crew, believing that the only explanation for what a patient just said was that I must be getting "punked." ("Wait, you were standing on a bridge huffing paint and then you fell off the bridge and only broke your ankle and then stood up and were struck by a truck?")

The challenge with arrogance is twofold. Everyone loves to see arrogant people fail and will often go out of their way to *not* help an arrogant person. As the late Notre Dame football coach Frank Leahy said, "Egotism is the anesthetic that dulls the pain of stupidity." Arrogant people are usually deeply insecure and as such will never take a risk that could result in being viewed as a failure. The most competent people I know are also the most humble.

The goal of any entrepreneur is to make a contribution and to be paid a fair price at some time for the business. However, the most important advice I can offer is this: While the payout is great, the fun is in the ride, not arriving at the destination. See you up the road! ■

25 Sales and Marketing Pearls

FRANK H. LEONE, MBA, MPH

This month's column provides some easy-to-execute sales and marketing tips that we have found helpful in moving a clinic's occupational health initiative forward:

Sales Skills and Techniques

1. **Use euphemisms to convert negative phrases into positives.** "You have a problem" should be "You have an opportunity." "You have a high injury rate" becomes "if we can help lower your injury rate, it would result in lower workers' comp costs."

2. **Orchestrate clinic visits to make the close.** Make clinic tours easy for the prospect, schedule tours at times that make sense, plan conversation points with key personnel in advance, and complete paperwork (e.g., billing) while the prospect is on site.

3. **Be a great communicator.** The great communicator expresses even the most complex topic in a simple and direct manner. Vary your pace, listen and probe intently, and maintain focus on your inherent message.

4. **Consider the "fear factor."** Recognize the potential importance of a prospect's parochial interests during a sales encounter. Structure questions to determine where a prospect sits on the "care about my company/care about myself" continuum and adjust accordingly.

5. **Focus on the golden minute.** The first 30 seconds and last 30 seconds of a sales call tend to be more important than all of the activity in between. Develop an orchestrated routine for both segments.

6. **Capitalize on the "herd mentality."** For every early adaptor, there are 10 others who prefer to follow the crowd. For every buyer who buys *offensively* out of desire, there are 10 who buy *defensively* out of fear. You can use this understanding to your advantage by discerning to what degree your prospect is a defensive buyer and by employing a "herd mentality" selling approach when you do identify a buyer.

7. **Emphasize the positive.** A positive attitude is a self-fulfilling prophecy for success. Respect the prospect's time, qualify every suggestion ("in my opinion"), guarantee nothing, memorize key points, and never call attention to a negative.

8. **Use an incremental approach to get to "yes."** Resist the use of tired closing jargon or simply "asking for the order." Instead, establish a sense of urgency ("according to your figures, you are spending $10,000 a week, or $2,000 a day, on workers' compensation. The sooner we get started...").

9. **Use questions to generate sales.** Speak no more than 20% of the time during a sales call, and use most of that time to ask relevant questions, probe (e.g., asking the prospect to expand on vague, yet critical terms such as "quality" and "responsiveness"). Move the prospect through a logical sales process.

10. **Structure your sales call.** Carefully plan several key components of your sales call, including your opening statement, the "roadmap," your program benefit statement, your basic close/action step, and your final comment.

Marketing Outreach

11. **Draw attention.** Draw attention to your services in a

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world of finite attention spans. Invariably, people notice—and remember—the unique rather than the traditional. Take a chance on something unproven but new, rather than always sticking with a "proven" yet tired approach.

12. **Simplify and keep repeating your message.** In our information-saturated world, you must keep your message ultra simple; keep repeating it and use multiple modalities (e.g., voicemail, e-mail, website, direct correspondence) to transmit the message.

"Leaders recognize the need to effect a sense of balance in everything they do."

13. **Market on a "shoestring."** New communication channels have made it easier, less time consuming and less costly to market services. Use modern outreach vehicles such as e-mail, voicemail, audio-based education, and your website to effect optimal marketing on a shoestring budget.

14. **Use customer service to enhance business.** Word-of-mouth from happy customers can enhance growth. Tips for upgrading your internal customer service include:
    - hiring people-oriented personnel
    - developing a written customer service plan
    - involving all personnel in this ethic
    - setting the bar high
    - providing ongoing training
    - evaluating continuously
    - rewarding exceptional service.

15. **Use e-mail as a core marketing tool.** Effective sales are in the details, and e-mail "paper" trails can preserve this detail in an easy, organized manner. You can write an effective e-mail in less than a minute. Compared to the old days, you can become an icon of productivity.

16. **Use your physicians in sales when appropriate.** Consider the nature of your market and the physician's inherent sales/marketing savvy. Include a definition of a physician's time commitment, parameters for participation, the nature of handpicked prospects, and appropriate follow-up in your plan.

17. **Use education as a marketing tool.** Although live educational seminars and conferences and printed newsletters may still have a place, the education card can be used more cost-effectively through web-based audio education, periodic e-mail blasts, and audio town forums.

18. **Speak eloquently to the community.** Offer your audience a clear objective and roadmap, involving them from the outset. Do not force movements; speak from the heart; minimize audiovisuals; throw out a challenge; and show genuine appreciation for everyone's time.

Sales and Marketing Management

19. **Embrace the culture of constant change.** Maintain an active plan to periodically assess every aspect of your program, constantly tweak your plan in response to changing market realities, and try at least one new marketing initiative every year.

20. **Use sales metrics.** Maintain and analyze sales metrics such as "quality" telephone calls, face-to-face sales apportionments, prospect/client conversion rates, and the mean dollar value per relationship.

21. **Constantly motivate sales professionals.** Include an effective feedback system, appropriate training, an inspiring workplace climate, and practical, challenging (but not *too* challenging), specific, and understandable goals in your proactive plan.

22. **Hire a superior sales professional.** Learn more about a candidate by asking such questions as "If I asked the 10 people who knew you best what was your best trait as a person, what would they say?" or "If you were hiring a person for this position, what four traits would you look for? Why?"

23. **Emphasize time management.** Fine tune the sales job description, cluster sales professional hours by activity type, tighten meeting time, script, and avoid being obsessive about little things.

24. **Provide a "win-win" incentive compensation plan.** A "win-win" incentive plan is gross revenue-based, never capped, paid quarterly, layered for higher compensation for higher levels of achievement, and supplemented with non-financial rewards.

25. **Be a leader.** Leaders recognize a need to effect a sense a *balance* in everything they do and *empower other future leaders*, for a true leader should leave behind a legacy of his or her leadership. As the eyes, ears, and spokesperson for their clinic, a sales professional must strive to become more of a leader. ■

Career Opportunities

NORTHERN VIRGINIA/D.C. SUBURBAN – Full- and part-time positions available at hospital affiliated urgent care centers. Send CV to: securemedical@gmail.com.

FAMILY PHYSICIAN OPPORTUNITY – Aurora Illinois' award-winning ED's urgent care section desires additional physician. Highly competitive compensation; flexible scheduling. Contact Mary Deans-O'Claire: (847) 697-8868; or tylercreek tvl@sbcglobal.net.

INDEPENDENT, democratic emergency physician group has need for part-time (6 hour/day) PA in our Immediate Care Facility in Chicago's western suburbs. Competitive salary, benefits and malpractice insurance included. Interested parties should contact: Sonia Mininni, M.D., Medical Director, Du Page Convenient Care, LLC, 6840 Main Street, Downers Grove, IL 60516. Email: smmvalentine @yahoo.com.

LOS ANGELES, CALIFORNIA – SmartClinic, is seeking BC/BE emergency or family medicine physicians to staff a new urgent care opening September 2009. Competitive compensation, flexible scheduling and great work environment. Must be ACLS certified. Submit inquiries and CV to: mysmartclinic@gmail.com.

PART-TIME PHYSICIAN for urgent care in Shenandoah Valley. Flexible hours, maximum 20 hours/week. No Sundays. Malpractice insurance provided. Mail CV to: Ana Mata, 3590 Traveler Road, Harrisonburg, VA 22801.

TEXAS URGENT CARE OPPORTUNITIES: Seeking BC/BP primary care physicians for hospital based urgent care in Palestine (near Tyler) and Byran/College Station. We are a stable group offering flexible scheduling, competitive compensation, paid malpractice and tail insurance, plus opportunity for partnership! For more information contact Gretchen Moen at: (888) 800-8237; or Gretchen@eddocs. com.

ALASKA - Fairbanks Urgent Care/Occupational Medicine Center is looking for an experienced primary care ANP to join our team. Competitive salary plus benefits package. Flexible schedule.
Contact Leonie Deramus, MD at (907) 378-7188

Dunkirk and Solomons, Maryland

Seeking part-time BC/BE EM, IM, and FP physicians to practice Urgent Care Medicine at Dunkirk and Solomons Urgent Care Centers in Calvert County, Maryland. Enjoy a collegial relationship with nurses, mid-level providers, and urgent care support staff, excellent work environment, a flexible schedule, and competitive compensation.

Send CV: Emergency Medicine Associates
20010 Century Blvd, Suite 200
Germantown, MD 20874
Fax: 240-686-2334
Email: Recruitment@EMAonline.com

ILLINOIS

Carle Clinic Association, a 330-physician multispecialty group practice, has several openings in urgent care for **BE/BC Family Medicine** physicians in **Urbana, Champaign,** and **Danville, Illinois**.

Facilities are staffed with both physicians and midlevel providers. Working hours range from 8:00am-8:00pm to 8:00am-2:00pm.

Locations are within easy driving distance to Chicago, St. Louis, and Indianapolis.

If interested, please contact Dawn Goeddel at (800) 436-3095 extension 4103, or by email at: dawn.goeddel@carle.com

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URGENT/EXPRESS CARE. I am available for coverage, as needed, in Missouri and Kansas. ABEM certified. Gary Randolph, M.D.: (417) 434-1236; jomorandolph@aol.com.

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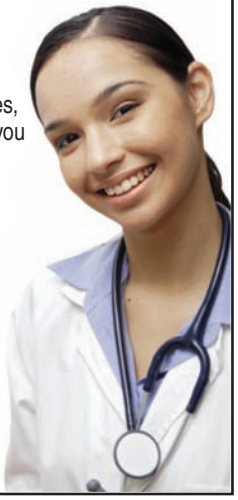

Gundersen Lutheran HEALTH SYSTEM — Urgent Care Physician

Gundersen Lutheran Health System, based in La Crosse, Wisconsin is seeking an Urgent Care physician. The La Crosse and Onalaska Urgent Care Department consists of 12 physicians which will enable you to lead a balanced lifestyle in a collegial environment. The successful candidate will be BC/BE in Family Medicine, Emergency Medicine, Internal Medicine or related.

Gundersen Lutheran is a large multi-specialty group practice than employs over 440 medical staff and serves a population base of 500,000 through its La Crosse campus and 20+ regional clinics based in Southwest Wisconsin, Southeast Minnesota, and Northeast Iowa.

We will consider full or part time employment. Our physician lead organization emphasizes quality and compassionate care.

Contact: Jon Nevala, Medical Staff Recruitment, Gundersen Lutheran Health System, (800) 362-9567, ext. 54224 or email JPNevala@gundluth.org

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Urgent Care Physician

Seattle, Washington

Group Health Permanente, the Pacific Northwest's premier multi-specialty group, is currently seeking a BC/BP Emergency or Family Medicine Physician to join our Urgent Care Center located at our Capitol Hill campus in Seattle, WA.

- Candidates should have a full range of urgent care skills & an interest in working with an innovative group
- Affordable housing, highly rated schools & pleasant neighborhoods, an unparalleled place to raise a family
- A flexible schedule, generous benefits and competitive salaries make this an opportunity worth exploring

For additional information or to submit your CV, please contact:

Josie Lavin, Physician Recruiter, at 206-448-6132 or e-mail: lavin.j@ghc.org

EOE/AA

www.ghc.org/greatjob GroupHealth

Urgent Care/Emergency Services Line Chief Opportunity

Seattle, Washington

Group Health Permanente, the Pacific Northwest's premier multi-specialty group, is currently seeking a BC/BP Emergency Medicine Physician. Group Health is dedicated to providing comprehensive, innovative, and patient-centered care and leads the nation in EMR integration.

- The UC/EM Services Line Chief supervises staff including physicians and PAs in 6 UC sites in the Puget Sound region—3 of which receive ambulances.
- Clinical shifts are primarily at Seattle and Bellevue sites with occasional travel to other clinic sites.
- We seek a physician who has tremendous communication skills, professionalism, high quality clinical skills, and will excel in a team environment.
- The outdoor enthusiast will especially appreciate the recreation and scenery of Puget Sound near mountains, water, and the Olympic National Forest.

For additional information regarding this position or to submit your CV, please contact:
Kelly Pedrini, GHP Physician Recruiter
pedrini.k@ghc.org or (206) 448-2947

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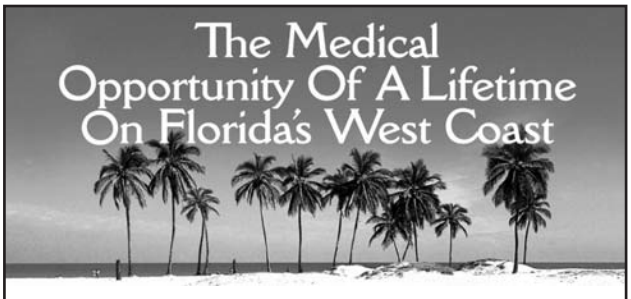

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Isn't it time for something better?

Certified Physician Assistant

Seattle, Washington

Group Health Permanente, the Northwest's premier multi specialty group, is currently seeking a Certified Physician Assistant to join our experienced Urgent Care team in Olympia, WA.

- The ideal candidate will have experience in the Urgent Care setting, a full range of skills, and team-oriented
- We offer competitive salaries and generous benefits
- A flexible schedule, generous benefits and competitive salaries make this an opportunity worth exploring

For additional information or to submit your CV, please contact:

Josie Lavin, Physician Recruiter, at 206-448-6132 or e-mail: lavin.j@ghc.org

EOE/AA

www.ghc.org/greatjob GroupHealth

Career Opportunities

~ CALIFORNIA ~

BC/BE Family Medicine, Emergency Physician or Internist
Valencia, California
(EMR, digital xray and digital ultrasound)

Permanent full-time employee sought for Family Medicine/ Urgent Care Office, outpatient only.
Santa Clarita, (Valencia) California is one of the safest cities in America.
Located 30 minutes from 9,000 ft snow covered peaks, 30 minutes from beach areas and 30 minutes from LAX, Valencia is a planned community that is very FAMILY oriented.
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We see NO HMO patients, 95% of our patients have PPO insurance.
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Please fax CV to: 661-294-0931
or email CV to:
scurgentcare@gmail.com
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Marketplace

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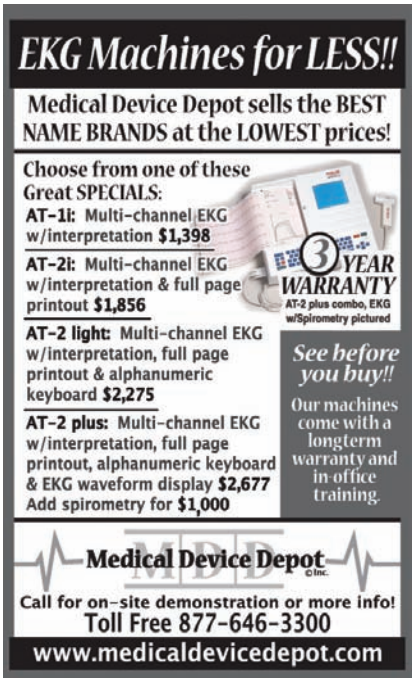

Practices for Sale

FOR SALE – Urgent care practice in Virginia. Free standing center in an excellent, high-traffic location. This well-established business is in a growing area. Owner is retiring. Contact MT Consulting, (610) 527-8400.

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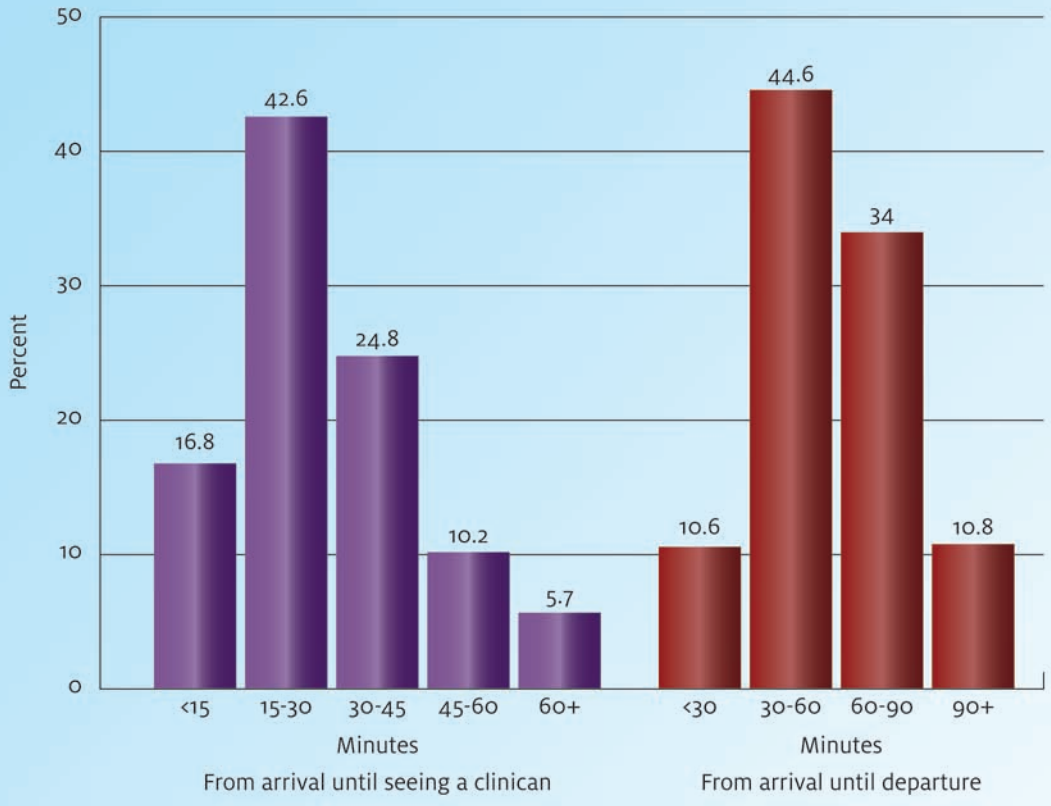
DEVELOPING DATA

In early 2008, UCAOA revamped its annual survey in conjunction with researchers at Massachusetts General Hospital and Harvard University with the goal of assuring that the UCAOA Benchmarking Committee's efforts produced a scientifically valid report.

Here we present some of the findings from this landmark survey, to which 436 urgent care centers responded.

In this issue: How much time do patients spend in urgent care centers, on average?

TIME PATIENTS SPEND IN URGENT CARE CENTERS



These data support—and, perhaps just as important, quantify—the oft-quoted notion that a typical visit to the urgent care center is less time consuming than the typical visit to the emergency room.

Acknowledgment: Data submitted by Robin M. Weinick, PhD, assistant professor, Harvard Medical School and senior scientist, Institute for Health Policy, Massachusetts General Hospital. Dr. Weinick is also a member of the *JUCM* Advisory Board. Financial support for this study was provided by UCAOA.

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

UCAOA

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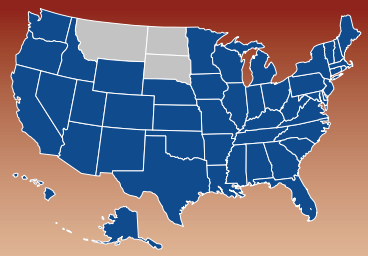

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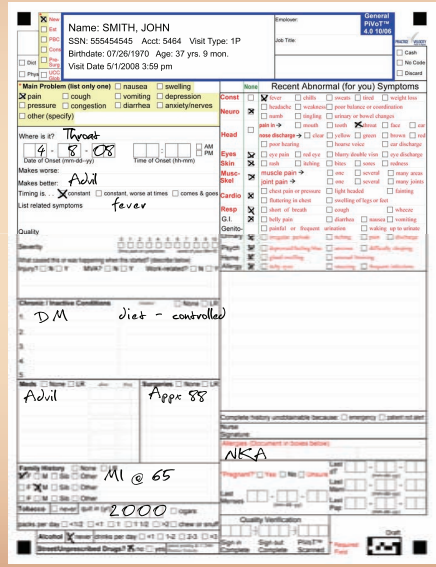

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