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MAY 2015

VOLUME 9. NUMBER 8

Urgent Care Association of America

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Upper Gastrointestinal Disorders in Urgent Care, Part 2: **Biliary Tract and Pancreatic Disease**

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"Why Are You Calling Me?" How to Fix Relationships with Emergency Departments



In my last column I covered the 3 main causes of poor communication in transferring patients from urgent care centers to emergency departments (EDs). I discussed how poor communication creates risk, disrupts work flow, and erodes professional sat-

isfaction. Poor interprofessional relationships and inadequate planning and structure are creating an environment ripe for these breakdowns. Reversing the trend requires a focus on rehabilitating relationships, initiating outreach, and developing coordinated policies and procedures for transfers and communication.

Step 1: Breaking the Ice

As with all functional relationships, getting to know the people and faces in area emergency departments is a critical first step. In the heat of a busy and frustrating shift, it is easy to demonize faceless names on the other end of the phone line. They are easy targets. Likewise, getting to know your colleagues offers a degree of protection against confrontation. That is just human nature. Scheduling a meeting with the ED medical director is an important first step, one that will almost always bear fruit.

Step 2: Mutual Goal-Setting and Prioritization

During this meeting, you and your counterpart have an opportunity to share your own unique situational challenges. Mutual understanding around limitations and needs is crucial. We make assumptions that our colleagues appreciate our circumstances and that they are simply just being insulting or obstructionist when they give us a hard time about transfers. This is a false assumption. In my experience, most ED physicians do not fully understand the urgent care model, its limitations, or its purpose within health care. Once they do, most are far more collegial. The ED itself has no shortage of challenges, and this meeting can help the urgent care physician better appreciate how those might be affecting the efficiency of transfers. Risk and liability issues should be a high priority for both parties. Nothing is more dangerous than discrediting your peers in front of patients regarding anything that can be interpreted as poor performance or poor decision-making. This is behavior that must be eliminated. Once each party's challenges are more clearly

understood, mutual goal-setting and prioritization can commence, and it is invariably productive and helpful.

Step 3: Policy and Procedure Development

Once the two parties are aligned, policy and procedure can be developed to help guide the clinical teams in both settings. The goals of this exercise should be to facilitate transfers, keep communication focused and relevant, reduce interruptions, and eradicate judgmental or insulting commentary. Each medical director should commit to clearly communicating the new policies and procedures to all of their physicians and, importantly, to all members of the nursing staff. A culture of mutual understanding and respect should be expected and clearly communicated to everyone involved.

Use of hospital transfer centers, where available, can dramatically facilitate this process. These serve as air traffic control for transfers to and from the hospital and can even assist with urgent referrals to specialists. In this case, all policies and procedures should be coordinated with the transfer center, and urgent care leaders should educate and communicate accordingly.

Step 4: Follow-Up and Reassessment

Once an action plan and policies and procedures are in place, both parties should commit to a scheduled follow-up when feedback from both sides should be reviewed. Incidents should be examined and collaborative performance-improvement plans can be initiated.

Conclusion

With a collegial and organized approach, urgent care leaders can eliminate confrontation with their ED colleagues. The effort is sure to improve the mood and productivity of staff members while reducing the risk of liability and bad outcomes.

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



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VOLUME 9, NUMBER 8



PRACTICE MANAGEMENT

CLINICAL

8 Upper Gastrointestinal Disorders in Urgent Care, Part 2: Biliary Tract and Pancreatic Disease

Biliary tract disease and pancreatic disease present as upper abdominal pain. Learn how to narrow the differential diagnosis. *Tracev O. Davidoff. MD*

Illustration showing gallstones

Illustration showing gallstones blocking the bile ducts.

IN THE NEXT ISSUE OF JUCM

What can myocardial infarction, aortic dissection, and a ruptured ectopic pregnancy have in common? Shoulder pain.



19 Six Elements of a Winning Patient Experience

To thrive, your urgent care center needs loyal patients. If you focus on the components discussed here, your patients will keep returning. *Alan A. Ayers, MBA, MAcc*

CASE REPORT

25 Epiploic Appendagitis

Because pain in the lower abdomen is a symptom that can indicate many diseases, it is easy to misdiagnose epiploic appendagitis.

May Mohty, MD, FAAP, FAAUCM, and Andrew Wang, MS-3



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

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JUCM CONTRIBUTORS

n this issue, Tracey Q. Davidoff, MD, continues her series on gastrointestinal disorders in urgent care, this time concentrating on biliary tract disease and pancreatic disease. In the United



States, approximately 6% of men and 9% of women have gallstones, and gallstones cause 35% to 40% of cases of pancreatitis. With the incidence of obesity rising, so is the incidence of gallstones and thus the incidence of pancreatitis. Severe pancreatitis can result in multiorgan system failure, so it is vital that urgent care clinicians be able to identify the disease and send these patients to an emergency department for additional evaluation. The article provides several helpful tables outlining etiology, diagnostic criteria, laboratory studies, and red flags.

Davidoff is an urgent care physician at Accelcare Medical Urgent Care in Rochester, New York, is on the CME Committee of the Urgent Care College of Physicians, and is a member of the editorial board of the *Journal of Urgent Care Medicine*.



Our case report this month concerns the case of a 56-year-old Caucasian woman who presented with acute-onset pain in the right lower

quadrant of the abdomen but had no fever, chills, or vomiting. The diagnosis: epiploic appendagitis. Authors May Mohty, MD, FAAP, FAAUCM, and Andrew Wang, MS-3, note that epiploic appendagitis can be tricky to differentiate from other conditions and is most often diagnosed during investigation when appendicitis or diverticulitis is suspected.

Mohty is a clinical assistant professor at the University of Arizona College of Medicine–Phoenix in Arizona and an urgent care physician at CIGNA Healthcare of Arizona. Wang is a student at Arizona College of Osteopathic Medicine.

Urgent care centers live and die by repeat visits from loyal

patients. May is National Urgent Care Awareness Month, a perfect time for your center to work on improving the 6 elements of a winning patient experience so that your patients will keep returning. In this month's Practice Management feature, by Alan A. Ayers, MBA, MAcc, takes you through how to ensure convenience, efficiency, appealing facilities, good relationships in the health-care-provider community, high-quality clinician face time with patients, and patient satisfaction.

Ayers is on the board of directors of the Urgent Care Association of America, is associate editor of the *Journal of Urgent Care Medicine*, and is vice president of Concentra Urgent Care.



Also in this issue:

In Health Law this month, John Shufeldt, MD, JD, MBA, FACEP, continues exploring a medical malpractice trial, this time letting you sit in on opening statements, testimony by witnesses for the plaintiff and for the defense, rebuttal, closing statements, jury instructions, and the verdict. Most valuable of all are Shufeldt's behind-the-scenes explanations throughout.

Sean M. McNeeley, MD, and the Urgent Care College of Physicians review new abstracts from the literature on opiates for pain control in children, pregnancy tests for female patients of childbearing age, treating tetanus, trimethoprimsulfamethoxazole versus clindamycin for skin infections, and early imaging in older adults with low back pain.

In Coding Q&A, **David Stern, MD, CPC**, discusses coding for treatment of rib fractures, giving joint injections, performing sports physicals, and administering tuberculosis skin tests.

Our Developing Data piece provides information on the incidences of various presenting conditions at U.S. urgent care centers.

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UCAOA Resources Help You Celebrate National Urgent Care Awareness Month

P. JOANNE RAY

ay is National Urgent Care Awareness Month. Let your community know about the importance and convenience of urgent care by hosting center events and staff activities throughout the month but especially during the week of May 18–22, 2015.

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Staff volunteer projects: Service to the community is a vital activity for any urgent care center. Get your staff involved in efforts that can truly benefit your community.



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

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Clinical

Upper Gastrointestinal Disorders in Urgent Care, Part 2: Biliary Tract and Pancreatic Disease

Urgent message: Upper abdominal pain is a common presentation in urgent care practice. Narrowing the differential diagnosis is sometimes difficult. Understanding the pathophysiology of each disease is the key to making the correct diagnosis and providing the proper treatment.

TRACEY Q. DAVIDOFF, MD

Part 1 of this series focused on disorders of the stomach—gastritis and peptic ulcer disease—on the left side of the upper abdomen. This article focuses on the right side and center of the upper abdomen: biliary tract disease and pancreatitis (**Figure 1**). Because these diseases are regularly encountered in the urgent care center, the urgent care provider must have a thorough understanding of them.

Biliary Tract Disease

The gallbladder's main function is to concentrate bile by the absorption of water and sodium. Fasting retains and concentrates bile, and it is secreted into the duodenum by eating. Impaired gallbladder contraction is seen in pregnancy, obesity, rapid weight loss, diabetes mellitus, and patients receiving total parenteral nutrition (TPN).

About 10% to 15% of residents of developed nations will form gallstones in their lifetime.¹ In the United States, approximately 6% of men and 9% of women have gallstones.² Stones form when there is an imbalance in the chemical constituents of bile, resulting in

Tracey Q. Davidoff, MD, is an urgent care physician at Accelcare Medical Urgent Care in Rochester, New York, is on the Board of Directors of the Urgent Care College of Physicians, and is a member of the *JUCM* Editorial Board.



precipitation of one or more of the components. It is unclear why this occurs in some patients and not others, although risk factors do exist. Gallstones can occur in all age groups, but the incidence increases with age. Everyone remembers the 4 F's from medical school: "fat,

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- BRANDON PENICK Chief Operating Officer First Med Urgent Care



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fertile, female, and forty." Estrogens cause more cholesterol to be excreted in bile, increasing risk. Obesity is certainly a factor, and family history is also contributory.

Biliary sludge is a mixture of particulate matter and bile that may turn into tiny gallstones. It is common in patients who are or have been pregnant or who are receiving TPN. Persistent sludge may become gallstones, or the sludge itself may cause cholecystitis. Most patients with sludge are asymptomatic.

The majority of patients found to have incidental gallstones are asymptomatic and are not at risk for developing gallbladder disease. Less than 20% will develop symptoms over 15 years, and their illness will not be severe. The risk of developing a severe complication from these stones is much less than the risk of a complication from a cholecystectomy, and therefore it is not recommended that patients with asymptomatic gallstones undergo cholecystectomy. Once a patient develops symptoms, however, their subsequent risk of developing complications is much higher, and prophylactic cholecystectomy is advisable.²

Biliary tract disorders are the second most common

surgical illness in pregnancy, with an incidence of symptomatic gallstones of about 0.1%.³ Surgical intervention should be delayed until after delivery if at all possible, although laparoscopic cholecystectomy has been proven safe in pregnancy.

Biliary Colic

The most common illness related to gallstones is biliary colic. The patient experiences right upper quadrant or midepigastric abdominal pain lasting for 2 to 6 hours, which then remits spontaneously. The pain is intense, sharp, and stabbing in nature and may be associated with nausea, vomiting, fever, and diaphoresis. It may radiate around (not through) to the back, specifically the right shoulder blade. It is not exacerbated by movement, and not relieved by position, movement, or passage of flatus or stool. Symptoms occur because of increasing intraluminal pressure and distention of the biliary tract as 1 or more stones migrate from the gallbladder into the cystic or common bile duct. Commonly the symptoms begin between 9 p.m. and 4 a.m. Dyspepsia, belching, and bloating are nonspecific symptoms that are just as common in people with gallstones as those without. A common trigger is a fatty meal, although association with meals is not universal. If the initial obstruction is not relieved by persistent contractions, or if the stone does not fall back into the gallbladder, an inflammatory response will occur by mechanical, chemical, or infectious means. If pain lasts more than 5 to 6 hours, think complications, such as acute cholecystitis or acute pancreatitis.

These patients look uncomfortable, but findings on the physical examination are usually benign. There may be some right upper quadrant tenderness, which is often underwhelming compared with the amount of pain the patient appears to be in. There are no peritoneal signs. There should be no jaundice. There may be some signs of dehydration, such as dry mouth or poor skin turgor if vomiting has been severe.

Although the diagnosis of biliary colic is frequently made by medical history, ultrasonography is necessary to identify the presence of stones and to rule out other illnesses or complications that may be occurring such as

Table 1. Complications of Gallstones

- Dehydration
- Acute cholecystitis
- Perforation

Sepsis

- Choledocholithiasis
- Acute pancreatitis
- Gallstone ileusMirizzi syndrome

• Gallbladder cancer

• Acute or ascending cholangitis

acute cholecystitis (see the section "Acute Cholecystitis"). It should be noted, however, that the absence of stones on ultrasonography does not rule out their existence; small stones and sludge may be missed,¹ and the sensi-

tivity of ultrasonography may be operator dependent. Once a patient has developed symptoms related to gallstones, definitive treatment with surgery is recommended, because the risk of subsequent symptoms or complications is high.⁴ Stones can occur and become symptomatic even after the gallbladder has been removed, months to even years after cholecystectomy. Therefore, a history of cholecystectomy does not rule out the possibility of biliary colic. The incidence of this is

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Table 2. Laboratory Studies to Rule Out Complications of Biliary Colic		
Test	May Rule Out	
Liver biochemical markers (AST, ALT, ALK, bilirubin)	Hepatitis, biliary tract obstruction, acute cholecystitis	
Serum amylase and lipase	Acute pancreatitis	
CBC count	Acute cholecystitis or acute cholangitis	
Urinalysis	UTI, renal colic	
Upper endoscopy	PUD, gastritis	
Endoscopic ultrasonography	Chronic pancreatitis	
ERCP with sphincter of Oddi manometry	Sphincter of Oddi dysfunction	
Cholescintigraphy with or without CCK	Acute cholecystitis and functional gallbladder disorder	
ECG	Ischemic heart disease	
Esophageal manometry	Esophageal spasm	

ALK = anaplastic lymphoma kinase; ALT = alanine aminotransferase; AST = aspartate aminotransferase; CBC = complete blood cell; CCK = cholecystokinin; ECG = electrocardiography; ERCP = endoscopic retrograde cholangiopancreatography; PUD = peptic ulcer disease; UTI = urinary tract infection.

Table 3. Differential Diagnosis of Upper Abdominal Pain Not Related to Biliary or Pancreatic Disease

- Esophagitis or gastroesophageal reflux disease
- Acute hepatitis
- Peptic ulcer disease
- Gastritis or duodenitis
- Dyspepsia
- Irritable bowel disease
- Disorders of the right kidney, including renal colic
- Right lower lobe pneumonia
- Fitz-Hugh-Curtis syndrome
- Subhepatic or intra-abdominal abscess
- Perforated viscus
- Cardiac ischemia
- Black widow spider envenomation
- Retrocecal appendicitis

unknown, but it is probably low.⁵ Stones occurring immediately after surgery are called retained stones, and those occurring months to years after are recurrent stones.

Patients with biliary colic should be treated for pain with opioids and nonsteroidal anti-inflammatory drugs: oral if possible, but parenteral if nausea and vomiting prevent the use of oral medications. All narcotics increase biliary pressure and spasm of the sphincter of Oddi and theoretically could make biliary obstruction worse; however, proof of this has never been reported in the literature.⁵ Pain relief is more important than any theoretical risk. Antiemetics may be required. Intravenous hydration should be given if dehydration is suspected. Patients having symptoms for more than 6 hours or who have evidence of complications should be referred to an emergency department (ED). Patients whose condition improves and who are asymptomatic after an episode of biliary colic can be referred to surgery for outpatient, elective cholecystectomy.

Red-flag symptoms and signs indicating impending complications (**Table 1**) include pain lasting more than 6 to 8 hours, intractable vomiting, fever, jaundice, elevated white blood cell (WBC) count, elevated enzyme levels on liver function tests, and elevated amylase and/or lipase levels.² Findings on all laboratory studies (**Table 2**) should be normal in patients with uncomplicated gallbladder disease or biliary colic. Patients suspected of hav-

ing a complication, or in whom the diagnosis is unclear, should undergo ultrasonography, if available, or should be referred to the nearest ED for further evaluation.

Atypical symptoms should prompt an investigation for other diagnoses (**Table 3**), *even if the patient has known or documented gallstones*. These include

- Chest pain
- Nonspecific abdominal pain
- Belching
- Fullness after meals or early satiety
- Fluid regurgitation
- Abdominal distention or bloating
- Epigastric or retrosternal burning sensation
- Nausea or vomiting without typical biliary colic pain

Acute Cholecystitis

Acute cholecystitis is an inflammation of the gallbladder most commonly caused by gallstones. Approximately 1% to 3% of patients with symptomatic gallstones will develop acute cholecystitis.³

In most cases, acute cholecystitis is caused by to obstruction of the cystic duct of the gallbladder by a stone or sludge that has impacted at the neck of the gallbladder. This obstruction causes the pressure in the gallbladder to build and, in combination with bile, causes an inflammatory response. Secondary bacterial infection may occur in up to 20% of patients,³ usually with enteric

organisms such as *Escherichia coli, Klebsiella*, and *Enterococcus faecalis*. The overall mortality of a single episode of acute cholecystitis is approximately 3%, depending on the patient's underlying health and surgical risk.⁴

In acute cholecystitis, pain is localized to the right upper quadrant and lasts for more than 4 to 6 hours,⁶ as opposed to biliary colic, in which the pain is more intermittent. The pain may radiate to the right shoulder or around to the back. Nausea and vomiting are common. There is abdominal tenderness in the right upper quadrant, there is voluntary and involuntary guarding, and there will be positive findings for Murphy sign (pain with palpation on deep inspiration in the right upper quadrant with associated inspiratory arrest). The sensitivity and specificity of Murphy sign are 97% and 48%, respectively.⁶ If septicemia is present, there may be fever. Mild jaundice may be present.

Typically patients will have a leukocytosis with increased band cells. Liver enzymes and bilirubin levels will more than likely not be elevated, because the obstruction is limited to the gallbladder. Think complications if alkaline phosphatase and bilirubin levels are elevated.⁶ Amylase and lipase levels may be slightly elevated because of the passage of smaller stones or sludge prior to obstruction. It should be noted that laboratory findings are nonspecific and cannot definitively distinguish colic from cholecystitis.

All patients suspected of having acute cholecystitis should be referred to a hospital.³

The diagnosis of acute cholecystitis can be made on the basis of medical history, but it must be supported by the characteristic findings on ultrasonography, which is the test of choice. Typically there is pericholecystic fluid around the gallbladder, edema of the gallbladder wall, gallstones, and a sonographic Murphy sign. The sensitivity and specificity of ultrasonography for cholecystitis are 88% and 80%, respectively; for gallstones, the respective values are 84% and 99%.⁶ Distinguishing biliary colic from acute cholecystitis can be difficult. Murphy sign is the most sensitive (65%) and specific (87%) element of the history and physical that can distinguish the two. In the sonographic Murphy sign, the ultrasound probe is used for palpation and visualizing the stones during the test.

Plain abdominal films show gallstones in only 10% of cases.³ Gas within the gallbladder may be seen in emphysematous cholecystitis, which is rare. Plain films should not be routinely ordered for suspected gallbladder disease.

When the diagnosis remains in question after ultra-



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BILIARY TRACT AND PANCREATIC DISEASE

Table 4. Diagnostic Criteria for Acute Cholangitis (2013 Tokyo Guidelines)

Diagnosis should be *suspected* if patient has one of the following:

- Fever and/or shaking chills
- Laboratory evidence of an inflammatory response (elevated WBC count, elevated CRP level, etc.)

And one of the following:

- Jaundice
- Abnormal liver enzyme levels (ALK, ALT, AST, GGTP)
- Diagnosis should be *definite* if the patient also has
- Biliary dilation on imaging
- Evidence of an etiology on imaging (stricture, stone, or stent)

ALK = anaplastic lymphoma kinase; ALT = alanine aminotransferase; AST = aspartate aminotransferase; CRP = C-reactive protein; GGTP = γ -glutamyl transpeptidase; WBC = white blood cell.

Data from Kiriyama S, Takada T, Strasberg SM, et al; Tokyo Guidelines Revision Committee. TG13 guidelines for diagnosis and severity grading of acute cholangitis (with videos). *J Hepatobiliary Pancreat Sci* 2013;20:24–34.

sonography, biliary scintigraphy or a hydroxyiminodiacetic acid (HIDA) scan can be performed. The patient is injected with radiolabeled HIDA. In healthy gallbladders, uptake can be seen in 1 to 2 hours, but in inflamed gallbladders, there is no uptake seen. The sensitivity and specificity of HIDA scans for acute cholecystitis are approximately 97% and 90%, respectively.⁶

The treatment of acute cholecystitis is ultimately surgical. In most patients, the disease is managed initially with medical treatment, including fasting, rehydration, and pain medications. The impacted stone falls back into the gallbladder, and then it can be removed electively. If this does not happen, gangrenous cholecystitis, empyema, or perforation may result. Nonsteroidal anti-inflammatory drugs, specifically ketorolac,⁶ are recommended as first-line treatment for pain because they also provide an anti-inflammatory effect. Some patients may require narcotic pain medications as well. Antiemetics may also be required. If an infectious process is suspected, treatment with a second- or third-generation cephalosporin and metronidazole is also recommended.

Twenty percent of patients with acute cholecystitis need emergency surgery when peritonitis or emphysematous cholecystitis (air in the gallbladder) is present.^{3,4} The remaining 80% can be observed with medical management to have the inflammation "cool down," and then laparoscopic cholecystectomy can be performed in several days, usually within 72 hours of presentation.^{3,4}

Choledocholithiasis

A stone lodged in the common bile duct may cause typical biliary colic pain, however it will last longer and eventually lead to more complicated disease. Serum aspartate aminotransferase (AST) and alanine aminotransferase (ALT) levels are typically elevated. If the stone does not pass, serum anaplastic lymphoma kinase (ALK), bilirubin,

and γ -glutamyl transpeptidase (GGTP) levels may become elevated out of proportion to the ALT and AST levels. Acute cholangitis may subsequently develop causing fever, leukocytosis, and sepsis syndrome. Ultrasonography may be helpful, but visualizing stones in the distal portion of the duct may be difficult. Magnetic resonance cholangiopancreatography, endoscopic ultrasonography, or ERCP may be useful in these cases.

Ascending Cholangitis

Ascending or acute cholangitis occurs as a result of infection and stasis of infected bile in the biliary tract. Its severity can range from mild to life-threatening. The patient will present with fever, abdominal pain, and jaundice (often called Charcot triad), then progress to confusion and hypotension. Septic shock can occur, progressing to multisystem organ failure. Patients taking glucocorticoids, especially the elderly, may have no symptoms until hypotension occurs. Laboratory findings include a cholestatic pattern of abnormal liver enzymes and an elevated WBC count.

Bacteria enter the biliary tract because of gallstones, sludge, or manipulation of the sphincter of Oddi, usually as an iatrogenic effect of ERCP, stent placement, or percutaneous drainage, but bacterial ingress can be spontaneous. *E. coli* is the most common gram-negative bacteria, followed by *Klebsiella* and *Enterobacter* species. *Enterococcus* species may also be responsible. Occasionally a mixed picture with anaerobes occurs (**Table 4**). *Ascending cholangitis is a medical emergency that requires immediate evaluation in an ED*.

Pancreatitis

Acute Pancreatitis

Acute pancreatitis is an inflammatory process that can range from mild to severe. Mild cases can resolve with minimum treatment and have a mortality rate of <1%, whereas severe cases can result in multiorgan system failure, with death rates of 20% to 30%. Gall-stones are the leading cause cause (35%–40%) of pancreatitis (**Table 5**), followed by acute or chronic alcoholism (20%); idiopathic (15%–20%); ERCP (5%); elevated triglycerides (1%–4%); and drugs (1%–2%).

The incidence of pancreatitis has been increasing, perhaps because of the increasing incidence of obesity and, by extension, gallstones.⁷ Acute pancreatitis is responsible for \$2.2 billion in U.S. health-care expenditures yearly.

The pathophysiology of pancreatitis relates to the unregulated activation of trypsin within the pancreatic acinar cells, as well as to a lack of elimination of excess trypsin. The trypsin spills into the interstitial and endothelial spaces, causing autodigestion of the gland and pancreatic injury. The result is inflammation, acinar necrosis, pseudocyst formation, and pancreatic abscess, or phlegmon. The inflammation and release of mediators may cause damage to surrounding as well as distant structures, initiating the systemic inflammatory response syndrome, multisystem organ failure, and death.

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Table 5. Causes of Pancreatitis		
 Gallstones Alcohol Idiopathic Hypertriglyceridemia Endoscopic retrograde cholangiopancreatography Drugs Autoimmune disease Genetic disorders Abdominal trauma Postoperative complications Bacterial infections (<i>Legionella</i>, <i>Leptospira</i>, <i>Mycoplasma</i>, <i>Salmonella</i>) Parasitic infections (<i>Ascaris</i>, <i>Cryptosporidium</i>, <i>Toxoplasma</i>) 	 Viral infections (mumps, coxsackievirus, cytomegalovirus, echovirus, hepatitis B virus) Hypercalcemia Hyperparathyroidism Ischemia Penetrating peptic ulcer Scorpion venom Organophosphates Pancreatic tumor Pancreas divisum Sphincter of Oddi dysfunction 	

Gallstone pancreatitis is caused by passage of gallstones through the cystic duct into the distal common bile duct, where they obstruct the biliary and pancreatic ducts. This obstruction and resulting dilation of the ducts causes inflammation, which activates the process of pancreatitis. Incidence is highest in patients with small gallstones or sludge because these materials are more likely to proceed as far as the common bile duct. Gallstone pancreatitis is more common in Caucasians, Hispanics, and American Indians. Obesity is not only a risk factor; obese patients are more likely to have more severe disease. Pregnancy is also a risk factor for gallstone pancreatitis.⁷

The incidence of alcohol-related acute pancreatitis peaks between the ages of 35 and 44 years. The risk of death is also higher in this group, perhaps because of poor baseline nutrition.

Idiopathic pancreatitis is more common in patients of African heritage.

Pancreatitis occurring after ERCP, or iatrogenic pancreatitis, occurs in about 3.7% of patients undergoing the procedure, although individual risk factors also play a role. Iatrogenic pancreatitis may also occur after abdominal surgery, cardiac surgery, liver biopsy, and abdominal procedures performed by interventional radiologists. Hypercalcemia from TPN may also be an iatrogenic etiology of pancreatitis.

Elevated triglyceride levels can be seen in familial disorders, the third trimester of pregnancy, poorly controlled type 2 diabetes, alcoholism, and hypothyroidism. Triglyceride levels can be falsely elevated during an episode of acute pancreatitis, so levels should be tested again after the pancreatitis has resolved.

Hypercalcemia is also a recognized etiology of pancreatitis, and it can be seen in malignancy, TPN, sarcoidosis, vitamin D toxicity, and as a complication of cardiopulmonary bypass.

Because of the strong relation of drugs to pancreatitis, it is important to obtain a thorough medication history for all patients presenting with pancreatitis, especially those whose disease is of an unclear etiology (**Table 6**). To be considered drug-induced, the pancreatitis must occur while the patient is taking the drug and resolve when the drug is stopped.

Rare causes of pancreatitis include autoimmune disease, trauma, ampullary carcinoma, intraductal papillary mucinous neoplasm of the pancreas, pancreas divisum, and other congenital anomalies of the pancreas.

If the underlying cause of pancreatitis is not identified and treated, the risk of recurrent pancreatitis within 6 years may be as high as 40%.⁷ If gallstone pancreatitis is recognized and the gallbladder is removed, the risk is reduced to 10%.

Patients presenting with pancreatitis will give a medical history that is based on the underlying disorder. For example, a patient with gallstone pancreatitis will present with symptoms of biliary colic. A patient with iatrogenic pancreatitis may present after having undergone ERCP the day before. A patient with drug-induced pancreatitis will have recently started taking a new medication or an increased dose. Alcoholic pancreatitis may be preceded by a binge or even a single alcoholic drink. Pancreatitis is heralded by a constant, boring⁵ midepigastric abdominal pain radiating through to the back, frequently accompanied by nausea and vomiting. The pain may radiate to other areas of the abdomen, and its intensity can vary from minor to severe. Abdominal distention or bloating is a common symptom, because patients can often develop ileus. Patients usually feel better sitting up with the knees bent than they do when lying flat.⁵

On examination, the patient may be in moderate distress from pain. Low-grade fever, tachycardia, and hypotension are often present. Midepigastric abdominal tenderness is usually present. Peritonitis, if present, is generally a late finding because of the retroperitoneal location of the organ. Bowel sounds may be diminished if ileus is present. Cullen sign is a traditional finding of bluish discoloration around the umbilicus, and Grey Turner sign is a bluish discoloration of the flanks rarely seen with hemorrhagic pancreatitis. As the patient becomes sicker, signs of multiorgan system failure, such as respiratory distress, third-spacing, and decreased urine output, may occur.

The mainstays of laboratory testing for pancreatitis are amylase and lipase levels. These are both digestive enzymes normally found in the pancreas whose serum levels increase as the pancreas becomes inflamed. Unfortunately, low levels of amylase may also be found in numerous other tissues and neoplasms, making a finding of an elevated amylase level less specific for pancreatitis. Amylase levels rise quickly and return to normal within 3 to 4 days of resolution of pancreatitis. Lipase level, however, is much more specific and more accurate in the diagnosis of pancreatitis. Its rise is also rapid, but it may take 7 to 14 days to return to baseline. It is the preferred test for pancreatitis. There is no benefit to ordering both tests when evaluating a patient for pancreatitis. It should be noted that the levels of amylase and lipase do not correlate to the severity of disease.

Plain radiographs in the setting of pancreatitis are useful only for excluding other disease processes that may be responsible for the patient's symptoms. Ultrasono-

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Table 6. Drugs Commonly Associated with Pancreatitis

• Azathioprine	 Sulfasalazine
 Valproic acid 	 Furosemide
 Mercaptopurine 	 Rifampin
• Mesalamine	 Carbamazepine
• Estrogens	 Acetaminophen
• Opiates	• Enalapril
 Tetracyclines 	 Hydrochlorothiazide
• Steroids	 Erythromycin
• Trimethoprim-sulfamethoxazole	

graphy is useful if it is thought that the pancreatitis is due to gallstones, whereas it is less useful in nonbiliary etiologies. Computed tomography scanning provides superior anatomic definition, especially when grading disease and when looking for abscess. It may be less useful in mild or early disease. ERCP may be useful in those patients in whom the etiology is unclear.

The Ranson criteria (**Table 7**) for determining the prognosis of pancreatitis have long been used to attempt



0

Table 7. The Ranson Criteria for Prediction of Severity

in Acute Pancreatitis		
Criteria	Values	
On admission		
• Age (y)	>55	
• WBC count	>16,000/mm ³	
Blood glucose level	>200 mg/dL	
• LDH level	>350 U/L	
• AST level	>250 U/L	
At 48 hours		
• Hematocrit	Decrease by ≥10%	
BUN level	Increase by >5 mg/dL	
• Serum calcium level	<8 mg/dL	
• Po ₂	<60 mm Hg	
• Base deficit	>4 mEq/L	
• Fluid sequestration	>6 L	
The presence of 1 to 3 criteria indicates mild pancreatitis; mortality rate increases when > 4 criteria are met. AST = aspartate aminotransferase; BLIN = blood urea		

when ≥4 criteria are met. AST = aspartate amind partreadus, mortanty rate increases introgen; LDH = lactate dehydrogenase; WBC = white blood cell. Adapted from Ranson JH, Rifkind KM, Roses DF, et al. Prognostic signs and the role of operative management in acute pancreatitis. *Surg Gynecol Obstet* 1974;139:69–81.

to predict poor outcome, but research has shown them to have a poor predictive value that does not improve on clinical judgment.⁵ Many other scoring systems have been developed, but similar to Ranson, they have not shown any clinical usefulness.⁸

The majority of patients with suspected or confirmed pancreatitis seen in an urgent care center should be sent to an ED for further evaluation.

Ninety percent of all patients with pancreatitis recover without complications and with the use of only supportive measures. The mainstay of treatment is to rest the pancreas by withholding oral intake, although in mild cases, patients can be given clear liquids. Adequate intravenous hydration should be provided to keep urine output at about 100 mL/h. Patients in unstable condition should be treated with aggressive supportive measures and may require treatment in an intensive care unit. Adequate pain medication and antiemetics should be provided. Patients with biliary disease should be treated accordingly. Empiric antibiotics are not recommended except in severe disease.

Chronic Pancreatitis

Chronic pancreatitis is a relapsing and remitting disease process that in most cases is not a complication of acute pancreatitis. Alcohol abuse is the most common etiology, with an idiopathic etiology accounting for most of the remaining cases. Patients may present with acute exacerbation of chronic pain. The pain is similar to that in acute pancreatitis: midepigastric abdominal pain radiating to the back. Patients may have nausea and vomiting. The episode may be precipitated by alcohol ingestion. Patients who have had pancreatitis for some time may appear chronically ill, with wasting, clubbing, and possibly stigmata of chronic liver disease. Abdominal tenderness may be less prominent. Amylase and lipase levels may be elevated, but they may also be normal in long-term disease.

When patients with chronic pancreatitis present with abdominal pain, other conditions should first be ruled out, and exacerbation of chronic pancreatitis should be a diagnosis of exclusion. Patients should be assessed for hydration status and be given pain medication. If pain or emesis cannot be controlled orally, they may need assessment in an ED for possible admission.

Conclusion

Upper abdominal pain is a common presentation in urgent care centers. Assessing for and ruling out the more serious illnesses is the key to successful management. Patients with red-flag symptoms should be sent to an ED in a timely fashion. Pain management and hydration status are important in all causes and should be evaluated and treated accordingly.

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Practice Management

Six Elements of a Winning Patient Experience

Urgent message: Successful urgent care centers depend on repeat visits from loyal patients, but if patients do not like the experience provided, do not value it, or do not think it meets their needs, they will not come back. Cultivating a loyal following entails understanding and building a service offering around the factors that attract patients and keep them coming back.

ALAN A. AYERS, MBA, MAcc

rgent care is differentiated from other medical practices because the term refers not to a specific disease state but instead to a delivery channel for general medicine that is based on consumer preferences for convenience, accessibility, and affordability. Therefore, urgent care is necessarily retail in its orientation, and so the main job of the urgent care operator is to cultivate repeat visits and positive word of mouth from satisfied patients.

The Value of Repeat Business

Just like any other retail business, urgent care centers will be successful by building a base of loyal clients. These are patients who view the center as their preferred place to go whenever a medical need arises. Given the costs of acquiring a new patient—including paid advertising and grassroots marketing tactics—a center likely does not profit from a patient's first visit. Future visits by that same patient are incrementally more profitable as the initial advertising costs become sunk costs. Because of patient-acquisition costs, it is always cheaper



to keep the patients you have than to attract completely new patients from the community.

Ideally a center's volume should grow organically, as new patients see the center's signage and advertising, as established patients return for additional services, and as word of mouth spreads. A center that is seeing flat or declining visit trends is likely suffering the consequences of patients who either did not care for the experience or who are sufficiently ambivalent about it that they are

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operator, because loyal patients tend to return more often, utilize more services, and make positive recommendations to others. If patients do not like the

Patient retention should therefore

be a key focus of the urgent care

experience provided, do not value it, and do not think it meets their needs and expectations, they will not come back. Providing a winning patient experience starts with understanding patients' perceptions of quality and value and the elements that attract patients and keep them coming back.

Six Elements of a Winning **Patient Experience**

Award-winning customer service organizations take a multidimensional approach to responding to customer needs and expectations while still making a profit. For urgent care, the ideal experience should entail no wait, no waste, and no hassle. Understanding the 6 factors (Figure 2) that determine quality and value in the eves of patients can help the urgent care operator plan a patient experience that will result in repeat business and positive word of mouth.

Convenience

The term *convenience* generally refers to the physical location and operating hours of the urgent care center. As a retail delivery channel, urgent care typically seeks high-visibility loca-

open to try a competing alternative (Figure 1).

If a patient refuses to return to an urgent care center, that patient has to be replaced by a new patient off the street, which requires further advertising investments by the center. If a center's reputation is bad enough, over time there will be insufficient numbers of people who are unfamiliar with the center and willing to give it a try. tions near patient homes, hospital emergency departments, or offices of referring medical providers.

Location naturally entails a strong retail draw-bigbox or food or drug strip centers-that patients patronize frequently. Such regularity of exposure contributes to top-of-mind awareness, meaning when patients have a medical need, they will think of the center. High traffic



counts and strong signage visibility enhance the effectiveness of other advertising activities by contributing to overall awareness.

Studying population density and household demographics can help identify the trade areas with the most available business (including the number of prospective patients whose insurance the center accepts). Understanding the locations and offerings of competing urgent care centers, pharmacy-based clinics, freestanding and hospital emergency rooms, and extended-hours primary-care offices can help position the urgent care center as the most convenient option.¹

In addition to the physical location, the on-demand nature of urgent care makes operating hours a convenience factor for patients. Especially for busy professionals, including parents with multiple school-aged children at home, urgent care is appealing because it allows them to show up without an appointment and be seen quickly by a physician. Thus, many urgent care centers are open evenings, weekends, and holidays, when access to primary care may be limited. Although urgent care is generally thought of as walk-in service, centers are increasingly adopting hybrid schedules with some appointments to flatten ebb and flow (thus reducing wait times) by shifting rechecks, physical examinations, vaccinations, and other prearranged services to nonpeak times.

Efficiency

The term *efficiency* refers to the time and effort patients invest in their urgent care visits. Patients do not like waiting, and they do not like hassles.² Both situations make patients feel helpless. In general, patients expect a "quick in, quick out," with a total time in center not to exceed 1 hour, and they expect transparency in the center's processes. A center's systems, operating policies, and culture should therefore be focused on moving patients through the center in a timely manner.

When wait times are inevitable, centers should not only frequently communicate information about the expected wait to patients but they should also empower patients by shifting the wait outside of the center by offering preregistration via the Internet, posting wait times online, providing call-ahead scheduling, and noting a patient's cell number and then texting them when it is their turn to be seen by a health-care provider. Web portals and smartphone applications can facilitate communication with patients about such issues as availability of the patient's chart and making payment after the visit.

"Traffic through every urgent care facility should flow well, taking patients through the building in a logical sequence, minimizing the number of steps for patients and employees, and providing sufficient waiting room seats and parking spaces for the expected patient load."

Efficiency also requires a smooth financial transaction. The center's front desk should have a list of all innetwork plans, and all staff members should be skilled in explaining common insurance terminology to patients. The center should verify a patient's eligibility and collect any co-payment, co-insurance, or deductible up front so the patient receives no unexpected bills after the visit. For the uninsured, self-pay pricing should be transparent, logical, and easily explained prior to the clinical encounter. Any billings after the visit should be prompt, accurate, and presented in a format patients can understand.

The opposite of *efficiency* could be *error*, which requires rework that distracts providers and staff members from serving the patients currently in the center. Given the thin margins in many urgent care centers, a single error may wipe out the entire profitability of any particular patient visit, such as if a patient has to be seen multiple times, if paperwork has to be redone, or if accounts receivable balances grow because of uncollectables. A culture of prevention entails active management—monitoring metrics and taking immediate actions to change business outcomes by the end of day—and standard operating procedures that reinforce existing processes and provide context and a framework for integration of new processes.

Appealing Facilities

Patients are generally unqualified to evaluate the clinical quality of medical services received, so they make inferences that are based on the appearance of the physical facility, the appearance and behavior of providers and staff members, and other factors they can see and feel. An appealing facility must be clean, so it is essential that there be a checklist to ensure that the center's janitorial contractor is doing a thorough job, that there is no clutter in rooms or public areas, that there is no ad hoc paper signage, and that the physical plant and furnishings, fixtures, and equipment are modern, in good repair, and in working order.

The importance of cleanliness to cultivating repeat visits and positive word of mouth cannot be overestimated.³ Just review the Yelp or Google

comments for urgent care centers in your area, and you will find some unflattering photos taken in those centers. Photos and video—accessible via nearly every patient's cell phone—are apt to go viral via email and social media, potentially damaging a center's reputation for years. For example, in September 2014, a Dayton (Ohio) television station reported that an urgent care center misdiagnosed one patient's fracture and that the patient's mother provided an image of a dirty sink in the center, which led to state lawmakers asking why urgent care centers are not specifically regulated in Ohio.⁴

Traffic through every urgent care facility should flow well, taking patients through the building in a logical sequence, minimizing the number of steps for patients and employees, and providing sufficient waiting-room seats and parking spaces for the expected patient load. Further, many urgent care operators invest in amenities like Wi-Fi; television, newspapers, and magazines; complimentary coffee, bottled water, and snacks; and libraries and children's play areas to enable productivity and help time pass more quickly for patients.

Relationship Management

Health care is a relationship business, and when patients select an urgent care center as their first-choice provider, they typically see the center as an entry point to a community's health-care resources. To ensure continuity of care for patients with conditions that are more complex than those the center typically handles, urgent care providers should maintain referral relationships with diagnostic imaging facilities as well as with practitioners in dermatology, allergies and immunology, podiatry, and orthopedics, among other specialties. In addition, because of the increasing number of patients with unmanaged chronic conditions such as type 2 diabetes, chronic obstructive pulmonary disease, and hypertension, urgent care

When patients feel that a

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word of mouth, reduced

patient compliance, and in-

creased malpractice claims and

complaints to licensing and

regulatory agencies.

centers should maintain a list of primary-care providers willing to take patients with longterm needs. Helping a patient get an appointment and forwarding the patient's chart and insurance information-with the patient's consent-can help ensure that follow-up actually occurs. For patients who already have a primary-care provider, the center should sustain a relationship with that provider, promptly communicating with the provider and sharing records as appropriate.

"The amount of time a provider spends with the patient, the questions the provider asks of the patient, how actively the provider listens to and addresses the patient's concerns, and the manner in which the provider speaks to patients have significant bearing on the patient's perceptions of that provider."

In integrated hospital systems, collaboration among facilities, specialists, and primary-care providers is often centrally coordinated and facilitated by a shared electronic medical record. For most independent urgent care physicians, however, developing professional relationships requires a deliberate effort to reach out to peers, explain the benefits of working with the urgent care center, and emphasize that urgent care is not out to steal patients but instead to be a tremendous source of referrals.

Clinician Face Time

Urgent care patients should feel like they are receiving high-quality care and should not feel rushed. The amount of time a provider spends with the patient, the questions the provider asks of the patient, how actively the provider listens to and addresses the patient's concerns, and the manner in which the provider speaks to patients have significant bearing on the patient's perceptions of that provider.⁵

Ultimately, it is up to urgent care clinicians to develop their own loyal following of patients, such that when patients return to the center they will ask for the particular provider by name. This means that urgent care providers need to consider the face that they project (including their appearance and demeanor) and how they personally may be perceived by patients.

The conundrum of urgent care providers is to move from room to room quickly—maintaining flow and minimizing wait times—while also spending the appropriate amount of time with each patient to hear their concerns, conduct an appropriate physical examination, diagnose their condition, devise a plan of medical treatment, and then document the encounter in the chart or electronic medical record.

Patient Satisfaction

Patients should feel like they are receiving friendly service, competent medical care, and a good value for their experience at your urgent care center. To ensure this, you should have a survey mechanism in place. Metrics enable managers to assess what is working and to change direction as necessary. Urgent care centers typically inquire about patient experiences via telephone surveys, mailed surveys, email surveys, comment cards in the center, kiosks at checkout, or some other mechanism. There are advantages and disadvantages to each method, including sample bias, statistical significance, and cost.

A common metric used in measuring patient satisfaction is the net promoter score, which is based on the question "On a scale of 1 to 10, how likely are you to recommend this urgent care center to family or friends?" The science is that patients who will actively recommend a business are patients who will be loyal themselves.⁶ Patients who answer the question using scores of 0 to 6 are considered detractors who will spread negative word of mouth, complain about the center on social media sites, file formal complaints with regulatory entities, and return only if they have no other option. Those who give scores of 7 or 8 are considered neutral, patients who are not necessarily dissatisfied with their experience but who are also likely to try a competing option next time. Patients giving scores of 9 or 10 are promoters who rave about their experience to others and intend on returning for care for their next medical need. The score is equal to the net of promoters over detractors—the percentage of respondents who are loyal to and actively promoting the urgent care center.

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"Patients should feel like they are receiving friendly service, competent medical care, and a good value for their experience at your urgent care center. To ensure this, you should have a survey mechanism in place."

Conclusion

Patients are looking for medical experiences that entail no wait, no waste, and no hassle. The rapid growth of urgent care in recent years has been attributed to centers that meet patient needs better than other settings do. As a retail delivery channel for general medicine, urgent care does not exist to solve a specific medical condition, and therefore it is always vulnerable if new competition arises that is more convenient, faster, and cheaper.

To survive and thrive, urgent care centers must focus on providing a better experience than other alternatives do, which entails the following:

- Basing decisions on what the patient wants and expects
- Thinking and acting in terms of the total patient experience
- Continuously improving all aspects of the patient experience.

The ultimate goal of the urgent care operator is to provide a patient experience that is sufficiently differentiated, adds enough value, and is so convenient, efficient, and clinically effective that patients would not think of going anywhere else for their medical needs, thus making urgent care the provider of choice in the community.

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Case Report Epiploic Appendagitis

Urgent message: Because pain in the lower abdomen is a symptom that can indicate many diseases, including acute appendicitis and acute diverticulitis, it is easy to misdiagnose epiploic appendagitis (EA). Thus, it is important that urgent care practitioners be able to distinguish EA from many other entities, especially because surgery presents the risk of complications.

MAY MOHTY, MD, FAAP, FAAUCM, and ANDREW WANG, MS-3

Introduction

An epiploic appendage is a fat-filled sac (1–2 cm thick and 0.5–5 cm long) that is found along the surfaces of the colon, primarily located in the transverse and sigmoidal regions (**Figure 1**). The human body contains anywhere from 50 to 100 appendages that run anteriorly and posteriorly in 2 rows parallel to the taenia coli (longitudinal muscles of the large intestine).¹ Epiploic appendagitis (EA), also referred to as appendicitis epiploica, hemorrhagic epiploitis, epiplopericolitis, or appendagitis, is an infection of an epiploic appendage.

Though the function of epiploic appendages is unknown, it is proposed that they may play a role in cushioning the colon as well as in immune responses. Each appendage is supplied by 1 or 2 colonic arteries and a small draining vein. Lymphatic channels run around an appendage or through it as a part of the mesenteric nodal system. Any torsion, elongation, irritation, or venous thrombosis of an appendage may impair the vascular supply and lead to an ischemic infarction, necrosis, and appendagitis.

Case Presentation

A 56-year-old Caucasian woman presented to our urgent



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care center with acute onset of right lower quadrant abdominal pain. The patient noted that these symptoms started a few hours before presentation and that the pain worsened with movement. She said that she had no fever, chills, nausea, vomiting, or diarrhea.

The patient had a medical history significant for diverticulitis, superior mesenteric vein thrombosis, hypercoagulopathy, a right breast mass, gastroesophageal reflux disease (GERD), anxiety, and hyper-

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cholesterolemia. She had a surgical history of left colon resection for recurring sigmoid diverticulitis and of cholecystectomy, appendectomy, tubal ligation, lumpectomy, and dilation and curettage. At the point when she presented to the urgent care center, she was taking a vitamin D_3 supplement, pantoprazole for GERD, and venlafaxine for anxiety. She reported no history of tobacco use, but she had a remote history of abuse of illegal drugs and of alcohol addiction.

Observations and Findings

At the patient's initial presentation, her vital signs were as follows:

- Oral temperature: 36.7°C
- Blood pressure: 112/73 mm Hg
- Heart rate: 77 beats/min
- Respiratory rate: 20 breaths/min
- Oxygen saturation: 95% on room air

Physical examination findings were significant for tenderness to palpation in the patient's right lower quadrant, with rebound tenderness and voluntary guarding. Bowel sounds were present in all quadrants, and there was no hepatosplenomegaly. All other findings on physical examination were benign.

Diagnostic Studies

The patient underwent a workup that included the following laboratory tests and imaging studies:

- Electrocardiography
- Complete blood count with differential
- Comprehensive metabolic panel
- Lipase test
- Troponin I assay
- Urinalysis
- Computed tomography (CT) of the abdomen and pelvis without contrast

An electrocardiogram was obtained because of the patient's midepigastric pain, but it showed a normal sinus rhythm. Findings for the complete metabolic panel and complete blood count were within normal limits, and urinalysis showed moderate amounts of blood and red blood cells. Troponin and lipase levels were also within normal limits and did not raise any suspicion of a myocardial infarction or acute pancreatitis.

The abdominal CT scan showed mild fat stranding in peritoneal reflection of the anterior abdominal fat, with a 9-mm confluent nodule of edema, new since a CT scan done 15 months earlier. The area of fat stranding was adjacent to the transverse colon. There was no thickening of the bowel wall and no obstruction. Findings were suggestive of a small area of fat necrosis or epiploic appendagitis (**Figures 2 and 3**).

Diagnosis

Epiploic appendagitis.

Course and Treatment

The patient was given a 1000-mL intravenous bolus of 0.9% sodium chloride, Zofran for nausea that developed during the course of her evaluation, and morphine as needed for pain. The patient was given prescriptions for Zofran and Percocet and then discharged home, with instructions to follow up with a gastroenterologist in 2 days and to go to an emergency department immediately if her symptoms worsened.

Two days after onset of symptoms, the patient had

complete pain resolution, and she has had no recurrences since then.

Discussion

Epidemiology

Epiploic appendagitis is reported in 2% to 7% of patients originally thought to have an acute diverticulitis and in 0.3% to 1% of those originally thought to have acute appendicitis.¹ EA occurs most often during the second through fifth decades of life, with patients having a mean age of 44.6 years (range, 12-82 years), and it is found four times more often in men than in women.² Though EA can occur in any part of the colon, it is most commonly found at the rectosigmoid junction (57%), followed by the ileocecal region (27%), ascending colon (9%), transverse colon (6%), and descending colon (2%). Appendages are found more commonly in obese individuals or those who have recently lost weight. Therefore, EA is more commonly found in these individuals as well.

Our patient was in the age range of most patients with EA, but location of appendages near the transverse colon, as was the case for her, is not common in EA.

Pathogenesis

As already mentioned, EA is caused by any torsion or elongation of an appendage or thrombosis of a vein within the appendage. When this occurs acutely, ischemia and infarction will occur, leading to fat necrosis. Gradual torsion results in chronic inflamma-

tion and thus chronic appendagitis, and it often has no clinical symptoms.

Clinical Presentation

Patients with EA present with localized, sharp, acute lower abdominal pain that is nonradiating and exacerbated with physical movement. Sixty percent to 80% of patients with EA have pain in the left abdomen. Patients also report postprandial fullness, bloating, vomiting, early satiety, diarrhea, and sometimes a low-grade fever. However, symptoms vary and are often vary among patients. Symptomatically, patients with EA have a presentation that is almost identical to that of patients with acute appendicitis (right-side abdominal pain) or acute diverticulitis (left-side abdominal pain).

In 10% to 30% of patients with EA, physical exami-

Figure 2. Computed tomography scan of the abdomen showed mild fat stranding (*arrow*).



Figure 3. Findings on a computed tomography scan of the abdomen were suggestive of fat necrosis or epiploic appendagitis (*arrow*).



nation findings are benign, besides the abdominal pain, with occasional guarding and a palpable mass. White blood cell count, erythrocyte sedimentation rate, and C-reactive protein levels are usually normal but may be mildly elevated because of inflammatory responses.

Our case is unique because of the abnormal presentation of pain in the right lower quadrant instead of the more common left abdomen location. The patient's initial presentation would normally have led us to suspect acute appendicitis, but because she had already undergone an appendectomy, this was ruled out. Acute diverticulitis was also suspected, but the patient presented with pain in the right lower quadrant instead of the left lower quadrant, where most acute diverticulitis presents. Furthermore, abdominal CT scan findings ruled out diverticulitis. The patient's white blood cell count, erythrocyte sedimentation rate, and findings on endoscopic retrograde pancreatography were all normal, and no mass was palpated on physical examination.

Diagnosis

EA is most often an unexpected diagnosis in patients undergoing imaging for acute abdominal pain or undergoing laparotomy. Furthermore, because EA presents similarly to acute appendicitis and acute diverticulitis, it is usually a diagnosis by exclusion when other causes of acute lower abdominal pain are ruled out.³ Abdominal CT is the preferred methodology for diagnosis, but abdominal ultrasound is an option if CT is not available.

Abdominal CT scans showed a fat-density ovoid structure of 1.5 to 3.5 cm in diameter, with a thin, highdensity rim adjacent to the colon and with a thickened peritoneal lining and surrounding inflammatory fat stranding. Often, a central hypodense dot is present in such structures, representing the thrombosed vasculature. In chronic EA, calcification of the infarcted appendage may occur, and it may detach and become an intraperitoneal loose body.²

Abdominal ultrasound showed that this patient had an oval, noncompressible, solid, hyperechoic mass with a subtle hypoechoic rim directly under the site of maximum tenderness. Doppler studies showed no central blood flow in the appendage but normal blood flow in the hyperechoic inflamed fat surrounding the appendage.

Differential Diagnosis

The differential diagnosis for EA can be long, consisting of any pathology that leads to lower abdominal pain. However, the clinical presentation along with physical examination findings will most often cause confusion of EA with acute appendicitis and acute diverticulitis.^{4,5} Most of the time, an abdominal CT scan can help differentiate between these 3 entities. Patients with acute appendicitis will most likely have fever, nausea, vomiting, and lower right abdominal pain. CT imaging will show a dilated appendix >6 mm, appendiceal wall thickening (>2 mm), periappendiceal fat stranding, and thickening of the cecal apex. CT imaging of acute diverticulitis shows thickening of the colon and paracolic fat stranding. The patient with diverticulitis will usually have a history of diverticulosis as well. Here are other etiologies to include in the differential diagnosis:

- Mesenteric panniculitis
- Omental neoplasm
- Omental infarction
- Crohn ileitis

- Ectopic pregnancy
- Ovarian torsion
- Ruptured or hemorrhagic ovarian cyst
- Ileitis

Treatment

Only limited research has been done on treatment of EA. Some authors believe that it is a self-limiting condition and will resolve itself in 10 days, with a course of oral anti-inflammatory medicine and opiates if needed. However, there has been some controversy regarding research that hints at the recurrence of EA when it is treated conservatively instead of surgically. Some authors believe that surgical therapy is the only way to prevent recurrence and rare complications such as inflammation-induced adhesions and intussusception. Nevertheless, because of complications that come with surgery, operations are usually avoided unless absolutely indicated.

Disease Course

In general, EA is a benign and self-limiting condition that can resolve in 2 to 14 days without surgery.¹ The risk of recurrence is substantially low. and complication rates are even lower. Under very rare circumstances, an epiploic appendage can fall into a hernia sac and be strangulated or, as already mentioned, it can calcify and break off to become a foreign body in the peritoneal cavity (one of the most common sources of intraperitoneal loose bodies). Such appendages also may adhere to other parts of the abdomen and be mistaken for a neoplastic process.

Take-Home Points

EA is an underappreciated cause of acute abdominal pain. In the urgent care setting, it will most often be diagnosed during a work-up for suspected appendicitis or diverticulitis. The vast majority of patients with EA can be treated conservatively with analgesics and antiemetics. Referral to a surgeon should be considered when there are signs of strangulation and intussusception.

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CLINICAL CHALLENGE

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

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



The patient presented with an upper respiratory infection after vertebroplasty. A chest x-ray was ordered to rule out pneumonia.

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

Resolution of the case is described on the next page.

INSIGHTS IN IMAGES: CLINICAL CHALLENGE

THE RESOLUTION



Diagnosis: Cement embolus. Note several thin linear densities in the right mid-lung (*arrows* in **Figure 2**). These represent vertebroplasty cement particles that have embolized into distal pulmonary artery branches. Patients are usually asymptomatic and treatment is supportive, though sometimes anticoagulation or embolectomy may be required. Most cases resolve within 1 year. A computed tomography scan of the chest should be done to rule out cardiac complications, including perforation.



HEALTH LAW

Medical Malpractice Trial, Part 3: The Trial

JOHN SHUFELDT, MD, JD, MBA, FACEP

Recap of the Facts

ohnny Dalton presented to the emergency department (ED) at St. Jacob's Hospital after ingesting liquid methadone, a long-acting opioid. Responsive Emergency Medicine and Dr. Beth Ange evaluated and monitored Johnny for nearly 12 hours and discharged him home. Johnny was found dead by his family approximately 20 hours after discharge.

- Case name: John and Cathy Dalton v. Dr. Beth Ange and Responsive Emergency Medicine
- Decedent: Johnny Trey Dalton
- Attorney for plaintiff: Bernard Elliot Greyson, MD, JD
- Attorney for defendants: Cristy Chait, Esq.

Opening Statements

In medical malpractice trials, the plaintiffs go first. Greyson presented an emotional and sensationalized timeline of case events, showing how Johnny's family was dealing with his death. His recitation was an incredibly sanitized version of both the facts and Johnny's life. Greyson painted the decedent as a loving person on his way to becoming a professional skateboarder, untouched by drugs, violence, or alcohol, describing his death as a completely preventable occurrence caused by premature discharge from the ED. Little mention was made of the fact that Johnny actually obtained the drugs illegally and, in fact, took them to get high.

The defense's opening statement was sterile and to the point. Through pretrial motion practice, the court prevented the defense from bringing up Johnny's criminal background, his use of street drugs, his parents' calling the police on him for domestic violence, or that he had dropped out of high school. The only way to get these facts before the jury was for the plaintiff to bring them up. Although on the surface this

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John Shufeldt is CEO of Urgent Care Integrated Network and sits on the Editorial Board of the *Journal* of Urgent Care Medicine. He may be contacted at Jshufeldt@Shufeldtconsulting.com. "[The attorney for the plaintiff] presented an emotional and sensationalized timeline of case events, showing how Johnny's family was dealing with his death."

seems unfair, it prevents undue bias either for or against the parties for facts that are generally unrelated to the case.

The Plaintiff Presents

Greyson started with testimony from both grandmothers. First, the grandmother with whom the entire family lived described how Johnny's death affected her and the family, what a kind and gentle soul he was, how his room was always clean, and how he went out of his way to help her. Oddly, she stated that although she was nearly blind, her sense of smell was heightened and that she never smelled drugs on him. The other grandmother had similar glowing memories of Johnny. Chait's cross-examination was gentle, direct, and short. There was little point in bullying the grandmothers, and bullying was not her style. Although both grandfathers were present, neither of them testified.

Next up was the decedent's mother. Greyson asked her about Johnny and the circumstances surrounding his death. According to the mother, Johnny was barely awake on the drive home from the ED and had to be carried into the house and put into bed. She did not say why, given the fact that he was so sick, that she did not check on him again until his death 22 hours later.

During the defense cross-examination, the wheels started to come off the bus. The mother contradicted herself multiple times. She also opened the door on the topic of his prior substance abuse and arrest, which allowed Chait to question every family member extensively about Johnny's past. She started what came to be the signature pattern of the plaintiff's witnesses: She recalled minute details when questioned by Greyson but said she could not recall anything when questioned by Chait.

HEALTH LAW

"The defense experts simply appeared more knowledgeable and more credible than the plaintiff's experts. The ED expert testified about the standard of care and ... did not stretch to reach conclusions...."

Greyson called Johnny's father, who stated that "no one told him anything" about the events leading up to Johnny's death and that the first time he was made aware of anything was when Johnny was found dead. Johnny's sister also testified. I felt sorry for her. She was clearly in way over her head. She told the jury that after she and her mom picked Johnny up from the ED, she pulled up at the home and dropped him off, and then went out to get food for her horses. Although seemingly trivial, this information contradicted the mother's testimony about having to carry Johnny into the house. While waiting for the elevator outside the courtroom, I heard her ask Greyson's assistant, "What did I do wrong?"

Johnny's best friend and brother also testified. Even though Johnny's brother had lived in the same room with him and even though Johnny's best friend had skateboarded with him "5 to 6 hours per day," neither person recalled anything about Johnny's life, drug usage, penchant for domestic violence, or the circumstances leading up to his death. Johnny's brother also testified that he did not know or could not recall why he took a video of Johnny during the middle of the night nor why, when he woke his mother, she would not come check on her son, who in the video looked like he was incredibly altered.

Next, Greyson called Dr. Ange. Although he did his best to try to bully her with condescension and rudeness, she remained calm, professional, and empathetic toward the parents during her 4 hours on the stand. Never once did she fall for Greyson's baiting.

Next came the plaintiff's experts. The ED physician testified that all methadone overdoses must be admitted, and the causation expert opined on all sorts of things, including postmortem drug distribution and the pharmacologic effects of methadone. Their testimony stayed consistent with their previous depositions and disclosures and was in agreement with every leading question asked by Greyson.

The ED expert drew a graph for the jury that he could not support with a literature citation. He said that despite the large amount of methadone found in the patient's stomach after his death and despite the fact that the patient was in stable condition during his 11-hour stay in the ED, his death was due to respiratory compromise caused by the *initial ingestion* occurring at least 33 hours prior.

The Defense Presents

In short, the defense experts simply appeared more knowledgeable and more credible than the plaintiff's experts. The ED expert testified about the standard of care and, like Dr. Ange, he remained calm and professional despite bullying by Greyson during cross-examination. Unlike the plaintiff's expert, he did not stretch to reach conclusions, and he did not believe that Dr. Ange breached the standard of care.

Our toxicology expert did a fantastic job educating everyone in the courtroom about methadone and its effects. He also showed graphs from one of his toxicology textbooks that contradicted the ED expert's hand-drawn graph on methadone metabolism. Moreover, he was unflappable during cross-examination.

Rebuttal

Greyson tried one last time to rehabilitate the mother in the eyes of the jury, bringing her back to the stand, but it did not seem to work. Instead of hammering her on every contradiction, Chait let jury members decide for themselves the credibility of the witness. Finally, Greyson presented a computer forensic expert who was simply an underemployed attorney moonlighting as a computer specialist. His testimony was odd, confusing, and without basis.

Closing Statements

Unlike during the rest of the trial, the courtroom was packed with Johnny's friends and family during Greyson's closing. During the rest of the trial, Greyson had talked down to the jury, and his closing was no exception. He made a heartfelt plea for the jury to give closure to the aggrieved parents in the form of money. In contrast, Chait's closing consisted of a skillfully prepared slide show about the events, facts, witnesses' testimony, and supporting literature.

Jury Instructions

One very important issue remained. In Arizona, the burden of proof for medical negligence claims was raised at one point to "clear and convincing" from "more likely than not"¹ [the italics are mine]:

A.R.S. 12-572. Burden of proof for treatment in emergency departments or rendered by on-call providers

A. Unless the elements of proof contained in section 12-563 are established by clear and convincing evidence, a health professional as defined in section 32-3201 who provides or who is consulted to provide services to a patient of a licensed hospital in compliance with the emergency medical treatment and labor act (P.L. 99-272; 100 Stat.

¹Arizona State Legislature. Arizona Revised Statutes: Title 12—Courts and Civil Proceedings; Article 1—General Provisions. © 2007 Arizona State Legislature [cited 6 April 2015]. Available from: http://www.azleg.state.az.us/FormatDocument.asp? inDoc=/ars/12/00572.htm&Title=12&DocType=ARS.

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"Despite the hundreds of thousands of dollars and the 2 years of angst needlessly spent on the trial, I would not have missed it. For me, it was an education in both how to be a better lawyer and how not to practice law."

164; 42 United States Code section 1395dd) or as a result of a disaster *is not liable* for any civil or other damages as a result of any act or omission.

B. Unless the elements of proof contained in section 12-563 are established by clear and convincing evidence regarding the acts or omissions of a licensed hospital or its agents and employees in cases that are covered by subsection A of this section, the hospital is not liable for any civil or other damages as a result of any act or omission.

For reasons I still do not understand, Greyson argued that statute 12-572, which was signed into law a year before Johnny's death, did not apply to this case. The judge ruled otherwise.

The Verdict

On the first vote, 6 of the 8 jurors voted for the defense. The other 2 jurors were undecided. Because only a majority was required, no more votes were taken and no further discussion ensued. When the jury returned to the courtroom, the plaintiffs and their friends were gone. Even Greyson's paralegal was absent. Greyson sat alone at the table and listened to the verdict.

Afterward, Chait talked with the jurors. They told her that they simply did not believe Johnny's mother, family members, or friends and that they thought Greyson was consistently condescending and rude, starting with his opening statement. They made it clear that they respected and believed Dr. Ange and the defense experts.

Commentary

Despite the hundreds of thousands of dollars and the 2 years of angst needlessly spent on the trial, I would not have missed it. For me, it was an education in both how to be a better lawyer and how not to practice law. As much as I would like to have the time and money back spent on defending our partner and group, I remain thankful that our legal system ensures that anyone with a grievance, whatever its validity, can argue their case before an unbiased judge and jury. However, the tale of Johnny Dalton is not over. As this was written, Greyson's team was demanding a new trial. I may have more updates in the months to come.

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ABSTRACTS IN URGENT CARE

- Opiates: Not Go-To Pain Controllers in Children
- Pregnancy Tests Are Underused in Women Receiving Potentially Harmful Medications
- Legality of Expedited Treatment of Sex Partners

- Still Necessary to Watch for Tetanus
- Trimethoprim–Sulfamethoxazole
 Versus Clindamycin
- Is Early Imaging Really Needed in Older Adults with Low Back Pain?

SEAN M. MCNEELEY, MD

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

Opiates: Not Go-To Pain Controllers in Children

Key point: Once again, opiates prove inferior for pain control in children.

Citation: Kelly LE, Sommer DD, Ramakrishna J, et al. Morphine or ibuprofen for post-tonsillectomy analgesia: a randomized trial. *Pediatrics*. 2015;135:307–313.

The potential for overuse of opiates is a frequent concern. This study compared opiates to ibuprofen for pain control. A total of 91 children were randomized to receive a combination of morphine and acetaminophen or a combination of ibuprofen and acetaminophen after tonsillectomy, which was performed to treat the children for pediatric sleep disorder. Patients receiving ibuprofen had fewer desaturations during sleep than the morphine group and no difference in pain control. This is additional evidence that ibuprofen is at least as good as opiates for pain control in children.

Pregnancy Tests Are Underused in Women Receiving Potentially Harmful Medications

Key point: Check for pregnancy before prescribing teratogenic medications.



Sean M. McNeeley, MD, is an urgent care practitioner and Network Medical Director at University Hospitals of Cleveland, home of the first fellowship in urgent care medicine. Dr. McNeeley is a founding board member of UCCOP and vice chair of the Board of Certification of Urgent Care Medicine. He also sits on the *JUCM* editorial board. Citation: Goyal MK, Hersh AL, Badolato G, et al. Underuse of pregnancy testing for women prescribed teratogenic medications in the emergency department. *Acad Emerg Med*. 2015;22:192–196.

In this retrospective cross-sectional study, investigators attempted to determine how often pregnancy tests are given before prescribing category D and X medications to women of childbearing age. Data for almost 40,000 patients were reviewed. Only 22% of these patients were given a pregnancy test before being prescribed medications. The most common prescriptions were for benzodiazepines, antibiotics, and antiepileptics. For urgent-care physicians, these findings are a good reminder to check whether patients of childbearing age are pregnant before prescribing potentially harmful medications to them.

Legality of Expedited Treatment of Sex Partners

Key point: Know your state laws on express treatment for sex partners.

Citation: Hodge JG Jr, Pulver A, Hogben M, et al. Expedited partner therapy for sexually transmitted diseases: assessing the legal environment. *Am J Public Health* 2008;98:238–243.

Sexually transmitted infections continue to be a great public health concern, creating morbidity and occasionally even mortality. One effort to reduce the transmission of these diseases is expedited partner therapy (EPT). The article describes EPT as the "delivery of medications or prescriptions by persons in-

ABSTRACTS IN URGENT CARE

"[Expedited partner therapy is the] 'delivery of medications or prescriptions by persons infected with an STD to their sexual partners without prior clinical assessment of those partners.'"

fected with an STD to their sexual partners without prior clinical assessment of those partners." This treatment method makes practical sense but may have medicolegal consequences. The article reviews the legal environment for this type of care. Back in 2005, a survey of medical boards showed that EPT was considered illegal or questionable. The authors have now reviewed current state laws regarding EPT. Twelve states expressly allow it, 13 expressly prohibit it, and the laws in the remainder are ambiguous. It is vital that acute-care providers know their state's laws, and checking for new state laws on a regular basis is very important before implementing EPT.

Still Necessary to Watch for Tetanus

Key point: Tetanus, although rare today, still occurs and can be fatal.

Citation: Yen C, Murray E, Zipprich J, et al. Missed opportunities for tetanus postexposure prophylaxis—California, January 2008–March 2014. *MMWR Morb Mortal Wkly Rep* 2015;64:243–246.

Although the number of cases of tetanus has dramatically reduced in the last 100 years, the disease still occurs. This article highlights the serious nature of the disease and how we can prevent it. In California between January 2008 and March 2014, 21 cases of tetanus were reported. Five of the patients died. Nine sought medical care, but only 2 were provided the appropriate postexposure prophylaxis. Of the 7 who were seen and not given proper prophylaxis, 1 had an anaphylactic reaction to tetanus but was not offered tetanus immune globulin, 5 had unknown tetanus vaccine histories and should have received tetanus immune globulin and vaccine, and the final patient had received a vaccine more than 10 years earlier but was not offered a vaccine booster dose. Also of note, exposures are not limited to metallic puncture wound injuries but also include working in soil with abrasions, animal bites, and any other breaks in the skin barrier. For the acute-care provider, a review of American College of Physicians guidelines for immunization and immune globulin after exposure is a good idea. It is also important to remember that recommendations vary on the basis of whether the injury is clean and uncomplicated. This article has a good, simple table (Table 3) that can serve as a reminder of the management of tetanus wounds.

Trimethoprim-Sulfamethoxazole Versus Clindamycin

Key point: Trimethoprim-sulfamethoxazole may be just as effective as clindamycin in treating certain skin infections. Citation: Miller LG, Daum RS, Creech CB, et al; DMID 07-0051 Team. Clindamycin versus trimethoprim-sulfamethoxazole for uncomplicated skin infections N Engl J Med 2015;372: 1093-1103.

Treatment of uncomplicated skin infections has changed since the 1990s because of the increasing incidence of infections caused by methicillin-resistant *Staphylococcus aureus* (MRSA). However, not much research has been done to help clinicians decide which antibiotic or antibiotics to use. This article reports on study a total of 524 patients enrolled into treatment with either clindamycin or trimethoprim-sulfamethoxazole for 10 days. All participants had cellulitis or abscesses that were drained. Clinical cure rates and side effects at 7 to 10 days were similar in both groups. No instances of infection with *Clostridium difficile* were noted. For the urgent care provider, this study is most interesting because the cure rate was only 80%, perhaps because there were causes of infection other than MRSA. For now, it looks like two-antibiotic therapy may still be best.

Is Early Imaging Really Needed in Older Adults with Low Back Pain?

Key point: Early imaging in low back pain may not be necessary even in older adults.

Citation: Jarvik JG, Gold LS, Comstock BA, et al. Association of early imaging for back pain with clinical outcomes in older adults. *JAMA* 2015;313:1143–1153.

Most guidelines suggest that early imaging in low back pain should be limited to adults older than 50 years. This concern is based on the greater risk in this age group of tumors or fractures. The study reported in this article assessed more than 5000 patients older than 65 years who had nonradiating low back pain and were evaluated either with or without early imaging, and it compared their outcomes at 1 year. Patients undergoing imaging were assigned to either a plain-film group or a computed tomography/magnetic resonance imaging group and were matched with control participants. The researchers found little difference between the groups in function or pain scores at 1 year, and they did not find a statistically significant difference between groups regarding more serious diagnoses such as cancer. However, the early-imaging group did have significantly higher costs and incidental unimportant findings that led to more tests and anxiety for these patients. The study's findings likely require confirmation, but they do put into perspective the risk involved in early imaging.



CODING Q&A

Rib Fractures, Joint Injections and Aspirations, Sports Physicals, and Tuberculosis Skin Tests

DAVID STERN, MD, CPC

What code do we use now to bill for closed treatment of a rib fracture?

In 2015, Current Procedural Terminology (CPT) deleted codes 21800, "Closed treatment of rib fracture, uncomplicated, each," and 21810, "Treatment of rib fracture requiring external fixation (flail chest)," because of lack of use. You are now to report closed treatment of an uncomplicated rib fracture using an appropriate evaluation and management (E/M) code.

We perform many joint injections and aspirations. Will the 2015 code changes affect how we bill these?

A. The phrase "without ultrasound guidance" was added to the arthrocentesis of small, intermediate, and major joint or bursa CPT codes 20600 (small), 20605 (intermediate), and 20610 (major). New codes were introduced in 2015 to represent these same procedures with ultrasound guidance:

- **20604:** "Arthrocentesis, aspiration and/or injection, small joint or bursa (e.g., fingers, toes); with ultrasound guidance, with permanent recording and reporting"
- 20606: "Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); with ultrasound guidance, with permanent recording and reporting"
- **20611:** "Arthrocentesis, aspiration and/or injection, major



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joint or bursa (e.g., shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting

If you do not use ultrasound guidance for your injections and aspirations, continue to use codes 20600 for small joints and bursa, 20605 for intermediate joints and bursa, and 20610 for major joints and bursa.

If you use guidance other than ultrasound, CPT instructs you to use codes 20600, 20605, and 20610 along with the appropriate code from the radiology section:

- 77002: "Fluoroscopic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device)"
- 77012: "Computed tomography guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), radiological supervision and interpretation"
- 77021: "Magnetic resonance guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), radiological supervision and interpretation"

What is the correct way to bill a school or sports physical? Are there specific CPT codes we can use? Our patients get upset when we bill our regular preventive medicine codes.

You could consider charging a flat fee for completing **1**. The examination and the school or sports physical form,

CODING Q&A

"Another option is to make the sports or school physical part of a well visit. Perform the physical on the basis of the requirement of the activity form presented, and . . . then continue with the well-visit examination."

without billing the insurance. Of course, you would need the patient or legal guardian to agree to pay the reduced fee and not file a claim with insurance.

Another option is to make the sports or school physical part of a well visit. Perform the physical on the basis of the requirement of the activity form presented, and document your findings on the form. Then continue with the well-visit examination and document all findings in the medical record.

In both cases, you would still use the age-appropriate codes and the codes for either new or established patients in the preventive medicine section, code range 99381–99397.

When giving a tuberculosis skin test, can we also charge for an injection?

A. This test is not a vaccine; rather, it is a screening test for the presence of an immune response, indicating the protein derivative (PPD). Use CPT 86580, "Skin test; tuberculosis, intradermal," for PPD testing in the office setting. This code includes the intradermal injection of the substance, so you would not bill separately for the injection.

The AMA Resource-Based Relative Value System (RBRVS) does not include the work for reading the test in calculating the reimbursement for CPT 86580. When the patient does return for a reading of test results, you may code 99211 for the reading done by a nurse. However, under incident-to regulations, a physician must be physically present in the office at the time of the reading to warrant a 99211 code.

If the test results are positive, you can code for the additional services rendered during the visit. Typically, the physician will engage in a face-to-face encounter with the patient for further evaluation and management (reviewing the diagnosis, performing a physical examination, assessing risk, determining the possibility of false positive test results, determining treatment options, etc.). You would use an appropriate E/M code (99212–99214). You should also code for any medically necessary additional testing (e.g., chest x-ray).

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

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DEVELOPING DATA

ata from the 2014 Urgent Care Chart Survey of 1,778,075 blinded patient visits to more than 800 different urgent care clinics, conducted by the *Journal of Urgent Care Medicine*, show that the top 3 conditions that patients reported at presentation were cough (10.9% of visits), sore throat (10.4% of visits), and pain of some kind (7.7% of visits).

The survey's methodology and data abstraction forms were initially designed in 2008 by researcher Robin M. Weinick, PhD, then an assistant professor at Harvard Medical School and a senior scientist at the Institute for Health Policy at Massachusetts General Hospital, and now associate director of RAND Health.

PRESENTING CONDITIONS DOCUMENTED IN PATIENT CHARTS AT U.S. URGENT CARE CENTERS IN 2014





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